**The association between neighbourhood greenspace and type 2 diabetes in a large cross-sectional study**

# Danielle H. Bodicoata, Researcher in Medical Statistics

# Gary O’Donovana, Researcher in Physical Activity, Sedentary Behaviour and Health

# Alice M. Daltonb,c, Senior Research Associate

# Laura J. Grayd, Senior Lecturer of Population and Public Health Sciences

# Thomas Yatesa, Reader in Physical Activity, Sedentary Behaviour and Health

# Charlotte Edwardsona, Lecturer in Physical Activity, Sedentary Behaviour and Health

# Sian Hilla, Project Manager

# David R. Webba, Senior Lecturer

# Kamlesh Khuntia, Professor of Primary Care Diabetes and Vascular Medicine

# Melanie J. Daviesa, Professor of Diabetes Medicine

# Andrew P. Jonesb,c, Professor in Public Health

a University of Leicester, Diabetes Research Centre, Leicester Diabetes Centre, Leicester General Hospital, Gwendolen Road, Leicester, Leicestershire, LE5 4PW, UK

b University of East Anglia, Norwich Medical School, Norwich Research Park, Norwich, Norfolk, NR4 7TJ, UK

c UKCRC Centre for Diet and Activity Research (CEDAR), MRC Epidemiology Unit, University of Cambridge, Cambridge, UK

d University of Leicester, Department of Health Sciences, Leicester Diabetes Centre, Leicester General Hospital, Gwendolen Road, Leicester, Leicestershire, LE5 4PW, UK

**Correspondence to:** Dr Danielle Bodicoat, Diabetes Research Centre, University of Leicester, Leicester Diabetes Centre, Leicester   General   Hospital, Gwendolen  Road, Leicester, Leicestershire, LE5 4PW, UK

Email: [dhm6@le.ac.uk](mailto:dhm6@le.ac.uk)

Telephone: 0116 258 8595

Fax: 0116 258 4053

**Word count.** Abstract: 236;Main text: 2973.

**Running Head:** Greenspace and type 2 diabetes

**Abstract**

**Objective:** To investigate the relationship between neighbourhood greenspace and type 2 diabetes.

**Design:** Cross-sectional.

**Setting:** Three diabetes screening studies conducted in Leicestershire, UK in 2004-2011. The percentage of greenspace in the participant’s home neighbourhood (3km radius around home postcode) was obtained from a Land Cover Map. Demographic and biomedical variables were measured at screening.

**Participants:** 10,476 individuals (6200 from general population; 4276 from high-risk population) aged 20-75 years (mean 59 years); 47% female; 21% non-white ethnicity.

**Main outcome measure:** Screen-detected type 2 diabetes (WHO 2011 criteria).

**Results:** Increased neighbourhood greenspace was associated with significantly lower levels of screen-detected type 2 diabetes. The ORs (95% CI) for screen-detected type 2 diabetes were 0.97 (0.80 to 1.17), 0.78 (0.62 to 0.98) and 0.67 (0.49 to 0.93) for increasing quartiles of neighbourhood greenspace compared with the lowest quartile after adjusting for ethnicity, age, sex, social deprivation score and urban/rural status (Ptrend = 0.01). This association remained upon further adjustment for body mass index, physical activity, fasting glucose, 2-hour glucose and cholesterol (OR [95% CI] for highest vs lowest quartile: 0.53 [0.35 to 0.82]; Ptrend = 0.01).

**Conclusions:** Neighbourhood greenspace was inversely associated with screen-detected type 2 diabetes, highlighting a potential area for targeted screening as well as a possible public health area for diabetes prevention. However, none of the risk factors that we considered appeared to explain this association, and thus further research is required to elicit underlying mechanisms.

**Keywords:** Diabetes Mellitus; Environment; Epidemiology; Greenspace; Public Health

**Strengths and limitations of this study**

* Evidence regarding the association between greenspace and type 2 diabetes is limited since only two cross-sectional studies have investigated this association, and while they showed an inverse association, both used self-reported measures of diabetes.
* A major strength of this study was that robust measures of type 2 diabetes, greenspace, and potential confounders were used.
* Other strengths include the large sample size, robust detailed analysis, and the multi-ethnic population.
* The limitations include the cross-sectional nature of the study, that only screen-detected diabetes was included rather than all prevalent cases, and it is not possible to determine from the available data which areas of greenspace were publicly accessible.
* We found that neighbourhood greenspace was inversely associated with screen-detected type 2 diabetes, with 11% prevalence of undiagnosed type 2 diabetes in the lowest quartile of greenspace compared with 6% prevalence in the highest quartile of greenspace.

