



Jennifer Davies – Breaking the Cycle Project

Good afternoon. I have a dual job. I work as a dietician and as a registered public health nutritionist, jointly for the Southampton City Primary Care Trust and for the University of Southampton.

I'm going to talk to you about a project called 'Breaking the Cycle'. It's very much about action research, because it started off at the University before I even arrived in Southampton. I'm going to highlight the different aspects of the project, what we actually found, what were the results of the evaluation and the lessons that we've learnt as a result of it.

The project started as research that was undertaken by the University of Southampton over a number of years looking at the rates of iron deficiency anaemia and low birth weight babies in the local South Asian population and, in particular the young women in the South Asian population. As most of you probably know, iron deficiency anaemia increases the risk of having a low birth weight baby, and being a low birth weight increases the chronic diseases such as cancer later on in life.

We knew we needed to break the cycle of one impacting on the rates of the other, because we were seeing that the rates were not improving over time, despite quite a lot of activity going on in the communities.

These findings were taken to the Public Health team by the University of Southampton, who had done all the work, but then needed to engage with the relevant partners in how would we use this to inform service delivery.

So, what did we actually do? We started off with doing a consultation event and actually drawing in key workers and members of the community, the voluntary sector and so on, looking at their perspective of what they saw as being key issues around this. And then from this we were able to develop an action plan with the overall aim of looking at breaking the cycle of ill health in young people, and specifically focusing on improving nutrition related health. And the objectives involved drawing on a variety of different partners, so a multi-agency steering group to oversee and co-ordinate and to drive forward this initiative, and the usual steps that we're all very, very familiar with, needing to identify sources of funding, developing initiatives that targeted young people.

But I think one of the key elements that made this a success and something that we've already heard several times today is really having a look at the whole family, a holistic approach, because you could argue iron deficiency anaemia, well, is that simply about increasing iron in the diet? Well, we know from the information that's out there that iron deficiency anaemia is an overall marker of a poor diet and family disadvantage. And they're often associated with other forms of malnourishment, under-nutrition and often associated with those.

We knew that we were looking at was to improve the overall diet of these individuals. And that's why this is relevant, because you might be sitting there thinking, well, we're here to talk about cancer, World Cancer Research Fund, how does this all fit together? So it was very much looking at the whole family, not just the young children, because they live as part of families. And again, this is something that we've picked up earlier on about the fact that you



can have interventions targeted at children, but that actually we need to look at the whole family. And within the black and ethnic minority communities I would say that's even more so.

It was key that local people were involved in the initiatives and that we had some form of evaluation built in. In the University we use a 'cycle' to teach the practitioners and public health nutrition. It's another version of the cycles that we've looked at heard from other speakers earlier, and involves the key steps of knowing what the problem is, identifying what it is that we want to achieve, by when, how we're going to get there and developing the programmes, implementing and then evaluating.

So building a workforce, this was the first element. This was the first time it had been done in Southampton where we set out to train local people to become peer led educators in food and nutrition. And we did this with the help of Luton who has been running a similar course over a number of years. They had already done a lot of work of developing training courses for black and ethnic minority communities. And they were very kind in helping me develop and run one in Southampton.

So, we tweaked the course to suit the communities that we had. We then recruited individuals from different black and ethnic minority communities in Southampton. And we ran a 15 week course, which covered the basics in terms of knowledge around healthy eating, around weight management, diabetes, coronary heart disease, cancer, all the different sort of aspects. But we also looked at the practical skills that they would need to put this across to the communities that they would be working with.

Everybody really enjoyed it and attended pretty much all of the sessions. They all achieved a certificate at the end of it. And as a result of that they were all offered employment with my team as a part of the Nutrition Dietetic Service, so that they could gain the additional skills that they needed to become Community Food Assistants.

Once the Community Food Assistants were employed with us they went on to be an extension and an important integral part of our extended workforce, because there was just me working and trying to make an impact. And they were working to the action plan that we'd developed in consultation.

They did this through a variety of different means. There was a lot of raising awareness that needed to happen. We've talked a little bit about knowledge and attitudes earlier today, and they are a key starting point. They in themselves do not equate to behaviour change. But equally, you need them as part of achieving behaviour change.

