Move Against Cancer: Equity, Diversity, and Inclusion (EDI)

‘The Evidence, Need and Demand’

We believe that everyone has the right to the highest attainable level of health and happiness, regardless of how much money they have, the colour of their skin, their age, sexual orientation, religion, gender identity, disability status or where they live. We would love for everyone to have equal and just opportunity to benefit from MOVE Charity. But sadly, we know that it's much easier for some people to access our areas of work than others.

The barriers to accessing our 5K Your Way groups, our MOVE Online Programme and our Move Your Way Resources will be incredibly complex, but we are committed to upholding the principles of EDI and play our part in the bigger picture of tackling health inequalities.

We are committed to making MOVE Charity as welcoming as possible to people from all backgrounds and we will make targeted efforts to identify and work with communities where action is most needed. Our goal is to understand the barriers to attending 5k Your Way and our MOVE Online Programme as well as our online resources for people from a range of diverse communities and take positive actions to reduce these barriers. We will strive to be a more inclusive organisation because we believe that everyone deserves to be treated fairly and have the opportunity to benefit from our community. By playing our part, we can welcome as many people as possible to join our efforts to MOVE Against Cancer.

Move Against Cancer’s Equity, Diversity and Inclusion (EDI) Strategy 2024

1. Introduction: evidence, need and demand

Following this brief introduction, Section 2 provides the background to Move Against Cancer’s commitment to EDI, with a focus on ensuring everyone has an equal and just opportunity to benefit from Move’s programmes.

Sections 3 summarises the plethora of ***evidence*** regarding the positive impact of exercise on cancer.

Section 4 stresses the ***need*** to understand and reduce the many barriers to engaging in physical activity faced by many minoritised ethnic communities. Section 5 sums up community interviews and focus groups with diverse communities facilitated by Move.

Finally, Section 6 highlights the urgent ***demand*** for persons affected by cancer in areas of Nottingham, Leicester, Greater Manchester and London to benefit from physical activity before, during and post cancer treatment, which will create a foundation for scaling Move’s programmes regionally and nationally.

2. Background

Move Against Cancer (Move) believes that every person impacted by cancer should feel supported and empowered to lead an active, fulfilling life. To achieve this, it is essential that every individual receives the necessary resources and information to engage in and maintain an active lifestyle. However, the charity's anecdotal evidence indicated that its initiatives were failing to reach all the communities it wished to serve, particularly those living in deprived areas, with a focus on Black, Asian and other minoritised ethnic groups. In response (and in accordance with Move’s

commitment to taking an evidence-based approach[1]) the Move team conducted an EDI survey during 2024, which received 256 responses.

The survey provides robust evidence that Move's membership is not sufficiently representative of the diverse groups it aims to serve (see Appendix 1 for the 'headlines'). Moreover, while the data from the Move Online Programme identified higher percentages of individuals from underserved community groups, it correspondingly highlighted the critical need to reduce barriers for people from these diverse communities

Consequently, Move is committed to **i)** understanding those barriers through desk and face-to-face research; **ii)** using that information to reduce systemic, structural, cultural, socioeconomic, individual and other barriers, so that everyone has an equal and just opportunity to benefit from Move's programmes (see Appendix 2); and **iii)** embedding equity, diversity, and inclusion into all of its activities.

This report focuses on the ongoing research and activities in Nottingham, Leicester, Greater Manchester and London but intends to inform future research and interventions on a wider basis. It first presents narrative research evidence supporting the benefits of exercise for individuals with cancer in both prehabilitation and rehabilitation, as well as post-treatment for maintaining an active lifestyle.

Through desk research, buttressed with data from semi-structured interviews and focus groups, such as those during the Move 'EDI Community Resources Pilot' in Birmingham, this report then identifies potential barriers to participation in Move's initiatives and suggests methods for reducing them. It concludes with a series of recommendations for the pilots, with a focus on making targeted efforts to identify and work 'hand-in-hand' with communities where action is most needed.

Importantly, we have already begun to secure partnerships within our pilot sites, including the Nottingham Indian Community Centre Association; West London Cancer Alliance; East Midlands Cancer Alliance; the Leicester Jayna Dance Academy; Nottingham's Tuntum Housing; Manchester's 'Move to Thrive' charity for Asian, Arabic and Middle Eastern women impacted by cancer; Nottingham City Hospital Oncology Department; Notts Frontrunners; the Birmingham Go-Woman! Alliance; Parkrun London Outreach; London Sport; Royal Marsden Cancer Alliance; and community representatives like Tyrone l'Yungo Thompson in Nottingham.

Desk research data limitations

As highlighted in the British Journal of Cancer (Delon, Brown, Payne *et al.* 2022), it is recognised that UK evidence on cancer incidence variation by ethnic group has various shortcomings, including incomplete ethnicity recording in routinely collected hospital data and a lack of reliable population data by ethnic group. Moreover, population estimates have been inconsistent with subsequent census data by the Office for National Statistics (such as its 2017 Population Estimates by Ethnic Group).

Further, many of the existing analyses are over a decade old and may no longer reflect current levels of risk factor prevalence, screening uptake etc, for which trends

[1] Move's EDI Strategy 2024

may vary by ethnic group.[2] This further emphasises the need for Move to continue carrying out its own research.

Consequently, Move will also take an active role in further research through collaboration with **i)** the University of Nottingham and the Oncology Department at Nottingham's City Hospital to identify robust evidence regarding the specific barriers to Black, Asian and other minoritised groups engaging in physical activity; and **ii)** the University of Leicester to develop ways in which patients from diverse backgrounds may be able to increase their physical activity. There is also potential for lung cancer patients from diverse backgrounds, who are being treated with immunotherapy, to take part in a clinical study to increase activity and assess quality of life – subject to sufficient volunteers and a successful feasibility study.

At each stage of our research, it will be shared in an eye-catching format (using appropriate methodology and languages) with stakeholders, particularly underserved groups in the pilot sites. See the on-line survey highlights at Appendix 1 for example.

