An evaluation of the Promotion of Walking for Health in South Asian communities

by

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A Doctoral Thesis (Volume I)

Submitted in the partial fulfilment of the requirements for the award of Doctor of Philosophy of Loughborough University

September 2004

Abstract

The promotion Walking for Health (WFH) in South Asian communities is an invaluable tool that will help to reverse the decline of physical activity and the 40% higher death rate of South Asian adults from Coronary Heart Disease (CHD). This research forms apart of the national evaluation of the demonstration WFH projects funded by the WFH initiative via the British Heart Foundation (BHF) and Countryside Agency (CA). Leicester's Chalo Chalay (Let's Walk) project was unique in both its primary target audience and its approach to promote the health benefits of walking. A key aim for Chalo Chalay as a demonstration project was to present evidence on walking as a positive preventive mechanism against CHD and other related conditions in South Asian communities and to develop a toolkit that promoted WFH in South Asian communities. It aimed to promote higher levels of awareness of the health and social benefits of walking and to increase the participation in daily walking activity by South Asian adults through increased walking opportunities, community action and improved environments.

The Chalo Chalay methodology used innovative approaches to deliver and research the intervention via culturally sensitive methods. It adapted quantitative and qualitative methods of action research, case records, questionnaires, interviews, focus groups and shuttle walk tests which were translated into 5 South Asian languages. It used the structure of DNA to relate the complexities of an action research model.

The results showed an increase in awareness of WFH via a tailored publicity campaign and the translation of leaflets and questionnaires into 5 South Asian languages. It increased walking opportunities via its walking groups and facilitated training of 41 walking activators. The behavioural questionnaires together with the shuttle walks tests provided strong evidence of an increase in participation of walking by the target group. 47 community groups were introduced to WFH and a majority were able to set up and sustain health walks. The walking groups were sustainable at 24 months. Findings were presented through five research questions;

1. *Did the project increase walking in the target groups?*

Chalo Chalay increased walking in its target group of sedentary South Asian adults, over 3 years, it recruited 182 walkers, and 66 case studies were followed. More women were recruited then men and the average age of the walkers was 55. At baseline 78% of walkers recruited were sedentary this was lowered to 53% thus a quarter were converted at the end of the intervention.

2. *Why did the people (individuals or users of community centre) go on the walks?*

The reasons why people went on the walks were four fold: health and social benefits, being outside and the personal qualities of the walking activator. The walkers experienced many benefits of walking including; improvements to health, enjoyment, making them feel good, the fresh air, meeting people, relaxation for mind and body, increased fitness, the social aspect of being in a group, getting to see and experience new environments, it added and promoted their interests and hobbies, passed time and was a routine, they enjoyed the company of the walking activator and it was a free activity.

3. *Was the local community involved in the development of the project?*

The statutory sector were involved in the writing of the bid and securing funding, whilst the local voluntary sector was engaged in delivering the initiative. At the end of the 3-year funding period, 47 community groups were involved in the development of the intervention.

4. *Why did patients (GP referred) go on the walks?*

At baseline 9% of walkers recruited had been told by their GP's to walk. They were told that it would help reduce blood pressure and sugar levels, alleviate back pain, and reduce stiffness of legs but most significant was walking would help in rehabilitation after a heart attack, and be preventive. Actual benefits reported were; it helped reduce arthritis, gave by-pass patients the confidence to walk again, it helped women who had irregular periods to become regular, alleviated menopausal symptoms and a reduction or stoppage of anti depressant intake.

5. *What environmental changes resulted during the course of the three-year programme?*

There were 4 major environmental projects that the intervention influenced. The launch of the national space centre brought more visitors to the riverside and increased security, the Belgrave Corridor project a 4-year major investment plan by the Leicester City Council to calm traffic. The writing of the Central Leicestershire Local Transport plan 2001 to 2006 walking and cycling strategy a key document to increase walking. The Single Regeneration Budget 4 provided funding for increase community safety on pathways.

In conclusion the study has constructively provided a comprehensive toolkit detailing how to promote walking or physical activity to South Asian or racial minority communities. The study has demonstrated that WFH interventions are a cost effective way to promote moderate physical activity, and in the longer term to prevent shortfalls of inadequate services provide by the NHS for the South Asian community. It has verified, that WFH can be the answer to South Asian inactivity if taken up on a regular basis and if service providers view it holistically.

Key words: Walking, Walking for Health, Coronary Heart Disease, physical activity intervention, South Asian, action research

Dedication

In loving memory of my Grandmother
Maa,
Jashoda Bhaichand Chudasama

December 1902 to September 2002

A timeless gift.

Acknowledgments

I am exceptionally grateful for those who have challenged me in this process, without these pushes and the enlightenments that followed, the learning and understanding could not have taken place. The individuals form the Confederation of Indian Organisations, the Health Promotion Agency, Leicestershire Health, Loughborough University have given me a great gift, as they have been my greatest teachers.

There are those individuals in your life that are there to love you and support and lift, however there are those in your life that challenge your beliefs and push you to question, it is the later that have been important to me in this learning process as they have taught me to question, without this, there would have not been a project, thank you.

I would like to extend my thanks to the funders the British Heart Foundation, the Countryside Agency and Leicestershire Health Authority. My current employers the Leicester Racial Equality Council for all their continuing support.

Len Almond and Professor Stuart Biddle my supervisors at Loughborough University for all their words of wisdom.

I am in gratitude to all Mataiji, Shivji and Krishna devotees without which I would be lost. And to the inspiration I have received through family, friends old and new and *Destiny – an invitation to be inspired.* This work is a personal tribute to all those who believed…the walkers and walk leaders!

I would like to thank my parents Bapuji and Ba, the source of who I truly am. The amazing team that has supported me every step of the way, Jayshreeben, Anaben, Yat's, & Usha.

Finally, in gratitude to my Soulmate Anil Lodhia – my true source of inspiration.

ॐ Jai Ganesh, Jai Ambay, Jai Santoshi ma

Content

Abbreviations and Terminology

Abbreviations

ADNFS	Allied Dunbar National Fitness Survey
AIDS	Acquired immune deficiency syndrome
BACRA	Training
BEM	Black and Ethnic Minority communities
BHF HPRG	British Heart Foundation Health Promotion Research Group
BMJ	British Medical Journal
BNC	Belgrave Neighbourhood Centre
BP	Blood Pressure
CA	Countryside Agency previously know as Countryside Commission
CHD	Coronary Heart Disease
CIO	Confederation of Indian Organisations
CPR	Culinary Pulmonary Resuscitation
DIY	Do-It -Yourself
DNA	Deoxyribonucleic
DTER	Department of Environment, Transport, Regions
DoH	Department of Health
EU	European Union
GATT	General Agreement on Tariffs and Trade
GIS	Geographical Information Systems
GP	General Practitioner
HA	Health Authority
HAZ	Health Action Zone
HDA	Health Development Agency
HEA	Health Education Authority
HIV	Human Immunodeficiency Virus
HPA	Health Promotion Agency
HPC	Health Promotion Centre
KAB	Knowledge, Attitude, Behaviour
LA	Local Authority
ICT	Information Communication Technology
LCC	Leicester City Council
LEAP	Local Exercise Action Pilots
NOF	New Opportunities Fund
NHS	National Health Service
NRF	Neighbourhood Renewal Fund
PAFITT	Physical Activity Frequency, Intensity, Time and Type Questionnaire
PAR -Q	Physical Activity Readiness Questionnaire
PHA	Public Health Agency
PCT	Primary Care Trust
PMT	Pre Menstrual Tension
S.A	South Asian

SRB	Single Regeneration Budget
SWOC	Strengths, Weaknesses, Opportunities, Constraints
SWOT	Strengths, Weaknesses, Opportunities, Timeframe
TB	Tuberculosis
TV	Television
UK	United Kingdom
UKK	Walk Test
WHI	Walking for Health Initiative
VAL	Voluntary Action Leicester
WFH	Walking for Health
WWH	Walking the Way to Health
WHI	Walking the Way to Health Initiative
WHO	World Health Organisation
YMCA	Young Men's Christian Association

Terminology

Antakshari	A singing game
Baheno	Sisters
Bhajans	Religious hymns
Bhangra	Dance from the region of Punjab
Bollywood	Indian version of Hollywood
Chalo Chalay	Let's Walk
Chapals	Slip on sandals
Dil	Heart
Diwa	Lamp/ Candle
Diwali	Hindi festival of light, return of lord Rama
Eid	Muslim festival
Farahri	Food without salt eaten by Hindu's of a fasting day
Ghathiya	Indian savoury made out of chickpea flour
Ghee	Clarified butter
Gharba's.	Dance from Gujarat celebrating the Indian festival of Navratri
Gujarati	A language from India from the region of Gujarat
Gurudwara	Sikh Temple
Halal	Blessed meat from the Muslim tradition
Hindi	Language spoken in India
Holi	A Hindu festival of colour celebrating spring
Jalabhi	An Indian Sweet
Janmastimi	Hindu festival celebrating Lord Krishna's Birthday
Janthatra	A pilgrim done by Hindu's on foot
Jihad	Level of fitness required by Muslims to fight in war
Kaka	Uncle
Katha's	Religious recital
Kathakar	The priest who recites the scriptures
Krishna	A Hindu deity
Madhir	Temple
Maraj	Hindu priest

Masi	Aunt
Mela	Indian Fate /fair
Medhi	Designs drawn with henna of the hands and feet
Mithaee	Indian Sweets
Mullah	A Muslim priest
Namaste	Welcome/ hello in Hindi
Namaz	Muslim pray time
Navaratri	Hindu 10 day dancing festival for the goddesses
Punjabi	A Language from India from the region of Punjab
Poojani Samaghari	Items required for blessing rituals
Rasgharba	Gujarti Dancing
Ras Lila	Gujarati dancing with sticks
Ratha	A Hindu female deity
Ravan	A Hindu demon character
Samaj	A Hindu cast community specific group
Sewa	Service
Salvar Kamis	An Indian outfit (Punjabi Suits)
Sarees	Traditional wear from India – 6 yards of material
Urdu	Language Spoken by Muslims
Vaisakhi	A Punjabi festival
Verwar	Rapport /etiquette
Vrindavan	Religious town in Gujarat – Krishna's Birth Place

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Summary of Thesis: an evaluation of the promotion of Walking for Health in South Asian communities

Stage 1: Foundation Pre – Intervention

Literature Review Lack of research into South Asian communities.

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Foundation project – promoting Physical activity to South Asian communities
Walking is an acceptable form of physical activity.

Community Consultation Views on Walking.
Walking in a group, health & social benefits & a better environment would encourage walking. Safety, pollution, lack of time & having a car were barriers to walking. 93% would take up walking in a group if the opportunity was provided.

WFH bid Partnership, 90K secured for 3 years

Collection of baseline data, audit & demographics of geographical boundary
Belgrave 70% BEM 49.7% have no car. Open spaces Parks & riverside on the doorstep. 47 community organisations, 30 GP practices.

Stage 2: Development Intervention Phase I

Pilot Projects. Development of 3 types of doorstep walks: urban, park & riverside. Set protocol and procedure for running a health walk. Role of a walking activator, paperwork.

Development of behavioural Questionnaire's in 5 South Asian's Languages. Culturally specific tool, gathered data on walking patterns& behaviour.

Walking Groups in Belgrave: Case Studies Average walker profile female aged 55. 182 walkers recruited over 3 yrs, 66 case studies followed.78% sedentary 25% met national guidelines at end of intervention. 22% suffered from a heart condition. Shuttle walk tests men 12% were fitter than women 10%. Went on walks for health & social benefits, being outside & the personal qualities of the walking activator.

Development of Walking Activator's Training. 1st nationally to be translated

Publicity Tailor made, word of mouth.

Ethnical Approval.

Stage 3:Delivery Intervention Phase II:

Recruitment of Full time co-ordinator. Monies reallocated.

Pre recruitment of full time co-ordinator. Operational strategy, steering group, training, community groups & statutory sector, planning for strands 2 &3, sustain walks, exit strategy.

Project Management Change. New management team at host.

Change in Direction & Philosophy of Project.
Payment of walking activators, extension of geographical boundary.

Strand 2:GP Referral.
Partnership of 3 key projects, guidance set.

Strand 3: Environment
Ongoing work with 6 main initiatives, riverside, corridor, golden mile, pedestrian route plans, walking strategy, SRB4

Evaluation Workshop of the WFH Demonstration projects BHF/CA.

Concept of Volunteering

Bid for Further Funding.

Stage 4: Sustainability Post Intervention:

Exit Strategy. 7.5k for 3 yrs maintenance. Walking activators network & Let's walk Leicester 5 yr strategy

Qualitative Interviews Walkers.42 walkers interviewed, 29 women, 13 men. Joined the walks for health reasons, meeting & talking to people, fresh air, and environment, walking in a group, unique activity & daily routine. Thought the walks were good. They felt walks could be improved by having more activities & facilities.

Interviews Walking Activators, Volunteer.
Role was effective, lacked support from the host.

Interviews Key People.
Steering group right people, too big. Issues on ownership. Funding. Holistic approach.

Stage 5: Acceptance Intervention Finale:

Final BHF/CA Evaluation Report.
Unique partnership. 3 research questions.

Toolkit to promote walking for Health to South Asian communities
Based on action research model look, think & act.

CHAPTER ONE

Introduction

'If you walk and walk and walk they will call it a road.'

Korean Proverb.

1.1 Coronary Heart Disease

Coronary Heart Disease (CHD) is a major cause of morbidity and mortality in the UK, and is regarded as a major priority for the National Health Service (NHS) (Department of Health 1998). The problem has substantial implications for the provision of health services in communities with high South Asian populations, as found in many of the large cites of the UK (Lowy 1991). Prevention can be effective in reducing mortality and morbidity from heart disease, however prevention needs to be culturally and religiously sensitive and should be accessible and relevant for the targeted community (Gupta *et al* 1995). The 1999 Health Survey in England and Wales demonstrated an excess of nearly 50% in CHD mortality for people born in the Indian sub continent (Health Survey of England and Wales 1999). Studies have also shown that South Asians have poorer knowledge of risk factors for CHD (Farooqi *et al* 2000). There is an increase in research exploring the health experiences of ethnic minority communities in terms of their racially disadvantaged position (Nazroo 1997). Leicester has a high South Asian population, whom a majority live in predominately deprived inner city areas, which has detrimental, affect on health via poverty. The 1991 Census showed that nearly a third of the population was of South Asian origin; it is anticipated by 2020 the majority of the city's population will be South Asian. With a relatively young South Asian community, the burden of CHD is likely to increase in the future (Farooqui & Bhavsar 2001).

Physical inactivity has joined high blood cholesterol, cigarette smoking and hypertension on the British Heart Foundation list of primary yet modifiable heart disease risks. 37% of mortality rates of coronary heart disease are accountable by being physically inactive (British

Heart Foundation 2000). One of the four targets from the Department of Health's publication 'Saving Lives, Our Healthier Nation' in 1999 relates to reducing the excessive mortality that results from coronary heart disease and stroke in the UK population. As more than half the population in England do not do enough exercise, tackling inactivity is regarded as a major health promotion issue.

1.2 Walking for Health, the answer to South Asian inactivity?

Walking can be an integral part of daily life whether it is for leisure or health. The promotion of walking for health would reap a number of health benefits and would be the answer to getting sedentary individuals active (Hardman & Morris 1998, Shephard 1997). Walking is a simple cost effective and positive means to prevent many health conditions including coronary heart disease (CHD) which is prevalent within the South Asian community. Death rates from CHD amongst the South Asian populations are 40% higher than the general population. Furthermore exercise among the South Asian population is very low -50% of South Asian women are sedentary compared to 24% in the general population (Health Survey of England & Wales 1999). It is therefore, important to promote walking as a form of physical activity, which can derive health benefits and in particular targeting strategies in this community. As Hardman stipulates;

'.....if the public health burden of ill health associated with physical inactivity and therefore also low fitness is to be reduced, the priority should be to address the needs of 'sedentary' middle aged men and women, defined as the majority of the population who at present engage in little moderately vigorous exercise.'

(Hardman & Morris 1998, page 184)

There is considerable evidence that regular brisk walking (average about 30 minutes a day) improves endurance fitness in previously sedentary individuals (Aldred *et al* 1995, Hardman & Morris 1998, Pollock *et al* 1971). Normal walking at 3mph is likely to improve fitness in sedentary individuals such as older men, many middle aged and older women and those carrying excess weight (Hardman & Morris 1998). Thus, regular, frequent walking at a brisk or fast pace (3.5 –5.0 mph) should allow the individual to attain and maintain an optimal level of physical fitness that would relieve this risk of cardiovascular mortality (Blair *et al* 1989,Whaley & Blair 1995).

Walking at a brisk or fast pace is an activity most likely to be taken up by people whose health is at risk through sedentary living furthermore walking is an activity that everyone could take each day. It is natural, inexpensive and carries a low risk of injury. In young adults who are in good health, it may enhance health through encouraging maintenance of a desirable body weight (Morris & Hardman 1997).

Moderate activity has the same health benefits as more vigorous exercise (Dunn *et al* 1999). This exercise recommendation has changed from 3 sessions of 20 minutes of vigorous activity per week to 5 sessions of 30 minutes of moderate activity a week. Thus, the message from fitness to exercise to physical activity and from structured-only to an 'active living approach' (Health Education Authority 1994, Surgeons General Report on Physical Activity & Health 1996). Walking schemes have considerable potential as they are structured, supervised, of low cost to the participants, emphasise low to moderate levels of activity and are an effective means of maintaining participants adherence to exercise (Hillsdon *et al* 1995). Previous consultation by the Confederation of Indian Organisations in the South Asian community has shown walking to be an acceptable form of moderate physical activity (Confederation of Indian Organisations 1999).

A general approach to promote physical activity in the South Asian community is not likely to be the most effective. There are significant cultural differences that may make more general approaches inappropriate. Mass media may not communicate effectively to all sectors of the populations and language may provide a barrier to effective communication (Almond 1999a). Thus, a starting point is to stimulate action within local communities, which would be long lasting. A clear message to follow is: *'Making more people more active more often'* (Almond, 1999a. *Page 7).*

1.3 Policies in support of Physical Activity and Walking

National initiatives support the notion of increasing physical activity, which include the National Health Service (NHS) plan: a plan for investment, a plan for reform (Department of Health 2000) states that;

'The NHS has a stronger role to play in prevention, as well as working in partnership with other agencies to tackle the cause of ill health so as to reduce health inequalities' Page 106.

Furthermore the Health Development Agency (2003) provided an evidence-briefing summary on the role of physical activity intervention in the prevention of obesity (Mulvihill & Quigley 2003), which was intended to influence policy, decision makers and NHS providers.

Physical activity was included in national initiatives from several of the governmental departments; Department of Transport, Local Government and the Regions (2001); Cabinet Office, Social Exclusion Unit (2001); Department of Culture Media and Sport (2001); Department of Environment, Transport and the Regions (2000); Department of Health (1999), Department of Education and Employment (1998) and Health Development Agency (1998).

Physical activity had been written into the five National Service Frameworks from the Department of Health, National Health Service Executive; Older People (2001); Coronary Heart Disease (2000a); The NHS Cancer Plan (2000b); and Mental Health (1999). At a regional level physical activity has been highlighted in the East Midlands Regional Transport Strategy (Government Office for the East Midlands 2002) and the East Midlands Integrated Regional Strategy (East Midlands Assembly 2003). At a local level physical activity has been recognised in the NHS Health Improvement Programme, Leicestershire 2001- 2004 (Leicestershire Health Authority 2001), Encouraging Walking advice to Local Authorities (Department for Environment, Transport and the Regions 2000c), Central Leicester Local Transport Plan 2001-2006 (Leicester City Council 2001a); City of Leicester Walking and Cycling Strategy (Salde 2000), Leicester Community Plan (Leicester City Council 2001b), Leicester Cultural Strategy Action Plan Leicester (City Council 2002), Leicester's Sports Strategy (Leicestershire, Leicester, and Rutland Sports Forum 2001) . Thus in terms of putting walking for health on agenda, policies are in place to give the initiative impetus.

1.4 Health and Transport

There has been a surge in the interest in walking, the oldest, most sustainable and healthiest of transport modes. Policy makers and the public are making connections between the rising congestion from short car journeys. Also the personal and community health impacts from the decline in the amounts of walking especially amongst children (Palmer 2001). The imperatives of health improvement, together with new opportunities presented by Local Transport Plans has driven towards integrated thinking on transport and health matters, and has pushed walking simultaneously up the health and transport agenda's (Department of Transport 1997). The key was to integrate these two agendas, to join up thinking, the doing and the funding.

'Cars have revolutionised the way we live. But the way we use our cars has a price – for health, economy and environment.' (Public Health Alliance News 1999 page 2)

Public Health Alliance states that for too long traffic gridlock had been accompanied by the gridlock of policy itself. In one of the follow up consultation papers on traffic congestion and pollution the; 'Breaking of the log jam' in his introduction the Deputy Prime Minister John Prescott claimed that his White Paper (covering the UK); 'A New Deal for Transport: Better For Everyone' Department of Transport (1998), radical for a generation, he now warned;

'if we don't act now we will be heading for gridlock.'
(Public Health Alliance News Spring 1999 page 2)

Prescott's problem was the fact that symbolically and economically the motorcar dominated over other more environmentally and healthier forms of transport. He wanted to avoid therefore a head on collision with motorists. The big idea of the Department of Environment, Transport, Region (DTER) was for road users and workplace parking charges, to reduce cars on the road (Department of Environment Transport Regions (DETR 2000b). The plan was to give motorists an incentive to switch to public transport and to use the income generated by charges to bring about improvements, meaning that motorist keep their

cars but used them less. Another strand of the government's strategy was to reduce non-business traffic, and journeys that were less than a mile, via the promotion of safer routes to school helping parents to leave the car at home (Department of Transport 1997). Thus the promotion of walking attracted a much higher profile.

1.5 Background

The National Walking the Way to Health Initiative

The Countryside Agency and the British Heart Foundation joined forces to promote walking as a means of improving health and enjoying the environment. The two organisations jointly funded the initiative; Walking the Way to Health together with substantial funds from the New Opportunities Fund (NOF) which, aimed to get more people walking in their local community. The project drew upon the experiences of similar schemes – in particular the Health Walks trial project in Sonning Common in Berkshire, and the Irish Heart Foundation's Sil na Slainte walking route project. The partnership drew up guidelines for setting up walking for health projects and funded three walking for health demonstration schemes (one of which was Chalo Chalay), which looked at ways of getting people out walking in their local areas. The demonstration schemes were monitored and evaluated with the help of the British Heart Foundation Health Promotion Research Group at the University of Oxford. The Walking for Health Project was particularly keen to find out the impact of schemes on the health of target groups such as people in deprived areas, people from ethnic communities and people who already had heart disease. The Countryside Agency Chairman Richard Simmonds commented:

'This project brings together the British Heart Foundation's message that walking is an important physical activity to improve people's fitness with the Commission's view of encouraging walking as a means of enjoying the countryside and green areas within towns and as a form of sustainable transport. There is an obvious synergy in ideas and interests, which our joint project aims to develop. On a broader scale, walking projects organised by local people could contribute to community development and reduce social exclusion'

'While the average distance walked has declined by 18 % over the past ten years, walking for pleasure has risen by 6%. This project seeks to build upon that trend by developing walking routes in and around urban areas which are safe, pleasant, well-used, and well marked.'

(Countryside Commission 1998, page 1)

Dr Vivienne Press Assistant Medical Director at BHF added;

'Many people already know that regular physical activity is good for them. But not enough people turn that knowledge into action that could prevent them getting coronary heart disease – one of the major causes of death in the UK. Physical activity can also help reduce the risk of stroke, diabetes and osteoporosis and walking is an ideal way of boosting activity levels. We hope this project will motivate people to get outdoors, enjoy the local environment and walk their way to a healthier heart.'

(Countryside Commission 1998, page 1)

The conception of Chalo Chalay, Let's walk project

One of the demonstration projects was *Chalo Chalay* based in the inner city locality of Belgrave in Leicester; jointly funded by the British Heart Foundation, Countryside Agency and match funded by Leicestershire Health. The Confederation of Indian Organisations (CIO) a national organisation hosted the project, at their local office in Leicester; their ethos was to strengthen and support South Asian voluntary projects. The Chalo Chalay project was unique in both its primary targeted audience and its approach to promote the health benefits of walking. Prior to securing funding CIO had carried out research on attitudes and beliefs about physical activity and the South Asian population. Walking had been shown to be an acceptable form of exercise (Confederation of Indian Organisation 1999). The consultation process involved participants discussing their experiences in the form of semi-structured interviews. The twelve-month health promotion project by CIO, promoted physical activity was established to meet the needs of the South Asian community in Leicester. It was recognised that a number of barriers stood between the community and the facilities available. For these reasons a number of exercise programmes were not suitable for the users, especially South Asian women. Quite early on in the project alternatives were identified and walking seemed to be the most appropriate, simple and cost effective way to exercise for sedentary individuals of the South Asian community. This was the beginning of the walking initiatives taken on by the CIO.

The initial walking-groups highlighted further barriers to walking, which were identified as *'not enough nice areas to walk in and the lack of pedestrianised zones'*. This was when the three-year funding from the British Heart Foundation and Countryside Agency was secured for the

Asian Walk for Life Project later named 'Chalo Chalay' which literally meant Lets Walk! The project concentrated in one area of Leicester, Belgrave, which was highly populated with the South Asian community and had a high incidence of CHD. The project involved pedestrianising the area and making available more walking, pollution free environments. The initiative was to provide the South Asian community with a choice of physical activities rather than the leisure centre.

Walking initially seems a simple cost effective way to exercise for all concerned, the participant, the group leader and the GP, but to derive any health benefits it needed to be conducted in a structured way, which is culturally tailored. This may sound daunting but with the correct advice and training the scheme could be fun and ensure health benefits.

1.6 Statement of Problems and Research Purpose

Chalo Chalay was a demonstration project to explore the impact of promoting walking with a South Asian population. The promotion of physical activity interventions to South Asian community was a new concept. Chalo Chalay Let's walk project was the only national project leading the way for ethnic minority communities. There had never been any published studies on the South Asian community and physical activity in England. The research gap had crippled the progress of physical activity and consequently the lack of funding in this field. Evidence based practice not only attracts funding, but clear guidance helps the practitioner in the field to break down the barriers that the South Asian community face. The naivety and the fear of the practitioner fade thus moving a step closer to providing equal opportunities for all.

The research study worked in rapport with the *Chalo Chalay* project effectively by assisting in its evaluation over the three-year period. However, its main purpose was to gather data on:

'Walking as a positive preventive mechanism against coronary heart disease and other related conditions in South Asian communities'.

The study collected evidence for the case of Walking for Health and attempted to present a tool kit and framework that promoted Walking for Health in South Asian communities which

then could be transferred to other regions via a practitioner in any setting whether that be primary care, voluntary, educational, leisure; private and public.

1.7 The aim and goals of Chalo Chalay

Aim

The project aimed to get people walking in the Belgrave area of Leicester by providing more 'walking friendly areas', that is, pedestriansed and pollution free zones and if successful would be extended to other regions of Leicester;

'The main project aim is to promote higher levels of awareness of the health and social benefits of walking and to increase the participation in daily walking activity by Asian adults through increased walking opportunities, community action and improved environments.'

Goals of the project were to;

1. Increase the number of walk leaders in the area.
2. To increase the number of community groups involved in the scheme.
3. To increase the amount of information available on walking for health and local health walks, to use the media to promote walking, to increase by 20% the number of Asian adults who know the health benefits of walking and report walking at least 30 minutes, 5 times a week.
4. To increase by 20% of Asian adults who have defined CHD who can walk a mile in 10% less time after a prescribed walking scheme.
5. To set up good working collaborative networks between professional groups and between people from statuary, voluntary and community sectors.
6. To make initial links with the community centres and voluntary groups in the area and to continue monitoring walking initiatives commenced by Confederations of Indian Organisations (CIO) in the Belgrave area.
7. Over 24 months local walking groups should have become self sufficient and self-running.
8. The study will provide guidelines in setting up walking initiatives specifically for the South Asian community and generically for health-walk projects nationally.

The study would continue to collate information on walking groups' set up and perhaps individuals using the walking areas provided. It would follow case studies via action research and health benefits derived and record attitudes towards walking pre and post after the exercise. If interventions have not worked, rethinking ideas and putting them into place.

Research questions

This project formed the basis for a research project, which would provide internal evaluation of the workings of Chalo Chalay and its impact on the South Asian population. In the first instance five research questions were identified. However the primary questions was; *would the South Asian communities of Belgrave in Leicester take up walking for health?* Which was a central issue.

The five main research questions identified,

1. Did the project increase walking in the target groups?
2. Why did the people (individuals or users of community centre) go on the walks?
3. Was the local community involved in the development of the project?
4. Why did patients (GP referred) go on the walks?
5. What environmental change resulted during the course of the three-year programme?

Walking for Health was a new concept and with any new idea it needed to be marketed. The way that walking for health had been presented in Berkshire- the original walking initiatives would not be appropriate in Leicester it would need to accommodate deprived inner city communities, a difficult task but not an impossible one. To get people walking more often and leaving their cars behind is not just health's problem, but it involves transport and the environment too. It is this joined up thinking that needed to be applied to the problem working in isolation would not have a huge impact, nationally, but on a local level a slight difference may be detected. The case needs to be built upon evidence base practice, which certainly will be presented in this thesis; a short walk, along a long journey over very harsh terrain.

1.8 Thesis Structure

The thesis is constructed of ten chapters;

Chapter one sets the scene, gives background to the conception of the project and its primary funders. It presents the research problems and sets the aim and goals of the project and the research study.

Chapter two is an extensive literature review and discusses previous studies and explores examples of good practices in other areas. It gives a general background to the health of South Asian adults and their inactivity. Interventions are looked at in detail, addressing cultural sensitivity and an intervention map is drawn. The chapter ends with an overview of the promotion of walking for health.

Chapter three examines the methodology of the study, a theoretical framework is presented and general methods are discussed.

Chapters four to eight are the results of the study, they present the data collected at intervention, foundation; development, delivery, sustainability, and endorsement.

Chapter nine is general discussion and answers the research questions presented in chapter one it draws on the concept of universal walking and presents its various angles.

Chapter ten states the conclusions of the study.

CHAPTER TWO

Literature Review

Walking for the first time, through a strange valley
A murmuring summer afternoon, I cupped my hands, and shouted
'Hello. Is anybody there?' Echo, Leonard Clark 1985

2.0 Introduction

The chapter begins by sketching the scene of the general health of adult South Asians in the Untied Kingdom. It reviews all the major surveys, which describe the poor health of South Asian communities, and the specific diseases they suffer from. It lays the foundation of why further research and interventions are needed. The scene is further painted by providing evidence on the physical inactivity of adult South Asians. Further data is provided via major physical activity and fitness surveys, which show the very low levels of participation. A breakdown of specific physical activity levels of Bangladeshi, Pakistani and Indian men and women is shown. The building blocks emerge as health intervention theory and policies are scrutinised. The types of interventions are described and the one most suited to a South Asian community is mapped out. A physical activity intervention policy framework is defined.

The cement for the building blocks is provided by a case for physical activity and health. This is further consolidated by the good practices found in delivering physical activity interventions to ethnic minority communities and a targeted intervention framework is drawn.

Finally the chapter ends by adding doors and windows to the building by reviewing current practices in the promotion of walking for health. Identifying the benefits and their relation to the prevention of specific diseases in particular Coronary Heart Disease (CHD) in the South Asian community. The reasons for the decline in walking are investigated and possible solutions, via encouraging walking through health, transport and the environment and contributing to local and national targets. The philosophy of a health walk is presented from which a framework for walking, health and transport is drawn. All this is bought together by reviewing the views of ethnic minority groups on walking.

2.1.0 The Health of South Asian Adults in Britain.

Local and national surveys confirm that people from Black and Ethnic Minority groups experience greater ill health (Arora *et al.*, 2000). As a consequence in 1992 the English government published the white paper on the Health of the Nation (Department of Health UK 1992), which set national strategies for health and included the needs of Black and Ethnic Minority groups. The report identified five key areas where Ethnic groups were at a greater risk of ill health one of which was CHD and stroke. Two health and lifestyle surveys carried out on the general population in 1994 showed that people in England were well informed about health risks and were motivated to change unhealthy aspects of their lifestyle, however this was not found amongst the Black and Ethnic Minority groups. (Balarajan & Raleigh, 1993).

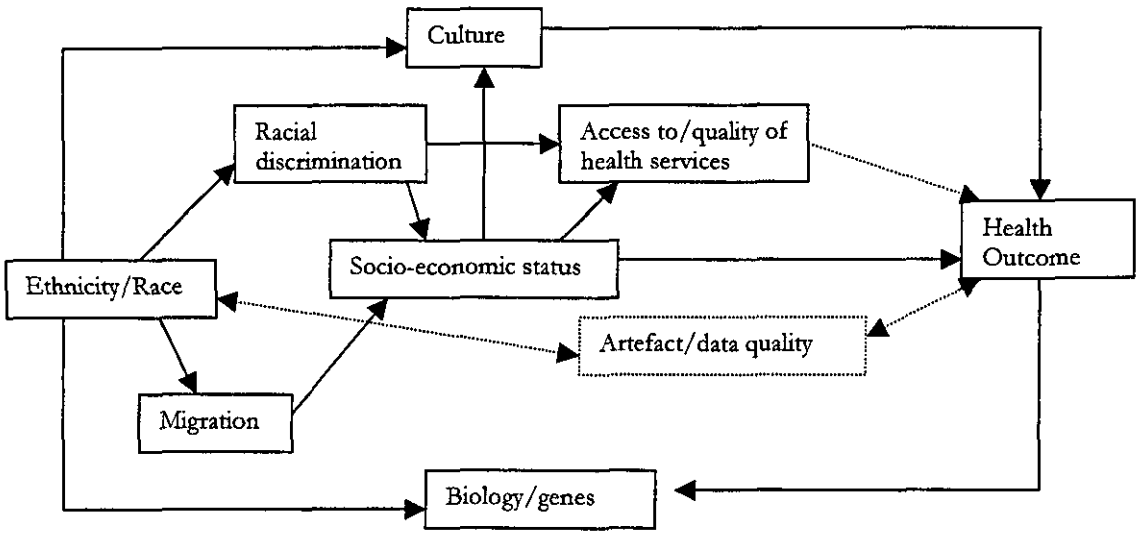


Figure 2.0 Understanding the relationship between Ethnicity and health (Narzroo 1997).

Represent possible explanations for differences in health status that were not assessed by the National survey.

The relationship between ethnicity and health is closely related to socio-economic status, environment and employment conditions as seen in Figure 2.0 (Nazroo 1997, Harding & Balarajan 2000, 2001, Balarajan & Soni Raleigh 1995).

Qualitative research showed complexity between and within Ethnic Minority groups, there was variation in knowledge, attitude and behaviour towards health, however broad commonalties were drawn. Groups viewed health holistically, which incorporated concepts of mental and spiritual well-being. Responses of worries and anxieties were often cited as factor of ill health, these varied between first and second generations of

United Kingdom residents. First generation stress factors included financial stability, housing, employment, children's future, and loss of cultural values, isolation and racism (Rudrat, 1994). For the second generation, again employment and racism, cultural conflict and education.

Opinions of the health services included misunderstandings and poor communication between GPs and clients, which led to feelings of resignation, fatalism, and the lowering of expectation and the exaggeration of symptoms. They also feared racial pigeon holing; being treated as unintelligent or time wasting. It was believed that a broader out look from health professionals would help identify specific needs and priorities of ethnic groups (Rudrat, 1994).

The most frequently mentioned risk factors of poor health for ethnic groups were unemployment and violent crime, most lived in urban neighbourhoods (Rudat 1994, Smaje, 1995). Perceived racism was racked in the same category as smoking or exercise and for Bangladeshis poor housing was the single most significant risk (Rudat, 1994). Smaje (1995) describes the physical development of South Asians to be shorter and more overweight which may be due to childhood environmental deprivation, thus may pose a greater risk of development of illnesses including cardiovascular disease.

2.1.1 Self-Reported Health Status

A survey by the Department of Health in 1999 found that Bangladeshi and Pakistani men and women were three to four times more likely to rate their health bad or very bad compared to the general population. This confirms earlier evidence from the Forth National Survey that over a third of Bangladeshis and Pakistanis described their health to be fair or poor and one fifth said that they had a long-term illness (Nazroo, 1997). For Indian men and women the rate was not as high but significant. It also stated that the prevalence of bad or very bad health increased with age and women were more likely then men to report poor health. Three major surveys provide evidence of South Asian ranking their health status as poor (Health Survey for England 1999, Nazroo 1997, Rudat 1994). Furthermore one in five Bangladeshi and Pakistanis and one in six Indians said that their health limited moderate activities such as climbing one flight of stairs, walking half a mile or more, or carrying groceries (Nazroo, 1997). South Asian women were more likely to report a long-standing illness than South Asian men, rates were significantly higher in the Bangladeshi and Pakistani community. Thus, there is consistent evidence

suggesting poor health amongst South Asians which is significant in older South Asian women and older Bangladeshi men.

2.1.2 The Use of Health Services.

Surveys have shown that there was a higher usage of primary care services and GP consultations amongst South Asians, which increased with age (Arora *et al.,* 2000, Balarajan & Soni Raleigh 1995, Rudat 1994). Higher consultation rates were found in older Indian women and men, and extremely high with Pakistanis (Health Survey 1999). Evidence was also presented on longer waiting times before seeing a GP (Arora *et al.,* 2000, Rudat 1994). South Asians are more likely to see a GP of the same ethnicity and who communicated in the preferred South Asian language, this was prevalent with older South Asians (Airey & Eren 1999, Rudat 1994). The use of formal and informal interpreting increased with age. Using family and relatives, as interpreters proved problematic as inaccuracies and inhibitions arose. South Asian women in particular Pakistani and Bangladeshi would prefer a consultation with a female GP. Barriers faced in accessing services included racism, discrimination, language and communication difficulties, stereotyping attitudes and a lack of information of services available (Arora *et al.,* 2000,Balarajan & Soni Raleigh 1995)

2.1.3 Specific Diseases.

The illness or diseases reported frequently in the South Asian Community include non-insulin dependent diabetes and insulin dependent diabetes, hypertension, respiratory problems, heart disease and in particular for Bangladeshis digestive problems which include stomach ulcers.

Cardiovascular Disease

The World Health Organisation has drawn attention to the fact that Coronary Heart Disease (CHD) is a modern epidemic, it is a disease that affects large populations and it is seen as a western 'lifestyle' disease (Laungani, 1998). A number of studies have documented that South Asians have about 40% higher death rates from CHD than the general population, (Arora *et al.,* 2000, Balarajan & Soni Raleigh 1995, Hine *et al.,* 1995, Laungani 1998, Mckeigue & Sevak 1994, Nazroo 1997, Primatesta & Brookes 1999, Samje1995), with a twofold excess of deaths in South Asian men before the age of 40 (Mckeigue & Sevak 1994). Similar findings were reported in urban settings in India (Arora *et al.,* 2000, Laungani 1998, Mckeigue & Sevak 1994). These rates increase to 60 to

70% in the poorest groups of Pakistani and Bangladeshi men (Health Survey for England 1999). In considering the relative young age profile of the South Asian population in the UK these figures would forecast a burden on the health care providers so it is essential to provide preventive mechanisms before a crisis arises (Beishon & Nazroo 1997, Lowy *et al.*, 1991, Nazroo 1997). Lowy *et al* (1991) further estimated that on the basis of the demographic structure of the South Asian population of Leicester, the number of deaths from CHD within the population will more than double between 1988 and 2008. The aetiology of heart disease is complex, both biological and social factors may be important. South Asians faced an additional risk of heart disease compared to other ethnic minority groups because of central obesity due to the lack of exercise and the relatively high prevalence of a metabolic disorder, insulin resistance syndrome which is genetically determined (Arora *et al.,* 2000, Balarajan & Soni Raleigh 1995, McKeigue *et al.,* 1991, Mckeigue & Sevak 1994, Samje 1995).

Risk Factors of CHD / Cerebrovascular disease (CVD)

Risk factors of CHD can be classified in terms of genetic (family history and pathology, other genetic predisposition's), biological (diabetes, high blood pressure, high levels of cholesterol), behavioural (physical inactivity, high levels of alcohol consumption, smoking, obesity, high fat intake), and psychological (stress and other personality variables.) (Arora *et al.,* 2000, Balarajan & Soni Raleigh 1995, British Heart Foundation 2000, Laungani 1998, Leicestershire Health Service 1993, Primatesta & Brookes 1999). Social stress and structural inequalities, lack of social support and stress arising as a consequence of lifestyle change and racism may underlie part of the excess in CHD mortality (Mckeigue & Sevak 1994, Samje 1995,).

It is suggested that control of obesity and greater physical activity offer the best prospects for preventing and reversing this metabolic pattern of diabetes and CHD in South Asians (Balarajan & Soni Raleigh 1995, Mckeigue & Sevak 1994)

Bangladeshi men were twice as likely to smoke than men in the general population, however there were low rates for South Asian women the only exception would be a Bangladeshi woman. South Asians are also less likely to successfully give up smoking (The Health Survey 1999, Rudat 1994, Nazroo 1997).

Low levels of alcohol consumption are reported among Pakistanis and Bangladeshis, but higher levels among Indians in particular Sikh men (Leicestershire Health Service 1993).

South Asians appear less likely to adopt a healthy diet although a higher proportion are vegetarian (Leicestershire Health Service 1993) Bangladeshi and Pakistani are less likely to eat fruit and vegetables. Bangladeshi women also have a higher rate of fat intake than the women in the general population.

Diabetes

Rates of diabetes mellitus (insulin dependant) are five times higher in South Asians than the general population, rates are higher in men than women (Balarajan & Soni Raleigh 1995, Health Survey 1999, Nazroo 1997, Primatesta & Brookes 1999). 20% of South Asians aged between 40-69 are diagnosed to have non-insulin dependant diabetes (Mckeigue & Sevak 1994) and again are five times likely to be diagnosed than Europeans and this increases with age (Leicestershire Health Service 1993). Diabetes and hypertension are risk factors for CHD because it leads to accelerated arteriosclerosis and accounts for 40% of CHD cases, it is also a risk factor for renal disease (Balarajan & Soni Raleigh 1995, Laungani 1998).

Mental, Psycho- Social Health

In South Asians there were high rates of admissions of, Schizophrenia, suicide amongst young Indian women and men born in the Indian subcontinent and Sikh men for alcohol problems. (Arora *et al.*, 2000, Balarajan & Soni Raleigh 1995, Samje 1995). A third complained that they felt tired and lacked energy (Nazroo, 1997). Stress and worry at home affected their health and was also higher in South Asians in comparison to the general population. South Asian men felt that they severely lacked social support, in which 55% of Bangladeshi men were affected (The Health Survey 1999).

Factors, which contribute to mental well being, have been associated with underlying genetic vulnerability, and the process of migration (Samje, 1995). It has also been suggested that psychological distress can present themselves as physical symptoms (Rack, 1982).

The pathway of ill health can be different for South Asian in particular with CHD, the causes and hence the methods of prevention may differ. In general South Asians are at more of a risk from the conditions identified in many of the key areas in the Government's health strategy. There are also differences between the various South Asian populations in terms of socio-economic status, lifestyles and genetic

predisposition's, and these are reflected in their disease patterns and death rates. Due to the demographic impact of ageing these risks will inevitably increase (Balarajan & Soni Raleigh 1995, Nazroo 1997).

2.2 Inactivity of South Asians

2.2.0 Quantitative Evidence

The Allied Dunbar National Fitness Survey (ADNFS) 1992 demonstrated the differences between the amount of exercise advised to improve health, and the actual levels reported. A more recent national survey by Sport England in 2000 (Rowe & Champion 2000) showed low participation levels of South Asian's in housework, gardening and DIY, walking, sports and exercise activities. South Asian's lead a sedentary lifestyle which increases the risk of heart disease, stroke, the onset of diabetes, osteoporosis- brittle bone disease in women and obesity, any increase in physical activity will be beneficial (Hine *et al.,* 1995, McKeigue & Sevak 1994, Rowe & Champion 2000, Samje 1995,Teers 1999,). The revised guidelines recommend that adults should take part in 30 minutes or more of moderate activity at least five times a week (Allied Dunbar National Fitness Survey 1992, Health Survey England 1999).

Physical Activity Levels of South Asian Men and Women

South Asian Men: Evidence of inactivity and low uptake of exercise has been reported and is shown in Table 2.1 (Hine *et al.,* 1995, McKeigue & Sevak 1994, Teers 1999). There was low uptake of all activities by Indian men followed by Pakistani men, with the exception of sport and exercise. The lowest uptake was by Bangladeshi men in all activities in particular heavy housework (5%). In the general population 18%, of the men participated at a moderate or vigorous level this was found to be lower in Indians, Pakistanis and lower still for Bangladeshis (Erens *et al.,* 2001). The preferred activity for South Asians men was sport followed by heavy housework, occupational activity, brisk / fast walking and finally heavy manual/ DIY, whilst it was evenly spread in the general population. In terms of intensity Bangladeshi men were the most inactive at 22% followed by Pakistani men at 15% and Indian men at 12%, compared to 8% of inactivity in the general population. A third of the men in the general population met the current guidelines this was the same for Indian men at 33% followed by Pakistani men at 29% and then Bangladeshi men at 24%. Meeting the guidelines decreased with an increase in age and was significantly lower for 55+, where only 7% of older Bangladeshi men were

compliant followed by older Pakistani men at 15 %. Older Indian men at 22% were slightly higher than the general population at 18%.

South Asian Women

The most popular activity for South Asian women in the general population was heavy housework being one and half times higher than the next common activity of sport and exercise. Among Pakistani women heavy housework was four times as high, for Bangladeshi women three times as high and for Indian women twice as high. This denotes low uptake for other activities in particular sport and exercise by South Asian women (Hine *et al.,* 1995, Teers 1999). Only 20% of Indian women took up sport and exercise, 13% of Pakistani women and 10% of Bangladeshi women. Brisk walking ranged from 10-13% much lower than the general population of 22% (Erens *et al.,* 2001). Same intensity patterns were seen with South Asian women as with the men that is Bangladeshi women were the most inactive at 34% followed by Pakistani women at 23% and Indian women at 16%, compared to 12% in the general population (Hine *et al.,* 1998, Teers 1999).

Overall strong evidence of inactivity 78% Indians, 85% Pakistanis and 92% Bangladeshis compared to 62% in the general population. That is, doing less than half an hour of physical activity peer week (Erens *et al.,* 2001). Many of the South Asian women reported self assessed poor health and limited knowledge of English and were economically disadvantaged thus exercise sessions outside the home would not reach many of these women. (Hine *et al.,* 1995). A fifth (21%) of the women in the general population women met guidelines, 17% of Indian women, 16% of Pakistani women and only 10% of Bangladeshi women. As with the older South Asian men, older South Asian women's compliance with the guidelines decreased with an increase in age. A significant drop was found at 55+, where only 1% of older Bangladeshi women met the guidelines followed by 2% of older Indian women and 6% of older Pakistani women. Overall Bangladeshi men and women had the lowest level of physical activity.

Table 2.1: Participation in moderate or vigorous level of the five main activities by men and women over a period of four weeks in percent (Teers, 1999).

	General Population		Banglade -shi		Pakista -ni		Indian	
%	Men	Women	Men	Women	Men	Women	Men	Women
Heavy House-work	36	52	16	37	25	51	34	49
Heavy manual/ DIY	30	12	5	3	12	5	19	5
Fast/ Brisk walking	28	22	18	11	17	10	19	13
Sports & exercise	38	33	24	10	36	13	33	20
Occupational activity	20	12	13	3	18	5	21	11

Table 2.2: Intensity levels reached over four weeks by men and women, does not represent frequency or the duration of the activity (Teers, 1999)

% Observed	General population	Bangladeshi	Pakistani	Indian
Men				
Inactive	8	22	15	12
Light	11	24	14	14
Moderate	49	30	36	43
Vigorous	32	24	35	30
Women				
Inactive	12	34	23	16
Light	11	17	8	14
Moderate	54	38	57	53
Vigorous	24	11	11	17

Gender Differences.

South Asian men had higher levels of participation in physical activity compared to the women with the exception of housework. 32 % of men in the general population are more likely to participate in vigorous activity compared with only 24% of women. Participation in vigorous activity for South Asian women ranged from 11-17%, which is significantly lower than the participation of South Asian men at 24-35%.

Physical Activity levels of South Asians by Age

Inactivity increases with age, but not at the same rate, and varies between the South Asian groups. 8% of young men (16-34) in the general population were inactive this doubled for Indian at 16%, Pakistani at 20% and was four times as high for Bangladeshis at 32%. The same trend was observed with young South Asian women where 44% of Bangladeshi young women were inactive. 41% of older men (55+) in the general

population were inactive again this increased to 56% for Indian men, 66% of Pakistani men and 80% of Bangladeshi men. The trend was much higher for older women at 46% in the general population, 69% of Indian women, 72% of Pakistani women and 92% of Bangladeshi women. Thus, the pattern for men and women differ, for men a clear decease in activity with an increase with age and for women similar level of activity at 16-34 and 35-54 but a sharp decrease at 55+. However a decline in activity is seen in both men and women between the middle and older age bands compared with the younger and middle age bands.

Table 2.3: South Asian inactivity and those meeting current guidelines by age (Teers, 1999)

% Observed	**Age**							
	Men				Women			
	16-34	35-54	55+	All	16-34	35-54	55+	All
General Population								
None in past four weeks	8	17	41	23	16	19	46	28
Meeting Guideline	48	36	18	33	26	26	11	21
Indian								
None in past four weeks	16	29	56	30	25	31	69	35
Meeting Guideline	34	37	22	33	18	23	2	17
Pakistani								
None in past four weeks	20	38	66	32	34	39	72	39
Meeting Guideline	33	28	15	29	17	18	6	16
Bangladeshi								
None in past four weeks	32	56	80	49	44	66	91	54
Meeting Guideline	31	25	7	24	13	7	1	10

Participation in Specific Sports

There are relatively low levels of participation of South Asians in sport in particular walking and cycling in relation to a healthy active lifestyle have been reported (Rowe & Champion 2000). Participation in sport was defined as having taking part in sport or physical activity on at least one occasion in the previous four weeks excluding walking. The national average for participation in sport was 46%; these were lower in South Asian groups at 39% of Indians, 31% of Pakistanis and 30% of Bangladeshis. A degree of complexity and variation of levels of participation exists between South Asian populations, men and women and between different sports. Some sports like cricket and Carram board had high participation levels whilst other such as swimming and tennis had low levels. The survey found a high level of interest in participating in sport and issues around service provisions. It also provided evidence, which would challenge stereotypical views on low participation in certain sports, which is a reflection of culture and choice rather than constraints on provisions, affordability and access (Rowe & Champion 2000).

Table 2.4. Participation of South Asian groups in % of 18 different activities at least on one occasion in the previous four weeks and the top ten sports ranked by the General Household Survey 1989.

Active Sport, games Physical Activities	General Population %	Indian %	Rank	Pakistani %	Rack	Bangladeshi %	Rack
Walking	44	31	1	24	1	19	1
Any swimming	15	11	3	8	4	8	3
Keep fit/yoga	12	13	2	9	2	7	5
Snooker/pool/ billiards	11	10	4	6	5	10	2
Cycling	11	4	7	3	8	1	
Weight training	6	5	6	4	7	6	6
Any soccer	5	7	5	9	2	8	3
Golf	5	1		0		0	
Running (jogging etc.)	4	4	7	3	8	1	
Tenpin bowls/skittles	3	2		0		0	
Badminton	2	4	7	3	8	3	7
Tennis	2	2		2		1	
Table tennis	2	1		1		1	
Cricket	1	3	10	6	5	2	8
Self defence/ martial arts	1	2		1		0	
Basketball	1	1		1		1	
Carram- board	-	1		0		2	8
Base	15696	890		514		155	

Although walking was omitted from the overall participation rates in sport it was recognised that walking done at a frequent or at a brisk speed plays an important role in an active and healthy lifestyle, the survey defined walking as; walking or hikes of at least 2 miles or more.

There was low participation in walking for South Asians, in particular the Bangladeshi community where only 19% undertook regular long walks compared to 44% of the general population. Swimming was the third most popular activity for Indians and Bangladeshis however only 11% and 8% respectively took it up compared to 15 % in the general population.

Participation of South Asian Men in Sport

Table 2.5. Participation of South Asian Men in % of 18 different activities at least on one occasion in the previous four weeks and the top ten sports ranked by the General Household Survey 1989.

Active Sport, games Physical Activities	General Population %	Indian %	Rank	Pakistani %	Rack	Bangladeshi %	Rack
Walking	49	36	1	26	1	22	1
Snooker/pool/ billiards	20	18	2	11	3	18	2
Cycling	15	5	8	5	8	2	9
Any swimming	13	10	4	10	4	8	5
Any soccer	10	13	3	16	2	14	3
Weight training	9	9	5	7	7	13	4
Golf	8	2		0		0	
Keep fit/yoga	7	8	6	8	6	2	9
Running (jogging etc.)	7	5	8	5	8	2	9
Tenpin bowls/skittles	4	2		0		0	
Badminton	3	5	8	4	10	4	6
Tennis	2	2		1		2	9
Any Bowls	2	0		1		2	9
Table tennis	2	2		1		3	8
Squash	2	2		1		0	
Weight Lifting	2	3		1		0	
Cricket	2	6	7	10	4	2	9
Self defence/ martial arts	1	2		2		0	
Basketball	1	2		2		0	
Canoeing	1	0		0		0	
Carram- board	-	1		0		4	6
Base (100%)	7186	437		248		66	

Swimming for Indian and Pakistani men was the fourth most popular activity where 10 % undertook the activity followed closely by Bangladeshi men at 8% compared to the national average for men at 13%.

Bangladeshi men were found less likely to participate in keep fit/ yoga whereby only 2 % took up the activity compared to the national average of 7%. The activities, which were the most popular amongst South Asian men and were, found to be higher than the national averages included football, Carram board and cricket. The national average for the uptake of football is 10%, it was higher in Pakistani men at 16%. Carram-board was another activity that was found higher in Bangladeshi men at 4% compared to the national average for men at 1%. The national average for cricket was 2% but for Pakistani men it was 10 %, Indian men at 6% and only 2% for Bangladeshi men. There

was a particular low uptake of cycling amongst South Asian men, only 2% of Bangladeshi, 5% of Indian and Pakistani men took up the activity compared to the national average for men at 17%.

Participation of South Asian Women in Sport

Table 2.6. Participation of South Asian women in % of 19 different activities at least on one occasion in the previous four weeks and the top ten sports ranked by the General Household Survey 1989.

Active Sport, games Physical Activities	General Population %	Indian %	Rank	Pakistani %	Rack	Bangladeshi %	Rack
Walking	41	25	1	21	1	16	1
Any swimming	17	12	3	5	3	8	3
Keep fit/yoga	17	18	2	10	2	11	2
Snooker/pool/ billiards	4	2	7	1	8	3	4
Cycling	8	4	4	1	8	0	
Weight training	3	2	7	1	8	1	8
Any soccer	0	1		2	4	2	5
Golf	2	0		0		0	
Running (jogging etc.)	2	3	5	1	8	0	
Tenpin bowls/skittles	3	3	5	0		0	
Badminton	2	2	7	2	4	2	5
Tennis	2	2	7	2	4	1	8
Weight Lifting	1	1		0		0	
Cricket	0	0		2	4	2	5
Self defence/ martial arts	0	2	7	0		0	
Basketball	0	1		0		1	8
Netball	1	1		0		1	8
Athletics track & field	0	0		0		0	
Gymnastics	0	1		1	8	1	8
Base (100%)	8510	454		266		89	

Walking for South Asian women was the most popular activity but up take was low only 16% of Bangladeshi women walked or hiked 2 miles compared to the national average of 41%. Keep fit/ aerobics/ yoga was the second most popular activity for women in all groups except for the Bangladeshi community, keep-fit after walking is taken up by most women from all ethnic minority groups, it is ranked as the third most popular activity in the general population. 2% of Bangladeshi and Pakistani women took up cricket, which again was higher than the national average for women at 1%.

There is a low uptake of swimming in all South Asian groups compared to the general population. Only 5% of Pakistani women took up swimming compared to 17% of women in the general population. Further evidence is presented in Sport England's 1997

survey of the use of local authority pools, where there was a significant under representation of ethnic minority groups using the facilities.

South Asian Gender Differences in the Participation of Sport

South Asian men are more likely to participate in sport then South Asian women. For South Asian women participation rates were lower; for Indian women at 31%, for Pakistani women at 21% and Bangladeshi women at 19% compared to the national average of 39%. For South Asian men the figure was higher than the women, Indian men at 47%, Bangladeshi men at 46% and Pakistani men at 42% compared to the national average of 54%. Gender differences showed that South Asian men are more likely to take up long walks than South Asian women. The rates were significantly low with South Asian women with only 16% Bangladeshi, 21% Pakistani and 25% Indian women taking up walking.

A significant difference between South Asian men and women could be seen in the uptake of cycling, women are less likely to participate, only 1 % of Bangladeshi women were found to cycle. The survey found that more men than women have had a negative experience of participating in sport, this maybe also due to the fact that more men undertake sport than women.

2.2.1 Qualitative Evidence of Inactivity of South Asians

The concept of exercising ones body for health reasons does not in general have a great appeal to South Asians (Laungani, 1998). However, the practice of exercise traces back to ancient Indian traditions (Laungani, 1998). Qualitative research among South Asians into factors prohibiting them from participating in physical activity found no cultural or religious reasons (Health Survey for England 1999, Rai & Finch 1997, Shephard 1986, Whitehead 1995). Besides notable differences between 'older' and 'younger' people the evidence found no significant differences within South Asians groups of their views of physical activity. The way in which participation occurred differed and different facilities for physical activity were required based on cultural or religious beliefs. Community specific issues and those communities that are culturally dynamic are influenced internally and externally. Settlement patterns around England showed variation in attitudes and in the use of local facilities. Variation also existed in the different lifestyles of each South Asian community thus, knowledge of local communities is vital in shaping local promotional strategies (Rai & Finch, 1997).

Barriers to Physical Activity.

Barriers can be classified into practical ones; that is lack of time, cost constraints, work & facility related. Then, those associated with attitudes and beliefs; that were perceived to be a barrier that is a lack of motivation, changing life stages, beliefs to old age, and perceived lack of importance (ADNFS 1992, Rai & Finch 1997, Whitehead 1995).

Physical Barriers.

No one barrier affected a person but a combination, which included; juggling home and work responsibilities, working long hours, and care of young children (women felt uncomfortable using child minders and preferred relatives but a lack of family support was flagged). A lack of spare time, appeal and tiredness stopped uptake but recognition was made that physical activity can produce a relaxed state, a lack of a companion or a self perception of not being the sporty type (HEA 2000, Rai & Finch 1997, Whitehead 1995).

Cost was a major factor, facilities were unaffordable but there was recognition of free and reduced rate activities, however these were at inconvenient times. Additional costs of equipment and clothing added to the constraint. For older people paying for physical activity was not natural as it was considered to be an integral part of life and should be free. It was considered to be wasting money, which could be spent on other priorities especially for the unemployed and South Asian women who believed in future investments such as jewellery (Health Survey for England 1999, Rai & Finch. 1997, Whitehead 1995).

Evidence of the lack of appropriate facilities was presented; different dress codes, lack of separate sex provision and actual and potential experiences of racism. Other barriers to facilities included lack of peers to go with, cost, and body size consciousness, location, cultural environment (a lack of Asian workers and users), opening times, and lack of crèche facilities (Health Survey for England 1999, Rai & Finch 1997, Whitehead 1995). A fear of personal safety and racism whilst using open public spaces was also a barrier and the absence of parks and dirty pavements (Greenhalgh *et al.*, 1998);

'Walking in the park a white boy threatened us with his barking dogs.'

'Walking down the road some white youths spat at me and called me horrible names.'

Some felt that their homes were restrictive due to the lack of space and what the extended family may think. Some of these structural barriers can be addressed by the facilities as well as perceived stereotypes of South Asian's that is they lack physical strength to participate in competitive sport (Whitehead, 1995). The lack of role models

has contributed to this image and a strategy is required to encourage them into sport and provide relevant opportunities. Also, South Asian women are classed as being 'housebound' instead of being understood in their context of their lifestyle (Rai & Finch. 1997, Shephard 1986, Whitehead 1995).

Barriers Relating to Attitudes & Beliefs

The main attitude and belief that acted as a barrier for the South Asian community was a lack of motivation, some were simply lazy, did not enjoy it, and lacked will power, whilst others life circumstances such as unemployment and loss of family members left them feeling depressed. Thus, changes in life stages diminish the opportunity for physical activity and priorities change. For some South Asian women marriage could affect their ability to go out and take up activities as family members may have a view on this. Stress emerged as an inability to do physical activity, as other pressures on the mind were more prominent. Some found doing physical activity on their own a barrier, which could relate back to general patterns of collective behaviour. Other enjoyable activities such as spending time with partners or going to the pictures were seen to be more important than physical activity (Health Survey for England 1999). Poor weather and television culture made participation in physical activity more difficult. A few had a view that physical activity was unimportant for fitness or looking good and felt that it did not produced the desired results and past efforts were ineffective (Rai & Finch 1997).

Motivational Factors

The most prominent motivational factor for the physically active was enjoyment; also habit (from childhood or school and particular activities such as cricket were identified) to look good, for health, to be a role model to children, convenient or appropriate facilities and social benefits. For the inactive it was felt that there was a lack of South Asians in fitness or sport thus self-motivation and like-minded friends were the motivational factors for the active (Health Survey for England 1999, Rai & Finch. 1997, Whitehead 1995). Suggestions to overcome motivational barriers included promoting the social aspect and participating with friends. For older people pushing sweating as a 'good sign of health' and physical activity as a stress reliever (Rai & Finch 1997).

'We need to be told that work only is not good for us. In fact your energy diminishes with work. Exercise has its own benefits it can restore energy. We all suffer from depression and stress and exercise is good for

you. It helps keep your mental health well. People need to be told'. South Asian female, age 50. (Rai & Finch 1997).

Community Specific Barriers

For Muslim women and men separate sex facilities was a requirement due to religious observations. In particular *namaz* prayers, which was considered as physical activity but was also seen as being restrictive and other things have to be fitted around it. South Asian women felt it was about lifestyle rather than cultural restrictions and communicating benefits to men. Gendered socialisation is the norm, thus separate sex facilities should be an extension of this lifestyle instead of being classed as a cultural restriction (Laungani, 1998).

Combining of physical activity with social events where the whole family can participate would be classed as the norm as social and leisure pursuits are centred on the family, gatherings and the participation in religious and festive events (Laungani, 1998). Large body size was a sign of good health and happiness for older women, for younger women views were mixed. Lack of South Asian role models and the perception existed that South Asians are not strong enough for sport. A lack of precise information on the relationship of South Asian diet and physical activity was also seen as a barrier.

The environment in which participants were raised showed differences for older people physical activity was about an integral lifestyle and being free whilst the younger people viewed as a separate and was a financial demand thus a lower priority. For the unemployed, physical activity occupies time, but was dependent on cost and others lacked motivation. Similar barriers were found amongst the different social classes however the activities they participated in were different for example the upper class played tennis and golf. Furthermore, people with a higher level of education were better informed on specifics such as heartbeat and exertion. Racist attacks were more of a concern for people living in 'pockets' of the community compared with people living in high South Asian populated areas but were concerned about past racial attacks on the community (Whitehead, 1995). There was also concern of the lack of adequate facilities in these 'pockets'. If facilities were not close by the specific community did not use them. For the South Asian women in the north there was a perception that the women in the south were much more close knit, and if transport were provided would take up opportunities (Rai & Finch 1997). For Bangladeshis, the Sylheti language has no expression for physical activity that is vitality, improvement in the body condition or

social desirability, thus the closest translation is exercise, which often has a negative impact in the community (Greenhalgh *et al.*, 1998).

Attitudes, beliefs and knowledge of Physical Activity

There was a clear distinction of physical activity, which is an integral part of life (e.g. walking, climbing stairs, housework, cultural dancing- bhangra, religious prayer activities such as *namaz*) and engaging in specific types of exercise and sport (e.g. aerobics, swimming, football, hill walking) (Rai & Finch 1997). However, awareness of the association between physical activity and health is very low amongst South Asians, less than a third knew that a lack of physical activity might result in heart disease (HEA 2000, Health Survey for England 1999). The integrated concept was related to 'back home' (originating countries) where there was more of an opportunity of an active lifestyle. In the UK physical activity was counted as 'separate' whereby booking or payment is required (Rai & Finch 1997).

A low priority was given to physical activity due to family obligations. Older people in particular felt that they were at an age where they should rest and slow down and it might become dangerous or painful. Physical activity was viewed as tiring this conflicted with the desire for good health and mobility (Rai & Finch 1997).

It was the consensus that physical activity in conjunction with a healthy diet would maintain, and improve current health and prevent future illnesses including heart disease (Beishhon & Nazroo 1997, Rai & Finch 1997). Other perceived benefits mentioned included; general well being, prevention of illnesses and diseases, relief from existing medical conditions, general maintenance of physical mobility in old age, mind-body connection, and body shape (more socially valued than health related). It was believed that any type of activity would offer protection and there was a lack of awareness between moderate and strenuous physical activities. Benefits to muscle tone, respiratory capacity and weight loss were stated the latter being perceived as having immediate health benefits (Beishhon & Nazroo 1997). It was felt that physical activity was just as important as healthy diet but less than non-smoking and views were mixed about alcohol consumption. Physical activity was also viewed as a compensation for health abuses such as an unhealthy diet and smoking. A few treated physical activity with scepticism due to the perceived lack of scientific evidence (Rai & Finch 1997). Physical activity was also seen as having psychological benefits, in giving the feel good factor, improved alertness, and reaction times and as means of dealing with stress.

For older people physical activity was important in weight management and sweating as it represented the removal of toxins and impurities from the body. Also, physical activity was central to their mobility and believed it can cure some diseases such as diabetes. Other South Asian older non-UK born respondents felt that physical activity would be harmful if taken up at a later stage as the body maybe intolerant to it and should be carried out by the young (Beishhon & Nazroo 1997, Mckeigue & Sevak 1994).

Current and Perceived levels of Physical Activity.

The involvement of health enhancing activities such as sport based, general physical activity, diet, medical treatment, or lifestyle modification was lower in South Asian groups (Rudat 1994). However, it was believed that levels of physical activity should be built up gradually and done regularly but is individually based and should be enjoyed. Reaching intensity where sweat was produced was believed to be a good sign. Heartbeat and breathlessness was unclear, as some thought these were danger signs to the possibility of a heart attack others thought this is an indication of reaching a beneficial level. Thus more information is required on the exact levels for reaching health benefits, also the connection of health, diet, and fitness (Rai & Finch 1997).

The types of activities undertaken by South Asians are shown in the table 2.7 and were perceived as being narrow. All believed that they were much more active in their school days where set times were allocated for physical activity and also when facilities were available at work.

Table 2.7: Physical Activities undertaken by South Asians (Rai & Finch 1997).

Physically Inactive:	
Young Asian Men	Weight training, press-ups, Karate, golf, badminton, tennis, squash, and cricket.
Young Asian Women	Occasional walks, basic stretching, sit ups, abdominal exercise, self defence, swimming.
Older Asian Men	Walking, brisk walks, sit-ups, press-ups, rowing machine (at home), badminton, squash, cycling with children (summer), gardening (summer).
Older Asian Women	Walking, brisk walk, cooking and cleaning, tummy exercises, yoga, aerobic (summer), and swimming.
Physically Active:	
Asian men	Walking, press-ups, running, weights, badminton, squash, football, cricket.
Asian women	Housework, walking, brisk walks, gentle exercises, sit ups, exercising to work out video, exercise bike, aerobic, swimming, dancing, ice skating, hill walking, mountaineering.

Participants highlighted the different lifestyle in the UK compared with 'back home' where there was more of an opportunity to have an integrated active life due to better weather and safer streets to walk on. They have adapted to a culture of privacy and isolation and taking public transport rather than walking, thus moving from an active lifestyle to a sedentary one. Walking was common back home, as it was the main mean of transport, and involved long distances (Beishhon & Nazroo 1997, Rai & Finch 1997). Older people were found to avoid physical exertion, and linked it to their poor health (Health Survey for England 1999).

'Its something that's in you all the time.... walking has become a habit.... When I was six or seven years old, in the mornings I used to get up about six o' clock, we'd (with father) go to the fields for a brisk walk before breakfast. The beautiful green grass helps your eyes first thing in the morning. You feel good. It's very difficult to describe the feeling.' Asian male age 39 (Rai & Finch 1997).

It was recognised that living in the UK was more stressful and thus more important to exercise. Physical activity was not seen as a western concept, but emphasis was placed that some activities were more western whilst other were connected to ' back home'.

Young university educated men and women were more likely to take up formal/ separate physical activity and young men more so than young women as a part of their healthier lifestyle. Young men in particular linked it to the social aspect, which was the driving force to increase participation (Beishhon & Nazroo 1997).

Parents felt that they were currently doing enough via child and household responsibilities, and manual work. The latter was more prominent with older respondents who had in the past worked on their home land and felt it was sufficient enough to prevent being overweight (Beishhon & Nazroo 1997, Mckeigue & Sevak 1994). This view was further consolidated by the perceived relationship between good health and weight loss, those that felt they were not overweight did not believe they needed to do any more physical activity than what their lifestyle enabled. Thus there was an inherent assumption that those that were not overweight were almost automatically healthy.

Gender and class divided the uptake of physical activity. Indian and East African women were more likely to take up or were taking physical activities compared to young Bangladeshi and Pakistani women. Bangladeshi women in particular were found to hold physical activity as a low priority compared to childcare.

Sources of Belief.

For younger people the sources of belief were the media, role models, family and friends. For older people, family and friends were more major, then followed by the media. Younger women felt a pressure to conform to a 'slim body shape' that is represented in the media and now in South Asian films. General role models have an influence such as Cher, Jane Fonda, Indian film actresses, but there is a lack of ordinary people from individual communities. For older people religious leaders such as Muslim *Mullahs* have an influence, also for Muslim men they are encouraged to conform to *'Jihad'* where a level of fitness is required to fight in war. Some believed in fatalism, whereby health and fitness was a predetermined factor. Family and friends were sources of shaping views, parents in particular felt that they were role models to their children and encouraged family outings to the park. Older women saw their daughters as potential sources of information from the events at school. Medical establishments such as hospitals were useful, but GPs were not, they tended to only give advice on physical activity when a health problem presented itself (Rai & Finch 1997).

Recommendations to promote physical Activity in South Asians

A number of recommendations were made (Rai & Finch 1997) to promote physical activity in the South Asian community this included; a need for active and long term promotion, community specific promotional vehicles such as word of mouth, social promotional events, home visits, advertisements within South Asian media-TV, press, radio, more role models and images of 'ordinary looking' (wearing traditional dress) South Asian people in health and exercise programme's, and increasing opportunity to participate in physical activity from a school age so that it becomes habit.

There was a high awareness of the benefits of physical activity thus encouragement and reminders seemed more important than re-educating, and repeating these precise messages through all forms of community specific promotional vehicles. However, some women felt that Asian men should be more informed about the benefits, which would have a knock on effect on them. It was suggested by Gujarati and Punjabi women the promotion of community specific physical activities such as Rasgharba and Bhangra which were much more appealing than aerobics (Rai & Finch 1997). Health promotion programmes should work closely with local authorities to ensure that appropriate facilities for leisure-time physical activity are available and those problems, such as access for people working long or unsociable hours are overcome (McKeigue & Sevak 1994).

Most elderly South Asians are isolated and only venture to places of worship, so there was a lack of information on services and activities available (Health Survey for England 1999).

Thoughts to current promotional ideas such as the exercise prescriptions were supported however did not believe that it could be sustained. Young people felt that the three 20 minute sessions per week were obtainable but the inactive thought this was too high. The active lifestyle, which incorporates physical activity as an integral part was welcome by all age groups, however walking was more appealing to the older people and less so by young people. Exercise in the workplace, was thought to be opposed by employers and the promotion of physical activity as a prevention to the onset of illness was thought to be helpful but may not necessarily prevent illness (Rai & Finch 1997).

Sports, which South Asian groups would like to participate in

More than half of all South Asians said they would like to participate in a sport which they currently do not, as high as 60% for Indian, 54% Pakistanis and 51% Bangladeshis (Rowe & Champion, 2000). South Asian women have expressed an interest in taking up activities to stay healthy, but current opportunities may be unsuitable (Greenhalgh *et al.,* 1998). These sports included; swimming, keep fit, aerobics, yoga, badminton, self-deference, football, motor sport, cricket, and tennis.

The reasons for the lack of participation in sport by South Asian communities

Home and family responsibilities, 'work or study demands', 'lack of local facilities', 'lack of money' and 'I am lazy/I am too embarrassed' were the main reasons stated for non-participation. Home and family responsibilities were the most popular reason for Indians at 43% and for Bangladeshis at 40%. 48% of the Bangladeshi community and 29% Indian men stated the lack of/ unsuitable facilities. For South Asian men work/study demands was frequently mention as a reason not to participate, 49% of Indian and 45% of Pakistani men. A lack of money was why 20% of Pakistani and 18% of Indian men did not participate. For South Asian women home and family responsibilities were often stated at 49% of Indian and 44% of Pakistani women. The second reason was the lack of unsuitable local facilities, 25% of Indian and Pakistani women felt this prevented them from participating.

Negative experiences of participating in sport.

Sporting experience commence from school, 46% of Pakistanis and 40% of Bangladeshis felt deterred from sport due to the experience. One in five said they had negative experiences of sport due to their ethnicity and identified with racial discrimination in sport.

2.3 Health Intervention Theory and Policies

2.3.0 Intervention Theory

An intervention theory guides development, delivery and the design of an effective study, which improves the validity of findings. It is an action on, or attempt to change, person, population or organisation, which is the subject of an evaluation. The practitioner would come between (inter venire) what would otherwise happen. Most evaluations examine an intervention, which aims to alter the course of events so that people gain a health benefit from the intervention (Overtveit, 1998). Theory in intervention evaluation has to explain the processes that mediate or condition the causal relationship between the intervention and the procedures to be performed to bring about the desired effects. An intervention theory need not be elaborate or detailed to be useful. Rather, it should be relevant in its content and sufficiently explicit.

Health interventions are rationally based, meaning that there is a reason or logical basis for the intervention. Delivery of an intervention requires inclusion of the full spectrum of target participants, selection of interveners with skills needed for providing the intervention, the availability of equipment or materials needed for performing the intervention activities, and organisation or institutional support for co-ordinating the intervention procedures. These resources represent the input factors needed for carrying out the intervention activities and have potential to condition the implementation processes and the consequence of the intervention. A prior knowledge of which resources are needed is important to ensure their availability and facilitate the treatment implementation procedure (Overtveit, 1998).

Community Intervention Programmes: a Management Model.

Two types of models have been denoted, the first involving actual or hypothetical causal relationships (effects or how it works, figure 2.1) and the second is a sequence of activities or events (stage or how to do it, figure 2.2) (Sanderson *et al.,* 1996). Existing stage models for health promotion programmes imply an ordered or cyclical set of activities in which preparation is followed by implementation, maintenance, evaluation

and revision. In practice this involves a series of parallel but independent activity streams. Both are needed, the stage model represents the plan of action and the effect model represents the scientific justification for it.

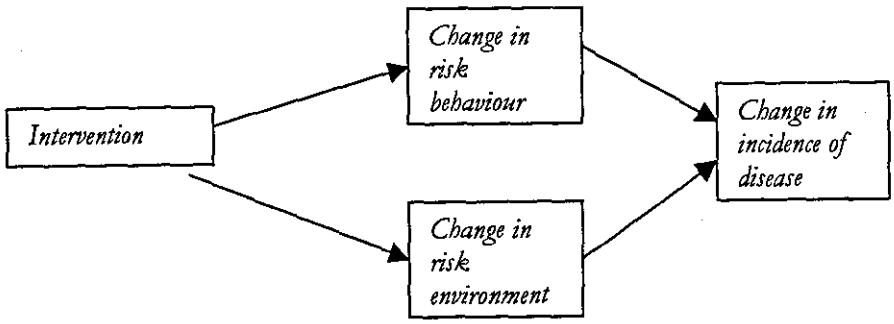


Figure 2.1 The basic causal or effect model for health promotion (Sanderson et al., 1996).

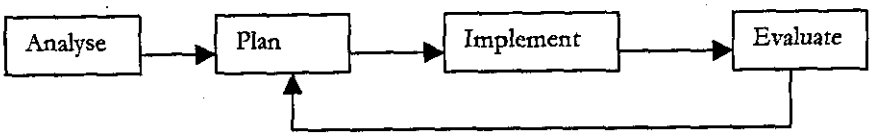


Figure 2.2 The basis planning or stage model for health promotion (Sanderson et al., 1996).

Sanderson *et al.*, 1996 took the models further and depicted the generalised effect model for health promotion, which has a number of inter-linked effect chains as shown below.

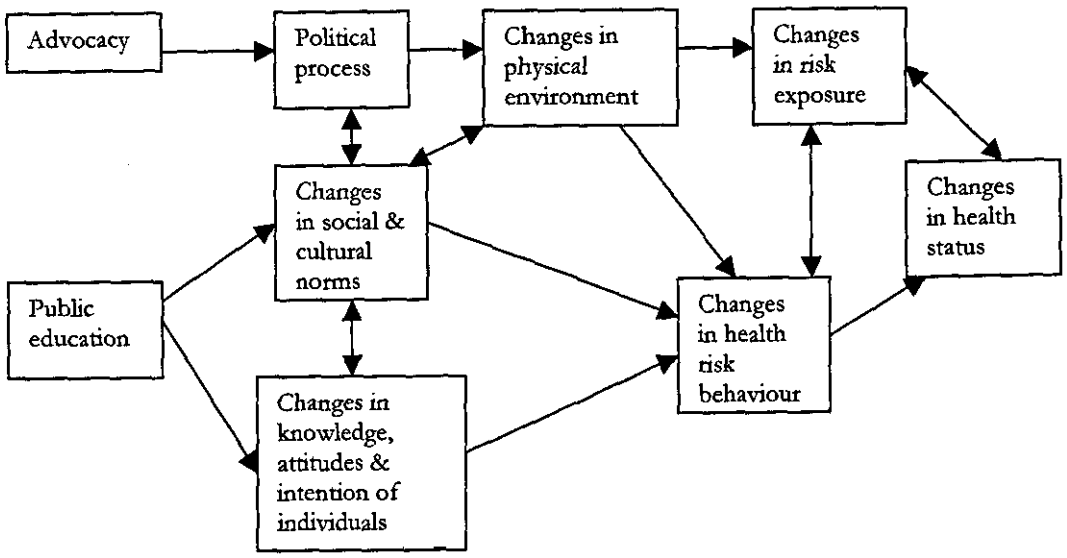


Figure 2.3 An effect model for Health promotion (Sanderson *et al.*, 1996).

The model in figure 2.3 recognised that different groups and organisations are reached through different kinds of channels and respond to different kinds of interventions. Green (1992) produced the Research Agenda Model, a map of casual relationships; six areas were identified as shown in figure 2.4

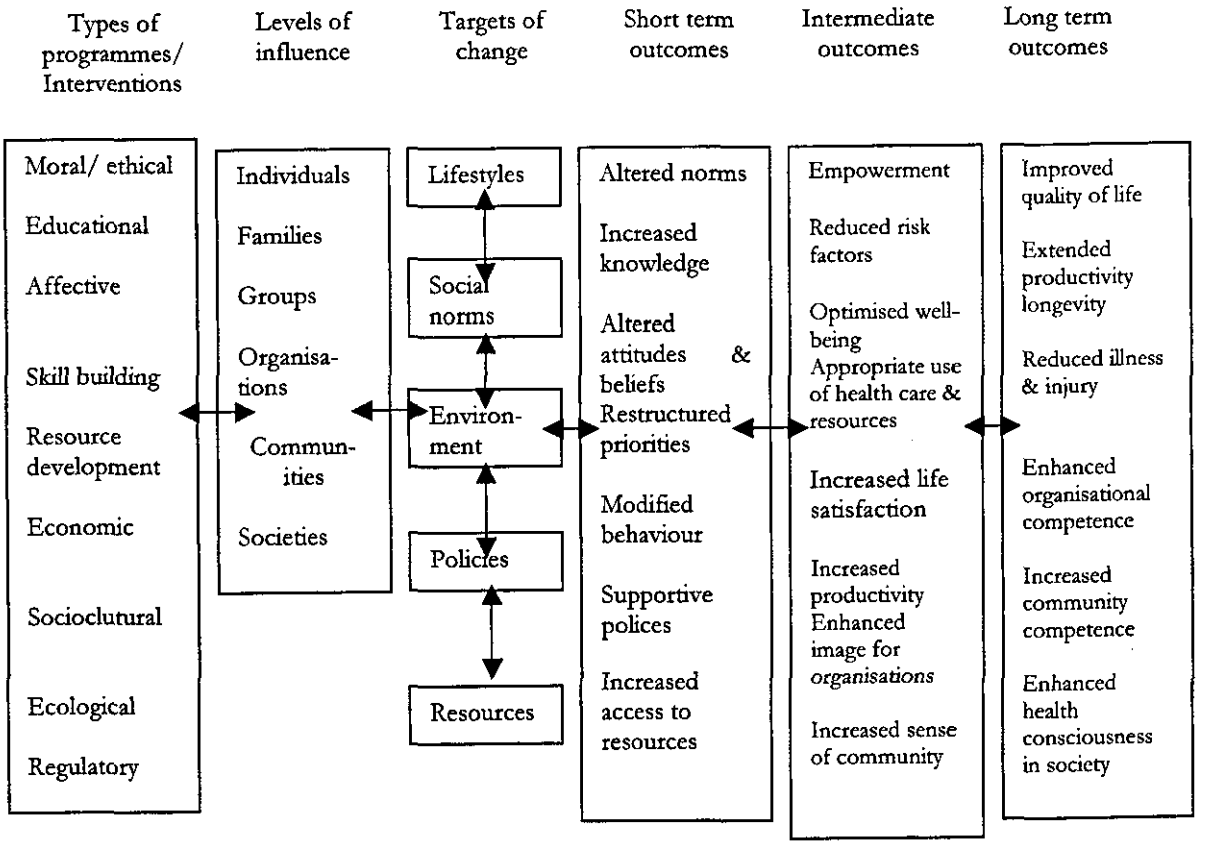


Figure 2.4 The research Agenda model for Health promotion. (Green 1992)

The Supportive Environment Action Model (SESAME) places emphasis on the participation and involvement by members of communities concerned from the very beginning. It's graphic representation of the cyclical nature of the process of, renewal; reinforcement and reorientation can be related to the action research model.

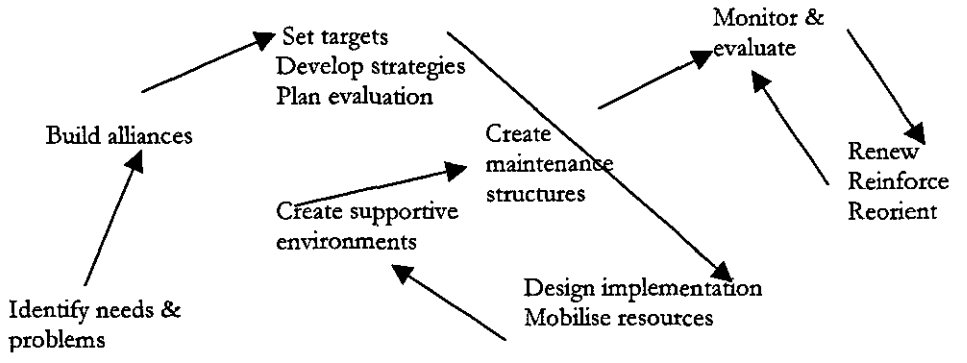


Figure 2.5 The supportive Environment Action model (SESAME) (Sanderson *et al.*, 1996).

A model, which uses both the effects and stages, is the PRECEDE/ PROCEED model.

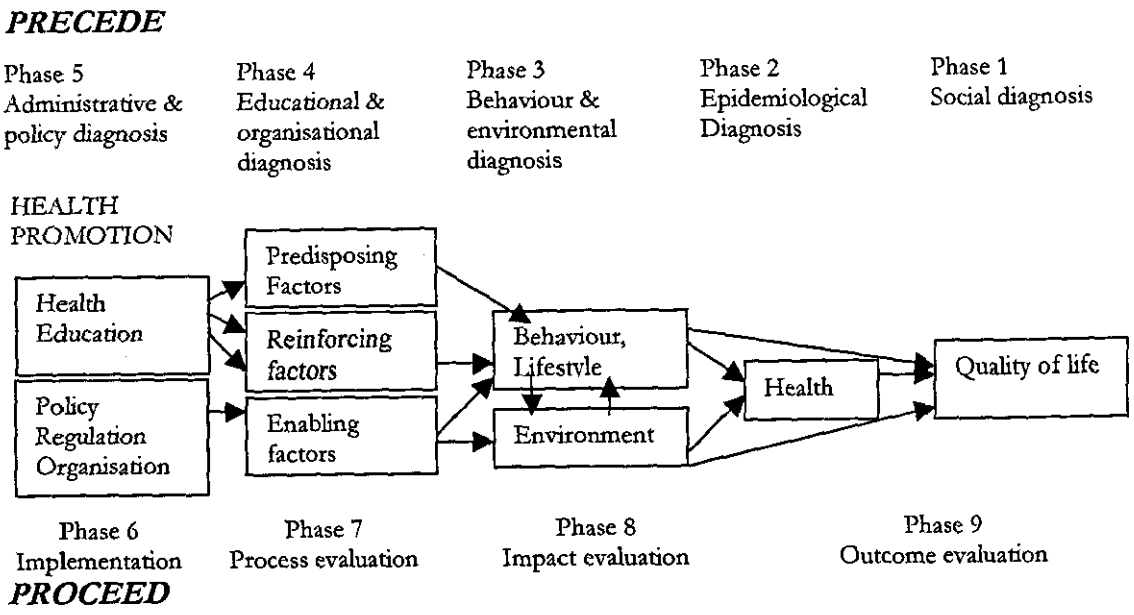


Figure 2.6 The PRECEDE/PROCEED Model (Green & Kreuter 1991)

A disadvantage of the stage models are that they are conceptual and are useful in communicating broad aims, but their linear nature does not provide a sufficiently detailed basis for co-ordination and management of a programme. In particular a programme development will involve a variety of people in a variety of parallel but independent activities in which work on some will not have a secure foundation unless sufficient progress has been made on others.

The philosophy of health education and promotion is built on the principle of self-determination of individuals and communities. Thus, the purpose of intervention mapping is to provide planners with a framework for effective decision making at each step in the intervention development process (Bartholomew et al., 1998). It also allows the discovery of relationships, locates desired destinations, plans a route to get from one place to another and executes this plan. It is visual with diagrams and matrices, the process is intended to make the steps in planning interventions explicit, to demystify the process, and to facilitate collaborative planning by the individuals of varying backgrounds (Schooler, 1995). Intervention mapping is a comprehensive approach to health education planning that links intervention development and design with needs assessment, programme implementation and evaluation. As with a road map, the planner can at any point in the process determines where s/he took a wrong direction and correct the route accordingly (Bartholomew *et al.*, 1998).

Theory driven effectiveness research should not be guided by a single design or research method. Resorting to a single research method leads to findings that are constrained by the limitations and biases of the method used. Rather multiple and diverse research methods including design, methods for data collection and strategies for data analysis, are needed to enhance the validity of findings (Bartholomew *et al.*, 1998).