And so this was done through a variety of different means, because what we did find was that the communities really were not aware that this was a problem. And they certainly didn't realise what impact it was potentially having on their health. So, we had a variety of different activities that we undertook to try and raise awareness in the community, as well as then taking this a step forward into actually giving people skills. This was through healthy cooking skills. We did a variety of cook and taste, cook and eat type sessions, but we also did shopping tours and cookery clubs, and so on.

Traditionally most of the black and ethnic minority communities have fairly good ingredients so quite a good base to start from in terms of the diet, it's just a case of tweaking it. And what



we wanted to do was to improve on best practise, on what they were already doing, which I think is a key thing.

We did health promotion type events. Going to the local stores and doing shopping tours. And we worked very closely with the local shopkeepers and retailers, because in Southampton we have a fairly small population, we only have a few shops really that provide culturally appropriate foods. And so we wanted to work with them and they were very much on board with the project, which was good. And then we would go on to do cooking in groups and the best bit was sitting down and actually having a chance to taste it.

We were doing evaluation on an ongoing basis, and at the end of each year of the project we would look at what the results were telling us. And one of the things that we found out was that men were quite a major barrier to change at home. So, although women were learning these skills, enjoying it and actually finding that the food didn't taste so bad once it was cooked with a little bit less fat and salt and so on. What they were saying to us was that "my husband really doesn't like this and he's giving me no end of grief".

So, we worked with some of the key male leaders in the communities and we did some targeted work based on their advice to us really on what they were saying might work to try and raise awareness so that male members of the community were also aware of why these changes were happening, so that they were less likely to be barriers in the home environment.

We worked with the younger age group. So, when I started my introduction I said that our key aim within Breaking the Cycle was to look at school age children. And that remained the focus. We realised that the more success the project was having the more people were aware of what was going on. And so we looked at how we might be able to extend that.

We worked alongside one of the Sure Start Teams within Southampton, of which we have several, because of the high rates of disadvantage and deprivation in Southampton. And as you may know, for those of you who've worked with or in those teams, there is quite a diversity of workforce in the sense of where they may come from. They're not all from a health background. They all have different levels of skills, and understanding, and knowledge around nutrition and food. And so, we had the task of working alongside that team and developing a new resource that met the needs of a diverse workforce that had opportunistically an ability to pass on information to various families with children in the nought to five age group.

And we also worked alongside the Healthy Schools Programme, who helped us identify local teachers who were able to develop the school nutrition curriculum pack. This was the first time that we'd been able to develop a tool like this whereby local teachers were producing a resource for other local teachers based on what we knew they were all using in terms of lesson plans and techniques. We developed tasks and activities in the classroom that would achieve the educational targets for reception year as well as key stage one and key stage two, which is still going on now.

In terms of the evaluation of the project, two levels – process evaluation and impact evaluation. In terms of the process, we looked at bums on seats type data, did people turn up, were the sessions runs, did people enjoy it. And we used a variety of different methods. We looked at baseline information that we'd collected, things like ethnicity age of the people



who attended, gender, reported health problems and so on. As well as doing, later on, focus groups and telephone interviews. And this was gathered from the people who'd undertaken the training course, the Food and Health Skills Community food course, as well as from the Community Food Assistants, so those people who'd come to work with us, and those who'd actually engaged with the project as a user.

And then in terms of the impact evaluation, again, we used a variety of different means, including questionnaires and focus groups and so on. And the things that we were looking for were really changes in knowledge and attitudes, eating patterns, shopping patterns, whether there were any barriers, because this was helping transform the project, and whether these changes had been maintained.

Not all of the people who undertook the Community Food and Health Skills course went on to become Community Food Assistants. So, it was quite important to see them as a separate cohort. And the motivation for these people to invest a lot of time and effort into gaining this qualification, and for learning and doing the assessments and homework, and so on was very much motivated around family history and the need in the community. So, they were people who were already tuned into the agenda.

They gained knowledge and skills beyond their expectations. And that was a key thing, because nearly all of them said that before they came to the course they thought they knew it. And for those of you who spend most of your time working in the field of food and nutrition this will be a common thing for you that most people think they already know about food and nutrition. And people know about food, but they don't necessarily know about health and nutrition and how it all fits together. And so it was reassuring to hear that from them and they hadn't realised just how much there was to learn. And they really enjoyed it.

They enjoyed the sessions themselves and it all fitted in with their home lifestyle to a certain degree. But they did find all of the course work and assessment, which they needed to do because it was an accredited course with the Open College Network, quite difficult because most of them had other pressures. They had family or they had jobs and so on.

