City of Marion
Healthy Communities Initiative

Evaluation Report:
Engaging with the Community

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Executive Summary

This document reports on an evaluation of components of the *City of Marion Healthy Communities Initiative 2011 – 2014*. The project is funded by the Australian Government under the Healthy Communities Initiative, Local Government Area Grants Phase 2 funding scheme. The project started in June 2011 and was due for completion in June 2013 but this has been extended to September 2014, with no additional funding.

Introduction

The project aims to reduce the prevalence of overweight and obesity within the adult population (18 years and older) living in the City of Marion by maximising participation in proven or innovative physical activity and healthy eating programs, with specific emphasis on those living in four selected suburbs and who are predominantly not in the paid workforce. Programs and activities include free or low cost community meals, healthy eating and cooking classes, edible gardens programs, exercise sessions and walking groups. Opportunities to socialise complement the educational, physical activity and healthy eating sessions. Volunteers trained through the program form a large part of the workforce implementing activities, and pathways from participation to volunteering to training and paid employment have been established. More recently the project has been successful in establishing a number of policies and models that should have an impact at a structural level. These initiatives are likely to be sustained through being embedded within the City of Marion and may flow on to other local governments.

Methods

Data sources for the evaluation included project documentation and discussion with the project manager, interview with advisory group members, a participant survey and two participant focus groups. Data analysis drew on the Community-Based Participatory Research (CBPR) model which operates under principles that include partnership and co-learning, capacity building of community members, applying findings to benefit all partners, and long term partnership commitment. Thus it is premised on rebalancing power differentials between professionals and communities.

Findings

Overall, the advisory group was in agreement that project staff had taken on an enormous task with limited resources. Advisory group members believed that the project had achieved or surpassed their expectations and that the role and value of community centres had been enhanced in the community. Perceived benefits included an increased awareness in the community of the
importance of healthy eating and physical activity and a reduction in participants’ isolation and an increase in capacity and skills.

Residents from the four target suburbs made up 40% of the survey respondents. The majority of participants were aged 65 and over (77%) were female (88%). Just over half reported they planned making changes to a healthier lifestyle. Nearly 90% reported an increase in physical activity and over half understood more about the importance of health food. Just over half reported an increase in fruit and vegetable consumption.

Both participant focus groups nominated the social aspects of the programs as important. Participants reported that being made to feel welcome and the low cost encouraged attendance. They valued the social aspects and the flexibility of the sessions so that people with different needs and abilities could be accommodated. The group facilitators were highly praised for their supportive and helpful manner.

Conclusions

Working in collaboration with other organisations is likely to lead to more sustainability. However, when organisations are under pressure to report against key performance indicators this can raise some tensions about attribution of achievements. Funders and policy makers need to be aware that shared outcomes cannot always be attributed to a particular program or organisation and take this into account when assessing performance.

Overall, the project has engaged with a large number of people and achieved its objectives. The focus on addressing barriers (disability, cost, cultural norms) has led to a more equitable approach to healthy eating and physical activity, reaching many who would not otherwise have been able to participate. The incentives offered to regular participants does not seem to have been a factor in attendance, rather the inclusive nature of the courses offered is most important. The sustainably of the project activities and achievements will depend on the priorities and resources within the City of Marion and other stakeholders. Extending the project to three years, while putting pressure on the budget, will allow more time for the project to become embedded within the community centres and known among the local community, and thus increase the likelihood of sustainability. Reducing the prevalence of overweight and obesity in the adult population resident in the City of Marion is a long term aim to which this project has made a significant contribution.
Introduction

Through the National Partnership Agreement on Preventive Health the Australian Government has provided $71.8 million over five years from 2010-2014) under the Healthy Communities Initiative (HCI) to support Local Government Areas (LGAs) in delivering effective community-based physical activity and healthy eating programs, as well as developing a range of local policies that support healthy lifestyle behaviours. Under the HCI, $61.5 million is available in grants to 92 LGAs across Australia to increase the number of adults predominantly not in the paid workforce engaged in physical activity and healthy eating programs and activities.

The LGA Grants:

- support a Healthy Communities Coordinator within LGAs to oversee and coordinate the implementation of the Initiative within target populations; AND any combination of:
- subsidise the costs to individuals of participating in healthy eating, physical activity or healthy lifestyle programs; AND/OR
- purchase or run community based healthy lifestyle programs; AND/OR
- purchase or subsidise training for community members to run community based healthy lifestyle programs where this does not contradict professional or accreditation requirements of specific programs.

This document reports on an evaluation of components of the City of Marion Healthy Communities Initiative 2011 – 2014.

Background to project

The project is funded by the Australian Government under the Healthy Communities Initiative, Local Government Area Grants Phase 2 funding scheme. The project started in June 2011 and was due for completion in June 2013. Following a funder-mandated extension, all projects under this scheme have been extended to September 2014, with no additional funding and with City of Marion external evaluation reports still due in June 2013.
Description of project

The project aims to reduce the prevalence of overweight and obesity within the adult population (18 years and older) living in the City of Marion by maximising participation in proven or innovative physical activity and healthy eating programs, with specific emphasis on those living in four selected suburbs and who are predominantly not in the paid workforce.

The context for the project is that nearly half the adult population in the City of Marion is overweight or obese (Department of Health, South Australia, 2006). Four suburbs (Oaklands Park, Dover Gardens, Seacombe Gardens and Sturt) were chosen as priorities by the City of Marion and the project has a particular focus on adults who are predominantly not in the paid workforce, are of low socio-economic status, from culturally and linguistically diverse background or new arrivals.

Project objectives are to:

1. Increase community awareness, knowledge and skills in healthy eating and physical activity
2. Increase community access and participation in programs that support healthy eating and physical activity
3. Increase community capacity and social connectedness around healthy eating and physical activity
4. Integrate with and build on existing local initiatives that support healthy eating and physical activity
5. Collaborate with stakeholders who have connection with the target group.

Activities have changed and evolved over the life of the project and include community evenings and lunches, edible gardening, cooking, physical activity sessions, and volunteer training. Participants have been supported to attend sessions by the use of incentives such as movie tickets and by reducing barriers to participation such as minimising cost, setting up ‘buddy’ systems, and providing appropriate clothing.

In addition to the Healthy Communities Initiative grant, support has been provided by the City of Marion, Community Foodies Program and other trained volunteers, and social work/nutrition and dietetics students at Flinders University.
Background to the evaluation

Overall, national and local evaluation of the program is being conducted by Klynveld Peat Marwick Goerdeler (KPMG). In May 2012, the South Australian Community Health Research Unit (SACHRU), Flinders University, was engaged to undertake an additional evaluation focusing on Project Output 2.6 Established programs at local Neighbourhood Centre. As far as possible the SACHRU evaluation has been designed to complement the national evaluation but with a focus on engagement of the target group through neighbourhood centre based programs and activities.

