



OLDER MEN MOVING

A Green Candle Dance Company project
funded by Tower Hamlets Clinical Commissioning Group

FINAL REPORT

CONTENTS

	Page
The key outputs of the project	3
Background information of the participating groups	4
Summary of responses to health questionnaires	4-6
Initial testing – group results	7-8
Interim feedback from participants June 2013	8
Preliminary observations	8
Key outcomes of the project	9-11
Areas of innovation	12
Lessons learnt	13
Recommendations	14
Appendix 1 – Proposal - Armchair Based Exercises	15
Appendix 2 – Physical activity and health inequalities	15 - 17
Appendix 3 – The Four Fitness Tests	18 - 19
Abridged ‘Guardian’ article 3 rd July 2013	20 - 21

The key outputs of the project

4th February 2013 – completed 27 November 2013

Description of the project:

Older Men Moving is an intercultural dance initiative for able and disabled, disadvantaged older men.

The aims and objectives were:

1. To develop skills in movement, including: co-ordination; balance; motor skills; body and spatial awareness – contributing to a diminution of the risk of falls to participants
2. To improve fitness and health through greater flexibility in tendons and joints, better cardiac functioning, muscle strength, resistance to osteoporosis and lessening of joint and muscle pain
3. To improve emotional well-being and combat isolation through socialising and co-operating in a shared endeavour; finding new and personal means of self-expression
4. To improve mental capacity through demands on memory, decision-taking and problem-solving
5. To increase participants' knowledge and awareness of each other's cultures
6. To contribute to the psychological well-being of older participants through social interaction and through the growth in self-confidence and self-esteem which the practice of dance and movement in a supportive environment often brings

All participants completed a **Physical Activity Readiness Questionnaire** and a pre- and post-course lifestyle questionnaire.

Green Candle Dance Company ran weekly workshops with three groups of men with up to 15 men attending each workshop. Each of the three groups participated in 30 workshops over the course of the project.

All workshops took place in the borough of Tower Hamlets. The three locations were:

1. Mayfield House Somali Day Centre
2. Horwood Estate Bangladeshi Lunch Club
3. Sundial Day Centre Shipton Street

Background information of the participating groups

1. Somali Men-only group:

Location: Mayfield House Somali Day Centre
Cambridge Heath Road
Bethnal Green

For older adults who meet at the centre for activities (mainly sedentary) and lunch. No dance sessions have been held prior to this initiative.

2. Horwood Men-only group:

Location: Bangladeshi Community School
Horwood Estate
Pott Street
Bethnal Green

Primarily a lunch club for Bangladeshi men, they have previously worked with Green Candle Dance with workshops at this location but due to a lapse in funding there was a corresponding break in sessions of approximately one year. Although a majority played a sport such as volleyball when younger none currently participate in any form of physical activity.

3. Sundial Men-only group:

Location: Sundial Centre
Shipton Street
Bethnal Green

Green Candle have for many years run dance sessions for older adults (mixed) and a Bangladeshi ladies-only group at this location. A group solely for men has never been done at this centre. Sundial is a busy meeting place, which also includes a day centre for older people, with a large number of activities on offer.

Summary of responses to health questionnaires

Anthropometric measurements and participants' personal perception of their well-being.

PARQ Questionnaire:

The statistics below are responses to the PARQ questionnaires and are for all three groups combined:

Number of respondents = **21**

Average age = **74 years of age**

Has your doctor ever said that you have a bone or joint problem, such as arthritis, that has been aggravated by exercise or might be made worse with exercise?

YES=38%

Do you have diagnosed Osteoporosis? **YES=14%**

Do you have high blood pressure? **YES=57%**

Do you have low blood pressure? **YES=10%**

Do you have Diabetes Mellitus or any other metabolic disease? **YES=48%**

Has your doctor ever said that you have raised cholesterol (serum level above 6.2mmol/L)? **YES=43%**

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by your doctor? **YES=38%**

Have you ever felt pain in your chest when you do physical exercise? **YES=24%**

Have you been diagnosed with Emphysema? **0%**

Is your doctor currently prescribing you drugs or medication? **YES=76%**

Have you ever suffered from unusual shortness of breath at rest or with mild exertion? **YES=38%**

Is there any history of Coronary Heart Disease/COPD in your family? **YES=10%**

Do you often feel faint, have spells of severe dizziness or have lost consciousness? **YES=10%**

Do you currently drink more than the average amount of alcohol per week (21 units for men)? **0% declaration of any alcohol consumption**

Do you currently smoke? **YES=48%**

Do you currently exercise on a regular basis, at least 3 times a week? **YES=38%**

One respondent declared Asthma – PRN for medication.

