The Health and Well-Being of People from Pakistani, Indian, African and Caribbean Backgrounds in Greater Glasgow

a report of research carried out on behalf of
Greater Glasgow NHS Board

by

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1 Executive Summary

This report summarises the research findings from a health and well-being survey of people from African, Caribbean, Indian and Pakistani backgrounds living in Greater Glasgow. The research was commissioned because the most recent general population health and well-being survey (RBA, 2002) was not designed to yield sufficient information on the health and well-being of minority ethnic communities in Greater Glasgow. A similar survey of Greater Glasgow Chinese community was also conducted on behalf of the Chinese Healthy Living Centre (FMR Research, 2004). This study employed a culturally sensitive methodology to obtain information on a number of indicators of health / mental health and well-being, as well as broader issues relating to service delivery, community involvement, home and environment, personal details, and experiences of racism. Purposive sampling techniques were employed and the sample (overall n=611) was stratified by age and gender according to 2001 minority ethnic census figures and geographic location. A team of minority ethnic fieldworkers, drawn from the respective minority ethnic populations, collected data with respondents’ informed consent, and informants were reimbursed for participating in the research. Fieldworkers were trained to help ensure standardised data collection.

Key research findings are summarised below. Where comparisons to the general population are made, these refer to the Glasgow-wide study conducted by RBA (2002). It should be borne in mind that the minority ethnic communities sampled in this research have a younger age-profile than the general population, and differences in findings between the current survey and that of the general population may be a consequence of this.

General Health

Respondents from Pakistani backgrounds tended to have the most negative perceptions regarding their general health and well-being, and also reported the most contact with service providers. For example, Pakistani respondents reported receiving treatment for a significantly greater number of conditions and illnesses than their Indian and African and Caribbean counterparts. African and
Caribbean respondents, in contrast, tended to have more positive self-perceptions regarding their general health, with 8% of African and Caribbean participants saying that they had a long-term condition that substantially interfered with day-to-day activities, compared to 19% of Pakistani and 18% of Indian informants.

**Oral Health**

Uptake of dental healthcare was lower in all minority ethnic groups sampled than in the general population, and Pakistani respondents were less likely to say that they brushed their teeth twice daily than the general population and the other ethnic groups participating in this survey. African and Caribbean respondents (89%) were significantly more likely than Indian (78%) and Pakistani respondents (77%) to say that all of their teeth were their own. At the same time, African and Caribbean (32%) respondents were less likely than Pakistani (50%) and Indian (40%) to say that they had visited a dentist within the six months preceding the interview. The finding that across ethnic groups, participants in this survey (62%) were less likely than the general population (67%) to have attended a dental surgery in the 15 months prior to being interviewed suggests that there may be a particular need to encourage minority ethnic communities in Greater Glasgow to visit (and/or register with) a dentist.

**Mental Well-Being**

In terms of mental well-being, Indian participants consistently scored lower on a range of measures of psychological distress than their Pakistani and African and Caribbean counterparts (i.e. indicated more positive mental well-being overall). For example, Pakistani respondents consistently reported the highest levels of perceived stress. Whilst, in contrast, African and Caribbean (20%) reported the lowest levels of perceived stress, they were more likely than Pakistani (16%) and Indian (12%) informants to have scores indicative of diminished psychological well-being using the General Health Questionnaire - 12 (GHQ-12). African and Caribbean respondents were also most likely to say that they did not feel in control about decisions affecting their lives. Elevated GHQ-12 scores were
associated with self-reported experiences of racism in all minority ethnic groups participating in this research.

**Satisfaction with Health Services and Perceived Need for Health Related Information**

Participants aged 50+ years were more likely than their younger peers to be satisfied with health services in all minority ethnic groups; examples include perceived ease of access to health service providers, feeling adequately informed about treatments for conditions and illnesses, and with feeling that they have a ‘say’ in how services are delivered. At the same time, however, respondents aged 50+ years were more likely than younger participants to report language barriers in understanding the advice given and in getting their views across. Moreover, Pakistani respondents reported more language difficulties both in terms of understanding the advice given as well as getting their views across than African and Caribbean survey participants. Independent of participant age, Indian informants felt that service providers understood their views and circumstances to a greater degree than did their Pakistani and African and Caribbean contemporaries.

There was a perceived need for more health-related information to be made available, in particular amongst participants from African and Caribbean backgrounds. Respondents from African and Caribbean backgrounds, who tended to have lived in the Greater Glasgow area for less time than Pakistani and Indian participants, were more likely than participants from other minority ethnic backgrounds surveyed to say that they required general information on NHS services and procedures.

