Report Prepared for:

Kirklees PCT

A Qualitative Insight into Obesity Adult Target Group
April 2008

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Introduction

The Kirklees Partnership, representing all the main partners' organisations in Kirklees has identified obesity as a major health challenge for the area. An Obesity Programme Plan has been developed to ensure there is a coordinated set of actions in place to tackle obesity. The Plan recognises the partners must invest in social marketing approaches to ensure that local interventions reflect the needs of the target groups. Social marketing has been identified as an approach to improve the effectiveness of interventions that aim to change behaviour.

Kirklees PCT, on behalf of the Council and its partners, commissioned qualitative research to assist in the development of a marketing and communications strategy, focussing specifically on people living in Kirklees who are over 16 years old and have a BMI of 30 or higher and not currently undertaking weight management activity at the time of interview and had not done so in the last 12 months:

The research findings will be used to inform the development of weight management provision in Kirklees and communication with the target audience, thus encouraging participation in appropriate weight management activity.

Research Objectives

The aim of the project was to:

- Prevent year on year weight gain and to achieve weight loss that results in health benefits within the adult population of Kirklees.

The research aim was to:

- Scope the behaviours and motivational issues related to weight management with the chosen target audience to inform current and future weight management provision in Kirklees.

Within these aims, the research objectives were to:

- Scope the behaviours and motivational issues related to weight management within the chosen target audience.

Methodology

The research was qualitative in nature and comprised a series of 18 in-depth interviews across Kirklees. Discussions were guided by a plan which covered the key areas important to the investigation but which also allowed respondents the flexibility to raise issues pertinent to the discussion which were important to them.

Respondents were recruited on the street by Enventure's experienced recruiters. With the use of quotas, a good spread of respondents in terms of BMI, gender, age and geographical location was achieved. Recruiters were briefed to ask potential respondents what their BMI was, and if the respondent did not know, they then made a judgement as to whether the respondent fell into the obese category, by referring to images of people with a BMI of over 30.

The interviews took place between 3rd and 10th April 2008 in respondents' own homes, and were approximately 30-60 minutes in duration. Respondents were given £30 to encourage them to take part in the research and thank them for giving up their time.

The sample comprised adults aged 16 years or over living in the Kirklees area who have a BMI of over 30 and who were not currently undertaking any of the following weight management activity at the time of interview or had not done so in the last 12 months:

- Weight management support via the NHS
- Commercial weight management activities
- Self-help weight management
- Exercise referral scheme

The interviews were spread across the Kirklees area and included the following interview locations:

- North Kirklees
- Holme Valley
- Colne Valley
- Central Huddersfield
- Kirkburton

Typologies of the adult target group were developed following the interviews and are detailed in the main body of the report.

A copy of the group discussion guide used in the interviews is appended.

Summary of Key Findings

A 'typological' approach has been used in the analysis of the interviews. This type of analysis groups individuals by factors they have in common, rather than by conventional demographic criteria. The three typological groups identified in this study are described in more detail in the main body of the report. For the purpose of this summary, the following demonstrates the descriptors and salient points to note in relation to each of the three groups:

The 'Strugglers' – characteristically morbidly obese, suffering from multiple health problems, living on state benefits and in poor quality housing.

The 'Fantasy Borderliners' – a group characterised by the fact that they seriously underestimate the scale of their weight problem and believe themselves to be in good health. They are not currently experiencing any noticeable health problems.

The 'Borderliners' – this group recognise that they are 'a bit overweight' but would rank towards the bottom of the obesity scale. They are healthy and feel that they can lose their excess weight quite easily, when they find the right motivation.

Health Awareness

Many respondents were aware of and recognised the need for '5 a day' in their diet in terms of fruit and vegetable consumption. They believed that fresh meat and fish were intrinsic parts of a healthy diet and that 'home cooked' food was likely to be more healthy than pre-prepared or processed food. Fruit juice and water were seen as healthy drinks.

They believed in order to follow a healthy diet, fried foods should be avoided, as well as sugary and starchy foods, salt in processed food and carbonated and alcoholic drinks. Some also mentioned cutting out caffeinated drinks.

There was little awareness of the need to incorporate the range of five key food groups into their diet and respondents were often hazy on the quantities of the different types of food required.

Respondents who had been on weight management programmes in the past showed the greatest level of understanding of a 'healthy diet', but again this was on a fairly simplistic level.

The fact that even on a diet you still needed to 'treat yourself' was a view that was common across all three typologies.

Whilst acknowledging the benefits of a healthy diet (improved sense of well-being, more energy, improved appearance and the longer term benefit of reducing the risk of heart attacks, etc), there were also a number of barriers for all three groups – the fact that they liked many of the 'unhealthy' foods, the perceived higher cost of fresh food, the need for greater culinary skills, the preparation and cooking time, other health issues which needed more immediate attention (eg stopping smoking or the health of children or partners) and finding the motivation to embark on a healthier diet.

All respondents were also aware of the need to incorporate exercise into their lifestyle in order for them to become healthier. Their general state of health and mobility problems were barriers to exercise for the 'Strugglers', (as well as lack of motivation); for both 'Borderliners' groups, motivation and lack of opportunity (exacerbated by long or irregular working hours) were the major factors. Both 'Borderliners' groups often had more positive attitudes to exercise and commonly *claimed* that they did some form of exercise (although this may be only on a weekly or less regular basis) or were about to embark on some form of exercise programme.

In terms of the reality of their current diet, it is likely that many were exaggerating the balance of 'healthy' food to 'unhealthy' food that they consumed. The desire to give 'socially acceptable' answers to this line of questioning is apparent in all sectors of the population and not just amongst people who are clinically obese.

Many respondents had elements of healthy eating within their diet but remarks made at various points during the interviews suggest that many were underestimating the number of 'treats' consumed and/or the sheer amount they ate and drank. Male respondents in both 'Borderliners' groups were more likely than their female counterparts to concede that their diet was 'unhealthy'.

Respondents believed that factors commonly contributing to weight gain were behavioural (eating the 'wrong' foods, eating too much), psychological (feeling depressed and comfort eating) and environmental (lack of understanding, a reliance on pre-prepared foods and 'takeaways', lack of opportunity/ability to exercise, lack of money). Some of the 'Strugglers' blamed the side effects of medication on both weight gain and on their inability to lose weight.

Weight Management Programmes

Respondents taking part in the research demonstrated a broad spectrum of feelings about their own body image. At one extreme, the 'Strugglers' were often depressed and extremely unhappy about their body image; at the other extreme, some respondents in both the 'Borderliners' typology groups thought that they looked 'okay'.

In terms of motivations to embark on weight management programmes, respondents drew on both their own experiences and that of their families and peers. Respondents in their 40s and 50s were likely to be motivated by health reasons – both short and long term. Across all groups (but particularly prevalent amongst females) the desire to 'look good' and to be able to wear mainstream fashions was also a motivational factor. Sometimes occasions such as holidays or weddings might provide this type of motivation.

The youngest respondents and some of the men (particularly those in the 'Borderliners' typology group) had little experience of weight management programmes. Many of the women (particularly those in their 40s, 50s and 60s) had a wealth of both direct and indirect experience of all the different types of programmes.

Attitudes to Weight Management

Commercial weight management programmes were known to be capable of producing successful outcomes, although the results might not always be long term. The benefits of these programmes lay in the information that was available and the support provided by the 'group'; disadvantages were: the cost, the fact that classes are attended mainly by women (from the male perspective), the (perceived) 'humiliation' of the weigh in and the fact that most people who go are not very overweight, ie not morbidly obese.

