Appendix 1 Review Protocol

1. Purpose of this document

This document describes the aims, scope and intended methods of the qualitative evidence review which will be produced by PenTAG to support the development of NICE Public Health Guidance on whole system approaches to obesity prevention. The results of this review will be presented at PDG4 in November.

Where appropriate, this review will be conducted according to the 2nd Edition of the *Methods for the development of NICE public health guidance* (2009). However, as CPHE have already indicated, it is clear that many of the reviews and research projects for this guidance may need to be more conceptually and methodologically innovative and flexible than standard systematic review methods. This review may need to be flexible about seeking relevant qualitative evidence relating to a whole system approaches to obesity prevention in order to respond to areas of available evidence.

We note that Review 1 of this series of reports strove to build a definition of whole system approaches. We did not identify for this any papers that described interventions to prevent obesity that exhibited all the key components of our developing definition.

2. Clarification of scope

This review aims to inform public health guidance on how local policy and decision makers can effectively implement a whole system approach to prevent and reduce the prevalence of obesity in different communities.

In the remainder of this review protocol we use the term “whole community” approaches as short-hand for approaches which are community wide (focusing on a particular area, or particular organizations and/or subgroups in an area) and which exhibit some of the core features of whole system working as defined in Review 1 and reproduced below. Findings from Review 1 suggest that there may be little or no evidence relating to obesity prevention projects which consciously use the language and methods of whole system working.

The focus of the scope is on local implementation and delivery. As such, we intend to prioritise research which asks those involved in the design, planning, delivery and

evaluation of obesity prevention activities (or other complex public health problems) which operate at multiple levels and involve multiple partners.

From Review 1, together with Programme Development Group input, identified a number of key attributes of about the design and implementation of effective partnership working towards obesity prevention within the wider system:

1. **Explicit recognition of the public health problem(s) as a system:** that is recognition of interacting and evolving system elements; self-regulation; synergy and emergent properties (see Review 1, Summary Statement 1)

However, since we did not identify any obesity prevention projects which met this first criterion, we intend to focus on community wide approaches which meet other components that are indicative of Whole systems working (see Review 1, Summary Statement 2), for example:

2. **Capacity building:** capacity building within communities and organisations was an explicit goal

3. **Local creativity:** local creativity and/or innovation was encouraged

4. **Relationships:** clear methods were used to develop working relationships, within and between organisations

5. **Engagement:** clear methods were used for engaging community members in programme development and delivery. Engagement of diverse people, organisations and sectors.

6. **Communication:** clear methods were used for enhancing communication between actors in the system

Additional suggested features of whole systems working, following Review 1 and PDG 1:

7. Focus on the **embeddedness of action and policies** for obesity prevention in organisations and systems.

8. Focus on the **robustness and sustainability** of the system to tackle obesity (this includes notions of the adaptability and learning capabilities of the systems/networks/partnerships established)

9. **Facilitative leadership** not necessarily located at any particular levels or organisations

The presence or absence of these factors is likely to have an important impact on the success of a whole system or whole community approach to obesity prevention. Further, while there may problems which are specific to obesity, the above attributes are likely to be generic across a range of complex public health problems which would benefit from this approach. We therefore anticipate growing the searches related to these key concepts in an iterative fashion, beginning with searches which focus on successful multi-agency working and community wide activities across a range of public health problems.

We note that CPHE has already produced guidance about community engagement and so we do not intend to revisit this here: that is, we will not search explicitly for such material, although if included studies raise important issues about this in relation to a whole system or whole community approach to obesity prevention we will consider this for inclusion.

3. Review Questions

Main research question:

What factors act as barriers to, and facilitators of, the successful development, implementation, delivery and effectiveness of a whole system approach to preventing obesity (or other complex public health problems) in a locality?

Supplementary questions:

What factors act as barriers to, and facilitators of, successful:

- Capacity building
- Encouragement of local creativity
- Relationships between individuals and organisations
- The engagement of all relevant sectors and workers
- Communication between individuals, organisations and the public
- Embeddedness of action for obesity prevention in organisations and systems

- The robustness and sustainability of the system to tackle obesity.
- Facilitative leadership

Who are the essential partners and packages of activities for a successful whole system approach to obesity prevention?

Are there any implications for evaluation and monitoring?

4. Populations

4.1 Groups that will be covered

Those involved in the planning, design, management, delivery or evaluation of local area initiatives to prevent obesity which are multi-level and multi-sectoral (whether from public, private, voluntary or lay populations).

4.2 Groups that will not be covered

Children and adults who are undergoing clinical treatment for obesity. This is covered by 'Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children'. NICE clinical guideline 43 (2006).

5. Initiatives/approaches

5.1 Initiatives/approaches that will be covered

There will be 2 phases to the review. The first phase will involve screening all those references tagged as qualitative research during the screening for Reviews 1 and 2 (neither of which used any filter for research type in their searches). For full definitions of the types of initiatives covered please see protocols for these reviews. Note that Review 2 will be searching for initiatives relating to smoking as well as to obesity.

The second batch of searches will take a targeted approach, in databases and online, looking explicitly for qualitative research, but focusing on:

1) Evaluations of key named obesity prevention activities which include relevant qualitative research.

2) Published research the content of which reflects the key features of our developing definition of whole system approaches related to community wide

public health programmes. These searches will not be restricted to obesity, but will also look for information about smoking prevention activities which take a multi-faceted, partnership approach, mirroring the focus of Review 2.

Research which investigates attitudes towards, and experiences of, obesity and its prevention but which does not refer to the implementation of delivery specific prevention initiatives or activities, will not be included.

5.2 Initiative/approaches that will not be covered

- Clinical management of children and adults who are overweight or obese. This is covered by existing NICE guidance on obesity.
- Prevention or management of medical conditions associated with being overweight or obese (such as type 2 diabetes or cardiovascular disease).
- Discrete interventions in a particular location, such as schools or workplaces. This is covered by existing NICE guidance.
- Complementary therapy methods to reduce or manage obesity.
- Assessment of the definitions of 'overweight' and 'obese' in relation to children and adults.

6. Inclusion and exclusion criteria

6.1 Inclusion criteria:

For details of inclusion criteria for review 1 and 2 please see relevant protocols.

Studies identified through new searches in this review will be screened in two phases, at title abstract phase and full text phase. Studies will be included if they are:

- Systematic reviews of qualitative research which use a recognised, structured approach to identifying and synthesising studies (including, but not limited to, meta-ethnography, meta-study, meta-synthesis, narrative synthesis, etc).
- Primary qualitative research designs which use recognised methods of data collection and analysis (including, but not limited to, observational methods, interviews and focus groups for the former and grounded theory, thematic analysis, hermeneutic phenomenological analysis, discourse analysis etc. for the latter.)

- Among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative) whether from public sector, private sector, voluntary or lay populations.

- About programmes that are based in the UK (initially. We may expand this to OECD countries if too little UK based information is available).

- Studies published from 1990.

- Written in the English language.

6.2 Exclusion criteria:

- Studies which do not illuminate barriers and facilitators to the successful planning, managing, delivering or evaluating whole community initiatives to prevent obesity or other public health initiatives.

7. Search methods

7.1 Identifying the literature: Overview

Building on search terms and programme names identified through searches already conducted in Review 1 and 2, searches of relevant bibliographic databases, and also selected websites will be conducted in order to identify relevant primary research. This will be supplemented by communication with PDG members, other experts and/or organisations involved in the relevant research or policy areas, reference searching and citation searching.

A separate and more detailed Search Protocol and Search Strategy will be agreed separately between this project's information specialists (at WMHTAC) and the relevant CPHE analysts and information specialists. Given the iterative nature of this review and the potential range of key features to be covered, the Search Strategies may need to be agreed separately from the Search Protocol (which will provide the overall framework of what types of searches may be conducted amongst which databases and sources, and using which key search terms).

7.1.1 Search processes and methods

- Databases to be searched and search terms will be detailed separately in the search protocol and strategy.

- Two information specialists (SB & AF-S) will conduct the searches alongside the two reviewers (RG & MP) undertaking the review with a third available (RA) where uncertainty or disagreement is found between the two main reviewers.

- All searches will be fully documented (databases and websites used, strategies and dates of searches etc.) References will stored on a bibliographic database.

7.1.2 Study selection at search stage

- Studies published from 1990
- Studies published in the English language
- Studies conducted in the UK.

8. Study selection process

Assessment for inclusion will be undertaken initially at title and/or abstract level by a single reviewer (and a sample checked by a second reviewer of at least 10%, more if resources allow), and then by examination of full papers by both reviewers independently. Any disagreement or uncertainty will be resolved through discussion. Where the research methods used or type of initiative evaluated are not clear from the abstract, assessment will be based upon a reading of the full paper.

If there are a large number of includable studies, such that a high quality review of them all would not be feasible within the time and resources available, then some studies may be excluded *post hoc* from the full review. This will be done at the full text stage. Inclusion will be determined by the extent to which the study explores and illuminates the key questions in the context of initiatives which are relevant to a whole system or whole community approach to obesity prevention. The overall rationale and reasons for such exclusions will be discussed and agreed with the CPHE team at the second interim progress meeting and at other points during the review if necessary.

9. Quality assessment and data extraction

We aim to use the Wallace checklist for quality assessment (Wallace et al. 2004).

Details of the studies' methods will be extracted into a pre-designed data extraction form. Key findings pertinent to informing the research questions, will be extracted in the form of quotes, themes and concepts in the primary research papers.

The extraction data and quality assessment will be conducted by a single reviewer, and checked by a second reviewer with a third available for consultations in case of uncertainty or disagreement. Ongoing discussions within the team will ensure that we develop a coherent picture of the body of relevant research.

Data synthesis and presentation, including evidence statements

Data synthesis and presentation, including evidence statements will be conducted according to the procedures outlined in the 2nd Edition of *Methods for development of NICE public health guidance 2009* where appropriate.

Key choices in how to synthesise the included evidence, or in how to develop evidence statements for this review, will be made in response to the information identified. If there is enough conceptual data we will undertake a meta-ethnography (Garside et al. 2008; Noblit & Hare 1988). Where findings are more descriptive, we will conduct a thematic synthesis.

References

Garside, R., Britten, N., & Stein, K. 2008, "The experience of heavy menstrual bleeding: A systematic review and meta-ethnography of qualitative studies", *Journal of Advanced Nursing*, vol. 63, no. 6, pp. 550-562.

Noblit, G. W. & Hare, R. D. 1988, *Meta-Ethnography: Synthesizing qualitative studies*, 1 edn, Sage Publications Ltd, London (England).

Wallace, A., Croucher, K., Quilagars, D., & Baldwin, S. 2004, "Meeting the challenge: developing systematic reviewing in social policy", *Policy and Politics*, vol. 32, no. 4, pp. 455-470.

Appendix 2 Search protocol

The aim of the review is to inform public health guidance on how local policy and decision makers can effectively implement a whole system approach to prevent and reduce the prevalence of obesity in different communities. As such, the following questions will be examined:

What factors act as barriers to and facilitators of the successful development, implementation, delivery and effectiveness of a whole systems approach to preventing obesity (or other complex public health problems) in a locality?

Supplementary questions:

- What factors act as barriers to and facilitators of successful:
    - Capacity building
    - Encouragement of local creativity
    - Relationship between individuals and organisations
    - Engagement of all relevant sectors and workers
    - Communication between individuals, organisations and the public
    - Embeddedness of action for obesity prevention in organisations and systems
    - Robustness and sustainability of the system to tackle obesity
    - Facilitative leadership
- Who are the essential partners and packages of activities for a successful whole system approach to obesity prevention?
- Are there any implications for evaluation and monitoring?

Proposal for Searches for Review 3

Searches for Review 1 sought to identify the key elements of the whole systems approach generally as well as in relation to obesity prevention. The searches for Review 2 sought to identify literature relating to the effectiveness of whole systems approaches for the prevention of obesity and smoking.

The searches for Review 3 will seek to identify literature relevant to the questions above and will have several phases. The first phase will involve screening all those references tagged as qualitative research during screening for Reviews 1 and 2 (neither of which used any filter for research type in their strategies). For full definitions of the types of initiatives covered please see protocols for these reviews.

Since scanning the references for Reviews 1 and 2 so far suggests that qualitative research relating to effectiveness of whole systems approaches for obesity and smoking prevention is scarce, searches for Review 3 will be widened to also look for information about prevention activities in other public health areas which take a multi-faceted, partnership approach. Building on search terms identified through searches already conducted in Reviews 1 and 2, searches of relevant bibliographic databases and selected websites will be conducted to identify primary research. Search terms identified in Review 2 representing the types of whole systems approaches will be used with a filter for qualitative research which is based on work done at the Health Information Research Unit, McMaster University (see http://hiru.mcmaster.ca/hiru/HIRU_Hedges_MEDLINE_Strategies.aspx#Qualitative). The filter is of 'high specificity' and will be used to ensure that most of the references retrieved are likely to be relevant, without the need to scan a disproportionately large volume of references, many of which will not be relevant. The search strategies were piloted and key references identified using a broader filter were also identified using the specific one.

If necessary, specific searches on some aspects of the supplementary questions above and for evaluations of key named programmes which include relevant qualitative research will be conducted.

The above will be supplemented by communication with experts and/or organisations involved in the relevant research or policy areas, members of the PDG, reference searching and citation searching.

Searches will cover bibliographic databases and grey literature sources, particularly websites.

A sample search strategy for MEDLINE is detailed at the end of this search protocol.

Bibliographic databases searches

The following databases will be searched:

- Cochrane Library (Wiley) (CDSR, DARE, HTA, CENTRAL) - current
- MEDLINE (Ovid) 1950 – current
- MEDLINE In Process (Ovid) – present
- ASSIA (CSA) Applied Social Sciences Index and Abstracts 1987 - present

- CINAHL (EBSCO) – 1981 - present
- HMIC Health Management Information Consortium (Ovid) – current
- Social Science Citation Index (Web of Science) – 1898 - present
- EPPI Centre – Bibliomap, DoPHER, TRoPHI - current
- EPPI Centre - database on Obesity and Sedentary behaviour studies – current
- NHS CRD databases (DARE, HTA) – current

All searches will be limited to English language publications and a date range of 1990-current.

The strategies will be adapted appropriately to the various databases.

Targeted website searches

Many obesity and smoking specific websites were searched for Reviews 1 and 2 (see protocols for these reviews) and potential qualitative research from here has been marked and will feed into Review 3. These sites will not be searched again but the general websites will be searched for references on public health areas other than smoking and obesity prevention not retrieved previously.

General Websites:

The whole systems partnership: http://www.thewholesystem.co.uk/

Department of Health: http://www.dh.gov.uk/en

European Public Health Alliance: http://www.epha.org/a/3149

Health EU The public health portal of the European Union http://ec.europa.eu/health-eu/health_in_the_eu/prevention_and_promotion/index_en.htm

National Institute for Health Services Research: http://www.sdo.nihr.ac.uk/

Local Government Improvement and Development Agency: http://www.idea.gov.uk/idk/core/page.do?pageId=1

The Association of Public Health Observatories: http://www.apho.org.uk/

OECD http://www.oecd.org/

State Government of Victoria, Australia http://www.health.vic.gov.au/doh

Additional grey literature searches:

Scrutiny committee reports (to be searched via an internet search engine)

ZeTOC database (British Library)

ISI Conference Proceedings Citation Index (Web of Science) 1990 – present

Other web searches:

Searches via an internet search engine (Google.co.uk) for any named programmes considered for inclusion.

Internet search portals (INTUTE, TRIP and HTAi Vortal) will also be used to facilitate more precise searching of the internet.

All searches will be fully documented (databases and websites used, strategies and dates of searches). References will be stored on a Reference Manager database and duplicates removed.

Sample search strategy

Ovid MEDLINE(R) 1950 to July Week 3 2010

1 (multi-faceted or multifaceted or multi-agency or inter-organi?ational or partnership$ or multi-intervention$ or multi-factorial or cross-sector$).mp. (22331)

2 (system approach$ or systems approach$).mp. (2226)

3 (complex adj2 system$).mp. (7051)

4 (whole system or whole systems).mp. (790)

5 ((system or systems) adj work$).mp. (1004)

6 (community adj (wide or based)).mp. (25318)

7 (qualitative or themes).tw. (89092)

8 1 or 2 or 3 or 4 or 5 or 6 (57497)

9 7 and 8 (2226)

10 limit 9 to (english language and yr="1990 -Current") (2094)

Information specialists' contact details

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Anne Fry-Smith a.s.fry-smith@bham.ac.uk

Appendix 3 Search strategy

Source: MEDLINE (Ovid) 1950 to August Week 1 2010

1 (multi-faceted or multifaceted or multi-agency or inter-organi?ational or partnership$ or multi-intervention$ or multi-factorial or cross-sector$).mp.
2 (system approach$ or systems approach$).mp.
3 (complex adj2 system$).mp.
4 (whole system or whole systems).mp.
5 ((system or systems) adj work$).mp.
6 (community adj (wide or based)).mp.
7 or/1-6
8 (qualitative or themes).tw.
9 7 and 8
10 limit 9 to (english language and yr="1990 -Current")

Source: MEDLINE (Ovid) In-Process & Other Non-Indexed Citations August 09, 2010

1 (multi-faceted or multifaceted or multi-agency or inter-organi?ational or partnership$ or multi-intervention$ or multi-factorial or cross-sector$).mp.
2 (system approach$ or systems approach$).mp.
3 (complex adj2 system$).mp.
4 (whole system or whole systems).mp.
5 ((system or systems) adj work$).mp.
6 (community adj (wide or based)).mp.
7 or/1-6
8 (qualitative or themes).tw.
9 7 and 8
10 limit 9 to (english language and yr="1990 -Current")

Source: Cochrane Library (all databases) (Wiley) 2010 Issue 3

#1 multi next faceted
#2 multi next agency
#3 multi next intervention*
#4 multi next factorial
#5 cross sector*
#6 multifaceted or partnership*
#7 inter next organisational
#8 inter next organizational
#9 system next approach*
#10 systems next approach*
#11 complex near/2 system*
#12 whole next system
#13 whole next systems
#14 system next work*
#15 systems next work*
#16 community next wide
#17 community next based
#18 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17)
#19 qualitative or themes
#20 (#18 AND #19)
#21 (#20), from 1990 to 2010

Source: ASSIA (CSA Illumina) 1987 – August 2010

(((multi faceted) or multifaceted or (multi agency)) or ((inter organisational) or interorganizational or partnership*) or ((multi intervention*) or (multi factorial) or (cross sector*)) or ((system approach*) or (systems approach*) or (complex system*)) or ((whole system*) or (whole systems) or (system work*)) or ((systems work*) or (community wide) or (community based))) and (qualitative or themes)

Source: **HMIC Health Management Information Consortium May 2010**

1 (multi-faceted or multifaceted or multi-agency or inter-organi?ational or partnership$ or multi-intervention$ or multi-factorial or cross-sector$).mp.
2 (system approach$ or systems approach$).mp.
3 (complex adj2 system$).mp.
4 (whole system or whole systems).mp.
5 ((system or systems) adj work$).mp.
6 (community adj (wide or based)).mp.
7 or/1-6
8 (qualitative or themes).tw.
9 7 and 8
10 limit 9 to yr="1990 -Current"

Source: CINAHL (EBSCO host) 1982 – Aug 2010

S1 multifaceted OR multi faceted OR multi agency or inter organi?ational OR partnership* OR multi intervention* or multi factorial or cross sector*
S2 system approach* OR systems approach*
S3 (complex N2 system*)
S4 whole system or whole systems
S5 (system work* OR systems work*)
S6 (community wide OR community based)
S7 s1 or s2 or s3 or s4 or s5 or s6
S8 (qualitative OR themes)
S9 S7 and S8
Limiters - Published Date from: 19900101-20100731; English Language; Human

Source: CRD Databases (searched 11th August 2010)

"system approach*" OR "systems approach" RESTRICT YR 1990 2010
complex NEAR system*
"multi faceted" OR multifaceted OR "multi agency" OR interorganisational OR interorganizational OR partnership* OR "multi intervention*" OR "multi factorial" OR "cross sector*" RESTRICT YR 1990 2010
"whole system*" OR "whole systems" RESTRICT YR 1990 2010
"system work*" OR "systems work*"
"community wide" OR "community based"
qualitative OR themes
#1 OR #2 OR #3 OR #4 OR #5 OR #6
#8 AND #7
#9 RESTRICT YR 1990 2010

Source: Social Science Citation Index (SSCI) (ISI WoS) Searched 11/8/2010

Search terms:
Title=(multi-faceted or multifaceted or multi-agency or inter-organisational or inter-organizational or partnership* or multi-intervention* or multi-factorial or cross-sector* or system approach* or systems approach* or complex system* or whole system* or system* work* or community wide or community based) AND Topic=(qualitative or theme*)
Timespan=1990-2010. Databases=SSCI.

Source: Conference Proceedings Citation Index (CPCI) (ISI WoS) Searched 11/8/2010

Search terms search 1:
Title=(multi-faceted or multifaceted or multi-agency or inter-organisational or inter-organizational or partnership* or multi-intervention* or multi-factorial or cross-sector* or system approach* or systems approach* or complex system* or whole system* or system* work* or community wide or community based) AND Topic=(qualitative or theme*)
Timespan=1990-2010. Databases=CPCI-S.

Search terms search 2:
Topic=(multi-faceted or multifaceted or multi-agency or inter-organisational or inter-organizational or partnership* or multi-intervention* or multi-factorial or cross-sector* or system approach* or systems approach* or complex system* or whole system* or system* work* or community wide or community based) AND Title=(qualitative or theme*)
Timespan=1990-2010. Databases=CPCI-S.

Source: ZETOC (British Library) Searched 11/8/2010

Search terms:

multi-faceted or multifaceted or multi-agency or inter-organisational or inter-organizational or partnership* or multi-intervention* or multi-factorial or cross-sector* or system approach* or systems approach* or complex system* or whole system* or system* work* or community wide or community based (terms used singly AND combined with term qualitative)

Source: EPPI Centre Bibliomap, TroPHI and DoPHER Searched 13/8/2010

Search terms as ZETOC for all databases

Source: TRIP database Searched 13/8/2010

Search terms used as with ZETOC

Source: HTAi Vortal 13/8/2010

Search terms used as with ZETOC

Source: Internet searches (Searched 13/8/2010)

Search terms: multi-faceted ; multi-agency; inter-organisational ; partnership* ; multi-intervention*; multi-factorial ; cross-sector* ; system approach* ; systems approach*; complex system* ; whole system* ; community based

Named programme searches

Source: Ovid MEDLINE(R) 1950 to August Week 4 2010

1 health$ action zone.mp.
2 healthy living centre$.mp.
3 new deal for communities.mp.
4 who healthy city.mp.
5 (who adj3 healthy cities).mp.
6 or/1-5
7 breathing space
8 smoking
9 7 and 8
10 6 or 9

Source: Internet searches: (Searched 8/9/2010)

Search terms as above

Appendix 4 Screening checklist

Title/abstract criteria (User Def 1)	
0	Retrieve (i.e. meets inclusion criteria[1])
1	Meets inclusion criteria, but NOT based in the UK
2	Does not meet inclusion criteria
3	Not in English
4	Published pre-1990
5	Potentially useful for case studies
6	Potentially relevant for cost-effectiveness review/ economic modelling
7	Duplicate
8	Not conducted in an OECD country
Additional criteria at full text stage (User Def 2)	
0	Include (i.,e. meets inclusion criteria[1])
1	Meets inclusion criteria, but NOT based in the UK
2	Does not meet inclusion criteria
3	Not in English
4	Published pre-1990
5	Potentially useful for case studies
6	Potentially relevant for cost-effectiveness review/ economic modelling
7	Abstract only
8	Publication withdrawn
9	Review paper – reviewed for references
10	Unobtainable
11	Focuses on community engagement
Focus of whole community approach *(complete for all inc. papers)* (User Def 3)	
1	Obesity (whole system approach)
2	Smoking
3	Physical activity or healthy eating (single-risk factor)
4	CVD or diabetes (multi-risk factor approach, e.g. diet and exercise)
5	Drugs and alcohol
6	Generic community health promotion
7	Other
8	Evaluation

[1] Primary qualitative research design which uses recognised methods of data collection and analysis (including, but not limited to, observational methods, interviews and focus groups for the former and grounded theory, thematic analysis, hermeneutic phenomenological analysis, discourse analysis, etc., for the latter)

OR

Systematic review of qualitative research which uses a recognised, structured approach to identifying and synthesising studies (including, but not limited to, meta-ethnography, meta-study, meta-synthesis, narrative synthesis, etc.)

AND

Conducted among those involved in the design, management, delivery, or evaluation of whole community initiatives to prevent obesity (or other public health initiative), whether from public sector, private sector, voluntary or lay populations.

Appendix 5 Quality appraisal tool and results of quality appraisal

Author (year) [Study ID]		**Appraisal: Y/ N/ CT/ NA**[1]	**Comments**
Research question	Is the research question clear?		
Theoretical perspective	Is the theoretical or ideological perspective of the author (or funder) explicit?		
	Has this influenced the study design, methods, or research findings?		
Study design	Is the study design appropriate to answer the question?		
Context	Is the context or setting adequately described?		
Sampling	Is the sample adequate to explore the range of subjects and settings?		
	Has it been drawn from an appropriate population?		
Data collection	Was the data collection adequately described?		
	Was it rigorously conducted to ensure confidence in the findings?		
Data analysis	Was there evidence that the data analysis was rigorously conducted to ensure confidence in the findings?		
Reflexivity	Are the findings substantiated by the data and has consideration been given to any limitations of the methods or data that may have affected the results?		
Generalisability	Do any claims to generalisability follow logically and theoretically from the data?		
Ethics	Have ethical issues been addressed and confidentiality respected?		

