

# **Food and Health in the Community Improving access to Healthy Affordable Food**

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## **NW Food and Health Task Force**

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Conference Report & Findings  
9th March 2001  
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With special thanks to Lisa Regan for transcribing the proceedings, Ann Kenyon for her comments on the manuscript, and Diana Leighton for help in preparing the manuscript for publication



# CONTENTS

|  | Page |
|--|------|
| Participants   | 4    |
| Foreword & Executive Summary<br>Angela Towers, NW Food & Health Task Force   | 5    |
| Introduction<br>Professor John Ashton, Regional Director of Public Health  | 8    |
| Food and Nutrition Policy<br>Cecile Knai, World Health Organisation  | 11   |
| Local Food Links and the NHS Plan<br>Danila Armstrong, Department of Health  | 19   |
| The Policy Issues - Nationally, Regionally & Locally<br>Dr Elizabeth Dowler, University of Warwick   | 24   |
| Making it Happen 1 - Local Solutions - Community Nutrition Assistants<br>Julie Holt, Community Healthcare Bolton (NHS) Trust   | 33   |
| Making it Happen 2 - Local Solutions - Food Initiatives in Practice<br>David Rex, Sandwell Health Authority  | 39   |
| Community Mapping - How Participatory Appraisal methods can be used to engage<br>large and diverse groups of people<br>Clare Allison, SUSTAIN & Stephen Robson, Barrow<br>Community Regeneration Company | 44   |
| Panel Discussion   | 52   |
| Appendix 1<br>NW Food & Health Task Force  | 60   |

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# FOREWORD & EXECUTIVE SUMMARY

## Angela Towers, North West Food and Health Task Force

The purpose of this conference and report is to raise awareness of some of the wider public health issues and implications around food and health. The association between food and health works on many different levels, whether we are considering the direct effects on human health of the foods we eat, or the indirect aspects of our food choices such as the social, environmental and economic implications. Many of these issues are becoming more prevalent as the food supply chain becomes increasingly complex; as the incidence of dietary related diseases increases and as concerns about where our food comes from and how it is processed escalates. The foot and mouth epidemic that has devastated many of the UK's farming and rural communities throughout the spring and summer of 2001 is the latest in a series of food related scares that have raised consumer concern about food and health.

Clearly the inter-relationships of food, diet and health are many, with a range of complex factors determining what people eat. On a global scale there is no shortage of food and many consumers have a large choice of foods. This ready supply of seemingly 'cheap' food is responsible for damaging people's health due to over-nutrition or consuming an excess of fatty, sugary, salty and processed foods. Very personal issues such as preference, lifestyle, ethical issues, culture, or the following of a particular dietary regime, often govern food choices and why we eat what we do. Yet for some people these individual choices can be limited by other factors (e.g. money, access to shops, lack of cooking skills etc.), which actually reduce the availability of healthy, affordable foods.

Alongside the problems of excess there are still significant numbers of people who do not have access to an adequate supply of affordable foods for a healthy diet. For many people food poverty is a real problem and as with many other inequalities it is often those people on the lowest incomes who live in the most deprived areas, for which this is a real day to day issue.

Broadly speaking the public health concerns fall into three main areas; food safety, nutrition and sustainable food supply systems. This report is mainly concerned with the importance of a healthy diet in preventing certain degenerative conditions and also with sustainability issues, particularly with the availability of affordable food for a healthy diet. It sets out to examine why food poverty exists, what is being done to address the problem on a European, a national and a local basis, both strategically and at ground level and identifies what more could be done to achieve food security for all.

**“We affirm the right of everyone to have access to safe and nutritious food ... and the fundamental right of everyone to be free from hunger .... Poverty is a major cause of food insecurity and sustainable progress in poverty eradication is critical to improve access to food.”**

Rome Declaration on World Food Security, November 1996

Many will be familiar with the above declaration, to which the UK government was a signatory. Clear links between poverty and food poverty have been shown and although poverty levels in the UK have fallen in recent years they remain unacceptably high, especially among children. The National Food Survey 1999 showed that families on a low income consumed on average half the amount of fruit & vegetables of their higher income counterparts and also consumed higher proportions of fats and sugars.

A diet that is low in fruit and vegetables and starchy foods but high in fatty, sugary, salty and over processed foods leads to many degenerative diseases such as coronary heart disease, certain cancers, diabetes and tooth decay. After smoking, diet is the second largest cause of cancer in the UK. The number of obese people in the UK has tripled over the past 20 years; figures for 1998 show that 17% of men and 21% of women were classed as obese - almost epidemic proportions. Even more worrying is obesity in children - more than one million children under the age of 16 are now classed as obese - almost twice as many as a decade ago. Overweight children tend to become overweight and unhealthy adults.

Obesity and related conditions bear many direct and indirect costs to the nation. They are a huge financial burden on the National Health Service in terms of treatment costs, which are at least £500 million per year. They are responsible for 18 million sick days per year and have a further cost to the economy as a whole in terms of lost output.

The North West of England has very high levels of incidence of many of these diet related illnesses.

It is important that we have available a range of interventions and agreed longer term strategies in order to reduce the burden of disease and improve the health of communities and individuals. The World Health Organisation has a pro-active Food and Nutrition unit which has a number of programmes designed to improve food security in member states and is currently promoting the adoption of food and nutrition action plans both nationally and regionally. Within the UK the current Government now recognises inequalities and the NHS Plan contains a number of new food related initiatives including a unique programme to provide schoolchildren throughout the country with free fruit.

While these strategies should have a beneficial impact in the longer term by addressing some of the underlying issues, there are also a large number of community based or local food projects which have been established to address some of the more immediate day to day issues in practical ways. These often involve volunteers and are based within the local community for the benefit of the local community.

Many of these projects are very innovative and some are real examples of good practice, both in terms of how they are set up and run and in terms of the benefits to the local community. However many more experience problems in attaining sustainability. Furthermore there is very little in the way of formal evaluation of these type of initiatives. While anecdotally many of them are seen to have a number of good outputs, more evidence is required in order that they may be moved into mainstream funding. In the short term some of the funding streams that support the projects should be encouraged to take a more long term view and should move away from enforcing hard outputs in the short term.

The full report covers a wide range of issues, which are discussed in greater detail in the relevant chapters. Some of the key points raised include:-

- Promotion of local food for local people. Consumers want to be able to buy locally produced foods, direct from the producer if possible.
- Local food directories, farmers markets and box schemes should be encouraged to promote the availability of locally produced and healthy foods.

- Supermarkets have too much domination of food retailing. Independent shops should be encouraged by, for example, reviewing local planning policies, reducing crime and reducing 'red-tape' for small businesses.
- Single people find it costly catering for one - pack sizes often too large.
- Brownfield sites used for food growing cause concern about potential land contamination and the possible effects on human health.
- Some areas suffer from 'Initiative overload' and could benefit from rationalising the many and various funding streams for projects.
- Communities need to 'own' their local food projects from the outset. Secure and long-term funding and partnership working are key factors in their success.
- Local food projects often operate in isolation. Regional co-ordination of such initiatives could promote best practice and would reduce fragmentation.
- The potential for growing more food in towns and cities should be explored.
- The planned 'National School Fruit Scheme' and 'Five-A-Day' projects should involve local farmers, growers and suppliers.
- Free school meals are often not claimed by eligible children. The current system is seen as stigmatised.
- School food provision generally needs improving. Cooking skills, basic nutrition and food education all need more focus in the school curriculum.
- Advertising and promotion of unhealthy foods to children needs regulating.
- Regional involvement in food safety legislation would bridge the gap between national policy makers and local controls.

The papers captured in this report hopefully form the web between European and UK strategy, the social issues and community solutions to some of the problems.

The report and proceedings are the first of their kind in the North West and the Food and Health Task Force is committed to ensuring that opportunities to exchange views and share information about food and health issues continue to be facilitated across the region.

# Introduction

## Professor John Ashton, Regional Director of Public Health (North West)

I would like to thank all the people who organised this event because I think that it is very important and very timely. It has been planned for a while now but it was important to time an event like this appropriately, and the current outbreak of foot and mouth disease puts issues of food at the top of the agenda. It is always important to try and think how we can turn a crisis like this to an advantage. It is quite clear that public interest and understanding in food issues has gone on a stratospheric trajectory over the last two weeks. Today we need to consider some of the current issues, and see how we can take the agenda forward in a practical way.

## Whole Systems

In terms of the broad sweep of policies in relation to food, it is becoming very clear what the issues are that need addressing. Academics can be very defensive of public criticism of scientific research, including that of genetically modified food, and can sometimes lose sight of certain fundamental truths. Academics would do well to remember, as Thomas McKeown pointed out in his book, *The Role of Medicine*<sup>1</sup>, that public health should be thought of as an ecological matter. In their natural habitat, animals are not normally sick but healthy and in balance with their environment. The time when animals do get sick, however, is when their habitats are disturbed and the conditions under which they have evolved are changed. The same applies to human beings: when their conditions are changed they become ill and the whole system has to realign itself to find a new balance. The problem with food issues is that we have cavalierly jumped in and made dramatic changes with a very positivistic approach, sanctioning change to go ahead without the precautionary burden of proof to guarantee against detrimental effects. To interfere with huge systems without really understanding what the consequences will be is not prudent and we saw this most clearly in the case of BSE.

We therefore need to think about whole systems. We have begun to address this, through the recent outbreak of foot and mouth disease, because although the outbreak started off being viewed primarily as an agricultural issue, it is now being considered in the context of whole systems. Recognising the inter-relationship of public health, environmental health, agriculture, food, and a whole range of other aspects including equity issues, poverty and food poverty issues, as well as sustainability questions, is fundamental.

Food miles are also becoming an increasingly important issue in this country whereas before they were only seen as an issue in developing countries where high added-value foods were grown for export instead of high-energy foods to nourish the home population. Similar disruptions to the food supply chain have occurred in Britain, typically in places like Liverpool and Manchester, where even until after the war in the 1940's, most of the food was provided locally from Lancashire and Cheshire, coming in on the morning trains from market.

## Regional Input

I would like to stress that there should be an explicit input at a regional level as far as food issues are concerned because I believe that this is what is needed. Before 1974 a typical local authority would have been responsible for food composition, labelling, quality, microbiological and chemical sampling, inspection of food processing plants, abattoirs, food premises, imported food, meat inspection, licensing of certain food and dairy operations, animal health functions, public houses, and export certificates for food. Local authorities were solely responsible for all these aspects of food provision, but now this responsibility is dissipated amongst many different authorities and agencies. The Food Standards Agency tries to take responsibility for some of them but only at a national level. There is no co-ordinated, intersecting arrangement between the national level and the practical implementations at ground level. The public are disempowered; although one is very sympathetic to the plight of the farmers, there is a tendency amongst them to talk, in the same way as doctors have done until recently, as if they alone are in a position to comment on agriculture. Yet there has to be a partnership between the urban and rural population if we are to rebuild British agriculture.

In light of this, the discussion about slaughterhouses has proved interesting. Frequent reports of appalling standards in slaughterhouses, particularly during the BSE crisis, resulted in many slaughterhouses being shut down. Now animals have to travel much further distances from market to slaughter, which has resulted in the rapid spread of foot and mouth disease to many parts of the country. This situation suggests that we need to have a framework in place, near enough to the ground to monitor the situation, but also at a regional level to co-ordinate people. I would suggest that the regional level is the appropriate level at which we should develop a capacity to deal with a whole range of food and health related issues. It could orchestrate a partnership between the Ministry of Agriculture, Fisheries & Food<sup>i</sup>, Department of Trade and Industry, the Department of Health, the private sector, the public sector, the universities and the agricultural colleges. All of these institutions could then be co-ordinated to respond to some of the questions about food and health.

I also think that we need to remind ourselves that this country is not homogenous and that national policy, as viewed from London, can be misleading. When we were discussing the issue of food deserts, civil servants in London did not believe that these food deserts existed, because in London, unless poor people live on the periphery, they always have easy access to supermarkets and a full range of shops. The situation outside London is different. This is just one of the issues that points to the need for a regional policy that can consider requirements at a more local level which national policy might overlook. There are opportunities for this at the present time. I hope that by the end of this conference we will have a clearer view of what these opportunities are, as well as of what the problems and the issues they entail, and that people are motivated to go away and see how they can take the agenda forward.

<sup>i</sup> As a result of the government reorganisation in June 2001, MAFF was replaced by the department for Environment, Food and Rural affairs (DEFRA).

## Looking Forward

On occasions like these, there are always three questions that we should ask, whichever public health issue is under consideration:

- what can we do ourselves in our local areas or communities?
- which other types of people or organisations can we work with whom we have not considered before?
- what can you do to set other people's agendas for them in order to instigate change?

We should also bear in mind certain demographic implications; people of the 'baby-boom' era are approaching retirement and within ten or fifteen years, 40% of people in Lancashire and Cheshire will be over 65 years of age. These people will not only have different shopping needs but will also be generally fit and healthy, with time to become involved in all kinds of activities, for example growing food in towns.

## References

1. Mckeown, T, 1980. *The Role of Medicine: Dream, Mirage or Nemesis*. Out of print.

# Food and Nutrition Policy – International Picture

Cecile Knai, Nutrition and Food Security Programme, World Health Organisation

I represent the Nutrition and Food Security Unit at the World Health Organisation (WHO), Regional Office for Europe in Copenhagen. I would like to outline the WHO policy strategies and activities, geared towards improving access to healthy, affordable food in the Region.

## European Diversity

First, a few words about our organisational structure. We have two offices that deal with food and nutrition issues; in Copenhagen we deal with nutrition policy, infant feeding and food security; the Rome office exclusively addresses food safety. The area covered by WHO/Europe extends from Western Europe over the entire former Soviet Union. It is an enormous area, encompassing a great social, cultural and political diversity.

The graph below (Fig. 1) shows the availability of fruit and vegetables in European Regions. Availability ranges from at least 250g of both fruit and vegetables in Greece eaten per person per day, compared to Kyrgyzstan where only under 20g per person per day are available.

