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“Swim for Health”: Program Evaluation of a Multiagency Aquatic Activity Intervention in the United Kingdom

Adam B. Evans and Mike Sleep

This study represents a program evaluation of “Swim for Health,” a multiagency partnership in two local authorities in the United Kingdom that sought to increase aquatic activity participation among four target groups. A theory-driven, scientific program evaluation model was used to assess if the program achieved its stated aims (Rossi et al., 2003). Chronological records were maintained. Participation figures were collected and triangulated with 20 semistructured interviews with program stakeholders. Barriers to program implementation included a lack of prior needs analysis of service provision, and the goals of the program did not always match those of stakeholders. Swim for Health increased participation in three of four target groups. Program enhancements were limited by availability of staff able to deliver novel activities other than aqua aerobics. Consequently, participants were primarily women. Implications for future programs are discussed.

Keywords: aquatic exercise, adult swimming, infant (baby) swimming, program evaluation, health

In the early 21st century, swimming was the United Kingdom’s (UK) second most popular physical activity behind walking (Sport England, 2010). In 2005 Sport England found that 6.6% of adults (or 2.8 million people) in the UK had been swimming (either indoors or outdoors) during the four weeks before their Active People 4 survey (2010). This figure represented a decrease from 2009 to 10 of some 600,000 participants and over a 1% decline since 2002. Indeed, participation in swimming has been shown to be consistently decreasing in England since 2002. It has been demonstrated that swimming has significant latent demand (Shibli et al., 2009). Swimming therefore has a potential role to play in encouraging social groups to become more active.

Although the health benefits of regular physical activity are well documented (Haskell et al., 2007; Nelson et al., 2007), inequality still exists in terms of participation rates and ease of access between some social groups (Sport England 2010). For instance, currently in the UK, participation in swimming is predominantly among women and children. Indeed, research has recognized that there are often complex barriers that stop people from engaging in regular physical activity, including aquatic

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activity (Schutzer & Graves, 2004). Consequently, a number of programs that promote aquatic activities and seek to overcome perceived barriers to participation have been introduced in the UK (Evans & Sleaf, 2008; Shibli et al., 2009). Moreover, it has been recognized that evaluation of the impacts of these programs is essential if future programs are to be delivered with maximum efficiency and efficacy. This paper outlines the key learning outcomes for the first large-scale aquatic activity program delivered in the United Kingdom by the Amateur Swimming Association (ASA). The principal aim of this paper is to present key evaluation findings to provide insight into the developmental processes occurring in Swim for Health. Recommendations for future programs involving aquatic activity will be made.

Study Context: Swim for Health

In 2003 the ASA obtained funding from the Department of Health to initiate a health program entitled “Swim for Health.” This pilot program began in November 2005 and was due to end in December 2008 in two local authority areas in the North of England: the port City of Kingston upon Hull and the rural East Riding of Yorkshire. The City of Hull is an area in which social deprivation is significant; in 2004, it was the 11th most deprived area overall and suffered from the highest level of obesity in the UK (Unit, 2004). The East Riding of Yorkshire is less deprived. It is situated in the rural region around the City of Hull from Goole in the west to the coast. In total, Swim for Health had access in these areas to 13 leisure centers with pools.

Swim for Health aimed to “improve access to swimming for the whole community with a focus on four target groups:

1. Employees through the work place
2. Older people (more specifically, those aged 50 years or more)
3. Young children and their families (more specifically, preschool aged children) and
4. People with specific health needs” (Marshall, 2005)

The Swim for Health Program was the first of its kind in the United Kingdom. It was a multiagency partnership run by the ASA in conjunction with Hull Leisure, East Riding of Yorkshire Council, Hull and East Riding Public Health Directorates, Hull University, Humber Sports Partnership, and Sport England. Although Swim for Health was primarily designed to increase participation rates among several key populations, program rationale also noted the importance that increased participation would have in “reducing health inequalities” among the four identified target groups.

