

# **WALKING THE WAY TO HEALTH**

## **2000 - 2005**

### **SUMMARY OF LOCAL HEALTH WALK EVALUATIONS**



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## **EXECUTIVE SUMMARY**

### **Age and Gender of Participants on Led Walks**

The majority of participants on led walks are older (over 50) with a predominance of female walkers (~73%). Older females tend to have the lowest levels of physical activity levels and those levels continue to decline with age, WHI has therefore tapped into an important target audience. The proportion of male walkers is increasing in many schemes. Campaigns such as the Ton Up Challenge, that specifically target younger people, and work with partners such as Sure Start that recruit young families into walks have proved successful and have the ability to attract new audiences.

### **Activity Levels of Participants**

The national evaluation by Oxford Brookes University (OBU) suggests that, in the early days of schemes' lives, they have a tendency to attract keen walkers: the so-called 'torch-bearers' for walking for health. However, as schemes become more established, more 'first-time' walkers and less active people join. These 'first-time' walkers are significantly more likely to represent disadvantaged groups. Many local scheme evaluations suggest that a significant proportion of walkers are not active enough to benefit their health before joining the walks and participants report that the walks contribute greatly to increasing their activity levels.

### **Health of Participants**

The OBU national evaluation found that one fifth of participants report a health condition. This is consistent with data from the health screening questionnaires analysed in many local evaluations where approximately 20% of walkers report a health condition. Many walkers report using the health walks to maintain or improve their health.

### **Reasons for joining and taking part in health walks**

Both the national and local evaluations indicate the social element of health walks as a major feature in people's decisions to join and to continue attending health walks. However, many schemes report that a desire to improve/maintain health is an important and, in some schemes, the

major factor for taking part. These findings are likely to reflect the way in which schemes are promoted, i.e. with either a 'health' or a 'social' emphasis.

The most commonly cited pathway for participation is 'word of mouth' or 'newspaper advert or leaflet'. A small proportion (~10%) of participants join the walks on recommendation from their GP.

### **'Adherence' to health walks**

Percentage retention rates of led walks are impressively high. Most people who do drop out of led walks do so only because of a health problem that prevents them from walking, or because of other commitments, and they intend to return at some stage. The randomised controlled trial of health walks (Lamb et al, 2002) indicated that people given information about health walks in their area were 13% more likely to still be active at 12 months (compared to those given general information about the benefits of exercise).

### **Reported health and well-being benefits of walks**

It is likely that health walks play an important part in increasing people's levels of physical activity thereby conveying numerous health benefits. Local evaluations report a range of perceived benefits to participants including increased stamina, increased mobility and reductions in blood pressure and in a few cases, weight. Studies by local schemes also report significant improvements in health-related quality of life as measured by the SF36 questionnaire (Clark, P, 2004).

Consistent with the national evaluation, many local evaluations contain qualitative evidence of improvements to mental health of participants. Walkers frequently cite decreases in depression, anxiety and stress as a benefit of the walks and report using the walks as a coping mechanism to deal with life's demands. More specifically, several mental health services have indicated that health walks provide a valuable resource in the rehabilitation of patients.

### **Effects of the walks on participants' social networks**

Most evaluations of health walks, including the national evaluation and the comprehensive evaluation of the Bristol scheme, record the fact that health walks play a vital role in providing an

opportunity to meet people and socialise. A significant proportion of walkers are at risk of being socially isolated which may compromise their health.

### **Effect of health walks on participants' transport habits**

It is likely that participation in health walks has a significant effect on walkers' transport habits with an average of 50% of respondents indicating that they are now more likely to use walking as a mode of transport for short distances.

### **Volunteer Walk Leaders**

WHI has trained more than 18,000 volunteer walk leaders and the numbers continue to grow as a cascade training system has been put in place. It is estimated that just over 50% of trained volunteers continue to be actively involved with schemes. The amount of volunteer time devoted to the health walks is considerable with many schemes reporting in excess of 1,500 hours of volunteer input every year. Moreover, many volunteers are now taking on the responsibility of running their own schemes. There is still a need, however, for volunteers to be supported by a statutory organisation. The standard of training provided by WHI is considered to be high with most volunteers stating that they found it 'very useful'. More than 12% of walk leaders are from ethnic minority groups.

### **Sustainability of schemes**

The majority of schemes are continuing to operate despite WHI funding coming to an end. Seven different models for sustainability have been identified including volunteer-run schemes and mainstreaming of health walks within existing local authority and PCT programmes of work. Details of how and where these have been applied are contained in Appendix II. Where schemes have not been mainstreamed or integrated, there is still a need for volunteer support from a statutory organisation. Although most volunteers are keen to continue operating existing walks, there is a risk that once funding is removed, schemes will no longer have the capacity to develop and attract new walkers.

### **Step-O-Meter campaigns**

The Step-O-Meter has proved to be an effective and popular device to increase levels of walking with a range of groups. Health professionals have welcomed this method for raising awareness and increasing activity levels in their patients/clients

### **CONCLUSION**

Walking the way to Health and led health walks in particular provide an important resource for people to maintain or improve their health. Health walks are safe and effective and have been shown to be sustainable both for the individual and at an institutional level.

The volunteer walk leaders are an important resource for WHI, but the amount of support that is required to keep them involved and interested should not be underestimated. Some schemes have shown that they can be self-sustaining by volunteers taking over the day-to-day running and administration of the led walks. However, this model of sustainability is not suited to all walk schemes, particularly in areas of disadvantage where co-ordinator time needs to be spent encouraging hard to reach groups to take part.

Targeted marketing can widen the appeal of walking for health to younger audiences, but led walks still hold the greatest appeal for older people (over 50). Since this age group has the most to gain from staying or becoming more active, this is not seen as a negative finding.

Whilst GPs and health professionals do have an important role to play in endorsing and supporting health walks, the majority of walkers are likely to hear about the walks from friends or from the local media. In order to encourage diversity amongst the walkers, it is important that as many different people and organisations as possible are involved in promoting walks.

Although schemes report an increasing number of first-time walkers and walkers from disadvantaged groups, there is a danger that health walks will attract significant numbers of people who are 'keen walkers'. This in turn risks alienating less fit walkers. Efforts to recruit sedentary

people and people who are irregularly active should be stepped up. Attracting walkers from disadvantaged backgrounds requires partnership working and co-ordinator time to be spent forging relationships with key community groups and officers.

More consistent data collection of attendance and drop out rates, as well as an agreed definition of 'adherence' is needed in order to combine data sets across schemes.

Any future evaluation of health benefits needs to capture true baseline data of people who are new to exercise so that the effects of any health walks intervention can be more accurately measured. Useful evaluation methodologies have included the SF36/SF12 questionnaire and the use of focus groups to identify perceived benefits.

## **1. INTRODUCTION**

Since its launch in September 2000, the Walking the way to Health Initiative (WHI) has enabled the creation of more than 350 health walk schemes across the UK. Direct grant aid has been provided to 202 schemes (grant-aided schemes) and further assistance has been provided to other non-grant aided schemes in the form of a range of services, including training, insurance, advice, accreditation and access to WHI networks. A comprehensive website ([www.whi.org.uk](http://www.whi.org.uk)) and a web-based learning network have also been created to support schemes

It is estimated that to date (September 2005) approximately 150,000 people have taken part in led walks run by the 202 grant-aided schemes. Data is not available for the other 148 schemes that do not have an obligation to report participation rates to WHI. However including participants from non-grant aided schemes, it is likely that there are more than 300,000 people participating in led walks.

### **1.1 Scope of Summary**

WHI has been the subject of extensive evaluation, including a randomised-controlled trial (Lamb et al, 2001), a national evaluation taking the form of a longitudinal study sampling from schemes across the country (Dawson et al, 2005) and an in-depth study of the Bristol Walking for Health scheme (Davis, 2005). In addition, local schemes have carried out evaluations to monitor participation rates, participant satisfaction and, in some instances, the impact on walkers' health. Very few of these local evaluations have been the subject of rigorous, robust research and none have included control groups. Nevertheless, a range of themes, issues and the potential health impact on participants can be identified from the reports that have emerged. The most robust surveys (in terms of sample size, response rate, data analysis and in-depth discussion) have been given priority in this summary.