3. The positive impact of exercise on cancer

For decades, it's been known that consistent exercise can help people live healthier lives, including lowering the risk of cancer. There is now a growing body of research evidencing that cancer patients can significantly benefit from physical activity before, during and post cancer treatment – including palliative and survivorship care.

Some earlier examples include the following: **i)** Mutrie, Campbell, Whyte et al. (2007) who identified that exercise could help mitigate cancer treatment side effects, such as chemotherapy-induced fatigue – they also supported the notion that regular physical activity can improve energy levels and overall health in cancer patients;[3] **ii)** Fisher, Wardle, Beeken, Croker and Williams, K. (2016) found that exercise can improve physiological wellbeing (such as improving health and fitness) in colorectal cancer patients and emphasised the importance of designing effective exercise interventions[4]; and **iii)** Cormie, Zopf, E. Zhang and Schmitz's research findings (2017), supported the view that exercise is an important adjunct therapy in the management of cancer.[5]

In 2017, a Journal of the National Cancer Institute (JNCI) article summarised that in a prospective observational cohort of 1,237 women who received taxane chemotherapy treatment, lifestyle factors, including low '*moderate to vigorous physical activity*' (MVPA), were associated with more severe and sustained Chemotherapy Induced Peripheral Neuropathy (CIPN) symptoms. The authors suggested increased MVPA is one of the modifiable risk factors for debilitating CIPN among breast cancer patients receiving taxane treatment. They stressed that the

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[2] Delon, C., Brown, K.F., Payne, N.W.S. *et al.* Differences in cancer incidence by broad ethnic group in England, 2013–2017. *Br J Cancer* **126**, 1765–1773 (2022). https://doi.org/10.1038/s41416-022-01718-5

[3] Mutrie, N., Campbell, A. M., Whyte, F., McConnachie, A., Emslie, C., Lee, L., & Kearney, N. (2007). "Benefits of supervised group exercise programme for women being treated for early-stage breast cancer: pragmatic randomised controlled trial." *BMJ*, 334(7592), 517

[4] Fisher, A., Wardle, J., Beeken, R. J., Croker, H., & Williams, K. (2016). "Perceived barriers and benefits to physical activity in colorectal cancer patients." *Supportive Care in Cancer*, 24(2), 903-910

[5] Cormie, P., Zopf, E. M., Zhang, X., & Schmitz, K. H. (2017). "The impact of exercise on cancer mortality, recurrence, and treatment-related adverse effects." *Epidemiologic Reviews*, 39(1), 71-92

management of CIPN relies largely on prescribed medications, with no lifestyle recommendations for CIPN prevention – and argued that patients are not counselled on the benefits and hazards associated with exercise during taxane treatment. They went on to recommended future studies aimed at providing effective lifestyle recommendations for patients who are at high risk of developing CIPN, following taxanes for breast cancer treatment.[6]

Buttressing these findings, a narrative review in the USA National Library of Medicine (2018) covering all stages of cancer treatment concluded that **i)** exercise is safe and effective for treating many toxicities; **ii)** patients can benefit from a variety of exercise modalities; **iii)** exercise should be started as soon as possible, even before treatment begin; **iv)** exercise should be continued as long as possible, as a lifestyle; and **v)** barriers to exercise should be identified and addressed; and **vi)** future research should inform definitive clinical guidelines for the use of exercise to ameliorate toxicities from cancer and its treatment.[7]

Further 2018 research (a randomised controlled trial, also reported in the National Library of Medicine) concluded that combined resistance and aerobic exercise effectively attenuated metabolic syndrome, sarcopenic obesity, and relevant biomarkers in an ethnically diverse sample of sedentary, overweight or obese survivors of breast cancer. Their findings **i)** suggested a targeted exercise prescription for improving metabolic syndrome in survivors of breast cancer; and **ii)** supported the incorporation of supervised clinical exercise programmes into breast cancer treatment and survivorship care plans.[8]

Importantly, Macmillan's document '*Move More: Integrating physical activity into cancer care*' (2018) was based on extensive research and evidence from the charity's work with pilot physical activity behaviour change projects. It concludes that "*physical activity from the moment of diagnosis has been called a 'wonder drug' as it plays a crucial role in both 'pre-habilitation' (before treatment) and rehabilitation. Not only does it help improve clinical outcomes, it can help people take control of their lives, reduce social isolation, and enable them to live independently*".[9] These findings have been buttressed by more recent research findings, including the Misiąg et al. (2022) review of 36 relevant papers. The authors identified that physical activity is recommended for patients with any type of cancer and at all stages of treatment because it **i)** decreases the severity of side effects of cancer treatment; **ii)** reduces fatigue; **iii)** improves quality of life; **iv)** has a positive impact on mental health; **v)** improves aerobic fitness in cancer patients; and **vi)** reduces the risk of cancer

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[6] Heather Greenlee, Dawn L. Hershman, Zaixing Shi, Marilyn L. Kwan, Isaac J. Ergas, Janise M. Roh, Lawrence H. Kushi, BMI, Lifestyle Factors and Taxane-Induced Neuropathy in Breast Cancer Patients: The Pathways Study, *JNCI: Journal of the National Cancer Institute*, Volume 109, Issue 2, February 2017, djw206, https://doi.org/10.1093/jnci/djw206

[7] Kleckner IR, Dunne RF, Asare M, Cole C, Fleming F, Fung C, Lin PJ, Mustian KM. Exercise for Toxicity Management in Cancer-A Narrative Review. Oncol Hematol Rev. 2018 Spring;14(1):28-37. Epub 2018 Feb 15. PMID: 29713475; PMCID: PMC5922767

[8] Dieli-Conwright CM, Courneya KS, Demark-Wahnefried W, Sami N, Lee K, Buchanan TA, Spicer DV, Tripathy D, Bernstein L, Mortimer JE. Effects of Aerobic and Resistance Exercise on Metabolic Syndrome, Sarcopenic Obesity, and Circulating Biomarkers in Overweight or Obese Survivors of Breast Cancer: A Randomized Controlled Trial. J Clin Oncol. 2018 Mar 20;36(9):875-883.

