Factors Affecting the Uptake of Community Recreation as Health Promotion for Women on Low Incomes

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ABSTRACT

Background: There have been repeated calls for research on the factors that promote the spread of successful local health promotion initiatives from one community to another. We examined the factors that affected the uptake of an initiative designed in one community to improve the health of women living below the poverty line through increased access to community recreation.

Methods: Workshops were held in three other communities and uptake efforts were tracked for one year through follow-up site visits and telephone interviews with workshop participants.

Results: Making the issue a priority, actively involving the women in planning, pooling resources, sharing responsibility through partnerships, and addressing the structural dimensions of poverty were factors that enabled uptake. Factors that inhibited uptake included an emphasis on revenue generation, professionally led planning, inadequate attention to structural barriers, the undervaluing of certain resources, and an over-reliance on one idea champion.

Conclusion: A shift in how municipal recreation departments view their role as partners in community health promotion is required if programs are to promote health and be accessible to under-served populations.

Researchers have long lamented that findings from local health promotion projects, including those that are unsuccessful, are rarely published, creating a void in our knowledge regarding the factors that enhance or inhibit the dissemination of these initiatives from one community to another.¹⁻³ Understanding these factors is important because a community's capacity to take action is heightened when there is high awareness of both the enabling factors and the potential pitfalls.^{1,4,5}

It is particularly important to understand the factors affecting uptake from the perspectives of those who are the intended beneficiaries of locally generated health promotion programs, as these individuals are often marginalized from the knowledge production process.^{6,7} Women living in poverty are rarely involved in the planning of community recreation programs or in the analysis of research, even though they are the most likely to experience poor health and the least likely to participate in physical activity and other health-promoting forms of recreation.⁸⁻¹² The individualistic approach to health promotion tends to blame those with poor health for not adopting healthy lifestyles, while ignoring how their living conditions and local government policies and practices create barriers to participation.^{13,14} Rather than expecting marginalized women to solve their own lifestyle problems or have professional staff do it for them, finding ways of bringing women on low incomes together with those who control local recreation program provision and policy development could lead to creative low-cost programming solutions.¹⁵⁻¹⁸

Municipal recreation departments in local government are well positioned across Canada to play an active role in health promotion and these departments typically have mandates to provide a wide variety of services to all members in a community. However, there are few documented examples of how these departments are collaborating with marginalized citizens and other community partners to promote community health. Municipal recreation departments are facing increased economic pressures and, as a consequence, user pay policies are being introduced, making programs increasingly inaccessible to those who live below the poverty line.¹⁹

The Kamloops Women's Action Project (KWAP) is one example of a collaborative

The translation of the Abstract appears at the end of the article.

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effort that involved a partnership between women on low incomes, a municipal recreation department, a number of community partners, and a research team. The impetus for KWAP arose when women on low incomes identified a lack of access to community recreation as a factor affecting their health and that of their families during informal discussions with a public health nurse. Other partners were then mobilized to address this community health issue. Principles of feminist action research that legitimized the experiential knowledge of the women, democratized the research process through a collaborative approach, and strove for personal and social transformation guided the project.^{20,21} Multi-level outcomes were achieved including increased participation rates and improvements in self-reported dimensions of physical and mental health, changes in municipal recreation policy, and the formation of new community partnerships.^{9,22}

The purpose of this study was to disseminate the "lessons learned" from KWAP to three other communities through a workshop intervention in order to examine the factors that enabled or inhibited the uptake of similar initiatives. While the researchers set the purpose of the study, the participatory and action-oriented principles of feminist action research guided the workshops and the evaluation component where workshop participant perspectives on uptake efforts were tracked for one year.

METHOD

After obtaining ethical approval from the University of British Columbia, a full-day workshop intervention was conducted by original members of the KWAP team (including the lead author) in three communities in British Columbia that had requested additional information. A contact person was recruited in each community to generate interest and to invite women on low incomes, municipal recreation staff, and representatives from a variety of community groups to the workshops (see Table I). One third of the day was spent sharing the lessons learned from KWAP using the Leisure Access Workbook as a guide.²² Workshop participants spent the rest of the day discussing the relevance of launching similar initiatives in their communities and making initial action plans.

