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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Healthy Food Made Easy

Evaluation

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Executive summary

The Healthy Food Made Easy programme

Healthy Food Made Easy [HFME] is a health-service initiated community-based and community-delivered food and nutrition programme. It has been delivered in communities across Ireland since 1992, including in Dún Laoghaire-Rathdown, where it has been delivered in conjunction with the Southside Partnership since September 2007.

The HFME programme can be described as a 'community food project'. There is increasing interest in such projects in Ireland and internationally and they take a variety of forms.

Evaluation terms of reference

This independent evaluation was commissioned by the Southside Partnership and addresses delivery of HFME in 2007-08. The evaluation seeks to:

1. determine if the programme is *meeting its original objectives*
2. *inform the ongoing planning and development* of the programme
3. *assess the coordinator's attitude* towards the programme
4. *assess the peer-leaders' attitudes* towards the programme

Specifically, the evaluation sought to:

- place the HFME intervention in the broad context of related and similar community food projects internationally and nationally
- identify what is already known about this particular project
- clarify a set of appropriate and reliable performance indicators to assess the outcomes of this project
- gather relevant qualitative and quantitative data to reflect people's experiences of the project, in line with the identified indicators
- analyse the findings
- report any recommendations to the commissioners of the evaluation and to other key stakeholders

Methodology

The evaluation adopted a mixed methods approach that included documentary review; secondary quantitative analysis of internal evaluations; focus groups; structured interviews; and observation.

A review of relevant literature, including prior evaluations of similar and related interventions was undertaken. This allowed the evaluation to place the HFME project in the historical and policy-related contextual framework of similar community food projects in Ireland and internationally.

The staff of the HFME project had gathered a range of feedback material prior to the evaluation: an invaluable source of information. It included: peer leaders'

evaluations of their own training (n=12); peer leaders' evaluations of course delivery (n=33); and participants' end-of-course surveys (n=136).

The evaluators carried out two semi-structured interviews with the Programme Coordinator; six semi-structured interviews with peer leaders; two focus group discussions with programme participants; and one observation of programme delivery.

Data was analysed as appropriate through SPSS and N5 software packages. Draft copies of the evaluation report were circulated to interested parties in the Southside Partnership and the HSE for comment.

Prior evaluations

Prior evaluations of HFME and similar projects have been conducted in the period 2002-08. Key themes that have emerged include:

- it is not practicable to apply rigorous quantitative analysis of food-related practices or outcomes in relation to such projects: they are intended to foster involvement and to maximise participation; not to provide rigorous scientific data. This needs to be kept in mind in assessing the validity or effectiveness of such programmes
- the community-based and community-delivered aspect of such programmes is of key importance
- participants and those involved in programme delivery have, overall, expressed a positive view of the programmes
- there is some evidence of attitudinal and reported behavioural change towards healthier eating practices

Key findings of evaluation

Peer leader preparation and training

Peer Leaders' experience of training and of course delivery was positive. Barriers to course delivery related to occasional insufficient group size and literacy challenges for some participants. Peer leaders expressed satisfaction with delivery venues; the main issue was in relation to the transfer of equipment and materials. Peer leaders and participants indicated a high level of satisfaction with course delivery and content; involvement of the community dietitian; and dishes prepared.

Participants' views

All participants enjoyed the course (100%). Participants reported that they enjoyed the information (29%), the cooking (26%), interaction with others (15%) and 27% reported that they enjoyed 'everything'. 98% of participants indicated that they had learned something new about healthy eating, cooking or shopping; specifically nutritional information (46%) and practical tips (40%). 88% of participants reported that they had put an aspect of HFME into practice related to: changes to their own or their family's diet (31%); trying out new recipes (28%); or an unspecified change (28%). Just 12% reported that they had not made any change.

Peer leaders' views

The evaluation report provides a detailed account of peer leaders' views of the programme. Key findings included:

- HFME groups very diverse; included (amongst others) young mothers; people with substance abuse problems; older single men; participants from non-Irish backgrounds; adults with special needs; and over 50s women's groups
- good preparation crucial for effective delivery
- preparation time for a programme was variable, from two hours to two days, related to peer leaders' other activities and obligations
- peer leaders would adjust delivery to characteristics of specific groups, while maintaining the integrity of the programme material
- main challenge for HFME delivery was in delivering to those less then enthusiastic about programme; peer leaders had developed strategies for engaging participants in such cases
- 'hands-on' element of programme crucial to its success
- key attributes of successful tutors included: interest in the subject matter; aptitude for communication; basic scientific/health knowledge
- key aim to encourage healthy eating; to reduce reliance on pre-prepared foods; to engage in more cooking/food preparation; to enhance nutritional knowledge
- reluctant to identify target groups for the programme: relevant to a broad range of groups, including some not currently targeted
- saw programme aimed at 'pre-formed' groups; could be made available to members of the public on a more flexible basis
- programme identified as being 'community-owned' in four respects:
    - delivered in community locations
    - supported by the Partnership, a community body
    - delivered by peer leaders from the community rather than 'outside' professionals
    - delivered in an informal and collective 'community atmosphere'
- Coordinator and the Community Dietitian seen in a strongly positive light
- little knowledge or recognition of the specific role of the Partnership in funding or initiation of HFME
- suggestions for improvement related to extension to more target groups
- saw the main determinants of contemporary Irish eating patterns as lack of time/busyness and the influence of advertising on TV

Focus groups

Two focus groups were held with HFME participants in order to elicit their views on the programme. Participants in these groups were limited to older female participants in pre-formed groups, so it is not possible to draw conclusions from these groups for the programme as a whole.

Participants were positive about their involvement in HFME. They focused on the social aspect, both amongst those who were still involved in food preparation, and those who were reliant on community meals services or support from family members. Both groups also expressed a positive valuation of the health and nutrition-related information provided through the programme.

Discussion and conclusions

In relation to the four issues to be explored by the evaluation the following conclusions were reached:

Objective 1: is programme is *meeting its original objectives?*

Given the nature of the data available to the evaluation team, it is not possible to assess if the programme is meeting its longer term objectives in terms of changes to dietary practices or changes in morbidity and mortality outcomes. This is the case for similar types of interventions.

In terms of process outcomes, the evaluation concludes that:

1. participants have indicated an overwhelmingly positive assessment of the HFME programme
2. the programme coordinator has expressed a high level of satisfaction with the outcome of the programme
3. the programme is reaching a diverse range of participants, many of whom fall within the Southside Partnership's targeting of more 'vulnerable' and 'marginalised' groups in its catchment area.
4. peer leaders express satisfaction with the programme and have made suggestions for its extension
5. findings of this evaluation reflect those of previous evaluations of HFME and similar programmes in other areas in Ireland

Objective 2: to *inform the ongoing planning and development*

The evaluation points to areas that may be explored in terms of future development of the programme:

1. HFME has been positively assessed by all those involved in it. This may help to justify further delivery of the programme, or its extension into new community groups or cohorts.
2. The training of peer leaders is satisfactory and fit for purpose. The Partnership may wish to explore the issue of external accreditation (through FETAC or similar body) of this training.
3. The majority of courses were delivered to the satisfaction of the peer leaders. Main problems with delivery related to small group size and to literacy issues. These are issues that may need to be further considered.
4. HFME is reaching a broad and increasingly diverse range of target groups.
5. Peer leaders expressed satisfaction with the venues for delivery of HFME. Issues related to the suitability of some venues in terms of size, cooking facilities, and the difficulties in carrying equipment from car parks into the venue. This last issue is one that may merit some attention.

6. The evidence suggests two types of outcome from HFME. Most participants have obtained new knowledge and have, in some cases, made changes to food and eating practices. Other participants are not in a position to engage in food preparation: for example those with specific learning disabilities or the frail elderly. For these groups, the programme may provide a valued diversionary activity and may lead to sociable interaction. It may also provide some useful information related to nutrition. The broader outcomes related to social interaction, mental health and leisure/recreation may merit consideration.
7. The role of the Programme Coordinator and Community Dietitian were both strongly endorsed by the peer leaders.
8. Knowledge of the Partnership's role in the development and delivery of HFME was low. The Partnership may wish to explore alternative ways to communicate with peer leaders. The HFME Steering Group, for example, may wish to explore the possibility of peer leader representation

Objective 3: to *assess the coordinator's attitude* towards the programme
For reasons of confidentiality, the evaluation does not focus on the responses of any one individual. Nevertheless it is clear that for the Coordinator, the overall feeling is that the programme 'has worked'. Of particular note is the success in extending the programme to an expanding range of 'hard to reach' groups in the community.

Objective 4: to *assess the peer-leaders' attitudes* towards the programme
The peer leaders report a high level of satisfaction with the programme – from initial training, to ongoing support, to materials used. They have suggestions for improvement and development of the programme that the Partnership may wish to consider:

1. ensure that group sizes to not fall to an unsustainably low level
2. address the issue of transferring course equipment and materials from car to venue
3. dispense with the tuna bake from the recipe list
4. recognise that familiarisation with new delivery materials takes peer leaders' time
5. recognise that some participants may feel that they 'have to' attend sessions, and that this may impact on commitment and involvement
6. some peer leaders may appreciate a clearer indication of the level of available employment on the programme, particularly if they see their involvement as a key source of income
7. make use of contemporary design and marketing techniques in the design of the manual and associated materials, including use of the internet as a source of information
8. consider whether a basic knowledge of food/science/nutrition be a formal prerequisite for appointment as a peer leader
9. consider whether the target audience for HFME should be expanded beyond those identified as 'disadvantaged'

10. recognise that groups of older people may derive different types of positive outcome from the programme, more related to sociability than nutrition information
11. recognise the different important ways in which HFME can be expressed as 'community owned'
12. as outlined above, consider how the role of the Southside Partnership as originator of the programme might be better communicated to the peer leaders and consequently to participants
13. recognise as a key resource peer leaders' own orientations to food and eating at various stages of the programme

Other issues

Though outside of the original terms of reference, two other issues did emerge from the evaluation process. These reflect findings of previous evaluations:

i) the Partnership and the HFME Steering Group may wish to look more critically at the notion of *peer leadership*, and explore if it can be pushed further in involving and supporting more members of targeted groups to become actively involved in the delivery of the HFME programme in the future, perhaps through expansion of relevant training. This may help to ensure the future efficacy and sustainability of the programme.

ii) the Partnership may wish to examine the long-term position of the delivery of the HFME programme in particular, and of health and lifestyle programmes in general, in the context of its own strategic direction and development.

Recommendations

Evaluability

1. Consider processes for gathering data about the operation of the HFME programme, so as to enhance future evaluability. This may involve devising appropriate measures for the assessment of dietary practices, attitudes and knowledge. Such processes should recognise a) the difficulty and complexity of measuring food intake and dietary practices; and b) the need to be sensitive to issues of literacy, confidentiality and privacy.

Programme delivery

2. ensure that group sizes do not fall to an unsustainably low level: a minimum group size of six may be appropriate.
3. address the issue, for peer tutors, of transferring course equipment and materials from car to venue
4. recognise that familiarisation with new delivery materials takes peer leaders' time and may need to be costed into programme development
5. peer leaders should, where possible, be provided with a clearer indication of the level of available employment on the programme
6. make use of contemporary design and marketing techniques in the design of the manual and associated materials, including use of the internet as a source of information
7. consider whether a basic knowledge of food/science/nutrition be a formal prerequisite for appointment as a peer leader
8. consider whether the target audience for HFME should be expanded beyond those identified as 'disadvantaged'
9. recognise that groups of older people and those not in a position to prepare their own food may derive different types of positive outcome from the programme, more related to sociability than nutrition information
10. recognise as a key resource peer leaders' own orientations to food and eating at various stages of the programme
11. consider how participants' own knowledge can be formally recognised as an input to the programme
12. explore the possibility of peer leader representation on the HFME Steering Group.

Strategic issues

13. recognise how HFME can be variously expressed as 'community owned'
14. consider how to recruit more peer leaders directly from the HFME target audience
15. consider how the role of the Southside Partnership might be better communicated to peer leaders and participants
16. examine the options available to the Southside Partnership in relation to the programme, in terms of its medium and long-term strategic development, in relation to an enhanced role in the delivery of health and lifestyle-related services

1 The evaluation

1.1 Terms of reference

The request for tenders to undertake an evaluation of the Healthy Food Made Easy [HFME] project was issued by the Southside Partnership on 30 May 2008. On completion of a competitive tendering process, the contract to undertake the evaluation was awarded to a research team from the Institute of Technology, Sligo [Dr Perry Share] and the Children's Research Centre, Trinity College Dublin [Dr Michelle Share; Ruth Geraghty]. The evaluation commenced in July 2008 and was completed in December 2008.

1.2 Evaluation aims

The aims of the evaluation were set out in the *Invitation to tender* (30 May 2008) and were further developed in the proposal submitted to the Southside Partnership by the research team. The overall aim of the evaluation is to assess the effectiveness of the delivery of the HFME programme in the Dún Laoghaire/ Rathdown area by the Southside Partnership, in conjunction with the Health Service Executive [HSE]. In particular the evaluation, in line with the project brief, sought to:

1. determine if the programme is *meeting its original objectives*
2. *inform the ongoing planning and development* of the programme
3. *assess the coordinator's attitude* towards the programme
4. *assess the peer-leaders' attitudes* towards the programme

In order to fulfil these requirements, the evaluation process sought to:

- place the HFME intervention in the broad context of related and similar community food projects internationally and nationally
- identify what is already known about this particular project
- clarify a set of appropriate and reliable performance indicators to assess the outcomes of this project
- gather relevant qualitative and quantitative data to reflect people's experiences of the project, in line with the identified indicators
- analyse the findings
- report any recommendations to the commissioners of the evaluation and to other key stakeholders

This initial plan guided the development of the evaluation methodology, detailed below. This methodology was then adjusted in accordance with the availability of and access to data and resources.

2 Methodology

The evaluation aims were addressed through a mixed methods approach that involved documentary review; secondary quantitative analysis of internal evaluations; focus groups; structured interviews; and observation.

2.1 Documentary review

A review of relevant literature, including previous evaluations of similar interventions was undertaken. This included published material; unpublished or 'grey' literature, such as internal reports; as well as some unpublished drafts, where final versions were unavailable. This review has been used to inform the approach taken to the evaluation and to place the HFME project within the historical and policy-related contextual framework of similar community food projects in Ireland, and internationally.

