age UK
Improving later life

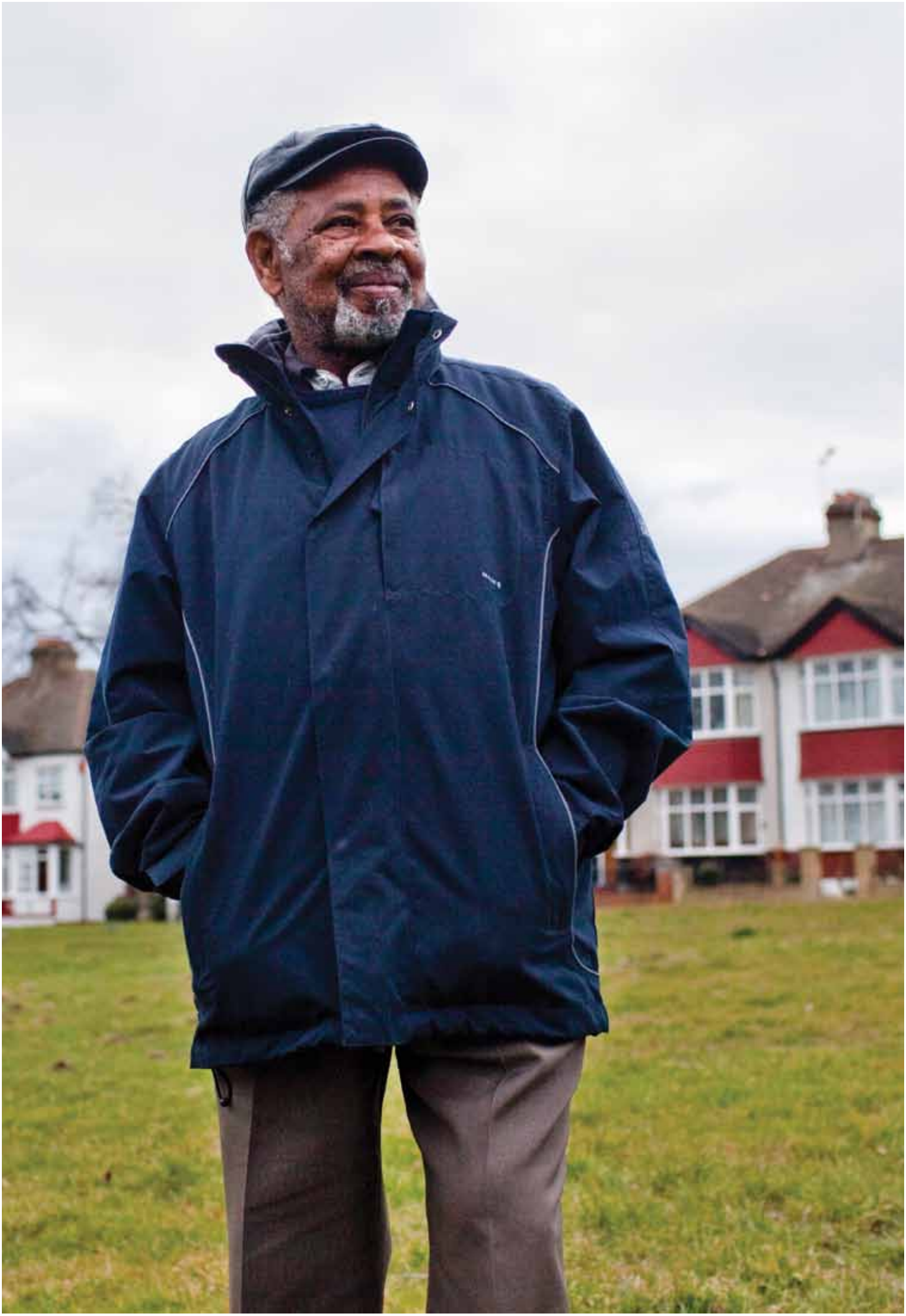
fit as a fiddle

Engaging faith and BME communities in activities for wellbeing

Sporting Equals
Promoting ethnic diversity across sport & physical activity

fit as a fiddle

LOTTERY FUNDED



Contents

1 Background and context

1.1 Introduction and the aims of this guide

Over the last few decades, the UK population has grown, has become older and is becoming more ethnically diverse.[1] The diverse experiences and needs of the UK's black and minority ethnic[2] (BME) population are often defined by other markers of identity such as age, faith, gender, sexuality, disability, marital status, education and socio-economic status. Often these issues play a critical role in relation to how people live and interact with the processes around them.

The issues for older BME communities are heavily interlinked with identity and are often compounded due to poor access to services for a variety of reasons, including language barriers, lack of awareness or information, social isolation, lack of culturally sensitive services and negative attitudes about communities. Sometimes this is about basics such as food, but at other times it may be about a lack of knowledge and respect for religious beliefs and practices.[3]

The particular needs of individuals from BME communities can only be addressed from within structures and systems that pay attention both to the diversity or differences between and within communities and to their shared common experiences.

This guide aims to provide general advice and guidance on how to engage older people from faith[4] and BME communities in physical activity, healthy eating and mental wellbeing activities. This guide draws on learning and best practice from the Sporting Equals delivery of the Fit as a Fiddle faith and community cascade training programme.

The guidance in this document can help service providers to understand some of the complexities encountered when working with BME older individuals in relation to identity and diversity and it offers advice on how to address some of the barriers and provide inclusive services.

An equal society protects and promotes equal, real freedom and substantive opportunity to live in the ways people value and would choose, so that everyone can flourish.[5]

(Equalities Review, 2007)

1.2 Policy background

The 2000 Race Relations (Amendment) Act,[6] subsequently updated by the 2010 Equality Act, places a duty on public bodies to eradicate racial discrimination and promote equal opportunities. Despite this, there is still evidence that ethnicity continues to play a part in influencing the quality of services that older people from BME groups receive.[7,8]

Reasons for this may include:[9]

- barriers to accessing services
- stereotypical ideas about the needs and preferences of older people from BME groups on the part of some professionals
- a lack of suitable, good-quality services.

