

Research Article

Understanding Physical Activity in the Daily Lives of Bangladeshi and Pakistani Elders in Great Britain

Christina R. Victor

School of Health Sciences and Social Care, Brunel University, Kingston Lane, Uxbridge, Middlesex UN8 3PH, UK

Correspondence should be addressed to Christina R. Victor; christina.victor@brunel.ac.uk

Received 22 December 2013; Accepted 18 January 2014; Published 26 March 2014

Academic Editors: W. Qidwai and A. Remes

Copyright © 2014 Christina R. Victor. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

In the United Kingdom, there are physical activity guidelines specifically for older adults. Self-report data indicate that approximately 15% of those aged 65+ the activity target of 30 minutes of moderate intensity exercise on 5 (or more) days a week and 30% when the 150 minutes may be achieved in 10-minute (or greater) bursts. Levels of activity are higher among men, the more affluent, and those aged 65–74 but we have little evidence about levels of activity among the ageing ethnic minority population. Reanalysis of 109 interviews conducted with people aged 50+ from Bangladeshi and Pakistani communities was undertaken to explore how participants talk about physical activity in terms of their daily lives. Few, 13 participants (7 females), reported that physical activity and/or exercise formed part of their daily routine; a further 7 had been advised to take exercise by their doctors but had not done so and 9 described why they could not exercise. Barriers to exercise included lack of time (because of work or childcare) and cultural factors such as ideas about age and gender appropriate behaviour. We need to develop appropriate interventions to encourage exercise which address these cultural factors and general barriers to exercise.

1. Introduction

Cassel [1] proposes that physical activity offers the “*the best treatment for aging*” given the well-established benefits of physical activity for health and well-being across the life course. There is a clear trend evident in public health across both the developed and increasing developing world that exercise and physical activity interventions are adopted as methods of improving the physical health and well-being of the population. In this context, physical activity is broadly defined as bodily movement that results in energy expenditure and which may result from activities undertaken for work and household activities such as cleaning or gardening as well as sporting activities and recreation. In the United Kingdom, guidelines for desirable levels of physical activity have been articulated for the general population; it was only in 2011 that the guidelines for physical activity for older adults (aged 65+) were published [2] and specific advice about physical activity for those at risk of falls was articulated. Initially, the guidance was to undertake 150 minutes in 30 minute bouts over 5 days and is now refined to achieve this in bursts of 10 minutes or more. This inclusion of older

adults as a distinct group for whom such guidance is offered represents a “paradigm shift” in terms of the remit of these guidelines in response to both a developing body of evidence as to the benefits of physical activity in later life [3] and the emphasis in health and social policy on enabling older people to “age well.” Although the term “ageing well” is rarely clearly articulated, it includes promoting physical and mental being, social engagement, and physical activity and may be summarized in the established adage of “adding life to years and years to life.”

1.1. How Active Are Older People? The physical activity target for adults aged 65+ is 150 minutes per week of moderate intensity activity. Achievement of these targets has been evaluated using a range of approaches including standardised physical activity scales (e.g., the Zutphen and GPAC scales), self-rating questions, and, more recently, devices such as pedometers and accelerometers [4]. Whichever method of evaluating physical activity is used, there is an age related decline in activity levels and comparatively few older adults in the UK (and elsewhere) achieve target levels of activity [5].

The 2008 Health Survey for England (HSE) classifies physical activity into 3 bands: (a) those who meet the recommendation, (b) those who partly meet the recommendations (30 minutes of exercise on 1–4 days per week: 30 to 120 minutes physical activity), and (c) those with lower levels of activity. Using self-reported data, 19% of those aged 65–74 and 7% aged 75+ meet the recommended activity level, whilst 50% and 74%, respectively, were in the “low activity” group (i.e., they self-reported less than 30 minutes moderate intensity exercise a week) [6]. With the revised achievement of the target in 10 minute bursts, the achievement levels are 50% of those aged 65–74, 30% for those aged 75–84, and 10% for those aged 85+ [7]. There is external validation for these data from other surveys conducted in the UK and internationally [8]. The Scottish Health survey reports that 17% of men and 12% of women aged 65+ achieve the prescribed guidelines, whilst in Wales the respective prevalence was 21% and 13%. These levels of activity seem to have been stable for the last decade. Between 1997 and 2008 there was a marginal change in the achievement of activity targets for older people (e.g., the level for men aged 75+ was 7% in 1997 and 9% in 2008; for women the respective percentages were 5% and 6%).

