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Walking the Way to Health Wales. Evaluation Phase 2 – Implementation. Final Report

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Walking the Way to Health Wales
Evaluation Phase 2 – Implementation

Final Report

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A report for the Countryside Council for Wales
March 2007

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Definitions

Active/Inactive

Defined in terms of the commonly accepted threshold for health i.e. an active individual is one who undertakes at least 5 x 30 minutes of moderate or greater intensity physical activity per week.

Activity and health questionnaires

These comprise four validated tools, selected in consultation with the local and national Walking the Way to Health Wales (WW2H) coordinators in order to balance validity and detail with practicalities of data collection and resources. The rationale for the choice is described fully in the Phase 1 report (see References). The questionnaires are included in Appendix C.

Stages of change questionnaire

A questionnaire to allocate individuals to one of five stages according to the Transtheoretical Model of Behavioural Change (Marcus et al. 1992). The stages run from 1 (no exercise) to 5 (habitual exercise for more than 6 months) and are described in section 4.2.2.

International Physical Activity Questionnaire

An internationally recognised questionnaire for establishing level of physical activity.

The SF-12

An internationally recognised questionnaire to assess health and well-being in physical, mental and overall categories. (This is a shorter version of the SF36 described in the Phase 1 report.)

The EQ VAS

A self-report visual analogue scale from 0 (worst imaginable health state) to 100 (best imaginable health state).

Local projects

22 county-level projects, each of which was responsible for organising walking groups, and producing and distributing self-help walking information, at various locations in their area (see Appendix B for map).

Local project coordinator

A person responsible for organising walking groups within a defined county area (see Appendix A for a list of these areas). There was usually one local coordinator per project although in some areas the role was shared.

Multiplier

A method by which the number of direct participants in led walks is multiplied by a factor to reflect the additional indirect impact of a scheme (see section 4.1.1).

Participant

A person who joined a walking group.

Person-walks

A measure of the total volume of activity in a local project. Determined as the number of led walks multiplied by the average number of participants per walk.

The Scheme

Refers to WW2H at the national organisational level.

Volunteer Walk Leader

A volunteer who joined a group, undertook training, and became responsible for leading group walks. Local projects had many volunteer walk leaders.

WW2H

Walking the Way to Health Wales. A country-wide scheme which aimed to increase health and well-being through the activity of walking.

1.0 Crynodeb

1. Nod cynllun Cerdded Llwybr Iechyd Cymru oedd hybu iechyd a lles drwy annog pobl i gerdded yn gyflym yn rheolaidd. Bu un prosiect a gynorthwywyd gan grant ym mhob un o'r awdurdodau unedol (sef cyfanswm o 22), yn ogystal â nifer fechan o brosiectau na chafwyd cymorth grant ar eu cyfer. Dechreuwyd y prosiectau cyntaf yn 2003.
2. Defnyddid pedwar dull o werthuso'r cynllun, sef a) roedd y cydlynwyr lleol yn darparu data archwilio am eu prosiectau eu hunain, gyda'r data yn cael ei gasglu a'i ddadansoddi yn ganolog, b) rhoddodd sampl o 370 o unigolion wybodaeth am eu hiechyd a'u lles a dilynwyd hynt 82 ohonynt dros ddeuddeng mis, c) gwerthuswyd agweddau ar y broses a'r rheolaeth drwy gynnal chwe gweithdy gyda chydlynwyr y prosiect, ac ch) bu sampl o'r cydlynwyr ac arweinwyr y teithiau cerdded yn llenwi holiaduron am ansawdd y cyrsiau hyfforddi.
3. Bu 18,069 o unigolion gwahanol yn cymryd rhan yn uniongyrchol mewn teithiau cerdded a arweiniwyd. Bydd y cynllun hefyd wedi achosi cynnydd mewn cerdded yn anuniongyrchol drwy bobl yn clywed sôn am y prosiect, drwy gyhoeddusrwydd a drwy anogaeth gan weithwyr iechyd proffesiynol. Casglwyd data am yr effeithiau anuniongyrchol hyn a'r brasamcan gorau o effaith y cynllun yn ei gyfanrwydd yw iddo annog 85,000 o unigolion i gerdded. Roedd lleoliadau daearyddol y prosiectau cerdded lleol yn golygu bod y rhan fwyaf o'r bobl hyn yn dod o ardaloedd o iechyd gwael.
4. Menywod yn bennaf oedd yr unigolion a ymunodd â'r cynllun (72%), ac roedd y rhan fwyaf yn hŷn (79% >56 oed) ac yn Brydeinwyr gwynion (> 95%).
5. Roedd y rhan fwyaf o'r bobl a ymunodd â'r cynllun yn gorfforol weithgar eisoes (70%) ac yn dda eu hiechyd. Ond roedd 30% ohonynt yn ymgymryd â lefel o ymarfer corff a oedd yn is na'r isafswm a argymhellir er mwyn cadw'n iach.
6. Drwy glywed sôn ar lafar gwlad neu drwy gyhoeddusrwydd lleol y daeth y rhan fwyaf o bobl. Amcangyfrifir bod 30% wedi ymuno yn sgil argymhelliad gan eu meddyg teulu neu weithwyr proffesiynol eraill ym maes iechyd.
7. Drwy gymryd rhan yn y cynllun, cafwyd peth gwelliant yn y lefelau iechyd ac ymarfer corff.
8. Amrywiai'r 22 o brosiectau lleol yn sylweddol o ran eu maint, sef o rai bychain (51 o gerddwyr) i rai enfawr (3,800 o gerddwyr).
9. Daeth swmp sylweddol o ddeunydd hunangymorth o'r prosiectau lleol (>300,000 o eitemau) yn ogystal â sylw yn y cyfryngau (962 o erthyglau yn y wasg, ar y teledu a'r radio).
10. Arweiniodd y cynllun at wella nifer fawr o lwybrau cerdded (455). Ac fe soniwyd am 1,228 o lwybrau cerdded newydd, sy'n awgrymu gwell gwybodaeth am yr ardaloedd lleol.
11. Hyfforddwyd 1,485 o arweinwyr ac mae 682 ohonynt yn dal i arwain teithiau cerdded. Mae hyn yn golygu y llwyddwyd i gadw 46% o'r arweinwyr a hyfforddwyd, sydd yn ganran uchel i wirfoddolwyr.
12. Cafwyd croeso brwd i'r rhaglen hyfforddi gan yr arweinwyr a'r cydlynwyr lleol, a oedd o'r farn bod yr hyfforddiant yn addas ac yn esiampl o arfer da.
13. Wrth werthuso prosesau a threfn reoli'r prosiectau dangoswyd iddynt fynd drwy gamau gwahanol, gan aeddfedu o ran eu nodweddion, rôl y cydlynwyr, a'r canlyniadau. Roedd rhan y cydlynwyr lleol yn allweddol i lwyddiant y prosiectau lleol. Gallai'r bwrn gweinyddol

fod yn drwm. Bu'r prosiectau lleol yn cydweithio ag ystod eang o gyrff, ar gyfartaledd 24 i bob prosiect lleol.

14. Deallodd y cydlynwyr beth oedd diben y gwerthuso. Derbyniwyd bod y gwaith hel data sylfaenol yn angenrheidiol, er braidd yn feichus. Teimlid bod y ffaith bod y data a'r atborth a gasglwyd ym mhob cylch hel data yn cael eu cynnwys yn y gweithdai yn enwedig o werth wrth wella datblygiad y prosiectau.
15. Mae'r adroddiad gwerthuso yn cynnig argymhellion strwythurol a methodolegol ar gyfer y dyfodol.
16. Dyma grynodeb o'r cyflawniadau wedi'u rhestru yn ôl targedau'r cynllun:
 - **TARGED - 80,000 o gerddwyr o ardaloedd o iechyd gwael neu gerddwyr nac oeddynt yn gwneud ymarfer corff gynt**
18,167 o unigolion gwahanol yn cymryd rhan yn y teithiau cerdded a arweiniwyd. O ystyried effaith anuniongyrchol y cynllun Cerdded Llwybr Iechyd, amcangyfrifir mai 85,000 o bobl sydd wedi elwa (y ffiniau isaf ac uchaf: 53 410 a 167,891). Mae'r rhan fwyaf o'r bobl hyn yn hanu o ardaloedd o iechyd gwael gan mai ar yr ardaloedd hynny y canolbwyntiodd y prosiectau lleol (gweler y map yn atodiad B), a chyn y cynllun hwn roedd rhyw draean ohonynt yn gwneud llai o ymarfer corff nag a argymhellir i gadw'n iach.
 - **TARGED – Gwella iechyd a lles y cyfranogwyr fel canlyniad**
Daeth y rhan fwyaf o bobl i mewn i'r cynllun gyda statws iechyd a lefelau ymarfer corff a oedd yn gymharol uchel. O ganlyniad i'r cynllun cafwyd peth gwelliant yn lefelau'r ymarfer corff a'r statws iechyd.
 - **TARGED – Gwelliannau ar raddfa fechan ar lawr gwlad yn gwneud ardaloedd lleol yn fwy hygyrch a mwy diogel ar gyfer cerdded.**
Adroddwyd bod 455 o lwybrau cerdded wedi'u gwella. Ar ben hynny, cafwyd 1,228 o lwybrau cerdded newydd sy'n adlewyrchu bod rhai lleoedd yn fwy hygyrch a bod gwybodaeth leol wedi gwella, er nad yw'r ffigur yn adlewyrchu gwelliannau diriaethol (megis cyflwr y llwybrau, camfeydd, ac yn y blaen).
 - **TARGED – Hyfforddiant a chymorth i bob gweithiwr proffesiynol a gwirfoddolwr sy'n cymryd rhan**
O 1 Ionawr 2003 i 30 Tachwedd 2006, hyfforddwyd 1,485 o arweinwyr newydd. Gan fod 682 ohonynt yn weithredol ar 30 Tachwedd 2006, roedd 46% yn dal i arwain teithiau cerdded. Cafwyd ymateb cadarnhaol ynghylch yr hyfforddiant, a oedd yn dangos bod yr hyfforddiant yn rhoi modd i'r arweinwyr a'r cydlynwyr gyflawni eu swyddogaethau. Rhoddwyd rhagor o gefnogaeth i'r cydlynwyr gan y Cydlynnydd cenedlaethol a'r Swyddogion Achos yn ogystal â thrwy weithdai'r cydlynwyr.
 - **TARGED – Rhoi cynllun achredu ar waith er mwyn cydnabod prosiectau o ansawdd da**
Cafwyd cytundeb â'r Gronfa Loteri Fawr bod nodau'r targed hwn wedi'u cyflawni drwy ddulliau eraill. Hefyd roedd y gweithdai gyda'r cydlynwyr yn helpu i amlygu a rhannu arfer da.
 - **TARGED □ - Bod prif ffrwd byd iechyd yng Nghymru yn arddel model Cerdded Llwybr Iechyd, a chael cyllid y prif ffrwd o 2006 ymlaen**
Er nad yw hyn o fewn cwmpas y gwerthuso hwn, ymddengys fod y targed hwn wedi'i fodloni gan fod Llywodraeth Cynulliad Cymru wedi cyhoeddi y bydd cyllid ar gael.