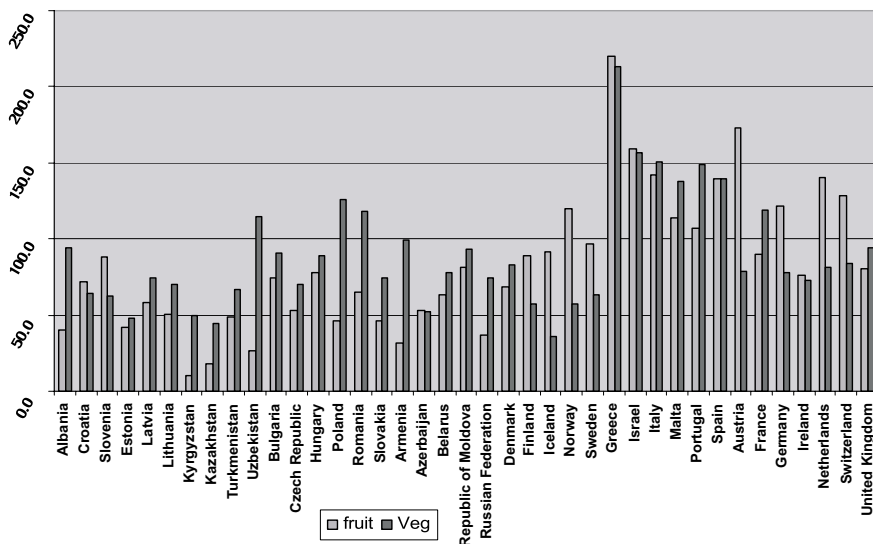
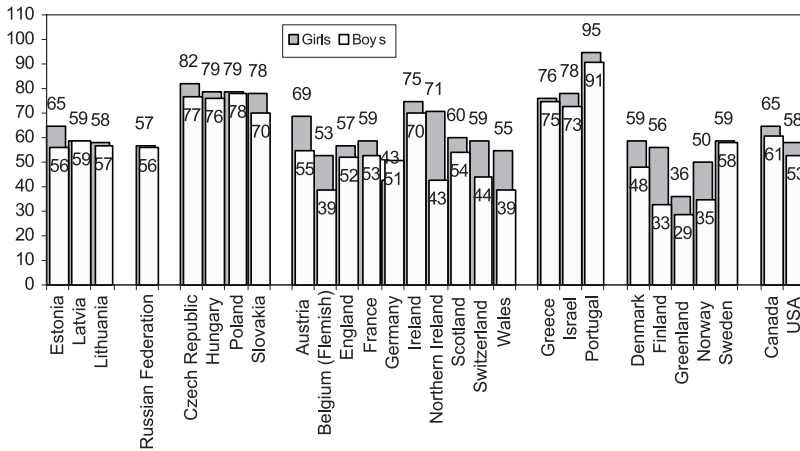


Fig. 1 - Fruit and vegetables eaten per person per day (WHO European Region)

The next graph (Fig. 2) shows great variability amongst 15 year-old students' self-reported daily fruit consumption. In England about 55% eat fruit on a daily basis, whereas in Portugal as many as 95% report eating fruit on a daily basis and in Greenland only 29% to 36% eat fruit every day.



Ref. Currie et al 2000 – Health Behaviour in School Children survey

Fig. 2 - Daily fruit consumption of 15 year olds

## WHO Food and Nutrition Action Plan, 2000 - 2005

There are a series of existing food and nutrition policy commitments that have paved the way for the Action Plan:

- World Health Assembly resolutions;
- UNICEF Convention on the Rights of the Child – 1989;
- UNICEF World Summit for Children – 1990;
- International Conference on Nutrition – 1992;
- Agenda 21 – 1992;
- HEALTH 21 (Health for All 2000) – 1998;
- EU Treaty of Amsterdam – 1999;
- EC White Paper – 2000.

The Action Plan provides a framework for the WHO Member States of the European Region to create a comprehensive national food and nutrition policy, comprising of three interrelated strategies: 1) a nutrition strategy, 2) a food safety strategy, and 3) a sustainable food supply strategy. To ensure that these food strategies complement each other we

advocate as multisectoral an approach as possible, including collaboration between the following sectors, for instance:

- Public health
- Agriculture
- Food industry
- Education
- Voluntary sector
- Environmental services
- Horticulture
- Food retailers
- Tourism
- The public

**The nutrition strategy** is geared to ensure optimal health during critical periods throughout life (fig.3). It begins with foetal development, as there is growing evidence that foetal health has an impact on the development of chronic disease in later life.

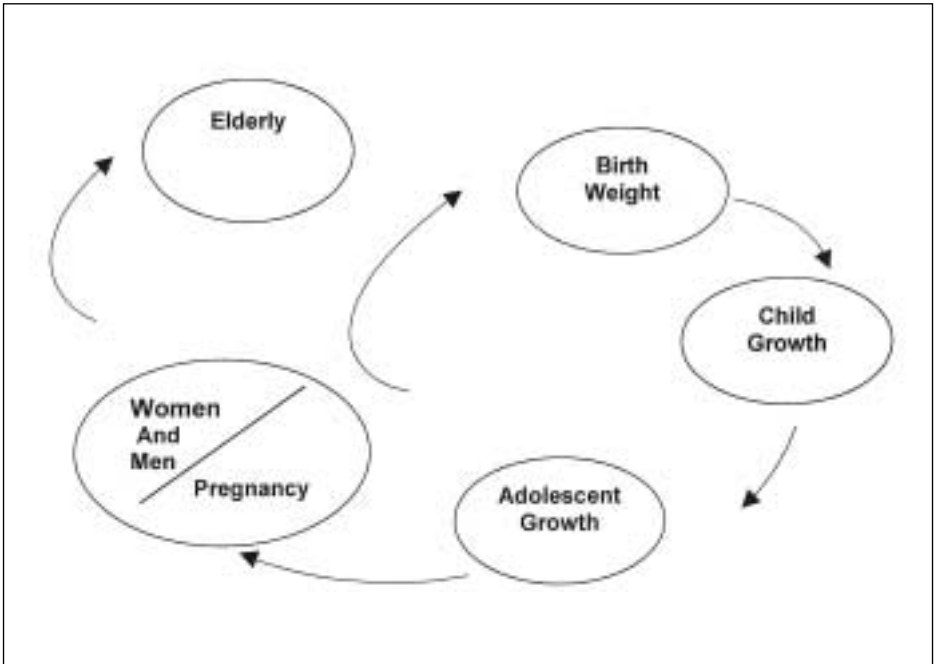


Fig. 3 Nutrition through the life course

The food safety strategy (fig.4) aims to prevent both biological and chemical contamination at all stages of the food chain.



Fig. 4 Food safety programme

The food security strategy aims to ensure that all people at all times have physical and economic access to good quality food for an active, healthy and productive life.

## How does WHO help improve access to healthy affordable food?

### 1. Develop an integrated approach to food, nutrition and health

The first thing we do is to get together all the people involved (fig.5); both health and non-health sectors responsible for the food supply chain, and to be effective our food and nutrition policy must harmonise the opinions and standpoints of all these sectors.

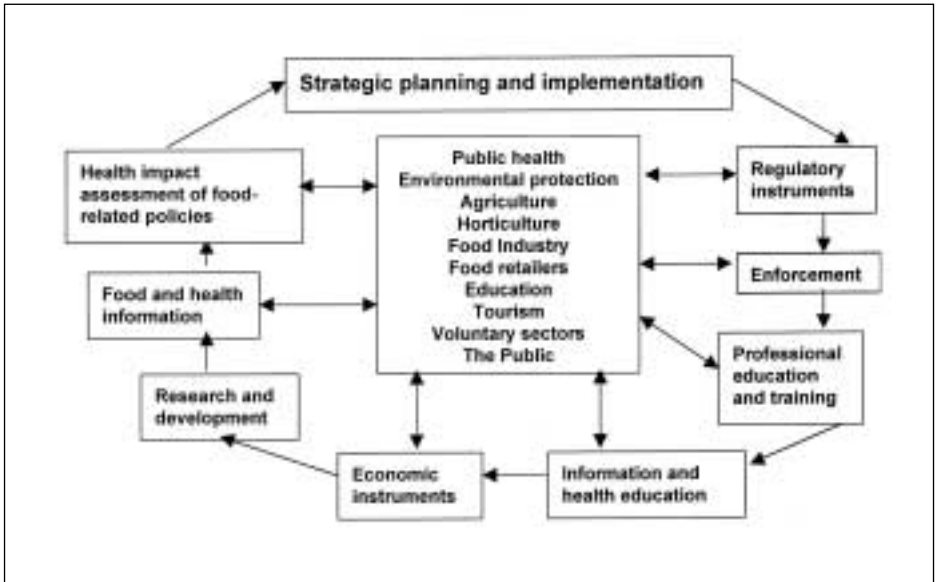


Fig. 5. Network of health and non-health public sectors

## 2. Monitoring health information

Only a few countries of our region have a comprehensive system for monitoring food and nutrition intake, nutritional status and the incidence of food borne diseases. So we work with the Member States to develop such systems. WHO is involved in the Global Burden of Disease Project which will calculate the cost of food related to ill health and the burden that it places on society.

## 3. Mobilizing partners

Partnerships at local, national and European levels and at global levels are the key to reducing ill-health related to food. We have national counterparts in each country that are the technical focal points. There are also Collaborating Centres for nutrition in five countries of the Region (Greece, Denmark, Kazakhstan, Norway and Italy). We work with expert colleagues such as UNICEF and the FAO and other UN organisations, with non government organisations (NGO's) promoting nutrition, with decision-making bodies like the European Commission, as well as the food industry, since they too have a significant impact on the food chain.

#### **4. Promoting advisory and coordination mechanisms**

Evidence shows that countries where national co-ordination mechanisms such as a food and nutrition council are in place are most effective in developing and implementing food and nutrition policies. For example, during the late 1960s Finnish adult men had the highest mortality rate in the world from cardio-vascular diseases. A major prevention project was started as a result of a petition conducted by people in a region that was particularly badly affected. Comprehensive community-based strategies were implemented to change dietary habits, for example to lower cholesterol levels. One of the battles that they were fighting was to find a local alternative to butter, so in the 1980s they developed a local market for rapeseed oil, thereby meeting both cultural and health concerns. Cardio-vascular diseases have fallen dramatically. Co-ordination mechanisms such as the national food nutrition council were and still are instrumental in implementing this initiative nationwide. The Nordic countries are good case studies for illustrating what can be achieved through national co-ordination mechanisms.

#### **5. Improving knowledge and sharing information**

Improving knowledge and sharing information is another very important element. An example relevant to this meeting is that food insecurity, particularly in the former Soviet countries, has led to increasing levels of dependence on home grown food and local food production initiatives, so our main focus regarding food insecurity in this area has been to develop the Urban Food and Nutrition Action Plan. This document aims to promote local food production and healthy foods for local consumption.

The CINDI dietary guide, Countrywide Integrated Non-communicable Diseases Intervention, is another WHO programme with which we collaborate very closely. The CINDI programme aims to reduce mortality and morbidity from non-communicable diseases and is developed alongside the WHO nutrition policy, 'Twelve Steps to Healthy-Eating' programme. This is based on the premise that the most appropriate dietary guidelines not only promote health but also conserve natural resources and promote food security. We have commissioned monographs on individual seed developments, for example the rooftop garden in St Petersburg, which was started by a local NGO because citizens recognised that food security was an issue, and which has been very successful. We work with Healthy Cities and other health promoting networks that are based at WHO, all of which are involved with, or are interested in, promoting food and nutrition policies.

#### **6. Formulating national food and nutrition action plans**

The final step is the formulation of national food and nutrition action plans. A comparative analysis of countries in our region shows that many of them have developed effective action plans, for example the Nordic countries. To those countries that have not yet developed action plans, we emphasise that 'The First Action Plan for Food & Nutrition Policy' was unanimously endorsed by all 51 member States (including their own governments) at our annual Regional Committee meeting in September 2000. We have started providing workshops to support countries in setting up action plans, using a model mainly written by Professor Tim Lang. Our intersectoral policy development approach formed decision-making groups and we attempted to get as many sectors around the table as possible. We have already had some workshops in Southeast Europe and in the Baltic regions and we are planning the follow-up of

this Southeast European meeting in FYR Macedonia in April 2001. All of these reports are on our website (<http://www.who.dk/Nutrition/main.htm>).

The evidence base for pushing forward these policies is currently being written up in the publication, 'Food and Health in Europe: A Basis for Action', to be published early in 2002.

## **Discussion**

### **Jenny Slaughter, Sure Start Dietician, Burnley**

I wonder whether you can be sure that the benefits that you see in coronary heart disease are merely due to the change in the consumption of butter to oilseed rape, and whether it is not multi-factorial. I also wonder whether there are any environmental hazards in devoting great areas of land to the growth of oilseed rape.

### **Cecile Knai**

I can provide you with several papers to answer that question in detail. As to your first question, I'm sure that it was more complex but I gave it as an example of positive changes at the community level and through national coordination mechanisms.

### **Claire Glover, CAN Co-ordinator, St Helens Health Partnership**

Does the regional policy include promotion of breast-feeding and research into breast-feeding and its implications for food policy?

### **Cecile Knai**

Yes, infant feeding is a whole section of our programme ( + close collaboration with UNICEF, INBFAN and other relevant organisations).

### **Jeanette Longfield, Food Standards Agency**

I want to ask about national policy frameworks and what makes them successful. I am absolutely convinced that you are right about the co-ordination issue with regards to the success in Finland and Norway. I also understand, however, that some of the other key elements in Finland and Norway's success, besides co-ordination, are also political commitment, and a large amount of money, but I am also curious as to what level of infra-structure was already in place. How many people were actually on the ground level to implement the policy?

### **Cecile Knai**

I am not really in a position to answer that question, but we have documents detailing this.

### **Mike Fox, Liverpool Community Against Poverty**

How will your organisation help people on a low income to access healthy food?

### **Cecile Knai**

Low-income groups are one of the principal target populations of our policies. (For the most part, WHO does not work directly at the community level).

**Andy Dunleavy, Men's Health Project Manager, Health Promotion, Widnes**

On every occasion, in every country, girls were consuming more fruit and vegetables than boys. Is there anything in your strategy that analyses the intake of 9 year old boys?

**Cecile Knai**

Yes, we do address the special needs of adolescent boys, particularly as their health behaviours are consistently worse than those of girls.

**Pete Cummings, Health Development Worker, North Liverpool Health Partnership**

I interested in the comments you made about inner-city brownland and its use as farmland. Small producers tend to have to produce the high-yield, high-value products, not staple foods. As a result, the economics of growing food in urban areas is skewed and is in competition with more large-scale agriculture. Can you see a role for gap funding for the conversion for brownland to farmland in the same way that there is gap funding for the conversion of brownland into other building usage? I am interested in how the WHO intends to work with the government in order to overcome structural barriers that prevent urban growing becoming a reality.

**Cecile Knai**

Again I am not in a position to answer that question but I can put you in touch with someone who might be.