However there are concerns as to the reliability and validity of questionnaire and self-report methods of physical activity assessment. For older people, it has been argued that they “underreport” physical activity by not including routine activities of daily living such as housework or gardening [9]. The availability of pedometers and accelerometers can now provide more accurate estimates of physical activity, as well as being used as “motivational tools” in physical activity interventions. Whilst there are debates about how best to interpret accelerometer data, these studies consistently and unambiguously demonstrate that self-report data overestimates levels of activity compared with accelerometry studies. Twenty percent of men aged 65+ 20% are classed as achieving the activity targets using self-report and accelerometry data are 10% and 0% respectively with 75% of both groups defined as “low activity” [6]. Similar disparities have been reported elsewhere in the UK and internationally [10].

1.2. What Factors Are Associated with Physical Activity in Later Life? Older adults both underreported the target levels of physical activity and overestimated their own levels of activity demonstrating a clear perceptual gap between their understanding of desired and actual activity levels. Developing a definitive list of “risk factors” that are consistently associated with lack of physical activity in later life is problematic because of (a) the variability and diversity across studies in “risk factors” included, (b) their method of operationalisation and measurement, (c) variability in the age groups studied, and (d) a focus on barriers to activity rather than facilitators. Within the British context, Chaudhury and Shelton [11] identify three key factors associated with physical activity for those aged 60–69: not being in employment (retirement has consistently been linked with a decrease in activity) [12], obesity, and the presence of a long-term illness. Harris et al. [4] report that age, health factors (general health; disability; diabetes; high body mass index),

and psychological factors (exercise self-efficacy and perceived exercise control) were associated with physical activity as measured by accelerometry for people aged 65+. These are all individually based factors which mirror the results of a review of barriers to exercise for older adults reported by Schutzer and Graves [13]. However, studies often exclude other important structural factors such as the nature of the local environment, financial/material resources, and social support and sociocultural factors.

1.3. What Are the Barriers/Facilitators for Activity in Older People? Our understanding of the barriers and facilitators for physical activity (and sedentary behaviour) for older adults is limited with the emphasis very much upon barriers rather than facilitators. Our evidence base includes a diverse range of concepts and measures related to activity. However, studies rarely include a common set of measures and are not rooted within theoretical or conceptual models of successful or active ageing. A recent systematic view of exercise after retirement was based upon 24 studies, of which 19 were quantitative and 10 were undertaken in the United States. Two factors were consistently associated with activity uptake, social factors (including giving structure to the day after retirement and offering opportunities to build new social networks), and perceived health benefits. The barriers focussed upon existing health problems, costs, caring responsibilities, psychological factors, and social expectations (the inappropriateness of exercise for older people). This latter issue, the perceptions of the appropriateness of physical activity of older people, is emerging as an important element in understanding these low activity levels [14, 15]. Koeneman et al. [16] reviewed factors promoting the uptake of physical activity/exercise by older adults (aged 55+) since 1990 and confirmed previously identified “risk factors,” namely, age, BMI, exercise self-efficacy, and social support [17, 18]. However, they were cautious about the robustness of these relationships because of the methodological weaknesses of the 30 studies reviewed concluding that “*Although a diverse set of possible determinants occurs in the literature (characteristics of the individual, and the social and physical environment) other possible determinants remain largely unstudied*” [16, page 13].

1.4. Linking Physical Activity with Active Ageing. Research evaluating the importance of factors in promoting physical activity in later life is strongly embedded within the public health, sports science, and health psychology traditions. It has rarely engaged with conceptual and empirical gerontological work examining “active and/or successful ageing.” We propose a model for explaining physical activity (and its corollary sedentariness) based on the existing literature combined with gerontological theories of successful/active ageing which highlight the importance of the social and physical environment, health resources, intrapersonal factors (identity, empowerment, autonomy, and self-efficacy), and age related factors and transitions such as retirement or bereavement (see Figure 1). We hypothesise that physical activity in later life reflects the interplay of resources across four key domains

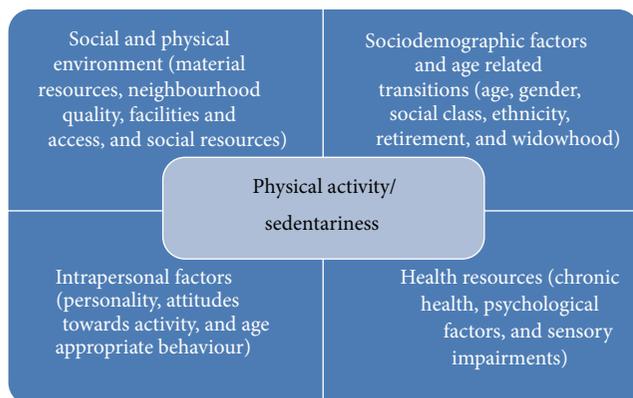


FIGURE 1: Factors associated with physical activity and exercise uptake by older people.

and that the importance of these dimensions may vary across time and between different groups of older people.

