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Citation: Caraher, M. & Richards, L. (2007). An evaluation of the Community Nutrition Assistant Training Programme Camden. London: Centre for Food Policy, City University London.

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COMMUNITY NUTRITION ASSISTANT TRAINING PROGRAMME CAMDEN

EVALUATION REPORT

APRIL 2007

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INTRODUCTION

The link between food and health is well established. A healthy diet is important not only for good health and wellbeing but also in the prevention of the development of illness and disease (WHO, 2003). The food and healthy choices people make are key public health issues needing to be addressed now more than ever (WHO 2004, Tulchinsky and Varavikova 2000).

National priorities have been highlighted including the prevention of the 'big killers' – cancer, heart disease and stroke, prevention of the growing epidemic of obesity and a commitment to 'health for all' (DH, 2004). Strategies to improve health must of necessity be implemented at local level to account for social, cultural and economic differences and complement national priorities (WHO 1986, DH 1998, Wanless 2004). Ways to include and reach a greater number of people in the community on health promotion are vital to be able to reduce health inequalities (WHO 1986, Acheson 1998, Wanless 2004). This should also include messages which are related and relevant to people's everyday lives.

Tackling these priorities has proved challenging thus far, however it has been suggested that Community Nutrition Assistants (CNAs) may provide a vehicle to improve diet in disadvantaged populations. Over recent years, this emerging group of lay workers has been developing in order to assist people to eat healthier, by increasing awareness and helping to translate advice into practice.

What are Community Nutrition Assistants?

The CNA model incorporates a structure for community leaders, recruited from the local community to be trained to deliver consistent messages on healthy eating in various practical ways. CNAs, sometimes referred to as peer educators, explore and act on the food and health needs of disadvantaged local communities.

Rationale for Community Nutrition Assistants

CNAs, if properly managed, can help increase coverage of health promotion; empower individuals and communities; help to reduce social exclusion and address inequalities in health (Kennedy, p.c., 2004). Evidence suggests that CNAs may increase awareness of healthy eating and help people translate dietary advice into practice thereby positively influencing patterns of behaviour (Kennedy et al 1999, Kennedy p.c. 2004). The impact may be far reaching; CNAs can communicate messages in an informal way to family and friends where messages can cascade out beyond the formal structure of organised groups or activities. Community involvement means that CNAs could facilitate change on a motivational, structural and organisational level in order to also achieve a healthier community environment (Kim et al, 2004).

CNAs can help to break down barriers for people who see them as sharing a common background or experience, understanding of their problems and helping them to see health as achievable. They can help bridge the gap between the professional or organisation and the community. Often professionals have difficulty in accessing local communities and likewise with the community members and the negotiated style in which community work ideally should be done may not be used so well by professionals or be unsatisfactory to community members (McGlone et al, 1999). They may thus be preferred to over health professionals (Kennedy et al, 1999).

CNA roles include the ability to communicate at the appropriate level to groups whilst facilitating practical food projects, having good links with the community, providing important social support, working to bridge the gap between services and the community and enable improved dietary changes through addressing issues at individual and community level. As has already been noted above, another key advantage is an understanding of the daily lives of the target audience and their food habits.

Programmes provide opportunities for people in the community to be trained, giving recognised skills and achievements to these people. This may both empower them and empower beneficiaries of the programmes to make healthy choices.

The outcomes of these programmes could be a reduction in morbidity (cardiovascular disease, cancer, obesity and diabetes), mortality and improved overall health and wellbeing as part of a broader strategy to improve health in the community. As well, there are potential improvements in both individual and community social capital to be gained.

Recent years have seen a shift from that of the health professional working within the community to that of lay people trained to work with the community and utilising more of a skill mix to bring about lifestyle change more effectively. Comprehensive and consistent evaluation on the value of CNAs in the community is needed to support and justify their work.

Policy Context for Community Involvement

The Choosing Health White Paper sets out the national strategy for action to improve health and reduce health inequalities placing the importance on improving diet and nutrition as a major component, highlighting obesity as a major public health problem. It emphasises the importance of people being able to make their own decisions about their lifestyle, aiming to play a supportive role at increasing awareness and practical skills and education, creating conditions for individuals to make healthy choices.

Targeting those worst off, new approaches and new action is needed to make progress. Choosing Health has identified the importance of 'health trainers' and the role of engaging communities using 'peers' as educators (DH, 2004).

Within Camden, the Local Area Agreement (LAA) outcome for health is to reduce inequalities and tackle obesity. Subsidiary outcomes are to reduce cardiovascular mortality and develop a broader and inclusive strategy on obesity.

The CNA programme is expected to contribute to halting the year on year rise in obesity and increasing capacity to deliver healthy eating sessions in Camden.

Camden also has Health Trainers which evolved out of the role of the Public Health Assistant within Camden PCT and Choosing Health. This is a very similar model to CNAs recruiting local people from the community to support and enable lifestyle changes.