The great majority of participants wanted health-related information to be made available in English. Additionally, survey findings suggest that this type of information should also be made available in Punjabi and Urdu, in particular when targeted at individuals from Pakistani and Indian backgrounds aged 50+ years. Widespread distribution of information via the postal services was found to be a popular distribution strategy amongst survey participants.
Diet

Self-reported intake of fruit and vegetables was particularly low amongst Pakistani respondents, whilst African and Caribbean respondents reported relatively high overall levels of fruit and vegetable consumption. Thus 19% Pakistani respondents reported eating the recommended amount of five or more portions of fruit and vegetables, compared to 34% of the general population, 33% of Indian and 47% of African and Caribbean respondents. Future research should investigate this finding further to determine whether low-levels of self-reported fruit and vegetable consumption are an artefact of distinct styles of food preparation and the manner in which fruit and vegetables are utilised in cooking practices.

Other findings indicated that individuals of Pakistani backgrounds reported relatively higher consumption levels of sweet foods, a significant predictor of excess body weight. Indian participants were least likely to meet the Scottish Diet Plan target of eating oily fish at least two times per week. The need for culturally sensitive Scottish Diet Plan guidelines with regards to recommended amounts of breakfast cereal and bread consumption, in particular, also emerged as part of the research process.

Physical Activity

Pakistani (32%) respondents were less likely than Indian (50%) and African and Caribbean (45%) respondents to undertake the recommended amount of physical activity per week, either five periods of moderate exercise for at least thirty minutes, or doing three sessions of at least twenty minutes vigorous exercise. This finding suggest that the general population, 58% of which reported meeting this target in 2002, appear to be more physically active than the minority ethnic groups participating in this survey.
Body Mass Index

Results relating to Body Mass Index (BMI) indicated that respondents in this survey had a similar likelihood of being classified as overweight as the general population. Regardless of their respective ethnic backgrounds, participants aged 30-49 years were significantly more likely to be classified as overweight than those aged 16-29 and 50+ years. Amongst other factors, elevated BMI scores were associated with treatment for medical conditions, self-reported stress, low levels of physical activity and eating sweet foods.

Findings also suggested that Pakistani (13%) and African and Caribbean (12%) respondents were significantly more likely than Indian informants (4%) to be classified as either obese or extremely obese. Regardless of their ethnic background, participants aged between 16 and 29 years (3%) were less likely than those aged 30-49 (12%) and 50+ (16%) years were less likely to be classified in this way. Across all participating minority ethnic groups men (7%) were less likely to be classified as obese / extremely obese than women (13%). This gender difference was also found in the general population survey.

Smoking and Alcohol Consumption

It should be borne in mind that levels of reporting alcohol and smoking behaviour may reflect socio-cultural sensitivities and may have also been influenced by data being collected by minority ethnic fieldworkers since responses may have been socially desirable rather than ‘truthful’. Recognising these social and cultural sensitivities, 22% of Pakistani, 11% of African and Caribbean, and 10% of Indian participants in this survey said that they smoked, compared to 33% of the general population in 2002. The current survey also found a tendency for smoking to be more common amongst respondents aged 50+ years than amongst those aged less than 50 years. In terms of passive smoking no differences between participants in this survey and the general population emerged, although this survey found exposure to cigarette smoke to be the most frequent response to an open-ended question concerned with perceived adverse effects of participants’ homes on their health.
Self-reported alcohol consumption was low in all ethnic groups, and in particular for female respondents. Thus 91% of Pakistani (85% of males and 97% females) of 57% Indian (34% of males and 79% of females) and 60% of African and Caribbean (56% of males and 64% of females) participants said they never consumed drinks containing alcohol. Moreover, the number of participants who said that they had consumed an alcoholic drink in the month preceding the interview (7% of the entire sample reporting very low levels of alcohol consumption) was not sufficient to be analysed meaningfully in terms of units of alcohol consumed.

Individual Circumstances, Feelings Towards Local Areas and Perceptions of Identity

With regards to indicators of financial well-being, African and Caribbean communities in Greater Glasgow were found to be less well off financially than Pakistani and Indian communities. Thus African and Caribbean respondents were significantly more likely than Pakistani and Indian respondents to say that all of their household income was derived from state benefits, and payment of an unexpected bill would be more difficult. Across ethnic groups, 67% of participants in this survey said that they were not in receipt of any state benefits, compared to 43% of the general population. Moreover, among this sample, participants who had lived in Greater Glasgow for a comparatively longer length of time were less likely to be in receipt of state benefits regardless of their ethnic background.

Respondents from Indian and Pakistani backgrounds were more likely than African and Caribbean participants to have Internet access in their homes, perhaps an indicator of financial well-being. Overall however, 62% of Pakistani, 71% of Indian and 79% of African and Caribbean respondents reported having access to the Internet, indicating other points of access for the latter group. This also has relevance in terms of access to health-related information.