**Judith Varley, Liverpool University**

I am concerned over your question about brownfield sites. This is an area where we have lots of land that has been used for industrial purposes for centuries and the accumulation of toxic materials, heavy metals and so on. Without a massive input of money this land is really unsuitable to grow food of any type, whether it is to feed animals or grow vegetables. A great deal of money needs to be put in to remedy that situation before such food would really be safe. What sort of policy does the WHO have on this?

**Cecile Knai**

I am not sure whether we have a policy recommendation on this particular issue, but I do know it is addressed in the wider framework of food security/food safety policies. The only example I can think of at the moment is a WHO booklet on how to deal with contaminated soil in gardens.

# Local Food Links and the NHS Plan

Danila Armstrong, Department of Health

## Prevention, a Government Priority

For this government, preventing and reducing health inequalities is of vital importance – we now have two national health inequalities targets. The NHS Plan<sup>1</sup>, the NHS Cancer Plan<sup>2</sup> and the National Service Framework for Coronary Heart Disease<sup>3</sup> recognise cancer and coronary heart disease (CHD) as major priorities – focusing not only on the clinical but also the preventive aspects of these diseases. By tackling the major risk factors for these chronic diseases, such as smoking, obesity, physical inactivity and poor diets, morbidity and early deaths can be reduced.

## Evidence

Evidence shows that eating at least five portions of fruit and vegetables a day could lead to estimated reductions of up to 20% in overall deaths from chronic diseases such as CHD, stroke and cancer. Experts suggest that it is the second most effective strategy to reduce the risk of cancer, after reducing smoking.

There is increasing evidence to link the benefits of fruit and vegetables in reducing chronic diseases such as CHD and cancer. A recent study, the EPIC-Norfolk prospective study<sup>4</sup>, reported that increased levels of plasma vitamin C were associated with lower all-cause mortality and mortality from cardio-vascular disease.

A healthy diet is one that has plenty of fruit and vegetables, and starchy foods (such as bread) but is low in fat, sugar and salt. The COMA Report<sup>5</sup> and the World Health Organisation<sup>6</sup> recommend at least 400g of fruit and vegetables a day, which is approximately 5 portions. On average adults are eating 250g, around three portions, while children are eating two portions a day. However, these average figures mask wide variations between individuals - professional groups eat 50% more than low income groups.

## National Service Framework for CHD

The NSF for CHD sets standards to reduce the risk of coronary risk factors in the population, for people with established cardiovascular disease and for people at risk of cardiovascular disease. By April 2001, all NHS bodies with their local authorities will have agreed and be contributing to the delivery of the local programme of effective policies on reducing smoking, promoting healthy eating, increasing physical activity and reducing overweight and obesity. By April 2002, there will need to be quantitative data about the implementation of these policies.

To support the delivery of effective policies, the Health Development Agency (HDA) produced 'Guidance for implementing the preventive aspects of the NSF for CHD<sup>7</sup>'. They are currently carrying out a review of these local policies. The first review is on healthy eating and initiatives to promote the consumption of fruit and vegetables. The reviews will be used to inform future needs to facilitate progress locally and to identify good practice for wider dissemination.

## The NHS Plan

People make their own choices about what to eat. The role of government is to ensure they have information and proper access to a healthy diet, wherever they live. The NHS Plan sets out the government's commitment to improving diet and nutrition and to reducing health inequalities. So by 2004 we will have in place:

- **A new National School Fruit Scheme (see below).**
- **A reform of the welfare foods programme** to use the resources more effectively to ensure children in poverty have access to a healthy diet. There has been a scientific review, but ministers have made no decisions on the recommendations. One recommendation is to offer choices other than milk.
- **Increased support for breastfeeding** - inequalities in breastfeeding exist – over 90% of social class one mothers breastfeed their baby initially, compared with only 50% in social class five.
- **Five-A-Day programme (see below).**
- **Reduce salt, sugar and fat in diet** - working with the Food Standards Agency and the food industry to improve overall balance of the diet particularly with regard to salt, sugar and fat. The government is in discussion with industry to reduce the salt content of processed foods. Sugar and fat content will be looked at by 2004.
- **Local action to tackle obesity and physical inactivity** informed by advice from the Health Development Agency. The recent National Audit Office report on Tackling Obesity in England<sup>8</sup> reported that most adults are now overweight, and one in five is obese. At this rate, in ten years time, this would bring levels of obesity in England up to those experienced now in the United States.
- **Hospital nutrition policy** to improve the outcome of care for patients.

## Five-A-Day Programme

The core strands under this programme are :

- **National School Fruit Scheme**
- **Five-a-day Community Initiatives - the five-a-day pilot projects.**
- **Working with industry** to improve provision and access to fruit and vegetables – there has been an initial meeting with growers and distributors of fruit and vegetables. This sector of industry is very supportive of the five-a-day programme.
- **Communications** programme - to increase awareness of fruit and vegetable consumption. A primary consideration is the development of the right messages, logo, and effective approaches for reaching and influencing low income groups.
- **Evaluation and monitoring** – focusing on the implementation and impact of the five-a-day programme.

We cannot develop the programme alone. The Department of Health will work in partnership with:

- other government departments and agencies - Food Standards Agency; Ministry of Agriculture, Fisheries and Food;
- the Department for Education and Employment, and the Health Development Agency
- the food industry - producers, retailers, caterers
- consumers, health and education organisations.

## National School Fruit Scheme

The National School Fruit Scheme is the first government funded scheme of its kind in the world. It will entitle every child aged 4 to 6, in infant schools, to a free piece of fruit each school day.

The National Diet and Nutrition Survey<sup>9</sup> showed that consumption of fruit and vegetables in children is particularly low. In the week of the survey 1 in 5 children ate no fruit at all. The aim is to get children to enjoy eating fruit from an early age.

The scheme presents a huge logistical challenge so we are examining the practicalities through pilots before rolling it out nationally. The aim is to get 2 million children in this age group eating a free piece of fruit each school day by 2004. The pilots are considering:

- How do we get the fruit from the farm to the school gate?
- How do we get the fruit from the school gate into the children's hands?
- How do we encourage the children to eat the fruit?

The first pilot started in autumn 2000 in 33 schools, and in spring extended to 510 schools. The pilots are now providing a free piece of fruit to around 80,000 children across England every school day. We have been delighted that the scheme has been very well received by schools, parents and children.

By 2004, if the scheme goes as planned, it will entail distributing around 400 million pieces of fruit to some 16,000 infant schools across England each year. This is equivalent to 40% of the British apple market. The school fruit scheme, of course, includes a range of fruits, including some grown in other countries. Fruits distributed to children through the current pilots include bananas, satsumas, and pears.

## The Community Initiatives – Five-A-Day Pilots Projects

These have been set up to develop a co-ordinated approach to increase fruit and vegetable consumption community-wide. They are testing the feasibility and practicalities of evidence based interventions in low-income areas. Over 1 million people are being targeted in five areas in England: Airedale and Craven, County Durham, Hastings, Sandwell, Somerset. Evaluation is taking place in each pilot site and a national pre and post fruit and vegetable consumption survey is also in place.

Some of the interventions include working with food retailers, farmers' markets, schools, leisure centres, workplaces, and setting up food cooperatives and a delivery service for those most in need. The evaluation outcomes and lessons learned will be used to inform the five-a-day programme and the national rollout of the five-a-day community initiatives, which will begin in 2002.

More information about the five-a-day community initiatives and the School Fruit Scheme can be obtained on the following websites:

[www.doh.gov.uk/schoolfruitscheme](http://www.doh.gov.uk/schoolfruitscheme) and [www.doh.gov.uk/fiveaday](http://www.doh.gov.uk/fiveaday)

## Discussion

### **Alexis Macherianakis, Specialist Registrar in Public Health, South Cheshire Health Authority**

How many children want to eat fruit or are willing to eat fruit?

#### **Danila Armstrong**

We are evaluating this. The results from the first pilot, which was in the autumn and involved 33 schools, will be available soon. The interim results show that a high percentage of the children are taking the fruit.

Evaluation of the first pilot phase, however, was not focusing on the children eating the fruit, but on getting the fruit from the school gate to the child's hand. The actual consumption of the fruit will be evaluated at the third pilot stage. We are planning to develop a dietary survey tool to look at how much fruit is being consumed by the children. We want to ensure that the School Fruit Scheme does not displace the eating of fruit at other times of the day. The third pilot phase will tell us the most about the pattern of fruit consumption by the children.

#### **John Ashton**

We welcome this scheme but the regional directors of public health have some concerns. One was that it was not clear who were to be the suppliers. There has been talk of one preferred supplier and, from a regional point of view, we were very keen that the scheme should be connected to the region, particularly in this region, and other regional directors felt the same. We felt it was important that farmers and growers secure contracts through regional regeneration efforts. As regards importing, I would question whether or not we are sure that we cannot grow fruit under glass in this region, and whether we have fully explored options of this kind. The second thing that we were concerned about was that this is yet another scheme that has gone straight from the Department of Health to the local level, by-passing the regional office of the NHS. We have therefore not been factored into the pilots at the regional office level. I notice that our region is not one of the five pilot regions that you mentioned. We have had a very active Food Task Force in this region for some time and would have been in a strong position to collaborate with you on that.

#### **Danila Armstrong**

Identifying the sites for the five-a-day community pilot projects involved a wide-ranging tender process. The Department of Health received over 70 applications from which a steering group selected the current five sites – County Durham, Sandwell, Somerset, Hastings, and Airedale and Craven.

#### **John Ashton**

If the regional office of the NHS had been played into the scheme, we would have facilitated a strong bid from this region but we did not have the opportunity to do that.

#### **Danila Armstrong**

The spring term pilots are investigating possible supply models, including national, local and catering routes. We are establishing a national specification for the type, quality and size of fruit. We are assessing the supply models for their ability to deliver to this specification and against other criteria such as the local acceptability of the model.

## **John Ashton**

I do think that there should be some discussion about the role of the regional level, say with the Regional Development Agencies, and an effort made to join up government at the regional level.

## **Michael Marston, Federation of City Farms and Community Gardens**

I think that if we are talking about the farming and growing industry of this country, and the issue of food miles, then it is not an issue about contracts but about supporting indigenous industry. The farming industry needs support. I also think this obsession that people have about fruit should be extended to include both fruit and vegetables, and not just fruit.

## **Danila Armstrong**

As mentioned earlier in my talk, there has been an initial meeting with a number of growers and distributors of both fruit and vegetables including representatives of the National Farmers' Union. They are all very supportive of the five-a-day programme to increase the consumption of fruit and vegetables.

## **Carol Ledwards, Food and Health Advisor, Halton General Hospital, Widnes**

The work of our local chief food and health advisor has highlighted the importance of health advisor's roles in helping people in deprived areas to eat more healthily.

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# The Policy Issues – Nationally, Regionally and Locally

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## Introduction

I want to start with a definition of what food access and food security might mean for England and Wales. I will look at some of the key initiatives that have been produced by the government and the voluntary sector at the national level to address health inequalities, poverty and social exclusion and look particularly how food access has figured within that. I will then go on and look at the challenges that are posed by those initiatives, particularly those connected to the community and food. I will conclude with a summary of a briefing from the New Policy Institute held in summer 2000.

## Food Security

Food is not just what you put on your plate; it is a major contributor to health and well-being, and it also reveals how you want to be viewed by other people, and how you value yourself and your community. Food is about who you are and what you represent as well as contributing to avoiding heart disease and cancer. In November 1996 at the World Food Summit, about 180 governments, including our own then under the previous regime, affirmed the right of all people to have access to safe and nutritious food and acknowledged that poverty was the major cause of food insecurity throughout the world. The concept of food security has been widely adopted by the international community in relation to food entitlement and access but has not been greatly explored in the English context. In Scotland, the Poverty Alliance has used it as the basis of a national consultation on food access and the experience of poverty<sup>1</sup>. There are many definitions of food security, but this is a powerful one that is widely used: food security is access to sufficient, affordable, safe and nutritious food which is necessary and appropriate for a healthy life and the security that such access is sustainable in the future<sup>2</sup>.

Food access itself thus has four components:

- **Economic Access**, which depends not only how much money you have but also how much healthy food costs, and how much other things cost that are a necessity, e.g. rent, children's shoes, gas, electricity, water. Many of these are commodities that can be cut off if they are not paid for, and the companies that provide them can arrange for payment of arrears directly from benefits, or install pre-payment meters. Nobody does this from outside the household for food; people can cut themselves off, when they reduce their living costs by cutting down on the money they spend on food, and going without.
- **Physical Access**, which refers to the range or the quality of the food commodities available in shops which people can actually reach when travelling by foot or by public transport, or by car if they have access to one. The first speaker (John Ashton) said there were no 'food deserts' in London, but that isn't entirely true; there

are areas in central London, where many poor people live, that have very few decent shops, but I do agree that on the whole this is not thought of as a London problem.

- Food must be necessary or **appropriate** for a healthy life. By appropriate, I do not necessarily just mean that it has to meet established guidelines as to what constitutes a healthy life but must also be both socially and culturally appropriate. It also needs to be safe. There is a large amount of anecdotal evidence indicating that poorer people are much more likely to have to eat, or to have to settle for access to, food that is contaminated or unsafe in many ways, but that has not been documented as far as I know. Food safety monitoring does not look at the socio-economic levels of the people who eat the food, but it is always presented as a kind of homogenous problem.
- Access must also be **sustainable**, and moreover must be seen to be sustainable by the consumer. People should be free from anxieties and fears over being able to eat properly.

There has been very little research done to show what it is about a particular way of living or set of household circumstances that render some people vulnerable to having regularly to go without food, whereas others somehow seem to get by. There has been a lot of work done on this kind of approach in the 'South', in developing countries but not in Britain. There are other insights, however, from international work on food security which do have strong parallels in the UK in terms of intra-household differentials, i.e. who goes without food in the household (usually parents, particularly women, trying to protect their children) and who has responsibility for making a limited budget stretch.<sup>3</sup> Finally, I think that governments and agencies of both North and Southern hemispheres are increasingly interested in public perceptions and, to some extent, participation in the process of defining what food insecurity is like – or more, what food security would be like - and in generating and implementing solutions.

## Inequalities in food access

Now, we know that inequalities in health have been on the political agenda for some time, and that the role of food and diet is very heavily implicated. Time and time again it is brought to our attention that food access for people living in deprived areas, including many, but by no means all, of those who live in deprived or low-income households, is critical in determining food patterns and food intakes. We can see government interest and concern in a number of initiatives and reports. The Food Standards Agency is likely next year to commission a national survey of food conditions and diet in low-income households. The White Paper, 'Our Healthier Nation'<sup>4</sup> and the Acheson enquiry into improving inequalities of health<sup>5</sup> recommended policies to increase the availability and accessibility of food stuffs to supply an average person with an affordable diet, and maintained that a firm development of policies will ensure adequate retail provision of foods for those who are disadvantaged.