2.2 Secondary analysis of internal evaluations

2.2.1 Peer leaders' evaluations of their training programme and course delivery

Three levels of internal evaluation were conducted on aspects of peer training and course delivery using questionnaires issued by the HFME organisers. The first evaluation examined the trainees' views on the HFME course before they embarked on their facilitation training (n =10). A second evaluation asked about peer leaders' perspectives on the training they had received (n = 12). The third evaluation sought peer leaders' views on aspects of course delivery in terms of barriers and enablers and their ratings of the appropriateness of the venue and feedback on the dishes cooked. These questionnaires (n=33) were completed for a total of 33 courses that were delivered in the period September 2007 to May 2008. All questionnaires were entered into an SPSS database and subjected to descriptive analysis.

2.2.2 Participant end-of-course surveys

At the end of each course participants completed a one-page evaluation survey. The brief survey consisted of open and closed ended questions about satisfaction with the course; what participants learned from the course; what they have put into practice; and general comments. These internal evaluation forms were administered by peer leaders and the results have been collated by the research team. Two hundred and twenty-nine surveys were available to the researchers for analysis. Data from a randomly-drawn sample of 136 surveys (60% of total sample frame) was entered into an SPSS database and descriptive frequency analysis was conducted. As demographic data was not collected in these surveys analysis and reporting is at a broad and descriptive level.

2.3 Focus groups

The terms of reference for the evaluation emphasised the need to assess the attitudes and experiences of peer leaders of delivering the HFME programme. Nevertheless, it was felt by the research team that there would be some added value for the evaluation if participants' perspectives were included. In the absence

of participant contact details it was necessary to gain access to participants through the HFME Coordinator. Access was arranged to two pre-existing groups who consented to participate in a focus group discussion. One group comprised six women who attended an active retirement group; the other comprised five women who attended a day centre for older people one day a week. The focus groups aimed to find out about people's motivation for attending; what aspects of the course interested them; whether food issues were prominent in their lives; what they could recall about the course; and the impact that the course had on their lives, as well as any recommendations for the future for similar groups as their own.

2.4 One-to-one structured interviews with peer leaders

Six one-to-one interviews were conducted with six peer leaders. These interviews were structured and lasted approximately one hour. The structured interview guide (Appendix 1) covered a broad range of topic areas:

- characteristics of peer leader, background and how they became involved
- experiences of delivering HFME sessions, from preparation to follow-up
- views about the programme - benefits for participants, intended and unintended outcomes
- views on programme components and organisational aspects of delivery, barriers and facilitators
- views on the future of the HFME programme
- general views on healthy eating

The interviews were tape recorded and transcribed. Transcripts were entered into QSR N5 qualitative analysis software which was used to analyse the material thematically.

2.5 Interviews with project coordinator

Two semi-structured one-to-one interviews were carried out with the HFME Course Co-ordinator. Each was of approximately two hours duration and written notes were made at the time of interview. The first interview aimed to obtain an overview of the HFME programme and to elicit detailed information in a number of areas. The second interview sought to confirm and illuminate some of the information obtained through other methods, and in particular to explore the strategic role of the HFME project within the overall activity of the Southside Partnership. The Education Coordinator of the Partnership also participated for the latter part of this second interview. The interviews were scanned for key themes and these were related to the other sources of data. For ethical reasons statements that can be sourced directly to individuals will be minimised in this report: this there will not be a specific analysis of these interviews.

2.6 Observation

Prior to embarking on data collection, one unstructured observation session was carried out at the final session of a HFME course on 10 July 2008. The aim of this observation session was to obtain a general feel for the delivery format of the

course and the level of participant interaction, as well as the possible generation of issues that could be explored with the peer leaders and participants during the data collection phase. Observation involved one researcher sitting as part of the group and observing the peer leader's delivery and the level of participant interaction in the session. Notes were recorded about issues that required further exploration. This exercise provided useful data in relation to guiding the development of the peer leader and Course Co-ordinator interviews.

2.7 Ethical considerations

The evaluation was conducted by adhering to good practice in the conduct of social research. All participants were provided with an information sheet (Appendix 2) that explained the purpose of the study and asked to sign a consent form if they were happy to participate. Participants were informed that their confidentiality would be protected and that they would not be named in the study findings.

3 Context and background

3.1 Community-based and community-led food projects

Healthy Food Made Easy is a health-service initiated community-based and community-delivered food and nutrition project. As such it falls within the category known as 'community food projects'. These are initiatives, either top-down or bottom-up, or a combination of both, that seek to place food and nutrition issues within a societal and social context. They seek to address issues of food poverty, food inequality and the social aspects of health. They also represent an alternative approach to nutrition education and health promotion. There are a broad variety of local food projects. As Dowler and Caraher (2003: 58) point out (referring to the UK context): they are:

> hard to characterise consistently. The term is used by a range of professionals and sectors to indicate initiatives which have in common: food (its production, preparation or consumption); local involvement (management, delivery, paid/unpaid workers) and state support (funding, space, professional input, transport equipment).

There has been significant interest in the linkages between people's food practices and their broader experience of health and wellbeing. There has been a particular concern with issues of obesity, and the increased incidence of related conditions such as diabetes; and in how food intake relates to broader questions of cardio-vascular health, cancers and other health outcomes (WHO, 2006).

In conjunction with individualised nutritional interventions there has been an increased interest in such community-based and community-delivered food projects (Contento, 2007). There has been recognition amongst health practitioners and policy-makers of the need to empower people themselves to make diet and lifestyle changes through a process of developing their knowledge, skills and resources in areas such as shopping and food preparation. Many of these projects and programmes are about 'reconnecting' people with a food landscape that has become increasingly industrialised, mobile and distant (Kneafsey et al, 2008). While many food projects have specifically targeted disadvantaged groups in the context of food poverty (eg All Ireland Healthy Food for All Initiative) other projects, particularly community gardening, take a broader remit (Share & Duignan, 2005; Share, 2006).

Hawkins et al (2008) argue that community-based approaches are an established strategy for health promotion. They point out that: 'cascading skills development via community based workers … is seen as mutually beneficial to public health professionals who lack local credibility and to community development professionals responding to local needs'. As such they seek to 'localise' the delivery of health promotion messages through the involvement of people 'from the community' or 'in the community', thus reducing the distance between the provider and the recipient of health promoting information. They may thus be more effective or efficient methods of promoting health than traditional education or public relations approaches. Such approaches also align with a key action area

of the Ottawa Charter for Health Promotion (1986) that calls for the strengthening of community action, the development of personal skills and the creation of supportive environments. These principles are furthered in the Bangkok Charter (2005) which indicates that effective health promotion requires participants to:

- *advocate* for health based on human rights and solidarity
- *invest* in sustainable policies, actions and infrastructure to address the determinants of health
- *build capacity* for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy
- *regulate and legislate* to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people
- *partner and build alliances* with public, private, nongovernmental and international organisations and civil society to create sustainable actions.

Writing within the UK context, Dowler and Caraher (2003: 57) note that the number and range of state-funded local food projects 'has increased as the link between food and health becomes more evident and local priorities are dominated by reducing inequalities in health and social exclusion'. While they see much merit in such programmes, they do point out that they may be unable to address broader, structural determinants of food and eating, such as retail planning activities and the operations of major food industry players. Rather, it may be that:

> [local food projects] cannot address longer-term challenges to social justice in that the realities of life lived on a low income, faced on a daily basis by diverse households, are by-passed in favour of quick solutions. Furthermore the rhetoric of dignity and self-help is used to cover up the lack of fundamental change and to locate both the 'problem' and the 'solutions' as belonging to those labelled – and living – as 'poor' (Dowler & Caraher, 2003: 57)

From this perspective, local food projects may be no more than a 'band aid' solution to issues of food and health inequality.

Against this pessimistic view, it may also be demonstrated that participants in local food projects do value them, and that such projects have both a long history, internationally, and are currently expanding in number and scope in many countries. The UK food body Sustain has argued that community food projects 'can be an essential component in the fight against diet-related disease and health inequalities' (Sustain, nd). In Scotland there is strong support at a ministerial level for community-based food and health activities. Community Food and Health (Scotland) supports low-income communities to have their say, to ensure that food policy is developed in a socially inclusive way (Community Food and Health Scotland, 2008: 2). In Australia, the Eat Well South Australia programme focused broadly on increasing the consumption of healthy food by children and young people in families (Smith et al, 2004). Evaluation of the programme pointed to the importance of understanding the capacity building elements of the work and the need for clarity about outcomes and planning and evaluation methods.

Community-based food projects are increasingly being used in the Irish context, following broader international trends (Kneafley et al, 2008). They have been supported, in particular, by bodies such as the Combat Poverty Agency and major non-governmental organisations such as Crosscare and the Society of St Vincent de Paul. In addition, they have obtained some support from the health services, through the then Health Boards and more recently through the Health Service Executive [HSE]. Such projects have included community gardening initiatives (Share and Duignan, 2005; Share, 2006); school gardening programmes (Organic Centre, 2008), school food schemes such as *Food Dudes* (Horne et al, in press); food cooperatives; and, of most relevance to this evaluation, cooking and nutrition programmes such as Eat Well, Be Well; Cook It!; and Healthy Food Made Easy. There is a small and rather fragmented literature on these programmes, with a dearth of systematic evaluation or analysis in the Irish context.

3.2 Measuring the outcomes of community-based food projects

According to McGlone et al (2005: 4) approaches to the evaluation of community food projects can usefully be divided into the following:

- *Impact measures* as short-term outcomes (such as nutritional knowledge; confidence in cookery; new skills in cookery; social support; views of users/participants)
- *Process measures* – why or how did the project or intervention work/not work (such as views of project workers; unexpected outcomes; cost, time and effort taken to run the project)
- *Outcome measures* as longer-term measures (eg nutritional intakes such as fruit and vegetable consumption; changes in clinical measures such as blood pressure, blood cholesterol)

This evaluation of the HFME was not in a position to examine the third of these: outcome measures. This would require extensive baseline data collection, and considerable effort in detailed recording of food intake and anthropometric features after the intervention had taken place. This was neither practicable nor reasonable, from the point of view of the project aims. For this reason, it was not possible to develop key performance indicators for the project: this issue will be further discussed in the final section of this report.

As McGlone et al point out (2005: 1): 'community food projects do not exist to produce evidence. The rigour required to produce evidence of effectiveness might be difficult for these projects to achieve'. Indeed, rigorous clinical evaluation of peer-led food and nutrition projects, even when they are conducted according to strict protocols, may indicate no observable change (Gibson, 2007). Rather, these are projects aimed at engagement of people at the community level: they are active interventions, not clinical research exercises. This is important to realise when the evaluation of such programmes is placed within a clinical or medico-scientific context. Nevertheless it is important for evaluation to address the first two aspects identified by McGlone et al: the impact and process measures. These aspects have been assessed through a number of methods, as outlined above.

4 Healthy Food Made Easy

The Department of Health and Children (nd: 55) incorporated nutritional health promotion into its activities in 1991. This period saw the establishment of community nutrition services, which reflected an expansion of dietetic activity outside of the hospital and into the community. The Food and Health Programme was initiated the following year (Newman and Associates, 2002: 3).

Within the former Health Board structure, community dietitians with a specific low-income brief were involved in the development of services and initiatives addressing food poverty at local level, specifically aimed at 'socially disadvantaged groups' (HFME manual, Foreword). The community dietitians now work in partnership with local community development organisations, such as Partnership companies, including the Southside Partnership which serves the Dún Laoghaire/ Rathdown local government area.

In 1994 the Health Promotion Unit of the Department of Health and Children, in conjunction with the Eastern Region Health Authority [ERHA] developed the Food and Health programme, a peer-led education programme among low-income groups. It was specifically 'aimed at women on low incomes' (Health Promotion Unit, nd).

The community-based programmes that have been developed include HFME, 'Eat Well, Be Well' and 'Cook It' (the latter adapted from a similar Northern Ireland programme). These activities were mainstreamed within the 2000 Health Promotion Strategy (DHC, 1999) and have been delivered in a variety of local areas (including Midlands; North Dublin; South Dublin; West Dublin; Cork; Galway; the South East) since that time.

4.1 Prior evaluations of HFME and related programmes

A number of evaluations of HFME and similar projects have been carried out. Some of these are only available in draft form and none is easily available in the public domain.

4.1.1 *Healthy Food Made Easy External Evaluation* (Newman and Associates, December 2002 – draft)

The HFME programme was delivered by the South Western Area Health Board [SWAHB] (Dublin) from 1992, where it had its origins in the Food and Health Programme, a peer-led nutrition intervention. Previous evaluations had been carried out in 1995 and 1997 and this evaluation was of the 2000 version of the programme, delivered in Clondalkin from February 2000.

The aims of this evaluation were to: assess the extent to which the project was meeting its objectives; its effectiveness as a peer-led initiative; the effectiveness of the teaching pack; how was the course received by participants; whether nutritional knowledge increased as a consequence of involvement in the course; trainers' and coordinator's attitudes towards the course; and relationship amongst the various stakeholders.

The evaluation sought to address both quantitative and qualitative measures. It involved a review of relevant documentation and literature and interviews with key stakeholders, though not with participants. It was noted in the evaluation report that it was not possible to accurately measure changes in participants' food or health practices, rather information from stakeholders could 'at best provide indications of change rather than absolute verifiable changes' (p. 6).

This evaluation had a strong focus on the organisation and management of the HFME and the efficacy of this. Specific questions were raised as to the ownership of the project within the community; the place of the project within the strategic development of health promotion within the then SWAHB; and the financial responsibility for the project.

The evaluation examined the role of the peer trainers. It described their recruitment and training; stressed the importance of their 'peer' (and non-'expert') status within the community; outlined the key supportive roles of the project coordinator and community dietitian; and noted that the delivery of the programme within community facilities (rather than in one central location) was of key importance. It also noted that it was important to build and maintain links with community-based organisations and networks.

The difficulties in obtaining reliable pre- and post-intervention data on participants' attitudes and knowledge were outlined. For example surveys could be viewed as a 'test'; language and literacy could provide barriers; and the use and usefulness of such information needed to be justified. Nevertheless the evaluation did suggest regular measurement of changes in attitude and response in order to inform service delivery: in other words such data could form a measure of the impact and effectiveness of the intervention.