As part of the evaluation contract a brief literature scoping on engaging with ‘hard to reach’ populations was undertaken (see below) to inform the analysis of evaluation findings. A simple program logic model and theory of change was designed in collaboration with the project coordinator (see Appendix A) to guide the evaluation design. Short term outcomes (the original two year timeline of the project) were identified as:

- Engagement of priority groups and whole of community capacity building
- Increases in knowledge, attitude and skills in healthy eating and physical activity
- Increased healthy eating and physical activity
- Decreased barriers to participation in healthy eating and physical activity
- Participants moving through to volunteering, skills training/education, employment (as appropriate)

Ethical approval for the evaluation was obtained from the Social and Behavioural Research Ethics Committee of Flinders University.
Literature scoping

This brief review scopes the literature on evidence on engagement of ‘hard to reach’ groups in health promotion activity. Hard to reach groups may include individuals and communities of low socio-economic status (often associated with low levels of education, unemployment), people of culturally and linguistic diverse backgrounds (recent migrants, refugees), and people with a disability. Key questions for organisations are ‘who is the community to be engaged?’ and ‘how should diversity be recognised?’ (Hashagan 2002).

This review is in three sections. The first looks at methods for recruitment into a program and the second considers good practice in ongoing engagement. The last section looks at evaluation of community engagement and draws on the Community-Based Participatory Research to propose a framework for the analysis of evaluation data from the Marion HCI program.

Recruitment

A common theme in the literature on recruiting participants to a program is to use and/or develop relationships with existing community-based organisations representing the desired community of interest (Altpeter et al. 2011, Tse and Laverack 2010, Yancey et al 2006). For example Browne-Yung and colleagues (2012), in discussing methods for recruitment of people from low socio-economic backgrounds to research, recommend identifying shared characteristics and using these for recruitment eg schools, seniors clubs, churches, voluntary organisations, community centres, and Altpeter and colleagues (2011), suggest drawing on housing organisations to access those with low levels of education.

For recruitment to an arthritis intervention, word of mouth, through local community leaders was the most productive recruitment method and the use of community-based organisations or local community leaders was found to lend credibility to the program (Altpeter et al 2011). However, Browne-Yung and colleagues (2012), report that a snowballing technique was not effective in engaging low socio-economic status participants for a research project.

Other recruitment enhancers include extending invitations to family and friends of the intended participants, and men specifically are more likely to attend if their partner is also enrolled (Altpeter et al. 2011).
Persistent ongoing communication is likely to be needed with frequent reminders (Altpeter et al 2011) and communication through mixed and culturally appropriate channels (Tse and Laverack 2010).

In summary, for successful recruitment, draw on relationships with existing community-based organisations, be persistent and include family and friends in invitations to participate.

Successful engagement
In terms of successful and ongoing engagement a number of factors have been identified. Hashagan (2002) describes a model for engagement in community planning. The model components are:

*Capacity - building skills for all partners*
Capacity building should not be used to imply that community members lack skills, knowledge and confidence to act in their own interests. Rather all partners need to develop an understanding of each other and develop skills and knowledge. However, the community is most often excluded (and relatively lower in power) and therefore investment is required to support development of skills that community members identify as needed and to enhance access to information and knowledge.

*Inclusion – building equality*
Inclusion implies not just formal community representatives but a whole range of people including the poor and those who are excluded through language, discrimination etc. It is important to recognise diversity within communities.

*Resources – sustaining change*
Lack of resources and assets is a determinant of poverty and exclusion. The engagement process should build on assets in the community – eg local knowledge, networks, energy.

*Building community organisation*
Engagement with and support to community-led organisations leads to increased social capital.

*Building understanding – listening and learning*
A range of techniques should be used to identify the diverse views, issues and needs of a community. Collecting information is not enough, effective engagement means working interactively in learning partnerships with all stakeholders.

The components of this model are echoed by other commentators. For example, the importance of establishing and drawing on partnerships and networks, and sharing learning is noted by Tse and Laverack (2010). Community capacity building is also a key factor in engagement for Tse and Laverack and linked to this is the notion of using leaders/coordinators of same ethnicity as the participating community groups (Altpeter et al 2011).

Use of lay workers, such as community-based bi-lingual health workers for CALD communities, is effective in promoting health and helping people to navigate the health and welfare systems according to Henderson and Kendall (2011). However, Henderson and Kendall found that lay workers are subject to high demand from their communities. This may lead to experience of overload and stress and they should be compensated accordingly.

Kennedy and colleagues (2008) also suggest that lay workers are promoted as a cost effective way to reach underserved population groups with community nutrition programs but they argue that a theoretical and empirical base for this approach is lacking. Further, Kennedy and colleagues (2008) found considerable uncertainty about the role and responsibilities of lay workers and their relationship to professionals. In their research, Kennedy and colleagues (2008) found that the primary role of lay workers is to encourage dietary change by translating complex messages into credible and cultural appropriate advice rather than working to address the social determinants of healthy eating. They suggest this presents a rather narrow and individualistic view of education about healthy eating and limits the role to an extension of the professional role.

Yancey and colleagues (2006) review the evidence for physical activity promotion in US underserved populations. They report that those people in ethnic minority and low income groups have more barriers to physical activity participation, and that for these groups environmental intervention is indicated rather than an individual behaviour focus. However they note that there is little good evidence on the effectiveness of physical activity interventions for these underserved groups, and, even when evidence-based interventions are used, these are less effective than for mainstream communities.

Similar to the Hashagan (2002) model described above, Yancey and colleagues (2006) note that for effective physical activity interventions, group members must have input and influence on the
program content, evaluation and dissemination of findings. These require partnership, mutual respect, trust, and development of leadership skills in community members. Contextual factors should be taken into account including sociocultural, physical, and economic factors (e.g., gender-related socialisation, age-related and role expectations, historical and political context). Diversity across and within cultural groups should be recognised and evidence-based program need sufficient flexibility to be adapted to suit educational levels and cultural preferences.

On a practical level, flexibility in timing of programs, for example to allow people in employment to attend, and offering transport has been identified as useful (Altpeter et al. 2011).

In summary, aim to build capacity in all partners, recognise diversity, work in partnership to share power and learning, and adapt programs to suit local context.

**Evaluating community engagement**

Two publications were found that address issues of evaluating community engagement and are relevant to the City of Marion HCI.

A National Institutes for Health publication (NIH 2011) provides a list of questions to ask when evaluating community engagement, including the following:

- Are the right community members at the table? This is a question that needs to be reassessed throughout the program or intervention because the “right community members” might change over time.

- Does the process and structure of meetings allow for all voices to be heard and equally valued? For example, where do meetings take place, at what time of day or night, and who leads the meetings? What is the mechanism for decision-making or coming to consensus; how are conflicts handled?