**Introduction**

Prevalence of type 2 diabetes mellitus, a chronic long term condition, is rapidly increasing, and it is estimated that there are 175 million cases undiagnosed worldwide.1 This may be largely due to environmental/behavioural factors.2, 3 Individual-level interventions that encourage healthy lifestyles can lead to increased physical activity and improved diet, which in turn lower glucose levels to reduce type 2 diabetes risk or improve type 2 diabetes control.4 However, public health solutions, such as changes to local environments, are also required to tackle the type 2 diabetes epidemic.5 Accordingly, policymakers have been urged to provide greenspace, such as parks and natural areas, to facilitate physical activity, encourage other healthy behaviours, and reduce type 2 diabetes risk.5, 6

Only two studies have however investigated relationships between neighbourhood greenspace and type 2 diabetes.7, 8 Both used self-reported diabetes, and found that greenspace was inversely related to diabetes.7, 8 The knowledge gap highlighted by this limited evidence base is gaining even more importance with the increasing urbanisation worldwide. Additionally, the underlying factors explaining any relationship between greenspace and type 2 diabetes are unclear. For example, physical activity could explain the purported relationship between greenspace and morbidity,9 but this has not been clearly shown in all studies.7 This might be because, to our knowledge, no studies have used objective measures of greenspace in conjunction with objective diagnoses of type 2 diabetes and measures of its risk factors.

We therefore investigated whether neighbourhood greenspace was associated with type 2 diabetes in a large multi-ethnic population characterised using robust, objective measurements. The primary objective was to investigate the relationship between neighbourhood greenspace and screen-detected type 2 diabetes, and the secondary objective was to explore possible explanations underlying this relationship.

**Materials and Methods**

*Participants*

Three type 2 diabetes screening studies were conducted in Leicestershire, UK, using identical standard operating procedures: ADDITION-Leicester (NCT00318032), Let’s Prevent Diabetes (“Let’s Prevent”; NCT00677937), and Walking Away from Diabetes (“Walking Away”; NCT00941954). This work only included cross-sectional data from the screening stage of each study. Ethical approval was from the University Hospitals of Leicester and Leicestershire Primary Care Research Alliance (ADDITION-Leicester) or the Nottingham (Walking Away/Let’s Prevent) Research Ethics Committees. All participants gave written informed consent.

Full study descriptions are available elsewhere.10-12 Briefly, ADDITION-Leicester (2004-2009) was a population-based study which screened people for type 2 diabetes.10 Individuals selected at random from participating general practices who met the eligibility criteria were invited. Eligibility criteria included age 40-75 years (white Europeans) or 25-75 years (other ethnicities), and no diabetes diagnosis, thus all type 2 diabetes cases are screen-detected. Recruitment methods and inclusion criteria were similar in Let’s Prevent (2009-2011)11 and Walking Away (2010),12 except that individuals in both Let’s Prevent and Walking Away were at high risk of type 2 diabetes based on the Leicester Practice Risk Score,13 and Walking Away had wider age inclusion criteria (18-74 years). Participants were excluded from the current analyses if their postcode was missing or invalid. If they took part in more than one of the studies then their most recent record was kept. In all three studies, participants attended a clinic visit where they provided a fasting sample, underwent an oral glucose tolerance test, had anthropometric measurement recorded, and completed questionnaires.

*Outcome*

Type 2 diabetes diagnosis was based on WHO 2011 criteria, using gold-standard oral glucose tolerance tests (fasting glucose ≥7.0mmol/l or 2 hour glucose ≥11.1mmol/l) or HbA1c (≥6.5%; 48mmol/mol).14

*Explanatory variables*

The main explanatory variable was the percentage of greenspace in the participant’s home neighbourhood, and this was categorised into quartiles for the analyses. ArcGIS 9.3 (ESRI 2009), a geographic information system, was used.15 To delineate neighbourhood boundaries, the postcode of each participant was geo-located using the UK Ordnance Survey Code-Point® database (2004-2013),16 which provides a set of coordinates depicting the average latitude and longitude of all mail delivery locations within each postcode, which contains 15 addresses on average. Neighbourhood was delineated based on distance around these coordinates. Neighbourhoods are typically defined as the area within 800m (approximating to a ten minute walk) of a home location.17 However, recent research from studies employing global positioning systems to track movement suggests that this may be overly conservative,18 and that individuals typically travel greater distances to access resources and be physically active, therefore we used a distance of 3km.19 We used a circular buffer because greenspaces are often accessible via footpaths and cut-throughs rather than roads. In sensitivity analyses, we also defined neighbourhood based on radii of 800m and 5km, and using road network buffers.

Estimates of greenspace were from the Centre for Ecology and Hydrology Land Cover Map of the UK (2007),20 which is derived from satellite images and digital cartography, and records the dominant land use type, based on a 23 class typology, per 25m by 25m grid cell. Broadleaved and coniferous woodland, arable, improved grassland, semi-natural grassland, mountain, heath, bog, and freshwater (including rural lakeland environments) were classed as greenspace. Each participant’s exposure was computed by overlaying the mapped greenspace with the neighbourhood boundaries in the geographic information system software to calculate the percentage of each neighbourhood area that contained these land cover types.

Other explanatory variables were treated as confounders, including age, sex, social deprivation score (Index of Multiple Deprivation score), and urban/rural location.21 Ethnicity was self-reported using Census categories and grouped as White European, South Asian and Other due to the small number of participants in some ethnic groups. Trained staff measured weight and height to the nearest 0.1kg and 0.5cm, respectively. BMI was calculated as weight (kg) / height (m) squared. Cholesterol was measured in the fasting blood sample. Self-reported physical activity was obtained using the International Physical Activity Questionnaire (IPAQ). Published standards were used to calculate the number of metabolic equivalents (METS) per day for total activity.22 Objective physical activity (average number of steps per day) was also available in Let’s Prevent (sealed piezoelectric pedometer, NL-800, New Lifestyles, USA) and Walking Away (tri-axial accelerometer, GT3X, ActiGraph, USA). Participants wore the devices during waking hours for seven consecutive days on the right anterior axillary line of their trunks.

