REACH

COMMUNITY HEALTH PROJECT

Mapping Exercise of Third Sector Food & Health initiatives with Minority Ethnic Communities in Scotland

A Report by REACH Community Health Project

Funded & commissioned by Community Food and Health Scotland (CFHS)

CONTENTS

REACH Community Health Project, established almost a decade ago in Glasgow, has since evolved into a national third sector organisation with a key strategic role in improving the health & wellbeing of Black and Minority Ethnic (BME) Communities, particularly those living

in Scotland. REACH has units engaged in culturally sensitive Service Provision, Policy and Research and Training and Development. These areas of expertise act to mutually reinforce one another, and this Triangulated Formula makes REACH uniquely placed to tackle health inequalities and service barriers faced by BME communities.

Our *vision* is a multi-cultural society in which all people have equal access to appropriate health & wellbeing services and our *mission* is to empower communities, (particularly ethnic minorities) by ensuring that their health needs are fully met.

REACH achieves this through its Triangulated Formula, which encompasses three units: Preventative Culturally Sensitive Service Provision, Policy and Research and Training and Development.

Chief Investigator
Shabir Banday

Researcher
Fariha Thomas

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FOREWORD

'…[H]ealth, which is a state of complete physical, mental and social wellbeing, and not merely the absence or infirmity, is a fundamental human right…' (Alma- Ata, 1978).
Health, as defined by the Alma-Ata Declaration, is a universal right. However, securing this right for all people, regardless of territorial or, indeed, cultural boundaries, has proven to be an almost insurmountable challenge. This has been particularly evident in respect to the needs of minority ethnic (ME) communities.

Though there are other socio-economic and environmental factors which affect an individual's health, Food and Health are intertwined and eating healthy food is paramount for better health and wellbeing. Minority ethnic communities are one of the disadvantaged communities in Scotland with numerous barriers to their health and wellbeing. Indeed, the Scottish Government has been very supportive in helping to reduce health inequalities, and have produced several significant policies to overcome the challenge of health disparities in Scotland.
Nevertheless, the challenges still exists, particularly in promoting healthy food among minority ethnic communities; partly due to lack of availability of support and advice on healthy ethnic food, more so changing food habit needs behavioral change, which is always a challenge for all, irrespective of ones ethnicity.

There is considerable demand for work on healthy eating and cooking among ME communities, but many organisations struggle to meet the demand for advice on healthy authentic tasting ethnic foods, linked to learning about health impacts of food.

Commissioned by Community Food and Health Scotland (CFHS), REACH Community Health Project has produced this research report in an effort to contribute to this topic. It is our hope that the findings herein will add to the knowledge of food and health initiatives for ME communities in Scotland and help produce right services and policies, and indeed encourage further research.

Shehla Ihsan
Chairperson
REACH Community Health Project

Summary

There is a wide range of food related work taking place within Scotland with Minority Ethnic (ME) groups. This is predominantly focussed on the main cities and Central Belt of Scotland, and with visible ME groups, however even for these groups there is a perception of considerable unmet need. For Scottish Gypsies/Travellers, for newer migrants, including asylum seekers and East European migrants, and for people living away from the main concentrations of ME groups, the unmet need is largely unknown, but likely to be considerably higher.

Published research on food and health issues amongst ME communities is similarly focussed on visible ME groups, predominantly on those of South Asian origin, leaving gaps in knowledge about needs of other ME groups. The evidence base for appropriate targeting of work is therefore patchy.

Many ME communities traditionally eat a healthier diet than people in the West, although this may be changing for the younger generation who are increasingly incorporating fast foods into their diet. Cooking skills are more prevalent among service users from ME backgrounds, but knowledge of how to cook with available ingredients, or of the health impact of e.g. high levels of oil, salt, sugar, are often not known.

The higher levels of certain disease states e.g. heart disease and diabetes, in a number of ME communities does not necessarily reflect an unhealthy diet - there appears to be higher predispositions to such diseases in some communities. There is a need for consideration of the whole lifestyle in counteracting or preventing problems (e.g. exercise taken, stress factors), but diet can play an important part.

There is considerable demand for work on healthy eating and cooking among ME communities, but many organisations struggle to meet the demand for advice on healthy authentic tasting ethnic foods, linked to learning about health impacts of food.

Ethnic monitoring of service usage is frequently not undertaken, especially out with the Central Belt, so many mainstream services do not know whether or not they are catering for minority ethnic communities, or from what backgrounds their service users may come. A perception that “all are welcome they just don’t choose to come”[1], may reflect services that are not aware of, or geared to meet, the specific needs of ME communities. It is important to be aware of the diversity of ME communities in relation to food – both inter and intra group.

[1] Quote from one respondent

Health messages and literature are frequently inadequately tailored to meet different communities' requirements, and therefore are not effective.

Both the literature review and the organisation mapping exercise identified that for the most part evaluation of work is short term and is not always linked to behaviour change. This is an area that would benefit from further work and support.

There are different reasons for projects being involved in food work, not always with a direct personal health focus. After health, the second most common reason for undertaking such work was around food as a vehicle for community integration. However, a health message can be incorporated in such work if service providers, who are often out with the food and health networks, are supported in incorporating this.

The biggest challenge facing organisations in providing existing services and in meeting unmet need are the lack other support (i.e. training, information and advice on healthy food tailored for ethnic diet), grants, and the short term nature and uncertainties of grants. For organisations whose primary purpose is not food and health access to information and expertise on food and health issues is also a major challenge.

Recommendations

Developmental Support & Advise

Support is required for minority ethnic community organisations (particularly those whose primary remit is not food or health) to implement effective work on food issues

- Community Food and Health Scotland (CFHS) should look at what measures it could take on an ongoing basis to ensure ME communities are aware of and able to benefit from its work.
- A free ME food and health developmental day with training workshops could develop skills, awareness and start a networking process
- Given there appears to be a lack of work on maternal and children's eating than might have been expected, consideration should be given to supporting additional work in this field

Support is required for some mainstream service providers in working with ME groups on food and health for provision of awareness raising on diversity of ME communities, their specific requirements and how to incorporate these in work.

Promotional Tools

- A range of materials suitable for work with different ME communities should be made available
- Work should be undertaken to collate and develop materials relevant to different cultures for use with ME communities
- Forums, e bulletins and other similar promotional materials providing information on aspects of health such as: sharing healthy versions of ethnic recipes; regularly updated contacts on who is working on aspects of healthy food could benefit ME organisations, groups and individuals.

Language & Translation

Support should be available to organisations for working with people for whom English language is limited

- Requirements for language translation should be taken into account, along with literacy levels and learning methods.
- A bilingual staff that understands the community and its eating behaviours and beliefs are more likely to be effective than leaflets.

Consistency in Funding

A funding strategy that moves beyond short term one-off projects should be developed and its existence circulated pro-actively to ME organisations or to organisations working for ME communities.

- Serious consideration should be given to levels of funding for food and health projects, to the duration of such funding, and renewability of funding, if long term changes are to be brought about.
- Signposting to sources of funding and help in developing funding applications would be beneficial smaller community groups/organisations.
- Funding for food work should be supported by more rigorous requirements and resourcing for evaluation including longitudinal measurement of behaviour change.
- Funders should insist on ethnic monitoring, as a condition of funding.

- Provision of advice and support for developing Social Enterprises and negotiating Service Level Agreements may be particularly fruitful in the food and health field.

Food provision for ME service users

- The development of training for chefs (e.g. Elderly Day Centres) on healthy eating choices , how to adapt traditional ethnic recipes to reduce salt and oil content, and to cook a wider range of dishes to suit the needs and tastes of service users, with provision of funding to enable this to be accessed.

- Facilitation of joint work between Day Centres, both those provided by the voluntary and statutory sectors could be beneficial, as some were better able to provide healthy traditional food.

Policy & Research

Further exploration into developing strategies for effective dietary behaviour change is required.

- The dearth of knowledge about food and health needs of some ME communities e.g. Scottish Gypsies/Travellers, East European migrants should be explored with these communities perhaps via action/research

- Resources should be identified for model projects to undertake more rigorous and longitudinal evaluation of work, how effective it is in promoting eating behaviour change, and health impacts.

- It may be worth considering the gender dimension in relation to behaviour change in more depth in any future research.

- It is strongly recommended to carryout a research with a developmental approach and help produce a tested model/tool for delivering effective food and health initiatives for ethnic minority communities in Scotland.

1. Introduction

This mapping exercise was commissioned by Community Food and Health Scotland (CFHS) as a follow up to research undertaken in 2004 regarding food and health work among Scotland Black and Ethnic minority communities.[2] It results from Community Food and Health Scotland's awareness that minority communities have specific health needs and frequently higher levels of ill health, such as heart disease and diabetes, but Minority Ethnic (ME) communities are often not engaged in community food and health projects, nor are ME organisations proportionately accessing the grants available in this field. This mapping exercise aims to provide information regarding the range of current initiatives that exist to promote healthy eating amongst these groups, and lessons that can be learnt from them, to assist Community Food and Health Scotland, policy makers and health providers plan for the future.

REACH Community Health Project is a national third sector organisation with a key strategic role in improving the health & wellbeing of Black and Minority Ethnic Communities, particularly those living in Scotland. The project is committed to facilitate change within mainstream health and wellbeing services to meet the specific needs of BME Communities.

REACH has three units engaged in Preventative Culturally Sensitive Service Provision, Policy and Research, and Training and Development. These areas of expertise act to mutually reinforce one another, and this Triangulated Formula places REACH in a unique position to tackle health inequalities and service barriers faced by BME communities.

Community Food and Health Scotland is the new name (since 2006) for the Scottish Diet Project which was established to take forward the recommendations of the 1996 Scottish Diet Action Plan to 'promote and focus dietary initiatives in low income communities and bring these within a strategic format'. Community Food and Health Scotland is a Scottish Government funded body located within Consumer Focus Scotland (formerly Scottish Consumer Council). Its over-riding aim is to improve Scotland's food and health. This is done by supporting work within low-income communities to identify barriers to a healthy balanced diet, develop local responses to addressing them and highlight where actions at other levels, or in other sectors, are required that improve access to, and take-up of, a healthy diet. It ensures that the experience, understanding and learning from local communities informs policy development and delivery. Major obstacles being addressed by community-based initiatives are:

[2] Craigie A *Community based research and activity into food and health in Scotland's black and minority ethnic communities 1994 to 2004* Scottish Community Diet Project 2004

AVAILABILITY - increasing access to fruit and vegetables of an acceptable quality and cost

AFFORDABILITY - tackling not only the cost of shopping but getting to shops

SKILLS - improving confidence and skills in cooking and shopping

CULTURE - overcoming ingrained habits.

1.1 Note on Terminology

While the term Minority Ethnic (ME) is the preferred terminology in this research, where studies use other terminology (e.g. Black, non-white) these terms will be used in referring to research findings. The research aims to cover all minority ethnic communities in Scotland; however the literature review reports primarily on the longer established minority groups as little research appears to have been done on food and Asylum Seeker, Scottish Gypsies/Travellers or East European migrant groups.

1.2 Population profile

The most comprehensive information about minority ethnic demographic information is the analysis of the 2001 Census[3]. However this information is now dated and likely to significantly underestimate the population given that ethnic minority groups have a younger age distribution than the White groups, and most Asylum Seekers in Scotland arrived after that date. With the exception of the Caribbean group, more than 20% of the population for all other groups was less than 16 years old; and the size of the minority ethnic population increased by 62.3% between the 1991 and 2001 Census. The 2001 Census did not include statistics for Scottish Gypsies/Travellers although they will be included in the 2011 Census. It is difficult to be clear about the numbers of Scottish Gypsies/Travellers as many are reluctant to self-identify as a Traveller or as a Gypsy for fear of prejudice or official interference. Some estimates consider the population to be around 15,000[4], while the Scottish Government January 2009 Count of Gypsies/Travellers living on sites and encampments recorded a total of 497 Gypsy/Traveller households, with an estimated

[3] Office of the Chief Statistician Analysis of Ethnicity in the 2001 Census - Summary Report February 2004 http://www.scotland.gov.uk/Publications/2004/02/18876/32937

[4] STEP Scottish Travellers Education Programme website http://www.scottishtravellered.net/travellers.html

population of around 1,590 people.[5] This does not record all ethnic Gypsies/Travellers as many live in permanent housing for all or part of the year and therefore is considered to be an underestimate by Gypsies/Travellers themselves.[6] Health problems amongst Gypsies/Travellers are between two and five times more common than the settled community.[7] [8]

At the 2001 Census the size of the minority ethnic population was just over 100,000 in 2001 or 2% of the total population of Scotland. Pakistanis were the largest minority ethnic group, followed by Chinese, Indians and those of Mixed ethnic backgrounds. Over 70% of the total ethnic minority population were Asian: Indian, Pakistani, Bangladeshi, Chinese or other South Asian. Over 12% of the minority ethnic population described their ethnic group as Mixed.

Christianity was the most common religion for all four White groups and also for Caribbean, African and Other Black Scottish people. Sikhism was the most common faith among Indian people (37.6%) followed by Hinduism (30.5%). 89.2% of Pakistanis, 84.3% of Bangladeshis and 43.2% of Other South Asian people were Muslim. 32.4% of people who listed their ethnicity as 'Other' were also Muslim as were 18.5% of African people. 63.1% of Chinese people responded that they had 'no current religion'. The group reporting the lowest level of 'no religion' was Pakistani people (2.8%).

The majority of people from minority ethnic backgrounds live in large urban areas - Indians (74%), Pakistanis (80%), Bangladeshi people (76%), Other South Asians (75%), and Africans (74%). Glasgow had the highest percentage of minority ethnic people with 31% of the total minority ethnic population living in the city, heavily concentrated in a few areas. This was followed by Edinburgh with 18% of the total minority ethnic population residing in the city. However there are people from ethnic minorities in all areas of Scotland, and the new EU migrants are particularly widely dispersed.

In addition since the 2001 Census Glasgow has become a host city for asylum seekers under the UK dispersal programme. The numbers of asylum seekers elsewhere in Scotland

[5] Scottish Government Social Research *Gypsies/Travellers in Scotland, the twice yearly count* No. 15 January 2009 http://www.scotland.gov.uk/Resource/Doc/283752/0085987.pdf

[6] http://www.gypsy-traveller.org/cyberpilots/Projects/scotland_newspaper.htm

[7] Parry G, Van Clement P Peters J, Moore J, Walters S, Thomas K, Cooper C *The Health Status of Gypsies & Travellers in England*: *A report to the Department of Health* University of Sheffield 2004 http://www.shef.ac.uk/content/1/c6/02/55/71/GT%20final%20report%20for%20web.pdf

[8] Matthews Z *Better Health Briefing 12 The Health of Gypsies and Travellers in the UK* Race Equality Foundation 2008 http://www.raceequalityfoundation.org.uk/health/files/health-brief12.pdf

is minimal. In 2006 it was estimated that there were 5,500 asylum seekers in Scotland (nearly all Glasgow – approx 1 % of Glasgow's population). Figures change quickly as people obtain or are refused asylum. In 2006 over one third of all asylum seekers in Scotland were nationals of four countries: Iran, Pakistan, and Somalia, and the Democratic Republic of Congo.[9] [10] There are also a significant number of Turkish people (including Turkish Kurds).[11] In addition Glasgow also hosts smaller numbers of asylum seekers and refugees from a range of countries including various Arab states, Albania, Kosovo, Algeria, Kenya, Nigeria and Sudan. Expansion of the EU has led to migration of new groups who have settled across Scotland, in particular of Poles, and in the Glasgow Govanhill area Slovakian Roma. There are no accurate statistics on numbers and these change as people move around for work.

1.3 Perceptions of health in the 2001 Census

The Chinese had the highest proportion of people reporting good or fairly good health (96%). This was closely followed by people in the Other Ethnic group and Africans with 95% of each group reporting good or fairly good health. Overall 90% of people reported themselves to be in good or fairly good health and 10% in poor health.

Self-perception of health was highly correlated with age. For children, the rate of long-term limiting illness or disability is very similar across all ethnic groups, with all groups reporting 4% or 5%. Within the 16-24 age group, Bangladeshi and Black Scottish/Other Black people had the highest incidence of long-term illness or disability with each group reporting 8%. The Black Scottish/Other Black population and people from Mixed backgrounds aged 25-34 years had the highest proportion of people with long-term illness or disability (12%). This was followed by White Scottish, Pakistani and Other South Asian ethnic groups who all reported 10% of people with long-term illness or disability in the 25-34 age group,. Within the 35-59 age group, Pakistanis have the highest rate of long-term illness or disability (28%). For all ethnic groups, at least 40% of people aged 60 years and over report themselves to have a long-term illness or disability. This is highest for the Pakistani group with 66% having a long-term limiting illness or disability.

[9] COSLA Asylum & Migration Statistics http://www.asylumscotland.org.uk/asylumstatistics.php
[10] Lewis M *Warm Welcome Understanding Public attitudes to asylum seekers in Scotland* 2006 p.1
[11] information centre about asylum and refugees http://www.icar.org.uk/9983/glasgow/current-situation.html

1.4 Policy Context

There is international recognition that healthy diets and regular, adequate physical activity are major factors in the promotion and maintenance of good health throughout the entire life course and that unhealthy diets and physical inactivity are two of the main risk factors for a range of medical conditions. In 2004 the World Health Organisation (WHO) adopted the "Global Strategy on Diet, Physical Activity and Health".[12] This was followed by the Second WHO European Action Plan for Food and Nutrition Policy 2007-2012, adopted by the WHO Regional Committee for Europe in Belgrade, 17-20 September 2007, and the European Charter on Counteracting Obesity, adopted by the WHO Regional Office in 2006. At European Union level the European Commission launched the EU Platform for Action on Diet, Physical Activity and Health in March 2005 to disseminate best practice across the European Union. In 2008 a European White Paper on Nutrition, overweight and obesity-related health issues[13] were adopted by the European Parliament in 2008 after a lengthy consultation period.