[9] Macmillan (2018) Move More: Integrating physical activity into cancer care evidence and guidance Macmillan Cancer Support

recurrence and death. They also stressed that the type of physical activity should depend on the condition of individual patients.[10]

Another study, led by Dr Lee Jones (Chief of the Memorial Sloan Kettering Exercise Oncology Service), involved 11,480 patients in a cancer screening trial. After a median follow-up, 16 years after diagnosis, exercise consistent with guidelines was associated with a significant reduction in cancer mortality and mortality from other causes (Journal of Clinical Oncology, 2023).[11]

> *"Regular exercise during cancer treatment appears to act like a good double whammy. It reduces the risk of dying from certain cancers. And the "side effect" of exercise is actually helpful because it reduces the risk of dying from causes other than cancer… That's especially important because more people are now long-term survivors of cancer… In fact, in the data we analyzed, people with some forms of breast and prostate cancer were at higher risk of dying from another disease than from cancer recurring..."*
>
> Dr Lee Jones

These findings have culminated in a number of international clinical guidelines, which advocate for the incorporation of exercise into cancer treatment plans to improve patient outcomes and quality of life (see '*Exercise for people with cancer: a clinical practice guideline*' for example).[12] Moreover, NHS Inform (2024) stresses that being active during cancer treatment can help to reduce tiredness and some treatment side effects; reduce anxiety and depression; improve mood and quality of life; strengthen muscles, joints and bones; look after the heart; and reduce the risk of other health problems. It also states that physical activity can be an important part of post-cancer treatment recovery and may reduce the risk of certain cancers coming back.[13]

The CHALLENGE Trial (2025) is the first published randomised controlled trial which has tested exercise in exactly the same way as drugs are tested, which 5k Your Way co-founder, Dr Lucy Gossage, has described as a '*turning point in cancer care*'. [14] The trial took a sample of 889 people who had completed chemotherapy after bowel cancer surgery and gave one group a three-year, personalised exercise programme with the support of a personal trainer and the other a series of general health education materials that simply promoted exercise and nutrition.

Results showed that the risk of developing a cancer recurrence, or a new cancer was 28% lower in the group given the exercise programme, while after eight years, the risk of dying from any cause was 37% lower in the same group.

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[10] Misiąg W, Piszczyk A, Szymańska-Chabowska A, Chabowski M. Physical Activity and Cancer Care-A Review. Cancers (Basel). 2022 Aug 27;14(17):4154. doi: 10.3390/cancers14174154. PMID: 36077690; PMCID: PMC9454950.

[11] Journal of Clinical Oncology (2023) Pan-Cancer Analysis of Postdiagnosis Exercise and Mortality Volume 41, Number 32 https://doi.org/10.1200/JCO.23.00058 (accessed 01.30 07.07.2024)

[12] Segal R, Zwaal C, Green E, Tomasone JR, Loblaw A, Petrella T; Exercise for People with Cancer Guideline Development Group. Exercise for people with cancer: a clinical practice guideline. Curr Oncol. 2017 Feb;24(1):40-46. doi: 10.3747/co.24.3376. Epub 2017 Feb 27. PMID: 28270724; PMCID: PMC5330628

[13] https://www.nhsinform.scot/illnesses-and-conditions/cancer/practical-issues/exercise-diet-and-healthy-living-with-cancer/#:~:text=Being%20active%20at%20recommended%20levels, you%20have%20to%20exercise%20intensely. (accessed 00.24 16 July 2024)

[14] Courneya, K. S., Vardy, J. L., O'Callaghan, C. J., Gill, S., Friedenreich, C. M., Wong, R. K., Dhillon, H. M., Coyle, V., Chua, N. S., Jonker, D. J., Beale, P. J., Haider, K., Tang, P. A., Bonaventura, T., Wong, R., Lim, H. J., Burge, M. E., Hubay, S., Sanatani, M., Campbell, K. L., Arthuso, F. Z., Turner, J., Meyer, R. M., Brundage, M., O'Brien, P., … Booth, C. M. (2025). *Structured exercise after adjuvant chemotherapy for colon cancer*. New England Journal of Medicine, 393, 13–25. https://doi.org/10.1056/NEJMoa2502760

Dr Lucy Gossage stressed, "*For the first time ever, we now have definitive proof that we should be prescribing exercise, alongside our prescriptions for drugs and radiotherapy. Exercise isn't just about feeling better. It's about living longer*.

"*When I read the results, I felt deeply moved, not just as an oncologist, but as a co-founder of a movement built on belief. For years, we've relied on observational data, anecdotal evidence, and lived experience to argue that movement matters in cancer recovery.*

"Through our Move Against Cancer community, I've watched exercise change lives, yet I've simultaneously observed barriers from colleagues who aren't willing, or perhaps don't feel able, to discuss exercise with their patients. But now, that belief that movement matters is backed by a trial as rigorous as any drug study."

"Just as cardiac rehab supports heart patients in their recovery, we should create a similar model for cancer patients. Exercise is something patients can do, for themselves, at a time when so much feels out of their control. We need to support and empower them to harness its benefits in a way that works for them".