TABLE I

Description of Communities and Workshop Participants

	Community #1	Community #2	Community #3
Approximate Population (1996 Census)	31,000	18,000	102,000
% English Speaking (1996 Census)	85.3%	90.50%	68.7%
Geographic Region in BC	South West	South Central	Lower Mainland
Municipal Recreation Annual Budget (2001)	\$13,481,630	\$3,830,500	\$20,940,196
# Workshop Attendees by Role			
Women on Low Incomes	3 (25%)	18 (75%)	75 (88%)
Municipal Recreation Staff	2 (17%)	1 (4%)	5 (6%)
Other Community Partners (e.g., staff from public health units, family services, women's centres, mental health organizations, schools)	7 (58%)	5 (21%)	5 (6%)
Total # Workshop Attendees	12 (100%)	24 (100%)	85 (100%)

The tracking of uptake efforts entailed two return visits to each community to attend follow-up planning meetings and thirty follow-up telephone interviews with workshop participants who voluntarily agreed to participate in the study. After the first return visits, transcripts from the meetings were coded to identify major themes. These were subsequently refined and verified in the telephone interviews and the second return visits when participants were asked to provide updates on action taken and to elaborate on the factors affecting uptake. Fifteen interviews were conducted with women on low incomes, five were with municipal recreation staff, and ten were with other community partners (e.g., staff from public health units, women's centres, family services, mental health organizations, schools).

Approval was obtained from the University of British Columbia and study participants to tape record the workshops, follow-up meetings, and telephone interviews. Tape recordings and researcher field notes were transcribed, coded, and analyzed with the assistance of the qualitative data analysis software package Atlas.ti.

RESULTS

The enabling and inhibiting factors that were discussed most frequently by workshop participants are identified in Table II. In all 3 communities, a lack of access to community recreation was deemed to be a relevant community health issue for women on low incomes and this enabling factor served as the stimulus for further action. The women on low incomes saw

increased participation as an avenue for connecting with their communities in a positive way, thereby reducing their social isolation and other related health problems (see E-1, Table II). However, there was a difference in how municipal recreation staff balanced the issue of relevance with the economic pressures faced by their departments. In Communities #1 and #3, the health issue took priority and creative new low-cost strategies for increasing access were entertained. As illustrated in Table II (see I-1), there was political pressure to make cost recovery and revenue generation a priority in Community #2 and this became an inhibiting factor because it was used as a rationale for not acting on the new ideas generated.

Actively involving the women on low incomes in planning through a community development approach was identified as a second enabling factor. This approach was evident in Communities #1 and #3 where professionals adopted facilitator rather than expert roles, encouraged shared leadership roles at meetings, and actively engaged the women on low incomes in discussions. The illustrative quote in section E-2 of Table II illustrates the positive impact this approach had on the women. In contrast, in Community #2, a professionally driven approach where municipal recreation staff adopted expert roles was viewed as an inhibiting factor. The women on low incomes quickly became disillusioned in this instance because their situations were not being taken into account and power imbalances were accentuated (see I-2, Table II).

Addressing the structural dimensions of poverty was also identified as an enabling

TABLE II

Factors Affecting Uptake

Enabling Factors (E-1 to E-5)

E-1. Relevance of the issue takes priority.

Illustrative quote:

Instead of focusing on all my problems alone, this has given me something positive to focus on ... something to look forward to. It's what's getting me out of the house in the morning. And it's not just me. Others have the same problems. (Woman on Low Income, Community #3)

E-2. Women on low incomes actively participated in planning.

Illustrative quote:

I've never had anyone care about what I have to say, but the staff people around the table are listening. They know how the system works, who to go to for help, and they care about my situation. (Woman on Low Income, Community #3)

E-3. Structural dimensions of poverty addressed.

Illustrative quote:

I've got a two year old and I'm trying to go back to school so I can get a decent job to support him. I'm exhausted at the end of the day and I wouldn't make it to these meetings unless childcare was provided and [her friend] picked me up and brought me here. (Woman on Low Income, Community #3)

E-4. Resources are identified and pooled.

Illustrative quote:

The community partners already have relationships with the women and learning more about their situations helps us make better decisions. We can find creative ways to get free space and keep costs to a minimum. (Municipal Recreation Staff, Community #3)

E-5. Responsibility for uptake is shared through partnerships.