Self-help weight management programmes were thought to have the advantage that they can be tailored to an individual's lifestyle; the major disadvantage was that this approach requires a large amount of self-discipline and determination.

Respondents thought that the type of person to approach and be provided with weight management support by their GP or hospital would have major health problems, that were caused or being made worse by their weight. This view was supported to some extent by the experiences of respondents themselves. Potentially the GP was, however, seen as a good source of information and support, as he was a 'trusted' source (unlike commercial organisations) and help would be available free of charge. The experience of those who had been referred to hospitals was not necessarily a good one, the lack of any sort of relationship with hospital staff was cited as a reason for this.

Respondents reacted favourably to the concept of PALS, although on three occasions where it had been suggested (for daughters and a partner), the opportunity had not been taken. Again, as this opportunity was provided by a doctor's or health professional's referral, it was judged to be for people with health problems.

Society and the Role of the Media

Female respondents were very clear that the ideal body shape for women, as presented by the media was 'thin'. This was neither a realistic nor a desirable objective for the women taking part in this research. Many female respondents welcomed the more recent introduction of a greater range of physical shapes into programmes and advertising campaigns (eg the Dove campaign and Coleen McLoughlin's 'Real Women') but the morbidly obese respondents tended to think that these initiatives had not gone far enough.

Male respondents (particularly those in their 40s and 50s) were often less immediately aware of an 'ideal' male stereotype. However, eventually, most put forward the 'ideal' for younger men as the 'six pack' or the 'fit and athletic' look epitomised by many of the professional footballers and male models.

Information

Historically respondents' knowledge of healthy eating and their own eating patterns derived from a variety of sources – school, parents, peers, the media, public health information campaigns and health professionals. Real and detailed knowledge about a healthy diet and lifestyle was, however, often limited.

Some respondents (most typically the two 'Borderliners' groups) were fairly confident that they knew the basics of what to do; it was simply a matter of finding the right motivation. Others did express a desire for more detailed information – particularly about the quantities needed from the different food groups or about appropriate calorific intake. Information on the availability of exercise programmes was also something that respondents in the two 'Borderliners' groups would often welcome.

In terms of how information should be presented to encourage people to adopt a healthier lifestyle, opinions were mixed. Whilst some thought 'people' needed to be shocked or scared into action, others thought a benefit-led approach would be more effective.

Male respondents bemoaned the lack of materials targeted at men.

In terms of providing easy access to information, for some (most commonly the 'Strugglers'), GPs and hospitals were logical sources as they were already in contact with them; for others, who were not in the habit of visiting either their GP or the local hospital, alternative channels were suggested – the media, supermarkets, community centres, the Internet and schools & colleges.

At the end of the sessions respondents were asked to what extent they thought it was the role of the Health Service to encourage people in the area to adopt healthier lifestyles. Many remarked that, from a financial point of view, it was very much in the interest of the Health Service to encourage ‘healthy living’. They recognised that obesity caused the early onset of a number of medical problems, which it was in the interest of the Health Service to try and prevent.

Conclusions & Recommendations

The research suggests that although many people who are obese or morbidly obese recognise the main causes of obesity - in essence the imbalance of calories consumed versus calories burned off – many do not see themselves as part of the group of people with 'health threatening' weight problems. This is particularly true of those with a BMI towards the lower end of the obesity scale (ie low 30s). To change the behaviour of this group of people requires that they first of all recognise that being 'a bit overweight' may be health threatening and puts them in danger of experiencing any of the obesity-related health problems.

The research illustrated that the causes of obesity in the sample population were a mix of lifestyle behaviours, and environmental and social factors. To encourage people in the region with such a range of 'barriers' to adopt a healthier lifestyle will require activities containing a number of different messages and using a range of different channels of communication.

A campaign will need to address the following issues that are currently inhibiting 'healthy living' in the Kirklees area:

Lifestyle Behaviours – eating 'too much' and the 'wrong' type of food, eating the foods they like even though these may be high in fat or sugar, eating foods that are more convenient to prepare and require few or no cooking skills and avoiding (or not taking enough) exercise.

Environmental Factors – lack of easy or convenient access to exercise activities and availability of information.

Social Factors – low income (high calorie, processed food costs less), poor health and mobility, lack of knowledge about the elements of 'healthy' living, lack of cooking skills to prepare fresh, home-cooked food and limited opportunities for exercise activities.

In the target group which is the subject of this research (adults), the task is seriously challenging, as many of the inhibiting factors are already well-entrenched. Key to the success of future activity will be in finding the key motivators and facilitating access to information that will allow the adoption of a healthier lifestyle.

A number of factors are key to the success of the planned social marketing initiative:

- Developing a campaign which incorporates appropriate motivational messages for a range of circumstances.

- Providing the information that is necessary for people within the region to adopt a healthier lifestyle within their own constraints of income, health, education and skills.

- Providing information through channels appropriate to their current lifestyle.

Motivational Messages

Currently, most of the emphasis in the public domain is on losing weight for reasons of appearance. Health considerations are almost secondary benefits, although an increasing number of people understand these benefits.

There exists not just an opportunity for the NHS to extend its role in helping people to lose weight but perhaps almost even a demand for it to do so. This demand is driven in part by what many see as an inequality between the effort expended by the NHS to help people stop smoking and its current approach to helping people lose weight. In simple terms, people are saying, "If it's that important, why aren't you helping me do something about it?".

And ‘help’ means more than just advice and leaflets, which is what people perceive they can expect from their doctor at the moment, with a prescription being a further resort in some cases.

In order to address the opportunity it is important that service providers recognise the potential gap between the reasons why *they* would like people to lose weight and the reasons why the target audiences would like to lose weight.

Short-term health benefits – the short-term benefits of improved energy levels, improved mobility, improved sleeping patterns, etc.

Long-term health benefits - reducing the risk of obesity-related health problems and premature mortality and being able to enjoy and support children and grandchildren, a healthy retirement (travel, holidays, etc).

Appearance – the benefits of ‘looking good’, being able to wear fashionable clothes and shop in mainstream fashion chains, improved condition of skin, hair, teeth, etc.

Improved self esteem – feeling better about their own body image, feeling happier, no more embarrassing situations (seatbelt extensions on aircraft, in the gym, 'figure of fun', etc).

To be successful, any publicly funded programme must help people to see these benefits.

Information Requirements

The five main food groups – the need for a varied diet, what the essential food groups are, the basics of a 'healthy diet.

Calorie intake - a reiteration of what is needed for different lifestyles, how this equates to both meals and 'treats' or snacks'.

Quantities – how much is too much? How to read food labels.

Menu Ideas – should include 'low budget', 'low skills' and 'convenient', ie short preparation and cooking times, meals.

Exercise – opportunities and how to incorporate exercise into their lifestyle, how often is regular?

The NHS 'Brand' and Its Promise

In many ways, the NHS 'brand' carries the necessary potential or promise to deliver all of what people want. This is not a case of stretching a brand beyond its natural territory, it is a case of allowing that brand to naturally occupy a territory that many feel it should already be in.

For example, people trust the NHS and they certainly trust the people who deliver NHS services. They know it will be a confidential service that can deal with embarrassing problems. They trust that healthcare workers will have the right training and expertise and (by and large) they anticipate that they will have the right approach and not, for example, be judgemental.

