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

by

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Chapter Seven

Results: Intervention Sustainability

The longest journey begins with a single step.

Lao Tsu Tao Te Ching

7.1 Introduction

This chapter concentrates on post intervention activities; it commences by outlining the exit strategy of the intervention and ends the formal intervention phase. The chapter then proceeds to the qualitative interviews. The data gave an overall picture of what all participants thought and gave a true picture of the project. Sustainability was the ultimate aim of project, and events and the qualitative interviews demonstrated this. The chapter ends by discussing the viewpoints of the interviewee's and recommendations are made in chapter ten.

7.2 Method

A series of fifty-two interviews between November 2000 and December 2002 were held with walkers, walk leaders and key people in the project, in particular the steering group. An interview schedule was set up and a series of questions were devised, and were ask by one interviewer, prompts were given if interviewees got stuck. Interviews were carried out in English and Gujarati. In the latter questions were asked in Gujarti but transcribed in English. All interviews were audiotape recorded and if done in Gujarati were translated by the interviewer and validated by sending a copy to the interviewee. All quotes in the chapter are from the original transcripts.

Walkers

Interviews were held with 42 walkers, 29 Women and 13 men, all were South Asian and aged between 48 to 72 years. They all came from the Belgrave, Rushey Mead, and Thurmaston areas of Leicester, and had been walking at least once a week with the project for more than six months 14 questions were asked.

Walk Leaders

Two walk leaders were interviewed both women who ran the ladies group from the conception of the project.

Key people

Nine key people were interviewed who formed apart of the steering group and had various roles on the project.

7.3 Results

7.3.1 Exit Strategy

During year three of the project that is from February 2001 to March 2002, resources were used to apply for further funding to extend the project, whilst continuing all other strands of the project. For the interim period that was April 2002 – July 2002, the Health Promotion Agency had agreed to fund the coordinators post for two and a half days for four months on terms and conditions agreed by both organisations. This allowed time for putting an airtight bid together for a further three years funding from the Walking the Way to Health Initiative. All parties concerned were confident that this money would be secured. As the question did arise as soon as funding was secured back in 1999, and the national coordinator assured the project that the funding would be made available to the all the demonstration projects. Thus, the project did not formally endorse an exit strategy, which was premature, as the Chalo Chalay project did not secure further funds for the continuation of the project. A series of events occurred that led up to this decision:

- Funding had already been acquired for Leicester for five years via the Health Promotion Agency, and there was a perception of a duplication of work, and the assumption that the Let's Walk Leicester Project would include Chalo Chalay in its plan and provide resources for it.
- The partnership between the funders and the delivers were not strengthened over the three-year period, due to a number of changes in structures and role of partnering organisations.
- When the coordinator left and the new coordinator was recruited there was a management change at the Confederation of Indian Organisations (CIO), which improved the working environment, however soon after the Director of CIO left

and a new director was recruited, she had very different focus and vision for the organisation.

- The Health Promotion Centre and Health Promotion Unit joined to become the Health Promotion Agency, there were tremendous restructuring and changes to roles and responsibilities.
- The Chair of the steering group stepped down as his role of Director of Health Promotion, due to becoming the Director of Health Action Zone. He was key a individual in the project, and was central in the partnership. He continued to play an advocate role for the project, but this dissipated when the Health Authority devolved to a Strategic Health Authority and moved onto new pastures meaning an active voice was lost in Leicester.

The above events were devils advocates, as the strength of the original bid was the partnership, which was non- existent when it came to reapplying for funds. The Confederation of Indian Organisations did attempt to buy time by liasing directly with Leicestershire Health who had under spent that financial year. Negotiation took place between the regional manager and an agreement was reached to fund the project a further £16,000. However, at that time the regional managers post had also come to an end, so at the time of negotiations the Health Authority was dealing with the Director of CIO directly, due to the sensitivity of the partnership, the funding was not received.

Before the regional manager of CIO left, he ensured that the coordinator received the £1000 bonus that was due as CIO were not happy with this arrangement, but eventually after a few battles agreed. The coordinator left in April 2002, and on an interim basis CIO sent a development worker to hold the fort in Leicester, as all staff contacts had come to an end. The project thus continued on minimal support. The walk leaders received some support from the Health Promotion Agency, but the steering group disbanded. The project partners continued some of the work commenced by the Chalo Chalay project, in their respective organisations.

Let's Walk Leicester

The main exit strategy that was viable but not preferable to the Chalo Chalay project was to integrate itself with the Let's Walk Leicester programme hosted by the Health Promotion Agency. Let's Walk Leicester was a five-year Health Action Zone funded

programme, with an aim to develop a coordinated programme of walking activity across Leicester City that promoted and improved access to walking for health opportunities to specific target groups in areas of high health need. It had links into the national walking the way to health initiative; which was a 5 year funded joint initiative of the British Heart Foundation and the Countryside Agency, and had received funding from the new opportunities fund and sponsorship from Kia Cars.

The focus was walking for health and increasing the number of people involved in moderate physical activity. The target group were people who took little or no physical activity, people who experience health inequalities and for the long-term reduction in the incidence of Coronary Heart Disease. The activities included; the Chalo Chalay project, Let's Walk Braunstone, coordinating the volunteer walk leader training courses for city/county, the safer routes programme, and HeartSmart/ active lifestyles sessions. The programme set out to set up a forum which tried to build partnerships, guided and advised on the promotion of walking activities, shared good practices, mapped existing opportunities, highlighted any gaps, and provided a focus for future work and direction.

Case Record 7.1

The five-year strategy of Let's Walk Leicester Programme

A number of walking groups and projects had been developed in Leicester; the initial evaluation of these projects showed the local effectiveness of community focused walking projects to increased participation in moderate intensity physical activity. The programme thus considered a more coordinated approach to the development of walking groups. The Leicester, Leicestershire and Rutland Health Promotion Agency instigated a multi agency working party to consider the future-walking programme. The working party consisted of the following agencies:

- Loughborough University
- Active Lifestyle GP referral Scheme
- Leicester City Sport
- Leicester City Council Traffic Department
- Sport England (East Midland Region)
- Leicester City West Primary Care Team
- Project Dil
- Leicester Health Promotion Agency

It has to be noted that Chalo Chalay were not on this working party, considering it had lead the initial walking activities in Leicester, why was this not questioned?

The aims of the programme

- The programme should work in a multi agency way to both promote both led and independent walking.
- That programmes targeted to include regeneration areas and other priority groups identified within other strategies for example young people, workplace, older people coronary rehabilitation and other risk factor groups.
- In the longer term walking programmes should be developed for people with special needs and mental health problems.
- Walking should be encouraged as a mode of transport, particularly in terms of walking to school and walking to work.
- There should be a programme of led walks, which should include led walks by volunteers and those led by exercise leaders for more vulnerable groups, for example GP referral sessions.

Health Action Zone

Leicester City Health Action Zone (HAZ) had provided five years of full funding to develop the programme across Leicester City. The HAZ had been in operation in Leicester City since 1999 and the target areas were those that had been experiencing health inequalities. In Leicester City there were 13 wards out of 28 which were in the 10 % most deprived wards in England, thus 48% of the city's population lived in wards which contributed to the 10% of the most deprived wards in the country. The HAZ aimed to address the health needs of these areas by:

- Increasing the effectiveness, efficiency and responsiveness of services.
- Developing community partnerships for improving people's mental and physical health.

The HAZ relates to programmes that reflect the national priorities of cancer, coronary heart disease, mental health, winter pressure and waiting lists.

Objectives of Lets Walk Leicester;

- To develop a programme of led walks across communities within Leicester City.
- To recognise and integrate the Chalo Chalay Project.
- To generate a team of community walk leaders.
- To encourage the recommendation of walking within primary care organisations.
- To promote the use of walking as a mode of transport across the city.
- To raise the profile of walking to key agencies across the city.

Vision of Let's Walk Leicester

Let's Walk Leicester had an ambitious vision to see walking for health groups develop in every community. To work in partnership towards an improved walking environment, to encourage more people to walk as a mode of transport and to see walking more actively recommended as a way to improve health. A main aim of the strategy was to build upon the outcomes of the Chalo Chalay Project.

Programme Management

The strategic management of the programme was coordinated by a steering group, which reported back to the Exercise Alliance (an umbrella organisation that coordinates physical activity and sporting opportunities offered by organisations in Leicester, Leicestershire, & Rutland funded mainly by Leicestershire Health), and was made up of the following representatives:

- Let's Walk Leicester coordinator
- Exercise Alliance Representative
- Walking the Way to Health Case Officer (East Midlands)
- Pedestrian Officer (Leicester City Council)
- Walk Volunteer (Chalo Chalay Walking Activator)
- English Federation of Disability Sport (Health initiatives representative)

The responsibilities of the group were to agree the Let's Walk Leicester programme priorities, continually adapt the strategy to reflect new research, local development

and good practice, bring together skills and new ways of working, ensure all areas of the community are equally and fairly represented, to ensure the sustainability of the project developed.

Integration of Chalo Chalay into Let's Walk Leicester

The strategy recommended that the Chalo Chalay be mainstreamed and recognised, as a project in it's own right. That the led walks programme of Chalo Chalay be supported as part of the Let's Walk Leicester programme. A project plan to be written which builds on the outcomes of Chalo Chalay;

- Targets a greater range of Ethnic Minorities across Leicester City.
- Develops links with a range of faith communities.
- Creates links with the Active Lifestyle Referral Community.
- To maintain and improve links with the Active Lifestyles Referral Programme.
- Involves Ethnic Minority communities in development.

Walking Activator volunteers were recognised and valued as apart of a wider walk leader volunteer development programme and that an Ethnic Minority project would be a major part of the Let's Walk Leicester Programme.

Reflection 7.1

The above recommendations stipulates to link with a range of faith communities assuming that the Chalo Chalay project had lacked on this aspect, but had already made these links. The way in which it has been recommended is that its only the role of Chalo Chalay to work with 'Ethnic communities', but this should be main streamed and generic workers should already be working with faith communities, to place sole responsibility on the Chalo Chalay is inadequate. In terms of working with the faith community the Chalo Chalay coordinator would be facing the same challenges as the generic worker and thus links into key workers in South Asian communities were needed to be linked into.

An Exit Strategy For the Walking Activators

The strategy had praised the Chalo Chalay for its concept and recruitment of Walking Activators from the community and would use a similar process. However, it recognised that a for a sustainable programme that it should not be totally dependant upon paid

professionals to deliver the led walks. To keep the Walking Activators enthusiastic and motivated, each leader was issued with a t-shirt, sweatshirt, umbrella and rucksack. A regular programme of training, regular meetings and input into the development of the Let's Walk Leicester Programme was planned.

Case Record 7.2

The Let's Walk Leicester strategy recommended;

- The production of a volunteering policy, which sets out, the programmes approach and commitment to volunteers.
- The supervision of volunteers including regular time to support and plan.
- The development of a job description for volunteers.
- The consideration of a contract for volunteers.
- The development of meaningful ways to recognise the contributions that volunteers make.
- To build in a support and recognition role for Chalo Chalay Walking Activator.

Sustainability

The Let's Walk Leicester after five years envisages itself evident and worthy of mainstream funding through Health Improvement Programmes, thus from 2006 onward it was anticipated that;

- Locality coordinators and volunteer walk leaders will be running local community led walk programmes.
- Communities will have ownership of their particular projects.
- Improvements to the walking environment highlighted within the Local Transport Plan will have been achieved.
- Walking for Health will have become a major project of the GP Referral scheme.
- Primary Care Professional will be recommending walking as part of general lifestyle intervention, with access to appropriate materials and support.

Thus Chalo Chalay ended March 2002, and it neatly fitted into the objectives for the Lets Walk Leicester Project till 2006.

7.3.2 Qualitative Interviews

A series of fifty-two interviews between November 2000 and December 2002 were held with walkers, walk leaders and key people in the project, in particular the steering group. The views were at varying points of the project to get a picture of what people thought of the project as it progressed and then when the funding ended. The interviews were strictly confidential and the participants were asked to be open, honest and critical of the Chalo Chalay project and their role.

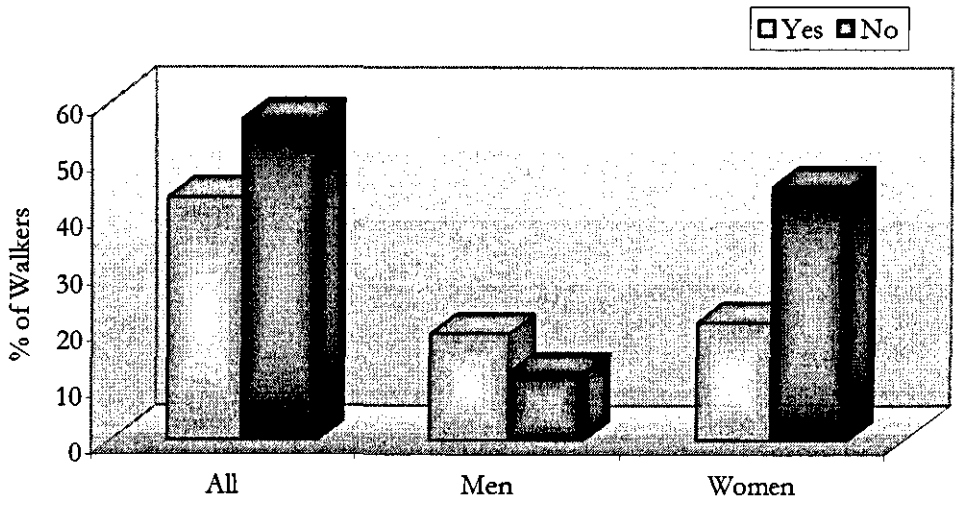
7.3.2.1 Interviews with Walkers

Interviews were held with 42 walkers, 29 Women and 13 men, all were South Asian age range from 48 to 72. They all came from the Belgrave/ Rushey Mead/ Thurmaston areas of Leicester, and had been walking at least once a week with the project for more than six months 14 questions were asked in Gujarati and English.

1. Pre Chalo Chalay Activity Levels

Activity Level before commencing the walking group

As seen in graph 7.1 57% of the walkers interviewed felt that they were not active before joining the Chalo Chalay walking programme, and 43% believed they were active.



Graph 7.1 Activity levels pre Chalo Chalay

The men stipulated that they lived fairly active lives before joining the programme, 19% answered yes and 12 % answered no to being active. The women felt that they were not active before joining the scheme 45% had answered no, and 24 % answered yes. Of the 43% that answered yes to being active, half after probing said that the activity did not make them sweaty or breathe hard, thus it was assumed that these activities did not raise their heart rate; as one of the men perceived that he was active, but did not know the intensity to be exercising at.

Other men in the group were however already very fit and healthy, 21% of the walkers were active and reached a level whereby it increased their heart rate. They saw the walks as an additional activity, but a way of getting fresh air too, in a social atmosphere:

Quote 7.1

'Yes, swimming, sauna, walking, yoga, gardening, walk everyday 3 to 4 times a day, make me sweat and out get of breath.'

The women that were not active;

The women felt that they were not active and that they did not do any aerobic activity, or were not part of any formal exercise classes. They did think that housework was an activity, and some looked after their grandchildren.

The ladies did not believe that their housework and picking up the children was activity even if done at the right intensity:

Quote 7.2

'No, just housework and walking the grandchildren to school and back everyday.'

The women who were not active and who had retired in the last couple of years saw work as apart of their active lives.

Other women recognised that just work was not sufficient in being active:

Quote 7.3

'Have been working, and have been active with that, usually lifting, so really was not that active; no didn't feel sweaty or out of breath.'

Some of the women attended Belgrave Neighbourhood Centre's exercise sessions once or twice a week but this was very light and they were not reaching their aerobic thresholds. The women did domestic walking that is shopping, and walked with their husbands in the evenings if the weather permitted. None of the women owned a car, but most of their husbands did. In some cases the women were advised by their GPs to walk:

Quote 7.4

'..... I walk to drop my children to school and the doctor said I should walk. I have a back problem and medical problems.'

Table 7.1 shows the type of activities the women participated in and what intensity at, of those who said that they were active. Some of the women were already active before joining the walks:

Quote 7.5

'Do exercise at home in the morning and sometimes in the evening 20-25 minutes, first slowly, I do feel sweaty. I go to Belgrave Neighbourhood Centre once a week on a Wednesday and I copy the exercises they have taught me.'

Quote 7.6

'Very active, circuit training, step aerobics, 4 times a week was quite hard in the beginning made me sweat and out of breath.'

Table 7.1 Activities and intensities of walkers who were active.

Activity/ Intensity	**Men**	**Women**
Walking	2miles twice a week at a medium or fast pace 3 to 4 times a day	Medium
Walk into town (2miles)	45 minutes Medium pace, 4 times a week 30 minutes medium stroll	
Shopping	Once a week	Twice a week
Sauna	Once a week	
Housework	Little hard	1 hour a day everyday
Exercise at home	Everyday light, 2 a week 20 –30 minutes	20-25 minutes per day Every day in am 30 minutes
Belgrave Neighbourhood Centre Exercise session, one or twice a week	Twice a week – 1 hour Medium	Once a week, Twice a week Medium
Gardening	2 hours in the summer big garden Once a week	

Swimming	Once a week	Once a week
Yoga	Everyday	1 hour per day Once a week
Circuit Training/ Step Aerobics		4 times a week
Chair based exercise		Twice a week
Aerobics		Once a week
Gharba/ Dancing		Three times a week

Table 7.2 Activities and Intensities of walkers who were not active:

Activity/ Intensity	**Men**	**Women**
Belgrave Neighbourhood Centre Exercise session, one or twice a week	Twice a week, slow pace	Twice a week once a week
Housework		Everyday
Swimming		Once a week
Working		Before retirement or made redundant Felt Fit Did a lot of lifting
Helping with children or grandchildren		Every day
At home		Everyday
Some Walking		Going from place to place With husband 1 hour everyday
Sauna	Twice a week	
Walking Children to school		Everyday
Walking in the park		To feed the birds 30 minutes
Gardening		Twice a week depending on weather

A few of the active women felt that they were influenced by their husbands to walk:

Quote 7.7

'.....since I left my job, I walk with my husband who is on dialysis..... at a medium paced due to my husband....'

Quote 7.8

'Walk with husband when we were free every day for one hour; housework gardening once or twice week depending on weather. Feel quite normal.'

Some of the women that were not active complained about pain in their legs before they started the walks, now this has eased and walking had made a difference.

A few of the women notice the change in their health after joining the walking group. Before joining they were suffering from depression and just by coming to the walks it had an impact on their lives.

For one of the ladies walking had greatly help with her menopause:

Quote 7.9

'No, due to my menopause I have not been able to work and have been depressed for the past year; one of the walk leaders was my neighbour and she convinced to come along'

The men that were active;

The men felt that they were active as they attended Belgrave Neighbourhood Centre's exercise sessions twice a week and also attended the sauna. They made a point of walking 30 to 60 minutes each day, 1 to 2 miles. Some had just given up work and felt their work was more manual and this equated as being active. Some felt that their health did not permit them to join any formal exercise classes. Thus, most of the men interviewed felt that they lead active lives and those that did join the walking group did so for the social benefits.

The men that were not active;

Some of the men recognised that they were not active enough, and they joined other exercises and activity classes since joining the walking group.

One of the men walkers had recently had a by-pass operation on the heart, and used the walking group as a part of his rehabilitation.

As with the women, the men felt that work was a form of activity and it made them feel healthy:

Quote 7.10

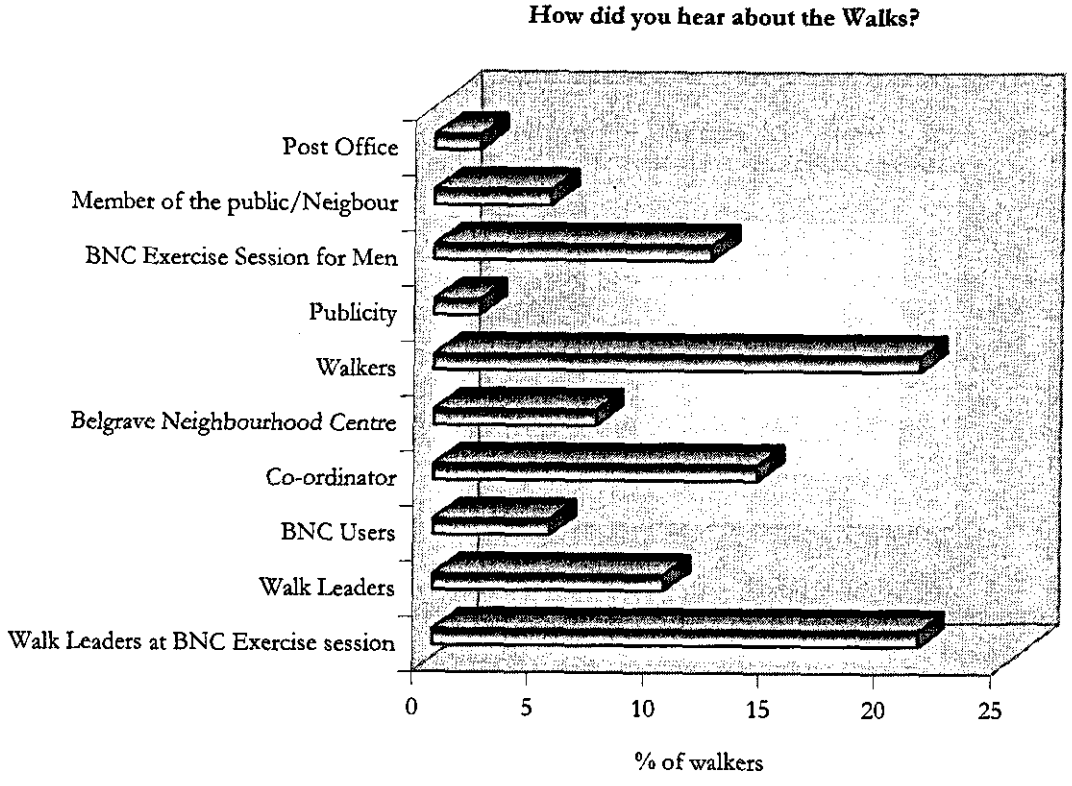
'No, but I feel fairly fit from working...not that much.'

2. Recruitment onto Chalo Chalay

How they heard about the walking group:

The Walking Activators at the Belgrave Neighbourhood Centre (BNC) and the walkers themselves recruited 42 % of the walkers; the coordinator recruited 14 % at the BNC

exercise session, and 12% from the men's session as shown in graph 7.2. The walk leaders recruited at their respective Samaj's (communities) and also at other organisations, which they volunteered or ran sessions at. The walkers recruited from various places including; the Cossington Street pool, which they swam at, and they told their relatives and neighbours. Belgrave Neighbourhood Centre was central to this process as it publicised its activities to all its members Thus, groups heard about the walks from Belgrave Neighbourhood Centres exercise session, where publicity talks were held. Word of mouth from the walkers was a powerful tool, and the walk leaders themselves were recruited via this process.

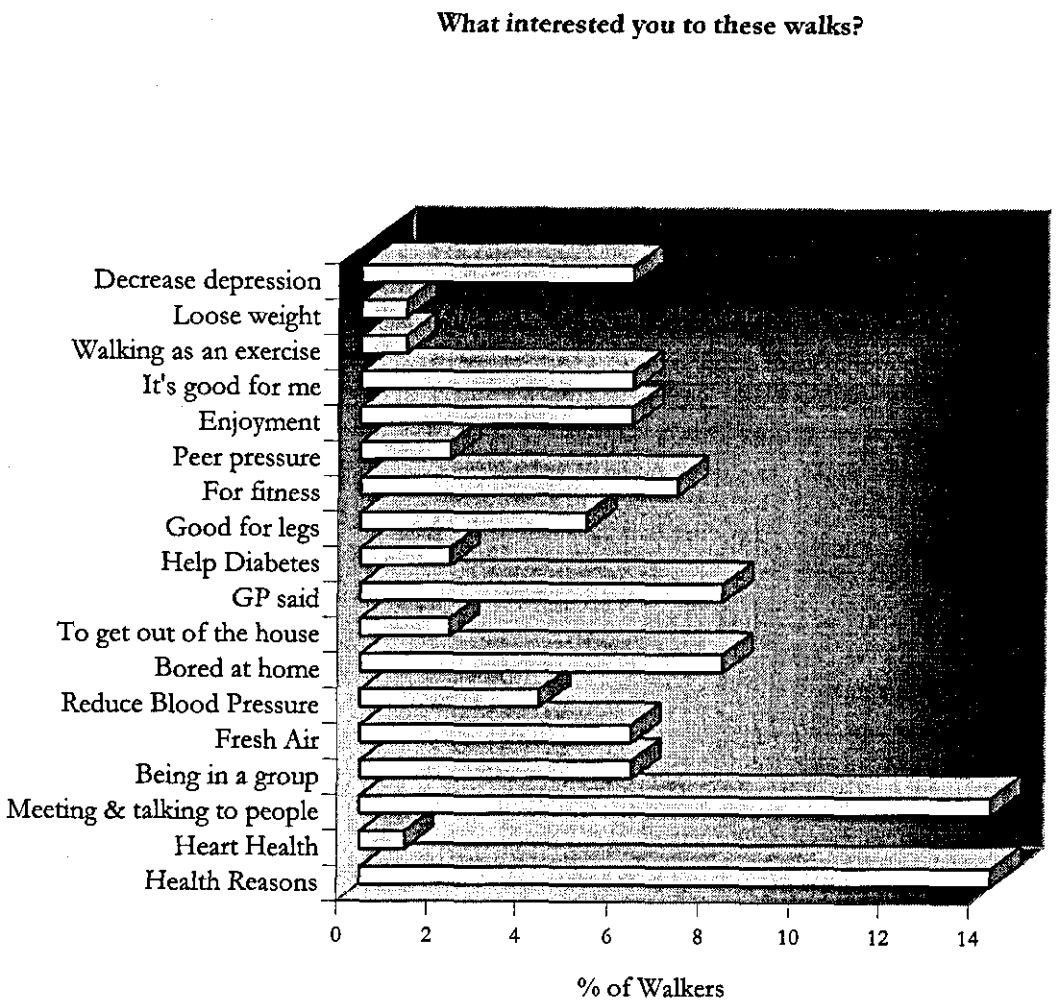


* BNC- Belgrave Neighbourhood Centre

Graph 7.2 Recruitment of Walkers.

3. What interested you to join the walks?

The most quoted reason for being interested in the walking group at 28% was for health reasons and for meeting and talking to people, this was followed by being told by their GP to do so and being bored at home at 16%. 7% were interested by the fitness aspect, only 1% were interested because of its heart health benefits and loosing weight as shown in graph 7.3.



Graph 7.3 Interest generated.

Why the Women were interested in walking:

The women joined the group initially for general health and fitness reasons but in a short space of time the social benefits out weighed the health ones. For others meeting people

and getting out the house to past time, was more important and getting lots of fresh air. They felt by walking in a group they could walk further and faster and enjoyed each other's company.

Health Reasons an the 'Doctor said so'

For a few of the ladies the doctor had suggested walking to reduce their blood pressure, stiffness of the legs, alleviation of back pain, and sugar levels (due to being diabetic).
The General practitioner played an important part, and influenced 8% of the women to walk. 5% of the women complained about their legs hurting and felt that walking would help. One of the ladies commented that the Physiotherapist was impressed with her improvement. Walking had also helped with irregular periods and stopping medication.

Meeting people and Walking in a group

The women recognised that there were lots of benefits of walking, but what interested them the most was being in a group and meeting peers:

Quote 7.11

'Lots of benefits of walking, being in a group and meeting other people.'

Quote 7.12

'We really enjoy the group, the group it's really good the walk leaders encourage us.'

Quote 7.13

'I have been walking since childhood I wanted to walk in a group it is more fun and we meet people and make friends.'

Quote 7.14

'We meet our sisters and we enjoy it we get to know stuff I do feel isolated at home and I need to get out.'

Fresh Air and Stamina

The initial reason for joining the group was the fresh air but then the other benefits became apparent, for example, it helped increased stamina, which was not expected by the walkers.

Influence

Many of the women were influenced to walk by family members and more so by husbands; they felt that the walking group was an extension of this.

Boredom and to get out the house

Most ladies after retirement were bored being stuck in their homes, and there was nothing they could do during the day when all housework was done, and before the children got back. Walking passed their time and it was an opportunity to just get out of the house:

Quote 7.15

'There's nothing else to do at home, the time goes by when I come to the group and I get to meet other people.'

Good for the body, good for me

Other women recognised that walking was simply good for their body and thus good for them and prevented them from becoming lazy:

Quote 7.16

'When I walk its good for my body, better than sitting at home, good for health, your body becomes lazy just being at home.'

Quote 7.17

'Good for my body; I feel lighter in my body.'

Only one of the ladies mentioned that walking could help her loose weight:

Quote 7.18

'Its good for my body to loose weight, good for my legs even when I was not in the group.'

To help ease depression;

Some of the women before joining the group suffered from various forms of depression and saw the benefits that walking in a group could have.

Why the men were interested in walking

For the men it was more about doing what the rest of the group was doing, and because friends had joined the group. Other members did it for specific health reasons and their doctor suggested it to them. One of the walkers had a by pass operation and walked independently, but liked the idea of walking in a group. Others, again like the women had high blood pressure and diabetes. Some of the members simply liked to walk and it was already a habit for them. The men were more influenced by peer pressure, and for the women it was more about the company.

Social Aspects and Enjoyment

The men more so than the women were interested in the walks for the social aspects rather than the health reasons:

Quote 7.19

'Well.....enjoyment, meeting other people.'

Walking in a group

Following on from the social aspect the men also liked to walk in a group and they learnt new things:

Quote 7.20

'Because walking in a group is different to walking alone, did not know of the other areas of Leicester learnt something new.'

Heart Health and GP advice

A few of the men had heart conditions and were told by their GP to walk.

Peer Pressure

Some of the men without realising had joined the group because their friends were doing it and they were going with the flow:

Quote 7.21

'Nothing in particular, I saw people going for walks I just join them; just joined due to friends.'

Nothing else to do and passes the time;

Again as with the women, most of the men had retired and had a lot of spare time on their hands:

Quote 7.22

'Its like an exercise and it better than sitting at home; and it passes the time away.'

Fresh Air and the Weather

The men felt that the walks would give them the fresh air they needed to make them feel better emotionally and physically:

Quote 7.23

'.....we enjoy the company of the people and walking as an exercise, I enjoy the weather whether its cold or hot.'

Quote 7.24

'Fresh air, keeps me fit, circulation for various parts of the body.'

Fitness

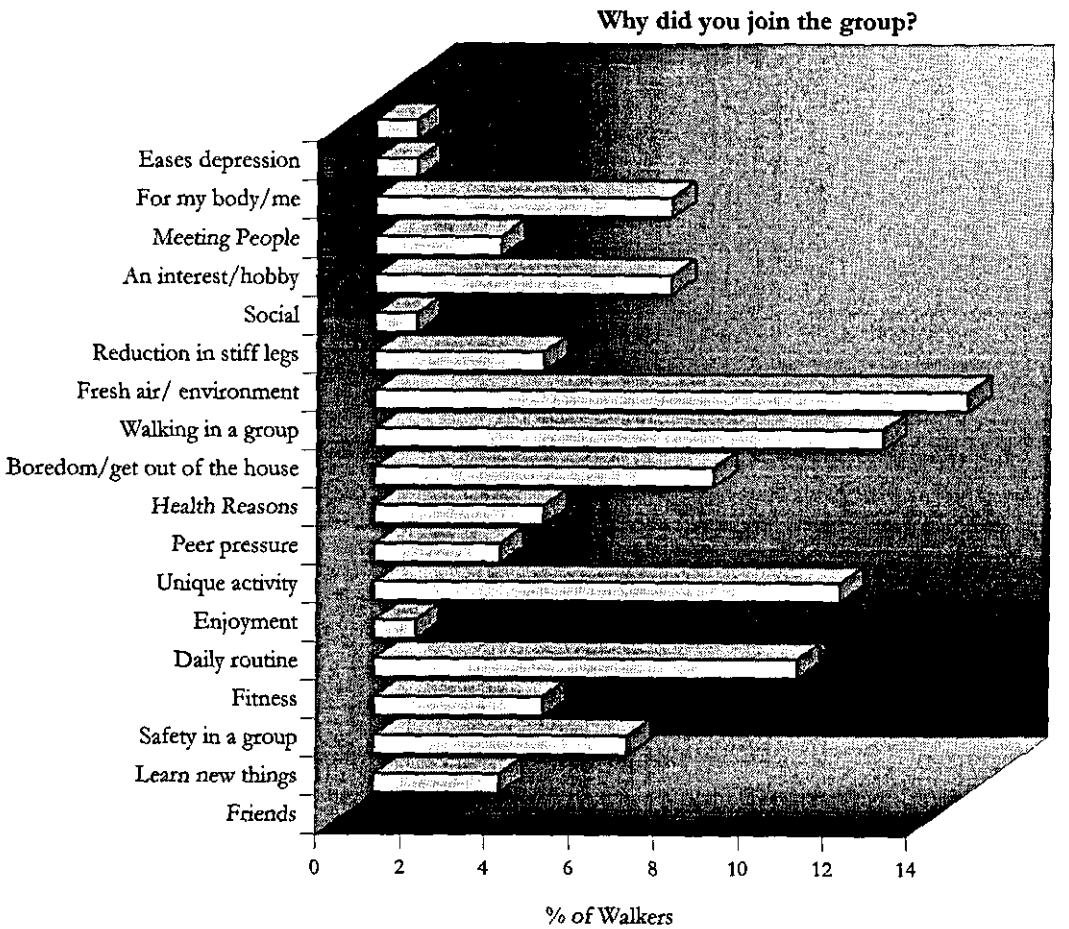
The men recognised the potential fitness gains they would receive by walking:

Quote 7.25

'Good for fitness and health gets the muscles moving, and mobilised, good for the breathing.'

4. Why did you join the group?

Most of the walkers had joined Chalo Chalay as it provided an opportunity to walk with a group, 14% stated this as a reason, this was followed by 12% saying that they joined because they were bored and it got them out of the house, 10% did it for fitness and 8 % stated health reasons, 14 % joined to meet people and the social aspect and 6% said that they learnt new things from it as shown in graph 7.4.



Graph 7.4 Reasons for joining Chalo Chalay

Why the women joined

The women never walked independently because they did not feel safe; hence the group provided them with a safe environment. Most joined for general health and fitness purposes and meeting other people. They felt that it had now become a part of their routine and they enjoyed it. One lady commented that there was no other outdoor groups they could join, and Chalo Chalay was the only one. Most of the women had retired recently, and found that they were getting bored at home, so the group was an extra activity they could do.

Get to learn new things

The women felt that since joining the walking group they have learned new things about the environment they live in, and other activities taking place, but also new ideas and concepts from new people:

Quote 7.26

'It's good to go with friends get to learn new things. Due to friends from the exercise group, I like walking with my friends, learning new things……'

Quote 7.27

'Its good to walk in the group, the people are nice and good for activities…they all show us respect especially the workers and we get to know of other activities happening.'

Safety walking in a group;

Quote 7.28

'……..safety in walking in groups, its better than walking alone.'

Quote 7.29

'Cannot walk alone it would be boring, and my husband works and I enjoy it in a group.'

Fitness;

Quote 7.30

'For fitness reasons, keep by body fit.'

Boredom and getting out the house;

Quote 7.31

'To keep my health in shape; for health reasons and to keep fit; there are only two of us living in the house so there's not a lot of work to do. I'm retired and have nothing else to do I have a lot of time, I don't like to sit around it's not good for me.'

Quote 7.32

'To pass my time, I do my walk and I get to leave the house.'

Enjoyment of walking in a group and meeting with friends/ social;

Quote 7.33

'I enjoy walking together, I get bored walking on my own and it makes me feel lazy.'

Quote 7.34

'I enjoy walking together even in cold weather.'

Quote 7.35

'To meet with friends.'

Quote 7.36

'I don't like walking on my own I like walking in a group.'

Quote 7.37

'Because I enjoy it, good exercise and we have a good laugh.'

Quote 7.38

'.....meeting people, make more friends and making walking an interesting exercise.'

Quote 7.39

'The social aspect to meet people.'

Health Reasons;

Quote 7.40

'It good for my health, and my legs do not hurt as much and we don't feel cold.'

Quote 7.41

'Its for my health? And if I am not fit who will look after me.'

Why the men joined the walking group

To meet people and social aspects

One walker, who was new to Leicester, found that the walks gave him the opportunity to meet the locals and make contacts.

Walking in a group:

Quote 7.42

'I like walking together, I enjoy it and for my personal fitness; now I walk every Thursday.'

Fresh Air;

Quote 7.43

'Find the activity better than sitting at home. Something which gives me strength and I enjoy the fresh air.'

An interest or hobby

For some of the men walking was an interest or a hobby they had and they could share this in a group.

Boredom and to past time;

Quote 7.44

'After retirement had nothing else to do, it passes the time away...and when I use to work time went by.... I cannot get a job now.'

Quote 7.45

'To past time, I have heart related problems, high Blood Pressure, high cholesterol.'

Fitness;

Quote 7.46

'Now that I am retired I wanted to keep active and fit.'

5. What do you think about the walks?

The women

In general all the women enjoyed the walks and felt it gave them the confidence to walk no matter how long the route was. They felt they had a lot more energy and stamina after the walks so that they could do other work. Others felt that the walks had improved not only their physical health, but helped them socially to meet other people. A couple of the women thought that sometimes the pace of the walks was too fast, and felt they were slowing the rest of the group down. Others said that they got their housework done more quickly just to come to the walks. One lady commented that when she first joined the group her legs use to hurt but now they did not.

The walks were good:

Quote 7.47

'Its so good that you have started this walking programme. I think its really good, I don't feel tired from it, it has increased my stamina and energy.'

Quote 7.48

'Its good, get good exercise for my body also the doctor said I should walk, and a get a little exercise I meet friends and it passes time, I get depressed at home....the time goes in the morning then in the afternoon I can do my cooking; the day goes.'

Quote 7.49

'Its good, I don't talk to anyone at home I get out to get to meet everyone, get to talk to people.'

Quote 7.50

'They are good because we walk to different places.'

Quote 7.51

'I like the walks, I like walking in a group I feel safe there's no need to worry, we exercise too. When the weather is not good we can exercise in the hall. It's better than being at home and having silly thoughts.'

Quote 7.52

'I like them they are good; we go quite far and time passes by in the morning, its ok scenery, morning walks are good.'

The walks were very good;

Quote 7.53

'It's really good, I feel really good for my health do not feel lazy.'

Quote 7.54

'Its very good. Its good walking; its an exercise and other activities including bhajans (hymns) in the park'

The walks are okay....

Quote 7.55

'I think the walks are okay I stay fresh but I cannot walk very fast.'

Quote 7.56

'The walks are very nice, its good to walk at our age, and with company we would walk instead of getting fat sitting at home, and its good for the heart.'

The walks have increased my confidence;

Quote 7.57

'I feel more confident, no matter how long the walk is I feel confident that I can do it.'

I feel fresh after walking.....

Quote 7.58

'I feel fresh after the walk, I feel energised to do more work. Just walking an hour makes me totally fresh'

Quote 7.59

'I enjoy it, 2 hours go quickly feel fresh when I get home.'

Having different levels;

Quote 7.60

'Walking is good but we have to have different groups and walking grades.'

What the men thought of the walks

The men were more critical of the walks and felt that they should start on time and finish and time, as the walks exceed an hour. Generally they felt that the contents of the walk, in particular the exercise component were very beneficial. Overall, the consensus was that they felt fit and energised after the health walks.

Timing:

Quote 7.61

'I wish we could stick to timing, stick to whatever the time is due, stick to one hour and finish on time.'

The walks are good:

Quote 7.62

'The walks are good, they keep me fit and I like the fresh air, it's a good form of exercise, instead of sitting at home. Walking keeps me fit and it's a good exercise its better than staying at home.'

Quote 7.63

'I think the walks are a good form of exercise; it's a good exercise for people suffering from disease this is the best exercise for them.'

Quote 7.64

'I think the walks are good for exercise, I feel fit from coming to the group, and I don't feel tired after it. Its good for my body and it does not make me tired.'

Quote 7.65

'It's a good idea for older people gives you exercise and keeps you fit plus socialising with it.'

The walks are very good....

Quote 7.66

'They are very good walks especially in the group I enjoy it.'

Quote 7.67

'It's a very good event.'

Walks are not bad;

Quote 7.68

'It not bad but needs a good motivator.....the walk leader is not very motivating.'

The walks are boring:

Quote 7.69

'They are boring there is no progress I'm feed up with walking in Abbey Park rather go to Bradgate park or other places. In the beginning there was 12 walkers now there's only 5 to 6.'

6. Do you intend to carry on with the walks?

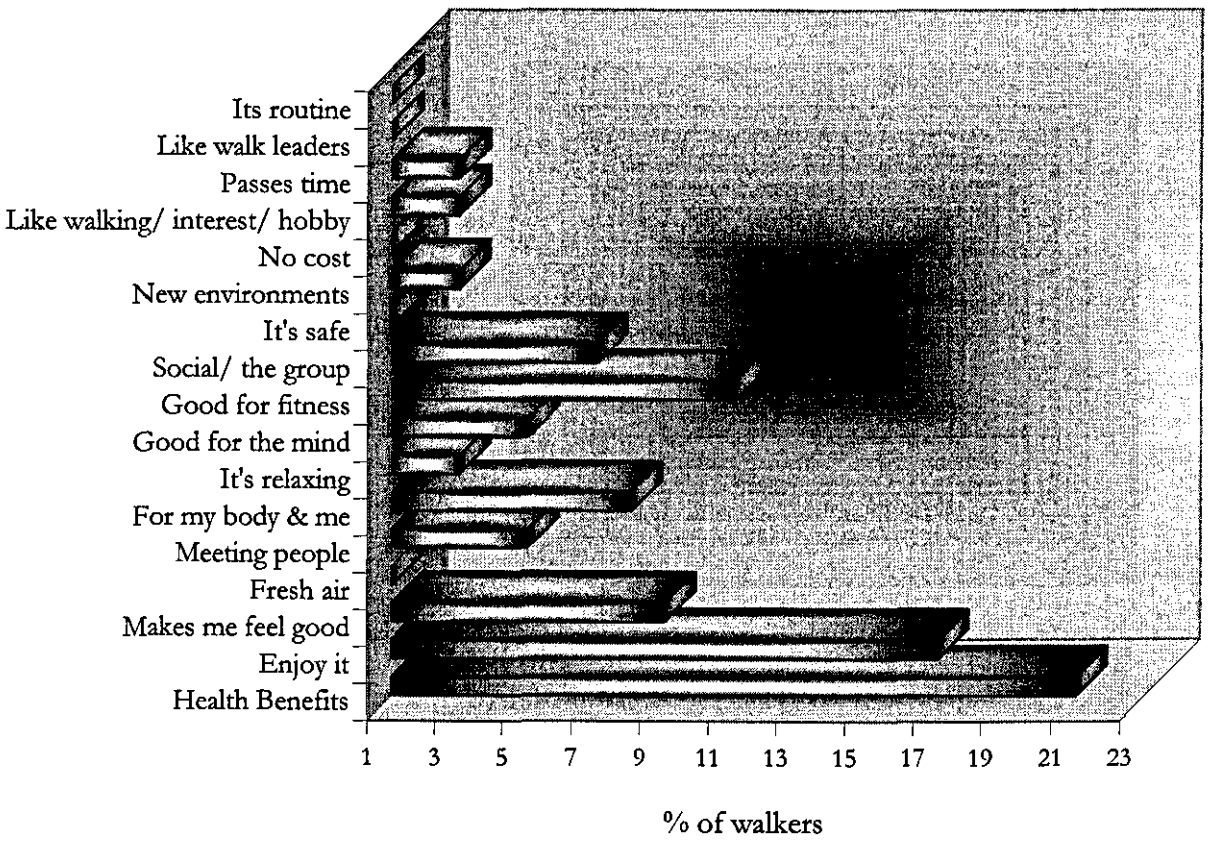
All the women would continue coming if their health permitted, and if they have did not have any household duties. They would continue coming mainly due to the health benefits, but they all enjoy each other's company. One of the ladies commented how her

doctor was pleased with how her diabetes was in control and she had lost weight. They all felt that it prevented ill health. It was satisfying to hear that they were doing it for themselves and were being selfish about taking time out for themselves. Only one of the men would not continue due to other commitments but the rest would keep on coming, as they thought it was a good form of exercise, and it was free.

Quote 7.70

'Would really like to but I work for different organisations I cannot commit the time.'

Why do you intend to carry on with these walks?



Graph 7.5 Reasons for continuing to walk with Chalo Chalay

The reasons why the walkers would continue the walks were for health reasons, 21% felt that their health had benefited, followed by 17% who enjoyed it and 11 % who believe it was good for their fitness. 9% would continue because it made them feel good and a further 8 % would continue, as they believed it was good for their body and them. 5%

would carry on for the mental health benefits and a further 5% for meeting people and finally 5 % would continue for the social aspect and the group as shown in graph 7.5.

The women

Other duties;

The women would continue as long as other duties such as household did not come in the way:

Quote 7.71

'Yes, as long as I can, but sometimes I cannot come because of household duties I have to look after my husband and mother-in- law sometimes there are problems at home. I will carry on because of the health benefits.'

Quote 7.72

'Yes, only if I don't have a problem, that is if no one has not come to my house… I do it for myself and my body.'

The doctor is happy…

Quote 7.73

'Yes, for my own health reasons, keeps the doctor away; it has made a difference I have arthritis in my hands and ankles it has help to heal it and don't take tablets for it now.'

Good for my health…….

Quote 7.74

'Yes, till the group continues, its better than staying at home, whatever walking I get its good for me and my health.'

Quote 7.75

'Yes, its good for my health, and my varicose vein condition; I feel lazy sometimes I have been told to walk because of my veins, sometimes it get so bad when I have to stand up and cook.'

It's formed a good habit….

Quote 7.76

'Yes, its good for my health, good for the mind it freshens it, it forms a good habit, become use to it, feel active and we keep ready for that time of the week'

Good for the mind……

Quote 7.77

'If my health is well I will continue if God permits. I feel better, you forget your problems when you get out, my health is better especially my legs. Instead thinking of silly thoughts at home, it good to get out.'

Quote 7.78

'Yes, once I've started I don't want to stop, I'm too bored at home, it freshens the mind.'

Its good for my body....

Quote 7.79

'Yes, it good for my body, I have a back and leg problems but I now can walk better I still have a little pain.'

Quote 7.80

'Yes, as long as I can for my body and its benefits, I'm doing it for me, not for someone else.'

If I have the time....

Quote 7.81

'If I have time I will if my health permits it, for myself its good for me.'

Its helped to control my weight.....

Quote 7.82

'I want too, only god knows. It looks after my health and I get exercise and there's been a change in weight it helps to control it!'

Cold weather....

Quote 7.83

'If there's a health problem I would stop in winter because of cold weather. But otherwise yes in good weather.'

The men

If health permits it.....

Quote 7.84

'Yes, as long as my health permits because I enjoy that kind of exercise and I enjoy meeting people.'

Its safe;

Quote 7.85

'Yes, because I feel better, it helps my fitness, my health has improved and I talk to my friends, it good to walk in a group, can talk to one or two people and its safer to walk in a group just in case something happens.'

It's free....

Quote 7.86

'Yes, as long as my health is okay, I feel fit from it; there's no cost involved. I feel fit from walking...and I have no illnesses beside the problem with my knee.'

Its fun....

Quote 7.87

'Yes, I'm having fun and it does me good and I'm passing time.'

Enjoy the weather....

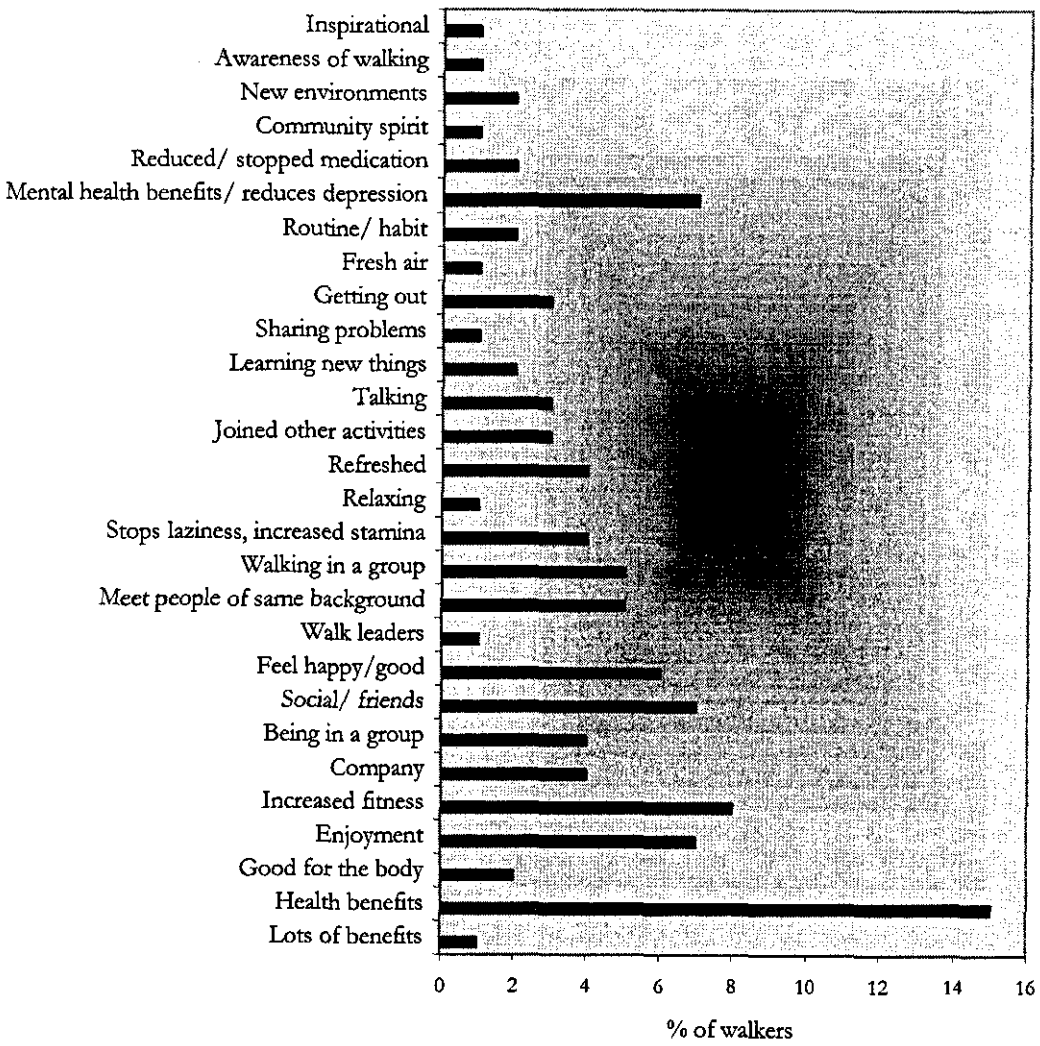
Quote 7.88

'Yes, enjoy the company exercise and the weather.'

7. Something good about being involved with Chalo Chalay;

All the walkers have felt since joining the group their health has benefited including their heart health. They enjoyed walking in a group and meeting other people. They have a better social life and they really enjoy the fresh air, they do not feel like they exercising or walking, but more of a social get together. The ladies felt that because they were all similar ages and mature they can understand each other's problems, and talking amongst them was important. They thought the walk leader was a good motivator, being good-natured, friendly, and helpful and had a good sense of humour. The men also thought the social benefits were good in that they could relate to each other and share problems as shown in graph 7.6.

Can you tell me something good about being involved with Chalo Chalay?



Graph 7.6 Something good about being involved with Chalo Chalay.

The walkers thought that the health benefits from joining Chalo Chalay were good 15% of the walkers described how a number of their health conditions had improved these included:

- Heart health
- Aided digestion
- Helped to sleep easy
- Helped to ease back problems
- Reduced hurting and stiffness of the legs

- Helped blood circulation
- Reduced blood pressure
- Helped the lost of weight and the control of
- Helped joints
- Helped with varicose veins

Besides health benefits, 8% felt that it had increased their fitness and walking was a good exercise, a further 7% enjoyed the walks and another 7% felt that the social aspects and friends were the most good thing about being involved with Chalo Chalay. Another aspect was that 7% of walker's thought that Chalo Chalay had helped reduced depression or eased it and the mental health benefits out weighed every thing else.

The women

It's a routine....

Quote 7.89

'Everyone are friendly with each other, we visit each other's houses and I really like the fresh air. It's a routine I get out on time.'

Quote 7.90

'I do not feel right if don't walk and don't feel like I have the stamina if I don't go.'

The walk leaders....

Quote 7.91

'..... the walk leader is very good, she has a good nature, very friendly and has a good sense of humour, she very helpful. All the ladies are the same age, and all mature; it' easy to fit in and we all understand each other....if they are young; points of views might be different...we agree on most things.'

Refreshing and relaxing.....

Quote 7.92

'I'm new to the programme, but it stops me from feeling lazy and I feel relaxed from it and my afternoon goes really well, and after an hour resting I feel totally refreshed.'

It could be better.....

Quote 7.93

'We all walk together.....but there's no trips should take us to the countryside once or twice a year.'

Joined other activities...

Quote 7.94

'In Chalo Chalay we all walk together, we enjoy it and we have joined other groups from it.'

Lowered or stopped medication.....

Quote 7.95

'I feel ok now that I walk I don't eat as many tablets, I feel much more healthy after joining the group. Its ok for me and I feel healthy I eat in moderation but I feel better now that I have started to walk.'

Quote 7.96

'I'm happy I feel that I have lost weight. I feel happiness I am not so depressed. I was on anti- depression tablets, I've stopped them now.'

Getting out the house.....

Quote 7.97

'Everyone is a friendly always-joking gets me out of the house.'

A social.....

Quote 7.98

'Everything is good we do a lot of activities together like picnics and we exercise too I have made some really good friends. We do gharbas and play ball games.'

Not so depressed.....

Quote 7.99

'Its good because my depression has lessened, its good for my health, its good I'm not feeling so lazy, mind is freshened.'

Good for the mind.....

Quote 7.100

'I've only joined for a short period of time I don't feel the benefits but its good for the mind.'

The men

Sharing problems....

Quote 7.101

'Personally is profitable for me become healthy and fit. Its very good for people to meet socially, they might be able to relate their social problems to each other and share problems.'

To get out...

Quote 7.102

'To meet with people to talk with them, the fresh air, I enjoy going out its better then being in the house in front of the TV.'

A routine.....

Quote 7.103

'Its regular event once a week.'

Good for general health.....

Quote 7.104

'Good for my health everyone should walk for their health fitness and mental health.'

Chalo Chalay....

Quote 7.105

'Nice team work, inspirational to boost people's will power.'

8. **Anything they did not like about the walks:**

In general 55% of the walkers had no problems with the walks. 45% disliked some aspects of the walks such as bad weather, and suggested walking indoors, or if a sports hall could be hired. A few of the walkers suffered from asthma and the cold weather did not help. All group members felt that organised activities including trips into the countryside were important and would help bring new members in.

One of the women walkers commented:

Quote 7.106

'There are no organised activities we need more facilities. It would be a good idea to have things around Christmas or Diwali. If we had get togethe'rs and parties we would enjoy it more. Could introduce other people to the walks would be like an incentive.'

The walker's felt that the different levels in the group was a problem; the slower group felt that the faster group were waiting for them and this made them feel awkward. The men's group had suggested having the walks twice a week and the slow or fast group could meet at a separate session. The men also felt there was a lack of publicity to the community it served and a flyer should be produced, which could be distributed at community centres. Some of the members thought that too much talking was going on during the walks and less of the walking. One member did not like the uphill walks and

muddy paths and preferred the level routes. The men in particular commented that the walks were too slow.

Overall 45% of the walkers interviewed did not like:

- The bad weather
- The lack of organised activities
- The lack of facilities
- No incentives
- The different levels in the group, and waiting for the slower walkers
- Not knowing the destination of the walk so that they could go ahead
- The lack of trips
- Some walkers talking too much
- Some walkers making fun of others in the group
- Walking too slow
- Walks that were slow
- Hilly walks
- Muddy paths
- Dog litter
- Low number of walkers in the group
- Going too far
- Walking through isolated places
- Walking in the woods / trees
- Fear of safety from attack
- Same boring routes
- Lack of teas and coffees
- Difficulties crossing the road, some of the routes have no pedestrian crossings
- The lack of way marking
- Not knowing the number of miles walked
- Running as apart of the warm up

The women commented

Bad weather.....

Quote 7.107

'I like everything about the walks except for the weather; in winter it gets difficult because I suffer from asthma. We need a place to go when its cold, to go inside.'

The lack of activities and facilities.....

Quote 7.108

'You should have a few activities so that we enjoy it, and you can tempt other people to come.....just a few facilities...you can convince people if you say that.'

Quote 7.109

'.... but it would be nice to go more into the countryside...if you had trips we could tell our neighbours to come, or boat trips...seaside.'

Varying levels.....

Quote 7.110

'Some of the ladies cannot walk very fast; the group has many different levels, sometimes the faster group has to wait....but I don't like to leave the slow people behind...and sometimes we have to wait for them....if the walk leader tells us the destination we can go ahead and do more rounds in the park for example...'

Not too far....

Quote 7.111

'I don't like to walk too far, and not in isolated places, and in the woods.....'

Safety....

Quote 7.112

'Safety, I fear if someone might come and attack us in the park, a group of women on their own, should have alarms.'

Lack of pedestrian crossings....

Quote 7.113

'There are 35 ladies, its hard work especially at crossings, its difficult to get all across safely. We would like to know how far we have walked, the number of miles and way marking would help.'

Quote 7.114

'I have no problems. The traffic lights on some of the roads are needed. If we had a van to take us a distance away like parks in the countryside we can then walk further. The walk leaders are really good...but they both were not here today so X took the walk.'

Quote 7.115

'Yes when we have to cross big and busy roads like Melton Road in a very big group'

The men

Slow walking....

Quote 7.116

'All is good, sometimes the pain stops me form coming, due to heart problems, I don't want to slow the group down and then sometimes I don't come but I do like to walk.'

Quote 7.117

'Everything is okay, I don't like walking to slow should be a medium to fast pace...it depends on your own stamina if you feel you can't do it slow your speed down.'

Quote 7.118

'...That's up to you....the walks are slow they should be faster.'

Level walks....

Quote 7.119

'I like straight walks, I don't like the hilly walks, or muddy paths, I prefer the level clean walks. Feel scared of tripping, I don't like the dog mess near the riverside.'

A lack of walkers....

Quote 7.120

'Well, there are not many people in the group once there was only 2, there should be an incentive to join group, anything like bowling, or a boat ride.'

Bad weather.....

Quote 7.121

'When the weather is bad and it's raining especially.'

Quote 7.122

'Bad weather or people who are suffering from pain- depend on the pain if they can carry on. When walking don't feel pain as much others forget them. When you are alone you feel the pain.'

Same routes.....

Quote 7.123

'The same boring routes, we should have two boat trips or trips to other parks there should be different activities. Tea and coffee and drinks and more sociable activities.'

9. How can the walks programme be improved?

Unlike the above where most liked the walking programme, 76% believed the walks could be improved as shown in graph 7.7, whilst 24 % thought no improvements were

needed and they were fine. Some walkers thought that the programme had already improved and this can be seen in the increase in numbers. However, they thought that the walk leaders should bring a First Aid Kit and water bottles to every walk. There had only been one trip, and there should be more organised activities and parties this would increase the number of walkers. The walks should be faster so it raises the heartbeat.

During bad weather the walkers wanted the programme to be held indoors and facilities were made available. They wanted two groups; one fast and the other slow, thus two walk leaders were needed so that destinations can be reached quicker and faster. One of the men walkers commented:

Quote 7.124

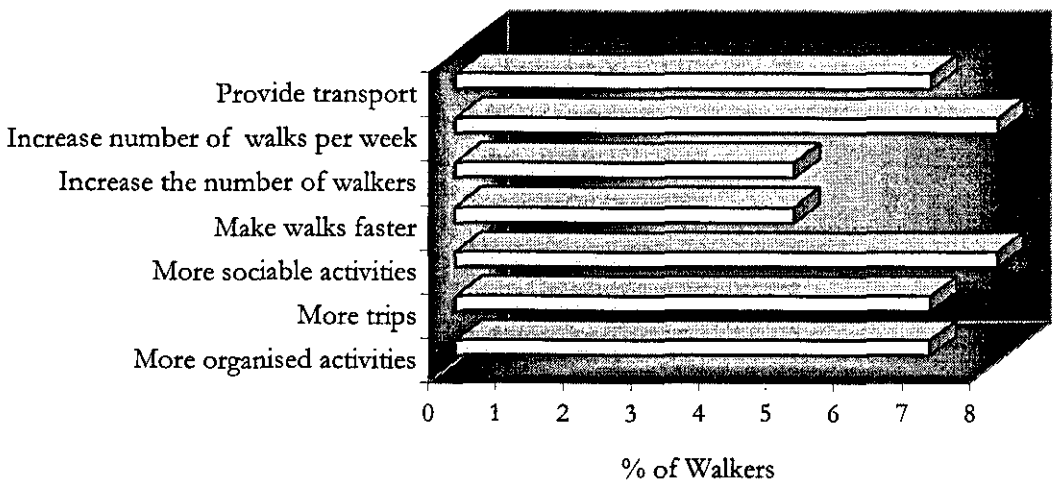
'Should motivate the walkers more, by providing educational messages and publicity and placing an emphasis on being regular walkers.'

Another walker suggested having walks twice a day a session in the morning and a session in the evening, but definitely twice a week;

Quote 7.125

'No, all that connected to the walks are very pleasant and nice no flattery to them. Maybe increase the group to twice a week. There is no sufficient publicity of the group in the community it serves, I didn't know about it for the first one and half years; could produce a leaflet or flyer through Belgrave Neighbourhood Centre when people join they could send information with the membership.'

47% gave the following improvements they would like to see on the walks programme:



Graph 7.7 Improvements on the walk programme

8% wanted more sociable activities, which was closely related to more organised activities and more trips at 7 % each. A further 8 % wanted the number of sessions or walks increased per week. 5% wanted the walks to be faster, and another 5% wanted to see an increase in the number of walkers participating. 7% wanted transport provided, to take them further away from the city to walk.