1.5. Ethnicity and Ageing. We agree with Koneman et al. [16] that there are key gaps in our knowledge base about physical activity in later life not just in terms of barriers and facilitators to activity but also in terms of populations studied. It is well established that the experience of later life is not homogeneous but varies according to sociostructural factors such as gender and social class [19]. One important gap relates to the prevalence and essential determinants of physical activity amongst Black and Ethnic Minority (BME) older people. This is a key gap in our knowledge base given the ageing of our minority population, the burden of morbidity characteristic of these groups, and the clear relevance of cultural factors for encouraging the uptake and maintenance of physical activity.

Like many other Western societies, Britain is undergoing important social and demographic changes, most notably the “ageing” of our population. Data from the 2011 census report that 16.4% of the population is now aged 65+ years. In Britain, ethnicity is defined on the basis of self-identification from a standard list of categories included in routine administrative data collection, social surveys, and the decennial census. This recognises that ethnicity is a multidimensional concept that embraces a constellation of characteristics including country of birth, skin colour, language(s) spoken, nationality, culture, and religion. Ethnicity represents an individual/group identity based upon shared origins or social background and shared culture and traditions that are distinctive and maintained between generations and a common language and/or religious tradition. It represents an individual’s self-assessment of their status and, consequently, may change over time. In terms of diversity, the 2011 census data reported that 16% of the population of England and Wales self-define themselves as nonwhite compared with 5% in 1991 with approximately 4% self-defining themselves as Black/African-Caribbean and 5% as South Asian (2.5% Indian, 2% Pakistani, and 0.8% Bangladeshi). These two trends intersect with the ageing of the communities of migrants who came to Britain in search of economic opportunities from the Caribbean and

India in the 1950s, from Pakistan in the 1970s, and with the Bangladeshi group arriving in the late 1970s and early 1980s. The overall population of Britain is becoming more diverse in terms of ethnicity. The 2011 census reveals that 12.2% of the population aged 65+ defines themselves as nonwhite compared with 6.5% in 1991. Although the median ages of most minority groups in the UK are young compared to the general population, for the African Caribbean and Indian groups, 14% and 10%, respectively, are now aged 65 years or older compared with 4% for the Bangladeshi and Pakistani populations and 18% of the white population. A key feature of these ageing members of our minority population is that they are almost exclusively comprised of first generation migrants who are ageing “in place” [14, 15]. Ten percent of the combined Asian group (Indian, Pakistani, and Bangladeshi) aged 65+ moved to the UK in later life (after age 50) as did 4% of the Black Caribbean/African populations.

The ageing of our minority communities is an important but relatively neglected issue in terms of research, policy, and practice in the UK context. Specifically, research focussing upon the ageing experience of older BME adults, sometimes referred to as “ethnogerontology,” is a relatively new field of research [20]. Research has focussed upon specific issues amongst individual minority populations within particular locations (e.g., social support systems of older South Asians in the south of England) [21]. Studies opting for a comparative approach across the key minority groups or adopting a national perspective are rarer but include a focus upon quality of life and loneliness/social exclusion [22]. Geographers, sociologists, and anthropologists who have focussed upon the Bangladeshi and Pakistani populations, the focus of this paper, have rarely engaged with issues of age and ageing [23–25] with Gardner’s study of older Bengalis living in East London a notable exception [25] but have documented their profound material, health inequalities, and social exclusion when compared with both the general population and other minority groups [26, 27]. Work from an explicitly gerontological perspective demonstrates a strong preoccupation with issues of health service access and/or the relationships between informal and formal care services and/or the support needs and experiences of informal carers [28]. Research with an explicit focus on broader issues of older age and later life is rare and there has been much less interest in broader issues of health such as physical activity and exercise or the broader topic of health promotion.

1.6. Physical Activity and Ethnic Minority Elders. Karlsen and Nazroo [29] argue that the relative disadvantage of older BME populations in terms of health status demonstrates the “double jeopardy” of being both aged and from a minority group and a “triple jeopardy” for older BME women [30]. Harper and Levin [31] quantify this differential by arguing that the health profile of a BME elderly equates to that of a person a decade older from the white population. How does this translate into engagement with physical activity and exercise? A systematic review of sport, physical recreation amongst BME groups of all ages, confirms that they participate less often compared to the wider population

[32] and for both casual (1x/month) and regular (1x/week) sport was 21% below the national average [33]. Focussing upon physical activity rather than sport, Stamatakis [33] reported that adult Asian (Indian, Pakistani, Bangladeshi, and Chinese) males and females were much less likely to achieve the target activity guidelines, with Bangladeshi men and women being especially vulnerable. This echoes the systematic review of Fischbacher et al. [33] who reported that activity levels of South Asian adults (not including those aged 60+) were generally lower than the white population with the differential varying across studies from 50 to 75%. For example 1% of Bangladeshi women aged 18–55 and 55+ self-reported that they achieved the physical activity guidelines [34]. Bowling [35] reports that minority elders were much less likely than the general population to consider that physical activity was part of “active ageing” and to participate in physical activity and that only 25% of minority elders had been for a walk in the previous month compared with 75% of the general population aged 65+.

