Mapping exercise of initiatives to increase physical activity amongst Black and Minority Ethnic (BME) groups

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This Mapping Exercise is carried out by REACH Community Health for NHS Health Scotland

REACH
COMMUNITY HEALTH PROJECT

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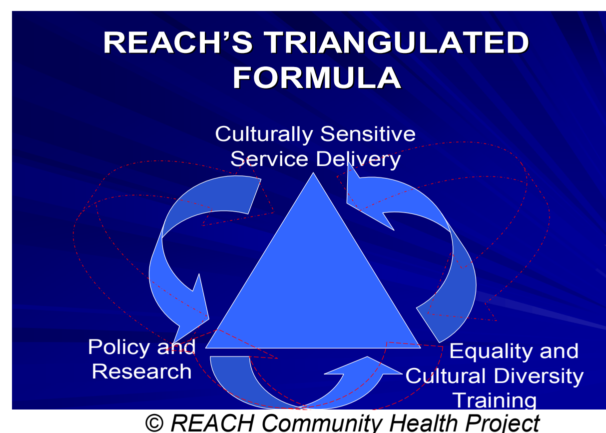
REACH Community Health Project

REACH Community Health Project is an innovative national voluntary organisation, whose aim is to improve the health of Black and Minority Ethnic (BME) communities living in Scotland. The project is also committed to facilitate change within mainstream health services to better address the health needs of this particular community. To achieve these aims REACH has developed a triangulated formula in the form of a Services Unit, Policy and Research Unit and an Equality and Cultural Diversity Training Health Unit.

Our ***vision*** is a multi-cultural society in which all people have equal access to appropriate health services and our ***mission*** is to empower BME communities by ensuring that their health needs are fully met.

REACH Community Health Project have three key objectives as working principles which, helps us to implement our policies into practice thereby achieving our aims. The objectives are as follows;

1. To provide a range of good quality, culturally-sensitive preventative health **services**
2. To influence mainstream **policy** and undertake innovative **research** so as to identify and remove barriers to health for BME communities
3. To provide **equality and cultural diversity training** for mainstream, voluntary and private sector organisations working for and with BME communities



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Executive Summary

The health of Scotland as a nation is one of the worst in the developed world, and Scotland has relatively high levels of heart disease, strokes, obesity and other illnesses. At the same time, regular exercise is known to decrease the risk of developing many of these diseases. Therefore, in order to improve the health of people in Scotland, the Scottish Executive aims to increase the nation's level of participation in physical activity.

Amongst the various groups and communities in Scotland, there exist different challenges to overcome before participation in physical activity is increased. One such group is Scotland's growing Black and Minority Ethnic (BME) population. This includes communities who are long established in this country, as well as people who have recently arrived such as asylum seekers, refugees and economic immigrants.

As a whole, the BME community in Scotland has lower than average levels of physical activity. Although the reasons for this have not been fully established, many BME people face practical and social barriers in their lives that may make it difficult to participate in mainstream physical activity provision. These include language barriers, cultural requirements, religious beliefs, living in poverty and experiencing racism. Moreover, the task of increasing exercise levels amongst BME communities is made more urgent by the fact that many groups within this bracket have relatively poor health compared to the average population in Scotland.

Before participation rates amongst BME people can be increased, it is necessary to know what provision already exists in Scotland serving this purpose. Thus, NHS Health Scotland commissioned REACH Community Health Project to map initiatives within Scotland that promote physical activity amongst BME communities.

In addition to this main research objective, REACH also sought to establish:

- who provides these initiatives, where they are delivered and which communities are targeted
- the aims and objectives of each initiative, the success to date at meeting these and whether or not any evaluation is in place
- whether or not funding is provided to each initiative, and whether this is long or short term
- any issues or concerns that the providers of the initiatives wish to raise.

To do this, a database of potentially relevant organisations was compiled from REACH's pre-existing contacts, internet searches and snowballing. Around 100 organisations were then contacted (mostly by telephone) and, if relevant, a telephone interview was requested. Semi-structured interviews were carried out with 47 organisations in the Glasgow, Edinburgh, Dundee and Fife areas of Scotland.

The resulting data was tabulated in order to provide an easy to use resource for NHS Health Scotland. Furthermore, the data was analysed both qualitatively and quantitatively to investigate some themes in more detail.

In all, 43 out of 47 organisations interviewed had one or more initiatives providing physical activity to BME communities. Only one organisation reported promoting physical activity to BME groups without offering activities themselves. Most of these organisations were voluntary, with a few being local authority, NHS or private organisations. A wide range of activities was offered, from walking and gentle exercise to more strenuous activities such as football and dancing. The size and time-frame of initiatives also varied greatly. For example some exercise classes involving 5 or 6 people ran every week, whereas a few youth programmes involved more than 100 young people at a time but only ran during school holidays.

Most organisations aimed to improve or maintain the health of people using their initiatives. At the same time, the majority also had other objectives aside from health, such as increasing social integration or reducing isolation. In addition, most initiatives were also aimed at specific target groups, whether in terms of age, gender or ethnicity. This was most pronounced with respect to gender, with many activities provided for women only. However, initiatives tended to have more relaxed policies with respect to ethnicity, with most organisations stating that their initiatives were open to people from all communities.

Who participated in each initiative tended to reflect these policies, with young and older people, as well as men and women, unlikely to take part in initiatives together? Most initiatives had mixed membership in terms of ethnicity, in keeping with the preference for 'open-to-all' policies. Only a minority of initiatives, however, did not have one dominant ethnic group who made up 70% or more of participants.

In general, organisations saw their initiatives as successful, reporting sustained participation rates, continuing demand and positive user feedback. A small number reported successfully meeting their outcomes in terms of health improvements, increased integration and reduced isolation. However, it was also reported that these outcomes are more difficult to evaluate, and evaluation was usually limited to monitoring numbers, age, gender and ethnicity.

