

## **Factors influencing participation in outdoor physical activity promotion schemes: the case of South Staffordshire, England.**

### **Abstract**

Policy exhortations for promoting outdoor physical activity have increased considerably in England and Wales over the past 20 years. Despite a considerable number of schemes developing during this period to encourage physical activity and exercise, marked population-level changes in outdoor physical activity behaviour have not been seen. The paper explores the triggers to this participation using a fivefold classification: physical infrastructure; information infrastructure; administrative infrastructure; participant constraints and participant preferences. Through a series of interviews in a case study 'healthy exercise' scheme in South Staffordshire, a district level authority in England, these triggers to participation are identified and explored. It is concluded that whilst the infrastructure triggers can be manipulated by scheme providers in an attempt to improve scheme participation, participant triggers fall largely beyond the control of scheme providers. Research suggests, too, that participant triggers tend to be stronger than infrastructure ones. Because of this, where there is a lack of healthy exercise scheme success, this cannot necessarily be attributed to scheme providers as it might be as a result of user triggers. For the same reason, it might be beyond the influence of scheme providers to turn 'failing' exercise schemes into successful ones.

**Key words:** health policy; triggers to exercise participation; participant constraints; participant preferences; barriers to exercise.

## 1. Exhorting the virtues of outdoor exercise

The volume of exhortations to undertake 'healthy exercise' in the outdoors has grown considerably over the past 20 years in England and Wales as (and possibly because) the nations both have become increasingly sedentary<sup>1</sup> (Burke *et al*, 2006). This paper briefly reviews these exhortations and the extent of their success before examining empirically the motivations for, and barriers to, taking part in healthy exercise programmes generally. Using the Physical Activity Care Pathway in South Staffordshire, a district level authority in England as a case study, interviews with a variety of stakeholders are reported. Importantly, these include interviews with non-participants in the scheme. Conclusions are drawn about which motivations and barriers can be influenced by policymakers and implementers, and which cannot. In this way, the research contributes to an explanation of the limits of provision-based interventions in reducing the sedentariness of the nations.

Whatever governments might wish for, participation in outdoor exercise it has been in steady structural decline since at least the late 1970s in England and Wales (Curry and Brown, 2010). Policy exhortations have moved from, at the beginning of this period, trying to stem participation at least in the rural outdoors:

*"almost complete destruction of vegetation is taking place where the public congregate at weekends in large numbers .... some control is necessary unless the places that they wish to visit are destroyed"* (Council for Nature (1965), page 24);

to fulsome attempts to encourage it:

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<sup>1</sup> Pate *et al*. (2008) define sedentary behaviour as activities that do not increase energy expenditure substantially above the resting level, including activities such as sleeping, sitting, lying down, watching television, and other forms of screen-based entertainment. Operationally, sedentary behaviour includes activities that involve energy expenditure at the level of 1.0-1.5 metabolic equivalent units (METs).

"People are missing out on the wide range of benefits that (recreation in) the natural environment offers, particularly to their health and wellbeing" (Natural England, 2007, page 1).

Possibly as a result of this long term structural decline, but certainly in response to the size (in both senses) of the 'sedentary nation', this latter statement typifies an increasing governmental commitment to the development of policies for healthy exercise.

Variations on the theme of "30 minutes daily exercise" have emphasised the consequences of *not* taking exercise (Department of Culture, Media and Sport (2002), Department of Health (2004), World Health Organisation (2007) and other government statements have stressed individual responsibility for well being through lifestyle 'choice'<sup>2</sup> (Sointu, 2005).

Many state-supported 'healthy exercise' schemes have resulted, the South Staffordshire case study reported below, *Let's Get Moving (LGM)*, being one. They have developed making explicit use of the 'rural outdoors' for walking (for example the Walking the Way to Health Initiative (Natural England, 2007)), green spaces for conservation works (the British Trust for Conservation Volunteers' 'Green Gym') and even a range of metropolitan health walks has been developed (Curry, 2009) as part of the walk4life campaign, (Department of Health, 2009a) deriving from the 'Choosing Health' White Paper. Sitting alongside these, Physical Activity Referral Schemes (PARS) have developed to serve both physical and mental health (Crone *et al*, 2008) often involving referral by a health practitioner (Dugdill *et al.*, 2005). A range is identified in Taylor *et al* (1998), Stevens *et al* (1998) Sørensen *et al*, (2008) and Isaacs *et al* (2008).