Focussing upon South Asian women, a review by Babakus and Thompson [36] highlights the importance of cultural factors as a barrier to physical activity. The importance of cultural factors in understanding physical activity is not confined just to women as is illustrated by participants in the study of active ageing by Bowling defining chess and dominos as “physical activity.” Horne and Tierney [37] undertook a synthesis of 11 qualitative studies, 6 undertaken in the UK, of physical activity in relation to preexisting conditions (e.g., CHD) amongst older south Asian adults. This highlights the importance of cultural norms about ageing, activity and growing old acted as significant barriers to the engagement in therapeutic exercise based activities. Horne et al. [38] report the findings of qualitative research exploring physical activity among adults aged 60–70 from Indian and Pakistani backgrounds. The location where the study took place was one where much health promotion work activity had been undertaken and where there was a specific south Asian support worker who had been in contact with study participants. Of the 48 participants, 22 reported that they were physically active. This study differentiated between factors linked to initiation of and adherence to physical activity. Initiation of physical activity was linked with anticipated health benefits, social support, and the support of health professionals. Adherence to physical activity was also linked to social support as well as health status, psychosocial factors, and integrating physical activities into daily life and routines.

Although empirical data are sparse, there is an emerging consensus that levels of physical activity are lower among minority elders than other groups of older people with the Pakistani and Bangladeshi groups having the lowest levels of activity. Few routine large surveys of older people in the UK include sufficient numbers of minority community members for subgroup analysis. For example, the survey of quality of life in old age by Bowling [35] included 5 minority elders out of a total sample size of 999 people aged 65+. Similarly surveys of activity and exercise usually have relatively small samples of older people and even fewer from BME groups. There is some uncertainty about our evidence base about

the barriers (and enablers) for physical activity because of the heterogeneity of the populations studied in terms of age, the presence (or otherwise) of preexisting health conditions, recruitment from those engaged with services, and lack of clarity about details of ethnicity, with the term South Asian being used inconsistently across studies to include populations of Indian, Bangladeshi, Pakistani, Sri Lankan heritage, and Chinese [39]. Previous studies are limited but highlight the importance of cultural norms about activity. This was identified as significant barrier to engagement in therapeutic exercise based activities but has been less discussed with regard to physical activity more broadly. Research have not examined how physical activity and exercise are embedded within the daily lives of older people from Pakistani and Bangladeshi populations. Given the lack of evidence about the role of physical activity in the lives of minority elders, this paper reports how older people from Bangladeshi and Pakistani populations talk about physical activity within the context of everyday life using the reanalysis of data collected for a project examining daily life and growing old amongst these populations.

2. Materials and Methods

In our project *Families and Caring in South Asian Communities*, we focussed upon understanding the daily lives and experiences amongst Bangladeshi and Pakistani elders. The initial focus was on daily life and routines, levels of participation in transnational and local communities, perceptions and experiences of family lives, social networks, “place” and locality, and ideas, meanings, and experiences of “care” and “support.” We aimed to recruit 60 Pakistani and 60 Bangladeshi participants (total 120) equally distributed across three age groups (50–59, 60–69, and 70+) and between men and women: a target achieved for the Pakistani but not Bangladeshi populations. Our data consists of 109 interviews with people aged 50+ from Bangladeshi ($N = 50$) and Pakistani ($N = 59$) populations. Almost half, 57, were female, the mean ages were 57 for the Bangladeshi group and 62 for the Pakistani group and the mean length of residence in the UK was 20 and 29 years, respectively. Participants were recruited from the general community and were not accessed via gate keepers or via participation in groups or clubs or via receipt of services.

Interviews, lasted for about an hour (range 25–100 minutes), were undertaken in the preferred language of the participant by bilingual researchers (104 in either Urdu or Sylheti) and 102 were recorded (with the permission of the participant) and transcribed verbatim and then translated. All participants were given a pseudo name and details which could identify them were removed from the transcripts. Further details of the recruitment of participants, the interview guide, the challenges of using translated interviews as primary data, and the ethnic matching of researchers, are available elsewhere [39]. Our initial analysis of the data identified 25 initial codes which were collapsed into 5 key themes: understanding and experiencing ageing, the context of ageing, resources for ageing, transitions, and culture and