1.0 Summary

17. The Walking the Way to Health Wales (WW2H) scheme aimed to increase health and well-being by promoting regular exercise through the activity of walking. There was one grant-aided project per unitary authority area (22 in total), as well as a small number of non grant-aided projects. The first projects began in 2003.
18. The evaluation used four methods: a) local coordinators reported audit data for their own projects, with the collation and analysis undertaken centrally, b) a sample of 370 individuals provided information on health and well-being. 82 of these were followed longitudinally over twelve months, c) aspects of process and management were evaluated through six workshops with the project coordinators, d) a sample of coordinators and walk leaders completed a questionnaire about the quality of the training courses.
19. 18,069 different individuals participated directly in led walks. The scheme will also have caused an indirect increase in walking through word of mouth, publicity, and the involvement of health professionals. Data were collected on this indirect effect and the best estimate of the total impact of the scheme is the promotion of walking in 85,000 individuals. The majority of these individuals were from areas of poor health due to the geographical location of local walking projects.
20. Individuals joining the scheme were predominantly female (72%), older (79% >56 yrs) and white British (> 95%).
21. Most individuals joining the scheme were already active (70%) and displayed good health. But 30% were undertaking activity at a level below the minimum recommended for health.
22. Participants joined mainly through word of mouth or local publicity. It is estimated that 30% of participants joined from a GP/health professional recommendation.
23. Participation in the scheme led to slight improvements in both health and activity levels.
24. The 22 local projects varied considerably in size, ranging from small (51 walkers) to very large (3,800 walkers).
25. The local projects resulted in a considerable volume of self-help material (>300,000 items) and media attention (962 features in press, T.V. and radio).
26. The scheme led to a large number of physically improved walk routes (455). A further 1,228 new walk routes were reported reflecting improved local knowledge.
27. 1,485 walk leaders have been trained and 682 remain active. The retention rate of 46% is high for volunteers.
28. The training programme for walk leaders and local coordinators was well received, fit for purpose and provided a model of good practice.
29. Evaluation of process and management demonstrated projects passing through stages of maturity in characteristics, coordinators' roles and outcomes. The local coordinator's role was central to the success of local projects. The administrative burden could be large. Local projects interacted with a wide range of organisations, averaging 24 per local project.
30. The purpose of evaluation was understood by the coordinators. The basic data collection was accepted as necessary, if somewhat burdensome. The integration and feedback from each round of data collection into the workshops was felt to be particularly valuable in enhancing project development.

31. The evaluation report makes structural and methodological recommendations for the future.

32. Summary of performance against scheme targets:

- **TARGET - 80,000 people walking who are from areas of poor health or who were previously inactive**
18,167 different individuals have participated in led walks. When account is taken of indirect impact of the WW2H scheme an estimated 85,000 people have benefited (lower and upper bounds 53 410 and 167,891). The majority of these people are from areas of poor health since these are where the local projects are focussed (see map in appendix B), and around 1/3rd were previously undertaking activity at below the recommended level for health.
- **TARGET - Improved health and well-being of participants as a result**
The majority of participants enter the scheme with relatively high health status and levels of activity. The scheme slightly improved both levels of activity and health status.
- **TARGET - Small-scale improvements on the ground to make local areas more accessible and safe for walking**
455 improved walk routes are reported. Furthermore 1,228 new walk routes are reported which, although not reflective of physical improvements (such as path condition, stiles etc.), do reflect improved accessibility and local knowledge.
- **TARGET - Training and support for every professional and volunteer involved**
From 1 January 2003 to 30 November 2006, 1,485 new walk leaders were trained. With 682 active walk leaders at 30 November 2006, there was an overall retention rate of 46%. Evaluation of the training was positive, indicating that the training allowed walk leaders and coordinators to fulfil their roles. Further support for coordinators was provided by the national Coordinator and Case Officers and through the coordinators' workshops.
- **TARGET - The implementation of an accreditation scheme to recognise good quality projects**
It was agreed with the Big Lottery Fund that the aims of this target have been achieved by other means. In addition, the workshops with coordinators helped to identify and disseminate good practice.
- **TARGET □ - The espousal of the WW2H model by the health mainstream in Wales, and receiving mainstream funding from 2006 onwards**
Although not within the scope of this evaluation, it appears this target has been met by the announcement of Welsh Assembly Government funding.

2.0 Introduction

The Walking the Way to Health Wales (WW2H) Scheme aimed to increase health and well-being by promoting regular exercise through the activity of walking. There was one grant-aided project per Unitary Authority area (22 in total), as well as a small number of non grant-aided projects. The first projects began in 2003. The evaluation began in 2005.

The specific targets of the scheme were:

- 80,000 people walking who were from areas of poor health or who were previously inactive
- improved health and well-being of participants as a result
- small-scale improvements on the ground to make local areas more accessible and safe for walking
- training and support for every professional and volunteer involved
- the implementation of an accreditation scheme to recognise good quality projects
- the espousal of the WW2H model by the health mainstream in Wales, and the receipt of mainstream funding from 2006 onwards

The accreditation scheme was not implemented and does not constitute part of this report. Neither “80,000 people walking” nor “inactive” were clearly defined in these targets. This evaluation report has interpreted these targets as follows. “80,000 people walking” has been interpreted as indicating the targeted total impact of the scheme, that is both direct participants and indirect participants (see section 4.1.1 for elaboration). “Inactive” has been defined as people whose activity levels were below the recognised level for health, that is, less than 150 minutes per week of activity at an intensity of moderate or above.

In Phase 1 of the evaluation, researchers from the University of Wales Aberystwyth proposed five possible methods to guide the evaluation of the WW2H project. These methods were detailed in *The Walking the Way to Health Wales Evaluation Phase 1 – Framework* report and included:

- Option A, which was designed to collect data on the size and participation rates of each local project
- Option Bi, which was designed to collect data on participants’ health (physical and mental) and local projects’ stages of development in addition to that collected in option A
- Option Bii, which was designed to collect the information from option Bi via the use of a central evaluation body
- Option C, which extended option Bii by collecting process and management data via a series of workshops with local project coordinators
- Option D, which involved a randomised control trial

Option C was selected, and the next section presents details about how the evaluation was implemented. Data collection occurred over 3 rounds and this final report has been preceded by three interim reports. This final report provides cumulative totals for the periods of data collection and, where possible, totals also include data from 2003 and 2004. These data help show the extent to which the scheme’s overall targets were achieved. Data from each constituent project are included in the appendix A.

Totals have not been included across the three rounds of data collection because these were not undertaken at regular intervals and so direct comparison of the numbers from the three rounds is not meaningful as a measure of the rate of activity in the various categories. In addition, totals for each local project at each round of data collection would be difficult to interpret given the varying stages of development and life spans of individual projects.

3.0 Summary of the evaluation project team's method

3.1 Local projects' volume and stages of development

In consultation with the WW2H Coordinator, a bilingual monitoring form was developed to collect data about local projects' volume and stages of development. The monitoring form was then sent to all local project coordinators to complete, and included questions regarding:

- The number of walk participants involved and their profiles
- The walking routes used
- Human resources
- Stage of project development
- Organisations with which projects had interacted
- The positive and difficult elements local coordinators had faced

The three monitoring periods surveyed were (a) January 1 to December 15, 2005; (b) December 16, 2005 to April 30, 2006; and (c) May 1 to November 30, 2006. In rounds 1 and 2, monitoring forms were collected from all active grant-aided projects. One round 3 monitoring form had not been returned by the deadline for inclusion in this report, due to a series of rapid changes in the project's coordinator (Rhondda Cynon Taff). One non-grant aided project (Treharris) submitted a monitoring form in round 1.

3.2 Participants' health and well-being

In early December 2005, a booklet was sent to local project coordinators to distribute among participants on their led walks. The booklet contained a series of demographic questions along with four validated tools for collecting health and well-being information viz: the Physical Activity Stages of Change Questionnaire, the International Physical Activity Questionnaire, the SF-12 Health Survey, and the EQ VAS. Detailed background about the selection of these tools is provided in the Phase I report. Materials were all bilingual (see References).

Each of the 22 local project coordinators was sent 30 booklets and asked to distribute them to walking participants of various ages, and to both males and females. Coordinators were also asked to give booklets to individuals who were new to the project and to individuals who had been walking for longer than one month. Included with the booklet was a self-addressed stamped envelope so participants could return the booklet to the evaluation team. In addition, a contact details form was included on which participants could indicate if they were prepared to complete the booklet again for the purposes of collecting longitudinal data. Participants were informed that their names and contact details would not be passed onto any other person or organisation. In round 1 a total of 218 completed booklets were returned, representing a response rate of 34%.

During round 2 of data collection, in May 2006, the booklet was sent to 198 individuals who had completed it in December 2005 and who had indicated they were prepared to complete it again. A total of 121 individuals returned completed booklets, a response rate of 61%. In addition, each local project coordinator was sent 10 booklets and asked to distribute them to people who had recently joined their projects. A total of 76 booklets were returned representing a 34% response rate.

In round 3 of data collection, during November 2006, the booklet was sent again to the 198 individuals who had completed it in December 2005, and 125 were returned, a 63% return rate. Also, 59 individuals who had completed the booklet for a first time in May 2006 and who had indicated a willingness to complete it again were surveyed. A total of 40 booklets were returned, a response rate of 68%. Finally, each local project coordinator was sent 10 copies to distribute among those who had recently joined their projects, and 86 were returned, a 39% response rate. These response rates are high compared with that of other mail-out surveys in the health sciences, which typically range between 20 and 30%.

3.3 Collection of data on processes and management via workshops

The collection of WW2H process and management data was undertaken via a series of workshops with local project coordinators. There were 6 workshops held, with 3 in South Wales at Abergavenny, and 3 in North Wales at Bala. Two workshops (one each in North and South Wales) were held in February 2006, June 2006, and November 2006. Dr Tony Hyde of Socio Economic Services Ltd. assisted with the workshops because of his experience and expertise. The aim of these workshops was to collect information regarding the processes and management of WW2H, to allow coordinators to network with each other, and to obtain their insights and assessments of the data that was being collected from the monitoring form and the participant booklet. As explained below, feedback from project coordinators indicated they appreciated the opportunity to participate in the workshops. They obtained considerable benefit from interacting with their peers and valued receiving regular feedback about the progress of the evaluation (and the opportunity to comment on the results).

3.4 Collection of data on processes and management via the training questionnaires

Process and management data were also collected via training evaluation questionnaires given to individuals who had completed Project Coordinator Training and to a sample of individuals who had completed the Volunteer Walk Leader training. The questionnaires for this aspect of the evaluation were developed in consultation with the WW2H Coordinator and the Director of Fitness Wales, the organisation that provided the training. Welsh and English versions of the questionnaires were produced.

During July 2006, the WW2H Coordinator provided the national evaluation team with lists of individuals who had completed either the coordinator or walk leader training courses. The project coordinator training list consisted of the 42 individuals who had completed the training course (i.e., the entire population). The walk leader training list consisted of 79 individuals sampled from the 710 people who had completed the walk leader training. The sample was obtained by taking every 5th name from the training course registers. The individuals on these two lists were sent the appropriate questionnaires by mail and they were asked to return them to the national evaluation team in addressed return envelopes. A total of 20 questionnaires were returned from those completing the project coordinator questionnaire, representing a response rate of 48%. A total of 31 questionnaires were returned from individuals completing the walk leader training; representing a response rate of 39%. As with the walk participant booklet, these response rates are high compared with other research.

Key point:

The evaluation method used four methods:

- Local coordinators reported audit data for their own projects, with the collation and analysis undertaken by a central body
- A sample of 370 individuals provided information on their health and well-being. 82 of these were followed longitudinally over twelve months
- Aspects of process and management were evaluated through six workshops with the project coordinators
- A sample of coordinators and walk leaders completed a questionnaire about the quality of the training courses

4.0 Evaluation findings

4.1 Fundamental data on volume and local projects' stages of development

4.1.1 Participation data as reported by local project coordinators

Table 1a presents the number of different individual people who took part in led walks and the total number of person-walks (which is the number of led walks provided multiplied by the number participating each time, be they the same individuals or not). The cumulative data covers the period from 1 January 2004 to November 30, 2006. A total of 18,167 different individuals have participated. This figure is likely to be a slight overestimate because of differences in the way the data was collected in 2004 and the other three reporting periods. Almost all the led walks took place during the working day.

