# Knowledge into Action – Community-led research that makes a difference

# Food security, diet and obesity – exploring the experiences of ethnic minority groups

## 1. Introduction

Central and West Integration Network (CWIN) was established in 2009. and works to support asylum seekers, refugees, black and minority ethnic communities and migrant workers across Glasgow and actively works to promote integration with these communities. We work to alleviate poverty in these communities, improve their standard of living and actively promote their settlement and integration within the wider community. We help destitute individuals and families in times of crisis and hardship where they may often have no other support available. We are based at the Garnethill Multicultural Centre, 21 Rose Street, Glasgow. Our services include: Emergency Food Aid through our weekly food bank, community meal, drop in service to provide help, advice and support, English classes, Youth club, Women's group CWIN also host events in the year including International Women's Day, Refugee Week, Black History Month, 16 Days of Action to Eliminate Violence Against Women, Health information days and Mental Health Awareness.

This community-led research approach builds on a previous CWIN project exploring food security in Black and Ethnic Minority (BME) people in Glasgow. We recruited and trained a team of 12 Community Researchers to participate in the design and implementation of the research project. 6 of the original Community researchers were joined by 6 new recruits.

For more information about Community-led research and a report about the CWIN food security research visit the Community Food and Health (Scotland) - CFHS website: www.communityfoodandhealth.org.uk

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## 2. Background

A current major issue in public health is diet and obesity, with the Scottish Government's new strategy "A Healthier Future"[1] , building on a previous policy - the Obesity Route Map [2]. The new strategy aims to change the food culture and combines polices to tackle environmental issues, encourage more active health lives and exemplary practice. There is considerable

[1] https://consult.gov.scot/health-and-social-care/a-healthier-future/user_uploads/00526543.pdf
[2] http://www.gov.scot/Publications/2011/03/17104457/2

quantitative data on diet and obesity[3], for example, 65% of adults in Scotland are overweight, 47% of type 2 Diabetes is attributable to overweight, and we also know that the public find it hard to recognise obesity though they do understand it is harmful and support action to tackle it[4]. We also know that minority ethnic communities can experience a high level of type 2 Diabetes and have cultural or religious beliefs or practices which influence how they cope with this condition[5]. In this context the particular needs and experience of BME, refugees, asylum seekers and migrant workers, are an aspect of the picture which is perhaps less well understood, or a voice less clearly heard.

## 3. The research project

### What did we want our research to explore?

- Cultural understanding and awareness about diet and obesity.
- Differences or factors that may affect attitudes to diet and obesity. E.g. culture, income.
- Barriers to eating well and having a healthy lifestyle
- Actions for change – individual, community, organisations, councils, government.

### Who did we speak with?

The Community Researchers designed a set of questions and arranged a Food, Diet and Obesity event (28/9/18) where local people from ethnic minority backgrounds (56) were interviewed. Other questions were used to interview BME focused voluntary sector organisations (3) and local councillors (3). One person answered the questions by e-mail where it was difficult to arrange a face to face interview. Most of our questions were open-ended. The Community Researchers discussed the findings and considered further questions they would like explored and actions for change.

### Limitations

We had less or no feedback from the under 20s and over 65s. These are gaps that we would like to explore in the future. Other gaps in data collection include NHS, statutory service providers and retailers.

We found that, despite the Community Researchers being a diverse group with many different languages, language was a barrier. One of the researchers used google translate to communicate with one person. We think that language difficulties may have led to misunderstanding some of our questions and some contradictory responses.

## 4. Findings

The following findings summarise the data collected from different stakeholders. We have also included individual stories to show different experiences of BME people and their views on diet, obesity and healthy lifestyles. We gave each individual a pseudonym.