Illustrative quote:

The responsibility is not all on my shoulders, so this is not so overwhelming. I've been energised by the interest and support from the other community partners who are involved. (Women's Centre Staff, Community #3)

Inhibiting Factors (I-1 to I-5)

I-1. Pressure to generate revenues takes priority.

Illustrative quote:

We need to have a minimum of 8 participants in a program in order to justify the cost of instructors, space and equipment. We've tried running programs in the past but did not get enough people so it just wasn't worth our while. City council wants us to demonstrate how everything we do contributes to the bottom-line so we have to achieve those minimum numbers. (Municipal Recreation Staff, Community #2)

I-2. Professional staff directed planning.

Illustrative quote:

The municipal recreation staff announced at one follow-up meeting that the swimming pool could be made available twice a week in the afternoons for the women and an instructor could be provided for the kids. However, it was clear that swimming was not something the women on low income wanted to do. They talked about not having the appropriate bathing attire, not having enough money to buy a bathing suit, and not wanting to wear one in public. The staff person did not respond to these concerns and emphasized that a minimum turnout would be required. She was basically doing what was easiest for her and her department based on the availability of a facility, rather than obtaining input from the women about their preferences. (Researcher Field Notes, Community #2)

I-3. Structural dimensions of poverty ignored.

Illustrative quote:

We jumped at a solution too quickly when the municipal recreation department offered free swimming lessons. We did not really consider the women's issues in any depth. (Public Health Nurse, Community #2)

I-4. Some resources are undervalued.

Illustrative quote:

We were only able to get three women out to our meeting. I'm sure that there are more who are interested but they are a transient group and are hard to reach. (Municipal Recreation Staff, Community #1)

I-5. An over reliance on one idea champion for uptake.

Illustrative quote:

[Name] was the person who got things started with the initial workshop. But when he left town, everyone else was just too busy to pick up where he left off. (School Principal, Community #1).

factor. During the workshops, the women described how poor public transportation, inadequate childcare, fears of going out in unsafe neighbourhoods, and previous degrading treatment, created major barriers to involvement in community recreation. Community #3 went the furthest in addressing these types of barriers by creating car pools, arranging free childcare, and creating telephone trees to provide social support for the women on low incomes (see E-3, Table II). In the other two communities, discussions in follow-up meetings centered primarily on recreation programming and less attention was devoted to structural barriers. This inhibited the ability of the women to actively participate in planning and programs because insufficient attention was given to transportation and childcare (see I-3, Table II).

Identifying and pooling resources was identified as a fourth enabling factor.

When women's experiences of living in poverty were combined with the recreation staff and community partners' knowledge of local politics, programs, and policies, a wider range of options were considered and in Community #3 this helped to create the social capital required for community activation (see E-4, Table II).²³ When this did not occur in Communities #1 and #2, it was viewed as an inhibiting factor because the resources brought by some of the women and community partners were undervalued (see I-4, Table II).

Sharing responsibility for action through partnerships was most evident in Community #3. This was viewed to be an important enabling factor because it reduced stress levels for the women on low incomes who were unable to attend all the meetings and for the community representatives who were increasingly feeling overburdened in their public sector jobs

(see E-5, Table II). Contrary to the health promotion literature,²⁴ relying on one "idea champion" was viewed as the main inhibiting factor that explained why uptake did not occur in Community #1 (see I-5, Table II).

The response to the workshop interventions varied considerably in the three communities and can be attributed to the presence of enabling and inhibiting factors that were identified by participants (see Table III). In Community #1, initial plans were developed but were not subsequently implemented, primarily because the "idea champion" moved to another community. In Community #2, women on low incomes assumed a major leadership role and implemented action plans outside of the existing municipal recreation system because they encountered a number of obstacles with that department's policies and practices. In Community #3, all of

the enabling factors were present. Partnerships emerged between a larger and more diverse group of women on low incomes, community representatives, and municipal recreation staff, and more extensive action plans both within and outside existing municipal recreation programs were implemented.