Table 1a: Total number of walkers and the number of person-walks from 1 January 2004 to November 30, 2006

Total number of walkers	Total number of person-walks
18,167	144,420

The scheme will also have caused an indirect increase in walking participation through word of mouth by participants, the impact of publicity materials, other recommendations from health professionals etc. For example, if a participant on a led walk subsequently takes a friend out walking independently then the scheme has influenced two people not one. It is common practice to use "multipliers" to estimate these indirect benefits. There are no standard or commonly accepted multipliers for walking schemes, or any physical activity. The present evaluation uses two sets of "multipliers": LM3 and the Lottery-agreed approach.

The LM3 method is based on a standard method used to assess the economic impact of a development. It determines the total impact in a series of rounds of direct and knock-on effects. In walking terms, the first round is the number of direct participants. The second round is those people introduced to walking by the participants but who did not join the scheme. The third round would be those introduced to walking by the second round people. Each round is progressively smaller. The vast majority of impact occurs in the first two rounds with subsequent rounds rapidly approaching zero. Whilst most commonly used in economics, the fundamental principles are as applicable to the dispersion of information and walking participation as to money, since the mathematics is fundamental and not based on economic assumptions. The Phase 1 report elaborates (see References). The LM3 multiplier for the WW2H scheme was estimated directly by asking the participants whether through their participation in the scheme they had influenced walking in other people, and how many. The value was 1.94, i.e. for every individual who participated in the scheme an average of 1.94 other people were encouraged to walk. Confidence in this number is indicated, since the values calculated from each of the three rounds of participant data collection (i.e. three independent samples) were within 15% of each other.

The Lottery-agreed approach is based on the approach taken in the evaluation of the Walking for Health Initiative in England (WHI). This approach estimates the total impact of a walking initiative and comprises the number of individuals taking part in led walks, plus 50 further walkers per health professional involved, plus one further walker per 10 items of printed self-help information, plus 33% of the local population per footpath improvement, plus a commercially used multiplier for media mentions. Relevant data are not available for Wales to allow the latter two additions to be included in this report.

The basis and evidence for the WHI multipliers are not referenced and some do seem rather high. It is also likely that individuals are exposed to a number of these sources. Summation as if the sources were independent is likely to lead to an over-estimation of the number of indirect beneficiaries.

Using the LM3 approach has the advantage that the multiplier is determined directly for the scheme, and is not assumed based on information from other schemes in other places. But the LM3 approach does not account for the (unknown) impact of self-help material and publicity (see Table 3). We also note that this final report lacks round three data from one project, and by February 2007 not all local projects were fully established (see Fig 3). The LM3 approach is therefore likely to provide a reasonable but somewhat conservative estimate of the total impact.

The involvement of health professionals, the production of self-help material, and features in the media may have further impact. Some of this impact will be on the people already involved in walking and therefore will not be an independent addition. The "best estimate" will therefore be the LM3 figure, plus an estimate for the independent impact of these other factors. We have taken 25% of the WHI multipliers to represent this independent additional impact. That is, for health professionals and for self-help materials. With the addition of a small number to account for the further effect of the media features the resulting total impact is a rounded best estimate of 85,000 individuals.

Table 1b presents all three measures. These data represent the best estimated lower (LM3) and upper (WHI) bounds of participation.

We conclude, as the best estimate, that the total impact of the scheme has been to increase the walking activity of 85,000 people, with upper and lower bounds of 53,410 and 167,891 people. The majority of these people are from areas of poor health since these are where the local projects are focussed (see map in appendix B), and around 1/3rd were previously undertaking activity at below the recommended level for health (see section 4.2)

Key point:
85,000 people have been encouraged to walk more by the scheme's activities

Table 1b: Total number of people benefiting from the WW2H scheme according to each method of estimation

Total number of different individuals directly participating in led walks	Best estimate of total number of beneficiaries (see text for explanation)	LM3 (see text for explanation)	WHI (see text for explanation)
18,167	85,000	53,410	167,891

Key recommendation:
That further research is conducted on appropriate multipliers to quantify the indirect impact of walking schemes

As shown by the detailed data in the appendices, there is considerable diversity in the size of local projects. The number of different people joining led walks varied from 51 to 3,800, and the number of led walks varied from 6 to 1,932. This range reflects a combination of the different scales of the projects, the individual projects' stage of maturity (see section 4.1.6) and the local population density.

Key point:
Local projects varied in size from the very small (51 people on led walks) to the very large (3,800 people)

4.1.2 Origin of people participating in led walks, as estimated by coordinators

Table 2 shows the number of new walkers joining the scheme as estimated by local project coordinators during the three reporting periods, along with their estimates of the numbers (and percentages) of walkers joining as a result of (a) being referred by a GP or other health professional, (b) local publicity, or (c) word of mouth. Percentages do not sum to 100% because either no primary source was identifiable or because there was a mixture of sources. Data prior to the three reporting periods were not available. Based on data provided by the local project coordinators, it can be estimated that of the 18,167 individuals involved in WW2H, 7,085 joined as a result of local publicity, 7,267 joined as a result of word of mouth, and 3,270 joined as a result of GP/Health professional referral.

The finding that word of mouth was the most common means by which people learned about the scheme prior to joining is complemented by the frequent positive comments that walkers wrote in the questionnaire booklet. Some of these comments have been included in this report to help illustrate other findings. It was clear that the majority of walkers who filled in the questionnaire booklet had enjoyed participating in the local projects, and it is likely that they encouraged others to join the scheme. As a possible limitation, those people completing the questionnaire booklet were possibly biased towards those who had found the led walks enjoyable. However, it seems reasonable to assume that those people walking regularly on led-walks enjoyed their involvement and would have told others about the projects. These observations highlight the value of ensuring that led walks are enjoyable experiences for participants. These observations are compatible with comments from the local evaluations of the England WHI scheme.

Table 2: The number and percentages of new walkers joining as a result of a GP or other health professional, as a result of local publicity and as a result of word of mouth from the three reporting periods covering 1 January 2005 - 30 November 2006.

Total numbers of individuals on led walks for the first time	Number joining from local publicity		Number joining from word of mouth		Number recommended or referred by GP/health professional	
	Num.	%	Num.	%	Num.	%
9,608	3,769	39	3,886	40	1,753	18

Key point:
Word of mouth was the most common means by which new participants had heard about the scheme. This reflects positive experiences of the scheme

4.1.3 Publicity and information produced as reported by project coordinators

Table 3 presents the number of self-help materials produced from 1 January 2004 to 30 November 2006, along with the number of press, radio and TV features. The self-help material figure is each item of print multiplied by its print run. This volume of self-help and publicity material will have increased the impact of the scheme. As a result it is likely (but quantitatively unknown) that other people will have increased their walking without formally joining a local led walk. The data in Table 3 supports the interpretation of the estimated total impact of the scheme (i.e. 85,000 walkers) given in section 4.1.1

Some marketing material was available nationally. It is assumed that local and national material was distributed appropriately and in full, but an integrated marketing strategy was not defined.

Table 3: Number of self-help materials produced, and the number of press, radio and TV features, from 1 January 2004 to November 30, 2006

No. of self help material produced	No. of press, radio, and TV features
304,857	915

Key point:
The scheme has led to considerable media attention and generated a large volume of self-help material

Key recommendation: National and local marketing strategies should be integrated to maximise the impact of self-help material and publicity.

4.1.4 Number of walks as reported by coordinators

Table 4 presents the number of led walks, number of new walk routes used for led walks, and the number of walk routes that were improved. The number of walk routes that were improved is the reported estimate made by project coordinators, rather than data from a systematic audit of footpaths.

Table 4: Total number of led walks, number of new walk routes, and the number of walk route improvements

No. of led walks	No. of new walk routes used for led walks	No. of improved walking routes
10,214	1,228	455

Walker Quotes:

“It is nice to see areas I would probably not have gone walking in”

“It encourages you to take an interest in your local environment and appreciate the natural beauty of local areas”

Key point:
The scheme has led to a large number of new and improved walking routes

4.1.5 Volunteer walk leaders

Table 5 presents the number of active walk leaders at November 30 2006, along with the percentage retention and the number of new volunteers trained to be leaders.

Walker Quote:
“This is a well organised group meeting”

Table 5: Number of active walk leaders at November 30 2006, along with the retention rate and number of volunteers trained since 1 January 2003.

No. of new volunteers trained as walk leaders since 1 January 2003	No. of active volunteers involved at the end, 30 November 2006	Percentage retention
1,485	682	46

The scheme has trained a considerable number of walk leaders since 2003. Attrition of volunteers in exercise and social outreach programmes similar to WW2H is usually high. Previous research has estimated that attrition over 1 year can be as high as 50%. The retention of nearly half of the walk leaders over a three year period is a positive feature of the scheme.

Key point:
1,485 walk leaders trained with half still remaining active in their role

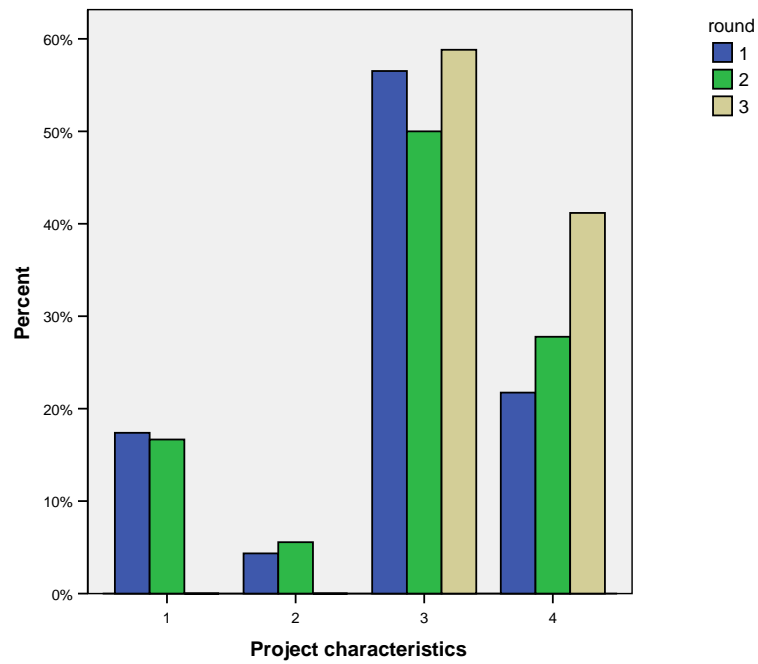
4.1.6 Evaluation of local projects' stages of maturity and the extent to which they interacted with other organisations

Figures 1–3 present the frequencies that coordinators rated their project's stage of maturity for rounds 1 (Jan to Dec 2005), 2 (Dec 2005 to April 2006) and 3 (May to Nov 2006) of the monitoring report. This is in relation to the dimensions of project characteristics, coordinator's role and project outcomes. To assist with the interpretation of these results, Table 6 presents the criteria local project coordinators used when making their decisions. It is apparent that across all three dimensions, the majority of local project coordinators report maturation and consider their projects to have become well-developed. Table 7 presents the combined numbers of organisations with which the projects interacted over the 3 monitoring rounds.

Key point:
Projects demonstrate a clear trend towards maturity in characteristics, coordinators' roles and outcomes over the duration of the scheme.