On average, African and Caribbean were significantly less likely to report feelings of connectedness towards the local areas in which they lived, perhaps reflecting shorter periods of residence in Glasgow (mean=6 years) compared with their
Pakistani (mean=17 years) and Indian (mean=17 years) contemporaries. Thus African and Caribbean informants trusted people living in their area to a lesser degree and also felt comparatively less safe. With 52% of African and Caribbean informants living in single-person households (compared to 19% of Indian and 15% of Pakistani respondents, and 20% of the general population), they were also the most likely to say that they felt isolated from friends and family. Moreover, these participants reported significantly more incidences of racism and discrimination than Indian and Pakistani participants.

These findings may go towards explaining why African and Caribbean respondents were also found to identify with being Scottish/British less strongly than both their Pakistani and Indian counterparts. African and Caribbean participants were also significantly more likely than Indian and Pakistani informants to act as volunteers and to be members of community groups, potentially valuable sources of social support in light of feelings of discontentment outlined above.

With regards to ethnic identity, which may buffer against adverse effects of perceived discrimination, findings indicated that regardless of ethnic background respondents who were aged 50+ years identified less strongly with their respective ethnic backgrounds than those aged 16-49 years.

**Conclusions**

NHS Greater Glasgow encompasses the highest proportions of minority ethnic communities in Scotland, and an overriding priority is to tackle health inequalities, with explicit linkages between health and social inclusion agendas. This study has provided a snap shot of health and well-being issues among three of the larger minority ethnic communities, identifying areas of concern as well as positive factors, which will inform planning and identify areas for future research. It also provides a baseline against which to measure changing issues and the impact of initiatives aimed at improving the health and well-being of minority ethnic communities in Greater Glasgow.
2 Introduction and Methodology

2.1 Background

Greater Glasgow NHS Board (GGNHSB) commissioned this piece of research concerned with the health and well-being of minority ethnic communities in Greater Glasgow with the aim of expanding on previous studies conducted in this area. Earlier general population surveys did not provide sufficiently large sample sizes of minority ethnic populations in Greater Glasgow to allow for an adequate description of health and well-being and service issues among these groups or to enable meaningful comparisons to be drawn with the population at large.

The research aimed to provide information on indicators of health and well-being in Pakistani, Indian, African and Caribbean communities living in Greater Glasgow, and commissioning this study is part of a broader strategy to monitor the impact of health initiatives over time with the aim of meeting local and national targets. Bearing in mind well-documented inequalities in health and well-being experienced by minority ethnic communities (e.g. Karlsen and Nazroo, 2002; Modood et al., 1997; Nazroo, 1997), this research is part of GGNHSB’s ongoing commitment to address the health and health service needs of black and minority ethnic people living in Greater Glasgow (e.g. Roshan, 2002; GGNHSB, 2002).

2.2 Research Objectives

Specifically, the study reported here aimed to provide information on health and well-being issues among minority ethnic communities in GGNHSB area, namely members of the Pakistani and Indian community and the African and Caribbean communities. Recently, the Chinese Healthy Living Centre conducted a similar exercise in the Chinese community. Based on a questionnaire derived from the Health and Well-being Study questionnaire (see Appendix) used in the general population, it obtained data utilising a culturally sensitive approach on:

- Indicators relating to progress towards local and national targets.
- Indicators to inform local service delivery.
- Indicators measuring social connectedness and personal circumstances.
The information collected was intended to allow for the description of the health and well-being of these communities together with identification of specific health needs and service issues, and enable comparison with the population of Greater Glasgow as a whole.

2.3 Method

2.3.1 Recruitment of Participants

A quota sample was derived (Arber, 1993; Creswell, 1994; Haslam and McGarthy, 2003; Babbie, 1992) based on 2001 census figures (e.g. Scottish Executive, 2004; General Register Office for Scotland, 2003) for Greater Glasgow (e.g. Minority Ethnic Census Data, 2001) comprising 350 Pakistani and Indian and 200 African and Caribbean respondents. Participants were recruited utilising purposive sampling techniques on the basis of convenience and availability of respondents (Babbie, 1992), bearing in mind difficulties (e.g. the lack of appropriate sampling frames) of sampling minority ethnic populations randomly (McGraw et al., 1992; Hughes et al., 1995).

Building on our existing links with minority ethnic community groups and individuals and making use of our research experience in this field, participants were recruited through a variety of approaches. Potential respondents were approached on the street and in areas frequented by minority ethnic individuals at different times during the day and evening. Additionally, we employed ‘snowballing’ methods of participant recruitment, and approached community organisations, groups and individuals to facilitate this.

Care was taken to ensure that participants were recruited via different social networks. Data collection was monitored on a continuous basis to stratify the sample in terms of age, gender and geographic area.

Respondents were interviewed at a time and place convenient to themselves, within the constraints of interviewer safety. Fieldworkers received research training (see below) that emphasised the desirability of conducting interviews in locations (e.g. community centres, cafes) that maximise the likelihood of obtaining ‘private’ responses (Malseed, 1990). Our budgeting allowed for
fieldworkers to pay for expenses (e.g. taxi fares, light refreshments) incurred by selection of appropriate venues.