[3] http://www.obesityactionscotland.org/briefings/
[4] http://www.healthscotland.scot/media/1705/public-attitudes-to-reducing-obesity-in-scotland.pdf
[5] P Holt Type 2 Diabetes in south Asian people Nursing Standard May 2012

## The BME stakeholder group (56)

- This group included a mixture of people living with their families or living alone, some were students, one was a carer, some people were on benefits, some were unemployed, and there were 19 refugees and asylum seekers.
- They came from 23 different countries including people from Iraq, United Kingdom, Iran, Pakistan, Russia, Sudan, Sri Lanka, Libya, Eritrea, Afghanistan, Burundi, Albania, Algeria, China, Ghana, India, Kuwait, Malawi, Scotland, Senegal, Sierra Leone, South Africa, Syria.
- The biggest ethnic groups were Asian (23 people) and African (15 people).
- 35 were women and 21 were men.
- Although there were people from 16-64 years, there was only 1 under 20 years, most were 25-35 years (21) and 45-64 years (15). There were no over 65 year olds.
- 13 people had lived in Glasgow for less than a year, 18 were more settled having lived in Glasgow between 1-5 years, and 24 had lived in Glasgow for more than 5 years.
- Nearly three quarters of the people in the group were either not earning or lived on less than £200 per week.

### *Diet, eating patterns and choices*

- People described a healthy diet as eating a balanced diet of vegetables, fruit, fish, meat, rice etc. Three quarters said they included fruit, vegetables and/or salad in their diet.
- Cultural foods were seen as healthy. But comments about cultural food being eaten in greater quantities e.g. three meals a day, when guests are visiting, suggest it could be more difficult to ensure a balanced diet.
- Everyone (56) in our survey said that they cooked their own food, and most cooked at home every day. From this survey we do not know what people mean by 'cooking'.
- Most people said they did not grow their own food.
- Most people bought their food from local shops, local markets and to a lesser extent, cultural shops. The most popular supermarkets were Lidl, Tesco and Aldi. One person said that they got food from the church, youth club and community meals.
- Most people said that they did have access to the cultural foods that they wanted. Others reported that their cultural food was important to them, but it was often too expensive.
- Affordability was the main barrier that prevented people from having a healthy diet. (33).
- Time (9) and accessibility (3) were also a barrier.
- If people couldn't afford the food they wanted they told us that they:
    - Go for any cheaper food; go for another choice; eat what is available.
    - Go to community places, giving free food like CWIN.
    - Skip meals or don't eat.
    - Make the best use of leftovers.
    - Rely on family for food and money or borrow from friends.
    - One person recognised that even though they could afford what they wanted, they make different choices depending on budget.

**Ji-Hye** is a Korean female from Russia living in Glasgow less than 6 months. She is between 20 - 24 years old. She is not earning at the moment and lives with her family. For her, cabbage, fruits, dairy foods and vegetables are a healthy eating lifestyle.

Ji-Hye cooks every day. She buys her cultural food ingredients from the local shops, but only certain shops sell the items. Sometimes healthy foods are very expensive for her to consume. She thinks overeating and sedentary lifestyle is bad for health and leads to obesity.

To keep up her healthy lifestyle, Ji-Hye goes jogging sometimes. She thinks that food shops affect attitudes and behaviour towards diet and obesity. If she needed help, Ji-Hye would go to her local GP, local community centres and local council or government. She would help herself by doing her own exercise.

### *Awareness of obesity and its impact on health*

- Being obese was seen as a health problem or medical condition *'… a kind of sickness'* and not good for you (35).
- Disadvantages were highlighted: poor health, fitness, poor mobility, lack of confidence, social stigma, low mood, low energy.
- Half of the people in the survey suggested that being overweight or obese could lead to a higher risk of conditions such as heart disease, high blood pressure, stroke or diabetes. A minority of people though it could also, or instead, be associated with asthma, joint problems, lack of stamina, depression, fatigue, cancer, digestive problems. 6 people simply said that it was associated with a range of conditions or that it could shorten life.
- People thought that the causes of being overweight or obese were: diet related (35), such as overeating and eating unhealthy foods such as high calorie food, sugary food, fats, fast food, junk food , lack of exercise (4) or both diet and exercise (7)  some physical or mental health issues such as stress, depression, some cancers were also mentioned.
- Other factors that people highlighted were linked to overweight and obesity included: poverty, inequality and lack of food security, lack of access to opportunities to exercise, lack of information.
- In a later prompted question, people (47) agreed that by doing more exercise and healthy eating you can help prevent obesity.
- Two thirds (33) said that they exercised every day. 5 said they exercised once a week and 7 did no exercise. One person said they were advised by their GP not to exercise.
- Walking was the most common form of exercise (26). Others would go running or jogging (9), or played football (8), went to the gym (5), exercised at home (3), cycled (1) and housework (1).

