

Group walking as a “lifeline”: Understanding the place of outdoor walking groups in women’s lives

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Abstract

Organised walking groups are increasingly widespread in the UK and elsewhere and have been shown to have many benefits for participants. They tend to attract more women than men, but little is known about how and why walking groups 'recruit' women. This is of particular importance given observed inequalities in physical activity participation by gender, in favour of men. To explore women's participation in walking groups, we conducted ethnographic fieldwork (in May-August 2017) with women members of five different walking groups in deprived areas of north-east England. Participant observation and informal 'go along' interviewing were conducted on 25 group walks, and 20 semi-structured interviews were undertaken. Fieldnotes and interview transcripts were analysed thematically. This paper presents five portraits to show how the identified themes played out in women's lives. For many of the women, the act of moving and socialising together in outdoor environments was highly valued. We show how walking groups found a place within the lives of women, becoming spaces of sharing, healing and enjoyment and acting as a positive resource or "lifeline", often around time-spaces of change (biographical disruptions). We contribute new understandings of how walking groups work by showing how women's reasons for participating were intimately intertwined with their life circumstances and relationships, thus furthering the ongoing theoretical shift from investigating health 'behaviours' to health 'practices'. We conclude that walking groups work well for some people at particular times in their lives, especially (but not only) for older women and, more generally, that life transitions offer an opportunity for interventions to enhance health if they work within the lives of prospective participants.

Key words:

Walking groups; social practice; life transitions; ethnography

Research highlights:

- Women's engagement with walking groups is dependent on their life circumstances
- Walking groups often act as a "lifeline" at times of biographical disruption in women's lives

- Life transitions can be an opportunity for interventions to enhance health and wellbeing if they fit within existing life circumstances

Introduction

Walking, including group walking, is increasingly promoted as part of strategies to encourage higher levels of physical activity (e.g. WHO, 2013; US Department of Health and Human Services, 2015; Department for Transport, 2016). In England, the Walking for Health scheme was set up in 2000 and works with local government, NHS trusts, and other organisations to run hundreds of walking groups across the country. It offers free, short walks led by trained walk leaders and is now one of the largest public health physical activity interventions in the UK, with 70,000 regular walkers in 2013 ((Coleman et al., 2011; de Moor, 2013:25). In Australia, Heart Foundation Walking has set up walking groups attended by over 22,000 regular walkers (Ball et al., 2017). In comparison to most public health physical activity intervention, walking groups have been very successful, and systematic reviews have shown that they can increase physical activity (Kassavou et al., 2013) and improve the physical and mental health of participants, including reducing blood pressure, total cholesterol and depressive symptoms (Hanson and Jones, 2015).

To help us understand the success of walking groups, we draw on a growing body of literature that has shown how conceptualising physical activity and mobility as social practices allows us to explore why and how they can be integrated into daily lives (Nettleton and Green, 2014; Guell et al., 2012; Wiltshire et al., 2018). Practices are understood as interrelated and “locally situated and composite” (Cohn, 2014:160) as they are enacted relationally, reproduced through interactions with other people and the material environment (Blue et al., 2016; Hargreaves, 2011; Shove et al., 2012; Reckwitz, 2002). Walking can thus be considered an embodied and “socially constructed discursive activity” (Green, 2009: 23) embedded in sociomaterial contexts (Edensor 2000; Carpenter, 2009).

We also draw on the notion of ‘therapeutic mobilities’ developed by Gatrell (2013), and idea that highlights the embodied, social and environmental aspects of the walking experience. For instance, Gatrell (2013) argues that walking rhythms created through the act of moving, whether solitary or social, help to restore wellbeing. This idea is extended by Phoenix and Bell (2019), for example in showing the value of walking as ‘slow movement’ that provides a way of achieving mindful stillness or

escapism. The importance of the sociability of walking together has also been highlighted, notably by Doughty (2013: 141), who uses her ethnographic study with ramblers and other walking groups in Southern England to show how the embodied experience of group walking becomes a shared form of social movement that results in a specific mobile therapeutic practice. In relation to the environmental aspects of walking, there is a large literature connecting the experience of 'nature' to wellbeing (Barton and Pretty, 2010; Korpela and Ylén, 2007) often implying that it can be isolated and medicalized into 'doses' and offered 'on prescription' (Carpenter 2013). Moving beyond this limited understanding, Bell et al. (2017) identify a multiplicity of ways in which people can experience a sense of wellbeing from moving through green (vegetated) and blue (aquatic-related) spaces, demonstrating the value of 'nature' for meaningful physical activity that is experienced as restorative and safe, partly due to the experience of therapeutic temporal rhythms provided by the stable, cyclical changes of the natural environment.