Health is a devolved matter in the United Kingdom. The current Scottish Government has made the health of the nation one of its five key priorities[14]. Within its health strategy food and diet are given considerable importance. *Healthy Eating, Active Living,[15] the Scottish Government's Action Plan to improve diet, increase physical activity and tackle obesity (2008-11)*, includes partnership work on community based interventions as one strand in the approach. Tackling obesity is a major health priority for the whole of Scotland's population, and there is a particular emphasis on nutrition of women of childbearing age and children in their early years, as healthy eating has been shown to be vital to brain and body development in childhood. The influence of diet and nutrition on health and wellbeing begins pre-birth, with maternal diet being found to play a role in pregnancy outcomes.[16]

Scotland has one of the worst obesity records amongst developed countries with levels that are higher than those in most other European countries.[17] The incidence of people who are overweight or obese in Scotland has been steadily increasing, with 26% men and 27.5% women clinically obese in 2008, and 38.2% boys outwith the healthy range (9% increase in

[12] The World Health Organization (WHO) Global Strategy on Diet, Physical Activity and Health 2004 http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf
[13] http://www.europarl.europa.eu/sides/getDoc.do?type=TA&language=EN&reference=P6-TA-2008-0461
[14] These are : Wealthier and Fairer; Smarter; Healthier; Safer & Stronger; Greener
[15] The Scottish Government Healthy Eating, Active Living: An action plan to improve diet, increase physical activity and tackle obesity (2008-2011) www.scotland.gov.uk/Publications/2008/06/20155902/0
[16] NHS Health Scotland *Nutrition in the under fives supplement Maternal and gestational nutrition* 2005 http://www.healthscotland.com/uploads/documents/MaternalGestationweb.pdf
[17] OECD *Health at a Glance 2007: Focus on Quality of Care*. OECD 2007.

10 years). Men and women in the most deprived areas had the highest age-standardised prevalence of obesity, although the patterns for men and women differ, with the correlation of deprivation and overweight/obese most marked for women[18]. Therefore it is felt that efforts to combat obesity in lower-income groups will contribute to the Government's aims of reducing health inequalities.[19]

The 2008 *Scottish Health Survey*[20] shows a clear link between lower consumption of the recommended 5 portions a day of fruit and vegetables and living in the areas of highest deprivation. The two leading causes of death in Scotland are cancer and coronary heart disease(CHD) with an estimated one-third of all cases of CHD attributable to diet.[21] Diet is thought to have a role in about one-third of all cancer deaths,[22] Increasing consumption of fruit and vegetables can significantly reduce the risk of many chronic diseases.[23]

Recipe for Success – Scotland's National Food and Drink Policy[24] launched in June 2009 brings together all aspects of Scotland's food and drink policy from production and sustainability to healthy eating. It outlines the Government's plans to tackle food poverty both at the macro scale and by encouraging community initiatives such as 'grow your own' schemes [25] and food education.[26]

The most recent policies build on a considerable foundation of work on food and health in Scotland, stemming from research in the early 1990's[27] which led to Eating for Health - A Diet Action Plan for Scotland (1996)[28]. This set out dietary targets and recommendations aimed at reducing diet related ill health and early mortality in Scotland, covering producers, manufacturers, retailers, caterers, the NHS, local authorities and consumers.

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[18] Bromley C, Bradshaw P, Given L *The Scottish Health Survey 2008* http://www.scotland.gov.uk/Publications/2009/09/28102003/0

[19] The Scottish Government 2008 p.16

[20] Bromley C, Bradshaw P, Given L *The Scottish Health Survey 2008* http://www.scotland.gov.uk/Publications/2009/09/28102003/0

[21] European Heart Network *Food, Nutrition and Cardiovascular Disease Prevention in the European Union* 2002 p.3 http://www.ehnheart.org/files/millenium_summary-143852A.pdf

[22] Doll R, Peto R. *The causes of cancer: quantitative estimates of avoidable risks of cancer in the United States today* Journal of the National Cancer Institute 1981;66:1191-1308

[23] World Health Organization (2003). *Diet, Nutrition and the prevention of Chronic Diseases: Report of a joint WHO/ FAO expert consultation.* Geneva: WHO Technical Report Series, 916.

[24] The Scottish Government *Recipe for Success – Scotland's National Food and Drink Policy* http://www.scotland.gov.uk/Topics/Business-Industry/Food-Industry/national-strategy 2009

[25] Ibid p.29

[26] Ibid pps. 30 -33

[27] Scottish Office Home, Health Department *Scotland's Health: a Challenge to Us All. The Scottish Diet*, report of Working Party to the Chief Medical Officer for Scotland, HMSO 1993

[28] Scottish Office Department of Health, *Eating for Health: A Diet Action Plan for Scotland*, HMSO 1996

After Devolution these policies were taken on board by the new Scottish Executive and developed in the 1999 White Paper *Towards a Healthier Scotland,*[29] *Improving Health in Scotland - The Challenge* (2003) actions 27-29,[30] *Eating for Health - Meeting the Challenge* (2004)[31] and *Better Health, Better Care Action Plan* (2007). [32] (Table 1 below outlines the Scottish Dietary Targets).

The Scottish Executive, and now Scottish Government, has a commitment to race equality. Within NHS Scotland the *Fair for All Improving the Health of Ethnic Minority Groups and the Wider Community in Scotland* initiative launched in 2001[33], provided a framework for achieving culturally competent health services,[34] [35] and established the National Resource Centre for Ethnic Minority Health, now housed within Health Scotland. *Partnership for Care, Scotland's Health White Paper*[36] 2003 confirmed the commitment to equal access for all.

In 2001 the Scottish parliament published its 'Inquiry into Gypsy Travellers and Public Sector Policies'. The Scottish Executive's initial response was published in October 2001 and followed up in 2004 by a further report which reported progress and a commitment to taking forward recommendations in Scotland including in relation to research on health needs, targeting with accessible health promotion materials, and development of new services in consultation with Gypsy Travellers in Scotland.[37]

The main partners involved in implementing the public health aspects of the strategies are Community Food and Health Scotland, Food Standards Agency Scotland, NHS Health Scotland, NHS Boards, Community Planning Boards, COSLA as well as the Voluntary and Community sectors. The Food and Health Alliance is the main formal network for such work and is managed by NHS Health Scotland.

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[29] The Scottish Executive *Towards a Healthier Scotland*. 1999. www.scotland.gov.uk/library/documents-w7/tahs-00.htm

[30] The Scottish Executive *Improving Health in Scotland - The Challenge* 2003 http://www.scotland.gov.uk/Publications/2003/03/16747/19929

[31] The Scottish Executive Eating for Health - Meeting the Challenge http://www.scotland.gov.uk/Publications/2004/07/19624/39995

[32] The Scottish Government *Better Health, Better Care Action Plan.* 2007.

[33] The Scottish Executive *Fair for All Improving the Health of Ethnic Minority Groups and the Wider Community in Scotland* 2001 http://www.scotland.gov.uk/library3/society/ffar-06.asp

[34] The Scottish Executive *Fair for All Guidance* HDL (2002) 51 http://www.sehd.scot.nhs.uk/mels/HDL2002_51.pdf

[35] The Scottish Executive *fair enough? Review of Race Equality Schemes and Fair For All Action Plans Briefing for NHSScotland Employees* 2003 http://www.scotland.gov.uk/Publications/2003/11/18471/28673

[36] The Scottish Executive Partnership for Care, Scotland's Health White Paper 2003 http://www.scotland.gov.uk/Publications/2003/02/16476/18730

[37] The Scottish Executive *Delivering for Scotland's Gypsies/Travellers an updated response to the equal* opportunities committee inquiry into gypsy travellers and public services 2001 June 2004 http://www.scotland.gov.uk/Publications/2004/06/19513/39159#1

The Food Standards Agency Scotland is an arm's length Government body established in 2000, as Food Standards are a devolved matter. It supports a programme of research and surveillance on food safety and diet and nutrition to inform future policy decisions in these areas. This programme ensures that specific Scottish issues are properly addressed and that the Agency's UK-wide research and surveillance programme takes full account of Scottish concerns. It's Diet and Nutrition Strategy 2003 - 6 makes clear its commitment to partnership and to the inclusion of the needs and views of ethnic minorities among other disadvantaged groups.[38] The Diet and Nutrition Strategy's four priorities are: promoting the consumption of healthy diet and food choices; making it easier for everyone, particularly those in low income or rural areas, to access healthier food choices; promoting the preparation and provision of meals which offer a balanced diet; and working with the food manufacturing, processing and retailing industries to further develop healthier food choices. The plan complements the activities of partners such as the Scottish Government and Community Food and Health Scotland in taking forward the recommendations of the Scottish Diet Action Plan.

Table 1 Scottish Diet Action Plan - Dietary Targets[39]

Fruit & Vegetables	Average intake to double to more than 400g per day
Bread	Intake to increase by 45% from present daily intake of 106g, mainly using wholemeal and brown breads
Breakfast Cereals	Average intake to double from the present intake of 17g per day
Fats	Average intake of total fat to reduce from 40.7% to no more than 35% of food energy Average intake of saturated fatty acids to reduce from 16.6% to no more than 11% of food energy
Salt	Average intake to reduce from 163mmol per day to 100mmol per day
Sugar	Average intake of NME sugars in adults not to increase Average intake of NME sugars in children to reduce by half i.e. to less than 10% of total energy
Breastfeeding	See breakout box on page 27
Total Complex Carbohydrates	Increase average non-sugar carbohydrates intake by 25% from 124g per day, through increased consumption of fruits and vegetables, bread, breakfast cereals, rice and pasta and through an increase of 25% in potato consumption
Fish	White fish consumption to be maintained at current levels Oil rich fish consumption to double from 44g to 88g per week

[38] Food Standards Agency Scotland Scottish Diet and Nutrition Strategy 2003-6 p.21

[39] From Scottish Government 2008 p.21

2. Methodology

This was a mapping exercise and did not require rich in-depth data, and in order to contact as many organisations and individuals as possible, an entirely desk based methodology was used, consisting of a literature review, internet search, and telephone interviews.

2.1 Literature Review

A short literature review was undertaken using “Google” and Pubmed internet searches, and bibliographies from identified literature, to locate Scottish and UK research relevant to the study. This literature review does not claim to be fully comprehensive due to limitations of time.

Internet search and the outcome of the interviews were used to identify a range of resources that may prove useful to some people working in the field, and which are included in Section 4 of this report.

2.2 Internet Research

2.2.1 Rationale and method

Third sector and indeed other mainstream organisations promote their work through online sources, i.e. websites and electronic directories. Therefore online searching, using search engines and existing directories is a simple, time-efficient, way to collect data on initiatives that are potentially relevant to this exercise. However, to reduce the risk of missing initiatives that have no details online (publicly accessible information), the telephone questionnaire contained a section asking respondents to provide information on other such initiatives in their area or field of work, therefore help snowball more contacts.

2.2.2 Database

A database of voluntary, key government and community organisations was compiled from the results of the internet search; this was complemented by a list of organisations provided by CFHS. In addition, REACH continually networks with other projects working with and within the ME community, and has a preexisting database of contacts within the ME communities. These were utilized in the building of the database, helping to reduce the risk that some organisations not available on the Internet would be missed.

Therefore the respondents were identified using REACH and CHFS databases, web based directories and supplemented by internet searches, scanning minority ethnic and equality based newsletters and bulletins, via Community Food and Health Scotland's newsletter and by utilising snowballing techniques.

2.3 Telephone research

2.3.1 Rationale and method

Contacting and interviewing organisations was primarily carried out by telephone interview using a semi structured question schedule (see Appendix 1 for full question schedule). The other options would have been to post self-completion questionnaire and, or one-to-one interviews. However, both of these methods would have been time consuming and we had limited time to carryout this mapping exercise. More so, a postal-self completion questionnaire method would have meant very low response rate. Therefore, it was decided that telephone interviewing was the most efficient and effective method at our disposal.
However, a secondary option was given of completing the question schedule in writing although personal contact was preferred as it was felt that more useful qualitative information was provided by conversation

2.4 Target groups

The types of group/organisations identified as relevant were:

- Voluntary/community organisations in general and particularly those targeting or working with/for ME communities within the arena of food & health.

- Social, community and religious groups, both organised and unorganized.

- A few mainstream organisations pertinent to the topic & intertwined with voluntary sectors were contacted

More importantly we explored the following broad areas/topics from the organisations and groups;

- Cooking/food preparation
- Selling Food
- Growing Food
- Learning about food and

Indeed, we also included other areas pertinent broadly to food and health.

2.4.1 Target areas

This was a Scotland wide mapping exercise, however the database of 123 organisations identified as potentially working on food and health reflect areas with highest concentration of minority ethnic communities, i.e Greater Glasgow and Clyde, Lothian, Tayside and Fife Health Board areas.

2.5 Telephone enquiries and interviewing

From among 123 potential organisations in the majority of cases organisations were initially contacted by telephone to identify it they were involved in such work, and if so, and it suited them interviewed immediately. In most cases a date was set for a follow up interview. Background information, including a version of the question schedule where desired, was sent out with confirmation of the interview time and date. In a few cases where a phone number was not available or was not answered after 3 attempts, an email was sent as first contact. A total of 79 organisations provided information for this research.

70 organisations were interviewed who are working on food issues with minority ethnic communities. 63 organisations completed a full interview with 2 organisations sending additional information via the question schedule. 7 undertook a shorter interview and 9 projects not currently undertaking any work on food issues with ME communities, but which either intended to do so, had done so, or had some other engagement were also interviewed.

Of the 70 organisations currently working on food issues with ME groups, 64 were voluntary sector organisations. 4 statutory sector organisations were also contacted, of which 2 were ME lunch clubs, 1 a family centre and 1 an NHS healthy living project which provided cooking to voluntary organisations. In the case of a further 2 Glasgow elderly centres there was a statutory/voluntary sector partnership with food provision being the voluntary partner responsibility. In a few cases the voluntary organisation contact was a statutory sector development worker.

In addition 9 voluntary sector organisations confirmed they were or had been working on these issues but did not undertake an interview or return the questionnaire within the time frame of the research. Where in the course of contacting these organisations information useful to this study was imparted this has been included.

3 organisations declined to participate – two due to staff shortages, the other because it was felt that funding should go to projects rather than research. A further 2 were sent question

schedules after an initial conversation, agreeing to contact if they felt it was relevant, but did not reply within the time frame of the research.

2.6 Semi-structured questionnaire

A standard semi-structured questionnaire was designed based on themes and topics suggested by the commissioning body, the rationale for a standard questionnaire was to ensure consistency in ascertaining information from the entire organisations who participated into this research. Concurrently, there was enough scope in the questionnaire to capture additional information from participants. (Please refer to appendix 1 for a copy of the questionnaire) To ensure that the questionnaire captures the required information and to maintain high quality of the questionnaire, a draft copy was discussed with the CFHS representative in addition to the chief investigator and the researcher.

2.7 Data Analysis

The telephonic interviews were transcribed by the researcher on the questionnaire, additional notes were written down to capture information provided by the participants over the phone. Notes and the questionnaires were analysed, transcribed and the information was tabulated using key criteria from the questionnaire. Furthermore, qualitative analysis was carried out to record important opinions, suggestions of participants.

2.8 Ethical considerations

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

- participants were honestly and comprehensively informed about the research in which they were taking part
- the rights of participants were treated as paramount
- participants were openly asked to give their consent to take part and to any subsequent attributable use of their comments (and any other material arising from the group/interview)

- undertakings made to participants will be honoured
- the research has respected the interests of clients
- participants have been treated with respect
- throughout the data collection and analysis, processes and procedures were used to ensure the quality and reliability of information.

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

3. Analysis and Findings

3.1 Service Provision

3.1.1 Table 2 Summary of work undertaken by identified projects

L = would like to provide X = provide

Organisation Name	Aim	Cooking	Selling/ Providing	Growing	Learning
Community Food Initiative NE **Aberdeen**	Increase healthy food consumption esp. fruit/veg.	X recipe book and leaflets	X food coops in NE Scotland		X talks to groups and schools
Multi Ethnic Aberdeen Ltd **Aberdeen**	Promote diversity & equality	X volunteers prepare and share different ethnic dishes			
Powis Gateway Community Centre **Aberdeen**	Support community through providing community centre for area now Council closed - reopened June 2009	X cooking classes (start Jan 2010	X cafe	X link with Powis Gardeners	X will develop more in 2010
Powis Gardeners **Aberdeen**	Build community capacity through promote gardening, growing food and community interaction	X barbecues using produce grown		X allotment and use of communal gardens	X learning built into activities
Sunnybank Park Steering Group **Aberdeen**	Develop allotments & community garden & preserve area as green space for community			X	
Fas Fallain Healthy Living Centre (NHS)/ Multicultural group (vol. sector)	Growing local produce, healthy eating, act as catalyst to community involvement & provide advice		X Demos and e.g. exhibition events with info on cultures included 3	X some groups now running schemes	X inputs to range of events

Western Isles	e.g. to Multicultural groups currently becoming independent		diff restaurants each doing course from nationality (Thai, Indian, Scottish), to mixed audience,		
Amina Muslim Women's Resource Centre (MWRC) **Dundee**	Community development and integration				X Muslim women's' health and wellbeing course including health eating with inputs from external orgs.
Dundee International Women's Centre **Dundee**	Support all women esp. ME to promote social educational, financial and political inclusion through activities, education and training	X Cooking Classes (with Dundee HLI)	X Social Enterprise providing catering for events, moving towards café developme nt	L	X inputs to range of events
Dundee Healthy Living initiative (NHS) **Dundee**	Improve mental & social wellbeing, using a community development approach in most deprived areas (60% Dundee)	X provide healthy courses and demos to broad range of communities including ME			X provide healthy eating inputs to broad range of communities including ME & open stalls at shopping centres etc.
Fife Arabic Society **Fife**	To promote understanding of Arabic cultures and reduce isolation	X occasional events bringing community together to share foods			X weekly women's group includes work on healthy food, adapting foods to suit ethnic tastes, educational inputs about food and nutrition e.g. from qualified nurse

Fife Chinese Older People Association **Fife**	To promote happy and healthy lives for the Chinese elderly in Fife		X lunch club for Chinese elderly, food provided by rotation of Chinese restaurants		X occasional inputs form organisations e.g. Frae Fife
Frae Fife **Fife**	Bridge/link between BME & service providers in Fife, health project focus on range of health advocacy	X delivered by NHS/Council food worker who did inputs to Frae Fife arranged events		L	X inputs to groups & events
Hillfoots Family Centre (Council) Central Scotland	Support to vulnerable families	X with mums group and children		X fathers group	X via cooking, also mums & toddlers group
Rainbow Muslim Women's Group **Central Scotland**	Meet the personal, social & educational needs of multicultural & Muslim women in area. Promote informal education, leisure & health needs of women and promote multiculturalism by being inclusive and raising awareness in group and outwith, promote integration and combat racism	X take turns to show each other different dishes & share recipes, putting together recipe book to use as fundraiser	X dinner club for older people (3 sessions so far)	L esp. for elders	X tasters, arranged with college for food hygiene course, NHS & Diabetes Scotland inputs to women's' and younger women's groups