A further 30% stated the following improvements they would like to see:

- All walkers should wear proper shoes and clothes.
- Walk leaders should set an example.
- Need to motivate walkers more.
- More educational messages about walking.
- Increase the exercise part of the walk.
- Start the walks on time.
- Introduce new programmes.
- Have things to give a way such as umbrella's etc.
- Increase safety of group – by wearing all the same coloured T-shirts.
- Need way marking of routes.

- Issue all walkers with step counters that work.
- More toilets on route.
- Clean canal and roads.
- More pollution free environments.
- Have more of a variety of places to walk.

27% would like the to see the following improvements;

- The walk leader should carry water bottles and a First Aid Kit.
- More facilities.
- A hall where indoor walking can happen in the winter.
- More incentives to walk and join the group.
- Have different level groups - a fast and a slow.
- Increase publicity of the walks.
- Improve environments.
- Increase safety of footpaths.
- Increase safety on the parks.

The women commented:

Already improved.....

24% of the walkers felt that walks were fine and needed no improvement, some felt that they already had improved:

Quote 7.126

'Everything is okay, you have improved a lot, since starting we go to a lot more places and we do a lot more exercises the numbers have already increased.'

Quote 7.127

'I don't think so, all is okay, and we are here to support you.'

Quote 7.128

'No, everything is okay and the timing is just right....the girls look after us well and they help us.'

Quote 7.129

'Its good walking in a group, no changes.'

Quote 7.130

'That's up to you,……I do like all the group, they are very caring and they look after us, because I do have angina, I do like coming. I like all the facilities…the hall you have given us….I cannot walk too fast because I have angina…you have provide for us like when we needed toilet or water breaks.'

Quote 7.131

'Its only been two months since I joined so I think its ok we have Cossington Sports Centre when it rains.'

The walk leader…..

Quote 7.132

'The walk leader needs to bring water and a first aid kit; we use to have these facilities. Since you left none of this happens. Need to do more activities, more organised trips and social activities. There has only been one trip…..its was only when you took us …since then we have had nothing.'

Wearing the right gear….

Quote 7.133

'I know some women have to were Sarees but they should wear warm clothing on top'

The walks should be faster……

Quote 7.134

'Could walk faster so it raises the heartbeat make you feel more fresh. Should walk faster to raise your heartbeat and breathing.'

More organised activities/ socials and trips……

Quote 7.135

'Parties, organised activities take people out once a year…everyone would enjoy it.'

Quote 7.136

'Lots of activities such as picnics bhajans, more activities like that, with summer coming a day trip away.'

Quote 7.137

We should have more trips it would be an incentive. Also parties, it would give us an opportunity to bring friends and they may become interested in joining If we could go further as an outing maybe on a picnic.'

Quote 7.138

'When its summer, even if its costs we could go somewhere further at a shared price.'

Increase number of walks and walkers…..

Quote 7.139

'Increase the number of walkers…if more people came it would be better.'

Quote 7.140

'Make it bigger.'

Quote 7.141

'We should continue to walk, should have the group another day maybe a Thursday.'

Indoor walking….

Quote 7.142

'If the weather is bad, I feel lazy, and feel that I would catch a cold. We should have it indoors in bad weather…it depends on the weather.'

More incentives or freebees……

Quote 7.143

'Should have new programmes, give us umbrellas and things in bad weather…so feels like we got something.'

More restrooms on route…..

Quote 7.144

'There are no toilets especially near Watermead, many ladies need to go due to medical reasons. If you could take us out, provide transport we don't mind paying we would enjoy it when the weather is so mild like today although we did go to Bradgate park.'

Quote 7.145

'There are a lack of toilets on route when we go far and water refreshments; we are in trouble when we forget water bottles, if it's good weather we should go on a trip.'

More facilities……

Quote 7.146

'Need facilities if we are going far, safe places in parks, a hall or sports hall we can be inside.'

The men

Different level groups…..

Quote 7.147

'There needs to be two groups, some are slow others are fast; the slow group is holding the other group back. Need another fast group; there needs to be two groups…the slow group hold people back no criticism to them they may have problems.'

A bit more motivating…….

Quote 7.148

'Should motivate the walkers more, by providing educational messages and publicity and placing an emphasis on being regular walkers. People would feel a bit more motivated and show commitment sometimes they come sometimes they don't.'

Walking faster……

Quote 7.149

'Once we reach the destinations that is Abbey Park or where we are going we should walk quicker and faster.'

Having more walks….

Quote 7.150

'Have the group twice a week.'

Quote 7.151

'There should be two groups one slow and the other fast that would be better, if we don't walk fast what's the point what the worth, health wise its not good. When I measured my blood pressure it has gone down its better.'

Quote 7.152

'To increase the number of walks per week.'

More exercise……

Quote 7.153

'I enjoy the exercise part of the walk there should be more of it, morning and evening walks that is 10-11 am and 5 to 6pm (2 hours a day). People should come on time and it is safer to walk together, its good for the people'

More members……

Quote 7.154

'If there's more members it would be better; more socialising and people will take more of an interest in it.'

Quote 7.155

'Once a week is alright, could tell other people to join.'

More incentives and publicity…..

Quote 7.156

'Have incentive so more people join; increase publicly, on radio, TV to pass on the information about the group, many people don't know.'

Need something new....

Quote 7.157

'More activities every Tuesday we announce the walking group if there is something new then people would certainly join. There's not been an improvement in the last three years and I'm feeling bored.'

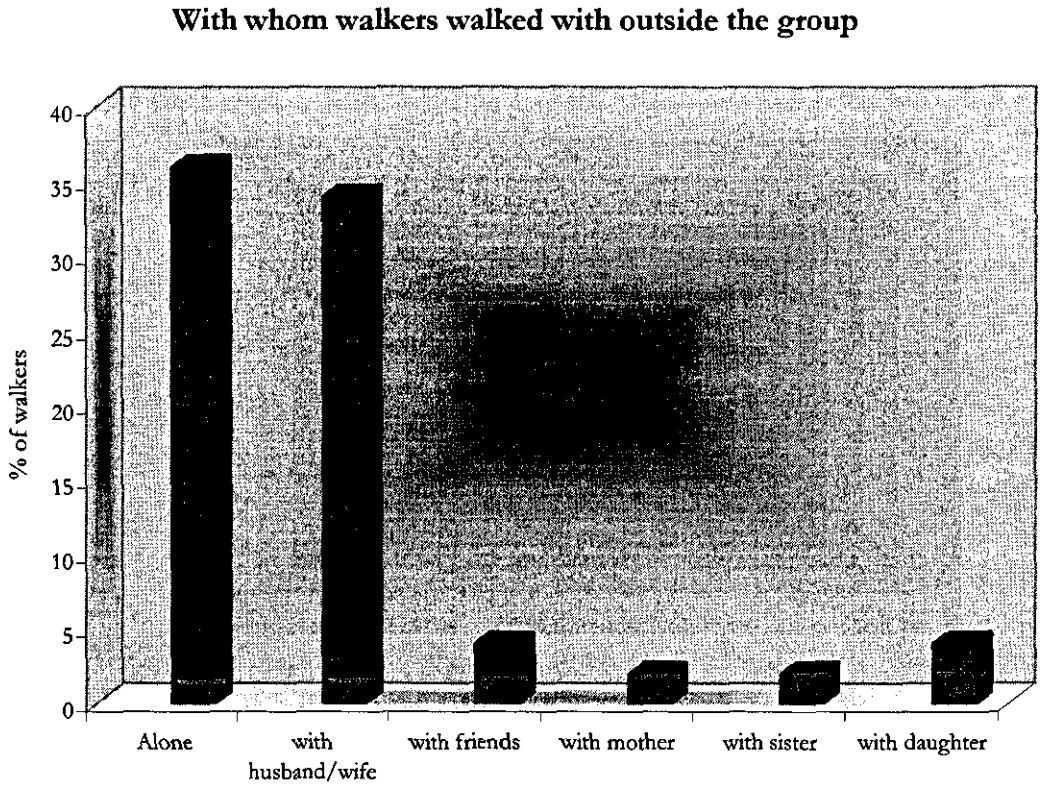
10. Independent walking since joining the group;

A majority of the walkers, 89% walked independently outside the group. 11% stipulated that they did not, but did however walk for domestic purposes such as shopping, and one walker felt that walking once a week with Chalo Chalay was enough and her health would not allow her to do any more.

Quote 7.158

'No, its enough once a week, its enough for me because of my arthritis.'

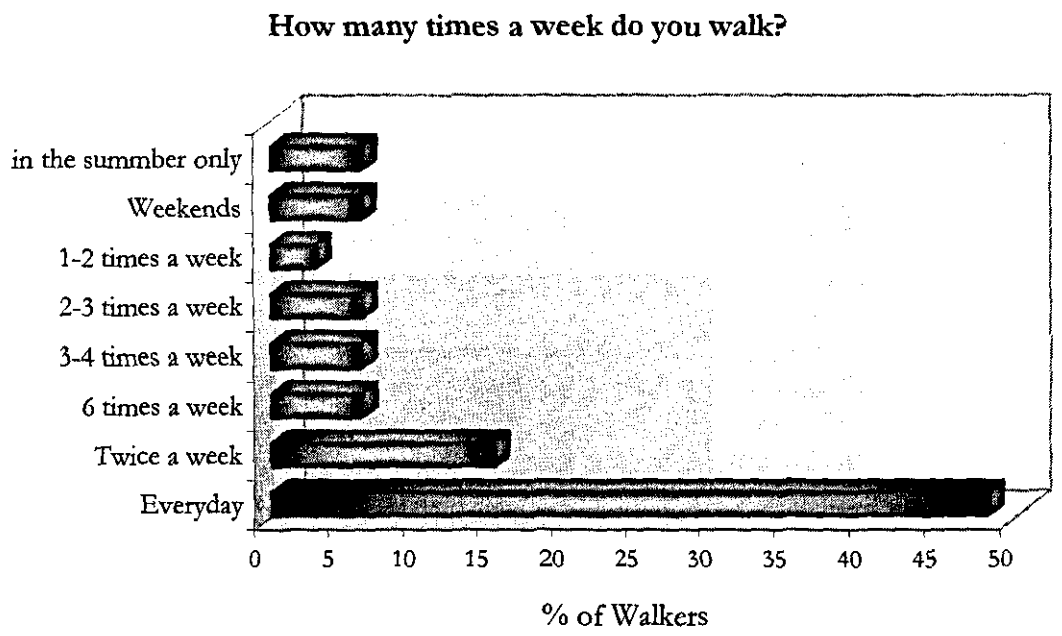
A break down of the 89% is shown in Graph 7.8 although the walkers answered yes to the question further prompting showed that they walked with others and not alone. However 36% did feel confident to walk independently and alone:



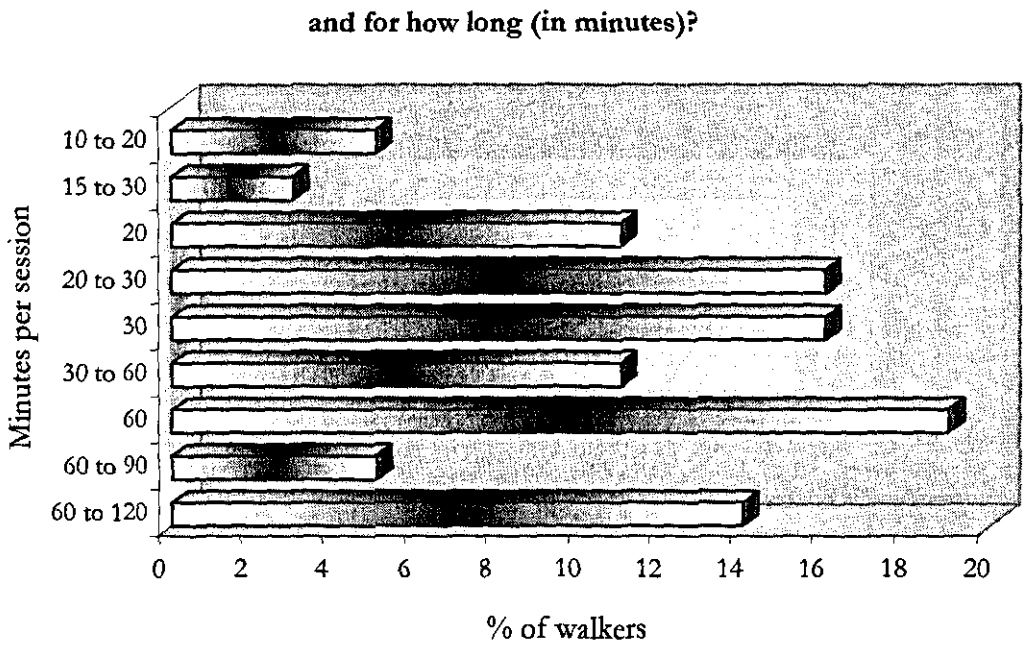
Graph 7.8 Independent walking

74% stipulated that they did not want to walk alone and hence 34% walked with either husbands or wives, 4% with daughters, and 4% with friends, 2% with sisters and 2% with mothers. Potentially, the walkers were being advocates of the project and were at least influencing one other person to walk with them, and thus the project had reached double the number of walkers participating.

The number of times a week the walkers walked independently is shown in Graph 7.9, 48% said that they walked everyday, graph 7.10 shows how many minutes walked



Graph 7.9 Number of times walked per week



Graph 7.10 Number of minutes walked per session

Where would you like to walk?

45% said that they would like to walk in the parks, 9% in open spaces, 6 % quiet places and 6% did not mind as long as they were walking. A further 33% specified;

- Away from the town and city

- Where its nice
- In green space
- Little villages with quaint houses
- The countryside
- Where there's nice scenery
- Shopping areas / Melton Road
- Where's there's no traffic
- In the fresh air
- Near water
- At the seaside.

The women

The women in general do walk outside the group but they walked with family members or for domestic purposes like shopping, they did not feel safe enough to walk on their own. Most of the women did not own a car but their partners drove if they had heavy shopping to carry, otherwise they walked everywhere.

Walking with husbands.....

Quote 7.159

'Yes, I go with my husband; I do not walk alone though. I walk more with the group for 2 hours, but a walk everyday between 1 –2 hours. I do walk more now since joining the group and I walk everyday. I do not walk on own.'

Quote 7.160

'I walk more with my husband now since joining the group. Usually do it everyday for about half an hour, but sometime occasionally I can't do it because I am busy with work'

Quote 7.161

'Yes, my husband likes to walk its his interest, after dinner we walk everyday for one hour. We don't use the car or the bus only for shopping. I don't like walking in town with the traffic, but like open spaces like the park and looking at open green spaces where there is fresh air. However, in this weather it is difficult. The countryside is not too far its quiet and there's no traffic so crossing is easy. We like to walk in little villages and see the quaint houses'

Quote 7.162

'Yes, I walk with my husband twice a week for 20 to 30 minutes, we walk everywhere, as long as we are walking.'

Quote 7.163

'Yes, I walk with my sister in law and my husband 2 to 3 times a week for 20 to 30 minutes near the house and to Melton road I like it there.'

Quote 7.164

'Yes, I walk with my husband everyday for 20 minutes, we like to walk in quiet places in parks, Wywern Park, Melton Road, Abbey Park, in the summer we walk for 1 to 2 hours.'

Quote 7.165

'We walk everyday since my husband and I retired....I do sometimes walk on my own. Go with my husband twice a day about 45 minutes to 2 hours go to Cossington Street Park and walk around the circuit.'

Do not want to take the risk of walking alone.....

Quote 7.166

'With husband, I would not take the risk of walking alone, everyday if its not raining about an hour sometimes less or sometimes more. In the park where's its open where there is water like Watermead Park.'

Walking independently.....

The women that did walk on their own did not seem to do it out of choice, walking was seen as a social activity and not to be done on its own;

Quote 7.167

'Yes, I walk everyday in the afternoon for one to one & half hours along Melton/ Belgrave Road, I do not go very far because I am on my own'

Quote 7.168

'I don't have anyone to walk with; I go to park everyday, 10 minutes a day. I like to walk with friends. The park and shopping, two jobs done in one go depends on time I do get out once a day.'

Quote 7.169

'Yes, daily more than one hour a day; I like to walk in parks, going to town, walking instead of taking the bus, going to friend houses anywhere really!'

Walking with friends.....

Quote 7.170

'I go walking with my friends in Cossington Park, four times a week for an hour. I liked to walk everywhere, where its nice.'

Quote 7.171

'I do walk with other friends; we walk everyday for one hour. The furthest away from town, outside town in the park its better.'

Walking with mothers.....

Quote 7.172

'I walk with my mother every evening for 30 minutes, just up and down Melton Road, due to my mother being old...yeah I like walking on Belgrave/ Melton Road.'

Walking with sisters.....

Quote 7.173

'Yes, with my sister 3 times a week, shopping one to one & half hours, we go up Loughborough Road, Melton Road. I like to walk in the park, where's there's nice scenery.'

Walking with daughters.....

Quote 7.174

'I walk with my daughter in the summer during the evening. In the summer walk everyday for 30 to 60 minutes. I don't do it in winter, Melton Road to Rushey Mead. I like to walk in open spaces. Only walk in the group in winter on Tuesday and Thursday.'

Quote 7.175

'I do walk to drop the children off, walk with shopping, I do not own a car so I have to do it everyday, My daughter has diabetes so we do it everyday, 20 to 30 minutes. I feel really tired when I walk. I like to walk everywhere, wherever the ladies take me – I don't mind.'

Quote 7.176

'At the weekends with husband and in the evening with my daughter, 30 to 45 minutes everyday or an hour into town, once or twice a week. I like different places Watermead Park, Belgrave Hall or on my own in Belgrave.'

Quote 7.177

'Yes at weekends, Saturday and Sundays morning walk with my daughter for about 20 to 30 minutes. I like to walk where there's no traffic, and we don't have to cross roads, continuous walking without no disturbance. Now we don't complain everyday about health and we set an example...people ask me why I'm so happy...and I say I go on the walks'

The doctor says I have to walk....

Quote 7.178

'Always walk my GP told me to walk because of back pain. Everyday 20 minutes on Melton Road safer for me. In the parks Abbey or Watermead.'

The men

The men do walk on their own but only on the main roads for safety reasons they would like to walk more in the parks, but think it would not be safe to do so. Most do own cars but only use them for shopping. The weather was the main deterrent that stopped them from walking.

Independent walking…..

Quote 7.179

'Yes, if the weather is fine, everyday twice a day roughly 2 to 3 miles for about 30minutes. I prefer to walk in the park, if near by.'

Quote 7.180

'I walk independently all the time around Rushey Mead park, everyday for one & half to two hours morning and afternoon I stop and rest if I have pain. I don't like to walk alone especially in the park. I have to use the main road. Sometimes shopping and I go out in the evening. I like walking in the park in a group.'

Quote 7.181

'Every Friday I go into town, unless it raining I do not use my car, only if I have heavy shopping to carry. I like to walk twice a week, if not town I do go somewhere else, for 30 minutes at least. I do like walking in the park but it's lonely; so I walk on the main roads I don't like the main roads.'

Quote 7.182

'I'm always going into town, 6 times a week, one to one & half miles. I like to walk into town.'

Quote 7.183

'Yes, I like walking sometime twice week, for half hour anywhere in town, on holiday I get up early and go for a walk I like different scenery.'

Fear of walking alone…..

Quote 7.184

'Yes at the weekend, I walk three times a week for 30 minutes, I do not like to walk on the main road I prefer open spaces, but sometime I have to walk on the main roads because its dark and I am on my own.'

Walking with wives….

Quote 7.185

'Sometimes twice week with the wife 30 to 40 minutes I prefer park, but I walk on the road and streets in the evening it gets too dark when the weather is bad and in the summer we walk in parks.'

Quote 7.186

'Sometimes in the summer walk from Gipsy lane to Sainsbury's on my own or with my wife twice a week for 50 minutes. Would like to go parks, and into town and when we go on day trips to seaside, places to see.'

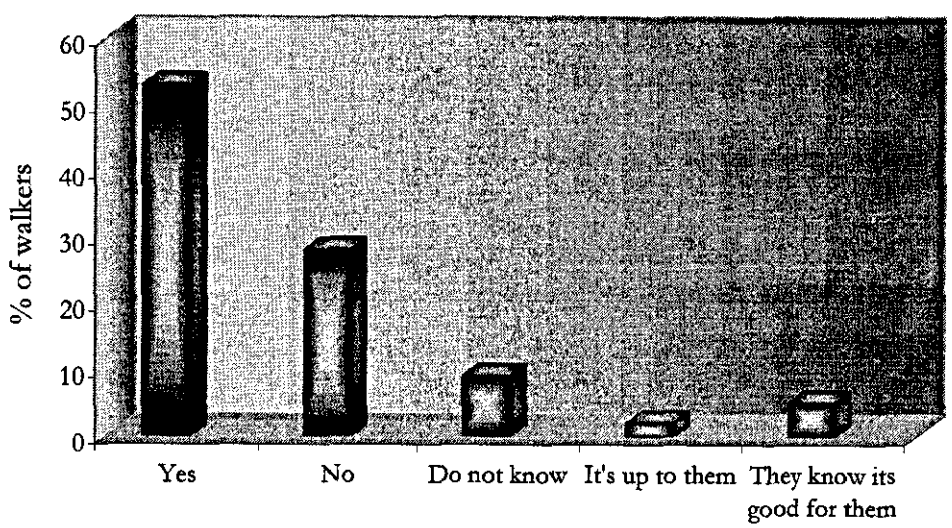
Just when shopping....

Quote 7.187

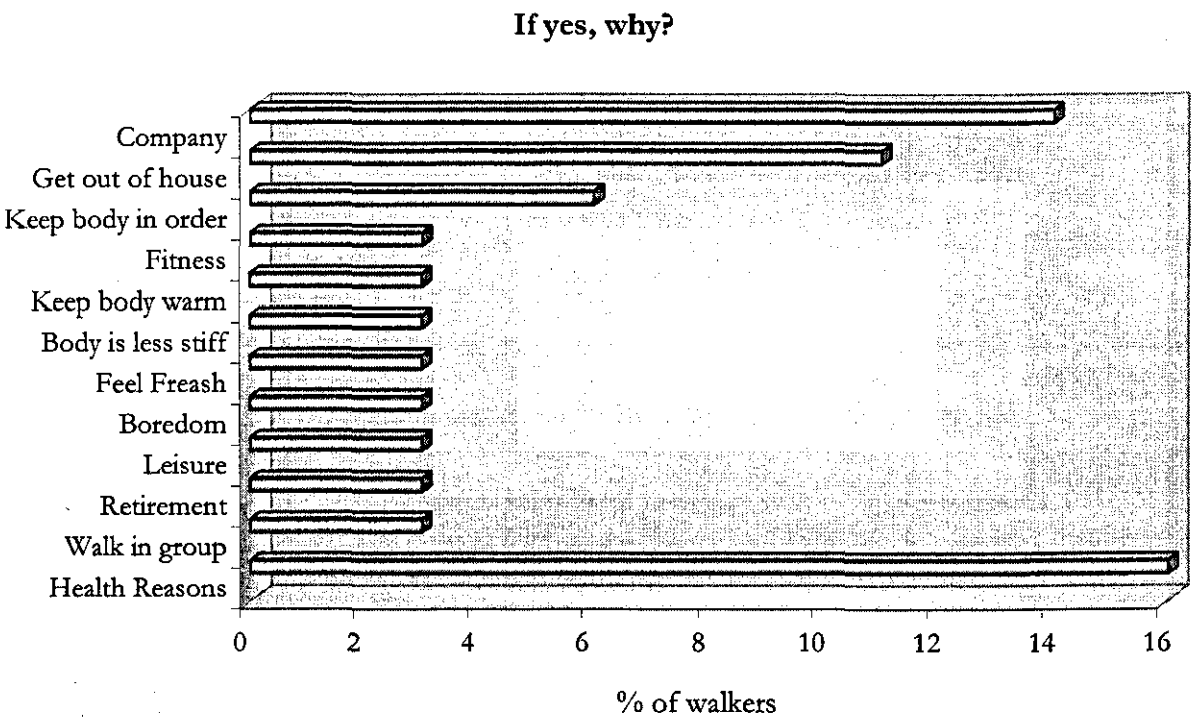
'No unless for shopping....; in the park different parks the countryside the canal but it's not safe. They have improved at the Abbey Park area but not enough anywhere else.'

11. Did they believe people walked enough for their health;

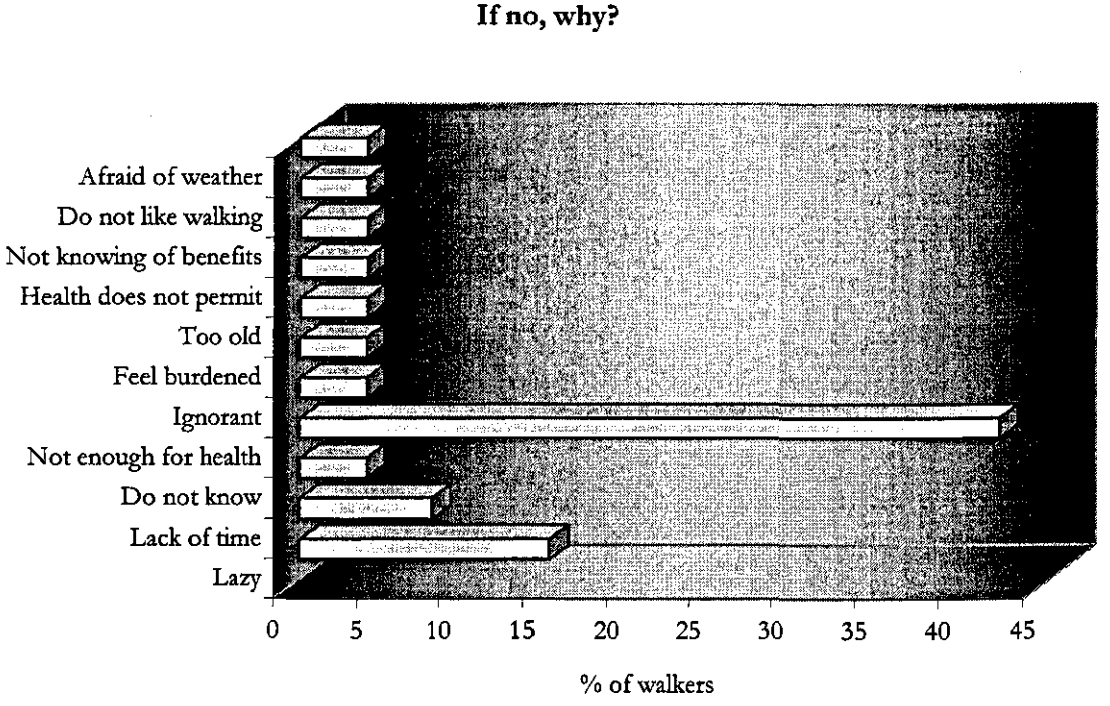
Some walkers misinterpreted this question; that is; do you think people walk enough for their health? They thought it was referring to the walking group and not the general public. Thus 53% answered yes and 28 % said no, of more concern was that, 9% did not know as shown in graph 7.11:



Graph 7.11 Do people walk enough for their health?



Graph 7.12 Reasons for walking for health



Graph 7.13 Reasons for not walking for health

There were mixed views of some of the walkers who thought that after coming to the group they realised the true benefits of walking as shown in graph 7.12, and other people did not know of these benefits or the group. They also recognised that it was up to each individual and their interests. There was a strong feeling that people were lazy and the British climate and weather did not help. The lack of walking was also dependant on whether people were working or not and if they had the time as shown in graph 7.13. Some recognised that walking for health and walking for leisure was different and if people did walk it should be for their health. Owning a car was an issue, if you did not own a car you would have to walk and use public transport. Others felt that people should walk more for their health but were not sure why people did not.

The women

Yes, within the group:

Quote 7.188

'Yes within the group they walk even if they have problems, but outside the group, they may not know the benefits and have no interest in walking. Maybe they cannot get away from the housework or maybe lazy due to the weather. Some people simply do not know about the group. It is also dependant on the interest in walking. They should join the group.'

People should walk;

Quote 7.189

'Everybody should walk, and should not sit down, but they don't just because they are lazy. I tell my neighbour all the time but she tells me that her legs hurt her all the time. People don't think I'm 63 they think I'm really fit...they don't think I'm a pensioner.'

They are walking for themselves....

Quote 7.190

'Yes they do walk for health, they do it for themselves.'

Quote 7.191

'Yes, for their health, they go to the madhir even in the cold weather they feel they are getting exercise so it must be good for them...and that's why they do it...if people don't think its healthy they would not do it.'

Walking for their health……

Quote 7.192

'Yes they do its good for blood circulation and stiff arms and legs which would seize up otherwise.'

Quote 7.193

'Yes they do, they feel fresh after walking and they don't become stiff.'

Quote 7.194

'Yes, for their health, if their legs and back hurt it alleviates the pain. Its good for their general health; If they sit at home it not good for you, you must try and walking a little even that has benefits.'

Quote 7.195

'Yes for their own bodies, lowers cholesterol, diabetes and lots of health benefits, helps breathing, get to meet people.'

They walk to get out the house…….

Quote 7.196

'Yes they do walk there's benefit they feel they can get out the house, from the support of the group they have got out.'

Quote 7.197

'Yes I'm the youngest in the group, they are all isolated especially in this country we have a get together we are like a family.'

Quote 7.198

'Yes for their health, they get out of the house and meet other people.'

No, they do not….

Quote 7.199

'No, because they are not free, if they are working, they may go in their own.'

Quote 7.200

'No they might not know the benefits and others may want to walk but have arthritis should have a slower walks for these people.'

Quote 7.201

'No, sometimes they don't like walking or they don't have time depends on each others nature.'

They know its good for them…..

Quote 7.202

'.....I think they know that walking is good for them , masi masi (aunt) talk about it, and they know what's good for them. I think they do try to walk for their health, I have been in this country 22 years, and I had not seen some of the places in Leicester where we go from the group.'

Not sure.....

Quote 7.203

'I don't know, depends on individual some watch TV too much and their own commitments to their families.'

Quote 7.204

'They should but they are on their own but I don't know.'

The men

No they are lazy.....

Quote 7.205

'No I don't think so, depends on individual, and most are lazy rather liked to be at home.'

Yes good for the body.....

Quote 7.206

'Yes, they do walk and they keep on walking its good to keep the body warm.'

Quote 7.207

'Yes to keep fit and keep body functions going.'

Yes for their health.....

Quote 7.208

'Yes they do for their health but they do not come to our group...I don' know why.'

They should.....

Quote 7.209

'They should, if they join they would improve their health, they do want to walk its good for their health all activities are good for health like swimming and exercise..... it definitely helps. Walking has helped my arthritis and any mental health.'

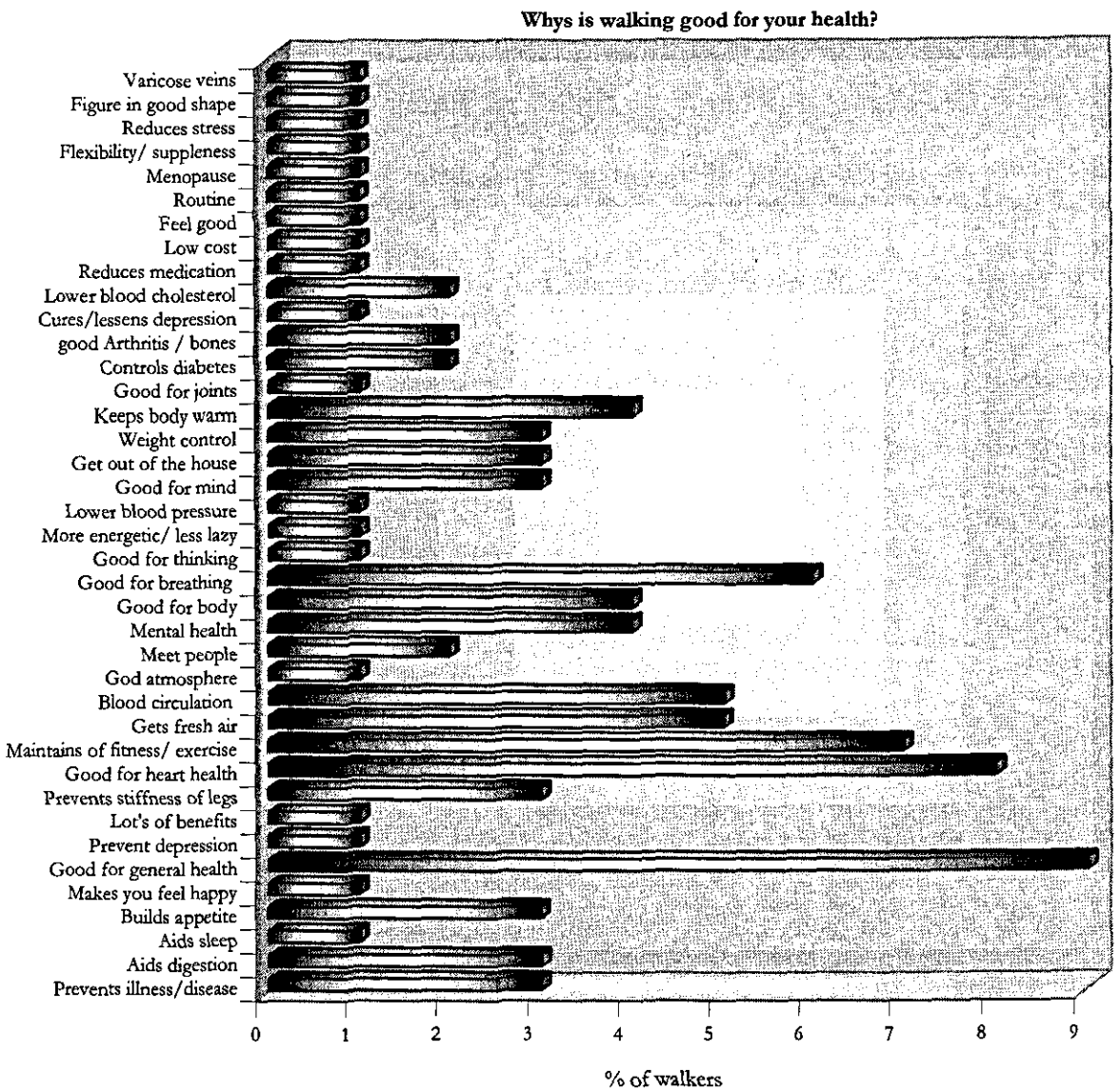
No the weather prevents.....

Quote 7.210

No, lazy watching TV serial's and sometimes afraid of the weather; wind and rain or due to suffering from flu or illness.'

12. Why is walking good for your health?

There were a number of benefits that were mentioned some that they had personally experienced as shown in graph 7.14.



Graph 7.14 Why is walking good for your health?

The women

Lots of benefits

Quote 7.211

'Walking prevents illness, helps digests food, can go to sleep properly, feel hungry builds up appetite, feel fresh, no sad thoughts, generally healthy, no depression. There are a lot of benefits of walking but I can't remember them all.'

Good for health

Quote 7.212

'It good for the health, Good for the legs stops them becoming stiff, good for the heartbeat, body fitness, fresh air, good for those who cannot get out of the house.'

Good for heart health.....

Quote 7.213

'Walking is good as it increases heart beat, it's good for health, feel more confident, good for breathing problems.'

The doctor say's walking is good...

Quote 7.214

'Walking is good for breathing, health and high blood pressure, the doctor says so.'

Quote 7.215

'Good for heart problems GP has said I should walk I feel my heart is working, good for fitness.'

Good for meeting people

Quote 7.216

'Walking is good for blood circulation, fresh air, enjoy the atmosphere, sometimes I feel feed up at home, it gives me the opportunity to meet people.'

Helps boredom.....

Quote 7.217

'Walking is good for health, the fresh air is good for the mind, and eyes feel like you have been somewhere, get bored in the house, I personally do not like to watch TV.'

Good for the body...

Quote 7.218

'It good for my body, I have no other problems except for thyroid and pressure. If I do activity I do not feel ill.'

Don't feel lazy……..

Quote 7.219

'Its good for your body, for your heart, it's a routine if you walk everyday and you don't feel lazy, it prevents illness.'

Good for digestion build appetite…

Quote 7.220

'Walking is good for general health, aids digestion, builds appetite and it's a good form of exercise.'

Quote 7.221

'I've seen the change in my health I feel hungry when I get home…at home I don't have an appetite, after the walk don't feel so tired…… We come for the walk and then we do our shopping, so we are doing two things at the same time.'

Good for the legs….

Quote 7.222

'Good for the legs, can get to sleep easily for those who cannot get to sleep, keeps my body fit, get to meet people.'

The men

Good form of exercise…..

Quote 7.223

'I'm not a medic but…walking exercises different parts of the body, its important for blood circulation, heart beats faster, its important for breathing too.'

Helps with heart health

Quote 7.224

'Walking is good, because you can not warm your body up by sitting at home it becomes stiff, anyone who has a heart problem should walk otherwise they would be in pain, it warms them up.'

Good for appetite….

Quote 7.225

'Walking helps you to eat more frequently or on time, builds an appetite, good for the joins, loosens them by walking its an exercise.'

Fresh Air….

Quote 7.226

'Fresh air, a little bit of exercise, coming out of the house from the T.V and gas fire, it keeps you fit.'

Mental Health benefits....

Quote 7.227

'Its good for mental health & breathing should be improved.'

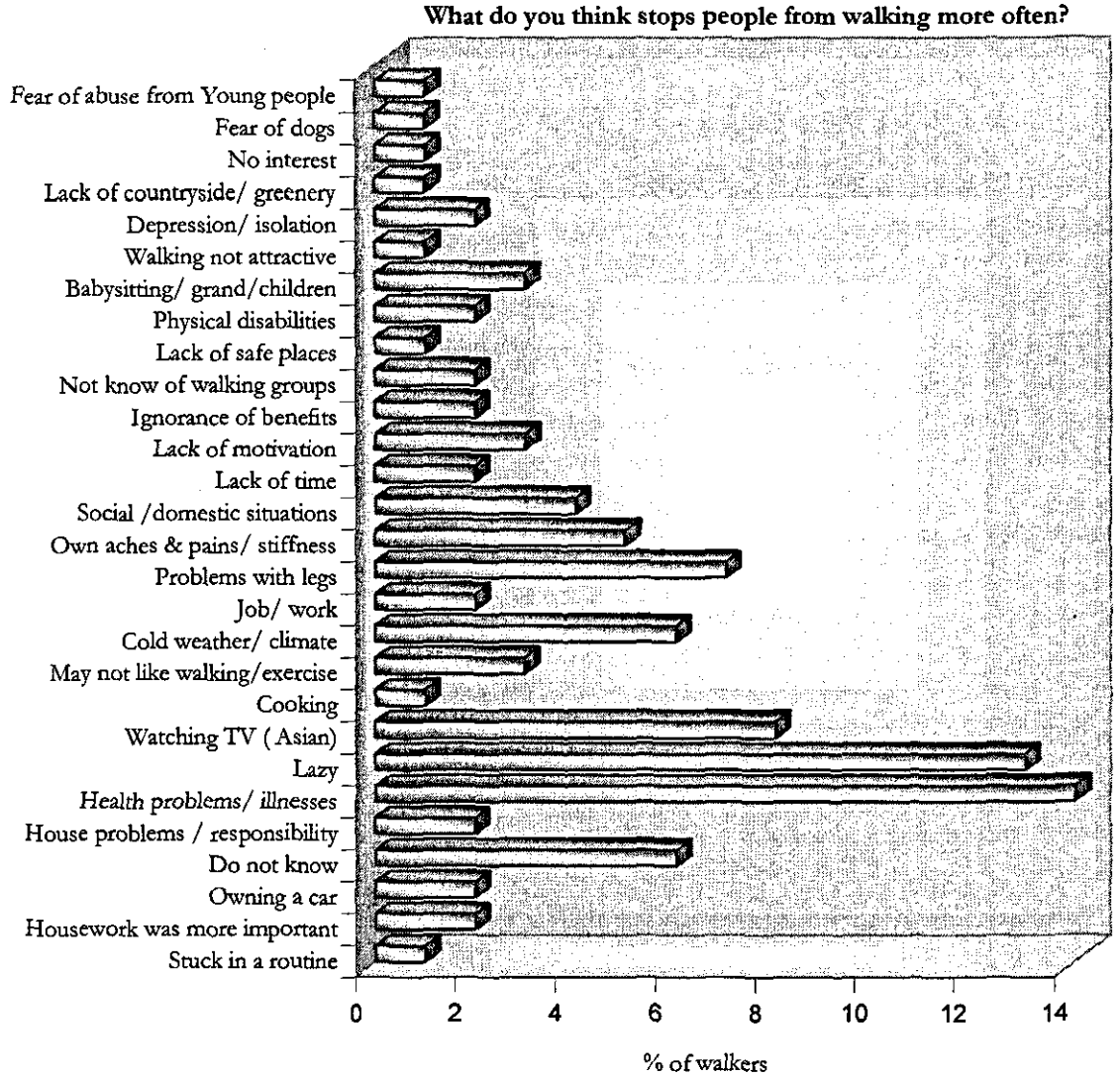
Builds confidence.....

Quote 7.228

'Keep fit, healthy, burns calories and a drop in sugar levels, meet other people and builds confidence'

13. What stops people from walking more often

The walkers felt that most women were stuck in a routine of doing housework, which was more important to them then doing something constructive about their health. Another main factor was if they owed a car and too many gadgets for peoples own good. Some thought that people had health problems, which made them, house bound. A major factor was laziness and the need to watch daytime T.V. The bad weather also stopped people from walking. It was also dependant on their personal interest, and also the perception that their legs would hurt more with walking. Time and work were also obstacles that prevented people from walking as shown in graph 7.15.



Graph 7.15 Factors preventing people from walking

The women...

Owning a car.....

Quote 7.229

'Having a car, I don't have a car that's why I'm always walking.'

Quote 7.230

'Because of the car, they are lazy especially in this country, we don't look after ourselves we are lazy.'

Household responsibilities…..

Quote 7.231

'House and health problems…some people legs cannot take it.'

Quote 7.232

'Most people do not walk because they are lazy and they may have house problems.'

Difficulties getting out….

Quote 7.233

'Each to their own, I don't know, maybe they can not walk, their legs may hurt. They do want to go out but maybe can't.'

Working…

Quote 7.234

'People do not walk because they work, they feel tired and they would like to watch TV.'

Lazy…

Quote 7.235

'People do not walk because they are lazy and they have problems with their legs.'

Quote 7.236

'They are lazy and it's too cold.'

Quote 7.237

'They are lazy, they might not like it, they may sit at home, they might have a serious weight problem so they may not be able to walk.'

They cannot walk….

Quote 7.238

'Some people cannot walk, some do exercise at home.'

We do advise it….

Quote 7.239

'Not sure we do advise people to walk, if you get depressed you can meet other people.'

Cold weather…

Quote 7.240

'Because of the cold weather and TV, older women have to many family problems that they cannot come out.'

Old age…

Quote 7.241

'Their bones hurt, their arms and legs hurt when they get to an age….but they should still do it would help them.'

Isolation….

Quote 7.242

'They feel isolated or are on depression tablets. If they do get there they may feel the walks are too fast, I use to be slow but now I can walk fast.'

Looking after grandchildren

Quote 7.243

'I know someone that does not walk due to children and baby sitting.'

Quote 7.244

'Babysitting problems for grand children. Some have no interest or they are working they become tired or they might not know it not advertised if they don't know they won't come. Others might not be interested or they might feel tired after work.'

The men

Domestic duties…..

Quote 7.245

'People do not walk because of domestic and social situations and naturally their own aches and pains.'

Aches and pains…

Quote 7.246

'People don't walk because of aches and pains in the legs, they can't walk and sit at home but it is good for them even if they walk a little.'

Climate….

Quote 7.247

'People do not walk because they feel lazy due to the climate, most of the people are retired they may have other things to do they don't have the time.'

Lazy, un-motivated….

Quote 7.248

'People don't walk because they are lazy and are not mentally geared towards it.'

Health problems….

Quote 7.249

'Their health might not be up to it maybe people don't walk due to their own personal pains e.g. leg pains etc.'

Quote 7.250

'They may have stiff muscles and pain in their legs.'

A lack of time....

Quote 7.251

'People do not walk because they are lazy don't have the time or they not like to exercise.'

Watching TV...

Quote 7.252

'They are idle watching TV they feel sick there's no enjoyment in their life's they might not know the benefits of walking.'

14 General comments

The women.....

Anytime.....

Quote 7.253

'I like to walk anytime and I enjoy it.'

You are doing a good job.....

Quote 7.254

'I think we should arrange for a hall in this bad weather it builds confidence in everyone. Otherwise you are doing a good job.'

Keep us walking.....

Quote 7.255

'Everything is good keep us walking... like this; and look after us we are too old and we may fall over.'

Concerns at Watermead a need for a pedestrian crossing

Quote 7.256

'At the traffic lights its very dangerous it's is a problem; when I go Watermead it is difficult to cross at the traffic lights and dangerous.....there's no pedestrian crossing'

Quote 7.257

'I like where we walk there no traffic especially at Watermead. Although the older ladies find it a problem crossing at the traffic lights'

Thanks to Chalo Chalay....

Quote 7.258

'Chalo Chalay has brought awareness to many people in Leicester and many of them have benefited from good health – reduced their weight, cholesterol, diabetes and blood pressure levels. Chalo Chalay played an important part in people lives where health is concerned. Thanks to Chalo Chalay.'

The men

A lack of Boat trips…

Quote 7.259

'Chalo Chalay its been three years and there's not been an improvement. The boat trip has been cancelled we are losing the trust in the system. But if you set a date you should do it, people are telling white lies. If its not going to happened then do not say.'

Quote 7.260

'Boat trip or picnic, should be included it becomes an outing event'

Has helped people at no cost…

Quote 7.261

'Since Chalo Chalay has been launched it has helped people to improve lifestyle and more people are joining and it costs nothing. You get too meet with different groups of people and they communicate well.'

7.3.2.2 Interviews with volunteer Walking Activators

Two of the female Walking Activators were interviewed they were initially volunteers for the project but then became paid walker leaders at the latter end of the funding period. They both lived in the locality and were aged 53 and 59 respectively; they had both been involved with the project since its conception and were leading walks for 3 years. Eleven questions were asked and they were both ensured that the interview was strictly confidential and to answer questions as openly and honestly as they felt comfortable.

Intentions of Chalo Chalay

1. *What do you think were the original intentions of the project?*

Both walk leaders felt that the project was set up for South Asians to raise awareness of walking to those who were inactive. There was a recognition that there were many benefits to walking, especially health ones and these needed to be sold to the participants.

Recruitment onto Chalo Chalay

2. How did you hear about the project?

Both walk leaders came to know of the project from the pilot at the Savera Resource Centre, both were users or volunteers of this group;

Quote 7.262

'From Rekha at CIO at the Savera Resources Centre and the Belgrave Neighbourhood Centre.'

Quote 7.263

'In Savera, Rekha came to introduce the walking project, thought it was a good idea ..... it's been beneficial for me and my anxiety and depression.'

Impression of Chalo Chalay

3. What do you overall think of the Chalo Chalay project?

The leaders felt that the project was good and that it had brought awareness to the South Asian community. However, more importantly had brought a sustained change in people health:

Quote 7.264

'It's a very good project it brings awareness especially to South Asian people who are not very fond of getting out of the house.'

Quote 7.265

'It very good since we started we have never cancelled, got 35 in our group they are all feeling healthy, they are more happy. Health wise every one says how its improved since walking and the social aspect is really good. Asian women don't go out do anything, they do enjoy each others company.'

Involvement with Chalo Chalay

4. How did you get involved?

The key to involvement was the project coordinator who provided the opportunity and generated the idea. They also liked to volunteer and thus they were doing something they liked as well as volunteering.

Quote 7.266

'....because I like walking and Rekha was there to pick us up for walking once a week. I like walking in a group instead of walking alone, so I decided to join Rekha, which was more fun in a group.'

Quote 7.267

'Because it has help my health, I like volunteer work – feel good! The more people that joined felt good and confident. Personally it's given me confidence in doing things better.'

Played an effective role

5. Do you think your role has been effective?

Both walk leaders believed that their roles had been effective, as they have progressed to leading their own group; the walkers felt that the walk leaders were committed and had endorsed this.

Quote 7.268

'All the walkers say, must be effective. I had been off for 3 weeks and they all missed me they must like me.'

Strengths of Chalo Chalay

6. What do you think the strength of the project is?

The walker leaders clearly stated that the walkers themselves were the strength of the project; they have set an example and have been role models to other members in the community.

The leader was convinced that the South Asian walkers would not come if it were someone else who could not speak the language was leading. The walk leaders felt that the programme was culturally appropriate and this was also the strength of the project.

The strength had also been the community spirit:

Quote 7.269

'The project has grown so much and so well, new faces joining us, groups are growing, they become like a family, the project is going very well and has grown quickly. Because once people started walking, more people joined then the walks grew –walkers themselves they are the strength.'

Problems with Chalo Chalay

7. What do you think the problems are?

There were a number of problems that the walk leaders faced, there was a clear recognition of these problems, but they felt that they could be overcome one by one:

Quote 7.270

'There are so many problems'

Pollution....

Quote7.271

'First is the pollution and the traffic.'

Pedestrian crossings.....

Quote 7.272

'Traffic lights, you have to be careful when the group is crossing, especially when we are going to Watermead there is not a pedestrian crossing, it's a big junction and very difficult to cross.'

Quote 7.273

'Road crossing especial at the Watermead junction, not a single crossing; we find it difficult especially with a big group and the safety aspect. The canal side is not wide, it's a nice walk but not safe there for the walkers.'

Dog litter....

Quote 7.274

'In the park, dog litter, Abbey Park in particular. ...It has got better over the years.'

Quote 7.275

'Dog mess in Cossington Street Park and Abbey Park.'

Uneven pavements.....

Quote 7.276

'Pavements are uneven on Belgrave Road and towards Abbey Park near the college. We have had a few stumbles...we have had a few falls....its her fault really...she cannot wear shoes she feel anxious each time.'

Need shelter.....

Quote 7.277

'Because we are walking in all weathers sunshine, snow, rain we don't have shelter, we use to have the visitors centre in Abbey Park, but I don't know why they don't give us it now we should ask X and XX to give the centre, I have asked them so many times to write to Leicester City Council we can spend time out resting after a 4-5 mile walk before we start back...Its shame we can't go else where for shelter...it would be better.'

Way marking

Quote 7.278

'Even the park can do with marking, like in half miles, way marking.'

Cyclists on the park

Quote 7.279

'Cycling on the park, scared of being knocked over taking up our walking space.'

Cleaning the park

Quote 7.280

'In Cossington Park the birds are messy, and really smelly walkers don't want to walk there and dogs.....'

First Aid Training

Quote 7.281

'We could do with more training in First Aid'

Potential of Chalo Chalay

8. What is the potential of the project?

The walk leaders thought that the project had potential if support was provided and the recruitment of more Walking Activators.

The impact of Chalo Chalay

9. What has the impact been?

For the walk leaders the impact had been the improvement of the health of the walkers, the raised awareness of the project and the benefits of walking. One of the leaders had commented how it has halved the workload of doctors.

Training

10. What did you think of the training?

The leaders felt that the training could have been better and needed to include First Aid training.

Satisfaction from Chalo Chalay

Quote 7.281

'Without Chalo Chalay or CIO helping us we would have not gone so far and so many people wouldn't have gained such happiness and liveliness.'

Quote 7.282

'I enjoy it!'

7.3.2.3 Interviews with Key People

Interviews were held with seven key individuals of the project who at some point during the time of the project sat on the steering group between the periods of February 1999 to December 2002, eleven questions were asked:

1. **Pre Chalo Chalay, what decisions do you think were made, did you have any background?**

There were mixed views of the pre information given to the key individuals before attendance at steering groups meeting. There was a general understanding of what the project aimed to do but nothing on what their role as steering group members were.

A project to help prevent CHD in elderly South Asian community;

Quote 7.283

'The key reasons were to lower levels of CHD in the South Asian community in Belgrave.'

Quote 7.284

'Yes I had background information to the project it was to improve the lifestyles of elderly Asian for preventing CHD, which there was a very high incidence of, as a preventive measure and also to help those who already had the condition.'

Other keys workers felt that they were allocated the responsibility of sitting on the steering group because they were the only people who fitted that role, and to a certain degree resented this and felt it should be a generic role.

Not briefed on the project:

Quote 7.285

'Brief by manager on the Asian walking programme, knew that HPA had been involved I did not have a sense of history about it.'

2. What do you think were the original intentions of the project?

The key individuals were clear on the intentions and aims of the project, and believed it to be an intervention targeted to the South Asian community with a hope that it would be a preventative mechanism against CHD.

3. What do you overall think of the Chalo Chalay project?

There were mixed views on this aspect of the project, individuals thought the project had been a success in many ways but also recognised that it also carried with it many problems and poor management was clearly seen and often felt by partners in the project.

4. What do you think of the steering group?

There were positive aspects to the steering group initially besides being rather big, however there were indications that hidden agendas were being played out, and not all work by the group was done in good faith. Later as the project progressed and the

stepping down of the chair the group dispersed into a much smaller management group, which was not as productive or supportive as in previous years.

5. What do you think to the structure of the steering group?

The response to this was question by all key individuals was not positive, there was constructive criticism on the set up initially and its progression through the three years. It had been a steep learning curve for all as partners from the voluntary and statutory sector who came together in a working, professional environment.

Structure was ok.....

Quote 7.286

'The structure....should have relevant people on it! I think the structure to a certain extent was ok its was the people who were involve it in, it had the relevant bodies on it but whether it had the relevant people I'm not sure.'

6. Do you think your role has been effective?

There was a consensus by the key individuals that their role had been effective toward specific parts of the project but there was room for improvement.

7. What do you think the strength of the project is?

The overall strength of the project had been the community themselves and the dedication of individuals of the project.

8. What do you think the problems are?

The problems are discussed in the summary 7.4.

9. What is the potential of the project?

The key individuals interviewed felt that the project certainly had potential, and it was the community themselves that had the power. The walk leaders were seen to be ambassadors of the project and transferring this good practice to other localities of Leicester.

10. What has the impact been?

There was clear evidence from key individuals that the project had raised awareness of physical activity and walking in the targeted community. There was certainty that it had increased walking levels but uncertainty on whether individuals were meeting guidelines (150 minutes of moderate activity on five or more days of the week) and actual numbers of people walking.

Comments made on strand three; environmental changes of the project

Strand three of the project never materialised during the life of the project, it may have been premature to have such high expectations within a short-lived project and the funding resources to hand.

Views on Walking from a Walking for Health Coordinator in the City

The Chalo Chalay was the start of the WHI in Leicester from which monies were secured from the Health Action Zone for a city coordinator who had been in post for 18 months. She had a wider perspective on walking through the city and had thoughts on the future of walking for health.

Thoughts on the future of walking for health in Leicester and the potentials for walking for health, 5 years ago there wasn't a WFH initiative....

Quote 7.287

'To be honest no I don't think it's the answer. In certain areas it's going really well and in other areas it's taking ages to set up and its one of those things obviously it's a bit like Chalo Chalay we are working in fairly deprived area's where people walk a lot anyway and its trying to convince them the benefits of taking up walking for health really. I think the interest is definitely being raised; we are always getting lots of calls, we are on the radio, in the newspapers, regular features in the community papers so people are always ringing us up, walking is the best buy for public health and all that.... what can we do...so its definitely getting over. We got a nice project in Braunstone that is coming on nicely there are 6 volunteers that are running the project. Part of the impact is being able to link into agencies like the sport action zone so not just looking at walking for health but also walking as a sport and that's been interesting to try and get specifically the sport action zone to think on a health basis because every time I read their documents they are very sport focus and they don't have an appreciation of how health services and Primary Care Trust's work its been quite interesting to work with those. The park rangers

are really getting on board now and recognising this is a way of getting people onto the parks and again having been successful in getting eight thousand from Neighbourhood Renewal Fund. GP's are becoming a bit more aware of physical activity and general moderate activity and are more keen to refer and promote the development of the GP referral scheme, its gone both city and county wide that's helped the promotion of walking and the regional and local transport plan, you know some of the issues raised reducing car travel, it's helping. In the middle of developing a walking forum for Leicester City we are trying to get all the agencies involved in promoting walking to think about how we want to do it now we want to look at walking in an environmental scheme, how we feed into those schemes and what kind of information we need to tell people about the walking environment. So it has been like a combination of things; the fact that Chalo Chalay had such a high profile, the fact that physical activity is getting more onto the agenda and community development, there much more community development happening now, and there's much more ability to build capacity within communities to think about these kind of things. I think my role has not just been about setting up groups its been about working with crime and disorder and youth offending teams and looking at ways in which young people can get involved. I've done a lot of work on safe routes to school, not only how school children travel to school but how parents can get involved in walking generally as a result. It's a combination of things that made it effective not just health action zone monies, the other thing about it is that its been so fairly low cost to set up, and the fact that we have been successful in getting grants for South Leicestershire, Braunstone and Chalo Chalay so (20k for South Leicestershire, 7.5k for Chalo Chalay, 10k for Braunstone from WHI) we did actually go for a lot more than that but some of it has actually been siphoned to LEAP projects –Local Exercise Action Pilots and the Department of Health, I've spent half my life doing nothing else...just literally written a bid for Eastern Leicester PCT, basically 200k per pilot there's going to be 9 in the country and we have written a bid on behalf of both PCT's actually but its going to be linked to walking ...funded by Department of Health supported by the Countryside Agency and Sport England.....all of a sudden there is 200k but there's nothing for walking for health, very strange, 3 –5 year project?'

Do you think WFH is the answer in 20 –30 years time?

Quote 7.288

I think its got lots of potential but you are battling against so much, you are battling against car travel, mod con's, culture generally, safety, the government has just announced a huge motorway expansion plan, and I think until you can get clinicians thinking about health promotion they are always going to prescribe a tablet rather than prescribe anything else so its got so much potential but in isolation where you've got a good traffic team, a good PCT, and people wanting to fund it I think you can do that ...in Australia, New Zealand have made significant improvements but that's because lots of people have been

working together....there's just too many things too many variables you have to change in order to get everybody active...but I think that.....I work on the principle more people more active more often, really...but some people don't leave their house and at least they've gone out on a walk or you have cardiac patients that weren't exercising because they have had heart attacks, you are making a difference to a small population but in the whole scheme of a PCT its not actually making that much of a significant difference and they are the people that have to fund it at the end of the day.'

7.4 Summary

The summary begins with describing the funding received for the sustainability of the project and the events leading up to the financial end of the project. It further states the working of the project with the small about of sustainability funds received. The summary then goes on to present the data collected from the interviews with walkers, walk leaders, and key individuals.

It was premature of the project to believe that it could secure funding and an exit strategy for sustainability should have formally been written. It was fortunate that some funding had been secured by the HPA for the sustainability of walks set up by Chalo Chalay. Although it had to be questioned whether this funding should have directly come to Chalo Chalay and not through the HPA, as they had secured five years of funding from the Health Action Zone (HAZ). Tactics were certainly played to receive this funding at the expanse of Chalo Chalay. The funders were not happy with the partners of the project, a number of management changes had occurred not in favour of the project and the steering group had dissipated, the key was the chair that had to step down. The host organisation during the funding period was perceived to be the main difficulty, and were not accommodating to the project. This did not favour the host organisation to received further funding, however, Chalo Chalay as an independent project out in the community, owned by the community may have been seen more favourably by the funders. What had been the strength of the bid at the start of the project, the partnership dissolved at the end of the funding period. Instead a smaller network of walking activators was committed to the concept to date still continue to lead walks.

CIO's Leicester's regional office came to the end of its short stint, it was unfortunate that the Chalo Chalay project was based at an organisation who had seen many changes and was not ready to embrace innovative idea's. The coordinator left in April 2002 with no

exit strategy in place; the only fall back plan in place was the HPA's Lets Walk Leicester programme. As seen from case record 7.1 the initial working party for the programme did not include Chalo Chalay, there may have been political reasons behind this considering all other partners from the steering group were involved and one of the distinct aims were to work in a multi agency and to targeted vulnerable groups. Upon reflection the Let's walk Leicester programme mirrored the Chalo Chalay project but with a city wide brief. It can be speculated that the HAZ funding that could have be allocated to Chalo Chalay was redirected to the Let's Walk Leicester Programme, however this funding was only available until 2003 evidence of this is provided by one of the programmes main objectives of; to recognise and integrate the Chalo Chalay project. Furthermore, a key aim of the Lets Walk Leicester strategy was to build upon the outcomes of the Chalo Chalay project suggesting that the matched HAZ funding had no intention of continuing its funding as it used the Chalo Chalay project as a learning tool and then to integrated it into its HPA function. This on the surface seems like a positive action as it has been recognise by the statutory sector and may in the future be mainstream, but as with any of the other services that the statutory sector provides it does not have community ownership, and thus community members are sceptical of such services.

A volunteer walk leader was invited to sit on the steering group on the Let's Walk Leicester programme but it never materialised. This was not an environment where the walk leaders would feel comfortable to voice their opinions. This action was tokenism towards the project and did not present real value. One of its key tasks was in breach, as it did not fairly represent all communities. It's integration did allow for Chalo Chalay to develop strand 2 and 3 of the project, and was in a better place to do so as the Active Lifestyles Referral coordinator was also based at the HPA. These aims and objectives were written before funding was refused to the CIO by the WHI, and when Chalo Chalay were hosted by CIO, there was an inherent fear that the HPA's Let's Walk Leicester programme would engulf the project. Case record 7.1 suggests that:

'An Ethnic Minority project would be a major part of the project'

This may hold true, but it was an *'Ethnic Minority project'* that lead the way in Leicester and in a truer picture the Chalo Chalay project should have integrated the Let's Walk Leicester project, this would have been a true reflection of success and expectance of our communities. Reflection 7.1 provides further evidence of the lack of responsibility of

generic workers in the field working with 'BEM communities' this will have to change if progress is to be made in meeting the healthier nations targets.

Many of the recommendations that the strategy made had been addressed by Chalo Chalay, but with the collapse of the project the walkers needed to continue to be supported which, it received from the Let's Walk Leicester Programme via the £7,500 awarded from the WHI to sustain the walks and walking activators established by Chalo Chalay. The sustainability of the strategy forecasted after 2006, were not impossible if the correct support was received, as these same targets were aspired to by the Chalo Chalay project. The major set back was the short timescale of three years as environmental changes needed to be committed to longer term funding. The objectives identified in case record 7.2 would have also been Chalo Chalay objectives but in the hope that the community were empowered to deliver all parts of the project.