The Social Exclusion Unit, under the national strategy of Neighbourhood Renewal, set up 18 cross-cutting Policy Action Teams (PAT) of which number 13, co-ordinated by the Department of Health itself, was committed to improving access to shops. Their report was published over a year ago, and outlined many of the major problems that retailers face in deprived areas: falling revenues, crime and the general struggle for small businesses. It also pointed out that key players in terms of the core provision of food stores in areas labelled 'deprived' often include many minority ethnic community retailers, discount providers and small grocery chains. I would argue, however, that the PAT 13

report largely avoided examining the role of large numbers of different types of food retailers. Instead most of the focus was on how to help the small local grocery chains and how to set up local Task Forces. The PAT 13 report still has a draft status and there is not much evidence of progress on many of its recommendations (a copy of the report can be obtained from the Department of Health website).

It is clear that the issue of food access is part of a wider set of issues, to do with area regeneration, planning, employment and consumer choices. Yet there is also no doubt that the major retailers, with their superstores, internet shopping and new high street 'local top-up' shops, dominate current retailing trends: over 80% of food is bought through them. They have to be part of solutions to current exclusion and inequalities. Food access issues need to be much more at the fore of regeneration and social exclusion issues.

## Local Food Projects

Many important policy responses to social exclusion and issues of poverty and inequality emerged in recent years and many have food implications. One important feature of these policies is that many do not look at structural barriers to improved food access, but focus instead on increased and improved community and voluntary participation. There is a great deal of enthusiasm for using community projects as policy instruments for improving food access. Indeed, there is great potential in local, community based food projects to achieve just that. As recent research shows<sup>6</sup>, food projects do provide powerful common ground for local people and professionals to work together, albeit in limited ways. The best of them succeed in achieving a wide variety of goals. The research was carried out on 25 different sorts of projects around the country, using document analysis, in-depth interviews and focus group discussions with volunteers and those who work in projects, and with those who use them as customers or members (of co-ops, 'cook and eat' or gardening clubs). The aim of the research was to identify how projects get off the ground, and what contributes to their sustainability and (self-defined) success.

Food projects are only part of the solution to reducing inequalities in health because they often work with quite small numbers of people, and are constantly evolving since they are usually running out of money. They can, however, contribute to quite marked changes in short-term indicators, such as people's skills and confidence in handling food, preparing it and trying out new things. Some projects have also influenced not only eating patterns but also food intake. This is often a hard thing to achieve even though these effects are set as target objectives by funding bodies and are often the targets stated in, say, Health Action Zone policies. What is also clear is that these projects give the people that are part of them, whether volunteers or customers, a strong sense of self-worth, wellbeing and control over their lives which for many had previously seemed an impossible dream.

## Funding & Community Involvement

A key finding of the research was that security of funding was usually vital to guaranteeing the success of food projects. A constant source of funding is important if people are to have the freedom to get on with the work, rather than perpetually trying to secure on-going funding. To some extent, start-up funding is easier to get (which is partly why projects often evolve and change, to obtain more running costs), but the follow-on funding is harder

to find. A second crucial element is community involvement and, to some extent, ownership. Projects that are 'parachuted in' by community based professionals, however hard working and well meaning, but which do not have good grounding and roots in what local people have identified as their wants and aims, tend to fail within a few months. Projects take a long time to set up and require a lot of time and effort from both volunteers and professionals, working together. Volunteers themselves often need support and training in particular skills (such as book-keeping), factors which are often overlooked. Local people have to be seen as equal partners with local professionals – 'part of the solution as well as part of the problem' - which is sometimes difficult to achieve given the structures of area- based initiatives.

## Cost of a Healthy Diet

I want to turn now to a fundamental issue: the costs of a healthy diet. Let's take the analogy of water. Water supply is a privatised public utility that ensures that good quality water reaches everybody's home. We don't at present solve problems of water access by putting a standpipe in an area where home supply is difficult, and expect people to collect their water in a bucket. Yet we seem to expect people to do this with food if they live in a deprived area, where establishing good quality shops does not seem economically viable. The main reason shops are not viable is because their customers don't have enough to spend. What people really need is more money. Box 1 shows the costs of meeting a very basic food budget, using low-cost foods, which meets current healthy eating guidelines, compiled at the end of December 1998 by the Family Budget Unit<sup>7</sup>, and also what families using the Saffron Lane Food and Health Project reckoned they regularly spent on food.

- **Family Budget Unit costings of money needed to meet healthy diet guidelines** (Sainsbury's prices, 1998)
    - one parent with 2 children (4, 10 yrs) needs £33.38/week for food; benefit shortfall in 2000 = £24
    - couple with 2 children (4, 10 yrs) need £59.16/week for food; benefit shortfall in 2000 = £32
  
  - **Families in Leicester at Saffron Food and Health Project spent** ~ £30-£35 a week to feed 4 - about £1.16 per person/day
- (Dobson and Kellard, (2000) Evaluation Saffron Food & Health Project, CRSP Loughborough University)

### Box 1 - Benefits shortfall

Changes to benefit levels and the minimum wage are not yet sufficient to make up the deficit between food prices and what people can actually afford. Moreover, the prices quoted are Sainsbury's prices that are about the lowest possible. Prices in local stores are likely to be higher.

# Poverty

Box 2 reminds us that 5 million households in Britain are still classified as being in extreme poverty by criteria used across Europe (below 50% average income after housing costs). This stresses the size of the problem that we are addressing, and as of yet, has not been vastly improved – indeed, inequality in household income has increased under the New Labour government's first term. Looking at the issues surrounding children, the government's aim is to end child poverty by 2019. Changes in taxes and benefits over the last two years have given extra money to families, largely through raising working families tax credit, raising child-benefit and child tax credit, as well as the promotion of paid-work through New Deal.

## Households below 50% average income after housing costs (figs 1997/8)

- 1 in 4 people (14 million) living in poverty
- 1 in 3 children (4.4 million) lives in poverty
- 62% lone parent households (2.8 million)
- 23% couples with children (4.7 million)
- 34% of poverty population are couples with children; 20% are lone parents in 1999 almost 8 million people depended on Income Support

### Box 2 - The extent of extreme poverty in Britain

It is true that the levels of child poverty, as measured by 50% average household income, have decreased by a million. Mostly, however, these were not children in the poorest households, but the ones just below the income cut-off. What is more, these decreases in child poverty depend critically on maintaining low levels of unemployment. One of the most important points is for people to recognise that poverty and inequality are still real issues in Britain and that tax cuts as incentives to prosperity are not the answer to wealth creation for all.

I have mentioned that local shops often charge more for food than large supermarkets, because they cannot operate the same economies of scale in purchasing and wholesaling. The following table of food prices was collected by a group of women in Edinburgh and measures a 'basket' of some of the basic commodities in their local shops (box 3). This 'basket' is not necessarily sufficient to feed a family for a week, nor are these especially healthy or unhealthy; they were simply chosen because they are the basic items in everyone's shopping basket each week. The shops the women chose were the ones they could get to and usually used, although they did walk extensively around their area to see what variety of shops were accessible. The table shows the price variation between major chain supermarkets and local shops. The difference in price was up to £6 per week – not much for people in work, maybe, but a great deal if you only have about £25 a week to feed a family.

| Commodity  | Prices in pence |  |         |
|--|-----------------|--|---------|
|  | Average         | Cheapest   | Dearest |
| White Bread  | 43              | 23   | 76      |
| Teabags  | 67              | 30   | 119     |
| Baked Beans  | 28              | 9  | 37      |
| Potatoes   | 42              | 19   | 69      |
| Apples   | 50              | 15   | 85      |
| The <b>difference</b> in price for a 'basket' of basic goods was £6.13 |                 |  |         |
| <b>Cheapest</b> 'basket' was £7.89<br>(large supermarket)              |                 | most <b>expensive</b> 'basket' was £14.02<br>(local shops) |         |

Box 3 - Data collected by local women near Edinburgh in 1997 (comparing like with like)

Something which is often missed in discussions about food and money is that people living on benefits often face arrears, debt repayments and money being deducted at source. I carried out a survey about 8 years ago which showed that lone parents who were on income support, but had money taken off their benefits at source, or who had to pay for their gas and electricity through key meters (which often meant they were paying back arrears), had nutrient intakes that were half that of people, also on income support but who did not have any money deducted<sup>8</sup>. These are hard, hidden aspects to poverty – hidden to the general population, but only too real to those who face them, week in and week out.

## School Food

There have also been policies on school food over the last year or so. Problems have been encountered with tuck-shops, vending machines, as well as piloting schemes for fruit in schools. There has been some small amount of government funding for breakfasts in school with volunteers to help out. Policy initiatives to improve food in schools to help children from families on income support are often varied. Free-school meals (for those whose parents claim Income Support) might be a child's main meal of the day, and the quality can be very variable. Twenty percent of children in Britain are eligible for free-school meals but many do not claim those meals because of the stigma attached to it and the fact that they don't like the food provided. Approximately a million children that are from poor families are not even eligible for these free-school meals because of the way entitlement works (e.g. those whose families claim Working Family Tax Credit are not entitled to them). A small amount of funding has been allocated to the Child Poverty Action Group to maximise the take-up of free school meals and there has been a campaign to promote them.

It isn't only young children about whom we should worry over school food. The chart below depicts a 'food mood diagram' from a young teenager, taking part in a participatory exercise in Leicester, who expresses distinct dislike for school dinners (fig.1). This reflects one of the major problems that we are facing and shows that current policy initiatives are not achieving enough.

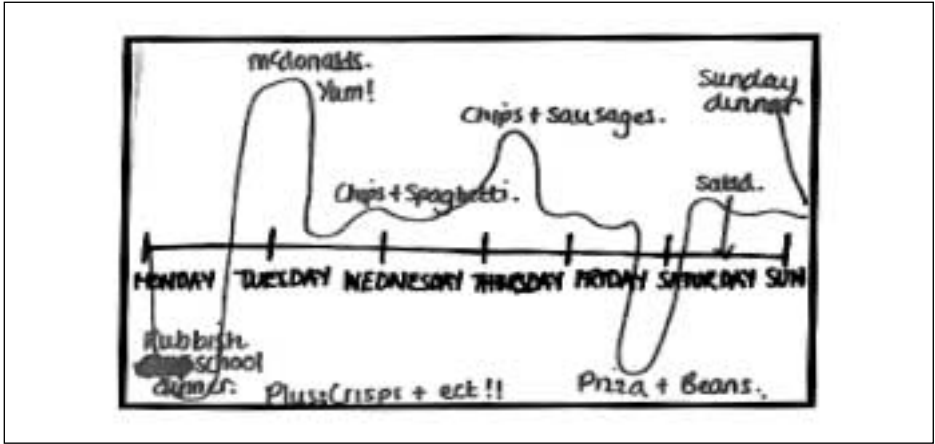


Fig 1 - Young Teenager's Week 'Food and Mood' chart taken from: 'Nosh and Dosh', 2000, Mendez et al, Leicester Community Health Project, Sustain, Oxfam

Local shops in deprived areas can be extremely run-down and poorly stocked which is demoralising both for the customers and for the retailers themselves. As a result, children are often disappointed with the food they can eat at home and are forced to grow up in a food culture that is monotonous and less likely to be healthy. We have been attempting to find solutions to this through measuring and mapping access to food at a local level<sup>9</sup>.

## Food Access - Whose Responsibility?<sup>10</sup>

I will close with a summary of the New Policy Institute briefing on food access held last April<sup>1</sup>. The briefing calls for better problem definition at local, regional and national levels; improved policy options; recognition of the importance of involving local communities; and the inclusion of major and smaller retailers, as well as retailers of local ethnic minority communities. At present the planning process seems only to address commercial considerations of retail provision. We thought this might become a responsibility of the Food Standards Agency through a collaboration with devolved territories and the National Food Standards Agency. There should be more resources for defining the evidence base for action and for monitoring policies and for co-ordination. In the Policy Action Team 13 (PAT 13) report<sup>11</sup> there was a call for setting up Local Task Forces. The New Policy Institute briefing calls again for the government to explore the potential for a New Deal for food. As the promotion of cross-departmental strategies reveals, food access is not just the responsibility of any one sector and we need much more guidance in promoting this approach.

Food security is also key. People should be free from fear and anxiety about being able to eat healthily, or even eat at all. I would argue that until recently households with low incomes have borne all the responsibility for solving food access problems. They have had no say as to how much money they can earn, or how much they can claim, or how much is deducted from their benefits at source. They have no say on what happens to local shops,

what prices they have to pay and how they can get to shops selling decent food at decent prices. This is changing, but slowly, and needs to change more rapidly. It is these people on low-incomes that have to manage and budget and make the best they could out of these extreme circumstances and the consequences for health and wellbeing have been widely documented. The answer is not to tell them to behave better.

Food is of course a matter of private choice and consumption but maybe in Britain it should be formally recognised as a basic entitlement. People should be free to eat what they want but given their incomes, many people, about 20% of the population, have very little choice. They do not participate in the dynamic, leading sector of society. I think that a statutory entitlement to food is needed, which must be recognised by national and local government. There ought to be a local obligation to implement this for everyone. This statutory obligation would permit a flexible response and private-public sector partnerships, which we need in order to enable people at the lowest levels to obtain and eat sufficient and appropriate food for health, now and in the future.

## Discussion

### **Anne Gorton, Liverpool Communities Against Poverty**

When people are on low-incomes and they buy meat at the correct weight to feed their families, they find that it is 50% water. People are making a lot of money out of it. There are no family restaurants or cafes for families on low incomes in the Liverpool area apart from greasy-spoon establishments. In terms of healthy food, we are importing poor quality foods like bread-crumbs. Also if we are promoting the slogan of 'Education education, education', we should have decent school meals for everyone at affordable prices and children should be learning to cook in school and learning about healthy diets. Why are we putting other systems in place when it could begin at school with education?

### **Mike Fox, Liverpool Communities Against Poverty**

I am a single male adult of 45 years of age and nothing has been mentioned about single people, of any gender. I cannot afford to cook with more than two items of food because this is all I can afford. There should be meals that can be prepared for one individual.

### **Elizabeth Dowler**

I absolutely agree with you. The figures I had up on the board were taken from the Department of Social Security reports and I mentioned that the Food Standards Agency is planning its national survey. I have been involved in some of the piloting for this. This is exactly the type of thing we have been pointing out. The point you have made is very powerful and vital, and I think there is probably going to be more evidence to support the anecdotal observations that people living on their own on low incomes are also badly off, and perhaps that men are worse off than women.