The evaluation also addressed the HFME teaching pack and made some suggestions for revision. These largely focused on making the pack 'more contemporary' and the insertion of optional elements on specific issues (eg young mothers; older people). It was recommended that any such changes be based on consultation with stakeholders and participants.

The evaluation identified four key areas for further action: ownership and operating structure, involving closer links with community development organisations and other partners; a broadening of the pool of peer-leaders to reflect a more diverse constituency of participants; revision of the HFME pack; and more effective evaluation processes.

4.1.2 An evaluation of a peer-led food and health project in the HSE Midland Area (McEvoy, 2006 - incomplete draft)

The Peer-led Food and Health Project [PLFH] was operated in the Midlands Area of the HSE in conjunction with a local community development group. It delivered a peer-led nutrition programme over a period of 6 years (2000-2005). This evaluation sought to assess whether the project had achieved its objectives in terms of reach, targets, sustained behavioural change, sustainability and accountability.

The data for the evaluation was obtained through both quantitative and qualitative research methods. Secondary data used included prior reports and project documents; 'screener forms' were used to assess the extent to which participants reflected the targeting criteria for the programme; while a self-administered questionnaire was administered to participants and other stakeholders. The post-intervention response rate to questionnaires was low (*c.* 28%). In addition two focus group discussions were held with participants two months post-intervention.

The (draft) presentation of the data indicates that the programme appeared to be reaching the desired target groups (eg in receipt of state transfer payment; medical card holder; unemployment in household). There were apparent increases in the consumption of portions of fruit and vegetables; little change in specific nutritional knowledge, but a greater awareness of food labels. Participants reported the 'most enjoyable' aspects of the course to be 'learning' and 'cooking'.

4.1.3 Evaluation of the *Cook It!* programme in the HSE Dublin North East Region 2007. (No author indicated. 2007?)

The Cook It! programme is an initiative of the Health Promotion Agency of Northern Ireland. It was originally developed in Northern Ireland in 1995 and was introduced into the Dublin North East region of the Republic of Ireland in 1999. Cook It! shares some attributes with HFME: it is a train-the-trainer programme delivered to community or agency-based trainers, such as family support workers, that seeks to combine nutritional education with practical cookery sessions. The trainers have then gone on to deliver the material to a broad range of groups in the community in the former Dublin NE region including parents, teenagers, Travellers, people with disabilities and other groups.

The evaluation of this programme focused exclusively on the experiences of the Cook It! tutors. It identified the practicalities (including costs) of running 67 Cook It! courses in a variety of settings. Other issues identified included difficulties in delivering the programme; suggestions for improvement; future plans; alternative uses made of Cook It! materials (eg on other training or educational programmes); and additional comments and feedback. Overall those who responded (36% of identified Cook It! trainers) saw the programme in a very positive light.

4.1.4 *Healthy Food Made Easy Evaluation 2008* (Newman and Associates 2008 – draft)

This most recent evaluation was commissioned by the HSE, in connection with the revision of the HFME manuals/packs. The aims of the evaluation were to:

- assess and comment on the quality of the revised HFME pack and the strategy towards supporting its delivery and impact in communities
- provide feedback from test sites on the roll-out of the pack by peer leaders with a specific focus on courses targeting Travellers; early school leavers; young parents; low income mothers; and participants from a rural setting.
- comment on the range and nature of supports required HFME in communities.
- propose recommendations on the national roll-out of the HFME programme.

The evaluation report is based on data gathered through a range of means, including:

- observations, focus groups with, and indirect feedback from, participants on four of programmes, spanning an active retirement group in a rural community, early school leavers, young parents and low income mothers
- consultations with peer leaders and coordinators and with community partners
- interviews with community dietitians and with those dietitians with responsibility for revising the HFME pack.

The evaluation suggests (p. 8) that, in line with HSE population health policy, the HFME 'represents an inter-sectoral and multi-disciplined approach where community development and health promotion meet to the benefit of both and ultimately to the benefit of those participating in the programme'.

The draft evaluation report outlines responses to the new manual. These are generally positive and suggest only some detailed tweaking is required.

The report addresses organisational issues related to the delivery of the HFME programme. The supportive role of the community dietitians (through their visits in week five of the sessions) was seen as very positive. These visits were seen to act as an important 'back-up support and an avenue through which difficult or specialist questions could be addressed'. They were also valued by the dietitians as a way of monitoring the delivery of the programme.

There is interesting material in the report in relation to the degree of 'flexibility' that should be allowed in the delivery of the HFME programme. This is an issue that has not been explored to any great extent in prior evaluations. This report suggests that amendments might be possible to the delivery as a consequence of 'literacy, facilities, group dynamics and/or profile of the group (eg mobility was an issue for older participants'. Nevertheless there is a concern voiced that peer leaders might 'stray' from the predetermined content and 'risk portraying inaccurate nutritional information'. It is seen as important that this not occur, and that peer leader recruitment, training and support would help to ensure consistency in delivered content.

The broader issue of flexibility in the delivery of HFME is outlined as follows, and this points to possible tension between community 'ownership' of the programme, and the perceived importance of dissemination of 'accurate' scientifically-based information:

> A challenge exists between having a flexible approach to the delivery of HFME in line with local needs and having a standardised programme that is followed broadly by all. In other words, how much flexibility is tolerable? To what extent can peer leaders adapt, change and amend sessions and how, if at all, might this influence consistent standards across the programme?

In terms of the outcomes for HFME participants, the following are listed by the evaluation. These changes were reported by peer leaders. Participants:

- found the courses very informative and 'fun'
- have the confidence to try new ideas, new recipes and have done so
- changed the meals being prepared for their families
- in one instance a young mother started to do weekly grocery shopping, in another, replaced fizzy drinks with water.
- all noted their surprise at understanding labels, portion size and at how easy and cheap healthy options can be.
- said they were more conscious of their shopping habits and of shopping under pressure, planning for a week, rather than daily shopping and how to save on shopping bill.
- are more conscious of health and nutrition.
- emphasised the importance of the social dimension to the courses

In terms of governance, this evaluation stresses the value of the partnership approach between local partnership companies/community development associations and the HSE. Interestingly the evaluation points to the potential for such organisations to become involved to a greater extent in health and education related actions: this raises a challenge for the partnership and community bodies in defining their service delivery role vis-à-vis the health services.

The evaluation addresses issues of who attends the programmes, the degree of voluntarism involved for some participants, and how this impacts on delivery. It is noted that local coordinator support (at the community level) is important in encouraging high quality participation. The 'peer-led' model is discussed, with indications as to its key features.

The third section of the evaluation addresses the potential roll-out of HFME at the national level. This possibility is discussed in terms of strategic positioning; the strength of the evidence base; the financial and other resources required; standardised peer leader training; interagency working; Monitoring, Quality Assurance and Evaluation, coordination and communication. It is argued in this section that 'the evaluations of this programme to date provide strong evidence of its effectiveness as a health promotion initiative'.

4.1.5 Evaluations – overall findings

It must be said that there is not a great deal of continuity across the evaluation process for HFME and related initiatives. Though there are some cross-references within evaluation documents, there is little evidence of a cumulative knowledge base. This lack is accentuated by the fact that few if any of the reports have been published in an authoritative or easily accessible form – many were only available in draft, sometimes incomplete. It may be that a full set of the final versions of these reports exists, but if so it was not available to these researchers.

There is clearly a difficulty, evidenced in these reports, in developing or applying rigorous measurements of outcome in terms of food and eating practices. It is recognised that it is neither practicable nor reasonable, with limited resources, to obtain this type of information from participants: particularly where sensitive social issues such as literacy or poverty are involved. Asking people what they eat can also be seen as highly intrusive! As a consequence proxies for observable change are generally measured: such as reports (often anecdotal) of participants' attitudes or behaviour; viewpoints of peer leaders and coordinators; viewpoints of other stakeholders (especially 'experts' such as dietitians) and descriptions of programme-related processes and structures. Rigorous financial or cost/benefit analyses are also absent.

Not surprisingly, given the commissioners of these evaluations, who are mainly associated with the programmes concerned, there is a consensus that the programmes have a positive outcome, in terms of participant appreciation; peer leader perception of efficacy and 'expert' endorsement and the main concern then is to further develop and expand them, in line with the recommendations for change outlined in the evaluation reports.

The summary above is not to suggest that there is anything amiss with this approach. Gibson (2007) has demonstrated how even clinically-located, well-planned, evidence-based, highly rigorous and generously funded peer-led food and nutrition programmes have great difficulty in demonstrating specific positive outcomes. The challenge, then, for those involved in the evaluation of programmes such as HFME is to produce a comprehensive picture of the processes and issues involved, within the constraints of a limited budget. It is for funders and programme managers to then make decisions as to the provision, extent and sustainability of such programmes.

5 The Southside Partnership HFME programme

The Southside Partnership, established in 1996, is the local development organisation for the area of Dún Laoghaire, Rathdown and Whitechurch, in south Co. Dublin, in the southern part of the Greater Dublin area. It has the largest catchment area of any urban local partnership body in Ireland, with a hinterland of 70km^2 and a population of over 45,000. It is funded through a number of state bodies, primarily Pobal, FÁS, the Department of Social and Family Affairs and the Health Service Executive [HSE]; and through European Union funding.

Though this region is amongst Ireland's most affluent, it contains significant areas of disadvantage. The Southside Partnership aims to respond to issues of inequality and is:

> committed to equality and inclusion of Travellers, people with disabilities, asylum seekers and refugees, lone parents, disadvantaged women, the unemployed, ex-offenders, early school leavers, older people and youth at-risk. [it] also help(s) local organisations, schools, community groups and statutory agencies to develop positive changes in the quality of life of disadvantaged communities and ensure comprehensive social inclusion (Southside Partnership website, accessed15 November 2008).

The HFME programme is delivered by the Southside Partnership under the rubric of 'Parent and Family Supports' as part of its 'Education, Youth Development, and Childcare Programme'. This programme area also embraces the delivery and coordination of a range of actions related to educational support and childcare.

The HFME programme employs a half-time Programme Coordinator and engages a number of Peer Leaders who are self-employed consultants; it also has access to specified support from the HSE Community Dietitian. It is funded through an annual grant of €40,000 from the HSE Health Promotion Service, governed by a contractual relationship. The Programme is advised by a Steering Committee that includes representation from the Southside Partnership, the HSE, Dún Laoghaire Vocational Education Committee [VEC] and the local RAPID scheme.

HFME is a peer-led nutrition project. It consists of a programme of six two-and-a-half hours sessions delivered by a 'peer leader' to a group of up to 6-12 participants (Steering group minutes, July 2007); usually within a community facility setting such as a community hall or organisational centre. The content of the sessions is outlined below. The aim of the HFME programme is 'to improve nutrition knowledge and eating behaviour and ultimately to reduce diet related morbidity and mortality from cardiovascular disease and other preventable diseases' (Steering group minutes, May 2007). The programme is targeted at specific target groups that have been described as 'disadvantaged' and 'marginalised'. In effect, the programme has been delivered to a broad variety of groups, including older people; young mothers; Transition Year students and their parents; men's groups; hostel residents; and people with a disability.

The HFME sessions are structured by the HFME manual. This is a loose-leaf binder that contains a sequence of 'lesson plans' and photocopiable material for use in the delivery of the sessions. This manual has recently been revised by a team of community dietitians and the response to the new manual has been measured through an evaluation exercise (Newman and Associates, 2008 - see *s.* 4.1.4 above). Participants are awarded a certificate on completion of the course and a copy of the *101+ Square Meals* recipe book (MABS & MHB, 2007).

The HFME course is divided into six 2-2.5 hour sessions, as follows:

1. *A fresh look at food* - an introduction to the programme; ice-breaker exercises; basic facts about food; an examination of participants' current eating patterns; initial data gathering for evaluation purposes
2. *Focus on fats* - examines food/energy/exercise; weight control; fat in foods; cookery session: spaghetti Bolognese or chilli con carne
3. *The fibre providers* - fibre in food; food labelling; cookery session: soup and brown bread
4. *Family food* - food issues for families/children and adolescents; cookery session: hamburger and oven chips
5. *Sensible shopping* - shopping practices; food advertising; Q&A with HSE Community Dietitian/Dietitian; cookery session: fruit crumble/smoothie/fruit salad
6. *Bringing it all back home* - reflection and second data gathering exercise; extended cooking session: stir fry/chicken casserole/tuna bake

The course is delivered to a group in location convenient to them – for example somewhere that a pre-existing group also meets, but perhaps also a community centre, school or similar location. All necessary resources – a 'kitchen in a box' – are provided by the peer leader and all the venue has to provide is a meeting place, a sink with running water and a source of power (Coordinator interview, 23 July 2008). The peer leaders purchase all foodstuffs, for which they maintain a cash float. Specific public liability insurance cover for peer leaders and participants has been secured by the partnership for the HFME programme.

As well as the materials that can be photocopied from the HFME manual, additional material (such as recipes) may be photocopied and distributed. The programme is accompanied by a recipe book *101+ Square meals* (MABS & MHB, 2007) that is made available to participants on completion of the course.

The typical HFME session (except for the first introductory session) typically features an interactive information session, with games, quizzes, discussions, demonstrations and so on, followed by a practical cookery session, making use of one of the recipes from the HFME manual, or in some cases from the associated recipe book. This is followed by tasting/eating of the prepared food. Questions that cannot confidently be answered by the peer leader are recorded and put to the Community Dietitian who attends in week five of the programme.

6 Research findings

6.1 Findings: questionnaire data

This section of the report presents the findings from the secondary analysis of four data gathering exercises conducted by the Programme Coordinator and/or peer leaders during the delivery of peer leader training and the public delivery of HFME sessions. The data gathered included:

1. peer leaders' evaluations of the HFME programme that they experienced (July 2007)
2. peer leaders' evaluations of the facilitation training they received (September 2007)
3. peer leaders' evaluations of HFME course delivery in the community (conducted in September and December 2007; January and May 2008)
4. participants' end-of-course satisfaction surveys (as delivered)

6.1.1 Peer leaders' views on the HFME course and initial facilitation programme

Before undertaking their training the future peer leaders participated in a six session HFME programme, similar to that to ultimately be delivered to participants, but delivered over a three-week period. Programme evaluation forms for nine of the future peer leaders were assessed. Overall the response from this group indicated a high level of satisfaction with the programme and the majority reported learning something new.