The ASA commissioned an evaluation of the program against its stated goals. Evaluation of the Swim for Health program began in December 2005 and ended in December 2008 (Evans & Sleaf, 2008). The day-to-day running of the program was the sole responsibility of a development officer. Strategic planning was provided by a steering group involving representatives of all program stakeholders (local authorities, the Primary Care Trust, the ASA and partners). Details of program organization are shown in Figure 1. The evaluation officer continuously consulted with the development officer to build an accurate portrayal of program developments, problems, and timescales for the implementation of planned services throughout the duration of the program.

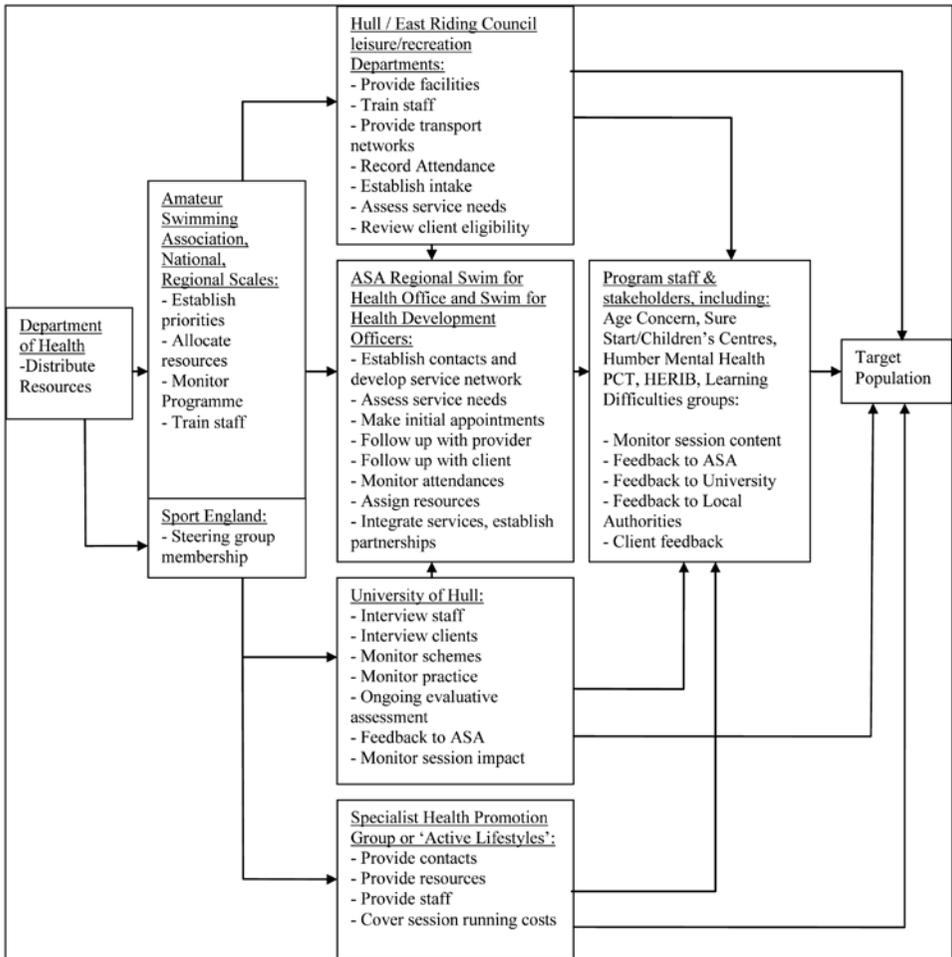


Figure 1 — Program organization and competencies of key organizations/groups (adapted from Evans and Sleep, 2008).

General goals for the program included ensuring target groups were able to access appropriate aquatic physical activity, encouraging them to do so, bringing about an overall upturn in attendances at pools within the Hull and East Riding area, raising public awareness of the benefits of aquatic activity, and improving the delivery and promotion of aquatic activity locally. The assumption was made that health inequalities among members of each target group would be reduced; that is, stakeholders assumed that participant health would also be positively affected by increased participation.