But in reviewing the success of a number of these schemes, Williams *et al.*, (2007) and Williams (2009) found their impacts to have been modest. Most exercise change lasted only 6 – 12 months with a very small reduction in health risk even amongst those that

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<sup>2</sup> The notion of 'choice' being a contested one.

do adopt an exercise regime. This was attributed to poor uptake and negligible longer term adherence, leading to poor value for money. Morgan (2005) too, in his review of schemes, found that they have little impact on sedentary people but some impact on those who were already somewhat active. This impact appeared short term, however Harrison *et al* (2004). Hard to reach groups also have largely proved resistant to these opportunities, possibly because of a lack of motivation, and cultural attitudes (Hilsdon *et al*, 2005) but also because of organisational complexity (James *et al*, 2010).

In the context of a lack of evidence of their success, the National Institute of Health and Clinical Excellence (2006) recommended suspending them unless they formed part of a controlled trial. Where these schemes in general have been successful, participants have been older, white, female and more affluent members of the population (Gidlow *et al.*, 2007), a demographic profile not coincident with those at greatest risk (Natural England, 2007). The 'healthy outdoor exercise' exhortation nationally, could be summarised as having limited success in terms of participation, despite a lot of policy effort. In England and Wales, some 60% of men and 70% of women are insufficiently active to benefit their health (Sport England 2010). In the case study area of South Staffordshire reported below, some 75% of adults are considered insufficiently active (Sport England 2010).

## **2. Understanding the triggers to participation in healthy exercise schemes.**

Why have such schemes met with limited success? This question can be informed through an understanding of the factors that trigger or prevent participation on the part of different individuals. A number of these is generalised in figure 1.

*Figure 1 near here*

Of the provision triggers, the physical infrastructure includes, for example, the available resource such as, statutory rights of way or permissive footpaths. The information infrastructure would embrace such things as guides to specific walks or advice on how best to take outdoor exercise to improve health. The administrative infrastructure relates to the way in which people who have agreed to take part in 'healthy exercise' schemes are encouraged to do so and informed of what is required of them. Of the participant triggers, constraints are those things that limit participation because people do not have the means to participate (for example, they cannot afford to) and preferences are those things that influence the motivation of people to participate (for example, they have no interest in the outdoors).

Importantly, whilst 'provision' triggers are largely within the control of scheme providers, most 'participant' triggers are not. Also, the weight of evidence suggests that the strongest influences over scheme participation are participant triggers and here preferences tend to be stronger than constraints (Curry and Ravenscroft, 2001). In implementing any scheme, therefore, its success cannot be guaranteed by (or be entirely the responsibility of) scheme providers because the strongest influences over success are likely to be beyond their control.

In such situations, providers can supply only a context which they hope will make participation more likely. This can be done by 'carrots' (if you take more exercise you will feel better) or 'sticks' (unless you take more exercise you are likely to become ill). Both of these are information triggers, albeit coercive ones. Such signals are supplemented by the physical and administrative supply-side infrastructure. But providers can only ever "take a horse to water ....."

Some of the *participant constraint* triggers can be influenced by providers of exercise schemes to a degree (e.g., subsidised participation for the less well off) but again, research suggests that constraints to participation in healthy exercise are more

effectively tackled by general social and economic policy (full employment, appropriate housing, available leisure time) than 'provision'-based interventions. *Participant preferences*, however, in general cannot be tackled by provision policy at all, and research suggests that they are the strongest determinants to participation: interest, motivation, will, ambition, lifestyle choices, and the disposition of the individual (Curry and Ravenscroft, 2001).

