






## Article

# Promoting Healthy Lifestyles: Availability of Healthy Resources and Prescriptions from Health Professionals—The Case of Tarragona, Spain

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**Abstract:** This research provides a comprehensive view of the geolocation of physical health assets in the city of Tarragona (Spain) and how these assets are used and recommended by healthcare professionals to promote healthy lifestyles. Focusing on the distribution and accessibility of sports facilities, such as outdoor gyms or football and basketball courts, this study highlights the importance of these assets in leading a healthy life and preventing chronic diseases. This article investigates the availability of these assets and their prescription by healthcare professionals to improve people's quality of life through surveys and fieldwork. It evaluates both the knowledge healthcare professionals have about these available assets in the area and the types of physical activity they prescribe. The results show significant variability in the availability of physical health assets across different neighbourhoods. However, most residents have good walking access to these assets, especially in the central and western parts of the city. This study concludes that while physical health assets are an underutilised resource for healthcare professionals, enhancing the awareness and prescription of these assets could improve public health outcomes, particularly for older adults.

**Keywords:** community asset mapping (CAM); cultural ecosystem services; environmental justice; health assets; physical activity; public health



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## 1. Introduction

Scientific and technological advancements have increased life expectancy [1], making human health an increasingly significant challenge for healthcare systems worldwide, especially when focusing on older adults [2]. Medical science has increasingly directed its treatments toward the use of drugs aimed at altering the body's condition to achieve a cure for disease [3]. However, it has been demonstrated that physical activity is a key element in the primary prevention of at least 35 chronic diseases [4].

Within the framework of Sustainable Development Goals (SDGs), numbers three, ten, and eleven, which aim to ensure healthy lives at all ages, equality among all people, and inclusive, safe, and sustainable environments, it is established that governments, entities, and individuals must take deliberate action [5]. Physical activity is fundamental in the process of healthy ageing due to its positive impact on health [6], as regular exercise, properly prescribed and at an appropriate intensity, serves as a highly effective non-pharmacological treatment [7] and helps prevent chronic diseases [8].

There is growing evidence suggesting the need to shift from a disease-centred care model to one that promotes holistic well-being, incorporating the physical and social environment as health assets [9]. According to Riera-Sampol et al. [10] and Rodríguez Benito et al. [11], the

prescription of health assets (HAs) by healthcare professionals presents an opportunity to improve people's quality of life. This approach avoids administering medication and promotes healthy lifestyles by using specific assets in the immediate environment. In this regard, social prescribing becomes an essential approach as the mechanism that allows healthcare professionals to connect patients from primary care centres to non-medical resources and support systems in their community, such as recommending physical activity or recreational activities, among others [12]. According to Dandicourt Thomas et al. [13], social prescribing has proven to be useful in helping people adopt healthy habits, lead more active lives, and improve relationships and social support, enhancing their quality of life, well-being, and self-perception of health, and reducing anxiety.

In this context, health assets (HAs) enhance the ability of individuals, communities, or populations to maintain health and well-being [12,14,15]. These assets can be human-related (such as access to healthcare or education professionals), socially related (such as associations, clubs, etc.), financially related (like job skills), environment-related (such as green spaces or the absence of pollutants), or physically related (like sports and recreational facilities) [16]. This research concentrates on analysing the latter, physical health assets (PHAs), defined as essential for promoting physical health [17]. These assets include sports facilities and outdoor exercise areas, which are the primary focus of this study, although they also encompass community physical activity programmes and social support networks.

Using these assets effectively not only improves the quality of life for older adults but also fosters a healthy and sustainable environment for the entire community. Integrating these assets into public health strategies can maximise the benefits of physical exercise and support active and healthy ageing. Healthcare professionals can encourage their patients to engage in activities or use assets and resources that promote a healthy lifestyle [18], which emphasises physical activity and recreation.

Accessibility to these assets and resources is key. Optimal accessibility is considered when these assets are located within a 5 min walking distance from the place of residence, while poor accessibility occurs when travel time exceeds 30 min [19]. Therefore, it is crucial that healthcare professionals are familiar with the environment and the PHAs available in the area where they work, allowing them to provide personalised relevant advice for their patients.

Physical activity has expanded beyond conventional and private facilities to take place in public spaces [20]. The geolocation of HAs related to physical activity allows specific geographic coordinates to be assigned to these assets, identifying their exact location on the map [21]. In recent years, HA maps have become increasingly prevalent tools in the field of health promotion [22], as they are useful for healthcare personnel to understand the availability and distribution of these assets.

This approach not only facilitates planning and informed decision-making by healthcare professionals but also helps determine the condition of these assets so that they truly serve healthcare initiatives in the community. Therefore, the use of georeferencing becomes a key tool, facilitating decision-making [23] in the prescription and management of strategies based on existing assets to improve living conditions. Additionally, it enables the creation of community asset maps (CAMs), allowing healthcare professionals to locate and prescribe these facilities as HAs.

The objectives of this study are (i) to geolocate public and free PHAs in the city of Tarragona, (ii) to evaluate their accessibility, and (iii) to determine the degree of knowledge of these assets among health professionals and the prescription of physical activity that they carry out. To achieve this, the following research question is posed: What are the free and publicly accessible PHAs in Tarragona, what are their conditions and accessibility levels, and to what extent are they prescribed by healthcare professionals? To address this research question, (i) the PHAs prescribed by healthcare professionals through an ad hoc survey are identified and (ii) fieldwork is carried out to geolocate and evaluate the free and publicly accessible PHAs present in the various Basic Health Areas (BHAs) across the city.

The prescription of PHAs by healthcare professionals, such as exercise programmes or recommendations to walk or run, is influenced by the availability of public facilities that meet the needs of the population. The results of this study not only support informed planning and decision-making by healthcare professionals but also help identify PHAs and assess their condition, ensuring that they truly serve as healthcare assets for the community.

The objectives of this research are aligned with three of the seventeen United Nations Sustainable Development Goals (SDGs) [24]. Specifically, they are aligned with SDG 3 (good health and well-being), SDG 10 (reduced inequalities), and SDG 11 (sustainable cities and communities).

## 2. Area of Study

This research focuses on the city of Tarragona, which is the capital of the province with the same name. The city is located in the north-east of Spain, nestled along the Mediterranean coast. Its characteristic climate of mild winters and warm summers is ideal for healthy lifestyles, such as, for example, engaging in physical activity in the open air. This climatic environment is essential for studying PHAs, particularly regarding how they are accessed and used by the local population.

According to the 2021 municipal population census provided by the Tarragona City Council as of 1 January 2022, the city has a population of 142,864 inhabitants, diverse in terms of age and socioeconomic status.

As for the healthcare regions, Tarragona is divided into eight BHAs, each with a primary care centre (PCC), which is a basic health centre (Figure 1). The prescription of PHAs by healthcare professionals from these centres is influenced by the availability of public facilities that meet the needs of the population. The prescribed PHAs may include exercise programmes or health parks distributed throughout the city. All participating healthcare professionals work in the eight BHAs indicated in Figure 1.