Participants were offered reimbursement of £10.00 in recognition of time and expense involved. A fee is now commonly offered to participants in research studies conducted in the Departments of Psychology and Marketing (and approved by respective ethics committees). Remuneration is likely to have had a positive impact on response rates, but the sum was not considered significantly large enough to coerce individuals into participation. Furthermore, bearing this ethical consideration in mind, and the fact that fieldworkers were being paid to conduct interviews, offering respondents reimbursement also went towards addressing equality between the participants and researchers, in recognition of their contribution to the study. Respondents were asked to sign a receipt that was sealed in an envelope and kept separately from the data obtained.

The research team and a representative from GGNHSB acted as arbitrators between participants and fieldworkers and received a number of calls from concerned participants. These phone calls were exclusively concerned with participants’ worries about complete confidentiality, and were relatively evenly spread among participating ethnic groups. More specifically, participants’ unease centred predominantly on the possibility that individual responses could be identified as a result of signing the consent and receipt forms. In the main these participants were afraid that their responses would be made available to immigration officials since some participants said that they had ‘unresolved issues’ with relevant authorities. Other interviewees expressed concerns about details of income sources being passed on to government departments dealing with benefits.

Before considering the research findings in more detail it is thus important to note that - despite guarantees of anonymity - some participants may have been reluctant to disclose personal information of this nature accurately. From this perspective, the number of concerned phone calls from participants worried about their personal details being passed on to authorities may have been an informally derived measure of concerns of this nature. Other participants, in turn, may therefore have chosen not to give accurate information in the first place.
A relatively large number of phone calls were also received from participants wanting to become involved in the research as fieldworkers, and a few minority ethnic organisations that were approached with the aim of participant recruitment also called to verify that fieldworkers were genuine.

2.3.2 The Sample

The final samples obtained are outlined below with overall figures for Greater Glasgow. Figure 2.1 illustrates the areas of Greater Glasgow most densely populated by people from Indian and Pakistani backgrounds and Figure 2.2 outlines the areas of Greater Glasgow most densely populated by the African and Caribbean communities.
Figure 2.1. The Indian and Pakistani communities in Greater Glasgow by postcode sector.
Figure 2.2. The African and Caribbean communities in Greater Glasgow by postcode sector.
The overall age profile of the minority ethnic communities taking part in this survey is younger than that of the Greater Glasgow population as a whole. This is made clear in Tables 2.1-2.3 below which also summarise the age profile of the Greater Glasgow general population according to the 2001 census. It is also important to note that the official census figures of minority ethnic groups may not be as accurate as might be hoped for, and there is dispute between Glasgow City Council and the Scottish Executive regarding the size of the population (including minority ethnic groups) in Glasgow (General Register Office for Scotland, 2003).

Bearing these limitations in mind, Tables 2.1-2.3 also provide the official 2001 Greater Glasgow census figures for the respective minority ethnic groups. The achieved samples are broken down by participant gender and age. It will become apparent that there are some slight discrepancies between the figures obtained and the census data. Whilst these discrepancies and the lack of an accurate sampling frame may make it impossible to be certain of the extent to which the sample is fully representative of the populations, the analysis by age and gender will go towards controlling for this potential limitation.

The target numbers, as detailed in the research brief, stipulated samples stratified age and gender with 200 Pakistani, 150 Indian, 160 African and 40 Caribbean individuals. As is illustrated in the Tables below, in terms of the total numbers of participants the intended sample sizes were exceeded with a total of 610 individuals volunteering to participate in the research. In particular, the achieved African and Caribbean sample size is noticeably larger than that targeted initially. As a result of difficulties in recruiting sufficient numbers of Caribbean respondents \(n<30\), it was decided on pragmatic grounds to combine these ethnic groups into an ‘African and Caribbean’ sample.

The Pakistani sample is summarised in terms of its age and gender makeup in Table 2.1.
Table 2.1. Age and gender breakdown of the Pakistani sample.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male (n=110)</th>
<th>Female (n=101)</th>
<th>Both Genders (n=211)</th>
<th>Greater Glasgow Pakistani Population</th>
<th>Greater Glasgow General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>29%</td>
<td>23%</td>
<td>26%</td>
<td>28%</td>
<td>16%</td>
</tr>
<tr>
<td>25-34</td>
<td>23%</td>
<td>29%</td>
<td>26%</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>35-44</td>
<td>16%</td>
<td>21%</td>
<td>18%</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td>45-54</td>
<td>21%</td>
<td>17%</td>
<td>19%</td>
<td>12%</td>
<td>15%</td>
</tr>
<tr>
<td>55-64</td>
<td>8%</td>
<td>9%</td>
<td>9%</td>
<td>7%</td>
<td>12%</td>
</tr>
<tr>
<td>65+</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
<td>5%</td>
<td>18%</td>
</tr>
</tbody>
</table>

