

**Complementarity of individual-level and community-level
health promotion programmes:
A longitudinal and qualitative study of empowerment**

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Abstract

Health inequalities are the result of social inequalities and a major concern in the UK. In 1986 the Ottawa Charter for Health Promotion committed to tackling such health inequalities and defined health promotion as '*the process of enabling people to increase control over, and to improve, their health*', with the concept of empowerment at the centre. Health promotion approaches can be broadly categorised into top-down and bottom-up programmes. Tensions between these exist and the value of a balanced approach has been recognised. However, it is not well understood if and how participants of programmes that take such different approaches experience empowerment and, if they could complement one another.

This research was set in Stoke-on-Trent, a city with considerable health challenges and inequalities. Two 'real world' health promotion programmes were considered: (i) The Lifestyle Service (LS), a top-down individual-level programme; and (ii) My Community Matters (MCM), a bottom-up, community-level programme. Each was studied using longitudinal qualitative methods. Baseline interviews (n=23, LS; n=28, MCM) were analysed using thematic analysis. At one year, follow-up interviews were analysed using comparative analysis and following constructivist grounded theory (n=13, LS; n=17, MCM).

For the LS, the thematic analysis revealed three master themes at baseline (past experiences, expectations, and barriers), and a model with three categories at follow-up (identification, planning, and action). The LS was primarily experienced with a providing role similar to person-centred approaches. For MCM, the thematic analysis revealed two master themes at baseline (community deterioration and perspectives towards community improvement), and at follow-up a model with four categories (power influences, community deciding, acting, and consequences). This programme was experienced with a providing role by 'disengaged' residents, but with a role of enabling action by 'engaged' residents.

This provides novel insight into participant experiences of empowerment through individual- and community-level health programmes with recommendations of how such approaches can better collaborate and complement one another as part of an overall effort to improve health and reduce health inequalities.

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List of Presentations

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List of Acronyms

BME	Black and minority ethnic
CLI	Community-level intervention
CWLP	Commercial weight loss programme
ILI	individual-level intervention
IPA	Interpretative Phenomenological Analysis
LS	Lifestyles Service
LS professionals	Lifestyle coaches, fitness instructors, CWLP leads
MCM	My Community Matters
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
PCSO	Police community support officer
RCT	Randomised Control Trial
WHO	World Health Organisation

Chapter 1

Introduction

1.1. Introduction

This thesis presents a qualitative, longitudinal exploration of two different types of health promotion programme, which have the common aim of tackling health inequalities through improving the health of people in socially disadvantaged groups. Empowerment is common to both programmes and central to this thesis. This chapter sets the scene of the thesis, introduces the research questions and briefly outlines the structure of the thesis.

Chronic diseases including heart disease, stroke, chronic respiratory diseases, and diabetes are responsible for 60% of all deaths across the world (WHO, 2005). Health profiles of individuals occupying a 'lower' social position in society appear to be worse than individuals occupying 'higher' social positions (Marmot, 2010). The life expectancy gap at birth between males living in better-off and worse areas of England is 7.9 years, and 5.9 years for females.(White and Butt, 2015)

Health is socially patterned. This means that there is a gradual relationship between socioeconomic position and health at every social level (Graham, 2004a). Lifestyle behaviours also tend to follow a social gradient (Marmot, 2010). Lifestyle plays an important role in preventing chronic disease, reducing risk factors, and potentially preventing millions of deaths. Therefore, lifestyle is a way to improve health and, if targeted, reduce health inequalities. However, addressing lifestyle also involves the risk of interventions increasing the health inequality gap, given the challenge of eliciting behaviour changes in socially disadvantaged populations.

The next section briefly introduces the concepts of health promotion and empowerment as a way to tackling health inequalities.

1.2. Brief introduction to the concepts of health promotion and empowerment

Health promotion is the discipline that aims to prevent chronic diseases and reduce health inequalities, where institutions such as the World Health

Organisation (WHO) play a leading role and provide direction at a global level. The Ottawa Charter for Health Promotion defined health promotion as '*the process of enabling people to increase control over, and to improve, their health*' (WHO 1986, p.1), putting the concept of empowerment at the heart of health promotion. Empowerment is a multi-faceted term, with the core principle of helping people to take control. In the context of lifestyles, taking control involves individuals being enabled to make sustainable changes to their lifestyle, avoiding harmful behaviours (e.g., alcohol intake) and enhancing healthy behaviours (e.g., physical activity). In the context of socially disadvantaged groups, taking control involves righting power imbalances in society, as Freire (2000) suggested (cited in Cattaneo and Chapman (2010)).

The domain of health promotion gives direction through interventions which should be evidence-based and often focus on behaviour change at the individual level. The impact of these interventions has been extensively evaluated. One has the desire that individuals who have attended a lifestyle intervention take control over their own health independently and should not have to keep going back. However, the main conclusion has been that behaviour change interventions lead to short-term benefits (Vermeire *et al.*, 2009; Pavey, Anokye, *et al.*, 2011). This suggests that, although individuals can benefit from attending these interventions, real sustainable changes may not take place since individuals tend to not take control. Therefore, addressing the concept of empowerment and taking control over health (in the long term) seems a key consideration when addressing the limited effects of interventions that aim to improve population health.

More recently, the focus of health promotion has shifted away from individual-orientated interventions, towards interventions targeting changes of upstream factors as a means of reducing health inequalities (Laverack, 2004). These interventions are more aligned with addressing the social determinants of health (e.g., housing, unemployment), enabling individuals and communities to take control over their lives (Marmot, 2010). Empowerment is at the heart of such approaches, and so this has stimulated research activities to advance the understanding of it.

From a research perspective, empowerment in the context of health promotion has mainly been explored through philosophical and theoretical approaches (Skinner and Cradock, 2000). Some research has focused on the 'delivery' of empowerment, that means, from the perspective of programme facilitators or

health care professionals (e.g., Laschinger et al. 2010; Bravo et al. 2015; Kuokkanen & Leino-Kilpi 2000). Yet very little research has focused on how participants of health promotion interventions 'experience' empowerment, which will be the main focus of this thesis.

1.3. Tensions between health promotion approaches

Interventions that promote health through individual behaviour change have been criticised by those who believe that social determinants of health are not taken into account, and by those who disagree with approaches that inherently blame the individual for making wrong choices (Freudenberg, 1978; Minkler, 1989; Laverack, 2004). Accordingly, two types of health promotion interventions developed. First, there is the more traditional one, which literature often refers to as 'top-down', and tends to take place at an individual-level; and then there is the more recent approach, usually referred to as 'bottom-up', which often takes place at a community-level. There are further approaches to health promotion such as ecological or policy interventions that tackle social determinants, but these are beyond the remit of this PhD thesis. Chapter 2 will comprehensively characterise both types of approaches but the core principle is that these approaches have gone in considerably different directions. They are underpinned by different principles (lifestyle change versus social change) and are delivered by a different type of professional (e.g., health professionals versus community development workers). With the widening differentiation between both approaches, tensions between them exist (Laverack, 2004). Nevertheless, the value of a balanced approach that can integrate individual-related and social-related responsibility for health is recognised (Minkler, 2000), and there is a growing belief that the combination of different approaches is important to improve population health (WHO, 2010a). To date, there remains a poor understanding of how these approaches can complement one another as part of collective efforts to improve the health of the general population, and especially in the most disadvantaged groups, as a means of reducing health inequalities.

1.4. Research questions

Based on the recognition of this gap in the knowledge base, this research aims to address two overarching research questions:

Research question 1: *How is empowerment experienced by the individuals taking part in an individual- and a community-level health promotion programme?*

Research question 2: *How can individual- and community-level health promotion programmes complement each other from an empowerment perspective?*

Two ‘real world’ programmes that take place in a city with high levels of deprivation will be studied using a longitudinal and qualitative design to gain in-depth and independent insight into each of the approaches (individual-level and community-level). The longitudinal approach will involve baseline and one year follow-up stages for the study of each programme. The baseline stage will aim to explore participant expectations from the upcoming programme (aim 1), and the follow-up stage will aim to explore how empowerment was experienced by participants (research question 1). Afterwards, the complementary role of both programmes will be discussed (Chapter 9).

1.5. Outline of the thesis

This section outlines the content of each chapter to illustrate how the above research questions will be addressed.

Chapter 2 – Literature review: Examines the range of health promotion concepts relevant to this research, including health inequalities, health promotion and empowerment (at an individual- and community-level). It also reviews the current evidence-base relating to individual- and community-level health promotion interventions from two perspectives: health outcome and empowerment.

Chapter 3 – Contextualisation and background to research: Describes the setting for this research in terms of the city, Stoke-on-Trent, and the selected health promotion programmes, the Lifestyle Service (individual-level) and My Community Matters (community-level).

Chapter 4 – Methodology: Presents a rationale for using a qualitative research methodology and provides detailed information regarding the longitudinal design and methods of investigation.

Chapter 5 – Individual-level health promotion programme: Client expectations (and experiences) before the start of the programme. Provides a thematic analysis of baseline data to explore the expectations of regarding their upcoming participation in the Lifestyle Service. This insight aimed to explore participant perspectives at the start of the programme since a change of perspectives and experiences was expected between pre- and post-programme.

Chapter 6 – Individual-level health promotion programme: Client experiences from the Lifestyle Service at one year follow-up. Builds on Chapter 5 by presenting data from a one year follow-up to explore how the Lifestyle Service was experienced by those taking part (research question 1). A modified version of a constructivist grounded theory was used to develop a model (also referred to as substantive theory), which is presented with discussion of the proposed categories and relationships between categories.

Chapter 7 – Community-level health promotion programme: Resident expectations (and experiences) from My Community Matters at the start of the programme: Provides a thematic analysis of baseline data to explore what expectations clients had regarding their upcoming participation in My Community Matters. Like in Chapter 6, this insight aimed to explore participant perspectives at the start of the programme.

Chapter 8 – Community-level health promotion interventions: Resident experiences from My Community Matters at one year follow-up: Builds on Chapter 7 by exploring at one year follow-up the role of My Community Matters and how this role is experienced by individuals taking part. A modified version of a constructivist grounded theory was used to construct a second model (or substantive theory). The model includes a number of categories and relationships between categories that will be discussed against the literature.

Chapter 9 – Discussion and conclusions: Summarises findings from both longitudinal qualitative studies. Then research questions one and two are discussed, and the strengths and limitations of the research are considered. Future research and recommendations for practice are presented. The researcher process of reflexivity is explained, before ending with general conclusions.

Chapter 2

Literature review

2.1. Introduction

This research focuses on exploring how empowerment is experienced by participants of two different approaches for health promotion (top-down and bottom-up) and studying their complementary role. The first aim of this chapter is to provide context to the concept of empowerment, by reviewing the concept and its relevance for strategies that tackle health inequalities (section 2.3). The second aim is to provide, discuss, and define concepts associated with health promotion, empowerment, and approaches to health promotion, for which there is considerable variation in terminology (section 2.4). The final aim of this chapter is to provide a rationale for this research through reviewing the relevant evidence available (section 2.5).

First, a brief introduction to the concept of health will be provided, followed by a discussion of some of the relevant terminology.

2.2. A brief introduction to the concept of health

Before addressing the concept of health inequalities, it is necessary to define health. In 1948 the World Health Organisation moved away from seeing health as merely the absence of disease, defining it as '*a stage of complete physical, mental and social well-being*' (WHO, 2006). This definition has received criticism from the notion that individuals could still perceive themselves as healthy, even if their health status is incomplete, for example due to having a chronic disease, whilst perceiving themselves as still being able to achieve their personal objectives on a daily basis (Huber *et al.*, 2011; Gottwald and Goodman-Brown, 2012a). Modifications of the 1948 WHO definition have been suggested, which include a range of contemporary health challenges (Huber *et al.*, 2011), but the former is still considered as the operational definition of health.

Gottwald and Goodman-Brown (2012) reviewed later definitions of health and concluded that the concept relates to each individual, where individuals' considerations of whether or not they are healthy are affected by beliefs, health

dimensions, and determinants. First, health beliefs depend on gender, age, culture, socio-economic status, life stage and past life experiences (Gottwald and Goodman-Brown, 2012a). Second, a number of health dimensions must be considered: physical (body status), mental (psychological status), emotional (capacity to recognise and express emotions), social (capacity to engage with others), spiritual (capacity to recognise, express and practice own core beliefs), and sexual (capacity to recognise, express and practice sexual preferences). Finally, there are health determinants that fall outside the individuals' control (Gottwald and Goodman-Brown, 2012a), which will be covered in depth as part of the following section on health inequalities.

2.3. Health inequalities

This section includes a review of the literature on health inequalities to help understand health inequalities from a conceptual perspective, and to identify the causes and current thinking about how health inequalities can be addressed.

2.3.1. Understanding health inequalities

Health inequalities are extensive between and within countries, between different social groups and geographical regions (Whitehead, 1991; Marmot, 2005, 2010; WHO, 2008). Health inequalities have become a challenge worldwide (Marmot, 2005) and a governmental priority for many nations, with the UK playing an important role in raising awareness, research, and policy making (Marmot, 2001; Mackenbach, 2006). Social inequalities in health were first recognised in the 19th century across several European countries. Absolute health inequality figures between 'the poor' and the 'wealthy' have improved since then, but relative figures remained stable until the end of the 20th century, experiencing an unexpected decline afterwards (Mackenbach, 2006).

The publication of the Black Report by the Department of Health and Social Security (1980) was one of the first milestones for acknowledging health inequalities in the UK, but also on a European level (Marmot, 2001; Mackenbach, 2006). Although the Black Report was dismissed by the British Government at the time, it eventually became influential. Firstly, it raised awareness and brought some key evidence to the attention of the general public. Secondly, it helped to set the policy

and research agendas for the next two decades (Marmot, 2001). These research agendas mainly focused on understanding the reasons for health inequalities in the UK and elsewhere; and a number of reports were published in order to tackle health inequalities, including the Acheson Inquiry (Department of Health, 1998). The Acheson Inquiry has been considered a second milestone in the domain of health inequalities (Mackenbach, 2006). It is based on a similar socioeconomic model of health proposed by the Black Report, with the important difference that at the time of publication it was welcomed by the Government (Marmot, 2001).

Since the Black report and Acheson Inquiry, there has been growing ambiguity over the term *health inequality* (Whitehead, 1991; Kawachi, Subramanian and Almeida-Filho, 2002; Graham, 2004b). Health inequality has been conceptualised by some as a descriptive term that is used to designate '*differences, variations, and disparities in the health achievements of individuals and groups*' (Kawachi, Subramanian, & Almeida-Filho, 2002, p.647). Another term that is often used interchangeably with the term health inequality is health inequity (Graham, 2004b). Health inequity differs however from health inequalities in adding to the meaning a form of injustice, which involves an ethical and a moral dimension (Whitehead, 1991; Kawachi, Subramanian and Almeida-Filho, 2002) and it can be identified by questioning whether health inequalities are avoidable or unnecessary. Both terms, however, often lack an adequate translation into some other languages, which is a possible explanation for ambiguity on either term (Whitehead, 1991). Nevertheless, health inequity is rarely used in the UK, at least within policy debates. Instead, health inequality tends to be considered not as a purely mathematical term, but also involving a sense of fairness (Graham, 2004b). In keeping with common UK practice, throughout this thesis, health inequality will be used to refer to both domains, descriptive and ethical.

Graham (2004b) identified three practical meanings commonly associated with health inequalities:

- i. 'Health disadvantages'. This relates to the rates of morbidity and mortality of poor groups, who have been left behind by the rest of the population. Through this meaning, public health policy focuses on a social exclusion agenda, targeting vulnerable groups who suffer from social disadvantage.
- ii. 'Health gaps'. This relates to the health of poor groups compared with other groups in the same society, usually indicated as a '*higher incidence of disease X in group A as compared with group B of population P*' (Kawachi

et al. 2002, p. 647). 'Health gaps' relate health inequalities to socioeconomic status and primarily focus on narrowing the 'health gap' between the worst-off in society and the better-off.

- iii. 'Health gradient' considers the existence of a gradual relationship between socioeconomic position and health at every social level. The lower the social position of the individual, the worse their health is. The understanding of 'health gradient' relies on a moral equality of health for all, independent of the social group an individual belongs to. Public health policy addressing the health gradient involves a more challenging approach than the previously described meanings, however, it is considered to be the better option to address health inequalities (Graham, 2004b).

How to tackle health inequalities and policy debates around will be further discussed in section 2.3.3. The causes and explanations of health inequalities will be identified first.

2.3.2. Causes and explanations of health inequalities

Health inequalities have often been explained through a combination of materialistic and psychosocial factors (Marmot, 2001; Kawachi, Subramanian and Almeida-Filho, 2002). The materialistic explanation refers to the tangible material conditions such as the food or shelter that an individual occupying a certain socioeconomic position has access to (Lynch and Kaplan, 2000; Marmot, 2001; Kawachi, Subramanian and Almeida-Filho, 2002). The psychosocial explanation refers to how stress affects those who occupy a lower position in the socioeconomic hierarchy (Kawachi, Subramanian and Almeida-Filho, 2002). The materialistic and psychosocial factors are related (Marmot, 2001; Kawachi, Subramanian and Almeida-Filho, 2002). In an attempt to explain this relationship, Kawachi et al. (2002) noted that the lack of control (psychosocial factor) experienced by certain social groups might be triggered by their day-to-day material circumstances, such as lack of income or bad housing. Accordingly, materialistic and psychosocial factors have been recognised as both affected by social structure (Marmot, 2001).

Certain scholars have added two more explanations: behaviours and biological factors (Marmot 2010; Macintyre 2007). Behaviours, such as smoking or drinking are understood as not being freely chosen by individuals (Marmot, 2001), most

likely being socially patterned. Biological explanations refer to certain conditions that have been developed before birth, such as stroke, stomach cancer or low birth weight, which are associated with the parents' socioeconomic status (Macintyre 2007). Marmot (2010) noted that conditions of daily life regarding education, occupation, income, gender, ethnicity and race, all shape the individuals' social position, affecting the four above mentioned factors that explain health inequalities. In addition, the political, cultural and social contexts also play a shaping role amongst the mentioned influences (WHO, 2008; Marmot, 2010).

The Solid Facts Report (WHO, 2003) was commissioned to gain further insight into the causes of health inequalities. This report summarised evidence from Europe and suggested ten messages regarding the social determinants of health as possible explanations of the causes of health inequalities, including social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport (WHO, 2003). Graham (2004a) also agreed with the lack of clarity of the term 'social determinants of health' as acknowledged in the Solid Facts Report, however, she associated this issue with a conceptual concern. In her review she highlighted that most reports refer to reducing health inequalities through a dual goal tackling two different types of determinants; social factors that undermine the individual's health (or 'social determinants of health') and social processes that promote an unequal distribution of those factors between individuals and groups occupying an unequal position in society ('social determinants of health inequalities').

In terms of the 'social determinants of health', there is extensive literature representing those in a number of models, with the one described in Dahlgren and Whitehead (1991) being one of the most widely used (see Figure 2.1). Graham (2004a) indicated that the existing models of social determinants of health, including Dahlgren and Whitehead's model, agreed in a 'web of social influences', which included: social structure of society (e.g., socioeconomic, cultural, environmental conditions or social context); intermediate social factors (e.g., social position together with working and living conditions, social networks); and individual-level influences (e.g., health behaviours, physiological factors, genetic and biological processes). As such, health is often considered as the outcome of a set of processes that originate in a social structure.

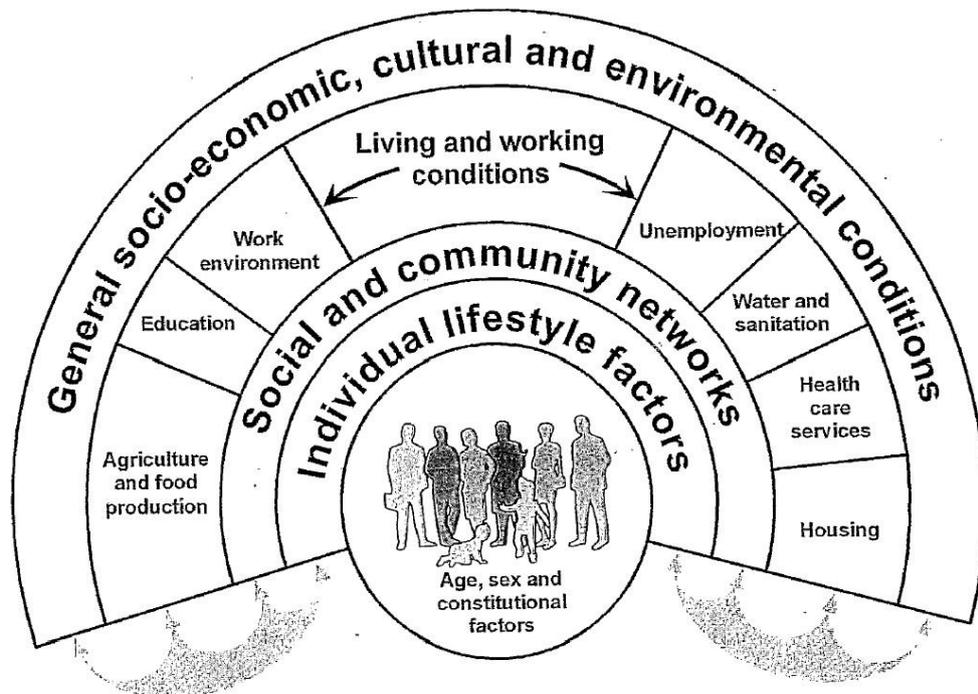


Figure 2.1. Layers of influence on health
(from Dahlgren & Whitehead, 1991)

In terms of the ‘social determinants of health inequalities’, models do not include the unequal distribution, but authors often acknowledge the links between health and health inequalities, where social position plays a pivotal role (Graham, 2004a; Marmot, 2010). Graham (2004a, p. 111) refined the meaning of social position in order to fill the gap found in her explorative review, as it was ‘rarely spelled out’. The concept of social position itself is inherently unequal, since it is part of a social hierarchy that dictates which societal resources can be accessed by individuals at each level (societal, environmental, and behavioural). In addition, the physiological mechanisms regarding all major causes of disease also affect the individual’s social position.

In summary, it has been suggested that social position is the fundamental cause of health inequalities, and models should be modified to reflect this central role, in turn helping policy makers to better understand the concept of social determinants. After gaining some insight into the causes of health inequalities, the following section will focus on how health inequalities should be tackled.

2.3.3. How to tackle health inequalities?

A number of reasons have historically been given to justify efforts to reduce health inequalities. From a humanistic point of view, tackling health inequalities is a matter of fairness and social justice (Whitehead, 1991; Marmot, 2010). A further reason is to tackle health inequalities for economic purposes (Whitehead, 1991; Marmot, 2010), as inequality is associated with high productivity losses and health care costs (Marmot, 2010). However, enhancing well-being should be a social priority on its own (Marmot, 2010).

Based on the three typologies commonly associated with health inequalities ('health disadvantages', 'health gap', and 'health gradient'; section 2.3.1), and how these are part of a continuum, Graham (2004b) also described the types of policies to tackle health inequalities:

- i. 'Health disadvantages' can be connected to policies that consider the health of the poor as top priority, and therefore, focus on a social exclusion agenda that employs area-based interventions and targets vulnerable groups. Although this approach has been, and still is, widely used across different countries, several scholars believe that it is not enough when they are applied without a complementary approach.
- ii. 'Health gaps' are located in an intermediate position in the continuum, and are referred to as the differences between the poor and the rest of the population. This typology involves more ambitious policies as the goal is to improve the health of the poorest at a faster pace than the rest of the population. Specifically it involves targeting minorities, which raises the question of how moral it is to focus efforts on the poorest in relation to those who occupy a marginally superior social position, or even those in any superior social position (Graham, 2004b; Marmot, 2010).
- iii. 'Health gradients' are next in the continuum, acknowledging the differences in health across the social strata. Associated policies involve a population-wide and comprehensive approach. The latter refers to Graham's continuum, meaning that policies must focus on remedying 'health disadvantages' and narrowing 'health gaps' in addition to addressing health inequalities across the socioeconomic hierarchy.

The Marmot Review reiterated the need to tackle the social gradient, which was identified as impossible to eliminate but possible to reduce in certain countries

such as England (Marmot, 2010). The authors agreed with the idea that focusing only on the disadvantaged population was not going to solve the problem, and suggested the use of proportionate universalism, meaning that actions should be universal and also proportional to the level of disadvantage in each social group (Marmot, 2010). Health inequality policies have also had some detractors, who suggested that such policies could have a negative effect on certain social groups, making them less healthy, and advocated policy and action should focus on 'levelling-up', aiming for the whole population to achieve the health of those occupying the better-off positions in the social hierarchy (Macintyre, 2007).

In terms of specific actions to tackle health inequalities, a variety of options have been suggested. For example, Whitehead (1991) suggested seven specific principles for action, such as for example enabling individuals to adopt healthier lifestyles; encouraging people to participate in official plans of work to become part of decision making processes; or improving living and working conditions. Macintyre (2007) suggested acting on three interconnected aspects of education, which will provide literacy, skills and job marketability; employment, which will build on skills and provide income; and income itself, which will increase the opportunities to access resources from society. These suggestions might appear to be different. However, the Marmot Review advocated that action should be taken across all the social determinants of health inequalities and aim to '*create the conditions for people to take control over their own lives*' (Marmot 2010, p.12).

This aim relates to the core meaning of health promotion and in turn the concept of empowerment. Literature concerning the meaning and practices of health promotion and empowerment will be comprehensively reviewed and included in the following section (2.4). From an empowerment point of view, the above noted suggestions for action made by Whitehead (1991) and Macintyre (2007) could be considered to agree with the aim suggested by the Marmot Review, as they represent specific forms of enabling people to take control. This is believed to play an essential role in the process of tackling health inequalities. It is expected that those individuals and groups who exert control over their own lives, will be able to influence their own health and health behaviours (Marmot, 2010).

Similarly, Graham (2004a) strongly advocated action that followed a determinants-oriented approach that could influence social position. However, she also highlighted how small-scale interventions can be easily overruled by mainstream policies. To illustrate, she made a comparison between countries with market-

oriented policies, such as the UK, and countries with combined economic and social policies, such as Scandinavian countries, whose social policies focus on equal opportunities, social solidarity and security for all members, concluding that welfare systems may play an important role in moderating inequalities and social position. This highlights an important issue concerning the effectiveness of policy actions in the form of interventions and mainstream policies. There is general consensus that action into health inequalities needs to be further researched, evaluated, and monitored to better understand the issue, and subsequently refine policies that better tackle them. However, it has also been highlighted that assessing the impact of action, including mainstream policies or interventions, is highly complex for two main reasons (Graham, 2004a): it takes time to see tangible outcomes (e.g., better health); and the research environment cannot be controlled, therefore further influences might mediate the impact, such as further interventions or policy changes. Therefore, knowledge on how to tackle health inequalities is limited and ambiguous (Macintyre 2007).

In terms of who should take action, the domain of public health has played the key role of promoting health, preventing disease and improving ill-health (Macintyre 2007). However, public health policy has undergone a process of change, moving across the above mentioned continuum described by Graham (2004b) from a relatively narrow view, remedying health inequalities, to a much broader view, reducing the social gradient. The latter type of action involves addressing aspects outside the public health domain, relating to the social determinants of health (Graham 2004a; Macintyre 2007).

In summary, this section has focused on the literature concerning the concept of health inequalities and how they can be tackled. Health promotion should address health inequalities in terms of the differences in health status between different populations as a result of social hierarchies (Gottwald and Goodman-Brown, 2012a). The literature suggests that enabling people to take control over their own health and lives is a key aspect to tackling health inequalities, and is discussed in the next section.

2.3.4. The concept of health promotion and empowerment in the context of health inequalities

Powerlessness leads to negative beliefs such as feeling excluded or feeling treated as inferior (Dixey, 2013). Power imbalances, and therefore health inequalities, should be challenged through health promotion and empowering strategies, enabling individuals who feel powerlessness to take control over their own life and act on the determinants of health (Green and Tones, 2010). However, empowerment cannot be told or given, it must be taken by those who pursue it (Rappaport, 1985). Collaborative work between professionals (who have power or access to it) and individuals (who want power) must take place in order to make empowerment possible (Laverack, 2004).

Professionals within the context of health promotion (or authorities in power) must increase people's power-from-within by carefully transforming power-over into power-with, defined by Laverack (2004, p. 33) as:

- i. Power-from-within: *'personal power as an inner strength or feeling of integrity'*
- ii. Power-over: *'the ability to influence the actions of others, even against their will'*
- iii. Power-with: *'the ability to share forms of power-over to increase people's power-from-within'*

The process of empowerment implicitly involves a transformation. Tones (1998) noted that the extent of individuals and/or community involvement will determine the speed of transformation, it may occur faster when individuals and communities participate in defining what priorities must be tackled and how to tackle those (instead of being defined by the professionals).

2.4. Health promotion and empowerment

2.4.1. What is health promotion?

Health promotion was defined during the Ottawa Charter for Health Promotion as the *'process of enabling people to increase control over, and to improve, their health'* (WHO 1986, p.1). According to Laverack (2004), this health promotion definition has its roots in individual and collective empowerment (explained in

section 2.4.3). The association of the concept of health promotion to the two types of empowerment has led to a 'double interpretation' of the health promotion concept.

Before addressing the 'double interpretation' of health promotion, a set of common features to both interpretations are outlined. First, health promotion primarily implies interventions that prevent disease and promote wellbeing, with the help of various sectors (Laverack, 2004; Gottwald and Goodman-Brown, 2012b). Some examples involve changing public policies to affect behaviours and choices of individuals (Laverack, 2004; Gottwald and Goodman-Brown, 2012b). Second, health promotion interventions should involve individuals or groups in all stages of the decision making processes. This has been understood as facilitating the empowerment process, so that individuals and groups can decide at any time whether or not they want to continue to work towards change (Gottwald and Goodman-Brown, 2012b). Third, health promotion is not a universal theory to health. Instead it describes the relationship between the state, the market economies, communities and individuals, where the main goal is to change the existing relationship through an empowerment process to increase people's control over their own health and lives (Laverack, 2004). Fourth, traditionally health promotion interventions have been implemented by nurses, health visitors, physicians and social workers, however, it is now also being delivered by health promoters, health educators and community developers (Laverack, 2004). Deliverers have the main role of providing support and guidance to make the intended change an easy one (Gottwald and Goodman-Brown, 2012b).

As with health inequalities, there is ambiguity concerning the term health promotion. Health education is often used interchangeably with the term health promotion. One can consider that health education aims to raise awareness and provide information on why it is important to improve health and how to change unhealthy behaviours (Gottwald and Goodman-Brown, 2012b). As such, health education is contained in health promotion (Laverack, 2004; Gottwald and Goodman-Brown, 2012b).

Next, the three main models of health will be outlined to facilitate a better understanding of the double interpretation of health promotion.

2.4.2. An introduction to the models of health to better understand health promotion

Models of health are conceptual frameworks of understanding health, and consequently, addressing health. Three models of health will be used to clarify the concept of health promotion and its double interpretation: the bio-medical, behavioural and social models (Laverack, 2004).

2.4.2.1. The bio-medical model of health

The bio-medical model of health is based on the concept of health as the absence of disease (Wade and Halligan, 2004). It was initiated in the eighteenth century and has been the most dominant model of health since then (Laverack, 2004). The bio-medical model involves the following set of beliefs (Wade and Halligan, 2004): disease is caused by an abnormality within the physical body of the individual; the individual is seen as mind-body dualism, where mental and physical health are unrelated; the individual is seen as a victim of the disease with no responsibility and will passively receive treatment.

This model has dominated the views of medical doctors, with a later incorporation of further health professionals such as nurses or physiotherapists (Laverack, 2004). Although a curative approach has been the main concern of this model, prevention of certain diseases has also become part of its interest through treatment to prevent illness (e.g., immunisation) (Gottwald and Goodman-Brown, 2012b). Interventions applying this model of health employ a top-down approach that is delivered by health professionals, who are considered to be experts (Laverack, 2004).

The dominance of the bio-medical model was challenged in the 1970's by a social movement, leading to both the behavioural model of health and the social model of health (Laverack, 2004).

2.4.2.2. The behavioural model of health

In the 1970s, the behavioural model of health became the dominant approach within the area of health promotion (Laverack, 2004). The behavioural model of health, also known as lifestyle model, considers that unhealthy behaviours (e.g., smoking, drinking, physical inactivity) are the main cause of illness and that it is

the individual's responsibility to change them (Minkler, 1989). The lifestyle of the individual is perceived as a factor to influence their own health (Laverack, 2004). This view led to interventions targeting the reduction or removal of unhealthy behaviours at an individual level (Minkler, 1989). Health promoters play the role of aiding individuals to change unhealthy behaviours (Minkler, 1989). The behavioural model of health does acknowledge that apart from individuals being made responsible for their own health, there are further factors to consider, including social, political and cultural aspects. However, the main focus is individual responsibility, not context (Laverack, 2004).

2.4.2.3. The social model of health

During the 1970s and 1980s the behavioural model of health received multiple criticisms, predominantly raised by the feminist, environmentalist and further social movements of the time (Laverack, 2004). The individual responsibility in the behavioural model was considered to be 'victim-blame' (Freudenberg, 1978; Minkler, 1989); it assumes that the lifestyle and personal behaviour is the main determinant of health, ignoring other factors such as the role that social positions play (Freudenberg, 1978; Minkler, 1989; Laverack, 2004). A further criticism to the behavioural model was the limited success of individual behaviour change interventions in addition to the increasing prevalence of unhealthy behaviours. Clustering of health-damaging behaviours, where certain population groups are more likely to smoke, drink alcohol to excess, and be physically inactive, provides further evidence that the determinants of health are not being addressed within the individually focused behavioural model of health (Freudenberg, 1978).

The social model of health claims to identify, and act on, the social determinants of health inequalities, focusing on enhancing social justice and sustainable environments (Freudenberg, 1978; Laverack, 2004). It is not a social movement itself, but shares ideas with social movement theory (Laverack, 2004), such as prioritising interrelations between individuals and groups, or mobilising large numbers of people who will collectively challenge settled structures, ideologies and oppressive forms. This social model has been criticised for systematically opposing medical explanations of health, failing to apply knowledge of behaviour change, and focusing on the future more than on the present (Laverack, 2004).

In summary, the double interpretation of health promotion relates to whether the main focus is on the individual or on the collective, with its roots in these different models of health. Although the bio-medical model of health can also be preventive instead of curative (e.g., cancer screening, immunisation), it has been primarily associated with medical aspects of health care concerning the individual's health (Laverack, 2004). Behavioural and social models of health instead provide the real fundamentals for a double interpretation of health promotion, that is, individual and collective. This forms the background to how empowerment is placed at the heart of health promotion (Laverack, 2004).

2.4.3. Analysis of empowerment as a health promotion concept

2.4.3.1. Empowerment as a key component of health promotion

Health promotion has already been defined in section 2.4.1 as '*the process of enabling people to increase control over, and to improve, their health*' (WHO 1986, p. 1). There is general agreement on defining empowerment as a process that implies exerting control (Zimmerman, 2000). Despite this agreement, empowerment has been described as a 'buzz word' (Raeburn and Rootman, 1998) that is difficult to explain. Different factors might have contributed to this ambiguity and complexity as a concept. On the one hand, the meaning of empowerment has evolved across the world in several directions, embracing various semantics (Dixey, 2013), which relate to specific cultural contexts within non-westernised countries (Laverack, 2004). On the other hand, the diversity of definitions of empowerment might mirror the ideological conflict that has been identified within health promotion, earlier outlined as 'double interpretation' (section 2.4.1): should health promotion focus on individualistic health status or on social justice with health as a means (Robertson and Minkler, 1994)? Recent definitions integrate both viewpoints as part of a broader concept of health promotion. This might be the result of an evolution of health promotion as a concept over the years, from an individualistic form to a more socio-political form (Whitehead, 2004).

The 1986 World Health Organisation definition of health promotion implied the start of a new health promotion movement, which encompassed the earlier described double interpretation of health promotion, and resulted in two types of

conceptions of the term empowerment: individual and collective (or community) empowerment (Laverack, 2004).

2.4.3.2. Empowerment at an individual level

At an individual level, empowerment is also known as psychological empowerment (Zimmerman, 1990). Rappaport (1985), one of the principal empowerment theorists, provided one of the first definitions of individual empowerment, which referred to having a sense of control over one's own life with regards to personality, cognition and motivation. According to Koelen and Lindström (2005, p. 11), this interpretation relates to '*feeling able to make a difference in the world around us*', or in other words, feeling in control. This sense of control is related to another key element of individual empowerment, making choices. Many scholars believe that the main aim of individual empowerment is to prepare individuals to make choices (Feste and Anderson, 1995; Sen, 1999; Tones and Tilford, 2001; Koelen and Lindström, 2005). The acknowledgement of individuals making choices recognises a context that surrounds individuals and offers them choices (WHO, 1986). It also identifies a social process that involves a shared responsibility between different levels (Gibson, 1991), where individuals have the responsibility of making healthy choices, and higher levels (i.e., health practice and policy) are responsible for enabling individuals to make those healthy choices.

The enabling process included in the concept of empowerment at an individual level involves providing support, education and counselling on the one hand, but also collaboration and negotiation between professionals and individuals (e.g., clients, patients), on the other hand (Gibson, 1991). Based on Laverack's (2004) distinction of power relationships, the former set of actions (i.e. support, education) could be considered as 'power-over' relationships. An example to illustrate this would be when health promoters consider themselves the experts and attempt to solve problems without asking the individual whether or not that suggestion is important to them or what they understand by it. This represents an unequal relationship between an expert (for having all the knowledge) and a subordinate. Alternatively, negotiation and collaboration could be considered to sit within 'power-with' relationships. According to Laverack (2004), power-with is an empowering relationship that facilitates individuals to identify their own needs, solutions and actions, where power-over gets transformed into power-with through

problem-solving. In addition, self-efficacy, sense of control, sense of mastery, and sense of connectedness are considered outcomes of the empowering process (Gibson, 1991). This indicates that empowerment can be treated as a process (or means to work) towards achieving a goal, and as an outcome (Laverack, 2004).

The above exemplified process- and outcome-related elements of empowerment were implicitly incorporated in the revised definition of empowerment suggested by Koelen & Lindström (2005, p. 12), which locates sense of control at the core of individual empowerment:

'A process by which people gain mastery (control) over their lives, by which they learn to see a closer correspondence between their goals and a sense of how to achieve these goals, and by which people learn to see a relationship between their efforts and the outcomes thereof'.

This definition is based on two of the main components of Antonovsky's salutogenic approach (1979), that is, the availability of resources, and the ability to use these. Koelen & Lindström's (2005) interpretation of individual empowerment brings together all the elements mentioned to this point, suggesting how these fit within the empowering process. The process involves identifying existing healthy choices, making individuals aware of these possibilities, supporting or enabling individuals to make use of them, and finally contributing towards the individual's feeling of control by associating efforts with outcomes. Koelen & Lindström's (2005) also added that individual empowerment implicates a complicated relationship between professionals and individuals, where the former act as enablers and must be committed to empowerment; and where the latter act as active participants who must want to play a proactive role 'to be empowered'.

2.4.3.3. Empowerment at a community level

Definitions of empowerment from a broader perspective have also been suggested, where exerting control is still at the heart of the concept, but the concept of empowerment here involves several levels, not only the individual level. Accordingly, Rappaport (1984, p. 122) defined empowerment as '*a process by which people, organisations and communities gain mastery over their affairs*'. This idea of empowerment goes beyond controlling one's health as it also implies exerting control (or at least having influence) in relation to wider determinants of life such as work, family, society or politics (Tengland, 2007). Thus, an ecological

position is adopted (Rappaport, 1987), wherein control over life can be accomplished by enhancing health-related abilities and/or contributing to social change (Wallerstein, 1992). To illustrate this idea with an example, obesity within disadvantaged areas could be tackled by, for example, educating local residents on how to incorporate and choose healthy food (individual level) and engaging local residents in social change, ensuring healthy food is accessible in the area (community level).

This wider concept of empowerment, also known as community empowerment, derives from several conceptual roots of health promotion such as the international development work, women's health movement, and community health activists (Laverack, 2004). Community empowerment comprises different levels of control: individual, organisational, and community (Israel *et al.*, 1994). Community empowerment at an individual level must not be confused with the previously described individual empowerment (section 2.4.3.2), which involves making choices. Here the individual level refers to the start of a continuum towards social change, encompassing three elements: exertion of control, personal efficacy, and participation to gain influence over decision makers (Zimmerman, 1990). Accordingly, it is related to having control over life, instead of just having control over health (Feste and Anderson, 1995). At an organisational level, community empowerment involves a democratic approach where decisions are taken collectively and information and power are shared (Israel *et al.*, 1994). Finally, at the highest level, community empowerment supports individuals and organisations to gain control (and influence) over quality of life by working collectively towards meeting community needs and addressing conflicts (Israel *et al.*, 1994).

Within the concept of community empowerment, the aforementioned individual, organisational and community levels are interconnected, forming a continuum in which one can gradually evolve from individual participation or individual action towards a better organised social change (Laverack, 2004). This continuum adopts different intensities over time at each level (Zimmerman, 1990; Israel *et al.*, 1994; Woodall *et al.*, 2010). Ultimately, community empowerment implies a dynamic, interactive and non-linear process that moves along this continuum (Israel *et al.*, 1994; Labonte, 1994; Laverack, 2004). The fact that all levels are interconnected also means that changes at one level can affect changes at other levels (Schulz *et al.*, 1995).

So far, empowerment has been discussed as a process, where empowerment is used as a means to work towards achieving a goal, but empowerment can also be adopted as an outcome, where it becomes the goal to accomplish (Laverack, 2004).

This section included an insight into empowerment from a conceptual perspective. The next section will focus on explaining the approaches to health promotion, which also relate to the double interpretation of health promotion.

2.4.4. Approaches to health promotion

Health promotion involves two conceptually opposite types of approaches: 'top-down' and 'bottom-up' (Laverack and Labonte, 2000; Laverack, 2004). Top-down programmes are typically delivered at an individual-level (e.g., individual behaviour change interventions). From here onwards, they will be referred to as individual-level interventions (ILIs). Bottom-up programmes, also known as community empowerment, community development or community engagement, generally take place at a community level. From here onwards, they will be referred to as community-level interventions (CLIs). The next two sections describe each of these approaches.

2.4.4.1. Individual-level interventions: a top-down approach to health promotion

In ILIs the priority is usually identified by an external agent, who belongs to a 'top' structure, which tries to process 'down' the predefined health agenda (Laverack, 2004). According to this 'top-down' approach, the identification of the health priority is based on evidence gathered through positivist approaches, including epidemiological studies and systematic reviews (which typically include evidence from controlled trials) (Laverack, 2004). The top-down approach primarily aims to prevent disease based on the behavioural model of health (outlined in section 2.4.2.2), which may explain why top-down programmes have been associated with behaviour change interventions.

Historically, ILIs emerged as a response to the health challenge particularly within Western societies (Thirlaway and Upton, 2009). Non-communicable diseases became recognised as the leading cause of death globally, and have been associated with particular patterns of health-related behaviours (WHO, 2010b). In

particular, heart disease, stroke, lung cancer, colon cancer, chronic obstructive pulmonary disease, and diabetes have been associated with unhealthy lifestyle behaviours, such as smoking, excessive drinking, unhealthy eating, and lack of physical activity (Blaxter, 1990; WHO, 2010b). Other factors include average weight status, sleeping less than 7-8 hours (Wingard, Berkman and Brand, 1982), illegal drug intake and unsafe sexual practices (Thirlaway and Upton, 2009). Also accidents have been considered to have a behavioural component depending on how preventable they are, but are usually tackled at a population-level via legislative interventions instead of at an individual-level (Thirlaway and Upton, 2009). All these behaviours can be grouped into two different types. Health-enhancing behaviours such as physical activity or healthy eating, which are associated with health improvement, and harmful behaviours, such as smoking or drinking alcohol, which are considered to improve health when avoided (Riemsma *et al.*, 2002).

Ultimately, non-communicable diseases are largely preventable through lifestyle change (Doyle 2001; cited in Thirlaway and Upton (2009)). In terms of the role of ILIs, behaviour change interventions have been defined '*as coordinated sets of activities designed to change specified behaviour patterns*' (Michie *et al.* 2011, p.1). The National Institute for Health and Care Excellence (NICE) adds to this definition that ILIs aim to offer a supportive role to individuals who suffer from a specific health condition or have adopted a specific (set of) unhealthy behaviour(s) (NICE, 2014). The supportive role materialises by helping individuals to understand how behaviours can be modified in order to enhance health through lifestyle change. Lifestyle has been defined as:

'A distinctive set of shared patterns of tangible behaviour that is organised around a set of coherent interests or social conditions or both, that is explained and justified by a set of related values, attitudes, and orientations and that, under certain conditions, becomes the basis for a separate common social entity for its participants'

(Stebbins 1997, p. 357)

This definition recognises that the life of an individual takes place in specific contexts, which in turn have been suggested to play a role in personal choices. This provides an alternative perspective to the traditional bio-medical model of health (as described above in section 2.4.2.1), which particularly focuses on

biological processes to explain disease (Thirlaway and Upton, 2009). In contrast, the behavioural model of health focuses on social processes, stressing the preventive role (instead of curative), highlighting individuals' choices, and assuming personal responsibility over health (Thirlaway and Upton, 2009). This shows that the behavioural model in general (section 2.4.2.2), and the ILIs in particular, have moved up the ladder of responsibility when being compared to the bio-medical model. Approaches to health based on the bio-medical model rely on the knowledge provided by the experts and consider the individual (or patient) as a passive agent, not exerting responsibility. However, the behavioural model assumes a shift of responsibility from the experts to the individual by enhancing personal choices within their own specific day-to-day contexts, as explained above as part of the 'empowerment at an individual level' (2.4.3.2). ILIs tend to operate on the basis of individual empowerment.

In terms of delivery, ILIs usually involve a fixed timeframe with targets that do not tend to change throughout the intervention (Laverack, 2004). ILIs adopt various delivery modes. Some examples are counselling, education and advice, behaviour modification, family therapy or self-help groups (Riemsma et al., 2002). Although it has been recommended to describe techniques (also called methods) in addition to delivery mode in order to specifically relate those elements to intervention effectiveness (Abraham and Michie, 2008), intervention techniques are rarely reported. Various systematic reviews have attempted to identify techniques within ILIs. For example, a review by Hardeman et al. (2002) revealed that intervention studies drawing on the theory of planned behaviour involved a variety of methods including verbal persuasion, goal setting, rehearsal of skills, modelling, and planning. However, the terminology used to report intervention methods or techniques has been problematic. For this reason, Abraham & Michie (2008) identified the need to standardise behaviour change vocabulary to associate the behaviour change intervention techniques with effectiveness, and then facilitate evidence-based theory testing.

Finally, ILIs are the predominant health promotion style (Laverack, 2004). In England, ILIs are still considered a high priority in the health promotion agenda. Accordingly, the recently published NICE recommendations regarding individual approaches to behaviour change (NICE, 2014) recommend using a person-centred approach tackling health-damaging behaviours (e.g., alcohol misuse, unhealthy eating, lack of physical activity) that have been linked with health

problems and chronic diseases (e.g., cardiovascular disease, type 2 diabetes, cancer).

2.4.4.2. Community-level interventions: a bottom-up approach to health promotion

Community-level interventions (CLIs) are usually referred to as 'bottom-up' programmes, and were explained by Laverack (2004) as individuals (or community members) identifying what issues, concerns and problems should be addressed. The outside agents support and enable community members to identify those issues and develop strategies to solve them. Therefore, problem identification and solution seeking start at the 'bottom', processing upwards. It adopts the principles of empowerment at a community level (section 2.4.3.3), primarily tackling social determinants of health inequalities, such as poverty, housing, or violence, and it is based on the social model of health (section 2.4.2.3).

Addressing the current view on what constitutes CLIs is not straightforward. First, agreement of a universal definition of community has not been accomplished. An example of community definition was proposed by Barnett and Casper (2001, p. 1): *'the immediate physical surroundings, social relationships and cultural milieus within which defined groups of people function and interact'*. This particular definition suggests that a possible target for CLIs could be geographical areas or groups of people. Second, there is little agreement on terminology regarding types of CLIs (NICE, 2008; Swainston and Summerbell, 2008; O'Mara-Eves *et al.*, 2013).

To address this conceptual barrier, this section includes a brief review of the most commonly used terminology within policy and research to refer to a range of CLIs, taking into account how these terms have developed over recent years.

In 2008, NICE first provided recommendations regarding health improvement at a community level. At this time, only two of the most common community-related approaches to health promotion were addressed: community development and community engagement. Community development was defined as *'building active and sustainable communities based on social justice, mutual respect, participation, equality, learning and cooperation'* and it focused on *'changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives'* (NICE, 2008, p. 41). The definition of community engagement was

borrowed from Popay (2006): *'an umbrella term encompassing a continuum of approaches to engaging communities of place and/or interest in activities aimed at improving population health and/or reducing health inequalities'*. These types of approach were suggested as different, but complementary. However, formulating specific recommendations for each approach was not possible due to a lack of consensus in terminology (NICE, 2008). This led NICE to adopt the label of 'community engagement' as an umbrella term that included both types of approach, with the common aim of addressing the social determinants of health and tackling health inequalities, with people who live in disadvantaged areas being considered one of the main beneficiary groups (NICE, 2008).

From a research perspective, one of the few systematic reviews regarding CLIs addressed the difficulty of terminology, and also adopted 'community engagement' as the umbrella term (O'Mara-Eves *et al.*, 2013). The concept remained unchanged, still following the definition from Popay (2006), but the authors highlighted the continuum within this umbrella term by visually representing several levels of community approaches (see Figure 2.2) (O'Mara-Eves *et al.*, 2013).

The continuum starts with limited engagement (external rings in Figure 2.2) and moves towards higher levels (internal rings). Accordingly, the continuum begins with *information and consultation approaches* that primarily involve answering questions and being consulted, and less active participation than subsequent approaches (O'Mara-Eves *et al.*, 2013). *Community development* was defined in accordance with WHO:

'A way of working underpinned by a commitment to equity, social justice and participation that enables people to strengthen networks and to identify common concerns and supports people in taking action related to the networks. It respects community-defined priorities, recognises community assets as well as problems, gives priority to capacity-building and is a key mechanism for enabling effective community participation and empowerment'

(WHO 2002, p. 16)

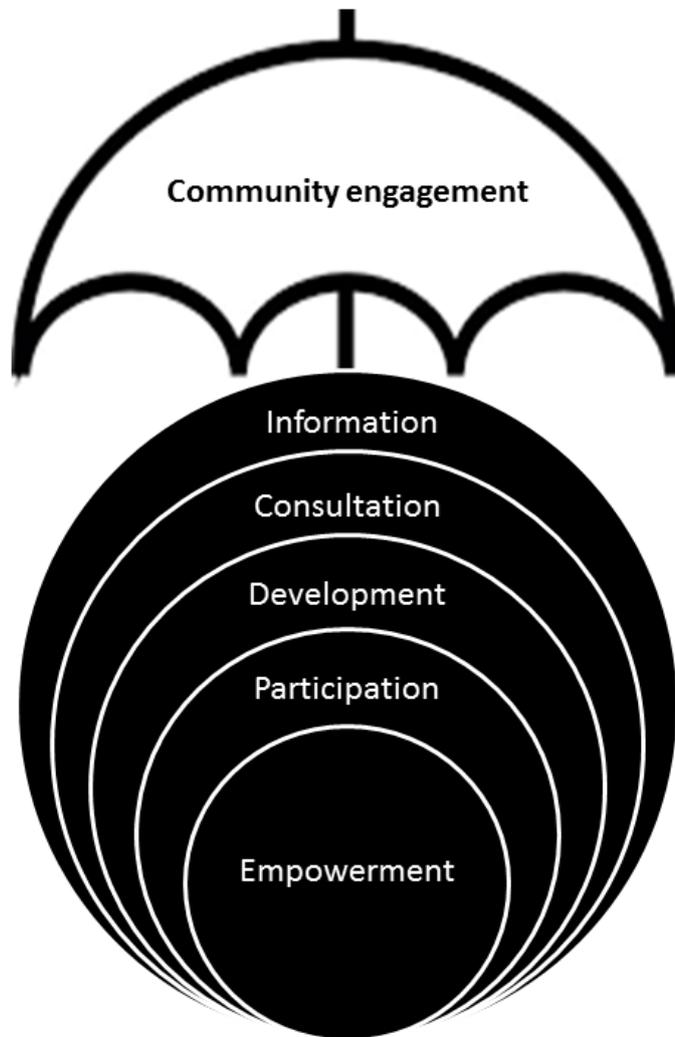


Figure 2.2. Community engagement continuum of approaches
(Modified from O'Mara-Eves et al. 2013)

The WHO (2002) and NICE (2008) definitions of community development have similar principles, including social justice, participation and equality. However, the WHO definition takes a step further by highlighting the concept of enabling community members and specifying how to do so, stating that this is an essential stage prior to achieving the more engaging approaches, such as community participation and empowerment.

Community participation is considered the next layer of community engagement (although the two terms are sometimes used interchangeably). To distinguish between them, O'Mara-Eves and colleagues (2013) borrowed the following definition of community participation:

'A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making

decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change'

(WHO 2002, p. 15)

Community empowerment approaches are considered the best approach to address social determinants of health inequalities (O'Mara-Eves *et al.*, 2013). Community empowerment approaches aim to change real conditions by mobilising into action (Zimmerman, 2000). This approach is also known as community-led interventions, in which the identification of community priorities and definition of strategies to tackle these priorities are ultimately driven by the community. The five types of approach within the community engagement continuum mirror the continuum explained earlier as part of the theoretical concept of empowerment at a community level (section 2.4.3.3) (O'Mara-Eves *et al.* 2013).

In terms of delivery, and in contrast with ILIs, CLIs tend to involve a longer and more imprecise timeframe (Laverack, 2004). In addition, initial programme goals are likely to be modified due to the 'bottom-up' design, particularly when the more intense forms of community engagement are adopted, where priorities and action are defined and led by community members (Laverack, 2004).

In summary, terminology such as top-down or bottom-up approaches, or individual behaviour change interventions versus community empowerment, has been used inconsistently. Therefore, in this thesis these terms will not be adopted as such, particularly as some top-down approaches can also adopt approaches that are more typical to bottom-up approaches (Laverack and Labonte, 2000; Laverack, 2004). In addition, it could be argued that information or consultation approaches suggested by O'Mara-Eves and colleagues (2013) may adopt strategies that are closer to the top-down approach defined by Laverack (2004). Rather, it was decided to adopt an all-inclusive terminology that would highlight the contrast between the fundamental characteristics of these approaches, individual-level versus community-level. This choice also mirrors the terminology used in the literature around the concept of empowerment, which distinguishes between individual and community empowerment. Consequently, the terms ILIs and ICIs will be used throughout.

This section (2.4) has covered the theoretical and conceptual understanding of different concepts regarding health promotion, empowerment and programming. In

the following section the evidence concerning individual-level interventions and community-level interventions will be reviewed.

2.5. Evidence of individual-level and community-level interventions

Grounded theory founders recommended to inductively generate theory from the data and suggested delaying literature review as it was considered a risk of bias in data interpretation (Glaser 1978). However, most researchers, particularly postgraduate students, must conduct a literature review to follow institutional requirements (Urquhart and Fernandez, 2006). To address this, some grounded theory publications include a draft literature at the beginning and a new literature review introduced in the discussion of findings (Urquhart, 2013). This thesis has adopted a similar approach since content of this section so far was mainly reviewed prior to data collection, and the evidence from this point onwards was reviewed after data were collected and analysed, to avoid as much as possible imposing theoretical concepts onto the interpretation of the data.

2.5.1. Evidence-base on individual-level interventions

This section includes a review of the literature relating to effectiveness of ILIs and what is known about the associated process and outcomes of empowerment.

2.5.1.1. The effectiveness of ILIs

Systematic reviews have demonstrated varying levels of effectiveness. There are examples of positive effects of ILIs such as counselling to promote smoking cessation (Stead *et al.*, 2013). However, physical activity related evidence suggests that ILIs may have a short term impact, with limited evidence for long-term effects (Pavey, Anokye, *et al.*, 2011). Similarly equivocal findings have been reported elsewhere; e.g., Vermeire's systematic review of interventions for improving adherence to treatment recommendations in people with type 2 diabetes mellitus was inconclusive (Vermeire *et al.*, 2009), and only moderate effects have been reported in a review of lifestyle interventions that promote a change in general practice (Ashenden, Silagy and Weller, 1997).

A review of reviews of behaviour change interventions up to 2008, that did not include any of the examples of reviews cited above, was consistent with the idea of finding different levels of effectiveness (Jepson *et al.*, 2010). Reviews of individual-level interventions were reviewed for four out of the six behaviours, including smoking (50% of the total number of reviews, n=48), physical activity, alcohol and healthy eating. Different levels of effectiveness were found across the spectrum of behaviours. Studies of smoking interventions generally showed positive effects on behaviour change. For physical activity, 10 studies of interventions that targeted adults were included, indicating moderate effectiveness in the short term. In terms of alcohol misuse, a small positive effect was identified in relation to three studies of brief behavioural counselling interventions. A positive effect was demonstrated in one review of brief interventions of people attending one to four primary care sessions. With regards to healthy eating, four reviews showed positive effects of stage-based interventions that involved primary care populations, telephone interventions, and nutritional counselling. Overall, the review of reviews concluded that at an individual-level, effectiveness was found to be related to short-term impact (less than three months) and individual counselling. However, counselling interventions have not always been found effective, as Pavey *et al.* (2011) found weak evidence of intervention effectiveness in relation to increasing physical activity. A scoping review of evidence relevant to the NHS Health Trainer programme, on which the Lifestyle Service is based, highlights the ambition of this national programme to deliver a sustained health improvement. But it does not include evidence to support this assumption, referring to the common practice of implementing interventions that are not based on evidence of effectiveness (Attree *et al.*, 2012).

Longer-term impact is not frequently reported (Fjeldsoe *et al.*, 2011; Pavey, Anokye, *et al.*, 2011). A systematic review of maintenance of behaviour change following physical activity and dietary interventions found evidence towards maintaining behaviour change (at least at three months follow-up), with three quarters of the included studies proving evidence in relation to at least one positive behavioural outcome (Fjeldsoe *et al.*, 2011). However, the authors suggested that a high proportion of the studies that reported long-term benefits could be explained by publication bias (Fjeldsoe *et al.*, 2011).

2.5.1.2. The process and outcomes of empowerment (ILIs)

As highlighted earlier, the theoretical understanding of empowerment suggests that empowerment may imply processes as well as outcomes (Laverack, 2004). This section initially aimed to review the evidence-base on empirical research regarding empowerment outcomes and processes involved within ILIs. However, different constraints have made this task difficult. Firstly, although there is an extensive body of literature concerning empowerment, the literature primarily relies on theoretical and philosophical issues instead of empirical research (e.g., Feste & Anderson 1995; Cattaneo & Chapman 2010; Aymé et al. 2008; Nyatanga & Dann 2002), as Skinner & Cradock (2000) also identified in their review. Secondly, while the level of intervention effectiveness has been reasonably well studied, the processes and outcomes related to individual empowerment have not, at least within health promotion. The little empirical research regarding individual empowerment that has been conducted in health care, comes from the field of nursing. Here, individual empowerment is seen in relation to patients suffering from chronic diseases such as diabetes, which may involve principles of the behavioural model of health (Marrero *et al.*, 2013). Within this field, the concept of individual empowerment was typically referred to as 'patient empowerment', which corresponds with the conceptualisation suggested earlier (section 2.4.3.2). Thirdly, empirical nursing research has paid little attention to empowering outcomes. The scarce empirical research of empowering at an individual-level has been primarily explorative, leading to findings that more frequently concern with processes rather than outcomes (e.g., Falk-Rafael 2001; Wilson et al. 2007; Aujoulat et al. 2008).

- **Empowering processes**

In terms of the study of empowering processes, qualitative studies that employed qualitative techniques such as individual interviews, focus groups or observation targeting nurses (or other health professionals) and/or patients in addition to some systematic reviews of qualitative evidence identified a number of empowering processes. *Learning* has commonly been suggested as a component of the empowering process. Learning is mostly understood as transfer or enhancement of knowledge where the health professional plays an active role and the patient is a passive agent (Virtanen, Leino-kilpi and Salanterä, 2007; Wilson, Kendall and Brooks, 2007; van Uden-kraan *et al.*, 2008). In contrast, Aujoulat et al. (2008)

suggested co-construction of knowledge, which involves a transfer of knowledge from health professional to patient, in combination with the health professional learning from the patient's personal story regarding their chronic illness. Additionally, the systematic review of Aujoulat and colleagues (2007) suggested a different angle, with learning as an experimental process instead of transmission of knowledge or information.

Self-awareness has been suggested as a further empowering process component. This has a number of implications for how empowerment is approached. From a rather narrow perspective, the review conducted by Virtanen et al. (2007) suggested self-awareness as a process that helped patients to become conscious about their own health problems. Alternatively, Falk-Rafael's (2001) findings associated self-awareness with two other processes: learning (as mentioned earlier) and a process of active participation, as it requires the patient's active participation. In addition, self-awareness was proposed as a key component of the process of empowerment, as Falk-Rafael (2001, p. 1) conceptualised empowerment as a 'process of evolving awareness'. Aujoulat and colleagues' (2007) review also supported the idea of self-awareness being central to the process of empowerment. In addition, they suggested self-awareness to be related to the process of self-change, which was proposed as the actual purpose of empowerment, suggesting that empowerment involves a personal transformation. This opposed the more established concept of empowerment as a process that implied behaviour or environmental change. Others also suggested empowerment as involving a personal transformation (Wilson, Kendall and Brooks, 2007; Aujoulat *et al.*, 2008).

As above, *patients' active participation* was considered a component of the empowering process (Pibernik-okanovic *et al.*, 2004; Aujoulat, D'Hoore and Deccache, 2007; Wilson, Kendall and Brooks, 2007). Hereby active collaboration seemed to be related to a further component, that is, *decision making*, since it has been considered to be a shared process between professionals and patients (Aujoulat, D'Hoore and Deccache, 2007).