One respondent declared Parkinson's.

N.B. BMI and weight levels were not included in this study. On purely visual assessment the Horwood (Bangladeshi) group appeared to be the heavier and the incidence of Type 2 Diabetes was greater by 35% in that specific group compared to the Somali group.

Incidence level: Mayfield House 42% Horwood 77%

Lifestyle Questionnaire:

The classes were advertised as dance/fitness classes, it was considered that to issue a questionnaire about 'self-confidence and self-esteem' at the first meeting would not elicit many clear responses as the target groups were more reticent to talk about 'self-' matters. Therefore a questionnaire was devised which covered the physical/psychological/social factors in a more covert style. The participants were more than happy to complete a questionnaire of this type as they viewed it as a health questionnaire much like many others.

A summary from all three groups is given below –

The statistics below are responses to the lifestyle questionnaires and are for all three groups combined:

I would rate my health as:

Very good = **13%**

Good = **27%**

Satisfactory = **20%**

Not good = **40%**

In the past year I have visited my Doctor:

0 times = **0%**

1-2 times = **20%**

3-4 times = **53%**

6 or more times = **27%**

I use a car or public transport to get around for short journeys:

YES = 93%

(most respondents were unsure of distances therefore actual local examples were given of two bus stops or less than one mile.)

Preferred exercise: **walking, exercises, dancing**

I prefer to exercise:

Alone = **33%**

With others = **67%**

I live:

Alone = **33%**

With family = **27%**

How would you describe your eating habits?

I will try new foods = **20%**

Happy with meat and vegetables/vegetarian = **47%**

Not really interested in food = **33%** *(almost exclusively respondents who live alone)*

Initial Testing – Group Results

Project Participant Numbers

Numbers of participants at the start of the project, on registers at 18.03.2013:

1. Mayfield House 11
2. Horwood 12
3. Sundial 5

Within three months the numbers had increased and stabilised for each location.

Number on registers at 18.06.2013:

1. Mayfield House Number on register 20 (average attendance 10)
Number increased by 9 - core group of 8
2. Horwood Number on register 16 (average attendance 10)
Number increased by 4 - core group of 7
3. Sundial Number on register 5 (average attendance 2)
Number remains static - core group of 2

Physical Testing

Physical testing was undertaken in April, July and November.

Combined *initial* testing group results are set out below:

'Step Test' (modified Harvard test) - April 2013

Results given as percentages/averages

Combined Groups results:

Average age - **74 years**

Combined age range - **50 – 93 years**

Average resting pulse rate - **72 bpm**

Average rate post exercise - **85 bpm**

Average rate post exercise + 1 minute - **79 bpm**

Average rate post exercise + 5 minutes - **74 bpm**

35% overall achieved a return to resting pulse rate within 5 minutes.

Both groups were adjourned for Ramadan from 10th July to 10th August, some members also travelled back to their country of origin prior to the festival to visit their families. Attendance returned to previous levels after the festival.

'Step Test' results – July 2013

A short round of testing was undertaken in July with all groups even though numbers were slightly less than usual.

1. Somali Group: 30% overall achieved a return to resting pulse within 5 minutes. It should be noted that the 'younger' members were the members who travelled home to visit relatives whereas our 'older' members remained in the borough and they were the participants who were tested; this certainly lowered the percentage of participants who achieved a return to resting pulse within 5 minutes.
2. Horwood Group: Statistically a younger group than Mayfield therefore the numbers were smaller for the July testing as a majority travelled before Ramadan. Test results show that 25% returned to resting pulse within 5 minutes.
3. Sundial: Continues to have a small attendance, Jewish festivals and Ramadan have both interrupted attendance.

