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Walking groups in socioeconomically deprived communities: A qualitative study using photo elicitation

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ABSTRACT

Walking groups can benefit health but uptake is more likely amongst those who are socially well-situated and need them least. This study worked with a new walking group in a community in England with poor health and socio-economic indicators to understand non-participation and barriers to involvement. It used a qualitative approach. Participant generated photographs captured the physical and social environments in which they walked and these were used with semi-structured interviews to inductively explore walking group participation and the wider social context of walking. We found that prior to joining there were low expectations of any health benefit and walking groups were not viewed as 'proper' activity. The group format and social expectations presented a barrier to joining. Having joined participants described a developing awareness of the health benefits of walking. The shared sense of achieving health goals with others sustained the group rather than socialising, per se. We suggest that walking group participation is a complex social practice. Promoting walking groups as a social activity for this group of people may well have been counter-productive.

1. Introduction

Physical activity has wide-ranging long-term health benefits (Reiner et al., 2013). Recent research has shown that the greatest gains to population health could come from inactive individuals becoming moderately active by exercising equivalent to just 20 min of brisk walking each day, reducing the risk of premature death by between 16% and 30% (Ekelund et al., 2015). Walking is a natural and safe form of exercise (Hootman et al., 2001). For most people it expends enough energy to be considered 'moderate intensity' activity. Furthermore, for individuals who are particularly unfit, walking at a pace of 3 mph can achieve activity that is of vigorous intensity and confer associated health gains (Kelly et al., 2011). Walking is therefore a sensible starting point for people overcoming inactivity (Murtagh et al., 2002). While exercise-based physical activity interventions appear to have only modest or short-lived success, promoting walking might appeal to the wider population as it does not require particular skill, equipment or a competitive nature. Walking schemes are encouraged at community level and may be used in Exercise Referral Schemes for those who are inactive and with health conditions (National Institute for Health and Care Excellence, 2014; Public Health England, 2014). Group walking has the potential to engage those who are interested in the outdoors, whether for leisure or as a health intervention. As outdoor walking group participation can confer both physiological and psychological multiple health benefits, with good adherence and few side effects they are a promising intervention as an adjunct to other healthcare, or as a proactive health promoting activity (Hanson and Jones, 2015).

However, while research shows that walking appears to be a popular form of physical activity across all socioeconomic groups in England, those more highly situated are nearly twice as likely to partake in recreational walking compared to those who are less well situated (46% compared with 25%) (Fox and Rickards, 2004). In walking interventions, uptake seems to be mainly by white, well-educated, middle aged women (Foster et al., 2011). Additionally, successful walking group recruitment is often judged by the numbers who join rather than those who would stand to benefit most (Matthews et al., 2012). As easily recruited participants tend to be those who already walk, recruiters are challenged about how to approach and persuade those who do not walk to walk often, especially in 'hard to reach' groups, such as the most deprived (Foster et al., 2011). Whilst walking groups improve health (Hanson and Jones, 2015) they also have the potential to widen health inequality if not well targeted (Foster

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et al., 2011; Ogilvie et al., 2007). This presents a need to understand how the health benefits of group walks can be 'democratised' to widen participation (Green, 2009).

Walking groups can be conceptually placed within social theoretical debates of public health's focus on lifestyle behaviours. Coined as 'new public health' in the 1990s, social scientists problematized its narrow focus on lifestyle related prevention, which places the onus and responsibility on the individual to exercise control, be healthy, and become productive citizens (Lupton, 2003). The population is handed "biological responsibilities […] embodied in contemporary norms of health and practices of health education" (Rose, 2007, p. 133).

Public health agendas have somewhat shifted in recent years towards wider social and structural determinants and a growing recognition that the context of people's lives needs greater consideration to reduce 'lifestyle' disease (Cohn, 2014). The life-course is subject to a range of influences and people are not merely 'blank sheets' awaiting and receptive to health promotion messages (Baum and Fisher, 2014, p. 215). Rather than being unaware of the risk, it is more likely that constraints in people's their lives makes behaviour change difficult (Baum and Fisher, 2014). It is possible that walking groups fit into this more holistic public health agenda by providing structure and opportunities for physical activity rather than narrowly focusing on sports and exercise. For example, within public health and epidemiology, there is an increasing research field on the health benefits of green space, either as opportunities to be physically active in, or more generally as health enhancing spaces. This includes Gesler's seminal work (Gesler, 1992) and more recently, work such as Gatrell (2013), Roe et al. (2013), and Bowler et al. (2010).