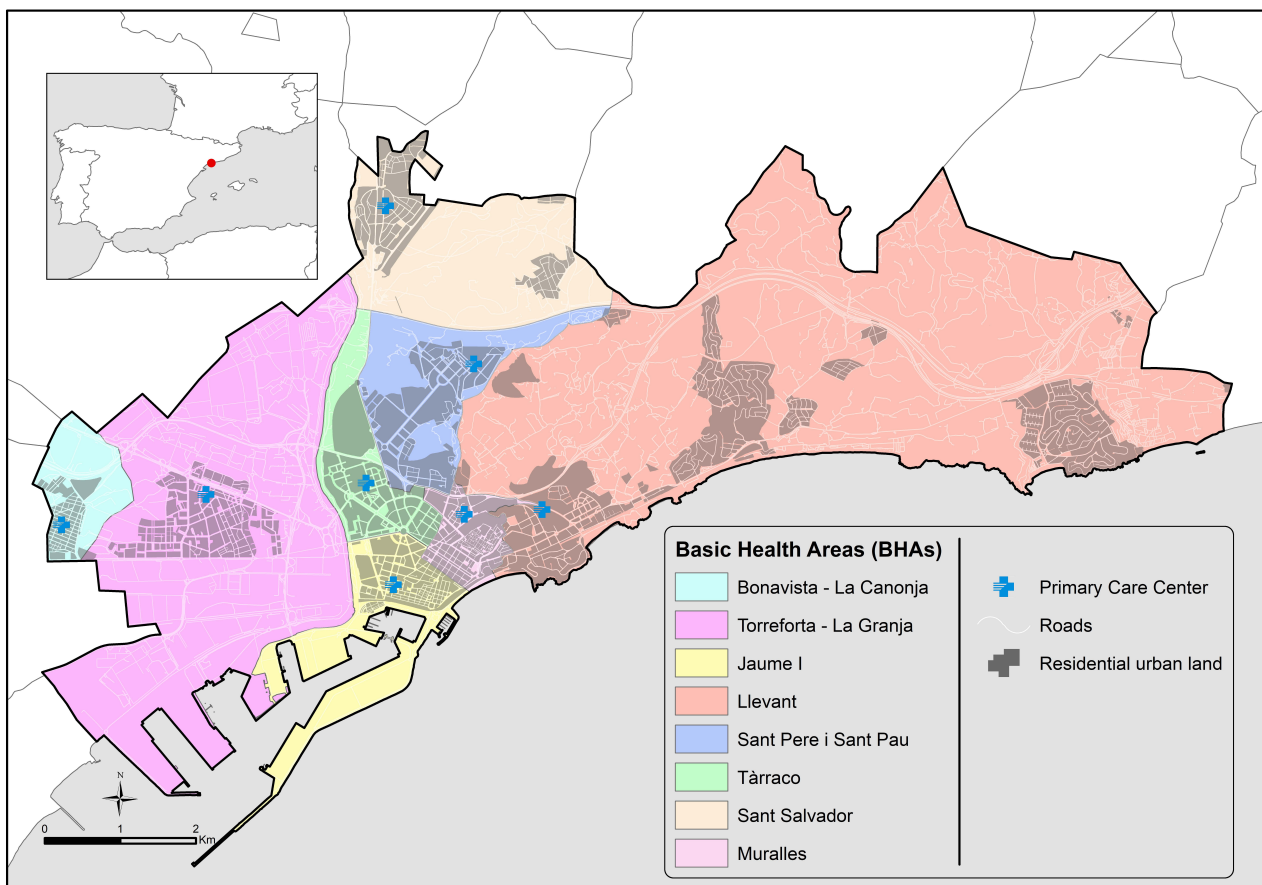


Figure 1. Area of study.

The population served by each BHA is very heterogeneous. There are small BHAs, serving less than 10,000 people (Sant Salvador or Bonavista—La Canonja), and larger ones, with populations of around 30,000 people (Torreforta—La Granja or Jaume I) (Table 1).

**Table 1.** Distribution of the population by age and BHAs.

BHAs	≤14 Yrs.		15 to 64 Yrs.		≥65 Yrs.		Total	
	Abs.	Rel.	Abs.	Rel.	Abs.	Rel.	Abs.	Rel.
Bonavista—La Canonja	1365	7.5%	6157	6.4%	1510	5.3%	9032	6.3%
Torreforta—La Granja	4167	22.9%	19,277	20.1%	4796	16.7%	28,240	19.8%
Jaume I	3366	18.5%	21,270	22.1%	7472	26.1%	32,108	22.5%
Llevant	1937	10.7%	9557	10.0%	2816	9.8%	14,310	10.0%
Sant Pere i Sant Pau	2271	12.5%	11,160	11.6%	2887	10.1%	16,318	11.4%
Tàrraco	2088	11.5%	11,945	12.4%	4165	14.5%	18,198	12.7%
Sant Salvador	1274	7.0%	5540	5.8%	1140	4.0%	7954	5.6%
Muralles	1700	9.4%	11,148	11.6%	3856	13.5%	16,704	11.7%
TOTAL	18,168	12.7%	96,054	67.2%	28,642	20.0%	142,864	100.0%

Own work based on the municipal population census. Year 2021.

According to data from the National Statistics Institute [25], the socioeconomic level also varies greatly across different areas of the city. By far, the BHA with the highest average net household income is Llevant (eastern part of the city), while the BHAs with the lowest income are Torreforta—La Granja and Bonavista—La Canonja (western part of the city), followed closely by the BHA Sant Salvador (northern part) (Table 2).

**Table 2.** Average net income per household in each BHA for the year 2021.

BHAs	Income
Llevant	56,389 €
Tàrraco	44,896 €
Muralles	40,733 €
Jaume I	35,838 €
Sant Pere i Sant Pau	34,673 €
Sant Salvador	29,788 €
Bonavista—La Canonja	27,232 €
Torreforta—La Granja	26,771 €
Average	37,040 €

Own work based on data taken from the National Institute of Statistics [25].

### 3. Methodology

#### 3.1. Study Design

This study is framed within an exploratory approach using a mixed method, which allows for the integration and use of various techniques to leverage their strengths and provide a more comprehensive understanding of the phenomenon under study.

To identify the PHAs, fieldwork was conducted based on georeferencing, aiming to locate and assess the condition of the PHAs present in the different BHAs of the city. Following the approach of Martín-Doménech et al. [8], all PHAs analysed in this study are freely accessible, contributing to a reduction in inequalities.

The status of urban outdoor facilities freely accessible for physical activity was evaluated to provide a comprehensive view of the available assets and their potential to promote physical exercise. As support for the fieldwork, a specific observation sheet was developed for this purpose.

The study population consisted of healthcare professionals from the 8 BHAs of Tarragona. Contact was made by phone with the heads of each PCC to obtain their authorisation and administer a survey among healthcare professionals. A convenience sampling method resulted in the participation of 75 health professionals from the area. For the statistical analysis of the study, a confidence level of 90% and a margin of error of 10% were defined. With these parameters, it was calculated that the sample size should be  $n = 68$  for the results to be significant.

### 3.2. The Spatial Analysis Resulting from the Fieldwork

The fieldwork was conducted in 2022 and updated in October 2023. The georeferencing of the PHAs was carried out by traversing the city using the Catalunya Offline smartphone application "<https://www.icgc.cat/es/Herramientas-y-visores/Apps/Catalunya-Offline>" (accessed on 16 May 2022)", which utilises a Global Positioning System (GPS) and allows for the geolocation of resources for sports practice. The evaluation of the PHAs was carried out using the observation sheet with a Likert scale from 1 to 5, taking into account both their maintenance condition and usability.

The collected information was processed using the ArcMap 10.8 Geographic Information System and was classified into 7 categories: outdoor fitness equipment, callisthenics areas, ping-pong tables, pétanque courts, football goals, basketball hoops, and skating parks (Figure 2).



Figure 2. Cont.



**Figure 2.** (a) Outdoor fitness equipment; (b) callisthenic area; (c) ping-pong table; (d) pétanque court; (e) football goalpost and basketball hoop; and (f) skate park.

### 3.3. Analysis of PHA Accessibility

To understand the accessibility on foot between the places of residence of the population and the PHAs in the city, two cartographic layers are required: one for the PHAs and the geolocation of the city's inhabitants at their places of residence.

The creation of the second layer was based on the municipal population register of Tarragona from the year 2021, provided by the City Council, which was georeferenced using the Instamaps software "<https://instamaps.cat/> (accessed on 20 May 2022). In this way, the place of residence, along with its X and Y coordinates, has been obtained for the population of the city, thanks to the information on the postal address of each inhabitant.

Using the software QGIS 3.28 and the Open Route Service extension, which takes into account the city's street layout, a routing analysis was conducted with the following time ranges: <5'; 5'–9'59"; 10'–14'59"; 15'–19'59"; 20'–24'59"; 25'–29'59"; ≥30'. The result is seven cartographic layers with the isochrones corresponding to each time interval.

In order to ascertain the distance of each inhabitant from the PHAs, it is necessary to overlay the georeferenced population layer with the isochrone layer. This allows us to know the number of inhabitants living in each distance interval.

### 3.4. The Survey and Its Statistical Analysis

To collect the data, a tailored questionnaire was developed, consisting of twenty-one questions distributed across three blocks.