*Statistical Analysis*

Participant characteristics were summarised by study and overall as mean (standard deviation [SD]) for continuous variables and percentage for categorical variables. The mean (SD) percentage of neighbourhood greenspace was summarised by subgroup of participant demographics and compared using one-way ANOVA. Generalised estimating equations with a binary outcome were used to investigate whether quartiles of neighbourhood greenspace were associated with type 2 diabetes, with a term for clustering by postcode. Quartiles were defined as ≤30%, 31-59%, 60-77%, and ≥78% based on the data. Three models were fitted. Model 1 was adjusted for ethnicity, age, sex, social deprivation score, and urban/rural status. Model 2 was adjusted for all variables in Model 1 plus body mass index and physical activity (total METS). Model 3 was adjusted for all variables in Model 2 plus fasting glucose, 2 hour glucose, and total cholesterol. Tests for trend were performed by fitting the greenspace quartiles as a continuous variable. Missing data were imputed in all models. Missing type 2 diabetes values were replaced as no type 2 diabetes, and missing ethnicity as white European, as these were overwhelmingly the modal values for those variables. All other missing values were replaced using multiple imputation with type 2 diabetes, age, sex and ethnicity as the predictor variables. Model 3 was also fitted using an objective measure of physical activity (average number of steps per day), rather than a subjective one (total METS reported via IPAQ), but this measure was only available in Walking Away and Let’s Prevent, so missing data for average number of steps per day were not imputed due to the large quantity of such data. Sensitivity analysis involved fitting the fully adjusted model (Model 3) for different neighbourhood definitions. Analyses were performed in Stata v13. P-values <0.05 were treated as statistically significant.

**Results**

*Participants*

The three studies screened 11,032 people (6749 ADDITION-Leicester, 3450 Let’s Prevent, 833 Walking Away), of whom 300 were excluded because their postcode was missing (all ADDITION-Leicester), and 12 because it was invalid (6 ADDITION-Leicester, 5 Let’s Prevent, 1 Walking Away). There were 244 people who participated in multiple studies; therefore, these analyses included 10,476 participants, whose characteristics are in Table 1. The mean age was 59 years, 47% were female, 21% were of non-white ethnicity, and 16% lived in a rural location. There were some differences between the studies, primarily because ADDITION-Leicester screened the general population, whereas the other two screened high risk populations.

*Amount of neighbourhood greenspace*

Percentage of greenspace varied by neighbourhood definition, however all measures were strongly correlated (Table 2). The remainder of the manuscript pertains to the circular 3km buffer unless otherwise stated.

Neighbourhoods comprised 57% (SD 26%) greenspace on average (Table 3). The amount of neighbourhood greenspace was higher for participants who were older (P<0.001), male (P<0.001), of White European ethnicity (P<0.001), lived in rural locations (P<0.001), and had low social deprivation (P<0.001).

*Associations with type 2 diabetes*

Increased neighbourhood greenspace was associated with significantly lower levels of screen-detected type 2 diabetes. In the lowest greenspace quartile, 281 (10.7%) of people had type 2 diabetes; the analogous figures were 236 (9.0%), 159 (6.1%) and 161 (6.1%) for the second, third and fourth quartile respectively. ORs suggested that inverse relationship was significant (Figure 1). The OR (95% CI) for screen-detected type 2 diabetes was 0.67 (0.49, 0.93) in the highest compared with the lowest quartile after adjusting for ethnicity, age, sex, social deprivation score and urban/rural status (Ptrend = 0.01). This pattern remained upon further adjustment for body mass index and physical activity (Figure 1). After further adjustment for fasting glucose, 2-hour glucose and cholesterol, the dose-response relationship weakened, but the inverse association between greenspace and type 2 diabetes remained (Ptrend = 0.01; Figure 1).

The effect sizes were similar in analyses stratified by recruitment type (fully adjusted OR [95% CI] for highest vs lowest quartile: population-based 0.48 [0.23, 1.01]; high-risk studies 0.47 [0.27, 0.81]; data not in Table). When objectively-measured physical activity was included in Model 3, rather than subjectively-measured physical activity, the inverse association between greenspace and type 2 diabetes remained (fully adjusted OR [95% CI] for highest vs lowest quartile: 0.45 [0.24, 0.82]; Ptrend < 0.01; N = 3541; data not in Table).

*Sensitivity analysis*

Table 4 shows the fully adjusted analyses (Model 3) for different neighbourhood definitions. When a distance of 800m was used to define the neighbourhood, there was not a significant association between type 2 diabetes and greenspace, regardless of whether a circular or road network buffer was used. Conversely, when a distance of 3km or 5km was used, there was a significant inverse association between greenspace and type 2 diabetes regardless of the type of buffer used.