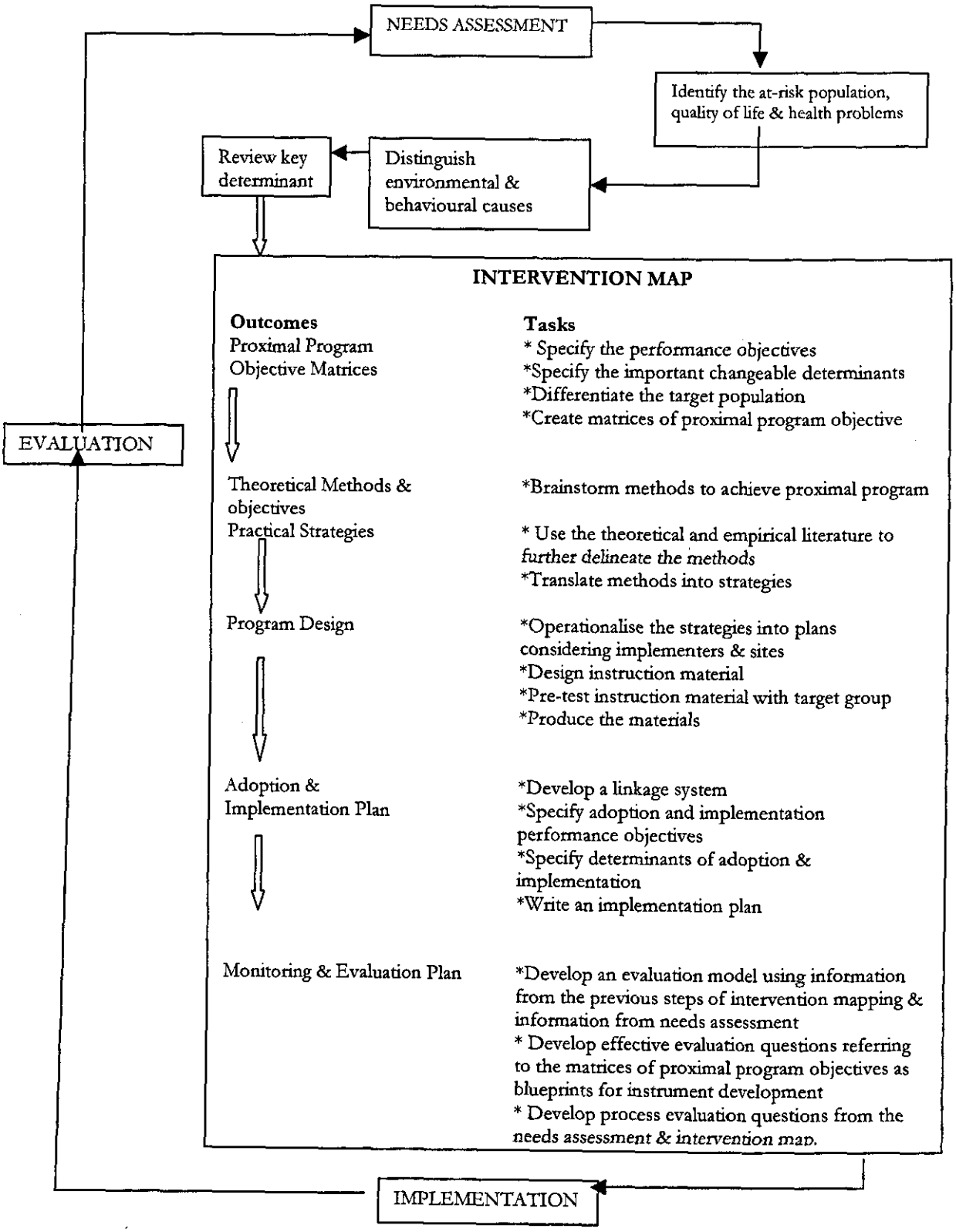


Figure 2.7 The steps of Intervention Mapping Framework (Bartholomew et al., 1998)

2.3.2 Physical Activity Intervention Policy Framework

Governmental and private institutions influence health behaviours by controlling funding for health care services, public transportation, parks and recreational facilities. In addition, businesses shape health by workplace health and safety policies. Institutional policies also influence health behaviour by providing normative sanctions and legitimacy to health innovations. Public health policies that invoke "passive" intervention are often more successful in achieving population-wide changes than those requiring active decision making by individuals (King, 1995). Such passive approaches can focus on making physical activity an integral part of work, home life, and transportation. Examples of passive interventions include restricting town centres to foot or bicycle traffic, placing car parks at some distance from buildings, and making stairways more convenient.

Linengar and colleagues (1991) demonstrated the effectiveness of environmental changes in increasing physical activity. The intervention included building cycle paths, extending hours at recreation facilities, installing new exercise equipment at gyms, scheduling community-wide athletic events, opening a women's fitness centre, marking running courses throughout the community, and organising running and cycle clubs. In addition, supervisors were encouraged to provide release time for physical activity and initiate rewards for improved physical performance. Significant improvements in fitness levels were reported in the intervention compared to the control.

King (1994) proposed a number of policy-level interventions that might provide an effective infrastructure for population-wide exercise behaviour change. These include; changing liability legislation to increase safety, zoning to encourage the use of stairs and to promote walking and cycling as a mode of transportation; and "tax breaks" for companies that provide employees with incentives such as work time for exercise, facilities for exercise, and lockers/shower facilities for employees who select an active commute. King also stresses the importance of the safety and comfort of leisure-time exercise facilities such as parks, ice rinks, swimming pools, and community centres.

The majority of health behaviour change efforts and research has focused on the individual. The KAB (knowledge, attitude, behaviour) model or educational model, hypothesises three steps for promoting behaviour change, the acquisition of knowledge about the behaviour and its importance, the development of a positive attitude about the

behaviour and the value of performing it and the acquisition of skills necessary to incorporate the behaviour into one's life (Sanderson *et al.*, 1996).

Interventions based on this model generally consist of a small number of information sessions, geared toward teaching the participant about the health benefits of exercise, creating fear about the results of inactivity, and providing techniques and strategies for exercise adoption (Cupples & McKnight, 1994; Dobs, *et al.*, 1994). Although these programmes have proved fairly successful in promoting short-term behaviour change, they are generally unsuccessful in the long term (Daltroy, 1985, Dobs, *et al.*, 1994; Kemenade *et al.*, 1994 , Scalzi *et al.*, 1980). A drawback of the KAB model is its tendency to assume a fairly homogenous audience. The reality of a heterogeneous society, with a population representing different ethnic backgrounds, income levels, past experiences, and dozens of other individual influences, argues for the utility of designing programmes targeted toward specific audience subgroups or segments. Social marketing principles stress the importance of developing health promotion campaigns that are "tailored" to audience needs. Messages, products, and services that are developed to be sensitive and appropriate to audience members are more informative, persuasive, and ultimately effective (Lefebvre & Flora, 1988). With increasing population diversity, mobility, and changing social roles, a number of other variables have been identified that can influence an audience's perception and reception of a health message: immigration status, family structure, language use and health beliefs and practices, such as those related to non-western healing systems (Earls 1993).

Increasingly, health planners divide populations into subgroups according to the transtheoretical or "stages of change" model which speculates that individuals move through five stages in the process of behaviour change: pre-contemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1992, 1985). Although the model was originally used to describe the process by which individuals quit addicting behaviours such as substance abuse, it has also been applied to the adoption of positive health-related behaviours, including exercise and physical activity (Marcus, & Prochaska 1994).

The social learning theory stipulates that individuals can develop the motivation and skills to change and control their behaviour through observation. Watching others perform new behaviours and overcome barriers, either directly or via mass media, not only builds confidence to attempt and persist in novel behaviours, but also teaches

people how to perform the healthy actions (Bandura, 1986). A substantial amount of research supports the effectiveness of techniques based on social learning theory in encouraging exercise uptake (Dishman, 1991) and even suggests that these skills contribute to leisure time physical activity.

Many models of behaviour change present a similar view of people cycling through several stages to successfully adopt new health habits. Owen & Lee (1984) propose that individuals move through five stages in becoming more physically active: awareness of the problem and a need to change; motivation to make a change; skill development to prepare for the change; initial adoption of the new activity or behaviour; and maintenance of the new activity and integration into the lifestyle. Perhaps the most challenging step is the last. Self-regulatory processes, such as building beliefs about personal control, can enhance adherence to a programme of regular physical activity. For example, a person who attributes her difficulty in an aerobics class to an inherent lack of ability or co-ordination will likely give up easily, whereas the person who thinks the class is too advanced may seek out a beginner's class and proceed to master the steps.

Perceptions of self-efficacy and personal control affect people's choices of activities, how much energy they will expend on these activities, and how much they will persist in the face of difficulty or barriers (McAuley, 1994). Exercise participation positively influences individuals' perceptions of their physical capabilities, including both physical competence and personal efficacy (Toshima *et al.*, 1990). Programmes that provide gradual shaping of successive approximations of the ultimate exercise and/or fitness goal enhances the likelihood that participants will persevere and achieve long-term maintenance (Dishman, 1982).

2.4. Physical Activity, Health and Interventions for Ethnic Minority Groups

2.4.0 A case for Physical Activity and Health

The major health authorities of the world agree that regular physical activity may be a cost effective and important preventive measure for all countries (Blair & Hardman 1995). Regular physical activity has been shown to be a component of a healthy lifestyle and well being having both physical and mental health benefits. It reduces mortality rates in both older and younger, male and female adults (ADNFS 1992, Blair & Hardman 1995, Pate *et al* 1995, Surgeons General Report 1996). Significant health gains are

benefited by including 30 minutes of moderate activity on most if not on all days of the week (Surgeons General Report 1996). This recommendation places emphasis of moderate- intensity physical activity that can be accumulated in relatively short bouts (Pate *et al* 1995). Physical activity can reduce the risk of Coronary Heart Disease, hypertension, colon cancer, diabetes mellitus, and osteoporosis. It also improves mental health and correct functioning of muscle, bones and joints (ADNFS 1992, Blair & Hardman 1995, Pate *et al* 1995, Surgeons General Report 1996). Epidemiological studies have demonstrated that exercise training improves health related factors such as blood lipid profile, resting blood pressure in borderline hypertensives, body composition, glucose tolerance, insulin sensitivity, bone density, immune function and psychological function (ADNFS 1992, Pate *et al* 1995,).

The Allied Dunbar National Fitness Survey (1992) concluded that population of England needed to be more physically active, to meet national targets and policies for the promotion of physical activity. A physical active life is the healthy biological norm: sedentary living is abnormal and unhealthy.

2.4.1 Physical activity Interventions for Ethnic Minority Communities

The California's physical activity initiative ON THE MOVE! (Manley 1999) was a competitive market programme for multiethnic populations, which allowed for maximum flexibility and creativity in the design of various programme interventions. The key to the success of these various projects was their community driven focus. The programme implementation strategies took into account the role culture plays in influencing attitudes, beliefs, and behaviour related to health promotion and disease prevention. The projects received funding for three years to develop community capacity plan, implement and evaluate culturally relevant and community specific activity programmes. These interventions have been tabulated in table 2.8 they demonstrate how the communities were keen to find meaning for change within their own culture, and their own environment. A dynamic relationship exists and change was empowering and was sustained (Manley, 1999).

Table 2.8: ON THE MOVE! Interventions.

Author / Target population	**Method /Intervention**	**Results**	**Outcomes**
Grassi *et al 1999* Latino Families A	**Walking Clubs.** Local Advisory Committee in each community identified. A free, club consists of 4 meetings in a	359 participants 90% female, age range 35-57. Perceived Barriers to physical activity decreased over time: No nearby	The best recruitment strategy was through word of month. Accommodation & timing was central ,based on agricultural season & trips

community based activity programme, La Vida Caminando	3-month period held at; community & senior centres & schools Self-paced activity, Resources in Spanish & English, Included shared meals or snacks. Childcare provided. Self report questionnaire at 6 months & 1 year.	locations, Unsafe neighbourhood. Lack of transportation Un-affordability Not knowing where to go Not knowing how to start Family responsibilities Work schedule Health problems.	out of state. Participation increased with low cost, flexibility, & informal structure & cultural appeal i.e. eating together & sharing stories of successes & challenges. Primary health concerns were addressed; prevention or control of diabetes.
Whitehorse et al 1999 Hispanic sedentary women. Tailored physical activity program, recruitment successes. La vida buena	**Salsa Aerobics** Bilingual certified aerobics instructors were hired to develop & lead the classes. Childcare &. printed nutritional messages in Spanish provided. 20 lay health advisors were trained. Media coverage in Spanish & English 50 demonstrations at community events. Questionnaires in English or Spanish. Promoters requested to become certified instructors & to give back 3 months of free classes back into the community. 5 completed training, 2 of which passed.	Total of 771 participants. 487 analysed, 97% women, male partners were reluctant to let the women join. Peer leaders & incentives were central. Coalition provided leadership & assistance in designing & implementing a comprehensive health needs assessment Presenting Salsa aerobics classes as Latin dance classes was more effective than prescribing as exercise aerobics. 2 classes still continued after funding ceased premises have a wavered charge & is taught by one of the trained instructor.	A collaborative process. Each community is different, incorporating community representatives during formative phase & critical decisions ensured culturally sensitive programmes. i.e. programme leaders & recruiters are bilingual. The idea itself; Salsa aerobics was generated by the target population. The classes incorporated dance steps from music popular to that community. Family members were included in social events. Most referrals were from friends due to the activity being culturally appealing.
Lew *et al* 1999 Asian American/ Pacific islanders Community education strategy	**Annual Walkathon** required participants to walk with others at a set time & raise money for the community. Coalition set up & co-sponsored event. Bilingual Officer recruited. Presentations made on benefits of exercise & promotion of walkathon. Flyers, posters & registration materials were all translated in 3 languages. 700 surveys conducted to find out exercise patterns. An incentive such as a bicycle was donated as the grand prize for the walkathon. Entertainment was diversified to provide walkers with sources of cultural identity and create a multicultural climate.	300 participated in walkathon representing 6 communities 15 agencies raised $5000. 2nd walkathon 400 participated 66.5% were female and 33.5% male. 285 surveyed out of the 400, 80.4% participating for the first time, & 95% felt that the walkathon encouraged them to exercise. Community outreach, sponsorship and assurance of ethnic diversity, translated flyers, & word of mouth were identified as the most important items to make the Asian Walk for Health a successful event. Raffles were also popular and increased participation in the event	Difficult to attract the media to cover the physical activity as it was not a priority to the community and was seen as a one-time event. Community coalition, central in process. Understanding of ethnic specific differences was also important in reaching populations, i.e. a tailored & targeted approach. Each community is different in terms of the type of exercise they prefer as well as the incentives that would motivate them to exercise. Food, which was always offered at community meetings, was a cultural sign of hospitality, appreciation and respect. Walkathon event was successful for 3 years.
Williams II *et al* 1999 African	**Walking & walking clubs** identified as no-cost activities. Task force established with a	Each walking group consisted on average of 4 to 8 members who walked between 3 to 5 days a	Successful in crime prevention walking clubs & individuals found a personal value beyond health. The

Americans Coalition for promoting Physical activity California Community Action and Mobilisation Project (C-CAMP)	community infrastructure. 17 block-walking captains recruited. Training provided with certified first aid. Groups launched in the target area & initiated other activities. Groups defined their own route maps. Churches became 'ambassadors of health'. Some walking groups were developed as a component of other planned activities, i.e. 'walking artists' older teens teaching art via walking to younger teens, or the women's walk & pray group, grandparents support group, senior men walk before dominoes.	week. Coalition gave members a basis from which to conduct future community programme negotiations with health officials. Created walking crime patrols. Promotional Presentations made. A walkathon was planned for health and hunger this raised money for the homeless, and expanded to highlight the need to reduce sedentary life styles It provided incentives in the form of T-shirts, caps, water bottles and tote bags. As a consequence of group indoor shopping malls opened for walking club members in poor weather.	project increased the communities' awareness of the need for physical activity and, reduced many barriers to walking regularly, and created a heightened sense of community esteem. The novelty of this programme was in its application and its close collaboration with a strong community coalition. A large factor in the success was the unique characteristics of Southeast Stockton; it had a rich history of community involvement. and the existence of strong community organisations.
Pargee *et al* 1999 American Indians Building on tradition Cultural health & mobilisation project (CHAMP)	7 community coalitions formed promoted fitness events, establishing community fitness sites & walking groups, training of community fitness leaders, publishing a peer led health education curriculum & culturally appropriate exercise guides, institutionalisation of wellness- based policies within tribal organisations and medical provider education on exercise & wellness. Recruitment occurred through personal invitations. Survey conducted face to face. Coalition members spoke about their coalition activities on local TV & radio programmes Representatives from each of the 7 coalitions combined to form a core coalition acted as an advisory group for policy & guidance.	7 communities held a different event: Rural, surf fish; 63 participants, Rural stick game; 200,Rural fitness walk; 29 Urban intergenerational walk; 75, Urban family fun day; 120, Rural community garden; 40, Urban Beach walk (2 miles); 114. A storyteller at one of the events reflected in a song how the community heals itself and maintains a healthy balance, also shared how her ancestors took care of themselves physically, mentally and spiritually. Community members donated 3 garden sites to the project. The coalition members sponsored a community fitness site where families can attend aerobic classes, walking and gathering groups & volleyball nights.	Not all of the coalitions were successful; most community support was received in areas where previously there were successful community efforts. Including all generations in activities, ensuring mastery of skills by active participation and drawing on the wisdom of elders to teach younger generations helped make the coalition successful. It was important that staff members be known and trusted by the communities in which they worked. Physical fitness is seldom a priority in communities in which they worked, staff had to learn to be flexible about health issues by listening to community concerns. One of the key strategies was to identify key people in each location who had been involved in other community programmes. Prevention strategy framework adopted based on values inherent in traditional native cultures, a holistic approach
Yancey *et al* 1999 African American Females Facilitating	**Fitness Funatics** Hosted on-site exercise instruction targeting community- based organisations rather than individuals. Baseline surveys	Pre-existing group cohesiveness & social support was significantly associated with institutionalisation of physical activity .The number of sites that	Community used sites tended to be more successful at establishing and maintaining activity than membership sites. Central to success was cultivating a programme champion, provision of social

initiation and institutionalisation of physical activity	completed. Identification of one or more 'natural' exercise group leaders at each site. Aggressive marketing & promotion via media & presentations. Paid fitness instructors were recruited from the African American community & emphasis was placed on low impact aerobics, flexibility and light resistance training activities. Support materials included positive images of African American culture.	initiated physical activity programmes included 33% senior centres, 15% churches, 33% clinics, 7% non-profits, 47% housing projects, 34% recreational centres, 19% schools, 15 % social services and 60% treatment centres. In total 181 sites showed interested and 119 sites accommodated activities. Those who missed sessions were called. Walking paths were utilised for the aerobic component of physical activity programme.	support, low cost & cultural specifics. In addition to the initial cultural tailoring, of the project strategies (music selection, ethnically relevant project leadership, support materials and selection, targeted media), it involved building a cultural competence of the participating organisations. Success based on committed staff & the time of the introduction of the programme within organisational cycle.
Steeples *et al* 1999 Influencing policy to promote physical activity	**Active Living Project** Looked for opportunities to change or create policies that would encourage physical activity & better health for low income & multiethnic residents of Pittsburgh. Physical activity promotion at ethnic health fairs & routine screening & counselling Presentations at churches & community events & the use of local media opportunities to promote community education Inventory resources were mapped.	Barriers included; transportation, & cost. Staff developed a video lending library with more than 20 culturally appropriate exercise videos. Installation of walking path signs provided a visual display with the paths total distance & basic information about exercise. The project funded sponsored walks, they were held at parks where walking path signs were installed. The walks were free and snacks, water and prizes solicited from local business encouraged maximum participation.	The project learned to do their research in advance (good intentions do not necessarily make good policy). There also can be value in including the body that must implement a policy in the planning process, however this can also backfire and thus should be assessed in advance of such inclusion.

Foo et al 1999 Southeast Asians Identifying policy opportuni -ties to increase physical activity	**Families in good Health programme** Outreach project-using bilingual, health advocates to create bridges for access to health care. Production of a music tape of traditional & original Cambodian songs with healthy messages to which people could exercise. Help with buying bathing suits & learning to take the bus to participate in water aerobic classes. Community garden project, walking clubs & chair aerobics classes set up. A programme manager recruited, 2 bilingual community health advocates initiated programme activities Community advisory boards set up provided feedback & mobilise resources to guide the direction of the programme. Helping the community to negotiate a lower membership cost & to hire Southeast Asian employees, to promote their facilities to Southeast Asian media and bringing community members to tour the facilities and meet their staff.	Increased policy opportunities, development and implementation occurred, Programme Champions were cultivated, Strong partnership were formed, Barriers included high cost of enrolment for large families an average of 6, difficulty of communicating with YMCA staff, lack of awareness that the facility existed, & perceived lack of interest of the YMCA in recruiting Southeast Asian staff. The YMCA addressed the lack of bilingual staff and recruited 11members as a result 66 Southeast youth joined the summer sports league & after school programme. Community gardens agreed to donated a vacant commercial lot to the programme & paid liability insurance. Partnerships overcame the barrier of cost. The water bill was the largest cost & the project fought for a city policy to provide reduced water cost for the community gardens.	The programme found policy development to be challenging because of the constraint of low funding and short grant period. With the lack of longer term funding only two health advocates were hired, one part time programme manager and one part time community liaison to attempt community wide policy development and implantation Benefits of the programme included increased youth programmes, employment opportunities, increased health advocates, improved safety in environment, increased relationships with mainstream organisations and increased leadership of the Southeast Asian community in health promotion programming.

Unique approaches were used in the 'ON THE MOVE' programme to tailor physical activities to each population requiring flexibility in the consideration of ethnic, cultural, geographic and socio-economic differences (Tanjasiri, 1999). Primary prevention of cardiovascular disease was traditionally employed. Community- based interventions aimed to change not only individual behaviours but also policies and environments of entire populations. Differentiating responsibilities in state and local partnerships in developing physical activity interventions, that were appropriate, and relevant to diverse communities in California presented enormous challenges for staff at the state and community levels (Tanjasiri, 1999). Partners assumed primary responsibility for guiding different phases of programme planning based on their experience in cultural tailoring. The selection of intervention approaches involves lay leader training, individual

communication strategies, mass media involvement and changes in broader community. The ways in which these approaches are specifically designed and implemented depended on the unique characteristic of the target population Pasick *et al.,* (1996). Frameworks for physical activity interventions have been described in the literature by Green & Kreuter (1991), McLeroy *et al.,* (1988) and Passick *et al.,* (1996) however these generic steps would need tailoring at specific stages for specific communities. Whilst goals and objectives of a health promotion programme are similar across cultures, the intervention designs and strategies will considerably differ based on cultural appropriateness. For example, project staff considered cultural issues by soliciting the involvement of elders from different tribes in order to understand the most culturally relevant and respectful way to incorporate physical activity into the communities. This resulted in the identification of traditional activities (Pargee *et al.,* 1999).

The funding required that the local projects utilised the spectrum of prevention (Swift, 1987), which represents an ecological approach that targets multiple levels for health promotion. The approach was selected because of its appropriateness to community level work, the recognition of community power structures and processes and the fostering of capacity building for long term community change for physical activity (Tanjasiri, 1999). According to McLeroy (1988) health behaviour is affected by multiple levels of influence from micro (face to face) to macro (cultural beliefs and values that influence different systems). Thus an ecological model for health promotion contains strategies targeting intrapersonal, interpersonal, institutional, community, and public policy factors (Tanjasiri, 1999).

All contractors were required to use coalition building as a component of their intervention. Coalition development calls for participation of a broad cross section of people in a community working on a common goal. It relies on consensus building among diverse community and interest groups with a co-ordinator functioning as a facilitator of group discussions and progress. Community coalitions represent a key component of such an approach because they bring together different sectors and can also ensure that cultural theme and socio-economic barriers are considered in programme planning (Thopmson & Kinne 1990).

In addition to brochures some contractors developed colourful posters with traditional images to promote physical activity or created music tapes with messages about physical activity and other cardiovascular health topics interspersed between traditional songs.

Two of the projects developed unique physical activity programmes based on cultural beliefs and practices of the communities they served. Farming was a tradition in many communities thus community gardens were initiated which promoted physical activity while preserving cultural concepts of self-esteem and self-reliance (Foo *et al.*, 1999).

The United Indian Health service went beyond exercise goals to embrace cultural beliefs of respect for elders and importances of oral histories for cultural continuation for example stick games. Some programmes incorporated culture into specific physical activities in their communities, that adapted standard physical fitness strategies e.g., dance classes, aerobics which included theme activities i.e. Afro-Haitian dance classes or Black dance performances.

In one of the projects three different languages were spoken. Thus budget consideration limited their employment to halftime which proved challenging to the programme planning and implementation in all three communities. Beyond project staff ethnic matching between community service providers and populations arose as an important concern. For example one of the programmes requested their desire for more bilingual staff at the YMCA and to provide language access and positive role models from their communities (Foo *et al* 1999).

A community health centre improved access to individuals by offering classes at near by non-fitness related localities such as schools, churches and housing complexes. One of the projects included a different aspect of economics into their walking clubs, beyond offering all of their clubs at no cost, they also partnered with a local community coalition that wanted to reduce crime in the neighbourhood. Thus, the walking club offered an increase in physical activity for participants while monitoring neighbourhood crime in this low socio-economic area (Williams II *et al.*, 1999).

Many of the projects were successful in obtaining considerable in-kind support and contributions to supplement funding for the promotion of physical activity. Examples included volunteer labour, facility space, physical activity equipment and incentive items such as bottled water and fruit. All projects tackled the challenge of making physical activity a priority goal in their communities by selecting strategies they felt would attract their populations. ON THE MOVE! made the greatest contribution by modelling a shared partnership between the state and local communities for physical activity. Such a mutually beneficial approach holds the key to long-term community capacity building. The shared partnership relied on the wisdom of communities to create their own uniquely tailored strategies (Tanjasiri, 1999).

2.4.2 Active for Life Interventions for people from Ethnic Minority Communities in England.

The Health Education Authority (HEA) identified a number of unpublished interventions, the Active for Life campaign, these have been tabulated in table 2.9. These are examples of innovative projects around England, which have secured funding from other sources.

Table 2.9. Interventions in England

Author, project, target population	Method, Intervention	Outcomes
H. Hussian. (1998) Bradford District Health Promotion Services Gardening for Health Bradford. Bangladeshi women	Consultation with Bangladeshi women identified community gardening as a form of physical activity. Piloted on an allotment & basic training was given. The women were interested in growing food as they had the skills and knowledge from cultivating plots in Bangladesh and it was something they had always enjoyed. Bradford community environment project, Heart Smart and volunteers from the Bangladeshi community staffed it.	Funded by Shell Better Britain campaign, the local Project Fund and Heart Smart. Benefit in kind was received from BEAT (Bradford Environmental Action Team) and Bangladeshi Porishad community Centre. Success in the first year of running via facing low motivation, lack of self confidence in ability, poor health status, unrecognised stress and mental ill health resulting in depression and very low self esteem, with hindsight assertiveness training should have been tackled first.
M.Dehaney 1998.Seated Movement to Music Exercise training for community Group Volunteers. Barnet Health Promotion Centre.	Free taster sessions were given to potential volunteer trainers. The course involved a series of 6 two-hour sessions. The 1st session familiarised with what would be covered & what would be required. Session 2 to 5 included; information on the benefits of physical activity, specific medical conditions to be aware of & the types of exercise that would be suitable, techniques of exercising safely, types of music to use and how to fit exercises to the music. Session 6 was arranged individually with each participant, the course instructor visited the participant while their sessions took place to check on their progress and to give advice where needed.	Since the start of the project in 1995, 5 training course have been held. During this time 83 volunteers representing 42 community organisations have participated in the training and all continue to hold sessions with their groups. In January 1999, Movement to Music training will form part of Barnet's Ageing Well Scheme and will offer local volunteers an opportunity to train as peer mentors / advisors on a variety of health topics including exercise, nutrition and mental health issues.
Shahabuddin Ahmed. October 1998 Promotion of Physical activity Amongst Bangladeshi Man in Camden and Islington. Camden & Islington Health Promotion Service.	Two groups of Bangladeshi men, the first group consisted of ten and the second eight, age group being over 35 and 18 to 35 respectively.	Older men were shy & embarrassed they did not realise the importance of starting physical activity at any age. Barriers included cultural & language, lack of affordable facilities nearby, a lack of peer pressure and role models. The word exercise was new to them. If they were to promote physical activity to their own community, they would put forward an image of; 'its important to lead a longer & happier life and to achieve this you need to be healthier by being fitter'. Younger group of men were very interested in physical activity & appeared already to be participating.

Kawser Zannath November 1998. Home based and Centre based physical activity. A combined strategy in the community. Kings Cross – Brunswick Neighbourhood Association.	Two female Bengali workers from the centre were trained by the health promotion service as peer educators to promote Bengali exercise video. Videos were distributed to women who normally do not come to the centre but might be interested to try out the exercise video at home.	A regular attendance of 8 /10 women, the exercise session has helped women to understand the relationship between physical activity and healthy lifestyle. The increased awareness regarding the importance of physical activity among the women was evident in the increased attendance at the exercise sessions The exercise sessions combined with the exercise video has helped the women to build up their confidence to use the facilities in the gym, where on average 10 / 12 women attend the sessions.
Work with ethnic minority communities. Liverpool Leisure Services	An exercise open day was organised at Piction Sports Centre. Activities were provided free of charge and included basketball; keep fit, fitness studio, swimming, squash etc. The day also featured a number of health information stands. The steering group for the event tried to overcome any potential barriers, such as single sex sessions. Sports centres arranged for female lifeguards to be on pool duty during women only swimming sessions. The centre has a swimming pool viewing area with glass panels. During the open day all of these panels were covered to respect the need of the community A further 8 open days were organised for the Asian community.	Training courses for ethnic minority communities were set up gaining national qualification in fitness. This qualification would allow them to apply for jobs as lifeguard's or instructors; this could assist in overcoming the barrier of a shortage of staff at centres from the ethnic minority communities. The work, which has taken place, and work planned for the future comes about as a result of the consultation between Liverpool Leisure Services, Health Promotion and the communities. 300 people attended the open day.
The Pagoda of Hundred Harmony Chinese Community Centre, Liverpool	Partnership formed between The Pagoda, Liverpool Leisure Services Directorate – Liverpool City Council, North Mersey Community (NHS) Trust, Liverpool Health Promotion Service to develop and promote the importance of physical activity to the Chinese Community through a number of events. A planning team was formed to examine the overall needs of the Chinese Community. An Active for Life Chinese Exercise and Health Fair was held at Pagoda. Promoted through bilingual information, posters and leaflets. The programme included Tai Chi, Gym Tots, 50+ keep fit, mixed circuit training, aerobic, and step aerobic plus life style fitness equipment, reflexology and aromatherapy. There was an opportunity for blood pressure monitoring and information from stands on diabetes, dental, diet and asthma. Healthy refreshments were provided.	There were over 100 participants on the day with 64 being 50+. 94 People filled in the evaluation forms with 84 stating they would like to attend a similar event. Barriers included lack of time, no Chinese instructors & accessing information. Many of the subsequent events came out of the recommendations from the day. The planning team continues to meet to develop and encourage the Chinese community to take up the more proactive role in the areas of sport and exercise by becoming instructors and trainers. The project had 2 Chinese candidates who were registered on the training scheme. The success of the project is due to the partnership.
Jeevan Asian Women's Exercise Video: Bedford Borough Council	The Jeevan (life) Asian women's exercise video was launched by Bedford Borough Council and Bedfordshire Health Promotion Agency. In liaison with an Asian community the word ' Jeevan' meaning ' life' was an acceptable title. Selection of participants for the video was made via positive role models in the community.	Prior to the production of the video an Asian Sports development officer in Bedford achieved a Winston Churchill travelling fellowship. She spent 2 months travelling and researching around north India focusing on sport in education from schools to university, women in the international sporting arena, in home and in the community.

	Qualified RSA Asian instructor was found after a lengthily national advertising campaign. Due to the lack of qualified Asian instructors an RSA teacher-training course specifically targeting women from the ethnic minority communities whose first language was not English was designed. The course enable woman to teach exercise to music within their own communities whilst at the same time creating an awareness of the benefits of exercise. A support network group was set up to help newly qualified teachers to put their newly found skills into practice.	The research in India and in Bedfordshire amongst the Asian community found that most women were eager to participate in exercise but were under pressure from their families to perform their duties within the home. Many women agreed that by promoting exercise and health issues through the home video they would be able to keep fit and concentrate on a healthy lifestyle in the comfort of their homes therefore reducing the pressure and ridicules from some community members who think that ' a women's place is in the home'
Asian Women's Sport Development Officer: Sandwell Borough Council	Asian women's sports officer funded by Sports Council and Sandwell Borough Council for 3 years. It has since then become a full time post. Consultation with women – to build up confidence of the women and gain their trust many Asian women feel that their leisure needs are not a priority. Activities on offer include keep fit, self-defence, Gidda lessons, Bhangra lessons. Coaching course for Asian women to become qualified, health and fitness awareness days, and leisure walks. Venues were difficult to get, appropriate times for activities were a problem trying to get staff at the centre to be culturally aware and sensitive to the needs of the women.	Consulting with community leaders, invariably males felt that women are wasting time doing leisure activities e.g. a religious leader would not let a small hall in the mosque to promote activities on offer. Transport, women only came to evening sessions if transport was available but it was difficult to find women drivers and meeting the cost of hiring a minibus. Gidda group has been very successful and has done many shows, charity events and has appeared at the National Exhibition Centre. The schools after clubs always have a good attendance and the girls are keen to participate. They also have participated in Bhangra shows. Asian girls football is popular, training sessions are set up to encourage girls to keep their interest alive. Two of the girls were encouraged to join a girl's mainstream football team and the rest joined a five a side Asian girls team.
Sheffield Swim-bus Scheme: Sheffield City Council	A weekly bus service provided equal access and opportunity for women of all ages, cultures and ability levels. A free pick up service to the nearest local swimming pool provides an accessible, door-to-door opportunity for the less able and socially/ economically deprived women. The scheme forms apart of a community based exercise referral scheme implemented by the council in conjunction with the local health authority Free Transport (funding permitting), Mother and Toddler swim available (under 5's go free), low cost swims (£1.35), Culturally sensitive facility; female life guards, warm pool, no dress restrictions, female bus driver, privacy in facility.	The result of a 16-month national pilot project 'Bumgreave in Action' successfully encouraged 1200 people to become more active over a 12-month period. The Swim-bus has proven to be very popular and allows women of all ages and cultures to integrate and create a social network. A mixed disability swim-bus service is also in operation for any member of the community who suffers with any health problem. This session plays a major part in GP referral scheme and specifically targets the 'infirm' and less mobile residents of the community.

Physical activity interventions can be classified into six main categories these include; education and training, personal health services, mass media information, community action, environmental support, economic and regulatory measures (Turball, 1998). The

most important of these is education and training approaches, which include improving knowledge, giving health advice and support and teaching new skills. For example an intervention designed for inner city, low income, overweight African American adolescent women, recruited from public housing developments. The intervention consisted of delivering sessions with three components; an educational / behavioural activity, 30 to 60 minutes of physical activity, and preparation and tasting of low fat meals (Resnicow, 2000).

2.5 The Promotion Walking for Health

Walking is the most natural form of physical activity; it's the nearest activity to perfect exercise (Morris & Hardman 1997). Walking continuously for at least a mile is an activity that is pursued by just over half of the men and women in every age group in England. This suggests that there is scope for increasing activity levels by encouraging those who do walk to do so more frequently and for longer distances at a faster pace (ADNFS 1992). It helps in the prevention of heart attacks, diabetes mellitus, and cancer of the colon (Hardman 1998, H.D.A 2001, Mayer-Davis 1998, Nathanson 2001). Walking is the best buy for public health; it's the only form of exercise that is accessible and realistic for 70% of the population who do not take enough exercise to protect their health (BHF & CA 2001). Walking is a year round activity, is readily repeatable, is self-reinforcing, self-regulated in intensity, and it can be incorporated into daily routines (Morris & Hardman 1997).

Health gains would be achieved without adverse effects, if there is a gradual progression from slow, to 30 minute or brisk (6.4 km/h) walking on most days of the week (Morris & Hardman 1997). It is a low impact activity with minimal strain on the feet and joints, which reduces the risk of injury. Uneven terrain increases the energy cost of walking; walking uphill on 5% slope increase energy expenditure by 50% and walking downhill is the same as walking on level ground. The rate of expenditure increases directly with pace but even walking at a normal pace (about 3mph) raises energy expenditure three times above resting level (Hardman 1998). The effect of walking about mile a day is not confounded by any other exercises.

2.5.1 Walking for Fitness: Training

Walking is a vigorous exercise for many people and regular brisk walking has been found to improve fitness in controlled trails in both men and women (Buchanan *et al.*, 2000, Hardman 1998). Fitness increases with training that is if the large skeletal muscles are rhythmically exercised with walking and the heart undergoes 'volume overload'. Training by brisk or fast walking results in improved cardiac performance and a reduction in heart rate (Hardman 1998). A study of older women and men during brisk walking showed that treadmill and outdoor walking at a 'fast, but not over-exerting' pace elicits an exercise intensity which, if undertaken regularly should result in improvements in cardio respiratory fitness, together with associated health benefits (Buchanan *et al.*, 2000). Changes in 'metabolic fitness' may be detected following a relatively short intervention period (Lad *et al.*, 2000). Walking at least for 1.6 km for a sustainable period can increase endurance or stamina. Walking faster or uphill can achieve strength of legs and flexibility of joints. Striding out may also improve posture and prevent or alleviate back pain (Morris & Hardman 1997).

2.5.2 Benefits of Walking

Walking is the most sensible form of exercise for the elderly with little risk of trouble. In the Thames Valley Health Walk scheme a greater number of older people participated, and preferred walking as an exercise, it was an essential element in promoting the quality of life and reducing social isolation (Health Walks Research Team 2001). For an older person to cross at pedestrian crossing they need to be able to walk ~4km/h, walking can increase speed and thus personal safety and independence. Additional benefits include heat generation, which helps in systematic and cardiac functions and eases the pain of Osteoarthritis. Leg muscle strength is important for independence in the elderly and to minimise immobility. Weakness makes it difficult to support bodyweight and to stand up from a low chair or toilet seat, to climb stairs or to mount a bus; it can be improved with short spells of walking (Morris & Hardman 1997). After prescriptive walking participants have shown a great improvement in stair climbing, lifting and carrying compared with those who only receive health education (Morris & Hardman 1997).

Mechanical loading in weight bearing exercise is an important functional determinant of bone architecture, stimulating new bone formation. Walking is the most common weight bearing activity, when carrying a load. An average of 20 min/day of brisk walking at

5.8km/h has a positive effect on bone density. Protection against hip fracture has been reported in association with walking (Morris & Hardman 1997).

2.5.3 Walking and Cardiovascular Disease

Vigorous aerobic exercise as in fast walking gives substantial protection against CHD other exercise gives little or none (Morris *et al.*, 1994). It was found that elderly participants who walked more than 4 hours a week had a lower risk of hospitalisation or mortality from CHD compared with those who walked less than an hour a week (Morris *et al.*, 1994).

With training there is a progressive reduction of heart rate, blood pressure and cardiac output and delays in the onset of angina pectoris. Thus walking has been successfully employed in training patients with congestive heart failure. With the programme the patients felt less disabled and the quality of life rose with improved exercise tolerance and reduction in fatigue (Morris & Hardman 1997).

Overall benefits of walking include; lower risk of injury compared with other activities, it is used during recovery form ailments such as heart attack, improves circulation and efficiency of capillaries that supply blood for cellular respiration. It generates a feeling of well being, relieves depression, anxiety and stress by naturally producing endorphins, the body's natural tranquilliser, it relaxes and stimulates thinking, improves quality and ease of sleep. Walking increases energy, improves muscular endurance, improves flexibility, increases bone density, improves self-esteem, and improves appearance. Its fun, has a sense of accomplishment, its a time for creative thinking, and provides quality time alone or with family or friends (Hillman 2001).

2.5.4 Decline in the Levels of Walking

83% of women and 78% of men in England do not walk at all (ADNFS 1992). Amongst men there was a significant decline in walking pace with an increase in age. The proportion of young women who walked at a fast or brisk pace was much lower than the young men. One third of men and over two thirds of women would find maintaining a walking speed of about 3mph up a moderate gradient an unaccustomed exertion and unable to sustain the effort. Even sustaining a 'normal' paced walking on level ground would be impossible for more than half of women aged 55 to74 years and a third of men in the same age group. People are generally not aware of the need to exercise above their current level in order to achieve improved health benefits and functional performance,

they have often adjusted behaviour to reduce demands rather than to have increase them (ADNFS 1992).

Major factors in the decline of walking are fear, actual or real, of suffering either a road accident or from street crime (Geffen 2001, Hillman 2001). They are deterred by heavily polluted air that is, the dirt and smell of traffic (Morris & Hardman 1998). The growing car and lorry emissions maybe a factor in the trigger and severity of asthma both in children and in adults. Other deterrents are; un-cleared snow, ice or wet leaves, cracked or uneven pavement and pavements being dug up for repairs. People have tripped or fallen over damaged pavements, there are 6.3 to 8.3 million such accidents per year, 450,000 needing medical attention (Morris & Hardman 1997). Physical barriers especially for disadvantaged groups such as sight or mobility disabilities include pathways that are narrow and poorly maintained and are obstructed by street furniture or parked cars (Geffen 2001). Other factors, which were obstacles to walking, identified by the Walking the Way to Health Initiative (BHF & CA 2001, Palmer 2001) included; urban environments, which often fail to encourage walking through its design or management. Routes for walking are often severed by busy road crossings, which create inconvenience and discontinuity (Hillman 2001). Parks play areas and other green open spaces, which are poorly maintained, are disagreeable and un-attractive for walking. Many people who will not consider walking unless there are opportunities to rest (Hillman 2001) there is a lack of seating or benches. In addition, the attitude of many highway engineers and transport planners, who do not recognise the value of walking, and planners who develop out of town shopping centres, discourage local walking (Geffen 2001).

2.5.5 Walking Targets for Personal Health

A basic target can be stated as 'middle-aged persons should be fit enough to walk 1.6km at 4.8km/h on the level without fatigue, sore muscles, sweating or uncomfortable fast breathing' (Morris & Hardman 1998). A consensus is growing that for adults to achieve and maintain a level of fitness of 30 minutes of brisk walking (or the equivalent of) on 4 or 5 days a week should be the personal and national goal (H.D.A 2001, Morris & Hardman 1997). The programme could consist of 10-minute bouts. Each session should begin with a short, slower warm up and a simple safety rule throughout is to be able to converse while walking. In a symposium by Oxford Brookes University, targets such as; getting slightly out of breath and sweaty, and walking at a speed at where you can just

maintain a conversation and to be able to walk a mile under 15 minutes were suggested (Health Walks Research & Development Unit 2000).

2.5.6 Brisk walking in Short 10 minute Bouts

In the classic studies of Harvard Alumni, there was an inverse relationship between the number of miles walked per week and the risk of dying over a follow up period. In the study men who walked more than 9 miles per week had a 21% lower risk of death than their peers who walked less than 3 miles per week. These men engaged in urban walking which was likely to be in short bouts, rather than prolonged hiking (Hardman 2001). Two other studies assigned obese women to short and long bout brisk walking, the short bout walkers expended more energy than the long bout walkers due to better adherence (Hardman 2001). Another study with middle-aged women, who were overweight, did either one 30-minute session of brisk walking or three 10-minute sessions for five days per week over 10 weeks. The short bout walkers experienced a greater weight loss and decrease in waist circumference relative to the controls (Murphy & Hardman 1998). A more recent study, where 10 sedentary people were studied on three separate days during which subjects walked briskly for 30 minutes before breakfast, 10 minutes before each meal and a control day with minimal activity. Triglycerides were 12% lower with both patterns, showing that repeated 10 minute exercise bouts reduces day long plasma tryglyceride concentrations (Murphy *et al.*, 2000). Furthermore it appears that a longer bout of low intensity exercise is as effective as a shorter bout of high intensity exercise. It is the amount of energy expended that is important. Thus the accumulation of rather short sessions through the day may be one way of meeting the 30 minutes of moderate exercise.

2.5.6 Encouraging Walking

The government has stated that it is committed to making walking easier, more pleasant and safer as it is good for people in terms of health and psychologically is good for communities, where streets are made safer acting as natural surveillance in public places. Walking accounts for 25% of all journeys, and 80% of journeys less than a mile, it is an essential part of most public transport journeys (DETR 2000).

The potential of walking to reduce the use of and the dependence of a car is huge. The ripple effects would include reducing: congestion, natural resource consumption,

greenhouse gas emissions, poor air quality and noise (Geffen 2001). Present travel practices, with their high levels of dependence on the car, contribute to accidents, congestion and pollution that cost individual, organisations and the economy dearly (Black 1990, DETR 2000). Walking is a relaxed and undemanding mode requiring little planning or preparation before travelling (DETR 2000).

Walking is also conducive to neighbourliness and social interaction thereby helping to turn places into communities making it socially inclusive and gives children independent mobility (Bowis 1996, Geffen 2001). People walk for many reasons, going to work, for business, leisure, health, domestic purposes, social interaction, keeping fit and even passing time.

Urban travel can be broader; planners can encourage walking both outdoors and within buildings (Black 1990, Hillman 2001,Palmer 2001). Walking to work is a major avenue, for example residents of small cities and villages are more likely to walk. A good climate encourages walking and people are likely to walk in the summer than winter. College, university and military based towns have shown to have higher rates of walking due to institutional housing situated in the vicinity (Black 1990). Thus the planner's conventional wisdom that a higher density and compact development promotes more walking is corrected but designing with pedestrians in mind is essential- that is vehicle free zones (Black 1990, Palmer 2001).

Benefits for walking would arise from encouraging and enabling local authorities to make wider use of lower speed limits, such as 20mph in town centres and residential areas (Geffen 2001, Palmer 2001). It was suggested that the national strategy for walking should be adopted as the ' national strategy for the promotion of walking', which would include a national target and or guidance on local targets for walking, (Geffen 2001). There is a lack of a national target to increase the amount that people walk without which there is no way of measuring success (BHF & CA 2001, Nathanson 2001).

Recommendations to the Government by the British Heart Foundation and Countryside Agency to encourage walking includes; taking a much more positive attitude to the provision and promotion of walking in recognition of the many social, environmental and economic benefits that can come from more people walking. Creating a more coherent and connected approach to walking which embraces health, crime, urban regeneration, environment, leisure and transport. Setting up a national focus for walking, which stimulates co-ordinated action nationally and reports on implementation (BHF & CA 2001).

On an individual level, the main factors which encouraged people to take exercise was to feel in good shape physically, to improve or maintain health to feel a sense of achievement, and to get out of doors (ADNFS 1992). For most sedentary groups, self-efficacy, family and friends support and consumption of a heart healthy diet were associated with walking for exercise (Hovell *et al.*, 1989).

2.5.7 Health and Transport

More people walking in towns can contribute to a cleaner, safer environment and a less polluted one if many of the short journey's people currently take in cars could switch to walking (BHF &CA 2001). The government plans to establish a strategic national initiative to promote walking and changes to the walking environment within an integrated transport environment by bringing together environment, transport, and health. In particular it will seek to exploit the potential synergy between health and transport policies where strong links and benefits are already apparent (National Strategy 1998). As a means of travel, walking is relevant to everyone, of all abilities, in all situations and geographical locations (DETR 2000). Walking as a means to travel can be an alternative, particularly for short journeys and can be integrated into other modes. It is the 'glue', which holds all other transport modes together. Walking is a zero-emission means of travel and thus reduces pollution and the effect of global warming (New Deal for Walking 1998, Nathanson 2001).

The cost provision to promote walking is a small fraction of public transport for example 1 kilometre of light rail system is the same as the cost of 50 safe routes to school projects or 20mph zones, so walking is cost effective (Hillman 2001). Only a few local authorities have a strategy for walking, they are waiting for the publication of the National walking strategy. This reflects the importance of walking and the lack of skill to develop such strategies.

2.5.8 Changing the Walking Environment

Increasing walking and improving the walking environment, especially in residential areas, is important in fostering the health sense of community and concern for other people. The pavement is a social meeting place, taking a stroll around a local town park, alongside a waterway or through a town centre is leisure walking. Recreational walking benefits individuals and helps build a culture in which people walk from choice (Ball, 1998). To develop the 'state of the art' for walking would mean addressing the physical and social environment, making the walking route more interesting and attractive. The

London planning advisory committee identified the 'five C's', the dimensions to the quality of the walking conditions (New Deal for Walking 1998); Comfortable; Convenient, Connected; Convivial diversity; and Conspicuous.

2.5.9 Effective Promotion of Walking for Health.

Walking schemes have considerable potential as they are structured, supervised, of low cost to participants, high adherence and has emphasis on low to moderate levels of activity (Health Walks Research Team 2001). A carrot and stick approach is needed to support walking. Carrots could include facilities for walking, i.e. the environment, and sticks could include parking controls, traffic calming, and pedestrianisation (Nathanson 2001).

Walking for Health would benefit with help from the GPs and Primary Care Teams by identifying individuals and groups. National accreditation of schemes may facilitate this (Health walks research and development unit 2000). There is some concern that the name 'Health Walks' may not be appropriate for certain groups. It may be the case that promoting the 'leisure' angle may result in greater uptake. Furthermore, the name does not encompass 'functional' walking such as walking to work/school or to the shops. Although this type of walking may benefit health, both by increasing activity and reducing vehicle emissions, it may not be perceived as 'health walking'. Using the term 'Health Walks' might undermine the motives of those who choose to walk purely for environmental/recreational reasons. If walking is to be restored to its rightful place, as a mode of transport there is a need for partnerships in all these areas. Effective promotion of walking includes; safer routes to school and the green commuter schemes, which target particular audiences. Route maps and information, publicity is important for promotion. Again success depends on the working partnership of central government, local authorities, national walking forum, education organisations, employers, voluntary groups and health services. It is important that they co-ordinate activities in their respective locality, and then come together as a whole.

2.5.10 The Philosophy of a Health Walk.

Organised exercise walking programmes are being actively set up across the United Kingdom to encourage sedentary people to become physically active by walking in their local area in the company of other people. Dr William Bird who was the founder of Health walks originally set up this concept in Sonning Common, South Oxfordshire.

Health walks goes back to the basics, walking in the local environment is the most basic form of exercise involving no special equipment, no cost and open to all. Not only is the physical health addressed but also the well being of each person is promoted by improving the health of both the environment and the community (Bird, 1997). The benefit to the individual is not only greater physical fitness but also increased well-being and mental relaxation due to increasing awareness of the local natural environment and more social interaction. Due to the low risk of injury it is the most suitable form of exercise for patients participating in home based exercise programmes. Health walks uses local outdoor environment, which allows individuals to appreciate the natural surroundings throughout the seasons. Even in an urban environment green health walks create a health ticket to encourage a deeper understanding of local natural history. This is beneficial in preserving and sustaining the local environment.

The walks allow those who are usually isolated to take part in local causes and make new friends. A closer community becomes more caring and therefore a healthier community. The programmes are developed very locally so that the ownership is clear. If too big an area is targeted this ownership and momentum may be lost. A strong community can also sustain the project. If the environment is seen to benefit local patients or those who are vulnerable then it is more likely that the community will safeguard their natural surroundings as a future health resource. Walking may improve the mind; animal studies have suggested modest increase in cardiovascular fitness can produce metabolic and neuro-chemical changes in the frontal and prefrontal lobes (Kramer *et al., 1999*).

2.5.11 A Framework for Walking, Health and Transport.

There is growing evidence to suggest that motivational strategies alone are insufficient, greater emphasis needs to be placed on contextual environmental issues, and planning walking as a mode of transport. Transport strategies and physical activity promotion can be combined to produce a more effective 'prescription' for intervention designed to promote walking for health (Lumsdon & Mitchell 1999). Transport policies have encouraged the use of the car at the expense of non-motorised forms of transport, while dispersed land use policies have also increased the journey length necessary to achieve essential access from homes to shops, education and places of work. Thus highlighting the absence of walking in policies, however more recent approaches to physical activity promotion have emphasised the importance of creating supportive environments alongside the development of personal skills. Together with the car dependency

syndrome and the 'lack of time' to walk or cycle, there is a decline in walking and no economic gain to do so (Lumsdon & Mitchell 1999).

Walking does not need specialised equipment but does require safe environments in terms of social and physical safety. Improved infrastructure for walking on its own is not sufficient to halt, or even stabilise a decline in walking. A holistic approach needs to be adapted to the management of streets for the benefit of residents, users and the environment. The concept embraces physical works, spatial, economic, legal, psychological and educational concepts within a policy framework. Thus strategies must consider 'enabling policies' which concentrate on improving the local environment. Walking must be encouraged through the course of the day, creating environments in communities, schools, and workplaces and afford maximum opportunity to be active. The framework shown in Figure 2.8 acknowledges and exploits the commonalties in all approaches (Lumsdon & Mitchell. 1999).

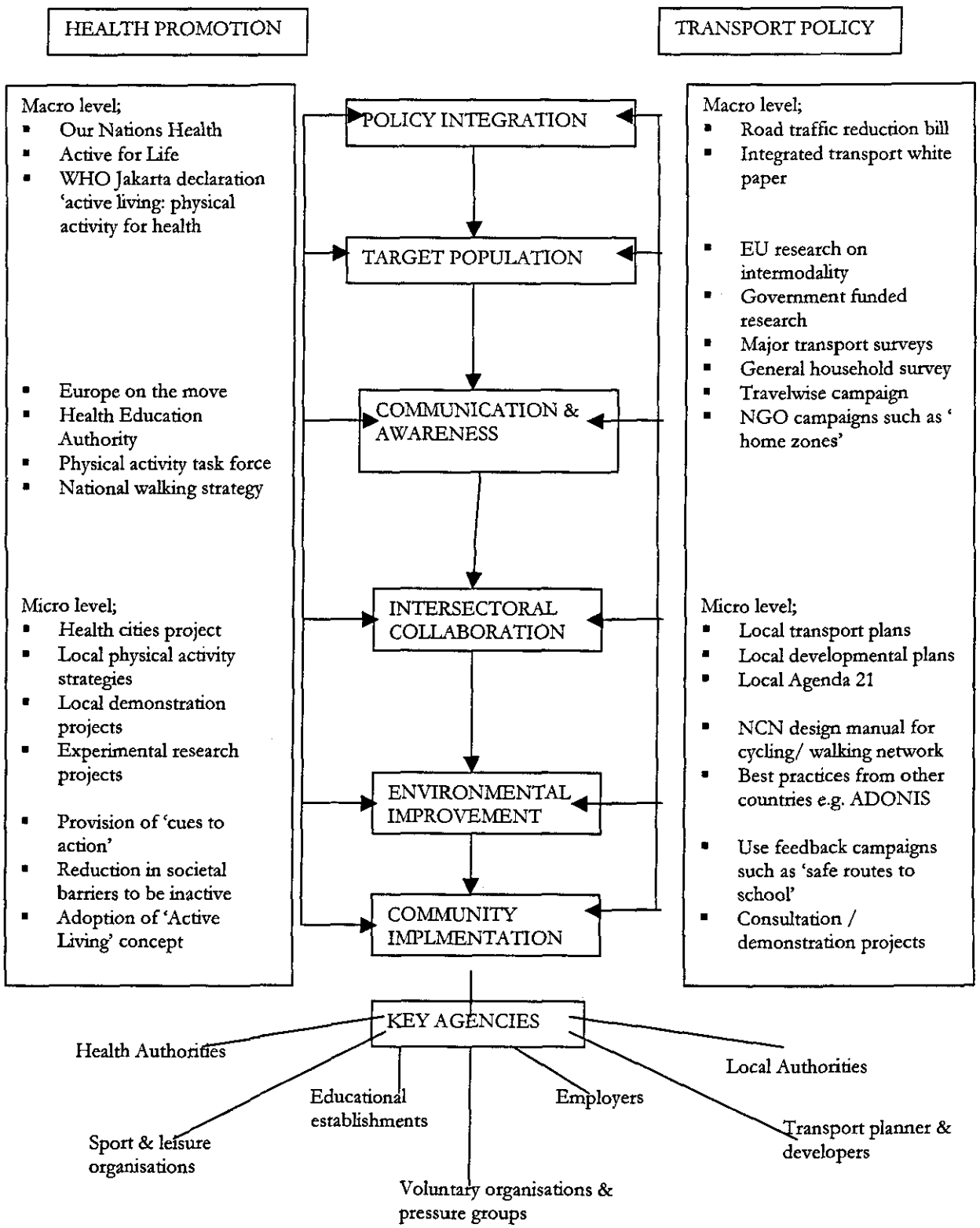


Figure 2.8 *Walking, transport and health: a development framework (Lumsdon & Mitchell 1999)*

The low levels of walking in the population provide a major opportunity for increasing levels of physical activity and health enhancement. This has stimulated an interest in bringing together policy interventions, which are designed to encourage more people to walk as part of daily routine and at the same time meet the objectives of health promotion. The challenge for the promotion of walking for health is to bring together the small scale, short-term physical activity promotion schemes into mainstream sustainable transport development. The framework can be adapted in initiatives such as Local Agenda 21 or longer-term approaches, which embrace local cultural dimensions.

2.5.12 Walking Interventions

Sonning Common Health Walks

The aim of a Health walk is to increase significantly the fitness and well being of an entire community using the resources of the local environment such as existing paths, walkways, open spaces and the local community (Bird 1997). It requires; routes that are mapped out and graded according to difficulty, quality walk cards with maps, history of the area and medical information. Organised health walks involve a trained volunteer to lead the group and a fitness assessment carried out i.e. Rockport 1 mile. Promoting the walks is an ongoing process via newspapers, flyers, and promotional events such as theme & sponsored walks, posters in shops and community organisations. Word of mouth is powerful in reinforcing that Health Walks exist, are open to everyone, not threatening and are free (Bird, 1997).

Sonning Common is on the edge of Reading but in reach of the countryside. It appeared that the local environment held the key to a sustainable form of exercise. An initial survey of 360 patients showed that there were many barriers to walking, including a fear of getting lost, not knowing where to walk, difficulty in climbing stiles, lack of time and women feeling vulnerable when walking alone. Originally the scheme offered maps with different graded walks, these were not a success and upon further investigation guided walks were launched. There was no money so volunteers were recruited to lead the walks. The scheme was strongly shaped by the patients and subsequently they have retained the 'ownership' of these walks. A local fitness instructor was recruited to organise the walks and recruit volunteers. Local sponsorship supported the training for volunteers, which included resuscitation training, the health benefits of walking and understanding of the countryside code. The initiative formed a management committee

to take over the running of the programme, about 1000 people per week were involved in one of a dozen walks.

The evaluation reported that three quarters of the participants felt the positive impacts of the health walks and significant health benefits. The continuing strength of Health Walks is due to the use of local leaders who strongly believe in the concept. They created a sense of community in which others felt that they belong to (Bird 2000). Motivating factors included maintaining fitness and the chance to be in the countryside. 85% continued walks the other 15% thought the walks were to fast or they had physical aliments that prevented them from walking. The health benefits reported included, 10% decrease in illnesses they suffered, 28% reduced stress levels, 20% reduced weight, 63% increase in stamina, and 50% increase in energy levels.

Peak Park Leisure Walks

The walking intervention encouraged and supported disadvantaged groups to increase their levels of physical activity via a series of walks in the Peak District. The project success factors included free transport, childcare, refreshments and publicity was targeted, health workers made recommendations (Hirst 1997). Furthermore timing of the walks was in conjunction with factors such as the weather. There was a start and finish point with a room for refreshments, provision for childcare and toilets. Tailored routes with rangers qualified in first aid that carried two-way radios built confidence in the walkers. Each of the 11 walks per year had a special theme that is from map reading to the natural history of the area. A Christmas party was held each year this maintained social networks. The intervention was a holistic approach, which produced physical and mental health benefits for the participants (Hirst, 1997).

Door Step Walking

An intervention to encourage brisk walking as a means of increasing physical activity levels. Ten attractive, accessible local walks were devise between 20 to 65 minute duration with a five-point scale of ease (distance and gradient). Five hundred free packs at a cost of £0.75 each were distributed around Salisbury via public outlets including GP practices. Funding was raised through a partnership between the local authority, the Health Education Authority, Travelwise and Wiltshire Rural Action for environment. There was a 71% uptake of the activity, and 61% perceived increase in stamina, energy and fitness. 25% reported that the pack was a major feature in their plans to improve or maintain their health. 38% got their packs from GP Practices, showing the potential of primary care settings for such initiatives (Vernon & Brewin 1998). The factors which made the intervention a success included the activity being unsupervised, home based, an

informal exercise of moderate intensity (brisk walking), not facility based and relatively un-structured.

The doorstep walks provided health care professionals an alternative to the GP exercise referral scheme. The most popular reasons for attending the walks was the chance to be outside, maintaining or improving health and keeping in good shape physically. Non-participation was due to the shortage of free time, no one to walk with and no walks near their home.

In addition to the doorstep walks, walkers were walking on a weekly basis and were walking short distances instead of driving. It maybe that this hands off approached to advocating exercise is more acceptable than the currently favoured exercise prescription schemes. The appeal of the intervention may be attributable to the enjoyable nature of this form of exercise, it is non-competitive, sociable (most choose to walk with other family members or friends) and educational, and knowledge of the locality had improved.

Thames Valley Health walks

The scheme was established in 1998 in Wokingham, and had a project officer who developed the walks, for women, cardiac patients and also school gate walks. A community-based programme with an emphasis on accompanied brisk-paced countryside walking. The aim was to investigate the effect of 'health walks' versus advice on increasing levels of moderate intensity physical activity in sedentary people. It used a pragmatic, randomised, single blind controlled trial and defined sedentary as taking less than 120 minutes of moderate intensity physical activity per week.

260 sedentary men and women, aged between 40-70 years old received either advice to increase physical activity from a primary health care practitioner or advice plus an invitation to participate in health walks. Physical activity levels were measured using a specially designed postal questionnaire and motivation to exercise (using the Stages of Change Model, (Marcus *et al,* 1992) at 0, 6 and 12 months. Resting heart rate, cholesterol, aerobic capacity and blood pressure were also measured using simple field tests in the primary care setting. In the health walks group, 33.3% of the people who were invited to health walk did. They completed 805 walks between them (mean walks 6 per year). The majority participated in a small number of the walks, but some people walked as often as once a week. People in the health walks group reported greater improvements in motivation to exercise at 6 months but there was no difference between groups at 12 months. Modest improvements in resting heart rate and aerobic

capacity occurred during the 12-month period, but there were no differences between the groups. There were no changes in body mass, cholesterol, or blood pressure.

Health walks were more effective than advice only in increasing the number of sedentary people engaging in moderate intensity activity. It appeared to be at least as effective as other primary care based exercise schemes, but was cheaper as it is run predominantly by volunteers (Lamb *et al* 2000).

The scheme has been successful in attracting over 700 people to walk since it was established in January 1998 (Ashley *et al., 2000*) the evaluation found that 90% of participants said they would continue walking. In addition to physical fitness, the countryside and the social side of the walks were important motivating factors. The majority of participants were over 50 years old, indicating the efficacy of this type of activity for older participants. The importance of the social aspect of the scheme cannot be underestimated, not only in motivating participants to continue exercising but also in reducing the likelihood of social isolation. However, the average number of walks being taken by each person every month was only three. Participants felt that to encourage them to keep walking, the scheme must have more varied and graded walks. Those who did additional walking felt their transport habits had changed to a greater extent, i.e. they tended to walk instead of driving short distances (Ashley *et al., 2000*). These findings indicate that health walks has the potential to change behaviour and encourage more walking for other purposes.

Walk about to Health

The walk about to health intervention wanted to encourage 'more people, to be more active more often'. A summer promotion of a Walk about to Health was organised by Look After Your Heart- Avon in 1992 (Velleman & MacKellar 1994). A total of 1211 packs were distributed and the evaluation indicated that the pack encouraged about half of the respondents to walk more. 69% of people either passed the pack on to friends or promoted it at work. Only 30 % had been on a walk from the pack and on average tried 3 walks each. Although the type of people who requested the pack were already walkers and the cost of the promotion were high.

2.5.13 Views on Walking by Ethnic Minorities

Reported views on walking by the Health Education Authority were found to be positive from the South Asian community. Walking appealed to older people but less was attractive to younger people (Rai & Finch 1997). Many of the South Asian's interviewed

tried to walked but there were perceived constraints. It was seen to be an activity that fitted into their work lifestyle, as an Asian male factory manager in his 40's described:

' I do about 12 miles of walking around the factory in three different parts. I look after about 2000 work people so I walk a lot...that's my exercise.'

Walking is not conceived as a separate activity but is built into other functions;

'Physical activity is part of our community 'back home'. Let me put it this way, when I was very young my school was miles away and I needed to walk every morning to get to school'

The overall view was that there was more opportunity to walk back home, the streets were safer, and they did not feel threatened walking at night. There was no use of a car so they had to walk to school, or go shopping in the markets and there were also nicer environments such as the beach.

' Its something that's in you all the time...Walking has become a habit.....When I was six or seven years old, in the mornings I used to get up about 6'O'clock we'd (with father) go to the fields for a brisk walk before breakfast. The beautiful green grass helps your eyes first thing in the morning. You feel good. Its very difficult to describe the feeling.' Asian male.

Thus in general the idea of walking as a physical activity was popular with older people, several of whom already spent time walking, or found it enjoyable or regarded as an easy activity, however it was suggested that the benefits of walking as an exercise should be highlighted.

'It will work in our generation. We already do a lot of walking anyway.' Asian female 40.

' Among older women, walking is still effective. For example, I never wait at a bus stop. I always walk to the shops. My husband also walks to the train station, when he's going work. Even when any of our children say I'll give you a lift', he declines the offer and he'll walk to the station, which is a 20-minute walk. That's his routine.... If I have to go alone somewhere, I'll always walk. If it's with someone else then I have to travel by car.' Asian female, 50

There were concerns of personal safety, the effects of pollution and for some, a lack of local parks in which to walk;

'Nowadays it's not safe to go for a walk by yourself. You hear of so many attacks, it's frightening. At 8'O'clock in the evening I sometimes feel like going for a walk, but all this puts me off, in case something happens to me' Asian Female 40

'There is no park nearby where you can take a walk.' Asian Male 45

Purpose walking for example country walking, was sometimes identified as a form exercise, but was perceived as an 'alien' activity undertaken mainly by white people.

Walks for charity were viewed positively but were seen as irregular:

'If you have a charity event sometimes, you know, like they have sponsored walks. But they are on the odd occasions' Asian female 24

Walking is a significant physical activity undertaken by a range of women from different ages, economic backgrounds and family situations (Henderson & Ainsworth 2000). A strong link exists between success and enjoyment, if people enjoy what they are doing; they are more likely to continue to do it (Manson *et al* 1999). In a study of older African and American Indian women walking was categorised into four areas; work related, necessity, health and pleasure walking. The physiological value of movement was the same but the motivations and implications varied (Henderson & Ainsworth 2000). Necessity walking included walking where there were no other options such as transportation or owning a dog it appeared to be an effective way of getting things done, because it accomplished another goal as well as providing an opportunity for exercise and physical activity (Henderson & Ainsworth 2000).

Walking for health was mention as their doctors suggested it. The health related outcomes associated with walking were generally apparent to the women interviewed. Walking was more often associated with pleasure;

'I just enjoy being out in the open and looking and just enjoying things. You know life is so fragile and so precious and I just don't have enough time to walk as much' (Henderson & Ainsworth 2000).

The women in the study described dimensions of availability including how walking could be done anywhere, required no particular equipment except a good pair of shoes and could be done at an individuals chosen pace or fitness level. A major enabler of walking was its convenience and the opportunities that existed in various places such as the local neighbourhood:

'When we walk around the mall or the flea market or places at the park...it's the only time I do some walking.'

Another enabler was the choices the women had about walking with others or alone. One woman described how she had a 'walking buddy' who she walked with at work and someone who she could talk to. Another describes how she walked with her sister and it was a time to catch up with the gossip. Others walked with friends;

'We use to walk and talk and have conversations... sometimes when you're walking and talking you can open up to people and they open up to you, and sometimes other people listen to some things that could give you better insight.' (Henderson & Ainsworth 2000).

Walking allowed a person to meet others but also can be done alone some of the women interviewed would only walk with others while some of the women looked forward to

the solitude. The options that existed appeared to be an important enabler. However not having others to walk with was also a constraint for some of these women (Henderson & Ainsworth 2000).

For American Indian women walking were perceived as a part of their culture, one of them was taught to go outside and walk in the morning before praying. Another described how she took young women into the mountains to show them the herbs used for many kinds of aliments. Cultural tradition and movement were mentioned positively and frequently there was a notion that as they get older they should stretch (i.e. exercise) more to be in tune with their bodies. They appreciate the ability to walk and do not take it for granted. Walking was an activity that had a connection to the earth and the opportunity to be outdoors, and was more important than the activity it self (Henderson & Ainsworth 2000). One of the American African women describe how she was not allowed to catch the school bus but had to walk everywhere.

The perception of walking as ' not really an exercise' was reflected in the adaptability it represented, it was perceived beneficial on different levels. It seemed to be taken for granted as a way to feel good physically without having to commit to a rigorous exercise programme (Henderson & Ainsworth 2000).

The constraints mentioned were often a matter of perception, some women were describing their excuses not to walk and admitted to simply being lazy. Time was the major constraint and the most frequently used excuse, others included seasons, weather, safety, being physically and emotionally tired and not having walking partners. Walking for pleasure was related to the temperature and the amount of light. Safety in an urban environment was a major constraint. One woman commented that her husband did not want her to go to the park in the dark, she did not tried to think about the dangers but realised they existed. Not having partners to walk with was raised as a safety issues as well as being a social support and companionship. Some of these women were physically active at work whilst others found work emotionally draining and were thus too tired to walk after work, these issues often related back to economic pressures, family issues and overall health. Most of the women were aware of the value of walking whether it was done for necessity, work, and health or as leisure and did not appear to be connected directly to the cultural background of the women. Only a few of the women identified their race or culture as having an impact on walking. Overall walking had value because it was ' not really an exercise' seemed to be related to the idea that choice was involved with where, how and with whom walking was undertaken. Choice was also involved

regarding the intensity of the activity and thus the enjoyment. When the women negotiated the constraints they were able to seek and find positive experience in walking. Individual behavioural choices such as the role walking plays in ones life are influenced by a combination of personal, cultural and environmental factors. Thus although women have to make the decision to get out and walk having safe and maintained places for walking is a way to encourage activity in individuals (Henderson & Ainsworth 2000).

2.6 Literature Review Summary

South Asian's in the UK have been reported to have poorer health than the general population and this is related to their socio- economic status. Of particular concern is CHD; the numbers of reported cases are rising at a rate whereby the National Health Service will reach a crisis.

Overall Bangladeshis had the poorest health and the highest level of inactivity followed by Pakistanis and then Indians. South Asian men were more likely to participate in vigorous activity and sport than South Asian women. There was generally a low up take of sport in South Asian's in particular walking and cycling. South Asian men were more likely to have a negative experience of participating in sport than South Asian women. In the general population 41 % of women took up walking, for Indian women it was 25%, Pakistani women 21% and Bangladeshi women 10%. For men 49% walked 36% of Indian men, 26% Pakistani men and 22% Bangladeshi men. Walking was more appealing to the elderly South Asian's than the young. There were no cultural or religious factors why South Asian should not participate in sport or physical activity, however the way in which participation occurred was dependant on these factors. More specific barriers for South Asians were the beliefs that they were not the ' sporty type'. Older South Asians felt that physical activity was an integral part of their life and should be free.

Major barriers were the lack of separate sex sessions, the dress code, the lack of cultural environment and racism that occurred in sporting facilities. Women felt that there was a non- acceptance of them undertaking physical activity due to the extended family. South Asian women wanted the men to be re-educated this would free them to undertake physical activity.

There is scope to promote sport and physical activity within South Asian's as more than half wanted to participate in a sport they do not currently do. A way in which this can be done is via good practices and physical activity community interventions. An intervention

map, which is specific to a target community, can be defined, but needs to be flexible to identify mistakes and to correct them.

Delivery of physical activity intervention to ethnic minority communities may be challenging but the process can be made easier if the focus is community centred. Interventions were successful due to their flexibility that is consideration is given to ethnic and cultural needs. Interventions, which were culturally aware and tailored, were self-sustaining, factors such as bilingual staff, single gender sessions, family orientated, and childcare provisions were successful. Identifying natural helpers or programme champions helped with convincing gatekeepers and gaining community support. The best publicity is word of mouth, recommendations, and training of lay members and providing free taster sessions.

Walking can help prevent and manage heart disease. Regular exercise can halve the risk of CHD, particularly in men who walk briskly (Morris *et al.*, 1990). Someone who is inactive has as great risk of having heart disease as someone whom smokes, has high blood pressure or has high cholesterol (Blair *et al.*, 1989).

Brisk walking is an ideal form of exercise, it is of sufficient intensity to improve fitness and reap numerous health benefits associated with exercise. Walking is within the physical capabilities of the majority of people. Sedentary individuals are likely to perceive walking as a more realistic challenge than other more vigorous forms of exercise.

Ethnic minority populations continue to be at higher risk for illness, disability, and death from chronic disease. They also have significantly lower activity rates than the general populations. The success of community programmes for multiethnic populations is one that allows for maximum flexibility and creativity in the design of various programme interventions and has a community driven focus. These programme implementation strategies all take into account the role culture plays in influencing attitudes, beliefs and behaviours related to health promotion and disease prevention. Projects for the ethnic minority community should be conducted with locally hired staff, community outreach workers and should have local control over programming and include a number of culturally sensitive activities such as dancing and walk and talk programmes in local parks (Manley, 1999).

The cause in reduction in physical activity is complicated by the ever-changing nature of society, for example the potential exposure of masses of people to the same information and entertainment culture through television and electronic communications. The

increasing societal diversity contributed by immigrants from countries with entirely different spectra of economic and cultural perspectives (Kumanyika, 1999).

For physical activity programmes to succeed in low-income and ethnic minority communities requires deliberate and sometimes aggressive actions to change the relevant social or financial conditions surrounding even the most basics options, like a walk in the park. It is important to get community leaders on board so that they can promote an environment that supports physical activity, can work with the media, and develop local partnerships to spread the word.

Much of the community intervention research has been conducted with relatively affluent white populations (King, 1991). The few studies targeting minority populations suggested that successful strategies included community involvement in the planning and implementation of health promotion activities, promotion of culturally relevant exercises, work with community base groups and organisations, use of bilingual and bicultural community staff and involvement of entire families in interventions (Cassady *et al.*, 1999).

There are no cultural or religious reasons prohibiting people from doing physical activity. Moreover there were no community specific definitive attitudes towards or barriers to physical activity based purely on cultural or religious differences. There were differences however in the ways of participating in physical activity and different requirements of facilities for physical activity, and these are influenced by cultural or religious beliefs.

Awareness of health benefits, particularly the link between physical activity and CHD is high. Other health benefits perceived by the South Asian community include general well-being; prevention of illness and diseases; relief from existing medical conditions and general good health and maintenance of physical mobility and old age. Health benefits are also often linked, in this community, with the mind and body- related benefits reflecting a belief in mind body connection. Older people think the concept of sweat plays an important role in ' good health' through weight control and the removal of toxins and impurities from their body.

CHAPTER THREE

Methodology

One step at a time is good walking.

Chinese Proverb.

3.0 Introduction

The research methodology encompassed both qualitative and quantitative techniques that ran parallel to each another. This chapter discusses the themes that were central to the development of the methodology:

- the selection of tools that were appropriate to the study and
- culturally sensitive methodologies for the targeted community.

The theoretical frameworks are also discussed of the chosen study tools; action research, case records and an anthropological approach. An action research model is depicted though relating it to the unit of life, DNA. The chapter moves on to discuss general methods used in the study; the collection of baseline, audit and demographic data; consultation mechanisms; questionnaires; interviews; walker profiles and walk registers; shuttle walk tests; calorie/ step counters and ethical approval. The Walking for Health intervention framework designed for South Asian communities brings the stages of the methodology together. The chapter closes with a summary of the methodology and chapter constructions of the proceeding results chapters four to eight, which contain detailed methods, and procedures of each stage of the intervention.

3.0.1 Tool selection

A number of considerations were debated for the selection of appropriate tools and techniques for the research design these included;

- the intended focus; that is the involvement and consultation process of the targeted community
- the timescale and urgency; the research project was to be moulded by the recruitment of the walkers and the funding period of three years
- the sense of community identity, common interest and past history
- the existence of community and user structures; an in-depth mapping of the targeted locality

- the level of understanding about decision making and change
- levels of literacy and knowledge of jargon for all that were involved
- an awareness and sensitivity to issues such as race, gender, physical or sensory ability and age.

A major area of concern when developing the methodology was the development of an anti –oppressive and participatory research technique. Douglas (1998) had developed appropriate research methodologies with ethnic minority communities, which used particular strategies for sampling ethnic minority populations, via matching interviewers to respondents for language and ethnicity. The research methodologies, involved the targeted community setting the research agenda, designing the research protocol, implementing research, analysing research findings and defining recommendations for changing practice better know as participatory appraisal. The use of participatory appraisal would have been beneficial for this study but the required resource was unavailable. However, the techniques used in participatory appraisal were integrated into the main methodology of the project.

There was recognition by ethnic minority communities of the dominance of white researchers and professionals in relation to their health needs and called upon more Black led research (Douglas, 1995). Research findings by Black researchers have been fed into influencing health service purchasing so that more appropriate services for Black ethnic minority groups can be developed. Research findings have also been fed back into local organisations. These reports were made to emphasise that the research project itself was independent and was not trying to put forward a particular view from that of the Health Authority or Health Promotion Agency. This was important in gaining confidence of the communities and being able to ascertain their views and experiences.

3.0.2 Developing an appropriate methodology which is culture sensitive

The knowledge base of people and their specific health needs were often taken for granted by most professionals and service providers who tended to operate as though all individuals were equally informed and have equal access to health services. In Britain social programmes and health services tend to be generic in nature essentially targeting the so-called average 'Brit' or 'Scot' (Hampton, 2000). While factors such as poverty and social class are usually considered when planning health services, gender and culture

sensitive aspects are often excluded. Strategies to address this have been slow to emerge (Hampton, 2000). Despite the strong support for verbal and face to face communication methods, communication in health promotion remain essentially generic with a great deal of emphasis being placed on written material; as Fraser & Smith (1997) stipulated;

'Printed material should be used in support rather than as an alternative to verbal and face to face communication.' (Page 76)

Other studies revealed that in certain cases even material written in appropriate languages failed to reach intended audiences because not all individuals within target groups were literate in their mother tongue (Hampton, 2000).

Attempts have been made, to explore appropriate methods of communication in health promotion using culture and gender specific approaches (Hampton, 2000). The use of an appropriate strategy involving members of the target community more directly would be more likely to succeed. While it was accepted that certain barriers especially language, might not be completely eliminated, it was hoped that at best these would be reduced through participatory collaborative approach (Hampton, 2000). A method based on a participatory culture sensitive approach had been described by Hampton (2000) it involved the recruitment and training of lay people from the trusted communities to take specific health education messages using appropriate languages back to the target group. A qualitative approach adopted not only succeeded in reaching and informing marginalized groups but also succeeded in breaking down certain community or professional barriers (Hampton, 2000).

3. 1 Theoretical Framework

The main synopsis of the thesis and study was action research; examples were drawn from education and adapted to health promotion in the community. Combinations of definitions were explored and were tailored to the specific need of the study.

3.1.1 Action Research

What is Action Research?

'Investigators can only speak for themselves; this speech is not 'findings' from nature but a 'reflection upon' nature and indeed 'critical reflection' (Winter, 1987).

The definitions of action research were dependant upon on the individual situation, the facilitator/ practitioner / researcher, and all the people that were involved in the project.

For the purpose of 'action research and the promotion of walking for health' the most suited and adaptable definition was used, which had a focus on community based action research. The definition described by Carr & Kemmis (1986) was thus adapted appropriately:

'Action Research is simply a form of self reflective enquiry undertaken by participant in a social situation in order to improve the rationality and justice of their own practices, their understanding of these practices, and the situations in which these practices are carried out'

Action research could bridge the gap between theoretical and practical knowledge, by integrating research and action or action and research; the latter sequence is more appropriate to the practitioner in the field.

Action Research originated from education, and many examples have been drawn around this field, paying particular attention to resolving the theory and the practice gap. This would suggest that action research's main aim is to link the enlightenment of research with the effectiveness of action (Winter, 1987). Education also incorporates 'interpersonal effectiveness' that is when 'teachers' have succeeded in helping 'students' to develop towards some form of educational ideal and thus the teacher –student can be substituted with 'walk leader' and 'walker'.

Action Research is based upon the assumption that the recording of events and formulation of explanation by the uninvolved researcher was inadequate. Those who had previously been assigned as 'subjects' should participate directly in the research process. These processes would then be applied in ways that benefited all participants directly. Community based action research was a derivative of this approach to inquiry. The 'subjects' themselves would become the researchers this lead to the practitioner who played a central professional role. The nature of the professional role is redefined in action research with relation to the professional workers relationship with their clients and with their bureaucratic superiors (Winter, 1987). The professional role or the practitioner would enact as the research facilitator whose main task was to provide co-ordination, leadership and direction to other participants or stakeholders in the research process (Stringer, 1996).

There are two main objectives of all action research: to improve and to involve. Action research aims at improvement in three areas (Carr & Kemmis 1986):

1. the improvement of practice

2. the improvement of the understanding of the practice by its practitioners
3. the improvement of the situation in which the practice takes place.

The aim of involvement stands shoulder to shoulder with the aim of improvement. Those that were involved in the practice would be in involved in the action research process in all of its phases of planning, acting, observing and reflecting. As projects developed, it was anticipated that the circle of those affected would widen and ultimately also become involved.

What are the key components of Action Research?

Stringer (1996) had formed a basic routine for community –based action research, which involved a collaborative approach to inquiry or investigation that provide people with the means to take systematic actions to resolve specific problems. The participatory process allowed people to:

- investigate systematically their problems and issues
- formulate powerful and sophisticated accounts of their situations
- Devise plans to deal with problems at hand.

The technique of inquiry focused on accounting for people's history, culture, interaction practices and emotional lives. The key components of community based action research as defined by Stringer (1996) are look, think and act. Each component is subdivided into steps, which form the process and methodology of action research as shown in figure 3.1.

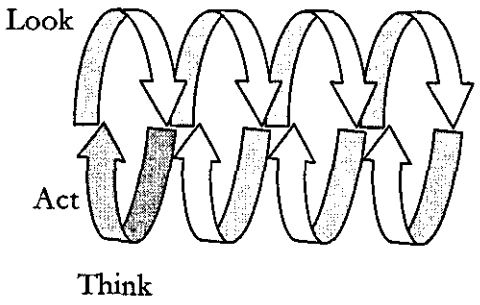


Figure 3.1 Action research interacting spiral (adapted from Stringer 1996)

- 'Look' involves the gathering of relevant information and building a picture of the situation for example; defining and describing the situation via audit and baseline data.
- 'Think' is exploring and analysing the situation by hypothesising, making sense of the data collected and asking what is happening here?
- 'Act' is planning, reporting, implementing and evaluating.

These three basic components were the building blocks of a complex framework that can be associated with a spiral of activity: plan, act, observe, and reflect (Kemmis & McTaggart 1988). The components fit into the second phase of action research methodology as stated by Carr & Kemmis (1986):

- First phase: a project takes on a subject matter in a social practice, regarding it as a form of strategic action susceptible of improvement.
- Second phase: the project proceeds through a spiral of cycles involving planning, acting, observing and reflecting, with each of these activities being systematically and self-critically implemented and interrelated.
- Third phase: the project involves those responsible for the practice in each of the moments of the activity, widening participation in the project gradually to include others affect by the practice, and maintaining collaborative control of the process.

The second phase, which incorporates look, think and act can be defined in other ways, but is always based around the spiral of activity network. These different definitions suggest the universal nature of action research and its use literally in all 'walks of life'.

There are many different ways of describing the same set of activities, but it is dependent on the particular situation, and the inquiry can be tailor made. Lewin (1946) described the process of action research as consisting of self-reflective spirals of planning, fact-finding and execution. The planning stage would start with a general idea, to reach a common objective. The way in which this common objective was reached was often unclear. The first step would then be to examine the idea in terms of all resources available. This would entail more fact-finding. If the first stage of planning is successful, two things would come to light;

(i) an overall plan of how to reach the objective and

(ii) a decision is made with regard to the first step of action.

The next loop of the spiral is dedicated to executing of the first step on the overall plan. Followed by fact-finding, which has four functions (Lewin, 1952):

- It should evaluate the action by showing whether what has been achieved is above or below expectation
- It should serve as a basis for correctly planning the next step
- It should serve as a basis for modifying the 'overall plan'
- It gives the planners a chance to learn that is, to gather new general insights, for instance, regarding the strength and weaknesses of techniques of action.

The next step again is composed of a circle of planning, executing and fact- finding for the purpose of evaluating the results of the second step, for preparing the rational basis for planning the third step, and perhaps modifying again the overall plan.

Figure 3.2 Four different sequences to interacting self-reflective spirals of an action research project:

1. Planning → fact-finding → execution

(Lewin, 1946)

2. Review → Diagnosis → planning → implementation → monitoring effects

(Elliott, 1981)

3. Strategic planning → Action → Observation → Reflection

(Brown et al., 1982)

4. Look → Think → Act

(Stringer, 1996)

In all four sequences a common recycling of activities or events is occurring. As each component is worked through a constant process of observation, reflection and action completes the first cycle before reviewing (re-looking), reflecting (reanalysing), and re-acting (modification of actions).

Steps for an Action Research Project.

In practice, an action research project is a complex process. It is not done step by step, or an orderly activity, often it was found that people worked backward though routines, repeating processes, revisiting procedures, re-thinking interpretations, leapfrogging steps or stages, and sometimes making radical changes in direction (Stringer, 1996). These are due to the affects of group decisions in facilitating and sustaining change in the duration of the project. Lewin (1952) had pointed out the value of involving participants in every phase of the action research process. Based on these principles the project would lead to:

'gradual independence, equality and co-operation'.

The action research design allows the research to be taken at the same time and is in collaboration and in partnership with other people running the project. The overall advantages of action research include:

- takes account of specific situation
- investigation and action co-exist
- provides immediate feedback to the participants
- evaluate effects of changes
- be collaborative
- increase ownership

Disadvantages include:

- not neat, precise or clear cut
- uncertainty, untidy, boundaries are blurred
- the researchers skills are more complex than for most before and after studies.

The DNA Action Research Model

The action research design for the promotion of walking for health would be similar to that of the interacting spiral shown in figure 3.1, however its complexity would be related to a vertical DNA double helix structure (Figure 3.3), which represents a spiral ladder.

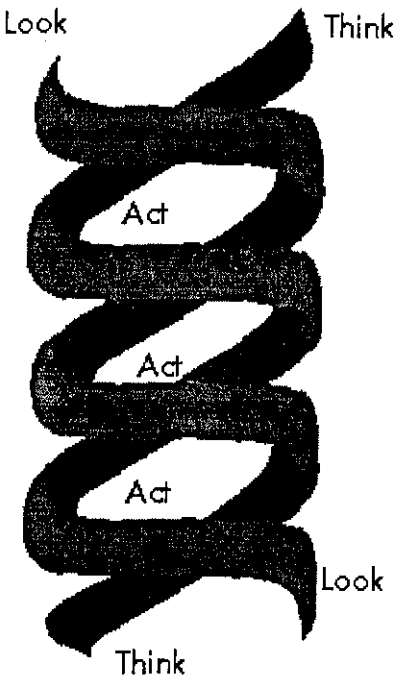


Figure 3.3: DNA interacting spiral ladder.

3.1.2 Proposed Theoretical DNA Action Research Model

The proposed theoretical DNA action research model draws upon the interacting spiral concept by Stringer (1996) (Figure 3.1) and relates it to the DNA helix structure, which is spiralling upwards shown in figure 3.3 and detailed in figure 3.4.

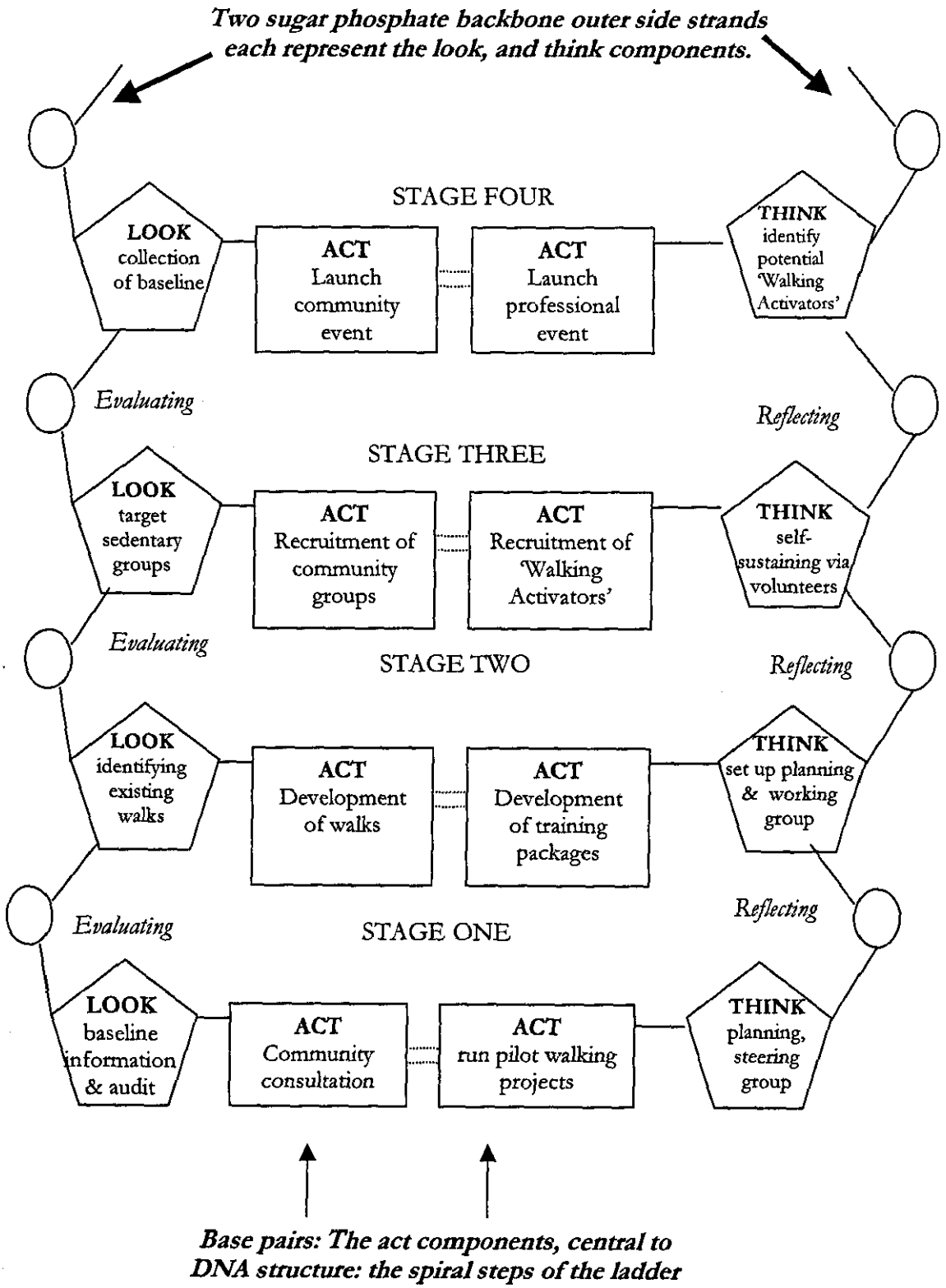


Figure 3.4: Magnified version of the DNA structure in relation to action research and the promotion of walking for health (DNA structure: Weaver & Hendrick 1991)

The two sugar phosphate backbone outer side strands each represent the look, and think components these would run anti-parallel to each other. Thus instead of being a linear process as suggested in Figure 3.1 it would be an upward, building up process. The recycling of the set of activities would also occur, but instead of one activity, several activities could be taking place at the same time. This is represented by the 'act' base pairs in the central part of the DNA structure, the 'spiral steps of the ladder'. The look and think spiral strands wrap around the 'act steps' Figure 3.4; shows in detail the components in a magnified version of the DNA structure: From figure 3.4, it must be stressed that each of the 'act bases' is constantly being re-looked at and re- analysed by reflecting and evaluating each activity. This would be a difficult task, as all participants in each loop of the spiral would interact with other loops in the spiral.