The majority of Peer Leaders expressed their level of enjoyment with the course to be excellent and all those responding expressed a positive view of the HFME sessions (Table 6.1).

Table 6.1 Trainee peer leaders' enjoyment of HFME sessions

Excellent	6
Very good	1
Good	2
Missing data	1
Total	**10**

All but one of those responding indicated that they had learned ‘something new’ (Table 6.2)

Table 6.2 Did trainee peer leaders’ learn anything new about healthy eating?

Yes	7
No	1
Missing data	2
Total	**10**

After the peer leaders (n=12) had completed the six-session HFME programme, they undertook a further eight sessions that involved training in facilitation skills. After completion of this facilitation skills training course, they completed a brief questionnaire that explored three areas:

1. concerns about leading the HFME course
2. the skills they felt they would need to deliver the course confidently
3. any comments they wished to offer

Half (n = 6) of the trainee peer leaders reported that they had some concerns, while the other half (n = 6) did not voice any specific concerns (Table 6.3).

Table 6.3 Peer leaders’ concerns

comment	**mentions**
own nervousness	4
would it go well?	3
feeling unconfident	3
literacy of students	1

The majority of the trainee peer leaders reported that they would need preparation skills (9). Other skills ranked were communication skills (4); skills in relation to personality (2) and confidence in their own ability (2).

In addition the trainee peer-leaders were asked to evaluate their own training. All (n=12) said that they had enjoyed the training course. Particular aspects of the training that were referred to as positive are listed in Table 6.4.

Table 6.4 Positive aspects of peer leader training

comment	mentions
group interaction and discussions	6
information/recipes	6
cooking and eating	4
meeting new people	3
every aspect	3
group work	2
teaching style	2

Just half (n=6) of the participants referred to negative aspects of their training. These are listed in Table 6.5.

Table 6.5 Negative aspects of peer leader training

comment	mentions
no aspect	6
'party line' approach	1
too much chat at times	1
too much paper to file	1
some participants did not listen	1
realising it will be six weeks before I can learn more	1

6.1.2 Peer leaders' evaluations of course delivery

On four occasions (September and December 2007, January and May 2008) peer leaders completed evaluation forms after they had delivered an HFME course. These evaluation forms captured information on 33 courses that had been delivered by the peer leaders. Aspects surveyed included duration of the programme; barriers to learning; delivery venue; responses to dishes cooked; and problems, if any, experienced within participant groups.

The 33 courses had been delivered across a wide range of venues in the south Co. Dublin area, and in a variety of community settings. Results from the peer leaders' course evaluations of the 33 courses revealed that 91% of the courses had delivered all six scheduled sessions.

The peer leaders were asked to rate their group from three possible options: willing to learn, disinterested (*sic*) and mixed. There was an option for peer leaders to complete extra detail on this question. Overall 82% of the courses

involved groups that exhibited a willingness to learn; 20% of courses were rated as having mixed groups.

6.1.2.1 Barriers to learning

In almost one third (30%) of the courses delivered no barriers to delivery were experienced by the peer leaders. Where barriers were reported just over one quarter (27%) related to small group size. One fifth (21%) of the courses were deemed to have barriers to delivery owing to literacy problems within the class. The remaining responses were spread across a wide range of categories.

6.1.2.2 Venue

The peer leaders were asked to rate the venue where they had conducted the HFME course. There were two response options: ideal for HFME or some problems with the venue. As noted above the courses in the evaluation period were conducted across a wide range of venues. The majority (67%) of courses were conducted in venues that were rated as being ideal for the HFME course. A third of the courses were conducted in venues where the peer leaders considered that there were problems with the venue. Analysis of this question by venue and rating shows that 10 courses were considered by peer leaders to have been conducted where there were problems with the venue. Over the evaluation period courses were run in venues more than once and problems with venues applied to just seven locations. Analysis of the open-ended questions that asked for detail on the problems illustrated that the most frequently occurring categories were the distance from the car park to the venue, problems with the oven, and size of the venue.

6.1.2.3 Comments on the dishes prepared in the course

The peer leaders were asked for their comments on five of the dishes that had been prepared during the HFME sessions (these dishes were: spaghetti Bolognese/chilli con carne; soup and brown bread; burgers and potato wedges; fruit crumble/smoothie/fruit salad; chicken stir fry/tuna pasta bake). Peer leaders were asked to comment on any difficulties experienced with recipes and ingredients. The responses to these open-ended questions were coded into four categories: positive feedback, neutral feedback negative feedback and no comments. The result for each dish is reported below in Table 6.6. Overall for each course there would seem to be a generally positive response to most of the dishes cooked but there appears to be lesser enthusiasm for tuna pasta bake and stir fry. The lack of enthusiasm for the tuna dish echoes responses in previous HFME evaluations.

Table 6.6 Feedback from peer leaders on dishes prepared in HFME courses (n= 33)

	positive feedback %	neutral feedback %	negative feedback %	no comment %	missing data* %
spaghetti bolognese	36	3	0	37	24
chilli con carne	61	9	0	0	30
soup & brown bread	82	9	6	0	3
burgers & potato wedges	67	6	6	0	21
fruit crumble/smoothie/ fruit salad	76	12	0	0	12
stir fry	57	6	0	21	16
tuna pasta bake	30	6	12	36	16

* Not all dishes were cooked in all courses: this is why missing data is high in some cases

6.1.3 Participants' end of course internal evaluation surveys

A random sample (60% of total administered) of 136 participant end-of-course evaluation surveys was analysed.

6.1.3.1 Satisfaction

All participants reported that they enjoyed the course (100%). Participants reported that they enjoyed the information (29%), the cooking (26%), interaction with others (15%) and 27% reported that they enjoyed everything.

Participants were asked if there was any aspect of the course that they did not enjoy. Almost two thirds reported that there was nothing that they did not enjoy. Table 6.7 indicates categories of responses for those that reported any lack of enjoyment:

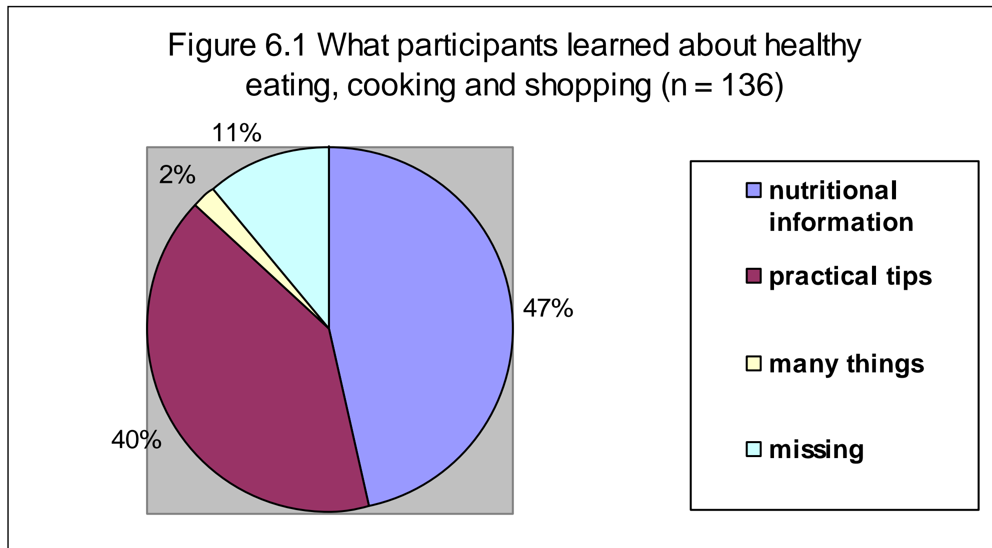
Table 6.7 aspects of courses not enjoyed by participants (n = 22)

having to learn about past mistakes	4
missing a class	3
would have liked more sessions	3
the recipe book	1
the talking in the class was too long	4
the venue was not comfortable	1
one of the recipes	6
total	**22**

6.1.3.2 Learning about healthy eating, cooking and shopping

A similar positive picture emerged in relation to learning (Figure 6.1). Almost all (98%) considered that they had learned something new about healthy eating, cooking or shopping. When asked what they learned, the most frequently occurring response was nutritional information (46%) followed by practical tips (40%). Just 2 per cent reported that they had learned many things and 11 per cent of responses were missing.

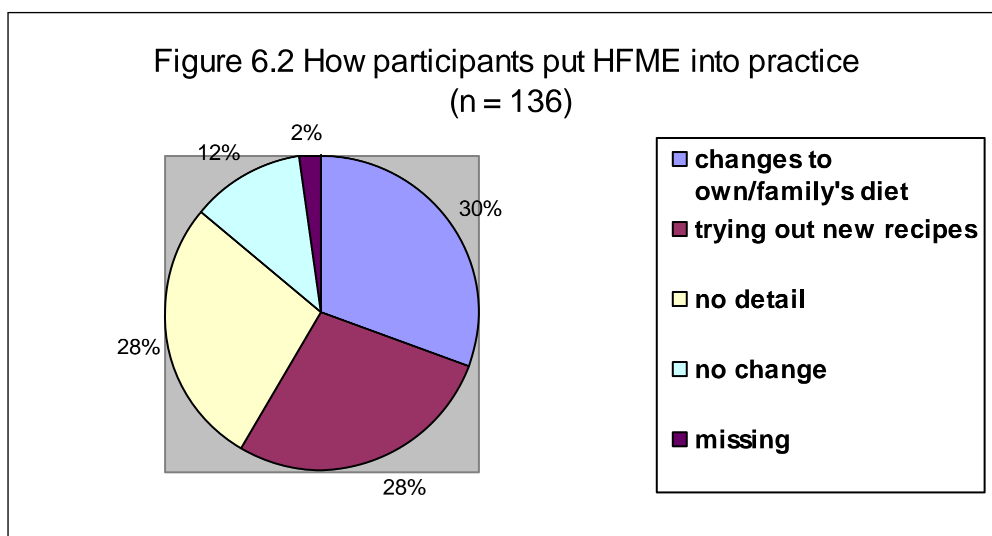
Figure 6.1 What participants learned about healthy eating, cooking and shopping (n = 136)



6.1.3.3 Putting HFME into practice

The majority of participants reported that they have put some aspect of HFME into practice (88%). Approximately one third related to changes to their own or their family's diet (31%). Just over one quarter (28%) reported that they are trying out new recipes; 28% gave no specific detail of the change; and 12% reported that they had not made any changes. Two per cent of responses were missing (Figure 6.2).

Figure 6.2 How participants put HFME into practice (n = 136)



6.1.3.4 Comments about the course

Analysis of the open-ended question that asked participants for their comments on the course generated 105 written responses (11 missing and 20 responding 'none'). Responses were coded into two main categories. Overall 54% of participants indicated that the course was a positive experience for them with a further 9% reporting that they would like follow up courses. The remaining responses were distributed across a wide range of categories.

6.2 Findings: structured interviews with peer leaders

Structured interviews were carried out with a 60% sample of the peer leaders (n=6). Each interview was carried out in the peer leader's own home or other suitable location and each interview was of 45-75 minutes duration, with the majority over an hour. The interviews were structured according to an interview schedule (see Appendix 1).

6.2.1 Getting involved in the HFME programme

The majority of peer leaders had originally expressed an interest in HFME through an application for the Coordinator position. A number of those who had not been successful in this application were subsequently contacted by the Partnership and offered positions as peer leaders.

It is striking that all the peer leaders interviewed had some prior involvement in people-focused occupations, whether in a professional or voluntary capacity. This included roles in, for example, public relations; fitness instruction and the retail industry (boutique; health store). A number had educational backgrounds related to the service sector (presentation skills, event management). Most expressed interest in matters of food and/or health, sometimes as a consequence of family circumstances (such as having a child with special needs).

One peer leader indicated how they had been able to link their involvement in the HFME programme to a more general orientation to health and food:

> I didn't do a lot of cooking before the course … I wouldn't say I was the world's best cook. I tried to stay as slim as I can all my life, I realised the benefit of doing sensible things if you like without being too strict on myself so it really was the ideal trigger for me to go on [PL1]

Some peer leaders also identified involvement in the HFME programme as an opportunity for a career change: either as a means of re-entering the workforce, or making use of existing skills in new ways. Involvement in the programme was attractive for some as it offered flexibility and the capacity to fit this work around other aspects of their lives, such as home duties or other part-time employment.

6.2.2 Characteristics of HFME groups

Interviewees had typically offered for to six HFME courses at time of interview. They were asked to identify the key characteristics of the groups that they had engaged with. What emerged was the sheer diversity of groups – they included young mothers; people with substance abuse problems; older single men; participants from non-Irish backgrounds; adults with special needs; 'the

converted'; over 50s women's groups; and so on. It was clear that the programme had been successful in reaching a broad diversity of audiences.

The peer leaders' responses provide an image of this diversity:

> An elderly group, living in sheltered accommodation that would come to the day centre in the hospital, loved that, worked out brilliantly … young mums with young families (2 groups in different locations) … Transition Years (one male group and one mixed group in two separate schools) … people recovering from psychological/drug problems in a kind of halfway house, going really well, really enjoying that group [PL2]

> All men, except two women, aged from mid-30s to retired. One woman dropped out. She only joined in for fun but didn't come back. The other was on work experience in the building. They were all kinds of men, some separated, some living alone, some with children. One seemed to have an intellectual disability. Most of them had bizarre eating habits such as not eating all day and having a fry at night which they changed during the course. Some made real life changes such as taking up a sport or the gym or changing eating patterns. The woman started making scones for the class for each session. The course had a huge impact [PL6]

> Over-50s women's group: very successful, so interested! I didn't think I could teach these women anything due to their own life experience [but] they were avid for the information, the topic was so common to home, I also learned a lot off them … Also a special needs adult group and their carers, age range is about 30-34, one man in his 50s. All are living in supported living with house-parents, in the community - they all have moderate learning disability … And a day care centre, people who were still living at home – did a lot of work about one-to-one cooking, I left out the lesson on the family as they live alone. Some people at that age think it's not worth it, but I would show them stews and spaghetti dishes. They would be older people, not disabled [PL5]

6.2.3 Delivery of the HFME programme

The peer leaders were encouraged to outline the processes involved in preparing for, delivering, and following up an HFME session or course.