Specific objectives for each target group were initially created in April 2005 and updated on two separate occasions in June 2006 and August 2007 as the program evolved. Initially, goals focused upon population-based increases in partici-

pation. An overall increase in participation of 1–5% of the local population was sought. After completing a needs analysis and assessment of facility availability and provision, goals were revised to encompass efficiency and specific service provision indicators because it became apparent goals targeting increases of 1–5% in participation would quickly outstrip facility capacity. Revised goals therefore included the following:

1. For target group 1 (people in full-time employment) the program sought to increase the number of employees involved in aquatic activity through improved signposting to existing activity / increased uptake of corporate leisure membership opportunities / organization of specific sessions where appropriate.
2. For target group 2 (preschool aged children and their families), the program sought to work with 10 local Sure Start schemes/Children’s Centres in Hull and the East Riding of Yorkshire to develop a program of aquatic activity and to ensure that 1% of parents linked to Sure Start schemes/Children’s Centre were involved in aquatic activity. Success would be assessed according to whether use of Sure Start swimming sessions / aquatic activity were at or near capacity—or maximum pool usage for their session. Where appropriate, additional activity would be organized to meet additional demands.
3. For target group 3 (people older than the age of 50 years), the program sought to offer aquatic activity appropriate for the over 50s to be available at all Hull and East Riding pool sites and to ensure that use of sessions organized for over 50s to be at or near capacity by the end of the program.
4. For target group 4 (people with specific health requirements), the program sought to ensure inclusion of aquatic activity on exercise referral schemes in Hull and the East Riding and to ensure that use of aquatic activity offered through Hull and East Riding Exercise Referral Schemes is at or near capacity.

Specific goals were subdivided into a number of key performance indicators, each with an associated timeline that would be targeted through the course of the program. For example, after initial needs analysis by the Swim for Health Development Officer, goals catering to each target group were divided into performance indicators that would enable achievement of increased service provision in an incremental manner by initially subsidizing sessions (Marshall, 2005).

Method

Program Evaluation

To assess whether the goals highlighted above were met, a theory-driven scientific program evaluation was completed by an evaluation officer during the program. This evaluation focused upon program processes and stakeholder uptake. An evaluation framework outlined by Rossi and colleagues (2003) was applied to a theory-driven scientific model of program evaluation (Clarke, 1999; Donaldson & Lipsey, 2006). Trends in program processes were noted and tracked and then compared with the initial plans for the program (Pawson & Tilley, 1997). This differs from scientific research because the goal is not to simply add to an existing body of knowledge, but additionally is to inform decisions, clarify options, reduce uncertainties, and to provide information about programs and policies; in short, it is aimed at action (Patton, 1987).

This study focused upon the integration of methods, theory, and outcomes (Rossi, Lipsey, & Freeman 2003). In the case of many experimental designs, focus is made on whether a program is effective rather than on the experiences of the agents who experience the intervention itself. Programs cannot be conceived as externally imposed forces that simply elicit responses from participants. Instead, they only become effective if participants choose to make them work and are placed in the right conditions to enable them to do so (Pawson & Tilley, 1994, 1997). Systematic approaches to evaluation suggest a change of focus is required away from objectively outlining outcomes toward exploring program activities (Clarke, 1999). This means describing the perceptions and experiences of those individuals and groups involved in a program.

This study used what Donaldson and Lipsey (2006, p. 17) refer to as the "systematic use of substantive knowledge about the phenomena under investigation and scientific methods to determine the merit, worth, and significance of evaluands." Such programs focus on the development of program theory and evaluation questions without being limited to the use of a single method (Donaldson & Lipsey, 2006; Rossi et al., 2003). This approach contrasts with previous approaches that focus on methods-driven or outcome-oriented approaches to evaluation (Christie & Alkin, 2008; Donaldson, 2003).

The type of evaluation used in this study has certain advantages. Primarily, the design and application of program theory allows comparison be made between initial plans and actual practice. Implementation is subsequently tracked during the duration of the program with outcomes examined postprogram (Rossi et al., 2003). In turn, problematic areas or unexpected obstacles can be isolated and solutions suggested while the drivers of success can be used to inform best practice and ensure that knowledge outcomes are transferrable to other contexts.