### **Frank Kennedy, Regional Co-ordinator, Friends of the Earth**

I cannot argue with research that states that supermarket prices are cheaper than local shop prices, but I think it should be noted that large supermarkets bully farmers, increase poverty, pollute communities, drive dangerous vans into communities and pollute the food they sell on the shelves. Supermarket domination of food is one of the major problems we have to address in this country, including the issue of imports and exports. We need to blow open that myth and the challenge is to do it without basing government prices on the supermarkets to allow a more level playing field.

## Elizabeth Dowler

I absolutely agree with your point. My point was that if we are looking at how much it costs people to eat properly then we have to include these data, showing how much more expensive local shops are. We need a wider discussion over why that is and what can be done to support local shopping economies.

## Liam Egerton, Foundation for Local Food Initiatives, Bristol

I'd like to address the point about supermarket dominance and the ideas about a partnership system. There are some very straightforward practical solutions to some of these problems. In terms of food access, security and sustainability the same issues apply to farmers and food growers. They need a secure, reliable and sustainable access to consumers. The whole issue around local food links will create a system whereby producers have direct access to consumers. In this way we will avoid the exploitation of farmers and consumers by large supermarkets that buy cheap and hike up prices. Local food directories are simple solutions that are rapidly becoming more widespread around the country. They are a way for local producers to identify themselves with local consumers. This is a cheap and simple link.

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# Making it Happen - 1

## Local Solutions - Community Nutrition Assistants

### Julie Holt, Community Healthcare Bolton (NHS) Trust

My colleagues and I are community dietitians and we work in a dietetic department of a community health trust. Our dietetic department had previously operated along the lines of traditional departments in terms of nutrition education: people were told what to do and it is assumed they do it. About ten years ago, we came to the understanding that this was ineffective. My colleagues undertook a qualitative research study of local people to identify what the local needs were, through focus groups and discussions with local people. As a result of this, they produced a report, called 'Just Desserts?'<sup>1</sup> which was about making changes. From this they decided that they needed to evolve the way they worked and to become Nutrition Facilitators rather than traditional Nutrition Educators. At that point they changed their title to Food & Health Advisors.

## Community Development

As Food & Health Advisors (FHAs) and Nutrition Facilitators, they found that they could work with people more effectively to enable positive behaviour changes. It felt more satisfying to work on a community development approach with people and they felt that they worked in a more empathic way with local people. However, they realised that there were still problems: the approach was time-consuming and there were still barriers between them as professionals and local people. Therefore, the idea evolved that we should be using more local people in a system based on overseas models, that trained local people as food workers. At that time community nutrition assistants and food workers were a new initiative. The right atmosphere to enable such a project was not in place and we had to push very hard to get our ideas accepted and in progress. The Community Nutrition Assistants (CNAs) were developed to work with all kinds of people, both individuals and groups, but particularly those on a low income. It was hoped that they would achieve objectives in a practical way and overcome barriers regarding health issues.

## Accreditation

Funding was finally achieved in 1994 for a two-year feasibility study. This was awarded to run the training course for Community Nutrition Assistants, who were local people, and also to employ support for the department in order to do this. The money was also used to conduct a full independent evaluation by an external evaluator. The training course was set up in conjunction with community education colleagues and community development colleagues. Over a ten-week period this included a wide range of topics, looking at the needs of the community, community development principles, communication skills, and working with people. We also had specific topics on food and nutrition issues and on defining the roles of community nutrition assistants, dieticians and other staff.

Part of the course was set up to enable accreditation through the Open College of the North West, so that the CNAs could achieve a qualification and from an employer's perspective it showed that they had attained a standard of skill and knowledge. This accreditation included a period of work experience.

## **Paid Appointments**

We appointed our CNAs through advertising in local newspapers, through posters, and through word of mouth using our community education colleagues. Seventeen people applied, all of whom met the criteria for the post. All were invited for interview, 15 came to interview and 12 were offered the post. Two people dropped out of the training course and so 10 completed and were accredited. This was in October 1995.

Following the training, the CNAs were contracted to work for 5 to 6 hours a week for 6 months and they were paid £15 a week. We wanted them to be paid rather than them work as volunteers, but we did not want their benefits affected. (We might do things differently now if we were to run the course again.) After they had finished the training and had six months experience, they were upgraded and their hours were also increased.

Since then we have had to reapply for funding because this was originally a short-term project, which links back to previously mentioned issues around insecure funding. From April 1998 until March this year, funding has been awarded jointly through Community Health Care Bolton, which is our trust, and the local authority, Bolton Metro. The CNAs have been upgraded and we have been informed that this funding will carry on until next March. Next March we will have to go through the process once again to secure further funding.

We are at a point now where we want to expand and include more CNAs. We recognise that there are issues over the level that they are paid and what their starting salaries should be. This is one of the difficulties of evolving systems because there was no prior experience as to what kind of career paths CNAs might take. We are now intending to start CNAs as trainees and after successfully completing the training they will be upgraded. The existing CNAs that work for us have expressed a desire to buddy, mentor and support any new CNAs that we appoint. If they take on this role then their responsibilities will increase and their pay will be upgraded.

## **Evaluation**

The evaluation of the project was done by the University of Liverpool who looked at aspects such as the steering group which was set up to support the project. They also looked at the recruitment process, the training programme and the effects of the work done by the CNAs, both on themselves and on existing services. Some of the results identified that the CNAs not only developed skills in working with people, but they also developed increased confidence and self-esteem. The research was produced into a report which identified that 54% of the people studied reported eating differently and shopping differently, and 42% reported cooking differently after having contact with the CNA. 66% of those studied stated that they preferred a local, trained person to a health professional. People often explained that the reason for this was because the CNAs do not tell people what to do, but work with people to find practical ways of addressing problems that people encounter in their own personal and local circumstances.

We have recognised that other positive aspects of the study have not been mentioned, including some of the advantages that Dr. Elizabeth Dowler raised, in terms of increased self-esteem and confidence, group participation and the local community's interest in health and food issues. The CNAs have developed quite a lot of this but these elements have not really been captured in some of the results. This is where we want to focus some of our evaluation in the future.

## Practical Help

At present we have retained four of the original CNAs, who now work on average between 11 and 16 hours a week. They also do additional hours depending on whether they become involved in specific projects. They always meet up with a group of people before they try to offer any kind of advice and they tailor the work they do to the needs of those people. It is always in terms of what people want, rather than the CNAs telling people what to do. They might carry out cooking sessions, or develop new resources, take groups of people shopping, work with food games, or encourage food allotments and growing schemes. They work with a wide range of people from young carers and teenage mums to centres for homeless people and hostels for young people. Until now they have been working in a broad area but have now recognised the need to focus more on certain areas. This is something that we will consider when developing future projects.

As a result of the project, concerns over family food access have led some groups in Bolton to develop their own food co-operatives, community cafés and community gardens. There has been a wide range of community initiatives that the CNAs have been involved with. The Food and Health Advisors now spend less time in direct contact with individuals and groups than previously. Most of our work is now involved with supporting, training and mentoring the CNAs, as well as with specialised work, particular projects and policy decisions. The CNAs themselves have become more experienced in their work and they are keen to share that with others, and we are hoping to recruit and train other CNAs to develop the scope of the initiative.

## Future Development

With a view to future development, we want our CNAs to be seen as a core part of our services in Bolton so we have to find ways of obtaining secure funding. We have already had a lot of support from various people, including our public health authority. We are also keen to secure the CNAs a base in Bolton because to date they have not had their own permanent base, which is accessible with user-friendly facilities. We are developing a bid for Sure Start funding and some of the CNAs will be working with families on Sure Start initiatives. We have also applied for funding to develop a project working with ethnic minorities, particularly Asian people, because we recognise that this is an area where we are not doing as much as we should be doing. We also want to start work with men and with young people.

## NHS Beacon

Outside Bolton there has been a lot of interest in our Community Nutrition Assistants programme and we receive many calls from people interested in setting up similar initiatives, who want our advice and support. We are keen to support other departments wanting to set up similar programmes. We applied for and were awarded Beacon status as part of the NHS Beacon Programme, which has given us a certain amount of money to promote our programme in Bolton and to support other organisations wanting to do something similar. We do this through visiting other departments, hosting open-days, setting up a website and publishing our information in the Beacon handbook. We do spend a lot of time advising people on how to set up their own programmes and we have documents available, detailing how we set up our programme. We are very keen to develop our programme, improve

and evaluate our service, and look forward to hearing any ideas that people might have in relation to this. We are hoping to set up a network of people doing similar projects so that we can share ideas and experiences and overcome some of the problems that we have encountered.

## **Discussion**

### **Anne Gorton, Communities Against Poverty**

I'm at a loss as to understand the difference between the FHAs and the CNAs. It seems that one has a salary and the other doesn't.

### **Julie Holt**

They both have salaries. The Food & Health Advisors are the new name for Community Dietitians; this was changed because the name Community Dietitians has such negative connotations. The FHAs are State Registered Dietitians. The Community Nutrition Assistants are local people who have been trained on food and health issues to discuss with local people issues of general healthy eating and practical ways of achieving a healthy diet. They are both employed by the Community Trust but one has a professional qualification, for want of a better word, and one is a local person, seen as more approachable and accessible by members of the local community.

### **Anne Gorton, Communities Against Poverty**

I don't think that the CNAs are really valued. They have training and qualifications but the community does not value this.

### **Julie Holt**

I agree with you. One of the difficulties that we have is that we have to continually apply for short-term funding. It is one of the things that we are quite concerned about and the CNAs themselves are also concerned because they see other people working for other organisations doing community development work for higher salaries. This isn't something that we are happy with. We want to raise the profile of the CNAs and we are pushing this as best we can. We value the CNAs enormously and so do the local people in Bolton.

### **Anne Gorton, Communities Against Poverty**

You say that they work in the same role as volunteers, but are paid. Do they get their expenses paid?

### **Julie Holt**

They get their travel expenses paid. They are paid employees of our Trust. They are not volunteers.

### **Community Food Worker, Halton General Hospital, Widnes**

I agree with what the lady before me said about how the CNAs' pay should be revised. Some of the work we do, although we don't have the knowledge of the community development workers, is actually doing community development work which is in addition to our own work. So when we go out into the community and talk to groups, we have to deal with the issues that lie within the scope of community development workers.

### **Judith Varley, Liverpool University**

I am interested in taking up the point mentioned about contaminated land, including allotment sites. I wonder if local authorities shouldn't have a statutory duty to assess allotment sites, particularly thinking in terms of last summer's publicity about the incinerator at Vikekirk, which distributed the waste-products of its fire over the land of nearby allotment sites, and contaminated them with carcinogenic dioxins. Could responsibility for this be transferred to local authorities?

### **David Rex**

Local Authorities don't have a duty to test existing allotment sites but it is a good point. The question would then be, although this is not necessarily a reason not to do it, what would they then actually do about the allotment sites. Would they close the allotment sites down?

### **Amanda Richardson, Senior Environmental Policy Officer, Oldham Metropolitan Borough Council**

Legislation was actually passed at the end of 1999 with regard to contaminated land, stating that authorities had to keep a contaminated land register and this could be done by the local authority. In Oldham we have employed an officer specifically to compile a register of contaminated land, which involves conducting a borough-wide search and testing. If you wanted to proceed with an urban growing project and you wanted to test the land, I would probably advise that you call the local borough council first and ask for someone in planning or technical services or some kind of environmental protection section as a first port of call.

### **John Ashton**

Some of the issues made about work with ethnic minority groups in this area, and issues about high-added value are very interesting. Some years ago in Toronto, migrants from the Caribbean had been particularly active in growing vegetables that they had consumed at home but which were not readily available in Canada. These also tend to be the kind of vegetables that are more expensive. This links the two things. It links dietary considerations in connection with where people have come from and the issue of high added-value foods. I wonder whether it would be useful to have an initiative called something like 'Growing Solutions', where needs for exotic foods are identified and where local growers might be able to help. Another example of this is the Yemeni community in Liverpool who have a demand for goat meat, which can be difficult to obtain. I have been trying to interest a local farmer in rearing goats. Maybe we need to operate a match-making process. Another point which might be worth consideration is the capacity for people to grow food in their own gardens. Again, an example in Liverpool was when the Aldonians developed their own housing co-ops. As they moved out of houses that did not have gardens into ones that did, a high proportion of people were keen to start growing food in their own gardens and to understand issues around land contamination. The housing association involved did employ a community development worker to help people get to grips with gardening for the first time. After the war, my father grew radishes, tomatoes and other vegetables in his own garden, which he could never have afforded if he had been restricted to buying them from shops. I think there is something in this that could be explored.

### **David Rex**

I think some urban growing projects addressed the potential of growing in back gardens, and some housing associations have actively encouraged it.

## Audience Member

I'd just like to take up the point about ethnic foods. I was on a course yesterday with my Bangladeshi colleague who had taken with her a bag of vegetables imported from Bangladesh, and who wanted to show them in order to decide whether we could grow similar vegetables in this country. However, it came up that the Bangladeshi people have eaten potato leaves all their lives and we think they are poisonous. They will actually grow the potato plant for its leaves and throw away the actual potatoes because they can buy these cheaply, whereas they cannot buy the leaves cheaply. This just goes to show that we have a lot to learn from inter-cultural interaction over food and diet.

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## **Making it Happen - 2**

### **Local Solutions - Food Initiatives in Practice**

**David Rex, Food Policy Officer, Sandwell Health Authority**

#### **Sandwell Borough**

Sandwell is in the heart of the Black Country, which was at the centre of the industrial revolution. It is approximately five miles West of Birmingham, and is a very highly urbanised area with about 300,000 residents, boxed in by Dudley, Walsall, Birmingham and Wolverhampton. It has a strong industrial past and a significant industrial present. It could be categorised as having just enough industry left to cause considerable pollution and enough industry gone to cause considerable unemployment. According to a range of indicators, Sandwell was the twentieth most deprived borough in England in 1981. Now it is the seventh most deprived borough, so it is continuing in the same direction as all industrial areas. According to data collected two years ago, more than half the households earn less than £10,000 per year so it is a borough that has significant and relatively consistent deprivation, rather than pockets of extreme poverty and extreme affluence. At the same time at least a third of the borough has a household income of less than £5500 per year. More up to date information shows that 36% of households do not have a car and this is reasonably accurate since it is based on a survey rather than census data. (If we look back at the 1991 census, the number of households who do not have a car is higher than this in some areas.) Therefore, instead of having small pockets of almost destitute people, there are large sections of the population within the borough where almost everyone living in a particular area will be on low-incomes and without a car.