**Discussion**

In this large cross-sectional study, older age, male sex, White European ethnicity, higher socio-economic status and rural locations were associated with having more neighbourhood greenspace. After adjustment for these and other factors, increasing amounts of greenspace were associated with lower prevalence of screen-detected type 2 diabetes. Sensitivity analyses suggested that this inverse association was somewhat dependent on neighbourhood definition.

Our study has major strengths. Notably, the objective measures of greenspace, type 2 diabetes and potential confounders, the large sample size, robust detailed analysis, and the multi-ethnic population, mean that we are able to add novel, robust information to an emerging area of type 2 diabetes prevention. Furthermore, the diverse ethnic, socioeconomic and geographical distribution of this population means that our results are generalisable to other populations. This study also has limitations. The most important is that the cross-sectional nature of the study means that we are unable to infer causality from our findings. Other limitations are likely to have weakened the association between greenspace and type 2 diabetes, and so it may be stronger than observed. These limitations are that only screen-detected diabetes was included rather than all prevalent cases, and it is not possible to determine from the available data which areas of greenspace were publicly accessible. Finally, we were not able to assess the quality of greenspace, and there is some evidence that better quality spaces, for example those free from vandalisms and with better accessibility, are more health promoting.23

Our finding that neighbourhood greenspace might be associated with lower screen-detected type 2 diabetes prevalence can be interpreted in two ways due to the cross-sectional nature of our study. First, it could suggest that areas with a low amount of greenspace would benefit from targeted screening programmes since these areas tend to have a higher number of undiagnosed type 2 diabetes cases. This could have important implications in terms of resource allocation, and might suggest that a general population screening programme is best suited to urban areas with low greenspace availability, whereas in areas with more greenspace then only those at high-risk of type 2 diabetes would need to be screened. It also suggests that areas with a low density of greenspace might benefit from community interventions, such as mass media campaigns, to raise awareness of type 2 diabetes and its prevention.

Second, it could suggest that greenspace might be protective for type 2 diabetes if the association between undiagnosed type 2 diabetes and greenspace is the same as that between overall type 2 diabetes and greenspace, which seems likely to be the case particularly after adjustment for socio-economic status, ethnicity and other demographic factors that are likely to lead to earlier diagnosis. The idea that greenspace might be protective for type 2 diabetes supports the findings of two other large cross-sectional studies, both of which used self-reported measures of type 2 diabetes,7, 8 as well as emerging evidence that more walkable neighbourhoods are associated with fewer diabetes cases.24 Maas et al used similar methods to ours to quantify greenspace in a Dutch population,8 and found that greenspace was inversely associated with diabetes in a 1km, but not a 3km, radius. Conversely, our results tended towards a stronger association when a larger radius was used. Differences depending on the neighbourhood definition used may occur for a number of reasons. For example, people living on the edge of urban developments may be linked with a small percentage of greenspace based on a road network buffer, and with a much larger percentage based on a circular buffer. Therefore, some neighbourhood definitions may better capture the amount of greenspace that people access than others. Astell-Burt et al also recently reported that greater access to greenspace was associated with lower diabetes risk in Australian adults aged 45 years and older.7 Our work extends the limited evidence in this area by demonstrating that the association between greenspace and screen-detected type 2 diabetes appears also to be present in multi-ethnic populations and when robust type 2 diabetes diagnoses are used. We estimated that people living in neighbourhoods with the highest quartiles of greenspace had a 47% lower odds ratio of type 2 diabetes compared with those in the lowest quartile. These quartiles relate to ≥78% and ≤30% neighbourhood greenspace, respectively, suggesting that those with the lowest prevalence of type 2 diabetes have access to approximately three times as much greenspace as those with the highest prevalence. It is also notable that those with the lowest neighbourhood greenspace had demographic patterns congruent with those of people at highest risk of type 2 diabetes, for example those of south Asian ethnicity, suggesting that public health guidance to increase greenspace access to prevent or delay type 2 diabetes would potentially be of greatest benefit to those at highest risk if it were to be implemented.5, 6

Intuitively, the most likely reason that greenspace might be associated with type 2 diabetes prevalence seems to be that increased greenspace might encourage healthy behaviours, particularly physical activity, which is known to decrease type 2 diabetes risk.25 However, we found little evidence to support this; adjusting for subjectively and objectively measured physical activity did not attenuate the association between greenspace and type 2 diabetes. This supports another observational study in England, which found that greenspace was not significantly related to the types of physical activity normally associated with greenspace.26 Possible explanations of this are that seven days of measurement may not reflect seasonal variation in physical activity and might bias towards the null any relationship between physical activity and greenspace,27, 28 and that we were only able to measure participation in physical activity without reference to where it occurs, such as in greenspace, the gym or at home. Astell-Burt et al also found that physical activity did not appear to explain the inverse relationship between greenspace and diabetes.7 Indeed, the association between greenspace and type 2 diabetes was not explained by any of the type 2 diabetes risk factors that we accounted for in the analyses. This could mean that they are not causally associated, or that these associations are due to confounding with an unmeasured factor. Similarly, other studies have found that the potential mediators that they examined did not explain the association between health and greenspace.7, 29 They therefore concluded that other unmeasured pathways might explain the association, such as air pollution,7 quality of sleep, or psychosocial factors,29 which seems highly plausible. Another potential pathway is through diet (for example, deficiency of metabolically active micronutrients analogous with modern dietary intake), but we could not explore this as there was not a consistent diet measure across the studies that we included.

