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Re- thinking sport: physical activity and healthy living in British South Asian Muslim communities.

ABSTRACT

An increase in the participation rates of British South Asian Muslim communities in sport and physical activity is a high priority in both the sport and health sectors. Interventions emanating from the sport development sector have to date achieved little significant growth of activity. However, interventions within the health sector appear to be more successful in engaging South Asian communities in activity. This paper is based on field research in a Healthy Living Centre in Blackburn, a town with a large South Asian Muslim community. The research suggests that within such communities a mode of delivery grounded in physical activity and personal health is likely to be more successful than one based on sport and competition. However, it also identified other cultural factors that will need to be addressed if participation rates are to be further increased.

1. INTRODUCTION

One of the most seemingly intractable problems in leisure management in the United Kingdom in the past three decades has been that of effecting an increase in participation in sport and physical activity amongst ethnic minority, and particularly, South Asian communities, that is, those of Indian, Pakistani and Bangladeshi heritage. The *Health Survey for England* (NHS, 2005), for example, found that although there were differing rates of participation within these groups, with that of Indians being higher than that of Pakistanis and participation by Bangladeshis being the lowest of the three, all exhibited lower rates than the general population. This survey did not suggest that any significant improvement had taken place since the Sport England (2000) survey of ethnic minority participation in sport. This issue has been extensively addressed not only in the United Kingdom (for example, Carrington and Macdonald, 2000; Fleming, 1995; Ismond, 2003; Lawton et al, 2006; Snape, 2005; Walseth, 2006) but in other western countries with culturally diverse populations, notably the United States of America and Canada (Kahan, 2003; Kalavar, et al., 2004; Kandula and Lauderdale, 2005; O'Loughlin, et al. 1999). An internationally common theme is the association of low levels of participation in sport and physical activity amongst Asian communities with a prevalence of diseases and illnesses which could be improved through higher levels of physical activity. Consequently, the promotion of sport and physical activity has become a dominant feature of health policy with, for example, the emergence of

medically based fitness centres in the United States of America (Jarmusz and Druck, 2004) and, in the United Kingdom, the Department of Health's (2005) policy document *Choosing Activity: a physical action plan* which places a priority on interventions with black and ethnic minority groups. Health based interventions in physical activity have, by definition, a focus on health, exercise and well-being rather than on elite performance and competition, which are concepts closely associated with sport. This paper presents an evaluative description of a health-based intervention to increase participation in physical activity within a South Asian community in Blackburn, England, and suggests that the health sector has developed models of good practice in engaging in physical activity within a community to whom the concept of sport does not universally appeal. Although the research did not set out to focus predominantly on women's participation, the significance of gender as a limiting factor of participation within British South Asian Muslim communities inevitably necessitated a more intensive investigation of women's participation than men's. However, a number of factors are highlighted which are of equal importance to both men and women, and those factors which are particularly related to women's participation are identified as such.

HEALTH POLICY AND PRACTICE IN SPORT AND PHYSICAL ACTIVITY

In recent years there has been a substantial conflation of public policy on health with that on sport. The promotion of exercise and physical activity amongst social groups with low rates of participation in sport is central to Sport England's national strategy, being clearly articulated in its current strategic plan *The Framework for Sport in England* (Sport England, 2004). The primary focus of this plan is on greater participation in order to achieve the target set in *Game Plan* (Department for Culture, Media and Sport, 2002) of increasing rates of participation to a point at which 70% of the population are "reasonably active", defined as 30 minutes of moderate exercise five times a week. In the health sector, the 1998 green paper *Our Healthier Nation* (1998) explicitly acknowledged the causal link between physical activity and the prevention of heart disease, bone disease and mental ill health and proposed the establishment of Healthy Living Centres which would promote health and whose brief would include the promotion of exercise. More recent government strategy on health (Department of Health, 2004), is grounded upon the enabling of individuals to make lifestyle choices that

would improve their own health while acknowledging that opting for such choices is easier for some people than for others. Although the adoption of exercise and physical activity as a lifestyle choice with a significant potential to improve health is repeatedly promoted throughout this document, the impact of social inequalities on the differing extent to which people might experience challenges in becoming more physically active is also recognised. Following a report on the inter-relationships between physical activity and health, (Chief Medical Officer, 2004), the Department of Health (2005) with the Department for Culture, Media and Sport published *Choosing Activity*, an action plan which positioned the promotion of exercise and physical activity as a core theme in the delivery of health services.