HISTORY AND DEVELOPMENT OF THE COMMUNITY NUTRITION ASSISTANT PROGRAMME

Food and nutrition initiatives in the community are contextualised by health issues and reducing health inequalities and the prevention of diet-related disease, and have been popular on a small scale in the UK for sometime. Anecdotal evidence suggests that CNAs now exist in many community nutrition and dietetic services (and other organisations) in the UK and the numbers have been growing (CNG, p.c., 2004). Programmes often link to existing national and local programmes of work that aim to promote health, improve diet and reduce inequalities. These include: Healthy Living Centres, Healthy Start/ Sure Start, Neighbourhood Renewal funded schemes, New Deal for Communities, Big Lottery Fund, Healthy Schools and 5 A DAY programmes. The aim is to work in partnership with communities and may be targeted at specific population groups. For example, mothers and children, the elderly, ethnic minority or socially deprived groups, specific diseases such as cardiovascular, cancer, or more broadly with health promotion and disease prevention.

In England, Bolton and Newcastle NHS Trusts pioneered approaches which provided accredited training for nutrition assistants in the early 1990's. Following on from this, the Bedfordshire and Luton NHS Trust later created a National Open College Network (NOCN) accredited course for lay people, based on their Asian Cookery Club leaders course. The framework for Luton's Community Support Worker programme was transferred to Haringey Teaching Primary Care Trust in 2004 which has further developed the training programme.

This programme was then transferred to Camden. Camden PCT, as part of the North Central London Sector and supported by Haringey tPCT, has implemented the training programme delivered by West Euston Healthy Community partnership.

This programme is not the first to be offered to lay people in Camden working or volunteering in the community, however it is the first to offer accredited training and over a longer period of time, thus with more comprehensive course content with a specific focus on food.

This programme has built on the success of the Community Food Worker training held in Camden and Islington throughout 2005 and 2006 and lessons learned from the Haringey programme (Elster Jones 2006, Daries 2006).

The CNA training was funded for one year through the Local Area Agreement (LAA), and is part of a wider programme for tackling Obesity in Camden. The training was targeted within "at risk" areas – namely Kilburn, Kentish Town, Gospel Oak, Regents Park and Kings Cross. This funding was intended to include six months of training and six months of follow on support for the trainees in the community. However, due to the late start of the training, there was only sufficient time to run the training.

PROGRAMME DELIVERY AIMS AND OBJECTIVES

The training supports the development of CNAs who through working with local community groups can facilitate improved diet and health for residents of Camden. The training aimed to provide local people with the knowledge and skills to support themselves and others to make health enhancing changes to their diet.

The training programme objectives, as agreed in Camden, were as follows:

- To develop participants' knowledge and give them confidence in understanding and explaining the principles of healthy eating
- To motivate and empower participants to make healthy eating changes in their lives and help to influence others to do so
- To develop participants' range of communication skills and empower them to work confidently with individuals and groups at all levels
- To strengthen learners' professional attitude and make them aware of the code of conduct for their profession
- To increase participants' awareness of a model that empowers communities by the community development model

Trained CNAs were expected following the training to offer a range of activities including cook and eat sessions, group health education (eg. healthy eating, weaning talks), running school activities and food co-operatives.

It is important to note that it was not possible due to time limits to evaluate CNAs working in the community post training as part of this evaluation report.

PROGRAMME OUTLINE

Recruitment

Community organisations were contacted; an information pack was then sent containing background information along with an application form. Informal interviews were then held with prospective participants before being accepted on the course.

A total of 15 participants were recruited to the training programme. They were either employed in a paid or voluntary capacity from various communities and organisations and worked with BME communities and community groups with users at risk of obesity. For example, Sure Start programmes, learning disabilities, older people, schools, black African and Caribbean communities and people of South East Asian origin.

The training was offered free in addition to crèche facilities, refreshments and lunch which were also provided through West Euston Partnership.

With support from the community food co-ordinator, participants were expected at the end of the training to return to their organisations to deliver healthy eating activities. Organisations were additionally expected to support participants' role in this capacity once trained and ensure the learning would be implemented in the setting and for the identified target group.

Format and Module Overview

The training delivery took place between October 2006 and April 2007. It consisted of once weekly, 5-hour sessions and a total of 3 modules, all of which are accredited through the London Region Open College Network (LR-OCN). Due to time constraints, many of the sessions in module 1 and 2 were doubled up. Table 1 outlines programme and module content.

At the end of each module, an internal moderation took place between Haringey tPCT, Camden PCT and West Euston Partnership to ensure satisfaction, consistency and quality assurance with the training. An external moderation session with LR-OCN was held at the end of the course in order for credits to be awarded. Successful completion of all three modules leads to the award of 'Community Nutrition Assistant'. Table 1 shows an outline of the programme content.

Table 1. Programme Content		
Module 1	Community Nutrition <ul style="list-style-type: none">▪ <i>Balance of Good Health</i>▪ <i>Fats</i>▪ <i>Salt and Sugar</i>▪ <i>Weight Reduction</i>▪ <i>Diabetes</i>▪ <i>Coronary Heart Disease</i>▪ <i>Pregnancy and Breastfeeding</i>▪ <i>Weaning</i>	Level 1 & 2
Module 2	Developing Community Food Advisor Skills <ul style="list-style-type: none">▪ <i>Role of the Community Food Adviser/Community Nutrition Assistant</i>▪ <i>An introduction to Health Promotion, and health beliefs</i>▪ <i>Food poverty</i>▪ <i>Factors affecting food choices</i>▪ <i>Nutrition through the lifecycle</i>▪ <i>Cook and Eat sessions, including recipe adaptation and producing nutritious food on a budget</i>▪ <i>Visiting local Food Projects</i>▪ <i>Working with groups</i>▪ <i>Communication skills, including presentations to individuals and groups</i>▪ <i>Developing and using resources</i>▪ <i>Cultural diversity</i>	Level 2
Module 3	Community Nutrition Work Placement <ul style="list-style-type: none">▪ <i>Use information resources</i>▪ <i>Assess the nutritional needs of the community} using a community development approach</i>▪ <i>Plan and deliver a nutrition activity} using a</i>	Level 2

