**Committing to a health promotion program: an Australian case study**

ABSTRACT

An Australian exercise and health promotion program for older people with diabetes is examined to explore what factors are required for participants to make a commitment to such a program. A two-phased qualitative hermeneutic phenomenology research design was used incorporating 15 semi-structured interviews, with adults aged over 55 with diabetes, followed by a Focus Group to ‘member check’ emerging themes. Commitment was recognized as a necessary factor for participants to continue to be part of an exercise and health promotion program. Two factors were perceived to be most critical in committing to such a program, firstly having an obligation to undertake the program – ‘*signing up and being part of’,* and secondly ‘*continuing in and being actively engaged’* in the program. This second factor was seen to be influenced by connectedness with others, experiencing personal benefits and feeling like an individual. The findings from this research could inform exercise and health promotion program strategies that then lead to increased engagement and stronger commitment of older people with diabetes to such programs.

INTRODUCTION AND PURPOSE

This paper examines what factors are required for older people with diabetes to make a commitment to a program involving exercise and health promotion. In addition, it explores what an awareness of these factors implies. Findings are drawn from a research study whose aim was to glean an understanding of the essence of meaning that older people with diabetes attribute to being involved in an exercise and health promotion program. The program was conducted in the state of NSW, Australia. The focus of the paper will be on the specific factor related to commitment.

BACKGROUND & REVIEW OF LITERATURE

Diabetes is a widespread and chronic diseaseboth in Australia and internationally, affecting 347 million people worldwide. The World Health Organization (WHO) estimates that diabetes will be the 7th leading cause of death by 2030, with a rise of more than 50 percent in total deaths from diabetes predicted over the next ten years (WHO, 2015b). Despite the documented health benefits and strong evidence that undertaking exercise can improve diabetes outcomes (Hu, Wallace & Mccoy, 2014), most people with type 2 diabetes do not engage in regular physical activity (Boudreau & Goden, 2014; Brouwer, Van Der Graaf, Soedamah-Muthu, Wassink & Visseren, 2010). In fact, estimates are that 80 percent of diabetes is potentially preventable through improved modifiable risk factors such as unhealthy diet and sedentary habits (Annuzzi, Rivellese, Bozzetto & Riccardi, 2014; Carson, Williams & Hill, 2014).

Physical activity/exercise and health promotion are critical aspects of health and are particularly important for people of any age with diabetes. Physical inactivity is the fourth leading risk factor of global mortality, is a burden of risk to quality of life, causes an estimated 3.2 million (annual) deaths globally and has a large financial cost implication associated with it (Li, 2014; Wasenius, Venojarvi, Manderoos, Surakka, Lindholm & Heinonen, 2014; World Health Organization, 2015a). Despite these risks, sedentary behaviors and lifestyles are progressively more prevalent in contemporary society (Lakerveld, Bot, Van Der Ploeg & Nijpels, 2013; Sluik et al., 2012; Wimalawansa, 2013).

The clinical relevance of exercise intervention(s) in treating people with diabetes is well established (Jennings, Vandelanotte, Caperchione & Mummery, 2014; Montesi, Moscatiello, Malavolti, Marzocchi & Marchesini, 2013; Wisse et al., 2010). There is a substantial body of literature to support the premise that physical activity improves diabetes outcomes by assisting glucose control, weight management and preventing related complications (Boudreau & Goden, 2014; Brown, Riddell, Macpherson, Canning & Kuk, 2014; Carson et al., 2014; Desveaux, Beauchamp, Goldstein & Brooks, 2014; Ferrer, Cruz, Burge, Bayles & Castilla, 2014; Hu et al., 2014; Huang, Cheng, Tsai, Lee & Lu, 2014; Montesi et al., 2013; Schneider et al., 2014), as well as improving an individual’s overall health and wellness (Law, How, Ng & Ng, 2013).