However, they were all using the information. They had become real activists, real food champions. They just couldn't help themselves. Every week there'd be a new story about "I saw so and so eating this and I just couldn't help myself. I just had to go up and tell them" or in the Gurdwara they made no end of fuss in the Gurdwaras. And I think it had come to blows at certain sessions, I think, about how it was being prepared, because it was primarily the men who were preparing the food in the Gurdwaras and not the women. But we came to an amicable agreement in the end and that's improved as well.

So, just because they had such an enthusiasm for it so they were out there giving out the messages. They did feel that targeting the younger age group was going to be more beneficial potentially. But partly because the older people are harder to change, but equally I would argue that because they remain a barrier in some communities it's important to engage them in the process. And that initially even though they'd done a 15 week course and all the assessments and course work, they didn't necessarily feel that confident in running activities, actual hands on work. So, the theory was fine, but how do you put into practise.

So, for those who then went on to become Community Food Assistants and these were then given a lot more hand holding, if you like. They were given shadowing opportunities with



myself. And I was really there to go through, work through, how they were going run sessions, because they found that once they started engaging with communities and they were talking to people then that spurred a lot of conversation and discussion and questions, which they weren't necessarily prepared for, because obviously this was still a fairly new area to them. So, just as you would expect from a newly qualified practitioner, the same scenario. So, we did some sessions together initially until they gained their confidence and competence.

They hadn't expected so much detailed preparation, very time consuming. This was around really preparing sessions and running sessions. I think it's because ... it's like with today's conference. We've turned up today. We've eaten the food. We've listened to the lecturers. For those of us who've done similar things we know how much work and time and effort goes into it. But when you're new to an area you don't necessarily think about everything that you need to do to make the finished product work well. And that's what they've found quite difficult. And for some was not something they could easily deal with. And we lost one person as a result of that. They just ... they found that that element was just too time consuming for them.

But the majority said that they would like to go on to develop their career in this area, whether it be around the diabetes service or chronic disease management in some way or another. And again, I suppose this mirrors really what we're seeing now in terms of what's coming out of the Choosing Health document, around health trainers, the same model really, the same idea. And certainly from our experience it's got great potential to work.

So, what were the dietary findings? We found that 80% of people reported that they were making changes to their cooking practises. And over 75% said that they were making changes to their eating practises, which was very reassuring. And I think one of the key surprises for me, and for the team I think, was the fact that these changes were maintained a year after contact with the project. We only tended to follow those people up to a year after and then we were moving on to other cohorts. But what we found was that these changes were maintained over that time, which is very reassuring, because I'm used to seeing things changing in the short term, having had that initial contact, but to be able to maintain it we were very pleased with.

Most people had, however, as I said, already found it difficult to make changes to their cooking and eating practises. And the key element was family and friends. So, what they were highlighting there were the men, children and then the elders – in that order, were the ones that were making it more difficult in the home environment to make the changes.

In terms of fruit and vegetables, this was probably the most disappointing for me, coming from a dietetic background. Having laboured the point about 5 A DAY and what was a portion and all of this, what we found was that there was no increase in the number of people who were having 5 A DAY. But what we did find was that before the start of the project there were a significant number reportedly not having fruit and vegetables every day. At the end of the project everybody was having some. So, in a way there was a shift in the right direction, which was encouraging. And certainly, fits with the research that we know is out there about people finding it difficult to eat more of things and that changing what somebody is eating is often easier. So, that seemed to mirror those other findings.



In terms of dairy products, milk and dairy products, this was one of the biggest changes that we saw. And as you can see there, what we saw was low fat milk in particular, we saw the before level using low fat milk was just over 40%, whereas by the end it was about 85%, so quite a significant shift there and a very, very easy thing.

And one of the reasons why a lot of the women we made contact with, and the men actually and the Asian elders, they were all saying the same thing. The reason they'd tended to keep with full cream milk was because they weren't aware that children could swap to a low fat milk by a certain age. So, that seemed to be a message that maybe wasn't getting across clearly enough. And then we had low fat cheese again. We had a change there and low fat yoghurt, so not quite as significant, but nevertheless very positive changes.

The other area that we saw quite big changes again, quite significant changes, was in the fatty and sugary food section. And in particular, the fats, oils, that were people were using for spreading and for cooking, and for the fatty and fried foods.

