UNIVERSITY OF BIRMINGHAM

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Ageing in a multicultural/superdiverse society: New challenges, new dimensions

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I. Health and Ethnicity

Life expectancy is increasing and it is estimated that by 2025 there will be a world population of 1.2 billion people older than 60 years of age (WHO 2002). The World Health Organisation estimates that across Europe the number of adults aged ≥85 years (defined as the "oldest-old") is projected to increase from 14 million in 2012 to 40 million by 2050 (WHO 2012), resulting in this age group being the world's fastest growing segment of the population (Collerton et al,. 2009). This extraordinary increase in the number of older adults has far-reaching implications for individuals, families, communities, and health- and social-care systems, as there is the potential for many older adults to live a greater number of years in poor health.

It is well established that chronic physical and mental disorders including obesity, cardiovascular disease, type 2 diabetes, hypertension, cancer, arthritis, osteoporosis, depression, dementia and cognitive impairment are primary causes of morbidity, disability and mortality in older adults. Lifestyle behaviours, specifically healthy eating and regular physical activity, are recognised as key contributors that can work both in combination and independently to reduce one's risk for developing these disorders and mitigate their impact in older adults with disease (WHO 2002). An older person who consumes a healthy diet and remains fit, active and engaged in community life is more likely to enjoy independence, enhanced physical and mental well-being, and a higher quality of life (Bruèyre et al 2005; Liu 2012; Sieverdes et al 2012).

Malnutrition is of particular concern in older adults. Malnutrition is defined as a state in which there is a deficiency, excess, or imbalance of energy and nutrients which leads to adverse effects on body tissues, function, and/or clinical outcomes (Malnutrition Action Group, 2011). In the UK, it is estimated that at any one time undernutrition affects over 3 million older people (The Advisory Group on Malnutrition, 2009). Approximately 10% to 14% of people living in sheltered housing have been found to be at risk for undernutrition, as well as 30% to 42% of residents recently admitted to care homes (BAPEN Quality Group, 2010, p. 4). Even older adults living in the community in their own homes are at risk; data from the 2010 Health Survey for England (The Information Centre for Health and Social Care, NHS, 2011) indicate that 0.3% of those aged 65-74 years and 1% of those aged 75 years or older are underweight (defined as a body mass index <18.5 kg/m^2). Concurrently, overweight and obesity are a growing concern in older adults as they increase the risks for, and complications of, chronic diseases such as cardiovascular disease, type 2 diabetes, hypertension, and some cancers. The prevalence of obesity in the UK is 28% in men and 37% in women aged 65-74 years, and 26% in men and 27% of women 75 years or older, respectively (The Information Centre for Health and Social Care, NHS, 2011).

It is well recognised that health-related behaviours specific to healthy eating and regular physical activity (PA) play an important role in terms of prevention of malnutrition, management of chronic diseases and coping with functional decline among the older adults.

Previous research has identified important factors that influence nutrition and physical activity behaviours in older adults. For example, national data from the UK indicate that only 37% of older adults (≥65 y) meet the recommendation of "5-a-day" portions of fruit and vegetables, and that they exceeded the recommendations for saturated fat (less than 11% food energy) (Bates et al. 2011). Barriers to eating more fruit and vegetables in older adults include relatively high cost, poor availability, inconvenience, living and eating alone, having to adapt to familial preferences, and early life influences (Baker & Wardle 2003, Thompson, 2002, Tucker & Reicks 2002, Devine et al. 1998). Regarding physical levels among older adults, the 2008 Health Survey for England indicated that less than 30% of those aged 65-74 years and 15% of those 75 years and older report engaging in moderate PA for more than 10 consecutive minutes in the previous four weeks (Craig et al. 2009). Reported barriers for regular physical activity among older adults include physical frailty and poor health, lack of support from family and friends, low self-motivation, poor knowledge of the benefits of regular activity, lack of access to facilities, lower socio-economic status, and neighbourhood environment (Fox, et al. 2011; Stathi et al. 2012; Schutzer & Graves, 2004).