Stirling Multicultural Partnership **Central Scotland**	Integration, input to Community Planning, multicultural events, influence policy on race issues	X sharing of meals between communities, community cooked traditional food, dietician critiqued, diabetes & heart experts invited & hope to produce recipe book			X via events
Wider Access to School Project Central Scotland	Promoting adult learning			X in planters	X classes including "beauty from Fridge"
Children First, West Lothian Young People's Healthy Living (Chill Out Zone) West Lothian	Promote healthy living for 12-20s	X cooking classes including Traveller group (will be taken over by Council TPLO)	X healthy café		
Africa Centre Scotland **Edinburgh**	Promoting the Health, Socio-Economic well being of peoples of African Heritage residing in Scotland.	L		L	L
Amina Muslim Women's Resource Centre (MWRC) **Edinburgh**	Community development and integration				X Muslim women's maternity group including nutrition for mums and babies, weaning etc
Black Community Development Project/ Community	Race equality, improving community relations, capacity	X 6 weekly cooking classes	X monthly World Café, food prepared by		X educational inputs to groups X organised volunteers food

Organisations for Race Equality (CORE) **Edinburgh**	building, integration via food + health		volunteers from different backgrounds		hygiene training
Broomhouse Health Strategy Group **Edinburgh**	Promote healthier lifestyles for people in Broomhouse	X small amount & recipe book	X food coop	L	X workshops, tasters, open days
Dr. Bell's Family Centre **Edinburgh**	Provide inviting place for families with kids under 8 to get encouragement support and advice in a relaxed atmosphere	X cooking classes at centre & family centres, nurseries, primary schools	X healthy food cafe		X supporting training of San Jog Social Enterprise in cooking & food hygiene etc X inputs to Summer children's' programme & African group
Edinburgh Community Food Initiative **Edinburgh**	Food & health promotion, access to healthy foods via food coop development	X cooking classes as part of outreach work at community centres, churches, family centres, nurseries	X food coop support, development & supply across Edinburgh		X health promotion with groups, classes etc X - host the Edinburgh food & heath training hub, include food hygiene training
MECOPP Carers Centre **Edinburgh**	Assist ME carers access support & services to manage & sustain care roles	X occasional e.g. booked Thai cooking school for day for classes & meal		L (applied for funding)	X workshops including specialist inputs on health & nutrition in relation to specific health states
MEN-IN-MIND (Mental Health & Wellbeing for Men **Edinburgh**	The project aims to develop mental health support services, and to raise awareness of mental health issues amongst				X small part of work, link with other aspects of physical health & impact on mental health

	black and minority ethnic men through a programme of events and activities				
MILAN Senior Welfare Organisation **Edinburgh**	Provides services for older Asian people from India, Pakistan, Bangladesh and Mauritius, living in Edinburgh and Lothians.		X lunch club 3 days p.w. food coop discontinued due to lack of funding		
Multi-Cultural Family Base **Edinburgh**	Overcome disadvantage promote life opportunities for families with children 0-16	X Cooking with young people at base & community centres			X healthy eating inputs to community groups at base & community centres
Pakistan Society **Edinburgh**	Help people with problems. Over 50's club-overcome isolation provide activities		X Weekly lunch club		X some speakers provide health related inputs
Pilton Community Health Project/Barri Grubb **Edinburgh**	Make health services available to all & break down barriers to healthy lifestyle, promote healthy eating	X cooking classes for BCDP	X Café (but few ME)		X limited contact with ME other than work with BCDP at present, but hope to do more in future
Score Scotland (Strengthening Communities for Race Equality in Scotland) **Edinburgh**	Promote social justice & equal opportunities for all by promoting service accountability & inclusion - put unity back into community	X cooking classes from Jan 2010			X link with sports activities, healthy snacks at groups, with women's groups do inputs on food

Shakti Women's Aid **Edinburgh**	Provide support and shelter for BME women & children fleeing domestic abuse & provide aftercare	X some work on cooking e.g. cooking demo	L would like to do to fundraise X distribute free food from FareShare to women with no recourse to public funds		X women's group - serve food (mostly sandwiches) and have speakers on e.g. healthy living, food hygiene
(Sikh) San Jog Centre **Edinburgh**	Support Sikh women & families access mainstream services	X cooking activities with girls and women's groups	X new social enterprise café due to start 2010		X healthy eating inputs with girls and women's groups
The Welcoming **Edinburgh**	community integration, with emphasis on good eating		X free weekday lunches & monthly pot luck suppers with focus on integration		X via weekly Health & wellbeing group
Wester Hailes Health Agency **Edinburgh**	Address food poverty and work with hard-to-reach population including ME by providing organic garden for fruit/veg. & training in planting & cooking	X cooking & recipe book (ran specific ME cooking groups up t 4 yrs ago but funding ended)			X classes & demos, workshops, taster sessions, diabetes groups, weight/get fit
Action for Children San Jai Chinese Family Project **Glasgow**	Provide support for Chinese children and young people, enhance parenting capacity of Chinese parents	L		L	X work with CHCP input on oral hygiene (includes impact of e.g. sugar, diet) L food hygiene training

	leading to wellbeing and safety of children and young people, address service gaps for the Chinese community, promote social integration				
African & Caribbean Network Ltd **Glasgow**	Brings together over 40, for Community, cultural, social & economic development for African & Caribbean orgs. in W. Scotland	L healthy cooking /eating, to promote and educate on how to eat authentically and healthily and share food across ethnic groups	X Social Enterprise healthy African food restaurant planned to open autumn 2010 and provide event catering etc		X inputs at AGM s on Diabetes
Amina Muslim Women's Resource Centre (MWRC) Glasgow	Community development reduce isolation, promote integration		X snacks provided at Women's friendship group		X healthy eating inputs from REACH at Women's Friendship group
Bridging the Gap **SE Glasgow**	Integration and support of asylum seekers	X volunteers cook lunches using healthy ethnic styles	X Lunches provided free for service users Free healthy snacks provided Food Co-op form SEAL weekly		X volunteers trained and achieved food hygiene certificate
Cranhill Community Project **E Glasgow**	Community development and personal growth in one of the most	X Cooking classes provided by Kids Co	X café not ell used by ME but undertakin g research & hoping to	X communit y garden (new, have 10K grant to start)	X food safety & hygiene training for café staff & 30 volunteers via local FE college

	marginalised communities in Scotland, particularly for the asylum seeker and most vulnerable communities in Cranhill, through integration, adult learning, advice and social activities.	In 2010 hoping to do ME cookery demos	develop café & do health promotion &weekly internation al food days		
Crossroads Youth & Community Association SE Glasgow	Integration		X free healthy vegetarian lunch		X informal discussion/ learning at Women's group
Darnley St Family Centre **SE Glasgow**	Community development and education and nursery provision	X previously with Hidden Gardens		X nursery	X inputs with women, girls and nursery
Dixon Community **SE Glasgow**	Day care for older ethnic minority people, mainly from Pakistan & India, support to carers		X lunch Tues from DACS & add fruit/veg., other days provide own		X some inputs from agencies
Food for Thought Ltd	Social integration and healthier lifestyles through training on food issues	X provide cooking & healthy eating inputs to other organisations	X sell services		X provide cooking & healthy eating inputs to other organisations
GAMH Glasgow	GAMH provides a range of other services including providing facilities for small self-help groups and the Greater	X recipe book food for recovery NW SE Get Shopping, Get Cooking	X Scotia club house lunch club & share festivals with food	X allotments	X including food hygiene; in N a vol./service user to be trained as Get Shopping, Get Cooking trainer

	Glasgow Mental Health Forum for members of GAMH to receive and share information.				
& in GAMH SW Glasgow	Mental health - create opportunities, reduce isolation, develop skills of service users	X SW Get Shopping, Get Cooking		X share allotment	X inputs at Thursday drop in
Gorbals Healthy Living Network SE Glasgow	Health promotion and development of opportunity	X cooking classes & demos , recipe book			x via cooking classes & play facilities with young children
Govan Youth Information Project SW Glasgow	Provide support, information and advice to young people 5 -25and empowersthem to contribute to development & regeneration of the local community.				x workshops in schools, drop in sessions at schools & base & some inputs at ME youth group
Govanhill Housing Association, Govanhill Social Inclusion Project (GOSIP) SE Glasgow	Social inclusion, women's self development				X informal inputs
Greater Pollok Integration Network **SW Glasgow**	Deliver services to individuals & families in the local community including asylum seekers, refugees &	X women's group do some cooking/teach each other different	X community café/drop in - give away produce from	X allotment with Greater Govan IN & via café container planting	X healthy eating inputs to groups

	newcomers; promote education & encourage integration	recipes/menus X Food cultural nights - healthy foods, share types e.g. refugee week, use as vehicle to explain the food and the culture	allotment and use to help people learn about new foods	for home e.g. ginger, onions	
Greater Pollok/Govan Integration Network **SW Glasgow**	Community integration, support for asylum seekers - outdoor access, growing environment, mental health			X allotment	X informal sharing of recipes & knowledge
Health Spot (a Glasgow South East Regeneration Agency Project) **SE Glasgow**	Provide accessible health services for 12-25 yr olds				X input to Slovakian group More work in E. Pollokshields in future though more addictions based
Hidden Gardens SE Glasgow	Improving quality of life for local residents, intercultural exchange, health improvement, improving skills & knowledge in local community	X Cooking classes -12 weekly blocks , with women's cultural group & for other local orgs e.g. .PDA, Darnley St. Cultural recipe exchange		X allotment plot & help other groups	X baby weaning classes 8 wk blocks (revamping to shorter course can dip in & out of), mum & toddlers food inputs, 1 off sessions on topics
Home-Start Glasgow South S Glasgow	Recruit & train volunteers to support families with children under 5. Volunteer befriending, family group, mums &	X soups, smoothies, hands on & fun X Penilee group have monthly healthy lunch with chef			x inputs & tasters at 2 groups train volunteers on healthy eating to help support families

	toddlers, English classes, parenting & STEPS courses to develop confidence	cooking for them X Get Shopping, Get Cooking course			
Kingsway Court Health and Wellbeing Centre **W Glasgow**	Community development helping local people to develop local solutions esp. on health & wellbeing	X Food Village at Kingsway Carnival X women's group occasionally cook	X pensioners lunch club (few me) X Qurbani meat distribution after Muslim Eid		X formerly at mums & toddlers X occasional at women's' group
Mel Milaap Centre **N Glasgow (GCC Social Work)**	Provide day care for elderly/vulnerable people		X Lunch Club food provided by vol. Management Committee		X limited input-posters inputs from agencies e.g. BHF did inputs
Multicultural Elderly Care Centre **Glasgow**	Provide support for ethnic elders to help them remain in the community-physical, mental, befriending. Food work is to encourage health		X daily halal lunch cooked on premises		x posters, materials, diabetic inputs from REACH
Muslim Day Centre (partnership Jamiat Ittihad ul Muslimin & GCC Social Work) **S Glasgow**	Socialisation for frail, isolated adults 55+		x lunch (halal 3 course)		x previously did diabetes awareness work
North Glasgow Community Food Initiative **N Glasgow**	Promote general health & wellbeing & community integration	X cooking classes	X food coops	X allotments	X healthy eating inputs

Pearce Institute **SW Glasgow**	Provide space for community groups/vol. orgs in Govan(house 30-40 groups) Food - Café Pearce aims to encourage healthy eating & social hub	X art of living club includes some food work jointly with Grassroots wholefoods - start with healthy meal	X café (policy to price healthy foods cheaply & use menus for healthy eating info)	L hope to develop with partners	X healthy eating inputs
Pollokshields Development Agency **SE Glasgow**	Benefit and advancement of residents of Pollokshields, Integration	X cooking & healthy eating by Hidden gardens funded CHCP		X allotment & cooking produce involve kids too	X healthy eating inputs to groups
REACH Community Health Project **Glasgow**	Engage BME community to ensure health needs fully met; vision : a multicultural society where all people have access to appropriate health & wellbeing	X provide cooking inputs to some groups			X workshops on healthy eating, engage with shopkeepers on healthy food messages & training on food health & hygiene
Rosemount Lifelong Learning **N Glasgow**	Improve confidence, skills, social integration	X not ME	X fruit stall Weds, some ME use if in for other things		X not ME
RNIB **Glasgow**	Diabetes awareness with ME groups				X some work on food in relation to diabetes/retinopathy e.g. inputs to community groups
Royston Youth Action **N Glasgow**	Youth development	X weekly cookery class	X provide free healthy soup to attract/ support users Healthy	L	X healthy eating inputs to groups

			snacks at youth club		
SEAL Community Health Project **SE Glasgow**	To reduce inequalities and ensure equal access to a healthy lifestyle		X fruit barras/deliveries		X weaning forums make up packs for mums X taster sessions and info e.g. fruit smoothies
Shanti Bhavan Day Centre N Glasgow (GCC Social Work)	Day centre for Hindu (mostly) elders		X daily healthy, authentic, vegetarian lunches in own kitchen		X inputs from NHS, GAMH etc on healthy eating
Urban Roots **SE Glasgow**	Work with local people on projects that improve the environment, health and nutrition work and environmental arts; food bringing people together	X Multicultural cooking classes (new),	X food coop -own produce & from Fruit Market	X 5 community gardens, organic X Kid's eco clubs and gardening clubs	X with cooking classes and food growing
YWCA Glasgow Glasgow	Learning and development	X Cooking with women and children			Xinformal learning
Wah Lok Jung Sam Day Care Centre Glasgow (GCC Social Work)	Day care for Chinese elderly		X daily lunch prepared in Social Work Chinese kitchen, includes fruit, salad		
Wing Hong Elderly Centre Glasgow	Enhance the quality of life for the Chinese elderly		X daily lunch , food provided by SW Chinese kitchen		

Renfrewshire Community Health Initiative **Renfrewshire**	Vehicle for delivering health message, Raising awareness on Tobacco, alcohol, Obesity in the community	X cooking on a budget, from scratch with groups & children's recipes		L hope to in future & link with cooking/healthy eating	X eat well plate & map, work in schools with parents & kids, & link with sessions on food groups
Knowetop Community Farm **West Dunbartonshire**	Provides a service to local regeneration priority on environmental awareness and education, animal care, horticulture & food.	X making soups from produce	X café including healthy recipes, cheap healthy food Youth cafe	X organic growing	Xworkshops, taster sessions
Milan Lunch & Social Club **S Lanarkshire**	Overcome isolation of older people, bring cultures together. Celebrate festivals	X pensioners lunch club			X inputs e.g. re heart disease
Girvan and District Food Co-op **S Ayrshire**	Provision of low cost fruit/veg., free range eggs etc	X recipe book	X food coop & Best Fed Baby £5 a wk fruit and vegetables voucher scheme to expectant mothers- in partnership with NHS		X advice on how to use e.g. healthy soups

3.1.2 Table 3 Organisations that confirmed they were working on food issues with ME groups but were not available for interviews

Organisation Name	Aim	Cooking	Selling/ Providing	Growing	Learning
Edinburgh Chinese Elderly Support Association Edinburgh			X Lunch club		
Nari Kallyan Shangho Edinburgh	A health and welfare project for South Asian women and children provides a common platform for South Asian women to act together to improve the quality of our lives & opportunities for health and welfare service providers to hear the concerns and views of South Asian women.	X Classes Recipes in newsletter	X Asian women's lunch club,		X Healthy eating inputs
Kingdom Development Project Edinburgh					
Fife African Caribbean Association Fife					X healthy eating information
Karibu Scotland Glasgow		X cookery with the vegetables once grown		X growing African vegetables with Hidden Gardens	
Maryhill Integration Network N Glasgow	Integration for all communities	X Oasis women's group - traditional lunches on			

		rota basis Recipe book linked to cultural information			
Kids and Co E Glasgow	Tackle food poverty	X Cookery classes			X interactive learning on food
Universal Connections Lanarkshire					Food information with young gypsies/travellers
Fyne Families Lochgilphead			Healthy snacks at after school sessions (Gypsy traveller site)		

The majority of projects included some work on learning about healthy food within their work. This varied from displaying posters and leaflets, through one-off inputs on particular topics, through to inclusion of healthy eating messages in ongoing activities such as cooking and baby weaning classes.

Many projects combined a range of activities, and undertook activities with different groups of people. Several projects indicated they would like to develop their work with the aim of combining cooking and growing the vegetables to be cooked.

3.1.3 Table 4 Analysis and Findings of Services provided and identified need (of 79)

	Cooking Classes, demonstrations, recipes	**Selling** Co-ops, cafés & meals	**Growing** Community gardens, allotments etc	**Learning** Courses, seminars, talks etc	**Other**
Provide	31	33	16	64	5 Free food provision e.g. **d**istribution of surplus produce, free lunches, tasters

Unmet need	10 More healthy cooking classes 3 Healthy Ethnic cooking 3 Follow up beyond class/home visits 1 cooking exhibitions to show what can be done	7 Access to healthy/ ethnic food e.g. food coops selling ethnic foods 3 Ethnic Café/restaurant 1 Social evenings focussed around food Cost - 1 Refrigerated van (rural food coop) 1 Bulk buying via consortium (Glasgow) Online delivery systems (N Scotland) 1 Healthy food supplier for events catering to multicultural events (Glasgow) which could then also promote a healthy message 2 Food provided by mainstream to Day Centres not very tasty or nutritious 1 ethnic meals on wheels	6 Projects planning to work on growing 4 would like to undertake	26 More work on food and health needed 1 Follow up work with school children 3 Food safety hygiene training (incl. 1 bilingual for men) 2 Vol. sector Day Centre cooks trained in healthy eating & adapting traditional menus/ alternative foods 1 Facilitate putting health into ME organisations' work e.g. inputs at AGMs 1 Workshops on natural alternatives/ healing foods	Food advice/ activities for vulnerable groups e.g. 2 older people, people with physical & learning disabilities, mental health issues, 2 carers, 1 homeless 1 Lunch club for middle aged /not vulnerable people 2 Diabetes more work needed with ME groups, are interested 1 Need Community based diabetes specialists as won't travel to hospital (Dundee)

3.2 Evidence behind current work

The main source of need identification was community demand, followed by awareness of statistics for ME communities on health, and to a lesser extent poverty. In a number of cases people were unable to answer this question, or indicated it was part of the remit when they came into post. Where food was seen as primarily a tool for integration, or was to meet client

needs (e.g. for lunch at a Day Centre) the health education aspects of food provision were more likely to be secondary if considered at all, although several respondents indicated that with support this was an opportunity that could be developed. Some projects gave multiple reasons for undertaking food work particularly in relation to the first two categories.

Table 5 Evidence behind current work

Community demand – from service users or surveys	Health & poverty statistics for community served	Food seen as tool for integration	Meet client needs	Development from other work	Part of the original remit
20	15	4	5	3	4

3.3 Evidence of unmet need

Evidence of unmet need was given as user demand (4), lack of services in the area (2), greater demand than can satisfy (1), but many respondents had indicated awareness of health needs of ME communities during the course of interviews

3.4 Organisational status

60 of the voluntary sector organisations were registered charities, 2 were not. 42 were companies limited by guarantee or similar, and 7 were not. 4 local authority projects were also interviewed – 2 elderly day centres in Glasgow, a healthy living project in Dundee, and a Family Centre in Central Scotland.