**Raza** is between 25 – 35 years old and has lived in Glasgow between 1-5 years. Raza is from Iran. He lives with his family and is currently not earning. He keeps his healthy lifestyle by eating fruits, vegetables and sea foods.

Raza cooks once a week and gets his food items from the local markets. Affordability is the barrier for Raza to consume his cultural food. He thinks that overweight and obesity is a kind of sickness caused by fast food and unhealthy food which will end up with heart attack.

Raza cycles every day. He thinks that doing exercise every day, eating healthy foods and volunteering are the way of healthy lifestyle.

### *Cultural effects and influences on attitudes towards obesity and diet*

- People said there were cultural influences on their attitudes towards obesity. 2 mentioned examples showing it was positive to be overweight, such as:

  '*In my country food is very expensive, if people become overweight it means they are rich. All people want to become fat.' (BME survey respondent)*

  *'In my culture, overweight women are considered attractive.' (BME survey respondent)*

  And 9 mentioned more negative examples, such as *'Overweight and obese people are ashamed in my culture, especially if they are unmarried women.' (BME survey respondent)*
- People also highlighted a culture influence of overeating – *'everybody offers you food'*, '*often cook three meals a day*'. '*Where I am from there is a culture of large portions of food which makes obesity more likely.*' *(BME survey respondents)*
- Others (13) thought there were no cultural influences on their attitudes towards obesity.
- Other factors that people thought effected their attitude and behaviour towards diet and obesity were:
  - The people they socialise with such as friends and family. (34)
  - The shops and the places where they buy their food (20).
  - The media such as adverts, newspapers, TV etc (19).
  - Living in Glasgow (10).

**Abeer** has lived in Glasgow between 1 – 5 years. She is an Arabic lady from Syria. Her age is between 36 – 44 years old. She lives with her family and lives on less than £200 per week. Abeer consumes vegetables, fruits, chicken and lamb to ensure healthy eating.

She buys her foods from Tesco, local markets and local shops. Even though cultural foods / ingredients are very expensive, she still buys these. She thinks that unhealthy foods, fast foods and not doing exercise are the main cause of overweight, obesity, illness and high blood pressure. Consuming ethnic cultural foods which contains more oily, spicy and deep-fried foods are also the cause of overweight and unhealthy lifestyle.

Abeer exercises everyday by walking. She gets help and encouragement from her friends, GP and attending community events and she believes in doing more exercise will prevent illness.

### *Changing lifestyles – barriers and actions for change*

Encouraging factors

- People said that the things that would motivate them to change their diet and lifestyle was wanting to be happy, fit and healthy. Avoiding sickness, poor health, and being overweight.
- For some, money was an issue if they could not afford to make the changes they wanted.
- Support from friends and family, seeing their GP, and a friendly approach would encourage people to seek help.
- Two thirds said they would seek help within their community from for example their local GP, nurse or a specialist clinic.
- About half said they would help themselves by for example walking, jogging and keep fit.
- About a third said that they would seek help from local projects such as CWIN, Saheliya, Amina. Others (15) said they would seek help from the local council such as Glasgow Life.