	<i>community development approach</i> <ul style="list-style-type: none"> ▪ <i>Demonstrate a professional attitude</i> ▪ <i>Use reflective skills to evaluate and improve own practice</i> ▪ <i>Understand the roles of other professionals</i> 	
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Teaching and Learning Methods

One tutor was recruited to deliver all 3 modules. The tutor had previous experience of the programme in Haringey, having been involved from the start of the Haringey programme and participated in the delivery of all the modules.

All modules were delivered at Open College Network level 2. This is the equivalent of NVQ level 2 or GCSE grades A-C. Module 1 can be offered at level 1 for those students who may be struggling, however, students must pass at level 2 to progress on to module 2.

Module 1 involved more of a teaching component, having weekly written assessments. Module 2 involved a combination of teacher-led and student-led learning, along with weekly practical, written or oral assessments.

Module 3 was intended as a transitional period (from student to CNA) where students were in charge of their own learning and development, and were responsible for creating their own portfolio as an evidence of work completed. Informal class sessions were provided in order to support this work, along with tutor observation during practical placements.

Programme Support

In addition to the course tutor, there was a programme coordinator within West Euston Partnership based at the venue who organised the timetable, crèche facilities, refreshments and other practical components. An administrator provided support for the training materials.

Additional support was offered by the Community Food Coordinator who the tutor liaised with on a regular basis.

There were extra sessions built in to the training by an independent life skills coach at the beginning, middle and end where participants received training on team building, goal setting and behavioural change, presentation skills, confidence building and career development. Support was also offered via the One Stop Shop in language, literacy and career guidance.

The evaluation methodology

The purpose of this evaluation as set out in the tender document was to determine the impacts and outcomes of the training programme for both individual participants and the effect on organisations and their support for the work of the CNAs. In addition to make recommendations for future direction for the Camden programme.

The aim was to find out whether a Community Nutrition Assistant training programme changes participants' knowledge and behaviour towards healthy eating and increases their intentions to deliver healthy eating activities.

The evaluation focussed on the following:

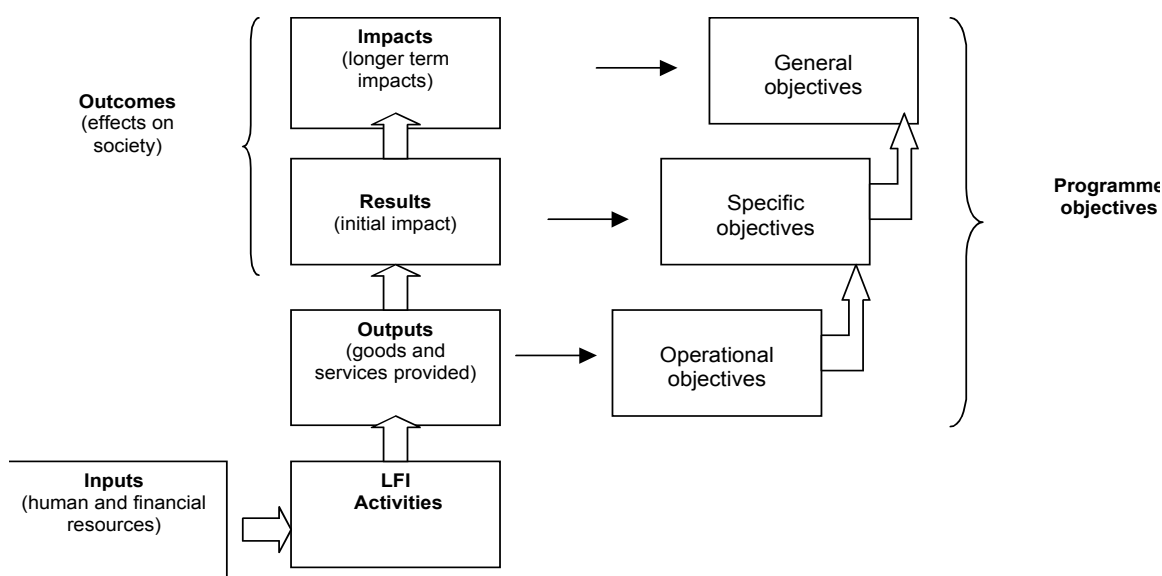
- measuring training course participants' knowledge on 5 A DAY and what counts as a portion and the numbers correctly reporting this
- measuring training course participants' knowledge in healthy eating and numbers successfully completing course work at level 2
- measuring training course number of participants reducing consumption of foods high in fat, sugar and salt
- measuring number of course participants who have increased their consumption of fruits and vegetables and high fibre foods
- measuring number of course participants who have increased their knowledge and skills in preparing and cooking foods in a healthier way
- exploring what plans and intentions participants have for delivering healthy eating activities
- identifying what support mechanisms are needed to aid delivery
- identifying what might be the barriers to delivery
- obtaining the views of key organisations involved in supporting the work

The following was available for analysis:

- pre, mid and end of course knowledge and cooking skills questionnaire (originally developed and validated as part of a FSA funded Cooking Skills training programme) and supportive questionnaire on knowledge, attitude and behaviour
- evaluation feedback sessions
- reflective diaries
- completion of course assessment at level 2 - course assessments undertaken as part of training
- tutor observations
- interviews with trainees
- interviews with key stakeholders from support organisations

Figure 1 shows the principles underlying the evaluation approach.