The first block included the collection of sociodemographic data from the participants, such as age and sex.

The second block aimed to obtain information about the professionals' activities, including their healthcare professional group, specialty, years of work experience, and the centre where they work.

The third block identified which PHAs they prescribed. Additionally, it inquired about the availability of protocols for recommending physical exercise; the type of population they attended based on age; the frequency with which they prescribed PHAs; whether they followed up on the recommended activity; the types of activities they usually recommended; the places they advised patients for physical exercise; their knowledge and opinion of PHAs near their health centre; their awareness of digital PHAs; and finally, their interest in promoting PHAs among patients.

This survey was distributed through the Catalan Health Institute (ICS) and the directors of the eight PCCs, among professionals in the BHAs of the study area via a Microsoft Forms application link. To increase the sample size of participants, the survey was

also distributed in paper format. The data collection period took place from October to December 2023.

Once all the responses from the healthcare professionals' survey were collected, a descriptive statistical analysis of the results obtained was conducted using MS Excel. The variables analysed included sex, age, healthcare group, years of experience, the age range of the patients they attend, and the PCC in which they work. Also, specific questions regarding the georeferenced PHAs during the fieldwork and those prescribed by the participating health professionals in the study were analysed.

## 4. Results

### 4.1. The Availability of PHAs

There are a total of 94 publicly accessible, free, and open PHAs distributed across the different BHAs of Tarragona, which can be prescribed for physical exercise.

Table 3 shows that the area with the highest concentration of PHAs is, by far, the BHA Torreforta—La Granja, with a total of 31, making this BHA the second most populated and the one with the lowest average household income. On the other hand, the BHA Jaume I, which has the highest population concentration, has 10 PHAs, while the BHA Llevant, with the highest average net household income, is the second BHA with the greatest availability of PHAs, totalling 18. The areas with the lowest concentration of PHAs are the BHA Muralles with three and the BHA Bonavista—La Canonja with four (see the number of PHAs per BHA in Figure 3).

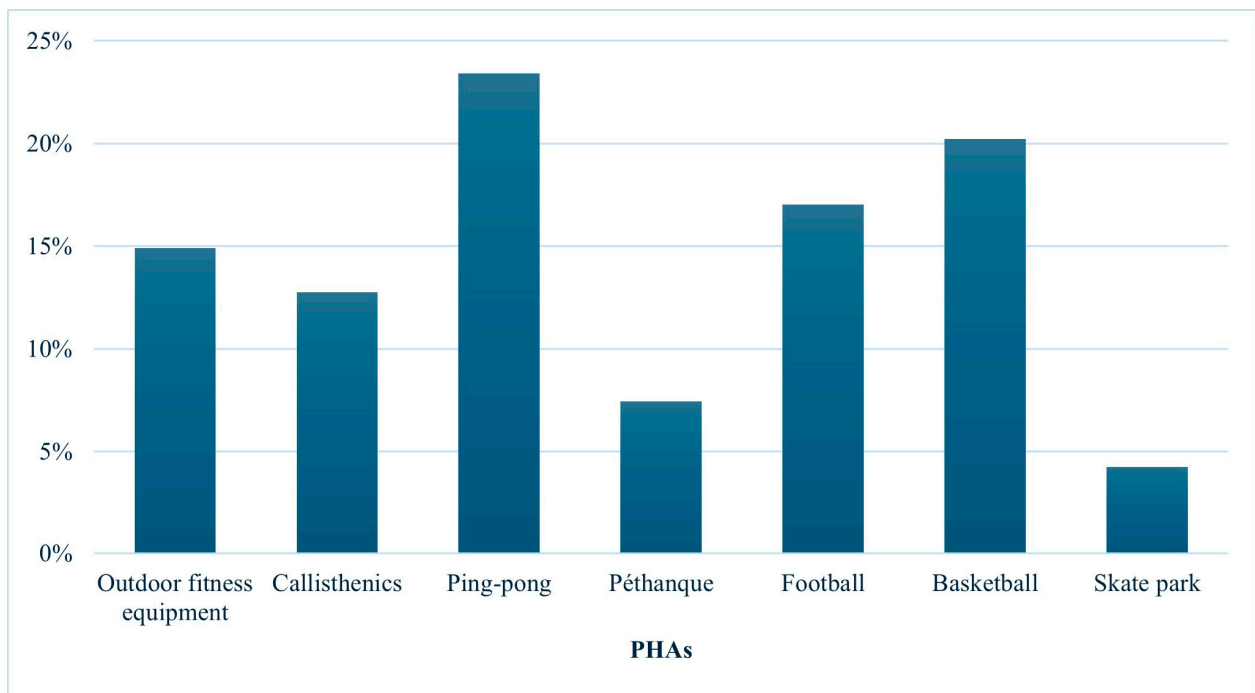
**Table 3.** PHAs distribution according to typology in each BHA.

BHAs	Outdoor Fit. Equip.	Callisthenics	Ping-Pong	Pétanque	Football	Basketball	Skate Park	Total PHAs
Torreforta—La Granja	3	4	6	4	7	6	1	31
Jaume I	2	1	2	0	1	3	1	10
Tàrraco	0	1	3	1	2	2	1	10
Sant Salvador	1	1	3	0	1	1	1	8
Llevant	1	3	5	0	5	4	0	18
Muralles	1	0	1	0	0	1	0	3
Bonavista—La Canonja	1	1	0	1	0	1	0	4
Sant Pere i Sant Pau	5	1	2	1	0	1	0	10
Total	14	12	22	7	16	19	4	94

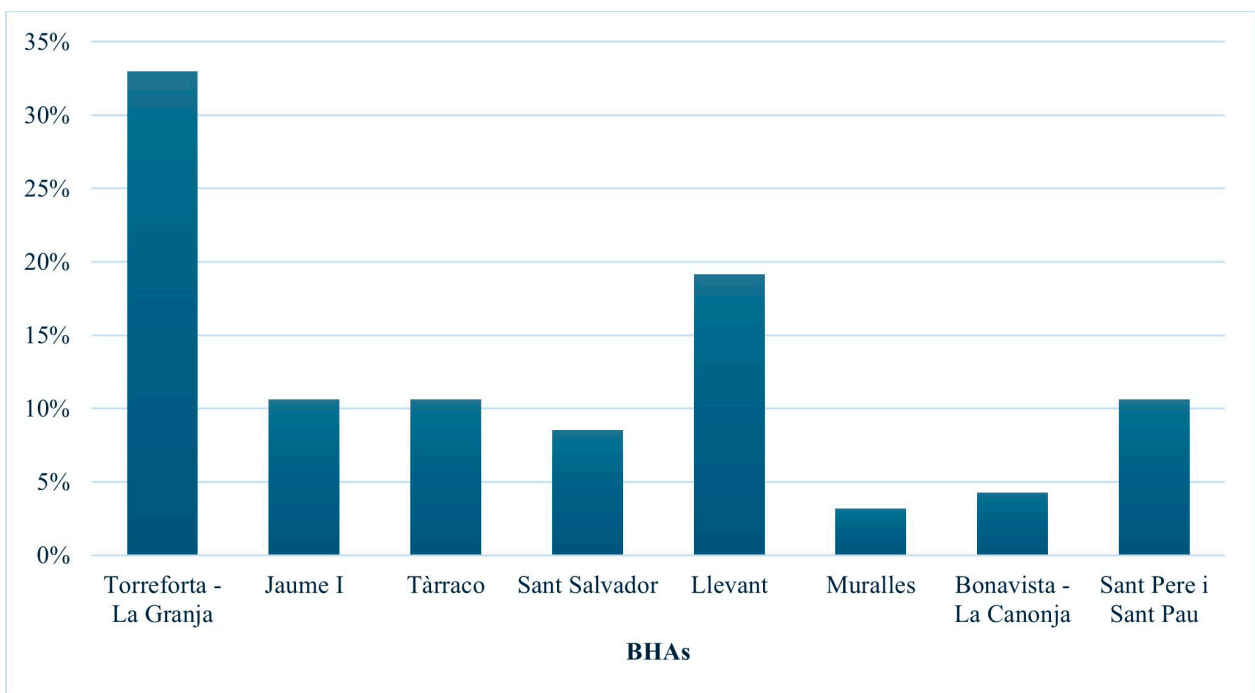
Ping-pong tables are the PHAs most prevalent in the city, with a total of 22, followed by basketball hoops with 19 and football goals with 16. Skate parks are the least common, with only four areas (see the quantity of each type of PHA in Figure 4).