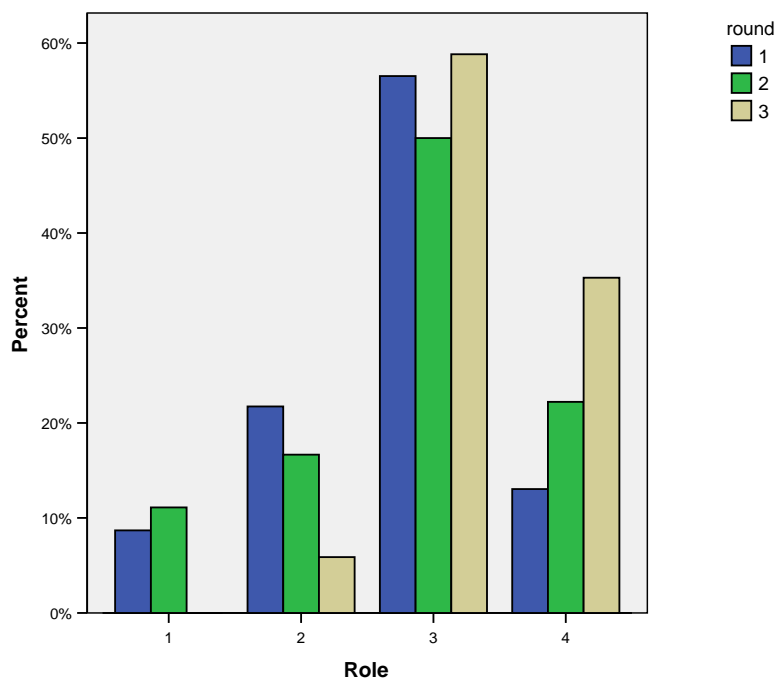
Key recommendation:
That the strategic planning for any scheme incorporates consideration of the phases through which a project will pass as it develops

Figure 1: Number of projects rated at each stage of maturity for the project characteristics dimension



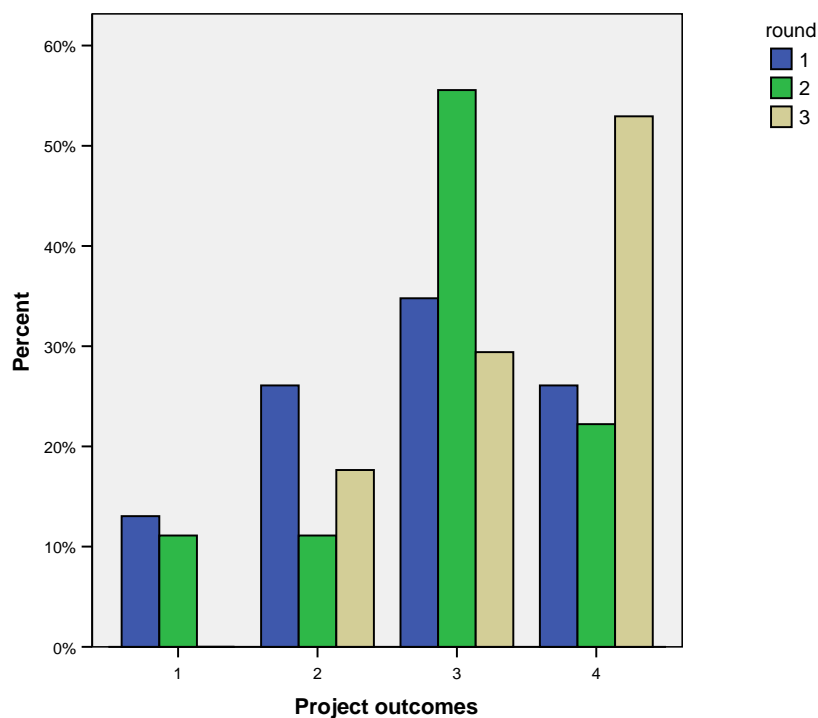
For an explanation of Stages 1, 2, 3 and 4 please see Table 6 (below).

Figure 2: Number of projects rated at each stage of maturity for the coordinators' role dimension



For an explanation of Stages 1, 2, 3 and 4 please see Table 6 (below).

Figure 3: Number of projects rated at each stage of maturity for the project outcomes/success dimension



For an explanation of Stages 1, 2, 3 and 4 please see Table 6 (below).

Table 6: Criteria used by coordinators to assess their project's stage of maturity

Stage	Characteristics	Coordinators role	Outcomes/success
One	Negotiating with partners Identifying target audience Developing structure of project Coordinator & partner owns the project	Negotiate with partners Develop first routes, Decide on methods/structure, Gather information Set up administration	Secure agreement on methods & resources Identify target audience/area, Set up administrative procedures & communications
Two	Recruiting walkers False starts Errors in targeting walkers, widely disparate ability in walking groups Few routes, not graded Poor communication with e.g. health providers Partial transfer of ownership from partners to coordinator	First contacts with target audience, Lead walks, Plan routes Advertise walks, first contact with appropriate bodies (e.g. GPs) Low but increasing administrative burden Functions as provider	Develop routes, encourage participation regardless of individuals status Form new & consolidate existing relationships Make best use of successes/ learn from false starts
Three	Growing range of walks/walkers Appropriate communication with health providers Social benefits to walkers VWLs Graded walks Offer incentives to participate Coordinator owns project	Train VWLs, occasional walk leader, supervise volunteers, promote scheme by personal contact (e.g. presentations to community nurses) negotiate with partners for resources (e.g. guides, specialists, mini bus), administrative role enlarged, Transition from provider to facilitator	Quantifiable successes in terms of number of repeat and new walkers and trained VWLs Increasing range of graded and themed walks, Effective communication, Social/well being benefits to some participants, some slight health benefits may be discernable Beginning of regular participation
Four	Themed walks Diverse range of graded walks Diverse range of walking groups Specialist walking groups e.g. learning difficulties, after work, family, pensioners Word of mouth encourages new walkers Joint ownership of project between coordinator & community	Large administrative burden, Acts as facilitator & manager of individuals who have replaced former roles of coordinator Assess project, use of large data sets Data used in planning and management roles of on-going project	Social/well being benefits widely felt, Regular participation Spin off activity (i.e. participation in other activities outside the project) Health benefits Social interaction outside of project Wide range of participants Possible community benefits (greater social cohesion, improved self respect of trained VWLs, new skills, increased confidence)

Table 7: Number of organisations with which each project has had contact

Round 1	Round 2	Round 3
361	477	533

Local projects are interacting with a large number of organisations, an average of 23 per project. Some of these interactions reflect partner organisations, some reflect necessary interactions for a walking project (such as with the local authority), and some reflect dynamic efforts by the project coordinators to promulgate the WW2H scheme. As discussed in the summary of workshop themes, some interactions result in a bureaucratic burden on coordinators.

Key point:
Projects interact with a large number of organisations, an average of 23 per project

4.2 Data on participants' health and well-being

4.2.1 Sample description

A total of 370 individuals who took part in led walks completed the participant booklet at least once. Of the total sample, 72% were female and 28% were male. Regarding age, 21% were less than 56 years old, 73% were between 56 and 75 years, and 6% were over the age of 75. Local project coordinators agreed during the workshops that the majority of individuals who attend led walks were older females. In addition, local project coordinators estimated in the monitoring forms that more than 95% of walkers were of white British descent.

Key point:
Participants are predominantly female (72%), older (79% > 56yrs), and white British (>95%)

Walker Quote:

“You meet up with like-minded people and this gives you an opportunity to make new friends”

Coordinators also speculated as to why these trends were apparent. First, these figures might reflect that older people, particularly retired individuals, may be the group who are free to go on daytime led walks because they do not have a range of family and work commitments. This speculation is supported by the participant data because approximately 60% of the sample were retired. Coordinators also suggested that walking may not be seen as a masculine activity or one that is attractive to males. Psychological research has revealed that traditional masculine characteristics involve the demonstration of extreme physical prowess. Potentially, males may not be attracted to walking if they perceive it to be easy, or there are other activities available to that might be perceived as more masculine (e.g., running). Coordinators again made reference to gender stereotypes when they suggested that walking was more attractive to females because it provided opportunities for social interaction, which appealed to females, and was not a competitive activity, therefore less attractive to males. Regardless of the reasons, it is very apparent that

walking schemes attract older white females. This is a positive finding because these individuals have traditionally been a neglected group in the provision of opportunities for physical activity. There are many activities, organisations, and commercial enterprises that cater for children, teenagers, and young adults. Traditionally, activity levels decrease with age and so walking schemes might provide opportunities for older females to stay active, when they might otherwise drop out of physical activity.

Key point:
WW2H provided opportunities for a priority target group of older people

Many walking interventions tend to draw upon older individuals (see section 6.0 for comparison with England and Scotland, and the Phase 1 report for a summary of other walking projects). This may be an entirely apt target group, but often schemes do not identify the demographic of their target population. Instead they express the target simply in terms of a total number of people. This may result in a lost opportunity to design the intervention to reach other target populations.

Key recommendation:
That at the planning stage, clear identification is made of the demographic of the desired intervention population

4.2.2 Extent to which the scheme drew on previously inactive people

New entrants were defined as those who had been involved in WW2H for less than three months and were completing a questionnaire for the first time. Table 8 presents the percentages of new entrants who had, or had not, been obtaining at least 150 minutes of exercise of at least a moderate intensity per week for the previous six months. The majority of new participants reported being active prior to their participation in the scheme. This finding was consistent across the three samples. The participants were asked directly whether involvement in WW2H had added to the physical activity they already undertook, and 100% reported their activity levels had risen as a result of joining.

The finding that 70% of new entrants were obtaining the minimum levels of physical activity recommended for health is likely to be influenced by a self-report bias on the part of the participants. Self-report measures rely on participants accurately recalling their physical activity levels, and possibly participants overestimated how much physical activity they were doing regularly. The amount of overestimation is unknown. All methods of measuring people's levels of physical activity have inherent limitations; for example, direct observation probably results in a change of typical behaviour and so researchers do not measure normal physical activity patterns. Even apparently 'objective' means such as pedometers or accelerometers have disadvantages. Internationally, research continues on the most appropriate method of assessing physical activity during free-living conditions (MacFarlane et al. 2006).

The methods used in the current evaluation are accepted by the scientific community as valid tools for measuring physical activity levels. In addition, compared to other possible methods, such as direct observation, the self-report measures were the most logistically feasible tools to use given the size of the WW2H scheme and the goals of the evaluation project. One reason for asking participants to return their completed questionnaires to the evaluation team directly was to by-pass the involvement of the walk leaders or project coordinators and help maintain the evaluation project's independence from the scheme, since otherwise the knowledge that walk leaders or project leaders were handling the questionnaires may have influenced participants' responses to the questionnaire.

Walker Quote:

“I enjoy the walking scheme because it motivates me to walk even when I do not feel well enough”

Table 8: Percentages of new entrants who had been regularly active in the previous six months ('active' is defined as at least 150 minutes of exercise of at least moderate intensity per week)

	(%)
Obtaining 150 minutes per week	70
Not active in previous 6 months	30

Key point:
The majority of new participants reported that they were already active (70%) but a significant minority were not (30%)

According to the Transtheoretical Model of Behaviour Change (Marcus, Selby, Niaura, & Rossi, 1992), people proceed through a series of stages when becoming involved in physical activity. The five stages are described below:

- To be in stage 1 means that the individual is currently inactive and has no intention of becoming physically active.
- To be in stage 2 means that the individual is currently inactive but is thinking of becoming more active in the next six months
- To be in stage 3 means that the individual is doing some activity but not on a regular basis
- To be in stage 4 means that the individual is doing enough physical activity to accumulate health benefits but has only started to do so within the past six months
- To be in stage 5 means that the individual has made activity a habit and has done so for at least 6 months.