A literature review conducted for this Commission confirms a paucity of research into ageing within multicultural and superdiverse communities. Existing evidence indicates that many ethnic minority groups are consistently shown to have significantly higher risks for various chronic diseases, including obesity and related metabolic complications (Misra & Ganda 2007). For instance, South Asian and African-Caribbean women in the UK have a higher prevalence of central obesity, hypertension and type 2 diabetes than the white British population (Gilbert & Khokhar 2008, Cappuccio et al. 2003). In relation to physical activity, data from the Health Survey for England (The Information Centre 2006) indicate that Indian, Bangladeshi, Pakistani, and Chinese men and women residing in England are less likely to meet physical activity recommendations than the general White British population. While genetic factors play an important role in the aetiology of disease, a genetic susceptibility combined with environmental and modifiable factors related to unhealthy eating and physical inactivity may explain these differences in health outcomes (Ngo et al. 2009, Jackson et al. 2006). Evidence indicates that many ethnic minorities experience genetic, cultural, social, environmental, and economic barriers to adopting and sustaining healthful lifestyle changes. This contributes to significantly increasing their risks for many physical and mental health disorders as compared to their white counterparts, which consequently leads to their relatively higher rates of morbidity and mortality.

II. The Shift from Multicultural to Superdiverse Communities – Implications for Researching Health and Ageing

Over the past 20 years, migration patterns in Europe, and particularly the UK, have moved away from the arrival and settlement of large numbers of low- or semi-skilled labourer migrants with colonial links to a new pattern of migration that has been labelled "superdiversity." Superdiversity is a complex interaction of individuals coming from a plethora of countries of origin via a multitude of migration channels, and who are extremely diverse across immigration status, rights and entitlements, gender and age, and patterns of spatial distribution (Vertovec 2007; Phillimore 2010, 2013). Compared to post-colonial migrants, these superdiverse migrant groups are smaller in number, more transient, less organised, and more economically stratified; they are also more likely to move into areas that are already ethnically diverse, bringing together multiple languages, faiths and religious practices, and cultural norms and values, resulting in diversity both between and within ethnic groups (Vertovec 2010; Phillimore 2010).

Although London has traditionally been considered the most ethnically diverse city in the UK, Birmingham is becoming increasingly diverse, with 42% of residents from a non-white ethnic group and 22% being born outside of the UK (Birmingham City Council, 2013). According to Phillimore et al (2010), Birmingham houses migrants from over 170 countries. These changing demographics, and the ageing of migrant populations, provide both challenges and opportunities for policy makers, researchers, and health and social care providers. It is doubtful that the existing multicultural model of provision can meet the needs of superdiverse communities due to the lack of established community groups that can engage in consultation, and our inability to locate the multitude of superdiverse groups to examine their needs and determine how to deliver effective provision (Phillimore 2010).

Despite many ethnic minorities suffering increased rates of morbidity and premature mortality, we know from research conducted by the University of Birmingham that ethnically diverse groups are under-represented in clinical and health research (Redwood and Gill, 2013; The Information Centre 2006). According to Redwood and Gill (2013), it is unclear whether this under-representation is due to 'planned exclusion', 'inadvertent exclusion', 'non-participation', or a combination of these. Lack of inclusion of diverse ethnic groups in clinical and health research is unacceptable: it affects resource allocation for services, and compromises the validity and generalisability of research findings (Yancey et al 2006; Redwood and Gill, 2013). An exploration of views about research among older ethnic minority UK adults indicated that they feel over-researched, and that the research conducted to date has not been of benefit in improving their health (Butt and O'Neil 2004). They expressed a need for services and research that directly involves their input and meets their needs of culture, language, and beliefs about health and wellbeing that may differ from the views of health care practitioners and the dominant community. They emphasised that older people can bring strengths, knowledge and wisdom to the research process and want to be seen as an asset, not a burden to communities. Researchers were viewed as being out of touch with what is needed to promote healthy ageing in their communities. However, Gill and colleagues (2012) emphasise that ethnic minorities are willing to participate in research if it is directly relevant to them as individuals and to their community, and if they are approached with sensitivity and a clear explanation of what the research will involve.