#### **Food Access**

Access to healthy food was highlighted as a public health issue in John Middleton's annual public health report as long ago as 1989<sup>1</sup>. Policy at that time related to inequalities of knowledge, of attitude and in what people ate, but not necessarily what might cause that. Instead it was thought that people ate poorly because they were either just stupid or feckless. At that time the Sandwell solution was to establish food projects which addressed food security and food access. The Sandwell Health Authority view at that time was therefore running against government policy. There is more consistency now. In 1995 the Sandwell Food Co-operative began in Tipton in the North West of the borough. By 1996 a Food Policy Advisor had been appointed and she developed some food and health policies in conjunction with a whole range of partners. These policies applied to different sectors of the population, for example older people, pregnancy, lactation and pre-conception, hospitals and school-age children. We have had those policies in place for some time but obviously implementing them is a different thing.

## Urban Growing Spaces

In 1998 Sandwell Urban Growing Spaces was created, SLUGS for short. The key principles of this food project was to look at how we could use food growing:

- to develop community networks;
- to regenerate the urban environment;
- to improve both the mental and physical health of the people involved in growing and consuming the food.

Some of the problems we encountered included the contamination of land and the level of skill required to actually test contamination levels in the soil and interpret the results. Many of the sites were contaminated with some very harmful substances: lead, cadmium, and mercury at relatively high levels.

Another problem was the small scale of the project. Although it looked impressive in policy documents, the scale was small. This returns to previously mentioned issues around brownfield sites and economies of scale. The small-scale nature of urban growing does not really allow us to address food access in a structural way. We have to grow real added-value products on quite a small scale, and not staple foods like potatoes.

The important thing to remember is that in a lot of areas where food access is at its worst, the actual capacity of the community to solve its own problems without a support framework is quite limited. Expectations of community capacity building in this project were therefore unrealistic.

There were also many difficulties with partnership working, even though we are always hearing that partnership working is a good thing. Progress is very slow. Partners have very different ideas of what projects and initiatives are about. There are so many people with a powerful interest in a project like this in terms of environmental regeneration, economic regeneration, and physical and mental health improvement. There are so many partners who want to become involved that it can get pulled apart in the process. The project also suffered from problems in relation to short-term funding.

## Smoke Screen

It is possible that the project also acted as a kind of smoke screen. Although small-scale, the project led people to accept the work as a solution, without looking outwards to the broader picture and to the further work that needs to be done. It is important to recognise what the Urban Growing Project can and cannot provide. It can provide an opportunity for people to become involved in food and to redress the value of food as an interactive, educational tool that communicates more effectively than say a poster or leaflet. Snack foods like chocolate and crisps are very heavily advertised and therefore highly valued by adults and children alike. Urban growing emphasises the value, not only of the healthier food itself, but also the process of growing it, which encourages people to take pride in the food they produce and to value it more than crisps and chocolate.

From our personal experience in Sandwell (because obviously these issues with our project are not necessarily transferable), we would suggest working with communities of interest rather than locality. This would ensure that people already have something in common, rather than using something as difficult as an urban growing project to yoke the community together. We have also found that it is useful to get charity-status and the project has only just re-modelled itself so that it can apply for charitable funding. Due to the fact that the project has so many interested partners, it is starting to receive money in order to pursue areas of interest.

## Land Contamination

When considering land for urban food growing it is obviously important to test for land contamination at the outset. Most of the sites we are using are disused allotments which raises questions over whether there are any testing procedures for allotments. Moreover, it raises questions over what food is grown on these allotments. If allotment land is tested then what measures should be taken? There are many difficult issues to take into account. Some of the land had not been used for industrial activity for many decades but is still heavily contaminated. Of course, not all land has these problems, but contamination testing is an important issue.

## Healthy Catering

In Sandwell it has been decided that one large-scale project should be developed, where people can actually see the effects and where the effort can be concentrated along one direction.

The Health Education Authority's (HEA) 'Heartbeat Award' aimed to improve access to healthy food when people are eating away from home and to teach people that healthy food can actually taste good. Community dieticians became involved with this initiative to improve the standards of catering food in Sandwell. Problems arose, however, because implementation depended on the goodwill of dieticians and environmental health officers to accept this on top of their statutory duties. This meant that it was one of the first things to be cut in the face of other work pressures. It was therefore quite difficult to actually keep the project on going. Moreover, the HEA's award tended to act more as a social commentary, rather than as an agent for change. Due to the fact that the criteria were very objective and everybody could use them to assess what a particular catering outlet was selling, it was inevitable that wealthier and more middle-class areas would have more expensive, healthier choices on the menu. It therefore began to reflect a more socio-economic picture of the area rather than actually changing anything.

In order to move forward with this approach we have appointed a Healthy Catering Project Officer with a background in the catering sector. She has developed the Five for Life award scheme and because she has been able to dedicate more time to the project, she has been able to measure improvement over time. We have managed to bring yet more partners into this which has proved useful in incorporating the principles of Local Agenda 21 and environmental sustainability. These are new elements that were not previously part of the award. We are still, however, committed to the original objectives: food safety, nutrition, and customer information.

## Sandwell Food Co-operative

Initially, the Sandwell food co-operative seemed a good idea and it still is in many ways; people were asked if they wanted improved access to fruit and vegetables. Whether they wanted a food co-op was a different matter. It did, however, offer an opportunity for people to take control over their own food supply with some support from the health authority and it did provide an opportunity for community capacity building. The sustainability problems with this were similar to those encountered with the Urban Growing Spaces:

- the scale was small;
- it could act as a smoke screen;
- there was low demand because people were used to shopping elsewhere or doing without;
- often people want high quality shops like everyone else which offer a service, rather than a voluntary work scheme;
- there were accusations of unfair competition from small, local retailers.

One way forward was for the co-operative to sell items other than fruit and vegetables, including heavy household items, as well as running it as a service and piloting home deliveries. We also looked at establishing partnerships with retailers.

## Advisory Board

We now have a Sandwell Food Policy Advisory Board, which has been established to address some of the issues at a policy level, as well as at the project level. We also have a food access mapping project, building on work that Dr. Elizabeth Dowler and colleagues have done elsewhere<sup>2,3,4</sup>. We will be doing a lot of qualitative research into retailers' experiences of the current situation. We are, as mentioned previously, one of the Five-A-Day Pilot sites for the Department of Health, with the chance to bring food policy and food education together.

## The Future

One of the practical lessons that we have learned is that if we are passing on health messages through the voluntary and community sectors, we cannot assume that these messages will be understood, unless people are given a lot of support and training. Health partners need to carefully evaluate community food projects. This has not necessarily happened in the past. We do need to stimulate supply and demand simultaneously, which is quite difficult. The major strategic lesson we learned was that we need to take needs assessments seriously and not assume we know what the solutions are. We should try and help communities to make policies, rather than expecting them to implement all the time without support. We should not expect communities to do all the work.

Good community food projects should make a lot of noise; they should not just be implementing, but lobbying for policy changes to support them. In terms of deciding on priorities, we need to avoid including too many or too few partners because we do not want to get pulled in too many different directions. However, there are many benefits to partnership working.

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# Community Mapping – How Participatory Appraisal methods can be used to engage large and diverse groups of people

**Clare Allison, Community Mapping Officer, SUSTAIN & Steve Robson, Community Development Worker, Barrow in Furness, Cumbria**

Food poverty happens as a result of a whole range of factors, from not having enough money, to problems with accessing good quality, affordable food, as well as transport problems to and from shops, children pestering their parents for what they want, and people just not having the right information or the right kind of equipment to cook. We feel that it is essential to understand local people's perceptions and opinions in order to be able to develop appropriate solutions to the problems that they face.

The Participatory Appraisal and Community Mapping Project is run by SUSTAIN, the Alliance for Better Food and Farming, which is a public interest organisation comprised of 100 different groups. I work in the food poverty section, which works on both a local and national level to get people involved in the policy-making and decision processes that affect their lives. This allows all people, right through to those on low-income, to have a say. This Participatory Appraisal and Community Mapping Project is also being run in conjunction with Development Focus, a consultant scheme based in Brighton dealing with exclusion and poverty issues, both in the UK and overseas in developing countries.

The Department of Health funds our Community Mapping project. It was set up about a year and a half ago to run a pilot project and to look at food poverty issues in specific locations in Britain. We looked at Brighton, Leicester and Coventry. Although it had previously been used to a much greater extent overseas, we introduced Participatory Appraisal (PA) tools into the UK context in order to look at food poverty in these communities, particularly where social exclusion was quite high. The pilots revealed that local people found PA a very engaging way of analysing their situations. It produced new information on food poverty in those three areas, as well supporting the current understanding that local workers had on the issues. As a result of the process each of the areas was credited with an action plan that they could then take forward and implement. We have now secured funding for a further year and are working in 5 areas: Islington, South Derbyshire, Wakefield, as well as Rochdale and Barrow in Furness in the North West region.

## Overseas Techniques

Participatory Appraisal was developed overseas to give people, traditionally left out of the decision-making process that affected their lives, a say in what was happening. Originally it was called Participatory Rural Appraisal because much of it happened in villages. The root belief of this programme is that local people are the experts in their own lives and their own circumstance, and therefore the starting point for change must come from them and their knowledge. Participatory Appraisal is non-extractive, empowering, engaging and seeks out the excluded. It embraces diversity and it leads to action.

## Local Issues

It is non-extractive and empowering because it is not about professionals coming into a community to mine information and take it away to create a report that is perhaps never seen by the community. Instead, local residents and workers are trained and supported to go out and collect information in the community. The work is compiled within that community setting and remains in the everyday language of the community.

Initially the work asks very broad questions and does not set its own agenda. We might start with a question like the one used in Barrow-in-Furness: "how important is food to you?." This was a huge question that provoked a lot of different issues. Similar starting questions might be about transport or children. From these very large questions, people start to indicate what some of their issues are. Then we start to ask more detailed questions and let them lead the agenda. Eventually, we reach solutions and action plans which are directed by the local people themselves. The programme also avoids forcing people to pigeon-hole themselves by agreeing or disagreeing with different issues. It is concerned with encouraging people to explore their situation and consider what they want to achieve.

## Visual Tools

Some of the tools we use in PA include pie-charts so that people can look at their own expenditure, 'Matrix' which is a tool to look at different types of food and the reasons that you might buy them, a 'Problem Wall' and a 'Solution Tree'. We use many different visual tools. These tools break down barriers caused by language or illiteracy and build up people's confidence so that they do not feel afraid to participate.

## Whole Communities

Rather than expecting people to respond to leaflets, meetings or fill in formulaic questionnaires where responses can be constricted, our team members try to get everyone in the community involved. They create a grid of all the different people in their community in terms of age, ethnicity and gender. Within these groups they then identify other groups such as homeless people, single parents and people who are unemployed. They then try to identify where people in these groups meet to allow a wide range of different voices to be heard within the community. They go to places where people gather, such as schools, pubs, working men's clubs or the market, travelling to where people are, rather than expecting people to come to them. Some people, of course, are not part of these groups, so street-workers try to make contact with people who are not very active in community life. Door-to-door work is also conducted to contact people who are perhaps housebound or isolated. It is very important to give as many different people as possible within the community an opportunity to become involved.

## Diversity

A report on the work done in Leicester<sup>1</sup> emphasises the importance of embracing diversity. It is very rare for there to be a consensus in community life. People are unlikely to all agree on something. This kind of work gives people

the opportunity to look at and explore all the different elements of an issue, so it will reflect a consensus if there is one, but it also welcomes diversity. It allows people to see all the different options surrounding an issue. We speak to all the various stakeholders; in Leicester, teams spoke to consumers and small retailers. We then try to build appropriate solutions and reach an agreement amongst everyone, rather than sidelining some opinions in favour of the majority. Everybody's views are important.

## Local Solutions

Local people direct the focus on issues arising from the broad question that we start off with. This sometimes means that discussions or solutions can take quite a personal note. For example, this might be suggesting that people eat as a family rather than individually whilst watching the television. Some solutions affect the community, for example setting up a crèche and bus service so that women can go to the supermarket, safe in the knowledge that their children are being looked after. Some solutions have much wider implications, for example the effects of advertising on children. We therefore effect a wide range of different changes, as well as a wide range of different methods for achieving change, including low, medium and high-cost solutions. People often know what is feasible and what is not, which makes it easier to reach appropriate solutions.

The solutions generated are area specific because each area has its own unique problems and questions that need answering. One of the important aspects about this work is that we can collect specific information about an area to make changes to specific communities, rather than trying to effect change through a blanket approach. The most important feature of this work is that it leads to action.

## Thorough Research

Often people assume that, because the programme works with visual material and people's opinions, the work is not rigorous. However, this is not the case. We have maps showing a key of involvement so that we can see who has participated. We conduct triangulation where we ask a wide diversity of people the same broad questions on the same broad issues. Used in conjunction with the key, this allows us to track which groups of people share particular opinions. We also carry out verification, whereby we go back out to the community, having already gathered the initial information and action plans, and ask people to verify whether they agree, or whether we have missed or misinterpreted anything.

In order to make sure that the action plans are actually effective, we have reference group meetings. In these meetings we gather together anyone who has had any input: community people, Sure Start people, school caterers, planners, and transport and SRB professionals. We get the community to feed back the proposals they have made and ask potential funding bodies to make a commitment to the findings and plans for action.

The most important aspect of the project is that it emphasises participation, action and ownership at all stages, for all of the people involved in the process.

# Steve Robson, Community Development Worker, Barrow in Furness

## ‘Take Part’

I am a community development worker in Barrow in Furness, Cumbria. Our Community Mapping project in Barrow is called ‘Take Part’, and we work in an area of Barrow called Hindpool, which is an electoral ward. We chose this area because it is high in the index of local deprivation. There was a new community post in that area and a higher level of activity, so it seemed like a good place to start. The team involved in ‘Take Part’ includes a diverse range of agencies and community members: people from the Barrow Students Health Programme and from Barrow Borough council workers, including people involved in housing, strategy and policy and Local Agenda 21. Health Promotion Workers also contribute, as well as community members who initially became involved through the WEA (Workers’ Education Association).

We started the community mapping in about November 2000 and collected information in a variety of ways. We have been out on the streets, outside schools and post offices, and worked with local community groups such as the ‘Twins Group’ and the Residents’ Housing Association. We have also carried out door-to-door work.

## Verifying the Issues

We have used a variety of different tools to address a variety of questions with different groups of people through a process of triangulation, and we have kept feeding the process back. We developed an initial question and then narrowed the questions down through working with local people. Over the coming months we hope to move onto the process of verification. We have four key themes that are arising and we are approaching the point where we can start to feedback results to the community. We hope to plan an open-day where people can come and see the information that we have gathered so far, so that we can refine the process and prioritise to facilitate further progress.

