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Promoting physical activity interventions in communities with poor health and socio-economic profiles: A process evaluation of the implementation of a new walking group scheme

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ABSTRACT

Walking groups have known health benefits but may not operate in communities with the greatest health needs, leading to the potential for increasing health inequity. This study examined the process of implementing a new volunteer led walking group scheme in a deprived community in England with poor physical activity, health and socio-economic indicators. Documentary evidence and semi-structured interviews with stakeholders and volunteer walk leaders undertaken at the beginning and end of the funding period were analysed thematically. It was found that utilising community-based assets, forming collaborative partnerships with health and non-health organisations and ongoing sustainability issues were all factors that affected the scheme's effective implementation. Passive recruitment methods and mass publicity did not attract participants who were representative of their community. The findings firstly suggest the necessity of identifying and mobilising community based assets at the 'grass roots' in deprived communities during the preparatory stage to access those in greatest need and to plan and build capacity. Secondly, the findings highlight the key role that health professionals have in referring those in poorest health and the inactive into walking interventions. In the new era of fiscally constrained public health embedded within local authorities these findings are pertinent in supporting the utilisation of local assets to address entrenched physical inactivity and inequity within deprived communities.

1. Introduction

Physical activity has wide-ranging long-term health benefits and reduces the risk of chronic disease (Friedenreich et al., 2010; Reiner et al., 2013). Even small increases in activity could benefit population health, with the largest gains coming from inactive individuals becoming moderately active doing 20 min of brisk walking each day (Ekelund et al., 2015). The simplicity of walking, associated with little cost, makes it economically accessible and thus one of the best ways to achieve recommended daily amounts of physical activity (ACSM, 2011). However, in England it has been estimated that 8% of the population do not walk continuously for five minutes in a four week period (Farrell et al., 2013).

Walking can be promoted through outdoor health walks in community settings (Public Health England, 2014). Walking groups have been shown to confer multiple physiological and psychological health benefits with good adherence and few side effects and are potentially a useful intervention for those who would benefit from increasing physical activity (Hanson and Jones, 2015a).

Physical activity interventions can be effective in low income groups but have the potential to increase intervention-generated inequalities (Bull et al., 2014). Preventative interventions are known to be socially patterned and more likely to be successful amongst the more affluent, a process which has been termed as the 'inverse prevention law' (Acheson, 1998). It has therefore been cautioned that all processes in the planning and delivery of health promoting interventions have the potential to widen inequity between groups, the implications of which are important to researchers, practitioners and policy makers (White et al., 2009).

As with other health promoting interventions there are therefore health inequity concerns. Firstly, without effective targeting of areas with the greatest health and socio-economic need, walking groups might not be set up in communities that need them most

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(Hanson and Jones, 2015b). Secondly, walking interventions tend to be taken up by white, well-educated, middle aged women (Foster et al., 2011). Finally, recent research with a walking group operating in an area of health and socio-economic deprivation found barriers for those very people for whom walking groups could potentially offer the greatest benefit (Hanson et al., 2016). For example, walking groups were viewed by participants as being of little purpose with a poor understanding of the health benefits of walking per se. Further, the group format itself represented a barrier by creating a general apprehension about what to wear, the fitness levels needed and an expectation of socialising with others in the group (Hanson et al., 2016). Walking groups could be well placed to promote the physical activity needs of those with intellectual disabilities as walking is a preferred form of physical activity (Finlayson et al., 2009). People with intellectual disability experience significant health inequalities and lead more sedentary lifestyles than the general population, they are also under-investigated and the best ways of supporting a more physically active, and less sedentary, lifestyle is a health improvement priority (Hanson and Jones, 2015a; Melville et al., 2015; Mitchell et al., 2013).

Setting up and promoting walking groups in deprived communities for individuals whose health would benefit the most therefore poses clear challenges. Unless addressed, there is the potential for walking groups to widen preventable health inequity.

'Walk Norwich' is a community wide intervention in the city of Norwich, England. It is part of the 'Walking Cities' project funded by the Department of Health (DH) in 2014 implementing walking initiatives to encourage local journeys on foot (Department for Transport, 2013). The new funding enabled Norwich City Council to develop different walking programmes, involving school children, lift-share plans (car-pooling) for people in work, plus a walking group initiative with short group walks for the inactive led by volunteer 'Walking Champions' (Norwich City Council, 2015a, 2015b).