Figure 1. Evaluation logic framework.



FINDINGS

The findings are set out in the following ways: sessional feedback, reflective diaries, measured changes in knowledge, attitude and behaviour, programme retention and commitment, interviews with CNA trainees and key stakeholder interviews.

Sessional Feedback

Students completed feedback forms for each session in module 1 and 2. This was not done in module 3 as feedback was by means of reflection as it was a student-led practice based module with no formal teaching sessions. Table 2 shows attendance and how students rated the enjoyment of the session (where 1 is 'a little' and 5 is 'a lot'). Note that some sessions were doubled up.

Table 2a Sessional feedback			
Module 1			
Session	Attendance	Average rating out of 5	Comments on questions <i>Did you learning anything new? Will you make any changes to what you eat as a result of this session?</i>
Balance of Good Health	14	3.8	<i>'understanding portion sizes' 'eat more fruit and veg' 'try to eat smaller portions' 'eating more of a healthy, balanced diet'</i>
Fat, Salt and Sugar	15	4.4	<i>'reading labels' 'cut down on fat, sugar, salt' 'substitutes for fat, sugar, salt'</i>

Weight Reduction	11	4.0	<i>'be more active' 'the importance of a healthy weight'</i>
Diabetes and Heart Disease	12	4.4	<i>'how much diet affects these diseases'</i>
Pregnancy, Breastfeeding and Weaning	13	4.7	<i>'up to date breastfeeding and weaning guidelines'</i>
Overall average for module	13*	4.3	

**Where total number of participants at the end of module was 14.*

Table 2b Sessional feedback			
Module 2			
Session	Attendance	Average rating out of 5	Comments
			<i>Did you learning anything new? Will you make any changes as a result of this session?</i>
Role of the CNA An Introduction to Health and Health Promotion	11	4.4	<i>'understanding our role in the community'</i>
Food Poverty	11	4.6	<i>'impact of poverty on nutrition and health' 'helping to eat healthy on a budget'</i>
Diet through the Lifecycle	10	4.1	<i>'requirements for different life stages'</i>
Working with Groups and Factors Affecting Food Choice	7	4.3	<i>'working more effectively with groups'</i>
Cook and Eat session	8	4.7	<i>'adapting recipes to be healthier'</i>
Food Projects	6	4.5	<i>'different types of food projects and how they are run'</i>
Developing and using Resources	7	4.5	<i>'lots of sources and information on appropriate resources'</i>
Communication Skills and Cultural Diversity	8	4.7	<i>'the importance of communication and different ways of communicating with different groups'</i>
Overall average for module	8.5*	4.5	

**Where total number of participants at the end of module was 10.*

Reported enjoyment of all sessions was high throughout module 1 and 2. In particular, certain sessions such as the 'Cook and Eat' and 'Communication Skills and Cultural Diversity' sessions were most enjoyed due to the practical nature. Feedback also showed that participants learned new information and intended to make changes based on each of the sessions.

Attendance was poor in some of module 2 due to the sessions being held in December and January and clashing with holidays.

Reflective Diaries

Students were required to complete reflective diaries at different stages throughout modules 2 and 3. Reflections in module 2 were about the training sessions and in module 3 were about the students' experiences in practice.

Students provided positive feedback about the teaching and learning. It was clear that this element was appreciated particularly in their practice based learning where they were able to reflect on their work and identify areas for improvement.

Changes in Knowledge, Attitude and Behaviour

Changes in Knowledge, Attitude and Behaviour were measured by the validated food frequency questionnaire (FFQ) and supportive questions the FFQ did not cover. These were administered at baseline, mid and post course.

All students have reported making changes since the start of the course.

The following quotes show a range of these responses:

'I have reduced salt, fat, eat more fish and nuts'

'I now exercise regularly'

'I am more creative in my cooking and alter recipes to make them healthier'

'I have cut back drastically on salts, sugars and fats'

They also stated that they were putting into practice what they have learned not only for themselves but with their family and friends.

Results from the validated FFQ showed that all participants were aware of the 5 a day message at the start of the course. However, in terms of breaking down the message into portion sizes and what constitutes a portion there was clear improvement in knowledge by the end of the course.

Those who did not increase their intake of fruits and vegetables were already consuming 5 portions a day. All participants have reported intakes of at least 5 portions of fruit and vegetables a day on the final questionnaire. Table 3 shows measured changes in consumption of fruits, vegetables, fibre, salt, sugar and fat. Reported changes were all very high.