3.1.3 Case Records

Case study research provides a credible representation of reality. A case study aims to give the reader a sense of 'being there' seeing the walk through the eyes of the walker, walk leaders or project coordinator. Lawrence Stenhouse developed the idea of a 'case record' in the late 1970's. Similar to action research it moved a step closer to bridging the gap between theory and practice, research and action, present and possible. The case record was a practical means of conducting and using case studies, addressing the enduring methodological issues of interpretation and generalisation that are central to qualitative methods. The practitioner could participate in the research process without extensive prior methodological training. The research methodology tries to address the key shift that had occurred in research from the use of quantitative to qualitative methods: from measurement and statistics to field research and case study.

Case records allow room for experimentation, which is radical, compared to descriptive methods, which are more conservative. Research is often isolated from action or used only in the most instrumental and bureaucratic ways. The present study moved away from isolation and engaged it with action, and delivery of change for improvement straight a way. An emerging issue thus in the research field is whether to continue to follow policy and practice or whether to experiment with other models. There is a need to move beyond evaluation to deliberation and beyond case study to scenario planning Stenhouse (1983).

What is a Case Record?

Not an analysis and not a portrayal but a record, which is the central research task. Stenhouse (1978) stated;

'Field study should... be concerned with the creation of sources and...not with the creation of report or portrayals. There should be an intermediate stage between fieldwork and reporting in a readable form to a general professional audience.....this intermediate level I shall call 'case records".

Stenhouse looked for ways of using empirical data that was less reliant on ascribed authority and more open to alternative interpretations. The case records provide this, since it provided a form for making evidence open to participation. Evidence is separated from interpretation, the aim was not to isolate evidence from critical scrutiny but to set evidential boundaries that would contain interpretation.

Case records establishes the grounds for verifying the case study, since the case record permits critical scrutiny of the interpretations and selections made by the case writer by allowing access to the background data

Representation ⟶

Case data	Case record	Case study	Case analysis

⟵ *Presentation*

Figure 3.5 Representation to presentation; case data to case analysis (Walker, 2002)

A case record is not a collection of raw data but equivalent to sets of data included as appendices in measurement study or a selection of documents and sources to be found on a scholar's desk. The difference between case data and case record; case data is all the materials assembled by the field worker studying the case, these are to be likely too be bulky to analysed repeatedly and in parts too sensitive for immediate release (Stenhouse, 1978). From the case data would be created the case record; theoretically a condensation of the case data produced by selective editing without explicit comment. Clearance of the case record would be negotiated with participants and regarded as an edited primary source.

The case record is a four-stage process, potentially secondary source and an interpretive presentation and discussion of the case resting upon quoting and citing the case record for its justification. The final stage is analytic survey involving retrospective generalisation across cases. It would be grounded in the case record archive and should cite it. Thus a

four stage process between fieldwork and analysis, which is seen as a move between the processes of representation and presentation (Figure 3.5);

- First Stage: Representation or fieldwork: data intended for researcher
- Second Stage; Presentation data organised in order to present to a reader an interpretation of its significance in relation to some topic, issue or problem.

The case record allows the reader to look at it from different angles and facets, being able to plot different routes through it and being able to tell different stories, which might connect its key features. A case study should be seen and used as providing a point of reference for the development of practice. Stenhouse (1985) stated generalisation as;

'...A matter of judgement rather than calculation...the task of case study is to produce ordered reports of experience which invite judgement and offer evidence to which judgement can appeal.'

3.1.4 Anthropological Approach

An approach that focuses on the cultural and social context of human behaviour; Krumeich *et al.,* (2001) described the 'thick description' approach borrowed from anthropology it offers a basis for sound interventions for understanding human behaviour. Changing people's behaviour is a major challenge for public health workers, particularly when interventions focuses on peoples whose social, cultural, ethnic or economic circumstances differ from health professional's own background. Fortunately in the present study the action researcher came from the same cultural background as the participants, however, upbringing did differ due to the age difference.

Current theoretical models assume that health behaviour results from separate isolated behavioural determinants, each of which explains different aspects of individual behaviour (Mcleroy *et al.,* 1988). Inspired by this gap Green *et al.,* (1994) and Mcleroy *et al.,* (1993) devised a combination of theories from multiple disciplines, to better comprehend health behaviour. The 'new' public health paradigm of health promotion was developed. It aimed to involve different levels of analysis, that is, interpersonal, organisational, community and public policy factors, in understanding and affecting health behaviours (Green & Kreuter 1991).

Health education has also been criticised for its self-evident acceptance of the superiority of western (scientific) culture. As Good (1995) stated;

'Developed specifically to help public health specialists convince people to act more rationally – to use preventative services, obey doctor's orders, or use medical services 'appropriately' such theories evaluate health beliefs for their proximity to empirically correct knowledge concerning the seriousness of particular disorders or the efficacy of particular behaviours or therapies. The wealth of meanings associated with illness in local cultures is thus reduced to a set of propositions held by individual actors which are in turn evaluated in relation to biomedical knowledge.'

Anthropology seeks to understand the links between social stratification (gender, ethnicity, and social class), access to material and immaterial goods (food, water, health services, education), illness representation, cultural constructions of femininity and masculinity attitudes to health promotion and health behaviour. These elements form a specific cultural system in which tasks; responsibilities and proper conduct have become self-evident (Krumeich *et al.,* 2001). Describing the relations between these elements is called a 'thick description' (Geetz, 1973). Thick descriptions are based on meticulous fieldwork, which may include participant observation, open ended, unstructured or semi-structured interviews and keeping a dairy.

Unravelling the way in which a specific culture links notion on the human body with gender constructions and perceptions of health and illness provides a fruitful basis for understanding that culture. Thick descriptions can demonstrate how different cultural elements centred on the concept of the human body influence each other. It reveals that the way in which these elements are connected differs from one setting to another and they show how cultural sensitivity improves problem analysis in health promotion. The anthropological perspective facilitates the interpretation of what people say and do and why they say and do this. It illustrates how human behaviour is so deeply grounded in its specific cultural system that speaking in terms of autonomous choices and barriers for health behaviour disregards its context and is therefore problematic. This cultural awareness prohibits ' victim blaming' an inevitable consequence of the assumption of the 'rational individual' that is at the core of the current health education paradigm.

An analysis based on anthropological theory and methods is also indispensable while planning and developing health promotion interventions. It provides clues to decide when, where, with whom, how and on which issues to intervene. In the first place, a problem analysis based on a thick description may result in broadly scoped interventions that at first glance appear not to have direct relation with health because they do not directly address a change in health beliefs, health counselling or health services. Instead

of just providing health education the health promoter cured from cultural naivety sets to change the whole society. They do not merely evaluate health beliefs but rather judges the way in which men and women relate in a particular culture. The victim may no longer be blamed but culture is.

Health promotion can take advantage of the richness of thick description as well as peoples experience by intervening by ongoing dialogue. Such a discussion will result in increased critical consciousness among both the target group and the health promoters about cultural mechanisms that underlie personal experiences with regard to health matters. A discussion might follow in which both parties can try to convince each other. Such a dialogue is an intervention in its own right. The discussion provides ideas for further steps regarding how, when and where to tackle the health problem.

Thick description especially when paying attention to cultural constructions of the gender and the human body are promising for problem analysis and intervention design in health promotion. They shed light on relevant aspects of local cultures that otherwise escape attention. It combines the voice of the researcher whose knowledge is based on scientific analysis with the voices of those whose knowledge is based upon personal experience. Thus it is often difficult to measure lifestyle change or direct impact of programmes but the anthropological approach taken during the evaluation allows the evaluator the opportunity to observe and record the true feelings of those involved in the project, the walk leaders and walkers were primary critics of the programme.

3.2 General Methods

3.2.1. Collection of baseline, audit and demographic data

The study has supplemented information collected from community groups, community workers and local demographic and census information to produce a community profile of the Belgrave locality of Leicester.

3.2.2 Consultation Mechanisms

The consultation process needed to be carried out in three phases; providing information and background to the project, the audit and then feedback and comments on plans. Information was distributed generally in the geographical boundary, leaflets were left at service points, and at community and voluntary organisations, published articles in newspapers and community newsletters, presentations at community groups and

meetings, and advertising. The audit consisted of focused groups, and random questionnaires or interviews with community groups at drop ins. Feedback happened at public meetings, conferences, presentations and discussions.

3.2.3 Questionnaires.

Questionnaires are a good way of collecting certain types of information quickly and relatively cost effectively as long as the subjects are literate (Bell, 1987). The information collected was a combination of both attitude and factual (Owen & Davis 1997). The questionnaires had to be well designed to get quality data and the information desired. Care had to be taken in; setting question types, in question writing, in the design, piloting, distribution and return of questionnaires. Thought was given to how responses would be analysed at the design stage. Through the process of administering a structured questionnaire a great deal of qualitative information was also gathered.

3.2.3.1 Chalo Chalay; Let's Walk Walking activities Questionnaire (Appendix I & II)

This questionnaire was adapted from physical activities questionnaire (Almond, 1999b) and Walking Activities (Foster, 1999). The questionnaire was further developed with the translation department at Leicester City Council. This ensured the simplicity and the compatibility of the questionnaire to the Gujarati language. The brisk category from the original questionnaire was omitted due to the confusion in translation. The whole questionnaire and the terminology were re-reviewed to ensure clarity of the data obtained to be clear and precise for both languages. The questionnaire was piloted in both languages, relevant changes were made and the final copies were printed both in English and Gujarati.

The questionnaires were given pre and post the scheme with minimal intervention from the walking activator. It tested the perceived walking activity at the start of the programme and gave some indication of baseline data.

3.2.3.2 Physical Activity Readiness Questionnaire (PAR-Q) (Appendix III)

Before the walkers commenced the scheme s/he was given a PAR-Q to fill out. This one-sided questionnaire assessed their medical and fitness levels. Once filled the Walking Activator went through it with the walker, and it was at their discretion whether the

walker was fit enough to undertake the activity or whether they should be referred back to their GP's.

3.2.4 Interviews

Interviewing is a system of conducting a survey where people are asked personally for the required information. A disadvantage of this method is that it is very time consuming both to undertake and to analyse it is however, the best method by which to draw an accurate picture (Owen & Davis 1997). A major advantage of the interview is its adaptability. A skilful interviewer can follow up ideas, probe responses and investigate motives and feelings, which a questionnaire format could never do. The way in which a response is made (the tone of voice, facial expression, hesitation e.t.c) can provide information that a written response would conceal. Questionnaire responses have to be taken at face value, but a response in an interview can be developed and clarified. Interviewing is a highly subjective technique and therefore there is always the danger of bias. Analysing responses can present problems, and wording the questions is very demanding but yields rich material and can often put flesh on the bones of questionnaire responses.

Consistency is very important in interviewing, each respondent should be asked the same questions by the same interviewer and the answers should be interpreted in the same way thus;

- the type of person interviewing should be the same for all respondents
- some form of written questionnaire should be used as a basis for interviews
- if more than one interviewer is used they should be trained to ask the same questions and interpret them in the same way.

If the interview consists of open questions, the interview maybe taped which then has to be transcribed for analysis.

The interview schedules were checked for cultural and religious sensitivity and that the questions were relevant and appropriate. Questions included information on lifestyles, behaviour and attitudes, toward walking and perception of health. Interviews were audio taped in Gujarati, transcribed, translated into English and analysed, and were validated. Some interviews were conducted in the participant's homes. As well as enabling access to local communities the method allowed the gathering of information about local organisations, groups and facilities in the area.

3.2.4 .1 Matching interviewers and respondents for ethnicity

Both research and community development, have been partially successful as they tend to be conducted by 'white' professionals who are usually accorded with polite but restrained responses from communities in question (Hampton, 2000). The interview situation in which white researchers have asked Black women questions about their lives was reflected upon by Bhopal (1995), and her experiences as a South Asian woman and reflecting upon whether Black women may affect how the people being research conceive and respond to her and states;

'Who is the best person to conduct re-search within the Asian community? Should we 'allow' white middle class men to conduct research on Black working class communities? In my own research this has become a serious problem and became evident in such areas as access, language and identity. My own identity as an Asian woman enabled me to gain access into the private homes of South Asian women, speak their language and empathises with them. Would a middle class male or female be able to gain such access?'

However Rhodes (1994) argues that:

'The use of Black interviewers to interview Black subjects may often be appropriate, but as a political strategy, it risks marginalization of Black issues and Black researchers within the research establishments and as a methodological approach, its assumptions of a single 'truth' or reality' in terms of which all accounts are judged is open to challenge'

'There is a risk that using Black interviewers for Black respondents may disguise internal conflicts and suggests an ' artificial harmony'.'

Further more (Hampton, 2000);

' The strategy of using 'ethnic' professionals to work with 'ethnic communities', although successful in breaking down certain community/ professional barriers also proved to have limited impact as appropriately trained' ethnic' professionals tend to be few and far between'

Walton (1986) stipulates;

'By definition it is impossible for any researcher white or Black to belong to all the multiplicity of group studies within such a complex situation. There should be a margin of freedom to comment upon the activities and social life of groups that one is not personally a member of.'

Research points to the advantages of interviewers being the same ethnicity and social class as respondents to encourage a more equal context for interviewing. It allows more

sensitive and accurate information to be collected and reduces bias in the interviewing process. However matching interviewers to respondent is a very complex process as there are not just questions around matching for ethnicity and language but other concerns such as gender and socio- economic status, which need to be considered. The major advantage of matching interviewers with respondents by ethnicity is that it gives more opportunity for respondents to communicate in their first language whenever they wanted to and therefore did not rely upon respondents reading or writing English. Also it was clearly emphasised that the importance of having local knowledge and belonging to the same ethnic group as the respondents aided in the research process. It was important to build trust with local community organisation and hence local people could see some action emanating from the research project.

3.2.4.2 Focus Groups/ semi -structured Interviews

There are two principle means of collecting qualitative data in social sciences these are individual interviews and participant observation in groups. As group interviews, focus groups combine elements of both better-known approaches. The intermediate nature of group interviewing means that focus groups not only occupy an easily comprehensible position within existing set of qualitative methods but also possess a distinctive identity of their own. On one hand, focus groups cannot really substitute for the kinds of research that are already done by either individual interviews or participant observation. On the other hand, focus groups provide access to forms of data that are not obtained easily with any other methods (Morgan, 1988).

Focus groups are a form of qualitative research; they are basically group interviews, although not in the sense of an alternation between the researchers questions and the research participant's responses. Instead the reliance is on interaction within the group, based on topics that are supplied by the researcher, who typically takes on the role of moderator. The fundamental data that focus groups produce are the transcripts of the group discussions. Focus groups are useful as either a self- contained means of collecting data or as a supplement to both quantitative and qualitative methods. The method is useful as a preliminary or exploratory tool but the results may have to be verified by quantitative work on representative samples. However, in the social science field the research does not have such narrow goals thus there is no reason to assume that focus groups or any other qualitative technique require supplementation or validation with quantitative techniques (Morgan, 1988). Thus, focus groups are useful for;

- *Orientating oneself to a new field*
- Generating hypotheses based on informant's insights
- Evaluating different research sites on study populations
- Developing interview schedules and questionnaires
- Getting participant interpretation of results from earlier studies.

3.2.5 Walker profiles and Walk Registers

When walkers joined a walk the walk leader took responsibly of filling out necessary paperwork such as the PAR-Q and behavioural questionnaire. During this process general details of the walkers were collated such as name, age, date of birth, address, postal code, contact numbers, emergency contact numbers and whether or not they were previously active. The walker leader also took a register of all walkers.

3.2.6 Shuttle Walk Test.

The Shuttle Walk Test was designed by the Glenfield Hospital in Leicester in collaboration with Loughborough University (Singh, 1992) to test the fitness levels of Asthmatic patients. In the present study it was adapted to test the fitness level of the walkers. The test consisted of an audiotape, which plays a series of bleeps and decreases at time intervals. In which time the walker has to have completed the 10m shuttles marked out by cones. As the time interval decrease, the fitness levels go up.

The test was performed in-doors on two of the walking groups, one male and one female. A few of the individual from the latter group did the test bare footed. Total test time per person was 20 minutes or less.

3.2.7 Calorie / Step Counters

These devices measured the number of steps and calories burnt per day. It also suggests targeted calories to burn per day according to sex, height, weight and age. The counters are clipped onto clothing near the hip. The walker will record the time the counter was put on and taken off and the number of steps and calories burnt per day, the device stores data up to seven days. On a more qualitative value the motivation of the walking activator that wore the counter for two months was recorded.

3.2.8 Ethnical Approval (Appendix V)

Ethical consideration that is reasoning about what is good or bad, right or wrong, acceptable or unacceptable is central to health-based research. Rules are laid down for the project for people, who are the subjects of research. Structures and processes are put in place to ensure that this is done in an acceptable way (Owen & Davis 1997). This means that if any health-based research is undertaken which involves other human beings, the researcher must:

- Gain the full, informed consent of anyone concerned
- Undertake research without putting other people at physical risk or psychological risk
- Gain the approval of a research ethics committee

Ethics approval was submitted to the Leicestershire Health Ethics Committee and was approved.

3.3 Walking for Health, Physical Activity Intervention Framework designed for South Asian Communities

The intervention framework in Figure 3.6 is an example of delivering a physical activity intervention to ethnic minority communities. It has used the spectrum of prevention by Swift (1987) as a skeleton to build upon; the major difference compared with other physical activity interventions would be the cultural tailoring. This would be different for each community, in each geographical area, outreach and development is central in gaining the trust of the community

> *'.....this influence of culture on health acts as a positive forces, joining communities to promote community wellness, weaving cultural wisdom into health promotion...'* (Swift, 1987)

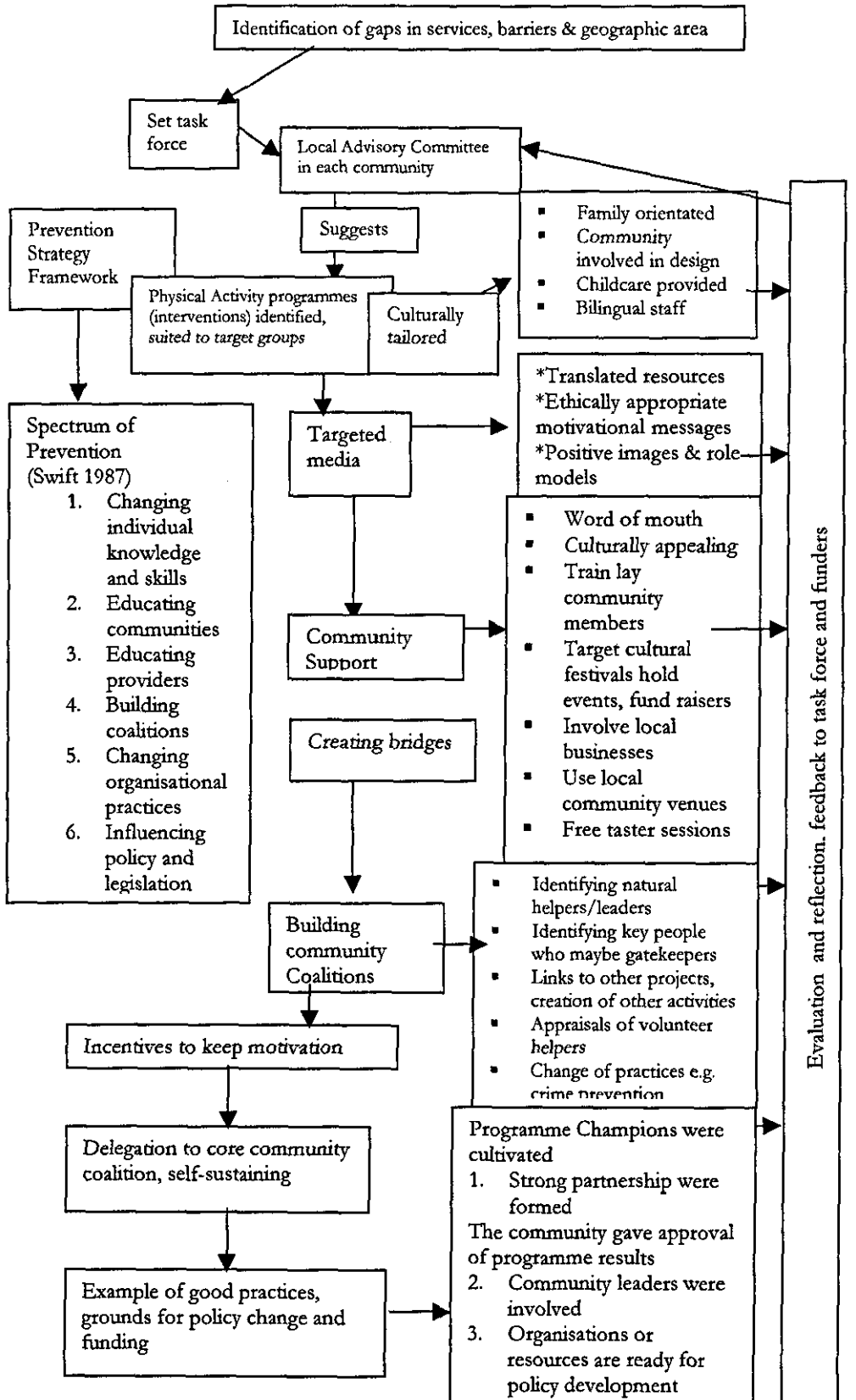


Figure 3.6 Intervention Framework (Swift, 1987)

The most important component of the framework is the cyclic nature of feedback to the task force from the grass root level. This can be an extension of the cyclical supportive environment action model (SESAME) (figure 2.5 page 36). The intervention framework can easily be related to and incorporated the action research interacting DNA spiral ladder (Figure 3.4), look would be related to the identification of gaps, think; culturally appropriate intervention and act; would be building community coalitions. Thus, the Action Research model shown in Figure 3.4 has been refined to reflect an intervention framework for the study. Figure 3.7 denotes the five main stages of the action research project.

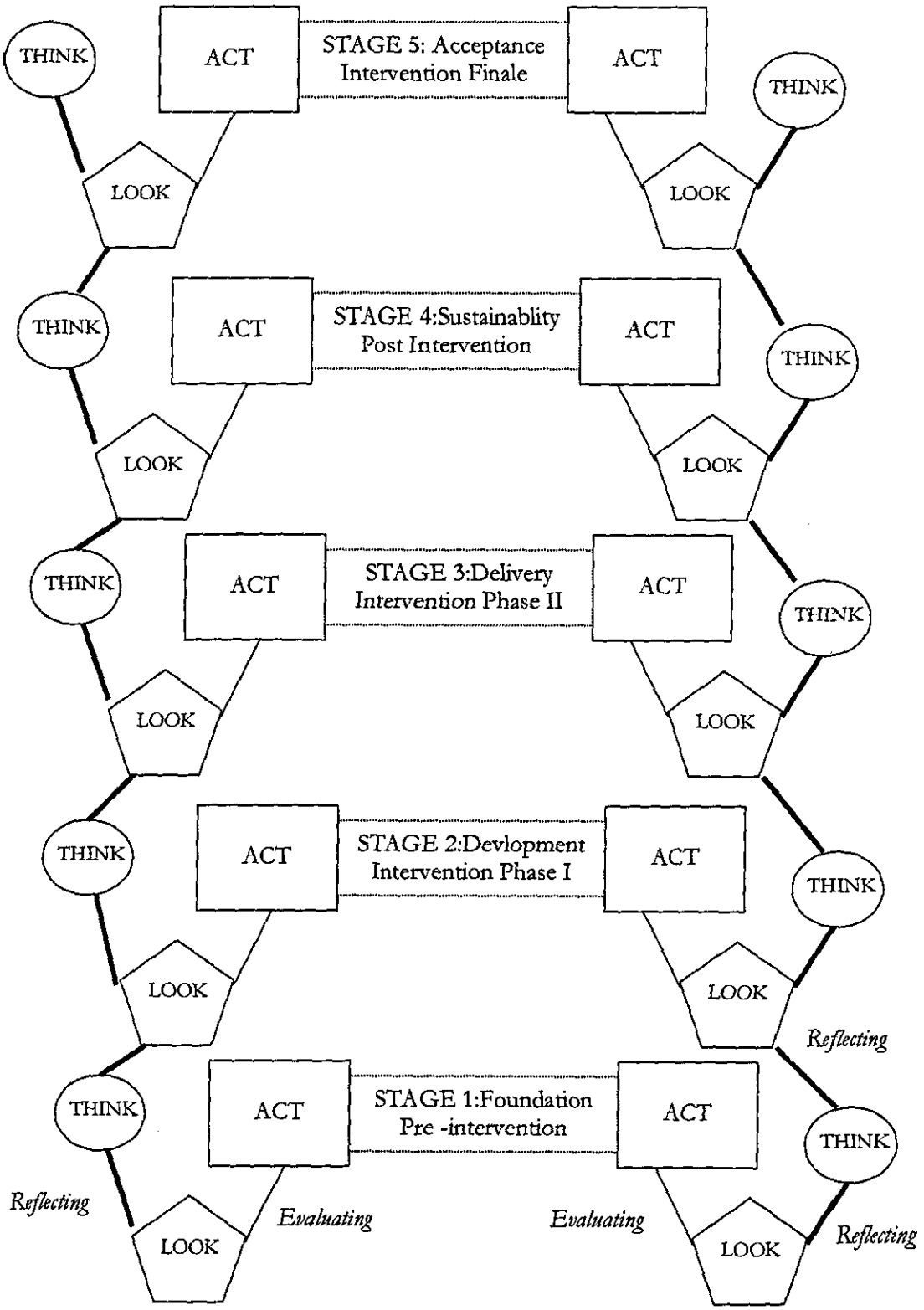


Figure 3.7 Refined DNA Action Research Intervention Framework

3.4 Summary of Methodology

The research methodology has been designed to be culturally sensitive to the targeted community. Action research and case records methodologies have been chosen, as they are practitioner focused. The action researcher is ultimately a reflective practitioner, who can implement change upon reflection, and can draw an accurate picture. The case records builds upon the action research evidence and provides information so that an un -biased judgment can be made. The two methodologies support each other and give the reader the feel of 'actually witnessing the events'. Combined into the methodology is anthropology, the study of human behaviour, via observation of the walkers and practitioners, change had been documented via a 'thick description'. The qualitative data has been supplemented by the quantitative data such as the shuttle walk tests and the walk registers, and builds a sound case for the promotion of walking for health in South Asian communities.

The proceeding result chapters four to eight have been structured so that detailed procedures can be followed. At the end of each step, reflections from the action research dairy have been denoted in grey boxes and where appropriate matched with relevant case records.

Chapter Four

Results: Intervention Foundation

All truly great thoughts are conceived by walking.

Fredrich Nietzche

4.1 Introduction

Pre intervention development and delivery a series of events occurred prior to the conception of the Chalo Chalay Let's Walk project. The initial co-ordinator/ action researcher was conducting a project for Confederation of Indian Organisation (CIO) as a Health Promotion Officer delivering the promotion of physical activity to South Asian communities. This project set the foundation for Chalo Chalay in terms collecting views on walking for health via a consultation within the targeted community. This initiated and supported the writing of the funding bid and a partnership formed. There after the success of the bid formed the geographical boundaries of the project and thus baseline information was collected. An audit and demographic study of the targeted area took place, from which planning of the project began. Thus, the look and think components of the action research DNA model were conducted via project development and support.

4.2 Method

The methodology of this particular chapter consisted of action research, the reflective diary, case records and reflections, which are denoted in grey boxes. Specific methods are discussed below, however further details can be found in Chapter Three.

Foundation

The information on the original walking activities were collected via the project officer's monthly report, meeting notes and the end of year report to the funders. Poster presentations were also made and an article written for the Active for Life Intervention's Conference.

Community Consultation

The community consultation was apart of the original Confederation of Indian Organisations physical activities project; it ran over a period of 7 months before the commencement of Chalo Chalay. It targeted 41 groups, in which all the participants were of South Asian origin. 24Follow up focus groups were conducted, and a further 315 questionnaires with eight questions were filled out at health fair in the Belgrave locality.

Baseline, Audit and demographics

These were collected during the foundation project, and via reports written on the area, in particular the Single Regeneration Budget (SRB4). Data was also extracted from the 1991 census data.

4.3 Results

4.3.1 Foundation Project Promoting Physical Activity In South Asian Communities.

Background

The promotion of Physical Activity to South Asian Communities' Project was based at the Confederation of Indian Organisation U.K (CIO) it was the foundation to the Chalo Chalay project. The CIO was established in 1975, a national organisation that aimed to serve the needs and interests of the South Asian community in particular strengthening and supporting the South Asian voluntary sector. In terms of physical activity it provided advice, support and information to South Asian communities of the benefit of regular exercise. The CIO had extensive experience in health activity having worked in many areas of health including, coronary heart disease, mental illness, and disability. As an umbrella group for voluntary organisations CIO had well established networks within the voluntary sector as well as having a clear perspective on the needs of the users of these organisations and how such needs were best met.

In April 1998, CIO set up a health promotion project focussing on physical activity in the South Asian communities of Leicester. The main aim of the project was to ensure that existing voluntary organisations that cater for the needs of many different user groups introduce physical activity within their service provision and encourage uptake by users. The project promoted physical activity as a positive means of preventing illnesses. It promoted physical activity within South Asian communities to reduce the risk of coronary heart disease (CHD), diabetes, hypertension, and obesity. The project created a

climate within which physical activity was on the agenda of all South Asian community organisations. It identified and addressed the barriers to physical activity, which the South Asian communities face.

Reflection 4.1

The CIO physical activity project was initially based in London, however the officer expanded his work to the Midlands, this was a tall order and the minimum was achieved over the two-year period. It was only when the project was based in Leicester that some suitable initiatives were achieved over twelve months. The organisation was very new to the field and a network was started from scratch.

Raising Awareness

The project undertook a consultation process, which involved the project managers of community groups followed by focus group interviews with the users. Each group had a different viewpoint to physical activity. The project had been selective in choosing a cross section of South Asian men and women from a number of community groups and were organised at; community centres, women's centres, luncheon clubs, places of worship and mental health projects throughout Leicester and Leicestershire. The participants discussed their experiences of physical activity in these groups as well as taking part in an informal semi-structured interview. Consultation meetings included a discussion on attitudes and beliefs to physical activity.

Forty-one south Asian voluntary organisations in Leicester and Leicestershire were consulted:

Women's Groups

Oshwell Mala Kugja, Bhagni Women's Centre, Sharma Women's Centre, Shanteer Stan (Bengali women's Group), Shree Lohana Majan, Ramgharia Social Sisters, Naari Lets, Belgrave Baheno.

Mental health projects

Severa Resources Centre, Vishamo/ – Visamo Carers Group, Roshni Day Care Centre, Mental Health Shop, Adhar.

Community Projects

East-West Project, Wanza Community Centre, St Saviours Neighbourhood Centre, Wesley Hall, Bangladesh Youth & Cultural Shomiti.

Religious Establishments

Ramgharia Gurudwara, Shree Ram Krishna Centre, Santan Centre, Gurunanak Gurudawara, Sikh Community Centre.

Elderly Projects

Stoneygate Asian Drop in Centre, Navjivan Day Care, Sevak Samaj, Santan Manvata Day Centre.

Support Organisations

Asian Marriage Counselling Service, Charnwood Racial Equality Council, Sahara Helpline Suno Sunaya - Centre for Deaf, Nirankari Advice Centre, Project Dil, Coping with Cancer, Ayurvedic Herbal Clinic.

Charities

Maruti Trust.

Sport / Physical Activity Specific

Asian Soccer Academy, Virndavan Project, Regal Arts Badminton Club, Leicester Nirvana Youth, Belgrave Sports Association.

Most groups consulted with had only a little understanding of what physical activity was and the health benefits derived from taking part. A few groups that were active in taking initiatives up did have an idea of what physical activity was and what the health benefits were. Managers and workers felt that they were overloaded with health initiatives from a variety of voluntary and statuary organisations. Many groups did not have the staff or the time to organise physical activity initiatives despite the willingness on the part of members to be involved.

Some women taking part in the consultation believed that housework was a form of physical activity but did not understand that this would not raise their heart rate if not done briskly enough to derive any health benefits.

The consultation meetings were also used to impart health promotion messages around physical activity, which users could relate to. For example using the stairs instead of lifts, walking instead of using cars or public transport, walking the children or grand-children to school, parking the car further away in supermarket car parks and not on the doorstep, gardening, cultural dancing and praying as a mobility exercise.

The users were receptive towards these ideas but less so to activities such as swimming, exercise to music, cycling and activities taken at leisure centres because they felt that there would be language problems, no single gender sessions, high cost, lack of transport

and a lack of company. Many women felt unable to do any sort of vigorous exercise, which would increase their heart rate due to their mobility and disability.

The activity co-ordinators seemed to be under pressure to include physical activity on their agenda but did not have the resources or information on hand or the expertise to carry out these activities. Some groups used volunteers to undertake light exercise classes, however, these volunteers were not qualified which made the activity dangerous.

Active Outcomes

The project worked closely with South Asian groups establishing itself as a key player in the promotion of Physical Activity within South Asian communities. It had become clear that there was a need for a project such as the one managed by CIO to undertake work of this nature.

The project had been successful on taking on board the results of the consultation and making change via unique health promotion strategies at a community level, along side health promotion initiatives which, included:

- Two major health events

  Family Health Day at St Saviours Community Centre in Leicester

  Launch of the Physical Activity & Exercise video by Padminni Kolapori

Both these events had press releases at the local radio stations and local paper. These events allowed local communities and other health professionals to experience exercise taster sessions from a traditional and modern point of view.

- Stalls: Belgrave Mela, Naari Letts, World Mental Health Day, ethnic minorities conference Birmingham
- Physical Activity and health eating sessions delivered to 33 community groups from the voluntary and statuary sectors.
- The project had acted as facilitator between grass root level groups, statuary organisations and national initiatives. For example, to allow professional communications between what is required from the community to training the trainers (i.e. fitness instructors) to national initiatives like Health Improvement Programmes, Primary Care Trusts, Health Action Zones, and Healthy Living Centres.
- It had built up resources and consulted with the Health Education Authority and British Heart Foundation to produce more quality South Asian material to address the lack of appropriateness of these resources. The project had produce a leaflet,

which, outlined the health promotion initiative taken on by the CIO and also had helped to promote the Exercise by Padmini Kolapuri Video and leaflet, funded by the Department of Health.

Preparing to Change

The project had created a climate within which physical activity was on the agenda of selected South Asian community organisations. It had enhanced personal skills and self-esteem of people in the community to stimulate community participation in relation to physical activity. The project had identified and tried to address the barriers to physical activity paying particular attention to cultural, social, economic and environmental issues. It explored mechanisms for achieving collaborative working partnerships between professional groups and between people from statutory, voluntary and community sectors. Guidance was offered to develop community initiatives concerned with physical activity.

The process of change

Over a 12-month period the project had taken on a community strand in Leicester and Leicestershire through a process of change as shown in figure 4.1:

- It worked with 33 South Asian community groups offering advice and information on physical activity and how groups should develop schemes for their users.
- It worked closely with staff at voluntary sector projects providing training and advised on appropriate initiatives.
- Early research indicated that walking was an acceptable form of physical activity to the South Asian community and with women in particular.
- It developed a strategy for the promotion of physical activity amongst South Asian communities, via the consultation process with the voluntary and statutory sector.
- It raised awareness of the importance of physical activity, and what constitutes moderate activity and what facilities are currently available.
- It provided information to individuals on any training opportunities for on going professional development e.g. South Asian physical activity instructors geared specifically for the South Asian community.
- It provided information to keep individuals and groups informed of current research, current developments and success stories to maintain enthusiasm.
- It explored examples of good practice from projects in other areas.

- It generated appropriate local exercise alliances and assisted in developing physical activity in South Asian communities in Leicester and Leicestershire.

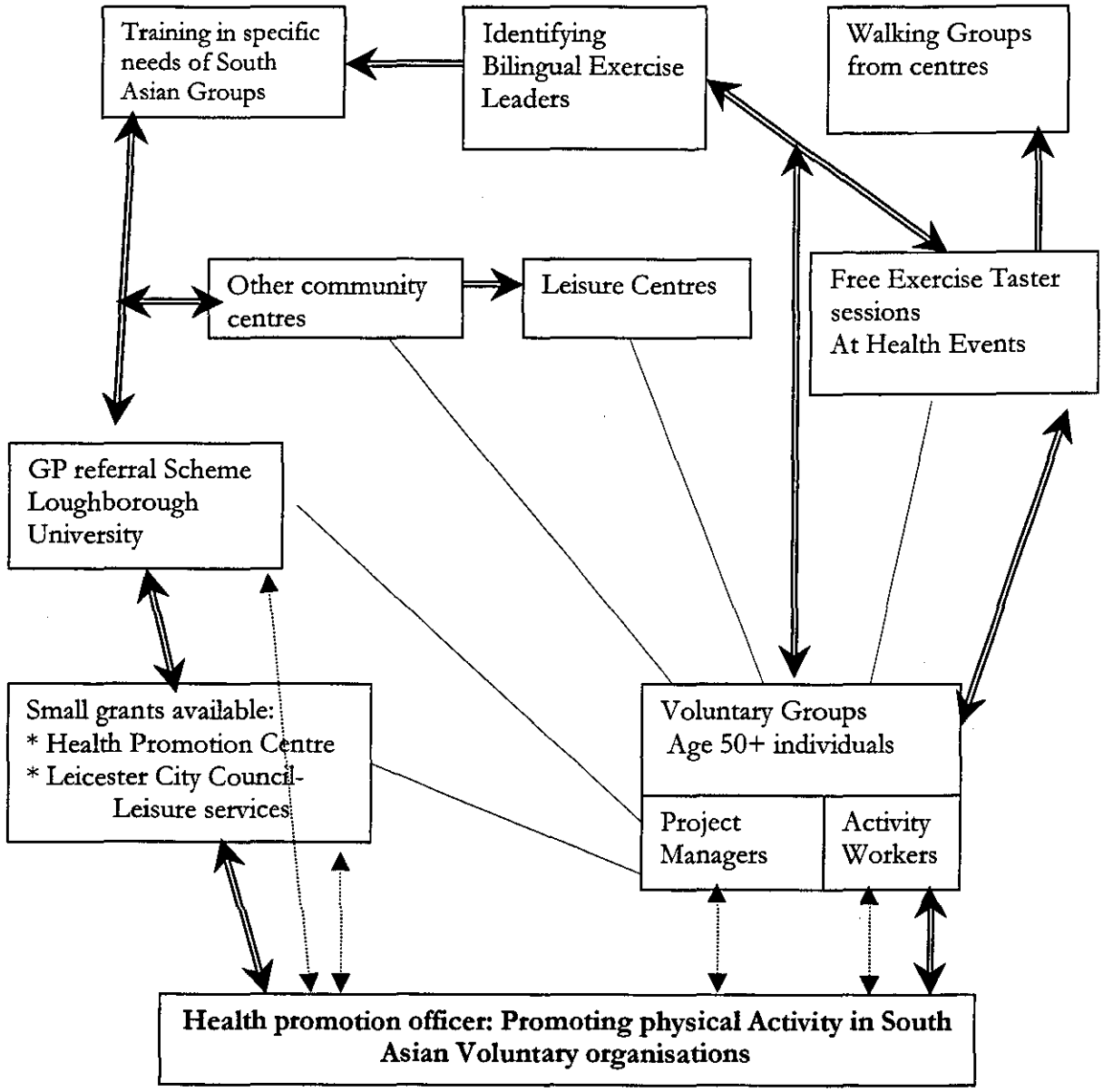


Figure 4.1 The Process of Change

Key:

Advice given

Contact made

Initiated change in partnership

Maintaining Change and Partnerships

The project had played an important part to set up links within the community and had also been involved in initiating a number of physical activity projects. It strengthened these links and developed new ones. The project had successfully set up a database of

qualified instructors that were bilingual and were available to take on specialised physical activity sessions in community settings. This informal working relationship between the instructors and community centres had worked well, but there was a need for more female South Asian instructors. To address this problem the project worked in partnership with the Health Promotion Centre, the Exercise Association and the Central YMCA to set up a specific course which attract more South Asian men and women into this field of work.

The project tied in with other aspects of health and made invaluable working partnerships with other health professional's and projects. These included; Leicester General Hospital Dietetic Department, Project Dil in Primary Care settings, Exercise On Prescription Scheme - Loughborough University, Leicestershire Health, Health Promotion Centre, Health Promotion Unit -Leicester City Council and more importantly a number of South Asian voluntary organisations. The supporting networks helped in pushing initiatives along and avoided duplication of work. The project played an active role in the mapping services in the area.

The project in the short time had set a foundation on which physical activity initiatives could build upon. The project had clearly identified barriers to physical activities faced by South Asian's in Leicester and Leicestershire, through questionnaires and interviewing, this included;

- A lack of facilities or appropriate physical activities for South Asian women especially the age 50+.
- Most activities that were running had a very strict dress code consequently the women would not participate or pursue the ideas of exercise further. Leisure and community centres could address these problems via link workers from the South Asian community.
- Cost was a major issue, and was in the process of being taken up by statuary bodies and other funders.
- A lack of South Asian instructors that could speak one of the five South Asian languages, which was addressed through a working partnership.

The only physical activity that elderly South Asian men and women were keen on was walking and gardening. Walking groups were set up successfully from community centres and voluntary groups but were dependent on the weather and alternative winter activities needed to be identified.

Video Launch.

The key component of the project was a video launch of 'exercise with Pandmini Kolapori' a well known Bollywood actress who was endorsing being physically active. At the launch a number of demonstrations of various physical activities were given including dance performances. Partner organisations had displays up and information available. Five hundred people from the South Asian community attended. The event was to be remembered by all, and set in motion a similar launch event for the walking project.

Reflection 4.2

The physical activity in South Asians project was an exciting project; it involved health promotion, thus created a lot of enthusiasm. However it was not easy, not having a voluntary sector background, it was a steep learning curve, however through logical thinking, the project achieved its goals, but it was a 'one woman band', as CIO lack the team in Leicester. The Leicester office was having problems in team building and administration difficulties. This arose from the relationship between the manager and the administrator, who were hostile to each other this precipitated through the team. It produced difficult working conditions. The project itself was challenging and rewarding but the environment was not. Thus, thoughts were to leave at the end of the 12-month contract. Simply because the team around were not capable of mentoring and providing support: they were not of a health promotion or physical activity background. When writing the 6 monthly report of the project, it was realised how much was achieved in such a short period, and if a supportive environment was created a lot more could have been achieved. At this point leaving CIO seemed the only productive way to move forward. The opportunity arose to build links with the Health Promotion Centre via the Exercise to Music course, which was undertaken. However time to do this as apart of the training at CIO was not welcomed.

4.3.2 Community Consultation: Views on Walking

Initial walking Activities.

Before the walking for health bid was written, a community consultation was carried out via focus groups with stakeholders. This was initially done within the Confederation of Indian Organisation's (CIO) Physical Activities Project. The groups consulted with (page

101) were in agreement that walking would be a suitable option to increase physical activity in their lifestyle.

Upon meeting with a colleague, a Health Promotion Officer, mentioned how she ran walking groups in her previous job:

'.....they are still happening.....you need to take water bottles, perhaps glucose tablets, and if you have one a mobile phone....'

Thus, the idea of walking for health came about. Walking groups seemed ideal as it addressed a number of barriers that were flagged up during the focus groups. At first it seemed a simple, no-cost effective way of promoting physical activity, and thus was marketed heavily by the CIO foundation project in this way. To test the idea, a mental health project in the Belgrave area of Leicester, Savera was chosen. Good links were already in place with the manager, workers and users of this organisation. Previous work had already taken place in terms of promoting the active for life message of 20 minutes of moderate activity three times a week. A video was shown and a question and answer session was held. The group in the first instance was interested in swimming, but this was rather difficult to organise for women only sessions. Walking was suggested, but was not received too well. In consultation with the activity co-ordinator, it was thought to give the walk an incentive; a shopping trip to Beaumont Leys Shopping centre in Leicester was organised.

The walk did not go to plan, once the users reached the shopping centre they went off their separate ways. It was not as easy as originally envisaged and a lot more thought and planning was required. However, the activities co-ordinator thought it went well, as the users did not go out at all or walk at all, so just by walking around shops and browsing increased their activity levels. Above all the users enjoyed themselves; this really shaped the future walks, as enjoyment and fun was central to the whole process.

Reflection 4.3

The source of the idea was the health promotion officer who had previously set up walking groups in her previous work place. In June 1998 at the launch of the Heart Health Strategy, contact was made with the director of Health Promotion, who was the health promotion officer's husband. Maybe there was an influence there, but the director was keen to promote walking, and thus links were made.

Consultation

The consultation period ran for six months between April 1998 and October 1998, targeting 38 South Asian voluntary and religious groups. At each session a questionnaire was distributed and collected at the end of each session. If the participant could not answer in English they were translated and then transcribed in English. Follow up focus group interviews were held with a further 24 groups, in English, Gujarati and Hindi. In addition questionnaires were filled out at the Belgrave Health Mela (August 1998) at the Belgrave Neighbourhood Centre in Leicester. This was a special event held for the South Asian community of the Belgrave locality, 5000 people attended. In total 315 people were interviewed and were asked about their views on walking initiatives. Eight of these questions on the questionnaire were specifically on walking;

1. Do you see walking as a physical Activity? Yes/ No/Unsure
2. Do you think walking can derive any health benefits? Yes/No/ Unsure
3. Do you do any walking? If yes, how often do you walk and at what intensity?
4. Do you know of any local walking initiatives in your area? Yes/No
5. What would encourage you to walk? Prompts: Social/ Health/ Environment/ Cheaper way to travel/ Reason to walk
6. What stops you from walking? Prompts: safety/ not enough scenic polluted free zones/ company/ time
7. If we were to provide you with the opportunity to walk in a pleasant surrounding in a group would you take these up?
8. Additional comments

Characteristics of Participants

A cross section of the South Asian community was taken from Leicester and Leicestershire as shown in table 4.1 The sample represented views of males and females of all ages, and the sub- groups of the South Asian community. This is a true representation of the communities residing in Leicester and Leicestershire.

Table 4.1 Characteristics of 315 participants involved in consultation

Age	All	Male	Female	Gujarati	Pakistani	Punjabi	Bengali
<16	21	5	16	9	5	5	2
17-24	35	8	28	15	8	7	6
25-35	45	14	36	25	11	10	4
35-45	60	25	46	31	13	15	12
45-55	28	13	23	13	7	10	6

55-65	30	18	24	17	8	15	2
65+	48	19	40	23	13	16	7
Totals	**315**	**102**	**213**	**133**	**65**	**78**	**39**

Walking as a Physical Activity

From table 4.2, 72% saw walking as a physical activity. More females than males saw walking as a means of physical activity. Males were shown to be unsure than females, overall 25 % were not certain whether walking was physical activity, and only 3% thought it was not.

Table 4.2: Do you see walking as a Physical activity? Yes / No/ Unsure

	Participants		Male		Female	
Yes	72%	(227)	14%	(43)	58%	(184)
No	3%	(8)	2 %	(6)	1%	(2)
Unsure	25%	(80)	17%	(53)	9%	(27)

The consultation showed that most South Asians in Leicester thought that walking could be a physical activity and thus can be promoted in this way. Of more concern were the 25% who were unsure, this provided a clear indication that education and raising awareness is required especially with men. The 3% who did not think it was a physical activity, were from a background of sport, and did not believe it could raise the heart rate enough to give health benefits.

Walking and Health Benefits.

Over half of the participants interviewed thought that walking derived health benefits, however 32% were unsure and 9% believed that it did not as seen in table 4.3. More males than females thought that walking was of no benefit to health. Being unsure was equally distributed between the genders.

Table 4.3 Do you think walking can derive any health benefits? Yes/No/Unsure

	Participants		Male		Female	
Yes	59%	(187)	15%	(47)	55%	(173)
No	9%	(28)	10%	(30)	3%	(11)
Unsure	32%	(100)	8%	(25)	9%	(29)

Over a quarter of those interviewed were not sure if walking would provide health benefit this would need to be addressed though appropriate educational and promotional campaigns and through increased opportunities. Of more concern was the 9% who

thought walking would provide no health benefits, this group would probably require further firm evidence.

Current Walking Activities.

Almost all the participants did some form of walking, 82% walked and 18 % did not. South Asian males were more likely to walk than South Asian females as seen in table 4.4.

Table 4.4 Do you do any walking? Yes / No

	Participants		Male		Female	
Yes	82%	(287)	28%	(89)	31%	(98)
No	18%	(58)	4%	(13)	37%	(115)

Of concern was the lack of South Asian females walking; this may be addressed via increasing walking opportunities for this group and providing single gender sessions.

Intensity Level

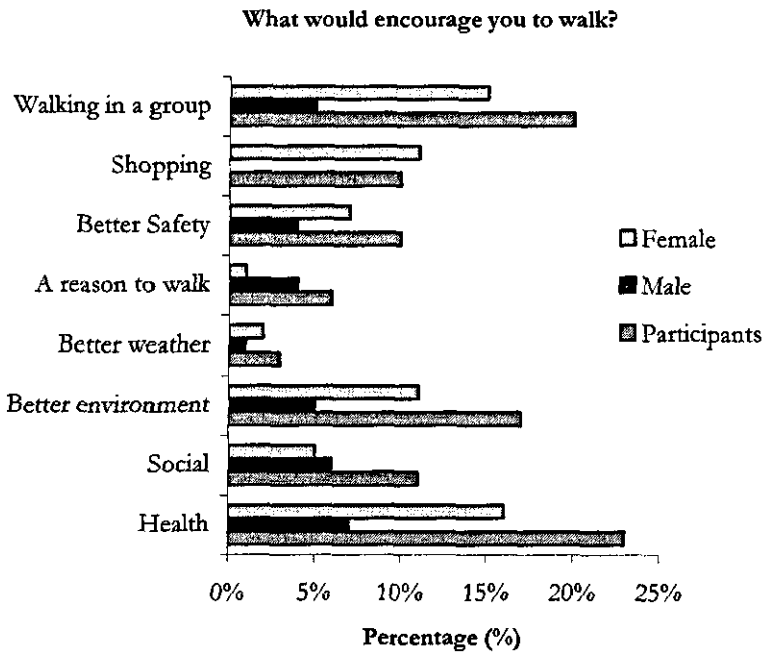
Most of the walking done was of an incidental nature, and was done daily that is walking during shopping, going to the post office, housework, and taking the children to school which was of a low intensity. A small percentage walked at a moderate level, and a couple of participants mentioned hill walking at a high intensity, on the whole all felt that they walked everyday, but not at a very high intensity.

Participation in Local Walking Initiatives

Participants were asked if they knew of any local walking initiatives in their area. All answered no to this question, none of the interviewees questioned had heard of local walking initiatives, which they could join.

Incentives to Walk

The incentives that would increase walking in South Asians in Leicester & Leicestershire were: good health at 23%, walking in a group at 20% and a better environment at 17% as shown in graph 4.1. Others felt that it was a sociable activity and they enjoyed walking with friends. 10% of the participants did not feel safe to walk and improving things like lighting, having more police officers on patrol and walking with someone would encourage them to walk more. Having a reason to walk like shopping would also motivate them.



Graph 4.1 What would encourage you to walk?

Some of the participants already walked and commented;

'I love walking already'.

Walking would be more of an option if there were more;

'Good places to walk and *nice scenery'.*

Cleaner pavements that were level were of particular importance to the disabled and wheel chair users. Having the company and friends to walk with was another important factor; participants really liked the idea of walking in groups. A few commented how the weather in England did not permit them to walk:

'It gets to dark early, and it rains most of the time plus the cold',

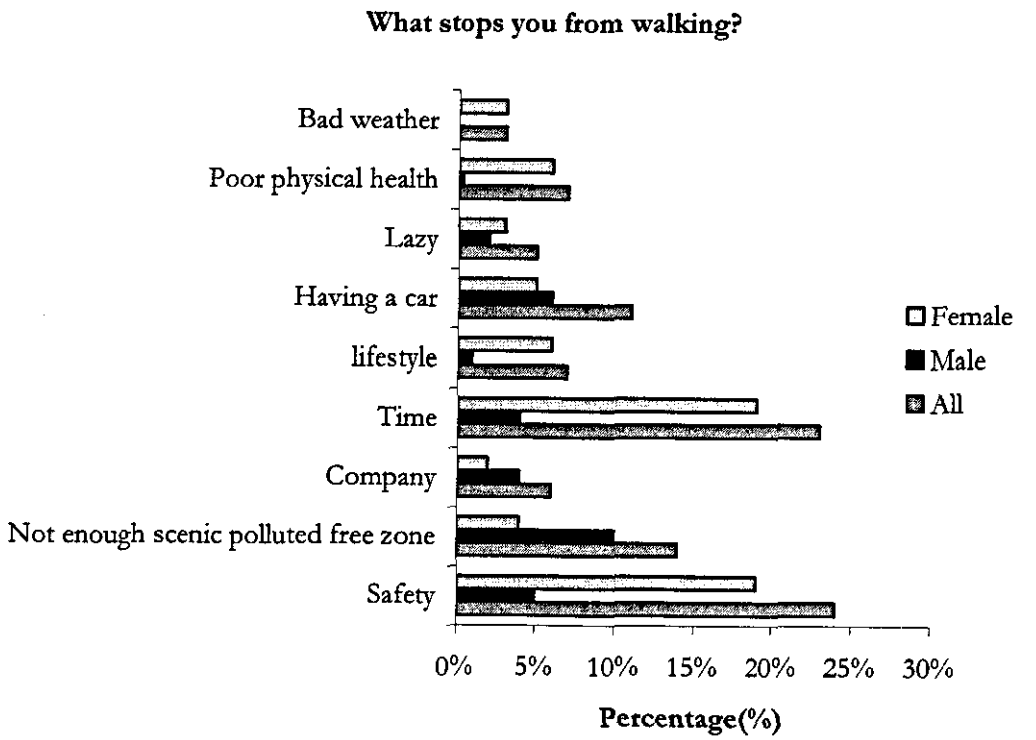
Putting on extra clothing and carrying umbrellas was not appealing. Also having more time on their hands would encourage them to walk more. Another mentioned about having hard-hitting health campaigns, which could motivate them to walk:

'Health scares often change peoples behaviour'.

One diabetic mentioned how she knew that walking would help control her condition, but there were not any walking groups, which would cater for her needs. She would of preferred walking in a group where people knew of her condition just in case anything happened to her, perhaps having special walks for diabetic sufferers. Furthermore having levels of walks were noted, people felt that they would not be able to walk very fast and the group should be of a slow pace.

Barriers to Walking

Safety and time were the two main factors, which stopped the South Asians of Leicester and Leicestershire from walking. 24% raised concerned about the safety in their respective local area and 23% said that they would like to walk but just did not have the time due to their busy lifestyles. Other barriers, which stopped people from walking, included; were not enough scenic pollution free zones at 14% and owing a car at 11% as shown in graph 4.2.



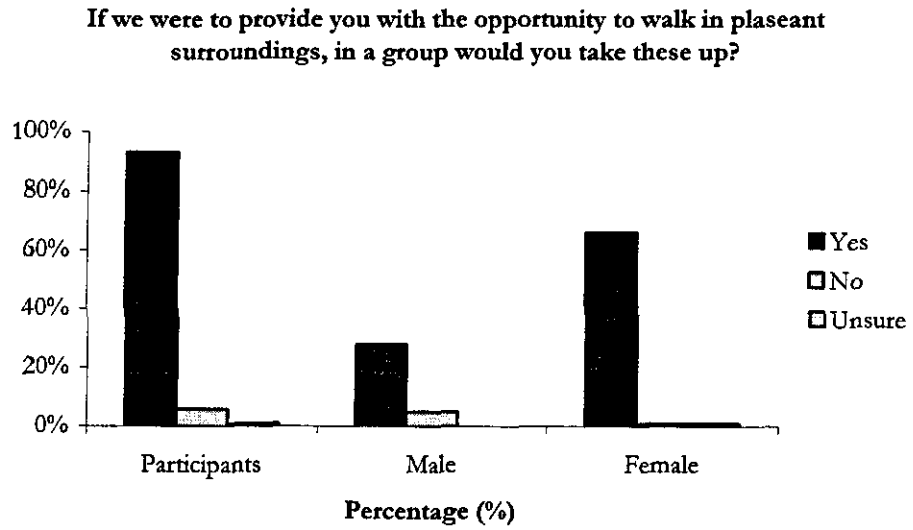
Graph 4.2 What stops you from walking?

Weather was a barrier to walking; the cold and the rain deterred people from going out. If the weather were warmer and sunny people would endeavour to walk more. General health was also a barrier if people felt unwell they lacked the motivation to do anything. Together with bad health people did not feel that their physical health permitted them to walk. Most of the participants did incidental walking like shopping, and picking up the children. They also felt that if transport was provided to take them to 'nice places' this would encourage them to walk more.

Busy lifestyles were often mentioned a combination of busy career's, family responsibility and owning a car were major issues. The disabled participants felt that the pavements in the local area were too difficult to manage and the lack of pedestrian crossings with correct signalling made it impossible. Others just did not feel motivated enough, and felt tired after a day's work, others honestly admitted to being lazy. Major concerns were raised of the safety of local areas like parks, previous attacks on the elderly was a major deterrent to walking, and walking alone in the dark was a definite no.

Opportunities to take up Walking

If the opportunity of walking in a group in pleasant surroundings was offered almost all of the participants would take walking up, 93% answered yes, 6% answered no and 2% were unsure as shown in graph 4.3.



Graph 4.3 Taking up walking opportunities in pleasant environments

There were conditions to taking up these walks;

'Not in the evening or in the dark, and walking in group'.

Time commitment was also an issue, as long as it was flexible and they did not have to attend every week. The length of walk was also raised short walks were preferable. Others said that if the walking had an activity encompassed within it they would give it a go. Making walking a family event was also important; mothers felt that they really would not want to leave the children out. In general, the participants felt that they would take up walking opportunities if they catered for individual needs.

Overall people would like to see more pleasant environments, and quiet areas where it's less crowded and no pollution, a *'healthy environment'*. There was an issue with walking in Belgrave locality of Leicester due to the traffic and the pollution it caused one of the male participants aged forty said;

"Walking in Belgrave could knock 10 years of you life!"

4.3.3 Creation of the Walking for Health Bid: The Asian walk for Life

The Confederation of Indian Organisations (CIO) Physical Activities Project developed a range of physical activity related opportunities for South Asian communities. This included a range of groups from elderly to the young, men and women and the disabled. The twelve-month community health promotion project by CIO was established to meet the needs of the South Asian community in Leicester. It was recognised that a number of barriers stood between the community and the facilities available. For these reasons a number of exercise programmes were not suitable for the South Asian users especially South Asian women. Quite early on in the project alternatives were identified and walking seemed to be the most appropriate, simple and economical way for people to exercise. This was the beginning of the walking initiatives taken on by the CIO. The work had been carried out within the context of the county wide physical activity strategy of Leicestershire Health. The Walking for Health Bid: The Asian Walk for Life was to help continue the walking initiatives commenced by CIO's physical activities project.

Lessons from initial walking groups

The project was not just about setting up walking groups in localities, but involved making contact with voluntary groups and building up trust of the users. The approach used was to first, meet with the project mangers and activity co-ordinators to establish current attitudes and whether they would be prepared to be trained as walk leaders to continue the walking groups after they had been set up by CIO. A talk was also given to the users to highlight the importance of physical activity in the prevention of Coronary Heart Disease. This was followed by an informal discussion on what would be suitable forms of physical activity. Once they felt confident, local walking groups were set up, so they could also get to know the local area they lived in and perhaps endeavour to walk more independently, but safety from criminal activity was a major issue. The groups progressed on to walking in places of interest and parks and brisk walking for health benefits were introduced. From these initial walking-groups further barriers to walking

were identified one of which was 'not enough nice areas to walk in and not enough pedestrianised zones'. This was when the three-year funding from the British Heart foundation and Countryside Agency was identified for the Asian Walk for Life project later named 'Chalo Chalay' which literally means Lets Walk!

The Bid

In July 1998 the Director of Health Promotion at Leicestershire Health, called a meeting with various organisations which included Leicestershire Health, Health Promotion Centre (Fosse Health NHS Trust), Leicester City Council various departments: Health Promotion Unit, Parks & Sports Services Division, Arts and Leisure Department Traffic Group, the Corporate Strategy Regeneration unit, the Environment and Development and CIO to discuss funding available from the British Heart Foundation and Countryside Agency. The funding was for 45 thousand pounds over a period of three years, which would, be match funded by its partners that is Leicestershire Health, thus 90 thousand pounds over three years would be available. Prior to this meeting attendees were asked to suggest a few ideas. From the outcomes of this meeting the Director of Health put the bid together.

A short report on CIO initial walking initiatives was forwarded on with some of the barriers faced and future ideas of promoting walking to the South Asian community these included;

- The lack of appropriate services for the South Asian community that is language barriers, i.e. sign reading.
- There were not enough rest points on route. These needed to be targeted to the elderly and disabled who need to rest on benches and need access to toilets and drinking fountains.
- A lack of expertise in voluntary organisations, they do not have the resources or the time to cater for every initiative, that is the activities co-ordinator would have to take time out to be trained to run walking groups. Also they need appropriate qualifications like First Aid and possibly a RSA qualification in walking.
- Health professionals needed to co-ordinate all health messages so not to confuse the users and not to 'overload' their learning or activity capacity.
- There is a need to train specific people to meet the requirements of walking groups paying particular attention to cultural needs and motivating people to 'get up and go!'
- Safer walking routes needed to be considered:

- ❖ Slippery surfaces
- ❖ Traffic
- ❖ Crime
- ❖ Sufficient time at pedestrian crossings to cross
- ❖ Toilets on route
- ❖ Directions either signs or a group leader who knows the routes, communities and area
- ❖ Signs need to be in South Asian languages and of an appropriate design so that all disabled people can read them.
- ❖ Pleasant places to walk in
- ❖ Creating a good/ welcoming atmosphere relating to cultural needs
- ❖ More pedestrian zones
- ❖ Giving reasons to walk, leisure and/or health.

- A need to build up effective resources in South Asian languages, also specific examples of the benefits of walking that is health, mental health, confidence and being independent.
- Co-ordinating everyday activity into walking e.g. shopping, going to day centres, visiting places of worship etc.
- Incentives to walk maybe relate it to physical activity in the workplace.
- Training for walkers and leaders on appropriate clothing, footwear, sunscreen etc to be aware of medical conditions e.g. asthma, hay fever, and diabetes. To carry water bottles, glucose tablets and mobile phones.

Reflections 4.4

A colleague mentioned that it is often best to always stand on the ground that;

'I don't speak for the whole community but in my opinion . . .'

There was an expectation that South Asian workers knew how the whole of the Asian community felt this is far from true. Each are there own individuals, and how can a worker represent all of their views, workers can only go by what their personal experiences are. In the same way that the Scots or the Irish defend themselves! There were several organisation represented at this initial meeting. 12 organisations were in attendance, and only CIO, had some walking initiatives up and running.

The walking project involved pedestrianising the area and making available more walking, pollution free environments. This would include a face-lift to the riverside and signposts in various South Asian languages. CIO were involved with setting up walking groups, and the GP referral scheme. This was an 'exercise on prescription scheme' whereby the GP refers a patient who might be suffering from diabetes, blood pressure, CHD etc or are in the process of rehabilitation and they would benefit from physical activity. This initiative was to provide the South Asian community with a choice of suitable activities rather than just the leisure centre. Qualified instructors would run these specialised walking programmes.

Case Record 4.1

Walking for Healthier Asian communities .A Leicester City Project Proposal.

Background.

The city of Leicester faces considerable health challenges as it moves to the new millennium, not least because of its multicultural diversity. The prevalence of CHD in Leicester's Asian population is forecasted to rise in the next century due to the ageing population. Health care budgets are unlikely to keep pace with demand and the York Health Economics Consortiums have suggested that for Leicester the answer lies in a major reduction in risk factor levels in the community. Achieving higher levels of physical activity, especially in our Asian population, is a key building block of our health strategy.

Project Context

Leicester's Health Partnership is supportive via:

- Leicester's status as the first 'Environment City' reflects its commitment to planned sustainable development.
- Long histories of partnership work at strategic and policy level on health and quality of life issues especially between health and local authority departments. This is demonstrated in major planning documents such as the transport policy for Leicester and Central Leicestershire, Local Agenda 21 Action Plans, Regeneration and Accident Prevention Strategies etc.
- Local Agenda 21 Action Plans include the development of a formal pedestrian strategy to identify a network of pedestrian routes, urban traffic control systems to

provide pedestrian priority and creating and protecting the extensive network of parks and open spaces.

- The transport plan places central importance on inter-agency work to achieve an integrated transport system, giving high priority to investment in public transport, cycling and walking.
- The Heart Health Strategy for Leicestershire, Leicester and Rutland represents a major long-term inter-agency commitment to meet he diverse needs of our population and to target inequalities.
- The Leicester City Council, Health Authority and other partners are committed to become a Health Action Zone and have responded to the invitation to bid (since then Leicester has become a Health Action Zone)
- Leicestershire Health has become a trail site for Department of Health initiatives to prevent CHD in the Asian Population. This will be of considerable support to the Walking for Health project particularly with its work with primary care teams.

Leicester's Asian Populations- needs, issues and constraints.

- The exercise starting point for the Asian communities is very low about 50% of Asian women are sedentary compared to 24% in the general population.
- The Asian population in Leicester is of significant size and is concentrated in distinct areas of the city. In Trent, the top 9 electoral wards with the greatest proportion of ethnic minorities are all to be found in Leicester and range from just under 50% up to 82% in the Spinney Hill ward. Within this the Belgrave area of the city has not only a high percentage of ethnic minorities but also a considerable concentration of Asian shops and businesses.
- The Asian population is not homogeneous but is typified by very clear patterns of community networks and groups, religious networks and extended families.
- Although there is no significant cultural or religious reasons for not exercising there may be important cultural and religious reasons that affect the manner of participation. There would appear to be belief systems about physical size and strength, concerns about breathlessness, sweating and the level of exertion that may affect the exercise message.
- There are few role models relating to exercise for South Asian communities.
- Only 16 % of Asian workers walk to work.

- Language, fear for personal safety, racism, dress code and footwear, lack of toilets, street furniture and a lack of attractive urban environments may all prove to be barriers to Asian people participating in walking programmes.

Whilst most of these are negative in their potential effect the more positive beliefs and attitudes include:

- There is a good level of awareness regarding the importance of physical activity for health.
- Media (both television and press) are important for establish role models
- There is a demand for more information
- There is high level for registration with GPs. It would appear that local medical staff are influential and highly regarded in their communities.
- It is reported that people are motivated by enjoyment, social benefits, a desire to look good and to be a role model for their children.

Project Aim

'To promote higher levels of awareness of the health and social benefits of walking and to increase the participation in daily walking activity by Asian adults through increased walking opportunities, community action and improved environments.'

Objectives

1. To increase by at least 10 % the percentage of Asian adults who know the health benefits of regular walking
2. To increase by at least 10 % the percentage of Asian adults who report walking at least 30 minutes duration, a minimum of 3 times a week.
3. To increase by at least 20 % the percentage of Asian adults who have defined CHD, in the target General Practices, who can walk a mile in 10 % less time after a prescribed walking programme.
4. To increase the length of pavement and pathway that has been improved and the number of safe crossing points in the study area as a part of a traffic management scheme.
5. To increase the amount of sign posted walks in the designated area year on year.
6. To increase by at least 5% the number of community groups involved in walking programmes
7. To increase the number of exercise/walk leaders active in the designated area.

8. To increase by at least 10 % in any one year to the broadcast time and column inches devoted to walking for health
9. To increase by at least 25% the amount of information available on walking for health and local health walks.

Action, Priorities and Methods.

The Action Plan had three connected strands

1. Promoting community walking action: The focus will be to promote walking to community groups, community facilities such as community centres and luncheon clubs, shopping areas, schools, temples, mosques and centres around which walks and walking is organised. This will involve 'spiders web' approach with circular walks being organised from such centres and walks to and from centres connecting where people live. This element will focus on social walking rather than lone walking and will promote 'budding' approaches, amongst neighbours, friends and family. The strand will include the recruitment of walking leaders and community links, walking to school initiatives, information and media programmes, links to festivals and winter alternatives. Target population will include adult especially families, older adults and women. Subsidiary targets will include religious leaders, community activists, leaders and community centre management committees.
2. Developing environments and walking facilities: the focus of this element is to make the links with future development priorities within transport and regeneration plans, which seek to improve the environment in favour of pedestrians. These would be long term major capital commitment; projects like the Belgrave Riverside Park, Belgrave Corridor project and Belgrave City Centre pedestrian route. Improving access, footpaths sign posting, street furniture, safety, pedestrian priority and information and marketing.
3. Promoting individual walking activity: this element is the smallest of the strands and will feed off work to be developed as part of the Asian CHD prevention programme. The focus will be on the promotion of walking as part of the lifestyle change management programme through approximately 30 General Practices. The main target group will be post coronary patients or those with diagnosed CHD. Walking via community groups will be apart of a modified exercise referral scheme with exercise leaders being linked to practices. Will attempt to recruit GP's exemplars.

Consultation, feedback and needs assessment

The project was centred a round a community development model consultation with community groups being a central activity of the steering group. The intention was to involve communities in needs assessment by defining both the problems and barriers to walking as well as the opportunities and solutions. An essential element of the process was to use the local media and publication of reports to provide feedback to the communities in terms of progress, results of consultation and celebration of success.

Evaluation.

A sub group of the steering group will be set up to develop and carry out evaluation programme. This will promote learning and will involve a mixture of quantitative and qualitative methods. Providing regular feedback to participants, communities and funders. This process will facilitate sharing experience.

Project management

It is proposed that a multi-agency project steering group will manage the project. This group will be responsible for strategic and operational development of the project and will be accountable to the British Heart Foundation, Countryside Agency and partner agencies.

Finances and Resources

Given the time scale of this project the proposal will require maximum funding available from the BHF/CA, which would be matched by resources in kind:

- Leicester City Council planned investment in the above structural work
- Heath promotion staff in the heath promotion centres, Heart Health programme, health promotion unit of LCC, the Asian CHD prevention programme.
- Leicester City Council staff in Parks and Sport services, Arts and Leisure, Sustainable Transport Team.
- Staff at Confederation of Indian Organisations
- Health promotion materials budget and commissioned Asian local radio programmes.

Success of Bid

The bid was short-listed to the next stage; an interview with the British Heart Foundation and Countryside Agency. Three people attended the Director of Health Promotion, Team Leader from Leicester City Council Traffic Group and Health Promotions Officer from CIO. A short presentation was put together. The interview panel consisted of representative from Countryside Agency, British Heart Foundation, a Health promotion Specialist- Wiltshire, Dr William Bird- GP Sonning Common Walks and Loughborough University. The interview went well, and the partnership was successful on securing the 90 thousand over a three-year period. CIO who helped secure the funding was to host the Asian Walk for life programme. The Leicester Walking for Healthier Asian communities project was one of two others that were chosen nationally as demonstration projects, the others were Walsall and Eastbourne. A year later Bradford came on board.

Reflection 4.5

When the bid was written, it was the general feeling that the project would be an ideal job opportunity, to continue the work commenced at CIO. At the British Heart Foundation interview, it was clear that CIO had commenced walking initiatives and the additional funding would extend this. The partners in the project felt the interview did go well, and all were confident. As CIO was central to this process, they were always in a good stead to host the project. Was this a good idea? Would the project be better situated in the Health Promotion Centre where it would have access to resources, and support from health promotion?

4.3.4 Baseline, Audit and Demographics of the geographical boundary of 'Belgrave' in Leicester

History of South Asians in Leicester

In the post-war period Leicester had become home to a number of different Asian communities. Like many British cities, Leicester experienced a significant migration of Asians from the 1950's onwards. However, Leicester differed from many other British cities in that a high proportion of the South Asian born population came from East African countries such as Uganda, but were born in India (O'Connor, 1995). East African-born residents in Leicester arrived after 1972. The arrival of the migrants in large

numbers put pressure on the housing stock in the city, particularly the Highfields district that was identified as Leicester's 'zone of transition'. Arrivals looked for and found accommodation in other wards, not only due to the housing shortage in Highfields but also due to their extended families. Asian's who arrived in Leicester from East Africa differed considerably from Indian and Pakistani migrants, due to them being refugees and involuntary migrants. Many arrived in family units, in some cases included members of their extended family, something uncommon amongst economic migrants who were usually young single people. As a result the housing need and aspirations of the East African Asians differed significantly from those of the predominately single migrants from other countries.

The emergence of the Belgrave and Melton Road areas of South Asian concentration can mainly attribute to this period and the arrival of East African Asians. South Asians in Leicester were faced with an overall shortage of private rented housing, hostile landlords and little hope of obtaining council property. In addition, there was a strong desire amongst them to purchase housing as an investment. As a result of the independence of a number of former British colonies in Africa, mass immigration of East African Asian families into the city developed in waves from 1968 to 1975. The first wave of Ugandan Asians arrived in 1968, to be followed by Tanzanian, Malawi and Kenyan waves (Winstone, 1996). The communities came as families with full citizenship rights. Newcomers arrived extremely disadvantaged having lost property and status, and with many families lacking languages skills. Extended families did not fit easily into small working-class houses, and the different climate, diet and general 'culture shock' resulted in illness, depression and turning inwards (Nash & Reeder 1993). At that time in between 1968 to 1975, Leicester had no non-Christian places of worship other than one synagogue. Now Leicester has 14 mosques, 5 Gurudwara's, 1 Jain temple and 40 Hindu places of worship and many more were being planned or constructed, as well as a council of inter-faith understanding.

In Leicester in the 1970's the majority did not accept multi- ethnic reality. Racial tension became an ugly fact of life as soon as East African Asians arrived. Physical assaults on ethnic minorities began to rise and whole areas of the city were seen as 'no go areas' for Black people. Two ethnic minority areas formed: the Highfields area behind the railway station and the Belgrave area – a neighbourhood of old terrace housing settled by East

African Asians. Both were very close to the city centre and surrounded by a ring of post war white working class housing projects (Winstone, 1996). Thirty years on, these two areas still exist and still have the highest proportion of South Asian residents. Leicester is now a multi- ethnic city where one third of the population consists of ethnic minorities, which in many inner city areas form the majority.

Setting of the Geographical Boundary of 'Belgrave'

The project concentrated in one area of Leicester, Belgrave, which is highly populated with the South Asian Community and the incidence of CHD. The geographical area was defined through a consultation (CAG Consultant's 1997) as the natural boundary of the community, 91% of a representative sample of more than 250 households agreed that the boundary included 'Belgrave'. Within the boundary were the residential population, the educational establishments, the open spaces, the River Soar and the National Space Centre. The geographical boundary consists of four main Leicester City Council ward boundaries Belgrave, Abbey, Rushey Mead, Latimer, and partly Mowmacre. An audit of the geographical boundary of 'Belgrave' locality of Leicester was carried out in February 1999. It built a picture of how walking for health and the 'Chalo Chalay' project would fit into the Belgrave area as defined by the 'Regenerating Belgrave' and the geographical boundary set by the Single Regeneration Budget 4 (SRB4).

Reflection 4.6

The geographical boundary was set at the steering group meeting (9.2.99), which included the wards Belgrave, Latimer, Abbey, Rushey Mead, and North Mowmacre. Health Promotion had passed on a number of contacts and organisations found in the Belgrave and city area. An extensive audit needed to be carried out of this area; there were approximately 47 ethnic minority organisations in Belgrave and Latimer wards (a list received from Leicester City Council Traffic group working on the Belgrave Corridor Project). Contact with Leicester City Council Project Manager of the urban regeneration team (SRB4 bid for Belgrave) passed on a consultation report on the Belgrave regeneration (May 1997). The collection of baseline data was ongoing and more detailed information was being collected through one to one consultations that were taking place with groups. The community planning session (held on the 25.3.99) had only an attendance of 3 people who were health promotion officers. Needed to rethink and plan, how to get more community representation. There was not a great response from the 44 groups that the project had written to, only one group showed an interest, Shree Swaminarayan temple. Needed to rethink how to recruit groups. This may involve doing one to one consultations, which took a longer time.

Demographic Data on Geographical boundary of 'Belgrave' Target Area.

Ward Profiles

At the 1991 Census approximately 70% (17,500) of the population in these wards were of an ethnic origin, a break down of which is shown in *Table 4.5.* The vast majority being Asian of Indian and East African origin, this figure has more than likely increased, as the population was predominately young.

Table 4.5: Ward Profile 1991Census of population Leicester City Council

Ward	Ethnic Composition %	Economic activity* %	Age
Abbey	Asian 47.6	**Employees 89.8**	**Largest 30-44**
	White 49.3	Unemployed 11.1	Smallest 16-19
	Black 1.7	Retired 49.4	
Belgrave	Asian 48.1	**Employees 89.5**	**Largest 30-44**
	White 48.8	Unemployed 15.3	Smallest 16-19
	Black 1.4	Retired 47.2	
Rushey Mead	Asian 61.2	**Employees 86.4**	**Largest 45-59**
	White 34.7	Unemployed 11.1	Smallest 16-19
	Black 1.7	Retired 47.0	
Mowmacre	Asian 1.0	**Employees 89.3**	**Largest 60+**
	White 97.2	Unemployed17.4	Smallest 10-15
	Black 0.8	Retired 59.2	
Latimer	Asian 66.7	**Employees 79.8**	**Largest 20-29**
	White 29.2	Unemployed 11.1	Smallest 60-64
	Black 1.7	Retired 49.4	

Source: Leicester City Council Leisure services Department Area North (1995) and Leicester Key Facts. Profiles 1991 Census.

*The percentage of employed and unemployed are taken from those sections, which are economically active. The percentage of those retired has been taken from the economically inactive sections.

Table 4.6 Cars and transport to Work

Ward	Abbey	Latimer	Belgrave	Mowmacre	Rushey Mead
Access to no cars	45.4%	50.6%	49.7%	55.7%	29.7%
Access to 1 car	42.1%	41.5%	42.7%	36.3%	54.9%
Driver or passenger	50.2%	39.5%	45.1%	49%	55.2%
By bus or train	21.6%	26.4%	28.1%	29.5%	20.4%
By foot	16%	16.8%	20.3%	7.8%	9.9%
By bicycle	3.5%	2.4%	4.6%	4.3%	1.4%
By motorbike	1.3%	0%	1.5%	1.3%	1.8%
Works at home	3%	3.1%	1%	2.6%	4%
By other means	2.1%	3.1%	1.5%	3%	1.2%

Source: Leicester Key Fact, Profiles 1991 Census 2nd Edition Leicester City Council.

The area north community profile done by the leisure services department of the Leicester City Council showed that many of the community members had no access to a car as shown in table 4.6. There was a need to ensure that good facilities were available to them, which were of walking distance from their homes. The main strategic aims of the leisure services department for the year 1999 that tied in with the Chalo Chalay were:

- To target 60+ in Abbey and Rushey Mead wards
- To target disabled people in Rushey Mead
- To target Asian people in Rushey Mead
- To target school children in all wards

Demographic Profile Sample of the geographical boundary of 'Belgrave' Target Area.

A consultation exercise carried out by CAG Consultants in May 1997 for the Leicester Partnership carried out a survey on 262 individuals within the Belgrave target area
The results of which are shown in *Tables 4.7 and 4.8.* The sample slightly over represented Asian residents in comparison to the 1991 census data but this is a true reflection of the change in population of Belgrave since 1991 (CAG Consultants 1997). The sample also over represented young people and under represented retired people when compared with 1991.

Table 4.7: Demographic profile of sample compared with population of Belgrave Target Area. Age and ethnic origin

	Total %	Belgrave Target Area*
16-20	13	7
21-29	17	22
30-39	20	22
40-49	16	14
50-59	15	12
60+	18	22
White	20	33
Asian	69	63
Black	1	1.5
Other	1	2
Base	262	

Source: Consultation on Belgrave Regeneration. A report to the Leicester Partnerships. CAG Consultant's. May 1997.
*Data for the SRB4 complied from 1991 census of population by the Leicester City Council
‡ Asian Comprised 60% Indian, 8% African Asian and 2 Pakistani respondents.

Table 4.8: Demographic profile of the Belgrave Target Area sample –Analysed by ethnic origin.

	Total %	Asian %	White %
Men	52	54	48
Women	48	46	52
16-20	13	16	7
21-29	17	19	12
30-39	20	24	11
40-49	16	18	11
50-59	15	14	18
60+	18	9	41
Has a disability	18	15	20
Has children under 5	20	23	12
Has children 5-10	22	24	16
Has children 11-15	20	24	10
Has children 16-19	14	14	8
No children	52	45	71
Working full time	34	39	21
Working part time	9	10	5
Unemployed	10	12	7
Student	11	12	8
Looking after home	14	14	12
Retired	17	9	38
Other	5	4	8
Base	262	181	73

Source: Consultation on Belgrave Regeneration. A report to the Leicester Partnerships. CAG Consultant's. May 1997.

The Physical Environment

There are a number of potential spaces for walks in the Belgrave locality these include:

- The open spaces of Abbey Meadows, Rushey Fields Recreation Grounds,
- The parks; Abbey Park, Watermead Country Park, Rushey Fields / Cossington Park and the Riverside Park

Educational Establishments

There are a number of schools and colleges in the area, a few of which host the safer routes to school initiative run by Leicestershire Health Promotion Centre and County Council Road safety section. The colleges in the area are: John Ellis Community College, Leicester College (formally known as Charles Keene College), and Soar valley Community College. The schools include: Rushey Mead School, Abbey Primary School, Meller Primary School, St Patrick's Primary School and Catherine Street Infants.

The Riverside Central Section

The riverside park stretches through Leicester, the central section is 12 miles long, and has a number of historical and multicultural features along side it. This includes; Abbey Park, Waterside Centre, Abbey Pumping Station, Belgrave Lock & Swans Nest Weir, Limekinn Lock & the canal and its industry, Belgrave Road-'the Golden Mile', Mills Soar Island, the West Bridge & Castle Park, National Space Centre, Freemens Lock and weir.

Events and Festivals

A number of festivals and events are held in the area, some of which are traditional and unique to the City of Leicester. Within the locality each place of worship celebrates Diwali, Eid, Vaisakhi and events such as Indian Independence Day.

Diwali – a Hindu Festival is celebrated in the October/November months of the year. Leicester hosts the biggest Diwali celebrations outside of India it attracts thousands nationally. The Belgrave area hosts three major events during this period; the switching on of the lights along the Belgrave Road and Melton Road; Diwali day and the burning of Ravan on the 10th day of Navaratri. In the first two events the road is closed off and there is live entertainment and radio stations along the length of the road. There is a firework display in the Cossington park grounds during all three events.

The Belgrave Mela is held over the first weekend in July and attracts over 50,000 people every year. There are shows, food stalls, cultural arts stalls and fun fairs. The riverside festival and Abbey park shows link into summer activities in the locality.

Sporadically there are inter-faith events which happen at the Rushey Mead grounds, these are know as *Kathas* or religious recitals on Hindu epics such as the Ramayan or the Shrimant Bhagvat. It has a Mela atmosphere and can attract up to 5,000 people per day, the *kathas* are usually held over 10 days.

Community Organisations in the Geographical boundary of 'Belgrave'

There are approximately 47 South Asian groups in the geographical boundary, these are changing on a day-to-day basis and increasing in number. Their focus is mainly of either community, religious or activity orientated. In support of these groups there are the key services such as social services, the voluntary sector, religious organisation's, sport and

recreation, public services, the police, housing, City Council officers, vocational preparation training, education and training, adult based training, schools, play groups, community centres and elderly groups. There are seven South Asian religious establishments based in the heart of Belgrave, these places are key in making community links, these include: Shree Santan Madir (Hindu temple), Husseini Mosque, Shree Lohana Mahajan (Hindu temple), Masjid-Ul-Imam-Il-Bukhari Mosque, Shree Shakti Madir (Hindu temple) Shree Singh Sabha Gurudawar (Sikh temple) and the Ravisdas Gurudawar (Sikh temple).

General Practices in Belgrave.

There are approximately 30 General Practices in Belgrave that may be involved in the GP Active lifestyle referral scheme or project Dil – the Asian CHD prevention programme.

Belgrave as a community and its Businesses and Facilities

As the South Asian community grew in the City of Leicester, associations were created to act, as voices for communities and later during the 1980's and 1990's were to run services developed from the central departments of the City Council. Thus, Leicester has a South Asian women centre, Belgrave Baheno's that is situated in the heart of Belgrave. There are also federations representing Muslims, Sikh's and Hindus and a federation of all voluntary groups – Voluntary Action Leicester (VAL). South Asians created many of these services after the original failure of mainstream provision. There are to date 47 organisations in the locality which support and strengthen the South Asian community these include; women's groups, mental health projects, community centres, neighbourhood centres, places of worship, support organisations, youth groups, charities and sport and physical activity establishments. Together with the high concentration of businesses in the locality, an intricate network is apparent.

The Leicester Asian Business Association, a major voice in the locality, has supported over 10,000 Asian businesses. Asians run 95% of small shops in Leicester. The commercial skills developed in East Africa enabled factory workers in the 1970s and 1980s to set up small corner shops staffed by other members of the family and then to establish factories in textiles, food and other goods.

Leicester has an Asian T.V station and a 24-hour Asian radio and an Asian edition of the local newspaper, representing massive growth of the media industry. Sabras radio is in the heart of the Belgrave locality and has good links with the Health Promotion Agency, it ran the Dil Se campaign against CHD. Leicester has twinned with Rajkot in India, Gujarat for trade and cultural exchange.

There is only one major sport facility in the locality, which houses a swimming pool, at Cossington Street. Specific Sport clubs are run from schools, such as the Badminton club at Soar Valley Community College. Rushey Parvlion Centre has some limited facilities. A number of community groups have their own halls, which they can hire out for weddings and parties, they also provide activities such as yoga and aerobics classes, table tennis, dance classes and if space permits sporting activities. On some occasions short courses such as cricket coaching is held. All facilitates have limited space and thus classes are always full, and are not able to provide a wider range of activities.

Within the boundary, facilities such as a library, dentist, garages, post office, restaurants and supermarkets are all walking distances from the heart of Belgrave.
Driving in from the Leicester City Centre, over the Belgrave flyover, a whole road full of bright, colourful shop windows are seen, Sarees, Indian jewellery, Indian restaurants, the Belgrave commercial centre, printing shops, Indian groceries, even a Bollywood cinema, its known as the 'Golden Mile'. This is rather deceiving as behind the row of shops are rows of terraced houses, where high levels of deprivation can be found.
The locality is interconnected and houses a close-knit community, which are influence by community leaders and elders of the extended family. However, a young generation of South Asians that have been born in Leicester are up and coming and attitudes and behaviours are changing as they are breaking away from stereotypical moulds.

Initiatives in the geographical locality

There are a number of initiatives running in the locality, which attempts to address the inequalities in Belgrave and increase the quality of life for the residents. These include; the Belgrave corridor project, Leicester Riverside project, Project Dil (Department of Health initiative to prevent CHD in the South Asian Population), Active Lifestyle Referral scheme, Sabras Radio Heart Health project, Health Promotion Agency's Heart Health and physical activity locality programme.

Community Involvement in Physical Activity initiatives

Two major organisations in locality the Belgrave Neighbourhood Centre and Belgrave Bahenos have been involved in health promotion initiatives. The other organisations have some limited physical activity, but would like to do more. There seems to be a lack of space and facilities in the areas to carry forward these initiatives.

Satisfaction with Belgrave as a place to live in

From the CAG consultation in 1997, three quarters of Belgrave residents were satisfied with the area, 29% were very satisfied. The satisfaction of South Asians was higher than that of white people, 83% compared to 59%. However 16% were dissatisfied, which was higher amongst the white residents 27% compared to 4% as shown in table 4.9.

Table 4.9 What residents liked about living in Belgrave as a place to live ranked in order

	Total %	Asian %	White %
Shops near	58	71	26
Friendly	23	24	19
Near other services	23	27	111
Near town centre	20	19	23
Schools near	18	21	10
Large Asian community	16	22	1
Near buses, good Buses	13	10	21
Parks/Riverside near	12	7	20
Quiet	11	10	14
Temple other community needs	9	13	0
Asian shops	6	7	1
Near work	4	3	5
Feel safe	4	4	3
Used to it	4	2	10
Family near	3	3	4
Multicultural	2	1	5
Clean	2	2	0
Other comments	2	1	5
Like nothing	6	1	18
Base	262	181	73

Source: Consultation on Belgrave Regeneration. A report to the Leicester Partnerships. CAG Consultant's. May 1997

The things that people liked about Belgrave included:

Shopping: it was considered to be very good in Belgrave for specific cultural and Indian amenities such as Sarees, jewellery and food, for others amenities the residents would need to travel into the city centre.