Because participant triggers can be more difficult to identify for healthy exercise providers, they are explored a little further here, before reporting on the empirical data from South Staffordshire. Some initial idea of participant triggers comes from the results of a series of questions in the UK Day Visits Survey of 1996 and 1998 about outdoor activity, which are presented in figure 2 below (Curry and Ravenscroft, 2001). These are the most recent national surveys in which questions of this nature have been asked. These serve to give some indication of the participant 'constraints' trigger and the participant 'preferences' trigger and the frequency of occurrence of each.

*Figure 2 near here*

Here, material constraints (lack of money and transport) account for only 16% (in 1999) of reasons for not undertaking outdoor exercise. Preferences for not undertaking such exercise include the fact that people simply have not participated, are too busy with work or have no interest in participating. Together these account for 63% of reasons for not taking outdoor exercise in 1999. Sitting in between these preferences and constraints is poor health or disability (18% of reasons). This is a complex trigger as it can be both a preference and a constraint. This evidence and other research considered below, suggests that participant preferences are a much stronger trigger to not participating in outdoor exercise than participant constraints, the area in which provision can be least effective in securing participation.

Seeking to change these preference-based triggers to participation is not easy as it is commonly considered to be culturally embedded (Carlisle, 2006), where lifestyles (Howson, 2005) and the media (Little and Wilson, 2005) have important roles to play. Significant here too is the influence of home-based leisure, particularly the sedentary nature of computer use. There is also evidence that certain demographic groups are more health conscious than others, and have different health risk profiles, for example, varying with age (Henley Centre, 2005), social grade (Burton & Turrell, 2000), education (Fletcher, 2008), gender (Carter, 2000) and ethnicity (Askins, 2004). Socio-economic influences over preference to exercise are also significant, including the availability of time, income (Henley Centre, 2005) and mobility (Pigram & Jenkins, 2006).

Further influences over preference relate to *motivations*. For some, exercise, and its context, can be relaxing (Schmidt & Little, 2007), but for others it is 'hard work' and painful (Allen-Collinson, 2005). Exercise in the natural environment (Macnaghten & Urry, 2000) and green spaces (Lea, 2008) can be an important trigger here but more generally peoples' attachment to particular places can have a positive impact on exercise motivation (Williams, 2002). Concomitantly, particular places and environments can be a deterrent to exercise for reasons of lack of privacy, threat of physical or verbal attack (Allen-Collinson, 2008) or cultural animosity (Milbourne, 1997). Some respond positively to taking risks through exercise (Kiewa, 2002) but others are risk averse (Dilley, 2007). Health motivations to take exercise are also tempered by perceived health risks regarding injury and personal safety (Milligan & Bingley, 2007).

The social context of exercise can be a preference trigger too, with some people using exercise as a context for developing social relationships (Wheaton, 2004) and others using it to set themselves apart from the general population through the development of exercise sub-cultures (O' Connor & Brown, 2007). There is also growing evidence suggesting that owning a pet can be a motivator to exercise, particularly with dogs,

because of the exercise needs of the animal (Wells, 2007). Again, all of these triggers can work positively or negatively on particular individuals.

The above 'preference' participant triggers are drawn largely from research that has observed and communicated with people undertaking exercise. It is harder to identify 'preferences' for not participating in exercise as non-participants are harder to identify and isolate. This issue is addressed in the empirical case study based on the South Staffordshire Physical Activity Care Pathway, below.

### **3. Participation in healthy exercise: the South Staffordshire case study**

An empirical exploration of these triggers was undertaken as a subset of a larger evaluation of the *Let's Get Moving* programme in South Staffordshire during 2009 and 2010. This is a Physical Activity Care Pathway (PACP) pilot programme<sup>3</sup> which was administered through General Practitioner surgeries but was not targeted at any particular socio-demographic group. All those visiting surgeries in the South Staffordshire pilot area for the period of the pilot were given the opportunity to complete the General Practitioner Physical Activity Questionnaire (GP-PAQ) to screen potential participants' and register their interest. The completed questionnaires were left at the surgery, and later followed up by a 'health trainer' (rather than the GP), if requested on the form. Based on a motivational interviewing approach suggested by the care pathway recommendations document (Department of Health, 2009b), the Health Trainer explored current physical activity levels and preferences, and then signposted the participant to suitable physical activity opportunities.