In contrast, consider what the commercial weight management organisations have to offer; uneven patterns of provision, provided by individuals with non-accredited and perhaps even questionable levels of training, delivered often via inappropriate venues to meet the needs of the organisations providing the services as much as the needs of the users. In making a profit, they can be seen to be benefiting from people's misery and this can lead to resentment amongst their "customer base".

To put this into context imagine that the NHS merely *diagnosed* sexually transmitted diseases, provided information but offered no treatment or support to help alleviate the condition. Treatment in this imaginary scenario was the responsibility of commercial organisations, some of which perhaps did not manage the embarrassment of their patients as well as they might. Not surprisingly, people would demand more from the NHS, seeing it as natural for the organisation to provide practical help and support as well as diagnosis and information. They might resent having to pay for treatment, especially if the NHS provided treatment that was free at the point of delivery for other equally serious conditions.

This comparison and imaginary situation makes the point that many people, as they become more aware of the risks to health from obesity, are starting to question the stance of the NHS. They see the provision of services that currently are provided largely by commercial organisations as being natural territory into which the NHS should move.

Channels of Communication

The campaign should include channels of communication capable of reaching all three typologies described in this report.

Essentially, this means that those with current health problems can be reached effectively through their GP or local hospital. GPs may be the preferred route, as this is often an established relationship. Practice nurses with specialised knowledge of weight problems and counselling on this issue could provide the appropriate information and advice. They would also offer the benefit of being able to provide an ongoing relationship with the ‘client’.

However, the group who are not yet suffering health problems is probably far larger, numerically. For this group, channels of communication will be traditional advertising media such as TV or local press, as well as the Internet and other places where their day-to-day life takes them, ie supermarkets, pharmacies, places of work, universities, colleges, community centres, etc. The key to success with this group is to take the campaign into their daily lives.

In contrast to a mass marketing campaign in which a very large number of people gain some awareness, it may be more appropriate to adopt a more targeted approach in which a relatively low number (at least initially) become aware of and are motivated to participate in, pilot programmes. This approach would utilise the hindsight of people who have been involved in NHS programmes such as PALS and Get Food Wise and Exercise to provide relatively healthy individuals with enough foresight to motivate them to change. It may well be appropriate to continue this approach over time, so that ‘graduates’ of any newly introduced programmes become the ambassadors who take the message to the "next generation" of participants.

It could substantially enhance the appeal of the programme and indeed the excitement relating to it, if it were initially limited, we might even say rationed, in the early days of its existence. The unavailability of something often makes it even more desirable. Whilst this might appear to generate the potential for "bad" publicity, this would ultimately be helpful in the longer term. The best gyms always have the longest waiting lists, but which came first; the fantastic gym or the demand that enabled it to be funded to a level that makes it fantastic?

A Phased Approach

Of course, it will undoubtedly be necessary to promote the existence of programmes. We suggest, however, that expenditure on promotion can be significantly reduced if the marketing of pilot programmes relies heavily on PR that hints at the ‘limited’ scope of the programme. For the pilot programmes, much recruitment can be referral from clinicians. This will effectively represent "Phase 1" of the marketing of programmes.

If successful, this will likely generate demand that cannot initially be met -- a waiting list. Any shortfall can be supplemented by further communications activities. "Phase 2" marketing might involve relatively low-cost activities such as the display of posters and the distribution of leaflets via NHS and council run facilities. It can also include publication in media that the Council or the PCT control, such as newsletters and of course websites. However, material published via these media needs to not only announce the news of the schemes but also to provide detailed information about what they are, how they work and how one can access them.

Naturally, it will also be important to address the needs of those who do not regularly attend their GP or visit any other type of health professional. "Phase 2" activities can continue alongside "Phase 3" promotional programmes which by then, may need to include local press advertising, household leaflet drops and, depending on the funding available, local radio campaigns.

As it may be important to actually hear and see people talking about their experiences in their own words, in order to communicate the accessibility of the programmes, it may be necessary to provide follow-up sources of information, such as a telephone line where the caller can hear a recorded message or a website which the potential user can visit in order to see video footage and to access further information.

Theme and Design

Communications materials must be accessible to those in the target audiences, including languages appropriate to the local population. There should be a markedly different approach to the glamour that typifies many of the commercial weight loss firms' materials. There should be an emphasis on realism; real people working towards realistic goals, talking about what helps and why the programme has helped them where others have failed. There is a clear case for the use of case studies featuring actual participants -- people speaking in their own words.

The ‘medicalisation’ of the programme should be avoided and the importance of weight loss for aesthetic and social reasons should be acknowledged at least as much as health-based reasons. Keep in mind that the main reason why people attempt to lose weight is for the former, supported by the latter.

The aim of content should be to empathise with potential users, not preach at them, frighten them or tell them what to do. Acknowledging that very many potential users may already have tried several different approaches yet failed, could be an important part of the message if the message is to overcome the resistance of those who have effectively given up on themselves.

It will also be important to address the barriers that exist, or have existed in the past, including the psychological barriers such as embarrassment.

Accessibility

Although we have spoken about using limited availability as a potential marketing promotional tool, it is of course important that ultimately, programmes of activity such as the ones we are describing should become available to all.

Ensuring this will mean that programmes should be offered for free at the point of delivery or at least at very low cost. Completely free options should be available to those on the lowest incomes. Cost is, for many, the biggest and the first barrier that has to be overcome.

When it comes to the times at which programmes are run and also the composition of those programs in terms of participants, it is clear that organisers will have to work hard if they are to completely meet the needs of everyone who would like to attend, eg fitting working hours.

The ideal is that programmes should be run at different times during the day and in the evening as well. There should be all-female classes and certainly classes where even the more traditional and perhaps older South Asian women can be assured that they will feel completely at ease.

Obviously, it might be tempting to believe that timing of classes and their composition should be considered together; for example, all-female classes being offered only during the day, alongside childcare/crèche facilities. However, our findings suggest that it is easy to jump to unhelpful conclusions and that nothing should be taken for granted. Ultimately, it may be important to survey local needs or to simply ask early adopters to comment on the timing and type of groups in order to fine tune the programme for future generations of users.

Programmes need to be run in venues that are accessible and which do not promote undue security concerns for females who may be attending alone. Many will be reluctant to travel, especially in the evening and so a number of different venues may need to be considered. The availability of public transport is important as is provision for parking, especially for disabled participants or those with otherwise limited mobility.

In Summary

There is an enormous need for public authorities to do more to convert the, as yet, not-fully-emerged understanding of the connection between obesity and ill-health into the kind of action that leads to people taking more care of themselves in a sustained way.

In the past, much of the desire to change has arisen for aesthetic reasons and these reasons are now being joined increasingly by a consideration of the impact on health. Previously the almost exclusive domain of commercial organisations, the NHS has so far been slow to join the battle to help people lose weight, in terms of practical, supportive and ongoing interventions.

As more and more people realise the connection between health and their weight, so they are becoming increasingly aware of a gap which, in their minds, should naturally be filled by publicly funded services.

Moreover, the NHS ‘brand values’ represent a near perfect fit with people's needs because unlike the commercial organisations, the NHS can put the needs of the participant first and has arguably the greatest body of knowledge and expertise that it can bring to bear on the problem.

Existing programmes, currently available to only a few who perhaps have the greatest need, have enabled the NHS to develop a body of practical experience and a series of activities and interventions that appear to work extremely well for those who have experienced them. There is a pressing need and indeed a public demand for these to be rolled out and made available to greater numbers of people. However, there is also a need to ensure that the experiences of those who have attended these programmes are used as a resource in persuading those who have yet to be convinced of the pressing importance of weight loss in cases of obesity.