The Walking Champion initiative in deprived communities in Norwich offered an opportunity for evaluation using natural experiment principles (Craig et al., 2012). The initiative was not under the control of the researchers and this enabled evaluation under 'real world' circumstances. The recent Cochrane review (Baker et al., 2015) suggested that process evaluations should be undertaken as they provide valuable information on potential barriers and facilitators plus an indication of how successfully an intervention has been implemented. Process evaluation focuses on the processes used throughout the intervention and aims to understand what went well and what went wrong. It does this by examining implementation; the mechanisms through which the intervention produces results and contextual factors external to the intervention which may influence its implementation (Moore et al., 2015).

This paper presents a process evaluation of a new walking group initiative within a community in England with poor physical activity, health and socio-economic indicators. Data were collected from semi-structured interviews with stakeholders responsible for the design, implementation and sustainability of the scheme and volunteer Walking Champions, the name given to the volunteers who led the group walks. Our aims were to identify the essential elements that stakeholders perceived as facilitating or presenting barriers to the implementation, impact and sustainability of the scheme and to produce a set of recommendations for how to best implement physical activity interventions in deprived communities to maximise their impact.

The study was given a favourable ethical opinion by the ethics committee of the Faculty of Medicine and Health Sciences at the University of East Anglia in July 2014.

2. Methods

This qualitative study was organised around the key functions of a process evaluation. The description of the intervention and its logic; how the delivery was implemented; the mechanisms through which the intervention produced results; contextual factors external to the intervention which may influence implementation and anticipated outcomes (Moore et al., 2015).

2.1. Setting of the walking programme

The group walking scheme was a programme of short health walks (of approximately one mile) in areas of multiple deprivation in Norwich and, where possible, connected to a cycleway (Department for Transport, 2013). The walks were mapped and risk-assessed by an experienced walks co-ordinator with responsibility for day-to-day management of the scheme when it was first set up. The walks ran approximately 3–4 times during the week. They were promoted to the public with brochures and posters in libraries, some doctors' surgeries and community centres. In the event, usually 2–4 people attended except when the walks were run in partnership with an organisation for adults with learning disabilities when 6–8 attended with an assistant. The area is urban with high density housing but with access to city parks, footpaths and riverside walkways, which were utilised for the group walks, led by the Walking Champions. The main focus was the Heartsease area with Bowthorpe and Mile Cross as examples of other neighbourhoods. All targeted areas had deprivation scores worse than the English average. For example, Heartsease is amongst the 40% most deprived and Bowthorpe and Mile Cross amongst the 20% most deprived neighbourhoods in England, based on the 2015 Indices of Multiple deprivation (Department for Communities and Local Government, 2015). Only 29% of people in Norwich are estimated to meet government guidelines of 150 min of moderate activity per week (Sport England, 2013).

2.2. Participants and interview process

A previous study examined the barriers and enablers for walking group participants (Hanson et al., 2016). Therefore the focus of this study was the process of implementing a walking scheme from the point of view of those organising it. Our participants were two groups of people, stakeholders responsible for setting up and managing the scheme and volunteer Walking Champions who led the walks. The first were key stakeholders suggested by the scheme's organisers. These stakeholders were involved in the planning, bid writing and implementation of the scheme and included people involved in the day-to-day management; from the public health department; the local clinical commissioning group; DH (the funding source) and a Councillor from Norwich City Council. All stakeholders were invited and agreed to participate. In total there were 12 participants, six men and six women. Two participants did not participate in the follow-up interview and a further informant was only suggested at the second time point.

The second group of participants were volunteer Walking Champions who led the walks. All those who volunteered for this scheme were invited and agreed to participate, except for one who was not available during the study time. In total seven volunteers were interviewed at the beginning of the programme and five at the end (some had left before the end of the programme and new volunteers joined), three were interviewed twice. Of these nine participants, five were women and four were men. All participants were approached by the scheme organiser in the first instance with a general explanation of the research. Subsequent to this all