Older people from BME groups continue to receive poorer treatment from health and social care services; they are also often under-represented among those using services. Barriers to accessing services include lack of information, language difficulties, and differing expectations about how services can help them. Stereotypical assumptions on the part of professionals may also act as a barrier to service use.[10]

A recent initiative by the Department of Health and the NHS is the Equality Delivery System (EDS), which is designed to make improvements for both patients and staff and applies to people afforded protection by the 2010 Equality Act from unfavourable treatment. The EDS is an optional tool, to help organisations review and improve their performance on equality and to assist them to comply with the public sector equality duty. The EDS will also help to tackle age discrimination in the healthcare system as well as other forms of discrimination against older people and is potentially a useful tool for tackling health inequalities and for embedding equality into organisational practice.[11]

Policy makers and practitioners need to ensure that when the diversity of experience of older people is addressed, ethnicity is part of the matrix. Due attention should be given to how older people are engaged in order to identify support needs. Older people from BME groups tend to report poorer health than their white counterparts.[12] Some also report that they experience age-related changes at an earlier age.[13] It has also been suggested that health differences by ethnicity are actually greatest among older people.[14]

However, despite evidence of greater need, for many years there has been a pattern whereby people from BME groups are over-represented among those consulting their GP, but under-represented among those using secondary healthcare[15] or social care.[16]

Government plans[17] aim to transform the way in which services are provided in order to raise standards and increase choice. Organisations responsible for planning local health and social care services will not be able to achieve this without a clear understanding of the needs and preferences of the communities they serve.

Inequalities in health are multifactorial; they are influenced by issues such as environment, housing, educational achievement, material wealth, discrimination and lifestyle and are commonly referred to as the wider determinants of health.

One study[18] looking at social care providers in four parts of England that historically have not had large numbers of older BME residents found that staff highlighted the challenges of providing culturally sensitive care. Reasons for this included their own lack of knowledge, and the absence of an infrastructure for these communities to contribute to planning and providing services or advocating on behalf of BME older people.

As such, reducing health inequalities cannot take a 'one size fits all' approach and requires a multitude of efforts across different layers of society, engaging a wide variety of stakeholders. These stakeholders range from government level through local statutory level and local voluntary sector level, to grass-roots community level. All can contribute to an individual's good health.[19]

Improving uptake of services among BME older people is sometimes described as needing a 'whole systems' approach.[20] This involves partnership approaches that involve all concerned in the decision-making process and working with others to raise accountability and share resources. The process should ensure that service providers do not make assumptions that all members of the same ethnic or religious community have the same needs.[21]

We hope that this guide can be used as a resource for both service providers and practitioners to help deliver change.

1.3 Equality and diversity

Equality is about developing our practices and actions, so that people feel included and valued and can participate practically in the projects we offer. Equalities work also addresses discrimination: tackling barriers systematically and creatively, so that all individuals eligible for services and activities benefit from what we offer.

Diversity focuses on difference: valuing and celebrating the differences between people and working positively with them to bring about change, integration and cohesion. Diversity is an important principle for equalities work.

It should be recognised that we do not all have the same needs, therefore treating everyone identically will not further equality, and that each individual's situation is constrained by barriers, structures and processes.[22]

An equal society recognises people's different needs, situations and goals and removes the barriers that limit what people can do and can be.[23]

(Equalities Review, 2007)

The 2010 Equality Act replaces previous anti-discrimination laws with a single Act to make the law simpler and to remove inconsistencies. The Act also provides strengthened protection in some situations and sets out the different ways in which it is unlawful to treat someone, such as direct and indirect discrimination, harassment, victimisation and failing to make a reasonable adjustment for a disabled person.[24]

The Equality Act provides protection against discrimination and unfair treatment in relation to nine protected characteristics. Every person has one or more of the protected characteristics, so the Act protects everyone against unfair treatment. The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.[25]

Equality and diversity are becoming more important in all aspects of our lives and work for a number of reasons. We live in an increasingly diverse society and need to be able to respond appropriately and sensitively to this diversity. The people you will be working with will reflect this diversity and may be of different gender, race, ethnicity, disability, sexuality, religion or age.

BME older people will come with different life experiences, values and cultures, which often need recognition and empathy. Often these experiences must be understood to help effect change. Effective implementation of equality and diversity in all aspects of your work will ensure that older people feel valued, motivated and fairly treated.

1.4 Demographics

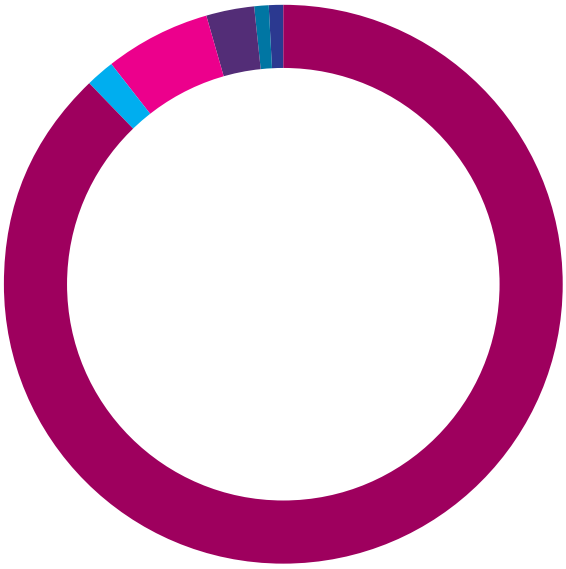
Ageing and ethnicity

The latest Office for National Statistics (ONS) figures suggest that people from BME backgrounds currently make up approximately 12 per cent of the UK population.[26]

The population of the UK is growing in size and becoming increasingly older. The growth in the older population largely reflects the ageing of those people resident in the UK and this trend is likely to continue into the future. In 2007 there were about 9.8 million aged 65 or over in the UK, but by 2032 this number is projected to be as high as 16.1 million.[27] Population ageing brings about a new set of challenges to society in light of health, cost and dealing with diversity.

The age profile of different ethnic groups varies, with most BME groups having a younger age structure than the White British population (see Figure 2). The White Irish group has the greatest proportion of people over the age of 65, followed by the White British and Black Caribbean group. However, there are also sizeable proportions of older Indian, Asian Other, and Chinese groups between the ages of 50 and 65. While proportions of ethnic minorities are still small at older ages, the ethnic composition of the older population is beginning to change in light of past immigration trends in the 1970s and 1980s from Pakistan, Bangladesh and China.[28]