Measures

Quantitative and qualitative methods were incorporated into the evaluation, including chronological record keeping, quantitative secondary sources (attendance figures and demographic data), and interviews with key stakeholders. Chronological records were kept of all developments within the program, including modifications to program goals, development of specific services, meetings with stakeholders, and taking minutes of steering group meetings. Full updates from the Swim for Health development officer were also obtained fortnightly throughout the period of program delivery.

Participation records were obtained on a monthly site-by-site basis and by Swim for Health service providers on a weekly basis. All sessions in which Swim for Health had a direct involvement in service planning and provisions were monitored. Finally, the above data sources were compared with semistructured interview data with a total of 20 stakeholders, including strategic managers, facility managers, service providers, and exercise professionals at swimming sessions. Interviews can shed significant light upon the perceptions, beliefs, and values of key individuals delivering a program (Bryman & Teevan, 2004; Krueger & Casey, 2009).

Interview schedules completed with stakeholders remained focused upon perceptions of the program, satisfaction with the program, the direction stakeholders felt the program should take, and how beneficial they felt the program had been for their

organization. Interview schedules were principally designed to inquire about stakeholder perceptions of the program from their perspective, thereby allowing them to outline their own common sense reasons and perceptions (Bryman & Teevan, 2004). Interviews were recorded using a Dictaphone and transcribed verbatim.

Data Analysis

Evaluation of Swim for Health was carried out at strategic, facility, and group levels of analysis. A regional timeline was maintained enabling developments to be mapped by region. Program developments were predominantly facility-based. Attendances were cataloged by service providers and timelines of the steps taken at each facility to enable contextual developments to be described. Analysis was carried out at the specific program or group level. Personal opinions and experiences were collated from stakeholders and participants to evaluate first-hand experiences of Swim for Health services. This feedback yielded a picture of how positive or negative the services had been and how they could have been improved.

Evidence at each level of analysis was used to assess the achievement of the program goals outlined above. The timeline of the program was charted. Quantitative data were analyzed descriptively using SPSS version 17 (Chicago, USA) to ascertain if the Swim for Health program had an effect on participation in the four target groups at the facility level.

Interview data were thematically analyzed by applying open codes and then themes refined by repeated investigation of both similar and anomalous examples to avoid a plethora of idiosyncratic codes. Codes were grouped into higher order themes that systematically summarize the data (Braun & Clarke, 2006; Bryman & Teevan, 2004). This process was essential due to the sensitive nature of the opinions expressed by interview participants in this research, which requires that specific data extracts remain confidential. The perceptions and beliefs expressed during interviews were corroborated against timeline and participation rate data to build a picture of program process (Rossi et al., 2003).

Results and Discussion

Program Development

Before the implementation of Swim for Health, two actions were required that took significant time that was not included in the initial project brief. First, no audit of services was completed before commencing the program. Therefore, the Swim for Health development officer completed a regional needs-analysis of existing service provision and capacity. This process took 6 months. A program theory for the Swim for Health program was then produced and corroborated by the program steering group. The program theory included an organizational plan, a generic service utilization plan, an impact theory, and a rearticulation of program goals (Donaldson & Lipsey, 2006; Gargani, 2012; Rossi et al., 2003).

Goals of Swim for Health had to be altered according to the contextual information and program theory gained by the needs assessment. Limitations on pool availability and capacity made population-based goals unattainable. For example, given that there were 65,000 people over the age of 50 years in the City of Hull in

2008 (www.hull.gov.uk), a 5% increase in participation for target group 4 alone corresponded to around 3,250 additional participants per month, or 812 per week. Given that many pools had a capacity of around 30 individuals per hour and limited additional pool time availability, it became apparent that there was insufficient latent pool capacity to cater to such an increase.

Therefore, goals were revised according to the number of sessions that could be offered and whether these sessions could achieve a sustainable financial model without exceeding maximum capacity. The development officer sought to promote maximum pool usage by targeting pool "dead time" and to organize additional aquatic activity sessions on a case-by-case basis. The number of additional aquatic activity services implemented by Swim for Health is presented in Table 1.