Almost all projects work in partnership with statutory sector organisations, with many of the food inputs being either funded or provided by statutory sector organisations.

3.5 Aims

Organisations were involved with food work for varying reasons, which primarily reflected their overall purpose. In some cases more than one aim applied. However, even where food was used primarily as a tool for integration, or for cultural expectations of hospitality, it was recognised that healthy eating messages could be productively incorporated.

3.5.1 Table 6 Main Aims

Health promotion	Community development tool	Means for promotion of equality and integration	Component of care service
28	22	19	12

3.6 Duration of projects

There was considerable variation in how long projects or food work had been running. Most of the work in the under 1 year category was food work as a small part of wider development work e.g. as part of the agenda for a women's group.

Table 7 Duration of projects

time	< 1yr	1- 4 yrs	5-9yrs	10-14yrs	15yrs	20yrs	29 yrs	41 yrs	100yrs
No. of projects	7	8	18	8	4	1	1	1	1

3.7 Geographic spread

The largest number of food initiatives with ME people was based around Scotland's Central Belt, with some work also being undertaken in Fife, Dundee and Aberdeen, reflecting the concentration of more settled visible ME groups. The initiative in the Western Isles is an exception to this. (For contacts see Appendix 2.)

3.8 Gender breakdown

While food work included both men and women, the bulk of the work on cooking took place with women, as did much of the educational work. The main variation to this pattern was in growing, where men were significantly more likely to be involved and 2 projects indicated they struggled to involve women in the growing aspects of food work.

3.8.1 Table 8 Gender breakdown of ME food work projects

Both sexes	Male only	Female only	Of which almost all female	Separate sex provision included
58	1	11	6	9

3.9 Work with vulnerable groups/ age categories

While a number of organisations undertook food related work with vulnerable client groups such as people with mental health or addiction problems, and some worked specifically with unemployed people on return to work issues, this tended not to be with minority ethnic people. However a number of projects commented that the majority of service users were not in employment and many had few recognised qualifications.

Of the organisations interviewed 11 focussed on older people, including lunch among services provided. The age range for attending ranged from 50+ (4), 55+ (3) and 60+ (4).

2 organisations had a specific focus on ME carers and undertook some food work with them. 1 further organisation which was not able to participate also fits this category.

2 organisations focussed on mental health issues, one of which was a mainstream organisation which included ME people and one of which was an ME organisation.

2 organisations working specifically with people with physical disabilities have done some work on food with ME people.

4 organisations interviewed focussed specifically on families with young children, including healthy eating work with children themselves as well as with their parents and 4 concentrated on work with young people. There were less work on maternal and children's eating than might have been expected given the demographics of ME communities.

Many other projects also included work with some or all of these categories of people.

3.10 Location and frequency

By far the majority of the work was undertaken in community locations – either a community project's base, or via outreach to a range of community and family centres. Two of the projects that included work with young people included work in schools. The ethos in almost all cases was about providing the service where people are, or feel comfortable attending.

Frequency of food related work was very variable, from regular daily inputs of the specific food and health projects, and daily lunches at some elderly centres, through to occasional educational inputs at e.g. women's groups, according to service user demand.

Cooking classes generally fell into 4 -6 week blocks.

3.11 Accessing services

The most common and effective means that people learned about projects' work was via word of mouth, with a range of other methods being used including articles in community newspapers, leaflets and posters at community venues and events, information on project websites, newsletters and mailings to service users and members, information spread though other organisations and networks. Several specific health related projects organised taster or health check sessions at community events as means to raise their profile.

The majority of food services were open access, provided criteria were met (such as meeting funders postcode criteria) either by turning up, or most frequently for classes by being included on a waiting list. Most elderly centres and some family centre services required agency or family referral followed by a needs assessment.

Apart from the cost of food at food co-ops and cafes, which was generally cost price or little more, and which in some cases e.g. Pearce Institute, was priced to encourage consumption of the healthier menu items, food work was free to the service user with only 2 projects charging. While for most projects where childcare was provided this was free, in 2 cases a small charge was levied.

4. Monitoring and Evaluation

4.1 Monitoring

Most organisations used some form of monitoring of service usage, usually in line with requirements of funders, and in some cases the Care Commission. For most organisations this included numbers attending, postcode or geographic area, sometimes ethnicity, gender, age, and depending on the agency remit learning or care needs and aspirations. The complexity of monitoring data varied with both the size of the organisation (small community based groups with little funding generally carrying out simple monitoring) and the remit.

4.2 Evaluation

Virtually all organisations considered their food work to be very successful or successful. For most this evaluation was primarily based on service users' feedback and comments and

the demand for the service. 6 projects indicated they took baseline information before any input and compared this with an evaluation at the end of the course, and 2 that they undertook evaluation at 3-6 months after the conclusion. 2 organisations indicated they felt that a longer term evaluation of impact would be useful e.g. follow up after 3 years to assess the real impact on diet that the work undertaken had achieved, if this could be funded. Only 6 projects indicated they had had any form of external evaluation of some or all of their food work. 1 organisation identified help with longer term evaluation as a development need.

5. Ethnic Monitoring

A number of organisations do not monitor ethnicity, and are thus unable to indicate who may be using their food services, although some provided information based on appearance (which may have led to an underestimate of non visible minority service users).

12 of the organisations identified from the CHFS website as working with ME indicated that they did not in fact do so, or that they had very little ME usage, with perhaps the occasional visibly different person. Ethnic minorities had been included as a client category as they are open to all. A perception that "all are welcome they just don't choose to come", may reflect services that are not aware of or geared to meet specific needs of minority communities.

Others may monitor for some activities where required by funders, but not for food work if this is not a funding requirement – one project indicated they used to monitor but following a change in funding no longer do so as this is not required, two organisations indicated they monitor for non food aspects of work. Most food coops, cafes and some other projects offering large open to all services, did not find it feasible to undertake ethnic monitoring of service users, although in some cases the organisations undertook ethnic monitoring of volunteers and other food activities. Several organisations were unable to access monitoring statistics for the purpose of the survey. Organisations out with the Glasgow /Edinburgh/Dundee areas were least likely to undertake ethnic monitoring.

Of those organisations that monitored ethnicity and were able to provide information the largest number included work with people of Pakistani origin, 45, followed by African origin (a diverse range of countries) 36, Indian 32, Chinese 25, and Arab 19. In the Glasgow area 6 organisations had service users from Iran, 4 from Afghanistan, and 2 from Turkey and Sri Lanka as well as others, reflecting the range of asylum seekers in Glasgow. In Edinburgh 3 organisations included work with people from Thailand.

The only organisations that worked almost exclusively with one ethnic group were several elderly Centres for Chinese and 2 for Indians, 1 project targeted at Chinese families, and 2

for Africans and African – Caribbeans. Of organisations working with a range of ethnicities 9 had almost all, or a large percentage of, service users of Pakistani origin, with 2 having large numbers of Africans, 1 of Indians 1 of Arabs and 1 of Chinese. The number of Bangladeshis, Arabs and other backgrounds in all mixed groups that responded was small. 14 identified organisations included work with East European migrants including 8 with Polish and 3 with Slovakian migrants (although of these latter, at least 2 were providing separate inputs to the same group of people). Numbers involved were small and this is an area of work that was identified as needing further development. Only 5 projects were identified that worked on food issues with Gypies / Travellers. The food work of one of these will be taken over by the local authority during 2010. Two of these were among the groups it did not prove possible to interview during the time frame of the research. Another voluntary organisation indicated this was an area they might wish to explore in future.

The large number of organisations working with people of Pakistani origin is consistent with that being the largest ethnic group present in Scotland. The number of organisations working with people of African origin is larger than statistics might predict. It would appear that there is less work than might be anticipated being undertaken with Gypsies/ Travellers and this may be an area that requires future development.

5.1 Table 9 Main Ethnic groupings included in food work by region

	White Scottish/ British	Pakistani	Indian	Bangladeshi	Chinese	Arab	African	East European	Gypsy Traveller	other
Dundee, Aberdeen & North	5	4	2	3	3	1	4	3	1	3
Lothians & Fife	11	7	9	5	7	6	9	5	1	6
Central & West	19	34	21	4	15	12	23	6	3	14
Total	35	45	32	12	25	18	36	14	5	23

Very few organisations monitored by faith background, although a number were aware of and made arrangements for e.g. vegetarian and halal provision in cooking and providing food. One Glasgow organisation had looked into faith based dietary requirements for their café (e.g. kosher, halal) but concluded that they did not have the physical space to make

such provision feasible, and while providing vegetarian food, could not meet the needs of the small numbers of people in the area requiring such provision. Consequently they had very few people from minority ethnic communities accessing their café – an issue of which they were very aware. 2 others which work with many ME people in other aspects are also aware that ME service users are under-represented in their café and one is embarking on a research project funded by CFHS to identify the reasons for this, and steps needed to redress this.

6. Funding

The main sources of funding for projects interviewed were:

- A broad range of voluntary sector grants including: Big Lottery (11), Awards for All (2), Heritage Lottery (1), Lloyds TSB Foundation for Scotland (4), Comic Relief (4), CFHS (10), Esmee Fairbairn (1), Scottish Community Foundation(3), Tudor (3), Agnes Hunter Charitable Trust (1), Robertson(3).

- Government sources including: Scottish Government e.g. Race Religion & Refugee Integration (RR&RI) (4), Gender Budget (1), Social Enterprise Fund (2), Sure Start (2), Climate Change Fund (1) Fairer Scotland (11), Local Authority (20), Community Planning (11) and NHS sources (22).

- In addition much work was undertaken in partnership with NHS or local authority staff providing inputs that enabled the work to take place.

Many projects did not indicate all sources of funding as they had a complex patchwork of funding sources.

The amount of funding for food related work received from 0 to over £200,000 p.a., but the majority of organisations received fairly small sums and food work was often covered from broader project funds rather than being specifically funded.

The majority of projects were funded short term – until March 2010 or 2011. While a number of those on annual funding were relatively optimistic about future funding, many were worried about the longer term. During the course of the research 1 project contacted for the research closed, another seems likely to have to close in March 2010, and others were struggling to continue their work. 8 organisations identified from the CHFS list as working with ethnic minorities were unable to be contacted and it seems likely that they are no longer operating. In addition two other organisations identified through other means that had been carrying out significant food and health work with ME communities had recently closed, and

others had either stopped carrying out this aspect of work or reduced their activities, due to funding difficulties. Several organisations highlighted the need for longer term funding as short term funding leads to a start/stop approach which is wasteful of resources and cannot achieve long term change.

17 organisations identified lack of funding as one of the challenges in carrying out their current work, 29 indicated this was the reason they were not able to meet identified unmet need, and 10 further organisations indicated that they felt they would benefit from help and information to access funding sources including 1 in relation to Service Level Agreements and 1 regarding developing a Social Enterprise.

6.1 Table 10 Funding - need for

Challenge to current work	Prevent meeting unmet need	Help & info on funding sources requested
17	29	10

11 projects had social enterprise arms, or were moving towards developing these to help sustain them in the longer term.

1 organisation indicated that further networking for food projects on social enterprise could be useful citing the benefits of an event in 2009 on fruit barras as social enterprise. Another indicated they would benefit from support in developing their cafe as a social enterprise.

7. Challenges to providing existing work

In addition to funding difficulties, 5 projects indicated that they struggled with insufficient staffing, and that while volunteers were highly valued, 7 projects indicated that they struggled with providing the resources to ensure that suitable volunteers were recruited and supported.

The cost of providing childcare was mentioned by 4 organisations and lack of suitable venue for crèche by 2 and this issue was also mentioned as a barrier to developing new work. Without separate crèche the presence of children impacts on adult learning and cooking classes cannot go ahead or women with small children are excluded.

Language issues in undertaking work were highlighted by 7 projects, and while some felt it was not a problem for them, because they had bilingual staff, it was felt this was an issue in relation to people accessing other projects. The cost of interpreters was prohibitive, especially in a diverse group, which meant some service users were only able to receive

very limited health messages. Language may particularly be a barrier/challenge for working with older people and newer migrants

10 organisations raised the challenge that working with very multicultural groups raised, in terms both of ensuring all needs were met e.g. while Muslims require halal meat, this is forbidden to Sikhs, and of ensuring respect and toleration by participants. All projects indicated that they successfully met this challenge but it did entail considerable work and planning. 1 project mentioned the difficulty of getting Scottish people to attend as the project was becoming labelled as for ethnic minorities. 3 organisations also mentioned the difficulties and disruption created by newer migrants being moved away just as the work involved in settling them in was paying off.

While gender segregation was only mentioned as a challenge by 1 organisation, resolved by a change of venue, this is likely to be because many community-based organisations built this in to work as a matter of course in response to anticipated requirements of service users. 2 projects working with young girls reflected on the measures they had taken regarding cultural sensitivity and safety to ensure families allowed their daughters to access provision.

3 organisations mentioned the difficulties and additional work required to ensure regular attendance, while 3 others talked of the fact that people often had other priorities which impacted on attendance, including racism and struggling to earn their living.

3 mainstream projects mentioned gatekeeping attitudes of ME voluntary sector organisations or professionals which acted as a barrier to conducting work (2 SE Glasgow, 1 Edinburgh). However one ME organisation (Dundee) specifically talked about the lack of understanding of mainstream organisations of the work entailed in bringing groups of ME people together, and ensuring attendance, for the mainstream partners to work with, and felt that reluctance to engage in work for this reason due to limited staff resources was sometimes misinterpreted as being unhelpful.

With regard to growing, while some projects reflected the delight of service users when they succeeded in growing traditional vegetables, the Scottish weather and short growing season came as a shock to many. A cheering response was the overcoming of local scepticism over the feasibility of a gardening project in S. Glasgow, where by not fencing and community involvement there has been very little vandalism.

With regard to cooking 2 organisations indicated that they felt cooking classes were inadequate without follow up home visits, but did not have resources to undertake this.

4 organisations identified challenges of trying to devise appropriate healthy ethnic menus and resources for working with ethnic groups.

4 organisations also indicated concerns regarding lack of awareness and support from the mainstream for working with ME groups. 2 lunch clubs indicated that food provided by the mainstream was neither tasty nor nutritious.

5 projects identified that ethnic minorities were accessing other provision such as classes or football and gym provision, but this was not translating into accessing food services such as cookery classes and the healthy eating café.

7.1 Table 11 Challenges

General	
Funding	17
Lack Staffing resources	5
Recruiting & Managing volunteers	7
Childcare	4
Venue unsuitable	6 (cooking) Including 1 venue not suitable for people with disabilities 2 crèche space needed
Language issues	7
Evaluation	2 Hard to measure change/involve staff in more rigorous
Accommodating Cultural issues	
Gender separation	1
Family confidence	2
Newer migrants/asylum rapid change	3
Identifying most vulnerable families	2
Motivating to attend regularly	3
Have more urgent issues e.g. racism, earning living, kids bullied	3
Multicultural working/accommodating wide range	10
Increasing ME participation in food work	5 (where use other facilities)
Increasing Scottish participation where MEs involved	2
Gate keeping by ME organisations	3
Growing	
	4 Weather, fertility, demonstration crops different, can discourage
	2 Negativity in area until saw it works (growing)
learning	
Schools work	1 Accessing secondary schools to undertake work
cooking	
	1 Appropriate support & materials

Healthy Ethnic menus	3
Follow up beyond class/home visits	2
Inadequate venue for cooking	6
Lack of awareness & support from mainstream esp. where small numbers ME	3
Selling/ Providing	
Access to healthy/ ethnic food	1
Cost of foodstuffs	Supermarket in area creates competition, & recession, fuel driving costs but most vulnerable still need (rural food coop)
Food provided by mainstream to Day Centres not very tasty or nutritious	2 lunch clubs
Health & care groups	
	2 Diabetes not taken seriously

8. Influences on food consumption

36 respondents identified poverty/cost of food as a factor in influencing diet. 3 particularly felt this to be the case for asylum seekers, with 2 mentioning the difficulties for those on vouchers. It was also identified as a particular problem for the Slovakian community. While many indicated cost as an issue in eating healthily, others considered this was due to ignorance of how to cook basic foods. It was however, pointed out that it is more expensive to eat healthily in Scotland than in e.g. India. Cost was also a factor in certain areas where there were few shops selling necessary provisions such as certain ingredients or halal meat, which were either costly or entailed the additional time and cost of travel. In some areas such as Govanhill/Pollokshields areas of Glasgow cost was not seen as a problem, with a plentiful supply of relatively low priced food available.

25 respondents considered accessibility was a problem, again dependent partly on location. Chinese (outwith Glasgow) and African communities suffered more from lack of availability of fresh traditional foodstuffs, leading to interest in both growing, and use of alternative vegetables.

Culture and Religion were seen as playing a major part in what is eaten, religion in terms of dietary rules e.g. halal, vegetarian, and culture in terms of how food is prepared. 3 organisations stressed that ME diets are often healthier than mainstream Scottish diet, utilising fresh ingredients and more fruit and vegetables, and that most minority groups have retained a knowledge of cooking, often absent in the indigenous communities. In line with published research respondents commented on changes with the younger generation, however while 2 felt that this was leading towards poorer western fast food habits, 2 others felt that young people had more concern over body image and interest in healthy eating

which was a positive direction. 1 respondent indicated that traditional foods gave comfort; making people feel at home in what is otherwise often quite a harsh external environment, and 3 others that for many people they only know how to cook “the way it’s always been done”.

33 respondents commented on the influence of food knowledge, with 9 commenting on the need to provide information to give confidence on healthier ways to produce traditional tasting foods and 1 commenting on faster lifestyles making it harder to take on new ways of doing things. Comments also included an indication that people do not understand food labelling so that they do not know how to reduce e.g. salt, and that for the Chinese community that there is little information on nutrition value of food in Chinese shops – seasoning and cheap food may be thought to be healthy but are not. Translated materials are rarely available.

21 respondents indicated that family expectations influenced what food was prepared and consumed, with examples being cited such as in-laws expecting a young wife to cook traditional foods, and older people having to eat the food prepared for them by their younger in-laws. The socialising aspect of eating was also mentioned with the expectations of traditional foods this entailed.

The power of advertising was mentioned as an influencing factor by 1 respondent, the lack of time for preparing food by carers by another and the absence of cooking facilities for homeless people in B & B accommodation can lead to poor eating habits.