Figure 1 **ONS population estimates by ethnic group, 2009**



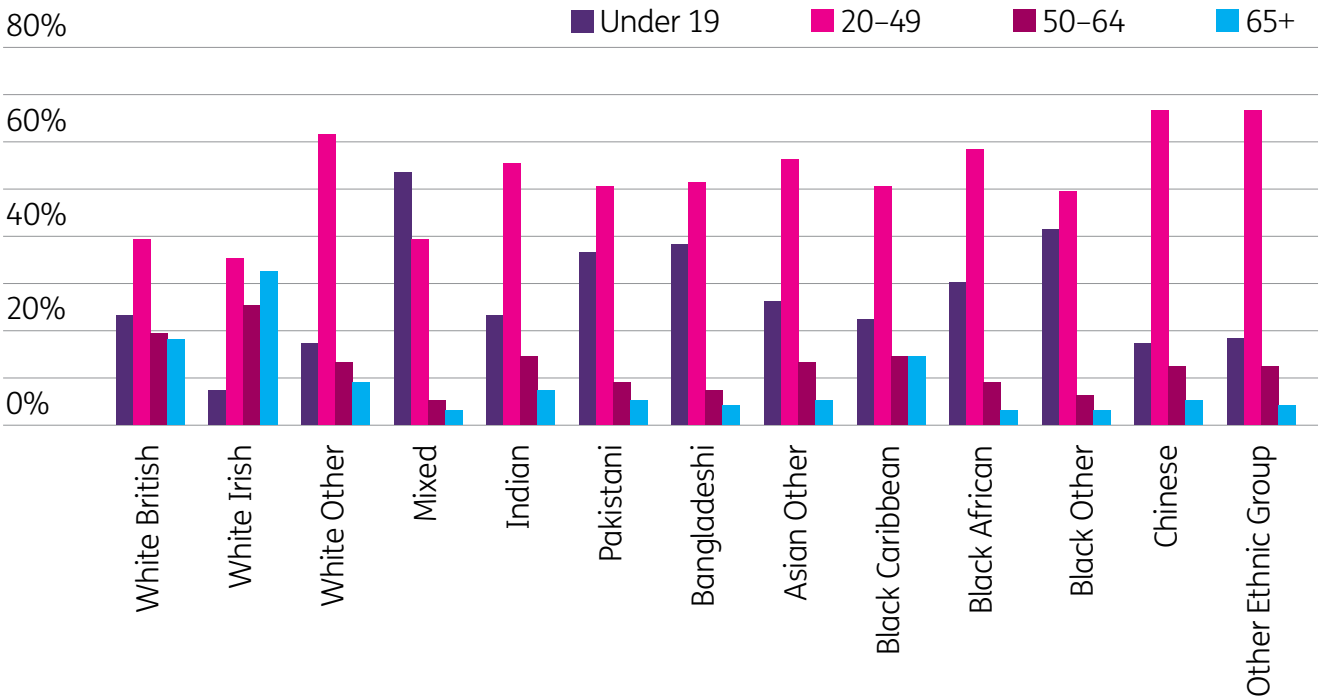
The older age profile of the Indian and the Caribbean groups is also closely tied to migration and settlement patterns of people from these communities who arrived in Great Britain as young adults in the 1950s and 1960s. In addition, the Indian and Black Caribbean groups also have a higher proportion of people in the 50–64 age groups. This has major implications for policy and practice development, as this age group will swell the ranks of over-65s in the near future.[29]

Of the nine government regions of England, London has the greatest amount of non-Christian faith-based groups, with the North East having the least amount. The highest percentages of BME groups are situated in London, the West Midlands and the South East, followed by the North West, Yorkshire and the Humber, the East of England, the East Midlands and the South West, and finally the North East. This highlights significant differences in population dispersal of BME groups, which will have an impact on how engagement is carried out.[30]

Overall BME older individuals:[31]

- are concentrated in large urban areas such as London and the West Midlands, which have high levels of unemployment and deprivation
- have lower pensionable incomes than the majority of their peers
- are more likely to be living in low-income households in poorer quality and overcrowded accommodation
- are more likely to suffer poor health and to suffer from a range of debilitating conditions.

Figure 2 **Age structure for different ethnic groups – England**



Source: ONS mid-2009 experimental statistics

Refugees

Refugees are classed as those who have fled persecution in their country of origin, regardless of whether they have been granted refugee status or not. A report produced by the Refugee Council in 2006[32] stated that refugees may become physically and/or mentally frail at an earlier chronological age due to experiences in their country of origin, en route to the UK or after arrival.

Experiences and needs are also different for recently arrived older refugees and/or their dependants, compared with refugees who have grown old in the UK. Illnesses found among refugees, such as high blood pressure and strokes,[33] are assumed to be caused by both past experiences and specific difficulties faced in the UK, such as language barriers and racism.

Isolation is also a consequence of restricted mobility, which tends to affect older people in particular. Often refugees are housed in areas with high crime rates, leading to fear and safety issues, which reduce their mobility and increase their health problems.[34]

New and emerging communities

Freedom of movement within a recently enlarged Europe is bringing migrants to a greater variety of areas in the UK. The settlement pattern of the new European migration extends far beyond the multicultural urban areas that have existing immigrant populations. Migrants from the accession states are moving to many rural areas for jobs and to areas that are not used to population change.[35] New migrant communities often have few social or cultural similarities to longer-established BME groups.

Net migration has become much more significant over the last ten years and is expected to form about half of population growth up to 2030. About 800,000 workers from new European Union (EU) states have registered for work in the UK. Many have only stayed short term, but aspirations about staying in the UK may be changing.[36]

EU migrants tend to be mainly people without families – usually single, less often in couples, and sometimes with family left at home. Migrants are slightly more likely to be male than female and most likely to be young adults. Studies also show that, of the Accession 8 nationalities, Polish migrants are more established and more likely to have family members of older age.

1.5 Health and ethnicity

Evidence suggest that rates of mortality and ill health tend to be worse in BME groups compared with the general population and that their health problems are often more severe. Health inequalities may result from many different interlinking factors such as genetics and lifestyle. However, research suggests that much of the difference can be attributed to the fact that BME groups are generally poorer than the ethnic majority.[37]

The national survey research *The Health of Britain's Ethnic Minorities*, led by the Policy Studies Institute, revealed some stark differences between health and the health experience of BME individuals and that of non-BME groups. The main findings revealed that the health and wellbeing of individuals from BME backgrounds is likely to be poorer than that of white people. Pakistani, Bangladeshi and African Caribbean individuals are the poorest groups in the country and have the poorest health.[38]

BME groups also suffer from what is known as health inequalities, for example type 2 diabetes is up to six times more common for African and African Caribbean communities; death rates from heart disease are two to three times higher in those of South Asian descent; while death rates from stroke are three times higher in those of African and African Caribbean descent.[39]

People over 65 from 'Asian' and 'Black' ethnic categories are disproportionately affected by poor health and high rates of life-limiting illness and have an increased risk of becoming dependent on others as a result of disability.[40]

Some black people experience particular barriers in accessing services as a result of their life experiences. Studies of older refugees suggest that people in their 50s and 60s often have health problems typical of much older people as a result of trauma and physical injuries experienced in their country of origin combined with stress, poverty and barriers to accessing healthcare in the UK.[41]

Reasons for health inequalities may be as a result of a combination of factors, including socio-economic deprivation; genetic risk factors; displacement and mobility; discrimination and racism; language, communication and literacy; cultural and religious influences on behaviour (including physical activity and food choices); the role and status of women; and access to services.[42]

The following case study, put together through the Sporting Equals Fit as a Fiddle project, demonstrates the key health inequalities in relation to poor health, communication, literacy, confidence and culture.