At a local level Primary Care Trusts, which receive 75% of the National Health Service budget, have a responsibility to promote health and well being within the communities they serve. Healthy Living Centres, which were introduced in 1998, have a crucial role in the implementation of this policy. Funded through the New Opportunities Fund, the Healthy Living Centre programme was launched in 1999 with 349 Healthy Living Centres being established throughout the United Kingdom. These Centres were expected to address health promotion in the widest sense and to reduce inequalities in health (NHS, 1999). Several have since done much to promote physical exercise amongst under-represented groups, including black and minority ethnic groups, through working in partnership with other local agencies (Big Lottery Fund, 2004). Many Centres facilitate or co-ordinate initiatives such as exercise referral schemes, walking for health programmes, rehabilitation exercise, women's only fitness sessions and other programmes of physical activity which make significant contributions to public health but which lie beyond the traditional parameters of sport development.

Health and Sport Policy and South Asian Communities

While South Asian communities represent only a small proportion of the national population of England and Wales, with Bangladeshis constituting 0.5%, Indians 1.8% and Pakistanis 1.3% (National Statistics, 2001), their spatial distribution exhibits a pattern of concentration, particularly in large cities and in the former textile towns in the Pennine regions of Lancashire and Yorkshire. Displaying several indicators of disadvantage in terms of health, South Asian communities have become a priority target for health improvement and increased physical

activity. The *Health Survey for England* (NHS 2005) recorded that one in seven Bangladeshi men and one in ten Pakistani men reported bad or very bad health, with one in seven Bangladeshi and Pakistani women reporting a similar condition. South Asian groups consistently displayed a high prevalence of angina and heart attack, particularly amongst those aged 55 and over in which the prevalence of angina was highest in Pakistani men (30.9%) and Indian women (14.7%), with the prevalence of heart attack being highest in the Pakistani group as a whole (19.0% men, 6.9% women). Indeed, a recent research publication (Patel and Bhopal, 2004), likening the prevalence of coronary heart disease amongst South Asian communities to an epidemic, showed not only that South Asian CHD mortality levels were 46% higher in males and 51% higher in females than in the overall UK population but also that premature death due to CHD was extremely high in comparison with other ethnic groups. The survey indicated too that levels of Type 2 Diabetes were high, particularly amongst Indian, Pakistani and Bangladeshi men and women. The potential positive contribution of physical activity to health improvement has been recognised within the health sector and research has consistently called for interventions to promote and increase greater participation (Dhawan and Bray, 1997; Hayes et al. 2002; Kandula and Lauderdale, 2005), notwithstanding the fact that the relationships between exercise and health are not always understood within South Asian communities (Greenhalgh et al. 1997). With reference to South Asian communities, there is thus a substantial policy overlap in the sport and health sectors. Given that there is little evidence that the sport development sector has enabled significant increases in participation amongst South Asian communities, this paper examines a health-based intervention to explore practice that might potentially be transferable to the sport sector and also investigates a number of factors which remain obstacles to further progress in this field.

CASE STUDY

The research upon which this paper is based was undertaken through field work centred upon the Blackburn North Healthy Living Centre in the period January -June 2006. Blackburn (pop. 137,470) is located in the north-west of England and was, in the nineteenth century, one of the principal centres of the Lancashire cotton industry. Its Asian community formed in the

nineteen-fifties as people from South Asia migrated to work in its textile industries, though these have not provided a significant source of employment for several decades. It was adopted as a case study locus because it has a long-established and proportionately large South Asian population with the third highest proportion of Muslim residents in England (Blackburn with Darwen Primary Care Trust 2006) and because it is representative of the post-industrial urban context in which the majority of Asian communities in the north of England live. This is essentially one of socio-economic disadvantage; for example, in Bastwell, one of the most intensively South Asian neighbourhoods of Blackburn, 39.4% of people aged 16-24 are unemployed in comparison to the national rate for England of 25.69%, while 9.96 % are economically inactive in comparison to the national rate of 3.10% (National Statistics, 2001). The neighbourhood also has a higher than average percentage of people of working age with a limiting long-term illness (National Statistics, 2001).