Despite these broad affordances, and public health messages highlighting the value of walking for most of those otherwise inactive, walking groups predominantly recruit well-educated middle-aged White women (Foster et al., 2011). In England and Australia the vast majority of walking group members are women aged between their 50s and 80s (Fitches et al., 2011; Ball et al., 2017). As older women have particularly low levels of physical activity (Sun et al., 2013) and walking for leisure declines in older age to a greater extent in women than in men (Pollard and Wagnild, 2017), their relatively high rate of participation in walking groups is encouraging. However, higher participation by the well-educated and poorer provision of walking groups in less advantaged areas has led to concerns that walking groups may contribute to health inequalities (Hanson and Jones, 2015).

While previous papers researching walking groups have often focused on understanding the motivations and experiences of members (e.g. Grant et al., 2017; Hanson et al., 2016; South et al., 2017), this paper explores how walking groups find a place in women's lives. Due to concerns about the lower levels of participation by the less advantaged, we chose to focus on walking groups in relatively deprived areas. We approach group walking as a social practice intimately bound up with the day-to-day routines of people and households (Guell et al., 2012).

Methods

Contexts

We focused on existing walking groups in north-east England, which were free to attend, in areas with relatively poor resources and health. We worked with five walking groups selected to encompass the range of walks available in the region. Local council employees and walk leaders enabled access to the groups. The 'urban group' convened in an area of a large city within the 10% most deprived nationally (Department for Communities and Local Government, 2015); the 'nature group' ran from a suburb of the same city that was within the 40% most deprived nationally and was advertised as a 'nature stroll'; the 'semi-rural community centre group' recruited from and started from a community centre in a small town located within the 20% most deprived areas nationally, that was previously dependent on the now defunct coal mining industry; the 'Nordic group' started in a large park towards the edge of a second city, located within the 40% most deprived areas nationally; and the 'BME group' was based in a large town, in an area within the 10% most deprived nationally, and was run by a fitness organisation that aimed to cater for Black and Minority Ethnic (BME) women specifically: at the time of our fieldwork, all its members were from South Asian ethnic backgrounds. This needs to be understood in the context of the town's high population of British South Asian people relative to Black/African/Caribbean/Black British people (UK Census data, 2011), and the establishment of the group via the organiser's (a woman of South Asian descent) existing social network. The 'BME group' was for women only, but the other groups were open to all (although most members were women). The 'urban', 'nature', and 'community centre' groups were part of the Walking for Health scheme.

Participants

We invited all existing women members and leaders of the walking groups to join the study, having explained the research orally and in writing. 51 women provided personal socio-demographic information, of whom 35 engaged in informal unstructured 'go along' interviews on the walks. 21 of these 35 women were recruited by convenience sampling to participate in a more formal semi-structured interview. Of the 35 women, 7 had walk leader training but had all participated in the walking group before becoming 'leaders'. In addition to the walking group

members, 2 non-walking group members of the semi-rural community centre were recruited and engaged in an informal interview, and have been included in our analysis in order to provide some insight into why some women may not join a walking group.

Ethical approval was gained from the [removed for double blind peer review] Ethics Committee. All women who participated in interviews or in-depth conversations on walks gave written informed consent. Other women verbally consented to be included in participant observation fieldnotes. All names of participants, walking groups and places used in this paper are pseudonyms.

Fieldwork

One anthropologist [initials removed for double blind peer review] conducted ethnographic fieldwork over a three-month period in the spring/summer of 2017, attending 25 walks during which she conducted participant observation and informal 'go-along' interviews. This involved taking contemporaneous fieldnotes which were expanded shortly after the walks. Participant observation and 'go-along' informal interviews allowed us to explore the walking group with the women in "real time" (Garcia et al., 2012:1395), interact with the walkers in their "natural milieu" (Christensen et al., 2011:232) and harness the "stream of perceptions, emotions and interpretations that informants usually keep to themselves" (Kusenbach, 2003:464). We found, as Porter et al. (2010:102) stated, that "the shared rhythm of walking encourages companionability and the development of rapport".