Interviews with participants

The interview data provided a true picture of what participants thought of the intervention and gave answers to many of the evaluation questions set at the beginning of the research period. The intervention had reached its target population, as shown in graph 7.1, 57% of the participants were inactive before the intervention. The women in the programme felt less active compared to the men. Those that said that they were active; half after probing; 43%, stated that the activities did not make them out of breath or cause any sweating, this suggested that the activity did not raise their heart rate:

Quote 7.289

'I use to go to the Belgrave Neighbourhood Centre's exercise session twice a week, for 2 years, for one hour, I did not sweat form these sessions and I was not breathing too hard, I also do some light exercises at home.'

Quote 7.290

'I use to do a little walk into town once a week it takes me 45 minutes, walking at a medium paced; no sweating and breathing was normal also go to the sauna once a week and exercise classes at Belgrave Neighbourhood Centre at a medium pace no sweating or heavy breathing.'

One of the men felt that he was very active because;

Quote 7.291

'Very active, various activities; gardening, help wife with housework shopping, the activities are a little hard, in the summertime I do gardening everyday for 2 hours we have a big garden; a little sweat.'

Furthermore 21% of the participants were active and evidence was provided that these activities raised their heart rate.

The women had conflicting views on housework and general household duties; some believed that it kept them active;

Quote 7.292

'No, but I am active I do all the housework and look after four grandchildren so I have lots to do.'

Quote 7.293

'No, but I am active at home, I do all the housework, and I do some light exercise at home.'

Whilst others did not believe it was an activity and perceived 'exercise as going to a formal class'. This shows the mixed messages being sent out to the community, and was a reason for consolidating messages, which governing bodies and authorities need to address. There was a perception that work was a substitute for being active and the women felt that their housework toped this up:

Quote 7.294

'No, I use to work, so I did not do any activities, but I did all the housework.'

Quote 7.295

'No but I use to do shift work, I was very active I used to work and I did all the housework.'

Quote 7.296

'No, but I was active I worked for 20 years then was made redundant, I worked and did all the housework, and help with the children'

There was an indication that the women walked for domestic purposes such as shopping and picking up the children, they did not have a choice about this as they did not own a car, which was a major incentive to walk. Together with attendance at informal exercise classes, a perception was built that these women may have already been active; however these activities did not raise their heart rate and they were misinformed.

The GP had suggested walking to the women:

Quote 7.297

'Swimming once a week, Belgrave Neighbourhood Centre's exercise group once a week, part time work – house wife now, do all the housework. I get out of breath because I am anaemic, I had to loose weight the doctor said this maybe causing the breathlessness. I feeling fitter and have lost some weight.'

One of the ladies in the group had a heart attack:

Quote 7.298

'Belgrave Neighbourhood Centre twice a week since having a heart attack, I have difficulties breathing. Swimming once a week, a little housework..... good for heart problems GP has said I should walk I feel my heart is working; good for fitness.'

The doctor had not stipulated at what intensity. The women that walked did so as they were also influence by their husbands to do so and having the support made it easier. Even at an early stage of the intervention, walking had made a difference; they did find it difficult initially:

Quote 7.299

'I use to walk less and not very hard as my legs hurt...they pained me, and I use to walk slow....the more I walk the pain becomes less, now I can walk faster.....'

Due to pain in the legs, which gradually decreased over time. There was also a significant effect on depression:

Quote 7.300

'No, not active; I was suffering from depression. Chalo Chalay was my first activity use to swim, but I couldn't continue my hands were given me problems.'

Quote 7.301

'No I was depressed that's why I enjoy it I was not active at all, I only joined in the last three weeks'

Evidence was also provided of how walking had helped with menopausal women.

The men interviewed felt they led active lives, but the walking group gave them more of a social activity:

Quote 7.302

'I use to do similar distance on my own rather than a social gathering or any company. I usually walk twice a week 2 miles each way, depending on weather, at a fast or medium pace and I feel slightly hot.'

It was quite clear that the men felt that their working lives were active and this made them feel fit and this had stopped with retirement. The walking group gave them a platform and the confidence to join other activities and classes:

Quote 7.303

'No, not active my health did not permit it...joined class afterwards.'

The intervention had successfully recruited its targeted population, who used the walking group as apart of his rehabilitation programme, after by-past heart operation:

Quote 7.304

'Before my by pass I was not active, but I feel better now. When I was better I use to do a lot more, use to go to the Belgrave Neighbourhood Centre, exercise sessions and the sauna, twice a week for an hour at a slow pace. Otherwise I get pain sweating, I have breathing problems due to asthma and heart problems.'

A majority of the walkers on the intervention programme were recruited via the Belgrave Neighbourhood Centre, which was the central venue of the geographical boundary. The power of word of mouth was effective in getting isolated individuals on board, as those that did not use the Neighbourhood Centre came via the recommendations from friends, neighbours and relatives. Graph 7.2 shows that the walkers and walking activators were the main tool used in the recruitment process. What interested walkers into joining the intervention was the health reasons and to meet and talk to other people from similar backgrounds and situations. Graph 7.3 clearly indicates that intervention had drawn individuals onto the programme via these set attributes. A further 8% were interested as their doctor had stipulated that they needed to walk and another 8% were interested, as they were bored at home. These latter two indicated that the project needed to target its publicity accordingly in particular at GP surgeries and also to add in the angle of relieving boredom. The women were more interested due to the health benefits, and the men more for the social benefits, but in a short period of time the social benefits out weighed the health ones. In particular getting out of the house, meeting in a group and getting fresh air.

The GP had influenced the women and had recommended walking to ease ailments such as; reducing blood pressure, diabetes, back problems, and asthma;

Quote 7.305

'Fitness and health reasons and to reduce my blood pressure; the doctor recommended me going for walks...I did it for my body.'

One of the ladies was particularly interested because of the heart health benefits:

Quote 7.306

'Health reasons in particular heart health, good for the heart, to improve general health.'

Quote 7.307

'Because of my health and its good for diabetes, the doctor said I should walk, excercise and keep fit.'

Quote 7.308

'I do feel tired after walking but it makes me feel fresh I feel better from joining the group. I have back problems and my legs hurt, the doctor said that I should walk everyday it would be good for me.'

Quote 7.309

'The more exercise I do the better for me and the doctor said I should walk.'

Quote 7.310

'The doctor told me to walk because I have high blood pressure. I enjoy it; it freshens my mind...my blood pressure is level now.'

Quote 7.311

'For health reasons and the doctor had suggested it as I have a lung, breathing, and asthma problems fresh air is good, helps oxygen levels.'

They did not however, direct them to any particular walking groups or advise on the intensity to which they should walk at or how often. More work needed to be done with primary care teams to provide constructive information on how to begin physical activity and walking programmes. In answering this question, it became apparent that many of the women did not initially walk, because they felt they were unable to because of their legs hurting, this eased and even stopped when joining the group:

Quote 7.312

'Walking is good for my legs, so I don't get any problems.'

Professionals in health care teams such as physiotherapists observed drastic differences in their patients as stipulated:

Quote 7.313

'Before I couldn't walk, I had painful feet, I've had operations on both feet, I feel much better since I started walking and we are now walking 4 to 6 miles...more and more. I have arthritis & varicose

veins, the Physiotherapist asked me what I did to make such a difference she said that I don't need medication, its ok.'

Evidence was provided that walking helped and stopped medication use with arthritis and varicose veins. Walking had also helped the women with irregular periods:

Quote 7.314

'Since walking I've stopped all medication and I feel much more healthier and my low blood pressure is normal. Since I had stopped walking it was not good for my circulation I feel much better now. I also had been suffering from irregular periods, but since I have been walking they have been regular ever since.'

It maybe deduced that with most of these ailments, the holistic approach of healthy mind led to healthy body.

Walking in a group was important to the women, as many felt isolated, and the walks were a way of getting out the house and talking to liked minded people who understood their problems. Some of the benefits were unexpected such as increasing stamina:

Quote 7.315

'I get fresh air. It keeps the mind fresh; speak to other people. It has increased my stamina now I can do all my housework before I could not, I'm less depressed; exercising and walking together has helped me to walk faster and further.'

The women felt that they could do other things such as housework much more quickly and gave them the motivation to join other activities and learn new things. The women emphasised how the group had helped ease their depression.

An active interest in walking was more predominant with women whose family also walked, and to an extent were influenced to join the group by this. Husbands played an important part and older members of the family:

Quote 7.316

'I used to walk with my mother whose 85 and husband, when I use to get bored at home I am free in the afternoon, what to do when I am on my own so I enjoy coming out.'

Retired women felt bored at home, so the group was a way of passing time. There was also recognition that walking was good for the physical body and ultimately good for their mental health and prevented them becoming lazy. Only a small percentage were

interested in joining the group to loose weight, whether they felt that it was not intense enough to do so or that there was not an awareness that walking could help loose weight.

What most interested the women to the walks was getting out and talking to other women who were like-minded:

Quote 7.317

'Didn't have any thing to do in the house use to get depressed. I enjoy the walks; maintains my fitness.'

Quote 7.318

'Can meet other women and enjoy and don't get depressed.'

Quote 7.319

'Meeting people, and talking about the same interests. When I left my job I went into a depression and suffered a lot of anxiety, walking with the group has helped me.'

Quote 7.320

'Thought I'd give it a go, I liked it; if it's going to make me better because I was depressed.'

Quote 7.321

'I was depressed and X told me to come'

This ultimately eased their various forms of depression. Mental health can be manifested in physical ailment, which sometimes are 'ghosts pains' these were eased and sometimes stopped by coming to the walking group once a week.

The men related to the walks more on a social level rather than a means of good health and were influenced by peer pressure. A few came because they were told by their GP, but found the walk enjoyable and the health aspects were a bonus. A renewed interest came from the social aspects of the walks and the enjoyment:

Quote 7.322

'It creates an atmosphere and is socially pleasurable.'

Quote 7.323

'I enjoy walking, the fresh air, gives me a fresh mind, and I enjoy it.'

Walking in a group was important and the fact that they were learning new things, and new parts of the environment also interested them to come back for more. GP's were also influential with the men; patients with heart problems, diabetes and blood pressure attended the walks and saw it as an opportunity, as they walked independently anyway;

Quote 7.324

'Since my by –pass operation I have been told to walk independently in the morning on my own but I like walking together in the group because the opportunity arose.'

Quote 7.325

'It good for my health I have high blood pressure and diabetes and the doctor suggested walking to me as well. Its good for me.'

Men who had retired saw the group as way of passing time with an additional benefit of exercising at the same time. It gave them fresh air as well as improving their fitness.

There were various reasons why the participants had joined the walking group the most frequent answers were being in a group, getting out the house, meeting people and the social aspect. Even though the walks were sold, as a health walk people did not join for health or fitness reasons, however these were more apparent after joining the group.

Women joined as it was the only activity on offer, which was outdoors, and they felt safe to do so. This was an important aspect when recruiting the women, to reassure that it was a safe activity and walking in a group they were less likely to get attacked or mugged. Learning new things was an often-quoted reason for joining the group not only of their environment and other activities but also of new ideas from other people. For the women the weekly walking group had become routine, and they arranged it around other responsibilities:

Quote 7.326

'It's become a part of my routine to go for a walk, and I enjoy it. I leave my housework.'

They felt that it was a unique activity and it was free:

Quote 7.327

'I enjoy group walking, besides there are no other groups to join. We have to pay for other activities and it's the only walking group there are no other groups like this.'

It was made more attractive by simply having women of similar backgrounds and ages:

Quote 7.328

'The group is very friendly, they are like me, that's why I liked it more; the walk leaders X…are really good.'

This also facilitated peer pressure from the existing walkers and walking activators:

Quote 7.329

'..... one of the leaders talked me into coming.'

Quote 7.330

'I joined with everyone else altogether...I enjoy walking in a group, also everyone else joined so did I...'

Quote 7.331

'Told from Belgrave Neighbourhood Centre / Cossington group on a Tuesday...so I just joined.'

Quote 7.332

'Walk leader said it would be good and I would like the people.'

This was an indicator of success as the women made recommendations to fellow peers. The group was an excuse for some of the women to leave the house and to stop boredom; retired women in particular felt these benefits. Walking in a group, and meeting friends and having a social were motivations for the women to join the group. The group became like a family to those that were isolated or lived on their own and just with basic conversations with fellow walkers released fears and anxieties:

Quote 7.333

'We get out and have a laugh and just by saying hello and how are you we feel so much better. We meet friends...find out how they are; we have become a family. It has improved my health and I get out more...no matter what.'

The women truly enjoyed the walks and they had a 'laugh' whilst making walking an interesting activity. The women joined initially for the health benefits but the walks helped more with their mental health and depression:

Quote 7.334

'Health reasons, was depressed helped me to get out of the house. I went to the Savera group and was involved with the pilots.'

The women felt that the walks were always apart of their lifestyle and was something that they grew up with:

Quote 7.335

'For myself and my body, exercise it good for you, we were taught at school; its good, good for body.'

The men joined the walking group for the social aspects such as meeting with people and having company:

Quote 7.336

'I am a stranger, new in Leicester, it gives me an opportunity to connect with the local people.'

Quote 7.337

'Basically for the exercise and social aspect you are doing both at the same time.'

Quote 7.338

'I like the good activity it gives me company and I get to meet people'

Walking in a group and getting fresh air were also reasons for joining but more defined was the fact that it was a hobby or an interest they had:

Quote 7.339

'...I had an interest and now I feel fit. It makes me feel fitter.'

Quote 7.340

'Personal hobby .....meet new people.'

It gave them the opportunity to get fit and meet new people. Again alike the retired women the retired men also felt that the group stopped them from getting bored and had the bonus of getting fit, it was something which passed time, which in the past was filled with work. There was no emphasis on joining the group for health reasons, although heart patients knew that walking would be good for their condition. A more pronounced reason was suggested, walking in numbers for safety and having qualified leaders just in case a medical emergency arose:

Quote 7.341

'It good to walk in a group, the people from the project are good to walk with leaders are there for an emergency & safety.'

The women in general felt that the walks had given them confidence with their physical body and how much physical activity they could do. On a social level, they felt much more confident in meeting new people and talking about their problems, it helped release tensions of family pressures. It gave them renewed stamina to cope with responsibilities such as looking after the family and doing housework, and balancing other social activities in their life. The women had noticed how their health had improved since joining the walks and it alleviated pain, in particular stiffness in the legs. The only concern was the pace of the walk, they felt that this was fast, and they felt that they were slowing other members of the group down. This suggested that the walking activator could reiterate that walkers can walk at their own pace and leaders should be able to facilitate this.

Many of the women thought that the walks were good for a wide range of reasons, which were personal to them. The women were not quite sure whether walking prevented ill health, but felt strongly that it was their responsibility to keep healthy:

Quote 7.341

'I really like the walks they are good for my health, I think the programme is good, in particular for my health, prevents ill health doesn't it? Its stops us from getting ill, we stop it from happening.'

The perception that South Asian women do not take care of themselves was overcome:

Quote 7.342

'I think its good for myself....not for anyone else.'

Quote 7.345

'I do like it, we are doing it for ourselves I don't feel pressurised to do it we don't have to do it.'

The women were doing the walks for themselves and being proactive. They were appreciative of the walks programme as it gave them something constructive to do about their health, and learnt about other health promotion interventions. The women thought that the walks had several benefits combined, it fulfilled what the doctor had advised, their day passed quickly, and it did not give them time to worry or have silly thoughts on other problems. Meeting other women in a group setting and visiting new places on the doorstep was central to this.

Other women in the group thought the walks were very good as it provided them with the opportunity to talk to other women. Instead of being stuck at home getting depressed and recognised how crucial it was for good health:

Quote 7.346

'I think the walks are very good; socially you get to talk to the other women, laugh with them and joke around. You cannot meet new friends being at home, so getting out I get to meet new people you don't get that at home. Its also good for health and you can look after you health.'

The women praised how the walks were inclusive of other cultural activities such as singing bhajans (hymns) in the park. This encompassed a holistic innovative approach to their lives and capitalised on their spirituality and cultural identity. The women felt the walks had progressed well from the number of sessions per week to the activities they did on the walk. A good selling tactic was to be inclusive of specific cultural games,

which they played back home, this increased the element of fun and enjoyment, and they could relate to the activity more:

Quote 7.347

'They have progressed really well... we did one group before now we do three. Keeps me healthy and my weight down, lowers blood pressure, which is now normal. Since joining the group I don't take anti depressants, not as many, meeting more people and I forget about my problems. At the walks we do different activities such as ghrabas, bhajans, play old games (Khoo, running around chasing 2 people), which includes running, and aerobic activities, ball games, games, picnics and that all helps. Now and then we go Bradgate Park, St Gabriel's Community Centre organised a mini bus for us but be had to pay for that.'

The women enjoyed the walks:

I enjoy the walks;

Quote 7.348

'I enjoy the walks, I am happy with it.'

Quote 7.349

'I really enjoy them I enjoy the walks a lot we are all active. We do our housework quickly to come to the group, and to get out of the house before we use to do our housework slowly but now we do it quickly.'

Quote 7.350

'They are alright, my legs used to hurt before now they don't now.'

Quote 7.351

'I enjoy them if I don't go my body feels heavy. I like walking together and the social activities like the bhagens (hymns) and birthday get together's.'

Quote 7.352

'I like going but I cannot walk very fast I'm always at the back but I still like it.'

Quote 7.353

'I really enjoy it its good for my body and bones and it has lots of benefits.'

Quote 7.354

'I get to sleep easily after a walk, I do things afterwards and I meet people, we are all friendly and so we enjoy it.'

Walking in a group brought with it many benefits; giving them the stamina to do their housework quickly so that they could come for the walk. The outcome of this was cascading, not only did it increase their moderate activity level but it gave them a goal, which was psychologically beneficial. Their bodies felt physically lighter, just by simply

enjoying themselves. It was this realisation of how simple it was for them to increase physical activity in their lives that made the walks attractive to them. Some of the women, who could not walk fast, still came to the group, as it sparked persistence in the activity. It helped them to sleep more easily, and this was an important aspect to them, as restful sleeps made them feel refreshed. Having a break from their routine energised the women and a feeling of refreshment. Thus, there was evidence that the walks had made a significant difference in their lives and was more prominent with depressed women:

Quote 7.355

'It has made a difference: my arthritis and depression, has lowered. I enjoy the company, talking in the group. My depression has really gone down...I have benefited from talking to the people.'

The only criticism the women had of the walks was that they needed to be different groups and grades of walks.

The men were more critical of the walks, and thought there was a lot of room for improvement. Timing of the walks was a concern, there was a strong consensus that they should start and finish on time and should be an hour long. In comparison with the women who did not mind and enjoyed the extra time to chat, whilst the men were more health focus, and seemed to plan other things around the walk. The men had an understanding of why walking was good for their health, and in particular people with specific illnesses. They did believe the walks were good for older people as it gave them the opportunity to participate in physical activity and to socialise. They did appreciate the walk and believed it was a good event, however felt that it needed a good motivator to get more men involved. The men's group were bored with the routes and felt that the walks had not progressed, this was a contrast to the women's group, who had designated motivational walking activators, whilst the men's group did not have this advantaged.

The women had not joined for health reasons, but their doctors noticed positive changes in them. Dr Burden, a well know consultant at the Diabetic Unit at the General Hospital in Leicester was pleased with his patients control and the weight lost after joining the group;

Quote 7.356

'Yes definitely, there are a lot of benefits to walking, it good for my health, my diabetes is in control, I had an appointment at the General Hospital at the Diabetic clinic...and I lost weight and Dr Burden (the head consultant) is very happy, the doctor is happy that my weight has also decreased.'

The women were going to continue for their personal health reasons and they enjoyed the activity; it made them feel good, a combination of these features of the walks programme convinced them of the benefits of continuing. The social aspects of the group were a part of their daily routines and it had become habit. An important aspect for continuation was enjoyment, they enjoyed the atmosphere it created not only at the session but when they got back home. Even if the women were in pain, from arthritis they still came back, because they enjoyed getting out:

Quote 7.357

'Yes I have benefited and I enjoy even when I am in pain with arthritis I still get out because I enjoy it so much.'

The women stipulated that the group had helped them to loose weight and to control it, this is difficult to do, but a continuous supportive environment had made it easier. The only reason that some of the women stopped during the winter period was because of the bad weather.

The men would continue with the walks as they felt safe and they got to see new environments on their doorstep:

Quote 7.358

'Yes, its a good way to meet people and walking together, helps with health. Also saw parts of Leicester which I never have seen before...I have been living in Leicester for the past 25 years not seen these footpaths.'

Many had been living in Leicester for 25 years and had not seen many of the pleasant walking areas and footpaths. Thus, clearly the project had met its objective stipulated by the Countryside Agency. The activity was more acceptable and easy to continue, as there were no cost implications for the walker. Overall, the men enjoyed the walks and thought they were fun. The latter was an aspect, which came from the pilots, and it was simple fun and enjoyment that brought the walkers back week after week.

All walkers interviewed felt something good about being involved with Chalo Chalay, not only the health benefits which they all had experienced but also the mental health

benefits, it significantly reduced depression, and help those that were feeling isolated. They appreciated the walking activators, which motivated them on all levels. The group itself was a motivational tool; walking in all weathers if left to individuals it would have not been possible:

Quote 7.359

'Whatever the weather, in snow and rain people turn up to the walks, if I was just walking on my own I would have not done it, it's a good incentive being in a group.'

For the women the walks had become a routine and did not feel as if they had the same stamina levels if they did not attend. It was painless and did not feel like they were 'exercising', this was made easy by being around like-minded people:

Quote 7.360

'Its good to walk and in the company of a group, don't feel like your walking feels like a social group. Walking in a group you don't realise how much you have walked and you feel happy.'

This was the most underpinning aspect of the intervention, as it worked really well to enhance the participant's confidence and will power:

Quote 7.361

'I get to exercise, I don't get to do that at home I feel like the whole weeks tiredness is gone after walking, after exercising I feel good, I do have a back problem and it helps it. My mind pulls me to come out and walk in the group.'

The walking group had renewed community spirit:

Quote 7.362

'.....meeting people, making friends, I've never had so many close friends before, and they all come to help if I need them too. I have made some really close friends they all come and help, its community spirit; it feels like they are all there to help, and they keep on giving.....'

They felt by joining Chalo Chalay they have made some very good friends, which are like family and gave them the opportunity to share similar cultural specific activities such as sharing food, praying and celebrating festivities through bhajans (hymns) and gharba's (cultural dancing). Significant improvements to their health had been verified by their GP's this increased their confidence in the intervention:

Quote 7.363

'Yes its helped my legs, joints, knees and veins; they were dried and were blocked the doctor said walking has made it normal. Mentally really good was depressed at home, I'm not like that anymore feel fresh

meet new people and I don't feel so tired. Before I use to climb the stairs and feel tired but now I don't. Good for health and good company of course.'

The men felt that they got a social by coming to the walks and gave them the opportunity to share problems and find solutions. It stopped them from sitting at home in front of the T.V and got them out the house. The walks had become a routine it had inspired them and boosted their will power.

The main dissatisfaction with the intervention was the bad weather during the winter period, which was addressed by the use of indoor walks. However, the walkers knew that it was no substitute for outdoor walking and fresh air. They wanted to see more organised trips and believed that this would be an incentive for new walkers to join. They also stipulated having more sessions per week but having a slow and fast group sessions. They also wanted to see more targeted publicity at community venues this was also suggested by the Institute of Volunteering. There were suggested improvements to the logistics of the walks such as making them faster and having them on level ground. If more walker leaders were available, different grades of walks would have been aimed for. The 45% that stipulated dissatisfactions were fair comments, and all of these dislike's could be addressed, and needed attention from either the project coordinator, or changes directly made by the walking activator.

A major concern of the women was their own safety in the park. There had not been any reported incidences during the duration of the intervention period, but still the women felt vulnerable, it was suggested carrying alarms, which may have allayed fears, but it was their perception of their environment. Pedestrian crossing's were a big issue and often compromised the group's safety. The crossings were often placed at wrong points or not at all, these comments and specific points were feed back into the Belgrave Corridor Project and were addressed by the traffic department at the local authority.

Walkers with serious heart problems still felt that the intervention did not cater for their needs, and walking activators needed to be sensitive towards their condition. The men's group had vast difference in levels and it may have been more sensible to have varying levels of walks as the men in general felt that they were too slow paced. The group dynamics of the men's group showed that they were sensitive and did not appreciated the laughing or joking around:

Quote 7.364

'Sometimes the people are talking too much and making fun and do less of the walking.'

There was a fine line between being social and taking the activity seriously. There was a concern with the men's group it lacked numbers, this was due to the failure of recruiting a walking activator from within the group, it was not just about leading the group but acting as a role model and a motivator, and was central in the recruitment process, as most participants were recruited via the walk leaders. Some of the male walkers were bored with the same routes and lacked motivation to create their own routes.

A high proportion of the walkers felt that improvements could be made to the programme significant changes included more activities and trips, some of the walker felt that all walk leaders should carry safety equipment on all the walks. There was a concern that walkers themselves were not dressed appropriately and feared for their safety, that is correct footwear and wrapping up warmly:

Quote 7.365

'...All the ladies should wear proper shoes and clothes; X walk leader needs to set the example, even if they don't like it. The walk leaders need to put the pressure on for them to wear socks, gloves, hats, and scarves so they don't catch a cold and they should wrap up warm. They should not walk with their hands in their pockets.'

There was also concern of the lack of motivation, educational messages and publicity on the benefits of walking and wanted emphasis to be placed on regular walking. Publicity was an issue and came up in various lines of questioning clearly the project was not delivering on this aspect. The walkers would of also like to see an increase in the number of sessions held per week and the number of walkers. Providing transport to other 'nicer' areas was also an issue. The improvements suggested would be more difficult to implement but not impossible with the right proactive partners involved in particular changes to the environment. The others were resources dependant and with an increase in funds equipment such as step counters could be issued to all walkers.

The women felt that the group and walks had progressed well and this was evidenced by the increase in the number of women walkers. They would have liked to travel to other

cites with similar schemes as other walkers often visited the Leicester project, this showed that the women were actively interested in the project.

Quote 7.366

'Transport; can go for a picnic or can meet other groups and we can go to other programmes in other cites. Can speak to one another.'

They also showed an interested in their walking environment wanting better pathways, open green spaces which were pollution free, this demonstrated an awareness of such issues.

Quote 8.367

'Like having special pathways for walkers on busy roads; more green parks near by. Clean canal side, clean roads and make it pollution free'

The project had given them lobbying power to local councillors; this had been a major milestone, from not knowing anything about their local environment to suggesting improvements. Not having enough toilets on route was a problem and those that were provided were always locked. Incentives in the form of t-shirts and umbrellas would have been welcome. Safety was an issue especially in the parks, no direct incident's were recorded by the group, but there had been one occasion when one of the men had tripped over a bollard which was rather low and the women's group had witnessed two young boy's smashing a car window, these incidents together with other stories reported in the press caused concern;

Quote 7.368

'T shirts for safety you can recognise the people in your group.'

Quote 7.369

'If way marking could be provided and step counters- the proper ones that work, the ones given do not measure a days walking accurately. If the canal way could be made wider, its not very safe the pathway is too narrow to take a group along it. In Abbey Park two lads come up and smashed a car window in front of us...that shook us up a bit...but we have not had any incidences in the group.'

The men would have liked to see more varying levels of walks, this was difficult to organise due to the lack of leaders but was a fair suggestion and the group could have progressed onto this. The men also felt the walks should increase the warm up and cool down components of the walks, as they thought these were beneficial. They thought that there should be something new in the programme and there was a lack of progression during the three years, change may have attracted new members. There was a feeling that

the project needed to provide a picking up and dropping off service so that they could walk in different and varied areas;

Quote 7.370

'Up to individuals for time & committed to specify whether to walk in a mixed environment or individual; ask what times they are available and what suits them. Involve the elderly, pick them up and drop them off. Choose areas like Cossington, Watermead, Abbey Park, New Walk and city area, various areas. Find different and various places'

A majority of the walkers interviewed walked independently outside of the Chalo Chalay group, of which most walked with their partners, family members or friends. The walkers played an advocate role by getting at least one other person to walk with them. Thus participants influence their immediate social circles around them and broke old behaviour patterns. Just under half of the participants interview walked everyday, which ranged from walking from 10 to 120 minutes per session. This suggested that the intervention had motivated walkers to walk outside the group and were meeting the suggested guidelines of 30 minutes on 5 or more days of the week. Walkers stipulated that they like to walk in parks and open spaces where it was quiet. This at first would seem a tall order in a city like Leicester, but fortunately there are pleasant doorstep walks in the locality, it was just a matter of the public being aware of them, which the project successfully achieved.

The women were not comfortable walking alone and would not take the risk, they did however walk outside the group with partners, and they walk more since joining the group. Husbands were a great influence, as they had someone to walk with, often the women made sure that if possible daily shopping was done either by foot or using the bus so walking was involved in this activity. The women that did walk alone did not do it out of choice as they lived alone. They felt that walking should not be done alone and should be more of a social activity. Most independent walking was incorporated into incidental walking such as shopping or taking the children or grand children to school:

Quote 7.371

'I do walk on my own quite close to where I live, just do around the block but not to far. My legs feel better after walking and I like the fresh air. I pick up the grandchildren and drop them off, go for shopping, depending what I have to do I go everyday except on Sunday. For about 20 minutes at a slow pace. I like walking in Abbey Park, I don't like the riverside and woody areas.'

Quote 7.372

'I do go shopping on my own, I go to the grocery's for light stuff, 2 to 3 times a week, occasionally I go to the post office and to the Madhir (temple), 15 to 30 minutes at a slow pace. The doctor said I should walk. I like to walk everywhere, we walk to Gipsy Lane as long as its in the morning as the air is fresh, I like the air in the morning its fresh. Walk and talk.'

For the women that did walk independently the walking group had given them the confidence to do so:

Quote 7.373

'No, except for domestic purposes like shopping, walk into town in the summer, one way catch a bus back, once a week. I am limited because I have a back and neck problem and asthma. I always use to walk but not such lengths, but since joining the group I've got the confidence to walk into town and then I come back on the bus when I have shopping to carry. I got the confidence now that we can walk.'

The women felt that they were in control of their health, and being confident about themselves they felt they were setting good examples. The intervention had changed the way the women felt about themselves:

'People ask me why I'm so happy...and I say I go on the walks.'

The women were clearly passionate about the walks and committed to it, as they changed their dress behaviour to walk, and they were usually very strict about their dress code:

Quote 7.374

'I walk with my husband once or twice a week for 20 minutes. Would like to walk in Abbey park, Melton Road, I don't wear Punjabi suits usually, but Saree's are hard to walk in.'

The men felt more comfortable walking independently, however were restricted to the main roads and well-lit streets for safety. The weather was more of a deterrent to walking than owning a car, which they only used for shopping. The men described a lot of domestic walking such as shopping and going to the post office, sometimes they would park a mile away from town or shopping area and walk the rest of the way;

Quote 7.375

'I usually do a lot of domestic walking from the home to the shops. Sometimes I park my car at Sainsbury's and then walk into town. I exercise twice a week for about 30 minutes.'

The walking group reassured the men and gave them confidence, some were previously deterred, from the fear of being attacked by muggers;

Quote 7.376

'Yes, I walk everyday for an hour at a time, daily one hour on the main roads.....I walk on the main road but there's a lot of traffic. I only walk in the park when I am in the group. It's really good walking in a group then there's nothing to be scared of.'

Thus, some of the men still feared for their safety and did not walk independently. They felt especially during the winter period the park and even roads became too dark for walking. There was evidence that they would like to walk more independently in green spaces and parks but feared the isolation and darkness.

Evidence from graph 7.11 showed there was a lack of understanding of how much walking was good for health. The walkers believed that people did walk for health reasons, the company and to get out the house. The people that did not walk were ignorant of the benefits of walking for health, as suggested in graphs 7.12 & 7.13 respectively. There was a strong association of the lack of walking and ownership of a car; thus more education was required of leaving the car at home for short journeys. It was stipulated that the British climate was not encouraging of walking, and this was a deterrent for most. The walkers interviewed felt that people only started to walk when something drastic had happened to their health and they did not have a concept of preventative medicine, there was a huge gap in this knowledge and opportunities to change this:

Quote 7.377

'No, people do not walk enough for their health, they are all lazy, will only do something when something happens and that's when they wake up.'

The women stipulated that other women may not walk due to feeling lazy from the cold weather and not being able to get away from household responsibilities. There was a recognition that some women walked for leisure, but the intervention had clearly educated the walkers of the difference between walking for health and leisure. However, work needed to be done on the concept of prevention as the women felt that those that walked did not have any health problems and did it for the company.

Quote 7.378

'Yes, they do but 5% walk for leisure, those that don't have health problems they want company.'

Of those that did walk indicated it did prevented stiffness in the legs and arms.

Women in the group believed that with the support from the other women walkers, had enabled them to get out of their house, which gave them great benefits. There was a concern that people in Britain were isolated, and the group had offered a sense of family and community, which was similar to back home. This had been an important aspect of the group, as many of the women had married and had left family and friends back home, and felt very isolated:

Quote 7.379

'Yes they can't walk at home, its loosened my legs good walking is good for their health and for fun because they are depressed and isolated at home, can't go to their parents homes because they are overseas.'

There was a feeling that the walks were too much of a fast pace and a group should be formed for slower paced individuals so that women with arthritis could join. The general attitudes of people in Belgrave, is that they were ignorant to the benefits of walking for health, the women felt that the opportunities were there, but they did not take them up because they were unaware;

Quote 7.380

'No, not in Leicester, not in Belgrave, I don't know why... they could via shopping and just to unwind, but people are not use to it, people don't understand, it helps their health, but they are still ignorant to it. There are lots of people in the park so they do walk especially in Cossington Park...but they may not be doing it for their health.'

In contrast other women in the group felt that the masi's (older women) knew what was good for them and did try to walk. Owning a television and the introduction of the new South Asian channels was also a reason that the women felt that other people did not walk for their health.

The men had similar attitudes to the women in that they felt in general people were lazy about their health, and only did something when they had a wake up call.

Quote 7.381

'No, people do not walk enough for their health, they are all lazy essentially, will only do something when something happens and that's when they wake up. Human beings are lazy unless you get a wake up call.'

There was an understanding that all individuals were different, and it was dependent on his or her nature whether he or she took up the activity. This was a deep understanding, which often workers in the field do not grasp, because they are trying to do a job, but it is this understanding and empathy in which interventions should be built on. For some walking is not an option and that should be equally respected. Again the men thought people were ignorant of the activity and thought they felt burdened about it:

Quote 7.382

'No, they are not bothered maybe ignorant, they may feel burdened.'

The message that walking for health, helped with heart health was received well, and these were the reasons why people did walk for health:

Quote 7.383

'Yes I think people walk because some people suffer from heart disease or other illness and cannot do the usual form of exercises and walking is the best for them.'

They felt walking was the only suitable exercise for patients with illness such as heart disease. There was acceptance that men walked outside the group, and recognised that the group only ran once a week, and walkers walked independently everyday in the local park:

Quote 7.384

'Yes for their health, in the Cossington Park, they like to walk in their own time, our group only runs once a week, they do it everyday daily in the morning and the evening.'

The walkers interviewed thought that walking had lots of benefits, which they personally had experienced. It had improved their general health, heart health, blood circulation, breathing and mental health. They felt that walking was a good way to exercise, to keep fit, to keep the body warm and to get fresh air. The walkers stipulated that the walks needed to be continued to maintain these benefits:

Quote 7.385

'Walking is good for the legs, we become more energetic, breathing gets better, good for general health, before I use to have problems breathing when I initially started...now I don't as long as you keep it continuous.'

Walking helped relieve chest pain, and made them generally feel healthy and physically fitter, thus the walking group had a major impact on their health.

Quote 7.386

'From my experience it has been good for me, before I had chest pain its now better. For your legs and veins, but has made a difference on lung problems. Mentally fresh use to feel sick but now I don't I now feel fit.'

The walkers also felt the mental health benefits simply by meeting other people, getting out the house and preventing boredom.

Besides the obvious health benefits, there were specifics that were not stated in other studies such as helping with menopause and PMT, both physically and mentally it eased depression:

Quote 7.387

'Good for menopause, good for the bones, it's hard at the beginning I couldn't sit with my legs folded but now I can do that when I pray.'

Quote 7.388

'Gets your heart rate up, blood pressure down keeps me fit, mental health gets you out of depression.'

Quote 7.389

'Some have problems we would be able to tell them the benefits; helps depression with ladies problems, hormones PMT if I walk it helps me and I have lost a stone in a year, I was eleven & half and now I'm ten & half although I also do the exercise classes at BNC three time week and yoga.'

It's good for thinking as one of the walkers experienced:

Quote 7.390

'Walking is the best exercise it's good for arms and legs, its good for breathing, you can change the rate that you walking fast or slow. Its good for clear thinking, problems are solved it opens up the mind. You can walk and think!'

The walkers also provided evidence that walking had helped with medical conditions, which were confirmed by medical tests such as blood sugars and cholesterol checks:

Quote 7.391

'Use to have breathing problems it has decreased and helped lower my cholesterol; a test from the Leicester Royal Infirmary Hospital, helps with Yoga too I can now sit on the floor crossed legged, it helps circulation. There is also more of my own age group we all mix and enjoy it, they all speak my own language and that's why we all mix well.'

It was also important for the walkers to feel comfortable in all aspects, such as communicating with the walking activators in their own language and this made them feel more confident.

There was evidence that the walking had lowered or in some cases stopped walkers taking medication, for anxiety, this should only be done under the advice of a GP.

Quote 7.392

'It's improved by health, I'm taking less medication, for my anxiety and depression it has really helped, the fresh air instead of going to the gym, it doesn't cost you anything I prefer walking, compare to the gym two my friends since joining the group don't go to the gym its saving them £500-600.'

Quote 7.393

'We don't have to take medicines and then there are no side effects, then we don't complain others follow our example.'

Others in the group had stopped going to the gym, but took up walking instead and it saved them money whether this was a hundred percent beneficial to their health compared to the gym was debatable. Other benefits that were mentioned was weight control; this was an important factor in keeping healthy and fit and walking was recommended by the doctor to be done on a regular basis:

Quote 7.394

'Walking is good for; blood circulation, makes the heart stronger, the mind becomes fresh, fresh air, good for weight management I use to remain slim then all of a sudden my tummy came out...so I started to exercise...its gone back in!'

Quote 7.395

'Walking it decreases weight if you are regular that's what the doctor said, it's also good for blood pressure and diabetes I don't know of any other benefits.'

Quote 7.396

'Walking is good because it prevents illnesses, you can become lazy sitting at home. If you don't exercise you become lazy and fat, its good for weight control. Something or another would come up....tummy problems.'

The main reasons quoted, which stopped people from walking more often was health problems or illnesses, being lazy, watching South Asian daytime T.V, and having

problems with legs. For the women they felt that their counterparts were stuck in a routine, and housework was more important to them:

Quote 7.397

'They are stuck in a routine; they think housework is more important. But walking is important and you must do it. Walking is more important for your health.'

The walkers believed that people were addicted to the South Asian channels, with extra variety now, they felt that people prefer to sit in front of the TV than walk:

Quote 7.398

'Some people can walk but they like to watch TV since our programmes started to be broadcasted there are pros and cons to this, they are addicted to the daytime soaps, they have other responsibilities like housework, cooking. But they can get organised to spend time on themselves.'

Quote 7.399

'ZEE TV and Sony they don't want miss any of their scheduled programmes they are really serious about it and watch without fail. Others may look after grand children and have family commitments.'

Quote 7.400

'Some people just do not like to walk, they are lazy they want to watch the TV and video.'

There was a concern that people were unaware of the walks, and the publicity was lacking:

Quote 7.401

'They are lazy, they don't like to go, others that live in city are used to it some just don't know about the walks.'

Others in the group felt that the walks were not attractive enough, and incentives such as trips should be run more often. The walkers described how one of the lady walkers had a heart attack and now she did not come to the walks thus the project needed to work with walkers on an individual basis and do more follow up work of walkers who had dropped out of the programme.

Quote 7.402

'Health problems with bad knees and legs, not attractive enough maybe putting on more trips it helps. One lady who use to walk regularly had a heart attack last year does not come out of her house now...she is so scared....if you were to bribe them with trips they might come.'

The walkers stipulated that there were too many barriers or a combination of barriers that stopped people from walking which were personal to their environment and this made it difficult and if people also lacked motivation;

Quote 7.403

'There are so many barriers such as TV, weather, no countryside near by, no greenery nearby.'

Looking after children or grandchildren was an issue for other women; this may have been addressed via a special walks for women and toddlers. The men felt that people did not know the benefits of walking, and the fitness aspect:

Quote 7.404

'They are not bothered; they like to sit in one place, they do not understand the goodness of walking it's a keep fit for one-self.'

There was also a genuine fear of their own safety from a variety of situations that could possibly arise, some of which could have been a perception of their environment. More people using the environment thus making it safer and also having more police patrolling the area could solve this.

Quote 7.405

'Fear sometimes dogs, young generations and abusive language not enough lighting in the area especially in winter afraid of being beaten or mugged which are most common.'

There was a strong view that people were responsible for their own health and they were responsible for gaining it, it was felt that you had to be in the right frame of mind to make an active change:

Quote 7.406

'Its good for me, I'll be 62 in June and I'm in good health you cannot buy health you have to gain it for yourself! Must be something in your mind that you can achieve good health there are some things in this country that helps, its up to the individual to take the advantages some people just sit and ignore it...its up to you.'

The walking group had a cascading effect for the women in that a number of other activities were started, in terms of physical activity:

Quote 7.407

'Since Chalo Chalay started we have a timetable of activities;

'On Monday St Gabriel's Aerobics we have 25-30 women, Tuesdays walking group Chalo Chalay around 20 –30 women, Wednesday Savera Walking mixed 15 people, and Belgrave Neighbourhood Centre Exercise to Music 50-60 women, the hall is too small, Thursday Cossington Street elderly ladies

5-6 and then Friday again Belgrave Neighbourhood Centre, Exercise to Music 50-60 women, Saturday Cossington Street Swimming 40 women."

The group dynamics of the women's walking group were a likened to a family and the women were comfortable with this and this drew them back to the programme every week:

Quote 7.408

'I enjoy walking with the walk leaders, they feel like friends they look after us well, when we go somewhere and we miss Tuesday we miss the group, and look forward to seeing them again.'

There were major concerns by the walkers and walking activators of the lack of pedestrian crossings especially on one of the more popular routes. These comments were feedback to the local authority and changes were implemented.

The men's group had not been as successful as the women's and the men felt this was due to the lack of attraction to the activity:

Quote 7.409

'The men are not taking an interest there should be an attraction, walking and talking. If people were attracted they would come and the group would get bigger and there would be more enjoyment ... more walking and talking!'

There was a degree of resentment from the men, of the lack of activities that were supposedly to materialise, such as the boat trips. The men felt that the walks had not improved and had lost faith in the system. However, there was recognition that the project had improved lifestyles and did not cost the participant anything.

Interviews with Walking Activators

The walking activators gave an insight to how they felt about the intervention, they believed the original intention of the project was to raise an awareness of walking to inactive South Asians; and in particular the health benefits they would gain:

Quote 7.410

'There is no awareness of walking to South Asian people's health who are inactive. People weren't doing enough exercise and walking they did not know the benefits of walking and physical activity it can reduce heart problems.'

Quote 7.411

'To bring awareness of walking which is the best exercise in day-to-day life for South Asians for everyone; It doesn't cost any money, keeps the body healthy, weight management, keeps cholesterol down and blood pressure in control, healthy diabetic control, lessens depression. To bring awareness of people, that only walking can do so many things like this, it doesn't cost money, you go out and breathe fresh air and enjoy your life.'

The walking activators had been recruited from a mental health project; by leading the walks, it had helped them recover from their own anxieties and depression:

Quote 7.412

'Yes, effective now that I lead my own group, I always wait for next week for the same day to arrive, I'm very anxious to meet them. They feel the same we are always on time in our meeting place since I started to lead the group I have also come out of my depression.'

There was evidence that they felt that the project had achieved its original intentions, and more. It had brought a sustained change in peoples lives and gave them an incentive to get out of the house. All walkers in the project noticed an improvement in their health and enjoyed the social aspect.

Quote 7.413

'My groups; I lead 3 walks they think they have come out of depression they enjoy walking in a group rather than alone – and there are so many unhealthy things which they have got rid of. Like some people that smoke do not while we are walking, while some people who chew pann don't.'

It was a good group for South Asian women who did not get out and was a safe opportunity for them. The reason why the leader got involved was that the opportunity arose and they liked the idea of someone taking the lead and they enjoyed walking in a group. An important factor was that the walk leaders had volunteered before on other projects and thus volunteering was not new to them. It was more difficult recruiting walk leaders that had never volunteered before or that were new to the concept. The walk leader role gave them added confidence and made them feel good this emanated to the group they were leading.

The walking activators felt that their role had been effective, and this was evidenced by them leading their own groups and having total responsibility of them. They also stipulated that the walkers themselves had commented how they were committed to the

project, and a change was seen as the group meet on time, which at the beginning had been a problem.

The strength of the project in their view was the walkers, they felt that they had set an example by being role models, but it was ultimately the efforts of the walkers that made it a success. They felt they have helped people get out a cycle of bad habits, which had affected their health. The walkers also believed that enjoyment was also the strength of the project and that's why people came back, as it clearly had a good impact on their health and they enjoyed themselves at the same time. The characteristics of a walking activator were described as friendly, sympathetic, a good listener and joyful, these attributes in the activators were also strengths.

Quote 7.414

'Because people enjoy walking in a group; walkers make the project, its good for their health. A 45-year-old woman said that her monthly period had become regular by joining the group. They enjoy it; it's worth it, it brings out all their troubles in their physical body, which vanishes. Its your ability, a leader must be friendly, a good listener, sympathetic and joyful to make the walkers or crowd to enjoy their walk.'

There was a belief that having activators that spoke the language was a strong point of the project, there was firm evidence that the project would have not been able to attract as many walkers if it were to be done in English:

Quote 7.415

'If the leader spoke English; the walkers would not come.'

They felt that communicating in their own language was much more effective than English and the cultural twists to the activity made it much more attractive:

Quote 7.416

'Cultural and language makes the walks very effective the things I want to tell them in I my own language would be more effective rather than English. We do cultural things like bhajans, celebrate events, Holi, Diwali, whilst walking and, singing 'antakshari' and bhajans and going to places like Abbey Park.'

The project had its strengths but it also had its problems; the walking activators were optimistic that these could be overcome. There were the general problems that most walking initiatives faced such as a bettering environments without traffic and pollution, but also the specifics such as a lack of pedestrian crossings on route and wider footpaths

along the canal and riverside. Dog litter also made footpaths and parks unpleasant, however penalties were being introduced for dog walkers. Other physical make up problems were uneven footpaths in particular in the built up areas and leading into the parks. The leaders had a few stubbles, but it was also about the women wearing appropriate footwear, which was not an option for them. Wearing tight shoes gave them anxiety, thus it was essential that pavements were up to standard, in the past year there had been many more claims made to the local authority than ever before. This was the responsibility of the council, and resources should be allocated accordingly.

The leaders felt that not having appropriate shelter in particular the winter months was difficult; having rest was an important social aspect to the group. The leaders could not understand why a centre they used was not available to them anymore, which was a local authority facility; upon investigation it was a lack of communication between them and the main partners and providers. Sports halls and community centres in the locality were informed of the project and did become available in the winter period. There was a problem with the shared space between walkers and cyclists. The walkers feared being knocked over by them and were resentful that they were taking up their space together with the lack of way marking on parks and footpaths. The walking activators felt that their environment was not conducive for walking. It made their job very difficult, when parks were untidy, messy and dogs off their leash. The walking activators main issues were about their local environments, which were longer-term goals for the project in partnership, with the local authority.

The walking activators felt that they were not appreciated enough, they highlighted that they volunteered three days of the week and no recognition was given to them. They felt the whole scheme lacked incentives, especially for the walkers:

Quote 7.417

'Not enough encouragement or appreciation; it's voluntary work, we volunteer 3 days a week its a lot of commitment. Some kind of appreciation, not enough of it, they should encourage the walkers too, some kind of incentive.'

They thought also that they needed training in First Aid and did not have all the equipment they needed:

Quote 7.418

'With a bigger group its hard to communicate between the walk leaders, would not know what's happening at the front and the back only one mobile phone and there's no credit on it...provide books for registration, Par-Q's, First Aid kits, not happening anymore don't know when we will get it.'

In terms of safety they felt they needed two mobile phones one for the front and the other for the back leader and First Aid Kits.

The walking activators had a belief in the project, and knew it had potential but it required support and more walking activators. They felt that the groundwork had been done and there was an awareness of the benefits of walking, it just needed expansion. The keys were the walking activators and they felt that if the project could understand their needs a little more problems could be overcome:

Quote 7.419

'Can recruit more leaders, praise them and try to understand the leaders difficulties, leaders have spent so much money such as telephone calls, refreshments to encourage people to join. Only last week I invited them over to my place and we had a little party and a little refreshment and watched a video. The project can grow why not because now there is an understanding it will be for their own benefit.'

There was resentment that the host organisations were not more supportive and were clear that this attitude would be reciprocated back by the walk leaders. There was issue on payment which had stopped with the end of the project funding however they stipulated that they continued to lead the walks but may not commit as much time to it:

Quote 7.420

'It was growing; if they (CIO), don't treat walk leaders right they won't care. We use to get paid but we don't now we still do 3 walks think twice about committing that time. Think it has potential if there was support.'

It was a fear that payment of walking activators would not sustain the intervention, however the walks continued and the activators were committed to the programme. Further funding was secured to over see the walks set up for a further three years.

The activators felt that the project had impacted on walker's health and had raised awareness of walking for health. It had relived pressures on GP's by half and more cardiac patients from the hospitals were referred:

Quote 7.421

'Everyone knows the benefits of walking now. There's a much higher level of understanding, it's the best exercise they don't go to the doctors as much. The doctors have sent so many people to us, more from the hospital they seem to know about the group more. It has halved their workloads by 50%; there are lots of benefits for heart patients. There's been a lot sent from the hospitals to join this particular walking group. It has benefited heart patients more so.'

This showed that phase two of the project had been successful in recruiting heart patients and satisfied the original objectives of the project. The success of the project and raising walking for health's profile is evidenced below, walkers were prepared to walk five days of the week, as they felt that their health had been improved and impacted upon:

Quote 7.422

'.....every walker in the group don't feel bad about their health as it's really improved, last week they said why don't we do five days a week people are willing to walk 5 days a week, and its raised health awareness.'

The initial training received by the leaders had improved over the years, but felt that the additional components such as the First Aid never materialised, there was a consensus that the training was very good for those who had no idea of what walking for health was about.

Overall the walking activators were satisfied and it was a good start, but above all they enjoyed it:

Quote 7.423

'It was alright.....it was useful, I think those who have never walked before they learnt a lot more especially about the techniques, instead of being all over the place. Learnt how to walk with your shoulders relaxed chin in, good posture they learnt all of this.'

Quote 7.424

'Training was good but we need First Aid'

Interviews with key people

Key people on the project were interviewed, there were mixed responses to all aspects of the project. When asked what background knowledge they had of the project, it was clear that they thought the initiative was set up for older South Asians in the Belgrave area of Leicester to prevent heart disease. Some key individuals resented being given the role of steering group member as they felt the task was *'dumped on them'* because they were South

Asian, and felt projects such as the Chalo Chalay should be generic. One could argue that Black voluntary organisations may not want to work with generic workers who may not have an understanding of diverse communities, however it is wrong to assume that workers want to take on a role because they fit a stereotypical image:

Quote 7.425

'.....once funding was secured got to know about the project, was an Asian project to make people walk more. My involvement was from the steering group of the project I was invited to be a steering group member once funding was secured. I was given little background from my organisation initially of the project but then found out more. The decision and support that came from the X was because I was an Asian and because no one else can deal with an Asian walking project and only an Asian worker has to be allocate I think this is wrong and it should be for generic workers as well.'

There was evidence to suggest that pre decisions were made prior to Chalay Chalay, the hosting arrangements were 'fixed' by partners and were not taken through the steering group. Decisions such as the coordinator post being part or full time were also done behind closed doors:

Quote 7.426

'I think that there were a number of decisions made pre Chalo Chalay in hindsight it would have been better, for the post to be full time. I think a political decision was made to base the project at CIO, in terms of it being a black voluntary sector project that supposedly was meant to be a partner. If the post was seconded too the HPA too many questions would have been asked. To many pre decisions were made behind closed doors that really should have come through the steering group. Yes, as one of the original people to have written the bid I did have a lot of background knowledge to the project.'

This was not good practice or ethical and may have breached equal opportunity policies, although the host organisation went through a formal tendering process. Other key individuals stipulated that they were not briefed by their organisation of Chalo Chalay however had heard of it via national, and regional presentations. It was interesting to note that the worker felt that she did not have to take note of the Chalo Chalay project, at the seminar because it was an South Asian project, it was this type of attitude that stops generic workers moving forward in working with a diverse community:

Quote 7.427

'At Loughborough University, you did a presentation, Dawn Vernon did it she must of have been going around the country doing presentations and you came, can't remember what you said but it was about

walking for health I didn't take much note as I was not working in that field, in particularly not working with the Asian community, I wasn't really thinking I needed it, so that was the first time I heard about it, but then when I came in post I realised that that it was the same project further down the line. None of my managers brief me on the project, but they did not brief me on many things. I did see the original paperwork from X, that project plan that she put together...and I had a look at that before I went to the steering group, I mean I really didn't get much information about anything to be quite honest, it wasn't just Chalo Chalay...it was a lot of things.'

The key individuals believed that the original intentions of the project were to increase the number of elderly South Asians walking on the doorstep with a view to prevent or recover from heart disease:

To get more South Asians Walking....

Quote 7.428

'To get more South Asians to walk and making them aware of the prevention of heart disease, the original attentions obviously were to get more people in the Belgrave area to start walking as a way of becoming healthier and to help prevent heart disease in the Asian community that was the main aim to start walking and the project I guess did meet those aims.'

Had not heard of it....

Quote 7.429

'I was recruited and the advert was the first I heard of it.'

To get elderly South Asians walking

Quote 7.430

'Original intentions of the project was to work with elderly Asians and to encourage walking as a means of exercise and recovering from CHD, as they were very prone to that particular type of illness.'

To get South Asians walking on their doorstep

Quote 7.431

'The original attentions of the project were quite simply to get more South Asians walking on their doorstep, with a further aim to reduce the incidence of CHD in our communities and other health problems.'

It was a national demonstration project

Quote 7.432

'As I understood it the aim of the project was that it was a national demonstration project, in particular walking programmes for Asian communities, the project had research elements, in terms of development of your PhD.'

To make physical activity culturally appropriate and cost effective....

Quote 7.433

'I think it was obviously to generate more interest in walking with South Asian communities and physical activity opportunities and to try and get those people that are not normally active to be active, to make physical activity culturally appropriate and at a low cost, it did not cost participants anything and they don't need any equipment and it increases peoples moderate physical activity.'

It was also stipulated that it was a national demonstration project, and that it was aimed to make it culturally sensitive, and costing nothing to the participant as these were barriers that were identified. The key individuals had clear ideas of the original intention but did not raise the other strands of the project, suggesting that these were not at the forefront of the project or were not implemented.

Thoughts on the overall project were mixed, there were clear successes that were praised but it came with its problems. Partners felt that the project was successful in what it had set out to do and had raised awareness of walking in the South Asian community of Belgrave with the added bonus of expansion out into other areas:

Quote 7.434

'It has been successful in raising the benefits of walking, the benefits of walking in a social environment. There are lots of walks, setting them apart from other initiatives... I think its has been a very successful project. I think that it was to raise awareness of the benefits of walking not just to your health but the social element as well. It was initially set up in the Belgrave area and then it expanded and from my understanding there are lots of walks going on now and people are still wanting to set up walks from their centres and from my point of view I think the walking initiative has been successful in what it has set out to do.'

Community groups continuously came forward wanting to set up groups from their own community centres. There was a feeling that the project had made links with the community, and it had impacted individual's lives:

Quote 7.435

'I think it has helped elderly Asians to get out of the house and lead walks within their own communities thereby increasing their physical activity levels. It's a genuine project it's made a difference in peoples lives and they have reaped the social benefits more so than the health benefits. The project was run well whilst making the link between the project and the community.'

It seemed that the social benefits were stronger than the health ones and the key individuals believed that it helped the isolated older South Asians get out of to their homes, thus helping the community dynamics overall. This was echoed in the quote below as it was described as being a success at a grass root level and reaching out into the community:

Chalo Chalay has achieved a lot in a short space of time...

Quote 7.436

'I believe that the concept of Chalo Chalay is fantastic, but to make it into a reality would take more than three years. It's changing the way people think and their behaviour patterns, which could take years. It does not help if the environment we live does not promote walking. If the environment was more 'walker friendly' then people would make the natural choices, it was unfortunate that the environmental changes were not in par with the project. If we continue to have cars, poor public transport, increased pollution and unpleasant pathways it's going to deter people from walking not just South Asians. On a positive note I feel that Chalo Chalay has achieve a lot in the short space of time, it has got South Asian's walking, which initially seemed an impossible task, there are some walkers that started to walk with the original initiative four years ago and they are still walking. It has helped especially the women to come out of depression and some even off medication. The walk leaders have widened their horizons and the project has empowered them to go on to other things. Thus the project was a success at a grass root level and has helped the community.'

It felt that the project had succeeded in getting South Asians walking but was not supported by the environmental changes, which were slow to catch up. There was a realisation that the project had achieved a lot in the four years that it was running and what initially seemed an impossible task was achievable. It was stipulated that the project had also engaged South Asian volunteers to lead walks and had empowered them to gain further skills to be put back into their own communities, which was not anticipated by the original development plans.

The key individuals having worked directly on the steering group witnessed the management problems the project endured; the reasoning for this was directed to the lack of resources:

Quote 7.437

'Overall when the project became regional it took it as an opportunity and challenge having looked into the history Chalo Chalay it is obvious that the project had a lack of resources, funding was given for a part time post while the demand of such a project was very high with no or little administration support was given. In terms of resources publicity, advertising and recruiting & retaining volunteers were virtually nil, common problems, which funders do not recognise. Personal contacts and the hard work of the project worker ensured the project was a success. Further to increase problems management structures were not in place for the part time worker, it was left to the good will of the steering committee.'

Issues such as the project coordinator-working part time, and the lack of publicity were raised. The lack of management structure placed more responsibility onto the steering group. Poor management of the project were highlighted as a weakness, and besides this major pitfall the project concept and idea were believed to be very good:

Quote 7.438

'I think it's a really good project, I think its had poor management. ...and it was unfortunate really that all the work that I had done in the past.... should have been done 2 or 3 years ago...I don't think that the people managing it, especially when I came into post were really thinking about its future....they were thinking about how it was operating sort of now and there was no conception of what would happen in the future and how this will be supported, and I think that was the main thing, I think the project was really good I just think that the management was very poor.'

It was also criticised for its lack of vision for the future and what would happen when the funding ended; an exit strategy was not formalised. The project did not have as much focus as other projects starting out at the same time:

Quote 7.439

'Difficult one I think as someone whose working with the project its been a frustrating process having said that it was different from similar projects that started about the same time they were tending to be much more focused. A large number of people were dropping out it didn't appear to be amenable, was number focused...we have... got a large number of walks going on that are sustainable and in that sense it was good... I think my overall impression and lasting impression of it in terms of working with CIO is particularly difficult because part of it was and a lot of it was CIO's perception of hosting the project and

what this meant. CIO seemed to think hosting the project meaning ownership of the project and therefore that has not been necessarily of benefit to the project either because the mechanisms that were set up to manage the project were not very effective leading for pushing them to deliver. It felt as though we were leading from the front and pulling them along.... the other way around all the other partner organisations were always pushing that what I am relating to when I say it was frustrating and basically they weren't particularly organised... we went to the end of the whole project, and although it was mentioned a year before about an exit strategy; that only in the last 3 months things were being done...its all those kinds of issues and the fact that...they had very little control of partner organisations, not us particularly but had very little influence on the work they were doing beyond being accountable to that steering group and that meant they had little knowledge of what they were doing most of the time...because you know day to day work what that actually meant...its all those kind of issues that meant it was difficult...I know that we have had an on going sager with them in terms of the ownership of the project and the ending of the 3 year funding.....the project has come under the wing of our Let's Walk Leicester programme...its been an agonising process of initially to work with them, CIO in terms of taking the project forward as a joint sort of partner....basically it was clear from the out set that it was their project and they were only and if I get be honest.....were only interested in getting some money.'

It gave the impression that a number of the walkers were dropping out and these were not accounted for. The key individual did stipulated that there were a number of walks that were running that were sustainable, but had difficultly coming to grips with the host organisations definition of hosting and differentiating it from ownership. There were clear differences between statutory and voluntary partners on the steering group and these were put down to perceptions. This had damaged the initiative, as perceived ownership battles occurred between the two sectors, however the statuary sector felt that ultimately ownership was with the community. There was a sense of resentment from the statuary partner as they were continuously pushing the host organisation; the mechanisms to manage the project were not effective this lead to frustration for all parties. The host organisation was further criticised for having a lack of control and influence over partner originations and not informative, making it difficult for partners to constructively help. There were strong indications from partners that the host organisation was only in it because they wanted funding and it raised a lot of difficulties in the coalition. The project thus went under the banner of the Let's Walk Leicester Project based at the HPA. A strong partnership that had secured the money, over a short

time fizzled away. It was only the dedication of individuals on the steering group, which kept it going.

There were mixed views on the steering group, these could be divided into those that were partners from the statutory sector and those that were from the voluntary sector, they all had different ideas of what a steering group role was. Another division was on the experience of the individuals and this was based on whether the individual was BEM (Black and Ethnic Minority) or not. There was a degree of resentment of the treatment of BEM projects, even from workers within partner organisations who themselves were BEM and could understand and relate to the intricacies of working with the South Asian community. There was a feeling that other members of the steering group had a lack of understanding of working with BEM projects:

Quote 7.440

'A difficult question... the steering group is political they have hidden agendas and so much so that the opportunities had been undermined; a lack of understanding, and they were pushing their own agendas. People are out there to promote themselves as opposed to the project I think people have got hidden agendas; I think some people are more so than others. I don't know whether their hearts were in the right place to help the this project, sometimes I feel that the opportunities they could have given the project they didn't give and they were hoping, they were hoping deep down somewhere, that the project would fail and obviously it hasn't but we had a couple of bad wishers on the group that had a lack of understanding of how a project with Ethnic Minority work and were basically trying to push their agendas on us which clearly does not work when it comes round to certain initiatives.'