Very few organisations reported negative findings from their evaluations. Where concerns were raised, this was normally to do with funding difficulties and long-term sustainability. Organisations often highlighted the fact that they could not provide the level, or variety, of activities they wanted to due to a lack of funding and resources. Additionally, a few initiatives had either been stopped or had their existence threatened by the discontinuation of short-term funding. It was pointed out by more than one provider that funding constraints meant their work could not be completed, as more needed to be done to ensure service users continued to participate in physical activity in the long-term.

Another issue to emerge was that of young BME women and older BME men being underrepresented amongst user-groups. This may be a result of the sorts of activities provided for different age groups, with football and fitness classes being unsuitable for young women and older men respectively. Although some effort was being made to address these issues, it is perhaps an area that needs further exploration in future research.

1. Introduction

1.1 Background

Scotland has long been labelled “the sick man of Europe”. The British Heart Foundation (2007) states that Scotland has the highest mortality rate from coronary heart disease (CHD) in the United Kingdom, and the prevalence of obesity in Scotland steadily increased from 1995 to 2003 (Scottish Executive, 2005: 5).

A major contributing factor to heart disease and obesity, as well as many other illnesses, is physical inactivity. Regular participation in physical activity has been shown to reduce the risk of developing illnesses such as cardiovascular diseases, strokes, type II diabetes, and certain cancers (World Health Organisation, 2008). However, in 2003, only 44% of Scottish men and 33% of Scottish women reported achieving the recommended level of 30 minutes moderate physical activity on most days of the week (Scottish Executive, 2005: 5).

The National Strategy for Physical Activity “Let’s make Scotland more active” (Scottish Executive, 2003) aims to change this. It sets out 2 main targets, so that by 2022:

- 50% of all adults will have met the minimum recommended levels of physical activity
- 80% of all children will have met the minimum recommended levels of physical activity (ibid: 22)

In addition, Scotland has a multi-cultural population, and a growing number of people in Scotland are from BME communities. These include groups who have recently arrived here as asylum seekers, refugees and economic migrants, and also those who have lived in this country for many years who have assimilated themselves into, and added to, Scotland’s culture. People from these communities often face specific barriers to participating in physical activity. For instance, there may be religious beliefs or cultural factors that prevent BME people from being able to use particular sport and leisure facilities. Some BME groups also speak little English and this, coupled with the social isolation experienced by many BME people, can discourage people from participating in mainstream physical activity provision.

The health, in general, of BME communities in Britain is worse than that of white British people. This can be put down to a number of factors. Higher rates of heart disease and diabetes amongst South Asian groups have been explained as partly to do with biological factors. Secondly, ethnic inequalities in health are connected to Britain’s wider socio-economic inequalities (Nazroo, 2003). On average, BME communities are less affluent than the indigenous white population and, whether in terms of mental health, physical health or mortality rates, poverty has been widely shown to be a root cause of health inequalities.

It is a matter of concern, then, that physical activity levels amongst BME groups in Britain have been found to be lower than the population in general. The 2002 General Household Survey reveals participation rates in any form of physical activity to be significantly lower amongst many BME groups than amongst the White British population (Fox and Rickards, 2004: 33). Although the reasons for this are not firmly established, research commissioned by Sport Scotland has indicated that it is not so much cultural and religious requirements that prevent participation amongst BME groups but fear and experience of overt and institutional racial discrimination (Scott Porter Research and Marketing Ltd, 2001: 32).

With these difficulties in mind, it is of interest what sort of, and how many, initiatives exist that support or promote physical activity amongst BME communities in Scotland. Accordingly, NHS Health Scotland commissioned REACH Community Health Project to map such initiatives within Scotland, whether provided by government, voluntary or private sectors, and whether operated at a national or community level.

1.2 Research aims and objectives

The key information REACH wished to gather for each initiative promoting physical activity amongst BME individuals was:

- what the initiative is – its aims and how it is designed to increase levels of physical activity, if at all. We also wanted to find out why particular activities are chosen, how successful they are, how long the initiative has been going on for and how regularly it is delivered

- who the target audience is – including any specific age groups, gender, ethnicity, culture, religion, employment status and educational background being targeted. We were also interested in how individuals are made aware of, and recruited to, initiatives

- where the initiative is delivered – e.g. pre-school/school setting, community (e.g. walking groups), leisure complexes, mosques, temples or other specific settings available to BME groups

- who the initiative is delivered and funded by – including whether it is community led, organised through a voluntary organisation or provided in partnership with Health Boards or Local Authorities. An indication of whether this is being funded, whether such funding is long or short term and who any funding bodies are was also sought.

- whether or not the initiative is evaluated – if there are any evaluations being carried out or proposed for each of the initiatives, including numbers accessing the initiative, age, gender etc., and if the demand is greater than what is available

- an indication of potential initiatives which would be beneficial but not yet established due to funding or resources.

1.3 Research question

What are the current initiatives available in Scotland that support physical activity amongst BME Communities; who are the organisations that deliver such initiatives and who is their target audience?

1.4 Definitions

To aid clarity, key terms used in this research are defined as follows:

- an *organisation*, in keeping with the Oxford English Dictionary, is defined as "an organised body of people with a particular purpose" (Soanes 2005)
- an *initiative* is understood as any attempt by organisations to achieve a certain aim. In many cases the aim will be to promote physical activity, but this may vary; e.g. some initiatives may aim simply to bring people together. An initiative can involve one type of activity or it can involve many, run at separate times with different groups of people. Sometimes, where an initiative has been set up by an individual or previously unorganised individuals, then that initiative can also be referred to as the organisation.
- *activities* refer to the different types of sports or exercises that are involved in the initiatives. Where different activities within an organisation have separate aims, they are each taken to be a separate initiative.
- *Black and Minority Ethnic (BME)* refers here mainly to groups that would not define themselves as 'white'. However, as many new economic immigrants from Eastern Europe face many of the same types of barriers to participating in physical activity, these groups are also included within this definition.