Measuring number of course participants who have increased their knowledge and skills in preparing and cooking foods in a healthier way is difficult to relate to the course as this was not a cooking course. All participants who completed the course already prepared food from scratch and did not use convenience foods. Certainly there were reported increases by all participants in confidence of cooking healthy foods and changing the way in which they cooked based on their improved knowledge of fat, sugar and salt etc.

Table 3 Changes in consumption Based on 9 participants			
Numbers increased fruit consumption	6 (67%)	Number decreased consumption of salt	9 (100%)
Numbers increased vegetable consumption	7 (78%)	Number decreased consumption of sugar	9 (100%)
Numbers increased consumption of high fibre foods	9 (100%)	Number decreased consumption of unhealthy fats and overall fat	9 (100%)

Programme Retention and Commitment

One student dropped out of module 1 after the second session due to a misunderstanding of reasons for taking the course. She thought the course was to help her lose weight and never intended to train to become a CNA. Three students completed module 1, however, were all elderly and for different reasons decided it would not be suitable for them to continue with the course, feeling that they gained what they needed to in module 1 and would not utilise further modules. One student who passed module 1 decided not to continue due to personal pressures and the course being too stressful and challenging (due to language difficulties, despite being offered additional support) at that time. All students who passed did so at level 2.

A further student was lost in module 2 due to immigration difficulties. Table 4 displays programme statistics. Module 1 had a pass rate of 73% and the programme achieved a success rate of 60%, which is high considering past programmes elsewhere, and has met the original target of training 8 CNAs.

Table 4 Programme statistics			
	Number registered	Number completed	Number passed
Module 1	15	14	11 (73%)
Module 2	10	9	9 (60%)
Module 3	9	9	9 (60%)

Of those participants who have successfully completed, five participants were from Sure Start/ Children's Centres, one was an existing community food worker within the PCT, one from the Somali community, one from a community garden project and another from a youth organisation.

Interviews with CNA trainees

Trainees reported how much they enjoyed the course.

'when I started this course I thought that I ate healthy and fed my family healthily, then I realised that our cultural diet wasn't really balanced'

'this course has changed my life'

'I am so much more confident now'

In terms of adequate support during the training, all students were positive and expressed that the support was also appreciated outside classroom time. The additional support sessions offered by the life skills coach was considered invaluable.

Main suggestions for improvement of the course came up as providing more practical opportunities and support for work after. Additionally, level of homework was noted as being very demanding.

'more practical group deliveries'

'more practical work and less homework'

'more support for paid work after'

Most felt that the training was sufficient but also stated they were looking forward to further training and updating of knowledge. Some have identified the need for more training but beyond the role of the CNA.

All participants had intentions for delivery of healthy eating activities. There is a split between those who had existing work within their organisations and those who were volunteering:

'I will use the information in my work'

'I will continue to develop activities within my organisation'

'I plan on using the course for my community, under 5's and breastfeeding mothers'

'I want to work as a CNA'

'I would like to continue working as have done on placements'

'I would love to have a steady part time job to deliver healthy eating talks and cook and eat sessions in the community'

Childcare and the need for paid work rather than volunteering came up as two main barriers to delivery of activities.

Most identified the need for continued support from the PCT, tutor, community food coordinator and constant contact with other CNAs.

Key Stakeholder Interviews

Four interviews from key stakeholders were conducted from a sample of the organisations from which participants came from. Stakeholders were managers or trustees of the organisations. These interviews were conducted in order to gain a strategic perspective of what they felt was expected and of future commitment to supporting those trained.

The rationale from the stakeholders for sending the participants on the course was to enable them to be in an enhanced role and that there is a real demand in the community for healthy eating activities in which they as organisations wanted to provide with competent and trained people from their organisation.

'at the moment there is not one thing about healthy eating and nutrition that we provide, I feel a gap and parents feel a gap'

Their expectations were generally around the CNA transferring knowledge and skills to people in the community. CNAs were seen as being able to communicate more practical messages. Some saw the role beyond practical and as an advisor to parents and staff or giving one to one help. It is recognised that both are needed as the CNA can do work at a practical level but not able to adequately assess individuals therefore professionals still have a role.

'I think you need a combination of different approaches, practical but need one on one to get more encouragement individually, she is an expert too as has done the training'

'I think she has put a lot into the course and is very knowledgeable'

'I am not expecting a specialist but an integrated approach to nutritious and healthy tasty food at a very grass root level'

Reported benefits to CNAs include: having people from the community at the same level, capacity building, cost effectiveness and community advocacy even.

Benefits within the organisation were reported as the organisation showing they are supporting their community and working towards improving health of the community members, also supporting training of members of the organisation and community.

'we are training one of our own'

'I can see the work building and building beyond her role in the centre'

Resources in terms of people capacity and funding were two of the major limitations mentioned.

All organisations were supportive of the CNA and had intentions to continue supporting their work, some also emphasising the need for continued support from the PCT for both the organisation and the CNA. One stakeholder recognised that they are not going to get the 'expertise' from elsewhere, that training and development needs to be ongoing from the PCT and it is a big leap to go from training to running a project.

All stakeholders felt the work of the CNA would be sustainable bearing in mind the resource limitations.

'the need is definitely there, but we may not be able to do it'

The importance of long term commitment was also highlighted.