For older people, exercise is an important factor in improving mobility and functional capability, increasing muscle strength and endurance, and optimizing aerobic capacity (Angevaren, Aufdemkampe, Verhaar, Aleman & Vanhees, 2008). Exercise also assists in reducing pain, building bone mineral density, and improving or maintaining quality of life (Howe and Skelton, 2012; Stanton, Reaburn & Happell, 2013). For older people with diabetes, this is even more pertinent, due to the fact that their muscle mass, quality and therefore strength is significantly reduced (Park et al., 2007; Rahi, Morais, Dionne, Gaudreau, Payette & Shatenstein, 2014). The value of exercise, particularly as people age, is clear. However, it is generally more effective when accompanied by behavioral and relational interventions (Conn, Hafdahl & Mehr, 2011; Klinner et al., 2015).

Current documented international research examining diabetes and exercise is prolific in terms of the potential for physical benefits. Despite the known physical benefits of exercise, many people with diabetes lack commitment to adhere to exercise programs and do not participate in physical activity to a recommended level (Balducci et al., 2014; Jennings et al., 2014; Zanetti et al., 2014). The need for people with diabetes to be engaged in exercise, particularly exercise programs that are therapeutic in nature, in order to effectively manage their diabetes and assist in maintaining muscle mass and strength is well supported (Annuzzi et al., 2014; Balducci et al., 2014; Centis et al., 2014).

Despite evidence suggesting that supervision from exercise professionals increases compliance in individuals to engage in exercise (Balducci et al., 2014), the challenge of how people with diabetes can be engaged and commit to therapeutic exercise and health promotion programs and interventions is clearly a challenge outlined in literature (Jennings et al., 2014). The vast majority of research about people with diabetes is physiological in nature and does not address the personal implications and meaning that exercise has for people with diabetes. This research sought to address these gaps by seeking to understand how exercise and physical activity in people with diabetes can be promoted and achieved. Such an understanding can lead to better engagement with this population and their sustained involvement in exercise and health promotion programs.

*BEAT IT,* AN EXERCISE AND HEALTH PROMOTION PROGRAM FOR PEOPLE WITH DIABETES

This study was conducted with participants enrolled in an exercise and health promotion program called *Beat It*. *Beat It* was established by the Australian Diabetes Council and delivered across Australia by accredited providers. The program (detailed in Figure 1), is an evidence-based exercise and lifestyle education/modification program (American Therapeutic Recreation Association, 2009; Hebblethwaite, 2013) involving twice-weekly individualized physical activity training and fortnightly lifestyle education (disease prevention, treatment, management), nutrition and goal setting sessions (Australian Diabetes Council, 2011). The 12-week program was offered to men and women over the age of eighteen who were diagnosed with any form of diabetes and who were not working in paid employment. The *Beat It* program was designed to assist those living with diabetes to improve and manage their diabetes and increase physical functioning, thereby enhancing quality of life (Australian Diabetes Council, 2011; Australian Diabetes Council, 2013; Department of Health, 2013).

**Figure 1: *Beat It* program implementation flow chart (adapted from ADC 2011, p.16)**

*Location*

Participants in this study were from the Illawarra region, a coastal community approximately 90kms south of Sydney, NSW, Australia (see Figure 2 below). More than 57 percent of the population in the Illawarra region is estimated to be overweight or obese. These rates are higher than the NSW state estimate of 52 percent (Ghosh, Mcdonald & Marshall, 2013). Recommended levels of physical activity are estimated to be achieved in only 58 percent of the population of the Illawarra (Ghosh et al., 2013). Global statistics are synonymous with the inadequate physical activity levels of the Illawarra region (Hallal, Andersen, Bull, Guthold, Haskell & Ekelund, 2012).