The research was conducted through a series of semi- structured interviews with staff involved in the promotion of physical activity and a number of informal and casual discussions with people using the Centre's facilities for physical activity. Although both researchers were white and male it was nevertheless possible to converse directly with Asian women in group-based social settings. Focus group discussions were undertaken with the Sitara Girls Group, an informal association of girls aged between 7 and 17 years old, in a supervised context at Little Harwood Community Centre where the girls met each Sunday afternoon. A further focus group discussion was conducted, again in a community centre, with fifteen members of the Milan Group of older Asian women who were mainly aged over 50 years. As most of the women did not speak English, a community nurse acted as translator. An interview with the Education Officer of the Lancashire Council of Mosques was also undertaken.

The Blackburn North Healthy Living Centre

The Blackburn North Healthy Living Centre (BNHLC) was established in 2002 to develop public awareness of health and lifestyle and to provide opportunities for physical activity within the local community (BNHLC, 2005a). A salient feature of the Centre was that it sought to promote physical activity within an holistic context of health rather than leisure or sport. A

further significant feature was its location in a neighbourhood comprising three inner urban wards, Bastwell, Little Harwood and Shear Brow, with the highest proportions of South Asian residents in the borough. (see Table One) As Blackburn has the lowest rates of participation in physical activity in north-west England with only 16.3% of the population undertaking thirty minutes activity of moderate intensity three days a week (Sport England, 2006) it could be expected that the neighbourhood served by the Centre would display the low rates of participation normally found within South Asian communities.

POSITION OF TABLE ONE

As is shown in Table Two, the majority of people living in the neighbourhood of the Healthy Living Centre were Muslims. The relationships between Islam, Muslim identity and participation in sport and physical activity are well-documented (Kay, 2005; Sfeir, 1985; Walseth and Fasting, 2003; Walseth, 2006) and thus the religious –cultural identity of the majority of the population the Healthy Living Centre sought to engage in physical activity was likely to be a significant factor of influence.

POSITION OF TABLE TWO

The BNHLC was jointly managed by the Blackburn with Darwen Primary Care Trust and Blackburn with Darwen Borough Council, the partnership being materially embodied both in its location in a local authority community centre in the Bastwell ward and in its staffing, with some personnel employed by the local authority and others by the PCT and the East Lancashire Hospital Trust. In addition to accommodating the Healthy Living Centre, the community centre housed a sports hall, separate men's and women's gymnasiums, meeting rooms, and the offices of Age Concern and the Lancashire Council of Mosques. The promotion of physical activity was thus conducted from a community building familiar to and used by the local Asian neighbourhood and normalised within a broad programme of English speaking lessons, baby clinics, parents and toddler groups, youth activities, adult classes and similar types of community activity.

Developing sport and physical activity in a Muslim South Asian community

The BNHLC was successful in enabling the emergence of a culture of physical activity and exercise in a community in which there had previously been little evidence of this. Prior to the establishment of the Healthy Living Centre there had been a very low take-up of mainstream exercise facilities in the area (Blackburn with Darwen Primary Care Trust, 2007). Although there were local authority leisure facilities within easy travelling distance, these tended to be little used by the South Asian community in general, though some young Asian males did use the seven-a-side football facilities provided by Council. Through consultation with the local Asian community the Healthy Living Centre had developed a range of physical activity facilities and programmes that included walking groups, tai chi, aerobics, yoga, men's and women's circuit training, dance classes, a football league project, and a table tennis project. Reflecting the fact that South Asian women are less likely to use a mixed sex facility than other black ethnic minority groups (Health Education Authority, 2000) the Centre also housed separate men's and women's gymnasiums. In the year August 2004 to July 2005 the Centre attracted 4,353 users of whom 1,683 were male and 2,670 female. The majority were drawn from the Asian community and included 1,887 Indian, 1,903 Pakistani and 4 Bangladeshi users. The relatively low number of Bangladeshi users is partly explained by the proportionately small size of this group within Blackburn (0.38% of the population in comparison to the 20.65% represented by the South Asian population as a whole), but also to a perception, voiced by a community health worker, that the Bangladeshi community tended to be more socially excluded than other South Asian communities within Blackburn. The high proportion of Indian users may reflect the tendency for this community to exhibit slightly higher rates of participation in physical activity than the other two groups (NHS, 2005). A further 87 people joined the exercise referral scheme, some of whom were older Asian females who had not previously participated in physical activity in their adult lives. While the range of equipment in the gymnasiums was neither as extensive nor as modern as would typically be found in a private sector facility, both were heavily used, with approximate memberships of 500 in the men's gymnasium and 1,000 in the women's. Both charged a single fee of £12 per annum and were open on weekdays from 9.00 a.m. to 10.00 p.m. with more limited opening at weekend. While the low fee and long opening hours may not be