Some local schemes have been the focus of research by students at both under-graduate and graduate level and summaries of these are also included here. This summary of local evaluations gathers the evidence from those reports and sets it in the context of the wider evaluation of WHI, in

order to identify the impact of the national initiative across a range of themes from percentage retention rates to health benefits.

Although much of the evaluation of local schemes centres around ‘led’ walks, this report also includes some data about independent walking, collected from those schemes that promoted and evaluated materials and methods to increase walking outside the led walks programme. This summary also draws on case studies of participants collected by schemes to illustrate the impact on their health, well-being and social networks. Other information that is included in this summary is drawn from the participation data reported by grant-aided schemes as part of the New Opportunities Fund monitoring protocol for its Healthy Living Centre evaluation.

## **1.2 Criteria for inclusion**

A full list of all the evaluation reports used in this summary is contained on page 47. This report contains evaluations from local schemes that were received as at 30th November 2005. Further evaluations that were not available at this time will be included in future versions of the report.

## **1.3 Limitations of this summary**

The majority of local schemes have collected data from own-design questionnaires. An example of a typical questionnaire is included in Appendix I. The partners involved and the relevant outcome measures influence the type of questions that were asked of participants. Although the standard of these questionnaires is generally good, many schemes used questionnaires that included directed questions and therefore may be potentially misleading. Some local schemes used focus groups to evaluate the walks and the richness of the qualitative evidence that emerged from these participants’ experiences is used to illustrate the various themes.

Limitations of this report reflect the fact that local partners were encouraged by WHI to adopt a ‘light touch’ in evaluating the impact of their scheme on walkers. This was done so as not to detract from the enjoyment aspect for participants and so that walk co-ordinators could focus on delivering and developing the walks to maximise participation and adherence, in the knowledge

that these figures in themselves are an indication of potential health benefit. Participants tend to be reluctant to fill out lengthy forms and just ‘want to get on with the walk’. This was borne out by the Chesterfield scheme where an exercise to monitor participants’ physical, mental and social health yielded a response rate to a questionnaire of just 15%. The national evaluation carried out by Oxford Brookes University (OBU) (Dawson et al., 2005) did manage an impressively high response rate (82% at 3 months and 78% at 12 months). However, this is likely to be due to a considerable amount of researcher time being spent on data collection and encouragement to complete questionnaires.

A list of partner organisations that have worked with WHI is included in Appendix III and a summary report about the sustainability of local schemes is contained in Appendix II.

## **2. ACTIVITY LEVELS, HEALTH AND PROFILE OF PARTICIPANTS**

### **2.1 Who are the walkers?**

#### **2.1.1 Age and Gender of Walkers**

A consistent finding across the schemes is that led walks tend to attract a large majority of older people and a predominantly female audience. Figures range between 90% aged between 56 and 85 (Hastings) and in Portsmouth, all participants are over 55 with 52% being 65 and over. The OBU evaluation suggests that participants are predominantly female (73%), young-old (age 65 to 74) and mainly retired. The over-representation of the older age groups are probably a reflection of the fact that many participants are retired and therefore are able to participate in weekday walks (which is when most of the walks take place). Walking is perceived as a relatively easy activity and therefore accessible to older people who may have limited mobility. Specific initiatives to engage younger audiences have proved successful, as in the ‘Ton Up’ challenge in Newcastle. Schoolchildren were invited to clock up 100 miles of walks as part of the campaign. Many schemes report a number of under-11s walking with their grandparents during the school holidays. Several health walks schemes have worked with organisations such as Sure Start to attract younger families into health walks, but it would appear from the national statistics that they still hold the greatest appeal for older females. Schemes are also expanding their walk programmes to include weekend walks that tend to attract a younger audience.

Although there is a predominance of female walkers on led walks, many schemes have successfully addressed this issue and more men are coming forward to take part in health walks. In the Wear Valley scheme men account for 33% of the walkers. Many schemes report that many men do not see walking as ‘exercise’ and therefore are put off joining for health reasons.

### **2.2 Activity levels of participants**

It is estimated that less than 28% of the UK population currently meet the Government guidelines of thirty minutes of moderate intensity physical activity, five times a week. The Government has set a target of increasing activity levels in the general population by 20% by 2020: a 1% year on year increase.

Measuring physical activity levels is complex and notoriously inaccurate. Most studies use self-report questionnaires to ascertain how active people are in their daily lives. Other methods include using accelerometers to record individuals' movement throughout the day, but these devices are expensive to use and require expert knowledge to interpret.

The OBU study used the Daily Activity Questionnaire to measure baseline and subsequent physical activity levels of participants. Questionnaires such as these are lengthy and, unless administered by a qualified researcher, subject to inaccurate self-reporting of activity. Consequently, accurate measurement of walkers' activity levels upon joining the scheme was beyond the resources of most local schemes. However, some schemes did include questions in their evaluation forms for walkers about how active they were prior to joining the health walks. Typically, in response to questions asking whether participants felt they were a)unfit, b)just fit, c) fairly fit or d)very fit, most people tend to describe themselves as 'fairly fit'.

Many schemes report that they appear to attract a large proportion of people who are already reasonably fit and active although few schemes have used validated methodologies to ascertain people's level of fitness. Attempts to capture this information in the Keystone and Wayland scheme were abandoned as the co-ordinator felt that most people over-estimated their activity levels .

In an evaluation of the Worthing walks, 12.5% of participants described themselves as sedentary or inactive before joining the scheme. In Chesterfield, 8% of participants said they hardly did any exercise before joining the led walks and 53% said that they did 'some exercise'. In the Outer Westie scheme, 32.4% of respondents to a questionnaire said that they did not currently exercise at the Government levels, i.e. 30 minutes, 5 times per week. The East Hampshire Walking for Health evaluation reports that 68% of participants saw a significant change in their activity levels as a result of taking part in health walks.

Data from the OBU study indicates that most participants were already quite active upon joining the scheme. This may to be due to the fact that the research was carried out in the formative months of new schemes when they were more likely to attract keen walkers as the 'torch-bearers'

of the scheme. Indeed, there is evidence in the OBU report to suggest that as schemes become more established, they attract more and more people who are walking ‘first-timers’. Several schemes report that recruiting sedentary individuals remains a challenge and targeted recruitment and marketing is needed to address this issue (e.g. Rom, K, 2005). This is particularly the case in more affluent areas where the walks tend to attract those in higher socio-economic groups who are more likely to pursue healthy lifestyles than those in the lower groups.

Some schemes have run one-off events in an effort to recruit more participants who are sedentary with mixed success. The Ton Up Challenge, an intensive, short-term initiative, was held in Newcastle to attract younger people to walking and involved lap-walking of the local stadium. Seventy percent of those taking part said that they took no other regular exercise apart from this campaign. However, some scheme co-ordinators report that the resource implications for one-off events designed to engage with sedentary people are very high and fail to engage enough people to justify the time spent on planning and delivery. New ways of engaging with hard to reach groups are constantly being explored by scheme co-ordinators and many are now seeing increasing numbers of unfit individuals participating in their led walks.

It is probable that health walks attract individuals who are keen to keep fit and healthy and who may have switched from other activities to taking part in led walks. However, were it not for the availability of health walks in their area, these individuals may have discontinued being active in the absence of suitable opportunities. Much anecdotal evidence from walkers suggests that health walks offer an important opportunity for people who want to keep fit but for whom other activities are no longer suitable.

Anecdotal and observed evidence from many local schemes suggests that they do in fact attract people who are sedentary or who do not exercise at the recommended level. However, these are also the people who would be reluctant to be interviewed or respond to questionnaires. Focus group findings for the scheme in East Newcastle and qualitative data from other scheme evaluations suggest that health walks do attract a significant number of very sedentary people. The fact that more than half of participants chose ‘easy/flat’ or ‘first steps’ walks suggests that health walks do in fact attract some less fit individuals as well as people who are already active at the

recommended levels. Attracting sedentary participants remains a challenge for most schemes, but focusing on offering short, slower walks ensures that many less fit people are able to participate.