Research is also ongoing into ways that the immune response to cancer can be improved by exercise. For example, Professor Adam Frampton of the University of Surrey asserts that *"…generating evidence that exercise can improve the immune response against the tumour in patients with oesophageal cancer would provide significant justification for introducing 'personalised' exercise programmes to improve immunotherapeutic treatment outcomes*".[15]

Disturbingly Cancer Research UK's 'Prevention Research Strategy' warns that the number of people with cancer in the UK is set to rise from 2.5 million to 4 million people by 2030 stating that "*this rapid growth is linked to increasing longevity (with ageing being by far the most significant risk factor) and a dramatic increase in exposures to various modifiable risk factors such as obesity, poor diet, declining physical activity… will be exacerbated by existing, significant, inequalities in public health and cancer outcomes*". It also asserts that primary prevention of cancer will have the greatest impact when it comes to saving lives and unburdening health systems across the UK.[16]

In summary, UK and wider research supports the assertion that exercise is a beneficial adjunct therapy for cancer patients, helping to manage symptoms, improve physical and psychological well-being, and enhance survival rates – as well as emphasising that exercise can lower the risk of cancer.

However, there is also research that highlights inequality in accessing both professional adjunct therapy and similarly beneficial community exercise programmes.

Consequently, the next section examines those inequalities and identifies some of the barriers that prevent some communities, particularly Black and minoritised ethnic groups and socially disadvantaged groups, from engaging in physical activity – with the intention of informing Move's plans to reduce barriers, enhance accessibility and embed equity, diversity, and inclusion into all its activities and services.

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[15] https://www.wcrf.org/researchwefund/exercise-and-outcomes-in-advanced-oesophageal-cancer (accessed 02.00 07.07.2024)

[16] Cancer Research UK (2024) The Future of Cancer Prevention: Our Prevention Research Strategy https://www.cancerresearchuk.org/sites/default/files/cancer_research_uk_prevention_research_strategy.pdf (accessed at 01.20 16 July 2024)

4. Barriers to engaging minoritised ethnic groups in physical activity

Delon, Brown and Payne *et al.* (2022) assert that understanding variation in cancer incidences between ethnic groups can inform **i)** measures to reduce inequality (for example, higher cancer incidences may reflect differential access to, or uptake of services such as cancer screening and weight management initiatives); and **ii)** inclusive cancer service planning (for example, addressing factors like language barriers or unmet cultural/religious requirements, which impact on routes to diagnosis, stage at presentation and type of treatment received).[17] Such cancer-specific research is supported by more general research, which indicates that members of Black and minoritised ethnic communities, particularly those experiencing a 'lower socioeconomic status', engage in insufficient exercise, both in the UK and globally.

Recognising that such crucial data could also inform Move's plans to reduce barriers, enhance accessibility and embed equality, diversity, and inclusion into all its activities and services, the following potentially transferable data has been identified through initial desk research. It is also a precursor to Move's on-site data collection (with partners from those communities) in the second pilot area Nottingham.

A number of early studies identified the health consequences of distinct levels of physical activity among different ethnic groups. For example, 2007 research by Coups, Manne, Meropol and Weinberg (focusing on multiple behavioural risk factors for colorectal cancer) found that individuals who were not adherent to screening reported having a greater number of risk factors, including low physical activity, than adherent individuals.[18] Further, a 2011 paper published in the British Medical Journals (BMJ) found that physical inactivity made a significant contribution to the excess coronary heart disease (CHD) mortality observed in the UK's South Asian population, principally among Pakistani and Bangladeshi groups, highlighting the need to prioritise the promotion of physical activity in high-risk populations.[19]

In the National Library of Medicine Author Manuscript '*Assessing Physical Activity Behavior of Cancer Survivors by Race and Social Determinants of Health*' (2019) it was recognised that Black cancer survivors remain at a higher risk for secondary cancers, cancer recurrence, and comorbid conditions than non-Hispanic White survivors. The research examined associations between race and physical activity in tandem with the effect of social determinants of health (SDH) constructs on physical activity. The study revealed that **i)** there are significant racial disparities in SDH constructs; and **ii)** Black cancer survivors are more likely than Whites to have lower economic stability, educational attainment, and access to health care. The authors asserted that these disparities are strongly associated with less physical activity among Black cancer survivors and recommended interventions to help them engage in physical activity – along with the need to address the overarching structural

[17] Delon, C., Brown, K.F., Payne, N.W.S. *et al.* Differences in cancer incidence by broad ethnic group in England, 2013–2017. *Br J Cancer* **126**, 1765–1773 (2022). https://doi.org/10.1038/s41416-022-01718-5

[18] Coups EJ, Manne SL, Meropol NJ, Weinberg DS. Multiple behavioral risk factors for colorectal cancer and colorectal cancer screening status. Cancer Epidemiol Biomarkers Prev. 2007 Mar;16(3):510-6

[19] Williams, E. D., Stamatakis, E., Chandola, T., & Hamer, M. (2011). "Physical activity behaviour and coronary heart disease mortality among South Asian people in the UK: an observational longitudinal study."

barriers.[20] Their findings are reinforced by the systematic review of qualitative studies by Ige-Elegbede et al. (2019) regarding both barriers and facilitators of physical activity among older adults from Black and Minority Ethnic groups in the UK. The authors asserted that physical inactivity is a global health issue[21]. Delon, Brown and Payne *et al.* (2022) further identified that patients from non-White minority ethnic groups rate their overall care less favourably than White patients and feel insufficiently involved in decisions about their care and treatment.[22]

This assertion that physical inactivity is a global health issue is still significant, as highlighted in the 2024 World Health Organisation (WHO) Factsheet '*Physical Activity*', which states that "*people who are insufficiently active have a 20% to 30% increased risk of death compared to people who are sufficiently active… **in adults,** increased all-cause mortality, cardiovascular disease mortality and cancer mortality and increased incidence of cardiovascular disease, cancer and type-2 diabetes*".[23]

The Ige-Elegbede et al. (2019) review also identified that adults and older adults from socially disadvantaged groups experience a higher burden of physical inactivity – emphasising that there is an association between "*low levels of physical activity among people from BME communities and a high level of health inequalities*". The following key themes emerged from their research respondents, who were 50 years or over.