Without understanding both individual needs and life situations, there are potentially barriers created for those who have the greatest health need (Matthews et al., 2012). For walking, it appears to be particularly important to understand both the physical and social environments in which the behaviour takes place. It may be that for those people from more deprived backgrounds, rather than being a pleasurable leisure activity, walking may be their only available and affordable mode of transport. Consequently, walking may be burdensome or stressful, for example when walking with small children or in unsafe neighbourhoods (Bostock, 2001; Green, 2009). This might partway explain why in the United Kingdom, despite its past history of socialist walking clubs, rambling (walking in the countryside for pleasure) has a particularly middle class identity (Green, 2009).

Using a qualitative approach, this study worked with a newly formed walking group as part of a referral scheme in a place of social and health deprivation with participants with multiple health problems. The aim was to add to our understanding of non-participation in walking groups for particular social groups and thus how they can be more effectively promoted to target people in those communities who could benefit most. To do so this study was framed within a social practice perspective which aimed to highlight the social context of walking and walking group participation, rather than understanding it as an individualised health behaviour (Blue et al., 2014). Social practice theories have recently been applied by sociologists to understand health behaviours as sets of activities that are shared across time and place (Blue et al., 2014). Understanding walking as a social practice, this relatively recent approach to conceptualise behaviour change suggests that we need to understand more broadly, how health practices emerge, persist or disappear as shared practices (Blue et al., 2014). Bourdieu (1977, p. 86) made sense of such socially shared practices as 'habitus', which they defined as the, 'subjective but not individual system of internalised structures, schemes of perception, conception and action common to all member of the same group or class'. Habitus includes knowing the right cultural codes and what works in different contexts and settings. It also refers to the values and expectations of particular social groups and the reactions of individuals within these groups in terms of behaviour that they see as reasonable and of common sense. When joining a walking group, the individual enters a new space or field. Each field has its own rules, coined 'doxa' by Bourdieu (1977). The individual brings to the group their habitus, which others in the group will evaluate and adapt to, thus the group is socially situated and evolving.

2. Methods

Semi-structured interviews were elicited using participant-produced photographs, as this method has previously been found to yield different insights and produce rich observational data (Guell and Ogilvie, 2013). This research focused on the factors that had influenced participation in a walking group and their perspective of how participation has impacted their health and wellbeing.

This study was given a favourable ethical opinion by the NHS NRES Committee South West-Exeter in June 2014. Participants were offered optional consent to their photographs being used by the research team in publications and presentations.

2.1. Setting and participants

The walking group is operated by East Coast Community Healthcare, NHS (East Coast Community Healthcare, 2015) in Great Yarmouth in the east of England. Great Yarmouth is a seaside town with built tourist attractions. It has deprivation that is higher than average and a health profile that is generally worse than the English average. For example, 29.7% of adults in this local authority are classified as obese, against an England average of 23%. Similarly, the under 75 years cardiovascular mortality rate is 92.6 per 100,000 compared to an England average of 78.2 (Public Health England, 2015). The district of Great Yarmouth has a population of approximately 97,000 inhabitants (Office for National Statistics, 2013). Socio-economically, by occupation, 51% are classed as decile 5–8 (lower supervisory, semi-routine, routine occupations and never worked) and it ranks in the highest decile of English districts for employment of unskilled and semi-skilled work (Office for National Statistics, 2013).

All participants were part of the UK National Exercise Referral Scheme (National Institute for Health and Care Excellence, 2014), referred by their family doctor to the physical activity (PA) trainer with a health need that would benefit from increasing physical activity. The scheme uses both a community gym option and outdoor walks run by the PA trainer who monitors participant's health with anthropometric measures and quality of life questionnaires recorded at baseline, 6 weeks and at the programme end. The walks were developed and risk assessed by the PA trainer as safe with variety (in surfaces e.g. beach and concrete and also gradient) and the ability to do switchbacks and wider loops for those who were more physically able. At the initial consultation with a PA trainer, both gym and walking are explained and participants make an informed choice based on their physical (dis) ability and what they consider they are most likely to adhere to. The participants in the study chose to join the walking option, walking with the group for 12 weeks, once or twice per week for 50 min on each occasion with 5 min cooldown exercises at the end.

Participants had a range of both physiological and psychological health needs. One was of normal weight (BMI 24.4) and nine were overweight or obese (BMI 29.1–48.5). There was also diagnosed chronic obstructive pulmonary disease (COPD), type II