Table 12 Influences on food consumption

poverty/cost	accessibility	culture/religion	knowledge	family	other
36	25	38	33	21	3

9. Factors that can help produce change

Several respondents commented on the importance of hands-on work such as cooking rather than watching a demonstration, in ensuring follow through on the health message. Emphasis was placed on relating classes to what people usually prepare or have expressed interest in (6 responses). The importance of having a safe, comfortable environment, with a same sex chef where required was highlighted. It was considered that mainstream agencies working with ME communities often do not know the issues or recognise diversity and it is important to recognise that it is “not one size fits all”.

3 organisations indicated that medical, and 4 that religious, inputs may have particular authority with their user group in terms of taking on a health message, and cited previous diabetes work involving medical professionals as having had an influence on understanding and diet of service users.

There were reflections on e.g. Asian and some Arab communities using too much oil/ fat and salt, some African communities eating too much starch, Chinese communities being unaware of the impact of preservatives e.g. MSG and salt in their diets, and perhaps thinking they are eating healthily because they meet the 5 a day criteria. It was suggested that the health messages and literature is inadequately geared to meet different communities' needs.

Care should be taken with written information that it is translated into appropriate language e.g. using the correct versions of Chinese script (traditional for older residents who came from Hong Kong/ simplified Chinese for newer migrants from mainland China). People may not be literate, so hands- on bilingual trainers are needed and agencies need to be trained to work effectively with interpreters.

Cooking skills are more prevalent among service users from minority backgrounds, but knowledge of how to cook with available ingredients, or of the health impact of e.g. high levels of oil, salt, sugar, are often not known.

2 projects indicated older Asian men are more interested than women in changing diet to healthier options, but 1 that men were particularly resistant to change.

9.1 Table 13 Factors that can help produce change

accessibility	**knowledge**	**try new options**	**religious teachings**	**affordability**	**improved confidence in cooking/shopping**
9	12	9	4	9	7

10. Support requested by organisations

A request was made for more high level lobbying regarding the voluntary sector which has the expertise to do sustained work but is continually hampered by a lack of recognition and sustained funding.

11. Networking

35 organisations felt they would benefit from further opportunities to network around food and health. These were from the organisations that were not already part of the CFHS Network, mostly ME rather than primarily food focussed organisations. Several organisations indicated they would struggle to find time to attend many events with 2 indicating this would definitely not be possible.

Suggestions for networking varied from fairly broad ranging such as a training conference focussed specifically on working with ME communities on food issues, an idea welcomed by a number of projects, to specific suggestions such as a network of allotment projects; a buying consortia to reduce food costs (Glasgow); and opportunities to share healthy ethnic recipes and learn what works regarding cooking. The Diabetes UK BME sub group was cited as a good example of networking. The BME event organised by the Forum for Environmental Volunteering Activity (FEVA) was seen as a useful model in that it had given impetus to new work.

12. Training

33 organisations felt they would benefit from training. This was subdivided into several categories:

- on food nutrition information, including how to make it interactive and interesting
- on how to do healthy ethnic cooking, as recipes alone won't work as people don't use
- cultural awareness and how to work with ME people (from mainstream agencies)
- building capacity for local people to become trainers (including peer mentoring and as employment opportunities for them)

It was also stressed that such training should not be too expensive, as cost could prevent attendance

13. Information

51 organisations felt they would benefit from provision of more information.

Due to constraints on time a large number of organisations felt that on-line information via an e.newsletter, website pages or an e.information exchange forum would be useful. This was specifically mentioned by 14 respondents; however 2 organisations working with elderly people indicated they would require paper based materials.

Information requirements included:

- Information and resources related to healthy cooking and eating for ME communities: healthy ethnic recipes; alternative cooking methods; ways to adapt local vegetables to own cooking styles; advice geared to ethnic diets and how to get across health messages
- Information on resources available including: interactive, interesting materials geared to their service user group (e.g. for young people in the same way that exists for

alcohol awareness); how to establish projects e.g. food coop; how to put together food workshops (rather than the time consuming starting from scratch).

- Information and insight into what is being looked for in working with ME communities and what should and shouldn't be done
- Contacts regarding organisations working in their field and to showcase examples
- Database of trainers, interpreters and people who can provide inputs who can work with ME communities
- Information on sources of funding and fundraising

14. Knowledge of CHFS

24 organisations interviewed were not aware of the work of CFHS, 39 were, and 7 had a limited knowledge. The vast majority of those unaware were ME organisations, most of which are not primarily working on food related issues. While the survey itself has raised the profile of CFHS, this does suggest that CFHS should look at what measures it could take on an ongoing basis to ensure ME communities are able to benefit from its work.

15. Literature Review Findings

As part of this mapping exercise, a brief literature review was undertaken, primarily in relation to the Scottish context, but also using wider UK sources as the Scottish literature is limited and much of the English work is applicable.

The Review of the Scottish Diet Action Plan Progress and Impacts 1996-2005 identifies that ethnicity and culture are variables in affecting health status that require consideration in addition to socio-economic factors in addressing health inequalities.[40] The Scottish Health Survey does not analyse health statistics by ethnicity, although it does recognise that ethnicity is a complicating factor in measuring for obesity in children and young people.[41] The Food Standards Agency Scotland and the Scottish Executive recommended in 2004 increasing of sample sizes from ethnic minority groups in monitoring of progress towards meeting Scottish Dietary Targets.[42]

The English Health Survey 2004[43] focussed on the health of minority ethnic groups with an emphasis on cardiovascular disease (CVD) and behavioural risk factors associated with CVD such as drinking, smoking and eating habits and health status risk factors such as diabetes, blood pressure, and cholesterol. This data can therefore provide insights to the situation in Scotland. Its findings include:

- Prevalence of cardiovascular disease increased significantly between 1999 to 2004 in Pakistani men (from 4.8 % to 9.1 %) and Indian women (from 2.3 % to 4.2 %). Additionally the British Heart Foundation estimates that South Asians have a 50% higher premature death rate from Coronary Heart Disease, rising to over 2.5 times higher for Pakistani women.[44]

- After adjusting for age, doctor-diagnosed diabetes was almost four times as prevalent in Bangladeshi men and almost three times as prevalent in Pakistani and Indian men as in men in the general population.

[40] Lang T, Dowler E, Hunter D The Review of the Scottish Diet Action Plan Progress and Impacts 1996-2005 Health Scotland 2006 http://www.healthscotland.com/uploads/documents/3158-SDAP_Review_Report_Full.pdf

[41] Bromley C, Bradshaw P, Given L The Scottish Health Survey 2008 vol 1: Main report Scottish Government p.196 http://www.scotland.gov.uk/Publications/2009/09/28102003/0

[42] Food Standards Agency Scotland & Scottish Executive Response of the Food Standards Agency Scotland and the Scottish Executive Health Department tot eh report of the Working Group on Monitoring Scottish Dietary Targets FSA 20[42]04

[43] Sproston K, Mindell J eds Health Survey for England 2004: Health of Ethnic Minorities - Full Report The Information Centre 2006

[44] British Heart Foundation Scotland *Scotland Coronary Heart Disease Statistics Fact Sheet 2008/9*

- Doctor-diagnosed diabetes was more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women compared with women in the general population. This was also true in 1999, when diabetes was more than five times as prevalent in Pakistani and Bangladeshi men and women, and more than four times as likely in Black Caribbean women (compared with men and women in the general population).

- Black African boys were more likely to be obese than boys in the general population (31 % and 16 % respectively). Otherwise the prevalence of obesity was similar among all groups. The prevalence of obesity among Black Caribbean and Bangladeshi boys increased between 1999 and 2004 from 16 per cent to 28 per cent, and 12 per cent to 22 per cent respectively.

- Indian and Chinese people ate more fruit and vegetables than other groups. In general minority ethnic men were more likely to eat "5 a day" than the overall population. Women generally tended to eat more fruit and vegetables than men.

- Fat intake among minority ethnic men was lower than for men in the general population, with Indian, Chinese and Black African having the lowest levels. Women generally had lower fat scores than men, and ethnic minority women, except Pakistanis, had lower scores than women in general, with Indian and Black Caribbean women having the lowest scores.

- Addition of salt in cooking was higher for all ethnic minority groups, with Bangladeshi men and Indian women having the highest levels by gender, however these groups were less likely overall to add salt to food without tasting.

In addition a Department of Health study on obesity identified that 15% men and 20% women in 'non-white' ethnic groups were obese in 2003.[45] The Foresight modelling programme for obesity indicates that obesity among Bangladeshi and Black African women are likely to rise along with the majority population. [46]

[45] Zaninotto P, Wardle H, Stamatakis E, Mindell J, Head J Forecasting obesity to 2010 Department of Health 2006 p.3

[46] Foresight Tackling Obesities: Future Choices - Project Report Government Office for Science 2007 http://www.foresight.gov.uk/Obesity/Obesity_final_part1.pdf p.37

The Food Standards Agency's UK study of Low Income Diet and Nutrition,[47] whilst warning of the limitations of sample size, particularly for areas outwith England, does provide some information on Minority Ethnic group diet and nutrition. Many of the differences in eating reflected traditional diets e.g. white men ate more potatoes and cooked vegetables, Asian men more rice and salads. Asian women ate more white fish (not coated or fried) than other groups, and Black women drank more fruit juice. Overall in Scotland adults consumed the least fruit and vegetables of all parts of UK. Black women in UK consumed more fruit but less vegetables than other groups, and Asian women consumed slightly more fruit and vegetables than other groups.[48] The DEFRA Family *Food in 2007* survey in England found that Chinese households purchased significantly more fruit and vegetables than other groups.[49] White men had a significantly higher energy intake than Asian men, while white women had a slightly higher intake than Asian women. There were no body weight or energy expenditure differences to explain this.[50] Asian men had higher levels of protein intake overall and as part of their food energy contribution than white men. Asian men and women had lower levels of non milk extrinsic sugars (NMES), and higher levels of intrinsic and milk sugars and starch. The DEFRA survey found that Black households had higher than average levels of NMES, while other 'non white' households had lower than average levels, with Chinese households particularly low.[51] While all groups fell below the recommended levels of non-starch polysaccharides, this was particularly low for Black women.[52] White people had higher intakes of saturated fats than Asians.[53] The DEFRA survey also found that Black and Asian households had a lower energy intake from saturated fat than white people.[54] Most people consumed the reference nutrient intake (RNI) of vitamins, however Black and Asian women tended to have lower levels of vitamin A, riboflavin and folate, with Asian women more likely to have riboflavin intakes below RNI and LNRI (lower reference nutrient intake). Black and Asian men were more likely than others to have vitamin A intakes below RNI and riboflavin below LRNI.[55] Black and Asian women were far more likely to have lower calcium intakes than RNI, while Black and Asian men also had lower intakes.[56]

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[47] Nelson M, Erens R, Bates B, Church S, Boshier T , Low Income Diet and Nutrition Survey: Volume 2 Food Standards Agency 2007 http://www.food.gov.uk/multimedia/pdfs/lidnsvol02

[48] Ibid ch 4

[49] Department for Environment, Food and Rural Affairs (DEFRA) *Family Food A report on the 2007 Expenditure and Food Survey* National Statistics 2008 p. 35
https://statistics.defra.gov.uk/esg/publications/efs/2007/chapter4.pdf

[50] Nelson T et al 2007 ch 5

[51] DEFRA p.30

[52] Nelson T et al 2007 ch.6

[53] Ibid ch.7

[54] DEFRA p.30

[55] Nelson T et al 2007 ch.8

[56] Ibid ch.9

A comprehensive work on contributory factors to dietary change among minority ethnic communities in UK was published in 1999[57] and was followed by the 2000 English Health and Lifestyle survey[58] which found that about half the respondents in each ethnic group (African-Caribbean Indian Pakistani, Bangladeshi) felt their traditional diet was healthier than that of the White community. The Indian, Pakistani and Bangladeshi groups said traditional foods were the major component in the food they ate at home. Religion and culture affected diet (80% Indians not eating beef and 25% being vegetarian for religious reasons; 97% of Pakistanis and Bangladeshis not eating pork & eating halal; and African-Caribbeans 22%, mostly not eating pork). Religious/Cultural health beliefs may impact in other ways on food consumption e.g. in relation to the importance and implications of hospitality, weaning and for South Asians the concepts of hot/cold foods stemming from Ayurvedic/Unani health belief systems[59] (also identified in the Edinburgh maternity group in this mapping exercise).

The understanding of health food terms such as starchy food, dietary fibre, and saturated fat varied between ethnic groups, with African-Caribbeans indicating a higher understanding (around 75% for the first 2 terms) and South Asians much lower – however knowledge of foods high in these was patchy across all minority ethnic groups, as was the knowledge of links between diet and e.g. cardiovascular disease, particularly among Bangladeshis.

HEA research on the Chinese population in 1999 found that 83% ate Chinese food most of the time, 60% agreed that a Chinese diet was healthier than a western one, but 47% agreed that it was hard to know what a healthy diet is while 37% disagreed.[60]

Recent research among the Somali community in London identified that the typical diet of participants largely consisted of rice, pasta and red meat, with low consumption of fruit and vegetables, uncertainty about what constituted a healthy diet and a stated desire for education around this. Cultural factors such as the traditional Somali diet, social associations

[57] Bush & Williams *Opportunities for and barriers to change in dietary behaviour in minority ethnic groups* Health Education Authority 1999

[58] Johnson Mark RD, Owen D, Blackburn C, Rehman H, Nazroo J. *Black and Minority Ethnic Groups in England: The second health & lifestyles survey*. Health Education Authority; 2000. Ch 8 Diet & Nutrition http://www.nice.org.uk/niceMedia/documents/healifes_blackx.pdf

[59] Bush & Williams *Opportunities for and barriers to change in dietary behaviour in minority ethnic groups* Health Education Authority 1999 p.23

[60] Sproston K, Pitson L, Whitfield H, Walker E Health and lifestyles of the Chinese population in England HEA 1999 ch. 8 http://www.nice.org.uk/niceMedia/documents/healthlstyles_chinesepopfull.pdf

of food and lack of appropriate information were identified as issues that need to be addressed. [61]

The HEA 1998 research identified that eating patterns outside the home changed over time, with subsequent generations being more likely to eat a western diet.[62] Other research has also identified that second generation offspring of former migrants appear to adopt British dietary patterns, increasing fat and reducing vegetable, fruit and pulse consumption compared with first generation migrants (as was identified by some respondents to this mapping exercise). They conclude that majority ethnic and younger migrant groups could raise and sustain high fruit and vegetable intakes but lower proportions of fat, by adopting many dietary practices from older migrants.[63] This is supported by a literature review across Europe that indicated that dietary habits of some ethnic groups are likely to become less healthy as individuals increase consumption of processed foods that are energy dense and contain high levels of fat, sugar, and salt. Such products often replace healthy dietary components of the native diet, such as fruits, vegetables, nuts, and grains. Mixed food habits are emerging mainly amongst younger people in the second and third generations, most likely due to acculturation and adoption of a Western lifestyle. Age and immigrant generation are the major factors accounting for changes in dietary habits, whilst income, level of education, dietary laws, religion, and food beliefs are also important factors.[64] A recent qualitative study of 100 20 - 45 year olds in Glasgow found that those from the non-white ethnic groups generally maintained a large part of their cultural diet, although they were slowly moving towards a mixed diet, incorporating western foods. Respondents were aware of the components of a healthy diet, and also about specific oral and general health campaigns. There was some limited evidence that the second generation is finding itself being culturally torn between the ideas and attitudes of their elders and the current ideas of their peers. There was evidence that hectic lifestyles and long working hours led to irregular eating habits. The findings show the importance that should be placed on the influence of

[61] McEwen A, Straus L, Croker H. Dietary beliefs and behaviour of a UK Somali population. Hum Nutr Diet. 2009 Apr;22(2):116-21.
[62] White M, Carlin L, Rankin J & Adamson A Effectiveness of interventions to promote healthy eating in people from minority ethnic groups: A review HEA 1998 p.8 http://www.nice.org.uk/niceMedia/documents/effective_eating_minorities.pdf
[63] Landman J, Cruickshank JK.A review of ethnicity, health and nutrition-related diseases in relation to migration in the United Kingdom. Public Health Nutrition. 2001 Apr;4(2B):647-57.
[64] Gilbert PA, Khokhar S. *Changing dietary habits of ethnic groups in Europe and implications for health*. Nutrition Review 2008 Apr;66(4):203-15.

lifestyle, which are not crudely related to class and deprivation, but rather to type of employment and the forms by which occupational work and time frames influence diet.[65]

Research published by the Department of Health in 2008 into families' attitudes and behaviour in relation to diet and activity included qualitative research with 6 minority ethnic communities.[66] Food related findings included the observance of religious dietary requirements, and found that: in some Muslim families children received 2 evening meals – before and after attending evening Mosque classes; that all the groups had a focus on preserving cultural foods as part of their heritage and that Pakistani, Bangladeshi and Black African families were particularly concerned to ensure their children ate these foods, which may not always be healthy due to high fat levels[67]. In Pakistani, and Bangladeshi families in particular mothers and mothers-in-law were cited as barriers to making family meals more healthy and also for feeding unhealthy snacks to children; parents, especially older Pakistani, Bangladeshi and Black Africans, were unlikely to be aware of the issues of childhood obesity or see this as relevant to them, misjudging their child's weight and feeling they were doing enough; some older Pakistani, Bangladeshi, Black Africans and Caribbeans were more concerned with children being underweight than overweight, with communities equating chubby with healthy. All ME groups were willing to engage in direct discussion about obesity without the barrier of stigma.[68] Food was very central for Pakistani, Bangladeshi and Black Africans, both in relation to attitudes to hospitality and as a central aspect of with women's role with home cooked meals being a priority. Large portions and often multiple evening meals also featured in these communities, as did snacking on western convenience foods; this was less widespread in the other communities. For these other communities diets were more mixed and quantities smaller.[69] Guidance for effective change include: ensure interventions are culturally appropriate; interventions to help make traditional foods healthier; engaging community leaders to give licence and sanction to change behaviour; engaging the extended family; using children to bring the message home; 1:1 community based interventions.[70]

A report prepared by the University of Sheffield in 2004 on Gypsies & Travellers in England identified that providing food was seen as part of nurturing role of mothers. Big children equated with healthy children and quantity was seen as more important than quality,

[65] Mullen, K; Chauhan, R; Gardee, R; Macpherson, L *Exploring issues related to oral health and attitudes to diet among second-generation ethnic groups* Diversity in Health and Social Care, Volume 3, Number 2, June 2006 , pp. 131-139(9)
[66] Department of Health Healthy Weight Healthy Lives: Consumer Insight Summary HM Government 2008
[67] ibid p.15
[68] Ibid pps 16-18
[69] Ibid pps 26-30
[70] Ibid p.57

although adults were more conscious of body image and did not wish to be overweight for that reason. There was limited knowledge and understanding of nutrition. There was suspicion of "unnatural" foods e.g. containing additives, by the older generation but younger Gypsies & Travellers were happy to consume fast foods.[71]

An information pack on Gypsies & Travellers produced by Hampshire County Council indicated that food beliefs included strict rules about hygiene and pollution and an emphasis on cleanliness in the home. To have a lavatory in the same place where food is prepared is considered distasteful and unhealthy. It is also considered polluting to wash yourself or your clothes in the same bowl that is used for washing food utensils and tea towels. This preoccupation with cleanliness has very beneficial effects for the community; the incidence of stomach and other infections in young children is extremely despite the lack of often basic sanitation such as toilets and showers on unauthorised sites.[72]

Due to the high prevalence of diabetes and heart disease among minority ethnic groups[73] a considerable amount of research has taken place into these disease states among minority groups. Type 2 diabetes may start younger leading to increased long term adverse health effects such as eye, kidney, nerve, heart and circulatory complications.[74]

There are suggestions that the standard Body Mass Index measurements should be revised for Asians as comparative studies indicate that metabolic responses to obesity may be greater in South and East Asians than their western counterparts. Metabolic syndrome not only increases the risk of coronary artery disease but also cerebrovascular disease in Asians.[75] [76]

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[71] Parry G et al p.49
http://www.shef.ac.uk/content/1/c6/02/55/71/GT%20final%20report%20for%20web.pdf

[72] Hampshire County Council Gypsy & Traveller Information Pack p.10 www3.hants.gov.uk/ gypsy _traveller_information_pack_2_.doc

[73] NHS Health Scotland / National Resource Centre for Ethnic Minority Health *Diabetes in Minority Ethnic Groups in Scotland* **2**004 p.9 http://www.healthscotland.com/uploads/documents/6234-Diabetes%20-%20full%20report.pdf

[74] Hawthorne K, Robles Y, Cannings-John R, Edwards AGK' *Culturally appropriate health education for type 2 diabetes mellitus in ethnic minority groups* Cochrane Database of Systematic Reviews, Issue 4, 2009 http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD006424/sect0.html

[75] Pan WH, Yeh WT, Weng LC. Epidemiology of metabolic syndrome in Asia. Asia Pacific Journal of Clinical Nutrition. 2008;17 Suppl 1:37-42.