- How are community members involved in developing the program or intervention? Did they help conceptualize the project, establish project goals, and develop or plan the project? How did community members help assure that the program or intervention is culturally sensitive?
• How are community members involved in implementing the program or intervention? Did they assist with the development of study materials or the implementation of project activities or provide space?

• How are community members involved in program evaluation or data analysis? Did they help interpret or synthesize conclusions? Did they help develop or disseminate materials? Are they co-authors on all publication or products?

• What kind of learning has occurred, for both the community and the academics? Have community members learned about evaluation or research methods? Have academics learned about the community health issues? Are there examples of co-learning?

Community-Based Participatory Research (CBPR) is a model which aims to bridge the gap between science and practice through community engagement and social action to increased health equity (Wallenstein and Duran 2010). CBPR operates under principles that include partnership and co-learning, capacity building of community members, applying findings to benefit all partners, and long term partnership commitment. Thus it is premised on rebalancing power differentials between professionals and communities. A conceptual logic model for CBPR is shown below (Figure 1.)

![Figure 1: Community-Based Participatory Research conceptual logic model adapted from Wallerstein and Duran 2010](image)

**Implications for City of Marion HCl evaluation**

Many of the questions identified in the NIH (2002) publication are relevant to the City of Marion HCl evaluation and have been used as a prompt in the evaluation process. Adapting and expanding the CBPR model for the City of Marion HCl identifies the factors below.
Contextual issues:
- Socio-economic, cultural, political, environmental factors
- Political climate, national state and local policies, local governance
- Historic degree of collaboration and trust between Council and community
- Community capacity, readiness and experience
- Council capacity, readiness and reputation
- Perceived need and significance of healthy eating and physical activity

Group dynamics & equitable partnerships:
- Structural dynamics – diversity, complexity, formal arrangements, power and resource sharing
- Individual dynamics – core values, motivation, personal relationships, cultural identity, individual beliefs, reputation
- Relational dynamics – safety, listening & mutual learning, leadership & stewardship, influence & power dynamic, flexibility, reflection, participatory decision making, integration of local beliefs, communication

Intervention/ research
- Intervention adapted within local culture
- Intervention informed by local settings & organisations
- Shared learning between academic, professional and community knowledge
- Partnerships input to evaluation
- Bi-directional dissemination

Outcomes
- System and capacity changes – policies & practice in Council and communities, culturally based sustainable interventions, power relations, empowerment
- Health outcomes – increased healthy eating and physical activity, decrease health inequities, transformed social conditions

These factors have informed the evaluation analysis.
Evaluation methods

A variety of methods and data sources was drawn upon in the evaluation. These are described below.

Project meetings and documentation

The lead researcher met a number of times with the project coordinator both formally and informally to be updated on the roll-out of the program, and issues and changes as they arose. Project documentation was reviewed to gain an understanding of the program as it was planned and implemented.

Advisory Group

The evaluator attended an Advisory Group meeting in December 2012. A focus group was planned for May 2013 but it proved impossible to find a time that was mutually convenient for members. Instead, individual interviews took place during May 2013.

Participant survey

In collaboration with project stakeholders a self-complete survey (see appendix B) was designed for community participants and volunteers. Initial discussions with the project coordinator indicated that a proportion of participants would be from culturally and linguistically diverse backgrounds. It was agreed that interpreters would not be used in the evaluation as new arrivals attend English language classes where they would receive assistance if needed. The survey asked respondents about their attendance at activities and any changes in healthy eating and physical activity. Some demographic data was also collected. The survey was handed out in March 2013, along with an information sheet about the research, to people attending activity sessions. Due to the high proportion of potential participants with limited English literacy, a volunteer was employed to explain the information sheet and help respondents complete the survey if required. This volunteer was not directly associated with the HCI but was familiar with the program. Respondents were offered a small incentive for completion of the survey.
The survey was adapted to electronic format using Survey Monkey and a link distributed to a further group of healthy cooking volunteers (n=100) in April 2013. This group was requested not to complete the survey again if they had already completed the paper copy.

**Participant focus groups**

Two focus groups (see Appendix B for question guide) were held in April/May 2013 asking questions similar to the survey but allowing for more comprehensive responses and group discussion. Two researchers facilitated the focus groups and hand-written notes were made.

<table>
<thead>
<tr>
<th>Group One</th>
<th>Gardening program volunteers</th>
<th>8 (6 female, 2 male)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Two</td>
<td>Heart moves participants</td>
<td>10 (all female)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>18</td>
</tr>
</tbody>
</table>

Ethics approval for the evaluation was obtained from the Social and Behavioural Research Ethics Committee, Flinders University.
Findings

Project meetings and documentation

Engagement with stakeholders was facilitated by an early forum where links were established with some 60 organisations and agencies from the government and non-government sectors. Regular communication has kept stakeholders informed about the project. The advisory group of key stakeholders was also set up.

Early activity included community nights at Cooinda Neighbourhood Centre with some physical activity followed by a meal prepared by volunteers and target group participants. These sessions took place weekly from March 2012 to early June 2012. Due to winter weather causing barriers for night activities, fortnightly community lunches replaced the night sessions from June to October 2012. Other activities include free or low cost healthy eating and cooking classes, edible gardens programs, exercise sessions and walking groups. Opportunities to socialise complement the educational, physical activity and healthy eating sessions. Strategies have been adopted to facilitate participation by pairing up a person from the target group with a trained mentor to identify barriers and then providing support to overcome these barriers.

Participation was encouraged by having a range of activities, locations and times so that sessions are accessible, offering activities at free or low cost and encouraging social inclusion by having free places for carers or support persons. Strategies to address barriers to attendance included provision of transport, financial assistance or clothing and equipment, low cost or free sessions, mentoring and ‘bring a friend’ opportunities. Incentives and prizes were offered as a way to sustain motivation and celebrate success.

Volunteers trained through the program form a large part of the workforce implementing activities, and pathways from participation to volunteering to training and paid employment have been established. For example, potential Community Foodies volunteers were identified from people within the target group and then supported to develop skills and confidence in healthy cooking, and other volunteers have been supported to undertake edible gardening accredited training. A community business model aims to up-skill volunteers to support them to set up a small business. The participants from non-Anglo cultures contributed skills and knowledge about different foods and at the same time gained skills in adapting traditional food preparation methods to a healthier option.
More recently, the project has contributed to policy and community-level change. A Community Gardens Policy for the City of Marion was supported in development, with the project identifying that capacity building was needed before additional community gardens would be viable. This has led to a broader community group – Community Green Thumbs – being established with volunteers planning to work with local schools and target community to increase capacity. The project also engaged with the state-funded Healthy Eating Local Policies and Programs project in developing the City of Marion Healthy Catering Policy. Implementation of the policy has led to a community food education model which provides guidelines to users of community centres on policy and modelling healthy eating education within the centre.