Chandrika Gordhan told us about how **Birmingham Arthritis Resource Centre (BARC)** had formed a network of champions from the local ethnic minority communities to help to recruit, mentor and educate older people with arthritis in the local ethnic minority communities [insert ref and link to Chan's presentation]. This enabled BARC to work with these communities, and demonstrated how willing communities might be to work with Universities if they are given meaningful opportunities to do so. The champions – many of whom came from disadvantaged backgrounds – all reported that they too had benefitted from the project, developing transferable skills and knowledge and acquiring confidence, as well as enjoying the experience of interacting with new people and being able to offer help.

These challenges of more inclusive research highlight the need for the development of new skills and approaches when conducting research and planning service provision for superdiverse communities. In addition, we heard evidence [+reference and link to their presentation]from the Centre for Policy on Ageing pointing to the need to train those working within health research, practice, and service provision in cultural competency. This includes awareness of the unique and defining characteristics of diverse populations involved in health care and research settings, and includes understanding the importance of social and cultural influences on individuals' beliefs and behaviours (Harvard Catalyst 2010). In the context of research, bringing cultural competence to study design and implementation, analysis and interpretation of results, and conclusions and presentation of

findings can help to ensure that research is applicable to ethnically diverse populations. Existing evidence indicates that most researchers do not understand the perspectives of ethnic minority communities and have not received training on cultural competence, and are thus unable to incorporate these perspectives into their work (Rabionet et al 2009). Phillimore (2010, p. 22) takes this one step further, suggesting that we may need to create "…a new profession of super-diversity specialists…" to develop and deliver appropriate and effective health, social and welfare services.

III. Factors Influencing Healthy Ageing in Ethnically Diverse Older Adults – Challenges and Opportunities to Conducting Research in Superdiverse Communities

One important challenge to researching healthy ageing within ethnically diverse groups is the diversity surrounding how individuals and communities define "old." The standard used to define "old" is traditionally based on chronological age, where becoming an older adult is defined as beginning at age 65 years. This is inconsistent with how individuals define getting "old," where many define getting "old" based on life events (e.g. menopause, becoming a grandparent, retirement) or the onset of illness, chronic disease, and/or chronic pain. As previously discussed, ethnic minorities experience a disproportionate burden of chronic disease, disability, and premature mortality; as a result they are also recognised as ageing much earlier than the White population. It is suggested that these greater health and social disparities throughout their lifetime contribute to accelerated and unhealthful ageing (Wolfson 1996). Thus within many ethnic minority groups, a person can be considered "old" in their 40's. This has important implications for both research and health provision, as the need for services for many ethnically diverse older adults will not necessarily be consistent with the current availability based on chronological age.

The following quotes illustrate this concept; these are quotes from focus groups conducted with ethnically diverse older adults from the Birmingham area as part of the evidence gathering process for this Commission:

"Getting old for a woman is when she stops her menstrual cycle, and starts going grey, that is how I see myself as old now." (Arabic Women's Focus Group)

"We had to wait until we were 60 to get the bus pass, it should be given out at 50. By the time we reach 60 we are too old to move, so what good is a bus pass at 60? Well I am now 66 and by the grace of god I am doing ok…" (Arabic Women's Focus Group)

"You have to age, but it is about how the individual feels about themselves. I think to age well is to age better. Eating properly & exercising regularly are really good for you if you do not have mobility problems." (Afro-Caribbean Focus Group)

"I have not aged the way that I wanted to and that is because unfortunately, I had a stroke at a young age way before I was due to retire. This left me with disability and felt I aged before my time." (Afro-Caribbean Focus Group)