[76] Lovegrove JA.CVD risk in South Asians: the importance of defining adiposity and influence of dietary polyunsaturated fat. The Proceedings of the Nutrition Society. 2007 May;66(2):286-98.

Knowledge about diabetes is poor among minority ethnic communities, particularly where English literacy is limited or non- existent.[77] [78] Research has shown that there may be misconceptions about healthy eating in some communities. South Asian (predominantly Pakistani) respondents in a recent study believed that traditional food could be 'dangerous' and detrimental to their diabetes control but described such foods as 'strength-giving'. For cultural/social reasons they continued to consume it, though reducing portions to the extent of putting themselves at risk. Male respondents often reported limited input into food preparation. The research proposed that perceptions that South Asian foodstuffs necessarily comprise 'risky' options need to be tackled amongst patients and possibly their healthcare providers and guidance should be given to those responsible for preparing the food about lower fat recipes for commonly consumed dishes, thus enabling them to manage their diabetes, while eating food they wanted.[79]

Studies involving Pakistani Muslims and Hindu and Sikh Indians in relation to CHD found that stress, including stress directly related to ethnic minority status, was seen as a causal factor, and identified barriers to improving lifestyle with respect to diet and exercise which included lack of information e.g. of how to cook traditional Indian food more healthily,[80] as found frequently during this mapping exercise. In a comparative study South Asians patients found it particularly difficult to make dietary changes. The study concluded that misconceptions about the cause of CHD and a lack of understanding about appropriate lifestyle changes were evident across ethnic groups in this study. The provision of information and advice relating to cardiac rehabilitation must be better tailored to the context of the specific needs, beliefs, and circumstances of patients with CHD, regardless of their ethnicity.[81]

Research in the Bangladeshi community found a lack of knowledge about causes and management of diabetes beyond a concept of the association of sugar and diabetes which

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[77] NHS Health Scotland / National Resource Centre for Ethnic Minority Health *Diabetes in Minority Ethnic Groups in Scotland* **2**004 p.9 http://www.healthscotland.com/uploads/documents/6234-Diabetes%20-%20full%20report.pdf

[78] Hawthorne et al 2009

[78] Lawton J , Ahmad N, Hanna L, Douglas M, Bains H, Hallowell N. *'We should change ourselves, but we can't':* accounts of food and eating practices amongst British Pakistanis and Indians with type 2 diabetes Ethnicity & Health, Volume 13, Issue 4 September 2008 , pps.305 - 319

[80] Farooqi A, Nagra D, Edgar T, Khunti K. Attitudes to lifestyle risk factors for coronary heart disease amongst South Asians in Leicester: a focus group study.Family Practice. 2000 Aug;17(4):293-7.

[81] Darr A, Astin F, Atkin K. Causal attributions, lifestyle change, and coronary heart disease: illness beliefs of patients of South Asian and European origin living in the United Kingdom. Heart & Lung: the journal of critical care. 2008 Mar-Apr;37(2):91-104.

led to an increase in eating bitter foods. The research concluded that there was need for improved information for Bangladeshi people which might need to come from health professionals, and in addition health professionals need to be more aware of dietary practices, such as eating bitter gourd (which may enhance the effects of rosiglitazone), and the influence these practices could have on the individual's diabetes management.[82] Similarly in relation to heart disease Asian communities were least likely to benefit from standard public health campaigns.[83] Research undertaken in Glasgow into the effectiveness of culturally-competent educational inputs with elderly minority ethnic groups in relation to Type 2 diabetes has shown that this is both feasible and can improve their knowledge, attitudes and practice.[84]

In 1998 the Health Education Authority had published a review of effectiveness of interventions to promote healthy eating in people from minority ethnic groups which found only 2 evidence based studies (both on infant & toddler food supplements) in UK and recommended further research and multidisciplinary and multi agency approaches tailored to the health needs of each ethnic sub group in relation to nutritional interventions e.g. South Asian men and cardiovascular disease; Afro-Caribbean women with hypertension/diabetes at risk of stroke; Chinese women and osteoporosis.[85]

A systematic review of published health promotion and prevention interventions related to cardiovascular disease and cancer in Pakistani, Chinese and Indian communities was commissioned by Health Scotland in 2008.[86] This again found that there was a paucity of evidence based assessments of health promotion interventions in this field, but identified that targeted health promotion initiatives can lead to change in health knowledge, behaviour

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[82] Choudhury SM, Brophy S, Williams R Understanding and beliefs of diabetes in the UK Bangladeshi population Diabetic Medicine. 2009 Jun;26(6) pps 636-40.

[83] Lip GY, Luscombe C, McCarry M, Malik I, Beevers G. Ethnic differences in public health awareness, health perceptions and physical exercise: implications for heart disease prevention. Ethnicity & Health. 1996 Mar;1(1) pps 47-53.

[84] Baradaran HR, Knill-Jones RP, Wallia S, Rodgers A. A controlled trial of the effectiveness of a diabetes education programme *in a multi-ethnic community in Glasgow [ISRCTN28317455*] BMC Public Health. 2006 May 18;6:134.

[85] White M, Carlin L, Rankin J & Adamson A Effectiveness of interventions to promote healthy eating in people from minority ethnic groups: A review HEA 1998 p.5
http://www.nice.org.uk/niceMedia/documents/effective_eating_minorities.pdf

[86] Netto G, Bhopal R,Khatoon J, Lederle N & Jackson A Health promotion and prevention interventions in Pakistani, Chinese and Indian communities related to CVD and Cancer a review of the published evidence in the UK, other parts of Europe and the United States. Health Scotland 2008
HealthPromotionAndPreventionInterventions20080801.pdf

and status, and that involvement of the communities in the design and implementation of strategies was beneficial. However there is not clear evidence of which of the wide range of measures taken is most effective, and a range of further research was recommended to ensure a firm theoretical foundation to work. The review indicated that given the resource implications of such targeted work, mainstream initiatives should also take steps to include minority communities in their work, and should wherever possible include ethnic monitoring of their work. Health promotion strategies at all levels should address structural factors such as poverty, racial discrimination and alienation in their work, and should take account of intra-ethnic, as well as inter-ethnic, differences and commonalities.[87] The Review found very little work on the Chinese community in the UK, and on cancer (only 1 study of cancer related work was identified, with the Chinese community, in USA). It identified only 7 evaluated diet related projects – which used a variety of methods, all with some success and learning points.

Similarly the National Institute for Health and Clinical Excellence (NICE) in looking at the cost-effectiveness of behaviour change strategies to reduce the risk of CHD found significant gaps in the evidence. There was little evidence on the cost-effectiveness of using behaviour change interventions with specified sub-groups e.g. particular ethnic groups and the quality of evidence was also a cause for concern. For example, there was a lack of reliable data from which to extrapolate the long-term health outcomes.[88] NICE guidance on behaviour change indicates that effective interventions target specific groups and are tailored to meet their needs and that service user views and working closely with communities over time, by tackling prejudice and discrimination in professional practice, and by using needs assessments to gather local and cultural information to ensure interventions are tailored appropriately when planning interventions. [89]

In relation to obesity NICE advises interventions should be tailored for particular groups e.g. ethnic minorities [90] who may have different beliefs about what is a healthy weight and different attitudes towards weight management.[91]

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[87] Ibid pps 4 -30

[88] National Institute for Health and Clinical Excellence Behaviour change at population, community and individual levels NICE public health guidance 6 2007 p.53
http://guidance.nice.org.uk/PH6/Guidance/doc/English

[89] Ibid p. 14

[90] National Institute for Health and Clinical Excellence, *Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children* Nice clinical guideline 43 2006 pps.6.17, http://guidance.nice.org.uk/CG43/NiceGuidance/pdf/English

[91] Ibid p.39

Research recently carried out in Wales of published material also looked at dietary intervention models in working with minority ethnic communities across UK, and found only two evaluated, and one ongoing, projects in Scotland.[92] Evaluation of:

- Four cooking projects, one based in Dundee, with primarily ME women reported positive results in relation to change in cooking practices, although these were resource intensive. Evaluation methodology was considered weak.

- Three Peer Education projects appeared successful, being inherently culturally appropriate with 2 reporting information spreading through the community. Evaluation methodology was considered weak to moderate.

- 5 other small group intervention projects. Of these, 1 which involved paying for women to attend a standard slimming class proved relatively unsuccessful. 3 reported positive results but evaluation methodology was considered weak. The final project, Edinburgh's Kush Dil which combined community development and health professional approaches, appeared successful and had a more robust evaluation methodology.

- Interventions with tailored professional support – two projects using health professionals appeared to provide positive outcomes but in one, using a bilingual worker for weaning work, numbers were small and cost effectiveness was not evaluated. In the other involving a number of inputs at temples and gurdwaras, the evaluation methodology was seen as weak

- 3 other interventions – a media campaign focussing on salt reduction in mixed BME communities reported positive outcomes although evaluation methodology was considered weak; a project aimed at promoting positive eating messages and a healthier menu at takeaway outlets was considered to have a very weak research design; and a two year school based intervention, reported limited changes and was assessed as having an evaluation methodology of weak-moderate.

- Two projects are still running – PODOSA: Prevention of Diabetes and Obesity in South Asians, is a family based nutrition project with dieticians visiting participants at home over 3 years and is being trialled in Edinburgh and Glasgow; and a Liverpool

[92] Stockley L *Review of Dietary Intervention Models for Black and Minority Ethnic Groups Pt 2 A review of* evaluated dietary interventions from the UK targeting BME Groups 2009

based project designed to ascertain why minority communities are not accessing the family based obesity services.[93]

This research also highlights the importance of taking account of, and including other family members such as the grandmothers in work around breastfeeding and weaning for South Asian families, and the effectiveness of small group work over written materials in this context.

The research found a weak evidence base in evaluation of most projects and recommended more rigorous evaluation and more appropriate methodologies in future, which should include cost effectiveness, sustainability and ability to generalise from the findings in the evaluation of intervention models in addition to effectiveness in changing behaviour, health status and attitudes.[94] Factors that appeared to increase success in working with BME communities included:

- The need to tailor interventions to different ethnic groups, address cultural acceptability, value different forms of behaviour and use appropriate languages
- Understand the lifestyles of ethnic groups in order to ensure reaching target sub populations e.g. men and women may require different approaches
- Understand the relationships between individuals, household and family in designing interventions
- Use a variety of activities to reinforce changes in knowledge, behaviour and attitudes
- Involve a trusted community worker in community based projects.
- Community and peer education approaches appear to be useful
- Interventions which combine health professionals and community based activities appeared promising[95]

In 2001 the Scottish Executive commissioned a review of research on ethnic minorities and health, which identified a need for further research.[96] A working group to look into the needs

[93] Ibid pps 13-20
[94] Ibid p.5
[95] Ibid p.4
[96] Netto G. Arshad R. de Lima P, Almeida Diniz F, Patel V and Syed R, *Audit of research on minority ethnic groups from a 'race' perspective.* Edinburgh: Scottish Executive 2001

was established in 2007 to undertake a consultation exercise, and reported in late 2009.[97] It found that there was surprisingly little information about the health of ME communities in Scotland, largely due to lack of consistent ethnic monitoring. It recommended: the use of consistent ethnic coding linked to the 2011 Census categories, to be used on death certificates and patient records; a health survey of ethnic minorities to include eating behaviour, obesity and levels of physical activity as well as other risk factors, to be compared with the majority population; evaluation of large scale interventions to improve ME health; qualitative research to provide insights into perceptions, attitudes, behaviour and experience of health services.

16. Discussion

This was a Scotland wide mapping exercise targeting voluntary & community organisations, and relevant mainstream organisations. We strongly believe that the sample of 79 organisations out of 123 identified potential participants is a true representation of organisations/groups involved in food and health initiatives for ME communities in Scotland. Nevertheless, with a limited time of 4 months we may not have been able to reach all groups particularly those who are not included into main directories, databases and linked into ME networks. Time constraints and the requirement of the mapping exercise meant that we focused voluntary sector groups/bodies involved in food and health initiatives for ME communities. A few exceptions where statutory organisations work was closely intertwined with voluntary sect have been including.

In addition to the challenge of limited time to accomplish the mapping exercise, following up with individuals from key organisations and their difficulty in finding time for telephone interviews was another a major challenge. The researcher manage to overcome this challenge by outlining the benefits to the participant's individual organisaitons and their service users, and by adjusting researcher's time to best suit with the time of individual participants.

The findings of this research is paramount to Community Food and Health Scotland (CFHS), policy makers, health care service providers, voluntary and community organisations and indeed to those who wish to endeavor to improve the health and wellbeing ME communities in Scotland. Certainly, we do not suggest these findings are exhaustive, as further research will be required to understand numerous other issues but these findings provide a foundation for further investigation within the area of food and health for ME communities in Scotland.

[97] NHS Health Scotland Health in our Multi-Ethnic Scotland Future Research Priorities The Scottish Ethnicity and Health Research Strategy Working Group 2009

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[1]The Scottish Executive *Fair for All Guidance* HDL (2002) 51
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http://www.scottishtravellered.net/travellers.html

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Useful websites

Community Food and Health Scotland http://www.communityfoodandhealth.org.uk/

REACH Community Health project http://www.reachhealth.org.uk

Scottish Government food and health
http://www.scotland.gov.uk/Topics/Health/health/19133

Scottish Public Health Observatory
http://www.scotpho.org.uk/home/resources/scottishpoliciesandstrategies/scottishpolicies.asp#foodhealthyeating

Other resources

Community in Action *Ramadan health guide - a guide to healthy fasting*

This guide has been written for the public and health professionals. It provides information and advice on maximising health gains during the Muslim fast. It is supported by the NHS and UK government.

http://www.fhascot.org.uk/Resource/ramadan-health-guide-a-guide-to-healthy-fasting

Appendix 1 Full question Schedule

Interview no Date

Section 1 - Introduction

Good morning/afternoon

My name is Fariha Thomas. I am calling from REACH Community Health Project. We have been commissioned by Community Food and Health Scotland to undertake a mapping exercise of voluntary sector organisations and projects working with people from Minority Ethnic backgrounds on food issues such as cooking, selling or growing food, food hygiene and nutrition information.

Could I please speak to the most appropriate person in your organisation who deals with this?

Are you familiar with REACH? Would you like me to tell you some information about REACH?

REACH Community Health Project is a national third sector organisation with a key strategic role in improving the health & wellbeing of Black and Minority Ethnic Communities, particularly those living in Scotland. The project is committed to facilitate change within mainstream health and wellbeing services to meet the specific needs of BME Communities.

REACH has three units engaged in Preventative Culturally Sensitive Service Provision, Policy and Research and Training and Development. These areas of expertise act to mutually reinforce one another, and this Triangulated Formula places REACH in a unique position to tackle health inequalities and service barriers faced by BME communities. Website www.reachhealth.org.uk

Background information

This mapping exercise results from Community Food and Health Scotland‘s awareness that minority communities have specific health needs and frequently higher levels of ill health, such as heart disease and diabetes which diet can impact positively on, but ME communities are often not engaged in community food and health projects, nor are ME organisations accessing the grants available in this field. This mapping exercise will be of great help to policy makers and health providers in providing information regarding what initiatives presently exists that promote healthy eating amongst these groups, and what works for them, in order that services can be supported and designed as well as possible in the future.

Are you familiar with Community Food and Health Scotland? Would you like me to tell you some information about Community Food and Health Scotland?

Community Food and Health (Scotland)'s over-riding aim is to improve Scotland's food and health.

This is done by supporting work within low-income communities that improves access to and take-up of a healthy diet. Major obstacles being addressed by community-based initiatives are:

AVAILABILITY - increasing access to fruit and vegetables of an acceptable quality and cost

AFFORDABILITY - tackling not only the cost of shopping but getting to shops

SKILLS - improving confidence and skills in cooking and shopping

CULTURE - overcoming ingrained habits.

Community Food and Health (Scotland) help support low income communities to identify barriers to a healthy balanced diet, develop local responses to addressing them and highlight where actions at other levels, or in other sectors, are required.

Community Food and Health (Scotland) value the experience, understanding, skills and knowledge within Scotland's communities and their unique contribution to developing and delivering policy and practice at all levels.