It could be argued that this is why such a project and steering group were set up so that fellow colleagues could have first hand knowledge of the *'right way of doing things'*. It was suggested that the steering group were political and opportunities that the project could have had were undermined. This was the clear truth as there were some very powerful individuals associated with the project that could of quite easily made the project more accessible to the wider community. It was a shame that the project was tagged to the host organisation, which in itself was a central political player in the South Asian community, and again, it was the everyday community that lost out. There was an indication whether members were committed to the ethos and vision of the project and questions arose regarding whether they wanted the project to fail which was debateable, but it was too often that voluntary projects were set up to fail; as they did not have the mechanisms or infrastructures that mainstream have and to be delivering the same targets was unfair. It

seemed that funders were not rectifying these mistakes, as lessons have been learnt too often; was it because they saw the voluntary sector as a direct threat? or that the voluntary sector just may be able to do the job at hand more effectively than the traditional statutory sector. If funding were to be given indefinitely, would it not see a better retention of qualified workforce who was committed to the job at hand, and it would not waste time devising exit strategies. Short term funding was not the answer, how could a project succeed in three years time? Pushing political agendas onto Ethnic Minority projects, clearly does not work and there was often a harsh barrier that was put up, and retaliation occurred.

There was a consensus that the steering group was too big and thus not productive as suggested:

An updating forum.....

Quote 7.441

'The steering group initially was a good support mechanism when the project started, I felt that it was rather big though, and instead of steering, it seemed to be more of an update forum. The members were not action orientated and it felt daunting reporting back to them. On more of an individual level outside the meeting some steering group members were more supporting than others whilst other members were just fuelling the concerns and making the issues more than what they were. I think there was a lot of focus on the project, purely because it was a demonstration, funders were also at these meetings, and this put a little pressure on the project, but after the 1st year and the national lottery bid was successful of 1.5m there was a step back, so that the group and commitment seem to fizzle out, and the current project coordinator had no support from the steering group.'

Too Big.....

Quote 7.442

'The positive aspects would be the contacts made and talking to people and linking into other work, besides the walking project. The negative aspect, from Chalo Chalay's point of view of how big the group was, around 20 representatives, I certainly felt shy or was quite reluctant to ask questions, not knowing how much people knew of the project, and not wanted to go over the same ground and keeping people back. More was achieved on an individual level away from the steering group and having one to one meetings or telephone calls, which was more constructive. Initially when the bid was written it was good to have a large group, but then afterwards the decision should have been made to have smaller working parties?'

This led to the group not steering but listening to updates and was not action focused. The project managers who had originally been involved in the writing of the bid volunteered individuals. This was not constructive as it added to their workloads and the same enthusiasm by line managers were not mirrored by delegated members. Members found it rather daunting speaking in such a large forums, not knowing the levels of understanding, and this held them back from contributing at the steering group meetings and asking questions. It would have been more constructive to have smaller sub groups set up that were more focused in set areas which also met partners development plans, such as setting up an environmental group. This would have kept members action focused and enthusiastic, as individuals were more supportive on an individual level.

There were concerns that certain individuals were fuelling issues, and these were noted in the change in the attitudes of individuals towards the project. The project steering group did feel under slight pressure as funders were present at these meetings, it may have been hasty to invite them to this meeting, and maybe quarterly updating meetings may have been more sensible. However, events suggested that funders were only interested in learning from the demonstration project to secure further funding from Nationally Lotteries, thereafter took a step back, and support was minimal, interest was lost, and thus funding became sparse, in essence there was no aftercare, and they were not bothered what happened to the project.

As key individuals moved onto other posts in particular the resignation of the chair the project steering group dispersed. The focus was more intense in the first year of the project but once funding was obtained nationally and locally for other WHI's, the support disappeared:

Dispersion of the steering group.....

Quote 7.443

'I got involved in the project from the 1st of April 2001, since then the project steering group has dispersed in terms of the level of support given by project partners. On the original group there were a number of members I think most of the original members have left.'

These events imply that Chalo Chalay was used to set infrastructures of good practice and gain resources after which it was swallowed into the larger projects and the perception to the wider community was that this work was done by the statutory sector.

Often good ideas come from Ethnic Minority groups, which are capitalised by larger organisations who have the capacity, and take the credit for it.

There were contradictory views on the make up of the steering group; some individuals thought it had the right people around the table:

Quote 7.444

'I think the steering group had a good mix of people on it. The steering group didn't have as much influence as it should have and part of the reasons were again about how things were set up with the CIO and with the really clumsy financial arrangements as well coming from the Health Authority (HA) and CIO which meant that the steering group never had any real handle on what was happening with the money, it went from the national CIO office. The regional case officer X from the National Walking for Health Initiative, didn't actually get involved until a later stage did they? Which meant that it was at a disadvantage...as it managed things better and gave it more impetus since joining the group. I think the HPA, CIO, HA, Public Health, Loughborough University, I think that worked well, I think they had the right people around the table but we didn't have the right mechanisms to manage the project.'

But others thought that it lack community representation;

Quote 7.445

'Well I didn't think there was one...because when I went there was only me, X, Y and Z, and I was amazed that the steering group was quite management focussed considering that it was a community project and I thought they would have had more community representation, even when I went back to look at the original minutes there wasn't really, it was always HPA, Leicester City Council, a few parks people, there wasn't really significant community people, I think it was just down to poor management and it was always oh well these people know about the meeting, I didn't think that was the case I just think that they weren't ever invited and I was specifically surprised that none of the walk leaders were involved in the management or decision making process.'

There was a feeling that the steering group did not have any real power as the CIO national office and the HPA controlled the money. It was felt that having the regional WHI officer gave the group more impetus. There was a perception that the control and influence of the project could only be done via the finances, but ultimately the decision of how this budget was spent lied with the project coordinator, which was guided and influenced by the steering group. There was a belief that the human resources were

available, these people had the correct links but there was a lack of mechanism to manage them.

There was a concern of the lack of walk leaders involved in the management and decision making process this was a fair comment, but the steering group format would have not been conducive of their knowledge. A sub-group may have been more appropriate and would have served this purpose more effectively, from which a representative walk leader could have gone onto the group. However, in terms of them volunteering their time, it may have been more effective using their time else where than updating the group. As the steering group became smaller this may have been more applicable. Whether walking activators were invited to the steering group was debateable, but certainly at the beginning of the project this would have been premature and the project coordinator may have made this decision, on sound reasoning.

There was a clear division on members who were genuinely dedicated to the project as advocated:

Quote 7.446

'As already mentioned there were a few on the group who were dedicated and helpful they had their own workload and priorities expert knowledge were forthcoming apart from the British Heart Foundation.'

It highlights that partnership working is not about the organisation that individuals come from but the individuals themselves. It was this initial group of individuals who had the good faith to write the bid and form the partnership; it was when these key links into the sector moved on that the partnership strayed.

The structure of the steering group was criticised by key individuals:

Not constructive....

Quote 7.447

'I don't think the structure of the steering group has helped the project at all, it has not been constructive.'

They did not think it was constructive for the benefit of the project. In the latter part of the project, the steering group meetings became sparse and unresolved issues were put on hold or forgotten as implied:

Quote 7.448

'There was not a proper support mechanism for the worker and steering groups meetings were postponed a number of times which then lead issues not being resolved on time or forgotten altogether.'

The structure was never right, as it eventually dispanded;

Quote 7.449

'I don't think the structure was never right, what was its roll? I think terms of reference should have been written by the group, and it should have had a limited membership, along side this group an operational group should of been set up. As it stood it was of no real value to the project, and update reports could of just been sent to members.'

If clear terms of reference were written and roles identified, then goals could have been set and aimed for. The steering group had no real value; an operational group would have been more productive in hindsight.

The structure of the steering group affected the balance of power, and there was a general consensus that the relevant bodies were represented but doubted that relevant people were on the group:

Quote 7.450

'I think the structure was ok...X tended to host it, didn't he? The structure affected the balance of influence .....it just reflected the way things were with the actual sort of...balance of power...those are not the right words but... the powers of influence coming through and you know that certain people like Loughborough University, Y was there but he was mainly there on the academic side, he was the academic manager wasn't he? He managed that side of things and X was there from the public health perspective and we were there as sort of partners from the HPA and CIO's contribution as a said earlier that was the difficult bit no matter how we structured it or changed it.'

The chair of the meeting played an important part:

A learning curve....

Quote 7.451

'Initially the managers were involved in putting the bid together, and then it was up to the individuals to decide who would be best placed to come along to the meetings. In the traffic team, the task was delegated from X (who went to the original interview) to me, as I knew more about walking.

There's a certain culture when working with the Health Authority, and in a sense the Leicester City Council was doing them a favour by being involved. There should be more links with the Health

Authority and the Leicester City Council, which was recognised initially, with all good intensions when getting involved with projects, but when it comes down to staff time, the Councils own priorities take over, in spending our own budgets. The Health Authority chairing the steering group is overpowering, now that Loughborough University are chairing it, it may make a difference, it is a shame it did not happen sooner as it is seen as a Health Authority project.

It has been a learning curve for all partners to be working together in particular the Health Authority, Leicester City Council, and the voluntary sector working with the statutory sector. Workers are working with people and styles they are not use to. The way project management occurs in each organisation is different and the cultures of working are different. Its a very new concept working together and helping other projects, it very early days and is setting a good foundation for future work together.'

There was a perception that the project was a Health Authority initiative as they chaired it, and members welcomed when this changed to Loughborough University. It was felt that those that were there in advisory role made acceptable contributions, the only difficulty were the host organisation. This may have been due to the fact that they were the only voluntary sector representation and they did not conform to the statutory or academic sector ethos, and this posed a problem. If the balance of power were tipped toward the voluntary sector, then outcomes may have been different.

The lack of skills and direction of the steering group were stated more towards the end of the project funding:

Quote 7.452

'I was amazed that X used to do the agenda which I thought was very strange, I thought it was absolutely ridiculous when there was a project officer in post and to be quite honest I don't think that project officer had the skills in order to chair that kind of particular meeting because we never got anything particularly in advance you only got things when you asked for them there was no kind of forward thinking he wasn't kind of pre-empting peoples questions you know and it was always you know when we said can we have this information or that information he always had it but well he should of really been more on the ball, we should have it now, we should be talking about it, we shouldn't have to be asking all the time. I think as well the project officer was too operational but he was not thinking globally about the project you know he was obviously in quite an operational post but he wasn't kind of standing back from that and thinking ok how can I manage this as a whole because, when I came into post and we actually got the volunteers together its was the first time that they had met each other so that to me said that it really wasn't a enclosed project but lots of individual people operating individually. I

think he also, well he did have difficulty with Leicestershire Health, the way the volunteers got paid which was just.....well I just couldn't work it out, the systems in places so I don't think necessarily its all CIO, I definitely think that the HPA could have been more proactive in terms. We could have manage this a bit more effectively you know, perhaps the HPA could have held the money rather than Leicestershire Health for a start off but I think that was obviously slightly different because they didn't have a person in post, you know the Health Authority were wary of giving the money to the CIO but that didn't help and the management of it either because the CIO couldn't afford, if that was me I would of got CIO to pay and then claim the money back they were always going to get their money back eventually it just took a bit of time really. And there were issues that kept coming up; waterproofs and boots and I'm thinking for God's sake just go and buy them you know, and why do we discuss this every time and I think that was a bit frustrating for the project officer. I think it never really got addressed we went from meeting to meeting talking about the same things there was no structure or direction, no sort of project plan I think that both X fault and Y fault because they should direct with this management but both of them didn't have the time, but that's what they should have been doing.'

There was an issue with who set the agenda, which was done by an officer at the HPA. This was historical and was put in motion by the original chair and thus the project coordinator took a back seat. Questions arose of the skills of the project coordinator, but this was a perception of the statutory worker who came from a background that meetings were conducted in a particular way. The background and previous history of the project had a lot to do with these perceptions and the wall between CIO and HPA became higher with the recruitment of new workers onto the project. Previous opinions of the project may have existed from previous workers, which may have affected the judgement of the newer recruits.

The lack of forward thinking of the project was criticised and to a certain extent the administration of the steering group. Since the Health Authority stepped down as chair the administration of the group was also lost. This support to the project was vital, as it did not have the capacity to administer the steering group. Thus, the lack of responsibility taken on by other partners left no choice but the host organisation to try its best. The pre sending of information may have been impossible for the host organisation to send out. The HPA as partners of the project could have offered to help, but there are always two sides to the argument, as HPA were undergoing organisational change.

Instead of increasing frustration levels, compromises such as using ICT, emails could have been used but it's about sitting around a table and discussing options.

The project coordinators role in the steering group were discussed at length by key members who thought that he was central to the whole process and should have been more operational focussed for example holding a volunteers meeting. These are all fair comments but again it has to be in highlighted that the host organisation only housed four workers and the partner organisation employed over 67 staff it simply did not have the support that potentially the workers at the HPA had. Walking activators did work in isolation, which was not out of choice; it was only with the support of HPA that the walking activators network started. This was a good example of how the working partnership should have been, if there was a gap then support should be provided.

The management of finances were mentioned, and clearly it was not an effective system. The viewpoint of key individuals was that the HPA should have held the money but again it was about the balance of power and overall ownership. If the money was directly handed over to the project, then they would have to be responsible directly to the funders, instead of complicating matters unnecessarily and sowing the seeds of distrust between partners. Other concerns raised were operational items that recycled themselves back onto the agenda and were never addressed. This was due to having a lack of direct control of the budget to pay for day-to-day operational items and no operational group with the powers to authorise it. The project was thus deviated from real steering group matters there was no structure, direction or project plan this was directly blamed on project partners who had responsibility towards the project but lack time.

A major problem with set up of the steering group was initially the group that came together was large and was made up of senior managers and directors. When it came to commitment of time on the steering group this was delegated to team members whose workloads were already full. Work priorities for the organisations overpower partnership projects. It was a learning curve for all partners who set out with good intentions but working cultures and management of organisations were totally mismatched.

Key workers felt that their roles had been effective in many parts of the project:

Quote 7.453

'Yes, I have supported the coordinator as best as I could I feel that my locality knowledge was essential, the liaison had been successful, I think I've tried to help support the project as much as I can with the best of intentions obviously to help the project along it's way .The project fell into my locality area and it complemented all the work that I was doing, I'm proud to be involved in a successful project and we broke the barriers that were put up against us as we proved all those bad wishers wrong.'

Quote 7.454

'I think it has in particular supporting the walk leaders they have increased their ownership of the project and have become quite well resourced.'

Quote 7.455

'Personally after I became manager; a lot of time was to ensure that we got resources to have a full time worker rather than a part time worker and also strengthen internal procedures at CIO to ensure a proper structure and support for the worker was given. Re-jigged the budget and subsidised some of the much-needed finances for publicity, adverts and setting up workshops and seminars to recruit and retain walk leaders as volunteers'

Quote 7.456

'.... to be honest I'm not sure if it was, I think my time could have better spent, if the right structure were in place...I feel I wasted time doing things that were not my role and thus this effected my effectiveness in the role that I was supposed to play, it felt like I was juggling too many balls that weren't even mine!!'

There was a feeling of success and achievement through bringing down barriers. There was clear evidence that workers involved in the project were carefully selected as their work programmes match the objectives of the project. There was a sense of effectiveness of making it a community owned project and the identification of resources.

Initially at the commencement of the project, people's roles were multi tasked thus they felt their role was not as effective, and their task in hand was skewed, but this was needed to set the foundations of the intervention. Whilst others felt that their role was most effective at the end of the funding period to keep the project going and aimed for it to become self sustained:

Quote 7.457

'Well to be honest I mean I've only had a major role really since the actual end of the funding period in terms of keeping it going and actually sustaining it and well in the last year of the project really when X

has been in post, the Let's Walk Leicester project coordinator, that's when I've worked most closely with the project, in supporting her and helping her to set up the walk leaders network and walks.... how to become sustainable. But I was involved with X in negotiating with CIO in terms of trying to engage them as a partner to take things forward and eventually to release that partnership, and we had to dissolve it because we really couldn't or we didn't have an outlook that we thought was about the general benefit of the project it was about their own agenda....in that sense we have been successful I think we move forward for the best for the project. The last year of the funding of the project was difficult, I was there, I wasn't very effective because we seemed to be always going around in circles, in the end we got them to decide on the way forward.'

There were particular parts to the project that key individuals felt that their role was not effective such as the negotiation procedure with the host organisation. The partnership eventually dissolved and this was seen as positive for the projects way forward.

Other key individuals were not sure whether their role had been effective, as they had joined the project in the latter funding period. They felt that they had tried to communicate with the host organisation, but it was made difficult by the rejection of their WFH bid and the acceptance of the HPA's; this made CIO vary, thinking that the HPA wanted ownership of Chalo Chalay. However, since the end of the project more was achieved in the last 18 months by the HPA than the last 2 years, this is evidence of what was originally said that the Chalo Chalay project would of had more of an infrastructure and support if it was placed in a health promotion environment but with close links into the community:

Quote 7.458

'(been in post past 18 months) I think so and we have managed a lot of discussion with CIO earlier on we had a lot of difficulty because they had submitted a bid in and it was completely rejected and you know I've been able to get what we call the Chalo Chalay network up and running we have actually got people meeting on a regular basis, we got a constitution, people in the group have got roles, and we have managed to secure funding directly for the volunteers and not through an agency so I think in 18 months I've actually probably achieved more than the last 2 years of the project.... but its not been easy to do that you know...I had to jump through various hoops and I'm sure I'm going be sort of attacked in awe by the CIO but its about...what I've really focussed on is about all the time at the back of my mind its been about how will these people survive when I'm not here, because that is what ultimately is going to be about because I'm not always going be here, the HPA are not always going be here and you know if

we want them to continue its got to have real community ownership and that's quite difficult to achieve I think that was what was lacking in the original project because no one was really looking at that; they were very much focused on 'God I must get 60 million walks up and running' there was so many training days but in affect we have only got 11 walk leaders, you know, where's the rest kind of thing and I think to be quite honest it was too focussed on you know getting so many walks up and running rather than how do we maintain what we've already got which is what I've been really doing since January last year.

There is an issue about payment for volunteers I mean they are not getting paid anymore now that might be an issue; also that people don't traditionally volunteer in that kind of community? And if the only way to get them involved is going be to pay them yet we don't have the funding to do that and we've been looking at lots of different ways that that these people can be supported other than through payment and they don't seem to realise that I say to them 'you must keep a record of the phone calls you make and you must keep a record of if you buy stuff for the project' don't forget because they can't get a lot of funding back providing they keep a record of everything they spent rather than getting directly in a pay packet. And the other issue is that they are actually getting paid more than an exercise instructor who has got a lot more qualifications so even if we were going to pay them in my view it would not be on the salary that they got, it just seems ridiculous that oh we got money left so we will pay them. What we are doing is we are looking at other projects they are going to do a visit to another Asian project so it will be very interesting to see how that operates in what kind of payment and support they get, we got a list, we've got about five projects across the country. Initially, it was to say that this can be done, people do volunteer, you know and not many people actually get paid for it...and we have to go back and look at why are you actually involved because if you are involved as a job then its not going deliver that but if you are involved in some other capacity like you know we have been able to get some of the volunteers involved in the chair based exercise training course some have attend the Exercise Alliance seminar some of them are coming to different meetings so we are looking and other sorts of capacity building not just through payment as an issue.'

The original groups had formed a network, which was supported by the HPA. It was the original foundation and the commitment of the volunteers that had continued the groups and the vision of the workers for it to be self-sustaining by the commitment of walking activators and walkers.

It was advocated that the original project lacked community ownership and sustainability, which was contradictory to earlier comments made. Both arguments are level at that

particular point in time of the project, as both workers perceive community ownership from differing angles. However, historically in year one of the project, community ownership and sustainability was a clear outcome and focus of the project this had changed with the payment of the volunteer walking activators, as it put a loop hole in the ethos of the intervention. There was a perception that South Asians did not volunteer and thus they needed to be paid, as described in the previous chapter that it was this formal concept of volunteering was hard to sell but the concept of 'sewa' was a cultural normality. The issues of payment in kind worked previously and were an extension of the training courses offered to build their capacity. It was further implied that the project was too focused on increasing numbers and not maintaining and increasing ownership of walks already set up. This focus originated from the stipulation of the funders and thus the project lost sight of its original aims.

Other key individuals that were not involved in the other strands of the project felt that their strand of the project was not a priority:

Quote 7.459

'The traffic group could have done more, by pushing certain issues, but there were major staffing problems. It has felt that all was ok since the co-ordinator has not asked for input, or has not pushed for the environmental strand, but then again we could of asked and pushed it more, but I simply have not had the time, and obviously it was not a priority for the Chalo Chalay project.

The role has benefited the traffic group with the connections made within the City Council and outside the group. The group has helped to look and identified other funds, which have been successfully secured. What would be useful is having a formal way of getting feedback from the walking groups, of any traffic problems they may be having. It would be ideal if the pedestrian officers could get involved, but there's a lack of staff time. Travel plans officers could also get involved with planning safer routes for various walks. The consultation could work both ways, in that information on walking/ patterns could be collected. A solution to the lack of staff time would be to train walk leaders/ lay community members to collect/ consult with the groups on a regular basis, this could be tied to providing an incentive such as free bus passes.'

The traffic partners did not push the agenda however they felt that by being apart of the project gave them the links to secure further funding.

The strength of the project was seen from a number of angles, by the key individuals from the achievement of the aims to the dedication of workers, volunteers and walkers as stipulated:

Quote 7.460

'It met the aims it set out to do which was to get people in Belgrave area more aware of walking groups...firstly it set up walking groups that was achieved, secondly to get people to raise awareness of the benefit of walking that had been done and thirdly to set up sustainable walking groups and now that is open to debate because although there a lot of walking groups around is the funding still there? Funding has come to an end for Chalo Chalay and again it has become a little bit of a political issue.'

Elders of the community:

Quote 7.461

'The strength has been the elders of the community they themselves, have been committed to the project on a day-to-day basis; it wasn't the coordinator that was driving the project forward but the community. The project had successful met its main aims.'

Quote 7.462

'It has tremendously benefited a number of elderly South Asians improving their health and also lifestyle. The medical results on their shuttle walk test exercise show positive results, the women's group is much better than the men's group. Obviously the women's group had started earlier and were much more consistent in their attendance at the lead walks.'

The community involved;

Quote 7.463

'I think well the strength is that people are still involved because to be quite honest if we didn't have those people then there would be no project and they have seriously been messed about because of lack of management from the original steering group. The HPA and the CIO not agreeing over anything and to be fair I never did anything I was always open with everything I did and they've got a file full of paperwork that I've done but the CIO haven't been and its been confusing for them because actually X you are saying one thing and CIO another and all I have been able to say is well its up to you what you do but I have been open and honest right from the start so I think it has really been difficult and to be quite honest if it was me I would have packed up weeks ago if I was a volunteer so really its them and their ability to come together as group I mean there's still issues you know. I would like such & such and I don't like that being in the chair there are all those kind of things which you get with any group but its about working through those because as I keep saying to them there is strength in numbers, you know individually you are not going to be able to do anything, you are not going to fight the system and get

money individually but as a group you stand a much greater chance and its really nice, I was actually panicking like mad when I thought saying oh my god I told them that I was going to be here for them and now that I am leaving but they were really good and they said to me 'we want to thank you for what you've done' because I thought they really didn't appreciated it because I thought I'm just coming in to take over the project or whatever but really I've always maintained from the start that that this is your project how do you want me to work with you , what kind of support do you need and I think that really came out at the last meeting when they said they really appreciate what I did. The CIO think the HPA want to take over that's not what the HPA is about, its about building community capacity, we never get.... you never see us highlighted in the press or anything because its normally the agency who delivering the works and I think it has been difficult because the CIO feel I wanted it for some other reason, soon as they found out there wasn't going to be a project officer they just weren't interested, yet I had to kind of pick up the whole work in the existing stuff I'm doing not because we are getting anymore out of it from the WHI. The other thing is the people that are involved have got such good community links that what's a really good selling point when we go to.... when we work in other area's, saying that these people are not only working on physical activity projects but other community based projects and so can highlight the work of Chalo Chalay in a range of different ways I think that's partly why that project has such a good standing in that community because they have made so many in roads.'

The community had been the driving force and the day-to-day commitment and a belief in the vision was the core strength of the project. There was confidence in key people on the project that did push its agenda and felt that they were the strength:

Dedication of individuals

Quote 7.464

'The dedication of the coordinators and the volunteers, without putting in all these extra hours the project would not have been as successful as it is, also to all those workers who wanted it to happen, I feel that there were key people in the project that believed in the concept and were not afraid to experiment and trusted the coordinator to do this. I think these few key individuals that were positive neutralised all the barriers that were put up.'

There was a belief that these few core people wanted the project to happen, and thus it did. This implied that having a few dedicated individuals who were in key positions could make or break the project.

There was an indication that key individuals felt that the project was set up correctly and had all links to hand however there had been a need for the project to be pushed by national partners to deliver:

Quote 7.465

'If the CIO wanted to take that role upon themselves, to date…it was in theory excellently set up because they had the community connections, the other partners to deliver for the Asian community as it were. It was only when the national project pushed for an increase in numbers…. it proved that, when they were really pushed, there was one stage when there were quite a few walks and the national project pushed them all of a sudden there was an increase in the number of walks quite rapidly so we have seen that that mechanism could work but its just that the time and effort that was actually put into it wasn't what it should have been …as I have said earlier the strength of it was the sustainability that we have actually got now, is the sustainable groups, people have stayed with the project basically because they saw the value of the project.'

A key strength contradictory to earlier statements made was the sustainability of the project at the end of the funding period. The walkers made the intervention work as they saw the value of the project. This was a key incentive for the community as they saw it benefited not only them and their families but also the whole community of Belgrave. The walkers and walking activators was key to Chalo Chalay and were praised for their levels of tolerance with the ongoing changes of the project and the dramas playing out between the host organisation and partner agencies and thus the lack of management from the steering group.

It was stipulated that the HPA had been quite open and it was suggested that the host organisation was not as honest. This may have been explained by the lack of trust generally between voluntary organisations and fund holders such as the statutory sector. The partnership did not start with an equal balance of power as the overall control was with those that held the purse strings, thus CIO may have acted in caution, but this was a natural response to protect their own, especially with funding being given directly to the HPA. Between these two parties the community were left torn and it was unfair of all concerned to have put them into such a situation. However, the walking activators and walkers were a strong group and they came together, it was this inherent community sprit that kept them going. There was a stipulation that funding would have been more likely to be allocated to a large number of people rather than individuals and it was about fighting the system. This was a perception, as viewing it from a different angle; the

essence of the project was that community members ran it and it was a simple yet effective intervention.

It was the requirement of agencies to have protocols that complicated matters and thus there was an indication that resources were needed to complete these. The resource was originally needed to set up the intervention, but through time it was to become self-sufficient. The leaders were genuinely grateful for all that the HPA had done and certainly without them intervening, the network would have not been formed and which was lead by the volunteers. It was clear that the HPA felt that CIO believed that they were wanting ownership of Chalo Chalay, it was unfortunate that events leading up the ending of the funding period, made it impossible for the two organisations to see eye to eye. HPA stipulated that it was committed to building capacity of the community and did not want the limelight. This was fair but it could quite easily be translated into the HPA using Chalo Chalay to secure the funding for the Let's Walk Leicester and wanting Chalo Chalay to be amalgamated into it. A broad statement made on community involvement suggested that CIO were not interested in the project if there was not a project coordinator, this may have been a logistical problem of CIO needing an officer in place to carry out day to day running, without this the initiative would fail. CIO was not like the HPA where the intervention could be incorporated into its functions. There was clarification from the HPA that they were not getting anything extra from the WHI for doing this, but they had received the funding to maintain walks set up by the Chalo Chalay over then next three years, and it was also apart of their overall work plan for the city and had the responsibility to over see the initiative. The overall strength stated was that the walk leaders had gone on to train into other HPA initiatives. This had made in roads into the community it had put Chalo Chalay in good stead as they had the trust of the community.

Problems that key individuals identified included recognising that the host organisation was political and this really did not do the project any justice, the host wanted ownership and this was against the main principle of health promotion and community ownership:

Organisational politics.....

Quote 7.466

'One of the problems is obviously is funding and the other problem is having I think CIO which is very political organisation hosting the whole initiative I don't think it should be hosted by them it has become

a community initiative and the project has been able to empower people in the community and these people now should be taking ownership that's how health promotion works; health promotion isn't about keeping ownership of the project that you have set up health promotion is about guiding people down a right path and helping set up the project and then taking a step back and letting the community take over and that's what should be happening but the communities are not allowed to take over because of these political bodies that got involved.'

The project was a community initiative and had empowered its participants but the host originations were not allowing the community to take the lead and this went against the principle of health promotion and problems arose.

Funding was raised as an issue by key individuals, and felt that this had become a political issue. Both future and access to current funding was a problem the system set up was inadequate and were impossible to change. All key individuals interviewed felt that funding and the financial structures to access funding was a core problem.

The steering group was also seen as a problem:

Quote 7.467

'Funding has been a major issue. The funding that we have got is hard to access, it is a very long process, and I needed to plan 3 months in advance if I had any chance of getting the funding on time. The steering group has also been a problem, there is a lack of representation of all the bodies and the numbers are low. It was the responsibility of the steering group to steer the project in the right direction and this was not happening.'

There was lack of direction from the group and towards the end of the funding period attendance was low.

A lack of structure of the host organisation was seen to be a problem:

Quote 7.468

'It's a good question I don't know where to start but obviously as mentioned the problems or the disappointments rather than problems I would like to mention that those were disappointments in the sense there wasn't a proper structure, the worker wasn't given proper support, the work programme was changed adhocly by the steering group, there was a lack of continuity as it was a pilot project, financial resources were not adequate. As far as the worker was concerned the three R's i.e. recruitment, retention and rewards were missing, in particular the reward not in terms of finance but in terms of appreciation. Some of the initial problems were overcome; finance, structure – internal CIO, support and reward of

worker took place on a regular basis at staff supervision meetings. At the completion of the project I ensured that workers were given a bonus.'

This affected the support the project coordinator received, and the steering group were criticised for often changing the work plan. It was stipulated the workers did not feel rewarded enough in particular via appreciation; this was at all levels of the project from walker to steering group members. The new line manager ensured that the project coordinator was given the bonus that was due at the end of the project. There was also recognition that the internal organisation of the host organisation needed a workable format.

There was a general feeling that the project had too many problems, especially the hidden agenda's of the steering group. The consensus was that there was a lack of trust between partners and individuals not trusting their own organisations:

Quote 7.469

'The problems...well too many to mention.... but the key ones were the relationships between the workers, there were too many hidden agendas that hindered the project. I think we had the funding but it was hard to access. The internal structures of CIO, the internal politics' of the health promotion centre, jealousy of certain workers, and partnership working between the voluntary and statutory sectors, and a lack of trust, honesty and transparency of all those that were involved, too many games were being played at the expense of the community....I could go on but they were the key ones....not only did we have barriers when we started but these were out up on the way.'

Central to this was the hosting arrangements and the accountability structure:

Poor Management....

Quote 7.470

'I think the issues are poor management right from the start of the project it did not have any direction and when it came to the end even at 8 months before the end CIO weren't really thinking about what was going to happen and I suppose in a way I think is it my fault because I didn't really get involved until January time before it was due to finish but partly because it was not my project I was running another project that was similar and I was happy to support whatever they decided but in the end to be quite honest if I hadn't sat down and written the bid we wouldn't have any money we still would be discussing it with CIO....so a part of me thinks if you had stepped in a bit earlier we might avoided this kind of thing but...so I think that's been the key. The second I don't think the CIO was the best place to hold it I know I had some discussions with X in hosting it with a community group and in the end that's what's happened. ...But to be honest he suggested that now why didn't he feel that he could develop

that? If he had been working on it before it had finished I think that would have been effective so I kind of got the impression that the CIO held him back a bit and I think that was one of the problems. This is a local community project not some sort of flagship for the CIO...some of the things has hindered its continuation of being... CIO raised the issue of oh well its our project and you can't use the name and we had to go to our solicitors and say where do we stand on this because I didn't care I would change the name, I wasn't that bothered ...they said that the name actually belonged to the WHI because they funded it.... so they were just pulling at anything just to try keep a hold of this thing, I wasn't trying to take it over, I was trying to work with them, but they were not happy with the fact that it was the volunteers that were making a decisions about various things ...and even XX said that same thing....I must admit when he left the organisation and was coming out with the same things that we were saying ..so I just thought God if you had stood up there a bit earlier we would not be in this situation now really....I think some of the other things like the lack of volunteer involvement, those people should have been involved they should have been telling the steering group or at least have some sort of say in the decisions that were made rather than alone, I suppose that was the project officer role. When the project officer went then there was no links at all to those people that were on the ground delivering and I think if they had some decision making process, had the money directed.... that might of made a difference. I think one of the problems was definitely paying the volunteers because it did take a while, I thought we weren't going to have anybody, because as I said right from the start we don't have any funding for you if you want to carrying on for whatever reasons that was fantastic but I would fully understand if you didn't want to because it was a significant income really. Some of the problems definitely arose through the Health Authority and trying to get the funding took some time, the volunteers didn't get paid straight away, but it wasn't just the Health Authority but the money actually went to London and then the CIO in London took ages to get it all organised those kind of bureaucratic systems were not helpful either ...but I can understand from the Health Authority's point of view they wanted it to go through procedures. It could have been more globally effective because there were lots of people that knew about it, when I talked to people at the City Council they knew about the project but were never involved in it...and well I thought you should have been because that would help you in your role...more specifically some of the park rangers...they are now starting to get into Walking for Health before it was X used to come and walk on this park but that was all they did, they weren't really saying we can do this, and this for you or we can support with this venue and its only now that they are starting to realise that walking is significant and has been written into their business plans they have been given 8 thousand pounds of NRF (Neighbourhood Renewal Fund) to promote walking so I think they finally got their act together. I think the links with the traffic group could have been better as well because when I got involved with the traffic group the pedestrian officer said to me that I had one meeting with one group, god you could have

been a bit more involved there. I know the Belgrave project is on hold but its still going ahead but just a bit quietly.... It took quite a few City Council people out and I took them to various walks because they have got it in their traffic plan but what are they actually doing about it isn't this wonderful we have got a relationship with an Asian Walking Project...right you've written it in your document now what are you going to do about it...that comes down to being able to make those links the balance between being operational project managing and being a bit more strategic. If the steering group were a bit more effective you could of used some of those more strategic people to do that role...and that comes down yet again to the management of the whole thing ...you know hindsight is a wonderful thing.'

A root problem it seemed was the 'free hand' this was not the way forward. There was a feeling that the host organisation used the project to raise its profile and secured further monies. This would have been a normal practice of the voluntary sector as there was a culture of voluntary organisations biding into the same pot of money. Sustainability was not on their agenda; this was a direct contradiction to earlier comment made by project workers:

Quote 7.471

'I think the problems were that, perhaps right at the out set it was a mistake to set up CIO as host with the accountability structure they were given, perhaps a different accountability structure might of worked, they really had a free hand to do what they wanted more or less and that just didn't work. The root problem was that because they had a free hand, that they really ....it became fairly apparent that they were using the project to their own ends ...and to attract... simply used the kudos' and the money that particularly became apparent when we looked at, when the funding ended, and what their priorities were it was about having the kudos of owning the project and having endless money rather than looking at sustainability and made a lot of lip service to those kinds of things but never saw any action. Then the actual financial problems, the financial accountability was very poor as well because of the very clumsy system. I came into the project late but never seem to have any targets, we were setting up walks but there never seemed to be any targets like wanting so many walks by this time or so many walks by, I know it's a community based project and you looked upon needs assessment but it didn't seem to have enough targets driving it having enough sort of impetus behind it, to be honest I'm laying a lot of blame at the CIO but I think once we realised, I think things were let to drift a little by the partner agencies and they did not know how to handle it.'

This provided further evidence of a lack of communication amongst key individuals and partners. A further concern was the lack of targets however recognition was made that it was a community-based project and was based upon needs assessment. This highlighted

the real differences between the statutory and voluntary sectors and their ways of thinking which often did not marry. As suggested if the project had targets it would have impetus. Project partners were also blamed for letting the project drift and the not gaining control. It can be put down to poor management and a lack of direction. It reached a stage that key individuals took their own action such as writing a bid and securing a smaller pot of money, but were resentful that it came to that, as they felt that they would have still been discussing it with the host organisation.

The host organisation were questioned whether the project was best placed there, there were discussions at the end of the funding period to place it within a community group. The individual walks that were set up by the project continued to be hosted by individual community groups as they took on board the concept, the project officer was scrutinised of not being able to develop this as it was felt that this would have been effective. It was suggested that the host organisation held developments back and thought it was their own 'flagship' project. To the extent that the host had issue with the use of the project name, the HPA had to consult with its solicitors. The attitude of the worker was to change the name. This demonstrated the level of conflict between the two organisations, and the name in essence was the overall ownership, which ultimately was, intended for the community. It was further stipulated by the worker that the host did not like the volunteers making decisions, this may have been again explained of them wanting control, it was mentioned that ex-employees of the host organisation appeared to have the same view. The worker strongly felt that if they had stood their ground within the host it would have made a difference and the project could have been prevented from reaching the stage it was in, however it could have meant their job at that time and was a case of 'easily said than done'.

The lack of volunteer involvement at steering group level was raised as an issue and was suggested to be the responsibility of the project officer, this was a difficult issue to tackle as volunteer time was at stake and the possibility of the host losing control.

There was a belief that the project could have been more 'globally effective' by getting the professionals who knew about the project to get involved such as the park rangers, it was as if the project promoted itself but did not materialise these partnerships. It was only after funding was secured that parks wrote walking into their business plans, similar

situations occurred with other city council departments such as traffic. The project was successful in increasing its profile but not so successful in engaging its partners. This may have been due to the lack of time or just being over cautious. Other departments such as the traffic group saw the importance of walking for health and included it into its plans but there was scepticism from key workers whether anything was being done about it. There needed to be a balance of being operational and strategic which the Chalo Chalay project overall lacked and was due to the ineffectiveness of the steering group and overall bad management.

The potential of the project was discussed with key individuals, they felt that the walk leaders had a lot of potential and were a scarce resource. They were role models in the community and acted as walking ambassadors for the project:

Quote 7.472

'It's got great potential the walking leaders themselves who have been empowered and have become role models in their community these people are now open to all kinds if things we can use them for other projects, and they really have benefited from the peer education project and have gone on to become Exercise to Music instructors. They are really influential with the groups that they run, using these people and having this connection in the community these can make a real difference. This project has great potential in terms of using people in the community to deliver health promotion messages.'

Quote 7.473

'The potential is that it can still continue with the 10 walks a week that they currently do, there could be much more links with primary care, GPs and practice nurses and really the whole primary care organisations, much more links with secondary care, much more links with mental health groups...they could really run a 100 more walks ...we are trying to get them to think about being ambassadors as walk leaders and going to other Asian areas like Oadby and doing taster walks for them so there is that kind of potential but not just in the Asian community but like in other communities, like a couple came over to Braunstone to lead a couple of walks for the potential volunteers so they have that kind of ambassador role as well. I think its got...well being apart of this community project now I think its got potential to be sustainable the fact that they can use the facilities there, they can get on the website being a major part of the work programme, also linking in with the county's Walking for Health coordinator she is trying to get a network going to support the group in Loughborough so not only Chalo Chalay but some independent walk leaders that are happening there so that's got real potential to get together. Its definitely got potential in providing information about walking for health and general health benefits to the South Asian population in terms of...these people will listen to the walk leaders, they got potential

not just in walking but delivering chair based exercise sessions and various other things. I'm trying to get them involved in the Belgrave Health Network as a key partner really to say look we can deliver on some of these...so being recognised really as a significant community project. I suppose I'm not really the best person to say but I think culturally it probably has more potential in terms of targeting other cultures, well I don't know how somebody who's Hindu would be able target someone from the Muslim community but in terms of walking generally that's a very weak link and I think if somebody from Chalo Chalay going into a Muslim community in Highfields might be more effective than me going in or whether its just...that's quite significant, and I know that was one of the things, the issues that came out of the evaluation nationally for Chalo Chalay was the fact that it was focussed much more on the Hindu population and I don't know personally how you would try and involve other communities groups we have some walks going on in Highfields. Try and get some sort of integration and transference of the initiative.....'

These trained individuals were key in health promotion as they were trained in other projects, which were linked to the concept of Chalo Chalay, and were multi skilled, widening this resource would be beneficially to the targeted community work and were making a real difference just by their connections:

Quote 7.474

'The potential is huge, a massive change can occur if the right approaches are taken, there would be an increase in the number of people taking these opportunities up.'

Quote 7.475

'I feel that the project could be a wider area of Leicestershire apart from the city. Furthermore Countryside Agency, X is aware that I had worked tremendously hard to replicate the project in Coventry, Northampton and Nottingham.'

If the right approach were taken mass change would occur and could expand not only in the city of Leicester but the East Midlands and wider:

Quote 7.476

'There is a huge potential as far as people could image, with the correct support and energies the project would be going leaps and bounds because it is such a simple concept that people can grasp and hence have full faith in...its been successful with all these set backs...just image without these set backs.'

If the right support and environment was created the initiative could have changed a number of lives, as it was a simple health promotion intervention that masses could easily grasp. There was also potential for the project to further develop:

Quote 7.477

'Where we are at the moment is because of...if go back a bit in terms of the history of the project.... because of the way it had been delivered talking about the funding period the national walking the way to health initiative wanting to fund it for any more than for a maintenance role, in other words rather than a development looking at maintaining existing projects and making that self sustainable groups...what we have done so far and so in that sense it has became a part of the Let's Walk Leicester programme ....but what we are hoping for is that now that it has got a strong core of group leaders and with time and other pots of money we could potentially develop as well and it does look sustainable with the group we have already got funding, what we got is for 3 years; two thousand five hundred per year from the national project to run operational maintenance . There is potential to develop it and then its got potential very much so to link in with all the other projects like the exercise referral projects as part of the main Let's Walk Leicester project, and link it into rehabilitation in the community projects.'

The project can link into other bigger physical activity initiatives, mental health, with primary and secondary care. A further aspect of the potential of the project was sustainability; there was a confidence that the 10 walks set up would continue and a further 100 could be set up. It had a potential in providing correct and acceptable information to targeted communities and the deliverance i.e. the walk leader was the ideal 'professional' to deliver this. These ambassadors of Chalo Chalay were seen as key stakeholders in future health promotion initiatives in the area and were incorporated into decision-making networks and were recognised as a significant community project. It was assumed that these role models for the particular community could be transferred to other communities in other localities that are from the Hindu culture to the Muslim culture. It was highlighted that this was a weakness of the project that it had not targeted the Muslim community, this would have been more possible if an additional project worker was recruited who could speak the language and who understood the culture, it was like drawing parallels with the English and the French...who are of the same colour but speak different languages and different customs. It has to be noted that initially funding was only allocated for the Belgrave locality of Leicester which was predominately Hindu and this was known at the commencement of the project, it was unfair to say that the Muslim community was not included in this, as they were never really a core group that was targeted in the demonstration. However there was potential if further funding was secured to expand out into predominately high-populated Muslim community, but the key was to have the right worker who could speak the language and understand the Muslim culture.

Key individuals measured the impact of the project by the raised awareness of the South Asian community of the project and its key principles. Participants felt better about themselves, and this helped their overall general health and gave them the motivation to do other activities, specific illness such as diabetes and depression were lowered.

Quote 7.478

'Whether the project has reduced heart disease.... this I don't know but when I have spoken to ladies that go to the walks that suffer from arthritis, diabetes, depression it has helped control all these things people are feeling better about themselves that's what we need to look at when someone feels better about themselves it improves their spirits and they are able to do a lot more other things and this has ***definitely, definitely*** *happened.'*

Clear evidence was presented that it had impacted on the community foremost and the walking group had made major shifts in participant's lives:

Quote 7.479

'It has impacted on the community the most; it has raised their awareness and what is out there for them it has made some major shifts in their lives. In terms of the health organisations, nationally there has been an raised awareness of the project.'

Quote 7.480

'It has changed peoples lives for the better, qualitative and quantitative evidence shows this.'

There had been an overall raised awareness of walking for health not only by the community but health organisations regionally and nationally:

Quote 7.481

'Awareness has not only been raised in the South Asian Community in Leicester but also nationally and the project has been a role model or looked upon as one from other counties and also London. Personal comments; I feel that the Health Authorities and other key stakeholders should be taking an active role rather than lip service in promoting this project because it will produce win win situations not only for people but also for the Health Authorities as they will be spending less money in the long term.'

There was a realisation that health authorities should be more apart of the action strategy as it would overall lower public health costs in the long-term future. There was further criticism of the project that it had not produced an evaluation that gave clear conclusions so that impact could be measured and was done only done on a small scale. Although the

individual did go on to say that what was achieved on a small scale was a lot and the key was sustainability:

Quote 7.482

'At the moment its really difficult...because there has never been a... there has been some evaluation ...but we haven't received any vigorous conclusions from it and it is fairly small scale, its only the walks in Belgrave that's 10-12. But I think its achieved a lot in terms of getting people to know about it in those communities, and it certainly seems to be working on that small scale. The impact will be the sustainability in the chance that we have got to continue it that there is something to continue afterwards unlike some of the projects perhaps certainly more on a smaller scale than we hoped for.'

Key individuals believed that it had increase walking levels and physical activity habits but were uncertain whether participants met national guidelines:

Quote 7.483

'...Its definitely got more people walking and I know there were some issues whether people were meeting the recommended guidelines but I don't know whether we got the information about that. When you talk to people they know and even you talk to professionals they say oh yes I have seen them walking in Watermead Park and I've seen them in Abbey Park so I think visually they are a well respected group and many of the people that have been involved probably since its conception have improved their physical activity habits. I would of hoped that it has had an impact on people being less socially isolated in those communities and I know with the Belgrave participatory appraisal work that there are a lot of issues around culturally appropriate physical activity and its great to be able to say well actually there's one very culturally appropriate option for people and the fact that most people can do it but there is obviously a lot of people out there...I'm trying to get them involved in park user groups so they have some impact in terms of how parks are developed and services are improved on the parks. There's definite impact in terms of consultation work.'

There was also recognition that the project had gained a high profile within a community and professional setting, it was a visual project that was respected by all involved in it. It was hope that it decreased social isolation. From current research via the participatory appraisal there was a lack of culturally appropriate physical activity opportunities and the key individual was keen to say that the Chalo Chalay project was available, which was a viable option, but this was the only option and there was a real need to increase the variety and availability of other physical activity opportunities. There was a clear indication that it had impact on consultation work in the targeted community.

There was passion from key individuals to serve the local community and there was resentment towards key political organisations that were unnecessarily tainting the task at hand.

Quote 7.484

'I think overall the project has really been a success it's a shame that CIO and HPA are both political organisations and there is all this talk going about who should get ownership and who should be looking for funding who the hell cares at the end of the day and what ever decision they are making are effecting genuine people out there in the community that we are suppose to be serving, they need to brush all their political agendas under the carpet and start learning to serve the community in a genuine and honest way.'

There was also confusion of the evaluation and where to get the information from, and if there were other studies from which models of evaluation could be taken from:

Quote 7.485

'Is this the evaluation? I have no knowledge only got the Lets walk Leicester programme and I know that works but this seems to be a slightly different animal and you have nothing to compare it with almost....I feel a bit of a vacuum if you like.'

Quote 7.486

'No not really, the only issue for me is that its going to be quite difficult to evaluate we have not really done that much on evaluation so far it been more about getting things up and running...and when you are getting isolated communities involved it's quite difficult to say to them come and do a shuttle walk test I think we have to look at other ways of evaluation and that goes back to the PCT (Primary Care Trusts) to recognise that not everything has to be scientifically valid and we should be looking at processes as well as outcomes and should be looking at hard and soft measures...and again until they recognise that then.....you might come to a point when you can't have anymore cars on the road or suddenly we will just got such a huge bill on the NHS there might just have to go to war on it really you never know.'

There was clear empathy that it was difficult to evaluate such an initiative and to get participants from isolated community to come and do quantitative testing was a very difficult task. It was of the opinion of the key worker that funding from PCT's should be not scientific but soft measures should also be acceptable. The eventualities were also discussed; the NHS in a number of years would have a huge bill that the government will have to reconsider its overall policies on transport and the cost of health.

A key partner in strand three (environmental) of the project explained why it never progressed. The Belgrave corridor project proved more difficult, as it lacked public support:

Quote 7.487

'The Belgrave Corridor project is having problems, in that the consultation has not been popular, and residents are not in agreement in with the proposed changes. This has had a cascading effect, in that the environmental changes have not yet occurred. Thus, the original targets proposed in the Chalo Chalay project have not been met, but this was anticipated, as the Belgrave Corridor project was a five-year timeline whereas the Chalo Chalay project was a three-year.'

This delayed the implementation of the proposed environmental changes. As stated in the bid the timescales of both projects were not on par Chalo Chalay being the shorter. There was not real input into the project from the traffic group right from the onset, it gained more from the project than it gave:

Quote 7.488

'Overall, the traffic team has not had an input into the project to date as anticipated. There has not been any links into transport due to staff shortages within the team. More time would of liked to be spent on the project but this has not physically been possible, due to the lack of time.'

Quote 7.489

'It would have been a good idea to get feedback from the walking groups on specific problems the walkers encounter with traffic in the area, not just on the devised routes but via independent walking. It was useful coming along to the group and talking to them about the Belgrave Corridor, and the comments from the group have been past on. It would be useful to get regular feedback, which could be linked into the individual walker interviews/ questionnaires. To be able to use the groups to hold focus group consultations, a lot of benefit would be derived.'

It would have been useful to have regular feedback from users of routes and independent walking but no information channels between the walkers and the department were ever set up. Partners felt that they had access to other professionals around the table, not only with external partners but also within their organisations:

Quote 7.490

'Being involved in the Chalo Chalay project has created good links with the Health Authority, via the Confederation of Indian Organisations, which has never happened before. Also making links and contacts within the Council and outsiders, who we would of never before worked with in other work areas

for example working with X from the Riverside Project. We have used Chalo Chalay and this working partnership with the voluntary sector and working directly with the community to bid for further monies for local transport and environmental plans. It has given us the extra brownie points to secure more money.'

This secured further funding for the department suggested that it worked closely with the voluntary sector and the community. Smaller environmental changes did occur via the project such as prevention of the closure of toilets on a walking route and the securing of a large amount of funding to implement seating and lighting due to partnership working with the Chalo Chalay group:

Quote 7.491

'As a result from the consultations with the group, and the feedback received, the closure of toilets have been prevented, as these are expensive to maintain; the group have previously commented the lack of toilet facilities on route. These comments from the Chalo Chalay groups have secured a further 90k for the Belgrave area for seating, lighting etc, it has been justified by the Chalo Chalay partnership working.'

Small steps were taken to make the walking environment safer, which was more of an important aspect than way marking and increasing natural surveillance:

Quote 7.492

'With the other demonstrations projects, set in rural areas way-marking is important, however in the urban areas it's about trying to reduce the clutter in the areas not adding to them. Its more important looking at the bigger issues, of providing safer environments to walk in and the money would be better spent on bigger issues such as lighting. Through the project, funding has been secured to this. Providing safer environments would increase the natural surveillance in the areas, the more people using the facilities, the safer it is.'

A discussion on the use of public transport by walkers was suggested and walking being the glue between modes of transport. Issues with traffic projects being out of synchronicity with community projects was a barrier to this:

Quote 7.493

'It would be good to link in public transport, so that walkers can use the bus to get to the 'nice' place to walk. This would build the confidence of the walkers to use public transport independently. Linking into Travelwise, to provide free bus passes may be an incentive to encourage walking, and using it as glue between the modes of transport. Again could use the group as a consultation for the planning of safer routes. However these are broken down into 10 main localities, and this may be out of the time phase of

the project. This has been an overall problem with transport input as the projects are at different stages to have an input. However, when the groups are set up after the three year period, they would have a say in the environmental changes taking place in Belgrave.'

A perspective on the future of walking from a walking for health coordinator for the whole of Leicester city was gained. She felt that walking for health was not really the answer, as it often did not engage individuals from deprived areas easily, it could be done with a lot more resource and time. Individuals do walk as apart of their daily routine but would not necessarily do it for the health benefits. She however, did stipulated that there was an interest from the public sector but more so from health organisations as it was best buy for public health. There was also an opportunity to link into sport action zones, which has not previously been tried, to get sport to think in terms of health. There had been clear success walking with ' park rangers' and securing of further monies from NRF. This had been quite difficult for Chalo Chalay to do, as the park ranger's role was reorganised during the project life span. There were clear activities with GP's who were now ready to come on board via the GP referral scheme as Chalo Chalay in essence had set the foundation, there was not as much fear about liabilities as there were five years ago. Strategically the HPA had the links and resources to set up a walking forum for Leicester and was written into the local transport plan. She stipulated that via the high profile of Chalo Chalay it had helped the city project to get involve with community development, which was at the core of the project. This had also branched out with working with young people via crime & disorder and youth offending teams, thus the scope of the project had widen to be inclusive of socially excluded groups. Work within the safer routes to school project and working with parents had proved to be an opsin for the project.

The main strength of the Leicester project was that groups were set up at a fairly low cost, and funding had been secure from the national project for 37.5 k, of which 7.5k was awarded to Chalo Chalay over 3 years for maintenance. Questions do arise here of why Chalo Chalay only receive only 7.5k; through bad planning and management funds anticipated were not received and will be further discussed in chapter 9. Another factor was the new funded initiative of the partnership between the Department of Health, Sport England and the Countryside Agency were LEAPs local exercise action pilots, which took away such localised funding.

When asked if Walking for Health is the answer in 20 –30 years time the worker replied that it had potential, but it was a battle against all other factors such as the car, safety issues and government plans to build more motorways. A second major obstacle was clinicians who thought about curing and not prevention. In isolation walking would not be the answer but in partnership it has a lot of potential, there was a good foundation such as PCT's, and traffic wanting to fund such initiatives other countries have succeeded as they have worked in partnership, but as it stood the worker believed there were too many variables to change in order to be active. It was a stipulated that the schemes had made a small difference in proportion of PCT's way of thinking that would be the main funders of such projects.

Chapter Eight

Results: Intervention Endorsed

Happy is the man who has acquired the love of walking for his own sake.

W.J.Holland

8.1 Introduction

The chapter commences by the analysis of the BHF/CA evaluation report written by the British Heart Foundation Health Promotion Research group (BHF HPRG) based at Oxford University (Foster 2001), which includes a series of processes and outcome evaluations from the three national Walking the Way to Health Initiative (WHI) demonstration projects Eastbourne, Leicester and Walsall. The three evaluation questions asked of all three projects were;

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

These questions allowed parallels and comparisons to be made across the demonstration projects although the demographics and target populations were different. The report was inclusive of the Chalo Chalay intervention for questions two and three but data for question one can be found exclusively in Chapters 5 and 6. The report presented quantitative data for the other demonstration projects and was a good tool to access the success of the Leicester project. In this chapter comparisons and generalisations are drawn from which the toolkit and framework is devised.

8.2 Research Design Method

The research method described was conducted by the British Heart Foundation Health Promotion Resrch Group University of Oxford (BHF HPRG); the Leicester project had commissioned Loughborough University as an integral part of this process. An observational study was conducted to answer question one, following a cohort of walkers over a twelve month period and assessing any change in their overall behaviour. A mixture of methods including semi- structured interviews, focus groups, participatory evaluation workshops and

audits of project records were used to answer questions two and three, these methods are described in chapter three.

8.3 Results

8.3.1 British Heart Foundation & Countryside Agency Evaluation Report

Back ground to the Final Evaluation Report

The report was written for the BHF, the CA and all the participants of the three national demonstration projects. It presented the results of a number of different evaluations of the three WHI demonstrations, which asked questions about the impacts, and development processes of each project. The report described each of the evaluation questions and the different approaches used to answer each question across the projects and their overall findings and thus made recommendations. The overall aim of the WHI was to improve the health and fitness of people, especially those who did little exercise or who live in areas of poor health.

Case Record 8.1

The Partnership

The WHI was formed by a partnership of the BHF and the CA. The collaboration was a response to a number of factors:

- A growing body of evidence for the relationships between physical inactivity and heart disease (U.S Department of Health and human services, 1996: Department of Health, 1996).
- New research findings advocating the appropriateness of walking as a starting activity for all sedentary adults groups (Hillsdon & Thorogood, 1996, Seigals *et al, 1995*).
- Encouraging results from a number of innovative walking promotion projects, including a pilot project based in the Thames Valley area, also funding by the Countryside Agency (Bartlett 1996).

Case Record 8.2

Outline objectives of the WHI

In 1998 The WHI put out a national call for proposals to fund a number of demonstration projects that would try out different approaches to the promotion and provision of walking. Successful projects were expected to offer walking opportunities to groups not usually served by other walking projects e.g. Ethnic Minorities. They were also expected to adopt different methods of motivation and supporting new walkers e.g. using signs or incentive schemes. These projects were expected to work closely with local communities, develop sustainable environmental changes to promote walking and construct supporting partnerships with other local statuary and voluntary agencies. The projects also needed to have local sources of funding for their proposal. The purpose of each demonstration project was to test and try out their ideas for walking promotion. It was anticipated that through the experiences of these projects the WHI could learn from successes and failures and begin to refine a number of approaches to the promotion of walking.

Over 20 proposals were received with three projects finally selected. The successful projects came from Leicester, Eastbourne and Walsall. Each project was very different in their approach to walking promotion, their target groups and project operation. All would be funded for three years from October 1998 till October 2001. Table 8.1 summarised the key characteristics of each of the demonstration projects at the start of their funding, including project aims, target groups, the different approaches to walking promotion, the lead local organisation for the project and other partner organisations.

Table 8.1 Key Characteristics of the three WHI demonstration projects

Key Characteristics	**Leicester**	**Eastbourne**	**Walsall**
Project name	*Chalo Chalay*	*Pathway to Health*	*Walsall Walk On*
Project aim	To get physical activity on the agenda of all South Asian community organisations by stimulating community participation, and in so, enhance the personal skills and self esteem of people in the	To encourage walking for health by increasing the awareness and understanding of the local population and visitors to Eastbourne on how they can make use of the pathway to health walking project to	To test ways of promoting higher levels of awareness of the health benefits of walking and increasing the rate of walking amongst specific targets groups within Walsall.

	community.	attain health benefits.	
Target groups	Sedentary adults from South Asian community	Sedentary adults from deprived areas, elderly adults	Children, adults, cardiac rehab patients, overweight, diabetic, socially isolated
Approaches to walking promotion	Led walks, environmental changes, links with primary care, specific cultural events	Sil na Slainte, especially marked walking routes with information and distance signs, lead walks, sculptures	Led walks, participants reward and incentive scheme ground miles, way marked walking paths in parks
Key local lead organisation	Confederation of Indian Organisations	Eastbourne Health Authority	Steering group of local partners, including health promotion, local leisure services and countryside services, Walsall Health Action Zone
Partner Organisations	Leicester Health Promotion, Leicester City Council, Leicester Health Authority, Loughborough University	Eastbourne Borough Council, University of Brighton, Age Concern, Bourne work rehabilitation unit, Royal National Institute for the Blind	Friends Reedswood Park, Local Agenda 21 groups, Walsall Headcare & Birchills local committee Art project

The results of the evaluation report provided four main pain products to the WHI:

- Identification and analysis of the demonstration project strengths, weakness and challenges.
- Identification of examples of good practice from the demonstration projects, common challenges and advice to inform future WHI projects.
- Identification of challenges to development, implementation and evaluation of future WHI projects.
- Recommendations for the development, implementation and evaluation of future WHI projects to meet and manage these challenges.

The role of the BHF HPRG was to support the evaluation of the WHI projects by conducting a comparative evaluation of the projects and evaluating the whole of the WHI programme.

Case Record 8.3

Two-Day Evaluation Workshop

The BHF HPRG began the process of focussing the evaluation agenda with the BHF and CA and the demonstration projects this process was initiated at a 2-day workshop held in Oxford in October 1998. The aim was to draw up detailed evaluation plans for the Walking the Way to Health (WWH) Projects. Six objectives were identified:

1. To provide the opportunity of the WWH project to share their aims and operational plans with each other.
2. To reflect upon examples of current UK physical activity research and upon different methods of evaluating a health promotion project.
3. To examine how the aims and objectives of the WWH projects might be evaluated.
4. (a) To identify the specific evaluation requirements of each WWH project and how these might be met.

   (b) To identify common methods by which the three WWH projects can be evaluated.
5. To identify the resources needed to carry out the evaluations and how to meet these resource implications (within agreed budgets).
6. To clarify roles and responsibilities for evaluating the WWH projects including the nature and level of support from the BHF HPRG.

Case Record 8.4

Results from the 2-day evaluation workshop

All the projects had detailed their projects aims, objectives, target groups and approaches to walking promotion, but at the workshop found it difficult to detail how the projects would operate on a day-to day basis e.g. how each project would market and publicise their led walks. This was not surprising as the participants at the workshop tended to be representatives from different organisations, with little experience of coordinating walking promotion projects. This proved a challenging task for the BHF HPRG team as they were asking specific questions about the projects to the participants who had little experience with projects that only existed on paper. Additional time was given during the workshop for projects to sketch out operational details for key parts of their project. The workshop was successful in producing three common research questions stated in the introduction 8.1, due

to the difficulty involved in the evaluation of question 1 the BHF HPRG would lead the evaluation of this question, the project would be responsible for the evaluation of questions 2 and 3 plus a number of other project specific evaluation questions.

At the workshop it was agreed that the goal for each project would be to recruit about 200 participants to take part in the evaluation of question 1. The combination of all these participants across all projects would have enough statistical power to detect change in physical activity and walking.

Case Record 8.5

Active Outcomes from the 2-day workshop

- The evaluation workshop successfully produced three general questions that covered the impacts and processes of all the demonstration projects.
- The evaluation workshop needed representatives from each project who would be acting as project coordinators or workers to provide deeper operational details.
- The evaluation workshop was held a little prematurely for the projects and for the BHF HPRG.
- The evaluation workshop did allow the new projects to share their hopes, fears expectations and challenges with each other for the first time. This sharing was felt to be very helpful by all participants.

Case Record 8.6

Question 1: Did the project increase walking in the target groups? – Developing pilot measures & protocols.

Background

Bartlett *et al.,* 1996 was the only published study on the evaluation of walking for health; the main findings of the study were;

- More women than men were participants (3:1 ratio)
- Older rather than younger people participated in the walks (mean age of participants was 53 years).

- Nearly all participants reported positive changes for taking part in the walks (feeling fitter, being in the countryside, enjoyment).
- No significant impact on fitness was found.
- The number of self reported walks for exercise increased in the participants who took part in health walks two months after the start of the project compared to their pre walk levels.