Advisory Group

At the Advisory Group meeting in December 2012, members were overall very positive about the project. There were some concerns about referrals, with practice nurses in particular noting they needed an updated list of activities. It was reported that GPs are sometimes hesitant to refer patients as the quality of programs is not always clear. It was expected that gaining accreditation for programs and facilitators would help with this.

The interviews in May 2013 with advisory group members were mostly positive but also revealed a mix of experiences in involvement in the project. The advisory group role was generally described as networking and information sharing, with two respondents also noting an oversight role. Another believed they had a role in bringing a specific focus on their client group. While some believed the networking and collaboration worked well other felt that there could have been more communication and relationship building and that their level of engagement with the project was less than expected. For some, changes in personnel, workplace restructuring or pressure of work contributed to limiting their level of engagement.

Respondents who represented a network of other organisations reported that they encouraged referrals but were not able to measure the number of referrals since this was outside their scope. It was suggested that the focus on the four suburbs created difficulties for organisations that worked across a broader catchment.
Respondents agreed that the project had been inclusive and catered well to client needs by, for example, training volunteers to work with people with disabilities, using a buddy scheme and addressing transport barriers.

Perceived benefits included an increased awareness in the community of the importance of healthy eating and physical activity and a reduction in clients’ isolation and an increase in capacity and skills. It was noted that this type of program needs to be long-term in order to sustain these benefits and it was hoped that the extension of the time line would help this sustainability.

There were contrasting views about the scope of the project and how it has engaged with others. From one perspective, the project was seen as having been set up with huge expectations in relation to the resources available and this meant that the project needed to tap into existing resources. This strategy was believed to increase sustainability into the future. On the other hand, there was concern that this led to the project claiming other’s work as its own. The sustainability of the incentive program was also questioned.

Overall, there was a general agreement that project staff had taken on an enormous task with limited resources. Advisory group members believed that the project had achieved or surpassed their expectations and that the role and value of community centres had been enhanced in the community.

**Survey**

This section reports the findings of the survey evaluating the healthy eating and/or physical activities being run at Cooinda Neighbourhood Centre and supported by the Healthy Communities Initiative. A total of 83 people completed the survey. Only one response was received through the electronic link and this has been included in the findings below.

**Profile of respondents**

As Table 1 shows, respondents resided in a range of Marion suburbs. Most common were Oaklands Park, Sturt and Warradale. Oaklands Park and Sturt are two of the targeted suburbs and represent 31% of respondents. Seacombe Gardens and Dovar Gardens residents were smaller in number but bring the total proportion of residents from the targeted areas to 40%.
Table 1: Resident suburb

<table>
<thead>
<tr>
<th>What suburb do you live in?</th>
<th>Response Percentage</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oaklands Park</td>
<td>18.75%</td>
<td>15</td>
</tr>
<tr>
<td>Sturt</td>
<td>12.5%</td>
<td>10</td>
</tr>
<tr>
<td>Warradale</td>
<td>12.5%</td>
<td>10</td>
</tr>
<tr>
<td>Mitchell Park</td>
<td>7.5%</td>
<td>6</td>
</tr>
<tr>
<td>Marion</td>
<td>7.5%</td>
<td>6</td>
</tr>
<tr>
<td>Seaview Downs</td>
<td>5.0%</td>
<td>4</td>
</tr>
<tr>
<td>Seacombe Gardens</td>
<td>5.0%</td>
<td>4</td>
</tr>
<tr>
<td>Clovelly Park</td>
<td>3.75%</td>
<td>3</td>
</tr>
<tr>
<td>Dover Gardens</td>
<td>3.75%</td>
<td>3</td>
</tr>
<tr>
<td>Glengowrie</td>
<td>2.5%</td>
<td>2</td>
</tr>
<tr>
<td>Park Holme</td>
<td>2.5%</td>
<td>2</td>
</tr>
<tr>
<td>Morphettville</td>
<td>2.5%</td>
<td>2</td>
</tr>
<tr>
<td>Darlington</td>
<td>2.5%</td>
<td>2</td>
</tr>
<tr>
<td>Seacombe Heights</td>
<td>2.5%</td>
<td>2</td>
</tr>
<tr>
<td>Plympton</td>
<td>1.25%</td>
<td>1</td>
</tr>
<tr>
<td>South Plympton</td>
<td>1.25%</td>
<td>1</td>
</tr>
<tr>
<td>Morphettville</td>
<td>1.25%</td>
<td>1</td>
</tr>
<tr>
<td>Plympton Park</td>
<td>1.25%</td>
<td>1</td>
</tr>
<tr>
<td>Trott Park</td>
<td>1.25%</td>
<td>1</td>
</tr>
<tr>
<td>Bedford Park</td>
<td>1.25%</td>
<td>1</td>
</tr>
<tr>
<td>Hallet Cove</td>
<td>1.25%</td>
<td>1</td>
</tr>
<tr>
<td>Edwardstown</td>
<td>1.25%</td>
<td>1</td>
</tr>
<tr>
<td>Pasadena</td>
<td>1.25%</td>
<td>1</td>
</tr>
</tbody>
</table>

Answered question: 80

The age-group of respondents is shown in Table 2. The majority of participants were aged between 65-74 (39.8%) and 75 years and older (37.3%) and were female (88%). This suggests that the program mainly attracted people who had retired rather than those in the paid workforce or seeking paid work.
Table 2: Age of respondents

<table>
<thead>
<tr>
<th>What is your age?</th>
<th>Response Percentage</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>25-34</td>
<td>1.2%</td>
<td>1</td>
</tr>
<tr>
<td>35-44</td>
<td>4.8%</td>
<td>4</td>
</tr>
<tr>
<td>45-54</td>
<td>4.8%</td>
<td>4</td>
</tr>
<tr>
<td>55-64</td>
<td>12.0%</td>
<td>10</td>
</tr>
<tr>
<td>65-74</td>
<td>39.8%</td>
<td>33</td>
</tr>
<tr>
<td>75+</td>
<td>37.3%</td>
<td>31</td>
</tr>
</tbody>
</table>

Answered question 83

The majority of respondents mainly spoke English at home (86.7%) with a variety of other languages spoken including Tamil (3 people), Italian (2 people), Gujarati, Spanish, French, Farsi, Dutch, Hungarian (1 person each).

Length of attendance

The next question asked respondents the length of time they had been coming to healthy eating and/or physical activities supported by the Healthy Communities Initiative. Table 3 shows that the majority had been attending for more than 12 months (69.9%). Table 4 shows that most people have attended five times or more (87.3%). These data indicate that most people had a long relationship with the program and attended multiple sessions, suggesting satisfaction and needs being met.