In communicating the existence of new schemes, there is the opportunity to use the latent demand for publicly funded programmes to generate a kind of “cachet”, specialness or even exclusivity which can act as a platform to generate awareness, appeal and demand. This approach could potentially reduce the cost of marketing the programmes, enabling more funds to be devoted to provision.

Referral by doctors and other clinicians will start out and should remain an important way in which potential participants are connected with programmes. However, in the longer term, it will be necessary to engage in mass social marketing activities, including leafleting and above the line media advertising.

Even so, the approach should be one that emphasises accessibility and which has with it a realism that is all too sadly lacking in many commercial weight loss programmes’ marketing activities.

Context

The Region

The Kirklees Metropolitan District is the seventh largest metropolitan district in England and the largest not based on a major city[1]. Its population was recorded as 398,200 in 2006.

The area has broadly average levels of income deprivation, but with significant pockets of poverty[2].

In terms of lifestyle, the region's eating, drinking and smoking habits are similar to the country as a whole and the same is believed to be true of exercise levels[3].

However, in terms of the region's health, life expectancy is lower than the national average (males 75.9 years v 76.6; females 80.1 v 80.9 years) and the population shows higher than average ratios of deaths from strokes, lung cancer, suicide, cervical cancer and coronary heart disease[4].

Obesity

In the UK, obesity is commonly measured in terms of Body Mass Index (BMI). The following are the commonly accepted definitions of BMI:

- BMI 25-30 – overweight
- BMI 30+ - obese
- BMI 40+ - morbidly obese

The focus of this research project was on people with a BMI of more than 30, ie obese or morbidly obese.

It is, however, relevant to the findings of this project to consider the body image of *some* people with a BMI of more than 30, who may not fit the perceived image of what is generally regarded as 'obese'. The photographs overleaf have been selected to demonstrate this point. They provide at least a partial explanation as to the reasons why some people taking part in the research denied or underestimated the scale of their weight problem.

[1] Kirklees Fact Sheets 2007
[2] Kirklees Fact sheets 2007
[3] Kirklees Health Profile 2007
[4] NHS Health Profile 2007 produced by the Association of Public Health Laboratories.

Rachel 5’ 3”, 185 lbs, BMI 32.8 (obese)

Sarah 5’ 11”, 225 lbs, BMI 31.4 (obese)

Detailed Research Findings

The Typologies

Typologies are an extremely useful tool for providing a better insight into the behaviour and motivations of subgroups within a broad population.

A 'typological' analysis approach allows us to group individuals in terms of things that they have in common, other than socio economic or demographic factors. This allows us to consider different ways of developing and targeting messages, compared with some of the more traditional socio-economic or demographic segmentation techniques.

The use of typologies in this study will facilitate the development of a social marketing plan in order to effect real changes in the behaviour and lifestyle of the target group.

The 'Strugglers'

This group is characterised by the fact that they are commonly morbidly obese and suffer from myriad of physical and mental health problems, eg diabetes, arthritis and other mobility problems, depression, self harming, anxiety, schizophrenia, underactive thyroid, etc. They may have other problems in the household, such as children with behavioural difficulties.

The 'Strugglers' often live in poor quality housing and are more likely to be living on state benefits than working.

Smoking and drinking are often endemic to this group.

They are likely to have the lowest levels of awareness of what constitutes a healthy diet and lifestyle.

They are aware that they are overweight but this is often just one of the many health issues and social problems that they are facing.

The 'Fantasy Borderliners'

This group is characterised by the fact that they underestimate the extent of their weight problem, but they are not yet suffering any major health problems.

Many of them are morbidly obese but believe they just need to lose 'a couple of stone'. This seems an achievable aim and something they are just about to tackle. The start of this programme will be 'cutting back a bit', meaning that they will cut back on some of their worst excesses but feel a need to continue with 'little treats', eg chocolate, crisps, etc.

They are often from (or part of) families with a history of obesity.

This group covers a broader socio-economic range and demonstrates a slightly better knowledge of what is a healthy diet and lifestyle, even though they may not actually be doing much or anything about it.

The 'Borderliners'

This group may be the most challenging in terms of social marketing as they do not recognise that their weight is a potential health problem. They recognise that they are 'a bit overweight' but may see this as something they can tackle quite easily, when they are ready to do so.

A key characteristic of this group is that they see themselves as reasonably healthy and they are not yet suffering from any health problems.

People in this category may have put weight on in recent years (due to 'getting older' or participating in fewer sports than when they were younger) or have previously been a lot heavier and are relatively happy with their current weight.

This group are likely to rank quite low down on the 'obesity' scale, ie with BMIs in the low 30s.

In terms of lifestyle, this group is the one most likely to be working, and long or irregular hours may be contributing to irregular or unhealthy eating patterns and difficulties in finding the opportunities to exercise regularly.

They often have a reasonable idea of what constitutes a healthy diet and lifestyle but many do not have the motivation to adopt either. Some will be planning to start 'cutting back a bit' and take more exercise; others see no reason to do so – at the moment.

Health Awareness

A Healthy Diet

Respondent views' on what constitutes a healthy diet reflect something of past and present public information campaigns aimed at improving the diet of the population.

Many respondents cited the need for '5 a day' in relation to the quantities of fruit and vegetables which should be consumed.

A healthy diet was commonly described by respondents taking part in the research as a combination of meat (chicken, pork, beef, etc) or fish and vegetables and daily portions of fruit. Cereals were also seen as a good way to start the day on a healthy diet. A sandwich at lunchtime was an acceptable component of a healthy diet.

*"Meat, fish, veg, salad, fruit and cereal". (*Female, 60+, 'Borderliner')

"*Fruit and vegetables, pork and chicken, ham sandwiches, water instead of pop, fresh orange juice".* (Male, 30s, 'Struggler')

Most respondents also believed that fatty and fried foods were not part of a healthy diet; nor should sugary, starchy foods or large quantities of alcohol be consumed as part of a healthy diet regime. Fruit juice and water were seen as 'healthy' drinks rather than carbonated, caffeinated or alcoholic drinks. This fairly simplistic view of a healthy diet was fairly consistent across the three different typologies of respondents.

Some respondents were concerned about the levels of sugar (especially those who suffered from diabetes) and salt in processed foods and did look at food labels to check the contents of what they were buying. However, most of the 'label readers' (who were very much in a minority in the sample) referred to food labels for the calorie or fat content and simply chose the product which contained lower levels of these elements.

Few respondents (even those who had had contact with dieticians in the past) demonstrated any detailed knowledge about what constitutes a healthy diet in terms of intake of the five main food groups. Issues such as saturated versus unsaturated fats, the need for fibre and starchy carbohydrates in the diet, etc produced few comments during the course of the interviews.

Female respondents and males who had had successful experience of diets in the past showed higher than average levels of understanding of the types of food to be avoided for people with weight problems.

There was a strong belief across all three typologies that a healthy diet should still include 'some treats'. The rationale for this belief was that to go without any 'treats' would eventually lead to consuming an excess.

"On a healthy diet you still have to have things like chocolate because if you don't have it you are going to crave it and then when you do have it you'll go mad…". (Female, 19 'Fantasy Borderliner')

There was also those occasions when, after a hard or difficult day at work, respondents simply wanted to eat something they really liked – healthy or not.

"*I've had one of them days at work, so I thought stuff it, I'm having a kebab*". *(*Male, 20s, 'Fantasy Borderliner')

Respondents acknowledged that a healthy diet had a number of benefits. These included the immediate benefits of an improved sense of well-being, higher energy levels, an improved overall appearance and particular improvement in the condition of the hair, skin, etc. They also perceived there to be longer term benefits related to the prevention of more serious health conditions such as heart attacks, strokes and cancer.