Figure 5 shows a map of the territorial distribution of all the PHAs in Tarragona, highlighting a greater concentration in the western and central areas of the city. Figure 6 confirms through a heat map that the area with the highest concentration of PHAs in Tarragona is located in Torreforta—La Granja and in the city centre, although there are also other points where various PHAs are concentrated, such as the BHAs Sant Salvador, Sant Pere i Sant Pau, and the eastern area of Llevant.

Regarding the condition of the PHAs, it is noteworthy that the vast majority are in optimal condition for sports practice. There are some exceptions, such as the lack of a net on a ping-pong table, a bent basketball hoop, and some rusted or worn-out outdoor fitness equipment. The poor condition of some facilities is a result of vandalism, lack of maintenance, or wear and tear from use. As for the areas with the highest concentration of facilities in poor condition, there is no defined pattern.



**Figure 3.** Amount of PHAs by typology.



**Figure 4.** PHAs by BHAs.

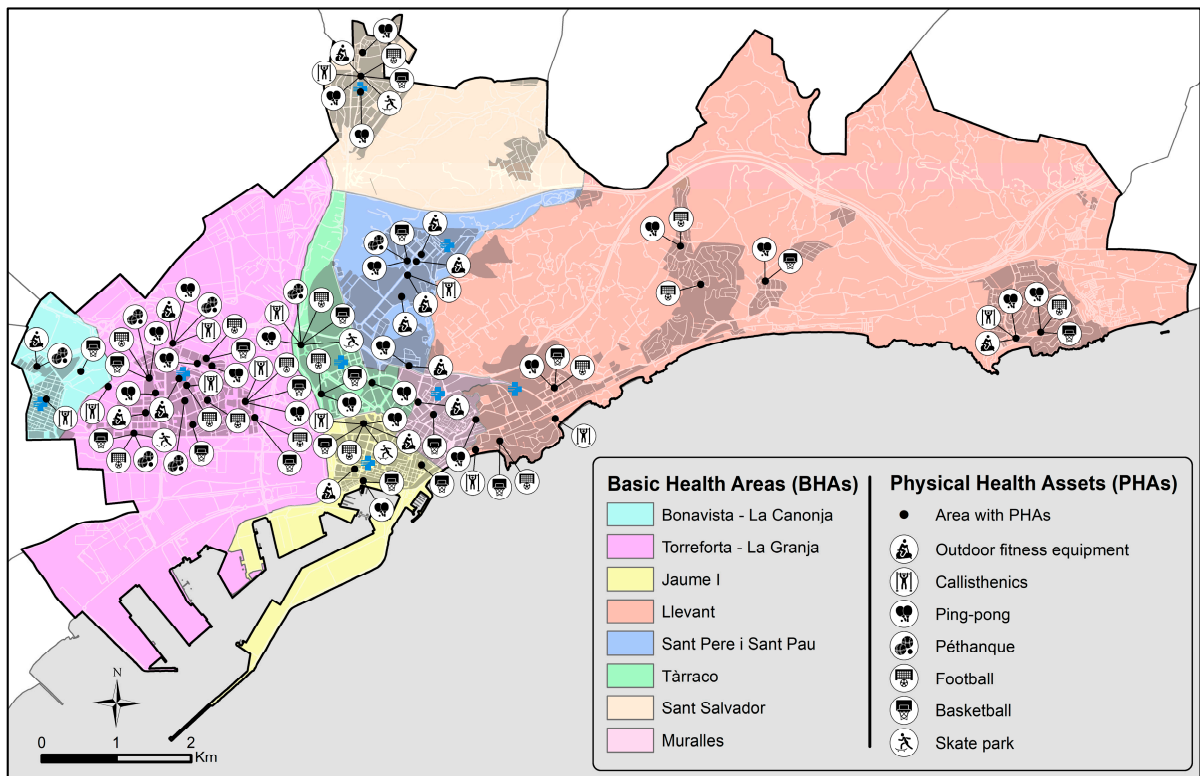


Figure 5. PHA georeferencing in Tarragona.

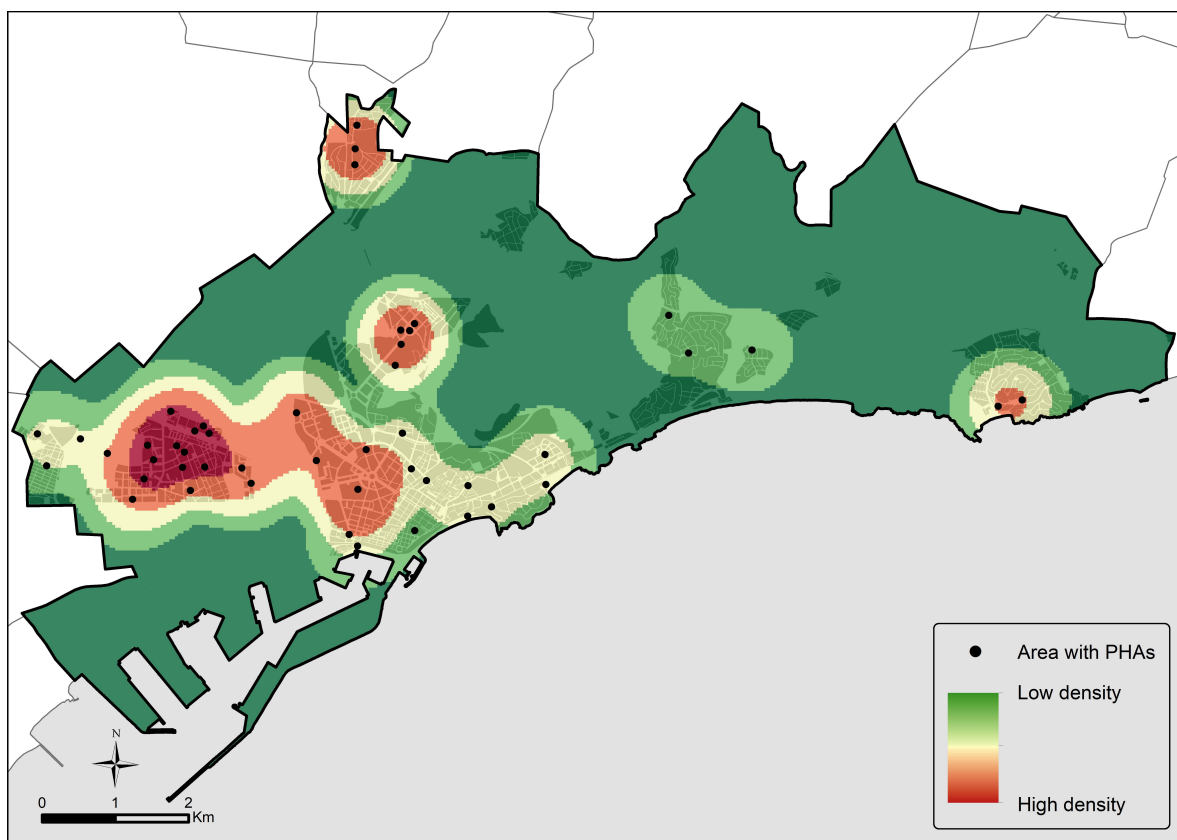


Figure 6. Heat map of PHAs in Tarragona.

#### 4.2. PHA Accessibility

As seen in Figure 7 and Table 4, the majority of Tarragona’s residents have good accessibility to the PHAs available in the city.