Empathy and understanding have also been suggested as components of the empowering process, involving different dimensions based on different viewpoints. For example, from the health professionals' viewpoint, Aujoulat et al. (2008) highlighted the importance of listening to the patient's stories of life. From the patient's viewpoint, Pibernik-okanovic et al. (2004) empathy and understanding

involved an appreciation of a professionals' non-judgemental approach. Additionally, Virtanen and colleagues' (2007) review highlighted the need for a respectful relationship between professionals and patients.

Finally, the study by Aujoulat et al. (2008) reconsidered the model of empowerment based on the unanimously agreed principle of gaining control and suggested relinquishing control as an essential component of the process of empowerment.

- **Empowering outcomes**

Empowering outcomes have rarely been addressed within evidence-based literature. When they have been suggested, it usually was in combination with a set of empowering processes as part of qualitative systematic reviews or studies. *Self-efficacy* appears to be the most commonly reported outcome. In the context of individual empowerment, self-efficacy is understood as the ability to control (e.g., a condition such as diabetes) and chose by yourself (Aujoulat, D'Hoore and Deccache, 2007; Wilson, Kendall and Brooks, 2007). From a quantitative epistemology perspective, Anderson's (1995) randomised controlled trial that aimed to investigate the impact of a patient empowerment programme on psychological self-efficacy, attitudes towards diabetes and reduction of glucose levels, found an improvement of self-efficacy. Self-efficacy was suggested as an outcome required to achieve self-management and control (Aujoulat, D'Hoore and Deccache, 2007; Wilson, Kendall and Brooks, 2007). However, Aujoulat and colleagues' (2007, p. 18) review questioned whether self-efficacy should be considered as an outcome or as a precursor of the empowerment process. They concluded that self-efficacy '*implicitly defines patient empowerment as a process of behaviour change*' but this is insufficient to define empowerment, and instead they suggested that empowerment should be considered as a process of personal change (Aujoulat, D'Hoore and Deccache, 2007), as highlighted earlier as part of the empowering processes section. Others did not suggest self-efficacy as such, but referred to an increase of confidence in the relationship with the professional and the treatment itself (van Uden-kraan *et al.*, 2008).

- **Empowerment in the context of the NHS Health Trainer**

The Lifestyle Service is the individual-level intervention selected for this research. It is based on the NHS Health Trainer model, a national programme that aims to empower individuals to change their lifestyle (Michie *et al.*, 2008). Therefore, empowerment appears as a key component of the intervention. Evidence suggests that programme deliverers perceive the role of the programme as empowering, since it facilitates client decision-making and provides support (South, Woodward and Lowcock, 2007). Although the government made a commitment in 2007 to establish this intervention throughout the country (Department of Health, 2004), there is limited evidence of its effectiveness (Attree *et al.*, 2012), and to the researcher's knowledge, little attention has been paid to empowerment processes and outcomes, particularly from a client perspective. This thesis addresses this evidence gap and provides a novel contribution to the literature through investigating whether this type of approach can empower participants to make sustainable changes to their lifestyle behaviours.

2.5.2. Evidence-base of community-level interventions

2.5.2.1. The effectiveness of CLIs

Evidence concerning CLIs is less developed than ILIs (NICE, 2007). Yet community engagement as a valid approach to health promotion has been recommended for a decade (Popay *et al.*, 2007; Swainston and Summerbell, 2008; O'Mara-Eves *et al.*, 2013). The underpinning belief is that communities can promote health from the bottom-up (Macdonald and Davies, 1998) and the prime endeavour is to '*give a voice to the voiceless*' (Whitehead & Dahlgren 2006, p. 20). This was considered particularly important for targeting individuals who are socially excluded and present the greatest health need (O'Mara-Eves *et al.*, 2013). In addition, NICE acknowledged in 2008 that community engagement was a valid approach to health promotion, and had a potential to improve health and social outcomes. NICE then published recommendations for community engagement initiatives in terms of the prerequisites for effective community engagement, including policy development, long-term investment, organisational and cultural change, levels of engagement and power, mutual trust and respect, types of community engagement approaches, and evaluation approaches (NICE, 2008). After publication, these recommendations made by NICE were to undergo a

process of scrutiny, which has recently been published, contributing with critical evidence, particularly regarding the effectiveness of community engagement approaches to health (Brunton *et al.*, 2014, 2015; Bagnall, Kinsella, *et al.*, 2015; Bagnall, South, *et al.*, 2015). Further detail of this evidence will be provided later in this section.

In addition to the NICE contribution, other institutions have joined efforts to support the implementation of community engagement as a valid option. After the recent transfer of Public Health from the National Health Service (NHS) to local authorities, Public Health England emerged and advocated community engagement, publishing a guidance document for practice (Public Health England, 2015a). The NICE and Public Health England community engagement recommendations have been endorsed with the development of growing evidence.

In terms of effectiveness of community engagement approaches, a systematic review of area-based interventions found that just five out of 24 studies demonstrated a certain level of effectiveness in reducing health inequalities (O'Dwyer *et al.*, 2007). The authors acknowledged that finding so few successful interventions should not be taken as a failure since it was difficult to attribute a causal relationship due to the ambiguous terminology referring to community engagement approaches. Similarly, a review of community engagement approaches to health-related behaviour interventions, including healthy eating, smoking, alcohol, physical activity, sexual risk-taking behaviours, and injury prevention (i.e. use of cycling helmet), could not assess effectiveness due to limited data on outcomes and impact, and a lack of control groups in the majority of studies (Swainston and Summerbell, 2008). In contrast, a recent systematic review on the role of community engagement highlighted the challenges of applying randomised control trials (RCTs) to assess community engagement interventions. These types of interventions often undergo modifications as implementation continues in order to address communities' needs, which is at the core of community engagement. This has led some to advise using RCTs to assess community engagement (Cyril *et al.*, 2015). South & Phillips (2014) debated methods to research community engagement and found middle ground by suggesting RCTs as an appropriate method as long as realities of community engagement approaches and disadvantaged communities are considered.

Milton and colleagues reviewed the evidence for the impact of community engagement initiatives, which aimed to improve the wider social determinants of

health inequalities (Milton *et al.*, 2012). Although positive impact on community wellbeing and social aspects were found, impact on health outcomes could not be determined since the studies did not include this information (Milton *et al.*, 2012). At this point, it was identified that theory was rarely supported by empirical evidence. This evidence gap was recognised by O'Mara-Eves and colleagues, who found indications of effectiveness in terms of '*improving health behaviours, health consequences, participant self-efficacy and perceived social support outcomes*' for disadvantaged groups through their comprehensive review and meta-analysis (n=319 studies) (O'Mara-Eves *et al.* 2013, p. 17). Subsequently, NICE commissioned an expansion of O'Mara and colleagues' review, which resulted in a systematic review that assessed community engagement interventions that involved disadvantaged communities and aimed to promote health outcomes (Brunton *et al.*, 2014). Brunton's systematic review assessed 28 studies, found between 2013 and 2014, which were not included in O'Mara-Eves' review. Benefits to a range of health behaviours, clinical measures, health/social status, self-efficacy and knowledge, attitudes and intentions were found across a number of studies (Brunton *et al.*, 2014). However, Brunton's systematic review acknowledged that the studies they included presented moderate to high risk of bias, concluding that the impact of community engagement approaches on health outcomes must be cautiously interpreted (O'Mara-Eves *et al.*, 2013; Brunton *et al.*, 2014).

In terms of effectiveness of specific community engagement approaches, some have been suggested as appropriate to address health and wellbeing at a population-level, such as collaborative partnerships (Roussos and Fawcett, 2000). Popay *et al.* (2007) suggested that individuals and communities having more control over their own lives could lead to health improvement. Later reviews of studies have not been able to suggest a specific community engagement approach as the most effective. Milton's systematic review did not find which approach(es) were most effective (Milton *et al.*, 2012), referring to the lack of consensus regarding terminology of community engagement approaches, as outlined earlier (section 2.4.4.2). O'Mara-Eves *et al.* (2013) suggested three different theoretical models that explained the nature of the community engagement types of interventions included in their review: patient/consumer involvement in development (e.g., collaboration with community about intervention design); peer/lay-delivered interventions, which emphasises the empathy of a lay

person; and empowerment of the community, which implies a mobilisation of the community into action. They found varied levels of effectiveness. Consequently, the study of relationships between community engagement approaches and outcomes was attempted, but statistically significant findings were not observed. It was suggested that *'community engagement in public health is more likely to require a 'fit for purpose' rather than 'one size fits all' approach'* (O'Mara-Eves et al. 2013, p. 138). To address this gap in the literature, as part of the aforementioned stream of projects commissioned by NICE, Brunton et al. (2015) conducted a systematic review and meta-analysis to assess what approach(es) were more effective. They found a trend to suggest that a higher extent of engagement conferred greater health benefits (where higher refers to community members leading or collaborating more on the design, delivery and evaluation of such interventions).

With regards to the lack of agreement on community engagement terminology, although this remains a problem, a further NICE commissioned review found that the umbrella term of 'community engagement' suggested by NICE in 2008 and adopted in subsequent reviews, seems to be consolidating the associated published and grey-literature (Bagnall, South, et al., 2015).

In addition to health outcomes, there is further evidence that supports community engagement approaches leading to social outcomes. Positive outcomes were found for housing management (Popay et al., 2007; Milton et al., 2012; Bagnall, South, et al., 2015), perceptions of crime (Popay et al., 2007; Milton et al., 2012), social capital and social cohesion (Wallerstein, 2006; Popay et al., 2007), improved communication between communities and service providers (Milton et al., 2012), community involvement in service delivery (Popay et al., 2007), and employment (O'Mara-Eves et al., 2013).

Despite these positive outcomes, caution is required as it has been found that community engagement initiatives seem to succeed in reaching community members who are already engaged in such initiatives (Milton et al., 2012). In addition, some individuals experienced negative consequences in relation to consultation fatigue and disappointment such as a drain of energy levels, time and/or personal financial resources (Attree et al., 2011). This reinforces the need to review the literature concerning how the process of empowerment is experienced, which will be covered within the next section.

2.5.2.2. The process and outcome of community empowerment (CLIs)

Community empowerment is used as a common term to approaches involving community engagement (Bagnall, South, *et al.*, 2015). However, as highlighted earlier, there is ambiguity around community engagement approaches. Recent reviews have attempted to associate specific community engagement approaches to health improvement (O'Mara-Eves *et al.*, 2013; Brunton *et al.*, 2015) (see section 2.5.2.1). Although the specific association between an explicit approach to a particular level of health improvement could not be made due to limitations of the available evidence, it was suggested that higher level of engagement could lead to better health outcomes (Brunton *et al.*, 2015).

Community empowerment has been presented as following a continuum of engagement (section 2.4.3.3). This continuum seems to be mirrored by the continuum of community engagement approaches suggested by O'Mara-Eves *et al.* (2013) (section 2.4.4.2). The higher level of engagement could be interpreted then as getting involved in more intense empowerment stages, which in turn could be understood to leading to higher levels of health improvement. However, the association between (the continuum of) empowerment and its contribution to health outcomes has not been empirically confirmed.

From a more theoretical perspective, a set of pathways that explain how empowerment contributes to health have been identified (Laverack, 2006; Popay, 2010). Popay (2010b) suggested four pathways: information flows, facilitating control, social capital, and gaining control. Laverack's (2006) review of the literature suggested eight specific components of the continuum process of empowerment: participation, gaining skills and competences, leadership, resources mobilisation, critical thinking, assessing problems, links with other people and organisations, and shift of ownership from outside agents to community. Popay's pathways and Laverack's components seem to be interconnected and will be combined and outlined next.

The *first pathway* refers to appropriate information flows between communities and services, which are considered to contribute to more appropriate service design and are expected to increase uptake (Popay, 2010). The *second pathway* was also suggested to increase uptake, but in this case through supporting community engagement and facilitating control (Popay, 2010). The component mobilisation of

resources suggested by Laverack (2006) could be considered similarly. Mobilisation of resources refers to raising resources and it can be carried out by individuals, groups or communities (e.g., increasing recreational opportunities to increase physical activity in particular disadvantaged group, resulting in health improvement). The *third pathway*, engagement, is considered to contribute to enhancing trust and social capital, which in turn are considered to bring health improvement. Accordingly, Laverack (2006) suggested participation and explained that this component allows connection with others in similar circumstances, to build trust between individuals but also at an organisational level, and to strengthen social support. All these aspects had been associated with social capital and cohesion and their benefits to health. Finally, the *fourth pathway*, gaining control and being empowered through social action is expected to modify power relationships and reduce inequality (Popay, 2010). Correspondingly, Laverack (2006) identified critical thinking as a component that is located at the heart of social action and refers to becoming aware of causes that lead to problems and to find alternative solutions that ultimately allow a different way of life. Both scholars proposed that social action and the expected resulting changes are linked to reducing health inequalities.

Returning to the main focus of this section, reviewing the empirical evidence regarding processes and outcomes of empowerment, recent literature reviews of community engagement approaches and empowerment have reported a number of outcomes (Laverack 2006; Wallerstein 2006; Wiggins 2011; Attree et al. 2011; O'Mara-Eves et al. 2013). There is little agreement on what components are processes or outcomes of empowerment. For example, learning how to manage resources, was suggested as a process by Miller and Campbell (2006) but reported as an outcome by Wallerstein (2006).

To address this impediment, the distinction as described in Miller and Campbell (2006) has been applied in the present thesis. They suggested empowerment outcomes as the set of individual and community-level behaviours that allow individuals and communities to pursue a plan for change, which is meant to lead to results (e.g., feel capable of change, engage in participatory behaviours). This distinction was based on Zimmerman (2000). Miller and Campbell (2006) distinguished empowerment processes as those aspects (or mechanisms) that make it possible to gain control (e.g., opportunities to work together, learning decision-making skills). In addition, findings that were reported as outcomes were

not always differentiated as empowerment outcomes, such as social outcomes (e.g., social capital). These nevertheless deserve the attention of this review. The content of the following sub-sections therefore covers empowerment processes, empowerment outcomes, and social outcomes.

- **Empowerment processes**

Learning skills and capabilities, opportunities to participate in decision-making, and (shared) leadership were theoretically suggested as empowerment processes by Miller and Campbell (2006) and were reported as outcomes (or unidentified) by others (Laverack, 2006; Wallerstein, 2006; Popay *et al.*, 2007; O'Mara-Eves *et al.*, 2013). However, a certain level of agreement on the fundamentals that construct the conceptual understanding of these aspects was observed, either when theoretically suggested as processes or empirically reported as outcomes.

Learning skills and capabilities were considered to be embedded in opportunities that facilitate learning through 'doing' (Laverack, 2006; Miller and Campbell, 2006), such as decision making skills or learning how to manage resources (Miller and Campbell, 2006), which can be learned by engaging in a range of opportunities linked to community-based organisations (Laverack, 2006). *Opportunities to participate in decision-making* were considered to be collective and a way of promoting community action (Wallerstein, 2006). Opportunities to participate in decision-making were believed to be linked to a *(shared) leadership* (Miller and Campbell, 2006; Wallerstein, 2006), where leadership can be seen as pluralistic in terms of those who have been elected or those who serve the community (Laverack, 2006), and as a process that is related to further empowerment outcomes, including participation, efficacy and sense of ownership (Wiggins, 2011).

- **Empowerment outcomes**

Sense of ownership, efficacy, critical thinking, self-esteem or connecting with others have often been reported as outcomes of community engagement approaches, which are assumed to involve empowerment (Wallerstein, 2006; Popay *et al.*, 2007; Attree *et al.*, 2011; O'Mara-Eves *et al.*, 2013), and empowering processes which are assumed to result in empowerment outcomes (Laverack, 2006; Wiggins, 2011). These aspects will be briefly described next.

Sense of ownership has been suggested as a prerequisite to leadership (Wiggins, 2011) and in a programme context refers to having the control, which is usually transferred by the external agents to the community itself (Laverack, 2006).

Efficacy has been reported as individual, collective and political (Wallerstein, 2006; Wiggins, 2011). Individual efficacy refers to an individual feeling that his/her actions can lead to results, and change as a consequence (Zimmerman (2000); cited in Wallerstein (2006)); Collective efficacy refers to the belief of a group of people that acting together can lead to making a difference (Sampson et al. (1997); cited in Wallerstein (2006)); Political efficacy refers to the belief of being able to influence political processes and organisations (Israel et al. (1994); cited in Wallerstein (2006)). Wiggins (2011) suggests that efficacy needs to be achieved in order to adopt a leadership role, explained as an empowerment process above, and also acquire critical thinking, which will be explained next.

Critical thinking was identified as an outcome within several reviews (Laverack, 2006; Wallerstein, 2006; Wiggins, 2011) and was addressed earlier in this section as an essential component of the fourth pathway to health suggested by Popay (2010b), which refers to gaining control through adopting social action.

Self-esteem, also reported as self-confidence, was a key aspect captured in the rapid review conducted by Popay et al. (2007) and the review on experiences of community engagement conducted by Attree et al. (2011). Although a popular outcome of community engagement, it was neither described nor defined by reviews reporting it (Popay et al., 2007; Attree et al., 2011; Wiggins, 2011). Only Wiggins (2011) provided an explanation, suggesting self-esteem as an essential outcome for adopting critical thinking (Wiggins, 2011).

Finally, *connecting with others* (Laverack, 2006), also reported as social relations (Attree et al., 2011), social networks (Popay et al., 2007) or social support (O'Mara-Eves et al., 2013), was a further common reported outcome. Reviews suggested different perspectives concerning this outcome. On the one hand, Attree et al. (2011) gave specific examples that were considered part of the outcome connecting with others, including going out in their community more often, getting involved in local groups, getting to know people and making friends, and as a result of connecting with others, an appreciation of a diverse range of points of view. Other reviews suggested how connecting with others was linked to an improvement in health. Popay et al. (2007) associated connecting with others

to quality of life. Laverack (2006) suggested connecting with others as a preliminary step to improve health. He considered that being able to connect with others demonstrated the ability of building relationships, an essential skill to engage in partnerships or coalitions that would be committed to address health inequalities. Connecting with others (or perceived social support) was suggested by O'Mara-Eves et al. (2013) as an outcome but also as a mediator of the effect of community engagement interventions to health behaviour. In fact this review suggested self-efficacy and social support as mediators of health behaviours.

The empirical evidence included in this section exclusively reported outcomes, and disregarded possible empowerment processes. Miller and Campbell's (2006) theoretical understanding of processes and outcomes denoted that the observed lack of reported processes could be related to an additional disagreement of terminology. However, the present literature review has disclosed that most review authors acknowledged empowerment as a continuum process that develops from individual involvement to social and collective change, with some suggesting clear interconnections between the suggested outcomes (Wiggins, 2011), as noted above along the explanation of reported outcomes.

This section (2.5) has presented evidence of the empowerment processes and outcomes at an individual and community-level, demonstrating a range of similarities of empowerment at both levels (e.g., learning, self-reflection, or self-efficacy). The main difference between empowerment at individual- and community-levels seems to be in the interaction of the individual with the environment. Empowerment at a community-level tends to involve other 'equals' (e.g., shared responsibility or connecting with others), whereas empowerment processes and outcomes at the individual-level focuses on intrapersonal aspects (e.g. self-reflection).

- **Social outcomes**

Social outcomes refer here to those not reported as health or empowerment, and were considered to benefit the individuals and their communities, such as social capital or improved perceptions of crime. These have already been covered earlier (section 2.5.2.1).

In summary, literature around empowerment at a community-level is largely theoretical, rather than evidence based. Therefore, there is little research that investigates the processes and outcomes involved, or how empowerment is experienced by participants.

2.6. Making the case

The present literature review has suggested that health inequalities are a concern globally, and in the UK. Health promotion is an area of public health that historically had the remit of addressing health inequalities. The definition of health promotion was reconsidered during the First International Conference on Health Promotion held in Ottawa (WHO, 1986), leading to a 'double interpretation' of the concept relating to individualistic health status and tackling social justice as a means of improving health (Robertson and Minkler, 1994). The double interpretation of health promotion has led to two contrasting theoretical and pragmatic understandings of empowerment (empowerment at an individual and at a community-level), which is at the centre of health promotion, and has also led to two health promotion programming approaches ILIs and CLIs. The interpretation of health promotion that focuses on individualistic health status, tends to adopt empowerment at an individual-level, favours the top-down approach to health promotion programming, and is based on the behavioural model of health. In contrast, the interpretation of health promotion that focuses on social justice, tends to adopt empowerment at a community-level, favours the bottom-up approach, and is based on the social model of health. These are the main underpinnings of the two types of 'real world' health promotion interventions: individual behaviour change interventions (referred to as 'interventions at an individual-level' or ILIs in this thesis) versus community engagement interventions (referred to as interventions at a community-level or CLIs in this thesis).

Evidence on the health impact of ILIs and CLIs has demonstrated that ILIs confer to short term benefits and CLIs lack evidence of effectiveness. Based on the theories and models of health, both types of health promotion programmes could lead to benefits to health and are advocated to varying degrees. In fact, the current tendency is to involve both types of programmes as part of an overall (combined) effort to improve health. For example WHO advocate a comprehensive approach to prevent cardiovascular disease risk factors and their social determinants,

implementing both types of health promotion programming approaches and practices (WHO, 2010a). However, tensions between health promotion regarding ILIs and CLIs remain, exposing the challenge of having to work in both directions (Laverack, 2004).

In support of the aforementioned comprehensive approach, the value of a balanced approach that truly integrates individual-related and social-related responsibility for health to achieve health promotion goals is also recognised within academia (Minkler, 2000), but there is lack of evidence on how this balance should be addressed. This makes the case for having public health interventions at different levels, empowering people to take control over their own health and lives. The ability and means by which different intervention approaches confer this control to participants emerges as an important area for study. A range of individual and community-level approaches exists, and enabling such control is central to their remit. But it is not well understood if and how this happens, and how the expected empowerment process is experienced by participants.

To date, the process of how empowerment is experienced by participants has not been investigated within ILIs. Evidence appears to come from health care and nursing research, which has paid little attention to patients' experiences, focusing primarily on the study of empowering processes and outcomes from the health professionals' perceptions. Therefore, participants' experiences of empowerment in relation to individual behaviour change interventions remain unknown. Empowerment at a community-level has been mostly discussed theoretically. From an empirical perspective, the investigation regarding CLIs has primarily focused on justifying the adoption of community engagement approaches from a health impact perspective. Consequently, little is known from the perspective of participants who have lived the experience of being empowered (or otherwise) through their involvement in CLIs.

Gaining further understanding of how empowerment is experienced at an individual and a community-level will also inform the field on how both approaches could complement one another as part of collective efforts to improve population health, especially in the most disadvantaged groups. The **purpose of this PhD** was, therefore, to use a longitudinal qualitative approach to study how an individual-level intervention (the Lifestyle Service) and a community-level intervention (My Community Matters) can empower participants within a single city (Stoke-on-Trent, with a potential common target population), for them to gain

control over their health and/or life, and how this links to health inequalities. This will provide a novel contribution to the evidence base and will help advance our current understanding of their respective roles in improving health in the most disadvantaged groups. First, a model will be developed to understand if/how the two types of intervention (individual and community-level) empower participants to take control over their health/lives. Second, the potential complementarity of the two programmes will be discussed. This research as such aimed to provide implementation and policy-related recommendations regarding the respective roles and complementarity of individual and community-level interventions to empower the most disadvantaged population groups to improve their health and, therefore, contribute towards reducing health inequalities.

This chapter has included a literature review relating to the concept of health; health inequalities; concepts of health promotion and empowerment; and evidence of individual-level and community-level interventions. The following chapter is concerned with providing background to the research.

Chapter 3

Contextualisation and background

3.1. Introduction

This chapter provides a brief introduction to the city of Stoke-on-Trent as a whole (for context to the Lifestyle Service (LS) and My Community Matters (MCM)), and three targeted areas (for context to MCM). It will provide contextual information regarding the demographic profile (including ethnicity and deprivation), the health profile at a city-level, and background regarding the delivery of the two 'real world' health promotion programmes: the LS and MCM.

3.2. Profile of Stoke-on-Trent

Stoke-on-Trent is a polycentric city formed by six towns (Hanley, Burslem, Tunstall, Longton, Stoke and Fenton). It is located in North Staffordshire together with Newcastle-under-Lyme and Staffordshire Moorlands boroughs. North Staffordshire is an area of the county of Staffordshire, in the West Midlands in England.

3.2.1. Population demographics (city level)

In 2014 Stoke-on-Trent had an estimated population of 251,027, with 50.2% being female (Office for National Statistics, 2014). Table 3.1 shows a breakdown of the population by age groups (excluding the age group from 0 to 17 years), showing the greatest proportion of the population is aged between 41 and 60 years.

Table 3.1 Age groups (Stoke-on-Trent)

Age category	n	%
18 to 25 years	28,722	14.7
26 to 40 years	49,481	25.3
41 to 60 years	64,702	33.1
61 to 75 years	35,658	18.3
75+ years	16,693	8.5

3.2.2. Ethnicity (city level)

The majority of the Stoke-on-Trent population is classified as White British (Table 3.2). Just 13.6% of the population belonged to a black and minority ethnic (BME) group in census 2011 (Office for National Statistics, 2011a); people from an Asian background made up the largest ethnic minority group (6.9%), from which the highest proportion came from a Pakistani background (4.2%).

Table 3.2 Ethnic groups (Stoke-on-Trent)

Ethnic group	n	%
White: English/Welsh/Scottish/Northern Irish/British	215,222	86.4
White: Other	5,490	2.2
Mixed: White and Black Caribbean	1,892	0.8
Mixed: White and Black African	559	0.2
Mixed: White and Asian	1,347	0.5
Other Mixed	693	0.3
Asian/Asian British: Indian	2,329	0.9
Asian/Asian British: Pakistani	10,429	4.2
Asian/Asian British: Bangladeshi	1,097	0.4
Asian/Asian British: Other Asian	3,363	1.4
Black/African/Caribbean/Black British: African	2,536	1.0
Black/African/Caribbean/Black British: Caribbean	834	0.3
Black/African/Caribbean/Black British: Other Black	371	0.1
[Asian/Asian British]: Chinese	1,224	0.5
Other ethnic group: Arab	408	0.2
Any other ethnic group	1,214	0.5

3.2.3. Deprivation (city level)

Stoke-on-Trent presents high levels of deprivation. In 2015 Stoke-on-Trent was ranked as the 14th most deprived local authority out of 326 in England, with a large number of areas within the city (30.0%) ranked among the 10% most deprived in the country (Department for Communities and Local Government, 2015).

3.2.4. Health profile (city level)

In 2015 the health profile of Stoke-on-Trent was generally worse than the average for England, including for alcohol related harm hospital stays, self-harm hospital stays, smoking related deaths, and for estimated levels of adult physical activity (Public Health England, 2015b). In the context of health inequalities in Stoke-on-

Trent, life expectancy at birth indicated a gap between those living in better-off areas and those living in worse areas of 10.1 years for men and 6.3 years for women for 2011-2013 (Public Health England, 2015b).

3.3. Profile of the specific areas targeted by MCM

The LS recruits participants from across the city, whereas MCM targeted specific areas. Therefore, this section includes a specific profile of the three areas targeted by MCM that were included in this research. A pseudonym of the areas will be used throughout the thesis to further ensure anonymity. Accordingly, areas will be referred to as *North*, *Centre*, and *South*.

The intervention areas were identified by the community development workers (CDWs) who reported the implementation area (via a list of street names) of MCM. The identified streets typically included approximately 1000 households. Postcodes of the selected streets were obtained and examined with the purpose of identifying each area with the corresponding Lower Layer Super Output Area (LSOA). LSOAs are geographical units for presenting local statistical information and include a population between a minimum of 1000 and a maximum of 3000 persons, with an average of approximately 1500 (Office for National Statistics, 2011b). Postcodes representing the targeted area usually belonged to one to six different LSOAs. Then the LSOA with higher number of postcodes was selected as the representative one to obtain the statistical information to profile each area.

3.3.1. Population demographics (LSOA level)

The 2014 mid-year estimated population was 1449 (46.1% female), 1582 (47.3% female) and 1315 (49.6% female) for South, North and Centre, respectively (Office for National Statistics, 2014). Table 3.3 shows a breakdown of the adult population by age group, showing the greatest proportion of the population being between 26 and 40 for South and North, and between 41 and 60 for Centre.

Table 3.3 Age groups (LSOA level)

Age category	South	North	Centre	Total	%
18 to 25 years	199	189	193	581	18.9
26 to 40 years	343	467	291	1101	35.9
41 to 60 years	271	317	359	947	30.9
61 to 75 years	128	115	87	330	10.8
75+ years	36	36	35	107	3.5

3.3.2. Ethnicity (LSOA level)

According to census 2011 and as shown in Table 3.4, South (58.6%) and North (58.1%) present a high proportion of population coming from a BME group in comparison with city level (13.6), whereas Centre follow a similar trend (13.9%) (Office for National Statistics, 2011a). As observed at city level (4.2%), Asian Pakistani background is the most common BME group across the three areas, particularly in South, with almost half of the population coming from this ethnic group (45.9%); followed by North (21.8%) and Centre (6.1%). Out of the three areas, North presents the most multi-cultural population and Centre the least.

Table 3.4 Summary of ethnic groups (per targeted areas)

Ethnic group	South		North		Centre	
	n	%	n	%	n	%
White: English/Welsh/Scottish/Northern Irish/British	572	41.4	658	41.9	1,102	86.1
White: Other	18	1.3	104	6.6	18	1.4
Asian/Asian British: Pakistani	635	45.9	342	21.8	78	6.1
Asian/Asian British: Bangladeshi	10	0.7	102	6.5	4	0.3
Asian/Asian British: Other Asian	68	4.9	53	3.4	20	1.6
Black/African/Caribbean/Black British: African	13	0.9	78	5.0	5	0.4
Black/African/Caribbean/Black British: Caribbean	3	0.2	28	1.8	2	0.2
[Asian/Asian British]: Chinese	14	1.0	32	2.0	4	0.3
Other ethnic group: Arab	0	0.0	16	1.0	1	0.1
Any other ethnic group	50	3.6	159	10.0	46	3.7

3.3.3. Deprivation (LSOA level)

The three LSOAs associated with the targeted areas belong to the most deprived decile1 (where 1 = most deprived, and 10 = least deprived) (Department for Communities and Local Government, 2015).

3.4. Health promotion interventions in Stoke-on-Trent

This section includes a description of both health promotion programmes included in this research and a demographic overview of the programme participants.

3.4.1. The Lifestyle Service

3.4.1.1. An individual-level intervention

The LS programme is an individual-level intervention established in Stoke-on-Trent in 2007. The LS is based on the Health Trainer model (Michie *et al.*, 2008) and is underpinned by health psychology theories such as Control Theory, the Health Action Process Approach and Social Cognitive Theory (Gardner *et al.*, 2012). Clients¹ are typically referred from primary care to see a lifestyle coach, who uses motivational interviewing to identify aspects of their own lifestyle that they would like to modify. Supported by lifestyle coaches, clients then set goals and plan for change, ultimately aiming to take control over their own health (Michie *et al.*, 2008). The LS programme usually involves five one-to-one meetings between the lifestyle coach² and the client over the course of a year. During this period, clients might get signposted to further schemes such as commercial weight loss programmes (CWLPs) or fitness centres. Appointments are arranged at venues local to the client, such as medical surgeries, council leisure centres or community fire stations. The LS programme targets clients across the city.

The facilitators of the LS programme are a team of 15 full/part time lifestyle coaches, '*trained lay people recruited from the same or similar communities as the target population*' (Gidlow *et al.* 2013, p. 2). In order to deliver the programme, the Lifestyle Coaches receive training in National Health Trainer competencies such as goal setting and motivational interviewing (Michie *et al.*, 2008).

¹ Clients: Participants attending the Lifestyle Service. The term clients is used by programme deliverers

² Lifestyle coaches: Deliverers of the Lifestyle Service (health trainers)

3.4.1.2. LS participant demographic characteristics

Between February 2014 and January 2015 a total of 1582 individuals were referred to the LS. From this, 763 individuals had the primary goal of losing weight; 74.0% were female; 88.7% were White British and 4.1% Asian or Asian British (Pakistani); 5.2% were overweight, 63.6% were obese, and 29.5% were morbidly obese. Table 3.5 shows a breakdown of the population by age groups, showing a similar distribution as the general Stoke-on-Trent population.

Table 3.5 Age groups attending LS (total intervention population)

Age category	n	%
18 to 25 years	61	8.1
26 to 40 years	278	36.9
41 to 60 years	355	47.1
61 to 75 years	57	7.6
75+ years	3	0.4

Table 3.6 shows that the total number of clients attending the LS presents a similar pattern of deprivation as Stoke-on-Trent does, with 30.7% coming from the most deprived areas.

Table 3.6 Index of multiple deprivation (decile) concerning the total number of clients attending LS

Deprivation	n	%
(most deprived) 1	485	30.7
2	352	22.3
3	117	7.4
4	116	7.3
5	125	7.9
6	125	7.9
7	102	6.4
8	68	4.3
9	60	3.8
(least deprived) 10	9	0.6
No match	23	1.5
Total	1582	

3.4.2. My Community Matters

3.4.2.1. A community-level intervention

My Community Matters is a community-level intervention that commenced in April 2012. Since it started, MCM has targeted six deprived areas of approximately 1000 households across the city of Stoke-on-Trent. Three areas targeted from April 2012 onwards were considered pilot areas for implementation of this new approach in the city. My Community Matters targeted three additional exemplar areas in September 2013 (South) and July 2014 (Centre and North). Only local residents³ from the three exemplar areas were invited to take part in this study.

My Community Matters is a bottom-up programme that pursues community empowerment by bringing community members together and working towards social change. It is based on the 'Connecting Communities' (C2) framework that involves seven steps that lead to the establishment of a community partnership (Stuteley and Hughes, 2011). It claims to employ an asset-based approach, recognising the capacities (skills, knowledge, resources, and personal networks) of local people to build powerful communities (Kretzmann and McKnight, 1993).

In order to engage with residents from the targeted communities, the MCM facilitators have been adopting diverse tailored approaches, which follow an iterative pattern, rather than linear and structured. The highly iterative approach implemented in the different areas usually involved meetings and/or activities aimed at: i) reaching out and bringing together local residents and public services; ii) listening to residents' concerns; iii) connecting local residents and public services; iv) identifying local priorities; v) and working together towards improving the community, by residents taking control over concerns, in particular, and their own lives, in general.

The facilitators of MCM are a team of three full time CDWs⁴ with extensive experience of delivering community-based health promotion. Prior to the onset of MCM, the CDWs were trained in the 'Connecting Communities' (C2) framework (Stuteley and Hughes, 2011).

³ Participants attending My Community Matters are typically referred to as residents

⁴ CDWs: Community development workers are the deliverers of MCM

3.4.2.2. MCM participant characteristics

My Community Matters started working in each area at different times (South, September 2013; Centre and North, July 2014). As part of an evaluation of MCM for the local authority, the CDWs were requested to monitor attendance to meetings and activities led or supported by their programme. This section includes figures of residents (Table 3.7) who attended MCM related activities at least once and completed a demographic form (Appendix 1). However, CDWs acknowledged building rapport with attendees before this demographic form was provided to be completed.

Table 3.7 Demographic characteristics of MCM participants per area

	South (n=187)	North (n=43)	Centre (n=51)
Ethnicity group (%)			
White British	46.0	76.7	92.2
White (Eastern European)	11.8	0.0	0.0
Asian (Pakistani)	31.6	0.0	0.0
Asian (Indian)	7.0	0.0	0.0
Black (Caribbean)	0.0	0.0	2.0
Black (African)	0.0	0.0	2.0
Other	2.7	9.3	0.0
<i>Unreported</i>	1.1	14.0	3.9
Age group (%)			
Under 18	5.3	4.7	0.0
18 to 25 years	13.9	9.3	0.0
26 to 40 years	43.9	53.5	23.5
41 to 60 years	26.7	27.9	41.2
61 to 75 years	7.0	4.7	31.4
75+ years	3.2	0.0	3.9
Gender (%)			
Male	24.1	44.2	31.4
Female	72.7	53.5	64.7
<i>Unreported</i>	3.2	2.3	3.9

Participant demographic data does not discriminate between those who attended meetings that implied taking an active role (e.g., partnership meetings with residents and service providers) and those who attended other types of activities, events or meetings that did not require taking an active role (e.g., fun days).

Table 3.7 shows that MCM meetings and activities reached mainly White British residents, with South engaging the most multi-cultural group of residents. Most residents were aged between 26 and 60 years across the three areas, with North

also engaging residents from the age group between 61 and 75. Female engagement was higher than male engagement overall, with North being the only area presenting a balanced proportion in relation to city-level figures.

In terms of deprivation, MCM targeted a high proportion of residents living in the most deprived areas, with 75.5% of the total number of residents coming from areas within the two most deprived deciles.

Table 3.8 Index of multiple deprivation (decile) concerning the total number of residents attending MCM

Deprivation	n	%
(most deprived) 1	220	53.9
2	88	21.6
3	24	5.9
4	6	1.5
5	8	2.0
6	17	4.2
7	19	4.7
8	5	1.2
9	1	0.2
(least deprived) 10	5	1.2
No match	15	3.7
Total	408	

Table 3.8 also shows that residents attending MCM lived within the three targeted areas (LSOA levels) but also came from further areas in Stoke-on-Trent.

3.4.2.3. Other programmes taking place in the three targeted areas of MCM

During interviews MCM participants referred to other programmes that were taking (or had taken) place in the area. This section includes a brief introduction to these programmes.

- **House market renewal pathfinders**

This programme started in 2002 and finished abruptly in 2011. The aim was to improve housing in neighbourhoods across England that were experiencing a decline in population, dereliction and poor social conditions. Renewal plans involved demolition and rebuilding houses. North was targeted by this programme

but funding stopped between boarding-up houses and demolition. For further information on the programme see resource at footnote.⁵

- **'£1 houses scheme'**

This programme is taking place in North and aims to address the empty houses that were left in the area after funding of the above programme stopped. A total of 33 terraced houses were sold for the nominal figure of £1. New owners were requested to invest a minimum of £30,000 to refurbish their property. For further information on the programme see internet link below.⁶

- **Selective licensing**

This programme aims to regulate the housing private rented sector through making tenants and landlords understand their rights and responsibilities. For further information on the programme see internet link below.⁷

This chapter has included context and background to this research at a city-level, LSOA-level and intervention-level. The following chapter provides an overview of the methodology used in this research.

⁵ CRESR Sheffield Hallam University (2012) The Housing Market Renewal Programme in England: development, impact and legacy

⁶ Stoke-on-Trent City Centre (2016) Clusters of Empty Homes Programme (£1 home scheme) http://www.stoke.gov.uk/ccm/content/housing/private-housing/empty-homes/clusters-of-empty-homes-programme.en;jsessionid=aSsf5YpBcfB_ (accessed 20th July 2016)

⁷ Department for Communities and Local Government (2015) Selective licensing in the private rented sector. A Guide for local authorities

Chapter 4

Methodology

4.1. Introduction

This research includes two longitudinal studies of two health promotion programmes. This chapter introduces and justifies the use of a qualitative approach to investigate the research questions (section 1.4), with a justification of the use of semi-structured interviews for data collection. Then, an overview of the methodological approaches used at baseline (thematic analysis) and follow-up (grounded theory) will be provided. Additional study-specific procedural factors are detailed in Chapters 5 to 8 as necessary. The chapter will end with an explanation of how quality was pursued in this qualitative research, and what types of roles the researcher adopted to conduct this research.

4.2. A qualitative thesis

4.2.1. The choice of a qualitative methodology

The initial overall research question was to explore how individual- and community-level programmes to health promotion can complement each other to better address health inequalities. This led to an investigation of separate roles and processes involved in each type of health promotion programme, with a particular focus on the process(es) of empowerment (and further types of support for pursuing change). A qualitative approach was selected for being compatible with studying processes of change (Flick, 2014). The overall research question was also concerned with how people make sense of the world (e.g., how do programme participants make sense of empowering?), how people experience events (e.g., how do clients and residents experience empowerment?), and with meaning (e.g., what does it mean to live in a deprived area?). The latter question emerged from the person-centred approach to interviews. This was expected to allow for gaining a better understanding of the texture and quality of people's experiences, instead of identifying a cause-effect relationship (Willig, 2008).

Although it is more common in the social sciences for the research question to initiate and lead the research process, there is empirical evidence that research

should not always be guided by the research question. Previous studies into social scientists' research practices demonstrated that researchers do not always apply what is called the particularistic practice, where research decisions are driven by the research question (Bryman, 2007). Often researchers apply an alternative practice, called universalistic, where methodological decisions are based on researchers' methodological commitments, and/or policy and funding expectations.

Likewise, this research was influenced to some extent by Bryman's concept of universalistic practice since this PhD scholarship was co-funded by Stoke-on-Trent City Council (Public Health Directorate), who required an overall evaluation of My Community Matters (MCM), a 'real world' and community-level health promotion programme. The familiarisation stage of MCM, explained in Chapter 7, revealed that MCM was a health promotion programme with relatively loose structure given the 'bottom-up' approach. It was, therefore, highly unpredictable in how it would progress through the course of the study. The selection of the methodology was, therefore, in part informed from a pragmatic perspective, as a highly flexible approach was required in to address data collection within an unstructured programme. This also favoured a qualitative methodology as the main research strategy for understanding the role and processes of MCM. To preserve consistency with the research strategy of both 'real world' programmes, the selected methodology for MCM was also applied to the individual-level programme, the Lifestyle Service (LS). Apart from the aforementioned influence of the funding body and the nature of MCM, the researcher was able to decide on a research question without further obstruction, with the research question predominantly guiding subsequent methodological decisions.

In terms of having a commitment to a particular research methodology, as Bryman (2007) highlighted, the researcher believed that her previous research did not influence the choice of the methodology, since she primarily used mixed methods before. She did not have a particular commitment to quantitative, qualitative or mixed methodologies at the beginning or at the end of the present research. Section 4.4 provides a justification of the selected methodological approaches in this research. The next sections present a brief debate between quantitative and qualitative methods and the epistemological position adopted.

4.2.2. The debate between quantitative and qualitative research

There is a long history of conflicts and debate over the use of quantitative versus qualitative research. The so-called wars between these two paradigms in the 1980's are in the past and led to widespread acceptance of combining quantitative and qualitative methods in empirical research during the 1990's. But nowadays, qualitative research is often seen as 'soft' by those who consider themselves 'hard' scientists, from a belief that qualitative research is subjective and unscientific (Denzin and Lincoln, 2011).

Those who consider themselves 'hard' scientists tend to adopt a positivist paradigm to research. Paradigms help to communicate how the world is seen by researchers. Interpretative paradigms are abstract principles that researchers adopt and are defined by three main components: ontology, epistemology and methodology (Denzin and Lincoln, 2011). Ontology refers to '*what kind of being is the human being*' and '*what is the nature of reality?*'; Epistemology is concerned with '*what is the relationship between the inquirer and the known?*'; and methodology relates to '*how do we know the world or gain knowledge of it?*' (Lincoln and Guba, 1985; Denzin and Lincoln, 2013).

Positivism concerns the natural sciences, where hypotheses are generated from theory to be verified as a fact or law (Bryman, 2012). From an ontological perspective, positivism makes the assumption that there is a single reality that can be measured and become a single truth (Guba and Lincoln, 2005). From an epistemological perspective, positivism believes that research must be conducted free of values, in order to adhere to total objectivity (Bryman, 2012; Guba & Lincoln, 2005). It is also assumed that there is no interaction between the knower (researcher) and the known (what/who is studied) (Guba and Lincoln, 2005). Positivism uses methodologies that believe in a single truth that can only be falsified with disproving results (Lincoln, Lynham and Guba, 2011), employs quantitative methods and data (Guba and Lincoln, 2005), and the employed methodological procedures can be replicated (Merriam, 1991). Quantitative researchers use these above characteristics to criticise qualitative research for being too subjective, difficult to replicate, lacking transparency, and presenting problems when it comes to generalisation (Bryman, 2012).

Qualitative research has been associated with the naturalistic paradigm, which considers the existence of multiple realities, from an ontological perspective; has

influential interaction between the knower (researcher) and the known (participant), from an epistemological perspective; and from a methodological perspective, involves inquiry that is value-bound and addresses hypotheses that are time and context-bound (Lincoln and Guba, 1985).

An accurate definition of qualitative research has not yet been suggested (Denzin and Lincoln, 2013), most likely due to the complexity and interconnection of terms, concepts and assumptions involved in qualitative research. Denzin and Lincoln (2013) borrowed a passable definition from (Nelson, Treichler, & Grossberg, 1992, p.4):

'Qualitative research is an interdisciplinary, transdisciplinary, and sometimes counterdisciplinary field. It crosscuts the humanities, as well as the social and physical sciences. Qualitative research is many things at the same time. It is multiparadigmatic in focus. Its practitioners are sensitive to the value of the multimethod approach. They are committed to the naturalistic perspective and to the interpretive understanding of human experience.'

This definition suggests an association between qualitative research and the naturalistic paradigm. As a matter of clarifying, it has been recommended that qualitative and quantitative research should not be utterly equated to the naturalistic and positivist paradigms, respectively (Lincoln and Guba, 1985), since the naturalistic paradigm would usually favour qualitative methods over quantitative, but not exclusively. In fact, certain qualitative methods underpin a positivist paradigm, such as the traditional version of grounded theory (Charmaz, 2000).

The definition provided by Nelson et al. (1992) also highlighted the association between qualitative research and interpretation. In order to 'understand the human experience', the knower is located in the world to take representations from it, such as field notes, interviews, conversations, photographs, recordings or memos (Denzin and Lincoln, 2013). Qualitative research does not simply narrate data that has been collected. Clarifications, elaborations and explanations of the meaning(s) are uncovered, with the assistance of interpretation (Willig, 2012). There is a considerable range of methodological approaches to qualitative research, such as grounded theory, narrative studies, hermeneutic approaches, discourse analysis,

participatory research approaches, or ethnography (Denzin and Lincoln, 2011; Flick, 2014).

Although this section has already highlighted some of the tensions between qualitative and quantitative research, it is not intended to debate whether qualitative approaches are better or worse than quantitative approaches. Both involve strengths and limitations and there is currently general consensus in terms of the research question being the instigator of the entire research process (Bryman, 2007; Flick, 2014), where the methodology provides ways to address the selected research question (Willig, 2008).

4.2.3. The interpretative paradigm of this research: ontology, epistemology and methodology

The purpose of this section is to explain the interpretative paradigm that has been embraced to conduct this research.

Researchers adopt abstract principles to see the world. These principles form the interpretative paradigm and are defined by three main components: ontology, epistemology and methodology (Denzin and Lincoln, 2011). Lincoln et al. (2011) summarised five possible interpretative paradigms (positivism, post-positivism, critical theory, constructivism, and participatory), providing differences between them. Qualitative research could adopt any of these five interpretative paradigms (Willig, 2008). The present research was aligned with the constructivist paradigm that assumes (Table 4.1): firstly, a relativist ontology, which accepts that multiple realities exist; secondly, a subjectivist epistemology, which agrees with constructing meaning through interaction between knower and known (participant); and thirdly, it requires naturalistic methods (Lincoln, Lynham and Guba, 2011).

Table 4.1 Adopted interpretative paradigm

Paradigm	Ontology	Epistemology
Constructivist/ Interpretivist	Relativist	Subjectivist

Relativist ontology is the philosophical belief that multiple realities exist, which are self-created by the individual, and are locally constructed (Lincoln and Guba,

1985; Guba and Lincoln, 2005). A subjectivist epistemology refers to constructing individual understanding of reality by interacting within one's own setting and surrounding (Lincoln and Guba, 1985). In terms of methodology, the constructivist paradigm believes that the process of research and seeking of knowledge must be achieved through qualitative methods, particularly naturalistic methods, such as interviews or observations, which allow researcher and participant to collaboratively construct meanings (Lincoln, Lynham and Guba, 2011).

This research employed two different methodological approaches that share the constructivist paradigm: the constructivist version of grounded theory method, which directly relates to constructivism; and thematic analysis, a flexible approach to qualitative research (Braun and Clarke, 2006) and has been applied using a constructivist perspective. In section 4.4 the key features of these methodological approaches will be outlined, as well as the rationale for using them in this research, and specifics regarding how data were collected and analysed.

To clarify how philosophical beliefs are compatible with methodology, Willig (2008) brought together ontology and methodology in an illustration that represented the wide ontological continuum, from naïve realist to radical relativism. Naïve realist assumes an objective and external reality, and radical relativism assumes multiple social realities (Charmaz, 2000). Willig (2008) showed which ontological position several qualitative methodological approaches occupy in this continuum (Figure 4.1). The present research adopted an ontological position located close to the pole of relativism, where the social constructionist version of grounded theory sits.

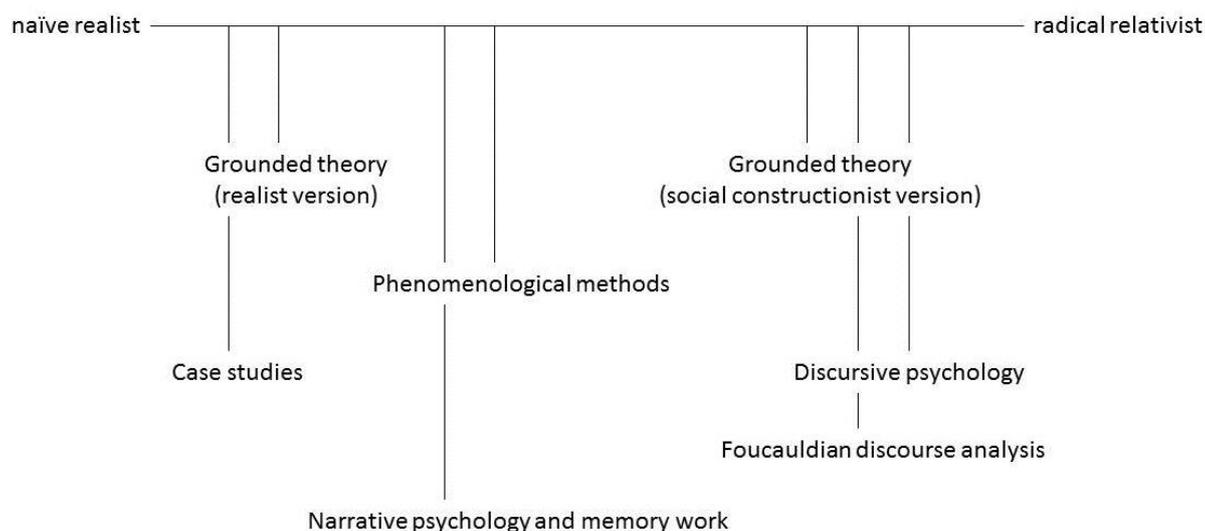


Figure 4.1. Ontological continuum (Willig 2008, reproduced with permission)

As part of the classification of the five interpretative paradigms suggested by Lincoln et al. (2011), the constructivist paradigm (adopted in this research) embraces philosophical beliefs from both social constructivism and interpretivism. Both stances agree on not existing a correct interpretation of the data, opposing naïve realism, which believes there is only one possible interpretation.

Symbolic interactionism is another feature of the constructivist version of grounded theory (Charmaz, 2006, 2014), and has been applied to the constructivist version of thematic analysis employed in this research. Denzin (1995) outlined seven basic principles of symbolic interactionism based on Herber Blumer's assumptions (1969): 1) human beings act towards meanings, 2) forming meanings follow a process of social interaction, 3) meanings are modified through individuals interacting with one another, 4) human beings are the creators of worlds of experience, 5) the meanings of these worlds come from interaction and self-reflections, 6) social and self-interaction (symbolic interaction) are the principal mechanism to form social and joint acts, and 7) social life is constituted by joint acts, and how these form, dissipate, conflict and merge.

This section has briefly highlighted the interpretative paradigm, ontology, epistemology, and methodology employed in this research. The next section focuses on justifying and describing the selected data collection technique, semi-structured interviews.

4.3. Data collection techniques

Chapters 5 and 7, respectively, aimed to explore individual's expectations about their upcoming participation in a health promotion programme, the LS and MCM (baseline stage). Chapter 6 and 8 aimed to explore experiences of individual's participation in those programmes (one year follow-up stage). In-depth, individual semi-structured interviews were considered the most appropriate data collection technique. The following section evidences why.

4.3.1. Individual, in-depth semi-structured interviews

Qualitative interviewing involves conversations that are driven by a purpose, which is informed by a research question (Smith, Flowers, & Larkin, 2009). Qualitative interviewing can be conducted in a varied range of ways such as in group or individually; formal or informal; unstructured, structured, semi-structured or guided; or face-to-face, via internet, or by phone (Sturges and Hanrahan, 2004; Olson, 2011; Richards and Morse, 2013).

This research used in-depth qualitative interviews with the purpose of seeking 'deep' understanding of personal experiences (Johnson and Rowlands, 2012). The researcher aimed to achieve a similar deep level of knowledge as the interviewee in relation to their experience. Thus, the interviewer adopted the role of learning as a student from the interviewee, who was treated as the expert (Johnson and Rowlands, 2012).

Interviews can be researcher or interviewee-led. If the interview is interviewee-led where merely general topics of discussion are introduced, the type of interview is unstructured (Corbin and Morse, 2003; Olson, 2011). Unstructured interviews allow interviewees to tell their story but it is easy to lose focus (Olson, 2011). Conversely, structured interviews are usually conducted in the context of surveys, where questions are asked in the same order, and the main use is to test a hypothesis as part of quantitative designs (Olson, 2011). Qualitative interviewing can also adopt a middle point in between structured and unstructured interviews, using a schedule to facilitate opportunities to discuss the topics relevant to the research question (Smith et al., 2009). The researcher needs to explicitly think about aspects that are expected to be covered during the interview, which addresses the likely lack of focus of unstructured interviews (Smith et al., 2009). Setting a schedule can also be useful in helping the researcher resolve difficulties, such as phrasing challenging questions, enabling reserved interviewees, and enhancing the engagement of the interviewee through active listening, flexibility and responsiveness (Smith et al., 2009).

There are two main types of interviews that sit between structured and unstructured interviewing, 'guided' or 'semi-structured' interviews. Guided interviews involve three or four opening questions, giving some level of structure to unstructured interviews (Olson, 2011). Semi-structured interviews take a step further in terms of providing a higher level of structure to the conversation with

questions that are more focused and detailed (Olson, 2011). Likewise, the interview schedule needs to be formed by open-ended questions, allow long answers, be posed in a manner that avoids making too many assumptions, treated with flexibility, and needs to allow prompting interviewees by active listening (Richards & Morse, 2013; Smith et al., 2009). Accordingly, semi-structured interviews follow an iterative line of questioning.

Interviewing is a challenging technique that requires a complex set of skills to elicit rich data (Smith et al., 2009). It is important for researchers to recognise that achieving the perfect interview is nearly impossible as it is common to forget questions, and also interviewing improves with practice (Smith et al., 2009). Interviewing skills include: i) minimising assumptions when posing questions; enhancing active listening in order to prompt further sharing of experiences; ii) building a rapport (especially in the context of semi-structured interviews). Building rapport can help the interviewee to feel comfortable with an interview that involves certain prescribed procedures, such as being voice-recorded with a Dictaphone, and which is a different experience than that of an informal interview, or a normal conversation (Willig, 2013). iii) Other interviewing skills relate to being able to pace the rhythm to the interviewee's needs and allowing silence(s) (Olson, 2011), which should be employed with an appropriate balance of probing questions.

Semi-structured interviews are compatible with a range of qualitative methodological approaches (Willig, 2013) and are the most common data collection technique when employing thematic analysis (Braun and Clarke, 2006) and grounded theory (Charmaz, 2014).

4.3.2. Comparison with other techniques

There are various approaches to collecting qualitative data. Some techniques concentrate on collecting verbal data, such as interviews or focus groups. Other techniques collect data beyond talk, such as observation or ethnography, visual data or using documents as data (Flick, 2014).

Focus groups are a form of group interview that seeks for interaction in order to generate discussion between research participants (Kitzinger, 1994). They are useful to explore knowledge, experience and views (Kitzinger, 1995). Focus groups were considered in this study for the above features, and because they

appropriately fit with the selected method, thematic analysis. They also fit the present study's research question, paradigm, ontological stance and epistemological stance. However, focus groups are not always appropriate when discussing sensitive topics, as it might be difficult to talk about experiences such as being overweight and trying to lose weight in front of strangers (Flick, 2014). Also from a more pragmatic perspective, arranging focus groups with different members of the targeted population is often not a feasible option regarding potential time and transport restrictions (Willig, 2008). This was true of the present study, particularly given the longitudinal approach.

Observation and ethnography are qualitative techniques where the researcher goes into the field of the research participants. Participant observation has been considered the most common form of observation for several decades. The researcher plays the role of observing by becoming a member of the participant's field and collects data through field notes (Flick, 2014). Ethnography has recently become the most common observation technique, surpassing participant observation (Flick, 2014). Ethnography tends to be complemented by further data collection techniques, takes place over a longer period of time, and involves non-participant and participation observation strategies (Gobo, 2008). Participant observation and ethnography claim to gain knowledge about 'how something occurs' (Flick, 2014). This fits with the main research question of this study, that is, 'understanding the process of empowering (or other forms of support)'. However, in the Lifestyle Service, the delivery team of this 'real world' health promotion programme advised against observing the face-to-face appointments between the lifestyle coach and client. The presence of 'a stranger' could negatively affect the delivery of counselling appointments between the facilitator and participant.

Documents can also be used as a form of qualitative inquiry. These are either routinely collected by organisations as a result of administrative processes, or participants are requested to complete a document (e.g., diary) with the purpose of informing the research process (Flick, 2014). The baseline data of the LS was informed by a digital database that is routinely completed by programme facilitators regarding monitoring data on each individual client. This information does not contain rich data to answer the research question, only monitoring data to give context to findings.

4.3.3. Pragmatic considerations

Pragmatic issues regarding the delivery of 'real world' programmes were also considered. As mentioned above, the LS deliverers were against the researcher observing the one-to-one appointments between the programme facilitator and participant, out of fear that this would negatively affect the session. These feelings were respected accordingly, and so ethnography could not be employed. In addition, it was not feasible for the researcher to observe participants during the period of engagement with the LS.

For participants to complete a diary also did not seem feasible, as this could create an unnecessary burden on them, particularly as they were already making considerable efforts to changing their behaviour. Eventually, interviews were preferred over focus groups, observations, or diaries as they could provide the required data richness, whilst being logistically easier to arrange (Willig, 2008) within the time and resource limitations of a doctoral research project.

Semi-structured interviews were preferred over other types of interview (i.e., structured, unstructured) for two main reasons. First, the researcher felt comfortable developing questions in the area of inquiry due to a process of familiarisation with both health promotion programmes (Richards and Morse, 2013). Second, the researcher felt more comfortable including detailed questions in the interview schedule than conducting unstructured interviews (Charmaz, 2014; Smith et al., 2009).

Finally, the researcher did not seek to identify during interviews if any of the research participants took part in both programmes (LS and MCM).

4.4. Methodological approaches

4.4.1. Understanding the selected methodological approaches

4.4.1.1. Understanding thematic analysis

Thematic analysis was selected to study the LS (Chapter 5) and MCM (Chapter 7) at baseline. Boyatzis (1998) has been one of the major contributors to thematic analysis. It was proposed as a process that helps the researcher to transform qualitative information into qualitative data and can be used as part of most qualitative methodological methods (e.g., grounded theory). The process mainly

consists of developing codes and themes; where codes are '*a textual description of the thematic boundaries of a theme or a component of a theme*' and themes are '*a unit of meaning that is observed in the data by a reader of the text*' (Guest, MacQueen, & Namey, 2012, p.50). Themes can also be seen as patterns found within the data that can go from a description of observations to an interpretative approach of the studied phenomenon (Boyatzis, 1998).

The process of thematic analysis offers a great level of flexibility from different perspectives. For example, codes and themes can be generated inductively, deductively or as a combination of the two; it can be used for varied purposes, such as analysing qualitative information or systematically observing a range of incidents (e.g., person, interaction, group, situation, culture); and it can also be employed from different theoretical, epistemological and ontological positions (Boyatzis, 1998).

Braun and Clarke (2006) acknowledged most of the above attributes to thematic analysis and indicated that thematic analysis is widely used but rarely acknowledged as a qualitative methodological approach across a range of areas of knowledge. In order to fill the gap of the literature regarding how little has been written on how to apply thematic analysis, Braun and Clarke provided with guidelines regarding the theory, application and evaluation. In contrast with Boyatzis' views on the main purpose of thematic analysis, they advocated it as a methodological approach for qualitative research (Braun and Clarke, 2006), rather than a process of analysis as part of further methodological approaches.

4.4.1.2. Understanding the grounded theory method and its different versions

Grounded theory was selected to study the LS (Chapter 6) and MCM (Chapter 8) at one year follow-up. Grounded theory is one of the most popular methodological approaches used in qualitative research and it has its origins in symbolic interactionism, within the area of sociology (Richards and Morse, 2013). Based on Blumer (1969), Richards and Morse (2013, p.61) simplified this concept and suggested that symbolic interactionism '*takes the perspective that reality is negotiated between people, always changing, and constantly evolving*'. Accordingly, grounded theory involves research questions that address processes and change over time (Richards and Morse, 2013). Glaser (1978) advised asking the following question at the start of an investigation: '*what's happening here?*',

which helps to emphasise the social processes and social psychological processes of the studied phenomenon (Charmaz, 2006). Its ultimate goal is to 'discover' theory, which is grounded in data (Glaser and Strauss, 1967). Charmaz (2006, p. 126) provided an interpretative definition of theory, *'the imaginative understanding of the studied phenomenon. This type of theory assumes emergent, multiple realities; indeterminacy; facts and values as linked; truth as provisional; and social life as processual'*.