### **2.3 Positive answers to Health Questionnaire**

A few schemes looked at the number of walkers who responded positively to one of the questions on the health walk questionnaire (PAR-Q) administered to all walkers upon joining a scheme, thereby indicating that they had a health condition. Data from these evaluations suggest that approximately 20% of walkers suffer from at least one of the seven health conditions identified on the questionnaire. The Bristol Health Walks scheme (Davis and McKenna, 2005) reports that nearly a third (32.6%) of walkers gave a positive answer to one of the questions on the PAR-Q and that walkers reported a wide range of health problems, most of which are linked to ageing processes. The Bristol evaluation concludes that it is attracting participants ‘where walking (a) reduces disease risks, (b) reduces risks associated with a sedentary lifestyle but (c) minimises risk associated with more intense exercise. Further, walking can have a powerful effect on reducing the negative effects of remaining sedentary in the presence of these conditions.’

### **2.4 Health of participants**

Participants rarely report having poor health, although a significant number of walkers tick one of the boxes on the health questionnaire upon joining the scheme. In the Wolverhampton scheme, 68% of participants reported that they were currently taking medication and in Wrexham 72.2% of men and 54.3% of women reported being treated for a medical condition when joining the walks. The proportion of people who report poor health is likely to be higher in schemes with a high number of GP referrals.

### **2.5 Ethnic minority participation**

Data from the NOF evaluation suggests that WHI has attracted 8% of participants from ethnic minorities. This figure is consistent with the national profile and representation of such groups within the UK population. A review of the evaluations from local schemes suggests that ethnic minority participation is greater where this was defined as a priority from the outset of the scheme.

In East Newcastle, ethnic minority participation increased significantly in year two of the scheme from 5% in year one to 13% in the second year. Some schemes have been set up for a particular ethnic group, e.g. The Chinese Association scheme in Islington, where the vast majority of walkers are Chinese. The Confederation of Indian Organisations has been running walks which are aimed at Asian men and women and where less than 1% of walkers are from other ethnic backgrounds. However, most schemes operate to be inclusive of ethnic background.

### 3. PARTICIPATION AND RETENTION

#### 3.1 How do people hear about the walks?

The most common pathway for joining health walks appears to be ‘word of mouth’, followed by ‘seen advert in local press’. On average, 40% of walkers hear about the scheme from another person. The Chesterfield evaluation found that 86% of walkers had recommended the scheme to a friend. In Wear, 70% of walkers reported hearing about the scheme from friends. Leaflets about the schemes have been reported as attracting 16% (North East Oxon) of walkers.

*“I keep telling everyone how wonderful it is” Walker on the East Newcastle scheme*

The proportion of people joining health walks on their GP’s advice tends to be low. Most schemes report findings consistent with those from the Calderdale health walks, where just 10% of people joined on their GP’s recommendation. There are exceptions to this, where schemes have been set up specifically with GP surgeries or where health walks are part of a GP referral programme. In Kirklees, 70% of walkers come via the Practice Activity and Leisure scheme. In Wear Valley, although only 9% of walkers were GP referrals, 24% of walkers said that they had reinforcement from their doctor to keep walking.

#### 3.2 Motivations for joining led walks

Many schemes have asked their walkers why they wanted to join the health walks. This has either been done with closed questions in a survey form, or through discussions in focus groups. A survey of the Middlesborough walkers suggested that 44% of walkers joined to improve their health and 46% of respondents reported that ‘prevention of illness’ was a factor in their decision to take part. ‘A chance to be outdoors’ was cited by 46% of participants as being influential in their joining up. The social element of the led walks is also a major factor in people deciding to take part. The OBU study revealed that a significant number of walkers in their sample had been bereaved in the previous 12 months and had sought out the company of the group as a coping mechanism. In Bristol, the majority of respondents (64.8%) cited social contact, such as “meeting people”, “companionship”, “making new friends”, “reduction of loneliness”, as the most important

motivations. The following quotes, collected from the East Newcastle evaluation, are representative of the reasons people give for joining health walks :

*"I only meet other people when I go on the walks. It is the only time I get to mix and talk with other people."*

*"Well I don't have any family, I mean I've got sisters and brothers but I don't have children and my husband's been dead for ten years, so it's ideal for me"*

*"One of the reasons I joined is that my husband died last year and I was on my own. Not only have I met new friends to go out with, I've met neighbours that I've known for years but never had anything to do with them really."*

Some people in the focus groups also report attending on their GP's advice to deal with problems like depression, high blood pressure and raised cholesterol.

Not wanting to walk alone is another frequently cited reason for joining the walks, particularly by women and people with poor health.

*"I love walking, but there are a limited number of places I can feel relaxed walking by myself, hence the groups are invaluable"*

The motivational reason given for joining a health walk group may reflect the way the scheme is marketed; in other words whether the health aspects or the social or other aspects are promoted. In the East Hampshire scheme where the health aspect is heavily promoted, 56% of people surveyed reported that they wanted to take part to improve or maintain their health. Other schemes which are marketed as 'Walk and Talk' are more likely to attract people who want company. Unfortunately it is not possible to draw comparisons between schemes as to which approach is more likely to attract the target audience of previously sedentary or irregularly active people as few schemes collected physical activity data and the OBU evaluation yielded only small samples from each scheme.

### **3.3 Participation rates on led walks**

Numbers of walkers attending each walk vary considerably but many schemes report between 20 and 35 walkers per walk. A group in Sawley reported that 68 people attend their Monday morning walk. A consistent pattern across schemes sees participation rates doubling year on year and continuing to increase as the walk schemes expand, adding new walks, recruiting new leaders and working with a wider range of partners. The annual report from WHI to NOF indicates that 50,000 people took part in led walks in the year 2003-2004. It is estimated that more than 150,000 people have taken part in led walks since the launch of the initiative in 2000.

It is useful to note that only 36 accidents or incidents have been reported on the walks in the past five years. Of these, only 6 were 'serious', mainly wrist or ankle fractures. Most reported incidents relate to minor injuries associated with a trip or fall. With an average of over a million person/walks per year on walking for health schemes, this accident rate confirms the fact that walking is a very low risk activity compared with other forms of exercise or sports.

### **3.4 'Adherence' to walks**

Typically, the term 'adherence' is used to define the percentage of people attending a set number of prescribed sessions of exercise. It is analogous with 'compliance' to a prescribed treatment. It is therefore probably not relevant to talk about 'adherence' to led walks, where their informal nature means that participants are free to attend as many or as few walks as they like. Many schemes have however attempted to record percentage retention rates : in other words the percentage of people who continue to attend walks on a regular basis over a set period of time, say 12 months. For the purposes of this report, the term 'adherence' is used interchangeably to describe percentage retention rates over a period of more than 12 months.

The randomised controlled trial of health walks (Lamb et al, 2002) indicated that people given information about health walks in their area were 13% more likely to still be active at 12 months (compared to those given general information about the benefits of exercise). Thus, walking has been described as the form of physical activity most likely to be sustained.

### **3.4.1 'Adherence' rates**

The literature suggests that approximately 50% of people who initiate an exercise programme drop out within the first six months (Dishman, 1988). The benefits of physical activity cannot be 'banked' and depend on continued participation. Anecdotal evidence from health walk schemes has suggested in the past that they enjoy high retention rates. This is consistent with the literature that states that 'interventions that encourage walking and do not require attendance at a facility are most likely to lead to sustainable increases in overall activity' (Hillsdon et al, 1995).

Many schemes have attempted to capture 'adherence rates' from their surveys, but there is little consistency in the methodologies used to do this. There is also no commonly used criteria to determine 'adherence'. However, many schemes have recorded percentage retention rates. Most studies have looked at the number of people still active (participating on average once a week) after 12 months. This data is mainly captured from annual reviews of databases of participants. The data is frequently distorted by the inclusion of walkers who attend one walk with no intention of attending any more. Many schemes record as participants people who attended launch events or who attend the scheme as stakeholders for 'one-off' events. However, some schemes are able to report reasonably accurate percentage retention rates, albeit in different formats. Thus Hastings reports that 58% of people had attended the scheme for over 10 months (17% for 7-9 months) and 83% report attending every week. In the Erewash scheme, 66% had been walking for more than 12 months. At the Sawley site, of 140 registered walkers, only 4 had lost interest, and 4 had 'dropped out'. At the Blyth Valley health walks, the coordinator estimated an adherence rate of 77% and the Redhill and Reigate scheme estimated that, after excluding walkers who had attended only once, their adherence rate was close to 90%. Data from the evaluation of the East Hampshire scheme suggest a retention rate of 88.4% between 2002 and 2005. However, the Stepping Forward project in Rochdale reports that 60% of participants only attended one walk. This may reflect the fact that many people join health walks and decide that 'it is not for them', but those who do return tend to participate regularly and for prolonged periods of time. It would certainly seem the case that, once attending regularly, participants rarely leave the walks without a reason which is beyond their control. Focus groups in the East Newcastle scheme support the idea that a large proportion of walkers attend the walks for more than a year. This finding is consistent with the national

evaluation which reports a 72% retention rate. Without a common definition of adherence, it is difficult to give an average 12 months adherence rate for all schemes.