Walking is a positive way to boost activity levels and wellbeing in later life

CASE STUDY

Mrs Shah, a 64-year-old South Asian female in the Midlands, was overweight and suffering from depression. She had been diagnosed with depression six months ago and had been prescribed tablets. Her mistaken belief that her treatment was completed at the end of her batch of tablets aggravated her condition.

Through the Fit as a Fiddle project, Mrs Shah's volunteer supported her in making an appointment with her GP to discuss her problems. Her GP also encouraged her to become active as a way of reducing her depression.

With the support of the project, Mrs Shah has taken part in joining other women in walking to the park, gentle exercise and tai chi. She has also been shown how to navigate the British Heart Foundation website to access diets and tips to help maintain good health.

Mrs Shah was also given information and advice on healthy eating and attended a healthy cooking session. Mrs Shah is now feeling better in herself, likes the gentle exercise and walking, and enjoys the company, but she does not yet feel confident enough to do any of the activities without the support of others.

Mrs Shah commented: 'I feel healthier and like the social side. I like the idea of having fun while at the same time getting healthier. I prefer structured classes but have also started to maintain gentle exercise at home too.'.

1.6 Cultural, ethnic and religious identity

Culture, ethnicity and faith are all important elements in how BME communities perceive themselves and relate to others. With age, these issues become more pronounced. Everyone has a cultural identity whether they are religious or not. It is important that culture and religion are recognised as two separate issues, especially when planning and delivering services to older BME individuals.

The 2001 Census found that Christians accounted for 71.7 per cent, Muslims for 3.1 per cent, Hindus for 1.1 per cent and Sikhs for 0.7 per cent of the population of England. In total, there were 1.5 million Muslims, 546,000 Hindus and 327,000 Sikhs. Muslims, Hindus and Sikhs are largely South Asian. Hindus and Sikhs are overwhelmingly Indian in origin while Muslims are much more ethnically diverse.[43]

By faith, the oldest on average are the Jewish and Christian groups, while the Muslim population has the youngest age profile. The average ages of Hindus and Sikhs are substantially greater than that of Muslims. While there are broadly equal numbers of males and females of the Sikh religion, males outnumber females in the Muslim and Hindu religions. While more than half of the Sikh population were born in the UK, less than half of Muslims and only 37.5 per cent of Hindus were born in the UK.[44]

Religious constraints, such as covering the head in Islam and wearing the turban in Sikhism, along with issues of dress modesty and the carrying of religious symbols, need to be considered to ensure that older BME individuals feel comfortable in their environment and that these issues do not become barriers to physical activity or access to healthcare.

Services need to be organised so that cultural preferences, such as the gender of a worker, can be accommodated as far as practicable. It is important to set out what is appropriate for each community, and for each individual, but services should:

- be aware of cultural differences
- avoid making culturally specific assumptions
- ask people how their needs can be met in an appropriate way.

The majority of older BME individuals choose to live in areas where there are others from the same community, with appropriate cultural and religious facilities nearby. This has an impact when considering physical activity facilities and exercise within BME geographical areas.[45]

1.7 Barriers to engagement

Sporting Equals research has identified two types of barriers that impact on how BME older people relate to physical activity.[46] These are shown in Table 1.

Table 1 **Barriers to engagement**

Intrinsic barriers	Extrinsic barriers
Relate to an individual's beliefs, motives and experiences concerning physical activity.	Relate to the broader physical activity environment, skills and attitudes of others and the types of opportunity available.
• Myths and perceptions about old age being a period of rest • Religious concerns about dress, segregation and prayer times • Previous bad experiences of service provision • Family advice that being active is not culturally appropriate for older people, particularly women, or they can only do certain things • Lack of confidence • Fears of overdoing it and safety concerns about risk of falls and injury • Absence of older BME role models from within the community • Stereotypical images of ageing • Lack of understanding about how being active can support wider health benefits	• Relate to the broader physical activity environment, skills and attitudes of others and the types of opportunity available. • Type of activities BME older people may prefer to get involved with • Access/location may be problematic for some BME older people who find it difficult to use public transport • Sport and recreation policy is often not culturally inclusive to the needs of BME older people • Skills and attitudes of instructors may lack empathy • Lack of support within the wider community, as physical activity seen as not appropriate for an older person's lifestyle • Cost of activities may put off people on low incomes • Lack of culturally appropriate facilities/settings

Organisations need to work with BME older people to help overcome the intrinsic barriers that result from fear, uncertainty and lack of education. Often volunteers can be a useful support mechanism for older people and can help break down barriers and give older people the confidence to address some of these issues and try new things. The idea of using volunteers as a support mechanism is explored further in this guide in relation to the Sporting Equals Fit as a Fiddle project.

The extrinsic barriers need to be dealt with directly by organisations through ensuring that services are made more accessible. Staff need to be receptive to cultural sensitivities, and internal policies should promote diversity and the need to treat everyone as individuals.

1.8 Exploring diet, physical activity and mental health from a cultural perspective

Diet

There is enormous diversity of culture, tradition and dietary habits both across and within different BME groups. Western influences on diet have affected traditional eating patterns to a considerable extent but many older people still retain their traditional eating practices, for example Bangladeshi men and women are more likely to eat both red meat and fatty foods and are less likely to eat fruit than any other BME group.[47]

Dietary practices, particularly within the South Asian community, are also heavily influenced by religious practices (e.g. fasts and festivals) and beliefs (e.g. food restrictions and religious laws). Certain faith-based groups do not eat poultry, fish and meat products. To combat this, a diet rich in fruit and vegetables and low in saturated fats, sugar and salts can give the right balance for a healthier lifestyle.[48]

The intake of ingredients in diets is important, but even more important in some cases is the method used to prepare or cook the ingredients. Most ethnic groups will often use raw ingredients to prepare foods, but oils, fats and preparation methods can often lead to unhealthy diets, for example the practice of adding a lot of salt to cooking is common among many South Asian, Chinese and Black Caribbean groups.

Often BME communities have a very poor awareness of what they are consuming and the related nutritional information for certain foods and diets. For some older BME individuals, cooking is done by other members of the household using traditional recipes.[49] There is therefore a need to educate older people and the wider family about healthier lifestyles and diets.

There are a number of recommended changes to traditional diets. For all faith groups, reducing the amount of salt, lessening the intake of saturated fats that can be found in ghee, butter, fatty meats and full fat diary products, and limiting the amount of fried food such as samosas, pakoras, gatya and kachoris can reduce the risk of heart disease. Limiting the amount of sugary and fatty foods will have a positive effect on obesity levels.[50]

It is important to offer group activities and advice on food, diet and how to create diverse menus in order to help encourage BME older people to learn new ideas about how to cook healthily, based on the food and recipes they know.