identity [38]. Given the dearth of information about physical activity in our minority groups, we undertook secondary data analysis of our existing data to focus on this new question. Secondary data of qualitative research is less common than for quantitative data sets. However, there is a growing recognition of the potential of reanalysis of qualitative data for this role. For this reanalysis, all transcripts were reviewed by the author and all mentions of physical activity, exercise/physical activity in general, and references to specific activities such as walking, exercise classes, swimming, cycling, going to the gym or participation in sports/games such as football and tennis, and other physical activities such as gardening and housework were identified. These narratives could be either positive remarks about exercise or descriptions of how/why the participant was unable to engage in exercise as well as reports of being advised to take/stop exercise proffered by health professionals, family, or friends. These transcripts were then reviewed in depth and the key factors linked to physical activity/exercise were identified and compared with the barriers/enablers previously identified, namely, age, appropriateness of activity in later life, cultural ideas about ageing, cultural norms about women, existing health problems, perceived health benefits, advice from health professional, support from family/friends, work, and caring responsibilities. Responses were further linked into the four domains of our theoretical model, namely, (a) resources, (b) sociodemographic factors, (c) individual characteristics, and (d) the social and environmental context.

3. Results and Discussion

Of the 109 transcripts reviewed, 23 contained some mention of physical activity or exercise in either a positive or negative way in the context of their daily lives. So, for the vast majority of our participants, activity and exercise were not mentioned at all. This demonstrates that, for most, of our group exercise and physical activity did not figure as a part of the way that they talked about their daily lives and their daily routines. This would suggest that either such activity is so “taken for granted” that participants did not talk about them or that, for the majority of our participants, 86 out of 109, exercise and activity were not part of their daily routine. This latter interpretation would seem to fit with the epidemiological evidence for the general population of older people where we know that most are not active. Furthermore, our interviewers probed in considerable detail the pattern and rhythm of participants’ daily lives and routines and thus we are forced to conclude that few were engaged in routine habitual activity of the type enshrined in government and health education guidelines. This suggests that studies such as that reported by Horn et al. [38] overrepresent the active: 22 out of her 48 participants were described as “active.” Thus whilst the results of that study are useful in terms of suggesting why individuals maintain activity, they may be less useful in understanding why the vast majority of the population do not engage in physical activity. Studying those who successfully embed activity and exercise into their daily lives is important and

useful but, unfortunately, provides little insight into those who do not achieve this.

Of those participants who mentioned exercise 14 were male and 9 were Bangladeshi with an age range from 46 to 71. Focussing upon this group, we distinguished those who reported that they exercised, those who wanted to or had been advised to exercise, and those discussed why they did not exercise. Four individuals, 3 male (aged 48, 51, and 54) and 1 female aged 67, presented reasons why they did not exercise. The 3 males were all employed as taxi drivers. For 2, exercise was seen as part of the job as illustrated by the following comments: “*I am a taxi driver and drive a lot. Also I have to walk and move around which are sufficient for me*” (Liyaqat aged 48) and, similarly, Tahir commented “. . . *my work is my exercise*” (Tahir aged 51). Taaj in his fifties gave the long hours he worked as the reason for not exercising: “*I (sic) do not have days off. . . If I need to take a day off, then I do. Otherwise, I work on weekdays and the weekends too? (sic) Sometimes, I feel like going and doing some exercise for myself, but I never get any time.*” These comments reflect their very long working hours in low status jobs in the restaurant trade or as taxi drivers. This demonstrates the intersection of ethnicity and class. Within the British context Bangladeshi and Pakistani communities are characterised by employment in low status, low wage occupations often characterised by long working hours. In this context we might suggest that lack of engagement in activity and exercise reflects issues of class rather than ethnicity.

Cultural factors were very important in constraining activity for the one woman who discussed why she could not be active. Zakira, a 67-year-old Pakistani women, articulated the requirement for gender specific spaces and activities and self-imposed cultural norms when she stated “*What would the neighbours think if I was walking in the street?*” Whilst the requirement for gender specific activities is well established, the power of the community via “informal” norms and sanctions to constrain women from being active in the public sphere is less well established. This latter explanation was hinted at in the study reported by Horne but in a positive sense that cultural values were changing such that activity was being positively evaluated. It is not just in the field of physical activity that cultural norms influence the lives of women. Victor et al. [39] discuss how expectations of age appropriate behaviour constrain how older women in these communities both dress and behave which are illustrated by the comments of Iffat Bangladeshi female aged 60 “*I buy clothes that are appropriate to wear for my age. . . I feel tired, weak, depressed and also I am aware that I should behave as people expect from a murubbi (elder) in our culture*” (Iffat aged 60) and “*As I am now an aged person, I have to wear different types of dresses matching with my age*” (Naila aged 50).