We asked at baseline how often they had these particular products, and which products they use. We asked those same questions at the end, but we also put in additional checks of asking did they now perceive that they were eating more or less, and so on. So, this represents a simplistic view of all of that data.

But what it does show is that they weren't using fats and oils less often, but they were using far less of them when they were using it. So, that was a positive move, but that's fats in cooking. So, over 70% were saying that they were now using less of that, consuming less and similarly, use of fats and spreads just over the 60%. And in terms of the fatty and fried foods we again saw over 70% there.

We didn't see the same scale of change in the sugary foods, which was quite interesting. And we're still unpicking why that might be. But I think that was mainly down to carbonated drinks from the communities that we were working with.

Another quite significant shift, and this was probably the most difficult thing to get changed in the communities, was cutting down on the salt. And this was a recurring theme. So it took us a while to come to an agreement as to how much less salt we would use. And it was a process of negotiation. And I think that that's really helped my negotiation skills no end, because they can be quite determined and quite persuasive!

But again, we didn't see any significant change in how often it was being used, because it's an integral part of the way that they were cooking. But we did see quite significant changes in the amount of salt that was being used. So, I would say that that is a success.

So, what then did the people who are actually engaged as a user in the project? They thoroughly enjoyed the sessions. We equally had some difficulties in getting them there in the first place. So, again, similar to previous speakers, how do we get people there? Word of mouth, actually physically going around dragging them out, calling on favours, giving incentives, doing all sorts of things, and we found this as well, because this is now something that we standardly do in lots of different communities, not just within the black and ethnic minority communities. It's ... we're finding similar success in the Caucasian communities. But it is about getting people there in the first place. Once they're there, they're grand. But it's



getting them there that can be difficult. But there are ways and means, it depends how devious you're prepared to be.

But I think the key element for me was can we have more sessions and that is a recurring theme. Whenever we run cookery clubs or food tasting, or those sorts of sessions, they just want more and more of it. And part of it is about the social aspect, which again we've touched on, getting out of the house and learning new skills, and moving on to what they see as quite exotic cooking, whatever that might be.

So, the lessons learnt? Basically that by investing in training of local people it can create real champions, real community champions, who are enthused and effective in influencing long term changes. And I think that's the key thing, because ultimately that is where our starting point was and what we aimed to achieve was the long term dietary changes. And they really did achieve that.

They do however need ongoing appropriate support that enables them to do their work properly so that they are competent in terms of their skills and confidence as well. And that requires people with the right level of skills to be able to do that. So, it's looking at the whole workforce as to how that can be supported. And there are issues of competency and in this day and age of public health, and how it's moving forward around competency based practise that is going to continue to be an issue, not just for those who are being trained, but for those who are doing the training. So, anybody in this environment needs to consider those issues.

And that's importantly, and I think something that we're probably all familiar with, that knowledge is important, but that the practical hands on sessions are effective. And that's again probably tied in with the self efficacy issues that we've been discussing earlier on today.

So, they're good in being able to engage with communities. Once you get them there you've got their attention. You can get into quite a lot of discussion about different issues and really start tackling attitudes, beliefs, and change in the home environment. And also, very, very important that it's able to motivate people to make the changes long term, even when they're faced with some barriers in the home environment, I think that's quite important. And that might be because again, they had several contacts with this.

Going back to the reviews that were mentioned earlier about successes and what are common to projects with success. And again, this mimics that in the sense that there was personal contact over several sessions, which helped them in putting this in place at home.

Finally really, the so-what factor, these lessons what we've learnt from this project is that it is now standard practise. So, we referred to the Breaking the Cycle project in Southampton a great deal, because it's where it all kicked off from. But really everything that we've learnt has been put into our standard baseline. We have training programmes now for a variety of different people at different grades, whether they be people from a health background, or people who've got no contact ... previous contact with health, even those people coming without any qualifications. We've also got the practical hands on activities we're constantly using. So, they're quite key elements that we're now using as standard and all the tools that we've developed, again, are standardly being used back in Southampton, which is good, and further afield.



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I think it has great potential really for developing a fit for purpose workforce, which is obviously what we're looking for, because we want to get our messages out there. So, the more people we have out there in various guises the better. And really I would say that it's a fairly simple idea, but it just goes to show that when you do simple things well, it can make quite a significant difference. Thank you.