The study also identified some key issues for future evaluations of walking for health projects:

- Projects should record individual participation in the health walks.
- Outcome evaluations of physical activity or fitness should be compared to a control group and conducted over a longer period of time.

Case Record 8.7

Piloting and Development of Behavioural Questionnaire

The BHF HPRG felt that the quality of the evaluation of the projects would be improved if the evaluation tool used to measure participants physical activity behaviours had been used elsewhere. The criteria used to select these tools included:

- Was it able to measure a range of different physical activity behaviours (especially walking)
- Has it been evaluated or used in similar work
- Did users find it easy to complete (readable and understandable)

Two tools appeared to match this criteria and one, which fitted after piloting, was the Physical Activity Frequency, Intensity, Time and Type Questionnaire (PAFITT)

Case Record 8.8

Development of a protocol for the collection of physical activity data

The process of collecting baseline physical activity data across each project was discussed with the BHF HPRG, the CA and representatives and coordinators during mid 1999. It was clear from the pilot process that the experience of a new recruit to a led health walk needed to be enjoyable and positive. All parties agreed the data collection of the evaluation must not

dominate or overshadow the participant's enjoyment of their first health walk. The decision about when to collect physical activity data was shaped by two key points:

1. The design of the evaluation and the recall period (the previous week) of the PAFITT questionnaire required data collection prior to starting in led walks.
2. Other types of information (personal details, PAR –Q forms) were now proposed by the CA's training team to be collected prior to starting led health walks.

Following further discussion it was agreed that all baseline physical activity data would be best collected at the attendance of the first health walk of a new walker.

Case Record 8.9

Evaluation of Chalo Chalay

Loughborough University was a key stakeholder in the Chalo Chalay project. The University was commissioned by Leicester Health Authority at the start of the project to lead the evaluation of Chalo Chalay for the duration of the project. Following the evaluation workshop the university and the project worker, the project's evaluation team, had produced plans to evaluate changes in fitness levels of participants. In addition the project worker had registered for a part time PhD at Loughborough University and planned to use the process and outcome data for her PhD thesis.

Further discussions were conducted with the projects evaluation team and the BHF HPRG during mid 1999. In May 1999 the project team produced the first progress report from the project that included preliminary evaluation results on question 2 and 3. The report was well written, detailed and had provided new insights into the particular needs and challenges of working with their target group. Based on the high quality of this report and further negotiations with the BHF and University of Loughborough it was agreed that the projects evaluations team rather than the BHF HPRG should lead on the collection of both the fitness and behavioural data from participants. The BHF HPRG would still provide and hands on support to the projects for all aspects of their evaluation.

Adapting PAFITT for the Chalo Chalay project

During the spring of 1999 it became clear that the proposed PAFITT questionnaire would be completely inappropriate for the target group of this project. Project staff strongly felt

there would be considerable problems with language and literacy. With support from University of Loughborough, Leicester City Council and the project worker, the BHF HPRG produced a shortened modified version of the PAFITT. This version now asked users to recall their walking related physical activity during the past week. It covered different types and intensities of walking. The project worker at a series of informal meetings assessed the acceptability of the measure to the target group. A final version of the measure were translated and produced by the Leicester City Council, based on the modifications of the PARFITT by the BHF HPRG. This was the first walking questionnaire produced for a South Asian target group in England (Appendix I & II).

Chalo Chalay Evaluation Protocol

The collection of baseline walking data would also become apart of the new walker administration procedures. Follow-up data would be collected at the time of participants follow up fitness tests, approximately 3 months from the start of the project. Walkers who did not attend fitness tests would be sent their questionnaire by post. All walkers, walking behaviour would be assessed either by postal questionnaire or during subsequent fitness test sessions, at approximately 3,6,9 and 12 months, from the date of their first walk. A similar protocol was used with the other two demonstration projects, followed up postal questionnaires were administered by the BHF HPRG.

The piloting of the PAFITT questionnaire was a critical part of constructing an appropriate and sensitive means of obtaining detailed physical activity data without ruining the experience of new health walkers. The choice of the before and after design, did allow the BHF HPRG to describe the physical activity status of participants from these projects during their first year of participation.

Case Record 8.10

Results: Question 1: Did the project increase walking in the target groups

In order to answer question 1, additional questions were asked:

a) What were the gender and ages of new health walkers recruited in the WHI demonstration project?
b) How active were the recruits to the health walks?

c) What changes in physical activity did the participants report during their 12 months of follow up?

d) What changes in brisk walking did the participants report during their 12 months of follow up?

a) What were the gender and ages of new health walkers recruited in the WHI demonstration project?

Over 150 participants were recruited to the Walsall and Eastbourne projects during the first year of the led walks. Out of the 150 twice as many women were recruited to the projects than men. This pattern remained steady across the first year of the project showing no variations in recruitment by gender. The majority of people were aged above 60 plus. The male health walkers appeared to be slightly younger than females but this difference was not significant. Based on the results of the baseline data from both projects the typical profile of an average new recruit to the WHI demonstration projects would be female and aged over 60 years. This profile would fit about 40% of all recruits in the first year of the projects.

b) How active were the recruits to the health walks?

Defining the level of physical activity of an adult can be done in a number of ways. Their behaviour can be compared against a recommendation to see if they are perhaps above or below a specific amount of physical activity. This recommendation is based on a calculation of occasions, time, intensity and type of different physical activities. This approach was used in assessing how much activity the new recruits undertook in the week prior to their first health walk.

In 1995, the Centres for Disease Control and prevention (USA) and the American College of Sports Medicine recognised the importance of physical activity and published a health message recommending that 'every adult should accumulate 30 minutes of more moderate-intensity physical activity on most, preferable all days of the week' (Pate *et al,* 1995). In 1996, the Department of Health issued a 'strategy statement on physical activity' promoting 30 minutes of moderate intensity physical activity on at least 5 days of the week, and of those already taking some vigorous physical activity, three periods per week of vigorous intensity physical activity of 20 minutes each (Department of Health 1996). This recommendation was used to categorise participants as active or as not active.

Over 70% of all new health walk recruits were already meeting the current recommendation for physical activity. Higher proportions of men than women were active at baseline 80% versus 71 %. There were no age groups where inactivity was significant higher than any other age groups.

c) What changes in physical activity did the participants report during their 12-month follow up?

More health walkers were in the active group than the inactive group at month 12 however this change was not significant. It was more helpful to examine the types of changes participants had made between baseline and month 12. There are four options for direction of change:

1. Become active
2. Become inactive
3. Stay active
4. Stay inactive

The majority of the participant's direction of change was staying active. The direction of change was about the same for the other three groups.

- The majority of participants who completed their 12-month physical activity measures did not change their baseline physical activity status.
- The number of people who became more active (changed from inactive to active) was balanced by the same numbers who became less active (changed from active to inactive).
- No evidence of any possible improvements to physical activity levels of participants was seen in this data.
- Few inactive health walkers were recruited to the projects and as such fewer people had the possibility to increase their overall levels of physical activity. The majority (who were already active) could increase/ stay the same or get less active.
- The overall physical activity levels still remained high in the final month 12. This final group may have been more willing to participate in the evaluation process and keener to report high levels of physical activity than those who did not return their month 12 questionnaires. One explanation may be that participants were keen to

'show' that they are still active. This type of finding is called 'socially desirable reporting' (Steven *et al* 1998).

d) What changes in brisk walking did the participants report during their 12 months of follow up?

The amount of brisk walking conducted by participants was assessed using self-reported data from the brisk walking items from the PAFITT questionnaire. At baseline nearly three quarters of participants reported none or little brisk walking in the previous week.

About one third of the final participants, 22 participants out of 64 reported no minutes of brisk walking at baseline and no minutes of brisk walking at month 12. 42 participants reported either an increase or a decrease in their self-reported minutes of brisk walking, with fifteen participants reporting an increase and the rest reporting a decrease.

To access the short-term effect of the project upon participants brisk walking the same approach was used to calculate the amount and magnitude to change over the first four months of the project. Over half of the final participants, 42 out of 78 reported no minutes of brisk walking at baseline and no minutes of brisk walking at month 4. Most participants reported a decrease in walking between baseline and month 4.

Case Record 8.11

Summary

- The projects were successful in recruiting older female and physically active participants.
- The success of the projects at recruiting a high number of older active participants is impressive. Keeping this group active would be a valuable contribution to public health.
- During the first year following their participation in the health walks few participants increased their levels of physical activity. No effects were observed in brisk walking behaviour, with either project.
- The apparently weak effect observed with this select group of volunteers may lie in the already high level of physical activity of the recruits.

- The high levels of baseline physical activity left most of the participant's with the opportunity to decrease rather increase their levels of physical activity.
- The small numbers of participants recruited at the start of the projects and during the first year left the evaluation team unable to access the observed impacts of both projects upon their participants' physical activity behaviour with any statistical confidence.

Case Record 8.12

Results: Question 2: Why did participants take part in the projects?

Identifying the motives of adults to take up and remain health walkers offers the WHI an insight into how to recruit and sustain participants. Barlett and colleagues (1996) identified over a dozen motives for participating in health walks. Four motives were identified as most important by at least 50 % of participants in this evaluation. These motives were:

1. Maintaining your fitness level
2. A chance to be in the countryside
3. The accessibility of the walks
4. The attractiveness of the scenery

All projects adopted a different evaluation method to answer this question:

Table 8.2 Characteristics of the evaluation method used by the WHI demonstration projects for question 2:

	Leicester	**Eastbourne**	**Walsall**
Evaluation method	3 focus groups (single sex only)	3 focus groups 5 interviews	1 Facilitated Evaluation Workshop
Sample	Elderly South Asian Adults	Health Walk leaders Frequent health walkers, In frequent health walkers	Health Walk leaders & Health walkers

All three projects found a common list of reasons for why people participated in their health walks projects. These reasons fall into four themes. First were themes related to the social aspects of participating, especially having fun and safety. Second were themes related to the health benefits of walking, especially becoming fitter, remaining healthy and helping with existing health concerns. Third were themes to do with wanting to be outside. Fourth were themes related to the characteristics and personal qualities of the walk leaders.

The social aspects of the health walks were cited as a powerful reason to start and to remain part of the project. Participants described two motives related to this social theme of the walks. First were themes related to having fun, enjoyment and making friends. The walks were described as a social activity rather than an activity related to becoming healthy. The walks provided a forum for people to interact and come together. The social themes of the walks appeared to be more often reported by female rather than male participants.

Second of the social themes was safety to walk. The walks provided a group organised activity which some participants felt, gave them a greater sense of safety rather than walking by themselves. All three projects had participants who were single and wanted to do an activity with other people that would welcome them as an individual. The organisation of the walks into regular weekly schedules helped to encourage some participants to go for their health walk even if they did not particularly want to do it. Taking part seeing everybody and talking and laughing with others were described as characteristics of the health walks that participants recognised as helping them to forget any worries or stresses, with the company of others.

All participants reported their participation in the health walks was related to improving or maintaining an aspect of their physical health. The most frequent aspect reported was the feeling that the walks would help participants to become or remain fitter. Many gave accounts of the walks as playing a part in improving their physical health, particular their heart health. Some specified that their walking would help with a particular chronic medical condition e.g. coronary heart disease, hypertension, diabetes, and arthritis. All participants expected their health to improve as a consequence of taking part in the projects, although men appeared to report more health reasons than females.

The *third group of themes for participating in the health walks projects related to wanting to* be 'outside'. Men more frequently reported this than women.

Finally another common theme for participating in the projects, particularly by more regular participants was the friendly nature and good humour of the walk leaders. This reason would

be more relevant for encouraging people to return regularly to the projects rather than starting out. Clearly the walk leaders appear to play an important part in the encouraging and maintaining of participants across all projects.

The reasons why participants took part in all three WHI demonstration projects were very similar. Four key themes for these reasons were social, health, being outside and the quality of the walk leaders. These themes are similar to previous work in this area. Different evaluation methods did not discover any new findings in this area.

Case Record 8.13

How were communities involved in the development of projects?

The construction or process of developing a walking project had not been subject to any evaluation before the demonstration projects. Previous walking project evaluations examined the impacts or outcomes of the projects upon its participants (Ashley *et al* 1999; Barlett *et al* 1996). Understanding the range and contributions of organisations used across different project development stages would allow future WHI projects to quickly identify common and useful community groups from statutory and voluntary sectors.

Methods and results for this question are presented for Eastbourne and Walsall only. The aim of this evaluation for both projects was to describe the involvement of community groups in the development and implementation of their particular project. A community group was defined as any organisation or group that had offered to contribute or had contributed in some way to the project at any time during the project lifespan. Both coordinators produced detailed reports in August 2002.

Project coordinators systematically identified and recorded information about the different organisations involved in their development of their project, using, their own, experiences, experiences of project workers and project records. The BHF HPRG produced a series of nine questions, after piloting with project coordinators in order to present the same information for each organisation. The questions were:

1. What was the name of community group?
2. What was the function and aims of group?

3. How was the group recruited to the project?
4. When was the group recruited to the project?
5. What did the project expect to receive from the involvement with this group?
6. What did the community group deliver to the project?
7. What was the impact of this contribution?
8. What type of involvement is recommended for the reminder of the project?
9. What are the project coordinators positive and/ or negative perceptions of the group's involvement in the walking project?

Further thematic analysis of these reports was undertaken by the BHF HPRG to identify what were the processes of development for a project, what types of community groups were used, and their function and contribution at different development stages of a walking project.

All projects identified two key types of community groups that were used at three different stages of the development of projects. These types were statutory organisations e.g. health authorities, and voluntary community groups e.g. Age Concern. These community groups were involved across all stages of project development process with the first two stages being:

1. Project development
2. Project implementation

A third stage was identified and described as ' project support'. Although not a clear stage in its own right, project support drew the help of a range of different community groups who offered a number of activities that crossed project development and implementation.

The project coordinators and the thematic analysis identified a number of steps at each stage of the project. These steps are presented in an order, mirroring, the development and implementation of the demonstration projects. Each step is described briefly including a description of the perceived importance of this step to the project, community organisation and any examples of good practice.

Case Record 8.14

Project Development

1. *Create a development plan, with action steps and audit the projects progress*

One lead community group undertook the role to initialise the development of a walking project. This was either a health authority's health promotion department or local council or both. The development plan and rationale for the project mirrored existing policy drivers and also local strategies for health and social development, e.g. Health Improvement Plans, Health Action Zones, Primary Care Groups, Local Authority Development Plans and joint investment programmes. The project identified its target group. Local transport or community walking groups were recruited to conduct a local audit of the current opportunities and facilities for walking.

2. *Identify different sources of funding*

Identifying different sources and types of funding from local community groups was also an early activity for projects. It was felt that projects should take into consideration what are the local needs but to have an emphasis on sustainability. This means the ability for a project to continue after the initial funding period had ended. Looking for funding included searching at local and national level. Examples of such groups included local transport departments in local authorities, local social regeneration grants from local authority urban renewal programmes i.e. Single Regeneration Budget (SRB), or disease related health project programmes for health authorities.

3. *Identify key deliverers and key supporters*

Local community groups who provide walking were identified during the creation of the development plan. It was recommended that key individuals who were apart of these organisations that could contribute to or support the project should be identified and contacted. Examples of community groups included local Ramblers groups, local parks and recreation departments based in local authorities or local residents groups.

4. *Looking into local strategies and priorities*

An examination of existing strategies and priorities gave each project a route into working within existing strategic frameworks. This process allowed projects and perspective partners

a strategic basis for taking actions and can justify investment plus it identified who the relevant local partners were. The projects held meetings or local conferences, which aimed to put health on the local agenda of non-health organisations, particularly local voluntary community groups who were serving particular population groups like the Volunteers Bureau, Age Concern or Cardiac Rehabilitation groups. Close ties with these groups offered a route to recruit project volunteers and participants.

5. *Identifying Partners (Steering Group)*

The previous step allowed the projects to identify local interested parties who could help deliver the project. Inclusion of these partners, at an early stage can possibly shape the success of the scheme. This may have helped to stop co-ordinators or the project team feeling isolated, especially during the development stage. Working with these community groups lead to support for other project initiatives, for example the Eastbourne Arts development officer helped the local co-ordinator with sculptures and other activities. Another identified advantage of partners was their ability to offer a project a different perspective and ideas on the project. One challenge of working with community groups at this stage was the difficulty in recruiting representatives from the local community.

6. *Defining the project aims and objectives.*

Being clear on the projects aims and objectives allowed the project to know what it is trying to achieve and how it will tell if it has or has not achieved it. This keeps it focused on the actions and avoids 'mission creep' (military term where the objectives of a mission are changed by events or circumstances and the original objective is not achieved). A clear definition of aims and objectives allowed the project to match its work programmes with possible funding opportunities. However, all projects stressed that local coordinators needed to be prepared and allow to adjust aims and objectives when appropriate. One challenge for the project was getting support for agreed aims and objectives with different community groups each with competing interests and target groups. This tension with competing interests of community groups led coordinators to observe that there was a risk on one hand that the project aim became too broad to appeal to different partners or on the other hand too narrow to not engage with a range of partners.

7. Establishing a project structure and an action plan.

This helps the project to achieve its aims. The project needs to define how it will achieve its aims and who is responsible for what, Project Coordinators observed that they were unable to tackle the problem of community groups who promised something to the project but failed to deliver. This was especially difficult with volunteer groups but also happened with statutory departments also.

8. Securing funding for the project

Each project needed funding to start. Initial monies were used to attract other funders. A number of different community groups were commonly found to provide small amounts of money or time for project related activity e.g. volunteer walk leaders. Projects reported one way to attract funders was to present how the project could contribute to funding body's aims and objectives. This was particularly important for local or health authority departments. Funding support-included options other than direct monies, for example a contribution of specified professional time to the project, a computer or administration support.

9. Appointing a project coordinator

The appointment of a project coordinator allowed the projects to have a focal point of contact, responsibility, development and review. The timing of the appointment of the coordinator was felt to be most productive when the project had clear framework and implementation plans. The coordinator acted as a 'progress chaser' in the development stage, essentially when trying to encourage other community groups to the project. The location of the coordinator was felt to be important as he / she could act as a point of access of key supporting organisations e.g. local council or health team. This also allows the coordinator to feel part of a whole and not isolated. Walsall managed their project coordinators function with a steering group and this allowed the project to be established within the work of its partner organisations and community groups.

10. Working with the community

Each project felt it needed to engage with the local community, especially with groups who were apart of the target group. It was vital to find out what level of importance the project

has with the local community. The community examined the projects aims and potential contribution to them but this process took time. The project also recognised it needed to recruit local walk leaders from the community it planned to serve.

Case Record 8.15

Project Implementation

A number of key steps were identified for community groups during project implementation.

1. *Identify realistic progress with working with community groups.*

The project coordinators felt that there was a danger of overestimating what could be achieved on the ground with working with community groups, versus what had been envisaged during the planning process. Community groups were observed to work at a slower pace, with less formality and obvious structure than working with 'professional' community groups like local authorities. Project coordinators and others learned to be more realistic about the progress of the project. Working with community groups brought in a set of new local conditions and dynamics, difficult to anticipate at the project planning stage.

2. *Implementing community development*

This step had two steps. Step one was to nurture a relation with community groups, particular voluntary groups. Step two was to recruit community volunteers often from these groups. Both steps allowed projects to access potential walkers or walk leaders and to expose the project to the local community. Project co-ordinators observed that participation in the project brought not only the project direct benefits but also benefits to the community groups and their members, e.g. creating new skills in the community, building self esteem, etc.

3. *Project marketing and publicity*

This step is as important as it allows the project to share individuals and group success stories in order to attract more participants. Both projects relied on the local media to highlight the project for example to share information on how new participants can access walking locally. It raised the projects profile with local agencies and possible participants organisations like GP practices. It attracted good publicity for partner organisations. It attracted other possible walk leaders. Examples of local marketing and publicity using local community group's included:

- Contacting all local voluntary organisations via mail shot.
- Using Tourist Information Centres and other public areas to distribute written material.
- Speaking to local key groups e.g. walking groups.
- Holding public meetings.
- Using local media, e.g. local press, free press.
- Involving a Higher Education College in producing a video to market walks in local areas, e.g. post offices, GP practices, shopping centres.
- Participating in local events, e.g. open days in local parks, 'come and try it' events.

Case Record 8.16

Project Support

A number of key issues or steps were identified for community groups in offering project support.

1. *Developing partnerships with community groups*

Developing partnerships with community groups related to three common areas in all demonstration projects, their steering group, their management and operations group and their use of 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 coordinator and broadened the input into the project. It ensured a consistent message across agencies and allowed opportunities for joined up thinking across different community groups; particularly statutory bodies e.g. health authorities and local authority environmental departments. Projects also observed their experiences of developing partnerships with community groups 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 from different community groups with operational roles into project steering group to ensure commitment to action.
- Keeping a shared agenda for the majority and not allowing one group to dominate the project.

- Trying to help the partners to be frank and honest about why they are part of the project, what they expect to get and what they can contribute.

2. *Funding and resources from community groups.*

Funding and resources supported a project in a number of ways at different project stages. For example resources in kind meant the chance for free training. Such examples will provide opportunities to develop local ownership and strengthen partnerships with community groups especially in the early stage of a working relationship. The project coordinators identified a number of good examples of good practice of funding and resources, which included:

- Financial support can pull in other partners (even reluctant and not so obvious ones, Single Regeneration Budget).
- Make joint funding application 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.

3. *Training*

Training played a key role in the support of all the demonstration projects. Training was felt to be critical in four project areas, coordinator training, walk leaders training, partners and community (briefings). Training became a currency to be spent in developing good relationships with community groups, particular volunteer groups. The timing of training, especially walk leader training needed 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 from local community groups, 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 running 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.

4. *Working with volunteers from community groups.*

The challenge of working with volunteers from community groups was reported by all projects. Working with volunteers was found to be tricky, e.g. volunteers were difficult to retain as they were not paid and there is a large amount of administration. Projects identified a number of examples of good practice for working with volunteers from community groups, 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 projects e.g. Sweatshirts, T- shirts.

Case Record 8.17

Summary

- Each project was built on a foundation of key community groups especially statuary agencies in the early development or initiation phase of the project.
- Accessing and using local voluntary community groups became more important as the project started to offer led walks. These groups offered the projects a means to recruit new walk leaders and walkers.
- As the projects established a walking programme new community groups were sought to widen the opportunities for walking and recruit new participants or offer another dimension to the project, e.g. art projects.
- Working with volunteer organisations was critical to the success of sustaining the project. Project coordinators needed support and training on how to work with these groups and their volunteers would be essential in the future.

Case Record 8.18

Additional Evaluation questions from Eastbourne;

1. What type of health walker did the project recruit?
2. What were the patterns and numbers of new recruits in the first two years of running health walks?

3. How frequently did participants walk at a health walk?
4. Did the projects recruit participants from local deprived areas?

The overall efficacy of the projects could not be assessed by the evaluation design (no control group) and was also hindered by the small numbers recruited by projects during their first year of operation. By focusing on the project's recruitment of its target group and retention of participants in the project a sense of potential exposure of the project to its target group could be evaluated. In addition the purpose of these additional evaluation questions was to identify a number of new evaluation approaches and methods for evaluating other aspects of WHI projects. This work could be applied to the development of any future WHI projects in order to offer a range and methods of different types of evaluation, particularly simple audit and process evaluations.

Case Record 8.19

1. What type of Health walker did the project recruit?

Understanding what types of people participated in a local walking programme in its first years of operation allows the projects to evaluate if it recruiting it's target group e.g. local residents. 286 health walkers attended at least one health walk since the start of the project (October 1999) till July 2001. Over 60 % of the walkers came from Eastbourne or the surrounding area. Just under a quarter were participants who attended a health walk as part of a training event. A handful of professionals or visitors attended the walks. A basis audit of different types of health walkers could easily be included as part of project record. Pre determined categories could be used on the administration form to further reduce any work in coding responses. Knowing what kinds of people are attending a project would allow a quick audit of the extent of participation of local residents compared to other groups in a project. Further analysis of which parts of the local areas walkers are from would also allow projects to identify local geographical areas with different levels of project participation. This allowed better targeting of local development, publicity and promotion of walks to reach low participating areas.

Case Record 8.20

2. What were the patterns and numbers of new recruits in the first two years of running health walks?

The patterns and numbers of new recruits to a walking project have not been previously examined. Observing recruitment rates across different seasons or times of the year may help projects plan for any highs or lows. Only one study in the UK has examined this relationship and saw a slight effect of the seasons upon self reported participation of sports and recreation activities including walking (Uitenbroek & McQueen 1992). It was important to focus upon the target group of the project (local adults) not just all attendees.

The pattern of recruitment did not appear consistent across the time period. Indeed the numbers of new recruits declined in the summer and early winter of 2000, between the 2nd quarter of 2000 and the 1st quarter of 2001. However, this pattern was affected by using an analysis of the sum of all walkers per three calendar months. A more variable pattern of recruitment could be seen across this period with a monthly mean of approximately 8 new recruits per month this dropped at the start of the summer of 2000 and remained low until the start of 2001.

The patterns of new recruits were affected by a number of factors. Explanations for these patterns by the project coordinator were that the effect of the weather did not play much effect on recruitment. Indeed very few walks were cancelled because of the weather. There did appear to be a drop in recruitment in the summer period between July to September. From October 1999 and May 2002 the health walks remained located in one place. It appears the introduction of new walks, in a new location to the walking programme in May 2001 made an immediate impact on the numbers of new recruits. From this data it appears that the patterns of recruitment did not appear to fluctuate due to the weather. There may be a dip in recruitment in the summer period. However, the numbers are not large enough for sophisticated analysis.

Case Record 8.21

3. How frequently did participants walk at a health walk?

- Over 75% of participants attended less than 6 walks in the first twelve months of the project in Eastbourne.

- The proportions of local health walkers who walked one or two times are much greater than the proportion that walked three or more (52% & 26% v 7% to 4 %) (n= 131: October 1999 to June 2001).
- The total frequency of attendance between October 1999 and June 2001 for all local residences showed that over 80% of participants attending less than 6 times, however some attendees had only recently started health walks so had less chance (fewer walks since their start date) to participate.
- The growth of the number of walkers in the 1 to 6 months (74 resident walkers) and 7 to 12 month (11 resident walkers) ranges also points to an influx of some new walkers, due to walks in different areas. This group had not had the chance to attend as many health walks and so are grouped in the lowest attending ranges for that time. It appeared that most walkers had tired health walks on a few occasions and had not continued.
- From Eastbourne's data it appears that most health walkers appear to try health walks on one or two occasions. This appears a consistent finding with previous research, (Thames Valley Health walks Ashley et al, 1999) into frequency of participation.
- Identifying new ways to encourage and maintain new health walkers beyond attending one or two walks could improve frequency of participation.

Case Record 8.22

4. Did the projects recruit participants from local deprived areas?

- The national health, transport and social policies have called for new public health physical activity programmes (Parliamentary Office of Science and Technology 2001). The emphasis has been on offering walking programmes to socially deprived communities. This has been re-emphasised in the Countryside Agency funding Application to the New Opportunities Fund (NOF) in 2000. Little is known in the UK about the relationships between deprivation and walking. Evaluating the participation has proved problematic.

- Deprived communities used geographical information Systems (GIS) as an evaluation tool to measure the uptake of walking programmes. This system brings together different types of data via the postcode or home address.
- 17% of project participants resided in deprived neighbourhoods compared to 83% from more affluent neighbourhoods.
- The walk leaders reported that this method overcame challenges of literacy and language that might be expected in a written method of accessing deprivation. The walk leaders also felt it was a more appropriate method of collecting sensitive personal information.
- The Eastbourne project recruited a small proportion of its participants from deprived neighbourhoods. Until further analysis of other projects participation data it is impossible to access if this is a realistic figure for future projects.

Case Record 8.23

Summary

'The demonstration projects did not appear to increase walking in their target groups during the follow up period. The projects recruited active older people and offering them the opportunity to take part in walks and lead others to try walking. Keeping people active, especially at an older age was a valuable contribution to preventing heart disease.' (Foster 2001)

'People reported that they took part in the walks mostly for social rather than health reasons. The organisations of lead walks was especially popular for older single adults and were seen as becoming a pleasurable, safe and fun part of everyday life.'

'The three demonstration projects all successfully developed, supported and sustained an innovative public health physical activity intervention in challenging circumstances with the help of enthusiastic and well trained coordinators and volunteers. Although the projects themselves were very different in character each brought together a common mix of statutory and voluntary community groups at similar stages of the construction and operation.'

Case Record 8.24

The evaluations have focused mostly on the impacts of the projects upon its participants. The additional evaluations shifted onto strengths and weakness of the project development and operation. Further process evaluation of the projects was conducted in July 1999 (Foster 2000). Eight Key areas were identified:

1. Improving communication with future projects
2. Capacity building for the Walking the Way to Health Initiative (WHI)
3. Developing wider links with other partners
4. Strengthening the WHI evaluation and research base
5. Strengthening the development of project coordinators
6. Developing a successful relationship with the local and national partners
7. Working with the local community.

Case Record 8.25

Recommendations for the BHF

- To develop and maintain the BHF's strong links with the new WHI management steering group to ensure the aims of the BHF are translated into the activity of the WHI.
- To develop the BHF's role as a key partner in the publicity and support of extended WHI scheme by using the BHF's national local networks of shops and volunteers and in house expertise.
- To develop the BHF national presence as the body of authority for walking and physical activity promotion in relation to the prevention and treatment of CHD by marketing and publicising the WHI project locally and nationally.
- To support further research into the efficacy of the WHI.
- To support further development and adaptation of the PAFITT Questionnaire (evaluation tool) for population groups who do not speak or read English as their first language.

Case Record 8.26

Recommendations for the Countryside Agency

- To research, develop and evaluate the impact of different publicity and marketing of led and independent health walks to specific population target groups, stratified by age, gender, social class and physical activity status.
- To research, develop and evaluate different behavioural and cognitive interventions, appropriate for the context and culture of health walks, to keep new health walkers participating in the project more than one or two times.
- To reinforce to projects and their volunteers the importance of the social e.g. enjoyment, post walk cup of tea, and meeting new people and the 'being outside; benefits of health walks.
- To develop training to support project coordinators in working more productively with volunteer organisations.
- To develop training, guidance documents or materials for project coordinators to emphasise the importance of developing a range of different walks in a number of different local areas.
- To monitor new walking projects participation numbers across seasons and the types of health walkers that they are recruiting.
- To develop new evaluation methods that uses current in house Countryside Agency expertise like Geographical Mapping System (GMS).
- To benchmark the WHI's current progress and systems against previous evaluation recommendations in order to identify any strengths and weaknesses for the future.
- To produce materials and training to help project coordinators and workers to conduct audits of different types of health walkers, e.g. pre determined categories could be used on the administration form.

Case Record 8.27

Recommendations for future WHI projects

- To ensure any outstanding recommendations from the process evaluation report for future WHI projects have been considered, approved or rejected (Foster, 2000).

- Recognise that walking may not be the most important part of a healthy life especially to deprived communities where the physical environment may be a barrier to walking. Project Coordinators need to build their project 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 priorities should be emphasised. Sustainable changes will take time.
- To be realistic in the expected uptake and numbers of new participants in the led health walks programme.

Case Record 8.28

The function of demonstration projects was to try and create something new while identifying and ideally minimising any risks along the way. These projects share common problems of recruitment, marketing publicity and retention of new walkers. These problems warrant further investigation so the next phase of the WHI which can benefit from the learning and the wisdom of these three demonstration projects.

8.3.2 Toolkit to promote Walking for Health Guidelines for practitioners in the field

The toolkit has been designed and tested via research and development in forgoing chapters. It has been specifically written to bring together the research and progressive practices of promoting Walking for Health to South Asian communities but can be used for any population and was one of the original aims and outcomes of the funders.

Background

This toolkit has been specifically written for any practitioner who would like to promote walking for health, it can be adapted to other physical activity interventions in any community. It has firm guidance on what works and what does not. Written from a practitioner perspective, it's an opportunity to share progressive practice. It centres on what needs to be done differently in order to engage communities effectively in walking for health principles. It takes it back down to the basics so whoever has an interest in the promotion of walking within their local community can be inclusive of communities or indeed Ethnic Minority communities. It is a toolkit that is motivation orientated, which is the most difficult part of any walking for health initiative; to keep the walkers, walk leaders, walking activators, project coordinators, planners, funders etc motivated and flexible.

Why a toolkit?

Most initiatives and projects in the voluntary sector need to be evidence base in order to attracted more resources; this could be money, but more importantly things done in kind by professionals from varying backgrounds. Simple evidence that a scheme works and has produced results no matter how small is enough foundation upon which community leaders and end users can build upon and are satisfied to make the change and to sustain it.

Who for?

This tool kit has been written for practical use and is quite detailed, it can be used by anyone at any point during the intervention as it is based upon the action research model: look,

think, and act. It is the looking, which the questions are based upon, and are part and parcel of the process of action planning. The toolkit eases the challenge of delivering a walking for health initiative to any community by making it community centred. A practitioner in any setting whether that be primary care, voluntary, educational, leisure or even private can use it.

How?

The toolkit is divided into five stages, it follows a linear order, however if a project is at a different stage, they can be ran parallel to one another, and the reflective cycle of look, think and act is run with every step, allowing maximum opportunity of bettering practices;

Stage One: Pre intervention

Stage Two: Intervention development

Stage Three: Intervention delivery

Stage Four: Intervention sustainability

Stage Five: Intervention evaluation, feedback and resource implication

Each stage consists of a number of steps, within each step a look, think and act cycle is presented. Within the look component the practitioner is given a series of questions to answer, the think component asks the practitioner to analyse these answers and base on the outcomes to take action. The action component gives outlines of the types of methods that could be used and examples of good practice. Each step ends with some recommended dos and don'ts. Before each stage is completed an audit of the stage is conducted via asking a series of yes or no questions, if no has been answered to any of the questions then the section needs to be completed.

Stage One: Pre Intervention

It is important to gather as much information as possible about the particular community that the intervention is being promoted to. Often statistics are outdated but are a good starting point; this needs to be refined with specific data. With most Ethnic Minority communities there are smaller sub groups that maybe attached to a community centre or a place of worship that has a 'leader'. Most of the questions below can be asked in general to community members or leaders and can be followed up with focus groups to verify data.

STEP 1.0: Pre intervention audit

STEP 1.1: Baseline Information on local population

STEP 1.2: Local community barriers to walking

STEP 1.3: Local walking levels and community views on walking for health

STEP 1.4: Current & perceived levels of walking or physical activity

STEP 1.5: How to promote walking/physical activity to South Asians communities

STEP 1.6: Identification of good practices in physical activity and health interventions for Ethnic Minority communities.

STEP 1.7: Intervention partnership and identification of resources

STEP 1.8: Community consultation

STEP 1.9: Intervention management, evaluation and planning.

STEP 1.0: Pre Intervention Audit

This step allows the practitioner to consider whether they have the necessary framework in place to develop the intervention and summarises the forgoing steps. Also it takes the practitioner though any pre history of the intervention commencing; there may have been an initial intervention that was the precursor or foundation to the current intervention. Initial lessons learnt are key in moulding actions for future initiatives.

Answer yes or no:

1. Is walking or physical activity on the agenda of local community groups?
2. Is there an awareness of the importance of walking for health and physical activity?
3. Have the local community groups the capacity to deliver the intervention?
4. Has there been any preparatory work for 'preparation of change' for community groups and / or professionals?
5. Is a solid partnership in place between the voluntary and statuary agencies involved in the intervention?
6. Are there any similar interventions in the locality?
7. Are their identified barriers to walking in the locality?
8. Are there any other regeneration initiatives in the locality?
9. Is there a management /steering group for the intervention?
10. Has an evaluation model been selected?
11. Have intervention personnel been recruited?

12. Has an intervention plan been drawn?
13. Is there a development phase of the intervention?
14. Is there a feedback mechanism to stakeholders and communities?

STEP 1.1: Baseline Information on local population

Gathering of baseline information such as audits, need assessments and demographics allows a comparison to be made pre and post intervention and assists in the planning stages.

LOOK:

Background to local population

1. What is the Ethnic Minority make up of the community? E.g. Indian, Pakistani, or Bengali?
2. Have they migrated into this country?
3. Have they faced racial discrimination?
4. What is their socio-economic status?
5. What are their cultural norms?
6. What is the state of their health?
7. Is there evidence that their genetics' thus Biology may be the cause of their ill health?
8. Do they have access to good quality health service?
9. Is there artefact data that should be taken into consideration?

Demographics

10. What are the demographics of the locality? Has this been mapped?
11. What is the make up of physical environment of the locality? E.g. educational establishments, the riverside, events and festivals, the number of doctor's surgeries, facilities, businesses e.t.c
12. What facilities are available in the locality to meet cultural and religious beliefs?
13. Is a need assessment required?
14. Are there history reports of the locality, which outlines migration patterns into the locality? Are there factors, which may account for attitudes and resentment from residents?
15. Does a geographical boundary need to be set? Does it encompass the targeted population?

16. Are there any previous consultation reports on the locality? E.g. the Health Authority, or the local authority may have indicators of inequalities and deprivation.
17. Are ward profiles available from the local authority?
18. How many community/Ethnic Minority groups and organisations, can potentially be targeted to deliver the intervention? If there are many, are there links already in place that can be utilise? If there are not do you need to re-access the geographical boundary?
19. What other initiatives are running in the locality? Can they be linked into the intervention? Is there a history of involvement in physical activity interventions?

Community Ethos

20. Is the community culturally dynamic? E.g. active in running annual festivals, celebrating their own identity and sharing this knowledge with other communities.
21. Are the communities influenced internally or externally or both?
22. What is the lifestyle of the South Asian/Ethnic Minority community?
23. Can the intervention cater for individual community needs?
24. Is there a council of inter- faith understanding that can be consulted with?

THINK:

Analyse the answers to the look questions; there may be reports on the local area that already have been written. Professionals and key people in the locality may also be able to answer these questions. There are different sources of information that will provide much of the baseline and behavioural attitudes. To understand what perspective the locally community are coming from sub-questions may be asked from theses broader ones. Be prepared to receive answers with an open mind, local communities may not buy into western concepts, but there should be enough flexibility within the intervention to incorporate eastern philosophies and their lifestyles, start at a level which is acceptable by all, build in attitude change which can work both ways for the practitioner and the local community.

Baseline data can identify current interventions that are examples of good practices, sharing these practices can give confidence to community groups to set up their own walking or physical activity intervention.

ACTION:

Map out the locality; this can be done physically or by gathering any previous reports written on the locality such as Single Regeneration Budget reports, census data, and previous consultations done in the area. Think wider than health; there could be transport plans, environmental strategies available from the local authority that would encompass local views and attitudes.

Consider using the KAB (knowledge, attitude, behaviour) model or education model. These are three steps for prompting behaviour change; gaining knowledge about the behaviour, developing a positive attitude about the behaviour and gaining the skills to incorporated the positive behaviour into lifestyles.

Example:

Information sessions can be ran in a community setting, either on the positive health aspect of physical activity or the fear angle of inactivity, suggestions can be made at these sessions to take on walking as a physical activity, views and attitudes can thus be collected in the process of raising awareness.

Do's

- Do consider the use of Shuttle Walks Tests; these could be used as baseline measurement and continued throughout the intervention.

Don'ts

- Don't be put off if not many community groups show an interest, initially work with community members that are keen do set a good progressive example, thus other community groups are more likely to follow.

STEP 1.2: Local community barriers to walking

The identification of local community barriers to walking gives the planning stage impetus to resolving issues and a strategy can thus be formed.

LOOK:

1. What are the physical, practical barriers to walking? E.g. family, time, pollution, not an appropriate environment, feeling isolated, and safety. How can these be resolved?

2. What are the barriers associated with attitudes and beliefs? E.g. perceived barriers such as lack of motivation, changing life stages, beliefs around old age or the lack of importance?
3. Is there a combination of barriers? Are there particular patterns for each community?
4. Are there community specific barriers, such as Muslim women wanting separated female sessions due to religious observations?
5. What are the current and perceived levels of walking?
6. Of those in the local community that have migrated, do they feel that they had more of an active lifestyle back home? Were there more opportunities to walk?

THINK:

The audience may need to be segmented in accordance to the data gathered; messages and interventions need to be tailored to cultural, linguistic and environmental factors. There maybe a need to focus around smaller incremental activity to provide longer-term adherence to the walk programmes (i.e. different grades of walks. Obvious barriers such as the lack of separate sex sessions, the dress code, the lack of cultural environment & facilities, cost of sessions, lack of Ethnic Minority personnel that can speak the relevant languages and racism need to be addressed. Leisure and community centres could address these problems via link workers from the Ethnic Minority community. Ethnic Minority women may feel that there is a non- acceptance of them undertaking physical activity due to the extended family and the need for the Ethnic Minority men to be re-educated in the importance of the women undertaking physical activity.

ACTION:

Once barriers to walking have been identified for the local community, consider innovative ways to address them. This should include working in coalition with all service providers and partners but also the individuals. A way in which to perceived barriers can be resolved is to consider using the behaviour change model (Owen & Lee 1984); in which individuals go through five stages in becoming physically active;

1. Awareness of the problem and a need to change
2. Motivation to make a change
3. Skill development to prepare for change

4. Initial adoption of the new activity or behaviour
5. Maintenance of the new activity and integration into their lifestyle.

Assess at which stage the potential participants; groups and organisations at can be targeted.

Examples;

Changing beliefs: Building beliefs about personal control is difficult; having others in a similar situation can ease this process, running a walk for cardiac rehabilitation or diabetic's participants is an example of this.

Stage of Change Walking groups just for South Asian women at the same stages of change, helps to maintain level of walking and integrate into lifestyle especially if they live in close proximity, a natural support network is formed. A programme that is tailored to a gradual progression to the individual's fitness goal increases the likelihood that participants would persevere and achieve long-term maintenance.

Addressing safety and time barriers: safety and time were the two main factors, which stopped the South Asians of Belgrave in Leicester from walking. Walking in a group reassured participants and made them feel safer and led walks allowed them to discover non-polluted scenic routes on their doorstep. Time, was dependent on lifestyle and this would have to be a behavioural change, taking time out for yourself is an investment in health this message was reinforced to potential participants.

Flexible walking opportunities; From feedback from pilot projects showed that opportunities of walking would be taken up if walks were flexible and if participants did not have to attend every week. The length of walks 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.

STEP 1.3: Local walking levels and community views on walking for health

Having awareness of what the attitudes and views of the local community on walking provides a starting point and to access at what level to pitch the intervention at.

LOOK:

1. Is walking for health a suitable option for the local community?
2. Does walking for health appeal to the local community? Is there an age or gender difference?
3. What percentage of the community participates in brisk walking? Do they meet the national guidelines?
4. Are there any cultural or religious reasons why the community may not participate in a health walk?
5. Are there any perceived constraints to Walking for Health?
6. Can walking for health be fitted into their lifestyle? Is walking a daily habit?
7. Do they feel that there are enough opportunities to walk, compared to 'back home'?
8. Do they find it an easy task?
9. How can the benefits of walking be highlighted to the local community?
10. What are the views on countryside walking and charity walks?
11. Is walking untaken by South Asians from a variety of economic backgrounds, family situations?
12. Does walking form apart of their culture? E.g. Meditation walking
13. Are there any other focuses, which would get the local community to walk? E.g being outdoors, and connecting to mother earth.

THINK:

Analyse whether the individual walking activity comes under the four headings of (Manson *et al* 1999):

1. Work related walking
2. Necessity walking
3. Health walking
4. Pleasure walking

Assess what the enablers and motivation factors are and whether they can be the focus of health walking.

ACTION:

There is strong link between success and enjoyment, making the intervention 'fun' is more likely to increase and sustain participation. The integration of social activities within the intervention makes it more attractive to participants.

Examples:

Making Walks Sociable: the Chalo Chalay ladies health walk group, once a month held a picnic by the river or park where women could bring a dish, it gave them the opportunity to socialise and exchange healthy recipes.

Disguising walking for health and making it enjoyable: During the pilot projects walking was suggested to users, 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. The walk was not a health walk, however, the activities co-ordinator stipulated that users did not go outside at all or walked, so just by walking around shops and browsing increased their activity levels. The users enjoyed themselves and this is what really shaped the future Chalo Chalay health walks, as enjoyment was central to the whole process.

STEP 1.4: Current & perceived levels of walking/ physical activity

This step accesses the baseline walking patterns of groups and individuals and thus pre and post intervention comparisons can be made. No presumptions are made on levels, if community do incidental walking, then building upon these levels are targeted, if not a suitable promotional strategy is implemented.

LOOK:

1. Has the community moved from an active lifestyle to a sedentary one? i.e. had more opportunities back home?
2. Does the community feel that physical activity is a western concept?
3. Do parents/ adults in the community feel they are doing enough physical activity?
4. Does gender & class divide the uptake of physical activity?
5. What are the uptake of physical activity of South Asian/Ethnic Minority women and their sub groups (e.g. Indian Pakistani, Bengali)?

6. What are the sources of belief? i.e. role models, family friends, older religious leaders or fatalism?

THINK:

Consider interpersonal dynamics such as working with pre existing groups that is luncheon clubs, social groups at neighbourhood centres, voluntary groups, family or peer groups. New groups can be created from existing ones; those that have an interest in walking for health can promote it to their peers. It is important to consider group dynamics as many of the Ethnic Minority communities hold gender sessions separately, these can become an important social support in implementing and maintaining behaviour change. However, married individuals may want to walk outside these groups and is a natural progression into integration of walking into lifestyles.

ACTION:

Consider using the stages of change model (Prochaska & DiClemenete 1992, 1985), five stages of behaviour change that all people go through; pre-contemplation, contemplation, preparation, action and maintenance. As with the previous step, assess where potential participants are at, and use a targeted media campaign that could get individuals thinking about walking.

Example:

Behaviour change: the Chalo Chalay pilot did a short stint of 3 walks, once a week for users of a South Asian voluntary mental health project, prior to the intervention user of the group used the transport provided to get to the centre which was a 10- 15 minute walk, after the intervention, some of the mobile users walked.

STEP 1.5: How to promote Walking/Physical Activity

This step outlines how specific promotional campaigns can be targeted to local communities.

LOOK:

1. Is there scope for active and long-term promotion?
2. Can community specific promotional vehicle be used? (i.e. word of mouth, local community newsletters, local community radio, news boards in of places of worship?
3. Can tailored social promotional events be used?
4. Is there a network of Ethnic Minority media where advertisements can be placed?

5. Can images of local and ordinary community members be used in publicity, such as women dressed in traditional clothes?
6. Is there an awareness of the benefits of walking/ physical activity? If so what precise messages can be sent out via community specific promotional vehicles?
7. Can Ethnic Minority men be re-educated of the benefits of their female households being involved in walking / physical activity?
8. Is there scope for the promotion of community specific physical activities, such as cultural dancing being integrated into health walks?
9. Do the local community know of any current physical activity schemes such as the exercise on prescription? Do they attend these, if not why?
10. Can the local community be divided into sub communities? Can messages be tailored to each of these groups for example by language, gender, and ethnic/cultural background?
11. Are messages and strategies designed to be relevant for and appropriate to cultural, linguistic and environmental factors?
12. Are there community base interventions in the locality where there has been a creation of a community coalition or a collaborative effort? Can this good practice be temped into?
13. Can the intervention be specifically tailored to meet the needs of the local community?

THINK:

Analyse the above answers and thus plan the intervention as suggested by stage model of health promotion which is analyse, plan, implement and evaluate and thus re- plan.

ACTION:

Draw up an initial action plan with key individuals from the local communities consult with partners. This should be an ongoing process as learning occurs and new ways of working are discovered. Is there any further information required? What else is needed?

To analyse answers from the above questions consider whether there is a need to change in risk behaviour or environment. Thus outcomes can be categorised into behavioural or environmental changes or both.

Example:

Using cultural norms: Walking is an integral part of daily life; Hindu's believe that a pilgrim by foot would add to their spiritual growth. Thus a walk was arranged to visit the local temples in Leicester, this related to the normal practices 'back home' but also provide the opportunity to promote the message of walking for health.

STEP 1.6: Identification of good practices in physical activity and health interventions for Ethnic Minority communities.

Before planning the intervention, look at other examples of good practice, these may address similar issues and could be transferred. When analysing other interventions some of the following questions should be asked:

LOOK:

1. What are the goals and objectives of the intervention? Is the design and strategy culturally appropriate?
2. Does the intervention allow maximum flexibility and creativity in the design?
3. Is the intervention driven by a community focus?
4. Does the intervention take into account the role that culture plays in influencing attitudes, beliefs and behaviour related to health promotion and disease prevention?
5. Does the intervention demonstrate the wiliness of communities to find meaning for change within their own culture and their own environment?
6. Is there a dynamic relationship that has caused change? Has it been empowering for the local community and has it been sustained?
7. Are there any interventions nationally that could be visited and good practice transferred?

THINK:

Are there good practices out there that can be adapted to the local community, using guidelines that exist such as the walk leaders training that can be adapted to meet the needs of a specific community.

ACTION:

When assessing other interventions identify if it follows a framework such as the supportive environment action model (SESAME) *(Sanderson et al., 1996).* Does the intervention:

1. Identify needs and problems
2. Builds alliances
3. Set targets, develop strategies, plans, evaluates
4. Design implementation
5. Create supportive environments
6. Create maintenance structures
7. Monitors & evaluates
8. Renew, reinforce, reorient.

Example:

' On the Move' California (Tanjarsiri 1999) tailored an implementation programme, where partners of the project who had specific knowledge and experience with working with specific communities, were recruited from the local community it served. The ways in which these approaches were designed and implemented depended on the unique characteristics of the target populations. 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). Intervention approaches made use of lay leader training, individual communication strategies, mass media involvement and changes to the broader community. Practically this meant involving elders of the community to understand the most culturally relevant and applicable way of incorporating walking or physical activity into local communities which led onto the identification of traditional activities (Pargee *et al.,* 1999).

Do

- Do use examples of interventions that may not necessarily be for Ethnic Minority communities but could be adapted.
- Do meet with similar projects and interventions, the target community may be different, but the core motions maybe similar, it can provide an informal support mechanism.

- Do try out new ideas with the local community, it may be surprising what they do take on board and are quite flexible this should always be a two way process.

STEP 1.7: Intervention partnership and identification of resources

The step allows the practitioner to think about partnerships wider than its funders, and immediate project partners. Building a coalition with all stakeholders increases the likelihood of sustainability.

LOOK:

1. Is there an involvement of a broad selection of people within the local community that are working towards a common goal?
2. Does the coordinator have the skills to build a consensus among diverse communities? Can a facilitator from the local community provide this function in terms of group discussions and action?
3. Does the partnership have the capacity to influence at a micro (face to face) to a macro level (cultural beliefs and values that effect different systems)?
4. Can the intervention partnership expand to be inclusive of other areas such as transport and environmental groups and local authority departments?
5. Is the intervention partnership strengthening links on an ongoing basis? How is it doing this?
6. Are other networks in the field informed so that there is no duplication of work? Are these networks complementary to the intervention?
7. Is there any innovative ways of building partnerships with other organisations that have never been tried before?
8. Can the partnership identify funding and resources? Can partnership bids be written? Are there any innovative pots of money that can be applied for?
9. Where is the project best place to enhance its partnerships? E.g. In a voluntary group, within the local community setting or a statuary organisation where resources and expertise may readily be available?

THINK:

Community partnership is a key component in the planning and delivery of the intervention, it can bring together different sectors that will sustain the intervention and ensure that the

cultural and socio-economic barriers are taken down. Involving other areas such as transport, education and health, gets it onto other agendas, whereby increasing chances of sustainability and other possible routes of funding.

ACTION:

Consider the use of Spectrum of Prevention (Swift 1987), an approach that targets multiple levels of health and incorporates community power structures and long-term capacity building within the local community:

1. Changing individual knowledge and skills.
2. Educating communities.
3. Educating providers.
4. Building coalitions.
5. Changing organisational practices.
6. Influencing policy and legislation.

Examples:

'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).

Innovative partnerships: A 'On the Move!' walking club, 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 its low socio-economic area (Williams II *et al* 1999).

The Creation of the Walking for Health Bid: The South Asian walk for life bid was a unique partnership in that it had representation from various sectors, but central was a Black voluntary project working with the Leicestershire Health Authority. The voluntary sector coming together with mainstream providers provided an opportunity for services to become mainstreamed.

STEP 1.8: Community Consultation

Accessing community opinion before intervention delivery will increase participation and ownership. This step outlines the ongoing consultation of a wide range of stakeholders.

LOOK:

1. Who are the stakeholders of the intervention?
2. Are there databases that specify Ethnic Minority voluntary groups within the locality? E.g. local authority, internal mail out list, or an overall community voluntary sector list. Can a cross section of these group be consulted?
3. Will the consultation focus on project workers, users or both?
4. Do the local neighbourhood centres know of any local community and voluntary groups?
5. Can the intervention partnership provide any links into the community?
6. Are there inroads to places of worship such as the local Mosque's, Gurudwar's, Madhir's?
7. Is there a particular superstore, grocer's, doctor's surgery or post office that can be targeted?
8. Are there any major events in the calendar year that can be targeted for a consultation or publicity? E.g. Mela's, carnivals, health fairs, recitals.
9. Are there any smaller local events that could be targeted?
10. Can information be distributed through Ethnic Minority media to raise awareness of the intervention?
11. Does the community or voluntary group have the capacity to implement the intervention?

THINK:

It may feel quite daunting to build up trust of the community, where to begin? There are often key people in groups and communities that can provide doors. Often places of worship have groups attached to them, just by visiting and talking issues through or celebrating good practices can build trust. If language is a barrier use an internal interpreter from within the community setting so that a friendly face can ease any tension. Aim to get a representative sample of the local community this may depend on the size of the locality.

Involve key community members from the outset; these can be identified through networks and partnerships. A cross section of groups should be consulted that is; community centres, women's centres, luncheon clubs, places of worship and mental health projects.

ACTION:

Data can be collected via focus groups, questionnaires and one to one interviews. It is key to use facilitators that come from the same ethnic background and that can speak the same language as the respondent. Feed information collected back into the community groups and provide regular updates. From these initial groups community members may facilitate to help gather information. Questionnaires are a good way of building up a general picture; these can be translated into applicable Ethnic Minority languages, but more effective is translation on the spot by a translator or volunteer who records the data in English.

Examples:

Talks and tasters at community and voluntary groups: Groups welcomed educational activities; the Chalo Chalay coordinator ran short talks and taster sessions on the benefits of walking. Short focus groups were integrated without participants feeling that they were targeted. It was a mutual two way process and raised awareness of the intervention.

Duel purpose consultations: The Chalo Chalay 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 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.

Do's

- Do consult in smaller community groups who are familiar with one another, you are more likely to get participation from all members.
- Do consult with project workers (managers or activity coordinators) but be prepared to face a difference of options from users of the services.
- Do take on board enthusiasm of workers and users but be realistic and what can be offered and sustained.

- Do provide support to activity coordinators who are often under pressure to include physical activity on their agenda but do not have the resources and information on hand or the expertise to carry out these activities.
- Do maintain cultural ethnics when consulting with the elderly (from what to wear to how you speak). Gender & age can be an in issue, but if you come across like a daughter or son then mutual respect will be gained. Do not go in with a dictator's attitude.
- Do take identification with you and be clear of which organisation you are representing. Groups may note that you maybe from an organisation that could provide funding and could be mislead.

Don'ts

- Don't overload groups with initiatives; try to work in partnership with other organisations that maybe delivering the same agenda.
- Don't make promises at this stage that cannot be met, but provide ongoing honest feedback.
- Don't represent the community; even if you are from the locality, you cannot represent the vast views, even if there is an expectation that you know it all.

STEP 1.9: Intervention management, evaluation and planning.

Intervention management, evaluation and planning can cause constraints if not considered carefully, this step takes the practitioner through the process of identifying the best practice for the local intervention.

LOOK:

Management

1. Are all stakeholders clear of the management structure? Are all partners clear on how their own agenda' s are being met? Are there any hidden agenda's that can be openly met?
2. What management structures are in place for paid workers, if there are any? Are these flexible to allow community members to have a say? Are these structures clear to all and realistically workable?

3. Does a steering group need to be formed to manage the intervention? Or are there other ways?
4. Who will sit on the steering group?
5. Will the steering group be lead by community members or partners of the project? Is it realistic to bring these two parties around the same table?
6. Would it be beneficial to have a wide range of members around the table or to have smaller working subgroups?
7. What would be the terms and reference of the steering group? Are there clear tasks delegated? Are they able to assist in the planning stage and gathering of baseline data?

Evaluation

8. Is there a need for an evaluation? Does an evaluation sub group need to be set? Is there enough resource to do this?
9. Can the role of evaluation be effective combined into other roles such as the project coordinator, walk leader? If so, is there clarity of how much time is allocated to each role?
10. Is the concept of Walking Activator (who leads and promotes the walk) realistic? Do other professionals need to be recruited (e.g. YMCA qualified instructors) until volunteer walking activators are in place? What is the recruitment criterion?

Planning

11. Who will be involved in the intervention planning? Will results be integrated into theses plans? Are there gaps?
12. How can the local community get involved in the planning? How will it increase community ownership?
13. Will a timeline / development plan be drawn with key leads? Is this realistic? Will the plan go out to consultation to key stakeholders including the local community?
14. What are the components of the plan? E.g. Collection of baseline information/ audit; raising awareness, publicity/ media, development of the health walks, and training of walking activators: evaluation and monitoring, pilot walks etc.
15. What are the development priorities for the intervention? E.g. training, awareness raising, recruitment of community groups, media and marketing, pilots of walk routes etc.

THINK:

A good evaluation can secure additional or further funding; it needs to be carefully thought through prior to the intervention commencing. It would be an advantage to have an active evaluation group that can feedback instantly on findings. The evaluation can become complicated, but simple questions are often the best ones and are good indicators of measuring progress.

ACTION:

A practical way forward would be to starting an initiative and then rolling it on after learning from the previous outcome. Evaluation questions that could be asked of a walking intervention could include:

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?

During the planning phase of the intervention consider using a community driven approach which involves the community all though the project via the 5 C's;

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? 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.

Example;

The Chalo Chalay project plan: was split into three strands which corresponded to each year of the project, the first being the community centred walking routes: the second the CHD rehabilitation integration with a current initiative and the third environment development.

Do's

- Do talk to partners and be open with agenda's, allow open and honest discussions.
- Do be aware of political games being played by senior management.
- Do voice concerns at the earliest convenience.
- Do get internal and external support if evaluation is going to be carried out in-house, have clear guidelines to present data to management of how this will look and be delivered.
- Do revisit plans and operational strategies; keep in line with what is possible.

Don'ts

- Don't take on board unrealistic tasks, try and delegate.
- Don't always be convince of the easy route, where a project is housed will make or break it, challenge but have clear arguments.
- Don't underestimate how much time evaluation can take, if taking on a model weigh up pros and cons in terms of 'real' resources available.

Stage two: Intervention Development

At this stage of the intervention the initial concept has been researched and phases of the intervention need to be developed via piloting and then modification. There are several strands to development, which run parallel to one another such as development of evaluation tools, walking activators training, publicity and setting up the operation group. This stage cannot be by passed it is time consuming so allow realistic timeframes.

STEP 2.0: Audit of Intervention Development

STEP 2.1: Preparing to Change

STEP 2.2: Pilot Projects

STEP 2.3: Development of Walking for Health Groups

STEP 2.4: Training for Volunteer Walking Activators

STEP 2.5: Effective promotion of Walking for Health & Publicity

STEP: 2.6: SWOC (Strength Weaknesses, opportunities and constraints) of the Intervention

STEP 2.7: Development of the Environment and Facilities

STEP 2.0: Audit of Intervention Development

Answering yes or no to the following question enables the practitioner to access what element of the intervention it needs to develop and what the priorities are for the local community.

Answer yes or no

1. Has the intervention acted as a catalyst to promote a positive health promotion message?
2. Does the intervention have a vision?
3. Does the intervention have community involvement?
4. Has the intervention developed its walk routes?
5. Has the intervention developed or adapted a training programme for its walking activators?
6. Has the intervention developed a publicity and launch campaign?
7. Has the intervention developed its community and/or professional networks?
8. Has the intervention developed an evaluation model?
9. Has the intervention developed and strengthen it's partnership?
10. Is the background knowledge's and community politics known?
11. Has protocols and procedures been tested and piloted?
12. Has a progressive practice been set?

STEP 2.1: Preparing to Change

This step identifies if any pre intervention foundation work has been done and if the community are already to embrace change. It also accesses whether coalitions are in place to support these changes.

LOOK:

1. Has any previous physical activity / walking interventions been delivered to the local community?
2. Is there an awareness and enthusiasm that can be built upon?
3. Are collaborative partnerships in place to successfully deliver the intervention and to thus support it?
4. Is there enough capacity to deliver the intervention?

THINK:

An important aspect for the intervention to be successful is the capacity to deliver it. Having all key local community members on board is crucial.

ACTION:

Consider using the following *process of change model* used by the Chalo Chalay pre foundation project.

1. Work closely with X number of Ethnic Minority community groups offering advice and information on physical activity and how groups should develop schemes for their users.
2. Work closely with workers and volunteers at voluntary sector projects providing training and advise on appropriate initiatives.
3. Conduct brief consultations to give an indication if walking for health is an acceptable form of physical activity to the local community or Ethnic Minority community group.
4. Develop a strategy for the promotion of walking/ physical activity amongst local communities, in consultation with the voluntary and statutory sector.
5. Raise an awareness of the importance of walking/physical activity, and what constitutes moderate activity and what facilities, if any, are currently available.
6. Provide information to individuals on any training opportunities for on going professional development e.g. A tailored YMCA Exercise to Music course for South Asian women.
7. Provide information to keep individuals and groups informed of current research, current developments and success stories to maintain enthusiasm.
8. Explored examples of good practice from projects in other areas and transfer these as progressive practices within a local setting.
9. Generate appropriate local exercise alliances, which can assist in developing walking /physical activity in local or Ethnic Minority communities.

Example:

Setting the scene; In preparing for walk leaders the pre foundation project had identified a lack of South Asian exercise to music/ fitness instructors it embarked on addressing this problem with project partners ad relevant bodies to construct a tailored training programme. A

database was created and these instructors went on to do the walk leaders training programme.

STEP 2.2: Pilot Projects

Innovative ideas should be piloted to see what works with specific communities. Each local community may react differently to the same set of circumstances. The key is to be flexible and to adapt and implement changes instantly. Testing and piloting can take up much of the development phase and resources and finances should be allocated accordingly.