**Figure 2: Location map of Illawarra**

RESEARCH DESIGN

*Methodology*

This research design used a qualitative hermeneutic phenomenological methodology. As a means of inquiry, phenomenology is relevant to gaining an understanding of the essence of meaning that people with diabetes attribute to being involved in an exercise and health promotion program. A phenomenological approach facilitates the question of how we as humans experience the world and conceptualize a gamut of phenomena (Crotty, 1996; van Manen, 1990). It is an approach that facilitates an examination about *experience* as understood from the individual’s perspective (Grbich, 2013). Phenomenology is subjective, with fundamental characteristics based on the observation that every phenomenon is experienced in individual ways and so should be understood from the perspective of the individual experiencing it (Berger, 2010; Crotty, 1996; Rydeskog, Frandin & Hansson Scherman, 2005).

Phenomenology as a research methodology, seeks to understand and describe the individual’s lived experience of a phenomenon (Berger, 2010; Polit & Beck, 2014). This makes it a powerful tool to gain insight into what motivates actions of individuals and how meaning is constructed by the individual within the context and frame of reference of their situation (Berger, 2010; Mackey, 2005; Paley, 2013). Participants in phenomenological research must experience the phenomena. For this research, that meant participants had to be part of the exercise and health promotion program(Crotty, 1996). Thus, a purposive sample was necessary.

*Method*

The design consisted of two phases. Firstly, 15 semi-structured interviews were conducted post participants’ engagement in the exercise and health promotion program - *Beat it.* The interview questions guided participants to speak about their lived experience and disclose the meaning they attributed to engaging in *Beat it*. The sample size of 15 was considered appropriate as smaller numbers of participants can be used in phenomenological research (Giorgi, 1997; Mason, 2010). The purpose of this approach is to elicit richness of data around a specific lived experience that may be transferable, rather than produce generalizable findings, which are based on a large sample size. The second phase consisted of a Focus Group, conducted after initial analysis of the interview transcripts, to ‘member check’ the emerging themes. According to Charmaz (2014), member checking refers to the process of taking ideas back to participants for confirmation.

*Ethics*

Data was collected only after formal, written ethics approval was acquired from the University of Wollongong Human Research Ethics Committee (HE14/057). A plain language information sheet, outlining the nature and purpose of the research, was provided to potential participants. Participants willing to be involved in the study were asked to contact the researcher.

FINDINGS

Participants described commitment and explained that it was a necessary factor for them to continue to be part of the exercise and health promotion program. They spoke of commitment with terms including *obliged*, *compelled*, *required*, *owed*. These words described an intrinsic meaning of commitment posited as “*coming from within*”. Participants didn’t feel “*obliged”* to continue as a result of external coercion, rather, they felt “*obliged*” to themselves, or they “*owed it to themselves”*

**Figure 3: Commitment theme and associated categories and elements**

The figure above diagrammatically represents the theme of commitment, and the categories and elements that informed it.

Two categories informed the theme of commitment, *signing up and being part of* and *continuing in and being actively engaged* in the exercise and health promotion program.

*Signing up for and being part of*

Participants discussed commitment to the program in terms of how they had signed up for and were now being a part of the program. This was a decision they felt they had to honor and were obliged to accommodate: This was evident in comments such as:

*‘Well, it meant that I'd committed to something and I needed to keep that commitment. I certainly didn't miss any activity if I was at all able to do it. (Participant (P5)*

*‘It was just that I'm gunna [sic] do this because I said I would. And even though sometimes I didn't feel like coming, I did. I think because I agreed to come, I was going to come. There was motivation to come because I agreed to something. When I agree to something, I generally do it’ (P6)*

*‘I guess you make a commitment and you keep to it. I mean the commitment is there because you can meet and you do it, but you [laughs]… do it because you'd said that you would do it’ (P14)*

The focus group explored the theme of commitment in greater depth. All participants agreed that commitment was a motivating factor driving engagement with the program and that participating in the program was “*non-negotiable*” due to the fact that a commitment had been made. Participant’s suggested commitment to be a “*generational thing*”. To finish what they started was a “*trait of being a baby boomer”*. This was illustrated in comments such as:

*‘Here’s the program, I’ve agreed to do it, so I’m going to do it’ (P4)*

*‘The only time I missed I was overseas, because as you say, you’ve said you’re going to do it so you’ve got a moral obligation’ (P5)*

*‘We’ve said we will, so we will’ (P7)*

*‘Yes, you’ve made a verbal contract and you’re going to stick with this’ (P1)*

*Continuing in and being actively engaged*

‘Continuing in and being actively engaged’ echoed the degree to which the program was person-centred and informed by connectedness, personal benefit and individual tailoring. The principle of *person-centeredness,* placing the person at the center of all interventions and decisions (Hawkins, Cory, Mcguire & Allen, 2012; McCormack, 2003), was a significant finding emerging from the data. Participants repeatedly talked about how they felt the program was *“about me”*, how instructors would do things particularly *“for me”*, how they felt the exercise and health promotion was delivered in a way that was *“fun for me”* and *“good and appropriate for me”*. A sense of community and camaraderie that the participants discussed individually and in the Focus Group supported the principle of person-centeredness being an integral aspect of the program. This principle strengthened the commitment individuals had to participating and continuing to attend the program each week. Participants mentioned that without these facets of person-centeredness, they would not have had the same compulsion to commit to the program, as noted in comments such as:

*‘Coming in a group and doing it together, I enjoyed that and kept coming because I like the group dynamic. If I hadn’t liked the group dynamic, I’d have stopped coming’ (P7)*

*‘You need [instructor] there or someone of that ilk. I’d have stopped coming if the instructors weren’t caring and personal’ (P5)*

Participants discussed that their commitment was enhanced when personal benefit was apparent. Access and cost of program were highlighted, including:

*‘I've always wanted to go to the gym but could never afford it. As I said I loved every minute of it, loved it. If I can and if I can afford I will be going back. (P13)*

*‘They were easy places to go to, easy parking and everything was easy which made it easy to get to’ (P15)*

*‘It was close so you could drive to it and park. It was easy parking and stuff like that (P11)*

*‘I caught the free bus every week, so it was easy’ (P3)*

Participants described how experiencing physical and/or psychological benefits through participating in the exercise and health promotion program was encouraging and drove their desire to continue, for example:

*‘You felt good about it. You could see change. It made me feel good about myself because I had put on muscle and lost weight. I suffer from high blood pressure. Not badly but I reduced my medication to half and it's still the same. So that's pretty good. The feeling that I got. You felt good about it. You could see change. For me, it was just finding out that my body could just be young again, in such a short time’ (P12)*

*‘I was enjoying how it made me feel about myself so I’d come along the next time’ (P1)*

*‘The feeling of feeling good about yourself and you weren't feeling good about yourself this morning. I felt relaxed and sometimes you - if you have few worries, you can forget about them for the hour that you're doing the thing and then afterwards, they don't seem so bad. …The general feeling of just feeling a bit more bouncy and being able to get through the day more easily’ (P4)*

*‘Feeling so much about myself. You know like I went in there doubting myself and came out positive. You know because at the start I thought oh shit am I going to be able to do this? I proved to myself that I could. Once I proved to myself that I could do it then I had to do better’ (P13)*

*‘As you get older your confidence goes I think. I think if you're with a group like that who have had the same type of experience as in not being as fit, I think emotionally you don't feel so isolated… I think exercise does make you feel better emotionally too. People said I was looking fitter, I was walking better. That was the other thing. I did find I was feeling better, my joints and everything. In the three months with Beat It, it (Blood Glucose Level) had gone down a fair bit, by about from 8.6 to about 6.6’ (P 2)*

*‘It just made me feel really good. Fitter and healthier and it meant a lot. It was good. I felt great, and I felt stronger and I felt I had more energy as It just gave me heaps more energy to do things and it impacted on my daily living too, I started going in the pool every morning and walking in the pool. … I was really disappointed when the program finished because I loved going. It made me feel really good, I was sorry when it ended’ (P9)*

Having a sense of connectedness with others was invaluable. Participants wanted to attend weekly to meet fellow participants, whom they shared an understanding and had much in common with, such as age, life experience and diabetes. This forged a commitment and desire to continue to support each other and provide encouragement, which motivated them to attend.