[1] Yes (Y)/ No (N)/ Can't tell (CT)/ Not applicable (NA)

		Theoretical perspective			Sampling				Data collection		Analysis			
	Overall score	Is the research question clear?	Perspective of author clear?	Influenced the study design?	Is the study design appropriate to answer the q	Is the context or setting adequately described?	Adequate to explore range of subjects/ settings?	Drawn from an appropriate population?	Adequately described?	Rigorously conducted so confidence in findings?	Rigorously conducted so confidence in findings?	Findings substantiated /limitations considered?	claims to generalisibility follow from the data?	Addressed and confidentiality respected?
Bauld et al 2005a	-	Y	Y	CT	Y	Y	CT	CT	N	CT	N	CT	Y	CT
Bauld et al 2005b	-	Y	Y	Y	Y	N	Y	N	N	CT	CT	CT	NA	CT
Benzeval, 2003	+	Y	Y	Y	Y	Y	Y	Y	Y	CT	Y	CT	CT	CT
Benzeval & Meth 2002	+	Y	Y	Y	Y	Y	Y	Y	N	CT	Y	N	Y	NR
Campbell-Voytal 2010	-	N	N	NA	CT	Y	CT	CT	N	CT	N	N	CT	N
Charlier et al 2009	-	Y	N	CT	Y	N	CT	CT	N	CT	CT	CT	CT	Y
Cole 2003	+	Y	Y	Y	Y	Y	Y	Y	N	CT	CT	N	NA	CT
Curtis 2008	++	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Dodson et al 2009	+	N	N	NA	Y	Y	N	Y	Y	Y	Y	Y	Y	CT
Evans & Killoran, 2000	+	Y	Y	Y	Y	Y	CT	Y	N	CT	CT	N	Y	CT
Hall et al 2009	+	Y	N	CT	Y	Y	CT	Y	N	CT	Y	Y	Y	Y
Khunti et al 2007	-	Y	N	NA	Y	Y	CT	Y	Y	Y	N	N	NA	NR
Platt et al 2003	++	Y	Y	Y	Y	Y	Y	Y	N	CT	Y	Y	Y	N
Po'e et al 2010	+	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	N	CT
Points 4 Life 2010	-	N	N	CT	CT	N	CT	Y	Y	Y	CT	N	NA	Y
Powell et al 2001	-	N	Y	CT	CT	N	CT	Y	N	CT	Y	Y	Y	CT
Rugkasa et al 2007	+	Y	Y	Y	Y	Y	CT	Y	Y	N	N	Y	N	CT

Appendix 6 Evidence tables

Study [quality appraisal]
Bauld et al 2005a [-]
Programme focus
Intervention name, Location HAZ **Year/ timescale over which implemented** 1997-2002 **Target population** Varied localities in England average 500,000 (range 200,00 to 1.4 million) concentrated in North and Midlands **Theoretical perspective** NR **Was local knowledge used in the design and/or delivery of the programme?** NR **Policy context** See other HAZ papers Initial enthusiasm nationally and locally for schemes which were seen as a real opportunity to influence change. In particular emphasis on partnership and community involvement, and focus on inequalities was welcomed. **Early pressures**: tension between need to early wins and longer term investment required for population change. Sense that tight deadlines was counter productive and could stifle creativity.. Communication problems between centre and HAZs: whether messages were clear and consistent and supportive of localities. Remit was broad and ambitious with a great deal of freedom about type of projects in which to invest. Resulted in a proliferation of early plans aiming to achieve very ambitious objectives in tight time frames. **Uncertainty:** National level had a considerable impact on the development and direction of the zones. Quarterly monitoring frameworks introduced. Shift to disease specific targets. Caused change of direction in HAZs. Future funding also in doubt. **Neighbourhood renewal and NHS reform:** Plethora of are based initiatives introduced by Labour after HAZs, and restructuring of the NHS. **Critical issues** **Exploring population level impact.** Neither HAZs nor national evaluation teams commissioned to use traditional evaluation tools such as household surveys to measure changes between baseline and FU. Bauld et al used Compendium of Clinical and Health Indicators and others to assess but concluded that data do not support the view that HAZs made greater improvements tio population health than non-HAZ areas 1997-2001. **Whole system features** “Whole systems change” (not further defined) a goal of the HAZ – this was centrally defined; details of what was done in any location or particular project limited. Bulding collaborative capacity was an aim. Local creativity acknowledged. Partnerships viewed as key. Communities contributed to designing projects and developing strategies. Set up to be learning organisations with extensive evaluation programmes.
Study details
Study name (if different) [year] Promoting social change: the experience of health action zones in England **Setting (e.g. school, community, etc.)** Community

Author (year) [Ref ID] plus associated paper/source
Bauld et al 2005 [4967]

Aim of study
- Examine the background to the HAZ and its evolution over time
- Introduce key features of the framework adopted for evaluation of HAZ
- Review what progress was made in relation to 3 key areas: planning for whole systems change, building collaborative capacity, & tackling health inequalities.
- Reflect on the overall progress made by HAZ
- Consider implications for policy design, implementation and evaluation of future initiatives.

Informed by theory?
Theories of change and realist evaluation

Study design
Evaluation
Case studies

Data collection method
Annual autumn visits to each HAZ interviewing the director/coordinator plus telephone interview in spring.
Collecting and reviewing all relevant documentation.
Reviewing high level statements in each HAZ.
"Seeking every opportunity" to meet informally with HAZ personnel at different events.

Case studies used survey & face to face and group interviews

Data analysis
Not reported

Sampling
Not clear

Study population
Not reported

Ethical issues?
Not reported

Source of funding
NR

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

See other HAZ papers

Findings

Primary emphasis of the evaluation would focus on a whole systems perspective on the management of change within the HAZs to promote modernisation and reduction of health inequalities.

Planning for whole systems change

Danger of placing too much reliance on logical planning structures to make progress in alleviating relatively intractable social problems.

Key HAZ assumption that local agencies could or had capacity to develop whole systems change and that in doing so would be able to share with central govt. clear plans against which they could be held accountable. This assumption seen to be naïve. HAZs struggled with task of planning activities and setting early and intermediate measures of success. Problems included:
- Lack of existing baseline data which would allow level of change HAZ's wanted to see. Targets sometimes in the absence of routinely collected data, or without being identified by needs assessment.
- Targets expressed without enough specificity to see if had been met.
- Selected targets only partially represented overall strategy.
- Targets imposed by central govt. not necessarily set at a level realistic locally because of a variety of contextual factors.
- Activities and interventions not conceptualised clearly enough to allow degree of change to be predicted.]Process measures not always plausibly linked to types of outcomes predicted to emerge from them.

Initiatives may require more support to develop integrated strategic approach.
Local players need time and training to engage partners and focus on developing strategic priorities and solutions. Balance between national context recognition and freedom at a local level, which will not have to react to every policy change is required.
Clarity of purpose for performance monitoring data is key. In some cases usefulness of data collected was contested, while others doubted that required data clashed with their local structures.

Building capacity for collaboration
Intended to be a partnership-based programme, best understood as a collection of agencies, groups and individuals rather than organisation in their own right. Whatever was achieved happened though collaboration across organisational and sectoral boundaries. In addition, was also facilitator for other area based initiatives (eg Sure Start).
HAZ created opportunities for developing new models of service provision to "established" as well as poorly served groups or service users, and new ways of working across boundaries. Community engagement also a key feature – contributed to designing projects and developing strategies.

Some evidence that "for collaborative capacity to become embedded in local systems, it needs to be present across a range of sites and levels from strategic to operational and in relation to governance as well as community engagement" (p.439) Mixed picture emerged. At strategic level, little evidence that HAZ made a major contribution to solving the challenges of partnership governance. Partly because little freedom to develop new governance arrangements. Accountability, both for performance and to the public, is a challenge for collaborations.
More success in contribution of new governance mechanisms and forms of accountability at levels below the strategic. Easy to establish within localities than across geographical boundaries.
At operational level, HAZs also made relatively little impact in furthering the application of collaborative mechanisms. There were contracts, joint appointments and secondments but did not explore pooled budgets or integrated services.
HAZs became more a top down initiative than initial aspirations suggested. Community involvement limited by accountability needs. Pririties laso became centrally set in unanticipated ways. Central changes led to more energy expended in negotiating place of HAZ in context of statutory systems than in establishing community priorities.

Reducing health inequalities
Not extracted – not considered relevant to WSA obesity.

Reflections on the HAZ experience
Encouraged to set themselves ambitious targets, few of which were achieved. But complexity and extent of activities make impact very difficult to assess.
Query whether they were given fair opportunity to demonstrate what they might be able to achieve.

Implications for policy and research
"In many important ways HAZs were the victims of the complexity that they set out to address" and the intricacy of social interventions, and weak evidence for health promotion activities. Clearer objectives, and better quantification of outcomes needed.

Notes
None

Study [quality appraisal]
Bauld et al 2005b [-]
Programme focus
Intervention name, Location HAZ **Year/ timescale over which implemented** 1997-2002 **Target population** Varied localities in England average 500,000 (range 200,00 to 1.4 million) concentrated in North and Midlands (Source: Bauld et al 2005 [4967]) **Theoretical perspective** NR **Was local knowledge used in the design and/or delivery of the programme?** NR **Policy context** See other HAZ papers **Whole system features** "Whole systems change" (not further defined) a goal of the HAZ – this was centrally defined; details of what was done in any location or particular project limited. Bulding collaborative capacity was an aim. Local creativity acknowledged. Partnerships viewed as key. Communities contributed to designing projects and developing strategies. Set up to be learning organisations with extensive evaluation programmes.
Study details
Study name (if different) [year] NA **Setting (e.g. school, community, etc.)** Community **Author (year) [Ref ID] plus associated paper/source** Bauld et al 2005 [5524] **Aim of study** To report project managers' perceptions of the implementation of HAZs **Informed by theory?** NR, but appears to be within a theory of change and realist framework (in common with the other HAZ evaluation work) **Study design** Evaluation **Data collection method** Interviews (n=NR) from eight of the HAZ areas – it is probable that these were supplemented by the other data collection methods detailed in Bauld et al 2005 [4967], but these are not explicitly referred to in this source **Data analysis** Theories of change and realist evaluation **Sampling** NR **Study population** Project managers across all 26 HAZs

Ethical issues?
NR

Source of funding
NR

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

See other HAZ papers

Findings

Many project managers identified the HAZs as being important drivers of joint working between statutory agencies
The fact that the director of public health post is a joint appointment between PCT and local authority is an example. Public health is now seen as a shared agenda… and [this] has been greatly helped by the HAZ. (HAZ project manager)

The nature of the problems that HAZs were supposed to address meant that the expectation of significant improvements in the short-term was wholly unrealistic, but that this was not particularly well-understood by others
Health and inequalities are about what people eat and whether or not they have a job and what their educational attainment is and the kinds of houses they live in… we are talking about the root causes of health, not about giving some existing services some additional capacity. So from that point of view, we haven't been given a fair opportunity. (HAZ project manager)

It [the HAZ initiative] has contributed to a whole range of interventions to tackle inequality in its broader sense and from that point of view I think it is very much to be applauded. However, I think if you really want to have a vehicle for tackling health inequalities then HAZs would have to be around fro another 25 years at least. (HAZ project manager)

The biggest interruption to HAZ strategy implementation that was identified came with national policy changes and ongoing uncertainty about the role and priority of HAZ within the Department of Health. For example, the development of National Service Frameworks (NSFs)
I know that some aspects of the implementation plan have probably changed dramatically, if I think about the primary care and community services programme… it pretty quickly moved into the big focus on elder care and intermediate care. I think I did that because they had good contacts and effectively guessed the NSF pretty well and those programme activities fitted… the NSF just absolutely brilliantly. (HAZ project manager)

The cross-cutting focus of some successful HAZ activities was credited with introducing a non-medical perspective to health and stimulating debate amongst all stakeholders about 'what it means to be healthy'
It has enabled a diversity of stakeholders, form Jo Public to the voluntary and community sector to mental health services through to children's services to PCT to be involved in this debate about public health and health promotion from a non-medicalised perspective. (HAZ project manager)

The existence of a HAZ and the funding that it brought in enabled professionals to imagine alternatives to conventional services and to see how they could benefit at the same time
The approach to intermediate care for elderly people was originally not seen as relevant to the acute trust, it was seen as social services type of service. Their consultants just wanted more money spent on hospital beds, but when they saw it began to work, it did have an influence. The acute trust completely revolutionised their whole approach to access, rapid assessment, they redesigned in building terms the ground floor and… they saw that success… was achieved by working across sectors in genuine joint ways. (HAZ project manager)

HAZs were identified by some as an important forum in which specific conflicts could be 'worked through' and genuine partnership working initiated
We have had one or two rough patches… notably the continuing care criteria… Funnily enough, there was a huge row but it started better working. And in a sense HAZ gave us the elbow room to begin to trust one another and develop again. (reviewers' edit) (HAZ project manager)
… [In the area concerned, prior to the HAZ there was] a tendency, an awful corrosiveness to speak disparagingly of parties not present and I think this was not just in the health service here but was a wider feature [through HAZ] I think we were able to see a more grown-up way of working and nowadays those comments are rarely uttered and when they are whoever utters them is made to feel uncomfortable for having done so. (HAZ project manager)

A number of respondents credited HAZs with fostering cross-professional partnerships and to the wider acknowledgement that changing outcomes was a collective endeavour
So you get 25, 30 people there quite regularly and they are not all Social Services and PCTs and partnership trusts… there is a whole broad range… this is the value that HAZ has had for us, it has brought people together, it has got people thinking in new ways, doing things in new ways. (HAZ project manager)

Successful HAZ activities were credited with facilitating shared learning locally, both about how to work in partnerships and how to deliver programmes that address health inequalities
I think what we have developed is a much more open learning culture, where people don't feel afraid to stand up and say, 'well this didn't work but this is why and I'm telling you so you don't go through the same process'… so I think we've had to stand up and say 'this hasn't worked and this is why but we're embracing the learning from it' and that enables others to do the same. (HAZ project manager)

Uncertainty over future funding was commonly cited as a constraint
One of the problems is that you can't put things in place until you know you've got the funding and then half the year is gone. (HAZ project manager)

Organisational restructuring was also commonly cited as a barrier to partnership working
There are three health authorities and eleven PCGs and even the NHS trusts, every one of these organisations within the past six months would have gone through some sort of organisational turbulence. That means a focus on their internal organisation, on people looking at what their own jobs are going to be… All of these things can have quite a dramatic impact on the people who are our main partners and therefore their ability to focus on partnership working. (reviewers' edit) (HAZ project manager)

Despite the national implementation of HAZs, many reported feeling isolated from the programme as a whole, which increased feelings of uncertainty and insecurity about the future
I think there's been a real wasted opportunity in terms of the amount of data we feed in regularly to them [Department of Health] and I don't see any evidence of it. You would have thought they'd have put together an annual publication on the work of HAZs. There's been nothing to raise the profile of HAZs at the national level and to galvanise that combined force in terms of expertise and experience. (HAZ project manager)

Notes

None

Study [quality appraisal]

Benzeval (2003) [+]

Programme focus

Intervention name, Location
HAZ, Sheffield, North Staffordshire, and East London & the City (UK)

Year/ timescale over which implemented
1997-2002

Target population
Populations of Sheffield, North Staffordshire, and East London & the City

Theoretical perspective
NR

Was local knowledge used in the design and/or delivery of the programme?
NR

Policy context (i.e. local policies & national initiatives - and other key contextual details)
See other HAZ papers

Whole system features
Not described in this source, but see other HAZ papers

Study details

Study name (if different) [year]
NA (1999 and 2001-2002)

Setting (e.g. school, community, etc.)
Community

Author (year) [Ref ID] plus associated paper/source
Benzeval (2003) [4968] (evaluation)

Aim of study
- To develop a better understanding of the strategies to tackle health inequalities of the selected HAZs and the implicit 'theories of change' or logic behind them
- To assess how these interacted with changing contexts to affect the achievement of HAZs' goals

Informed by theory?
Theories of change

Study design
Case studies

Data collection method
Semi-structured interviews with HAZ project managers (twice in 1999) and stakeholders (2001-2002) – emphasis was on understanding perceptions of the HAZ in the 2001-2002 research, as the realities of HAZ activitiesin an uncertain funding climate (and how HAZs could act to ensure health inequalities continued to be addressed when HAZ funding ended) were considered more appropriate to focus on.
Documents (HAZ plans, high-level statements, progress reports and local evaluations (where available)

Data analysis
Framework approach (Spencer & Ritchie 1994):
1) Familiarisation with the data
2) Identification of thematic framework (from research questions, emergent issues from respondents, and analytical issues identified during research phase)
3) Indexing of textual data (in relation to the thematic framework)
4) Charting of the text (by considering the range of attitudes and experiences under each theme)
5) Mapping and interpretation of the data (to develop patterns and connections and to seek explanations)

Sampling
Purposively selected case studies designed to represent different approaches to addressing health

inequalities in different circumstances:
1) Sheffield (strong focus on tackling the root causes of ill health as a way of reducing health inequalities)
2) North Staffordshire (strong equity focus within an agenda to modernise health and social care)
3) East London & the City (primary focus on improving average health between the area and the national average)

"Interviewees were purposively selected to ensure that a range of perspectives relevant to the research questions were identified" (p.20) – identified through HAZ Leads and project co-ordinators:
Sheffield n=15
North Staffordshire n=20
East London & the City n=22
N=57

Organisational affiliations of interviewees:
HAZ teams n=7
Health authority n=8
Local authority/ Local Strategic Partnership n=13
Primary Care Trust n=12
Other public sector agencies n=3
Healthy Cities n=2
Voluntary/non-profit organisations n=12

Study population
HAZ project staff and managers and other key stakeholders

Ethical issues?
NR

Source of funding
National evaluation of HAZs/ Department of Health

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

See other HAZ papers

Findings

'HAZs as a policy space'

- Across the HAZs, the initiative was felt to have created a policy space focused on health inequalities – bringing a clearer and stronger focus and commitment to tackling them. HAZs were felt to have shined a 'spotlight on public health' locally in ways that put it on the agenda so that it could not be ignored
- HAZs acted as a policy vehicle for local leaders and champions to employ to push forward and agenda that they were already concerned with – HAZs were described by respondents as creating this 'space' in terms of:

a) legitimising activity around health inequalities
b) providing resources to facilitate activities around health inequalities that they would not have otherwise been able to support
c) providing intellectual space to come together with like-minded people to think about health inequalities in a way that was not possible in their day jobs – respondents said that HAZs enabled them to 'think bigger' and/or 'outside their usual boxes' and had given them a sense of what was possible for the future

National factors affecting the role of HAZs

- Change in central priorities and subsequent funding uncertainty, both of which made it appear that HAZs had fallen off the national agenda, had a detrimental effect on their local ownership and hence their ability to fulfil their goals
- All HAZs had to reshape their programmes to better match the government's revised priorities – there was a perception that this shifted them away from tackling issues around the root causes of ill health and inhibited their ability to innovate and to invest in evaluation, as well as reducing attention on local priorities in favour of NHS ones – this had a detrimental effect on ownership of the HAZs and what they were trying to achieve among local authority, community and voluntary sector partners
- National inequalities targets were welcomed, but were felt to be too broad to be able to pin down and shape meaningful local targets and activities. In places, some of these targets were considered irrelevant because of the particular nature of health inequalities in certain areas (e.g. TB in East London). This was an issue as, although in principle these national targets were intended to include local priorities, this was difficult to achieve with the weight given to national targets
- Consultation document on how to deliver on the inequalities targets was felt helpful locally – and was used as a way of organising and explaining local HAZ work programmes, as well as a trigger for pushing health

inequalities onto the local agenda
- Many organisations involved with HAZs were felt to be struggling with their own agendas and hence were not particularly receptive to organisational learning or attempts to change their culture and practices
- Increasing role of PCTs in the local health economy during the time in which HAZs were implemented created ownership problems for the HAZs – the changes in organisational configurations and boundaries , and hence coterminosity between HAZ partners and the HAZ, created problems

Local factors affecting the role of HAZs
- Without a very specific definition of the goal of the HAZ, the range of partners involved, and the nature of the problem, meant that almost anything could legitimately be defined as a priority – in East London, given the universal problems, everything was considered relevant to health inequalities and hence there was quite a struggle to agree priorities; as a result, the HAZ was felt to have spread its investments very thinly. In North Staffordshire, it was suggested that the initial investment structure simply reflected the bids that had been received, rather than a more strategic approach to addressing health inequalities
- Lack of clarity over the goal to aim for when reducing health inequalities, e.g. whether focus should be on the most disadvantaged groups or on 'narrowing the gap' by ensuring that any health improvements were larger or faster among disadvantaged groups than the rest of the population
- Not all departments that were involved with HAZs had understandings of the determinants of health – in all areas, it was difficult to get issues around health impact on the overcrowded agendas of different departments, although each HAZ had some successes in relation to this

Organisational configuration and histories
- Neither East London or North Staffordshire were felt to be 'natural communities' – there was a lack of joint working across these areas, and the local authorities that made up their boundaries could see little value for themselves in working with other geographical organisations. This could also create tensions within organisations, e.g. when HAZ resources were being spent in one part of their area, but they felt that another area was at least as in need of such investments
- In East London, there was a history of tensions between the voluntary and community sectors and the statutory agencies – setting up the HAZ exacerbated some of these tensions
- The close links between HAZs and health authorities, with (at least in the early stages) the chief executives of health authorities being held accountable for HAZ meeting its performance targets, created ownership problems with other agencies – HAZ was seen as a 'NHS entity' rather than a true partnership endeavour – these perceptions were exacerbated when the change in HAZ priorities increased the pressure for HAZ resources to be spent on NHS issues

Public sector labour market – differed considerably in the three HAZs
1) East London – tight labour market with high rate of staff turnover at all levels and a shortage of staff (all of the statutory agencies faced problems with recruitment and retention), meaning that
a) at any one time, staff vacancies meant that all other staff were stretched to or beyond capacity, making adding HAZ activities to their job very difficult – the extent to which agencies or individuals were willing to do this was influenced by the overall perception of the importance the government attached to the HAZ and to reducing health inequalities, as well as staff members' own personal commitment to the issues
b) high turnover of staff at all levels, e.g. a range of project managers described their key contact 'disappearing' and not knowing who to liaise with instead – this degree of turnover created continuity and ownership problems for the HAZ, often despite the best endeavours and huge commitment of individuals
c) concern was raised about the consequences for organisational learning from the HAZ when a range of key people involved had moved on to new jobs outside of the area

2) Staff turnover in Sheffield and North Staffordshire was much lower, with key staff having worked within the area for long periods of time – in Sheffield, there was concern that this made the health economy rather 'cliquey' and that the 'baggage' of past jobs and working relationships could affect new roles. In North Staffordshire, local agencies were felt to be rather 'conservative' as a result of the low staff turnover, and subsequently 'stagnant' and unwilling to embrace new ideas and change

Champions and blockers
Across the HAZs, key individuals were highly significant for the way that they championed the HAZ and made significant personal commitments to its progress. The perception was that much of the HAZs' achievements would not have been possible without them. Examples of roles played by these key individuals were:
a) networking – making connections and fostering relationships to support the partnership process
b) vision – to see the opportunities that the HAZ had created, and using them to open doors, get issues on agendas, lever resources into the system and bring about change
c) project managers 'with tremendous energy to get the job done'
Problems could occur when such individuals moved to another work role outside of the HAZ, as the initiatives concerned were seen as being too closely associated with these individuals

All three HAZs also had significant personalities who were seen as 'blockers', for example by skewing HAZ priorities away from those shared by the broader partnership, and by being generally unsupportive of the HAZ and not valuing the contribution of other partners
Notes
None

Study [quality appraisal]

Benzeval & Meth (2002) [+]

Programme focus

Intervention name, Location
Health Improvement Programmes (HImPs), UK
Year/ timescale over which implemented
1999-2001

Target population
Five English towns/cities, with diverse socio-economic characteristics

Theoretical perspective
NR

Was local knowledge used in the design and/or delivery of the programme?
NR

Policy context
Reduction in health inequalities, through recognising and addressing the determinants of health, a New Labour priority. Health Authorities (HAs) were given lead responsibility for taking this forward at a local level in partnership Local Authorities and other parts of the NHS. 'Duty of partnership' on the part of HAs and other bodies was an expectation of national government; also, accountability mechanisms were established to hold local agencies to account for public health, equity and health inequality activities.

Towards the end of the time in which the HImPs reported in this study were implemented, major restructuring took place through the merger of all Health Authorities into 25 strategic authorities. The authors note that this is likely to have impacted on the perspectives of study participants.