It is important to be aware of any gaps in the information collected and our mapping process reveals this. We are constantly aware that we have geographical gaps. The dots on our map represent where we have spoken to people. Some represent clusters. Orange dots represent males and green represents females. We keep our map up-dated all the time. The key enables us to pinpoint the age and gender of the people who offer comments on the issues at hand.

## Common Themes

The four themes that are emerging from our research are:

- **Cooking-skills.** People say that they lack confidence in their cooking skills and this affects what food they cook and eat.
- **Access** to cheap, good quality food. People say that it is very difficult to access good food when they are on benefits.

- The relationship between **food and health** problems. A number of people have commented on the fact that they have to be careful about what they eat because of heart problems, blood pressure and, very commonly, diabetes.
- Concern about **what children should and will eat**. There are issues about children not eating what their parents cook for them and about them eating too much junk food due to advertising pressure from places like Burger King and McDonalds.

We went to the market to find out what people thought about issues surrounding children and food. We asked the broad question: "what foods would you give your children to eat?" People identified with a series of twelve factors that might affect what they gave their children to eat, for example cooking skills or money. They would place a post-it note under the appropriate heading on a large sheet of paper on the wall with a comment on why this factor affects what their children eat. The next question was then about how people would change this and they would write another comment, giving a possible solution.

## Positive Progress

Although we are aware that we have not reached the stage where we are ready to implement action, there has already been a workshop on food poverty, organised by Barrow Sure Start and Barrow Health Promotion agency. They used some of the material that we had gathered on issues concerning children and food as the basis of the workshop, which proved very successful. Some positive action has come out of this workshop, such as a 'cook and eat session'. This is a fun, social activity where people can share ideas and experiment with exotic foods that they might not otherwise be able to afford to experiment with.

We always offer people the opportunity to give us feedback on what they think of the process. So far responses have always been positive. People think that it is easier, more fun, more relaxed and more interesting than a questionnaire or a survey. We are pleased with our progress to date. We can definitely see the value of the project and intend to use it again in the future.

## Clare Allison, Community Mapping Officer, SUSTAIN

### Community Mapping in Rochdale, Lancashire

There is also the Community Mapping project in Rochdale, which is actually focused on a very defined local community just outside Rochdale called Heywood. It has a very strong sense of community identity and is an ex-mining town. Heywood is a New Deal area and part of the area we are mapping is therefore under the New Deal initiative. Our team, as in Barrow, is very diverse and is comprised of school nurses, people working in consultation, community dieticians, local residents, and people involved in New Deal. It is important to have such a diverse group of people who can share knowledge and skills.

### Outcomes

It is very exciting that we will be able to implement action and there have already been some examples of action underway in some of the pilot areas. Examples include:

- a notice-board in a hairdresser's where people can get local information;
- lunches at summer schools where children have the opportunity to try exotic fruits that they do not normally have;
- child-care and a bus-ride provided by a local women's centre so that mums can go shopping;
- open-college accredited courses so that people can become involved in community capacity building projects.

In Brighton they have a new part-time community worker as a direct result of the Community Mapping work and think that they will get neighbourhood renewal money from doing this project, which will feed it into a local strategy. In Coventry, our work is feeding into the SRB funded work already in progress there. In Leicester they are beginning to employ Community Health Development workers through New Deal and Health Action Zone schemes, with the intention of using the report as a basis for their work over the next 3 years.

The project has two strands of success; everybody has found the process to be a new and useful way of getting changes to happen and of establishing a different way of consulting with the community. SUSTAIN will continue to evaluate the pilot areas, to check that action is happening, and to see if it was worthwhile in retrospect.

### Future Plans

We will continue our work in the current areas and evaluate how well the information we have learned is being implemented. The findings will feed into SUSTAIN's policy and lobbying work. Originally we did a lot of work on the style and the tools of Participatory Appraisal but now we are keen to feed the findings on food poverty into the current work that we are doing. We will also continue working with people at all levels of the community to make things happen.

## Discussion

### **Sarah Hausanen Roberts, Red Rose Forest, Manchester**

You mentioned that you were going into communities to train local people. Do you mean by this that local people will be part of the decision process or part of the local action groups?

### **Clare Allison**

Both. We try to get local people involved and sometimes they would rather participate in the field work rather than facilitate, where they cannot have any input in terms of their own agenda. We do try, however, to get local people and local workers involved where possible.

### **Sarah Hausanen Roberts, Red Rose Forest, Manchester**

What do you do about payment for these local people?

### **Clare Allison**

That is up to each of the individual areas.

### **Sarah Hausanen Roberts, Red Rose Forest, Manchester**

I am concerned about how we should communicate with ethnic minority communities. There seems to be a culture whereby we talk about improving food access or health inequalities and disseminate the information in leaflets, but we do not take into account that some people do not speak English as their first language. How do you communicate with groups of ethnic minority people in terms of getting them involved in consultation, taking their views on board, and communicating with them if they do not speak much English?

### **Clare Allison**

Interestingly enough, in our areas there is a majority white population and there are not many people of ethnic minority involved. The one exception to this is in Islington, which has a very diverse ethnic population. On this team, we have Turkish speakers who are bilingual, a Turkish interpreter and a Bengali woman. They go out to work with the groups to do the same type of work so that we can see specific issues for those communities.

### **Steven Robson**

In terms of Barrow, the population is 99.9% white, although there is a small Kosovan group in the area that we are working with.

### **Sarah Hausanen Roberts, Red Rose Forest, Manchester**

Do you tend to engage with one representative of that Kosovan community? This is what tends to happen in the area that I work in and I think it is quite difficult for that person to raise all the possible health issues of that community.

### **Steven Robson**

In Barrow we had a translator working with the group of Kosovans.

### **Clare Allison**

Again in Islington, the Turkish people go out to do street-work and just talk to Turkish people as they pass on the street. We do as much as we can to get everybody involved.

### **Mike Fox, Communities Against Poverty**

You have shown us a host of solutions but which was the overall solution?

### **Steven Robson**

We haven't got that far yet. It is not really about finding an overall solution but about finding a variety of solutions for a variety of problems.

### **John Ashton**

It sounds like you are making a very important contribution but we do have a problem with initiative overload. I notice that Barrow has the highest density of area-based initiatives of anywhere in the country and if you add up all the money, it is sufficient to give each household approximately £12,000. The methodology that you are using is clearly an applicable one. There is a danger that the same methodology will be employed over and over again by different groups. The challenge is to use the methodology itself to help to integrate all these other initiatives that are going on, which you mentioned towards the end of your talk. Has this been recognised as an issue and has there been some consideration of explicitly using the methodology as a generic methodology to stitch everything else together?

### **Steve Robson**

Certainly in the case of Barrow in Furness this is the intention and that is primarily why we became involved in the pilot. We were more interested in the methodology than the food issue. My company was interested in the possibility of applying the methodology to a whole range of regeneration developments. We have a record of some 30 agencies that have made some level of commitment to experiment with this methodology.

## **References**

- 1 Reaching the parts... Community mapping: Working together to tackle social exclusion and food poverty. (2000) Sustain, London

## Panel Discussion

### Moving Forward – Supporting and Sustaining Local Food Projects

#### **Sue Naylor, Health Promotions Specialist, Chorley and South Ribble NHS Trust**

I'd like to return to the issue of fruit in schools. It is a welcome initiative because it is a step forward in the sense of health promotion in some ways. However, I think we have to bear in mind the issue of 'joined-up' thinking that John Ashton raised earlier. We have had a variety of people talk about how to get food into local communities. My feeling is that the Department of Health, with its National School's Fruit Scheme, is looking at a large-scale scheme, when in my view we should be looking to implement the scheme on a more local level, involving local schools and green-grocers. I also noticed that the aims of the scheme are committed to creating awareness and I'd like to know what you mean by the term 'creating awareness'. I would argue that most people already know that it is good for them to eat fruit but what this does not address is the whole question of food access. You also talked about a base line survey or audit being done about levels of consumption and that at the end of the initiative you will repeat this. In my view this will achieve nothing. It is an outcome measure and instead we should be looking at all the other issues involved. It will act, as David Rex mentioned, as a smoke screen. It will be just a plaster over the wound.

#### **Audience Member 1**

Following on from that about not addressing issues of food access, I totally agree that there are problems with access to healthy food. I work in a very deprived area and in a lot of communities there isn't any healthy food in the shops. The area where I actually live is quite near a deprived estate and our local shops have a lot of reasonably priced fruit and vegetables, but because people are on very low incomes and have very stressful lives, they often choose to buy items that will relieve that stress, rather than fruit and vegetables.

#### **Danila Armstrong**

Firstly, I think that you are confusing the two initiatives. The base-line survey is being done on the Five-A-Day pilots which are separate one-year interventions. So there will be an original base-line survey of fruit consumption and then a repeat after the year's intervention.

In terms of the evaluation in the schools, the aim is not raise awareness but to actually give children a piece of fruit to eat since many children come to school not having eaten breakfast. The evaluations coming out of breakfast clubs are very positive. Teachers report improved attendance and concentration. The aim is not to raise awareness with children but with teachers and the communities and there is the other over-arching programme which will be implemented next year where we will working with industry over issues of food access. There are different levels. It wasn't about raising awareness with the children but about actually getting fruit to the children. In terms of the Department of Health's involvement, these projects are pilots and need departmental support before they can be implemented on a national level.

The Department is piloting the three different strands which address how we get the fruit to the school (whether it is feasible, whether the cost is prohibitive), whether the children will actually eat the fruit once we get it to the schools and whether eating fruit at school will displace eating it at other times. I think that it is unfair to say that the Department of Health is parachuting in.

**Sue Naylor, Health Promotions Specialist, Chorley and South Ribble NHS Trust**

I still think that the scheme raises lots of questions. If you are suggesting that children are going to school hungry, then it is not fruit that they need but something more substantial like a piece of toast or even a bacon sandwich to boost their calorific intake.

**Danila Armstrong**

There are a lot of issues and these issues will be addressed through the evaluation.

**John Ashton**

I think another point at the heart of this is that ministers like to have initiatives because it gives them visibility. We have to face the problem of trying to find ways of letting them have that, because it is a political reality, whilst seeking to make sure that these things make sense on the ground. So we need to help out the civil servants who are told to go away and set up something. If the scheme is going to be conducted on a large-scale, then I think it raises the issue of ownership. The notion of being parachuted in is in total contradiction to everything that we have been talking about today. Somehow we need to give ministers their visibility but at the same time we need practical suggestions from the field about how to implement the initiatives so that they are most effective. That is the challenge.

**Audience Member 2**

My question relates to alcohol. This city, like many others, is promoting the development of food 'joints', particularly 'fast food joints', and licensed bars. I am appalled to see the extent to which alcohol is now consumed and how this affects children. I live in Birkenhead and every night there are 7 and 8-year olds drunk on the streets of Birkenhead. This does not seem to have been addressed at all in today's conference and it is a real problem.

**John Ashton**

There will be an opportunity to address these issues because the alcohol strategy is due to come out this year, which will give us the opportunity to put the focus specifically on alcohol.

**Andy Dunleavy, Men's Health Project Manager, Health Promotion, Widnes**

A lot of the initiatives on food do generally seem to be aimed at women, obviously to ensure that children are well nourished. I wonder whether there is anything planned in policy to focus on men as well and to increase their involvement? Looking at the Participatory Appraisal project, there seems to have been many more women involved than men. I know that it is notoriously difficult to get men involved in community programmes, as has been shown in the past.

**Clare Allison**

This is why we have the key to our maps so that we can see clearly when we are not getting enough input from men.

**Anne-Marie Coufopoulos, Researcher, Liverpool Hope University College**

I'd like to return to the presentation on the statutory entitlement to food. I think that we need to think about a minimum income guarantee in this country. A lot of people don't have a minimum income guarantee, despite the fact that we have a minimum wage. Years ago we had a low-income task force that looked at low-income groups

and food intake, but they didn't address the problem of maintaining a healthy diet whilst living off benefits and I think we need to return to this. We need to look at benefit levels, not only at income support, but also working families tax credit and all the benefit levels in this country. We need to look at the cost of a healthy diet. Although we had one costed years ago which worked out as £10 per person, it wasn't actually socially acceptable. In some Scandinavian countries they consider both fixed and variable costs in terms of benefits and the fixed costs for food and heating guarantee levels for benefits.

### **Elizabeth Dowler**

I absolutely agree. Although I would add that the St Clare's Trust, run by Paul Nichol森 (who provided the money on the family budget and work), provide debt support. They do not cancel debts but accompany and support people who have to appear before magistrates. Debt is also a big issue as well as benefits with regard to food. Paul Nichol森 is also constantly lobbying parliament. He has a fantastic network amongst members of the House of Lords and, because he is a priest, he also has a good network amongst the clergy. He certainly believes in a fixed minimum benefit guarantee. He has supported many petitions for this before the House of Lords and the House of Commons.

### **John Ashton**

Elizabeth Dowler has referred to the work of Jeremy Morris and if you want to look this up it is in The Journal of Epidemiology and Community Health, December issue<sup>1</sup>. Jeremy Morris looked at how much money young adult males need to be above the poverty level and this methodology could be used for other groups and is very useful for doing the accountancy.

### **Anne Coufopoulos, Researcher from Liverpool Hope University College**

That research has already been done in terms of the lowest cost of acceptable food.

### **John Ashton**

It is in the Rowntree's edition but it hasn't been done for a while.

### **Elizabeth Dowler**

Firstly, they haven't done it for young men.

### **Nada Ali, African Women's Health Forum, Zion Health and Resource Centre, Manchester**

I would just like to address some points made by Elizabeth Dowler in relation to the ethnic and racial subtext of food access policies. Firstly, I do not think the issue of having access to ethnic and exotic foods for people who are not from that community is of utmost importance. Secondly, I would like to raise the issue of food access for some ethnic minorities, refugees and particularly for asylum seekers, who have to use food vouchers, which limit the choice of which foods they can buy and from where.

### **Elizabeth Dowler**

In the Latvian work that we did in London we had five ethnic groups and we gave them food baskets. We used the methodology established in London again in Sandwell and Birmingham. What I am going to say applies mainly to London and Sandwell. Black ethnic minority communities were better served than the poor white communities because there tended to be shops that catered for the needs of black ethnic minority groups where those people

were living. This is because the parts of London that we were working in and in Sandwell tended to encourage people to house together and the shops had grown up in that area as a result and were well patronised. I think an ethnic issue that is rarely talked about is the fact that poor whites are often overlooked in terms of retail provision. This is a difficult issue because although ethnic minority health issues are important, I do think that there is an issue with regard to poor white people. I agree that there are huge problems for asylum seekers. There has been some work done recently at University of Warwick, School of Hygiene on this issue. This was qualitative and participative work done with different refugee and asylum seeker groups, looking at the different problems encountered by each. The work does not offer any solutions but provides a comprehensive documentation of the issues involved.