### **3.4.2 Frequency of participation**

Little analysis has taken place to examine the frequency of attendance although Portsmouth found that 91% of walkers attended at least once a week and 57% attended more than once per week. In Erewash, 39% walk more than once a week with the scheme and 55% walk at least once a week. In East Hampshire 58% walk once a week and 34% more than once. Although this frequency of participation falls below the Government guidelines for 30 minutes, five times a week, a large proportion of evaluation reports indicate that people walk more outside the led walks as a result of taking part. This phenomenon is discussed in more detail in chapter 6.

### **3.4.3 Reasons for drop out**

Some schemes have followed up people who attended the walks at least once and then stopped attending. The Age Concern scheme in North Yorkshire surveyed non-attenders and reasons for giving up centered on issues such as not having enough time or other commitments. A study of the Chiltern and Benson schemes focused on investigating reasons for participant drop out, contacting walkers who had not walked for 6 weeks. There was a 71% response rate to the questionnaires and 28% of people cited ill-health as a reason for quitting, 24% said they were 'too busy' and 14% said the walks were 'too fast' for them. Thirty percent of the people surveyed said they intended to return to the walks at some point in the future. The report from the Keystone and Wayland scheme states that 92% of people who had dropped out intended to return. (Of these, 71% responded positively to a question asking whether they had encouraged other people to walk more, indicating that although they had not decided to continue to attend the walks, they were happy to recommend them to others and were aware of the potential benefits.) This is consistent with the Stages of Change model (Prochaska J. O, Di Clemente, 1983) which suggests that behaviour change involves a cycle of uptake, relapse followed by renewed uptake. The fact that health walks tend to attract older people clearly contributes to the drop out rate due to ill-health. Research suggests that 19% of men and 34% of women over 65 report illness and injury as a barrier to exercise (Stephen & Craig, 1990)

Drop out is reduced where all abilities are catered for within the walks and people do not feel that the pace is either too fast or too slow for them. Many people who stopped attending did so because they felt the walks were too slow and were expecting something more vigorous. However, as illustrated by the following quote, it is important to recognise that, as schemes evolve and walkers become fitter, there is a danger that the needs of newcomers or the less fit are no longer met.

*“The Wednesday evening walk became very fast and competitive before I stopped going. It’s not every time you feel capable of being so fit and yet you don’t want to spoil it for others, so I stopped going...”*

*“I kept holding people back because of being out of breath, I will come again when I improve.”*

Walk co-ordinators and leaders have an important role to play in determining participation and adherence rates. Franklin (1988) stated that ‘exercise leaders play an extremely important part in ensuring the success of exercise programmes, they can be the single most important variable that ensures effective adherence’. The conclusions in the Forestry Commission report on the West Midlands Woodland Health Pilot Evaluation states that the enthusiasm of walk leaders is a major factor in the success of a scheme in terms of it being well-attended.

A small number of people reported that they had stopped coming on the walks because they had become bored with the same routes or the lack of variety in the walks. The fact that only a small proportion of people cite this as a reason for non-attendance suggests that other factors are more important in determining adherence, notably the social nature of the walks.

### **3.5 Barriers to walking**

Most frequently cited barriers to walking include worries about personal safety and not knowing where to walk. In East Hampshire, 44% of people reported personal safety as being the main reason they did not walk alone. Not having anyone to walk with is also frequently cited as a reason for not walking.

#### **4. IMPACT OF LED WALKS ON PARTICIPANTS' HEALTH and WELL-BEING**

Several local evaluations have sought to establish the impact of led walks on participants' health and well-being. Health benefits can be measured indirectly through health indicators. Certain health indicators have been found to be associated with health benefit. Some main groups of health indicators are:

- Change in physical health measures e.g. blood pressure, Body Mass Index (BMI), VO2Max (lung efficiency).
- Change in mental health measures e.g. SF36 Health-related quality of life questionnaire, General Health Questionnaire scores, Beck Depression Inventory, hospital anxiety and depression questionnaire scores.
- Change in health behaviours e. g. level of physical activity.

##### **4.1 Physical Health Measures**

A few schemes have looked at objective measures, i.e. changes in blood pressure and BMI of participants. The Life Walks scheme in Epping offered 'Walkchecks' to some of its walkers who suffered from high blood pressure. Although the results of the blood pressure checks have not been analysed in any detail, it would appear that, after 6 months, all 11 of the participants surveyed noted reductions in both systolic and diastolic measurements. It is not clear how much of this reduction is attributable to the walks themselves, but many comments given in local evaluations indicate that people perceive that the walks are beneficial to their blood pressure.

The Clayton and Newton Heath project in North Manchester offered six-monthly mini health checks to participants and collected data on 33 people who attended follow up checks. Although the data was not analysed for statistical significance, there are indications that a large proportion of people showed reductions in blood pressure, body mass index and body fat percentage. It is not clear how this data relates to their participation on the walks, but clearly the health checks themselves were instrumental in raising awareness of fitness issues and also in helping to identify

people with high blood pressure which had previously gone undiagnosed.

*“I have more energy. It has also helped to control my blood pressure.”*

Future evaluation of the benefits of the walks could include controlled trials of patients suffering from high blood pressure to ascertain the contribution that participation in health walks can make in controlling this condition.

Several schemes have encouraged diabetic patients to join the led walks and anecdotal evidence suggests that they experience an improvement in their condition from taking part. One evaluation looked specifically at Type II diabetes patients (Billington, 2005). The study did not find any significant changes in a range of physiological variables, including glycemic control. However, meaningful trends in all variables were identified. The short time-span and the small sample size were seen as major limitations of the study.

*“This walk has helped me feeling good. It shows me what I was lacking in my life, it shows me how lazy I was, it helps me have a really good nights sleep, I use my car less, my skin looks better, my legs feel stronger, I have made some friends. I move better now. I have lost some weight. My breathing is better, I can walk up hills easier and not be left behind. I feel good. Thanks a lot for this programme. “ Lewisham Walking for Health participant.*

#### **4.2 Mental Health Measures**

A study by a student of the Newham scheme looked at the effects of walking on the multidimensional concept of quality of life using the SF36 questionnaire. The study followed participants over 9 weeks of participation in the London Borough of Newham’s health walks. Although 100 questionnaires were distributed, only 40 of those yielded usable data. However, there were significant changes in mean scores in both the Physical Component Score and Mental Component Score, with an improvement in the Vitality and Role Emotional ( $p < 0.01$ ) scores and an

improvement in the Physical Function scores ( $p=0.0004$ ). Improvements were observed as early as 4 weeks into the study, indicating that it does not take long for the benefits of regular walking to show.

*“Mentally, I look forward to Wednesdays – friendship, companionship.”*

### **4.3 Changes in health behaviours**

The OBU study is one of the few evaluations of health walks to employ a validated questionnaire to measure physical activity levels of participants upon joining the scheme and then again after 3 and 12 months. Other health walk schemes have simply posed questions about walkers’ activity levels in their surveys of participants (see Appendix I) and how the walks had affected the amount of physical activity they currently did. In local evaluations, few walkers report being ‘inactive’ but there is evidence from some studies to suggest that walkers felt that the led walks had led to increased levels of physical activity in their lives (Clark, 2004).

The Hastings evaluation concludes that participants were motivated to be more active thanks to health walks, with 8 out of 12 people attributing their level of physical activity to joining the regular walks. In East Newcastle, members of the focus groups felt there had been an increase in other physical activity such as cycling and jogging and that the scheme had been successful in attracting previously sedentary members. Middlesborough Healthy Stepping reports that 54% of survey respondents felt that the scheme had a positive impact on their enjoyment of physical activity. Eighty-four percent of walkers in the Epping scheme said that they are more optimistic about keeping fit and healthy in the future. The East Hampshire evaluation states that 68% of walkers saw a significant change in their activity levels since attending with 44% reporting an increase in other walking and 27% reporting an increase in the amount of gardening they do.