Physical activity

Over the last decade, the benefits of regular physical activity have become widely recognised in preventing chronic disease and promoting health and wellbeing, including being endorsed for a number of specific health conditions in the National Institute for Health and Clinical Excellence (NICE) guidance.[51]

A report produced by the Department of Health in 2004 noted that adults who are physically active have up to 50 per cent reduced risk of developing diseases such as coronary heart disease, stroke, diabetes and some cancers.[52]

The level of physical activity undertaken varies across different ethnic groups. Pakistani and Bangladeshi communities have the lowest levels of sport participation rates, contributing to greater health inequalities, and over half of people in the BME demographic do little or no sport.[53]

Having the opportunity to enjoy exercise, sport and recreation is vital to the health and personal development of all individuals, regardless of gender, physical ability, cultural background, age or socio-economic status. However, for many BME older individuals, lifestyle choices are often restricted by a poor understanding of what they should be doing as well as the lack of confidence to get involved.

For many older people with a strong religious allegiance, participation in sport and activity may be problematic due to the requirements of their faith, particularly with regard to single-sex provision and the appropriateness of clothing. It is therefore important that consideration is given to the provision of single-sex activity and that older people are allowed to wear traditional dress or other clothing they feel comfortable with.

Diverse BME communities may have different views and cultural preferences relating to the types of exercise they wish to get involved with. An Australian study by Monash University found that Italian, Greek and Jewish participants considered exercise to be a range of energetic activities, whereas the Indo-Chinese group considered gentler activities more appropriate for their age group.[54]

Previous research has shown that motivation to exercise is substantially increased when exercise is recommended by health professionals, particularly doctors. Barriers such as language, sedentary behaviour, fear of injury and change of routine should be considered for future implementation of exercise activity.[55] Consult on the type of exercise activity to ensure correct cultural fit and appropriateness. Also consider culturally competent venues and exercise settings in light of the types of BME groups you are working with.

Often a native-speaking instructor or a buddy can help provide structure and continuity as a good way to help those older individuals who do not like being active. A bit of reassurance and making the experience fun can be a great way of reaching out to the most isolated groups.

Mental health

There are specific mental health concerns for older BME adults. For example there is a higher percentage of dementia and depression within BME communities.[56] Many cultural groups fail to recognise dementia as an illness and tend to attribute dementia to simply growing old.

Studies document the lack of support and the isolation and loneliness felt by BME older people. One study noted that although Asian older people were more likely to live in large households, it did not mean that Asian older people were actively involved in household life. Research also suggests that even within the extended family setting, there was often conflict and loneliness.[57]

There is a deep-rooted misunderstanding of mental health problems that is passed from generation to generation. BME individuals with mental health problems battle to get the right professional support and treatment while also struggling with ingrained attitudes that promote stigma, discrimination and isolation.[58]

In some cases older people from different ethnic groups have a shared understanding of the causes of depression, but they have differing ideas about strategies for dealing with it and their preferences for medication or counselling. The existence of stigma, particularly about mental health problems in old age, may also be greater in some communities than others.[59]

Physical activity has consistently been shown to have a positive effect on various measures of mental health. Most well-documented are the effects of walking in improving depression, reducing anxiety and improving mood.[60]

Lifestyle changes that incorporate exercise can improve physical and mental functioning, benefiting the quality and duration of life across all sub-groups of the older population.[61] It is therefore important to introduce physical activity and exercise into older people's lifestyles as part of wider measures for achieving mental wellbeing.[62]

2 Fit as a Fiddle good practice and learning

2.1 Sporting Equals Fit as a Fiddle Faith and Community Strand

Sporting Equals was commissioned by Age UK in August 2009 as one of five national partners for the Age UK Fit as a Fiddle cascade training programme to deliver the Faith and Community Strand. Sporting Equals is an independent body developed to promote ethnic diversity in the area of sport and physical activity.

The aim of the Fit as a Fiddle Faith and Community Strand project was to devise and develop a tailor-made training package to support volunteers to work with BME and faith communities in order to enable opportunities for physical activity and wellbeing through supported interventions. The training model was called Moving Moments and was initially piloted in the Midlands before being rolled out nationally.

Sporting Equals engaged with organisations in each geographic region, enabling 289 volunteers to participate in specialist training across 39 local, community-based organisations. Through the project, Sporting Equals engaged with over 5,200 older beneficiaries from BME communities enabling greater outcomes for health and wellbeing.

This good practice guide draws on learning from this project and other similar Age UK interventions that have also had an impact on the lives of BME older individuals.[63]

2.2 Key learning

Healthy eating

The Faith and Community Strand cascade training sought to raise awareness of specific dietary issues for a range of BME communities, with an overall message that older people tend to eat too much saturated fat, sugar and salt and not enough dietary fibre or fruit and vegetables each day. A key aim was to improve awareness of natural ingredients, preparation techniques and portion control.

Religious and cultural issues often heavily influence the diets of those from a BME background. Older people may hold traditional views of how food should be prepared and cooked, and often education about the benefits of healthy eating is necessary before people will welcome change.

It has been an eye opener for some older people as they did not know some of the risks associated with their lifestyle.

(Co-ordinator, BME Network, Middlesbrough)

Activities offered by the partner organisations included looking at healthy cooking methods, food hygiene, and specific diets for common illnesses such as diabetes and heart conditions. This advice was linked to how cultural diets can be modified to healthier alternatives.

Staff in partner organisations also commented that the impact of healthy eating activities had resulted in some older people thinking beyond the meal content to wider issues relating to diet and health.

Members are happily enjoying their attendance at the Luncheon Club and being involved in activities. There is much discussion about food and exercise in maintaining the benefits of wellbeing.

(Watford African Caribbean Association)

TOP TIPS

- Raise awareness of natural ingredients, particularly the use of fat and ghee and portion control.
- Introduce healthy cooking methods, food hygiene, and specific diets for illnesses such as diabetes and heart conditions and link this to cultural diets.
- Introduce more fruit, vegetables and healthily adapted recipes linked to country of origin.
- Try to get the older person to be mindful of shopping habits and what is purchased.
- Diet is an important part of religion, and vegetarian or alternative options such as 'halal' food should be provided.
- Events should be planned around major festivals, fasting periods and religious days.
- Advise BME older people to flavour food with herbs and spices when cooking, rather than adding salt.

Physical activity

A wide range of physical activity and exercise sessions were offered by partner organisations taking part in the Fit as a Fiddle Faith and Community Strand. The variety of activities delivered in the programme ranged from sport and keep fit exercises to less strenuous strength and balance activities, such as tai chi and chair-based exercise.

The older people have formed good relationships with the volunteers. Those who have been reluctant to take part are now willingly participating in the activities and they appear to be enjoying themselves more and more.