### **Danila Armstrong**

With the Five-A-Day programme we are looking across the board in terms of low-income groups and ethnic minority groups. We will be looking at a whole range of people, so these issues are actually being considered by the Department of Health.

### **David Rex**

In Sandwell we are hoping to use some of the participatory methodology with asylum seekers to see how food and diet issues impact on their physical and mental health and how this can be used to lobby for more supportive measures. It also links to what we mentioned earlier about men's health. Originally we were approached to address the needs of asylum seekers because of concerns over significant numbers of single men who were asylum seekers, living alone and with very poor cooking skills. The issue was presented to us in terms of food vouchers, the problem of unfamiliar foods and the need for some action to improve cooking skills. As a result we want to take a step back and look at the whole issue of food and asylum seekers, using some of the Participatory Appraisal techniques that we talked about earlier.

### **Becki Chamberlain, Health Development Agency, West Midlands**

I was interested to ask both the Task Force and the speakers whether they had considered the benefits of co-ordinating the different existing projects, particularly looking at maximising the learning benefits from that and feeding that back into the overall structure and policy.

### **Julie Holt**

From our point of view, as one of the CNA (Community Nutrition Assistant) type projects, part of our role as a Beacon project is to identify other people around the country who want to set up similar projects with community food workers. Through this we hope to co-ordinate and network together to share ideas and offer support. Obviously this is something that we can do because we are a Beacon project and have the funds available, but it would require a lot of money to be able to co-ordinate many, different projects and I am not sure this would be entirely possible for everyone. It might be possible, however, for some projects.

### **John Ashton**

I think that one of the action points that we should take away from this conference is that we should establish a food and health network for the region.

## **Mike Eastwood**

One of the aims of the Task Force is to establish and pull together all of these initiatives across the region, to share good practice and give us a clearer idea of all the good work that is going on. It is only when we begin to do this, however, that we realise exactly how much good work is in progress and the need for this to be co-ordinated into a network.

## **Liam Egerton, Marketing Director, Foundation for Local Food Initiatives, Bristol**

The project that we are setting up at the moment is called FLAIR, the Food and Local Agriculture Information Resource, and it is actually taking over a directory of all the local food enterprises and projects around the country. We have run a national conference and are preparing an annual report on the local food sector, so in fact there is the start of a national network in place. I think that it is always important to try and link people into existing networks rather than starting up a host of new ones so we would be very interested to work with people and link them into our project.

## **Anne Gorton, Liverpool Community Against Poverty**

If people had decent incomes and lived in a decent environment there would be no need for all these different initiatives. An awful lot of money and a lot of careers are made out of poverty.

## **John Ashton**

This is a real dilemma. John McKnight<sup>2</sup> is a guru of community development working out in Chicago and he has showed that something like 70% of the money intended for poverty programmes finishes up paying professional salaries and goes straight through communities without touching the sides. The dilemma therefore in all these initiatives is how to ensure that people living in communities experiencing difficulties have access to the jobs involved in relieving those problems. This has been pertinent to the medical and healthcare professions for some time now; 70% of medical students are from professional backgrounds and we have enormous gaps in understanding and communication between doctors and patients. We need to recruit a much more representative cross-section of society into medical school. We should apply the same thinking not only to other healthcare professions but to a wide range of other professions as well. The problem is that we have been ill served by schools. Expectations in schools are low in areas that are having difficulties. We need to find a way of opening up access to professional careers for a greater range of people. We are about to import 300 healthcare professionals from Spain to work in the North West and instead we should be providing access routes for people in the community into the health service. This is something that is being addressed now through New Deal with a view to establishing a special New Deal initiative with the NHS. All the initiatives that we are talking about today need to take these issues on board. The Bolton scheme is good example for showing how people are beginning to take action on this. This point is probably the most important one that has been raised today and we need to think about it collectively.

## **Ruth Little, Community Development Worker, Breckfield Neighbourhood Council, Liverpool**

I think we are all aware of the importance of good quality shops and food access. Part of our area has been working for 12 months on a regeneration issue. We have been meeting local people with different focus groups to discuss issues around shopping in local high-streets, social facilities, transport and the environment. Part of the area is very run-down with no local shops and the evidence has shown over the past four years that the places where people shop depends on where they collect their benefits from. We have identified that the pattern of declining and

failing shops mirrored the extent to which people used, or stopped using, certain post-offices. We addressed the issues surrounding people's choice of retail outlets and the fact that if they could many would shop from supermarkets. We all know that this is the case but it is the way that we deal with this issue that matters. Another important factor was the frequency in which people ate in snack shops. We found that people were choosing to feed their children in snack shops after school rather than spending money on electricity at home to cook a meal. The question is how we address that. In terms of issues around swimming and exercise, local schools don't have access to local swimming pools and have to travel further afield. It was discovered that schools were spending over £1000 per term to take children swimming when the children would only get 20 minutes actually in the water.

### **David Rex**

We can use food to lobby for a minimum income guarantee, which is important. Alongside this, however, if we imagine a deprived estate, ripe for the input of regeneration money, increased incomes and benefits might mean that local shops or services may not be given any money to improve or become established, and local shops have a big impact on sustaining local economies.

### **John Ashton**

We have the rural and urban white papers and we will have the rural and urban strategies coming through. Much of the rural white paper has been addressing the loss of facilities in rural villages and the need to have a multi-purpose approach, for example a post-office that might organise community transport, or employing the school secretary to pay out benefits. The same logic could be applied to the urban setting. The key issue is to attain the critical mass to maintain the services and to trap the money in the community. We did some work a few years ago in Vauxhall, looking at how to keep money recycling within the community. One of the announcements I noticed in the budget was that people who were earning £5000 p.a. would stand to gain about £5000 from this budget. We need to have some accountancy around the size of the budget going into particular areas. We need to look at the flows of money and use this information to develop strategies of trapping it there, and that the goods, services and jobs are provided out of that community to that community. A lot of this has been done in Vauxhall over the past 10 or 15 years which has included providing residential care for the elderly when before this type of employment was given to people from more middle-class areas from outside of Vauxhall. We have to use budget schemes to address social administration questions about who is paying and who is benefiting at a more micro level which can then be fed into broader regeneration programmes and neighbourhood renewal.

### **Ruth Little, Community Development Worker, Breckfield Neighbourhood Council, Liverpool**

We are planning to provide a local financial service that will be linked in with development funds.

### **John Ashton**

We need the asset map. We need to look at people's skills, the opportunities for building community capacity and access routes for education. I have also noticed recently that community groups often do not have the facilities to handle their own accounts and what we need to establish is a public sector, common services support system. Perhaps the Primary Care Trusts could provide a finance function for the neighbourhood groups and be the budget holder or provide them with personnel support.

### **Frank Kennedy, Regional Campaign Co-ordinator, Friends of the Earth**

We need to convince the North West Regional Development Agency, who are responsible for the social regeneration of this region, that the main issues are: social justice, looking after people's health, taking care of the environment, and allowing local communities, particularly those that are socially excluded, to make decisions for themselves. We have to convince them that these issues are fundamental for a decent society and sustainable economy and that if we cannot convince them, then we must replace them.

### **Mike Fox, Communities Against Poverty**

I exist on a low-income and I know what foods are good for me. If I have the choice between an apple or a slice of chocolate cake then I will choose chocolate cake and that is my choice. This is not just a case of poverty status but a question of personal choice.

### **Audrey Oates, Co-Manager, Leaf Street Community Garden, Zion Health and Resource Centre, Manchester**

I helped to set up and manage a community garden in Hulme, Manchester, which is an incredibly deprived council estate. We had no encouragement from the local authorities whatsoever when we presented the idea to them, even though we are living in a food desert. We have to travel to a middle-class area, into the city centre or to a supermarket some distance away in order to buy fresh fruit and vegetables. In order to obtain our own piece of land within the council estate we had to conduct our own community consultation through the housing department. There was overwhelming evidence that the vast majority of the population of the estate wanted a community garden. We had no professional support and, despite the fact that most people were on very low-incomes, we managed to set up the garden using our own resourcefulness. We have planted apple and pear trees, vegetables and herbs. We only received a small bag of wood-chips and three packets of lettuce seeds from the local authority. This is a conference on food and health, and health has as much to do with what food you eat, as with the housing and environment that you live in. Local authorities should also pay attention to planning and provide green spaces. They should use the space in a way which best suits the inhabitants, There is very little point in devoting large amounts of space to car-parking facilities when very few people in the community actually own a car. Local authorities should have more contact with the health sector in order to use urban space to provide people with healthier places to live.

### **Mike Eastwood**

The Task Force has embraced people from a wide sector, which includes local authorities. Obviously we are only concentrating on the food issue and not the wider issues that you have raised but within the public health sector there has been consideration of all of those issues regarding regeneration.

### **Sarah Hausanen Roberts, Health Liaison Manager, Red Rose Forest, Manchester**

Red Rose Forest is a partnership between the six Manchester districts and we are trying to work with local authorities but it is generally a very slow process. This is a huge area and we are working with the local health authorities and the health sector and with other voluntary organisations.

### **Danila Armstrong**

I would just like to address the point made previously about personal choice. Our scheme is not about telling people what to eat. It is about providing the correct and accurate information and enabling access. However, at the end of the day it is a matter of personal choice.

## **Mike Eastwood**

When I was working with the previous government's Health of the Nation strategies, we were not allowed to mention the environment, housing, poverty or food and yet we were supposedly guiding the strategy for a healthier nation. At least we now have a more integrated approach.

## **Jeanette Longfield, SUSTAIN**

Although it is obvious that if we make poor people richer we will reduce health inequalities, it is a very difficult thing to achieve. Yet if we compare the nutrient quota of the richest and the poorest families there is almost no difference at all. Rich people just eat 'posh fat'. The real difference is in fruit and vegetables. There is also a lot of work to be done to encourage rich people to eat more healthily, not just in terms of the information that is available, but in the way that the food industry works and the suppliers.

## **Audience Member 4**

If you look at the different socio-economic groups there are huge differences in fruit consumption but not in vegetable consumption. This shows that it is not necessarily cooking skills or facilities that are at issue but cost, because people do perceive fruit as more expensive.

## **Mike Eastwood**

I think that the support and responses that we have had today show that there is a great deal of interest in food and health issues and in implementing action for improvement. I would also like to stress that it has been the NHS that has recognised the interdependence of food and health. Previously, say in Environmental Health, food has been considered in terms of hygiene but not in terms of the wider economic and social implications for health, and I think, as the conference has shown, that attitudes and initiatives are changing.

## **References**

- 1 J.N. Morris, A.J.M. Donkin, D. Wonderling, P.Wilkinson, and E.A. Dowler. 2000. A Minimum Income for Healthy Living. *Journal of Epidemiology and Community Health*. 54, 885-889.
- 2 John McKnight, Professor of Communication Studies and Education and Social Policy, Asset-Based Development Institute, Northwestern University, Chicago. Co-author with John P. Kretzmann of 'Building Communities from the Inside Out: A Path Towards Finding and Mobilizing a Community's Assets' (1993).

# Appendix 1

## North West Food & Health Task Force

### Introduction

The relationship between diet and health is now widely recognised. Food quality, composition, availability and cost have a direct effect upon the health profile of many communities. Within the North West, with its poor health record, there are marked variations in dietary patterns and nutritional status. People living in the more deprived areas and low income families have the worst diets.

The NHS Executive North West, NHS(E)NW, has established and resourced a Food & Health Task Force to act as a focus for identifying, addressing and improving food and health issues across the region.

### Aim of the Task Force

The Food & Health Task Force is accountable to the North West Regional Office of the Department of Health for developing and supporting the implementation of policies aimed at improving patterns of dietary behaviour, to improve health, reduce nutritional inequalities, support the local food economy and improve standards in food safety and food quality in the region. This will be achieved by working closely with the relevant organisations in the region and beyond.

### Terms of Reference

- To review the evidence base for existing food and health strategies and initiatives aimed at addressing food and health issues and assess their effectiveness.
- To commission a review of best practice, relevant to promoting food and health and to disseminate this information to all relevant agencies across the region.
- To provide a forum for all sectors of the food chain to meet and to address food and health issues in the North West region with the aim of improving diet and health.
- To act as a point of expert reference and support for district health authorities, local authorities and other agencies in developing local programmes.
- To advise the NHS(E)NW and the local authorities on the health implications of new policy or legislation relating to all aspects of food safety and standards and on certain aspects of nutrition formulated by the Food Standards Agency.

- To encourage strategies based on multi-agency working involving local authorities, Health Action Zones (HAZ), Regional Development Agency, Food Standards Agency, food growers, manufacturers and retailers.
- To fund and manage a region wide review of food and health intelligence incorporating relevant information on nutrition, epidemiology, food safety, food production, food economy, food transport and food retail activities.
- To develop an action plan, with milestones, aimed at addressing priority issues to improve diet and health in the North West.
- To identify research & development priorities in the North West for improving:-
  - Diet and health
  - Food safety standards
  - And for reducing nutritional inequalities

## Membership

The Task Force membership is multi sectoral and comprises representatives of a wide range of interest groups representing food and health across the region, including consumer and community representation. The Task Force is able to co-opt members as appropriate for advice on particular issues.

## Status

The Task Force has appointed a Regional Food & Health Development Officer. A workplan, which meets the objectives of the Task Force, has been drawn up and agreed.

## Objectives

- In the medium to long term the Task Force will:
- Encourage the development of a 'regional food forum' to provide a multidisciplinary platform for communication and collaboration on matters relating to food and health.
- Review the current food and health situation in the region identifying important issues and priority areas for action for the Northwest.
- Encourage the development of local food and health policy across the region in collaboration with key parties.
- Encourage the development and implementation of local food and health strategies based on the broader public health approach (i.e. management and prevention of major health conditions such as coronary heart disease, diabetes and obesity) and which link into the NHS Plan and the National Service Frameworks.

- Develop region wide capacity to implement the food and health agenda through relevant education, training and information for health professionals and other relevant parties
- Advocate on behalf of the people in the Northwest on food and health matters.
- Contribute to policy development ... national developments ... and debate on issues affecting consumers ...relating to food and health.
- Raise awareness of food and health issues in the Northwest.

## Contact Details

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