There were, however, numerous barriers to the adoption of a truly healthy diet. These included the perceived higher cost of fresh foods, a lack of time to prepare the food, a lack of the skills involved in 'home cooking', other health issues which required attention before a healthy diet was attempted (eg stopping smoking or combating depression or anxiety) and perhaps the most difficult barrier to overcome, finding the motivation to change their diet and lifestyle.

"The expense, especially fruit, you've got to do a lot of cooking to eat healthily……..I used to be a chef but I lost it, all the skills and motivation to do the cooking". (Male 30s 'Struggler')

"It's the next thing on my list". (Male, 40s, 'Borderliner')

"*The last thing you want to do when you get in a 6.30pm at night is start cooking up a meal – you want to sit down with your feet up*". (Male, 20s, 'Fantasy Borderliner')

A Healthy Lifestyle

All respondents were aware of the need to exercise as part of a healthy lifestyle, however, the amount of exercise taken by respondents was minimal.

The 'Strugglers' were the group least likely to be involved in exercise. Some had obvious mobility problems that would make many forms of exercise difficult; for others, the barriers were emotional or motivational or the fact that they simply did not like to exercise, preferring a more sedentary lifestyle and avoiding exercise whenever possible.

Many respondents in the 'Fantasy Borderliner' and 'Borderliner' groups had more positive attitudes towards exercise, but sometimes it was years since they had undertaken exercise regularly, and 'regularly' did not necessarily equate with 'frequently'.

"I like cycling and walking and used to do Karate about 12 years ago. I do go swimming once a month". (Male, 50s 'Borderliner')

*"I try to walk a bit for exercise. I did join a gym but working patterns made this difficult". (*Female, 40s, 'Fantasy Borderliner')

It was not uncommon in these two groups for respondents to outline to the interviewer their plans for becoming more active (joining a gym, going swimming more often, and walking instead using the car or public transport). Only a tracking study would confirm whether or not these plans ever come to fruition or whether they are part of an ongoing self-deception, or simply the desire to offer socially acceptable answers to the questions on exercise.

'Typical' Diet

Respondents taking part in the research were asked to describe their diet, in term of what meals and types of food they ate in a typical day.

To this end, respondents were encouraged to describe the previous day's food and drink intake or what they had eaten or drank/were planning to eat/drink on the day of the interview, in an attempt to encourage them to be realistic. However, it was clear from observations made by the interviewers, and comments made at other points during the visit, that many respondents displayed a tendency to minimise what they ate and drank and/or tended to concentrate on the aspects they felt were 'healthy' rather than the food and drink that might be the cause of their weight problems.

Across all three typologies, there were respondents who described their diet as 'quite healthy', whilst acknowledging that it was not perfect. The diets described often had some positive elements (eating fruit or avoiding fried food), but avoided mention of the 'treats' that were inevitably part of their daily intake. More women than men described their diet in this way.

"I try to eat healthily but a lot of it is from the freezer or tins, with not very much fresh. I buy fresh meat that I cook and then freeze for later. I don't eat salad, as it doesn't agree with me……..I don't eat chips but do like a fish from the fish and chip shop once a week". (Female 60+, 'Fantasy Borderliner')

"I have cereal for breakfast, then ham salad or Cuppa soup at lunchtime, if at work it's a Cuppa soup or nothing – then nibbles – in the evening maybe low fat sausages from Sainsburys, little potatoes and veg all cooked in the steamer; chicken with stuffing or sauce with potatoes and veg, no supper but occasionally Pringles". (Female, 40s, 'Fantasy Borderliner')

Respondents who conceded that their diet was not healthy tended to be in one of the two 'Borderliner' groups and therefore did not think their weight was a major problem. They tended to feel that they were 'doing all right' in terms of their general health and were, therefore, not that concerned about their diet. Male respondents were more likely than female respondents to admit to an 'unhealthy' diet.

"I try to eat the right things, like having fish twice a week, eating lean meat, salads but sometimes it doesn't happen. We like bacon sandwiches, sausages and pork pies but try not to have them too often. We know you are supposed to eat 5 fruit and veg a day, but it's hard as I don't really like fruit, but I do like veg". (Male, 50s, 'Borderliner')

"For breakfast I had bacon and toast. I'm waiting for my fish and chips that one of the lads has gone out for, for lunch. Tonight, about 8, I'm having home made steak pie and peas & bread and butter". (Male, 50s, 'Borderliner')

Alcohol was not uncommonly a part of respondents' lifestyle across all three groups. However, many stated that they were now 'cutting back' (this might mean changing from lager to wine or lager to Pils) or that consumption had reduced in recent years because they simply did not go out as much (this tended to be respondents in their 40s upwards).

In terms of eating patterns generally, many respondents (and especially those who were working and had busy lifestyles) 'skipped' breakfast and also had various 'snacks' or 'treats' both during the day and into the evening (biscuits, cakes, chocolates, crisps).

Factors Contributing to Weight Gain

Respondents sometimes talked about the reasons for their *own* weight problems, but both 'Borderliner' groups often talked about this issue in the context of what made *'other people'* overweight.

Behaviours that respondents suggested as contributing to weight gain included a range of things including diet (eating the 'wrong' foods), the quantities of food consumed (large portions and too many 'snacks' or 'treats'), and lifestyle factors (eg a lack of regular and frequent exercise).

"Fatty and sugary foods, convenience foods, sweets, biscuits and cakes… Some people have a sweet tooth or eat for comfort or eat anything that comes to hand". (Female, 60+, 'Fantasy Borderliner')

"Being lazy. We do a lot of motability cars and 9 out of 10 (owners) are gross...they sit and wait, can't do without their car...it's being lazy. (Male, 50s, 'Borderliner')

Some respondents with health problems believed that weight gain was a side effect of the drugs they were prescribed by the doctor.

Several respondents brought up the issue of obesity in children and strongly believed that this was on the increase. Factors contributing to this phenomenon were thought to be the consumption of convenience and takeaway foods, the 'eating on demand' approach to family mealtimes and lack of exercise. The latter was exacerbated by the lack of 'playing out' opportunities for children and the popularity of electronic games and the time that children spent 'at the computer' rather than engaged in more physical activity.

"There isn't as much around for kids. When I was a kid I was out playing football all the time….doesn't seem to be the play areas for them compared to what we used to have. Noticed kids these days are bigger than we used to be….you get all these McDonalds snack foods and they can just go and get them when they want, we weren't allowed to do that….if you weren't there you didn't get your meal, that was it". (Male, 50s, 'Borderliner')

The reasons for behaviours leading to weight gain were believed to be both psychological and environmental.

Most respondents really liked many of the foods that they knew contributed to weight gain. They acknowledged that when they were tired, depressed, under pressure or stressed they were likely to reach for the 'wrong' types of food as comfort. Those who recognised that they had a weight problem might then immediately feel guilty; others felt better as a result of their 'treat'.

"I've always suffered from depression but didn't know what it was. If I'm not feeling too good I'll go and open the fridge door and anything that I feel….anything that looks nice, like left over stew, I'll eat and when I'm eating it, it does the job. But afterwards I'm ashamed of myself". (Female, 50s, 'Struggler')

Environmental factors which respondents thought were contributing to obesity were: a lack of understanding of what constitutes a healthy diet; the lack of perceived opportunities or the physical ability to exercise; the increased reliance on convenience foods and 'takeaways' as a normal part of a family diet.