In total, 39 additional aquatic activity sessions were offered across the region. Of these, only four were discontinued before the end of the program, meaning that 35 continued throughout the program. Facility management personnel were vital in identifying such service availability. The length of time required to implement services varied considerably. On average, around 30 weeks between inception and the first delivery of a service were required, taking around seven meetings between stakeholders and the development officer. The time taken to implement services varied between 5 weeks and 50 weeks and between 3 and 12 meetings with stakeholders. Interview participants recognized that the length of time required to implement services depended upon the prevalence of stakeholder support and the existence of third party groups with established participant bases and a vested interest in the program. If support was offered and goals shared, services developed more rapidly.

Table 1 Number of Swim for Health Sessions Offered by Region During the Program and at the Completion of the Program

| Region | Target Group 1 | Target Group 2 | Target Group 3 | Target Group 4 | All Groups Combined |
|---|----------------|----------------|----------------|----------------|---------------------|
| East Riding | | | | | |
| Number of additional sessions implemented | 0 | 7 | 5 | 9 | 21 |
| Number of sessions running at the completion of Swim for Health | 0 | 6 | 5 | 9 | 20 |
| City of Hull | | | | | |
| Number of additional sessions implemented | 0 | 6 | 2 | 10 | 18 |
| Number of sessions still running at the completion of Swim for Health | 0 | 5 | 1 | 9 | 15 |
| Both local authorities combined | | | | | |
| Number of additional sessions implemented | 0 | 13 | 7 | 19 | 39 |
| Number of sessions still running at the completion of Swim for Health | 0 | 11 | 6 | 18 | 35 |

During interviews, stakeholders also acknowledged four operational barriers to development that impinged upon achievement of goals:

1. Difficulty in communication existed, particularly between steering group members operating at a strategic level with those delivering services.
2. Stakeholders themselves, or their colleagues, admitted that they had not engaged to a sufficiently-high degree with the opportunities offered by the Swim for Health Program. This admission was particularly noted where stakeholders felt their goals were not shared or were considered incompatible with those of Swim for Health or where Swim for Health goals were thought to impinge upon staff responsibilities required to meet other goals.
3. A lack of trained staff existed to offer new activity types such as aqua circuit “aquafit” or fitness swimming and aqua gym.
4. Poor participant uptake in new services offered was evident.

Each of these operational barriers requires further explanation. First, communication of goals between strategic management and facility management was not always as structured as it might have been. Moreover, communication between the two local authorities was limited. A sense of competition between authorities was apparent. For instance, there was a prevalent view among East Riding employees that Swim for Health was a scheme initially designed for the City of Hull. Indeed, the East Riding was a later addition to the scope of the project. This view gave rise to perceptions of East Riding as the “outsider” party and that location-specific, rural barriers to participation, such as access to facilities, had not been taken into account during initial planning. Consequently, the level of support for Swim for Health in East Riding was more limited at the strategic level.

Second, stakeholder support was limited if program goals did not match organizational goals. In large-scale, community-based programs, the organizational hierarchy and relationships between different groups of service providers can be key variables in defining program success (Alkin, Patton, Weiss, & Conner, 1990). For instance, there was a worry among some stakeholders that subsidized Swim for Health services would undercut existing services by offering similar sessions at cheaper prices. For example, the East Riding Sure Start schemes that incorporated a swim instructor were seen as a threat to “mainstream” post natal and preschool swimming lessons. These existing programs brought in considerable revenue to facilities. Similarly, the emphasis on selling monthly memberships to consumers in this authority did not always match the widening participation ethos of Swim for Health, which appeared to be based upon encouraging more casual usage of facilities among groups without the means or inclination to pay monthly subscriptions. At the same time in the City of Hull, concerns were raised about the long-term sustainability of offering subsidized rates to participants in schemes such as GP Exercise referrals and Age Concern (renamed AgeUK since 2009), indicating an increasing pressure for economic sustainability at the strategic level that was not always supportive of the equity and inclusion ethos promoted by the program. On the other hand, many facility level staff members were often supportive of initiatives, particularly if services targeted groups with whom they were keen to engage. Consequently, an uneven, regional development occurred in Swim for Health that depended as much on strategic stakeholder uptake as on participant uptake. One

consequence was a lack of consistent service provision increases. Instead, services were provided on a more ad hoc basis according to stakeholder uptake, the availability of pool time and space, and instructor availability.