The emergent product, or theory, focuses on explaining 'what reality is like' from participant perspectives (Walliman, 2001) through employing inductive reasoning, which involves a bottom-up approach that identifies patterns from specific observations (Trochim and Donnelly, 2008). Constant comparison of data and reflection is one of its fundamental features, which leads to the development of concepts (categories) and linkages (relationships between categories), as an intermediate step to the generation of theoretical insight (Richards and Morse, 2013). Therefore, grounded theory provides theory as the end-product of the research process, but also guides the researcher when collecting and analysing data (Willig, 2008).

To describe what grounded theory is, based on Cresswell (1998) and Dey (1999), Urquhart (2013) provided a set of key clarifying features of this methodological approach, which also add a few more characteristics to the ones already mentioned so far in this section: i) requirement of researcher setting aside theoretical ideas; ii) focus on interactions between individuals and studied phenomena; iii) theory involves relationships between concepts; iv) theory is generated from data (interviews, observation or documents); e) data analysis is systematic and starts once data is available; v) concepts emerging lead further data collection; vi) concepts and categories are formed through constant comparison of data; vii) once new concepts do not emerge anymore, data collection can be stopped; and viii) data analysis involves different levels of coding (e.g., open, selective and theoretical).

So far grounded theory has been referred to as one methodological approach. However, there are different versions within grounded theory, which are the result of an evolution of the method through time and history. This evolution will be summarised next, following Richards' and Morse's views (2013). Grounded theory originated as one complete and single method from Glaser and Strauss (1967). Each author then worked independently for two decades. Their publications during

this time led the method to evolve and divert, resulting in a clear division in the early 1990s between the 'Glaserian' and the 'Straussian' grounded theory. The 'Glaserian' version selects the most objectivist stance, where there is a clear separation between researcher and participant, and theory is developed through interaction of the components of that theory (i.e., processes, categories, dimensions, properties); on the other hand, the 'Straussian' version focuses on any possible contingency of the data through constantly asking 'what if?', where theories emerge from reflections and discussions by employing open coding and using memos.

These two versions are the most popular and are frequently included as part of the grounded theory method in qualitative methods texts (Bryant & Charmaz, 2007; Richards & Morse, 2013; Urquhart, 2013; Willig, 2008). From an epistemological point of view, the 'Glaserian' and 'Straussian' versions of grounded theory are considered to both take an objectivist perspective. According to Charmaz (2000), the 'Glaserian' version is close to traditional positivism since it adopts the assumptions of having an external reality that is discovered by a neutral researcher; the 'Straussian' version aligns with post-positivism as participants are given a voice, which might conflict with researchers' views of reality.

Although the founders of grounded theory adopted objectivist assumptions, Charmaz (2000) believes that grounded theory does not need to subscribe to these assumptions, suggesting a further version, which derives from a more interpretative approach: constructivist grounded theory. This version seeks deep meaning such as views and values, in addition to surface meanings such as acts and facts (Charmaz, 2000). According to Richards and Morse (2013, p.66), in constructivist grounded theory *'both the data and the analysis are created from shared experiences and relationships with participants'*. The ontological continuum of qualitative methods suggested by Willig (2008) (Figure 4.1) illustrates the ontological contrasts between the objectivist ('Glaserian' and 'Straussian') and constructivist versions of grounded theory.

In addition, Richards & Morse (2013, p.66) identified two more versions, dimensional analysis and situational analysis. The former was developed by Schatzman (1991) and focused on *'providing a fuller approach to social life'*. The latter was developed by (Clarke, 2005) and focused on complex situations, which are considered the unit of analysis. All these different approaches demonstrate

that there is not only one way with fixed and rigid rules to achieve grounded theory (Richards and Morse, 2013).

This research aligns with the constructivist version of grounded theory. The following sections compare the selected methods to other qualitative methods and outline the rationale of using an inductive approach of thematic analysis (at baseline) and a constructivist version of grounded theory (at follow-up) as the methodological approaches.

4.4.2. Comparison with other methods of qualitative data analysis

Thematic analysis was first introduced as a process of data analysis that could be adopted by a range of methods for qualitative research. As covered in section 4.4.1.1, thematic analysis has recently been advocated as a stand-alone method for qualitative research (Braun and Clarke, 2006). Some have argued that data analysis procedures of grounded theory and the inductive approach to thematic analysis are similar, where codes are first identified, following a data-driven approach, and then grouped into larger themes (or categories for grounded theory) (Braun and Clarke, 2006; Urquhart, 2013). The main difference lies with the purpose of each method, where grounded theory goes beyond thematic analysis, aiming at building a theory that is grounded in the data by relating the identified categories (Urquhart, 2013). Those relationships are explored by employing a further stage of coding, theoretical coding (Glaser 1978). Grounded theory was therefore first considered for the analysis of both baseline and follow-up stages. However, it was dismissed as the aim of the baseline stages was to explore programme participant expectations at a descriptive level, instead of at a theoretical level.

This section compares thematic analysis with other methods of qualitative research, including content analysis, interpretative phenomenological analysis, discursive analysis and narrative inquiry to justify the appropriateness of the selected method for this study. The principles mentioned in this comparison should be applicable when comparing grounded theory to other qualitative methods, due to the similarities between both approaches.

Boundaries between thematic analysis and content analysis have been unclear (Vaismoradi, Turunen and Bondas, 2013). Content analysis has in common with

thematic analysis that the entire text gets fragmented into smaller units of text and its analysis aligns to a descriptive approach to qualitative inquiry (Sparker, 2005). According to Vaismoradi et al. (2013), the main difference between thematic and content analysis relates to quantification of data. Thematic analysis focuses on coding data and finding themes from a purely qualitative perspective, and aims to answer the research question by finding important insights (Braun and Clarke, 2006). Content analysis likewise focuses on coding data and finding themes, but also on the quantification of counts of codes (Morgan, 1993). This means that themes can be reached by high frequency of certain texts or words, which only enables surface insight (Bloor and Wood, 2006). This distinction has not always been clear due to major contributors to thematic analysis suggesting that it could be used to help transform qualitative information into quantitative data (Boyatzis, 1998). Content analysis was not considered suitable for the present research given the aim of exploring participant expectations from the forthcoming health promotion programme. Therefore, a method that enables deeper insight was required.

Interpretative phenomenological analysis (IPA) is a method of qualitative research that also seeks to find patterns across qualitative data. Braun and Clarke (2006) suggested that the main difference between IPA and thematic analysis is epistemological, as IPA is bound to phenomenological epistemology and focuses on the study of experiences lived by people (Smith & Osborn, 2003). The original aim (aim 1, section 1.4) of the baseline study was to explore participant expectations from the health promotion programme and attitudes towards behaviour change (in the case of the LS), at the referral stage, prior to the start of the programme. Therefore, IPA was not suitable at the planning stage as accounts related to experiences were not expected. This also applied to the baseline data of MCM. It is important to clarify at this stage, in order to avoid incongruity with previous references to the research questions, that aim 1 (section 1.4) evolved during the progression of the work due to the inductive and flexible approach employed, allowing the emergence of a different perspective, which for the LS related to lived experiences of losing and gaining weight, instead of solely focusing on participant expectations. Similarly, the baseline study aim 1 of MCM evolved from participant expectations to also exploring experiences of living in a deprived area.

Discourse analysis is considered to be more than a method, a perspective in social life and research (Potter, 1996). There are various versions of discourse analysis. Although the most common ones are discourse psychology and Foucauldian discourse analysis (Willig, 2008), up to six forms have been identified (Wetherell, 2001). Common to all of these versions is a focus '*on the role of language in the construction of social reality, and are therefore critical of cognitivism*' (Willig, 2008, p. 95). Therefore, discourse analysis implies the study of certain aspects of language, such as '*the choice of terminology, grammatical constructions, repetitions, use of metaphors, and other rhetorical features*' (Willig, 2012, p. 38). This method was not appropriate for present purposes as the overall aim was concerned with understanding participant experiences and their inner worlds (attitudes towards taking responsibility over own health and expectations from the programme), rather than the capacities and characteristics of language (Willig, 2012).

Narrative inquiry is concerned with the life experiences that are narrated by those who live them (Chase, 2011) and how people construct meaning in their lives (Willig, 2008). Narrative inquiry can take on different approaches such as: i) what the stories are about (plots, characters, structure/sequence of content); ii) how the lived experiences are narrated; iii) the relationship between narrative practices and narrative environments; or iv) researcher's life experiences (Chase, 2011). This method was rejected as the present research did not solely focus on exploring past experiences, as discussed above.

4.4.3. Rationale of selected qualitative data methods

4.4.3.1. Rationale of thematic analysis for baseline

Alternative qualitative research methods were discussed in the previous section. Thematic analysis was selected for its flexibility in terms of purpose and epistemological stance (Braun and Clarke, 2006). Thematic analysis has been defined as a method '*for identifying, analysing and reporting patterns (themes) within data*' (p. 79). This definition alludes to that level of flexibility regarding purpose. In addition, thematic analysis allows exploration of data without being bound to any particular theoretical framework, like other methods, such as grounded theory or IPA. Therefore, thematic analysis can be employed from varied epistemological stances such as realist, constructionist or critical realism

(Braun and Clarke, 2006). Due to the level of flexibility that thematic analysis involves, a lack of transparency is common in thematic analysis studies. It is important to clearly report the epistemological stance positions to transparently disclose what assumptions have shaped the researcher's understandings of the data (Braun and Clarke, 2006).

The epistemological position taken in the study of participant expectations and experiences in both programmes (LS and MCM) was from a constructionist perspective; *'events, realities, meanings, experiences and so on, are the effect of a range of discourses operating within society'* (Braun & Clarke, 2006, p.81). An inductive approach to thematic analysis was used, meaning that the analysis was data-driven and might have little to do with the questions asked or a pre-existing frame (Braun and Clarke, 2006). The inductive approach to thematic analysis was informed by the 'initial coding' and 'focused coding' analytical techniques borrowed from the constructivist version of Grounded Theory (Charmaz, 2006). These coding techniques will be described in section 4.4.4.1.

Although similarities have been found between grounded theory and thematic analysis, thematic analysis was chosen over grounded theory for two main reasons. Firstly, at baseline it was not intended to create a theory (Braun and Clarke, 2006). Secondly, 'real world' restrictions favoured selective sampling and convenience sampling instead of theoretical sampling. Interviews were transcribed immediately after facilitation, but not analysed until after the first 20 interviews had been conducted. These pragmatic decisions were not consistent with theoretical sampling as one of the fundamental features of grounded theory. The combined approach of collecting and analysing data proposed by grounded theory (Charmaz, 2006), was not possible, given the time restrictions, volume of data, and number of interviews.

4.4.3.2. Rationale of grounded theory for one year follow-up

This section provides with a rationale for selecting a constructivist version of grounded theory for the data analysis of the one year follow-up studies of the LS and MCM (Chapters 6 and 8). The choice was principally led by the research question. Grounded theory is a methodological approach that addresses research questions related to process and change over time (Richards and Morse, 2013). Accordingly, the one year follow-up studies aimed to explore and understand how

an individual- and a community-level intervention could enable individuals to change (changing behaviours for the LS; and social change for MCM), as well as how being empowered was experienced through attending these 'real world' programmes, if at all. Therefore, grounded theory was most appropriate.

Additionally, the LS is based on the NHS Health Trainer Handbook, which has the goal of enabling participants to take responsibility over their lifestyle (Michie *et al.*, 2008). MCM aims to enable communities to pursue social change. These assumptions relate to the fundamental concept of empowerment, '*taking responsibility over health (and life)*', as highlighted in the literature review section (WHO, 1986). However, little is known about how participants experience the process of change and/or experience being empowered. Fittingly, one of the features of grounded theory is that it facilitates learning from participants as to how a process takes place and is experienced. This provides further justification for using the selected grounded theory (Richards and Morse, 2013).

In terms of the area of knowledge, the research question is framed within the discipline of public health. As a general rule, grounded theory has been frequently employed within areas where processes are a central part, such as health or business (Richards and Morse, 2013), and it has been successful when investigating health behaviour change (Hutchison, Johnston and Breckon, 2013).

Finally, a justification for choosing a constructivist version of grounded theory amongst other versions relates mainly to the ontological stance of the researcher. Once familiarised with the range of ontological positions in the search for new knowledge (Lincoln, Lynham and Guba, 2011), the existence of multiple realities fitted best with the researcher's beliefs. This 'way of seeing the reality' agrees with the inquiry paradigm called interpretivist (or constructivist). Therefore, the researcher opted for the version of grounded theory that best fitted her ontological position at a personal level, in order to apply the same principles as a researcher.

Constructivist grounded theory requires certain commitments from the researcher, such as being able to openly listen to feelings and experiences and being able to establish relationships with research participants (Charmaz, 2000). The researcher felt at the beginning of this research that these two particular commitments were well aligned with her approach and way of interacting with others. This further supported a constructivist, rather than objectivist version.

4.4.4. Data analysis

4.4.4.1. Process of data analysis at baseline

This section includes a detailed description of how interview data was transformed into textual data, which support was used to analyse data, and which procedure was used for data analysis. All interviews were voice-recorded using a digital Dictaphone. Voice tracks were transferred onto a password secured laptop and verbatim transcribed by the researcher immediately after completion of each interview. Table 4.2 shows the list of transcription conventions that were used during transcription of interviews. A digital copy of all 81 interview transcripts that have informed this thesis can be made available upon request for inspection by the PhD examiners.

Table 4.2 Transcription conventions

Character	Description
I	Interviewer (Researcher)
P	Interviewee (LS client/MCM resident)
xxx	Inaudible
(number)	Indicating time on the interview track for inaudible sections
...	Pause
... {+5}	Longer pause
{verb}	Indicating action: {laughs}, {cries}, {mimics}, etc.
{person name}	Interviewee pseudonym
[word/sentence]	a) Anonymising names of individuals, places, venues, etc. b) Researcher understanding of who/what interviewees mean by stated pronouns, such as 'it', 'them', 's/he' c) Adding context to quotes to clarify meaning

Interview transcripts were transferred into NVivo (version 10) to assist with analysis. Nvivo has been used to organise, store and retrieve data in order to assist with coding data extracts (nodes), storing memo-writing, and being able to quickly retrieve data from nodes (Richards and Morse, 2013). However, further analysis options within the software that usually require an additional level of input from the researcher, such as constructing models, were not used.

In terms of the data analysis process, interview transcripts were submitted to thematic analysis (Boyatzis, 1998), following the six phases of thematic analysis proposed by Braun and Clarke (Braun and Clarke, 2006), which were informed by two of the coding procedures (initial and focused coding) of the grounded theory method (Charmaz, 2006, 2014).

Phase 1: The familiarisation with data phase was carried out by, firstly, transcribing all the interviews immediately after each interview took place, and secondly, by reading and re-reading the transcript. The latter was carried out once all interviews of a study were transcribed, and immediately before the start of phase 2.

Phase 2: This phase focused on generating initial codes. Coding is ‘a procedure that disaggregates the data, breaks it down into manageable segments, and identifies or names those segments’ (Schwandt 1997, p.16). This coding phase was informed by initial coding proposed by Charmaz version of grounded theory method (Charmaz, 2006, 2014). The initial coding entails exploring the data line-by-line in order to allocate words to the examined extract (Urquhart, 2013). This first attempt to coding is data-driven as it is not applying a pre-existing coding frame, meaning that an inductive approach to data analysis was employed (Braun and Clarke, 2006). As an example, for the LS the first four interviews were analysed using initial coding, which generated a total of 198 initial codes. Table 4.3 illustrates what types of initial codes were assigned to data extracts.

Table 4.3 Data extracts with initial codes applied (3 examples from the LS)

Data extract (line-by-line)	Initial code
<i>‘And I think by talking to somebody and somebody... asking you what, what your lifestyle is and looking at your lifestyle, looking how bad it is and how you can make it better ehhh’</i>	Expecting guidance
<i>‘I’m hoping that they possibly weigh you, measure you, do your BMI, blood pressure and then, she said, there will be 5 appointments over 12 months’</i>	Expecting being measured
<i>‘so yeah you get fed up of trying on your own, don’t you?’</i>	Frustrating to lose weight without support

Phase 3: This phase focused on collating codes into themes, with the purpose of gathering relevant data from the whole dataset into the generated themes. Firstly, focused coding was borrowed from the Charmaz version of the grounded theory method (Charmaz, 2006, 2014), which consists in grouping (or scaling-up) initial codes into higher level codes or sub-categories, having the research question in mind (Urquhart, 2013). For the LS, the 198 initial codes were grouped into 81 focused codes, as exemplified at table 4.4. The generated framework of focused

codes was employed to analyse again the four previously analysed interviews. New focused codes were generated when new topics emerged.

The second stage of phase 3 involved further grouping. After coding the first half of the interviews (n=11), a thematic map was generated in order to assist the grouping of codes and themes.

Phase 4: This phase focused on checking if the generated themes were representative of the data. This was approached by analysing the remaining interviews of the baseline study stages and checking whether or not the generated thematic map worked. At first, the generated thematic maps were not working, consequently, several versions of thematic maps were generated and checked until one of the versions worked satisfactorily.

Table 4.4 Focused codes (2 examples from the LS)

Initial codes	Focused codes
Being listened Being asked to do Expectations from programme External (professional) support Lacking 'weight loss' provision LS not being advertised Maintaining behaviour change Social support	Relying on external support
Health problems of relatives Reasons to attend the LS Wanting a better health Wanting a change for family Wanting to be capable of Wanting to be fitter Wanting to be valued Wanting to improve appearance Wanting to improve mental health Wanting to live long	Wanting a better life

Phases 5 and 6: The final phases focused on ongoing analysis to refine themes and report findings from the analysis.

Memo-writing was also used to assist these six phases. Memo-writing consists of stopping the analysis and writing down the ideas that come to you when you are coding and analysing in order to allow space to think creatively (Urquhart, 2013). Although this technique was proposed by Glaser (1978), it is no longer confined to grounded theory (Urquhart, 2013).

The six-phase procedure described above was not employed linearly, but involved an iterative process, as suggested by Braun and Clarke (2006). Reflections about the iterative process of coding, memo-writing, generating themes, verification and writing up were kept on a reflective journal using Microsoft OneNote. For further insight on the used reflective practice, see Chapter 9.

4.4.4.2. Process of data analysis at one year-follow up

As already highlighted, methodology at one year follow-up goes one step further, to an increasingly analytical level, using grounded theory. As earlier highlighted, there are certain similarities between inductive approaches to thematic analysis and grounded theory. Therefore, this section complements the explanation provided in section 4.4.4.1, which covered the process of data analysis employing thematic analysis.

The transcription procedure and use of Nvivo were as described in section 4.4.4.1. In terms of the data analysis process, generated transcripts were submitted to the coding suggestions provided by Charmaz (2006) in her practical guide of constructivist grounded theory. These were compatible with the initial and focused coding procedures indicated in section 4.4.4.1, as the thematic analysis conducted on baseline data was also informed by Charmaz's guidelines (2006). Initial coding was again carried out manually on the initial interviews of each study (e.g., n=4 for the LS), without using Nvivo at this preliminary stage, to facilitate spontaneity and interpretation to the analysis (Richards and Morse, 2013).

The initial codes that had more significance were selected to become focused codes. Many of the initial codes were also synthesised into further focused codes. A list of focused codes (e.g., 69 focused codes for follow-up of data from the LS) was constructed and used to analyse the entire dataset, including the first interviews which were manually analysed. Nvivo was then employed and the list of focused codes was treated as open and dynamic, being amended when new ideas emerged. Focused coding led to an initial formation of concepts that led again to a subsequent formation of categories (and category attributes), and relationships between sub-categories and categories.

Analysis of follow-up data then involved a third level of coding. This third level of coding was identified by Strauss (1987) as axial coding, which focuses on

exploring relationships between categories and sub-categories. This research aimed to align with Charmaz's (2014, p. 148) 'emergent' approach:

Although I have not used axial coding according to Straus and Corbin's formal procedures, I have developed sub-categories of a category and showed the links between them as I learned about the experiences the categories represent. My approach differs from axial coding in that my analytical strategies are emergent, rather procedural applications.

With this statement Charmaz referred to the specific procedural applications that Strauss and Corbin (1998) suggested. They proposed trying to answer the following questions employing axial coding: 'when, where, who, how, and with what consequences' through using a specific scheme, which included a specific number of items to concentrate on, such as 'conditions', 'actions', or 'consequences'.

Table 4.5 Example of extracts representing relationship codes (LS)

Relationship(s) between categories and sub-categories	Data extract
A suggested change <u>becoming</u> a habit	<i>in all day I just drink water, whereas before... every time I had a cup of coffee, I had a biscuit, so it's completely cut out the biscuits because I only drink juice, or you know, water, so I'm like... never even thought about it because... it was, it was suggested to me</i>
Continuous relationship (<u>cycle</u>): <ul style="list-style-type: none"> - Identification stage - Planning stage - Putting into action stage 	<i>[The lifestyle coach] always said, 'little goals all the time', like I say, for the first month it was to have breakfast, for the second month was to have breakfast and have a lunch, and then it was to introduce more exercise, and so it's not trying to do everything all in one go, it's doing little steps, getting you, after a month of having breakfast every morning, and I never thought about it</i>
Identification stage <u>informing</u> planning stage	<i>If you are struggling you can say [to the lifestyle coach], 'look, I'm struggling with this' and perhaps they've got new ideas, different ideas that can help you</i>

Data stored in each focused code using Nvivo was revisited and imported to an excel file to further explore categories and sub-categories. This opportunity was also used to further explore relationships between these categories and sub-categories. Table 4.5 illustrates a few examples of the relationships identified within specific extracts.

At the time the categories and sub-categories were emerging or being constructed through constant comparison of data, further interviews were simultaneously being conducted as part of the theoretical sampling strategy. Data collection stopped when no new concepts and attributes emerged (data saturation) (Charmaz, 2014). Data from new interviews was coded using focused and axial codes and was constantly compared with previous data.

Date: 14/08/2015

Category: Data collection (which became category of 'identification stage')

In relation to the category of 'data collection', it seems like the professional will keep asking questions or will ask the client to complete a diary. This aims at finding the cause of the problem (being overweight). Some clients referred to trying to find out the reason of conducting an unhealthy behaviour (e.g., emotional eating) and some others referred to behavioural causes (portion sizes, balancing meals, etc). Especially in the case of the diaries, the lifestyle coach shows the client what the possible causes are. Then the lifestyle coach makes suggestions (taking into account the context of the client). In some occasions the client will oppose those suggestions, suggestions will be re-adjusted and the client will give them a go. While giving them a go, the client will face some problems and difficulties, these will bring up during the meeting and new suggestions will be made. Some clients felt like this is a *'trial and error process'* {Jacqueline}.

Some clients will be 'disengaged' at 'data collection' stage as they did not seem to fully understand why they had to be asked so many questions. Others were disengaged with the suggestions, *'not being a gym person'* {Raquel}.

In addition, I feel like a group of clients give it a go, encounter difficulties in the process, then come back to the LS with the expectation of being given solutions. Are they actually taking responsibility? Are they going to disengage? Could I say that those only focus on being weighed and rely on external support? Then, those who try and 'construct' (not sure what I mean by this just yet), are showing to take responsibility?

Figure 4.2. Example of memo

Three additional analysis techniques have been used during this research: memo-writing, methodological journal, and clustering exercises. Memo-writing has been defined as *'the pivotal intermediate step between data collection and writing drafts*

of papers' and is useful to 'catch your thoughts, capture comparisons and connections you make, and crystallise questions and directions for you to pursue' (Charmaz, 2014, p.162). Memo-writing was continuously employed during all stages of this research, including initial coding, focused coding, axial coding, raising focus to conceptual categories, exploring relationships, explaining clustering, constructing the provisional and final theoretical models, assisting data comparison throughout the entire data analysis, and assisting the initial stages of the writing up included in the results section. Memos varied in deepness, structure, content, style, and length. Short and 'disconnected' ideas were presented in earlier memos, which became more cohesive and deep towards the end of the analysis process. Microsoft OneNote was employed to keep an organised record of the whole set of memo-writing. An example of a later stage memo is provided in Figure 4.2. Note that the informal writing style recommended by qualitative research experts has been kept (Charmaz, 2006). The reason being is to give freedom to analysis and thoughts through writing, instead of focusing on being grammatically correct, which might imply a constraint for the analytical process.

A methodological journal was also used to keep a record of all steps taken from a methodological perspective on a daily basis. This has assisted the writing up of the methodology section, and also the reflection about '*methodological dilemmas, directions and decisions*', as Charmaz (2014, p. 165) suggested.

Clustering was unsystematically used as a flexible technique at different moments of the data analysis, which aims to provide an active and changeable image of the analysed data and the different relationships amongst it (Charmaz, 2014). This tool helps to address two of the purposes highlighted by Charmaz (2014). Clustering primarily helps organising the eclectic ideas emerging from data and assists in the construction of a central idea of the process. Clustering can also be used as a pre-writing technique of memos.

The initial organisation of eclectic ideas into more central ideas steadily transforms these into conceptual models. These conceptual models also employ visual representations of concepts and relationships, however, its main goal is theory development (Soulliere, Britt and Maines, 2001). Conceptual models assisted this research at different stages, such as with the constant comparison of data and category saturation, but it particularly allowed continuous checking of data and ideas as an essential component to ensure rigor, as suggested by Morse, Olson and Spiers (2002).

In summary, this section has covered a detailed description of how data analysis was conducted at one year follow-up for the LS and MCM interview data. It is essential to mention that analysis was not employed linearly and was iterative.

4.5. Quality in qualitative research

There has been a historical interest in demonstrating quality of qualitative research to justify the scientific approach of interpretivist paradigms in contrast to the traditionally established positivist paradigm (Flick, 2008). Nowadays the search for quality in qualitative research is less philosophical and more pragmatic, since quality stems from four levels (Flick, 2008): researcher's interest in assessing the quality of their research; funding institutions; publishers' interest in what should be published; and readers' interest in what is good quality research.

Quality in qualitative research has traditionally used criteria that stem from the positivist paradigm, including internal and external validity, reliability and objectivity (Guba and Lincoln, 1981). Since these sets of criteria miss features of qualitative research, a new set of criteria was suggested: trustworthiness, credibility, dependability, transferability and confirmability (Lincoln and Guba, 1985). However, Morse et al. (2002, p. 19) challenged Lincoln and Guba's suggestion by returning to the concept of validity, arguing that '*whether quantitative or qualitative methods are used, rigor is a desired goal that is met through specific verification strategies*'. These are supposed to continuously engage the researcher in taking responsibility for rigor, rather than leaving rigor for post hoc practices, such as reflecting once the work has been finished. The quality of the present research will be highlighted next using Morse and colleagues' verification strategies. With the aim of avoiding repetition, multiple references will be made to further methodological sections.

- **Methodological coherence**

It was suggested that the research question should be coherent with data and analytic procedures. Sections 4.4.3 and 4.4.4 provide with this rationale. Morse and colleagues' (2002) also highlighted that the research question or even methods sometimes need to be modified. Accordingly, the constant reflective

practice applied by the researcher led to several modifications throughout this research.

First, the interviewee-centred approach (described in section 4.3.1) meant that the researcher had to reconsider aim 1 for both programmes at baseline and follow-up. At baseline, aim 1 mainly focused on expectations from the programmes. However, clients and residents gave an extremely high number of accounts that concerned their past experiences (i.e., similar health promotion programmes, losing weight, living in a deprived area). Consequently, these were considered for data analysis. This resulted in a better understanding of the expectations that residents and clients had from the upcoming programmes.

Second, the initial intention was to use the grounded theory method to analyse baseline data. However, theoretical sampling was compromised as explained in section 4.4.3.1 and a change of methodological approach needed to be considered.

Before applying the indicated modifications, these issues were first thoroughly considered, always taking into account the related methodological, epistemological and ontological assumptions, as suggested by Morse et al. (2002).

- **Appropriate sample**

This verification strategy suggests a sampling strategy that shares features with theoretical sampling (e.g., checking for negative cases). The baseline studies, which applied thematic analysis, included 23 in-depth interviews for the LS and 28 for MCM. Theoretical sampling was not possible due to several constraints related to 'real world' research. However, thematic analysis is a descriptive method (Braun and Clarke, 2006) that does not aim to create theory, therefore, theoretical sampling is not a principle of the method. Nevertheless, data saturation was checked and data collection stopped once '*sufficient data to account for all aspects of the phenomenon have been obtained*' (Morse et al., 2002, p. 18).

Grounded theory was applied for the one year follow-up studies (Chapters 6 and 8). Theoretical sampling is an integral principle of this method. Similar 'real world' research related constrictions affected the application of theoretical sampling and data saturation, which have been highlighted elsewhere (section 6.2.1.1). This led the researcher apply a modified version of grounded theory.

- **Collecting and analysing data concurrently**

Collecting and analysing data concurrently was not possible for baseline studies but was applied in follow-up studies, as explained in section 6.2.1.1. The restrictions of baseline studies in collecting and analysing data concurrently were partly mitigated by making sure that baseline data were analysed before the start of the follow-up stage. Follow-up interviews were then used to clarify aspects of the baseline data and to ensure saturation.

- **Thinking theoretically**

Morse et al. (2002, p. 18) suggested that '*ideas emerging from data [must be] reconfirmed in new data; this gives rise to new ideas that, in turn, must be verified in data already collected*'. This was reported through the findings sections. Findings will refer to implicit and explicit accounts. Particularly within the follow-up studies, an explicit indication led the researcher to ask: have I heard this before? A constant check and re-check of the collected data would confirm or weaken the finding. When confirmed, it would also be further explored with subsequent interviews, when appropriate.

- **Theory development**

This concerned the follow-up studies where two theoretical models were developed from inductive analysis of the data, which means, not adopting a particular framework to theory (Morse, Olson and Spiers, 2002). Categories and relationships between them have been demonstrated to be grounded in data, forming the proposed theory, as suggested by Urquhart (2013). The suggested theoretical models have been compared to existing literature in the range of topics to further develop the theory (Morse, Olson and Spiers, 2002).

Transparency is another component associated with quality (Yardley, 2000). Methodology and findings sections have been attempted to reveal a high level of transparency within the given space limitations, providing evidence for statements and being truthful with procedures, even when these became a limitation for the undertaken research.

4.6. The role of the researcher

Several roles have been adopted by the researcher. In the constructivist version of grounded theory, the researcher is integrated into the research process, playing an active role during data analysis in constructing theory. Therefore, it is recommended to be aware of, and to reflect on, the potential impact of personal and professional characteristics on the research. A reflective diary was used to acknowledge this influence, which has informed section 9.6.

Interviews with residents and clients were approached as being a learner who needed to learn from an expert (the interviewee). Interviewees were made aware of this approach. In addition, the researcher made use of her well-developed social skills to build rapport with interviewees. This took place during meetings for MCM and during interviews for LS and also MCM. The reflective diary was also informed by how building rapport and approaching interviewees as experts went.

For MCM meetings, the researcher adopted a very proactive role by participating in meetings with ideas and action. The participatory approach of MCM led the CDWs to treat the researcher as another 'professional' attending meetings, therefore, the researcher's opinion was often required and valued. The researcher also decided that taking an active role on helping with different matters (e.g., setting up venues for events, creating didactic maps of walkabouts, summarising issues) would help to build rapport with residents. These interventions were also included in the reflective diary.

Finally, as part of the professional role, the researcher was also the evaluator of the MCM programme, which involved further data collection and interaction with the deliverers, managers and commissioners of the programme. This led the researcher to have a greater insight in MCM when compared to the LS.

This chapter has included an overview of the methodology used in this research. The following chapter is concerned with the baseline stage of the study of the Lifestyle Service.

Chapter 5

Individual-level health promotion programme: Client expectations (and experiences) before the start of the programme

5.1. Introduction

The study of the Lifestyle Service (LS) aimed to improve current understanding about what role the LS plays, and how empowerment is experienced by participants taking part in an individual-level intervention (ILI) to health promotion. Little is known about this, thus, a longitudinal qualitative methodology has been employed (Phillips and Pugh, 2000). Consequently, this study has been divided into two chapters. Chapter 5 focuses on exploring programme client's expectations (and past experiences of losing weight) before the start of taking part in the LS programme. This has been investigated using an inductive approach to thematic analysis. Client's experiences with the LS programme after taking part for one year will be explored in Chapter 6.

5.2. Methodology

The methodology in terms of data collection techniques and data analysis was described in Chapter 4. The present section describes the process of data collection.

5.2.1. Process of data collection

5.2.1.1. Familiarisation stage with the LS programme

The researcher engaged in a period of familiarisation with the LS programme to gain an understanding of the programme background and delivery. This stage was useful when managing the practicalities of data collection to minimise burden to staff and participants, and inform the development of interview schedules and data analysis.

As highlighted in Chapter 3, the LS is based on a national programme, the NHS Health Trainer. Thus, familiarisation involved a number of activities. First, the NHS

Health Trainer Handbook (Michie et al. 2006) was consulted to gain insight into the general principles of the programme and recommended practice. Second, the LS manager and the researcher met on several occasions during the month of September 2013 to discuss the programme purpose, target population, day-to-day operational characteristics, and also discussing different scenarios for an efficient strategy for client recruitment. Third, the coordinator of the lifestyle coaches (LS deliverers) and the researcher met to discuss the logistics of the proposed recruitment strategy and data collection, which led to further modifications. And finally, the researcher met with the five lifestyle coaches who were designated to assist recruitment. During this meeting they were introduced to the purpose of the research and to the protocol to introduce the research to their clients, and they were given the opportunity to raise concerns.

During this familiarisation stage of this programme the researcher learned that the LS (and the Health Trainer model) originated as an alternative to top-down approaches (White, Woodward and South, 2013); i.e., trying to use a more participative approach, where 'the power' is shared by employing lay workers and involving participants in decisions rather than being a prescriptive model. In fact, the Health Trainer model has previously been included as a particular approach to community engagement (O'Mara-Eves *et al.*, 2013). Considering the LS as a top-down approach can be challenged. However, compared with MCM, the Health Trainer model (and certainly this example of its implementation) was more aligned with a top-down approach to health promotion in a number of ways. For example, i) taking place at an individual-level; ii) having a fixed timeframe; iii) intervention infrastructure that supports certain behaviours (e.g., subsidised exercise programmes, weight loss programmes); iv) intending to prevent disease; v) and the overall goal (i.e., obesity) being set by external agents who base this on 'positivists' investigations (i.e., empirical studies) (Laverack, 2004).

5.2.1.2. The interviewer

It is recommended in qualitative research that the researcher reflects on the connections between the person and how data is interpreted (Pillow, 2003). This section includes a brief description of the main personal characteristics and past experiences that could have a potential connection to how data were collected, analysed and interpreted.

Interviews were conducted by a 34 year old, Spanish, white, female, researcher employed by Staffordshire University (MR-V). The interviewer is a reasonably slim and fit individual who regularly participates in recreational sport (trail running, mountain biking, and high intensity fitness activities) and leads a reasonably healthy lifestyle (diet and physical activity).

5.2.1.3. Sampling and recruitment

Several pragmatic decisions were necessary due to various restrictions (e.g., time and access to participants attending 'real life' programmes) with regard to the selected sampling strategy, and when data collection and analysis could be carried out. These pragmatic decisions did not permit 'true' theoretical sampling, one of the strongest sampling strategies in qualitative inquiry necessitating interpretation (Marshall, 1986). Such restrictions are a consequence of 'real world' research which favour selective sampling through making a decision at the beginning of the study (Sandelowski, Holditch-Davis and Harris, 1992) and convenience sampling, which involves the selection of the most accessible participants (Marshall, 1986). To gain access to enough participants for the one year follow-up phase of this study, which employed grounded theory, the initial goal was to interview 30 participants at baseline.

In September 2013, the LS manager and the researcher met on several occasions to discuss client recruitment to minimise burden for referred clients and lifestyle coaches. It was also agreed that five out of the 18 lifestyle coaches would help with recruitment. Each was asked to recruit six clients.

Following advice from the LS manager, it was agreed that clients from specific patient groups, such as pre-bariatric surgery or community cardiac rehabilitation would not be recruited as each would be likely to have specific external drivers related to their condition. Rather, the general referral group was used for sampling; those presenting with a BMI \geq 30 who were referred to the LS with a primary lifestyle goal of weight loss.

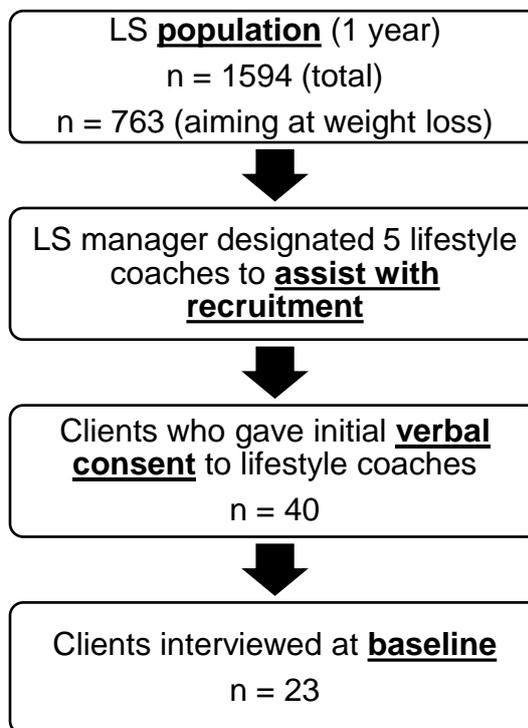


Figure 5.1 Baseline recruitment process of LS clients

Lifestyle coaches were first met by the researcher to state the purpose and procedure of the study. Follow up calls were made to discuss further and address possible concerns. As part of LS delivery, the lifestyle coaches were allocated a number of referrals to contact each week. During the first call made by the lifestyle coach, clients were asked if they were interested in taking part in an evaluation study of the LS, which involved an interview with a Staffordshire University researcher. Those clients who gave verbal consent (n=40) to the LS coach were contacted by the researcher by telephone to introduce them to the purpose of the interview, topics to be discussed, and the estimated duration of the interview (approximately between 30 minutes to an hour). Out of those who expressed interest, an interview was arranged (n=23), as shown in Figure 5.1.

5.2.1.4. Development of the semi-structured interview schedule (LS and MCM)

Interview schedules for each programme (LS and My Community Matters (MCM)) were jointly constructed as they shared the same research questions, which led to a similar set of topics: understanding of the programme, reasons for taking part, expectations from the programme, and previous experiences with similar programmes. To assist the researcher to conduct the interviews, those topics were

then transformed into detailed questions (Charmaz, 2014). However, in reality these questions were suggested in a rather open manner, as if they were topics and making sure that a participant-centred approach could be implemented.

The development of the interview schedules involved four stages. Firstly, for data collection to be aligned with an inductive approach, the interview schedule was informed through limited literature review (Charmaz, 2014). Secondly, a familiarisation stage with MCM (section 7.2.1.1) and LS (section 5.2.1.1) informed the initial set of questions. This familiarisation stage with MCM implied an extensive involvement of the researcher with the MCM programme and its participants before any interview took place, lasting from one to four months (depending on the targeted area). The familiarisation stage with the LS involved several discussions with the programme organisers and deliverers regarding programme implementation and the research design. The familiarisation stage with both programmes helped the researcher to understand dynamics of the programme and their participants, and reflect on the appropriateness of topics and questions. Thirdly, the interview schedule was piloted in a focus group conducted by the researcher with residents from one of the formerly targeted areas of MCM, which was excluded from this research. Feedback from this pilot focus group was considered and the schedule was amended accordingly (see MCM interview schedule in Appendix 2). Fourthly, the final version of MCM interview schedule was adapted to the characteristics of the LS and target population (BMI>30). Finally, the LS interview schedule was piloted with two researchers from Staffordshire University with knowledge of the programme. Following these pilot interviews, a number of further changes were made, particularly in the terminology used, leading to the final version of the LS interview schedule (Appendix 3). This was open with fluidity in the order of questions and prompts as appropriate and, although further changes after conducting the first interviews with LS clients were possible, they were not necessary.

5.2.1.5. Data collection procedure

Ethical approval was gained from the Faculty of Health Sciences at Staffordshire University before the start of data collection. Appendix 4 includes the main ethical considerations for this research.

Clients were offered interviews at their home or an alternative preferred venue (i.e., local community centre). Twenty-two LS clients opted to be interviewed at home and one opted to be interviewed at her work place. All semi-structured interviews took place in a quiet room, but three were frequently interrupted by family members entering the room. Interviews were held between January 2014 and June 2014, prior to the start of the individuals' period of programme support. Interviews were conducted following three stages:

First, once the clients were met at their home, they were asked to read an information sheet that explained the research (Appendix 5) with a verbal explanation. Clients were told a number of details: they had been invited to take part as part of a convenience sampling procedure; the interview was going to be voice-recorded using a digital Dictaphone; interview data would be anonymised; the research involved a second interview to take place either at six month or one year follow up; this was part of an evaluation of the LS programme, the interviewer's doctoral thesis, and potentially scientific papers. Finally, clients were reminded that they had the right to withdraw their participation at any time. After clients had been given the opportunity to ask questions, participants were handed a consent form (Appendix 6) to specify whether or not they were willing to participate in this research and whether or not their lifestyle coach could provide the researcher with information gathered routinely as part of the programme delivery, such as body mass index (BMI) or agreed goals with the lifestyle coach. Once the client gave written consent, demographic data were collected (gender, age, ethnic group, work status and postcode).

Secondly, before the voice recorder was switched on, the researcher mentioned that there were no right or wrong answers as the interview focused on learning from their individual experiences and views. Clients were informed that some concepts might be explored during the interview, with the intention of understanding what those meant to the interviewee, instead of assessing the client's knowledge. The researcher also highlighted that language clarifications may at times be needed, as English was not the interviewer's first language.

Thirdly, interviews ended by asking clients whether they would like to add anything else to the conversation, whether they would like to ask any question of the researcher, and whether they wanted to see any results materials from the research (e.g., interview transcript, evaluation report, or thesis). Participants were thanked and reminded about the possibility of being contacted for a second

interview. Written consent to be contacted again was obtained accordingly. Interviews ranged from 22 minutes to one hour and two minutes, with an average duration of 47 minutes. The 22 minutes interview was something of an outlier. Its relative short duration related to the presence of several relatives during the interview. The researcher invited them to leave the room, but opted to stay. Consequently the researcher-participant rapport was less strong and, as a result, the interview was shorter.

To avoid bias by only capturing experiences from those who successfully completed the programme (one year), all participants were asked to be contacted at six months follow-up to check for their involvement with the LS. Those who dropped out at six months follow-up would be invited to take part in a second interview then. Those who did not drop out would be contacted at one year follow-up and would be invited to a second interview then.

Immediately following each interview, the researcher reflected on the interview. Reflections involved making notes (Microsoft OneNote from a password secure laptop) covering a brief description of personal features of the interviewee with the purpose of remembering each interviewed participant at the end of data collection. Reflections also covered a description of the place and room of the interview, how the interview went, and reflections on how the researcher felt during the interview.

Participants' accounts are described in the findings section using pseudonyms to protect participants' identity. In very specific occasions, relevant quotes involved personal information, which could breach anonymity when combining with the rest of quotes from the same interviewee. Pseudonyms were not provided then to ensure total anonymity. The word 'anonymous' was used instead of the suggested pseudonym.

5.3. Findings

5.3.1. Participant characteristics

Table 5.1 shows a breakdown of the demographic data from all interviewees who took part in either the baseline (Chapter 5) or follow-up interviews (Chapter 6).

Table 5.1 LS interviewee demographic data

Pseudonym	Gender	Ethnicity group	Age	Participation in interviews
Anna	<i>All female</i>	<i>All White British</i>	40	Both interviews
Jane			45	Only baseline
Kim			26	Only baseline
Joanne			50	Both interviews
Tina			36	Only baseline
Sarah			48	Only baseline
Hope			37	Both interviews
Kelly			27	Only baseline
Charlotte			59	Both interviews
Iris			61	Both interviews
Chloe			33	Only baseline
Jacqueline			52	Both interviews
Helen			55	Only baseline
Andrea			40	Both interviews
Samantha			26	Only baseline
Alice			60	Only baseline
Laura			52	Only baseline
Molly			50	Only baseline
Toni			46	Only baseline
Amanda			40	Only baseline
Keira			22	Only baseline
Sophie			45	Only baseline
Gill			34	Only baseline
Rosalie			57	Only follow-up
Raquel			28	Only follow-up
Alexandra			35	Only follow-up
Karen			60	Only follow-up
Claire			27	Only follow-up
Tamara	39	Only follow-up		

Participants' ages ranged between 22 and 61 years at the time of the first interview. Participants were categorised into five age groups (see Table 5.2 below) and most interviewees (86.9%) were between 26 and 60 years, following a similar trend to the general participation pool (84.0%).

Table 5.2 Comparison of age groups (LS population and interviews sample)

Age category	Total of LS clients (n=754)	%	Total of interviewees (n=23)	%
18 to 25 years	61	8.1	1	4.3
26 to 40 years	278	36.9	9	39.1
41 to 60 years	355	47.1	11	47.8
61 to 75 years	57	7.6	2	8.7
75+ years	3	0.4	0	0

All interviewees were female and White British, slightly deviating from programme participant demographics (74% female; 88.7% White British). Recruiters (lifestyle coaches) were encouraged to invite males and participants from different ethnic groups to take part in this study but only White British female gave consent. English was first language for all interviewees. After taking part in the baseline interview, all clients except one attended at least the first appointment with the lifestyle coach.

Table 5.3 Comparison of index of multiple deprivation between total programme population and interviews sample

	Clients attending		Sample of interviewees	
	n	%	n	%
(most deprived) 1	485	30.7	10	27.8
2	352	22.3	4	11.1
3	117	7.4	5	13.9
4	116	7.3	2	5.6
5	125	7.9	5	13.9
6	125	7.9	1	2.8
7	102	6.4	4	11.1
8	68	4.3	5	13.9
9	60	3.8		
(least deprived) 10	9	0.6		
No match	23	1.5		
Total	1582		23+13	

In terms of index of multiple deprivation (Department for Communities and Local Government, 2015), Table 5.3 shows deprivation levels for clients taking part in baseline (n=23) and follow-up interviews (n=13). Although interviewee figures are small, interviewees followed a similar deprivation trend when comparing with the total population attending the LS.

In terms of BMI, most interviews were obese (BMI \geq 30, n=6) or morbidly obese (BMI \geq 40, n=12), which does not correspond with the programme BMI distribution, where 63.6% were obese and 29.5% were morbidly obese.

5.3.2. Overview of findings from thematic analysis of baseline interviews

Analysis of interviews with clients at baseline revealed three master themes. Master themes have been split into sub-themes, and sub-themes split into topics (Table 5.4). A description of each master theme has been provided within the next three sections, which incorporates illustrative direct quotations from clients.

5.3.3. Master theme 1: Past experiences

This master theme includes past experiences from two points of view, losing weight (sub-theme 1) and being obese (sub-theme 2).

5.3.3.1. Sub-theme 1: Past experiences of losing weight

Interviewed clients described experiences of losing weight in the past. A number of approaches to lose weight prior to referral to the LS were mentioned. These have been grouped in two types: Supported and unsupported approaches.

- **Supported approaches**

This refers to methods of losing weight that are supported by professional help. For example clients: '*went on diet and tablets from the doctor*' {Jane}, '*got a gastric bypass*' {Toni}, or '*went to [a Commercial Weight Loss Programme (CWLP)]*' {Gill}. The most commonly supported approach was attending a CWLP. While some clients' accounts revealed positive experiences that seemed to motivate attendance and weight loss, others revealed difficulties. In terms of positive experiences, many clients reported having succeeded when they had attended a CWLP in the past, achieving considerable weight loss, '*I lost nearly 3 stone*' {Anna}. This is supported by recent research that has shown that a range of CWLPs are effective in achieving weight loss at short term (Ahern *et al.*, 2011; Jolly, Lewis and Kipping, 2011; Dixon, Shcherba and Kipping, 2012).

Table 5.4 Overview of findings from thematic analysis (LS)

Master theme	Subthemes	Topics
(5.3.3) Past experiences	(5.3.3.1) Past experiences of losing weight	<ul style="list-style-type: none"> · Supported approaches · Unsupported approaches
	(5.3.3.2) Past experiences of being obese	<ul style="list-style-type: none"> · Perceived reasons for being obese · Re-gaining lost weight
(5.3.4) Perceptions of taking responsibility over own health	(5.3.4.1) Expectations from the LS	(None)
	(5.3.4.2) Level of self-involvement at baseline	(None)
(5.3.5) Perceived barriers and (some motivators)	(5.3.5.1) Barriers and motivators concerning intrapersonal matters	<ul style="list-style-type: none"> · Improving mental health as a motivator · Experiences of physical illness as a barrier to change · Improving physical health as a motivator · Current way of life
	(5.3.5.2) Barriers concerning clients' environment	<ul style="list-style-type: none"> · Barriers concerning surrounding area · Barriers concerning characteristics of services

(number) = specific section

Positive experiences included aspects such as being easy to follow, receiving social support within a comfortable and non-judgemental environment, gaining new ideas to address weight loss, or perceiving being weighed as an incentive.

Basically they [CWLP] just say 'well, we are all here for the same reason', you know, so you know, 'why judge each other sort of thing? {Molly}

All of the clients who had a positive experience and verbalised feeling satisfied with CWLP also mentioned implicitly or explicitly to have re-gained the weight afterwards. These clients shared a sense of depending on their preferred CWLP, as they verbalised not feeling able to lose weight without the type of support described above. In addition to reinforcing the short term effects of CWLPs, this also highlighted a preference for weight loss approaches that help to quickly achieve a meaningful weight loss, independent of whether or not the weight loss

could be sustained over time, which is consistent with previous research (Thomas *et al.*, 2008).

A small number of clients viewed their experience of CWLP less positively. The most commonly reported reason was a sense of dependency, as these clients believed it was not a success to lose weight if they were not able to maintain the weight loss post-CWLP. Therefore, it was appreciated that being able to maintain the weight loss was a critical part of accomplishment. In the context of empowerment, enabling people to gain control over their own health (WHO, 1986), clients wanting to maintain their weight loss could be interpreted as being a step forwards in taking responsibility (or control) over their own health, when comparing to those who are not concerned about sustaining weight loss.

In terms of further difficulties, one client also shared her negative experience of losing weight slowly: *'I already lost about 5 stone, but that's taken me 8 years'* {Jacqueline}, reporting that she had been attending a particular CWLP for all that time, which was no longer helping. She also reported negative experiences related to feeling a lack of professional support and feeling pressurised by the social support of the group session.

[The CWLP leader]'d say, 'well, I can't see where you've gone wrong there, try better next week' {mimicking}. The following week I went back and I had put half a pound on yet I'd eaten the same of what I'd eaten the week before. And she'd say 'I don't know why that is, try better for next week', and I'm thinking 'what I'm paying you this money for? You're not encouraging, in fact you're patronising and all I want to do is stamp on your head {laughs}' {Jacqueline}

Accounts from Jacqueline highlighted blaming of CWLP for her lack of achievement. In the context of taking control over their own health, clients providing positive and negative views on their past experiences with CWLPs seem to agree on one aspect, expecting an external solution to solve their weight problem. This idea will be further explored in section 5.3.4.1, which focuses on understanding clients' expectations from the LS.

This sub-section has included a description of the supported approaches that LS clients had tried in the past to lose weight, mostly commonly, CWLP with positive and negative experiences. The next sub-section includes a similar account in relation to the clients' experiences regarding undertaken unsupported approaches.

- **Unsupported approaches**

Unsupported approaches refer to diet and/or exercise approaches to weight loss that were largely self-led. Exercising at a fitness centre was most commonly reported. Unsupported experiences were mainly perceived as negative since clients' accounts focused on the difficulties, with only few positive views.

A small number of clients reported experiences of following a diet by themselves. In most cases clients were applying principles that they had previously learned when attending a 'supported' CWLP. However, all who mentioned following a diet by themselves explained having difficulties in '*sticking to it*' or '*coming to a standstill*', which led them to yo-yoing with their weight.

I tend to be on a cycle at the moment, I lose two and half stones, three stone, then I'm doing so well that you kind of 'well I'm losing weight, I can increase the calories or have a bit of something else coz I'm still losing them', you have a few bad weeks and you kind of come off it again. Whereas if you're following a [CWLP], you can't do that {Molly}

This reinforced the idea of expecting an external solution such as a CWLP to solve their weight problem (noted above).

Those clients who reported exercising as a combined or stand-alone method to lose weight stated that attending a fitness centre, with one exercising at home using a fitness video game, and another client attending group fitness classes. Most clients who shared the experience of fitness centres disclosed feeling self-conscious in such environment.

I joined a gym before but you can only do so much because [you are obese and unfit]. And I think that's what's put me off because you do get breathless and you're conscious of everybody else around you {Kim}

Finally, a small number of clients found exercising at a fitness centre '*boring*'. This contrasts with the views of some other clients, who enjoyed exercising at a fitness centre and also perceived health benefits as a result. However, barriers such as financial constraints or lack of transport made them stop exercising.

In addition to enabling clients, the LS is meant to address barriers associated with attending a fitness centre by providing free vouchers to specific centres across the city, including access to a personal trainer who can provide the client with a

specific exercise programme. This further suggests that the LS approach is appropriate to the needs of this population (Marin *et al.*, 1995; Kreuter *et al.*, 2003). However, one could also argue that this aspect of the LS might jeopardise the enabling process implicated in the concept of empowerment, which suggests enabling individuals to identify needs themselves, but also find their own solutions and take action (Laverack, 2004). Therefore, follow-up data will need to clarify whether clients experience the problem-solving process as being given solutions or as participating in finding solutions.

5.3.3.2. Sub-theme 2: Being obese

Clients described how they had become obese as well as how they had re-gained the lost weight through previous relapses. This section covers a description of both types of clients' perceptions.

- **Perceived reasons for being obese**

Many of the clients reported periods when they had struggled with their mental health and wellbeing. Numerous clients stated that they had suffered from a range of conditions, such as depression, anxiety and/or experiencing panic attacks, with some stating that they were medicated, *'I am on depression pills like since I lost me parents'* {Laura}. Further clients referred to struggling with their mental wellbeing, referring to demands of daily life (e.g., being a full-time carer) or feeling isolated, *'I'm in here on my own so a bit of company'* {Charlotte}. Most clients associated mental health with their unhealthy weight. Some even made a specific relationship to binge eating. A small number also perceived mental health as a barrier to carry on a healthy lifestyle, which will be further explored in section 5.3.5.

Only two clients stated having always been overweight, not associating their unhealthy weight with any particular reason. However, one of these clients gave numerous accounts of feeling censured by certain individuals (or society) for being overweight, contributing to mental health problems. The experience of being overweight or obese leading to further mental health and wellbeing issues, and that in a vicious cycle was frequently shared.

People are embarrassed about the way they look, so they don't wanna go out of the house and then they get depressed because they don't go out of the house {Samantha}

Therefore, on the one hand, some clients suffered from a mental health condition, which was perceived as the cause of becoming obese. Others perceived that becoming/being obese had led them to mental health problems. In both cases, the idea of being trapped in a vicious cycle that was making them feel worse was often shared. The inductive methodology of this research exposed this finding, which questions the general consensus of addressing obesity through initiatives targeting energy intake and expenditure through promoting dietary habits and/or physical activity (Caballero, 2007). Therefore, it raises the question of whether obesity prevention initiatives should consider the role of mental health issues when tackling obesity. Through systematic reviews of the literature it has been suggested that the epidemic feature of obesity makes it difficult to generalise a relationship between obesity and depression (Markowitz, Friedman and Arent, 2008). However, severely obese individuals, females, and individuals with low socioeconomic status were suggested to have increased risk of depression. These characteristics match with the sample of this study, which might explain the high number of accounts of lacking mental health and/or wellbeing.

Two further clients provided additional reasons for weight gain, that is, retention of weight gained in pregnancy, *'I never lost me pregnancy weight at all'* {Gill}; and smoking cessation, *'you do that [quitting smoking] and then it makes you put all that weight on'* {Chloe}. Both pregnancy and smoking cessation have been previously associated with weight gain and obesity (Rooney and Schauburger, 2002; Filozof, Fernández-Pinilla and Fernández-Cruz, 2004).

- **Re-gaining lost weight**

As already highlighted in the 'supported' and 'unsupported' sections (5.3.3.1), most clients who had attended a CWLP reported losing weight but not being able to maintain their weight loss. The detail of such accounts was provided in section 5.3.3.1.

5.3.4. Master theme 2: Perceptions of responsibility over own health

The second master theme focuses on the extent to which LS clients felt responsible for their own health before the start of the LS programme. These are broadly grouped as relying on external support and taking responsibility. These should be considered as part of a single continuum; at one end there is total reliance on external help; at the other end, there is full responsibility over health and an autonomous healthy lifestyle. This continuum will be outlined next as part of two sub-themes: expectations from the LS and level of self-involvement at baseline.

5.3.4.1. Sub-theme 3: Expectations from the LS

Descriptions of clients' accounts have been presented as a sequence, initially introducing clients' accounts that expressed expecting higher levels of external support; to conclude with clients' expectations that expressed lesser levels of external support and a higher level of intentions to make an effort.

Starting with accounts indicating reliance on external support, a high number of clients expected continued support from the LS, especially during challenging times: *'if I'm struggling one week, and I know [the lifestyle coach] is at the end of the phone if I need her, that will help me'* {Chloe}. Many also expected the programme to take action for them, as they hoped the LS would *'encourage'* and *'motivate'* them, and also *'set targets'*. In terms of being encouraged, clients suggested slightly different interpretations of this concept. Some aspired *'to be made to do it'* {Helen}, others preferred *'not being told what to do'*, just being suggested alternatives {Iris}, and some others were expecting to *'be pushed'* {Jane} or *'get a kick'* {Keira}. In terms of being motivated, many clients expected the LS to make them believe they can do it.

For somebody to say 'yes! you can do it', and 'yes! It's possible to do this' instead of just pushing you off and say 'no, just go away' and 'do this and you'll be fine' {Kim}

From a slightly different angle, one client wondered if counselling would be part of the process of getting motivated:

I had been for counselling [due to losing a close relative] and that helped, so I don't know if this is gonna be some counselling in some way? For motivation maybe? {Sarah}

A high number of clients expected to be weighed as an integral part of the LS, as it was previously seen as an essential supportive element: *'I only go to be weighed'* {Tina}. A small number provided with further insight, disclosing that being weighed on a regular basis helped them adhere to the diet plan.

You will do it [diet] because you know somebody is going to weigh you. If you think 'oh! I want that cake!' nobody will know about it, you tend to slip back [when not being weighed] {Joanne}

In contrast, only being weighed was not enough for everyone:

I've done it [losing weight] through the doctors in the past and didn't go very far coz you just go in, they do your blood pressure, weigh you, and then you're out, there is no support or telling you where you're going wrong {Molly}

Further analysis of interviews reinforced the idea of gaining further support, with clients also expecting additional evaluating strategies that would uncover what reason(s) are the causes in addition to gaining advice to address the cause of the problem or encountered difficulties.

If you could sort of say [to the lifestyle coach], 'well, I don't think this is working', 'how can I change that?', 'how can I do this different?' {Hope}

Finally, a high number of clients' accounts denoted expecting guidance from the LS. The guidance was expected to be individualised, particularly when clients mentioned exercising at a fitness centre as an option:

I don't want to overdo it [exercising], and I don't want to set myself back anyway, by injury or causing something else to happen [in addition to the ailments I've got] {Andrea}

Some clients expected that guidance would provide them with knowledge, with some expecting the transfer of knowledge enabling them to make healthier choices. However, this contrasted with those who had attended a CWLP and reported gaining knowledge related to healthy eating, but they gave accounts of feeling incapable of losing weight by themselves.

I followed [name of CWLP] in the past so I know roughly what I'm doing with that, but obviously the class, because I've done it online last time, so by going to a class you get a little bit more support {Laura}

This suggests that providing knowledge needs to be accompanied by additional component(s). The fact that many clients added that they were not able to adhere to healthy eating after stopping attending CWLPs also suggests that a piece of the puzzle is still missing with CWLPs. The following client implicitly indicated having missed a component:

It's long term I need to look at because I've done things in the past and they worked for a short period and I slipped back to old way and then put weight on, and get lazy basically. So I need something, I don't know if it is change your attitude mentally {Sarah}

In terms of accounts indicating taking responsibility, a number of clients suggested understanding that they also needed to bring something to the table. Clients indicated taking ownership to a certain extent, with a small number of clients providing accounts that it was their responsibility to work together with professionals to achieve a better health status.

They sort me out at hospital [lung operation], I've got to do my part this end [losing weight to a healthy level] {Charlotte}

Along the same lines, a few other clients' accounts referred to taking a level of responsibility to give back to the LS, *'in return I've got to give back'* to those LS professionals who are going to be *'helping me'* {Kim}. Further clients mentioned a willingness to contribute, acknowledging that they needed to take a level of responsibility over the process of losing weight and adopting a healthier lifestyle.

The doctor said 'I can offer you so much stuff', he says 'you either take it or you don't, but if you take it then you're helping yourself' and that's what I've got to do {Gill}

5.3.4.2. Sub-theme 4: Level of self-involvement at baseline

This section presents clients' accounts that refer to what type of action they were taking at baseline with the purpose of achieving a healthier weight or lifestyle. In terms of taking responsibility before being referred, a small number of clients'

accounted of being asked by the health professional to attend the lifestyle service and did not show an initial concern about their weight or health themselves.

[The general practitioner] just asked if I wanted to go on [the lifestyle service]
{Sophie}

A larger number of clients provided accounts of having concerns about their own weight and health, which led them to ask for help.

*I asked about if I could get any help [with high blood pressure and high BMI],
and obviously the doctor referred me to the Lifestyle [Service]* {Helen}

Once clients had been referred to the LS, many implicitly suggested not taking any action as they were waiting for the programme to start: *'I'm looking forward to it [the LS], so I can get started'* {Jane}. Some took the initiative to sign up for a CWLP at their own expense, and consequently had already started losing weight. A further step was incorporating some changes without or in anticipation of professional support. Various clients reported having made changes to their diet: *'[my friend and I] changed from all the food that I was previously eating to things like fruit and veg'* {Kelly}; *'in three weeks that I've been waiting for [the LS to start], I've been following [the Heart Foundation recommendations provided by nurse]'* {Jacqueline}; and/or regarding their physical activity levels: *'walking up the stairs a bit quicker, and I started doing pilates at work'* {Andrea}; *'I've started walking past the car now'* {Laura}.