Table 3: Length of time attended

<table>
<thead>
<tr>
<th>Length of time attended</th>
<th>Response Percentage</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>About one month</td>
<td>6.0%</td>
<td>5</td>
</tr>
<tr>
<td>2-6 months</td>
<td>15.7%</td>
<td>13</td>
</tr>
<tr>
<td>6-12 months</td>
<td>8.4%</td>
<td>7</td>
</tr>
<tr>
<td>More than 12 months</td>
<td>69.9%</td>
<td>58</td>
</tr>
</tbody>
</table>

Answered question 83

Table 4: Number of times attended

<table>
<thead>
<tr>
<th>Number of times attended activities</th>
<th>Response Percentage</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 4 times</td>
<td>12.7%</td>
<td>10</td>
</tr>
<tr>
<td>5 times or more</td>
<td>87.3%</td>
<td>69</td>
</tr>
</tbody>
</table>

Answered question 79
Activities

The next question asked respondents to identify which activities they had participated in. Table 5 below shows that a large majority of respondents attended physical activity sessions (79.2%).

Table 5: Activities attended

<table>
<thead>
<tr>
<th>Activities attended</th>
<th>Response Percentage</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical activity sessions (e.g. Table Tennis, Dancing, Heart Moves)</td>
<td>79.2%</td>
<td>57</td>
</tr>
<tr>
<td>Healthy Meals</td>
<td>15.3%</td>
<td>11</td>
</tr>
<tr>
<td>Edible Gardening Groups</td>
<td>13.9%</td>
<td>10</td>
</tr>
<tr>
<td>Cooking/food preparation</td>
<td>11.1%</td>
<td>8</td>
</tr>
<tr>
<td>Walking Groups</td>
<td>9.7%</td>
<td>7</td>
</tr>
</tbody>
</table>

Answered question 72

Volunteering

The next question asked whether participants had helped with any activities as a volunteer. Of the 81 respondents who answered this question, the majority (80.2%) had not acted in a volunteer role, with 19.8% (16 respondents) reporting they had volunteered. Table 6 below shows that those that had acted in a volunteer role had helped out with healthy meals (58.3%), physical activity sessions (50%) and edible gardening (25%).

Table 6: Volunteer activities

<table>
<thead>
<tr>
<th>Activities that respondents had acted as a volunteer</th>
<th>Response Percentage</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Meals</td>
<td>58.3%</td>
<td>7</td>
</tr>
<tr>
<td>Physical activity sessions (e.g. Table Tennis, Dancing, Heart Moves)</td>
<td>50.0%</td>
<td>6</td>
</tr>
<tr>
<td>Edible Gardening Groups</td>
<td>25.0%</td>
<td>3</td>
</tr>
</tbody>
</table>

Answered question 12

Respondents were asked why they had volunteered and some gave more than one reason. Responses focused on wanting to keep fit and healthy (5 people), wanting to help people and the community (4 people), and for friendship and companionship (4 people). Two mentioned volunteering as part of NewStart requirements but are now enjoying the activity. Two stated that had time available to volunteer and a further two said they were invited by staff.
Making changes to live a healthier lifestyle

The next questions asked respondents whether they planned to make changes to live a healthier lifestyle as a result of participating in Healthy Communities healthy eating and/or physical activities. Of those responding, 43 people (54.4%) said yes, 35 (44.3%) no and one (1.3%) was unsure. For those that indicated they were going to make changes, a range of activities was planned and again some respondents mentioned several planned changes. Increasing exercise, such as walking, was planned by 11 people, eating better (more vegetables, less junk food, smaller portions) by 8 people, and edible gardening by 3 people. Others had more general plans to continue doing at home what they had learnt and to keep fit and healthy.

For respondents who indicated that they wouldn’t make changes, most reasons for this were that they already lived a healthy lifestyle. Others reported specific barriers such as ‘too old to make changes’, ‘living on my own’, ‘depended on finances’, ‘in a wheelchair’.

The next question asked whether as a result of their participation in the Healthy Communities activities respondents had increased their physical activity. Of the 83 replies, only 10.8% stated ‘no’. The majority (63.9%) stated ‘yes’ they had made some increases to their level of physical activity and (25.3%) stated ‘yes, lots’.

The next question asked whether as a result of participation in the Healthy Communities activities respondents now know more about the importance of healthy food and cooking. As shown in Table 7, 64% reported knowing more about healthy eating and cooking, while 36% respondents answered ‘no’.

<table>
<thead>
<tr>
<th>Do you know more about healthy eating and cooking?</th>
<th>Response Percentage</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, lots</td>
<td>28.8%</td>
<td>23</td>
</tr>
<tr>
<td>Yes, some</td>
<td>35%</td>
<td>28</td>
</tr>
<tr>
<td>No</td>
<td>36.3%</td>
<td>29</td>
</tr>
<tr>
<td>Answered question</td>
<td></td>
<td>80</td>
</tr>
</tbody>
</table>

Following this respondents were asked whether as a result of participating in Healthy Communities they had increased the amount of fruit and vegetables they ate. Table 8 below shows that 52.5% reported this while 47.5% had not.
Table 8: Fruit and vegetable consumption

<table>
<thead>
<tr>
<th>Have you increased the amount of fruit of vegetables you eat?</th>
<th>Response Percentage</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, lots</td>
<td>22.5%</td>
<td>18</td>
</tr>
<tr>
<td>Yes, some</td>
<td>30.0%</td>
<td>24</td>
</tr>
<tr>
<td>No</td>
<td>47.5%</td>
<td>38</td>
</tr>
<tr>
<td><strong>Answered question</strong></td>
<td><strong>80</strong></td>
<td></td>
</tr>
</tbody>
</table>

The next question asked respondents what had made it easier to take part in the activities (see Table 9). The majority of respondents (80.5%) reported that being made to feel welcome and included was important as well as the activities being free or a low cost (69.5%). The least important was the community bus (4.9%) and the incentives (3.7%).