Section 2 – organisational contact details (complete in advance where possible)

1. Name of organisation_____

2. Type of organisation
(e.g. are you a registered Charity….)
Charity unincorporated association

Co Ltd by guarantee/CIC etc Other

3. Name of Project (if different)_____

4. Name of contact person_____

5. Role of contact person (+in relation to any health work):_____

6. Address:_____
_____
_____Postcode_____

Phone _____ Mobile ___ _____

email_____Website_____

7. Does your project provide any food and health services for people from minority ethnic backgrounds? **YES/ NO**

A Cooking/food preparation cooking classes, recipe books

B Selling food food co-op, community café, lunch club

C Growing food community gardens, allotments, demonstrations and classes

D Learning about food workshops, taster sessions, training for food trainers. Food safety and hygiene

If yes to 7 or 8, I would be grateful if you could arrange to spare me 20 -30 minutes to answer a few questions. and go to q 10

Unmet need

8. **A. If No**, would it be relevant for your organisation to provide such services if funding or other support were available? YES/NO

B. If so what types of support?
networking opportunities training, information other

Snowballing

9. **If No,** are there any projects you think I should be aware of?

_____

Title of initiative:
Type of activity:
Communities involved (such as ME):
Name of organisation:
Address of organisation:
Name of key individuals providing project:
Position of individual within organisation:
Telephone number: Mobile:
Email:

If Yes to 7 or 8, I would be grateful if you could arrange to spare me 20 -30 minutes to answer a few questions.

Section 3 Awareness of CHFS

10. A. Are you aware of Community Food and Health Scotland 's work? YES/NO

    B. If not would you like them to send you some information? YES/NO

Date of interview if different_____

(If a different date, repeat preamble)

Section 4 Permissions

A report will be prepared from this research and a copy of the report will be sent to you once it has been finalised. Are you happy for your organisation to be named in the report YES/NO and for contact details to be included in the report YES/NO and kept on the databases of Community Food and Health Scotland YES/ NO and REACH YES/NO.

Section 5 Project information

11. Could you briefly explain what your organisation / project aims to do

    _____

    _____

12. Does your food work have a separate name(s)?

13. What geographical area do you cover?

14. Does your project provide / OR would it like to provide any of the following food and health services? (P= provide L = like to provide)

    A Cooking/food preparation cooking classes, recipe books

    B Selling food food co-op, community café, lunch club

    C Growing food community gardens, allotments, demonstrations and classes

    D Learning about food safety and hygiene workshops, taster sessions, training for food trainers. Food

    E Other _____

15. Why was this work chosen(evidence base and aims) _____

16. For the activities that you provide, can you indicate where each activity takes place

17. How frequently does it take place_____
And at what times? Weekday daytime evenings weekends

	P	L	day	eve	weekend
Cooking/food preparation					
Selling food					
Growing food					
Learning about food					
other					

18. How are people made aware of the activities
posters in public areas leaflets in GP surgeries leaflets at community venues advert in newspaper/ radio word of mouth website referred by other service

19. How do people access these services?

Self referral by turning up *self referral by appointment* *agency referral*

20. When was this activity set up/ How long has it been in place

_____

Section 6 Service users

21. For the activities that you provide, can you indicate which services are used by a) women b) men c) both

22. For the activities that you provide, can you indicate which services are used by a) pre-school, b) primary aged children c) secondary aged children d) 18 – 25 e) 25-40 f) 40-55 g) 55-65 h) over 65

	m	f	both	0-5	5-11	12-17	18-25	25-40	40-55	55-65	65 +
Cooking/food preparation											

Selling food											
Growing food											
Learning about food											
other											

23. Are any of the activities aimed at people with particular employment status (such as unemployed)? *f yes, please state which*

_____

24. Is the initiative aimed at people with a particular educational background (e.g. no formal educational qualifications)? *If yes, please state which*

_____

25. For the activities that you provide, can you indicate which ethnic and faith groups, and approximate numbers from each ethnic group for each food activity you undertake (ask to self ascribe) White British Irish Pakistani Indian Bangladeshi Chinese Arab African (which country) African/Caribbean East European (which country) Gypsy/Traveller Mixed Other (which)

	WB	Irish	Pk	In	Bng	Chn	Ar	Af	AC	EE	mx	G/T	oth
Cooking/food preparation													
Selling food													
Growing food													
Learning about food													
other													

If relevant

	Muslim	Sikh	Hindu	Christian	Buddhist	Jewish	none	other
Cooking/food preparation								
Selling food								
Growing								

food								
Learning about food								
other								

Section 7 funding

26. Who funds you to do this work?

27. A. What is the duration of this funding (start……finish…….)
    B. Would you be willing to tell me the size of your funding for each piece of health related work?

    _____

28. Do you receive any other kind of support?

29. Do people pay for using this service? Yes/No If so how much? _____

Section 8 Monitoring and evaluation

30. Can you tell me about your successes in delivering these services and how you have monitored and evaluated this

    _____
    _____
    _____

31. External evaluation & if so by whom, what type, how frequent, any available reports?

    _____

32. Would you say it was: very successful successful moderately successful not very successful unsuccessful don't know

33. Can you tell me about any challenges you have faced

    _____
    _____

Section 9 Unmet need

34. If you do not currently provide a particular service but would like to, what evidence of need do you have (include who it would be aimed at , approx numbers etc?)

_____

_____

35. What factors prevent you providing this?

Funding lack of expertise in how to establish no suitable venue lack of personnel with relevant expertise other_____

Section 10 Factors affecting healthy eating

36. What do you think are the most significant factors that influence diet among your service users?

Poverty /Cost Accessibility of healthy food Culture/religion

Knowledge about healthy eating Family demands/ preferences

Knowledge and confidence to buy and prepare food .Other

37. What do you think could change eating behaviour among the groups you work with?

Accessibility of healthy food Knowledge about healthy eating

Trying new things Religious teaching on health

Affordability of healthy options Improved confidence in shopping and cooking

Other

Snowballing

38. Could you give me contacts for any other health projects I should speak to

---

Title of initiative:
Type of activity:
Communities involved (such as ME):
Name of organisation:
Address of organisation:
Name of key individuals providing project:
Position of individual within organisation:
Telephone number: Mobile:
Email:

39. Thank you for your time. Before I finish can I ask if there is any support you would find useful in taking forward work on this issue

networking opportunities training, information other

Appendix 2

Useful Resources

Many respondents identified a need for a range of information to assist with developing their work. This section identifies some resources that may be of use.

Health Guides

While many general leaflets will be useful in working with all communities, a number of respondents identified the need for either translated materials or materials geared to the specific needs of certain communities. This section includes a number of such resources.

The Chest, Heart & Stroke Association Scotland

Fact sheets in Chinese, Bengali, and Urdu with English translation on

High Blood Pressure

Preventing Heart Disease & Stroke

Risk Factors for Heart Disease and Stroke A4 poster South Asian A4/A3 poster General population

65 North Castle Street

EH2 3LT

Tel: 0131 220 6313

http://www.chss.org.uk/publications/documents/CHSS_Publication_List_And_Order_Form.pdf

Diabetes UK Focus on Diabetes 2007

A guide to working with black and minority ethnic communities in Scotland living with long-term conditions

'Focus on Diabetes: A guide to working with black and minority ethnic communities in Scotland living with long-term conditions' offers Scotland's healthcare professionals information and practical approaches to working with minority ethnic communities who are affected by conditions such as arthritis, epilepsy, asthma and diabetes.

Jointly produced by Diabetes UK Scotland and the National Resource Centre for Ethnic Minority Health

The aim of the pack is to:

- provide an integrated toolkit covering long-term conditions
- provide useful information for frontline staff working with minority ethnic communities
- help develop sensitivity and cultural competence
- Give guidance on useful resources and where to get further information.

http://www.diabetes.org.uk/In_Your_Area/Scotland/Diabetes_in_Scotland/Focus-on-Diabetes/

You can order a copy by contacting Diabetes UK Scotland on 0141 245 6380 or by emailing scotland@diabetes.org.uk.

Communities in Action 2007 Ramadhan health guide

This guide has been written for the public and health professionals. It provides information and advice on maximising health gains during the Muslim fast. It is supported by the NHS and UK government.

http://www.fhascot.org.uk/Resource/ramadan-health-guide-a-guide-to-healthy-fasting

South Asian Health Foundation

Organise a range of events and have useful website with downloadable leaflets etc

E-mail: info@sahf.org.uk
Phone & Fax: 020 8846 7284

http://www.sahf.org.uk/

Heart failure tips for patients - 2007

Punjabi http://www.sahf.org.uk/uploads/docs/files/9.pdf

Urdu http://www.sahf.org.uk/uploads/docs/files/10.pdf

English http://www.sahf.org.uk/publications.aspx?id=4

Heart Disease in South Asians NHS 2004

The toolkit contains a selection of best practice case studies illustrating where service providers are working together to provide innovative and successful CHD services to South Asian communities.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4102918.pdf

British Heart Foundation 2009

G453 Healthy hearts kit - a new interactive BHF training resource designed to help people understand their own hearts and how they can look after them, includes vital information for particularly high risk groups like South Asian and black and minority ethnic communities.

To order the Healthy Hearts Kit, please call the BHF Orderline on 0870 600 6566

http://www.bhf.org.uk/publications/view_publication.aspx?ps=1000870

Health Scotland – Table 14

http://www.healthscotland.com/resources/publications/search-result.aspx?type=Health+publication&topic=2	
Publication name:	**Fun first foods: An easy guide to introducing solid foods**
Date:	**4 March 2009**
Summary:	This booklet gives information on the different stages of weaning with tips, advice and recipes.
Language(s):	Bengali, Chinese, English, French, Polish, Russian, Turkish, Urdu
Publication name:	Eating for health
Date:	15 February 2009
Summary:	Leaflet providing simple healthy eating advice, tips on food preparation and hygiene, a consumer checklist, and practical ideas for making changes to your diet with simple recipe suggestions.
Language(s):	Arabic, Bengali, Chinese, English, Gaelic, Gujarati, Punjabi, Urdu

Publication name:	**Give teeth a chance**
Date:	**6 October 2008**
Summary:	This leaflet explains clearly the basics of good dental and oral health and how to help children establish good habits.
Language(s):	English, Polish

Table 15 NHS Lothian

Dietary information leaflets and resources for Ethnic Minority Communities Living in Scotland (various languages)

Information Leaflet	Cost	Produced By	Address/ available from	**Contact Numbers**
***South Asian Balance of Good Health Available in Urdu, Hindi, Punjabi and English *Leaflet of Choice	£4.24 for 20	SNDRI (Scottish Nutrition and Diet Resource Initiative)	John McCormick and Co Ltd (Order on line from SNDRI web site)	**Tel:** 0141 429 9405 www.sndri.gcal.ac.uk
A Healthy Affordable Diet for the South Asian community	Available on request: small cost	The Healthy Alliance	The Healthy Alliance Equinox South, Great Park Road, Almondsbury, Bristol BS2 4QL	
Healthy Eating in Diabetes: Eastern and Western food ideas (English or Urdu)	Small cost	The Multicultural Health Programme NHS Greater Glasgow	120 William Street Clinic Glasgow G3 8HS	**Sunita Wallia** **Tel: 0141 314 6234**
How Common is Coronary Heart Disease Available in Hindi, Punjabi, Urdu, Chinese and English	Free	MEHIP NHS Lothian	MEHIP or Lothian NHS Board Library and Resource Centre Deaconess House	**0131 537 7538 / 537 4585** **0131 536 9451**

Information Leaflet	Cost	Produced By	Address/ available from	**Contact Numbers**
			148 Pleasance Edinburgh	
Preventing Heart Disease a guide for South Asian Families Available in Hindi, Bengali, Urdu and English	Free/small cost	NKS, 7 Gillespie Street. Edinburgh	NKS, 7 Gillespie Street. Edinburgh EH3 9NH	**0131 221 1915**
Paan Chewing: Mouth Cancer: Prevent it! Paan and tobacco chewing	Free	NHS Health Scotland	Health Scotland Canaan Lane Edinburgh EH10 4SG	**0131 536 5500**
Review of Diabetes Material and Resources for Minority Ethnic Communities Living in Scotland		NRCEMH and Scottish Diabetes Group	NHS Health Scotland Clifton House, Clifton Place, Glasgow G3 7LS	**0141 300 1010**
Information for All A directory of resources available Minority Ethnic Community Languages (2005)	Free	NHS Health Scotland	Health Scotland Canaan Lane Edinburgh EH10 4SG	**0131 536 5500**

Information Leaflet	Cost	Produced By	Address/ available from	**Contact Numbers**
Interpretation and Translation Services Central Library			**George IV Bridge, Edinburgh EH1 1EG**	**Tel: 0131 242 8181** **Fax: 0131 242 8009** **E Mail: interp.trans.services@edinburgh.gov.uk** 9 am – 5 pm Monday-Friday

NHS Greater Glasgow and Clyde Public Health Resource Unit

The results of research on Black and Ethnic Minority Health Information resources conducted in 2007 can be downloaded as below

Diabetes: http://library.nhsggc.org.uk/mediaAssets/PHRU/2007%20Directory%20-%20Diabetes.pdf

Heart disease: http://library.nhsggc.org.uk/mediaAssets/PHRU/2007%20Directory%20-%20Heart%20Health.pdf

Healthy lifestyle: http://library.nhsggc.org.uk/mediaAssets/PHRU/2007%20Directory%20-%20Lifestyle.pdf

Nutrition: http://library.nhsggc.org.uk/mediaAssets/PHRU/2007%20Directory%20-%20Nutrition.pdf

Cooking

A number of areas used the cooking packages to promote healthy eating including with ME communities. These are sometimes delivered by the Voluntary Sector and sometimes by Statutory organisations – for further information contact local Community Health Partnerships.

Get Cooking Get Shopping

A short practical course which aims to put cooking back on everyone's agenda and look at shopping for healthier options and what foods contain higher levels of sugar and salt.

The course contents cover:
- Basic nutrition and looking at a balanced diet
- Food safety
- Cooking methods
- Recipes
- Using herbs, spices and reducing salt

Recipes

Many respondents asked for information on how to cook traditional foods in a healthier manner. The following are a few on-line resources that aim to do this

British Heart Foundation

Healthy Meals Healthy Heart — Asian Recipe Book. 2008.

Available free as a PDF [Part 1, Part 2]

or by ordering online http://www.bhf.org.uk/publications/view_publication.aspx?ps=1000606

The Ismaili Nutrition Centre

http://www.theismaili.org/nutrition

The Nutrition Centre is a resource for anyone who enjoys traditional foods of African, Central and South Asian, and Middle Eastern origin. It features a library of recipes annotated with nutritional information and healthy eating tips, as well as *Eating for health*, a regular column written by our resident dietician, Azmina Govindji.

The site draws on the findings of the *South Asian Food Survey* as the primary source for its nutritional data. The survey is a research project that investigated the nutrient content of foods commonly consumed by various South Asian groups living in the United Kingdom. Since its publication in 2000, this data has been available to health professionals but has not been widely accessible to the general public. The Nutrition Centre bridges this gap.

The Nutrition Centre allows traditional recipes to be evaluated against dietary guidelines. Being aware of the healthy and less healthy aspects of your own diet is the first step towards making better choices. In selecting from among the recipes available on the site, choose those that are tasty and healthy — new ones are being added regularly.

Authentic Chinese Cooking Recipes

A Collection of Favorite Chinese Recipes

Download from: http://www.healthychineserecipes.com/

"This collection of my favorite *Chinese recipes* are legacy from my maternal grandmother, who was an expert in Chinese cooking. Over the years, I have modified and added some of my own recipes and cooking tips. This is a complete set of recipes that are simple and quick to prepare, yet healthy, in keeping with today's desire for healthy eating. You'll find that these Chinese cooking recipes are good for health because the recipes do not require deep-frying and avoid the use of monosodium glutamate (MSG)."

Growing

The Federation of City Farms and Community Gardens produces a number of publications for the benefit of its members, as well other community groups, people interested in the work of the movement and potential visitors or volunteers

The Green House, Hereford St, Bristol BS3 4NA

Tel: 0117 923 1800
Fax: 0117 923 1900 Email: admin@farmgarden.org.uk

Scotland Office, PO Box 17306, Edinburgh EH12 1AJ

Tel/Fax: 0131 623 7058 email: scotland@farmgarden.org.uk

http://www.farmgarden.org.uk

Scotland Community Garden Starter Pack **Price: Free to download; £6 for hard copies**

.Hard copies are free to FCFCG members in Scotland - visit our Scotland page for more details

City Farm Starter Pack **Price: £6**

This pack highlights many of the issues covered in the Community Garden Starter Pack as well as additional information specific to keeping farm livestock. Revised 2005.

Chillies & Roses **Price: £10**

Working alongside minority ethnic communities is an important element of the community gardens and city farms movement. This publication showcases examples of good practice and identifies innovative ideas that will help all of our members meet the needs of, and engage with, multi-ethnic communities. This lively and very readable publication is packed with useful information, colourful photographs and plenty of case studies, as well as details of other resources.

Please note: A single copy of this publication is free to FCFCG member groups. If members require additional copies, these can be purchased at cost price.

Fundraising

Funding is a major issue for the voluntary sector as a whole, particularly at this time of recession.

Community Food and Health Scotland's website includes a useful section on fundraising

http://www.communityfoodandhealth.org.uk/projects/raisingfunds.php

and lists a wide range of potential funding sources for food work

http://cfhs2.the-graphics.net/funding/links.php

Voluntary Health Scotland, the UK national network of voluntary health organisations has a web page which provides information on a selection of sources of funds and grants for the voluntary and community sector.

http://www.vhscotland.org.uk/info/funding.php

CHEX supports community development approaches to health improvement and challenging health inequalities. It also facilitates a network of community health initiatives and works to support them in developing good practice and influencing health and social policies. It provides a range of useful toolkits and resources for marketing, organisational development and partnership working.

http://www.chex.org.uk/healthy-living-centres/toolkits-resources/

Contact with other organisations

Community Food and Health Scotland's Directory of organisations working in this filed can be searched for those working with minority ethnic organisations, however during the course of this research it was found that several of these did not in fact work with minority ethnic groups http://www.communityfoodandhealth.org.uk/plugins/directorysearch/index.php

Tackling Health Inequalities in Scotland: working with communities - a partnership of Scottish Intermediary Bodies Community Food and Health (Scotland) December 2009 http://www.communityfoodandhealth.org.uk/fileuploads/tackling-health-inequalities-in-scotland-working-with-communities-9934.pdf

is also a useful resource

Evaluation

A number of projects indicated that they would like to improve their evaluation of the effectiveness of their food interventions.

P.McGlone, J, Dallison, M Caraher *Evaluation resources for community food projects* NHS 2005 is the report of a mapping exercise which may provide pointers to s some useful tools

http://www.nice.org.uk/niceMedia/documents/comm_food_projects_eval_resources.pdf

Some projects indicated they used the LEAP framework to for planning and evaluation

The LEAP framework is a toolkit designed to support a partnership approach to achieving change and improvement in the quality of community life.