When attending group walks, the researcher invited women to be formally interviewed in a place of their preference. Of the 20 semi-structured interviews conducted, all were one-to-one apart from one paired interview. Most interviews were conducted in participants' homes, cafés, or community centres, while two were conducted formally on walks. The interviews with the walking group members followed a semi-structured interview guide (co-produced by all authors) and were audio-recorded. The interviews began with a discussion of any forms of physical activity women had engaged in before joining the walking group and how walking featured in their daily lives. The conversation then moved on to discuss the interviewees' accounts of joining the walking group, and their experiences as a

group member. Interviews typically took 45-60 minutes but ranged from 20- 90 minutes.

Data Analysis

Voice recordings from interviews and the fieldnotes from participant observation and informal conversations with women were transcribed by [initials removed for double blind peer review]. Data analysis was also carried out by [initials removed for double blind peer review], allowing for immersion, familiarity, and conversation recall. The transcripts and fieldnotes were analysed thematically (Boyatzis, 1998): they were annotated and coded in an inductive manner, with the help of the qualitative analysis software, Nvivo 10. First the researcher annotated the transcripts and fieldnotes and created content-based, often in-vivo codes. Broader themes or categories were formulated by sorting and collapsing multiple nodes into parent nodes and node hierarchies, and analytic themes relating to the research question were created. Analytic memos were simultaneously made to articulate the cognitive processes underlying theme formulations. The final analysis was developed iteratively, discussed with all authors, and in-depth feedback was gained from participants and relevant stakeholders in a knowledge-exchange workshop.

Results

Table 1 shows the demographic characteristics of the full sample of participants across the 5 walking groups and the samples of women who engaged in informal 'go-along' interviews on walks and semi-structured interviews. The sub-samples were broadly representative of the full sample. Study participants were mostly aged between 60 and 80 years and retired. All had voluntarily joined the walking groups; none had been referred to the walking group by a health professional. Most walking group members lived in areas that were less deprived than the area in which the walks themselves were located.

There were some notable demographic differences across the walking groups. For example, most of the younger women were from the 'BME group', and all but one of the women we spoke to from the 'Nordic' and 'BME' groups lived with family members or partners, whereas over half of the women from the 'Urban', 'Nature stroll' and 'semi-rural community centre' groups lived alone. Members of the 'semi-

rural community centre group' were more likely to live in more deprived areas than members of other groups.

Of the two participants who were not walking group members, one was in her 50s, lived with her family, and resided in one of the 30% most deprived IMD areas in the country, and the other was in her 70s and resided in the 10% most deprived IMD areas in the country.

Table 1. Demographic Characteristics of Participants

	Women walking group members (N=51)	Participants informally interviewed on walks (N=35)	Key participants formally interviewed (N=21)
Age			
18-40	3	2	0
41-50	6	4	3
51-60	7	6	4
61-70	24	16	12
71-80	10	6	2
81+	1	1	0
Living situation			
Living alone	17	13	9
Living with a spouse/partner/family	34	22	12
Employment Status			
Employed part-time	4	2	1
Homemaker	10	7	4
Seeking work	2	2	2
Long-term ill	2	2	2
Retired	33	22	12

Ethnicity			
White British	43	30	19
British South Asian	6	4	1
British South East Asian	1	0	0
Black British Caribbean	1	1	1
Index of Multiple Deprivation Quintile for Home Address			
1-20% (most deprived)	11	7	4
21- 40%	9	5	5
41-60%	10	5	2
61-80%	15	13	8
81-100% (least deprived)	6	5	2

For most of the women, their current walking group participation was their first experience of (or with) organised walking groups. However, many had positive past experiences of walking in daily life or for leisure, and generally enjoyed walking. Approximately half of the women engaged or had engaged in other organised forms of physical activity, such as dance, Pilates or Zumba classes. The women's (n=35) length of participation at the walking groups ranged from 2 months to 10 years (mean=3 years and 3 months). Several women experienced long term health conditions, ranging from arthritis and type 2 diabetes to bronchitis, whereas others reported no health issues or short term injuries or illness experiences at points in their lives.

Analysis revealed a complex pattern of reasons for engagement with group walking. Following Nettleton and Green's (2014) urging to consider the interplay between practices, contexts and circumstances, we illustrate this complexity with five cases. Berg et al. (2014) and McQuoid et al. (2012) have used a similar approach to portray context-dependent knowledge. The first four women (Iris, Zunaisha, Samantha and Marianne) were regular walkers, each with a different group. We chose their stories to exemplify the different ways in which walking groups came to be incorporated into women's lives. The fifth woman, Rose, was one of a few women we met from

the semi-rural community centre who did not engage in the walking group based there. Examining these stories in detail allows us to convey the way that recruitment and continuing participation in a walking group was intertwined with daily practices, social relations and broader life circumstances and social structures (Flyvbjerg 2006, Berg et al., 2014), while illustrating the findings of our thematic analysis. Each woman's story is of course unique, and we also refer to information obtained from other parts of our data throughout our analysis.