In conclusion, these data support the hypothesis that access to greenspace is inversely associated with screen-detected type 2 diabetes, thus highlighting a potential area to be considered for targeted screening programmes and type 2 diabetes prevention. However, none of the confounders that we considered appeared to explain this association, which highlights that more research is needed in this area before public health policies are generated. Future research areas that would be of particular interest would be to incorporate dietary indicators, and to subjectively delineate quality of greenspace.

**Competing Interests**

All authors have completed the Unified Competing Interest form at [www.icmje.org/coi\_disclosure.pdf](http://www.icmje.org/coi_disclosure.pdf) (available on request from the corresponding author) and declare that all authors have no relationships with companies that might have an interest in the submitted work in the previous 3 years; their spouses, partners, or children have no financial relationships that may be relevant to the submitted work; and (4) all authors have no non-financial interests that may be relevant to the submitted work.

**Sources of Funding**

ADDITION-Leicester was funded for support and treatment costs by NHS Department of Health Support for Science and project grants. Let’s Prevent Diabetes was funded by a National Institute for Health Research Programme Grant. Walking Away from Diabetes was supported by funding from the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care for Leicestershire, Northamptonshire and Rutland. The study funders had no role in the collection, analysis or interpretation of the data, in the writing of the report, or in the decision to submit the article for publication.

**Acknowledgements**

The research was supported by The National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care – East Midlands (NIHR CLAHRC – EM), the Leicester Clinical Trials Unit and the NIHR Leicester-Loughborough Diet, Lifestyle and Physical Activity Biomedical Research Unit which is a partnership between University Hospitals of Leicester NHS Trust, Loughborough University and the University of Leicester. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health. The work of AD and APJ was supported by the Centre for Diet and Activity Research (CEDAR), a UKCRC Public Health Research: Centre of Excellence. Funding from the British Heart Foundation, Economic and Social Research Council, Medical Research Council, the National Institute for Health Research, and the Wellcome Trust, under the auspices of the UK Clinical Research Collaboration, is gratefully acknowledged (RES-590-28-0002). The study sponsor and funders had no role in study design; in the collection, analysis, and interpretation of data; in the writing of the report; or in the decision to submit the article for publication. The researchers are independent from the funders.

**Contribution statement**

KK, MD, LG, TY and SH designed and conducted the Let’s Prevent Diabetes study. KK, MD, DW, and LG designed and conducted the ADDITION-Leicester study. KK, MD, TY, CE and LG designed and conducted the Walking Away from Diabetes study. DB, GO, AD and AJ conceived and designed the current analyses. DB conducted and is responsible for the data analysis. DB wrote the first draft of the manuscript with GO. All authors contributed to interpreting the data, revising the manuscript, and approved the final version. DB is the guarantor for the study. DB affirms that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted, and that any discrepancies from the study as planned have been explained. All authors had full access to all the data in the study and can take responsibility for the integrity of the data and the accuracy of the data analysis.

**Data sharing**

No additional data available.

**Exclusive license**

The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, a worldwide licence (<http://www.bmj.com/sites/default/files/BMJ%20Author%20Licence%20March%202013.doc>) to the Publishers and its licensees in perpetuity, in all forms, formats and media (whether known now or created in the future), to i) publish, reproduce, distribute, display and store the Contribution, ii) translate the Contribution into other languages, create adaptations, reprints, include within collections and create summaries, extracts and/or, abstracts of the Contribution and convert or allow conversion into any format including without limitation audio, iii) create any other derivative work(s) based in whole or part on the on the Contribution, iv) to exploit all subsidiary rights to exploit all subsidiary rights that currently exist or as may exist in the future in the Contribution, v) the inclusion of electronic links from the Contribution to third party material where-ever it may be located; and, vi) licence any third party to do any or all of the above. All research articles will be made available on an Open Access basis (with authors being asked to pay an open access fee—see <http://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/copyright-open-access-and-permission-reuse>). The terms of such Open Access shall be governed by a [Creative Commons](http://creativecommons.org/) licence—details as to which Creative Commons licence will apply to the research article are set out in our worldwide licence referred to above.