Our second group consists of those who wanted to be active or had been advised to be active by their family/friends and/or a health professional. Previous research by Victor et al. [39] stressed the importance of support from health professionals and also perceived health benefits in the initiation and continuance of activity. Seven participants, 2 of whom were women, had been advised by their GP to be more physically active. Zakira, 65, commented that she did not like to exercise

although she had been advised to do so by her doctor “he said to do exercise and walk but I do not like it very much.” Qudisyra, a decade younger, reported that her GP had advised her to exercise for weight and blood pressure reasons. She had been to the gym once but was yet to return. Alim’s, a 54-year-old male, comments are typical of the types of responses given to the advice to exercise “I need exercise, but I do not exercise. . . Nowadays, I—like to walk—(sic) but there is no time. For health, for health to improve a little.” His wife interjected “Since he had a bypass, doctors have told him to walk at least 3 miles every day. He has not done even 3 furlongs.” To which Alim replied that “There is just no time.” Although his family supported and wanted him to exercise, he was clearly advised by his GP to do so and was aware of the health benefits; he did not exercise. For our participants although clearly appraised of the potential benefits of exercise and with the support and the encouragement of their doctor and family this was not sufficient to get them to start exercising.

There were 12 participants, 6 males and 6 females, who reported that physical activity and/or exercise were part of their daily routine. However we have limited details of their engagement with activity and no details of the duration or intensity of these endeavours. One 47 male reported that he had *chosen bicycle for this* (to keep fit) (Faatih) but did not give any further details. Zamine, a 67 year old male, commented “Often, the thing that I do regular is (sic), recently I have joined swimming. Exercise at least 4, 5 times a week and golf (sic).” One the women was unusual in stating “I go to the gym 3 times a week.” Aisha a 53-year-old female observed “I go swimming, I go to the sauna. I go to the sauna as I really like it, after you go swimming and then you enter into the sauna, the pain that you have in your body goes away. I also do, they teach us some aerobic exercise in the water, and I also do that.” Whilst Laila who was 52 reported “I go to exercise classes with friends. . . I go to exercise classes twice a week. I do not know how much it is helping my weight but all my friends go so I enjoy it very much and we always have a chat at the end,” her comment was the only one that reported—unprompted—the importance of the social side of engaging in physical activity. No other participants commented on this which previous studies have shown to be an important facilitator of engaging in exercise.

The most commonly reported form of exercise was walking and participants referred to their doctors as promoting walking as the most appropriate form of exercise for this group. Mahmood, a male in his seventies stated “I take my grandson and walk him to school. After leaving him there, I take a long round on foot, and then I walk back home.” Wajida, a 51 year old woman, commented “I also go for a walk. That is for my health, so I walk for a while, that’s how the day goes. I go out for the sake of it sometimes so I can walk.” Our interviewer then asked, in a surprised tone, “You go out walking by yourself?” To which Wajida replied “Not by myself but with my mother-in-law, my daughter-in-law goes too and I go too, there are other Bengali’s that go too.” This links back to the issue of cultural norms raised earlier. Uzma, a 62 year old, commented “I pray to Allah to keep me healthy, control my diet & eat less, do some walk and exercise, although I am not that healthy. . . I’ll prefer if it (her arthritis of the knees)

is cured by using medicine only, or by walking, exercise, losing some weight. I do try.” She went on to comment further about the importance of who women were seen walking with “if you are walking with someone good, they say that she is also good. If you walk with someone bad they say that she is also bad.” So social sanction and constraints operate to both deter women from walking in public on their own and then, if they walk in a group, make judgments on their character and reputation by whom they were seen walking with. Within the UK walking is promoted as the safest form of exercise for older people but—in the context of women from the subcontinent—adherence and engagement with this is problematic as it offered multiple ways in which they could breach accepted norms of behaviour with resultant consequences for their reputation within the community.

3.1. Concluding Comments. Within the UK, there are few studies looking at exercise and physical activity among older people from our minority communities. Those studies that have often been conducted with more engaged members of our minority groups such as the studies by Horne et al. [37, 38]. The strength of our study is that we interviewed members of our Pakistani and Bangladeshi communities who were not accessed via services or gatekeepers and that our in-depth interviews focussed upon their daily lives. We did not specifically ask about exercise but did ask about health and what they did to maintain it. As such, there were clear opportunities within the interview where participants could talk about activity and exercise. Qualitative research is powerful in the fact that that it clearly indicates what participants do and do not talk about. In this context, the failure of participants to “talk about” activity suggests that this was just not something that figured in their daily lives. We see that, for this group of individuals, engagement in physical activity was low, at best 11% (12 out of 109), but is in line with quantitative estimates. Fewer still build exercise and activity, including walking, into their daily lives. Explanations for why they did not exercise, often in the face of clear explanations of the potential health benefits and the encouragement of their GP, need further investigation. For a large proportion work—either in employment or looking after dependents (grandchildren or spouses) was a contributory factor and such explanations are unlikely to be limited to this group of older people. It is a clearly implicit assumption within many exercise interventions that older people are not “busy” and have plenty of time to engage in activity. For both our participants and the wider population, this was not the case. In addition, cultural factors, including expectations of age and gender appropriate behaviour, were also important. We need to recognise the importance of both generic and specific factors if we are to develop interventions to promote physical activity that are both culturally appropriate and effective in bringing about long term behaviour change.