6.2.3.1 Preparation

All peer leaders indicated that they would spend time prior to the sessions in preparation – this ranged from 'a couple of hours' to 'a few days'. To a large extent the amount of preparation time was influenced by a peer leader's other responsibilities. Some had the time to devote a number of days to reading the manual and materials and obtaining resources; whereas others were able to integrate their preparation with the processes of everyday life:

> I do my prep work the day before, or if it's a later session I'll drop the children to school, pick up the shopping and bring it to the course. I can integrate it into my own shopping, or I'll make a special trip for the class items to the shop [PL4]

> A day or two before hand I would look over the particular session that I'm working on that week. I would buy a few things during the week for the class,

> if I was doing my own shopping I would buy things for the class such as fruit. If I'm in Lidl I'll get my fruit to keep the budget down. I'll buy the meat for the dish the day before so there is preparation required especially for fresh ingredients [PL2]

Familiarity and experience makes preparation easier and quicker:

> You need to know every week what you're going to cook that week and what to bring with you, then you need to do your shopping before you go to the course. It wouldn't even take an hour, at this stage I can flick through it as I know the information so well [PL4]

Peer leaders did identify that the introduction of the revised HFME manual had resulted in some extra preparation work, as it was necessary to become familiar with the new material, but that this extra load was only temporary.

6.2.3.2 Session delivery

Peer leaders spoke about the necessary attributes for the delivery of the HFME programme. As indicated earlier in the quantitative data, good preparation for delivery was seen as crucial.

It is clear that most peer leaders made use of adult education strategies, interacting actively with the participants, rather than adopting a more didactic approach. One peer leader described their approach as follows:

> I try to not just stand there and deliver down the information … I would ask every week 'did any of you manage to cook at home?' to get them interested, to get a discussion going … Presentation has to be funny, amusing, inject humour into it. To get them to partake is helped by games, get them involved [PL6]

Peer leaders talked about how they aim to adjust delivery to the specific audience they are working with, though there were differences in confidence as to how they could do this. One of the leaders described how:

> I adjust the course to suit the group, I judge what is most useful for them to learn, such as more cooking for people in halfway house as a response to what they respond to best, they have no need for certain lessons such as feeding your child. With transition years I won't go into anything heavy or to the faddy eaters section as I am aware that they are young girls and I won't even mention the word 'diet'! As I get each target group I'll look over the manual and re-evaluate what to use … I'll assess what is appropriate or [what to] bring for each group, but there's always something there that people will latch on to, there is enough in the manual to do this [PL2]

6.2.3.3 Challenges to delivery

When the peer leaders were asked to identify key challenges to the delivery of HFME, they did not offer many instances. They did identify challenges with some participant groups that may have been less receptive to the HFME course. It appeared that this occurred mainly amongst those who felt, for whatever reason, they 'had to' undertake a course:

> [some] young mothers, even though they've signed up to it, it's a chore. And I know they're probably the ones that we need to reach the most. They have good ideas and they mean well … mothers today are under a lot of pressure in other areas and it wasn't top of their list [PL 5]

This orientation might be reflected in a lower level of involvement in the programme, or in lack of attendance at some sessions:

> the (same) group seemed to come to my course out of a sense that they had signed up for it, but they wouldn't care, they would come in late, they wouldn't physically partake and get up and cook. It just seems to depend on where they are and what's going on for them in their own lives. They did not drop out, but they would go home early or come late [PL5]

If participants were not interested in the programme; this could be disruptive to others:

> Talking about other stuff and I had to keep going 'come back here now'! I'm not a teacher so I wouldn't have had those skills. She was only disrespectful in that she was probably bored by it because she wasn't as young as the mothers, in fact I thought she talked better sense but she did distract the class a lot [PL5]

A number of peer leaders said that they would use their teaching and facilitation skills to work with such participants:

> I always feel if I get a disruptive or unhelpful individual and I can meld them in to the course in the way that I want to they're usually a very good influence on everybody else then. I don't let them take over [PL1]

The only other issues that emerged was one peer leader who spoke of the unpredictability of the available work; another who referred to the tiring nature of physically handling the cooking and other hauling material from car to venue; and another who mentioned that she had to be aware of the idiosyncrasies of gas cookers at different venues, otherwise '[the food could] just burns to cinders and you make a show of yourself for not being able to correctly deliver the thing' [PL1].

Nevertheless, as suggested by the quantitative data referenced earlier, the feedback from the peer leaders was that the large majority of participants found the sessions a positive experience.

6.2.3.4 Follow up

Most peer leaders alluded to the 'paper work' that was involved in the follow up to delivery of an HFME session. This might be involved dealing with petty cash and ensuring the completion of attendance and evaluation sheets. For some, the 'paper work' was an onerous aspect of the process: 'the paper work is a nightmare!' [L5], though the same leader did recognise that as she does more session she 'gets more used to it'. Leaders also indicated that they would liaise with the Programme Coordinator after sessions, to identify any issues or

problems. One leader [L2] indicated that about a days work might be involved in all the follow up work for two sessions.

6.2.4 What works well?

The peer leaders were asked what 'worked well' on the HFME programme. There was general enthusiasm for nearly all aspects of the programme, but it was clear that the practical, 'hands-on' aspect was particularly valued:

> I think the making of the meal together, it really cements the information. They see it, you're giving them information about that menu, you're talking about fibre that day [PL5]

> The fibre lesson is good (string one and Weetabix one) as it's visual and people get up and do it [PL4]

> The recipes were fabulous; the recipe book is fantastic; all the recipes are very simple, very cheap and very delicious. Making the food (actually producing something to try out) was an excellent way to convince people … I think it's excellent the whole way it's structured so that nearly the second half is done in the kitchen and everyone's together [PL3]

> Absolutely the hands-on with the cookery. Sitting on seats won't hold attention. I like the pack as no exercise takes more than half hour, 15-20 minute exercises keep things moving all the time, the cookery is brilliant! [PL2]

6.2.5 The HFME manual

A number of points related to the HFME manual. It should be noted that this was revised during the course of delivery of the programme. Some peer leaders had made use of the new manual, whereas others had not seen it; some had positive views about the revised version; others preferred the original. It is not possible to provide any clear picture from the data gathered, but responses to the revision of the HFME material has been extensively examined elsewhere (Newman and Associates, 2008 – see s. 4.1.4 above).

The peer leaders were asked about the extent to which they stuck closely to the syllabus outlined in the manual, or whether they introduced variations. The overall response was that peer leaders aimed to follow the material closely, but would adjust at times to suit different audiences or situations.

> I only deviated with the elderly and with the special needs but this seems to have been more to do with a faulty oven rather than participants' needs, or doubling up measures due to a larger class [PL5]

> I follow the format but if somebody brings me off I go with it but I come back to what is scheduled. I have no problem with that and will always deliver what is on the course that day … It's not hard to adapt the course but it does have to be adapted at times … I judge the situation so that the participants don't ask me to do something else if it's not relevant, I decide based on their reaction and I let them lead it, get across the information that's needed on that day [PL4]

> After six or eight deliveries you could become kind of impervious to what's in the book but I really don't do that. Either the day before I go over the information to make sure I know it, as it's not my job to override somebody else's work. I wouldn't leave out something because I didn't have a personal like for something. I would put in a few little points of interest or I would divide the class into two and get them to work in groups, but I would always try to keep it focused on food at all times, you can get old people who would wander off on you but you can drag them back [PL1]

There was not a great deal of discussion in relation to the manual content or design. Again, the process of revision, which included the addition of extra handouts and photocopied material, means that it was difficult to assess responses to the manual *per se*. One peer leader did suggest that the manual 'could use the techniques of modern advertising to keep people's attention and get the point across [PL1] while for another it was fine the way it was: 'it's lovely and colourful and it attracts them, so they're browsing through it. It's very simple' [PL5].

6.2.6 Key knowledge and skills for the delivery of HFME

Peer leaders were asked to identify the key knowledge and skills required to successfully carry out their work on HFME. Three key sets of attributes were identified.

The first was interest, passion, or friendliness – these were attributes that were expressed through the personality of the peer leader:

> interest, passionate, able to deliver a bit of personality, able to engage people [PL6]

> Being very much part of the group and identifying yourself as part of the group from day one … people who are giving it should be genuinely friendly people and like other people and think all people are equal [PL3]

Second, a number of peer leaders suggested that some knowledge of food, health, nutrition or basic science would be useful, though this was contradicted by others (it would be fair to say that this related to the different knowledge base of the peer leaders):

> you need knowledge of basic nutrition – I did that in [my earlier] training … if they don't have a knowledge of basic nutrition the tutors can get lost … [if you] didn't have basic knowledge of vitamins, minerals, protein, carbohydrates and if you don't know it I don't know how you can deliver it properly to people [PL4]

> I know a little about vitamins and supplements, and know where to look these things up if needed [PL5]

> If you don't have a basic knowledge of some kind of food/nutritional biology you can answer their questions incorrectly [PL3]

Third, the peer leaders pointed to the ability to communicate effectively, to have basic presentation, facilitation or teaching skills:

> Skills - you've either got it or you don't in terms of standing up presenting [PL4]

> You have to have an aptitude as such and a belief that you need to get the message over to a particular audience. I try to use key stimuli and other methods that I learned in [earlier occupation] [PL1]

> Personable, a good speaker, friendly, get to know the people, go early and greet them, say hello and always thank them for coming each time they come back. It makes them feel special and appreciated [PL2]

6.2.7 What is HFME trying to achieve – and is it succeeding?

6.2.7.1 Aims

The peer leaders were asked about the aims and objectives of the HFME programme. One peer leader summed up the objectives succinctly:

> To get people back to cooking and not take ready-made meals out of the freezer, or going down to the chipper. Get people back to basics a bit [PL4]

Encouraging people to shift away from 'ready meals' and to prepare 'healthy food' from scratch was seen by all peer leaders as a key objective of the programme. This was seen as part of a broader move towards improving people's health:

> In my opinion there's a need there to go out into society and get the word over to people that they haven't been living healthily and they need to do something immediately and it will prolong their lifespan [PL1]

Mention was made of the importance of reaching young people (Transition Years) and young mothers – in order to influence them later in life [PL2]. As one peer leader commented: 'I did not know about nutrition when I was rearing my own family and it would be ideal for parents of young children and babies' [PL5]. Another aspect, in relation to older people, was to provide an interesting activity in order to 'occupy their time' [PL1]. This is an aspect of the HFME that is explored further later in this report.

A number of the peer leaders alluded more specifically to the nutrition education aspect of the programme, making reference to 'trying to get across that the food pyramid is the basis on which we should all be buying and eating food for the rest of our lives' [PL3]; to 'obesity, cholesterol, the well being of people' [PL2]; and to 'calories and how to burn them' [PL6]. But the references to specific nutrition-related aspects were outweighed by those to a more general sense of eating healthily and perhaps regaining some control over food intake.

6.2.7.2 Target groups

For one peer leader HFME would or should be valuable to anybody: 'it would work anywhere, not just disadvantaged areas' [PL6]. Nevertheless it was the

intention of the programme that it would address the needs of the community organisations and populations of specific concern to the Southside Partnership.

The peer leaders were asked whether they thought HFME was targeted effectively. The strongest response from the leaders was that a) they were not too prepared to identify any specific target groups; and b) they thought that the HFME course was widely applicable in society and should not be narrowly confined to any specific target group. It may be that this question did not clearly differentiate between the specific focus that the programme might have in social terms, and the possible audiences for a nutrition education programme such as HFME. Thus it is not possible to gauge the extent that the peer leaders were aligned with the intended targeting of the programme.

Thus, an issue raised by peer leaders was that the programme was perceived to be aimed at 'pre-formed' or existing groups, rather than a more general public. In this way it might fail to reach some people that would benefit from it:

> I don't know who they are trying to reach, but I know who they are reaching, which is pre-formed groups. A lot of people who are not being targeted at all - there's a lot of people out there who can't avail of the course because they're not part of those groups, they're not part of a community and they're not addressing them at all [PL4]

> I think it seems to be low income families, basically women with children, that's who's doing it because of the way it's been rolled out, it's targeted that way but I don't know why [PL3]

6.2.7.3 Success

All the peer leaders interviewed saw the HFME programme as being successful in meeting its objectives, which were expressed in the potential impact on health and diet, rather than, as is suggested by the section above, the penetration of the programme within targeted groups.

The peer leaders spoke enthusiastically about the perceived positive impact of the programme, and how this was conveyed to them directly through participant feedback. Statements such as the following reflect this perception of success:

> Although the teens may be difficult at start of course (bravado 'I'm not eating that') by the end of the course things do sink in [PL2]

> In one group I had a participant who on night one was trying to find out if she would do this course or do Weightwatchers and she found out Weightwatchers wasn't going to keep the weight off so she came back and I was delighted [PL1]

> People are stunned by how much they save on their food bill …they could relate it very definitely to their lives [PL6]

> Absolutely, really I do think it's a success! We're not running enough courses. Everyone that completes the course, they're absolutely thrilled with it [PL4]

> I would say it's about 75% successful, and this is affected by how interested somebody is in the course [PL5]

> Without a shadow of a doubt it has definitely been successful. Maybe not every single thing that was taught went in but everyone went away with the basics - how much of the basic food groups they need, an awful lot of myths were cleared up which is extremely important. For example a lady who used to give up coffee on a diet as she thought it was fattening; or information that they don't know such as if they drink a can of soft drink, it has 17 spoons of sugar. That's spelled out to them. Those kind of changes people did immediately when they saw the huge things that they didn't know about Coke or Yop, things that they didn't know, that should be common knowledge but they didn't know. I think those things are brilliant [PL3]

As will be obvious from these comments, peer leaders were able to point to specific instances where participants had been challenged as to some of the myths about food and nutrition; to situations where participants had expressed enthusiasm; and where changes in attitude and even practices had taken place.

The peer leaders suggested that it was difficult or indeed impossible for them to assess the longer term impact of the programme, in the absence of a follow-up programme. Thus one [PL4] noted that: 'once they go out the door you're wondering if they're going to go with it' and another agreed the programme was successful, but 'what happens after the courses end?' [PL6].