1. **Awareness of the links between physical activity and health** – the link between physical activity and health was well understood by many respondents including weight loss (the most commonly reported); improved general wellbeing; improved mental health; and prevention of chronic conditions.
2. **Religion and religious fatalism** - Religion and religious norms were perceived as both a barrier and potential facilitator. For example, some respondents identified a resonance between Islamic teachings and the need to lead a physically active lifestyle; walking was generally perceived to be an appropriate form of physical activity as it did not contradict Islamic teachings and values.

   However, some respondents held the view that observing the five times daily prayer of Muslims was adequate exercise. Religious fatalism was predominantly identified as a barrier to healthy living among some of the older Muslim women. For example, some of the Pakistani Muslim respondents with coronary heart disease held fatalistic religious beliefs about their condition i.e. that the illness came from Allah (God) and they simply accepted it.

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[20] Asare M, McIntosh S, Culakova E, Alio A, Umstattd Meyer MR, Kleckner AS, Adunlin G, Kleckner IR, Ylitalo KR, Kamen CS. Assessing Physical Activity Behavior of Cancer Survivors by Race and Social Determinants of Health. Int Q Community Health Educ. 2019 Oct;40(1):7-16. doi: 10.1177/0272684X19857427. Epub 2019 Jun 26. PMID: 31242086; PMCID: PMC7262605.

[21] Ige-Elegbede J, Pilkington P, Gray S, Powell J. Barriers and facilitators of physical activity among adults and older adults from Black and Minority Ethnic groups in the UK: A systematic review of qualitative studies. Prev Med Rep. 2019 Jul 13;15:100952. doi: 10.1016/j.pmedr.2019.100952. PMID: 31367514; PMCID: PMC6656684.

[22] ibid

[23] https://www.who.int/en/news-room/fact-sheets/detail/physical-activity (accessed 11.24 09/07/2024).

3. **Interaction and engagement with health professionals** – although health professionals were identified as a key source of information, respondents reported that information was inadequate and not clearly communicated. For example, the lack of information on recommended levels of physical activity deterred many older adults from outdoor walking as they did not know the appropriate distance to cover – with some expressing anxiety about 'exceeding the body's limit', which was fuelled by a lack of knowledge on what sort of activity was appropriate and safe. Others stated that all conversations were around medication.
4. **Cultural expectations and social responsibilities** – some respondents (both male and female) felt that prioritisation of family duties was an integral responsibility of a woman and part of her identity – stating that "*some older South Asian women perceived exercise as damaging to their personal reputation and family honour*". Others felt that mixed-sex physical activity or exercise was considered highly inappropriate as it compromised their values of modesty – particularly swimming.
5. **Lack of a suitable environment for physical activity** – some older women reported not knowing any 'safe walking routes or not having facilities within walkable distance'. Others expressed concerns with walking in unsafe neighbourhoods – and people with poor English literacy felt more vulnerable when walking in public spaces. Respondents also emphasised that "*the safest place to walk was in their homes, although over-crowding posed a practical challenge*".
6. **Practical challenges** – included **i)** a lack of time caused by women needing to take care of the home and look after children; **ii)** male Pakistani and Bangladeshi adults affirmed that working seven days a week did not afford them much time to engage in physical activity; **iii)** financial constraints; **iv)** lack of child-care facilities; and **v)** inability to communicate in English, which reduced confidence levels and was a major deterrent to attending physical activity classes or walking in public areas.

The Bristol Myers Squibb company (2024) reinforced some of the above in its research 'Cancer Equals', which identified the following 'inequalities in cancer', **i)** knowledge of cancer is lower in people from minority ethnic groups; **ii)** there is less understanding of cancer from people with a 'lower socioeconomic status'; **iii)** people from minority ethnic groups do not want to waste NHS time and resources; **iv)** lower socioeconomic groups are more likely to deal with health issues on their own and not bother a doctor; **v)** minority ethnic groups find it harder to make an appointment due to work constraints; and **vi)** the financial impact of cancer is felt most strongly by minority ethnic groups.[24]

Cancer Research UK's 2020 report on socio-economic deprivation also provides stark reading, stressing that "*More than 30,000 extra cases of cancer in the UK each year are attributable to socio-economic variation*" and explaining that there is a clear variation between socio-economic groups in the determinants of both cancer incidence and outcomes in the UK. A 2021 report commissioned by The King's Fund and published by the NHS Race and Health Observatory '*Ethnic health inequalities and the NHS: Driving progress in a Changing System*' also identified that

[24] Bristol Myers Squibb (April 2024) Cancer Equals: Highlighting Differences in Cancer Care in the UK

people from Black and minoritised ethnic groups experience inequalities in health outcomes – as well as inequalities in access to, and experience of, health services compared to White groups. It further recognised the complexity of the issue, with variation between and within ethnic groups is exasperated by the lack of good-quality data and analysis. Moreover, it identified that the majority of Black and minority ethnic groups are disproportionately affected by socio-economic deprivation – a key determinant of health status. Whilst the report's recommendations naturally focused on the NHS, they buttress the importance of **i)** identifying and targeting communities at higher risk of poor health; and **ii)** addressing target risk factors such as obesity and exercise.

5. Community interviews and focus groups

Move implemented an 'EDI Community Resources Pilot' in Birmingham, which included discussions with community health staff about their experiences with cancer from social, community, and cultural perspectives. In addition to highlighting many barriers, the pilot culminated in the successful establishment of a walking group.

The East Midlands Regional Move Ambassador and her volunteer EDI team have attended a number of cultural events and meeting (face-to-face and online) to obtain the views of community representatives regarding 'moving against cancer' through informal discussions, semi-structured interviews and focus groups.[25]

Whilst recognising that this data gathered during the Birmingham pilot and the East Midlands visits is predominantly anecdotal, important issues were raised by community members regarding barriers to engaging in physical activity. Therefore, they are summarised here.