Whole system features
Partnership working
Community enagagement
Embeddedness – evaluations proposed to feed into Local Strategic Partnerships planning

Study details

Study name (if different) [year]
NA

Setting (e.g. school, community, etc.)
Community

Author (year) [Ref ID] plus associated paper/source
Benzeval & Meth (2002) [4969]

Aim of study
Central aim: to assess how HAs could make an effective contribution to tackling inequalities in health
Three objectives:
- to describe what HAs are doing to tackle health inequalities
- to identify inhibiting and enhancing factors in getting health inequalities (and how to tackle them effectively) on the local agenda
- to develop policy lessons for the NHS about how best to develop and implement local policies to reduce health inequalities

Informed by theory?
Realistic evaluation

Study design
Evaluation

Data collection method
Interviews (n=64)
Documentation

Data analysis
Framework (Spencer & Ritchie 1994)

Sampling
Five case study sites purposively selected on the basis of:
- the extent of health problems and health inequalities within the HA
- the extent to which reducing health inequalities appeared to be a local priority (based on a local survey)

(aim was to "ensure a reasonable spread of case study sites between regions" (p.14))

Study population
'Key players' in relevant local organisations (i.e. HA (in particular in public health); PCGs or PCTs; acute trusts and, where appropriate, community trusts; local district or county councils; local voluntary and community groups; large regeneration partnerships; key local projects aimed at reducing health inequalities)

Ethical issues?
NR

Source of funding
Department of Health

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

NA – the research reported is about getting health inequalities onto the local agenda, i.e. a key pre-requisite for implementing HImPs at the local level

Findings

Getting health inequalities onto the local agenda
The importance attached by central government to addressing health inequalities was perceived to have had a significant impact at the local level
I think the impact of current government policy cannot be underestimated. It has been fantastic at getting health inequalities on the agenda as a legitimate part of health authority and partnership working. (unattributed)
… it is good that we have got such clear guidance, what's good about this government is that they have linked health and poverty, whereas the Conservative government didn't link health and poverty. (unattributed)

The national priorities guidance had enabled local resources to be used in priority areas to address health inequalities
In the past people were very aware of issues around pregnancy but… because of all their other priorities, weren't necessarily geared towards doing anything about it, and the national guidelines on teenage pregnancy have made a huge difference because I have been able to go to the SaFF [Service and Financial Framework] and say you need to do this, this is not a choice, this is a national priority, these are national guidelines, and we need to look at how that fits in with what you are doing. (unattributed)

'General sense' from interviews that there were far too many priorities
I think the general view among health service managers is that there are far too many priorities, the danger is if everything is a priority, then really nothing gets done properly. (executive director, acute trust)

Despite the commitment to addressing health inequalities, it did not become a central priority
… you can't avoid the focus on central priorities. If you had loads and loads of money that wouldn't matter, but we don't even have enough money to achieve the central priorities, and therefore anything else is entirely peripheral and just doesn't get the attention… there is no money for it, the view is why waste time on it. (unattributed)

Many respondents identified the key role played by individuals in getting health inequalities onto the local agenda
Unless you have committed people doing the work it isn't going to work, so you have to have champions and I don't think they have had enough champions… in health to be able to take this forward. (unattributed)

However, there was also acknowledgement of the risks of relying on personal commitment and willingness to push things forward
I think you need a local champion, or champions, in a sense just to keep it on the agenda, but again what you have to do is manage that and understand that it cannot be the sole responsibility of that one champion. (unattributed)
I am pulled in about 100 different ways – and it has taken every hour of the day to put as much time and energy into it, and if I personally was not committed to it, it would not be happening. I think a lot of it is very dependent on people's personal commitment and doing that bit extra in order to make things happen – in

your own time, a lot of it. (unattributed)

Some powerful individuals within organisations were perceived as blocking HImP processes
And then you are still fighting a battle with a medical consultant, on what they think should be the priorities that are taken forward, so I think that there is still a value change here that has to happen (unattributed)

A lack of interest in health improvement and health inequalities was noted as a problem, particularly as a result of GPs taking what was perceived as a significant role in setting the Primary Care Group/Primary Care Trust agenda
… the GPs – most of them probably – you know, they are not young, new doctors and I think trained in a traditional mode, I think it would be fair to say and this is an assumption… they appear less interested in that aspect [addressing health inequalities] of our work, they are more interested in primary care development and hospital admissions. (Primary Care Group chief executive)

… the problem with basing it in a health care delivery organisation is that all the resources will get subsumed to health care, it always has, it always will. (Health Authority executive director)

Other respondents felt that if addressing health inequalities was not prioritised in PCGs/PCTs, then this was simply a reflection of national priorities
… some PCGs are really quite keen on their health inequalities responsibilities, encouragingly so… but what will happen of course is that their priorities will also be national priorities despite their very best endeavour, I don't think they will find much time to spend on health inequalities work. (Health Authority director)

Organisational restructuring
Staff morale could be significantly adversely affected by restructuring
… it is a big organisational issue, and people are distracted at the minute by – people who should be doing that [inequalities work] are distracted by – am I going to be merged? Are we out of a job? Is my career going? Can I pay the mortgage? It take your mind off important things. (executive director, acute trust)
… it is very difficult when you come down to the actual people that are working in any organisation within a changing agenda, to ask them to see this as an exciting opportunity, to try and look at how they might impact on some of the issues like inequalities, when [what] they are actually worrying about [is] will I have a job when all of this reshuffling is finished? (HA senior manager)

Capacity building
A lack of understanding of public health was identified in PCTs
… the main thing is to basically make PCTs public health agencies and actually get, say, both members and the staff trained in public health so they actually think in public health terms, and that is the crux of it. (Health Authority director)

Some respondents felt that there was a need for a stronger broader public health presence on PCT boards. Whilst, for example, some PCTs did have public health consultants as executive committee members, their perspective was often felt to be lacking at the highest level of PCGs/PCTs

Community health staff were identified as potentially being able to play a much greater role in addressing health inequalities through their work, but caution was aired that too much should not be expected of the role these staff could play
I think there is huge potential for health visitors in their daily jobs… there is just a range of stuff that they can be doing, but most of it is one-to-one or with families and most of it is opportune, there is no way you can co-ordinate tackling root causes through health visitors. (Health Authority director)

Adequate resources were considered vital for the development of partnership working
… the nub of looking at health inequalities, social inequality and that can only be done by working together with the local authority and the local community, it is hard work… in my PCG there is only myself and my deputy who can do that. (PCG chief executive)

Many respondents felt that the locality level was the most appropriate scale to address health inequalities, as:
- many PCGs/PCTs were coterminous with district councils, thereby facilitating partnership working
- PCTs were seen to be 'embedded in the local communities', which helped frontline staff to use their local knowledge to ensure services were provided in ways that would meet local needs

Weighed against these advantages was the concern that by shifting to a locality focus, strategic input could be lost and efforts to tackle health inequalities hindered

Partnership working
Differences in organisational structure (e.g. between NHS bodies and Local Authorities) could inhibit partnership working, but different cultures in these organisations could also act as a significant barrier

I think that there are also dangers around different organisational approaches and you know we are all working as best we can to the partnership mantel and we are all working to very different cultures. Not only actually to be honest with you with different organisations, but also within our own organisations. (county council senior manager)

The pressure on acute trusts to meet targets was perceived, by those within these trusts, to significantly limit the work they could do on addressing health inequalities
… oh, within the trust, we all have a will for it, but you get driven out by the imperatives. You get driven to do the short term and miss the long term in a whole range of areas. You don't get time to deliver the basics before somebody wants a result so you don't develop the basics right. (acute trust director)

Some perceived partnerships to be working well 'on the ground' in specific projects, but that at a senior level there was little understanding of partnerships working
My perception is that one of the breakdowns in partnership working is where the chief execs go… My perception is that those chief execs don't even know what is going on in their own organisation… so that weakens partnership working at different tiers, and it means it is not very well informed. (unattributed)

A number of respondents were concerned about the limited connections between the health partnership and other partnerships that were responsible for significant determinants of health (e.g. housing, economic development, social exclusion)
We have got these wonderful strategic partnerships but they are still in silos. (unattributed)

HImPs
Although there was 'rhetoric' about establishing local priorities, this was not felt to be the reality
One thing about that is that the priorities… which you are expected to build into your HImP and there is relatively little leeway when it comes down to what your HImP chapters need to be and what your key areas need to be… what you are going to address isn't really up for debate. (unattributed)
This was broadly felt to reflect wider NHS processes, e.g. the National Service Framework which, whilst helpful in many ways, reduced local flexibility
The NHS traditionally has been very much a centralised top down bureaucracy, historically, professionally-led, and driven from the centre. (unattributed)
The NSF is very good in lots of ways but it does mean that with it there are very clear needs to find ways in which money… is spent on the national 'mist dos', And I think that gives us less flexibility than we had in the past to fund broader health agenda projects, which were about health and well-being as opposed to health services. (unattributed)

Notes

None

Study [quality appraisal]
Campbell-Voytal (2010) [-]
Programme focus
Intervention name, Location Case 1: Healthy Eating Everyday; Active Living Everyday Case 2: Active for Life; Active Living Everyday **Year/ timescale over which implemented** 1) 12 or 14 wk programme 2004-08 2) 5 yr project 1999-2005 **Target population** 1) Mexican immigrant parents (n=50) and Mexican American youth (n=100) in Michigan. 2) Senior African American women in grassroots organistaion (Detroit NW Neighbourhood Health Empowerment Centre) **Theoretical perspective** "pre engagement" capacity building provide mutual awareness, exchanged perspectives, and leadership between parties previously unknown to each other. **Was local knowledge used in the design and/or delivery of the programme?** 1) Community members certified to facilitate adult lifestyle programs 2) ? see findings **Policy context** 1) Funds allocated by state health policy leaders to address obesity in high risk communities. Awareness of childhood obesity low. In this neighbourhood, no immediately identifiable partners to engage in order to raise awareness and mobilise community response. **Whole system features** Case 1: Healthy Eating Everyday; Active Living Everyday Community engagement – learning about the community's concerns before attempting to develop a health programme Capacity building – school and community capacity for community-level health planning was developed Case 2: Active for Life; Active Living Everyday Community engagement – academic partner, community health practitioner, and researcher worked together with a voluntary grassroots organisation
Study details
Study name (if different) [year] Phases of Pre-engagement capacity building: discovery, exploration, and trial alliance **Setting (e.g. school, community, etc.)** 1) Community and school based 2) Community **Author (year) [Ref ID] plus associated paper/source** Campbell-Voytal (2010) [188] **Aim of study** To describe the pre-engagement stage of capacity building that precedes formal research collaboration in 2 cases. To use critical social theory to identify themes and strategies for pre-engagement work in similarly under resourced settings. **Informed by theory?** Critical social theory. "Current definitions for prevention describe multi-dimensional community or organisational traits and characteristics, such as the presence of involved citizens, visionary leaders, functional social networks an groups, coordinated sources of power, resources and shared concerns. Theoretical foundations for the construct "community capacity" have been linked to psychological, community development (diffusion, social action) and organisational theory. These traditions delineate how prevention capacity is intentionally developed in communities, organisations ad programs. However, when social and material conditions have

starved local capacity, a third theoretical perspective, critical social theory and the construct of "ecologies of practice," suggest an alternative approach for initiating contact with a community not yet ready for intentional capacity building that is consistent with the core principles of [Community based participatory research (CBPR)].
Critical theory introduces the concept of praxis, or practice, involving habitual or systematic behaviours that exemplify core values, knowledge and assumptions. For example, family or neighbourhood health habits make observable fundamental beliefs about disease, wellness, causality and control….Similarly the practices of prevention researchers are emblematic of their assumptions about the value and purpose of science, access to scientific knowledge and power. The intersection of these perspectives in collaborative research gives rise to potential contradictions and dilemmas where existing beliefs and practices are called into practice and new practices emerge.
The construct "ecologies of practice" is a conceptual tool for thinking through what is happening when community and academic practices intersect. For academic researchers, pre-engagement work provides the opportunity to establish a social identity and demonstrate professional values and beliefs…..The opportunity to observe, listen and try out a tentative alliance is a cyclical and iterative effort of discovery and working out tensions, and preceded willingness to engage." (p.156-7)

Study design
Case studies

Data collection method
Not detailed – observation?

Data analysis
Not detailed

Sampling
Not detailed

Study population
Not detailed

Ethical issues?
None reported

Source of funding
Not detailed

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

NR

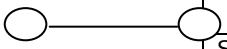
Findings

Presents 2 case studies where pre-engagement capacity building involved partners who were initially unaware, disinterested or unable to engage in prevention activities

1) Mexican-American Immigrants. *Pre-work.* team of clinicians and bilingual health workers began volunteering at local health fairs, rallies and celebrations. Parents invited to have their child's BMI, blood pressure, glucose & behavioural risks assessed. Families without primary care access followed up. Tailored health education provided. *Phase 1* During pre-phase, team became better informed about community attitudes and perceptions about risks, barriers and motivations. Parents were concerned about children's vulnerability to a range of social conditions: bullying, gangs, drugs, violence. They describe family stress, difficulty controlling children and shared norms about body shape, gender & physical activity and family food priorities. Team began to understand health care access and use, impact of employment and immigration patterns on family composition and overloaded clinics.
Over time, team gained recognition in the community. Discussion with community leaders helped them to understand organisational and funding barriers to addressing obesity at the community level: organisationally; understaffed, overwhelmed, lacked health promotion experience.
Phase 2: year 2 – 6 school principals invited team to conduct health screenings in schools (source of data for team) – first organisational alliance – introduced team to school culture & needs and perspectives, raised school awareness of obesity. Families got individualised reports. However, prevention programming remained unfamiliar in the community, capacity undeveloped – past efforts disease focused and clinical. No partner organisation yet identified.
Phase 3: year 3 Alliance initiated with youth workers in small community centre motivated by academic team and middle school families who wanted non competitive, safe activity options. Community leaders interested but concerned about resource implications. Academic team wanted to scale a reasonable

program to existing assets and interests. Alliance tailored an existing healthy lifestyle (PA & HE) program which was piloted over the next 6 months. Evidence of benefit from data inspired more enthusiasm.
Outcomes in 3 areas: prevention awareness and community mobilisation; community member training; prevention programming (see table). These fed into each other and ultimately, evidence of effect was used by community leaders to secure future funding.

Table: Pre-engagement phases for 2 case scenarios

Pre-engagement phase	**Themes: Activities; systems; knowledge/power**	**Neighbourhood case study**	**Senior centre case study**
Discovery 	Activities independent	Team provides clinical services Operations self contained	Researcher serves on the centre's board
	Systems independent	No direct relationship with potential partners	Academic and organisational systems are separate
	Little mutual awareness		Mutual awareness low
Exploration 	Activities coordinated	Team is engaged by middle schools	Researcher as "guest speaker", group leader at centre; services are coordinated but separate
	Systems are parallel	Team and school systems are coordinated	Personal values and perspectives on life, health, and prevention are exchanged
	"Insider" knowledge is exchanged	Values and priorities regarding health, learning and confidentiality exchanged	
Trial alliance 	Activities intersect Limited test of shared process (Not clear where this theme should go, and which egs it relates to – seems to be a type in paper itself as this follows on directly from previous with no space or hard break)	Team and community form an alliance	Researcher and centre director implement organisational evaluation
	Hint at knowledge power link	Organisational and academic committees work to adapt and implement youth lifestyle program	Participatory strategies used to test shared decision making
		Outcomes motivate additional lifestyle programs	Results lead to involvement in subsequent prevention research

2) A voluntary organisation of active African American women developed a grass roots organisation to sponsor self help support, health screening and education programs for seniors. >100 volunteers run programs, 1 paid director.
Phase 1: 1999 academic researcher and centre leader introduced by senior public health leader. Doctor interested in new resources, researcher interested in citizen led model of health promotion. Informal meetings led to academic partner invited to serve on board, where grant writing and health resource knowledge valued.
Phase 2: year 2. Direct services provision evolved – expertise in diabetes prevention part of the acidic partners reputation at the centre, and after a year of consultation chance to work directly with diabetes support group came up. Group meetings led to researcher understanding of personal factors (such as spirituality & social connectedness) seen as important. Trust and respect led to restructuring of fundamental notions of power and control as academic and community parties recognised the expertise of the other.
Clear that decisions made based on organisational values and tradition rather than data – evidence was

experiential, and there were no methods of safely storing information or data. Organisational history was living history into which the researcher was invited.
Phase 3: years 3-4. Relationship entered critical third stage. Start up funding ending, sustainability in question. Centre knew different kind of "evidence" needed to secure funding. Community-academic partnership launched to use CBPR methods to evaluate health outcomes.
Centre input into centre impact on QoL, defined concepts, measures, methods. Partners learnt each others language and debated concepts. Some small arguments threatened the relationship (for eg, ethics required it to be called "research" giving ownership to University, rather than "evaluation" which would have given ownership to community)
Pre-engagement activities ultimately tracked to 2 prevention outcomes – co-authored paper and activities related to involvement in national translational research study.

Phases of Pre-engagement
Discovery phase & strategies
Potential partners introduced, academic partners offer needed service to community partners. Initiated through personal contacts and preceding any sense of potential alliance. Key strategy at this stage is to establish credibility through scrupulous practice.

Exploration phase & strategies
As awareness develops, parties with mutual interests are identified. Involves learning about environment and needs. Issues of knowledge-power not explored. Strategies needed include being a good cultural learner, demonstrating cultural sensitivity and being willing to explore the norms and values of new systems.
Trial alliance & strategies
Final stage involves trial of coordinated work that tests collaborative possibilities. Communicating, negotiating, working co-operatively and achieving mutually desirable outcomes are the goal. Interests now intersect and a limited set of shared processes are tested. Strategies in this phase involve keeping the scope and expectations of the trial alliance limited, maintaining flexibility to changing conditions and exhibiting patience when issues of power and trust emerge. Important for all to realistically appraise their ability to be involved in a more formal research partnership.

Barriers and challenges
Primarily linked to money and politics.
In neighbourhood case, money for health promotion was scant, with more focus on housing, workforce and economic block development grants. Much of work achieved though "in-kind" support. In senior centre, pre-engagement activities were absorbed into the graduate training program, providing a field training site. Significant personal commitment and little funding is the reality.
Politics involved working through occasional resistance and uncertainty. Some historical love-hate relationships with academe:
When academics come to the door, there is always a research agenda….We have been researched to death (reviewers edit).

Recommendations
Work together in common spaces. Credibility is earned through action. Learn each others language. Direct practice makes way for unrecognised talents, resources and leadership to emerge. Identify and trust established through pre-engagement work.
Work from bottom-up or outside-in. Change can be introduced through informal networks. Leaders are sensitive to emergent interests. Organisations respond to constituent change.
Work incrementally through small shared projects.

Notes

Although case study methods were clearly used, the findings are purely descriptive with no way of knowing what activities informed these conclusions.

Note that partner not identified within the first 2 years.

Study [quality appraisal]
Charlier et al (2009) [-]
Programme focus
Intervention name, Location Keeping Kids Smokefree, Auckland (New Zealand) **Year/ timescale over which implemented** 2007-2009 **Target population** Approximately 4000 students aged 8-9 years (and their parents) of four South Auckland schools; schools were selected on the basis of serving higher proportions of Maori, Pacific and lower socio-economic status students **Theoretical perspective** 'Community development' **Was local knowledge used in the design and/or delivery of the programme?** This was attempted through an 'Intervention Overseers Group', but its formation floundered because of lack of interest/time for involvement from school Principals **Policy context** NR **Whole system features** Partnership working - Schools, local community 'smokefree' organisation Students involved in the production of programme materials
Study details
Study name (if different) [year] NA **Setting (e.g. school, community, etc.)** School **Author (year) [Ref ID] plus associated paper/source** Charlier et al (2009) [5423] **Aim of study** To investigate the process of gaining community participation in a school-based project, the difficulties experienced with engaging community stakeholders and adaptations made by the project team **Informed by theory?** Broadly, 'community development' – but few details provided **Study design** Evaluation **Data collection method** Review of programme documents (team meetings, field reports, research proposal) Focus groups (n=unclear) Interviews (n=5) **Data analysis** 'Analysis of the focus groups and interviews involved identifying and summarising the predominant themes under each category identified (strengths, challenges, opportunities, threats to success and potential improvements), including any concerns of the participants' (p.951) **Sampling** Convenience sample of students (mixed gender and ethnicity) and school staff for focus groups Purposive sample of key stakeholders (focus groups) Purposive sample of stakeholders (based on high level of involvement in the programme, history of working on the programme, specialist subject knowledge)

Study population
Students (mixed gender and ethnicity) and school staff
Stakeholders (health service providers, community 'smokefree' group, programme and research teams)

Ethical issues?
Ethical approval obtained (University of Auckland Human Participants Ethics Committee), but no details of how implanted in the course of the study

Source of funding
Human Research Council of New Zealand

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

Comprised of five components, designed to involve students, parents, families, members of the intervention community, teachers and school principals:
1) Promoting non-smoking amongst parents
2) Health education for parents on how to reduce the chance their children will start smoking
3) Reducing the sale and supply of tobacco to minors
4) Student involvement in the production of programme materials
5) Health promotion events for students' families

Programme was intended to build community participation, so that the interaction of people can address a broad range of common needs by sharing their ideas and experiences

Findings

Programme planning phase
'Intervention Overseers Group' (planned to consist of representatives of the university research and intervention team, health provider institutions, school representatives, and parent and student representatives) was proposed to involve a broad base of participants in shaping, commenting on, critiquing and helping to guide the programme – also to provide community buy-in, ensure successful implementation, and sustainability. It is rather unclear from the reporting, but it appears that the reluctance of school principals to become involved (because of time pressures?) scuppered the formation of the group

At one school, the management liaising with the programme were current smokers with no intention of changing their smoking behaviour within the timeframe of the project – due to the perception of the project as a personal affront, participation was rejected

Programme implementation phase
Although principals agreed their support for the programme, there was little active support from teachers, e.g. some teachers felt uninformed by their management and therefore experienced the programme as a burden that was imposed on them

Communication with teachers – initially, programme workers updated teachers about the project by posting flyers or newsletters in their school letterboxes, which in some cases was experienced by teachers as 'being subjected to the project without their input' (p.953). Focus group data showed that personal face-to-face communication was teachers' preferred method of communication (e.g. at morning tea and staff lunches, where teachers congregate and discuss school-related topics)

Providing suitable materials for teachers, such as teaching and learning resources on smoking and health that are aligned with national education curriculum standards, would have helped gain the support and enthusiasm of teachers

Programme was able to play a facilitative role for other health providers, e.g. to a local Maori-speaking smoking cessation service, who commented:
We received a lot of referrals through [the programme]. We got approximately 80 referrals, which resulted in 30 new clients. We didn't need to do all the background work to get these clients, which helped us out. (Local smoking cessation service worker)

'Family fun days' run by the programme were perceived as giving local providers the opportunity get acquainted and work together more closely

Consistently throughout the interviews and focus groups, the issue of staff turnover was identified as disrupting the continuity of the programme
The turnover of staff has been significant and frequent. New people have come up to speed and then left also. This has contributed significantly to timing barriers and the process got changed and dropped with

different people involved. (Programme worker)

Some external providers felt that they were not trusted by the programme implementation team to deliver what they were expected to do

Facilitators to programme implementation
Programme team members with experience of both academic roles and community participation facilitated the process of translating evidence-based practice into a community context. This was particularly important because of the (sometimes) different goals of, e.g. university researchers and school teachers

Having a strong connection to and understanding of the community's daily life and concerns is important to bridge the gap between academic expectations and community readiness

Matching ethnicity and cultural background of intervention staff helps to ensure easier access to the target audience and reduce language and cultural barriers

Building on the knowledge, experiences, and personal relationships gained from previous work in the community can enhance the implementation of the project

Notes

None

Study [quality appraisal]

Cole (2003) [+]

Programme focus

Intervention name, Location
Health Action Zone (HAZ), Plymouth

Year/ timescale over which implemented
5-7 years from 1998

Target population
Plymouth city
12 programme boards relating to user groups, whole community concerns with overarching or strategic remit and one that developed an overarching framework.
60-70 project were funded, or attached HAZ logo.

Theoretical perspective
NR

Was local knowledge used in the design and/or delivery of the programme?
There was a formal policy of community or voluntary representation on all boards.

Policy context
HAZs part of New Labour's public sector reform agenda, and a renewed focus on health promotion and the need for new methods to tackle health inequalities. 26 zones established in areas of high deprivation.
Change of Secretary for Health shifted away form broad health concerns of the HAZs and onto a more disease focussed agenda.
Also attracted academic critique that it risked repeating the weaknesses of previous area/partnership initiatives.

Whole system features
See other HAZ papers

Study details

Study name (if different) [year]
The Health Action Zone Initiatives: Lessons from Plymouth

Setting (e.g. school, community, etc.)
Community

Author (year) [Ref ID] plus associated paper/source
Cole 2003

Aim of study
To evaluate the Plymouth HAZ

Informed by theory?
Evaluation based on theories of change (how and why an initiative works) models and realist evaluation (context + mechanism = outcome).

Study design

Data collection method
Semi-structured interviews
Sept 2002-Feb 2003.
Interviews focused on project achievements, problems encountered, impact and effect of user involvement.

Data analysis
Projects evaluated in the context of three themes: presence or absence of a theory of change approach; extent to which they achieved their goals and how well these fitted the HAZ objectives; reasons for success or failure

Sampling
From 37 HAZ projects sponsored by 5 programme boards (Improving Primary Care; Oral Health; Children

and Young People; Older People; Substance Misuse). Purposively selected to reflect range of HAZ work.
72 key participants – initial interviews with lead of each board to get list of funded projects and the name of a key person responsible for each project. These "Project People" were then interviewed and snowballing used to identify others to talk to about the project.
Those from statutory health sector restricted to half the sample.