**Table 1.** Participant characteristics by study and for the entire sample combined.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Variable** | **Addition-**  **Leicester** | **Let’s Prevent Diabetes** | **Walking Away from Diabetes** | **All** |
| Age, years | 56.2 (10.8) | 63.2 (8.2) | 63.1 (8.2) | 59.0 (10.4) |
| Social deprivation score | 19.7 (14.1) | 17.3 (15.0) | 20.2 (16.3) | 19.0 (14.6) |
| Total METS | 3376.2 (3579.6) | 2293.5 (3038.0) | 3380.0 (3949.8) | 3007.3 (3475.3) |
| Average steps per daya | - | 6544.1 (3100.0) | 6610.3 (3210.9) | 6557.6 (3122.7) |
| Body mass index, kg/m2 | 28.0 (5.0) | 32.4 (5.7) | 32.5 (5.6) | 29.8 (5.7) |
| Waist, cm | 93.7 (13.2) | 108.8 (12.9) | 101.8 (12.4) | 99.4 (14.8) |
| Fasting glucose, mmol/l | 5.2 (0.9) | 5.3 (0.8) | 5.3 (0.8) | 5.2 (0.9) |
| 2 hour glucose, mmol/l | 6.0 (2.4) | 6.6 (2.5) | 6.5 (2.4) | 6.3 (2.5) |
| HbA1c, % | 5.7 (0.6) | 5.9 (0.5) | 5.9 (0.6) | 5.8 (0.6) |
| Total cholesterol, mmol/l | 5.5 (1.1) | 5.1 (1.0) | 5.1 (1.1) | 5.4 (1.1) |
|  |  |  |  |  |
| Female | 53.1 | 39.1 | 36.5 | 47.2 |
| South Asian | 23.5 | 10.7 | 8.1 | 18.0 |
| Other ethnicity | 2.6 | 2.6 | 3.5 | 2.6 |
| Rural location | 11.7 | 24.5 | 17.5 | 16.3 |
| Type 2 diabetes mellitus | 6.2 | 10.9 | 9.4 | 8.0 |
| **Total** | **6200** | **3444** | **832** | **10476** |

Data are mean (standard deviation) or percentage.

Missing data: 0 Age and Sex, 21 Social deprivation score, 1481 Total METS, 208 Body mass index, 33 Fasting glucose, 81 2 hour glucose, 149 HbA1c, 108 Total cholesterol, 190 Ethnicity, 21 Rural location, 13 Type 2 diabetes.

a Measured using pedometers in Let’s Prevent Diabetes and using accelerometers in Walking Away from Diabetes (735 missing values).

**Table 2.** Average percentage of greenspace and correlations between percentage of greenspace according to neighbourhood definition.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Mean (SD) % of greenspace** | **Correlations** | | | | | |
|  | | **Circular buffer** | | | **Road network buffer** | | |
| **800m** | **3km** | **5km** | **800m** | **3km** | **5km** |
| **Circular buffer** | **800m** | 38 (27) | 1 |  |  |  |  |  |
| **3km** | 57 (26) | 0.81 | 1 |  |  |  |  |
| **5km** | 65 (22) | 0.74 | 0.97 | 1 |  |  |  |
| **Road network buffer** | **800m** | 33 (28) | 0.94 | 0.72 | 0.65 | 1 |  |  |
| **3km** | 50 (27) | 0.85 | 0.97 | 0.92 | 0.77 | 1 |  |
| **5km** | 58 (24) | 0.77 | 0.98 | 0.98 | 0.69 | 0.96 | 1 |

Abbreviations: SD, Standard Deviation.

**Table 3.** The percentage of neighbourhood greenspace by participant characteristics.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Variable** | **Category** | **N** | **Mean (SD) percentage**  **of greenspace** | **P-value** |
| Age, years | <55 | 3208 | 51 (26) |  |
|  | 55-64 | 3548 | 58 (25) |  |
|  | ≥65 | 3720 | 60 (25) | <0.001 |
|  |  |  |  |  |
| Sex | Male | 5534 | 58 (26) |  |
|  | Female | 4942 | 55 (25) | <0.001 |
|  |  |  |  |  |
| Ethnicity | White European | 8167 | 62 (24) |  |
|  | South Asian | 1847 | 35 (17) |  |
|  | Other | 272 | 33 (20) | <0.001 |
|  |  |  |  |  |
| Urban/rural location | Urban | 8749 | 50 (22) |  |
|  | Rural | 1706 | 91 (06) | <0.001 |
|  |  |  |  |  |
| Social deprivation score | Low | 5872 | 68 (21) |  |
|  | High | 4583 | 41 (23) | <0.001 |
| **Total** |  | **10476** | **57 (26)** |  |

Abbreviations: SD, Standard deviation.

P-values test for a difference in the percentage of greenspace across the categories and were estimated using one-way analysis of variance.

**Table 4.** Sensitivity analyses considering different definitions of neighbourhood for the risk of type 2 diabetes mellitus in relation to quartiles of neighbourhood green space in 10,476 participants.a

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Adjustedb Odds Ratio (95% CI) of outcome** | | |  |
| **Greenspace definition** | **Quartile 2** | **Quartile 3** | **Highest Quartile** | **P for trend** |
| Circular 800m | 0.96 (0.73, 1.27) | 0.98 (0.72, 1.32) | 1.00 (0.68, 1.47) | 0.990 |
| Circular 3km | 0.71 (0.54, 0.93) | 0.76 (0.54, 1.05) | 0.53 (0.35, 0.82) | 0.008 |
| Circular 5km | 0.65 (0.50, 0.85) | 0.79 (0.56, 1.09) | 0.65 (0.44, 0.95) | 0.041 |
| Road network 800m | 1.07 (0.82, 1.40) | 0.92 (0.69, 1.24) | 1.03 (0.73, 1.45) | 0.888 |
| Road network 3km | 0.71 (0.55, 0.93) | 0.67 (0.49, 0.93) | 0.48 (0.30, 0.77) | 0.001 |
| Road network 5km | 0.67 (0.51, 0.88) | 0.75 (0.54, 1.05) | 0.58 (0.39, 0.86) | 0.013 |

Note: Lowest quartile is referent category.