exclusively relevant to the community under review, they were nevertheless part of the overall design of delivery and the fee in particular seems likely to be important in view of the economically disadvantaged context of the local neighbourhood. The local authority provided two instructors to deliver classes. A survey undertaken in 2005 revealed that although more than half of all respondents had never used a gymnasium previously, 56% made two or three visits each week. This survey also found that health was the principal motivation for using the gyms (BNHLC, 2005b) and this was later affirmed in the comments of older women in the Milan group who had taken up exercise for health because Islam approved this. The gymnasiums were not heavily promoted and had no external signing and had become known to users mainly through word-of-mouth and to a lesser degree through exercise referral. The evidence quoted above relating to the proportion of first-time users of the gym further suggests that the Healthy Living Centre increased participation in physical activity within the South Asian communities it served. The degree of success of the Healthy Living Centre in engaging the Asian community in physical activity contrasted sharply with that associated with local authority sport and leisure services in general and was based on a number of factors, including the processes of community consultation and orientation through which services were developed. Its presentation of physical activity within a context of health rather than sport, an association highlighted in previous research (Snape, 2005), was of major importance, as was its perception within the Asian community as a place of cultural and physical safety. The importance of health as a motivating factor in participation was further emphasised through the fact that the local authority Healthy Living and Sports service had engaged some members of the Asian community through exercise referrals, cardiac rehabilitation programmes, health walks and an allotment scheme, whereas mainstream leisure provision opportunities had in the main not been successful in engaging the community. These factors were integrally related to the Muslim religious – cultural identity of the neighbourhood.

CONTRIBUTORY FACTORS TO INCREASED LEVELS OF PARTICIPATION

Bhopal (1998) has commented on the cohesive insularity of British Asian communities and their tendency to view external interventions with suspicion, thus consultation with the local community on the design of provision was considered by the Centre's managers to have been crucial to its success. This was effected through Community Action Teams and a young peoples' consultation initiative in which young Asians – both male and female – were trained as community consultants through a local authority grant. The resultant provision of services reflected community preferences, for example the separate men's and women's gymnasiums in which both gender segregation and neighbourhood location were considered a higher priority than the standard of equipment.

The perceived cultural homogeneity between the Centre and the neighbourhood it served created a sense of a place in which visitors did not feel alienated. A high proportion of the staff of the BNHLC was drawn from the local Asian community and spoke an Asian language and this was crucial to the inclusion of some people, especially older women, whose first language was not English. Furthermore, the regulations governing the use of the women's gymnasium reflected neighbourhood cultural patterns in allowing women to wear everyday dress, thus ameliorating concerns about being seen in revealing clothing either by men or other women. Furthermore, the absence of a licensed bar did not promulgate the western association of sport with alcohol. However, a corollary of the strong community orientation was the reluctance of many respondents to join activities delivered outside their neighbourhood. A potential disincentive lay in the fact that the BNHLC was developed through lottery funding as Islam does not approve of gambling. However, while it remains possible that some people may have declined to use the Centre because of its association with the Lottery, the relatively muted style of external and internal acknowledgement of lottery funding in the building reflected local concerns about this.