LOOK:

Pilot Aims & objectives

1. Are there specific aims set for the pilot project such as testing a tailored made doorstep walk?
2. Are there set objectives for the pilot such as the development of urban, riverside and park walk routes, identification of volunteers and their training needs, to set a protocol and procedure for a tailored health walk?

Community pilots

3. Can the intervention be piloted, within a community group that would welcome an innovative way of working and would have the time to answer research questions?
4. Is there a good working relationship or a history of working between the intervention workers, can the community workers be non-bias and critical of the pilot project?
5. What is the background to the community group where the intervention will be piloted?
6. Who is the key link person (e.g. Activities Coordinator)? Do they have knowledge of key attitudes of the participants in the pilot?
7. How will the community group be rewarded for their time?

Pre pilot

8. What are the pre intervention views on walking for health? Can focus groups be used as a tool to gather information?
9. What is the proposed action from these focus groups? Are there any initial things that are highlighted that are culturally appropriate to the group?
10. What were the deterrents to walking? What would encourage them to walk more?

11. Is the protocol flexible enough to integrate evaluation tools? Is it appropriate to use PAR –Questionnaires? Can these be translated? Are they necessary?
12. Is there enough capacity and skills to get feedback from the participants after the pilot walks?

Pilot delivery

13. Are activity coordinators or link persons required to stay with their users? Are there any special conditions that the walker leader needs to be aware of?
14. Are there translators readily available, if there are going to be guided interest walks such as riverside walks by the Riverside Officer?
15. Is there a balance between a walk being an interest walk and a health walk?
16. Are there suffice helpers and volunteers to run the pilots?

Post Pilot

17. What are the outcomes of the pilot? E.g. development of routes: procedure and protocol for running a health walk; checklist for running a health walk: the recruitment of exercise leaders and volunteers; role of a walking activator.
18. Do other pilot projects need to be run? If so, who else to target?

THINK:

It is important to discover what motivates individuals and what incentives the community group has in becoming involved in a pilot project. To attract the local community, things that interest them may be incorporated into the walk this can initially be the carrot then once hooked can introduce the brisk walking element.

ACTION:

Run pilots from groups that has the capacity to do so. Clarify protocols & outcomes with all participants. Ensure all paperwork and guidelines and are in place.

Example:

Chalo Chalay Pilots: involved the development of the health walk protocol, there were some apprehension about South Asian women stretching and cooling down in potentially public places, but until you try you don't know, the ladies were comfortable with the concept due to being in a group they felt confident. The pilots ran well due to clear aims and objectives,

four doorstep walks, in different environments were developed the success criteria was measured by the level of trust between the key link workers and the walking activators.

Do's

For the pilots

- Do carry out pre and post focus groups, often a change in attitude it noted.
- Do run 2nd and even 3rd pilots to confirm protocols and procedures.
- Do use the pilot projects as good examples to attract other community groups to have a go.

For the development of health walks

- Do accept that western concepts may not be taken on board; ladies may prefer to where sandals with their traditional dress such as Sarees or Punjabi suits, instigate safety but that which is comfortable and with time natural behaviours will take precedence.
- Do introduce an element of the walk at a time, e.g. warming up and cooling down can be taught over a number of weeks instead of all in one go.
- Do experiment with length of walks; start with short distances and gradual increase them.
- Do reinforce why certain things are done e.g. the benefits of stretching and brisk walking.
- Do experiment of using professionals like riverside rangers to facilitate walks, walkers may use some of their English language skills, and gives them the confidence to do so, it's a two way process; it gives the opportunity for professional's to work with 'excluded communities'.
- Do expect that promptness may not be adhered too allow 15 minutes either side to start and finish times.

Don'ts

- Don't be put off by any negative comments, any new activity for participants can bring doubts and breaking a routine is hard. Empathise and be patient, respect the participant's wishes if they do not want to walk.

- Don't rely on activity coordinators or a link person to lead walks; they may have other duties to attend to.
- Don't expect miracles from the first walk, it will take time for the walkers and walk leaders to become familiar with the concept and the environment.

STEP 2.3: Development of Walking for Health Groups

This step identifies with the elements needed to develop walking for health groups for the local community, and in particular outlines debates on group dynamics.

LOOK:

Health Walk Components

1. Do factors such as temperature, weather, the distance; the length and time affect the number of walkers?
2. Are walkers aware that walking can be undertaken by anyone but if they have a specific condition they should consult their doctor first?
3. Are there route maps that can be developed? Can these routes be transferred to audiotapes?
4. In terms of the walk routes: Are there any languages barriers on route such as reading signs?
5. Are there enough rest points and toilets on route?
6. Is local knowledge being utilise to plan walking routes?
7. Are there enough pedestrian and 'nice' places to walk in the locality?
8. Can walks be integrated into incidental activity such as going to a place of worship?

Walking Activators/ Leaders

1. Is there a resistance of walkers progressing to become walk leaders? Are there any other options? i.e. other ways of helping facilitate the intervention.
2. Do natural leaders emerge in the group?
3. Are their special qualities that the walking activators have that can be incorporated in the walks, such as Tai Chi or Yoga?
4. Do leaders need practical things such as mobile phones water bottles, first aid kits?
5. Can walking activators be trained on route?
6. Are the walking activators training being targeted effectively?

Group Dynamics

1. What makes the group gel?
2. Are tailored walking groups designed for men and women?
3. Is the walking groups best place within community groups? Can they become independent and thus more sustainable?
4. Can special needs walks be run? Are there groups, which can be targeted?
5. Is a hands *off* approach better for selected groups than a walk leaders approach?
6. Is the local community confident of being involved with walking for health groups?

Motivation

1. Can motivation tools such as step counters or shuttle walks tests be used? Are they motivational incentives?
2. Do interest walks motivate the group? Could they be incentives?
3. Are marketing gadgets such as free t-shirts, umbrellas or trainers effective?
4. Could integrating educational activities into the walks be an incentive? E.g. riverside guided walks, a ranger pointing out plants and points of interest.
5. How do you engage de-motivated groups such as 60+ South Asian women?
6. Would charity walks motivate the group?
7. Can culturally orientated elements be used in walks to motivated participants such as religious pilgrims by foot? Can interest walks be organise to visit all the places of worship in the locality?
8. Do peers and other walkers motivate participants and potential walkers? Are they potential role models?
9. Has a relationship been built between the practitioner and the community?
10. Is there fair and unbiased feedback on the walks and how the overall intervention is progressing?

THINK:

Protocols set from the pilots can guide walks but it is important to assess what works and what does not. Walking activators are best placed to judge this, encourage them to use techniques that would retain walkers but also recruit new participants. Understanding the group dynamics helps to maintain a balance of power. It is vital to have separate sessions for men and women.

ACTION:

A way, in which behaviour is influenced, is by the social learning theory, which helps develop motivation and skills to change via observation of role models in targeted publicity, or by trained peer educators. Develop a plan to increase the number of peer role models via tailored training and ongoing support, allow community members to shadow intervention deliverers but also if possible shadow community members thus a two way learning process occurs.

Examples;

Adapting the walking activator/ leader role: the Chalo Chalay men's group were resistant to becoming leaders but were quite happy to take on a shared responsibility, this model worked well for this particular group.

Formation of independent groups: the Chalo Chalay women's group became independent from the community centre it was running from, there had been some conflict of interest between both parties which thus pushed them to become independent this gave strength to the group and hence is an example of community ownership.

Special needs walks: a walk was organised for the partially sighted and blind group, the leaders had to give clear directions and trust was imperative, a lot more volunteers were needed to facilitate the walk.

Motivation: places of interest on the doorstep increased motivation, it was found that walkers living in the locality over the past 20 to 30 years had not realised some of the places on their doorsteps that were a five minute walk away.

Peer Role Models: enthusiastic South Asian women were sponsored to train as Exercise to Music Instructors using Bollywood Music and their own language skills thus delivering sessions back into their local communities.

Do's

- Do allow food/ and picnics on the walks, these are sociable events that act as incentives- try to promote health eating!

- Do expect teething problems at the start of newly formed walking groups, such as late starts and walk leaders turning up late reinforce messages and always set an example.
- Do keep re-launching the group and keep publicity ongoing to remind people that the walks are still happening.
- Do try and by pass the bureaucracies of filling out too much paper work especially when working with local authority funded projects who seem to have more than their fair share, try and integrate these procedures.
- Do be prepared to work with all sorts of characters in the community and public sector and remember you are a 'public servant'. Some public workers are really set in their ways do not waste time trying to change their practices, create your own its easier!
- Do try indoor walking during period of bad weather incorporate other forms of physical activity such as cultural dancing, yoga and make it fun!
- Do plan around the summer season there might be a drop off in walkers due to summer festivities and the wedding season, try and incorporate these activities into the walks.

Don'ts

- Don't target training just to community workers they may not have the time to deliver walking groups, however can act as middle markers.

STEP 2.4: Training for Volunteer Walking Activators

This step takes into account how culturally appropriate current training packages are for the South Asian community and how they can be adapted to suit particular needs. It also considers the formal concept of volunteering within the local community.

LOOK

Training

1. Can the training be held in any of the South Asian languages? Or can a translator facilitate the process?

2. Are culturally sensitive issues addressed, such as single sex issues, footwear, clothing, wearing sunscreen and desecration of the warm up and cool down exercise? These may be an alien concept for local communities.
3. Is the warming up and cooling down exercises appropriate? Can cultural dancing be incorporated?
4. What components of the course are priorities for the participants? E.g. safety, CPR, leading etc.
5. Can the course be adapted to meeting the needs of the local community? Are there elements that need to be added in? E.g. how to motivate the local South Asian community?
6. Does necessary paperwork need to be translated?
7. Is there clarity on whose responsibility insurance is?
8. Can the publicity for the training day be targeted? E.g. the use of local South Asian radio?
9. Would one day of training be sufficed or do other days need to be arranged to concentrate on various aspects?
10. Can individual potential walk leaders be supported on a one to one?
11. Can experienced walking activators, on the intervention be used as potential facilitators of training days?

Other Courses

12. Can YMCA qualified instructors be used initially to run the walks?
13. Can a module of walking for health be incorporate into a tailored YMCA exercise to music courses? (Tailored courses for South Asian women using Bollywood music, addressing barriers such as language and dress).
14. Are their other initiatives that are recruiting the same target audience? Can these databases be shared? Are there other trainings that participants can attend to increase their knowledge base in health promotion? E.g. Coronary Heart Disease Prevention programmes?
15. Can these courses be run in partnership with local Health Promotion Departments or Primary Care Trusts? Can volunteers be sponsored and in return they deliver sessions back into their communities?

Volunteering

16. Does the 'formal' concept of volunteering exist in the local community? Or is it seen as a natural part of being a community member? Is further investigation or research needed?
17. Will the notion of being a Walking Activator be accepted, or are there any other innovative ways that the concept can be promoted?
18. Can walking activators be paid for their time?
19. Is there a support network for walking activators?
20. Is there a rapport (*verwar*) with the walking activators and the community?

THINK:

The way in which volunteers are recruited would be need to thought through carefully, as volunteering may not exist in the local community but the notion of 'seva' or service may. A promotional campaign could be targeted with its focus on this aspect of service back into their own communities. A way in which 'volunteers' can be recruited onto the intervention is via 'verwar' or building a rapport with the local community. This is about having an understanding of the cultural etiquette of the local community. Also take into consideration the time and the cost of translating material, it may be more effective using a translation unit, but cost could be a major issue, budget well in advance for these ongoing costs.

ACTION:

An English speaking facilitator may conduct the training sessions, and translators used in conjunction, however allow more time in-between components for translation to occur and questions to be asked.

Examples:

Innovative recruitment: it may be difficult to recruit walking activators in the initial stages of the intervention. A prior initiative trained South Asian women as Exercise to Music instructors, these were further trained to run walks, and were an asset as they could speak the relevant languages.

Peer pressure: helped recruit local community members to participate in a tailored and specific community orientated walk leader training, walking activators used their skills to influence fellow peers in the local community.

Volunteering/Sewa: serving in the temple informally is a part and parcel of the South Asian culture. During the Gujarat Earthquake disaster an appeal was made by one of the temples and it held a charity walk, which was routed, around the several temples in Leicester. This encompassed people volunteering in *sewa* and was influenced by the temple and the good cause; it got the community working and walking together.

Do's

- Do offer volunteer walking activators the option of progressing with qualifications; this is a good incentive to retain their commitment.
- Do hold the training programme locally and use routes that they potentially could be leading on.
- Do provide culturally appropriate lunch, as food is apart of the social norm- healthy options can be requested, do ensure vegetarian options and halal meat.
- Do review the training day programme with facilitator ensure its appropriateness.
- Do translate material into the appropriate languages.
- Do evaluate the training day, include pre and post views of the knowledge of walking for health.
- Do provide ongoing support to walking activators, they may want to continue shadowing current walks before endeavouring to lead walks independently.

Don'ts

- Don't rely on exercise to music instructors to lead walks; they may not have the time.

STEP 2.5: Effective promotion of walking for health & publicity

This step is the most important; it considers how the local community can be convinced of taking up walking for health and raises the awareness of the intervention via innovative ways of marketing.

LOOK:

1. Are there innovative ways to way marking routes? E.g. using seasonal walk directional flags to mark festivals such as Eid, Diwali, and Christmas- these could be designed by local school children.
2. Are there any 'real ideas from real people'? E.g. getting more South Asians to use the riverside by holding a Diwa –candle walk to celebrate Diwali
3. Has the intervention an authentic name? Do choose a name that is universal and can be understood by all, Hindi is widely understood by all South Asian communities
4. Has the intervention got its own logo? The local community can get involved in designing it; this will increase ownership and raise the profile.
5. Does the intervention have the appropriate promotional tools that can be translated? Leaflets may not be the first option, consider the use of audiotapes and videotapes and the use of the World Wide Web.
6. Can a newsletter be produced in the various languages?
7. Are there festivals, events or charity walks held annually that could be targeted? E.g. holding stalls at these events would the raise profile of the intervention and could also potentially recruit volunteers.
8. Can more local events be targeted that are run from community groups such as health fairs, fundraisers?
9. Can religious festivals be targeted? These can often encapsulate all of the community. Those that did not use local groups, or are not captured in the normal routes of a media campaign would be via religious events.
10. Are there any partners that could run join publicity campaigns? This demonstrates partnership to the wider community and keeps costs low.
11. Is word of mouth utilised? How is this being monitored? How can it be promoted?
12. Would the intervention benefit from a local community launch? Could it attract media coverage from local newspapers, radio stations, television.
13. Are there local community newsletters or guides that can be targeted? E.g. local authority guides to events in the locality, specific community group newsletters.
14. Can taster walks be run for local community groups to raise the profile?
15. Can interest walks provide incentives for current walkers and publicity to others? E.g. Barge trips

16. Can a carrot and stick approach be used to promote walking? Carrots could include facilities for walking, i.e. the environment, and sticks could include parking controls, traffic calming, and pedestrianisation.
17. Can GPs and Primary Care Teams promote the intervention by identifying individuals and groups?
18. Can walks be publicised at unique local events held by the walking activators?
19. Are there particular health and social angles of the walks that can be publicised? E.g. the involvement of GP's promoting walking, giving individuals more responsibility of their own health?

THINK:

Word of month is the most powerful form of publicity; the walks can sell themselves such as 'gold sells itself'. When developing promotional events and material, priority should be given to equality, from baseline data the composition of the local community should be known. Be representative of all communities as they are all unique in their characteristics, advice should be sought from key workers in the community of what is appropriate, and what festivities can be targeted.

ACTION:

Keep publicity ongoing and build a rapport with local media networks, support walkers and walking activators to facilitate events 'to tell their success stories', share and celebrate achievements with a wide audience.

Examples:

Word of mouth and key local events: walks were publicise at the Leicester Belgrave Mela, a very specific event that runs in the locality which local people attended, Walking Activators that were previously walkers promoted the walks at this event and was an effective means of word of mouth.

Promotional material: Audiotapes that have the route explained and the benefits of walking would be a good tool to promote independent walking. Promotional videos can demonstrate how stenches can be done whereby the walker can practice at home. It may also be use for those that are illiterate, or those that have a disability.

Effective promotion of walking includes: safer routes to school and the green commuter schemes, which target particular audiences.

T*argeted Religious Festivals:* The Chalo Chalay project used Katha's (recital of Hindu' scriptures) as a means of promoting the project. The recitalist endorsed the intervention and the key message of Walking for Health.

Community Launch: The Chalo Chalay used a floating candle walk to launch its project; candles were placed into the riverside and were followed down by participants. A local priest came to bless and officially launch the project; it was linked into the festival of *Janmashtami* Krishna's Birthday. This attracted the local community as it represented similar rituals that happen at the River Ganges in India. The launch had a real cultural flavour, with the use of bright colours and was a photo opportunity.

Do's

- Do get walkers, walking activators involved when publicising to the local community, hearing it from the 'horses mouth' is a powerful tool.
- Do make all campaigns and community launches equitable, if targeting religious festivals, make sure they are inclusive of all communities or there are plans to do specific launches for each of the communities in the locality.
- Do remember that not all can be pleased, try and working within 'equality' with the resources available.
- Do budget in for translation costs.

STEP 2.6: SWOC (Strength Weaknesses, opportunities and constraints) analysis of intervention

To reflect on the progress of the intervention a SWOC analysis may be run on a 6 -12-month basis. It maybe done from the perspective of the practitioner and/or by partners and thus outcomes can be drawn together.

LOOK

Strengths of the intervention

1. Are there committed individuals / peers / mentors?
2. Is it a positive health promotion mechanism or climate?
3. Is it a grassroots level up approach?
4. Is it an opportunity to research needs and fill gaps creatively?
5. Does it provide an environment in which individuals take responsibility of their health?
6. Does it have a one to one partnership with participants?
7. Does the intervention act like a catalyst for change?
8. Does the intervention work across the 'range' i.e. from grassroots to the stakeholders (walkers to policy makers)?
9. Does the intervention build a rapport and to help identify skills and training needs to equip the individual to provide a positive walking experience?
10. Are the walks self-sustainable?
11. Have the walks sparked off other forms of physical activity?
12. What are the social benefits of groups?
13. Has it changed the lifestyles of walkers?

Weakness of the intervention; these can be converted to opportunities

1. Is there clarity on the role of the co-ordinator and how 'best' their time is used?
2. Who are they accountable to whom and why?
3. Is there support for walkers / volunteers in the project who have to achieve short-term goals?
4. Are expectations high in the short space of time?
5. Is there clarity of the roles and responsibilities of each steering group member?
6. Is there a structure for project management?
7. Is there an appraisal system both for the co-ordinator and the volunteer walking activators?
8. Is there an understanding of the recognition of what parts of the project are important and to prioritise these?
9. Is there a delegation process of the tasks to partners who may be able to deliver to grassroots?

10. Is the project a top-heavy structure?

Constraints that can be turned into Challenges

11. Can the top heavy structure be utilised? Does it need to delegate its powers?
12. Is there accountability? To whom and why?
13. Are the expectations too high in the short term?
14. Is there a clarification of roles and responsibilities of steering group?
15. Is there a need for an appraisal system?
16. Is there recognition of what the important priorities are?
17. Are all religious groups included in the intervention?
18. Is the intervention being realistic in achievements?
19. Is there an expectation that the intervention can represent all Ethnic Minorities?

ACTION:

Take an issue at a time consider if it is at Red, Amber or Green stages, red denotes that nothing is happening or having difficulty in getting started, amber its happening but there are barriers and green that all is going well and needs to continue.

Do's

- Do be aware of: time commitment of community centres, conflicts of interest, the lack of qualified Ethnic Minority instructors, the slow recruitment and training of volunteers, maintaining working partnerships, the lack of motivation and incentives, the lack of safe and pleasant routes, the issues of footwear and lack of transport to 'nicer places', and the weather.
- Do be honest, with the community and volunteers even when politics are being played this will gain trust.

STEP 2.7: Development of the environment and facilities

This step outlines links to developing more suitable walking environments and thus increase participation this would run in par with other intervention components.

LOOK:

1. Are there any major developments in the locality that the intervention can influence by its progressive practice?
2. Are there any regeneration plans in the locality that can be linked into?

3. Is there a transport plan for the locality? Does it include walking?
4. Are the riverside and parks in the locality aware of the intervention? Are they partners?
5. Are there any consultation reports on these developments and plans, which can be used as baseline information?
6. Are there any existing key strategic frameworks that can be influenced?

THINK:

There are key elements of environment plans that can be influenced by the intervention, and feedback from local walkers on changes needs to be ongoing.

ACTION:

Linking into local plans addresses fears that walkers and residents may have such as crime, the lack of lighting, uneven pavements, and safety. It is a constructive way of getting opinions of local residents that may feel excluded from the normal routes of consultation.

Examples:

The Belgrave Riverside Park area development: One of the major aims of this development was a community focus via encouragement of participation in development of the park with events to create a sense of local ownership, the Chalo Chalay project facilitated to meet this aim and increased the awareness of South Asian walkers.

Enforced Public Opinion: The Belgrave Corridor project aimed to introduce traffic calming measures along a central shopping road in the locality, and pedestrianise the area. This fitted into the Chalo Chalay aims however it contradicted the views of the local community and there were issues around the lack of parking for residents and visitors. Thus, the project was halted and only continued with the safety measures. This is an example of how the intervention empowered a small section of the community to feedback into these major changes in their locality.

THINK:

Link into local regeneration plans, and local authority departments on transport, environment and leisure services. Feedback on public consultations and empower local communities to make a difference in their local environment.

ACTION:

Invite potential partners onto the steering group who can deliver on the environment and facilities agenda.

Do's

- Do include wider partners such as the police who are responsible of providing a safe environment for residents.
- Do be aware of any previous and current regeneration plans and their outcomes.
- Do link the intervention into wider agendas such as regeneration- work and employment for local residents as this will ensure suitability in the longer term.

Stage Three: Intervention Delivery

Once the intervention has been researched and piloted it is ready to be delivered to the wider community. The protocol and procedures are implemented and may be tailored to the need of the local community. The intervention is expanded and recruitment and retention strategies are developed. The core elements of the intervention are progressed and links are made into other similar initiatives as successes are celebrated in a wider marketing and publicity campaign.

STEP 3.0: Audit of intervention delivery

STEP 3.1: Implementation of intervention

STEP 3.2: Recruitment and retention of volunteer walking activators

STEP 3.3: Recruitment and retention of community groups

STEP 3.4: Health walks progression

STEP 3.5: Links into Exercise on Prescription Schemes

STEP 3.6: Intervention administration

STEP3.0 Audit of Intervention Delivery

This step gives the practitioner an overview of intervention delivery.

Answer yes or no to the following questions;

LOOK:

1. Are operational plans in place? Do they have realistic timelines?
2. Is the steering group effective? Does it have the power to influence?

3. Is there an effective management structure?
4. Is there an effective financial structure?
5. Is an operational group in place?
6. Are there clear lines of communication between the operational, steering and management groups?
7. Do all groups have terms of reference?
8. Do they all have clear roles and responsibilities?
9. Is there a support mechanism in place for all that are involved in the intervention?
10. Are clear routes of capacity building in place for volunteer walking activators?
11. Is there evidence of independent walking outside of the lead walks?
12. Is the intervention being represent at conferences and workshops and sharing its progressive practice?
13. Is the intervention being put on the agenda of strategic boards?
14. Is the intervention inclusive of all the community groups and faith communities?
15. Has the intervention been included in initiatives such as the exercise referral scheme and CHD prevention projects?
16. Is an incentive scheme in place to retain and recruit walking activators and walkers?
17. Is the intervention hosted outside of the local community? Does this need to be reviewed?
18. Are all partners active?
19. Are all partners working in synchronicity?
20. Are procedures in place, whereby, anyone involved with the intervention, can give constructive feedback?
21. Are there procedures that can be flag up issues and concerns?
22. Is there evidence of all procedures being set up to be self-sustainable by the local community?
23. Is a publicity and marketing strategy in place?
24. Is there community involvement at every stage of the intervention?
25. Is there an understanding of what volunteering means for each community?
26. Is there bureaucracy that can be avoided by the walking activators?
27. Is the training package for walking activators in place? Does it include amendments suggested by participants on previous trainings?

STEP 3.1: Implementation of intervention

The step guides the practitioner into implementing the community strand of the intervention and scrutinises the real involvement of the local community in the operation of the intervention.

LOOK:

1. Does the intervention timeline need to be revisited to identify realistic goals?
2. Has outreach work in the local community commenced? Are community groups aware of the walking for health protocol? Can it be adapted to meet their needs?
3. How many community and voluntary groups have been recruited? Is there a strategy to recruitment?
4. Is translated material in place to deliver promotional talks on the intervention?
5. Once groups are recruited are all parties clear on outcomes and time commitment to the intervention? Has action been delegated?
6. Can Walking Activators be used to promote the intervention in their local community?
7. Is there a safer routes to school initiative in the locality? Can this be used to raise awareness of the intervention?
8. Is an operational group in place? Does it represent a cross section of the local community? Do walking activators get involve in these?
9. Is the operational group action focused?
10. Is the intervention developed locally to increase the ownership by the local community? Does it have a continued momentum?
11. Are there flexible structures in place that the operational group can feed into management structures such as steering group?
12. Is there a conflict of interest between the operational, steering and management group? Are there ways that these can be resolved?
13. Have relationships and networks formed to bounce ideas that may work in the local community? Is there a team sprit?
14. Are project parameters such as support, implementation & development set? Can these parameters be tested via SWOC (Strength Weaknesses, opportunities and constraints) analysis?

15. What sort of support is available to the intervention? E.g. partners, the steering group, community centres & walkers, peers in the field.
16. What is the style of coordinating the intervention? Community focused or strategic? What individual inherent skills are needed to promote the intervention?
17. Are there link workers/ community champions for each community in the locality, that guidance can be received on a regular basis?
18. Are there gatekeepers for the local communities? Can they be persuaded?
19. Is there a partnership between the voluntary and statuary sector? Is it working? Is there a power of balance? Can the power of balance be shifted in favour of the local community?
20. Is there a feedback mechanism? Are successes shared?
21. Can realistic targets be set in terms of the resources immediately available?
22. Are support structures in place for the intervention workers and volunteers?
23. Are there any other projects influencing physical activity or walking in the wider area? Can links be made?

Intervention capacity

24. Is there enough resource & expertise in the voluntary group to deliver the intervention? Do they have time for training? Is it realistic, or are they simply adding to their qualifications? Are there any other practical options?
25. Can health professionals in the locality coordinate initiatives and messages so it prevents an 'overload' for community groups?
26. Was there specific training requirements such as cultural training or motivation that is needed?
27. Are there effective resources available in the various languages?

THINK:

The style of coordinating the intervention needs to be flexible, skills are needed to convince and build trust with the community but also have the flair to work strategically. Operational groups are key in delivery and thus ownership and sustainability of the intervention by the local community.

ACTION:

Community development work prior to intervention implementation is a key factor, raising awareness of what the intervention is about and the benefits eases the process of recruitment of other groups and individuals. Use successes of pilot projects to convince the participants and project workers of benefits. From the onset let the community drive the intervention, this will eventually lead to ownership, and thus sustainability. The key is to provide walking activators with training and skills to give them the confidence to run walking groups.

Examples;

Community ownership: The ladies group of the Chalo Chalay project had formed their own circle of social activities as well as walking together; they decided to call themselves the Chandni Fitness group.

Community Support: Community groups & walkers can provide constructive criticism and can help to refine routes and protocols and are key in selling the product.

Do's

- Do be aware of conflict of interest between the community groups and the intervention. Let community members decide where their priorities are and support them through the process.
- Do facilitate community involvement & ownership, foster community champion roles; this may take time, be patient but persistent.
- Do delegate tasks to walkers they may not commit to leading but will support the intervention, foster two way support.
- Do take on constructive criticisms and implement necessary changes.
- Do recruit a coordinator that has a knowledge base in the community it's serving, if this is not possible; team them up with a community champion that may act as a mentor.
- Do be prepared to work in isolation during the initial period of the intervention until partnerships and networks are fostered. Isolation may act as a catalyst to think innovatively of other sources of support within the local community.

- Do create sustainable partnerships, but be aware of the difficulties of marrying the voluntary and statutory sectors. Reassess if this is possible, if not act as a facilitator.
- Do cultivate a few committed volunteers from the community that can share responsibility.
- Do get community involvement, allow them to drive agendas forward and create new ideas.

Don'ts

- Don't rely on recruiting community groups just by letter, follow up with a phone calls and arrange to meet with workers.
- Don't rely on enthusiasm, be realistic with community partners on what can be delivered, small deliverable goals are better than no delivery.

STEP 3.2 Recruitment and retention of volunteer walking activators

Direction is given on the recruitment and retention of volunteer walking activators highlighting other ways that walkers can progress their role and redefining volunteering in terms of the local community.

LOOK:

1. Has the role of a walking activator been adapted so that it is an appropriate request for the particular local community? Is the role informal and is an extension of service they put back into their own communities?
2. Can potential walking activators shadow more experience ones?
3. Are community volunteers aware of the benefits of supporting the intervention? E.g. the health benefits or creating new skills to further own personal development.
4. Is there a cultural angle to influence volunteering onto the intervention? E.g. a service back into your community?
5. Can the local radio station be used to have an ongoing campaign to push the recruitment angle? Can competitions be used?
6. Are there any community hotspots where translated publicity can be displayed, but also signing individuals up on the spot? i.e. canvassing?
7. Are there particular motivations that can be emphasised, e.g. improving their own health?

8. Can suggestions and requests be made to walkers to push them into becoming leaders or activators?
9. Are there other skills the walkers have that they feel they are able to share with the group instead of becoming a walking activator?
10. Can the social peer group push individuals to becoming walking activators?
11. Have the walking activators the opportunity to influence the overall intervention delivery?
12. Is there an ongoing training programme?
13. Time may be an issue, how can this be address? Can potential walking activators commit time on an ad hoc basis?
14. Can walking activators be flexible in their volunteering, maybe just at weekends?
15. Does the recruitment process need to be targeted? Will individuals be interviewed informally before attending the course to ensure retention?
16. Are there structures in place to manage the walking activators? Is one needed or will a hands off approach be welcomed?
17. Is the word of mouth publicity being utilised in recruitment? Can friends, family, intervention staff influence potential walking activators?
18. Are current walking activators being used as advocates of the intervention?
19. Is it a possibility for other volunteering opportunities within the intervention such as administration or assistant walk leaders?
20. Is there a walking activators network set up?
21. Are there incentives for recruited and potential walking activators?

THINK:

If reluctance is shown to become a volunteer walking activator there is the option to pay them. Careful thought needs to be given in how this would be sustained after the funding period. There maybe innovative ways to approach the non acceptance of 'formal volunteering', research needs to be carried out with the specific local communities, to identify with the concept of helping others such as '*sewa*' and how this can be capitalised on.

ACTION:

Research the concept of volunteering in the specific communities; plan a recruitment strategy and pilot. Target publicity with messages drawn from the research.

Example

Hands off approach: the Chalo Chalay recruited and retained its two most longer serving Walking Activators from its pilot projects. It was a natural progression for the walkers who saw the value of the intervention. It was suggested that they come along to a training day that was organised with no pressure to lead walks. A trusting relationship was fostered with the intervention coordinator who slowly took a back seat in leading the group, this took over six months without the walkers knowing that they were officially leading the walks. It is this slow shadowing process that gave the walking activators the confidence to lead the groups with the obvious support of the walkers.

Dos

- Do support volunteers walking activators so they don't feel isolated.
- Do reassure them that walkers are not dependant on them and they do not have to take the responsibility.
- Do give volunteers recognition and thank them often.
- Do encourage walking activators to be the ' boss' and take ownership of the walking group.

Don'ts

- Don't overload walking activators with too much responsibility, paperwork and equipment.
- Don't make the walking activators role too prescriptive; allow room for their own innovations.

STEP 3.3: Recruitment and retention of community groups and facilities in the locality

This step assesses if the right approach has been taken to recruit and retain local community groups and that all faith communities are aware of the intervention.

LOOK:

1. Are community groups interested in the intervention?

2. Has a project leaflet been produce to explain to groups and individuals of what the intervention is about?
3. Are the benefits of undertaking the intervention clearly explained?
4. Is there a session or event available that the intervention can be promoted to the community group users?
5. Are the local facilities such as the sport centres, libraries, neighbourhood centres aware of the intervention? Are they on board?
6. Is there an ongoing nurturing process once community group are recruited onto the intervention?
7. Are all community groups and faith communities being recruited? Are there community link workers or health professional such as midwifes, dieticians or health visitors that can facilitate this process?

THINK:

Are there key community groups in the area that can be targeted and used as examples of good practice so that other community groups in the locality may want to join the intervention? Can community workers suggest any other community group that they have working relations with, can they act as a mediator. From the baseline information of the locality, plan and form a timeline to be inclusive of all faith communities.

ACTION:

Use the good practice from the pilot projects to recruit further community groups. Use the expert knowledge of the volunteer walking activators who have links into other community groups, involve them in the recruitment presentations and talks, this will have more impetus with potential walkers as they act as role models and will be able to communicate more effectively in their own language.

Example:

Recruitment at a South Asian ladies exercise group; A recruited walking activator attended an exercise class at the local Neighbourhood Centre; an introduction was made to the activities coordinator who was keen to get involved with the intervention. Subsequently the worker and a few of the volunteers at the centre trained to become walking activators.

Do's

- Do use the immediate links and networks in the area and the local knowledge of the walking activators.
- Do arrange to meet with community project managers and workers, have literature to hand to explain the intervention.
- Do invite community groups to form an operational group and if confident invite them to the steering group.
- Do provide on going support and updates to community groups of the progress and celebrate successes.
- Do coordinate with other physical activity/ health promotion initiatives in the area to visit community groups together, firming the partnership and avoiding 'overloading' the community group.

STEP 3.4: Health Walks Progression

This step considers what other walking initiatives the intervention can liase with and ensures the progression of the lead walks.

LOOK:

1. Can the intervention support and liase with other walking initiatives outside the locality such as the Ramblers? Can walkers be referred to these are they culturally appropriate?
2. Can outdoor walks continue over the winter period? Can there be an adaptation to routes that have shelter points if required?
3. Are key walking for health messages appropriate to the community identified and agreed? How will these messages be publicised?
4. Is independent walking an option? Are route maps and grades of walks devised to encourage this?
5. Are there enough lead walks in the locality that participants have the option to attend more than one walk a week?
6. Are there planed interest walks, which are linked into annual festivals? Can they introduce a friend?

THINK:

What mechanisms will ensure that walkers will progress onto other walks, will the intervention give them the confidence to join other walks or walk independently? The walking activators may naturally increase the pace of the walk so that the walkers can challenge themselves and gain maximum health benefit whilst newer walkers may be more comfortable with the back leader.

ACTION:

Ensure that all participants are aware of other local walks in the area, by perhaps giving them a timetable. Walkers, as a group with the walking activator, could join other walks run by other initiatives such as the Ramblers to sample other ways of walking, this may influence them to progress other groups.

Example:

The Chalo Chalay lead walks were initially on the doorstep, as the groups progressed they became inclusive of interest walks such as barge trips down the river, visiting country parks that required transport. This in turn motivated them to visit and walk to these places outside of the group and increased independent walking.

Dos

- Do regularly update walking activators of current walks in the locality.
- Do include a section of the training day of how leaders can progress their own walks.

STEP 3.5: Links into Exercise on Prescription Schemes

Walking for health is an option that can be included on Exercise on Prescription Schemes or Active Lifestyle Referrals; it takes away facility base exercise, which often is a barrier to communities in particular, Ethnic Minority communities. Links need to be made into schemes that are working with GP's and primary care teams.

LOOK:

1. Is there an Exercise on Prescription Scheme that can be linked into?
2. Can a walking referral scheme be set up? i.e. walking via community groups, which would modify the exercise referral schemes and would be away from leisure centre based activities.

3. Is there an infrastructure to promote the intervention to with GP's and primary care teams? E.g. via projects already working on CHD prevention?
4. Are these professionals, partners on the intervention? (Referral coordinators, instructors)
5. Can the qualified referral instructors attend the Walking for Health training?
6. Are guidelines needed, who will write these?
7. Can GP's be recruited to promote the intervention? i.e. use a 'do as I do' approach as GP's are looked upon as good exemplars.
8. Can pilots be run from GP practices in the locality?
9. Can self-help and referral mechanisms be set up? That is the high or low risk patients would be able to access the resources and materials themselves to undertake a comprehensive health walks programme.
10. Can peer educators from other health promotion initiatives or walking activator facilitate the referral process?

THINK:

Are there referral coordinators in the locality that can be temped into, can they facilitate the walks referral process? GP's and primary care teams need to be informed of the intervention via bulletins or if time permits a short presentation. Awareness should be raised at Primary Care Trusts to ensure allocation of resources.

ACTION:

All staff need to be trained in referral procedures and establishing record keeping systems using the 'stage of change' framework. Links need to be developed between walk/exercise leaders and primary care teams. Media and marketing of walking for health needs to happen at practices with the provision of information on local walks and community activity.

Example:

Partnership delivery: Strong links were formed between Chalo Chalay, Exercise on Prescription Scheme and Project Dil a CHD prevention programme for South Asian communities. Each project complemented one another to deliver the walks referral: Chalo Chalay provided the concept, the Exercise on prescription scheme provided the procedure and Project Dil provided the GP Practices.

Do's

- Do target other health professionals besides GP's; i.e. health visitors, community and rehabilitation nurses often they are more available and have more contact with the wider community to promote the intervention.

STEP 3.6: Intervention administration

This step prepares the practitioner to ensure the smooth administration of the intervention.

LOOK:

1. Is there suffice administration support? Can 'volunteers' who do not want to lead walks help with this?
2. How can finances be accessed? Is there an easy to use system in place?
3. Are partnership politics known can these be addressed?

THINK:

How much paperwork can realistically be avoided, can a coordinated approach between partners be used to minimise bureaucratic procedures? Ensure systems are easy to access and all paperwork is simplified and uses plain English, as this will make the process of translation easier.

ACTION:

Be clear from the onset how financial systems are accessed across partner organisations and if processes need to be changed these are agreed.

Example:

Behavioural Questionnaire: This questionnaire was originally four pages long; working in partnership with evaluators and translators it was simplified down to a page and produced quality data even when translated into five South Asian languages.

Do's

- Do collect relevant data.

Don'ts

- Don't overload the walking activator with paperwork it can be daunting, provide assistance when using a referral scheme.

Stage Four: Intervention Sustainability

This stage should be encompassed in all aspects of the intervention delivery, at the back of the mind the question that should continually be asked; *'Will what I'm doing be sustained and taken on board by the local community?'*

STEP 4.0: Audit of Intervention Sustainability

STEP4.1: Exit Strategy

STEP 4.2: Operational Sustainability

STEP4.3: Promote Leadership Roles

STEP 4.4: Walker Sustainability

STEP 4.0: Audit of Intervention sustainability

This step gives guidance on the strategies to sustain local community support and delivery of the intervention.

LOOK: *Answer yes or no*

1. Is an exit strategy in place? Are all partners informed?
2. Does the community own the intervention?
3. Do all relevant boards know of the intervention? E.g. physical activity task forces, Primary Care Trusts, sports, education etc.
4. Is there a sustainable partnership in place?
5. Is there a local community spirit and will power to sustain the intervention?
6. Is a local walking activators network in place?

STEP 4.1: Exit Strategy

This step outlines the components of an exit strategy whether at the end of the funding period or as an ongoing process.

LOOK:

1. Has an exit strategy been devised in consultation with the local community and partners?
2. Is the community skilled enough to sustain the intervention? If not, is any there specific capacity building that is required? Can partners deliver this?

3. Is there an overall city/county/regional strategy that would integrate the intervention and mainstream it? However, keep its local focus?
4. Is there a multi agency group such as an Exercise Alliance that can push the intervention forward?
5. Is it known to the walking activators that networks are in place that would support them? These can provide on going training, regular meetings and national updates administered by the National Walking the Way to Health initiative (BHF/ CA).
6. Are partners aware of the different working styles, can they adapt? Will this sustain an active partnership?
7. Have partners been given sufficient training and support to continue their role in the intervention? Have they got direct links into the community?
8. Has the intervention stipulated community ownership from the inception of the concept? If not, how is responsibility going to be delegated?
9. Can the intervention be used by partner organisations to secure further funding for the local community? E.g. traffic department
10. How will longer-term goals be implemented and monitored? E.g. environmental changes

THINK:

Are all those involve in the intervention aware of the exit strategy? Has it been explained why the intervention has taken this route? It is imperative that false hopes are not built and honesty and transparency in the procedure is adhered to. This will set the grounding for the local community and partners to take the intervention forward. There needs to be clarity from the beginning of the intervention that it was a catalyst for change, this can be done via carefully planning.

ACTION:

Aim for an ongoing process of an exit strategy, once the logistics of the intervention are in place, let the local community drive it forward, let them take the decisions, this frees the practitioner to move onto another locality. Let partners take responsibility of supporting the intervention and shape what realistically can be done. Always work on the principle that the

walker can do the job of the walk leaders and coordinator, this will ensure that there are working links between the local community and professionals that can support them.

Example:

New partnerships securing further funding: The traffic department at the Leicester City Council by being involved with Chalo Chalay project created new links with the Health Authority, and new contacts within the Council. They used Chalo Chalay and the working partnership with the voluntary sector to work directly with the community to bid for further monies for local transport and environmental plans. It gave them the extra brownie points to secure more money to use in the local community.

Do's

- Do form an exit strategy from the conception of the intervention.

Don'ts

- Don't rely on the same funder for further funding, look to other sources and resources in kind.

STEP 4.2: Operational Sustainability

This step highlights how community sprit can be fostered and how the intervention can be delegated to the local community.

LOOK:

1. Will recruitment onto the intervention continue by word of mouth?
2. How will the interest to join the walks be sustained?
3. Will there be a cost implication to the participant? Will walking activators charge to cover the cost of insurance? Will this affect the rate of participation?
4. How will the extra social activities be sustained? E.g. trips to county parks, barge trips. Do the walking activators have the relevant contacts? Are they attached to a community group that could book a mini bus for them?
5. Will motivation be sustained?
6. How will the walks progress?
7. Will incentives like social trips continue?
8. Will the intervention continue to give confidence to walkers to walk more independently and also after a period of illness?

THINK:

Has the intervention created community spirit and will power to continue the intervention? This is a key element of the operational sustainability, if the local community have a belief in the intervention and value it, they will continue with the behaviour change and cascade it to their social circles. The creation of a few strong role models in the immediate local community will sustain the change; it is about ensuring that there is a transfer of these skills to other peers.

ACTION:

Build a trusting relationship with key role models in the community; be open and honest at the expense of targets, outcomes and professional networks. It is not the latter that will deliver sustainability but the former.

Example:

A belief in the product: Chalo Chalay was fortunate to have two key role models/ advocates in the community; they had an inherent belief in the outcome of the intervention through personal experience. They sustained support even after all the changes of the procedures, at first they were volunteers, then they were paid volunteers and then at the end of the funding period they were volunteers again. Even through this continued roller coaster ride they maintained commitment and motivation of their peers.

Do's

- Do aim to create a belief in the intervention, even if you only have one community taking the vision forward.

Don'ts

- Don't have an expectation that the community will embrace the original intervention, it may mutate into a similar intervention that they have created and thus have ownership of.

STEP4.3: Promote Leadership Roles

This step focuses on the suitability of leadership roles such as the walking activator, peer educator, community champions and ensuring that they have or know how to access relevant tools and support.

LOOK:

1. Who will continue to be the catalyst for change?
2. Do walking activators or peer educators in the community have the tools to promote the health benefits of the walks?
3. Do they have access to these resources?
4. Will the walking activators have access to up to date health education messages?
5. Who will stipulate the safety of the walks, such as carrying mobile phones and first aid kits?
6. Will walking activators continue to be role models? How will it be possible to keep recruiting role models?
7. Who will support walking activators? Do they know where they can get help?
8. Where can walking activators access ongoing training?
9. Has the intervention coordinator supported walking activators in a way that they have the skills themselves to sustain their own support from other partners?
10. Are key incentives in place with partner organisations to pay walking activators in kind? E.g. free bus passes.
11. Do the walking activators have good links into the community? Are they involved in other community projects where they can continue to make links?
12. Have the walking activators become ambassadors of the project have they formed a network?

THINK:

Is there a strong sense of motivation? Are the intervention deliverers satisfied by the difference they are making to participants? This is a core challenge in the process of nurturing a community leadership role and can be resolved by praising individuals to increase their self-esteem.

ACTION:

Give individuals the capacity to make informed choices, ensure that they are aware of all the support that is available to them, buddy them with a intervention partners this may act as a two way mentoring process, as the partner will also increase their own links into the community.

Examples:

Peer educator programme: Chalo Chalay walking activators went on to the Project Dil (CHD prevention programme for South Asians) peer education training. This gave them skills in the wider health promotion arena and pushed them to becoming informants in their own community, thus increasing their own profile.

The Traffic Department: took the initiative from the intervention partnership to conduct a consultation, which worked both ways, in that information on walking/ patterns could be collected. However, there was a lack of staff time, which was resolved by training walk leaders/ lay community members to collect/ consult with the groups on a regular basis and tied it to providing incentives such as free bus passes.

Do's

- Do encourage walking activators or community champions to undertake other forms of training that may be outside the remit of the intervention.
- Do appraise intervention delivers.

Don'ts

- Don't push individuals that are clearly not comfortable taking a leadership role, assess other ways in which their skills can be used and thus increasing their confidence.

STEP 4.4: Walker Sustainability

This step gives guidance on how to sustain walker's participation.

LOOK:

1. Are the benefits of walking enough to sustain participation?
2. Are potential walkers aware of the benefits including the mental health and social ones?
3. Will walkers sustain group walking and independent walking?
4. Has there been a behaviour change?
5. Is there a sustained change in participant's behaviour, attitude and health?
6. Do they see the value of the intervention?

THINK:

Have precise messages of walking for health been stipulated? Are they aware of the national guidelines of 30 minutes on five or more days of the week? If walkers have a clear understanding of the benefits and have personally felt them in short period of time they will continue the intervention.

ACTION:

Run an ongoing campaign of reinforcing benefits of walking, share success stories, and get partners on board with publicising messages whether this is through the library, neighbourhood centres, local sports facilities, or parks. Ensure partners sustain on going publicity.

Example;

Behaviour Change: The Chalo Chalay ladies group were clearly passionate about the walks and committed to it, as they changed their dress behaviour to walk, from wearing a Saree to Salvar Kamis (Punjabi Suits) to trousers, from sandals to trainers and they were usually very strict about their dress code.

Do's

- Do get partners to commit to an ongoing publicity campaign.
- Do inform walkers of the walks in the locality.
- Do ensure that walkers have information and resources to perhaps set up their own walking groups and continue independent walking.

STEP 4.5: Sustainable walking groups

Pointers are outlined in this step on how to achieve sustainable walking groups.

LOOK:

1. How are the walking groups going to be sustained?
2. Is a natural support system in place with mainstream partner organisations such as, neighbourhood centres, Primary Care Trusts, health promotion departments and the various departments at the local authority?
3. Do the participants feel that they have a real ownership of the intervention?
4. Is funding required to keep groups sustained? Are walking activators aware of small grants that are available?

THINK:

Intervention success is dependant on its flexibility; and consideration is given to ethnic and cultural needs, geographic and socio economic factors. Interventions, which are culturally aware and tailored, are self-sustaining, thus if the walking groups have bilingual staff, single gender sessions, are family orientated, and have childcare provisions. Identifying natural helpers or programme champion's help to convince gatekeepers and gain community support.

ACTION:

Continue to allow for maximum flexibility and creativity in the design of various walk programmes with walkers driving its focus.

Examples:

Socially based activities: that are encompassed in health walks have shown to be more sustainable as there are other motivations to attend. Having socials allowed walkers to exchange information and share stories from a cooking tip to how to claim for a bus pass!

Do's

- Do let walkers take responsibility, from early on in the intervention, from which routes they would like to take to the timings of the walks.

Stage Five: Intervention evaluation, feedback and resource implication

Evaluation is key in securing further resources and funding, this stage details the types of evaluation that would be appropriate to use with specific communities.

STEP 5.0 Audit of intervention evaluation and feedback

STEP 5.1: What needs to be evaluated?

STEP 5.2: Refined tool selection

STEP 5.3: Development of Behavioural Questionnaires in different languages

STEP 5.4: Securing further resources

STEP 5.0 Audit of intervention evaluation and feedback

This step outline key issues when considering evaluating a community base intervention

LOOK:

1. Is an evaluation protocol in place?
2. Is data being collected and analyse on an on going basis?
3. Is there feedback procedure to all those that are involved?

Step 5.1: What needs to be evaluated?

Consider what needs to be evaluated and what can provide constructive feedback to local communities and thus what is time and resource effective.

LOOK:

1. What is the intended focus of the evaluation? E.g. is it involvement or a consultation process of the targeted community?
2. What is the timescale and urgency? E.g. the funding period or by the recruitment of the walkers
3. Is there a sense of community identity, common interest and past history?
4. Is there an existence of community and user structures; e.g. an in-depth mapping of the targeted locality?
5. Is there a level of understanding about decision-making and change?
6. What are the levels of literacy and knowledge of jargon for all that are involved?
7. Is there an awareness and sensitivity to issues such as race, gender, physical or sensory ability and age?
8. Is ethical approval required for the evaluation?
9. What are the drivers of the evaluation? E.g. requirement of the funders

THINK:

What realistically can be evaluated and will provide quality data so that shared learning can be dissipated to all intervention partners. The evaluation will provide reflective practices that should improved intervention delivery and allocate resources adequately.

ACTION:

Decide on what will be the most beneficial aspect of the intervention to evaluate, make it simple and cost effective, ensure skills and resources are in place.

Example:

Walk registers: are a simple way of collecting data, they can model future walks and provides information on the uptake of the intervention and thus whether further investigation is needed or not.

Do's

- Do evaluate what really needs investigation and not what funders may stipulate.
- Do get community involvement in the evaluation and feedback successes and failures.

Step 5.2: Refined tool selection

This steps give guidance on the types of evaluation methods used to collect data on the defined community however is solely dependent on resources and skills available.

LOOK:

1. What resources are available for conducting the evaluation?
2. Is it going to be an internal or external evaluation? Or both?
3. Can the evaluation methodology involve the local community setting the evaluation agenda? Can community members be recruited to implement this agenda?
4. Can the local community be involved in designing the evaluation protocol?

THINK:

Evaluation tools that are readily used with community groups include:

1. Participatory appraisal; involves the targeted community setting the research agenda, designing the research protocol, implementing research, analysing research findings and defining recommendations for changing practice. Recruitment occurs within the communities, of lay trusted community members.
2. Action research: Carr & Kemmis (1986) is simply a form of self reflective enquiry undertaken by participant in 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.
3. Case Records Stenhouse (1978) 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, walking activators, or project coordinator.

4. Anthropological Approach Krumeich *et al* (2001) an approach that focuses on the cultural and social context of human behaviour; described the 'thick description' approach borrowed from anthropology it offers a basis for sound interventions for understanding human behaviour. 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.

ACTION:

Motivate all intervention participants and workers to involve themselves in the evaluation as it sets good practice and can secure resources.

Example:

One to one interviews: The Chalo Chalay used interviewing to gather information, the interviewer match the respondent's language and ethnicity and provided an opportunity for participant to give constructive feedback into the intervention.

Dos

- Do evaluate it provides the opportunity to learn and reflect and sometimes provides surprising results.
- Do keep a reflective dairy

STEP 5.3: Development of Behavioural Questionnaires in Different Languages

Measuring behaviour change pre, post and during the intervention provides key indicators whether the intervention is reaching its desired objectives and provides constructive feedback to the participants. Tools may be available, however may need to be developed in other languages. There are a number of considerations to make and it's not just a matter of straight translation, a simplified version of questionnaires may produce quality data.

LOOK:

1. Are there any translated tools that have been tried and tested in the local community? If not, is there English version that can be adapted?
2. Is there a translation organisation that can help facilitate this process?

3. Is there the resource to do this? How many languages would material need to be translated in?
4. Is the terminology in ' plain English' and thus translated at a basic level?
5. Can the translations be piloted and amendments made?

THINK:

Consider the background of the target group, make tools as universal as possible, simplify questions down, but then can be supplemented with one to one interview or focus groups. Make sure that the length of questionnaires are short, one side of A4 is a good target to aim for, which should not take more than five minutes to fill out.

ACTION:

Consolidate a partnership that has the awareness of collecting specific data from the particular communities, take on board recommendations made and model questionnaires accordingly.

Example:

Chalo Chalay (Let's Walk) Walking Activities Questionnaire (Appendix I & II): was the first nationally to be translated into five South Asian languages, it consisted of four questions that required circling of answers. It provided data that judged whether participants were meeting the national guidelines of 30 minutes on five or more days of the week.

Do's

- Do consult with interpreters this provides uniform quality data.
- Do allocate time and resource for translations.
- Do redesign and simplify evaluation tools such as questionnaires in accordance to the community its targeted at.

STEP 5.4: Securing further resources

One of the core reasons for evaluation is to obtain further resources on the grounds of evidence base. However, sharing of good practice can also secure resources in kind from local partners thus integrating it into the heart of the community.

LOOK:

1. Can the intervention be linked into other initiatives in the locality? Such as Health Improvement Programmes, Primary Care Groups, Health Action Zones, and Healthy Living Centres. Can joint-funding applications be made?
2. Are there possibilities of resources in kind? E.g. free training?
3. Are there any match funding opportunities?
4. Are there other angles to the intervention that can draw in other partners such as Single Regeneration Budgets?
5. What can realistically be achieved without any funding? Can the intervention run on resources in kind?
6. Can commercial partners or sponsorships be drawn in?
7. Do the resources encourage long-term sustainability?
8. Is there a continued strengthened partnership of deliverers?
9. What other groups have formed from the interventions that have a physical activity component to them? Can other pots of funding be secured for these and thus be used in kind to source the walking groups?

THINK:

Are resources in kind available to the intervention? They can provide opportunities to develop local ownership and can strengthen partnerships.

ACTION:

Initial funding can be used to secure further funding. Have a clear definition of the intervention this enables matching of work programmes with possible funding opportunities. A number of different partners can provide small amounts this could spread the risk of the intervention and allows a broad base for support. This funding could come in kind for example administration, a computer, or professional time.

Example:

Use of local authority facilities: as apart of the Chalo Chalay walks the Abbey Park Visitors Centre was used for socials and running of walk tests and during poor weather the sports hall was used for indoor walking. These facilities were donated in kind by project partners and continue to do so at the end of the funding period. A two-way partnership has formed benefiting both parties.

Do's

- Do identify possible routes of funding early on in the intervention.
- Do think innovatively how other resources on the doorstep can be used effectively.

Don't

- Don't apply for funding which may take the ethos of the intervention away; funding can have high target outputs that may damage the group.

8.4 Summary

The summary begins by describing the differences in methods used by each demonstration project including evaluation methods. Comparisons are then drawn between the data collected from each project such as target groups, age of walkers, and how active they became. The shuttle walk tests are discussed and the patterns of brisk walking. The data from the original research questions are compared across all demonstration projects and the profiles of walkers recruited. The development, implementation and support elements of the projects are further compared and discussed. The initial set-up of the projects is highlighted. The type of health walkers recruited and the frequency of attendance are compared across all demonstration projects. The recruitment strategies are also compared. The summary ends with describing the innovative approached used by the demonstration projects and recommendations made.

Each demonstration had a different method of targeting their local community, from case record 8.2 the main difference was noted in the management of each project; Leicester was housed by a voluntary organisation, Eastbourne by their Health Authority and Walsall by a steering group made up of the statuary sector. Thus, the other two demonstration projects did not have the added challenge of nurturing new partnerships between the voluntary and statuary sector, however there were pressures for the other projects to work within their own statuary structures.

The Leicester project stipulated the adaptation of the PAFITT questionnaire used to test behaviour change across the projects. It worked closely with the BHF HPRG to produce the first walking questionnaire for a South Asian community group in England. This had more of a time and resource implication compared to other projects. It also led more of an active role in collecting its own data, as language was a barrier.

The Leicester project did increase walking in its target group more so than the other demonstration projects. Across all three projects more women were recruited then men, the Leicester project recruited two thirds more women than men, whilst the other two projects recruited twice as many women then men. Thus there were more women participants in the Leicester project compared to the other two demonstration projects during the first year.

The average age range of the Leicester walkers were 55, 5 years younger than the majority of walkers of the other two demonstration projects. The average age of the Leicester male walkers was 61 and the female 54, thus the male health walkers were older than the female health walkers this was opposite to that found in the other two denomination projects. The baseline profile of a new Chalo Chalay walker at baseline was female aged 54, this profile fitted 66% of the walkers recruited during the first year, this profile was similar to the other two demonstration projects but the female walkers were more likely to be over 60. At baseline only 22% were meeting the recommendations of dong 30 minutes of moderate activity on 5 or more days of the week, compared to 70% from the other two demonstration projects. Again the opposite trend was found that at baseline more South Asian women were active than South Asian men whilst in the other two demonstration projects the men were more active than the women. However, Chalo Chalay had recruited more South Asian women than the two demonstration projects. The oldest South Asian walker recruited was 77 and the youngest 35, the age group for the South Asian men was 43 to 77 and for the South Asian women it was 35 to 66. Highest levels of inactivity was found in South Asian males in the age band of between 64 –68, for South Asian women this ranged from 39 to 62, whilst the other two demonstrations found no age group where inactivity was significant. Thus inactivity was more evident in older South Asian men over 64 and all aged bands for South Asian women. This was in line with the other demonstration project that noted inactivity of the older age groups.

The other demonstration projects noted that more health walkers were in the active group than the inactive at 12 months but the change was not significant, the Leicester project found the opposite at 28 months where 47% of South Asian walkers were active, this was a significant change from the baseline of 22% an increase of a quarter.

The majority of the South Asian participants direction of change was to become active, whilst the other demonstration projects showed the majority as staying active. 21% of South Asian participants at 28 months became inactive whilst the other projects showed no change in the three categories of becoming active, becoming inactive and staying inactive at 12 months. Thus, the majority of South Asian participants at 28 months did change their baseline activity status which was opposite for the participants of the other demonstration projects at 12 months.

14% of South Asian walkers became active from being inactive that is at the start of the intervention period they were doing less than 150 minutes of moderate activity per week (i.e. fast walking or walking with shopping). 9% of South Asians became less active from being active that is at baseline they were doing 150 minutes or more of moderate activity per week, however only one walker was doing less than 150 minutes per week at the end of the 28 month period. The rest had showed a decrease but were still meeting the guidelines as they were doing more than 150 minutes at baseline. Thus, unlike the balanced situation with the other demonstration projects, who showed the same number of participants became active as inactive, whilst the Leicester walkers became more active or were meeting the guidelines.

The Shuttle Walk tests results from graphs, 5.7 and 5.8 indicate together with the self reported increase or decrease in reported minutes walked via the behavioural questionnaires data in graphs 5.9 and 5.14, is evidence of improvement to physical activity levels for Leicester's target population, this was not seen in the data presented by the other two demonstration projects.

The majority of the Leicester participants recruited at baseline were inactive and thus had the possibilities to become active or to stay inactive; this trend was not seen in the other projects, as the majority of their participants were already active.

The changes in brisk walking over a 12-13 month follow up showed that 15 South Asian walkers out of 54 at baseline reported no minutes of brisk walking, and 9 of which reported no brisk walking at the end of 12 months. Thus 28% of the Chalo Chalay walkers reported no change in brisk walking compared to 34% of participants from the other demonstration projects. The participants that did not walk briskly at baseline did not increase brisk walking in the short term of 4 to 6 months. Unlike the participants from the other demonstration projects, the majority of Chalo Chalay reported an increase in overall walking between baseline and 6 months, whilst the other demonstration projects reported an overall decrease. During the 12-13 month follow up of the Leicester project 21 participants out of 54, that is 39 % showed an increase in brisk walking behaviour, and 33% showed a decrease.

The original research question was whether projects increased walking in the their target groups: Leicester had met its target by recruiting South Asian adults walkers and the majority were not meeting the national guidelines on physical activity and thus were classed as sedentary. Eastbourne had met its targeted of recruiting the elderly from deprived areas. Whilst Walsall in recruiting adults were not successful in the first year of the project-recruiting children, cardiac rehab patients, the overweight, diabetic's and the socially isolated.

The overall profile of the type of walker that was recruited by the projects was female aged 54 to 60+. The majority of participants on Leicester project were inactive whilst Eastbourne and Walsall recruited active participants at baseline. During the first year of the project a quarter of the participants increased their levels of physical activity whilst the other demonstration only reported a 'few'. No observed effect in brisk walking behaviour was found in the other two demonstrations whilst 39% of Leicester walkers showed an increase in brisk walking behaviour. This suggests that Leicester had recruited sedentary adults and the intervention had changed their brisk walking behaviour whilst Eastbourne and Walsall had not been successful in changing behaviour as most recruited were already active. Leicester thus, had more of an opportunity to increase overall physical activity compared to

the other demonstration projects during the first year. However, all projects had recruited only a small number of participants during the first year for any of the data to have any statistical confidence. These comparisons do suggest that Leicester was effective in recruiting its target audience that is sedentary South Asian adults. Having this specific target audience had been advantageous, and could be argued that the other two demonstration projects target groups were still too wide.

The reasons why people went on the walks were similar across the demonstration projects, social, health, being outside and the personal qualities of the walk leaders. The social aspect was inclusive of enjoyment and company of others but also the safety of walking in a group. Women reported the social aspect more than men whilst men reported on the health and being outside aspect more than women. For the Leicester project from the one to one interviews (Chapter 7), the women after probing had joined Chalo Chalay initially for the health benefits but soon realised that the social benefits out weighted the health ones. The men other the other hand related to the walks more on a social level but were quite clearly there for the health reasons as they were advised by their GP's to walk more often and were influenced by peers, they saw the health benefits as a bonus.

What interested Chalo Chalay participants initially was the health reasons and meeting and talking to people but the actual reasons for joining was the fresh air and being outside, safety in walking in a group and it being a unique activity. This suggested that walking for health was never tried before and was a new concept to South Asian participants. Having a South Asian walk leader that participants could communicate with in their mother tongue encouraged them to sustain their attendance at the walking groups.

The involvement of communities in the development process for the two demonstration projects were similar and were grouped into the involvement of the statutory and voluntary sector this was found with the Leicester project with the addition of the development of individual community members. The three main stages to the process was; development, implementation and support.