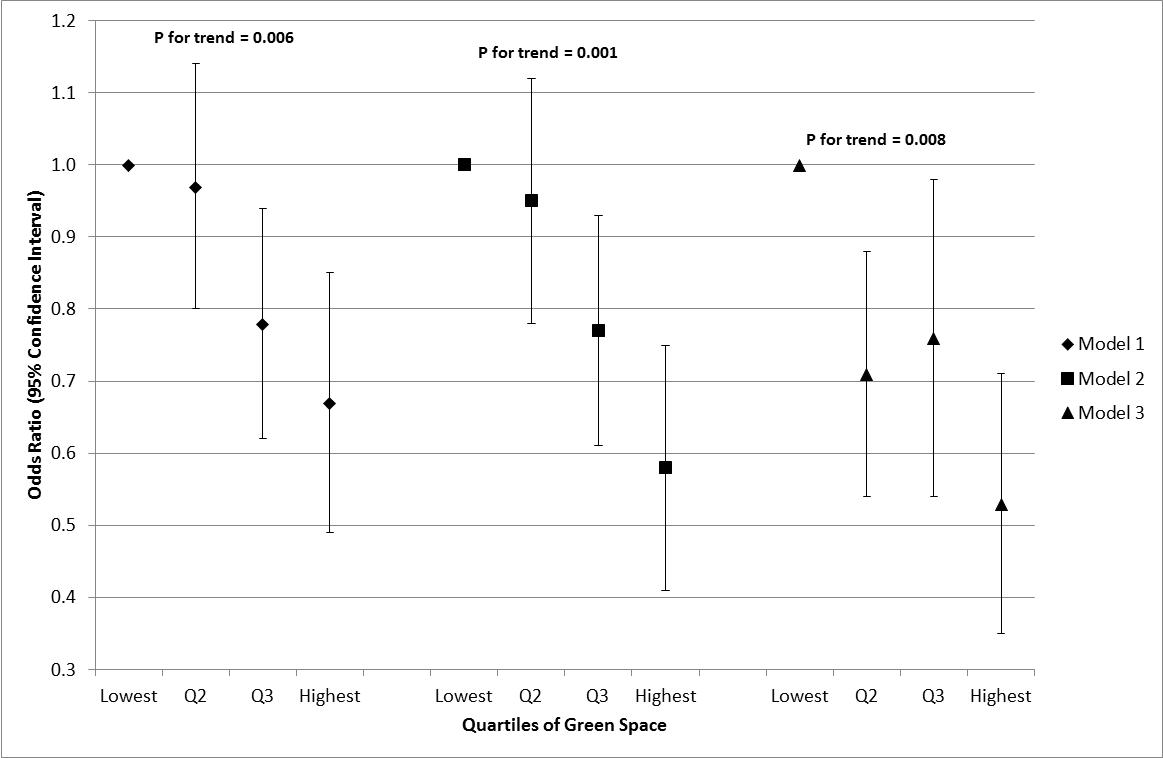
Abbreviations: CI, Confidence Interval; Q2, Quartile 2; Q3, Quartile 3.

a Missing data were imputed so analyses included all participants.

b Odds ratios were adjusted for ethnicity, age, sex, social deprivation score, urban/rural status,

body mass index, physical activity (total METS), fasting glucose, 2 hour glucose, and total cholesterol.

**Figure 1.** Odds ratios of screen-detected type 2 diabetes mellitus in relation to quartiles of neighbourhood greenspace in 10,476 participants.a



a Missing data were imputed so analyses included all participants.

Note: Lowest quartile is referent category.

Abbreviations: Q2, Quartile 2; Q3, Quartile 3.

Model 1 was adjusted for ethnicity, age, sex, social deprivation score, and urban/rural status.

Model 2 was adjusted for all variables in Model 1 plus body mass index and physical activity (total METS).

Model 3 was adjusted for all variables in Model 2 plus fasting glucose, 2 hour glucose, and total cholesterol.

**References**

1. International Diabetes Federation. IDF Diabetes Atlas: 6th Edition. Brussels, Belgium: International Diabetes Federation; 2013.

2. Kaprio J, Tuomilehto J, Koskenvuo M, Romanov K, Reunanen A, Eriksson J, et al. Concordance for type 1 (insulin-dependent) and type 2 (non-insulin-dependent) diabetes mellitus in a population-based cohort of twins in Finland*. Diabetologia* 1992;35(11):1060-7.

3. Poulsen P, Kyvik KO, Vaag A, Beck-Nielsen H. Heritability of type II (non-insulin-dependent) diabetes mellitus and abnormal glucose tolerance--a population-based twin study. *Diabetologia* 1999; Feb;42(2):139-45.

4. Gillies CL, Abrams KR, Lambert PC, Cooper NJ, Sutton AJ, Hsu RT, et al. Pharmacological and lifestyle interventions to prevent or delay type 2 diabetes in people with impaired glucose tolerance: systematic review and meta-analysis*. BMJ* 2007; Feb 10;334(7588):299.

5. National Institute for Health and Clinical Excellence. Preventing type 2 diabetes: population and community-level interventions (NICE public health guidance 35). London: NICE; 2011.