Study population (from whom was data collected?
N= 72. Those involved from: Statutory health (n=34), Statutory social services (n=7) Statutory education (n=3) Statutory other (n=1) Community/ voluntary (n=22), private sector (n=5).

Ethical issues?
Not discussed

Source of funding
HAZ

'Lessons' for the evaluation of obesity prevention programmes
Evaluation recognized in key HAZ documents. There was a research and evaluation board and this was well funded.
Each project asked to articulate their intervention in terms of theory of change and realistic evaluation but most reluctant to engage with this process - ¾ didn't return the monitoring form that was structured in terms of a theory based model. Noted that: (1) the Research and Evaluation board failed to promote the importance of evaluation within Plymouth HAZ, so seen as irrelevant. Many people at the operational level resented the amount of money allocated to evaluation. (2) *Learning Communities* undermined by changing composition of board and absence of a dedicated lead. (3) Most practitioners unable to handle theory based approach and didn't understand presentations about it. (4) Mismatch between agenda of *Learning Communities* and work of other agencies. (5) Common framework of evaluation was not sensitive to diversity of projects, in particular, those with small grants perhaps shouldn't have been expected to engage with this process.
"After almost two and a half years of the three year programme, *Learning Communities* had generated almost no information about the success or failure of Plymouth HAZ's projects" (p.103) Some superficial information – insufficiently critical and non using theory based approach.

Programme delivery

HAZ's were envisaged as a catalyst and mechanism to improve the delivery of health services and provide a framework within which the NHS, local govt and range of local stakeholders could combine to address health issues. Health linked to employment, regeneration, education, social services, housing and anti-poverty initiatives. Linked to wider commitment to service delivery through partnerships and commitment to area-based initiatives.
HAZ underpinned by 7 principles (achieving equity; engaging communities; working in partnership; engaging frontline staff; adopting an evidnce based approach; developing a person-centred approach to service development and taking a whole systems approach.)

Findings

Theory of change and realistic evaluation approach
Despite failure to fill out evaluation forms, many projects had made significant links between programmes/mechanisms, context and outcomes. Some central govt. theory of change models had been adopted.

Achievements
28/36 projects (78%) had achieved substantial success towards meeting their objectives.
(details of these for specific projects not extracted)

Explaining successes and failures
National policy agenda
Success of some of the most important projects was linked to national policy initiatives (eg Grab Five and local promotion of healthy eating for children). NSF also motivated some projects.

Local policy agenda
Had both positive and negative effects. While in some cases alignment of previous initiatives or crucial local problems enhanced success, low priority for some issues locally prevented future funding being obtained for some projects.

Trust
Success facilitated through development of trust between partners. Overcoming a tradition of mistrust between relevant agencies essential for th Integrated Substance Misuse Service.

Cultural convergence

In particular, essential to reconcile social and medical models of care (through aligning culture and language differences) and persuade participants to modify working methods to accommodate people from different disciplines. This may lead to new and integrated modes of working combining the strengths of each partner and may also involve a change to the role of the professionals.

Expertise
Skills of key personnel crucial to success – research based projects suffered from weak research skills in health and social care professionals responsible for this work. Suggested that the appointment of non specialists (non-statutory) can lead to innovative and improved methods of working.

Managerial clout
Advocates in senior management can be crucial to success of projects. Junior status of one project manager meant she had little credibility in LA or with hospital consultants.

Engagement with crucial agencies or individuals
Success dependent on engaging a wider group of organisations/ individuals and placing health issues on agenda of other agencies. Therefore, effective methods of engagement are needed. Sensitivity to time constraints of partner organisations may need to develop. Also need to recognise that the marginal stake in, and interest in, the project by other organisations. Questionnaires should eschew jargon and be as succinct as possible to encourage their return.
Different ways in which failure to engage with organisations and users correctly hampered project success.

Managerial structure
Clear responsibility, line management and accountability crucial for successful project.

Legal constraints
Eg morning after pill provision, copyright issues and DoH refusal to allow voluntary sector to establish drug services.

"Wide ranging partnerships appear to be useful as a catalyst to promote joint working between agencies." Also partnership at board level promoted co-operative culture and HAz helped to shift some local policy agendas to address long standing problems.

Notes

None

Study [quality appraisal]

Curtis (2008) [++]

Programme focus

Intervention name, Location
National Healthy School Programme (HSP) South Yorkshire, UK

Year/ timescale over which implemented
Not clear ?1999-2009

Target population
School children

Theoretical perspective
NR

Was local knowledge used in the design and/or delivery of the programme?
NR

Policy context
Part of WHO Global School Health Initiative (from 1995) whose aim is to encourage health promoting schools as healthy environments providing "nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counselling, social support and mental health promotion" p.410

In England, Healthy School Standard first introduced in 1999 aiming to promote "social inclusion, reducing inequalities and raising educational achievement" with schools expected to achieve this by 2009 through taking a "whole school approach" in relation to 4 core themes – personal, social and health education (PSHE) ; healthy eating, physical activity; and emotional health and well-being. Formally assessed through Ofsted. (p.411).
Healthy Schools include explicit priority to reduce obesity.

Whole system features
'Whole school approach', possibly also involved public health departments (but unclear)

Study details

Study name (if different) [year]
Experiences of young people with obesity in secondary school: some implications for the healthy school agenda

Setting (e.g. school, community, etc.)
Community. Inner city, relatively deprived area in S. Yorkshire
Data collected 2005

Author (year) [Ref ID] plus associated paper/source
Curtis (2008) [682]

Aim of study
To explore the experiences of young people with obesity within the secondary school environment in relation to areas of concerns prioritised by the HSP

Informed by theory?
Investigation informed by understanding of competing discourses around obesity: public health which sees obesity as an epidemic, with a range of social, psychological and physical negative impacts. Alternatively, rather than seeing obesity as necessarily problematic, it has been suggested that the "obesity myth" stigmatises fat people and "legitimises racialised, middle class prejudices that equate fatness with "sickness and badness". From this perspective, body weighty is not….the cause of social inequalities, rather, social inequalities are consequent upon the discursive construction of (undesirable) fat bodies". (p.411) (Campos 2004. Monaghan 2007. Evans 2006)

Study design

Data collection method
4 focus group discussions of 2-5 people
1 interview (person preferred to be interviewed alone)

Data analysis
Tape recorded and transcribed verbatim
Reading to familiarise, then to identify key words and phrases and to look for concurrence and contradictions within and between narratives, then initial thematic codes applied, further literal and interpretive readings enabled the process of creating analytic categories and themes to progress.
Thematic analysis following Mason (1998) methods of cross sectional, categorical indexing.
NVivo 2 used for coding.
Participants given chance to comment on transcripts (no comments) and preliminary analytic themes (feedback about this informed final analysis).

Sampling
Programme leader contacted young people and parents from the community group by post (n not reported).
17 had parental consent and consented themselves.
18 chose to participate

Study population
18 young people aged 11-17 attending a community based obesity intervention programme.

Ethical issues?
Parents and children both had to consent to participate.
Ethical approval obtained from University of Sheffield Ethics Review panel

Source of funding
Research stimulation grant from School of Nursing and Midwifery, University of Sheffield

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

NR

Findings

School based physical exercise
As they have to change, PE lessons put the overweight body on display.
The worst bit was getting changed and getting into the uniform for PE, which was shorts (Georgie)
Group lessons mean that their physical efforts are open to scrutiny form their peers. In some cases, also seen by pupils of the opposite sex – girls reported taunting from boys. Strenuous exercise (athletics, running, trampolining, jumping etc) emphasises the overweight body and performance, and is more likely to draw comment.
Georgie: I hate PE
INT: What do you dislike about it?
Georgie: Everyone stares at you, you become a target when it's PE, even more so, even if you're not scared because you think that you're going to become a target, and you know that you can't do that area or whatever and you become more self-conscious at which point you get bullied more.
A range of strategies are used to respond to or avoid challenging or uncomfortable situations (RG note – actually all of these seem to be about getting out of PE – faking notes, getting notes from parents, claiming sore ankle – quotes not extracted).
School requirement to participate in PE exacerbates young peoples' vulnerability at school and heightens their sensitivity to those around them. Young people, especially girls, perceived themselves to be under constant scrutiny, and were acutely sensitive to any implied or assumed criticism relating to their body, bodily performance or social practices.
*Alice: This girl, I saw her looking at me like that (*sideways glance*), and you know like, you know when they're going to do something to you, but you don't know what, and she went "oh I'm right fat me, I need to lose some weight" and she were, all the time she were looking at me going "oh I'm right fat me, I need to lose some weight", and Miss actually said to her "you've got more fat on brain if you think you need to lose weight" but…she were looking at me al the time, she was saying….the girl who was saying it she sat there al the time, looking at me and going "oh I'm so fat I need to lose some weight" sand there's nothing on her, and I know that that was meant as an insult, because I thought well she thinks, if she thinks I'm fat, if she thinks she's fat, but then, what am I?(edits in original)*

Healthy Eating
Sensitivity to surveillance also noted in other areas of school life, such as choosing and eating food.
Jade:….they feel like they have to watch you eat because "Oh, Oh look at her stuffing her face", but then you're thinking to yourself I'm eating a sandwich, you're stuffing yourself with pizza and chips and all that, and chips and gravy and everything, they're eating all that and you're just like having your sandwich and there looking at you like "Oh look at her eating, look at her!" (edits in original)
Food that are associated with dieting or "healthy eating" symbolise the need for control over the body and

control over eating – assumed to be lacking in the overweight young person. Eating healthy foods may be interpreted by peers as validating and justifying their difference, confirming to hostile peers that there is a problem and reinforcing the problem as one that is understandable in terms of individual food choices and eating practices.
Policy initiatives such 5-a-day and the fruit in schools programme have associated particular foods, such as fruit and vegetables, with healthy eating. For young people with obesity "apples can be dangerous things".
Jannine: I'm more self conscious when I'm eating healthily than when I am not, I feel like people look at me like you know because you are fat you're going to eat unhealthily but if you are eating healthy I think, I don't know, I just, just feel its more of a big deal that you're eating an apple or something, they like look and wonder why….. (quote selected by reviewer from longer conversation)
…….
Kym: I don't eat anything, because I'm kind of like, I like, I still take sandwiches, well I take dip things, Weight Watchers I think they are, but I don't really eat them because I'm, I don't eat like in a cafeteria, I eat outside, and because people walk past I'm always self conscious of the fact that they'll see me like, eating Weight Watchers, and think, oh she's fat, she's on a diet, and they'll take the mickey out of me, so I just don't eat.
(quote selected by reviewer from longer conversation)
Young people police their own food choices in an attempt to reduce surveillance from peers. Some use avoidance tactics - avoid eating at school, take their food away form designated eating spaces.

Emotional well-being and bullying
Almost all in the study had been bullied, much of it at school.
Eve: Day after day, walking in…you're that terrified that you don't want to go school, this is my point of view like, three years, I did, a year three years I tried not going to school because I used to get bullied and my mum got took to court.
School based PE and the promotion of "healthy eating" can accentuate the otherness of overweight young people, and creates opportunities for surveillance and persecutory behaviour from peers: discussion of PE and school dinner times often referred to bullying.
Moreover, obese young people often felt outside local peer culture, denying them the potential mediating effects (social capital) of social networks.
Georgie: …you were classed, if like in the first year, you were decided that you were one of the outcasts, you weren't the same as everybody else you were pushed to the outside, and you weren't let in and then everybody on the inside looked to the people on the outside and went "Ha ha, you're different, you can't be like us, we've pushed you out".
This was an area of divergence in the data with 2 participants reporting no bullying at school – both able to draw ion the support of a strong friendship group. It is notable that neither of these 2 completed the obesity support programme – perhaps it was less needed as they had a support network outside.
For others, various responses to the challenges of the school environment were seen – absenteeism, or responding with aggression (perhaps gendered), burying self in work and not going out, keeping quiet.
Note that the results relate to those attending an obesity support programme and may not be representative of a broader obese population, possibly have more profound problems. Also more girls than boys. Some potential participants did not take part as no parental consent – impact of this unknown

The Healthy School reconsidered
(RG note – from discussion section – all 2nd order interpretation)
Experiences from the groups suggest that the HSP, which had an explicit aim of promoting social inclusion, may contribute to the further marginalisation of young people with obesity "and play an important part in the construction of undesirable young bodies" p.415. Increased ficus onm PE and healthy eating heighten their vulnerability to bullying and lead to social exclusion. HSP reinforces the individual's responsibility for making healthy choices – these become imbued with moral.
Darwing on Aksinson & Hill's (1998) theoretical framework about social exclusion. 1) Relativity – relates to social exclusion of a young overweight person determined by the activities of others – "people become excluded because of events elsewhere in society". Dominant public health discourses (including HSP) reinforce intolerance for "unhealthy" big bodies. This morally laden value judgment sets young people apart by dint of their weight.
2) Agency – exclusion is the result of actions by people – peers participate in exclusionary practice through interactions with those who are obese, and these may be reinforced by the obese young people through their own actions – excluding themselves from practices within school and even school itself. HSP may inadvertently make it more difficult for those with obesity to negotiate "life passages" with others (social elements of group identity like group membership or types of clothing, or psychological factors which enable them to negotiate challenges they encounter). Agency is constrained through lack of access to peer groups.
3) Dynamic character – exclusion has implications across different spheres of life – within and beyond school, makinmg exclusion from other spheres of life more likely.
HSP has the potential to exacerbate marginalisation of young people with obesity.

Notes
None

Study [quality appraisal]

Dodson et al (2009) [+]

Programme focus

Intervention name, Location
Arkansas, California, Connecticut, Illinois, Maine, Massachusetts, Nevada, New hampshire, South Carolina, Texas, Washington, USA

Year/ timescale over which implemented
2003-2005

Target population
State level policy

Theoretical perspective
NR

Was local knowledge used in the design and/or delivery of the programme?
NR

Policy context
Paper notes the potential for state legislation and regulation to wield substantial power over specific actions that affect public health.
From 2003-2005 over 230 pieces of legislation addressing school nutrition standards and vending machines (such as school nutrition & vending machine standards; farmers' markets; soda & snack tax; restaurant menu & product labelling), and 190 addressing physical activity (physical education & physical activity; curriculum for health & physical education classes; safe routes to school; walking and biking paths), were introduced at state level. Paper lists potential stakeholders in these activities.

Whole system features
Unclear, so cannot specify

Study details

Study name (if different) [year]
Preventing childhood obesity through state policy: qualitative assessment of enablers and barriers

Setting (e.g. school, community, etc.)
US states

Author (year) [Ref ID] plus associated paper/source
Dodson et al, 2009
Linked quantitative papers referenced.

Aim of study
Expressed differently in 2 places:
To identify from legislators and staffers from 11 states the factors that enable and impede state level childhood obesity prevention legislation.
To use lessons learnt from state policy makers to improve understanding of the link between public health research and policy, and to inform the development and passage of future policies aiming to reduce the prevalence of childhood obesity.

Informed by theory?
Schmid et al 2006 framework for conceptualizing policy research: researchers (1) identify policies; (2) examine determinants of policies; (3) study the development and implementation of policies; (4) evaluate outcomes of policies.
3 streams of policy making process are involved- problems, policies, politics.

Study design

Data collection method
Key informant interviews with legislation and staffers (who can influence priorities of elected officials).
Trained interviewers used semi-structured scripts covering background characteristics, and experience with childhood obesity legislation.
Data collected Dec 2005-April 2006

Data analysis
Tape recordings transcribed verbatim. 2 independent coders analysed texts using "focused coding" (Hesse Biber & Leavy 2006) so coders would use the same set of thematic categories. These were predetermined. A subsample was done in duplicate to ensure accuracy – high level of inter-rater agreement (86%).

Sampling
States were selected with consideration of geographical location, adult obesity prevalence (4 low, 3 high and 4 mid), and dominant political party during 2003-5 – 6 democratic, 3 republican, 3 split.
Within states, leaders in obesity policy identified by their history of introducing or sponsoring legislation related to childhood obesity.
"A goal of 10-20 completed interviews was set to achieve content saturation".
Interviewers contacted legislators staff by telephone to book interview slots (mean 26 mins range 17-60 mins). 3 attempts made to reach each.
16/48 interview attempts successful

Study population
N=16
6 staffers and 10 legislators,
80% members of Democratic party
20% had formal health related background, law & education most common
Worked in state legislature median 12 yrs (range 4-21)

Ethical issues?
None mentioned

Source of funding
Robert Wood Johnson Foundation & CDC

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

NR

Findings

Enablers to the introduction and adoption of childhood obesity prevention legislation
Gaining support of stakeholders in process of considering

No. times cited	Thematic categories	Remarks
In your view, what factors support of facilitate the introduction & adoption of childhood obesity prevention legislation?		
16	Gaining support or involvement of key players (parents, physicians, schools, community members, health departments mentioned]	*It's easier to pass if you've had a broad group of individuals working on the actual language of the bill, what needs to be included in the bill, rather than someone saying "Oh, this is great idea. Let me sit down and write a bill about it." But the more people you involve, the more buy in you get, the stronger the coalition that you have supporting it, certainly the easier it's going to be to pass*
6	National media exposure	*Well I think, I guess I would say that there's been much more in the media about the need to rethink…..obesity and what we need to be doing, particularly for children, because there is this tremendous increase in obesity. And so I think that there's been much more attention through the media so that I think people are beginning to rethink what they're doing. So I think that's been helpful, though it seems to come in waves so it's not always consistent. But I think that the more we see of that in the media and the more we understand the need to be addressing this issue that, I think, can be very helpful in pushing legislation forward* *[Which bills pass] depends on what makes it into the media.*
4	Political climate	*The politics are working against us in those early years. And the politics were working against us even*

	(timing of intirduction)	*in a Democratic-controlled legislature, in which the Assembly Health Committee was, for a period of time, the greatest challenge to good health policy…And then a couple of years later, all of those legislators embarked upon their own [health] initiatives as a result of the political wake-up call in their district.*
3	Introduction by senior legislators and those with strong personal interest (willing to work creatively to address the problem)	*We said that we need to do something about the obesity issue instead of just inform the public… We just did basic fundamental thinking of, what can we do to help? And then: what can we do that will pass?*
In your view, what factors oppose or inhibit the introduction and adoption of childhood obesity prevention legislation?		
9	Lobbyists for manufacturers of unhealthy foods and beverages	*You can't blindside the lobbyists…I had this one….bill, we had as many lobbyists in the room as legislators…Lobbyists are there. They get paid and they can watch things a lot more carefully than public interest groups, which are not as well funded.*
9	Misconceptions about the problem and proposed solutions	*Representatives who voted no [on school junk food bill indicated] that their schools had encouraged them to vote no. Some of them implied that soft drink companies had put pressure on them as well. But most of them, even the ones who said they got pressure from the soda companies, all of them mentioned pressures from their school districts they represented, saying that their school districts feared they would lose money.*
6	Program costs	*Always in any legislative meeting, there's always somebody that will pop up and say "what's this going to cost us?"… so I think that the monetary issues is the most important to some people and the medical issue is the most important to other people. And in this instance [policy to reduce childhood obesity] both groups can benefit.*

"Do you think obesity legislation is more likely to progress through 1) a series of several incremental bills or 2) a few comprehensive bills?"
Of those answering, 73% believed incremental efforts more likely to be passed.

Recommendations for addressing childhood obesity through policy
(based on data and other cited literature)

- Clearly defined goals and policy
- Identify potential stakeholders
- Form coalitions and traditional and/or non traditional partnerships
- Develop a common language to build consensus and understanding
- Describe how diverse interests could be supported through policy action
- Strive for a neutral forum for discussion, a fair process, and clear facilitation
- Study examples from other states, understand your own state contexts, and adapt examples appropriately
- Engage local media
- Educate the public about misconceptions regarding proposed policy
- Allocate resources to support implementation, enforcement, and evaluation of policy
- Utilise sanctions or incentives to encourage compliance

Notes
None

Study [quality appraisal]

Evans & Killoran (2000) [+]

Programme focus

Intervention name, Location
Health Education Authority's Integrated Purchasing Programme (HIPP)

Year/ timescale over which implemented
1996-1999

Target population
Projects in Northumberland, Nottingham, Tameside and Glossop, Sandwell and Yelford and Wrekin.

Theoretical perspective
NR

Was local knowledge used in the design and/or delivery of the programme?
NR

Policy context
Part of the late 90s raft of policies aimed at addressing health inequalities – HAZ, HImP, HIPP, Healthy Cities and PCG/Ts.
All emphasised partnerships working. However, "there is still a lack of evidence based operational guidance for the development of effective local partnerships in tackling health inequalities". (p.126)
Launched when Conservative govt. was still committed to a quasi-market approach to health policy and ambivalent about initiatives directed at tackling health inequalities.
HIPP designed to represent a new way of "bottom up" working, responsive to views of local organisations.
But HEA had to balance this with what was politically acceptable to the government.

Whole system features
In Northumberland, a "whole systems event, Living Well in Tynedale" with professionals and community stakeholders

Study details

Study name (if different) [year]
Tackling health inequalities through partnership working: learning form realist evaluation

Setting (e.g. school, community, etc.)
Community

Author (year) [Ref ID] plus associated paper/source
Evans & Killoran, 2000 [4973]

Aim of study
To evaluate three HIMPs

Informed by theory?
Realist evaluation (Pawson & Tilley 1997)
Context + mechanism = outcome.

And drawing on Petticrew's concepts of receptive and non-receptive contexts for change – linked receptive contexts:
Key people leading change
Managerial-clinical relations
Cooperative inter-organisational networks
Simplicity and clarity of goals and priorities
Change agenda and its locale
Supportive organisational culture
Environmental pressure
Quality and coherence of policy.

Study design
Over 2 years
Case studies using qualitative methods.

Data collection method
Semi-structured interviews
Observation at meetings

Data analysis
Evaluation reports shared with stakeholders to validate analysis.

Sampling
NR

Study population
Project managers, project sponsors, steering group members and other stakeholders for each project interviewed.
Project steering group meetings, seminars & other events observed.

Ethical issues?
NR

Source of funding
HIPP porgramme

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

HIPP launched by HEA in 1996 and aimed to "provide practical support and guidance to health authorities, local authorities and those working in primary care, for making progress on local health strategies and targets."
Operated through 4 main elements: 1) establishment of 5 demonstration projects. 2) a national Practice Exchange Network, 3) a learning and dissemination programme, 4) resource base of knowledge.
Independent, process-orientated evaluation was a core element of programme: to describe different models; to identify enabling and obstacles to progress in each model; to compare and contrast the different models.

Northumberland: rural community, HA, CHT and Total Purchasing pilot partnership. Mergers and transition to PCT during project. Provided foundation for HAZ,. HImP and PCG. But not all stakeholders involved (notably public) and others did not feel equal ownership.
Nottingham: part of wider HA inequalities strategy. Model developed and tested to Mirpuri Punjabi speaking community. Focussed on access to primary care and supporting primary care team to understand their needs. Project champion role of projects manager and facilitation skills of external consultant important enablers. Obstacles included lack of sustained communication with community and primary care stakeholders and internal project management problems were obstacles.
Sandwell: Piloting locality commissioning in which HA, SS and local practitioners developing partnerships with local people, other agencies in commissioning services and health promotion activities. Teams involving HA commissioning manager, GPs, SS locality manager. Both teams had distinct models and different experiences. One played a major role in interagency health partnerships but marginalised in PCG development, the other was the reverse. External consultancy and the devolution of budgets to localities were enabling factors while the turbulence created by national policy (PCGs, HAZs etc) was an obstacle to sustaining locality developments.
Tameside & Glossop: Focused on developing the role of GPs in needs assessment and health strategy development/ implementation. Aimed to develop processes others could follow, by comparing experiences of 2 practices with different characteristics and environment. 1 used community development approach, with HA and Trust support, identified and prioritise health needs and plan for investment. The other focused initially on an information technology project, then diabetes project. Being selected as a national demonstration project and commitment from core group were enablers; lack of shared understanding and ownership was an obstacle.
Telford & Wrekin: focused on 2 linked development and evaluation components about health partnerships and reconfiguration of health promotion service. Joint with HA and Council. Much use of existing informal networks and forums. Development of national policy emphasis on partnership working and health inequalities, and external consultant were enabling factors; lack of agreed conceptual model, and of resources, for evaluation were barriers.

Findings

Petticrew et al developed 6 categories of enabling factors, which were used to generate HIP evaluation initial hypothesise
Achieving a shared strategic vision between organisations requires shared language and definitions
Effective project management depends on project manager operating at both strategic and grassroots levels.
Shared ownership among participating agencies requires equity of participation and accountability

Effective local relationships are achieved where projects develop mechanisms to overcome inequalities in power
Project work will be sustained where there is a culture of organisational learning
Effective projects will adapt their objectives and actions to the changing policy context.