Portraits

Finding a 'lifeline' after lost companionship: Iris (aged 70; Urban group)

Iris' participation in the walking group was embedded in a time-space of mourning and being without her husband in retirement. Iris said: "You wonder, what can I do to fill all these hours?" and explained that "I think as long as Colin lived, I would have just have stayed with Colin. No, I really don't think I would have joined (the walking group)." Iris explained that when her husband died she was "a wreck", but that her two friends, Margaret and Geraldine, both suggested 'why don't you join the walking group?'. Iris explained "it was the best thing I did, saved my life I would say, yeh... I find now these are my companions all the time. I mean I've got good friends at home and I've got good family but without coming out twice a week at least to walk with the group, I think I would still be moping around, you know I really do. It brought me back to life."

Although Iris had worked in health care, and talked about always being "active" in her work and daily life, "walking everywhere" and not being "one for sitting around lazing", she also explained that she was not a "gym person": she liked "keeping fit now, but only with walking". Years previously, Iris had been diagnosed with diabetes and recognised herself as "big". Although she explained that the doctor had not suggested joining the walking group, she said that "they tell me that if I went now to the doctors for the very first time, I wouldn't

be classed as a diabetic. That's how well controlled it is, and I'm sure it's because I'm fitter [and have] lost weight", both of which had happened since joining the walking group.

When Iris was asked how the walking group fitted in with other parts of her daily life in the present, she said purposefully, "my daily life fits in with the walking group".

For Iris, and other women who were retired and/or had lost their partners, the walking group was a resource that could fill time, and provide companionship, a new social routine, and a means of being active outdoors in a social way that was enjoyed. Like Iris, many other women mentioned the 'social benefits' of the group: women commonly reported enjoying meeting "new", "like-minded" or "different" people. Some moved within the group on walks to mix with others, whilst others tended to walk with one or two people for the duration. The 'social benefits' were produced through talking whilst walking, through coffee stops after the walks, and through social 'spin offs' such as organising their own walks, and joining other clubs together. A welcoming, friendly, and supportive group composition appeared essential for these elements to occur, and a sense of group solidarity was often present on the walks. Engagement with passers-by external to the group provided another form of social interaction. These interactions, for example with groups of mothers with prams, individuals with dogs, or other known South Asian women in the case of the 'BME group', occurred most often when walking in local parks.

For many women, the walking group was an opportunity or 'reason' to "get out" in the "fresh air" and meet people. Being social in the outdoors on a regular basis was particularly beneficial for those who could potentially experience social isolation. Beryl, who was a retired widow, had a similar experience to Iris, saying:

"I think it just gives people a lifeline. Especially those people that live alone that's lost wives or husbands, you know...I feel lucky that I've found it".

As Beryl saw it, this "lifeline" "saved" her, Iris and others in comparable situations, from potentially becoming socially isolated and increasingly depressed within emotionally traumatic time-spaces of their lives.

Like Iris, many of the other women across the groups said that their participation in the walking group was timely. Many retired women in particular felt they had not been able to engage in the walking group in the past due to their life circumstances. For instance, Annette explained, "I probably would have (joined) but with working- it was never a choice for a Monday you know".

Finding a social physical activity amongst child care responsibilities: Zunaisha (aged 33; BME Group)

Each time Zunaisha attended the walking group, she drove to the start point and manoeuvred her toddler's push chair out of the car. She explained how she dropped her other young children off at school and then came for the walk. She said that she saw the walking group as an opportunity to get out of the house, explaining that she used to feel that she was cleaning her house all the time and for no real reason. She said that she was glad to come out, and noted when it was raining on one walk that she even came out in the rain. She said this was because she wanted to socialise and also wanted to "lose weight". She also said she likes that she can bring her child, has known the leader since they were 17, and knows others in the group from the women's fitness classes she recently became involved in. At a café following a walk (where the women often reconvened), Zunaisha explained further about how young motherhood interacted with the walking group and exercise classes. She explained:

"I was quite stressed, obviously with this issue going on [she was having family-related difficulties], and I was depressed. But since I've started going to Safeenah's [fitness] classes I love it, you forget about your anxieties and depressions and stress and you love it, and I feel fit basically, active, - I love it... And I think she's made a lot of difference to Asian girls because we are just sat at home ...but she's like 'you can

bring the kids'. Then we go home and we do the cleaning and the cooking, so we have a good time now and we go home positive."