The Indian sample is summarised in Table 2.2

Table 2.2. Age and gender breakdown of the Indian sample.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male (n=74)</th>
<th>Female (n=81)</th>
<th>Both Genders (n=155)</th>
<th>Greater Glasgow Indian Population</th>
<th>Greater Glasgow General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>20%</td>
<td>25%</td>
<td>23%</td>
<td>23%</td>
<td>16%</td>
</tr>
<tr>
<td>25-34</td>
<td>31%</td>
<td>31%</td>
<td>31%</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>35-44</td>
<td>15%</td>
<td>15%</td>
<td>19%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>45-54</td>
<td>23%</td>
<td>15%</td>
<td>19%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>55-64</td>
<td>7%</td>
<td>6%</td>
<td>7%</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>65+</td>
<td>4%</td>
<td>9%</td>
<td>7%</td>
<td>8%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Finally, Table 2.3 details the achieved African and Caribbean sample.

Table 2.3. Age and gender breakdown of the African and Caribbean sample.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male (n=125)</th>
<th>Female (n=119)</th>
<th>Both Genders (n=244)</th>
<th>Greater Glasgow African &amp; Caribbean Population</th>
<th>Greater Glasgow General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>13%</td>
<td>19%</td>
<td>16%</td>
<td>22%</td>
<td>16%</td>
</tr>
<tr>
<td>25-34</td>
<td>36%</td>
<td>33%</td>
<td>34%</td>
<td>33%</td>
<td>20%</td>
</tr>
<tr>
<td>35-44</td>
<td>34%</td>
<td>27%</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>45-54</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>12%</td>
<td>15%</td>
</tr>
<tr>
<td>55-64</td>
<td>7%</td>
<td>9%</td>
<td>8%</td>
<td>5%</td>
<td>12%</td>
</tr>
<tr>
<td>65+</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>4%</td>
<td>18%</td>
</tr>
</tbody>
</table>
2.4 Interviews, Questionnaire and Data Collection

2.4.1 Fieldworker Recruitment

Conducting interviews through interpreters has been criticised for compromising the quality of the data and using bi-, or multilingual, researchers is generally preferred (McGraw et al., 1992: 283). Additionally, researchers are advised strongly to involve study communities in the entire research process and ensure diversity among researchers (McGraw et al., 1992; Gil and Bob, 1999), for example, by recruiting minority ethnic postgraduate students as co-researchers (Casas and Thompson, 1991) and building a research team with members of minority ethnic groups sampled (Atkinson, 1993).

With this in mind, we built a multi-ethnic fieldwork team that included both males and females. This was developed in three ways. First, we drew on our existing pool of multi-lingual interviewers who have contributed to earlier studies. Second, we recruited by email among postgraduate students from the University of Strathclyde MSc marketing courses which have an international intake of students, including those from Indian, Pakistani and African and Caribbean backgrounds. Third, we approached community groups and individuals with the aim of recruiting fieldworkers.

Thus the fieldwork team comprised 23 workers overall, including males and females, competent in a mix of relevant languages, and with ages ranging from 16 years to 40 years. All fieldworkers were from Pakistani, Indian and African backgrounds. Potential respondents were offered the opportunity to be interviewed in the language of their choice and any concerns over fieldworker gender could be accommodated.

2.4.2 Fieldworker Training

Socio-cultural sensitivities in relation to the target populations and the topic area necessitates that interviewers comprehend and are comfortable with the
questionnaire and develop a range of interview strategies. Interviewers were therefore given a comprehensive research training that promoted an awareness of the sensitive nature of this research and prepares them for the challenges faced. The training allowed for familiarisation with research aims and methodology to facilitate standardised data collection, and covered the following areas: ethical considerations, sampling, consistent data collection (minimisation of random and systematic errors), attaining ‘private’ responses, rapport building, probing/rephrasing, situational problems, ‘problem’ respondents, selection of interview locations, taking field notes, impression management, safety, fieldworker fatigue, familiarisation with research instruments (including role-play trials) and support mechanisms (Gilbert, 1993; Creswell, 1994).

Special emphasis was given to consideration of the socio-cultural characteristics of the target communities and cultural sensitivities in relation to health surveys (McGraw et al., 1992). To this end we invited representatives from the Pakistani, Indian, African and Caribbean communities to the research training, and asked members of our fieldwork team from the respective communities to contribute. Fieldworkers and community representatives were paid to contribute and take part in the research training.

2.4.3 Questionnaire Design

The aims of the study meant that, in order to allow meaningful comparisons, much of the questionnaire should as far as possible duplicate questions from the Glasgow-wide general population health and well-being study as well as the survey of the Chinese community. Thus question areas included:

Health

• Personal health conditions
• Use of health services
• Lifestyle factors (e.g. smoking, diet, exercise)
• Quality of life

Community Involvement

• Participation / volunteering in local groups
**Home and Environment**

- Access to telephone / internet
- Impact of home conditions on health
- Feelings of neighbourliness / personal safety
- Experience of racism

**Personal Details**

- Health information needs and preferred format / communication routes
- Education experience and confidence in spoken and written languages
- Indicators of financial and employment status
- Family and household composition and care roles
- Birthplace and nationality

However, it was also important to include questions that would reflect issues specific to the study populations, such as experiences of racism and so on. The questionnaire was developed with the support of the Steering Group and was piloted among members of the appropriate communities.