*“It motivates me to do things e.g. shopping, attend the gym. It is helping me to obtain a healthy lifestyle.”*

*“It stops me watching TV.”*

Although the OBU study found that 75% of people said that they were more active as a result of taking part in health walks, this finding could not be supported by the physical activity data collected via the Daily Activity Questionnaire. It may be that there is purely a *perception* of being

more active that goes with taking part in health walks.

#### **4.4 Reported health benefits of walks**

##### **4.4.1 Physical health**

Evaluations of local schemes employed either open or closed questions to identify a range of other health benefits that walkers may have experienced. Some evaluations asked whether the walks had an impact on the number of GP visits that participants made and the Wrexham scheme indicated that 12.2% of walkers report fewer visits and a decrease in prescription and medication.

Qualitative research carried out in the same scheme using focus groups support these perceived benefits with participants describing the walks as ‘effective therapy’ and having ‘physical and holistic benefits’. One walker reported a dramatic reduction in visits to his GP from once every three weeks to once every three months. He attributed this reduction to the fact that the walks had brought his blood pressure under control and he therefore did not need such regular check ups.

Forty two percent of Middlesborough walkers said they had higher energy levels and 51% said that their overall health is better now. In the Wrexham study, 65% of people reported positive changes to their health with most walkers feeling fitter and enjoying improvements to stamina and energy levels. Participants in the Epping Forest scheme also reported improvements in perceived fitness with 64% of respondents stating that they walk up stairs and hills more easily and 59% saying they walk more quickly. Thirty four percent state that they sleep better as a result of taking part in the walks. East Hampshire found that 33% report increased general health. Fifty five percent of the walkers from the Chesterfield scheme said that they felt that their health condition had improved as a result of taking part. These findings indicate that, regardless of objective measurement of health indicators, most people *perceive* their health to be better as a result of walking with the group.

A telephone survey of 40 people from the Wirral Walk On project identified that almost 90% of people who joined the scheme believed they had experienced physical benefits as a result of taking part in the led walks. Many had also made other changes to make their lifestyle healthier since starting the walking scheme.

The evaluation of the Bristol scheme looked at walkers' expectations in terms of how they felt the walks might improve their health. Of those that reported that they expected their health problems, such as asthma, diabetes, high blood pressure, arthritis, joint problems, low back pain, and obesity, to be improved by joining the led-walk programmes, two thirds (67.9%) reported improvement following a period of participation. Analysis indicated that the change of walking frequency was weakly but significantly related to improvements in perception of general health ( $r=0.363$ ,  $p<0.01$ ). This might indicate that, as a result of becoming healthier, walkers walked more. Alternatively, it may be that as result of led walks involvement, walkers felt that their health had improved.

*"I felt really fit after a walk – thinking I would have to lie down, but instead I did my garden"*

Comments by walkers in Hastings summarise some of the perceived benefits suggesting that the walks help to improve lung capacity with qualitative remarks such as "I'm less out of breath", "I don't puff and pant as I did".

*"It helps with my asthma."*

Other physical benefits are illustrated by comments such as : "lower back problems benefited", "leg is now stronger" and "better control of blood glucose level". Many people identify benefits to their mobility by saying that the walks help "keep them supple" and "keep the joints working".

*"Back pain has decreased significantly, my stamina has improved.."*

There are few reported cases of the walks contributing to significant weight loss, with most responses to questions about the effect of the walks on weight suggesting that there is no effect. However, 'maintaining weight' is identified as a benefit by many walkers. One walker in the Hastings scheme said the walks had helped her to lose a stone and 5lbs in weight. In East Hampshire 8% report 'weight loss' as a benefit of taking part.

*"I have lost weight and feel better both physically and mentally and don't get out of breath."*

*“Four years ago I was 20 stone+. I could barely walk due to weight and back problems. I am now 15 stone, a lot fitter due to walks and gym workouts, and getting out and about.”*

#### **4.4.2 Mental Health**

Many of the qualitative findings of the various evaluation reports highlight recurrent themes that suggest that the led walks have a positive effect on walkers’ mental health. These include : “helps cope with stress” and “prevents depression”.

*“For me, psychologically, it’s been absolutely wonderful”*

*“It has literally saved my life”*

*“You can get down in the dumps like scared, but you get out on the walks and you see the trees coming into bud and you say ‘come on you’ve got to get on with it and it’s going to be alright’”*

*“I have felt uplifted by scenery and fresh air..”*

Walking for Health has also played an important part in providing a much-appreciated service for mental health care users. This is discussed in more detail in chapter 5.

#### **4.4.3 Social networks and health**

Research has shown that people with strong social networks tend to enjoy longer and healthier lives than those people who live in relative social isolation. The sociable nature of the walks and the fact that a significant proportion of participants live alone means that health walks may have a significant impact on people’s health by increasing the amount of social contact they have. A recurrent theme in all the evaluations is that the social element of taking part is highly valued by walkers. Ninety three percent of respondents in a postal survey to evaluate the Keystone and Wayland scheme stated that one of the benefits was ‘meeting people’. This topic is explored in

more depth in the evaluation of the Bristol Health Walks scheme carried out by Bristol University (Davis & McKenna, 2005).

*“We’re neighbours, but we wouldn’t have become friends like we are (without the scheme)”*

For many people, particularly older people who live alone, health walks provide a structure to their week with one walker saying that it gave her “a reason to get up in the morning”.

*“It sets a pattern to my week” Torbay walker*

## 5. WALKING THE WAY TO HEALTH and SPECIFIC GROUPS

### 5.1 Cardiac Rehabilitation

From its inception, WHI sought endorsement from the British Association for Cardiac Rehabilitation (BACR) for the led walk schemes. As a consequence, several Walking for Health schemes (particularly PCT-led schemes) have targeted cardiac rehabilitation patients and employed BACR trained instructors to lead walks. Little formal evaluation has taken place of the health benefits to these patients, although there are many examples of schemes that report that health walks are successful in attracting and retaining cardiac patients. The patients see health walks as a safe and effective method for rehabilitation in the absence of continued gym-based programmes or where such programmes are not available. Both the Bradford and the Coventry schemes have good examples of cardiac rehabilitation programmes.

*“After my unexpected heart attack and rehabilitation with the cardiac unit, I was pleased to find a group to walk with as I was apprehensive about going far alone. I quickly gained confidence and my recovery has been good. I have now trained as a walk leader.” David, aged 56.*

*“My angina is less frequent.”*

### 5.2 Diabetes patients and walking for health

A study carried out by a student (Billington, 2005) looking at the effect of taking part in health walks on diabetic patients concluded that there may be a positive effect, with improvements in glycemic control. The findings were not significant however and the limitations of the study included a very small sample size (6 people). Anecdotal reports from many schemes report that diabetic patients often use the walks to improve their condition and feel that they have benefited their condition.

*"I'm a diabetic and am delighted that the walks have improved my fitness in many ways - they've decreased my blood sugar level, helped me lose weight and also given me more confidence and stamina. I'm very keen to promote the message that walking is good for you and have now trained as a walk leader and I now regularly lead walks across the city".*

### **5.3 Working with people with disabilities**

Several health walks schemes have formed partnerships with organisations working to deliver services for people with a range of disabilities. Health walks have proved to be a successful intervention in the mental health care setting as outlined in the quoted extract from a letter from the Hollybush scheme :

*"One of the service users I have been supporting on the walks has been involved in mental health services for a long time and has had very little contact with mainstream community organisations. Not only does he enjoy being outdoors and appreciate the benefits of exercise on his mental wellbeing, but he seems to be becoming more comfortable with communicating with other members of the public who go on the walks."*

The Coronation Centre in Cheshire has used health walks with its patients and reports the following:

*"The benefits have been numerous including an improved awareness of road safety, an increase in confidence, an improvement in communication and interaction skills, better observational skills, an increased awareness of the importance of listening and following instructions. This, with an awareness of the numerous health benefits have made it a huge success."*

The patients at the Coronation Centre gave the following comments about their experiences of health walks:

*"Walking is good for exercise" "You could breath morning fresh air and it feels good"*

*“I was frightened of the hills, now I’m fine” “I was very nervous about the walking” – how do you feel now? “kind and beautiful”.*

The fact that health walk schemes offer group walks means that they are particularly suitable for partially sighted people who enjoy the safety and confidence that they offer. All schemes aim to provide walks that are inclusive of people with a range of disabilities.