- Cancer is still seen as a death sentence.
- Some believed that cancer patients would reduce their life expectancy if they exercised.
- Fear of exercising, believing they should rest in order to recover.
- Cancer is a taboo subject.
- People feel the need to be secretive if they have cancer in order to protect their own emotional health – believing that other people think they are going to die and, subsequently, will cry in front of them
- People/friends/colleagues don't discuss it with cancer patients, because they don't know how to support them.
- People believe they should be seen as strong, and that they keep things to themselves.
- A lack of understanding of modern medicine and its benefits.
- Underestimating the amount of exercise required to have discernible benefits.

[25] For example, but not limited to, the Hindu Festival of Chariots in Nottingham City Centre; Leicester Cancer Clinical Research Afternoon in the Community; the Boobie Ball in Nottingham; yoga class at the Nottingham Indian Community Centre Association; Tuntum Housing; the East Midlands Cancer Alliance 'Advancing Cancer Equity' group; and Leicester Jayna Dance Academy.

- Historically, and currently, there is a lack of culturally tailored physical activity interventions.
- The activities that are culturally tailored (such as cultural dance classes) are not informed enough to support cancer patients – believing they could do more harm than good – often despite a desire to help.
- An interest in partnering with Cancer Prehabilitation and Rehabilitation Specialists to effectively target and support cancer patients was voiced by three established exercise groups.
- There is a lack of peer interaction about the benefits of physical activity, and the challenges faced with having cancer.
- Community members trust their peers and, as a consequence, they are their main source of information (accurate and inaccurate), especially when English is not a primary language.
- Creating a space where community members affected by cancer could speak to each other, supported by a specialist, was identified as important.
- A lot of medical letters get missed, because people receiving them cannot read, so pass them to their older children. However, they may be unable to prioritise medical appointments and/or understand medical terminology – resulting in the patient being unable to understand their diagnosis.

The highlighted barriers have informed the ongoing implementation of Move's EDI strategy, including the design or training interventions.

Additionally, this document was edited and proofread by volunteers from minoritised ethnic groups in Nottingham. Some of their personal comments are included here as they made important points that were not covered elsewhere. The first from a Muslim male who has lost two female relatives due to cancer, he described their reluctance to seek help when going through cancer treatment due to religious beliefs, saying *"In relation to religious fatalism it can be a real problem, but there is nothing in Islam that says one should not look after him/herself and pursue treatment – be it formal, such as hospital, or otherwise such as exercise. One of our hadiths tells of a Bedouin man who left his camel without tying it. The Prophet (Peace Be Upon Him) asked, "Why don't you tie down your camel?" The Bedouin answered, "I put my trust in Allah." The Prophet replied, "Tie your camel first, and then put your trust in Allah. More widely, the hadith tells us that we can look after our health, family and property and trust in Allah – there is no contradiction – I tell my children often to 'tie and trust' as a way of teaching them to take responsibility for themselves."*

His belief is buttressed by the Muslim Sports Foundation (MSF), which states

> "*The Prophet Muhammad exemplified balance in mental, physical, and spiritual wellbeing through practices like Salah, walking, and archery, activities that not only nurtured his body but also the mind and soul. Embracing these Sunnah based practices allows us to integrate faith with the benefit of wellness strategies… Islam encourages a holistic approach to wellbeing, just like the Prophet Muhammad ﷺ taught caring for your physical, emotional and spiritual health together. Simple daily practices like prayer (Salah), eating well,*

staying active, connecting with others and practicing mindfulness (Dhikr), can all contribute to overall wellbeing."[26]

Other supportive volunteers made the following comments.

*"A barrier for some migrants is **more about location than race or colour** – especially if they came from a rural background and now find themselves in an urban area – it can be frightening."*

"There is also another avenue to be explored... I know women from our culture who never talk about their health because their role is to care for the family – therefore they should not worry them with talk of disease or illness."

"Some believe that joining in will destroy their identity… who they are assimilation if you like… and would prefer to do something that maintains their own cultural identity. It's hard to lose yourself and where you're from."

"Don't forget intersectionality – it's not as clear cut as skin colour, gender etcetera. For example, a black lesbian could face barriers to engaging in physical exercise that stem from sexism, racism and homophobia."

"We have experienced the trauma of cancer in our family... For the future, I want to protect my daughters, but there is nobody who looks like them at 5K Your Way… I would like to help change that, even though we're OK now by coming along to 5K Your Way – simply to show our support for cancer sufferers, whether they look like you [white woman] *or me* [black man]*."*

Collectively, these studies, reports and individual contributions highlight the challenges and disparities in physical activity levels among Black and minoritised ethnic cancer patients, emphasising the need for culturally sensitive and accessible exercise programmes tailored to the communities. Axiomatically, such findings increase the necessity of Move fulfilling its commitment to reach a higher number of persons from minoritised ethnic groups – particularly those living in socially disadvantaged areas.

In order to obtain reliable, valid and primary data, Move is actively contributing to further research through collaboration with **i)** the University of Nottingham and Nottingham City Hospital's Oncology Department to identify specific barriers to Black, Asian and other minoritised groups engaging in physical activity; and **ii)** the University of Leicester to develop ways in which patients from diverse backgrounds may be able to increase their physical activity. There is also the potential for lung cancer patients from diverse backgrounds, who are being treated with immunotherapy, to take part in a clinical study to increase activity and assess quality of life – subject to sufficient volunteers and a successful feasibility study.

In summary, it is clear that supporting those living with and beyond cancer from Black and minoritised ethnic groups to engage in physical activity requires a multifaceted approach, which addresses systemic, structural, cultural, socioeconomic, individual and other barriers. Having discussed the evidence and identified a generic need, it is now critical to identify specific communities where there is both a need and demand, as covered in the next section.

[26] MSF working with Mind (2025) Mindful Sunnah 2025 (available at https://muslimsportsfoundation.org.uk/wp-content/uploads/2025/07/Mindful-Sunnah.pdf)

6. Identifying Demand and Areas of Need

Move's initial target areas are in Nottingham, Leicester, Manchester and London. It is anticipated that the lesson learnt from these areas will be cascaded across Move through training, workshops and coaching enabling the interventions and programmes to be scaled regionally and nationally.