Table 9 presents the proportion of new entrants at each stage of change. It is apparent that the majority of new entrants are at the higher stages of change. This finding was consistent across the three reporting periods. As with the finding above regarding the percentage of individuals obtaining the minimum amount of physical activity needed for health, the stages of change results rely on participants being able to recall accurately their physical activity intentions and typical behaviours. Perhaps participants overestimated the amount of regular physical activity in which they engage and so the “actual” sample proportions at each stage of change are less skewed towards to upper end of the continuum than shown below. However, the stages of change questionnaire may be less open to overestimation because the level of precision needed from participants is lower than with the questionnaire collecting information about physical activity levels. Although some self-report bias may be inherent, it is still likely that a significant proportion of new entrants were already at the higher stages of change when entering the scheme.

Table 9: The self-reported proportion of the new entrants at each stage of change

	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Total sample (%)	0	16	7	20	57

To explore further the longitudinal data, a matched sample consisting of the 82 people who had completed the booklet three times were examined regarding their stages of change and activity levels. Table 10 presents the percentage of the sample at each stage of change at each data collection round. Table 11 presents the percentage of individuals achieving sufficient amounts of exercise at each data collection round. These findings support earlier ones, i.e. that individuals involved in the scheme are in the higher levels of the stages of change when they start walking with local projects and then maintain their levels of activity over the year in which their progress was followed.

The literature on behavioural change identifies that an intervention is most likely to succeed if it is formulated appropriately for the level of the target group. For WW2H, it appears that the nature of the project and the way it was promoted at a local level was not well matched to an aim to recruit substantial numbers of less active people. Nevertheless, it is likely that already active “torch bearers” are required to create the impetus to make projects vibrant and draw in new walkers from the desired demographic groups.

Table 10: Percentage of the 82 individuals in the longitudinal study at each stage of change at each data collection round

	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Round 1	1	1	19	1	78
Round 2	0	4	17	3	76
Round 3	1	1	19	1	76

Table 11: Percentage of 82 individuals in the longitudinal study achieving sufficient amounts of exercise at each data collection round

	Sufficiently active	Insufficiently active
Round 1	54%	46%
Round 2	58%	42%
Round 3	58%	42%

Key recommendation:
That established behavioural change models are used to identify the most appropriate intervention approaches according to the target population

4.2.3 Evaluation of extent to which the scheme caused changes in health and well-being

As shown in table 12, on entry participants perceived themselves to be in good health and well-being. The longitudinal data shows all scores improving slightly over time (one year), and it is apparent that people who remain in the scheme continue to display high levels of perceived health. Such a finding may indicate that physical activity has value in helping older individuals maintain high levels of health and well-being, given that these variables tend to decrease with age.

Walker Quotes:

“An excellent way to meet people as a group, who all want to improve health and mobility”

“A pleasant healthy social activity”

“Due to my incapacity, walking on level ground has made quite a difference to my health”

“I’ve had an operation for a knee replacement recently (as well as hip!), and got over that quicker than the hip operation due to walking. Steps and stiles are a little difficult, but with the help of my many friends I’m having the time of my life.”

Table 12: Means and standard deviations from the health related questions

Measure	Completing for a third time		
	First	Second	Third
Current health (VAS)	72 ± 17	76 ± 15	75 ± 15
SF 12 Physical health	74 ± 21	76 ± 18	76 ± 19
SF 12 Mental health	71 ± 16	75 ± 14	74 ± 15
SF 12 Overall health	72 ± 16	75 ± 14	75 ± 15

Key point:
The new participants display existing good health and participation in the scheme improves this further.

4.3 Workshop Themes

4.3.1 Improved health and well-being of participants

Local project coordinators had a number of stories or examples of individuals who had benefited physically, mentally, and socially from participating on led walks. For example, one story was related about an obese individual who had started walking as a result of a doctors’ health warning and over a two year period had been a regular walker, had lost weight, made new friends, and was now preparing himself to be a walk leader. Although these are subjective stories, they do provide some insights into what structured walking programmes like WW2H are capable of achieving. It remains the domain of other types of research methods, such as those used in the current evaluation to quantify the magnitude of these qualitative changes. Nevertheless these stories related by local project coordinators provide some evidence of the ways WW2H projects have touched the lives of participants.

4.3.2 Relationships with lead and partner organisations

Coordinators discussed the benefits obtained from clear communication and guidance with lead and partner organisations via mechanisms such as email, regular meetings, newsletters, etc. Specific to WW2H, clear communication was needed to allow complex issues, such as insurance and evaluation, to be managed in practical ways that assisted coordinators to run projects according to safety and funding requirements set down by external organisations. Clear communication helped with the strategic direction and day to day administration of projects, and specific topics discussed by coordinators included the securement of future funding, marketing and branding, and evaluation procedures.

Among the coordinators there was a lack of consensus about issues such as evaluation and insurance. Some coordinators felt strongly about the lack of common understanding that existed about the issues they discussed, and several believed that both lead and partner organisations could be providing more support or guidance. Some disparity of perception is to be expected when projects operate in a fluid and mutable social environment and there is turnover of coordinators. Also, strong opinions may be understandable given that many coordinators felt unable to cope with the various demands of their role (see below). When stressed, individuals may attribute difficulties to external factors to help protect them from admitting they cannot cope. The signed conditions of grant, however, clearly stated certain requirements of the co-ordinators and it is difficult to understand how they were confused, for example, about the need to audit their own project.

4.3.3 Training and support for every professional and volunteer involved

The coordinators felt that the results from the training questionnaires (described below) matched their own experiences and the feedback they had received from walk leaders who had undertaken training. They believed the training contributed to the ability to function as either a coordinator or walk leader. One of the major benefits from training was the ability to network and learn that other people were in similar situations. Such benefits helped individuals realise that they were not alone, were able to draw on the help of others, and were not dealing with unique, or unsolvable, issues. Also, coordinators valued the chance to learn that their own knowledge was often in accordance with that information presented by the trainers (who were typically perceived as experts).

Key point:
The training programme proved effective for both coordinators and walk leaders.

Key recommendation:
That the training programme provides a model of good practice. Formal training should be supplemented with informal workshops to facilitate networking and the sharing of knowledge

4.3.4 The centrality of the project leader

One reason that coordinators perceived that training and support was helpful was because they viewed their role as central to the success of local projects. There was a frequently expressed opinion that in the absence of a local coordinator led walks would not continue long-term. Responding to questions regarding the skills needed to be an outstanding coordinator, workshop participants suggested that individuals had to be passionate about walking, had to engage in a lot of networking, had to be creative, and had to have good interpersonal skills. Also, there needed to be a good fit between the coordinators and the projects they were running (in terms of other individuals involved, the partner organisations, and participants). If the person in the local project coordinator's role changed, and there was not a good fit with the new individual, then that particular project may suffer and fail.

Key point:
The project coordinators' role is central to the success of a scheme, requires multiple skills, and on-going networking and communication is beneficial

Many individuals perceived that the coordinator role had changed as projects had matured, and among the longer serving coordinators there was dissatisfaction regarding these differences. As projects developed, coordinators spent more time involved in administrative work and less time interacting with participants and walk leaders (which was often the reason they had been attracted to the position initially). In addition to finding administration unrewarding, many believed they did not have the skills needed for tasks such as project evaluation and writing grant funding applications. The difficulties several individuals faced may have been compounded by their related perception that partner organisations and steering committees were unhelpful. There were mixed responses to questions about partner organisations and steering groups. Some project coordinators believed they were well supported by these groups, whereas others thought such groups could offer more assistance.

Perhaps unsurprisingly, the local project coordinators considered their role as critical. Structurally, the coordinator is responsible for a multitude of central roles, and therefore a project's level of success. It was clear that many coordinators felt stretched to fulfil all the roles due to a lack of time and a limited skill set. When individuals are feeling stressed and anxious regarding their responsibilities, attributing their positions to external factors (e.g. partner organisations) helps protect them from admitting they do not have the ability to cope. In addition, stressed individuals may not believe they are able to delegate tasks to other people, and many coordinators tried to undertake all the tasks themselves rather than, for example, managing skills from within their pool of volunteer walk leaders. The stress that coordinators felt may well have been compounded by the perception that their job had changed. It is perhaps inevitable, however, that their changing role reflects the growth of an organisation where the leader is forced progressively away from being hands-on to being an administrator. It would seem that any continuation of existing projects or development of new walking projects will benefit from considering the various demands that are made on project leaders. The succession plan for WW2H (see references: *Steps into the Future*) provides recognition of these issues by recommending that increased resources be made available to support the local project coordinator role.

Key point:
The administrative burdens of co-ordination can be significant, lead to stress and dissatisfaction, and detract from the primary purpose of walking.

Key recommendation:
That an appropriate level of administrative resource and support is available to projects. Consideration should be given to the use of on-line methods for data collection, and for promoting coordinator interaction through web pages, message strings, emails, etc.

4.3.5 The implementation of an accreditation scheme to recognise good quality projects

Project coordinators had a number of suggestions for helping projects establish and maintain themselves including:

- (a) coordinators being passionate and enthusiastic about the project,
- (b) identifying influential individuals within the community who could be “champions” for the projects,
- (c) networking and forming good relationships with community organisations associated with the target walker population,
- (d) adjusting walks to fit the target populations (e.g., speed date walks for single people),
- (e) maximising walker adherence via incentive schemes, the encouragement of social identity and interaction, and focusing on walker enjoyment,
- (f) interacting with walk leaders and ensuring they were satisfied, and
- (g) recognising barriers (explained below). In addition, successful projects initially focused on getting people walking rather than emphasising the establishment of administrative systems.

Regarding administrative systems, coordinators believed these could be adapted from existing projects.

A number of barriers that hindered the establishment of local projects included:

- (a) coordinators being “outsiders” or not part of the communities in which walks took place,
- (b) the changing role of the local project coordinator (discussed above),
- (c) perceived politics and competition with related health organisations,
- (d) their inability to be involved in the projects full time, and
- (e) negative perceptions held by target populations.

Regarding negative perceptions held by target populations, several coordinators believed that many people in the target populations thought they did not need to start walking for health reasons, that walking was not intense enough to obtain benefits, and it did not fit their lifestyles.

4.3.6 The value of the workshops for the local project coordinators

Several times throughout the workshops, project coordinators indicated that they found the opportunity to express their opinions in a safe and confidential environment helpful. A parallel seems to exist between the project leaders’ experiences and those of individuals undertaking counselling. Often one of the most valued benefits of counselling is the opportunity to talk through uncomfortable topics because individuals feel better for having verbalised their thinking, having been listened to, and obtaining new perspectives on their problems. Likewise, the project coordinators expressed similar benefits: they felt better for having had the chance to talk about their experiences to empathetic individuals (the workshop facilitators) and had appreciated learning the perspectives of other coordinators. Echoing these comments are those related to the project coordinator and walk leader training where the value of informal networking was emphasised. This theme indicates how evaluation can be an interactive process from which both parties (researchers and participants) benefit. Evaluation of exercise schemes does not have to be viewed as additional work by scheme members, but rather can be viewed as integral to the life and well-being of local projects.

Key point:
Evaluation of exercise programmes can be interactive with both researchers and participants benefiting. Evaluation may be best viewed as an integral part of a local project.

4.4 Results from the Project Coordinator and Volunteer Walk Leader training questionnaires

4.4.1 Sample description

Of the 20 project coordinators who returned questionnaires, 85% were female and 15% were male. The average age was 46 with a standard deviation of 16 years. 10% spoke Welsh and 70% had completed the training in post as local project coordinators. Regarding the 31 individuals who returned the walk leader training questionnaire, 68% were female and 32% male. The participants' average age was 57 with a standard deviation of 16 years. 13% spoke Welsh and 87% did not. Although the response rate for walk leaders was 39%, a sample size of 31 represents 4% of the 710 individuals who had been trained at the point in time when the sample was originally drawn. In addition, the majority of individuals completing the questionnaire were still active walk leaders and may have represented individuals who believed in the value of the scheme. Potentially, the walk leader questionnaire results are biased towards a positive evaluation of the training, although the degree of any such bias is unknown. As presented below, the walk leaders did evaluate the training positively, and confidence in these results is strengthened by the project coordinators' comments during the workshops that walk leader had told them that the training had been worthwhile.