*“As I am partially sighted, it is wonderful to come out in the security of a group. Besides, no one else of my age walks fast enough for me!” Hilda, aged 90*

## 6. IMPACT OF LED WALKS ON PARTICIPANTS' TRANSPORT HABITS

A study of a pilot Health Walks scheme in Sonning Common (Ashley, 1999) indicated that taking part in led walks had an impact on participants' transport habits. Sixty four percent of people surveyed reported that they had changed their transport habits 'to some extent' and 27% said that they had changed 'a great deal', reporting that they were more likely to walk short distances than prior to taking part. Several surveys of local schemes posed similar questions about the effect of the led walks on their walking habits. The Wrexham study (Clark, 2004) reported that 60.6% of women and 31.9% of men said that their transport habits had changed 'quite a lot' to 'a great deal'. In East Hampshire, 44% of walkers report walking more for transport as a result of the scheme. Analysis of the data on whether people were more prepared to walk rather than drive short distances did not yield a significant result ( $p=.137$ ), however qualitative evidence from focus groups and individual interviews supported the theory that people were now happier to consider walking instead of driving.

Other schemes that looked at the effect of the health walks on participants' transport habits reported similar findings. Of the 108 people who responded to a questionnaire survey in Wolverhampton, 72% said that taking part 'had increased the distance they are prepared to walk' and 42% agreed with the statement that taking part 'had reduced the number of short driving trips' they took. Sixty four percent said they were more encouraged to 'walk to the shops' and 18% would consider walking to work. Thirty six percent of participants in the Wear Valley scheme reported reduced car use, as illustrated by the following quote from one walker:

*"I do get comments from my friends "Oh why is he walking? What has happened to his car"!"*

A common theme across all schemes is the suggestion that participants on led walks walk more generally outside the scheme, partly as a result of increased confidence and fitness and a desire to continue reaping the health benefits of walking. It is likely also that walkers walk more simply because they are more aware of where to walk and feel safer. Ninety percent of the Calderdale walkers walked independently outside the scheme and 98% of the Wear Valley walkers and 67% of the Wolverhampton walkers said that their knowledge of the local area had improved.

*“I have lived in Willington for 53 years and I have seen places I have not seen before with going on these walks.”*

*“We have been through woods that I had passed by in the car I never knew they were there!”*

## **7. WALKING THE WAY TO HEALTH VOLUNTEERS AND TRAINING**

An evaluation of the training services provided by WHI was carried out in June 2001 surveying 178 walk leaders. This showed that the majority of walk leaders were female (62.5%) and 87.6% of walk leaders described their ethnic origin as white British. Just over 12% of respondents were from other ethnic backgrounds. Forty-two percent of walk leaders were retired and 28% were in full time employment. Eighty-three percent of people surveyed were actively involved with the led walks, mainly leading walks, but also helping with developing new walks and publicity and administration for their scheme. The majority of walk leaders found the training ‘very useful’, with 72.3% of walk leaders saying that they were ‘very likely’ and 23% saying they were ‘quite likely’ to have continued involvement.

Several schemes have calculated the amount of volunteer time given to the health walks. Many report in excess of 1,500 hours per year of volunteer time spent in leading walks, raising awareness and developing the local scheme. With 350 schemes across the country, the commitment of volunteers on a national level is likely to be considerable. There is also evidence from schemes that many volunteer walk leaders are new to volunteering, indicating that WHI has the ability to attract people who might not otherwise give their time to volunteering activities. It should be noted however that some schemes have found it easier than others to attract volunteers and, in areas of deprivation and disadvantage, recruitment may be more challenging.

Examples of volunteer-run schemes are emerging as funding streams terminate. Several schemes are now successfully run and administered by the volunteers themselves with little input from statutory organisations. The volunteer-run model of sustainability is one that has proved successful in some areas, but may not be suitable for schemes that are looking for continued development and expansion and need to attract hard to reach audiences. A focus group made up of leaders from the Lewisham scheme felt that the volunteers benefited from the support of a full-time coordinator.

Some schemes have surveyed volunteers to establish the perceived benefits of becoming involved with the health walks. Hollybush Healthy Walking Project used focus groups of walk leaders to explore their experiences. The reasons given for volunteering are varied, yet all are positive.

Volunteers report benefits to themselves in terms of mental, physical and social health as well as career development.

*“I thought it would assist the group. The more the merrier!”*

*“I get a lot of satisfaction from seeing the group enjoying the walk. Also it is very gratifying when you get good feedback from walks that I have helped to plan.”*

The role that walk leaders play in making the walks a success was explored by the Bristol evaluation which found that they are crucial in developing a positive social experience for the walkers. ‘They quickly learn walkers names and the details of their lives; they find common interests between walkers so they weave a strong social network, indicating their interest in developing sustainable community effects. It is evident that walk leaders strive to play “...a critical role in the functioning of the group”. ‘ (Davis and McKenna, 2005)

*“a very warm person, makes everybody feel welcome, and I think that’s important..!”*

There is anecdotal evidence from many schemes that the walk leaders encourage a sense of community cohesion and provide a valuable support network for other leaders and walkers. There are several incidences where walk leaders have visited other walkers when they are ill and provided support at times of bereavement. An example from the Dacorum Health Walks scheme is quoted below :

*News was received at the Gadebridge Park walk a few weeks ago that Alan had been admitted to Hemel Hospital for tests. (Alan in his 50s joined us after knee replacement surgery and now walks on average 3 times a week with different groups in Dacorum). Straight after the walk one of the leaders, Gordon, walked straight down to the hospital to visit. At another walk group a card was signed by everyone and delivered in person.*

*Last week, Gordon (who's in his 70s, has had a triple heart by-pass, lives alone since his wife died and has no transport) managed to fall off a ladder and break a leg. When I phoned he said that*

*Alan had already visited and 2 local Grovehill walk ladies had been cooking him meals. He's decided against going to stay at his daughter's (in York) as he feels better supported staying at home.*

Dacorum Health Walks Coordinator.

A focus group of leaders from the Lewisham scheme found that they felt that being a walk leader had huge social benefits: getting out of the house, making contact with people, making new friends and also, for some, gaining confidence in talking to all kinds of people. A major motivation also, though, was the desire to make a contribution and help others.

The Chesterfield survey found that 38% of walkers had become involved in other community activities since joining the scheme, suggesting that health walks can play a valuable role in encouraging community cohesion and community-focussed activities.

The Bristol evaluation found that the health walk scheme there was reaching a number of individuals who would not normally be involved in community-based activities.

## **8. EVALUATION OF INDEPENDENT WALKING**

Many schemes have produced independent walking materials to encourage people to walk more outside the led walks. These have usually taken the form of maps of local, short walks, together with information about the health benefits of regular walking. Evaluation of these materials depends on collecting information about the people who receive them so that they can be 'followed-up' in order to ascertain how they used the maps.

A study of the Doorstep Walks scheme in Salisbury (Vernon, 1998) established that such materials may play an important part in encouraging people to walk more. A survey of 322 people yielded a 71% response rate. Just over a third of respondents had received one of the 500 packs of walks from their GP. Twenty-two percent of the respondents indicated that the maps were a 'major feature' in their future plans to improve or maintain their health, with 69% saying that they were more likely to use the walks for exercise rather than attend exercise sessions at a local leisure centre.

A survey of 768 people in Southampton who had received maps of walks in the city indicated that people exercised more as a result of the packs, with 23% saying they do 1 to 2 hours per week more.

Evaluations of locally produced walk materials suggest that people use the packs with family and friends (New Forest walks : 54%, Doorstep Walks : 69.8%) which suggests that walk maps and other materials may have an impact on more than just the person who is given them.