The selected areas emerged as the most suitable for the initial interventions, based on the following evaluations have been based on research highlighting health inequalities, diversity and demand in these regions.

Move has also ensured that there is an experienced team of Ambassadors in each area to support new Ambassadors and their physical activity support groups. The following table summarises the selection process.

Nottingham	Leicester	Greater Manchester	Barking & Dagenham
Nottingham has a strong team of Ambassadors and other volunteers, including a proactive Regional Ambassador with 6 years of experience – and an EDI team that has led initiatives in diverse communities.	Leicestershire has the same proactive Regional Ambassador, EDI team as Nottingham – along with proactive and keen Ambassadors across Leicestershire.	Greater Manchester has an exceptional and active Regional Ambassador	London has a strong Regional Ambassador, who recently recruited Ambassadors to start new 5K YW groups in areas of diversity, including Barking with a view to some becoming part of an EDI Team.
The under 75 mortality rate from cancer in Nottingham is 157.4 compared to England's rate of 129.2 per 100,000 population.	In 2017–2019, the age-standardised death rate in Leicester was 141.7 per 100,000 people under the age of 75 (national rate was 129.2). Oral cancer is significantly higher – and increasing faster – than England overall, resulting in almost double mortality rates - risk factors include smoking, alcohol, chewing tobacco, betel quid or paan chewing.	Greater Manchester has a higher cancer incidence rate and mortality rate than the UK average. With approximately 6,500 deaths per year. Some cancers are higher than the England average e.g., lung cancer by 24%; head and neck cancers by16%; ovarian cancer by 7%; and stomach cancer by 6%.	Residents are more likely to develop cancer and less likely to survive than residents in other London boroughs and England. They have the lowest net survival amongst London and West Essex Clinical Commissioning Groups.
28.5% of the population of Nottingham are from Black and Minority Ethnic groups compared to 14.6% in England. The Muslim population is diverse and from various ethnicities including Pakistani, Arab, African, Indian, and Bangladeshi - making up approximately 9% of the Nottingham population. Nottingham has a high rate of migration, with 15.1% of the population having arrived in the UK since 1991. The city attracts young	49.5% of the population of Leicester are from Black and Minority Ethnic groups compared to 14.6% in England. Leicester has one of the country's largest Asian communities (37% of the population), with 28% of all residents defining themselves as of Indian heritage. Over two thirds of Leicester's school children are from minority ethnic backgrounds.	The ethnic make-up of Greater Manchester's districts varies. Manchester is the most ethnically diverse district, with 51.3% of the population from an ethnic minority. Oldham and Bolton are the next most diverse districts (34.8% and 31.2% of their population from an ethnic minority respectively). Overall, the 2021 census estimated that 28.7% of Greater Manchester's population was from an ethnic	A diverse population, with 25.9% identifying as Asian, Asian British or Asian Welsh; 21.4% as Black; Black British; Black Welsh; Caribbean; or African; 44.9% as White; and 4.3% as Mixed or Multiple ethnic groups

Nottingham	Leicester	Greater Manchester	Barking & Dagenham
adults through international and domestic migration. In Nottinghamshire, around 38% do not meet the recommended physical activity guidelines for adults, with 114,000 (14%) adults doing no physical activity at all. People in lower socio-economic groups (including Nottingham City) are the most likely to be inactive (33%) and the least likely to be active (54%). Physical Activity levels also decrease as deprivation increases, from 72% active in the least deprived areas, to 57% in the most deprived areas.	The 2020/21 Active Lives Survey shows higher rates of inactivity in Leicester compared to England generally. 36.8% of Leicester's population aged 16+ did less than 30 minutes of physical activity per week and are therefore classed as physically inactive compared to 27.2% in England overall.	minority, higher than the England average of 26.5%. Results from the Active Lives Survey (2019/20) shows a downturn in activity levels, which also sit below the national average. However, the region sees 72.0% of adults moving (active and fairly active). There are clear differences between boroughs (11.4% between the most active, Trafford, and the least active, Bolton). Inactivity has also gone up since 2015/16 for three ethnic groups: Black (+9.1%), South Asian (+7.7%) and Other (+4.3%). The inactivity socio-economic gap in GM is 19.4%.	Barking and Dagenham has higher levels of inactivity adults than the rest of London and Great Britain. Lower rates of active children and young people in Barking and Dagenham (44%) than the London average (46%). Rates of fitness activities, walking, cycling, and active travel are lower than the London average. These areas have a higher percentage of adults who are described as inactive (less than 30 minutes of physical activity a week): 1) The areas of north of Chadwell Heath (35%) 20 North-east of Becontree, north of Valence, and west of Valence (34%); and 3) Heath and north-east of Eastbrook & Rush Green (34%)
There is a great interest from community leaders and organisations but there are many complex barriers. The EDI team is actively working with communities to find solutions.	Engagement with local community leaders and organisations through an innovative '*cancer clinical research afternoon*' held at the Belgrave Neighbourhood Centre revealed strong demand for physical activity programmes, particularly those tailored to cultural needs.	The Regional Ambassador has made many significant contacts, including becoming a patient representative Greater Manchester Cancer Prehab4Cancer initiative. Axiomatically there is a strong demand for physical activity programmes.	The Regional Ambassador has identified a number of potential volunteers within diverse communities, who are keen to act as 5K YW Ambassadors.

Nottingham	Leicester	Greater Manchester	Barking & Dagenham
Nottingham is ranked 11th most deprived out of 317 Lower Tier Local Authorities in England. 56 of the 182 City Lower Super Output Areas (LSOAs) (30.8%) fall amongst the 10% most deprived in the country. 29.5% of children (under 16 years) live in low-income families in Nottingham, compared to 17.0% in England.	Leicester is ranked 22nd most deprived out of 317 Lower Tier Local Authorities in England. 23.4% of children (under 16 years) live in low-income families in Leicester, compared to 17% in England.	In the 2019 Index of Multiple Deprivation Manchester ranks 6th rank among England's most deprived areas, with 33.6% of Manchester residents over 60 experience income deprivation. Additionally, 50% of its Lower Super Output Areas (LSOAs) were in the top 10% most deprived nationally. In 2021, 58.3% of children and young people in Greater Manchester lived in the 30% most deprived LSOAs nationally.	