Based on the general findings associated with 'expectations from the LS' (sub-theme 3) and 'level of self-involvement at baseline' (sub-theme 4), approaches that implied access to external support were favoured, reinforcing findings from sub-theme 1. Only a small number of clients gave accounts that suggested taking action at baseline towards losing weight or that recognised the responsibility of having to contribute. In general, this revealed an expectation of on-going support from professionals, including detailed advice and close monitoring of progress, in other words, expecting to be told what to do. This finding confirms earlier work by Bidgood and Buckroyd (2005), where obese adults were described as needing external support to lose weight.

Expecting external support was common with the few clients who did not report having gained support from CWLPs, but also amongst those who had had experiences with CWLPs, irrespective of whether positive or negative. This expectation is incongruent with the principles of empowerment. One possible

explanation, particularly for the group with no experience with CWLPs, might relate to the type of power relationship they are used to since all clients were referred to the LS from the health care system, usually by their general practitioner or nurse. As already highlighted in the literature review (Chapter 2), health care is mainly based on the bio-medical model of health, where professionals are considered to be the experts and patients act as passive agents, being told what to do to solve the problem, which often implies a power-over relationship (Laverack, 2004). Therefore, a predetermined mind-set based on past experiences with the health care system might have played a role when clients gave accounts of relying on external support. For clients who had prior experienced with CWLP, the repeated weight loss attempts mentioned by clients suggested that despite weight loss, this was frequently regained. This supports Markowitz et al. (2008), who suggested that obese individuals finding difficulties to adhere to diet and exercise regimes. Lack of self-efficacy and optimism were suggested as possible mechanisms to explain difficulties with adherence (Markowitz, Friedman and Arent, 2008).

The LS may well be appropriate to alleviate a lack of self-efficacy as it aims to enable individuals to change their harmful behaviours. Relating to the concept of empowerment, this has often been associated with self-efficacy (Gibson, 1991; Anderson, 1995; Aujoulat, D'Hoore and Deccache, 2007; Wilson, Kendall and Brooks, 2007). Furthermore, lifestyle coaches get trained in motivational interviewing, which is a counselling technique that supports self-efficacy, trying to increase clients' beliefs that they can change, and accentuates the positive (Miller and Rollnick, 2002). The follow-up study (Chapter 6) will clarify how participants experience the LS and such programme components.

Another possible explanation for expecting external support could be related to the type of approach used in CWLPs. Clients' accounts frequently involved being given instructions to follow. This finding is supported by a study from Thomas et al. (2008), which concluded that CWLPs primarily focused on short-term guidance, lacking a sustained approach in which clients would be supported or encouraged to continue in the long term, post-CWLP. Again, the short-term and restrictive approach does not align with the concept of empowerment, enabling individuals to take control over health, and could serve as an explanation of why many clients expected a great level of weight loss in a short period of time and were not considering weight loss maintenance. In addition, past experiences seemed to

have shaped their expectations, indicating a dependence on specific CWLPs, in particular, and external support, in general.

The next master theme is expected to add further insight into understanding the perceptions and experiences of taking or not taking responsibility over one's own health.

5.3.5. Master theme 3: Perceived barriers (and some motivators)

The third master theme focuses on describing what type of barriers clients perceived towards losing weight and/or adopting a healthier lifestyle during baseline interviews. Two sub-themes were identified: barriers and motivators concerning intrapersonal matters (subtheme 5) and barriers concerning physical environment (subtheme 6).

5.3.5.1. Sub-theme 5: Barriers and motivators concerning intrapersonal matters

Three types of intrapersonal barriers (and motivators) were identified: 'mental illness' 'physical illness' and 'current way of life'.

- **Experiences of mental illness as a barrier to change**

Mental health has already been discussed in this chapter as part of 'perceived reasons for being obese' (sub-theme 2). Findings indicated an association between clients' mental illness and their unhealthy weight. The present section focuses on a different perspective, aiming to gain insight into how mental illness was perceived by clients as a barrier to adopt a healthy lifestyle.

Those who reported suffering from a mental illness (e.g., depression) considered their mental condition as a barrier itself, *'when you're battling with depression as well that's another thing, everything is too much hard work for you'* {Jane}. Others also indicated some further experiences that showed how their day-to-day life was affected by their mental illness.

With me depression obviously I don't want to do, I don't want to get up in the morning from times or I don't want to get out of bed or I don't, I just want to be in the house {Amanda}

This quote represents experiencing a lack of energy to engage in 'normal life'. This is supported by evidence that individuals suffering from depression (or other mental illnesses) may be unable to undertake day-to-day activities, in addition to experiencing low mood, tiredness, sleep problems and high rates of absence from work (Tylee et al. 1999; Keyes 2002). It is assumed that trying to dedicate energy in making a change in lifestyle might be particularly challenging for people suffering from mental illnesses, as suggested by Ussher et al. (2007) in their study of barriers to physical activity amongst individuals with severe mental illness. The latter study suggested individuals' interests in gaining access to external support, such as from a fitness instructor or medical doctor, as a suitable solution. These suggestions for implementation support an appropriateness of the LS. Although the LS does not provide support from clinicians, referred individuals have access to appointments with a lifestyle coach over the course of one year. In addition, those who plan to exercise are entitled to see a fitness instructor.

One particular client who was morbidly obese (BMI>40), and suffered from mental and physical health constraints, gave numerous accounts that denoted perceiving substantial barriers to attending the LS. For example:

I don't know how I have to get up there [for the appointment with my lifestyle service, which has been arranged at the first floor of the leisure centre] if I haven't got a lift [to reach the room] {Anonymous}

I'm like with my confidence of like walking into a room where there is loads of other people is very low. I have panic attacks {Anonymous}

Lack of confidence was shared particularly amongst clients who disclosed suffering from a mental illness, but also amongst some who did not indicate suffering from a mental illness, stating: '*you don't really like going out*' {Kim}. This was perceived to affect the current lifestyle:

If I've got somebody with me, I could probably walk in a gym, but I do hate going anywhere like that, you know, no, I'm not confident in that respect {Keira}

The lack of confidence reported in this research might explain why clients would find it difficult to engage in daily life activities, in general, and lifestyle related activities, in particular. Ussher et al. (2007) found lack of confidence influencing

exercise, but lack of confidence appears to go beyond the specificity of any targeted behaviour. It appears to be a barrier that affects the entire life of the individual, particularly from a social function perspective (e.g., going out). This is an additional barrier that the LS might have to deal with. Follow-up stage will clarify whether or not this was dealt and how it was experienced by clients.

- **Improving mental health as a motivator**

Many clients mentioned the aspiration of improving their confidence and self-esteem. Most clients associated gaining confidence as a direct consequence of losing weight, *'plus make myself feel better, get myself more confident because I lack confidence, loads'* {Laura}. A lack of confidence has been described above as a barrier but could also be considered a motivator. For example, a number of clients stated that giving priority to others' needs was a barrier (described below, as part of the topic 'current way of life'), but some also perceived this barrier as a motivator, wanting to start dedicating time to their own needs.

I love all me children and me grandchildren, but I'm not just a mum and I'm not just a grandmother, I'm a person on me own right, and I think 'well, I should have to move myself to do these things [exercising and eating healthier]', to make myself feel better about myself' {Alice}

Similar to this, some clients identified personal needs, including feeling isolated or being drained by personal circumstances (e.g., being a carer) and perceived their participation in the LS as an opportunity for improvement.

If [the LS] works for me, it's gonna make me a lot happier, you know, give me a bit more energy, you know, because I've cared for both of my parents for the past four and half years {Helen}

In the context of empowerment, perceiving some aspects as barriers and motivators could signify a step forwards towards taking control over health. Data revealed two approaches to dealing with barriers. There were those who stated barriers as the end point, and those who saw barriers but at the same time added opportunities to change. It could be argued that those who see problems and opportunities might be more in control than those who can only see the problems, following empowering theory of enabling individuals to identify needs and to find solutions to problems (Laverack, 2004).

- **Experiences of physical illness as a barrier to change**

Most clients reported a physical condition that affected their day-to-day life. Most reported conditions related to their musculoskeletal system: *‘[severe] neck pain’, ‘arthritis’, ‘hypermobility syndrome’ and ‘flat footed’*; and their respiratory system: *‘idiopathic interstitial disease’, ‘pulmonary embolism’, or ‘asthma’*. Some further clients reported conditions related to other body systems: *‘epilepsy’, ‘prolapse’, or ‘[severe] skin abscesses’*. Most clients gave accounts of the reported physical condition preventing them from exercising:

Last year I couldn’t get into [exercise] again because my knee was so bad that I could hardly walk, coz I’ve got arthritis in my knees {breathes in} {Helen}

Some clients associated their obesity with mobility restrictions:

I don’t want to be breathless anymore, going upstairs, and walking around and, you know, my back aches {Kim}

I’ve got two choices on how to get down the stairs, I either fall down the stairs or I have to hold both sides and get myself down that way. The issue with it now is obviously getting out of the bath once you’re in {Kelly}

However, many of these clients indicated having a positive attitude towards exercising as part of the LS, as they were expecting the programme to address this by providing them with an individualised exercise programme that could consider their condition and ailments.

- **Improving physical health as a motivator**

Many clients’ accounts revealed a desire for being able to comfortably undertake daily life activities, such as *‘walk without being out of breath, if I can walk up and down the stairs comfortably’ {Keira}*.

Some clients who were already suffering from a chronic condition (e.g., asthma) indicated having the motivation to attend the LS and lose weight and improve their current condition.

I always had a bit of problem with my joints, so I keep thinking to myself, ‘oh the less weight that I carry, the better will be for my joints’ {Andrea}

In the context of empowerment, this mirrors the same pattern of seeing both the problem and the solution, as suggested above in relation to mental health/illness barriers and motivators.

From a different perspective, many clients' accounts involved a sense of fear towards developing a lethal condition as a consequence of being obese. Their fear was often associated with having lost a close relative.

So then you get to thinking 'well, if that [dying as my dad from a heart attack] happens to me' {Laura}

Those who gave accounts of feeling fear to develop a serious illness also suggested a desire of wanting to live long, *'I want to be able to see me grandchildren grow up'* {Jacqueline}; and be able to enjoy life, *'playing with [my children] football'* {Tina}. It was observed that these two types of ideas were often exemplified with a reference to own offspring. Clients who shared feeling fear to die at a young age gave accounts that indicated a desire for addressing risk factors to prevent further serious conditions.

I've got the cancer gene in my family so, again, weight is a big factor in that as well, so if I can get down to... the more weight I lose, the less chance [of cancer] obviously {Molly}

In the context of empowerment, most clients showed awareness of how obesity could lead to developing serious conditions, some being life threatening, which has been identified as an essential component of empowerment (Virtanen, Leino-kilpi and Salanterä, 2007). Therefore, they indicated having the knowledge and also gave accounts of showing motivation to try to look after their health by preventing further complications, showing an intention to take control over their health.

- **Current way of life**

Being busy was a barrier that a small number of clients mentioned, providing examples such as having family commitments or long commutes on the top of their daily lives. These were suggested as added constraints towards adopting a healthier lifestyle. A number of clients also added a need to prioritise everyone else's needs. This was identified as a further dimension of the barrier being busy.

I was on me own [no partner and no kids at the time], so I think I got more time to me, and I didn't have to consider somebody else {Gill}

This barrier was suggested as a motivator as mentioned above (as part of topic 'improving mental health as a motivator').

5.3.5.2. Sub-theme 6: Barriers concerning clients' environment

As part of the environment, clients perceived two main types of barriers.

- **Barriers concerning surrounding area**

Some clients referred to a lack of weight loss services within the immediate area where they lived. Therefore, the lack of public transportation was a commonly reported barrier.

'I suppose you've got to have a car to start off with' {Charlotte}

One client also referred to perceiving the area where she lived as unhealthy due to the type of food available, considering choosing healthy food as a challenge.

[Take-away] is too readily available [on this street], 'I want to be healthy' but you know 'I can't do it on me own' {Kelly}

Many clients indicated a sense of lack of trust in the area where they lived. One particular client associated this feeling of unsafety with other residents' lifestyles.

I just don't like [son, 16] getting out at night [there are] too many people out now and too many people fighting and night crime {Tina}

- **Barriers concerning characteristics of services**

The most commonly disclosed barrier concerning services was the elevated cost of services:

Yeah, it's a lot! And at the moment I can't afford it [to pay for gym and CWLP] {Anna}

And having to commit to (the cost) of a long term contract:

But I don't want to join a gym and pay for 12 month contract, if 4 weeks down the line they say to me, 'no this is no for you' {Toni}

A small number of clients also referred to the elevated cost of healthy eating. The researcher was made aware at the familiarisation stage that the LS addresses the financial barrier (for a number of weeks) associated with attending a local fitness centre. This gives further evidence of an initial level of appropriateness to clients' needs. Whether or not clients are enabled to find solutions to their difficulties through the LS still remains a question which will be addressed at follow-up.

Whilst lack of transportation and lack of healthy food options have previously been suggested as barriers to engage in healthy lifestyles amongst individuals living in deprived areas (Chinn *et al.*, 1999; Wrigley, Warm and Margetts, 2003), less studies have explored how social environment affects individuals and their behaviours (McNeill, Kreuter and Subramanian, 2006). Taking into account that the LS is an individual-level intervention focusing on behaviour changes instead of environmental issues, these barriers were *a priori* expected to go beyond its scope. Nonetheless, follow-up interviews will explore how individuals were supported and/or enabled to find solutions to all types of barriers.

5.4. Summary and conclusion

This Chapter explored individuals' past experiences of trying to lose weight and expectations from their upcoming participation in the Lifestyle Service, a health promotion programme that aims to help individuals to adopt a healthier lifestyle. The inductive approach to thematic analysis of 23 semi-structured interviews revealed that most clients had relied on external support to lose weight in the past, which seemed to align with expectations about the LS. Clients perceived that mental health and wellbeing were a major contributor towards their obesity, and self-perceptions of obese individuals were a possible barrier to adopting a healthier lifestyle. Thematic analysis also revealed a high level of appropriateness of the LS, as the main clients' needs seemed to be addressed by the general components of the LS. The question remains whether the LS can play a supportive role (addressing difficulties for clients, also referred to as providing role) or an enabling/empowering role (helping clients to address own difficulties) that might facilitate sustainable behaviour change. The follow-up stage will reveal what type of role the LS plays and how this is experienced by clients (Chapter 6). In conclusion, the LS is a needed programme from the perspective of having clients

who rely on external support, potentially helping them to transform external responsibility into internal responsibility, and gaining control over their own health.

*This chapter has included the baseline stage of the study of the Lifestyle Service.
The following chapter is concerned with the one year follow-up stage.*

Chapter 6

Individual-level health promotion programme: Client experiences from the Lifestyle Service at one year follow-up

6.1. Introduction

This study forms the second stage of a longitudinal study of the Lifestyle Service (LS). With baseline findings outlined in Chapter 5, the present chapter outlines client experiences with the LS programme after taking part for one year. A modified version of the grounded theory method (detailed in Chapter 4) was used to explore client experiences and explore what role the LS had in how empowerment is experienced, if at all.

6.2. Methodology

Methodology employed at the one year follow-up study has many similarities with that at baseline (Chapter 5), which will be referred to throughout this section to avoid repetition.

6.2.1. Process of data collection

A description of the familiarisation stage and interviewer are not different from Chapter 5, therefore, an insight into these components can be found in section 5.2.1.

6.2.1.1. Sampling and recruitment

Theoretical sampling is one of the fundamental elements of grounded theory (Charmaz, 2014). As discussed in section 5.2.1.3, 'real world' restrictions of the programme led to some compromises around the principles of theoretical

sampling. These were accommodated whenever possible, hence applying a modified version of grounded theory.

First, all 23 clients who took part in the baseline interview gave consent to be contacted again after six months and after one year, to identify those who had dropped out of the programme. At the six month follow-up call, a total of six clients had dropped out from the LS, none of whom agreed to take part in the follow-up interview. With two clients an invitation to a second interview was not possible due to change of personal contact details. One year follow-up calls were made to those clients who at 6 month follow-up reported that they were still attending the programme (n=17). From those, seven clients took part in the one year follow-up interview (see Figure 6.1, left hand side). These interviews took place between March and May 2015.

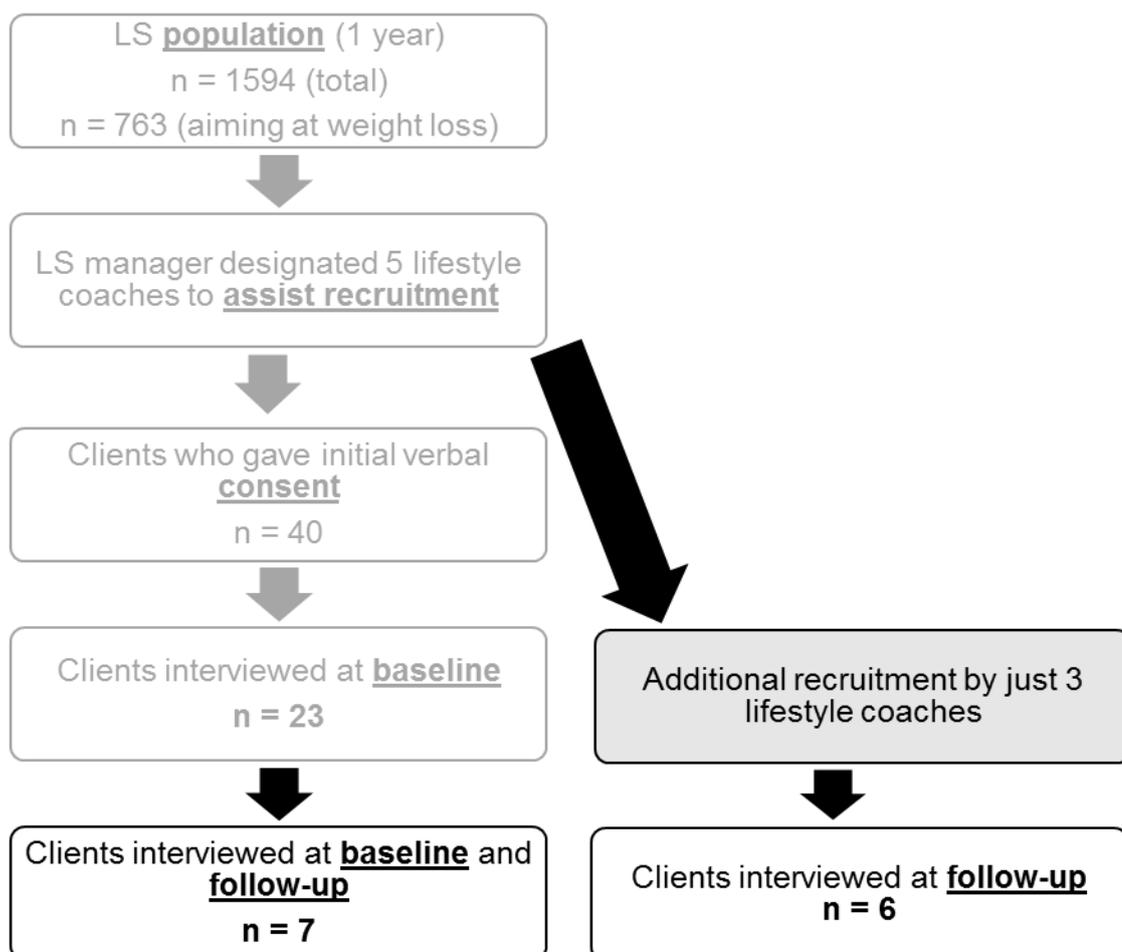


Figure 6.1 Follow-up recruitment process of LS clients

These first seven interviews form part of the initial sampling, where sampling criteria was established before the start of the study, and are not part of theoretical sampling (Charmaz, 2014). Data collection and analysis of these interviews took place simultaneously, revealing that data saturation was not achieved. Further data collection was necessary to further understand the categories to further the theoretical development of the analysis (Charmaz, 2014). Consequently, the LS manager and the most proactive lifestyle coaches at baseline (n=3) were contacted in May 2015 to recruit more clients. As recruitment proved to be highly challenging for the first seven clients, the inclusion criteria were broadened to include both those with BMI \geq 30 looking to lose weight and those considered part of a special population group, such as post-natal clients or post-bariatric surgery clients. Such clients who had arranged a final appointment to be signed off from the LS were invited to take part. It was expected that data from these new clients would help saturate categories from the point of view of 'taking responsibility'. This strategy was used to find negative cases, which '*typically refer to data that demonstrate sharp contrasts with the major pattern that accounts for most of the data*' (Charmaz 2014, p. 198). A total of nine further clients gave initial consent and six took part in an interview between June and September 2015 (see Figure 6.1). Data collection ended once analyses confirmed data saturation; i.e., not finding new insights regarding the attributes or properties of categories and relationships (between categories) (Charmaz, 2014).

6.2.1.2. Development of the semi-structured interview schedule

The development of the semi-structured interview schedule for follow-up adopted a similar approach to baseline (Chapter 5), as at the start it was informed by the research question and familiarisation stage. Researchers typically hold knowledge in their field before deciding on the research topic (Charmaz, 2014), which challenges the principle of seeing the researcher as a 'tabula rasa' (without previous knowledge about the research topic) (Dey, 1999), as was originally suggested by classic grounded theorists (Glaser and Strauss, 1967). Nevertheless, the researcher tried to avoid the baseline results influencing the development of this interview schedule (and further analysis). This involves bracketing, a technique that helps identify what the researcher knows about the experience before the phenomenon is studied (Tufford and Newman, 2010). In

addition, questions were formulated with flexibility and freedom to allow the phenomenon to be explored in-depth, avoiding conducting the study deductively (Strauss and Corbin, 1998).

The grounded theory method also suggests a dynamic interview schedule that develops as data collection and analysis take place, aiming to accommodate data saturation (Olson, 2011). Accordingly, starting data collection with open questions has been suggested (more typical of unstructured interviews), with subsequent follow-up of certain aspects constructed through data analysis (Olson, 2011). To illustrate this with an example, the following question was asked at baseline: *'Can you tell me about changes that you have noticed and might be related to your involvement with the Lifestyle Service?'*; At follow-up, the following question was asked instead: *'Can you give me an example of something that you have changed and has become a habit? How was this identified? How was this addressed? How did it become a habit?'* Appendix 7 includes the interview schedule employed at the beginning of the data collection and Appendix 8 includes one of the interview schedules employed towards the end of data collection.

6.2.1.3. Data collection procedure

The procedure for data collection at one year follow-up is similar to the one described at baseline (Chapter 5). The only differences are highlighted below and concern the two different types of clients: those interviewed twice (baseline and follow-up) and those only interviewed at follow-up.

The seven clients who also took part in the baseline interview had already provided written consent. These clients were again given the option of being interviewed at their home or a convenient venue (i.e., local community centre). Six LS clients opted to be interviewed at home and one at the work place. These interviews were held between 12 and 16 months from baseline interview. Before the start of the interview, clients were verbally reminded about the aspects stated in section 5.2.1.5, for example, the content of the participant information sheet or that there are no right or wrong answers. A de-brief of the interview was also implemented. The same interviewer (MR-V) as in Chapter 5 conducted interviews.

The six additional clients gave verbal consent to the lifestyle coach to be contacted by the researcher to arrange an interview. All opted to be interviewed at home. Interviews took place 13 months after attending the first LS appointment. They

followed the three-stage procedure outlined in section 5.2.1.5. Interviews ranged from 13 to 93 minutes, with an average duration of 51 minutes. The one short interview (13 minutes) was a result of the participant forgetting about the pre-arranged interview start time and having to leave early for an alternative engagement.

The constructivist version of grounded theory requires establishing a relationship with the participants to allow them to share their deep experiences, thoughts and feelings (Charmaz, 2000). In general throughout the interviews, the researcher had a feeling of being able to establish a relationship with participants that allowed them to speak deeply and freely. Several interviewees confirmed the researcher's approach towards listening with openness. For example, a number of clients suddenly cried during interviews when sharing certain feelings and experiences (e.g., living with a particular illness or living within a 'big size' body). This was interpreted as a sign that people were comfortable with the interviewer, and of positive rapport between researcher and interviewee, particularly in those cases that the researcher initially felt that her own 'healthy size' had presented a barrier. Furthermore, numerous participants surprised the researcher by a heart-warming farewell (e.g., saying goodbye with a hug), often stating how much they had enjoyed being listened to *'for a change'*.

Charmaz (2000) suggested that to differentiate from the objectivist versions of grounded theory, researchers using the constructivist version of grounded theory should also try to understand assumptions to avoid prior unfounded conjectures affecting the interviewing approach. Therefore, the researcher played an active role in looking for true meanings behind expressions. One advantage was that English was not the researcher's first language, so that she could ask interviewees for exact meanings behind their expressions, experiences and feelings, without coming across as looking down on the interviewee. As a result, participants seemed to realise that it was acceptable to share their views in great detail, which led to lengthy and in-depth interviews.

6.3. Findings

This section presents the findings from the grounded theory study of the LS. First, a profile of the clients who took part in the follow-up interview will be presented;

and then the constructed substantive theory (*'the type of theory that grounded theory produces in the first instance'* (Urquhart 2013, p. 193)) will be described and discussed. According to Charmaz (2014) and Urquhart (2013), a grounded theory must include categories and relationships between these categories. A diagram (model) will be used to illustrate the categories and relationships, as it has been suggested as one of the easiest ways to present the theory (Urquhart, 2013). Additionally, the researcher must describe the categories in terms of which properties or attributes define the suggested categories (e.g., under which conditions the category is operative, and under which conditions the category changes (Charmaz, 2014). Each relationship must also be described, referring to the findings that support it (Urquhart, 2013). The description of the model will be outlined describing all the categories first (section 6.3.3) and all the relationships second (6.3.4). Attributes (indicated with 'bullet points') will be suggested within the description of each category and relationship. This structure was inspired by Reid's thesis (2006); an example provided by Urquhart (2013).

6.3.1. Participant characteristics

This section includes characteristics in terms of age, gender, ethnicity, and deprivation levels of the clients who took part in the follow-up interviews. This information is only provided for general information about the clients who took part and does not aim to represent the total population (LS clients attending the programme), which would contradict the principles of theoretical sampling (see section 6.2.1.1).

A total of 13 clients took part in the follow-up interviews, from which seven also took part in the baseline interview. Interviewee age ranged between 27 and 62 years at the time of the follow-up interview. All interviewees were female and White British, and English was their first language. In terms of deprivation, Table 5.3 (section 5.3.1) showed deprivation levels for clients taking part in baseline (n=23) and follow-up interviews (n=13).

6.3.2. Overview of the model: Client experiences of the role played by the LS

A model was constructed based on the insight from analysis of client experiences, which helps to gain understanding of the role played by the LS (Figure 6.3). A broad range of experiences were identified, which suggests that the model should be interpreted from different perspectives. Experiences were then grouped as shown in Figure 6.2. Most clients gave accounts that implied 'receiving support', particularly referring to the initial stages of their participation in the LS. Some client accounts denoted evolving towards 'taking responsibility' over their own health. Others did not indicate this shift, rather suggesting a 'continued reliance on external support' towards the end of their participation in the LS, highlighting the recurring need of 'receiving support'.

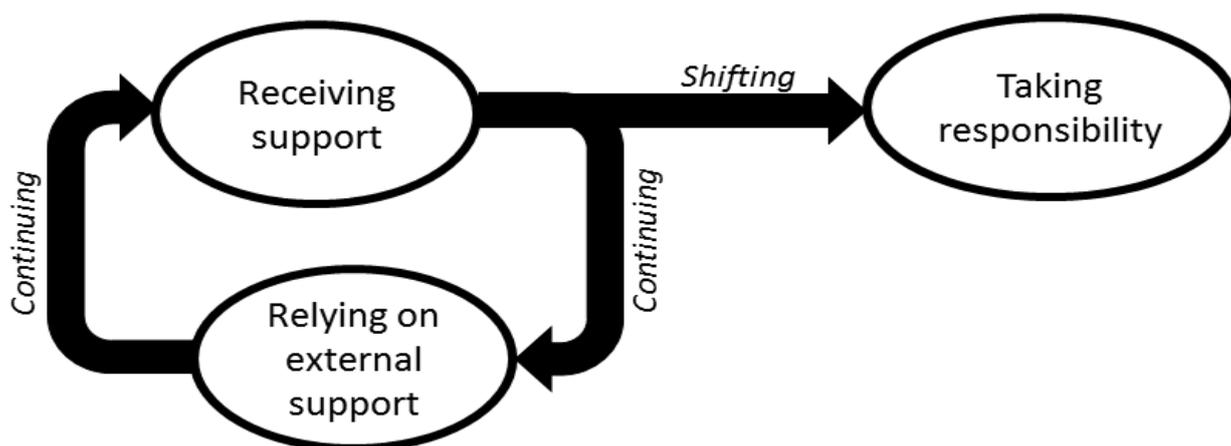


Figure 6.2 Type of client experiences of the Lifestyle Service's role

Experiences of 'taking responsibility' and 'relying on external support' should be considered as opposite poles of a continuum, where accounts can fully align to one or the other pole, but it was also possible to see 'taking responsibility' and 'relying on external support' within the same interview. In fact, only a few clients gave accounts that were entirely aligned with one or the other. This idea resembles the dynamic continuum suggested by some scholars in the context of community empowerment (Laverack and Labonte, 2000; O'Mara-Eves *et al.*, 2013), which implies moving from initial individual action to social action. However, little has been published in the specific context of patient empowerment.

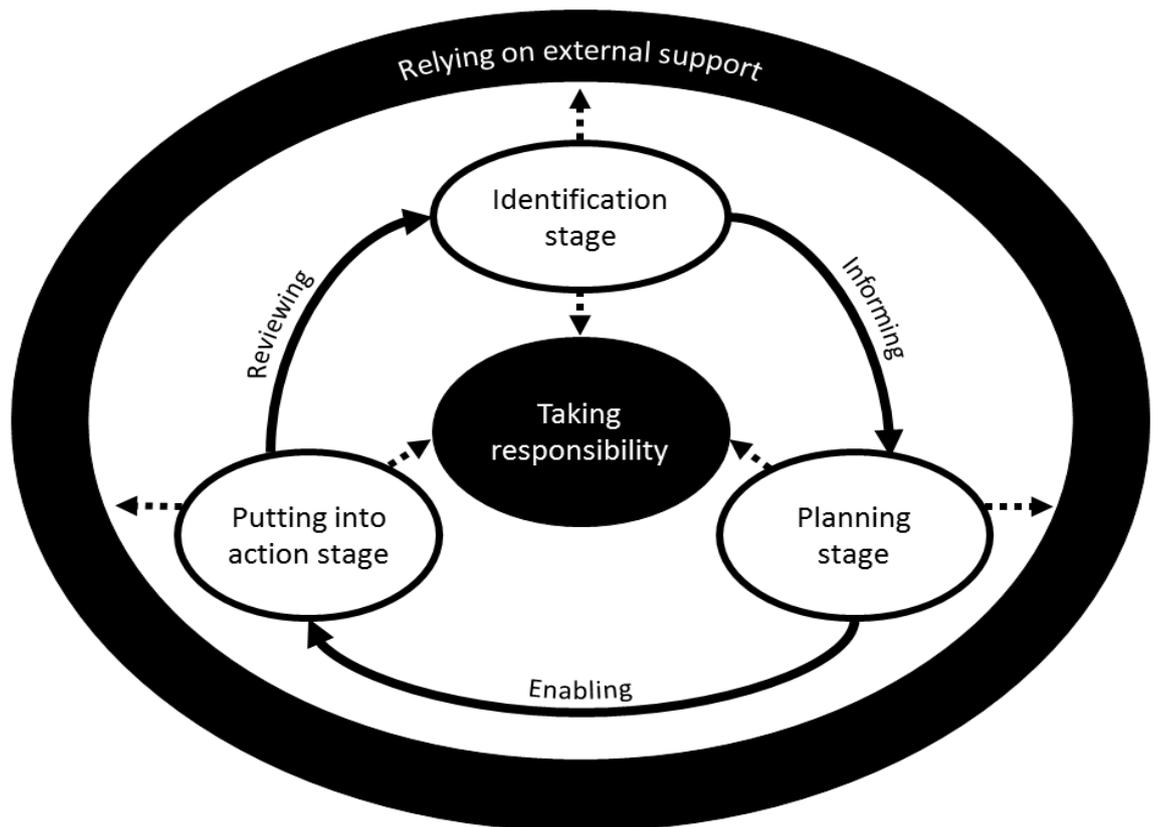


Figure 6.3 Client experiences of the LS role

Based on these types of experiences, a model of the role of the LS was constructed (Figure 6.3). Data analysis revealed that three skeleton categories of the model ('identification', 'planning' and 'putting into action stages') plus the relationships between these categories ('informing', 'enabling', 'reviewing' and the overall 'continuous cycle') were shared across all groups of clients. Importantly, analysis revealed that with regard to each category of experiences, they could result in account of 'taking responsibility' or 'relying on external support'. Therefore, in the next sections experiences underpinning the skeleton categories of the model, and their relationships, will be described. Client accounts will be discussed by highlighting how within the context of the LS these can lean towards 'reliance on external support' or 'taking responsibility'.

6.3.3. Model categories

6.3.3.1. Identification stage

Most clients acknowledged that at the beginning of the programme the identification stage serves as an initial evaluation in which the Lifestyle Coach aims to uncover the possible reason(s) for clients' obesity ($BMI \geq 30$), identify what goal(s) the client would like to achieve, and what support may be required.

You talk about your problems, and all that type of thing, it was just like that, dead relaxed, to talk about everything, why you feel you need to lose weight, where you think you need help, or where you think you struggle with, or is there a reason what triggers you to eat more I suppose {Alexandra}

Client accounts revealed that this stage is primarily led by LS professionals (e.g., lifestyle coach, gym instructor), particularly at the beginning of the programme. The professional regularly gathers information using a variety of sources: asking questions, *'you see the lifestyle coach, who talks to you about what you want to achieve and what method you want to use to achieve'* {Andrea}; food diaries, as Jacqueline stated, *'[the lifestyle coach] asked me how I ate, she asked me to do a food menu [diary] to show what I ate'*; or through anthropometric and cardiovascular measures, *'[the lifestyle coach] kind of oversees what you're doing, and she checks weight, blood pressure measurements, that kind of thing'* {Hope}. Some client accounts associated the identification of the elements, such as cause of being overweight, barriers to engage in a healthy lifestyle, or intentional goals, with tailoring the programme to their individual needs.

The 'identification stage' has been suggested as a component of the process of patient empowerment (Ellis-Stoll and Popkess-Vawter, 1998). However, according to the concept analysis conducted by Holmstrom & Roing (2010), being sensitive to the individual's needs is not the only road to patient empowerment. Patient-centred approaches tend to make use of the same tailoring and individualisation strategy. There are also many similarities between the identification stage in the model proposed from the current findings and that in the model of empowerment suggested by Cattaneo & Chapman (2010). These authors also suggested an identification stage where the real personal aim(s) of individuals were acknowledged, instead of focusing on the professional's agenda. They associated identifying meaningful goals with the self-determination theory (Ryan and Deci,

2000), suggesting that meaningful goals are expected to be more suitable to achieve when future difficulties arise during the process of behaviour change.

Although most clients perceived the 'identification stage' as an important and meaningful phase, a small number gave accounts of not fully understanding the need for, or benefit of, asking so many questions.

It's more about 'how are you feeling?', 'how often have you done physical exercise?' 'how often have you drunk?', 'how often have you eaten vegetables and things like that?', 'how often have you eaten fatty foods?' So it was very top level, there was no depth to it, it was more questionnaires than support {Hope}

Considering how experiences associated with the 'identification stage' can be placed on the continuum between 'reliance on support' and 'taking responsibility', the majority of experiences reflected a 'reliance on support'. However, some clients gave accounts that already denoted progress towards 'taking responsibility'. Their accounts indicated having the ability to reflect on previous actions, such as raising questions themselves similar to the ones asked by the LS professionals. This will be further explored as part of the relationship 'reviewing' (section 6.3.4.3). Overall, the general lack of experiences related to 'taking responsibility' at the 'identification stage' suggests that these might not be unique to the process of empowerment.

6.3.3.2. Planning stage

The 'planning stage' aims to construct a plan that addresses client difficulties and/or needs that were detected during the 'identification' stage. This category is further defined by two attributes: setting targets and creating conditions.

- **Setting targets**

Client accounts referred to two types of goals or targets: an overall target and smaller targets. With the overall target clients referred to what they aspired to achieve by the end of their participation in the LS. This was usually pinpointed at the 'identification stage'. Client accounts also revealed smaller targets that shaped the backbone of the action plan and guided the client towards the overall target.

These were experienced by a number of clients as the milestones of a continued cycle.

Because [the lifestyle coach] always said, 'little goals all the time' {Jacqueline}

Particularly in the beginning, targets were suggested externally by the LS professionals, who made suggestions based on information gathered at the 'identification stage'. As an example, according to Jacqueline, her lifestyle coach pinpointed at the 'identification stage' through a food diary that the client was persistently eating throughout the day. This was identified as one of the possible causes of the problem (high BMI). Consequently, the client was first suggested to steadily modify her diet towards a three meal diet. Once this was achieved, she was given further targets to focus on, such as exercising. A number of clients experienced the suggested targets as suitable, realistic, and achievable, as Joanne put it, *'[fitness instructors] didn't set massive goals'*.

According to Anderson & Funnell (2010), setting targets will help individuals to become autonomous, instead of having to comply with targets suggested by professionals. Most client accounts did not reveal a shift of the setting of targets from the professional to the client. Therefore, this category attribute was mostly experienced as the responsibility of the LS professional throughout the programme. However, some clients stated working in partnership, which involved a shift of the power from the professional to the client (Hickey and Kipping, 1998). According to motivational interviewing, targets need to be endorsed by clients, and not to pursue people to do something against their choice (Miller and Rollnick, 2012). For example, the following quotation indicates targets being suggested by the professional but in agreement with the client:

[The lifestyle coach] used to say to me, you know, 'the decision is yours, if you don't want to do it, you tell me, and if you tell me what you don't want to do, and it's a feasible reason, we can work on it' {Jacqueline}

The latter experience was shared by a small number of clients, and suggests that setting targets in the context of LS was experienced towards relying on external support.

- **Creating conditions**

Creating conditions was identified as the second attribute besides setting targets of the category 'planning stage'. The concept of creating conditions involves suggestions, usually made by the LS professionals, which are meant to assist the client to achieve their targets. Clients referred to receiving these recommendations particularly at the beginning of the programme. Recommendations often addressed difficulties and causes from the 'identification stage', which are addressed in more detail in the relationship description of 'informing' (section 6.3.4.1).

Client experiences indicated a range of recommendations. In some cases, they indicated having gained knowledge about a previously unknown aspect, usually increasing physical activity and healthy eating. On numerous occasions, clients mentioned having been given alternatives to their 'unhealthy' habits, which were perceived as broadening existing options, allowing them to choose from a variety of healthy alternatives.

They gave you the ideas, 'incorporate [the fish] with something, just don't try and eat it if you don't like it on its own, and see what happens', and now I do [eat fish], and I wouldn't think twice if it was a choice of, you know, having a chicken sandwich or having tuna and sweet corn, I'll have tuna and sweet corn {Jacqueline}

Being given such alternatives and raising awareness were experienced by some clients as an experience of discovery.

You don't realise how much of these things [sugar, fat] are in things until you start reading. And I wouldn't have done that if they hadn't said 'well, have you thought to check in labels? do you realise this?' I mean not only sugar and fat, but salt as well {Joanne}

Most client accounts showed that creating conditions was mainly driven externally by the LS professionals. However, whilst these recommendations were externally suggested, they were often experienced as client-centred, that means, tailored to the individual's needs.

[The fitness instructor] really listened to how I felt and how my body felt and obviously is accommodating all me ailments, you know, the fact that I can't run, I can't row, and I can't do aerobics {Andrea}

Clients also revealed having a voice in the way they wanted support, as some mentioned being given the opportunity to choose between gaining support with exercise and/or diet, or to choose specific referrals. As Alexandra mentioned, ‘a gym membership, or go for help with like [name of a Commercial Weight Loss Programme (CWLP)]’ were the type of referrals most commonly reported. One particular client did challenge the individualised approach of the LS since she strongly felt that the LS was not tailored to her personal preferences.

I had said ‘oh, I like swimming’ and the gym had a swimming pool, but the gym instructor told me that I couldn’t use the swimming and I had to stick to this [fitness programme] {Raquel}

Experiences of individualisation and a client-centred approach are further explored in section 6.3.4.4.

For those who gave accounts that denoted ‘taking responsibility’, the conditions were perceived as a set of instruments that enabled them to adopt a healthy lifestyle.

Everyone is different so you’ll have to take the knowledge [provided by the LS professionals] and take it into your life, and put it into your life how you feel is needed. But they’re there for full support for you, not to tell you off or anything, they’re just there for support to help you to lose weight {Alexandra}

Clients who took responsibility to a certain extent gave accounts of taking over the LS professionals’ role regarding the ‘planning stage’ category. Two main aspects were reported. On the one hand, clients gave accounts that implied a search for further opportunities to carry on a healthy lifestyle.

There’s a bike thing that you can hire in [name of the park], and you can hire a four wheel bike, and two of you can peddle, so me and me husband would like to have a go on that, when the weather is good {Rosalie}

On the other hand, some client accounts indicated finding solutions towards difficulties encountered on a daily basis.

I mean there is a couple of cafes that know me now, and they only give me small portions, and the other, if I ask for a cheese wrap, half of the cheese wrap comes home with me and I have it the next day {Rosalie}

Finding solutions to identified needs has been suggested as a key component of empowerment (Laverack, 2004). Cattaneo & Chapman (2010, p. 653) referred

more specifically to a component of '*knowledge as an understanding of the relevant social context, including the power dynamics at play, the possible routes to goal attainment, the resources needed, and ways to obtain them*'. For the LS, creating solutions seemed to be a step preceding finding solutions. However, the attribute of 'creating conditions' is subtly different, suggesting that the LS provides options to choose from, such as a concrete referral (e.g., fitness centre) or a particular food alternative. This might explain why Raquel was not satisfied with the options provided, and perceived the LS as not being tailored to their needs. This client highlighted the mechanism of LS, which seems to be based on offering specific options, and raises a question regarding the extent to which LS supports or enables clients to find solutions, in terms of finding possible routes and identifying the needed resources, as suggested by Cattaneo & Chapman (2010). This could explain why some client accounts revealed the LS professional finding solutions, even towards the end of the 12 month intervention.

When the gym stopped, I couldn't afford to carry on with the gym, because it was twenty odd pounds a month, but [the lifestyle coach] came up with some good ideas, well, a stepper or... do extra walking {Joanne}

Not finding solutions themselves towards the end of the programme is a demonstration of the client's ongoing reliance on external support.

6.3.3.3. Putting into action stage

The 'putting into action stage' constitutes the third and final category. Here the client takes action to apply the suggested plan, incorporating it into daily routines. This stage requires a shift of responsibility from the LS professionals to the clients who become the main drivers in putting into action the plan and suggestions. However, clients reported to still experience access to different levels of external support during this stage.

A brief overview regarding this support will be described first to provide context to the findings. Overall, clients opted for: exercise, being referred to a fitness centre or swimming activities; for diet, being referred to a specific CWLP; or for a combination of diet and exercise, which usually involved a fitness centre referral in combination with dietary support from the lifestyle coach. Clients who opted to attend a CWLP reported gaining support on a weekly basis. They described five main types of support: i) a diet plan to follow, based on calorie counting; ii) gaining

new ideas (e.g., recipe ideas or coping mechanisms towards certain social events such as going out for meals); iii) a supportive social environment by meeting other overweight people; iv) being weighed to help them adhere to the diet plan; or v) being reassured after achieving weight targets, usually rewarded by the CWLP lead. These types of support resemble the accounts from baseline interviews (Chapter 5). Clients who opted for an exercise referral provided accounts of varied support. Some clients reported having contact with a gym instructor every time they were at the fitness centre (e.g. weekly), while others would only see the gym instructor periodically (e.g., every four weeks) to take measurements and revise the exercise programme ('identification stage') to then discuss the exercise regime ('planning stage').

The 'putting into action stage' varied considerably in terms of how the experiences could be placed on the continuum from 'reliance on external support' to 'taking responsibility'. Based on where experiences were located on this continuum, as well as relating to 'receiving support' itself, eight category attributes were identified (Table 6.1).

Table 6.1 Attributes of the 'putting into action stage' category

	'Receiving support'	'Taking responsibility'	'Relying on support'
Category attributes	Choosing differently	Self-efficacy	Following instructions to perform at the scale
	Changes becoming habits	Thinking positively	Thinking negatively
	Discovering	Changing attitude	

- **Choosing differently (relates to 'receiving support')**

Recommendations provided by LS professionals at the 'planning stage' were experienced by clients as help to broaden their views regarding how to lose weight and improve their lifestyle. As a consequence, clients listed a large number of changes that they had incorporated from those recommendations. These primarily related to two aspects: dietary modifications (e.g., portion control, avoiding unhealthy options, balancing meals, etc.); and/or increasing physical activity (e.g., following an exercise regime or undertaking less structured options, such as swimming or walking). A small number of clients also reported having undertaken

substantial life changes as a consequence of taking part in the LS, such as changing jobs or divorcing spouse. Therefore, the 'created conditions' at the 'planning stage' seemed to support clients in making real changes during the 'taking action' stage. One could argue that this mainly relates to one of the three main components of behaviour change interventions as suggested by Michie et al. (2011, p. 5): opportunity, defined as '*all the factors that lie outside the individual that make the behaviour possible or prompt it*'.

- **Changes becoming habits (relates to 'receiving support')**

Several clients gave accounts explaining how the above changes had become new habits. By new habits they meant actions they had incorporated as routine in their lifestyles. Although client accounts disclosed that adopting these actions implied meaningful efforts in the beginning, they reported at one year follow-up that they did not have to put any extra effort in to maintain those early changes.

Just little things, certain foods that you wouldn't, that you start to use because they are the healthier alternative, I don't really think about that anymore
{Andrea}

As the scope of this study was to investigate empowerment (rather than one of the many behaviour change theories), explaining how achieved changes were transformed into habits falls outside the main remit of this thesis. Nevertheless, this was specifically followed up during the last interviews as part of the theoretical saturation strategy. In particular, aspects such as sense of achievement and enjoyment were considered, which will be addressed below as part of the attributes associated with 'taking responsibility'.

- **Experiences of discovery (relates to 'receiving support')**

As a consequence of the 'putting into action stage', various client accounts denoted experiences of discovery, becoming aware of an unexpected outcome. The most common discovery related to the fitness centre environment. Most clients who received a fitness centre referral recognised having the preconception that fitness centres were only for fit and slim individuals, such that they would feel 'out of place' due to their size ($BMI \geq 30$) and their low level of fitness. This preconception might be explained by an association between weight stigma and avoiding exercise among obese adults (Vartanian and Shaprow, 2008), but also by

exposure to the widespread anti-fat attitudes (Flint, Hudson and Lavalley, 2013), or even anti-fat attitudes within fitness professionals and exercisers (Robertson and Vohora, 2008). However, clients often gave accounts of feeling comfortable at the fitness centre environment despite earlier preconceptions.

I was really really worried about going to the gym, thinking 'oh, you know, all this skinny people, and men with weights and all the rest of it' and actually through going to the gym and going at different times, you see huge cross-section of people. So yeah, you've got the gym-fanatics, but then you've also got people like meself, who are on [the] lifestyle [service] {Hope}

This discovery helped some clients to de-normalise their general pre-conception of fitness centres.

These slim girls like, you know, and all of the leotards and all that, like you know, I don't know where I got them, most probably watching too much television {laughs} {Charlotte}

And one of the most commonly shared barriers in baseline and follow-up interviews was addressed:

I do feel quite confident walking around the gym, emm... I don't feel self-conscious {Hope}

Client accounts revealed that the main two reasons for feeling comfortable at the fitness centre environment were realising that people like themselves were also present, and realising how friendly and supportive staff members were. One could argue that the LS was experienced as appropriate to address one of the major barriers (Kreuter *et al.*, 2003). However, as discussed at baseline, data revealed that the LS provided this instead of clients finding solutions. Again, this is indicative of that the LS had a supportive, rather than empowerment role.

Most clients also discovered further aspects such as health benefits, which they related to their exercise routine.

Your resting pulse rate is stronger, and it's not as fast, it all means [exercise is] working, and you're thinking, well, 'how can it be really in this short space?' But yes, it was {Joanne}

Some clients also discovered that exercise was having a positive effect on their mental health, which is consistent with well documented positive association

between evidence physical activity and mental health (Biddle, Mutrie and Gorely, 2015).

I was feeling very tense, very wound up, and again I pushed really really hard [at the fitness centre] and then came out thinking ‘oh actually that was amazing’ {laughs}. So I kind of didn’t expect [exercise] to be so, such a big impact [on my mental health] {Hope}

Some clients also gave experiences of continued discovery across the ‘identification stage’, ‘planning stage’, and ‘taking action’ stage, which is further explored in section 6.3.4.4.

- **Self-efficacy (towards ‘taking responsibility’)**

Some clients reported that exercising made them improve their self-efficacy, defined as ‘people’s beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives’ (Bandura 1994, p. 71). Some clients referred to this as feeling able to exercise in a comfortable environment, which was earlier interpreted as improving self-confidence; but also some were able to exercise in an unfamiliar environment.

Because I’ve taken that step [of going to the fitness centre], it wouldn’t matter now to me of getting me jog shoes on and going down the road {Jacqueline}

Additionally, a small number of clients also verbalised that being able to exercise had helped them to believe that they could accomplish further tasks of daily life.

[Going to the gym has] actually impacted on quite a few aspects of my own life, I’m more confident in my own ability, I’m coping with things a lot better. I’ve been able to prove that I’m not as unfit as I think, it’s sort of giving me a confidence boost in terms of thinking, well, if I can do that, I can go and do this, I can go and do that, I have my own home, I can, you know, do things I never thought I could {Claire}

At baseline (Chapter 5), a lack of self-efficacy was evident among obese individuals, with mental health problems as a possible explanation for low adherence to diet and exercise regimes (Markowitz, Friedman and Arent, 2008). Motivational interviewing was the LS component suggested as a possible way of addressing self-efficacy (Miller and Rollnick, 2002), but also as a possible outcome of the process of empowerment, as suggested previously (Gibson, 1991;

Anderson, 1995; Aujoulat, D'Hoore and Deccache, 2007; Wilson, Kendall and Brooks, 2007). Although it is difficult to distinguish what mechanisms helped clients to increase their self-efficacy, the present data analysis revealed that self-efficacy improvement was usually mentioned in contexts that involved undertaking physical activity, as part of the 'putting into action stage'.

The field of exercise psychology has paid considerable attention to the effects of exercise on self-efficacy. Biddle et al. (2015, p.244) noted that '*self-efficacy is one of the most consistent correlates of physical activity*'. Clients who gave numerous accounts of 'relying on external support' often indicated how target setting had supported them in achieving a specific level of performance ('*well, start with 2 minute, then build it up to 5, then 10, and now 20 minutes a go [on the cross training]*' {Joanne}). Clients who gave numerous accounts of 'taking responsibility' made associations between their achievement and self-motivation. This association has been extensively investigated and there is consistent evidence linking both aspects with self-efficacy (Bandura, 2002; Bandura and Locke, 2003). Experiences of increased self-efficacy through exercise were more meaningful among those 'taking responsibility' but they were also mentioned by some who gave accounts of 'relying on external support'. This supports the relationship between self-efficacy and physical activity benefits, but it does not provide supportive evidence for an empowering process as part of the LS.

- **Thinking positively (towards 'taking responsibility')**

Thinking positively seemed to be a consequence of the category 'putting into action' for those who had given accounts of 'taking responsibility'. Positive thinking was observed in terms of reporting observed benefits and experiencing satisfaction with achieved targets. The benefits that were reported covered a range of topics: physical health, such as 'feeling better' or 'improvement of fitness'; mental health and wellbeing, such as 'feeling more confident' or 'feeling energised' with the consequence of being able to take over tasks that in the past would have been avoided (e.g., house holding); or social wellbeing, such as feeling more comfortable when engaging with others. Experiences of satisfaction with achieved targets were related to the aforementioned attributes of 'choosing differently' and 'changes becoming habits', where some clients also suggested finding their new way of life enjoyable, which they associated with feeling motivated to carry on.

Before I was probably doing something because people expected me to do it, and now I'm doing it because I want to do it, and I'm enjoying what I am doing, and that is my lifestyle {Jacqueline}

Two main explanations are suggested for the finding of positive thinking. One comes from the motivational interviewing technique used by the lifestyle coaches, which is meant to empower clients through encouraging hope and optimism, such as using supportive statements or encouraging the patient to focus on past successes (Miller and Rollnick, 2002). Numerous clients referred to having experienced their interactions with the lifestyle coach as such:

When I went back for a review [with the lifestyle coach], and then I lost weight, and then you get like a bit of an appraisal like, you get recognised by the lifestyle coach that you've done well, so that makes you feel good, and then they give you more like another goal to get to then to the next time {Raquel}

Another possible explanation could be through the connection between improving self-efficacy and self-motivation as a consequence of achieving targets, as outlined in the attribute 'self-efficacy'. The quotation from Claire provided within the 'self-efficacy' attribute reflected how improving self-efficacy had helped her to embark in positive thinking.

- **Changing attitude (towards 'taking responsibility')**

Clients who gave accounts of gaining responsibility over their health also reported experiences of changing their lifestyle, which they associated with having developed new habits, but also a different attitude. For example, some clients stated preferring to feel healthy and fit, instead of focusing on losing a certain amount of weight; and they gave accounts of feeling assured that the weight loss would be achieved as a result of carrying out their newly adopted lifestyle.

So if I've lost two pounds the week after, great, if I haven't, and I still feel the same, it doesn't matter because I'm still going for it, and it's, and I think that is what you need to get across to somebody is that, it's not going to happen overnight {Jacqueline}

Client accounts also revealed the need for a long term approach to achieve the target weight (e.g., two years) and seemed content with it. These experiences

were at times compared and contrasted against past experiences concerning specific diets or attending CWLPs. Clients indicated having followed such diets at some point in the past and no longer agreed with CWLP approaches; as individuals were rarely able to maintain the weight loss post-diet, they did not consider this a healthy long term option.

Although these experiences were only based on intentions, they indicate an increase in taking control over their health from two perspectives. First, moving from the rather restrictive view of certain approaches that focus on losing a certain amount of weight in the short term, towards a broader and longer-term view, which focuses on the act of undertaking a healthy lifestyle, from which the desired physical and mental health benefits will be conferred. Second, this attitude change could be interpreted as engaging in critical thinking to make informed decisions, suggested by Anderson & Funnell (2010) as an important component of patient empowerment.

When comparing baseline and follow-up interviews as a whole there was a shift from most clients 'relying on external support' to a certain number of clients 'taking responsibility'. However, when looking at individual cases, those taking responsibility at follow-up gave accounts that contrasted past disappointment(s) from their experiences with CWLPs. Therefore, it remains unclear whether the LS would have contributed to experiencing a change in attitude without those past disappointments.

- **Following instructions to perform at the 'scales' (towards 'relying on support')**

In terms of the 'putting into action stage', client accounts denoted relying on external support in different ways. A common feature amongst clients who opted for a CWLP referral was incorporating suggestions to perform better at the 'identification stage', with some clients acknowledging that being weekly weighed at their CWLP was the driver for continuing with the diet.

So if you go for sort of eat something that you, that's not on this plan, like a pack of crisps, you think, 'oh I've got to be weighed on [at the end of the week], I've gotta put that on the plan' {laughs}, so you don't [eat it], so it's always sort of there in your mind, that you have to go and be weighed {Charlotte}

Data analysis revealed that particularly those attending a CWLP as part of the LS favoured being told what to do and their participation was limited to following instructions. They showed compliance to the programme, but not giving evidence of being empowered through critically thinking (Anderson and Funnell, 2010) or finding solutions to their difficulties (Laverack, 2004; Cattaneo and Chapman, 2010). Moreover, clients who were supported by an exercise referral also gave accounts of 'following instructions' rather than engaging in empowering processes. The present data has shown that having critical views on previous experiences with short-term approaches to weight loss, such as CWLPs, can help clients to favour approaches that share responsibility between professionals and individuals, or that even empower individuals. This might relate to the traditional idea that individuals cannot be empowered by others, but that empowerment should come from oneself (Rappaport, 1985).

- **Thinking negatively (towards 'relying on support')**

Thinking positively was earlier described as an attribute that leans towards 'taking responsibility', where it was indicated how a sense of achievement and self-motivation might act as a possible mechanism through which individuals take responsibility over health. Where there is a lack of achievement or self-motivation, this seemed to increase the likelihood of participants 'relying on external support'. This was particularly the case for Andrea, who felt that she had put considerable efforts in making changes but this had not led her to achieving her target weight loss, to 'see a dress size change'. She found this lack of achievement demotivating. Her frustration could be the reason of trying to attribute blame to the LS, and consequently give accounts that denoted a reliance on external support.

I'm thinking I'm putting in all this hard work, and I'm not really seeing any results so that's a bit demoralising for me, and make it as when I think I said to you before about having a text message or a little bit of a follow up and a catch up might had helped, because it kind of feels you're sort of [on your own], I think I know if I contacted the lifestyle coach, she'd probably say 'yeah, wanna see me sooner'? or something like that, but I just felt like you are kind of on your own a little bit, and sometimes I think you need a bit of a motivator {Andrea}

Interestingly, Andrea was still able to list a small number of health benefits, but these seemed to have been denied by the negative experiences associated with the LS.

6.3.4. Relationships between categories

The three main categories of the suggested model have been explored and described to this point. This section aims to explain client experiences regarding the relationships between the three categories.

6.3.4.1. Informing

This is a relationship between the ‘identification stage’ and the ‘planning stage’. It is a unidirectional relationship that connects both categories through feeding information gathered in the ‘identification stage’ to the ‘planning stage’. This relationship was primarily implicitly suggested, but also explicitly. This was particularly expressed in accounts of the LS professional’s intervention. The following quote shows how a finding from the ‘identification stage’ informed the plan.

So [the lifestyle coach] looks at your diary and see if there’s a way, if you’re not eating enough, I suppose she’ll advise you trying, ‘instead of eating that at this time, try and eat it at that time’ {Alexandra}

This relationship shows how individuals were aided by the LS to identify their own needs to focus on during the course of the intervention. Individuals identifying needs has previously been suggested as one of the mandatory principles of empowering interventions (Laverack, 2004). However, as earlier highlighted, this strategy is not unique to empowerment, but common to other approaches, such as patient-centred approaches (Holmstrom and Roing, 2010).

6.3.4.2. Enabling

This relationship is also unidirectional and has the purpose of enabling clients to take action after planning. The two main attributes of the ‘planning stage’ category give direction (setting targets) and facilitate action (creating conditions), involving features that further support this relationship. In addition, clients provided

numerous accounts that represented encouragement and enabling. A common example was clients reporting that they were being provided with healthy alternatives and that they were learning about healthy options (creating conditions). This was experienced by most clients as broadening the spectrum of options to choose from, enabling them to take steps towards a healthier lifestyle.

I suppose the way they teach you is a healthy way of eating, where people will automatically think if they're hungry, they'll have a bag of crisps, or they'll have a couple of biscuits, where there is nothing wrong then having some fruit, or a rice cracker for instance {Alexandra}

Another common example was being given the opportunity to go to a fitness centre to exercise.

I doubt I would ever have just walked in into a gym and said, 'where do I sign up?' But knowing there was someone to give me support, an induction, and an introduction and all the rest of, it was definitely a motivator {Hope}

This relationship aligns with the characterisation of enablement interventions as described by Michie et al. (2011, p.8). Enablement interventions were defined as having the aim of 'reducing barriers to increase capability or opportunity', where capability was suggested as going 'beyond education and training' and opportunity was suggested as going 'beyond environmental restructuring'.

6.3.4.3. Reviewing

The cycle between the three main categories is completed with this last unidirectional relationship, which connects the 'putting into action stage' back to the 'identification stage'. The aim of this relationship is to review the action taken to identify further existing and new barriers, and difficulties.

You can go to [LS professionals] and say, 'I've got this problem, what do I do?' {Rosalie}

Again I have said to [the fitness instructor] 'I need to change...' maybe looking at some of the classes as an alternative, so that I don't get bored, coz I feel like I'm getting to that point of... I'm just doing the same thing every time I go [to the fitness centre] {Andrea}

These client accounts revealed that clients were able to share the difficulties encountered during the 'putting into action stage', instead of the LS professional having to bring that type of information to light like at the beginning of the programme. From an empowerment point of view, this denotes a shift of responsibility from the LS professional towards the client. This shift of responsibility was identified at the 'reviewing' relationship, by those clients considered to be 'taking responsibility', but also by those who otherwise had mainly shared experiences of 'relying on external support'. This feature of the reviewing relationship slightly differs from the other relationships, with the informing and enabling relationships primarily being led by the LS professional.

The assessment of what happens following the individual's actions, where the individual is taking the lead in self-assessing their own actions, was also suggested as a main component of Cattaneo and Chapman's (2010, p.653) model of empowerment. The present study stage revealed that most clients gave accounts of experiencing this type of self-assessment, as most were able to identify difficulties faced during action towards the end of the programme, but this self-assessment was not necessarily making them shift towards taking responsibility. Therefore, self-assessment might be an important component of the process of empowerment, but perhaps not unique to empowerment.

The ability to self-reflect seemed to lead clients to gain self-awareness. This was often exemplified by the use of a food diary:

Like the food diary, you could see what you're having, you don't realise actually how much you do eat in a day, how many calories, a food diary can track it, so you knew how many calories you're having, then you realise, be more aware of food and... what you're eating and empty calories {Raquel}

Similar to self-reflection, self-awareness has previously been suggested as a central component of the empowerment process. Two points of view have previously been provided: requiring the activation of the individual (Falk-Rafael, 2001), but also involving a personal transformation as a result of being empowered (Aujoulat, D'Hoore and Deccache, 2007). However, findings from this research do not indicate that greater self-awareness is exclusively associated with 'taking responsibility'.