(Capita)

Projects through Fit as a Fiddle made small changes to people's daily routines by introducing small ideas such as walking to the bus stop, walking trips to the library, seated exercise to music, etc. Projects reported that once a few people started taking an interest, others also got involved.

As a result of taking part in the exercise classes, participants have improved flexibility and are generally feeling better. Participants have experienced improvement in health conditions such as arthritis and have been encouraged by seeing their own progress.

(Co-ordinator, Stratton Street Community Centre)

Religious and cultural issues often influence whether people are comfortable in taking part in sport and exercise activity. It is important to recognise the complexities and differences within faiths and cultures and to consult with groups before carrying out activity. Some women are not comfortable with carrying out activity with men present and therefore separate sessions may need to be organised.

TOP TIPS

- Incorporate exercise as part of daily activities and make small changes to routines.
- Start with less demanding activities and build up as you go.
- Link religious teachings to promote health benefits in light of body and mind.
- Involve places of worship in promoting physical activity and exercise.
- Highlight the benefits of physical activity in community languages in light of weight loss, feeling healthier and easing stress.
- Be culturally sensitive to older people's needs concerning dress and segregation, particularly when carrying out activities, changing and showering.
- Adapt activities to take account of culture and faith.
- Offer women-only sessions and female coaches and instructors.
- Respect issues of modesty, to allow the head to be covered and participants to wear outfits they feel comfortable with.
- Be aware that fasting is practised by most religions in different ways (this may result in dehydration and low sugar levels).
- Get buy-in for exercise from doctors and health professionals.
- Account for different perceptions of exercise, e.g. Chinese groups may consider gentler activities as more appropriate for their age groups.
- Involve BME older individuals in planning, marketing and implementing exercise.
- Go to places where older BME groups feel most comfortable rather than expecting them to come to you.
- Use music from the culture of the older adult participants to forge connections with the activity and create a more pleasurable experience.
- Offer physical activity sessions with a buddy to provide support and encouragement.

Mental wellbeing
Partner organisations offered a range of activities designed to impact on mental wellbeing. The physical activity and healthy eating sessions offered as part of the Faith and Community Strand were seen as directly linked to achieving outcomes for mental wellbeing. For example gentle exercise or relaxation through yoga, alongside changes to diet to increase intake of valuable nutrients, has led to a positive difference to mental wellbeing.

The volunteers have been facilitating a variety of activities centred on health and wellbeing. They now run a crafts and exercise session and the training has helped to embed the idea of keeping wellbeing and life balance at the forefront of their minds.

(Co-ordinator, Movers and Shakers)

Partner organisations reported that the activities successfully encouraged participants to come out of their comfort zone to join in learning and get involved with other people.

Although there was a high level of dementia among the group, participants who would normally sit quietly in a corner would suddenly come alive and become more alert when these sessions were on.

(Co-ordinator, Black Elderly Group, Southwark)

People of Asian origin felt that learning about healthy lifestyles was very important, but that mental wellbeing was of even greater importance, particularly among older Asian men and women who were perceived to be isolated and to have limited social interaction outside family life and religious gatherings. In particular, it was felt that giving this opportunity to participate in new activities would allow them to build a new network of friends and acquaintances and would contribute significantly to their overall wellbeing and that of the wider community.[64]

TOP TIPS

- Offer opportunities for shared experiences, reminiscences and activities to keep the mind active, e.g. social walking groups.
- Introduce opportunities for social interaction and activity and try to link this to places of worship.
- For people with language difficulties, use volunteers who speak the same language to help support them.
- Offer befriending opportunities to help develop confidence and self-assurance, particularly for BME women.
- Link some type of physical activity into daily routines to help support wellbeing.
- Connect the mind/body movements through activities such as yoga and tai chi to enable older adults to relate to both physical and mental wellbeing.

OTHER GENERAL TIPS

- Involve elders, professionals, carers and families.
- Respect the need for prayers during certain times in the day and make available a room for this.
- Support classes in the language from the country of origin and provide interactive ways of communication.
- Use peer education by motivating elders to take up physical activity.
- Build rapport with communities and community leaders and other key members of the community to help disseminate information.
- Develop greater signposting and distribution of information through culturally appropriate venues such as mosques, community centres, etc.
- Provide peer information that is appropriate and not patronising.

2.3 Case studies from Sporting Equals Fit as a Fiddle projects

CASE STUDY

The Irish Community Garden

Sporting Equals partnered with the Coventry Irish Society to successfully deliver the Moving Moments cascade training programme to seven of their volunteers. Activities organised by the volunteers included walking groups, aqua aerobics for women, boccia, and healthy eating initiatives. One of the successes of the project has been the opening of an allotment, which has contributed to healthy eating, exercise and wellbeing.

With the allotment, it has been great to see people outside enjoying themselves in the fresh air

Tommy was motivated to help set up Gort no Mona, the Irish Community Garden. 'When we first started working on the site in April, it was overgrown and neglected. With the help of several Fit as a Fiddle volunteers and service users, the land has been transformed into a fruit and vegetable garden providing fresh and organic produce to members. Our potatoes are especially tasty.

'People are starting to buy produce from the allotment and using it to make home-made soups and stews rather than buying ready-made meals. With the allotment, it has been great to see people outside enjoying themselves in the fresh air while getting exercise and learning about fruit and vegetables.

'We have also made new friends and are enjoying the opportunity to socialise while keeping healthy. I feel fantastic, I'm always occupied now and the allotment keeps me healthy.'

CASE STUDY

Tai chi for the community

Through the Fit as a Fiddle project, Sporting Equals trained eight volunteers from the BME Network to help support the local BME community and encourage healthier lifestyles. The volunteers supported the BME Network and worked in partnership with the Tees Valley Chinese Community Centre to develop and support tai chi sessions for older Chinese community members living in sheltered accommodation close to the centre.

The ladies have experienced wider health benefits while also making new friends and learning about different cultures

The sessions engaged mainly Chinese elders, but a number of older people from the South Asian community were also encouraged to attend the sessions. Despite obvious language barriers, both communities were able to participate in the activity often using hand signals, broken English and a lot of laughter to get their messages across. The intergenerational volunteers helped the integration process and are now involved in setting up a similar initiative at another centre.

Idrees, the Project Manager, explained, 'The ladies look forward to their weekly activity and the opportunity to socialise and we have brought two very different communities together. By carrying out activities regularly, the ladies have experienced wider health benefits while also making new friends and learning about different cultures. The project has definitely raised awareness of the need for healthier lifestyles. Volunteers have gone on to put together a community awareness health event that all the ladies will be attending.'