Interim feedback from participants June 2013

Of the 18 people who filled in a Participant's Evaluation form, 100% said they were 'Very satisfied' with the sessions and 100% 'agreed' with the 4 statements: 'I am treated with respect by teachers', 'The support I get helps me to stay as independent as possible', 'The information I get from the sessions is clear, useful and easy to understand' and 'My views are listened to and acted on where possible'.

Comments included: 'Happy with the dance'; 'I enjoy standing up and dancing with the music'; 'I enjoy meeting people'; 'I enjoy the music and the exercises'; 'Keep on the exercises'; '[I would like] weights to lift'

Preliminary Observations

There is a considerable difference in age range between the two groups – the average age of the Bangladeshi men is 57, whereas the average for the Somali men is 80. Despite this differential, a higher proportion (21%) of the Somali men returned to a resting pulse rate within 5 minutes than of the Bangladeshi men (14%). This would seem to indicate that the Somali men have better basic cardiac fitness than the Bangladeshi men. It may be significant that a majority of the Somali men were sailors in earlier life and that this active life-style has contributed to their greater cardiac fitness. There may be other significant factors, such as diet, which we cannot comment on.

At the end of the 30 weeks, the tests undertaken at the start of the project (Step in Place test, Sit and Reach test, Chair to Standing test) were repeated to give comparative 'before and after' measurements.

The key outcomes of the project

Physical Wellness

Evidence from the tests outlined in Appendix 3 of the original service level agreement. Combined group results:

Improved lower body flexibility (measured through the chair-based sit and reach test)

93% improvement overall

Improved general fitness (measured through the two-minute step in place test)

79% improvement overall

Seated to standing test

71% improvement overall

Improved cardiovascular fitness (measured through the modified Harvard fitness test)

79% achieved a return to resting rate within the specified time

Sample: Horwood participant

Test >	Rest/ Recovery 1	R & R 2	R & R 3	Hip Flexion	Seated to Standing	Steps
Start date 13/3/13	110	100	96	8"	27	68
End date 27.11.13	92	104	90	6"	40	92

Sample: Mayfield participant

Test >	Rest/ Recovery 1	R & R 2	R & R 3	Hip Flexion	Seated to Standing	Steps
Start date 6/2/13	72	94	76	2"	19	49
End date 9/11/13	60	72	60	1"	33	100

Sample: Sundial participant

Test >	Rest/ Recovery 1	R & R 2	R & R 3	Hip Flexion	Seated to Standing	Steps
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Start date 14/2/13	80	90	80	2"	28	112
End date 28/11/13	80	100	80	2"	40	162

Participant Feedback

Personal health rating. **Final** feedback:

8% rated their health as 'excellent'

26% as 'very good'

53% as 'good'

11% as 'satisfactory'

0% as 'not good'

2% gave no answer

Personal health rating. **Initial** feedback:

0% rated their health as excellent

13% rated 'very good'

27% rated 'good'

20% rated 'satisfactory'

40% rated 'not good'

66% claimed to have informed their GP that they are attending the sessions.

81% stated that they have told their friends that they attend the sessions.

97% stated that they would recommend the sessions to other men.

90% stated that the sessions had made them think about exercising regularly.

90% stated that they would like to continue with the sessions.

Asked WHY they would like to continue the sessions the following results are shown in categories: physical, social, emotional/psychological.

Physical – 80% (out of responses to the category)

Social – 19.5%

Psychological/emotional -62.5%

Supporting Statements

Statement from Deborah Earls, Assistant Manager Mayfield House Somali Day Centre:

I see the biggest impact to having the support of Green Candle is the buzz of activity at the centre on a Wednesday. I can always tell it's a Wednesday as the users of our service are here on time... (ok... the majority are). We have service users who make the trip from North London to come only for the Green Candle sessions. There is an overall feeling of true participation, anticipation and encouragement. We have some service users who can be withdrawn, with underlying mental health issues. Some require a lot of support to engage with others, but when the music starts and the sessions begins, the hour is packed with social interaction and engagement with all of the men, who encourage, praise, dance and laugh together.