Interviews were conducted in participants’ preferred language, which may not have been English, and it was therefore essential that the questionnaire be translated appropriately. Following best practice in minority ethnic and cross-cultural epidemiological research, but also recognising resource limitations, a modified back translation was used. The original instrument was translated into Urdu, Hindi, Punjabi and French. We then had different fieldworkers verbally translate these versions back into English, allowing for their comparison and scrutiny. This helped ensure that the research instrument was appropriate to the target groups in terms of use of languages, and did not make inappropriate use of ‘high’ forms of the languages in translation when more colloquial forms may be more appropriate (Bhopal et al., 2004). This procedure also helped to ensure that translations were equivalent in meaning and measurement in each of the languages (Brislin, 1993). This is vital since responses obtained needed to be conceptually alike to maximise reliability and validity, allowing for legitimate comparisons of responses across target groups (Bhopal et al., 2004; McGraw et al., 1992).

With the aim of enhancing reliability and validity and helping ensure equivalent responsiveness across target groups, the research instruments were revised, as
appropriate, in consultation with lay people from respective minority ethnic communities. Additionally, the instruments were piloted on individuals (males and females of different ages) from each of the target populations with the aim of ensuring their comprehensibility, and minimising the likelihood of questions being socially, culturally or religiously inappropriate, offensive or irrelevant (Bhopal et al., 2004). A number of changes to the translated versions were following these procedures to help ensure that the different language versions were as equal in meaning as was achievable.

In practice, the majority of interviews in the older age groups in the Pakistani and Indian samples were conducted in a language other than English. A number of interviews with Pakistani and Indian respondents were also conducted in English with interviewers making use of translated versions of the questionnaire in addition to the English version. Almost all of the African and Caribbean participants were interviewed in English.

2.5 Ethical Issues

The research team was aware of ethical issues involved in research in general and working with black and minority ethnic communities and were committed to adhering to established ethical standards. The research was conducted in accordance with the University of Strathclyde’s Code of Practice on Investigations on Human Beings (2000) and ethical approval was obtained from the University’s Ethics Advisory Committee following minor amendments to the information sheet, consent form and questionnaire.

Potential participants were given a study information sheet in appropriate languages summarising the aim of the research, stressing its confidential nature and stating that respondents were free to terminate involvement at any point without giving a reason. It also clearly stated that all information collected would be made anonymous and that data would only be reported in aggregate form. The information sheet also stated that data might be used for future analysis and that confidentiality and anonymity would always be ensured. It also contained contact telephone numbers for the research team to give respondents the opportunity to make further enquiries and to comment on the study.
Participants were given the opportunity to ask questions about the study. To help ensure informed consent, participants were asked to sign a consent form (also written in appropriate languages) and tick ‘yes’ or ‘no’ boxes to indicate they had read the information sheet, had the opportunity to ask questions, and understood they could withdraw and that information would remain confidential. The signed consent form was sealed in an envelope and kept separately from data obtained. For quality control purposes, where participants were happy to provide a contact telephone number to facilitate back checking of interviews, this was sealed in an envelope and kept separately from data. We contacted more than 10% of participants to confirm that interviews had been undertaken, and that key data were collected accurately.

The data were collated on a computer database in secure files accessible only to main researchers. In the interest of complete confidentiality no personal information such as a person’s name or initials was recorded on that database. A unique research number was assigned and only this was entered into the database along with age, gender, ethnicity, and other data obtained.

2.6 About the Report

The findings detailed in this report are summarised in the following chapters:

- Perceptions of Health and Illness
- Health Services: Use and Satisfaction
- Health Behaviours
- Social Health and Capital (including individual circumstances)

In addition, the final chapter, general conclusions, draws together the principal research findings at a more abstract level with the aim of making recommendations for improving the health and well-being of minority ethnic individuals and communities in Greater Glasgow.

All data underpinning this report were analysed inferentially as a function of ethnicity, participant age and gender using SPSS. This helped ensure that the minority ethnic groups sampled were not treated as homogenous, and that
analysis would allow for consideration of more specific circumstances and characteristics. Additional analysis linked key indicators of (mental) health and well-being to perceptions of: (i) personal wealth, (ii) social isolation and living conditions, (iii) experiences of racism, (iv) educational attainment and employment status. The report details statistically significant differences (p<0.05) between variables, in addition to providing descriptive statistics.