Learning about enabling factors

Context	Mechanism	Outcome
Shared strategic vision		
History of working together	Local champions	Shared strategic vision on health inequalities
New national focus on health inequalities	Partnership development work	Prioritising process for health inequalities
Co-terminosity	Stakeholder events focusing on community health needs	Project outputs fed into HImPss, HAZs, PCGs
	Strategic steering groups	
Leadership and management		
National policy turbulence	Local champions	Health inequalities higher up local agendas
Local organisational turbulence	Consultancy support	Project members taking on local leadership roles
	HIPP network	
Relations and local ownership		
Lack of GP involvement in health partnerships	Attention to inter-professional and inter-agency relations	Shared ownership of needs assessment and strategy to tackle health inequalities
Limited local authority involvement in partnerships	Community based needs assessment	
Accountability		
Different professional and organisational accountabilities	Formal project accountability arrangements	Accountability remained a source of tension
Lack of accountability to community	Lack of explicit discussion of different/ conflicting accountabilities	Lack of accountability to community
Organisational readiness		
History of working together	Partnership development work	Project links with/outputs fed into HImPs, HAZs, PCGs
Good interagency personal relationships	Local champions	
Co-terminosity	Stakeholder events	
Responsiveness to a changing environment		
National Policy turbulence	Ability to scan the policy horizon (linked to HIPP network)	Raised profile for project work
Local organisational turbulence	Local champions	Project outputs fed into HIMPs, HAZ, PCGH

Notes

None

Study [quality appraisal]

Hall et al (2009) [+]

Programme focus

Intervention name, Location
Healthy City (Brighton and Hove)

Year/ timescale over which implemented
Healthy cities: Phase I 1987-1992
Phase II 1993-1997
Phase III 1998-2002
Phase IV 2003-2008 – this reported here.
Brighton and Hove joined in 2001

Target population
Brighton and Hove >250,000 people over 222km^2 on S. Coast known for large LGBT community. 32,000 students form 2 universities.
Falls into most deprived 25% of LAs in England with pockets of severe deprivation. Significant inequalities.

Theoretical perspective
NR

Was local knowledge used in the design and/or delivery of the programme?
See whole system features

Policy context
WHO healthy Cities project launched in 1987 to implement action areas of Ottawa Charter for Health Promotion. Focuses on facilitating community based health enhancing initiatives via a multi-sectoral approach to health in urban settings. Rejects top-down approach in favour of community based bottom up strategies. Aims to place health high up on the agenda of political decision makers and health and social systems as well as raising awareness among a broader population.

Whole system features
Capacity building - Creating new structures to act as change agents
Local creativity fostered through rejecting top down approaches and negotiating evaluations with key local stakeholders
Relationships - strategic links with other sectors built
Community engagement
Explicit target setting. Innovation and sustainability were promoted.

Study details

Study name (if different) [year]
Health in the Urban Environment: A qualitative review of the Brighton and Hove WHO Healthy City program

Setting (e.g. school, community, etc.)
Community/ Urban

Author (year) [Ref ID] plus associated paper/source
Hall et al 2009

Aim of study
To assess:
1) Whether healthy cities approach was making a positive contribution to health and well-being of citizens in Brighton and Hove.
2) Whether relationship with healthy Cities network facilitated progress of public health policy and practice within the network.
3) How healthy City Partnership could evolve to optimize potential for health improvement and reduction in health inequalities in the city.

Informed by theory?
NR

Study design
Qualitative review

Data collection method
Documentary analysis
In depth interviews (n=27) approx 1 hr
Half day facilitated workshop (health of the healthy Ciry partnership – aimed to review processes and make recommendations)
Project advisory group (healthy city manager, voce chair of partnership and IHDRC research team) monitored review progress.

Data analysis
Transcribed interviews and analysed thematically by 3 authors working independently. Initially categorised into 3 areas – 1) Healthy city approach – principle achievements and added value; 2) participation in phase IV; 3) healthy City partnership
All materials gathered at workshop were content analysed for inclusion

Sampling
Purposive. Stakeholders reflected in the Local Strategic Partnership (public, statutory, elected, community & voluntary, neighbourhood and communities, business)
30 identified (35 planned) and 27 agreed (3 too new in post and felt had insufficient knowledge).
3 people involved in health cities Sweden and Belfast interviewed by telephone.

Study population
Health sector (HS) n=7
Local authority (LA) n=6
Health sector/ Local authority (HS/LA) n=3
Business (BS) n=2
Community and Voluntary sector (CVSF) n=6
European/Other n=3

Ethical issues?
Ethics approval gained from University of Brighton

Source of funding
B&H Teaching Primary Care Trust.

'Lessons' for the evaluation of obesity prevention programmes
Ongoing debate about appropriate assessment methodology.

Programme delivery

NR

Findings

Heuristic framework from Tsouros (1990) used for review. Characteristics of a successful health cities project:

- Strong political leadership
- Effective leadership
- Broad community ownership
- High visibility
- Strategic orientation
- Adequate and appropriate resources
- Sound project administration
- Effective committee(s)
- String community participation
- Inter-sectoral collaboration
- Political and managerial accountability

Healthy City Approach
Principal achievements and added value
Related to awareness of WHO badge – which legitimised health issues, facilitating political "buy-in" for programme and increasing strategic partnership working.
It has bought a lot of kudos and raised the profile of health issues in the city by having that stamp of WHO…and that an achievement in itself (CVSF4)
…It has created a high profile and has legitimised health and well-being as an important issue – so health shouldn't be seen in isolation but very much part of the wider work that the City Council does as well, in terms of education, planning, environment etc. (SA10/LA) Reviewer truncation
Also raised the city profile internationally.

However, some stakeholders were unable to identify core achievements because: recently joined programme, lack of clarity around objectives, targets, benchmarks; failure of Healthy City Program to reflect

on and celebrate successes; difficulties attributing impact to project itself.
It has brought key stakeholders together, it has supported collaborative thinking and planning. But it is sometimes difficult to say what has happened as a result of the HC and what might have happened anyway…it is a difficult thing to separate. (HS1)

In terms of what had NOT been achieved it was felt that approach and concepts needed to be more widely understood through increased marketing and branding.

The introduction of HC and HC concepts hasn't been sufficiently known and understood to enable it to be embedded across all policy areas,. In terms of marketing, there has been an insufficient lack of overall marketing within Brighton and Hove as a HC…you need an overall marketing strategy to go with it. (HS1)

Phase IV core themes
Important achievement related to themes of healthy urban planning (HUP) and health impact assessment (HIA), included raised awareness of the impact of urban planning on health and wellbeing, embedding HUP principles and objectives into City Council planning strategy and enabling HIA to form a key part of council planning developments. Achieved through a series of training programmes to council planners.

Healthy Urban Planning
HUP is a core theme of Healthy Cities addressing natural (parks, green spaces etc) and built (housing transport workplaces etc) environments. Brighton and Hove was a key member of the HUP subnetwork.
Raising awareness of potential impact of HUP seen as significant achievement
[HUP] has been very successful in raising awareness amongst the planning groups, that there's more to their role than just, you know the physical layout of the city, and the physical infrastructure of the city, that they need to see how it impacts on the residents and the communities – I get the sense that Brighton is seen as having done this very well. (BS1)

Strategic and political impact of HUP see as important achievements – eg embedding HUP principles into strategies and policies and thus engaging planners and planning systems, leading to HIA being established as a key component of council planning devlopments.
Embedding HUP principles and objectives into strategy in a pragmatic, feasible and achievable way. We can demonstrate that through the local development framework and its core strategy and its various development plans and supplementary documents. (HS10/LA)

Training of city planners around health and well being was seen as a key achievement – also helpful in addressing challenges of inter-sectoral working.

It's enabled us to get health training, health promotion, publioc health training onto the agenda of staff devlopent for planners throughout the city. I know that quite a number of planners have been through these staff development courses and I think this has been a major benefit. In some ways it's been a challenge breaking down the barriers that people have in their understanding about health and trying to move health in a very medicalised or health sector narrow concepts to one considering holistic health, and particularly the way environment influences people's health. (HS9)

Health Impact Assessment
B&H a member of WHO HIA subnetwork since 2006. Raising awareness of HIA in urban development arena considered a major achievement. All major built developments now screened for HIA.

Healthy aging
B&H a member of WHO Healthy Ageing subnetwork since 2005: key principle = "action on wider determinants of urban living can enhance the health and independence of older people". Key achievement = awareness raising and strengthening the role of older people in decision making and incorporating consultation into strategic plans.

Physical activity/ active living
Is a "fundamental means of improving people's physical and mental health". HC encourage as part of everyday life, not an optional extra. Responses concerning this theme were sparse, and tangible attribution to the scheme was difficult.
Encouraging people to enjoy open and green spaces is a very good initiative – they have health walks organised and quite a few older people I know are involved in that, so that's been a very good initiative…also the green gyms, that's been good. (CVSF2)

Health inequalities and wider determinants of health

Most challenging aspect of HC: addressing poverty, social exclusion, needs of vulnerable groups and other social determinants of health. Respondents tended to discuss outcomes related to health inequalities rather than how the programme had addressed health inequalities. Awareness was raised, although lack of understanding about role of the programme was noted.
We're addressed inequalities through health promotion, smoking cessation, teaching cooking skills…. Also with active living. We've had an active living worker first in [E Brighton] and then we've sp[read it to the rest of the priority areas (HS5).
Stakeholders found it difficult to make a direct link form specific ongoing projects and infrastructural developments to the HC programme.

Participation in Phase IV of HC programme
Asked if WHO HC network was functioning well, stakeholders were divided, some focused on benefits of being part of a wider (inter)national network – meeting people and sharing what is being done, was thought to boost moral and increase ambition locally. Technical training was invaluable.

But relationships with WHO drew mainly negative responses – lack on ongoing technical and practical support and advice. Communication mechanisms perceived as inefficient, there was lack of engagement with meeting subnetworks, and as a result the sub-networks had been unable to work in a cohesive and sustained way.
What hasn't worked well is the regularity of communication from the WHO office and the lack of participation in meetings. Sub-network meetings are there to provide advanced development and progress by the cities in the delivery of Phase 4 objectives. There has been a lack of clarity about budget allocation and just a general sense of malaise and strategic drift. They are very, very slow in getting strategic papers out to us and in the UK context, if we to keep our politicians on board we need to be kept regularly briefed about the future direction of the Prorgamme. (HS10/LA)

The setting of the strategic direction and the quality and regularity of communication, leadership and guidance form WHO head office, resources or the lack of them particularly administrative resources. (HS1)

However, European HC network supported each other.
(more here not extracted)

The Healthy City Partnership
Themes related to the "health" of the HC partnership included: value of involvement, appropriate priorities, community consultation and engagement; terms of reference; membership; working practices; vision for the future and key challenges.

Value of involvement: Sense of legitimacy by the partnership for endorsing action at a local level, facilitating intersectoral collaboration and enable g joint working.
It has given us a focus to move upstream whether you see it as a health promotion or public health or health improvement – it has given us strategic focus where we are more accountable form a local partnership perspective in terms of how we spend NHS capacity and resources focusing on the wider determinants of health. (HS10/LA)

Appropriate priorities: HC priorities appropriate for Brighton and Hove, though some additional priorities suggested (mental health, sexual health, substance use.)

Community consultation and engagement: Existing mechanisms used for consultation (not usually thought to be effective). Most felt that there were too many consultations with communities and that it was necessary to work in a more joined up way with other sectors and organisations to maximise resource use. The purpose of consultation and engagement also needed to be clear.

Terms of reference: Generally supported, but need to be reviewed and updated to evolve with the partnership. Changes might be needed in terms of working practices, membership, elaboration of the link to the local strategic partnership and specific measureable objectives/targets.

Membership: Most felt reasonably mixed in terms of sector representation and seniority, others disagreed (wanted more seniors and more involvement from for example the business sector). Also wanted clarity about accountability, role and function within partnership and how to recruit other members.

Working practices: felt to be good within confines of resources and policy context, but not as efficient and effective as it could be. Common concerns were related to lack of capacity and resources and lack of strategic direction.
Brighton has so many partnerships, partnership on partnership, and my question is how can we make this partnership something form which specific actions emerge and something that is…really tangible as well…it could be improved. (HS6/LA)
Proposed improvements included: development of a strategy and operational plan, more focused and

interactive meetings, linking more explicitly to the Local Strategic Partnership and becoming involved in commissioning.

Maybe its getting people m more smaller, more flexible action groups, time limited because otherwise you create silos that engage in different areas and have a task and achieve it then take it back to the group…rather than just go to the meetings being bombarded with reams of paper…there's no opportunity for me to actually sit down and network with those people (BS2)
…to have more strategic meetings, away-days if you like, which would enable members to be consulted on a more strategic basis of what I call business meetings with very tight agendas and a number of key issues which need to be reported…share their experiences on a much more productive basis…allowing members to engage more activity with decision making, particularly around resource allocation. (HS9)

Vision for the future; Overlaps with other sections reported here. To become more strategic and collaborative, and clearer about objectives, with measureable outcomes, and becoming more visible and influential. Ongoing evaluation needed.

Key challenges: Potentially competing priorities at local, national and European level, and which they should prioritise.
Others were ensuring senior member participation and for it to address strategic credibility and power to influence action at a local level as well as becoming embedded in the mainstream.
The key challenge is making sure that we have the right people working on the right agenda – making sure those people are senior enough to go and drive change in their organisations or who they represent. (HS8/LA)
Addressing strategic credibility and power to influence action at a local level. In order for the HC programme to be embedded into the mainstream, stronger links would need to be made with the LSP as well as current and future LA liaison mechanisms.

Discussion:

Key drivers of success:

Strong political support

Strong support needed form the top of key organisations, including understanding core values and principles underpinning the HC approach.

Effective leadership: Vital to facilitate health promotion action. Dedicated healthy city core staff resources essential to take on this leadership role. Experience showed that staff often work beyond capacity. More equity across partners needed.

Broad community ownership and strong community participation: Confusion between terms such as community consultation, engagement, development etc. Need to be clarified. Community often not as involved as they should be, despite the fact that the WHO HC is supposed to be based on community activity.

High visibility Kudos from WHO HC a tangible benefit. Comprehensive communication strategy directed at carefully segmented target audiences needs to take advantage of this in order to raise visibility and add credibility to the programme.

Strategic orientation: Long term strategy and shared vision needed to build on existing plans with the aim of moving the programme into the mainstream.

Notes
None

Study [quality appraisal]

Khunti et al (2007) [-]

Programme focus

Intervention name, Location
SALAD – Schools Acting in Leicester Against Diabetes
Action research project

Year/ timescale over which implemented
1 year

Target population
Five inner city secondary schools serving a predominantly (77%) S. Asian population of Indian origin in Leicester UK

Theoretical perspective
Action research approach – assumed that involving the population in identifying interventions would increase the likelihood of achieving an impact. Key features include "participation, democratic practice facilitated by reflective working and contribution to both change and scientific working." P.2

Was local knowledge used in the design and/or delivery of the programme?
Yes – through activities like the research reported here

Policy context
None mentioned

Whole system features
Local creativity - involved population in identifying interventions
Community engagement - involved population in identifying interventions. Schools involved at all stages from funding application to considering results.
Communication - Yes – see above. However, links with the school over the year consisted of "Efforts…made to maintain links with the schools and the research team thorough meetings and telephone calls" – however noted that key contacts changed at least once in all schools, and communication difficult as didn't use email and not contactable by phone while in class. Commitments make it difficult to maintain links and organise meetings. Difficult to gauge overall levels of interest and involvement, and clearly lack of dedicated staff time.
Action research methods ensure adaptation/ learning organisations

Study details

Study name (if different) [year]
Primary prevention of type-2 diabetes and heart disease: action research in secondary schools serving and ethnically diverse UK population

Setting (e.g. school, community, etc.)
School

Author (year) [Ref ID] plus associated paper/source
Khunti 2007
Linked papers also report survey data – not included in this review.

Aim of study
To elucidate barriers, and facilitators related to healthy lifestyles ad to gather ideas for interventions

Informed by theory?
"Basic principles" of grounded theory informed open coding of themes grounded in the data.

Study design
NR

Data collection method
FU survey about food and physical activity (not extracted)
Focus group discussions facilitated by academic team at start and end of year
Observational visit to each school to record food and physical activity provision.
Staff focus groups recorded but as this was felt it might restrict pupils willingness to contribute, notes taken instead.

Data analysis
Key findings from preliminary content analysis of pupil FGDs used in staff focus groups and planning meetings, including consideration of practicality of implementing interventions suggested by pupils.

Sampling
All 6 invited schools agreed to participate but only 5 took part.
Deprived area.
18 FGDs with pupils (2-4 per school 5-8 per group) organised by school staff "who were given guidance about including a range of pupils in terms of age, gender, ethnic background and educational ability."

Study population
Pupils aged 11-15

Ethical issues?
No mention of ethical approval or consent for participation

Source of funding
British Heart Foundation

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

NR

Findings

Barriers to adopting and promoting healthy lifestyles

Pupil perspectives	Staff perspectives
Diet	
Cost: Healthy foods costs more and unwillingness to "waste" money on trying different foods	Commercial basis of school meals provision
Control: enjoyment of freedom to make food choices in secondary school compared to home and primary school	Lack of control over pupils food choices in secondary compared to primary schools
Motivation: acknowledgment that food choices are made on basis of taste, hunger satisfaction, presentation and peer pressure (not "cool" to eat an apple) rather than health	Perceived difficulty of changing food choice behaviour through education
Other food sources: obtaining food from local retail outlets seen as offering better value, greater choice in surroundings	Competition from nearby retail outlets
Influence of process and presentation on choice: lack of clear pricing and labelling leading pupils to make "safe" choices such as chips	Limited time for lunch break leading to rapid throughput and pressure to encourage rapid choices
Physical activity	
Facilities: impact of poor facilities such as changing rooms on attitude to PE; lack of safe storage for bikes and PE kit deterring pupils from cycling and bringing kit for extra curricular activities on non-PE days	Restrictions caused by limited in-school resources such as sports hall space and inner city location with lack of green space.
Ethnicity and gender issues: cultural commitments such as attending mosque limiting time available for physical activity; interest in sport is higher in boys.	Perceived lack of "exercise culture" and resistance to allowing pupils to walk to school amongst S. Asians; resistance to physical activity amongst girls
Current provision: PE choices not seen as appealing to all pupils	Perception that current PE provision is good but also acknowledgment of limitations imposed by availability of staff to supervise extra-curricular activities
Diet & Physical exercise	
Priorities: impact of lifestyle on health seen as an issue more relevant to older people.	Demands of curriculum and pressure to achieve good exam results limits time available for healthy lifestyle promotion in schools

Staff perspective
A. Barriers causing frustration: lack of resources and competition form retail food outlets (lack of control)
"…we've only got one gym that is it. We've got an all weather pitch which is called an all weather pitch but that's about as far as it goes and it floods.."

"…for all the work (the cook supervisor) is doing providing healthy eating for children, suddenly the children are going across the road (to the burger van parked outside school) for burgers and chips and they have no idea of the fat content and I have tried the legal route and I have tried everything and apparently I cant challenge that because they aren't doing anything illegal.

B. Defensiveness leading to reluctance to acknowledge the need for change. (at FU group)
"I wouldn't say (there have been) many changes because I think we are doing a good job anyway….we have always had such a supportive staff here that are willing to give up time to encourage students to participate (in PE activities).

C. Impact of action research
"I think it has helped us to focus, it's something that happens (change) and it's an ongoing process, but in terms of this school it has helped us to focus on this issues which we might not have focused on in this way. We don't always meet as one group… it's brought together that this is the kind of thing we might continue doing"
"I think it has had an impact because the children who did the questionnaires took it very seriously and every question raises awareness in any case… I think it's had a little ripple effect"

Intervention suggested by pupils & staff	Comments	Outcome
Motivational visit by sports personality	Pupils said would be effective only if very high profile (eg David Beckham)	Rejected: pupils themselves felt unrealistic
"Walk to school" campaign	Local initiative identified as way of encouraging physical activity	Rejected: intention to participate expressed, but later found it was aimed at primary school children
"Dance" option for PE	To appeal to girls	Introduced: one school able to offer after getting funding for another member of staff
Wider provision of free drinking water	Schools recognised as good alternative to fizzy drinks	Rejected: practical barriers cited by schools
No chip days	Mixed reactions among pupils. Staff receptive.	Introduced, but impact limited by retail provision outside schools
Clearer labelling of food	Pupils cited clearer pricing and labelling might make it more likely that tried less familiar food	Introduced: some attempts made by caterers to address this

Useful dialogue between school meal providers was initiated, changed food offered, removed vending machines, reducing salt availability, no chip days, and "grab and go" bags with at least one healthy item. Not always well done though – for eg. chip cob replaced by cheese pasty with higher fat content.
One school introduced incentive scheme with stamps obtained for healthy food and taking part in extra curricular physical activity with prize draw for stamped cards.

Author conclusions
Limited changes in existing sub optimal pupil lifestyles.
Realistic prospect of achieving greater impact in schools require implementation resources including dedicated staff time.
Although wide involvement of school community, limited scope did not include active parental involvement.

Notes

Although principles of grounded theory evoked, this is rather spurious given the focus of the research question and the fact that pupils' own words were not transcribed verbatim.

The action research approach was valued by staff who thought that it provided a focus for change. Half of the six interventions suggested by staff and pupils were implemented, although those relating to no chip days, and clearer food labelling were somewhat undermined by external food retailers. We suggest that this illustrates how a true whole system approach needs to be taken to allow alterations in one are to be supported, rather than undermined, by those in another. The paper also notes that the scope was limited by a failure to actively involve parents. Within the school, dialogue with the school meal providers led to positive changes, including removing vending machines, reducing the availability of salt, and "grab and go" bags containing at least 1 healthy item. However, these were not always undertaken in the spirit of overall healthier food provision, as exampled by chips being replaces by a cheese pasty that had an even higher fat content.
The paper also notes that implementation resource, including dedicated staff time, would be required to achieve more than the limited impact recorded buy the project.

Study [quality appraisal]

Platt et al (2003) [++]

Programme focus

Intervention name, Location
Breathing Space, Wester Hailes, Edinburgh (Scotland)

Year/ timescale over which implemented
1998-2001

Target population
Residents of Wester Hailes, a low-income area of Edinburgh (population: 22,884, deprivation category score of 5 (scale runs from 1 (most prosperous) to 7 (least prosperous)) (Ritchie et al 2008)

Theoretical perspective
'Community development principles' – aimed to provoke a 'normative shift' towards a less permissive and tolerant community valuation of smoking

Was local knowledge used in the design and/or delivery of the programme?
Yes, through mapping exercise (see under Programme delivery)

Policy context
White Paper (*Smoking Kill,* 1998) proposed a comprehensive plan of action to reduce smoking:
- measures to reduce smoking among young people
- new smoking cessation services for adults
- action on smoking in pregnant women
- proposals for abolishing tobacco advertising and promotion
- proposals for altering public attitudes to smoking
- proposals for working with workplaces regarding restricting smoking in public places

Prior to the implementation of the programme, the local community in Wester Hailes had begun to address smoking through implementing no-smoking policies and the provision of support (by the local health agency) for smokers who wanted to quit

Study details

Study name (if different) [year]
NA

Setting (e.g. school, community, etc.)
Community

Author (year) [Ref ID] plus associated paper/source
Platt et al (2003) [5458] (all data in this table taken from this study unless otherwise stated)

Supplemented with additional reporting of the study in:
Ritchie et al (2004) [5521]
Ritchie et al (2008) [705]

Aim of study
To investigate barriers and facilitators to the successful design, development implementation and receipt of the programme

Informed by theory?
Not specifically, but a considered approach to evaluating the wide range of factors that may be important in a complex programme

Study design
Evaluation

Data collection method
In-depth interviews (n=59)
Focus groups (n=6)
Observation at programme meetings and key events (not explicitly analysed)
Monitoring of local newspapers and community publications (not explicitly analysed)

Data analysis
Interviews: thematic analysis of transcripts (coding scheme developed prior to the interviews, but developed in response to ongoing analysis of transcripts), using QSR NUDIST
Interview transcripts were read in conjunction with data from other research methods (observation and examination of official documentation).
Both pre-identified and emergent thematic categories were tested by reference to the individual cases, and conditions and circumstances of these formulations were compared and contrasted. A random selection of transcripts were coded by two different researchers, discrepancies were reviewed and agreement of the final coding scheme negotiated

Focus groups: analysed thematically within (rather than across) each group (as group compositions were quite different)

Sampling
NR

Study population
Programme managers and intervention and sub-group members (interviews)
Young people aged 12-15 years (2 FGs); 16-25 years (1 FG); local community workers with a youth remit (1 FG); primary care practice-based smoking cessation counsellors (1 FG); and workers from local community organisations (1 FG)

Ethical issues?
NR

Source of funding
Department of Health

'Lessons' for the evaluation of obesity prevention programmes
NR

Whole system features
Involved community and local health agencies

Programme delivery

The aim of the programme was to capitalise on local knowledge and encourage local involvement in the development of a programme of activities that would create a supportive environment to enable local people to make healthy choices (Ritchie et al 2004)

See Figure 3.1 Structure of the intervention (extracted after evidence table)

Note that the proposed community and workplace sub-groups were not formed (due to resource-limitations)

The alliance aimed to support settings based subgroup whose remit was to take forward project objectives. Subgroups consisted of members of the main intervention team and other community workers with particular expertise or interest in that setting. In keeping with the initiative's community development ethos, it was envisaged that others, who were not members of a settings subgroup or the main intervention team, but who worked or lived in the community, would also be involved in progressing specific activities

'Mapping' exercise (6 months duration) to identify community needs was undertaken to provide a picture of smoking policies, workers' and lay people's perceptions about smoking as an issue, and smoking prevention practices in the area. Findings were used to inform a 'brainstorming exercise' to develop a draft action plan – this process was undertaken by representatives from community organisations and intervention team members. Key individuals were then invited to join sub-groups, whose first task was to re-shape the action plan.