A little later in our conversation, Zunaisha said, "when I had my other two kids, we didn't have this walking group but now I have had this baby I've enjoyed this baby, but the other two, I was stressed. Same with Amilah. So imagine if she had this walking group..., she would have loved it but she was stuck at home."

Zunaisha enjoyed being outside of the house, and seeing other women in the "community". These benefits and the reasons she gave for engaging in the group were echoed by other women in the 'BME group' and were discussed by them as strongly connected to their understandings of themselves as "Asian women" who tend to prioritise themselves last and spend a lot of time sedentary in the home. The women felt "better", a "boost" and more "energised" from walking, which then influenced their roles as mothers and wives, completing domestic tasks throughout the day. However, this was not unique to the 'BME group': it was apparent in some of the other women's words, including in Samantha's narrative below.

Zunaisha, like other members of the 'BME group', also said she felt the walking group could help her lose weight gained since having children. Similarly, some of the older women from other groups discussed keeping off the weight they could potentially gain in retirement. Many of the retired women suggested they did not want to "sit around" with their "feet up all the time" (Geraldine). This was intertwined with an awareness that walking is "good for your heart and everything" (Marianne), and a desire to "keep active", "look after yourself" (Angela) and "fight old age" (Patricia). Both groups of women's desires surrounding weight loss/maintenance and fitness were heavily intertwined with their life stage circumstances. The walking group was an accessible route to fitness, wellness and weight loss for the young mothers because it fitted with their life circumstances: they could be sociable outside the house and take young children in pushchairs.

Although the women in the 'BME group' were mostly British Pakistani, unlike for the Muslim women interviewed by Warren (2017), our data gave no sense that walking in public was constrained by concerns about modesty. However, safety was

mentioned as a concern that made group walking appealing, as it was in other groups.

Finding a healing activity: Samantha (aged 57; Nordic Group)

Samantha recalled being a very active teenager and yet, in the present, she commented about "losing the battle with her fitness". She had experienced chronic health problems since she was young: she said that when she was ill in bed for two years as a teenager, she kept telling herself "when I'm better, when I've got over this bout of illness, I'm gonna take long country walks... and read the classics". Due to her chronic health condition, she said she "had to really think about what sport I could do". She explained that walking gives her an "extra boost", it has helped her fitness, and although she finds it difficult at times, she feels that she "can do this".

Samantha stopped working to be available to her son who has a disability. She explained that for the first 10 years of her son's life she did very little physical activity. She said: "As I was hitting sort of mid 40's, I began to realise that my health wasn't great." In response, she said: "I had to start and think a bit more about me." She joined a Pilates exercise group around this time and "in that group there were some walkers who were doing a walking group and they said come along, give it a go." A friend she met at the Pilates group was going through a challenging time so Samantha and a few other friends began attending a health walk with her to help her through it. They then joined the Nordic walk. She says, "we all took our turns walking and talking...God did we talk." She says that when her own "life became even more difficult" due to a family member's illness, "there was a lot of to-ing and fro-ing and walking and talking". During this period, her attendance at walks became "a little bit more random" so she "picked up" a weekday Nordic walking group because at the time it fitted into her schedule better.

She explained: "I think... it (the walking group) is something for you, the rest of your family aren't involved and the relationships that you

make are literally you and the other person or you and your little group"... "I do think that actually is very helpful because... as a mother in a family, you're sort of tending to everybody else's needs and balancing everything, but when I go out walking... it's very much for yourself that you're doing it, and the people know you individually, not as the wife of, the mother of, the grandmother of, or whatever and I think that is quite a big thing really."

Samantha's story resonates with Zunaisha's experience and that of other mothers in the 'BME group', who said they prioritised their children but came to feel that they also had to also think about their own health and wellbeing. However, Samantha's story also shows how life circumstances, social relations and understandings of walking as a leisure pursuit affect women's reasons for participation and how they benefit from group walks; Samantha's engagement was strongly connected to her friend in need and what she herself needed at a point when she was experiencing particular difficulties in life. Her continued participation then became a form of liberation from daily life and 'something for' her. Her vision of 'long country walks' was embedded in her illness experience and in the present feeling physically capable in the face of illness was key to Samantha's engagement in Nordic walking and other forms of exercise. The physical fitness benefits of the walk were central to other women too, especially those who attended the 'Nordic' group. Although Samantha said that "life interferes" with participation in the walking group, as far as possible she negotiated life circumstances to engage in the walks.