Where comparison is made with the population of Greater Glasgow, this refers to the study conducted by RBA (2002).
3 Perceptions of Health and Illness

3.1 Self-Perceived Health and Well-Being

3.1.1 General Health

Indian and African and Caribbean participants in this survey had more positive self-perceptions of their health than the Greater Glasgow population and Pakistani participants in this survey. In Greater Glasgow 67% of respondents rated their general health as ‘Excellent’ (24%) or ‘Good’ (43%). By comparison, 86% of African and Caribbean and 76% of Indian interviewees rated their health as either excellent or good. Pakistani participants (65%), on the other hand, were very similar to the general population. Table 3.1 summarises the ratings obtained in this survey.

Table 3.1. Participants’ responses to the question ‘how would you describe your health over the past year’ by ethnicity.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=210)</th>
<th>Indian (n=155)</th>
<th>African &amp; Caribbean (n=244)</th>
<th>Entire Sample (n=609)</th>
<th>Greater Glasgow (n=1802)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>23%</td>
<td>31%</td>
<td>40%</td>
<td>32%</td>
<td>24%</td>
</tr>
<tr>
<td>Good</td>
<td>42%</td>
<td>45%</td>
<td>46%</td>
<td>44%</td>
<td>43%</td>
</tr>
<tr>
<td>Fair</td>
<td>28%</td>
<td>19%</td>
<td>12%</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Poor</td>
<td>7%</td>
<td>6%</td>
<td>2%</td>
<td>5%</td>
<td>15%</td>
</tr>
</tbody>
</table>

There was a clear and significant trend whereby positive self-perceptions of general health decreased with age. This is illustrated in Figure 3.1.
Further analysis indicated no differences in this trend as a function of gender. However, across age groups, Indian and African and Caribbean respondents tended to have more positive perceptions of their general well-being than do Pakistani respondents.

### 3.1.2 Self Perceived Physical, Mental/Emotional Well-Being and Overall Quality of Life

Participants were asked to rate their overall quality of life; their physical and mental/emotional well-being with the aid of the following ‘faces scale’.

When the first three ‘smiley’ faces were combined into a ‘positive perception’ category, 94% of the sample rated their overall quality of life positively, whilst 93% rated their physical well-being positively, and 90% of the overall sample rating their mental/emotional well-being positively. The face rating did not differ significantly as a function of ethnicity, age, or gender. When the data were
analysed as a seven-point continuous scale from 7 (positive) to 1 (negative), no significant gender, age or ethnicity differences emerged. The mean ratings across ethnic groups are summarised in Table 3.2.

<table>
<thead>
<tr>
<th></th>
<th>Current Survey Mean (SD)</th>
<th>Greater Glasgow Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which face best rates your overall quality of life? (n=586)</td>
<td>6.09 (0.97)</td>
<td>5.56 (1.12)</td>
</tr>
<tr>
<td>Which face best rates your general physical well-being? (n=586)</td>
<td>6.02 (1.0)</td>
<td>5.24 (1.35)</td>
</tr>
<tr>
<td>Which face best rates your general mental or emotional well-being? (n=579)</td>
<td>5.97 (1.10)</td>
<td>5.45 (1.29)</td>
</tr>
</tbody>
</table>