4.4.2 Training questionnaire results

Both questionnaires included items relating to the specific learning outcomes for the coordinator and walk leader training. For example, coordinators were asked the degree to which they felt they learned about:

- (a) the benefits of physical activity and walking for health,
- (b) the national context for WW2H,
- (c) devising, planning, and researching independent walks,
- (d) promoting independent walks,
- (e) marketing,
- (f) managing a programme of lead walks
- (g) working with a local community, and
- (h) project management and action planning.

On a Likert scale from 1 (not at all) to 5 (a great deal), the average of all items were above 3, which was taken as a minimum level of adequacy.

The individuals completing the walk leader training questionnaire were asked about the extent to which they learned about:

- (a) the benefits of physical activity and walking for health,
- (b) identifying barriers to physical activity,
- (c) motivating people to walk,
- (d) the components of a health walk,
- (e) safety,
- (f) special health issues,
- (g) how to lead a walk, and
- (h) essential paper work.

Again the average of all items were above 3.

Regarding the location of training and resources, both samples were asked:

- (a) how suitable was the training room,
- (b) the extent to which appropriate facilities were available, and
- (c) the suitability of the training manual.

Respondents replied on a Likert scale from 1 (not at all) to 5 (a great deal). Figure 4 reveals that both samples believed that the location of training and available resources were more than adequate.

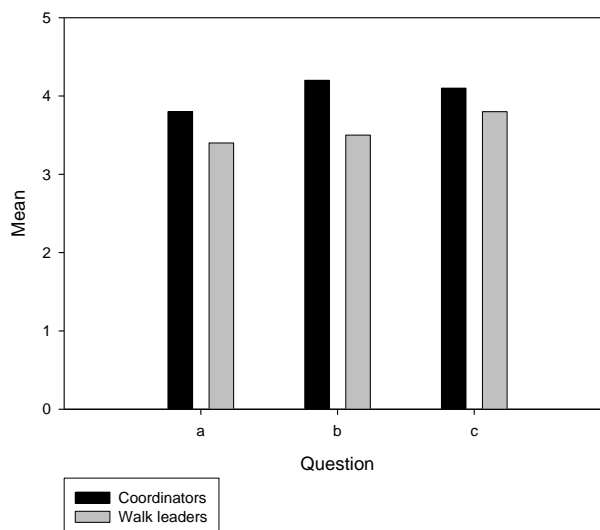
Project Coordinator and Volunteer Walk Leader training participant quotes:

“It was taught with a sense of humour, we felt confident that the teacher knew their job”

“I liked learning how best to help others and correct procedure to lead healthy walks – it finished too soon”

“I liked meeting like minded people”

Figure 4: Response to questions regarding the location of training and available resources (scores rated on a 0-5 scale. A score of 3 reflects adequacy.)

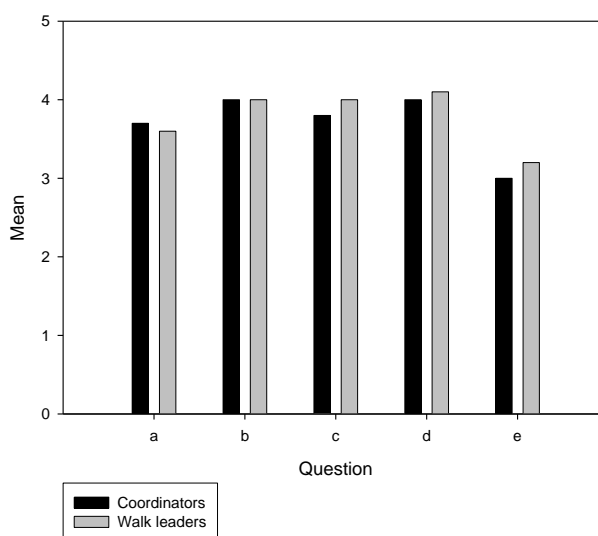


Regarding the quality of the training course both samples were asked to indicate on a five point Likert scale whether the courses were:

- (a) boring or highly stimulating,
- (b) useless or highly useful,
- (c) irrelevant or highly relevant,
- (d) poorly taught or extremely well-taught, and
- (e) undemanding or highly demanding.

As shown in figure 5, the means for each item were above 3, reflecting that responders believed the courses were of high quality.

Figure 5: participants' responses to items regarding the quality of training (scores rated on a 0-5 scale. A score of 3 reflects adequacy.)



Regarding the questions that asked participants about their overall impression of the training courses, both samples were highly impressed with the training. Taken together the results provide evidence that both samples:

- (a) believed the training courses helped them achieve the specific learning outcomes,
- (b) were satisfied with the facilities and resources provided,
- (c) thought the training had been stimulating, useful, relevant, well-taught and demanding.

It would appear that the training undertaken as part of the WW2H scheme could serve as a useful model for any continuation of the scheme or for other exercise projects. In using the WW2H training model as a guide, minor adjustments to planning and organisation may help tailor courses to the needs of project leaders and volunteers. For example, during the focus groups, local project leaders indicated they felt the training was an excellent opportunity to network with peers and so planners of future courses might well ensure they include sessions that allow for informal interaction and formal sharing. In addition, project leaders suggested that one of the great benefits of training was the security and confidence that came from learning that others were experiencing similar difficulties and pressures; further evidence that informal interaction and formal sharing sessions have value during training. With respect to the specific target of the WW2H scheme that every professional and volunteer involved would receive training and support, the training questionnaire results provide evidence that the walk leaders and project coordinators believe that they received high quality training that provided them with the skills and knowledge needed to fulfil their respective roles.

Key point:
 The training courses were successful. They were well taught, relevant, achieved the intended outcomes, and took place in appropriate places with good resources.

5.0 The value of the evaluation to the local projects

Although evaluation may be perceived as additional work on top of the day-to-day running of an exercise scheme, and some local project coordinators did express such thoughts in the monitoring forms, this need not be the case. There were several benefits that project coordinators mentioned regarding the evaluation project that highlight how it can be integral to the life of an exercise scheme. One of these has already been discussed above regarding the counselling-type benefits that were gained during the workshops: the opportunity to talk in non-threatening environments

with colleagues from other projects. Another benefit of the evaluation for projects, particularly as observed from the workshops, was the increased enthusiasm and sense of ownership that coordinators seemed to gain from interacting with the facilitators and colleagues. For example, a number of the questions asked during the workshops by facilitators were designed to help coordinators consider the rationale for their local projects, and as individuals shared their views with each other they began to realise how much they believed and valued the WW2H scheme. Such an observation parallels psychological research that has suggested that such a persuasion strategy (asking individuals to come up to justifications for specific activities) can be a powerful way to convince someone of an activity's value.

The evaluation project was designed to be a transparent process and interactive with the results from the participant questionnaires, monitoring forms, and workshops presented to project coordinators for their comments and insights. Individuals expressed gratitude for the opportunities to learn about the results because this helped them reflect on their own project's progress, formulate problem-solving strategies, and consider ways they might develop their schemes. In addition, some coordinators learned about issues that need to be considered when undertaking evaluation, such as ways to collect data, how to maintain a database, and ways to present results. These added to and reinforced project coordinators' existing knowledge and skills about evaluation.

The indication that the evaluation process contributed to coordinators' professional development provides an example of how on-going formal and informal training and support may be linked to the stages of project development. Coordinators do not need to have a complete evaluation skill set during the initial stages of a project but can develop a number of specific and technical skills on an ad hoc basis when needed. During the early stages project coordinators probably need knowledge about the key principles of evaluation and individuals did demonstrate such an understanding during the workshops (e.g., evaluation is best when begun at the start of the project, standardisation across projects for comparability). In many ways the people best suited to evaluate a project are those individuals involved, with guidance from an independent group to help address any deficits.

Key point:
The purpose of evaluation was understood by the coordinators. The basic data collection is accepted necessary, if somewhat burdensome.

Key recommendation:
Evaluation should be integrated into project development and reporting from the outset.

6.0 Comparison with England and Scotland schemes

Walking for Health Initiative (England) has been running since 2000 along similar lines to WW2H, and reports helping 1,000,000 people to walk more. WHI has been evaluated by local evaluations of over 50 individual projects, and by a national evaluation using a sample of 750 participants. The participants in WHI were mainly female (73%), mainly older (over 50), and predominantly white (95%). The majority of entrants were already reasonably active although 20% reported a health problem. The WHI schemes helped people increase or maintain activity levels, and the evaluations report improved levels of perceived health and well-being. All of these findings are similar to the findings detailed in this present evaluation of WW2H.

Using the WHI multipliers, it is estimated that WHI has impacted upon 2% of the population of England (1m from 49m people). WW2H has impacted upon 2.9% of the population of Wales

(85,000 from 2.8m) using the best estimate for direct and indirect participation. Using the England multipliers on the Wales scheme, it has impacted upon 6% of the population (167,891 from 2.8m)

The Paths to Health scheme in Scotland, which was established on the same model as WW2H and WHI, reports 10,000 people walking each week and over 100 community based schemes. However further comparison is not possible since the Scotland scheme does not report systematic data. Its annual monitoring report for 2006 comments "...there is considerable diversity in the schemes grant aided which does not always make for easy comparison. Schemes are encouraged to utilise the Paths to Health Monitoring and Evaluation Framework. However we have found that the quality of annual reports varies considerably and is often a reflection of the resources available to local schemes...."

Across the three countries of Wales, England and Scotland, evaluation of walking initiatives has provided much valuable information about the benefits of such schemes. Nevertheless, much of this evidence is relatively informal and there is a lack of systematic data of high quality. Furthermore, for understandable reasons of resource, the number of randomised controlled trials of walking schemes is extremely low. In recent statements on exercise interventions, the National Institute for Health and Clinical Excellence (NICE) has commented on the dearth of clinical-standard evidence (NICE 2006).

Key recommendation:
Consideration be given to conducting controlled trials to improve the quality of evidence available concerning the efficacy of exercise interventions

7.0 Summary of performance against scheme targets

- **TARGET - 80, 000 people walking who are from areas of poor health or who were previously inactive**
18,167 different individuals have participated in led walks. When account is taken of indirect impact of the WW2H scheme an estimated 85,000 people have benefited (lower and upper bounds 53 410 and 167,891). The majority of these people are from areas of poor health since these are where the local projects are focussed (see map in appendix B), and around 1/3rd were previously undertaking activity at below the recommended level for health.
- **TARGET - Improved health and well-being of participants as a result**
The majority of participants enter the scheme with relatively high health status and levels of activity. The scheme slightly improved both levels of activity and health status.
- **TARGET - Small-scale improvements on the ground to make local areas more accessible and safe for walking**
455 improved walk routes are reported. Furthermore 1,228 new walk routes are reported which, although not reflective of physical improvements (such as path condition, stiles etc.), do reflect improved accessibility and local knowledge.
- **TARGET - Training and support for every professional and volunteer involved**
From 1 January 2003 to 30 November 2006, 1,485 new walk leaders were trained. With 682 active walk leaders at 30 November 2006, there was an overall retention rate of 46%. Evaluation of the training was positive, indicating that the training allowed walk leaders and coordinators to fulfil their roles. Further support for coordinators was provided by the national Coordinator and Case Officers and through the coordinators' workshops.
- **TARGET - The implementation of an accreditation scheme to recognise good quality projects**

It was agreed with the Big Lottery Fund that the aims of this target have been achieved by other means. In addition, the workshops with coordinators helped to identify and disseminate good practice.