6. Lachowycz K, Jones AP. Towards a better understanding of the relationship between greenspace and health: Development of a theoretical framework*. Landscape Urban Plann* 2013; 10;118(0):62-9.

7. Astell-Burt T, Feng X, Kolt GS. Is neighbourhood green space associated with a lower risk of Type 2 Diabetes Mellitus? Evidence from 267,072 Australians*. Diabetes Care* 2014; September 11;37(1):197-201.

8. Maas J, Verheij RA, de Vries S, Spreeuwenberg P, Schellevis FG, Groenewegen PP. Morbidity is related to a green living environment*. Journal of Epidemiology and Community Health* 2009; December 01;63(12):967-73.

9. Coombes E, Jones AP, Hillsdon M. The relationship of physical activity and overweight to objectively measured green space accessibility and use*. Soc Sci Med* 2010; 3;70(6):816-22.

10. Webb DR, Khunti K, Srinivasan B, Gray LJ, Taub N, Campbell S, et al. Rationale and design of the ADDITION-Leicester study, a systematic screening programme and randomised controlled trial of multi-factorial cardiovascular risk intervention in people with type 2 diabetes mellitus detected by screening. *Trials* 2010;11:16.

11. Gray LG, Khunti K, Williams S, Goldby S, Troughton J, Yates T, et al. Let's Prevent Diabetes: study protocol for a cluster randomised controlled trial of an educational intervention in a multi-ethnic UK population with screen detected impaired glucose regulation*. Cardiovascular Diabetology* 2012;11(56).

12. Yates T, Davies MJ, Henson J, Troughton J, Edwardson C, Gray L, et al. Walking away from type 2 diabetes: trial protocol of a cluster randomized controlled trial evaluating a structured education programme in those at high risk of developing type 2 diabetes*. BMC Family Practice* 2012;13(46).

13. Gray LJ, Khunti K, Edwardson C, Goldby S, Henson J, Morris DH, et al. Implementation of the automated Leicester Practice Risk Score in two diabetes prevention trials provides a high yield of people with abnormal glucose tolerance*. Diabetologia* 2012;55(12):3238-44.

14. World Health Organization. Use of glycated haemoglobin (HbA1c) in the diagnosis of diabetes mellitus. Geneva: WHO Press; 2011.

15. ESRI. ArcGIS 9.3 2009;.

16. OS Code Point 2004-2013. Available at: <http://www.ordnancesurvey.co.uk/business-and-government/products/code-point.html>. Accessed 11/28, 2013.

17. Dalton AM, Jones AP, Panter JR, Ogilvie D. Neighbourhood, Route and Workplace-Related Environmental Characteristics Predict Adults' Mode of Travel to Work*. PLoS ONE* 2013;8(6):e67575.

18. Boruff BJ, Nathan A, Nijënstein S. Using GPS technology to (re)-examine operational definitions of 'neighbourhood' in place-based health research*. International Journal of Health Geographics* 2012;11:22.

19. Hurvitz PM, Moudon AV. Home versus nonhome neighborhood: quantifying differences in exposure to the built environment*. American Journal of Preventative Medicine* 2012;42(4):411-7.

20. Land Cover Map 2007 (LCM2007). Available at: <http://www.ceh.ac.uk/landcovermap2007.html>. Accessed 11/28, 2013.

21. Bibby P, Shepherd J. <br />Developing a New Classification of Urban and Rural Areas for Policy Purposes – the Methodology. London: ONS; 2004.

22. Guidelines for Data Processing and Analysis of the International Physical Activity Questionnaire (IPAQ) - Short and Long Forms. Available at: <http://www.ipaq.ki.se/scoring.pdf>. Accessed January 2014, 2014.

23. Groenewegen PP, van den Berg AE, Maas J, Verheij RA, de Vries S. Is a Green Residential Environment Better for Health? If So, Why?*. Annals of the Association of American Geographers* 2012;102(5):996-1003.

24. Do “Walkable” Neighborhoods Reduce Obesity, Diabetes? Available at: <http://www.diabetes.org/newsroom/press-releases/2014/do-walkable-neighborhoods-reduce-obesity-and-diabetes.html>. Accessed 25/06/2014, 2014.

25. Sigal RJ, Kenny GP, Wasserman DH, Castaneda-Sceppa C, White RD. Physical Activity/Exercise and Type 2 Diabetes: A consensus statement from the American Diabetes Association*. Diabetes Care* 2006; June 01;29(6):1433-8.

26. Mytton OT, Townsend N, Rutter H, Foster C. Green space and physical activity: An observational study using Health Survey for England data*. Health Place* 2012; 9;18(5):1034-41.

27. Merchant AT, Dehghan M, Akhtar-Danesh N. Seasonal variation in leisure-time physical activity among Canadians*. Canadian Journal of Public Health* 2007;98(3):203-8.

28. McCormack GR, Friedenreich C, Shiell A, Giles-Corti B, Doyle-Baker PK. Sex- and age-specific seasonal variations in physical activity among adults*. Journal of Epidemiology and Community Health* 2010; November 01;64(11):1010-6.

29. Lachowycz K, Jones AP. Does walking explain associations between access to greenspace and lower mortality?*. Soc Sci Med* 2014; 4;107(0):9-17.