Indian Culture: the elderly in particular thought the area was good for religious activity, which was very important to them and others in the community. The household survey found that 16% of residents like the area because it was predominantly South Asian. 9% specifically mentioned temples, 6% for the South Asian shops and 2% referred to the fact that it is multicultural.

Friendly: In the survey 23% mentioned the friendless of the area and the reason for liking it. The elderly did not feel isolated or lonely as other Indians do in other areas. The Indian culture and friendliness were also valued by the young people, however many wanted to move out of the area for better jobs, better housing and wider opportunities, many elderly people choose to remain when their siblings decided to go.

Lively: the young people thought the area was lively and there was a lot going on, but there was a need for organised leisure facilities.

Public Transport, there was an agreement that public transport was good, 13% in the survey like Belgrave due to public transport.

Racial harmony: Racial tension was not regard as a serious problem, 42% thought it was not a problem at all in the area, so thus this was why many of the residents like Belgrave.

Table 4.10: What residents disliked about living in the Belgrave area.

	Total %	Asian %	White %
Parking	26	28	19
Traffic	13	13	12
Litter/untidiness	11	8	18
Burglary	8	12	0
Crime	7	9	4
Noise	7	5	11
Car crime	6	8	3
Not enough places to play	6	6	4
Housing needs improving	6	2	15
Troublesome youths	6	6	5
Shops poor	5	0	8
Too many Asians	5	0	14
Melton Road Shabby/ boarded up	4	1	12
Vandalism	4	4	4
Violent crime	4	5	1
Pavements uneven	2	2	3
Nothing for teenagers	2	0	5
Not friendly	2	1	4
Other	9	11	7
No dislikes/nothing	26	31	15
Base:	262	181	73

Source: Consultation on Belgrave Regeneration. A report to the Leicester Partnerships. CAG Consultant's. May 1997

Overall only 6% did not like living in Belgrave, the main reasons were: problems parking 26% mentioned this, 13% traffic, 11% litter and untidiness, 8% burglaries, and 7% crime in general as shown in table 4.10.

Crime and community safety was the most serious issue for Belgrave residents. Two –thirds thought burglary and vandalism were major problems and a third thought violent crime was a big problem. Fear of crime is high among South Asians in Belgrave, 61% thought that regeneration projects should focus on ways to help reduce crime and fear of crime. The focus groups revealed a large number of victims of crime, under reporting of offences and lack of confidence in the police. Incidents that come up were cars being broken into, muggings, a young girl had been attack, voluntary organisations – playgroup had been broken into 3 times in the last 6 months, burglaries and vandalism. There was a general concern about the unchecked growth crime, much of which was attributed to young people and 'gangs'. Some children claimed that they were not allowed to use the bridge outside their school because they got 'taxed' by other youth gangs. Some acknowledge that crime in Belgrave is not as bad as it is in other parts of Leicester, but they were concerned that it was increasing. There was considerable concern expressed about the inadequacy of the police response to crime, which may be one reason for under reporting.

Businesses expressed a concern that Belgrave was getting a reputation for crime (based almost entirely on petty crime) and that it was affecting trade. The damaging impact of crime on business and tourism was mentioned. This principally affected retailers, but manufacturers said that customers whose vans had been vandalised now wanted their vans guarded while they collected goods. Insurance premiums were rising, and some companies would not provide cover in Belgrave.

Parking gave rise to many complaints, 73% regard lack of parking a big problem, more than any other issue. Tourists caused problems for local residents at the weekend. This draws attention to potential conflict between the interests of business and those of residents, and a danger that successful promotion of Belgrave as a tourist venue could antagonise local people unless the parking problem is satisfactorily resolved.

Traffic congestion and speeding, especially in the side streets was a major concern, 63% felt that it was a problem in regard to the fumes and smell and more importantly accidents.

Litter was mentioned, unprompted, as the thing that 11% of people disliked about Belgrave. The potential conflict between tourism and residents was evident in the complaints.

Several residents mentioned the lack of *public toilets* for visitors.

Inadequate *Leisure facilities* in general were a concern, 29% regarding it as a big problem. Closely connected was the lack of youth facilities, some regarding it as the cause of the prevalence of youth crime. 34% thought the lack of places for young people was a big problem. There is only one park, one leisure facility, which was small, and one neighbourhood centre serving the whole locality. These are often blocked booked by schools and clubs thus limited time available for the general public. Other facilities that are seen as inadequate to meet demand, was the adventure playground which had a small capacity. Provision for youth was as much a matter of having youth workers, as having an infrastructure, there had been a decline in provision for youths due to the reduction in grants.

Lack of safe places for children to play was seen as a major problem by 46%, this was connected to traffic dangers and accidents, also with limited capacity or poor existing facilities. The outdoors pursuit centre was said to be predominately white and not used by the people of Belgrave.

Housing was seen as major problem by 29%, and the fact that most of the housing was terraced. Problems may be due to the smaller size of houses in Belgrave and consequent overcrowding.

Environment, concerns were raised about, parking, traffic, litter and lack of facilities for children to play. Other comments were about parks, specifically Cossington Park, which was thought to be dangerous and dull and in need of staffing and imaginative painting. Pollution of the river Soar by refuse and industrial waste was mentioned and was considered to be a blight on the riverside caused by the accumulation of rubbish from other parts of the city upstream.

Health facilities, 37% thought that health facilities were adequate, only 10% thought lack of facilities was a serious problem. The appointment system in local surgeries was a cause for complaint. Although there was Gujarati speaking GP's there was a concern that language barriers prevent some doctors from communicating effectively with older people. One voluntary sector representative made a link between leisure facilities and health and the contribution of leisure facilities to the health of the entire family.

The geographical boundary of Belgrave has its history; upon first impression it seems to be a thriving part of the City of Leicester, however the residents face a number of inequalities. Projects have often been set up in the short term, but in there has not been any long-term commitment to the locality in terms of investment. In the last thirty years, since the arrival of refugees and migrants, Belgrave has built itself up, although still in the background, are the same old issues which have left residents and workers alike quite sceptical of; yet another project to 'help us'.

4.3.5 Project Development & Support

Project Management and the Formation of the Steering Group.

The project was to be managed by a multi agency project steering group. The group were responsible for the strategic and operation development of the project and were accountable to the British Heart Foundation, the Countryside Agency and partner agencies. The individuals representing the organisations were responsible for taking forward action within their own organisations. The group provided six monthly reports to the Health Action Steering Group and the Joint Strategic-Planning Forum for community public health.

The original partners that were involved in the bid were; Leicestershire Health, the Confederation of Indian Organisations, the Health Promotion Centre (Fosse Health NHS Trust), and members of the Parks and Sports Division, Arts and Leisure Department, the Traffic Group, the Health Promotion Unit, the Corporate Strategy Regeneration Unit and the Environment and Development departments of the Leicester City Council. In addition to these original partners, Environ, Faith and Health forum, the Asian CHD prevention project (Project Dil), and representation from the voluntary sector e.g. Belgrave Baheno, Sharma Women's Centre Bhagini Centre, and Voluntary Action Leicester were all invited to sit on the steering group.

Members of the steering group

In addition to the core partners the Project co-ordinator and representatives from the British Heart Foundation, the Countryside Agency, and the Oxford evaluation group were also invited. Overall membership included:

- Leicester City Council, Health Promotion Unit, Team Leader,
- Leicester City Council Sustainable Transport Team, Traffic Group, Traffic Officer

- British Heart Foundation Oxford Health Promotion Research Group, Evaluator/ Research officer
- Leicester City Council, Traffic Department, Team Leader
- Countryside Agency, national walking the way to Health Coordinator
- Dawn Vernon Associates
- Leicester shire Health, Director of Health Promotion
- Leicester City Council, Public Health Manager
- Leicester City Council the Corporate Strategy Regeneration Unit, Manager
- Leicester City Council, Arts & Leisure Depart, Country Parks Manager
- Leicester City Council, Riverside Project, Riverside officer
- Health promotion Centre- Fosse Health NHS, Health Promotion Officer Physical activity
- Health promotion Centre- Fosse Health NHS Team Leader
- Health promotion Centre- Fosse Health NHS Health Promotion Officer City East
- Health promotion Centre- Fosse Health NHS General Manager
- Confederation of Indian Organisations Health Promotion Officer / Project Coordinator
- Confederation of Indian Organisations Project Supervisor
- Project Dil –Asian CHD prevention programme, project Manager
- Loughborough University, Director of BHF National Centre Physical Activity and Health
- Leicester City Council, Health Promotion Unit, Health Promotion officer
- Leicester City Council, Sports & Leisure facilities Manager
- Leicester City Council, Parks development Service Manager

These 22 members were invited by Leicestershire Health to be partners in the project. After the initial meeting, called by the Director of health promotion, in July 1998 a steering group meeting was called in August 1998, for the first 6 months of the project these were held every month and then bi-monthly.

Pre Intervention steering group Meetings

Five steering group meetings were held before the intervention. These were used to plan the project and gather baseline information. Structures were set and a core group of

members formed as shown in figure 4.3. At the second steering group meeting the contract was presented from the British Heart Foundation and Countryside Agency, it laid out the terms and conditions to the project, and agreed to allocated 45 thousand pounds over three years. At this meeting the external health promotion consultant from Dawn Vernon Associates was also present. This was a very good link in terms of training volunteers.

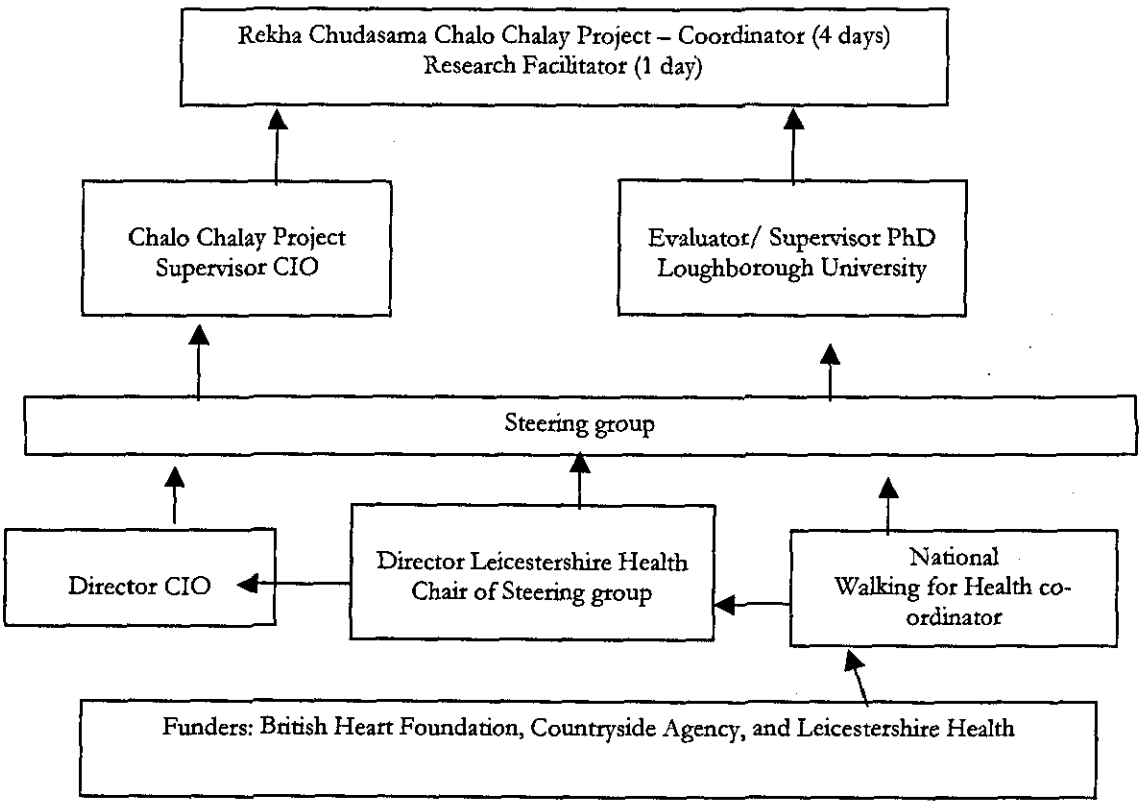


Figure 4.3 Management structure

Evaluation Sub- Group.

In addition to the steering group a sub group, which focused on the evaluation, was set up, this was made up of Loughborough University, the Oxford Group and the Project co-ordinator. The Health Promotion Research Group in Oxford provided technical input on the evaluation; a supporting and guiding role and an input into data analysis. He also made links and co-ordinated common action between the three demonstration projects. Although some elements of the Leicester project were comparable with other projects it was felt better to develop an evaluation that worked for Chalo Chalay.

The evaluation initially concentrated on the first strand of the project, and the aim was to try and learn from the process of implementing a walking programme. An initiative was

started and then rolled on after learning from the previous outcome. Practical problems were envisaged whilst the evaluation procedure was conducted via testing, interviewing and promotional work. There were some issues that arose and could not be dealt with by the Co-ordinator and were addressed during the course of the project.

Case Record 4.2

Steering Group Meeting December 1999

- It was proposed to use a walking test and other screening tests to establish a baseline. The launch event would provide the captive audience to test. It was hoped that a group of 200 people would present an opportunity to test and monitor using relevant questions. Language could be a problem amongst the older population but should be easier with the younger generation.
- The first community event should be held in a major community centre. Exercise leaders may need to be brought in until volunteers have been trained from the centres/ community groups. It would be helpful to have an idea of the volume, which might attend. The co-ordinator found it difficult to encourage people to walk in the winter months, a programme was suggested to attract more people via 'walking games for indoor walking'.
- Training local leaders, or to use previously qualified exercise leaders for initial walks was agreed. It was foreseen that there might be problems with available time and language skills. The Heart Start and First Aid techniques needed to be incorporated into the training programme for the walking activators.

The role of the Co-ordinator as a Participant Evaluator

The role of project co-ordinator and evaluator was to be productively combined. The projects would be tightly managed to avoid them drifting into new areas, the aim was for them to be sustainable at a quality level. At the initial evaluation meeting it was agreed to call walk leaders, walking activators, this concept was happening in Northern Europe, not just leading walks but promoting them too.

Reflection 4.7

After the success of the bid, a meeting with the Director of Health Promotion and Director of BHF National Centre – (who was managing the evaluation) was arranged to discuss linking the project into a PhD. It was initially thought that 2 days could be spent doing the evaluation and three days co-ordinating the project. It was quite simple, if the contract was seconded to the Health Promotion Centre or Loughborough University, but what started out to be a simple idea turned into a very difficult situation. Instead of leaving CIO, the project was tied in for a further 3 years. The project did not occur any recruitment costs, but inherited the internal problems that CIO was facing. On the face of it losing CIO would not look good, in terms of the partnership with the South Asian voluntary group. It seemed a few of the hidden agendas were being played out by all partners but at the expense of the project. The dilemma was to leave CIO and the project or to continue knowing that the partnership is being set up to fail. Both main partners wanted different outcomes, and the co-ordinator was stuck between them trying to be politically correct! From December 1998 the post became 3 day, the Director of CIO was not impressed that the post had gone from a full time position to a part time one. He suggested resignation, and could not see the PhD fitting into CIO. The director was not keen in allowing links to be made into the evaluation part of the project, he refused for the co-ordinator to attend the pre evaluation workshops, and these were done in the co-ordinators own time.

Concerns of the supervisory role of the current manager were resolved by the appointment of the policy officer, who was based at the London office, and had a background in health promotion. This eased the problem, but the ethos of the organisation remained the same. Via conversions with the policy officer and his experience of working in Tower Hamlets, with the Bengali community, it was recognised the lack of research on South Asian communities. His thoughts were very precise; there were not enough published articles, of good practices in promoting physical activity to ethnic minority groups.

The thoughts of doing research in this area began in August 1998, being disappointed with the lack of good practice in this field. Marrying the co-ordinator position with the evaluation was ideal. These thoughts were relayed to the supervisor, via further personal development. The CIO director did not believe that the process had been conducted through the right channels and should have been cleared with CIO. Thus, friction arose and support for the research lacked, he did not approve of the set up.

Things at CIO were not ideal; the lack of administration support was affecting the current project. This transpired into the Chalo Chalay project and was flagged prior to CIO hosting Chalo Chalay. CIO responded and an office manager replaced the administrator in July 1999 which, alleviated the situation

Project Planning

The initial project planning commenced in November 1998 and was presented to the steering group in December 1998. At this meeting a framework was put together by Leicestershire Health, Project Dil (CHD prevention Programme), Health Promotion Centre and an in put from the Confederation of Indian organisations. The three strands to the project were drawn which corresponded to each year as shown in table 4.11:

Table 4.11 Project Strands

Year	Strand	
1,2,3	1	Community Centred walking Routes
2	2	CHD Rehabilitation (Project Dil)
3	3	Environmental development

Each strand had its own pathway and plan, and developed at its own paced. In effect the project had 3 mini projects within it, and required different infrastructures. Thus the development of each of the strands affected the development time frame and the nature of the development of the other strands; thus they were individually planned but also were inter dependant. Not all the strands commenced in year one, priority was given to strand 1; the commencement of stand 2 was dependant upon the development of Project Dil and the requirement and training of General Practitioners. Strand 3 was envisaged to be more long-term development being dependent on the availability of capital investment, and would not be on board till year 3. However, it was thought that smaller environmental developments would occur as a result of Strand 1, such as sign posting, street furniture, minor modifications to parking etc.

The group set early key developmental priorities:

- Training programmes, and awareness raising programmes- focusing on improving awareness and understanding of the key 'walking for health messages'.
- Contact and recruitment of community groups.
- Media and marketing programme.

- Planning and development and trial of 1-2 early walking routes and associated material, early assessment of the availability of 'walking to school' routes and programmes.

The project also envisaged that there were a number of campaigns linked to festivals e.g. Summer Belgrave Walk and Diwali-Festival – Golden Mile Walk. The planning group produced a detail development work plan for the first year, with detailed tasks, timetable, outputs, resources, lead responsibility & partners, monitoring, evaluation and achievements. This became a working document as tasks and priorities changed during the course of the project.

Reflection 4.8

In October 1999 the steering group accepted Chalo Chalay as the project name. It meant 'Lets Walk' in Hindi/ Gujarati. The name was thought of by the project co-ordinator who thought it was a good iteration. It originated from India, Gujarat, where the bus conductors there used the word 'Chalo, Chalo' as to hurry people and the bus along...and Chalay is walk...so the idea was born.

CIO was central to the project, and had links into the community, they were envisaged to play an active role;

'...the key targeted area is Belgrave, CIO has many organisation based in this locality and would be key players in setting up links in this community.'

However these links out weighed the problems that CIO was having.

Case Record 4.3

Table 4.12 Important dates:

Date	Action
14th April 1998	Commencement of Physical Activities project at CIO
17th June 1998	Contact with the director of Health Promotion
23rd June 1998	Walking group Savera Beaumont Leys Shopping centre
1st July 1998	Initial Meeting
14th July 1998	Bid Submitted
21st July 1998	Interview at BHF/CA
23rd July	Walking group Sevak Samaj Luncheon club
24th July 1998	Walking Group east park road Gurudawra
7th August 1998	Walking group Ramghariya Social sisters, Sikh community centre (8 Males, 2 females, 1 child)
17th August 1998	Walking group Bradgate park
August 1998	Belgrave Health Mela Consultation Views on walking.
21st August 1998	Walking group Abbey Park
23rd August 1998	Health Fair St Savours Neighbourhood Centre
24thAugust 1998	Walking group Abbey park Ramgharya Gurdawara
26th August 1998	1st Steering group meeting
19th & 20th october 1998	Pre- Evaluation Workshop
27th October 1998	2nd Steering Group meeting
	Project named Chalo Chalay 'Lets Walk'
10th November 1998	Planning meeting
19th November 1998	3rd Steering group meeting
30th November 1998	Ethnic Minorities Physical Activity Conference
15th December 1998	4th Steering group meeting
19the January 1999	5th Steering group meeting
9th February 1999	6th Steering group meeting Commencement of Project co-ordinator role
11th March 1999	3-month mapping exercise
16th March 1999	7th Steering group meeting
22nd March 1999	Recruitment of Exercise Leader
19th March 1999	Attended walk leaders Training at Wiltshire Dawn Vernon Associates
24th March 1999	Get together Dinture Pastures Reading. Visit to existing health walk
25th March 1999	Community planning event
8th, 15th, 29th march 1999	Savera Consultation
12th, 19th, 26th April 1999	Pilot Project Savera
13th April 1999	Walking the Way to health conference
16th,h 23rd, 30th April 1999 7th 14th 27th May 199 Fridays	Commencement Women's Walking Group BNC
6th May 1999 to present date Thursdays	Commencement for Men's walking group BNC
18th May1999	8th Steering group meeting
20th May 199 or 15th July	Men's Boat trip
21st may199 16th July?	Women's Boat trip
24th may 1999	Evening walk Yoga Reflexology group Madhir Walk
10th June 1999	Seaside walk Hunstanton –Water DA (walking activator) leaves
14th June1999	Interpretation of Behavioural Questionnaires

5th July 1999	Commencement of New Office manager
20th July 1999	9th Steering group meeting
21st July 1999 Wednesday Commencement of	50+ Women's Walking Abbey Park
2nd August 1999	1st Walk Leaders Training
6th September 1999	Launch of the Chalo Chalay Project
9th September 1999	Project get together in Walsall
21st September 1999	9th Steering group meeting
4th October	Walk Inner Vision Paragna Chakshu Mellor School
7th & 8th October 1999	Commencement of Shuttle Walk Tests
12th October 1999	Active for Life conference
28th October 1999	Sport through education conference
2nd November 1999	Commencement of women's Tuesday morning walks 10-12 noon Chandni fitness group
9th November 1999	WFH Network Loughborough University. Dawn Vernon Associates
15th November 1999	Walk Abbey Park 1-3
22nd November 1999	Adhar Walking group
23rd November 1999	10th Steering group meeting
1st December 1999	DETR National Pedestrian, walk Forward Conference Commencement of PhD
5th December 1999	Video launch
6th December 1999	Walk Inner Vision Paragna Abbey Park
8th December 1999	1st Evaluation meeting
15th December 1999	11th Steering group meeting
22nd December 1999	Get together of demonstration projects
18th January 2000	HEA Conference
19th January 2000	Site Walk Liz Flood
25th & 27th January 2000	Shuttle walk tests
4th February 2000	Last day for Coordinator at CIO

Reflection 4.9

One of first walking group was held in July 1998 as shown in table 4.12 with the Sewak Samaj in Wigston in Leicester, apart of Age Concern Group. The activity co-ordinator was very keen and supportive. A physical activity talk was given, in the session one of the *Masi's* (older aunt), who had a disability, felt isolated and unable to participated and was in tears. This was really disheartening, however quoting a verse from the Gitaji (A Hindu scripture) turned around the situation. All the participants agreed and the *Masi* felt a little more confidant. It is this background knowledge, which a co-ordinator or a walking activator may need to resolve such situations. This cannot be learnt through a training session, it is inherent within a person. These are the qualities that should be sought when recruiting individuals who work with specific communities. Thus, whenever recruiting walking activators this was kept in mind. The walk itself was excellent, it was held very informally, and was very short, around the block. There was a pathway through the park,

near a riverside, which was ideal for waking. The men in the group knew the area well, and were taking the lead.

Case Record. 4.4

Keys tasks that were outlined for Strand 1, Year 1

- Development of baseline lists and information on community groups including contact names and current involvement in health promotion and physical activity as shown in table 4.13.
- Make contact with all community groups, describe project and enlist support.
- Draw up baseline of current walking activity
- Identify potential exercise leaders
- Develop training programme for exercise/ walking leaders
- Define geographical boundaries of the project
- Develop media/ marketing/ publicity programme
- Carry our a review of physical environment
- Promote knowledge base of local community groups on walking for health messages.

Table 4. 13 Development of the baseline

Action	Lead	Time scale
Information on community groups-profile	Health Promotion Centre Confederation of Indian Organisations	Start Dec1998 complete end Jan 1999
Develop briefing document on current activity	Health Promotion Centre Confederation of Indian Organisations	Start Dec1998 complete end Jan 1999
Audit of locality	Project Co-ordinator	By end March 1999
Development outline for Walking leaders training	Loughborough University	Start by Feb 1999
Evaluation Baseline	Evaluation group	Commence data collection Feb 1999
Development of referral protocols	GP referral co-ordinator	To be agreed

Reflection 4.10

It was appreciated that some of the main themes in the project were highlighted however the development plan produced with time scales seemed really unrealistic, until the programme commenced it was difficult to predict how long things would take and the uptake of the scheme by the community. How long does it take to build community trust? The plan was produced by the Health Promotion Agency, and done in a way that followed their patterns and procedures. Written from a statutory point of view to be transferred into a project that was based in the voluntary sector. Thus, there were conflicts arising just from the gesture of presenting a plan with time-scales to the project.

Maybe this plan should have been written by the Project co-ordinator once recruited and some input from the management team at CIO

Recruitment of Project Co-ordinator

Until the project co-ordinator was recruited the project paid for the physical activity specialist from the Health Promotion Centre. Their initial task was to gather the baseline data and to write an operation guidance plan. This was allocated one working day a week from the period commencing August 1998 to February 1999. The project co-ordinator, based at CIO, then commenced in February 1999 for 3 days a week on the project.

The steering group collectively made the decision that the Walking for Health project would be best placed in the community, and thus was hosted by CIO, who put in a proposal. At that time CIO was just completing the 'Promoting physical activity in South Asian communities project' and funding was to end in February 1999. Thus it was a natural progression that the original walking initiatives should be continued by CIO in the Walking for Health project.

Reflection 4.11

Co-ordinator support

Meeting with the director of Health Promotion and then CIO two weeks into the project Mid –February 1999, it was realised that three days was not sufficient and an extra 4th day was requested. It was discussed that the research part of the project is interchangeable with the co-ordinator's post as apart of the 'action research' component. Therefore, an extra day could be allocated to the project. Work was undertaken to map out 'realistic goals' and identifying overlaps between the operational and action research parts to the project.

Operational Strategy

This was written by the project co-ordinator in March 1999, it included all of the tasks identified by the planning group but detailed them further. An annual draft-work plan was submitted in April 1999. A GATT chart with tasks listed with a time frame can be found in Appendix IV.

Case Record 4.5/ 4.17 Operational Plan

Task	Objective	Steps	Deadlines Achievements
A. Raising Awareness	To raise awareness of the Chalo Chalay Project within: 1. Community settings 2. Leisure Centres 3. Primary care Health professionals 4. Statutory Organisations 5. Local Authority	1. To run community planning sessions 2. Need to identify & agree key walking for health messages 3.Need to produce resources & translation. Publicity/ information, investigate appropriate resources. Marketing strategy 4.Indentfy the interest via community consultation, invite key workers/ leaders. Include info on project, aims & objectives.	1st session taking place 25.3.99 End of April
B. Pilot Projects	• To use 2 groups in the area to pilot integrating walking programme into activities based within the group • To learn from these & refine good examples of practice	1.To recruit 2 groups that are willing to participate. 2. To consult with the group, the types of walks the would like, urban/ riverside 3.The development of the walks 4.To recruit exercise leaders & provide training 5.To put into place & write procedures for volunteers/ sessional contracts, & payment of 5.To find appropriate screening tools	End of April: Savera: 12.4.99 Urban walk 19.4.99Abbey Park 26.4.99 Riverside Recruited an exercise leader. BNC recruited Baheno's shown an interest.
C. Developing Baseline Information	To identify all groups & networks in geographical boundary & to target sedentary groups.	1. To carry out comprehensive audit of area. 2. Current walking activity	End of April
D. Training Walking activators	• To develop a training course sensitive to the needs of the Asian community • To run a course for exercise leaders • To run a course for Workers volunteers in preferred language.	1.Pilot walk with co-ordinator and exercise leader 2.Identfy correct walking messages 3.Devlopment of urban walks 4.Equipment required: First Aid kit, water bottles, mobile phones	
E. Planning for links into events & festivals	• To promote the Chalo Chalay project via events happening in the area • Cultural events		Ongoing

Case Record: 4.6

Annual Work-plan: Chalo Chalay

A. Collection of Baseline information / Audit

Objectives
1. Interviews with Activity co-ordinators: establish current activity levels of group.
2. Focused group questionnaires: Views on walking
3. Behavioural questionnaires

Success criteria

To have filled questionnaires and collected various data from a variety of sources (e.g. annual reports, minutes) and to collate into a report.

B. Raising Awareness.

Objectives
1. Sending letters/questionnaires to all community groups in all wards in the geographical boundary. (Belgrave and Latimer = 44 groups, Rushey Mead, Abbey and Mowacre). Identifying all interested parties.
2. Public meeting of community centre and group representative.
3. Professional meeting (Primary care, health promotion, statutory organisations and departments, Leisure services).
4. Raising awareness in schools and linking in with Safer Routes to Schools programme, designing a logo, designing directional flags for walks
5. Holding a number of festivals, events and charity walks.

Success criteria
1. To receive questionnaire's back, and to set up walking programmes with the groups
2. To recruit community centres on to the programme and identify possible volunteers
3. To link the project to other health initiatives in the geographical boundary and to build a foundation for the 2nd year of the project.
4. To involve the seven schools in the area, and to set up a competition.
5. To have at least one cultural/ festival linked walk per 'community' in the geographical area.

C. Publicity / Media Links

Objectives
1. To identify and agree on key walking for health messages appropriate to the South Asian community.
2. To launch project and have key Asian Radio stations and local newspapers involved, and try to continuous use the media to publicise the walks and the recruitment of groups and volunteers.
3. To develop appropriate publicity material, using the market strategy theory.

D. Development of the Health walks

Objectives.
1. To raise awareness of the project and build networks within the community setting.
2. To consult with groups, on what type of walks they would like, their current walking levels, their attitudes to walking, current understanding of walking for health, and their views on walking.
3. The development of walks within the geographical boundary that is; urban (which would be doorstep to where the group is based), riverside, and park areas.
4. The recruitment of exercise leaders and activity co-ordinators

5. To identify potential volunteers and their training needs.
6. To learn and set the protocol and procedure of running a health walks.
7. To identify essential equipment needed for the walks.

Success Criteria
To recruit pilot projects and learn from these.

E. Training Walking Activators

Objectives.
1. To develop a training course sensitive to the needs of the South Asian community.
2. To run course for exercise leaders, volunteers as and when the project grows.
3. To update the Walking Activators of new health messages and techniques for walking.

Success Criteria
To have recruited and trained walking activators to run health walks from their community centres or area.

F. Evaluation and Monitoring.

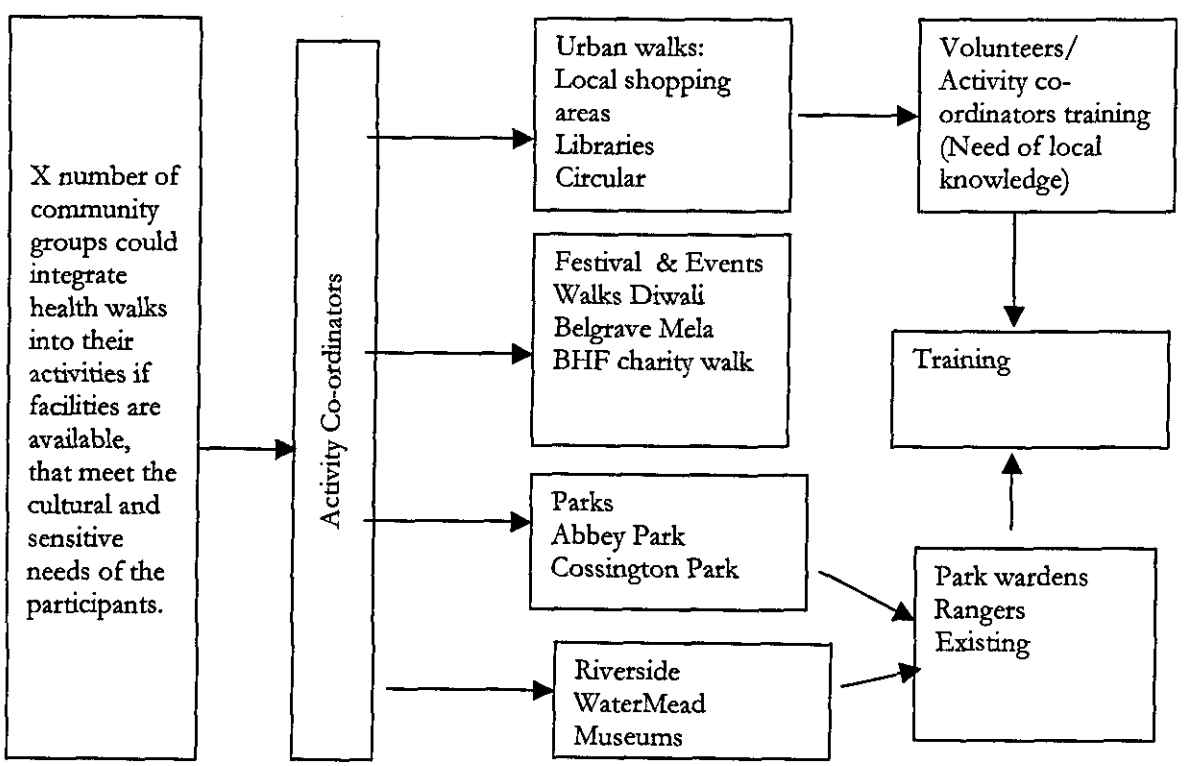
1. To keep records and to monitor all health walks, by developing a walks register, Feedback questionnaire from the group, and a leaders feedback questionnaire.

Success Criteria
To produce a short report on each walk.

G. Personal Development

1. Project management skills
2. Focussed group interview skills

Figure 4.4 Strand one: Community Centred Walking Routes.



Reflection 4.12

Re-visiting planning and mapping out Operational Strategies for Stand- One community centred walking routes as shown on figure 4.4.

The plans distributed at the steering group meeting (9.2.99) were unrealistic in terms of timeframes. These plans originally done by Health Promotion Centre did set some guidelines on what needed to be done. A further meeting with Director of Health Promotion suggested mapping out what needed to be done over the next three months. The main areas that were identified and which needed to be put under a microscope were; raising awareness, pilot projects, developing baseline information, training walking activators, planning for links into other events and festivals. The possible partners or resources available, monitoring and evaluation, deadlines and achievements was left blank and will be needed to be filled in once consulted with the other members of the planning group (which also needed to be identified).

Planning and mapping out Operational Strategies. At the steering group meeting the operational plan for the three months was discussed. It was suggested by the group that a GATT chart should be produced for the year (strand one) and the break down of the components: awareness raising, pilot projects, developing baseline information, and training walking activators.

The training aspect would be taken up by the BHF/CC on a national basis, in conjunction with Loughborough University and The HPC. The main aspects of the training were identified as training for exercise leaders/riverside and park rangers, training for activity co-ordinators (English version, training for volunteers (other languages), and training the trainer.

Pre -Evaluation Workshop British Heart Foundation /Countryside Agency

Prior to the initiative commencing, the British Heart Foundation Health Promotion Research group of Oxford University held a pre – evaluation workshop over a two-day period in October 1998. The Director of Health Promotion, Leicestershire Health, a representative from the Health promotion Centre and the officer form the Confederation of Indian organisation attended. The aim of the workshop was to draw up

detail evaluation plans for the walking the way to health projects having the following objectives:

- To provide the opportunity for the Walking the Way to Health Projects to share their aims and operational plans with each other.
- To reflect upon examples of current UK physical activity research and upon different methods of evaluating health promotion projects.
- To examine how the aims and objectives of the Walking the Way to Health projects might be evaluated.
- To identify the specific evaluation requirements of each Walking the Way to Health projects and how these can be met.
- To identify common methods by which the three Walking the Way to Health projects might be evaluated.
- To identify the resources needed to carry out these evaluations and how to meet these resources implications- within the agreed budgets.
- To clarify the roles and responsibilities for evaluating the Walking the Way to Health projects including the nature and level of support from the British Heart Foundation Health Promotion Research Group (Oxford).

The workshop emphasised a need for collaboration between researchers and practitioners. Having an evaluation puts projects into better stead of receiving future funding. The stakeholders of the evaluation were the funders, the academic sector and the project's themselves. Publishing data provides a method of sharing good practices, and thus a better environment for the public. The Walking for Health projects, were evaluated on the process rather than quantitative data.

The common research questions for all three-demonstration projects were:

1. How was the local community involved in the development of the scheme?
2. Why did people go on the walks?
3. Did the project increase walking in the target groups?

All the projects were keen to capture the different types and levels of community involvement within their project. In order to do this each project defined its local community, community groups and organisations within it locality that were of relevance to their project. The level and range of community involvement, this could be from

putting up posters to running walking groups. Furthermore, the value of the level of participation from nothing to volunteering time to the project. Chalo Chalay used focus groups and one to one interviews to obtain this information. All the projects were keen to evaluate motives for people's participation in the walks.

Visit to Wiltshire health walks Scheme and Training day in Wiltshire

Dawn Vernon Associates had been running training's for walk leaders. In March 1999 the project co-ordinator and a representative from the Health Promotion Agency attended. The session was all day and began by identifying individual training needs. A Physical Activity Readiness Questionnaire (PAR-Q) (Appendix III) was also filled out.
The procedure for running a health walk was as outlined below:

1. Fill out walk registers and the names of the front and back walk leaders.
2. Prior to the session PAR-Q's should be filled with names, addresses and ages.
3. The walk must start with a warm-up and end with a cool-down
4. Directions or signs need to be put up by the front walk leader and collected by the back walk leader.
5. Have mid- markers, these are usually the regular walkers.
6. The walk leaders should be identifiable by wearing the same colour, or a bright coloured jumper.
7. If there is only access to one mobile phone then the back leader should carry it, with the first aid kit.
8. It is worth remembering that the walk leaders themselves may have a medical condition.
9. Leaders also need to stretch out; these can be done after the session is completed.

The training day highlighted the importance of a walk leaders role, in keeping up, having clear directions, making their role known to all walkers, making sure each walker can go at their own pace, and ensuring everyone's safety. The training day also included the importance of walking and physical activity; it gave a demonstration of a health walk and stretches. Examples were given of schemes already set up such as the Salisbury Doorstep Project, Woking - Reading and Sonning Common.

Volunteer Walk Leaders were recruited from the walkers, who wanted to take it step further, they were responsible for planning the walks, and as with the case in Woking

they become social groups, doing other activities such as coffee mornings, and art groups.

Safety was an important aspect of the training day, prevention of injures were avoided by carrying out a risk assessment, making sure all walkers wore appropriate foot wear, stretching out before and after the walk and doing mobility exercises. If the weather was bad, it was up to the walk leader to cancel. Also when teaching stretches it was important to teach the three main ones for the legs, and not to rush walkers into doing them until they are confident. The message of intensity was highlighted but at the same time being able to hold a conversation.

The effectiveness of walk leaders were measured on their recording techniques, follow ups such as writing to people, fitness awareness, and surveying the site and area. The role of the leader on the walk was to be professional in that they are doing a head count, being punctual, being welcoming and keeping paperwork up to date and in order. The role after the walk was to get the relevant equipment to the next walk leader. Thus the leader needs to be trained in carrying out the exercises correctly, ensuring a back leader is present, being punctual and arriving 10 minutes earlier. That they are motivating and can communicate with all, they should be able to carry out a risk assessment of the scheme and the walks.

If an incident occurs on the walk, communication channels are needed, maybe via mobile phones, they need to wait for back walk leader to arrive with the First Aid kit, also with water bottles, antiseptic creams or a mouth to mouth piece, they need to get help promptly. After the incident they need to keep a record of it, and need to carry out a risk assessment of the walk; this might vary from day to day, thus it needs to be carried out often. If there are more than 15 people on the walk middle markers are needed.

Insurance is required this could be done by the projects that recruit the volunteer walk leaders. Walkers are walking at their own risk when they sign Par-Q's (Appendix III). Footwear should be of appropriate nature; it is the responsibility of the walk leader to reiterate this to the walkers. It is up to the individual whether they are there for the health or social benefits, but brisk is best!

Route Planning and meeting with co-ordinators protocol

- Introduction Welcome
- Leaders Introduction
- Par-Q's to be filled out
- What do if worried
- Length and description of the walks
- Purpose of the walk and if it is going to be brisk
- Any questions
- Advice on pace and remind them of talk test.
- Explain the purpose of warm up and cool downs and why the walk is brisk.

Reflection 4.13

Training for volunteers Wiltshire: This training was held for a similar project-taking place in Reading. The volunteers were already walkers and some were associated with the Rambler's. The training was organised by Dawn Vernon Associates. The training day gave a basic out line of what the components of a health walk were, but it would need to be adapted if it were going to be transferred to the Belgrave locality of Leicester. The people that attended the training day, were from a middle class background, the recruitment of such motivated individuals in Leicester would be difficult. The vision of retired South Asians volunteering to lead a health walk could not be pictured! A lot more barriers were being identified than making the process transferable. Footwear was an issue, Masi's (older South Asian aunts) were comfortable wearing Chapals (slip on sandals), in particular with Sarees and Punjabi suits. To get them to wear trainers and socks was a challenge in itself. More of a concern was volunteers teaching stretches, even at the session a few were doing it incorrectly and to be expected to teach others after a days training? Chalo Chalay's training would need to be adapted to meet our cultural needs.

Meeting with the other Demonstration projects and a visit to a scheme running in Reading Dinture pastures

In March 1999 all three-demonstration projects had a get together in Reading and also to have first hand experience of a current walking scheme and of an actual health walk, set

up in Dinture Pastures, Reading. The co-ordinator of the project gave a brief summary of the scheme and some dos and don'ts but the theme was how to promote the walks.

In terms of publicity, the Reading project used big displays placed in organisations such as libraries and schools. This needs to be done before the scheme commences, via the walk leaders. It raises awareness and the schemes become apart of the community. It is important to launch the scheme, it is the highpoint of the project, having the press involved and making it high profiled. The publicity should be ongoing after this, and keeping everyone informed of change and to re-inspire and remind, this gives continual motivation. Publicity can be done door to door, and press releases, but needs to be kept going and writing personal letters gives it that little extra. Publicity should be aimed at walkers, walk leaders, 'word spreaders' and also funders. All these can be targeted; often communities have their own press channels and notice boards. For example, parish news, shops, community centres, council offices, web sites, libraries, sports centres, primary care teams and all health visitors, CHD rehabilitation, clubs such as scouts and guides, weight watchers, mothers and toddlers, youth groups and schools, the latter three require timing. Press releases, letters and posters need to be accurate, inspiring, motivating and welcoming. Communication needs to occur with leaders, local radio, community events and businesses.

Reflection 4.14

National Demonstration projects get together in Reading.

The get together of the three projects, Leicester, Walsall and Eastbourne was to update each other on progress made. Walsall would be launching their project in May 1999 and would be using participatory appraisals as an evaluation tool. Eastbourne like Leicester had appointed their co-ordinator and was awaiting planning permission to set signs up on the sea front. Leicester was the only project, which would be running health walks in the near future. It was very useful to meet the other project co-ordinators, as this was a new role, it was supportive to meet others in the same situation. However, each demonstration project was quite different in target audiences and in its structure. The health walk in Reading itself was really quite 'hard core', that is its emphasis was on health and brisk. The attendees and leaders were retired and middle class. It was like an extension of the Ramblers, but of a shorter nature. Speaking to some of the walkers, they were religious in attending and were feeling the health benefits. The walkers were of a total different background from the potential walkers in Leicester; it was literally like

'Chalk and Cheese!' The principles were the same but there would have to be considerable modifications. The attitudes of the walkers were fantastic; the leaders were so motivated. This would be a challenge to get walking activators in Leicester to become mirror images. The Leicester scheme would be very different to this one and would have different incentives altogether. Lots of questions were raised whether walking can be promoted in this way to the South Asian community? And did the concept of volunteering exist in the South Asian community, in this way?

Walking the Way to Health National Conference.

A one-day conference was held in April 1999, at Leicester University for health and leisure professionals on setting up Walking for Health schemes. It was organised by the British Heart Foundation and Countryside Agency and managed by Dawn Vernon Associates. The conference's main objectives were to understand the various steps involved in planning, implementing and evaluating a scheme to learn from existing schemes and to provide up to date evidence on the physical and mental health benefits of walking.

The conference endorsed what the health walks were about, positioning, packaging, pricing, production and promotion. It was a new deal for walking via the national strategy, integrating it into Primary Care Trusts, Health Improvement Programmes, the new Opportunities Fund, Healthy Living Centres and Local 21 Agendas. If promoted correctly walking worked, it can help people increase their physical activity levels to a moderate level and sustain it. The conference emphasised that the schemes do not have to be 'fancy' it's the simplicity of it that makes people want to make walking an inclusive part of their lifestyle.

The conference's main speaker was Dr William Bird, the founder of the Walking for Health concept; he commenced the original health walks set in Sonning Common. The most important outcome for him was the 'daily organised walks'. He raised his concerns for women walking alone, and how vulnerable they were. The walks needed to be of a brisk nature if they are going to reap any health benefits and catered for fast or slow levels. Re-launching the walks was really important as it keeps up the publicity. In terms of promotion, the market needs to be defined that is, the number of men and women,

whether they like to walk on pavements or in the fields. To have an awareness of who the 'suppliers' of these people might be, that is Primary Care Trusts, Health Action Zones or Local Authority, its about convincing these organisations and groups, and users who maybe sedentary, obese, or cardiac patients. He reiterated the message of doing 30 minutes of physical activity on 5 days of the week. In terms of community walking programmes:

'*...But enough of me, lets talk about you.*' (Dr Bird 1999).

Involvement of the community representation right from the beginning was central to the process:

'*Remember we are public servants*'. (Dr Bird 1999).

The conference also focused on how to involve the community. The community driven approach involved the community all through the project;

Customise: survey the local need; match the scheme to the community and an emphasis of the benefits to them. For example health or social aspects, trips, economically is it viable? Reduce the load, how will people get to the walk?

Collecting: Obtain information on the need and preferences of the community, the need for community walking sources such as local residents, general practices or libraries. Make use of private or public meetings.

Contacting: identifying local target groups need, motivating walkers. Promote the scheme to the community.

Creating: establish a walks programme appropriate to the needs of the community.

Committing: maintaining community walks and walk leader interest.

Considering; Evaluating and monitoring the scheme, feedback to the communities, walkers and walk leaders. Expanding to form social groups and activities.

The conference reinforced some of the well-known tools to work within a community setting. A major marketing tool that worked with all schemes was the power of 'word of mouth'. In summary schemes should inspire, empower, support, shape and thus celebrate and evaluate outcomes!

Case Record 4.7
Workshop, A case Study Kennet walking Scheme.
Why we got involved?

- Leisure Strategy Objectives
- Community demand
- Support from leisure and community Wiltshire Health Promotion
- Success of other schemes in Wiltshire

How did we do it?

- Initial meeting on: What do we want? How do we do it?
- Initial thoughts and proposal (based on 30 organisations).
- Outcomes- four area groups established guided walk set up; the walks were researched and prepared. Some Doorstep walks lead by volunteers.
- Seven walk packs were produced
- Travelwise grants received
- Media interest at the launch event
- Huge pubic interest, 5000 packs sent out

Who was involved?

- Parish councils
- Local Schools
- 50+ groups
- General Practice Surgeries
- The Ramblers
- Interested individuals

All of the above provided guided walks.

Problems

- Scales of project
- Trying to get more general practitioner involves
- Clearer guidelines and realistic time scales
- Maps/ detail

Where are we now?

- Joint appointment of walk co-ordinator
- Formation of four walk forums
- Wiltshire Health promotion is providing training for walk leaders.

The future

- New editions of existing packs and new packs
- Led walks
- Evaluation of the use of existing packs
- Wiltshire walking charity

Successes

- Partnership with Wiltshire Health promotion & other organisations
- Local demand
- Four-point plan: Partnership, local Interest, and clear objective. Continual evaluation

Reflection 4.14

The conference did give a background on setting up a scheme, and there was a large turn out, however for an event that was in Leicester, there were not many South Asian groups and organisations represented. This placed an emphasis on that publicity had not reached these groups, and it is a real issue. The main outcomes of the conference and the issues raised were safety, that is volunteers insurance and carrying mobile phones. It was also realised that partnership working was key to a successful project.

4.4 Summary

Summary of chapter four outlines the importance of the foundation project and the initial walking activities. It goes onto describe the results from the consultation and how this influenced the foundation project. After which the geographical boundary was set and illustrates Belgrave's infrastructure. The next stage of the project was to set up its management structure that is the steering and evaluation group. Thereafter the project was named Chalo Chalay and project planning took place. The summary then goes on to describe the operational strategy and ends with looking at available resources and guidelines.

The foundation project by CIO raised the awareness of the importance of physical activity and put it onto the agenda of local community groups. The forty-one groups consulted with had some idea of physical activity but had no idea of the intensity needed to produce health benefits. Interviews with managers and workers revealed that they were bombarded with initiatives but did not have structured support in delivering them. The foundation project also identified with the lack of confidence of older South Asian women participating in physical activity and the perception of 'their bodies' not allowing them do to so. This initial stage was a preparation for change not only for South Asian individuals but also setting up partnerships between the statutory and voluntary sector. From these outcomes a process of change was drawn which linked grass roots to strategic initiatives and showed a holistic approach to the promotion of physical activity. The foundation demonstrated capacity building with community members who were

trained to deliver back into their communities. Barriers to physical activity were highlighted that is cost and appropriate dress codes were of major concern.

The initial walking activities commenced by the CIO were the foundation to Chalo Chalay. There was recognition at the pre intervention stage that making walking a structured activity would be difficult and in general walking for health was not received well by the users of the community groups; they would have preferred swimming as a structured activity. The idea was well received by professionals in health promotion and in particular the Director of Leicestershire Health, and it was this enthusiasm that pushed the agenda of walking for health forward.

During the consultation period a cross section of the South Asian community were spoken too over 72% of the participants questioned saw walking as a physical activity, which was encouraging, more females than males thought walking could be taken up as an exercise. This portrays that women are more likely to take up the opportunity than men, whose view of physical activity were towards more structured sporting types of activities. A quarter was unsure if walking was a physical activity, and thus the scope of convincing them via educational messages was a possibility. 3% with clarity believed that walking was not a physical activity, and were from a sporting background, they believed that walking would not be able to raise their heart rate sufficiently for health benefits. Following on 59% believed that walking could derive health benefits, more females than males took on this view. 32% were unsure of its health benefits, so there was a potential for targeted messages for this section of the community.

Surprisingly, 82% of the participants did some form of walking, even with a smaller sample of men interviewed, they seemed to walk more that the females, a gap existed in the number of women walking. The intensity was of incidental nature and not high enough for health benefits. None of the participants were a part of a walking group and clearly this would be one of its kind in the Belgrave locality. The reasons that would encourage participants to walk were: walking in a group, health reasons and a better environment. Specialised walks tailored for individuals who suffer particular illness such as diabetes were welcomed, and having a trained professional if anything were to happened gave the potential walkers confidence. If barriers such as safety and time were

addressed, participants were likely to take part. If the opportunity were provided most South Asians in the sample would be willing to give it a go.

The foundation project was a springboard for the Chalo Chalay project, it recognised that a number of barriers stood in between facilities and South Asians participating in physical activity. The research from the initial 12 month foundation project made up a bulk of the Walking for Health bid, as the foundation project stipulated that walking was an acceptable form of moderate physical activity and it solved the facility based issue as it was done on the doorstep. It linked in well with plans to regenerate Belgrave and the Belgrave Corridor project, which aimed to improve the environment over a five-year period. The local environment was a major deterrent for the people of Belgrave. The bid was successful due to the history of good practices happening in Leicester previously, a good partnership had formed and this had been the strength of the success of the bid.

The geographical boundary of the project was set around Belgrave; deep routed histories have formed these boundaries, and have the highest population of South Asians in Leicester. Previous hostile racist tensions have left the older generation un-nerved and are wary of the area they live in. This had to be taken into consideration; it would be a challenge to build confidence in people that their doorstep was a safe environment for them to walk in. Over 70% of the population in this boundary were from an ethnic minority background, and from table 4.9 just over 50% had no access to cars. The potential for walking with these individuals were vast, as they must have been already practicing incidental walking. The make up of Belgrave is such that most services should be of walking distance of their homes. Belgrave is a close-knit community, all services are local, and they are interconnected. There is potential to get groups on board, but community leaders and elders would need to be convinced initially. The infrastructure of Belgrave is in place and in roads into the community can be made easily with the correct workers. The physical make up of Belgrave may be deceptive with its outer shell of shops on Belgrave Road, but in the heart and inner suburbs are high levels of deprivation, run down housing and a number of empty properties. There are high volumes of traffic bringing with it pollution. Thus they are not ideal walking conditions and are deterrents to the locals. Previous attempts have been made in the locality, to engaged the community health enhancing initiatives, but have failed to be sustained, and lacked co-ordination between them. A holistic approach needs to be taken between partners in

delivering services, as there is a lack of space in facilities in the areas in particular for sport and physical activity.

Belgrave has built itself up and residents are generally satisfied living in the area, 29% liked it because the shops were near, services such as schools and bus routes, and being near to the city centre. Others felt at home with the large South Asian community and other community needs such as temples. The major dissatisfactions were parking in particular at weekends, when tourists are in the locality to shop on Belgrave Road, there was an increase in traffic and litter. Belgrave has seen a number of short term projects to address its inequalities and residents and workers have become sceptical of new projects, short term funding it not the solution. If there is going to be sustained change in the locality long-term capital funding needs to be invested.

Leicestershire Health Authority put the 22 member steering group together; this was too large, and not workable. The correct members were subscribed onto it, that is people with power who could go away and make change, but they delegated these tasks to officers who could only take things back, these members would have been more useful on an operational level. There was a lot of interest in this project as it was a new concept. As seen from figure 4.2 the management structure of the project was very top heavy, and was not very productive on an operational level. However, a sub group to the steering group was set up to work on the evaluation, this smaller group was much more productive and short-term realistic tasks were achieved. From case record 4.2 these initial tasks of collecting baseline data were not conducted instead the walking test, which is the Shuttle Walk Test was conducted when walkers joined the programme. This reflected the action research and experimental case record nature of the study.

The evaluation group identified at the foundation stage of the project that walk leaders played a larger role than just walking, they were the inroads to the community, and were in 'role model' position's, so they were thus called Walking Activators, as they promoted walking for health. The qualities required of a walking activator are unique as stated in refection 4.9, this episode dictates the type of situation that may occur, human behaviour is unpredictable, but having the skills and the know how are important tools to diffuse situations. To learn cultural sensitivity would be impossible for an 'outsider', these skills are inherent.

The combined role of the project coordinator and evaluator as a reflective practitioner fitted well in the evaluation model, as it was a criteria set by the funders, 10% of the budget had to be dedicated to evaluation and was tendered over to Loughborough University for this purpose. As noted in reflection 4.7 the Director of CIO was not happy with this arrangement in particular a full time post becoming part time. This could be understood from the director's position, as staff time was lost, however the post could have been job shared and was discussed. CIO agreed after negotiation as stated in refection 4.11 to make the post four days. The post should have been full time, as it did become in the second year of the project, but it has to be noted that the project was a demonstration, and thus the evaluation input was imperative if not just as important as the delivery; its was not about quantity but the quality and what learning took place.

The project was named Chalo Chalay, and in a short space of time as shown in table 4.15 the project hit the ground walking briskly. This was the most difficult stage of the project, the setting up, and convincing people that this product is well worth investing into. It has to be noted that the coordinator was only working three days a week on the project and was responsible for all aspects of the project, from setting up meetings to leading walks in this initial phase. This could have been managed better, and support mechanism from CIO should have certainly been in place, but this was the peril of the voluntary sector: a lack of a team. As reflection 4.8 states the CIO in theory were ideal to host the project, but it did not deliver the basic day-to-day management. The coordinator was juggling to many balls walking on a tight rope.

Project planning was done out of sync, it was not realistic, but was valuable in setting guidelines. The project was heading to be a number crunching exercise, instead of a 'demonstration project'; what is going to be done in what timescale? From reflection 4.10 the coordinator felt that the planning was done from the statutory sectors viewpoint, and in practice should have really been written by the voluntary host organisation, although some in put had occurred. The plan was action focus, which needed to occur in the background, it was first and foremost more important to build the communities trust, and this would only happen if the in-house procedures were in order. This development phase was omitted and had serious repercussions in the progress of the project.

The operational strategy was focused in setting realistic targets which it delivered on, accurate records were kept, but what it did lack was feedback to community members on an ongoing basis this would have been a more of a motivational tool. Sporadic feedbacks did occur informally, but more success stories should have been published in local newsletters. Thus a box that needed to be added to Figure 4.4 was a feedback, to all stakeholders.

The pre intervention support received, was general written guidance on the theme of walking. Evaluation questions set were general across all three-demonstration project and general methods were suggested. Walk leader training was also offered, via a similar project in Wiltshire, it helped to set guidelines but as in reflection 4.13, the health walks and training in Leicester was envisaged to have a lot more specific details added to match the culture of the participant. Walk leaders role's would initially need to be watered down, and support given by the project coordinator. Upon first impression, the whole scheme seemed very middle class, and the question arose would inner city communities accept such an initiative? It may need restructuring totally. These thoughts were solidified by the get together of the demonstration projects, a second similar scheme visited, the issue of volunteering in the South Asian community was flagged, and an inherent belief that the promotion of walking for health in this way could not be transferable to Leicester's targeted community's, and certainly the responsibility placed on the walk leaders. The process was re thought and delivered in a culturally sensitive way, which is discussed in the following chapter.

The Walking for Health Conference was inspiring, Dr Bird the founder of the concept focused on working with the community and letting them guide and direct it. The schemes are individual and the more simple they are, the more appealing they were to the participants and the more chance of them sustaining it. The conference flagged up quite clearly the lack of South Asian presence by the number of delegates from ethnic minority communities.

Chapter Five

Results: Intervention Development

There is nothing like walking to get the feel of a country. A fine landscape is like a piece of music; it must be taken at the right tempo. Even a bicycle goes too fast.
Paul Scott Mowier

5.1 Introduction

Elements of the foundation project, and pre intervention action plans were put into place via the development phase. A bulk of the development phase of the intervention was dedicated to the running of the pilot project, from which a protocol and procedure for running a walking group was developed. Several development strands of the project were running parallel to one other such as the development of; behavioural questionnaire evaluation tool, the walking activators training, publicity and the operational group. Due to the action research model, which was being followed, the learning from the pilot projects were implemented straight away and community and voluntary groups recruited onto the programme. Case studies are also presented in this chapter of the walkers recruited onto the programme. The study looked at how the project linked into other initiatives in the locality, such as the safer routes to school and how it took a holistic approach. The chapter goes on to describe the steps taken for moving on with the project, such as ethical approval, active outcomes and resolving challenges. It uses the Look, Think Act, and components of action research.

5.2 Methods

Themes were continued from the pre intervention phase that was described in chapter three and also section 4.2. Additional procedures used are described below;

Focus groups

Pre and post focus groups on views about walking

The pre Savera focus group consisted of 14 ladies aged between 25-62, and was conducted in Gujarati and translated into English and Hindi by the paid exercise instructor and transcribed directly into English by the Project Co-ordinator. The post Savera focus group was carried out with 6 ladies and was conducted in Gujarati and translated and transcribed by the project co-ordinator.

Meetings

The meetings attended by the Project Officer were recorded and formed apart of the case recorded evidence. Reflections were made on these meetings via the action research journal.

Questionnaires

Physical Activity Readiness –Questionnaire (PAR-Q)

These were filled out in a group, the project officer translated the questions verbally into Gujarati and Hindi and the 2 workers helped the participants to tick the boxes, and write answers in.

Question testing exercise

The Walking, Home, Garden and other activities Questionnaire (Foster, 2001) was four pages long and was piloted, in the same way that the PAR-Q was filled out this questionnaire was also filled out in a group, and translation of each question was done verbally. This took one and half-hours to do with three workers translating.

Postal Questionnaires

Postal questionnaires were used to carry out a needs assessment of potential walking activators and to gather data on training needs, as shown in case record 5.11, 24 responses were analysed.

Pre and post questionnaires

Pre and post questionnaires were used at training days as shown in table 5.14, to measure the change in knowledge.

General Questionnaires

General information gathering questionnaire were used at events as an evaluation tool at the launch 60 questionnaires were analysed.

Survey

Survey of students at Rushey Mead School

A class of thirty asked verbally if they walked to school, and if not what mode of transport they used.

Quantitative evidence

Quantitative evidence was collected via case records of walk registers and facts were recorded on the walk registers which asked general details of the physical walks such as temperature, walking conditions, number of miles walked and the time it took. These data were recorded for 60 walks. The number of walkers participating was recorded for the men's and women's group, averages are presented. The walks were measured in metres by a walk metre worn by the walking activator.

Pre Walking Group Consultations

These consultations took place at the Belgrave Neighbourhood Centre with 25 South Asian men aged between 45-80, and 40 South Asian women aged 40 – 75. The consultation was done in Gujarati, and tested the bilingual skills of the consultant.

The Shuttle Walking Test (also see section 3.2.6)

This test (Singh 1992) was chosen due to the simple equipment needed and it can be conducted easily in the field; also its sensitivity can be used with individuals with varying severity of health problems and disabilities, the test protocol is shown in table 5.0.

Test Procedure

Equipment

1. A flat non slippery surface, at least 10m in length
2. Cassette player
3. Audio Cassette
4. Suitable footwear
5. Measuring tape to measure 10 m course
6. Marker cones, these are placed 0.5m in from each end avoiding the need for any abrupt change in direction.

Preparation

1. The explanation to the walker is found at the beginning of the tape and a 1-minute calibration period is presented.
2. Explanation to the walker is standard- however the tape is stopped to translate in the relevant language; 'walk at a study pace aiming to turn around at each end

when you hear the signal. You should continue to walk until you feel that you are unable to maintain the required speed without becoming unduly breathless'

Starting the tape

1. There is a triple bleep to start. Thereafter the tape emits a single bleep at regular intervals. The subject should aim to be at the opposite end to the start by the time the bleep sounds.
2. After every minute the speed of walking is increased by a small increment, so the walker walks progressively faster, this is indicated by a triple bleep.
3. The first speed of walking is referred to as level 1, the second level 2 and so on. Each level lasts for 1 minute and the tape continues for 12 levels. Each level contains a number of shuttles (10 lengths), the number of which is dictated by the speed of that level.
4. To help the walker establish the first very slow speed of walking the operator walks alongside for the first minute.

End point of the test

1. The walker determines the end point of the test, i.e. when s/he becomes too breathless to maintain the required speed.
2. Indication for the operator to discontinue the test is failure of the walker to complete the shuttle in the time allowed, i.e. is more than 0.5 m away from the cones when the bleep sounds another 10m length is allowed to give the walker the opportunity to recover the 'lost' distance. If they are unable to do this, the test is discontinued.

Protocol to analyse data obtained

Table 5.0 Protocol for the 10m Shuttle Walking Test

10m shuttle walking test – 60 second increments

	Speed			No of shuttle in each	No of shuttles	Distance
Level	M/s	Km/h	mph	level	total	m
1	0.5	1.80	1.12	3	3	30
2	0.67	2.41	1.50	4	7	70
3	0.84	3.03	1.88	5	12	120
4	1.01	3.63	2.26	6	18	180
5	1.18	4.25	2.64	7	25	250
6	1.35	4.86	3.02	8	33	330
7	1.52	5.47	3.40	9	42	420
8	1.69	6.08	3.78	10	54	520
9	1.86	6.69	4.16	11	63	630

10	2.03	7.31	4.54	12	75	750
11	2.20	7.92	4.92	13	88	880
12	2.37	8.53	5.30	14	102	1020

For example if a walker completed 9.2 levels:

9 completed level = 63 completed shuttles lengths

2 completed shuttles =2 shuttle lengths

Total length = 65 Shuttles

= 650 metres

5.3 Results

5.3.1 Pilot Project One: Savera Resources Centre

Previous contact with the Savera group and the workers showed that they were very committed and enthusiastic towards the walking project. There had only been one occasion where the manager could not attend a planning meeting. The activity co-ordinator was very keen and undertook the walk leaders training programme. Most of the group were interested in the programme, however it needed to be integrated in some sort of activity and not just a health walk.

The steps involved in setting up a walking programme with the Savera group are summarised in Table 5.1. The method was based around an action research model that is Look, Think and Act. Steps 1 –3 (look and think) were concerned with the collection of base line data that is collecting views and finding out what the group does and what their needs are. Step 4 (act) is the delivery of the product and evaluating it and finding out what could be done better next time.

Table 5.1: Summary of contact made with Savera

Date /contact by	**Contact with**	**Subject**	**Arranged for**	**Outcome**
Step 1: Initial contact with activity co-ordinator 15.2.99/ via telephone	Activity Co-ordinator	Arrange meeting	8.3.99	
8.3.99 Meeting	Activity Co-ordinator &	Intro to project/collecting	15.3.99	Recruited women's group, which meet

	Project Co-ordinator	views		every Monday afternoons. Activity Co-ordinator interested in being trained as walking activator. Filled out views of walking.
Step 2: Consultation with group 15.3.99/ meeting	Activity Co-ordinator & Project Co-ordinator + group	Consultation with group	29.3.99	Filled out views on walking. Places they would like to walk. Short talk on the benefits of walking.
Step 3: Introduction to exercise leader 29.3.99	Activity Co-ordinator, Project Co-ordinator, Walking Activator + group	Introduction to walking activator. Fill out Par-Qs and Question testing	12.4.99 Abbey park 19.4.99 Urban walk 26.4.99 Riverside walk	Filled in Par-Qs translated as we went along. Question testing was also filled out. Walks arranged.
Step 4: The Walks	Activity Co-ordinator & Walking Activator	Phoned to make sure walk was on before each walk	As above	

Background to Savera Resources Centre

The main aim of the Savera Resources Centre was to;

'Serve Asian people experiencing mental health difficulties and their carers. Provides social, recreational, educational and therapeutic activities for people using mental health services. Included are anxiety management; anger control; social skills; assertiveness and confidence building. Provides advice and information and individual counselling when necessary. Aims to promote awareness of mental health issues and develop and support a network for people with mental health problems.' (Taken from the Leicestershire health information network 1999.)

The group met Monday to Friday afternoons and held a number of activities.

Step 1: Initial meeting with Activities Co-ordinator

A meeting was set up with the activities co-ordinator to find out as much information on the group. Some of the group were very active and others not as much, it was a mixed group. A few of the members were keen walkers in warm weather and would walk into the town centre. As a part of the activities of the group, trips were made to Belgrave Road, via a mini-bus, which dropped them off near the shopping area. The group would then walk around the shops. The group attended a shopping trip to Manchester Shopping Centre, walked around, but they needed time (2mins) to rest on the benches. They had also been to Loughborough Park for a picnic; the group enjoy these sorts of trips.

The working history with Savera via the Confederation of Indian Organisations (CIO) involved delivering a talk on the Active for Life material and followed up by facilitating an informal walk with the Activities Co-ordinator to Beaumont Leys Shopping Centre in Leicester. The group had basic health promotion activities i.e. health talks on healthy eating, basic yoga and exercise sessions, by the Leicester Community Health Project.

The activities co-ordinator views on walking were very positive and thought it to be relevant to the clients. The group knew what was good for them but needed motivation for them to walk. Some of the clients lived across the road from the Savera Resources Centre but would not walk across due to the main road. The activity co-ordinator felt that group walking would encourage them to walk and that walking can be disguised and integrated into activities run at the centre. At the end of the meeting the proposed action was to meet the group and ask them what type of walking activities they would like to do.

The person taking the lead was a part time activities co-ordinator and part time administrator. She felt that she could take on training if it was during work time and she already possessed a first aid certificate.

Step 2: Consultation with the group via a focus group.

The ladies thought walking was very relevant to them. They walked in variety of settings such as, to the resources centre, into the town centre, to pick up the children, to go shopping, to the bus stop, around the house after the children! One of the ladies said her General Practitioner had advised her to walk. They were also concerned about their weight gain, a side effect of taking anti-depressants; they would like to lose it via walking.

A few of the deterrents of walking mentioned:

' If it is cold I wouldn't walk, I just don't feel like it.'

' I have diabetes, I should walk but it makes me feel tired.'

' I only walk a short distance and I get puffed out.'

' If the car is parked outside and my husband is in the mood he would drive me down to the shops otherwise I would have to walk.'

' I am too scared to walk across the park (Cossington Park) *just in case someone attacks me.'* another lady replied *' you should only walk during the daytime and don't carry your purse around.'*

General comments were; a quarter of the ladies walk everywhere, but needed reinforcing the intensity of walking to derive any health benefits. The other ladies would like to walk but were worried about their health conditions.

The things that would encourage them to walk were;

' If it is good weather.'

'Open spaces and fresh air.'

' I would like to walk in parks.'

' Walking in groups and talking to one another.'

The proposed action within the group was to participate in walks, held at Melton Road, Cossington and Abbey Park, and the riverside when the weather gets warmer. Initially once a month, and if they feel confident increases this to weekly walks.

During the focus group questions asked were:

- *'When I walk I get really bad leg cramps what do I do?'*

  (Need to see you doctor)
- *'I like to walk but the back of my legs start to ache. Why is this?'*

  (Need to do a warm up)
- *'If I walk I get chest pain and the back of my arms hurt?'*

  (See your doctor)

Case Record 5.1

The following contact sheet was filled out with the Activities Co-ordinator, to introduce the project and to find out more about the group.

How active is the group?

The Activities Co-ordinator knows the group really well. Some of the group members are keen walkers in warm weather and will walk to the resources centre. The group went on trips to Belgrave Road, but needed to take the mini bus and then be dropped off near the shopping area and will walk around the shops. The group also attended a shopping trip to Manchester shopping centre, walked around the centre, but they would require time at

least two minutes to sit on the benches. The group went to Loughborough Park for a picnic; they enjoyed these sorts of trips.

History; Confederation of Indian Organisations have worked with Savera by delivering a talk on the Active for Life material and followed it up by facilitating an informal walk with the Activities Co-ordinator to Beaumont Leys Shopping Centre in Leicester.

Set-up: Monday: ladies Support Group

Tuesday: Mixed support group

Thursday: Activities support group meeting.

Views About Walking (Activity Co-ordinator)

1. **How relevant is walking to them?**

The group knows what is good for them but need motivation for them to walk.

2. **What deters them from walking?**

Some clients live across the road from the Savera Resources Centre but won't walk across due to the main road (Loughborough Road).

3. **What might encourage them to walk?**

The Activities Co-ordinator feels that group walking would encourage them to walk. Personally she does not walk due to having a car, the time aspect, house duties and child-care. She felt that walking could be disguised and integrated into activities run at the centre.

Proposed Action

To meet the group and ask them what type of walking activities they would like to do, if not perhaps a shopping trip to Belgrave Road or Lydi's supermarket.

Action

To meet with the women's group and arrange for walks, the Project Coordinator will pass on details on of Exercise To Music training for April 1999. Activity Co-ordinator will pass on annual report.

General

Activity Co-ordinator is very keen on integrating walking into every day activities. The Project Co-ordinator talked about the benefits of walking i.e. reduction in osteoporosis and CHD but also to relieve stress and the help emotional well-being.

Community Groups worked with in the past.

Belgrave Neighbourhood Centre

Belgrave Baheno

St Gabriel 's Community Centre

Step 3: Meeting with the exercise leader.

The group were introduced to the qualified exercise instructor who would be leading the walk. The objective of this meeting was to fill out the Physical Activity Readiness – Questionnaire (PAR-Q) (Appendix III) the results are shown in table 5.2 and to test Oxford's behaviour changes questionnaire. This took one and half-hours to do with three workers translating. The three walks undertaken by the Savera Ladies Group is shown in table 5.3.

Table 5.2: Summary of results from the PAR-Q.

All walkers' South Asian females aged from 32-64. 17 Par-Q's filled in:

Question No from Par-Q, Health Problem	*No of ladies answered Yes to*	In %
1.Heart condition	1	3
2.Chest pain during physical activity	2	7
3.Chest pain at rest in the last month	2	7
4.Lose balance/dizziness	6	20
5.Bone/ joint problem	8	27
6.On prescribed drugs	8	27
7.Any reason why you should not do physical activity	3	10

Step 4: The Walks

Table 5.3: Details of the 3 walks undertaken by the Savera Ladies Group

Walk details	**Walk 1Shopping: Cossington Park/Belgrave Rd**	**Walk 2 Belgrave Hall Gardens**	**Walk 3 Riverside/ Central section**
Date	12.4.99	19.4.99	26.4.99
Length of Walk (Miles)	0.8	1.3	0.7
Walk Leader	DA	DA	RC, PF
Back Walk Leader	RC	RC	DA
No of walkers	11	13	9

Start time	1:30pm	1:30pm	1:30pm
Finish Time	2.45pm	2:35pm	2:30pm
Time taken for leader to finish	1hr	55mins	1hr
Time taken for back leader to finish	1hr 15 minutes	1hr 05mins	1hr
Weather Conditions	7-8°C Heavy rain then cleared but still quite cold in the wind.	8-9°C Sunny/Slight breeze	9-10°C Light showers, Sunny spells
Any problems	Lady with walking stick, finding it difficult to keep up, had sore feet.	Lady with walking stick has to rest, was not feeling to well	Couple of ladies not feeling well had to rest.

Case Record 5.2

Abbey Park Walk; (Circular walk)

Project Co-ordinator and the Walking Activator measured walk with a trucmeter (a wheel) to be 02556.8 metres (1609m =0.621mile)(2556.8 /1609*0.621)=0.989 miles. It took 50 minutes around the route at a leisurely pace and 2 five-minute stop off points. The route was marked out.

Directions

- Meeting point is the car park; stretching exercises.
- Walk begins out of the car park onto the footpath, turn right heading towards the main gates and pass the park lodge, continue round.
- Head towards the bridge passing the boating lake on the left and the river on the right.
- Cross over the bridge and turn left in to the gardens. (If group is tired can take a short cut down the river side.)
- Turn left out of the garden pass the cafe.
- Take a left around the open field pass the play area and swings.
- Head towards the pets corner and follow the signs.
- Stop for a drink/ break if needed.
- Carry on straight out of the pets corner pass the back gates and head towards the ruins.
- Pass the ruins and down the steps turn right along the riverside and back over the bridge.
- Turn left and head back toward the car park for cool down stretches.

If the weather does not permit then the back up walk would be a short urban one.

Walk one: Shopping Cossington Park/Belgrave Road.

This Walk was not planned in great detail, as it was the back-up walk, instead of the Abbey Park walk due to the weather conditions).

- Starting point Savera Resources Centre, turn left out of the centre heading toward the Belgrave Road shopping area.
- Cross at the pedestrian crossing onto Cossington Street.
- Pass the library onto the Cossington Park, do one circuit, and head for the Belgrave Neighbourhood Centre. A stop off point to use the toilets (the faster group headed off onto the Belgrave Road to browse in the shops. The slower group caught up with them.)
- Looked into 3 or 4 shops, the group split up at this point to look at the different shops.
- Carried on up to the Melton Road/ Belgrave Road and Loughborough Road junction.
- Carried on pass the junction up to Windsor Avenue, which takes you back on to Loughborough Road heading back to the centre.

Feedback on Walk One

Group and leaders feedback was obtained by a short focus group after each walk:

Group feedback on walk one:

The group felt that the walk was too short and there was a difference when walking in the park, the pace was rather slow and would have been better if it was not raining. The group enjoyed the walk and going to the shops. However, they felt they should have really continued walking and not gone into the shops. A couple of the ladies did feel sweaty implying that their heart rate was raised.

Project Co-ordinators (Back Leader) feedback on walk one

The walk did not go to plan; due to the weather therefore the back up walk took place instead. It was not appropriate do any mobility or stretches due to the weather being cold. The pace was slow to begin with, but increased when the Cossington Park was reached. The group split into three, a fast, medium and slow group. The walk leader waited and set the fast group a task to go around the Cossington Park, which is about 0.2 of a mile circuit, and stayed with the medium group in the middle. This middle group

waited for the back group to join them at the main crossing before entering the park. The weather did not help but did increase the pace due to the cold weather. Coming onto the main road the pace slowed down and the walk become a stroll. Overall, it did run well but there were stops, which were necessary for the lady with a walking stick.

It was easy to observe the group in the park, which was an open space circuit. However, the front leader decided that the middle group needed more support and direction. The walk leader therefore did not necessarily need to stay at the front as long as the fast group were informed of where they are going. The fast groups (two ladies) were finishing the walk at Belgrave Neighbourhood Centre, and were not completing the circular walk back to the Savera Resources Centre.

In terms of effectiveness, people did walk faster due to the rain and wind. However, when they looked inside shops, the momentum was lost and they strolled along as the weather improved. For the next walk encouragement would be given to the participants to increase their speed when walking around the park. It would include activities such as games at the park, which would raise their heart rate, and to teach mobility and stretching exercises. The group was controlled effectively and safely, both front and back leaders worked cohesively in order to maintain control of the group and the direction it was heading.

Reflection 5.1

Walk One.

It did not go as planned, due to the rain the Abbey Park walk was cancelled, the ladies felt cold. It was fortunate that back up plans were in place to do a short walk to the Cossington Park and Belgrave Road the situation was resolved effectively.

Some of the ladies had not signed their Par-Qs so this needed to be done and really wasted time. Most of the ladies initially did not want to come to the park but eventually liked the idea of shopping, so the health walk was disguised.

It was off putting that one of the ladies said that;

'This type of activity is a waste of time and I don't want to get any more depressed than I am.'

Eventually, they got going, after a quiet word with the lady she was convinced to come along. Once out of the door, it started to rain again, a choice was given to the ladies at this point and a few of the group opted out.

It was not appropriate to do a warm –up or cool down as they did not work that hard. In total 11 ladies were on the walk with others joining and leaving at three points on the walk. It was noticed that the ladies were walking faster in the rain around the park area, compared with when the sun came out and they ended up browsing in the shops.

Reflection 5.2

Interpretations of walk one

The walk was a good stating point, there are some really keen people who are connected with the Belgrave Neighbourhood Centre. Part of the walk was a health walk, but the other half was social.

The group naturally split into two groups and the Walking Activator took lead of with the faster group whilst the Project Co-ordinator stayed behind with the slower group. The Cossington Park area was ideal ground for walking in, as it is circular (approximately 0.5 miles in circumference) and one can see right across. It was decided that the ladies in front were doing well so that leader joined and motivated the middle group. The faster groups (two ladies) were set a task to do a circuit of the field, after which they left due to other engagements. This was perfectly expectable, as long as walkers notify one of the walking activators.

Problems; The crossings of main roads were a problem and it was natural for the group to slow down, and to make sure the rest of the group caught up.

Barriers; The main barrier was the weather; if it were warmer the ladies would have liked the trip to the park.

Things that went well; The ladies attire and footwear were acceptable, they were all wearing what was comfortable for them, i.e. Sarees and Punjabi suits.

It was good to see the ladies walking in the rain and perhaps this was a motivating factor to walk faster as the speed dropped when the rain stopped.

Things that did not go so well; It was disheartening that the activity co-ordinator could not come along. Half the group did not want to participate so she had to stay behind with them. May have to rethink using activity co-ordinators as leaders due to time commitment.

Reflection 5.3

It was decided that the front walk leader does not necessarily need to stay with the fast group as long as they know where they are going, and the leader might need to move to motivate the middle group. There were a lot of pauses in the walk, these need to be cut down and to make sure the walks are more continuous, although breaks were important. For the next walk an introduction should be made to the concept of warming up, mobility exercise, stretches and cool down stretches.

Case Record 5.3

Group feedback Walk One Cossington park / Belgrave Rd. (shopping)

1. **How did you feel about the walk?**

   Did you think it was too long or short?

   ' The walk was too short.'

   'There is a difference when you walk in the park.'

   'The pace was slow.'

   'It would have been better if it was not raining.'

2. **Did you enjoy the walk? (The social aspect, socialising with people / company, the weather, the breaks)**

   'I liked it very much'

   'I liked going into the shops'

   'We should of really continued walking and not gone into the shops'

3. **What you did not enjoy / like about the walk?**

   'The weather.'

4. **Did you like the route?**

   'Would have enjoyed it more if the route was longer.'

5. **Did the walk make you feel slightly hot and sweaty (did it increase your heart rate)?**

   'Yes' (a couple of the ladies)

   'My feet were slightly sore.'

Case Record 5.4

Walk 2: Belgrave Hall Gardens.

This walk was planned to include mobility exercises and the cool down stretches

Warm-up

- Turn right out from the centre onto Loughborough Road carry on past the Checketts Road junction and cross at the pedestrian crossing.
- Turn left into Thurcaston Road passing Belgrave Hall.

Mobility Exercises

- Stop in the playing area in front of the Belgrave gardens, for mobility exercises conducted by Walking Activator for 10 minutes.

Main walk around the gardens

- Head toward Belgrave House following the path past the play area and along side River Soar. Walk around the Belgrave House Gardens ending up on Church Road.
- Enter Belgrave Hall and through into the gardens. Walk across the formal garden and turn right into the botanical gardens, follow the path clockwise into the woodland garden. Turn left back out into the herbaceous garden, follow the maze into the monument garden and follow it around into the rock and water garden.

Cool-down stretches/ Circular route back

- There are benches here to rest on, follow the path into the glasshouse unit, return into the rock and water garden and into the herbaceous garden. Follow the maze circuit, and finally head back towards the formal garden for cool down stretches conducted by the walking activator.
- Walk back through Belgrave Hall Museum, turn right onto Church Road heading onto Thurcaston Road, and turn right heading back onto Loughborough Road. Turn right again down Loughborough Road, back towards the centre.

Group feedback walk two

Compared to the shopping walk it was continuous and felt much longer. There was more green area and fresh air. There was no pollution and really good walking weather. The length of the walk was just right for the participants. The group liked the walk in particular the weather, the flowers, the plants and just visiting a new place. The only thing that the group did not enjoy was that the leader did not allow any short cuts. They also did not realise how long the route was. Three of the ladies felt that their heart rates went up. They did feel warm but did not sweat.

Leaders Feedback: walk two

All activities were safe the walking activator did ask them if they were warm enough to stretch. The fast group did get to an aerobic level, however the slower group needed reinforcing with the health benefits. On the next walk it might be an idea, to reinforce the importance of stretching and why this is done. The group needed to be motivated for them to walk a little faster. Being, at the back means strolling with them, perhaps pushing them a little more but making sure they are walking at a comfortable pace.

The leader had a difficult job teaching the stretches. It was difficult from the back to see what she was doing. The back leader tried to reinforce the movements with the ladies at the back but they were not to keen. Perhaps because it was the end of the walk and it was an open space. Instead of the walking activator being at the front of the group it might be a good idea to form a circle, therefore observation and teaching position would be clearer.

Reflection 5.4

Walk Two: Belgrave Hall Gardens

The walk went very well and to plan. The activity co-ordinator of the group attended this time, and that's why there were 13 people, as they had no choice but to come on the walk. Two natural groups formed, however others felt obliged to wait for the slower ones. Mobility and cool-down stretches were introduced this week. There were some apprehensions that the ladies would refuse to exercise in the open, but they adapted well. The play area was away from the road, and quiet. Not all the ladies were doing the exercise correctly, but this would come with practice. All the ladies coped well doing the mobility and cool-down stretches in the open air really well. The weather was ideal for walking and this made a real difference in their enthusiasm to come for the walk. They enjoyed themselves and from the group feedback the walk got their heart rate up.

The walk went particularly well with the activity's co-ordinator present, as she acted as the middle marker. This walk was a real 'health walk' due to the exercise components and being continuous. The ladies did feel tired, meaning that the heart rate was increased for a short period of time. It was great to see the group really enjoying the scenery, at one point a town fox was spotted. It was a difficult task keeping the group continuously walking and not pausing for others to catch up. However, compared with the shopping trip the walk was continuous, there were only two catch up points, one for the mobility

exercises and the other for the cool-down stretches as this was done in a group. Two of the ladies had a 5-minute sit down break with activity co-ordinator, due to not feeling well. It was only a 10-minute walk to Belgrave Hall from the centre and 10 minutes back. The leaders made a conscious effort to keep the group moving and being real firm. A real impact just by saying 'move those arms and no short cuts.'

Problems; the lady with the walking stick was feeling unwell on the walk; she managed to complete the walk, with rests in-between. It was fortunate that the walk had planned in benches for rest breaks. The co-ordinator was present to recognise the client symptoms, as at one point she was felling dizzy.

Observation and correcting the group was a little difficult, needed to arrange them in a circular format. Crossing the main road at the pedestrian crossing again slowed the pace. The walking activator picked up on some of the logistics of the group.

Barriers: Most of the ladies footwear was suitable, but there were one or two with slip on saddles on and court shoes. One of the ladies had brought her training shoes but forgot to wear them. All the ladies seemed to be comfortable in wearing their Punjabi suits and Sarees but needed to reinforce that they must be cotton.

Things that went well: The continuous pace of the walk and the exercises. Both front and back leaders changed the positions in leading the walk in the gardens. This would be explored further in the next walk. The gardens themselves were a motivation to walk around; the maze in particular helped the ladies motor skills.

Things that did not go so well: Recognising symptoms of when someone is not feeling well, especially if you do not know them. Would be relying on walker to tell the leaders if they were not well. It was fortunate on this occasion that the activity co-ordinator knew her clients. It is important for the walking activators to be approachable in any situation and can understand one of the South Asian languages.

Implications: The walk needs to increase its pace as some of the ladies are not walking briskly but strolling, need to re-define brisk. Next time could stop inside the museum to look around (this would be ideal if it started to rain). A major task would be not to have the ladies waiting for each other; leaders have to jump between the groups to do this.

Case Record 5.5

Group Feedback

How did you feel about the walk? Did you think it was too long or short?

'Compared to the shopping walk it was continuous and felt much longer.'

'There was more green area and lots more fresh air.'

'There was no pollution and really good walking weather.'

'The length of the walk was just right.'

Did you enjoy the walk? (The social aspect, socialising with people, company weather, breaks)

'Did like the walk in particular the weather, the flowers, the plants and just visiting a new place.'

What you did you not enjoy or like about the walk?

'Nothing, the walk was reasonable.'

'The teacher was strict, and didn't allow any short cuts...but this was okay.'

Did you like the route?

'We didn't realise it was that long.'

Did the walk make you feel slightly hot and sweaty (did it increase your heart rate)?

Three of the ladies felt that their heart rates went up. They did feel warm but did not sweat.

Case Record 5.6

Walk Three: Riverside Central Section

The Riverside officer planned this walk. The project co-ordinator met with the riverside officer and specified that the walk had to be on flat ground and no more than a mile long. The walk would be a cross between a health walk and a guided walk of the riverside. This was experimental and to see if this type of walk would work. The project co-ordinator would translate into Gujarati.

Walk Three:

- The same route was taken as to the Belgrave Garden Walk, the group met up with the riverside officer.
- Walk though the Belgrave House garden where Riverside Ranger pointed out an Oak tree.
- Through the play area over the Thurcaston Road Bridge onto the opposite side of the river, Riverside Ranger pointed out sweet smelling flowers, nettles and dot leaves.
- At the entrance of the riverside were patches of blue bells. The group stopped to observe.
- Walking further along pointed out a number of trees and also a Japanese cane weed, which was pushing the rest of the plant life way. Saw a few butterflies.
- Continued up to Holden Street cable bridge, (Riverside Ranger left), cross the bridge up onto Vann Walk back to the centre for cool down stenches.

Group feedback: walk three

The group enjoyed the walk being educational, but thought it was very short. They also enjoyed looking at the plants, and thought it was a nice easy walk. They liked in particular the fresh air, walking together and the company they enjoyed the talk given by the riverside ranger, which was interesting, learning about the plants. The walk did not make them sweat.

Leaders feedback: walk three

The walk was much shorter than planned; this was due to the lady with the walking stick not feeling well. Therefore, after the riverside guided walk the group headed back to the centre. No mobility exercises were done due to the late start and the riverside ranger needed to get away. The group really enjoyed learning about the riverside and it made the walk much more interesting, however this was not a health walk as there were too many stop off points. However, some of the group really benefited, as it was a suitable pace for them. Half of the walk was social and the other half health orientated that is walking briskly from the centre and back. This worked really well as the group got best of both worlds. The walk did not consist of mobilising the joints, it was debatable if this is really needed, and the group were not really warm enough to perform these exercises.

There was a need to somehow integrate educational activities into the walk. It was difficult setting a pace and translating and pointing out at the same time.

The group really felt tired after the guided walk, they seemed to lead themselves back to the centre, and found a short cut for themselves. This was not a planed part of the walk so it was interesting for the group to take over. One of the ladies was not feeling well at all so two of the volunteers took her back to the centre.

People tended to stroll along the riverside as the ranger pointed out some facts about the surroundings. The walk was not effective as it was short and it did not pick up speed. Participants did enjoy the walk and the mobility exercises were completed at the end of the walk. The leader needed to refine what a health walk is for this particular group. It seems that very gentle form of walking, mobility and stretching is required for majority of the group at this initial stage. With time, the group may be able to increase the time of the walk or shorten the time and increase the speed.

Reflections 5.5

Walk Three Riverside Central Section

The groups were not very keen on coming to the walk; it was cloudy outside, with occasional light showers. Most of the group were feeling tired. The activity co-ordinator therefore had to stay behind, and one of the ladies could physically not walk. Not many takers, one of the ladies asked to take her daughter so that she could have a rest from her. This had to be confirmed with the activity co-ordinator she was not happy for her to go on her own. It had to be explained to the mother, who in the end decided to come, because her daughter wanted to go. At this point, two other ladies that were staying behind came, because they did not want to be just siting at the centre on their own. There were a total of 9 ladies. The riverside ranger was waiting at Belgrave Hall. The project co-ordinator introduced him and the ladies were fine having a male guide. The riverside ranger gave a short-guided walk along the riverside, translation occurred on route. The group was much easier to handle as they stayed together. One of the ladies was taking notes in Gujarati about all the different plants, and what can be eaten and what not. It was very enjoyable, but the walking activators frowns indicated that: ' *this is not getting their heart rate up*'. As soon as the guided part of the walk was over the group naturally led itself back to the centre, it really goes to show how good their local knowledge is, and of the short cuts!