6.3.4.4. A continuous cycle

The three previous sections included a description of the three relationships between the three categories included in the model. However, client accounts also referred to the three relationships as a single and overall relationship. Data analysis revealed four attributes of this continuous cycle: continued and repetitive, targets as ‘the engine’, individualisation, and discoveries.

- **Continued and repetitive**

The following quote serves as an example of how a relationship is perceived that is continued between all three categories, and that is repetitive.

*[The fitness instructor] takes you through [an exercise] programme, and then we set the programme every so many weeks, dependent on **‘Planning’** how well you are doing, if you feel you need to step it up a little bit **‘Putting into action’** **‘Identification’** more or, which I’ve done quite a lot [...] probably changing it every 4 **‘Continued and repetitive’** weeks {Andrea}*

- **Targets as ‘the engine’**

Some clients perceived setting targets as ‘the engine’ of the LS. A number of accounts showed that setting targets was an integral part of the three stages, not only of the ‘planning stage’. They referred to targets at the ‘putting into action stage’, in terms of guidance towards action. Also at the ‘identification stage’, targets were revisited to make modifications to the planning stage (or additions to continue the cycle). The following quote illustrates how targets were experienced as the driver for making changes:

[Lifestyle coach] saying ‘well, this month you need to have breakfast every day, and next month you need to have, make sure you drink your water, and then you need to have your exercise’, so it’s just continued, and like I say, after doing it for, you know, three or four weeks each time, it comes natural to do it {Jacqueline}

This finding was also consistent with the model of empowerment described by Cattaneo and Chapman (2010, p. 1), suggesting that '*individuals move through the process with respect to particular goals*'.

- **Individualisation**

Many client accounts indicated having experienced an individualised approach, which was associated with the 'identification' and 'planning' stages, as earlier highlighted. The LS professionals took the lead in identifying needs and making appropriate suggestions, which is in line with a patient-centred approach (Holmstrom and Roing, 2010). Additionally, a small number of clients gave accounts regarding individualisation at the 'putting into action stage'. They indicated being encouraged to take action and adapt the suggested plan to their own needs, being persuaded to find appropriate solutions themselves. This also might have made clients realise that suggestions by the LS professionals were not part of a rigid plan and could be modified when needed.

- **Discovery**

Experiences of discovery were reported across the three categories. However, discoveries appeared slightly different depending on the category. At the 'identification stage', some of the client accounts revealed that they were able to discover certain aspects through self-reflection that led them to self-awareness. At the 'planning stage', client accounts indicated that the experience of discovery related to learning something new through conversations with the LS professionals. As an example, some clients gave accounts of 'discovering' the use of food labelling to help plan healthy choices. At the 'putting into action stage' the experience of discovery was gained through taking action and, consequently, being exposed to new activities and/or environments, such as the example earlier provided of de-normalising fitness centre environments.

The experience of discovery was disclosed as a learning experience through three types of learning: transfer of knowledge from professional to client, learning through practice, and self-reflection. Learning has already been identified as a key component of the empowering process (Virtanen, Leino-kilpi and Salanterä, 2007; Wilson, Kendall and Brooks, 2007; van Uden-kraan *et al.*, 2008). Based on Kieffer (1984), Cattaneo & Chapman (2010) associated learning skills with taking action

and gaining self-efficacy. Client accounts often reflected the two first types of learning, whereas self-reflection was not as commonly reported.

6.4. Summary and conclusion

This chapter explored client experiences of the LS after taking part for one year, with the aim of understanding the role of LS based on client experiences. A modified version of grounded theory was adopted to conduct and analyse 13 semi-structured interviews, six of which were with clients who had already been interviewed at baseline. Data analysis revealed a model that involved three main categories: identification, planning and putting into action. Within each category, the ranges of experiences could be placed on a continuum between relying on external support and taking responsibility. Whereas at baseline, client expectations had shown high levels of reliance on external support to achieve weight loss goals, the follow-up data analysis revealed that clients were, to varying degrees, moving away from that initial position across the range of experiences. Most category attributes identified in this chapter (e.g., self-reflection, self-efficacy, individualisation) have previously been suggested as components of the empowerment process. Therefore, one could conclude that the LS does have an empowering role. However, if the concept of empowerment is taken into account, there is agreement on three main principles: individuals must identify their needs, they must find solutions, and they must take action to solve problems. Findings from this research suggest that clients were enabled to identify their needs and perhaps take action to solve problems, but experiences of findings solutions were rarely evident. Therefore, one could also argue that the LS plays a supportive role that is client-centred, and involves professionals providing for clients. Chapter 9 will discuss how participant experiences of LS and MCM relate to the theory of empowerment and how these two approaches to health promotion can complement each other.

This chapter has included the follow-up stage of the study of the Lifestyle Service. The following chapter is concerned with the baseline stage of the study of My Community Matters.

Chapter 7

Community-level health promotion programme: Resident expectations (and experiences) from My Community Matters at the start of the programme

7.1. Introduction

Chapters 5 and 6 studied an individual-level health promotion intervention, the LS, through thematic analysis at baseline and a modified version of the grounded theory method at one year follow-up, respectively. Chapters 7 and 8 mirror the methodology and longitudinal design for the study of a community-level intervention, My Community Matters (MCM). The present chapter explores resident expectations of MCM at baseline (and past experiences of living in the area and of MCM). Resident experiences with MCM after taking part for one year will be explored in Chapter 8.

7.2. Methodology

The generic methodology related to thematic analysis was described in Chapter 4 (section 4.4). The current section describes the process of data collection carried out to study the community-level intervention at baseline. As the process of data collection largely mirrors the methodology described in Chapter 5, the present section will only focus on aspects that are different.

7.2.1. Process of data collection

7.2.1.1. Familiarisation stage with the MCM programme

The researcher engaged in a period of familiarisation with MCM to understand its broad background. This stage informed practical aspects of the research and data collection. Three main steps were followed.

First, the researcher consulted the handbook of 'Connecting Communities' (C2), a practical guide to help facilitators to deliver the programme. These facilitators will be referred to as community development workers (CDWs). Second, the researcher took part in regular meetings and activities of one of the pilot areas (as

explained in Chapter 3), which was not included in this research, from May to September 2013. These activities included a listening event, a feedback event (from results gained during the listening event), a fun day, several partnership meetings, several walkabouts within the targeted areas and partnership meetings that brought together local residents and professionals (e.g., antisocial behaviour or environmental departments from the council and police). In addition, the researcher took part in meetings and activities of the three exemplar areas (the three areas that have been included in this research). For the first targeted area (South), the researcher was able to attend most meetings and activities that took place between onset of the programme (September 2013) and the end of baseline data collection (January 2014). This helped to build rapport between researcher and regularly attending residents, and to invite them to take part in the interviews. A shorter period of time was required for familiarisation in North and Centre, where only four meetings per area were attended. Ideally a longer period would have been dedicated, but this was not possible due to time constraints to allow a one-year follow up interview. During the familiarisation stage the researcher adopted a participative role, giving opinion on matters and volunteering towards tasks (e.g., helping out setting a venue for a fun day). The researcher completed a self-reflective diary after each attendance (included in Chapter 9). Finally, the researcher was appointed by the Public Health team of Stoke-on-Trent City Council to evaluate MCM in parallel with completing this PhD. The evaluation of MCM involved process evaluation techniques such as collecting monitoring data, attending quarterly meetings with the programme deliverers and the commissioners, where deliverers would provide with updates on progress. Process evaluation interviews were conducted every six months on all targeted areas⁸ with CDWs from October 2013 to October 2015. Data from self-reflective diaries and evaluation were exclusively used to provide contextual information to inform this familiarisation stage and to give some possible explanations to findings, when appropriate.

⁸ The evaluation focused on all the targeted areas (n=7). From which, the PhD focused only on the areas that allowed baseline and follow-up data collection (n=3).

7.2.1.2. The interviewer

In addition to the profile described in section 5.2.1.2, the researcher comes from a modest Spanish working-class family that has experienced periods of household unemployment. She has extensive volunteering experience working with people living in highly disadvantaged areas. While living in Spain, the researcher was part of a scout group, where she experienced as a participant some aspects that agree with the philosophy of bottom-up approaches (e.g., being part of a teenagers-led project, where participants decided on a goal [solidarity camp in a deprived area of Czech Republic] and then needed to organise and fundraise to sponsor the initiative throughout the year). Later on in life she enrolled in a Spanish university to become a physical education teacher, learning the differences between directive and non-directive teaching methods, which could be linked to some of the general principles of delivering top-down and bottom-up approaches. In the last four years she has also acted as a fundraiser for cancer research, organising several crowdfunding events in several European countries.

7.2.1.3. Sampling and recruitment

Selective and convenience sampling were employed as explained in section 5.2.1.3. Due to the availability of group-based meetings as part of MCM, the recruitment strategy was different from the one employed in the LS. The research design and recruitment strategies were discussed during the initial meetings with the CDWs and commissioner. It was agreed that the researcher would get involved in a familiarisation stage first with MCM as a programme. All MCM meetings involved new residents and service providers. Consequently, meetings started with a brief introduction of each individual, where the researcher would state that she was leading the programme evaluation. In addition, the CDWs would dedicate some time during certain meetings to explain why MCM was being evaluated and what taking part in the evaluation involved. Those who had an interest in taking part were invited to approach the researcher at the end of the meetings to provide contact details or ask further questions.

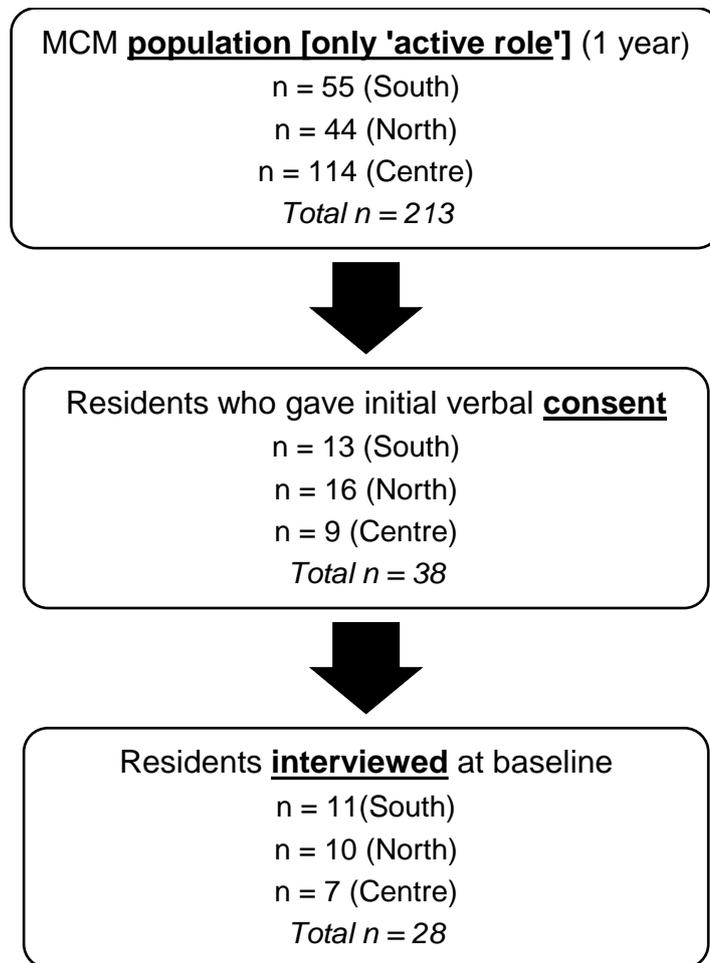


Figure 7.1 Baseline recruitment process of MCM residents

Monitoring data indicated that approximately 213 residents attended MCM meetings during the first year of the programme across the three areas included in this research. The MCM meetings had the purpose of enabling residents to take an 'active role' (e.g., identifying area priorities, finding solutions and/or taking action to solve identified problems). Residents also attended other types of activities that were organised with the support of MCM (e.g., fun days), of which attendance figures were also collected (these have not been included here to describe the MCM population since they do not represent resident taking an active role) (Figure 7.1).

Residents who gave verbal consent and provided contact details (n=38) were called by the researcher in the days following the meeting to arrange an interview. They were reminded of the purpose of the interview (experiences and expectations from MCM) and the estimated duration (30-60 minutes). An interview was arranged with 28 residents, as shown in Figure 7.1.

7.2.1.4. Development of the semi-structured interview schedule

The interview schedule was jointly developed for the LS and MCM programmes. See description in section 5.2.1.4.

7.2.1.5. Data collection procedure

The data collection procedure followed during interviews with MCM residents was similar to the one used with LS clients, explained in section 5.2.1.5.

During the phone conversation between researcher and residents, which served to arrange the baseline interview, residents were offered an interview at their home or a convenient community venue. Twenty-two residents opted to be interviewed at home and six opted to be interviewed at a convenient venue. All interviews were held once the programme had started and residents were involved. Interviews ranged from 27 to one hour and 42 minutes, with an average duration of 54 minutes.

The three main stages, in addition to the final reflective stage described in section 5.2.1.5, were followed during interviews with MCM residents. The only difference was that the MCM programme did not collect any sensitive personal data, such as BMI or type of lifestyle. Therefore, residents were not asked to give consent for access to such data.

Out of the 28 semi-structured interviews, two took place in a noisy room with relatives present. Both interviews were interrupted considerably. The 26 remaining interviews took place in a quiet room, with three interviews involving some interruptions from relatives entering the room. When this occurred, the Dictaphone was temporarily turned off.

7.3. Findings

7.3.1. Participant characteristics

A total of 28 local residents were interviewed at baseline (Table 7.1). The majority were females (n=19). Participant' ages were relatively broad ranging, but the majority were aged 26-40. All interviewees were able to understand English, but

five of the South residents belonged to an Asian (Pakistani) ethnic background and for these participants English was not their first language. Age, gender and ethnicity of the interviews sample reflect the demographic characteristics of residents attending MCM (Chapter 3).

Table 7.1 My Community Matters participant characteristics

	South (n=11)	Centre (n=7)	North (n=10)
Gender			
Male	4	1	4
Female	7	6	6
Ethnicity			
Asian (Pakistani) British	5	0	0
White British	6	7	10
Age category			
Under 18		0	
18 to 25 years		2	
26 to 40 years		10	
41 to 60 years		8	
61 to 75 years		7	
75+ years		1	

In terms of deprivation, Table 7.2 shows deprivation levels of residents taking part in baseline (n=28) and follow-up interviews (n=17). Most (93.3%, n=42) lived in areas that fell in the most deprived 20% national rankings.

Table 7.2 Comparison of index of multiple deprivation between total programme population and interviews sample (MCM)

	My Community Matters			
	Residents attending MCM	%	Sample of interviews (n=28+17)	%
(most deprived) 1	220	53.9	32	71.1
2	88	21.6	10	22.2
3	24	5.9	1	2.2
4	6	1.5		0.0
5	8	2.0		0.0
6	17	4.2		0.0
7	19	4.7	2	4.4
8	5	1.2		0.0
9	1	0.2		0.0
(least deprived) 10	5	1.2		0.0
No match	15	3.7		0.0
Total	408	100	45	100

All interviewed residents had at least attended one meeting organised by MCM. Therefore, they were expected to have a level of understanding about the programme approach. However, interviewees' exposure to the programme varied. Interviews with North and Centre residents took place one month after programme onset, whereas interviews with most of the South residents took place four months after the onset of the programme. Whilst two of the baseline interviews with South residents took place seven months after programme onset, one of them was new to the programme at that point {Ahmed}, and another resident had been attending meetings and activities organised through MCM since the beginning, but availability constrained an earlier interview arrangement {Elsa}.

In contrast to Chapter 5, this study (Chapters 7 and 8) does not include an individual breakdown of the demographic characteristics for interview participant's taking part in either the baseline or follow-up interviews. This decision was to protect participant anonymity. Given the defined geographical areas and relatively small numbers of individuals involved, providing this detailed information could allow individuals to be identified.

7.3.2. Overview of findings from thematic analysis of baseline interviews

Analysis of interviews with residents at baseline revealed two master themes. Master themes have been split into sub-themes, and sub-themes split into topics (Table 7.3). A description of each master theme has been provided within the next two sub-sections, which incorporates direct quotations from clients for illustrative purposes.

7.3.3. Master theme 1: Deterioration of community

Baseline interviews included a topic regarding residents' concerns in relation to the area/community in which they lived. This led residents to discuss a broad range of experiences over a number of years, which according to the interviewees, had led to a deterioration of the targeted areas. Analysis revealed five sub-themes.

7.3.3.1. Sub-theme 1: Abandonment

Most residents from the three areas referred to at least one form of abandonment. Ultimately, three forms of abandonment were identified: abandonment of the area as a whole, losing community venues, and uncontrolled private housing.

Table 7.3 Overview of findings from thematic analysis (MCM)

Master theme	Subthemes	Topics
(7.3.3) Deterioration of community	(7.3.3.1) Abandonment	<ul style="list-style-type: none"> · Abandonment of the area as a whole by the institutional-level · Losing community-based premises · Uncontrolled private housing
	(7.3.3.2) Loss of sense of community	<ul style="list-style-type: none"> · Loss of community pride · Loss of community spirit
	(7.3.3.3) Feeling affected by community issues	<ul style="list-style-type: none"> · Feeling scared · Feeling stressed · Feeling 'depressed' · Feeling ashamed
	(7.3.3.4) Coping and protecting strategies	<ul style="list-style-type: none"> · Isolation · Distrust · Giving up
	(7.3.3.5) Community deterioration also being generated at the individual-level	(None)
(7.3.4) Perspectives towards community improvement	(7.3.4.1) Levels of engagement	<ul style="list-style-type: none"> · 'Objecting' · 'Having a voice' · 'Taking action' · 'Leading action and enabling others' · Continuum and overlap of levels
	(7.3.4.2) Perspectives on MCM as an approach	<ul style="list-style-type: none"> · Understandings of the approach of MCM · Expectations from MCM · Feelings concerning the upcoming action
	(7.3.4.3) Initial experiences of the programme	(None)

(number) = reference to an specific section within this thesis

- **Abandonment of the area as a whole at the institutional-level**

Many MCM participants' accounts reflected a sense of abandonment at institutional-level (i.e., local authority), which denoted a feeling of having been ignored for a long time.

They have spent a hell of a lot of money up [name of the city centre]. That is where the main money is going. We went up [name of the city centre] today, if you went up, well at least 3 years ago, you wouldn't've recognised it now, seats you sit on with all lighting on underneath, they light all the town hall up at night. A lot of money has been spent [there], but I have been here 40 years and I can't remember any money being spent in Centre... not one penny!
{Jennifer, Centre}

In addition to abandonment of the area as a whole, residents from North also referred to further similar experiences of feeling abandoned at an institutional level. Some contextual information needs to first be provided to illustrate interviewees' perspectives. Residents explained that North was targeted for a regeneration plan five years before the baseline interviews took place. The regeneration plan involved demolition of houses. However, the plan was only able to be implemented partly. Residents were asked to move out, many houses were emptied and boarded up, but demolition and regeneration did not take place. Residents indicated that this was due to a change of government, which stopped funding such schemes across the country. In terms of the physical environment, this resulted in numerous empty houses, which were associated with a number of social environment issues (e.g., squatting). For further information on this scheme see Chapter 3.

Thematic analysis disclosed that the unfinished demolition and regeneration plans had a psychosocial impact on residents living in North. First of all, North resident accounts denoted strong disagreement with the initial regeneration plans, which involved the demolition of houses. They expressed feelings of powerlessness, such as '*they were getting ready to pull us down*' {Keith}. Furthermore, accounts revealed having felt abandonment a second time, when regeneration plans were suddenly stopped.

[Name of the housing group] comes in this area because we're supposed to have been pulled down, they were pulling us down! every... houses and all at once, they have got no money to pull us down {Keith, North}

Feelings of abandonment in North were much stronger than in the other two areas, South and Centre.

- **Losing community-based premises**

Residents from the three areas mentioned a lack of community venue within their immediate surroundings, citing the need for access to a premise for community use as an essential step to re-building the community.

I think [a community centre] would be one of the things to try and get back as some sort of community centre, like a hub, where we can go and... just do... everything that a community does {laughs} {Gareth, North}

Residents from South and North referred to local community venue(s) having been recently closed (i.e., past 12 to 24 months). Centre residents did not give accounts regarding the closure of community venues, but often referred to the inconvenience of not having access, and needing to use other types of facilities for community-related activities, e.g., using the local pub for community meetings.

Closure of community venues within the South and North were associated with a lack of financial investment in the area. North residents added that it was associated with the unfinished demolition and regeneration plans for the area and consequent lack of general interest in the area by the local authority and housing organisations. This represents another example of feeling abandoned at an institutional-level, including organisational-level in the case of North.

Deprived neighbourhoods have previously been reported to have less access to community resources (Pearce *et al.*, 2007), which is consistent with the perceived inequality in community investment reported here. Additionally, the government austerity measures as a result of the financial crisis that have led to greatly reduced budgets for local authorities have negatively affecting the social welfare and health of individuals and communities, particularly of those living in more vulnerable circumstances (WHO, 2009). Such budget cutting might have contributed to the closure of venues, putting populations of disadvantaged areas in even more powerless positions.

North residents gave numerous accounts that denoted strong feelings of abandonment in addition to a sense of powerlessness regarding the closure of further local facilities, as they often used expressions such as 'we've things took

off us {Sophia}. This was interpreted as a further feeling of abandonment, where no additional action was taken to look after the area, with residents attributing the closure of further local premises within the subsequent years to the institutional-level, leaving them feeling abandoned one more time.

The park's useless, the community centre closed down, the pub shut down {Sarah, North}

Several residents from North gave the symbolic example of losing the post box.

With regards to facilities actually here on this estate... nothing, everything gets taken from us. We woke up one morning and they were digging the post box up on the corner, early hours of the morning just taking it! {Sarah, North}

This was interpreted as a strong symbol of feeling powerless but also as an indication of lacking trust. On the one hand, North residents referred to this event as *'even the post box was taken from us'*, which symbolises that even small fundamental services were declining, making the area further deteriorated. On the other hand, residents' accounts on this event denoted feeling tricked by the institutional-level, which was perceived to be secretly acting behind their backs. The lack of trust topic will be addressed in detail below (section 7.3.3.4).

- **Uncontrolled private housing**

Private housing was regularly mentioned as one of the main reasons of area degeneration over the past years, directly affecting the tenants and indirectly affecting the area as a whole.

Although local residents occasionally acknowledged that certain property landlords seemed to look after their property and tenants, they were repeatedly described in negative terms. Residents' accounts disclosed a double tiered abandonment at a community-level. On the one hand, certain fellow residents were seen as 'abandoning' the area for better-off areas.

That was the start of the downhill spiral for the area, because you started getting more and more people in who were anti-social, so... more and more people decided, 'I don't really want to live in this sort of environment' so they moved out, the landlords bought those houses... more and more anti-social people were moved into the area {Sam, North}

British neighbourhoods have previously been identified as 'stuck in a spiral of decline', where the main priority of residents is moving out due to aspects such as antisocial behaviour, leading to an increase of empty properties and a reduced sense of community, which in turn raises crime, further fuelling the migration (Social Exclusion Unit, 2001).

On the other hand, landlords were perceived as only having a financial interest, rather than looking after the area.

[Name of a landlord] is playing God, he is making people live in surroundings and circumstances that you wouldn't put an animal in, and he is just taking the money from it, and he is not giving anything back {Jasmine, Centre}

The above quotation indicates perceived financial exploitation led by private housing. Some residents believed landlords' general lack of care for tenants was mirrored in tenants' mistreatment of their physical and social environment.

Some accounts suggested the institutional-level as the ultimate responsible of the uncontrolled private housing:

The council has never taken an interest in holding the landlords to account and making sure that they are actually, you know, maintaining the homes to a reasonable standard, and they aren't taking responsibility for the people that they are renting the houses out to, which they are supposed to do {Sam, North}

The high prevalence of house moving behaviour in Britain has previously been acknowledged and investigated, where dissatisfaction (with home conditions and immediate surroundings) has been higher amongst residents of poor areas (Kearns and Parkes, 2003). In the present study stage, residents' experiences regarding house moving behaviour and subsequent area deterioration was associated with private housing. Kearns and Parkes' study did not suggest any particular renting option (e.g., private renting) as the main instigator of community deterioration. However, Malpass and Victory (2010) identified a change of direction of social housing in England, from the public sector towards the private market. This might explain why resident accounts exclusively indicated private housing as the origin of problems in the area where they live. Kearns and Parkes (2003) strongly encouraged the government to prioritise the stabilisation of residents in deprived areas, supporting resident views heard in the present study stage.

As highlighted in Chapters 2 and 3, the UK, in general, and Stoke-on-Trent, in particular, are affected by high levels of social inequality, meaning that some sections of society live in vulnerable circumstances. Therefore, addressing inequalities has become a policy priority in the UK, where cross-governmental institutions have been suggested to enable populations to take control over their lives (Marmot, 2010). However, to the researcher's knowledge, very little is known about how the institutional-level (unintentionally) disempowers individuals and communities. This section has contributed to better understanding of individual's experiences of disempowerment, illustrating how certain residents develop a lack of trust towards the local institutions, which together with cynicism, have previously been suggested as a frequent citizen position (Berman, 1997).

7.3.3.2. Sub-theme 2: Loss of sense of community

Many residents gave accounts that denoted a 'loss of community sense'. It was often indicated that certain residents did not have 'community pride' or 'community spirit'.

- **Loss of community pride**

Interviewees often referred to a loss of community pride, which was associated with specific residents neglecting the physical environment. Although accounts around this topic brought interviewees to uneasy conversations in some occasions (e.g., many interviewees seemed to feel uncomfortable inculcating foreigners in front of the interviewer, who is also a foreigner), thematic analysis indicated that those seen as neglecting the area were described as being '*misfits from the English community or they're gypsies from the Czech Republic [referring to Eastern European Backgrounds] [...] Pakistanis*' {John}, '*on benefits, so they don't work*' {Janiece}, or '*a lot of the properties are rented so people come and go a lot*' {Madison}. Poor neighbourhoods have been identified as comprising high unemployment, high rates of single parents, and high levels of multi-ethnicity (Kearns and Parkes, 2003). Giving housing as an example for perceptions of different classes amongst residents, those who own a house tend to have a sense of security, control and mastery (Dupuis and Thorns, 1998), and see owning a house as a source of pride and social status (Shaw, 2004). In fact, Macintyre et al. (2003) demonstrated a better position of owners in society when comparing with

renters, such as being married, higher incomes, having a paid employment, or holding a non-manual job. This is consistent with referring to tenants as if they belonged to an inferior class (being foreigners, having less financial resources, or not owning a house), as highlighted above. From now on this class differentiation will be referred to as 'second class citizens'. The term is a result of the researcher's interpretation of data.

As highlighted earlier (section 7.3.3.1), some residents' accounts implied perceptions of an association between the abusive private housing and the attraction of 'second class citizens' to their areas. In turn, the abusive approach towards these citizens was considered by some to induce tenants not to look after their rental property and surrounded area, negatively influencing the physical environment of the area.

If you are living in a house that's very poorly maintained, because that's all you can afford or that is the only landlord who will accept you for whatever reason, but you are not going to take any pride in that house, you are not going to take any pride in your surroundings, it is pretty much going to make you not really care, and if you don't really care, then you end up causing problems for others {Sam, North}

Commonly cited examples of negligence of the physical environment were fly-tipping, leaving wheelie bins by front doors all week, and not looking after (rental) property and surrounding areas. Issues of appearance of the surrounding environment has previously been suggested as a significant predictor of unhappiness amongst residents living in poor areas (Kearns and Parkes, 2003).

In terms of fly-tipping, this issue was frequently mentioned as a priority and interpreted as a further form of abandonment, complementing section 7.3.3.1. It was perceived to take place at a community-level, as this resident sarcastically indicated: '*Put a big sign up 'please come dump your rubbish in Centre*" {Jennifer}. Fly-tipping was seen as attracting further negative consequences, becoming a major contributor to area deterioration.

You have got rubbish strewn all over the place, then you get rats, first off, you also get people thinking, 'well, this area is a dump', so it attracts more rubbish, and it attracts people, who don't care about the area in any shape, way or form, who will actually come in to the area to cause trouble, starting

fires in empty properties, that sort of thing. So the fly-tipping really is a magnet for other anti-social behaviour, so that is one issue {Sam, North}

Many interviewed residents associated fly-tipping with tenants that moved houses on a frequent basis. Beekman et al. (2001) also suggested that owners tended to see tenants as causing problems in poor areas, even if they did not have evidence to support their perceptions.

A couple come, saw them moving in, mattresses going down everything going in the next day, they dumped everything in the back, mattresses they didn't want, shoes, coats, clothes, bottles, cans... {Jennifer, Centre}

Leaving wheelie bins out throughout the week, instead of putting them outside only on collection days, was also reported by many residents as a major environmental issue. Some suggested that leaving this had become the norm in certain streets, which was very difficult to address unless the council would enforce regulations.

[Leaving wheelie bins outside] just doesn't set a good example for people who probably have moved into this area, from probably like for whatever reason, another country or what have you. It doesn't set a good example for them, when they come and they see this happening, straight away they must think... it is the norm, they think it is normal and carry on the trend {Jasmine, Centre}

One could interpret the above quote as showing a level of understanding of immigrants' behaviour, for just coping with what is the norm; and also expecting the institutional-level to fix the problem. Expectations will be addressed in detail as part of the second master theme (section 7.3.4).

- **Loss of community spirit**

Residents gave accounts that revealed a loss of community spirit in the area, a deterioration of the social environment. These descriptions were related to two forms of community spirit. On the one hand, it featured a functional perspective, missing residents who look after each other, as in the past. On the other hand, community spirit was explained from a hedonist perspective, with reference to a lack of community gatherings that involved entertaining and enjoyable activities, such as street parties, which usually were described as resident-led.

Data analysis revealed that the lack of community spirit was associated with a general feeling of disconnection with other residents living in the area.

People just ignore you, you could go out and speak to them, they would ignore you, they wouldn't speak to you, so there is no other way of describing it really, that's it like I say, they just come in the door... and keep themselves to themselves, but they forget they have got to live here as well as us
{Jennifer, Centre}

Again, such experiences of disconnection might find their root in residents' dissatisfaction with surroundings and perceptions of decline of their neighbourhood, and the associated increase in churn rate of the local population (Kearns and Parkes, 2003).

Residents' accounts implicitly and explicitly referred to segregated communities (see quote directly above), often using the terms '*them versus us*' {Rebecca}. Segregation was expressed through accounts of clashes between groups of the population. A clash of lifestyles was appreciated between those who were interviewed and considered themselves as permanent residents, and those who were considered to belong to a 'second class citizens'. Examples of disagreement with ways of living included self-harming behaviours (e.g., alcoholism, drug addiction) and associated consequences (e.g., drug dealing, noise, crime, different day patterns).

They are up all night drinking, then in the day they are asleep, so it's quiet in the day, and then mayhem at night. Where normal people, you have got to go to bed at night, because you have got to get up for work, haven't you?
{Janiece, Centre}

There is a lot of drugs, drug dealing, there is thieving, there is noisy neighbours, music blaring loud all hours of day and night, bad language
{Jean, Centre}

Data analysis also revealed a clash between ethnic groups living in the area, particularly in South. Ethnic groups were typically referred to as separate communities with '*different languages, they have different cultures, they have different faiths, and they have different classes*' {John}, '*pulling in different directions*' {Peter}. Residents from a White British background viewed the other

groups as responsible for causing friction and issues, for not adapting their lives to local ways:

[Parking and blocking the road] is being antisocial, when, I could've gone up a few yards up the road and park the car, you know, that will be sociable, that would be considerate but no... 'we are in South, we are Pakistani, we are the majority here' {mimicking a deep and virile voice}. It becomes little Pakistan
{John, South}

Residents from North gave accounts that denoted a different type of clash between the existing community and the new incomers, who were arriving at the time of the baseline interviews as part of the '£1 houses scheme', to inhabit and upgrade the empty houses. The following quote shows an example of how the newcomers were experiencing difficulties integrating within the existing community.

If you come and join in the neighbourhood, it is difficult to get to know everybody, coz everybody is already friends and they see you as an outsider
{Gareth, North}

Conflict instead of sense of community has been suggested as an issue within mixed communities in Britain, where being forced to live together or unfamiliarity of British residents with multicultural communities have been indicated as possible explanations (Cole *et al.*, 1997).

Most aspects mentioned above referred indirectly to experiences of antisocial behaviour. Many residents believed that antisocial behaviour was also related to lack of youth provision.

Because most of the problems in this area are boredom, because there's nothing for the young lads to do, so when they're bored they're open to danger as things out there, which you can get involved in, which because they're bored, they're more likely to {Sophia, North}

Residents' accounts regarding community spirit and the loss of pride seemed to relate to the concept of sense of community, defined as 'a feeling that members have of belonging, a feeling that members matter to one another and to the group, and a shared faith that members' needs will be met through their commitment to be together' (Mcmillan and Chavis, 1986, p. 9). Findings from this research suggested a low sense of community across the targeted areas with high levels of

disconnection amongst residents. When a sense of belonging was noted, clear distinctions were made in terms of belonging to a specific separated group, notable throughout the type of language used during interviews, such as: '*our community*', referring to the Asian (Pakistani) community in South; '*the £1 pound people*', referring to the new incomers as a result of the '£1 house scheme' taking place in North; or '*tenants*', indicating their own position as house owner.

7.3.3.3. Sub-theme 3: Feeling affected by community issues

This sub-theme covers how life in targeted areas is experienced by local residents. Only one out of the 28 interviewed residents did not provide any account of feeling affected by the deterioration of the area. The rest gave accounts that denoted an impact on their health, particularly their mental wellbeing.

- **Feeling scared**

Several residents recounted experiences of their houses having been burgled, '*we were burgled*' {Jean}. Others felt intimidated by antisocial behaviour in their area. These types of events led residents to feel frightened. This feeling was particularly observed amongst female interviewees.

I feel very scared at times, I've actually avoided going into the shop. I'd go in the morning, because they're not there in the morning [individuals gathering on the street] {Lena, South}

There is nowhere around here that I can sit and go and not feel threatened {Jasmine, Centre}

- **Feeling stressed**

Feeling stressed was a commonly reported feeling with regards to experience of living amongst individuals who carried out harmful and antisocial behaviours. Data indicated how residents' way of life was affected, that they were unable to feel relaxed within their surrounded area, with some also indicating feeling stressed even when being at home.

When you, like I said, when you are in your front room or your living room, you can hear banging, banging, loud music going and, that's got to affect you, hasn't it? It's psychological. It's causing stress, worry... {Paul, South}

- **Feeling 'depressed'**

Thematic analyses revealed a range of experiences that led to residents feeling depressed. A small number of residents reported experiencing high levels of stress due to personal circumstances, which were aggravated by their social environment.

I should be able to make a phone call [to check how my dying father was] in me own home and be able to hear what the other person is saying at the other end of it. And I couldn't do that, because they were making so much noise, they were literally smashing this car for absolutely no reason, they broke the windscreen, they smashed the headlights, they dented all the doors, all the bonnet, with a bloody big hockey baton thing, like a baseball bat and just smashing the hell out of this car and that did affect me because I came in and it was stress added to stress... I didn't need... so yeah, that I think contributed towards it [nervous breakdown and depression] {Jasmine, Centre}

Many residents' accounts indicated high levels of isolation. Pathways to becoming isolated will be described in section 7.3.3.4. However, living an isolated life was associated with expressions of depression, particularly female residents from South and Centre. Depression within isolated Asian (Pakistani) females living in South was commonly reported as an important issue to address. In this context, isolation was usually associated with Muslim religion and culture.

Depression is something that it's shoved under the carpet with the Asian religion, [Asian (Pakistani) females] don't want to recognise it {Nazie, South}

Some residents gave accounts that indicated feeling depressed due to the constant negative issues taking place in the surrounded area.

Whether it'd be mental illness or depression or just general basic, just your pride and everything, it just makes you feel negative, you know, and I think that has an adverse effect on your health in general, and I think that is quite ripe at the moment around here {Dan, Centre}

A few permanent residents from North also gave accounts that implied feeling heartbroken by seeing other residents leaving the area due to the unfinished demolition and regeneration plans for the area, as many were asked to move and did so, as Sophia put it, *'it's been [difficult] to [see] everyone go'*.

- **Feeling ashamed**

Some residents' accounts denoted that the severe deterioration of the physical environment led them to feeling ashamed, particularly in North. This was considered as the opposite to feeling community pride.

I'm ashamed sometimes of people [relatives] coming up to my house, and I lived now here 43 years and I never felt like that {Sophia, North}

Research supports these findings suggesting that deprived environments are associated with stressful experiences (Steptoe and Feldman, 2001; Latkin and Curry, 2003). The above findings illustrate how the stressful experiences are lived. It also places these experiences in the context of a wider community deterioration process. The next section covers how residents cope with and defend from these stressors and further aspects of deteriorated neighbourhoods.

7.3.3.4. Sub-theme 4: Coping and protecting strategies

Coping strategies were usually provided in combination with explanations regarding how issues in their living area and surrounds made them feel. Thematic analysis revealed three types of coping and protecting strategies.

- **Isolation**

Social isolation has been associated with deprived areas (Böhnke, 2008). This research indicated isolation as a coping strategy to stress related to living in a deprived area, but also as being externally enforced. Both types will be outlined next.

In terms of isolation as a coping strategy, many residents gave accounts of choosing to stay at home as a strategy to avoid possible trouble in the area.

You come through your door and you lock that door, and you don't let anybody else, you don't get involved with anybody else, you don't want to

know. We only get involved with {names of a couple}, because of their age, but everybody else... we wouldn't get involved with. I would go out of my way to avoid them {Jennifer, Centre}

Some residents also indicated not using the physical environment or engaging within the social environment of their areas. Some stated that it was a conscious decision to cope with their experiences of 'feeling scared' or 'feeling stressed' within their surrounds (outlined earlier).

I would never let my grandchildren go into [the park] because it's not safe enough. There's alcohol, bottles around, dog mess, people aren't cleaning up after dogs {Sophia, North}

Van der Land and Doff (2010) studied the coping strategies used to deal with the stress of living in deprived areas, suggesting two main types: voicing or exiting. With the exiting strategy they referred to coping by moving out from the area, but also withdrawing socially, physically and mentally was considered exiting. This supports the findings presented above. This coping strategy was associated with low self-efficacy, as residents feel incapable to take control, which increased feelings of insecurity and transformed in low levels of trust of other residents and at the institutional-level (van der Land and Doff, 2010). Institutional decisions that disempower citizens by contributing to a sense of lack of control have previously been suggested (Bleas, 2003), which supports the deterioration process being outlined in this chapter (master theme 1).

In terms of the environment imposing an isolating lifestyle, different types of forces were evident. Some attributed their isolation due to other residents not having an interest in socialising.

There have been quite a few people who have lived here in a rented accommodation, but they still don't want to socialise or interact, you know, when you, because you have been here a long time, people move in they say 'oh hello' but they {mumbling} they just ignore you {Jasmine, Centre}

The experience of disconnection from other residents could be the consequence of choosing to socially 'exit' the area, as suggested above, but also because of a missing sense of community, which highlights the reported different cultural backgrounds, lifestyles and values of residents.

Not having access to community venues within the surrounded area was suggested as a sign of abandonment (section 7.3.3.1), and was implicated as a cause of social isolation by limiting access to opportunities or places where other residents would gather and socialise.

But no as far as I am concerned, it is like... there is nowhere for me to go if I wanted to socialise or meet people {Jasmine, Centre}

Some residents from North referred to permanent residents being forced to leave the area, due to the incomplete regeneration affecting the social relationships of the residents who managed to stay in the area. This could relate to the negative experiences previously reported regarding neighbourhood demolition, relocation and urban regeneration plans, also taking place in the UK (Egan *et al.*, 2015).

Within South, interviews with White British and particularly British Asian (Pakistani) residents revealed that certain cultural 'informal' norms associated with the Muslim religion were forcing Asian females into isolation.

First they will have to ask for a lift [to attend an activity] coz most of women don't drive. They need a lift to get there, we do not allow taxis. Our women don't go for taxis {Anonymous, Asian (Pakistani), female, South}

Data analysis of these particular interviews nonetheless revealed contrasting views on this matter. Some agreed that these norms were part of who they were and needed to be respected, *we [Asian (Pakistani) community] really don't like our girls going out {Nazie}*. Others did not understand some of these 'unofficial' norms that were dictating the life of certain Asian females in the area:

And coming up here [South] it's like, 'you can't do this', 'you can't go out the door, there is too many men outside', 'you can't go to town', 'this is going to happen', and it's like, 'what?' {Anonymous, Asian (Pakistani), female, South}

- **Distrust**

A level of distrust was commonly denoted within residents' accounts from the three areas. It was mostly indicated at an individual-level, distrusting further residents. Distrust amongst residents has previously been identified as a consequence of living in deprived areas that signifies a lack of community spirit (Cattell, 2001). However, residents (particularly from North) also gave accounts that denoted high

levels of distrust at an institutional-level, which is consistent with previous research (Jarvis, Berkeley and Broughton, 2012).

So what is that saying to the children? Saying these people who are supposed to be in power... they don't keep their word {Sarah, North}

It seems that distrust was a strategy that acted as a subconscious defensive mechanism. Many residents disclosed accounts that denoted distrust but only a small number recognised that they were actually distrusting. Also a generalisation of distrust felt towards peers or institutions was often implicitly disclosed.

I think it's going to the point now where you tend to class all of them [harmful residents] the same, you don't trust them, I suppose it's unfair really {Kate, South}

Distrust of other residents and institutional-level has been indicated as a common characteristic of residents who decide not to move away from a deteriorated community, but decide to 'exit' at a social, physical and psychological level (van der Land and Doff, 2010).

- **Giving up**

Many residents' accounts showed a pessimistic attitude towards change and improvement of their areas and lives. Some residents also gave accounts that disclosed a high level of desperation, lacking any hope of change, as Paul put it, '*I think it's virtually an impossibility you can get a peaceful community*'. Many residents mentioned knowing a growing number of residents giving up and moving out from the area, and had considered the same option. At the same time their accounts denoted resistance against that.

[Relatives] say we should move and... but why should we move if we've been here for 35 years? Why should we move? [Offenders] should move, they shouldn't be let in to our area {Kate, South}

This supports again the type of residents who are not satisfied with the area where they live but who opt to remain, most likely due to an attachment to it, and who consequently feel unable to make or see a change (van der Land and Doff, 2010).

The three identified strategies were interpreted as leading individuals to contribute to the deterioration of their area. The next sub-theme partly covers how this contribution happened and was perceived.

7.3.3.5. Sub-theme 5: Community deterioration generated at the individual-level

Data analysis revealed multiple factors that were considered to be interconnected and contributed towards the process of deterioration. Abandonment led to a loss of community sense, which stressed individuals living in the area, who adopted coping strategies that led to disengagement from the physical and social environment of the area, and this again, perpetuated the deterioration. The latter component of the deterioration process will be outlined next.

A common example was not accessing the existing services or venues provided in the area. A small number of residents gave accounts of a lack of awareness of certain aspects or locations within the area, giving accounts of discovering these through their involvement with MCM.

And I didn't actually realise that there was still a play park, I thought when they built the school, I thought all the ground had been used, and it was only up until the last meeting of My Community Matters that I found out that the play park is still there {Jasmine, Centre}

Lack of participation in community life has previously been associated with feeling unequal (disempowered) and a lack of sense of community, which reflects a lack of social wellbeing (Higgins, 1999). This confirms once more the disempowering process experienced by residents taking part in this study stage that has been explained through the present master theme.

Some residents gave accounts that related services which were not being used by the community to closure of those services. These residents seemed to understand institutional-level decisions regarding the closure of facilities due to budget cuts. This contrasts with the frustration that residents showed towards the institutional-level abandonment of the area (outlined earlier in section 7.3.3.1).

When we had [name of a community venue] it may have not been utilised as much as it should have been. I think the reason why obviously the council shut it was because it was underutilised' {Ahmed, South}

Along the same lines, one Centre resident exemplified how racism was contributing towards further deterioration:

The shops all changed hands, and they all became like Asian or different owned, and then the small community, which unfortunately there is a very big

racial tendency like 'I'm not going in there, I'm not giving them me money', so then those shops struggle to survive and then people move out of the area {Lea, Centre}

The following quote adds an example of how some residents from the Asian (Pakistani) community coped with racism, further contributing to a fragmented community.

I said [to my kids], 'you keep your mind straight, you're there [in school] to get your education, get your education and walk out to there, lunch time see your friends, and that's it. When you're in class, you're not there to chat to your friends, you're there to pick up your education. Do that, concentrate on that and walk away' {Anonymous, Asian (Pakistani), female, South}

This suggests that some residents opted for escaping involvement in their neighbourhood as a coping strategy, which clashes with the main principles of participatory approaches to community improvement (referred to as community engagement in this thesis, Chapter 2) (Shalowitz *et al.*, 2009; O'Mara-Eves *et al.*, 2013). The present research added that residents seemed to further contribute to the deterioration of their area by 'exiting' it, but were not always aware of their contribution.

7.3.4. Master theme 2: Perspectives towards community improvement

Baseline interviews also aimed to understand residents' expectations from MCM and initial experiences of the programme. These topics led residents to share some further aspects that did not exclusively refer to their expectations, leading to the following three sub-themes.

7.3.4.1. Sub-theme 6: Levels of engagement

Thematic analysis revealed a range of engagement levels amongst interviewed residents.

- **‘Objecting’**

‘Objectors’ are represented by residents’ accounts that involved negative views concerning their area and a tendency of attributing responsibility for addressing problems of the area to the institutional level (e.g. local authority).

I just feel [professionals] are not doing enough, that park... These kids, it’s just, I know they are kids and I understand, but if you talk to them, they say, there’s bin. Then make a play area for these little ones, on their area, and then get a bit of the park for the people who’ve got dogs. That’s their [area], that’s where the dogs go {Abigail, North}

- **‘Having a voice’**

Many residents were willing to get involved in community-related meetings and provide their opinion on setting priorities for the area and reporting on ongoing issues. Some also treated those meetings as opportunities *‘to keep myself informed with what is going on’* {Jean}. Residents from this group generally gave accounts that denoted an expectation of the organisational- and institutional-level to have the responsibility to address reported issues, *‘if we outline the problems, which need addressing [by local authority]’* {Sophia}.

- **‘Taking action’**

Many residents gave accounts that involved ‘taking action’. Context clarifications have been made when necessary to explain certain findings.

Several residents from South reported their involvement in an existing community group. Residents’ involvement referred to holding a role, such as *‘I’m the treasurer and I write the minutes for the Residents Association’* or *‘I enjoy the [Residents Association] meetings, I do go to their meetings yeah’*. The research familiarisation stage (explained in section 7.2.1.1) and interviews with residents from South disclosed the existence of multiple community groups in the area. It was also observed that attending meetings of other community groups, in addition to their own, could be a consequence of MCM efforts to bring different community groups together.

Residents’ accounts revealed that South community groups had been formed to address local issues. For example:

So essentially [a community venue] what's really lacking within South. And as I said, one other reason, what we wanted to kind of start something kind of practical was so that the kids, and even the adults, is kind of keep them off the streets {Anonymous, Asian (Pakistani), male, South}

Data analysis revealed a high level of engagement of certain South residents at an individual-level but also at a community- and organisational-level, where a group of residents had joined efforts with the intention of self-organising themselves to act on local concerns.

For North, thematic analysis revealed two types of resident. Residents who had lived in the targeted area for a long time, and consequently had experienced the unfinished regeneration process with severe deterioration of the area (explained in section 7.3.3.1), are referred to as 'existing community'. Residents who had just arrived into the area after having recently bought one of the 33 houses as part of the '£1 houses scheme'. They are referred to as the 'incoming community'. Most existing residents gave accounts of having taken action in the past as part of a committee that was formed to fight against the demolition and regeneration plans for the area and also the organisation of activities at the local community centre. Interviews with residents of the 'existing community' revealed a high level of connectivity since interview accounts often indicated knowledge about other existing residents. Incoming community residents were part of a scheme that was explained as a way of addressing the empty houses of the area, and bringing new residents to the area, who were expected to have an interest in community engagement:

So, everyone that became involved in the £1 pound home project had to have some kind of vested interest in the community side of things as well, that was a key factor with the agreement [to be able to buy a '£1 house'] {Anonymous, White British, female, North}

As part of the '£1 house scheme', the 'incoming community' reported to be financially supported to tackle some of the identified community concerns. This has previously been suggested as a type of empowerment since this scheme '*invest[ed] or [gave] power or authority to others*' (Israel et al. 1994, p. 154).

In contrast to North, residents from Centre provided accounts that disclosed neither existing community groups in the area (except for one Neighbourhood Watch group), nor existing connections between residents attending the meetings.

At an individual-level, residents from all three areas and from all four described levels of engagement gave numerous accounts that indicated taking action, yet not always involving self-organisation and addressing local concerns. Some residents referred to greeting people, *'I walk up the street, 'hello, good morning, ok?' it's like, no, you don't get that [greeting] off people'*; others tried to encourage community participation, *'I do invite them [to activities going on in the area] you know'*; others helped further residents to address family and cultural barriers, *'her husband didn't want [the lady] going anywhere, so I sorted everything out for her [to attend a course], I went and personally pick her up, didn't ask for any fuel'*; others maintained a high level of community pride, *'you always see these houses, which are immaculate compared to all of them around there, so you can see that there is people who really do take pride'*; others exemplified how they tried to mix with different ethnic groups, *'I mix myself up, I don't just stick with the Asian women. I find my own way and I talk to who I want to, go and mix with other people, which a lot of the Asian people round here don't like'*.

- **'Leading action and enabling others'**

Accounts in particular from residents who had adopted a specific role as part of a local community group denoted experiences of making decisions, taking leadership, and trying to enable others to get involved, taking action and working together.

But there's been no continuous, we get the Asian [Pakistani] community coming up [to community group meetings] with some great ideas. And then that's it, they're gone. And I personally take minutes of the meetings down, put them through their door, handing them to them, you know, 'so, we've got a meeting, couple of days time', 'I'll be there!' {Anonymous, White British, male, South}

Some of the residents' accounts of this level of engagement and also the previous one (taking action) denoted frustration in relation to the negativity of some residents and/or lack of participation.

A lot of people [from existing community] there just go [to meetings] to vent their frustrations {Anonymous, White British, male, North}

The above characterisation of the levels of engagement mirrors the typology of community engagement suggested by O'Mara-Eves et al. (2013), where

'objecting' and 'having a voice' types of engagement correspond with 'informing' and 'consulting' community engagement approaches, which involve little participation. Suggested features of residents presenting 'taking action' as an engagement level correspond with 'community development' and 'community participation' approaches to community engagement, as these approaches support individuals to strengthen networks, identify common concerns, make decisions and take action to achieve change. Finally, the 'leading and enabling' level of engagement corresponds with 'community empowerment' approaches, which demands that individuals mobilise into action and drive change.

- **Continuum and overlap of engagement levels**

The above described levels of engagement show a continuum of engagement, from residents showing a low level of engagement ('objecting') to higher levels ('leading action and enabling others'). Thematic analysis also revealed an overlap between this range of levels, where accounts from a particular resident would not always belong to one specific level of engagement. Some residents gave accounts that aligned with the explanation of 'leading action' (e.g., chairing a community group) and also providing negative views and blaming the institutional-level, which better aligns with the description of 'objecting'. Data analysis also revealed that levels of engagement were not static, with some residents, particularly from North, showing high levels of engagement in the past, but no longer. This refers to the continuum that interconnects individual action and higher levels of organisation towards social change (Laverack, 2004), which has previously been featured as dynamic, interactive and non-linear (Israel *et al.*, 1994; Labonte, 1994).

7.3.4.2. Sub-theme 7: Perspectives on MCM as an approach

The interview topic of expectations from the programme revealed varied understandings of the particular approach used to deliver MCM, which deserves some attention prior to focusing on the actual expectations.

- **Understandings of MCM approach**

Variation in levels of exposure to the programme (highlighted in section 7.3.1) might have affected residents' understanding of the MCM approach. However,

data analysis did not support this. Residents' accounts denoted a high level of uncertainty regarding what the approach of MCM was, irrespective of the level of their exposure. When residents were asked about MCM approach, phrases were stated as questions rather than statements, as Jean put it, *'is it perhaps reassurance to the community? that maybe something can be done to improve the community?'* The use of expressions such as *'I don't know', 'I think', 'I might be wrong'* was common, denoting uncertainty, with a small number of residents accusing MCM representatives of failing to explain who they are and what they do: *Exactly, what is their goal?! What is it?! {Sarcastic and angry tone} All they say to us is to improve the area {Shahinaz}.*

Residents' understanding of what outcome MCM was trying to achieve was consistent. Most residents, if not all, identified improvement of the area and/or community as the outcome. Some specified the outcome in terms of improvement of the physical environment, *'just generally tidying the area up first thing, making it a bit more presentable'* {Janiece}; others specified the outcome in terms of improvement of the social environment, *'they are involved in terms of the social side of developing communities, which need help in setting up residents' associations, and getting people involved in the community'* {Garrett}. A small number also referred to a health related outcome, as they understood MCM as a way to *'improve the wellbeing of the community and that both means with the physical health and also the mental health'* {Sam}. The latter relates to the main purpose of MCM since the ultimate goal of community engagement approaches is to have a health and wellbeing impact (O'Mara-Eves *et al.*, 2013). However, based on reflections from the familiarisation stage and interview data, the researcher suspects that this purpose was not overtly stated by the CDWs.

Understanding of the approach appeared very inconsistent in terms of the process carried out in order to achieve the improvement of the area and/or community as an outcome. Data analysis revealed three main steps as part of that process, but there was inconsistency in how many of these were recognised and what each involved.

The first step referred to residents coming together. This was generally mentioned across baseline interviews and also similarly articulated. Some residents perceived the role of MCM as a step to *'arrange all the meetings and try to bring everything altogether'* {Jasmine}. A resident from North specified that MCM had the role of *'trying integrating the [incoming] community and the [existing]*

community {Gareth}. Many residents (especially from South) only identified this first step, not mentioning the other two subsequent steps.

The second step referred to identifying priorities. This means that residents who recognised this second step perceived the approach of MCM as a process to bring people together (step one) to identify the problems within the targeted area (step two). Some residents coming from South and 'existing community' of North identified step one and two as the entire process. Their expectations were different to those who also identified step three, seeing steps one and two as a consultation, where residents identified issues and professionals solved problems.

Local residents to have an opinion on what goes around here, the good things, the bad things, and what they [MCM] can make better and what we'd [local residents] like to see better {Lena, South}

The third step referred to tackling identified priorities *by 'work[ing] with the professionals like the Council, the Police'* {Madison}. For those who recognised all three steps of the process, step two was perceived as an intermediate part of the process towards change, which did imply assuming a level of responsibility. Data analysis revealed three slightly different interpretations of the third step: i) residents and professionals working together, with residents identifying issues and professionals solving them; ii) residents 'becoming entirely in charge' of solving the problems, *'get[ting] more people involved to do it yourself a bit, to take over what [MCM] are doing I suppose'* {Janiece}; iii) shared responsibility over problems between residents and professionals.

[MCM] created [name of partnership formed by residents and professionals with the support of MCM], which they obviously got the council involved, there was the police, ourselves, [names of three community groups], so they had a number of different organisations and [MCM] kind of wanted [residents and professionals] just kind of sit together and work together, to trying, I think essentially, improve the local area {Ahmed, South}

Many residents also mentioned the intention of the programme to form a partnership between residents and professionals working together. Most referred to MCM wanting to form this partnership and did not show a great level of ownership over it.

I think what they're trying to do is probably they want to set up a group within the community, that's what they're talking about {Nazie, South}

The three steps, when identified as part of the process, were interpreted as a continuum, where getting together will take place first, then identifying priorities, and finally tackling the identified priorities. Data analysis revealed an association between the sub-theme 'levels of engagement' (section 7.3.4.1) and these three steps. Those frequently 'objecting' tended to have a limited understanding of the approach of MCM (step one or two), whereas those 'leading and enabling others' tended to report a more complete understanding of the MCM approach (step three).

Participation is central to participatory approaches (Eversole, 2012). It has previously been suggested that nobody can be empowered against their will; empowerment should come from oneself (Rappaport, 1985). Findings from this research indicate a group of residents, who did not show an interest in participation, or in being empowered. The data also suggest a range of understandings of the MCM approach. Overall, residents' accounts suggest a connection between holding general low levels of engagement ('objecting') and having a limited understanding of the approach of MCM (recognising step one or two), and vice versa. This might be a manifestation of community disengagement, where their lack of interest in getting involved does not allow them to see the whole picture, or perhaps it is a picture they do not want to see as it involves their participation. On the other hand, Eversole (2010) indicated the challenges that 'bottom-up' and participatory approaches face by being trapped in a 'top-down' frame, primarily referring to the institutional-level. Findings from this research suggest that the lack of understanding might share a root with Eversole's suggestion, where some residents gave accounts that aligned with 'top-down', showing a lacking of understanding of the principles of a 'bottom-up' approach.

- **Expectations about the approach of MCM**

As earlier highlighted, at baseline interview, residents had already been exposed to the MCM approach (as it was not possible to recruit people prior to any contact with MCM). Therefore, their expectations had already been influenced by their experience (albeit limited) of the programme. Data analysis revealed four main expectations.

First, residents expected the approach of MCM to lead to an outcome of improved physical and social environment of the area. Some residents gave accounts of

expecting improvements by the time of the baseline interview, as MCM was perceived as addressing the suggested local needs. One particular resident also suggested the need to show improvements to help residents restore their lost trust. However, their accounts did not show the intention of getting involved in participation towards such improvements:

By showing improvements, and getting people's confidence back with this, 'yes! something has been done', and set it up and taking notice, like 'yes! we are being listened to', 'yes! We are having something done' and then, they will all feel better then {Sophia, North}

Second, several residents expected MCM to remain working in their areas long-term. This type of expectation was coming particularly from engaged and disengaged South residents, who often expressed their concern over having only short-term support by MCM.

I'm just thinking if they're not there, if they're willing to think, they're gonna make the group and then walk away, I don't think it's gonna work. I think they still need to keep on top of it, to keep it running. It's a good thing for them to approach this and set up a group and everything but... nothing really happens unless there's a professional {Nazie, South}

It could be argued that the concern for MCM to keep working for longer periods was related to the type of involvement the residents were opting for, a less personal involvement. A small number of engaged residents from Centre also shared this concern. In contrast, engaged and disengaged North residents did not seem to show a concern with MCM moving out from the area at a later point.

A third expectation was receiving more guidance from MCM, which referred to:

I would have expected [MCM] to say, 'ok, these are the processes that we will need to go through to get the end the product', and that's again through this, tick them off, and have something... more guidance there for people who haven't been down this route before {Anonymous, White British, male, South}

This finding combined with those relating to residents' understandings of the MCM approach (section 7.3.4.2) suggests a limited appreciation of the MCM principles and approach. Again, the directly above quote shows an expectation of guidance that is more typical of a top-down approach, as has been suggested and discussed above.

A fourth concern, particularly shared within engaged and disengaged South residents, was the need of involving more residents from the area. It was identified as a continuous barrier that each individual community group from South had faced in the past and it seemed to still be an essential component to make the MCM approach work.

As I'm saying sort of people that come to everything so like the residents association, it's the same sort of, it's the same people really, just a few more, but not many, that's enough [Interviewer asks: Why do you think that's a problem?] Because I think unless you got more people involved, it's not gonna work {Kate, South}

Data analysis revealed that in the particular case of South, involving people was an essential part of the process, but also a desired outcome, as individual-level (residents) and community-level (residents from different ethnic groups) participation had in the past been acknowledged as a challenge. Consequently, engagement and community cohesion became one of the desired outcomes for this area.

Finally, a number of residents from the 'incoming community' of North gave accounts of also wanting to have more direction, but their expectation did not seem to come from a misunderstanding of top-down or bottom-up approaches. They seemed to want to move on and proactively act on the raised issues, instead of remaining within the stage of 'venting frustrations'.

I suppose it was right at the beginning, so it was about information giving, but I am hoping to see some different sort of meetings happening from now on, where people can actually start to sort of work together because that [previous meeting] was just a lot of talking and quite negative talking {Allison, North}

Most suggested expectations (improvement of area by MCM, longer term approach, more guidance) highlight once more a reliance on external support that solves the problems through an approach that better aligns with top-down principles.

- **Feelings about upcoming actions**

This part will be explained in relation to each targeted area, as the local context seems to play an important role.

In terms of South, local residents who shared their perspectives and feelings about the upcoming actions, gave generally negative accounts such as feeling suspicious towards the CDWs:

It's gonna be nasty to say , [MCM] are taking things that people have already got in their community, and trying to get up and running, and then turning it round and doing something else in a different location, just to get their numbers up, just to try and up their name, if you understand what I mean?
{Shahinaz, South}

Further for South, there was a lack of interest in getting involved. Lack of hope and trust were two aspects that have already been mentioned as possible reasons of disengagement. On top of that, the residents who still believed in the approach and wanted it to work did not show interest in adopting a leading role.

It is frightening keeping coming [to MCM meetings] because I worry about how much danger I'm putting myself in being given a job to do. You know, I have a lot of time demanded of me for... like I'm the [role] for the [name of the community group] {John, South}

In terms of Centre, residents who shared their feelings about the upcoming action appeared to be more positive than South residents. Some residents' accounts denoted an appreciation for the work carried out by MCM representatives and further involved professionals.

I can't moan about it at the moment, I think [MCM representatives] are doing what they can... they are getting the right people on board, they have got a bit more power and they can say 'yes, we want these people to get involved' more than I am, that is what we do need {Jennifer, Centre}

Although some residents questioned if the upcoming action was going to lead to the desirable impact, some residents' accounts denoted a certain level of hope on the work supported by MCM.

We do feel more positive knowing that something is actually being done, somebody is on our side thinking the same thing that we are thinking, 'let's move on, let's be positive' {Dan, Centre}

Some also shared their hopes in relation to the arrival of a recent housing programme called 'selective licensing' (outlined in Chapter 3).