Barriers to change

- The barriers that prevented people from seeking help were costs, access to transport, language barriers, feeling self-conscious, shy or ashamed, lack of time, opening hours, waiting times or simply being lazy.
- Two people said that their status was a barrier: *'Until now I don't have proper documents to access anything and also financial difficulties.'*

Actions for change

At the event, discussion with a small group of BME people (14) told us what they thought could be done to help people from ethnic communities to change their diet and lifestyle:

- The community and local projects:
- Language – learned informally through talking with others and ESOL classes.
- Create awareness groups (about healthy eating and healthy lifestyle) in community centres.
- Provide community activities that involve every individual to complete exercises that help build up their healthy living. Speaking and eating food together. Provide walking groups and dance groups.
- Could offer free provision of healthy food to help people build/improve their health status, dignity with respect and equality.
- Projects like CWIN to give food, money, house, school, hospital. Information and awareness.
- The local council: should provide access to leisure centres, walking groups, gym membership for people on benefits.
- The Scottish Government/UK Government should tell retailers to use the traffic light symbols on food products and should ensure healthy food for schools
- Retailers should not sell sugary, oily and salty stuff, move sweets and offers from tills and lower the price of healthy foods

**Raju** who is from India has lived in Glasgow for more than 10 years. His age is between 45-64 years old. Raju's weekly income is £300-400 and he is living with his family. According to Raju

"healthy life means happy life by consuming more vegetables and fruits". Raju eats fish, rice, steak and pasta.

Raju cooks daily and he buys his food items from the local shops / local markets. He consumes cultural food to remain healthy and it is affordable for him. Raju thinks that overweight and obesity will slow down daily activities and cause cancer, fatigue and stroke.

Raju exercises everyday by walking, jogging and running. He thinks that social groups, family, friends, and media advertisements affect attitudes and behaviour towards diet and obesity. He suggests encouragement, group talks, discussions and practicing what you have learned are the key points for keeping healthy.

Voluntary sector organisations (3) told us:

*Their role with BME people and communities was to:*

- Advocate, support and advise asylum seekers and refugees to claim asylum and to support people who get their legal status.
- Work with families e.g. access to school, clothing grants, school meals.
- Work with BME young people (10-25) e.g. access to positive opportunities such as healthy eating and cooking on a low budget linked in to ESOL, sports groups e.g. football, cycling linked to food and nutrition. Trips to the countryside are popular with newer asylum seekers.
- Signpost other organisations and services such as CWIN, Social Bite, foodbanks.
- Deliver services such as food banks, vouchers etc to BME people living in poverty in the community.

*Barriers to eating a healthy diet and having an active lifestyle for BME people included:*

- Low income, reduced choice, need to prioritise what is most important/urgent need.
- Affordability, cost of cultural foods, transport costs.
- In asylum process, not being able to work so very little money.
- Lack of/no cooking facilities if you are homeless and destitute, living in temporary accommodation, hostels etc.
- Racism and fear of racism deter people from outdoor exercise, walking and cycling etc.
- Cultural stigma e.g. BME people not wanting to be seen to be seeking help, lack of knowledge about food banks in the indigenous communities.

*Cultural factors that they felt influenced BME attitudes towards diet and obesity:*

- Some cultures frown on women cycling and walking although there has been some movement on this among the Scottish Pakistani community.
- Traditions of hospitality and richer food to offer guests can lead to weight gain.
- For people coming from a background of starvation or lack of food, putting on weight seems healthy.
- People are influenced by what they know, the people that feed them, family, culture.

*The things that they thought would help people from ethnic communities to improve their diet and lifestyle included:*

- Running healthy eating/low cost cooking classes and activity groups like cycling and walking.
- Offering safer opportunities and groups for different age groups and genders.
- Providing ESOL classes especially for new comers.
- That BME people have opportunities for part-time work, training, education and courses.
- Awareness and messages about diet and health need to be culturally relevant for BME community.
- Access to information about healthy diet and active life style and where to go for support.
- People need to know the effects of certain foods on their health e.g. fast foods, good and bad fats and that what you do now can affect you in the future e.g. heart attack, diabetes.
- Local projects/organisations linking up with other organisations and working together to provide opportunities.
- Local council:
    - Making leisure facilities more available to be utilised by the community
    - Providing funding to access gym and swimming pools especially for children.
    - Providing a safer environment e.g. improve street lighting.
    - Increasing number of plots for allotments and community gardens.
- Government (Scottish/UK):
    - Need for change – refugee rights to work.
    - Changing policies on destitution e.g. need end to end support, more humane approach.
    - Obesity/health agenda given priority and make resources available e.g. free leisure passes.