DISCUSSION

As called for in a recent dissemination research agenda,¹ the results of this study provide insights into the factors that affect uptake when efforts are made to disseminate successful health promotion initiatives from one community to another. While the program offerings of municipal recreation departments show considerable promise as vehicles for community health promotion, existing professional norms and practices can inhibit the uptake of initiatives like KWAP. As other studies have shown, when professionals adopt expert roles, it is unlikely that initiatives involving the active participation of marginalized groups will be adopted.^{5,25} A community development approach where the views of marginalized populations and community partners are valued fosters community mobilization through mutual learning, more equitable power relations, and the pooling of resources.^{2,3,26-29}

The question remains as to whether municipal recreation staff possess the training and support required to effectively engage in participatory planning with marginalized populations. Addressing the structural dimensions of poverty is critical if the barriers to participation in community health planning and municipal recreation are to be overcome. However, staff are under pressure to generate revenues so business tactics targeting members of the public with disposable incomes are being adopted. Partnering with staff from other community groups with experience in community development and ongoing relationships with women on low incomes provides a starting point for sharing responsibility and working collaboratively on issues of social relevance.

Additional insights into the role of "idea champions" were obtained in this study. While they can play a crucial role in advocating initiatives like KWAP, an over reliance on one "idea champion" can

TABLE III
Response to the Workshop Intervention

	Community #1 E-1	Community #2 E-2	Community #3 E-1, E-2, E-3, E-4, E-5
Presence of Enabling Factors	E-1	E-2	E-1, E-2, E-3, E-4, E-5
Presence of Inhibiting Factors	I-2, I-3, I-4, I-5	I-1, I-3, I-4, I-5	I-1, I-3, I-4, I-5
Response to Workshop Intervention	Initial plans were made but were not implemented.	Some plans were initiated outside the municipal recreation department.	Extensive plans were initiated within and outside the municipal recreation department.

undermine uptake efforts if that person is no longer able to participate.

This study was limited to three communities and uptake factors were tracked for only one year. As a result, it is possible that other enabling factors will permit Communities #1 and #2 to uptake initiatives like KWAP in the future and other inhibiting factors may prevent Community #3 from sustaining the action it has undertaken. Nonetheless, the overall findings suggest that a shift in how municipal recreation departments view their role as partners in community health promotion is required if programs are to promote health and be accessible to under-served populations.

Additional research is required that documents the physical and mental health benefits of participation in community recreation. The examination of leisure access policies across the country, particularly from the perspectives of those on low incomes who are trying to access services, is also warranted.

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RÉSUMÉ

Contexte : On encourage beaucoup la recherche sur les facteurs qui favorisent la propagation, d'une localité à l'autre, des initiatives de promotion de la santé. Nous avons donc examiné les facteurs de propagation d'une initiative locale conçue pour améliorer la santé des femmes vivant sous le seuil de pauvreté en les amenant à participer à des programmes de loisirs municipaux.

Méthode : Nous avons organisé des ateliers dans trois autres localités et suivi les efforts de propagation de l'initiative sur une période d'un an par l'entremise de visites aux centres de loisirs communautaires et d'entrevues par téléphone avec les participantes aux ateliers.

Résultats : Parmi les facteurs qui ont favorisé la propagation de l'initiative, on compte la participation des femmes à la planification, la mise en commun des ressources, le partage des responsabilités par le biais de partenariats et l'étude des aspects structurels de la pauvreté. Par contre, l'obligation de rentabilité, l'embauche de professionnels pour effectuer la planification, le peu d'importance accordée aux barrières structurelles, la sous-évaluation de certaines ressources et la confiance excessive en un maître d'œuvre sont des facteurs qui ont nui à la propagation de l'initiative.

Interprétation : Les services de loisirs municipaux doivent revoir leur rôle dans la promotion de la santé communautaire s'ils veulent que leurs programmes favorisent la santé et soient accessibles aux populations mal desservies.

Coming Events Activités à venir

To be assured of publication in the next issue, announcements should be received by **April 1, 2002** and valid as of **June 30, 2002**. Announcements received after **April 1, 2002** will be inserted as time and space permit.

Pour être publiés dans le prochain numéro, les avis doivent parvenir à la rédaction avant le **1^{er} avril 2002** et être valables à compter du **30 juin 2002**. Les avis reçus après le **1^{er} avril 2002** seront insérés si le temps et l'espace le permettent.

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