The co-ordination of provision for physical activity through a Healthy Living Centre rather than a leisure centre both materially and symbolically placed activity in a context of health rather than sport. This more readily accommodated Islamic approval of physical activity for personal health whereas, as was proposed in a meeting with the Lancashire Council of Mosques,

western interpretations of sport as competitive and elitist exclude substantial sections of the British Asian Muslim community. The culture of the Healthy Living Centre was one of participation rather than performance and did not privilege connotations of competition and masculinity. A focus on health was also a prominent characteristic of the activities provided for young people which integrated education on healthy lifestyles with sports activities.

The perception of the Centre as a place of both physical and cultural safety was a further contributory factor to its appeal within the neighbourhood. Asian parents place a high priority not only on the physical safety but also on the cultural safety of their children. Cultural safety is a complex concept and in this context it refers to the notion of the preservation of values, beliefs and self-identity. Previous research (Beishon et al. 1998 p.63) has suggested that South Asian parents are concerned to avoid the assimilation of their children into British culture; situations which might endanger both the physical and cultural safety of women and girls – for example through exposure to men or certain western values – tend to be avoided. Kay (2005) also refers to the fact that culture is valued in Muslim communities as a way of retaining difference. Sport development initiatives that are not sufficiently culturally sensitive to ensure the preservation of difference are therefore less likely to appeal to members of South Asian Muslim communities. There may too be factors beyond the control of providers such as the necessity of travel and the use of public transport beyond the neighbourhood that inhibit the potential success of sport development initiatives. However, activities delivered through the Healthy Living Centre were perceived to be safe as they were related to health, provided in the local community, delivered by or in close proximity to members of the Asian community who shared community values and did not necessitate travel out of the neighbourhood.

Cultural barriers to participation

Notwithstanding the success of the Healthy Living Centre in increasing participation, the research located a number of factors which present challenges to wider access. A common strand in these factors related to the cultural connotations of sport and sporting contexts. Several were grounded in cultural norms within the Muslim Asian community, particularly

those related to *izzat*, or personal reputation and family honour. Asian communities place a higher priority on the family and household than the white British community and the normal role of women is to care for and support the extended family (Beishon et al., 1998; Kay, 2005). Participation in activity which could be interpreted as a neglect of this responsibility – through causing women to leave the house for a perceived leisure activity - therefore carried the risk of being identified through the intensive networks of informal communication within the community as what one respondent described as a “bad” housewife or mother. While it was considered culturally permissible in Blackburn for Muslim Asian women to visit the gymnasium, it was nevertheless an activity which attracted notice, particularly that of other women. One respondent related that some women had felt comfortable in using the gymnasium only in a period in which their family had not been living with them in Blackburn. The strength of the impact of cultural values and norms on participation was greater than had been expected by the authors. However, it transpired that this was a localised phenomenon. Recent research has indicated that Islamic cultural norms are more restrictive in Britain than in other countries (Dagkas and Benn, 2006) and this was affirmed by a female Asian community worker who reported that concern for the potentially negative impact of physical activity on *izzat* was more pronounced in the Blackburn than in some other countries, notably Pakistan, which was perceived to be more culturally liberal in terms of women’s participation in extra-domestic activity and sport. In addition to being seen as a leisure-orientated distraction from domestic duties, participation in exercise could also be interpreted as being undertaken to make one’s self more attractive and thus have sexual connotations. The contextualisation of bodily activity within health rather than sport circumvented many of these barriers. Asian community workers emphasised that health was a crucial legitimating factor in participation in physical activity within the local Asian community, whereas activity for fun or body image was less so, not so much because it offered an enjoyable experience but because it was felt to be necessary that this should not be perceived by others to be the primary factor in participation. Hence, the use of “club” was avoided because of its associations with sociability and leisure; similarly an “aerobics class” conducted to music was preferable to “dance”, the latter being associated with the performance of the female body under the male gaze. The cultural implications of the labelling of activities exercised a marked

impact on patterns of activity amongst post-pubescent Asian girls. The older girls of the Sitara group reported that they enjoyed playing games at school, for example netball, hockey, football and aerobics. However, when one girl said that she enjoyed dancing there was a perceptible embarrassment amongst the other girls.