The walk was not a health walk and it did not get their heart rate up. However, they did enjoy the educational part of the walk, and the chance to touch, smell and learn about the plant life along the riverside. All were laughing and the ladies were genuinely enjoying themselves. The expressions of interest were different to the Belgrave Garden walk. Having someone explain things really held their attention, otherwise they seem to always chat amongst themselves. The group stayed mostly together for this part of the walk, and the group were communicating with the ranger and asking questions though the project co-ordinator. Some of the ladies who spoke a little English were asking him questions directly. Half of the walk was a normal pace and the other half a stroll. This seemed to work well with the group; they did achieve to walk briskly for 25 minutes.

Problems; the slow pace of the guided walk and then motivating them again to walk further and faster, some of the ladies were not feeling well; it was fortunate to have volunteers who could take the lady back to the centre. Some ladies, who left the walks early, did not give the leaders a chance to get feedback.

Barriers: Sensible footwear.

Things that went well; from a social point of view the guided walk, and getting to know the riverside better and the confidence of the group to lead themselves back to the centre. It was really admirable how the groups have gelled together and look after each other, and the trust between them.

Things that did not go so well; The time keeping, not starting promptly means that the leaders are pushed for time to conduct the exercise safely and effectively. The group really does become restless after an hour.

Implications; to include, the points of interest on the riverside, but not to pause and discuss them, A way forward maybe to invite the riverside ranger to the training session and allowing him to point these things out to the trainee walking activators, so that they have the sound knowledge to make the walk interesting. If both front and back leaders are trained they can point things out to the group as they walk past.

Case Record 5.7

Group Feedback

How did you feel about the walk? Did you think it was too long or short?

'Did enjoy the walk, but was very short.'

'Found the walk very short but it was educational.'

'Enjoyed looking at the plants, it was a nice easy walk.'

Did you enjoy the walk? (The social aspect, socialising with people, company weather, breaks)

' We enjoyed the walk, especially the fresh air, walking together and the company.'

'The talk was really good, I liked learning about the plants.'

What you did not enjoy / like about the walk?

'Nothing, we enjoyed it.'

Did you like route?

'yes.'

Did the walk make you feel slightly hot and sweaty (did it increase your heart rate)?

Some of the ladies did get warm, but the majority didn't.

Post Views on Walks

The group after the final walk were asked post views about walking. This again was done in a focused group session. The Walking Activator asked the questions in Gujarati and the project co-ordinator wrote the answers reinforcing some of the questions. A final evaluation meeting of the Chalo Chalay sessions was also set up with the walking activator, two of the activities co-ordinator's and the project co-ordinator

Case Record 5.8

View About Walking (Post group Evaluation)

Group: Savera Ladies group

Date: 26.4.99

No: 6 **Age:** 35-62 **Gender:** Female

Interviewer: DA and RC (focus group held in Gujarati)

1. **Did you or did you not enjoy the led walks? Why?**
   Which walk did you prefer?

- Did not like the walks when the weather was cold and it was raining or when we were unwell.
- Enjoyed the walks more when it was sunny.
- Really enjoyed the riverside walk because it was something new and educational. It was different for the group, as they have never had a guided walk. They enjoyed the change and also going into the museum.

2. **Has the led walks helped you to walk more often, aside from the group walking?**
   - No. Still continuing the incidental walking that is shopping, picking up the children.
3. **Would you like to continue to walk with the group? Would you like to join other walking groups in the areas, when available?**
   - If the weather was permitting and it was much warmer.
   - If transport was provided
   - Would be dependant on time, this is the only session when they are free from other commitments.
4. **Do you feel safe and confident to use the route in the led walks?**
   - No, would only walk in-group.
   - Would never really walk near the riverside alone.
5. **Do you think walking is important? Why?**
   - Yes, all the health benefits.
   - It keeps us mentally active
   - It exercises the whole body.

Other comments:

'We have enjoyed the walks, but the weather could have been better. It would have been better in the summer.'

Maybe arrange a few sessions later in the year. Will pass on details of other walking sessions and promise to comeback to show the photos.

Case Record 5.9

Views about walking (Post- Co-ordinator Evaluation)

Meeting with: all workers Activities Coordinator LC, MM Project Officer, DA Exercise Leader, RC Project Officer

Date: 26.4.99

1. **Do you think the walking programme went well? Why?**
    - It went really well, but the programme cannot continue due to other activities and other time slots.
    - The fresh air, open green spaces and the educational part, of getting to know the local environment motivated the group.
    - The walks cannot just be based around a health walk but around activities, otherwise a walk can be boring, long, tedious, and a long distance, which is off putting.
    - The take up was good, didn't think that the women were motivated enough to do this kind of activity.
    - Thought that the walking activators needed more knowledge on the type of medication the walkers were on, this needed to be incorporated into the training sessions. The side effects of this type of medication have a real effect on their stamina.
    - All agreed that most of the group were willing and enjoyed the programme, however some of the clients could not physically walk due to the side effects of the medication. Perhaps next time can arrange for wheel chairs.
2. **Do you have the confidence to run similar led walks with the group? Do you want further training to become a walking activator?**
    - Already running activities with the groups, which includes walking, but don't put emphasis on it.
    - Would need training to do this and a volunteer to help with the activity (i.e. back walk leader.)
3. **Do you think you had sufficient support from the co-ordinator and the walk leaders?**
    - Yes, just enough.

- One of the workers needs to stay behind at the centre to sit with the people who could not walk or did not want to come.
- The Chalo Chalay project could share resources.
- An important factor in working with this group is client's confidentiality.

4. **Would you want to continue with the Chalo Chalay Project?**
   - Would be interested in running an active woman's walk.
   - Would like to attend the training session with 3 other volunteers from the centre
5. **What next, proposed action?**
   - The walks cannot be left open; the group really need to be told specific detail verbally i.e. going from A to B. It needs to be targeted to activities, which they enjoy.
   - Need to include training on medication
   - Run walks for the men's group after September
   - Some of the women were now are walking to the centre they only ring to ask for a lift in real bad weather (this is a real achievement).

Outcomes

Pilot project one reached most its aims and objectives. It provided three doorstep walks within the geographical boundary and walking distance from the Savera Resources Centre. It required six sessions (plus an evaluation session) to deliver the programme and a further six sessions to prepare and plan the walks with the exercise leader. The process was slow and required a great deal of patience with all parties concerned. The key to its success was the trust between the activity co-ordinator, and the walking activators.

Development of Doorstep Walks and Routes

Four short walks were researched and tried. Each with its own interests and individuality: Belgrave Road/ Cossington Park, Belgrave Hall Gardens, Riverside Central Section, and Abbey Park. This particular group enjoyed the Riverside walk due to its educational component, and the guided tour by the riverside officer.

Procedure and Protocol for running a health walk.

The pilot walks allowed experimenting with different styles of leading health walks. The following procedure is only a guide and it is really dependent on how well the walking activators work together, which is a key factor to success.

Checklist for running a health walk

1. PAR-Q's must be filled out, to check general health, if in doubt ask the activity co-ordinator or refer them onto their GP's. Ask walkers to bring with them their medication and inhalers. Ask how they are feeling today. Responsibility of Back Walking Activator.
2. Fill out walk register, responsibility of front Walking Activator. All details must be filled out in block capitals (these are recorded). Liase with back walking activator to identify any problems. Introduce the walking activators, and describe the route. Let walkers know who is carrying the first aid kit and water.
3. If group is large, and if activity co-ordinator or volunteer is present ask them to be a middle marker, or to help with the rest breaks.
4. Front Walking Activator leads a short warm up walk, before doing mobility exercises. These must be done in a secluded area away from the main road and the public eye. Make sure walkers are warm before stretching. Reinforce why these are done and where they are felt.
5. Before taking any photographs ask permission.
6. If confident set the fast group tasks to continue the route on their own, but make sure they are still in vision (i.e. circular field or confine space), whilst you can concentrate on motivating other slower groups.
7. The back Walking Activator must stay at the back and make sure that the slower groups are walking at a comfortable pace.
8. If for any reason a walker feels ill, send them back to the centre with a volunteer or the activity co-ordinator; let the walking activator with the register know.
9. If for any reason any of the walkers leave before the end of the walk they must let the front activator know so that they can advise on appropriate cool-down stenches.
10. The front activator will end the walk with the cool down stretches with the fast group, the back activator with the slower group. If possible do these together, if more than 10 minute apart do them separately.

11. Make sure all walkers are back. Complete group feedback (one ask the questions whilst the other writes). Let them know of details of next week's walks; hand out timetables of other walks.
12. Fill out leaders feed back. Send together with the group feed back and register back to the Project Officer.
13. Enjoy the walk and the walkers company.

The recruitment of exercise leaders and volunteers

The Walking Activator/ Exercise Leader was central to the pilot project and had identified other exercise leaders who may have been interested in leading health walks and have experience in walking. The pilot identified 3 possible walking activators, one of which was running physical activity sessions at the Belgrave Neighbourhood Centre and was currently helping to running walking programmes with the group. The following criteria were put together and were essential for becoming a volunteer walking activator:

Role of a Walking Activator

- To run led health-walks locally in the Belgrave, Latimer, Rushey Mead, and Abbey area of Leicester for the specific needs of the South Asian community. Can be a front or back leader.
- To motivate client group walkers into walking briskly, but at a comfortable pace.
- To explain the health benefits of walking and the reasons for warming up and cooling down.
- To have the interpersonal skills to communicate with the client group walkers at a social level.
- To help develop walks and ideas that make the health walks more interesting.
- To liase with the co-ordinator and other Walking Activators to arrange walk details.
- To complete walk registers and to ask new walkers to fill out Par-Q
- The back leader is responsible for carrying the First Aid Kit, water, and to follow procedure if an emergency arose.
- The ability to speak a South Asian language
- To be friendly and approachable.

The volunteers would need to be trained in many of these aspects. However, the most important skill would be their interpersonal skills and the ability to communicate. This would be required to build the trust of the walkers and ultimately be the only motivating factor. The walking activators must also be able to liase with one another, as this was central to planning, conducting and evaluating the walks. The health walks would need to be based around an activity or interest of the recipient group this could be the motivating factor for the up take of the walks.

5.3.2 Development of Behavioural Questionnaires in South Asian Languages

A requirement of the funding from the British Heart Foundation and Countryside Agency was evaluation. They had commission the British Heart Foundation Health Promotion Research Group in Oxford to evaluate all four-demonstration projects. A question testing exercise was carried out, via the Savera Resources Centre. The Walking, Home, Garden and other Activities Questionnaire was three pages long consisting of three questions, each with a sub question, the overall document was four pages long including the covering letter. The questionnaire was filled out alongside the PAR-Q. It took over one and half-hours to fill out with a group of 13 ladies whom English was a second language, and 3 workers translating. It was too long especially when translating, some of the questions were rather confusing, and thus it needed to be simplified down preferably to one page with tick box answers. These comments were taken on and a further questionnaire was produced in collaboration with the Project Coordinator, on one page, with five questions dedicated to walking activities in the previous week. Participants were asked at what levels they were walking at, the number of occasions per week, the length in minutes or hours and whether it made them breathe hard, all these answers were circled. This was further adapted to produce The Chalo Chalay (Let's Walk) walking activities questionnaire (Appendix I & II). Parts of the Physical Activities Questionnaire by Len Almond, Loughborough University (in house document) and Walking, Home, Garden and other Activities Questionnaire by Charlie Foster British Heart Foundation Health Promotion Research Group (in house document) were also used.

The questionnaire was further developed with the translation department at Leicester City Council. This ensured the simplicity and the compatibility of the questionnaire to

the Gujarati language (Appendix III). One of the categories from the original questionnaire was omitted due to the confusion in translation. This was finding a differentiation between fast and brisk, the word fast was used for its simplicity. The whole questionnaire and the terminology were re-reviewed to ensure clarity of the data obtained and to be clear and precise in both languages. The final version contained four questions on the levels of walking, and the number of times per week, and the number of minutes and whether it made them breathe hard. The questionnaire was piloted in both languages, relevant changes were made and the final copies were printed both in English and Gujarati the first of it kind nationally.

The questionnaires were initially given pre and post the scheme with minimal intervention from the walking activator. However, with the 66 case studies they were done in parallel with the Shuttle Walk Tests. The questionnaire tested the perceived walking activity at the start of the programme and gave some indication of baseline data. In year two of the project, with extra funding allocated the questionnaire was translated into four of the other main South Asian languages spoken in Leicester that is Hindi, Punjabi, Urdu and Bengali.

Reflection 5.6

Translators at the Leicester City Council Translation Department were recruited to translate the Chalo Chalay questionnaire. A meeting between the translators, the project co-ordinator, the evaluator from Loughborough University, and a representative from the Leicester Health Promotion Unit discussed the format of the questionnaire. The translators advised that a simplified version of the questionnaire would produce more quality data. The meeting bought an awareness of the terminology used and it's varying meanings. The question flagged was how to translate brisk walking this could mean different things to each individual and their own translation of it! Brisk is different to a 30 year old compared to a 60 year old. The level of language used also had to be simple 'plain English'. Some of the Gujarati words that the translators translated were of a high level, and most of the Gujarati population would not understand, only those who were educated to that level would. The designers of the questionnaires felt the meeting was very productive and made them rethink, the way they thought, from a different angle, it stimulated a different thought process. Consulting with the translators first, was an excellent way of producing quality translations in the view of the interpreters. Often

documentation is written in English, and when translated has a different meaning due to the terminology used, thus working with translators through the process ensures quality data. The questionnaire was simplified down from five levels to three levels of walking: slow, medium and fast.

The amount of time spent with the translators was considerable; resources in time were given in kind by other colleagues. The actual process of translation is expensive. No extra funding had been allocated for this, and the other demonstration project would not face these kinds of costs- it should have been seen in hindsight to budget in these extra costs.

The main setback to the project has been the lack of resources to promote walking to this community, in terms of literature, videos, and qualified professionals. Time has been invested in developing these resources prior to delivering the intervention. For example, the evaluation questionnaire was redesigned and simplified in accordance to the community it was targeted at. There were a number of interesting outcomes, when the evaluators and the translators sat together and discussed how this community would perceive the questions. A straight translation from English to Gujarati was not the answer as the meaning, and thus answers may change. A word may mean one thing in English but as a different meaning in another language. Considering the background the target group was coming from, which would apply to all cultures, the level of language used needed to be simplified down. The first questionnaire was translated into Gujarati and has been received well, although the font size could have been bigger. The questionnaires have now been translated into Hindi, Punjabi, Urdu, and Bengali.

5.3.3 Project Implementation

Five main areas were identified in relation to project implementation, which were developed alongside the production of guidelines and training.

1. Outreach in the community

The first step in project implementation was the audit of the area, identifying any physical activity opportunities and projects that could link in. There was a gap in services for single gender sessions and in general physical activity opportunities for the elderly that were free. Next, focus group discussions were held with grassroots within community structures on what physical activity opportunities would be viable. Views on

walking were collected and analysed, routes were devised, and time slots allocated. Workers and managers were informed of the projects and the results of the focus groups, tailored training was offered.

2. Co-ordinators Time

In the first year of the project, the co-ordinator was working part time, this did not allow time for detailed strategies to be implemented. There was a serious lack of time; the co-ordinator, as well as planning, developing and running of day-to-day walks did a lot of administration. The co-ordinator in the second year left, and the post became full time, however the expectation of the number of walks and walkers grew thus, the new recruited co-ordinator was still in the same situation.

3. Pilot Projects

These were run with the Savera group a mental health project for South Asians, the Belgrave Neighbourhood Centre women and men's group. It consisted of testing routes, and receiving feedback from the walkers. The process helped refine the lead walks, the procedures for leading walks, and the role of a walking activator and their training needs.

5. Evaluation

This had been an integral part of the project, but the challenge was how it could be incorporated with the recruitment of the new co-ordinator, as previously data was collected via action research. However, close links continued with Loughborough University, the evaluators of the project. The shuttle walk tests had been an important motivational tool and the questionnaires were translated into five South Asian languages.

Project implementation had been a difficult process, due to the lack of walking activators and a lack of an appropriate resource, which thus had to be developed in-house. The walking activators that have been recruited had a high calibre and had expanded the project in a short space of time.

Recruitment of Community Groups and Voluntary Organisations

In line with the action research model, the component of look was explored by identifying existing community groups in the geographical boundary. A list was obtained from the Leicester City Council, which had 47 registered South Asian groups in the

Belgrave and Latimer Wards. To identify all interested parties; all 47 groups were sent an introductory letter outlining the project and it benefits, attached was a short questionnaire on the groups details and what sort of involvement they would like in the project and if they wanted to be kept informed of progress. Only one of the community groups replied, and showed an interest in the project.

Reflection 5.7

It was not a good idea to approach the community groups via a letter, however this was the only means initially to give all groups an equal opportunity to access the project. The approach was re-thought and decided to select 3 groups previously worked with to promote the project by physically visiting the groups, delivering a general physical activity talk with Active for Life material produced by the Health Education Authority (UK) which promoted activities such as walking, cycling, gardening, swimming and dancing.

It had been very difficult to recruit community centres, and often they could be interested, but had no time to commit to the project. This is due to the workloads of activity co-ordinators who were often overworked. It was often the case the activity was taken on but no input and effort had materialised from the community centre, however the credit had been taken on.

Reflection 5.8

There was a lack of support from the Confederation of Indian Organisations, however a dedicated supervisor was allocated, but it felt like an updating procedure and not really constructive. Thus, there were barriers also from the community, as well as internally; it came down to the project co-ordinator to take the lead and not enough action from other partners.

The community development work prior to the project commencing was essential for the local contact formed. Community groups were recruited by giving physical activity talks and the benefits to health. Groups were recruited by word of mouth and via the Asian media network these included Savera Resources Centre, Belgrave Neighbourhood Centre, Vishamo a mental health project, and Pragna Chakshu (Inner Vision) based at Abbey Primary School.

Raising awareness in schools and linking in with Safer Routes to Schools

Links into schools and Safer Routes to Schools programme were initiated. Rushey Mead Secondary School was a very active school in the community. The Chalo Chalay project was promoted in personal and social education class Year 7 (11-12 year olds). An informal survey was carried out to find out the number of students who walked to school, which was a third. The rest came by car because they lived more than a mile away, and because of safety reasons i.e. crime and bullying. At this session the logo competition was launched for the project to the year 7 students. Existing routes around the school, were identified together with the Riverside and Park Rangers, these were promoted to the students.

Reflection 5.9

The head teacher at Rushey Mead School was very active and enthusiastic member of the community. A number of ideas were generated from this meeting, however resource and time needed to be allocated. The ideas generated were viable if the involvement of parents on to the initiative was assured.

The head teacher invited the project to a swimathon event that was taking place at the school to promote the project. It was also suggested to target the parents that drop their children off to the Hindu Indian Association, twice a week to learn Gujarati, and have an evening walk for them, when their children are learning.

Development of Operational Group

Visiting groups in the locality and marketing the project helped set up local and professional networks. It was essential to make the project a community owned initiative and to set up a working operational group. A select group were invited to an introduction meeting at the project. The attendance was poor and no community members were represented. This may have been due to the venue being in the city centre and the lack of parking.

Reflection 5.10

It was essential to targeted individuals to make an informal working group involving volunteers. It was difficult to get members to take a lead on the operational group; To

ensure that the initiatives were self-sustaining, active volunteers in the community were sought to have ownership of the project. It had been an advantage to have a few committed individuals rather than more as a conflict of interest arose between the community centres and all individuals concerned.

Project Structure and Management

The project co-ordinator was allocated time with a supervisor once a month, these sessions were not really supportive. They were initially perceived as a good way of getting support but materialised into an up date session, actions from the meetings were never communicated back to the director of CIO. Often the project co-ordinator directly dealt with the director if the matter needed an urgent decision. The project co-ordinator on a monthly basis also met with the Chair of the steering group, the director of health promotion, again initially these meetings were good to discuss ideas but also became an update meeting. Time was being wasted attending these two meetings as the same ground was covered in the steering group meeting. Supervision really needed to be redefined.

Reflection 5.11

Considerable support was received from one of the qualified exercise to music instructors, who came on board during the pilot project phase. She had an active interest in community work and had experience shadowing the project co-ordinator for four months. It was a great help having someone who had first hand experience of leading the walk to bounce ideas off. This extra help left in June 1999, and the project was having difficulties recruiting committed walking activators.

Community Involvement

In the first ten months of the project an extensive consultation took place, which included all stakeholders. Links were made with major establishments in the area. The community and volunteers helped in route development around the area. All existing groups and local business had been informed about the project and had been given the opportunity to get involved. All local events such as the Belgrave Mela and Riverside Festivals were targeted. Finally in every stage of the project, the ownership had been bias towards the community to the extent that the women's group name their walking group Chandni. A number of local networks had been established including community groups

and religious establishments. Professional networks had been set up locally and nationally with other demonstration projects and other potential walking projects. The task in hand was to maintaining working partnerships, which had been difficult, to get firm time commitment from partners.

Project Parameters

The main parameter was the setting of realistic targets and goals. The first year of the project had reached some of its aims successfully, but it had been a difficult process and a number of new barriers were identified. Time was required to address these new barriers; it put unnecessary pressure onto the project and its workers. This could have been avoided if realistic targets and goals were set initially. To allow for time for the development work would have been an asset and many of the challenges faced would have been overcome efficiently. A SWOC (Strength Weaknesses, Opportunities and Constraints)(case record 5.10) analysis of the project was carried out.

Project Support

Eight areas were identified which were the main sources of project support, in terms of capital or more importantly in kind.

1. Partners

Six partners had taken an active role in the project, there were many more that sat on the steering group but were not active. The project kept the partners informed of development, and to prevent duplication of work. The main partner was CIO who hosted the project. The second partner, the match funder was Leicestershire Health, the local health authority; it organised and administered the steering group meetings. The chair, the director of health promotion in the first year supported the co-ordinator in planning, via monthly sessions. The main funders of the project were the British Heart Foundation and Countryside Agency; they produced the Walking the Way to Health guidelines and held support workshops. The support had been a two way process, whereby all concerned had been learning and sharing information.

The Leicestershire Health Promotion Centre, NHS Trust had offered time and advice, in-terms of specialist advice on physical activity, and the audit of the Belgrave area (1 day a week for 2 months), also the heart health specialist for city east helped with contacts and audit. Finally, the Health Promotion Unit at Leicester City Council had advised on how to reach the Muslim community.

2. The Steering group

The steering group in the first instance had a large membership; this provided a forum of generating ideas from both the statutory and voluntary sectors. However, it was not constructive in providing the co-ordinator with practical and implementation strategies. Specific details could not be discussed and would seem just to be an informative meeting updating all other partners of current development in the project. The group developed as members changed and toward the end became more constructive. It was suggested to set up an operational group, which could meet more often and provide the grassroots level support that was needed. A major concern was the membership and the actual role of each partner.

3. Community Centres and Walkers

Considerable support had been given to the project by the community centres and voluntary groups within the Belgrave area. In terms of recruiting walkers, locality politics, contacts and identifying walk routes. The pilot projects such as the Savera group and Belgrave Neighbourhood Centre, provided constructive criticism of the walks and the project, this was very useful information in refining routes and writing the protocol. The workers at these groups were enthusiastic, and supported setting up the groups, however some of the workers were committed but did not have the time to run the activity. It was found they would come to the training but did not actually lead any walks, it would seem that they had a hidden agenda, in that they would like to see it as an extra activity for the centre but reluctant to put any labour into it.

The walkers themselves had been the strength of the project, which supported and stepped in as walk leaders whenever required. The power of word of mouth had been tremendous; it had only been by the referrals and recommendations of walkers that the group numbers increased. The walking activators although few in number had been a great asset they suggested a number of ways to publicise the project and helped in organising events and outings, constructive criticism was taken seriously and implemented. For example the days and times of the walks were negotiated so that it did not clash with other activities held in the area. In particular, with the women's group Chandni. The walking activator had gone on to do her YMCA circuit training

Qualification which was supported by Health Promotion Centre and refereed by the Chalo Chalay project.

4.Project Co-ordinators own Knowledge Base

External support had been vast, but often top heavy. The internal support from the organisation was minimal, thus building upon the co-ordinators own knowledge base was often the only source of real support and motivation. This however, was only achieved via experiences but also through 'ones own initiative'. To be able to wear a number of different hats and to be well received from a grassroots level to a policy, strategic level takes a certain type of character. From the research carried out by the Institute of Volunteering it was noted that the styles of co-ordinating were very different in the two people that had co-ordinated the project. In the first instance a relationship had to be built and a certain level of trust gained between the co-ordinator and the community, in the second instance a strategic role was being aimed at.

To have had the background knowledge of the community that was being targeted was essential, if one had lived in the community and the environment one could relate to and empathise with the situation more easily. Both co-ordinators had that background knowledge being Hindu but felt that they did not represent the whole of the South Asian community.

5. Peers ~ other demonstration projects

The project found it useful communicating with the other demonstration projects, although serving different target audiences, there were a number of similar issues faced, that is recruiting walkers, a lack of communication between partners, retaining walkers, motivation and funding. It was comforting to know that it was not just Leicester having these challenges but also Walsall, Eastbourne and Bradford and the advice given was from first hand experience, sharing of this information and training together had been a major backbone to the project.

6. Isolation

This was a major setback for the project; the co-ordinator in the first instance was working in isolation within the voluntary group's structure. It may have been more appropriate in the development phase of the project to be around other health workers and resources, so that suggestions and constructive criticism could take place. As the

project progressed it may have been better placed in the community setting to which it was serving.

7. Conferences/ seminars/HEA~ Next Steps; Leicester University Walking the Way to Health Conference.
These conferences gave a good networking opportunity and helped with the production of innovative ideas.

8. Professional/ Voluntary Networks
Colleagues and networks provided support in terms of advice and contacts within the community. Identification of gatekeepers and active members of the community shortcut the process of getting walkers and workers on board. Linking with projects such as Project Dil a Coronary Heart Disease prevention programme for the South Asian community prevented a duplication of work and allowed the community members to take advantage of other projects. These networks provided opportunities for future funding and the creation of other projects.

The main sources of project support were: the partnership, community centre/walkers and isolation. The isolation component prompted to seek support from the walkers, and other colleagues, which helped to build a relationship of trust. The project lacked other workers in terms of administrative support and ground level workers such as volunteer walk co-ordinators. If a team of workers were pulled together a natural system of support would have emerged.

The main outcomes for project support were that the project acted like a catalyst with its positive health promotion message. This was amplified and reiterated via the word of mouth process, more importantly it was the walkers own peer pressures within each walking group, which motivated the walkers. This was the major support mechanism for all concerned.
The 'vision' of the project was often revisited and was ever changing, however worked towards the same outcome, which was supported via the internal infrastructure.

Project Development.

Project development had laid a foundation so that the initiative could be built upon but more importantly replicated into other localities. This consisted of most of the following components, but was an ongoing process and could change on a day-to-day basis.

1. Confederation of Indian Organisations / Leicestershire Health Liaison

The liaison of the voluntary and statuary sector was a new concept for all, and often had different agenda's. It was only the good working relationships between professionals that made this partnership work. A lot relies on the worker who had to take forward the view of community members to a policy-making forum. This had been achieved successfully via the project and voices were being heard and services were being provided.

2. Regular Updates

Regular updates to funders and partners on the steering group equated a stronger case to securing further funding. The 'action information on project' enabled partners to judge for themselves where support or development was required. Any suggestions were taken forward and implemented.

3. Confederation of Indian Organisations/ Health Promotion Centre Liaison

Advice was sought from the Health Promotion Centre where a heart health specialist had been working with this community. This allowed for a collaboration of initiatives to be targeted together. Setting a good impression to the local community, and not just; *'some project, which would disappear'* allowed a route into the community.

4. Audit of Health Promotion activities via Health Promotion Centre

An audit was conducted of the area via the Health Promotion Centre a further community audit of Health Promotion activities via Confederation of Indian Organisations and Loughborough University identified physical activity gap in services.

5. Setting up of steering group

The steering group was a continuation of the members that had initially participated in the writing of the bid. This was a very large group consisting of approximately 15 members from the voluntary, statuary and academic sectors. As the project progressed the group decreased and only statuary sector members attended. There was a real lack of

voluntary representation. The meeting turned into an updating forum. It was considered to set up an operational group to support and strengthen the project, but this never seem to materialised due to the time constraints of the co-ordinator as well as the local voluntary groups themselves. The question thus arose what is the real benefit of the steering group? It was a top-heavy structure and generated a wealth of good ideas but a lack of resources to implement them.

6. The partnership between the voluntary and statuary sector

It is difficult to set up any sort of partnership, but to set up a partnership where the members have a different ways of working can put a strain on the coalition. The statutory sector would seem to be; target and number oriented simply due to the relationship of 'the more we serve the more money we get', which is a fair strategy. What drives the voluntary sector is a similar force, in terms of securing funding, but at the same time to provide a service, which is truly required. For both the sectors to succeed they needed to think and operated in a similar fashion to the private sector, by simply offering a quality service which in itself draws in the customers.

The hidden agendas of all coalition members slowed the process down; instead of building upon a trusting partnership they are producing a lack of communication. When communicating it needed to be heard and understood by all partners the Chalo Chalay project had tried to break some of these barriers.

7. Ethical approval

Ethical approval needed to be sought form the local committee based at Leicestershire Health, so that the questionnaires and the shuttle walk tests could be administered.

8. Pilot Project(s) Guidelines

The pilot projects were the basis of the guideline's produce to setting up a Walking for Health programme in the South Asian community. The activity created a lot of information and realistic routes were devised, taking into account the ability of the group. At an early stage the role of the Walking Activator was defined and was crucial to the success of project, in particular motivating, and convincing lay members to walk. The guidelines have proven to be adaptable to other groups in other localities.

9. Reality of part-time inputs

What at first seemed to be a quite a simple concept, in reality had a number of components, which ran parallel to each other. This takes time, and short cutting the development phase had serious repercussions. The thought that the project could be run in part time hours was premature; in fact the project idealistically would need a full time co-ordinator, part time local co-ordinators, an administrator and a part time evaluator and trainer.

13. Unrealistic job expectations

Even when a full time co-ordinator was employed for the second year, there was still an expectation to wear all hats, and to effectively carry out each role is unrealistic, once again a team of workers were required.

The main stages in the development of the project were the audit of health promotion activity available to the community, the setting up of the steering group and the partnership. These components are the main building blocks to the project.

Case Record 5.10

Strengths, Weaknesses, Opportunities, Constraints (S.W.O.C) Analysis

This analysis was for the first and second year of the project.

Project Strengths

1. Committed individuals / peers / mentors
2. Positive health promotion (mechanism / climate)
3. Grassroots level up approach
4. Opportunity to research needs and fill gaps creatively
5. Providing an environment in which individuals take responsibility of their health (which is to be celebrated)
6. The one to one partnership
7. The project is acting like a catalyst
8. To be able to work across the 'range' i.e. from grassroots to the stakeholders (walkers to policy makers)
9. To build a rapport and to help identify skills and training needs, to equip the individual to provide a positive walking experience
10. Walks are now self sustainable

11. Sparked off other forms of physical activity
12. Social benefits of groups
13. Changed lifestyles of walkers

Challenges

To achieve points 10 to 13 with all groups

1. Achieve what has been accomplished within Belgrave to four other groups
2. Target hard to reach groups
3. To co-ordinate all walking initiatives within Leicestershire
4. Volunteering / involve other age groups.

Project Weaknesses

Co-ordinators perspective;

1. To identify the role of the co-ordinator and how 'best' their time can be used.
2. To be clear of accountability to whom and why?
3. To provide support to walkers / volunteers in the project to achieve short term and realistic goals.
4. Expectations are high in the short space of time
5. To make clear the roles and responsibilities of each steering group member.
6. To organise a form of project management
7. To have an appraisal system both for the co-ordinator and the volunteer walking activators.
8. To recognise what parts of the project are important and to prioritise these
9. To delegate the rest of the tasks to partners who may be able to deliver to grassroots
10. The only major weakness is the top-heavy structure.

General Project Perspective;

1. Top heavy structure
2. Accountability to who and why?
3. Expectations are too high in the short term
4. Clarification of roles and responsibilities of steering group
5. Need an appraisal system
6. Recognise what is important the priorities

7. Religious groups

8. Being realistic in achievements

9. We don't represent all ethnic minorities

These are management constraints.

5.3.4 Walking Groups in Belgrave Case Studies.

The four health walks from pilot project one were further developed into pilot projects two, three and four. Three more doorstep routes were developed. These were all run from the Belgrave Neighbourhood Centre (BNC), the women's group, the men's group and the 60+ ladies group. The three led walks per week were run by trained and qualified exercise to music fitness instructors who were paid the going rate. The guidelines developed in stage one were followed, however were slightly adapted to suit each individual group. During these walks potential walking activators were identified and were encouraged to participate in the training programme. The walking activators were recruited via the walks themselves, and others through the Exercise to Music course sponsored by the Health Promotion Centre.

Reflection 5.12

What was the next step after the pilot projects? It was natural to develop the routes piloted that is the Abbey Park and Belgrave Hall Gardens, Who to target? The Belgrave Neighbourhood Centre was the obvious choice. The volunteers at the Savera Resources Centre also ran basic exercise classes on Friday mornings and invited the project to come along and present a talk. Thus, these groups were targeted via a key individual in the community.

To ensure that the initiative was self-sustaining, active volunteers in the community were targeted to have ownership of the project.

Quantitative evidence

In year one of the project 76 health walks were lead in which 100 participants attended one or more walks. The breakdown of the walks is found in *Tables 5.4* to *5.6* including the number of walkers, the number of miles and time taken. The factors, which affected Men's walking programme was the temperature, as this rose the number of walkers fell, and became more constant with a cooler temperature. The distance and the time it took to walk were constant.

Table 5.4: Break down of Men's Walking Group from Belgrave Neighbourhood Centre on Thursday Morning 10-12am. Walks held once a week during the period 5th May 1999 to 11th November 1999

Walk No	Walk	No of Walkers	Time Hours	Miles	Temperature °CTemperature	Weather
1	Abbey Park	14	1.25	2	13	warm
2	Riverside Central Section	12	1.25	3.5	15	warm
3	Abbey Park	12	1.25	4	16	warm
4	Riverside	9	1.25	4	18	warm, sunny
5	Belgrave Hall	6	1.5	4	8	cloudy, breezy
6	Canal	7	1.17	3.5	10	cool
7	Abbey Park	9	1.33	4	15	Cloudy
8	Canal Walk	8	1.17	3.5	12	Cloudy
9	Abbey Park	7	1.33	4	20	warm, cloudy
10	Riverside	10	1.25	3.5	24	hot
11	Boat trip/ Watermead	10	2.25	1	20	hot
12	Abbey Park	7	1.25	3.5	21	hot
13	Riverside	5	1.25	4	20	sunny
14	Rushey Fields	6	1.25	3.5	23	hot
15	Abbey Park	6	1.25	4	25	hot
16	Riverside	9	1.33	4	18	warm
17	Rushey Fields	8	1.17	3	20	hot
18	Belgrave Gardens	9	1.33	3.7	16	warm
19	Riverside	11	1.25	4	16	warm
20	Abbey Park	11	1.17	4	15	warm
21	Belgrave Gardens	10	1.17	3.5	14	warm
22	Rushey Fields	10	1.33	4	12	warm
23	Abbey Park	12	1.33	4	10	rain
24	Abbey Park -Riverside	10	1.25	3.5	10	damp
25	Cossington Park	5	1	2.5	9	cloudy
26	Riverside	9	1.25	4	9	clear
27	Cossingtton Park	8	1	2.5	9	rain
28	Canal Walk	10	1.33	3.5	10	cloudy
Total		250	34.58	98.2	-	
Mean		9	1.24	3.5	-	

Consultation Belgrave Neighbourhood Centre Men's walking group

A consultation in April 1999 with the Men's fitness group at the Belgrave Neighbourhood Centre, showed that the group were interested in walking activities. The group of 25 South Asian men aged between 45-80 felt they were active (one session of exercise a week). It was made clear to the Men's group that the project was funded by the British Heart Foundation and Countryside Agency and was solely to promote walking for

health initiatives. The group thought that the project was representing the Leicester City Council and thought funding could be obtained for swimming sessions via the Scope initiative, this was taken back to the Scope co-ordinator based at the Belgrave Neighbourhood Centre. The men were genuinely interested in the project and asked many questions and what it would entail. As a female worker it was awkward liasing and talking with the men's group, and being much younger than they were. This soon dissipated and father-daughter relationships were established. It was important when speaking to the elders of the community that a degree of respect is always adhered to, once they realise that good values and ethics were in place, the respect precipitated back. The consultation was done in Gujarati, and tested the bilingual skills of the consultant. The training course was also offered at this meeting, but only a quarter of the group were interested. It was asked if changing times and the day of the course would make a difference; most preferred the mornings as they had short naps in the afternoon, due to the medication they were taking. A small proportion of the group was concerned about the conditions they had, and enquired if the walks were safe for them. It was suggested to clear it with their doctors first, but reassurance was given that the Walking Activators were First Aiders, if an incident were to occur. On a lighter note, they requested *Ghathiya* and *Jalabbi* (Indian sweets and savouries) to be brought along, it was suggested a healthy picnic instead!

Reflection 5.13

The Men's Walks

The men's group progressed very well and quickly by the fourth walk to the riverside and were walking up to four miles in 1hour 25 minutes. At this particular walk a duty officer from the Cossington Street Sports Centre came to observe. The officer was interested in leading walks as apart of the GP referral scheme. It was fortunate, as one of the walkers needed to rest and the officer sat with him. The weather was warm, and made the group quite tired. However they were enthusiastic, and seemed to lead their own way, one of the walkers would make a good walk leader, as his leadership skills were excellent, for example at one point during the walk, the group were lost and he resolved the situation. The men's group particularly enjoyed and felt confidant with the Abbey Park walk, they were managing three and half to four miles. However by the seventh walk the numbers were becoming unstable, but a core group of 5 walkers had become regulars, attending every week without fail. The group progressed, and was challenging the Walking

Activator, the core group increased to 7, who were dedicated to the programme and were interested in exploring other routes. Nine weeks into the programme the walks were going steady, and the group was reaching three to four miles in 1 hour 15 minutes. The numbers of walkers were constant, and were pushing themselves further; their motivational levels were exceptional.

Interest walks such as the barge trip motivated the group. They were a lively and confident group. They requested that the interest walks should become a monthly event. This could have been an incentive and the project could of paid for these. The men's group gelled well, and in a short period of time were all very sociable with one another. At events and trips they often bought food that their wives had cooked to share amongst the group. Food played a social and central part to the South Asian community.

A lack of Male Volunteer Walk Leaders

The men's group had a strong group dynamic, and supported each other, but in terms of leadership, they were more comfortable not having a walk leader but all shared equal responsibility. It would have been beneficial for them to be trained as Walking Activators, however this was their decision.

Progression of the Men's Walks

The men were confident of the way things were and were increasing the length of the walks each week. The men's group was very committed and was always present 5 minutes before the walk and often before the Walking Activator. Seven of the *Kaka's* (uncles) were committed to the project, and were keen to push themselves to the limit; getting up to four miles per walk. Always chatting, laughing and joking and before you know it one and hours later, four miles walked. They continuously requested the interest walks, and wanted another barge trip. A few of the men's fitness levels had visibly improved and they began to walk every morning.

In August 1999 the number of men participating increased as well as their enthusiasm. They often asked questions on how they could improve and how much walking they should do per day. They already incorporated 30 minutes on most days of the week. Most of them clearly used walking as a form of exercise in their lives, but a few used the car, on a regular basis.

In early September 1999 the weather was still bright and sunny; the men's group were very lucky with the weather they had. During a walk at the Belgrave Hall Gardens, Central Television were filming for a programme called the Signpost, they were talking about the Belgrave area and how it got its name. They requested the project co-ordinator to be apart of delivering the competition which was to guess how Belgrave got it name, *'Belgrave got its name from the bell at St Peters Church.'* And also *' Belgrave means beautiful grove'*, which was the correct answer. The walkers were also keen to be interviewed. Contact was made with Central Television, to publicise the project, and the launch.

Breakdown of the Women's Walking Group

The factor that affected the women's walk was temperature as it increased the number of walkers fell, while the distance and time it took to walk was constant.

Table 5.5: Women's group Belgrave Neighbourhood Centre Friday Morning 10-12am Walks held once a week during the period 4th April 1999 to 16th November 1999

Walk No	Walk	No of Walkers	Time (Hours)	Miles	Tempera -ture °C	Weather
1	Cossington Park	13	1	1	11	rain
2	Cossington Park	12	1.25	3.5	15	warm
3	Abbey Park	15	1.25	3	14	warm
4	Abbey Park	16	1.5	3	18	warm, sunny
5	Belgrave Hall	12	1.5	4	8	light rain
6	Abbey Park	9	1	2	15	warm
7	Riverside	9	1	2.5	15	cloudy
8	Canal Walk	8	1.17	3.5	12	cloudy
9	Abbey Park	8	1.17	3	20	warm, cloudy
10	Riverside	10	1.17	3.5	24	hot
11	Abbey Park	10	2.25	1	20	hot
12	Belgrave Hall	9	1.5	3	20	clear
13	Abbey Park picnic	8	2.5	2.5	24	humid
14	Riverside	5	1.25	3.5	20	sunny
15	Rushey Fields	9	1.25	3.5	23	hot
16	Abbey Park	11	1.25	3.5	25	hot
17	Riverside	6	1.33	3.5	18	warm
18	Rushey Fields	7	1.17	2.5	19	warm
19	Belgrave Gardens	9	1.33	3.7	16	warm
20	Cossington Park	3	1	1	16	warm
21	Abbey Park	4	1.17	3.5	15	warm
22	Cossington Park	5	1	2	14	warm
23	Abbey Park	12	1.33	3.5	12	warm
24	Abbey Park	6	1.17	3	10	rain
25	Abbey Park -Riverside	7	1.25	3.5	10	damp

26	Canal Walk	9	1	2	9	cloudy
27	Riverside	9	1.25	4	9	clear
28	Cossington Park	9	1	2.5	9	rain
29	Rushey Fields	8	1.33	3.5	10	damp
30	Riverside	7	1.25	3	9	cloudy
31	Cossington Park	6	0.75	1	7	cold
Total		**271**	**38.59**	**87.5**		
Mean		**9**	**1.25**	**2.8**		

Women's Walk Belgrave Neighbourhood Centre

At the first health walk for the women's group, it rained for the first 45 minutes. The warm up and stretches were conducted. Initially 24 women were interested in participating in the walk, but the weather was not favourable one of the Masi's (older aunts) commented:

'I really cannot go outside to walk because I have an asthma problem perhaps when it's warmer.'

After a little push 16 of the women made it outside, once at the park, a 2 minute walk from the Neighbourhood Centre it started to rain, and half of the group left. The ladies were dressed in Sarees, and footwear was a mixture of sandals, *chapales*, and slip on's. A discussion was held with them about wearing appropriate footwear such as shoes or trainers.

The Cossington Park is a circuit, which is half a mile in circumference, and is flat ground, ideal for walking. It took some of the ladies 20 minutes to get around. Other women on the park were walking with their husbands, and this was more frequent in the warmer months.

One of the volunteers, at the Belgrave Neighbourhood Centre, had been active in promoting the project and was keen to help. She had been having problems with the Scope co-ordinator at the Belgrave Neighbourhood Centre; she flagged this up at the very start of the project. The project co-ordinator arranged to meet with her and discuss a way forward.

Reflection 5.14

Walk at Abbey Park on the 30th April 1999

No matter how much planning happened, walks never went to plan! Timing was already becoming an issue; three of the ladies were there at 10am, ready to fill out their PAR-Qs. After 30 minutes of waiting, upon the request of the group, 4 other ladies arrived,

however the volunteer walk leader did not materialise. Due to the time delay, a choice was given and the shorter route was opted for due to some of the ladies needing to get back for 11am. The first circuit was completed, and a few other ladies arrived, mobility exercises and stretches were conducted outside in the open air. It was amazing there were no problems, the ladies looked confident and comfortable. This maybe because they were all in a group and were doing it altogether, there was such concern about this part of the walk, but they had no problems with it. No complements were given at the time, which was a shame, but then again it was felt that it should not be made into an issue, and be a natural part of the activity. Another circuit around the park was completed but this time more briskly, at this point a few other ladies joined in. The two walk leader volunteers arrived, rather late. After the 2nd circuit, one of the ladies rested there, she was in sight and was asked to join in again when she felt able too. The lady was requested to wave if she needed anything, after a while another lady joined her to rest. Considering this was their first health walk they did really well. The group were lead back to do the cool down stretches, but only the slighter fitter ladies stayed to complete this, the rest lead themselves back. The walk was a success in that it introduced all components of a health walk, all exercises were completed out in the open and heart rates were raised. The only set back was time keeping, and the commitment of volunteer walk leaders.

Change of walk Leader

By the eighth walk, the group was going from strength to strength. The group were lively and gelled well. There were a consistent core number of women walkers attending each week. The walk was not as popular as when it initially started, and maybe needed to be re-publicised. The project co-ordinator was still taking the lead and was in the process of training a qualified Exercise to Music leader to take over. However, this leader was South Asian and could understand Hindi and Gujarati but could not speak it. The two volunteer walk leaders were there to support her. Mobile phones needed to be given out as a precaution to the walk leader so that they could keep in touch with the project co-ordinator or with the emergency services. The new walk leader was invited to train on the job, that is shadowing the project co-ordinator. The group liked her, and she bought with her new skills for example as apart of the cool down, she incorporated Tai Chi. This worked really well, and relaxed the walkers, the ladies really enjoyed it, and to be doing it in the open air made it feel authentic. At future walks, Yoga could also be incorporated. By the ninth walk, she was trained and leading the walks, it was a nervous time to pass

the responsibility on. She had all the equipment including a mobile phone, first aid kit, water bottle and paperwork. By the 2nd walk the project co-ordinator felt confident, for the walking activator to lead the walks. One of the volunteers was really keen to get involved and be trained but could not commit due to priorities at home these were the constraints of volunteering.

Eleven weeks into the walk programme the women's group were progressing slowly. But a few of the women were committed to the project. They agreed to some promotional work over the summer festivals such as the Belgrave Mela. They also showed a keen interest in participating in the training. The only concern was the time keeping of the women; they were not arriving on time, which had a consequence of having less walking time. The group were however venturing further a field, and were committing more time to do this, some of the walks were taking around one and half hours to complete.

Twelve weeks into the walk programme, the numbers of walkers were fluctuating; this was due to the beginning of summer festivities that the women had to prepare for and the wedding season. It showed that most of the female walkers had more responsibility of the domesticated tasks, than the men, as the men's group was constant. There were five loyal walkers who were committed, and were regular. The volunteer walk leader, was rather busy too, and was not regular; it was reconsidered whether she would be a good candidate to continue the walks?

The walks continued strength to strength and were particularly popular as the weather improved and during the summer. It increased their enthusiasm and more women participated. Once the group became independent from the Belgrave Neighbourhood Centre, more of the walkers wanted to become trained, and thus were trained on route. Timing was of the essence, as events like religious festivals were happening during the summer so numbers dropped. It was a good idea to have the walks timetable coinciding with these festivities, and maybe linking into them. Another aspect, which was particular to the Hindu community, was the eclipse, it was seen to be bad luck to look at it, and even come out of their homes. On that day only the volunteer walk leaders attended the walk.

Table 5.6: Women 60 plus group Belgrave Neighbourhood Centre Thursday afternoon 2-3pm. walks held at Cossington Park once a week during the period 20th May 1999 to 29th July 1999

Walk Number	Number of **walkers**	**Time (minutes)**	**Miles**	**Weather**
1	10	15	0.5	10°C warm,
2	11	30	0.5	10°C warm, sunny
3	10	30	0.5	8°C cloudy, breezy
4	4	30	0.5	10°C clear
5	4	45	1	15°C cloudy
6	4	45	1	12°C cloudy
7	4	45	1	20°C warm, cloudy
8	4	45	1	24°C hot
9	2	45	1	20°C hot
10	3	45	1	20 °C hot
11	7	45	1	20°C sunny
Total	**63**	**420**	**9**	
Mean	**6**	**38**	**0.8**	

Reflection5.15

60 Plus group

The luncheon club walks were not being taken up, they were really slow, these older women were not motivated at all. There were only four women that came for a short walk around the Cossington Park on a regular basis. The women had a number of excuses why they could not walk. The logistics' of the group needed to be re-thought, how could they be motivated? By the 5th walk only 4 ladies were attending, they were not interested in the walking group, they preferred to sit in the lounge and chat after their lunch. It may not be worth continuing this walk, and invite the ladies that were interested to join the Friday's group. By July, the group was not progressing, thus it had to be cancelled.

Special Needs Walks

A special needs walk in October 1999 (4.10.99) was organised for the Inner Vision (Pragna Chaksa) group at Abbey Primary School, in Belgrave it was a group for the partially sighted and blind. The walk was organised along the riverside up to Belgrave Hall Gardens, a length of two miles, which took one hour and thirty minutes with a total of 9 walkers and 4 volunteers to help. The paperwork, like the PAR-Q's were filled out with the assistance of the volunteers. It was envisaged that it would be difficult to run this walk but due to the number of volunteer walk leaders it felt 'normal'. The walk

commenced from the school, up Ross Walk and into the Belgrave Hall Gardens and through the riverside. There were a few stumbles on the way, but all was in hand. A cool down was conducted, back at the school.

Reflection 5.16

It was an amazing experience; the volunteers were trained, and explained to the walkers what they saw on the way. It was a totally different experience to the other health walks. The idea of not being able to see the walker leader to lead, but to have someone explain it; there was a great deal of trust, in the walk leader. This should be transpired into the training of Walking Activators, clear directions, and trust.

Summary of Lead Walks

Table 5.7 shows the summary of lead walks each walk was lead following the guidelines produced from the pilot projects and were lead by the walking activators who were made up of the co-ordinator, worker, qualified instructors, volunteers, and trained walk leader volunteers. In all cases the walkers were age ranges from 35 to 80.

Table 5.7 Lead Walks

Group	Date Started	Date Ended	No of lead walks	Range in length (miles)	Range of walkers	No of Leaders	Time of day
1. Savera	12.04.99	26.04.99	3	0.7-1.3	9-13	3	1.30 to 2.30 p.m.
2. Men's group	06.05.99	To date	80	2-4	5-14	1	Thursday 10-12am
3.Women's Group Chandni	16.04.99	To date	84	2-4	3-16	2	Tuesday Morning 10-12
4. Women's 60+ BNC	20.05.99	29.07.99	11	0.5 -1	2-10	2	Thursday 2-3am
5. Inner Vision	04.10.99	04.10.99	1	2	9	4	
6.Sanatan Community Project	07.09.00	To date	17	1-2	8-10	2	Thursday 6.30-7.30pm
7. Lough-borough	03.09.00	To date	18	1-2	6	2	Sunday 3-4pm
8.Bhagini Women's Centre	06.12.00	To date	3	0.5	4-6	1	Wednesday 10.30 - 11.30am
9. Savera	6.12.00	To date	4	1	5	2	Wednesday

							11-12 noon
10. Hindu Madhir	7.12.00	To date	4	1-2	6	1	

Reflection 5.17

It was hoped that the walks would be run at specific times and the activity co-ordinators at the various centres would run the walks, and would rotate leading. Thus the workers would liase between themselves. This was a very difficult task to accomplish; the activity co-ordinators were being trained but did not have the time to run the sessions.

Case Studies

A total of 66 case studies were followed as shown in table 5.8 during the duration of the project that is: in between April 1999 to June 2002. There were more walkers who participated in the programme but only 66 were interviewed, tested and questioned. Out of the 66 case studies 22 were men and 44 were women and 5 of which lived outside the target area. The age range for the men's group was between 43 and 77 with an average age of 61 years, for women the range was between 34 and 66 with an average age of 52 years. Of the 66 walkers participating in the study 78% were inactive, they did not meet the physical activity guideline set by the government (UK), that is an accumulation of 150 minutes of moderate activity on 5 or more days of the week. After the study period via walking alone this figure was lowered to 53 %. The men completed 67% of the walks programme compared to the women who completed 59%. The men's fitness levels increased 12%, compared to the women's at 10% tested via the Shuttle's Walks Test.

Table 5.8 General Details of walkers and number of walk's attended.

Walker number	Sex	*Date of birth/	Age	#No of walks	% of walks	Start	Finish
1	Male	23.03.35	64	98/158	62	May 1999	To Date
2	Male	13.10.31	68	142/158	90	May 1999	To date
3	Male	15.07.30	69	138/158	87	May 1999	To date
4	Male	11.10.37	62	145/158	92	May 1999	To date
5	Male	15.05.39	60	89/158	56	May 1999	To Date
6	Male	14.10.36	63	52/99	53	July 2000	To date
7	Male	01.01.42	57	83/99	84	July 2000	To Date
8	Male	28.04.56	43	30/48	63	May 1999	May 2000
9	Male	17.09.22	77	18/55	33	Jan 2000	Feb 2001
10	Male	06.03.54	45	46/56	82	July 2000	Aug 2001
11	Male	26.02.35	64	147/158	93	May 1999	To date
12	Male	25.03.35	64	89/158	56	May 1999	To date

13	Male	20.10.66	66	94/118	80	May 1999	Aug 2001
14	Male	02.06.38	61	58/118	49	May 1999	Aug 2001
15	Male	17.04.49	50	149/158	94	May 1999	To date
16	Male	18.11.35	64	109/158	69	May 1999	To date
17	Male	30.12.29	70	145/158	92	May 1999	To date
18	Male	13.05.33	66	45/144	31	May 1999	Feb 2002
19	Male	17.03.32	67	56/158	35	May 1999	To date
20	Male	27.06.50	49	58/158	37	July 2000	To Date
21	Male	01.12.38	61	78/158	49	May 1999	To date
22	Male	08.06.47	52	151/158	96	May 1999	To date
23	Female	11.04.53	55	155/161	96	April 1999	To date
24	Female	26.05.46	54	56/161	35	April 1999	To date
25	Female	18.11.47	52	29/68	43	Feb 2001	To date
26	Female	01.06.38	61	135/161	84	April 1999	To date
27	Female	7.6.49	50	24/44	55	Aug 2001	To date
28	Female	01.01.40	59	19/44	43	Aug2001	To date
29	Female	25.06.44	55	125/161	78	April 1999	To date
30	Female	28.09.50	49	119/161	74	April 1999	To date
31	Female	07.05.47	52	57/83	69	Nov 2000	To date
32	Female	05.04.37	62	41/83	49	Nov2000	To date
33	Female	28.06.41	58	146/161	91	April1999	To date
34	Female	01.07.40	60	39/68	57	Feb 2001	To date
35	Female	23.11.56	43	132/161	82	April 1999	To date
36	Female	03.11.51	48	124/161	77	April 1999	To date
37	Female	16.04.63	36	48/94	51	April 1999	Feb 2001
38	Female	14.08.50	49	24/94	26	April 1999	Feb 2001
39	Female	21.04.53	46	28/56	50	May 2001	To date
40	Female	18.03.61	38	49/68	72	Feb 2001	To date
41	Female	21.04.49	50	152/161	94	April 1999	To date
42	Female	17.02.38	62	54/99	55	July 2000	To date
43	Female	16.11.65	34	21/56	38	May 2001	To date
44	Female	12.09.47	52	26/95	27	Oct1999	Aug 2001
45	Female	10.09.60	39	74/83	89	Nov 2000	To date
46	Female	02.05.49	50	19/44	43	Aug 2001	To date
47	Female	25.06.33	66	124/161	77	April 1999	To date
48	Female	05.05.38	61	136/161	84	April 1999	To date
49	Female	31.08.43	56	129/161	80	April 1999	To date
50	Female	17.06.39	62	146/161	91	April 1999	To date
51	Female	06.01.38	61	98/161	61	April 1999	To date
52	Female	21.01.50	49	115/161	71	April 1999	To date
53	Female	08.11.47	52	34/83	41	Nov 2000	To date
54	Female	18.08.40	59	26/83	31	Nov 2000	To date
55	Female	17.01.46	53	145/161	90	April 1999	To date
56	Female	1950	50	20/83	24	Nov 2000	To date
57	Female	18.12.41	58	42/83	51	Nov 2000	To date
58	Female	04.08.52	47	147/161	91	April 1999	To date
59	Female	12.01.64	35	19/44	43	Aug 2001	To Date
60	Female	06.07.56	43	23/44	52	Aug 2001	To Date

62	Female	23.12.42	57	31/56	55	May 2001	To date
61	Female	17.06.44	55	76/161	47	April 1999	To date
63	Female	11.06.43	56	16/83	19	Nov 2000	To date
64	Female	20.04.39	60	108/161	67	April 999	To date
65	Female	15.07.37	62	24/56	43	May 2001	To date
66	Female	03.06.50	49	96/161	60	April 999	To date

*.\t start of walks programme 1999
During the start of study period 1999-2002 out of the possible maximum

PAR-Q Results
Table 5.9 shows PAR-Q's filled out during the study period:

Table 5.9: Summary of result from the PAR-Q.
Percentage of walkers who answered 'yes' to PAR-Q question (can answer yes to more than one question)

Question No from Par-Q, Health Problem	*Savera*	*Ladies Group*	*Men's Group*	*Ladies 60+*	**Inner Vision*
1.Heart condition	3	4	9	6	0
2.Chest pain during Physical Activity	7	14	5	11	0
3.Chest pain at rest in the last month	7	5	7	6	0
4.Lose balance/dizziness	19	19	14	22	1
5.Bone/ joint problem	26	22	32	33	3
6.On prescribed drugs	26	33	33	22	3
7.Any reason why you should not do Physical Activity	10	3	0	0	0
Total number of walkers in group	**13**	**44**	**22**	**10**	**9**

* Data in the number of walkers answering 'yes'

Calorie / Step Counter

The *Kenz Calorie Counter Select 2* was piloted amongst 6 of the walkers, to assess whether it would be a motivational tool. Some of the ladies found it difficult to operate, and the instructions were difficult to follow. One of the ladies lost it, as it did not clip onto her Saree very well. The men found it much more comfortable to wear. From the data collected it can be said that it was motivational to wear especially with the target calories to be burnt. It was a good measure in comparison to the shuttle walk test and behavioural questionnaire. However, the women found it more difficult and left it at home. From these initial results, the counters would be expensive to distribute to all the walkers, but benefits of doing so could be foreseen.

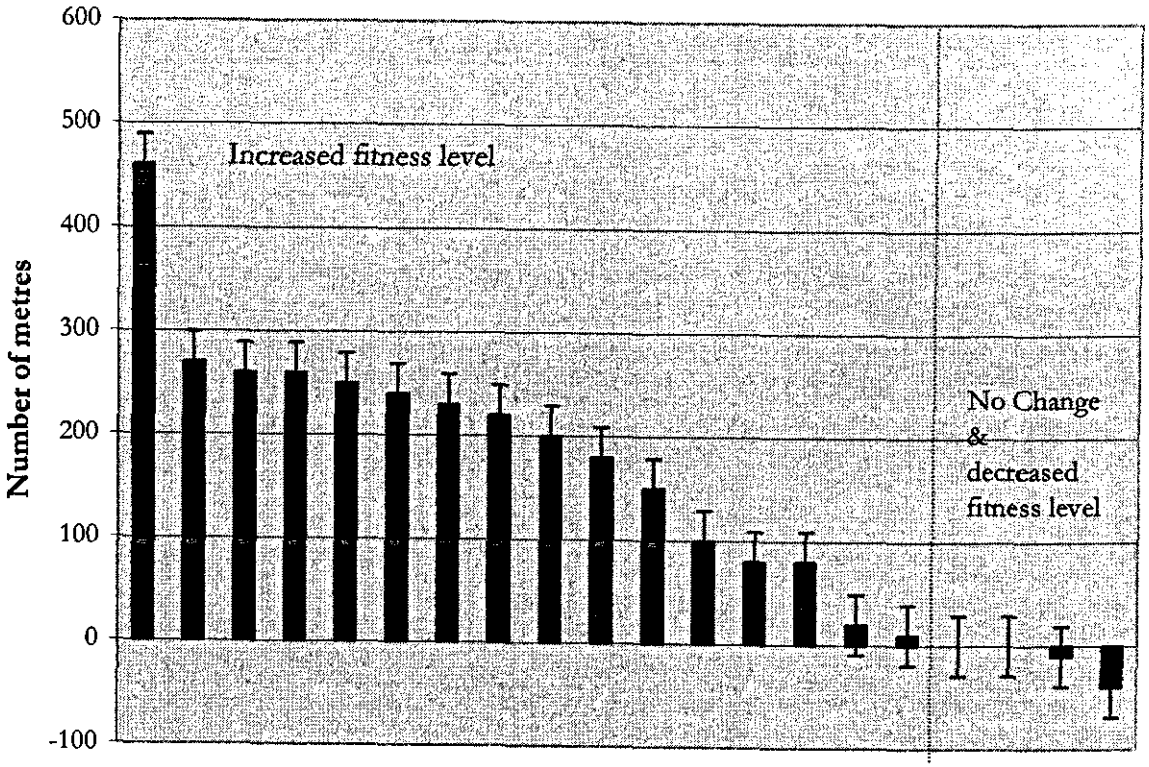
Reflection 5.18

It was difficult accessing the budget to buy the counters, and if bought it would be unfair not for all the walkers to not get one, and would cause unnecessary conflict. Some of the counters were given in kind by the Walking for Health initiative, who was also testing them out. They were massed ordered from Japan and all instructions initially were in Japanese! In year three they were mass-produced by the initiative as promotional material, but these had not trickled down to all the walkers in the demonstration project. There was confusion of how to use the counter and had to be verbally explained, a protocol had to be written to do this. The questionnaire was very easy to administer compared to these gadget, which were difficult to monitor.

Shuttle Walk Test Results.

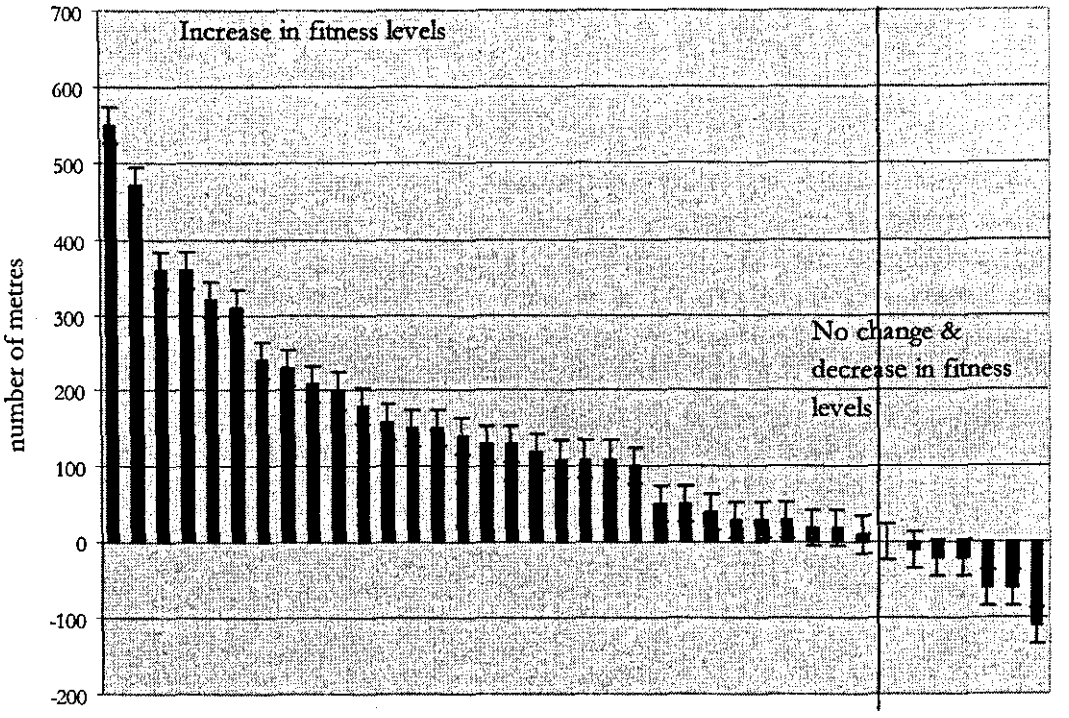
The following Shuttle Walk Tests were carried out using the test developed by Hardman *et al* 1992 at Loughborough University and Glenfield Hospital. It consisted of a shuttle of 10m, which the participants had to walk between the time allocated, denoted by bleeps the time intervals decrease as the level increased. The highest level was 15, which can get a fit person warmed up. The test was originally designed for patients with asthma. Table 5.10 and 5.11 show results from the shuttle walk tests carried out on the men and women's group respectively. Graphs 5.1 and 5.2 show the changes in fitness levels by the number of metres walked in the shuttle walk test for men and women respectively. The men were slightly fitter than the women: the higher the score the fitter the person.

Changes in fitness levels by the number of metres walked in the shuttle walk test , the men. (n=20)



Graph 5.1 Shuttle Walk Tests Results Men's Group

Changes in fitness levels by the number of meters walked in the shuttle walk test:women (n=38)



Graph 5.2 Shuttle Walk Test Results Women's Group

*Table 5.10: Shuttle Results Men's Group. *w/n =Walker number*
Rows highlighted in grey show levels reached, below in white are the conversions into metres

*w/n	Oct 1999	Jan 2000	July 2000	Nov 2000	Feb 2001	May 2001	Aug 2001	Feb 2002	June 2002	Unit Change	% Change
1	9.1	*	10.2	*	10.5	10.6	10.8	11.0	11.2	1.9	15.77
	640		770		800	801	830	880	900	260	
2		8.2	8.4	8.8	9.0	9.3	9.6	9.8	9.9	1.7	14.11
		540	560	600	630	660	690	710	720	180	
3	7.3	8.0	8.2	8.4	8.9	8.8	8.4	8.6	8.8	1.5	12.45
	450	520	540	560	610	600	560	580	600	150	
4	7.3	8.6	8.2	8.8	9.0	9.4	9.2	9.6	9.8	2.5	20.75
	450	580	540	600	630	670	650	690	710	260	
5	6.2	*	7.0	8.7	8.9	9.2	9.0	9.1	9.3	3.1	25.73
			420	590	610	650	630	640	660	240	
6			7.1	6.8	6.8	7.0	7.2	7.1	7.0	-0.1	-0.83
			430	410	410	420	440	430	420	-10	
7			8.7	9.9	9.4	9.8	10.2	10.6	10.9	2.2	18.26
			590	720	670	710	770	810	840	250	
8.	*	7.8	7.9	*	8.0	8.8	*	*	*	1	8.3
		500	510		520	600				100	
9		7.2	7.1	7.0	7.2	*	*	*	*	0	0

		440	430	420	440					0	
10			10.5	10.9	11.5	11.9	12.0	*	*	1.5	12.45
			800	840	930	970	1020			220	
11	7.5		9.4		10.4	10.3	*	*.	*	2.8	23.24
	770		670		790	780				10	
12	8.3	9.5	9.3	9.4	9.6	9.8	9.9	10.1	10.0	1.7	14.11
	550	680	660	670	690	710	720	760	750	200	
13	8.9	*	8.2	9.2	9.1	9.4	9.6	*	*	0.7	5.81
	610		540	650	640	670	690			80	
14	9.2	9.1	9.1	*	9.4	*	9.2	*	*	0	0
	650	640	640		670		650			0	
16	10.1	*	9.6	11.2	*	10.3	10.2	10.3	*	0.2	1.66
	760		690	900		780	770	780		20	
17	8.4	9.5	*	*	10.3	11.9	12.0	12.0	*	3.6	29.88
	560	680			780	970	1020	1020		460	
19	9.1	*	*	*	9.5	9.8	9.6	9.7	9.9	0.8	6.64
	640				680	710	690	700	720	80	
20			10.4	11.5	*	*	11.8	11.9	12	1.6	13.28
			790	930			960	970	1020	230	
21	10.1	9.4	8.8	8.9	*	*	*	9.2	9.9	-0.2	-1.66
	760	670	600	610				650	720	-40	
22	10	10.6	10.1	*	11.5	11.8	11.9	12.0	12.0	2	16.6
	750	810	760		930	960	970	1020	1020	270	
										Σ	236.55
										mean	12%

Table 5.11 Shuttle Results Women's Group *w/n =Walker number
Rows highlighted in grey show levels reached, below in white are the conversions into metres

*w /n	Oct 1999	Jan 2000	July 2000	Nov 2000	Feb 2001	May 2001	Aug 2001	Feb 2002	June 2002	Unit Change	% Change
23	9.4	8.7	8.9	10.7	*	10.7	10.8	11.0	11.2	1.8	14.94
	670	590	610	820		820	830	880	900	230	
24	7.2	7.2	7.3	7.4	7.4	7.7	7.9	8.4	8.7	1.5	12.45
	440	440	450	460	460	490	510	560	590	150	
25					9.6	9.4	9.4	9.6	9.9	0.3	2.49
					690	670	670	670	720	30	
26	5.9	6.3	6.3	6.6	*	6.8	*	7.1	7.5	1.6	13.28
	340	360	360	390		410		430	470	130	
27							8.1	8.3	8.2	0.1	0.83
							530	550	540	10	
29	5.4	5.6	6.5	*	7.1	7.3	7.8	*	*	2.4	19.92
	290	310	380		430	450	500			210	
30	7.2	*	7.8	8.3	*	8.6	8.2	*	*	1	8.3
	440		500	550		580	540			100	
31				9.3	9.2	9.4	*	9.4	9.6	0.3	2.49
				660	650	670		670	690	30	
32				6.3	6.1	6.4	6.7	6.6	6.8	0.5	4.15
				360	340	370	400	390	410	50	
33	5.2	5.2	5.6	5.9	6.6	7.8	8.0	8.5	8.7	3.5	29.05
	270	270	310	340	390	500	520	570	590	320	
34					7.6	8.3	8.5	8.9	9.2	1.6	13.28
					480	550	570	610	650	170	
35	10.4	10.6	*	9.6	9.8	10.4	10.8	11.2	*	0.8	6.64
	790	810		690	710	790	830	900		110	

36	9.2	7.5	7.2	7.6	7.9	8.1	8.1	8.2	8.4	-0.8	-6.64
	650	470	440	480	510	530	530	540	540	-110	
37	10.4	10.6	10.8	10.6	10.9	*	*	*	*	0.5	4.15
	790	810	830	810	840					50	
38	9.4	9.7	9.9	10.2	10.5	*	*	*	*	1.1	9.13
	670	700	720	770	800					130	
39						9.1	9.2	9.2	9.3	0.2	1.66
						640	650	650	660	20	
40				*	9.5	9.8	9.9	10.3	10.7	1.2	9.96
					680	710	720	780	820	140	
41	8.9	9.4	9.6	9.8	9.2	9.5	9.7	9.9	10.1	1.2	9.96
	610	670	690	710	650	680	700	720	760	150	
42			7.5	8.2	*	7.8	8.1	8.3	8.6	1.1	9.13
			470	540		500	530	550	580	110	
44	7.2	7.4	*	7.1	*	7.4	7.6	*	*	0.4	3.32
	540	460		430		460	480			-60	
45				8.2	8.7	10.4	10.7	10.8	11.2	3	24.9
				540	590	790	820	830	900	360	
47	8.1	8.5	*	9.4	*	9.5	9.6	9.9	10.2	2.1	17.43
	530	570		670		680	690	720	770	240	
48	9.2	*	9.2	9.6	9.6	9.8	9.8	9.8	9.9	0.7	5.81
	650		650	690	690	680	680	680	690	40	
49	9.1	9.4	9.7	9.8	*	10.1	10.5	10.7	*	1.6	13.28
	640	670	700	710		760	800	820		180	
50	8.9	9.2	9.6	9.9	10.2	10.8	11.3	11.6	11.9	3	24.9
	610	650	690	720	770	830	910	940	970	360	
51	8.0	8.4	9.1	9.6	9.6	10.3	10.7	10.8	10.8	2.8	23.24
	520	560	640	690	690	780	820	830	830	310	
52	7.4	*	8.6	9.8	9.6	10.3	10.4	10.4	10.5	3.1	25.73
	460		580	710	690	910	920	920	930	470	
53				9.7	*	9.5	9.4	9.5	9.6	-0.1	-0.83
				700		680	670	580	690	-10	
54				8.4	8.5	8.5	8.6	8.6	8.7	0.3	2.49
				560	570	570	580	580	590	30	
55	8.0	8.6	9.0	*	9.6	9.4	9.5	9.7	9.9	1.9	15.77
	520	600	630		690	670	680	700	720	200	
56				8.1	8.1	8.0	8.1	8.2	8.3	0.2	1.66
				530	530	520	530	540	550	20	
57				8.7	7.7	8.2	8.2	8.3	8.5	-0.2	-1.66
				590	490	540	540	550	570	-20	
58	7.5	10.6	10.2	9.9	10.2	10.7	11.1	11.8	12.0	4.5	37.35
	470	810	770	720	770	820	890	960	1020	550	
61						8.8	9.0	9.5	9.8	1	8.3
						600	630	680	710	110	
62	6.9	7.1	7.6	7.8	*	8.1	8.3	8.6	*	1.7	14.11
	420	430	480	800		530	550	580		160	
63				9.0	*	8.6	8.6	8.5	8.5	-0.5	-4.15
				630		580	580	570	570	-60	
64	7.2	*	*	6.6	6.6	6.7	6.7	6.9	6.9	-0.3	-2.49
	440			390	390	400	400	420	420	-20	
65						9.1	9.1	9.2	9.1	0	0
						640	640	650	640	0	
66	6.3	6.5	6.1	6.4	6.8	*	7.1	7.6	*	1.3	10.79
	360	380	340	370	410		430	480		120	
										$\sum$	385.12
										mean	10%

The test has been carried out at three-month intervals over the period October 1999 to June 2002 and most walkers have shown a gradual improvement in fitness level. However, the mental and social benefits have outweighed the physical ones. Gaps in data are due to walkers being absent, on holiday or that have just joined the group. The levels in the group are vast ranging from level 6.2 to 11.5 for the men and level 6.3 to 10.7 for the women.

Reflection 5.19

The shuttle walk tests protocol with the men's group

The men were taken on a normal health walk prior to the test. They met at the Cossington Street Sport Centre and walked to Abbey Park, which took 20 minutes, where they were mobilised, and lead to the visitors centre. The evaluator from Loughborough University helped administer the test on the first occasion. Ten metres were marked out, and cones were placed either side. The men had to walk the shuttle in the time allocated which was denoted by a bleep, not before or after it. This was all explained on the tape; times were measured by the bleeps, which also represented different levels. It was quite difficult to judge when the next level was reached. Although one had to listen out for the double bleep which represented the next level. All of the 12 men were tested. One of them had angina, but completed it up to a satisfactory level. All of the levels were recorded for each of the participants. They all enjoyed it and were very enthusiastic; they loved all the extra attention that they were getting.

The same was repeated by the project co-ordinator for the women's group. The women's levels were not too different from the men's. Some undertook the test in bare feet due to unsuitable footwear, or they thought they could walk faster with bare feet. However, this did not make much of a difference. They all did really well in following the instructions, and the overall levels achieved. The test was not as hard to deliver in another language as envisaged. The women also enjoyed participating.

Chalo Chalay Walking Activities Questionnaire

All walkers who participate in the scheme filled out the Walking Activities questionnaires, when they join i.e. at base line, then at 3-month intervals, they were done in line with the shuttle walk tests. The physical activity recommendation guidelines in 2002 by the U.K government were that adults should aim for 30 minutes of moderate intensity activity on 5 or more days of the week. This would be classed at doing 150 minutes of fast or carrying shopping walking. Graph 5.3 & 5.3 shows an increase or decrease of self-

reported walked minutes per week over 28 months and detailed in table 5.12 & 5.13 for men and women respectively. At baseline 9% of men and 13% of women were meeting this guideline at the end of the intervention this rose to 14% of men and 33% of women.

An increase or decrease of self-reported walked minutes per week, for men over 28 months (n= 22)

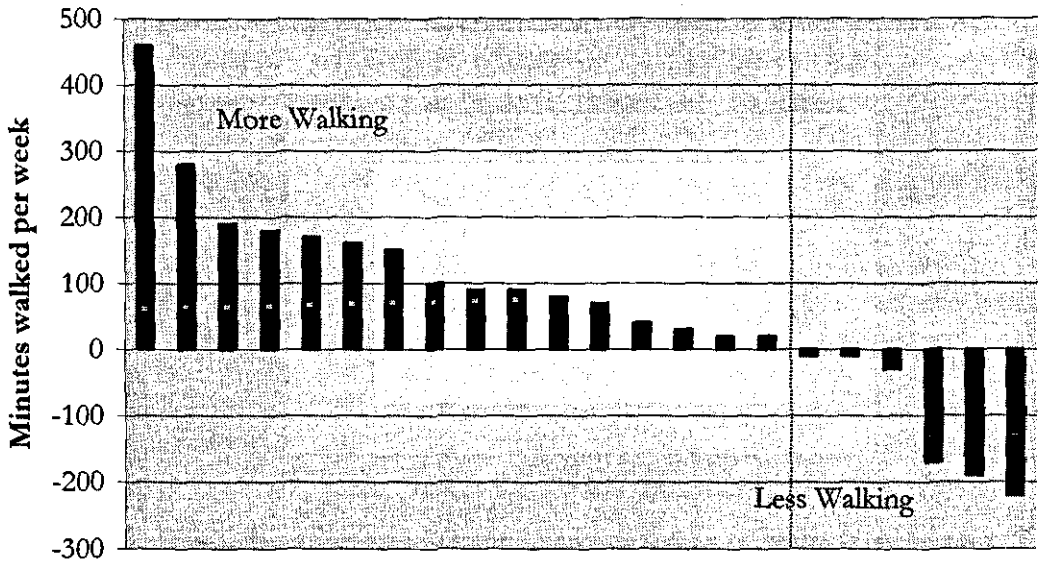
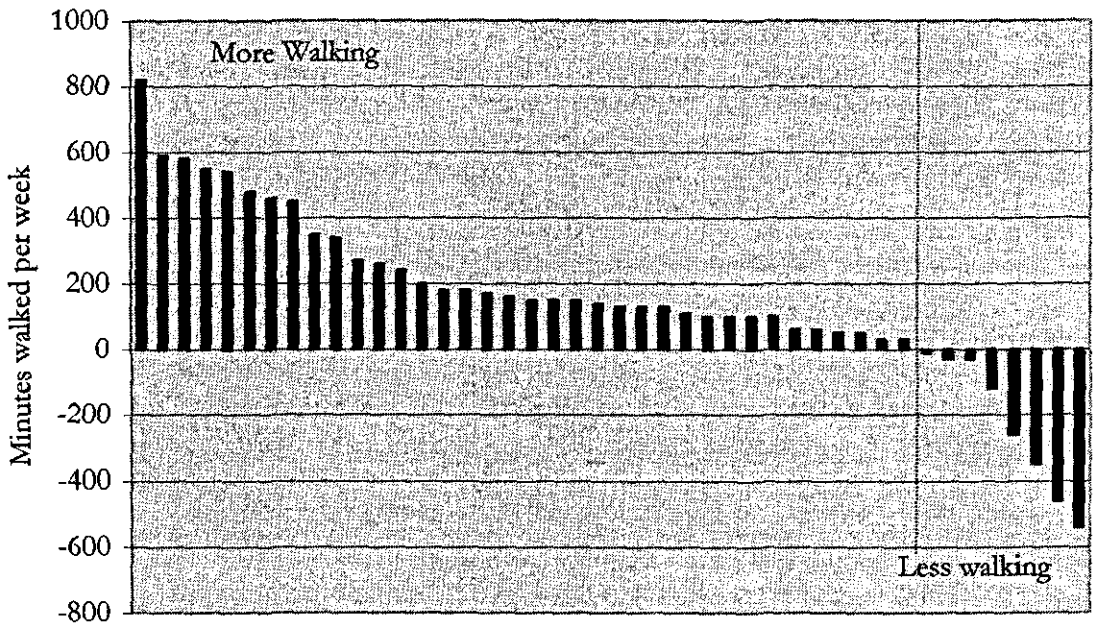


Table 5.12 Perceived Minutes walked per week by the Men's group. Behavioural Questionnaire

w/n	B	3	6	9	13	16	19	22	28	Change
	Oct 1999	Jan 2000	July 2000	Nov 2000	Feb 2001	May 2001	Aug 2001	Feb 2002	June 2002	
1	60	70	80	60	60	50	70	80	50	-10
2		60	60	240	80	100	80	90	90	30
3	460	610	600	700	680	660	660	650	740	280
4	400	440	400	450	160	510	520	520	580	180
5	420	420	420	430	430	420	370	440	500	80
6			20	20	40	30	30	30	40	20
7			210	210	260	270	270	260	310	100
8	210	200	180	250	220	180				-30
9		120	100	110	100	100	110			-10
10			430	440	460	510	580	590	600	170
11	540	620	700	780	690	660	730			190
12	10	30	45	60	40	30	40	60	100	90
13	60	65	70	110	100	140	130			70
14	1110	1040	930	895	860	890	920			-190
15	1150	1190	1110	1150	1170	1190	1200	1220	1240	90
16	480	520	560	630	630	625	620	640		160

17	330	420	545	670	180	450	440	480		150
18	840	770	750	640	560	480	620			-220
19	350	300	200	100	60	120	150	200	180	-170
20			500	470	480	485	490	490	520	20
21	240	250	260	240	250	270	280	290	280	40
22	260	140	840	650	460	550	540	640	720	460

An increase or decrease of self-reported walked minutes per week, for women over 28 months (n= 44)



Graph 5.4 Self reported an increase or decrease in minutes by walked per week by the women's group over 28 months

Table 5.13 Perceived Minutes walked per week by the Women's group. Behavioural Questionnaire

w/n	B	3	6	9	13	16	19	22	28	Change
	Oct 1999	Jan 2000	July 2000	Nov 2000	Feb 2001	May 2001	Aug 2001	Feb 2002	June 2002	
23	420	1120	910	950	1020	1010	960	990	970	550
24	110	115	130	140	165	170	180	200	220	110
25					60	90	100	130	120	60
26	780	780	830	820	850	875	900	920	960	180
27							240	210	210	-30
28							110	120	140	30
29	150	170	190	190	190	200	190	230	250	100
30	70	85	100	135	150	165	190	190	220	150
31				310	500	590	710	780	890	580
32				130	150	190	260	310	330	200
33	220	190	150	140	190	400	360	370	320	100

34					140	170	205	250	270	130
35	960	1000	840	740	590	410	330	650	700	-260
36	910	910	720	720	730	700	700	730	790	-120
37	960	1190	1280	1370	1440					480
38	220	260	280	280						60
39						1240	1280	1350	1400	160
40				210	235	230	310	440	470	260
41	470	570	530	330	420	850	830	880	930	460
42			210	300	300	290	290	320	340	130
43							310	340	360	50
44	560	580	570	560	530	500	530			-30
45				80	310	710	610	750	900	820
46							440	520	570	130
47	400	470	455	440	410	380	430	510	550	150
48	220	185	150	170	360	590	630	730	760	540
49	1150	1210	1140	960	710	460	540	610		-540
50	1040	1080	1160	1210	1170	1170	1150	1190	1220	180
51	1080	1140	1090	780	670	530	550	570	490	590
52	760	755	750	960	770	360	390	340	410	-350
53				200	270	300	380	390	470	270
54				100	140	160	190	210	240	140
55	180	270	400	530	410	360	440	440	530	350
56				420	430	450	510	470	470	50
57				180	270	420	430	490	420	240
58	910	1040	1140	1180	1290	1270	1270	1330	1360	450
59							310	360	410	100
60							610	670	710	100
61						590	660	680	740	150
62	650	780	700	580	430	190	210	170	190	-460
63				120	100	60	100	120	150	30
64	230	240	250	260	190	200	180	200	220	-10
65						210	270	360	380	170
66	120	150	190	190	310	330	370	390	460	340

Development of Health Walks and Barriers

In year one of the project six routes on the doorstep were established which were in the vicinity of the Belgrave locality, three of which, the walkers felt safe and confidant using on a regular basis. Two lead walks were being run every week, one for the women and the other for men. Two sets of specialised walks were set up for a mental health group, which helped develop and pilot the walks, and one for a partially sighted and blind group which met once a month.

In year two, progression was made to seven regular walks per week and the project expanded out to the Highfields locality of Leicester, which is predominately Muslim. The health walks had their own walking activators that were trained by the project.

The factors that were taken into consideration as the health walks developed included issues such as *motivational incentives,* which were key in bringing walkers, back every week. A degree of spontaneity was required to keep the interest going, for example having interest walks once a month. There was a *lack of safe and pleasant routes.* Due to the urban area there was a fear of crime. A working partnership with the riverside rangers and Police to patrol the area at the relevant walk times had eased this problem. The routes become monotonous and the lack of pleasant areas became a problem. The cost of *transporting* the walkers to pleasant areas had been an issue, in conjunction with the time constraints. The challenge of appropriate *footwear* gradually resolved itself, it was more prominent with the ladies as trainers really did not look quite right with Sarees, also the cost of buying a pair of trainers, which the women may only wear once a week. When the *weather* had been poor the attendance dropped in particular with the women's group. Indoor walking activities were arranged but the walkers felt that they wanted to continue outside. The men's group wanted the fresh air and said they would bring umbrellas and would wrap up warm and thus the walks were continued over the winter period.

Reflection 5.20

Footwear. The steering group had agreed to pay for trainers, to those who had been with the project for over a year, it would have also acted as a marketing tool. Transport was incorporated and paid for the interest walks and the social activity, which occurred once every two months.

Paperwork i.e. PAR Q's, Walk Registers

All the paperwork was developed and tested via the pilot projects; alterations were made and tested again. The PAR-Q's (Appendix III) was difficult to administer, the easiest way of administering was to get the walking activator to translate them into the preferred language, a lot of explanation needed to be given to clarify the questions.

Interest Walks

To keep the group motivated, interest walks were held; of particular success was the barge trip along the riverside. This idea arose from a meeting with the parks manager at Abbey Park in Leicester. Two barge trips were arranged one for the men's group and the other for the women's group. The barge took the groups from Abbey Park up the Riverside to Birstal lock and onto Watermead Park, where the group got off and went for a short walk around the lake, and had a picnic there. The barge took the group back

to Abbey Park; the overall trip was around three hours; the barge operator was a member of the parks team and pointed things out of interest along the way. The trip was enjoyed by all, and motivated them about their environment. The weather was perfect on the day it was not too hot. Some of these individuals had never experienced the environment on their doorstep.

Reflection 5.21

The meeting with the parks manager went really well, they were keen to promote the park via the health walks. The meeting took place at the Visitors Centre, which was based, centrally in Abbey Park; the conservation and parks department were situated there. The idea for using the centre during the winter months would potentially solve the difficulties of finding a venue for indoor walking activities and ideal for a training venue. The centre catered for about 70 people, and had facilities to make tea and coffee. The centre itself had displays of the wildlife in the park and riverside, things like stuffed foxes and badgers, also literature including maps of the area. The centre was currently used for coffee mornings for a group of pensioners. The idea of using it for Chalo Chalay walkers was welcomed. The venue was used when weather was poor, or if the shuttle walking tests needed to be done, it was offered in kind by the manager. A number of links into the project were made via the visitor's centre, which was central to the walks in Belgrave, and offered a new and relaxing atmosphere for the walkers.

Reflection 5.22

The Barge Trip

This interest walk (barge trip) was challenging to organise due to the lack of contribution of the Scope development worker from the Belgrave Neighbourhood Centre. This was the peril of partnership working with this particular part of the local authority. The worker forced upon the interested walkers that they had to pay £ 3.50, for the walk. The project felt that the trip was a promotional, marketing ploy to get people involved in the project. The interest raised was tremendous, as it was something totally new to them. Potentially two sessions for the women could have been run. However, the development worker seemed to be arranging the trip according to her project needs it seemed; that she was just trying to reach targets. There was a clash in agendas of both projects, which put a strain on the partnership. The worker was irritating the rest of the group, in particular, dictating to the Chalo Chalay project volunteers. They raised this with the project co-ordinator of Chalo Chalay who tried to resolve the situation. The worker was

conforming to the procedures set out by the council, in terms of filling out paperwork such as medical forms, this meant that the walkers had to fill out two sets of paperwork, one from the council and one from the project. The project paper work was very concise and only took a few minutes whilst the other set from the council was to long. These bureaucratic procedures just for statistics, was not what the project was about, and it had major concern's whether it wanted to conform to these or whether one set of paperwork would be suffice, as the project took full responsibility of its walkers and participants, and were fully insured.

The trip took much longer to organise due to this partnership then it would of done otherwise. There were no ends of paperwork. When finally all was sorted, and some sort of understanding was reached, the trip itself was dampened with the attendance of the worker, the men's group did not mind her as much as the women's group.

The worker had no right and had acted unprofessionally. The group was the sole responsibility of the Chalo Chalay project, and to be authoritarian, in this was a breach of the partnership. This would be raised with the manager. The project felt that it had made good links with the Neighbourhood Centre, but the problem arose with the individual concerned.

Women's Group becoming Independent

Following the incident with the worker, a meeting of the group was called at the visitor centre. It was decided to move the walks from a Friday to a Wednesday, for two reasons, firstly the playgroup were running on the Friday and the space at the Belgrave Neighbourhood centre was not available, secondly the women did not want anything more to do with the centre and wanted to run independently. All were happy with this decision, and now the focus would be at the visitor's centre where they could carry out their activities. The ladies were much more relaxed after that, and became more social, in terms of picnics, and having the space to carry out trips & events.