Mayfield is electric when we all join together for the dance at the end, it is unifying... regardless to culture, language and abilities we are all united through dance and shared laughter.

I asked a few service users as to how they felt and was told:

'At home I sit down for 5-6 hours in a chair all day, this doesn't help me. I like Green Candle because it gives me incentive to get up and move. It's not easy to do this when I am home alone. I feel alive when I dance'

'I used to exercise before, when I was younger, I don't anymore. There is not a lot of space in my flat and this is my only way. I never dance any other times, it's not the same when you are on your own'

'Exercise is good for my body, and I like to keep healthy. When I dance with Green Candle it is exercise but it isn't hard, they make it fun'

'I want to be able to keep active and do things for myself. Exercises keep my body healthy and means I can still do things for myself'

'This is why I come to Mayfield on a Wednesday. I am 89 years old and the exercises are suitable for my age. This is the only exercises I get apart from prayers'

Staff:

I have worked at Mayfield for over 10 years and this is the first time I have seen some of the individuals dancing

I have certainly noticed an improvement in individual's mobility, peer interaction and social engagement. I hope this gives some insight as to the benefits that Green Candle has brought to our service. When I spoke directly with individual service users to gauge their feedback the first question I was asked was 'Are they coming back/ When are they coming back?'

I hope this illustrates the success that Green Candle has been at Mayfield.



Horwood Men's Group

Areas of Innovation

- 1) The Somali group are older on average than the other two groups and appreciated an extra short session of exercise on Fridays led by a member of the Mayfield House staff, under advisement from Green Candle, before the weekend began.
- 2) The session leader introduced the subject of 'falls awareness' with associated exercises to improve core strength.
- 3) The session leader introduced a number of '**Armchair-Based Exercises**' which could be done during the advertisement breaks in TV programmes. Eventually became known as **Ad Break Exercises**.
- 4) Health promotion leaflets were distributed at every session on various topics in English and relevant languages.

Lessons Learnt

- 1) 'Rest and Recovery' rates data is a very crude measurement of cardiovascular fitness. Done as a group it is not a precise exercise as there were difficulties demonstrating the precision required to make the data meaningful.
- 2) Fitness Logs were designed and given to each participant in order that they may track their progress against age-related fitness targets. Logs were lost or forgotten and after enquiring the reason why they were not of much interest it was found that the participants would prefer to know how they were progressing on a personal level ('How am I doing') and not measured against any national targets.
- 3) Participants may not attend all sessions regularly, as an older age group they were subject to GP/Hospital appointments, visits from family and other reasons so absences must be accepted as par for the course.
- 4) The Mayfield House (Somali) group performed significantly better in the tests possibly due to having proportionately more hours of instruction over the project period.
- 5) Through talking to the participants about their home routine participants were much more receptive to trying armchair exercises – all groups had an aversion to being approached in a patronising manner.
- 6) The older participants are aware of the dangers of falls - even if they had not had a fall, they were keen to learn about *prevention*.
- 7) Health promotion leaflets were taken up with more enthusiasm than expected.
- 8) The sharing meal and dance session were an unprecedented success and requests have been made to repeat the event visiting another host venue.

Recommendations

- 1) That a partnership be set up between the participants and their respective GPs. Ideally it would be more effective, in data terms, to ask the participants to have their blood pressure taken and recorded on a regular basis. This would not necessarily mean an appointment with the GP but a Practice Nurse during normal Surgery hours.
- 2) That the sessions be increased from one per week to two, this would:
 - a) Enable all participants to attend at least one session in a week when other appointments may preclude them from attending just one therefore making a gap in attendance of possibly two weeks.
 - b) Significantly increase fitness levels as demonstrated by the Somali group who were able to have extra time given.
- 3) Personalised targets be introduced, as the Rikli and Jones table, whilst age-related, does not take into account the individual health conditions declared on individual PARQ returns.
- 4) Health promotion events/publications should be made available during the period of the sessions in order to promote the holistic nature of health matters. The emphasis being on 'total well-being' not physical fitness alone.
- 5) That the production of an Armchair-Based Exercise user-friendly publication be investigated. Many of the participants are very sedentary when in their home environment, regrettably the TV being their sole company in some instances. The average commercial television programme has at least three advertisement breaks per hour of three minutes duration therefore 'ad-break exercises' would yield some health benefits. *See A.B.E. proposal in Appendix 1 (below).*