In the context of sport and physical activity puberty marked a cultural as well as a physical stage. The younger Sitara girls – those aged seven to eleven years old - tended to prefer arts and crafts to sport and physical activities although they also played rounders, netball and bench ball. An after-school dance club was both popular and seen to be culturally normal. The girls also enjoyed swimming and being pre-pubescent could use the local pool “any time at all” and were also allowed by their parents to use the fun pool in the town centre. Some played football “just for fun” and not necessarily as part of school PE lessons. Being too young to take a serious interest in relationships with boys or to be fully conscious of the sexual symbolism of physical movement, they pursued active leisure as freely as white girls. They enjoyed experiencing new activities, for example rock climbing, go-karting, quad bikes, trapeze gymnastics and visits to the countryside, one commenting that “it was so peaceful that I just didn’t want to come back”.

There were however marked differences between the relatively free access to sport amongst the younger girls and the restrictions imposed on the post-pubescent girls when issues of sexual safety and *izzat* become active. For example, although the older girls were keen to maintain an interest in ice skating, *izzat* necessitated that this be undertaken in closed sessions which were at inconvenient times and expensive. These girls felt that it would become more difficult to maintain an active lifestyle as they grew older, although all said they would like to do so. They believed that they would be expected to conform to normal standards when married by being seen to dedicate themselves to family and domestic responsibilities but hoped they would adopt a more permissive approach to their own daughters’ participation in sport, even though they foresaw that this might be problematic. There was an apparent lack of desire to challenge the cultural regulation of women’s access to sport and active recreation and representations of such a challenge were viewed

circumspectly; the film “Bend it like Beckham” which portrays an Asian girl defying parental wishes by donning a football kit and joining a women’s team was felt by the Sitara girls not only to have done Muslim girls a disservice but to have “made things worse” through suggesting that “we can’t show our legs” and that “Asian parents won’t let girls play football”. Simultaneously, however, the girls drew a sense of pride from the achievements of the Pakistani Women’s Cricket Team and felt that they had “showed that women can do it”, a view possibly based in the knowledge that this team had been formed and had played in its first major competition in Lahore in 2005 despite resistance.

The group was, at the time of the meeting, exclusively Asian in its composition, although there had been a previous experimental period in which white girls had joined. This had been unsuccessful as some Asian parents withdrew their daughters through concern for their cultural safety which had led, according to one of the girls, to an “us and them” scenario. Some girls noted that their parents “did not talk about sport very much. Although the older girls wanted to join a netball league, provided that they could wear “something underneath” their netball shorts, there was nevertheless very little regularity in their patterns of out-of-school physical activity. The infrastructure that underpins sport activity for girls in white communities – leagues, clubs, facilities, parental engagement, peer group appeal – was conspicuously absent in the Blackburn Asian community. The girls preferred to “try” a wide range of activities rather than develop a sustained commitment to a smaller number of specific activities. The absence of regular opportunities tended to limit the girls to a beginner standard in sport as there was no access to sustained technical coaching. In part this may have been a reflection of the relatively low numbers of female Asian instructors and coaches, though the suggestion that they might consider reading sport management at university was received neither with enthusiasm nor with any sign of a belief that this might be possible for them.

Factors related to safety also influenced participation by the older women of the Milan Group. A lack of confidence was a major deterrent: one woman, for example, had not pursued an exercise referral because, never having previously visited a gymnasium, she was afraid of appearing foolish because she would not know what to do. Another woman had visited the

gymnasium but had found the induction too brief. The fact that the gymnasium was not staffed throughout its opening hours was also a deterrent as help would not always be available. A further concern was the presence in the gymnasium of a security camera which had prevented some of them using it. Fear was a further deterrent to visiting the gymnasium and to swimming and embraced a range of concerns which included drowning, the male *and* the female gaze, being seen by other people and thus becoming the subject of gossip, feeling uncomfortable in the presence of younger women, having to wear a costume (some said they would go if they could swim fully clothed), inability to swim, concern that there would be no-one to help them once in the water, being recorded on security cameras in the baths and the pictures subsequently being seen by another person, loss of respectability, for example through gossip, and the threat to *izzat* should compromising information about them become public. Walking was popular and some of the women enjoyed participating in the health walks. One woman liked to walk regularly but "only on the streets in my neighbourhood". Few had considered going to the countryside as they "would not know what to do". Some of the women had taken up gardening activities through the opportunities provided under a local project co-ordinated through the Horticultural and Gardening Projects Co-ordinator of the Council's Healthy Living and Sport.