The councillors (3) told us that:

- They are aware of issues of diet and obesity and emphasised the council's role to promote healthy living across the whole population.
- The council's role in getting funding to the BME community through for example the Participatory Budgeting Citizen's Panels.
- The council's role in signposting people to different services and advice and working with organisations like CWIN.
- The council also supports green spaces, community gardens, community meals and events. promoting the health benefits and the reuse of derelict land.
- Barriers for BME people were identified as not knowing where to go for information, financial issues, accessing services, cultural differences.
- Low income e.g. through Universal Credit as a barrier and discriminatory against BME people who may have large families and maybe cannot afford a healthy diet.
- Councillors talked about wanting to engage with BME people but highlighted challenges where BME people don't go to their politicians to talk about issues and were less likely to speak up for themselves.

- One councillor thought that asylum seekers should be allowed to work, to contribute and to be part of society for their own health and wellbeing.

## 5. Discussion and conclusion

Overall, BME people in this survey have a strong knowledge and understanding about the link between obesity, diet and health. BME people surveyed thought that obesity could be prevented by doing more exercise and eating a healthy balanced diet. These findings are comparable to a national survey[6] on attitudes to overweight and obesity. The national survey showed that

- most people (when provided with a list of conditions) are aware of the links between being overweight or obese and health conditions, particularly health disease, high blood pressure, diabetes and strokes.
- When asked, most people are aware that diet and a lack of exercise cause overweight and obesity

More people in our survey had a negative view of obesity than a positive view which included cultural attitudes both positive and negative towards being obese. Affordability was the main barrier to eating a healthy diet and limited access to activities like swimming and going to the gym. Affordability was a particular issue for the BME people we surveyed, three quarters of whom were living on very low/no income and included refugees, asylum seekers, unemployed and people on benefits. This finding was slightly different to a national survey[7] which had asked people to indicate from a list of options what the barriers to a healthy weight was, including 'healthy food is too expensive for most people'. The national survey found that 40% agreed with this statement (50% of people from the lowest income group). Our survey found that affordability was an issue for 33 people (63%).

Other key findings included:

- BME people told us that they cook at home whereas in the rest of the population, the use of convenience foods or food and drink bought out of the home has increased[8] [9]. Cooking at home has been associated with improved diet quality, although the evidence can be inconsistent.[10]
- Cultural food was seen as healthy but also acknowledged as unhealthy when it is eaten in greater quantities for example the custom of offering guests food. Cultural food is also acknowledged as very oily.

[6] http://www.healthscotland.scot/publications/public-attitudes-to-reducing-overweight-and-obesity-in-scotland
[7] http://www.healthscotland.scot/publications/public-attitudes-to-reducing-overweight-and-obesity-in-scotland
[8] https://www.foodstandards.gov.scot/downloads/An_assessment_of_the_out_of_home_market_in_Scotland_2015.pdf
[9] http://openaccess.city.ac.uk/18189/
[10] https://www.emeraldinsight.com/doi/full/10.1108/BFJ-09-2016-0432

- There were different cultural influences on attitudes to obesity such as being fat as a sign of wealth; in some cultures, as a woman it is attractive to be overweight yet in another culture, being overweight is unattractive especially for unmarried women.
- However, those people who said that being overweight was a sign of wealth in their culture were also aware of the health conditions associated with being overweight.
- Obesity was seen as a medical issue. It is a health problem that can lead to long term illness such as heart attack, stroke, diabetes, but obesity can be prevented by eating a healthy diet and doing more exercise.
- Most people said they did not grow their own food. This may be lack of space, not living in their own house, concerns for the weather and/or they don't know about growing produce.
- Nearly all the BME people we surveyed told us that they exercised every day. The most cited activity was walking. We need to find out if BME people walk as a leisure activity or as a need for example because they can't afford transport.
- There was reference to the importance of social interaction through activity groups and eating together as a way to include people, reduce isolation and limit the effects of food insecurity.