6.2.8 Who gets most out of the HFME programme?

The peer leaders were asked to suggest who, in their opinion, benefitted *the most* from the HFME programme. As with the targeting issue, the peer leaders were reluctant to identify specific categories, rather suggesting that the programme had a broad benefit – both to people who could immediately put some of the recommendations into action, and to others who had a less active role but could still influence others. There is some suggestion that those more actively involved in the cookery element of the programme benefited more:

> it was the older groups, they always sat down and shared what they had just made. They were the same age as me so it was possibly more sociable and informal [PL5]

> the people who are eager and are looking for change, but all the age groups from teens to grannies, even if they took one or two things out of it, I wouldn't say one group is better then another [PL4]

> the people who are still shopping whether they're old and it's for themselves or their grandchildren or whatever, or they're middle aged and it's for their husbands and children, I think it's people where there's some degree of touching food. But when they come along to say 65 or 70 I think they're not out there on the day to day basis and they don't know the brands anymore and they can't understand grams. [But] those people can influence the people around them even if they're not cooking for themselves they would be influencing their direct contacts [PL1]

> I don't think everybody got a lot out of it. Maybe the more outgoing people might have cooked a little but more and got into it a bit more [PL3]

> Probably the mothers because they're worried about their own health and their children's health. Especially if they have teenagers due to faddy eaters, they are very interested [PL2]

Asked to identify who might not benefit, one mention was made of older people who were not actively cooking or shopping for themselves, while other comments related more to individuals who for one reason or another expressed some negativity about the programme.

6.2.9 HFME as a 'community owned' programme

As outlined earlier in this report, HFME is described as a 'community owned programme'. Peer leaders were asked what this meant for them. Responses suggested that there were a number of dimensions to this concept.

First, the programme was offered in 'community' locations:

> you are offering it to communities as opposed to factories. The participants signed up for what they saw on the notice board of their local school or in their local community centre [PL5]

Second, it is supported by the Southside Partnership, which is identified as a community-based organisation:

> It's free and anyone can come in and do it, and it's administered by the Southside Partnership and it's in the community and it should be nearby [PL3]

Third, it was provided by 'peer leaders' rather than outside professionals, and this reduced the distance between provider and audience:

> 'community owned' means it is led by peer leaders similar to Jamie Oliver programme – the knock on effect where each person teaches someone else [PL6]

> My attitude is that we're along here this evening, say on the first night, not as a teacher and pupils but as an information gathering and I can learn as much from you as you can learn from me, and I would like you to keep that attitude going right throughout the course [PL1]

> The [peer leaders] don't do it for anything other than the interest in healthy food and getting that message over to the communities [PL1]

> I do think that it's very important that a peer leader doesn't consider themselves any better than anybody else so I think they should be very carefully chosen on that [PL3]

> I'm here, I've lots of information and I hope you will learn lots from me but I'm looking forward to learning from you and we're all going to learn from each other [PL2]

> It's peer learning and I think that's why it works [PL2]

Fourth, was that the programme was delivered in a 'community' atmosphere:

> There's a great community atmosphere when you're in it, I feel like staying there, it's wonderful. And I feel like going to cha cha lessons with the girls, they'd be talking about what ever they do on a Thursday night … you'd be just having a bit of craic, you're not talking about anything deep and meaningful and it's just cheerful and nice and I think women love getting away from the house and having a good old natter [PL3]

> its like a party, especially if it's a big group and everyone makes a different thing [PL3]

Finally, one peer leader did question the concept of community that underpinned the programme, specifically the extent to which it might favour pre-formed community groups. This was seen to be reflective of a lack of a more generalised community spirit in contemporary society:

> Does that not exclude those people who are not part of the community? I only know 4 people on this block, and I've been here for 14 years now. There's no sense of community unless you're already in a community group, so that becomes just something other people do. Even to know it exists you'd have to be part of a group already [PL4]

6.2.10 Supporting personnel

A number of questions to the peer leaders referred to their perception of the roles of the support structure for the programme. These included the coordinator, the community dietitian and the broader role of the Southside Partnership itself.

6.2.10.1 The Partnership

It would be fair to conclude that the peer leaders had little idea of the role of the Partnership as a whole. Responses to this question included 'no idea' [PL6]; 'I wouldn't say it made a huge difference' [PL5]; 'would need to think about that as I don't want to get it wrong' [PL1]; 'they could be more open with us about when to expect our next bit of work' [PL3] and 'don't really know, I don't really deal with the partnership' [PL2]. Responses to this question often made reference to the roles of the coordinator and the community dietitian, who were very much seen as the 'face' of HFME.

6.2.10.2 The HFME coordinator

The Coordinator was seen to have both an organisational and an advisory/support role. Thus she was a person to whom paperwork had to be forwarded; she was also able to provide guidance in the practical aspects of delivery:

> she's there to organise, give advice - sometimes participants take up too much attention at the cost of the quieter participants so she has to learn how to control them a little [PL6]

> I would ring [the coordinator] about a problem such as the disturbance I was having in the class, rather than taking matters into my own hands. So [the

> coordinator] would advise me on how to handle things to keep it running and everyone involved [PL5]

> Great, she's the person who's providing me with all my sheets and handouts for each course. Very accessible, only a phone call away, its reassurance, if something is going wrong or if she was sick, I'd be lost without her [PL2]

> There's a certain amount of paper work that you have to give to [the coordinator] as she wants proof that it has been delivered and it's done, and feed back on the classes [PL5]

6.2.10.3 HSE Community dietitian

The community dietitian was also seen in a positive light by the peer leaders. She was seen as the person who brought 'expertise' to the programme, and also 'the official line' [PL5]. Making a visit to the programme in the fifth week of delivery, to address queries that have been identified by participants or the peer leader, the dietitian's role is very clearly seen as providing answers: 'she has all the knowledge' [PL5]:

> She brings the medical explanation to the course – the participants love to think there's an expert to speak to [PL6]

> I'm trained to give answers from the pack and I feel I have a good knowledge but as I say, I don't know everything and that's where [the dietitian]...if I don't know it I'm not going to give misinformation and that's why I record it [PL2]

The dietitian provides confidence to the peer leaders that they can respond to participants' queries, and also provides an endorsement for the material presented by the peer leaders:

> I feel that she cements all that I've done for the previous five weeks [PL5]

> [the dietitian] would pop in during a session and give out the recipe books on session five. She would answer any more scientific questions from the class which had been written down when I was not sure of an answer. This worked really well as I never felt stuck [PL3]

> Most important, most helpful, even if we only had two questions for her, she would have lots of information to divulge anyway, very interesting, generates questions on the night [PL2]

The friendly and positive approach of the dietitian is noted by the peer leaders:

> excellent, great personality, pleasant way of putting things over, very knowledgeable … [the dietitian] spends the time on it that is required and maybe even more to answer the questions in a reasonable attitude and in a way to link to the individual that asked the question - I think that's respected by everybody [PL1]

> Super, brilliant! [PL3]

As similar queries (such as allergies; diabetes) often arise across programme cohorts peer leaders have identified that they themselves can also draw on the dietitian's responses to support their own subsequent responses to queries. In this way the expertise of the dietitian is being transferred to some extent to the peer leaders: 'I find the more I do it the more I can answer people's questions' [PL4].

6.2.11 Suggested changes to HFME programme

Based on their experience to date, the peer leaders were asked for their suggestions about altering or extending the HFME programme. Two of the six interviewees saw no need to make changes to the programme. Other suggestions were to include an introductory workshop or 'taster' workshop for people to attend before they signed up for the full six weeks.

Another peer leader would – again drawing on earlier responses – like to see the programme 'modernised' – with more use of computer-based materials and resources drawn from popular culture and advertising/marketing:

> present it in a way that's attractive to different groups, different age categories. I would try to put it over in amore of an inclusive and fun way, not be so dogmatic way, not possible to do it that way nowadays [PL1]

Another peer leader [PL3] would shorten the sessions to two hours, in recognition of the time pressures for women.

In terms of extending the reach of the programme, reference was made again to those not already in 'pre-formed groups'. One peer leader strongly expressed the view that the HFME programme should be offered to others outside of the designated target groups:

> if I was doing this I would put the programme in the clinic, credit union, bank, shopping centres and grocery stores, to advertise this widely because if you are contacted by people they are genuinely interested. And maybe through schools where the letter is sent home to parents. Mother and toddler groups also. I am more concerned with who the programme is targeted at than the actual content of the programme [PL5]

This was supported by another who remarked that their 'neighbours and family often ask how they can come along and [the peer leader] would almost have to set it up' [PL4]. This peer leader remarked that: 'everybody pays their tax so everybody should be entitled to do it, it should be open to everybody but it's not'.

In terms of specific additional target groups, those mentioned included 'men' [PL6]; 'separated fathers' [PL1]; 'exercise groups and yoga classes - already interested in things like their weight, they're a captive audience' [PL1]; 'firms and companies in general' [PL1]; 'mother and toddler groups' [PL3]; 'people are in hospital after having a baby' [PL3]; 'pregnant women', 'teenagers' [PL3]; 'people who are leaving the kids off to school in the mornings' [PL4]; 'in schools, starting from Junior Infants' [PL3]; and 'single mums without support' [PL2].

Overall the peer leaders were strongly supportive of the programme and would like to see it offered more widely within the community – both to those who might be identified as target groups for the Southside Partnership, but also for other groups.

6.2.12 How people eat today

It was thought useful to ask the peer leaders about what they perceived to be the key factors that shaped the contemporary food and nutrition landscape; and also what changes – if any - they had made to their own eating practices since becoming involved in HFME.

A key theme that emerged in relation to eating today was *time* – or the lack of it. As PL6 remarked 'people are so short of time'. PL5 agreed: 'time – people do not have time - especially family time where both parents are working now'. PL4 said that the 'pace of life is so fast now, we're not all able to sit around and plan meals'. This was seen by PL1 to be linked to stress, seen as endemic. It was notable that all the peer leaders referred to time as a key constraint on healthy eating.

A second major theme was the role of television and food advertising, mentioned by a number of the peer leaders:

> Far too much advertising, too much choice. Trying to simplify people's choices and the way that you shop. The Shop Smart week is always brilliant, even for me. Be smart and be wise with the way you're shopping, you don't need all these extras, make lists, use fresh produce, don't go off hungry [PL2]

Again the need to have some control over food intake was linked to good time management. Another factor alluded to was 'education' and knowledge, for example in relation to portion size: 'participants were always stunned by portion size – how small it should be' [PL6].

The third theme was the need to link food intake with sufficient exercise. Overall, though the notion of a harried, busy, disconnected, work-dominated lifestyle that led to poor food choices was the dominant message:

> Obesity comes with it too, when you're driving around in the car all the time, filling up on McDonalds, not having breakfast, the whole thing kind of spirals, you're eating every hour or two rather than sitting down at a table and enjoying it with your family [PL1]

6.2.12.1 Changes to own dietary practices

So – have the peer tutors used the knowledge and practice they are imparting to change their own lifestyles and eating choices? One peer leader said they had made specific changes as a consequence of involvement in HFME:

> my healthy eating has been the best thing that's happened to me and my family, because my sons have started cooking, my frying pan doesn't exist anymore [PL2]

Another has ‘lost over a stone and half in weight since doing the programme’ [PL4] while another has dealt with a family cholesterol issue ‘by eating well instead of medicine due to this course’ [PL6]. Others also point to changes in food preparation practices: ‘I do more experimenting’ [PL1]; ‘the Foreman grill was introduced to me by a participant. I use the cookery book, my teenage sons use it’ [PL2] while another referred to a ‘simple thing you can change such as changing from cornflakes and sugar to Weetabix and raisins’ [PL4]

It is interesting that while the peer leaders may have changed their own practices, they do not necessarily find it easy to affect their families’ behaviour:

> Yes, I’ve started making soups all the time. I couldn’t believe how easy, quick, healthy and delicious it is. But I still have trouble getting my daughter to eat vegetables though [PL3]

This might help bring a personal perspective to the challenges of bringing about change in others’ practices.

6.3 Findings: participant focus groups

Two focus group discussions were carried out with some of the HFME participants. In each case the focus group was made up of older participants, so this data can relate only to the experience of HFME for this particular category of participant. It was not possible to arrange focus group discussions with other participants during the time frame of this evaluation, though see Newman Associates (2008) for findings from other focus group discussions amongst HFME participants (though not necessarily within the Southside Partnership programme) (see *s*. 4.1.4 above).

6.3.1 Focus group 1: Active retirement group

The first focus group was made up of six women over 60 years of age. They were already meeting as members of an existing community group.

6.3.1.1 What made HFME attractive to this group

All of the group were very enthusiastic about the HFME programme and had found it to be a very enjoyable experience:

> When we did get togther it was great gas too
>
> We had a good time doing it (chopping the vegetables) and it was funny and we had photographs.

While the group highlighted the fun aspect of the course, the convenience of time and location made a big difference to them, in that the ‘course came to them’ in a location where they were already meeting. Furthermore, they were attending with people they ‘already knew’. While some members saw this as an advantage, others were keen to point out that they would attend a course by themselves – having a friend go with you was not a major priority:

> But I have attended courses on my own. It's not because of the group. If I am interested I'll go
> - So have I

While convenience was important most of the group was interested in food and health issues. One woman recalled that she was very conscious of food and health since her husband died of a heart attack; another reported that her husband had coeliac disease. One woman had recently been diagnosed as diabetic. The group reflected that food is a big issue for everyone:

> Food is always an issue
>
> Everyone has concerns about what they are eating. There is so much advertising about food.

6.3.1.2 What stands out from the HFME course?

When the group was asked to recall what stood out for them in the course a wide range of topics emerged that included:

1. *Labelling*

    She told us to look at the backs of the packages and the calories and the fats, particularly the transfats and all the hidden things in it. Things that people are inclined to … salt, everything has salt and sugar in it
    - I watch now on the fats – what she says, the bad fats

2. *Using tins of tomatoes instead of jars of sauces*

    The spaghetti Bolognese well I always poured in the jar of bolognese. She didn't. So I learned you don't have to have a jar (but do you do it?) yes but I added in two tins of tomatoes.

3. *Frozen vegetables being as good as fresh*

    Another thing was the frozen vegetables everyone was saying that frozen vegetables are the same they have the same goodness in them. I was always a bit dubious about frozen vegetables
    - So was I, I have to say.

4. *New tastes*

    The soup she made: parsnip and apple and we though oh this is going to be …
    - I wasn't there
    - She made parsnip and apple soup. I make vegetable soup and I don't go beyond that
    -It was beautiful.