2. Methodology

As this mapping exercise did not require rich in-depth data, and in order to contact as many organisations and individuals as possible, an entirely desk-based methodology was used, consisting of a literature review, internet search, and telephone interviews. In addition, 2 face-to-face interviews were carried out where this was more convenient.

2.1 Literature review

A brief literature review was carried out in order to assess up-to-date developments in the areas of BME health, specifically with regards to exercise and physical activity. Scottish-based research on this topic is limited, but that BME communities in Britain have lower participation rates in physical activity is well established in various UK research studies (e.g. Fox and Rickards, 2004; Rowe & Champion 2000). However, the exact reasons as to why this is so are unclear, and there exists only a small amount of research in this area.

A previous study in the East of England commissioned by The BME Sports Network East (Ploszajski Lynch Consulting Ltd., 2005) has involved a

mapping exercise of BME organisations servicing both sporting and non-sporting needs of BME groups. This report provided useful sources of further background information on BME participation in physical activity, and also offered useful lessons for our methodology, discussed below in section 2.3.

2.2 Internet Research

2.2.1 Rationale and method

Many, though not all, voluntary, government and private organisations provide contact details on online directories, and some also have their own websites. Online searching, using search engines and existing directories, is therefore a simple, time-efficient, way to collect data on initiatives that are potentially relevant to this exercise. However, to reduce the risk of missing initiatives that have no details online, the telephone questionnaire contained a section asking respondents to provide information on other such initiatives in their area or field of work.

2.2.1 Internet search

Websites of Councils for Voluntary Organisations (CVOs) Local Government and web-based telephone directories were accessed in order to build a database of organisations potentially offering services promoting physical activity amongst BME groups. These included: organisations that identified themselves as, or were identified by others as, working with BME groups; organisations offering, or promoting, physical activity; and organisations concerned with health. Many organisations with websites also provide useful links on their webpage to other similar initiatives, and this allowed us to further expand our database. In a small number of cases where information was not made available during telephone interviews, web pages provided an alternative means of gathering details of activities on offer.

2.2.2 Database

A database of voluntary, government, private and community organisations was compiled from the results of the internet search. This was divided into separate Scottish regions. In addition, REACH continually networks with other projects working with and within the BME community, and has a pre-existing database of contacts within the BME community. These were utilised in the building of the database, helping to reduce the risk that some organisations not available on the Internet would be missed.

2.2.3 Contact by email

The ability to contact organisations by e-mail was another useful facility offered by the internet. However, as it tends to be less time efficient, and has a lower response rate, than phoning people directly, email was usually only resorted to after contact by telephone had proved unproductive.

2.3 Telephone research

2.3.1 Rationale and method

Contacting and interviewing organisations was primarily conducted by telephone. This departs from a previous mapping exercise of organisations in the East of England supporting physical activity amongst BME groups

(Ploszajski Lynch Consulting Ltd., 2005), in which contact and interviewing were achieved through a postal self-completion questionnaire. One problem with this method is that response rates tend to be low, with the aforementioned exercise eliciting a 20% return rate (ibid: 34). A more active approach, then, was sought in order to achieve as high a response rate as possible. Given that face-to-face interviewing is timely in terms of organisation and execution, it was decided that telephone interviewing was the most efficient and effective method at our disposal.

2.3.2 Target groups

The types of group identified as relevant were:

- health boards, specific departments and key individuals within each of the health boards
- local authorities, specific departments and key individuals within each council
- voluntary/community organisations in general and particularly those targeting or working with/for BME Communities within the arena of health
- social, community and religious groups, both organised and un-organised.

2.3.3 Target areas

When we refer to BME, we are referring to groups of people from very different backgrounds living in various locations throughout Scotland (see section 1.4). Hence, approaching every BME group or community within Scotland was not feasible in the time allocated. Instead, geographic regions with the highest concentration of BME people (The cities of Glasgow, Edinburgh and Dundee) and those areas where REACH has the strongest network of established BME contacts (Fife) were targeted in order to achieve the most detailed picture possible in the available time.

2.3.4 Telephone enquiries and interviewing

Organisations on the database were phoned in order to establish whether or not they provided initiatives promoting physical activity amongst BME communities. Where this was not so, individuals were asked if they knew of any relevant initiatives within their community, geographic area or field of work. In cases where organisations did provide such services, telephone interviews were requested with the main organisers of the initiatives, and these were either carried out immediately or at a later time more suitable to the respondent. Overall, around 80 organisations identified as potentially relevant (see section 2.2.2) were contacted in this way by telephone and around 20 were made contact with by email.

47 of those organisations contacted resulted in completed interviews, giving around a 50% response rate. Most of those organisations with which interviews were not completed had no initiatives promoting physical activity amongst BME groups. A small number did provide such initiatives but an interview could not be arranged. This was usually because the organisers of the initiatives were difficult to contact. Only in one case did an individual

refuse to be interviewed, although in this case it was unclear whether or not the project in question had BME users.

An additional benefit of telephone interviewing was that individuals from contacted organisations, whether interviewed themselves or not, could be asked for any information about other initiatives they knew of promoting physical activity amongst BME communities. This allowed for contacts in the database to 'snowball', and facilitated interviews with initiatives that might not otherwise have been known about.

2.4 Semi-structured questionnaire

2.4.1 Format

In order to ensure that all six aims and objectives of the mapping exercise (section 1.2) were addressed, a standard semi-structured questionnaire was used in the telephone interviews. However, considerable scope was provided for individuals to raise themes and concerns they themselves found important. This was achieved by using mainly open ended questions and, where questions were 'closed', either an 'other' option was made available, or enough space was left on the page to capture answers not already catered for. This flexibility made it possible to collate data regarding our own research aims, while at the same time enabling all issues that were important to the interviewed organisations to be recorded (see section 3.4.4 for opinions on funding issues recorded in such a way).