A number of scheme characteristics are relevant to this paper. Firstly, because the scheme was not targeted, those who met minimum weekly activity thresholds for physical activity were as likely, *a priori*, to fill in the forms as those who did not. Indeed

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<sup>3</sup> The Department of Health launched the Let's Get Moving PACP toolkit in November 2009



a number could be considered 'intensive' exercisers. Secondly, it was a pilot designed to provide a 'rural' comparator following an earlier pilot scheme in London (Bull and Milton, 2010). In this context the emphasis in activity recommendations had a focus on outdoor exercise opportunities, particularly walking and cycling within the context of the 'natural' environment.

The mixed methods evaluation involved a quantitative assessment of participant socio-demographic and health data from 124 people who had expressed a wish to be contacted by the Health Trainers. This quantitative aspect of the research monitored participants as they progressed through the scheme. A smaller element of the research – the one that is reported here – was to act in support of the quantitative data collection by asking a series of open-ended questions of a variety of 'stakeholders' to provide further information on people's attitudes and motivations that help to explain their actions. The purpose of this work was to provide empirical evidence for the existence of the various triggers to participation, discussed above, which have not previously identified in this relational way. A particularly valuable part of this process was to be able to interview people who filled out the questionnaire but who subsequently decided not to take part in the scheme. These responses provided unusual insights into the triggers for *not* participating in outdoor exercise.

Such an approach has the function of understanding more about mechanisms, contexts and outcome patterns, and in the case of this research, how these elements are connected, to better inform policy and practice (Pawson and Tilley, 1997). As such it reflects the acceptance, in applied research in physical activity, that pragmatic approaches to the development of an evidence base, such as those used in this research, need to be adopted to understand more about processes and their influence on outcomes (Dugdill *et al*, 2009).

The research as a whole employed a range of different data collection methods, and for the 'triggers' part of the research presented in this paper, these included a number of interview types. A focus group, in-depth face-to-face and telephone semi-structured interviews were undertaken with participants and, importantly, non-participants (8; 3 male, 5 female) (identified as P), GP receptionists who administered the scheme (1; female) (identified as R), health trainers (3; 1 male, 2 female) (identified as HT) and the providers of 'healthy exercise' (3; 2 female, 1 male) (PHE) to whom participants were to be referred (for example walking clubs, cycling groups). The dominance of non-participants in the sample (there were five of them) provides an insight into their general views about healthy exercise provision, without specific knowledge of the nature of the physical activity care pathway in operation.

The study was scrutinised, with approval granted, by the local NHS Research Ethics Committee in June 2010. As stipulated by the protocol accepted by this Committee, the identification, approach and subsequent recruitment of interviewees was systematic. Ensuring interviewee choice regarding involvement was paramount at all times. Interviewee recruitment was undertaken in two ways. Participants and non participants who had provided their telephone number on the initial GP-PAQ screening form were contacted via telephone and asked if they would be prepared to be interviewed. Upon a positive response they were sent a letter of information and invitation which when returned led to them being contacted again to arrange an interview time and date. All participants and non participants expressed a preference to be interviewed by telephone. Each of these was conducted by one or other of the first two named authors.

All of the other interviewees were recruited via an information and invitation letter, their contact details having been obtained through their professional involvement in the scheme. Upon a positive response to the letter (a reply slip returned to the researchers), they were contacted and interview dates and times were arranged. Health trainers attended a focus group which took place at their main headquarters, the GP receptionist

was interviewed via the telephone and the providers were interviewed in person at their place of work, for example a leisure centre office. The focus group and provider interviews were conducted by the first two named authors.

The interview schedules for the interviews and focus groups were devised based on the aims and objectives of the study and in accordance with Charmaz's (2006) recommendations for interview schedule design. The topics discussed, through open-ended questions, were structured around the five triggers to participation, derived in section 2 above. The focus group lasted approximately one hour, telephone interviews with non attenders between 10 and 20 minutes, interviews with provider's approximately one hour and the telephone interview with the receptionist, 8 minutes. These were taped and analysed for content, based on the five triggers to participation. Any information in the recordings that could lead to the identification of participants has been removed, anonymised or replaced with pseudonyms to ensure the confidentiality of all participants. The participants ages were not made available to the researchers.