The project development from case record 8.14 identified ten steps which included: create a development plan, with action steps and audit the projects progress; identify different sources of funding; identify key deliverers and key supporters; look into local strategies and priorities; identifying partners (steering group); defining the project aims and objectives; establishing a project structure and an action plan; securing funding for the project; appointing a project coordinator and working with the community. These steps were mirrored with the Leicester project, however a lot of pre intervention steps were taken and this can be seen from the toolkit that identifies 10 additional steps that need to be taken before delivering an intervention to a South Asian community. A further 7 steps of intervention development which focus on pilot projects and training for volunteer walking activators. Individuals from the a South Asian voluntary group and the local authority neighbourhood centre at the heart of the local community were involved heavily in the pilot projects and determined development of the intervention.

During the development stage a key difference between the demonstration projects was the coordinating of the project, Leicester and Eastbourne had recruited a coordinator from the commencement of the project whilst Walsall managed this function through their steering group thus the work was integrated into partner organisation remit. This way of working ensured sustainability of the project at the end of the funding period.

The project implementation from case record 8.15 included 3 steps; identify realistic progress with working with community groups, implementing community development, and project marketing and publicity. The toolkit identified a further 6 steps which included the recruitment and retention of community groups and volunteer walking activators. The same issues around volunteering were faced by all demonstration projects however Leicester had the additional issue of the concept of volunteering in the South Asian community.

The project support element from case record 8.16 identified 4 steps: developing partnerships with community groups, funding and resources from community groups, training, and working with volunteers from community groups. The Leicester project identified a further 4 steps via it's intervention sustainability stage which include the

promotion of leadership roles. Leicester had developed key community champions that were advocates and thus a support to the project.

Upon reflection of case record 8.17, the initial set up of the projects have statuary input at the start of the project. This was a catalyst for change however it hindered the process of community ownership, as in essence the statuary sector had the upper hand in terms of funding. All three projects had steering groups set up that had an active input from the statutory sector and there was an attempted to get operational and voluntary members on board. This may have not been the best way forward as it came over as a top-heavy management structure and not community driven.

In comparing the type of health walker recruited by the demonstration projects; Eastbourne had recruited 60% from its locality whilst Leicester had recruited 98% from its geographical boundary. Although Eastbourne had recruited over 4 four times as many walkers, Leicester had met its objective in recruitment and its target population within its targeted geographical boundary during its first year of operation. Leicester had from the onset aimed to target the local geographical boundary that had been set on the premise of a high incidence of CHD and deprivation. The other demonstration projects had targeted a wider area and were looking to refine where walkers came from to targeted their promotion and publicity to walkers. Both Eastbourne and Leicester saw a drop off of walkers at the start of the summer. The Leicester walkers with the cooler weather returned but for Eastbourne the number remained low till the beginning of the year. Overall weather did not affect the running of the walks, as no walks were cancelled due to the weather. The drop in the summer season maybe explained by a number of competing activities such as holidays, the wedding season, other events in the locality, day trips away, wanting to make use of the warmer weather and doing the garden. For Eastbourne having a new location of walks saw a drop thus having a consistent meeting point may resolve this.

Case Record 8.21 shows the frequency of attendance of Eastbourne's participants over 75% attended less than six walks in the first 12 months, whilst Leicester showed an average of 63% attendance of the maximum number of walks that participants could attended in the study period of April 1999 to June 2002. Once participants were recruited onto Leicester

walks there was a high level of retention was observed whilst in Eastbourne participants try health walks once or twice. There are a number of factors of why Leicester retained its frequency of walkers; from the one to one interviews participants like the routine of the walks, they have built a relationship with the walking activator and other walkers and thus have become family and also due to the pre work that Chalo Chalay used to recruit walkers outlining the benefits.

Eastbourne had recruited 17% of participants from local deprived areas compared to Leicester's 98% (based on the collection of post codes), the reason for this large difference is due to Leicester's stipulation from the onset of the geographical boundary which encompassed deprivation.

Leicester had successfully recruited individuals from its target population, in comparison to the other demonstration projects who had recruited more walkers but were not from their original target groups. Leicester participants originally joined for the health benefits, but as with the other two demonstrations the social benefits outweighed the health ones. The walkers were overall popular with older females.

Each demonstration project was innovative in its approach to delivering a health walk intervention, and were described to have similar stages of construction, this in essence was because of each project being set up by a steering group that had a large representation of statuary organisations and thus more of a statutory input. The ways of working were similar, for example facilitating steering group, setting targets, work plans, report writing etc. The funders also influenced this process, of meeting their targets and objectives. If this were turned around where a facilitating role for the voluntary group was set up, would the outcomes be different? In all the projects the statuary sector was the catalyst to funding, Leicester was slightly different as the project was housed in the voluntary sector, and did attempted to make the community the catalyst for change.

The recommendations made to the BHF, CA and future WHI encompassed the learning that happened during the three years of the projects. The main funders of the WHI initiative the BHF and CA were also an integral part of the evaluation as this 'new' partnership came

into fruition. The BHF could have had more of a future role in publicising the WHI projects and giving the initiative more impetus in particular the angle of CHD prevention. The BHF is a widely known body that individual can relate to thus using this influence more effectively and supporting further research and helping with the production of more resources in other languages. The recommendations made to the CA case record 8.26 were more operational and would support future WHI projects in equipping them with up to date resources and guidelines. Future WHI projects were fortunate to have access to evaluations of the demonstration projects; the recommendations made in case record 8.27 could be addressed at the initiation of the project and prevent the setting of unrealistic targets. Development work with communities should start by sowing a seed, the growth of this seed cannot be predicted but there should be insurances in place that the seed is watered, has the right light and temperature to ensure its growth.

The evaluations of the three demonstration projects was useful in providing guidance to other potential walking for health projects, Leicester in particular had endeavoured to produce an evidence based approach to convince South Asian communities to take up more walking for health opportunities.

Chapter Nine

Discussion

For travellers, there is no path, paths are made by walking.

Antonio Machado

9.1 Introduction

This chapter begins by validating the hypothesis set in chapter one and answers the research questions, aims, and goals. It answers a key question asked in the introduction whether: walking for health, is it the answer to South Asian inactivity? It addresses the statement of problems and research purpose and relates it back to the literature review. It then proceeds to analyse what factors made the intervention a success so that they could be adapted to other localities and regions. A key element to intervention delivery was the identification of motivational factors, which are discussed in detail. The chapter then outlines how the intervention fits into the bigger picture of Chalo Chalay delivering the governmental ' New Deal for Transport' and further elaborates on universal walking and group dynamics. The chapter ends with the future of 'walking for health' initiatives in Leicester and then an overall summary of the thesis.

9.2 Hypothesis Validation

The hypothesis was based upon whether South Asian communities of Belgrave in Leicester would take up walking for health initiatives. It was correct in predicting that the initiative would need targeted publicity and marketing and was denoted in chapter five: intervention development. The project had not been able to reach all parts of the community as majority of participants from the qualitative interviews in chapter seven felt that Chalo Chalay could be publicised and marketed better. Previous frameworks used to promote walking for health to the general population was envisaged not to work with the South Asian community this was proven by the lack of participation of racial minorities in the other demonstration projects. Leicester had been successful in recruiting South Asian walkers by using culturally tailored interventions, which were inclusive of bilingual walking activators. There was a clear

recognition that promoting walking for health to South Asian communities would be difficult but not impossible and making it universal via the toolkit was evidence of this.

The stipulation that the initiative would procure health benefits were felt at a local level, but would take years for it to alleviate the pressures on the NHS, however walking activators felt that they were getting a number of referrals from hospital cardiac rehabilitation units and were thus at a minimum halving medics work loads as stipulated in quote 7.414 – chapter seven. The hypothesis also suggested that there were too many variables to get people walking more often and to get people to leave their cars behind, was not just health's problem, but had wider implications for transport and environment. Chalo Chalay found that people did take up walking opportunities if they were provided, and reminders of the health benefits did convince them to walk independently. The hypothesis also suggested that joined up thinking would move towards finding solutions to the problem, working in isolation would not have a huge impact on national targets, but on a local level a slight difference may be detected, this was found on a local level, small steps were taken via the national initiative to secure monies for walking for health via the national lotteries to set up other similar initiatives, thus increasing overall participation in walking.

The government in July 2003 announced that its was going to spend 7 billion over the next ten years to widen the major motorways in England adding a 4th and 5th lane to the M1 and M25, thus change in the behaviour of the government in writing its policies and investment strategies as stipulated did not occur for walking for health to be a practical solution instead the government were motivated financially.

9.3 Outcome of research purpose, aims, goals and questions

Outcomes of research purpose

The purpose of the study was to gather data on walking as a positive preventive mechanism against Coronary Heart Disease (CHD) and other related conditions in South Asian communities. Qualitative evidence was gathered via the case studies over a period of 28 months and was supported via the quantitative evidence of the shuttle walk tests.

Chalo Chalay was a demonstration project and thus it presented evidence on the health benefits of walking. Its main purpose was however, was to strengthen the case of the reduction of CHD in South Asian communities via walking for health from table 5.9 (chapter five) it can be seen that only 5% throughout the study period stipulated that they had a heart condition, a further 9% said they felt chest pain during physical activity and 6% felt chest pain at rest in the last month. A further 19% felt they lost their balance as a result of dizziness, 29% said they had a bone/ joint problem and a further 29% said they were on prescribed drugs. This suggested that only a small number of walkers used the intervention as a way of rehabilitation. It can be deduced that the intervention may have prevented CHD as only one lady during the intervention period had a heart attack and was not confident to return back to the intervention as stated by the walking activator. Thus, more work needed to be done around one-to-one follow-ups.

Evidence of the benefits of the health walks were presented in chapter seven, the qualitative interviews indicated that all participants had benefited and thus significant evidence was gathered for securing future funding for the continuation of the intervention. More importantly, Chalo Chalay was a new concept and all community members including the statutory and voluntary sector endorsed it. The walking for health concept was new to South Asian communities but was accepted and integrated into lifestyles. It had set an example for other localities and regions to follow, which often came to visit the project and the walking groups to view how it worked at a grass roots level. A toolkit had been written for practitioners who have an interest in promoting walking to South Asian/Ethnic Minority communities. The intervention led the way nationally as it set the framework for promoting walking for health for racial minority communities. By the end of the first year of the intervention, it had aided the national Walking the Way to Health initiative to secure a further 6.4 million from the New Opportunities Fund. Getting more people active more often via walking for health was a vehicle for the prevention of a crisis in the NHS for treating CHD patients.

The current study provided a starting point for further research into the South Asian community in relation to physical activity. It would raise enough interest in the field to increase the amount of research and supporting evidence to attract further funding and resources. The

toolkit and framework had provided the practitioner with tools to offer a better understanding and thus equal services to racial minority communities.

Outcome of research aim

The main aim of the project was to promote higher levels of awareness of the health and social benefits of walking for health and to increase the participation in daily walking activity by South Asian adults through increased walking opportunities, community action and improved environments. The project had achieved a majority of the aim and evidence is presented in chapters 4 to 8. Awareness was raised through its publicity campaign and via promotional talks at community groups, events and local and national conferences. The project had successfully increased walking opportunities over the three-year period via its walking groups and facilitated a lay walking activators training. The behavioural questionnaires together with the shuttle walks tests provided strong evidence of an increase in participation of walking by South Asian adults in the Belgrave locality of Leicester. Not so clear were community action and the improved environments, these two latter components had been difficult to measure due to the time frames. Community action had been an ongoing process since the foundation project that commenced in 1998, six years on, sustainability can be seen, and seeds of development have germinated. The local environment had been apart of the wider regeneration agenda and was slow to deliver, monies had been secured for environmental changes but were slow on action and delivery, a few significant changes of traffic calming measures were seen, but not any major changes on the parks or the riverside.

Outcomes of research goals

Nine goals were identified for the intervention over the three-year period:

To increase the numbers of walk leaders in the area

The project had increased the number of walk leaders in the locality in view that at baseline there were not any. It had trained over 41 walk leaders over 2 training sessions however only 10 were active in leading walks. The first training session had 22 participants, of which 20 completed and 3 went on to led walks. The second training session housed 21 participants and 7 went onto to lead walks. Further research is needed to define why there is a drop out rate and what could be done differently. The project had changed its procedure of recruitment to

be inclusive of an interview and limiting the training day to 10 individuals this had increased the retention rate.

To increase the number of community groups involved in the scheme.

During the foundation pre intervention phase over 41 South Asian community groups were consulted on physical activity and walking interventions. It further supported 33 South Asian community groups to develop their own physical activity schemes. During the first year of Chalo Chalay it facilitated ten community groups to set up walking for health interventions, this included two mental health projects, three religious groups, two neighbourhood centres, two Samaj's (a Hindu cast community specific group), a secondary school and a group for the partially blind and blind. Some of the community groups had various groups it hosted, for example the Belgrave Neighbourhood Centre had a men's, women's, 60 + and a reflexology group, all of which set up their own walking for health groups. In year two of the intervention, a mental health project was recruited, two women's organisations, the local authority sport centre, and two health centres. At baseline there were no community groups aware of walking for health or did not have the capacity to run a walking for health intervention. At the end of the intervention period 47 community groups were introduced to walking for health and a majority were able to set up and sustain health walks.

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.

At baseline no information was available for walking for health interventions to the South Asian community. At the end of the intervention period leaflets were produced explaining the benefits of walking, how to get involved and where further information can be obtained. This was translated into the five main South Asian languages. The project ran a number of media campaigns, which used local radio stations, newspapers and targeted local events such as the Belgrave Mela and riverside festival. It raised its profile further by launching the project alongside the national launch, which provided photo opportunities. The local radio, T.V and newspapers were involved but also national journals and newsletters.

From the 1991 census a possible 17,500 South Asians could have been targeted in the geographical boundary, it needed to recruit 3,500 onto the intervention to reach its target of 20%, the intervention recruited 182, which is just over one tenth. Of those that were meeting the national guidelines of physical activity this figure would be lowered. What may have increased this figure is the number of participants that walked independently outside the walking groups and influence others to do so, such as family, friends and peers.

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.

During the three-year study period 5% of South Asians recruited had a heart condition. The latter part of the goal was difficult to measure as ' prescribed walking schemes' were not enforced, however from the behavioural questionnaire and shuttle walk tests overall perceived and actual fitness of these participants had increased, and were meeting the national guidelines.

To set up good working collaborative networks between professional groups and between people from statutory, voluntary and community sectors.

This goal was met during the pre intervention and the first year of the project, however during the end of the project the partnership between the voluntary and statutory sector was not sustained. During the initiation phase, the statutory sector had been key in getting partners around the table from various sectors locally. At a director level there was an influence of getting statutory managers working together, however when the director, the chair, stepped down this momentum was lost. At the end of the intervention period no further monies were secured, however the statutory sector secured monies to sustain the what was set up, thus the sector worked directly with community members from a grass roots level.

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.

The project was fortunate that it had strong links into community centres and voluntary groups via the foundation project based at the CIO, over a period of 12 months. During the intervention delivery phase these links were maintained and expanded. More difficult was to

monitor walking activity within the Belgrave locality, during the first year, the action research model gave detailed reports and reflections, during the second and third years, monitoring continued via the use of behavioural questionnaires, the shuttle walk tests and walk registers.

Over 24 months local walking groups should have become self sufficient and self-running.

The walking groups set up in Belgrave were partially self sufficient and self-running after 24 months when funding ceased. Minimal support was given from the Health Promotion Agency, who facilitated a network for walk leaders from the city and county. Minimum funding was given to sustain walks already set up. In July 2003, 12 months after the end of the funding period, the walking groups still meet regularly once a week, for the ladies group there was membership of 40 women, and on average of 20 women attended per week, the walking activator was still going strong. The men's group had an average membership of 30, and 12 walkers attended per week; they still lead themselves, and did not have a specified walk leader. Six years after the initiation of the intervention, these two groups are an example of a self-sustaining walking group, who have taken the concept and integrated it into their daily lifestyles. They were making a positive contribution to the prevention of CHD and other related diseases and influenced their peers also to do so.

The study will provide guidelines in setting up walking initiatives specifically for the Asian community and generically for health-walk projects nationally.

This goal has been met successfully; a toolkit that can be used by any practitioner has been constructed to provide comprehensive detail on how to promote walking or physical activity to South Asian or racial minority communities. Specific guidelines have been given to transfer the progressive practice of Chalo Chalay.

Responses to research questions

Five research questions were set at the beginning of the intervention, the study has gone beyond the research questions and has provided in-depth insights to the sequence of events during the intervention period and follow up.

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

Chalo Chalay did increase walking in its target group that is sedentary South Asian adults, over a period of three years it recruited 182 South Asian adult walkers. During this period 66 case studies were followed. More women were recruited then men and the average age of walkers was 55. At baseline 78% of walkers recruited were sedentary that is, they were not meeting the national guidelines. At the end of the intervention period this was lowered to 53%. Thus the project had addressed the needs of 'sedentary' middle-aged men and women, and the majority became active by increasing the number of minutes of moderate walking per week.

2. Why did the people (individuals or users of community centres) 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 walk leader.

For those who used the walking opportunities – why did they? How often did they? And what did they see as the benefits?

The participants used the walking opportunities for a combination of reasons; they got to meet other people and 'to get out of the house' this reduced the feeling of isolation and boredom. Walking had previous been a hobby and an interest they had, the group provided the opportunity to share this with others. They liked to be outside in the fresh air and be out in the environment learning new things. They liked walking in a group, as they felt safe and that it was a unique activity outdoors, it had become a weekly routine. There was also recognition that it helped their health, reduced stiffness in the legs and increased their fitness. They enjoyed being in the company of friends and to a degree were pressured by peers to join and give it a go!

Once the walkers were recruited and felt the benefits in the short term the majority were regular walkers, 67% of men and 59% of the women completed the walks programme.

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 the time and was a routine, they enjoyed the company of the walk leaders and it was a free activity. There were many mental health benefits which included; feeling happy / good, relaxed, refreshed, meeting people of the same background, talking, sharing problems, learning new things, inspirational, routine/ habit, increased community sprit and overall reduced depression. There was a clear indication that there had been a reduction in the use of anti depressant medication and in some cases the total stoppage. They had also joined other activities and the intervention acted as a catalyst, it stopped their laziness and increased their stamina.

There were overall 39 specific health benefits identified by the participants as shown on graph 7.14, the most significant ones were benefits to general health, prevention of illness and diseases, building of appetite and aiding digestion, prevention of stiffness of the legs, good for heart health, maintaining fitness and exercise, good for blood circulation, mental health, good for breathing, weight control, keeping warm, good for arthritis and the bones. A few of the women specified it helped with varicose veins and menopause.

For those who did not take up the opportunities? – Why not? – What might have attracted them to participate?

Walkers who had taken up the walking opportunities were asked why they might think that other members of their community did not take up the walking activity. From graph 7.15 28 reasons were identified why people did not take up the opportunities. The most significant reasons were bad health and illness, laziness, and watching daytime South Asian T.V – soaps. From graph 7.13, the walkers believed that not enough people walk for their health because they are ignorant of the benefits of walking, they had a lack of time and they did not know about the walking groups. Thus, there was a definite need of more publicity and education of the benefits of walking. Selling the social aspects of the walks would attract more people and integrating it with trips to places of interest or a walk with a purpose such as visiting temples, going to the post office or charity walks.

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

The local community can be defined by the voluntary sector but also the service providers, the statutory sector, both were involved in the development of the project, initially the statutory sector in the writing of the bid and securing funding and then the local voluntary sector in delivering the initiative. The voluntary sector, that is the community and voluntary groups within the geographical boundary were extensively involved during the first year and were key in piloting the walk routes and refined health walk procedures. This type of involvement reduced at the end of the intervention, and community groups were recruited into buying into the walking for health package.

At the end of the project what was the number of community groups that were involved in the development?

At the end of the three-year funding period, 47 community and voluntary groups were involved in the development of the intervention. A wide range of South Asian community groups were recruited, to be representative of the diverse community in the geographical boundary, thus from mental health projects to women's groups.

How were the community groups involved i.e. the nature of the involvement, the extent of the involvement, the type and ranges of activities that the community groups were involved in.?

In the initial stages of the intervention, the community groups were involved in piloting the walking routes, testing the health walk protocol, feedback on the process and recommended changes. As the intervention progressed, they were involved in publicising the walks, and promoted the intervention and facilitated the increased in the number of walkers recruited. The community groups also facilitated links into other community groups, provided the contacts and links. In part they helped pilot the walking activators training day, and undertook the training, and suggested other volunteers from their community groups. Ongoing criticism and support was given to the intervention. The walkers and walk leaders organised interest walks, trips and events to keep all motivated. At the end of the funding period walk leaders were involved in the regional network and went onto other training programmes to support their local walks. They all volunteered to be apart of the evaluation process, and gave their time to be interviewed, tested and monitored.

Why did community groups become involved?

The reason why community groups got involved was two fold, the interest of putting on a new activity and secondly they were influenced by the intervention that highlighted the benefits of walking. A key was that the intervention coordinator who would support, advise and guide them through the process and provided training for the volunteers. Intervention groups influenced other community groups to get involved who also wanted to be apart of the intervention.

Why did they not become involved?

Other community groups did not get involved as they did not have the capacity to deliver the intervention, a lack of time, staff and volunteers. There was also a concern that the intervention was only for the Hindu community, and other religious groups were being omitted. This perception prevented the Muslim community from participating, however this perception was soon dissipated, and the intervention became more transparent and open to all.

Are the community groups still involved?

The community groups were still involved at the end of the intervention period, effective links were built so that the community groups had direct links into the statutory sector, they knew of contact persons they could seek support from. The intervention had given them the skills to continue the walking groups and walking.

Are the community groups still involved in the project six months after the end of the three-year period?

The walking groups set up still ran 6 to 12 months after the three years, the initial bigger groups set up continued to go from strength to strength, taking on the responsibility, even though there was a lack of support from the network set up. However, the small satellite walks continued but did not recruit any further walkers. There was concern that after Chalo Chalay being constituted and having a chair, and a committee, the maintenance funding was not distributed evenly.

What support was required and provided to the community groups?

Initially human resources to set the walks up and motivation for users to participate, then free training for volunteers to continue the walks. Many of the community groups required information and links into the statutory sector where they could access more funding and resources. The coordinator chased people up and monitored progress and kept a check of what was happening. Practical support such as hiring mini buses and providing first aid kits, paperwork or leading a walk when the walk leaders could not attend.

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

This strand of the project only came on board in the final year of the intervention. Draft guidelines were produced and a partnership formed between the active lifestyle referral scheme and the South Asian CHD prevention project (Project Dil). No significant changes were observed; however 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 (aiding in the control of diabetes), alleviate back pain, and reduce the stiffness of legs but most significant was walking would help in rehabilitation after a heart attack, and be preventive. The walk leaders also stipulated that they had referrals from the hospital cardiac rehabilitation unit and felt that their work had reduced doctors workloads by half and have benefited heart patients.

Did the patients who took part value / benefit from the walking programme?

There were a number of benefits that helped patients after attending the walking group, it helped reduce arthritis, gave by-pass patients the confidence to walk again, and could walk longer periods without getting out of breath, it helped women who had irregular periods to become regular, it also helped women who were going through their menopause. The most significant outcome was that walkers that were on anti depressants showed a reduction in medication or had stopped.

What was the GP perception of the value of the walking programme to the patients?

The consultant at the Diabetes unit was very happy with the reduced weight and blood sugar levels of his patient and recommended that she continued walking to maintain the levels. It had also helped lower cholesterol with one of the walkers. The walking group also impressed

other professionals such as physiotherapists as it helped their patients with arthritis and varicose veins and in this case stopped all medication.

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

There were five major environmental projects in Belgrave that the intervention liased with during the three years, all of which commenced during the intervention period. The first was the Belgrave riverside park area development, which saw the launch of the national space centre, and brought more visitors into the riverside areas and thus increased security. The scrubby vegetation was thinned out to open up the view of the river and making visitors feel more secure. A towpath had been widened at the back of the park, which was used to make revenue to feed back into the improvements. At the St Margaret's pastures a canal frontage was restored and created a more attractive landscape up to the car park. The second and third projects were the Belgrave Corridor project and the 'Golden Mile' a four-year major investment plans by the Leicester City Council to calm traffic and increase pedestrianisation. These improvement plans were delayed due to the opposition of businesses and residents. However, the safety aspects of the initiative were implemented, a duel carriageway leading to Belgrave and pedestrian links to Watermead Park. Controlled crossings and a bus lane were installed along Belgrave Road and pollution levels monitored. A pedestrian crossing was installed at the Watermead junction; this was a direct result of the consultation with the Chalo Chalay walking groups. The forth project was the Central Leicestershire local transport plan 2001-2006 walking and cycling strategy which was a key document to increase walking in Leicester City but also joint yearly plans were written with the county to improve walking across Leicestershire. The fifth was the Single Regeneration Budget 4, strategic regeneration of Belgrave 4 people, fencing and safe vegetation were implemented to increase community safety, paths were realigned to provide continuation from the Belgrave Hall gardens and open up views. There were installation of gates on the Holden Street Bridge to prevent motorcyclists and cyclist crossing thus increasing pedestrian safety.

9.4 Previous Studies

From the literature review South Asians were denoted as having poor health, in particular having an increase likelihood of CHD, the current intervention has proven that it can reverse this trend. South Asian women in other studies have shown not to take up sport or physical activity. The current study showed by removing barriers such as dress code, mixed sessions, racism and providing a culturally tailored environment, increased participation of South Asian women in physical activity in particular walking. Providing separate walking groups for men re-educated them as the women stipulated this as a barrier.

Intervention mapping (Bartholomew *et al.,* 1998) was taken into consideration, and natural helpers and programme champions were identified, all the walking activators were bilingual as suggested by the 'On the Move!' intervention (Manley 1999). Publicity of the intervention capitalised on the power of 'word of mouth' as recommended by Manley (1999). The walking for health intervention took into account cultural activities as advocated by the 'On the Move' programme, it used locally hired walking activators from within the community who knew and incorporated cultural dances, games and songs into the walks. Recommendations to promote physical activity to South Asians presented in the literature review, were implemented in the delivery of the walking intervention in particular role models that were 'ordinary looking' the walking activators wore traditional clothes such as Punjabi suits whilst leading walks. Foo *et al.,* (1999) suggested positive bilingual role models from the community to deliver the intervention, all walking activators recruited could communicate effectively with participants, not only on the walks but also at the facilities, which the walkers used.

Cassady *et al.,* (1999) stipulated targeting Ethnic Minority populations via community involvement of health promotion activities. Chalo Chalay linked into other health promotion activities in the locality such as the Project Dil, CHD prevention programme and the Exercise on Prescription scheme. The locally recruited walking activators undertook their trainings, so that a holistic approach was taken to deliver the intervention.

The intervention was delivered in accordance to the casual or effect model of health promotion as suggested by Sanderson *et al.,* (1996). The walking intervention changed behaviour of the walker by introducing a new environment, which thus lowered the likelihood

of disease. The behaviour change was based on the KAB model of knowledge, attitude and behaviour (Sanderson *et al.,* 1996). Thus walking was introduced to the participant, who understood the importance of the activity, developed a positive attitude towards the activity and learnt the necessary skills from the walking activators to implement the behaviour changes that promote well being.

Walking in the current study showed it to be an effective intervention against the prevention of heart disease as advocated by Blair *et al.,* (1989) and Morris *et al.,* (1990) only one participant over the 28 month study period suffered from CHD, the rest showed greater improvements in their general health.

The targeted population were at higher risk of chronic diseases, this was observed in the 66 case studies who were inactive and suffered illness such as diabetes, angina, osteoporosis, heart disease and depression. The intervention helped ease these and allowed a better control and less medication.

Tanjasiri (1999) recommended shared partnerships that relied on the wisdom of communities to create their own unique tailored strategies. At the end of the Chalo Chalay funding period the walking activators continued to lead walks, they incorporated activities into the walks that motivated walkers to keep coming back, there must be a strong group dynamic as walkers have continued walking over six years. During this period the social benefits have outweighed the health ones, as walking has improved their minds as stipulated by Kramer *et al.,* (1999). Bird (2000) suggested that the walkers created a sense of community in which they felt they belong to, the same was found in the current study, the women in particular found the group to be an extension of the family, where they could share and solve their problems. Hirst (1997) advocated that the intervention was a holistic approach, which produced physical, and mental health benefits for the participants, this was also observed with the Chalo Chalay walkers.

The intervention clearly met the walking targets for personal health as stipulated by Morris & Hardman (1998, 1997). The intervention recruited sedentary South Asian adults who by the end of the intervention period were meeting the 30 minutes of brisk walking on 5 or more days of the week.

The reasons for continuing the doorstep walks as suggested by Vernon & Brewin (1998) was the chance to be outside, maintaining or improving health and keeping in good shape physically. These were similar reasons to the current study of health and social, and chance to be outside and the qualities of the walking activator.

The Intervention provided information sessions in small groups about walking for health and the benefits of physical activity and using scare tactics of inactivity, this helped the participants to initially start the activity this was seen to be a successfully strategy in other studies by Cupples & McKnight, (1994) & Dobs, *et al,* (1994).

Lefebvre & Flora, (1988) suggested using social marketing principles, these were used in the intervention to provide tailored messages for the South Asian community, highlighting that heart disease was more prevalent in this community gave participants ' food for thought' and pushed them to taking up the opportunity.

Prochaska & DiClemente (1992 1985) "Stages of Change" was applied to the intervention, and was successful in recruiting participants at a precontemplation stage as publicity talks were targeted to this stage. However, there was a high drop out rate and the maintenance stage was difficult to sustain. Overall the intervention was very good at recruiting but needed more work in retaining and should have looked at strategies to do this.

A key motivation for the walkers were that the walking activators were 'the same as them' that is in age and fitness. The 'do as I do approach' worked well, walking with participants that were the same age and fitness level gave the feel ' if she can do it so can I', this was also shown by Bandura, (1986) who stipulated behavior change through observation.

Green & Kreuter (1991), McLeroy et al., (1988) and Passick et al., (1996) describe frameworks for physical activity interventions these were tailored to the South Asian community, that is taking account of language, dress code and single gender sessions, these basic changes encouraged walkers to participate.

Thopmson & Kinne (1990) used coalition building as important component of intervention delivery, it was found in the present study that this was key and partnerships needed to materialise at all levels, failure to do so meant a failure in sustainability. This was more pronounced at a management level and the dispersion of the steering group. However, grassroots partnerships were strong and community members were committed to the concept.

Results showed that there were three categories of positive outcomes associated with leading a health walks for South Asian communities improving health, personal satisfaction, group motivation, and partnership working this was also found by Nguyên *et al.,* (2005) who implemented walking clubs. The difficulties associated with running the walks included high participant turnover rates, isolation of walking activators, and a lack of support from management oraganisations this was supported by Nguyên *et al.,* (2005).

The low levels of walking in the population provided a major opportunity for increasing levels of physical activity and health enhancement (Lumsdon & Mitchell 1999). This stimulated an interest in bringing together policy interventions which are designed to encourage more people to walk as part of a daily routine and at the same time meet the objectives of health promotion as the transport department at the Leicester City Council wrote Walking and Cycling strategy for the city. However, the challenge was to promote 'walking for health' into mainstream sustainable transport development.

9.5 Factors making the intervention a success

There were a number of factors that contributed to the success and active outcomes of the intervention.

Pre intervention work

The pre intervention work in terms of the foundation project was key as it raised awareness of physical activity and put walking for health on the agenda of local community groups. This pre work built up the trust of the users first before introducing the activity. Meeting prior with the project managers and activity co-ordinators established current attitudes and gave clear starting points. Talks and informal discussions with the users highlighted the

importance of physical activity in the prevention of CHD and suitable forms of physical activity were identified. Building confidence and convincing community groups and its members with this one-to-one approach worked well.

The pre intervention work provided the intervention with a springboard, as it identified major barriers that were addressed quickly and effectively. Knowing that the local community members did not feel that local authority facilities met their needs. The intervention was able to provide a short-term solution by introducing walking on the doorstep but in the long- term worked with the facilities to change their practices.

Using a holistic approach and capacity building of communities.

Linking strategic initiatives to grass roots facilitated a process of change and increased understanding at all levels. Having transparency between these layers provided more opportunities to work across boundaries. Offering training and opportunities to shadow professionals allowed key individuals to drive agendas forward in their locality and networks.

Key individuals, which were champions of the intervention

Having key individuals that can champion the intervention at all levels, gave the intervention impetus with individual local communities. Thus, having the director of health promotion chairing the steering group, pushing it in his networks gave the project professional links it needed and created leverage. Whilst having walking activators progressing as role models provided the intervention with acceptability and sustainability at a grass root level.

Defined geographical boundaries

The intervention targeted sedentary South Asian adults, having a geographical boundary that encompassed wards with high percentage of South Asians ensured that targets were met and remained focus to the task at hand. Knowing the demographics of the locality also allowed targeted strategies and campaigns. It was fortunate that the locality had an infrastructure that could be utilised, such as a network of voluntary and community groups.

Action orientated evaluation

The evaluation consisted of administering shuttle walks tests; it helped monitor the progress of walkers and was a motivational tool for the participants. Having a dedicated sub-group for evaluation was productive and assisted in achieving short-term realistic tasks. Having a combined role of a project coordinator and evaluator built the trust of the walkers to participate more willingly in the process of evaluation, having an outsider would have not produced such qualitative results.

Quality not Quantity

The intervention recruited a relatively low number of participants and walking activators, this permitted quality time and data from the participants. This enabled comprehensive frameworks and toolkit to be set.

Dedicated walking activators and role models

Walking activators were core to the intervention, they acted as role models to peers and were key in recruiting and maintaining participants. They possessed inherent skills to liase with local communities and adhere to cultural sensitivity. Their enthusiasm and support to the project kept its momentum. They were committed to the intervention and had a belief that it worked as they had personally experienced the benefits of the intervention. There were key attributes of the walking activator that brought it successes that is; they were friendly, sympathetic, good listeners and joyful. Also, they could speak the mother tongue language. The walking activators at the end of the intervention period were multi-skilled in delivering different aspects of health promotion and were a rare resource. This helped to sustain the project via the number of connections into the local community.

Housing the intervention in a voluntary group

There was definite advantage of housing the intervention in a voluntary organisation, as it had the flexibility to work in innovative ways, and have good links into the community. Other voluntary initiatives could be easily linked into, however just as important were management structures and working in par with statutory partners which can sometimes lack.

Realistic targets

The operational strategy was rewritten and reflected upon often to deliver realistic targets. Accurate records facilitated this process.

Pilot projects

Testing out walking routes and refining protocol and procedures was an essential component to the intervention. It helped raise awareness of the concept and set a good example and facilitated recruitment of other community groups onto the project.

The variety of doorstep walks

Having a variety of doorstep walks, such as urban, park and riverside gave the participants easy access and choice. Factors such as difficulty and length could be varied and new environments were discovered on the doorstep. The intervention was thus successful via having these environments nearby, in comparison to other localities where there were only run down parks and the issue of transporting out of the locality arose. Six doorstep routes were developed in the geographical locality that were safe, pleasant and a short walking distance away.

Flexibility in attire and footwear

The ladies and volunteer walking activators were comfortable wearing the South Asian cultural dress (Sarees, Salwar kamis e.t.c), this flexibility encouraged women to participate.

Working in a team

The health walks were a success as walking activators and volunteers worked in a team.

Creating resources in South Asian languages

A key to the success of the intervention was the commitment of individuals to translate resources effectively. Evaluators working alongside translators provided quality data. It took a longer time but the end product was of a high standard and could be transferred to other walking for health initiatives nationally.

Ownership of walking groups by lay community members

Members of the walking groups over the 6-year period moved away from community groups and became independent, this overall increased ownership and sustainability. Having done this over a longer period of time, it increased their confidence and capacity, via training and building links directly with service providers.

Different approaches to leading walks

Some of the groups did not have a walking activator and shared responsibility amongst themselves. This worked well for the group and was a different approach; strength of the intervention was being flexible to cater for different ways of working.

Volunteer participation

The success of specialised walks for the blind was due to the number of volunteers available to help.

Shuttle walk tests

This aspect of the walks provided ongoing monitoring and feedback to participants. It was also motivating for the participants who could measure their own progress.

Specific volunteer walking activators training

This training was adapted for the South Asian community; it incorporated South Asian cultural specifics and ethics. It provided the opportunities for potential walking activators to test out new ideas and adapt cultural physical activity into the walks in a safe environment. Further training in other aspects of health promotion helped build capacity of volunteer activators and continued to build their self-confidence to adapt and deliver the intervention according to the needs of the participants and walkers. From this initial training some of the walking activators went onto to YMCA courses and provided adapted classes for the local community.

Minimal paperwork.

The intervention produced paperwork that was clear and simple to administer and easy to understand.

Real idea's from real people

One of the successes of the intervention was implementing ideas from the local community and incorporating these into the project. Officers who felt that if the ideas came from the community it would be sustained.

A targeted publicity campaign

Attendance at local events, and one to ones with community groups created enthusiasm and recruitment on to the project. Word of mouth was a key success factor for recruiting participants and community groups. Volunteer walking activators facilitated this process.

Rapport 'verwar' with walkers and walking activators

This was a major success of the intervention as all project workers had an understanding of how this worked.

Locally based intervention launches

Having targeted launches that incorporated local events and festivals gave participants a number of reasons to join in. Linking walking for health with key cultural norms gave the project coordinator gateways into the local community. Thus, linking the launch to the riverside and placing candles into the river was a ritual carried out in India which worships the water goddess *Gangama*. These types of ideas helped the local community to become involved and gained commitment from volunteers and community groups. The launch events facilitated the production of innovative ideas that were unique to the local community.

Peer pressure and word of mouth

Those that were recruited onto the walking groups, spread the word of the intervention, and shared the benefits of walking for health with their peers. A majority of the walkers were recruited via peers pushing them to give it a go. Peer pressure and recommendations of the walkers was a key indicator of success of the principle.

Committed individuals at all levels

Having committed individuals at different levels of the intervention made it a success on all agendas, from community management committees to meeting targets at the strategic health authority. Dedicated workers, volunteers and walkers made it a success. There were key individuals in key positions that wanted the project to happen and thus the intervention was able to deliver. It was the strength of these individuals that made the intervention a success.

Key partners around the table

Having the key stakeholders around the table was a good foundation to the project; they facilitated the intervention onto other key agendas such as health, transport and environment.

Promotion of a positive health promotion message

The intervention provided an environment whereby community members could do something constructive about their health and having the information to make an informed decision. This gained commitment from individuals to sustain the walking activity.

Support of community groups

Key community groups in the locality made the intervention a success by providing ongoing support to the intervention and its volunteers. They embraced the intervention and took forward the concept even after the end of the funding period.

The promotion of independent walking

The intervention enabled walkers to walk outside the walking group and develop their own walking routes and discover their local environment on the doorstep.

National recognition

The Chalo Chalay project was a national demonstration project and thus it paved the way for other racial minority interventions. These projects looked to Chalo Chalay for logistical and operational detail and helped reinforced its procedures and protocols. It raised the project's profile and awareness.

Links into primary care

Making links with primary care professionals such as health visitors and GP's, increased the human resources and bodies promoting the intervention, and increased the population targeted.

A full time project coordinators post

The intervention benefited when there was a full time coordinator, it was impossible to expand the intervention without more time being dedicated to it.

Recruitment of a new management team at the host organisation and gaining internal support

The intervention expanded out quicker with a new management team that were more focused on the local needs of the community and had a better understanding of Leicester's racial minority voluntary sector.

Flexibility and innovative ways of working

The intervention was flexible and accommodated new ways of working with local community groups and partners, it created the space for ideas from the community to materialise. It helped to allow room for mistakes and learning from these to implement change effectively.

Other partner projects in experimental phases

The intervention was fortunate that other key partners were delivering interventions that were at experimental stages; it helped to assess what worked and adapted good practices into the intervention and allowed different methodologies to be tested.

Intervention written into policy

The intervention was written into Health Action Zones, and Health Improvement Programmes by statutory partners this gave the project impetus to secure further monies for walking for health. For example the demonstration project secured 40K for Leicester City via Health Action Zone, and 11.4 Million from National Lotteries Charity Board for 500 other national schemes.

Forming key partnerships

The main reason that monies were secured for the intervention was the history of good practices happening in Leicester and the good partnership formed that is the coalition between the statuary, voluntary and academic sector. Also forming partnerships that can deliver on targets of the intervention such as GP walks referral scheme and partners such as Project Dil and Exercise on Prescription.

Partnerships working towards the same goals

There was a cross contamination of targets that were shared with two other initiatives in the same period this added a resource to the intervention and integrated other project plans that could deliver the project targets. These unique partnerships were mutually beneficial and provided a better service to the local community.

Feedback from walking groups

The walkers were confident in feeding back any constructive changes to the intervention and also any environmental changes these were feed back to the local authority that implemented smaller changes.

Group Dynamics

An understanding of the group dynamics, set in motion the formation of strong walking groups that were self sustainable.

The local community

The local community were a key factor in making the intervention a success, in that they genuinely wanted the involvement of other members of their local community and to take a proactive role in their own health.

The walking activators network

A key success factor at the beginning of the intervention was the steering group partnership this responsibility was delegated to the walking activators at the end of the funding period, it was these key individuals committed to the concept that sustained the intervention after all other partners pulled away.

An Ethnic Minority project leading the way

The Chalo Chalay project set the foundation for the Let's Walk Leicester project; it used the framework used by the demonstration project, endorsing Chalo Chalay's protocol and procedures. The success of the intervention was measured by being transferred into the whole of Leicester from one locality.

The walks

Having the intervention in a walking group format was a success, as the participants liked to walk in a group and met other like-minded people. Also learning new things such as the local environment and being out in the open. Emphasis on the social aspect of the walks saw an increase in recruitment however; more emphasis was put on the health aspect once recruited. Having a choice of walks on the doorstep was a key factor of making the intervention a success as this allowed walkers to take advantage of their environment.

The walkers

The walkers had made the intervention a success via their enthusiasm and taking the risk of trying something new and their continuous effort, commitment and support.

Inclusion of cultural activities

A key aspect to the success of the intervention was the integration of cultural activities into the walks from using *gharba* (traditional dancing) as warm ups to singing *bhajans* (hymn's) in the park. It was innovative of the intervention to use a holistic approach and cultural norms.

Fun & enjoyment

This was a key theme in the success of the intervention from the evaluation of the pilot projects, making the walks fun was central to the protocol and adapting social & cultural activities into the walks brought new recruits and sustained participation. The walking activators and members of the group made this happen. The walks created an atmosphere of enjoyment, which extended out into other aspects of their lives. Even at the end of the intervention the walkers still felt that what drew them to the walks was enjoyment.

Simplicity

The simplicity of the concept of walking and increasing physical activity in a fun way attracted participants to the walks, simple yet an effective intervention.

Community spirit

A major success factor of the intervention was how the intervention was a catalyst for an increase in community spirit. It created a sense of family and community that was similar to being 'back home'. The local community had been the driving force and there was a definite belief in the concept and vision that made it a success. The walkers and walk leaders gelled well and formed a strong group, coming together; it was an inherent community spirit.

The cascading effect and advocating role

The walkers recruited onto the intervention were influenced by its positive message and the experience of the benefits cascaded down to their circle of family and friends.

The creation of a safe environment

The walkers felt that the intervention created a safe environment for them by meeting their cultural needs. Besides walking in a group and safety in numbers, they felt that having single gender sessions and walking activators that spoke their mother tongue influenced their uptake of the walking opportunities.

The evidence of the health and social benefits

The intervention used example of walkers that had experienced the intervention, and that had benefited via health or mental well being, to recruit other participants without these initial case studies it would have been difficult to recruit other community groups and walkers.

Continuous recruitment of community groups

The intervention showed good progressive practice, it continued to recruit further community groups and organisations.

The walking activators network

The network set-up after the end of the funding period supported the walking activators to continue running the walking groups and was a source of support.

High profile

The intervention had a high profile in the local community and also nationally, it was visual and this gave it the impetus and respect of all those involved.

Retaining cultural identity

The main theme of the intervention had been to listen to South Asian communities and consider their view points, and thus integrating these into mainstream projects but allowing them to retain their cultural identity.

There were fifty eight major factors that made the intervention a success, these were found at all levels and different stages, it was the process of integrating all these factors that brought the various strands of the intervention together.

9.6 Motivational Factors.

The essence of the intervention was the motivational factors that had driven it forward for it to be accepted by the local community and be ultimately sustained. These motivational factors can be generalised into extrinsic and intrinsic motivations. Those who are intrinsically motivated will perform an activity for the inherent satisfaction of the activity itself, while those who are extrinsically motivated will perform an activity in order to attain a separate outcome. Intrinsically motivated people tend to be better able to regulate their behaviour than extrinsically motivated people (Ryan& Deci 2000).

A key tool in motivating participants was incentives these could be external or internal. The walkers were the key people in the intervention that needed motivating, however on par were the walking activators, key individuals and community groups that were involved in the intervention. Once the walkers knew of the benefits of walking for health they were self-motivated to continue walking this has been also stipulated by Deci and Ryan (1985) in their theory of self-determination.

It was found that once extrinsic influence, such as the walk activators recruiting the walkers occurred, the intrinsic influence took precedence that is the walkers continued because they were self motivated, this was also found by Ryan *et al.,* (1984). The study (Ryan *et al.,* 1984) made an important distinction concerning motivation in exercise and sports that is between intrinsic and extrinsic motivated behaviour for participation. Both intrinsic and extrinsic motivational sources have shown in this study to increase walking activity, however, extrinsic motivation was temporary, and intrinsic motivation was the primary goal, this was also shown by Schnider *et al.,* (2003). For example many walkers were told by their GP to walk, an extrinsic factor that initiate the activity, it was once they attended the walks that they felt better physically and mentally an intrinsic motivation.

The extrinsic motivations is related to external factors (Vallerand & Perrault, 1999), for the walkers this included; the shuttle walk tests that helped walkers monitor their progress and pushed them to do more walking outside of the group. Devices such as step or calorie counters also helped monitor how much walking the health walkers were doing outside the group. Interest walks that integrating educational activities, such as guided walks were incentives, these increased enthusiasm and membership amalgamating the social aspects of the walks. Having places on the doorstep, which were quiet, pollution free, and were 5 minutes away stimulated walkers to continue walking. Discovering new parts of their environment motivated walkers to explore further a field and gave them a refreshing change.

Incorporating different component to the walks such as Tai Chi / Yoga kept the interest up of both the walker and walking activator. Incentives such as socials and trips kept individuals motivated to come back each week. Not owning a car was a motivation to walk short distances and to use it as an incidental activity.

Having professionals such as GP's stipulating that walking was beneficial to health simulated walkers to give it a go. Once the initial step had been taken to join the walks, the motivation that sustained their attendance was the experience of the health and mental benefits of walking, which were verified by their own GP's and consultants. Thus, fitness activities often start with an extrinsic source of motivation, such as 'doctor's orders', and as the individual

sees increased benefit and reward motivation is slowly internalised. Those activities that are performed with more fully internalised regulation were shown to performed better, the walker had larger increases in well-being and feelings of goal attainment, and was more likely to continue with the activity (Deci & Ryan 2000).

The walks themselves were a motivational tool, walking in a group, meeting friends and having a social made walking for health more easy as it was being around 'like minded people'. The walk leaders also motivated the walkers on all levels. A key motivation of the walking groups was meeting with their peer group on their doorstep, who they could share and solve their problems with. The walkers were motivated to walk outside of the walking groups and thus individuals had taken on the key concept of the intervention. They were motivated to walk in parks and open spaces that were quiet. The walking groups were a motivation as it prevented participants from walking alone.

The group dynamics drew walkers back each week as they were a likened to a family and were similar to the group dynamics they had back at home in terms of closeness and making your neighbours your bothers and sisters. The activity did not cost anything and this motivated individual to come and do something constructive about their health as often cost was a barrier to participation.

After the intervention period the walking groups sustained themselves as the community saw and felt the benefits for themselves, their families and their local community, this motivated and drove them to taking responsibility and to lead the intervention. Physical motivations for walking activators were reimbursement and payment for their time.

Having a project coordinator to drive the intervention was a prompting factor as they brought the various aspects of the intervention together which lacked in other demonstration projects that did not have a coordinator.

The above motivational factors gave the participants the incentive to join and create activities outside the walking group. A key theme for walkers to sustain the intervention was that they were learning new things about their environment. It was important that extrinsic

motivational factors were identified so they may be understood, and replaced or integrated into a larger picture of what drives the individual.

Intrinsic motivation refers to an individual who participates in an activity simply for the satisfaction of doing so (Fortier, *et al.,* 1995). Intrinsic motivation applied to walking as it became pleasurable to the walkers it was found by the study that most walkers will not stick with an activity that they do not enjoy this was found in other studies by Ryan & Deci (2000).

The intrinsic factors for the walkers included self-motivation, positive thinking and gelling within the group that pushed walkers along. This is further supported by studies positively linking self-efficacy and perceived ability to performance outcome, feelings essential to intrinsic motivation (Rhodes, 2004). Intention, positive attitude toward exercise, feelings of self-efficacy, and competence were consistently higher in individual's who are participating in the recommended amount of physical activity, and all these feelings supported intrinsic motivation (Deci & Ryan 2000, Gauvin 1990, Godin & Shephard 1990, Kerner & Grossman 1998, Rhodes, 2004).

The health and social benefits of walking were reiterated often and these re-motivated individuals to continue walking. The physiological factors, which motivated the community groups, were the ongoing positive feedback to them on the progression of the intervention. This is supported by studies that have shown that negative feedback decreases performance when compared to no feedback at all, while positive feedback increases performance (Deci & Ryan 2000, Tenebaum 2001). When the walkers received positive feedback on their achievements they continued to focus on what they are doing right this was also found by Deci & Ryan (2000).

The physiological motivation was volunteering and the concept of *seva-* helping others informally without recognition. The walk leaders were also motivated by the strong friendships they had made.

The average age of the walker in the intervention was 55, and followed the trend of other projects that recruited older people, it was an accepted form of exercise, it was shown to promote the quality of their lives which was a key motivating factor together with the reduction of social isolation. Meeting peers of the same age gave walkers the confidence to participate in the social activities.

The key motivational factor for participants once onto the walking programme is the 'high' they receive from walking that gives them the self-esteem to continue. This is related to model of the psychological effects of exercise (Spencer 1994), that is the external motivating factors to exercise, emotional 'lift' or 'high', negative thoughts replaced by positive, increase in self esteem and thus confidence which spills over into other areas of life. This was seen in the participants who took up the intervention, just by attending the walking they began to participate in other social activities organised by the group.

Setting goals for the walkers would have been the next step for the project as generally people who set goals are happier and healthier than those who are not (Carpenter 2001). Goal setting was done with the walking activators who were offered further training. Deci and Ryan (2000) further support this as long as the goal provides basic needs satisfaction, and is focused on intrinsic aspirations. Improved health has to be, or becomes, an intrinsic aspiration, which was found with the majority of the walkers. Increased health becomes the motivator and it promotes further activity such as independent walking and other fitness related activities such as exercise to music. Improving health in turn promotes more activity and this was also found by Deci & Ryan (2000).

9.7 Chalo Chalay delivering governmental 'New Deal for Transport'

The intervention has been central in assisting local strategies that is the Central Leicestershire Local Transport Plan 2001 –2006 Walking and Cycling Strategy, a component of the National Integrated Transport White Paper (New Deal for Walking 1998). Chalo Chalay has facilitated the 'new deal for transport' by increasing the number of people using walking as a

part of their everyday journeys and also by raising the awareness of walking for health and the promotion of a greener environment.

One of the key aims of the strategy was facilitated by the Chalo Chalay was the improvement of the attitudes of local residents to walking. At the end of the intervention period more people used walking as a part of their daily journey, such as shopping. Also an increase in incidental walking was reported that is going to the post office or picking up the children. A small change was seen in improving the safety of walking, as walkers felt comfortable walking in groups, and were more visible. More walkers using the streets and parks naturally increased safety and surveillance.

Chalo Chalay walking groups were consulted and involved in the writing of the local strategy. This was the first time that isolated South Asian communities had a means to state their opinions and see a constructive change. The key element was the writing and accepting of the local walking and cycling strategy, which came into its delivery phase at the end of the intervention period. The majority of aims and objectives were longer-term environmental changes, which would be delivered with longer-term capital investment. However, the strategy supported the ongoing success factors of the intervention in particular the improvement of public health.

The main theme of active transport was to get away from walking being a leisure pursuit or a formal exercise. The walking for health initiative contradicts this by making walking structured via walking groups. However, it does have a cascading effect in that walkers with family and friends walk outside the group and make a conscious effort to include walking as an incidental activity.

It is more easy to influence individual behaviour by the environment they are in rather than trying to change their individual character Bowis (1996), thus by offering viable active transport means would enable individuals to make an informed choice. Giving the residents of Belgrave in Leicester the option of walking in a group changed the environment, rather than their individual character. Providing the option of walking showed behaviour change and this influenced the behaviour of the wider community.

9.8 Universal Walking

It is only when something as simple as the option of walking is taken away, that there is a realisation, that we are imprisoned. This may lead to frustration, stress, guilt and disillusionment. If the option of walking was taken away, what is it that we would really loose? Walking is inclusive in many components of every day life; in incidental activity, health & fitness, emotional well-being, and culture. It has been used by many of our great leaders as a form of meditation and to gain clarity in thinking.

Walking in this study has been shown to be used as an incidental activity, via walking the children or grandchildren to school, during shopping, doing every day errands such as going to the post office, or a place of worship. It is the most natural mode of transport and costs nothing to the participants, building on this incidental activity, meets the national guidelines that would prevent major illness. Taking this a step further some walkers use the activity for leisure by taking walks in open green space, undertaking hiking holidays and thus using it as a part and parcel of a health and fitness regime. Power walking is increasingly becoming popular means of getting fit. Walking for health is not a new concept, people have been using it for centuries as a means of keeping active, over the years due to modernisation and increased mechanisation, there has been a need to reintroduce one of the most natural forms of exercise, walking.

Walking for emotional well being and mental health was a major outcome from the study, participants reported on how their depression had lifted and noted a reduction in their intake of anti depressant medication. In the UK a high proportion of the population at some point in their lifetime would suffer from depression. Physical activity and exercise have been shown to ease symptoms of depression. Thus, walking can alleviate anxiety of participants, and the psychological effect of exercise can prevent depression and can be used in the treatment of (Folklins & Sime 1981).

A healthy mind leads to a healthy body and by simply taking a walk in the fresh air and greenery helps relax the mind. It's a natural trigger for humans to take a walk to clear the mind when they are exposed to stressful situations. Gandhi Bapu a renounced scholar writes about the benefits of long walks:

'I may mention however, that I was none the worse for abstaining from exercise. That was because I had read books about the benefits of long walks in the open air, and having likened the advice, I had formed a habit of taking walks, which still has remained with me. These walks gave me a fairly hardy constitution.'

M.K.Gandhi 1958. My Student Days.

Walking is seen to be a natural part of our cultural heritage. Why were we given legs, joints, feet and toes? They must have a purpose. Apart of the South Asian culture is the notion of pilgrimage to pious places of worship, Mecca, the Golden Temple, the river Ganges. These pilgrimages are done on foot, and are counted to bring good luck and fortune. Within the philosophy of the Hindu culture, to do a pilgrim or 'Jathatra' bare footed to a chain of temples, which are usually situated on top of mountains and hills, are counted as pious. In most South Asian traditions one enters the place of pray-bare foot, this is a mark of respect. Being bare footed allows a connection with mother earth and is grounding. Walking on sand, grass, and smooth pebbles is a form of relaxation, and puts pressure on the reflexology points on the soles of the feet.

Walking is thus universal, it's our gift from the day we learn to balance and walk on our two feet. Our great leaders have been practicing it from the beginning of time as a form of mediation, transport and connection. It is stated in the Hindu scriptures of the Gitaji that;

'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

Moderation and balance leads to a healthy and long life, great leaders and incarnations such as Gandhi, Nelson Mandela, Mother Teresa, the Dalai Lama, Lord Krishna, Lord Rama, Jesus, Mosses, Mohammed have set us an example of how we can use the simple act of walking in our lives to enhance our physical and spiritual well-being.

9.9 Group Dynamics

A major element of the success or failure of the intervention was the understanding of group dynamics. A concept that became apparent through the study when working with South Asian cultures, splitting of genders is the normal cultural behaviour. It can be compared to oil and water, where by the two liquids do not mix, unless a surfactant is added and crystallisation occurs. The Ethnic Minority communities of UK can be compared to the oil, and the community at large the water. There has been an on going effort to integrate Ethnic Minority communities, but has failed due to the lack of understanding on the basic principles of the community, and thus separation occurs.

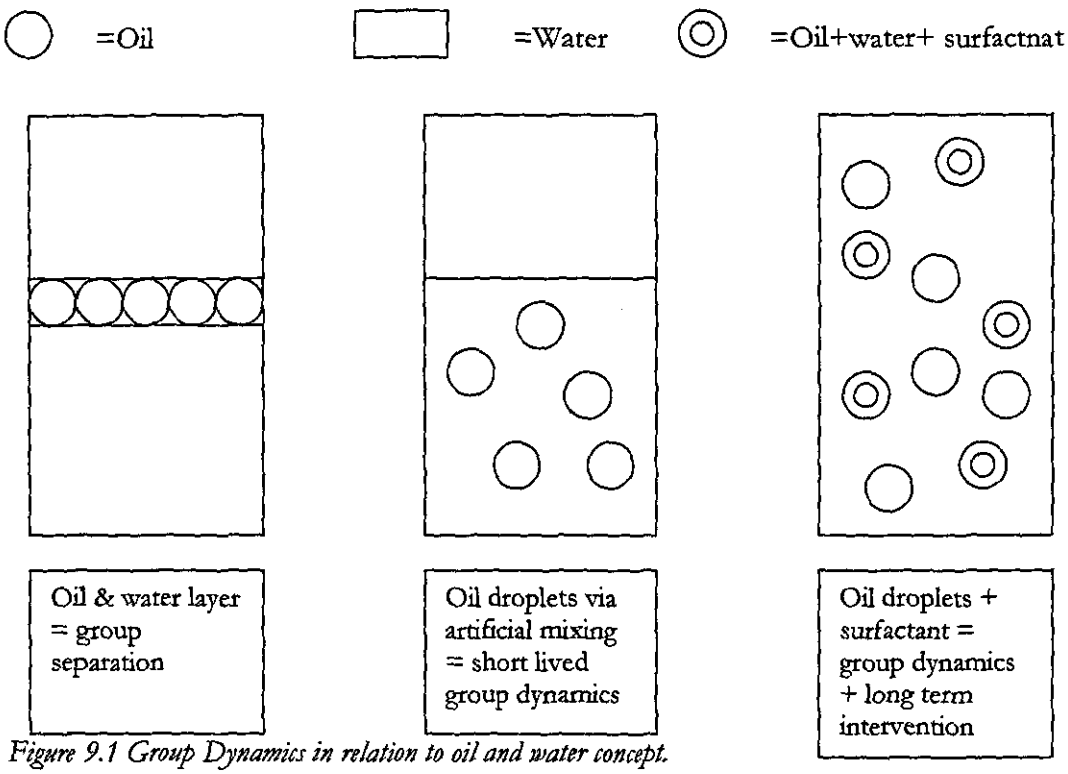


Figure 9.1 Group Dynamics in relation to oil and water concept.

Often artificial interventions that are not researched or developed are delivered and produce short-lived group dynamics, which are not sustainable. Adding an intervention into a known group dynamic act's as a surfactant that produces long-term suitability in the medium. Thus, in the present study the group dynamics of the South Asian community were accounted for and naturally the intervention delivered separate genders sessions. These formed a strong emulsion into which other racial minority communities could be added that does not affect the overall group dynamic. Forming a group that are like minded builds their confidence,

there is safety in the majority, thus when others are added into the group dynamic it does not loose it balance and is more likely to form cohesions with other communities.

The group dynamics concept could have been applied to the steering group. An artificial mixing of voluntary and statutory representation set it up and there were more balances of power towards the statutory sector. If a strong voluntary group were set up, with the correct support acting as the surfactant then it would have been easy to add in statutory sector representation, and would have not shifted the balance of power.

The concept of group dynamics has been developed through this study, and observed through various mediums, it can be applied at all levels, from grass roots to senior management.

9.10 Future of Walking for Health

Current transport structures as stated in the active transport guidance (Davis 1999) do not support walking but car travel. Convenience is a major issue and if drastic measures are not taken, there will be a continuing trend in the decline of walking and active transport modes. To address this a holistic approach needs to be taken and partnerships between all sectors to deliver this agenda, the walking for health initiative has taken the first step by forming these partnerships and has been a catalyst in forming these partnerships at a local level. Often partners have different ways of working and delivering the same agenda this makes the process slow. There are clear health, environment, social and economic benefits of walking that have been demonstrated in this study, however the government priories are still to expand our motorways, for example a 7 billion pound investment was announced by the government over the next 10 years and has sent a clear message of where its priorities lie. A number of initiatives published by the government have demonstrated their recognition of the connection of transport, health and environment, documents such as Our Healthier Nation, Department of Health (1998), strategy statement on physical activity (1996), and the Integrated Transport White Paper (1998). At the same time there has been a delay in the launch of the national walking strategy and the setting of unrealistic targets that have failed to be met in the short turn around times.

Walking as a mode of transport has been neglected for three generations, thus the launch of these strategies and change in policy was to win hearts and minds. Thus, the future of transport was set to be a multi model and with walking having a vital role, however changes were needed on the ways of walking and for it to become a priority. Targets were seen as an essential part of this new deal from 200 to 250 miles per person by 2008, and the operational targets needed to be set locally. Overall actions needed to be based on four themes; local transport plans, land use planning, partnerships and common sense actions.

Walking needs to be considered as an overall policy that promotes safer, greener, and healthier travel. It is not suffice just to make the environment saver and convenient for walking but to focus its campaign on incentives such as subsidies to walk short journeys to work, school and to use it as a glue with public transport.

The future of walking for health in Leicester as stipulated by the Let's walk Leicester coordinator indicated that it needed more resources and time as it was a difficult task of engaging individuals from a deprived area. However, Chalo Chalay via its programme tailored to the needs of the local community increased participation, these elements could be transferred to deprived communities. It was further specified that individuals walked as part of their daily routine but required a different methodology to promote walking for health.

There is an interest in Walking for Health by the health sector as it is the best buy for public health Erens *et al.*, (2001), it can link in with health and sport action zones, parks, GP referral schemes, and safer routes to school. The profile of Chalo Chalay promoted links into community development and gave other similar interventions the impetus to develop further partnerships with young people via crime & disorder and youth offending teams.