Reflection 5.23

The women's independent walks were getting a better turn out, more so than when they were attached to the Belgrave Neighbourhood Centre. They were much happier, and the supported was tremendous. They felt the Chalo Chalay project was all the support they needed and this really influenced their decision to go out on their own. The influence the

project was having had been prominent and the women were much more confident to challenge.

The manager of Belgrave Neighbourhood Centre had called a meeting, with the project co-ordinator, the development worker and himself. The project welcomed this meeting, this provided the opportunity for the project co-ordinator to liase between the walkers and the Neighbourhood Centre. They simply wanted to become an independent group without the interference from the development worker. The volunteer walk leader was trained to lead and took forward the group. The group were very supportive of the project and were please to see that the co-ordinator was defining the development workers role with the manager.

The meeting was very productive; the manager called the meeting to be updated on the initiative, and was a post evaluation meeting. The project stood on the ground that they had achieved the objective of recruiting walkers and volunteers, however felt that the group was better placed at the Cossington Street Sports Centre/ Abbey Park visitor's centre, due to the access of indoor space during the winter months. The manager thought this was good idea also, it would help their working partnership with the Cossington Street Sport Hall. Both are local authority facilities, based on the same street but lack communication. He also indicated that he would like to see the walking for health initiative to continue but via the GP referral scheme. It was brought down from management that in the future all neighbourhood centres would be taking on this initiative. This meant that guidelines and procedures needed to be adhered to. The project offered three walking activators that were qualified to run this type of walking programme. The development worker knew that she was in the wrong and to a degree was made known indirectly, by the meeting being called and making it very clear that the Belgrave Neighbourhood Centre would like to continue with the initiative and to take it to the next level.

The men's group increased its numbers, however they were also experiencing mixed messages from the development worker. They wanted to continue the walks over the winter period; they felt that the fresh air did them good. The men's group were not keen in participating in other walks such as the annual British Heart Foundations charity walk. They were fine sponsoring other people but to participate was difficult, it was during the weekend and may be this was not a convenient time.

The 2nd interest walk, in September 1999 group was a picnic at the visitors centre at the band stand in the Abbey Park for the men's and women's group respectively. The group got on so well that it did not really matter where they were. They were genuinely interested in visiting new places. Some had live in Leicester almost over 30 years, and had not seen things like the Belgrave Hall Gardens and the riverside, which was on their doorstep. The numbers of walkers were stable during autumn, with the wet weather, the men were just as keen as they were in the summer, and this was impressive. The men were consistent in their walking. The women were also keen, they asked questions such as whether its better to walk with or without shopping, for short distances or walking long distances without shopping, the stages of change model was applied.

5.3.5 Development of Training for Walking Activators

The training that had been delivered in Wiltshire and Reading had not been appropriate for the Chalo Chalay project. The original training developed by the British Heart Foundation and the Countryside Agency was the basis upon the specific training was developed for the South Asian community. This was done in partnership with Dawn Vernon Associates – the training and advice service for the Walking the Way to Health initiative commissioned by the British Heart Foundation and the Countryside Agency. The main differences in the training were the language in which the training was conducted, discussion and addressing of cultural sensitive issues such as appropriate clothing and footwear; warming up and cooling down exercises, which would incorporate cultural dancing. Motivational factors, such as relating health to traditional values, for example, cultural pilgrims by foot were also discussed. A walk was thus specifically designed to visit all the temples in Leicester to fund raise for a good cause, and to publicise the project.

Exercise to Music Training

The project needed to develop instructors who could speak the relevant South Asian languages. It was recognised from the previous CIO Physical Activities project that there were a lack of South Asian instructors. In conjunction with the Health Promotion Centre, South Asian women were sponsored through the YMCA training. There was a high drop out rate, and it was noted that the YMCA course as it stood was inappropriate for the target audience, in consultation with the women, and the CIO project a foundation course was run, and was tailored to the women's needs. Instead of having a full on Exercise to Music course, circuit training was also offered; there was a higher retention and passing rate. After qualifying the women were asked to 'pay back' the fees by holding 10 sessions back into the community for free. It was hoped that afterwards these would continue at these community venues, and would help the trained women into employment. The initiative was to empower the women to promote physical activity in their own communities and thus would form apart of a capacity building programme. The qualified instructors from the tailored Exercise to Music course were used to commence the initial walks after they had successfully completed Chalo Chalay's Walking Activator training.

The 10 South Asian Exercise to Music instructors that were on the database were written to inviting them to become Walking Activators for the project. A short questionnaire was also sent to them identifying their key training needs and if they knew of any other qualified South Asian instructors, of which one responded to and put forward, a South Asian male instructor, which are rare to find!

The project had an active part on a two-day foundation course that was run for potential South Asian Exercise to Music instructors. A module was incorporated into the course on walking for health, lead by the project. The option was also given that the 'paid back sessions' would also include leading health walks for the Chalo Chalay project. A further 6 instructors were recruited onto the project.

When the instructors were trained it was difficult for them to be committed, due to being employed full time and this was something that they did for as an interest. Most of the walks were run were during the day, so it would have impossible for them to run these sessions. They were however kept informed of the project, and of any evening work or one off opportunities that arose. Thus the recruitment of volunteer walking activators seemed more realistic, as they could offer the project more time. One of the volunteer walking activators had successfully completed the YMCA circuit training and now was qualified.

Recruitment and Training Volunteers

An important implementation strategy of the project was recruitment and retaining of volunteer walking activators. This had been the most challenging part of the project. The concept of formal volunteering within the community was non-existent. Volunteering was a natural part of being a community member. It did not required to ask members to become volunteers, but if help was needed people usually just helped out. This sort of informal working relationship worked well within the community. The concept of becoming a volunteer Walking Activator had been difficult to promote. It was interesting to note that the women were more receptive to the idea compared to the men. The women liked the idea of responsibility whilst the men were more relaxed. The project had recruited more women walking activators than the men. The volunteers felt they could not give the project time commitment as such but could help out as and when required.

A recruitment drive and campaign was planned via flyers and posters it raised awareness but was not successful in recruited volunteers. It was decided to research into the concept of 'volunteering in the South Asian community,' and the British Heart Foundation and Countryside Agency commissioned a report (Refer to 6.3.8 Concept of Volunteering).

Project Dil

The trained walking activators went on to do the Project Dil training - a Coronary Heart Disease prevention programme. It widened their understanding of heart health, and incorporated modules on eating healthy and stopping smoking. The opportunity arose from this training to go onto to leading walks for cardiac rehabilitation patients.

Research into Training Needs

Before the training was planned a needs assessment was carried out into the training requirements of potential walking activators. A questionnaire was sent to over 30 people who were intending to come to the training. It ascertained their interest, and tailored training according to their needs. Graph 5.5 shows the outcomes.

Case Record 5.11

Letter and questionnaire sent to potential Walking Activators

Dear Colleague,

Want to become a Walking activator with the Chalo Chalay Let's Walk Project and lead a Health Walk?.....

Walking is set to play a central role in creating a healthier nation. Evidence increasing shows that walking has many benefits including:

- Reduction of heart disease
- Weight control
- Improves co-ordination and joint flexibility
- Lowers the risk of brittle bones & increases bone density
- Reduces anxiety and depression
- Improves confidence
- Gives greater stamina & energy
- Improves posture and tones muscles
- Social and community benefits.
- A better shape and appearance

The British Heart Foundation/ Countryside Agency/ Leicestershire Health and the Confederation of Indian Organisations have joined forces to create the 'Walking the Way to

Health' initiative; Chalo Chalay (Let's Walk) for the South Asian community in the Belgrave, Latimer, Rushey Mead, and Abbey areas of Leicester. The projects main aim is to:

'To promote higher levels of awareness of the health and social benefits of walking and to increase the participation in daily walking activity by Asian adults through increased walking opportunities, community action and improved environments'

The project is recruiting, walking activators and is providing free training. For the project to develop the right training for you we would appreciate if you could fill out the attached short questionnaire.

If you would like to get involved with the project in any other aspect, or just want to be kept informed please fill out the attached slip. If you know of other colleagues who may be interested please feel free to photocopy and pass on or let me know on the return slip. If you would like any more information please do not hesitate to get in touch with me on 0116 2424017

In order for us to arrange the training promptly could you please return the attached slip by 1st May 1999 and specify what days and times you are available for a days training. Thank –you for your time, I hope to hear from you in the near future

Yours Sincerely,

Rekha Chudasama
Chalo Chalay Co-ordinator

Name
Address
Tel No Fax No
Mobile No

YOUR TRAINING NEEDS

Have you had any experiences walking with the inactive? Yes/ No
Details:

Have you had any experience leading walks?
Details:

Training requirements (tick box as appropriate)

1. Background to walking for health ☐
2. Safety issues ☐
3. Researching walks ☐
4. Leading walks ☐
5. Motivating participants ☐
6. CPR (Cardiac Pulmonary Resuscitation) ☐
7. Monitoring intensities ☐
8. Environmental considerations ☐
9. Screening Participants ☐
10. Other ☐

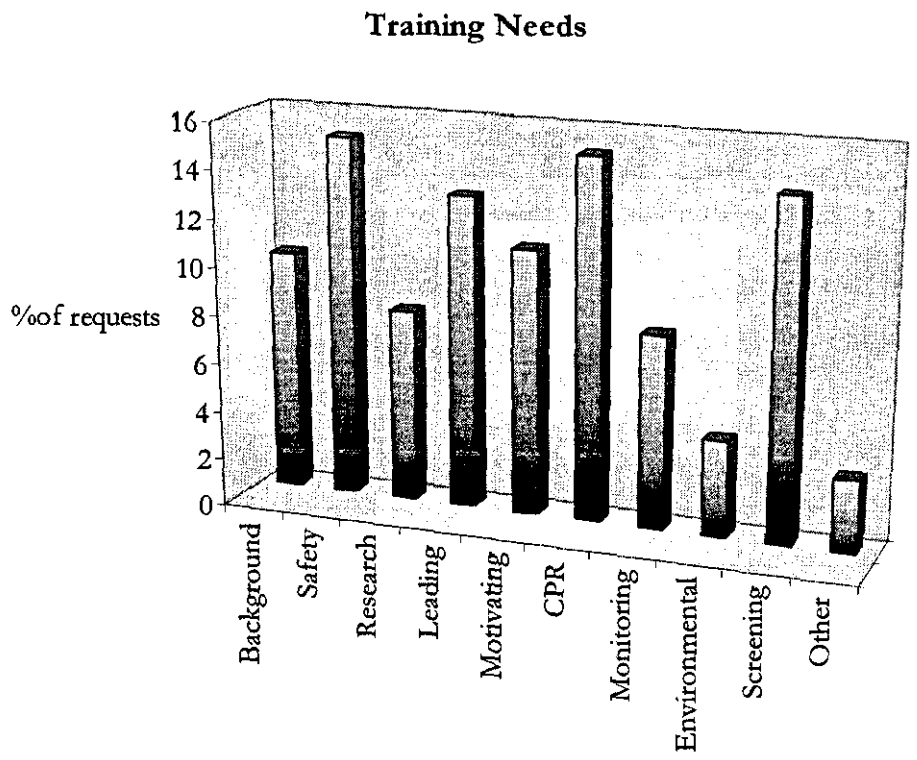
Please specify

Details of any community groups that you are working with that might want to get involved in the project (Belgrave and surrounding wards only?)

Times and days available for training

Would you just like to be kept informed of the project? Yes/ No
Know of any colleagues who would be interested in the project or would like to become a walking activator? Details:

Thank you, once again for your time, I shall be in touch with you in the near future.



Graph 5.5 Training Needs

Out of the possible 30 questionnaires sent out 24 replied. Most respondents felt that the safety aspects were what they needed training on together with CPR training and screening participants for health concerns. It was clear that the safety of walkers both in their environment and also their health was a major concern. This was incorporated into the training.

Planning Session

The walk leader workshop was designed to establish a group of local people trained to promote walking on an ongoing basis. The participants may have already been apart of a walking group, local organisation or just enjoyed walking with friends.

The training session was planned in conjunction with the Dawn Vernon Associates. The training was held at the Abbey Park Visitors Centre . The walking routes were pre

planned around the park as well as the programme for the day. The programme allowed five minutes in between each session so that the project co-ordinator could translate into Gujarati. The park and the visitors centre were ideal for running the training day, and the trainer was impressed with the facilities it had to offer. The training was delivered in four separate sessions, which included:

- Attending 3 to 4 walks to get a feel for what a health walk was.
- A stretching and mobility exercise training day, lead by one of the South Asian Exercise to Music Instructors.
- To attend a First Aid and HeartStart training course.
- A formal training day and assessment- to check on teaching of stretches and mobility correctly.

The Walking Activators role was clarified to the participants, that is to motivate people to take up walking as a health enhancing activity, and organising and leading safe and enjoyable walking sessions for people of all ages and abilities.

Objectives of the training day workshop

After participants had completed the workshop they would have been able to:

- Outline the main health benefits to be derived from a programme of regular walking.
- Organise and lead a health walk.
- Access safe routes, and recognise potential safety hazards.
- Advise on practical issues such as: safety and effective walking, posture and technique.

Training Day Packs

The project co-ordinator put the training packs together. The training pack included; a copy of the programme, walkers paperwork that is: walks register, evaluation questionnaire, group and leader feedback forms, the PAR-Q's and a volunteering application form devised by the project with advise from the Volunteers Centre and a copy of the Walking the Way to Health, volunteers manual (Vernon 1999). Dawn Vernon Associates upon reflecting on the needs of the target audience rewrote the training manual given out on the day.

Pre Workshop

Prior to the workshop participants were sent a programme of the day (Case Record 5.12), aims, objectives, what to bring, PAR-Q questionnaire and a map to the visitors centre Abbey Park. Also they were sent information on what the workshop would entail, an introduction and objectives. They were asked to fill out PAR-Q questionnaire prior to the training day and to bring with them on the day. They were also asked to wear comfortable, loose clothing and suitable footwear. For purposes of equal opportunities, the participants were asked whether they had a hearing, visual aid or mobility problems.

The First Training Session

The training had to be redesigned to incorporated culturally sensitive issues such as single gender issues, footwear, clothing and discretion of the warm up and cool down exercise. Forms of cultural dancing were used to warm walkers up and all instructions were translated into Gujarati. The first training day was held on the 16th August 1999 at the Abbey Park Visitors Centre from 10am to 4.30pm. 133 flyers were sent to all the groups in Belgrave, affiliated members of the Confederation of Indian Organisations, physical activity instructors, health professionals and steering group members. The initial response from this post out was 17. Organisations were keen to send its workers to be trained as Walking Activators as they saw it as an additional skill and thus an additional activity. Riverside Rangers were also keen and expressed an interest to be an active part of the project.

Twenty-nine individuals signed up for the training, there was a last minute interest from the exercise referral scheme with the signing of four of their exercise leaders. On the day 22 attended and 20 completed the course and were trained; three of which went on to lead walks. A further day was arranged for the First Aid and HeartStart training. The group was a mixture of volunteers and health professionals. 10 were committed to running health walks but need more training and practice.

Three trainers ran day; one from Dawn Vernon Associates, the coordinator from the Reading project and the project co-ordinator. The day included lunch, which was ordered from one of the healthy restaurants (Tandurast) campaign via the Health Promotion Centre. It was important to maintain partnerships and support other initiatives in the locality.

The Training Day

All paperwork for the walking activators is shown in case records 5.13-516.

Case Record 5.12

Walking Activator Training day Program.

16th August 1999

10:00am –4:40pm Abbey Park

10.00am	Welcome/ Introductions & Domestics Background to British Heart Foundation and Countryside Agency & Leicester project: Confederation of Indian Organisations.
10:05 am	Ice Breaker (describe favourite walk)
10:10am	Brainstorm & Trainer Input: 'what is health'; what are the benefits of exercise'
10:45am	Heath Walk around Abbey Park (to include cultural dancing warm up games and stretches)
11.40am	Coffee – Initial Thoughts
12:00 noon	Safety & effectiveness (Talk Test) Importance of warm up Teach Warm –up stretches (to each other in pairs Warm up games – work in-groups to identify suitable games or moves
1:00pm	Lunch (Shuttle walk test- optional)
2:00pm	Safety aspects: Route Assessment- Risk assessment & maps What to carry (Mobile Phone/ First Aid kit etc) Essential Paperwork
2:30pm	Starting a Walk: Discussion –formal versus flexible approach
2:45pm	Practice starting a walk (Introduction. Paperwork, warm up) in groups of 4, each having a turn
3.15pm	What makes a good leader? Brainstorm and general discussion: Roles and Responsibility of a leader
3:30pm	Tea
3:45	Setting up walks in the community 1. How to do it 2. What are the problems and how to overcome them 3. Where do we go from here? (Heart-start/ Stretch check/ new routes)
4.20pm	Evaluation
4.40pm	Close.

Case Record 5.13

Checklist for running a health walk

1. PAR-Q's must be filled out, check general health, if in doubt ask the activity co-ordinator or refer them onto their GP. Ask walkers to bring with them their medication and inhalers. Ask how they are feeling today. Responsibility of Back Walking Activator.
2. Fill out walk register, responsibility of front walking activator. All details must be filled out. Liase with back walking activator to identify any problems. Introduce the walking activators, and describe the route. Let walker's know who is carrying the first aid kit.
3. If group is large, and activity co-ordinator or volunteer is present ask them to be a marker for the slower group, or to mind the rest/ break groups.
4. Front Activator leads a short warm up walk, before doing mobility exercises. These must be done in a secluded area away from the main road and the public eye. Make sure walkers are warm before stretching. Reinforce why these are done and where they are felt.
5. Before taking any photographs ask permission.
6. If confident set the fast group tasks to continue the route on their own, but make sure they are still in vision (i.e. circular field or confine space), whilst you can concentrate on motivating other slower groups.
7. The back activator must stay at the back and make sure that the slower groups are walking at a comfortable pace.
8. If for any reason a walker feels ill, send them back to the centre with a volunteer or the activity co-ordinator; let the Activator with the register know.
9. If for any reason any of the walkers leave before the end of the walk they must let the front activator know; who would advise on appropriate cool-down stenches.
10. The front Walking Activator will end the walk with the cool down stretches with the fast group, the, back activator with the slower group. If possible do these together, if more than 10 minute apart do them separately.
11. Make sure all walkers are back. Complete group feedback (One Activator asks the questions whilst the other writes). Let them know of details of next weeks walks; hand out timetables of other walks.
12. Fill out Walking Activators feed back. Send together with the group feed back and register back to the Project Co-ordinator.
13. Enjoy the walk and the walkers company.

Case Record 5.14

Want to become a Volunteer Walking Activator with the Chalo Chalay Let's walk project and lead a health walk .....

Walking is set to play a central role in creating a healthier nation. Evidence increasing shows that walking has many benefits including:

- *Reduction of heart disease*
- Weight control
- Benefits to older people, strengthens bones and the reduce risk of osteoporosis and associated fractures, improves co-ordination and joint flexibility
- Reduces anxiety and depression
- Social and community benefits.

Project Aim

The British Heart Foundation/ Countryside Commission/ Leicestershire Health and the Confederation of Indian Organisations have joined forces to create the 'Walking the way to health' initiative; Chalo Chalay (Let's Walk) for the South Asian community in the Belgrave, Latimer, Rushey Mead, and Abbey area of Leicester. The projects main aim is to;

'To promote higher levels of awareness of the health and social benefits of walking and to increase the participation in daily walking activity by Asian adults through increased walking opportunities, community action and improved environments'

What is a health walk?

A health walk is walking at a brisk pace, within the person's capabilities, so that they feel slightly warm and sweaty and to reach aerobic activity. The pace would start gently and gradually increase. The walk would commence with warm-up and mobility exercises and end with cool- down stretches.
The walk could be a local doorstep walk or can be further a field and can include other activities, depending on the group's needs. On the health walk there would be two walking activators one at the front and one at the back also a middle marker depending on how large the group was.

Role of a Walking Activator

- To run led health-walks locally in the Belgrave, Latimer, Rushey Mead, and Abbey area of Leicester for the specific needs of the South Asian community. Can be a front or back leader.
- To motivate client group walkers into walking briskly, but at a comfortable pace.
- To explain the health benefits of walking and the reasons for warming up and cooling down.
- To have the interpersonal skills to communicate with the client group walkers at a social level.
- To help develop walks and ideas that make the health walks more interesting.

- To liase with the co-ordinator and other walking activators to arrange walk details.
- To complete walk registers and to ask new walkers to fill out Par-Q (Physical Awareness Raising Questionnaires).
- The back leader is responsible for carrying the First Aid Kit and water and following the emergency procedure.

Full Training Provided

All walking activators will be asked to attend a one-day training course and a basic First Aid Course. Further support and training is available on request.

Case Record 5.15

Chalo Chalay Project Policy and Guidelines

CONFIDENTIALITY
It is of the utmost importance that confidentiality is fully understood and adhered to AT ALL TIMES, Any details given by the Project Co-ordinator or walker's via PAR-Q forms walking regarding walkers health condition must always remain strictly confidential and should not be discussed with anyone at anytime. Breach of confidentiality is a very serious issue.

Reliability /Absence

If for any reason you cannot lead a walk, you must inform the Project Co-ordinator well in advance if possible. If not available contact the back up walk leader. If weather is unsuitable, you must attend the meeting place to let walkers know that the walk has been cancelled.

Insurance
All project volunteers are covered by Confederation of Indian Organisations (U.K.) insurance policy.

Car Insurance
You need to inform your insurance company if you are using your vehicle in connection with voluntary work and particularly if you are transporting walkers. This information should not affect your premium in any way.

Travelling Expenses
These can be claimed to and from your home or place of work. Please fill in the appropriate forms and submit them at the end of each month. Please enclose receipts/tickets for expenses with the completed form.

Complaints Procedure.
If (a) A volunteer feels that a member of staff has treated him/her unfairly,
(b) A volunteer has behaved in a way contrary to the guidelines and policies of CIO, then the procedures outlined in the complaint procedure will be followed.

Volunteer Rights

1. Placements will be on the basis of a volunteer's skills and abilities
2. Support will be given to volunteers
3. Volunteers with a complaint against staff are entitled to use the complaint's procedure.
4. Volunteers will be given clear information about their voluntary role.

Volunteer Responsibilities

1. Volunteers are expected to treat all clients, staff and other volunteers with respect and dignity.
2. Any form of discrimination, abuse or other offensive behaviour can be treated as a disciplinary offence.
3. Volunteers must respect confidential information.
4. If clients have complaints or suggestions, volunteers should encourage these to be raised with appropriate staff.
5. Volunteers must refuse to take on tasks, which go beyond their job description.

You are responsible to the Project Co-ordinator for all aspects of your voluntary work.
If you have any doubts about your work- however trivial it may seem please contact the Project Co-ordinator

Case Record 5.16

Chalo Chalay (Let's walk)/ Walking the way to Health
LEADERS FEEDBACK
Walk Leader:
Group Name:
Group:
Date:
Walk:

1. How did the walk go, did it go to plan?
2. Were all your walk activities safe and effective?
3. How can you improve your activities in the future?
4. Was the group controlled effectively e.g. directions, instructions, teaching position, observation?

Chalo Chaly (Let's walk)/ Walking the way to Health
GROUP FEEDBACK
Walk Leader:
Group Name:
Group:
Date:
Walk:

1. How did you feel about the walk? Did you think it was too long or short?
2. Did you enjoy the walk (the social aspect, socialising with people/ company. The weather, the breaks?)

3. What did you not enjoy / like about the walk?
4. Did you like the route?
5. Did the walk make you feel slightly hot and sweaty (did it increase your heart rate)?
6. Other comments.

Reflection 5.24

Confederation of Indian Organisations recruited a short-term trainee – this was the only administration support available to the project. The training day was a huge step for the project. The project co-ordinator put in a lot of effort to make the day happen. Volunteers helped in kind. The facilitators arrived however the trainee could not come so it was left to the three facilitators to handle the day. The display boards were set up and teas and coffees were laid out, 10 am and no one had arrived, maybe it was just Indian timing! By 10:10 they started to arrive, 22 in total. Translation was happening in-between the sessions for a couple of the Masi's (older women) from the Belgrave Neighbourhood Centre. There were more South Asian participants, however a few more workers were present due to the newness of the initiative. A few of the GP exercise referral instructors and officers of the Cossington Street Sports Centre did not materialise this was rather disappointing.

The trainer lead the session and the project co-ordinator translated. Most of the discussions occurred in the morning session. The project co-ordinator introduced the project and talked about the initiative and its partners. The venue was excellent; the right atmosphere was created.

The Project Co-ordinator and the Reading Coordinator lead the walk. Those who had not filled out a PAR-Q did so. The leaders warmed the participants up outside, during the walk some of the participants got lost. The trainer who was the back walk leader called the Project Co-ordinator via mobile phone and they lead themselves back to the centre. Thus, a use of a mobile phone seemed to be an essential. The participants were cooled down in the traditional way. The walk was only 30 minutes long and was enjoyed by all. The route taken was short one from the visitors centre over the bridge around the circular cricket field and back over the bridge to centre, a distance of half a mile.

There was a working coffee break, where the participants where registered and received a pack and a badge. Names and addresses were taken so that attendance certificates and

further information could be sent to them. The food arrived which was the healthy option of a vegetarian Indian meal it was enjoyed by all.

The warm up activities were opened out, they were asked to generate ideas, and these included some of the traditional Gujarati dancing such as Gharba and Ras Lila. They all enjoyed this component of the training day. The afternoon session was on how to promote walking in the community, this session was lead by the project co-ordinator. It was very productive; a lot of ideas were generated on how walking activities could take place in the community and how to set up their own groups. The session finished on time and there were 10 people who were committed to doing the HeartStart programme. It was agreed that the group would meet in 3 to 6 months time to review how the walking activators were progressing. The overall evaluation of the course was positive, but they would have like to seen more of the resources translated.

The day went very well, but happen very quickly and time was too short. The leaders were expected to come to a few walking sessions before they lead a walking group out on their own. There was a lot of enthusiasm generated; however the question of commitment arose.

Publicity

The publicity for the training was done in-house and targeted the specific audience. The training was advertised on the local radio stations. The training day was advertised, and promoted on the basis of the individuals wanting to learn about walking techniques, managing a group of walkers, motivational or leadership skills, and how they would benefit highly from this enjoyable course. It was considered if the need arose to translate the training manual in the specific language required. All resources needed to arrive in advance to make this possible.

Case Record 5.17

Chalo Chaley Let's Walk

Want to help your community get fit and healthy? How about becoming a walking activator?

A free training day on Monday 16th of August 1999 10-4pm at Abbey Park

Will give you the skills to lead a health walk. No obligation and Free Lunch.

For booking & more information contact
Rekha Chudasama Project Co-ordinator
Confederation of Indian Organisations
24-26 Imperial House
St Nicholas Circle
Leicester LE1 4LF
TEL 0116 2424017

Places are limited so book your place by Monday 9th August

CIO
Working with Asian Voluntary Organisations

Health for Leicestershire
LEICESTERSHIRE HEALTH

Participants

Out of the 22 participants:

- 7 were existing walkers
- 3 were from the Belgrave Neighbourhood Centre, that is 2 volunteers and the Scope Co-ordinator

- 2 were from the Savera Resources Centre, the Activity Co-ordinator and a volunteer
- A Health Promotion specialist from City West- Health Promotion Centre
- 1 of the sponsored Exercise to Music instructors
- An existing qualified walking activator
- A Health Promotion Officer from the Health Promotion Centre
- 2 Riverside Rangers from the Leicester City Council Urban Design Group
- 3 interested individuals who lived in the area
- 5 of these were professionals from organisations which were partners in the project
- Out of the 22, 19 were females and 3 were males

Second Training day 12th April 2000

Out of 21 attendees

- 4 were from St Gabriel's Community Centre in Rushey Mead, Centre Manger and 3 volunteers
- 2 were from the current Chalo Chalay men's group
- 3 were Health Visitors from the Charnwood Health Centre
- 1 was a keep fit instructor
- 8 were interested volunteers
- Out of the 21; 4 were professionals
- Out of the 21, 18 were females and 3 were males

In attendance was the new Chalo Chalay Co-ordinator.

HeartStart U.K

The follow up training, which was offered, was First Aid and or HeartStart. HeartStart was a national initiative, co-ordinated by the British Heart Foundation to promote and develop emergency life support training throughout the United Kingdom. The ethos of the training was to promote the techniques used to a wide range of emergencies, which would prompt the action of a bystander, and could mean the difference between life and death. HeartStart schemes were made up of people who shared a commitment to training the public in Emergency Life Support. The schemes varied in size, and were organised in different ways, they were run mostly by volunteers, and trained specific groups of people,

in local communities or larger communities such as the NHS or Health Authorities, and aimed to create partnerships between all relevant organisations.

Emergency Life Support comprised of the essential actions needed to maintain life in an emergency. These included:

- General care of casualty include procedures from obtaining help
- Dealing with unconscious person who is breathing
- Performing rescue breathing
- Performing cardiopulmonary resuscitation (CPR)
- Dealing with choking or an obstructed airway
- Dealing with serious and life threatening bleeding
- Dealing with a suspected heart attack victim

Certification

A certificate was sent to all those who had completed the training day, it had the logos of all the project partners.

Evaluation of Training Days

A questionnaire (Wiltshire Health Promotion Service, Brewin 1999) was handed out pre and post the training day with 17 statements, which participants were asked whether, they agreed or disagreed with. The purpose of the questionnaire was to examine their views and knowledge of health walks. Leader roles and the relationship between walking and health, 43 sets of questionnaires were analysed (22 from 1st training day and 21 from the 2nd training day). Table 5.14, show all the statements with the desired response, and the percentage agreeing with the desired response pre and post the training day.

Table 5.14 Pre and post Evaluation Reponses

Statement	Desired Response	Concurrence with Desired Response PRE (%)	Concurrence with Desired Response POST (%)
Health Walks			
1. Must always be done at a brisk pace	Agree	58	90
2. Are basically like other lead walks	Disagree	47	28
3. Have a set structure	Agree	72	93
4. Need to be continuous (i.e. 'stops not allowed)	Agree	37	90
5. Require everyone to walk together	Disagree	32	86
6. Require monitoring	Agree	88	100
7. Should recruit individuals who are active	Disagree	60	49

Health Walk Leaders			
8. Need to be the fastest walker in the group	Disagree	79	65
9. Need to understand how people change their behaviour	Agree	100	100
10. Need few specific skills	Disagree	21	14
11. Can shape the way in which the scheme is evaluated	Agree	81	100
12. Need to be able to judge their success as a leader	Agree	74	95
Walking and Health			
13. Smokers are more at risk of Coronary Heart Disease than sedentary people	Disagree	34	49
14. Exercising regularly has no effect on the risk of getting Diabetes	Disagree	51	88
15. There are more smokers than inactive people in the UK	Disagree	58	86
16. Exercising regularly has no effect on the risk of getting cancer	Disagree	72	79
17. Walking can halve the risk of getting Coronary Heart Disease	Agree	91	100

From Table 5.14 changes in all areas were noted post-training day:

Significant effects were shown in the following areas:

- Health Walks should be continuous, that is not stopping
- There are more smokers than inactive people in the UK
- Raised awareness of the effect of walking on the prevention diabetes
- Walkers need not all walk together whilst on a health walk.

Improved knowledge levels were observed in the following areas;

- Health walks should be done at a brisk pace.
- Health walks should have a set structure.

High levels of knowledge were observed, pre-training in the following areas;

- Health walks should be monitored.
- Leaders need to understand how people change their behaviour.
- Leaders can be influential in shaping evaluation.
- Leaders need to be able to judge their own success.
- The relationship between regular walking and the prevention of heart disease and numbers of sedentary people in the population.
- Walking can reduce the risk of Coronary Heart Disease by half.

Low levels of appreciation were observed Pre and Post training in the following areas:

- Health walks are different from other lead walks.
- Leaders need specific skills.

Ambivalence was noted in the following areas:

- The need for leaders to be the fastest walker.
- The targeting of sedentary or active people for recruitment to Health Walks.

General Evaluation of the Training Day

The participants were given a short evaluation questionnaire to fill out about what they thought of the content, venue and whether they felt confident of running a health walk. 68% felt the content was useful and relevant; the rest felt that there needed to be more specifics on the South Asian community and how to motivate them. The venue was appreciated by all, and liked the lunch provided. Only 10% of the participants felt confident enough after the training day to run a walk, the rest felt that they needed to attend a few more health walks before endeavouring to go out on their own. There was a high understanding of the benefits of walking but a perception of what a health walk was that is that you have to be very fit to become walk leader, which was dismissed after the training. Most of the participants found the stretching part the most difficult to grasp, but felt more at ease when further sessions of practice were offered. The techniques were very poor, and needed a lot of work before this could be taught properly to others, safely.

Another aspect of the workshop, which needs to work on, was the translation component, the material needed to be translated. It was difficult, running the workshop in both languages. It would have been easier to run it in either English or Gujarati. Overall the workshop was received well, and taken to be of practical use.

5.3.6 Publicity

Project Name: Chalo Chalay

The project name was thought of by the project co-ordinator who had discussed it with colleagues. The idea originated from a phrase used in India, Chalo Chalo, which was used to push people or modes of transport along. It was something that was picked up by the co-ordinator on her last visit to India: where the conductors on coaches would use the phrase to communicate with the driver. The iteration was catchy, Chalo Chalay, Chalay meaning walk. It was chosen also as it translated well in Hindi and Gujarati and was universal within the South Asian languages; Let's Walk! It was taken back to the steering group, a short discussion followed on its meaning, and its translation into Hindi, with a member from the Health Promotion, Unit Leicester City Council and all bilingual members of the group whose language skills were of a high level. All members were happy and the project formally became know as Chalo Chalay Let's Walk Project in October 1998.

Project Logo

It was important for the project to adopt its own community lead focus, and was achieved by getting the community involved in the designing of the logo. Rushey Mead School in Leicester were keen to promote the project with its students and surrounding residents. The head teacher suggested a competition to design the logo and to open it out to year 7 students, 11-12 year olds. This was done via a personal and social education class, where the project co-ordinator had previously spoken to and conducted a short survey of students who walked to school via promoting the safer routes to school programme. The students were given six weeks to design the logo, which was then taken to a professional designer. The winner received a £20 voucher from J&B Sports in Leicester. The entries were taken to the steering group who judged them for the winning design. All of the entries had their own viewpoint of what the project was about, thus themes where taken from each winning entry, to be incorporated into one design. The designer volunteered his time to the project; he worked for a design company, which did corporate logos. The final project logo is shown in figure 5.5.

Figure 5.5 Project Logo

Reflection 5.25

A meeting held with the Head of Rushey Mead School in Leicester was very productive. He had a lot of contacts and influence in the locality and was popular with the students, parents, residents and governors of the school. His working relationship with key individuals in Leicester was invaluable. He suggested at this meeting a number of ways of promoting the project. The first was via the Belgrave Corridor Project, and secondly via the safer routes to school programme. The head requested whether the project could do a survey of the number of actual students that walked, used public transport or travelled by car to school. It was thought that the student's parents could possibly do a health walk, when they come to drop their children off. The head also suggested targeting parents from the evening language Hindi/ Gujarati classes, who were a captive audience for two hours. The project was publicised at the annual Swimathon held by the school, where there was a high attendance of parents. The project also met with the student council who were enthusiastic to help.

Development of Project Leaflet

The leaflet for the project was developed by the project coordinator and was sent to the London office to be proofread. It was agreed at the steering group meeting, that the leaflets would be translated into the five South Asian languages. It was also agreed that any other resources produced should be in consultation with the community. Leaflets may not be their preferred choice; thus the project considered the use of videos and audiotapes upon request.

Case Record 5.18

Leaflet

Chalo Chalay – Let's Walk Project

Aim
The Confederation of Indian Organisations, British Heart Foundation, Countryside Agency and Leicestershire Health have joined forces to create the 'Walking the Way to Health' Project; 'Chalo Chalay' (Let's Walk) for South Asian Communities throughout Leicestershire. The project Aims to:

' Promote higher levels of awareness of the health and social benefits of walking and to increase the participation in daily walking activity by Asian adults through increased walking opportunities, community action and improved environments.'

Walking is set to play a central role in creating a healthier nation. Evidence increasing shows that walking:

- Reduces the occurrence and re –occurrence of heart disease
- Improves co-ordination and joint flexibility
- Helps in weight control
- Lowers the risk of brittle bones & increases bone density
- Reduces anxiety and depression
- Improves confidence
- Gives greater stamina & energy
- Improves posture and tones muscles
- Brings social and community benefits and
- Can help people improve shape and appearance

Why become active?
Besides all the health benefits, 30 minutes of physical activity per day will give you the stamina and energy to do everyday chores and have a good nights sleep. It can be done in three bouts of 10 minutes, for example walking to the local shops for a paper, or picking up the children from school. The young, older people and even those recovering from an illness can enjoy walking. Whether you join a group or walk with family and friends a little goes a long way.

Getting Doorstep Walking into your Life
You can join one of our walking groups, each one of which runs once a week or set up a new group at your local community centre or organisation with our help.

Remember:

- You **do not** have to be ' fit' to start
- You **do not** need a lot of time
- You **do not** have to do it alone

Also

- You **do** need to build up gently if you are unfit

But we **can** help you achieve health benefits and it **does not** have to hurt.

Want to get involved as a volunteer?
If you have the time and would like to help your community, why not become a Walking Activator

Role of a Walking Activator

- To lead health-walks locally in Leicestershire in ways that address the specific needs of South Asian communities

- To motivate client group walkers into walking briskly, but at a comfortable pace.
- To explain the health benefits of walking and the reasons for warming up and cooling down.
- To have the interpersonal skills to communicate with the client group walkers at a social level.
- To help develop walks and ideas that make the health walks more interesting.
- To liase with the co-ordinator and other Walking Activators to arrange walk details.
- To complete walk registers and ask new walkers to fill out a Par-Q (Physical Activities Questionnaire).
- The back or (rear) leader is responsible for carrying the First Aid kit, water and for following emergency procedures.

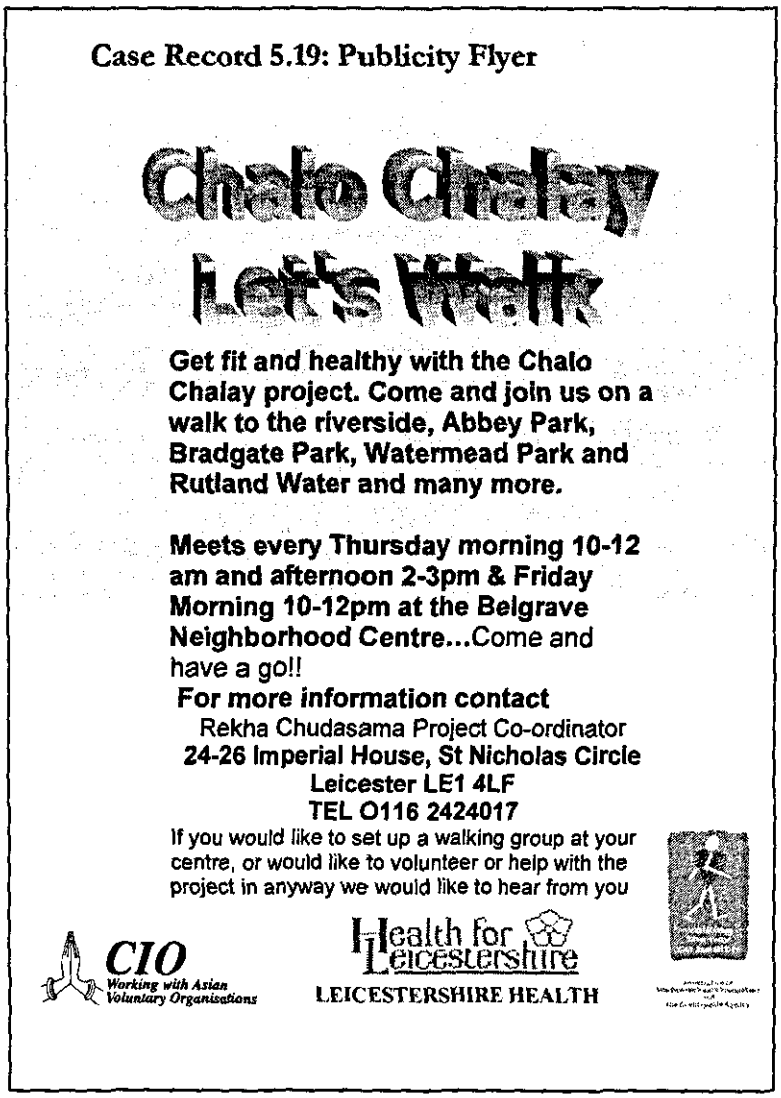
Full Training provided
All Walking Activators will need to attend a one-day training and a Basic First Aid Course. Further support and relevant training is available upon request.

For further information please contact the project co-ordinator at:
Confederation of Indian Organisations

Publicity Flyers

These were developed by the project co-ordinator and sent to all organisations in the locality. They were used on display boards, and events for general distribution.

Case Record 5.19: Publicity Flyer



Audio Visual Resources

The idea of producing a newsletter for the project was accepted, but was also time consuming. Maps did not seem appropriate, as maps of the riverside section were already in place, and seemed pointless to duplicate. If routes were going to be mapped it was more appropriate to have audio tapes and also a video explaining what a health walk was and with stretches demonstrated so that people could do the walks independently or start their own group at their own convenience. The video would have been produced in all of the South Asian languages, but there was a cost implication. It would have addressed the issue of those who may not be able to read or those that were disabled.

Way Marking/ Maps

Designing directional flags for walks was supported by the Leicester City Council they agreed to help with the development of the maps with all six-doorstep walks. Concerns of way marking the walking routes were bought up at a very early stage in the project. The project co-ordinator had an in-depth and long conversation with the Riverside Development Officer, she was concerned about sign posting along the riverside, as a number of signs were going up and the riverside was becoming cluttered. Alternatively, the idea came about of directional flags to represent seasonal walks for example Diwali, Navarati, Holi, Christmas, Eid, and Halloween etc. Local schools were envisaged to designing these. The project would print the flags on a regular basis in accordance with the themes; along side the promotion of the project as the flag would encompass the project logo, and partner agency logos.

The meeting with the riverside officer generated a number of ideas; it was thought at Diwali, a diwa (candle) could be paced into the river and followed down and making the event culturally appropriate, and promoting the link with water and Hinduism. The officer was keen to support this and increase the number of Black and Ethnic Minorities using the riverside. She was also keen on resource building and maps, making them simple to follow instead of permanent signs. 'Real ideas from real people' was the theme, in particular when looking at the Cossington Park area.

Promotion at Community Events/ Networking

A number of festivals, events, charity walks were held annually in the Belgrave locality. The project was promoted at each of these events. This was done via stalls and the distribution of the project leaflets and general information on becoming a walking activator. It was also used as a platform to recruit volunteers onto the project.

Displays were taken to targeted cultural events that were held locally in the area. For example health fairs, Belgrave Riverside Festival, open days at community centres, religious festivals, British Heart Foundation and Age Concern sponsored walks.

Volunteer Conference at DeMontfort Hall

The project was publicised at this event, the publicity boards were set up together with the promotional material. Not many ideas were generated on how to recruit South Asian

volunteers. There were a few South Asian volunteers that received a certificate at the event. It was a good networking event; a women's organisation Bhagini was interested in setting up walks with their women. There were a few others who were interested but did not believe that their health was up to it.

Belgrave Mela

The project was represented at the annual Leicester Belgrave Mela. The event was very successful; over the weekend period approximately 300 people visited the stall. The stall was in partnership with Cossington Sports Centre and Chalo Chalay. It was originally planned for a few of the walkers and volunteer walking activators to demonstrate some of the stretches and mobility exercises on stage but this were cancelled at the last minute. The ladies group were disappointed; their dedication to the project was impressive. The stall set up was professional and attracted a lot of potential walkers, 500 leaflets were distributed.

Vishamo

A stall was set up at the Vishamo fun day fund raising event. This organisation served the needs of mental health patients and their carers in the community. It's main objective was to provide day care for their clients. There was a lot of interest, and the group was looking forward to the walking group being set up by the project. There was also interest amongst community members outside of Belgrave. It was emphasised that volunteers did not have to live in the immediate local area of Belgrave to become a volunteer or to take part in the walks. A demonstration of stretches and mobility exercises were carried out to give a taster of the types of things that happened at a health walk. Displays boards were set up, and the promotion material distributed.

International Millennium Women's Day

The project sat on the steering group for the International Millennium Women's Day. It organised a one-day event in March 2000, with a number of activities for women and children. The event raised awareness of the project and gave taster walks around the event and follow up walks. It was a huge event co-ordinated by all the women's groups in Leicester, it publicised the Chalo Chalay Project within these groups and all organisations involved with the event. The event attracted a wide range of women, who wanted to join an existing walking group, a few wanted to set up their own in their neighbourhoods.

Belgrave Riverside Festival

The event was discussed at length with the riverside development officer. In the previous three years that the event was held there were 50% Asian attendance and the rest a mixture. It was considered an ideal event to launched the project in July 1999 but did not coincided with the national launch in September. It was however successful, and generated interested via the stall set up. It was a good liaison event, and allowed for networking with other health professionals that worked in the locality.

Pragna Chakshu (Inner Vision) Group

At the project launch a contact was made with the above group, who invited the project to speak to the group in a bit more detail about the benefits of walking. The co-ordinator of the group was keen to work with the project. The group was based at Abbey Primary School and met every Monday afternoons. The group was for the visually impaired and blind people. They were enthusiastic and asked a number of questions in particular about the health benefits. They all wanted to walk but found it difficult with their disability. The project set up a walking group with them, which met once a month. From these initial walks other schools such as the Mellor Primary School approached the project to set up specialised walks.

The Ramblers Association

The co-ordinator of Leicestershire and Rutland Ramblers Association approached the project to help support a series of walks they were running for the 'normal' walkers. The project was also invited to the Leicestershire and Rutland Sports and Recreation forum, who ran a series of workshops on the future of walking in localities, and what could be done to promote walking to those who are sedentary. The Ramblers were good option for current walkers to go onto once they felt confident. There was only one South Asian man who used the association.

Sponsored Walks

Links were made with the local project co-ordinator of the British Heart Foundation (BHF). They ran an annual charity walk which Chalo Chalay took part in. The women's group were keen to participate and a few of the Kaka's came too from the men's group. It was recognised that doing sponsored walks was a good publicity campaign and would

raise the profile of the project. The walk was well attended there were six of the Chalo Chalay walkers who attended and completed the walk. Four, of which did the full eight mile walk which was an excellent achievement. It was a well-organised event and all that participated enjoyed it. Links were strengthened by the presence of the Chalo Chalay walkers. The charity walk had seen many more South Asians in attend than in previous years, due to the links with Chalo Chalay. Further meetings were arranged with the local BHF representative, to discuss translated resources and some visual information on walking and keeping healthy, this liaison strengthened her case for more relevant translated resources. The specialist cardiac rehabilitation nurses raised these same concerns of a lack of translated resources. The contact made was useful in that links were made into the HeartStart training. A similar walk was held for Age Concern Leicester and it reaped the same benefits of attracting a wider audience.

Religious Festivals

The project recognised that religious events often encapsulated all of the community. Those that did not use local groups, or were not captured in the normal routes of a media campaign would be via religious events. These events were family orientated and all have to participate. Understanding this principle was the foundation to this arm of the targeted publicity.

One of the religious festivals that was targeted included *Katha's* - recitals of the Hindu scriptures, which touched upon living a healthy life and yoga principles. In conjunction with the Health Promotion Centre the concept of working within inter- faith communities took a strategic role. Religious leaders were interviewed to support healthy living, physical activity and walking. These were then broadcasted on local radio where people could call in and ask questions directly to the specialists. Parts of the recitals were recorded and replayed on radio to spark debate on the issue. This was the first step in the process of change where it got sedentary individuals on the grounds of religion to think about physical activity. The Kathakar (recitalist) interviewed was Morari Bapu, a renounced scholar, who recited the Ramayan, he drew in a crowd over 30, 000 people over a 10 day recital, which included the philosophies;

'Of what we eat is what we are' and

'Pilgrims by foot, if able, are the only way to travel on your spiritual journey.'

Professional and Community Launch

The local launch was arranged just after the national launch, which took place on the 3rd of September 1999. The project local launch took place on Monday 6th September 1999, via a floating candle walk. A *Maraj*, an Indian priest was requested to bless the project, and officially launch it by placing the first candle into the river. It had a wide publicity campaign; 500 launch flyers and walk timetables were sent to existing walkers, local community groups, organisations and 30 GP practices in the geographical boundary. The project received wide publicity from the local press, radio and television stations also in the Practice Manager Journal. Two hundred people participated in the activities and celebrations. The event was successful and reached its aims and generated an interest in setting up walking group's in different localities.

A number of people from the press and media were contacted. Live press coverage was received from radio stations, a live radio interview for Asiannet and a live telephone interview for Century 101.4 FM prior to the event. On the day, interviews were done for MATV – a local television channel, who publicised the event on their news-desk. They videoed the whole event for a community programme to be showed on a weekend show. Live interviews were conducted for East Midlands Today in their weather programme from Abbey Park and for Central Television's Asia spot light programme. Finally the launch got half a page cover with three photographs in the Leicester Mercury.

Reflection 5.26

Pre Launch

At the pre planning stages, a meeting was held with the Riverside Ranger to work out the logistics of diwa's /candles floating down the river and the walkers following them down. The ranger did not see it as a problem, as the candles could be collected up further up the river. Different versions of the diwa's were tested out which were made by the project co-ordinator and the ranger gave his comments on which he thought would float the furthest. The diwas, which were hand made with tin cake foil, *ghee*, and cotton wool, were much heavier than the floating candles, which travelled further along the river. These various versions were made on the day together with the floating flower shaped candles. It was discussed to make this an annual event if it worked, and whether it created an interest towards the riverside. The route was planned; the best place to launch the diwa's was tested. Along the edge of the river, was good but due to the wind the diwa's were blown onto the bank. Several points along the riverside were tested, there

was a point along the riverside situated within the basin area where there were steps leading down to the river, near the bridge. It was a perfect spot for some of the candles to be launched from there. It was decided to launch the other diwa's from a boat, which would take the candles more into the central part of the river. This was the basin part of Abbey Park where the river opened out into a little lake where the bridge was located. This was the landing area where boats could be anchored. The rest of the diwa's were launched further up the river, where it was more sheltered from the wind and the walkers could follow the candles floating down. Thus, the first diwa was launched from the boat, then the rest from the steps. The boat itself was a lifeboat, and was sponsored by the Leicester Mercury- the local newspaper; it was a good photo opportunity.

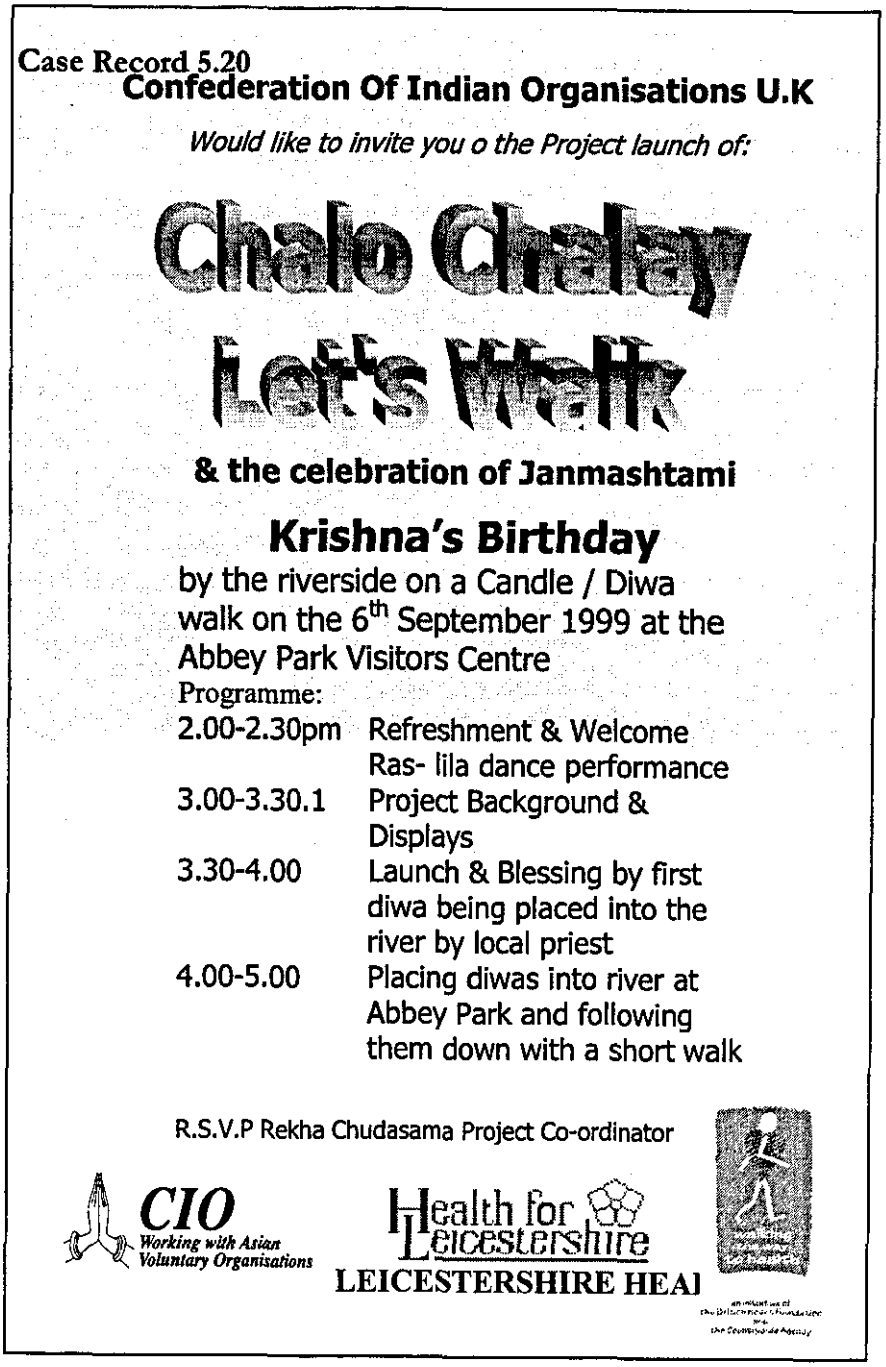
The riverside team were keen to promote the area; it was discussed to campaign for an area, whereby people could perform their religious rites, by placing their biodegradable items into the river. In Hinduism, water is a significant part of the culture; religious items used in pray cannot just be thrown out, but placed into the mother river. The river plays an important part in the death rituals that are performed. The ashes of a Hindu's are usually taken to the sacred River Ganges in India. The souls are washed of all sins and are liberated. However, some families in England cannot afford, or may not have the resources to do this so ashes are sometimes placed in local rivers. This is an illegal practice, and often people are fined, without knowing why people are carrying out such acts. A lot of respect is given to the river as it is seen as apart of mother earth and not to damage the river or use it as a dumping ground. It was decided to work with groups and reach a consensus, which would work both ways and produce a natural surveillance. Thus, links and innovative way of working were discovered.

Another idea generated was to get the walking group involved in the Green Life Boat Project, which helped keep the riverside clean. Free trips were on offer to volunteers who would help to clean up, this formed apart of the physical activity programme.

The local launch in Leicester was to be held around a religious event of *Janmastimi*, Krishna's Birthday, which was also on the 3rd, but it was more convenient for the project to be launch on the 6th of September, as then it would not clash with the national launch. This was published nationally by the initiative. The launch was planned to be from 2 to 5pm. The cultural dance performance would set the scene, followed by a couple of short talks and then the official launching of the project by the first diwa being placed into the river by the *Maraj* (Hindu Priest).

Programme/ post out

The programme was devised for the afternoon, and the publicity was done in-house by the project co-ordinator as shown in case record 5.20. A mail out was done; 500 organisation and individuals, all affiliated groups, and professional contacts. All the groups in the geographical boundary of Belgrave, and all the walkers were invited. The management committee of the Confederation of Indian Organisations were also invited.



Case Record 5.20

Confederation Of Indian Organisations U.K

Would like to invite you o the Project launch of:

Chalo Chalay

Let's Walk

& the celebration of Janmashtami

Krishna's Birthday

by the riverside on a Candle / Diwa walk on the 6th September 1999 at the Abbey Park Visitors Centre

Programme:

2.00-2.30pm	Refreshment & Welcome Ras- lila dance performance
3.00-3.30.1	Project Background & Displays
3.30-4.00	Launch & Blessing by first diwa being placed into the river by local priest
4.00-5.00	Placing diwas into river at Abbey Park and following them down with a short walk

R.S.V.P Rekha Chudasama Project Co-ordinator

CIO Working with Asian Voluntary Organisations

Health for Leicestershire

LEICESTERSHIRE HEAl

The food was ordered from a local catering outlet on Belgrave Road. It was a special fasting day, agyarus (11th day of the 15 day light cycle of the month), a special meal of

farahri food was ordered. This included food made without sea salt, and included meals made from potatoes and yoghurt. An order for 300 people was requested. Considering it was Krishna's Birthday a cake was ordered for 70 people to celebrate it, it formed apart of the launch, that is cutting the cake to celebrate the success of the project.

Reflection 5.27

The launch was a success, however it was done in the budgets stipulated by CIO, this caused friction, the funders wanted a significant event as national photo opportunities were set up. The project officer worked within the constraints and delivered upon the objectives of the launch event.

Invited Media

All press releases had to be passed by the National Co-ordinator at the Countryside Agency. Press releases were sent to all media contacts in Leicester and East Midlands, this included, Radio –BBC, Asian Network, Sabra's and local newspapers – Leicester Mercury, Television- Central TV, East Midlands Today, MATV who had been broad casting everyday for a week prior to the event, and a few of the professional journals – The Practice Manager. From this initial contact a number of inquires were made.

Live radio interviews were done for the radio stations, one was also done for the Asian Network in Gujarati. The presenter asked about how Confederation of Indian Organisations were celebrating *Janmastimi*, it was a different angle to the launch. The time, date, and venue of the launch were told to the listener. A number of people heard this interview; the listener-ship was around 64,000 in Leicester. A live radio interview for Century 101.6 FM was also done via telephone. It was much easier doing it in English than in Gujarati. The interview was more focused on the health benefits of walking.

The Launch Day

With the support of volunteers, things like drinks and shopping were done. Chocolates were brought for the ladies that were performing and the children that were dressing up. Flowers were brought for Savera Activities Co-ordinator for organising the dance performance. The Visitor's Centre was transformed and decorated with flowers and a little shrine of Lord Krishna was set up.

Before the launch a couple of television interviews were done. *MATV* the local Asian channel for Leicester did an interview. It was done in English, and general questions were asked on where and why the project was being launched.

East Midlands News: a live on air interview was done for East Midland News, which was presented just before the weather forecast in the afternoon. Live coverage was done whilst reading the weather report from Abbey Park. A few practices runs were done from the landing basin area of the park. The presenter joined the project co-ordinator walking along the riverside and asked a few questions on the project and the launch, and the double celebration of *Janmastimi.* Questions were also asked about why South Asians had a higher risk of coronary heart disease. A balanced answer was given in terms of the physical and social aspects. The national co-ordinator was there to support, and was watching the live interview.

Asian Spot Light Central TV- this interview was long, around half an hour of footage, a number of questions were asked whilst filming around the park and the gardens around the visitors centre. The questions asked were very professional and ranged from why the project commenced, how long it was running, who was getting involved and why coronary heart disease was affecting the South Asian community.

The Practice Manager Journal wanted an interview and photo opportunities and wondered if were all going to be dressed in classical dress such as Sarees, thus the project co-ordinator, and the rest of the staff team were in traditional wear such as Punjabi suits or Sarees. The weather on the day was warm and bright, perfect walking weather. Articles were written in the Leicester Mercury and Sports and Leisure guide produce by the Leicester City Council.

The officer manager and trainee from CIO were in attendance. They helped set up the presentation boards, and the entry's from the logo competition. Directions and signs were put up. The diwa at the shrine of Krishna was lit and together with the staff welcomed everyone. Refreshments and food were laid out.

Dance Performance By Savera Ladies

The Savera group did the *Ras Lila* dance – a special Hindu cultural dance that encompassed the stick dance around *Ratha Krishna*, two of the Hindu deities, to celebrate their love. Some of the group's children dressed up as Ratha Krishna, they had taken time out from school and the ladies from the group had been practicing hard. Consequently this was the picture on the main publicity done by the Walking the Way to

Health Initiative by the British Heart Foundation and Countryside Agency. Thus, the six ladies from the Savera group including the activities co-ordinator performing the Ras Lila opened the event. This was done in conjunction with the celebration of *Janmastimi.* It involved the ladies, doing the stick dance around Ratha Krishna, who were dressed up in the middle. It also demonstrated a form of physical activity. The performance was of an excellent standard and the ladies had been practicing hard. The ladies were thanked via boxes of chocolates and flowers for the activity co-ordinator who had organised, and choreographed the piece. It set a good stance for the rest of the event.

The Presentation

Around 70 people had arrived, and a short ten-minute presentation was given about the project. It was done both in English and Gujarati and explained the aims and objectives of the project and described each strand in detail. The traffic officer from the Leicester City Council was invited to speak about the third, environmental strand of the project. This was translated into Gujarati by the project co-ordinator. The *Maraj* (priest) was also invited to say a few words both in English and Gujarati, about the health aspects of walking and the project. He also spoke about *Jamastimi* and blessed the project to be successful. It was very important to have religious leaders promoting the project, as often they were seen as gatekeepers. The *Maraj* was open in his outlook and very supportive of the project, it was useful that he could speak both languages as he related the message to both the older and younger generations. Coming from a priest the message was listened to and respected.

Unfortunately Harish Bhai, the Maraj, passed away soon after the launch of the project, he will be remembered for all his support towards community initiatives, may Mataji bless his soul with peace.

Launch Of the Diwo (candle) from the boat.

After the talks all walked down to the landing basin area and towards the boat, the Maraj had brought with him the 'Poojani Samaghari', which were religious artefacts used to bless the project. The women sang religious songs whilst this was happening. It was very picturesque, and the local newspaper photographer as well as the professional photographer got lots of shots.

The boat was tied to the steps, which lead down to the river, the *Maraj* and project co-ordinator, climbed on to the boat to launch the project. The *Maraj* said a few prays, and lit the first diwo, and placed it into the river, the project was officially launched, the rest

followed suite, and candles were floating along the river it looked amazing. It was beautiful, members of the steering group attended, such as the national co-ordinator, the evaluators, and supervisor from the London office, they all placed candles into the river to wish the project luck and success.

Physical Activity and a Short Health Walk

Afterwards outside the women continued to sing songs, and people joined in the cultural dancing, of *Gharba* and spinning each other around. People continued to place diwa's into the river in the background. The dancing continued and a short walk was lead around the lake by the trained volunteer walk leaders. They did very well and were a great help on the day. It was disappointing that not many of the local steering group members or the director of CIO and the Chair could not attended.

Cake Cutting

Everyone had paced a candle into the river and they all headed back to the visitors centre. The *Maraj* said a few words and stated that it was not only Krishna's Birthday but also his, the project co-ordinator's and a few of the volunteers so it was celebrations all the way around. Happy Birthday was sung and the girls who had dressed up as Ratha Krishna and the children cut the cake, and was shared between all. People were invited to stay for food and to ask questions to staff and steering group members.

Step Counters

The national co-ordinator thought it was good idea to hand these out, as a promotional tool. However, the protocol had not been written, and people that were not currently with the project received one, some of walk leaders did but not the rest. Thus, they were not evenly distributed. Problems were envisaged; the groups complained that they did not get a counter, whilst others did. It had to be explained that the project could not afford to give out counters to all the walkers.

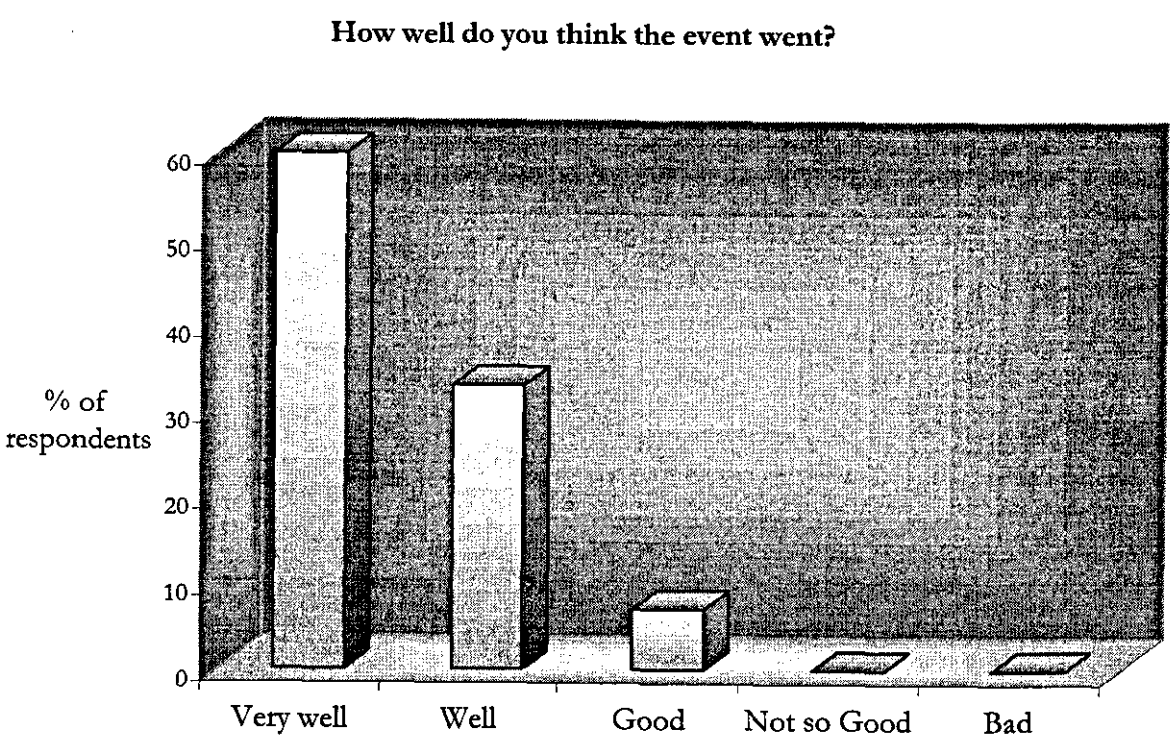
In Closing

The event was successful and reached it main objective of increasing awareness of the project via the media. Approximately 200 people attended the event. Positive feedback was received from the steering group members who thought that it all went very well. All enjoyed the event, and the message of health walks was heard clearly. Publicity was

received in the main local tabloids, General Practice Journal, local radio stations, and local and Midlands wide, television coverage.

Evaluation of Launch

A short questionnaire on what people thought of the launched was distributed to 200 attendees, out of which 60 were returned, the results are shown in graph 5.6. Overall, people felt that the launch went very well and was novel. They thought the event was useful, and met their expectations and provided information to set up walking groups within their organisations and communities. The aspect of the launch, which they enjoyed the most, was placing their own floating candles into the riverside. The event was successful; the candle theme became an annual event.



Graph 5.23 Evaluation of Launch

Cannot Please All.

An anonymous contact was made to the Chair who did not attend as he was held up at a meeting. He informed the project that there had been an anonymous complaint from the Muslim community over the launch, they said that it was only for Hindu's. The

complaint had been over the phone, but it was expected that they would put it into writing. The project was pleased that some sort of response was received from the Muslim community, as previous correspondence seemed to have been ignored, so it was seen optimistically that communication channels were being open, even if it was via a complaint. It was made clear that at this point the initiative by the British Heart Foundation and Countryside Agency, wanted the launch to be based around a festival. The Chair suggested that this should be feed back to them, and state the difficulties of working with such a wide community.

Reflection 5.28

The pre planning of the launch was discussed with the supervisor and chair they both felt that it was an appropriate event. Confiding in Muslim colleague in confidence of what he thought of the situation and whether he felt offend by the event. He clearly stated not to worry about it, but was curious as to who it was, there were known activists in the community, *'...and everything is not perfect.'*

Talking to other steering group members, they all thought event went really well and it was *'spectacular'*.

Launch in Highfields Spinney Hill Locality of Leicester

The health visitors from the Highfields locality approached the project to help with the launch of walking for health in the Spinney Hill Park targeted at Asian women and children. The project agreed to help develop some of the routes around the area. It was made clear that if the initiative was to be successful then it could not be just a one off event. A series of walks leading up to the event was suggested and was to be self-sustained by volunteers from the local community centre. It was agreed to work in partnership, as the project expanded out into that area in the second year. Consequently, a training session was held at the Spinny Hill Health Centre, specifically for the health visitors and their volunteers.

National Launch of Walking the Way to Health Initiative

The local launch was organised so that it would coincide with the national launch on the 3rd September 1999. The other three-demonstration projects were also launched in the same week, and provided ample photo opportunities and national publicity for all the demonstration projects. The formal launch event of the initiative took place a year later

in October 2000; this allowed the initiative to receive funding and sponsorship from the New opportunities Fund and Kia Cars

Case Record 5.21

National Press Release
A GIANT STEP FOR THE NATIONS HEALTH
A new initiative to get people to walk more in their own communities kicks off in Walsall today (3.9.99). Three pilot schemes in Walsall, Leicester and Eastbourne's are testing new ways of encouraging walking – as part of a nationwide network of health walks by the British Heart Foundation (BHF) and the Countryside Agency. Plans for a forth scheme in this *Walking the Way to Health* initiative are also underway in Keighley, Yorkshire.

In Walsall three measured walks in Reedswood Park have been established, with different community groups creating their own mosaics on the routes. A new *Groundmiles* scheme has also been introduced across the borough, offering discounts in local shops in return for evidence of attendance on organised walks.

The Leicester scheme works closely with the Asian community in the Belgrave area of the city, where people are being encouraged to go walking with friends from lunch clubs, temples and mosques. Improvements to local streets and parks also make walking safer and more attractive.

In Eastbourne a route along the historic sea front is marked at half kilometre interval with bright attractive signs. The signs, originally devised by the Irish heart Foundation, have been found to motivate people to walk in several European counties and Canada.

Local volunteers are being trained to run programmes and lead walks in all three schemes, and GP's are being encouraged to recommend walking to their patients who are unfit or at risk from heart disease. Evaluation by the BHF Health promotion Research unit at the University of Oxford will measure the impact of the schemes.

Countryside Agency chairman Ewen Cameron said: 'the countryside in and around towns has much to offer local people. If we can get them out of their cars and on their feet to walk, either for health reasons or the sheer pleasure of it, then they and the environment will benefit.'

Dr Vivienne Press, assistant medical director at the BHF added: 'Evidence is increasingly showing that walking can have huge benefits for public health. We hope our innovative scheme will introduce the habit, and the pleasures, of regular walking to the millions of sedentary people who make little use of the countryside and green spaces in our towns and cites'.

A training and advice package is being developed to help local groups interested in setting up a walking project and funds are being sought to expand the programme with a target of 200 schemes in the next five years.

Media Publicity – Newsletters, Newspapers; national and local

The project had also been publicised in local community newsletters. It had been apart of the local CHD awareness raising campaign on a commercial local radio station in conjunction with the Health Promotion Agency, Campaign *Dil Se*. An article was also published in the Diwali Guide 1999, 30,000 copies were distributed, 22,000 of which

were door to door, the rest were sent to local organisations, libraries, surgeries, business so forth, potentially a 50 thousand readership.

Case Record 5.22

Article In Diwali Guide 1999

The festive season has arrived again, a time for munching on *Mithaee* and all things sweet. We see the New Year in and start those crash diets that never seem to work. Well why not make this year different by doing it the healthy way, exercise and fresh air. This will help you become fit and healthy, stay in shape and prevent coronary heart disease, the main killer in the South Asian community.
The project's main aim is to get the inactive, active in their local environment by short health walks on their doorstep: Abbey Park, the riverside, Belgrave Hall Gardens just to name a few. The group meets every Thursday and Friday morning, near the Cossington street library. We are always looking to expand the project and need volunteers; if you think your local community can benefit from this activity get in touch.
Why not make it your New Years resolution to join the Chalo Chalay Project. We look forward to walking with you at our special festive candle walk, and walking the New Year through.

Other projects successfully recruited volunteers via advertising on the local radio station, this was how most of the exercise to music instructors were recruited, it was an expensive way of advertising, and it was difficult to access the funding for this type of campaign.

Over the lifetime of the project, articles were publish in the following media outlets:

- Walking the Way to Health Newsletter for health and leisure professionals
- National press releases via the British Heart Foundation and Countryside Agency
- Diwali Guide 1999, Leicester City Council
- Namaste Newsletter- Confederation of Indian Organisations (U.K)
- Leicester Mercury – various articles
- Countryside Focus –Countryside Agency
- Leicester Link Leicester City Council, sent to all household free
- Press releases sent to all organisations, to put into their own newsletters.

Raising Awareness of Community Groups/ Health Walks Promotion

Community groups requested health walk tasters and talks on what the project was about. The South Asian community, in particular the Hindu community had a number of casts that were grouped, which were called Samaj's. For example, the Soni Samaj had approached the project to speak at their health promotion event. It was constructive and

raised the profile of the project. There were a number of questions from the community members. They asked for the project to help set up a walking group for their centre. Most of the Samaj's in Leicester were visited and were helped to set up their own individual walking groups.

National Publicity

Links were made with the Midlands Countryside Agency. The co-ordinator brief the project on the wider picture of what the agency was trying to achieve in the long term, also the possibilities of future funding. Links with the rest of the region were discussed and how the project could liase with other projects.

Southampton Health Promotion Service

A couple of the Health Promotion Specialists from Southampton came up to Leicester to learn how the project was running, as they were wanting to set up a similar project. The logistics and parameters of the project were discussed. They also had a taster of a health walk. Publicity in the national newsletter put the project in the spot light and many calls were received nationally by the project. Other organisations wanted to know how to set up similar projects with their Black and Ethnic Minority communities, and often came to walks to find out what it was all about.

East Midlands Network Meeting British Heart Foundation (BHF)

The training consultant from the BHF requested the project to present at the East Midlands network meeting for setting up Walking for Health projects. There was a lot of interest and enthusiasm from the participants to set up similar projects in their localities. It was a well-attended meeting with 25 participants from all of the East Midlands, it was a good networking event.

Coventry Health Promotion Service

Coventry Health Promotion Service and the Forestry and Canal department invited the project to speak and advise at their network meeting. The group wanted to set up a series of walks near the canal areas in particular targeting the Asian community in the area.

Publicity via Interest walks

Barge Trips

To keep the walkers interested, the project held interest walks once every couple months. A barge trip up the riverside to Watermead Park was organised, attended by 10 ladies and 11 men. It created enthusiasm to continue with the group, and was an opportunity to bring new members along.

Hunstanton Coastal Resort

An interest walk to Hunstanton seaside, the walk along the sea front was a fantastic experience for the walkers. It helped to broaden their experience of walking especially in different environments. It was a calming walk, and was yet another angle from which walking could be promoted, in terms of relaxation and improvement of mental health.

The Walks/ Word of Mouth

The walks themselves were publicity for the project, and the walkers, who spread the word. It was amazing the number of people who had heard positive things about the project from the current walkers. The scheme was selling itself, the power of word of mouth was the most useful tool to publicise the project. As friend once said *'Gold sells itself'.*

5.3.7 Ethical Approval

Ethical approval was sought from the Leicestershire Health Authority research committee. The application was submitted together with:

1. Letter of invitation to research subjects
2. The behavioural questionnaire (both in English & Gujarati)
3. The physical activity readiness questionnaire (PAR-Q)
4. Literature on the shuttle walk test
5. A map of the geographical boundary to which subjects are to be tested.

The ethical approval was given to the project in December 1999 (confirmation letter Appendix V), with the request of:

1. That the letter to the walkers should be produced on headed notepaper

2. That the costs of being involved in the project should be made clear before entry into the study.

3. Reassurance that translation will be provided of the letter and other written material.

4. How will subjects be recruited? If walkers who had illness were recruited their General Practitioner would need to be notified.
5. What inclusion and exclusion criteria will be used?

The project adhered to the above specifics and the *guidance for researchers* ethnical approval was received.

The project with the resources it had translated written material, but often all was interpreted by workers verbally. In terms of inclusion and exclusion criteria the PAR-Q form was used, if any matters arose, the walker was referred back to the GP, to get clearance. All walkers were asked to sign the PAR-Q at their own risk.

5.3.8 Active Outcomes (February 1999 to February 2000)

The main outcomes of the project were that Chalo Chalay acted like a catalyst with its positive health promotion message. This was amplified and reiterated via the word of mouth process, more importantly it was the walkers own peer pressures within each walking group, which motivated the walkers. This was the major support mechanism for all concerned.

Community Involvement

At the end of year one, an extensive consultation had taken place, which included all stakeholders. Links were made with major establishments in the area including the safer routes to school strategy. The community and volunteers helped in route development around the area. All existing groups and local business were informed about the project and were given the opportunity to get involved. All local events such as the Belgrave Mela and Riverside Festivals were targeted. In every stage of the project, the ownership had been biased towards the community. An example of this is the *Chandni* fitness group for women, who gave themselves a personalised name.

Development of Walks and Routes

At the end of year one, six routes on the doorstep were established which were in the vicinity of the Belgrave locality, three of which the walkers felt safe and confident to use on a regular basis. Two lead walks were being run every week, one for the women and the other for men. Two sets of specialised walks were set up for a mental health group,

which helped develop and pilot the walks, and one for a partially sighted and blind group, which met once a month. 76 walks were led in year one in which 100 walkers had participated in one or more walks.

By year two, seven regular walks were taking place per week and the project had expanded out to the Highfields area of Leicester, which had a high population of Muslims. These walks had their own walking activators that were trained by the project. By the end of the four-year period 16 walking groups were established around Leicester and Leicestershire.

Development of Training

A training session for volunteer walking activators had been developed and delivered, taking into account the language barriers. Twenty volunteers participated, three of which were leading walks. In year two the training package had developed well and had continued to be adapted to the target audience it was serving, 4 sessions had been held with an average of 8-20 participants at each session. Some of these walking activators had gone on to do the Project Dil training CHD prevention programme. One of the walking activators had successfully completed the YMCA circuit training and now was qualified. The training became available upon requested and was run every time the project expanded out into another locality.

Publicity and Launch

The project was launched in September 1999, it had a wide publicity campaign, and 500 launch flyers and walk timetables were sent to existing walkers, local community groups, organisations and 30 GP practices. The project received wide publicity from the local press, radio and television stations also in the Practice Manger Journal. The event was well attended around 200 people participated in the activities. The project had also been publicised in local community newsletters. The project had been apart of a local CHD awareness raising campaign on a commercial local radio station and had ongoing publicity with the local newspaper and word of month.

Networks

A number of local networks had been established including community groups and religious establishments. Professional networks were set up locally and nationally with other demonstration projects and other potential walking projects.

Evaluation

A questionnaire had been developed and translated into Gujarati, first of its kind to be produced in a different language. By the end of the project it had been translated it into five languages, Gujarati, Punjabi, Urdu, Bengali and Hindi. A journal had been kept of the progress and barriers. Finally shuttle walk tests had been conducted on select group of walkers for the duration of the project.

Evaluation Workshop

An evaluation workshop held by the Oxford British Heart Foundation Health Promotion Research group, analysed the active outcomes of the Leicester project. The main outcome was the setting of realistic targets and goals. The first year of the project had reached its aims successfully, but it had been a difficult process and a number of new barriers were identified. The time allowed to address these new barriers was not allocated putting unnecessary pressure onto the project and its workers. This could have been avoided if realistic targets and goals were set initially. To allow for time for the development work would have been an asset and many of the challenges faced would have been overcome efficiently. These challenges can be defined as project support, implementation and development, each component was analysed separately. Furthermore a SWOT analysis of the project was carried out.

Project Implementation

Four main areas were identified in relation to project implementation;

1.Outreach in the Community

The first step in project implementation was the audit of the area, identifying any physical activity opportunities and projects that would link in. There was a gap in services for single gender sessions and in general physical activity opportunities for the elderly that were free. Next, focus group discussions were held with grassroots community groups on what physical activity opportunities would be viable. Views on walking were collected and analysed, routes were devised, and time slots allocated. Workers and managers were informed of the project and the results of the focus groups, tailored training was offered.

2. Co-ordinators Time

In the first year of the project, the co-ordinator was working part time, this did not allow time for detailed strategies to be implemented. There was a serious lack of time; the co-ordinator, as well as planning, developing and running of day-to-day walks did a lot of the administration. In the second year the post became full time, however the expectation of the number of walks and walkers grew, and the new co-ordinator was still in the same situation.

3. Pilot Projects

These were run with the Savera Resources Centre and the Belgrave Neighbourhood Centre, women's and men's group. It consisted of testing routes, and receiving feedback from the walkers. The process helped refine the lead walks, the procedures for leading walks, and the role of a walking activator and training needs.

4. Volunteer Walking Activators / Training

An important implementation strategy of the project was the recruitment and retention of walking activators. This had been the most challenging part of the project, the concept of formal volunteering within this community were non-existent. Volunteering was a natural part of being a community member. It did not required to ask members to become volunteers, but if help was needed people usually just helped out. This was not set and was very informal, thus the concept of become a Walking Activator had been difficult to sell. It was interesting to note that the women were more receptive to the idea compared to the men. The project had recruited more women walking activators compared with the men.

The training had to be redesigned to incorporated culturally sensitive issues such as single gender issues, footwear, clothing and discretion of the warm up and cool down exercise. Forms of cultural dancing were used to warm walkers up and all instructions were translated into Gujarati. The walking activators needed to be kept motivated by retraining.

5.Evaluation

This has been an integral part of the project, but the challenge was how it could be incorporated with the new co-ordinator, as previously data collected was via action

research. Close links continued with Loughborough University, the evaluators of the project. The shuttle walk tests had been an important motivational tool and the questionnaires were translated into all five South Asian languages.

Project implementation had been a difficult process, due to the lack of walking activators and appropriate resources, which had to be developed form scratch. Quality had been targeted rather than quantity; the walking activators that had been recruited had a high calibre and had expanded the project in a short space of time.

Summary of Main Outcomes

The two main outcomes of the project have been two fold, firstly from the achievement of the project being written into policies and the formation of the partnership.

Action to Policy

- Small initiative run by a voluntary project that worked in a targeted community.
- Project networked with the statutory sector forming partnership facilitated by informal working.
- Statutory sector identified funding from British Heart Foundation/Countryside Agency.
- Wrote partnership bid, received funding which was matched by local health authority
- Evaluation provided evidence of success.
- Project written into Health Action Zone, Health improvement Programmes by statutory partners.
- Further funding secured 40K for Leicester City via Health Action Zone, 11.4 Million from National Lotteries Charity Board for 500 other national schemes.

The Partnership

It had been difficult to work with the partnership, but it was this working partnership that had set the foundation to the project. The voluntary sector in a sense was similar to the private sector in that the more services that it provided the more users it would get and thus increased in funding. The sector had become very competitive as a number of bids were put into the same funders and the same pot of money. Thus the voluntary sector if it were to succeed in this environment it needed to use strategies that the private sector used. The statuary sector did not really allow for this creativity, and friction

occurred when both these sectors tried to work together, with different agendas. However, a small step had been taken, but as with any coalition, it needed to be fostered through comprises.

5.3.9 Resolving Challenges.

The project outlined challenges through the duration of the first year which were resolved or addressed, however as with any process of renewal new challenges arise.

Time commitment of community centres It had been very difficult to recruit community centres, and often they were interested, but had no time to commit to the project. This was due to the workloads of activity co-ordinator's that were often overworked. This had been addressed by offering the training to the centre volunteers on a regular basis who were then supported by the activity co-ordinator.

Conflict of interest there had been a conflict of interest between the project goals and aims with the community centres. It was often the case the activity was taken on but no input and effort had materialised from the centre. The solution was that the walking groups became independent, and thus would receive the credit directly and had more of an influence of what was said and done. Thus, the women and men's group moved away from the community centre, they had their own volunteers and began to socialise outside the group. The women's groups did particularly well as it had set up an indoor fitness group at another community centre and was self funded.

Lack of qualified South Asian Instructors For the project to commence and develop, instructors were needed who could speak the relevant language. With the support of the Health Promotion Centre, 12 South Asian women qualified either from Exercise to Music or circuit training. They had gone onto become walking activators and vice versa.

Recruitment and training volunteers To get volunteers from the South Asian community was a hard task, in the sense the theme of volunteering did not really exist in the Asian community, instead just helping out, when needed. The volunteers felt they could not give the project time commitment as such but could help out as and when required. This sort of informal working relationship had worked well. It has been very difficult recruiting male volunteers compared with female. The women liked the idea of

responsibility whilst men were more relaxed. The British Heart Foundation and the Countryside Agency commissioned the Institute of Volunteering to do research into the area of volunteer walk leaders. It was found that often payment in kind was a good incentive.

Maintaining working partnership It had been difficult to get commitment from partners and a lot of chasing occurred. Project partners who sometimes put pressure onto colleagues to 'get a move on' helped ease this.

Motivation Incentives such as the interest walks kept walkers motivated and a degree of spontaneity to keep the interest going.

Lack of safe and pleasant routes Due to the urban area there was a fear of crime; a working partnership with the riverside rangers and police to patrol the area at the relevant times had eased the problem. The routes became monotonous and the lack of pleasant areas had become a problem. More interest walks were being lead, and transport was arranged into other areas.

Footwear. This had been a problem and it slowly resolved, it was more prominent with the ladies as trainers really did not look quite right with Sarees, also the cost of buying a pair of trainers, was an issue. The steering group agreed to pay for trainers, to those who had been with the project for a year or more; it would also act as a marketing tool.

Transport The cost of transporting the walkers to pleasant area had been an issue, also within the time constraints. It had been incorporated into the interest walks and the social activity, which occurred once every two months, and walkers were asked to make a small donation towards the cost of transport.

Weather When the weather had been poor the attendance had dropped. Indoor walking activities were arranged but the walkers felt that they wanted to continue outside. They wanted the fresh air and said they would bring umbrellas and would wrap up warm. The walks continued over the winter period. Arrangements were made with the community centres and the local sports facilities to use the indoor hall for indoor walking.

5.4 Summary

The summary begins with the results of the pilot projects and the testing of the evaluation tools. From which, implementation strategies were drawn and the recruitment of community groups. Results from a sample survey at a local school are presented. The summary goes on to describe the project management difficulties and the setting of realistic goals. The data from the case studies are summarised and highlights the main findings. The motivational tools are discussed alongside the results from the Shuttle Walk Tests and the Walking Activities Questionnaire. The six doorstep routes and interest walks are presented with the key health messages. Organisational politics are flagged which caused problems for the project. The main outcomes of the development and delivery of the training is described as well as the recruitment and retention of walking activators. The way in which publicity and launch was delivered is outlined. The summary ends with the active outcomes and strengths of this phase of the project.

The Savera pilot project was successful in reaching its aims and objectives, prior to intervention the group had little or no knowledge of what levels of walking could benefit their health. The activity coordinator pre warned that the users of the group were not very active, she had previously attempted to encourage walking but had failed, she herself was keen to promote the activity as she felt that the users would benefit not only physically but mentally too. She was keen to undertake the training but stipulated that it had to be done in work time. The results from the focus group showed that participants knew that walking was good for them, and felt that doing incidental walking was enough.

At this early stage in the project participants highlighted that their GP's had often told them to walk more. The side effects of the anti depressants were weight gain thus they recognised the benefits of walking for this purpose. The barriers that stopped them walking was the cold weather, their poor general health, safety and owing a car. Thus what would encourage them to walk was good weather, open space, fresh air and walking in a group and talking to one another. All of which could be offered by Chalo Chalay, except for good weather, however indoor walking was a strong possibility. There was a real concern if walking would do more damage than good for their health. If the participants had any health conditions, they were referred back to their GP, so that they felt confident prior joining the group.

The group were introduced to the qualified walking instructor- who had a YMCA qualification in exercise to music and a module in walking. There was a prerequisite to fill out a PAR-Q; the results from table 5.2 showed that 27 % suffered from a bone or joint problem, 20% described dizziness and a loss of balance maybe due to the medication they were taking, 7% suffered from chest pain, but of more concern was the 27% said that they were on prescribed drugs, for this reason alone the coordinator felt that it would be safer for the activity coordinator to be apart of the walk.

The three types of walk that were piloted were; urban / park, gardens and riverside and all were successful as shown in table 5.3. They ran to the protocol, but were adjusted accordingly; they were just over an hour long, enough time to achieve health benefits. They did not however run to plan, and it was fortunate that other walking routes were planned, with unpredictable factors such as bad weather. The walkers felt that the walks could have been longer and for some it had raised their heart rate. The leaders adjusted the walking protocol to the needs of the group, for example not conducting stretching exercises, as the group were not warm enough after a short brisk walk.

The leaders felt that the role of the walk leader does not necessarily mean to be just at the front, if walkers, in a circuit format were visible, the leader may join a group that they felt needed more motivation. The walk in principle ran well, but to convince people to attended was rather more difficult as stated in reflection 5.1, whereby a lady felt that this type of activity would make her feel more depressed. This was understandable, as on that particular walk it was raining heavily, but the thought was much more deep rooted, and behaviour changes needed to be initiated. The lady in question did come along, after being convinced, this reiterated the importance of interpersonal skills of the walking activator, and their persona of being a 'role model';

'If she can do it, and she is my age then why can't I?

The Chalo Chalay walks were not the like the ones in previous studies and schemes, parts of it was health focussed, but more overriding was the social aspect.