    Well I tell you one thing. She did a chilli and there were soya beans in it and I had never eaten soya beans and I have eaten them since

5. *Shopping in cheaper outlets*

    I picked up going to Lidl – it is much cheaper there and much fresher.

> The budget was very good: she gave a good few tips on where to get things cheaper and it was stuff that I wouldn't have thought of.

6.3.1.3 HFME in the context of their everyday lives

While this group showed that they were generally interested in learning about food and health, and for some this linked directly or indirectly to personal health issues, the course seemed to benefit them in other aspects of their daily lives.

Most of the group was involved in caring for grandchildren. Comments on this aspect of their lives revealed the intergenerational changes that were occurring in terms of child-rearing and food work associated with children. In some ways this group felt that they were doing things better for their grandchildren (in terms of food) than they had for their own children:

> Because we all have our grandchildren most of the time and we are probably cooking better for them than we did our own kids.

All have minding responsibilities:

> I find the young people though now are - my little grandson's dad and his mam are very fussy about what he eats – you are not to give him drinks and you are not to give him ...
> - But they have learned a lot more than we did

While the HFME course connected with their life situation in terms of grandchild care, it also aligned well with their stage in the life-course. All were retired from the paid workforce and emphasised the need to keep active and keep learning. The group was clear on the need to make a healthy transition from working life, where they were always with other people, to a retired life where there was the potential for periods of loneliness:

> No because an awful lot of people – we have given up work well most of us and like you might as well come down and do something and you're learning
> - It is learning as well no matter how old you get
>
> Meet other people and mix with them, then after working so much and then you are back home and you are lonely
>
> There is only so much housework you can do in your own house
>
> You feel better when you get out

6.3.1.4 Peer interaction

As noted above the group was very enthusiastic about the HFME course and in particular commented on how the course was delivered. They were impressed by the non-didactic nature of the course: 'she gave us a choice and we would decide what she would cook next week'. The group responses about the course illustrated to some extent that interaction among peers was taking place:

> And she learned from us
> - She was only a young girl. We would say we wouldn't do it that way and she would say how would you do it ?
>
> She wasn't that sort 'you can't tell me what to do'
> - And we were telling her and reminiscing when we were young – no processed food so we didn't have to worry about transfats
> - She was very interested in that

In addition, the group reflected on how the peer leader's experience as a mother of young children was applied in the sessions: 'the tutor has children and she could relate to what children wanted', This was considered useful for them when they cared for their grandchildren.

6.3.1.5 Recommendations for future HFME courses

The group was asked if there was anything they would like to see changed if another course was conducted. Some of the group mentioned having a focus on cooking for children, in particular snacks. While other members of the group agreed that HFME was good because they were cooking and eating 'real food – not this designer food', recommendations for a future course centred on food that was not so plain:

> I would love a few more stir frys – they were lovely - saw one today now – bacon and chicken and he threw in a bit of chilli powder (referring to something on television) quick things like that and they are very healthy
>
> Interviewer: is there room to go up?
> - Yes, up-market there definitely is, because if you look at that book …
> - Things you wouldn't be ashamed to give to anybody
> - The recipes in the book they are lovely (they are homely) but they are if you are cooking you would . . . . have something else too
> - Give it a bit of a kick!

6.3.2 Focus group 2: day-care centre for older people

Focus group two was conducted with a group of five older women (aged 70+) who attended a day centre one day a week. Here they took part in social activities, ate lunch and had access to medical care, such as physiotherapy, if needed. All of the women, apart from one, lived on their own. The group had been involved in the HFME course approximately five months earlier and had some difficulty with recall. The group were offered the course by a staff member as it was felt that they would benefit from it as they lived on their own.

6.3.2.1 What made the HFME attractive to them

All apart from one member of the group lived alone and had their main meals provided through a combination of meals on wheels, day centre service and family member provision:

> A lot of people here live on their own I think. And also they were telling us about nutritional food and easy ways of cooking for one. It was all very interesting.

A lot of us are living on our own.

I live alone as well. I don't cook though. Most of us live alone. I get the meals on wheels four days a week and the other days my daughter brings me my dinner

While the group mentioned the fact that they lived alone as a reason for their attraction to the course, primarily they were interested in social interaction and the oportunity to do something new.

Interviewer: what did you think you were going to get out of the course?
- I like the company because ...

Interviewer: was it the social bit as well?
- I had a nurse coming to me after my husband died and I was very much down and she got me in here.

Interviewer: What did you think you would find out from HFME, what interested ...
- Much like (name) here. I live alone and I get meals on wheels and I look forward to Friday because it is a social meeting and we have great chat and great fun together.
- Like the other ladies I live alone and my son comes to me every week and we have a discussion about what went on here today. On Saturday he makes up a dish and I might get two or three days out of it'.

6.3.2.2 Food issues in their lives

In general the women in this group did minimal cooking in their everyday lives. Cooking activities involved re-heating in a microwave or preparing breakfast or a snack. Food and health issues were not prominent in their lives now, although two women recounted how they had experienced difficulties with feeding children many decades previously. For this group food issues revolved around trying to shop and cook (albeit to a limited extent in this group) for one:

I live in sheltered accommodation. We get our main meal everyday and as I am always hungry I have to be thinking of things for my breakfast and for my evening meal and even before I go to bed I am still hungry. So I am looking for things. I am a hungry person.

I think a lot of people reach our stage in life they are after cooking meals all their lives and they don't want to be cooking for one person and they are looking for something nutritious easy and quick. They haven't got the energy to be standing over a stove.

Interviewer: is that a big thing if you have been used to cooking for a family.
- I was very fond of baking'
Interviewer: but then when you are on your own.
- You don't bother
- Oh I do
- You have no initiative to bake or cook or anything anymore.

6.3.2.3 What stands out from the HFME course.

This group had not been involved in cooking during the course although some had been involved in chopping vegetables. While the group had some difficulty with recalling memories of the course, cooking and shopping for one and changes in nutritional information were aspects that stood out for them:

> Interviewer: was that the big thing in the course? What stands out for you?
> - Well it gives you ideas about cooking for one
> - It is so far back I can't remember
> - I have to tell you we all have the same problem we cannot remember back that far!
>
> What stood out for me I remember something about eggs. Well going back to when my children were small you started off giving them the yolk of the egg because the white wasn't good and you gradually increased that to a whole egg over a period of time. And it was one egg a week. Now I believe you can have one egg a day.
>
> He told us about the bananas – the bit we threw away the string was very good for you.

6.3.2.4 HFME in the context of their everyday lives

Although this group were at a stage in their lives when they depended upon others to prepare their food, they did shop for some food items. They highlighted that living alone and cooking and shopping for one could be problematic.

It was difficult to buy small quantities. Eggs could only be bought in six packs or the alternative four packs were the organic ones that were more expensive. It was hard to buy two rashers. The HFME course had provided them with some strategies for shopping, cooking and storing food for one person:

> Because of cholesterol. I was only to have two eggs - but you have to buy six.
> - It is very difficult to buy for one person.
> Interviewer: did you learn anything about that?
> - Yes making enough for two days or three days soup and stews.

This group emphasised their attraction to the course was related to the opportunity for social interaction. Important to the group was the fact that the course took place where they were and they did not have to travel to it. For some members of the group attendance at the day centre appeared to be the main outing of their week and they most likely were not in a position to arrange transportation to other places. The convenience of attending the course at the day centre agreed with their everyday life situation and gave them the opportunity for more social interaction:

> Well it is convenient for us.
> - Yes a big factor
> - Or anything that would help us that it comes to us otherwise we would have to get transport.
>
> For the company
> - That's the main thing
> - Human contact.

7 Discussion

The aims of the evaluation were as follows:

1. determine if the programme is *meeting its original objectives*
2. *inform the ongoing planning and development* of the programme
3. *assess the coordinator's attitude* towards the programme
4. *assess the peer-leaders' attitudes* towards the programme

In order to fulfil these requirements, the evaluation process sought to:

- place the HFME intervention in the broad context of related and similar community food projects internationally and nationally
- identify what is already known about this particular project
- clarify a set of appropriate and reliable performance indicators to assess the outcomes of this project
- gather relevant qualitative and quantitative data to reflect people's experiences of the project, in line with the identified indicators
- analyse the findings
- report any recommendations to the commissioners of the evaluation and to other key stakeholders

This discussion initially focuses on the specific aims of the evaluation as outlined above. It addresses the specific questions listed in terms of the research evidence that has been presented in this report.

The discussion then also considers some additional matters, outside of the original terms of reference, but which arose during the research process. These include the nature of the peer education process; and the need to consider the strategic location of the HFME programme within the overall work of the Southside Partnership.

7.1 Does the HFME programme delivered by the Southside Partnership meet its original objectives?

It was not possible to clearly identify one single easily accessible document that fully outlines the aims and objectives of the Southside Partnership's HFME programme, but an overall understanding can be obtained from a variety of sources.

The aim of the HFME project, as delivered by the Southside Partnership in conjunction with the HSE, has been outlined as follows:

> to improve nutrition knowledge and eating behaviour and ultimately to reduce diet-related morbidity and mortality from cardiovascular disease and other preventable diseases (Steering group minutes, May 2007)

More specifically, according to promotional literature for HFME, the objectives for participants are to:

- encourage healthy eating
- improve knowledge of nutrition when eating meals at home
- eat healthy meals on a budget

(promotional leaflet for HFME, Southside Partnership)

The HFME manual states (p. 12) that the aim of the programme is to encourage participants to:

> learn how to make good food choices for us and our families using the healthy eating guidelines from the Department of Health and Children

With the current available data it is not possible to evaluate the extent to which the HFME programme has achieved any of these objectives. For example, in order to determine changes in food consumption, it would be necessary to obtain a baseline measure of the food consumption of participants. In HFME the participants were, during the first session, encouraged to identify 'what did you eat yesterday?'. This question was repeated in the final session, in order to draw attention to any changes that may have occurred. But this data is not collected from participants, but is for their own consideration only. There is also sensitivity to questions of confidentiality and literacy skills. Thus an external evaluator, or indeed programme staff, cannot ascertain through this means whether any changes in consumption have taken place. To then demonstrate that any such changes are a consequence of the HFME programme would be another matter again.

It is a notoriously difficult and complex process to measure dietary intake (Rutishauser, 2005) at the best of times. Furthermore, it is very difficult to demonstrate a significant change in eating behaviour or nutritional status as a consequence of peer-led food and nutrition interventions, even when these have been constructed within controlled clinical environments (Gibson, 2007). Therefore we could anticipate that even if a robust and thorough process was established to accurately record all participants' food intake and nutritional status, anthropometric data, and so on, it is unlikely that a statistically valid association could be demonstrated between an intervention such as HFME and any specific health outcome – in particular one as long-term as a reduction in overall morbidity or mortality rates.

Thus we may only be in a position to comment on the *process* of delivering the current HFME programme. The evidence that has been generated by this evaluation process suggests that:

1. participants who have responded on evaluation sheets have indicated an overwhelmingly positive assessment of the HFME programme

2. the programme coordinator has expressed a high level of satisfaction with the outcome of the programme

3. there is evidence that the programme is reaching a very diverse range of participants, many of whom fall within the Southside Partnership's targeting of more 'vulnerable' and 'marginalised' groups within the Partnership's catchment area.

4. peer leaders have expressed an overall level of satisfaction with the programme and have made a range of suggestions for its extension to further groups within the community

5. the findings of this evaluation are broadly in line with the findings of previous evaluations of prior HFME programmes in other areas in Ireland

7.2 How might this evaluation inform the ongoing planning and development of the HFME programme?

7.2.1 Overall attitude towards the programme

The evaluation, as indicated above, suggests that the HFME programme has been positively assessed by all of those who have been involved in it, as participants, peer tutors, or as coordinator. This may help to justify further delivery of the programme, or its extension into new community groups or cohorts.

7.2.2 Initial training

Peer leaders express overall satisfaction with the training they have received. They indicate that they learned new information during the training. There was little that was negative in the feedback on training; the few negative comments related to the approach of other trainees, rather than any significant shortcoming in the training itself. It may be concluded that the training of peer leaders is satisfactory and fit for purpose. An issue that was raised by the evaluator, but that does not appear to have been raised by the peer leaders, is the external accreditation (eg through FETAC or similar body) of peer leader training. This is something that the Partnership and Steering Group may wish to consider in the future.

7.2.3 Delivery of courses

Generally speaking the majority of courses were delivered to the satisfaction of the peer leaders. The main problems with delivery related to small group size and to literacy issues. These are issues that may need to be further considered.

7.2.4 Target groups

There is strong evidence that the HFME programme is meeting a broad range of target groups, and that the diversity continues to increase. It is fair to conclude that in this regard the programme is meeting its objectives. A number of peer leaders have raised the issue of availability to groups of people that have not pre-formed, audience groups that are not already extant in the community. A small number of programmes have been openly advertised, but the expansion of such programmes to a broader range of community members on a 'walk-up' basis may merit consideration.

7.2.5 Venues

Peer leaders expressed overall satisfaction with the venues for delivery of HFME. There was minimal negative comment from participants in relation to the venue. The issues raised by peer leaders related to the suitability of some venues in terms of size, cooking facilities, and perhaps most significantly, the difficulties in

carrying equipment from car parks into the venue. This last issue is one that may merit some attention.

7.2.6 Manuals and teaching materials

The manuals and teaching materials for the programme were in the process of revision for the duration of this evaluation, and have been the subject of a separate independent evaluation (Newman and Associates, 2008). Thus this matter is not considered in any detail in this report.

7.2.7 Dishes prepared

Overall there was satisfaction expressed with the dishes prepared as part of the programme, and particular enthusiasm for some of these. The only dish to consistently attract negative comment, in line with other evaluations, was the 'tuna bake'. The inclusion of this dish in the repertoire may need to be reconsidered.

7.2.8 Variable outcomes of programme

The evidence suggests that there are two types of outcome from the HFME programme. On the one hand participants indicate that they have obtained new knowledge and have, in some cases, made changes to food and eating practices. Another group of participants are not in a position to engage in food preparation: for example those with specific learning disabilities or the frail elderly. These groups may be in residential or day-care and not in a position to exert control over the preparation of their food (though the programme may aid them in advocating for specific choices). For these groups, however, the HFME programme may provide a valued diversionary activity and may lead to sociable interaction. It may also provide them with some useful information related to nutrition. This outcome has been identified with other food and eating projects and services (see M. Share, 2005; P. Share, 2006). The broader outcomes related to social interaction, mental health and leisure/recreation that the HFME programme may provide may merit consideration.