Faith and religion are important factors that can act as either promoters or inhibitors of adopting and sustaining healthy lifestyle behaviours and subsequently affecting a person's potential for ageing healthfully. For instance, commonly reported barriers to participation in physical activity among Muslim women is the lack of access to female-only facilities and programmes, clothing restrictions, cultural norms that discourage participation in physical

activities, and the concept of fatalism or the perception that one's health status is Allah's will and out of a person's individual control (Babakus and Thompson 2012). In contrast, research participants have indicated that education about the Muslim faith can be used as a potential motivator of physical activity, as being physically active is seen as central to the Muslim way of life (Grace et al 2008). This view is consistent with the findings from focus groups conducted during evidence gathering for this Commission (refer to quotes below), as older adults from a range of faith groups emphasised the importance of faith-based community groups, centres and activities as vital components of enhancing both physical activity and social engagement within the community.

"I am 67 now, and I am really happy with my life and attending the mosque regularly is very important for me to feel good about myself." (Ladies Gujarati Shia Muslim Focus Group)

"We are here for each other, and that makes us feel stronger. We learn from each other and we just feel that everyone here is like our family, we feel really wanted and that is really important. I think when you share your concerns with people you can trust than it helps you to cope better with things in life." (Ladies Gujarati Shia Muslim Focus Group)

"Our faith is also very important that helps us to be understanding and provide that mutual support."(Ladies Gujarati Shia Muslim Focus Group)

"Yes…being part of the community [referring to faith-based community group] is really important for me and am right to say for us all. My community is supportive and it is good to meet here as a group, and we talk and have some food and drink and share our concerns and have a good laugh too." (Arabic Women's Focus Group)

"I feel really positive knowing that there is a community spirit to help and support each other, which makes me feel really confident to seek help when needed." (Arabic Women's Focus Group)

"We come here at this centre. and we really feel at home, and there is so much community spirit here with this group" (Afro-Caribbean Focus Group)

"Church is my community too"..... (They all agreed unanimously) (Afro-Caribbean Focus Group)

"…I am really blessed that I have good family, and my faith really helps me to keep going but also being part of this [community] group has given me strength and motivation to enjoy my life to the full." (Mixed Gender/Faith South Asian Focus Group)

"My faith is really important to me; it helps me to stay on a right path. Having a good amount of wisdom and education will help you age better, because you will know what to do during difficult times. If you are mentally healthy, then I feel that generally you can cope with difficult times as you could find ways of managing with stress and do something about it, and I think this would really help in the ageing process." (Mixed Gender/Faith South Asian Focus Group)

"With this [community] group we come together from diverse backgrounds, but together we are so much stronger and we provide mutual support and friendships, it does not matter what faith you are. We are all one family and we share in each other, [the] good and sad times together"...That to me is what makes a good community." (Mixed Gender/Faith South Asian Focus Group)

"My religion provides me with spirituality and selfless care, which bonds the community together. Strangers become good friends and together I feel we make our lives and others' a meaningful one". (Mixed Gender/Faith South Asian Focus Group)

A considerable amount of research has been conducted over the past 30 years exploring the associations between health and social support. Early research confirmed that individuals who are isolated and have limited social support are at increased risk for mortality from various causes, recurrence of traumatic health events such as myocardial infarction, and poorer survival rates following such events. Subsequent research indicated that the structure and composition of social networks and strengths of social ties are associated with perceived health and disease outcomes (Cohen 1988; House et al 1988; Berkman 1995). Among older adults, diverse and strong social networks are associated with higher morale, lower risk for depression, higher physical function and mobility, better perceived health, and maintenance of optimal cognitive function (Litwin 2001; Fiori et al 2006; Yeom et al 2008; Michael et al 1999; Thanakwang 2009; Barnes et al 2007). Older adults from ethnic minority communities report greater risk of isolation, poor social support, and changing family structures that challenge existing stereotypes that ethnic minority families "take care of their own" (Butt and O'Neil 2004).