Table 9: Enablers to participation

<table>
<thead>
<tr>
<th>What has been important in making it easier to take part in activities?</th>
<th>Response Percentage</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling welcome and included</td>
<td>80.5%</td>
<td>66</td>
</tr>
<tr>
<td>Free or low cost</td>
<td>69.5%</td>
<td>57</td>
</tr>
<tr>
<td>Wide choice of activities</td>
<td>36.6%</td>
<td>30</td>
</tr>
<tr>
<td>Wide choice of sessions times</td>
<td>28.0%</td>
<td>23</td>
</tr>
<tr>
<td>Being able to bring a friend</td>
<td>13.4%</td>
<td>11</td>
</tr>
<tr>
<td>Public transport to Centre</td>
<td>8.5%</td>
<td>7</td>
</tr>
<tr>
<td>Community bus to Centre</td>
<td>4.9%</td>
<td>4</td>
</tr>
<tr>
<td>Incentives</td>
<td>3.7%</td>
<td>3</td>
</tr>
<tr>
<td><strong>Answered question</strong></td>
<td><strong>82</strong></td>
<td></td>
</tr>
</tbody>
</table>

Best things and suggestions for change

The final questions asked respondents to comment on the best things about the activities they took part in and whether anything could be done differently or improved. For the best things about the activities, comments focused on three main areas: 1) being able to learn new skills, 2) the social aspect of the activities such as the companionship, feeling welcome, the friendly instructors, and the opportunity to meet people and develop friendships and 3) health benefits they received from the activities. Health-related comments were about keeping fit and healthy, feeling well, sleeping better and mentioned improvements in health such as increased fitness, better balance and strength.
The majority of respondents could not suggest anything that should be done differently or changed. A few suggestions were made, mostly about the venue and equipment. For example, the room or garden space was too small for the number of people, parking could be difficult, better yoga mats and more stable chairs were needed. Comments about the courses were that these should run for longer and offered on different days. Better promotion of courses to encourage more people to attend was also mentioned.

Final comments indicated that, overall, the majority of respondents (80.7%) were very satisfied with the activities they had participated in. Respondents were very happy with the Cooinda Neighbourhood Centre and the staff, with many comments about how welcoming the centre is, how friendly and helpful all the staff are. The centre’s close proximity to Marion Shopping Centre was also seen as an added benefit. Some people suggested the equipment could be improved and others would like to see the centre promoted more through more advertising or pamphlets so they knew what other activities were coming up and others in the community could also find out about the centre and what it has to offer.

**Participant focus groups**

Both participant focus groups nominated the social aspects of the programs as important. Benefits were that the programs brought local people (who were often were isolated or living alone) together to share a meal or an activity. This was believed to be supportive of positive mental health and keeping people motivated in making changes.

The edible gardening group appreciated the opportunity to learn and share knowledge and experience with each other – both new and experienced gardeners said they had gained in self-esteem and confidence. Participants liked the practical ‘hands on’ nature of the program and the interactive presentation of information. The material covered was described as broad, incorporating recycling, healthy food, edible gardening and sustainability. The program’s inclusiveness was also valued with participants noting that everyone was included whatever their age, ability or culture. The volunteering component of the edible gardening group was noted as beneficial. It provided motivation, gave participants confidence to present to other groups, was supportive of future employment and the opportunity to obtain a reference.
For the physical activity group, benefits centred on increased strength and tone, flexibility, bone density, coordination and balance, and sleep patterns. The group session was believed to provide motivation and encouragement to participate in the activity. Most participants said they were now more active and had a greater understanding of the importance of physical activity. Most also walked regularly and those who were unable to walk due to injury reported that the class helped them to find other ways to stay active. Only one person was involved in healthy eating courses, being booked in for cooking classes ‘Cooking for One’ and ‘15 minute meals’.

Both groups nominated factors that made it easy to attend the groups. These included being local and close to home, ease of access geographically and by time of day, and being inexpensive. Once at the groups, participants stated that they felt welcome, everyone was friendly and helped each other and there was no pressure to contribute but rather staff were very supportive and encouraged people to do what they were comfortable with. For example, exercises are flexible to suit individual needs and can be adapted to suit people’s physical limitations. Both group facilitators were praised for their supportive and encouraging manner. One Heart Moves participant mentioned the movie ticket incentive but most said they didn’t know about these.

Only the edible gardening group made any suggestions about how things could have been done differently. It was suggested that the edible gardening and sustainability course could have run for longer and although it is a TAFE accredited it would have been good if it flowed on to something else rather than just finished.

Both groups commented about advertising and promotion of programs. A more personal approach was suggested, such as someone coming into an existing group and promoting an upcoming course. It was also noted that promotional material for some courses had only been seen two weeks prior to commencing and this made it more difficult to attend due to other commitments.

The groups were asked about perceived barriers to taking part in the activities. Both mentioned the potential for initial fear in coming along and the need for the person to be ready to take this step. Other commitments could prevent attendance, for example, work, study, medical appointments, caring for children or grandchildren. It was noted that crèche facilities were not available and this had prevented one person from attending the Heart Moves group. It was thought that transport could be a barrier as both Mitchell Park and Glandore Community Centres were harder to access by public transport than Cooinda and participants were unsure about the availability and assessment
criteria for using the community bus. It was suggested that the previously held lunches were a draw card to encourage attendance and that the centres should be to open at weekends.
Discussion

This section presents some limitations to the evaluation and then discusses the findings in the light of the literature reviewed earlier.

Limitations

Due to the method of administration, an accurate response rate for the participant survey is not able to be calculated. However, eighty-three completed surveys were returned with the survey administrator reporting her attendance at most courses and only two refusals in total. Respondents self-assessed their behaviour change and no baseline or anthropomorphic data was collected as this was considered inappropriate for a community-based project. At one of the focus groups the facilitator was present and actively contributed in the discussion but participants were given an opportunity to speak individually to the evaluators after the group session. It had been planned to hold a further focus group with Community Foodie volunteers but this was abandoned as the state program funding for Community Foodies was under threat at the time.

Recruitment

The literature reviewed above points to some strategies for successful recruitment. These include drawing on relationships with existing community-based organisations, being persistent and including family and friends in invitations to participate. The target group for this project includes people who are socially isolated and this necessitated a lot of effort being put into recruitment. The project engaged with a number of local organisations through the Advisory Group and other links and this led to referrals to programs. Accreditation of facilitators and the adoption of nationally quality assured programs helped to reassure referring agencies of the quality of the programs. Promotion of programs and courses was fairly consistent and strategies such the buddy system appeared to encourage people to attend.

Engagement

The literature on engagement suggests the need to build capacity in all partners, recognise diversity, work in partnership to share power and learning, and adapt programs to suit the local context. The
project was strong in building capacity, particularly among the volunteers, in terms of skill development and building confidence and self-esteem. Diversity of culture and ability was valued and steps taken to overcome barriers to engagement that may result from diversity. Program facilitators took the approach of sharing learning rather than presenting themselves as the ‘expert’.

Community-based participatory research
This section considers the project process and outcomes against the four factors described in the CBPR model outlined above.