In North, residents' accounts denoted a mix of feelings towards the upcoming action. As already highlighted, residents from the 'existing community' disclosed sceptical views towards the institutional-level, particularly the council, and towards the organisational level, particularly two housing associations that were involved during the attempted regeneration programme. Some residents' accounts also denoted not trusting the 'incoming community'.

Some of them [existing community] may feel like we [incoming community] are coming in and taking over their community, but that's not what we want, we want to be working together with them, so we're trying to work with them and sort of prove to them that we're not here to take over, we're here to sort of build on what their strong community that already exists {Rebecca, North}

These views seemed to be leading to a clash between existing and incoming community, with some residents of the incoming community realising that they are not being trusted and finding that difficult to deal with it.

Nevertheless, on the positive side, some residents from the 'existing community' gave accounts that denoted having hope again, which seemed to refer to the three main programmes taking place in the area at the time of the baseline interview: MCM, selective licensing, and '£1 houses scheme'.

This time like, everything is positive about the area, isn't it? Because before there was empty houses and you had nobody really to back you up, because the area was rough and it was horrible, but this time it is nice {Sarah, North}

In contrast to the lack of trust of the 'existing community' towards several levels (outlined in section 7.3.3.4), they were able to establish positive relationships with professionals, as long as they were independent of the local authority. Being able to connect to others has previously been suggested as a positive step towards empowerment (Laverack, 2006).

Findings from the analysis of this topic indicate that trust plays an important role in engagement at an individual-level. Those who gave accounts of distrust also gave accounts of not intending to engage, expecting external professionals to solve the problems. The opposite was also observed; higher levels of trust in those already taking an active role (or intending to). Disengagement has been associated with distrust on institutional level (van der Land and Doff, 2010; Jarvis, Berkeley and Broughton, 2012). This study stage also indicated that the identified lack of trust by

the residents of the institutional-level may also be rooted in past negative experiences (e.g., demolition plans), and not only in disengagement *per se*.

7.3.4.3. Sub-theme 8: Initial experiences of the programme

The three areas seemed to have reached the stage of identifying local priorities at the time of the baseline interviews. Therefore, initial experiences of the programme will focus on this common aspect.

Data analysis initially identified a set of statements that referred to having reached a level of agreement amongst residents '*well, we [White and Asian (Pakistani)] kind of had the same issues [that were identified during a MCM meeting]*'. However, these priorities differed when compared across interviews. For example, in South, the White British residents seemed to agree on a main concern, lacking community cohesion amongst the three identified communities: Asian (Pakistani), Eastern European and White British. In contrast, Asian (Pakistani) British residents identified lifestyle and females' mental health in the Asian community as the main concern.

The [Asian (Pakistani)] women can't go to any gyms, don't go to any gyms, because they're too far, or they can't pay... or there's nothing local for them either {Nazie, South}

For North, priorities within the two identified communities, 'existing' and 'incoming' were similar, but attitudes towards each other and towards change were very different, as outlined earlier. A main contrast was related to the negative views and disempowering experiences of the 'existing community', compared with the urgent desire of the 'incoming community' to move from negativity towards action on the other hand.

For Centre, priorities and general attitudes towards change seemed to be similar across interviewed residents. This could be the consequence of having interviewed individuals who identified themselves as part of the same type of community.

This finding highlights clashes between communities. One could argue that those clashes represent further barriers to address and make the process more difficult. Israel et al. (1998) found in their review of partnership approaches for improving public health that conflicts were common regarding priorities, assumptions, beliefs

or values, particularly when gender, race, ethnicity, class, age and sexual orientation are different. Interviews with Centre residents revealed similar priorities and interviewees' characteristics (most were British White and house owners). The follow-up stage will reveal how residents' clashes and agreements affected the empowering process.

7.4. Summary and conclusion

This chapter explored residents' past experiences of living in a disadvantaged neighbourhood, current experiences of participating in a community-level programme to health promotion (MCM), and initial expectations from this programme. Thematic analysis of the 28 in-depth semi-structured interviews revealed a steady deterioration of the area where the local institutional-level was perceived as one of the major contributors towards decline, negatively affecting the sense of community and residents' wellbeing. Adopted coping strategies led residents to disengage, further contributing to the deterioration of the area. In terms of expectations, these seemed to be associated with current levels of engagement (or intended engagement) at an individual level. Residents indicating low levels of engagement at baseline expected the highest levels of reliance on MCM (addressing identified priorities). Distrust was identified as a major barrier to participation and engagement, which was associated with negative past experiences with the institutional- and organisational- level (e.g., local authority). Clashes in priorities and preferred approaches to work (bottom-up versus top-down) were interpreted as potential barriers to the empowerment process.

This chapter has included the baseline stage of the study of My Community Matters. The following chapter is concerned with the one year follow-up.

Chapter 8

Community-level health promotion interventions: Resident experiences from My Community Matters at one year follow-up

8.1. Introduction

This chapter forms the second stage of a longitudinal study of My Community Matters (MCM). With baseline findings outlined in Chapter 7, the present chapter outlines experiences of the programme after taking part for one year (or dropping out). A modified version of the grounded theory method was used to explore resident experiences and explore what role MCM had in how empowerment was experienced, if at all.

8.2. Methodology

The methodology in terms of data collection techniques and data analysis was described in Chapter 4. This section describes the process of data collection applied to follow-up data regarding the community-level intervention. The process of data collection mirrors the methodology described in Chapter 6, and the present methodology section will only focus on those aspects that are different.

8.2.1. Process of data collection

The sections regarding intervention, familiarisation stage, and interviewer are not different from baseline (Chapter 7) and can be found in section 7.2.1. The development of the interview schedule was carried out as indicated in the follow-up methodology section of Chapter 6 (section 6.2.1.2).

8.2.1.1. Sampling and recruitment

In accordance with Chapter 6, theoretical sampling was also applied at follow-up interviews with MCM residents. First, all 28 residents who took part in baseline

interviews were contacted at six months and after one year follow-up. At six month follow-up call, a total of nine residents had dropped out from attending MCM meetings, one mentioned to be only involved via email due to work commitments, and it was not possible to contact two further residents, most likely due to changes of contact details. From the nine residents who dropped out, three still agreed to take part in a follow-up interview, arranged between six and nine months after baseline interview.

Residents who reported attending the programme at 6 month follow-up were contacted again at one year follow-up (n=15). Nine reported being involved at follow-up and agreed to be interviewed; three reported not attending MCM meetings but attending activities organised for the whole community and agreed to take part in an interview; three reported neither attending meetings nor activities, two of whom agreed to take part in an interview. As a result, a total of 14 residents who were interviewed at baseline agreed to be interviewed at one-year follow-up.

Combined data collection and data analysis took place as highlighted in Chapter 6. From the 14 residents who agreed to be interviewed at follow-up, analysis of the first 11 interviews revealed that data saturation was not reached. Experiences and perspectives of residents who were taking a very active role in improving the area were still being missed. It was decided to only focus on those residents who had adopted an active role. After checking with the community development workers (CDWs, MCM deliverers), the three remaining residents who also took part in a baseline interview were invited to the follow-up interview, as the CDWs confirmed that they were actively engaged with MCM. In addition, the CDWs were asked to facilitate contact with further residents, suggesting three new residents that were playing an active role. These residents gave verbal consent to be contacted by the researcher and ultimately took part. Data analysis subsequently revealed data saturation (Morse, Olson and Spiers, 2002), resulting in a total of 17 one year follow-up interviews with residents who showed a varied level of engagement (i.e., disengagement, attending some activities, attending meetings and helping towards decided action plans, taking an active role). Figure 8.1 summarises the recruitment process from baseline (grey font) to the completion of follow-up data collection (black font) for MCM.

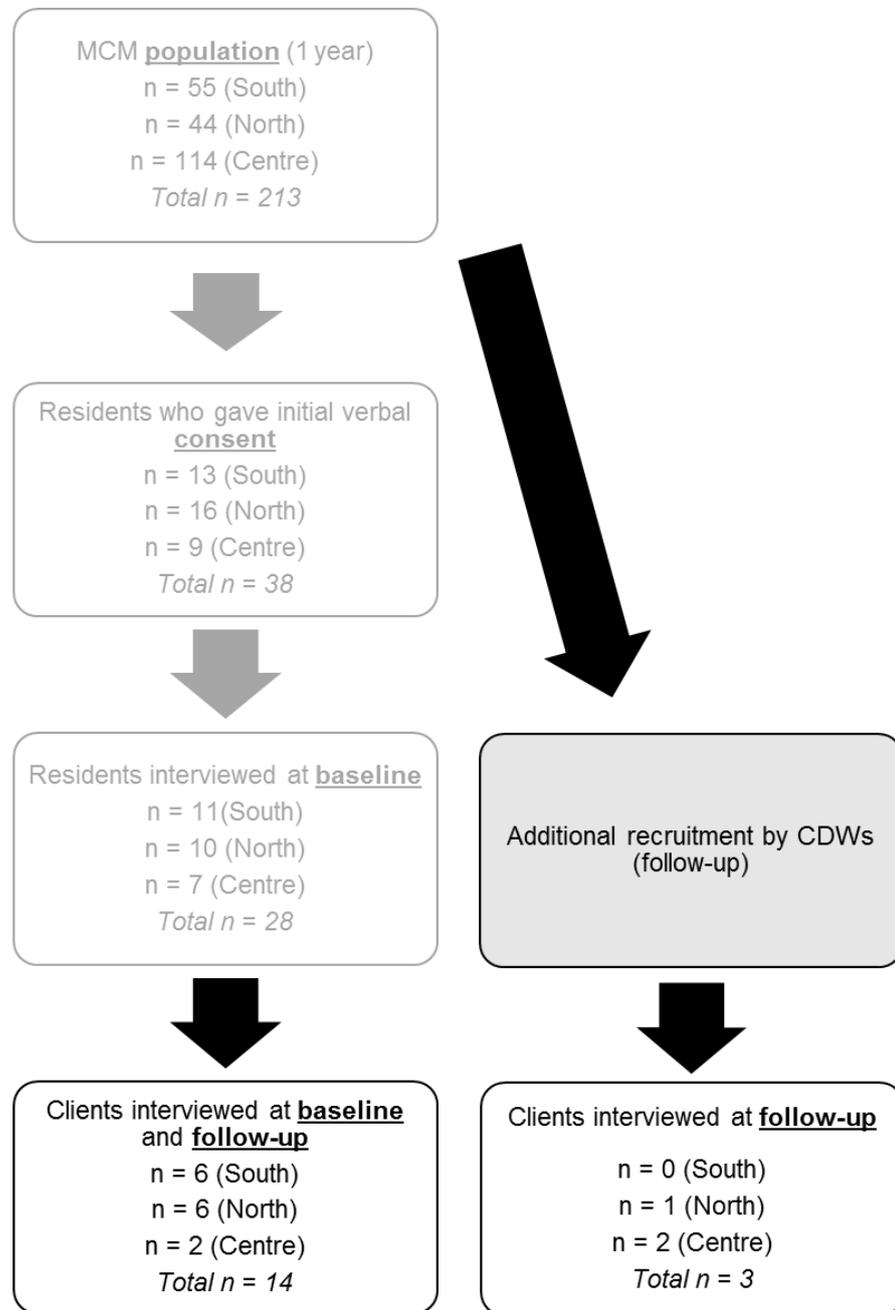


Figure 8.1 Baseline and follow-up recruitment process of MCM residents

8.2.1.2. Data collection procedure

The procedure of data collection at one year follow-up is similar to the one described at the LS follow-up (Chapter 6, section 6.2.1.3). Dissimilarities with this section have been highlighted below.

- **Procedure with residents who were interviewed at baseline and follow-up**

The 14 clients who took part in both baseline and one-year follow-up interviews were offered interviews at their home or at an alternative venue; 10 chose interviews at home and four chose a local venue (e.g., children's centre). Before the start of the interview, clients were verbally reminded about the procedure described at baseline (Chapter 5, section 5.2.1.5).

- **Procedure with residents who were only interviewed at follow-up**

The three further residents who did not take part in the baseline interview gave verbal consent to the CDWs to be contacted by the researcher, and opted for a home visit to be interviewed. Interviews followed the procedure described in section 6.2.1.3.

Considering the disruptions to some baseline interviews, residents were gently reminded of the importance of arranging the interview at a quiet place to allow the Dictaphone to capture the conversation. Accordingly, all but one interview took place in a quiet room and were barely interrupted. Interviews were held between November 2014 and October 2015. Interviews ranged from 33 to 130 minutes, with an average duration of 59 minutes.

Participants' accounts will again be described using pseudonyms to protect participants' identity. Some provided quotes include personal information that could allow identification, particularly by further residents and CDWs. To protect anonymity, some quotes have been described using the word 'anonymised' (rather than using the pseudonym). Immediately after each interview, the researcher reflected on the conducted interview as described in section 5.2.1.5.

8.3. Findings

8.3.1. Participant characteristics

This section includes characteristics in terms of age, gender, ethnicity, and deprivation levels of the residents who took part in the follow-up interviews. This information is only provided for general information on the clients who took part and does not aim to represent the total population, as justified in section (6.3.1).

A total of 17 residents took part in a follow-up interview, of which 14 also took part in the baseline interview. Most interviewees (n=9) were aged between 26 and 40 years. Eleven out of 17 were female. The majority of interviewees were White British (n=13), with the remainder belonging to Asian (Pakistani) or Black (Caribbean and African) ethnic groups. All participants understood English, and English was the first language for White British and Black participants. Table 7.2 (section 7.3.1) showed deprivation levels for residents taking part in baseline (n=28) and follow-up interviews (n=17), again, confirming the generally high level of deprivation in the sample.

8.3.2. Introduction to model

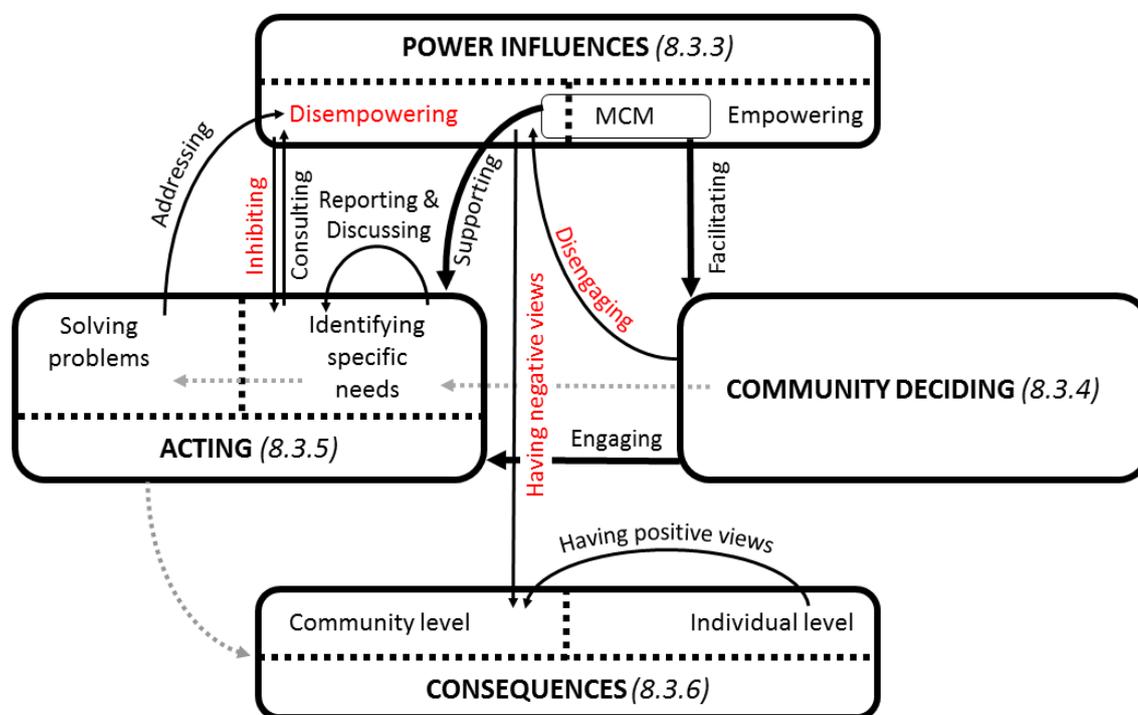


Figure 8.2 Resident experiences of the MCM role

Analysis revealed that some residents stopped participating after baseline, whereas others carried on for the entire year and some got involved after baseline interviews. This grounded theory study stage suggested a model that outlines how empowerment was experienced by residents. Experiences of support were also identified as part of the MCM role. In terms of the shift of responsibility, analysis revealed that some residents were already taking action and responsibility over issues before the introduction of MCM, some were not taking any action and did

not change this position, and whereas others did. A diagram (model) has been constructed that represents all levels of involvement, support and experiences of empowerment (Figure 8.2), to represent the substantive theory. This model contains four categories, which in turn contain sub-categories. Categories, sub-categories and relationships will be addressed next. Similarly to Chapter 6, the structure of these research findings have been inspired by an example provided by Urquhart (2013).

8.3.3. Category: 'Power influences'

Data analysis revealed that MCM was not the only 'power influence' acting amongst the three areas, other 'power influences' were interacting. These were not initially intended as a focus of this study stage, but it was necessary to include them due to the strong influence on resident experiences of (dis)empowerment and support concerning MCM. The following two sections describe the broader spectrum of resident experiences about empowerment (and also disempowerment), and briefly highlight the position occupied by MCM. Findings from baseline (Chapter 7) gave context to this category. Therefore, this category will include references to Chapter 7 to avoid repetition. Context not covered at baseline will be briefly included and referred to as findings from baseline.

8.3.3.1. Sub-category: Experiences of empowering influences

Experiences of empowering influences referred to external (i.e., the enabling programme) or internal (i.e., self-empowerment) influences that would result in a group of residents taking action to solve problems in the area where they live. Resident accounts provided experiences of empowering influences that were initiated at two different levels.

- **Empowering influences at an institutional-level**

Residents across areas continued to provide accounts at follow-up that designated two specific programmes as encouraging active participation: the '£1 houses scheme' and the MCM programme. As noted earlier in Chapter 7, the '£1 houses scheme' was described by residents as a programme administered by the local authority that aimed to address housing related concerns through bringing new

residents to the empty houses of the area. The programme targeted young professionals with interest in community engagement and a budget was allocated to improve some aspects of the physical environment (e.g., green areas).

As already highlighted in Chapter 7, some residents experienced MCM as involving three main phases: bringing residents together, identifying priorities and acting over those priorities. This agrees with the fundamentals of community empowerment theory (Laverack, 2004). It could be argued that MCM intends to start the process of empowerment at an institutional-level since it is commissioned by the local authority and would convert Laverack's (2004) understanding of 'power-over' (of institutional- and organisational-level) into 'power-with' (residents), earlier explained (Chapter 2).

- **Empowering influences at an individual-level**

Baseline and follow-up interviews revealed that some residents were involved in a community group. Some of these groups were explained to have been recently formed with the aim of addressing specific needs of the area. This suggested self-empowerment, corresponding with Laverack's understanding of 'power-from-within', defined as '*personal power as an inner strength or feeling of integrity*', where power has not been given by an external agent (Laverack 2004, p. 33). Here the empowering process started at an individual-level and transformed into higher levels (i.e., community- or organisation-levels), with some individuals joining forces, becoming a group, and forming a community group, as has previously been suggested as part of a continuum that progresses from individual to social action (Laverack, 2004). Other residents stated holding a role in an existing community group which was also trying to improve aspects of the area, such as in the role of chair, secretary, or treasurer.

8.3.3.2. Sub-category: Experiences of disempowering influences

In contrast to experiences of empowerment influences, experiences of disempowerment seemed to be originated at higher levels than the individual level. Disempowering influences inhibited the engagement of residents, who gave numerous accounts of being dragged towards disengagement. Experiences of disempowerment referred to two main types.

- **Disempowering influences as a whole, at multiple levels**

The inclusion of this type of disempowerment in the model was mainly through baseline data. Thematic analysis of baseline interviews resulted in the emergence of community deterioration as one of the master themes (Chapter 7, section 7.3.3). The description of community deterioration through the five suggested sub-themes illustrated a disempowering influence, which resulted in a generalised attitude of apathy. Based on follow-up data, the model of resident experiences of the role of MCM (Figure 8.2) illustrates how community apathy is being addressed with the support of MCM and how community apathy affects the role of MCM. These aspects have been represented as relationships between categories and will be described accordingly (sections 8.3.5.4 and 8.3.5.5).

- **Disempowering influences at an institutional-level**

Baseline and follow-up data also revealed how two specific programmes that originated at the institutional-level were experienced as disempowering by certain residents. These experiences related to the '£1 houses scheme' amongst some North residents and MCM amongst some South residents. For North, it is not clear whether the disempowering influences came exclusively from the housing programme. It seems to be also related to the intense experiences of disempowering lived by the 'existing community' over previous years, which led to distrust towards any initiative or person who would be related to the local authority, as already suggested in baseline findings (section 7.3). Disempowerment is with those who are at the wrong side of inequality, amongst the most marginalised (Marmot, 2007) where empowerment is meant to better distribute power, in terms of decision-making and resources (Laverack, 2004). However, the fact that the '£1 houses scheme' exclusively targeted (and tried to empower) a group of individuals could be a possible explanation of further disempowerment of the 'existing community' as a side effect of the empowerment of a few. The 'incoming community' might have become stronger, forcing the ones who do not desire to engage ('existing community') to an even more powerless position.

At baseline, a few South residents who were holding a 'leading role' at one of the existing community groups before the arrival of MCM, had given accounts that involved an unnecessary duplication of those roles by MCM.

MCM come in to the area, they want to get all the residents, all the organisations to work together to improve the area, which is exactly the same as we're trying with [name of the community group] {Peter, South}

Some of those accounts were interpreted as implicitly denoting feeling threatened by MCM. This could be related to their experiences of distrust towards the CDWs as described at baseline. Similarly, some residents from the 'incoming community' in North, who were identified as having adopted a 'leading role', referred to MCM as a barrier more than an enabler. However, this clash seemed to have disappeared at follow-up interviews.

I should talk about how I felt a bit about My Community Matters, because when I talked to you last time [baseline interview] I think I was quite sceptical about [MCM] involvement in the area [Interviewer states: Yes, I remember]. I was really concerned because I felt like emm... I suppose some of the interventions that happen can be unhelpful and I guess I talked about one intervention that has been happening that has been unhelpful, you know, as I mentioned {Allison, North}

Getting back to the case of South, the very few residents who kept attending MCM meetings but had stated not wanting to adopt the extra responsibility that the approach of MCM requires, gave numerous accounts at follow-up that showed further clashing with the approach of MCM. They felt that MCM was enforcing their approach against their will by wanting them to adopt a leading role.

They [CDWs] were the professionals, they were just all of the sudden, you know, with [name of partnership created with the support of MCM] not being substantially real [as little people were involved], there was suddenly saying, 'well, the future's in your hands, we're [CDWs] leaving it to you', but we had nothing, we had only asked to, who were already got commitment with something else [another community group], which is doing the same job really sort of, and they are making [the work in relation to this partnership] bigger and more responsible... {sighs} {Anonymous, White British, male, South}

This suggests that MCM was most likely experienced by South residents as a traditional form of empowerment, where the relationship between facilitators and individuals is vertical and the form of participation is dictated (Toomey, 2009). This experience questions the intended 'bottom-up' approach of MCM in the case of

this particular area. They also felt that decisions and actions were being taken without them being fully aware of the approach, or even disagreeing with it.

MCM won't tell us everything. Police don't tell us everything, so it's a shame. A lot of the time that you can't just share, you don't need to share every detail, but you could share in general {Anonymous, White British, male, South}

However, this might be a consequence of not wanting to take responsibility and MCM taking over certain aspects. If this was the case, this might relate to the versatile role of MCM, which seemed to be tailored to resident levels of engagement. South residents showed little interest in forming a partnership and taking action that could lead towards social change. As a consequence, MCM seemed to have adopted a provider role, 'by doing things for people instead of helping them to do things for themselves' (Toomey, 2009), acting as a disempowering influence.

8.3.4. Category: 'Community deciding'

This category focuses on understanding how the general priorities of the area were decided. Analysis of follow-up data revealed that residents attending meetings (and in some cases activities) made decisions on what priorities to focus on. There was complete unanimity across interviews on this matter since no differences were found when comparing interviews between residents who presented different engagement levels at follow-up, or demographics such as gender, age, ethnicity and area.

They [MCM] wanted the local people to decide what was most important {Lena, South}

We did a walk around and we just pinpointed and highlighted what we [residents] needed doing, so that was a big thing {Ellen, North}

Most interviewees mentioned involvement in this initial stage of identifying priorities. As it will be later explained (section 8.3.4.2), after this initial stage some residents disengaged, stopping attending MCM meetings. The 'community deciding' category was experienced by those who disengaged at the consultation stage, where opinions were provided. Consultation can be as a step towards full

participation (Arnstein, 1969) but it does not require high levels of involvement (O'Mara-Eves *et al.*, 2013).

Some residents denoted negativity by perceiving the decision making process as '*just such a slow winded process*' {Lena}, '*a lot of the people who were around this table didn't live here*' {Paul}. As outlined later (section 8.3.6.3), negativity has been associated with disengagement. This suggests that, although consultation approaches do not tend to lead to the same health outcomes as those involving higher levels of participation such as community empowerment (Popay, 2010), the present research suggests that consultation might be a suitable approach for residents not yet ready for higher levels of participation.

8.3.4.1. Relationship: Empowering influences 'facilitating' community deciding

This relationship connects the sub-category of 'empowering influences' (section 8.3.3.1) and the category of 'community deciding' (section 8.3.4). The relationship of 'facilitating' refers to opportunities that were created by the empowering influences to local residents to partake in community decisions. An example of MCM facilitating was:

[MCM] do actually try to speak to all the residents around them, they arrange meetings, ask what the problem is, how [residents] need support {Nazie, South}

A further example of local residents acting as an empowering influence and facilitating the identification of needs was:

Whereas [name of resident from 'incoming community'] and a lot of the other ones [from 'incoming community'], you know, are always asking 'what can we do?' {Sarah, North}

The empowering influences, such as MCM or resident groups, were experienced as creating opportunities that would facilitate the community to identify priorities to address.

8.3.4.2. Relationships: 'engaging' versus 'disengaging' from community action

The relationship 'engaging' connects the categories 'community deciding' and 'acting', whereas the relationship 'disengaging' connects the categories 'community deciding' and 'disempowering influences', as illustrated in Figure 8.2.

Deciding the main priorities for the area appeared as a critical point for the type of involvement that residents would adopt afterwards. Some would keep engaged, which involved continuing to attend meetings and taking some sort of action to work towards the improvement of the area. In contrast, other residents would disengage from the action supported by MCM (or other programmes) and go back to what seemed to be their initial status, disengagement with high levels of isolation.

So yeah, I do prefer my own company [than wasting my time attending meetings], if you weren't here, you know, I'd do my housework and then I just go on my internet or I take out my sewing, going start doing that, you know, I'll find things to do rather than, to be honest, I have so much to do, I hardly get time to get bored, but I like being at home, you know, because there's nothing else to do {Lena, South}

This reinforces the idea that empowerment is not provided since it can only be pursued by those who want it (Rappaport, 1985). Findings from this research indicated that those who are most affected by disempowering influences presented high levels of community apathy. They might not be ready to engage and, therefore, not open to being empowered. Research has previously shown that participation is a challenge for community engagement approaches due to disempowering influences that result in distrust and apathy (van der Land and Doff, 2010; Jarvis, Berkeley and Broughton, 2012). However, only empowering those who are ready for it seems to contradict the equal distribution of power, one of the principles of empowerment, (Laverack, 2004), since those who are not ready for it were expected to belong to the most powerless populations.

Next, the features of those who engaged and those who disengaged are identified. At baseline four types of engagement were suggested: 'objecting', 'having a voice', 'taking action' and 'leading action and enabling others' (section 7.3.4.1). The relationship of 'engaging' suggested in this model related to residents who at follow-up were either 'taking action' or 'leading action and enabling others' (from now on referred to as 'engaged' residents), whereas the relationship of

'disengaging' related to residents profiled at baseline as 'objecting' or 'having a voice' (from now on referred to as 'disengaged' residents).

8.3.5. Category: 'Acting'

This category refers to types of actions that 'engaged' residents got involved with, in the hope of improving their area. Although resident accounts denoted a range of experiences related to 'actions', they can be broadly categorised as identifying specific needs and solving problems.

8.3.5.1. Sub-category: 'Identifying specific needs'

This stage should be considered as a development of the category 'community deciding', where general needs had been identified, towards the identification of more specific priorities. Only residents who were still 'engaged' took part in this stage. They gave accounts that indicated being involved in two types of action within this sub-category, which have been suggested in the model as relationships.

- **Relationship: 'Consulting'**

This relationship connects the category of 'acting' with the category of 'disempowering influences', where the disempowering influence is mainly represented by 'disengaged' residents, who present high levels of apathy.

Consulting was the approach most commonly reported in North to identify specific priorities. Consulting the disengaged community was adopted as an alternative to the initially intended community engagement approach, as it requires a lower level of participation (O'Mara-Eves *et al.*, 2013), but at least views from the whole community could be gathered and be taken into account during the subsequent stages of action.

The first thing that we did was we worked with the Council when they were trying to do a consultation with the community about some money that they needed to spend on the environment. So myself and a couple of the other people from the group, helped in sort of forming the questions and then we kind of made an on-line version, which we shared and we set up a Facebook

Group and things like that. And then we went and knocked on doors and interviewed people about what they wanted to see happen and how they wanted the money to be spent. So we were quite involved in that process and then we did a kind of cross-checking activity at a Christmas Party that we also organised {Allison, North}

Therefore, two different roles were identified within North residents, those who would provide opportunities to listen to the whole community through consulting opportunities; and those residents who would use those opportunities to give their opinion, *'residents just said 'you know cut [the green area] and make a path through', because everybody used to cut through it, but it wasn't really a path'* {Sarah}. This suggests that those residents who were engaged adopted a providing role, by solving problems or addressing suggestions for 'disengaged' residents (Toomey, 2009).

For South, data did not refer to any particular way of acting. Two possible reasons are suggested. Various interviewees had stopped being involved with MCM not long after baseline interviews, so they were not aware of the working approach. But also, interviews with 'engaged' residents focused on explaining their disagreement with the approach and action led by MCM, instead of explaining their experiences of the process. Nevertheless, the following example represents how a particular ethnic group (Asian (Pakistani)), identified at baseline with high levels of isolation, was consulted by a local resident and MCM, who joined efforts:

[The CDW] decides funding she can get, s/he actually approaches me first, I actually go and talk to all the ladies [from the Asian (Pakistani) community], coz they are from my community and a lot of them know me, they look to me, instead of everybody else. I'm a familiar face and they feel secure with me. So I ask them what they want, what their need is... and then I talk to [the CDW], obviously I translate for [the CDW] as well, and then we [the CDW and I] decide on a thing, 'right we're gonna go for this funding, we're going try set up this thing' {Anonymous, Asian (Pakistani), female, South}

This highlights again the providing role of MCM in South (Toomey, 2009).

Data revealed a range of consulting methods, including *'we had a meeting and the ideas that were put forward'* {Paul}; *'then it got put on Facebook, [residents] had a vote of what to name [the park]'* {Sarah}; *'if you see somebody in the street and they mention something and then obviously it gets put around [during the following*

meeting] {Sarah}; 'we also filled in a questionnaire of what we would like to see [in the green areas?] like and the order of importance' {Ellen}.

- **Relationship: 'Reporting and discussing'**

Several residents gave accounts that indicated meetings supported by MCM as an opportunity to report day-to-day concerns and then discuss possible solutions amongst residents and professionals from different services who also attended the meetings on a regular basis. This approach was particularly described by residents from Centre, who perceived to have adopted the role of:

Reporting on what's going on in the community and just taking it to the meetings. That's [our] role. It's really just keeping an eye open, seeing what's going on, seeing what's needed in the area and reporting back {Robin, Centre}

The identification of specific needs automatically led to the following sub-category, solving problems.

8.3.5.2. Sub-category: 'Solving problems'

The sub-category solving problems referred to taking action on identified issues. Solving problems usually involved action from professionals of specific service providers (e.g., council, police), from the CDWs delivering MCM, or from residents. Three examples that refer to how problems were addressed will be provided. These are based on the three examples used in previous section (8.3.5.1), which covered the approach that was used to identifying specific needs.

- **Solving problems for those who are disengaged**

Consulting disengaged residents led to an approach that involved 'doing the work for those disengaged residents':

I worked with My Community Matters, they helped us to getting funding for us to have the place that the ladies wanted [safe and trusted by men] and has set up keep fit classes {Anonymous, Asian (Pakistani), female, South}

In relation to the example of consulting 'disengaged' residents, the 'engaged' residents from 'incoming community' kept taking action after consultation to solve problems for them. Sometimes by themselves:

I have applied to the council's sustainable [name of the grant] and got some funding to put some raised planters at the top of the street {Allison, North}

Some other times they took action with the support of further professionals, where residents led the action:

So we're just working with a couple of local [residents] who feel strongly about [a clean-up day], linking with the council and My Community Matters and a few other people to just get resources for a couple of days to get it done {Gareth, North}

Findings from this research suggest that high levels of resident disengagement led to community engagement approaches that involved low levels of participation, such as consultation. Subsequently, participants with low levels of engagement did not get involved in action, which led the agencies in power (e.g., MCM) to adopt a providing role (doing for), rather than 'helping them to do things by themselves' (Toomey 2009, p. 185).

- **Solving problems through working in partnership**

Reporting issues and discussing solutions usually led to a working approach that required residents and professionals to work together.

Like the drug problems and that, it is not something that we [as residents] can take on anyway, but then we have got the Police there [attending meetings], so any issues, you know, it is reported to them in the meetings as well, they will come and tell us what has been reported and what's gone on [what action has been put in place to solve the problem], which is good. So, you know, we know what is going on {Robin, Centre}

Although the action of 'solving the drug problem' was mainly led by the police in this particular case, residents felt like they were also working on this issue by continuously reporting through meetings what they have experienced on a daily basis. As a result, resident accounts denoted a sense of working together with the professionals involved to improve the area. Some further resident accounts indicated residents contributing with action to solve other problems.

A very simple leaflet that... [said] 'what to put in your bins?', you know, 'what numbers to phone if you want to get rubbish removed?' and things like that. We [residents and professionals] did do a leafleting [of some streets of the area] {Lea, Centre}

Reporting and discussing priorities relates to a higher level in Arnstein's (1969) Ladder of Participation, called partnership, where power is redistributed through negotiation between residents and service providers.

8.3.5.3. Relationship: My Community Matters 'supporting' acting

The relationship 'supporting' connects the categories of 'empowering influences' and 'acting', where 'empowering influences' primarily refer to MCM. As earlier highlighted, resident accounts suggested that CDWs, residents and professionals were involved in solving the identified problems. Resident accounts also revealed a range of degrees of involvement from professionals and MCM. Data analysis indicated that MCM adopted the most versatile involvement, from 'doing the acting' themselves (earlier highlighted) to enabling residents:

So [MCM] might make a suggestion and then nobody [from residents] kind of really seems to take that [suggestion] up. So instead of pushing it and going 'well, come on, doesn't anyone want to do this?', you know, they don't do that, they kind of back off from that, which I think it seems to be quite astute actually, and so looking at where the energy is in the group [of residents] and then supporting that energy, rather than kind of pushing their own agenda {Allison, North}

This suggests that MCM was not experienced as adopting a provider role here. Rather, residents experienced MCM as adopting an alternative role, which involved working together by the empowering agency asking questions to residents and supporting efforts (Toomey, 2009). In terms of professionals, accounts denoted a less flexible approach, where professionals would listen to resident concerns and fix the problems themselves or in combination with residents, as already highlighted through several examples in section 8.3.5.2.

This suggests that MCM in particular, and professionals to a certain extent, were experienced as working in accordance to the level of engagement of the residents. If the engagement was very low, MCM adopted a role that involved 'doing for them', featured as a traditional type of empowerment role (Toomey, 2009). If the

resident engagement was very high, MCM adopted a role of 'supporting the energies from residents', featured as an alternative type of empowerment role (Toomey, 2009). And finally, if resident engagement was somewhere in between those options, the role of MCM was similarly in between 'acting' and 'enabling':

Well that's how we did it like, when we got that other money, we [a group of residents with the support of MCM] sat down together and put a structure like, 'why we thought it would help and why we wanted this money and what it was'. And we were lucky so, now we have got that pocket of money {Lea, Centre}

This example can still be classed as an alternative type of empowerment role since the agency 'does not do for', rather the agency helps residents to do things for themselves (Toomey, 2009). These three types of roles adopted by MCM mirror the classification of community engagement approaches suggested by O'Mara-Eves et al. (2013), and the continuum of approaches based on participation levels. Higher levels of participation and engagement have been suggested as involving higher impact on health (Popay et al., 2007; Brunton et al., 2015). Therefore, one could argue that these approaches are preferable. However, findings from this research suggest that resident's levels of engagement played an essential role in determining what type of community engagement approach might be appropriate.

As further forms of support, some residents mentioned being given the chance to attend certain training opportunities, '*[the CDW] said to all of us, who are in the [partnership] roles will get some training, you know, for [learning about] the role'* {Robin}. Multiple examples of feeling connected to local service providers were also provided:

You have got the police that come, like the PCSO's they come, you have got the children's centre, so like the social workers that are out working with the children in the local area, they were all there [in the steering group]. You have got representatives from the community group [partnership], they go up... council, there's '£1 houses scheme' team and everyone reports back, oh! the environment housing people, so any concerns with rats, or litter, or anything we can report back to them {Carol, North}

A small number of residents experienced being made aware of some of the services that were local to them:

Then [the CDW] also speaks to like the Councillors, Care Home, that was really, really informative, that was, and what a shame no one was there to listen to it. This is just from my own personal view, my mum's not well, my mum has got very bad dementia, but ten years ago my mum was just starting with the problem and I have walked these streets, nowhere to go, I didn't know where to go {Lea, Centre}

Some resident accounts also referred to the supportive role of MCM in forming a group (also referred to as a resident-led partnership). For South, the formation of the group was perceived more like a barrier than being supported, as residents did not show interest in this approach. For North, a partnership was formed and constituted by members from the 'incoming community' a few months after MCM got involved with the area. For Centre, a partnership was being formed and constituted at the time of one year-follow up interviews.

8.3.5.4. Relationship: 'Addressing' barriers (from disempowering energies)

The relationship of 'addressing' connects the categories of 'acting' and 'disempowering energies', meaning that taking action at times aimed to address some disempowerment energies. Resident accounts denoted numerous barriers or difficulties associated with those 'disempowering energies' (community apathy, lack of sense of community) and how these had been addressed (or the attempts to address them).

[The 'incoming community'] were just trying, you know, sort of introduce ourselves to everybody [of the 'existing community'] and get more participation and people's opinions and things, and we didn't wanna go and do something if the majority of the residents didn't really want it, so it was quite difficult trying to get everybody's opinion across because there was quite a feeling of 'oh, there's no point in these meetings because we used to do this 10 years ago and nothing happened from them, so nothing will happen from this one' {Gareth, North}

8.3.5.5. Relationship: 'Inhibiting' acting

Residents often gave accounts that indicated further difficulties in the process of 'addressing' the initial barriers. This was experienced by residents as perceiving

the process of 'acting' as challenging, involving a process of constantly having to find solutions for upcoming barriers. The following quote shows how different solutions were put in place to increase community involvement (underlined):

So we got the council to just email out all the residents' emails and the '£1 house' [resident] emails that they had. It wasn't a big... xxxx {inaudible} people and that was for the first couple of meetings, just to get people's ideas. And then we realised it wasn't enough of the existing community who were coming there. So we put flyers up around and organised another meeting for another month's time, we put some leaflets in the local shop at the end of the road as well, and did it at the [name of a local club], rather than, I think the first one was [name of a venue located in another area of the city], and then we realised it wasn't getting enough people, coz it was quite out of the way, so we did a more local [meeting]. Spread it by worth of mouth, did a bit of door knocking as well, 'we are having a meeting about improving the park', and that got a lot more interest {Gareth, North}

Some residents gave accounts of feeling frustrated by having to constantly deal with finding solutions to those barriers, leading them to consider the option of giving up and join the 'disengaged' population, and consequently, be exposed to the disempowering energy of that 'disengaged' population.

I think it is very disappointing and very sad... you strive to try and maintain, but where does it all go wrong? You know, do you need the police to tell you to keep your dog in {laughs}, do you need the environmental health to tell you to put your bins in {laughs}, where do you start really? And then you just feel frustrated and just think... 'oh, just forget it' {Lea, Centre}

Some other residents gave accounts of not wanting to give up as a strategy to deal with some types of 'disempowering energy', which usually led to frustration in other cases and even inhibition of taking further action. Addressing and inhibiting relationships relate to the concept of resilience, which will be covered in more detail in the sub-category of consequences at an individual-level (section 8.2.6.1).

8.3.6. Category: 'Consequences'

Taking action led to several types of consequence that were appreciated by residents in terms of changes to the physical environment (community-level), but

also changes at an individual level, which were particularly noticeable when comparing between accounts from 'engaged' and 'disengaged' residents.

8.3.6.1. Sub-category: Consequences at an individual-level

'Engaged' residents gave numerous accounts of experiencing changes at an individual-level, which were interpreted as direct consequences of engaging in social change. These will be outlined next as five key attributes of the present sub-category.

- **Becoming aware**

One of the most reported consequences from engaging and taking action to improve the community was becoming aware. 'Engaged' residents gave numerous accounts that demonstrated being aware of action being taken either by a number of individuals, by a community group, by MCM or by further service providers. The more engaged they were in a particular type of action, the more they seemed to be aware of it. These types of accounts contrasted with accounts from 'disengaged' residents. The following two quotes denoted this contrast of awareness from one 'engaged' resident (Nazie) and another 'disengaged' resident (Lena) from the same area, referring to the same type of effort (addressing youth anti-social behaviour):

I know there's a youth club that [MCM] is running, boys sessions, they're running boxing sessions and stuff, that's another problem there [being addressed], they've taken the boys off the street to go to that class at that time {Nazie, South}

In regards to having activities and things for the younger generation in the evenings, I don't think anything has come up from there [work supported by MCM] {Lena, South}

This supports Zimmerman's (1990) notion that empowered individuals are aware of the factors that might have an influence on addressing identified problems to better inform decision-making processes. This could also relate to seeing the glass half empty or half full, as explained below in sections 8.3.6.3 and 8.3.6.4.

- **Understanding how ‘the system’ works**

‘Engaged’ residents gave accounts that denoted a more empathetic attitude towards problems. It seemed like the blaming and complaining attitudes observed at baseline had changed. Therefore, accounts referring to specific individuals or service providers involved a more positive tone, and a better understanding of the causes of problems:

They [Eastern European community] are still in this vulnerable situation where they don't have any money, they don't even have the language, they don't have any skills, what can they do? And the government makes life more difficult, for good reasons, 'benefit' tourism, and... so this causes problems, you know, because they have nothing to do, they will be looking to thieve, break in, you know, they would be getting money out of people... {John, South}

Analysis did not indicate whether this change was a direct consequence of learning about these particular aspects through MCM involvement (or further empowering energies), or if it was a result of self-reflection. However, showing more understanding and empathy was often reported. This might relate to learning skills and capabilities through opportunities that facilitate learning through ‘doing’ (Laverack, 2006; Miller and Campbell, 2006).

The two attributes of becoming aware and understanding how ‘the system’ works lead to critical thinking, which has been suggested to be at the heart of empowerment. It requires becoming aware of the causes of problems and finding alternative solutions (Laverack, 2006).

- **Resilience**

A first step to achieving resilience was identified, which involved recovering hope. Analysis of baseline interviews had indicated that some residents had become hopeless. Both ‘engaged’ and ‘disengaged’ residents from Centre and North gave numerous accounts of recuperating their hope for improvement.

Yeah and just the feel of people coming together and wanting to change things, like the open space up the top of the road, it was not really used for anything and yeah, just people wanting to make a change, you know, and I

think if we can get more people on board as well, you know, I think we will do well {Robin, Centre}

This contrasted with experiences of most of the residents from South, both 'engaged' and 'disengaged':

If they [residents from South] appreciated it [efforts made], I'd carry on doing it, but they don't, and I don't think they're ever going to. I don't know what's gonna make them realise 'well, maybe we should all get on' {Elsa, South}

Analysis of follow-up data revealed two relationships between the categories 'acting' and 'disempowering energies', where 'engaged' residents would try to address aspects related to the community deterioration process. Having to continuously address barriers or difficulties led some residents to stop taking action and led to further levels of disengagement. Analysis of the follow-up data, particularly the loop formed by the relationships addressing and inhibiting, seemed to relate to the concept of resilience, 'a process linking a set of adaptive capacities to a positive trajectory of functioning and adaptation after a disturbance' (Norris et al. 2008, p. 41):

['Incoming community'] have got like little fruit beds at the top of the street, strawberries and stuff, and what's happened is people are ripping them up, but they said 'we are just keeping doing it until [vandals] get the hint that we are not giving up' {Ellen, North}

Others gave accounts of how they were experiencing the cycle formed by the relationships 'addressing' and 'inhibiting', *'it's just keep plodding on [addressing barriers] and trying not to get frustrated'* {Lea}.

Community resilience has previously been defined as 'to learn to cope with, adapt to, and shape change' (Magis 2010, p. 412). It has been described as involving a set of ingredients, including i) a continuous flow of information regarding the situation, services and/or resources; ii) taking responsibility instead of relying on external support; iii) mutual support between community members, particularly towards weaker ones; iv) an ability to take action in an effective manner; v) a resident-driven leadership; and vi) hope (Ganor and Ben-Lavy, 2003). Findings from this research suggest that all of these ingredients have been experienced in one form or another by interviewed residents who reported taking action.

- **Confidence**

A very small number of residents mentioned feeling more confident as a consequence of 'acting':

It's something I like doing [helping people, e.g., filling forms] as well and I'm building my confidence by doing it, I'm getting more experienced by doing this kind of stuff, and yes, it's like I've come out of my shell, and I've got the time to do it, I know the right people to do it with... I'm more confident {Nazie, South}

Another resident associated the increase in confidence with being given the opportunity to meet regularly with others:

People just seem more confident in the meetings as well, you know, being able to bring things up and talk about things. But I suppose that just comes with time and feeling more comfortable with people anyway, at first it takes time, doesn't it? {Robin, Centre}

Self-confidence has previously been reported in several reviews as an outcome of empowerment (Popay *et al.*, 2007; Attree *et al.*, 2011; Wiggins, 2011).

- **Increase of 'disengaged' resident involvement at an individual-level**

Although 'disengaged' residents were not involved in the major actions taken towards social change, data analysis revealed that most gave accounts of taking minor action at an individual level, which was not noticeable at first. Some had already reported taking these types of minor actions at baseline, but interview data suggested increased involvement across follow-up interviews with 'disengaged' residents. For example:

Like people seeing that the green space has been done and that's been positive, and to be honest at the moment, no one has ruined it, which is lovely. There is litter but we are picking it up ourselves {Ellen, North}

These actions suggest small steps, moving from community apathy towards community care through maintaining their physical environment. The negative spiral of community deterioration could possibly have been interrupted by residents helping to maintain the improvements during MCM (e.g., green areas renewal).

Two main reasons could explain this minor increase in involvement. First, positive changes in the area may have encouraged residents to take some action. Second, 'disengaged' residents may actually have had the desire to engage, but needed some type of recovery to take place beforehand still prevented them from doing so. The second suggestion was implicitly present within certain follow-up interviews. North 'disengaged' residents gave numerous accounts of previously having very active roles in the community. However, most had gone from being 'engaged' to 'disengaged' at the time of MCM and the '£1 houses scheme':

I shut that door [the entrance door], I am not bothered what goes on outside, as long as it doesn't damage my house, and damage my car, they could kill one another for me {Keith, North}

But at the same time, some of them were looking forward to opportunities to participate:

We will have disco on up there [at the park] and everything, I have still got all my disco equipment, I am picking that up and we are going to have a good night up there, when the park is done. So that is something to look forward to {Keith, North}

High levels of disengagement require the empowering forces to roll out approaches that require low levels of participation. This has also led empowering forces to adopt a provider role ('doing for them'). However, this attribute suggests a minor shift taking place in those who were highly disengaged, towards the engagement pole of the continuum. This seems to be a consequence of being carried along by the positive improvements led by others and/or having continuous access to opportunities that encourage participation and engagement, as suggested elsewhere (Arnstein, 1969).

8.3.6.2. Sub-category: Consequences at further levels

This section focuses on describing the context that is necessary to understand subsequent interpretation of data (sections 8.3.6.3 and 8.3.6.4). As a result, a list of positive changes at a community- and institutional- level will be provided.

Most changes at a community-level were associated with the work of MCM within the three areas. However, some were connected to other initiatives, such as

involvement with a particular community group (e.g., residents association) or another programme targeting the same areas as MCM (e.g., selective licensing).

Data analysis revealed general agreement on improvement of a number of aspects concerning the physical and social environment. In terms of the physical environment, a cleaner environment was indicated across the three areas by most residents: *'the council helped a bit because they clean the backs now'* {Paul}, *'the clean-up was organised, so we got a skip and it was like an amnesty so anyone could get any rubbish they have and putting it in the skip for free'* {Madison}, *'my entrance is spotless'* {Sarah}. However, defiling the physical environment was perceived as an unsolved problem. Two main aspects were indicated. First, specific streets were highlighted as not seeing the same level of improvement, *'streets are cleaner, a little bit, but that can just vary'* {Robin}. Second, improvements of the areas were perceived by a small number of residents as not making the most with the available financial resources:

What is costing the council the clean-up, surely that money could, if we targeted them, who are doing it [defiling], then the money that we'd save could go into the green areas and make it a nicer place to live {Sophia, North}

However, data analysis revealed that the above view could be part of not being able to modify existing negative views on changes, explained below in section 8.3.6.3.

The general view across the three areas was an improvement of the social environment, being perceived as less destructive than it used to be: *'Anti-social behaviour, that's definitely got better'* {Paul}, *'the drug problem seems to have been pushed under, I won't say solved, but it's not as in your face as it was'* {Lea}, *'Just lately though we have had nothing, burglaries, or nothing around here'* {Keith}. However, most residents indicated scope for further improvement, *'it isn't as bad as it used to be, but I think we could get it better'* {Keith}.

At an institutional-level, most residents perceived an increased level of involvement by some key services, which were linked to improvements of the social and physical environments listed above. The most common service providers suggested were the police, *'[Police] take a more if you like community role now'* {Robin}, and environmental units from the council, *'the council is taking all complaints [e.g., when residents report fly-tipping over the phone] or anything concerns seriously in, addressing them problems'* {Sophia}.

In North, a small number of residents gave accounts that indicated a small, but positive restoration of trust in the institutional-level:

But the Council now actually seem to just work with us [residents] now, so it's no fighting between us [residents and council] now {Sarah, North}

8.3.6.3. Relationship: 'Having negative views' of community improvements

This relationship connects the sub-categories of 'disempowering energies' and 'consequences at a community-level'. Interviews with 'disengaged' residents revealed high levels of negativity, which resembled the negativity noted amongst most baseline interviews. 'Disengaged' residents usually identified the same types of community improvements as 'engaged' residents (section 8.3.6.2), but tended to add a negative connotation, denoting a stronger focus on negative aspects of their achievement(s):

There's boxing, and there's a ladies exercise class, and you know, we've done our events there, so that's all... so opening up opportunities, but a lot of it tends to be rather segregated, you know, different community groups do things and not others, and there's only women for the exercise, and they are all Pakistanis, so it's still not people, you know, English middle age women and Pakistani middle age women exercising together {John, South}

Negativity was interpreted in two ways. On the one hand, experiences of negativity and complaints shared in follow-up interviews could have been related to a lack of understanding of the whole picture. For example, the following resident suggested a solution.

If we got somewhere where a council would come once a month [name of a local venue], which is the centre of the area and having surgery, meaning people go and say their concerns, and they log it down and they getting feedback {Sophia, North}

This did not seem feasible at the time because of a clash between 'existing' residents and the council, where residents from the 'existing community' avoided any contact with the council. This finding suggests that disengagement led to suggesting solutions that involved action by others, and often based on a limited understanding, which negated their usefulness.

Not taking action also seemed to result disengaged residents lacking ownership over achievements in the area. This might explain why such changes were expressed in somewhat negative terms. A lack of ownership was implicitly mentioned across several interviews with 'disengaged' residents, and explicitly mentioned by an 'engaged' resident who had also noticed the negativity that comes with it.

[Some residents who were very active in the community years ago] feel like the change is someone else's change, [they have] been quite negative towards that {Allison, North}

Additionally, residents from South provided numerous accounts that denoted negativity regarding the approach undertaken by MCM. Lack of understanding and lack of ownership were also observed. Notable differences between areas in terms of resident negativity could be explained by variations in how MCM was implemented across areas. This variable implementation was captured during the familiarisation stage; the researcher noted that the role of MCM was clearly explained during MCM meetings in North and Centre, and while supporting residents to take action. In South, the programme had started the previous year, and here a lack of understanding and ownership was noted. This could be related to different factors: generally greater apathy of residents in South, a clash between preferred ways of working, and/or a lack of clarity regarding the MCM purpose and approach.

Findings from this research suggest that residents living in the targeted deprived areas were more likely to have low levels of subjective well-being at baseline, as were the disengaged residents at follow-up. Subjective well-being has been referred to as the formal term for happiness, and:

'People experience abundant subjective well-being when they feel many pleasant and few unpleasant emotions, when they are engaged in interesting activities, when they experience many pleasures and few pains, and when they are satisfied with their lives'

(Diener 2000, p. 34)

Low subjective well-being might have affected their views on community improvements, struggling to perceive positive changes. This relates to findings outlined in Chapter 7 of the negative effect of deprivation in a neighbourhood on its resident stress levels. Previous research has specifically demonstrated the effects

of distressed neighbourhoods on subjective well-being (Ludwig *et al.*, 2012), which is consistent with this finding.

8.3.6.4. Relationship: 'Having positive views' over community improvements

This relationship connects the categories of 'acting' and 'consequences'. Interviews with 'engaged' residents revealed positivity when reporting changes and sharing experiences about the approach of MCM. The main difference with the relationship 'having negative views' was that accounts did not focus on the negative aspects as much. Barriers and difficulties were mentioned, together with feelings of frustration, but the main focus was the positive change. If any barriers were mentioned, it was in the context of how they were/were going to be addressed, indicating optimism, proactivity and the intention of action.

[The park] was supposed to be done before September but {laughs} difficult delays there. And once that's done, depending when it's finished, we'll probably gonna do another opening event thing there. And if it's finished around the Christmas time it'll coincide with the Christmas event {Gareth, North}

The observed difference between accounts from 'disengaged' and 'engaged' residents suggests that being engaged and working towards transformational change might have improved individual's outlook of the area, and, therefore, positively influenced their view on community improvements. This is consistent with a previous study in volunteers, who reported higher optimism, better perceived control, and improved subjective well-being compared with non-volunteers (Mellor *et al.*, 2008).

Although initial analysis suggested a shift from negative to positive views, it cannot be conclusively confirmed from the present data analysis. This relates to one of the strengths of this study stage. In order to secure data saturation, further views from highly engaged residents were recruited at follow-up (as described in section 8.2.1.1). These residents only took part in the follow-up interview (not baseline). It was not possible to further confirm through data analysis whether or not engaging in community action had an effect on thinking more positively (subjective well-being), or whether holding such positive views is a personality trait, as it has been suggested elsewhere (Mellor *et al.*, 2008).

8.4. Summary and conclusion

This chapter explored resident experiences of MCM, a community-level 'real world' programme, taking place in three deprived neighbourhoods of Stoke-on-Trent (UK). The aim of the study stage was to gain a better understanding of what role MCM played and how this was experienced by residents. A modified version of grounded theory was used to conduct and analyse 17 in-depth semi-structured interviews. A model was constructed that involved four categories: i) power influences, with two sub-categories: experiences of empowering and disempowering influences; ii) community deciding; iii) acting, with two sub-categories: identifying specific needs and solving problems; and iv) consequences, with two sub-categories: consequences at an individual-level and at further levels. Categories and sub-categories were also linked through a number of relationships. Resident experiences were varied and seemed to be based on the individual's level of engagement. Overall, those who were 'engaged' with MCM indicated experiences of identifying priorities, finding solutions and solving problems through partnership work with professionals. Those who were 'disengaged' only reported experiences concerning identifying priorities, having negative views of life in the area (similar to the ones reported in Chapter 7), and having high expectations of professionals solving the problems for them. The role played by MCM seemed to be experienced as tailored to the different levels of engagement. At a lower level of engagement, MCM played a 'provider' role. At a higher level of engagement, MCM played a role that enabled residents to making the change themselves. In conclusion, MCM involved a set of approaches (and roles) that were tailored to different levels of engagement, which formed an engagement continuum. MCM was experienced as empowering amongst 'engaged' residents. Their experiences aligned with empowerment processes and outcomes that have previously been suggested, such as critical thinking, increasing awareness, ownership, shared leadership, learning by 'doing', or increasing confidence levels. In addition, two further components of empowerment were indicated: resilience (process) and subjective well-being (outcome). The latter supports evidence of community engagement approaches having an impact on health, and adds to existing knowledge how well-being can be improved. The two substantive theories

(models) that have resulted from the grounded theory studies (Chapter 6 and present chapter) will be further theoretically integrated in Chapter 9.

This chapter has included the follow-up stage of the study of My Community Matters. The following chapter includes: a discussion of the findings (Chapters 5 to 8) in relation to the research questions; strengths and limitations of this research; future research; recommendations for practice; the reflexivity process; and general conclusions

Chapter 9

Discussion and conclusions

9.1. Introduction

The chapter brings together findings from the longitudinal study of an individual-level intervention (ILI, Chapters 5 and 6) and the longitudinal study of a community-level intervention (CLI, Chapters 7 and 8). First, the two overarching research questions (section 1.4) lead the discussion of findings. Second, the research strengths and limitations are outlined. Third, recommendations for future research and practice are suggested. Fourth, the chapter addresses reflexivity, the important analytical process that was carried out throughout this research to establish credibility of the research outcomes by gaining an understanding of the researcher's role. And finally, general conclusions are suggested.

9.2. Discussion of findings

This section presents overall findings and a discussion regarding the two main research questions.

9.2.1. Research question 1: How is empowerment experienced?

9.2.1.1. Summary of findings: Experiences of empowerment from the Lifestyle Service

The longitudinal study of the Lifestyle Service (LS) revealed that at baseline clients had the expectation of the LS 'fixing the problem for them' (Chapter 5). Many clients reported previous experiences of tackling the problem. Most experiences related to losing weight by attending a Commercial Weight Loss Programme (CWLP). So, client expectations resembled past experiences with this type of programme, expecting to lose a substantial amount of weight in a short period of time. Maintenance of weight loss was not always reported as an ambition. In terms of expectations regarding support, clients anticipated 'to be told' what to do to lose

weight. The overall expectation related to a general reliance on external support to 'fix the problem'.

At one year follow-up (Chapter 6), all clients had experienced a range of support through attending the LS. Experiences of the role of the LS involved three main stages that formed part of a continuous cycle. Firstly, there was an identification stage, in which an overall goal, cause(s) of the problem, and barriers to address the problem were usually identified. Secondly, there was a planning stage, where targets were set and conditions were provided to achieve these targets. Finally, there was a putting into action stage, where the client would action the agreed plan. A recurrent component was an experience of individualisation, particularly at the identification and planning stages. Most residents felt that their individual needs had been identified and addressed accordingly. Experiences of the programme denoted a continuum from relying on external support to taking responsibility. Some clients seemed to align to one of these two poles, but most occupied a more central position, sharing experiences of both. Components that had previously been suggested as being part of the process and the outcomes of empowerment were also indicated in this research (e.g., self-efficacy, self-reflection and self-awareness). However, clients did not report how they were supported to finding solutions by themselves. Most of the solutions were experienced as suggested by the LS professionals. Although empowerment components had been identified as part of the process of change involved in the LS, the lack of experiences in being enabled to find solutions raises questions about the degree to which empowerment was experienced. Findings suggest that the experiences of the LS align with a supportive role (also referred to as a providing role) that embraces the principles of patient-centred approaches, rather than empowerment.

These findings cannot necessarily be generalised beyond the studied group (White British females) as individuals from other groups (e.g., males, Asian) were invited to participate, but did not. The inability to generalise to other groups is because their experiences of the intervention might not be the same as those of the group studied.

9.2.1.2. Summary of findings: Experiences of empowerment from My Community Matters

The longitudinal study of My Community Matters (MCM) revealed that at baseline (Chapter 7) residents presented different levels of engagement with the community, in general, and with MCM, in particular ('objecting', 'having a voice', 'taking action', 'leading action and enabling others'). Expectations and understandings of the programme were varied and seemed to depend on personal levels of engagement. Those who adopted an 'objecting' or 'having a voice' position understood the programme as playing a consulting role, asking residents to identify the local needs of the area; and a provider role, fixing the problems identified by residents. Those who adopted a more engaged position ('taking action' or 'leading action and enabling others') understood the programme as involving three stages of: identifying local needs; finding solutions; and taking action. Although they also expected the institutional and organisational-level to be responsible for taking action, the more engaged residents intended to share the responsibility by participating in meetings with professional providers and helping with certain actions (e.g., clean-up day or organising a fun day).

At one year follow-up (Chapter 8), a range of the empowering and disempowering influences that were apparent at baseline were confirmed. MCM was mainly experienced as an empowering influence by those who were engaged. The '£1 houses scheme' (in one area) was also identified as an empowering influence. However, some residents experienced both programmes as disempowering. In addition, the process of community deterioration identified at baseline was experienced at follow-up as a further disempowering influence due to the community apathy generated as a result of area deterioration.

MCM was experienced as a multi-role programme. Resident levels of engagement seemed to be related to the approach implemented by MCM. When levels of engagement were low, MCM was experienced as a provider to address local needs, whereas when levels of engagement were high, MCM was experienced as an enabler of action.