The influence of family can also serve to promote or inhibit the adoption of healthy lifestyle behaviours and social engagement. This is illustrated by the results of an ESRC-New Dynamics of Ageing funded study investigating migration, nutrition and ageing across two generations of Bangladeshi families living in Cardiff, UK and Sylhet, Bangladesh (Thompson et al, in press). Older women (45+ years old) who migrated from Bangladesh to the UK and their younger adult daughters (18-35 years old) participated in assessments of nutritional status, physical function, food environments, traditional plant knowledge and use, and cultural, social, familial and life history influences on perceptions of nutrition, health and ageing. Results indicate that although older mothers and adult daughters report being the key figure in the family for food shopping, food choice and food preparation, it is the preferences of their husbands and children that exert the predominant influence over what is cooked and served. Although health professionals were identified as a key information source for health advice after disease diagnosis in UK women, family members (children, siblings, parents) were the main source of health-related, cooking, food/plant and nutrition information in both countries; these individuals were reported to exert a very strong influence on older women and their ability to make dietary and physical activity changes. Older UK women were found to have significantly lower physical function suggestive of high risk of frailty as compared to older women in Bangladesh. Many older UK women reported being socially isolated, with desire for diverse social connections identified as the primary motivator to get out of the house (Vera-Sanso et al, in press). Although many daughters recognised the benefit of their older mothers being more active and socially engaged, PA was not consistently supported in families, as social norms and expectations of ageing were reported to discourage physical activity and promote minimal activity as a means to honour older adults. These findings support the existence of a complex interplay between families, cultural norms and social influences that impact the ability of some ethnic minority older adults to make healthy behaviour changes.

Language is a major determinant of whether individuals can understand how to access health and social care services, incorporate professional advice into their daily lives, and engage with the wider community. Although language support is supposedly provided for the main ethnic minority groups in the UK, translation and interpreters are costly, and as a

consequence these services are not always available when needed. Gill and colleagues (2009) conducted an analysis of the number of people within ethnic minority communities in England who required translation services, finding almost 300,000 individuals from the four main ethnic communities (Indian, Pakistani, Bangladeshi, and Chinese) who required translations services. This number represented over 2.5 million general practice consultations per year that might require interpreting services. The actual need for these services will be much greater within superdiverse communities where hundreds of languages and dialects may be spoken. Additionally, professional interpreters appear to be under-utilised in relation to need, with bilingual staff, family and friends commonly used to provide translations (Gill et al 2011), and interpreters may not always be reliable due to poor attendance and may lack the ability to effectively translate information about symptoms (Phillimore 2010). The lack of validated, culturally and linguistically tailored research tools to assess the wide range of health-related behaviours of ethnically diverse older adults is a major limitation that needs to be addressed to ensure that any research conducted within superdiverse communities can accurately measure key health behaviours and outcomes.

IV. Conclusion

Although a standard definition of "healthy ageing" has not been agreed, various factors influencing one's potential for healthy, active ageing have been identified and include culture, gender, health and social services, physical environment, and social, behavioural, economic, and personal factors. Despite the recognition of the role these factors play in healthy ageing, we lack a clear understanding of the specific role of each factor, and the interaction between these factors, in influencing lifestyle choices and health-related outcomes among ethnically diverse older adults living in superdiverse communities. Both ageing and lifestyle choices occur within the context of others, including family members, friends and neighbours. This interdependence can serve as a positive, health-promoting force in the lives of older adults, or can prohibit or limit the ability of older adults to adopt and sustain healthy lifestyle changes. To date, the majority of research has mainly focused on the older adult population as a homogenous group (e.g. white older men). The limited research that has been conducted with ethnic minorities to date focuses on examining discrete ethnic groups (e.g., South Asians or Afro-Caribbeans). There is a critical need for research examining ageing through the lens of superdiversity, and to move away from traditional approaches and funding calls that examine, and assume homogeneity, within a single ethnic group. It is imperative that we rethink our approaches to policy, research and practice and develop processes that will allow us to gain a deeper understanding of how living within a superdiverse urban environment influences ageing. To continue relying upon existing approaches of examining individual ethnic groups creates an artificial environment that does not reflect the realities of how older adults live their lives in the current era of superdiversity.

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