The ladies wore appropriate attire, which they felt comfortable in, and they were safe. There were apprehensions about this at pre intervention stage, but the ladies were just asked to wear comfortable shoes, and what they wore everyday was safe.

At the planning stage it was envisaged that there would be commitment of activity coordinators and workers to run walking sessions, this was not feasible or practical due to time allocation for their own work programmes. It was back to the drawing boards a good idea in principle, but not deliverable, instead a focus was channelled into volunteers and community members.

The second pilot walk confirmed that the protocol and procedure of a health walk could be followed. The participants felt that the walk to the gardens was continuous and much longer; they enjoyed the walk more due to the good weather and new open environment. The advantage the walk had was that there were 3 walk leaders, the activity coordinator, was the back leader and the project coordinator was the middle maker. The group naturally split into a fast and slow group. The extra person was very useful, as a couple of ladies need to rest and the extra leader could stay behind with them. One of the ladies felt dizzy, and the symptoms were recognised by the activity coordinator; this flagged up how important it was to carry out the PAR-Q. Also knowing a bit about symptoms of illnesses and side effects of medication is useful; this may be incorporated into the training. The health walk had a long way to go before all the groups heart rate increased sufficiently for health benefits, but the environment catered for this to happen at each individual's own pace.

To integrate educational activities into the walk was an incentive as the guided walk to the riverside showed in case record 5.6. However, it was not a health walk maybe a pre brisk walk needs to be done before the guided part. These types of walks could be led once a month as an interest walk. It would be a good way of recruiting new walkers but also keeping the current walkers interested. There was a fine balance between walking for health, and walking for social pleasure. An apprehension at pre intervention stage was the mixing of genders. The riverside officer was male, and the women in the pilot had no problems with that, they saw him as a wealth of information. The group enjoyed the riverside but it did require the women to wear sensible footwear. The riverside officer would not commit to leading walks, but as suggested in reflection 5.5 training walking activators about the facts of the riverside would be possible. This would make the translation much easier as translating on the walk itself took too much time.

The post views on walking via the focus group as shown in case record 5.8 were positive. The health walks were well received by the pilot but the only deterrent was the weather. The walkers enjoyed participating in the interest-based walks like the visit to the gardens and museum and the riverside. However, these three pilot walks did not overall increase their walking pattern, they still continued with the incidental walking, with time this behaviour may changed. The group stipulated that walking was hard just to do on its own, the weather did not help and they could not find the time. They would not use the routes on their own especially the riverside, as they did not feel safe or confident to do so. There was an increase of an awareness of the benefits of walking compared with pre pilot, they recognised the health and mental benefits as well as the physical exercise. The workers involved in the pilot also felt that it had gone well as stated in case record 5.9, but reiterated that the walks needed to be based around activities. The activities coordinator was surprised at how many women had actually taken up the activity and were motivated to do so. The worker did not feel that they could run the activity themselves without further training. Due to the nature of illness of the users, confidentiality was important, but also extra support would be needed as many were on medication that had an affect on the balance and stamina. A major outcome for the Savera Resource Centre was that before the pilot the users came by transport even if they lived across the road, but now they walked to the centre, and only asked for transport in during bad weather.

The pilot project had successfully produced three routes, which were tried and tested, all with different focuses and terrains. A procedure for running a health walk had been mapped but the success of running a health walk was how the walking activators worked as a team. They needed to be able to make walkers feel comfortable so that they did not realise they are walking. There was some uneasiness about carrying out the warm up's and mobility exercise in the open, but the women in the pilot, seem to take it in with no problems and carried it out with ease. The role of a walking activator was defined, but central to it were the interpersonal skills and the culture 'know how'. The most important factor learnt through the pilot was that the health walk would need to be based around an activity or interest of the recipient group for it to be taken up and sustained.

The evaluation tools were also developed through this pilot; The Walking, Home, Garden and other Activities Questionnaire (Foster 2001) of four pages were tested with

13 of the participants it was not a welcomed tool due to its complexity and length. Suggestions were taken on board and a questionnaire that was one page with tick box answers was produced. Further adaptations occurred to produce: The Chalo Chalay (Let's Walk) walking activities questionnaire (Appendix I). It was simplified down, but gave precise information and only took 5 minutes to fill out compared to half an hour with a translator. In conjunction with translators the questionnaire was developed and translated into the various South Asian languages and was initially translated into Gujarati, the first of its kind nationally it was further translated into four other South Asian languages. This process flagged up, the cost involved in translating material, which was expensive, this was not budgeted into the original funding. It was an invaluable lesson for the designers of the questionnaire as it made them think about their own choosing of words, as stated in reflection 5.6 the questionnaire brought up how important clarity of information is, and thus the quality of data. The project had spent a considerable time producing it's own material, as the resources available were inadequate and often only found in English.

Project implementation strategies were blurred due to the pre intervention development guidelines that were produced by the British Heart Foundation and the Countryside Agency, they were not only late in being produced but were not adaptable to the target audience. The initial stages of the project was the most difficult, as there was no administrative support. The pilot project had produced two walking activators that were committed to the project, however thereafter recruitment lacked, the project focused on producing material and training before any further recruitment occurred.

The project was not successful in recruiting community groups via the normal means of invitation by letter. A more sensible approach was to select groups previously worked with to set examples. With good working practices it was hoped that other community groups would join by hearing and seeing these success stories. The walking group initially started at the Neighbourhood Centre but moved away and became independent, this natural cause was much more beneficial to the group, as it gave the walkers an ownership of it.

A sample survey from students from Rushey Mead Secondary School showed that a third of its students walked to school the rest came by car. There was scope for increasing

walking to school as the main reason was safety and bullying, walking busses could be introduced. From reflection 5.9, the head teacher was enthusiastic, and it was important to recruit active individuals on the project, however resources lacked to implement all ideas, and thus may have left a negative impression on the community.

The project management fell into difficulties quite early on in the project, most of which were inherited from the previous foundation project. Central to the difficulties was the host organisations in house management structure. The organisation was facing major change with a new director in post who was trying to change the ethos. This was not a good time for a new project to come on board. The project coordinator was enthusiastic to get things rolling, but was always put at the bottom of the agenda, as other organisational change took priority. The director did allocate a policy officer to the project in a supervisory role but this did not work as he was based in London and had his own workload. It was suggest for an outside supervisor and a mentor from the community, but the finances for this were not allocated and thus rejected. As stated in refection 5.11 considerable support was received from the ground workers, and it was their enthusiasm, which counteracted internal stifling management structures.

In the first year of the project, the major set back was the setting of realistic goals; there were high expectations of the project, and the thought that the high calibre of the partnership would transcend down to an operational level. The project had a lot of external advisors via the partnership, but no real directional and operational guides. To a certain level the community groups and walking activators, filled these as they were very supportive, however this was small scale, and more committed individuals were needed to push the agenda forward.

Background knowledge and community politics was essential information for the project to progress that is being able to relate to the culture of the target audience and to help to get walking on their agenda. Often there was no recognition that there are sub groups within South Asian communities, and they are all lumped into the same category. There are defined cultural differences within these distinct and often religious based cultures. With this in mind, it would be difficult to related to someone, that speaks a different language, and to expect the project coordinator to be universal was rather unlikely. Historically Pakistani and Bengali communities migrated at a later date compared to the

Hindu community, and thus concepts vary. Each community has its own sets of gatekeepers, and often there are sub communities within each culture, a complex set up. To be able to get all gatekeepers on board would take much longer than three years, and was beyond the scope of the project.

The most perfect of set up's can be criticised, and to please everyone is impossible, but to set an example for others so that they can follow is achievable, and often the best way. The initiative was thus a catalyst for this process to occur. Key individuals in a project make it work, and it was the trust that was gained by the project coordinator by all partners that held the project together. Working with well-known individuals facilitated this process, and was not labelled as a project that would disappear in three to four years. Building up evidence put the project in a better stance to gain further funding.

A discussion on the steering group and partnership will be discussed in more detail in Chapter 10, but suffice to say that the set up of the group was not as productive as it could have been.

The theme of the first year of the project was how were the walks going to be sustained, after the volunteers had been recruited. This message was made clear; that it was the walkers project, and the coordinator pushed for its independence. The project at this stage only had two-walk leaders but they were totally committed and was to the advantage of the project. If more walk leaders were on board it would have been difficult for the project to retain them due to the initial politics that were being played between the host organisation and the steering group. The two walk leaders knew of this situation, and were, more supportive of the coordinator.

Three walks form the Belgrave Neighbourhood Centre were further developed, the men's, women and over 60's women's group. Seventy-one walks were analysed over a 7-month period. The factor, which remained constant for the men's group, was the number of miles and the time it took to walk. The temperature did vary as the walks study period ran from early May to November. The higher the temperature the number of walkers fell; as the temperature lowered between 9 to 12 °C the number of walker became constant. The hotter summer weather may have not suited the men walkers; they may of preferred doing other activities in the summer period, or were away on holiday.

From the 28 walks analysed for the men's group there was an average of 9 walkers per walk that walked 3.5 miles in 1.24 hours. All consultations with the men's group were carried out in the most culturally appropriate way, there was recognition that the project coordinator was a ' young girl' and respect was shown to the elders. The coordinator always showed etiquette, following all cultural principles. Once this relationship was established, the men were more like *Kaka's*, older uncles, and advised the coordinator accordingly.

There was a commitment of a core group of 5-7 men that would attend the walks religiously, and were self-motivated, in a short period of time the group gelled well and pushed each other along. They particular enjoyed the interest walks, the barge trip, and requested a number of times that they become regular occurrences. They pushed for a lot more social activities rather than the health. Food was central to this process, and sharing of food was a cultural normality as stated in refection 5.13.

It had been difficult to recruit male walk leaders generally but more so from within this group, however this may have been to their advantage as all the core-committed walkers distributed the responsibility evenly amongst themselves, as none wanted to be 'leader' as such. Not having a specified walk leader suited this group, and their approach was more suitable for them, they were however bordering more on the side of social walks than health. A few of the men were committed to their health, and asked how to incorporate walking into their everyday lives, this was a major milestone, as the group began to walk outside of the group for health purposes. This hand's off approach had worked well for this particular group and the men after 6 months physically looked and felt fitter.

The women's walks followed a similar pattern to the men's in that the number of miles walked and the time it took was constant, and again like the men the number of walkers fell in hotter weather, during the summer months. The reasoning behind this was the same as the men, other summer activities and in particular the wedding season took precedence. From the 31 walks analysed for the women's group there was an average of 9 walkers per walk that walked 2.8 miles in 1.25 hours.

An apprehension at pre intervention was about South Asian women walking in their cultural clothing and footwear. They wore a mixture of classical clothing, and some of

the footwear was inappropriate for walking, they were comfortable. As the walks progressed into the second year the ladies had brought trainers & shoes especially, so their behaviour and attitude had changed.

The logistics of the women's walks as stated in reflection 5.14 was different to the men, whilst the men got to the walk 5 minutes prior to the walk commencing, the women were always late, some as much as by 30 minutes. This gradually became better, but starting late meant shortening the walks. The women in more ways than one had more responsibilities at home, which they needed to complete before leaving the house. As with the pilot project, the women did not have a problem with completing the warm up and cool down stretches outside. Being in-group made it easier, but the attitude was just to follow what the walk leader was doing. The women's group needed short rest breaks, whilst the men preferred to continue, this suggested that the men's baseline fitness levels were higher than the women's.

The women's walks also progressed to have five core members of committed walkers. The walking activators changed from the project coordinator to a qualified South Asian Exercise to Music instructor who experimented using Tai Chi as a part of the cool down, this worked well in the open air and enthuse the walkers. The women eleven weeks into the programme seemed less enthusiastic as the men, and numbers had dropped from the initial up take. The women were keen on taking on the training. The two volunteers recruited from the pilot had signed up to it. They had been key individuals in getting the women from the Belgrave Neighbourhood Centre to join the group. Even at this early stage there were some conflict with the volunteers and the Scope project worker from Neighbourhood Centre, the coordinator at this time set up a meeting with the Scope worker to diffuse the situation.

Timing was of the essence not only on a daily walk basis but also about being aware of religious festivals and events of the local community. As at these times number of walkers drastically fell, it would have been beneficial to link festivals into walks, and this would have also been a mechanism for targeted publicity. At the end of the study period that is the initial 31 walks the group became independent as the volunteer walking activators were trained and they called themselves the *Chandni* fitness group.

A more challenging group to motivate as stated in reflection 5.15 were the older ladies luncheon group. These women were inactive at the start of the 11-week programme running from mid May to the end of July 1999. Eleven walks were analysed for the women's 60 plus group; there was an average of 8 walkers per walk that walked 0.8 miles in 38 minutes. There were a core group of 4 ladies that came, it was difficult convincing the luncheon group to come for a walk. The group ceased and the core group joined the women's, *Chandni* fitness group.

The special needs walk for the partially blind and blind group was very inspiring. The walk to the riverside highlighted the importance of clear directions, which was incorporated into the training, and the level of trust of the walk leader. What made the walk so successful was the number of volunteers to help.

The summaries of the lead walks shown in table 5.7 at the end of year two, demonstrated that walking activator's that were trained were confident in delivering the walk. The thought that activity coordinators could take on this role was misjudged unless the activity becomes a priority on the organisations agenda.

In the course of the study period 66 case studies were followed of which, a third were men and two-thirds were women, nearly all of which lived in the targeted geographical boundary. The average age at baseline of a male walker was 61 and for a female walker was 52.

The intervention had recruited 22% of participants with a known heart condition as shown in table 5.9, a higher percentage of 37% suffered chest pain during physical activity and a further 25% had felt chest pain in the last month. Higher percentages of participants were on prescribed medication and had bone or joint problems. Thus the characteristics of the participant fell into the criteria of the project.

Motivational tools such as step calorie counters were piloted and were of benefit, but for South Asian women the gadgets were difficult to clip onto Saree's. They did have an effect of increasing the number of steps, but were of not good quality and were unreliable, as even sitting the counter would detect motion, and clock up the steps. What was motivational and a good measurement tool was the Shuttle Walk Tests. It was an

easy to administer test, which was translated easily, and measured the increase or decrease in fitness levels of walkers. The men were slightly fitter than the women, which correspond with other quantitative data presented in the study. From Graphs 5.7 and 5.8 the percentage change in fitness level were varied between individuals, 10% of the men and 13% of the women showed a decrease in fitness levels a further 10% of men and 3% of women showed no change. The rest showed an average increase in fitness levels of 12 and 10 % for men and women respectively. From Tables 5.10 and 5.11 the Shuttle Walk Test levels for men ranged from a base line of 6.2 to 12, a change of 5.8 units and for women from 6.3 to 12 a change of 5.7 units. In the number metres walked it varied from an increase of 260 metres to a decrease of -40m for men and an increase of 360m to a decrease of -110 these are significant changes over the study period, however it had been gradual over 2 years and 9 months.

The Walking Activities Questionnaire at baseline showed that 22% of the walkers recruited were active that is meeting the guideline (30 minutes on 5 or more day of the week) (9% of men and 13% of women) at the end of the intervention this rose to 47% (14% of men and 33% of women) that is an increase of 25%. The majority of walkers had increased the amount of walking since the start of the intervention. However, all individuals were different and have different walking regimes, thus making monitoring and evaluation difficult. The increased or decreased of the number of minutes walked per week at the end of 28 months of the intervention, is shown in tables 5.12 and 5.13 for men and women respectively; since the start of the intervention 21% showed that they walked less and 79% walked more this ranged from an increase of 800 minutes and a decrease of 540 minutes per week. The 21 % who showed less walking might be explained by over estimating the amount walked at the start of the intervention.

The men that walked over 1000 minutes per week were stable in doing so, the rest in this higher data range increased levels of walking except for one who showed a downward pattern. Those men that were in the lower data range that is between walking 10 to 150 minutes per week showed more fluctuations in their walking pattern than those in the higher data range. The men walking between 200 to 600 minute per week that is the middle range, showed a gradual increase in walking, except for two men who showed a down ward trend. It can be stipulated from these results that those men that walked over a 1000 minutes per week were more consistent in their walking, than those that walked

less than 150 minutes per week who fluctuated in their walking patterns. Those men that walked over 200 minutes per week were showed a gradual increase in the number of minutes walked per week.

The majority of the women in the sample increased the number of minutes walked per week with the intervention. The women in the lower data range that is walking between 60 to 50 minutes per week demonstrated a consistent increase in the number of minutes walked over a period of 28 months. Those women in the middle data range of 200 to 1000 minutes, showed a constant pattern and increase in the number of minutes walked, there were 3 women in this data range that showed a down ward trend. Within the higher data range for women as with the men, those woman that walked over a 1000 minutes per week were consistent in their walking pattern. However there were 3 women in this band that showed a decrease in walking, which were drastic drops, again, this may be due to over estimation at baseline.

Those women who joined the programme at 6 and 9 months showed clear indication on increasing walking patterns. Joining at 13 months over a period of 16 months, the women did not see much change; a similar pattern was seen over a period of 10 months. These results suggested that walkers needed to participate in the intervention over 22 months before an increase in walking pattern are seen.

Six doorstep routes were established in the geographical boundary at the end of year one; were used on a regular basis by the participants. It was satisfying that the walkers who had been living in Leicester for the past 20 to 30 years had never seen these beautiful places, that were literally on the doorstep, and were appreciating them much more. In year one two regular walks were being lead, which increased to seven in the second year due to expansion out beyond the geographical boundary. The key elements in the development of the lead walks were motivational incentives, safe and pleasant routes and the paperwork (Walk registers, PAR-Q's, behavioural questionnaire etc).

Key health messages were reiterated to motivate walkers to come back each week, however the interest walks held, were a great crowd puller, as amalgamating the social aspects of the walks worked really well. The walkers enjoyed the variety in the doorstep walks and enjoyed exploring different parts of Leicester. The development phase of the

intervention faced may challenges, which were resolved effectively, however ongoing issues around transport for the walkers to go further a field, were not resolved due to the lack of funding. All paperwork in relation to the project were develop they had to be translated into various languages and needed testing and piloting, this took up much of the development phase, and budget.

The interest walks were central to the development stage of the project as it created enthusiasm of the walkers and increased membership. The first interest walk via a barge had created links into the Visitors Centre at Abbey Park, which became a central venue for Chalo Chalay, and from this point onwards, the social aspects of the walks grew as stated in reflection 5.21. The venue provided the walkers somewhere to rest and chat over tea and coffee after the walk. It was also where all the evaluation such as the filling of questionnaires, shuttle walks tests and some interviews took place.

Organisational politics of local authority establishments had delayed the development phase. The filling out of two sets of paperwork just to go on an interest walk or trip was time and resource consuming. Individuals working for such organisations, on the whole are professional, however on the odd occasion certain workers felt that they had more power than others. A worker at the Neighbourhood Centre was one such character; she had issue with her volunteers progressing on the Chalo Chalay programme. This transcended into the partnership and caused friction as stated in reflection 5.22. This partnership tested the tolerance levels of the project and its volunteers, but pushed the women's walk to become independent. As stated in reflection 5.23 there were many more benefits for the group to become independent from the Neighbourhood Centre. However there were persistent problems from the worker and this was a barrier in itself, but the group withdrew from that environment and went from strength to strength.

The training for walking activators that was devised by the BHF/CA for previous schemes in the south of the country was redeveloped. A foundation to this was the lessons learned from the exercise to music course run for South Asian women. Factors such a language and cultural sensitivity were addressed. This training empowered the South Asian women and formed apart of a wider capacity building programme. These 10 trained women could have been better utilised and flexibility in time could have been addressed.

The most challenging strand of the implementation of the project was the recruitment and retention of walking activators. The task had been made difficult by the lack of understanding of volunteering in the South Asian community. The concept of *'seva'* meaning 'service' played an important part in the Hindu religion, this did not necessarily mean volunteering but could play a part of it. Within the culture, *seva* was not formalised like volunteering is, but time is given back into the community on a relaxed ad hoc basis whenever the individual felt that they needed to. With this deep-rooted concept, the formal model of volunteering was difficult to sell. Thus, the project resorted to paying the 'volunteer' walking activator, which may have not been the best way forward. With a little more research a better solution may have been reached. Research was carried out on all three demonstration projects and recommendations implemented; however the support mechanisms for the volunteers that had been recruited lacked. More women volunteers were recruited then men, this maybe due to more women being associated with the project then men. However, the women were more active in taking a lead role then the men who had a more relaxed attitude, which worked well for the group.

Training of the walk leaders was a substantial part of the development phase, a pre training needs assessment showed that 30% of the attendees wanted information on safety and CPR and a further 14% on screening walks as presented in graph 5.21. Thus there was an overall concern of the safety of the walkers in the environment they would be walking in. Each course was tailor made for workshop participants and the cultural sensitivity was the focus along side their personal concerns. The Walking the Way to Health Initiative had appointed Dawn Vernon Associates to help plan and deliver initial training, it was flexible and allowed tailoring to individual schemes. The most challenging part of the delivery of the training was the translation, both of pre material and delivering on the day, it was time consuming and costly even when done in house. It may have been more beneficial to tender this out to a professional translation unit, but the resources to do this were unavailable, it should have been budgeted in at the original bid stage.

The first training session saw a huge response of 29 individuals, a mixture of individuals who were interested in walking, walkers, workers from organisations and health professionals. Twenty completed the course and three went onto lead for Chalo Chalay. A new initiative brought a lot of interest, but practicalities of time to deliver were a different issue. Many of the individuals went to lead or integrate walking for health in

their current practice, which were outside of the geographical boundary. In hindsight a more targeted approach should have been taken, and an informal interviewing process, this was done in subsequent training sessions. Although the benefits of raising the awareness of Walking for Health in Leicester was fruitful as it attracted more money in the region for other similar projects in other area's, and the training gave organisations a head start.

A time consuming part of the development was the development of the training workshop; the writing and piloting of paperwork such as; checklist for running a health walk, project policy and guidelines, an introduction to the project and the role of a walking activator, feedback forms, these are shown in case records 5.13 to 5.16. There was no administration support to facilitate this process and the project coordinator who worked a three-day week did it all. It had become a major issue, and delayed the progression of the project, and frustrations mounted.

A vast amount of learning took place at this first training session; evidence was provided that a use of a mobile phone was an essential for a large group and for emergency purposes. Ideas were generated such as using cultural dancing for the warm up exercises these were thought of by the South Asian participants and volunteers who had a good idea of what would work within this particular community setting.

From the evaluation of the training day, criticism was raised to the lack of translated material on the actual day and for the whole initiative in general was flagged up. 68% felt happy with the overall training but only 10 % would go ahead and run a health walk the rest felt that they needed further training and would need to be kept motivated by retraining.

Knowledge levels of participant's pre and post training day were tested. There were high levels of knowledge on the walk leaders roles and the relationship of walking and the prevention of heart disease. Low levels of understanding that health walks were different from lead walks and leaders need specific skills. Ambivalence was shown whether the walking activator needed to be the fastest walker, hence the high level of fitness, and how to target sedentary individuals. Evidence of improvement in knowledge was shown in the areas of health walks needing to be brisk and having a set structure. Significant changes

were observed in the knowledge of walking being continuous, that there were more inactive people in the UK than smokers; walking helped in the prevention of diabetes, and walkers need not all walk together on a health walk. Thus, knowledge levels of walking for health were increased after the training session.

At all development stages of the project, the project used and linked into other initiatives in the locality demonstrating partnership work and non-duplication.

Publicity was a central component of the project; the logo design demonstrated the integration of community ownership within the programme. It helped raise the profile of the project within a community setting as stated in reflection 5.25. The project leaflet and flyers as shown in case records 5.15 and 5.19 respectively were targeted and with the South Asian community being its focus, however these needed to be translate in all five South Asian languages which was expensive. Different publicity tools such as video and audio tapes were discussed and were excepted as good idea but were too costly to be produce by the project alone, but could have been done so in partnership. Further novel ideas such as directional flags with cultural themes were generated to publicise the project. *'Real ideas from real people'* were welcomed and the promotion of the riverside to more Black and Ethnic Minority communities by making the atmosphere safe and culturally welcoming with signs and novel ideas.

A more targeted approach to publicity was taken, for example the attendance at cultural events within the geographical boundary. This visual approach and physical liaison with smaller community's worked well and gave the project a personal touch which was remembered, and thus word of month become a powerful tool. A concept known a 'verawar', which can be loosely translated from Gujarati to 'rapport', is an important cultural aspect of the community. It is a higher standard of etiquette, this translated into being apart of cultural festivities and being a good host and simple things like offering a glass of water or just taking off your shoes when visiting homes. These are all good signs of being from a good family.

A lot of support was given to the publicity campaign by the volunteer walking activators; they made an impression wherever they went. They were talking to people about the initiative; they set good examples, and were used heavily in manning stalls at community

events. The outcomes of these events were recruitment of new walkers, but most were not from the geographical area. This suggested that Chalo Chalay was a unique initiative and was not to be found outside of Belgrave. Most interested individuals wanted to join walks happening in Belgrave and were reluctant to set up their own group in their own localities, there was a perception that this would be difficult to do.

The most powerful publicity method was word of month not just in terms of community members but community workers and organisations. For example, the walking group set up for a blind group based within a school was so successful that other groups who used the community wing were wanting similar support, including the school itself. The interest walks were a huge selling point of the project; it gave potential walkers a taste of a health walk in a social environment where they had the opportunity to meet with other fellow walkers.

Apart of the targeted publicity approach was religious festivals and Samaj's that is specific community groups, this helped reached individuals that were isolated. Using festivals, as a platform to push the agenda of physical activity, and recruited saints to promote messages would have a higher impact as they are listened to, even by a younger audience. The ancient philosophies talk of moderation and yoga principles, religious leaders who translated them into modern day living welcome these, and they are listened to and respected by the community.

The launch used a cultural specific approach; linked it to a major festival of the Hindu calendar; Lord Krishna's Birthday and the placing of candles into the riverside. This novel idea on its own attracted interest from all sectors and the media saw it as a great photo opportunity and a new story to report on. Upon reflection 5.26 a wide range of learning happened, in particular for the riverside worker, via this event, more understanding of the Hindu culture became apparent and further innovative ways of working were established.

Management problems persisted at the development stages of the project, which caused continued damage. However it had gone to the next level where by the project coordinator felt that actions were unreasonable such as those stated in refection 5.27. In addition to the administrative work load, dictatorship was being practiced of how

budgets were being spent, for example two days before the launch of the event, the budget of the of the food was cut in half. This outraged the project coordinator who simply had not got the time to organise another caterer. This suggested the power struggle that was happening at the London office as the supervisor had agreed the budget, and the Director must have changed this.

The launch day was unique and also promoted other forms of physical activity which could be integrated and formed apart of the Hindu culture. The commitment of voluntary organisations and their volunteers was commendable, if it was not for them the day would have not been possible. The pilot project in particular, had faith in the concept and showed continuing support. The launch was a picturesque day that attracted 200 people to come along and find out what was happening. Overall 60% of attendee's thought that the launch went very well, although a complaint was received from the Muslim community after the event. It was recognised that the launch was based around a Hindu event, but this was the only South Asian event that was near the national launch date, if it had been near Eid the project would have incorporated these festivities. Management should have picked up this equality issue. This demonstrated the caution needed when organising culturally appropriate activities, as those who come from that culture can get it wrong. Equality is a priority issue and should have been taken into consideration. The complaint is evidence that there are variations within the South Asian community and cannot be put under the same heading. Just as classifications are made on the census, culturally tailored initiatives and services should be provided. These are mini projects within themselves and would need their own project coordinators. These key workers should have an understanding of the particular community; to expect a worker to work across all communities is a very large task.

At the end of the intervention development a number of active outcomes were established. The intervention had acted like a catalyst, which produced a number of chain reactions; the substrate was the walkers who provided the word of mouth process. Peer pressure was an additional coenzyme, which gave impetus to the scheme. The key development stages included; community involvement; development of walks and routes; development of training; publicity and launch; networks; evaluation; project support, implementation and development.

There were a number of strengths to the intervention, in particular committed individuals across all levels. It was an area, which promotes a positive mechanism, as organisations were sceptical of scare tactics. The project used a grassroots level approach, which worked well. It gave room for innovative ideas and new ways of working and conducting research. An environment was created where by walkers were given the opportunity to do something constructive about their health, which would automatically attract other ways of well-being. Walks in theory were self-sustainable and helped created new opportunities for other physical activity. It changed lifestyles of those who participated and had a cascading effect on their own social and family circles. The challenges that were faced in the second phase of the intervention was to transfer this good practice into other groups within Belgrave and other deprived wards of Leicester. To recruit hard to reach groups such as Muslim women and to coordinate all walking initiatives in Leicester to build a case for further funding. To address the concept of volunteering and targeting other age groups. At the end of the first year the major issue was management constraints which needed to be addressed if the project was to progress.

Chapter Six
Results: Intervention Delivery

'Yoga becomes the destroyer of pain for him who is moderate in eating and recreation (such as walking) who is moderate in exertion, in actions, who is moderate in sleep and wakefulness'
The Bhagavad-Gita; Chapter 8, Verse 17

6.1 Introduction

The delivery phase of the project were exciting times as all previous work done was in preparation for the delivery of the health walks. The foundation and development of the intervention were perfected and ready to be tested again. Although, there was a delay in the delivery due to the recruitment of the new project coordinator, however a continuation period by the ex-coordinator facilitated the delivery phase. These components of the delivery are described in the pre predecessor section of the chapter and follows to explain the recruitment of the full time project coordinator. The issues of management constraints were addressed by the project management change, of the host organisation and the steering group. This brought with it a change in direction and philosophy of the project, which had to be embraced by all participants. The challenges identified at the development phase were met head on by extending the intervention to other deprived wards of Leicester and the inclusion of other South Asian communities. The chapter introduces strand two and three of the intervention, the independent walking GP referral initiative and the environmental changes in Belgrave. All components of the project thus far were consolidated by the findings presented by the British Heart Foundation Health Promotion research group on all four-demonstration projects. Working with volunteers had been an issue for all projects and was flagged as a challenge to be addressed in phase two of the intervention, and the concept of volunteering for the South Asian community was defined. The chapter ends by stating the active outcomes of year two of the project and builds a case for further funding and celebrates the coordination of all walking activities in Leicester. Throughout the methodology the action research reflective cycles were implemented however, concentrated its resources on the action component.

6.2 Methods

Themes were continued from the intervention development these are described in chapter three and also section 5.2 Additional procedures that are particular to this chapter are described below and two major methodologies from two external commissioned research organisations are also described.

Monthly Reports

Information and data from the project were extracted from monthly reports that updated the progress of the Chalo Chalay project to the management committee of the CIO.

Oxford Evaluation Workshop

This was a two-day workshop held by the British Heat Foundation Health Promotion Research Group; it consisted of a series of research questions that were answered by the evaluation sub groups of all four-demonstration projects. A SWOT analysis of the project was conducted. A report was written from all data generated via the four demonstration projects.

Concept of Volunteering

This report encompassed the view of the volunteers and non-volunteers of all four-demonstration projects. It used desk research; interviews with potential and actual walkers and a comparison made with other volunteer walk leaders from two other walking for health schemes. Basic profiling data was collected via a simple postal questionnaire sent to all those who had expressed an interest in being a walk leader, which was followed up by telephone and face-to-face interviews with walk leaders and non- volunteers; project co-ordinators and representatives of the local volunteering infrastructure. The Institute of Volunteering also interviewed co-ordinators and volunteers from two other walk schemes to compare recruitment and management practices. 34 Questionnaires were sent to all those who had attended training for the walks, 15 were returned; two walk leaders and 13 non-walk leaders. A total of 19 interviews were conducted.

6.3 Results

6.3.1 Pre Predecessor.

The project had progressed into the second year (strand 2) with a major set back in that the project co-ordinator, left in February 2000. The following is an account of the events and components of the project leading up to the resignation of the co-ordinator and the appointment of the new co-ordinator who joined the project in April 2000. During the time gap the project co-ordinator held the fort by working one day a week on the project and continued leading the walks, so the project had a continuum. The project continued to be evaluated via Loughborough University, who had an active role, the ex-coordinator still acted as an evaluator.

Reflection 6.1

The observation made over the handing over period, had been useful, since the divorce from the project gave the co-ordinator/ evaluator the opportunity to reflect on the project progress. Any remarks or observations made were by the action researcher; they were by no means the opinions of individuals or organisations. These remarks were not directed to any persons, or any one organisation. They were mere observations of the situations, which have been analysed to provide constructive criticism. It had been a learning process for all. In naivety, situations were perceived negatively, but upon analysis would show the positive outcomes and outlooks from these processes.

The one-day a week, was used effectively in planning an exit strategy for the co-ordinator and to plan the development work plan of the new co-ordinator. This would build upon the project components and included a planning session with the operational sub group.

Project Components Prior Predecessor

Prior to the predecessor commencing an overlap period was arranged so that the project co-ordinator could train the new co-ordinator and familiarise him with all the work areas the project had initiated and that would need to be continued. These areas were the foundations to the project, which could then be rolled out into other localities.

Operational Strategies for Stand- One community centred walking routes.

Unrealistic project plans and timeframes were distributed at the first steering group meeting in February 1999. The key health promotion officer at the Health Promotion Centre originally wrote these plans. Further guidelines were written and a mapping exercise was done by the project co-ordinator. The main areas that were identified were awareness raising, pilot projects, developing baseline information, training walking activators, planning links into other events and festivals, the possible partners or resources available, monitoring and evaluation. This plan and operational strategy was tabled as strand one of the project. A sub group to the steering group, was formed it had a community focus and helped with operational procedures. The intervention was based on three strands that corresponded to each year of the project, each with its own forward plan; strand 1: community walking, strand 2: independent walking and GP referral and strand 3: environmental. The plan specified the type of support needed from various partners and departments that were involved in the project.

Steering Group Meetings

A steering group was formed made up of funders, partners and stakeholders. A number of issues were raised at the steering group meetings, one of which was the use of mobile phones. It was agreed that the project needed them for the safety of the walkers and the leaders and also the purchasing of hand held alarms to increase safety.

Operational Group

It was decided that the project really needed an operational group who could help with the groundwork of the project. It was stressed that it should not mirror the steering group. A list of people that were interested in being on this group were passed onto the supervisor who had been delegated to make contacts.

Reflection 6.2

The relationship between the Director of CIO and the project co-ordinator was sometimes good and but at times could not see eye to eye. The Director was busy at CIO as they were going through many changes and often would not return the project co-ordinators calls. There was a real sense of a lack of support on issues and matters arising from the steering group. The supervisor from London was to attend the steering group meetings but never did. This was noticed by the national co-ordinator of the Countryside Agency and a letter was written to CIO to resolve the matter. The project co-ordinator

did not have the power to make decisions overall and had to go through the supervisor and then through the Director, this management structure was stifling, as to contact the supervisor was impossible, so the co-ordinator resorted to speaking to the Director directly which was the previous arrangement. At this particular steering group meeting mobile phones were being discussed the supervisor clearly stated that was no money in the budget for this. It was agreed that an account would be set up with Leicestershire Health instead, but again CIO were adamant that the account should be held at CIO's London office, slowing the process down even further. When speaking to the Director he did not seem to care at all, as long as it did not come out of CIO budget. It was felt that if only quick decisions could be made instead of going around in circles the project could move forward. The Director did however promise that the supervisor would attend all future steering group meetings. It felt like deja vu, this was the attitude with the previous project at CIO, there was no room for creativity, and unnecessary barriers were put up. A build up of these restrictions were a part of the reasoning of why the project co-ordinator felt the need to leave.

At the following steering group meeting management issues were raised, and were ongoing. The supervisor attended this meeting, and he was playing a political game by getting the Director of Health Promotion on board. The Chair received some constructive criticism from the Riverside officer on operational issues. The supervisor said that he would set up an operational group but this did not materialised.

Training

A Tailored Course

After analysing the results form the first training course held in August 1999 it was decided that the training needed to be done in four different sessions. It included the participants to attend 3 to 4 walks to get an idea of what a health walk was. To attend a stretching and mobility exercise training day, lead by one of the qualified exercise leaders. To complete a basic First Aid course and the HeartStart programme. Then complete an assessment and training day held by the project and Dawn Vernon Associates to check whether the walk leaders were teaching stretches and mobility exercises correctly.

Further Training for Walking Activators

A walking activator trained by the project, was supported to undertake further training. She became a qualified circuit trainer via the sponsorship of the Health Promotion Centre. She was the main walking activator for the women's group, and other project volunteers supported her. The project continued to give on hand support and training to volunteers and monitoring their progress.

Meetings with Heath Promotion Centre and Leicestershire Health

Monthly meetings were held with two of the Health Promotion officers, the physical activity specialist and City East heart health specialist and the Director of Health Promotion (Chair). These sessions were informative of how things were developing.

National Demonstration projects get together-Reading

The get together of the three projects, Leicester, Walsall and Eastbourne was to up date each other on progress made. Walsall launched their project in May 1999 and used participatory appraisals as an evaluation tool. Eastbourne like Leicester had appointed a co-ordinator and planned to set signs up on the sea front. Leicester was the only project, which had been running health walks in the first three months of receiving funding.

Working With community Groups

Belgrave Baheno

Belgrave Baheno was recruited as a pilot project. They were keen on taking on the initiative and its sustainability with the Peepel's project in Belgrave. It was a key organisation represented on the steering group.

Belgrave Neighbourhood Centre: Walking Groups

Consultations were carried out with the over 50's women and men groups at the Belgrave Neighbourhood Centre. The walking groups commenced with the women's group in April 1999, and the men's walking group in May 1999, an evening walk for the ladies yoga group, and women's luncheon club walk. These sessions were run by the project co-ordinator and took up most of the project timeframe. This integrated the process of training volunteers on the job. The walks went well and the numbers were steady. There had been a set back in that not many of the exercise leaders were interested in running the walks another strategy was considered to use qualified exercise leaders.

Numbers decrease only over holiday or festive periods. The group had shown an active interest in the pedometers/ calorie counters and had enquired about the cost and began to develop their own routes.

Vishmo Day Care Centre

The centre had approached the project to run walking groups for their carers and clients. The consultation with the group showed the difficulties to get this group out due to wheelchair access. The group co-ordinators were very enthusiastic, and the project manager gave their support. A stall was set up at the Vishamo fun day fund raising event.

Project Dil Official Launch/ Health Promotion Community Workshops.

The project attended both of these events and helped facilitate workshops. Links were made with particular reference to the training and physical activities component of Project Dil.

Cossington Street Sports Centre

The head of leisure services was very keen to set up walking groups in the Belgrave area from the Cossington Sports Centre. Instead of duplicating it was suggested that the centre take over the sessions running at the Belgrave Neighbourhood Centre, and training for their instructors was given. An officer at the department was the link person who helped co-ordinate the programme and had attended the exercise on prescription scheme training course. In the winter period when the weather was bad the project had access to the sports hall where other activities and walking games were introduced. Only one member of staff was available to the project and they had attended a few of the walks. A meeting held with the centre manager supported the initiative, he suggested that promotion of the walks were done at the Belgrave Mela and offered space on their stall and on stage.

The walks from the Belgrave Neighbourhood Centre were thus transferred to the sports centre with a hope that they would take them over once the officer was trained. There was a good relationship with the manager of the centre and he showed a real commitment to the project, but had a lack of resources.

Health Walks Promotion at Soni Samaj.

The Soni Samaj had approached the project to speak at their health promotion event. This went well and there were a number of questions. They asked the project to help set up a walking group for their centre.

Riverside project.

The riverside officer at the Leicester City Council suggested having a stall at the Belgrave Riverside Festival. The department were supportive of designing maps and in an alternative language when appropriate.

Riverside Walks

Interest walks along the riverside were developed via the riverside rangers. Links were made with the countryside officer, who ran boat trips to Watermead Park at a subsidised cost.

Belgrave Riverside Festival

The event was successful and interest was created via the project stall. It was a good liaison event, it allowed for networking with other health professionals that worked in the locality.

Conferences

Walking the Way to Health Conference

The conference had a high attendance nationally, however there were not many South Asian groups present nationally or locally. This placed an emphasis on South Asian groups not being reached. The main outcomes of the conference and the issues raised were of safety that is volunteers insurance, carrying mobile phones and partnership working.

Active for Life Briefing Conference

The conference was useful; the campaign was now concentrating on equalities, i.e. equal opportunities for all in the sport's field. It was a good networking event, a number of new South Asian physical activity projects were represented. The co-ordinator from the Health Education Authority approached the project to ask for some advice in setting up walks for the Coventry Sikh community; he came up to Leicester to observe the logistics of the project.

DETR National Pedestrians Walking Forward Conference

The conference held in Birmingham was an update of the National Walking Strategy; its launch had been delayed. It was discussed to integrate the strategy with the cycling strategy, also linking in with the safer routes to school.

Midlands Countryside Agency

Links were made with the local Countryside Agency via the local co-ordinator who briefed the project on the wider picture of what the agency was trying to achieve in the long term. Also the possibilities of future funding; discussions were held on links that could be made to the rest of the region and how the project could liase with other initiatives.

Year Two Walks

There were two group's, a men's and a women's running from the Cossington Street Sports Centre, with an average of 8 walkers per walk. The numbers were consistent, and were rising in the men's group. Both the men and women's group have approached the project and requested that the walks continue outdoors over the winter period. The walkers were enthusiastic and enjoyed the group. Arrangements were made for bad weather with the Abbey Park Visitors Centre the premises were used for indoor walking activities. The tea and coffee making facilities were used. Over the winter period, numbers dropped due to the holiday season.

Planning of Strand Two – GP Referrals

It was discussed at a steering group meeting the planning of the second strand of the project and to make links with Project Dil and the Exercise Referral Scheme. The project had a discussion with the Exercise Referral co-ordinator and negotiated the guidelines, which would feed into Project Dil, contact was made with local Primary Care Groups. A meeting with the exercise referral co-ordinator from the local authority showed her support in the project and was keen to get walking as an option. She was also keen to see as many of her instructors as she could on the training but was honest in that she could only dedicate one instructor to the walking referral scheme. Support and resources in kind were offered such as using the Cossington Sports Centre, free as a venue for the training. She also mentioned that it was crucial to have the right people on board.

Incentive scheme

Incentives for walk leaders were discussed. The co-ordinator was keen to develop a reward scheme that paid after a certain number of sessions. That is vouchers, leisure centre sessions or healthy restaurant meals. The group were in agreement with the principle of a reward system and the National Walking for Health Co-ordinator pointed out that there was funding in the budget for this. Ground Miles in Walsall worked on a similar principle- a card system where walkers gain stamps, which can be exchanged at local shops.

The group agreed that the project entry points should be via all areas such as community, GP's advertising etc. It was decided at the next steering group meeting that the project would focus on the remuneration of walking leaders which would include free kit, money was available in the budget to do this but possible local sponsorship would be looked at. Things like t-shirts sweat shirts, training shoes and waterproof clothing would also be good marketing and advertising tools. The incentive should also be used to reward regular walkers and would come into effect after a set number of walks.

An Exit Strategy for the Project Co-ordinator

Tasks for the new coordinator

The main themes for the second year of the project were to:

- Develop a package of remuneration
- Gain feedback from training
- Meet with Project Dil to discuss overlaps
- Further develop the strand in Highfields

Planning Session/ Consolidating the Operational Group

Prior to the project co-ordinator leaving a community planning session was held and was based around the projects aim.

Case Record 6.1

Operational group session

The sessions objectives were to:

- Generate ideas.
- To learn from work already happening in the community and to draw from these experiences.
- To build and secure commitment from partners.
- To strategically plan the project, to increase the community ownership.
- To link into events already occurring.

The ideas for the way forward that were discussed were:

- Identifying local need and level of interest.
- Discovering what people want.
- Identifying places to walk.
- Linking in with other/projects/partnerships.
- Measuring and monitoring the project.

The candidates that attended the session were:

- Riverside Ranger- Urban Regeneration Team, Leicester City Council
- Parks Manager for Abbey Park, Leicester City Council
- Manager of Belgrave Neighbourhood Centre
- Manager of Savera Resources Centre
- Current Walking Activator- Exercise to Music Instructor
- An interested Exercise to Music Instructor
- Health Promotion Officer, Health Promotion Unit, Leicester City Council
- Heart Health Specialist, City East, Heath Promotion Centre, NHS Fosse Trust

Forward planning and pass over between January to April 2000

In order for the project to benefit from one day a week from the project co-ordinator, a forward plan was written, which would also help the new co-ordinator. The one-day week was used to oversee the project development in the city and to make sure the programmes were following guidelines and procedures. The role was a supportive and

advisory one on how to set new schemes up. It was central to recruit new community groups such as the Muslim and Bengali communities.

Case Record 6.2

Forward Planning

January 2000

1. The continuation of strand one of the project and the walks.
2. The planning of strand two and three and to make links with Project Dil and GP Referral Scheme.
3. To plan and give presentations to Primary Care Groups.
4. To write journal articles to publicise to GP's.
5. To translate project leaflets into appropriate languages.

February 2000

1. To plan for training programme for deliverance in April.
2. To write guidelines for GP referrals.
3. To continue monitoring current walking groups.
4. To promote project to GP's and patients.
5. To run a First Aid course for current volunteers.

March 2000

1. Publicise training programme and recruit groups and volunteers.
2. To have the GP referral scheme up and running.
3. To update training material and to have it translated appropriately.
4. To recruit and publicise to other groups in particular the Muslim community.
5. To expand to the Highfields locality of Leicester.
6. To support other groups who would like to set up a walks programme.

April 2000

1. To continue the ongoing support and training of current and new volunteers.
2. To recruit walkers via incentives.
3. To monitor and evaluate the delivery of the GP referral scheme.
4. To plan and organise interest walks for the summer.
5. To run a large publicity campaign in readiness for the summer period.
6. To develop appropriate resources to provide continuing support to the walkers.

At the end of the first year of the project, the funding partners became quantitative focused that is the number of walkers participating in the walks. The project focus had always been quality rather than quantity. The funders were making comparison with the other demonstration projects, which had increased participation by much more than Chalo Chalay. It was stressed that Leicester were only targeting 12% of the population that were South Asian, whilst the other demonstration projects potentially had the whole population. This became a priority of the project to increase numbers expanding out in to Highfields, and Charnwood (i.e. Leicester & Leicestershire), which would target the Muslim and Bengali communities.

Key targets for the second year of the project were to:

- To hold a public meeting to recruit and identify individuals who may be interested in the project. This event needed to be planned with clear objectives. To run workshops to get a clear direction of the project within a community setting.
- A professional meeting to present project to health professional to solidify links into other projects
- To identify and agree on key walking for health messages appropriate to the South Asian community and develop publicity material using the market strategy theory.

Project Co-ordinator leaving Confederation of Indian Organisations

There were a number of reasons and events that lead up to the resignation of the project coordinator these are discussed below.

CIO Physical Activities Project

The 12-months project prior to the Chalo Chalay commencing was an interesting time for the coordinator. The vision of the organisation was to support and strengthen all South Asian voluntary groups in Leicester. It was a very political organisation, with the executive committee having strong political views. There were not any women represented on the committee when the coordinator joined. This was a steep learning curve, and the organisation found it difficult to accommodate for younger generations especially women. The director was also newly appointed and wanted to turn the organisations image around.

The coordinator needed someone she could make suggestions to, someone who would listen to ideas. The manager seemed to be talking at her and not listening to her. Although the manager had some experience of the voluntary sector and working within South Asian communities, he had no experience of health. This was recognised within the initial probationary period that supervision with the manager was irrelevant. The coordinator flagged up the issue and it caused friction throughout the small office environment. The relationship between the manager and the administrator was also very distraught and affected the whole office. It was not a good working environment and there was no administration support for the project. The administrator's contract was not renewed and a gap of 8 months was endured until the office manager was recruited. The organisation was given the benefit of doubt as it was newly formed, but the coordinator strongly did not believe in some of the inward prejudices that the organisation resonated.

The hosting arrangements of the Chalo Chalay Project

When the walking for health bid was written CIO was an active partner in the process, the coordinator felt that the project would of been best placed at the Health Promotion Agency. However, a decision was reached and was biases to the project being hosted by CIO who formally put in a tender. The coordinator knowing the management problems happening at CIO knew that the project would be better placed for at least the first year where administrative and peer support could have been given. A possible secondment of the coordinator could have been made. There was a consensus by the chair that the project would be better placed in the community in a voluntary project, as this was a part of the reason the funding was secured. The coordinator was in an awkward position, in that internal politics could not be discussed outside the organisation.

Job Description and contract.

The following points were highlighted by the co-ordinator to the director of CIO, the Chair and the evaluator from Loughborough University. The coordinator felt that after reading the job description that the post should have be a full time position and requested that a part time administrator should be recruited, also that the post should be increased from three days a week to four days a week which was agreed.

Case Record 6.3

- The job description and contract of the coordinator post was a full time position.
- The research and evaluation part of the project was interchangeable with the coordinators post, meaning that both positions work hand in hand and in rapport with one another.
- The salary scale was debatable and would question on what basis the post had been graded that is on the spinal column for a Health Promotion Officer or coordinator or project manager.
- An officer from the Health Promotion Centre had been working on the project one day a week, which gave the project 4 days a week, this decreased to 3 days a week.
- The whole project needed to be re-thought in realistic terms and how could CIO buy into a further two days via job share or the coordinators time as evaluator.
- The job description was a tall order; a lot of work was involved and required specialist support. The project really needed to set realistic targets in terms of the resources immediately available.

Finances and Budgets

The overall control of the budget was held with CIO however a part of the funding came from Leicestershire Health, a meeting was set up between the Chair- the Director of Health Promotion at Leicestershire Health and their finance people. A system was needed whereby the project could access the funds; this was impossible as the Leicestershire Health system was so complicated. For the coordinator it felt like a bottomless pit. The project came to a stand still with this aspect and did not achieve anything but added to the bureaucracy of the whole system. This was one aspect that the statutory sector and the voluntary sector could not see eye to eye on. This left the worker in the middle, which had to access the funds somehow and was totally frustrated. It was a waste of time and resources; there were higher priorities in the project than implementing a financial administration system.

Reflection 6.3

Closed Partnerships

A 'tokenism' gesture may explain the relationship between the Health Promotion Centre (HPC) and the Confederation of Indian Organisations. When the project initially began with the foundation project, the Health Promotion Centre had one Black worker this changed with the merger of the Health Promotion Unit: Leicester City Council and the Centre in 2000. Black and Ethnic Minorities were on their agenda but always were past onto the one worker and were not taken seriously. It became more important when funding became partnership orientated and most capital was directed at reducing inequalities. This can be one angle to explain the difficulties of working relations. The second aspect could be the strong presence of previous relationships between the workers within the department, which could not be penetrated. The coordinator felt that if one of the workers made a judgment on a colleague, it would filter to all other workers, and colleagues in that network. Often the project felt that it was the centre of these judgments and was not allowed to prove itself, and was very de-motivating. It was unprofessional behaviour that made the coordinator uncomfortable.

Thus, support from these key workers was minimal and maybe due to the overall HPC tokenism of working for the Black and Ethnic Minority communities and organisations. This pushed the project to become more self sustainable and finding the support within its internal structure, and a vast resource of dedicated community members, a positive outcome of a lack of support. Furthermore, it came across as if decisions were made behind closed doors, and was patronising to the host organisation. If the decisions were debated openly, in an open forum, then they would be acceptable to all partners concerned. It was not raised at that moment in time as these decisions were already made, and to whom to complain to, when the chair seemed to be endorsing these decisions.

Another example, of this is when the Health Promotion Centre *was given* the task of audit and baseline data collection. The worker was allocated and paid for one day a week for two months to carry out this task. The steering group did not discuss this, it was never a formal agenda item or was never agreed, and it was simply endorsed. The work carried out filled its aim. However, this piece of work could have been tendered out, with particular preference for an individual or organisation in the locality, in which the project were to serve. This would have shown an equal opportunity, but would have also built relationships with the voluntary sector, private sector or individual.

A vast amount of knowledge lies within the professionals within the locality, and would have used resources already available. It was unfair on the key worker to audit a community area, which she had no working knowledge of and to be put on the spot. It seemed an irresponsible use of resources. If done correctly, a more comprehensive report would have been produced in the perspective of the community, and would of highlighted local politics, and unless one has worked in the locality for a period of time this would have not be known. It would have been more useful to know these internal structures than skimming the surface, which was common knowledge to the project, considering it had been working in the locality for the previous 12 months prior to the project commencing. CIO had experience of working within the community, for five years. These resources seemed to be overlooked.

The initial impression, of the project co-ordinator was that an internal network existed, that this network made decisions informally, in a social environment. In hindsight terms of reference for the steering group and project partners should have be written in consultation with all stakeholders and should have been a working document.

A lack of support from CIO

The issue of non-attendance of the supervisor from CIO to the steering group meetings was a statement in itself. This was discussed at a steering group meeting and it was decided by the national co-ordinator from the Countryside Agency and the chair, director of health promotion to write a letter to the director of CIO. This received the attention the project needed. Meetings in June 1999 with the supervisor and director were arranged with the project co-ordinator. The meeting was open and honest, and the project co-ordinator did not direct any blame towards anyone but hoped for constructive solutions. The role of the steering group was questioned and its purpose and what actions it was taking to support the project. It was reiterated that the project co-ordinator felt isolated and a lack of general support from everyone that were concerned with the project. The administration support to the project was an ongoing problem but was in the process of being resolved with recruitment of a general office manager for CIO.

The director also confirmed that the supervisor should be spending more time at the Leicester office supporting the coordinator. A mentor was discussed, somebody that knew the Belgrave area well. The coordinator was trying to suggest that the current

supervision was not suitable to supervise on this project, but this did not come across so easily or clearly.

The above events really got the co-ordinator down and were un-motivating. Serious thought was given to the reasoning behind being the coordinator and the evaluator, and whether she wanted to continue with either of these roles, and the initial thought of leaving occurred. It seemed that advantage was being taken of the two interchanging role's of coordinator and evaluator.

The lack of administrative support

Most of the projects time was wasted on administration and paper work for the project. Volunteers were looked to for support; a new office manager was not recruited until eight months later. The project co-ordinator had to man the reception and CIO's general enquires also. The office environment did change after the office manager was in post, support was received and the whole tension was relieved. However, the manager of CIO was still a problem, and very unprofessional. The support was still scanty as the office manager had her hands full with CIO work. The coordinator continued to do a majority of the administration work for the project, which was often created unnecessarily. A trainee work experience had started and was dedicated to the Chalo Chalay project this was a great help. Things finally settled down at CIO.

Inappropriate Supervision

Supervision sessions were a waste a time; it was just an update meeting. Ideas were generated but they always seemed a lack of resource to implement them. The actions that the supervisor was suppose to carry out never happened, and he seemed impossible to get hold of and never returned calls. He had a little background in health, but not enough to support the coordinator or the project.

Meetings with the Chair

The Chair – the director of health promotion offered support by meeting monthly to discuss ideas, especially on the health issues. These meetings eventually also became an update session. The coordinator felt towards the end of her stint that they were a waste of both their time. However, it was a good opportunity for the coordinator to off load, in the hope that some action would be taken. It was felt that the chair was not as enthusiastic as at the commencement of the project in the belief that the tender had gone

to CIO so it was their problem. At this time the coordinator felt that 3 main management issues needed to be resolved; mobile phones, budget and updating people.

6.3.2 Recruitment of New Co-ordinator

From a three-day post to four day to full time

It had been a challenging first year, it may appear that with the co-ordinator leaving the project would suffer, however it has managed to employ a full time co-ordinator. This had been an ongoing challenge with the lack of time having a part time co-ordinator; it seemed impossible to expand the project with the lack of workers. Now the project was gradually building a team.

The project coordinator on good terms offered to continue the project until the new coordinator was recruited, to her shock when her post was advertised at £18,000 per annum plus a £1,000 bonus if the applicant stayed on a full 23 months till the end of the project. The coordinator was being paid £15,500 per annum pro rata, which was an increase of £ 3,000 per year including the bonus. These exact pay scales were discussed with CIO a year ago and they said there was no possibility of increasing it, as there was no money in the budget. A request was made to the funders to make it a full time post and this had materialised. There was no change in the job description, and in fact it was more difficult in the first year to set the project up, than in the second year with all infrastructures in place.

Case Record 6.4

Job Advertisement:

Coordinator (Walking Project) £18,000 (plus bonus) based in Leicester

CIO wishes to appoint a committed worker to take the walking initiative (Chalo Chalay) into the second phase of the project. The project coordinator will develop tailor made doorstep walks for group and ensure that these are linked into primary care and other local health initiatives. The successful candidate should have knowledge of issues around exercise and coronary heart disease, a good understanding of primary care and experience of working with South Asian voluntary sector. The successful candidate will have good inter-personal skills and an ability to speak at least one South Asian language is essential. The post is available on a fixed term contract until March 2002 with the possibility of an extension subject to future funding.

The new project coordinator was a young male in his mid twenties having experience in community and sport development. There was a concern how the new recruit would continue the development of the women's group.

6.3.3 Project Management Change

There were two major management changes during the second year of the Chalo Chalay project. The first was the management change at the host organisation the Confederation of Indian Organisations. The whole staff team had left, except for the newly recruited office manager. A new team including the manager of the Leicester office had been recruited. The organisation had also moved to new premises. This has had a positive influence on the project with fresh new ideas and contacts. The new coordinator was fortunate to have a new manager and administrative support. Relationships with the new manager and director were strong and this made a difference to the staff in the Leicester office. The manager was very supportive of the project and attended all steering group meetings.

The second management change was that the Director of Health Promotion had step down as Chair due to taking on more responsibility at Leicestershire Health Authority. This was unfortunate as the number of steering group members fell. This showed the influence he had on the project.

6.3.4 Change in Direction and Philosophy of Project

At the new co-ordinator's first steering group meeting the project plan was looked at and thought it was appropriate to re-plan the current scope of the walking programme as only one of the religious groups had been involved to date. This had previously been noted as a weakness of the project. At this meeting it was agreed to use the trained exercise to music instructors sponsored by the Health Promotion Centre, and agreed that they should be paid. This was a major turning point in the projects philosophy of volunteer walking activators. At the following meeting in June 2000 payments were discussed, Leicester City Council sessional workers were paid £9.45 per hour, however the going rate for exercise leader were £15 per hour with their own insurances and First Aid qualification. A strategy was formed to continue the work of the first year, and to target functions, such as religious, cultural events and religious places of worship such as Hindu temples and Mosques.

Reflection 6.4

The project to date had only paid the initial walking activators who helped with the pilot projects. All walking activators were volunteers, the focus had been that members of the community would volunteer their time to run the walks, making it more, sustainable at the end of the project. Thus, to pay the exercise to music instructors was a turning point, it was recognised that, this may have been an incentive to join the project, but went against the philosophy of the project. The ex-coordinator was not present at the meeting when this action was agreed and felt that repercussions would be felt in the long term.

Development of Highfields Strand

Concerns and difficulties were raised by the new coordinator on setting up attractive walks in the Highfields area, as there was a lack of parks and open space. There had been a millennium walk planned in this area, and this was used to inform the public of the project. The project also sat on the local area health forum. There was a good response from groups in Highfields however residents were not keen on walking in their local area, as they felt unsafe. The Spinney Hill Park was very hilly, thus it was considered to make more use of walking on interconnecting spaces and being transported to other areas.

Publicity

Marketing was a continued development for the second year; it continued having mini launches at regular intervals throughout the year so that people are constantly aware of the importance of walking. The launches were linked to religious celebrations and major events such as the HATT (Health Action Today and Tomorrow) conference 2000. It was necessary to create a constant drip feed into the local media programme and monthly coverage was aimed for. It was recognised that problems were occurring when trying to cover all religious events and if some cultural events were omitted it might course undue upset. It was agreed that all groups should be written to highlighting and agreeing major opportunities, and as far as possible putting together a calendar of events. It was suggested that a company like MATV could be approach to make a promotional video on walking.

A website was launched to promote walking and publicising the walks as well as advertising campaigns such as publicity on buses with contact telephone numbers. The project continued publicity in regional newsletters and at health fairs.

Leicester City Walking for Health Project Coordinator

By September 2001: 10 walking groups were set up, and 8 active walking activators and 3 were in the pipeline. Monies were secured for a post at the Health Promotion Agency the Walking Project Co-ordinator, had been appointed for 5 years commencing in April 2001 with a remit to coordinate all walking activities in Leicester and Leicestershire. The steering group for both projects were kept separately but feedback through the Exercise Alliance Group.

6.3.5 Strand 2 Promoting Individual Walking: CHD Rehabilitation & GP Referral.

Strand two of the project corresponded to year two, it was the smallest element of the three strands and was envisaged to feed off the work developed in the first year of the project. The focus was on the promotion of walking as an integral part of the lifestyle change management programme through approximately 30 general practices. The main target group was the post coronary patients and those with diagnosed Coronary Heart Disease (CHD). Walking via community groups was apart of the modified Exercise Referral scheme. The action that the project undertook to give impetus to this strand was:

- Strong links were formed with Project Dil and Exercise on Prescription Scheme.
- Training staff in referral procedures and establishing record keeping systems using the 'stage of change' framework.
- Development of links between walk/exercise leaders and primary care teams.
- Media and marketing of walking for health at practices.
- The provision of information on local walks and community activity.

It was proposed to recruit GPs and other practice staff into walking programmes and to demonstrate the 'do as I do' approach and use their position as significant community leaders and exemplars. This was difficult to do with GPs however health visitors and nurses were recruited and undertook the Chalo Chalay training.

The commencement of strand 2 was dependant on the development of Project Dil. That was the recruitment and training of GPs and the development of community walks and walking leaders in strand one. Referrals thus began from General Practices to lead health walks and community centre based programmes.

Project Dil

Project Dil was a unique initiative funded by the Department of Health for two years and thereafter was hosted by Eastern Leicester Primary Care Trust. It aimed to reduce the risk factors for morbidity and mortality from Coronary Heart Disease amongst the South Asian community in Leicester, the project commenced in 1998 and its key objectives were to;

- Introduce a coordinated multi- agency community heart health promotion programme.
- Improve primary and secondary prevention of CHD amongst the South Asian population by enhancing health promotion and screening in practices with high a South Asian population.
- Improve the knowledge base by undertaking action research into knowledge and attitudes to ischaemic heart disease and also effective methods of health education amongst South Asians.

The community health programme of Project Dil had used several strategies to deliver health promotion for CHD to South Asian population of Leicester;

Community Health Education Strands of Project Dil.

The first strand involved health workers delivering to the volunteer's organisations the heart health education sessions on: smoking/ alcohol, physical activity which included walking, nutrition and diet, stress management, diabetes and heart facts, these where delivered in 8 one hour sessions. The second strand focused on training the volunteers to become peer educators through a unique course developed by Project Dil and the Open College Network the course allowed volunteers to:

1. Understand Coronary Heart Disease and the implications of this for the South Asian community.
2. Gain the skills and knowledge to be in a position to help disseminate heart health messages to the South Asian community of Leicester.

The course ran over a 10-12 week period, for 2-3 hours per week. The requirement to become a volunteer was:

- To have basic English reading and writing skills.
- The ability to speak a South Asian language.
- Organisational skills.
- The ability to communicate well.
- A commitment to learn.
- A good knowledge of the community they lived in.
- Time commitment.
- Enthusiasm to tackle heart health issues in the South Asian community.
- The willingness to receive basic health education training with further opportunities for development (the peer educators considered whether they would became volunteer walking activators).
- Support from their respective organisations
- There was no age or gender restriction on becoming a volunteer.

Project Dil's commitment to volunteers was to provide the necessary support to enable volunteers to access the heart health education training. It funded the course for each volunteer in exchange for a negotiated amount of sessions back to Project Dil. Once these sessions were completed each volunteer was paid for any additional heart health education sessions that were delivered back into the community. A small grant scheme was set up whereby peer educators submitted a bid to help them develop, promote and work in partnership with community organisations and other agencies to demonstrate that their initiative would have sustainable outcomes. 45 community volunteers had completed an external accredited peer education programme.

The second main objective of Project Dil was to have a tailored training session for primary care staff at GP practices. A multi- disciplinary staff team from 23 volunteer practices accessed project Dil's training programme. Organisational development in practices including CHD registers; action planning and establishing CHD clinic, had taken place more quickly than non- intervention practices (Farooqi & Bhavsar 2001).

By March 2000 Project Dil had been working with 21 practices that were not aware of the exercise referral or were not sure who to contact, the projects training incorporated this into the programme. The chair suggested building on this relationship and targeting practices specifically for referral to walking. Getting GPs on board was central to getting referrals through. The peer educators could be given extra sessions to cover training in rehabilitation, however a protocol covering training in rehabilitation would have to be developed for GPs. The use of rehabilitation nurses was also considered. A package for GPs would need to be put together. It was envisaged that 2 or 3 practices in Belgrave would be targeted to highlight GP referral to walking. Patients that had CHD would be initially targeted.

The parallel strands that would run along side this pilot would include piloting GP referrals, using the self-help approach, plus materials for individuals, and a more comprehensive programme of walks for high or low risk patients. The peer educators were crucial in linking the process of referral. A criterion of the referral was drawn up. GPs received clear guidelines in the form of a protocol. Training had been put together for GPs and Primary Health Care Teams, so that they had an understanding of what they are referring to and were asked to attend a health walk. There was a gap in the process of referrals, which were based on the language barriers this needed to be addressed. For the health walks to have a reduced risk it was central that all walking activators had access to a mobile phone and a First Aider.

Exercise Referral Scheme.

The development of exercise on prescription schemes had been rapid, as leisure centre operators and primary care professionals had collaborated to encourage patients who would benefit from more exercise. The process involved a referral or prescription from a medical setting to a leisure or recreational setting e.g. leisure centre or County Park. The patient would receive some form of activity in this new setting and would attend for a specific period. The introduction of this new activity should result in some change of health status and improve the original referral condition.

The exercise prescription scheme was based in five geographical areas including Leicester City. Its main objective was to improve the health of target populations through the encouragement of more active lifestyles. The scheme aimed to do this by linking local leisure providers with GP practices in order that inactive individuals may be introduced

to safe, appropriate and effective exercise programmes that were based locally. The target population comprised of 53 practice surgeries, 18 of which were from Leicester City, and only 4 of which were from the east of the city (which had the highest population of South Asian patients). The practices involved in the scheme agreed to refer individuals in accordance to the schemes protocol. Activity sessions were supervised by specifically trained instructors (Radcliffe 1998). There were 211 patients from Leicester City between the periods of May 1996 to March 1998 that participated in the scheme. The recommendations from the Exercise on Prescription initiative Report: May 1996 to March 1998 suggested:

- Identification of the needs of targeted at risk groups that were not being reached (for example South Asian groups and middle aged men) and to address these needs where possible.
- Investigation of activity opportunities other than those offered in the 'leisure centre'. For example, the development of supervised walks, or the provision of activity sessions in alternative community venues.
- Exploration into more disease specific exercise programmes for local groups.
- Incorporation of reputable private health and fitness centre or clubs who may wish to buy into the scheme.

These recommendations were put forward after discussions with the project coordinator and the lack of South Asian referrals. In most cases patients were unaware of the scheme, this was addressed by a targeted media campaign and also the translation of the Exercise on Prescription leaflet. There was also a reluctance of GPs, due to liability. Project Dil training incorporated these issues into their training for Primary Care Teams to ease fears. The most significant barrier was facilities; these were not culturally appropriate for South Asian communities. Women in particular were more comfortable using community and religious venues so these were developed. Often the activities that were on offer were inappropriate, and Chalo Chalay offered an acceptable alternative. Furthermore the recruitment of female only private health and fitness clubs encouraged more South Asian women to participate.

Patients who were referred decided which area of exercise they preferred after discussion with their GP. Walking was not a preferred option and had not been successful. However, an exercise referral linked walking programme had worked well in other areas

of the city such as New Parks in Leicester. An exercise referral coordinator for Leicester City had been recruited to expand the exercise referral and to support and deliver.

Independent Walking

The encouragement of independent walking or self-help walks was an essential component of Chalo Chalay. The walkers felt confident to walk independently (often with partners or friends) after they had been on the led walks. It was an effective way of increasing levels of walking both within target groups and in the local community as a whole. Independent walking whether by individuals on their own or with family or friends was more flexible than led walks and allowed people to walk at times which was more convenient for them, it was very important as time was a major barrier to participation. It enabled people to walk at their own pace without feeling pressurised to adjust their pace to other members in the group. It was more likely that walkers would endeavour to walk everyday, and it was not reliant on walk leaders. It provided people with an opportunity to get away from it all.

6.3.6 Strand Three: Developing the Environment and Facilities

The focus of strand three corresponded to year three which was to make the links with future developmental priorities within transport and regeneration plans. It promoted the improvement of the environment in favour of pedestrians. The main aim of this strand was to increase participation in walking through improving the environment and developing environments and facilities that encouraged walking. The project did this by working with the main initiatives in the locality, which had extensive public consultations:

- The Belgrave Riverside Park Area Development.
- The Belgrave Corridor Project.
- The Golden Mile.
- The Belgrave City Centre Pedestrian Route Plans.
- Central Leicester Local Transport Plan 2002-2006: Walking and Cycling Strategy.
- Single Regeneration Budget 4 (SRB4): Strategic Regeneration Bid of Belgrave.

The Belgrave Riverside Park Area Development

The Belgrave area of Leicester Riverside Park lays between Abbey Park and the Thurcaston Road Bridge a stretch of riverside about a mile long. The area has open space along the riverbanks, much of which has a high wildlife value. The section possessed a number of important facilities including the Abbey Park Pumping Station, Belgrave House and Hall Gardens, the Outdoor Pursuits Centre, National Space Centre, Leicester Marina Site and the Waterside Centre. The area linked into the Watermead Country Park, and Abbey Park and was close to the Belgrave Road shops and restaurants. The local community stemmed from a wide range of cultures including British and Ugandan Asian.

A consultation carried out in January 1997 (Flood 1997) highlighted a number of associations with Belgrave Riverside. A route, which linked the housing estate and school via the Holden Street Bridge, was heavily used, whilst other parts were much less used. The area had a poor local image and there were significant security problems and the local community saw the river as a barrier. College students were sometimes 'taxed' on the bridge, burnt out cars were dumped and the run down appearance of the school boundary and factory units added to the feeling of insecurity experienced by many visitors.

The river however linked many important places; these were under used and were sometimes difficult to get to. It was difficult to get to the river from Belgrave Road without walking quite a long way round through the back streets. There were limited entrances to the area, and the long sections of the riverside path with no way out created a perception of insecurity with some visitors. Signs were lacking and paths were narrow or poorly maintained, particular along the Abbey Meadows section.

Aims & Objectives of Belgrave Riverside Park Area Development

The development included the National Space Centre, which opened in April 2001, and the extension and improvement of footpaths to make the riverside more accessible. This included improving access points, seating and furniture, signing, promotional maps and information, landscaping, and footbridge construction. The development also linked in with a public art plan and the national cycle route. The project attempted to increase the usage of the riverside by South Asian communities.

To overcome existing problems with the Belgrave riverside which led to a lack of use and a cycle of decline a consultation was carried out. The consultation identified the opportunities within the park and its surroundings developments to increase use as a community focus, and to produce a corridor for visitor activity and enhance wildlife potential:

Security: Improve personal security on the park by increasing surveillance on the park, realigning footpaths, boundaries and planting to reduce blind corners, improve lighting and circulation.

Circulation: Increase pedestrian access to park and river overcoming the current east-west barrier and to restructure open spaces and formalise existing routes to the college. Provide new access from the main Loughborough Road/Ross Walk to the river & Space Centre.

Public Art; to use public art in key areas to involve the local community and in particular young people in exploring themes along the riverside and to foster local identity and sense of place.

Nature Conservation; Retain the most important areas and enhance Biological value as a wildlife corridor.

Heritage Value: Conserve the most important elements of canal 'industrial archaeology' alongside the central section to enhance local character and continuity.

Entrances: Formalise and improve entrances with coordinated material, information and furniture to promote and attract use, restrict car and motorbike access.

Community Focus; Encourage participation in development of park with events to create a sense of local ownership

Visitor Activity: Promote, links between visitor attractions along the riverside in particular the National Space Centre, Abbey Park, the Museum of Technology, the Belgrave Museums and the waterside centre.

Outcomes

- The National Space Centre had been launched in 2001 along the riverside and had brought with it an increase in visitors to the area.
- The towing path at the back of Abbey Park had been broadened, development guidance had been prepared, and were looking at capital programmes.
- The walking initiatives were integrated into transport plan, and the community consultation was important in this process.

- In the year 2000 priorities had been improvements to the areas of Abbey Park Road and Corporation Road.
- In terms of the operational plan for Chalo Chalay the coordinator meet with the riverside rangers, they had a vast local knowledge, on the wildlife and nature such as fig trees, and also areas, which were no go areas.
- The other objectives in the developmental plan were still yet to be implemented.

Case Record 6.5

Update on Riverside development Summer 2002

- National Space Centre / Abbey Meadows river frontage; scheme to thin out scrubby vegetation and open up view of the river, changes to be implemented by end of 2002.
- St Margaret's Pastures Canal frontage; further phases of improvements completed, the canal edge has been restored Leicester City Council have renewed towpath, created a more attractive landscape up to the car park and constructed the first phase of a new cycle path.

The Belgrave Corridor project and The 'Golden Mile'

The traffic congestion, parking problems and overcrowded footpaths all hampered shopping in Belgrave. The proposed transport project aimed to help regenerate and develop the economy of Belgrave. It was a major investment plan by the Leicester City Council over a four-year period to improve the environment, provide jobs and promote Belgrave as an attractive and thriving area in which to live and work. The project aimed to include safer conditions for cyclists and pedestrians following diversion of through traffic from a heavily traffic route.

The problems that were recognised in the locality were:

- *Congestions, delays, accidents and poor air quality in the area.*
- *High traffic flows along the 'golden mile'; creating problems for buses, pedestrians, cyclists and the local economy.*
- 32,000 vehicles per day travelled along the Belgrave Road- some of the traffic passes through to access the city or beyond.

- In the period 1993–1998, 65 injures and accidents were reported between the Loughborough Road end Belgrave flyover, 40% of these involved pedestrians and cyclists.
- These problem are amplified during Saturday shopping.
- Due to the traffic growth it was forecasted that the economy of the golden mile would suffer, accidents would increase, walking and cycling would decline and environmental pollution would increase.

Aims: The Belgrave Corridor Project

- To improve and promote the Belgrave shopping area and to improve access for more sustainable transport modes.
- Two air quality-monitoring stations would be installed to monitor changes.
- To promote attractiveness and accessibility into and through the area by making non-essential car trips difficult by the implementation of bus priorities and physical measures such as gating.
- Non-essential traffic would be encouraged to divert to less sensitive alternative routes, and to change the time of travel or to use public transport services.

Benefits

Benefits for pedestrians would include wider footpaths, more seating and improved landscaping, slower moving and reduced traffic, improved air quality, greater priority given to pedestrian street crossing. This would reduce the incidence of pedestrian accidents. Links were made to signposting walking routes and especially community shopping routes, and the marketing and walking safety issues. As a result of essential trips to Belgrave shopping area there would be an improved and physical engineering of the shopping area enhanced to offer an improved shopping environment.

Funding

The proposals included joint funding arrangements from Single Regeneration Budget 4 and transport, on the reasoning that congestion of the areas were link to the degeneration of Belgrave. The provisional Local Transport Plan contained funding profile to achieve the £2.5 million required investment over 4 years 1999-2002.

The project included a number of features to encourage walking. Consultation and research was carried out in the locality to determined walking patterns and areas of improvements. The Belgrave Corridor project aimed to provide comprehensive solutions to some of the ongoing problems found.

Outcomes

- The public consultation of proposal resulted in an opposition from the local residents, business's and the councillors, who decided not to continue with the work, and postpone it indefinitely. The opposition was due to local demands of the council to provide public parking for visitors to Belgrave Road and for reserved parking for residents, it was thought that this would be compromised by the corridor project. The transport project manager in defence stated that there was no technical linkage between car parking demand and the corridor project. In this defence the corridor project was to be reconsidered by the councillors following the general election.
- When consulting with officers in December 2002, there was no news on the project and as all was quiet it was assumed that the project was still on hold and needed to be readdressed after the elections. However the safety aspects of the initiative were underway.
- The corridor programme for 2000 and 2001 started on Troon Way, a duel carriage leading into Belgrave, with a pedestrian link between Watermead Park and the Troon way junction.
- In 2001 and 2002 there were further crossing opportunities in the Belgrave area, which impacted, on traffic. The Belgrave corridor was linked with civilising cites project set up with monies from central government. Part of the study was collecting data on pollution to ascertain whether people were not walking due to poor air quality.
- It was envisaged that parts of the walking strategy would be linked into the local transport plan.
- The steering group agreed that there should be a communication and education plan, which would also link into local transport plans, promoting the positive benefits of walking and the new improvements to the environment.
- A bus lane and control crossings were installed over a two-year project along the 'Golden Mile'.

- In December 2002 work had started on installing pedestrian crossings at the Watermead junction (one of the main routes for Chalo Chalay).
- Work on junctions was complete in the summer of 2001.
- Road safety measures were to be completed at the end of 2003 and public transport by 2004.

The Belgrave – City Centre Pedestrian Route Plans

The plans were in place to improve footpaths leading from Belgrave into the City Centre, including removal of a major roundabout, which was a barrier to pedestrians. Improvements were planned for lighting and the environment. Links were made to community walking routes with this as a possible development of a 'into city' walking route.

Central Leicestershire Local Transport Plan 2001 – 2006/ Walking & Cycling Strategy

The Walking & Cycling Strategy aimed to encourage people to walk and cycle. In July 1998 Department of Transport, Environment and the Regions (DETR) published the integrated transport white paper 'a new deal for transport – better for everyone'. It outlined the need to introduce a range of measures, which would offer travellers genuine choice and encourage more sustainable transport decisions. It also asked government to prepare a strategy that would revise existing advise and work with local authorities in improving the environment for walking. The national guidance on encouraging walking was published in March 2000; it stated that DETR were asking all local authorities to provide a strategy to encourage walking. A core part of the white paper was the encouragement of local integrated transport policies through the introduction of local transport plans. The walking and cycling strategy formed a part of the Central Leicestershire Local Transport Plan. It would further develop into:

- Improved road safety and the environment and contribute to improving the quality of life.
- To minimise the need to travel.
- Maximise peoples accessibility to facilities, services, opportunities and resources.
- Support the local economy.

The strategy priority was to promote walking and cycling, then followed by the development of public transport and providing for other road users. A joint strategy between walking and cycling was formed to prevent bidding against each other for the limited space and thus both would be given priority. It aimed to encourage people to walk and cycle via seven action plans which overcame barriers to participation; planning, engineering, maintenance, promotion, education, monitoring, and links into other strategies.

Aims

- Improving accessibility for pedestrians and cyclists.
- Creating pleasant environments in which to walk and cycle.
- Improve attitudes towards walking and cycling.
- Improve safety of walking and cycling.

Objectives

1. To maximise the role of walking and cycling as a transport mode as a means of reducing the use of private cars.
2. To reduces local pollution levels.
3. To improve the physical environment.
4. To improve public health.
5. To improve accessibility for pedestrians and cyclists.
6. To create a pleasant environment in which to walk or cycle. A study by the pedestrians association in April 1997, highlighted the deterrents to walking were; poor weather, air pollution, traffic speeds, difficult/ dangerous to cross roads, poor pavement quality, fear of assault, personal disability and obstacles on the footway.
7. To improve the actual and perceived safety of walking and cycling. Traffic dangers are why 40% of parents in England prevent their children from walking or cycling to school. There are some real safety issues to be resolved in terms of being hit by a vehicle and the maintenance of footways and cycle routes, and there is also a requirement to reduce the perceived fear of assault.
8. To improve attitudes towards walking and cycling. Reducing journeys by car that are within 2 miles of their respective destination. Promotion of walking children to school.

The strategy had included funding resources from the British Heart Foundation and Countryside Agency via the Walking for Health Initiative. The Countryside Agency remit was to protect the English countryside and promote sustainable recreation, providing grants for schemes that develop and promote new recreational activities including pedestrian and cycling facilities. Local Health Authorities and Trusts have the responsibility for health promotion within their areas. This may include the promotion of walking and cycling as healthy physical activities. The strategy would be delivered by various partners these included the adjoining local authorities, Police Authority, Health Authority and the voluntary sector such as the Confederation of Indian Organisations.

Outcomes

- The draft strategy had been approved by the Leicester City Council but was waiting approval by Leicestershire County Council, who would have to consult with the district councils.
- The strategy was accepted by Leicester City in May 2002, however the County felt that it did not meet its needs and opted to write their own Walking and Cycling Strategy for the County, and it covered more rural walking, than compared to urban walking in the city. The two still met and wrote jointly yearly plans so that walking just does not stop at the edge of the Leicester City but there was a continuum through to the county.

SRB4: Single Regeneration Budget 4 = Strategic Regeneration of Belgrave 4 People

A key theme to the bid was 'enhance the environment' by tackling environmental problems, which centred on the problems of crime experienced by residents and businesses. Crime had increased significantly in recent years and had been identified through the consultation as a key concern of local people. A package of community safety initiatives was envisaged to tackle the fear of crime and enable the community and the police to co-operate on a strategic approach to crime reduction. The programme was to develop imaginative ways to bring back into use commercial and residential properties thereby increasing the economic capacity of the area and reduce ' wasted space'. There was an emphasis on improving and increasing green space in the area. The Millennium Greens initiative was interested in supporting a Vrindavan Garden project, which would

have created a new facility specifically designed to meet the needs of the South Asian community to enhance the quality of the environment for local people.

Space to breathe

Belgrave enjoyed very little by way of easily accessible, quality open space. The riverside and Rushey Mead areas were greatly underdeveloped and underused. Cossington Street Park was in the heart of the area but felt by many to be untidy and unsafe. Improvements to the park area have been identified as a key priority for local people.

Traffic

The volume of traffic and pollution in the area made it an unpleasant environment for pedestrians and was identified as a major problem by the consultation process. There were concerns that the levels of nitrogen dioxide were in breached in the Belgrave area. Upon counting traffic was found to flow at between 25-30,000 vehicles during the core daytime 12-hour period, which was unacceptably high for a shopping street with high pedestrian volumes.

'There is no park or green areas where we can take our children to play. They remain cooped up in the house. I don't have a garden so the poor children are stuck indoors.' Comments from local residents

CAG consultation report (1997).

Cossington Street Park

The consultation showed that there was an awareness of the depth of feeling over the state of the Cossington Street Park and became the number one priority for the SRB 4. The Millennium Greens initiative had been the potential to match fund a worked up proposal for a Virndavan Garden in the area. This project was more than a garden; it would have represented an important link to the spiritual and cultural heritage of the local community.

Other opportunities that existed on the riverside were underused, overgrown and deemed unsafe by many in the local community. The development of the National Space Centre added to the impetus for improvements of the Abbey Meadows area of Leicester. The project would have had added value and leverage to the whole riverside development strategy. Other derelict and unused land at Ross walk could have been

brought back to use as a mini park and maintained by trainees from the Ross walk site for minimal cost.

The project had links to welfare to work and employment/ skills agenda alongside a practical mechanism, which can deliver much, needed environmental improvements to the area. Thus, the overall vision of the SRB 4 bid was the quality open spaces offering a safe and pleasant environment for the local community and greater use of peripheral areas such as the Riverside and Rushey Mead by the community.

The National Space Centre

A £46 million investment in the centre had given a huge impetus to development and created scope for targeted training and educational projects throughout the city and the Belgrave area. The Leicester City Council was committed to offering £2million towards this project. The space centre would also add impetus to proposals designed to develop the riverside area around the Abbey Meadows, as a major visitor attraction centre, it also added weight to the transport plans for an out of town park and ride scheme to keep excessive traffic away from the city.

Links to Enhancing the Environment

The police have illustrated their commitment to tackling problem in the areas by devoting £400,000 to the construction of a new police station on Melton Road and thereby increasing the number of police officers present in the area. This enhanced the effectiveness of the challenge fund scheme and the capacity of the police to work closely with the local community.

Transport Planning

Traffic diversion alongside a bus priority lane and traffic calming for Belgrave were key priorities for the transport plan and would cost £1.3million. Linked was the radical approach to parking charges in the city centre and plans for introduction of residents parking in Belgrave and other inner city areas. It offered scope to deal with some of the traffic and environmental problems in the area.

Case Record 6.6

Update of SRB4 Projects November 2002

SRB4 had been working since 1998 to improve the Belgrave area. It was to focus on Belgrave West – the eastern side of the riverside, which covered Thurcatson Road to the pedestrian bridge at Ross Walk. The main barrier was safety; the projects set up to address these were;

- Fencing and safe vegetation: Fencing along the Belgrave Hall Gardens footpaths and lower plants/ low maintenance vegetation would promote suitable community safety
- The Ross walk link: realign path and fencing of Belgrave Hall Gardens to provide continuation and open up view to the opposite back by removal of some planting
- The Holden Street Bridge the installation of gates to slow down cyclists, prevent the crossing of motor cyclists and deter criminals that use the bridge as an escape route.

6.3.7 Evaluation workshop of the Walking the Way to Health Demonstration Projects BHF/CA

A two-day evaluation workshop was held in July 2000, by Oxford British Heart Foundation Health Promotion Research Group. Contributions were made from the four demonstration projects, Leicester, Walsall, and Eastbourne and later on board Bradford, also in attendance were representatives from the Countryside Agency, and the trainers Dawn Vernon Associates, and Loughborough University.

The workshop and the demonstration projects worked toward six major outcomes;

1. The identification of the stages and steps undertaken by the demonstration projects.
2. The identification and analysis of the demonstration projects strengths, weaknesses and challenges.
3. The identification of a number of common steps a typical walking project takes from development to implementation for new Walking the Way to Health projects.
4. The identification of examples of good practice from the demonstration projects common challenges and advice for new Walking the Way to Health projects.

5. The identification of challenges to the development, implementation and evaluation of future Walking for Health Projects.
6. Recommendations for the development, implementation and evaluation of future Walking for Health projects to meet and manage these challenges.

There were three main strands to the projects, which included; project development, project implementation, and project support.

Project Development.

Key steps that were universal to all projects were;

1. Creating a developmental plan, with action steps which audits the progress, this must include all local strategies for health and social developments; clarity on target audience and who it was aiming to involve; a local audit of current walking opportunities and facilities for walking. There should be an examination of project development needs and training gaps e.g. funding, co-ordinator training, organising groups and committees.

2. Identify different sources and types of funding; this should be an early activity for the project; the emphasis should be on sustainability, enabling the project to continue.

3. Identifying key deliverers and key supporters, this is a continuation of audit.

4. Looking into local strategies and priorities: an examination of existing strategies and priorities can give a project a route into working within existing strategic frameworks. This process would allow projects and prospective partner's strategic basis for taking actions and can justify investment. The project should be part of local conferences to put walking for health on agenda of all local organisations.

5. Identifying partners (steering group): the previous steps allowed a project to identify local interested parties who would help to deliver the project. Inclusion of these partners, at an early stage can help to shape the success of the scheme. This may help to stop the co-ordinator feeling isolated especially during the development stage; also it may offer the project differing views and ideas. The challenge was the identification

of partners from a grass root level, and motivating steering group members to actively participate within the schemes and putting commitment into action.

6. Defining project aims and objectives; these should include short and long term, and be SMART: Specific, Measurable, Aim related, Realistic, and Time specific. Being clear on the projects aims and objectives allowed a project to know what it was trying to achieve and how it would tell if it had achieved it or not. A clear definition allowed the project to match its work programme with possible funding opportunities. However, all projects needed to be prepared to adjust these when appropriate. The challenges were getting partners to agree with a common aim. There was a risk that the project aim was too broad to appeal to different partners.

7. Establish Project Structure; this helped to achieve aims and how the aims were going to be achieved, and who was responsible. A timeline may set a clear work programme. The challenge was political delays for example planning permission, also when other partners do not meet deadlines.

8. Securing funding for a project: initial funding can be used to secure further funding. A number of different partners providing small amounts could spread the risk of the project and allowed a broad base for support. This funding could come in kind for example administration, a computer, or professional time.

9. Appointment of a project co-ordinator; the appointment of a project co-ordinator allowed the project to have a focal point of contact, responsibility, development and review. The co-ordinator acted as a 'progress chaser' in the development stage, essential when trying to get or to encourage others to contribute to the project. The location of the co-ordinator was felt to be important as s/he could act as a point of access for key supporting organisations, e.g., local council or health teams. Being easily recognisable and available was crucial to develop the projects momentum. This also allowed the co-ordinator to feel a part of a whole and not isolated. The challenge was to *'keep everyone happy above and below'*. The role of the co-ordinator changes as the project develops e.g. project developer to walk leader.

10. Develop the project as a pilot; this was good for raising the profile of the project. It allowed the project to test ideas and assumed knowledge. The project can then learn and develop a better action plan for the next stage of the project. The challenges with this were how to reach the people that are being targeted, e.g. getting the message across to GPs to get their patients to walk.

11. Working with the community: the project needs to engage with the local community, especially with groups who are a part of the target audience. There was a sense of finding out what level of response the community had for the project and its aims and matching local interest and need with the project resources. The project needed to recruit local walk leaders from the community it planned to serve.

Project Implementation

A number of key steps were identified for project implementation;

1. Revisiting a project time line and identifying realistic progress.

The demonstration projects felt that there was a danger of overestimating what could be achieved on the ground, versus what had been envisaged during the planning process. Reviewing what aims had been set during project development and making appropriate adjustments would allow co-ordinators and others to be more realistic about the progress of the project. A new time line would allow the project to monitor progress and to identify new elements of the project, e.g. organising led walks and recruiting walk leaders. Progress should be reviewed every three months to allow projects to react appropriately to local conditions and dynamics. The challenges in this task were tackling the actions, having realistic goals, being able to do what you need to do when you need to do it, and being patient to observe impacts.