The authors addressed issues of trustworthiness and authenticity by employing a variety of techniques (Denzin & Lincoln, 2000; Lincoln & Guba, 1985, Erlandsen *et al.*, 1993; Sparkes, 1995). These included for example prolonged engagement (the research took place over a period of 12 months), triangulation (a range of interview types was employed), undertaking the analysis at the end of the research process, reviewing and reflecting on findings (the first two named authors reviewed regularly the findings as they emerged and then latterly towards the end of the analysis with the other authors) and by critically appraising themselves, for their own biases, such as ethnicity, gender and beliefs through a process of reflection during the research process.

The findings that are presented below include quotations from participants where these offer a particularly concise summary of the issue under consideration (Erlandsen, *et al.*, 1993) although they are not intended to represent a detailed qualitative perspective.

These quotations are presented in italics with a code to determine which group of participants they were from. Names are omitted to ensure participant anonymity.

### ***3a. Physical infrastructure triggers***

Health trainers felt that the biggest physical infrastructure spur to participation was the pedometer. Participants responded well to increasing their number of steps a day as a progressive challenge. Whilst 'feeling better' is a subjective experience, doing more steps each day was seen as 'scientific' measurable progress:

*"Pedometers are the most valuable piece of equipment. They can become 'addictive' and have an element of competitiveness about them – competing against oneself" (HT2).*

In terms of provision, group activities could be problematic as participants had widely differing needs. Short group walks for example were a challenge for some but unfulfilling for others. Graded walks allowed progression, and providers noted that some participants had progressed from 'short walking' eventually to becoming volunteer leaders on longer walks. The physical environment was considered an important instrumental context here, with the natural and rural environments being particularly significant.

A further limitation to the physical infrastructure could be characterised generally as 'stigmatisation'. Many participants felt self-conscious if they were participating in events that had been identifiably organised specifically for them as scheme participants or were embarrassed because activities were in the public gaze. The supply response here called for a greater integration of activities with more routine events:

*“People feel embarrassed and stigmatised in respect of being identified as having been referred to take exercise. Where people are given choices, it is easy for them to opt out”* (PHE 1).

To a degree, this stigmatisation overlaps with the participant preferences trigger to participation: embarrassment will lead people to wish not to participate. The interviews identified other physical infrastructure triggers that also link to participant constraint triggers. Apart from walking, all other forms of exercise were reported, by participants and providers alike, to be problematic because of cost (too expensive) availability (too far away) or the need for ancillary equipment (bicycle).

### ***3b. Information infrastructure triggers***

The *initial* information infrastructure was considered problematic in this case study. Non-participants in particular were often unclear about the purpose of the form. One, for example, felt it was a survey of people’s active lifestyles and not a programme *per se*. Another presumed that *Let’s Get Moving* (LGM) was about making sedentary people more active but had not been told this explicitly:

*“I think it was something to do with exercise and so forth”* (P3)

All non-participants claimed to have filled in the form because they were asked to and not because they necessarily wanted to be part of the scheme. All said that they knew nothing about the scheme before they filled in the form and most said that they found out nothing about the scheme subsequently (although not all would have expected to):

*“Information is the critical thing, but somehow it got lost down the line”* (P5)

One non-participant was keen to be part of the scheme but couldn't find out how to join even after filling in the form and making further enquiries. She was keen to be a leader and ambassador for the scheme, but asked:

*"what are you offering? Are you offering a health programme? Are you offering a recreational exercise programme? Are you offering me a financial incentive? I haven't a clue what it is all about .....I haven't a clue" (P2)*

Lack of information was the only reason for her not participating.

Providers of exercise found it difficult to distinguish the *Let's Get Moving* scheme from what they considered to be a large array of similar schemes and they had a limited amount of time for getting to understand individual programmes. They felt that the large number of schemes available would be confusing for participants, too. The information links *between* providers were not considered to be very strong either.