2.4.2 Using the questionnaire

As interviews were conducted by telephone, respondents' answers were written down in short hand by the interviewer. Questions were often asked according to the topic that the respondent had turned to themselves, and not in their numbered order. This was so as not to interrupt the flow of conversation, risking losing potentially valuable insights. Immediately following each interview, these answers were written up more fully to provide a completed questionnaire in the standard format. Furthermore, this helped avoid memory bias and greatly assisted comparative analysis of the different initiatives.

2.5 Data analysis

2.5.1 Tabulation of data

The important data from the interviews was tabulated using Microsoft Word. Partly this was to provide an easy to use resource for NHS Health Scotland, summing up the range of initiatives mapped across the targeted geographic locations. Furthermore, the table facilitated both quantitative and qualitative analysis by displaying the significant facts and figures in one easily accessible document.

2.5.2 Frequency count

Frequency counts were conducted in order to generate information on:

- the numbers of different types of organisations interviewed
- the number of organisations targeting different groups, in terms of age, gender and ethnicity

- the sorts of activities offered
- which communities were served by the initiatives
- how both genders were engaged in such initiatives
- the spread of ages across the different initiatives.

2.5.3 Qualitative analysis

As the interviews left considerable room for respondents' own views on the topic, a reasonable amount of qualitative data was generated on issues ranging from the difficulties faced by BME communities in accessing suitable services to matters of funding. Qualitative analysis was therefore used in order to establish the broad tendencies with respect to such data, as well as to record some of the more striking opinions and suggestions that emerged from the interviews.

2.5.4 Caveat

Used in combination, these methods of data analysis provided a reasonable overview of the range of initiatives promoting physical activity in Scotland. However, as only contactable organisations are represented, it is questionable how generalisable the findings are.

2.6 Ethical considerations

Throughout the process of the mapping exercise we adopted ethical procedures from the Market Research Code of Conduct (MRS, 1998). The MRS includes principles that relate specifically to eliciting the views of members of the public, so is applicable to some part of this mapping exercise where the researcher involved members of BME communities.
The basic principles employed were:

- participants were honestly and comprehensively informed about the research in which they were taking part
- the rights of participants were treated as paramount
- participants were openly asked to give their consent to take part and to any subsequent attributable use of their comments (and any other material arising from the group/interview)
- undertakings made to participants will be honoured
- the research has respected the interests of clients
- participants have been treated with respect
- throughout the data collection and analysis, processes and procedures were used to ensure the quality and reliability of information.

It is not anticipated this research will lead to any distress to the members of the BME communities or any officials working within voluntary and statutory sector. The research team and the management from REACH have ensured that there was no coercion in seeking information about initiative/activities intending to increase the physical activity amongst BME communities.

3. Findings

The main research question of this exercise was to map the initiatives promoting physical activity amongst BME groups in Scotland. Therefore this section is primarily focussed on establishing what initiatives exist, where they are located, who they are aimed at, and who provides them. At the same time, the opportunity has been taken to gather more detailed information from organisations on the services they deliver, and therefore a range of other points and issues emerging from the data will also be discussed.

3.1 Types of Organisations

3.1.1 Overview

Altogether, out of 47 completed interviews, 43 were with individuals from organisations offering physical activities that either targeted or were used by a significant amount of BME individuals (more than 10% of service users). Out of the other four, one offered services promoting physical activity to BME communities without offering any activities themselves; a second was involved in training health care workers working with BME communities to promote healthy living, including exercise; a third did not currently deliver any initiatives but wanted to; and another did not involve significant numbers of BME participants but was considered to be worth interviewing as was based in a community with a relatively high proportion of BME residents.

3.1.2 Voluntary Organisations

The large majority of organisations interviewed were voluntary, mostly registered with charitable status, but also smaller community-based groups. Many of these organisations' main target groups were not specifically BME, but they nevertheless worked with BME groups in the local community. However 14 were either organisations specifically focused on working with BME groups, or were sporting clubs organised by members of the BME community themselves.

3.1.3 Local government services

Local councils were found to provide 2 types of service that are relevant to this exercise. Firstly, councils in all 4 of the mapped regions (Glasgow, Edinburgh, Fife and Dundee) directly provided some form of women-only swimming or gym classes. Secondly, Glasgow City Council funds 5 day care centres for older people from BME communities, all of which provide gentle exercises for their service users.

In addition, local councils can be seen to assist such provision indirectly through the support and funding they offer voluntary organisations promoting physical activity amongst BME groups. For instance, Culture & Sport Glasgow provides free instructors and equipment to numerous initiatives throughout Glasgow, and has a dedicated BME Sports Equality Officer.

3.1.4 NHS bodies

Two particular services, relevant to this exercise, were found to be offered by regional NHS bodies, as well as the recently introduced Community Health Partnerships (CHPs). One of these was a training initiative offered by NHS Greater Glasgow and Clyde raising awareness amongst health workers of BME health issues. The other was provided by NHS Lothian's Minority Ethnic Health Inclusion Project, who oversaw Khush Dil, a project offering free instructors to local exercise initiatives working with the South Asian community. It is possible that more is offered within the 4 Health Boards. However, in most instances, CHPs and equalities departments were unable to identify any such initiatives.

3.1.5 Private organisations

Initiatives existing within the private sector were, to an extent, under-explored. This was partly justified by the fact that our background research did not uncover any existing private organisations promoting physical activity amongst BME communities in Scotland, and also by the fact that only one or two individuals interviewed, when asked about other physical activity provision for BME communities, pointed in the direction of the private sector.