Appendix 1

Proposal - Armchair-based Exercises

Following well-received chair-based exercises in all groups it is proposed that funding be made available to create a small compilation of exercises for those older people who prefer chair-based exercises in order to maintain and ultimately increase their mobility.

The book would comprise of coloured zones corresponding to each part of the body and simple exercises depicted in line drawing format. Eg: Using the colours of the rainbow for the 'zones' Blue: head and neck. Purple: shoulders upper torso. Pink: arms and hands etc..

There are over one hundred exercises available therefore production would not require research.

The size of the publication should be no more than A5 and comb bound for ease of balancing on a chair arm.

The exercises can be done during the advertisement breaks on TV – most advertisement breaks are of three minutes duration with approximately three per hour. If 10 hours of commercial TV was watched in a day this would equate to 90 minutes maximum of chair-based exercise.

Health 'hints' could also be incorporated onto the reverse of the exercise pages.

It is also proposed that the Armchair-based Exercise book (or Ad Break Exercises) be distributed freely through health centres or GPs to appropriate patients.

Appendix 2

Physical activity & health inequalities with particular reference to older people

In the UK there are significant inequalities in levels of physical activity in relation to age, gender, ethnicity and disability, and corresponding inequalities in health.

Compared with the general population in England, Indian, Pakistani, Bangladeshi and Chinese men and women are less likely to meet physical activity recommendations. Only 26% of Bangladeshi men and 11% of Bangladeshi women meet the recommended levels (11).

Prevention and risk reduction

Cardiovascular disease (CVD)

CVD is the largest cause of death in the UK. In 2010, 80,000 people died of Coronary Heart Disease (CHD) and 49,000 from strokes ([11](#)).

The cost of CVD to the UK economy was £19 billion in 2009 ([11](#)).

[For active people] “there is a 20% to 35% lower risk of cardiovascular disease, coronary heart disease and stroke” ([1](#)).

CVD is estimated to cost the UK economy just under £26 billion a year ([11](#)).

Cancer

Macmillan says “Lack of physical activity increases the risk of bowel cancer, womb cancer and post-menopausal breast cancer. There is an approximately 30% lower risk of colon cancer and approximately 20% lower risk of breast cancer for adults participating in daily physical activity ([1](#)).

Obesity and overweight

“It is likely that for many people, 45–60 minutes of moderate-intensity physical activity a day is necessary to prevent obesity”([9](#)).

Rates of obesity are estimated to rise, by 2035, to 47% and 36% for adult men and women respectively. By 2050, 60% males and 50% females could be obese ([20](#)).

By 2050, the NHS cost of overweight and obesity could rise to £9.7 billion, with the wider cost to society being £49.9 billion (at today's prices) ([20](#)).

Diabetes

By 2025 it is estimated that five million people will have diabetes. Most of these cases will be Type 2 diabetes, because of our ageing population and rapidly rising numbers of overweight and obese people ([16](#)).

This type of diabetes usually appears in people over the age of 40, though in South Asian people it often appears after the age of 25.

The prevalence of diagnosed diabetes in English men rose from 2.9% in 1994 to 7.0% in 2011, in women from 1.9% to 4.9% ([17](#)). In addition, it is estimated that 850,000 people in the UK have the disease but as yet undiagnosed ([16](#)).

People who are at least moderately active have a 30% to 40% lower risk of type 2 diabetes ([1](#))

Mental ill health

“Regular physical activity reduces the risk of depression and has positive benefits for mental health including reduced anxiety, and enhanced mood and self-esteem”(9).

Physical activity may improve at least some aspects of cognitive function that are important for tasks of daily living, and is also associated with a reduced risk of developing problems of cognitive impairment in old age (18).