Health trainers, on the other hand felt that they had been fully inducted into the precepts and operation of the scheme through a training day. This had successfully engendered enthusiasm for the scheme and prepared the health trainers for dealing with people who are inherently reluctant to exercise. Their perception also was that once participants became active, the information flow became valuable. When exercise was discussed with participants at initial assessment interviews, for example, they were often quite shocked at how little exercise they did. This was seen as being likely to nudge people into action.

### **3c. Administrative infrastructure**

A number of different elements of the infrastructure of the scheme influenced participation. The untargeted nature of the scheme meant that take-up was low,

particularly amongst the already fit and active who saw the scheme as having no relevance to them. The same people also were filling in the form several times if they were regular attenders at GP surgeries. Others filled it in for 'something to do' whilst waiting to see the doctor, with no intention of joining the scheme.

*"I filled the form in only because I was trying to help" (P6)*

The untargeted nature of the scheme meant, it was felt, that it was not reaching those who needed it most and that this diminished its legacy value. Patients were signed off after 3 months so there were not necessarily any longer term benefits to the scheme anyway. One of the stakeholders felt that the scheme should generally be more accountable:

*"A GP referral to do exercise should be seen as a prescription – instead of a bottle of tablets. Participants should not be able to go back to the GP to say "I'm no better" if they haven't taken the medication, taken the exercise" (S1).*

Second, there was considered to be a lack of coordination of healthy exercise providers in a crowded market. Some felt that the profusion of schemes was impacting negatively on their established markets and that the coordination of all supply side provision would be beneficial. The relationship between health trainers and exercise providers also could be improved, particularly in terms of health trainers gaining a greater understanding of the full range of what providers had to offer. In addition, exercise providers had been asked in some of these schemes, to adjust their provision to target the more sedentary specifically and this provided difficulties for them in that it compromised provision for their normal, core clientele. This was particularly difficult for voluntary organisation providers in that, as volunteers, they could not be *directed* to change the focus of their provision.

A third issue of infrastructure was that of liability against participants becoming ill or injured whilst exercising as a consequence of the reason for their referral, for example, in relation to a cardiac problem. Whilst this could be ameliorated by the participant requiring a permissive letter from the GP, GPs were often reluctant to sign these (they take on the liability), or would charge.

### ***3d Participant triggers: constraints***

A particular advantage of this data collection was that non-participants were able to speak personally about the constraints on them participating. The lack of information on how to become a participant has been noted above, but also a lack of information about cost and an apprehension about how much this might be also provided limits to participation. The possible time commitments also remained unstated, but potentially a barrier, particularly for full-time carers.

Two non-participants felt that they were too ill to participate because of encephalopathy and arthritis (rheumatoid and osteo). One interviewee did not like 'formalised' exercise programmes and he did not particularly want to mix socially with the old and unfit (despite being 74 years old):

*"It sounds silly, but I don't like mixing with too many oldies"* (P3)

Finally in terms of these personalised constraints, some felt the scheme was just inappropriate for them because they were already fit and active.

Comments from the other groups interviewed (and indeed some comments from non-participants) were less personal and concerned their general view about why people were not able to join such schemes.



An inherent antipathy towards exercise was discussed by all groups. Some suggested that this was culturally seated: working long hours and poor diets created unhealthy lifestyles and there needed to be a cultural shift so that exercise becomes the norm. The majority of the public simply has no interest in exercise and does not appreciate its value. This can be helped by developing a sense of 'competition' and can be influenced by 'sporting heroes' but there are no sporting heroes that only walk. Others suggested that this antipathy was more to do with personal temperament. Some people are inherently motivated to exercise, whereas others are not, whatever the circumstances that suggest that they should.