Accounts from engaged residents revealed empowerment components that confirmed previous evidence (e.g., learning, self-reflection). These components were not experienced by disengaged residents. Accounts from engaged residents

also revealed two additional components that are not part of the most common empowerment components: resilience and subjective well-being.

9.2.1.3. Comparing findings to theory of empowerment

The grounded theory method suggests that findings (substantive theory) must be related to theory (Charmaz, 2014). Accordingly, findings from the two grounded theory study stages were individually compared to literature in Chapters 6 and 8. Here findings from this research are brought together to highlight which aspects support or contradict theory (Urquhart, 2013).

Theory and evidence-based literature refers to a set of components involved in empowerment (outlined in Chapter 2, sections 2.5.1.2 and 2.5.2.2). Table 9.1 provides a list of the main components previously suggested and summarises how findings from both interventions supported previous knowledge. This table only represents the most positive experiences, which typically corresponded with individuals who showed the highest levels of ‘engagement’ (MCM) or ‘taking responsibility’ (LS).

Previous research on empowerment has focused on specific components. The present research has considered the process of empowerment as a whole, as previously suggested (Cattaneo and Chapman, 2010). Table 9.1 shows that findings from this research supported similar components of empowerment previously suggested, but to varying degrees. Consequently, in response to the first research question, one could argue that both programmes were experienced as empowering.

Most LS clients reported feeling enabled to making healthier choices, which has been associated with the main goal of patient empowerment (Feste and Anderson, 1995; Sen, 1999; Tones and Tilford, 2001; Koelen and Lindström, 2005). From this understanding of empowerment, findings from this research suggested that the LS played an empowering role. A shift of responsibility was also observed when comparing baseline and follow-up interviews. At baseline, accounts denoted very high levels of ‘relying on external support’ across all interviews; whereas, at follow-up, the intensity of ‘relying on external support’ had decreased, particularly amongst clients who gave accounts of shifting to the opposite pole of the continuum (‘taking responsibility’), but also to a certain extent across further

interviews that aligned with the ‘taking responsibility – relying on external support’ continuum.

Table 9.1 Summary of findings that support components of empowerment

Theory of empowerment / Evidence-base	Findings from the individual-level programme (LS)	Findings from the community-level programme (MCM)
<i>Identifying goals / needs</i>	Real personal aim(s) were acknowledged as part of the identification stage, instead of focusing on professional agenda Setting targets was experienced as driving action	Needs were identified by ‘engaged’ and ‘disengaged’ clients
<i>Learning</i>	Learning through conversations with professionals, taking action and self-assessment	Learning through ‘doing’ led some residents to have a better understanding of the situation
<i>Self-awareness</i>	Self-assessing own action led clients to self-awareness	Taking action and participating increased resident awareness of action taken by other stakeholders (group of individuals, community groups, MCM, or service providers)
<i>Critical thinking</i>	Realising the need for a long term approach was interpreted as engaging in critical thinking, instead of preferring ‘quick fix’ solutions	Understanding ‘how the system works’ led residents to critical thinking, becoming aware of causes of the problem and being able to find alternatives
<i>Confidence (self-esteem or self-confidence)</i>	Increase in confidence when attending fitness environments	Feeling more confident through attending regular meetings with same individuals
<i>Self-efficacy</i>	Increasing self-efficacy through exercise	Increasing ‘confidence’ through acting and gaining experience
<i>Finding solutions</i>	Solutions were provided by professionals and agreed by participants. Very few clients gave examples of finding solutions	Reporting issues and discussing solutions usually led to a working approach that required residents and professionals to work together.
<i>Active participation (in solving problems)</i>	All clients experienced putting the agreed plan into action	Engaged residents participated in suggesting and solving problems

Nevertheless, the LS was suggested in Chapter 6 as being experienced with a providing role (instead of an empowering role) that better aligned with patient-centre approaches and with approaches that involved high levels of appropriateness. The rationale for this suggestion relates to two aspects. Firstly, some of the components were experienced by clients who gave accounts of 'taking responsibility' but also by clients who gave accounts of 'relying on external support', with the latter showing high levels of dependence on continued support. A dependence on external energies opposes the concept of empowerment, which by definition is meant to involve an exertion of control. Therefore, the empowering role of the LS was questioned. Secondly, empowerment has been described as involving three main types of process (Laverack, 2004; Cattaneo and Chapman, 2010): individuals identifying priorities, finding solutions, and taking action to solve problems. The study of the LS revealed abundant experiences of clients identifying priorities and taking action, but few experiences of individuals finding solutions, or even experiences of being enabled to find solutions. Patient empowerment has been suggested to align with self-determination theory, where individuals are allowed to decide about personal goals and strategies to achieve those goals (Aujoulat, D'Hoore and Deccache, 2007). However, the study of LS indicated that solutions were usually provided by the LS professionals, clashing with the principle of empowerment. This suggested a providing role of the LS (Toomey, 2009), which involved high levels of individualisation towards personal needs. Addressing individual needs has been suggested as a first step to ensure patient empowerment (Aujoulat, D'Hoore and Deccache, 2007), but not unique to empowerment since it is also a feature of patient-centred approaches (Holmstrom and Roing, 2010). Generally speaking the provisions of solutions were not imposed on clients. Rather they were usually negotiated between client and LS professional, following one of the principles of empowerment, shared responsibility and decision-making (Aujoulat, D'Hoore and Deccache, 2007). Experiences of the LS indicated that the decision making process was usually led by the LS professional, who would make suggestions, and the client would often choose from the range of possible solutions. The providing role is again highlighted here.

The understanding of the providing role was supported by findings from the study of the community-level intervention (CLI). It was suggested in Chapter 8 that MCM involved a providing role as part of a continuum of multiple roles. The providing

role was primarily experienced by 'disengaged' residents, who only took part in identifying needs, usually through consulting methods. Finding solutions and taking action to solve problems were led by the providers, who could be: i) 'engaged' residents participating in consulting 'disengaged' residents and addressing identified needs; ii) MCM, which adopted a providing role when residents did not engage in leading action; iii) and/or service providers working in partnership with residents and MCM. The providing role involved action towards identifying meaningful needs (consultation) and addressing those needs (taking action). This relates to approaches that involve high levels of appropriateness (Popay, Rogers and Williams, 1998; Kreuter *et al.*, 2003). However, consulting methods are at the opposite end of empowerment within the continuum of community engagement approaches suggested by O'Mara-Eves *et al.* (2013). This further supports the suggested providing role.

In addition to the suggested providing role as part of the LS and MCM, both programmes shared further similarities, which could be associated with empowerment. As suggested above for the LS, decision-making was shared by professionals and individuals. For MCM, residents were given the opportunity to have a voice (Bagnall, Kinsella, *et al.*, 2015). Both experiences should be considered as little steps that involve being enabled to take responsibility.

In terms of differences, the LS seemed to be experienced very similarly by most clients. Small differences were observed between those who took responsibility and those who relied on external support. This suggests that the control might have remained with the professionals, rather than being shifted towards the clients. This appeared to be different for MCM. Although MCM also played a providing role with 'disengaged' residents, this stemmed from the low level of engagement of residents. 'Disengaged' residents experienced numerous barriers towards engagement and participation. Therefore, a consulting and providing role might have been most appropriate as it requires the lowest level of participation (O'Mara-Eves *et al.*, 2013).

Theory of empowerment alludes to person-centred approaches as part of the empowering process (Holmstrom and Roing, 2010), where individual needs are meant to be addressed, leading to high levels of appropriateness of the intervention. Findings from this research raised the question of whether the providing role might become a barrier to the process of empowerment since addressing needs for the individual might stop individuals finding solutions

themselves. This process was particularly observed with the LS, where most clients gave accounts of the LS being tailored to client needs. A small number of clients gave accounts of finding solutions themselves to certain aspects (e.g., incorporating exercise in daily routine), but the general pattern pointed towards the LS providing the solutions. The sustainability of the approach and how clients took control over their health can therefore be questioned. The general solution that the LS provided to clients who chose to exercise was to subsidise attendance at an associated fitness centre. Most client barriers were addressed with this solution (e.g., financial, tailored programme to personal ill-health needs, accessing an 'all-sizes' friendly fitness environment). This resulted in adherence to the agreed fitness plan. However, once the exercise subsidy finished, clients needed to find a solution to continue, which usually involved paying for the fitness centre themselves. Some clients found a solution to carry on paying (e.g., family members paid for it as a birthday present), but others mentioned having to stop due to lack of finances. These clients gave accounts of not knowing how to carry on exercising post-LS. Therefore, findings from this research suggest that the appropriateness of the LS is in conflict with empowerment in terms of enabling individuals to find solutions by themselves, and gaining control over their health.

Addressing needs 'for' individuals led to a different line of thought in MCM. The consulting and providing role seemed to be the only possible option of engaging with individuals who presented high levels of disengagement. Apathy seemed to be the major barrier to engagement. Community engagement approaches demand high levels of participation (O'Mara-Eves *et al.*, 2013), which clash with the indicated disengagement and apathy levels. The providing role (e.g., fitness classes for Asian (Pakistani) females in South; or the physical regeneration of the green areas in North) was usually combined with parallel opportunities to take action (e.g., Asian females were encouraged to lead an extra fitness class, with one resident volunteering for it; North 'disengaged' residents were encouraged to help organise and deliver an event to celebrate the opening of the green areas, with one resident intending to take an active role). This reveals that the multi-role approach adopted by MCM provided a continuum of engagement, where 'disengaged' as well as 'engaged' residents could take part at the level they were ready for. Therefore, searching for appropriateness to address the needs of the most powerless residents seemed to complement and enhance the empowering process in the case of MCM. This subscribes to Toomey's (2009) understanding of

the providing role, which was suggested as empowering when services and resources are provided to those individuals who lack such drive, but disempowering when things are systematically done for individuals, rather than supporting individuals to do things for themselves.

To continue with how findings from this research relate to the theory and evidence-base of empowerment, Table 9.2 discloses further components that are less frequently suggested in relation to the theory of empowerment.

Table 9.2 Suggestions of new components to the theory of empowerment

Theory of empowerment / Evidence-base	Findings from this research
<i>Disempowerment</i>	Empowering/enabling strategies clashed with those clients/residents who were already taking action (and possibly felt empowered before getting involved with the LS and MCM programmes)
<i>Thinking positively</i>	For the LS, sense of achievement led to positive thinking about the process and results. For MCM, engaged residents perceived achievement more positively than those who were disengaged (and unaware)
<i>Resilience</i>	Only for MCM, engaged residents gave accounts of having to deal with frustration generated from the constant barriers faced to pursue change (finding solutions that work).

In terms of the disempowerment component, several programme participants gave accounts that conflicted with the approach of the programme they were attending, either with the LS or MCM. The conflict seemed to stem from how the power was owned and distributed. When participants were already (self-)empowered before participating in the programme (e.g., already undertaking physical activity (LS); being part of a community group (MCM)), some programme activities were experienced as disempowering. Those suggestions were often taking individuals away from their preferred (or already decided) way of working. For example, one LS client was only able to exercise in a fitness centre, while she preferred swimming or running. In another example, residents were persuaded to form a resident-led partnership and taking on roles (e.g., chair, secretary), but they were already taking part in further community groups and did not wish to take on additional, similar roles. These examples show how programme participants and professionals can ‘pull the power’ in different directions, resulting in a clash of

intentions and ways of working. This was interpreted as being disempowering since these became a further hurdle to overcome for those who were meant to 'be empowered'. This imbalance of dealing with power was also suggested by Lorion and Mcmillan (2008). They remarked that to empower individuals (i.e. clients and residents) the professionals needed to 'lose some of their power'. This suggests that the LS and MCM were experienced as disempowering by some.

In terms of the thinking positively component, the LS and MCM studies suggested that those who relied less on external support perceived achievements more positively. This supports the connection between empowerment and health improvement (Wallerstein, 2006), particularly of mental well-being. However, the improvement of mental well-being has previously been suggested from a different perspective, i.e., having an effect on self-efficacy, self-esteem and confidence (Woodall *et al.*, 2010). In Chapter 6 the possible influence of motivational interviewing on the clients' positive mind-set was discussed, and in Chapter 8 it was discussed how empowerment might have influenced subjective well-being (or happiness) of those who were engaged in problem solving and achieving change. Although findings from this research cannot confirm whether the positive thinking relates to personality traits instead of being involved in the empowerment process, the fact that the same pattern of thinking positively was found in both studies is encouraging. This is supported by a recent study on urban regeneration that found an association between feelings of community empowerment and mental health, in particular with positive wellbeing (Baba *et al.*, 2016).

The grounded theory study stage of MCM (Chapter 8) suggested a further component that was experienced by a number of residents. This related to the capacity of solving problems, which has previously been associated with empowerment (Israel *et al.*, 1994). Some residents experienced adopting a continued approach to problem solving, which involved constantly finding solutions and taking action to address the changing difficulties associated with the initial problem. To give an example (outlined in section 8.3.5.5), the initial problem in one area was the low engagement of residents. The first approach involved inviting residents to a meeting to identify issues in the area and encourage them to take part, but attendance was low. Then, possible causes or barriers were analysed and new actions were suggested and implemented, such as having a second meeting in a more local venue, together with door knocking to spread the word. This approach continued until the first initial problem seemed to be addressed

(increase engagement to identify priorities). Some residents were convinced that this was the only way forward; others felt frustrated and expressed doubts about continuing to battle (joining the engagement route of the suggested model, section 8.3.4.2) or giving up (joining the disengagement route, section 8.3.4.2). The drive to 'keep battling' seemed to relate to the concept of resilience.

Resilience has previously been suggested as an essential component in community psychology (Morgan and Ziglio, 2007; Brodsky and Cattaneo, 2013). In the literature related to asset models of health, resilience has been associated with capability. Based on Bartley's (2006) work, Morgan and Ziglio (2007, p. 19) described capability and resilience as '*two concepts used to refer to the ability to react and adapt positively when things go wrong*'. This definition agrees with one of the contributions of this research, positive thinking, which was also highlighted by Zautra et al. (2008) as a feature of community resilience. Zautra and colleagues indicated the importance of environments that support hope, positivism and collective efficacy. The connection between capability, resilience and positive thinking supports findings from this research.

Efficacy is often suggested to be a component of empowerment (e.g., Anderson 1995; Gibson 1991; Wallerstein 2006; Wiggins 2011). In contrast, findings from this research, particularly from the study of MCM, did not offer much support for this. Nevertheless, in trying to understand the 'keep battling', efficacy appeared as a possible theoretical attribute of it, particularly amongst residents who expressed the conviction of one particular solution being the only way forwards. This relates to efficacy at an individual level (feeling that actions can lead to results, (Zimmerman (2000); cited in Wallerstein (2006)) and it could also relate to a collective level (belief that a group of people acting together can lead to making a difference (Sampson et al. (1997); cited in Wallerstein (2006)). Therefore, positive thinking and resilience might be further components that explain the acquisition of efficacy in the context of empowerment, and further explain the empowering role of MCM.

This section has addressed the first research question through discussing findings in the context of the theory of empowerment. The next section answers the second research question.

9.2.2. Research question 2: How can an individual- and community-level approach to health promotion complement each other?

This section discusses how an individual- and community-level 'real world' intervention could complement each other from an empowerment perspective, but also to better address health inequalities. Socio-ecological models provide a useful framework to guide the discussion.

9.2.2.1. The socio-ecological models as a guide to explore the complementary role of LS and MCM health promotion programmes

Findings from the studies of the LS and MCM made references to different levels of influence (individual-, organisational- and community levels). Results from the study of MCM made many references to three levels, whereas results from the study of the LS mainly referred to the individual-level, and to a certain extent to the organisational-level. Accordingly, the socio-ecological and its multi-level framework was considered a useful tool in guiding the exploration of the complementary role between both programmes.

Socio-ecological models emphasise the individual's interactions with the social and physical characteristics of their environment (Stokols, 1992), and advocate the consideration of multiple levels (intrapersonal, interpersonal, organizational, community, and public policy) to achieve positive impacts on health (Sallis, Owen and Fisher, 2008).

One could argue that combining these two particular programmes might benefit each other by acting at several levels of influences within an overall health promotion system, particularly when geared towards changing specific behaviours (Sallis, Owen and Fisher, 2008). Another principle of the socio-ecological model is the interaction of influences across levels, which refers to variables working together (Sallis, Owen and Fisher, 2008). An example from the present research is the LS encouraging individuals to undertake physical activity and MCM pursuing social action to improve the physical and social environment, which could be considered as a supportive environment to exercise. This example will be further explored below in section 9.2.2.5.

The in-depth exploration of the complementary role of these programmes will follow the framework of the socio-ecological models, structuring the discussion first

by levels and then across levels. Each level will include a summary of findings, which will be followed by a discussion.

9.2.2.2. Exploration of the complementary role at an individual-level

The individual-level includes the intrapersonal (biological and psychological) and interpersonal levels (social and cultural) (Sallis, Owen and Fisher, 2008). In the context of empowerment, findings from this research have led to the construction of two models of how empowerment was experienced by individuals taking part (Figures 6.3 and 8.2), which were based on individual experiences.

When comparing the two proposed models, both included experiences that related to three stages: identification of issues, planning for action, and acting towards change. These three stages exactly corresponded to the three categories of the LS model (Chapter 6, Figure 6.3), but were less obvious for the MCM model (Chapter 8, Figure 8.2), which was more complex. Figure 9.1 below highlights the similarities of the MCM model with the aforementioned stages.

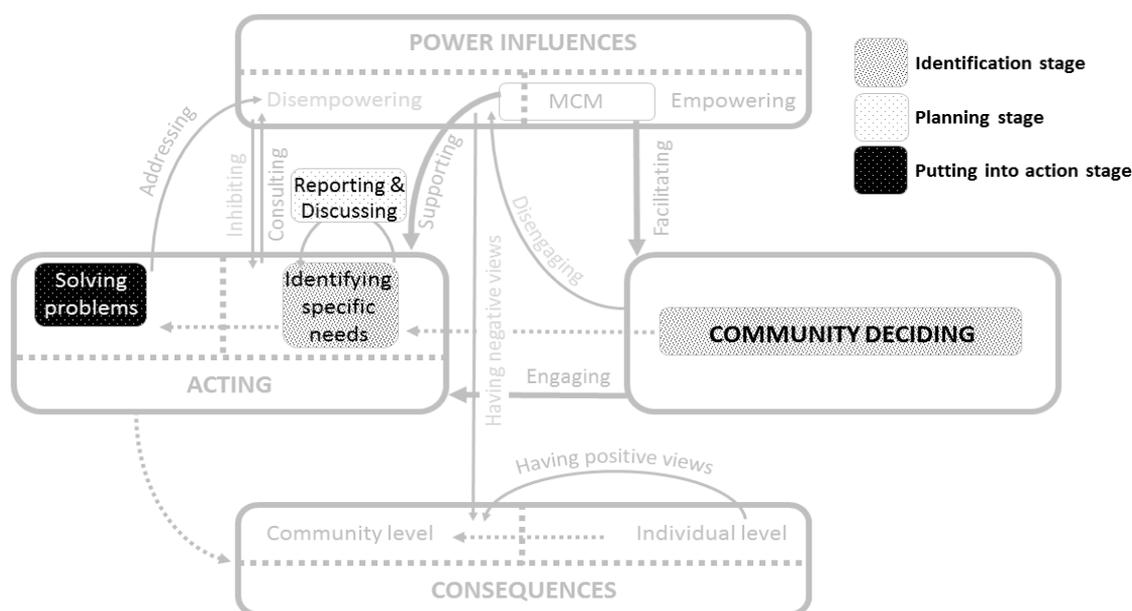


Figure 9.1 Similarities between findings from MCM and the LS: identification, planning and action

In addition, Tables 9.1 and 9.2 highlighted further similarities in relation to key components that have previously been suggested, but also three new suggestions, two of which were part of both models. Therefore, there was a high congruence between the suggested models in terms of the stages (i.e., identification, planning, and action).

The main difference was found at the planning stage, particularly how solutions were found to address the identified issues. When comparing experiences from MCM residents who were 'engaged' to experiences from LS clients who were 'taking responsibility', a different role was found. LS was experienced as involving a providing role (programme doing for clients), whereas MCM was experienced as involving an enabling role (supporting residents to do it themselves). However, the less engaged residents from MCM also experienced the providing role, presenting barriers to engagement that resembled barriers experienced by LS clients. Mental illness and lacking mental wellbeing were commonly suggested together with isolation with reference to the most disengaged individuals across both programmes. Experiences of isolation mentioned by LS clients were often related to feeling self-conscious in social occasions due to their body size. For MCM, different paths to isolation were suggested, such as 'exiting' the social environment of a deprived area, lack of provision, high levels of perceived crime, or lack of trust in other residents. However, most disengaged residents seemed able to attend activities and meetings supported by MCM, whereas various LS clients mentioned difficulties attending events that implied socialising, even when relatives or friends would be attending. LS clients experienced an improvement in self-confidence and self-efficacy by the end of their participation in the programme. Therefore, it could be argued that the LS helped address some of the barriers that initially would have stopped these individuals to engage in their communities.

Experiences from disengaged individuals seemed consistent with the notion suggested by one of the pioneer theorists of empowerment: empowerment cannot be told or given, it must be pursued by the individual (Rappaport, 1985). This research adds to Rappaport's notion that perhaps individuals did not have the option to choose (or not to choose) to be empowered since individuals who live in rather powerless circumstances face numerous barriers to being empowered at several levels (community, organisational and individual). This suggests that highly 'disengaged' residents and clients who 'relied on external support' might not be ready for an empowerment approach. This might explain why programme participants often referred to experiences of 'being provided', instead of 'being empowered to do it myself'.

From a complementary perspective, community engagement approaches require high levels of engagement and participation (O'Mara-Eves *et al.*, 2013). However, this clashed with the profound isolation and disengagement of some individuals.

Therefore, a less empowering approach to reach these individuals seemed appropriate, if these aimed to address barriers and somehow make them more ready for approaches that require high levels of participation. From this point of view, one could argue that the LS contributed to addressing barriers that might support individuals to start feeling ready to attend opportunities that require social involvement, such as a consultation, which requires low levels of participation from a community engagement point of view (Arnstein, 1969). Therefore, individual-level interventions (ILIs) like the LS have the potential of complementing community engagement approaches, such as MCM, by bringing individuals to a state that allows them to participate in approaches that require (low) engagement (e.g., consultation), through a more individualised and tailored approach. In the particular case of the LS and MCM, the multi-engagement continuum provided by MCM (consultation, participation and empowerment) could be extended at the lowest engagement pole.

9.2.2.3. Exploration of the complementary role at an organisational-level

The organisational-level of socio-ecological models refers to settings such as schools, workplaces or community-based programmes (Sallis, Owen and Fisher, 2008). In the case of this research it refers to organisations or agencies involved, such as MCM or the LS, or community groups, council departments and police. Findings from this research suggest that the LS and MCM could complement each other at this level in terms of engaging and improving the lifestyle of black and minority (BME) groups.

During the familiarisation stage with the LS, the difficulties that the programme faced in terms of reaching individuals from BME groups were highlighted. However, MCM managed to reach 53.1% residents from BME groups in South (n=187), with 31.6% coming from an Asian (Pakistani) background (see Table 3.7). The study of MCM included baseline interviews with six Asian (Pakistani) residents, who strongly indicated the unhealthy lifestyle of Asian (Pakistani) as a priority, which is consistent with findings from quantitative studies on the lifestyle of UK inhabitants from South Asian backgrounds (Williams *et al.*, 2011). This research highlights that a top-down (LS) and a bottom-up programme (MCM) had a common priority. Interview data revealed that MCM worked with two 'engaged' Asian (Pakistani) residents to address local needs to support physical activity

amongst individuals coming from an Asian (Pakistani) background. Needs were listened to, understood and prioritised. For example, one of the needs was for a female fitness activity being given access to a local venue that would feel safe for 'the men'. This meant that the venue needed to be in the surroundings of the local Mosque.

Interestingly, the description of the fitness activities matched with some of the experiences reported by clients attending the LS. For example, having access to an exercise programme, advice on healthy diet, and regular measurements (i.e., blood pressure, weight). This suggests the potential for both programmes complementing each other. MCM could complement the LS with the appropriate engagement of individuals coming from a BME group and the LS could complement (or support) MCM with the delivery of a lifestyle related service.

9.2.2.4. Exploration of the complementary role at a community-level

The community-level of the socio-ecological models sits between the organisational-level and the policy-level (Sallis, Owen and Fisher, 2008). As mentioned in Chapter 2, there is no consensus on the concept of community. For this research the following definition was used: '*the immediate physical surroundings, social relationships and cultural milieus within which defined groups of people function and interact*' (Barnett & Casper 2001, p.1), which highlights the geographical area and the social environment.

Findings from this research revealed two main characteristics of individuals attending the individual-level intervention (ILI) and the community-level intervention (CLI). A high level of disengagement of individuals living in deprived areas, for MCM; and a high rate of obesity, for the LS. These could be considered the most tangible characteristics of individuals taking part in these programmes. However, data analysis revealed a further aspect, which was common to most participants: lacking mental wellbeing (across both programmes) and mental illness (particularly amongst LS clients). This is consistent with research that associates living in deprived areas with high stress levels (Steptoe and Feldman, 2001; Latkin and Curry, 2003) and obesity with depression (Markowitz, Friedman and Arent, 2008). This raises the question of whether disengagement and obesity amongst disadvantaged have a common root in mental illness and unsupportive environments. If so, the complementary role of these two approaches should

consider addressing mental illness and mental wellbeing in combination with addressing the most tangible features (disengagement and obesity). Therefore, the LS could complement MCM by improving mental health and wellbeing in those who already struggle, with the aim to increase the continuum of engagement, as suggested above in section 9.2.2.2. Additionally, MCM could complement LS by improving the social and physical environment of deprived communities, preventing associated mental wellbeing issues at the individual-level through improving stressful social and physical environments at the community-level. In this case, further research should focus on understanding whether this approach would have an effect on obesity, by reducing the levels, or at least by supporting those who suffer from obesity and mental health with a more accommodating community, to reduce the detrimental impact in terms of stress (and associated health consequences) of living in deprived areas.

9.2.2.5. Exploration of the complementary role across levels

Socio-ecological models are *'more effective when they are behaviour-specific'* (Sallis et al. 2008, p. 470). If physical activity is taken as the specific behaviour to change, and the community- and individual-level are the chosen levels of influence, there is further potential for MCM and the LS to complement each other.

Stoke-on-Trent has high levels of deprivation. MCM is a community-level intervention that focused on specific areas, which have been classed as falling within the 10% most deprived areas of the country. According to the Marmot Report *'many of the key health behaviours significant to the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition'* (Marmot 2010, p. 26). It can be expected then that individuals living in deprived areas will have a worse physical activity profile compared with individuals living in better-off areas (Macintyre 2007). Findings from this research highlighted how the deterioration of MCM areas in terms of the social and physical environment can affect the lives of individuals, who end up living highly isolating lives. This research suggested that such negative environments lead to disengagement. Another side effect might relate to enhancing sedentary behaviours (e.g. staying at home) and inhibiting physical activity (e.g., individuals feeling afraid to walk within the area). Therefore, it could be argued that if a CLI such as MCM supports individuals to improve the social and physical environment

of their neighbourhood area, and connects residents with each other and to local physical assets within their surroundings (e.g., green area, a new community hub), residents at an area-level might have more opportunities for engaging with their community. This might result in a decrease in sedentary behaviours (i.e., by not being at home most of the time), but also improvements of the area might encourage residents to undertake physical activity (i.e., by feeling safe going for walks at any time of the day) or even take part in structured physical activity opportunities (i.e., fitness class at a community venue).

In terms of the complementary role, clients attending the LS could also benefit from having access to a more supportive environment. Findings from the LS study showed that clients opting for an exercise route to lose weight were consistently referred to a local fitness centre to undertake an exercise programme. This was suggested as playing a providing role that ultimately clashed with the intended empowering process (outlined in section 9.2.1). If the providing role of the LS is kept, this ILI could refer clients to local opportunities (e.g., fitness classes at a local community venue) and let them know about improvements in the area that might support the target behaviour (e.g., renewal of a green area to increase and support exercise). This suggestion could also address the barrier of clients accessing a fitness programme in the short-term, with no further opportunities post-LS, supporting clients to maintain their physical activity levels. But also, taking part in activities supported by the work of MCM might provide a bridge for moving from highly disengaged levels (due to mental health barriers) to higher levels of engagement, as suggested in section 9.2.2.2.

9.2.2.6. Policy and societal levels

Section 9.2.2 has discussed how an ILI and a CLI can complement each other to better empower individuals and communities, and address health inequalities. The present section briefly discusses empowerment programmes in the context of societies with high levels of health inequalities.

As highlighted in the literature review (Chapter 2), ILIs are the most traditional type of approach to health promotion. CLIs emerged a few decades ago claiming to address the social determinants of health inequalities that lead to unhealthy behaviours. One of the arguments against ILIs (and in favour of CLIs) was that even when ILIs would involve a positive impact in the long term, the health

problem will not be solved since the environment would still encourage individuals to undertake unhealthy behaviours. As an example, a smoking cessation programme will reach smokers and might help smokers to quit (Freudenberg, 1978). However, social inequalities might induce further individuals to smoke. Therefore, the root of the problem (social determinants of health inequalities) was not being addressed. Enabling individuals to take control over their lives has been suggested as one of the most appropriate paths to tackling health inequalities (Marmot, 2010). This research has shown that CLIs can empower individuals living in disadvantaged circumstances and improve the physical and social surroundings. It has also been discussed in this research how CLI and ILI could join efforts to complement each other and better address health inequalities. Therefore, it can be suggested that both approaches can complement each other and perhaps even help each other to enable individuals to take control of their health.

However, the promising potential of the complementary role of these approaches to tackle health inequalities might not be sufficient to solve the problem. The rationale behind this perspective follows the same pattern of the critique of ILIs (failing in addressing social determinants of health inequalities). Perhaps CLIs and ILIs together can enable targeted individuals to take control over their health and lives, but social inequalities and health inequalities continue to rise in countries (and systems), such as in the UK, that permit inequality in social policies (Graham, 2004a). Whilst it seems a valid and fair approach to tackle health inequalities through 'small-scale' interventions, such as ILIs and CLIs, action further upstream at the higher societal and policy level (see Figure 2.1) would also be necessary to address the underlying inequalities, as attempted through the social policies and socio-economic systems of Scandinavian countries (Graham, 2004a).

9.2.2.7. Difficulties in combining individual- and community-level approaches

This research did not seek to investigate experiences of participants taking part in both programmes. Rather, the separate study of both programmes was used to allow inferences around the broader complementary roles of individual- and community-level approaches and their associated benefits, as discussed above (section 9.2.2.6). Referring to each other and working in partnership are recommendations for practice (section 9.5). It would not be realistic to expect all

individuals living in Stoke-on-Trent to benefit from the complementary role of both programmes; doing so would depend not only on co-location of the programmes in/close to people neighbourhood areas, but also would only be relevant to a subsample who require both types of approach.

9.3. Strengths and limitations of this research

9.3.1. Strengths

- **Design**

This research is the first to combine the study of how empowerment is experienced at an individual and community-level and their complementary role, and to do so with participants of 'real world' programmes operating in the same city. The research design allowed each type of approach to be studied individually, which resulted in two independent models of experiences of empowerment. Studies of both interventions used a qualitative longitudinal design with a one-year follow-up, where the researcher followed up the same participants, where possible (Flick, 2008). Longitudinal design is considered to involve a superior analytical capacity than single in-depth interviews that helps to make sense of change (Plumridge and Thomson, 2003). The longitudinal design also allowed understanding of the whole process of empowerment, which has been recommended as a stronger approach than just studying individual components of the empowerment process (Cattaneo and Chapman, 2010).

- **Two types of analysis**

Baseline interviews for each programme were analysed using thematic analysis to descriptively gain understanding on individuals expectations of the programme. The one-year follow up used a grounded theory method to study how empowerment was experienced. The grounded theory method is similar to thematic analysis but it does not give the same results since it allows a more analytical approach towards building theory through a rigorous method (Urquhart, 2013). The two follow-up grounded theory study stages led to two models, which included a formation of categories and relationships between categories. The resulting set of categories and relationships is known as substantive theory (Urquhart, 2013). These two were first compared with literature adding a further

level of abstraction (Chapters 6 and 8). Both substantive theories were brought together and proved to share three main aspects (identification, planning and action). This was considered a further strength of the research since two independent studies resulted in similar findings. Then results were compared with theory of empowerment once more (section 9.2.1.3), adding a further level of abstraction, by highlighting consistency with existing knowledge and suggesting new knowledge. This analytical process led to a highly abstract substantive theory (Urquhart, 2013).

- **Recruitment**

And finally, a further strength refers to the recruitment process. This research managed to recruit a large sample of individuals living in highly deprived areas, who have been indicated to be difficult to access (Sixsmith, Boneham and Goldring, 2003). The intense familiarisation stage, particularly with MCM, proved to benefit recruitment. Resident characteristics showed that residents came from a range of age groups, gender and ethnicity (see section 7.3.1). The study of MCM also managed to recruit at one year follow-up several residents who had dropped out from the programme. Once the researcher accesses the community, the psychosocial barrier between participants and researcher needs to be addressed (Sixsmith, Boneham and Goldring, 2003). Here the researcher benefited from her own personal background and past experience of working with highly vulnerable groups.

9.3.2. Limitations

This section has been structured in limitations regarding three elements of the research process: sampling, recruitment, and results.

- **Sampling**

This research involved the study of two 'real world' programmes, and consequently it was affected by the challenges and complexities typical of 'real world research' (Robson, 2002). Theoretical sampling was meant to be the most appropriate type of sampling for the baseline study stages. However, the lack of control on the recruitment process by the researcher and the criteria of

interviewing individuals before the start of the programme (for the LS) and as soon as the programme started (for MCM), meant that combining data collection and data analysis (a main principle of theoretical sampling) was not feasible (Marshall, 1986). A pragmatic approach based on 'what works' was adopted (Robson, 2002), where baseline data were collected first and then analysed. It was decided that a sample size of 30 interviews at baseline (for each study) would provide a satisfactory pool of participants for the grounded theory study stages at follow up, which usually involve between 30 and 50 interviews (Morse, 2015). The limitation of this approach was that the same questions were asked during baseline interviews, leading to high levels of repetition, but this was only discovered once the researcher commenced data analysis.

- **Recruitment**

The recruitment strategy used in the studies of both programmes was earlier suggested as a strength of this research. Programme deliverers (lifestyle coaches for the LS; Community development workers (CDWs) for MCM) recruited participants. This resulted in a lack of researcher control over who was invited to take part, in the LS. The lifestyle coaches were frequently reminded of the importance of recruiting males and individuals from BME groups, but interviews only involved female from a British White background. However, White British and females were represented by 88.7% and 74.0%, respectively, in the pool of participants taking part, suggesting that recruitment of other groups could be challenging. Challenges and barriers were never shared by lifestyle coaches, so it was not possible for the researcher to reflect on possible reasons. Another possible and related limitation is the potential for social desirability bias; i.e., only inviting clients who were expected to give positive experiences about the programme. In contrast, the familiarisation stage with MCM allowed the researcher to oversee the recruitment process. A further limitation of recruitment was dropout in LS, whereby the researcher was not able to interview clients at follow-up. In contrast, the study of MCM included follow-up interviews with residents who were no longer involved (n=3), with additional follow-up participants recruited to boost the sample.

- **Results**

As detailed earlier, the analytical process carried out at follow-up led to two highly abstract substantive theories (Figures 6.3 and 8.2). The level of abstraction achieved was sufficient to answer the two research questions (how is empowerment experienced? How can these approaches complement each other?) and produce a novel contribution to the evidence base. However, grounded theorists advise scaling up substantive theories to the level of formal theories. This involves the highest abstraction, by comparing results to theories amongst a range of theories within and outside the area of knowledge (e.g., education, workplace). This final stage was not attempted and it could be considered as a limitation.

The following two sections will provide recommendations for future research and for practice.

9.4. Future research

This research has provided evidence of how the role of two different health promotion programmes was experienced by participants. Supporting and enabling roles were identified. A series of components were also experienced, which have usually been associated with theory of empowerment. However, this research suggests that these might also be present in people-centred approaches to health improvement. Based on evidence from this research, the complementary role of ILIs and CLIs has been discussed in an individual-, organisational-, and community-level to better address health inequalities. A number of areas for further research have been identified.

Firstly, this research revealed that participants attending both programmes were affected by low levels of mental well-being, with a large number of LS clients reporting suffering mental illnesses. In the context of MCM, deprived areas have previously been associated with high stress levels (Steptoe and Feldman, 2001; Latkin and Curry, 2003). In the context of the LS, depression has been associated with obese females coming from low socio-economic status (Markowitz, Friedman and Arent, 2008). Two questions arose from this, can CLIs improve the mental health and/or mental wellbeing of individuals living in the local area? And

subsequently, could CLIs help prevent overweight and obesity when there is an association with mental health? Addressing these specific questions would complement the existing evidence around the impact of community engagement approaches on health. Although this research aimed to understand empowerment, a pattern of thinking positively was suggested, particularly when engaged with community action or taking responsibility over personal health. The component of thinking positively was associated in this research with the concept of subjective well-being, which could be understood as optimism, which appeared to be combined with resilience. Further research should seek to understand how these two components related to empowerment.

Secondly, this research suggested that the initial level of engagement of individuals might determine the 'level of empowerment' that the individual is ready to work with. For example, very disengaged residents (classified in Chapter 5 as 'objectors') identified many barriers at an individual-level that gave insight into why they were opting for the disengagement route instead of taking action (or being enabled to take action). A similar pattern was found with LS clients who were classed as 'relying on external support' (Chapter 7). Perhaps it was not as clear as with MCM since most clients experienced a providing role, rather than the multiple roles in MCM (providing and empowering). From an applied perspective, it would be beneficial to be able to assess at the start of the programmes what type of role (i.e., empowering or supporting/providing) residents and clients are ready for, and to tailor initial efforts accordingly. To inform this initial assessment, future research should expand on featuring the different levels of engagement (i.e., 'objecting', 'having a voice', 'taking action', 'leading action and enabling others'; or 'taking responsibility' versus 'relying on external support') and further explore the relationship with the type of role they are ready for.

Thirdly, this research has identified several components that previous evidence has associated with the process of empowerment and empowerment outcomes. However, this research suggests that some of these are not unique to empowerment, but form part of other approaches, such as individual-centred. Further research must clarify whether these components relate to empowerment or further approaches. By researching this, the entire process of empowerment should be considered, as previously suggested by Cattaneo and Chapman (2010).

Finally, the discussion point around addressing physical activity from different levels that complement each other (outlined in section 9.2.2.5) shed light on the

idea of social and physical environment inhibiting physical activity and enhancing sedentary behaviour. Recent research has studied the effect of physical environment on physical activity (Macintyre 2007). Future research should focus on understanding whether sedentary behaviours in particular could be tackled with community engagement approaches that focus on the improvement of the physical and particularly the social environment. Additionally, further exploration is needed of how CLIs and ILIs could collaborate to support communities. A natural experiment that captures the effects of acting at the different levels of socio-ecological models would be beneficial.

9.5. Recommendations for practice

This section includes the recommendations for practice in the context of empowerment that emerged from the findings of this research. These are outlined in relation to each study, and also by the complementary role of both health promotion approaches.

9.5.1. Recommendations based on the study of the ILI: the Lifestyle Service

The LS is based on the Health Trainer model, which claims to support and empower individuals. This research has shown that the main role of this programme is supporting individuals to make healthy choices. However, individuals did not provide experiences of being enabled to find solutions for their problems, but were generally given the solutions. Therefore, to incorporate empowerment within the programme, the main recommendation is to modify the approach to enable clients 'to do by themselves', if ready. For example, a possibility could be to encourage participants to find suitable opportunities to exercise. Based on the data presented in this thesis, the programme in its current form does not operate through empowerment, but plays a supportive client-centred role.

9.5.2. Recommendations based on the study of the CLI: My Community Matters

Findings from this research indicated that MCM was experienced as disempowering when dealing with individuals who were already empowered (i.e., self-empowered or empowered by further programmes). In such cases, a clash of approaches and purposes emerged between individuals and MCM. Therefore, it is recommended that MCM (or the empowerment agent) should respect, enhance and support the existing power within targeted communities. Findings from this research provided an example of this recommendation, where disempowerment was transformed into empowerment (section 8.3.3.2, the case of North). This shift was experienced as the programme moving from own purpose (forming a partnership) to support the existing power of the 'incoming community', already empowered by another programme. If this recommendation would be adopted, it is important to bear in mind, particularly for programme deliverers and commissioners, that supporting the existing power amongst programme participants may imply having to move away from the original implementation approach (programme aim; e.g., not forming a partnership).

Findings from this research also identified low levels of engagement as a disempowering influence. This has been characterised as 'community apathy', which should be considered as a negative symptom to be addressed, rather than being ignored through further institutional-level abandonment (e.g., closure of community venues). Accordingly, high levels of disengagement should first be addressed with approaches that require low levels of participation (e.g., community fun days). A continuum of engagement should be made available to all community members, providing opportunities that accommodate varied community member readiness.

Deliverers and commissioners should be made aware that community members who present high levels of disengagement might also show increased levels of distrust. This research revealed that distrust is experienced as a barrier to take part in social action. Therefore, the low level of trust must first be addressed before other activities are considered. This is likely to increase the delivery time. Accordingly, more realistic timeframes must be considered to help disengaged communities to progress towards higher levels of engagement (i.e., years not months).

9.5.3. Recommendations based on the potential complementary role of ILIs and CLIs

This section includes recommendations regarding the potential complementary role of ILIs and CLIs at individual-, organisational- and community-level.

In the context of individual-level, it was suggested to extend the continuum of engagement (section 9.2.2.2). The providing role of the LS should be maintained to ensure the engagement of individuals who face barriers from a mental health and wellbeing perspective. Individuals could also be referred to mental health services, which are currently part of the LS. This approach might help such individuals to engage in community-level opportunities, such as some of the MCM activities that require the lowest level of engagement. Once engaged, they could hopefully move up on the 'ladder of participation' and engagement continuum (Arnstein, 1969; O'Mara-Eves *et al.*, 2013). To be able to align the LS and MCM in a common continuum of engagement, links between the implementation of both programmes must be built. For instance, a possible link could be LS clients being informed about activities or meetings supported by MCM to get involved as a 'low engaged' participant (e.g., attending a community-based fitness activity) or as a 'highly engaged' resident (e.g., attending a partnership meeting to find solutions to address local problems). Therefore, this recommendation suggests informing LS clients about MCM local opportunities.

In the context of organisational-level, it was suggested that LS and MCM could complement each other in engaging and improving the lifestyle of BME groups (section 9.2.2.3). It is recommended again to build links between MCM and LS. Here the recommendation proposes that both programmes work together as partners, where MCM provides skills and knowledge about engaging BME groups, and the LS provides skills and knowledge about how to enhance lifestyle. A possible path to this collaboration is that the LS becomes a partner of the partnership formed with the support of MCM, if residents involved in the partnership wish to address the improvement of lifestyle of BME groups.

In the context of community-level, lacking mental health and mental wellbeing was found as a common feature (and possible underlying cause) in obese clients and (dis)engaged residents. It is recommended to keep focusing efforts on enhancing 'positive thinking' through both programmes on an individual basis. A shared

strategy that appeared to be related to positive thinking was clients and residents taking action and achieving targets. Therefore, it seems essential that, once participants are ready for change, they should get involved in action. An adaptable role of both programmes is also recommended to implement different levels of support, which will be determined by the engagement or level of responsibility that the individual holds.

In the context of the complementary role across levels, physical activity was suggested as the single behaviour to be addressed by the individual-level and community-level (explained in 9.2.2.5). The recommendation here refers again to build a link between both approaches to primarily inform clients about improvements at a community-level (e.g., exercise classes or physical environment improvements, such as the renewal of a green area), as a form of an alternative (or complementary) 'referral' to the fitness centre referral.

Specific recommendations regarding the complementary role of both programmes have been suggested in this section in reference to three levels of the socio-ecological models. Central to these is a move away from the historical tensions between these types of approaches to work together towards their common remit, which involves tackling health inequalities. However, it is essential that all these recommendations are considered when both programmes are targeting individuals who come from the same geographical areas.

9.6. Reflexivity

Reflexivity is an important process of qualitative research since it contributes to rigor throughout the research process (Morse, Olson and Spiers, 2002). It is a strategy to identify who the researcher is and how data are represented by him or her (Pillow, 2003). Reflexivity also gives the opportunity to consider how the research has affected the researcher. This section will include how reflexivity has been conducted, how the researcher might have influenced the research process from a methodological perspective, and finally how the researcher has been affected at a personal level (Olson, 2011).

9.6.1. Reflexivity as part of the research process

Reflexivity is key in constructivism (the epistemological stance adopted in this research) since the researcher is part of the research process rather than being outside of it, as objectivists would claim (Charmaz, 2014). Reflexivity offers a range of strategies, such as discussions with team, research diary or creative approaches like poetry (Olson, 2011). This research has pursued reflexivity through three main strategies that are aligned with the constructivist grounded theory method (Charmaz, 2014): memo-writing, methodological journal, and research diary. These three strategies have been used throughout the research process of the baseline study stages (Chapters 5 and 7) and the follow-up study stages (Chapters 6 and 8).

Firstly, memo-writing has been defined and explained from an implementation point of view in Chapter 4. In the early stages of coding, memo-writing involved recording some sentences that were usually suggested as questions ('what is happening here?'), instead of statements. Memo-writing became more insightful with the grounded theory study stages, when constructing categories and relationships of the substantive theory. An example of memo has been provided in Chapter 4. Secondly, a methodological journal, also defined in Chapter 4, was used throughout the research to reflect on methodological dilemmas and possible directions, and to support methodological decisions. And finally, a research diary was kept to reflect on: i) interviews (e.g., context, how the interview progressed, or what ideas emerged); ii) encounters with stakeholders of the programmes (e.g., meetings with the LS coordinator, or evaluation meetings with MCM deliverers and commissioner (every six weeks)); iii) for MCM, interactions with the programme (e.g., attending community events, activities or meetings). In addition, the researcher reflected weekly for about 30 minutes to an hour on any aspects related to the research process and personal feelings and experiences. The following two sections briefly include the key aspects that emerged.

9.6.2. Researcher influence on the research process

- **Recruitment and data collection**

The intensity of the familiarisation stage with each health promotion programmes was very different. Initially, the purpose of the familiarisation stage was twofold: gain an insight into the implementation of the programme and build rapport with

potential participants. These formed part of the familiarisation stage with MCM, but not the LS (as explained in section 5.2.1.1) since participant observation of the first LS appointment between the lifestyle coach and client was advised against. Therefore, the differences in the familiarisation stage led to the researcher meeting MCM residents a minimum of three times (up to 6 times in most of the cases), which was not possible with LS clients.

The researcher found that the intense familiarisation with MCM might have led to a smoother recruitment process. In addition, the researcher felt that baseline and follow-up interviews with MCM residents were conducted in a more natural atmosphere than interviews with LS clients. Residents came across as feeling relaxed throughout interviews. A less relaxed atmosphere was felt by the researcher during interviews with LS clients, with some stating feeling nervous and the researcher having to make more efforts to put interviewees at ease. Furthermore, interviews with MCM residents proved to be longer than with the LS clients, which could be interpreted as a further indication of the positive rapport between the researcher and MCM residents. And finally, the lack of familiarisation stage with the LS was perceived as positive in relation to explaining lived experiences since the attendance of the researcher to meetings and activities might have prevented residents from giving in-depth explanations of their experiences during these encounters.

The researcher tried to balance the power between herself and the interviewee, stating that the interviewee was the expert and the researcher was there to ask questions and learn from the interviewee experiences. This was supported by a person-centred approach to the interview, which recommends following up aspects that seemed important to the interviewee and relate to the research question of the study (Johnson and Rowlands, 2012). However, the researcher found difficult to distinguish which aspects related to, or could inform, the research question. Therefore, any aspect that seemed important from interviewee's perspective was followed up with probing questions (e.g., can you tell me more about that experience?), even if this did not appear to have direct relevance to the research question. This helped to build rapport with interviewees and avoid socially desirable accounts. It also helped to gain insight into aspects that at first were not considered relevant, but ultimately provided a deeper answer of the research questions. The disadvantage of this approach was the large amount of

data that overwhelmed the researcher at the analysis stage, particularly during initial coding.

The researcher felt high levels of negativity during baseline interviews with MCM and LS interviewees. Negativity was felt during interviews and often captured through memo-writing, rather than specific codes during the analysis stage. The researcher did not feel affected by this negativity, adopting an empathetic attitude during interviews and analysis, which led her to a feeling an important appreciation of barriers and issues faced by interviewees. However, similar negative accounts were involved at follow-up, particularly amongst the first interviews with MCM residents. The researcher felt overwhelmed by this negativity, not understanding where it was coming from and feeling rather judgemental towards participants, which made her feel uncomfortable and unprofessional. Therefore, she decided to adopt a professional attitude, listen equally actively as during baseline interviews, aiming to make residents comfortable, and, finally, to focus on understanding why this negativity was still apparent by probing during further interviews and interrogating the collected data. Although the researcher was satisfied with how this issue was solved, she felt relief when interviews slowly turned into positive accounts.

During some early baseline interviews with LS clients, the researcher felt that the interviewees were uncomfortable with the 'slim and fit' appearance of the researcher. The building of rapport seemed to be affected. From then onwards, the researcher dressed differently, to avoid showing her figure and also by remarking on several occasions that the interview aimed to learn from the interviewees since they were the experts. This combined approach seemed to help solve the problem since the researcher did not observe further verbal or non-verbal disapproval.

And finally, for MCM, the researcher tried to dress correctly and modestly when interviewing and visiting areas to help the build rapport, since programme participants were supposed to come from deprived areas. In addition, when meeting residents from Asian (Pakistani) backgrounds, the researcher made sure that her dress code was respectful to the Muslim religion (e.g., by not wearing skirts or low necks).

- **Data analysis**

Baseline data collection led to a high number of long interviews (n=23 for LS, n=28 for MCM). As described earlier in section 9.3.2, this led to repetition. If this research were to be repeated, priority would be given to combining data collection and analysis, instead of prioritising volume of interviews; such theoretical sampling, which might have provided further insight.

Section 9.3 outlined that arriving at similar findings through two independent grounded theory study stages made the findings of this research robust. However, there is also a chance that findings from the LS study informed data interpretation of MCM study, and vice versa. Reflective practice was helpful in identifying these potential limitations, which were mostly addressed by engaging in a data checking and re-checking process to ensure that interpretation was grounded in the data, rather than on findings from the other study. The researcher felt that this approach was satisfactory achieved and contributed to the quality of the research process, as outlined in section 4.5.

9.6.3. Influence of the research on the researcher

The highly intensive familiarisation stage affected the researcher. The CDWs treated the researcher as part of the MCM delivery team, which was beneficial to build trust between researcher and residents, and to facilitate recruitment. Meetings and activities were characterised by a participatory approach from everyone attending. Therefore, the researcher decided to adopt a volunteering role, when possible. The familiarisation stage in South lasted the longest (4 months), which involved a high number of encounters. At some point the researcher felt she was becoming one more CDW, being expected to deal with certain tasks. It was then when the researcher decided to take a step back and make an effort to re-assert her role as a researcher. It only took one conversation with the CDWs, who understood. However, the researcher felt guilty regarding the residents since a relationship had been built with some. Adopting a more passive role and the subsequent exit from the area was felt as challenging, although residents understood when the researcher explained. This experience reminded the researcher of her role as a qualitative researcher, leads her to build relationships with research participants, but these also needed to be managed appropriately. The researcher learned from this experience that it feels appropriate

to dedicate some time to building rapport, and a similar amount of time should be dedicated to terminate those relationships.

This research led the researcher to 'discover' new aspects at a professional and a personal level. From a professional perspective, the researcher 'discovered' a broader picture regarding health promotion. As an example, the researcher has become more aware of the complex phenomenon of obesity (related to the LS). This research has made the researcher realise that tackling obesity is not only a matter of asking individuals to increase activity levels and eat healthily. Similarly, the researcher has become more aware of the complex lives of people living in deprived areas (linked to MCM), and how vital it is for policy-makers, researchers and further professionals involved to first fully understand these experiences before taking any type of action.

From a personal perspective, this research has changed the researcher's way of looking at some relatives. The negativity embedded in the research participants' accounts was very similar to the negativity the researcher has felt with some family members. This research has unexpectedly helped her to understand why they may have such cynical and negative views over life.

Additionally, it has been an interesting journey to become more aware of empowering approaches around the researcher. For example, doing this PhD feels like an empowerment process, where supervisors have played the role of 'empowers' and the researcher has taken the role of 'being empowered'. The researcher has also come to realise that her teaching style or even her way of interacting with others involves to certain extent a role of 'enabling others to do things by themselves'.

9.7. General conclusions

This longitudinal research demonstrated that programme participants tended to rely on external support at baseline, particularly LS clients and disengaged MCM residents, who expected an external influence to solve the identified problems.

Grounded theory stage studies (one year follow-up) indicated that both programmes involved components that have been previously associated with empowerment. However, a providing role that seeks high levels of appropriateness by addressing programme participant needs was experienced as

the main role for the LS, and as one of the roles for MCM. This research suggested programme appropriateness from two contrasting perspectives: as a negative process that inhibits empowerment when it takes the role of 'doing for' individuals; as a positive process that contributes to help those who present barriers to being enabled to take control over life and health. In addition to the providing role, MCM was also experienced as involving an empowerment role by supporting residents to take control. And finally, a disempowering role was also experienced by those who were already empowered at the programme onset, when different purposes and ways of working were introduced.

This research demonstrated that there is potential for a complementary role at different levels of the socio-ecological model of health. At an individual-level, the continuum of engagement provided by the multi-role of MCM can be complemented by adding further engagement levels through the LS, by supporting individuals to be 'more ready' to take part in participatory approaches to health promotion. At an organisational-level, if both programmes collaborated, the LS and MCM could better address engagement with BME groups from a lifestyle and community engagement perspective, perhaps helping to address the associated health inequalities. At a community-level, there is potential to complement each other to better address the lack of mental well-being, particularly of individuals living in deprived areas. Finally, from a multi-level perspective, healthy behaviours such as physical activity could be supported at an individual-level, by supporting individuals to start being active, and at a community-level by improving the physical and social environment of deprived areas, to create more supportive environments.

The novel combination of studying empowerment from the perspective of participants taking part in two 'real world' health promotion programmes using qualitative methods provided a unique contribution to the area, identifying important next steps for research in the domains of health inequalities, empowerment and health promotion.

References

- Abraham, C. and Michie, S. (2008) 'A taxonomy of behavior change techniques used in interventions.', *Health psychology*, 27(3), pp. 379–87. doi: 10.1037/0278-6133.27.3.379.
- Ahern, A. L., Olson, A. D., Aston, L. M. and Jebb, S. A. (2011) 'Weight Watchers on prescription : An observational study of weight change among adults referred to Weight Watchers by the NHS', *BMC Public Health*, 11(434), pp. 1–5.
- Anderson, R. M. (1995) 'Patient empowerment. Results of a randomized controlled trial', *Diabetes Care*, 18(7), pp. 943–949.
- Anderson, R. M. and Funnell, M. M. (2010) 'Patient empowerment: Myths and misconceptions', *Patient Education and Counseling*, 79(3), pp. 277–282. doi: 10.1016/j.pec.2009.07.025.
- Antonovsky, A. (1979) *Health, stress, and coping*. London: Jossey-Bass.
- Arnstein, S. (1969) 'A ladder of citizen participation', *Journal of the American Institute of Planners*, 35(4), pp. 216–224.
- Ashenden, R., Silagy, C. and Weller, D. (1997) 'A systematic review of the effectiveness of promoting lifestyle change in general practice', *Family Practice*, 14(2), pp. 160–175.
- Attree, P., Clayton, S., Karunanithi, S., Popay, J. and Read, D. (2012) 'NHS health trainers: A review of emerging evaluation evidence', 22(1), pp. 37–41.
- Attree, P., French, B., Milton, B., Povall, S., Whitehead, M. and Popay, J. (2011) 'The experience of community engagement for individuals: a rapid review of evidence', *Health & Social Care in the Community*, 19(3), pp. 250–60. doi: 10.1111/j.1365-2524.2010.00976.x.
- Aujoulat, I., D'Hoore, W. and Deccache, A. (2007) 'Patient empowerment in theory and practice: polysemy or cacophony?', *Patient Education and Counseling*, 66(1), pp. 13–20. doi: 10.1016/j.pec.2006.09.008.
- Aujoulat, I., Marcolongo, R., Bonadiman, L. and Deccache, A. (2008) 'Reconsidering patient empowerment in chronic illness: A critique of models of self-efficacy and bodily control', *Social science and medicine*, 66, pp. 1228–1239. doi: 10.1016/j.socscimed.2007.11.034.
- Aymé, S., Kole, A. and Groft, S. (2008) 'Empowerment of patients: Lessons from

the rare diseases', *Lancet*, 371, pp. 2048–2051.

Baba, C., Kearns, A., McIntosh, E., Tannahill, C. and Lewsey, J. (2016) 'Is empowerment a route to improving mental health and wellbeing in an urban regeneration (UR) context?', *Urban Studies*, p. Published online. doi: 10.1177/0042098016632435.

Bagnall, A., Kinsella, K., Trigwell, J., South, J., Sheridan, K. and Harden, A. (2015) *Community engagement - approaches to improve health: Map of current practice based on a case study approach*. Leeds: Centre for Health Promotion Research, Institute for Health and Wellbeing, Leeds Beckett University. Available at: <https://www.nice.org.uk/guidance/ng44/evidence> [Accessed 28 Apr. 2016].

Bagnall, A., South, J., Trigwell, J., Kinsella, K., White, J. and Harden, A. (2015) *Community engagement - approaches to improve health: Map of the literature on current and emerging community engagement policy and practice in the UK*. Leeds: Centre for Health Promotion Research, Institute for Health and Wellbeing, Leeds Beckett University. Available at: <https://www.nice.org.uk/guidance/ng44/evidence> [Accessed 28 Apr. 2016].

Bandura, A. (1994) 'Self-efficacy', in Ramachaudran, V. (ed.) *Encyclopedia of human behavior*. New York: Academic Press, pp. 71–81.

Bandura, A. (2002) 'Social cognitive theory in cultural context', *Applied Psychology*. Wiley Online Library, 51(2), pp. 269–290.

Bandura, A. and Locke, E. A. (2003) 'Negative self-efficacy and goal effects revisited', *Journal of Applied Psychology*, 88(1), p. 87.

Barnett, E. and Casper, M. (2001) 'A definition to social environment', *American Journal of Public Health*, 91(3), p. 465.

Bartley, M. (2006) *Capability and resilience: beating the odds*. London: UCL. Available at: <http://www.ucl.ac.uk/capabilityandresilience/> [Accessed 08 Aug. 2016].

Beekman, T., Lyons, F. and Scott, J. (2001) *Improving the understanding of the influence of owner occupiers in mixed tenure neighbourhoods*. Edinburgh: Scottish Homes. Available at: <http://hdl.handle.net/10068/584292> [Accessed 01 Aug. 2016].

Berman, E. (1997) 'Dealing with cynical citizens', *Public Administration Review*, 57(2), pp. 105–112.

- Biddle, S., Mutrie, N. and Gorely, T. (2015) *Psychology of physical activity: Determinants, well-being and interventions*. 3rd edn. London: Routledge.
- Bidgood, J. and Buckroyd, J. (2005) 'An exploration of obese adults' experience of attempting to lose weight and to maintain a reduced weight', *Counselling and Psychotherapy Research*, 5(3), pp. 221–230. doi: 10.1080/17441690500310395.
- Blaxter, M. (1990) *Health and lifestyles*. London: Routledge.
- Bleas, H. (2003) *Communities in control: Public services and local socialism*. London: Fabian Society.
- Bloor, M. and Wood, F. (2006) *Keywords in qualitative methods: A vocabulary of research concepts*. London: Sage.
- Blumer, H. (1969) *Symbolic interactionism: Perspective and Method*. New Jersey: Prentice-Hall.
- Böhnke, P. (2008) 'Are the poor socially integrated? The link between poverty and social support in different welfare regimes', *Journal of European Social Policy*, 18(2), pp. 133–150. doi: 10.1177/0958928707087590.
- Boyatzis, R. (1998) *Transforming qualitative information. Thematic analysis and code development*. London: Sage.
- Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative research in psychology*, 3(2), pp. 77–101. doi: 10.1191/1478088706qp063oa.
- Bravo, P., Edwards, A., Barr, P. J., Scholl, I., Elwyn, G. and Mcallister, M. (2015) 'Conceptualising patient empowerment: A mixed methods study', *BMC Health Services Research*, 15, p. 252. doi: 10.1186/s12913-015-0907-z.
- Brodsky, A. E. and Cattaneo, L. B. (2013) 'A transconceptual model of empowerment and resilience: divergence, convergence and interactions in kindred community concepts', *American Journal of Community Psychology*, 52, pp. 333–346. doi: 10.1007/s10464-013-9599-x.
- Brunton, G., Caird, J., Kneale, D., Thomas, J. and Richardson, M. (2015) *Review 2: Community engagement for health via coalitions, collaborations and partnerships. A systematic review and meta-analysis*. London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education University College London. Available at: <https://www.nice.org.uk/guidance/ng44/evidence> [Accessed

28 Apr. 2016].

Brunton, G., Caird, J., Stokes, G., Stansfield, C., Kneale, D., Richardson, M. and Thomas, J. (2014) *Review 1: Community engagement for health via coalitions, collaborations and partnerships. A systematic review*. London: EPPI Centre, Social Science Research Unit, Institute of Education, University of London. Available at: <https://www.nice.org.uk/guidance/ng44/evidence> [Accessed 28 Apr. 2016].

Bryant, A. and Charmaz, K. (2007) 'Grounded theory in historical perspective: An epistemological account', in *The SAGE handbook of grounded theory*. London: Sage, pp. 31–57.

Bryman, A. (2007) 'The research question in social research: What is its role?', *International journal of social research methodology*, 10(1), pp. 5–20. doi: 10.1080/13645570600655282.