A small handful of organisations were contacted that might be considered private. One Dance Company and a Scottish branch of an international yoga organisation were interviewed, although both are also registered charities. Additionally, Future Fitness gym in the Shawlands area of Glasgow, an area with a large South Asian community, reported significant amounts of BME customers.

3.2 Details of Initiatives

3.2.1 Overview

A large variety of initiatives, both in form and scope, were provided by the above organisations. This mainly depended on the particular type of organisation. For instance, day care centres tended to provide gentle forms of exercise for the benefit of older people's joints, whereas youth organisations ran more strenuous activities such as football and adventure sports. Accordingly, the size and costs of different initiatives also varied greatly, with some activities costing little and involving 5-6 people, and some having up to 150 participants and relying on large amounts of external funding. Furthermore, and as the following sections will now explore in more detail, the specific activities, aims, target groups and levels of success tended to vary as well.

3.2.2 Activities provided

Dance-based exercises, keep-fit classes, aerobics and yoga made up by far the largest category of physical activities provided. In total, 53 different examples of such an activity being provided were reported, with up to 5 being provided within the same initiative. The second most commonly provided type of activity was team-sports, with 18 recorded examples. Football made up the majority of these, but other team-sports existed such as cricket, basketball

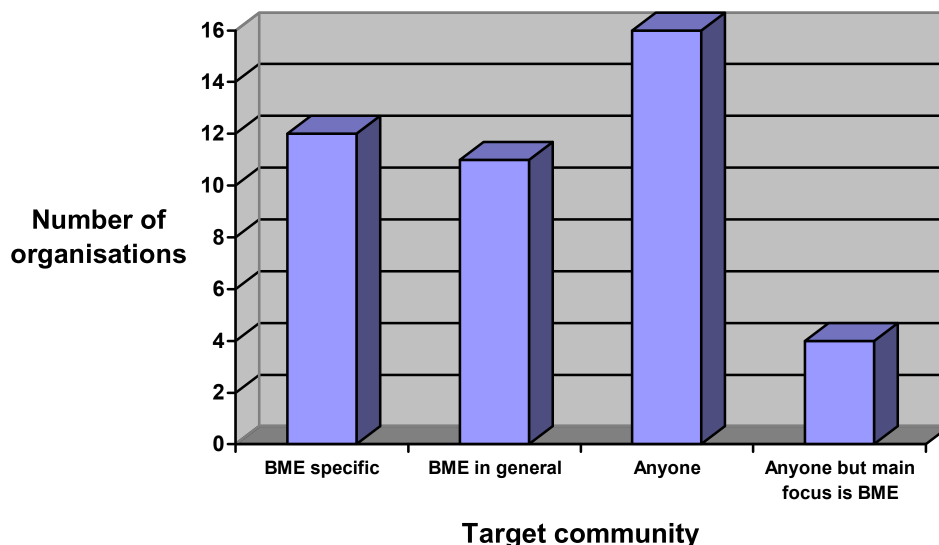
and netball. Aside from these main categories, other types of activity more frequently provided were swimming, walking, use of gym equipment, and adventure sports. Around 10 diverse activities made up the remaining number, ranging from badminton to gardening.

3.2.3 Aims of Initiatives

Slightly less than half of all organisations interviewed stated their aims solely in terms of health. These included day care centres, which mostly provided exercise in order to ease users' joint movement, and voluntary health projects, which tended to be focussed on improving health in the community. However the majority of organisations said that they had other aims which were equal to, if not more important than, improving people's health. For instance, many initiatives were set up in order to tackle social isolation or to facilitate integration. Youth initiatives were often additionally concerned with providing young people with more self-confidence and teamwork skills, and with diverting young people from crime and anti-social behaviour.

In many cases, initiatives were targeted at specific groups in the community. Around half of all organisations offered gender specific physical activities, with most of these initiatives being women-only. Often, this was in response to cultural barriers to mixed-gender provision, and recognition that some BME women are socially isolated, even within their own communities. Only a small number of initiatives were restricted to men only, and mostly this was in centres where women-only classes existed as well. However, one organiser of a football team admitted that women could not join as the league his team played in would not allow it. It is possible that other football and cricket teams in this study would be in a similar situation.

Figure 3.1 Target communities of organisations (n)



Approximately half of all organisations providing physical activity said their initiatives were targeted at either the BME community in general or at one particular group within the BME community (figure 3.1). Of the 12 organisations who stated the latter, 8 aimed their physical activity provision at the South Asian community, 3 at the Chinese community, and one at asylum seekers and refugees. The remaining half stated that their services were open to all communities, although 4 of these organisations said that their main focus was on BME groups.

An additional factor was age, with many initiatives being directed at particular cohorts such as teenagers and over 65s. The target age often had a bearing on the ethnic background being aimed at, in that a large proportion of those organisations stating that their services were solely targeted at BME groups were day care centres. In contrast, youth-targeted organisations tended to open their provision to all ethnic backgrounds, including young people of White British background.

3.2.4 Success to date

Some form of evaluation and monitoring was conducted within most initiatives, almost always by the organisations themselves. The most common form of evaluation was monitoring of numbers of people using the project, with many also monitoring gender, age and ethnicity. However, a good number of initiatives also used feedback forms to assess users' experiences and any outcomes relating to the aims and objectives of each project. More often than not, the extent of evaluation depended on whether or not initiatives were externally funded. For example, Big Lottery funding requires that providers carry out detailed half-yearly progress evaluations.

In the large majority of cases, respondents pointed to positive findings of evaluation, such as sustained participation rates and users' enjoyment. Furthermore, all the organisations spoken to saw their initiatives as successful, with most (60%) describing themselves as "very successful". In the main, such a view was once again based on the fact that participation rates had been sustained or had even grown, and that demand continued to exist. A smaller number of organisations said that their success was due to positive outcomes relating to their aims, such as improvements in health, increased integration and reduced social isolation.