'health is always a need and a priority but it is not short term, it needs continuity in the medium and long term... only then will we see outcomes such as reduction in diabetes or heart disease'

Some wanted more training to be offered to other community members to contribute to the sustainability of the work rather than relying on just one CNA.

DISCUSSION

The evaluation of the community training programme in Camden points to many strengths but also some weaknesses. The positive aspects are the overall commitment to the process of training and the concept underpinning the approach which is community involvement and tackling inequalities. The weaknesses focus on the lack of ongoing support, resources and clarity of purpose for both the individuals trained and the organisations they work for.

The first thing to point out is that the CNA programme of activities in Camden while it can contribute to reducing the dietary inequality cannot on its own address the issues, a wider policy approach is needed in which CNAs have an identified role.

The findings from the evaluation of the training programme itself clearly show:

- The need for such a programme
- The enthusiasm for the programme from participants and greater demand for such training in the community
- That learning takes place in terms of knowledge transfer
- That there is a reported increase in skills
- That participants reported increased confidence
- That participants reported improved changes in diet for themselves, family and friends
- The need for ongoing training and support
- There is a gap between expectations of the CNAs and their intended role

Tutor observations, lessons learned from other programmes, interviews and both tutor and CNA experiences have raised the following points to consider for the training itself and for future training:

Camden recruited members of community organisations based on open opportunity and response. In the end those who successfully completed the training were predominantly linked to work with mothers and children. Who should the training be targeted at? Who is being trained and who is benefitting? This programme has seen participants who have benefitted from multiple training courses on offer through their organisation, possibly doing this for self development rather than intending to use these skills as CNAs. This may not be a negative finding but there are concerns as to whether the same people are benefitting over and over again and others, likely the least able, are not. Having said that, these same trainees have expressed great enthusiasm for making use of these skills as CNAs in the community.

Furthermore, there is a question as to what level should the sessions be pitched at, particularly if students are at different levels, as has been raised in other programmes (Chauhan, 2005). This is an issue that tutors need to be aware of.

Some have reported that these types of training programmes are beneficial for those who may have not had a positive experience with formal education or who had very low level educational attainment. However, all the participants were at a higher level than to which this course was aimed and there is a concern that some people joining at a lower level may not feel confident enough in this environment to begin with.

It is difficult to tell what this training is aiming at and at what level. Some of the sessions involved great detail whereas others did not. There were times when the tutor was unclear and students were unclear due to an imbalance in material and assessment criteria not matching to learning outcomes. This was dealt with by the tutor using prior experience of the sessional material and adapting it to be more suitable to the group whilst adhering to the learning outcomes and trying to correct it where issues arose. There were also some recognised gaps in learning due to lack of clarity around roles. This is the risk with transferring a programme from elsewhere. Accreditation gave it status however there should be more scrutiny to the content and training must still be adapted to local needs and priorities enabling local identity to the programme.

Comparison of the approaches used in the training in Camden with those from other programmes shows that there are benefits to more than one tutor in terms of participants gaining different exposure to teaching styles and expertise. However drawbacks include sharing of workload difficulties, communication issues and lack of consistency. The major advantage to a single tutor was enabling consistency with delivery and the tutor could also see the progression and development of the students throughout the course much more clearly.

Multiple partners involved in running the training meant a shared responsibility and everyone having a role to play however communication issues arose at times and some people remained disconnected from certain aspects of the programme.

The time constraints the Camden programme was under could raise questions as to whether the training time and material was sufficient. Indeed, some of the sessions such as the fat, salt and sugar were delivered within very short time periods in which the tutor had concerns about whether this was enough. There were no breaks between modules which caused some backlog in work. Module 1 and 2 were delivered over 5 weeks and 8 weeks in Camden compared with 10 weeks and 13 weeks in Haringey.

The last module was very pushed for time particularly with the additional opportunities that were given, this contributed to an increased workload and many students were under pressure to meet the demands by the end of the course along with their other commitments. Despite class time being longer, this meant that there was twice as much homework for participants to complete on a weekly basis. Assessments had already been identified as heavy in Haringey. This compounded the pressures students felt by the end of the course.

On the positive side, delivering this programme within a shorter period of time kept the momentum up for students and gave an added push for getting assessments completed. There has been some debate about whether offering these courses for free, along with other expenses paid for, does bring about the motivation and commitment needed from participants. Whilst nine participants have shown the commitment to follow through, there is always a fairly high drop out rate with these programmes. Additionally, punctuality and attendance were problems for certain students and the tutor felt that these privileges were taken advantage of by some. Again, these were the most able students on the training.

Also, if it is not clear what people will do once trained or what opportunities there will be for them, it is difficult to have the motivation or drive to continue to the end. There must be continuation of the programme built in from day one in order to be reflected better in the training and for students to feel that they are working towards something and understand what their role will be.