Table 3.1 Summary of intervention activity

Setting	Programme activities
Community	Provision of smoking cessation support and holistic healthcare as an alternative to practice based support Development and delivery of training programme for community workers in smoking cessation support Distribution of information regarding support available to those who want to quit

	Profile raising activities: community events, posters, local newspaper (adverts/competitions), post-card drop to every household
Primary care	Operational and strategic input into local smoking cessation planning Training of health professionals in brief and in-depth intervention methods including motivational interviewing Support of smoking cessation counselling services set up through LHCC Provision of NRT through a community venue (WHHA)
Young people	Production of a sustainable education pack suitable for use as a teaching aid in secondary schools Leaflet design project and competition involving first year pupils in local secondary school Clear signage about no smoking policy adopted in local secondary school Funded community grant projects: posters, video, web-site design, alternatives to smoking/activity groups Development and implementation of a protocol for the provision of smoking cessation support for those aged under 16 years (WHHA)
Workplace	Offer of health audit/support to SMEs

Findings

The aim of the programme was to capitalise on local knowledge and encourage local involvement in the development of a programme of activities that would create a supportive environment to enable local people to make healthy choices (Ritchie et al 2004)

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Workplace	Offer of health audit/support to SMEs

Findings

Leadership and management issues

Although there was commitment from partner organisations, respondents felt it lacked overall leadership. Respondents felt that the programme required "someone driving it forward" and lamented the absence of any one person or group "taking that kind of role"

Some respondents felt that representatives from the partner organisations should have been more actively involved, and demonstrated categorically that they were committed to the programme

The authority to make and act upon decisions relating to the programme often lay outside the control of key programme workers, instead requiring referral to line managers who did not necessarily have in-depth knowledge of the programme. Respondents reported being unsure "which manager was responsible" for what, while lacking the authority to make their own decisions – this meant that many felt they had insufficient backing to confront issues arising around difficulties in the partnership process

High level management decisions impacted on the intervention group, with respondents talking about a "lack of consultation" and "goal posts moving" as the more powerful organisations responded to changing political climates

There was a perceived imbalance between the status of statutory bodies and community agencies with regards to their authority over and input into the programme – respondents from the community agencies tended to see themselves as "poor relations" and "peripheral to the group"

Respondents found it difficult to make the links between different programme settings and talked of "getting involved in our own settings" at the expense of "losing touch with what's happening in the wider project" – resource-limitations placed limits on what programme staff could realistically achieve, and in addition there was insufficient knowledge and experience of community development work. The result was limited working across different settings. The appointment of a programme co-ordinator did not make much of a difference, as this co-ordinator 'filled in the gaps' of what frontline staff were unable (because of time limitations) or unwilling (because of conventional notions of their remit) to do

Issues of power and equality

Role of the Health Board identified by many respondents as being too prominent in both the development and implementation of the programme, leading to a view that the programme was "developed effectively by one organisation". Health Board workers in the early stages of the programme, despite having the goal of facilitating the involvement of community groups and other local organisations/professionals, in the event carried out much of the work themselves.

Little consensus among members of the partnership organisations about what was meant by community participation and who should be involved – Health Board senior staff members tended to identify health professionals and local businesses as 'the community', whilst others questioned whether this was really the community, and brought attention to the low level at which actual residents of the community were represented in the programme

Smoking as a community identified priority

A number of respondents across all of the partner organisations questioned whether smoking was an

appropriate focus for the programme, with issues such as drug and alcohol being identified as higher priorities (despite the perception of those who had been involved in the 'mapping exercise' that smoking was indeed a 'community-identified' priority)

The focus on smoking in young people was also questioned in terms of priorities, with sexual health being identified by some as of greater importance. There were significant difficulties in gaining young people's interests in smoking cessation, when this was perceived as "an adult issue" and "not high on the agenda of young people". The absence of young people in programme planning was also criticised by a community-based youth worker who claimed that she had been unable to "establish the issue with the young people first and then work it up from there"

Ways of working

The vast majority of respondents felt that the programme was affected by institutional constraints placed upon those working within the different partner organisations, e.g. Health Board workers felt they were expected to demonstrate the type of tangible outcomes associated with direct action about smoking targeted at the individual level. This was exacerbated by the Health Board being a major funder of the programme (which was itself linked to a high profile evaluation), with tangible outcomes that were not necessarily compatible with the aims of community development

Some respondents were uncomfortable with, and resistant to, the idea of project objectives which were shaped by the community agenda and which could evolve over time, despite high level support from the Health Board for this emergent process. Those implementing the programme expressed personal concerns about what they felt to be "amorphous" and "shapeless" aspects of the endeavour – some acknowledged that "to start with I didn't have a clue what the principles were" and that they were "not so used to working in that way". Even where workers were knowledgeable, or gained familiarity with the approach, they did not find it easy to translate this knowledge into practice

People are probably more used to working in a way that's erm, you know, you do this and then you do this and then you do this. Whereas what we are trying to do is allow a process to emerge… and what people are finding difficult is being diffuse… very difficult, the anxiety is enormous. (Programme team member) (Ritchie et al 2004)

Respondents perceived the modus operandi of the Health Board as "set" and "working in the other direction" to a community development approach, whilst respondents representing the Health Agency saw themselves as more appropriately placed with "more facilities and support services" and "better qualified to support a community based approach"

… there are tensions in doing community development if you're a statutory organisation… it doesn't quite fit, because on one level it's home grown, it's grass roots development, it's power located in the community and then you are there as a totally different, like well quite a powerful structure with certain ways of working. (Programme team member) (Ritchie et al 2004)

Respondents generally associated smoking cessation work with working at the individual level, e.g. health care professionals saw their role as working with individuals "to identify to that person what's the best way to quit smoking", despite the programme's focus on community development rather than one-to-one interventions. Primary health care professionals were perceived, despite the nature of their contact with community members being on a one-to-one basis in a clinical setting, to have the greatest understanding of people's circumstances and life

Interpersonal relationships

Relationships within the programme team became strained, particularly between community partner organisations and the Health Board, for a number of reasons:

1) community representatives were concerned that the balance of power was weighted heavily towards the Health Board
2) some community representatives felt that they were denied their sense of rightful programme ownership
3) some community representatives felt that the Health Board employees viewed them negatively, seeing themselves as "professionals and we as amateurs" (however, note that some Health Board employees perceived the community organisations as the more powerful stakeholder)
4) team members found it difficult to establish a common language, partly because of a reluctance to relax the strong disciplinary boundaries which traditionally informed their respective approaches
5) tensions were exacerbated by the perceived inadequate leadership, line management and support

Resource allocation

Respondents felt that resource allocation, including programme funding and staffing, was dictated more by internal structuring and the priorities of the partner organisations, than by programme needs, e.g. because "the ground has shifted so much over the time of the project", some respondents felt that they were "dealing with a completely different beast now from six months ago"

Each agency has transformed completely. [The Health Board] went through restructuring. The partnership is winding down towards closure and the Health Agency have got staff shortages and are now completely, well

until recently, out of the loop. (Programme team member) (Ritchie et al 2008)

High turnover of team members meant that by the end of the programme there were "few members of the original team left" – this was perceived to be as a result of staff cut-backs in partner organisations, organisational restructuring, and long-term sickness among key programme members. Respondents were particularly critical of "arbitrary" staff changes arising from organisational restructuring, which involved "starting from square one with a new person". Staff changes impacted on the programme in a number of ways:

1) when key members of the team left, particularly those involved in the conception and early development of the programme, they took their knowledge and expertise (crucial to successful implementation) with them

I think her particular community development skills will be [missed], she has worked in that way before, her understanding of that will be a great loss, actually. (Manager) (Ritchie et al 2008)

2) replacement staff found it difficult to come into an established programme, and were often less committed to objectives decided upon before they took up the post

… it has taken me a long time, a good while to get my head around what it's all about. And I think there have been difficulties in people informing me about things because there are so few members of the original team left. (Programme team member) (Ritchie et al 2008)

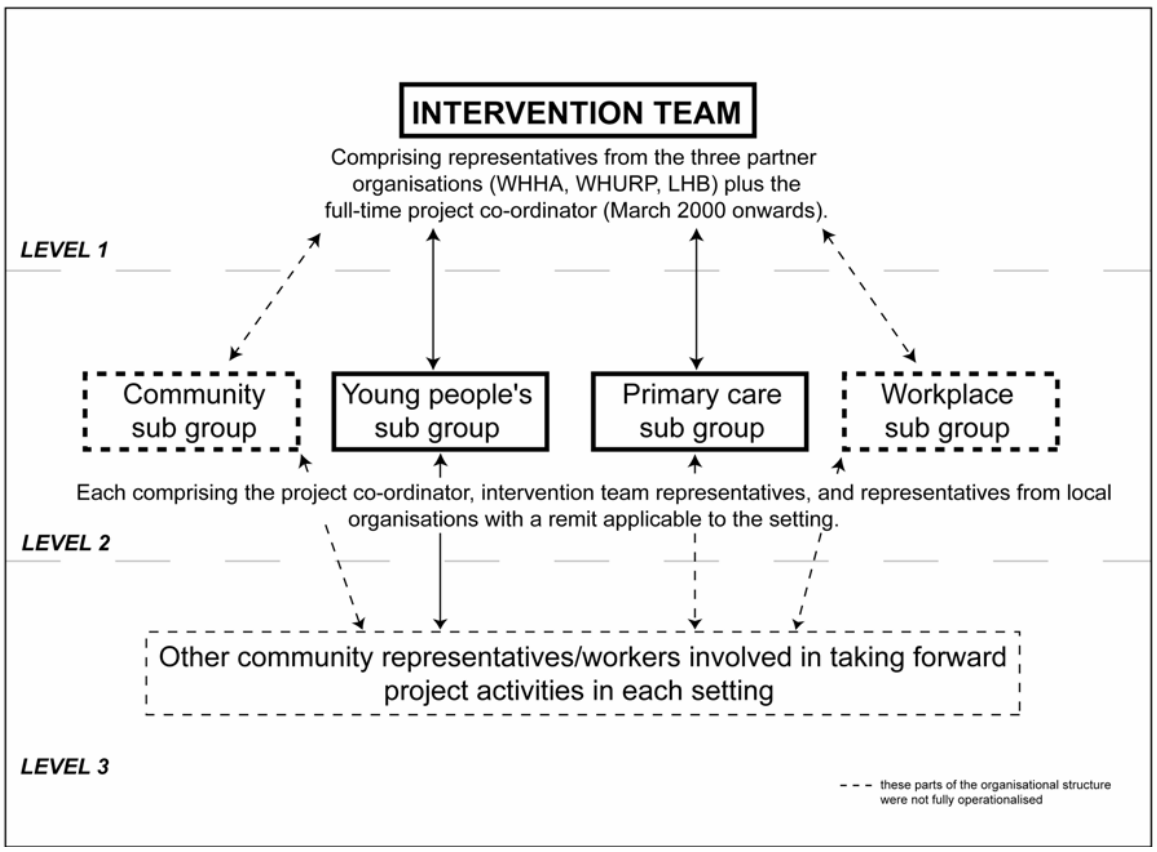
3) induction of new members of staff became the responsibility of programme team members who did not have the programme formally written into their remits until the second year of the programme

The understanding of new programme leaders was not always consistent with the original programme objectives

One of the big objectives has kind of almost been forgotten about… is about changing perceptions, and that we've very much concentrated on primary care and not the community. And I think that's partly through the coordinator when he took over post maybe not being given a fully accurate understanding of what the project was about and then maybe lost it again with someone else. A bit like Chinese whispers: you start off and you end up with a very diluted message. (Programme team member) (Ritchie et al 2008)

Restructuring and cutbacks affected the amount of money available for actual programme work – some respondents spoke of "a failure to follow through" on original pledges and "the rug being pulled from under your feet all the time". Programme team members also found that they needed to raise extra funding to compensate for understaffing in community organisations or in order to carry out specific pieces of work – intervention team members spent time attempting to secure additional funding at the expense of progression of the programme work

Figure 3.1 Structure of the intervention



Study [quality appraisal]

Po'e et al (2010) [+]

Programme focus

Intervention name, Location
Not named – "currently active community based pediatric prevention/intervention programs.
Self identified programs related to pediatric obesity, service provision to children and youth (0-18 yrs), with emphasis on healthy lifestyles behaviours.

Year/ timescale over which implemented
NR

Target population
In a community where 1 in 3 children are overweight – Davidson County, Nashville TN.

Theoretical perspective
NR

Was local knowledge used in the design and/or delivery of the programme?
NR

Policy context
NR

Whole system features
"A number of studies suggest that the next generation of interventions must involve the community or systemic societal changes. In a recent article Huang et al argue that a systems-oriented multi-level framework must be established given the complexity of the obesity epidemic, suggesting that structural modifications to multilevel interventions must be put in place on order to effectively address the pediatric obesity."

Study details

Study name (if different) [year]
Pediatric Obesity Community Programs: Barriers and Facilitators Toward Sustainability

Setting (e.g. school, community, etc.)
Community

Author (year) [Ref ID] plus associated paper/source
Po'e et al 2010 [5294]

Aim of study
To assess the elements that support or deter program sustainability

Informed by theory?
Grounded theory

Study design
"Exploratory, cross sectional, qualitative research study based on grounded theory"

Data collection method
In depth face to face one to one interviews over Dec 2007- Feb 2008.
Semis structured survey of 9 open ended questions to ascertain scope of services provided, facilitators and barriers to successful implementation and sustainability efforts.
Average length 21 minutes.

Data analysis
GT used to create a substantive theory grounded in empirical data (Glaser & Strauss 1967; Glaser 1992; Strauss & Corbin 1990 referenced).
2 independent researchers analysed written transcripts. Cyclical team process of abstracting, comparing and agreeing codes for themes until saturation.
Constant inductive and deductive analysis to extract words and concepts and generate themes and subthemes (the form of the questions was considered a theme and the separate constitute properties were collected as categorical subthemes). Once consensus reached, codebook developed. Both reviewers independently reread transcripts and tallied subtheme frequency. These were compared to establish

validity.

Sampling
Supervised student interns reviewed Community services directory to identify and recruit eligible agencies by phone. 80 met the criteria. 30 randomly selected for interview, 24 took place (5 failed due to inability to arrange convenient time, one was not involved in obesity prevention). Directors of each invited to participate in face to face interview. 1 person per organisation.
Further interviews not sought due to theme saturation.

Study population
3 main types of organisation: community outreach programs, after school programs, clinic based programs.
70% explicitly focused on obesity prevention or treatment, 30% focused on healthy living.
50% had existing resources, such as partnerships, volunteers, paid staff or external funding.
54% provided actual education or services
46% focus on vulnerable populations
29% tailored for a specific age group
35% targeted a geographical region
Ethical issues?
Written consent obtained.
Vanderbilt University Institutional Review Board approved study.

Source of funding
NR

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

NR

Findings

Facilitators and success
Referring to an organisation's capacity to reach or maintain their goals.
1) Programmatic enhancements (73%). Newly renovated programs, recent increase in the number of activities, or an extension of services for a broader target population.
In terms of the Veggie Project, there were thousands of pounds of fresh fruits and vegetables sold in neighbourhoods where we know there's not as much access to healthy fresh fruits and vegetables, and so I think that's a huge success.

2) Community involvement (63%) i.e. interaction with community organisations or its members.
We like to say that we foster uncommon connections between our partner organisations. We bring together a nutrition educator with a farmer and do outreach to kids and adults. We'll bring people together to talk about an issue like women in agriculture. But that also includes a discussion of families and feeding practices and so I think we're tracking these uncommon connections that are created, there are also some huge successes in how people are thinking about the work that they do. I think that's something that people see as a win-win.

3) Establishment of partnerships (54%): Alliances such as partnerships or coalitions that integrate resources were important. Also agencies with one focus (eg healthy eating) joining up with others focusing on others (such as physical activity). Coalitions include those at multiple levels – school, home, community, and public, private sector, community agencies and community members.
We measure success by the number of kids that come to the program. Not by whether they leave healthier than when they began. So that's where the partnership [with hospital] has been great to get us to see the importance of that…I'd love to say that we had 800 kids in the softball program or dance program and 90% of them are living a healthier lifestyle, to be able to cite those example, but we can't do that [yet].

We're very lucky because [one community liaison brought together a ton of different folks, some dieticians, folks who were really involved in exercise at Vanderbilt, and then a lot of different community partners. So I think what really worked was [them] already having a relationship with a lot of different community partners. We hope to continue to bring a lot of different groups together.

Barriers and challenges
1) Limited funding (44%): especially steady findings. Examples included for translation services for mixed language population.
….So [people in the community] donate costs to run a phone interpreting line…and then when they have no money at all, then you have to find whatever you can to help them that's free. (reviewer selection of longer quote)
2) Lack of participation (42%): in community services by intended participants.

For me the biggest frustration or challenge would be getting consistency among children. I might see [the children] 5 out of 10 weeks, but not consistently every single week. It's after school and we're a community centre, so its totally their decision whether to come to community centre or not.
3) Lack of organisational support (21%): Not enough support staff.
Some people want to have a person, a different face, to promote [physical activity] with their individual schools. And it's just tough for us to make that happen. So we do try to work with our volunteers. And we try to make it work to have a staff member there… But there are only so many of us that can help that way.

Sustainability
1) Establishment of partnerships (50%)
Our goal is to make our programmes sustainable – that was built into the program from the beginning – the farmers would be paid a fair price for their food. The food would also be fairly priced for the communities where the food was sold, and several of the Boys and Girls Clubs have already indicated that it's a program that they'd like to incorporate into how they think about their work.
2) Funding (42%) (quote supplied – seems to discuss need to evidence based programs too, and that funds tend to be linked to those programs that can demonstrate effectiveness through well designed outcome evaluation)
3) Support staff (27%): such as existing staff or volunteers.
…..Our staff have struggled with [eating healthily and exercise] We have staff at our school age service sites that are promoting this, but they're struggling with doing it themselves…So we see that some work with even our staff promoting this is one that we need to continue to be working with. We did not have a total buy in from our staff team to change their eating habits and increase their physical activity. We had about 50%. So we feel very strongly that we need to set an example for what we are promoting.

Notes

None

Study [quality appraisal]

Points4Life (2010) [-]

Programme focus

Intervention name, Location
Points 4 Life

Year/ timescale over which implemented
NR

Target population
Manchester city

Theoretical perspective (if mentioned – e.g. Social Ecological Model)
Not clear

Was local knowledge used in the design and/or delivery of the programme?
Not clear

Policy context
Points4Life is a loyalty points programme developed by Manchester City Council and the NHS Manchester.
Membership free – people earn points through healthy behaviours like walking, exercising or healthy eating.
Badged as part of the Change for Life family.
Funded by DoH Healthy Towns initiative with additional resources from Manchester City Council and NHS Manchester.

Aims to improve health and tackle inequality. Based on 4 objectives: Lift motivation; improve health; feasibility; equality

Whole system features
Department of Health and City Council involved

Study details

Study name (if different) [year]
Points 4 Life
Barriers and enablers to a healthy lifestyle

Setting (e.g. school, community, etc.)
Community

Author (year) [Ref ID] plus associated paper/source
Points 4 Life 2010

Aim of study
Not stated

Informed by theory?
Not stated

Study design
NR

Data collection method
Focus groups (2 hrs)
Interviews with those unable to take part on a group
Facilitated by experienced researchers matched for ethnicity and language.

Data analysis
Recorded and transcribed. Translated into English where needed.
Participants sent copy of the transcripts for comment.

Sampling
On-street, face to face recruitment, also locality based in supermarkets, POs, community halls, leisure centres, support groups and councils. Letter of confirmation confirmed attendance and details with FU telephone call .

FGD participants paid £40 and interviewees £15.

Study population
Aimed to have groups relating to most deprived; least deprived; Black African/ Caribbean; Bangladeshi/ Pakistani/ Indian female; Bangladeshi/ Pakistani/ Indian male.

Ethical issues?
Information sheets provided, confidentiality outlined and consent obtained.

Source of funding
Not clear

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

NR

Findings

Barriers to eating well
Differed by SES. Participants in least deprived groups identified cost as the main barrier
If the NHS wanted people to lose weight, the low fat things should be less than the full fat things, in the supermarkets it's the other way round.
Also cited poor will power, lack of time, stress and the ease of availability of "unhealthy" fast food.
BME groups echoed these, but Black African/ Caribbean/ British cited cultural norms (lots of carbohydrates and fats) as a barrier.

Least deprived groups identified fewer barriers, and many felt they already ate well. Personal responsibility for health was emphasised and there was evidence that they understood about healthy foods.

Barriers to physical activity
Similar to healthy eating. Cost referenced by all groups.
Most deprived groups: Lack of knowledge about and access to exercise facilities. Reluctance to go out at night locally. South Asian women especially reluctant to use public facilities, prefer to exercise at home. Home responsibilities also a barrier for S Asian men and women.
Least deprived: more able to state barriers. Health problems the most common barrier. S Asian men also felt, however, that a health scare was the biggest motivator to exercise.

Enablers for a healthy lifestyle
All mentioned: lowering costs of healthy eating and activity; increased time; more motivation (often through family support).

Most deprived felt that supermarkets should make fruit, vegetables, fish and high quality meat more affordable. Information (clearer packaging and advertising of sports facilities) was also highlighted
I've only been in Manchester a year and I still don't know where things are, there could be a gym round the corner form me and I wouldn't know.
Least deprived also thought cost was important.

BME had different enablers: improved time management – for men, time set aside outside work and for women freeing up time through support with child by family cooperation or crèche facilities.

Attitudes towards points4life
Generally positive with most, apart from the least deprived (who felt they were already healthy), willing to join. The least deprived also disagreed with the concept of incentives and rewards used to change behaviour. Some were critical about rewards they felt to be wrongly directed (for example suggested gym membership instead of theme park days). Some concern about personal data (eg housing tenure and income) collected by the scheme. Accuracy if self reported data for monitoring also caused scepticism.
Still some positive comments in this group though:
Times are hard for everybody and you know, we've got to look after ourselves….sometimes you just need a shove in the right direction.

Most deprived generally positive, but also concerned about providing personal financial or housing information. Some concern that allocation of rewards might not be equitable if more could be obtained by spending more money.

BME groups also questioned how participation would be monitored. But generally positive about the programme as encouraging healthy living.

Attitudes to specific programme elements
Least deprived group most sceptical.
Rewards
Sufficient choice (of type and of partners) needed to make rewards worth while. Proximity and access to partners (supermarkets, leisure centres) biggest barrier to joining the points4life scheme.

Ongoing rewards
Most deprived and S Asian women keen that ongoing rewards were available where they shopped (eg cash and carry). Most deprived group were also concerned that rewards should not be dependent on a minimum purchase of goods. Least deprived concerned that smaller retailers should be involved so as not to lose out.

Lottery rewards
Mixed views but this the most criticised. Aversion to gambling based on religious beliefs (Back African/ Caribbean/British and S Asian women). Also pragmatic as no guarantee of a prize, so less motivating. S Asian men suggested more, smaller prizes so more winners would be better. Choice of prizes was also desirable.

Vouchers
Very popular among most deprived group. While some thought they should only be for healthy goods and services, others favoured luxury items (eg money off a day at Alton Towers). All groups thought they should be unique to the programmes.
Least deprived discussed how bronze, silver and gold activity levels, which dictate the way in which vouchers are awarded, should be set. Suggested that missing a level by a small amount would be demoralising.
Some concern, especially among the least deprived, about the cost of providing lots of vouchers to the NHS.

Pledges
Overall pledges thought to be a good way to motivate behaviour change – keen that these should be backed by friends and families as well as professionals. Professional support needed for setting achievable goals, advice how to achieve these and measuring when they had been met. Some also suggested that professional role was to give more detail about why behaviours were bad and should be changed. This latter was linked to feeling that a "health scare" could be a motivator. Smoking cessation particularly popular for this approach.

Scepticism about pledges related to difficulties monitoring attainment, especially in the least deprived group. Health believed to be a personal responsibility by this group, so did not believe that people should be "bribed" by a "nanny state", as health itself should be a sufficient motivator.
Most deprived thought that rewards should be given out for all improvement, even if short of fulfilling pledge, to avoid discouragement.

Personal information and registration forms
Most happy to share general demographic information and contact details, but less comfortable about sharing income and housing tenure information. Least deprived least happy to share any information due to concerns about safety and security of storage and how it would be used.
For all, the shorter forms were preferred. Mixed opinions about sharing health information – BA/C/B group thought it too personal as would make people feel bad about their habits:
Health's a personal thing anyway and anybody who dares admits to themselves, never mind the rest of the world, that they could do with being healthier, I think feel some form of shame about their current state.
S Asian men thought they'd be happy to share information about drinking and smoking, but only because they did not partake in these habits and so had nothing to "hide." But felt others who did do these things might not admit to them.