Third, the impact of staff training upon service provision was noteworthy. Over the past two decades, the number of aquatic exercise sessions offered at local authority pools had proliferated (Campbell, 1992; Mintel Group, 2004; Sylva, Melhuish, Sammons, Siraj-Blatchford, & Taggart, 2004). These sessions had been predominantly delivered in an "aqua aerobics" format, that is, exercise to music loosely based upon the aerobic fitness industry (Baun, 2007). As demonstrated in the Active People Survey (Sport England, 2010), these exercise classes were primarily attended by women. In response to this trend, the ASA designed and implemented four new forms of aquatic exercise that, in theory, would appeal across sexes. These included (a) aqua gym and (b) aqua circuit, both of which were based upon resistance training and circuit training principles taken from traditionally gymnasium-based activities; (c) aqua jog, which incorporated buoyancy aids to allow participants to "jog" upright in the water; and (d) aqua fit, which incorporated elements of exercise with fitness swimming (www.swimming.org).

Training courses for instructors in all four of these exercise formats were not delivered until the Swim for Health program had only 15 months remaining. Moreover, participation among staff in training courses in the East Riding Authority was negligible compared with staff participation in the City of Hull. This impinged upon the types of activities offered during the initial stages of the program. Consequently, many services provided by Swim for Health were delivered by the same limited number of instructors using variations of the existing aqua aerobics format, as well as parent and toddler sessions rather than offering the new types of aquatic activity.

Fourth, the actions described in the first three operational barriers as well as the provision of services impacted upon participant involvement. The program produced an additional 16,767 attendances in both regions combined over three years (10,076 in Hull and 6,691 in the East Riding). Each attendance count pertained to one participant attending one session as recorded by each facility, so they do not necessarily represent different individuals. In addition, there was a yearly increase in participation as more services were established at more facilities. In Hull, sessions initiated by Swim for Health accounted for 0.3% of total aquatic participation across the city between April 2006 and March 2007, increasing to 1.1% between April 2007 and March 2008 and to 1.7% between April 2008 and July 2008. These increases were higher than the national target of a 1% annual increase in participation set by Sport England (Sport England, 2004).

Data quality depended upon the methods used to record attendances. Simple counts of attendance were recorded for the most part; no demographic variables were documented. Data quality also varied between local authorities. While Hull Leisure recorded monthly data clearly and included "casual" users (i.e., nonmembers), emphasis on membership sales in East Riding meant that only membership numbers per center were available. Therefore, casual users were harder to track.

Target Group Impact

At the target group level, work with target group 1 proved most challenging, and developments did not progress further than the consultation stage for a number of reasons. The rationale for including people in full time employment in the Swim

for Health program was to promote the idea that a healthier workforce would have increased productivity. Four major employers were approached throughout the Swim for Health program, involving a significant time investment from Swim for Health Staff. Only one of these employers showed support for the Swim for Health program. Consultation was completed with employees of a regional Health Trust. This consultation found that while employees showed interest in swimming, they considered this more important for their clients (i.e., people under their care), not the employees themselves. When considering their own motivations for taking part in swimming activities, organized sessions outside the workplace were preferred. The majority of female employees expressed hesitation about swimming with colleagues, which stemmed from angst about putting their bodies on display in a bathing costume in front of colleagues (Evans & Sleep, 2008). For example, a number of participants described how being without make-up or being hot and sweaty after exercise was enough to prevent their participation. Finally, a number of participants in this target group expressed a fear that colleagues might view their swimming ability or fitness levels negatively. Many of these perceived barriers have been observed previously in groups of older adults participating in aquatic physical activity (Evans & Sleep, 2012). These strong reservations led the development officer to decide to “signpost” participants into existing sessions as the most cost-effective use of time rather than create separate workplace programs. This finding, although only uncovered at a preliminary level, suggests the perceptions of health and exercise among employees as inherently separate to their work, both socially and in terms of the activity itself, were widespread. Studies have previously found that without motivational support, work-based physical activity interventions have a limited impact (Marcus et al., 1998, 2006). In relation to aquatic activity, this finding has implications for the implementation and promotion of similar work-based schemes in the future.