Funding for walking for health was received from the health action zone for five years, further funding of 37.5K was secured from the Walking for Health initiative (WHI) for three years, of which 7.5 was allocated to Chalo Chalay to sustain walks set up. Chalo Chalay's direct bid to WHI was not successful, a number of reasons can be hypothetically listed of why the HPA received funding and CIO did not but no further evidence can be provided to

back these reasons. CIO's overall track record with the WHI had deteriorated however the same could be said for HPA?

Overall for Walking for Health to be a real option for Leicester the Primary Care Trusts would have to commit a lot more resource, it would have to work in partnership with all stakeholders and move forward on a holistic approach.

9.11 Summary

The study addressed the lack of participation of South Asian communities in physical activity and sport, with a particular reference to the promotion of walking for health. It concentrated on removing barriers to participation such as providing an intervention that had bilingual walking activators, single gender groups, was lenient on dress code and supported the wearing of cultural dress. It ran the sessions in a familiar environment and walkers felt safe walking in a group. The intervention by-passed many of the barriers put up by local facilities. It focussed itself around the community and was driven by the participants from where to walk to organising of socials outside the group. The intervention was fortunate to have two community champions, which were the catalyst for this process and were instrumental in the sustaining of the walks at the end of the intervention period. Word of mouth was the best publicity of the intervention, which had a cascading effect whereby walkers influenced their peers to walk outside the group. There were no major reasons why the South Asian community in Belgrave in Leicester did not participate in the intervention, the only stipulation was if they were physically not able to, however the intervention could facilitate the use of wheelchairs.

The methodology built an accurate picture of the intervention. Relating action research to the upward spirals of DNA assisted in the intervention framework (figure 3.7), which can be transferred to any other health promotion or physical activity intervention. A balance of quantitative and qualitative data was procured through the research tools used. The case records and action research were time consuming but were effective in collecting data which otherwise would have not been collated and analysed. The researcher needed to have bilingual skills and have an awareness of the South Asian culture. Having the human

resource that could deliver the specifics of the intervention was difficult and was an added pressure to the action researcher.

The foundation project gave the intervention the impetus it needed to move forward onto running the pilots. The preparation of change process was successful, as the foundation project had made the links into community groups where the intervention could be tested safely. The steering group was fortunate to have a voluntary project that already had strong links into the community and could easily deliver the intervention. A key strength of the intervention was the partnership, and having key individuals to support the concept. However, when these individuals moved on the key link went with them, it was thus more important to build partnerships with organisations and be inclusive of working closely within policy frameworks.

The pre intervention consultation showed that more South Asian men than women walked, the post intervention results were contradictory in that more women than men were recruited, this may be due to the women feeling safer walking in a group whilst the men may have been happy walking independently.

The consultation prior to the intervention flagged a number of barriers that prevented residents of Belgrave walking. The key barrier addressed was the opportunity to walk in a group. Little progress was made on addressing the barrier of a poor environment for walking. The intervention had linked into Local Authority environmental projects, these were delayed and thus were out of sync, and this was disheartening for all intervention workers.

The residents found places of interest on their doorstep, which they never knew existed, the perception of lack of safety was alleviated by walking in a group, although walkers were not convinced to walk alone on these routes. Belgrave is overcrowded and there is pressure on facilities, the intervention provided an alternative means to using resources on the doorstep that were under used by the South Asian community. There had been a history of short term projects in the locality with short term funding, thus residents were sceptical, the

intervention from its inception aimed for self sustainability and initiated providing the locals with the skills to manage the intervention.

The steering group formed at the pre intervention stage was recognised to be too large and top heavy. It was suggested by steering group members to have a smaller focused management group with a larger advisory panel or operational group, or a sub group for each of the strands, these could have been formed to feed into the central steering group, all of which is in hindsight.

The role of walking activators was developed throughout the intervention, they were much more than volunteer walk leaders, and were seen as an invaluable resource into the community. They progressed into becoming community champions and undertook being peer educators and role models. They helped to understand the concept of volunteering in the South Asian community and promoted the concept of '*sewa*'– service back into the community, an element that was integrated into the role of a walking activator. These key champions were vital to the intervention and sustained the walking groups after the funding period. The major advantages of using local community members was they had the inherent skill's to promote the intervention to their local community, they had the understanding of what would be acceptable and motivating to their peers, besides being able to speak the language.

A number of lessons were learnt through bad management decisions in particular having the coordinators post part time in the initial phase of the project although it integrated the evaluation and research element of the intervention. The hosting of the intervention by the voluntary organisation seemed ideal, however it was unfortunate that the organisation was going through its own management change. It would have been more productive to have the administration of the post by the steering group members in particularly the Health Promotion Agency, and then the intervention would have had the best of both worlds. This was an ongoing issue during the development phase of the intervention, the strong partnership that had secured the funding did not transcend down to an operational level. However, as with any project one needs to go beyond politics and work with the resources available, which the intervention managed effectively. A few committed individuals made the

intervention work both at a grass root and management level. Funders were keen to see it work, and provided on going support.

Project planning in the initial phase had been done from a statutory viewpoint and this was quickly amended to include realistic targets at an operational level. What the intervention did lack during these initial phases was community input and focus. Thus, at the end of the intervention period this had to change with the setting up of the walk leaders network.

The walking for health concept had been delivered to the middle class in the South of England there was scepticism at the start of the project whether South Asian communities would accepted walking for health, which had worked with these communities but never tried with inner city residents. After culturally tailoring the programme, surprisingly the intervention had been taken on by the local South Asian community quickly, and was a well-respected group.

Engaging with the South Asian community was effective by working along side community champions. The building of trusting relationships took time, and the walking activators after a year of walking with the group began to lead their own groups and after the end of the funding period took responsibility of managing the group. During the initial period the community group needed a lot of support and were not vocal or driving the intervention forward it was only after a period of a year that walkers began to take direction. Building trust of the community and the walkers was a key element of the intervention; a standard of etiquette was adhered to when working with older South Asian community members.

Running the pilots prior to launching the intervention was key to refining the processes and protocols. On this smaller scale behaviour change was noted in the short stint of four walks. The activity coordinators of the community projects were helpful in facilitating the pilots but could not run the walks after the pilots, it was fortunate that the volunteers at the project were keen to get involved and continued the walks. At this early stage participants had knowledge of why walking was good for them and were willing to give it a go. Upon reflection it was due to an outsider coming into the community group that motivated users to participate. In the past the activities coordinator found it difficult to motivate individuals.

The pilots also identified the difference between a health walk and walking for pleasure, it did however integrate interest walks into the health walk protocol. The social aspects of the walks were important to motivate individuals to join but these had to be balanced against raising the heart rate of the walkers. Most of the pre intervention apprehensions such as the doing stretching exercises in open air; footwear and having male walk leaders leading an interest walk were dispelled. The women due to being in a group were not bothered about these things and the footwear they wore was safe. At this stage it was felt that the walks would need to be based around an interest or activity for them to be taken up on a regular basis, however as the intervention progressed, the walks had become a part of the walker weekly routine and a social to meet with friends, thus needed no other incentive to attend.

Evaluation tools were developed throughout the life time of the intervention, a key success was the production of the first ever walking activities questionnaire translated into Gujarati (Appendix II) then into four other South Asian languages. This questionnaire was the first of its kind translated nationally. The evaluation team worked closely with the translators that facilitated the quality data obtained from the questionnaires. The intervention highlighted that most of its development time was producing resources in South Asian languages and entailed a cost implication.

One to one meetings and raising awareness of the benefits of walking facilitated the recruitment of community groups. The intervention was undertaken by community groups on the pretence that the Chalo Chalay staff support and deliver the intervention. It was fortunate that volunteers from these community groups were willing to be trained to run the walks. Community groups initially hosted these walks but by the end of the intervention period they had become independent.

The three demonstration projects were all successful as a year into the projects they aided the National Walking the Way to Health to secure a further £6.4 million from the new opportunities fund to develop and support a further 200 walking for health schemes nationally. In total the demonstrations helped procure £11.6 million for the scheme nationally. There had been a trend to move away from fitness, and to go toward physical activity, from a structure only approach to an active living approach.

Translating research into practice via action research had made the process more accessible. This study has shown to engage racial minority communities in an intervention which has only attracted white middle class and middle aged participants (Hillsdon 1998), it had done this by culturally tailoring the intervention and targeted it in a geographically boundary that had a high proportion of racial minority communities.

The intervention has provided evidence of the links between the health of an individual and the health of the community. In this era the community and family structure have been fragmented increasing the risk of poor health amongst the disadvantaged and excluded. The intervention, through the focus of walking for health had created other social activity such as picnics, playing games, celebration of birthdays, festivals and religious recitals, recreating a social structure. Via arts and creative activity, healthy living was promoted and thus, having a healthy mind promoted a healthy body.

The analysis of the walk factors showed that there was drop in the number of walkers during summer hot weather, contradictory to assuming that a drop would be seen with colder winter weather. No walks were cancelled due to the weather; a drop was more likely to be seen during religious festivities, which could thus be linked into the walks. It was found that both men and women pushed for the social elements of the walks rather than the health ones which were seen as a bonus. There were clear differences in the way the men and women's groups managed themselves, the men's group lead themselves without a 'specified walk leader', this worked well for them as they shared responsibility between the core members, whilst the women group needed an activator to act as a role model.

The women's group who eventually wore trainers to the walks showed a behaviour change, however other women in the group were happy to wear sandals. No major incidents had occurred, and all walkers were safe.

The case studies showed that the intervention increased walking in the community by 25% to benefit their health via data gathered from the walking activities questionnaire compared to the shuttle walk tests that showed an overall increase of 22% over a period of 28 months.

Walkers that had been consistent over 22 months showed and improved level of fitness. Six doorstep routes had been developed in the geographical boundary, two regular led walks in the first year and seven in the second year outside the boundary. Testing and translating the paperwork such as the ParQ's, and behavioural questionnaires took up a bulk of the development period.

The interest walks and reiteration of health messages were incentives for walkers and potential walkers. The social aspects of the walks became more apparent as venues for a tea breaks were identified. The venue helped facilitated the conducting of the evaluation as it was integrated the shuttle walk tests, interviews and filling out the behavioural questionnaires. Indoor walking during the winter period was not as popular, and walkers preferred to be outdoors.

Unexpected barriers such as friction from development workers pushed volunteers to become independent from the local authority facilities.

Walking activator training was developed using previous good practice in engaging South Asian women. Key was the recognition of *sewa* or service back into the community, the intervention could have capitalised on this concept more when recruiting volunteer walking activators. A large proportion of the development phase was used to test and pilot the training that was culturally tailored to suit the needs of the participants. Translation occurred during the delivery of the programmes and extra resources were needed to translating the material. Participants who undertook the training felt that a one-day training was not suffice and they needed more to feel confident to run a health walk. The intervention found that it recruited more women walking activators than men and more women than men completed the training.

A targeted publicity campaign was conducted that was inclusive of the concept of *'verwar'* or building a rapport with communities this supported the word of mouth, which was the strongest publicity element. The walking activators also sold the intervention to peers via being role models and to communities groups via local events. Having interest walks also increased the publicity of the intervention, as friends and family can be introduced to the

programme without feeling pressurised to make a commitment. Using targeted launches helped to maintain the enthusiasm of the local community. It was important to maintain equality with all communities and what may be appropriate for one community may not for another; careful research should be conducted before delivery.

The delivery phase of the intervention was frustrating as the structure of the financial system was difficult to access by the new coordinator, the budget was held by the host organisation and the health authority. The steering group really did not have the power to make any decisions about the budget. The impact of the project coordinator leaving, was minimal as parts of the project continued. It was beneficial to the intervention as the post became full time and the boundaries of research and delivery were clearer. The management structure of the intervention needed to be more productive, it was very top heavy and partners had very different ways of working. As with all new partnerships the initial period can be difficult however the partnership did not grow. Besides these core management issues, the grassroots level work continued to grow and in a sense the coordinator received more support from the community groups and walkers than management.

Core strength of the intervention was that it provided capacity building to individuals via pathways to progress. It offered further qualifications and training that would not only benefit the individual but also the communities they served.

The intervention was under a little pressure to deliver progressive practice, as it was the only demonstration project funded BHF/ CA that was totally dedicated to Ethnic Minority communities. This was clearly not enough and the WHI needed to recruit more Ethnic Minority projects. The WHI lacked in addressing other Ethnic Minority groups and it could have demonstrated a lot more commitment by supporting other Ethnic Minority projects and encouraging more Ethnic Minority groups to attend its national conference. Chalo Chalay was the only progressive practice and was only a drop in a huge ocean, Chalo Chalay can be seen as the drop of essence in perfume.

The geographical boundary was expanded in year two of the intervention, which facilitated the recruitment of a wider group of Ethnic Minorities including Muslim communities and

thus increased the overall number of participants. The GP referral strand of intervention progressed and the training of health visitors as walking activators was key. The intervention was strategically placed to work with the CHD prevention programme for South Asians, Project Dil and the Active Lifestyles Referral Scheme. In theory this was a key partnership, to deliver this strand of the project as all three interventions mutually benefited.

The intervention was held back by the lack of internal support from the host organisation during the first year. It had to recruit a whole new management team during the second year of the intervention. Thus, initially there were many teething problems that were remedied but the host organisation continued to have persistent problems. Again it was individual workers that made the intervention work not the organisation. The host did not address key logistical issues such as an easy to access financial system and no administration staff during year one of the intervention.

To attract the right kind of worker the host raised the salary of the post and undervalued its current staff members. It was unfortunate that the intervention was placed with the organisation that was undergoing so much change. There can be speculation if the intervention was placed in another voluntary organisation or within the statutory sector or academia would the intervention have different more significant outcomes?

The visualised problems with steering group materialised and they were under more pressure to deliver due to the lack of management support from the host organisation. The structure was not conducive, variations were suggested and if taken on board may have prevented the group becoming dormant. There was evidence to suggested that tokenism work towards Ethnic Minority communities was seen during the intervention period, by the Health Promotion Agency, South Asians interventions were always passed onto the only Black worker at the time. Things have drastically changed at the HPA but there was certainly a feeling that workers from Ethnic Minority communities were automatically given the tasks. A level of politics were played between organisations and sectors, what looks good on paper and meets the needs of the current government are shown but are not realistically delivered. Often it is individuals that make the partnership work and not the organisation conversely if individuals are forced into a task they will not perform. It is unfortunate that only links into

the Ethnic Minority community happen through Ethnic Minority workers, and if they were not in post these links would not materialise. There was an overall lack of trust between intervention partners this caused the intervention to lose out on many options and pathways. This overall lack of support pushed the intervention to secure partnerships and beliefs of walking activators and walkers.

Evidence from Ethnic Minority workers within and outside the organisation suggested that the HPA stemmed institutionalism racism, which affected the partnership. The tread of tokenism ran throughout the intervention period and a lack of support was shown. The question may arise if the Ethnic Minority worker employed were not in post would there have been such commitment? At the end of the intervention period funding was not extended. This ultimately affected the users of the intervention, as the opportunities offered were limited to the capacity of the committed individuals of the project. Even if these were the perceptions of the workers and the host organisation it's the foundation upon false and closed partnerships are formed, and thus overall unprofessional behaviour on all sides. The innovative ideas should have been written in all strategies, project plans, and mainstream funding should have been received. Leaving differences aside and learning from mistakes the intervention had overcome so many barriers it would have been successful without the additional barriers put up by professionals.

The partnership between the voluntary and statuary sector theoretically was a sound concept but in reality needed five to ten years to mature, having short term funding was setting up a partnership to fail. Until there is long term commitment from funders this will continue to sabotage small voluntary group projects. Behaviour change for participants was carefully thought, but this change was also applicable to partners who did not anticipated it, they were naive to think that it could hit the ground running.

The resignation of the combined role of the coordinator and evaluator to become adviser and evaluator, brought with it the changes the intervention needed, in that it became a full time post. It was difficult for the coordinator to think constructively and critically in the situation, however being removed from the situation, clarity was redeemed. There were major positive changes at the host organisation that enabled the intervention. It received the

support structure it needed internally, and what was previously attained from the steering group dissipated as the steering group disbanded after the resignation of the chair, the director of health promotion, a key individual to push the agenda forward.

The funders stipulated, the increase in the number of walkers and to address the criticism of the lack of other racial minority communities, this dictated the philosophy of the intervention to change. These two stipulations caused a knee jerk reaction by expanding the geographical boundary, which there were clearly no resources for. To work with individual racial minority communities were interventions in themselves and to be watering them down and spreading resources thinly would not do the community or the intervention any justice, as it was not self-sustainable. Twelve months into the intervention these stipulations were unfair and that payment of walking activators was a short cut to the original aims of the intervention. However, those who commenced as volunteers on the project continued even after the end of the funding period.

Transferring the intervention to another geographically boundary had logistical problems, which could have been overcome by working holistically with key partners in the locality such has the neighbourhood renewal fund team. Key issues were the lack of pleasant places to walk in inner city localities, which were on the doorstep.

The second strand, which corresponded to year two of the intervention, was slow to progress. Although the key elements such as other project partners were in place for the GP referral scheme to happen. However, the components were out of sync, again a perfect, mutually beneficial partnership theoretically but in practice difficult to deliver clear project outcomes.

The third environmental strand of the intervention was unrealistic and the proposed changes and projects had too many variables to be in sync with the intervention. It was a key element to the project and needed a constant feeding mechanism into the strand that helped shaped future developments and allowed residents that had been isolated from the consultation to air their views. The increased understanding of the locals of the various departments and objectives of the environmental allowed them to push or resist these changes. Five years

since the inception of the intervention, the environmental changes were going to provide a better walking environment for the residents of Belgrave. These have still not been implemented, however the safety measures of reducing the speed of traffic have been put into place.

The setting of realistic targets was a key issue for the intervention, reviewing targets on a regular basis helped to focus outcomes. This should have assisted partners to be critical and open about what it is that they want from the intervention. It was important to be flexible as most lessons were learnt through mistakes and were thus incorporated into the toolkit for other interventions to consider.

The role of the walking activator was sold on the stipulation that it was a service back into the community (*sewa*) and moved away from the more formal concept of volunteering. This was a key understanding within the South Asian community and helped to facilitate the recruitment of volunteer walking activators from the local community. An independent report on the three demonstration projects by the Institute of Volunteering showed that there was a narrow recruitment drive, which needed to expand itself. Those volunteers that were recruited were previously walkers with the intervention and were convinced of its benefit to become walking activators. The walking activators felt unsupported by the host organisation and did not appreciate the level of responsibility they had. They felt they had no powers to influence the project and did not feel appreciated. There was a gap in the intervention and it was not addressed which was a significant weakness of the intervention. Building a rapport with the walking activators and thus the local community was a clear indication of success, the individual workers on the intervention needed to have these skills and these were not constant through out the intervention period.

There was an overall high drop out rate of volunteers that undertook the training and did not continue the walks, due to the underestimation of the amount of time it would take up. There was a genuine interest in the opportunity however flexibility in time should have been endorsed by the intervention. A further analysis showed that that the volunteer walking activators were not confident in leading walks with one days worth of training and would have liked to be supported more and would have liked more training. The intervention

addressed its recruitment process and stipulated an informal interview process that showed the commitment of the volunteers and identified areas of further training and support. When the walking activators were committed to the intervention there were many benefits that they personally gained and which cascaded through to their local community and environment, although it was a double edge sword that there were a number of factors that they were demoralised by. The lack of support from the host organisation and the bureaucracy produced a ripple effect.

The intervention successfully increased the number of walkers which was made possible by expanding out the geographical boundary and the payment of walk leaders, ten walks were up and running and were aiming to be self sustainable.

Chalo Chalay was a landmark for the other 60 Walking for Health initiative in Leicestershire; an Ethnic Minority project had demonstrated that Walking for Health is an acceptable form of physical activity for inner city deprived communities. However, the intervention was seen to be highjacked by the HPA Let's Walk Leicester project that received the funding from the HAZ and WHI and was written into Leicester's health and physical activity strategies. There were many 'sensible' reasons for this to happen; however there was a perception of the Ethnic Minority communities were yet again left high and dry. The premise of being used as a guinea pig and then left to survive was further evidence of the lack of real support from the HPA. Further funding for the intervention was not secured which was unexpected as it was a stipulation at the beginning of the intervention that there was commitment from the funders. Politics were played between partners in that the HPA received funding for the Let's Walk Leicester project. In the eyes of the community the small racial minority intervention had been swallowed up by the statuary sector. There was a real lack of understanding of keeping the intervention out in the local voluntary sector. HPA became a dictator to Chalo Chalay and its overall structure; there was a fear of its amalgamation into the HPA Let's Walk Leicester instead of it retaining its own identity.

No formal exit strategy was in place for the intervention and this had key repercussions, there was a fear around the minimal funding received by the HPA to continue to sustain the walks over a three year period, however it was the only resource it had. There were certain

politics that were played for the host organisation not receiving funding, and on their part not getting their act together, but as with any voluntary project there needed to be patience. There was an attitude around the host organisation that rippled out into all sectors. Having trust in the community would have been a better approach, but it was unfair for key people to label the organisation and not to give them a second chance. Instead the host organisation came to an end and the intervention was integrated into HPA's Let's Walk Leicester project. It was unfortunate that none of the partners aimed toward integrating this function into the local community. An evidence-based story can be seen from the application and allocation of the funding pot that favoured the HPA, which used the good practice of Chalo Chalay and was a key part of the HPA's work programme.

The Chalo Chalay project was the first Ethnic Minority project to pave the way for other generic projects in Leicester instead of celebrating this, its was engulfed in politics. Simply by making this statement it would have given the Ethnic Minority voluntary sector a vote of confidence on to continue building many more partnerships with the statutory sector. To be given one fifth of the funding to continue to sustain the walks set up Chalo Chalay, seemed outrageous and not to continue the development work went against the original intention of the WHI. Irony of the situation was that the objectives of the Let's Walk Leicester programme mirrored the original aims of Chalo Chalay and was a expansion to be inclusive of the whole of Leicester.

There was a clear indication that the intervention had recruited from its target population, 57% of the participants were inactive before the intervention and the rest who were thought they were active at 43% said that these activities did not make them feel out of breath. Small percentages used the intervention as rehabilitation from CHD and by pass operations. There was a definite need to reaffirm clear physical activity messages with the South Asian community in particular the South Asian women. Walking had been suggested to the women by their GP's but no indication of where and what intensity the activity should be done. Some of the women were fortunate to have husbands, which influenced them to walk.

During the end of the first 4 months of the intervention the women began to feel the benefits of the walks, as their leg pains that originally stopped them participating in walking

ceased and it had also lifted them from depression. It helped them through menopause, which had not been, or stated by any other studies. Whilst the men felt more of the social benefits than the health ones, as they believed that they were physically active before the intervention. The most significant benefit for all the walkers was that it gave them the confidence to join other activities.

The intervention successfully recruited its target group, via using a key venue that the locals used. This initial catalyst cascaded the recruitment via word of mouth, which, was the main tool to recruit isolated individuals. The GP had also told a small percentage of the participants to walk, but they were not told how to go about it, thus there was a potential to target this avenue.

The social benefits of the walks for this particular group were out weighted by the health ones. It helped individuals to meet other like-minded people via a safe group setting, and reduced isolation and depression. The effect of healthy mind, healthy body was significantly apparent from the study. Participants under the care of health care professionals such as physiotherapists and specialists in diabetes's were impressed with the reduction of ailments and medication.

The walks significantly increased participant's stamina and encouraged them to join other activities and not isolate themselves from the community, as they made friends and increased the overall influence of peer pressure. A significant factor that promoted walking was the influence of family and partners. The more family support that was given the more independent walking was recorded. The social aspects kept participants interested and the health benefits were an added bonus but with a regular continuation these benefits were seen as equally important.

The walking group was the only outdoor activity on offer for the locals this made it unique and endorsed the environmental benefits. The more locals using their local environment increased its overall safety and increased the likelihood of more investment in the area. A significant reason for joining the group was that they felt safe walking in a group, and it was not an activity they would have participated in otherwise. For a majority that were retired it

helped them to get out of the house and relieve boredom. For many of the individuals there were not enough suitable activities in the area that they could afford. Offering something which was free that they could do on there doorstep made it easy for them to participate, and did not necessarily need permission from the 'purse holders of the house' this also reduced the feeling of guilt.

The participants that had significant health conditions knew of the benefits of walking as they were told by their GPs but never had the motivation to walk on their own. With regular commitment to the walks participants noticed their own health improving and had more confidence in the levels of physical activity they could undertake. What was surprising was in a short period of time the women in particular became proactive in their health, a simple walking intervention made them think about their overall health. This potentially could be a key tool in health promotion and ultimately the reduction of cost to the health service.

A key success of the intervention in the view of the participants was the integration of cultural activities into the walks. Capitalising on traditional activities that encompass walking and physical activity, gave participants the leverage needed to continue walking on a regular basis. This innovative approach was only possible due to the flexibility of the intervention and openness of the intervention deliverers. The simplicity of the intervention gave it the impetus to be integrated into the participant's routine.

There was a general consensus that the walks had progressed but there was room for improvement. A significant criticism of the intervention was that it needed to progress to provide different grades of walks. There was also a stipulation that the walks should run in the times allocated and more routes, sessions, transport and motivators were needed. A major concern was the lack of organised trips, they felt these would act as a magnet to recruit other walkers and maintain interest. The groups also highlighted the lack of pedestrian crossings on major routes and were feed back to the local authority. Major improvements were needed to the walks with regards to catering for walkers with serious heart conditions, and specialist rehabilitation training for the leaders were needed, as walkers felt the facilities were inadequate for their special needs. The intervention was criticised for the lack of publicity and educational messages of the benefits of regular walking.

Post intervention walkers felt that the walking activators did not adhere to the protocols of carrying water bottles and first aid kits. These elements of the walk were critical to health and safety. There was evidence of behaviour change as walkers criticised on appropriate outdoor wear, and stipulated that the walking activators should act as role models.

The major reason for continuing the walks was the fun and enjoyment of the group, and getting to see new parts of their environment which they had no knowledge of, over the past 25 years. The group concept and having motivating leaders brought them back every week. It was a routine that become painless and caused 'pain' if they did not attend as stamina levels dropped. A significant finding was that it renewed community spirit and confidence that was felt 'back home'. It helped participants to become more independent and have a belief in themselves. A key element of this was the sharing of cultural activities and festivals and the group overall inspired them.

Group dynamics of the men's group was different to the women's group, in that the men's group were much more focused and serious about the health aspect of the walks, whilst the women used laughter and fun as a key motivators of the group. A further element of the group dynamics was that they were a likened to a family and were supportive of one another. The women's group as a direct effect of the intervention set up other physical activity groups and met on a regular basis.

There was an active interest in the intervention by the participants as they felt it was important to visit other projects that were delivering similar interventions. They were keen to promote the intervention when organisations nationally came to visit them. At the end of the intervention period the local community took an active interest in their local environment by lobbying for improvements.

A majority of the Chalo Chalay participants influenced their social circles either to join the group or walk independently with them. This increased the number of participants walking indirectly and helped individuals to meet the national guidelines of 30 minutes of moderate activity on five or more days of the week. Behaviour change was noted as participants opted

to leave the car at home and walked short journeys, many made it a point to do more domestic or incidental walking such as dropping the children to school or shopping. The intervention had given the participants the confidence to walk independently and genuinely feel good about themselves.

There was a strong view about walking independently, some were more confident others still feared their own safety and were unsure of their environment. This was more significant in winter when it got dark on the walking routes.

There were other people in the locality that did not walk due to being ignorant of the benefits of walking and not knowing of the walking group, they felt that more publicity and incentives were needed. There was also a stipulation that the winter weather and South Asian T.V channels made individuals lazy and for some it was difficult to get away from household responsibilities. There was a consensus that the South Asian community only started to take note when they got a wake up call. However, there was a clear understanding and respect for individual choice of not walking and other priorities maybe more important.

A number of health and mental benefits were listed by the participants, which were maintained by being regular walkers. Medical tests such as cholesterol and blood tests supported these findings. The most significant benefit was that walking in a group had eased depression and anxiety in a proportion of the walkers and helped others to stop taking medication.

The walkers interviewed felt that it was up to individuals to take an active role in their health and that it was their own responsibility. They felt that the intervention had improved lifestyles at no cost to the participant.

The walking activators had an understanding of the aims and objectives of the intervention. They were recruited from the walking group and thus had the knowledge of being a participant; they had first hand experience of the benefits of the intervention. The walking activators had volunteered on other projects and were not new to procedures. The key element was that the opportunity arose and they like the concept of a health walk. Their

roles as activators were effective, as they believed that it brought a sustained change in participant lifestyles. Having total responsibility of running the groups and having feedback from participants of their commitment to the group was further evidence of effectiveness. In essence the group helped the walking activators with their own health problems and felt that it was mutually beneficial. In the view of the activators key strengths of the intervention were the walkers, walking activators who were role models and had key attributes, enjoyment of the walks and having deliverers that spoke the same language as the participants.

The walking activators faced similar problems to those running schemes nationally in that the inner city environment was not conducive of walking and was in need of some major environmental changes. There was also an issue of lack of sheltered spots on route and space for a social after the walk. More specific issues were the lack of appreciation and incentives for the walking activators and this they felt cascaded down to the walkers. The activators felt that they had not been given the full training or the equipment needed to conduct the walks safely.

There was clear commitment to the intervention by the walking activators, which did not seem to reciprocate back from the deliverers. The difficult task of laying the foundation had occurred but was slow to progress in the expansion. The walking activators had issues with payment, they took on the extra sessions and continued even after payment and funding ceased.

The walking activators provided evidence of the raised profile of the WHI and the impact it had on walkers life's. They also felt that they had a number of referrals from GP's and cardiac units to reach objectives of strand two of the intervention. It was satisfying for them that they were able to make a difference and continued due to the enjoyment of leading walks and walkers wanting sessions five days a week.

There were key themes that arose from interviews with key individuals involved in the project; some were tasked with the intervention because that were from an Ethnic Minority background and they felt that the role should be for generic workers also. Evidence was also provided that workers really did not take note of South Asian projects unless they were

working with that particular community, missing the point that the good practice from racial minority project can be transferred to other areas of work and other communities. There was also a consensus that pre decisions were made prior to Chalo Chalay that were not beneficial to the project.

Key individuals felt that the intervention was successful in that community groups requested groups to be set up in their locality and helped isolated individuals. It was highlighted that goals were achieved that were outside the original objectives of the intervention such as the empowerment of local South Asian women to participate in training to deliver back into their local communities.

Individuals flagged up difficulties in the management structure and the lack of vision and exit strategy was seen as a major pitfall of the intervention. However, praise was given to what was achieved in four years considering the overall lack of support across the board. A key issue that ran during the intervention period was ownership; there were battles between the host and HPA of the definition of ownership. This provided evidence of the different ways of thinking of the two sectors voluntary and statutory. What started out to be strong partnership, fizzled away amongst the politics of all partners. It was not the strength of the organisations that individuals came from, but the commitment of individuals that made the intervention work, when these individuals moved on they took with them this key resource. It was unfortunate that politics came in the way of a constructive intervention receiving funding. The ethos it required to boost the confidence of all the walkers and walk leaders involved in the intervention was also thus lost. The statutory sector via the HPA applied for monies that could have been in rapport with Chalo Chalay but were not able to utilise the direct contacts it had with other voluntary sectors projects or community members. The HPA secured monies from HAZ and the WHI to set up Let's Walk Leicester for five years and Chalo Chalay's funding came to an end, but were give minimal to sustain the walks already set up. The walks set up kept going strong, as for the HPA it dissolved and were taken on by the Primary Care Trusts. These smaller initiatives were thus dissolved in these large statutory organisations whilst those out in the community, lead by community members were integrated into the local service structure.

The themes arsing from the steering group were split into those who were from the voluntary sector and those from the statutory sector and further split of those from an Ethnic Minority background to those from a non – Ethnic Minority group. All groups had their hidden agenda's to meet their own targets and used it as a political arena. Members felt that the intervention was used as a springboard to get members into more powerful positions at the expense of the community that they were supposedly serving. Despite the membership of powerful individuals on the group, and the negotiating and compromising skills they brought, issues were never resolved and in fact escalated. Clear pathways into mainstream did not materialise and there was an uneasy feeling that it was yet another voluntary project set out to fail. The steering group was too large and not workable, it seemed that all wanted a piece of the cake, but did not give any constructive input. The funders were further criticised for their presence at the commencement of the project but once nationally lotteries monies were secured their presence at the steering group was withdrawn the project was truly treated as a 'guinea pig'. Good innovative ideas from small racial minority community groups were often capitalise by larger organisations which seem to get the ethos and funding to strengthen the idea, Chalo Chalay was the original concept but in the view of the community it has sprung from the Let's Walk project Leicester, due to having the funds for a wider publicity campaign. The steering group had the right representation on it but lacked the management to get decisions actioned. There was a consensus that there was not enough community representation on the group in particular the walk leaders.

The structure of the steering group was never right and was never resolved; the balance of power always favoured the statutory sector. There was a perception that the intervention was a health authority project and clearly this was not as productive as it could have been. A key element that hastened Chalo Chalay's progression was the influence of the opinions of steering group members on new workers instead of giving the new workers the opportunity to make their own decisions; they were given an edited version of the events.

There were major criticisms of the project coordinators role by the statutory sector this showed the lack of understanding of the particular officers of the role. The way in which the finances were managed were also criticised and never were resolved by partners, this caused

undue frustrations for all and delayed overall administration of the intervention. The steering group engaged in the discussions of operational matters and deviated from the task at hand, project partners had a responsibility to steer the project but overall lacked the time.

Besides major setbacks with the overall management of the intervention, workers ensured that it not affect the delivery of the walks. There was evidence that key workers felt that their role was effective as it fitted into their work programmes. There were more self-criticisms from a management level on negotiating skills. Their role was more effective at the end of the intervention period to ensure that it became self-sustaining. All key individuals viewed community ownership and sustainability differently and the ethos also changed during the intervention period. This provided evidence of the differing opinions of steering group members. Ultimately the intervention had no choice at the end of the intervention period to become self-sustaining and ownership was taken on by walk leaders who were always committed to the intervention with or without payment and as saw intervention as *'sewa'* and service back into their own communities.

Strengths stipulated by key individuals were the achievement of aims and the commitment and vision of a few core workers. Another core strength was the walkers and sustainability of the walking groups as the walkers believed in the benefits of the activity. It was the community spirits of the participants that saw them through all the political games played by all the partners.

Core problems were associated with the dispute between CIO and HPA, that stopped the progression of the intervention, funding was also an ongoing issue and the access of current funds. A major difficulty was the overall structure of the intervention and how it fitted into the host organisation a key element was the lack of direction from the steering group. Also a lack of trust between partners caused undue pressures especially between the voluntary and statutory sector. The overall hosting arrangements and accountability was the root cause of the majority of the problems. There was also criticism of the intervention not widening its partnership, it promoted itself well but did not deliver on these partnerships.

The potential of the intervention was discussed with key individuals who believed that the walking activators role could be expanded and used in a variety of settings. There was potential for the intervention to be linked into wider physical activity strategies and to expand outwards. The potential to use the walking activators as ambassadors with other communities was stipulated. Targeting other communities would require workers who can speak and understand the culture.

The impact of the intervention viewed by key individuals was the raised awareness of the concept by the South Asian community, the local & national organisations. It had a high profile in the community and was visual, it impacted the lifestyles of its participants. The intervention participants were key individuals that were consulted with to shape future services and developments in the locality.

In the wider picture of Chalo Chalay, being the demonstration project for Leicester, it was the only demonstration project housed in a voluntary sector and was solely for the South Asian community. It produced its own questionnaire that was the first to be produced nationally in another language and played more of active role in collecting its own data compared to the other demonstration projects. Thus it had more of resource implication than the other projects.

In comparison with the other demonstration projects Leicester recruited its target population and the average profile of a Leicester walker was an inactive female aged 55, Leicester recruited more female participants than the other projects. 98% were recruited from the geographical boundary of the target population. Leicester recruited more inactive participants compared with the other demonstration projects and had more of an opportunity to increase activity levels. Inactivity was prevalent in older South Asian men and with all age groups of South Asian women.

The Leicester project significantly increased activity levels by 47% over 28 months whilst the other project reported no significant changes. Leicester walkers became active or were meeting the national guidelines whilst the other projects showed an equal number of walkers becoming active as inactive. Quantitative data from the shuttle walks tests and questionnaires

support the improvement of physical activity levels of Leicester target population. Leicester clearly had recruited its target audience of inactive South Asian adults whilst the other two demonstrations had a wider target group and had more difficulties in recruiting the inactive. Leicester had recruited sedentary adults and the intervention had change their brisk walking behaviour, this was not observed with the other demonstration projects.

The reasons why people went on the walk were similar across the demonstration project's that is social, health, being outside and personal qualities of the walker. The social aspect was more important for the Leicester project. The development phase of all three-demonstration projects was also similar, however Leicester identified additional steps to the process through the toolkit.

One of the major differences with one of the demonstration project was its coordinating function, which was done by the steering group and had not recruited a coordinator this had worked well and was integrated into work plan, this in hindsight would have been identified for Chalo Chalay if it were to be known that further funding was not going to be secured.

Implementation strategies across all three demonstrations were the same, however Leicester identified a further 6 steps, it had the additional task of researching into the formal concept of volunteering. Support mechanisms were similar; Leicester had an additional four steps in relation to the promotion of leadership roles.

All the demonstration projects had a top-heavy management statutory sector input and thus processes were similar. This overall hindered the community ownership of the intervention. Different outcomes may have been seen if facilitated by the voluntary sector or community members. Leicester had recruited participants within its geographical boundary and was very clear in setting its targets. The other demonstrations were not so clear and did not manage to recruit its target audience however had many more walkers outside its objectives. Once recruited the retention levels of walkers of the Leicester project were higher (attendance level 63%) than the other demonstration projects, which only came to the walks once or twice.

Development work took a longer period of time; all projects faced similar challenges in that fruitation of development work out grew the lengths of the project. However, evidence base was aimed for so that good practice could be transferred to other localities.

Chapter Ten

Conclusion

'I have walked that long road to freedom. I have tried not to falter; I have made missteps along the way. But I have discovered the secret that after climbing a great hill, one only finds that there are many more hills to climb. I have taken a moment here to rest to steal a view of the glorious vista that surrounds me, to look back on the distance I have come. But I can rest only for a moment, with freedom come responsibilities, and I dare not linger, for my long walk is not yet ended.'

Nelson Mandela 1994. Long Walk to Freedom.

10.1 Conclusion & Implications

In conclusion the project has met its main aim of promoting higher levels of awareness of the health and social benefits of walking and increasing the participation in daily walking activity by South Asian adults through increased walking opportunities, and community action. The findings in this study support the evidence provided in previous studies of the benefits of walking for health (Hardman & Morris 1998, Shephard 1997). It further verified, that walking for health can be the answer to South Asian inactivity if taken up on a regular basis and if service providers view it holistically. The cohort of detailed case studies presented evidence that walking is an acceptable form of physical activity for the South Asian community and can be delivered simply and effectively via key community members in the locality. The intervention met the needs of 'sedentary' middle age men and women as stipulated by Hardman & Morris 1998, and addressed the concerns of a 'public health burden' of the lack participation in physical activity by the South Asian community.

The intervention increased the number of participants that met the national guidelines of moderate walking by a quarter in the cohort at the end of the intervention period. These findings provide firm evidence that the intervention can be used as a tool to reduce the overall sedentary levels of the South Asian community in England and addressing the 50% sedentary levels of South Asian women. Regular attendance at a lead health walk once a week over 28 months in line with independent walking outside the group promoted inactive

walkers at baseline to meet the national guidelines of 30 minutes of moderate activity on five or more days of the week which benefited their health.

The qualitative evidence supported previous consultations with the local community that walking for health was an acceptable form of moderate physical activity for a majority of the middle aged South Asian community. The promotion of physical activity and walking for health interventions to South Asian community was a new concept for organisations, the voluntary sector and members of the local community. However, findings showed that if marketed and tailored appropriately it is the preferred choice of activity and is an enabler of *'making more people more active more often'.*

The findings of this study have implications on the overall provision of health services in communities with a high South Asian population as stipulated by Lowry 1991 in relation to CHD. It has constructively provided a toolkit that can be used by any practitioner in any setting as a preventative and rehabilitation programme for CHD thus delaying the forecasted crisis in the NHS. The study has demonstrated that walking for health interventions are a cost effective way to promote moderate physical activity, and in the longer term to prevent shortfalls of inadequate services for the South Asian community, these can be medical or mental health services provide by the NHS.

The Chalo Chalay intervention formed apart of the overall demonstration projects funded by the BHF and CA it thus presented evidence of the benefits of Walking for Health and gave practical guidance via the toolkit on how a walking for health intervention could be delivered to a South Asian community. It justified the relationship between walking and the reduction of CHD as it delivered strand two, the GP referral scheme. Both quantitative and qualitative data verified that the intervention can be used to address high inactivity levels in the South Asian community and helped address the 40% more likelihood of the mortality of South Asian communities from CHD than the general population. As a demonstration project Chalo Chalay has nationally lead the way for other similar initiatives attracting funding in other regions to set up similar interventions. It was the only detailed study on the South Asian community and physical activity and walking. Thus, it provided evidence based practice and clear guidance for other practitioners in the field to break down the barriers that the South

Asian communities face. The findings presented in this study have facilitated closing the gap of the lack of research into South Asian inactivity. The intervention has got more people walking in their local community, an objective set by the WHI initiative, via raised awareness of the benefits of walking. It gave South Asian adults a choice of joining a local doorstep-walking group prior to which this opportunity was not on offer.

Chalo Chalay has contributed to the agenda of health and transport; it has encouraged participants to under take short journeys by foot and leaving the car at home. It has promoted via general awareness raising an overall increase in the use of public transport by using walking as the 'glue', participants walked into the city centre and caught the bus back home with shopping.

The shuttle walk tests and detailed case studies have verified that walking can be used as a positive preventive mechanism against CHD and other related conditions in South Asian communities. The intervention has achieved a lot more than it set out to do, by simply introducing walking into lifestyles increased the quality of life and broke unproductive behaviour patterns. It revived participant's minds and gave them a new outlook by stepping out of their home onto their doorstep. By doing so they have met liked minded people and have become facilitators of good health. The concept of going to see a doctor had become dormant for the participants, instead meeting and talking with peers had become their way of receiving advice.

The intervention gained a lot more than expected, it had helped participants to come off anti depressants, thus it has succeeded not just in the humane sense but it also has saved the NHS money, money that can be spent on more preventive interventions. A simple act such as walking has impacted people's lives, the simple basics of social and human interaction has been the strength of the intervention. The group dynamics have been astounding, the oneness of having similar goals to achieve good health in a safe, familiar environment.

The Chalo Chalay health promotion intervention for the South Asian local community was developed and local people were able to see the translation of research into practice and action. A model of community action and community development was integral to this

action research project and a commitment to change. It delivered to improve the health and health experience of South Asian communities.

Success of the intervention was reflected in the number of walker's willingness to recommend the walks to members of their community and social circles. There was an acceptance of the intervention by the South Asian community of being relevant to their health.

The project demonstrated that professionals and lay members of the community despite cultural, age and class differences can work together successfully by sharing experiences and gaining a better understanding of each others behaviour and expectations through collaborations and meaningful consultation. The strategy used succeeded not only in building beneficial links into marginalized communities but also contributed towards developing the skills and confidence of the targeted community.

The findings demonstrate the engagement of the South Asian community in an intervention which has only attracted white middle classed and middle aged participants (Hillsdon 1998). It has achieved this by culturally tailoring the intervention and targeted it in a geogtraphically boundary that has a high proportion of the South Asian community. It further tailored its programme by being inclusive of bilingual walking activators.

The intervention has presented evidence of the interlinking between the health of an individual and the health of the community. In this era the community and family structure have been fragmented increasing the risk of poor health amongst the disadvantaged and excluded. The intervention, through the focus of walking for health had created other social activity such as picnics, playing games, celebration of birthdays and festivals and religious recitals. Thus, arts and creative activity was shown to promote healthy living, having a healthy mind promoted a healthy body.

There was an assumption at the commencement of the intervention that South Asian communities did not walk, however there was evidence of incidental walking and thus the intervention reawakened the natural activity by promoting walking for health.

The intervention was researched using Stringer's (1996) action research model of look, think and act which was related to the DNA spiral helix structure. This denoted the continuous upward spirals of action research but also allowed for mutations to occur. Thus, the final intervention represent the survival of the fittest that is elements of the intervention that worked for the South Asian community. For example the concept of group dynamics a mutation that occurred during the DNA action research process made the group stronger. Thus the splitting of genders and analysing the likes and dislikes of the groups, the motivational factors were refined.

The cohort of 66 case studies showed during the follow up period that a majority continued walking, via the walking groups, through leisure or by increasing incidental walking. The motivation to continue at the end of the intervention-funding period was a measure of success.

What initially seemed an impossible task became universal, as the toolkit would assist any practitioner in any setting to promote walking for health. It also provided a framework for intervention delivery specifically for racial minority communities. The intervention researched and developed a walking activities questionnaire (Appendix I & II) that was the first nationally to be produced in another language it was translated into five of the main South Asian languages. Thus through the action research process tools have been developed and tested to promote walking for health, specifically for the South Asian community which can be transferred to other Ethnic Minority communities.

10.2 Recommendations

Recommendations for the Chalo Chalay intervention

- To recognise that the South Asian community is a diverse group and have very different needs due to lifestyles and to tailor interventions accordingly.
- To progress using walking for health, physical activity and sports as a tool for health promotion, incorporating in into future healthy living centres and integrated social and health care centres.

- To continue progressing with the GP referral schemes and using walking as alternative and making it an integral part of the CHD prevention project, Project Dil.
- To attract more men onto the walks programme and highlight its challenging nature, by introducing different grades of walks.
- To increase the number of translated resources available to community groups.
- To recruit bilingual outreach workers to deliver translated resources to specific South Asian communities, and to encourage residents to take part and mould a local intervention.
- For generic workers to have a better understanding of racial minority interventions and not to pass the buck.

Recommendations to the steering group

- The steering group should be a multi racial team, which incorporates the Black perspective from the beginning and throughout the project. The project workers and steering group should have a range of expertise with diverse communities; they should not be added on or brought on at a particular stage.
- There should be commitment from all levels within the partnership to work towards anti –oppressive practice and to encourage all partnership members to contribute.
- To encourage discussion about some of the more difficult issues in terms of 'race' and ethnicity, and to look critically at methodologies being developed.
- To ensure senior level of support and commitment from voluntary and statutory organisations and community groups.
- To ensure funding is available for longer periods a minimum of five years.

Recommendations for the progression of the GP Referral Scheme

- GP's in the targeted locality should have ongoing reminders of encouraging walking for health schemes.
- GP's wherever possible should participate in walking for health, as the South Asian community see them as an active role model.
- Ongoing training should be provided to health care teams on the benefits of promoting physical activity and allay any fears they may have.

Recommendations to the local authority and the progression of the environmental strand

- To extend the safer routes to school programme to be inclusive of South Asian communities, to have a walk to school week which is inclusive of festival and events that relate to the South Asian community.

Recommendations to national and local government authorities

- To use the toolkit provided to enhance the twelve national initiatives, which support the notion of increasing physical activity from strategy to practical delivery of interventions.
- For the departments of; Transport, Local Government and the Regions; Cabinet Office, Social Exclusion Unit; Culture Media and Sport; Environment, Transport and the Regions; Health, National Health Executive; and Education and Employment to use the evidence base data provided by the study to support documentation in the allocation of national and local funding.
- To distribute findings to support all relevant government and local bodies who can influence, National Service Frameworks, physical activity & transport strategies, and Health Improvement Plans.
- To change the attitudes in constructing and widening motorways and the investment in more local interventions.

Recommendations to national and local policy makers

- To integrate all the variables that stop people from walking more often by integrating, health, and transport and environmental policies.
- To increase joined up thinking to meet national targets.

Recommendations to the WHI initiative

- To deliver a national targeted mass media campaign on walking that is inclusive of racial minority communities and to use the good practice demonstrated in the present study.
- BHF should have a role in publicising the WHI projects and giving the initiative more impetus in particular the angle of CHD prevention.
- The BHF is a widely known body that individuals can relate to thus using this influence more effectively and supporting further research and helping with the production of more resources in other languages.

- The CA should influence more on an operational level and continue to support future WHI projects in equipping them with up to date resources and guidelines.
- For future WHI projects to have access to evaluations of the demonstration projects and toolkit.
- To ensure that future projects set realistic targets that is in line with recommendations made by all the demonstration projects.

10.3 Limitations

Evaluation

There was recognition at the commencement of the initiative that the evaluation of the project was rigorous and the targets set were extremely high. It was also stipulated that methods should be identified that measure behaviour change and that an external evaluation would help secure support to replicate practices elsewhere. This was achieved on a smaller scale due to the human resources on hand, specialist research skills including bilingual researcher would have been beneficial as a more precise record of behaviour change could have been recorded. Having the role of the project coordinator combined as an action researcher produced an in depth understanding however, this aspect was lost when the project coordinator left.

Steering Group

The steering group stipulated that it was important to avoid over management of the project and that the steering group appeared large and wanted the project to reconsider the resource implication of this and recommended having a small steering group with a wider advisory panel. It was not clear how the steering group and the project fitted into the existing joint health groups and joint planning mechanisms.

Lack of workforce diversity to deliver Ethnic Minority interventions

Throughout the intervention a major set back was the lack of bilingual workers that could deliver the intervention and carry out the research. This has been an ongoing constraint for all aspects of health care provision, although translators have been recruited, a more skilled workforce would be beneficial in particular using their language and cultural skills. The

secretary of state in 1993 stipulated, *'by the achievement of racial equality, not only in service delivery but also in the employment in the NHS. These are two sides of the same coin.'* A decade on we are only a small step closer to reaching a diverse workforce. There are also assumptions made that an South Asian worker can understand all the different practices of Indian, Muslim and Sikh cultures, there are distinct differences and key workers for each community are required. The South Asian worker may also need specific training of cultural awareness issues.

Different needs of South Asian communities

The intervention in the first year mainly attracted the Indian community of Belgrave, it widened this in the subsequent years after extending its geographical boundary and attracted the Muslim community. It needed more human resources to research the needs of each of the South Asian communities to make the intervention sustainable. Each community had its own set of gatekeepers and to be able to work with them all in three years was beyond the scope of the project. However if funding were given to recruit key link workers within each community who spoke the language the agenda may have been progressed.

Funding

The intervention was a success on many levels due to the resources in kind from community members, without their enthusiasm and a belief in the concept it would have not been delivered. There is a lack of committed individuals and the national government needs to assign more resources to prevention, this is not happening thus the physical and financial resources have to be found at a local level.

Project Management & Coordination

The structures in place were not productive and a few bad management decisions were made that affected the intervention. The project was hosted in an organisation that was going through its own management change. The human resource allocated to the intervention was initially part time and then in the second year became full time due to the research aspect of the project. It has to be weighed up what is more important the delivery of the intervention or the evaluation. Having external evaluators would have been more beneficial in this case as funders were stipulating meeting targets and widening the project out in a short period of time, compared with keeping it small and having the evidence based research.

The partnership

The on going politics between the host organisation and the Health Promotion Agency caused the intervention to loose key workers and partners on the project, it unfortunately meant that the funding was not renewed. The voluntary sector has organisations within it that can deliver the agenda required by funders, however with the particular voluntary organisation it was newly set up in Leicester and was really run from its London head quarters this added complications in the management and financial structures.

10.4 Suggestions for future research

- Walking as an active transport? Do South Asian walkers who participate in the walking groups use it as a tool to get to places, how can this be promoted?
- Using the current good practice to recruit other venerable groups within the South Asian community, such as Muslim women and clinical groups such as those with diabetes or osteoporosis having specialised walks for them.
- Widening the age group to be inclusive of younger age groups, what would attracted them onto the group or what would encourage them to use it as a from of active transport.
- Gaining a better understanding of the concept of volunteering in the South Asian community.
- Follow up on the drop out rate of trained walking activators, and thus improvements on the walk leader training.
- Increase and engagement of GP's to promote walking for health.
- There are major cultural differences between South Asian communities. Further research is needed to define these so they can be addressed accordingly. There needs to be clarity on the difference between these groups who have been clumped under one group. For example a publicity campaign can home in on particular religious reasons why being physically activity is important, it is an inherent part of Hindu religion to walk during pilgrims whilst in Islam, one needs to be physically fit to protect their country and be apart of their army. These are two quite distinct and different ways of promoting the same message to be physically fit.

- The effects of walking on reducing stress levels of South Asian communities could prevent a number of stress related diseases these need to be further researched.
- After feeding the findings to health service providers and funders to monitor whether these recommendations have been implemented.
- After feeding back findings to local people and organisations, to follow up what has been sustained.
- An important principle in research with local communities is to ensure that research is translated into policy and practice, to effect change and improve the health experiences and health chances of racial minority communities thus to monitor progress.
- ADNFS (1992) it has been a decade since these figures have been published have we moved forward on this agenda or are we still static?
- Funding was an issue, at the end of the funding period, the walker leaders reverted back to being ' volunteers' and with the ladies group the activator charged a pound per walk, a few of the walkers had a strong view about this and left further follow up interviews would gather data on what happened to these individuals.
- How to get walking into the local communities belief structures? Ways of thinking need to be transferred to strategies.
- Translating research into practice via action research, is the process more accessible, are there any other methodologies that a practitioner can use in day-to-day work?

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Chalo Chalay (Let's Walk) Walking Activities Questionnaire.

Could you please fill in the following table in order for us to monitor your progress in this walking program by circling one answer

e.g. Average time per occasion in minutes 0 (10) 20 30 40 50 60 or more

Below is a list of different paced **walks** that you may have done during the **last week.** For each of the walks please indicate:

a) The number of times you did this type of walk in the last week.
b) On average, how long each walk lasted.
c) Whether or not the walk made you breathe hard.

Circle answers

Activity	Number of times you have walked in the last week (circle one number only)	Average time per occasion in minutes	Did the walking make you breathe hard?
Walking at a slow pace	0 1 2 3 4 5 6 7 8 or more	0 10 20 30 40 50 60 or more	Yes No
Walking at a steady average pace	0 1 2 3 4 5 6 7 8 or more	0 10 20 30 40 50 60 or more	Yes No
Walking at a fast pace	0 1 2 3 4 5 6 7 8 or more	0 10 20 30 40 50 60 or more	Yes No
Walking with heavy shopping	0 1 2 3 4 5 6 7 8 or more	0 10 20 30 40 50 60 or more	Yes No

Thank you for your time

ચાલો ચાલીએ – ચાલવાની પ્રવૃત્તિઓ અંગેની પ્રશ્નાવલિ

કૃપા કરીને નીચેના કોષ્ટક (ટેબલ)માં એક જવાબ ફરતે સર્કલ દોરશો જેથી ચાલવાના આ કાર્યક્રમમાં તમારી પ્રગતિ પર અમે દેખરેખ રાખી શકીએ.

દા.ત. દરેક વખતે મિનિટોમાં સરેરાશ (એવરેજ) સમય 0 ⑩ 20 30 40 50 60 અથવા વધારે

ગયા અઠવાડિયે તમે કદાચ જુદી જુદી ઝડપથી ચાલ્યા હોય તેનું નીચે એક લિસ્ટ છે. ચાલવાની ઝડપના દરેક પ્રકાર માટે કૃપા કરીને નીચેની બાબતો દર્શાવશો:

(ક) ગયા અઠવાડિયે તમે આવા પ્રકારની ઝડપે કેટલી વાર ચાલ્યા તેની સંખ્યા

(ખ) સરેરાશ રીતે દરેક વખતે ચાલવા માટે કેટલો સમય લાગ્યો હતો

(ગ) ચાલવાથી તમને શ્વાસ ચડી ગયો કે નહિ

તમારાં જવાબો ફરતે સર્કલ દોરશો

પ્રવૃત્તિ	ગયા અઠવાડિયે તમે જેટલી વાર ચાલ્યા તે સંખ્યા (ફક્ત એક જ નંબર ફરતે સર્કલ દોરશો)	દરેક વખતે મિનિટોમાં સરેરાશ (એવરેજ) સમય	શું ચાલવાથી તમને શ્વાસ ચડી ગયો?
ધીમી ઝડપે ચાલવું	0 1 2 3 4 5 6 7 8 અથવા વધારે	0 10 20 30 40 50 60 અથવા વધારે	હા ના
એક સરખી સરેરાશ ઝડપે ચાલવું	0 1 2 3 4 5 6 7 8 અથવા વધારે	0 10 20 30 40 50 60 અથવા વધારે	હા ના
ઝડપથી ચાલવું	0 1 2 3 4 5 6 7 8 અથવા વધારે	0 10 20 30 40 50 60 અથવા વધારે	હા ના
ભારે શોપિંગ સાથે ચાલવું	0 1 2 3 4 5 6 7 8 અથવા વધારે	0 10 20 30 40 50 60 અથવા વધારે	હા ના

તમે જે સમય આપ્યો તે બદલ તમારો આભાર

'Walking the Way to Health' Programme

Personal Details:

Name_____

Address_____

_____

Telephone No_____ Emergency Telephone No_____

Age_____

How did you hear about the Walking Programme?_____

The PAR - Q (Physical Activity Readiness Questionnaire)

If you have decided to increase the amount of physical activity in your life, start by answering the eight questions below.
For most people physical activity should not pose any problem or hazard, but this PAR-Q has been designed to identify the small number o f people for whom it would be wise to have medical advice before starting.

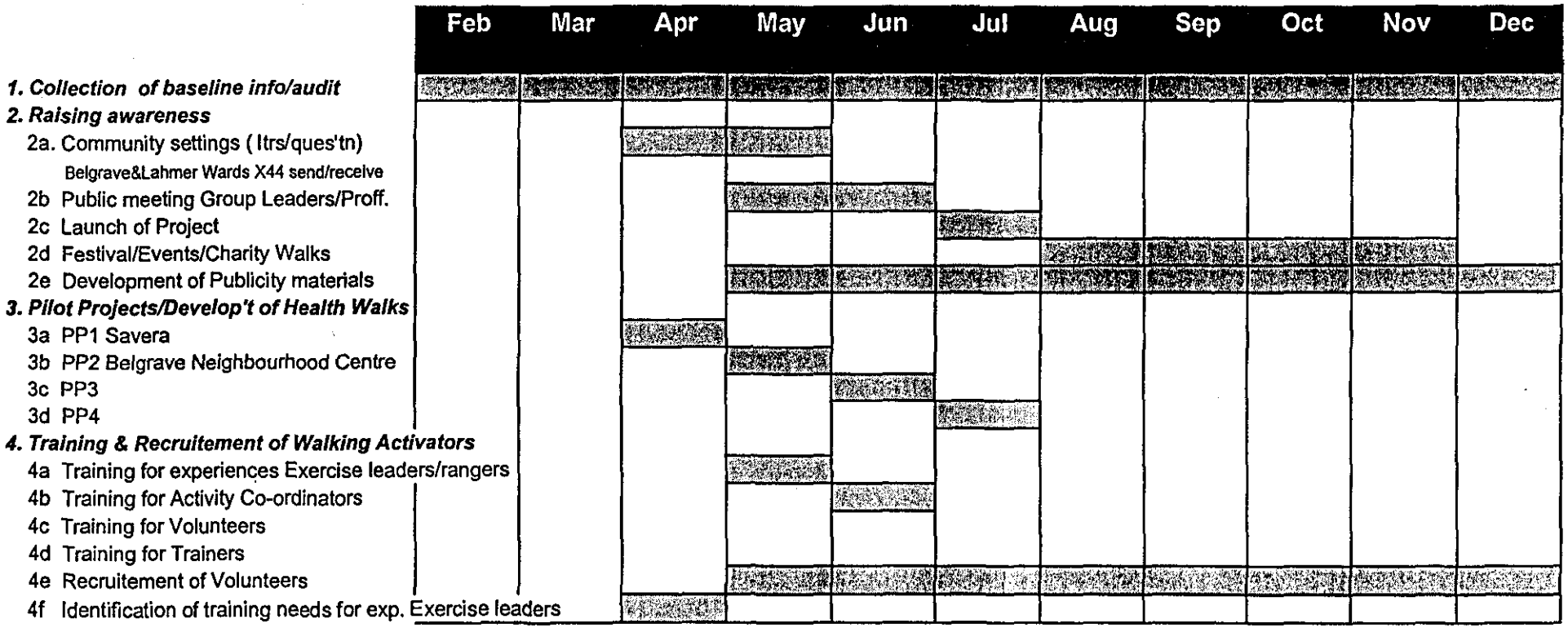
		Yes	No
3.	Has your doctor ever said that you have a heart condition and recommended only medically approved physical activity?	☐	☐
4.	Do you have chest pain bought on by physical activity?	☐	☐
4	Have you developed chest pain at rest in the past month?	☐	☐
4	Do you lose consciousness or lose your balance as a result of diziness?	☐	☐
9	Do you have a bone or joint problem that could be aggravated by the proposed physical activity?	☐	☐
10	Are you currently on any form of medication (e.g. tablets, inhaler)?	☐	☐
11	Are you aware, through your own experience or a doctor's advice, of any other reason against exercising without medical approval?	☐	☐

I understand that if I answered YES to one or more of the above questions, I should have the consent of my doctor before undertaking a walking programme.

Signed.....

Date.....

STRAND ONE COMMUNITY CENTERED WALKING FEB 1999 - DEC 1999



Appendix IV

REKHA CHUDASAMA07/04/99

Health for Leicestershire
LEICESTERSHIRE HEALTH
Gwendolen Road, Leicester LE5 4QF
Tel: (0116) 273 1173 Fax: (0116) 258 8577
DX 709470 Leicester 12

Melanie Sursham
Direct Dial 0116 258 8610

7 December 1999

Miss R Chudasama
Project Co-ordinator
CIO 24-26 Imperial House
St Nicholas Circle
Leicester LE1 4LF

Dear Miss Chudasama

Chalo Chalay : Let's Walk Project (Walking the way to Health) – our ref. No. 5695

Further to your application dated 26 October, you will be pleased to know that the Leicestershire Research Ethics Committee at its meeting held on the 3 December 1999 approved your application to undertake the above-mentioned study.

The Committee requested:

1. That the letter to 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 in Hindu and also Urdu?
4. How will subjects be recruited? If walkers who had disease were recruited their General Practitioner would need to be notified.
5. What inclusion and exclusion criteria will be used?

Your attention is drawn to the attached paper which reminds the researcher of information that needs to be observed when ethics committee approval is given.

Yours sincerely

Dr R F Bing
Chairman
Leicestershire Research Ethics Committee

(NB All communications relating to Leicestershire Ethics Committee must be sent to the Committee Secretariat at Leicestershire Health)

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