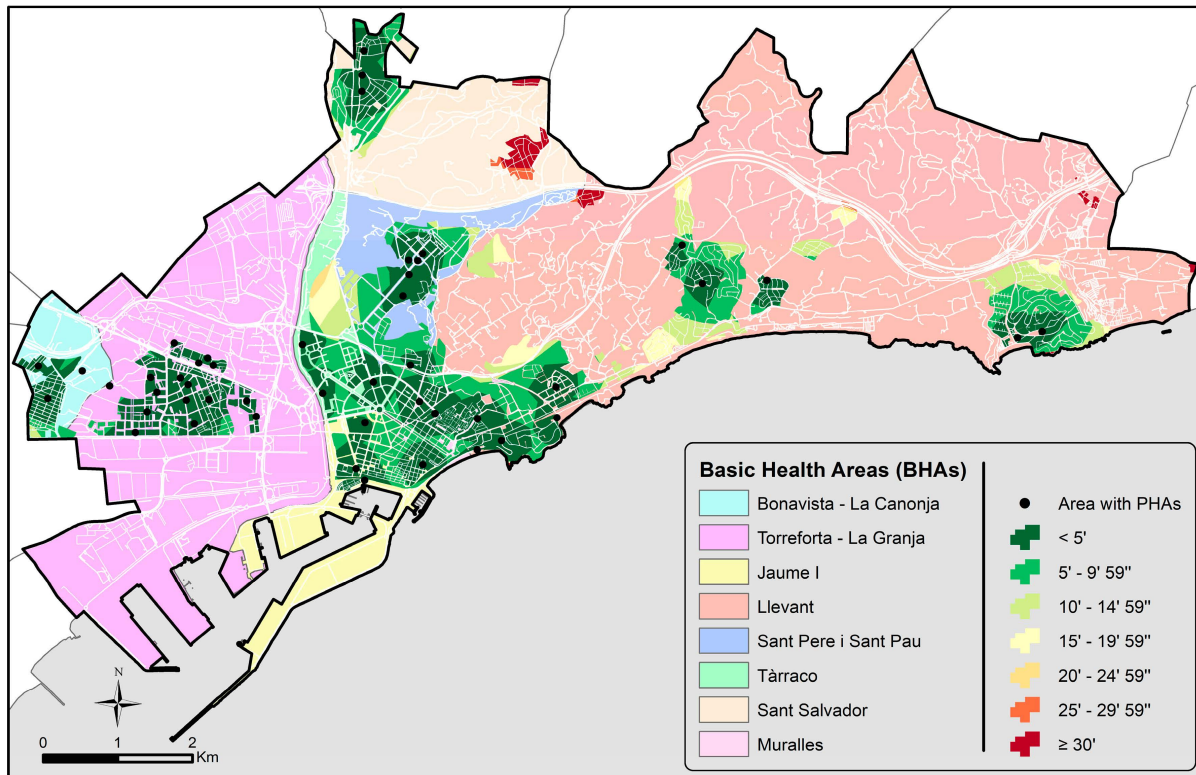


Figure 7. Population’s accessibility to PHAs in Tarragona (in minutes walked).

Table 4. Population’s accessibility to PHAs in Tarragona (in minutes walked).

BHAs	<5'	5'–9:59"	10'–14:59"	15'–19:59"	20'–24:59"	25'–29:59"	≥30'	Total
Bonavista—La Canonja	89.1%	10.9%	0.1%	0.0%	0.0%	0.0%	0.0%	100.0%
Torreforta—La Granja	86.3%	13.5%	0.1%	0.0%	0.0%	0.0%	0.1%	100.0%
Jaume I	53.3%	46.7%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Llevant	49.3%	28.7%	15.5%	5.7%	0.2%	0.0%	0.6%	100.0%
Sant Pere i Sant Pau	55.0%	42.4%	2.5%	0.0%	0.0%	0.0%	0.0%	100.0%
Tàrraco	61.3%	38.4%	0.4%	0.0%	0.0%	0.0%	0.0%	100.0%
Sant Salvador	49.1%	45.7%	0.1%	0.0%	0.0%	0.6%	4.5%	100.0%
Muralles	83.9%	16.1%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Average	66.2%	30.9%	1.9%	0.6%	0.0%	0.0%	0.3%	100.0%

Analysing optimal accessibility, 66.2% of Tarragona’s inhabitants have at least one PHA within a 5 min walk from their residence. The BHAs with the best optimal accessibility are Bonavista—La Canonja (89.1%), Torreforta—La Granja (86.3%), and Muralles (83.9%). In contrast, the BHAs with the lowest accessibility within the first five minutes of walking are Llevant (49.3%) and Sant Salvador (49.1%).

In these last two cases, as shown on the map, the areas with the worst accessibility correspond to small, decentralised urbanisations located within the mentioned BHAs. Additionally, the case of Sant Salvador is particularly relevant, as 4.5% of its residents must walk more than 30 min to reach the nearest PHA. This is due to the urban layout of Tarragona, which is characterised by a dispersed structure with an “oil spot” distribution,

featuring a consolidated urban centre and a polarised periphery [26], where smaller urban plots further from the centre have not been considered for PHA provision.

#### 4.3. The Profile of the Survey Participants

A total of 75 responses were obtained from healthcare professionals affiliated with the different health centres in the analysed BHAs. Table 5 presents the descriptive results of the sample.

**Table 5.** Description of the participating healthcare professionals.

Variable	Categories	Absolute	Relative
Gender	Female	65	86.7%
	Male	10	13.3%
Age	Under 35 yrs.	9	12.0%
	Between 35 and 44 yrs.	18	24.0%
	Between 45 and 54 yrs.	25	33.3%
	Between 55 and 64 yrs.	18	24.0%
	Do not know/no answer	5	6.7%
Healthcare group	Physiotherapy	1	1.3%
	Human and dietary nutrition	1	1.3%
	Psychology	1	1.3%
	Medicine	24	32.0%
	Nursing	48	64.0%
Years of experience	Less than 1 yr.	2	2.7%
	Between 1 and 5 yrs.	4	5.3%
	Between 5 and 10 yrs.	8	10.7%
	Between 10 and 15 yrs.	9	12.0%
	Between 15 and 20 yrs.	18	24.0%
	More than 20 yrs.	34	45.3%
Population for whom they usually care	Under 15 yrs.	6	8.0%
	Between 15 and 44 yrs.	0	0.0%
	Between 45 and 64 yrs.	17	22.7%
	65 yrs. and over	52	69.3%
PCC where they practise	Torreforta—La Granja	3	4.0%
	Jaume I	6	8.0%
	Tàrraco	7	9.3%
	Sant Salvador	8	10.7%
	Llevant	11	14.7%
	Muralles	12	16.0%
	Bonavista—La Canonja	14	18.7%
	Sant Pere i Sant Pau	14	18.7%

A total of 86.7% of the study participants were women. In total, 33.3% were between 45 and 54 years old at the time of their participation, with an average age of 46.4 years (Standard Deviation—SD:  $\pm 1.2$ ).

Regarding the distribution by healthcare professions, 64% were nurses, 32% were doctors, and the remaining 4% belonged to other healthcare professions. More than 94% of the professionals had been practising their profession for 10 years or more, and 45.4% had 20 years or more of professional experience.

Approximately 70% of the population attended by the healthcare professionals were 65 years old or over.

#### 4.4. PHAs on Prescription

Regarding the prescription of physical exercise (Table 6), 60% of healthcare professionals indicate that they do not have any protocol or guidelines regarding the recommendation to prescribe exercise to their patients. Despite this, over 90% regularly prescribe exercise, although nearly 40% of these professionals do not conduct any follow-up once the exercise has been prescribed.

**Table 6.** Physical exercise on prescription.

Variables	Categories	Absolute	Relative
Do you have a protocol to facilitate recommending physical exercise?	Yes	45	60.0%
	No	30	40.0%
Do you usually prescribe doing physical exercise?	Yes	70	93.3%
	No	4	5.3%
	Do not know / no answer	1	1.3%
If you prescribe doing physical exercise, do you monitor it?	Yes	44	62.9%
	No	26	37.1%
Type of exercise prescribed the most	Walking	70	27.9%
	Swimming	39	15.5%
	Aqua aerobics	35	13.9%
	Pilates	26	10.3%
	Dancing	20	8.0%
	Yoga and Thai-chi	20	8.0%
	Gymnastics	13	5.2%
	Cycling	12	4.8%
	Running	9	3.6%
	Tennis and padel	4	1.6%
Places where you recommend doing exercise	Other	3	1.2%
	Swimming pool in sport facilities	43	18.5%
	PAFES	38	16.4%
	Sport facilities (gymnasia, tennis, padel, ...)	29	12.5%
	Old people's club	29	12.5%
	Outdoor fitness equipment for the elderly	28	12.1%
	Cultural or neighbourhood associations	19	8.2%
	Callisthenics or bar park	10	4.3%
	Private sports clubs	9	3.9%
	Other places	10	4.3%
Nowhere specific	17	7.3%	

The type of exercise most commonly prescribed by professionals to their patients is walking (27.9%), followed by swimming (15.5%) and aqua aerobics (13.9%). In contrast, the least recommended exercises are high-impact sports such as tennis, paddle tennis, and running.