The program saw further progress with the other three target groups. Enhancements for target groups 3 and 4 in Hull and for target group 2 in both Hull and the East Riding progressed to the point where sessions not only were self-sustaining, but future sessions were being negotiated between stakeholders even before the Swim for Health Program concluded. For target group 2, preschool aged children and their families, preexisting groups such as “Sure Start,” a Government scheme promoting community activities for children in deprived areas, proved vital in developing aquatic activities, particularly for parents and children together. The same was true for services provided for target group 3, people with a range of health needs and for target group 4, people over fifty years of age. Two agencies were key in this progress: The Active Lifestyles GP Referral scheme in which general practitioners and exercise professionals prescribed physical activity as treatment (Williams, Hendry, France, Lewis, & Wilkinson, 2007) and services offered in partnership with Age Concern, a charity providing services and assistance to older adults. Both took ownership over a number of additional services. Many of these latter services addressed the needs of target groups 3 and 4 simultaneously because many of those with health-based needs were over the age of 50 years. Other groups who engaged with the program included a learning disabilities group with sessions designed to cater to people with severe and enduring mental health needs and a group catering to the Hull and East Riding Institute for the Blind (HERIB).

Even the most popular Swim for Health sessions were primarily attended by women. For target group 2 sessions, between 79% and 100% of participants were

women. Among target groups 3 and 4, between 77% and 92% of participants were women. Participants were primarily either young parents (group 2) or older women over the age of 50 years (groups 3 and 4). The main reasons for this appeared to be sociocultural. For instance, swimming with young children was, according to a number of participants, traditionally associated with the role of a mother. It was also apparent that targeting pool "dead time" also limited who participated. Most unused time at facilities occurred during the daytime. This had an impact, particularly upon participants from target group 2 (preschool aged children and their parents). Traditional gendered family roles were apparent. Many fathers worked during the day while many mothers stayed at home. Consequently, it was almost exclusively mothers who participated in services delivered during the daytime. Finally, the aqua-aerobic exercise sessions were associated with femininity with connotations of dance and lower intensity exercise that was suitable for older women (Evans & Sleaf, 2012).

Another limiting factor in participant uptake was perceptions of aquatic activity. During Swim for Health, we discovered that participants from all target groups sometimes perceived participation in public aquatic activity as both enabling but also potentially intimidating and risky (Evans & Sleaf, 2012). To help participants overcome such negative perceptions, Swim for Health aimed to introduce individualized exercise programs, expert support from instructors, and health-based measurements. Groups of older adults, obese individuals, people with a range of health problems including mental health needs, learning difficulties, people with sight impairments and those with chronic illness were all given access to aquatics during the program. Levels of participation among such groups were high and the inclusiveness of Swim for Health services, particularly in Hull, was substantial.

The high levels of participation and substantial inclusion were achieved using a slightly different philosophy of delivery than was initially envisioned. This philosophy emphasized the enabling social context of aquatic activity. In the early stages of planning, it was thought that individually-tailored exercise in the pool using the expertise of instructors would aid in improving participant motivation. Conversely, many of the most successful services for the groups in Swim for Health were based upon promoting a sense of inclusiveness in providing sessions with a strong group ethos and where support from health professionals was present but not all-embracing. Evaluation demonstrated clearly that many participants valued this sense of inclusiveness and enablement very highly (Evans & Sleaf, 2008, 2012). The informality and inclusiveness of aquatic activity in groups like those provided in GP exercise referrals, learning difficulties, and age concern, for example, were consistently described as one of the biggest attractions to participate.

Conclusions: Shared Learning Outcomes From Swim for Health

The main aim of the Swim for Health program was to increase participation in aquatic activities by improving equality of access in four target groups among whom participation was low (Sport England, 2004). The assertion that these specific target groups found participation in aquatic activity difficult remains questionable. The inclusion criteria for each of the target groups were incredibly broad. By basing

target group membership upon age or health status alone meant that each target group included large subsections of the local population. In short, the target groups included members who already took part in regular aquatic activity such as women and children. This made it easier for the development officer to achieve goals of increasing participation.