2.4 Examples of regional good practice

Engaging BME older people in physical activity

CASE STUDY

Cronkshaw Farm project

The Eastern Lives Cronkshaw Farm project was set up to focus on health and wellbeing in Haslingden, in the area of Rossendale. The aim of the project was to enable BME older women to lead healthier lifestyles. Two Pushto housewives with limited English were recruited as volunteers to support a four-month programme to engage local Bengali, Pushto and Punjabi older ladies to lead healthier lifestyles. The three groups, however, spoke diverse languages and no English, which created additional challenges for engagement.

The volunteers knocked on residents' doors and spoke to their family members about the benefits of the older women taking part in the project. Flashcards were made with colourful pictures to illustrate what was appropriate for a walk to discourage the ladies from wearing unsuitable clothing or footwear.

One lady expressed, 'I have been living in the area for over 40 years but never realised I had so much beauty at my feet. I wait for every Wednesday, I find it so relaxing. Even though us ladies live in the same area, because of the language barriers we never acknowledged each other, but now even though we don't talk much our facial expressions and gestures communicate.'

CASE STUDY

HOPE women's yoga project

Fit as a Fiddle, in partnership with Gravesham Council and the GHS Gurdwara Sikh Temple in Dartford, has supported free yoga sessions for members of the local community. The sessions were led by Manju Singh, an experienced yoga teacher for 30 years. The activity was requested by the local community and targets women in the area, who have little provision currently for physical activity. Sessions begin with a gentle warm-up and build up into more strenuous exercise. Manju explains each technique and stresses the importance of each member only doing what they feel comfortable with.

Sessions last one hour, but afterwards refreshments are provided and half an hour is allocated for members to socialise. As the weeks have progressed so has the size of the group. At the last session there were 30 members, with more new members expected the next week. Such has been the success of the group that members from a wide area are now attending from all over the Dartford district and there is the possibility of running similar groups in other areas.

CASE STUDY

Newham Nordic Walking project

In Newham's Fit as a Fiddle project, Nordic Walking has been one of the most popular activities with all ethnic groups. After completing their walk leader training, the trained instructors first delivered to a group of Asian women who had been part of a Fit as a Fiddle cookery course.

In Newham's Fit as a Fiddle project, Nordic Walking has been one of the most popular activities with all ethnic groups

The Nordic Walking led on from this: engaging the group in healthy eating first was important to building trust and it was felt that if Nordic Walking had been offered first, this certainly would not have worked as well in developing such participation.

There were practical considerations involved in the planning of the project. Some of the women wore saris so they had to be helped to position the poles so that they did not place them on their saris and trip up. All members of the group had diabetes, which is very prevalent in this community, so the organisers had to make sure that there was always a toilet nearby. Language was also an issue for consideration. One of the women from the group, who spoke quite good English, was identified and trained by the project staff to become a walk leader, and she also translated for them. If they had asked her to be a 'volunteer' or 'leader', she would not have had the confidence to do this, but they approached it very 'softly softly' with her, and now she is able to lead a small group. This was perceived to be a cultural barrier due to older Asian women's view of their role in society and being uncomfortable with the idea of 'leading'.

Engaging BME older people in healthy eating

CASE STUDY

Healthy eating for the Jewish community

Age UK Hackney worked with older women from the Charedi (Orthodox Jewish) community in partnership with Senior N'shei, which enabled them to run bi-monthly sessions supporting up to 32 older women.

The Stamford Hill area in Hackney has the largest population of Charedi Jews in Europe, estimated at around 20,000, and the community is very self-contained, living in strict accordance with the Torah and its laws. The group used their own facilitators to run the sessions, as dietary laws are very important to the Charedi community. This was the most effective way of ensuring that older people from this community could access the project.

Each session had a different theme, mainly based on encouraging people to make healthy choices, increase the amount of fresh fruit and vegetables eaten, and gain a better understanding of the importance of a healthy diet in controlling high blood pressure and preventing diabetes. In addition to bread making, choosing a healthy breakfast and healthier Shabbat dishes, the sessions also included ways of reducing the amount of fat and salt in diets. Although the sessions have now ceased, the group will continue to incorporate healthy eating into their meetings.

CASE STUDY

Healthy South Asian cooking

The Fit as a Fiddle networks in the south-east worked in partnership with a local Indian Community Centre to provide healthy South Asian cooking for the community. The project used a local cook with extensive knowledge and experience of cooking South Asian cuisine to demonstrate cooking techniques and to encourage the eating of healthy foods. Group members got involved in food preparation and cooking activities. Each participant was provided with a copy of the British Heart Foundation Healthy Meals, Healthy Heart Asian recipe book as well as other healthy eating pamphlets to encourage them to try new healthy recipes at home. Each week the group members decided on the menu for the following week, allowing personal tastes to be catered for. This approach also allowed the participants to take ownership of the group.

One participant commented: 'I already cook a lot of Asian foods but to see how to cook food in different ways was quite good. I have been encouraged to do more baking instead of frying, as too much frying could block the arteries.'

Through a consultation, some members of the group said: 'We have made some changes but the family are not keen, they still like to have their old habits.' This highlights the need to involve other family members of the group where possible in order to target more widespread attitudinal change.

Sessions included looking at healthier alternatives to traditional ingredients and cooking methods

CASE STUDY

Healthy Eating and Cookery active network

In partnership with Khidmat, a group of older Asian women who meet at the mosque in Woking, and with the help of a volunteer interpreter and one instructor, Fit as a Fiddle South East supported a Healthy Eating and Cookery active network.

Before the sessions started, a demonstration day was held for members of Khidmat and various community workers to find out more about the sessions and to sign up for the network. With the help of a volunteer interpreter, a Food Technology teacher and a former Masterchef competitor, the sessions were tailored to meet the needs of the group – diet, religion and capabilities were all considered. Topics covered included special diets, five-a-day, food labelling, food safety, low salt, low fat, shopping economically, and hydration.

Participants also brought their friends and children along so that a wider audience could benefit from the sessions. The course offered a sharing of cultures, and although many of the women already knew how to cook, this network offered them advice on healthier alternatives to traditional ingredients and cooking methods.

Engaging BME older people in mental wellbeing

CASE STUDY

Older men's community health group

An older men's community health group was set up in East Lancashire to raise awareness of the health problems in the community.

Initially the men's group was initiated through consultations at the local mosque. The support worker met with mosque and church leaders and local older residents after prayer events to help provide information about exercise, health and wellbeing. A group of 15 men joined the project, which allowed them to get involved in gentle exercise and walking and to attend workshops about healthier cooking alternatives.

One participant commented: 'I am a partially blind man and I was depressed and disappointed that I could not go out and meet friends. I started coming to this group and now I feel good and have got the opportunity to socialise and take part in gentle exercise.'

The project outcomes saw that the engaging and socialising elements had a great impact on mental health. The participants enjoyed the interaction time and felt part of a group that encouraged them to have a good laugh, share stories about their childhood and take part in activities.