Barriers to eating well and having a healthy lifestyle:

- Affordability was the main barrier to people having a healthy diet. Cultural food and healthy foods were seen as expensive especially for refugees, asylum seekers and people living on very low income.
- Affordability was also a barrier to exercise and activities e.g. the cost of the gym and transport costs.
- For some, immigration status meant inability to work, very low/no income, poor access to cooking facilities.
- Language was highlighted as a barrier by BME people and voluntary organisations. Discussion with the Community Researchers identified other difficulties that arise such as communicating the need for help, accessing information, knowing where to buy cultural food ingredients, social isolation and the effects on mental health.
- Voluntary organisations highlighted the fear of racism as a barrier for BME people going out alone e.g. walking, jogging, cycling.
- Councillors described how there are difficulties in addressing need when BME people do not speak up and/or engage with politicians through for example their surgeries.

Further questions to explore:

- What do BME people mean by 'cooking'?
- Do BME people walk as a leisure activity or is it a need because of the cost of transport?
- Is cultural food different in Glasgow/UK? Is it less fresh? Is there a barrier to growing cultural food?
- Does the 'fear of racism' affect exercising and going out alone given that walking was the most common physical activity?

## 6. Actions for change

BME people in this survey gave their suggestions for individuals to change their lifestyle:

- To stay active – walking, gym, swimming, whatever you are interested in.
- To eat healthy.
- To start volunteering.
- To join in events and activities in your local community centre.
- To share with friends, socialise, join a club.
- To ask, find out, communicate, seek help.
- To stay positive.

Community and voluntary organisations:

- Linking up with other organisations and working together to provide opportunities such as ESOL classes especially for new comers, healthy eating, low cost cooking and activity groups.

Councils:

- To provide better access to leisure facilities for refugees, asylum seekers and BME people on a low income e.g. free access to swimming, gym and bus tickets (transport). Currently, refugees and asylum seekers have access to reduced costs of £1 for swimming and £4 for gym. This is still too much for people on very low or no income.
- To promote activities provided by voluntary organisations like CWIN such as walking groups.
- To provide funding for services to support positive activities that encourage BME people towards a healthy diet and lifestyle in the prevention of obesity.

Retailers and cultural shops:

- To provide food vouchers for refugees, asylum seekers and BME people on low income.

Government:

- To ensure that the BME voice and experience is included in government policies and plans that encourage healthy diet and lifestyle in the prevention of obesity and promotion of good food such as Good Food Nation[11] and the Public Health Priorities[12].
- To address concerns about refugees and asylum seekers status and the ability to work.

What will CWIN do as a result of this research?

- Share findings from our research and the community-led research approach:
  - Hold an event for BME people, voluntary organisations, councillors, and agencies like NHS and funders.
- Use the knowledge from our research to inform and influence change:
  - Communicate through social media, conferences, etc.
  - Seek meetings with government, NHS and local authorities.

[11] https://www.gov.scot/policies/food-and-drink/good-food-nation/

[12] https://www.gov.scot/publications/scotlands-public-health-priorities/

    - Contact the councillors we met about funding opportunities and to discuss allotments and spaces for growing your own food.
- Seek funding to support positive activities that encourage BME people towards a healthy diet and lifestyle in the prevention of obesity such as starting a men's groups.
- Embed healthy diet and lifestyle activities into existing groups: women's group, community meals, food bank and ESOL classes. Activities could include social outings to the countryside, a 'pick-your-own' outing, baking cultural bread etc.
- Use an assets-based approach to develop for example volunteering opportunities that draw on the talents and skills of BME people.