Weight Management Programmes

Feelings about Body Image and Weight

People participating in the research demonstrated a broad spectrum of attitudes towards their own body image.

At the most negative, some respondents were both embarrassed and depressed about their weight. This reaction was most commonly found in the 'Strugglers' typology group.

"I hate it [her body]. *I'd give anything to be a normal weight. For me I weighed 9 stone 7lbs all my* life [this was actually when she was in her teens, she is now in her 50s]*".* (Female, 50s, 'Struggler')

However, some of the 'Strugglers' were too concerned with other health problems (or problems within their family) or behaviours that were health threatening (eg smoking) to be concerned about their body image.

Interestingly, quite a few of the people taking part in the research did not admit to being unhappy with their body image. This group tended to be the 'Fantasy Borderliner' and 'Borderliner' respondents. Whilst most were happy to concede that they needed to lose some weight, their own body image was not a major problem for them.

"Generally, I'm happy with myself, but I know I need to lose weight" (Female, 19, 'Fantasy Borderliner')

"I just want to lose a bit because my jeans are a bit tight". (Female, 40s 'Fantasy Borderliner')

"I've got a bit of a belly….but overall, not bad at all". (Male, 50, 'Borderliner')

"I'm a bit overweight". (Male, 50s, 'Struggler', 5' 9", 17 stone)

Motivations for Weight Loss

To better understand reasons for not being involved in weight management programmes, respondents were asked about what prompted people to embark on weight loss programmes. The reasons given for finding the motivation to embark on such programmes came from both their own personal experience and that of other family members and peers.

For respondents in their 40s and 50s, health reasons were commonly cited. These included the fact that weight loss would give them an improved sense of well-being and more energy. More seriously, however, for some respondents their additional weight was actually causing or exacerbating existing health problems; others were concerned about the

increased chances of premature death or incapacitation as a result of heart attacks, strokes, cancer, etc. In the latter case, respondents were motivated by the desire to live longer in order to enjoy retirement, and to support and enjoy their children and grandchildren.

Across all age groups, but particularly for respondents aged less than 30 years of age and for females, the desire 'to look good', be attractive and to be able to buy and wear mainstream fashion were strong incentives for losing weight. This type of motivation was sometimes prompted by forthcoming occasions such as weddings and holidays, which meant that the weight management objective had a clearly defined timetable.

Experience of Weight Management Programmes

Experience of weight management programmes varied enormously across the sample.

The youngest respondents (ie those aged less than 20 years) and some of the men had no real experience of any types of programme. Although they may have 'cut back' on certain foods in their diet or made a tokenistic approach to include some exercise in their daily regime, they had not embarked on any form of serious weight management programme. In terms of the typologies, the 'Borderliners' were the group with the least experience of any type of weight management programme.

At the opposite extreme, the sample included people who had been involved in commercial programmes, referred to dieticians at the local hospital, prescribed medication such as appetite suppressants or 'fat pills'[5] and tried to embark on self-help regimes. The more seriously overweight respondents had often tried a number of approaches without any long term success.

"I've tried Slimming World, WeightWatchers, done my own diet, been to dietician at the hospital……" (Female, 50s, 'Struggler')

Female respondents were more likely than their male counterparts to have tried a range of weight management approaches and to have more knowledge of the different approaches through the experiences of their female relatives and friends.

[5] 'fat pills' are the commonly used term for the drug Orlistat which blocks the enzymes in the gut which digest fat. The undigested fat is then passed out of the body.

Attitudes to Weight Management

Commercial Weight Management Programmes

WeightWatchers and Slimming World were generally well known brands to many of the people taking part in the research. Lighter Life was known, but to a lesser extent. Attitudes to these commercial programmes were based on a mix of personal experience (a minority of the sample) and the experiences of partners, friends, other family and work colleagues and their partners.

These programmes were known to be capable of producing successful outcomes, although not necessarily on a long term basis.

Respondents saw the benefits of these programmes as providing information, advice and support for people wanting to lose weight.

"It would be for people who have tried to diet and failed in the past and need some form of incentive and to keep to it". (Female 60+, 'Struggler')

These programmes were seen as generally more attractive to women (ie most people who attended were female) and to people who were 'a bit overweight' rather than people who were obese or morbidly obese.

"When you go to WeighWatchers or Slimming World, most people are there for vanity you never come across anyone who is ill and told to lose weight…..". (Female, 50s, 'Struggler')

One of the disadvantages of the commercial programmes, from the male perspective, was that far more women than men were involved in them.

"My wife's doing it and she's lost 11 pounds in about six weeks. I did it a few years ago, but I was too embarrassed to keep going, even though I managed to lose about a stone…. there were too many women there and it wasn't my sort of thing. I didn't like being weighed by a woman. I wouldn't go again, unless more men were there". (Male, 20s, 'Fantasy Borderliner')

A common misconception about these programmes was that the weigh ins and feedback were heard by all. This 'humiliation' aspect was a major deterrent to being involved in such a programme, particularly for the 'morbidly obese'.

"People don't go because you've got to do everything in front of people - like being weighed and everyone knows how much you weigh". (Female, 16, 'Fantasy Borderliner')

Another commonly cited downside of the commercial programmes was the cost of them. For some of the people involved in this research programme, the perceived cost (£6 per week) was yet another barrier to participation.

Self-help Weight Management

As many of the respondents themselves had tried this approach (albeit largely unsuccessfully) to some level, it is not surprising that they believed it took a large amount of self-discipline to be successful. Some hypothesized that people who would be attracted to this method of weight management would be 'professional' people or people who did not have time to attend classes.

The benefit of this approach was that it could be tailored to the individual's lifestyle. The major downside was that it was all to easy to 'cheat' or give up, so people embarking on this approach would need to find support within their own family or social circle.

"The big advantage is you can adapt to suit you…..difficulty is if you are not sure where to start and you have to decide to do it yourself and you don't have any actual support….". (Males, 40s, 'Borderliner')

Practice based Weight Management Support

Respondents demonstrated mixed reactions to the idea of practice-based weight management support.

A perspective provided by the 'Borderliner' males, who were not suffering from any health problems and, therefore, rarely went to the doctors, was that GPs were there to deal with illnesses, rather than weight problems. An obvious exception to this was if weight problems were causing other health problems.

"It would be for people who are really big and probably too embarrassed to go to WeightWatchers. They probably have health problems as well". (Male, 17, 'Borderliner')

However, for people who did visit and have a relationship with their GP, this was seen as a trusted (ie non commercial) source of information and advice that was available locally, on a one-to-one, confidential and free basis.

"*Commercial weight places are there to make money, whereas, your GP is not*". (Male, 50s, 'Borderliner')

Several of the female respondents had approached their GP in the past for weight management support and were quite willing to try this approach again.

NHS Weight Management Support

Some respondents had had experience of being referred to a dietician at their local hospital in the past. Experiences had been mixed and never resulted in permanent weight loss.

A downside to this type of support was that there was likely to be little continuity in terms of the person they were allocated to at each appointment. As a result, respondents were often unhappy or frustrated at reiterating their problems again and again and the lack of 'rapport' with the person they were dealing with.

Respondents who had no experience of this type of support hypothesized that this approach was applicable only to people with serious health issues.

Exercise Referral Schemes

Respondents were questioned in their awareness of and feelings about the concept of schemes such as PALS (Practice Activity and Leisure Scheme), whereby people are referred to organised activity schemes via their GPs or other health professionals.