A brief evaluation of the independent walk maps produced for the Test Valley scheme in Hampshire revealed that the majority of people surveyed had collected the packs from GP surgeries and Tourist Information offices. The comments included in this evaluation suggest that it would be more useful to distribute the packs directly to individuals who would benefit the most from shorter walks. Keener walkers will always pick up information about walks, without realising that health walks may not be appropriate for them if they are used to longer walks and may not understand the target audience for health walks. The Test Valley evaluation suggests that more than half of the

people surveyed felt that the walk packs had increased their awareness about the health benefits of walking.

An ethnographic evaluation of the Thames Chase Therapi Project (Kessel et al, 2004) included some information about the walk maps used in the local health walks scheme. Some of the comments received from people who were shown the maps and leaflets indicate that ‘health’ messages may not always be the most appropriate ones for engaging with sedentary individuals. Emphasis could be placed on the ‘enjoyment’ value of the walks or the opportunity to get out into green spaces in order to attract a wider range of people on the walks.

*“It all looks a bit too hale and hearty for me!”*

Most health walk schemes produced self-help information about the health benefits of walking as a way of promoting the led walks, but also to raise awareness levels within local communities. Few of these materials have been evaluated to identify their impact, although the Chesterfield scheme surveyed 200 people (56% response rate) about their walking for health leaflets. The survey demonstrated that 74% of respondents had a good understanding (7 or more correct answers to questions) about the health benefits of walking.

## 9. STEP-O-METER INITIATIVE

A promotional campaign was run in the Spring and Summer of 2002 as an additional activity to WHI whereby 85,000 Step-O-Meters were distributed through 'reader offers' run in the Daily Mail and other regional newspapers in the Midlands and North of England. Follow-up surveys were carried out of user groups including people who had received the device through reader offers and also of health professionals who had received packs of 20 Step-O-Meters after expressing interest in the campaign. The main findings of the evaluation of the campaign indicated that more than half of the people surveyed who were taking insufficient exercise to benefit their health when they first received the step-o-meter, had reached the recommended level of 30x5 by the end of 12 weeks. Health professionals who received the Step-O-Meters to give to their patients felt that they were successful in reaching a range of high risk groups and 82% of health professionals found the step-o-meter was a positive influence in helping them to get their patients or customers more active. The survey found that 13% of people who responded found the device difficult to set up and some health professionals felt that some of their clients had difficulties in understanding the instructions.

As a result of the positive feedback from health professionals, a subsequent Step-O-Meter campaign was run in 2003. Six 'Loan Packs' each including 10 step-o-meters were distributed to 127 PCTs across England. The evaluation of this campaign was based on a sample from 40 PCTs who were contacted to ascertain their views on the usefulness of the Step-O-Meter in primary care. The loan packs were perceived to have raised the profile of walking and physical activity in their area. In particular, health professionals were able to place the Step-O-Meters with a range of 'at risk' groups. There was a significant increase ( $p < 0.001$ ) in the mean number of daily steps from 7591 to 9113 in all age groups.

The success of the two step-o-meter campaigns has led to a new national campaign, funded by the NHS and administered by WHI, which will distribute Step-O-Meters to all PCTs across England and provide training for health professionals about how to use the device with patients.

## **10. LESSONS LEARNED**

### **10.1 Attracting hard to reach individuals and groups**

Both the national and local evaluations indicate that led walks tend to attract keen walkers in their early stages: the so-called ‘torch-bearers’ of walking for health. Attracting sedentary or disadvantaged individuals requires significant input from walk co-ordinators and community development officers to develop relationships with key community groups and individuals.

Every effort should be made to provide walks that are accessible to these groups, either by virtue of their geographical location, their distance or their pace. Emphasis must be placed on ensuring that leaders are sympathetic to the slower or less able walkers and that these individuals are prioritised in any development of schemes

Input from health professionals plays a key role in engaging with individuals who have the most to gain from health walks. Endorsement from GPs is important in giving schemes credibility and attracting new participants. Working with a range of organisations and community groups as well as forging partnerships with care providers will ensure that the walks are promoted to a broader diversity of individuals.

### **10.2 Evaluation methods**

Focus groups have proved to be both popular and effective in assessing the benefits of walking for health and in monitoring the progress and development of walk schemes. Qualitative methodologies may be more appropriate for evaluating community exercise programmes such as health walks given the broad range of benefits that can be experienced from taking part.

The SF36 questionnaire, which looks at the multi-dimensional concept of health-related quality of life, has proved useful in showing benefits to participants. However, larger sample sizes and rigorous administration of questionnaires is required if studies are to yield usable data. Given the length of the SF36 and the reluctance of walkers to fill in lengthy questionnaires, the SF12 may be

the more appropriate tool for measuring health related quality of life in this group. Capturing baseline data on walkers can prove difficult given the informal nature of schemes.

Where health walks are developed for specific health groups such as cardiac rehabilitation patients, evaluation protocols could be developed to ascertain the contribution that walks make to their health.

A standard definition of ‘adherence’ should be adopted across schemes so that data sets can be combined to establish the effectiveness of health walks in maintaining people’s activity levels. One suggestion is to categorise participation in terms of once, twice or more times per week over a six and twelve month period.

## 11. CONCLUSION

Walking the way to Health and led health walks in particular provide an important resource for people to maintain or improve their health. Health walks are safe and effective and have been shown to be sustainable both for the individual and at an institutional level.

Walking the way to Health has challenged the traditional perception of walking as something you do at a weekend, in a country park, with walking boots for 3 –4 hours. The Walking for All project in Salford reports :

*“I feel we have made it socially acceptable for people to go for a walk locally, from their doorstep..”*

The volunteer walk leaders are an important resource for WHI, but the amount of support that is required to keep them involved and interested should not be underestimated. Some schemes have shown that they can be self-sustaining by volunteers taking over the day-to-day running and administration of the led walks. However, this model of sustainability is not suited to all walk schemes, particularly in areas of disadvantage where co-ordinator time needs to be spent encouraging hard to reach groups to take part.

Targeted marketing can widen the appeal of walking for health to younger audiences, but led walks still hold the greatest appeal for older people (over 50). Since this age group have the most to gain from staying or becoming more active, this is not seen as a negative finding.

Whilst GPs and health professionals do have an important role to play in endorsing and supporting health walks, the majority of walkers are likely to hear about the walks from friends or from the local media. In order to encourage diversity amongst the walkers, it is important that as many different people and organisations as possible are involved in promoting walks.

Although schemes report an increasing number of first-time walkers and walkers from disadvantaged groups, there is a danger that health walks will attract significant numbers of people who are 'keen walkers'. This in turn risks alienating less fit walkers. Many schemes report that walkers, as they progress, request longer walks. Although many schemes are now offering longer walks for the keener walkers, there is a need to continue to cater for the newcomers. Efforts to recruit sedentary people and people who are irregularly active should be stepped up. Attracting walkers from disadvantaged backgrounds requires partnership working and co-ordinator time to be spent forging relationships with key community groups and officers.

The step-o-meter has proved to be an effective and popular device to increase levels of walking with a range of groups. Health professionals have welcomed this method for raising awareness and increasing activity levels in their patients/clients.

More consistent data collection of attendance and drop out rates, as well as an agreed definition of adherence is needed in order to combine data sets across schemes.

Future evaluation of health benefits needs to ensure that it captures true baseline data of people who are new to exercise so that the effects of any health walks intervention can be more accurately measured. Useful evaluation methodologies have included the SF36/SF12 questionnaire and the use of focus groups to identify perceived benefits.

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## Wirral Walking Project’ – Telephone Questionnaire for standard participants

*Interviewer:* “Hello, we are phoning on behalf of Ron King at the ‘Wirral Walking for Health Initiative’. We are conducting a confidential questionnaire and were hoping you’d be willing to answer some questions to help us evaluate the scheme.

**1) When did you join the scheme (approximately) and where did you find out about it?**

.....

**2) On average, how often do you participate in walks run by the scheme?**

Less than once a fortnight [ ]      Once a fortnight [ ]  
Once a week [ ]      More than once a week [ ]

**3) On average, how long do the walks you participate in last?**

Less than ½ hr [ ]      ½ hr to 1 hr [ ]  
1 to 1½ hrs [ ]      Longer than 1½ hrs [ ]

**4) Do you prefer taking part in longer walks or shorter walks?**

Prefer longer walks [ ]      Prefer shorter walks [ ]  
No preference [ ]

**5) Do you have any problems in completing the walks?**

Yes [ ]      No [ ]

*If the response is other than ‘Yes’ or ‘No’, please record details:*

.....