*‘Something that's really good with the program is the bulk of the people who did it are people who are similar age. So maybe some different health issues, that didn't matter but being a similar age I think is a benefit. Everyone was doing it at their own pace and if you stopped it wasn't like people were looking at you and singling you out because you're not participating. There’s not all that rushing and you don't feel like you've got to keep up with them or - I mean, even though we're all the same age we're still all at different levels but it just, to me, felt more comfortable… because it was like-minded people’ (P10)*

*‘I really liked the people there so that was an encouragement to keep coming back. The group kind of bonded after a few weeks and people talked to each other and told each other their stories and setbacks and steps forward and achievements and accomplishments and, oh crap, I had a cream cake yesterday and that kind of thing. So it was a bonding sort of exercise (P7)*

*‘Perseverance of some of the people there was really quite - and it was really good to watch them do it. They were feeling better about themselves. That made me feel quite good too, just talking to different people. I think because we did a lot of mutual encouragement - you got it from everybody, sort of telling you were good’ (P4)*

The program instructors facilitated an environment that engaged participants and contributed to commitment. Participants felt instructors tailored the program to them, to their needs and abilities. Instructors were described as encouraging, attentive to individual needs, extending and supporting them throughout the program with knowledge, skill and instruction as noted:

*‘I would like to say again how good the instructors were and how effectively they tailored people's difficulties and disabilities and so on. It wasn't just me. There was a range of people with a range of things wrong with them, and they were always very encouraging and always very helpful. The other participants likewise were encouraging and helpful to each other. I felt like an individual. It wasn't sort of like a boot camp or line up and parade and march and so on. It was good. You did feel like you got individual attention and understanding’ (P8)*

*‘what the instructors did, as you got stronger, and better, they’d say “well to stretch yourself a bit, try doing …” and that was actually quite good. It was more of the individualization, along with more of their competence and their level of training and knowledge’ (P2)*

*‘They made the classes, themselves - I think very quickly there was a nice feeling of people having fun together and doing things together’ (P12)*

Commitment was described as easier to keep when treated like an individual and social connections developed.

The sense of community and camaraderie was extensively discussed and motivated participants to continue and attend willingly. They wanted to *“honor their commitment to the program”*. This was true even of one participant who didn’t like exercise and said:

*‘If I could’ve got out of it I would’ve, but I made a commitment to keep going. And it was fun when I got there’ (P14)*

DISCUSSION

Participants explained that factors contributing to their ongoing commitment to a health and exercise program were related to ‘*signing up and being part of’* and ‘*continuing in and being actively engaged’*. They explained that a person-centered approach was not only important it also prompted their ongoing commitment and active engagement in the program

Participants asserted that it was their generational values of honoring one’s word that influenced their decision to commit and *‘sign up and be part of’* the program. They claimed it was an inherent part of being a Baby Boomer[[1]](#footnote-1), that they kept their word.

There were three aspects of being actively engaged and therefore continuing in the program identified: connectedness, which involves social connection; personal benefits and individual tailoring, being treated as an individual and in a person-centered way.

Participants acknowledged that they shared a sense of community and connectedness to each other. Fun and camaraderie, which are important aspects of connectedness because humans need these in their social relationships (Hebblethwaite, 2013) were offered as affordances of the program and emerged as important contributors to participants committing to the program. This finding is reflective of Skov-Ettrup, Petersen, Curtis and Lykke’s (2014) findings that fun and camaraderie are integral to older adults entering and remaining in an exercise program. Further, the fact that all participants were from the same generation, had a shared disease and reasonably homogenous life experiences contributed to a level of perceived comfort, safety and connectedness.

van Stralen, De Vries, Mudde, Bolman and Lechner (2009) found that the impact of the instructor was key in helping participants maintain commitment to an exercise program. In this research, participants described how the instructor created a sense of connectedness – individualizing and focusing on people rather than the program. They were treated in a person-centered way, making them feel valued. This contributed to wanting to continue to attend and engage in the program. Participants also reported the connection with the instructor was a factor in their commitment to the program.