CONCLUSIONS

The research found evidence of a range of socio-cultural factors which influenced participation in physical activity in a specific South Asian Muslim community. While some of this evidence confirmed the findings of previous work cited in the earlier sections of this paper, it also revealed the importance of subtle nuances in the labelling of activities and the significance of these to community perception. It was found that activities promoted as "sport" or "leisure" did not have as great an appeal as those delivered under the aegis of healthy living. Much writing on participation amongst Asian women deals with the concept of the male gaze, but the findings of the current research suggest that, for women particularly, not only the male gaze but the "community" gaze too is an important factor, with sport and physical activity for leisure perceived to have negative associations. Health, in contrast, offers a socio-cultural validation of activity. The research subsequently showed that initiatives originating in

the health sector were, when appropriately culturally-orientated, gender segregated and community-based, able to engage Asian communities effectively. The health sector appears to employ a higher proportion of people of Asian heritage than is normally found in the sport development sector, and this seems likely to be a further factor of importance.

In postulating a cultural explanation of involvement in physical activity in the community under review it is acknowledged that the nature of the relationship between cultural behaviour and ethnic identity is dynamic and that important variations exist within the same ethnic group (Ahmad, 1996; Smith et al., 2003) and thus the results of the current research should not be assumed to apply in their totality to similar communities elsewhere. It was pointed out during the field research that even within the Asian community in Blackburn there were subtle but potentially significant variations in cultural patterns. Gujurati women, for example, were reported to be more conservative than other Asian women, being more religiously orientated and more orthodox in dress. By inference, their participation in activity might accordingly be more culturally challenging. Many Gujurati women in Blackburn also worked twelve hour shifts in terraced housing that had been converted into sewing shops, again potentially minimising time and opportunity for exercise or sport. The Bangladeshi community was also reported to be more culturally conservative and subsequently less likely to take advantage of the new opportunities for involvement in physical activity. Nevertheless, the research affirmed the impact of cultural factors on participation and clearly demonstrated that further research is needed to explore the extent to which this may vary in differing localities. The research also raised questions relating to the likelihood of cultural change in the conceptualisation of sport and leisure within British South Asian Muslim communities. Although Syson and Wood (2006) point to the challenge of the younger generation to community norms and the possibility of a process of acculturation, there was little evidence, certainly amongst the young female respondents in the current exercise, to suggest that this process is in place in Blackburn in the context of sport and physical activity. However, if higher education providers in the field of sport and leisure management were to develop courses which located sport and physical activity within a health context, this might lead to an increase in the number of Asian people, particularly women, willing to opt for degree level study and career progression in this field.

The research also suggests that the sport development sector should become more responsive to cultural differences in the conceptualising of sport and activity. The dominant western concepts of sport appear to be insufficiently sensitive to the cultural diversity found within South Asian and specifically Muslim communities and seem unlikely, on the evidence of this research, to achieve the targeted increase in participation rates. Conversely, interpretations of physical activity grounded in health, which may accommodate sport without prioritising it, are likely to be more successful.

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Table One

Table One	Ethnicity by percentage of population at ward, town and national level				
	White	Mixed	Asian	Black	Other
Bastwell	16.6	1.3	79.2	0.5	2.4
Little Harwood	59.11	1.41	37.38	0.19	1.91
Shear Brow	24.2	1.5	73.5	0.4	0.4
	77.9	0.9	20.6	0.2	0.4
England and Wales	91.3	1.3	4.4	2.2	0.8

Source: 2001 Census, National Statistics, www.statistics.gov.uk

Table Two

Table Two Number and percentage of population stating religion as Muslim					
Ward	Population	Number of people stating religion as Muslim	% of ward population stating religion as Muslim	% of population stating religion as Muslim in Blackburn	% of population stating religion as Muslim in England & Wales
Bastwell	7,389	5,430	73.46	19.4	3.10
Little Harwood	6,178	2,186	35.38	19.4	3.10
Shear Brow	7,402	5,202	70.28	19.4	3.10
TOTAL	20,969	12,818	61.12%	19.4	3.10

Source: 2001 Census, National Statistics, www.statistics.gov.uk