Marketing materials
Figures used in material thought to look young and fit so potentially alienating to the general population. Most deprived group also felt that sports personalities, already fit and healthy, weren't relatable. S Asian men and women felt that the footballer (not widely recognised) looked sad and depressed so not inspiring.

Across groups, materials felt to contain insufficient information about benefits of points4life, which could help to motivate people to join. BA/C/B groups thought more emphasis on exercise than healthy eating. Most deprived thought not enough images of young people. There was also concern that sports company involvement would lead to them being able to take advantage of the scheme in some way.
Images where people were seen as having fun and enjoying what they were doing.
It was suggested by one participant that before and after pictures could be inspiring, another that alterative actovotoes (smoking on your break vs doing some exercise for example) could help.

Notes

Briefly, it is notable that the least deprived group was the most sceptical about the scheme. They were least

likely to use it as they already believed themselves to be healthy, and expressing concern about the cost to the NHS of provision of rewards and vouchers. They also expressed doubt that self monitoring could be relied upon to Further, some appeared to have ethical objections to the idea of the scheme as they believed that health is a personal responsibility which should be sufficient motivator to healthy behaviour without the need for "bribes" form a "nanny state". Such attitudes could prove to be a barrier to public health initiatives which take a whole system approach given the understandings of other determinants of health on which this is based. Interestingly, this attitude contrasted strongly with participants form the most deprived groups, who were concerned that people should receive maximum encouragement, for example, suggesting that those who made progress, but missed their own targets should still see some reward to avoid being discouraged from continuing.

There were concerns expressed about the nature or, use and safety of personal information collected for the scheme.

Other potentially important points relate to the inclusiveness of schemes. The proximity and access to participating partner organisations was identified as the biggest barrier to joining the scheme. Marketing material which only used images of young, fit looking people were felt to be potentially alienating.

Study [quality appraisal]

Powell et al 2001 [-]

Programme focus

Intervention name, Location
Partnership networks aimed at addressing health inequalities – Health Improvement Plans (HImps)

Year/ timescale over which implemented
NR

Target population
NR

Theoretical perspective (if mentioned – e.g. Social Ecological Model)
See rhetoric of "partnership" outlined below

Was local knowledge used in the design and/or delivery of the programme?
NR

Policy context
Part of the 1997-99 raft of policies aimed at addressing health inequalities – HAZ, HImP, HIPP and PCG/Ts.

Whole system features
Networks comprised LAs, NHT trusts, PCGs and voluntary sector

Study details

Study name (if different) [year]
Playing the game of partnership

Setting (e.g. school, community, etc.)
Health Authority

Author (year) [Ref ID] plus associated paper/source
Powell et al 2001

Aim of study
To illustrate evolving framework on partnerships using empirical examples from case studies where partnerships aimed at reducing health inequalities.

Informed by theory?
No

Study design
Case studies

Data collection method
Interviews

Data analysis
Transcriptions read independently by 2 reviewers. Initial framework predefined and emerging themes devised for analysis (Ritchie & Spencer 1995). Framework applied using NUD*IST. Further refined as emerging themes were incorporated.
Meetings to feed results back to case studies and validate emerging findings.

Sampling
Purposive – 3 cases rural, urban and mixed urban/suburban chosen. Partnership network based on HA and identified through key staff, documents and observation.
43 Individuals interviewed

Study population
HA managers, Community health Council Chief officers, local authority policy officers, senior LA managers, voluntary sectors reps, GPs, PCG managers, NHS trust staff.

Ethical issues?
Not reported

Source of funding
NR

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

New Labour govt considers equity to be best achieved through partnership: "connected problems require joined up solutions" (DoH 1998). Conceives of the Third way as "a system based on partnership" (NHS White Paper 1997). Emphasis on working together within the NHS and between NHS and other organisation, as well as 3-way partnership between people, communities and government.
3 types of levels of joint working set out in "Partnerships in action": the removal of constraints to joint working, introduction of new incentives and closer monitoring of achievements. Some NSFs require multi-organisational responses. Joint working is part of performance frameworks.
Authors note that the concepts of "partnership" surprisingly vaguely defined and develop the concept of a "ladder" of partnership (informed by Arnstein's (1971) ladder of citizen participation and Hudson et al (1997,1999) framework for collaboration (continuum of isolation, encounter, communication, collaboration, integration). Suggest that fully integrated partnerships would exhibit at least some of:

- Joint goals
- Very close knit and highly connected networks.
- Little regard for reciprocation in relationships
- Mutual and diffuse sense of long term obligation
- High levels of trust and respect
- Joint arrangements which are mainstream not marginal
- Joint arrangements encompassing both strategic and operational issues
- Some shared or single management arrangements
- Joint commissioning at macro and micro levels.

A further rung would be unification.

Paper discusses existing literature about understanding partnerships, noting 5 proposed categories of barriers to partnership (structural, procedural, financial, professional & status and legitimacy, Hardy et al 1992).
6 principles of recognising and accepting the need for partnership (developing clarity & realism of purpose, ensuring commitment and ownership, devloing And maintaining trust, creating clear and robust partnership arrangements, monitoring, measuring& learning. (Hardy et al 2000)
6 Categories of enabling factors (shared strategic vision, leadership and management, relations and local ownership, accountability, organisational readiness, responsiveness to a changing environment) (Evans & Killoran 2000)
Ling (2000) gives 4 dimensions through which partnership might be compared: membership, links, scale, boundaries.
6 dimensions of community health partnership: governance of strategic intent and reasons for organising, determining the partnership's domain and setting the strategic direction, partnership composition, resources, coordination & integration issues, accountability. (Mitchell & Shortell 2000)
DoH (1999, 1998) outlined ingredients of successful partnership working: clarification of purpose of the partnership, recognition and resolution of areas of conflict, agreement on shared approach to partnership, development of strong leadership, continuous adaptation to reflect lessons learnt form experience, incentives for successful joint working.
Successful policy (extent to which local goals are shared), process (mechanisms to achieve goals) and resource streams required. "failure to connect them may lead to "rhetorical policies", and to the realm of symbolic politics: words that succeed and policies that fail" (p.44)

Findings

Policy stream
Limited development of shared vision between partners. Vague statements about HI did not address more problematic uissues about where they fit on the policy agenda. Impression that HI are largely rhetorical policy or symbolic politics.
Many HImPs echo words of national government as their aim in terms of reducing health inequalities, but locally selected focus for this varied although central govt. objectives often crowded out local strategies:
You just haven't been able to get HI onto the agenda because there have just been these other major pressures that have to be resolved, a wealth of "must-be-dones" which…are not related to HI. (DPH, Rivertown)

[Social exclusion] now appears as one of the corporate priorities…but it's not a great deal because you know that's mainly rhetoric…Well you know, it is very marginal to the work of the health authority. (PH doctor, Uptown)

Shared vision lacking in Uptown as different priorities for tackling HI held by different agencies. Large number of agencies involved and perhaps difficult for LAs to engage with HI agenda broadly.
In Melchester, partnership working still had to transcend the myriad perspectives of stakeholders – example is clash of criteria for success between HA (EBP) and Community health Council ("realpolitik", eg clinic as visible commitment to deprived are).

Process stream
HImP as prime instrument for tackling HI, and various developments still in their infancy. Initial work developmental, emerging.
HImP seen as too ambitious:
We have 82 action pages and 200 or 300 individual actions to try and implement to improve health. For each one of those we are gong to have a very close monitoring of performance. (HA manager, Rivertown)

2 ideal types of policy ownership emerged:
1) Dedicated approach – responsibility for developing partnerships resting with small groups of individuals.
2) Diffuse approach – responsibility widely devolved through agencies.
Central or vertical performance management tended to focus on central priorities and mitigated against wide ownership. Central government not joined up leading to low profile for HI beyond the health service at a local level.
What [LA depts.] contribute to reducing HI, which is technically a huge amount as far as I can see, is not what they are measured on. (health strategy officer Uptown)
What [education depts.] are interested in is where their school is in the league tables. That's what gets their money, that's what drives their roles. (health strategy officer Uptown)
Even if there were agreement on broad areas, joint approaches were hampered by different views about ownership, feasibility and time scales.
Progress towards jointness seen in, for eg, joint appointment of a HI Impact Assessment manager between 2 partner agencies, HIMP facilitators in each of the PCGs, health strategy officers based in Las, part funded by HA.

Resource stream
All HAs were in budget deficit at the time of field work – hindering their ability to shift significant funds towards HI and the partnership agenda. Tight budgets and the need to solve "now" problems conspired to make resource shifts to long term, more diffuse objectives, without an established constituency, more difficult. There was evidence if little absolute funds being allocated to tackling HI.
In a Dedicated Strategy, all efforts to reduce HI are badged as a "HI strategy".
In a Diffuse Strategy, all policy is viewed as being influenced by reducing HI, and rather than focus on special projects, mainstream activites may be seen as reducing HI.

Like performance indicators, finance was also siloed:
It can be very difficult trying to bring together mainstream budgets in any sensible way because of the way that every government department likes to have increasingly centralised control over everything that happens. (Rivertown LA director)
In addition, central govt. earmarked some finances for specific initiatives, which limited local autonomy:
But that [policy] got torpedoed by last year's funding because it all came down highly targeted, particularly the mental health modernisation fund, and meant that we had to give as much money to an area we regarded as overfunded. (Senior HA manager, Uptown)
Financial difficulties also related to short term funding, and the long term nature of addressing HI.
Cross funding raised issues of accountability (for eg HA funding of speed cameras in area of high traffic accidents was questioned by some who thought money should go to traditional NHS activity).

Appointment of a Health Inequality Impact Assessment manager reflected the need to collate and synthesise existing data and to collect new data on HI across agencies, but this was hampered by differing information systems between agencies especially in relation to performance indicators (different even where ostensively measuring the same thing).

In some cases, as resources were conditional on partnership, it is possible that getting partnership money became and end rather than the means.
We're being told to go and talk to these agencies…and certainly form a funding point of view, you can't get the funding unless you can demonstrate a real partnership. (HA manager, Rivertown)
But those in charge of funds were sometimes suspicious of motives
I don't believe health inequalities are particularly high up the trust's agenda. And I mean they may occasionally dabble, but I mean, it is very low down on their agenda and I think most of them wouldn't really recognise it apart from when they are arguing that health inequalities can lead to them to have more resources. (HA manager Melchester)

Voluntary sector also felt there was little sharing of power.

Part of it is also the issues of power. At a very real level we don't in the voluntary sector have a say in the kinds of money there is in the NHS, or the council, nothing like it. We don't have perhaps the same explicit control over people's lives, power is something that's difficult to give up. And I mean we can make expert interventions, we can provide lots of evidence, but it doesn't always get taken on board. (Voluntary sector Melchester)

Level of trust was influenced by previous relationships, good where there was a well-established history of joint working, however, there were signs of geographical, social and political rivalries, in some cases mirroring local council political affiliations.

Conclusion

Vertical vs. horizontal

note the challenge of undertaking horizontal partnerships in vertical performance management structures. While "partnership" implies equality, in reality there are junior and senior partners and agencies with risks of exclusion.

Enforced vs. voluntary

Successful partnerships unlikely to result form being told to work together. Government has no remit to compel voluntary agenices.

Sanctions vs. incentives

NHS plan has both, but neither seen in case studies to be particularly effective: *You only do it if you really have to these days…or if there is a whole load of money behind it of course. (trust manager)*

Diffuse vs. dedicated

Is it possible to have the "ideal" of senior leadership and wide ownership? Either/or in case studies. Note that delegation of responsibilities like meeting attendance to junior members by senior may lead to them needing to go pack to seek permission for decisions. May lead to over reliance on a few "champions".

Means vs. ends

Partnership as process or outcome? Audit Commission suggests outcomes more important than the health of the partnership, but these may be long term.

Objective vs. Subjective

Health of partnership as objective measures (joint appointments, meeting etc) or how stakeholders feel about it.

Cooperation vs. integration

Notes
None

Study [quality appraisal]

Rugkasa et al (2007) [+]

Programme focus

Intervention name, Location
Home is where the heat is (initiated by the Armagh and Dungannon HAZ), Northern Ireland

Year/ timescale over which implemented
2000-2002

Target population Two remote rural communities with small village centres, with most of the population resident on the surrounding farmland. Both communities had operational community associations that were willing to take part in the project and had community development officers in post

Theoretical perspective (if mentioned – e.g. Social Ecological Model)
'Community development approach'

Was local knowledge used in the design and/or delivery of the programme?
Reports that representatives from all sectors, including the community, acknowledged that community groups had been central in decision-making as well as project implementation

Policy context (i.e. local policies & national initiatives - and other key contextual details)
NR

Whole system features
Statutory, community and voluntary organisations involved.

Study details

Study name (if different) [year]
NA

Setting (e.g. school, community, etc.)
Community

Author (year) [Ref ID] plus associated paper/source
Rugkasa et al (2007) [5505]

Aim of study
To investigate the benefits and challenges of the project, and how it had impacted on local communities

Informed by theory?
'Boundary-spanning' approaches – literature on cross-boundary working. 'Boundary spanners' have "the ability to see how an issue looks from a number of different viewpoints, and can relate to people in different circumstances who are from different cultures and have different value bases" (p.222)

Study design
Evaluation

Data collection method
Focus groups (n=4)
Interviews (n=12)

Data analysis
'Standard content analysis' – to identify common themes and patterns

Sampling
NR

Study population
Focus groups (n=4) with members of the partnership and community associations (a total of 27 people took part)
Interviews (n=12) with representatives from statutory, community and voluntary sectors, and local elected political representatives

Ethical issues?

Although confidentiality and anonymity were assured to participants, no details provided. No mention of approval by an ethical board

Source of funding
NR

'Lessons' for the evaluation of obesity prevention programmes
NR

Programme delivery

Programme aimed to address fuel poverty through making properties more energy efficient and increasing household income (by encouraging higher uptake of social security benefits). Implemented by a partnership of 21 organisations from the statutory, community and voluntary sectors, as well as local elected political representatives established under the auspices of the Armagh & Dungannon HAZ. It is reported that the programme was widely considered to be a success in the local area, with 100% uptake of the energy efficiency measures.

Findings

Linking 'up and across': spanning organisational and policy environments
Community groups reported positive experiences of participating in the partnership – many referred to the way in which the HAZ manager had led the project
The management board worked well. Community groups were prominent on it. They were really telling us what to do. This was, in a way, laid down by [the manager]. She would not allow the big guys to determine the terms. (Private sector participant)

There was a sense of shared ownership of the project – it was a distinct entity in which they all had a stake, worked to the same agenda and avoided 'hijacking' by any particular individual or group. The role of the HAZ manager in building and maintaining relationships was identified:
There were times when [name] wouldn't make a meeting. [The manager] would have rung her, you know, if there was a decision-making process and she wasn't part of it, and [the manager] did go out on a limb to make a meeting to try and still involve her. (Partnership member)

A firm focus on the overall aims of the project helped people to stay engaged – the HAZ manager was described as a 'dynamic person with passion and energy'
Phone calls were made to people in high places. [The manager] was very good at finding out who she needed to speak to, to get some movement going in a certain area. (Voluntary sector participant)

The HAZ manager herself emphasised that the lead role played was only possible because of the trust that had been built up, which meant that the other partners had trusted her to take an explicit lead and 'get on with things'

The HAZ manager explained her way of working:
There's a bit of manipulation, there's a bit of cajoling, there's a bit of actually identifying what makes these people turn on, and then playing to what's important to them. It's just clever partnership working… Seeing an opportunity and mixing it together and pulling those people together to point in the same direction needed a very, very strategic approach… and what you have to do in that situation is identify for everybody how being there is going to meet their agenda.

Linking 'down': floating support for recipients
Role of Community Energy Advisor (CEA) agreed by all to have been vital for the programme's success – the CEA remained in contact with the community groups on an almost daily basis, which served as an informal mechanism for engaging the groups in the development of the project

The CEA identified all homes that would be assessed for inclusion in the programme, and completed the majority of the assessment surveys in people's homes herself. The CEA's background and personality enabled her to bond with the local people
She could talk about the price of cattle, lighting in the outhouse. She <u>knew</u> people. (Community sector participant, emphasis in the original)

CEA immersed herself in community life throughout the course of the programme, attending school concerts, carol services, community raffles, and funerals. The CEA was also practically involved on a number of levels, e.g. together with representatives from community associations, she would help participants prepare for installations, clear loft spaces, or do other practical preparations if the recipients, many of whom were elderly, were unable to do so themselves. The CEA would also follow-up after installation of heat efficiency measures to see that the measures were effective and that people understood how to use them
No matter what happened, if there was a problem [she] would write it down, she would phone me that evening or the next day or whatever, and she would have talked to Joe or Lisa [in the meantime and say]

'Don't worry about it, we'll get it sorted' – and she did. [She] was exceptional. Oh, she's an honorary citizen of Aughnacloy now! (Community sector participant)
Notes
Authors argue that whilst the role played by the HAZ manager in this project (i.e. as an 'across and upward spanner', involving organisations and connecting the project to a policy agenda) is more generally acknowledged, 'downward spanners' (the CEA in this project) are equally important in their role as local enabler: a) acting as a mediator between the local communities and the partnership b) grounding the project in local communities c) recruiting project participants and ensuring that they stay on board and receive the support and information they require

Appendix 7 Studies excluded at full text stage

Reference	Reason for exclusion
Alexander, J. A., Weiner, B. J., Metzger, M. E., Shortell, S. M., Bazzoli, G. J., Hasnain-Wynia, R., Sofaer, S., & Conrad, D. A. 2003, "Sustainability of collaborative capacity in community health partnerships", *Medical Care Research & Review*, vol. 60, no. 4 Suppl, pp. 130S-160S	Whole community programme, but outside of UK
Anon. 1999, *Health action zones: learning to make a difference*.	Report is an earlier draft of research that was subsequently published elsewhere, and which is included in this review (Review 3) (See Bauld et al 2005a; Bauld et al 2005b)
Aronson, R. E., Norton, B. L., Kegler, M. C., Aronson, R. E., Norton, B. L., & Kegler, M. C. 2007, "Achieving a "broad view of health": findings from the California Healthy Cities and Communities Evaluation", *Health Education & Behavior*, vol. 34, no. 3, pp. 441-452	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
Attree, P. 2006, "A critical analysis of UK public health policies in relation to diet and nutrition in low-income households", *Matern.Child Nutr.*, vol. 2, no. 2, pp. 67-78	Interesting critique of UK policy (based on two systematic reviews of qualitative research), but not about barriers and faciltators to the implementation of a whole system approach
Bandesha, G. & Litva, A. 2005, "Perceptions of community participation and health gain in a community project for the South Asian population: a qualitative study", *Journal of Public Health*, vol. 27, no. 3, pp. 241-245.	Focuses on community engagement only
Barnes, M., Bauld, L., Benzeval, M., Judge, K., Lawson, L., Mackenzie, M., Mackinnon, J., Matka, E., Meth, F., Sullivan, H., & Truman, J. 2003, *National evaluation of Health Action Zones: Final report*.	Reports research that was subsequently published elsewhere, and which is included in this review (Review 3) (See Bauld et al 2005a; Bauld et al 2005b)
Bess, K. D., Prilleltensky, I., Perkins, D. D., & Collins, L. V. 2009, "Participatory organizational change in community-based health and human services: from tokenism to political engagement. [Review] [52 refs]", *American Journal of Community Psychology*, vol. 43, no. 1-2, pp. 134-148	Focuses on community engagement only
Barroso, C. S., Cullum-Gomez, C., Hoelscher, D. M., Kelder, S. H., Murray, N. G. 2005, "Self-reported barriers to quality physical education by physical education specialists in Texas", *Journal of School Health*, vol. 75, no. 8, pp. 313-319	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)

Reference	Reason for exclusion
Bauld, L. & Judge, K. 2002, *Learning from health action zones* Aeneas Press, Chichester	Insufficient reporting of research methods to establish whether or not qualitative research used (apart from chapter 16, but this is about 'modernisation' and therefore not on topic). Numerous 'reflections' on barriers and facilitators to programme implementation throughout the book, but whether these are based on research, anecdote, or other source is unclear
Barnes, M., Matka, E., & Sullivan, H. 2003, "Evidence, understanding and complexity: evaluation in non-linear systems", *Evaluation*, vol. 9, pp. 265-284	Not about barriers and facilitators to evaluation
Beery, W. L., Cheadle, A., Greenwald, H. P., Nelson, G. D., Pearson, D., Procello, A., & Senter, S. 2005, "The California wellness foundation's health improvement initiative: evaluation findings and lessons learned", *American Journal of Health Promotion* pp. 286-296	Whole community programme, but outside of UK
Boon, H., MacPherson, H., Fleischman, S., Grimsgaard, S., Koithan, M., & Noeheim, A. J. 2007, "Evaluating complex healthcare systems: A critique of four approaches", *Evidence Based Complementary and Alternative Medicine*, vol. 4, no. 3, pp. 279-285	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
Burton, S. & Diaz de Leon, D. 2002, "An evaluation of benefits advice in primary care: Camden and Islington health Action Zone," in *Learning from Health Action Zones*, L. Bauld & K. Judge, eds., Aeneas Press, Chichester, pp. 241-250	Focuses on primary care rather than the whole community
Cheadle, A., Senter, S., Solomon, L., Beery, W. L., & Schwartz, P. M. 2005, "A qualitative exploration of alternative strategies for building community health partnerships: collaboration- versus issue-oriented approaches", *Journal of Urban Health*, vol. 82, no. 4, pp. 638-652	Focuses on community engagement only
Cheadle, A., Beery, W. L., Greenwald, H. P., Nelson, G. D., Pearson, D., & Senter, S. 2003, "Evaluating the California Wellness Foundation's Health Improvement Initiative: a logic model approach", *Health Promotion Practice*, vol. 4, no. 2, pp. 146-156	Not about barriers and facilitators to evaluation
Cheadle, A., Senter, S., Procello, A., Pearson, D., Nelson, G. D., Greenwald, H. P., & Beery, W. L. 2005, "The California wellness foundation's Health Improvement Initiative: evaluation findings and lessons learned", *American Journal of Health Promotion*, vol. 19, no. 4, pp. 286-296.	Whole community programme, but outside of UK
Cheadle, A., Beery, W., Wagner, E., Fawcett, S., Green, L., Moss, D., Plough, A., Wandersman, A., & Woods, I. 1997, "Conference report: Community-based health promotion - State of the art and recommendations for the future", *American Journal of Preventive Medicine*, vol. 13, no. 4, pp. 240-243	Whole community programme, but outside of UK
Chervin, D. D., Philliber, S., Brindis, C. D., Chadwick, A. E., Revels, M. L., Kamin, S. L., Wike, R. S., Kramer, J. S., Bartelli, D., Schmidt, C. K., Peterson, S. A., & Valderrama, L. T. 2005, "Community capacity building in CDC's Community Coalition Partnership Programs for the Prevention of Teen Pregnancy", *Journal of Adolescent Health*, vol. 37, no. 3S: Supplement: S11-9 ,(16 ref, p. Supplement-9	Focuses on a single aspect – teen pregnancy

Reference	Reason for exclusion
Chrisman, N. J., Senturia, K., Tang, G., & Gheisar, B. 2002, "Qualitative process evaluation of urban community work: a preliminary view", *Health Education & Behavior*, vol. 29, no. 2, pp. 232-248	Whole community programme, but outside of UK
Clark, A. M., Barbour, R. S., & McIntyre, P. D. 2002, "Preparing for change in the secondary prevention of coronary heart disease: a qualitative evaluation of cardiac rehabilitation within a region of Scotland", *Journal of Advanced Nursing*, vol. 39, no. 6, pp. 589-598	Not a whole community approach
Clark, R., Conning, R., Waters, E., Armstrong, R., & Petrie, R. 2009a, *Evidence summary: remote and rural issues in the prevention of obesity for pre-adolescents and adolescents*, Deakin University, Geelong	Not about barriers and faciliators to programme implementation
Clark, R., Waters, E., Armstrong, R., Conning, R., & Petrie, R. 2009b, *Evidence summary: Achieving equity in community-based obesity prevention interventions for children and adolescents*, Deakin University, Geelong	Not about barriers and faciliators to programme implementation
Clark, R., Waters, E., Conning, R., Armstrong, R., & Petrie, R. 2009c, *Evidence summary: considerations regarding harm minimisation for obesity prevention policies and programs for pre-adolescents and adolescents*, Deakin University, Geelong	Not about barriers and faciliators to programme implementation
Coid, D. R., Williams, B., & Crombie, I. K. 2003, "Partnerships with health and private voluntary organizations: what are the issues for health authorities and boards?", *Public Health*, vol. 117, no. 5, pp. 317-322	Not a whole community approach
Conrad, D. A., Cave, S. H., Lucas, M., Harville, J., Shortell, S. M., Bazzoli, G. J., Hasnain-Wynia, R., Sofaer, S., Alexander, J. A., Casey, E., & Margolin, F. 2003, "Community care networks: linking vision to outcomes for community health improvement", *Medical Care Research & Review*, vol. 60, no. 4 Suppl, pp. 95S-129S	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
CRESR 2005, *New deal for communities 2001-2005: an interim evaluation*, ODPM, London	Although programme has a broad focus that stretches across organisational boundaries (and health/social domains), the analysis is at a broad level that has largely moved onto policy recommendations without presenting the research that informed these recommendations. Also, the majority of data collection from interviews and focus groups has quantitative, rather than qualitative
Daley, J. M. & Marsiglia, F. F. 2000, "Community participation: old wine in new bottles?", *Journal of Community Practice*, vol. 8, no. 1: 61-86 ,(53 ref, pp. 61-86	Programme focuses on a single aspect - drugs
Dooris, M. & Doherty, S. 2010, "Healthy universities--time for action: a qualitative research study exploring the potential for a national programme", *Health Promotion International*, vol. 25, no. 1, pp. 94-106	Not a whole community approach
Dwyer, J., Needham, L., Simpson, J. R., Heeney, E. S., Dwyer, J., Needham, L., Simpson, J. R., & Heeney, E. S. 2008, "Parents report intrapersonal, interpersonal, and environmental barriers to supporting healthy eating and physical activity among their preschoolers", *Applied Physiology, Nutrition, & Metabolism = Physiologie Appliquee, Nutrition et Metabolisme*, vol. 33, no. 2, pp. 338-346	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)