*Benefits* to the participants are necessary to actively engage in a program. Participants described benefits as biophysical and/or psychological. Ease of access was also described as a benefit.

All participants described positive biophysical benefits like changes to body shape or decreased blood glucose levels. Experiencing biophysical benefits and ultimately tangible improvements in health reinforced participants’ commitment to the program. Psychological benefits, in the form of personal emotional wellbeing, were often described by participants and repeatedly voiced as key to being involved in the program. Seeing and feeling real and purposive change be it physical and/or psychological was critical to committing to the program.

Cochran, Rothschadl and Sperazza (2009) discuss how Baby Boomers as a generation are the first to appreciate that exercise can enhance wellbeing. Gilroy (2008) adds that the Baby Boomer generation has been influential in driving change throughout their lives and so may want to continue seeing change and/or purpose in later life. Factors as to why the participants wanted to see benefits warrant further exploration.

Another contributor to commitment was ease of *access* to the exercise and health promotion program. Participants’ valued the accessibility of the program, and noted that there being no associated cost was particularly important. Close and easy parking and access to public transport and the program environment were significant to commitment. van Stralen et al. (2009) confirms that access is an important consideration in an older persons’ decision to choose an exercise program and maintain commitment to it.

Participants felt strong commitment to the program when they encountered individual tailoring - were the center of the program and perceived it met their needs. Muller-Riemenschneider, Reinhold, Nocon and Willich (2008) support this concept with older adults. A tailored approach with personal contact promotes individuals’ development of long term patterns of physical activity and associated behaviors as well as accountability and commitment to the group and the program. Balducci et al. (2014) suggest that tailored programs are critical to helping improve functional status and that benefits can be more targeted to individual needs when participant engagement is evident. Such evidence validates the use of an appropriately skilled instructor to individualize the exercise and health promotion components of the program. In this research, commitment to the program was fortified when the needs of participants were met and they could see and feel personal benefits.

SUMMARY AND CONCLUSION

Recently, the 18th Surgeon General of the United States, Regina Benjamin spoke about people doing things to enhance their physical and psychological wellbeing. She talked about how people need to ‘find their own healthcare joy’ (World Leisure Congress, 2014). For people undertaking exercise and health promotion programs, this is essential so that commitment to personal health is established and maintained. Hence, understanding why people choose to be physically active and exercise and why others do not is crucial so that exercise and health promotion programs can be effectively designed to assist individuals to establish patterns of exercise and good health routines. It is therefore important to establish why people with diabetes engage with exercise and health promotion programs such as *Beat It* so that future programs can be more effectively designed, promoted and delivered. This is particularly important as physical inactivity becomes more frequent and acceptable (Hallal et al., 2012; Lane, Murphy & Bauman, 2015) and obesity and sedentary behaviors (risk factors for diabetes) in modern society are on the rise (Lakerveld et al., 2013). The lack of research focusing on reasons why people with diabetes engage in exercise and health promotion programs is evident. To effectively design and deliver programs that encourage exercise and health promotion for people with diabetes requires insight into the lived experience of those who have undertaken such programs. The findings from this research, can inform exercise and health promotion program strategies that then lead to increased engagement and stronger commitment of older people with diabetes to exercise and health promotion programs.

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1. Baby Boomers are people born between the years 1946 and 1964 (Cochran et al., 2009). All of the participants interviewed and in the program were born prior to 1964 [↑](#footnote-ref-1)