Fewer organisations (37%), when asked, reported negative findings from their evaluations. This ranged from integration between groups being hard to achieve (2 instances) to having membership fluctuate (1 instance). A small number of organisations that worked with individuals on a short term basis mentioned that the most difficult outcome to achieve, and also to measure, was long-term sustainability. The concern here was that, however successful events or programmes had been while in operation, clients would not continue in the sports they had been introduced to. This uncertainty was fuelled by the difficulty of evaluating such outcomes. One project co-ordinator providing outdoor sports to young BME people said that out of 70 post-programme forms evaluating sustainability only 12 were returned.

3.3 Details of participants

3.3.1 Overview

Despite many initiatives being formally open to all, the overall tendency was for them to be used mainly by specific groups within the community, whether in terms of age, gender or ethnic background.

3.3.2 Numbers

Amongst activities run on a weekly basis attendances were usually reported at between around 10-20 people per week. At the lowest end, some weekly activities had 5 or 6 regular users, but others attracted up to 50 people each week. Some organisations, such as those providing adventure sports for young people, ran intensive initiatives for short periods of time only. The 3 organisations contacted who ran such programmes all reported having 100-150 young people on the previous years programmes.

3.3.3 Age

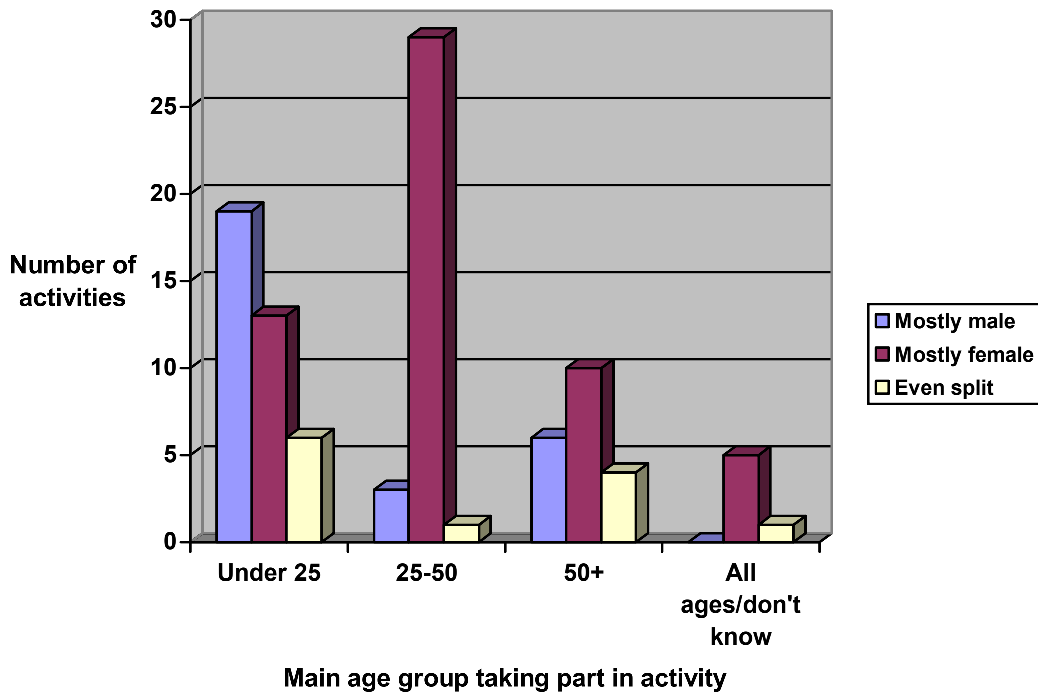
All ages were well represented in this exercise, with roughly equal proportions of young, middle-aged and older participants overall, across every initiative: Those under 30 tended to participate in team and outdoor sports organised by youth groups; people in their 30s, 40s and 50s took part mostly in dance-based exercise and keep-fit classes; and older people usually participated in gentle or chair-based exercise.

The initiatives with the broadest range of ages of participants were likely to be local council-run sport-centre provision, although all 4 councils contacted did not monitor age, so this cannot be verified. On the whole, however, such a broad spectrum of ages was rare, with most initiatives being dominated by participants from particular age groups. To an extent, this was expected, as more than half of the organisations contacted aimed most of their services at specific age groups, such as young people or over-65s. However, even initiatives that did not have age-specific objectives tended to have users mostly from specific age-groups. This is most likely due to the types of physical activity provided, with football and other energetic sports being participated in mostly by under 30s and many keep-fit and aerobics classes being used in large part by middle-aged and older people.

3.3.4 Gender

As with age, although there was an even distribution of both genders across all initiatives, there was more variation when it came to the type of physical activity being provided. Whereas most team sports such as football and cricket were male-dominated (13 out of 18 examples of such activities), dance, exercise and keep-fit classes were mainly female-dominated (40 out of 49). Once again, this was partly due to the fact that around half of all organisations ran gender-specific initiatives, but it is likely that a combination of factors such as gender preferences for different sports and cultural barriers to mixed gender participation is also at work.

Figure 3.2 How age groups are gendered (n)



Taking what has been said about the age and gender distributions of participants together, a more complex picture emerges in which particular groups of men and women may be under-represented (figure 3.2). For instance, it was mostly men who took part in activities involving mainly young people. 50% of activities involving mainly under-25s were male-dominated compared to 34% that were female-dominated. At the same time, 74% of activities involving mainly middle to older age groups were participated in mostly by females. Younger women, therefore, as well as middle-aged and older men, have not been involved in these initiatives as much as their male and female counterparts respectively. It is possible that initiatives involving these groups may simply have been missed by the mapping exercise. However, individual accounts from organisations back up the hypothesis that young BME women and older BME men participate less in such initiatives. For example, the project manager of a day care centre for older Chinese people explained that aerobics classes provided within the centre involved only women as “men are not interested”. In addition, a local authority employed community worker who helped organise football and breakdancing for Slovakian Roma youths admitted that there was not enough activities for girls from the Slovakian Roma community, who currently only participated in so far as they came to watch the boys play football.