Bryman, A. (2012) *Social research methods*. 4th edn. Oxford: Oxford University Press.

Caballero, B. (2007) 'The global epidemic of obesity: an overview', *Epidemiologic reviews*, 29(1), pp. 1–5.

Cattaneo, L. B. and Chapman, A. R. (2010) 'The process of empowerment: A model for use in research and practice', *American Psychologist*, 65(7), pp. 646–659. doi: 10.1037/a0018854.

Cattell, V. (2001) 'Poor people, poor places, and poor health: the mediating role of social networks and social capital', *Social Sciences and Medicine*, 52, pp. 1501–1516.

Charmaz, K. (2000) 'Grounded Theory: Objectivist and constructivist methods', in Denzin, N. and Lincoln, Y. (eds) *Handbook of qualitative research*. 2nd edn. London: Sage, pp. 509–535.

Charmaz, K. (2006) *Constructing Grounded Theory. A practical guide through qualitative analysis*. London: Sage.

Charmaz, K. (2014) *Constructing Grounded Theory*. London: Sage.

Chase, S. (2011) 'Narrative inquiry: Still a field in the making', in Denzin, N. and Lincoln, Y. (eds) *The SAGE handbook of qualitative research*. 4th edn. London: Sage, pp. 421–434.

Chinn, D. J., White, M., Harland, J., Drinkwater, C. and Raybould, S. (1999)

- 'Barriers to physical activity and socioeconomic position: implications for health promotion', *Journal of Epidemiology and Community Health*, 40, pp. 191–192.
- Clarke, A. (2005) *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: Sage.
- Cole, I., Gidley, G., Ritchie, C., Simpson, D. and Wishart, B. (1997) 'Creating communities or welfare housing? A study of new housing association developments in Yorkshire/Humberside'. Coventry: Chartered Institute of Housing.
- Corbin, J. and Morse, J. (2003) 'The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics', *Qualitative inquiry*, 9(3), pp. 335–354.
- Cresswell, J. W. (1998) *Qualitative inquiry and research design: Choosing among five traditions*. London: Sage.
- Cyril, S., Smith, B. J., Possamai-inesedy, A. and Renzaho, A. M. N. (2015) 'Exploring the role of community engagement in improving the health of disadvantaged populations. A systematic review', *Global health action*, (8).
- Dahlgren, G. and Whitehead, M. (1991) *Policies and strategies to promote social equity in health. Background document to WHO – Strategy paper*. Institute for Futures Studies.
- Denzin, N. (1995) 'Symbolic interactionism', in Smith, J., Hairé, R., and Van Langenhove, L. (eds) *Rethinking psychology*. London, pp. 43–58.
- Denzin, N. and Lincoln, Y. (2011) 'Introduction: The discipline and practice of qualitative research', in Denzin, N. and Lincoln, Y. (eds) *The SAGE handbook of grounded theory handbook of qualitative research*. 4th edn. London: Sage, pp. 1–20.
- Denzin, N. and Lincoln, Y. (2013) 'Introduction: The discipline and practice of qualitative research', in Denzin, N. and Lincoln, Y. (eds) *The landscape of qualitative research*. 4th edn. London: Sage, pp. 1–42.
- Department for Communities and Local Government (2015) *English indices of deprivation 2015*. London. Available at: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015> [Accessed 28 Jul. 2016].
- Department of Health (1998) *Independent inquiry into inequalities in health*.

- London. Available at: <https://www.gov.uk/government/publications/independent-inquiry-into-inequalities-in-health-report> [Accessed 8 Apr. 2016].
- Department of Health (2004) *Choosing health: making healthy choices easier*. The Stationery Office: The Stationery Office.
- Department of Health and Social Security (1980) *Inequalities in health: Report of a research working group*. London. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265503/ih.pdf [Accessed 8 Apr. 2016].
- Dey, I. (1999) *Grounding grounded theory: Guidelines for qualitative inquiry*. San Diego: Academic Press.
- Diener, E. (2000) 'Subjective well-being: the science of happiness and a proposal for a national index', *American Psychologist*, 55(1), pp. 34–43. doi: 10.1037//0003-066X.55.1.34.
- Dixey, R. (2013) *Health promotion: Global principles and practice*. Boston: CAB International.
- Dixon, K. J. L., Shcherba, S. and Kipping, R. R. (2012) 'Weight loss from three commercial providers of NHS primary care slimming on referral in North Somerset: service evaluation', *Journal of Public Health*, 34(4), pp. 555–561. doi: 10.1093/pubmed/fds034.
- Doyle, R. (2001) *By the numbers: lifestyle blues*. Scientific American.
- Dupuis, A. and Thorns, D. C. (1998) 'Home, home ownership and the search for ontological security', *The Sociological Review*, 46(1), pp. 24–47.
- Egan, M., Lawson, L., Kearns, A., Conway, E. and Neary, J. (2015) 'Neighbourhood demolition, relocation and health: A qualitative longitudinal study of housing-led urban regeneration in Glasgow, UK', *Health and Place*. Elsevier, 33, pp. 101–108. doi: 10.1016/j.healthplace.2015.02.006.
- Ellis-Stoll, C. and Popkess-Vawter, S. (1998) 'A concept analysis on the process of empowerment', *Advances in Nursing Science*, 21(2), pp. 62–68.
- Eversole, R. (2012) 'Remaking participation: Challenges for community development practice', *Community Development Journal*, 47(1), pp. 29–41. doi: 10.1093/cdj/bsq033.
- Falk-Rafael, A. (2001) 'Empowerment as a process of evolving consciousness: A

- model of empowered caring', *Advances in nursing science*, 24(1), pp. 1–16.
- Feste, C. and Anderson, R. (1995) 'Empowerment: from philosophy to practice', *Patient Education and Counseling*, 26(1–3), pp. 139–44.
- Filozof, C., Fernández-Pinilla, M. and Fernández-Cruz, A. (2004) 'Smoking cessation and weight gain', *Obesity Reviews*, 5, pp. 95–103.
- Fjeldsoe, B., Neuhaus, M., Winkler, E. and Eakin, E. (2011) 'Systematic review of maintenance of behavior change following physical activity and dietary interventions.', *Health Psychology*, 30(1), pp. 99–109. doi: 10.1037/a0021974.
- Flick, U. (2008) *Managing quality in qualitative research*. London: Sage.
- Flick, U. (2014) *An introduction to qualitative research*. 5th edn. London: Sage.
- Flint, S., Hudson, J. and Lavalley, D. (2013) 'Counterconditioning as an intervention to modify anti-fat attitudes', *Health Psychology Research*, 1(2), p. e24.
- Freire, P. (2000) *Pedagogy of the oppressed*. New York: Continuum.
- Freudenberg, N. (1978) 'Shaping the future of health education: from behavior change to social change', *Health Education and Behavior*, 6(4), pp. 372–377. doi: 10.1177/109019818700600404.
- Ganor, M. and Ben-Lavy, Y. (2003) 'Community resilience: Lessons derived from Gilgo under fire', *Journal of Jewish Communal Service*, 79, pp. 105–108.
- Gardner, B., Cane, J., Rumsey, N. and Michie, S. (2012) 'Behaviour change among overweight and socially disadvantaged adults: a longitudinal study of the NHS Health Trainer Service.', *Psychology and Health*, 27(10), pp. 1178–93. doi: 10.1080/08870446.2011.652112.
- Gibson, C. H. (1991) 'A concept analysis of empowerment', *Journal of Advanced Nursing*, 16, pp. 354–361.
- Gidlow, C. J., Cochrane, T., Davey, R., Beloe, M., Chambers, R., Kumar, J., Mawby, Y. and Iqbal, Z. (2014) 'One-year cardiovascular risk and quality of life changes in participants of a health trainer service', *Perspectives in Public Health*, 134(3), pp. 135–144. doi: 10.1177/1757913913484419.
- Glaser, B. G. (1978) *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. and Strauss, A. L. (1967) *Discovery of grounded theory: Strategies*

for qualitative research. Chicago: Aldine.

Gobo, G. (2008) *Doing ethnography*. London: Sage.

Gottwald, M. and Goodman-Brown, J. (2012a) 'An introduction to why health promotion is important', in Goodman-Brown, J. and Gottwald, M. (eds) *A guide to practical health promotion*. Berkshire: McGraw-Hill Education, pp. 7–25.

Gottwald, M. and Goodman-Brown, J. (2012b) 'An overview of health promotion theory', in Goodman-Brown, J. and Gottwald, M. (eds) *A guide to practical health promotion*. Berkshire: McGraw-Hill Education, pp. 26–52.

Graham, H. (2004a) 'Social determinants and their unequal distribution: Clarifying policy understandings', *The Milbank Quarterly*, 82(1), pp. 101–124.

Graham, H. (2004b) 'Tackling inequalities in health in England: Remedying health disadvantages, narrowing health gaps or reducing health gradients?', *Journal of Social Policy*, pp. 115–131. doi: 10.1017/S0047279403007220.

Green, J. and Tones, K. (2010) *Health promotion: planning and strategies*. 2nd edn. London: Sage.

Guba, E. G. and Lincoln, Y. S. (1981) *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Francisco: Jossey-Bass.

Guba, E. and Lincoln, Y. (2005) 'Paradigmatic controversies, contradictions, and emerging confluences', in Denzin, N. and Lincoln, Y. (eds) *The Sage handbook of qualitative research*. 3rd edn. London: Sage, pp. 191–215.

Guest, G., MacQueen, K. and Namey, E. (2012) *Applied thematic analysis*. London: Sage.

Hardeman, W., Johnston, M., Johnston, D., Bonetti, D., Wareham, N. and Kinmonth, A. L. (2002) 'Application of the theory of planned behaviour in behaviour change interventions: A systematic review', *Psychology and Health*, 17(2), pp. 123–158. doi: 10.1080/08870440290013644a.

Heggen, K. and Guillemin, M. (2012) 'Protecting participants' confidentiality using a situated research ethics approach', in Gubrium, J., Holstein, J., Marvasti, A., and McKinney, K. (eds) *The Sage handbook of interview research. The complexity of the craft*. 2nd edn. London: Sage, pp. 465–476.

Hickey, G. and Kipping, C. (1998) 'Exploring the concept of user involvement in

- mental health through a participation continuum', *Journal of Clinical Nursing*, 7, pp. 83–88.
- Higgins, J. (1999) 'Citizenship and empowerment: a remedy for citizen participation in health reform', *Community Development Journal*, 34(4), pp. 287–307.
- Holmstrom, I. and Roing, M. (2010) 'The relation between patient-centeredness and patient empowerment: a discussion on concepts', *Patient Education and Counseling*, 79, pp. 167–172. doi: 10.1016/j.pec.2009.08.008.
- Huber, M., Knottnerus, J., Green, L., van der Horst, H., Jadad, A., Kromhout, D., Leonard, B., Lorig, K., Loureiro, M. I., van der Meer, J., Schnabel, P., Smith, R., van Weel, C. and Smid, H. (2011) 'How should we define health?', *BMJ*, 343, p. d4163. doi: 10.1136/bmj.d4163.
- Hutchison, A., Johnston, L. and Breckon, J. (2013) 'A grounded theory of successful long-term physical activity behaviour change', *Qualitative Research in Sport, Exercise and Health*, 5(1), pp. 109–126. doi: 10.1080/2159676X.2012.693529.
- Israel, B. A., Schulz, A. J., Parker, E. A. and Becker, A. B. (1998) 'Review of community-based research: Assessing partnership approaches to improve public health', *Annual Review of Public Health*, 19, pp. 173–202.
- Israel, B., Checkoway, B., Schulz, A. and Zimmerman, M. (1994) 'Health education and community empowerment: conceptualizing and measuring perceptions of individual, organizational, and community control', *Health Education Quarterly*, 21(2), pp. 149–70.
- Jarvis, D., Berkeley, N. and Broughton, K. (2012) 'Evidencing the impact of community engagement in neighbourhood regeneration: The case of Canley, Coventry', *Community Development Journal*, 47(2), pp. 232–247. doi: 10.1093/cdj/bsq063.
- Jepson, R. G., Harris, F. M., Platt, S. and Tannahill, C. (2010) 'The effectiveness of interventions to change six health behaviours: A review of reviews', *BMC Public Health*, 10, p. 538. doi: 10.1186/1471-2458-10-538.
- Johnson, J. and Rowlands, T. (2012) 'The interpersonal dynamics of in-depth interviewing', in Gubrium, J., Holstein, J., Marvasti, A., and McKinney, K. (eds) *The SAGE handbook of interview research. The complexity of the craft*. 2nd edn.

London: Sage, pp. 99–114.

Jolly, K., Lewis, A. and Kipping, R. R. (2011) 'Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten Up randomised controlled trial', *BMJ*, pp. 1–16. doi: 10.1136/bmj.d6500.

Kawachi, I., Subramanian, S. and Almeida-Filho, N. (2002) 'A glossary for health inequalities', *Journal of Epidemiology and Community Health*, 56(9), pp. 647–652.

Kearns, A. and Parkes, A. (2003) 'Living in and leaving poor neighbourhood conditions in England', *Housing Studies*, 18(6), pp. 827–851. doi: 10.1080/0267303032000135456.

Kieffer, C. (1984) 'Citizen empowerment: A development perspective', *Prevention in Human Services*, (3), pp. 9–36.

Kitzinger, J. (1994) 'The methodology of focus groups: the importance of interactions between research participants', *Sociology of Health and Illness*, 16, pp. 103–21.

Kitzinger, J. (1995) 'Introducing focus groups', *BMJ*, 311, pp. 299–302.

Koelen, M. and Lindström, B. (2005) 'Making healthy choices easy choices: the role of empowerment', *European Journal of Clinical Nutrition*, 59(1), pp. 10–17. doi: 10.1038/sj.ejcn.1602168.

Kretzmann, J. and McKnight, J. (1993) *Building communities from the inside out*. Chicago: ACTA Publications.

Kreuter, M., Lukwago, S., Bucholtz, D., Clark, E. and Sanders-Thompson, V. (2003) 'Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches', *Health Education & Behavior*, 30(2), pp. 133–146.

Kuokkanen, L. and Leino-Kilpi, H. (2000) 'Power and empowerment in nursing: Three theoretical approaches', *Journal of Advanced Nursing*, 31(1), pp. 235–241. doi: 10.1046/j.1365-2648.2000.01241.x.

Labonte, R. (1994) 'Health promotion and empowerment: Reflections on professional practice', *Health Education and Behavior*, 21(2), pp. 253–268. doi: 10.1177/109019819402100209.

van der Land, M. and Doff, W. (2010) 'Voice, exit and efficacy: Dealing with perceived neighbourhood decline without moving out', *Journal of Housing and the*

Built Environment, 25, pp. 429–445. doi: 10.1007/s10901-010-9197-2.

Laschinger, H. K. S., Gilbert, S., Smith, L. M. and Leslie, K. (2010) 'Towards a comprehensive theory of nurse/patient empowerment: applying Kanter's empowerment theory to patient care', *Journal of Nursing Management*, 18, pp. 4–13. doi: 10.1111/j.1365-2834.2009.01046.x.

Latkin, C. and Curry, A. (2003) 'Stressful neighborhoods and depression: A prospective study of the impact of neighborhood disorder', *Journal of Health and Social Behavior*, 44(1), pp. 34–44.

Laverack, G. (2004) *Health promotion practice: power and empowerment*. London: Sage.

Laverack, G. (2006) 'Improving health outcomes through community empowerment: a review of the literature.', *Journal of Health, Population, and Nutrition*, 24(1), pp. 113–20.

Laverack, G. and Labonte, R. (2000) 'A planning framework for community empowerment goals within health promotion', *Health Policy and Planning*, 15(3), pp. 255–262.

Lincoln, Y. and Guba, E. (1985) *Naturalistic inquiry*. London: Sage.

Lincoln, Y., Lynham, S. and Guba, E. (2011) 'Paradigmatic controversies, contradictions, and emerging confluences, revisited', in Denzin, N. and Lincoln, Y. (eds) *The SAGE handbook of qualitative research*. 4th edn. London: Sage, pp. 97–129.

Lorion, R. P. and Mcmillan, D. W. (2008) 'Does empowerment require disempowerment? Reflections on psychopolitical validity', *Journal of Community Psychology*, 36(2), pp. 254–260. doi: 10.1002/jcop.

Ludwig, J., Duncan, G. J., Gennetian, L. A., Katz, L. F., Kessler, R. C., Kling, J. R. and Sanbonmatsu, L. (2012) 'Neighborhood effects on the long-term well-being of low-income adults', *Science*, 6101, pp. 1505–1510.

Lynch, J. and Kaplan, G. (2000) 'Socioeconomic position', in Berkman, L. F. and Kawachi, I. (eds) *Social Epidemiology*. New York: Oxford University Press, pp. 13–35.

Macdonald, G. and Davies, J. (1998) 'Reflection and vision. Proving and improving the promotion of health', in Macdonald, G. and Davies, J. (eds) *Quality, evidence*

and effectiveness in health promotion striving for certainties. London: Routledge, pp. 5–18.

Macintyre, S. (2007) 'Deprivation amplification revisited; or, is it always true that poorer places have poorer access to resources for healthy diets and physical activity?', *International Journal of Behavioral Nutrition and Physical Activity*, 4(1). doi: 10.1186/1479-Received.

Macintyre, S. (2007) *Inequalities in health in Scotland: What are they and what can we do about them?* MRC Social and Public Health Sciences Unit. Available at: www.sphsu.mrc.ac.uk/reports/OP017.pdf [Accessed 11 Apr. 2016].

Macintyre, S., Ellaway, A., Hiscock, R., Kearns, A., Der, G. and McKay, L. (2003) 'What features of the home and the area might help to explain observed relationships between housing tenure and health? Evidence from the west of Scotland', *Health and Place*, 9(3), pp. 207–218.

Mackenbach, J. P. (2006) *Health inequalities: Europe in profile*. London: COI for the Department of Health. Available at: http://www.who.int/social_determinants/resources/european_inequalities.pdf [Accessed 8 Apr. 2016].

Magis, K. (2010) 'Community resilience: an indicator of social sustainability', *Society and Natural Resources*, 23(5), pp. 401–416. doi: 10.1080/08941920903305674.

Malpass, P. and Victory, C. (2010) 'The modernisation of social housing in England', *International Journal of Housing Policy*, 10(1), pp. 3–18. doi: 10.1080/14616710903565647.

Marin, G., Burhansstipanov, L., Connell, C., Gielen, A., Helitzer-Allen, D., Lorig, K., Morisky, D., Tenney, M. and Thomas, S. (1995) 'A research agenda for health education among underserved populations', *Health Education & Behavior*, 22(3), pp. 346–363.

Markowitz, S., Friedman, M. and Arent, S. (2008) 'Understanding the relation between obesity and depression: Causal mechanisms and implications for treatment', *Clinical Psychology: Science and Practice*, 15(1), pp. 1–20. doi: 10.1111/j.1468-2850.2008.00106.x.

Marmot, M. (2001) 'From Black to Acheson: Two decades of concern with inequalities in health. A celebration of the 90th birthday of Professor Jerry Morris',

International Journal of Epidemiology, 30(5), pp. 1165–1171.

Marmot, M. (2005) 'Public health social determinants of health inequalities', *Lancet*, 365, pp. 1099–1104.

Marmot, M. (2007) 'Achieving health equity: from root causes to fair outcomes', *Lancet*, 370, pp. 1153–1163. doi: 10.1016/S0140-6736(07)61385-3.

Marmot, M. (2010) *Fair society, healthy lives. The Marmot review*. UCL Institute of Health Equity. Available at: <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> [Accessed 20 Jan. 2014].

Marrero, D., Ard, J., Delamater, A., Peragallo-Dittko, V., Mayer-Davis, E., Nwankwo, R. and Fisher, E. (2013) 'Twenty-first century behavioral medicine: A context of empowering clinicians and patients with diabetes. A consensus report', *Diabetes Care*, 36, pp. 463–470. doi: 10.2337/dc12-2305.

Marshall, M. N. (1986) 'Sampling for qualitative research', *Family Practice*, 13(6), pp. 522–526. doi: 10.1093/fampra/13.6.522.

Marzano, M. (2012) 'Ethics of the interview. Informed consent', in Gubrium, J., Holstein, J., Marvasti, A., and McKinney, K. (eds) *The SAGE handbook of interview research. The complexity of the craft*. 2nd edn. London: Sage, pp. 443–457.

Mcmillan, D. and Chavis, D. (1986) 'Sense of community: A definition and theory', *American Journal of Community Psychology*, 14(1), pp. 6–23.

McNeill, L. H., Kreuter, M. W. and Subramanian, S. (2006) 'Social environment and physical activity: A review of concepts and evidence.', *Social Science and Medicine*, 63(4), pp. 1011–22. doi: 10.1016/j.socscimed.2006.03.012.

Mellor, D., Hayashi, Y., Firth, L., Stokes, M., Chambers, S. and Cummins, R. (2008) 'Volunteering and well-Being: do self-esteem, optimism, and perceived control mediate the relationship?', *Journal of Social Service Research*, 34(4), pp. 61–70. doi: 10.1080/01488370802162483.

Merriam, S. B. (1991) 'How research produces knowledge', *Adult education: Evolution and achievements in a developing field of study*, pp. 42–65.

Michie, S., Rumsey, N., Fussell, A., Hardeman, W., Johnston, M., Newman, S. and Yardley, L. (2008) *Improving Health: Changing Behaviour. NHS Health Trainer Handbook. Manual*. Department of Health Publications.

- Michie, S., van Stralen, M. M. and West, R. (2011) 'The behaviour change wheel: A new method for characterising and designing behaviour change interventions', *Implementation Science*, 6, p. 42. doi: 10.1186/1748-5908-6-42.
- Miller, R. L. and Campbell, R. (2006) 'Taking stock of empowerment evaluation. An empirical review', *American Journal of Evaluation*, 27(3), pp. 296–319. doi: 10.1177/1098214006291015.
- Miller, W. R. and Rollnick, S. O. (2002) *Motivational interviewing. Preparing people for change*. 2nd edn. New York: The Guildford Press.
- Miller, W. R. and Rollnick, S. O. (2012) *Motivational interviewing: helping people change*. New York: Guilford press.
- Milton, B., Attree, P., French, B., Povall, S., Whitehead, M. and Popay, J. (2012) 'The impact of community engagement on health and social outcomes: a systematic review', *Community Development Journal*, 47(3), pp. 316–334. doi: 10.1093/cdj/bsr043.
- Minkler, M. (1989) 'Education, health promotion and the open society: An historical perspective', *Health Education Quarterly*, 16(1), pp. 17–30.
- Minkler, M. (2000) 'Personal responsibility for health: Contexts and controversies', in Callahan, D. (ed.) *Promoting healthy behavior. How much freedom? Whose responsibility?* Washington, DC: Georgetown University Press, pp. 1–22.
- Morgan, A. and Ziglio, E. (2007) 'Revitalising the evidence base for public health: an assets model', *Promotion & Education*, Suppl 2, pp. 17–22. doi: 10.1177/10253823070140020701x.
- Morgan, D. (1993) 'Qualitative content analysis: A guide to paths not taken', *Qualitative Health Research*, 3, pp. 112–121. doi: 10.1177/104973239300300107.
- Morse, J. M. (2015) 'Analytic strategies and sample size', *Qualitative Health Research*, 25(10), pp. 1317–1318. doi: 10.1177/15258.
- Morse, J. M., Olson, K. and Spiers, J. (2002) 'Verification strategies for establishing reliability and validity in qualitative research', *International Journal of Qualitative Methods*, 1(2), pp. 13–22.
- Nelson, C., Treichler, P. and Grossberg, L. (1992) 'Cultural studies', in Grossberg, L., Nelson, C., and Treichler, P. (eds) *Cultural studies*. New York: Routledge, pp. 1–16.

NICE (2007) *Behaviour change at population, community and individual levels*. London. Available at: <https://www.nice.org.uk/guidance/ph6/chapter/3-recommendations> [Accessed 20 Jan. 2014].

NICE (2008) *Community engagement*. London. Available at: <https://www.nice.org.uk/guidance/ph9> [Accessed 1 Jul. 2014].

NICE (2014) *Behaviour change: Individual approaches*. London. Available at: <https://www.nice.org.uk/guidance/ph49> [Accessed 14 Jul. 2016].

Norris, F. H., Stevens, Æ. S. P., Pfefferbaum, B., Wyche, Æ. K. F. and Pfefferbaum, R. L. (2008) 'Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness', *American Journal of Community Psychology*, 41, pp. 127–150. doi: 10.1007/s10464-007-9156-6.

Nyatanga, L. and Dann, K. (2002) 'Empowerment in nursing: the role of philosophical and psychological factors', *Nursing Philosophy*, 44, pp. 234–239.

O'Dwyer, L. a., Baum, F., Kavanagh, A. and Macdougall, C. (2007) 'Do area-based interventions to reduce health inequalities work? A systematic review of evidence', *Critical Public Health*, 17(4), pp. 317–335. doi: 10.1080/09581590701729921.

O'Mara-Eves, A., Brunton, G., Mcdaid, D., Oliver, S., Kavanagh, J., Jamal, F., Matosevic, T., Harden, A. and Thomas, J. (2013) 'Community engagement to reduce inequalities in health: A systematic review, meta-analysis and economic analysis', *Public Health Research*, 1(4). doi: 10.3310/phr01040.

Office for National Statistics (2011a) *Census data on Nomis*. Durham. Available at: <https://www.nomisweb.co.uk/census/2011> [Accessed 28 Jul. 2016].

Office for National Statistics (2011b) *Super Output Area*. London. Available at: <http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/census/super-output-areas--soas-/index.html> [Accessed 28 Jul. 2016].

Office for National Statistics (2014) *Mid-year population estimates for 2014*. London. Available at: <http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/2015-06-25> [Accessed 28 Jul. 2016].

Olson, K. (2011) *Essentials of qualitative interviewing*. Walnut Creek: Left Coast
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Press.

Pavey, T., Anokye, N., Taylor, H., Trueman, P., Moxham, T., Fox, K., Hillsdon, M., Green, C., Campbell, J., Foster, C., Mutrie, N., Searle, J. and Taylor, R. (2011) 'The clinical effectiveness and cost-effectiveness of exercise referral schemes: A systematic review and economic evaluation', *Health Technology Assessment*, 15(44). doi: 10.3310/hta15440.

Pavey, T., Taylor, A., Fox, R., Hillsdon, M., Anokye, N., Campbell, J., Foster, C., Green, C., Moxham, T., Mutrie, N., Searle, J., Trueman, P. and Taylor, R. (2011) 'Effect of exercise referral schemes in primary care on physical activity and improving health outcomes: Systematic review and meta-analysis', *BMJ*, 342, p. d6462. doi: 10.1136/bmj.d6462.

Pearce, J., Witten, K., Hiscock, R. and Blakely, T. (2007) 'Are socially disadvantaged neighbourhoods deprived of health-related community resources?', *International Journal of Epidemiology*, 36(2), pp. 348–355. doi: 10.1093/ije/dyl267.

Phillips, E. and Pugh, D. (2000) *How to get a PhD. A handbook for students and their supervisors*. 3rd edn. Philadelphia: Open University Press.

Pibernik-okanovic, M., Prasek, M., Poljicanin-filipovic, T., Pavlic-renar, I. and Metelko, Z. (2004) 'Effects of an empowerment-based psychosocial intervention on quality of life and metabolic control in type 2 diabetic patients', *Patient Education and Counseling*, 52, pp. 193–199. doi: 10.1016/S0738-3991(03)00038-7.

Pillow, W. (2003) 'Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research', *International Journal of Qualitative Studies in Education*, 16(2), pp. 175–196.

Plumridge, L. and Thomson, R. (2003) 'Longitudinal qualitative studies and the reflexive self', *International Journal of Social Research Methodology*, 6(3), pp. 213–222. doi: 10.1080/1364557032000091815.

Popay, J. (2006) 'Community engagement for health improvement: Questions of definition, outcomes and evaluation. A background paper prepared for NICE', *NICE*. London.

Popay, J. (2010) 'Community empowerment and health improvement: The English experience', in Morgan, A., Davies, M., and Ziglio, E. (eds) *Health assets in a global context. Theory, methods, action*. London: Springer.

- Popay, J., Attree, P., Hornby, D., Milton, B., Whitehead, M., French, B., Kowarzik, U., Simpson, N. and Povall, S. (2007) *Community engagement in initiatives addressing the wider social determinants of health: A rapid review of evidence on impact, experience and process*. Lancaster: University of Lancaster.
- Popay, J., Rogers, A. and Williams, G. (1998) 'Rationale and standards for the systematic review of qualitative literature in health services research', *Qualitative Health Research*, 8(3), pp. 341–351. doi: 10.1177/104973239800800305.
- Potter, J. (1996) 'Discourse analysis and constructionist approaches: theoretical background', in Richardson, J. (ed.) *Handbook of qualitative research methods for psychology and the social sciences*. Leicester: The British Psychological Society, pp. 125–140.
- Public Health England (2015a) *A guide to community-centred approaches for health and wellbeing*. London. Available at: <https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches> [Accessed 7 Dec. 2015].
- Public Health England (2015b) *Stoke-on-Trent health profile 2015*. Available at: <http://www.apho.org.uk/resource/item.aspx?RID=171746> [Accessed 15 Aug. 2016].
- Raeburn, J. and Rootman, I. (1998) *People centred health promotion*. Chichester: John Wiley and Sons.
- Rappaport, J. (1984) 'Studies in empowerment: Introduction to the issue', *Prevention in Human Services*, (3), pp. 1–7.
- Rappaport, J. (1985) 'The power of empowerment language', *Social Policy*, 16(2), pp. 15–21.
- Rappaport, J. (1987) 'Terms of empowerment/exemplars of prevention: toward a theory for community psychology', *American Journal of Community Psychology*, 15(2), pp. 121–48.
- Reid, G. (2006) *Non-ICT executive perceptions of, and attitudes toward, ICT infrastructure projects*. University of Auckland.
- Richards, L. and Morse, J. (2013) *Readme first for a user's guide to qualitative methods*. 3rd edn. London: Sage.
- Riemsma, R., Pattenden, J., Bridle, C., Sowden, J., Mather, L., Watt, I. and

Walker, A. (2002) 'A systematic review of the effectiveness of interventions based on a stages-of-change approach to promote individual behaviour change.', *Health Technology Assessment*, 6(24), pp. 1–231.

Robertson, A. and Minkler, M. (1994) 'New health promotion movement: A critical examination', *Health Education and Behavior*, 21(3), pp. 295–312. doi: 10.1177/109019819402100303.

Robertson, N. and Vohora, R. (2008) 'Fitness vs. fatness: Implicit bias towards obesity among fitness professionals and regular exercisers', *Psychology of Sport and Exercise*, 9, pp. 547–557. doi: 10.1016/j.psychsport.2007.06.002.

Robson, C. (2002) *Real World Research. A resource for social scientists and practitioners-researchers*. 2nd edn. Oxford: Blackwell Publishers Ltd.

Rooney, B. L. and Schauburger, C. W. (2002) 'Excess pregnancy weight gain and long-term obesity: one decade later', *Obstetrics and Gynaecology*, 100(2), pp. 245–252.

Roussos, S. T. and Fawcett, S. B. (2000) 'A review of collaborative partnerships as a strategy for improving community health', *Annual Review of Public Health*, 21, pp. 369–402.

Ryan, R. M. and Deci, E. L. (2000) 'Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being.', *American Psychologist*, 55(1), p. 68.

Sallis, J., Owen, N. and Fisher, E. (2008) 'Ecological models', in Glanz, K., Rimer, R., and Viswanath, K. (eds) *Health Behavior and Health Education: Theory, Research and Practice*. 2nd edn. San Francisco: Jossey-Bass, pp. 465–485.

Sampson, R., Raudenbush, S. and Earls, F. (1997) 'Neighborhoods and violent crime: a multilevel study of collective efficacy', *Science*, 227, pp. 918–924.

Sandelowski, M., Holditch-Davis, D. and Harris, B. (1992) 'Using qualitative and quantitative methods: the transition to parent-hood of infertile couples', in Gilgun, J., Daly, K., and Handel, G. (eds) *Qualitative Methods in Family Research*. California: Sage, pp. 301–323.

Schatzman, L. (1991) 'Dimensional analysis: Notes on the alternative approach to the grounding theory in qualitative research', in Maines, D. R. (ed.) *Social organization and social process*. New York: Aldine, pp. 303–314.

- Schulz, A., Israel, B., Zimmerman, M. A. and Checkoway, B. N. (1995) 'Empowerment as a multi-level construct: perceived control at the individual, organizational and community levels', *Health Education Research*, 10(3), pp. 309–327. doi: 10.1093/her/10.3.309.
- Schwandt, T. A. (1997) *Qualitative inquiry: A dictionary of terms*. London: Sage.
- Sen, A. (1999) *Development as freedom*. Oxford: Oxford University Press.
- Shalowitz, M. U., Isacco, A., Barquin, N., Clark-kauffman, E., Delger, P., Nelson, D., Quinn, A. and Wagenaar, K. A. (2009) 'Community-based participatory research: A review of the literature with strategies for community engagement', *Journal of Developmental and Behavioral Pediatrics*, 30(4), pp. 350–361. doi: 10.1097/DBP.0b013e3181b0ef14.
- Shaw, M. (2004) 'Housing and public health', *Annual review of public health*, 25, pp. 397–418. doi: 10.1146/annurev.publhealth.25.101802.123036.
- Sixsmith, J., Boneham, M. and Goldring, J. E. (2003) 'Accessing the community: gaining insider perspective from the outside', *Qualitative Health Research*, 13(4), pp. 578–589. doi: 10.1177/1049732302250759.
- Skinner, T. and Cradock, S. (2000) 'Empowerment: What about the evidence?', *Practical Diabetes International*, 17(3), pp. 91–95.
- Smith, J., Flowers, P. and Larkin, M. (2009) *Interpretative phenomenological analysis*. London: Sage.
- Smith, J. and Osborn, M. (2003) 'Interpretative phenomenological analysis', in Smith, J. (ed.) *Qualitative Psychology. A practical guide to research methods*. London: Sage.
- Social Exclusion Unit (2001) *A new commitment to neighbourhood renewal: National strategy action plan*. London. Available at: <http://hdl.handle.net/10068/581283> [Accessed 10 Aug. 2016].
- Soulliere, D., Britt, D. W. and Maines, D. R. (2001) 'Conceptual modeling as a toolbox for grounded theorists', *Sociological Quarterly*, 42(2), pp. 253–269.
- South, J. and Phillips, G. (2014) 'Evaluating community engagement as part of the public health system', *Journal of Epidemiology and Community Health*, 68, pp. 692–696. doi: 10.1136/jech-2013-203742.
- South, J., Woodward, J. and Lowcock, D. (2007) 'New beginnings: Stakeholder

- perspectives on the role of health trainers', *The Journal of the Royal Society for the Promotion of Health*, 127(5), pp. 224–230.
- Sparker, A. (2005) 'Narrative analysis: Exploring the whats and hows of personal stories', in Holloway, I. (ed.) *Qualitative research in health care*. Berkshire: Open University Press, pp. 191–208.
- Stead, L., Hartmann-Boyce, J., Perera, R. and Lancaster, T. (2013) 'Telephone counselling for smoking cessation', *Cochrane Database of Systematic Reviews*, (3).
- Stebbins, R. (1997) 'Lifestyle as a generic concept in ethnographic research', *Quality & Quantity*, 31, pp. 347–360.
- Stephoe, A. and Feldman, P. J. (2001) 'Neighborhood problems as sources of chronic stress: Development of a measure of neighborhood problems, and associations with socioeconomic status and health', *Annals of Behavioral Medicine*, 23(3), pp. 177–185.
- Stokols, D. (1992) 'Establishing and maintaining healthy environments. Toward a social ecology of health promotion.', *The American Psychologist*, 47(1), pp. 6–22.
- Strauss, A. (1987) *Qualitative analysis for social for social scientists*. Cambridge: Cambridge University Press.
- Strauss, A. and Corbin, J. (1998) *Basics of qualitative research: Techniques and procedures for developing grounded theory*. London: Sage.
- Sturges, J. and Hanrahan, K. (2004) 'Comparing telephone and face-to-face qualitative interviewing: a research note', *Qualitative Research*, 4(1), pp. 107–118.
- Stuteley, H. and Hughes, S. (2011) *Connecting Communities Handbook*. Exeter: University of Exeter.
- Swainston, K. and Summerbell, C. (2008) *The effectiveness of community engagement approaches and methods for health promotion interventions. Rapid Review Phase 3 (including consideration of additional evidence from stakeholders)*. NICE.
- Tengland, P.-A. (2007) 'Empowerment: a goal or a means for health promotion?', *Medicine, Health Care, and Philosophy*, 10(2), pp. 197–207. doi: 10.1007/s11019-006-9027-1.
- Thirlaway, K. and Upton, D. (2009) *The psychology of lifestyle. Promoting healthy*

behaviour. New York: Routledge.

Thomas, S. L., Hyde, J., Karunaratne, A., Kausman, R. and Komesaroff, P. A. (2008) "They all work...when you stick to them": A qualitative investigation of dieting, weight loss, and physical exercise, in obese individuals', *Nutrition Journal*, 7(34), pp. 1–7. doi: 10.1186/1475-2891-7-34.

Tones, K. (1998) 'Empowerment for thealth: the challenge', in Kendall, S. (ed.) *Health and empowerment: Research and practice*. London: Arnold.

Tones, K. and Tilford, S. (2001) *Health promotion, effectiveness, efficiency and equity*. Cheltenham: Nelson Thornes.

Toomey, A. H. (2009) 'Empowerment and disempowerment in community development practice: eight roles practitioners play', *Community Development Journal*, 46(2), pp. 181–195. doi: 10.1093/cdj/bsp060.

Trochim, W. M. and Donnelly, J. P. (2008) *The research methods knowledge base*. Mason, OH: Atomic Dog/Cengage Learning.

Tufford, L. and Newman, P. (2010) 'Bracketing in qualitative research', *Qualitative Social Work*, 11(1), pp. 80–96. doi: 10.1177/1473325010368316.

van Uden-kraan, C., Drossaert, C., Taal, E., Shaw, B., Seydel, E. and van de Laar, M. (2008) 'Empowering processes and outcomes of participation in online support groups for patients with breast cancer, arthritis , or fibromyalgia', *Qualitative Health Research*, 18(3), pp. 405–417.

Urquhart, C. (2013) *Grounded Theory for qualitative research. A practical guide*. London: Sage.

Urquhart, C. and Fernandez, W. (2006) 'Grounded theory method: the researcher as blank slate and other myths', in *ICIS 2006 proceedings*, p. 31.

Ussher, M., Stanbury, L., Cheeseman, V. and Faulkner, G. (2007) 'Physical activity preferences and perceived barriers to activity among persons with severe mental illness in the United Kingdom', *Psychiatric Services*, 58(3), pp. 5–8.

Vaismoradi, M., Turunen, H. and Bondas, T. (2013) 'Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study', *Nursing and Health Sciences*, 15(3), pp. 398–405. doi: 10.1111/nhs.12048.

Vartanian, L. R. and Shaprow, J. G. (2008) 'Effects of weight stigma on exercise motivation and behavior: a preliminary investigation among college-aged females',

Journal of Health Psychology, 13(1), pp. 131–138. doi: 10.1177/1359105307084318.

Vermeire, E., Wens, J., Van Royen, P., Biot, Y., Hearnshaw, H. and Lindenmeyer, A. (2009) 'Interventions for improving adherence to treatment recommendations in people with type 2 diabetes mellitus', *Cochrane Database of Systematic Reviews*, (2). doi: 10.1002/14651858.CD003638.pub2.

Virtanen, H., Leino-kilpi, H. and Salanterä, S. (2007) 'Empowering discourse in patient education', *Patient Education and Counseling*, 66, pp. 140–146. doi: 10.1016/j.pec.2006.12.010.

Wade, D. T. and Halligan, P. W. (2004) 'Do biomedical models of illness make for good healthcare systems?', *BMJ*, 329, pp. 1398–1402.

Wallerstein, N. (1992) 'Powerlessness, empowerment, and health: implications for health promotion programs', *American Journal of Health Promotion*. Sage, 6(3), pp. 197–205.

Wallerstein, N. (2006) *What is the evidence on effectiveness of empowerment to improve health?* Copenhagen: WHO Regional Office for Europe. Available at: <http://www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making/publications/pre2009/what-is-the-evidence-on-effectiveness-of-empowerment-to-improve-health> [Accessed 3 May. 2016].

Walliman, N. (2001) *Your research project. A step-by-step for the first-time researcher*. London: Sage.

Warren, C. (2012) 'Interviewing as social interaction', in Gubrium, J., Holstein, J., Marvasti, A., and McKinney, K. (eds) *The SAGE handbook of interview research. The complexity of the craft*. 2nd edn. London: Sage, pp. 129–142.

Wetherell, M. (2001) 'Debates in discourse research', in Wetherell, M., Taylor, S., and Yates, S. (eds) *Discourse theory and practice: A reader*. London: Sage.

White, C. and Butt, A. (2015) *Inequality in health and life expectancies within Upper Tier Local Authorities: 2009 to 2013*. London: ONS. Available at: <http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/inequalityinhealthandlifeexpectancieswithinuppertierlocalauthorities/2009to2013> [Accessed 19 Jul. 2016].

White, J., Woodward, J. and South, J. (2013) 'Addressing inequalities in health, what is the contribution of health trainers?', *Perspectives in Public Health*, 133(4), 268

pp. 213–220. doi: 10.1177/1757913913490853.

Whitehead, D. (2004) 'Health promotion and health education: advancing the concepts.', *Journal of Advanced Nursing*, 47(3), pp. 311–20. doi: 10.1111/j.1365-2648.2004.03095.x.

Whitehead, M. (1991) 'The concepts and principles of equity and health', *Health Promotion International*, 6(3), pp. 217–228.

Whitehead, M. and Dahlgren, G. (2006) *Concepts and principles for tackling social inequities in health: Levelling up part 1*. Copenhagen: WHO Regional Office for Europe.

WHO (1986) *Ottawa Charter for health promotion*. Ottawa. Available at: <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/> [Accessed 8 Apr. 2015].

WHO (2002) *Community participation in local health and sustainable development: approaches and techniques*. Copenhagen. Available at: <http://apps.who.int/iris/handle/10665/107341> [Accessed 1 Aug. 2014].

WHO (2003) *The financial crisis and global health*. Copenhagen. doi: 10.1016/j.jana.2012.03.001.

WHO (2005) *Preventing chronic diseases, a vital investment*. Geneva. Available at: http://www.who.int/chp/chronic_disease_report/en/ [Accessed 19 Jul. 2016].

WHO (2006) *Constitution of the World Health Organization. Forty-fifth edition of basic documents*. New York. Available at: www.who.int/governance/eb/who_constitution_en.pdf [Accessed 01 Mar. 2016].

WHO (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva. Available at: http://www.who.int/social_determinants/thecommission/finalreport/en/ [Accessed 11 Apr. 2016].

WHO (2009) *The financial crisis and global health*. Geneva. Available at: http://www.who.int/topics/financial_crisis/en/ [Accessed 05 Jul. 2016].

WHO (2010a) *Equity, social determinants and public health programmes*. Geneva. Available at: <http://apps.who.int/iris/handle/10665/44289> [Accessed 5 May. 2016].

WHO (2010b) *Global status report on noncommunicable diseases*. Geneva. Available at: http://www.who.int/nmh/publications/ncd_report2010/en/ [Accessed

29 Jun. 2014].

Wiggins, N. (2011) 'Popular education for health promotion and community empowerment: A review of the literature', *Health Promotion International*, 27(3), pp. 356–371. doi: 10.1093/heapro/dar046.

Williams, E. D., Stamatakis, E., Chandola, T. and Hamer, M. (2011) 'Assessment of physical activity levels in South Asians in the UK: findings from the Health Survey for England', *Journal of Epidemiology and Community Health*, 65, pp. 517–521. doi: 10.1136/jech.2009.102509.

Willig, C. (2008) *Introducing qualitative research in psychology*. 2nd edn. Berkshire: Open University Press.

Willig, C. (2012) *Qualitative interpretation and analysis in psychology*. New York: Open University Press.

Willig, C. (2013) *Introducing qualitative research in psychology*. Maidenhead: McGraw-Hill Education.

Wilson, P. M., Kendall, S. and Brooks, F. (2007) 'The expert patients programme: a paradox of patient empowerment and medical dominance', *Health and Social Care in the Community*, 15(5), pp. 426–438. doi: 10.1111/j.1365-2524.2007.00701.x.

Wingard, D., Berkman, L. and Brand, R. (1982) 'A multivariate analysis of health-related practices. A nine-year mortality follow-up of the Alameda county study', *American Journal of Epidemiology*, 116(5), pp. 765–775.

Woodall, J., Raine, G., South, J. and Warwick-Booth, L. (2010) *Empowerment and health and wellbeing: Evidence review*. Leeds: Centre for Health Promotion Research, Leeds Metropolitan University. Available at: <http://www.apho.org.uk/resource/view.aspx?RID=96495> [Accessed 03 Oct. 2014].

Wrigley, N., Warm, D. and Margetts, B. (2003) 'Deprivation, diet, and food-retail access: findings from the Leeds "food deserts" study', *Environment and Planning*, 35, pp. 151–188. doi: 10.1068/a35150.

Yardley, L. (2000) 'Dilemmas in qualitative health research', *Psychology & Health*, 15(2), pp. 215–228. doi: 10.1080/08870440008400302.

Zautra, A., Hall, J. and Murray, K. (2008) 'Community development and community resilience: an integrative approach', *Community Development*, 39(3),

pp. 130–147. doi: 10.1080/15575330809489673.

Zimmerman, M. (1990) 'Taking aim on empowerment research: On the distinction between individual and psychological conceptions', *American Journal of Community Psychology*, 18(1), pp. 169–177. doi: 10.1007/BF00922695.

Zimmerman, M. (2000) 'Empowerment theory: psychological, organizational and community levels of analysis', in Rappaport, J. and Seidman, E. (eds) *Handbook of community psychology*. New York: Academic/Plenum Publishers, pp. 43–63.

Appendices

Appendix 1: MCM demographic form



community matters

Connecting Communities



More about our community

Design 2013 Chris Atkinson

Today's Date / /

Full Postcode

Ethnic Group

White British Irish

Mixed White & Black Caribbean
 White & Black African
 White & Asian

Asian Indian Pakistan
 Bangladeshi Chinese

Black British Caribbean
 African

Other (please specify)

Work Status

In full-time work
 In part-time work
 Student
 Unemployed
 Retired
 Looking after home/family
 Unable to work for health reasons
 Other (please specify)

Gender Male Female

Age Group

U18 18-25 26-40 41-60 61-75 75+ State your age (optional)



community matters
Connecting Communities

Thank you for taking the time to complete this questionnaire.

Appendix 2: MCM interview schedule (baseline)

PROGRAMME: My Community Matters (MCM)

Have you heard of MCM before?

What do you understand by MCM?

- *What do you think the Community Development Workers' role is?*
- *What do you think MCM is about?*
- *What is it trying to achieve? What is the purpose of MCM?*

Could you describe how you got involved in MCM?

- *Where did you hear about MCM?*
- *What made you come along?*
- *When did you start to attend MCM meetings/events/activities? What types of activities?*
- *What made you keep attending meetings?*

What do you think about MCM?

- *How do you feel about the approach that MCM is using?*
- *What aspects of MCM have worked well so far?*
- *What aspects of MCM could be improved? How?*

AREA WHERE YOU LIVE or COMMUNITY

How would you describe your community (or area where you live)?

- *What area do you consider to be your community?*
- *What about people who live in your community? Do you feel connected in your community? Let us know about it*
- *What about physical aspects (facilities, activities) of the community?*
- *What about access to services in your community?*

What do you think about your community?

- *What do you like about your community?*
- *What issues concern you, if at all? What you don't like as much about your community?*

How, if at all, can MCM impact your community?

- *Do you think MCM can impact somehow your community? How?*

HEALTH

How do the issues and concerns that you have from the area where you live affect you?

- *Tell me how do you feel about this [issues happening in the community]?*
- *Tell me how you cope with this [issues happening in the community]?*

What do you think about the general health of people living in your community?

TERMINOLOGY TO EXPLORE DURING INTERVIEW

- *How would you define (WORD)?*

Health / Wellbeing / Lifestyle	Community-based/led
Neighbourhood	Partnership
Community	Community development

Appendix 3: LS interview schedule (baseline)

Questions: Programme	
	<p>Could you describe how you got involved in the LS?</p> <ul style="list-style-type: none"> · <i>When is your first appointment? What is making you to attend it?</i> · <i>Where did you hear about the LS?</i> · <i>Why have you been referred to the LS? And who referred you?</i>
	<p>What do you understand by the LS?</p> <ul style="list-style-type: none"> · What do you think it is going to be about?
	<p>What do you think the LS is trying to achieve?</p> <ul style="list-style-type: none"> · What are the LS objectives from your point of view?
	<p>Have you been informed about how the LS works?</p> <ul style="list-style-type: none"> · How does it work? What's its approach? · How do you feel about the LS approach?
	<p>What are your personal reasons to take part?</p> <ul style="list-style-type: none"> · Why are you attending the first appointment?
	<p>What do you expect from the LS?</p> <ul style="list-style-type: none"> · What would like to achieve through attending the meetings with the Lifestyle Coach? · Have you tried anything like this before?
	<p>What do you think about the LS so far?</p>

Questions: Health-related	
	<p>How could the LS affect you?</p> <ul style="list-style-type: none"> · <i>Tell me how you feel about attending on the (date) an appointment with (name), your lifestyle coach?</i>

Questions: Terminology to explore	
<p>Lifestyle, Health, Wellbeing, Community, Neighbourhood</p>	<p>Individual-based/level; Community-based/led</p>

Appendix 4: Ethical considerations for the research

- **Informed consent**

The history of informed consent started with the horrors occurring at Nazi extermination camps and entered the field of social sciences a few decades ago, especially amongst English speaking countries (Marzano, 2012). Written informed consent was obtained prior the start of the interview.

- **Protection of participants**

International ethical frameworks ensure researchers adhering to ethical principles of respect, beneficence and justice. Respect for research participants involves a consideration of potential physical, economic, psychological, legal and social harm. Those have been addressed in this research by guarding anonymity at different stages of this research (data collection, analysis and dissemination), following Heggen and Guillemin's suggestions (2012), as described next..

During the data collection stage, the researcher made considerable efforts to build rapport with the research participants in order to encourage participants to share their experiences with the programmes, treating the interviewees as participants who contribute to the generation of data and trying to find an appropriate balance, where boundaries were not pushed in order to get rich data. Research participants were given the choice for a home interview or elsewhere, at a convenient venue, ensuring they had a say in terms of meeting at a location that was comfortable and accessible to them. All participants but one opted for a home visit, which warranted familiarity with the meeting location. Participants were also able to select the day of the week and the time. Giving participants the opportunity to choose themselves for a convenient location and time was intentionally carried out in order to enable participants to talk more freely because of meeting in a familiar place.

During the analysis stage, this research employed in some occasions a person outside the research team to transcribe interviews into text. This transcriber was selected from a different city, who is regularly employed by Staffordshire University researchers. Therefore, she is familiar with ethical and data protection requirements.

During the publication and dissemination stage, personal information that could identify participants was anonymised when reporting findings from interviews. Interviewees were informed that certain illustrative text extracts from the interview transcripts might be used as part of the thesis (and scientific articles, reports, presentations) and they would be presented using pseudonyms and removing any identifying material.

Practicing reflexivity throughout each stage of the research process is well-established in terms of enhancing methodological rigor in qualitative research. Reflexivity also enables ethical rigor, as aspects that are 'not quite right' can surface during reflective practice (Heggen and Guillemin, 2012). As an example, during one interview I did not notice that the participant was feeling uncomfortable with some of the questions in relation to her weight. I only noticed this possible discomfort once I was transcribing the interview. Reflecting made me realise about the problem and helped me to be more alert and sensitive during the rest of the research process.

- **Participant de-briefing**

Participants were de-briefed at the end of the interviews and given the opportunity to ask further questions. Time allocated to interview appointments was generous to give sufficient time to conduct interviews, allowing participants to find their own pace, and to appropriately end the interview, avoiding abrupt and impolite terminations (Warren, 2012). The researcher exited participants' home after having the feeling that the participant had been able to restore a similar state of mind as at the start of the interview.

- **Withdrawal from research**

Participants were informed that they had the right to withdraw from this research at any time, without needing to give a reason. Participants were also informed that they would have then the right to request the researcher to destroy any data generated during the research process.

- **The right to see results**

Participants were given the opportunity to access the dissemination materials generated from this research, including a summary and a final report produced for organisers and commissioners of both programmes; final thesis; and forthcoming scientific articles. Participants were also asked if they were interested in accessing further material, with some requesting access to interview transcripts.

Appendix 5: Participant information sheet (LS and MCM)



Dear Sir / Madam,

Thank you for taking the time to read this information sheet. I am part of a team from the Faculty of Health Sciences at Staffordshire University and our research focuses on improving health of populations. We would like to invite you to take part in the evaluation of the 'Lifestyle Service' that you have been referred to.

This information sheet is designed to inform you about the programme because it is important to understand why the study will be done before you decide whether or not to take part. Please take time to read the following information carefully. Please take your time before coming to a decision and please feel free to ask any questions if anything is unclear or if you would like more information.

What is the purpose of the study?

The purpose of this study is to evaluate the 'Lifestyle Service' by learning more about your experiences, opinions of the programme and your health. This information will help the programme organisers to understand more about the different aspects of the programme and to help to develop and improve the programme in the future.

Why have I been chosen?

You have been chosen because you have been referred to the 'Lifestyle Service'. A number of other individuals in Stoke-on-Trent who are also taking part in the programme will also be asked to participate.

Do I have to take part?

Taking part is voluntary. It is up to you whether or not to take part. If you decide to participate then you are free to withdraw from the evaluation at any time without stating a reason. You will not be disadvantaged in any way if you decide that you do not wish to take part or wish to withdraw from the study at any time.

What will I be asked to do if I decide to take part?

You will be asked to take part in an interview that will last between 30 and 60 minutes. The interview would take place before your first appointment with your Lifestyle Coach. If you give consent to be contacted for further conversations, you may be invited to take part in a follow-up individual interview in 6 months and at the end of your involvement in the programme (one year from now). Interviews will involve questions relating to your expectations, experiences, and perceptions of the 'Lifestyle Service', and also regarding your own health. To ensure that we have an accurate account, the interview would be audio recorded. We would also ask your Lifestyle Coach to provide us with some of the information that they routinely gather during your meetings with the Coach (e.g., reason for referral, lifestyle goals).

Will taking part in the study be kept confidential?

All information you provide will be stored securely. Only members of the Staffordshire University evaluation team will have access to the names of those taking part. Consent forms and interview recordings will be kept in a locked draw at Staffordshire University for the duration of the study, and up to one year after the publication of any research findings. After this time all consent forms and interview tapes will be destroyed. Any information on the interview transcripts that allows identification will be removed. Participant identity codes will be used to identify those who have taken part to ensure your anonymity.

What are the benefits of taking part?

The information that arises from this study will help to evaluate the 'Lifestyle Service'. Finding out about your experiences will help to improve the programme in the future. Please be assured that any information you share with us will be anonymised. You will not be identifiable from any reports that are produced as a result of this work.

What will happen with the results of the study?

The results of the study will be written up into a report for the organisers of the programme and publication in academic journals. All results will be reported such that no individuals can be identified.

If you wish, you will receive a copy of this report. It is hoped that finding out about your experiences of the programme will help organisers to make improvements to the programme. We also intend to publish some of the findings in professional journals to share the findings with other professionals in the area.

If you need further information, please contact:

Maria Romeo-Velilla
Doctoral Student

Dr. Christopher Gidlow
Senior Research Fellow

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Faculty of Health
Leek Road, Stoke-on-Trent
ST4 2DF

Email:

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Telephone: 0178 229 4089

Email:

C.Gidlow@staffs.ac.uk

Telephone: 0178 229 4330

Dear Sir / Madam,

Thank you for taking the time to read this information sheet. I am part of the My Community Matters team and I am based in the Faculty of Health Sciences at Staffordshire University. My work focuses on improving well-being of populations living in communities. I would like to invite you to take part in the evaluation of 'My Community Matters' programme that you have been involved with.

This information sheet is designed to inform you about the programme because it is important to understand why the study will be done before you decide whether or not to take part. Please take time to read the following information carefully. Please take your time before coming to a decision and please feel free to ask any questions if there is anything that is unclear or if you would like more information.

What is the purpose of the study?

The purpose of this study is to evaluate 'My Community Matters' Programme by learning more about your experiences and opinions of the programme, your health and your surrounded neighbourhood area. This information will help the programme organisers to understand more about the different aspects of the programme and to help to develop and improve the programme in the future.

Why have I been chosen?

You have been chosen because you have been involved with the 'My Community Matters' programme. A number of other individuals in Stoke-on-Trent who have also taken part in the programme will also be asked to take part.

Do I have to take part?

Taking part is voluntary. It is up to you whether or not to take part. If you decide to participate then you are free to withdraw from the evaluation at any time without stating a reason. You will not be disadvantaged in any way if you decide that you do not wish to take part or wish to withdraw from the study at any time.

What will I be asked to do if I decide to take part?

You will be asked to take part in a group interview and two individual interviews that will last between 30 and 60 minutes. The group interview will take place in same location as 'My Community Matters' in (*specify community venue*). Other local residents from your community will be also invited to take part in this group interview. If you give consent to be contacted for further conversations, you may be invited to take part in a follow-up individual interviews. These individual interviews will take place at a convenient community venue or at your home, depending on your preference. Group and individual interviews will involve questions relating to your experiences, attitudes and opinions of 'My Community Matters' programme, and also regarding your own health and perceptions of your neighbourhood area. To ensure that I have an accurate account of your experiences the interview will be audio recorded.

Will taking part in the study be kept confidential?

All information you provide will be stored securely. Only members of the Staffordshire University evaluation team will have access to the names of those taking part. Consent forms and interview recordings will be kept in a locked draw at Staffordshire University for the duration of the study, and up to one year after the publication of any research findings. After this time all consent forms and interview tapes will be destroyed. Any information on the interview transcripts that allows identification will be removed. Participant identity codes will be used to identify those who have taken part to ensure your anonymity.

What are the benefits of taking part?

The information that arises from this study will help to evaluate 'My Community Matters' programme. Finding out about your experiences will help to improve the programme in the future. Please be assured that any information you chose to tell us will be anonymised.

What will happen with the results of the study?

The results of the study will be written up into a report for the organisers of the programme and publication in academic journals. All results will be reported such that no individuals can be identified.

If you wish, you will receive a copy of this report. It is hoped that finding out about your experiences of the programme will help organisers to make improvements to the programme. I also intend to publish some of the findings in professional journals to share the findings with other professionals in the area.

If you need further information, please contact Maria Romeo-Velilla

Staffordshire University

Email: r021242c@student.ac.uk

Faculty of Health

Telephone: 0178 229 4121

Leek Road, Stoke-on-Trent

ST4 2DF

Appendix 6: Participant consent form

Title of Project: Evaluation of 'My Community Matters' / 'the Lifestyle Service' project

Name of Researcher: Maria Romeo-Velilla

Please tick the appropriate box(es) on the right if you agree with the correspondent statement(s):

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

3. I understand that the group interview will be audio taped for the purposes of an accurate account of my experiences and for data analysis purposes.

4. I agree to be contacted again to take part in further interviews via letter, email or telephone.

5. I agree to take part in the above study.

Name of participant Date Signature

Maria Romeo-Velilla, Researcher Date Signature

1 for participant; 1 for researcher

Appendix 7: LS interview schedule (follow-up, initial interviews)

INTRO

Anything **IMPORTANT** that you would like to tell me since we last spoke?

PROGRAMME

Can you tell me about your experience with the Lifestyle Service?

Imagine I am new to the Lifestyle Service, how would you explain to me how the LS works?

- *How is LS run?*
- *How are goals set?*
- *How have the solutions been found?*

Can you tell me about changes that you have noticed and might be related to your involvement with the Lifestyle Service? How have these changes occurred?

- *How is your life different since the start of the LS, if at all?*
- *How is your health different since the start of the LS, if at all?*
- *How are YOU different, if at all?*

How, if at all, have you been enabled to... make decisions?... Make choices?... take action?

- *How have you gained control over your health, if at all?*
- *How have you gained control over the process of losing weight, if at all?*

How did has your involvement with the LS helped you to manage your weight?

FOLLOW UP QUESTIONS (from baseline)

- *Support was an expectation that most participants stated during the previous interview. How have you been supported? Can you give an example please?*

EVOLUTION OF QUESTIONS (from this follow-up interview)

Note: To develop once a few interviews have been conducted and analysed

TERMINOLOGY TO EXPLORE DURING INTERVIEW

- *How would you define xxxx? Dieting , wellbeing*

Appendix 8: LS interview schedule (follow-up, final interviews)

INTRO

Anything IMPORTANT that you would like to tell me since we last spoke?

PROGRAMME

Can you tell me about your experience with the Lifestyle Service?

Imagine I am new to the Lifestyle Service, how would you explain to me how the LS works?

- *How is LS run?*
- *How are goals set?*
- *How have the solutions been found?*

Can you tell me about changes that you have noticed and might be related to your involvement with the Lifestyle Service? How have these changes occurred?

- *How is your life different since the start of the LS, if at all?*
- *How is your health different since the start of the LS, if at all?*
- *How are YOU different, if at all?*

How, if at all, have you been enabled to... make decisions?... Make choices?... take action?

- *How have you gained control over your health, if at all?*
- *How have you gained control over the process of losing weight, if at all?*

How did has your involvement with the LS helped you to manage your weight?

EVOLUTION OF QUESTIONS (from this follow-up interview)

- *Can you tell me what would you do when you were facing a particular difficulty at the beginning of the programme? Can you tell how this has changed, if at all? Examples?*
- *Can you give me an example of something that you have changed and has become a habit? How was this identified? How was this addressed? How did it become a habit?*
- *What's made you to take ownership/control?*

TERMINOLOGY TO EXPLORE DURING INTERVIEW

- *How would you define xxxx? Dieting , wellbeing*