Finding a safe and enjoyable space in the outdoors: Marianne (age group 51-60; semi-rural community centre group; IMD 20% most deprived)

Marianne had become involved in the semi-rural community centre during a difficult time in her life, having been made redundant. Marianne suffered from what she termed "mental health problems", so had claimed Employment Support Allowance until she was taken off it and put onto 'job search'. It was at this moment in time that she began attending the community centre with which the semi-rural walking group was linked. She explained, "I was very nervous when I first came [to the centre] but after a few sessions it was just

like home from home really". It was the "nice small group" that attracted her to join this particular walking group: she had joined one other group walk previously but found it "too big" and "concerning", partly because the meeting places varied week to week and were located in unfamiliar places. In contrast, she liked this group because it was "friendly, everybody knows everybody and all the routes". Marianne joined the walking group "from day one", and participated every week. She explained, "I live on me own so it's nice to come out and chat with people that I'm familiar with." Getting to know people also helped her gain confidence over time, and she enjoyed the feeling of safety and familiarity that the group provided. She further explained:

"I don't like big open spaces and lots of people. I like to be just in my little close knit [group], and that's what I get from coming here. And that's what I get from the walk. You know, I know that I don't suppose I would go walking in the village like I've done today if I were by myself. I wouldn't have done it no, but because there is people there that I know and because they are a nice group, so that's why I come- it's good therapy for my mental health."

She continued to explain what she enjoyed about the walk, saying, "sometimes when you go out you can like kind of lose yourself, you know if you have worries, cos I'm like a born worrier really... Cos you see, like we saw today, the nice trees, countryside, and just the fresh air, a lot of fresh air and a different environment to your own."

Marianne's condensed and simplified story is relatively unusual in that she was one of only two women who discussed having "mental health problems". Marianne's desire to attend the walks every week was connected to her unique social circumstances and mental health: she took comfort from this small group as a "safe space", which provided her with a routine, predictable activity and familiar social contact to gain confidence and "self-esteem". This particular group 'recruited' other people who were dealing with long term illnesses and/or unemployment. Some of these other women commented that they would not have joined any other walking group, and that the familiar community centre and the friendships they had made there were central to their decision to initially engage and continue to participate.

Marianne's experience also highlights what was typical across data collected from many women: how contingent joining the walking group was on her life circumstances, and how her situation, external to the walking group, was integral to how she benefited from the social and outdoor elements of the walking group.

Like Marianne, many of the other women enjoyed being outside and the outdoors appeared to facilitate socialisation. The women tended to enjoy the "fresh air" and connected with the environment in multiple ways, discovering, learning, and sharing knowledge regarding their surroundings, including local history, places they "never knew existed", and what was often called "nature". For most women, variation in routes was important but others appreciated variety in the same physical spaces. For example, Barbara explained that "even in a place that you go every week you can still see something different". These themes surrounding being outdoors often appeared to play into time-spaces when women finally had the time for discovery: when they wanted to "get out and about" after moving to a new area, when living alone, or during retirement or unemployment; or when being outdoors was particularly beneficial, such as during mental illness recovery/management in Marianne's case.

Life circumstances incompatible with group walking: Rose (aged 57; Semi-rural community group non-member; IMD 30% most deprived)

Rose was a member of the women's group at the semi-rural group Community centre; however, she did not engage in the walking group and explained this was connected to her role as a full-time carer for her disabled daughter. She said, "It's not a case of not wanting to, but in my situation, it's not being able to. Because walking groups, ... it's a set time and a set place and you know what I mean, for me personally, I've got to have the ability to- you've got to have someone else in the house who can take care of my daughter...I couldn't say 'yes, I will be there at 10am Monday morning, we'll go for a walk'." She explained that "wherever they walk you may not have the ability to, you know, you could be two miles away and it's like ok how do I get home quick."

Rose also indicated that while she enjoyed walking, she liked to walk alone: "I prefer the solitude of walking" she explained. She said: "it's me and the dogs and wherever, whatever, walk a while, sit down a while, listen to music, whatever. It's my head space if you like". She explained that "to walk on a personal basis, to do it yourself, is, it's yours, not sort of fixed to anyone else."

Constraints around attendance at timetabled walks are likely to apply to other women who act as full-time carers for family members. Rose's comments also suggest that for some people the social setting of group walking is a deterrent to participation. The other non-participant interviewed felt the pace of the walking group was too slow and so she preferred walking with a friend rather than with the group.