3.3.5 Ethnic background

By a significant amount, it was the South Asian community who made up the largest group of participants using the initiatives provided. The Pakistani community, in turn, made up the majority of this group, with the Indian community also being prominent, followed by a smaller number of the Bangladeshi community. Another prominent BME group consisted of those

from Chinese descent. Other groups catered for specifically were Eastern European, Afro/Caribbean and asylum seekers/refugees from various backgrounds. White British people also frequently participated in many of the initiatives.

As with age and gender, there was less ethnic diversity within each initiative than there was across all initiatives. In 34 out of 43 organisations providing physical activity to BME groups, 70% of participants were from one BME community (e.g. South Asian, Black African, Romanian, and Chinese).

3.4 Funding

3.4.1 Overview

Most of the initiatives owed their continued existence to various governmental and semi-autonomous funding bodies. As this funding was normally short-term (3 years or less) there were many concerns raised about the long-term viability of projects.

3.4.2 Who provides funding?

The national body providing funding to the most organisations was The Big Lottery Fund, with Lloyds TSB and Children in Need also being cited. Funds made available by The Scottish Executive were also made use of, such as The Voluntary Action Fund, The Community Regeneration Fund and The Women's Fund for Scotland. The NHS was also a source of support whether nationally as NHS Health Scotland or as a more local body such as NHS Lothian. Further local assistance was available from local government, with one example being Culture and Sport Glasgow, who provide instructors, equipment and advice to initiatives being set up to provide physical activity to BME communities.

Finding out who provides funding was not always a straightforward issue. Local funding bodies that supported local initiatives could themselves be funded by national funding bodies. This was the case with Culture and Sport Glasgow, who relied on Lottery and Scottish Executive funding as well as small grant schemes.

3.4.3 Who is funded?

Out of the 44 organisations providing physical activity initiatives, only 6 reported these initiatives as being financially secure on a long-term basis. Five of these were either provided or funded long-term by local authorities as council-operated sport centres and day-care centres respectively. Only one initiative run by an independent voluntary organisation – a multicultural women's fitness class in Glasgow – was funded long-term. A further 17 organisations ran initiatives that were funded short-term.

20 organisations ran initiatives providing physical activity to BME people that received no direct funding. Out of these, there were 5 examples of initiatives paid for mainly through funding given to the organisation as a whole. Additionally, 6 of these organisations were provided with an instructor by an outside organisation, and 2 had received free equipment from such bodies.

This left 7 organisations who stated that they had received no funding whatsoever.

3.4.4 Funding concerns

Whether or not funding was provided, and no matter whether any funding was long or short-term, most organisations (30 out of 44) reported that they could not provide the range and/or extent of physical activities they would like to. A total of 22 out of 40 organisations that relied on funding were concerned that they could not expand their services or meet existing demand due to a lack of resources and finance. The precise barriers ranged from not having the transport needed to get older people to and from centres to being too busy with full time jobs to run the activities young people wanted.

A small number of organisations were specifically concerned that short-term funding did not allow for stable provision of services. In addition, the 4 dance/exercise classes in Edinburgh provided by instructors from Khush Dil (overseen by MEHIP) were threatened by the fact that funding for this project was due to end in May 2008. Finally, Culture & Sport Glasgow's 10-20 week provision of fitness instructors was viewed as too short by some organisations, who wanted to be able to provide activities all year round.

Interestingly, Culture and Sport Glasgow, without being prompted, raised the point that their support was geared towards helping initiatives become self-sustaining in the long-term. The Sports Equalities Manager spoken to remarked that the aim should be that people feel comfortable using all exercise/sport facilities whatever their race or background. This was similar to the views of the Team Leader at MEHIP in NHS Lothian, who also commented that the ultimate aim should be "equal access".

3.5 Discussion

The point of this mapping exercise was to find out what initiatives exist in Scotland that promotes physical activity amongst BME groups. Due to time constraints, the areas covered were limited to 4 cities or regions – Dundee, Edinburgh, Fife and Glasgow. Nevertheless, given that only 4 out of 47 completed interviews were with organisations from Fife and Dundee, it appears that most relevant initiatives in Scotland are likely to be based in Glasgow and Edinburgh. This reflects the fact that the highest concentrations of BME people in Scotland are in Edinburgh and Glasgow (2001 Census). As other areas in Scotland have proportions of BME people similar to, or smaller than, those of Dundee and Fife, extending this exercise to cover all of Scotland would be unlikely to uncover many relevant initiatives.

However, it is important to consider that some of the most isolated BME groups or individuals will be those who live in areas where concentrations of BME people are low, and that such groups may be the most in need of assistance when it comes to participating in physical activities. Therefore, although focusing on larger conurbations with higher BME populations made sense within the confines of this project, it would no doubt also be useful to

find out what initiatives existed for these smaller, more isolated, BME communities.

Another area possibly under-explored is of initiatives existing within the private sector. For instance, private gyms will often run women-only exercise classes, and certain private organisations, such as the UK-wide Bums and Tums, are female-only at all times. Furthermore, in areas with higher densities of BME groups, gyms may offer services specifically for BME communities, such as ensuring that all staff members working during women-only sessions are female.

Attempts were made to interview 5 gyms in the Glasgow area, but only Future Fitness in the Shawlands area of Glasgow – an area with a relatively large BME population – agreed to be interviewed (not in enough detail to be included in the mapping exercise table however). They reported that approximately 30% of men and 20% of women who used the gym were BME (mostly South Asian), and that they offered female-only sauna and steam-room sessions, which were aimed particularly at Muslim women.