2. Implementing community development.

This step had two steps. Step one was to nurture a relationship with community groups. Step two was to recruit community volunteers. Both steps allowed the project to access potential walkers or walk leaders and expose the project to the local community. Benefits can be found by working with both participant groups, e.g. creating new skills in the community, building self-esteem etc.

3. Project marketing and publicity

This step was important as it allowed the project to share individuals and groups success stories in order to attract more participants. It included sharing information on how new participants can access walking locally. It raised the projects profile with local agencies and possible participant organisations like GP practices. It attracted good publicity for partner organisations and other possible walk leaders. Examples of local marketing and publicity included:

- Contacting all local voluntary organisations via mail shot.
- Using Tourist Information Centres and other public areas to distribute written materials.
- Speaking to local key groups, e.g. Walking Groups.
- Holding public meetings.
- Using local media, e.g. local press, free press.
- Involving a local Higher Education College in producing a video to market walks in local areas, e.g. post offices, GP practices, and shopping centres.
- Participating in local events, e.g. open days in local parks, "come and try it" events.

Project Support

A number of key issues or steps were identified for project support:

1. Developing partnerships

Developing partnerships related to three common areas in all the demonstration projects: the steering group, the management and operations group and the community groups. All the projects felt good partnerships brought advantages to the project by adding new skills, knowledge, commitment and time. A strong partnership brought in resources in kind, personal support for the co-ordinator and broadened the input into the project. It ensured a consistent message across agencies and allowed opportunities for joined up thinking across different agencies, e.g. health and environment. Projects also described their experiences of developing partnerships by:

- Recognising that the aspirations of partnership are hard to achieve quickly. Partners need to recognise that other agendas may be realised before their own.
- Inviting managers with operational roles into project steering group to ensure commitment to action.

- Keeping a shared agenda for the majority and not allowing one organisation to dominate the project.
- Try to help the partners to be open and honest about why they are part of the project, what they expect to get and what they can contribute.

2. Personal support for project workers

Personal support appeared important for the demonstration project workers, who highlighted three areas of greatest need - support from line managers, support from other co-ordinators and finally support from mentors and peers. There was a common fear of isolation expressed across projects that could be reduced by encouraging networking, tackling the feeling of *"has this only ever happened to me!"* Co-ordinators also reported the contribution of their own volunteers in providing personal support. On occasions co-ordinators felt this support was more helpful than their immediate managers. Good support, characterised by good communication was recommended by the demonstration projects to be encouraged as it brought a number of examples of good practice from the projects that included:

- Good support, trust and communication established with walkers allowed their views to be taken back to inform the project and shape its implementation.
- Having the support of partner agencies to make mistakes. Mistakes provided a chance to learn and improve with the support of good management.
- Support for co-ordinators that acknowledges the multiple levels and roles they need day to day.

3. Funding and resources

Funding and resources can support a project in a number of ways. For example resources in kind could mean the chance for free training. Such examples will provide opportunities to develop local ownership and strengthen partnerships. Funding gave projects the security to plan and grow but may also become a challenge if it appears to come with "strings attached". Projects identified a number of examples of good practice of funding and resources, which included:

- Financial support can pull in other partners (even reluctant and not so obvious ones, e.g. SRB)
- Make joint funding applications, e.g. Local health promotion and Agenda 21 bids.

- Projects should recognise that much can be achieved without funding or financial support, e.g. walking groups.
- Funding can access commercial partners.
- Project funding should encourage sustainability.

4. External advice and information

All the demonstration projects recognised the benefits of having a source of external advice and information. This external source allowed projects to feel part of a bigger picture, encouraged new energy, the chance to share learning, and offered help with problem solving. Offering reassurance was also mentioned as a plus of having an external expert source, as projects described feeling better about their own progress. Finally projects mentioned that external information gave them a range of ideas, and allowed creative thinking to common problems by canvassing a range of views. Projects identified a number of ways that the role of external advice and information could be improved that included:

- Providing the opportunity for regional and national conferences for sharing learning.
- Providing the opportunity to borrow the best bits of other people's work and use it locally.
- Giving the chance for others to meet around certain issues, e.g. Black and Ethnic Minority groups, social exclusion and walking.
- Giving current political and strategic information on national policy directives and direction.

5. Training

Training played a key role in the support of all demonstration projects. Training was felt to be critical in four project areas, co-ordinator training, walk leader training, partners and community (briefings). Training was recommended to be a major part of the induction of a new co-ordinator and walk leaders. Projects also suggested walk leaders training could be tailored to local needs, delivered locally and of high quality to set standards following initial training from the Countryside Agency.

The timing of training, especially walk leader training needs to be right for the project to build on it. The use of pre-training briefings was felt to be very helpful to allow all potential participants to be clear on the aims of any training. Pre-training briefings

allowed projects and trainers to evaluate if either was in a position to run and then develop the project post training. This allowed projects to assess if the timing and development stage was appropriate for the training on offer. Projects also suggested an informal contract with volunteers post training. Other areas for further training and development included evaluation, marketing, recruitment methods and creating conditions for a sustainable project.

6. Evaluation

Evaluation was felt to be an important role for projects to tackle. It offered the co-ordinator the chance to learn and reflect and provided surprising results. Evaluation results motivated project workers and provide information to bring in new partners. Examples of good practice and evaluation included participant's diaries, co-ordinators diary and community needs assessment. A challenge was the conflict between evaluations for projects, the time it takes, and practical difficulties it raises for leading and supporting walks.

7. Working with volunteers

The challenge of working with volunteers was found in all projects. Working with volunteers was found to be tricky, e.g. volunteers were difficult to retain as they were not paid and there was large amount of administration. Projects identified a number of examples of good practice for working with volunteers, which included:

- Volunteers could be used in roles other than just leading walks.
- Learning about what motivates each volunteer.
- Recognising volunteers get a range of different things from their involvement.
- Organising social events to reward volunteers
- Offering incentives for supporting the project e.g. Sweatshirts, T-shirts.

Challenges included;

- Little is known about the role and function of volunteers in walking projects.
- The qualities of walk leaders are undervalued and more work is needed to help identify good qualities.
- Useful but not essential qualities for walk leaders to have basic counselling skills, e.g. good listening.

8. Marketing and publicity

Every project talked about the challenge of marketing the programme of walks to their target group. Recruiting new walkers to the led walk programmes was problematic. Projects were able to generate local media publicity for their projects that did contribute to marketing the project. Projects found it harder to keep press interested in the projects unless they created a new story or angle for example using an 85-year-old walk leader. The challenge was that little was known about marketing walking and walking programmes to target groups. Further evaluation and research was crucial.

Recommendations

The work of the four national demonstration projects and the Countryside Agency's internal and external analysis generated a huge amount of information. This information was translated into a series of recommendations for two key groups involved in the Walking the Way Health initiative. The two identified groups are: The Countryside Agency and Future Walking the Way Health projects.

The project steps and stages outlined in the previous section acted as recommendations for future projects. The recommendations in this section are based on the suggestions of the participants of the workshop. The information they produced was searched and grouped into themes which are presented under the following headings:

1. Improving communication with future projects.
2. Capacity building for the Walking the Way Health Initiative.
3. Improving publicity and marketing of walking and the Walking the Way Health Initiative.
4. Developing wider links with other partners.
5. Strengthening the Walking the Way Health Evaluation and Research base.
6. Strengthening the development of project co-ordinators.
7. Developing a successful relationship with the local and national partners.
8. Working with the local community.

Recommendations for the Countryside Agency

1. Improving communication with future projects
   - To identify the reporting and communication procedures necessary to maintain appropriate contact with developing and developed projects. These would

include details on the levels and type of support requested by projects and the ability of case officers to meet in person or meet the needs of a growing number of new projects.

- To produce a document that clearly states the roles and responsibilities of all key partners in the Walking the Way to Health initiative, including their expectations of new project's roles and responsibilities. This document would also state what projects could expect from the case officers, support services and other agency staff. It should also emphasise the need to communicate openly and honestly about the relationship between the Countryside Agency and projects.
- To develop a regional system of networks for co-ordinators and to encourage local "buddy" support systems between local projects and staff. This will reduce co-ordinators feeling isolated and reduce demands on a central advice service.
- To hold an annual national Walking the Way to Health conference to celebrate successes in the projects and foster the sense of identity of being part of a national project. This conference would also provide a forum for walk leaders to network and celebrate successes. Recognition of good practice should be celebrated by the Walking the Way to Health Initiative and include various awards for different participants in projects (for example co-ordinators, volunteers and supporting organisations).

2. Capacity building for the Walking the Way to Health Initiative

- To develop a central information service for the Walking the Way to Health initiative. This service would provide information for case officers, prospective project and project workers. The service could use a range of media, electronic/virtual, print and personal advice to help supply information and gather intelligence on needs. Virtual support should include full use of the World Wide Web, Frequently Asked Question's pages and "chatrooms". The service should look to provide links to other existing support service sites, e.g. Evidence related sites – British Medical Journal Clinical Evidence base, and DETR walking related policy. Print media should also be used to develop links with walk leaders and projects.
- To produce guidelines for new co-ordinators and project workers that acknowledge the multiple levels and roles they will perform day to day. This guidance will include clear definitions of project stages, steps and the co-

ordinators roles and responsibilities. These guidelines could model a "project" with examples of aims, objectives and timelines. This model could be used for the induction and development of regional case officers and the training of co-ordinators and walk leaders. This model would clearly show project stages, steps and the functions of project workers and organisations.

- To continue the development of guidelines and information for local projects. This should include information and examples on how local projects can identify typical local partner organisations with examples of their roles and potential contribution to a local project. It should also have guidance on current walking related statutory strategies and policies. It should include examples of how to audit the "walkability" of local environments and sources of local information on current walking activity, e.g. local clubs, existing walks, local paths and rights of way.
- To lobby the Department of Health to facilitate a meeting with the British Medical Association in order to agree the roles and responsibility of a GP in advising a patient to participate in the Walking the Way to Health initiative. This meeting would clarify current uncertainty about the promotion of physical activity in primary care and tackle the biggest barrier to engaging this group in the initiative.
- To develop information and guidelines about walking and the initiative for health care professionals. Further work is needed to satisfy the concerns of primary care professionals about the efficacy and benefits of walking to a wide range of diseases and conditions. The efficacy of the initiative, its potential contribution to chronic disease management and examples of working with primary care. These materials should aim to build bridges with primary care, encourage primary care practitioners to use walking as an appropriate behavioural intervention with specific groups. The demonstration projects have found working with primary health care bodies challenging and unproductive.
- To develop current training provision to include examples of the sequence of development of a project. Local projects must be clear that different training courses are needed at different stages in the planning and running of a project. For example, the project co-ordinators first training course could focus on project development up to the point of engaging the target group. Once a particular point has been reached, additional training on project marketing,

publicity (e.g. working with local press), evaluation, report writing, recruiting and managing volunteers and creating conditions for a sustainable project could be offered.

3. Improving publicity and marketing of walking and the initiative.
   - To identify what the national and local publicity mechanisms are for the initiative and projects to promote themselves in order to secure favourable publicity and local political capital.
   - To collect information on new and innovative ways to market walking and walking programmes with new angles on walking related publicity. Inclusion of any examples of marketing tools for the concept of walking for health, the concept of led walking and the concept of independent walking, based on formative evaluation with target groups would be helpful.
   - To hold an annual conference to market the initiative to potential new projects.

4. Developing wider links with other partners.
   - To audit other national and local strategies and funding bodies that could share the agenda for the promotion of walking.
   - To develop guidance on how projects can access a variety of local funding sources, including identification of different funding sources (e.g. SRB, Agenda 21) and organisations and examples of different types of required resources (e.g. officer time, computers).

5. Strengthening the Walking the Way to Health evaluation and research base.
   - To review the evaluation and research needs of the Walking the Way to Health initiative.
   - To try to ensure that evaluation and monitoring mechanisms are simplified for future projects. It is recommended that any evaluation activity for future projects should be part of monitoring project activity. Evaluation guidelines should be created for project co-ordinators, include data collection methods e.g. questionnaires and ask projects to describe rather than analyse data. Any data analysis should be conducted centrally or via a specialist service.
   - To audit current walking promotion across the UK this will allow a baseline assessment of types, levels and quality of current activity in walking promotion

for monitoring future growth. Included in this should be the distribution of current activity across areas of social deprivation, highlighting the pattern of provision, political and social priorities and deprived communities.

- To conduct further formative evaluation into the beliefs and attitudes of the population to Walking and Walking the Way to Health related initiatives, including identification of appropriate marketing mechanisms and strategies to specific market segments e.g. social economic status, Ethnic Minority groups. This will allow some feel for the readiness for the promotion of walking across different socio-demographic groups and communities. Particular target groups should be the priority for evaluation and research activity, especially Ethnic Minorities and people with disabilities.
- To evaluate the roles, benefits and functions of volunteers in walking projects. This should include strategies for engaging with volunteers and local communities with the Walking the Way to Health initiative.
- To evaluate what skills a good walk leader requires and the ways of identifying potential walk leaders.
- To evaluate the short and long term motivations of walkers and what incentives would maintain their participation in led and independent walking.

Recommendations for future Walking the Way to Health projects

1. Strengthening the development of project co-ordinators

- To appoint a local co-ordinator as early as possible in the development of a project ideally as much time as possible should be given to the post in the project development stage, with 60% full time equivalent appearing to be a minimum level in this first phase. This may not be appropriate for projects of a smaller scale than the current demonstration projects. In this case the roles of a co-ordinator need to be shared across the project team or steering group. In this case specific time and resources are committed to the project.
- To encourage co-ordinators to be physically based in a place of work most suited to the stage of the project. For example working in a local council setting may be helpful during the development of the project, however a location within the target area will be more helpful when implementing the project with local volunteers.

2. Developing a successful relationship with the local and national partners

- To encourage open working relationships with all partners the production of clear guidelines on the roles and responsibilities of potential partners, with examples of how these relationships have worked elsewhere. Included in this information should be a commitment to help potential partners to be frank and honest about why they are part of the project, what they expect to get and what they can contribute.

3. Working with the local community

- To encourage projects to work with the local community and to build their projects with the local community with patience, care and sensitivity. All projects must acknowledge that a lack of walking may not be a priority for the most needy groups and those who work with them. The promotion of walking can offer the community the chance to change slowly, at their own pace and this will take time. The danger of a project moving beyond local community priorities should be emphasised. Sustainable changes will take time.

Evaluation Workshop. Chalo Chalay Leicester.

The Leicester evaluation group consisted of the evaluator, ex-coordinator and action researcher Loughborough University, the new project coordinator, from the Confederation of Indian Organisations.

The main outcome was the setting of realistic targets and goals. The first year of the project had reached some of its aims successfully, but it has been a difficult process and a number of new barriers were identified. The time allowed to address these new barriers was not allocated putting unnecessary pressure onto the project and its workers. This could have been avoided if realistic targets and goals were set initially. To allow for time for the development work would have been an asset and many of the challenges faced would have been overcome efficiently.

Case Record 6.7

Examples of learning for future Walking the Way to Health initiatives, managing common challenges and constraints

BRADFORD

1. Lobby more - politicians/councillors, council officials.
2. Use national and local guidelines (i.e. transport plans – national walking strategy).
3. Work together with SUSTRANS.
4. Make greatest benefit of our examples of improvements!
5. Get local support/comments.
6. Prioritise! Re-focus revisit priorities – work less on objectives.
7. Identify additional funds – HA/LA fund finders.
8. Identify key political players.
9. Try promoting health as a very important issue – of concern to all political parties.
10. Big question!! - Community development – IS IT really the best way?
11. Well-funded projects – encouraging local involvement but not relying on it.

COUNTRYSIDE AGENCY AND OTHERS

- Encourage open, honest and realistic relationships with local partners from outset.
- For further learning and refining of initiative, to enhance pool of knowledge and strengthen future schemes (not stuck in '98 thinking).
- Celebrate and promote this local diversity of WHI.
- 'Play Up' low key components (i.e. self-help information)
- Being honest about what we know and don't know (ad recording it).
- Getting answers for what we don't know.
- Regular bulleting to 'Team'
- Regular review/feedback from 'Team':
  - meetings
  - one to one
  - sub-groups
- Record frequently asked questions
  - Devise answers
  - Disseminate by web-site and hard copy

Manage specific 'one off' questions (encourage use of e-mail) shared questions.

- Agree valid budget and monitor
- Absolute numbers / benchmarks

EASTBOURNE

1. Dissemination of evaluation findings to GP's.
   Targeting supportive / receptive personnel / staff within the HA.
2. Maintaining community involvement in project -
   re: development and progress of project their integral and valuable contribution to project.
3. Continued high profile of project – developments and successes of project, via lobbying of councillors and statutory organisations and voluntary bodies.

LEICESTER

1. Getting different Ethnic Minority groups on board.
2. Specialised training and resources e.g. different languages.
3. Involve specialist link workers (gatekeepers) from various groups.
4. Establish operational groups to replace "Steering group".
5. Accountability route/safe guarding.

WALSALL

1. Control – Balance to be struck as to how much the steering group control elements of the project. Top down approach can lead to a well-structured project without communities participating.
2. Bottom up approach (community led). That is flexible to meet needs of community. May take longer (or may not!), but have to be flexible and adaptable with structure of the project.
3. How important is community ownership?
4. Roles emerge that you have not identified as being as important / significant / time consuming as they become.
5. People have to change roles between development and implementation stages. Membership may change. Do we need different skills for each stage?
6. MAINTAINING COMMITMENT from partners - was it a real commitment at start?

If people don't stay on board, to deliver as originally stated. Can you adapt your plans? Are your networks far reaching? Can you extend them?

Is it just a problem with community led development and you say OK, adapt and get on with it.

7. IT IS ALL ABOUT FLEXIBILITY TO ADAPT.

6.3.8 Concept of Volunteering

Volunteering in the South Asian Community of Leicester

Across the demonstration projects there was a concern that there was a high dropout of individuals between expression of interest in becoming a walk leader and becoming an active volunteer, equally important was retention. Despite attendance at an induction and training day relatively few went on to lead walks. Thus, the Institute for Volunteering Research an independent research and consultancy specialising on volunteering was commissioned by the British Heart Foundation and the Countryside Agency to explore the motivations of people who contemplated volunteering as walk leaders on the three national demonstration projects.

The research methods used desk research, interview with potential and actual walkers and a comparison made with other volunteer walk leaders from two other established walking for health schemes and other community based schemes in similar socio-economic areas. The research involved gathering basic profiling data via a simple postal questionnaire sent to all those who had expressed an interest in being a walk leader. This was supplemented by telephone and face-to-face interview with walk leaders and those who decided not to lead walks; project co-ordinators; representatives of the local volunteering infrastructure and where possible other exercise base schemes involving volunteers locally. The institute also interviewed co-ordinators and volunteers from two other walk schemes to compare recruitment and management practices.

The report was written in November 2000, but the interviews were conducted in March 2000, about 12 months into the project. The research only covered a short period of time and cost the initiative £18,400.

Motivations to Volunteer

Previous studies in psychology (Argyle 1997) and national surveys of volunteering (Davis Smith 1998) gave a clear idea of who volunteers and why and draws on the motivations

and barriers. Motivations include satisfaction of seeing results of efforts, meeting people, helping in the search for paid work, being part of a personal philosophy to help others and enjoyment of the experience. The National Survey (1997) highlighted why individuals stop volunteering; their volunteering seems no longer relevant to them or they had moved away from the area. Reasons for stopping may not just be the volunteer but the organisation that they were volunteering for. 71% of the volunteers from the National Survey felt that their volunteering could be better organised, with frequent complaints about a lack of support, non-payment of expenses and lack of appreciation.

Volunteers were not a homogenous group, what motivates one group may not motivate others. For example young people were more likely to see volunteering as a means of gaining experience which would stand them in good stead for their personal and career development (Gaskin 1998) whereby older people were more likely to express their motivation in terms of feeling useful.

From the national survey of volunteering 1997, there were differences in participation rates between sub groups. Although men and women were equally likely to volunteer, there were clear differences by age, with people aged 45-54 the most likely to volunteer and lower levels of involvement among the young and retired. There were also differences between Ethnic Minority groups; with the survey suggesting that white people are more likely to volunteer than Black or Asian people- this however was based on a small sample. There was some evidence that Black and Asian people were more involved in volunteering at the informal neighbourhood level than through an organisation or group of some kind.

The national survey found that the most common areas of volunteering were education, sport and social welfare. Men were twice as likely as women to be involved in volunteering connected with sport and exercise and are also more likely to be involved with hobbies, recreation, the arts and politics. Women are three times as likely as men to be involved in volunteering connected with children's education or school and are also more likely to be involved with social welfare, elderly people and religion.

Barriers to Participation

Older people (Hutchinson 1999)

Barriers to volunteering for older people include:

- Economic circumstances of some older peoples and the fact that many continue to be reliant on state pension.
- Competition with other leisure activities.
- Ageist practices of some organisations, such as compulsory retirement age for volunteers.
- Lack of access to information about available opportunities.
- Lack of public transport facilities.
- Apathy and lack of interest in volunteering.
- Being asked to do too much.

Ethnic Minority Communities

Research has identified barriers for ethnic minority potential volunteer as:

- Language needs, those that cannot speak English may not be aware of, or able to access, volunteering opportunities.
- Some groups, for example Asian women have children and family responsibilities that prevent their participation.
- Many from Ethnic Minority communities prefer to be involved in informal community based activities. Some research suggested that motivations are more about helping and less about instrumental motivations such as acquisitions of new skills.
- Sometimes people from Ethnic Minority organisations feel more comfortable volunteering in their own communities (Foster & Mirza 1997).
- Potential volunteers can take the view that mainstream organisations are reflective of society at large and because of racist experiences within society would not feel comfortable becoming involved outside their communities (Niyazi 1996).
- Young people have a stereotypical view of volunteering as for white, middle class, middle aged women with time on their hands this may also be the view of some of the Black and Asian communities.

Specific work in Leicester by Leigh (2000) showed a number of barriers to volunteering for Black and Asian elders:

- Disability, poor health, ageing.
- Elders need help/ support themselves.
- Being relied upon too much/ organisations are inflexible.
- Not getting a response from an organisation.
- Organisations' recruitment process is too formal.
- No reimbursement of travel or other expenses.
- Lack of transport i.e. inconvenience of getting to and from voluntary work.
- Safety i.e. being away from immediate neighbourhood/ lack of transport.
- Language where English is a second language.
- Lack of confidence.
- Lack of money.
- No time.
- Fear of benefits being cut.
- Prejudice.

Recruiting and retaining Volunteer Health Walk Leaders: An Evaluation of the walking for Health Programme In Leicester – Chalo Chalay.

34 Questionnaires were sent to all those who had attended training for the walks, 15 were returned; two walk leaders and 13 non-walk leaders. A total of 19 interviews were conducted.

Two of the walk leaders were available to interview in March 2000, one of which lead the walks regularly and the other had more of a deputising role. Both were South Asian women in the 45-64-age bracket. They were both fluent in Gujarati and Hindi and described themselves as 'retired' and unemployed respectively.

The non-volunteers

34 people attended the Chalo Chalay training day, 32 of which did not go on to becoming walk leaders, the breakdown of the attendees showed that

- Most of those expressing an interest were in the middle age range; with 8 out of 32 were aged 33-44.

- Nobody was below the age of 35.
- There was only one retiree.
- All training attendees, except one were female.
- Most training attendee were part-time employed (4), full time employed (3), or unemployed (3).
- Nine of the training attendees described their ethnicity as Indian, four described themselves as ' white'.
- All the people who were Indian were fluent in Gujarati and in some cases Hindi.
- Nine of the 13 questionnaire respondents had volunteered in the last three years.

Recruitment of Volunteers

The two walk leaders had been active in the previous project at the Confederation of Indian Organisations and were amalgamated into the Chalo Chalay project. Other potential volunteers who had attended the training had heard about the initiative through a variety of channels. Seven had seen or heard about the training through contact with their local community centre (4 of which worked in the community centres). Three had heard of it via the ex- coordinator, two from contact with a health visitor and one through an exercise class.

The project had a leaflet and poster campaign, which asked people if they would like to become involved as a volunteer to help ' your community'. Both coordinators had been on local radio programmes to talk about the project and to generate interest amongst possible walk leaders. Many of the training attendees commented that South Asian radio was a good medium through which to relay information about Chalo Chalay.

Potential volunteers who had attended the training suggested ways in which leaders could be recruited. In their opinion the project needed to improve its contact with the community via presentations at local group gatherings, appropriate language publicity at community centres, promotion at health centres and doctors surgeries, schools, local shops and ideally wherever there was a community hotspot.

The report highlighted that the volunteer requested form produced for the Leicester Volunteer Centre stipulated that; *' volunteers must be able to speak an South Asian language.'* It further suggested that given four people who returned questionnaires were 'white' and

were not fluent in any Asian Language, that the project needed to re-consider this stipulation by pairing a bi-lingual walk leaders with one who did speak a South Asian language. If the research were done in more depth it would have discovered that these 'white' attendees were professionals or steering group members who have benefited from the training to purely understanding the dynamics of the project and what they would have been referring into. These included Health Promotion Specialist from the Health Promotion Centre and the Health Visitors from the Spinney hill Health Centre. The project could have implemented the stipulation, but the projects clear target audience was the South Asian community.

From previous studies the Black and South Asian communities feel more comfortable volunteering within their own communities and projects. Some of the training attendees thought that the remit of the project should be extended and should;

Quote 6.1

'Involve more youngsters, they are turning into couch potatoes right now.'

Other ideas included having a mother and child-walking group, or walks for people who work. Another training attendee, who had volunteered previously in another community project, drew the link between volunteering and employment.

Motivation of the Volunteer walk Leaders

The two walk leaders gave their reasons for their involvement as an interest in health issues, in their own fitness, in meeting people and in walking.

Quote 6.2

'I try to tell walkers that it does a lot of good. The people my age have more health problems than me and this could be because I have been walking all my life.'

Furthermore the walk leader went on to say that walking was a hobby since she was young and having a general interest in health issues being an aerobic instructor herself (qualified after becoming a walk leader). She never consciously wanted to become a walk leader, but naturally fell into volunteering through being a walker in one of the pilot groups.

The second walk leader indicated that she was interested in being involved in a community project and in volunteering. Volunteering had helped her through her depression.

Both walk leaders were enthused within the aims of the project and promoted it to the community. However both commented that it was harder to promote the initiative due to other commitments that Asian women have.

Retention and Drop Outs

Making a difference

Among those participating in the walks was a group of elderly South Asian ladies who had become regulars, their participation and enjoyment attributed to the enthusiasm of the walk leaders. In return, being appreciated by the group was a factor in motivating the walk leaders:

Quote 6.3

'....it means a lot to me. I feel like I'm helping all our Asian ladies. In our group we have made so many friends. We are just looking forward to that time.'

The main walk leader said that:

Quote 6.4

'Many of the walkers were friends before the initiative. Before I did the walks, many of them were coming to my exercise class at the Belgrave Neighbourhood Centre.'

Support

The walks were fairly informal, and that was how they liked it:

Quote 6.5

'We go, we meet and we walk. Sometimes when we are tired we just sit there and talk and joke.'

The report via the interview suggested that at times, the walk leaders felt unsupported, and this was a de- motivating factor. These feelings had been formed by several instances when the leaders felt that their voices were not heard. On one occasion the walk leader had requested a mobile phone. After some time she had been given a phone, but it did not work. The phone was replaced but the issue had left her feeling unhappy about the support she had received, and demoralised about her involvement as a walk leader.

The lack of support was also evident at one time when the walk leader could not lead a session. Neither the project coordinator nor any Confederation of Indian Organisations staff were there for her to inform. Consequently she had to phone all 20 walkers herself to let them know of the cancellation of the walk. The leader was on friendly terms with all walkers meaning the telephone call was lengthy and contributed to an increase in her normal phone bill.

Responsibility

The walk leaders felt isolated, and it troubled the walk leaders who recognised how much the group depended upon them. Furthermore the second walk leader agreed that they both had a lot of responsibility. It was not a responsibility that they welcomed.

Recognition

It was frustrating for the walk leaders that they did not receive recognition or thanks for their efforts. The project coordinator acknowledged that at that time in the project there was no system or mechanism to thank volunteers. This was brought home to walk leaders at Christmas when a lunch event was organised but leaders and walkers had to pay £5 each. Whilst it was recognised that resources were scarce, it was felt that at the very least the organisation could have paid for her lunch as a thank you.

It has to be noted that informal systems were in place to give recognition, in previous months, a Diwali lunch at a local restaurant was paid for; trips and outings were also paid for by the project. Support in kind was given, the project coordinator had to fight battles for these, an incentive scheme was always on the back burner. These incentives were put on hold as walk leaders began to be paid for their ' volunteering activities.'

Influence

The leaders felt that despite having responsibility over their own walking group there was no mechanism to influence the project itself. When asked if they had been given the opportunity to feed in suggestions or been asked for opinions one walk leader said that the project had;

Quote 6.6

'Never done anything like that.....definitely they should ask me'

The project had invited comments to be made on evaluations and also been asked to sit on the operational group. The relationship between the walk leaders and the project coordinator was recognised to be at formative stages. One walk leader said that she had found the pervious coordinator very supportive:

Quote 6.7

'We don't know (the new coordinator) that well. Once we start knowing him we might be able to go to him more...but then we don't meet regularly. I don't even have his phone number. Maybe he could ring us. We don't really have a relationship. Sometimes maybe he should come on a Thursday morning walk and take some ideas from them (walkers) and us.'

As said the coordinator was new in post, he did have an opportunity to build a relationship with the group. It was noted that the styles of co-ordinating were very different in the two people that have co-ordinated the project. In the first instance a relationship had to be built and a certain level of trust gained between the co-ordinator and the community, in the second instance a strategic role was being aimed at.

Training

One of the walk leaders would of liked to go on more training. The other walk leader was bitter about the lack of training given by the Confederation of Indian Organisations. She added that any development she undertook she initiated. She added she would be keen to learn anything about health.

Reasons for not volunteering

Time Pressures

The main reason given for not continuing with the project was a lack of time. Volunteering for the project was competing with other work or leisure commitments. All but one of the questionnaire respondents was of working age. A breakdown of the reasons showed:

- 5 out of the 10 people interviewed gave full time work as the reason.
- 2 more people also worked full time in community centres and went on to incorporate walking projects into their own jobs.
- 2 people said that personal circumstances did not allowed them to become involved.
- 1 person was engaged in other voluntary work.

Comments made were:

Quote 6.8

'I thought at the time I could do it, but then realised it was taking up too much time.'

Those attendees for whom time was the main barrier, still showed an interest in the project. One person who could not get involved, as it would have clashed with his other voluntary commitment said that:

Quote 6.9

It's a good project. I know the area well and would have liked to do it.'

Quote 6.10

Another person said the only barrier was:

'My job.....no other reason. I did want to go and do it really.'

One person, when asked if they would volunteer if asked again;

Quote 6.11

'I would try, considering my time commitments.'

Lack of Flexibility

The volunteering could not be fitted into people's schedules, especially in cases where people were working full time. There was some indication that people might have been able to volunteer, if the walks had been during the weekend. This was highlighted when an attendee was asked whether they thought volunteering was flexible.

Training

Some of the attendees discussed the downfalls of the training course not equipping them as volunteer walk leaders. A more personalised approached was suggested by another attendee. Other attendees said that it would have been useful to know about walks for people with disabilities and about mental health issues. One person had gone on to set up their own scheme in New Parks and the Fosse area. She said that prior knowledge had been gained through being an aerobic instructor and said that this had helped her in becoming a walk leader with her own project. The same training attendee said that the approach needed to be built up until it represented the idea of ' holistic health', in terms of physical, mental and social well being;

Managing the project

At the time of this particular research the new coordinator had been in post for a short period of time. However he assessed that the project needed to look beyond the areas it

was serving. He believed that to build an effective walk leader required more of a selective approach to recruitment.

The new coordinator identified the hardest part of managing volunteers was keeping them enthusiastic. He said that if the project expands this would become even more difficult and would require the project to be better supported from the Health Promotion Centre. The coordinator identified his walk leaders as one of the strengths of the project, citing her as an ideal role model whom he wished to involve in future training days to talk to potential walk leaders. He envisaged that future work on recruitment needed to work through contacts in community groups throughout the city and build on one to one contact as.

Volunteering in the South Asian Community of Leicester

Research by the previous coordinator found that people in South Asian communities do not naturally identify themselves as being volunteers. There was no word for volunteering in Gujarati or Hindi, rather people identified with the spirit of 'Sewa', a Hindi word translated in to ' helping', the coordinator argued that;

Quote 6.12

' Selling the idea of volunteering is hard – why sell it when they don't want to be in this formal framework.'

One suggestion of the coordinators research was to popularise walking by likening it to the concept of the religious pilgrimage that elderly people usually do by foot in India. Through this both the idea of volunteering and walking can be progressed. At the time of the research there was a feeling that walking was not popular. A representative from the Ramblers Association in Leicester who was a walk leader highlighted how difficult it was to get people from ethnic minority communities involved. She said that in the Belgrave area they had tried to get people involved but that;

Quote 6.13

' They came once, but don't come back. Its not in their culture to walk.'

This is perception held by many workers in the field who do not dig deeper to address why people do not come back, when by understanding the culture, would explain that walking plays a big part.

Helping out in the community also has faith associations in ethnic minority communities. Leigh's survey (2000) of 22 black elders who were active in the community found that 59% found out about the activity through the temple, church, gurudwara or mosque. He suggests refining volunteering in a way that removes culture bound assumptions. Findings from the previous coordinators consultation with various faith groups in Leicester found that the term 'volunteering' put people off. The project, instead recruited the term 'Walking Activator' which included peer education role in the community and a cascading effect would follow from their initial involvement. This was seconded by a volunteer at a local community centre who agreed that working through an informal setting was more effective than formal ways of getting people involved;

Quote 6.14

'We can motivate the people as we know them....they are our friends and part of our local community. We can say to them 'get up and get involved!" Furthermore; 'from my experience of other activities in the Asian community, a person may be trained for example leading walks, but still may not be able to lead the walks and encourage others to do it. There is a need to introduce it to them slowly. Other communities participate in walks all the time. But with our people, you need to prepare them and introduce it to them slowly.'

Within the wider volunteering infrastructure of Leicester, the project received a mixed reaction. A representative at the Leicester Volunteer Centre commented that when the scheme was introduced, it did not have professional posters and that they themselves made some for the project. She said that the current format was 'okay' but was not the best marketing approach. She suggested that the initiative needed;

Quote 6.15

'A re- launch with a lot more publicity....and that some adverts are like hotcakes they are so well designed.'

However, she also commented that problems of recruiting and retaining volunteers were common across many voluntary organisations in Leicester and suggested mediums such as the community action page in Leicester Mercury or making use of the display board at the Leicester Volunteer Centre. She also highlighted that there were many exercise schemes especially for Asian women that had been introduced in the last few years and that Chalo Chalay idea was probably quite a difficult thing to attract volunteers for.

This representative was different to the one the project coordinator had previously worked with. All Chalo Chalay publicity had been produced in house due to the lack of resources and the feeling that these could be better spent. The posters were thus produced, and may be internal communication did not occur. The Volunteer Centre was suggesting a mass media campaign; this does have its advantages, however both coordinators felt that targeted publicity to the South Asian community was more beneficial. Boards set up at the centre would of also had its benefits, but the clients that the centre brought in were not of South Asian origin. All publicity was, whenever, possible translated into the relevant South Asian languages.

The Director of Voluntary Action Leicester believed that projects that have a specific ethnic minority focus do not require different kinds of support, but rather the challenge was to get general support to them, as some can be quite isolated. His advice was getting the advertising right from the start was vital. He expressed a concern about the remit of the Confederation of Indian Organisations itself, which was a small developmental agency with responsibility for developing voluntary work in surrounding regions of Leicester, he questioned;

Quote 6.16

'How do they split thinking between this project and other regional stuff, given that they are very small organisation?'

Comparative Studies

The research went further on to compare the three-demonstration project with two other similar initiatives that were identified as successful involvers of volunteers, Goring and Wiltshire. There were similarities in terms of the profiles of volunteers and motivation. However there was a differences in the environment and locality in which the volunteering took place this had an impact. Leicester was the only project that was targeted at ethnic minority communities and the comparison studies did not have any.

The profile of the volunteers interviewed suggested that older people were more likely to be attracted to the groups, which was consistent with the research into Eastbourne, Leicester and Walsall Project. The overall profile in the Goring group was younger than the Wiltshire or the demonstration projects. Neither of the schemes attracted volunteers

below the age of 25. It has to be noted that the Leicester project was targeted at the older population and not the younger aged profiles.

The motivations for walk leaders were similar, that was an interest in walking and fitness emerged as a strong theme, this reflected the age structure of volunteers – attracting those that were thinking about lifestyles and health issues. Social aspects and community service were also motivators. Where the comparative studies had been successful was to emphasise how volunteers can capitalise on their interest. The Wiltshire group recruited volunteers who had been encouraged to develop their own walks and this had been mentioned as a factor in establishing the group. The Goring group had also made an important connection with the local GP. The initial meeting of the group was held at the local surgery and there was input from the doctor in explaining the benefits of health walks. This was allied to a feeling of personal responsibility within the community, which was expressed as people recognising they ought to be responding to their own health needs. There was an indication that they felt they could not go to the doctor if they themselves *'had not tried to do something about it.'* Much of the recruitment was based on personal contact, which in a community like Goring was very successful.

The environment for voluntary action had to be right for health walks having the support of a local GP, and the local newspaper was seen as important to promote an involvement in the scheme. Wiltshire recognised the difficulty of getting people involved as leaders:

Quote 6.17

'We try to get people who are walking, but so far they have not been keen. They don't like the responsibility of having to turn up each time and be in charge. It's the same with all groups, no one wants to be chairman or treasurer.'

This was found with the Leicester Project, they were interested in walking, but not wanting to become leaders, this was particularly evident with the men's group.

Management of Volunteers

The coordinators did not think in terms of managing volunteers, arguing that what they did was ordinary 'people management.' Identifying one volunteer was being to demanding of co-leaders and walkers and organising a group session to identify best ways to work together and lead walks was a better option. Having a hands off approach to management allowed the leaders to define their own roles. In both groups leaders could

adapt walks. In Wiltshire this meant deciding between fixed routes, but in Goring leaders made decisions about where to walk at the beginning of the walk depending on who turned up. In both groups some leaders decided not to do the exercises at the start of the walks.

The autonomy of walk leaders was seen as important. Volunteers needed to feel as though they had ownership, within the group and helped maintain their interest in participation. In contrast the demonstration projects were found to be more directive to volunteers about where to walk and about the need to follow procedures such as the warm up exercises.

There was an indication that much of the work fell to the same people and this was accepted, and only occasionally resented. Both Goring and Wiltshire had one volunteer that was totally committed to the group and was willing to accept the responsibility of taking a lot of work off the coordinators shoulders.

The comparative studies had no formal structure of volunteer management and did not need it. The key was management of volunteers with hands off approach and informal, a formal style would have not fitted into the style of the organisation. This was what had happened with the Leicester project in that the host organisation was quite use to an informal way of working whilst its funders were formal and led to friction. The comparative walking groups were not in receipt of large grants that needed to demonstrate how the money was being spent.

Findings from the comparative studies suggest:

- The usefulness of training committed volunteers who were prepared to take a greater role in organising the project.
- The need to forge greater links with GPs for referral and legitimacy.
- The benefit of combining enthusiasm to walk with other interests volunteers may have such as local history.
- Recognition that recruitment is often by word of mouth, and that's its success can depend on the quality and density of local networks.
- Sensitivity over degrees of management – more formal projects may need more formal styles of management.

Recommendations

Recruitment

Word of mouth was the most effective means of recruiting volunteers, most people tend to get involved not in response to an advert of some kind, but because they were asked by a friend, family member or work associate. There was little evidence from the demonstration projects to capitalise on this approach however Leicester had a number of people come through contacts through the local community organisations, and people heard via the neighbourhood centres. An option maybe to encourage existing walk leaders to try and recruit a friend, on the basis that existing volunteers make the best advocates, although there was little enthusiasm for this approach among volunteers in Eastbourne. Care should be taken not to put too much pressure onto the volunteer. Some people may shy away from being expected to take on the added burden of recruitment. In any case it would be ill advised to rely on word of mouth alone, as it could produce a 'cloning effect' -people tend to ask people from similar social backgrounds to themselves. Over reliance on word of mouth a as recruitment tool will thus work against attempts to bring new types of people. A representative sample of the community should be aimed for.

There was little evidence of a targeted approach to recruitment. A targeted approach required the organisation to think through much more carefully what it was that motivates different people to volunteer and to adapt their recruitment message and an advertising strategy accordingly. Different messages would be required to attract different groups of people. The targeted approach requires more thought and preparation up front but this investment should be repaid in terms of a higher volunteer return.

Motivations

Quote 6.18

'Having a bit of authority, it may sound funny but if I didn't have the badge and T-shirt I probably wouldn't do it.'

- *Recommendation 1:* 'Projects should explore the potential for encouraging existing volunteers, participants and other involved with the scheme to act as advocates to spread the word about opportunities to volunteer.'

The Leicester project to an extent did capitalise on this concept by promoting the walk leaders as 'Walking Activators' and was encompassed into their role.

- *Recommendation 2:* 'Projects should develop an advertising strategy utilising a mix of approaches as deemed appropriate. For example projects might choose to make a general call to people to volunteer to raise awareness about the scheme in the locality but follow this up with a much more targeted approach directed at specific groups of people.'
- *Recommendation 3:* 'Projects should carefully think about the type of person they are trying to recruit and develop an appropriate advertising strategy with this in mind. The whole recruitment process will need to be considered as part of the strategy from designing leaflets and posters to where to place adverts.'
- *Recommendation 4:* ' Projects should look to place adverts in places where potential volunteers are likely to see them, e.g. for older people GP surgeries, community and day centres. Projects should explore possibilities of linking up with local companies whose staff might be interested in volunteering as part of an Employee Volunteering Initiative.'
- *Recommendation 5:* ' To help projects develop the most appropriate recruitment strategy they should consider seeking advice from local volunteer development agencies. Projects should seek the advice of people from the group to be targeted. For example; if the project is interested in involving more people from Black and Ethnic Minority backgrounds, it would be sensible to talk through the issues involved with representatives from the local Black community.'

Recruiting volunteers from Black and Ethnic Minority Communities.

There were particular considerations that needed to be considered when involving people from Black and Ethnic Minority communities. The Leicester project was predominately South Asian led and run. The other demonstration projects were primarily 'white' in nature but were keen to involve people from Ethnic Minority groups. The Leicester project provided pointers for success for both types of project. Language was the key, for Black projects it was essential that the advertising leaflets were prepared in Ethnic Minority languages. Mainstream organisations also needed to consider translating their material if they are serious about recruiting Black and Ethnic Minority communities.

The nature of volunteering and the word itself can be culturally and ethnically loaded. In many Ethnic Minority communities the culture of volunteering is related to notions of self-help and mutual aid and that more formal volunteering schemes have far less relevance. The Leicester project suggests that if organisations wanting to appeal to Ethnic Minority communities they need to first establish good links with the community groups and develop forms of volunteering which would build upon the rich traditions of volunteering in Ethnic Minority communities rather than attempt to impose models from them from the outside.

Walk Leader from Walsall

Quote 6.19

'Some multi- cultural training ...so that I couldn't offend anyone accidentally through any of my comments..... also perhaps a pack about the history of the park.'

- *Recommendation 6:* 'Projects wishing to involve people from Ethnic Minority groups need to think not only about translation, but about presenting the volunteering experience in a way that builds on the rich heritage of volunteering within Ethnic Minority communities. In particular this means building partnerships with the local Black voluntary and community sectors.'

Selection:

- *Recommendation 7:* ' Projects should produce a comprehensive introductory pack of material to give to all initial enquirer's, giving full details of the nature of the project and the volunteer task, the level of responsibility and commitment required, and the nature of support provided.'
- *Recommendation 8:* 'Projects should follow- up on sending out this pack with a discussion (telephone or face to face) with would be volunteers to try and ensure that only those interested in (and suitable for) becoming a volunteer should attend the training day.'

Training

Quote 6.20

'It needs to be fun for leaders, why should I volunteer if I am not going to enjoy it?'

- *Recommendation 9:* ' Project should review and if necessary amend the training programmes in light of criticisms made by previous attendees. In particular projects should place greater emphasis on training for volunteering leadership

role. Projects should look at ways of making the training less of a formal learning experience and more of an informal information exchange.'

Training Walsall:

Quote 6.21

'....it seemed that you had your induction and that's it. It was talk and chalk. We needed someone with experience to come to your area and look at the terrain and give you site guidance.'

Management:

- *Recommendation 10:* 'Projects should draw up a volunteering agreement with all volunteers setting out the rights and responsibilities of both parties.'

Flexibility

Projects could recruit a group of volunteers who would take it in turn to lead the walks. This would allow people to take time off for health problems or family commitments without feeling they were letting the project down. This would alleviate concerns about committing themselves and taking on more than what they can cope with and who may at some future time go on to lead walks. There is a possibility to diversify the tasks on offer. There was only the opportunity of becoming a walk leader, however many people ascribe to the walking for health but do not feel that they could lead a walk. By facilitating some other form of involvement, maybe a walk assistant, the project would retain enthusiastic volunteers who could otherwise be lost. They would certainly be powerful advocates for the project whatever the role they fulfil. Volunteers could also be usefully involved to provide administrative support to the project coordinator. The Leicester project had a walk leader shadow her during the pilot project phase, it was useful to have someone to devise with.

- *Recommendation 11:* 'Projects should endeavour to provide walks at various times to fit in with the lifestyles of walk leaders. Projects should explore the feasibility of introducing a range of alternative volunteer roles in addition to that of walk leaders.'

Walk times could not be flexible as the project coordinator only worked a 3 or 4 day week to extend this at the weekend, there would not be emergency cover, this changed however when the post became full time. The coordinator from Eastbourne was also

only worked 3- days a week. She spent up to 35% of her time on volunteer management, equating to one day in her three-day week. The coordinator felt that the time spent recruiting and managing volunteers was not appreciated at the onset of the project and plans for other walks were on hold until a core team of ten volunteers could be recruited.

Retention and commitment

Teamwork can be beneficial to building commitment. Some volunteers interviewed said that they did not feel a part of a team – they did not have the opportunity to meet other walk leaders and that this was affecting their desire to stay with the project.

- *Recommendation 12:* 'Projects should explore ways of enabling volunteers to feed into the design of their volunteer role and the project as a whole. Regular meetings should be held with volunteers to ensure that personal motivations and needs are being met through the volunteering as far as is possible.'
- *Recommendation 13:* Projects should find appropriate ways of recognising and rewarding volunteers for the contribution they make. This might simply entail a thank you letter or a telephone call and an occasional social event (which would have the added advantage of enabling volunteers to meet together), or a more formal reward scheme such as a certificate or green miles scheme.

Quote 6.22

'As we are walking I get a chance to talk about the effects on health – in a way people can understand. Its re-iterating what I have learnt and my interpersonal skills have improved that's another plus.'

General comments

Being over committed.

Quote 6.23

'I was expected to carry boards, drinks and first aid if I wasn't expected to carry so much and the paperwork. It stress me a bit, I can see the official need but it wasn't me.'

Quote 6.24

'We had been given the impression that we were going to lead the groups, then somebody else came along and I thought why bother? Even given the time factor I would have given up anyway.'

Lack of belonging

Quote 6.25

'I enjoy what I do but I have the feeling that something is not quite right. I feel I want to be committed but something holds me back. When they get more people I shall gracefully bow out.'

Lack of success

One person who had expressed an interest and then decided not to walk had previously volunteered with a similar project. He was disappointed that the project was not following the model of being ' interest walks' which he felt had been its strength. For him the ' Pathway to Health project' was less attractive because:

Quote 6.26

'Walking for enjoyment needed to play a more significant part. Health assessing a persons needs, and particularly the exercise took primary place.'

6.3.9 Active Outcomes end of Year 2 (February 2000 –February 2001)

The project continued to be in the spot light in the second year and there were continued requests for assistance in setting up similar projects in the counties. There was a continued struggle into the Muslim community but in roads were successfully made in all South Asian communities. There were also concerns on GPs and their recommendations to the walks. It was recognised that the project could be more successful in targeting a wider audience locally.

Walking Groups

In July 2001 there were ten active walking groups, shown in table 6.1, that were established under the Chalo Chalay banner, nine were undertaking one walk per week. One of the groups was walking less regularly as the walk leader had found full time employment and was unable to lead the walks. There was a total membership of 136, with an average of 85 walkers per week

Table 6.1 Walking Groups

	Group	*Day/ time*	*Where*	*Member -ship*	*Average Attendance*	*Commence -ment*
1	Belgrave Ladies	Tuesday 10am	Cossington St Library	35	20-22	Before April 2000
2	Loughborough Ladies	Wednesday 10am	Loughborough Health Centre	10	6-8	25th April 2001
3	Bhagini Women's Centre	Wednesday 10.30am		8	5-6	29th November 2000
4	Savera Centre	Wednesday 10.30am		12	7-8	13th December 2000
5	Belgrave Men's	Thursday	Cossington St	18	8-10	Before April

		10am	Park			2000
6	Women's over 55's	Thursday 10am	Cossington St Library	10	6-8	7th December 2000
7	Hamilton Walk	Thursday 4pm	Cranesbill Road	8	5-6	22nd February 2001
8	Sanatan Walking Club	Thursday 6.15pm	Sanatan Community Project	15	8-10	6th October 2000
9	Sunday Strollers	Sunday 10am	Abbey Park Lodge	10	6-8	10th June 2001
10	Bradgate Park	Sundays 3pm		10	6-7	3rd September 2000

Community Groups/ Organisations introduced to Chalo Chalay

Forty-seven groups in Leicester and Leicestershire were introduced to Chalo Chalay since April 2000 – July 2001. Many of these groups were able to start their own walking groups. Some of the organisations expressed an interest but did not take their interest further. Taster walks were provided for a number of the organisations.

Walk Leaders

Since the commencement of the new project coordinator in April 2000 there had been three volunteer walk leaders training days. These had taken place in July 2000, November 2000 and May 2001. Twenty- four participants attended the three-days in total. Seven of these were now active walk leaders.

Marketing and Publicity

The project had used various means of publicity; promotional project literature in English and the five main South Asian languages were made available to those who were interested. Chalo Chalay had appeared in both the Leicester Mail and Leicester Mercury, reflecting a successful run project. The project had also been advertised on Radio Leicester and Sabras Sound – a local South Asian radio station. The coordinator had appeared in the Walking the Way to health promotional video and appearing on MATV Leicestershire's local Asian television channel, he also appeared on ' Health Matters; a weekly show on Channel East, a national South Asian channel based in London. Adverts for the project had appeared on local buses.

Extensive networking had been undertaken with groups, 47 in total, which marketed and advertised the project to groups and its users. Twelve health fairs were attended where

the project was successfully publicised. Pakistani, Sikh and Hindu health fairs had all been attended in an attempt to inform the public of the project. Various forms of media were exploited in an attempt to raise the profile of the project and ensure there was constant coverage of Chalo Chalay in both local and national media.

Finance

The expenses incurred in the period April 2000- June 2001, were detailed in the new coordinators report at the end of the year, it was noted that a most of the budget was being paid out in walk leaders payments, which amounted to £2200 over the period of 25th April 2000 to May 23rd 2001. The overall budget was still held by Leicestershire Health and Confederation of Indian Organisations head office in London. When finance for equipment, publicity and other material were required, the appropriate individuals were approached.

Milestones.

The new coordinator felt that were no major problems with the project but did make a number of modifications upon arrival. The major challenge was to increase the number of walks and walking activators as soon as possible; on his arrival there was two walks per week with two active leaders. The new coordinator besides extensive one to one networking decided to introduce a selection procedure for the volunteer walking activators training days.

Reflection 6.5

From the first training day two walk leaders became active, on the second training day, which the previous coordinator had organised, but had left the post, thus these participants were not followed up. The third training day was organised by the new coordinator, as during the first year of the project only two training days were conducted. The high drop out ratio was due to participants being from professional organisations, and went on to implement health walks in their workplaces. Even though they did not become active walk leaders on the project, they became activators and advocates of the walking for health concept in their respective areas.

The first change to the training implemented was to limit the number of attendees to ten; this allowed quality time with each of the participants. Interviews were held with the

majority of those that were interested ensuring that they were genuine and that they would commit to the scheme once qualified. If the candidate seemed enthusiastic and felt that they could work within the scheme they were invited to attend. These changes had proved to be effective.

At the end of the second year the project was working successfully despite the fact that the coordinator had changed. The project had been recognised by organisations across the country. Coventry and Bristol City Councils as well as community development workers from Northampton, London and Worcester requested assistance in developing schemes in their local area.

The project had genuinely changed the lives of many walkers involved, making them more physically active in their every day lives. Results from the shuttle walk tests have shown that level of fitness have improved over a period of 18 months.

The project had been able to reach all South Asian religious groups, Bengali, Hindu, Muslim and Sikh groups, they had all been visited in an attempted to increase the size of the project. Walkers from all four main religious groups were now involved in the scheme. The majority of the groups are community led. This was one of the major aims at the launch of the project. Walk leaders have been encouraged to be 'the boss' and take ownership of their respective groups, which they have achieved successfully. Sustainability had been developed; the walkers have a strong belonging to their walking groups and would like to continue the walks on a permanent basis.

Nationally

In March 2001 four further national bids for Walking the Way to Health initiatives had gone through and received funding. There were over 60 names on the database from Leicestershire that were interested in walking schemes.

Equipment

Further mobile phones were purchased, as safety was a major issue the finance for incentives were ongoing, nationally t-shirts were produced and given to walk leaders. Items, which were essential, such as mobiles phones, sweatshirts, waterproof gear and trainers were priority to receive funding for.

Recruitment of Women and Muslim Groups

The new co-ordinator was male, this was perceived as a problem, in particular targeting women. It was resolved quickly due to the trained volunteer, who had continued the group, and had also been doing outreach work, using her influences to recruit more women onto the project. The walkers, naturally compared the styles of each co-ordinator, and are still adjusting to the change. Having a male on board had helped to recruit Muslim groups, which also was an ongoing problem. This had been resolved by collaborating with Dieticians in the areas who have good links within the community, the project for the Muslim community was launched in August 2000.

Recruitment of Leicester City Walking Project Coordinator (Let's Walk Leicester)

A five-year walking project coordinator had been appointed and was based at the Health Promotion Agency. The post commenced in April 2001, it was not quite clarified how the coordinator will be involved with the Chalo Chalay project, but it was suggested that the two project steering groups should be kept separate and would feed back through the Exercise Alliance group for Leicester, Leicestershire & Rutland. There was a concern about the number of representatives from the Health Promotion Agency sitting on the steering group at the end of year two there were 4, and now with the possibility of the coordinator there would be 5, the agency decided that the Manager of Physical Activity in the city locality, and the exercise specialist would attend.

Reflection 6.6

The Health Promotion Agency had decided to go for a city wide post for the promotion of walking for health, considering the project was already in existence, would have it not been better to build upon the good practices already in place instead of reinventing the wheel? This was a first for Leicester, where a Black and Asian lead project was leading the way and thus had been mainstreamed to other communities.

Recruitment of Exercise Referral Coordinator Leicester City

The Health Promotion Agency had also recruited an Exercise Referral Coordinator for Leicester City her remit was to expand the exercise referral scheme.

Future Work

The project in the final year would have liked to address the gap, of not having young people involved in the scheme, this would have needed other areas of Leicester City to be exploited. The new coordinator did not doubt that Chalo Chalay would continue to be a success in the final year provided that the relevant levels of specialist support would be given to walk leaders and other interested parties. Most of the avenues in Leicester are to be explored by the project deadline date of March 2002.

The walkers were keen to continue their led walks on a regular basis, and many of the participants of Chalo Chalay saw it as a regular part of their lives. The new coordinator recommend that a specialist in community work would be required to communicate with those involved, providing support and coordination. The groups would continue and expand successfully, if the relevant support from the relevant individuals was to be given.

6.3.10 Bid for Further Funding

The funding period ended in March 2002, discussions were held on the linkages to the Let's Walk Leicester Project and avenues of funding and links into Primary Care Trusts. The steering group agreed that the project needed to be developed as well as maintain its successes. The National Walking the Way to Health initiative was likely to provide additional funding for a re-focussed project. Suggestions for the new project included:

- Other geographical areas across Leicester/ Leicestershire.
- Targeting other faith groups.
- Young People.
- Linking to GP recommendations and cardiac rehabilitation programmes.
- A female worker.
- Links to project Dil.
- Support for walk leaders.
- The fit with the Leicester Project.
- Links to the Leicester Transport Plan and Walking Strategy.

Draft Project Plan.

The components included in the draft were:

- Confederation of Indian Organisations reorganisation was occurring there would be a devolved structure.
- Walk leaders packs to be created into a filo-fax style.
- A calendar of religious festivals and practices to be included.
- A new approach to GP referral and involvement to be established.
- There would be a phased development of new projects.
- Evaluation in progress, but further work to be continued from the new baseline.
- The partnership was to be widened.

Interim Project Management Proposal April 2002 – July 2002

In order for the project to ensure a successful bid to the Countryside Agency, the Health Promotion Agency agreed to financially support the project on the following terms:

The Health Promotion Agency would:

- Provide financial support for a two and half day project coordinator for 4 months, which amounted to £4,250.
- Agree a joint work programme with the Confederation of Indian Organisations.
- Provide desk and administration support 1 day a week for the project coordinator to enable closer working and peer support with the Let's Walk Leicester programme.
- Provide walk leaders resources via the Let's Walk Leicester programme.
- Support the project coordinator to engage local partners to develop the future Chalo Chalay project.
- Provide advice to improve the grant application as highlighted by the Countryside Agency.
- Include the work of Chalo Chalay as part of the Health Promotion Agency's wider physical activity programme.
- Create an environment, which develops closer links with the Let's Walk Leicester Programme.

The Confederation Of Indian Organisations would:

- Agree a joint work programme with Health Promotion Agency.

- Place the project coordinator within the Health Promotion Agency for 1 day per week for four months and if a Walking for Health Initiative bid is successful for the next 3 years.
- Develop the Chalo Chalay steering group to include community-based representatives.
- In preparation for the Countryside Agency grant, develop partnerships within the Belgrave area and fully explore funding options e.g. Eastern Leicester Primary Care Trust, Project Dil, and Belgrave Health Forum.
- Provide a full break down of project costs April 2000 – March 2002.
- Obtain the remaining funding from Leicestershire Health Authority (£6,000) by December 2001).
- Develop a regular programme of walk leader network sessions.
- Develop community ownership of the project to ensure its future sustainability.
- Continue the 1-day per week base of the project coordinator at the Health Promotion over the next 3 years of the project.

Health Promotion Agency Business Plan Performa

The Let Walk Leicester project included Chalo Chalay in its development and envisaged a number of links being made. The drivers of the Chalo Chalay programme would be Health Improvement Plans, National Service frameworks, Leicester, Leicestershire and Rutland Physical Activity Strategy.

Reflection 6.7

In February 2002 the first network meeting took place, it was agreed that it had a positive impact, and the idea of a regular monthly meeting was discussed. The Let's Walk Leicester Walking coordinator felt that her role was misunderstood that day, and she would write to them all clarifying her role. The regional manager of the CIO office Leicester explained that the Walking Activators were anxious about the future of the project. The walk leaders wanted Chalo Chalay to keep its identity. Confederations of Indian Organisations were clear about the Let Walk Leicester coordinator role and it was fully understood. Chalo Chalay cleared this with all of its participants. The manager highlighted the need for the continuation of the project to be on a full time basis. The community needed high levels of support from organisations such as the Confederation of Indian Organisations. Volunteers would need to take a proactive role.

6.4 Summary

The summary begins with outlining the difficulties recruiting a new project coordinator and the re-writing of operational strategies. The lack of support from partners is highlighted and the failure of the recruitment of qualified exercise instructors. Successes are reported on the walking groups set up in year one but then goes onto describe the lack of BEM representation on a national level. The project widened its network and began to work in other localities and became more inclusive of the Muslim community. As the project progressed it had difficulties retaining walk leaders and walkers. The summary then details the events leading of to the project coordinators resignation and the effect this had. During this process it highlighted the problems with the financial management structure. It continually faced management problems and identified closed partnerships. The summary then described the new era and the changes made with the recruitment of a new project coordinator. There was a new direction and philosophy of the project. Progression of strand two & three is described together with the evaluation and recommendations made from all four-demonstration projects. The summary ends with the report from the institute of volunteering amalgamating quotes from the interviewees and the active outcomes of year two.

The second year of the intervention was a testing time with the resignation of the project coordinator and the recruitment of a replacement. This had an affect on the research direction as the action researcher changed roles in the project, from being the project coordinator, to walking activator/ advisor and evaluator of the project. It was a beneficial move as the process helped reflect upon actions taken more critically, as previous boundaries were blurred. The new recruit that joined in April 2000 provided the opportunity to look critically at the way in which the project had developed as it reached its delivery phase.

Strand one of the project had been successfully completed and the intervention was ready to be delivered. At this stage the operational strategies that were written, were reworked. Implementation on a larger scale was difficult task due to the top-heavy structure in terms of the steering group and management. The steering group progressively became less productive and could not really make decisions without holding the purse strings. The budget was held in two places, one at the Leicestershire Health and the other at the London CIO Office. The set-up was frustrating and slowed

actions right down. Operational matters were often discussed at the steering group, and time was wasted as these matters could be resolved, if responsibility were given to the coordinator. The basics were not in place for the project to move forward in a professional way. The coordinator often played messenger between the steering group and management at CIO. The supervisor was not helpful, and did not turn up to meetings. The national WFH coordinator writing to the director at CIO resolved this. The most frustrating thing was that the coordinator could work often very well with the director of CIO as decisions were made instantly and that was all that was needed instead of fruitlessly going around in circles. Sometimes things were often made more complicated than they really were and partner organisations often hid behind policies and procedures, instead of seeing the clarity and logic of the situation. Logic was however very pronounce at a grass root level and if an operational group was set up, it may have been set up to fail as they would have never been able to see eye to eye. It was an in house partnership problem in which all the directors needed to sit down and sort it out, instead of getting workers involved.

There was a continuing lack of support from the host organisations. Thus, support from outside agencies such as the Health Promotion Centre, Leicestershire Health and the other demonstration projects; eased some of the frustrations, however the core problem persisted to grow. Further support was received from the community groups, the good practice shown with the pilots was slowly filtering through and community groups were coming on board.

The strategy of qualified exercise leaders to lead the walks had failed, as most held day time jobs, instead a capacity building approach described by Crisp *et al* (2000) was opted for whereby;

'A community organising approach in which individual community members are drawn into forming new organisations or joining existing ones to improve the health of community members'

This was delivered by offering the volunteer walking activators further training, as in the example of the women's group walk leader who was sponsored to do the accredited YMCA circuit training course. From which she went on to set up an exercise to music class's at St Gabriel's Community Centre, and formalised the exercises classes held at Belgrave Neighbourhood Centre. Realising the potential of this she went onto to do Project Dil's peer education programme, which gave her the skills to incorporate healthy

eating into her sessions and preventive measures against heart disease. These qualifications not only have given her sufficient skills to help improve the health of all individuals that attended her sessions but has given her a small income and could provide her with paid employment; thus addressing the issue of health and also directly addressing the issue of inequality and deprivation.

The walking group set up in strand one continued to reach significant milestones such as walking outside the group evidenced; by the request of pedometers so that the walkers could measured how much they were walking, and also developing their own routes and discovering their environment. In a short period of time evidence was gathered on one of the main objectives of the national WHI and Countryside Agency to open up environments. However, changes in the local environment needed to be addressed before users of wheel chairs could access walking routes as the project gathered evidence via the Vishmo walking group.

Throughout the project there had been a lack of evidence that constructive actions were being taken to address the lack of participation of Black and Ethic Minority communities in physical activity and walking. The partnership and funders seemed to have done extensive research but there was no delivery of other such intervention besides Belgrave in Leicester. The other demonstration projects were looking to Leicester to pave the way and were attempting to be inclusive of all their communities. There was a lack of overall guidance from the funders, who may of have been premature to think that providing funding for a scheme in Leicester is enough. This was demonstrated at the lack of delegates from the BEM communities at the national walking the way to health conference. It had been obvious that the ground work and targeted publicity did not occur, resources for the funders would have not been a problem, so why was this not done? The irony of the situation was that the conference was held in Leicester where a third of its population come from BEM communities, it was an opportunity missed yet again. Often the project attended conferences and workshops on physical activity and sport, and often it was the only BEM project, there was a long way to go, but targeted publicity from national organisations such as the British Heart Foundation and Countryside Agency should be a basic principle. Further evidence of the lack of action was presented at the Active for Life briefing conference in 1999. Whereby a handful of BEM projects were presented however, lacked coordination and research to disseminate

these good practices. Even at these conferences senior officers such as the regional coordinator from the Health Education Authority looked at Chalo Chalay for detailed logistical information of how to run a project of this nature at an operational level.

The project widened its networks and thus the scope of the project, it aimed to put walking on the agenda of key organisations in Belgrave, but also of strategic players such as the Leicestershire and Rutland Sports Recreation Forum. An awareness was raised but unfortunately no organisation was leading the way of BEM communities in sports at such time, however walking was on the agenda and again recognition was given to address inequalities in deprived communities and ways of promotion. Liaison with the Rambler's Association began to address some of these issues, and inroads were made so that future Chalo Chalay walkers could go onto the next level and thus fulfilled the community cohesion agenda. Networking extended regionally and nationally, many visits were made to the project to learn how it was working, thus the intervention was unique in its concept, and raising awareness was key.

A major milestone was reached as the intervention laid foundations to widen its geographical area to Highfields which predominantly housed a large Muslim community, it created the opportunity to work with Muslim women in particular, who were the most deprived compared to other communities. The launch of the walks at the Spinney Hill Park were supported and guided by the project in conjunction with the Spinney Hill Health Centre and its committed health visitors. This was the commencement of action for strand two of the project and was the basis to develop the GP referrals programme. A sub group was formed to plan for this strand of the project, it coordinated the objectives of the Exercise Referral Scheme and Project Dil, and both were in position to deliver the operational strategy of year two of the project. Clear guidelines needed to be written between all three initiatives. There were firm commitments from each of the partners.

The project had a major challenge of retaining walk leaders and walkers, thus a major theme of the second year was the incentive scheme similar to the ground miles scheme happening at the Walsall demonstration project. These types of schemes kept individuals motivated to come back each week. A second major challenge was to increase the number of participants on the programme; the funders had stipulated this. The project

had been set up to be a demonstration however numbers meant money. It was decided to widen the geographical boundary to meet this stipulation, which was twofold; to increase numbers but also to target the Muslim community as the project had been criticised for not being inclusive.

The project saw a change in coordinators, and survived, a number of events lead up to the coordinator resignation, which were both unfortunate and preventable. Knowing the pre history of the CIO Leicester office and the political games the London office played it was difficult to stay in an organisation whose ethics lacked. The problems were two fold; the ethos of the organisation and the professional/ personal relationships between staff members both brought negative vibes into the office. Prejudice behaviour was unacceptable and the members of staff concern were not tolerated and contracts were not renewed. This had left the organisation in a difficult position and set backs were endured until staff were replaced in particular the administration support. The coordinator knew that the basic functions of the organisation were not in place such as the administration and the management, prior to the hosting arrangement of the Chalo Chalay project. These were raised formally and indirectly but came to no avail, as higher-level politics were played. The project may have been totally different if a secondment to the HPC or Loughborough University had occurred during this awkward period.

Prior to the project the points in case record 6.3 in relation to the job description and contract were raised. The coordinator felt that a fair deal was not given as a project management role was being undertaken, the job description and salary did not reflect this. Negotiations were not taken on board and the coordinator felt under estimated, together with previous management problems, friction escalated. The job was re-advertised the salary was increased in accordance to the job description.

The basic management components of the financial administration system had to be set up and no agreement could be made on a system, which should have been easy and quick to access. Time was wasted throughout the project and tensions increased, the bureaucracy of the whole system could not be penetrated. These should have been made clear at the signing of contracts stage for the project, and not 'made up as the project progressed' it was naive to think that a statutory procedure from Leicestershire Health could be transferred to a voluntary set up and vice versa. Thus, access to no funds and

no administrative support lead the coordinator continually being stressed. No real management direction to the project existed, as the steering group were advisory and had no power to make operational changes. It may have been more useful to have a focus group format and one dedicated external supervisor, this would have been much more productive.

The persistent management problems became apparent to the steering group and partners but they could not help, as it was the host organisations internal matter. The project sought support from outside agencies and fellow Black workers. With the reputation of the host organisation being tarnished partner organisations in particular tried to be 'allies' but were patronising in the process as stated in reflection 6.3. Evidence of passing the buck is demonstrated by all work relating to the South Asian community being passed onto Black workers. The internal politics of the HPC at the time could be classed as institutional racism, as tokenism of working for the BEM communities. If the Black worker were not in post there would have not been a relationship between the sectors. This could have been demonstrated if any member of the community or workers from the Black voluntary sector were to be ask 'Do you know of the Health Promotion Centre and what it has to offer?' Things have slowly changed, but the project felt the ripples of this change.

Evidence of 'closed partnerships' was shown during the study period, which were sourced from being unprofessional and judgements made towards the host organisation. The fire was further fuelled from a lack of trust between key workers and steering group members on the project. This pushed the project to become more self-sustainable in its support mechanisms and survived these set backs and put it in good stead with the 'real people' of the project, the walking activators and walkers.

All the above events and the lack of negotiation forced the coordinator to seriously think whether change was ever possible in particular with deep-rooted issues within each organisations internal politics. A series of meetings were held with all directors to address and to find compromising solutions however the culture of both sectors, the voluntary and the statuary were totally different, but not impossible if change were embraced. Ironically this was what the project was out to deliver, behaviour change. However, the partnership was out of synchronicity, in that the project had made preparations for

behaviour change and walkers were ready to change, but the in house partnership which was seen as a strong partnership were not prepared for this new way of working.

Everyone sets themselves standards, whether these are personal or professional; and when these standards are lowered its up to the individual or if in a team the group to decide whether these standards can be brought up or whether too bow out gracefully. This was the coordinator's dilemma, in order to bring standards up, a game needed to be played, which were beyond the coordinator values, and often its better to step away from a situation to give constructive help and provide solutions. It was not the pettiness of the management structures; which would of eventually been resolved that pushed the resignation of the coordinator, but the ethos of the individuals concerned, and having to lower personal standards to accommodate these games, this the coordinator would not entertain. Moving away, and not being employed by any of the partner organisations, put the coordinator and action researcher in a better position to continue working at a grassroots level that is continue leading walks, and being neutral in an advisory role on the steering group.

The project went into a new era with fresh new blood, a young South Asian man, who had previous experience in sport development. The post was advertised at a higher salary, evidence that monies were available in the budget and the true scale of the post. It was not about the money, but the recognition of posts in the Black voluntary sector are of the same if not more important than similar posts offered in the statuary sector. Having the correct grades increased respect of the worker in the field. The project truly deserved a full time post and thus a milestone was reached, which emanated from drastic action.

Positive changes at the host organisation happened at the same time the new coordinator was recruited, a whole new staff team was in post including the new regional manager, it moved into new premises, thus a brand new start to the second strand of the project. With the proper management mechanisms in place, the project lost the focus of its steering group with the resignation of the Chair the Director of Health Promotion. This suggested that he did have a lot of influence over partners and was a key individual in pushing the projects agendas forward. Thus, the project had finally gained internal

support but at the expense of external the steering group. This could take the direction and steer of the project to a new destination.

The change in direction and philosophy came immediately as the new coordinator was appointed. The issues of targeting more Ethnic Minority groups were addressed via the expansion of the geographical boundary to be inclusive of more of the Muslim community. The second major change was the payment of walking activators; the decision was made to address the lack of volunteers. Payment was seen as an incentive, this seemed at the time a hasty decision, because the project were pushed to increase the number of walkers. It might have been beneficial to wait until the recommendations from the research by the Institute of Volunteering were released. The repercussions of these decisions were hypothesised to have an unsustainable initiative. The philosophy of the project was *volunteer* walking activators and ownership; it never wanted to create an environment whereby community members were motivated by payment. Only time would tell how this would work.

Expanding the project brought with it new challenges, the Highfields area was different in its physical make up, and there were not enough pleasant walk routes and were up hill. The project took the route of transporting walkers to other areas. This option made the walkers more dependent on the project to organise the transport. The new mini project had a launch of its own via the Spinney Hill Millennium Walk; this launch renewed interest in the project. Throughout the second year constant coverage in the media was aimed for, sensitivity at targeting all religious events on the calendar was also aimed for.

The initial plans for strand two of the project, that is the CHD and GP referral components were slow to progress. GP's were slow to take on the idea, and to get GP's to come on walks was an impossible task. Health visitors and nurses showed more of an interest and were trained as walking activators in the Highfields locality. This worked well and the health visitors were leaning more on the side of being activators than actually walk leaders.

The strand was dependent on the development of other projects, and thus often the projects were out of synchronicity, but work towards the same goals and outputs. Project Dil in particular like Chalo Chalay were at experimental phases and were learning new

ways of working. Thus implementation into Chalo Chalay was delayed. Project Dil's peer educators were an imperative source for the project. It was looking towards, making the training more user friendly, for those who did not even have any basic English and translating the course into the five main South Asian languages.

Project Dil's main focus was the training of GP practices of good CHD practice within South Asian communities. This was a platform to integrate GP walking referral strand two, coordinated by all three initiatives (Chalo Chalay, Exercise on prescription and Project Dil: the sub group partnership). These were the first steps of getting GPs and practices on board, the main barriers were time and the perception of insurance issues, both were addressed by the sub group partnership. A practice in Belgrave was targeted during this period to formalise referral procedures.

The exercise of prescription scheme was facing a challenge of the lack of Asian participants (Radcliffe 1998), the main barrier was the lack of appropriate facilities, thus Chalo Chalay was ideal, as it short circuited the whole process by not being facility based.

The second strand was thus developed in partnership with project Dil and the Exercise on Prescription Scheme, a protocol was written so that it benefited all partners. The physical activity component of Project Dil's training incorporated the knowledge and expertise from Chalo Chalay and the Exercise on Prescription scheme. It allowed the peer educators to take advantage of the training offered by the latter two initiatives. Whilst the Exercise on prescription scheme benefited from Project Dil as it had access to practices previously presenting barriers and providing a tailored physical activity via Chalo Chalay.

The Chalo Chalay project worked with all the environmental initiatives as stated in section 6.3.6 closely. The initiatives were investment driven and these took time to come on board and were not in synchronicity with the project. From a community consultation angle the residents were clearly not happy with the proposed plans and the local authority needed to work with the community, instead of offering options. The environmental strand of the project was long term and through the walkers effective changes were identified, quick fixes such as seating, lighting, uneven payments were resolved, but ongoing was the Cossington Park area and parking for residents. It can be stipulated that

if the changes were made as planned and in line with the project, it would have created a better and safer walking environment.

The evaluation of all four-demonstration projects showed similarities in their development, implementation and support phases. These will be further discussed in section 8.3.2 in drawing up a framework for the promotion of walking for health. The key steps in the development of the projects were; writing of developmental plans, identification of funding, an audit of stakeholders, deliverers and opportunities, working with existing strategic frameworks, identification of partners and steering group, defining aims and objectives, setting a project structure and timeline, recruitment of project coordinator, pilot projects and working with the local community.

The project implementation process from the evaluation of all the projects identified three key tasks; revisiting a project time line and identifying realistic progress; implementing community development; and project marketing and publicity. The setting of realistic targets was a challenge and these had to be revisited every three months. This was pronounced in the Chalo Chalay project, as a number of individuals were involved in the planning phase and often was not realistic in the timeframe setting, revisiting plans often allowed for change to meet the needs of the stakeholders. Involving the community was a long and challenging process but trust had to be built and this took time. The challenge with project marketing was to develop new and innovative ways to market walking and walking programmes, and new angles on walking related publicity.

Project support were identified via eight areas; partnerships; personal support for project workers; funding and resources; external advice and information; training; evaluation; volunteers and marketing and publicity. Across these areas it was important to help the partners to communicate openly and honestly about why they were part of the project, what they expected to get and what they could contribute. Another important aspect across the project was making mistakes and allowing room for learning and making change. Support was also received from external agencies; however the challenge was the need to reconcile tension between best values or local authority to project agenda versus joined up thinking, and gaining local political awareness. In terms of training all projects felt that the challenge was, who was available locally and nationally to deliver walk leader training and co-ordinator training.

Recommendations were made by all the projects these will be further discussed in Chapter 10. It was encouraging to see that some of the recommendations from the evaluation workshop were implemented by the Countryside Agency and the demonstration projects. The recommendations set a direction for the Walking the Way to Health Initiative and built upon the hard work of the Countryside Agency, the four demonstration projects and the contribution of all the volunteers and participants. Each national demonstration project identified three common stages: Project Development, Implementation and Support. Over 20 key steps for projects were identified across the three stages. These steps are typical of other types of health promotion projects that are moving from "conception to action."

The understating of the concept of volunteering in South Asian community was essential in this study. Evidence was shown from the Institute of Volunteering report (2000) that Black and Asian people were more involved in volunteering at the informal neighbourhood level rather than through an organisational group. The project supported the national findings of barriers to volunteering for the South Asian community. Women in particular found it difficult to volunteer their time due to family commitments:

Quote 6.27

'I am telling no end of people, but it is very hard for Asian ladies to get out.'

In general motivations for South Asian communities was about helping others rather than the formal concept of volunteering and acquiring new skills. Thus the Chalo Chalay project endeavoured to promote its walking activator role in such a manner.

The report stipulated that the recruitment drive should be wider and that most of the non-volunteers had heard of the initiative in their communities:

Quote 6.28

'On Wednesday evenings at our neighbourhood centre there are around 60-100 women....someone should go and talk to them and get more walkers.'

Quote 6.29

'I would like to see more adverts in free magazines and would like to see more like this in my own area of Humberstone as there is nothing at all like this'

Quote 6.30

'It needs to be made more aware in all different cultures. I've not see it anywhere I live actually.'

Some of the individual interviewed said that volunteering opportunity did give individuals the skills to secure employment:

Quote 6.31

'reward them... give them training courses and this will help them to getting a proper job. That's what I have found in my life.'

One of the walk leaders had gone onto to find full time work, this was a contradiction to previous findings however there were difference in age brackets of these stipulations, and hence adds to the argument of generation differences and thinking.

Those walk leaders that had volunteered onto the project did so because of their own health and social well being in particular relieving depression and naturally progressed from being a walker to a walk leader;

Quote 6.32

'I never wanted to get involved as a walk leader, but the leader sometimes couldn't take the walks, so she would ask me as she knew that I could do it. Then she asked me to take the training, and after that I just sort of became a walk leader.'

Quote 6.33

'I tried it a couple of times and it really helps me I needed help and I thought I'm helping everyone else.'

The leaders felt that they were genuinely making a difference in people lives and the atmosphere of the group; the strong friendships made motivated them.

The lack of support throughout the project rippled towards that walk leaders they felt that the host organisation could have been more responsible of operational matters. They disliked the degree of responsibility they held but were obliged towards the walkers:

Quote 6.34

'They like my company so much. When I wasn't there so many people dropped out.....they wanted a Wednesday group, but I doubt they would go on it unless I was the walk leader. They prefer me as we have been together for a long while.'

Quote 6.35

We take on quite a lot. If one of us doesn't come, the other always makes sure that the group keeps on going.'

Quote 6.36

'I don't want all these responsibilities. So many times I have wanted to quit but then I think all these people will not walk.'

It was accepted that structure were not in place to recognised volunteers, but attempts were made to give volunteers recognition in kind such as paying for socials. However, when the philosophy of the project changed, these were assumed to be encompassed in the payment of the leaders. The walk leaders felt that they had no influence on the project. With previous arrangements prior to the new coordinator joining, a mechanism was in place to receive feedback, but the focus of the project had changed into a strategic one, and this element became aloof. There was a clear difference in the way the project had been coordinated with two very different styles. This had an affect on the walk leaders more so than any other strand of the project, and left the leaders unsatisfied.

The reasons of those who had come onto the training programme and did not volunteer was due to the lack of time, and the underestimation of how much time commitment was needed for the project. This was a vicious circle for the project, in that the lack of volunteers added pressure on current volunteers. The time element could have solved itself even if volunteers committed to leading one walk a week, which would mean that the other volunteers could do the same. The project in all other aspects were recruiting volunteers but time seemed to be the main barrier this could have been resolved by running walks during the evenings and weekend;

Quote 6.37

'It was flexible, but flexible during the daytime...not evening, when I would have more time.'

'Weekend would be great....I would consider doing it.'

There was lack in a continuing training programme:

Quote 6.38

'I would like to learn more kinds of things around helping people.'

Quote 6.39

'Never even had a map or told that you walk this way or that.'

Quote 6.40

'I am doing peer education course...through which I have to do 45 hours of voluntary service communicating health promotion to the community.'

The project should have filled these gaps by consulting more with recruited volunteers. These training dissatisfactions were further stipulated:

Quote 6.41

'One or half days training is not enough. You have to know about exercising. You have to be able to talk to people...you need more.'

Another said that they had not be informed properly and that they;

Quote 6.42

'Just went there and they took us around. It should be extended into a whole weekend, so we know how to make people enjoy the walk and have more information and guidance.'

Others felt that they did not receive all the information they would of liked:

Quote 6.43

'...general exercise and cool down. I would have liked more information about specific health problems and how to encourage them (walkers) more and what would have helped them.'

A more personalised approached was suggested by another attendee;

Quote 6.44

'Individual training would have helped me to understand better...there should have been more walk leaders to train each person.'

In contrast, one training attendee found the input from the coordinator helpful:

Quote 6.45

'The way she explained it was that even if you didn't want to volunteer, you would do it.'

Quote 6.46

'One days training with Chalo Chalay is not enough. Teaching physiology to someone who doesn't know about it can be dangerous...you need to teach it properly.'

Quote 6.47

'You need to be well adjusted in all terms; therefore you need to build other things around it. All those links have to be built as well. It is quite important that there is somewhere they can have coffee afterwards. Its not just health, its emotional as well, because some of them may be on their own.'

These concerns meant that those that were being trained were not confident in leading walks, and ongoing support and training may have changed this attitude. These constructive criticisms should have been taken on board and moulded further training sessions. These issues were addressed as stated by the project coordinator:

Quote 6.48

'the right ones have not been chosen in the past. It was too open as to who has been involved to go on training....it was basically anyone who showed an interest.'

Quote 6.49

'Mass marketing is not the right way of marketing in the community, individual contact it better.'

One of the training attendees agreed with this:

Quote 6.50

'a personal approach is better.....rather than leaflets, people are more reserved that way'

A more selective approach to recruitment occurred and to use current volunteers to be involved in the training. It has to be noted that the period these interviews were carried out was when the coordinator had only been in post four months and the project was undergoing change.

Evidence was presented that the notion of formal volunteering was not acceptable to the South Asian community, but promoting it on the basis of '*Seva*' or serving was widely accepted. Evidence of the lack of understanding of the South Asian community:

Quote 6.51

'They came once, but don't come back. Its not in their culture to walk.'

The scope of the project was to break these misconceptions. The marketing approach, which are designed for the general public would not work as suggested by Leicester Volunteer Centre, instead tailored targeted marketing was aimed for.

Two major volunteering organisations that were included in the report were Voluntary Action Leicester and the Leicester Volunteer Centre both showed a lack of understanding to fine details of working with the South Asian community. Both organisations stipulated general support and media campaigns when clearly these were failing, by the actual number of South Asian volunteering at both organisations. There was a perception that the host organisation was trying to address volunteering, but it was Chalo Chalay on a small scale that were producing the Walking Activators roles which were different to 'volunteers'.

The Leicester project could not really be compared to other similar projects happening in the south of the country as none had the inclusion of Ethnic Minority communities.

However, the project could relate to some of the basic logistics of working with volunteers. Such as not wanting to take a leader role but wanting to be apart of the group, this can be explained, by the group dynamics of the men's group who in a sense, were all equally apart of the group, and had not pushed for a leader. This was apart of the *'seva'* concept in serving all equally.

Many of the volunteers were satisfied with their volunteering. Benefits noted included personal gains such as the development of their skills, the gaining of experience, the maintenance and improvement of fitness, and meeting people. It also included altruistic aspects such as a sense of achievement by helping individuals in the community. However, volunteers could become demoralised in their involvement. The reasons for this were the lack of support, training, appreciation and a feeling that they did not belong to the scheme and had no influence over their work. Some expressed anxiety about the level of responsibility they were asked to take on, while others felt they were wasting their time because of the failure of the scheme to recruit sufficient walk participants. Bureaucracy was a big turn off for most volunteers, who complained about the volume of forms to fill in and their concerns were heighten by a lack of shelter for people to use in bad weather. The warm ups and cool down stretches troubled many, for some it was forgetting what to do and when, while others felt embarrassed conducting the warm- up exercises in public.

For those not going on to volunteer, time pressure was a major reason. Many of those who worked decided that they could not lead walks as well. Weekend walks were not taken up; when the option was available, but some walk leaders stipulated that they would take these opportunities up. Flexibility was an issue on several levels besides the timing of the walks; it was the way in which the walks were organised. In Eastbourne leaders were not able to vary the route, a restriction that was criticised by non-volunteers. One of the walk leaders indicated that a fixed starting and endpoints restricted variation. The ability of leaders to make judgements on who was attending the walk and to vary the walk accordingly was seen as important.

Training was a major issue, there were criticisms both of the content and style by walk leaders that were undertaking health walks. Some attendees said that it did little to allay fears and instil confidence in those who were unsure about leading and there was a

general feeling that the training tended to focus too much on the health aspects of the walk and too little on the volunteering.

The twelve recommendations made from the report on recruitment, motivation, inclusive of BEM communities, selection, training, management, flexibility were taken on board and implemented in the final year of the project, some were more applicable to the Leicester project than others. The issue of volunteering as a walk leader was summed up in quote 6.52; the bureaucracies of the project sometimes counter affected the health of the walkers.

Quote 6.52

' There surely must be a way of encouraging people to walk and exercise without obsessive blizzard of paper being showered on them. I actually found this disturbing, intrusive and ultimately a disincentive to be further involved. A lot of older people are understandably wary, even frightened of giving personal information on forms. A few who sampled the project made this point to me and in the end, the exercise becomes counter productive.'

The active outcomes of year two of the project were impressive, and the change from part time to full time was seen and felt by the walking activators. Ten walks per week were running with an average of 85 walkers per week lead by 11 walk leaders, there was a membership of 136 as shown from table 6.1 The new coordinator had effectively made changes that increased the number of walkers, walk leaders and walks. These however were influenced by the payment of walk leaders, which previously was not happening. There was a number of reasons for the increase in the number of walks; the widening of the geographical boundary, the fruits of the foundation that had been set; and the full time hours that were allocated to implement the project. The changes made to the training were successful, having a selection process and limiting it to only ten participants.

The project had change lives via behaviour change of the walkers; evidence of this was presented by the shuttle walk tests. A weakness of the project that had been the inclusion of all religious groups within the South Asian community, this had been achieved by widening the geographical boundary and having a targeted recruitment campaign. Of particular concern was the recruitment of Muslim community, which was addressed, and the male coordinator found it easier to make in roads to facilitate this.

The project attracted interest from regional and national projects, which had benefited from visiting and meeting with Chalo Chalay and facilitated setting up their own projects in their regions, there were 60 such projects in Leicestershire alone. This had put Leicester in good stead for leading the way, and from this money was secured by the Health Promotion Agency for a five-year post of a Walking for Health Coordinator for the whole of the city the Let's Walk Leicester programme. Chalo Chalay a Black project had led the way as stated in reflection 6.6. There may have been confusion in the similarity of the names, but the HPA were getting the limelight. In essence, it felt like the Chalo Chalay project was used to secure this additional money from the Health Action Zone, without even consulting with Chalo Chalay, it needed to go hand in hand with the project rather than becoming a separate entity.

The project coordinator stipulated that the Chalo Chalay project would continue its success into the final year if specialist community help was provided, this suggests that he, too like the previous coordinator felt the lack of support from partners around the table.

The project-funding period came to an end in March 2002; prior to this endeavours were made to secure further funding from the walking the way to health initiative. The project would continue to build on the foundation but would refocus to widen its participation in other geographical areas and the inclusion of young people. It envisaged making stronger links into strategies such as the Leicester Transport Plan and Walking Strategy and pushing GP referrals and cardiac rehabilitation programs. Due to the delay in the submission of the bid an interim project management proposal for the period of April 2002 – July 2002 was agreed with the Health Promotion Agency (HPA) who funded £4,250 for the four-month period. Terms and conditions were agreed, but to a degree were dictated by the HPA, a key condition was that the coordinator would be based at the HPA for one day a week. It seemed the project had come a full circle, as this was what was stipulated three years ago, however, the project was in a different phase and may necessarily not need to be based at the HPA, but out in the community. These terms and conditions were really a little too late, if presented three years ago, they would have been ideal and suited to the situation, but came at a time where it would have been patronising to the host organisation, and projected that the Chalo Chalay project should

just be amalgamated into the Let's Walk Leicester programme. Evidence of this can be seen in the; Health Promotion Agency Business plan performa for the Let Walk Leicester project which included Chalo Chalay on the assumption that Confederation of Indian Organisations (CIO) would agree the work programme and Walking for Health grant would be achieved for the next 3 years. Naturally CIO was not happy with these decisions, as the post had gone back to being part time, and the work plan mirrored the Let's Walk Leicester programme. There was a perception that HPA were trying to take over the Chalo Chalay Project as stated in reflection 6.7 and there was genuine concern from the walkers that the project should retain its own identity.

There were a number of issues raised at the end of year two of the project, which had to be addressed in the final year, but a key challenge was the sustainability of the walks set up.