The engaging and socialising elements had a great impact on mental health

CASE STUDY

The Haringey Explorers group

The Haringey Explorers group is a group of men from all communities in Haringey who like to meet up and explore the area where they live. They visit local attractions and go for healthy walks together, but more importantly they support, encourage and motivate each other.

The men have all attended the Age UK Fit as a Fiddle wellbeing buddies training, which is designed not only to give older men a knowledge of men's health issues but also to give them skills to support and encourage other men to look at their lifestyles and maybe make some small changes that will improve their health and wellbeing.

An event with Haringey Explorers, Tottenham Hotspur and Age UK Hackney

The training for the Explorers was tailored to look at these health issues and at traditional cooking methods, which if slightly adapted would make for a healthier diet. This was particularly helpful for men from African Caribbean descent, who are now more aware of the dangers of a traditional diet, which can be high in fats and salt.

One participant stated that: 'There is ignorance among African Caribbean and Asian men about diet and health issues, and a refusal to go to the doctor with any problems, especially mental health issues.' Age UK classes have alerted him to the need to do more to look after his own health – for example, he went to a presentation event about men's health, which led to him going to the GP to have his prostate problem checked out – and receiving the needed attention.

Another of the men went to his GP following the training and was diagnosed with Type 2 diabetes, which is now being treated with the support of a healthier diet and more physical activity.

For more information about these projects, please contact Fit as a Fiddle: www.fitasafiddle.org.uk

3 Recommendations for good practice

The following recommendations have been developed in light of the good practice and learning from the Sporting Equals Fit as a Fiddle Faith and Community Strand.

3.1 Planning and developing services

Community knowledge
In planning and preparing a programme of activity, it is essential that knowledge of the identified community is obtained. The use of local data is essential to ensure that the programme is specifically targeted and relevant.

Involve service users in both planning and delivery
Provide a range of options and discuss the pros and cons of different activities. Identify volunteers or community champions to help encourage involvement and to sustain participation long term and try to build exercise into daily routines.

Recognise different motives
People get involved in physical activity for different reasons. Key motivations for BME groups may include social interaction, keeping fit, health, and being encouraged by a friend or peer. Design the service to satisfy these motives, for example, use cultural diets to discuss healthy eating and link this to health.

Use existing learning and good practice
Effective information already exists about how to work more productively with BME communities on exercise and activity. Draw on this expertise from people who have been through the process rather than keep reinventing the wheel (see 2.3, 'Case studies from Sporting Equals Fit as a Fiddle projects' and 2.4, 'Examples of regional good practice').

Make use of wider networks, partnerships and resources
Consult with your local authority, healthcare trusts, sports providers, etc. for links and resources. Agendas often overlap – for example, the primary care trust may want to link its health activity with your group and may help to encourage access. Your local sports provider may want to raise participation and may offer subsidised or free facilities.

Capture project information
Capture as much information about your project as possible, for example numbers of participants, age, ethnicity, religion, reasons for coming, what they did, how much they enjoyed it and what they would like to change, etc. This information can be invaluable for reporting what you have achieved and when asking for resources or grants to sustain or grow activity.

3.2 Making services accessible

Ensure that locations are accessible
It is much easier to take a sport or exercise session to a location where people already assemble (e.g. a community centre or faith centre) than to entice people to an unfamiliar venue. Where this is not practical (e.g. for swimming), make it easy for people to get to the location by organising safe and reliable transport.

Signposting and community engagement
Distribute information through culturally appropriate venues such as mosques, temples and community centres. Build rapport with communities and community leaders to support dissemination of information and to gain their support when promoting events.

Communication
Consider that many people may not be able to speak English, particularly new arrivals, and provide interactive ways of communication. Word of mouth often works best with BME communities. Places of worship can be a good avenue for marketing.

Programming activity
Be flexible with programming to stimulate greater involvement. Approaches may have to vary according to the client group and delivery and it may be relevant to plan a range of physical activities to gain commitment and interest.

Offer low-cost or value-for-money activity
Many older BME groups have low incomes, so cost will be a barrier. Make the most of free events, and use parks and local facilities. Walking, dancing, gardening and keep fit are all easy activities that do not need a special facility and can be carried out without expensive equipment. Such activities will already be familiar, so start small and build confidence before encouraging people to try new activities.

Educate staff, professionals, carers and families
Use education as a means of changing the habits of BME communities. Use peer education as a means of persuading older people to try something new. Service providers should be aware of the type of BME communities that are present in their area and their different needs. Service providers should collaborate and share good practice.

3.3 Making services culturally sensitive

Provide culturally sensitive activities
Take account of users' values, religious faith, culture and community norms in planning physical and wellbeing activities. This will influence whether BME older groups will take part in activity. Think about gender-specific sessions, the timing of sessions to take into account prayer times or holy days, the types of venue that will be attractive, the types of exercise or activity that will be supported, dress code and any fasting periods.

Respecting modesty should be considered to allow the head to be covered and participants to wear outfits they feel comfortable with. Segregation is important, particularly when carrying out activity, changing and showering, so consider whether venues are suitable. Ensure that same-sex instructors are available when putting on activity.

Use volunteers
Train volunteers to respond to cultural sensitivities or use volunteers within the community who can provide advice and information. Many BME communities will respond to community development initiatives run at a local level and a good way of recruitment is to recruit community leaders to help promote projects and build links with potential volunteers.

Diet
Diet is an extremely important part of religion and it is important to ensure that vegan/vegetarian options are provided, or, according to the client group, that halal food is provided for Muslims and kosher food for the Jewish community.

Celebrate success
Make everyone feel good about what they have done and achieved. This will help sustain participation and attract new people. Recognise volunteer contribution and promote role models.

4 Further information and acknowledgements

The following organisations may be useful for accessing further information about equality, older people and health.

Sporting Equals
www.sportingequals.org.uk

Age UK Fit as a Fiddle team
www.ageuk.org.uk/health-wellbeing/fit-as-a-fiddle

Age UK Equality and Human Rights team
www.ageuk.org.uk

PRIAE (Policy Research Institute on Ageing and Ethnicity)
www.priae.org

Equality and Human Rights Commission
www.equalityhumanrights.com

Department of Health
www.dh.gov.uk

Equality and Diversity Forum
www.edf.org.uk

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- Age UK Berkshire
- Age UK North West
- Age UK Newham
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Notes

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2 The term 'black and minority ethnic' (BME) includes both 'visible' (non-white) minorities – for example, Asian or Asian British and Black or Black British – and white minority ethnic groups, such as Irish, Gypsy or Traveller or other white ethnic groups

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4 The term 'faith communities' refers to those who have a specific religious affiliation to a particular faith and lead their lives in accordance with the rules and observances of this faith

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24 www.homeoffice.gov.uk/equalities/equality-act (accessed on 24/04/12)

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