Four respondents were aware of the Kirklees scheme, but no one had had direct experience of it. In two cases, female respondents had become aware of the scheme because their GP had suggested it as an approach to weight management for their daughters. Neither had pursued the option – one because her daughter was already involved in a similar activity programme through her school, the other because the promotional literature seemed to suggest it was for 'older people' (her daughter was 15). The partner of one male respondent had been referred to PALS but had been unable to attend because the time of the activities did not fit in with her working patterns. A fourth respondent who worked as a carer had been made aware of it because her client (who had suffered a stroke) had been referred to the scheme. For this person, the referral had been a successful one.

The concept of the scheme was generally thought to be 'a good idea', although it was thought to be most appropriate for people with existing health problems, rather than people who were simply 'a bit overweight'.

Society and the Role of the Media

Many respondents were aware of and had seen at least some of the television programmes focussing on health, diet, looking good and weight management, eg 'Supersize vs Superskinny', Gok Wan's 'How To Look Good Naked', Trinny and Susannah, Gillian McKeith's 'You Are What You Eat' and numerous cookery programmes and documentaries on hugely overweight people. Female respondents were also exposed to multitudinous images of women in magazines.

All respondents were asked about their thoughts on the messages that came across from the media in terms of body image.

Female respondents agreed that the 'ideal' body image for women, as portrayed by much of the media, was 'thin' or 'size 0'. This was not a realistic portrayal of women generally and most of the women participating in this research did not aspire to this extreme. Many thought that this was 'unhealthy'. They thought that the portrayal of this type of ideal presented potentially harmful stereotypes to young girls, resulting in eating disorders and low self-esteem.

"People in magazines promoting fashion are underweight and this can be damaging for young girls who try to get down to that size to be in fashion. They try to be like models that are too thin; this can lead to anorexia and can be tragic". (Female, 60+, 'Borderliner')

From their own point of view, many female respondents (and also males) welcomed some of the more recent attempts to steer away from the ultra-thin body shape as 'ideal', eg the Dove advertising campaign which is part of the brand's 'Campaign for Real Beauty' and Coleen McLoughlin's 'Real Women'. They appreciated the fact that these initiatives sought to put forward a greater variety of physical shapes and sizes as 'beautiful' or 'attractive', rather than the unrealistic standards which have conventionally been promoted.

For women who were morbidly obese, however, these images did not go far enough. Although they tended to show bodies of different shapes and heights, they rarely presented anything over a size 14 or 16. For women who are morbidly obese, this is a distant fantasy.

"I've seen those but they just show people of different shapes, not really overweight like me…they're just size 8 but smaller". (Female, 50s, 'Struggler')

Male respondents were less clear on what their 'ideal' should be – particularly those in their 40s or over. However, on consideration, most agreed that the 'six pack' or 'athletic and fit' look was the ideal put across in the media (particularly for young men). This type of perfect body image was epitomised by the likes of David Beckham and other footballers, models and sportsmen.

"For people my age 'the pack' is the ideal body shape – like how the models look. But I don't pay much attention to it – I'd like to look like that but I'm not desperately bothered". (Male 17, 'Borderliner')

Male respondents had their own views on the portrayal of the ideal body shape for women via the media. All agreed that the 'ultra thin' shape as an ideal was very much contrary to their own views and they welcomed the idea of more 'real women' in all aspects of the media.

Information

Historic Sources of Information

The knowledge that people taking part in the research had acquired about diet and a healthy lifestyle had been acquired through a diverse range of sources.

In terms of the types of food eaten and eating patterns, the youngest respondents (ie those under 20), tended to follow patterns set down by their parents, with some of their own variations. Their understanding of the quantities of the different nutrients or food groups that would constitute a healthy diet was extremely limited.

For most respondents, their current knowledge was based on a mix of information gleaned over the years from a variety of sources including school (Health and Education classes), families and peer groups, the media (TV programmes, magazines, etc) and GPs and other health professionals (this source was usually restricted to those who were the most overweight).

Information Requirements

All respondents were questioned on the type of information that they would like to see made available in the area.

Some respondents (most typically the 'Borderliner' typology groups) were fairly confident that they knew enough about healthy diets and lifestyle to be able to implement such a programme when they needed it (in terms of when the motivation was right or their health started to suffer because of their weight).

Where respondents did acknowledge a need or desire for more information, the type of information varied. Some of the information requirements related to what constituted a healthy diet. Some wanted basic information on the quantities of food needed within each of the basic five food groups to constitute a healthy eating programme. Others were unsure about the number of calories appropriate for their body and lifestyle.

"You need to be told what quantities you can have, like 'you can have beef with so much veg', people should have it spelt out. Most people haven't got a clue". (Male, 50s, 'Struggler')

"I'd like to know, does a fruit smoothie count as one unit of fruit or more?". (Male, 17, 'Borderliner')

"People should be given basic information on how many calories and stuff they should every day – I can never remember whether it's 1,400 for women or 14,000! I don't think most people would have any idea". (Male, 50s 'Borderliner')

Respondents who were more confident about their knowledge of healthy eating (although this was not necessarily accurate), were more interested in information relating to exercise options – either organised activities or how to incorporate more exercise in to their day-to-day lives.

"Sometimes living healthily is portrayed as something that is really hard to do and I think it should be portrayed as you can still have a normal life and there is a variation in exercise - can go for a walk, you don't have to run a marathon. Can still eat out, have the odd take away…doesn't mean life is going to be miserable". (Male, 40s, 'Borderliner)

Respondents' opinions were divided about the type of promotional approach that would encourage them to take action about their weight. For some, the 'shock' or 'scare' approach was likely to have most effect; for others, the promotion (or promise) of good health into middle and old age was a stronger incentive.

"I think the shock approach might work for people my age - the ill health effects of poor diet and no exercise". (Male, 17, 'Borderliner)

"*I want to be able to get more out of life. I want to travel, see my grandson grow up, go walking, go off in the caravan, have holidays abroad*...". (Female, 50s, 'Struggler')

In terms of targeting, several male respondents expressed a desire for more materials and messages aimed at men. They believed that most of the advertising and materials concerned with weight management were currently targeted at females.

The Availability of Information

Respondents were asked about where information should be made available in order to provide easy access for them.

In terms of advertising and generally promoting a healthy lifestyle respondents suggested a range of both above the line and below the line media – TV, newspapers, posters, 'flyers', etc.

For more detailed and specific information on diet and exercise, respondents were divided into two camps. For those who were regular visitors to their GPs or local hospital (because of existing health problems), these were obvious and trusted information channels and information made available via these channels was easy to access for them.

Respondents who were not currently experiencing any specific health problems were unlikely to access information by these channels. For this 'healthy' group, it would be necessary to make the information available in places that they accessed in the course of their day-to-day lives, eg supermarkets, community centres, the Internet, colleges, etc.

In terms of a preventative approach, respondents from all typology groups believed it was important to educate children and young people, via the education system, in the benefits of healthy living and how to achieve this.

The Role of the Health Service

Towards the end of the sessions, respondents were questioned on what the role of the Health Service should be in encouraging a healthier lifestyle for people in the Kirklees area.

Many acknowledged that it was in the interests of the Health Service to do this, as there were obvious cost benefits to the Service if they could defer, alleviate or prevent many of the health problems that were concomitant with unhealthy lifestyles and obesity.

"I think the Health Service should be more active in preventative work rather than solutions. They should be campaigning to make more people take more exercise, etc". (Male, 50s, 'Borderliner')

However, a view more prevalent amongst the 'Borderline' typology groups was that the Health Service could only make information available and it was then down to the individual to take responsibility from that point, for their own health.