As expected, given the most prescribed type of exercise, the most recommended places for practising these activities are, first and foremost, swimming pools in sports facilities (18.5%), followed by the routes of the physical activity, sports, and health plan (PAFES), which offers healthy routes for easy or moderate walking accessible to everyone (16.4%). Finally, they also recommend exercising in sports facilities, community centres for seniors, and outdoor fitness equipment for older adults, with 12.5% in each of these cases.

Only 12.1% of professionals recommend the use of outdoor fitness equipment for physical activity among older adults. The least recommended places are private sports clubs (3.9%). Notably, 7.3% of professionals do not recommend any specific location for exercise practice. It is important to emphasise that the only public, free, and open access spaces recommended by healthcare professionals are the PAFES routes, outdoor gyms, and callisthenics areas.

Almost 50% of healthcare professionals claim that the facilities distributed throughout the city are sufficient for prescribing physical activity (see Table 7). Broken down by BHAs, on one hand, the professionals from the PCCs of Torreforta—La Granja (100%), Sant Salvador (75%), Muralles (58.3%), and Bonavista—La Canonja (57.1%) consider the areas with physical activity facilities to be sufficient and close to healthcare centres. On the other hand, nearly 67% of the professionals from the PCC Jaume I (south-central area of Tarragona) believe that there are not enough facilities in that part of the city. It is noteworthy that the professionals at the PCC Tàrraco state they are unaware of whether the physical activity facilities close to the PCC are sufficient for prescribing physical activity (42.9%).

**Table 7.** Equipment sufficiency for prescribing physical activity near the health centre.

PCCs	Yes		No		Do Not Know/No Answer	
	Absolute	Relative	Absolute	Relative	Absolute	Relative
Torreforta—La Granja	3	100.0%	0	0.0%	0	0.0%
Jaume I	2	33.3%	4	66.7%	0	0.0%
Tàrraco	2	28.6%	2	28.6%	3	42.9%
Sant Salvador	6	75.0%	0	0.0%	2	25.0%
Llevant	4	36.4%	4	36.4%	3	27.3%
Muralles	7	58.3%	3	25.0%	2	16.7%
Bonavista—La Canonja	8	57.1%	4	28.6%	2	14.3%
Sant Pere i Sant Pau	5	35.7%	5	35.7%	4	28.6%
Total	37	49.3%	22	29.3%	16	21.3%

In general, 60% of healthcare workers indicate that the equipment near their PCC is adequate (Table 8). The professionals who rate the adequacy of facilities for physical exercise the highest are those from Torreforta—La Granja (100%), Bonavista—La Canonja (71.4%), and Llevant (63.6%). The healthcare workers who rate these facilities the lowest are those working at PCC Jaume I (50%). Meanwhile, one in four professionals is unaware of the adequacy of the physical exercise facilities near their BHA.

**Table 8.** Adequacy of the equipment near the health centre for prescribing physical activity.

PCCs	Yes		No		Do Not Know/No Answer	
	Absolute	Relative	Absolute	Relative	Absolute	Relative
Torreforta—La Granja	3	100.0%	0	0.0%	0	0.0%
Jaume I	3	50.0%	3	50.0%	0	0.0%
Tàrraco	4	57.1%	0	0.0%	3	42.9%
Sant Salvador	5	62.5%	0	0.0%	3	37.5%
Llevant	7	63.6%	1	9.1%	3	27.3%
Muralles	6	50.0%	1	8.3%	5	41.7%
Bonavista—La Canonja	10	71.4%	3	21.4%	1	7.1%
Sant Pere i Sant Pau	7	50.0%	3	21.4%	4	28.6%
Total	45	60.0%	11	14.7%	19	25.3%

## 5. Discussion

It has been demonstrated that physical inactivity is one of the four modifiable risk factors, along with smoking, alcohol consumption, and unhealthy diet, in terms of morbidity and mortality worldwide. Engaging in physical activity provides short-term health benefits [8,27]. Furthermore, Marquina-Márquez et al. [28] emphasise the importance of encouraging the use of non-pharmacological methods and techniques, and researchers such

as Kallings et al. [29] and Thornton et al. [30] explain that one of the actions to promote physical activity is social or exercise prescription.

The prescription of PHAs allows healthcare professionals to connect patients with available assets in the area to improve their health [31]. In this context, the city of Tarragona offers a wide variety of public, free-access physical activity assets distributed across different BHAs for exercise. However, the distribution of these assets is not balanced throughout the city, as evidenced by the results of this study. According to Kohler et al. [32], people with socioeconomic disadvantages are more often insufficiently active, so providing them with accessible facilities would help reduce this inequality. In the case of Tarragona, except for the BHA of Torreforta—La Granja, which has the most assets with a total of 31 zones, other BHAs with lower incomes have fewer assets available: Bonavista—La Canonja has 4 zones, and St. Salvador has 8 zones. This means that the city is not equitable in terms of health, as not all areas of the city are adequately equipped. Furthermore, the PHAs in areas with sufficient infrastructure (Torreforta—La Granja) are less functional than those in the city centre, due to the deterioration of the infrastructure which renders it unusable. However, it is true that, when working with BHAs as a spatial unit of analysis, some PHAs are very close to neighbouring BHAs, making some of these zones more accessible to populations from different BHAs.

Long distances, as well as lack of information, are the main reasons why some communities are excluded from accessing services that could benefit their health [33]. In the case of Tarragona, it has been found that there is good walkable access to all of the city's PHAs for the population, except for some scattered residential areas.

In any case, it would be advisable to incorporate elements that facilitate physical activity for all age groups and reduce the distances that need to be travelled. In this regard, locating PHAs within the community can encourage patients to engage in prescribed physical activity, thereby improving the quality of life of citizens [34]. This approach would align with the 2030 Agenda for Sustainable Development and the global recommendations for health, equity, and urban and social development [5].

Walking is the most recommended physical activity by healthcare professionals to their patients, which can be accomplished freely or by following the PAFES routes available in the city of Tarragona. The difference between the values for the prescription of walking and those for the locations where it can be achieved (PAFES routes) shows that, in many cases, the prescription is not accompanied by recommendations. In other words, while walking is recommended, patients are not informed about the healthy routes of the PAFES programme. Exercises in water such as swimming and aqua aerobics are highly beneficial, but although there are several public pools available, they are not freely accessible, limiting availability for lower-income populations. Nevertheless, this type of exercise could be performed on the city's beaches, thereby promoting equity in access to healthy activities [35,36].

The healthcare professionals surveyed serve a high percentage of the population aged 65 and older. However, only a minority of them prescribe the use of outdoor fitness equipment for physical activity among older adults. These gyms are available in all BHAs except for BHA Tàrraco and are free for the entire population. Considering that health imbalances are increasing in cities and neighbourhoods worldwide and pose one of the greatest challenges to environmental health equity, it is essential to improve and promote the use of public spaces for physical exercise, ensuring that all citizens, regardless of their economic situation, have access to environments that encourage a healthy lifestyle [37,38].

Although health professionals have a protocol for prescribing physical activity, this study reveals a low prescription of physical exercise by healthcare professionals, despite the availability of PHAs in the city. This phenomenon can be attributed to two principal factors. The first factor is the restricted time professionals are able to dedicate to each patient during the consultation, due to the high workloads within healthcare teams [8]. This results in a tendency to prioritise the cure of illnesses over the prevention of disease through the prescription of physical exercise. Secondly, health professionals are frequently unaware of the existence and location of free and public health assets in the vicinity of

their place of work. This may be attributed to the fact that health professionals frequently change the health centre where they are employed, which makes it challenging for them to be aware of nearby resources [8].