Although rigid timings and social settings may deter some women, others may negotiate these. For instance, one woman member of the 'community centre group' noted that the group walk was at an inconvenient time for her as she suffered with chronic pain more in the mornings, but she attended sometimes.

Discussion

Our portraits illustrate common themes in our data: the walking group enabled women to find safe and enjoyable experiences within the outdoor environment, a social resource and/or a space for healing, and an accessible route to increased fitness/wellness. Overall the group walks supported women members through becoming spaces of sharing, healing and enjoyment. These findings echo those of previous studies that show participants appreciate elements of group walking such as moving sociability (Doughty, 2013), 'fresh air', enjoyment of the environment (Grant et al., 2017), being close to nature, being part of a group, getting away from other aspects of their lives (Priest, 2007) and a shared sense of achieving health goals (Hanson et al., 2016). We make a new contribution in showing that the group members' appreciation of these aspects of group walking was often intimately linked with their life circumstances.

A central theme to emerge from our data was the importance of biographical disruption or discontinuities (Hörschelmann, 2011: 378) that created time-spaces for joining walking groups and meanings for continued participation. Scholars across geography, sociology and anthropology have been re-thinking socially constructed life-transitions to focus on life events and biographical 'ruptures' (Hörschelmann, 2011). Thomson et al. (2002) refer to such ruptures as 'critical moments', highlighting the contingent manner in which individual agency interacts with social processes and structures at particular time-spaces. Johnson-Hanks' (2002) presents a similar theoretical notion: the 'vital conjuncture', which is a "socially structured zone of possibility that emerges around specific periods of potential transformation in a life or lives" (Johnson-Hanks, 2002:870). Johnson-Hanks' 'vital conjuncture' further helps to explain how "structures contingently combine to shape action in particular spaces of time" (Jeffrey, 2010:498). Thinking in terms of time-spaces allows us to understand women's lives as intertwined with spatial and temporal contingencies (Hörschelmann, 2011).

In our data, 'zones of possibility' (Johnson-Hanks, 2002:870) emerged within the socially constructed life stages of retirement and motherhood, as well as in the uncertainty of redundancy, illness and bereavement. Group walking became a possibility partly because of changes in daily and weekly routines during these times, precipitated, for example, by ceasing paid employment. More importantly, however, becoming a member of a walking group gave women a resource that was highly valued at this time in their lives, an opportunity that, following our participant Beryl, we identify as a 'lifeline'.

Most women in the walking groups were aged between 61 and 80 years and retired, as observed in other walking groups (Foster et al., 2011). There was a desire amongst these older women to 'keep active', a desire that can be understood as tied up in discourses around successful ageing and living 'well' in retirement (Katz and Calasanti, 2015). Similarly, Rudman (2015) has previously argued that Canadians preparing for or living in retirement shared embodied positive ageing discourses, expressing intentions to work to mitigate the risks presented by an ageing body. Thus, as women approach and first experience retirement, which may act as a 'vital conjuncture', the notion of joining a walking group sits well with dominant discourses around healthy and active ageing. The related ideas of 'keeping busy'

and having a purpose were seen by older people in New Zealand as key components of successful or resilient ageing (Wiles et al. 2012). In these ways, for many of our older participants, joining a walking group became part of a “life project” (Carpenter 2015) to age well.

For the younger mothers, group walking was also partly a way of responding to a health discourse, in this case emphasising the importance of regulating body weight following pregnancy, as also observed by Lloyd et al. (2016). More than this, however, for some of the women, predominantly those with young children, their regular group walk was a rare period of time during which they were able to prioritise their own social, mental and physical health. Lloyd et al. (2016) also show how Australian mothers of young children appreciated leisure time physical activity as restorative ‘me-time’. In a similar vein, Bell et al. (2017) found that one new mother joined a ‘buggy fit’ group at her local beach as a way of maintaining an important aspect of her personal identity in the face of time-intensive parenting demands. In line with our analysis, they suggest that biographically disruptive events (re)shaped their participants’ use of green and blue spaces. Other mothers may postpone paying attention to self-care until later in their children’s lives (Bialeschki and Michener 1994). For instance, Samantha turned to leisure time physical activity and ultimately group walking as her child grew up, and other women waited until their responsibilities as grandmothers decreased, appreciating the opportunity to walk with a group as “something for you”.

