Exercise on prescription

Promoting physical activity in South Asian Muslim women through 'exercise on prescription'

R Carroll*
N Ali
N Azam

Centre for Physical Education and Leisure Studies,
University of Manchester, UK

* Corresponding author

Executive summary

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Executive summary

Background

Exercise on prescription (EoP) schemes have existed in England and Wales since the early 1990s; in national surveys, the number of schemes has been estimated at approximately 150–200. EoP schemes are based in primary healthcare settings; general practitioners (GPs) prescribe exercise as the preferred course of treatment for a range of conditions, including those related to coronary heart disease. In the wide range of models of EoP schemes, the key features from the patient perspective are a preliminary fitness assessment, followed by a recommended programme of physical activity (e.g. swimming, aerobics, dancing, gymnastics) over a period of weeks. There is a dearth of information specifically relating to EoP schemes and their actual and potential contribution to the promotion of physical activity in South Asian Muslim women.

Objectives

- To review the literature relating to EoP schemes and South Asian Muslim women to provide the theoretical framework for the investigation.
- To carry out a national survey of health authority districts with large South Asian populations in order to find out what schemes exist and what provision is made for these women.
- To undertake case studies of schemes in which provision is made for South Asian Muslim women and to note good practice and issues arising.
- To undertake and evaluate a pilot intervention programme with special provision for South Asian Muslim women.
- To make recommendations for good practice in EoP schemes.

Methods

A review was undertaken of selected literature related to activity and health, EoP schemes, South Asian communities and activity levels of South Asian Muslim women. A questionnaire was sent to health authorities with South Asian populations of at least 0.5% to determine the existence of EoP schemes, the agencies involved and the key contacts. Questionnaires were then sent to GPs and leisure centres in areas where such schemes existed. Quantitative analysis of the replies was undertaken.

In five selected areas, interviews were conducted with each of the parties to the EoP schemes – GPs, EoP providers, leisure centres, South Asian Muslim women participating in the schemes and community workers. Qualitative analysis of the results was undertaken. In one area, an EoP pilot intervention programme was introduced, and interviews were held with EoP providers and South Asian Muslim women. Again, qualitative analysis of the results was undertaken.

Results

There are some EoP schemes in which special provision is made for South Asian Muslim women; however, in many no such provision is made. The perceived barriers to exercise for these women include access to facilities, cost, childcare facilities, cultural codes of conduct and language. Some of the general issues in existing EoP schemes are a cause for concern, including communication and cooperation between parties and between agencies and the community, monitoring and evaluation.

The pilot programme was seen as being successful both by the providers and the South Asian Muslim women who participated in it.

Conclusions

While the research indicated that many EoP schemes have clear protocols and procedures and excellent facilities and programmes, many others suffer from shortcomings that need to be addressed, including communications between all participating parties and clarification of procedures.

Consideration should be given to the needs of South Asian Muslim women, in the form of the use of local community facilities and the employment

of bilingual and sympathetic staff. Costs to these women should be kept as low as possible and consideration should be given to the provision of childcare facilities. To be effective, EoP programmes should be long rather than short term.

Recommendations for research

Further trials are needed with large samples, clear criteria for groups and intervention programmes, and with outcome measures at specific intervals up to 1 year. A further study should also be undertaken to try and establish schemes for South Asian Muslim women along the lines of the pilot programme described, in which the value of the specific interventions for these women are assessed. In measuring the effectiveness of EoP schemes and in their evaluation, a variety of methods and measures should be used including health outcomes (physiological, behavioural) and process (procedures, cooperation between parties).

An investigation into the cost implications of EoP schemes set against cost benefits would be useful, including ways of funding such schemes. There is also a need to investigate the best ways in which exercise programmes could be promoted in different communities, including exercise as part of a holistic programme.

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NHS R&D HTA Programme

The NHS R&D Health Technology Assessment (HTA) Programme was set up in 1993 to ensure that high-quality research information on the costs, effectiveness and broader impact of health technologies is produced in the most efficient way for those who use, manage and provide care in the NHS.

Initially, six HTA panels (pharmaceuticals, acute sector, primary and community care, diagnostics and imaging, population screening, methodology) helped to set the research priorities for the HTA Programme. However, during the past few years there have been a number of changes in and around NHS R&D, such as the establishment of the National Institute for Clinical Excellence (NICE) and the creation of three new research programmes: Service Delivery and Organisation (SDO); New and Emerging Applications of Technology (NEAT); and the Methodology Programme.

This has meant that the HTA panels can now focus more explicitly on health technologies ('health technologies' are broadly defined to include all interventions used to promote health, prevent and treat disease, and improve rehabilitation and long-term care) rather than settings of care. Therefore the panel structure has been redefined and replaced by three new panels: Pharmaceuticals; Therapeutic Procedures (including devices and operations); and Diagnostic Technologies and Screening.

The HTA Programme will continue to commission both primary and secondary research. The HTA Commissioning Board, supported by the National Coordinating Centre for Health Technology Assessment (NCCHTA), will consider and advise the Programme Director on the best research projects to pursue in order to address the research priorities identified by the three HTA panels.

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Reviews in *Health Technology Assessment* are termed 'systematic' when the account of the search, appraisal and synthesis methods (to minimise biases and random errors) would, in theory, permit the replication of the review by others.

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The National Coordinating Centre for Health Technology Assessment,
Mailpoint 728, Boldrewood,
University of Southampton,
Southampton, SO16 7PX, UK.
Fax: +44 (0) 23 8059 5639 Email: hta@soton.ac.uk
http://www.ncchta.org

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