- **TARGET 1 - The espousal of the WW2H model by the health mainstream in Wales, and receiving mainstream funding from 2006 onwards**

Although not within the scope of this evaluation, it appears this target has been met by the announcement of Welsh Assembly Government funding.

8.0 Overall observations

The WW2H scheme has promoted a significant volume of walking activity, distributed across the entire country. There has been an improvement in the activity levels and the health of the participants, but this is slight. The scheme has drawn predominantly upon a relative narrow segment of the population – the older female – and predominantly upon the already active. The scheme did not aim to draw upon any specific demographic, but should future schemes wish to target other groups then consideration of project structure is necessary since a community-based, daytime, walking group approach is unlikely to draw widely across the population. This conclusion is compatible with contemporary views on the psychology of behavioural change, and the broad pattern of evaluations from the England WHI scheme.

Local projects pass through stages of development. The attainment of maturity is likely to be enhanced by structures that facilitate interaction between project coordinators, by strategic planning at the national level which recognises these developmental stages and provides appropriate support and at the right time, and by evaluation mechanisms which are integrated in projects from the start and which feedback continually throughout the lifetime of a project.

This evaluation report is felt to be robust in many respects, but not all. The basic audit data on participation and demographics is that reported by the local project coordinators. This was to a standard template and collected over three time periods and is probably sound. The direct assessment of a multiplier coefficient provides greater confidence in the reliability of the estimate of indirect beneficiaries than those estimates provided by other walking schemes in the U.K. But there is a dearth of research on multipliers for walking schemes and further investigation is required.

The scheme has trained a large number of volunteer walk leaders and it has led to a large number of more accessible or improved walking routes. The training programme was considered good. The evaluation of training was based on a random sample and a good return rate. This aspect is robust.

The data on activity, health and well-being are based on a reasonably large sample (370 individuals) taken from across all projects. They rely on self-report data and no independent direct measures were taken of activity levels or health outcomes. Nevertheless, the use of confidential postings from/to participants (i.e. independent of the local coordinator or other walkers) and the use of an independent evaluation team reduces the risk of positive bias.

Participants self-select to join a walking group and self-select to keep walking. In this evaluation there is no control group and therefore an unknown amount of bias (positive or negative) in the results. For pragmatic reasons - the nature of this scheme and the resources available - a higher standard of evaluation design was not possible. As describe in the recent NICE (2006) review of exercise interventions there is a major deficiency in controlled studies of exercise interventions and thus a major deficiency in the evidence base. As well as fulfilling audit, monitoring and development needs, evaluation can provide an opportunity to enhance the evidence base and greater investment in this respect is warranted.

9.0 References

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Appendix A: Tables of project totals

Appendix A table 1: Total number of different walkers, number of new walkers, new walker percentage, and person-walks for each project, for the three reporting periods that cover 1 January 2005 – 30 November 2006, and in 2004

Project	Number of different individual walkers on led walks	Number of new walkers	New walker percentage	Total number of person-walks
Blaenau Gwent	453	394	87	789
Bridgend	849	48	6	1,337
Caerphilly	206	206	100	3,121
Cardiff	485	451	93	9,580
Carmarthenshire	386	386	100	2,451
Ceredigion	365	365	100	3,439
Conwy	51	51	100	148
Denbighshire	1,943	1,180	61	951,392 ¹
Flintshire	3,842	2,315	60	22,139
Gwynedd	45	45	100	81
Merthyr Tydfil	350	350	84	2,618
Monmouthshire	437	413	95	5,743
Neath Port Talbot	100	100	100	1,622
Newport	355	234	66	2,407
Pembrokeshire	544	544	100	3,488
Powys	397	347	87	22,633
Rhondda Cynon Taff	123	113	92	637
Swansea	265	145	55	160,339 ²
Torfaen	880	880	100	15,578
Treharris (non-grant aided)	65	30	46	940
Vale of Glamorgan	234	176	75	2,294
Wrexham	1,106	688	62	8,372
Ynys Mon/Anglesey	544	147	27	12,887
Total from 3 reporting periods	14,025	9,608	68%	144,420 ³
Total from 2004	18,167			

¹ Data as reported by local coordinator. The total number of person walks is clearly wrong at 493 walks per person. Estimate correct number based on 10 walks per person or 19, 430 total person walks for the project

² Data as reported by local coordinator. The total number of person walks is clearly wrong at 605 walks per person. Estimate correct number based on 10 walks per person or 2, 650 total person walks for the project

³ Using revised totals as describe in footnotes 1 and 2

Appendix A Table 2: The number and percentages from each project of new walkers joining as a result of a GP or other health professional, as a result of local publicity and as a result of word of mouth for the three reporting periods that cover 1 January 2005 – 30 November 2006

Project	Number of new walkers	Number joining from local publicity		Number joining by word of mouth		Number recommended or referred by GP/Health professional	
		Number	%	Number	%	Number	%
Blaenau Gwent	394	55	14	89	23	61	15
Bridgend	48	17	35	30	63	30	63
Caerphilly	206	44	21	105	51	67	33
Cardiff	451	205	45	175	39	110	24
Carmarthenshire	386	105	27	105	27	90	23
Ceredigion	365	183	50	179	49	13	4
Conwy	51	15	29	30	59	0	0
Denbighshire	1,180	460	39	608	52	134	11
Flintshire	2,315	546	24	826	36	430	19
Gwynedd	45	45	100	23	51	0	0
Merthyr Tydfil	350	55	16	190	54	39	11
Monmouthshire	413	278	67	120	29	0	0
Neath Port Talbot	100	40	40	78	78	4	4
Newport	234	74	32	42	18	10	4
Pembrokeshire	544	198	36	340	63	57	10
Powys	347	211	61	137	39	12	3
Rhondda Cynon Taff	113	8	7	25	22	22	19
Swansea	145	104	72	96	66	45	31
Torfaen	880	616	70	156	18	108	12
Treharris (non-grant aided)	30	5	17	25	83	0	0
Vale of Glamorgan	176	139	79	60	34	24	14
Wrexham	688	325	47	375	55	451	66
Ynys Mon/ Anglesey	147	41	28	72	49	46	31
Total	9,608	3,769	39%	3,886	40%	1,753	18%

Appendix A Table 3: Number of self-help materials produced, and the number of press, radio and TV features, for each project

Project	Number of self-help material produced 1 January 2004 to 30 November 2006	Number of press, radio, and TV features from 1 January 2005 to 30 November 2006
Blaenau Gwent	1,800	6
Bridgend	1,344	4
Caerphilly	2,650	11
Cardiff	16,650	13
Carmarthenshire	61	26
Ceredigion	1,600	42
Conwy	0	5
Denbighshire	57,500	74
Flintshire	117,000	104
Gwynedd	350	3
Merthyr Tydfil	2	25
Monmouthshire	0	107
Neath Port Talbot	500	14
Newport	500	45
Pembrokeshire	3,550	133
Powys	13,900	53
Rhondda Cynon Taff	0	11
Swansea	3,680	11
Torfaen	1,850	29
Treharris (non-grant aided)	0	1
Vale of Glamorgan	23,800	62
Wrexham	24,100	104
Ynys Mon/ Anglesey	34,000	32
Total	304,857	915

Table 4: Total number of led walks, number of new walk routes, and the number of walk route improvements for each project for the 3 reporting periods that cover 1 January 2005 – 30 November 2006

Project	Number of led walks	Number of new walks	Number of improved walking routes
Blaenau Gwent	79	10	3
Bridgend	110	22	1
Caerphilly	523	20	14
Cardiff	730	40	5
Carmarthenshire	247	57	15
Ceredigion	339	14	0
Conwy	60	6	1
Denbighshire	451	10	13
Flintshire	1,932	425	106
Gwynedd	6	9	9
Merthyr Tydfil	230	31	28
Monmouthshire	266	81	4
Neath Port Talbot	189	12	0
Newport	200	24	3
Pembrokeshire	319	48	2
Powys	524	69	70
Rhondda Cynon Taff	199	42	7
Swansea	115	21	1
Torfaen	272	70	5
Treharris (non-grant aided)	94	5	0
Vale of Glamorgan	411	10	110
Wrexham	1,444	98	58
Ynys Mon/ Anglesey	1,474	104	0
Total	10,214	1,228	455

Appendix A Table 5: Number of active walk leaders at the November 30, 2006 for each project, along with the retention rate and number of volunteers trained 1 January 2003 – 30 November 2006

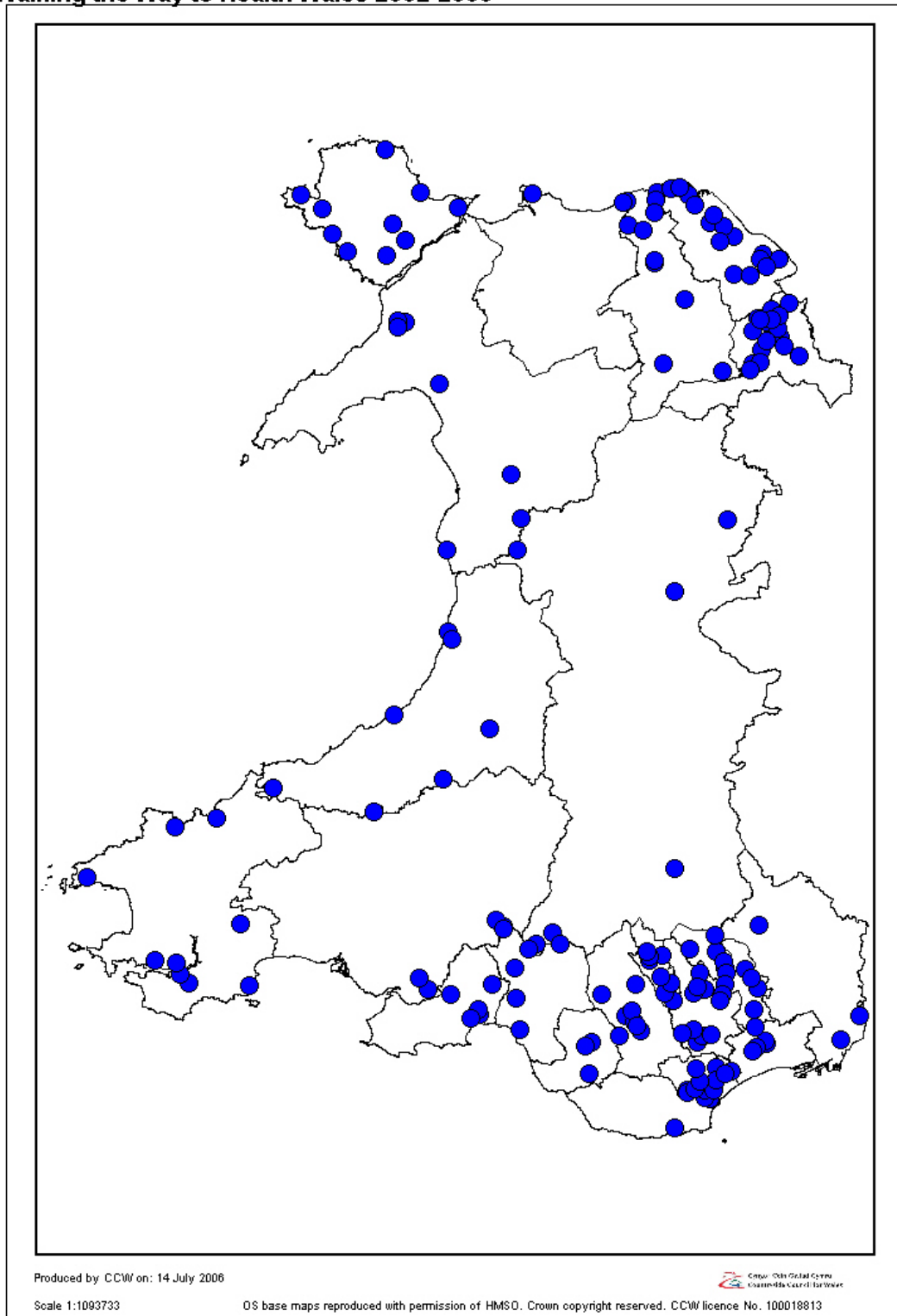
Project	Walk leaders trained	Walk leaders at end	Percentage retention
Blaenau Gwent	11	2	18
Bridgend	22	12	55
Caerphilly	44	32	73
Cardiff	65	70	107
Carmarthenshire	13	34	262
Ceredigion	119	61	51
Conwy	21	6	29
Denbighshire	48	33	69
Flintshire	179	91	51
Gwynedd	73	7	10
Merthyr Tydfil	44	16	36
Monmouthshire	45	35	78
Neath Port Talbot	36	17	47
Newport	44	14	32
Pembrokeshire	65	42	65
Powys	73	35	48
Rhondda Cynon Taff	72	No information	
Swansea	32	4	13
Torfaen	30	5	17
Treharris (non-grant aided)	1	No information	
Vale of Glamorgan	24	55	229
Wrexham	92	54	59
Ynys Mon/ Anglesey	55	57	103
Total since 2004	1,208	682	56
Total since 2003	1,485	682	46