Appreciation of the sociability of group walking was also often linked to life changes, such as the death of a spouse, no longer caring for children, grandchildren or others, retiring, moving to a new area or becoming isolated through illness or unemployment. For example, Iris’ experience of bereavement left her with free time, which friends and companions at the walking group helped to fill. And at a time when Marianne had lost her job and was experiencing mental health problems, she identified the feeling of security offered by a small group of known walkers as particularly valuable. Similarly, Bennett (2010) showed that finding social support or joining a club was identified as a common route to resilience for bereaved men. In line with the findings of Hanson et al. (2016), we suggest walking groups appear less likely to ‘recruit’ women for whom sociability of group walking is less desirable and feasible within their life circumstances, as for Rose. Likewise, as particular forms of

sociality existing within walking groups can be concerning for some (Hanson et al. 2016), it is possible that walking groups may sometimes increase health inequalities by socially excluding those from some marginal groups.

Connections between life events and taking up a new activity, as well as changes in physical activity have been observed previously. For example, both retirement and the death of a spouse have been linked to an increase in physical activity undertaken for leisure (Engberg et al., 2012; Barnett et al., 2012). Our results help us to understand how a new form of physical activity may be adopted at such times of change, and demonstrate that this process is contingent on both individuals' particular circumstances and on wider social structures. We show that links between life changes, such as retirement, motherhood and bereavement, and adoption of group walking, should be understood in the context of women's socially constructed understandings and appreciations of walking and group walking. Similarly, Berg et al. (2014) showed how increases in walking for transport at retirement emerged as a consequence of engagement in new practices such as volunteering and caring for grandchildren, and were consequently understood by retirees as a valued way of structuring the day, getting 'fresh air' and 'getting out of the house'.

Following social practice theory, we suggest that the motivations and benefits expressed by the women can to some extent be considered "outcomes of engagement" in group walking, rather than "preconditions for it" (Blue et al., 2016:44). For the women in our study, group walking often *became* a therapeutic mobility and a 'lifeline' for wellness of the physical and social body (Gatrell, 2013) commonly following 'vital conjunctures' in their lives, such as retirement or bereavement. Walking groups therefore appear to 'recruit' women with similar types of life circumstances who share in enjoying similar benefits.

The rich data generated in this study provide in-depth understandings and yet are, as with all qualitative work, specific to the research setting where they were constructed. The spring/summer setting meant temperatures were mild although the weather conditions varied from sunshine to persistent rain.

We suggest that in order to fully understand why walking groups do or do not work for different women and men, future research should seek to conduct studies with

those who have dropped out of walking groups and those who (like Rose) know of walking groups but opt not to attend. We should also pay attention to those for whom walking is difficult, whether due to disability or to socially constructed constraints (Warren 2017).

Conclusions

Our analysis shows that women's participation in walking groups was intimately linked with their life circumstances and often with moments or periods of change within their lives; for many walkers, the walking groups acted as a positive resource or "lifeline" for social, emotional and physical health and wellbeing at these times. The disruption of previous routines consequent on biographical 'ruptures' also opened up opportunities to adopt the practice of group walking. We recognise that this was not the case for all women, but it was nevertheless a strikingly common thread through our data.

Psychologists have highlighted opportunities to promote behaviour change at times of change in the life course, such as moving house or workplace, focusing on the effects of a disruption of habits (Verplanken and Roy 2015). We emphasise the need to understand that those practices (including those promoted as interventions) that successfully 'recruit' participants do so because of shared meanings regarding their value. Thus, while 'life transitions' may appear to offer opportunities for public health interventions (or alternatively conceptualised, for the provision of resources to people at a time when they are likely to be most welcomed) different kinds of approaches may be appropriate for different people living in different circumstances. For example, group walking may be less likely to find a place in the lives of those for whom practices of self-care are not so salient or feasible, the outdoor sociability of group walking is not so valuable, or whose opportunities to access or pursue such resources are constrained.

Our analysis shows that becoming part of a walking group is a complex and varied process, and that examining individual de-contextualized 'motivations' or 'benefits' can obscure the social structures and practices within which this process occurs. Walking groups work well for some people at particular times in their lives,

especially for older women, providing a greatly valued resource, even a “lifeline”. They make an important contribution to improved population wellbeing and health and we should celebrate and build on that success and work to increase their accessibility to those living in disadvantaged circumstances. However, it is valuable to also acknowledge that one size will not fit all and other types of opportunities may be more successful in improving health for people whose circumstances do not lend themselves to participation in a walking group. Our understanding of the way health interventions work in general will be enhanced by considering the processes by which they ‘recruit’ participants and fit into people’s lives.

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