7.2.9 Support structure

The role of the programme coordinator and community dietitian were both strongly endorsed by the peer leaders. It would be fair to say that knowledge or appreciation of the Southside Partnership's role in the development and delivery of the HFME programme was low. The Partnership as a body may wish to explore ways to better communicate with the peer leaders. The HFME Steering Group, for example, may wish to explore the possibility of peer leader representation.

7.3 What is the coordinator's attitude towards the programme?

Two face-to-face interviews were carried out with the HFME Coordinator (on 23 July 2008 and 30 October 2008). It would not be ethical in terms of best research practice to reveal extensive details of the outcomes of these individual interviews. Nevertheless the material obtained in these interviews served a number of important purposes for the evaluation process:

- they provided a factual orientation in relation to the purpose, establishment and future direction of the HFME programme
- they provided a measure of triangulation in relation to research findings from other sources – for example participants and peer leaders
- the coordinator provided a gatekeeper function, for example in terms of access to groups for focus group discussions
- the coordinator (and the Education coordinator of the Partnership) engaged in a valuable discussion in relation to the strategic location and direction of the HFME programme

It can be reported that, for the Coordinator, the overall feeling is that the programme 'has worked'. Only one course was closed as attendance was low, while a small number of others proceeded with numbers that were less than was optimal. On the other hand she is particularly proud of the extension of the programme to what might be termed 'hard-to-reach' marginalised groups within the community, such as single homeless men; those in recovery from substance use; and Traveller groups. This is related to a preparedness to be flexible about programme delivery, but is also indicative of a commitment to the welfare of such groups. The coordinator has expressed an enthusiasm for the delivery of the programme to new groups, perhaps through the use of new types of venue or meeting places, such as crèches and sports or social clubs. She also has expressed an interest in sourcing a suitable follow-on programme or programmes from the HSE or other bodies.

7.4 What are the peer-leaders' attitudes towards the programme?

The responses of the peer leaders are extensively reported in Section 6.2 of this report and it is not necessary to repeat them here. There is a high level of satisfaction with the programme – from the initial training, to the ongoing support, to the materials used. Inevitably, given their high level of engagement with the programme, the peer leaders have a number of constructive suggestions, that have been identified in Section 6.2.

Some notable suggestions that may merit consideration, include:

1. ensure that group sizes to not fall to an unsustainably low level [6.1.2.1]
2. address the issue of transferring course equipment and materials from car to venue [6.1.2.2]
3. dispense with the tuna bake from the recipe list [6.1.2.3]
4. recognise that familiarisation with new delivery materials takes peer leaders' time [6.2.3.1]
5. recognise that some participants may feel that they 'have to' attend sessions, and that this may impact on commitment and involvement [6.2.3.3]
6. some peer leaders may appreciate a clearer indication of the level of available employment on the programme, particularly if they see their involvement as a key source of income [6.2.3.3]

7. make use of contemporary design and marketing techniques in the design of the manual and associated materials, including use of the internet as a source of information [6.2.5]
8. consider whether a basic knowledge of food/science/nutrition be a formal prerequisite for appointment as a peer leader [6.2.6]
9. consider whether the target audience for HFME should be expanded beyond those identified as ‘disadvantaged’ [6.2.7.2; 6.2.11]
10. recognise that groups of older people may derive different types of positive outcome from the programme, more related to sociability than nutrition information [6.2.8]
11. recognise the different important ways in which HFME can be expressed as ‘community owned’ [6.2.9]
12. as outlined above, consider how the role of the Southside Partnership as originator of the programme might be better communicated to the peer leaders and consequently to participants [6.2.10.1]
13. recognise as a key resource peer leaders’ own orientations to food and eating at various stages of the programme [6.2.12]

7.5 Other issues

7.5.1 Peer-led community development

The HFME programme is specifically based on a model of ‘peer-led community development’. This suggests two key aspects: that the programme is based on a community development philosophy, and that it is delivered to participants by their ‘peers’ from within the community. According to Gibson (2007) the particular attributes of peer educators and their recruitment, training and commitment may all influence the success of community-based food initiatives

Dowler and Caraher (2003: 60) have recognised the importance of the peer-led, community-based approach:

> The characteristics facilitating projects’ sustainability are those of sound community development, such as community consultation, ongoing involvement and ownership, the scope for reconciling different agendas, and continuity of funding. By contrast projects which are exclusively owned, meeting only professional agendas, and parachuted into a community with short-term start-up funding, are likely to flounder. Dynamic local workers and discreet professional support also contribute to project success.

This statement points to the crucial importance of dynamic peer involvement in the sustainability of projects such as HFME. HFME is delivered by non-experts, but it can be questioned the extent to which they are embedded within the communities to which they deliver the programme. The programme coordinator (interview, 23 July 2008) suggests that two to three of the peer leaders are (locationally) ‘from the community’, while the remainder are from ‘near the community’. It may be important for the efficacy and sustainability of the programme for the programme to identify peer leaders from directly within the

groups targeted, though this may cause some conflict of interest with the existing peer leaders, especially if they are asked to help in this identification process. In this way the possibility of ‘cascading’ the messages of HFME may be enhanced (Gregg, 2008; Hawkins, 2008).

A related matter is the relationship between ‘expert knowledge’ as expressed through the manual, the recipe book and the input of the community dietitian, and local or indigenous knowledge brought to the HFME sessions by participants. To what extent could we say that this project is either participant or trainer led – as opposed to dissemination of authorised nutritional information? Some of the peer leaders spoke of how they incorporated participants’ knowledge, and this was also alluded to by participants in their focus groups. A consideration of how to systematically recognise and incorporate the existing knowledge of participants would be in accordance with community development, peer education and adult education principles. This may involve further adaptation of the programme for specific audiences – as has already happened at the local level in the delivery by some of the peer leaders. This should be recognised as a strength of the programme, not as a deviation from the standard approach. As Gibson (2007: 985) notes:

> an approach which is successful in one setting may not translate to a different one. Thus, in evaluating the effectiveness of peer education, there is a need to become more sophisticated in thinking about the context and avoiding generalisations.

The suggestion from this section is that the Partnership and the HFME Steering Group may wish to look more critically at the notion of peer leadership, and explore if it can be pushed further in involving and supporting more members of targeted groups to become actively involved in the delivery of the HFME programme in the future, perhaps through the expansion of relevant training. This may help to ensure the future efficacy and sustainability of the programme.

7.5.2 Strategic issues – the role of the partnership

It was not clear to the evaluation team, from the research outlined in this report, nor from discussions with the coordinator or partnership staff, where the HFME programme fitted in relation to their overall strategic direction of the Southside Partnership.

It is beyond the scope of this report to examine the complex issue of the role of local partnership companies in either advocacy or service delivery. Nevertheless there is a need to examine where the HFME activity sits within the range of activities of the Southside Partnership. More broadly there is a question of how community partnerships engage with health and lifestyle issues, in conjunction with the more usual employment, welfare and education matters that have been their ambit beforehand. This is particularly relevant at a time of retrenchment of public services when bodies such as the HSE may be less likely to engage in this type of activity.

7.5.2.1 Options in relation to the delivery of HFME

There are four apparent options for the Southside Partnership in relation to the HFME programme:

a) to discontinue involvement in this field and to allow delivery by some other organisation. The Partnership would focus on 'core business' and encourage the HSE or other health bodies (eg commercial health companies) to deliver community-based food and nutrition programmes as part of their mainstream activities

b) the Southside Partnership should maintain involvement at the current level of engagement. Delivery of HFME remains a valued but subsidiary element of the Partnership's activities, dependent on support and partnership from HSE or other funding bodies

c) the Southside Partnership maintains involvement in HFME and seeks to supplement this with some other externally-funded health/lifestyle programmes, such as the 'Ageing with confidence' programme, which has a similar delivery mechanism; and stress-management and other health/lifestyle programmes.

d) position health and lifestyle issues as a strategic priority for the partnership, seeking direct funding as a service provider, either independently, or in conjunction with the HSE or other bodies

Each of these directions would have implications for the HFME programme, but would also involve a decision by the Southside Partnership as to its involvement in an expanded range of activities to include health and lifestyle issues.

8 Recommendations

The following recommendations derive from the issues raised by participants, peer leaders, programme coordinator and evaluators, based on the data gathered in the course of the evaluation, and a consideration of the broader literature in relation to community food projects:

Evaluability

1. Consider processes for gathering data about the operation of the HFME programme, so as to enhance future evaluability. This may involve devising appropriate measures for the assessment of dietary practices, attitudes and knowledge. Such processes should recognise a) the difficulty and complexity of measuring food intake and dietary practices; and b) the need to be sensitive to issues of literacy, confidentiality and privacy.

Programme delivery

2. ensure that group sizes do not fall to an unsustainably low level: a minimum group size of six may be appropriate.
3. address the issue, for peer tutors, of transferring course equipment and materials from car to venue
4. recognise that familiarisation with new delivery materials takes peer leaders' time and may need to be costed into programme development
5. peer leaders should, where possible, be provided with a clearer indication of the level of available employment on the programme
6. make use of contemporary design and marketing techniques in the design of the manual and associated materials, including use of the internet as a source of information
7. consider whether a basic knowledge of food/science/nutrition be a formal prerequisite for appointment as a peer leader
8. consider whether the target audience for HFME should be expanded beyond those identified as 'disadvantaged'
9. recognise that groups of older people and those not in a position to prepare their own food may derive different types of positive outcome from the programme, more related to sociability than nutrition information
10. recognise as a key resource peer leaders' own orientations to food and eating at various stages of the programme
11. consider how participants' own knowledge can be formally recognised as an input to the programme
12. explore the possibility of peer leader representation on the HFME Steering Group

Strategic issues

13. recognise how HFME can be variously expressed as ‘community owned’
14. consider how to recruit more peer leaders directly from the HFME target audience
15. consider how the role of the Southside Partnership might be better communicated to peer leaders and participants
16. examine the options available to the Southside Partnership in relation to the programme, in terms of its medium and long-term strategic development, in relation to an enhanced role in the delivery of health and lifestyle-related services

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10 Appendices

Appendix 1 – structured interview guide

Characteristics of tutor

- How did you yourself get involved in HFME?
- What is your background (career, education, what are you doing now)?

Delivering HFME sessions

- How many HFME sessions have you run?
- What groups did you run these sessions with? What are the key characteristics of these groups?
- Describe the work involved in running an HFME session: from preparation to follow-up

About the programme

- What do you think the HFME programme was/is trying to achieve?
- How successful do you think the HFME programme is in achieving its aims?
- Who are the target group for HFME? Is HFME reaching its target group?
- Do you think that the programme has any *unintended* outcomes? What might these be?
- What type of people get the most out of HFME?
- Are there people that don't really benefit from HFME? Who are they?
- The HFME is described as a 'community-owned' programme? In what ways is (not) this the case?

Programme delivery

- Which aspects of the programme work well/not well do you think?
- How closely did you follow the programme manual? If you made changes, why? What are your general views on the manual?
- What particular skills and knowledge do you think are required to be a tutor on HFME?
- What was the biggest challenge for you in delivering the HFME programme?
- How would you describe the input of the dietitian (Deirdre) into the programme?
- How would you describe the input of the programme coordinator (Ann) into the programme?
- How would you describe the input of the Partnership as a whole into the programme?
- If you could redesign the programme yourself, what changes would you make?

The future

- Should HFME be extended to other groups in the community? If so, which ones?

General context

- What do you think are the most important factors affecting people's eating behaviour these days?
- His involvement in this programme changed any of your own ideas about food or your food practices (eg how you cook, what you eat)?

Checklist

Have any of the following issues been raised in the HFME sessions? How were you able to respond?

Topic	didn't come up at all	was scheduled as part of the session	not scheduled, but was able to discuss anyway	the dietitian covered it later	I couldn't cover this topic at all
school lunchboxes					
recipes for specific ethnic/cultural groups					
diabetes					
exercise and diet					
infant foods					
food for children					
vegetarian food					
low-fat options					
budgeting					
allergies					
nutrition-related illness					
fish dishes					
losing weight and dieting					
fibre					
vitamins and minerals					
convenience foods					
cooking for the elderly					
diets for pregnancy					
use of fats and oils					

Were there any other specific topics that people raised?

Appendix 2 – participant information sheet

Healthy Food Made Easy Evaluation: Information for study participants

We have been contracted by the HSE and the Southside Partnership to carry out an evaluation of the Healthy Food Made Easy [HFME] programme that you have been involved in as a course tutor. The evaluation aims to:

- review the aims and objectives of the programme
- determine what has worked well and what might be improved,
- describe course tutors' and course participants' experiences of being involved in the programme.

We are inviting you to take part in an interview lasting approximately 45 minutes. This interview will broadly explore:

- how you became involved
- how you experience programme delivery
- your views on the objectives of the HFME programme
- barriers and facilitators to programme delivery

This information will be collated into a report by the Researchers that will be used to inform the future development of the HFME or other similar programmes.

Your responses will be strictly confidential. Your name will not appear in the research results. We may publish a summary of everybody's responses or present such a summary at a conference, but your identity will be made anonymous. If you say something that sums up a situation very well we might like to use your words - but we would not put your name next to what you say.

You do not have to take part in this study and if after starting you do not wish to continue then you are free to stop.

Contacts for further information

If you have any questions about any aspect of this study you may contact the researchers:
Dr Michelle Share, Trinity College Dublin on 01 896 3977 sharem@tcd.ie
Dr Perry Share, Institute of Technology Sligo on 071 91 55340 share.perry@itsligo.ie
or
Aileen O'Brien, South Side Partnership on 01 2090648 aileen.obrien@sspship.ie
Deirdre Walshe, HSE on (01) 2355404 deirdre.walsh1@hse.ie

Healthy Food Made Easy Participant Consent Form

If you tick **"yes"** it means that you have decided to participate and have read everything that is on this form and the information sheet about the study.

Yes, the purpose of the research has been explained to me and I have read and understood the information sheet given to me ☐

Yes, I have been given the opportunity to ask questions about the research and received satisfactory answers ☐

Yes, I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason ☐

I consent to take part in the above named study ☐

OR

No, I do not want to participate in the study ☐

Name	Date	Signature