It describes both an approach to changes and a 5 step planning and evaluation cycle the can be used to implement this approach.

The LEAP approach is based on 4 simple but important principles:

- We should plan and act according to **need**
- We should be clear about what we hope to achieve and to whether we've achieved it – planning and evaluation should be **outcome focused**
- We should plan, act and evaluate in partnership and involve communities as key stakeholders
- We should be committed to learning from what we do, and from each other and applying this learning to improve our effectiveness and efficiency

The LEAP planning and evaluation cycle is based on 7 simple but important questions:

1. What is the need we are trying to address?
2. What specifically needs to change?
3. How will we know if change has taken place?
4. What will we actually do?
5. How will we make sure we're doing it as planned?
6. How successful have we been and what have we learned?
7. What now needs to change?

It can be downloaded from http://www.iriss.org.uk/opencontent/leap/

And further information can be obtained via

Scottish Community Development Centre
Suite 305
Baltic Chambers
50 Wellington Street
Glasgow
G2 6HJ 0141 248 1924
Fax: 0141 248 4938
Email: info@scdc.org.uk http://leap.scdc.org.uk/

Further Reading

Netto G, Bhopal R, Khatoon J, Lederle N & Jackson A *Health promotion and prevention interventions in Pakistani, Chinese and Indian communities related to CVD and Cancer a review of the published evidence in the UK, other parts of Europe and the United States*. Health Scotland 2008 HealthPromotionAndPreventionInterventions20080801.pdf

Stockley L *Review of Dietary Intervention Models for Black and Minority Ethnic Groups Pt 1 : An analysis of the BME situation in Wales & pt 2 A review of evaluated dietary interventions from the UK targeting BME Groups* prepared for the Food Standards Agency Wales Lynn Stockley & Associates 2009

Appendix 3

Contact details for organisations working on food issues with ME communities that participated in the research and gave permission for inclusion/ have public contact details

organisation name	contact
Community Food Initiative NE Fiona Rae	4 Poynernook Road Aberdeen AB11 5RW 01224 596156 cfine@btconnect.com www.cfine.org
Multi Ethnic Aberdeen Ltd Godfrey Joseph Volunteer Coordinator	15/17 Belmont Street Aberdeen AB10 1JR 01224 645268 Godfrey@multiethnic.co.uk
Powis Gateway Community Centre T A Cowie Chairperson	11 Powis Circle Aberdeen B24 3YX 01224 484056
Powis Gardeners Suzy Hunter Acting Senior Com. Learning Worker & **Sunnybank Park Steering Group**	Sunnybank Community Centre Education, Culture and Sport Sunnybank Primary School Sunnybank Road Aberdeen AB24 3NJ 01224 261 727 sunnycom@aberdeencity.gov.uk
Fas Fallain Healthy Living Centre / multicultural group Mary MacLean Health Promotion Officer	Health Promotion Department, NHS Western Isles Granite Building, 36/1 Cromwell Street Stornoway, Isle of Lewis HS1 2DD 01851 702712 marymaclean1@nhs.net
Amina Muslim Women's Resource Centre (MWRC) Sara El-Farargy Development Officer	Brown Street Dundee O1382224687 O7733221669 sara@mwrc.org.uk /info@mwrc.org.uk www.mwrc.org.uk

Dundee International Women's Centre Pervin Ahmad Manager	Unit 9, Manhattan Business Park Dundonald Street Dundee DD3 7PY 01382 462058 mail@diwc.co.uk **www.diwc.co.uk**
Dundee Healthy Living initiative (NHS) Beverley Black Manager	R21 Mitchell Street Centre Dundee DD2 2LJ 01382 435848 beverley.black@nhs.net www.dundeehealth.co.uk
Fife Arabic Society Sura Sulaiman	7 William Street Kirkcaldy Fife KY1 ITW - 07994277302 admin@fifearabicsociety.org.uk
Fife Chinese Older People Association Helen Hoang	1 Wellbank Gardens Glenrothes Fife KY7 4TR 01592 772480 fifecopa@hotmail.com
Frae Fife Daksha Patel Health Advocacy Development Worker	(temp) 21 Tolbooth Street Kirkcaldy Fife KY1 1RW 1 Victoria Road, Kirkcaldy Fife KY1 1DT 01592 204005 daksha.patel@fife.gov.uk
Hillfoots Family Centre Ann-Marie McInnes Administrator	Park Street Tillicoultry FK13 6AG 01259 751206 amcinnes@calks.gov.uk
Wider Access to School Project Pat Beattie	Denny High School Herbertshire Park Mydub Road Denny FK6 6EE 01324 822895 admin@dennywasp.org.uk
Stirling Multicultural Partnership Maya Varyani Development Worker	Stirling Council varyanim@stirling.gov.uk
Children First, West Lothian Young People's Healthy Living (Chill Out Zone) Wendy Fowler Youth Worker	Chill Out Zone 7 Gardeners Lane Bathgate EH48 1TP 01506 652 436 wendy.fowler@children1st.org.uk www.children1st.org.uk
Black Community Development Project/ Community Organisations for Race Equality (CORE) Khalida Hussein Operations Manager	G 4-5 Inchgarvie Court, Ferry Road Drive, Edinburgh EH4 4DA 0131 467 7990 khalida@bcdp.org.uk www.bcdp.org.uk

Broomhouse Health Strategy Group Lucy Aitchison Project Coordinator	1 Broomhouse Market Edinburgh EH11 3UU 0131 467 7678 info@healthstrategygroup.org.uk www.healthstrategygroup.org.uk
Dr. Bell's Family Centre Lesley Craise Project Manager	Junction Place Leith Edinburgh EH6 5JA 0131-553-0100 lesley@drbellsleith.org.uk www.drbellsleith.org.uk
Edinburgh Community Food Initiative Ian Stewart Chief Executive	22 Tennant Street Edinburgh EH6 5ND 0131 467 7326 istewart@ecfi.org.uk http://www.ecfi.org.uk/about_ecfi.htm
MECOPP Carers Centre Suzanne Mundy Manager	172 Leith Walk Edinburgh EH6 5EA 0131 467 2994 suzanne@mecopp.org.uk www.mecopp.org.uk
MEN-IN-MIND (Mental Health & Wellbeing for Men	40 Shandwick Place Edinburgh EH2 4RT 0131 225 8508 chris@health-in-mind.org.uk www. health-in-mind.org.uk
MILAN Senior Welfare Organisation Neena Aggarwal Manager	Norton Park 57 Albion Road Edinburgh EH7 5QY 0131 475 2307 neena@milanswc.org / admin@milanswc.org http://www.milanswc.org/
Multi-Cultural Family Base Steve Gowenlock	50 Coburg St Edinburgh EH6 6HE 0131 467 7052 steve.gowenlock@mcfb.org.uk www.mcfb.org.uk
Pakistan Society Mr Malik/ Mr Bukhari 50 plus group organisers	145 Buccleuch Street Edinburgh EH8 9NE 0131 662 9446 pakistansociety@btconnect.com http://www.pakistansociety.co.uk/
Pilton Community Health Project/Barri Grubb Sami Stewart Development Worker	73 Boswall Parkway Edinburgh EH5 2PW 0131 551 1671 barrigrubb@pchp.org.uk

Anita Aggarwal Sr Development Worker	www.pchp.org.uk
Score Scotland (Strengthening Communities for Race Equality in Scotland) Annette West Clerical & complementary therapist	The Whale Learning Centre 30 Westburn Grove Edinburgh EH14 2SA 0131 442 2341 info@scorescotland.org.uk www.scorescotland.org.uk
Shakti Women's Aid Mridul Wadhwa Info & Education Officer	Norton Park 57 Albion Rd Edinburgh EH7 5QY 0141 475 2399 mridul@shaktiedinburgh.co.uk www.shaktiedinburgh.co.uk
(Sikh) San Jog Centre Angela Austin Youth worker	22 Laurie Street Edinburgh EH6 7AB 0131 553 4737 info@sikhsanjog.com www.sikhsanjog.com
The Welcoming Jon Busby Project Organiser	The ALP Association Ltd - The Welcoming Project C/o Tollcross Community Centre 117 Fountainbridge Edinburgh EH3 9QG 0131 221 9756 thewelcoming2006@hotmail.co.uk http://www.thewelcoming.edin.org/
Wester Hailes Health Agency Linda Arthur Manager Fiona Bell Community Dietician (NHS)	40 Dumbryden Drive Edinburgh EH14 2QR 0131 458 3080 linda @whhealthagency.co.uk fiona@whhealthagency.co.uk www.whhealthagency.co.uk
Action for Children San Jai Chinese Family Project Louise Chan Project Manager	53 Rose Street Glasgow G3 6SF 0141 332 3978 louise.chan@actionforchildren.org.uk www.actionforchildren.org.uk
African & Caribbean Network Ltd Graham Campbell Network Development Coordinator	2nd Up Right 34 Albion Street Glasgow G1 1LH 0709 288 3657 gcampbell@acnglasgow.org www.acnglasgow.org
Amina Muslim Women's Resource Centre (MWRC) Samina Ansari Development Officer Asma Abdalla Capacity Building Officer	311 Calder Street Glasgow G42 7NQ 0141 585 8026 samina@mwrc.org.uk / info@mwrc.org.uk /asma@mwrc.org.uk www.mwrc.org.uk
Bridging the Gap Tricia McConalogue	c/o Duns Scotus 270 Ballater Street Glasgow G5 OYT

	0141 418 0241 tricia@bridging-the-gap.org www.bridging-the-gap.org
Cranhill Community Project Marie Manager	109 Bellrock Street Cranhill Glasgow G33 3HE 0141 774 3344 marie@cranhillcp.co.uk www.cranhillcp.co.uk
Crossroads Youth & Community Association Anna Griffiths Community Worker	19a Belleisle Street Glasgow G42 8HL 0141 423 5955 info@cyca.org.uk
Darnley St Family Centre Nabila Khan Centre Manager	175 Darnley Street Glasgow G41 2SY 0141 424 3920 darnleystreet@hotmail.com
Dixon Community Rahat Syyed Project Manager	656 Cathcart Rd Glasgow G42 8AA 0141 423 8815 dixon.carers@btconnect.com
Food for Thought Ltd Claire Bannerman Food & Health tutor Graham Campbell (Chair) Chair	1103 Argyle St Glasgow G4 9YA 0141 248 8513 developmentchef2@btconnect.com www.foodforthoughtglasgow.org
GAMH Glasgow Jacqueline Croft Operations Manager	St. Andrew's by the Green 33 Turnbull Street Glasgow G1 5PR 0141 552 5592 j.croft@gamh.org.uk www.gamh.org.uk
GAMH Glasgow SW Leslie McHugh Senior Project Worker SW Glasgow	Pavilion 3a 11 Dava Street Glasgow G51 2JA 0141 425 4850 hspsouth@gamh.org.uk
Gorbals Healthy Living Network Loraine Devine Community Health Development Officer	17 Norfolk Court Glasgow G5 9AT 0141 429 0360 loraine.devine@ghln.co.uk www.ghln.co.uk
Govan Youth Information Project Stewart Clark Project Coordinator	9 Water Row Govan Glasgow G51 3UW 0141 445 4505 mail@gyip.org.uk www.gyip.org.uk
Govanhill Housing Association, Govanhill Social Inclusion Project (GOSIP)	Samaritan House 79 Coplaw Street

Amra Nazim	Glasgow G42 7JG 0141 636 3628 ANazim@govanhillha.org www.govanhillha.org
Greater Pollok Integration Network Londi Beketch Volunteer Development worker	Flat 1 70 Kennishead Avenue Glasgow G46 8RP 0141 649 2000 Londib@gpintegrationnetwork.co.uk
Greater Pollok/Govan Integration Network Elizabeth Oliver Fiona Ferguson/ Laura Divers	SW CHCP 135 Fiftyswitches Rd Cardonald Business Park Glasgow G52 4EB 0141 276 4630 laura.divers@sw.glasgow.gov.uk
Health Spot (a Glasgow South East Regeneration Agency Project) Davey Blackie Development worker	6 Ardencraig Street Castlemilk Glasgow G45 0ER 0141 560 3034/3035 davey@healthspot.org.uk www.healthspot.org.uk
Hidden Gardens Clem Sandison Programme Manager	25 Albert Drive Glasgow G41 2PF 0141 433 2722 clem@thehiddengardens.org.uk www. thehiddengardens.org.uk
Home-Start Glasgow South Margaret Gillies	207 Shawbridge St Pollokshaws Glasgow G43 1QN 0141 585 6712 theteam@homestartglasgowsouth.org.uk www.homestartglasgowsouth.org.uk
Kingsway Court Health and Wellbeing Centre Jassim Johe Asylum/Refugee Development & Support worker	Block 50 Kingsway Court Scotstoun Glasgow G14 9SR 0141 959 9168 jassimjohe@kingswayhealth.co.uk
Mel Milaap Centre Kuldeep Sharda Manager Asghar Ali Day Care Officer	134 Berkeley Street Glasgow G3 7HY 0141 222 2287 Kuldeep.sharda@sw.glasgow.gov.uk
Multicultural Elderly Care Centre Shahida Zafar Community Care Manager	Network House 311 Calder Street Glasgow G42 7NQ 0141-585 8014 shahida@taleemtrust.org islam@taleemtrust.org
Muslim Day Centre (partnership Jamiat Ittihad ul Muslimin & GCC Social Work) Angela McHendry Social Work external Manager	Glasgow Central Mosque 1 Mosque Avenue Glasgow G5 9TA 0141 429 3280/ 0141 276 5154 Angela angela.mchendry@sw.glasgow.gov.uk

	www.centralmosque.co.uk
North Glasgow Community Food Initiative Fiona Sinclair Development worker	71 Lenzie Terrace Glasgow G21 3TN 0141 558 2500 volunteer@ngcfi.org.uk www.ngcfi.org.uk
Pearce Institute Norie Mackie Manager	840 -860 Govan Road Govan Glasgow G51 3UU 0141 445 6007 norie@pearceinstitute.org.uk www.pearceinstitute.org.uk
Pollokshields Development Agency Liz Goold Co-ordinator	East Pollokshields Multicultural Centre 15 Kenmure St Glasgow G41 2NT 0141 429 4249 liz@pdaglasgow.org.uk www.pda.org.uk
REACH Community Health Project Monika Fotedar Training & Development Officer	Network House 311 Calder Street Glasgow G42 7NQ 0141 585 8105 monika@reachhealth.org.uk http://www.reachhealth.org.uk
Rosemount Lifelong Learning Fariba Namdarzanganeh Information support/guidance worker	221 Millburn Street Royston Glasgow G21 2HL 0141 552 3090 Fariba.Namdarzanganeh@rosemount.ac.uk www.rosemount.ac.uk
RNIB Gozie Joe Adigwe Ethnic Minority Project Development Officer	Head Office 12-14 Hillside Crescent Edinburgh EH7 5EA 0131 652 3140 gozie.joeadigwe@rnib.org.uk www.rnib.org.uk
Royston Youth Action Harry Young	325 Royston Road Glasgow G21 2BS 0141 572 0984 harry@roystonyouthaction.co.uk www.roystonyouthaction.co.uk
SEAL Community Health Project Brenda Sowney Manager	192 McNeil Street Gorbals Glasgow G5 0NZ 0141 429 2568 seal01@btconnect.com
Shanti Bhavan Day Centre Kavita Aggarwal Manager	41 Doncaster Street Glasgow G20 7DQ 0141 276 8491 kavita.aggarwal@sw.glasgow.gov.uk
Urban Roots	Toryglen Community Base

Abi Mordin Project Manager	18-34 Prospecthill Square Glasgow G42 OLE 0141 613 2763 abi@urbanroots.org.uk www.urbanroots.org.uk
YWCA Glasgow	3 Newton Terrace Glasgow G3 7PJ 0141 248 5338 admin@ywcaglasgow.org www.ywcaglasgow.org
Wah Lok Jung Sam Day Care Centre	Burnbank House 25 Burnbank Gardens Glasgow G20 6HD 0141 276 3907
Renfrewshire Community Health Initiative Carolann Watson Community health development worker	1 Lyon Road Foxbar Paisley PA2 0NA 01505 815943 carolann_rchi@yahoo.co.uk, www.rchi.org.uk
Knowetop Community Farm Janine Ward	113 Castlehill Road Dumbarton G82 5AT 01389 732734 janine@knowetopcommunityfarm.co.uk www.knowetopcommunityfarm.co.uk
Girvan and District Food Co-op Alexandra Dunn Secretary	18/19 Boyle Court Sheltered Housing Complex Girvan KA26 9ED 01465 713158 sandra.dunn@s_ayrshire.gov.uk

Organisations which confirmed they were working on food issues with ME groups but were not available to undertake an interview or return the questionnaire, with publicly accessible information

Edinburgh Chinese Elderly Support Association	25 Home Steet, Edinburgh, EH3 9JR 0131 228 5808 ecesa@fsmail.net
Fife African Caribbean Association	http://www.faca.org.uk
Fyne Families	Community Centre Manse Brae Lochgilphead PA31 8LZ 01546 606 885
Nari Kallyan Shangho	Darroch Annexe 7 Gillespie Street Edinburgh EH3 9NH 0131 221 1915 nks@ nkshealth.co.uk www.nkshealth.co.uk
Kingdom Development Project	200 Great Junction Street EDINBURGH EH6 5LW

	07932 978 560
Karibu Scotland	48 Albion Street 3rd Floor Glasgow G1 1LH 0141 237 7926 Karibu_glasgow@yahoo.co.uk
Maryhill Integration Network	35 Avenuepark Street Glasgow G20 8TS 0141 946 9106 admin@maryhillintegration.org.uk www.maryhillintegration.org.uk
Kids and Co **Michael McDermott**	Unit 15, 95 Boden Street Dalmarnock G40 3QF Glasgow 0141 551 8811 mick@kidsandco.org.uk www.kidsandco.org.uk
Universal Connections (Larkhall)	23/25 Union Street Larkhall ML9 1DR 01698 883725

Organisations which work with ME groups and have interest in developing food work

Africa Centre Scotland Agnes Ngulube Holmes Chairperson	45 Blackfriars St Edinburgh EH1 1NB 0131 557 6145 info@africacentrescotland.org.uk www.africacentrescotland.org.uk
Govanhill Youth Project Carol-Anne Vallery Equalities worker	172 Butterbiggins Road GlasgowG42 7AL 0141 423 8793 gypyouthwork@btconnect.com www.govanhillyouthproject.org.uk
WECAN! Food for Fife Project Ellen McCance	Rural Business Centre Elmwood College Carslogie Road Cupar, Fife KY15 4JB 01334 658704 ellen.mccance@wecan.org.uk www.wecan.org.uk

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