So the training programme needs to be adapted for future use in the following ways:

- Medium and long term investment needs to be incorporated from the start of the programme
- Establishing clear roles and purpose for CNAs, which need to be agreed and to be communicated to partners, organisations and CNAs themselves
- Better communication and contact from the beginning with professionals who CNAs would link with, in particular with the Nutrition and Dietetics and Public Health departments in the PCT
- Learning modules and assessment criteria should be adapted more appropriately in line with goals of the programme and the time allocated for delivery of the training should be sufficient, perhaps building in more practical components and allowing for more time between modules
- Consideration as to who may be targeted for the training, for example to prioritise training of mothers to help other mothers or that of certain ethnic groups to ensure they are better reached with trained CNAs

Following on from this, there is a lack of clarity as to the role of those trained on the programme and their activities post-course. Some see themselves as sufficiently trained to provide basic advice while others only see their role as one of providing the most basic advice on healthy eating and the source of referrals. While there may be a place for variation in the application of skills and learning on the course there is a need to develop a job description or set of guidelines or principles for both individuals and organisations. A job description was developed in Haringey and perhaps a mere tweaking of this is needed. In addition the ability of the CNA programme to contribute to meeting targets is hampered by a lack of long-term vision and commitment in terms of support and resources. There is a feeling of a stop/start approach with no clear future direction for the programme. The current focus on the evaluation of the training programme needs to be balanced with a monitoring of activities of trainees once trained. This latter can only be done in the light of medium term plan (3-5 years) for CNAs, their training and activities in the community.

Therefore our recommendation is that monitoring of trainee activities and their organisations be undertaken over the next two years.

The role of 'Health Trainer' as seen developing from Choosing Health and existing within Camden must be considered. Is the role of the health trainer that of providing individual advice on a broad range of health issues including nutrition through GP referrals and that of the CNA to provide practical advice at group level? Interviews with representatives from key organisations have shown there is a real lack of clarity around health trainers. This again links back to identifying clear roles and understanding of why these roles exist, how they can complement one another and deliver on agendas. Again, monitoring what activities are happening in the community will be necessary.

The relationship of the CNAs and their organisations with the formal community dietetic service and nutrition based projects in the PCT is ill-defined and not utilised to its best ability. This needs to be clarified and specifically laid out. **We recommend the development of a contract with each agency specifying roles, activities and contribution to the wider borough food and nutrition plans.** This should be agreed at the time of recruitment of trainees.

CNAs have traditionally been used to access 'hard to reach' communities and or to provide advice to lay others in a non-threatening way. The scope of this situation remains unclear, with evaluations of such programmes showing that the training changes the nature of the situation. A critique often levelled at such projects is that those trained simply target their immediate friends and contacts and no wider reach is achieved. CNAs may already be well placed within the community and be better able to reach out to those most in need. But there is still a question as to who is accessing these services. And are these people who are targeted, the most in need? How much is this contributing to reducing inequalities?

Another issue concerns the growing professionalism of those trained. For example the community mothers project which began in Dublin and rolled out in England showed that many of those trained soon began to see themselves as 'semi-professionals' and entitled to being paid for their work. The current situation where some are volunteers, some others provide advice as part of a wider role and still others get paid for specific dietary input is currently raising questions among the CNAs in Camden themselves and the organisations they work for. This is not necessarily a negative development and shows the growing confidence and awareness of those trained. But thought does need to be given to the role, functions and activities of the CNAs.

All participants who were not in existing paid work with their organisations expressed the desire for this training to develop into paid opportunities and wanted clarity on what these opportunities were. Small amounts of work did develop towards the end of their training, but this was only short term. Tensions developed when volunteer work was offered and some funding made available through a supporter organisation did not make provisions for payment of CNAs. Here is where discrepancies have arisen between what was told to participants at the beginning of the training and what was intended. Many were happy to return to their organisations in enhanced roles however felt that if they were expected to go beyond this it would not be in a volunteer capacity.

Part of the monitoring recommended above should include an element of the developing role and function of the CNAs as well as career trajectories (such as job changes and access to further education).

Another weakness is the lack of identified and structured on-going support/ follow up for both the organisations and those trained. Those on the training programme expressed a need for on-going support and updating. It is not felt that this should be particularly onerous perhaps two to three sessions a year on specific topics. This could also act as a way of inducting new and old trainees of monitoring activities and developments.

Whilst support throughout training and additional supporting sessions were appreciated by all, participants reported wanting ongoing support within their roles from the PCT and their organisations and despite this now being provided, it hadn't been made clear from the start. Organisations also require support for the CNAs in the way of funding to be able to carry the work forward.

It is a challenge to ensure that these messages and the appropriate amount of information and detail is embedded in the participants by the end of the training.

Training should thus not been seen as having a beginning and an end, but rather should be ongoing and be revisited in good practice along the lines of continued professional development, and possibly to make this mandatory as a working condition.

The risk is that these people are seen as highly trained within the community and their supporting organisations and have expectations beyond their role.

The recommendation is that ongoing support is incorporated and continuous from the beginning of the training to post training and further needs are identified, supporting both the CNAs themselves and the organisations.

Interviews with managers of the community organisations show a lack of clarity of purpose as the role of the CNAs. Some see them as now trained in nutrition and with more specialist capabilities of giving advice beyond their training and intended role - the Gillian McKeith's of community development! Indeed, they have already been referred to as 'nutritionists'. This also undervalues and confuses the role of more extensively trained professionals in the field compounded by a lack of clear written guidance. There is the concern that if CNAs are not tightly monitored and supervised by nutrition professionals, they will be free to fill these roles which poses a serious potential quality assurance issue. It is not sufficient to expect the organisations to provide the monitoring of these roles. Many programmes of training elsewhere have a tight management structure through primarily, the nutrition and dietetics departments whereby CNAs are directly working under. If the management structure is via their supporting organisation the management will not be relevantly qualified to ensure quality of messages in food and nutrition, nor understand the boundaries of the CNA. What they are trained and qualified to do needs to be established early on and reinforced.