Appendix A table 6: Number of organisations with which each project has had contact at each monitoring round

Project	No. of interacting organisations 1 January – 15 December 2005	No. of interacting organisations 16 December 2005 – 30 April 2006	No. of interacting organisations 1 May – 30 November 2006
Blaenau Gwent	10	12	18
Bridgend	9	19	11
Caerphilly	10	18	18
Cardiff	34	37	42
Carmarthenshire	6	40	75
Ceredigion	24	46	24
Conwy	0	6	10
Denbighshire	31	25	40
Flintshire	28	34	13
Gwynedd	7	12	21
Merthyr Tydfil	14	24	21
Monmouthshire	48	2	26
Neath Port Talbot	6	8	16
Newport	19	95	84
Pembrokeshire	28	24	25
Powys	11	0	13
Rhondda Cynon Taff	7	12	No information
Swansea	4	7	12
Torfaen	12	20	19
Treharris (non-grant aided)	4	No information	No information
Vale of Glamorgan	14	7	16
Wrexham	22	16	10
Ynys Mon/ Anglesey	13	13	19
Total	361	477	533

Appendix B: Map of local projects

Walking the Way to Health Wales 2002-2006



Appendix C: Questionnaires to assess activity, health and well-being

Part A: Levels of physical activity

For each of the following questions, please circle Yes or No. Please be sure to read the questions carefully. Physical activity or exercise includes activities such as walking briskly, jogging, bicycling, swimming, or any other activity in which the exertion is at least as intense as these activities.

		No	Yes
A1.	I am currently physically active	0	1
A2.	I intend to become more physically active in the next 6 months	0	1

For activity to be **regular**, it must add up to a **total** of 30 minutes or more per day and be done at least 5 days per week. For example, you could take one 30-minute walk or take three 10-minute walks for a daily total of 30 minutes.

		No	Yes
A3.	I currently engage in <i>regular</i> physical activity	0	1
A4.	I have been <i>regularly</i> physically active for the past 6 months	0	1

Part B: Types of physical activity

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spend being physically active **IN A USUAL WEEK**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and gardening work, to get from place to place, and in your spare time for recreation, exercise or sport.

SECTION B.1

Think about all your activities that take **hard physical effort** and make you breathe much harder than normal. Only think about the activities that last for 10 minutes or more.

B1 In your usual week, how many days do you do activities that take **hard physical effort** like heavy lifting, digging, aerobics, or fast bicycling?

_____ **days per week**

I do not usually do such activities (***Skip to question B3, Section B.2***)

B2 How much time do you usually spend doing activities that take **hard physical effort** on one of those days?

_____ **hours per day**

_____ **minutes per day**

Don't know/Not sure

SECTION B.2

Think about all your activities that take **moderate physical effort** and make you breathe a bit harder than normal. Only think about the activities that last for 10 minutes or more.

- B3 In your usual week, how many days do you do activities that take **moderate physical effort** like carrying light loads, or bicycling at a regular pace? **Do not** include walking.

_____ **days per week**

I do not usually do such activities (**Skip to question B5, Section B.3**)

- B4 How much time do you usually spend doing activities that take **moderate physical effort** on one of those days?

_____ **hours per day**

_____ **minutes per day**

Don't know/Not sure

SECTION B.3

Think about the time you spent **walking** in your usual week. This includes at work and at home, walking to travel from place to place, and any other walking that you might do for recreation, sport, exercise, or leisure.

- B5. In your usual week, how many days do you **walk** for at least 10 minutes at a time?

_____ **days per week**

No walking (**Skip to question B7, Section B.4**)

B6 How much time do you usually spend **walking** on one of those days?

_____ **hours per day**

_____ **minutes per day**

Don't know/Not sure

SECTION B.4

The last question is about the time you spend **sitting** on weekdays during your usual week. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

B7 In your usual week, how much time do you spend **sitting** on a **week day**?

_____ **hours per day**

_____ **minutes per day**

Don't know/Not sure

Part C: Your health and well-being

This survey asks for your views about your health. This information will help us understand how you feel and how well you are able to do your usual activities.

For each of the following questions, please tick the one box that best describes how you feel.

C1 In general, would you say your health is:

Poor

Fair

Good

Very good

Excellent

C2 Does your health limit you in performing moderate physical activities?

Yes, limited a lot

Yes, limited a little

No, not limited at all

C3 Does your health limit you in climbing several flights of stairs?

Yes, limited a lot

Yes, limited a little

No, not limited at all

C4 As a result of your physical health during the past 4 weeks have you accomplished less than you would like?

Yes

No

C5 As a result of your physical health during the past 4 weeks have you been limited in the kind of work or other activities?

Yes

No

C6 As a result of emotional problems, during the past 4 weeks have you accomplished less than you would like?

Yes No

C7 As a result of emotional problems, during the past 4 weeks have you not done work or other activities as carefully as usual?

Yes No

C8 During the past 4 weeks, how much did pain interfere with your normal work?

Not at all A little bit Moderately Quite a bit Extremely

C9 How much of the time during the past 4 weeks have you felt calm and peaceful?

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time

C10 How much of the time during the past 4 weeks have you had a lot of energy?

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time

C11 How much of the time during the past 4 weeks have you felt downhearted and blue?

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time

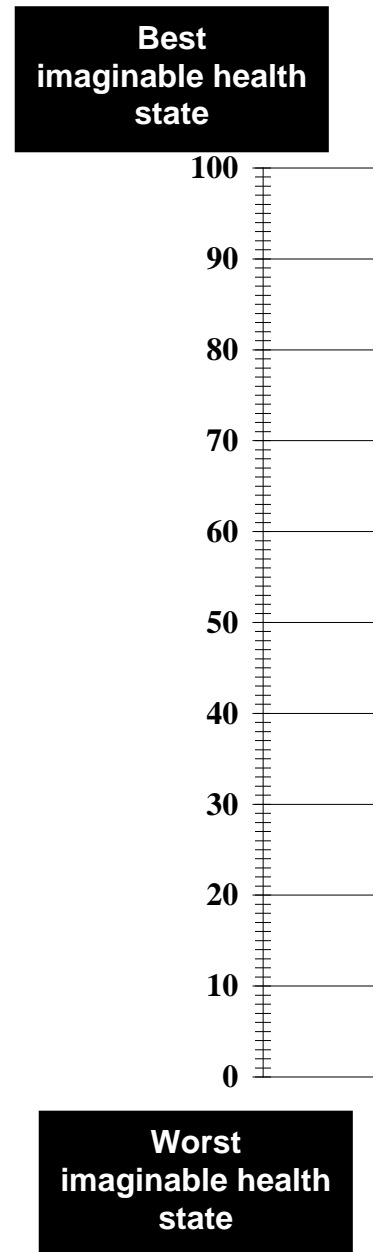
C12 During the past 4 weeks how much of the time has your physical or mental health interfered with your social activities?

All of the time Most of the time Some of the time A little of the time None of the time

Part D: Current health status

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can image is marked by 0.

We would like you to indicate on this scale how good or bad your own health is, in your opinion. Please do this by circling whichever point on the scale indicates how good or bad your health state is.



Part E: Tell us about yourself

E1 Please tick which age bracket you belong within

- | | |
|--------------------------------|--------------------------------------|
| <input type="checkbox"/> 15-20 | <input type="checkbox"/> 51-55 |
| <input type="checkbox"/> 21-25 | <input type="checkbox"/> 56-60 |
| <input type="checkbox"/> 26-30 | <input type="checkbox"/> 61-65 |
| <input type="checkbox"/> 31-35 | <input type="checkbox"/> 66-70 |
| <input type="checkbox"/> 36-40 | <input type="checkbox"/> 71-75 |
| <input type="checkbox"/> 41-45 | <input type="checkbox"/> 76-80 |
| <input type="checkbox"/> 46-50 | <input type="checkbox"/> 81 and over |

E2 Please indicate your gender

- Female Male

E3 Please tick the following statement that best describes you

- Single
- Couple, living with a partner etc

E4 Please tick the following statement that best describes you

- I care for dependents (e.g., children, elderly)
- I do not care for dependents (e.g., children, elderly)

E5 Which one of the following statements best describes your current employment situation

There may be two boxes that could describe you: please tick the one that you think fits best

- Full time paid work in a job, business or profession
- Part time paid work in a job, business or profession
- Casual paid work in a job, business or profession
- Work without pay in a family or other business
- Home duties, not looking for work
- Unemployed, looking for work
- Retired
- Permanently unable to work
- Student
- Other, please specify _____

E6 When did you start walking with the Walking the Way to Health exercise scheme?

Month: _____ Year: _____

E7 On how many walks would you typically go each week?

Walks _____ per week

E8 Has involvement with the Walking the Way to Health scheme replaced or added to the other physical activities you do? (please circle)

Added to or Replaced

E9 Please describe the other physical activities that your Walking the Way to Health involvement has either added to or replaced.

E10 Which statement(s) best describes how you heard about WW2H led walks (tick as many as apply to you):

- I picked up a leaflet or programme of local WW2H led walks
- I saw an advert for local WW2H walks
- A friend or family member who was already walking with WW2H told me about the walks
- A friend or family member who wanted to take part asked me to accompany him/her
- I was recommended or referred by my GP or another health professional to take part in a WW2H led walk
- I heard about local WW2H led walks on the TV/radio or read about them in a newspaper/newsletter
- Other reason (please describe)

E11 Have you introduced any other people to walking, outside of the Walking the Way to Health Scheme? (please circle)

Yes or No

E12 If yes, how many? _____

E13 Are there any positive comments you would like to make about the Walking the Way to Health scheme?

E14 Are there any negative comments you would like to make about the Walking the Way to Health scheme?

E15 Which county project do you participate in?

Thank you for completing this questionnaire, please return it via the stamped self-addressed envelope provided

If you have any questions, please contact Dr David Tod (tel: 01970 62 8567; Email: dvt@aber.ac.uk). If you feel at all distressed by taking part in this project you may speak with Dr Joanne Thatcher, Psychologist (tel: 01970 62 8629).