Ethical Approval

This was given by the University of Reading Ethics Committee and all participants gave written informed consent.

Conflict of Interests

The author declares that there is no conflict of interests regarding the publication of this paper.

Acknowledgments

This study was funded by ESRC Grant reference RES-352-25-0009A as part of the *New Dynamics of Ageing Programme* directed by Professor Alan Walker of Sheffield University. Dr. Wendy Martin was the coinvestigator and Dr. Maria Zubair was the research fellow. The author wishes to formally acknowledge Dr. Subrata Saha for her work on the project between 2007 and 2009 and the author is especially grateful to all of those who participated in the study.

References

- [1] C. K. Cassel, "Use it or lose it: activity may be the best treatment for aging," *Journal of the American Medical Association*, vol. 288, no. 18, pp. 2333–2335, 2002.
- [2] "Start active, stay active: a report on physical activity for health from the four home countries' Chief Medical Officers," 2011, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128209.
- [3] E. Tulle and N. Dorrer, "Back from the brink: ageing, exercise and health in a small gym," *Ageing & Society*, vol. 32, no. 7, pp. 1106–1127, 2012.
- [4] T. J. Harris, C. G. Owen, C. R. Victor, R. Adams, U. Ekelund, and D. G. Cook, "A comparison of questionnaire, accelerometer, and pedometer: measures in older people," *Medicine and Science in Sports and Exercise*, vol. 41, no. 7, pp. 1392–1402, 2009.
- [5] N. Anokye, S. Pokhrel, M. Buxton, and J. Fox-Rushby, "Physical activity in England: who is meeting the recommended level of participation through sports and exercise?" *European Journal of Public Health*, 2012.
- [6] "Health Survey for England," 2008.
- [7] "Health Survey for England," 2012.
- [8] F. Sun, I. J. Norman, and A. E. While, "Physical activity in older people: a systematic review," *BMC Public Health*, vol. 13, p. 449, 2013.
- [9] M. H. Murphy, P. Donnelly, G. Breslin, S. Shibli, and A. M. Nevill, "Does doing housework keep you healthy? The contribution of domestic physical activity to meeting current recommendations for health," *BMC Public Health*, vol. 13, p. 966, 2013.
- [10] K. Kowalski, R. Rhodes, P. J. Naylor, H. Tuokko, and S. MacDonald, "Direct and indirect measurement of physical activity in older adults: a systematic review of the literature," *The International Journal of Behavioral Nutrition and Physical Activity*, vol. 9, p. 148, 2012.
- [11] M. Chaudhury and N. Shelton, "Physical activity among 60–69-year-olds in England: knowledge, perception, behaviour and risk factors," *Ageing & Society*, vol. 30, no. 8, pp. 1343–1355, 2010.
- [12] D. Barnett and C. Guell, "Physical activity and the transition to retirement: a mixed methods systematic review," *Journal of Epidemiology & Community Health*, vol. 65, supplement, p. A345, 2011.
- [13] K. A. Schutzer and B. S. Graves, "Barriers and motivations to exercise in older adults," *Preventive Medicine*, vol. 39, no. 5, pp. 1056–1061, 2004.
- [14] E. Costello, M. Kafchinski, J. Vrazel, and P. Sullivan, "Motivators, barriers, and beliefs regarding physical activity in an older adult population," *Journal of Geriatric Physical Therapy*, vol. 34, no. 3, pp. 138–147, 2011.
- [15] J. Herbert, *Negotiating Boundaries in the City: Migration, Ethnicity and Gender in Britain*, Ashgate, Aldershot, UK, 2008.
- [16] M. A. Koeneman, M. W. Verheijden, M. J. M. Chinapaw, and M. Hopman-Rock, "Determinants of physical activity and exercise in healthy older adults: a systematic review," *International Journal of Behavioral Nutrition and Physical Activity*, vol. 8, article 142, 2011.
- [17] M. M. van Stralen, H. de Vries, A. N. Mudde, C. Bolman, and L. Lechner, "Determinants of initiation and maintenance of physical activity among older adults: a literature review," *Health Psychology Review*, vol. 3, no. 2, pp. 147–207, 2009.
- [18] S. G. Trost, N. Owen, A. E. Bauman, J. F. Sallis, and W. Brown, "Correlates of adults' participation in physical activity: review and update," *Medicine and Science in Sports and Exercise*, vol. 34, no. 12, pp. 1996–2001, 2002.
- [19] C. Phillipson, *Ageing*, Polity Press, 2013.
- [20] S. Koehn, S. Neysmith, K. Kobayashi, and H. Khamisa, "Revealing the shape of knowledge using an intersectionality lens: results of a scoping review on the health and health care of ethnocultural minority older adults," *Ageing & Society*, vol. 33, no. 3, pp. 437–464, 2013.
- [21] C. R. Victor, W. Martin, and M. Zubair, "Families and caring amongst older people in South Asian communities in the UK: a pilot study," *European Journal of Social Work*, vol. 15, no. 1, pp. 81–96, 2012.
- [22] M. Bajekal, D. Blane, I. Grewal, S. Karlsen, and J. Nazroo, "Ethnic differences in influences on quality of life at older ages: a quantitative analysis," *Ageing & Society*, vol. 24, no. 5, pp. 709–728, 2004.
- [23] J. Brice, "Migrants and the second generation: health inequalities in Bristol's Bangladeshi community," *Durham Anthropology Journal*, vol. 15, no. 1, pp. 59–105, 2008.
- [24] A. M. Bowes and N. S. Dar, "Researching social care for minority ethnic older people: implications of some Scottish research," *British Journal of Social Work*, vol. 30, no. 3, pp. 305–321, 2000.
- [25] K. Gardener, *Narrative, Age and Migration: Life History and the Life Course Amongst Bengali Elders in London*, Berg, Oxford, UK, 2006.
- [26] J. Nazroo, "Ethnicity and old age," in *The Futures of Old Age*, J. Vincent, C. Phillipson, and M. Downs, Eds., Sage, London, UK, 2006.
- [27] J. Nazroo, M. Bajekal, D. Blane, and I. Grewal, "Ethnic inequalities," in *Growing Older. Quality of Life in Old Age*, Maidenhead, A. Walker and C. Hennessey, Eds., pp. 35–39, Open University Press, 2004.
- [28] G. Giuntoli and M. Cattani, "The experiences and expectations of care and support among older migrants in the UK," *European Journal of Social Work*, vol. 15, no. 1, pp. 131–147, 2012.
- [29] S. Karlsen and J. Y. Nazroo, "Religious and ethnic differences in health: evidence from the Health Surveys for England 1999 and 2004," *Ethnicity and Health*, vol. 15, no. 6, pp. 549–568, 2010.
- [30] A. Norman, *Triple Jeopardy: Growing Old in a Second Homeland*, Centre for Policy on Ageing, London, UK, 1985.
- [31] S. Harper and S. Levin, "Family care, independent living and ethnicity," *Social Policy and Society*, vol. 4, no. 2, pp. 157–169, 2005.