"It is the role of the Health Service to some extent because they are trying to look after everyone's health but I don't think it's all down to them, people have to try to be healthy, you can't expect the NHS to make you healthy'. (Female, 19, 'Fantasy Borderliner')

"People make themselves healthier; they are not made healthier by the Council or Health Care Trust. The most you can do is make sure stuff is available and people know it is available….can't force people and I don't think you should do. People are fed up of the 'nanny' state……" (Male, 40s, 'Borderliner')

As mentioned in the previous heading, many respondents strongly believed that schools and colleges also had a major role to play in encouraging and educating younger people into healthier lifestyles.

Appendix 1

Case Studies

The 'Struggler'

Mr F is in his 50s, and is 5' 9", 17 stone. He lives with his wife and stepson. His stepson has ADHD. Neither he nor his wife work and money is an ongoing problem.

Mr F suffers from many health problems including chronic depression, diabetes, angina and arthritis. His poor general health makes it difficult for him to exercise.

He has 'a cup of tea' for breakfast, a salad wrap for lunch and a casserole for 'tea'. He also has a weakness for cream cakes according to his wife and admits to the occasional kebab or pizza. He rarely drinks, but is a heavy smoker.

He has tried to lose weight in the past, as he knows it would improve his general health but doesn't equate what he eats with his weight. The family has other concerns that take priority over weight management – his depression, his stepson's ADHD, etc. Money is a problem in terms of buying fresh foods – he doesn't believe that they can afford them. He has also tried the 'fat pills' but experienced the predicted side effects and many other aches and pains. As he didn't seem to be losing any weight, he gave them up.

His wife has been provided with literature from her GP on healthy eating but they haven't read them. They would, however, like to have more information about the types of food you can eat on a weight management programme and portion control. As a couple, they would be interested in exercise schemes, so long as the cost was not prohibitive.

The Fantasy Borderliner

Mrs B is in her 40s and lives with her two daughters and husband. Photographs of her daughters suggest that they are both overweight – a factor confirmed by Mrs B. Her husband, however, is 'just big built, he's not overweight'. She says that 'I just want to lose a bit, my jeans are a bit tight'. She does not want to be as thin as the models.

She is about 5 feet tall and is approximately 3 stone overweight but is not currently experiencing any health problems.

Mrs B works as an auxiliary nurse in a coronary care unit and thinks she should be setting an example to the patients. She works shifts at the hospital so her eating patterns are disrupted and she would find it difficult to attend classes such as WeightWatchers because of this. She has thought of joining a gym but again making a regular commitment is a problem for her.

She tries to eat healthily and describes a typical day as cereal for breakfast, salad or Cuppasoup at lunchtime and a meal involving meat, potatoes and veg at night. She does not eat supper but occasionally succumbs to the temptation of Pringles at some point during the evening. She blames her excess weight on her fondness for crisps.

She does look at food labels for the sugar, fat and calorie content – and always chooses the product with the lower value. She doesn't believe in 'fad' diets, and thinks you just put weight back on when you return to 'normal' food.

She has been on some form of weight management programme via her GP in the past but did not like the fact that her irregular working hours meant that she saw a different nurse every time she went for her 'weigh in'. She would like to pursue this option again but feels a bit guilty because she feels really that this should only be option for people who are 'really overweight' or who have health problems associated with their weight.

The Borderliner

Mr T lives on own and is in his 40s. He recently moved into a cottage in Slaithwaite and works as a teacher at a sixth from college in Huddersfield. He was very overweight but lost several stones about 18 months ago (by 'just cutting back').

Although he still thinks he needs to lose 'a bit' of weight, he is reasonably comfortable with himself now that he can shop in 'normal' clothes shops like Next. His health is good and he can't remember when he last visited a GP. He is, however, a smoker and this is next on his list of things to tackle.

His diet has been dependant on convenience foods because of a lack of cooking facilities but he tended to choose the healthier options, ie pasta in tomato rather than cream-based sauces. He does however eat a Danish pastry for breakfast (sometimes two), a sandwich at lunchtime or pasta salad and fruit and a ready meal for 'tea' (he consults the labels for calorie content). He thinks his diet is 'OK' but a healthy diet would include more fresh ingredients and more home-cooked food.

He thinks other people are overweight because of sedentary lifestyle and lack of exercise. He thinks diets are just ‘fads’ and people who would go to the GPs or take part in an exercise referral scheme would have to have serious weight problems.

In terms of information he would like to see more information targeted at men and people being made to see they can incorporate exercise into their life (through walking, etc) rather than it being a different and separate thing. He thinks it is down to individuals to tackle their own problems and is wary of the ‘nanny’ state approach.

Appendix 2

Discussion Guide

Introduction

Introduce moderator/Enventure – independent, confidential etc
Explanation of research
Assure confidentiality
Respondent introduction:

- Family composition (married, co-habiting, single and number & ages of children)

Health Awareness

How would you describe your current state of health?
Why do you say that?
How would you say you compare with your family/friends in terms of health? *Probe: better/worse?*
How would you describe your feelings towards your body image?
Probe: positive/negative? Why is this?

Can you describe your diet in terms of the types of food you and your family tend to eat regularly?
Do you think this is a healthy diet?
What is a healthy diet to you?
What would you say are the advantages/disadvantages of a healthy diet? *probe barriers to healthy diet*.
How aware or unaware would you say you [and your family] are of healthy eating, eg do you look at labels on food etc? Why? Why not?
Attitude to exercise?
Would you say some family members are more unaware/aware than others?
Why do you think this is?
What do you think the contributing factors to weight gain are generally? *Probe beyond responses such as 'eating too much'*.

Society & Weight Management

Thinking about television programmes, advertisements on television and in magazines etc, what do you think the media tells us is 'normal' in terms of body weight? *Probe for feedback on recent campaigns/programme using 'real women' etc.*
How does this image of 'normal' fit in with people you know?
What effect does this have on people, in your experience?
How could more positive messages be conveyed by the media? *Probe on television, magazines, advertisements etc.*
What type of images would you like to see?
Can you think of any examples of where these types of images were shown?

Weight Management

Have you ever taken any action with regard to weight loss? *Probe: diets, exercise, internet, magazines etc*.
Have you or anyone you know been involved in commercial weight management programmes (WeightWatchers, Slimming World, Lighter Life etc)?
What do you think motivated you/them to take action?
What was your/their experience like?
What would you say motivates people to be involved in weight management programmes?
Why do you think some people choose to attend more formal programmes, eg classes and some prefer to do it themselves?
What do you think puts people off different kinds of weight loss programmes?
What do you think encourages people to get involved with?

- Commercial weight management, eg WeightWatchers, Slimming World, Lighter Life
- Self help weight management, eg books, magazines, internet, dieting, regular physical activity
- Weight management support via the NHS, eg GP practice-based
- Exercise referral scheme, eg via PALS (Practice Activity and Leisure Scheme).

What would you say are the pros and cons of various types of weight management?
If not involved probe why have they never accessed those services? Is there an alternative they would like that is not available?

Information

What information, if any, would you like to find out about weight management programmes in Kirklees?
Where would you go to find information about weight management programmes?
Would you consider approaching the health service?
Would you go to your GP? Why? Why not?
What role, if any, do you think the health service should play in assisting people with weight management?

Thank you and close
Respondent to make any final comments
Thank respondent on behalf of Enventure and the PCT
Ask whether respondent has any questions.