In this context, the results of the study could serve as a foundation for designing a tool aimed at healthcare professionals that includes mapping the PHAs. The purpose of this tool would be to encourage the prescription of these assets among the population, as researchers such as Dandicourt Thomas et al. [13] and South et al. [39] suggest that such tools enable health teams to recommend local health facilities to their patients. This mapping and its georeferencing could be available in the social prescription database [11] for healthcare professionals, on a website, or in a smartphone application. Moreover, these tools are particularly useful for healthcare professionals who face time constraints and lack knowledge about the available PHAs in the area, as they allow for informed and efficient decision-making regarding exercise prescriptions. However, it is important to consider that for certain population groups, a paper map may be much more useful than a mobile application [22].

In any case, municipal sports and health policies should be coordinated, jointly contributing to improving the health of citizens by sharing and optimising efforts and resources [7]. It is essential for municipal policies to consider the physical activity needs of their citizens, creating an appropriate offer to reach all individuals [40]. The relevant authorities must recognise the importance of increasing the availability of gyms for older adults, as there are only 14 such spaces throughout the city, and, as previously mentioned, they are not available in all BHAs. Expanding and adapting these spaces to the physical capacities of the older population, considering that their needs may differ from those of younger individuals, would help reduce inequity and improve the quality of life for these individuals. Additionally, a public space of about one hundred square metres is sufficient to build a park with health-oriented exercise equipment, which would allow for placement in city centres, urban parks, or gardens [41].

## 6. Conclusions

The identification, georeferencing, and assessment of the condition of PHAs are key tools for creating favourable environments for physical activity among individuals, especially for older adults.

This study demonstrates that the availability of PHAs distributed across the territory for sports practice not only contributes to increasing equity, accessibility, and the use of these spaces but also provides healthcare professionals with valuable information about the usability and condition of the PHAs. This facilitates the prescription of specific and tailored physical activities, which can lead to a significant improvement in the health and well-being of individuals. Therefore, we strongly recommend developing resources aimed at assisting healthcare professionals in prescribing physical activity by utilising the existing assets in the area.

In order to improve and promote the use of PHAs in Tarragona, it is proposed to create a tool for both the population and health professionals that includes an inventory of all physical health resources in the city, classified according to their suitability for different age groups, and available in both paper and digital formats. In addition, health policies should ensure that all health professionals are aware of all public and free resources near their place of work, have guidelines for prescribing these resources, and provide patients with detailed information on the health benefits of PHAs.

It is also recommended that municipal sports policies (i) include awareness campaigns on the use of physical health assets, (ii) improve the maintenance of these assets, and (iii) implement strategies to increase the use of these health assets, such as hiring a monitor to support users once a week.

A limitation of this study is that it has not been possible to correlate the availability of physical health assets with prescribing by health professionals due to inadequate response rate numbers in some health centres.

As future lines of research relate to PHAs, and given that walking is the most prescribed activity, it would be advisable to evaluate the condition of the existing walking routes and identify their suitability for physical exercise, as well as their adaptation to the different ages of users. Additionally, a detailed analysis should be conducted to verify whether the other available PHAs are suitable for all population groups, especially the most vulnerable, such as older adults.

Finally, it would be of interest to conduct focus groups with professionals from the PCC in the study area to identify the specific challenges they encounter when prescribing PHAs and, if they do not prescribe any, to establish the reasons for this. This aims to explore, from a phenomenological perspective, the perceptions and experiences of healthcare professionals regarding the prescription of physical activity to the patients they attend to. It would also be beneficial to gather the opinions of users of the exercise facilities.

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**Informed Consent Statement:** Informed consent was obtained from all subjects involved in the study.

**Data Availability Statement:** The raw data required to reproduce the above findings are available to download from "[https://osf.io/q259w/?view\\_only=ec7122da45074366b0ce6ada24fb9ce1](https://osf.io/q259w/?view_only=ec7122da45074366b0ce6ada24fb9ce1) (accessed on 4 October 2024)".

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## References

1. Gort, H.M.; Guzmán, C.N.M.; Mesa, T.D.; Miranda, J.A.; Espinosa, F.Y. Caracterización Del Consumo de Medicamentos En El Adulto Mayor. *Rev. Cuba. Med. Gen.* **2019**, *35*, 4.
2. Rice, D.P.; Estes, C.L. Health of the Elderly: Policy Issues and Challenges. *Health Aff.* **1984**, *3*, 25–49. [[CrossRef](#)] [[PubMed](#)]
3. Cintra, C.O.; Balboa, N.Y. La Actividad Física: Un Aporte Para La Salud. *Lect. Educ. Física Y Deportes* **2011**, *159*, 5.
4. Booth, F.W.; Roberts, C.K.; Laye, M.J. Lack of Exercise Is a Major Cause of Chronic Diseases. In *Comprehensive Physiology*; Wiley: Hoboken, NJ, USA, 2012; pp. 1143–1211.
5. Naciones Unidas Objetivos de Desarrollo Sostenible (ODS). Available online: <https://www.un.org/sustainabledevelopment/es/> (accessed on 31 July 2023).
6. Martínez, H.N.; Santaella, R.E.; Rodríguez-García, A.-M. Beneficios de La Actividad Física Para La Promoción de Un Envejecimiento Activo En Personas Mayores. Revisión Bibliográfica (Benefits of Physical Activity for the Promotion of Active Aging in Elderly. Bibliographic Review). *Retos* **2020**, *39*, 829–834. [[CrossRef](#)]
7. Chiner, P.M.; Herreros, J.L.; Beltrán, J.; Marzal, A.C.; Aliaga, A.R.; Blasco-Lafarga, C. Retos y Análisis de Un Programa Municipal de Prescripción de Ejercicio Físico Para La Salud: El Programa VIU-ACTIU (Challenges and Analysis of a Local Program of Exercise Prescription for Health: The VIU-ACTIU Program). *Retos* **2020**, *39*, 993–997. [[CrossRef](#)]