On this note, the mapping exercise provided a good opportunity to explore facilities available for South Asian groups, especially those of Pakistani and Bangladeshi origin. This is because of the well-documented health inequalities experienced by such groups, and their lower than average participation rates in physical activity. It is a positive finding, therefore, that across all initiatives, the largest user group by far was South Asian, and that the largest South Asian group, in turn, was Pakistani (as most user profiles were rough estimates no exact figures can be given). Numbers of reported Bangladeshi users were much lower. However, as the Bangladeshi community in Scotland is relatively small compared to Pakistani and Indian groups, this is not necessarily a concern.
Another positive trend was the fact that most organisations saw their initiatives as having been very successful in terms of participation rates, user feedback and, to a lesser extent, outcomes being met. Furthermore, the wide range of possible sources of funding available to initiatives was a welcome discovery.

However, a degree of frustration at having service provision limited by funding and resources was almost universal. In one way, this is quite hopeful in that both demand and the willingness to satisfy it exist. The shared view amongst many initiative providers, then, is that what is mainly needed in order to involve more BME people in physical activity is increased funding and resources.

A few organisations highlighted the fact that they could no longer provide certain activities, or had their current provision threatened, because of short-term funding coming to an end. Indeed the policy of funding for 3 years or less would appear to conflict with the overall goal of encouraging sustained participation in physical activity amongst BME communities.

One possible counter argument was raised by Culture and Sport Glasgow, who hold that their short-term provision of free instructors and other

assistance is aimed at helping organisations to become self-sustaining in the long-term. Moreover, both they and MEHIP (Multi Ethnic Health Inclusion Project) at NHS Lothian commented that the ultimate goal should be to encourage members of BME communities to access mainstream provision.

This latter point is a reasonable one, and gives added incentive to ensure that mainstream facilities are more culturally sensitive (respondents in both Edinburgh and Glasgow pointed out, for instance, that very little swimming exists in these cities that is suitable for Muslim women). If cultural integration is the main concern, another possible avenue for progress would be to build on the 'open to all' policies of many initiatives, encouraging more diversity amongst participants. This would have the added advantage that such initiatives would already be geared towards being culturally sensitive, better facilitating inter-community participation in physical activity.

Both Culture & Sport Glasgow's 'Active Glasgow' and MEHIP (who have incorporated Khush Dil – a voluntary organisation providing keep-fit classes to South Asian people) are examples of integrated cross-sector approaches to providing physical activity for BME groups. This is something which can no doubt be built on in the future.

A final issue to emerge from the mapping exercise is the manner in which certain activities were gendered. Many of the sports organised for younger BME people were male-dominated, such as football and cricket. In contrast, activities arranged for middle to older aged people such as keep-fit dancing classes were participated in much more by women. This was a situation recognised by some organisations, and a few initiatives were designed in order to specifically provide physical activity to younger BME women or older BME men. However, these gendered dimensions may require further exploration in future.

3.6 Conclusions

This mapping exercise has identified a range of initiatives promoting a wide variety of different types of physical activity amongst a spectrum of different groups within, but not exclusive to, BME communities in the Glasgow, Edinburgh, Dundee and Fife areas of Scotland. These organisations have primarily been located in the voluntary sector, but initiatives have additionally been provided by local authorities, the NHS, private organisations and community groups.

Initiatives varied considerably in both form and scope, from gentle exercise classes at day care centres involving less than 10 people to youth groups with hundreds of young people on their books. Correspondingly, aims and objectives ranged from keeping older people's joints healthy to facilitating social integration.

Most organisations had some form of evaluation in place for their initiatives, although the extent of monitoring ranged from taking a register to detailed assessments of project progress – often a requirement of funding bodies.

Organisations' own views of their work tended to be positive, and often it was reported that evaluation backed this up. Activities were mostly well-attended, with good user-feedback. It was harder for organisations to assess progress in terms of health and social benefits but, where this was possible, outcomes were again positive.

The main concern, as discussed in the previous section, was funding. Future research is needed in order to establish funding needs in more detail. However, it is clear that the tight availability of mostly short-term funding makes it more difficult for initiatives to bring about health and social change in the long-term.

Another finding was that there was a lack of initiatives involving younger women and older men. The group most notably absent was men aged 25-50. Although this may be because this is a group who are more likely to be in full-time employment, this is also a group who have most to gain in terms of preventative health measures. Once again, future research may be required to uncover more about how such initiatives are gendered, and why certain groups are underrepresented.

3.7 Recommendations

The following recommendations are inferred from the findings of this mapping exercise and complemented with REACH's experience of working with BME communities for the past 6 years. However, we strongly suggest that there is a need for further evidence into the area of physical activity initiatives among BME communities in Scotland in order to facilitate exploring the recommendations further.

Policy:

- there is a need for a more coherent and integrated (NHS, Councils (Schools), and the voluntary sector) policy by the Scottish Government aimed at long-term sustainability of physical activity initiatives for BME groups. More emphasis should be put on sustaining initiatives run by voluntary/community groups

- it is recommended that the funding agencies (government and non-government) should look into providing long-term financial support to initiatives in order to achieve better outcomes

- the Scottish Government along with other stake holders should seriously consider looking into how accessible government run health and wellbeing initiatives are to BME communities, i.e. leisure centres etc. Furthermore, they should also consider encouraging BME communities with high health risks i.e. Pakistani and Bangladeshi to take part in physical activity initiatives

- it is recommended that NHS Health Scotland, working with other relevant stake holders, should encourage a greater amount of physical activity initiatives tailored for BME younger women and middle-aged men.

Research:

- more research is needed into funding issues, and specifically whether greater availability of long-term funding is required in order to achieve sustainable project outcomes

- more specifically further research is recommended into how activities are gendered, with a focus on middle-aged BME men and younger BME individuals, particularly girls

- research is also recommended into the cultural and religious issues among BME communities, which may act as barriers for accessing certain initiatives/service. Such research could help in designing needs based services for BME communities.

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