Contextual issues
The project started at a time when there was strong interest from all levels of government in addressing the growth of overweight and obesity in the Australian population. This led to a focus on programs aiming to increase healthy eating and physical activity in the community. Local government, being close to local communities, was seen as ideal setting for such programs. The City of Marion already had demonstrated readiness to take on this role by, for example, its support of community centres and becoming a WHO-accredited Healthy City. Latter in the life of the project, budget constraints and structural changes at Federal and State level put pressure on many health promotion programs, with the SA State Government review recommending cutting almost all health promotion programs from its primary health care services (McCann 2012). The expectation is that local government and the federally funded Medicare Locals will take on this role, but it is unclear at the time of writing how this will roll-out in practice

Group dynamics and equitable partnerships
The project advisory group was the main formal mechanism for establishing and maintaining partnerships with stakeholders. The advisory group appeared to share similar values and aims as the project and for the most part was seen to work well. Some organisations, for example Medicare Locals, were undergoing major development or change and this sometimes made it difficult for people to fully engage. The partnership approach was valuable in sharing information and resources and was integral to getting referrals to the courses. However, some partners found the focus on four specific suburbs did not fit with their own catchment areas. The advisory group could have played a more pro-active role in advising on the project implementation and evaluation but to some extent this was already laid down in the Federal funding agreement. There was occasional overlap between outcomes that could be attributed to the project and what was already in place and this led to a perception that the project was claiming achievements that, in part, were attributable to others.
Intervention/ research

It was helpful that support and resources for the project appeared to extend beyond the immediate project staff to include the broader City of Marion staff and elected members. Thus, the project has value-added to the infrastructure and work place culture that exists in the City of Marion. This has contributed to the ability of the project to be far-reaching in the local community and engage with a large number of people while staying within budget.

The courses were adapted to suit the local context and the whole program informed by local organisations through the advisory group. The project remained flexible and responsive to local needs and environments. There was a shared approach to learning among community participants, volunteers and paid facilitators. Most responding participants reported that the welcoming and friendly atmosphere and the low cost were the main enablers to attendance and participation.

Outcomes

The project did not aim to bring about change at a structural level other than to build sustainability and capacity within the local community and the community centres used as venues. It is unclear at this stage what courses and activities will be maintained beyond the life of the project but the extra year of operation should assist to embed healthy eating and physical activity within the community centres. In terms of health outcomes, over half the responding participants had made, or were planning to make, changes to a healthier lifestyle. Nearly all had increased their physical activity, over half had increased their knowledge about healthy eating and over half now consumed more fruit and vegetables.
Conclusions

The most visible work of the project has been at the individual end of the health promotion spectrum rather than aiming to influence system policies. The focus on addressing barriers (disability, cost, cultural norms) has led to a more equitable approach to healthy eating and physical activity, reaching many who would not otherwise have been able to participate. The incentives offered to regular participants does not seem to have been a factor in attendance, rather the inclusive nature of the courses offered is most important. There has been some individual empowerment through the pathways offered to participants to become volunteers and then move on to paid work.

More recently the project has been successful in establishing a number of policies and models that should have an impact at a structural level. These initiatives are likely to be sustained through being embedded within the City of Marion and may flow on to other local governments.

Working in collaboration with other organisations is recognised as good practice in health promotion. It enables sharing of skills and resources and increases the capacity of the project to reach a larger population. It is also likely to lead to more sustainability when organisations work together to achieve shared outcomes. However, when organisations are under pressure to report against key performance indicators this can raise some tensions about attribution of achievements. Funders and policy makers need to be aware that shared outcomes cannot always be attributed to a particular program or organisation and take this into account when assessing performance.

Overall, the project has engaged with a large number of people and achieved its objectives. The sustainability of the project activities and achievements will depend on the priorities and resources within the City of Marion and other stakeholders. Extending the project to three years, while putting pressure on the budget, will allow more time for the project to become embedded within the community centres and known among the local community, and thus increase the likelihood of sustainability. Reducing the prevalence of overweight and obesity in the adult population resident in the City of Marion is a long term aim to which this project has made a significant contribution.
Acknowledgments

Thanks are due to following people who assisted with this evaluation: Sue Barnes (City of Marion) assisted with distribution and administration of the survey; Patricia Lamb (SACHRU) entered the survey data and Elsa Barton (SACHRU) analysed and reported on this data. Elsa also took notes at the focus groups and summarised these.

Thanks also to the project staff, Sue Elliott Healthy Communities Coordinator, Cherice Jenner, Healthy Communities Project Officer, Deb Opie, Healthy Communities GEM Coordinator; members of the advisory group and all participants for their time in contributing to this evaluation.
References


## Appendix A: Healthy Communities Initiative simple program logic model, theory of change and evaluation framework

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short term outcomes 1-2 years</th>
<th>Medium term outcomes 3-4 years</th>
<th>Long term outcomes 5 years plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal grant</td>
<td>HE &amp; PA activities eg Cooninda community nights, lunches, garden, cooking</td>
<td>#, scope and quality of HE and PA programs activities</td>
<td>Engagement of priority groups and whole of community capacity building</td>
<td>Increased healthy weight in population</td>
<td>Improved health</td>
</tr>
<tr>
<td>Council staff and resources</td>
<td>PA programs eg HF walking, Wise Moves, Health Moves, aqua</td>
<td>Attendance by priority groups</td>
<td>Increases in knowledge, attitude, skills re HE &amp; PA</td>
<td>Decreased overweight/obesity in population</td>
<td>Increased health equity</td>
</tr>
<tr>
<td>CF/volunteers</td>
<td>CF and other volunteer training</td>
<td>Networks and links with relevant agencies</td>
<td>Increased HE &amp; PA</td>
<td>Increased community capacity and sustainability</td>
<td></td>
</tr>
<tr>
<td>Facilitators</td>
<td>Advisory group and agency linkages</td>
<td>Capacity building community eg TAFE community mentors</td>
<td>Decreased barriers to PA participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work and N&amp;D students</td>
<td>Activities to increase social links and decrease barriers to participation in individuals</td>
<td>Pathways for participants</td>
<td>Participants move through to volunteering, skills training/education, employment (as appropriate)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Context:** National evaluation; locally higher than SA average overweight/obesity rates; priority groups – adults, Oaklands Park, Dover Gardens, Seacombe Gardens and Sturt and who are predominantly not in the paid workforce, low SES, CALD, new arrivals.
Theory of Change

**Inputs**
Federal grant, council staff & resources, CFs, group facilitators, social work and N&D students, new N&D graduates

**Activities**
- Healthy eating activities
- Physical activity sessions

**Short term**
Engagement of priority population in programs and activities
- Increased knowledge, attitude, skills re healthy eating
- Increased knowledge, attitude, skills re physical activity

**Medium term**
- Increased proportion of population at healthy weight
- Decreased proportion of population who are overweight / obese