Sources:

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https://www.gmmoving.co.uk/data-and-learning/greater-manchester-adult-activity-levels-may-2019-20/#:~:text=The%20inactivity%20socio%2Deconomic%20gap,a%20Black%20background%20(46.2%25).

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https://www.nottinghamshire.gov.uk/media/1727148/nottinghamshireareaprofile.pdf

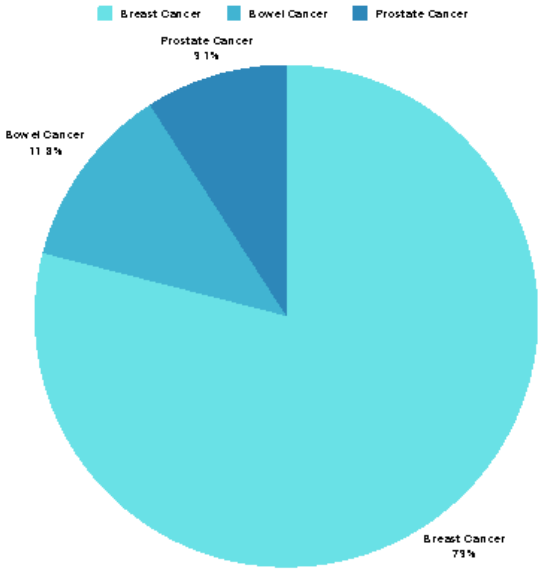
Appendix 1

February 4th 2024

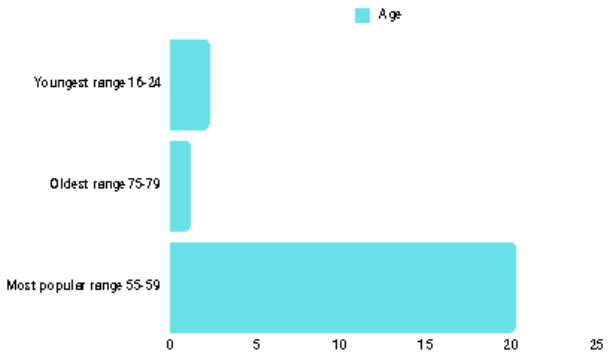
MOVE Against Cancer Charity: Diversity Survey

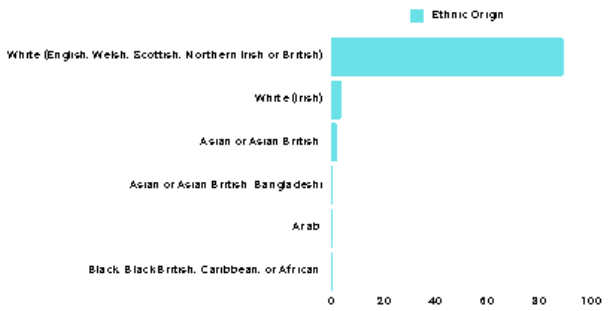
Please find the key findings from our survey below:

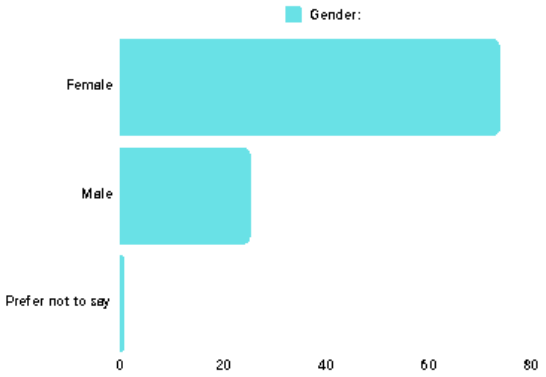
CANCER

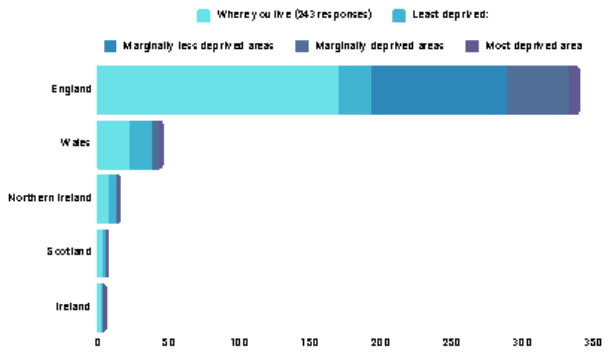


DEMOGRAPHICS









Thank you for your participation! More detailed report coming soon.

Appendix 2: Move Against Cancer Flyer

Our 3 key areas of work are:

5K Your Way Initiative

Our 5k Your Way groups encourage those living with and beyond cancer, families, friends and those working in cancer services to walk, jog, run, cheer or volunteer with a 5k Your Way group at a parkrun event on the last Saturday of every month. Visit www.moveagainstcancer.org to find out more and locate your nearest group.

Online 8 week support programme

Available to children and young people between the ages of 13-30 living with or beyond cancer. The programme is an 8-week online building foundations programme led and designed by MOVE cancer rehab specialists. Email the team via onlinesupport@movecharity.org

Move Against Cancer Podcast and online resources

- The Move Against Cancer Podcast aspires to support and inspire people to move, exercise and live an active and fulfilling life despite a cancer diagnosis.

- The Move Against Cancer YouTube channel includes workshops on topics such as cancer related fatigue & exercising during chemotherapy.

- 'Move Your Way' sessions delivered by cancer rehab specialists and blogs from members of our community, guests and experts.

SCAN ME