The health trainers in particular felt that many referred participants lacked confidence: being referred in the first place was a stigma. Such people tended to be less well, older and often overweight. This made them commonly very inhibited about taking exercise, particularly in 'public' places such as swimming pools. In these circumstances, where people are given choices, it is easy for them to opt out. Two interviewees mentioned home and school contexts as constraints to participation. Home life and associated social support and perceived norms can have a negative influence on exercise behaviour. For example, a partner discouraging exercise versus participating and supporting (Burton et al., 2003). There are strong 'habits' in families that are passed from parent to child (Jarvis and Wardle, 2006). This is the same for diet and drinking as well as exercise. School has a similar influence with respect to peer behaviour but the way sport in the curriculum is constructed is also problematic. It is pursuing excellence only and is not perceived as inclusive.

Finally, two interviewees also mentioned the influence of risk in causing reluctance on the part of many people to take exercise. Simply put, they fear that they will harm themselves or otherwise make themselves ill.

### **3e Participant triggers: preferences**

As with constraints, the discussion of preferences as a trigger to participation had both a personal element (mainly from non-participants) and a generalised element. Each of these is considered in turn. The personal preferences of the non-participants were in the main about why they preferred *not* to participate. The exception to this was a preference to participate (thwarted by not knowing how to join the scheme) as a means of *keeping fit*. One non-participant suggested that that was why most of her friends took exercise. She suggested that:

*“they don’t want to get fat, or have a streak of vanity” (P2).*

Another felt it important as a means of staving off the effects of an illness (emphysema) and also would have liked to have joined for social reasons as she was new to the area and had moved into sheltered housing. The scheme would have been a great way to get to know people and to get involved, to be less isolated:

*“I like the idea of the social side of it – that you meet new people” (P5).*

Social reasons also were a motivation for *not* joining in for non-participants: they did not want to mix with older people, they already had enough friends; they did not want to be associated with unfit people or more simply, the social element was of no interest.

The other two personalised reasons for non-participation were that people already considered themselves to be fit, or that they couldn’t be bothered. Of the former, one non-participant was a regular user of the gym (P6), one (P2), at 67, swam nearly every morning, walked at least three miles a day, body boarded, danced and rode horses, and another was a regular exerciser before she became too ill to participate (P4). P1 was

critical of the blanket nature of the scheme because it 'caught' a number of people to whom the scheme simply was not relevant:

*"I'm very fit for my age and exercise is not something that I worry about". (P1)*

One non-participant (P3) was resigned to *not taking exercise* beyond pottering about (gardening and cleaning the car) and spending time with the family.

*"I don't do as much exercise as I should". (P3)*

His muscles were wasting away a bit anyway, he said, and whilst he was thinking about buying a bike, he had not got round to it and apparently accepted an age-related decline in physical activity. He preferred the computer:

*"I've always been a bit idle ..... when I did cross-country at school I would always sit down if I got a bit tired ..... I have never had the motivation to win ..... you have to accept that when you are in your mid 70s that you are on the decline rather than the improvement". (P3)*

Other comments about preferences to take part (or not) in the scheme were generalised views about *others*, largely from the health trainers and the exercise providers. In respect of delusion, most people think of themselves as being more active than they actually are. When they realise this they are quite susceptible to trying to put more activity into their daily lives.

In respect of types of activity, group activity was felt to be important, particularly for older people. It is a good motivator and people often remain socially engaged with exercise groups even after they have ceased exercising. Such activity also is more cost effective to run. Whilst group activity is a spur to action for many, others, particularly

the least fit, are too self-conscious about their inabilities to join groups – at least initially. In terms of specific modes of exercise, walking is seen as the most gradual introduction (back) into exercise and it can be away from the public gaze to begin with. Incidental exercise (doing exercise whilst doing something else) is often the most successful part of regular exercise, according to the health trainers.

Equity considerations also were felt to be important. One provider put on organised weekly walks starting in a deprived area of Cannock and running on flat terrain. Over 12 weeks, only two people attended, despite extensive publicity. The health trainers also noted that even when walks are put on in deprived areas, it is the non-deprived that tend to join in with them: those most in need of the programme often seem to choose not to take part.

Finally, health trainers were able to cite positive legacy values from the *Let's Get Moving* scheme. Many people, they note, are significantly positively influenced by having being on the scheme. It has given them an energy, enthusiasm and self esteem that they did not have before. In paraphrasing a letter that had been received:

*"Thank you xx (health trainer) you have made my life ..... I feel so much better.....and.....it has been built as just part of my daily routine without me even thinking about it." (HT2)*

Most people who stick with the programme become enthusiastic about it, many taking on the responsibility for their own health.