**Long term**
Improved health and increased health equity
## Evaluation framework

<table>
<thead>
<tr>
<th>Evaluation question</th>
<th>Indicators</th>
<th>Data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>What programs and activities have been implemented?</td>
<td>Number, scope of programs and activities</td>
<td>Program docs</td>
</tr>
<tr>
<td>Have the programs and activities been of high quality?</td>
<td>Quality of programs(^1) and activities including strengths and challenges</td>
<td>Good practice/ research literature, Project staff interviews, Participant survey and focus groups</td>
</tr>
<tr>
<td>What have been the enablers and barriers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have the priority groups been reached?</td>
<td>Attendance by priority groups</td>
<td>Registration / attendance records</td>
</tr>
<tr>
<td>To what extent have the priority groups been engaged in the project? What have been the enablers and barriers to this engagement?</td>
<td>Level of engagement of priority groups including enhancers and barriers</td>
<td>Good practice/ research literature, Project staff interviews, Participant survey and focus groups</td>
</tr>
<tr>
<td>To what extent has there been an increase in knowledge, attitude, skills re HE</td>
<td>Increase in knowledge, attitude, skills re HE</td>
<td>Project staff interviews, Participant survey and focus groups</td>
</tr>
<tr>
<td>To what extent has there been an increase in knowledge, attitude, skills re PA</td>
<td>Increase in knowledge, attitude, skills re PA</td>
<td>Project staff interviews, Participant survey and focus groups</td>
</tr>
<tr>
<td>To what extent has HE increased?</td>
<td>Increase in participant HE</td>
<td>Project staff interviews, Participant survey and focus groups</td>
</tr>
<tr>
<td>To what extent has PA increased?</td>
<td>Increase in participant PA</td>
<td>Project staff interviews, Participant survey and focus groups</td>
</tr>
<tr>
<td>What are the other benefits of participation?</td>
<td>Increase confidence, Decrease in social isolation</td>
<td>Participant survey and focus groups</td>
</tr>
</tbody>
</table>

\(^1\) Healthy Living Network registration as quality assurance indicator
Appendix B: Evaluation tools

Participant survey

1. How long have you been coming to healthy eating and/or physical activities supported by the Healthy Communities Initiative? (please circle one)

<table>
<thead>
<tr>
<th>About one month</th>
<th>2-6 months</th>
<th>6-12 months</th>
<th>More than 12 months</th>
</tr>
</thead>
</table>

2. How many times have you attended activities? (please circle one)

<table>
<thead>
<tr>
<th>1-4 times</th>
<th>5 times or more</th>
</tr>
</thead>
</table>

3. What activities have you taken part in? (circle all that apply)

- Cooking/food preparation
- Edible Gardening Groups
- Walking Groups
- Healthy meals
- Physical activity sessions (eg Table Tennis, Dancing, HeartMoves, Yoga)
- Other activities (please describe) .................................................................

4. Have you helped with any activities as a volunteer?  Yes  No (go to qu. 6)

If yes, which activities?

- Healthy meals
- Edible Gardening
- Physical activity sessions
- Other activities (please describe) .................................................................

5. Why did you volunteer for these activities? .................................................................

6. As a result of participating in Healthy Communities healthy eating and/or physical activities do you plan to make changes to live a healthier lifestyle?

<table>
<thead>
<tr>
<th>Yes, what are your plans?</th>
<th>No, why is this?</th>
<th>Not sure, why is this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>.................................................................</td>
<td>.................................</td>
<td>.................................................................</td>
</tr>
</tbody>
</table>
7. As a result of participating in Healthy Communities activities have you increased your physical activity?

Yes, lots  Yes, some  No

8. As a result of participating in Healthy Communities activities do you know more about the importance of healthy food and cooking?

Yes, lots  Yes, some  No

9. As a result of participating in Healthy Communities activities have you increased the amount of fruit and vegetables you eat?

Yes, lots  Yes, some  No

10. What has been important in making it easier for you to take part in the activities? (circle all that apply)

- Wide choice of activities
- Public transport to the Centre
- Community bus to the Centre
- Wide choice of session times
- Incentives (eg movie tickets, vouchers)
- Free or low cost
- Feeling welcome and included
- Being able to bring a friend
- Feeling welcome and included
- Other (please describe) ..........................................................................................................................................

11. What was the best thing about the activities that you have participated in?

..........................................................................................................................................................................

12. Is there anything you would like to have been done differently or changed?

..........................................................................................................................................................................

13. Overall how satisfied are you with the activities that you participated in?

Very satisfied  Satisfied  Not satisfied

14. Any other comments? .................................................................................................................................

15. What suburb do you live in? .................................................................

16. What is your age? (please circle one)

18-24  25-34  35-44  45-54  55-64  65-74  75+

17. Are you (please circle one)  Female  Male

18. What language do you mainly speak at home? ..............................................................................................

THANK YOU FOR YOUR TIME AND INTEREST
PLEASE PLACE YOUR COMPLETED SURVEY IN THE BOX PROVIDED AND COLLECT YOUR GIFT

40
1. What is the best thing about the healthy eating and/or physical activities supported by the Healthy Communities Initiative?
   (Prompt for what encourages them the most to get involved in these activities)

2. What has been important in making it easier for you to take part in the activities?
   (Prompt for aspects including: choice of activities; choice of session times; incentives (movie tickets, vouchers); public transport to Centre; community bus to Centre; free or low cost; feeling welcoming/included; being able to bring a friend.) (For volunteers – training and support from HCI)

3. Is there anything you think could have been done differently or changed?
   (Prompt – anything you didn’t like about the program or challenges to participating?)

4. Do think the Healthy Communities activities have helped you or other people to be more active? In what ways?

5. As a result of participating in Healthy Communities activities do you know more about the importance of being active and how to increase activity in your life?
   (Prompt for individual, community and structural factors)

6. Do think the Healthy Communities activities have helped you or other people to increase healthy eating such as cooking with more fruit and vegetables? In what ways?

7. As a result of participating in Healthy Communities activities do you know more about the importance of healthy eating such as cooking with more fruit and vegetables?
   (Prompt for individual, community and structural factors)

8. To what extent do you think the Healthy Communities activities were welcoming of people from diverse backgrounds and abilities? In what ways?

9. Do you see any barriers in getting involved or attending these sessions?

10. Anything else you would like to say about the Healthy Communities activities?

   Thank you
Advisory group interview schedule

1. What has been your role in the project?

2. Has this role changed over time and if so in what ways?

3. Has the project rolled out as you expected? If not, what changed and why do you think this is?

4. What would you say have been the major achievements of the project? (Expected and unexpected)

5. What has not been achieved as expected? Why do you think this is?

6. What have been the enablers of achievement?

7. What have been the barriers to achievement?

8. How successful has the project been in engaging with the target groups? (that is residents of Oaklands Park, Dover Gardens, Seacombe Gardens and Sturt who are predominantly not in the paid workforce).

9. What have been the enablers of this engagement?

10. What have been the barriers to this engagement?

11. Looking back, what could have done differently to improve the project’s processes and outcomes?

12. Is there anything else you would like say about the project?

Thank you