It is important to point out that many of the students have expressed a thirst for more knowledge which is positive, but how and where they are getting this from is difficult to control. Partners need to be made aware that nutrition information is everywhere, these students have shown their ability to access it from different sources and despite the tutor trying to address these issues of where reliable information comes from it will remain difficult to control unless messages are overseen and agendas clearly defined.

Choosing Health found that people were often confused by conflicting messages from different sources and that they also did not fit into the way they lived their lives (DH, 2004). CNAs are intended to provide an avenue for which to provide consistent and appropriate, tailored messages that people can rely on but this must be matched with ample training and support.

The recommendation is that as part of the on-going monitoring process, recommended above, there is consideration in how these CNAs will be managed.

A major impediment to this seems to be the lack of financial commitment and place of the CNA programme in contributing to targets as set out in 'Choosing health? Choosing a better diet' and the targets on inequalities. We know from other work that community based initiatives such as this require two to three years of operation and support before they become operational and begin to contribute to addressing targets. At the moment the work appears to be funded on an ad hoc basis from year to year. There is a disconnection between the training and support offered, for some it seems enough to see this as a six month project. Although there is awareness of this with others, it has not translated into action by decision makers. While we recognise the financial restraints on PCTs we recommend that a commitment be given to supporting and expanding the CNA programme of activities. Key barriers to delivery of capacity and funding were consistent with the previous findings of the community food worker training (Elster Jones, 2006). If not already done so, the LAA would be means of achieving borough wide commitment.

The recommendation is that there is medium and long term financial commitment for the CNA programme amongst all partners involved.

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Some positive aspects of the programme development are worth mentioning. There is a community food network developed by the community food coordinator which will involve the CNAs. This is intended to enable strong links with the community and keep communication strong amongst the CNAs and the work they are doing. Regular contact and meetings means that additional training could be identified and addressed as well as the network acting as a support mechanism for the CNAs and allow for continuity of projects and complementary services within the community.

There is additional support now being offered through another organisation, but as a rather late development.

Furthermore, through some of the practical placements students were on during module 3, much positive feedback through beneficiaries and managers of these projects has opened up opportunities for some to gain further work experience. However, all of these projects have funding constraints and therefore work is limited but it should also be seen as positive that there is great appreciation of healthy eating activities in the community and again with more financial commitment could be made more possible.

RECOMMENDATIONS

A summary of key recommendations are as follows:

1. Consideration should be taken to who is recruited on these programmes, and whether they should be from hard to reach communities and specific groups, and who they should be targeting once trained
2. The training material should be adapted for future use with some developing of content and style in line with aims and objectives of programme to enable a local identity
3. Continuation of the programme built in from day one so that it is clear with course participants what they are working towards and what opportunities exist for them upon completion in addition to establishing whether the goal of the CNAs is to be able to work with a broad spectrum of people in the community or with specified groups
4. Continuous support is provided for the CNAs and additional support provided to organisations, how this would be provided should be made clear from the beginning of the training
5. Tight monitoring and control mechanisms should be put in place particularly if CNAs are not working centrally under one department or organisation including regular supervision by nutrition professionals and ongoing monitoring of CNAs post training for quality assurance
6. Monitoring of number of CNAs delivering healthy eating activities and types of activities they are delivering within their organisations, along with how these link with Health Trainers and meet LAA Service Level Agreement outcomes

7. Partnership work should ensure that agendas meet and priorities are agreed, everyone working toward the same goal and with the same understanding within the programme of CNAs, thus a contract with each agency specifying roles, activities and contribution to the wider borough food and nutrition plans
8. It would be useful to develop a local job description, including responsibilities and work programmes, for CNAs that is shared among partners, organisations and CNAs from the beginning that states clearly the role, function and activities of CNAs along with a code of conduct that should be adapted from the existing dietetic assistant code
9. The developing role and function of the CNAs as well as career trajectories (such as job changes and access to further education) should be built in, thoughts should be also be consistent on how much these roles are professionalised
10. Medium and long term financial commitment is needed beyond the training from all partners and achieving borough wide commitment

CONCLUSION

Results of this evaluation show that many of the aims and objectives for the CNA training have been met. Participants have been empowered, added value to their existing roles and developed beyond this. The programme has demonstrated a cascading of learning and messages out to family, friends and the wider community.

Whilst there is a great buzz and positive feedback from all those involved in the programme, there is also the recognition for some improvement in structure and support during and post course.

The potential impact of these programmes could be a reduction in morbidity (cardiovascular disease, cancer, obesity and diabetes), mortality and improved overall health and wellbeing only as part of a broader strategy to improve health in the community.

The CNA programme is expected to contribute to halting the year on year rise in obesity and increasing capacity to deliver healthy eating sessions in Camden, identified with the Local Area Agreement.

This will only be seen with a more structured, long term approach and invested commitment from all those involved. While the programme can contribute to reducing the dietary inequality it cannot on its own address these issues, a wider policy approach is needed in which CNAs have an identified role.

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