Musculoskeletal health

A physically active lifestyle offers benefit in a number of areas – improved bone and muscle strength, reduced risk of falls and fractures, protection against osteoarthritis and pain relief for those who do suffer the condition.

The total cost of hospital and social care for patients with a hip fracture amounts to more than £2.3billion per annum in the UK (19).

The risk of hip fracture is lower in active people, reduced by up to 68% at the highest level of physical activity. Increases in exercise can increase spine and hip bone marrow density, and can also minimise decline in spine and hip bone density (1).

Various levels of walking are linked to a risk reduction of incident osteoarthritis ranging from 22% to 83% (1).

Physical decline in older people can be reversed relatively quickly. Among over-75s, 15 years of rejuvenation of muscle strength (27 per cent increase in leg strength) can be regained in three months (18).

A broad range of physical activities can reduce pain, stiffness and disability, and increase general mobility, gait, function, aerobic fitness and muscle strength in older adults with osteoarthritis (18).

1. Department of Health (2011). Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers
9. Department of Health (2005) Choosing Activity: a physical activity action plan
11. British Heart Foundation (2012) Coronary Heart Disease Statistics
16. Diabetes UK (2012) Diabetes in the UK 2012
17. Health and Social Care Information Centre (2012) Health Survey for England 2011
18. British Heart Foundation (2006) Active for later life
19. National Osteoporosis Society
20. Government Office for Science (2007) Foresight: Tackling obesity – Future Choices

Appendix 3

Fitness Tests for Older Men Moving

Modified Harvard Fitness Test: to test cardiovascular fitness.

Test to be performed at the beginning and end of each term.

This test will be performed to assess the individual's rest and recovery rate.

- 1) Resting pulse rate taken.
- 2) Steps onto a low bench performed for 3 minutes.
- 3) Pulse taken immediately after cessation.
- 4) Pulse taken after five minutes.
- 5) Difference between 1), 3) and 4) will be logged.
- 6) Termly data should show an improving resting/recovery rate.

Two-minute step in place test: To measure general fitness

Test to be performed at the beginning of the project and at the final session.

- 1) The individual stands up straight next to the wall and a level corresponding to midway between the patella and the iliac crest is marked on the wall.
- 2) The individual marches in place for two minutes.
- 3) Knees must be lifted to the height of the tape.
- 4) The number of times the knees reach the marker during the two minutes are recorded. Resting is allowed.
- 5) All individuals will be given an age-related target to aim for. This will be noted on their personal record cards.

The measurements should demonstrate an overall improvement in a general level of fitness.

Chair-based Sit and Reach Test: To test lower body flexibility.

Test to be performed at the beginning of the project and at the final session.

- 1) The individual sits on the edge of a chair.
- 2) One foot remains flat on the floor.
- 3) The other leg is extended forward with the knee straight and the ankle bent at 90degrees.
- 4) Clasp hands and stretch towards extended ankle, holding for two minutes at maximum stretch.
- 5) Distance is measured between fingers and toes.
- 6) All individuals will be given an age-related target to aim for. This will be noted on their personal record cards.

The measurements should demonstrate an overall improvement in a general level of flexibility.

Chair to Standing Test: to test leg strength and endurance.

Test to be performed at the beginning of the project and at the final session.

- 1) The individual will sit in the middle of a chair (without arm rests, seat at 17" high) with feet shoulder width apart.
- 2) Arms will be crossed at the wrists and held close to the chest.

- 3) From the sitting position the individual stands completely up and then completely back down.
- 4) A complete chair stand up and seated again is counted as ONE stand and the number of complete stands will be counted for TWO MINUTES.
- 5) All participants will be given an age related target to aim for. This will be noted on their personal record.

The measurements should demonstrate an overall improvement in leg strength and general endurance.

Normal range of scores for men, with *normal* defined as the middle 50% of the population. Those scoring above this range would be considered *above average* for their age and those below the range as *below average*.