.....  
.....

**6) What are the main reasons that motivated you to join the scheme?**

Socialising  The chance to enjoy the countryside

Improving fitness  Recommendation from a GP

*If the respondent has other reasons for joining the scheme please record details:*

.....  
.....  
.....  
.....

**7) On a scale of 0 to 10, with 0 being 'not active' and 10 being 'very active', how active would you say you were before you took part in the scheme?  
(circle the appropriate number)**

0    1    2    3    4    5    6    7    8    9    10  
*Not active* *Very active*

**8) Using the same 0 to 10 scale, how active would you say you are at the moment?  
(circle the appropriate number)**

0    1    2    3    4    5    6    7    8    9    10  
*Not active* *Very active*

**9) Have you noticed any physical benefits as a result of taking part in the scheme?**

Yes  No

**9a) If yes, what benefits have you noticed?**

.....  
.....

.....  
.....

**10) Will you continue walking in the future?**

Yes [ ]                      No [ ]

**10a) If yes, why?**

Because it increases my feeling of well being [ ]

Because it gives me more energy [ ]

Because it helps me sleep better [ ]

*If the respondent gives answers other than those listed please record details:*

.....  
.....  
.....  
.....

**11) Since starting the walking scheme have you made any more changes to your lifestyle?**

I have been walking more independently of the scheme [ ]

I have taken up other forms of exercise [ ]

I eat a more healthy diet [ ]

*If the respondent has made changes to their lifestyle other than those listed above please record details:*

.....  
.....  
.....  
.....

**12) Outside of the scheme, what type of walking do you do most frequently?**

Don't walk outside of scheme [ ]

Walking at a slow pace (below 3 mph) [ ]

Walking at a steady pace (about 3mph) [ ]

Walking at a brisk pace (about 4 mph) [ ]

Walking with heavy shopping [ ]

**13) How did you feel the scheme was organised overall?**

Poor [ ] Fairly Good [ ]

Good [ ] Very Good [ ]

Excellent [ ]

**14) Are there any ways in which you would suggest that the scheme could be improved?**

More varied or graded walks [ ]

More people joining [ ]

More advertising [ ]

*If the respondent feels there are other ways that the scheme could be improved apart from the options listed above, please record details:*

.....  
.....  
.....  
.....

**15) Would you say your experience of the scheme has been positive?**

Yes [ ] No [ ]

**15a) If yes, in what way?**

Social aspects (eg. meeting people) [ ] Health benefits [ ]

Walk more in addition to led walks [ ]

*If the respondent indicates that their experience has been positive in a way other than those listed above please give details:*

.....  
.....  
.....  
.....

**15b) If it has not been positive, could you please explain what you mean?**

.....  
.....  
.....  
.....  
.....

**16) Would you recommend the scheme to others on the basis of your experience?**

Yes                                  No           

Don't know   

**17) We are interested in hearing about your experience of the project. Is there anything else you would like to share with us that you think we would find useful or interesting.**

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....

*These questions are to help us learn about the different types of people who take part in our walks:*

**i) What sex are you? (Please tick one only)**

Male                       Female

**ii) What is your age? (Please tick one only)**

15-24 [ ]      25-34 [ ]      35-44 [ ]      45-54 [ ]      55-64 [ ]  
 65-74 [ ]      75 or over [ ]

**iii) What is your current employment status? (Please tick one only)**

Working full-time (more than 30 hrs per week) [ ]  
 Working part-time (less than 30 hrs per week) [ ]  
 Caring for home or family (not seeking paid work) [ ]  
 Unemployed and looking for work [ ]  
 Unable to work due to illness or disability [ ]  
 Retired [ ]  
 Student [ ]

**iv) How would you describe your Ethnic Group? (Please tick one only)**

Asian Bangladeshi [ ]      Asian Indian [ ]      Asian Other [ ]  
 Asian Pakistani [ ]      Black African [ ]      Black British [ ]  
 Black Caribbean [ ]      Black Other [ ]      Chinese [ ]  
 Mixed Other [ ]      Somali [ ]      Yemeni [ ]  
 White British [ ]      White Irish [ ]      White Other [ ]  
 Mixed White and Asian [ ]      Mixed White and Black African [ ]  
 Mixed White and Black Caribbean [ ]

v) If the respondent wishes to provide any information in written form please record full address (including postcode).

.....  
 .....  
 .....

*Please thank the respondent for their time.*



## APPENDIX II

### SUSTAINABILITY MODELS

MODEL OF SUSTAINABILITY	EXAMPLE
<b>Voluntary led - informal</b>	Goring on Thames – SE Salute – WM
<b>Voluntary led - constitution</b>	Sonning Common – SE Whitney – SE Stepping forward in Oldham – NW Weymouth and Portland Amblers – SW Thurnscoe – Yorkshire
<b>Voluntary led - charity</b>	Reigate and Redhill – SE Erewash Health walks - Derbyshire – EM Mansfield in Step – Nottinghamshire - EM
<b>Integrated</b>	Footsteps to fitness – NE East End Walkers - NE Kirklees walking for Health – Yorkshire Stroll on Exeter – SW East Birmingham health walks – WM
<b>Mainstreamed</b>	East Kent Scheme - SE Horsham – SE Salford – NW Middlesbrough – NE Sedgefield – NE Wear Valley –NE Trent Tickers – EM Life Walks – EoE Mayfair Walking for health – WM
<b>Wider programme</b>	L.B. Barking/Dagenham – LON STEPS – National forest – EM Nuneaton and Bedworth - WM East Staffs –WM
<b>Private sector</b>	Solutions Croyden - LON 3M – NE

	<b>Model</b>	<b>Characteristics</b>	<b>Funding opportunities</b>
1	<b>Voluntary; self managed</b>	<ul style="list-style-type: none"> <li>• No formal structure</li> <li>• VWL's continue to lead walks and promote to local people</li> </ul>	<ul style="list-style-type: none"> <li>• Needs little or no funding</li> <li>• May charge or use membership fees or fund raising to cover expenses</li> </ul>
2	<i>Voluntary; self managed</i>	<ul style="list-style-type: none"> <li>• VWL's create a constitution</li> <li>• VWL's continue to lead walks and promote to local people.</li> </ul>	<ul style="list-style-type: none"> <li>• Having a constitution means that groups can apply for grants from local authorities/lottery</li> </ul>
3	<b>Voluntary; self managed plus</b>	<ul style="list-style-type: none"> <li>• VWL's create a charity</li> <li>• VWL's continue to lead walks and promote to local people</li> <li>• May employ and organiser</li> </ul>	<ul style="list-style-type: none"> <li>• Wider range of sources of funding for eg. charitable trusts</li> <li>• Higher status when competing for other groups of funding</li> </ul>
4	<b>Integrated</b>	<ul style="list-style-type: none"> <li>• <b>Some aspects of the WHI scheme is transferred to one of the partners, which may/may not include co-ordinator</b></li> </ul>	<ul style="list-style-type: none"> <li>• Costs met by local host</li> <li>• Costs may be lower than that for the full scheme</li> </ul>
5	<b>Mainstreamed as WHI scheme</b>	<ul style="list-style-type: none"> <li>• Scheme keeps most of its features and staff and continues to develop</li> </ul>	<ul style="list-style-type: none"> <li>• Costs transfer to local host</li> <li>• One possible host is the PCT, especially if the scheme is written into the local delivery plan. More likely to focus on patients with known health condition</li> </ul>

## APPENDIX III

### LIST OF PARTNERS WHO HAVE HELPED DELIVER WALKING THE WAY TO HEALTH

#### **National**

BLF  
Kia  
BHF  
DOH  
ITV  
ASDA  
Kellogg's  
SUSTRANS

#### **Regional**

Sport England  
Local Primary Care Trusts  
Local Hospitals  
Local Doctors surgeries  
Groundwork  
BTCV  
Ramblers  
Mind, Mencap, and other mental health charities  
Age Concern  
Sure Start  
Local Authorities - Borough, District, Parish and County  
Community Forest  
National Forest  
Forestry Commission  
Voluntary community groups  
Voluntary Action/CVS/Community Service Volunteers  
Local Schools  
Local Universities  
Local companies  
Local papers  
Local Radio  
Local TV  
National Trust  
National Parks