8. Martín-Doménech, A.; Peiró-Pérez, R.; Esplugues, A.; Castán, S.; Legaz-Sánchez, E.; Pérez-Sanz, E. Valoración de Un Programa Piloto de Prescripción de Actividad Física En Atención Primaria En La Comunitat Valenciana. *Gac. Sanit.* **2021**, *35*, 313–319. [CrossRef]
9. Hernán-García, M.; Blanco, D.G.; Llanes, J.C.; Cofiño, R. Fundamentos Del Enfoque de Activos Para La Salud En Atención Primaria de Salud. *FMC* **2019**, *26*, 1–9. [CrossRef]
10. Riera-Sampol, A.; Tauler, P.; Bennisar-Veny, M.; Leiva, A.; Artigues-Vives, G.; De Pedro-Gómez, J.; Pericàs, J.; Moreno, C.; Arbos, M.; Aguilo, A. Physical Activity Prescription by Primary Care Nurses Using Health Assets: Study Design of a Randomized Controlled Trial in Patients with Cardiovascular Risk Factors. *J. Adv. Nurs.* **2017**, *73*, 2191–2200. [CrossRef]
11. Benito, L.R.; Azagra, C.B.B.; Llanes, J.C.; Larrañaga, S.C. Prescripción Social y Recomendación de Activos En Atención Primaria: «el Círculo de Calidad». *Rev. Clínica Med. Fam.* **2023**, *16*, 286–292. [CrossRef]
12. Bonal, R. Prescripción Social, Una Dimensión de La Promoción de Salud En La Medicina General Integral. *Rev. Cuba. Med. Gen. Integral* **2019**, *35*, 1–11.
13. Thomas, D.C.; Bagué, B.A.; Guiza, V.M.N.; Gutiérrez, F.L.M.; Pelegrín, M.R. Prescripción Social y Activos de Salud Comunitaria Para La Promoción de Salud y Bienestar de Las Personas. *Rev. Cubana. Enferm.* **2023**, *39*. Available online: [http://scielo.sld.cu/scielo.php?script=sci\\_arttext&pid=S0864-03192023000100018&lng=es](http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S0864-03192023000100018&lng=es) (accessed on 5 July 2024).
14. Picón, E.B.; González, J.A.; Albert, Y.P.; Morales, J.I.M. Parques Urbanos, Activos de Salud y Personas Mayores. Un Análisis de Justicia Espacial En Los Barrios de La Ciudad de Tarragona. *Cuad. Investig. Urbanística* **2022**, *142*, 59–77. [CrossRef]
15. Morgan, A.; Ziglio, E. Revitalising the Evidence Base for Public Health: An Assets Model. *Promot. Educ.* **2007**, *14*, 17–22. [CrossRef] [PubMed]
16. Harrison, D.; Ziglio, E.; Levin, L.; Morgan, A. Assets for Health and Development: Developing a Conceptual Framework. In *European Office for Investment for Health and Development*; World Health Organisation: Geneva, Switzerland, 2004.
17. Van Bortel, T.; Wickramasinghe, N.D.; Morgan, A.; Martin, S. Health Assets in a Global Context: A Systematic Review of the Literature. *BMJ Open* **2019**, *9*, e023810. [CrossRef] [PubMed]
18. Howarth, M.; Griffiths, A.; da Silva, A.; Green, R. Social Prescribing: A ‘Natural’ Community-Based Solution. *Br. J. Community Nurs.* **2020**, *25*, 294–298. [CrossRef]
19. Cerin, E.; Conway, T.L.; Adams, M.A.; Barnett, A.; Cain, K.L.; Owen, N.; Christiansen, L.B.; van Dyck, D.; Mitáš, J.; Sarmiento, O.L.; et al. Objectively-Assessed Neighbourhood Destination Accessibility and Physical Activity in Adults from 10 Countries: An Analysis of Moderators and Perceptions as Mediators. *Soc. Sci. Med.* **2018**, *211*, 282–293. [CrossRef]
20. Hunter, R.F.; Nieuwenhuijsen, M.; Fabian, C.; Murphy, N.; O’Hara, K.; Rappe, E.; Sallis, J.F.; Lambert, E.V.; Duenas, O.L.S.; Sugiyama, T.; et al. Advancing Urban Green and Blue Space Contributions to Public Health. *Lancet Public Health* **2023**, *8*, e735–e742. [CrossRef]
21. Loaiza, D.P.B.; Álvarez, C.V.; Palacio, N.S. Cartografía Social: Construyendo Territorio a Partir de Los Activos Comunitarios En Salud. *Entramado* **2019**, *16*, 138–151. [CrossRef]
22. Cubillo-Llanes, J.; Botello-Díaz, B.; Gea-Caballero, V.; March, S.; Segura-Benedicto, A.; Hernán-García, M. Activos: De Los Mapas al Territorio. Informe SESPAS 2018. *Gac. Sanit.* **2018**, *32*, 98–102. [CrossRef]
23. Layes, E.S.; Morales, F.; Leivas, J. Implementing Georeferencing in the Decision-Making Process of a Health Care Provider in Uruguay. *Stud. Health Technol. Inf.* **2015**, *216*, 925.
24. United Nations Sustainable Development Goals. Available online: <https://www.un.org/sustainabledevelopment/sustainable-development-goals/> (accessed on 19 September 2024).
25. Instituto Nacional de Estadística Atlas de Distribución de Renta de Los Hogares. Año 2021. Available online: <https://www.ine.es/jaxiT3/Tabla.htm?t=31223&L=0> (accessed on 14 August 2024).
26. Borraz, S.Ö.; Soler, R.S.; Samitier, O.J.; Morales, M.J.I. Història de Tarragona: La Ciutat Actual. In *Geografia i Urbanisme*; Pagès Editors: Lleida, Spain, 2012; Volume 6. Available online: <https://dialnet.unirioja.es/servlet/libro?codigo=739028#volumen162508> (accessed on 28 June 2023).
27. Organización Mundial de la Salud Envejecimiento y Salud. Available online: <https://www.who.int/es/news-room/fact-sheets/detail/ageing-and-health> (accessed on 18 July 2024).
28. Marquina-Márquez, A.; Olry-de-Labry-Lima, A.; Bermúdez-Tamayo, C.; Ferrer López, I.; Marcos-Marcos, J. Identifying Barriers and Enablers for Benzodiazepine (de)Prescription: A Qualitative Study with Patients and Healthcare Professionals. *An. Del Sist. Sanit. De Navar.* **2022**, *45*, e1005. [CrossRef]
29. Kallings, L.V.; Leijon, M.; Hellénus, M.-L.; Ståhle, A. Physical Activity on Prescription in Primary Health Care: A Follow-up of Physical Activity Level and Quality of Life. *Scand. J. Med. Sci. Sports* **2008**, *18*, 154–161. [CrossRef] [PubMed]
30. Thornton, J.S.; Frémont, P.; Khan, K.; Poirier, P.; Fowles, J.; Wells, G.D.; Frankovich, R.J. Physical Activity Prescription: A Critical Opportunity to Address a Modifiable Risk Factor for the Prevention and Management of Chronic Disease: A Position Statement by the Canadian Academy of Sport and Exercise Medicine. *Br. J. Sports Med.* **2016**, *50*, 1109–1114. [CrossRef] [PubMed]
31. Cofiño, R.; Aviñó, D.; Benedé, C.B.; Botello, B.; Cubillo, J.; Morgan, A.; Paredes-Carbonell, J.J.; Hernán, M. Promoción de La Salud Basada En Activos: ¿cómo Trabajar Con Esta Perspectiva En Intervenciones Locales? *Gac. Sanit.* **2016**, *30*, 93–98. [CrossRef] [PubMed]
32. Kohler, S.; Dippon, L.; Helsper, N.; Rütten, A.; Abu-Omar, K.; Birkholz, L.; Pfeifer, K.; Weber, P.; Semrau, J. Population-Based Physical Activity Promotion with a Focus on Health Equity: A Review of Reviews. *Int. J. Equity Health* **2023**, *22*, 18. [CrossRef]

33. Fenny, A.P.; Kusi, A.; Arhinful, D.K.; Asante, F.A. Factors Contributing to Low Uptake and Renewal of Health Insurance: A Qualitative Study in Ghana. *Glob. Health Res. Policy* **2016**, *1*, 18. [[CrossRef](#)]
34. Botello, B.; Palacio, S.; García, M.; Margolles, M.; Fernández, F.; Hernán, M.; Nieto, J.; Cofiño, R. Metodología Para El Mapeo de Activos de Salud En Una Comunidad. *Gac. Sanit.* **2013**, *27*, 180–183. [[CrossRef](#)]
35. Coen, S.E.; Ross, N.A. Exploring the Material Basis for Health: Characteristics of Parks in Montreal Neighborhoods with Contrasting Health Outcomes. *Health Place* **2006**, *12*, 361–371. [[CrossRef](#)]
36. Baker, D. Developing and Implementing a Robust Asset-Based Approach to Public Health. *Perspect. Public Health* **2014**, *134*, 129–130. [[CrossRef](#)]
37. Corburn, J. Urban Place and Health Equity: Critical Issues and Practices. *Int. J. Env. Res Public Health* **2017**, *14*, 117. [[CrossRef](#)]
38. Richardson, E.A.; Pearce, J.; Mitchell, R.; Kingham, S. Role of Physical Activity in the Relationship between Urban Green Space and Health. *Public Health* **2013**, *127*, 318–324. [[CrossRef](#)]
39. South, J.; Coan, S.; Woodward, J.; Bagnall, A.-M.; Rippon, S. Asset Based Community Development: Co-Designing an Asset-Based Evaluation Study for Community Research. *SAGE Open* **2024**, *14*. [[CrossRef](#)]
40. Haggis, C.; Sims-Gould, J.; Winters, M.; Gutteridge, K.; McKay, H.A. Sustained Impact of Community-Based Physical Activity Interventions: Key Elements for Success. *BMC Public Health* **2013**, *13*, 892. [[CrossRef](#)] [[PubMed](#)]
41. Romo-Pérez, V.; García-Soidán, J.L.; Chinchilla Minguet, J.L. Circuitos Biosaludables y Cumplimiento de Las Recomendaciones Sobre Actividad Física Para Mayores. *Rev. Int. Med. Cienc. Act. Física Deporte* **2012**, *12*, 445–458.

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