#### **4. Participation in healthy exercise schemes: the limits of influence**

These short interviews and focus groups shed useful light on a range of factors that stimulate or deter active participation in outdoor exercise. Views about physical

infrastructure triggers suggest that, although they are complex motivators, they can be manipulated by providers to better serve the desires of participants. In particular, supportive technologies such as pedometers can stimulate participation but also the interviews show that participant groups are diverse in their needs and desires and a 'one size fits all' activity offer is as likely to disenfranchise some participants as it is to attract others.

In the case study, the information infrastructure was fully within the influence of the scheme providers and yet this was seen as a particular barrier to participation. People were confused about the purpose and structure of the scheme and a number of non-participants claimed that they would have taken part had they had a clearer picture of what they were supposed to do. The survey also draws attention to the importance of good information between the various parts of the provision infrastructure as well as between the providers and the recipients. Such commentary provides clear scope for manageable change.

The administrative infrastructure too, was seen to have limitations that were within the gift of providers to resolve. The scheme could have been more clearly targeted and more effectively situated within other available schemes. The relationship between the various different people that made up the provision infrastructure also could have been better orchestrated and issues of possible liabilities against injury, clarified.

This kind of exploration through discussion with all stakeholders in the scheme therefore was able to identify a range of actions that could be undertaken by providers to improve the full set of provision triggers for outdoor exercise. But is also served to identify some of the triggers to participation that providers are unlikely to be able to influence, because they rest within the circumstances and attitudes of participants and non-participants. Thus, constraints to participation confirmed Pigram & Jenkins, (2006) findings relating to a lack of mobility and the Henley Centre's (2005) identification of time and income

constraints. Carlisle's (2006) cultural attitudes towards outdoor exercise, Allen-Collinson's (2008) motivational drivers and Dilley's (2007) risk of harm were all articulated through the discussions as things that fell beyond the gift of providers to influence.

But other constraints to participation may be subject to adjustment by scheme providers. In particular here, the building of confidence amongst participants was seen as a critical trigger to participation. This could be used to overcome the stigma that some participants felt, particularly if used in conjunction with a physical infrastructure that did not isolate participants.

The discussions also identified a set of preferences that simply fall outside of the influence of providers. And the interviews with non-participants allowed the articulation of preferences not to participate. Here, Wheaton's (2005) social context comes into play in that some simply did not wish to mix with other people. Most intractably, some simply could not be bothered, seeing exercise as too much like 'hard work' (Allen-Collinson, 2005).

These discussions, then, provide useful information in relation to those things that are within the gift of providers of schemes to manipulate, those over which they can have limited influence, and those over which they have no control at all. Clearly, actions can be put in place to ameliorate nearly all of the issues relating to provision and some participant triggers relating to constraints could be softened by providers of such schemes, particularly those relating to cost and the appropriateness of schemes for the particular needs of potential participants. It is possible, too, that particular parts of the provision infrastructure might be able to ameliorate more personal perceptual issues relating to a lack of confidence, a sense of being stigmatised and the perception of risk.

But things such as diet, temperament, antipathy, lifestyles, home and work contexts and 'busy lives' do not fall within the direct control of providers. Some of these may be addressed by broader economic and social policy but, as has been noted in section one above in the context of health exhortations, may be less than successful. Participant triggers brought about by illness straddle constraints and preferences and again, at the point of participation, are largely beyond the scope of influence of individual scheme providers.

What is critical from this research then, is that it is erroneous to attribute the limited success of individual healthy exercise schemes, reviewed in section one above, to those providing them, if the reasons for the lack of success is beyond the providers' sphere of influence. For many schemes, improvements can be made by providers by addressing supply side issues. There is sufficient research evidence to suggest, however, that lack of success where it does occur is strongly influenced by participant preferences and constraints that are beyond the ability of providers to influence. In these cases, supply manipulation at the individual scheme level will make little difference to scheme performance.

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