All goals were not achieved in a uniform manner. Goals set at the facility and group level were not always met. For instance, some facilities were deemed unsuitable for broader participation after needs analysis, including one school pool which was used largely by schools during the daytime and had minimal free time during the evenings. This finding highlighted the need to engage in needs assessment before program implementation. Considerable time and resources could have been saved if a period of needs assessment had been conducted before service implementation. The number and availability of trained staff, resources, pool time, and local demand for specific services among participants were all assessed after the program had begun. Moreover, staff training in expanded aquatic activities such as aqua fit, aqua jog, and aqua circuit took place well into the program because initially courses were simply not available. This had a number of impacts, including slowing initial development and making delivery of novel sessions difficult. The predominance of traditional and customary aqua fit sessions meant that most participants in Swim for Health were women, perhaps because of the traditional association between aerobics and women's leisure (Markula, 1995). If, however, needs assessment and staff training had been carried out before the program, the impact of Swim for Health may have been more far reaching. Due to the broad inclusion scope of target groups 2, 3, and 4, the program was a qualified success. The overall program achieved its participation-based goals, although many participants were from social groups among whom participation in aquatic activity was already relatively high.

The health promotion rationale for Swim for Health initially envisaged was not always entirely appropriate for the target groups engaged. Swim for Health was grounded in a health promotion rationale and was envisioned as a program that would reduce health inequalities among its target groups. The program instead sought to increase aquatic activity participation broadly. No specific health message was stipulated, and no physiological or anthropometric measures were specified that would have enabled changes in participants' health to be tracked during Swim for Health.

The difficulties of employing a health-based rationale within Swim for Health included the large-scale of the program. The resources of the program were not great enough to enable physiological and anthropometric measures of health and well-being to be taken among all participants. Activity levels during participation in services provided were relatively low for some groups. Consequently, not all services provided during Swim for Health had a purely health-based rationale. For example, parents considered swimming with children to be beneficial, primarily as a social activity in which children could be socialized into feeling safe and confident in water, while many older participants also emphasized the socially-enabling context of aquatic activity (Evans & Sleaf, 2012). Consequently, promoting many of the benefits to participation, including perceived social and emotional benefits, were not initially included as goals in the program theory.

The unexpected emphasis on social inclusion rather than health along with the high proportion of women and children participating in Swim for Health was

not expected in initial planning and the program theory. Indeed, the flexibility of theory-driven evaluation has been questioned in the past, particularly in relation to community-based interventions (Stufflebeam & Shinkfield, 2007). These authors note that real-world programs often work with a level of flexibility and unplanned direction that is difficult to incorporate into a fixed program theory model. In this case, the emphasis upon understanding program process and development in relation to a program theory allowed a critical and dialectical approach to be taken. This approach enabled emphasis of the unintended consequences of program actions to be outlined in relation to the initial program rationale; that is, divergences from the initial rationale were highlighted in a systematic manner (Rossi et al., 2003). This process enabled weaknesses or oversights in preprogram assumptions to be highlighted in a way in which, should an initial program theory not have been produced, might have gone unnoticed.

Overall, while Swim for Health in many cases reproduced some of the inequalities it had sought to eliminate, including provision of exercise services dominated by women and an uneven distribution of service provision that favored certain sites over others, it also improved access to aquatic activity among many groups. The potential for additional programs of this kind has begun to be realized since Swim for Health and schemes such as "Everyday Swim" and "The Big Splash" have already been implemented in the UK (www.swimming.org). Swim for Health was both a catalyst for these developments, but also a proving ground in which best practice was investigated. A number of learning outcomes were described including the recognition that sufficient needs assessment of existing services and facility capacity is required before service implementation as well as the need to have trained staff able to offer a variety of aquatic activities before any program. Finally, it is suggested that, in conjunction with greater stakeholder involvement, specific goals should be set which are based upon increased participation rather than health-based targets.

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