- [32] J. Long, K. Hylton, K. Spracklen, A. Ratna, and S. Bailey, *Systematic Review of the Literature on Black Minority and Ethnic Communities in Sport and Physical Recreation*, Sports Councils, 2009.
- [33] E. Stamatakis, "Physical activity," in *Health Survey for England 2004: the Health of Minority Ethnic Groups*, K. Sproston and J. Mindell, Eds., National Centre for Social Research Royal Free and University College Medical School, London, UK, 2004.
- [34] E. D. Williams, E. Stamatakis, T. Chandola, and M. Hamer, "Assessment of physical activity levels in South Asians in the UK: findings from the Health Survey for England," *Journal of Epidemiology and Community Health*, vol. 65, no. 6, pp. 517–521, 2011.
- [35] A. Bowling, *Ageing Well: Quality of Life in Old Age*, Open University Press, Maidenhead, UK, 2005.
- [36] W. Babakus and J. L. Thompson, "Physical activity among South Asian women: a systematic mixed-methods review," *International Journal of Behavioral Nutrition and Physical Activity*, vol. 9, p. 150, 2012.
- [37] M. Horne and S. Tierney, "What are the barriers and facilitators to exercise and physical activity uptake and adherence among South Asian older adults: a systematic review of qualitative studies," *Preventive Medicine*, vol. 55, no. 4, pp. 276–284, 2012.
- [38] M. Horne, D. A. Skelton, S. Speed, and C. Todd, "Attitudes and beliefs to the uptake and maintenance of physical activity among community-dwelling South Asians aged 60–70 years: a qualitative study," *Public Health*, vol. 126, no. 5, pp. 417–423, 2012.
- [39] C. Victor, M. Zubair, and W. Martin, *Families and Caring in South Asian Communities in Walker A, the New Science of Ageing*, vol. 2, Policy Press.



Hindawi
Submit your manuscripts at
<http://www.hindawi.com>