Reference	Reason for exclusion
Economos, C. D., Folta, S. C., Goldberg, J., Hudson, D., Collins, J., Baker, Z., Lawson, E., Nelson, M. 2009, "A community-based restaurant initiative to increase availability of healthy menu options in Somerville, Massachusetts: Shape Up Somerville", *Preventing Chronic Disease*, vol. 6, no. 3, p. A102	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
Emmelin, M., Weinehall, L., Stenlund, H., Wall, S., & Dahlgren, L. 2007, "To be seen, confirmed and involved--a ten year follow-up of perceived health and cardiovascular risk factors in a Swedish community intervention programme", *BMC Public Health*, vol. 7, p. 190	Not about barriers and facilitators to implementation
Exworthy, M., Blane, D. and Marmot, M. (2003) `Tackling health inequalities in the UK: progress and pitfalls of policy.' Health Services Research, special issue: social determinants of health; part II, 38, 6, pp.1905-1921	Insufficient details provided about qualitative research methods used
Exworthy, M. and Peckham, S. (1999) `Collaboration between health and social care: coterminosity in the `New NHS.`` Health and Social Care in the Community, 7, 3, May 1999, 229-232.	A critical review of co-terminosity in relation to New Labour reforms - but exclude as not a piece of qualitative primary research or a systematic review of qualitative research
Exworthy, M. and Powell, M. (2004) `Big windows and little windows: implementation in the congested state.' Public Administration, 82, 2, pp.263-281.	Qualitative research methods used to investigate policy making process (i.e. *not* about the design, management, delivery or evaluation of a whole community initiative); quantitative research methods (survey) only used to investigate experiences of practitioners in local agencies about programme delivery
Faith, M. S., Fontaine, K. R., Baskin, M. L., & Allison, D. B. 2007, "Toward the reduction of population obesity: macrolevel environmental approaches to the problems of food, eating and obesity", *Psychological Bulletin*, vol. 133, no. 2, pp. 205-226	Review – not about barriers and facilitators to implementation (checked for references)
Faulkner, G., McCloy, C., Plotnikoff, R. C., Bauman, A., Brawley, L. R., Chad, K., Gauvin, L., Spence, J. C., & Tremblay, M. S. 2009, "ParticipACTION: Baseline assessment of the capacity available to the 'New ParticipACTION': A qualitative study of Canadian organizations", *Int.J Behav Nutr.Phys.Act.*, vol. 6, p. 87.	Whole community programme, but outside of UK
Flynn, M. A. T., McNeil, D. A., Maloff, B., Mutasingwa, D., Wu, M., Ford, C., & Tough, S. C. 2006, "Reducing obesity and related chronic disease risk in children and youth: a synthesis of evidence with 'best practice' recommendations", *Obesity Reviews*, vol. 7, no. S1, pp. 7-66	Review – not about barriers and faciliators to programme implementation (checked for references)
Gabriel, R. M. 2000, "Methodological challenges in evaluating community partnerships & coalitions: Still crazy after all these years", *Journal of Community Psychology*, vol. 28, no. 3, pp. 339-352	Not about barriers and facilitators to evaluation
Gates, D., Brehm, B., Hutton, S., Singler, M., & Poeppelman, A. 2006, "Changing the work environment to promote wellness: a focus group study", *AAOHN Journal*, vol. 54, no. 12, pp. 515-520	Not about an actual whole community programme – just about what would appeal (or not) to workers and managers

Reference	Reason for exclusion
Goldberg, J. P., Collins, J. J., Folta, S. C., McLarney, M. J., Kozower, C., Kuder, J., Clark, V., Economos, C. D., 2009, "Retooling food service for early elementary school students in Somerville, Massachusetts: the Shape Up Somerville experience", *Preventing Chronic Disease*, vol. 6, no. 3, p. A103	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
Gonzalez-Zapata, L. I., varez-Dardet, C., Millstone, E., Clemente-Gomez, V., Holdsworth, M., Ortiz-Moncada, R., Lobstein, T., Sarri, K., De, M. B., & Horvath, K. Z. 2010, "The potential role of taxes and subsidies on food in the prevention of obesity in Europe", *J Epidemiol Community Health*, vol. 64, no. 8, pp. 696-704	Not qualitative research
Gonzalez-Zapata, L. I., varez-Dardet, C., Ortiz-Moncada, R., Clemente, V., Millstone, E., Holdsworth, M., Sarri, K., Tarlao, G., Horvath, Z., Lobstein, T., & Savva, S. 2009, "Policy options for obesity in Europe: a comparison of public health specialists with other stakeholders", *Public Health Nutr.*, vol. 12, no. 7, pp. 896-908	Not about barriers and facilitators to implementation
Gonzalez-Zapata, L. I., Ortiz-Moncada, R., & varez-Dardet, C. 2007, "Mapping public policy options responding to obesity: the case of Spain", *Obes.Rev.*, vol. 8 Suppl 2, pp. 99-108	Not about barriers and facilitators to implementation
Goodman, R. M. 2008, "A construct for building the capacity of community-based initiatives in racial and ethnic communities: a qualitative cross-case analysis", *Journal of Public Health Management & Practice*, vol. 14 Suppl, p. S18-S25	Whole community programme, but outside of UK
Green, G., Price, C., Lipp, A., & Priestley, R. 2009, "Partnership structures in the WHO European Healthy Cities project", *Health Promotion International*, vol. 24 Suppl 1, p. i37-i44	Whole community programme, but cities are not identified, therefore cannot know which aspects of the research relate to UK cities
Greener, J., Douglas, F., & van, T. E. 2010, "More of the same? Conflicting perspectives of obesity causation and intervention amongst overweight people, health professionals and policy makers", *Soc.Sci.Med.*, vol. 70, no. 7, pp. 1042-1049	Individuals' understanding of obesity and related issues
Hearn, L., Miller, M., & Cross, D. 2007, "Engaging Primary Health Care Providers in the Promotion of Healthy Weight among Young Children: Barriers and Enablers for Policy and Management", *Australian Journal of Primary Health - Interchange*, vol. no. 2, no. pp. 66-79	Revew focuses on primary care professionals rather than a whole system approach
Helitzer, D. L., Davis, S. M., Gittelsohn, J., Going, S. B., Murray, D. M., Snyder, P., & Steckler, A. B. 1999, "Process evaluation in a multisite, primary obesity-prevention trial in American Indian schoolchildren", *Am J Clin.Nutr.*, vol. 69, no. 4 Suppl, pp. 816S-824S	Only about diet and physical activity within schools; not a whole community approach. Hardly any details of qualitative research methods used, so difficult to actually classify as qualitative research
Hesketh, K., Waters, E., Green, J., Salmon, L., & Williams, J. 2005, "Healthy eating, activity and obesity prevention: a qualitative study of parent and child perceptions in Australia", *Health Promot.Int.*, vol. 20, no. 1, pp. 19-26	Only about people's understandings of food and physical activity; not about an actual programme
Hills, M., Mullett, J., & Carroll, S. 2007, "Community-based participatory action research: transforming multidisciplinary practice in primary health care", *Revista Panamericana de Salud PÃºblica*, vol. 21, no. 2-3, pp. 125-136	Focuses on primary care professionals and other professional within the multi-disciplinary team (not a whole system approach)

Reference	Reason for exclusion
Hoddinott, P., Britten, J., & Pill, R. 2010, "Why do interventions work in some places and not others: a breastfeeding support group trial", *Social Science & Medicine*, vol. 70, no. 5, pp. 769-778	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
Holdsworth, M., Delpeuch, F., Kameli, Y., Lobstein, T., & Millstone, E. 2010, "The acceptability to stakeholders of mandatory nutritional labelling in France and the UK--findings from the PorGrow project", *J Hum.Nutr.Diet.*, vol. 23, no. 1, pp. 11-19	Not a whole community approach.
Holdsworth, M., Kameli, Y., & Delpeuch, F. 2007, "Stakeholder views on policy options for responding to the growing challenge from obesity in France: findings from the PorGrow project", *Obes.Rev.*, vol. 8 Suppl 2, pp. 53-61	Not about barriers and facilitators to implementation
Horowitz, C. R., Robinson, M., & Seifer, S. 2009, "Community-based participatory research from the margin to the mainstream: are researchers prepared?", *Circulation*, vol. 119, no. 19, pp. 2633-2643.	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
Johnson, H. H., Bobbitt-Cooke, M., Schwarz, M., & White, D. 2006, "Evaluation and practice. Creative partnerships for community health improvement: a qualitative evaluation of the Healthy Carolinians community micro-grant project", *Health Promotion Practice*, vol. 7, no. 2: 162-9 ,(13 ref, pp. 162-169	Programme focuses on a single aspect – micro-grants
Kane, B. 2002, "Social capital, health and economy in South Yorkshire coalfield communities," in *Learning from Health Action Zones*, L. Bauld & K. Judge, eds., Aeneas Press, Chichester, pp. 187-109	Not about barriers and facilitators to programme implementation
Kegler, M. C., Norton, B. L., Aronson, R. E., Kegler, M. C., Norton, B. L., & Aronson, R. E. 2008, "Strengthening community leadership: evaluation findings from the california healthy cities and communities program", *Health Promotion Practice*, vol. 9, no. 2, pp. 170-179	Not qualitative research
Kegler, M. C., Painter, J. E., Twiss, J. M., Aronson, R., Norton, B. L., 2009, "Evaluation findings on community participation in the California Healthy Cities and Communities program", *Health Promotion International*, vol. 24, no. 4, pp. 300-310	Whole community programme, but outside of UK
Krieger, J., Allen, C., Cheadle, A., Ciske, S., Schier, J. K., Senturia, K., & Sullivan, M. 2002, "Using community-based participatory research to address social determinants of health: lessons learned from Seattle Partners for Healthy Communities", *Health Education & Behavior*, vol. 29, no. 3: 361-82 ,(64 ref, pp. 361-382	Not about barriers and facilitators to evaluation
Letcher, A. S. & Perlow, K. M. 2009, "Community-based participatory research shows how a community initiative creates networks to improve well-being", *American Journal of Preventive Medicine*, vol. 37, no. 6 Suppl 1, p. S292-S299	Focuses on community engagement only
Lewis, S., Thomas, S. L., Hyde, J., Castle, D., Blood, R. W., & Komesaroff, P. A. 2010, ""I don't eat a hamburger and large chips every day!" A qualitative study of the impact of public health messages about obesity on obese adults", *BMC Public Health*, vol. 10, p. 309	Individuals' understanding of obesity and related issues
Livingstone, M. B., McCaffrey, T. A., & Rennie, K. L. 2006, "Childhood obesity prevention studies: lessons learned and to be learned", *Public Health Nutr.*, vol. 9, no. 8A, pp. 1121-1129	Not about barriers and facilitators to evaluation

Reference	Reason for exclusion
Mackenzie, M., Lawson, L., & Mackinnon, J. 2003, *National evaluation of Health Action Zones - the integrated case studies: a move towards systems change*, University of Glasgow, Glasgow	Unobtainable – alternative source (included in this review, Review 3) identified through contact with author
Maley, M., Warren, B. S., & Devine, C. M. 2010, "Perceptions of the environment for eating and exercise in a rural community", *Journal of Nutrition Education & Behavior*, vol. 42, no. 3, pp. 185-191	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
Matson-Koffman, D. M., Brownstein, J. N., Neiner, J. A., & Greaney.M.L. 2005, "A site-specific literatur review of policy and environmental interventions that promote physical activity and nutrition for cardiovascular health: what works?", *American Journal of Health Promotion*, vol. 19, no. 3, pp. 167-193	Review – not about barriers and faciliators to programme implementation (checked for references)
Mendez, D. 2010, "A systems approach to a complex problem", *American Journal of Public Health*, vol. 100, no. 7, p. 1160	Not about barriers and facilitators to evaluation
Metzler, M. M., Higgins, D. L., Beeker, C. G., Freudenberg, N., Lantz, P. M., Senturia, K. D., Eisinger, A. A., Viruell-Fuentes, E. A., Gheisar, B., Palermo, A., & Softley, D. 2003, "Addressing urban health in Detroit, New York City, and Seattle through community-based participatory research partnerships", *American Journal of Public Health*, vol. 93, no. 5: 803-11 ,(65 ref, pp. 803-811	Whole community programme, but outside of UK
Millstone, E. & Lobstein, T. 2007, "The PorGrow project: overall cross-national results, comparisons and implications", *Obes.Rev.*, vol. 8 Suppl 2, pp. 29-36.	Not about barriers and facilitators to implementation
Mitchell, C., Cowburn, G., & Foster, C. 2010, *Assessing the options for Local Authorities to use the regulatory environment to reduce obesity*, Department of Public Health, Oxford.	No details of qualitative data collection (only that respondents were 'interviewed') and no details of how the data was analysed
Mizrahi, T. & Rosenthal, B. B. 2001, *Complexities of coalition building: leaders' successes, strategies, struggles and solutions*.	Whole community programme, but outside of UK
Moore, S., Murphy, S., Tapper, K., & Moore, L. 2010, "From policy to plate: barriers to implementing healthy eating policies in primary schools in Wales", *Health Policy*, vol. 94, no. 3, pp. 239-245	Not a whole community approach. Uses partneships, but only in a single setting
Murimi, M. W. & Harpel, T. 2010, "Practicing preventive health: the underlying culture among low-income rural populations", *Journal of Rural Health*, vol. 26, no. 3, pp. 273-282	Not a whole community approach; only education 'in the community' and screening
Murrock, C. J., Higgins, P. A., & Killion, C. 2009, "Dance and peer support to improve diabetes outcomes in African American women", *Diabetes Educator*, vol. 35, no. 6, pp. 995-1003.	Not a whole system approach
Nguyen, M., Gauvin, L., Martineau, I., & Grignon, R. 2005, "Sustainability of the impact of a public health intervention: lessons learned from the Laval Walking Clubs Experience", *Health Promotion Practice*, vol. 6, no. 1: 44-52 ,(20 ref, pp. 44-52	Programme focuses on a single aspect – physical activity
Padgett, S. M., Kinabrew, C., Kimbrell, J., & Nicola, R. M. 2005, "Turning point and public health institutes: vehicles for systems change", *Journal of Public Health Management & Practice*, vol. 11, no. 2, pp. 116-122	Whole community programme, but outside of UK

Reference	Reason for exclusion
Pagnini, D., King, L., Booth, S., Wilkenfeld, R., & Booth, M. 2009, "The weight of opinion on childhood obesity: recognizing complexity and supporting collaborative action", *Int.J Pediatr.Obes.*, vol. 4, no. 4, pp. 233-241	Only about people's understandings of food and physical activity; not about an actual programme (although study does elicit respondents' ideas for 'what might work')
Patel, A. I., Bogart, L. M., Uyeda, K. E., Martinez, H., Knizewski, R., Ryan, G. W., & Schuster, M. A. 2009, "School site visits for community-based participatory research on healthy eating", *Am J Prev Med.*, vol. 37, no. 6 Suppl 1, p. S300-S306	School-focused programme only
Pocock, M., Trivedi, D., Wills, W., Bunn, F., & Magnusson, J. 2010, "Parental perceptions regarding healthy behaviours for preventing overweight and obesity in young children: a systematic review of qualitative studies", *Obes.Rev.*, vol. 11, no. 5, pp. 338-353.	Not related to a programme
Popay, J., Bennett, S., Thomas, C., Williams, G., Gatrell, A. & Bostock, S. 2003 "Beyond 'beer, fags, eggs and chips'? Exploring lay understandings of social inequalities in health. *Sociology of Health & Illness*, vol. 25, no. 1, pp. 1-23	Only about people's understandings; not about an actual programme
Powell, M. and Exworthy, M. (2001) `Joined-up solutions to address health inequalities: analysing policy, process and resource streams.' Public Money and Management, 21, 4, pp. 21-26	Insufficient detail about the qualitative research methods used
Power, T. G., Bindler, R. C., Goetz, S., & Daratha, K. B. 2010, "Obesity prevention in early adolescence: student, parent, and teacher views", *J Sch Health*, vol. 80, no. 1, pp. 13-19	Only about people's understandings of food and physical activity; not about an actual programme
Pullen, N. C., Upshaw, V. M., Lesneski, C. D., & Terrell, A. 2005, "Lessons from the MAPP demonstration sites", *Journal of Public Health Management & Practice*, vol. 11, no. 5, pp. 453-459	Whole community programme, but outside of UK
Reininger, B. M., Vincent, M., Griffin, S. F., Valois, R. F., Taylor, D., Parra-Medina, D., Evans, A., & Rousseau, M. 2003, "Evaluation of statewide teen pregnancy prevention initiatives: challenges, methods, and lessons learned", *Health Promotion Practice*, vol. 4, no. 3, pp. 323-335	Not a whole system approach
Rummery, K. & Coleman, A. 2003, "Primary health and social care services in the UK: progress towards partnership?", *Social Science & Medicine*, vol. 56, no. 8, pp. 1773-1782	Not a whole community approach (focuses on primary care/social care partnerships)
Sanderson, B., Littleton, M., & Pulley, L. 2002, "Environmental, policy, and cultural factors related to physical activity among rural, African American women", *Women & Health*, vol. 36, no. 2, pp. 75-90	Only about people's perceptions of physical activity not about a whole community programme
Schulz, A. J., Zenk, S., Odoms-Young, A., Hollis-Neely, T., Nwankwo, R., Lockett, M., Ridella, W., & Kannan, S. 2005, "Healthy eating and exercising to reduce diabetes: exploring the potential of social determinants of health frameworks within the context of community-based participatory diabetes prevention", *American Journal of Public Health*, vol. 95, no. 4, pp. 645-651	Focuses on community engagement only
Shepherd, L. M., Neumark-Sztainer, D., Beyer, K. M., & Story, M. 2006, "Should we discuss weight and calories in adolescent obesity prevention and weight-management programs? Perspectives of adolescent girls", *J Am Diet.Assoc.*, vol. 106, no. 9, pp. 1454-1458.	Only about people's perceptions of nutrition and weight; not about a whole community programme
Shortell, S. M., Zukoski, A. P., Alexander, J. A., Bazzoli, G. J., Conrad, D. A., Hasnain-Wynia, R., Sofaer, S., Chan, B. Y., Casey, E., & Margolin, F. S. 2002, "Evaluating partnerships for community health improvement: tracking the footprints", *Journal of Health Politics, Policy & Law*, vol. 27, no. 1, pp. 49-91	Whole community programme, but outside of UK

Reference	Reason for exclusion
Simmons, A., Mavoa, H. M., Bell, A. C., de Court, Schaaf, D., Schultz, J., & Swinburn, B. A. 2009, "Creating community action plans for obesity prevention using the ANGELO (Analysis Grid for Elements Linked to Obesity) Framework", *Health Promotion International*, vol. 24, no. 4, pp. 311-324	Focuses on community engagement only
Smith, KE, Bambra, C. and Joyce, KE. et al (2009) `Partners in health? A systematic review of the impact of organizational partnerships on public health outcomes in England between 1997 and 2008.' Journal of Public Health, 31 (2): 210-221.	Not a systematic review specifically of qualitative research (used a source of references)
Stafford, M., Nazroo, J., & Popay, J. M. 2008, "Tackling inequalities in health: evaluating the New Deal for Communities initiative", *Journal of Epidemiology and Community Health*, vol. 62, pp. 298-304	Does not meet inclusion criteria (reports quantitative survey data)
Sullivan, H., Judge, K., & Sewel, K. 2004, "'In the eye of the beholder': perceptions of local impact in English Health Action Zones", *Social Science & Medicine*, vol. 59, pp. 1603-1612	Unclear how the research conducted was used to inform the analysis and interpretation presented in the paper
Sweeney, K. 2004, "Time for change? An exploration of complexity in health-care practice... including commentary by Hopayian K", *International Journal of Therapy & Rehabilitation*, vol. 11, no. 11: 529-34 ,(21 ref, pp. 529-534	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
Svyantek, D. J. & Brown, L. L. 2000, "A complex-systems approach to organizations", *Current Directions in Psychological Science*, vol. 9, no. 2, pp. 69-74	Not about barriers and facilitators to programme implementation
Tesoriero, F. 2001, "Partnerships in health promotion and the place of trust and equality as obstacles to promoting health", *Health Promotion Journal of Australia*, vol. 11, no. 1: 48-55 ,(33 ref, pp. 48-55	Whole community programme, but outside of UK
TCRU NFER 2004, *Evaluation of the impact of the National Healthy School Standard*, Department of Health, London.	Not a whole community approach
Thomas, S. L., Lewis, S., Hyde, J., Castle, D., & Komesaroff, P. 2010, ""The solution needs to be complex." Obese adults' attitudes about the effectiveness of individual and population based interventions for obesity", *BMC Public Health*, vol. 10, p. 420	Individuals' understanding of obesity and related issues
Thompson, J. L., Jago, R., Brockman, R., Cartwright, K., Page, A. S., & Fox, K. R. 2010, "Physically active families - de-bunking the myth? A qualitative study of family participation in physical activity", *Child Care Health Dev.*, vol. 36, no. 2, pp. 265-274	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
Thompson, M., Minkler, M., Bell, J., Rose, K., & Butler, L. 2003, "Facilitators of well-functioning consortia: national Healthy Start program lessons", *Health & Social Work*, vol. 28, no. 3, pp. 185-195	Whole community programme, but outside of UK
Thompson, M., Minkler, M., Bell, J., Rose, K., & Butler, L. 2003, "Facilitators of well-functioning consortia: national Healthy Start program lessons", *Health & Social Work*, vol. 28, no. 3, pp. 185-195	Whole community programme, but outside of UK
Trafford, S. & Proctor, T. 2006, "Successful Joint Venture Partnerships: Public-Private Partnerships", *International Journal of Public Sector Management*, vol. 19, no. 2, pp. 117-129	Focuses on a single aspect – public-private partnerships

Reference	Reason for exclusion
van Kleef, E., van, T. H., Paeps, F., & Fernandez-Celemin, L. 2008, "Consumer preferences for front-of-pack calories labelling", *Public Health Nutr.*, vol. 11, no. 2, pp. 203-213	Only about product labelling
Vecchiarelli, S., Takayanagi, S., & Neumann, C. 2006, "Students' perceptions of the impact of nutrition policies on dietary behaviors", *J Sch Health*, vol. 76, no. 10, pp. 525-531	Not qualitative research
Vermeer, W. M., Steenhuis, I. H., & Seidell, J. C. 2010, "Portion size: a qualitative study of consumers' attitudes toward point-of-purchase interventions aimed at portion size", *Health Educ Res*, vol. 25, no. 1, pp. 109-120	Only about portion sizes
Vermeer, W. M., Steenhuis, I. H., & Seidell, J. C. 2009, "From the point-of-purchase perspective: a qualitative study of the feasibility of interventions aimed at portion-size", *Health Policy*, vol. 90, no. 1, pp. 73-80	Not a whole system approach
Vyth, E. L., Steenhuis, I. H., Mallant, S. F., Mol, Z. L., Brug, J., Temminghoff, M., Feunekes, G. I., Jansen, L., Verhagen, H., & Seidell, J. C. 2009, "A front-of-pack nutrition logo: a quantitative and qualitative process evaluation in the Netherlands", *J Health Commun.*, vol. 14, no. 7, pp. 631-645	Not a whole system/ whole community approach, just an evaluation of product labelling
Waqa, G., Mavoa, H., Waqa, G., & Mavoa, H. 2006, "Sociocultural factors influencing the food choices of 16-18 year-old indigenous Fijian females at school", *Pacific Health Dialog*, vol. 13, no. 2, pp. 57-64	Not primary qualitative research (or systematic review of qualitative research) conducted among those involved in the design, management, delivery or evaluation of whole community initiatives to prevent obesity (or other public health initiative)
Whitehead, M., Doran, T., Exworthy, M., Richards, S. and Matheson, D. (2009) Delivery systems and mechanisms for reducing inequalities in both social determinants and health outcomes. Task Group submission to the Marmot Review	No details of review methods used (e.g. search strategy, synthesis) (Part 4)/ Insufficient details of qualitative research methods used (Part 7)
Woodman, J., Lorenc, T., Harden, A., & Oakley, A. 2008, *Social and environmental interventions to reduce childhood obesity: a systematic map of reviews.*, EPPI-Centre, Social Science Research Unit, Institute of Education, University of London., London	Whilst a useful 'map' of 'intervention reviews', none of these use a whole system approach; also, does not include any reviews of barriers and facilitators to programme implementation