Normal Range of Scores – Men

	60-64	65-69	70-74	75-79	80-84	85-89	90-94
Chair stand (no. of stands)	14 - 19	12 - 18	12 - 17	11 - 17	10 - 15	8 - 14	7 - 12
Arm Curl (no. of reps)	16 - 22	15 - 21	14 - 21	13 - 19	13 - 19	11 - 17	10 - 14
6-Min Walk (no. of yds)	610-735	56 -700	545-680	470-640	445-605	380-570	305-500
2-Min Step (no. of steps)	87-115	86 -116	80-110	73-109	71-103	59 -91	52 - 86
Chair Sit-&-Reach (inches +/-)	-2.5-+4.0	-3.0-3.5	+2.5 -4.0	+2.0 -5.5	+1.5 -5.5	+0.5 -6.5	-0.5 -4.0
Back Scratch (inches +/-)	-6.5	+0.0 -7.5	-1.0 -8.0	-1.0 -9.0	-2.0 -9.5	-2.0 -10.0	-3.0 -10.5
8-Ft Up-&-Go (seconds)	5.6 - 3.8	5.7 - 4.3	6.0 - 4.2	7.2 - 4.6	7.6 - 5.2	8.9 - 5.3	10.0 - 6.2

Functional ability framework indicating the physiologic parameters associated with functions required for basic and advanced everyday activities. R.E.Rikli & C.J.Jones Senior Fitness Test Manual 2001.



Horwood and Mayfield House men exercise together

From theguardian.com, Wednesday 3 July 2013 08.29 BST

Ageing population

Sponsored by



Why older people should give dancing a whirl?

There's a growing interest in the power of dance to improve physical and mental wellbeing in later years.

Hannah Fearn



The social dimension of dancing is as important as the physical health benefits, experts say.

Muhammad Yusuf was a good dancer as a young man. He drew in women with his fine footwork, he says. Now the 75-year-old Somali takes part in a dance class for older men to keep fit. "I'm old and I can't move like that anymore. I have heart problems and leg problems, but it has helped."

His weekly exercise group is run by the Green Candle Dance Company at Mayfield House, a day centre for older Somali people in Tower Hamlets in London. The class, funded by the local clinical commissioning group (CCG), reflects a growing interest in the power of dance to improve health in later years.

Susan Venn, co-director of the Centre for Research on Ageing at Surrey University, says it's not just the benefit of physical movement that improves health and wellbeing for older dancers.

"There's quite a lot of research that show that the social dimension is almost as important as the physical dimension. Engagement with others in the community has as many health benefits in terms of mental wellbeing as the physical benefits of keeping moving in later life."

Though there's evidence of its value, encouraging people to get involved with dance may be more difficult – especially when it comes to men.

"[Dance] is most commonly associated with older women, and I think there's a bit of a trick missed in terms of older men, who are often more isolated anyway.

Sometimes older men need a lot of encouragement to get out," says Venn.

But tutors working with the group of Somali men found creative ways to spark their interest. The group are largely retired seamen who trained on the boats that linked Britain to its colonial outpost. To a backdrop of traditional Arabic music and British sea shanties, they attempt circle dance in which the movements mimic their former work: rowing, lifting, pulling ropes to hoist a sail.

Ibrahim Abdullah, 81, suffers from a heart condition and wears a pacemaker but still takes part, albeit from his seat. He's not shy about getting involved: "When we were younger we used to work together. We all know each other here," he says.

Fergus Early, Green Candle's artistic director, says the charity's work with older people demonstrates that dance is also good for preventing other conditions such as dementia. "What's interesting about dance is that its demands and its effects are both mentally stimulating," he says. "People don't appreciate what a cerebral exercise it is: there's memory, there's decision making. We have lots of anecdotal evidence of that."

Green Candle will report back to the CCG with its findings at the end of the summer, and Early hopes that a longer series of sessions will be funded as part of its spending on public health and wellbeing.

But despite the overwhelming evidence that dance is beneficial to health and wellbeing in later years, cuts to the arts sector means few groups will find public funding.

"Even doctors are struggling to find the resources to help," says Venn. "The answer must come from older people themselves, or from inter-generational groups.

Perhaps younger people could be encouraged to accept older people into their groups ... [for] older and younger people to work together."

A copy is now displayed at Mayfield House.