### 3.2 Illness

#### 3.2.1 Treatment for Conditions

Participants were asked to indicate whether or not they were currently being treated for a number of conditions (see Table 3.3). Pakistani (mean=0.69, SD=0.07) participants reported being treated for significantly more conditions than did African and Caribbean (mean=0.4, SD=0.68) respondents. The mean number of conditions reported by Indian respondents for which they were currently receiving treatment was 0.64 (0.09). There were no significant gender differences in terms of number of conditions reported. However, the finding outlined above that the likelihood of positive perceptions of health decreased with age was mirrored by the finding that participants aged 50+ years (mean=1.44; SD=1.63) reported that they were being treated for significantly more conditions than both the younger age groups. Participants aged 16-29 years (mean=0.19, SD=0.44), in turn, reported being currently treated for significantly less conditions than those aged 30-49 years (mean=0.47; SD=0.9).
Table 3.3  Conditions currently treated for by ethnicity (number of participants in brackets).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pakistani % (n)</th>
<th>Indian % (n)</th>
<th>African &amp; Caribbean % (n)</th>
<th>Entire Sample % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>3 (7)</td>
<td>3 (4)</td>
<td>1 (2)</td>
<td>2 (13)</td>
</tr>
<tr>
<td>Stroke</td>
<td>2 (5)</td>
<td>1 (2)</td>
<td>0</td>
<td>1 (7)</td>
</tr>
<tr>
<td>Arthritis or rheumatism or painful joints</td>
<td>6 (13)</td>
<td>8 (12)</td>
<td>4 (9)</td>
<td>6 (34)</td>
</tr>
<tr>
<td>Clinical depression</td>
<td>3 (7)</td>
<td>2 (3)</td>
<td>1 (3)</td>
<td>2 (13)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>9 (19)</td>
<td>5 (8)</td>
<td>2 (5)</td>
<td>5 (32)</td>
</tr>
<tr>
<td>Cancer</td>
<td>0</td>
<td>1 (1)</td>
<td>1 (2)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Asthma, bronchitis, or persistent cough</td>
<td>6 (12)</td>
<td>6 (9)</td>
<td>3 (8)</td>
<td>5 (29)</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0</td>
<td>1 (1)</td>
<td>0</td>
<td>&lt;1 (1)</td>
</tr>
<tr>
<td>Stress related conditions (e.g. difficulty sleeping or concentrating)</td>
<td>5 (10)</td>
<td>7 (10)</td>
<td>3 (8)</td>
<td>5 (28)</td>
</tr>
<tr>
<td>Hearing problems</td>
<td>3 (6)</td>
<td>3 (5)</td>
<td>1 (2)</td>
<td>2 (13)</td>
</tr>
<tr>
<td>Eyesight problems</td>
<td>8 (17)</td>
<td>8 (13)</td>
<td>8 (19)</td>
<td>8 (49)</td>
</tr>
<tr>
<td>Accident / injury</td>
<td>1 (1)</td>
<td>4 (6)</td>
<td>1 (2)</td>
<td>2 (9)</td>
</tr>
<tr>
<td>Gastro-intestinal problems (e.g. peptic ulcer disease, irritable bowel syndrome)</td>
<td>5 (11)</td>
<td>2 (3)</td>
<td>3 (8)</td>
<td>4 (22)</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>11 (22)</td>
<td>8 (13)</td>
<td>7 (18)</td>
<td>9 (53)</td>
</tr>
<tr>
<td>Drug or alcohol related conditions</td>
<td>1 (1)</td>
<td>1 (2)</td>
<td>1 (2)</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Other/s</td>
<td>6 (13)</td>
<td>4 (6)</td>
<td>4 (9)</td>
<td>5 (29)</td>
</tr>
<tr>
<td>None</td>
<td>58 (121)</td>
<td>65 (100)</td>
<td>77 (188)</td>
<td>67 (409)</td>
</tr>
</tbody>
</table>

The mean number of conditions for which the Greater Glasgow population is currently being treated is 0.8 (SD=1.2). This is somewhat higher than was found in this survey.

Across the sample 21% of participants reported being treated for one condition, 5% of respondents reported being treated for two conditions, and 6% of interviewees reported being treated for three or more conditions. As Table 3.3 illustrates, there is a trend by which Pakistani interviewees report being treated for comparatively more conditions than Indian or African and Caribbean informants. Pakistani participants reported the most conditions for which they were currently receiving treatment, and African and Caribbean respondents the least (see also Figure 3.2). The latter were also the most likely to say that they were not being treated for any condition.
Figure 3.2. Percentage of participants reporting that they receive treatment for at least one condition by ethnicity and age.

N.B. Numbers of African & Caribbean participants in the 65+ years age category are very small.

3.2.2 Prevalence of Long-Term Conditions Interfering with Day-To-Day Activities

Figure 3.3 summarises the percentage of participants who reported suffering from distinct conditions (multiple responses were possible) that substantially interfered with day-to-day activities by ethnicity.

Figure 3.3. Percentage of participants reporting conditions /illnesses by ethnicity (multiple responses possible).
Analysis of the total number of participants reporting at least one condition suggests that 19% (40 participants) of Pakistani, 18% (28 participants) of Indian and 8% (19 participants) of African and Caribbean respondents said that they had at least one long-term condition or illness that substantially interfered with their day-to-day activities. In the Greater Glasgow population, which has an older age-profile than the populations surveyed in this piece of research, 23% of respondents reported having a long-term condition or illness that interfered with day-to-day activities. This percentage is only slightly higher than that of the Pakistani and the Indian informants in this survey. African and Caribbean participants, in contrast, reported suffering from substantially fewer conditions that interfered with day-to-day activities.

Consideration of the mean number of conditions reported by participants reveals the following picture. Across the sample, participants aged 16-29 years (mean=0.04, SD=0.23) reported significantly less conditions than those aged 30-49 years (mean=0.12, SD=0.36). Respondents aged 50+ years (mean=0.16, SD=0.4) reported significantly more conditions than both of the younger age groups. The comparable figures for Greater Glasgow suggest a similar trend. In the RBA survey (2002) respondents aged 16-20 years reported a mean of 0.29 (0.73) conditions/illnesses currently treated for, those aged 30-49 years reported 0.56 (0.99) conditions/illnesses, and those aged 50+ years reported 1.35 (1.4) illnesses/conditions. Additionally, across the sample, African and Caribbean participants (mean=0.08, SD=0.27) reported significantly fewer conditions than both Indian (mean=0.21, SD=0.48) and Pakistani (mean=0.21, SD=0.44) respondents.

As Figure 3.4 illustrates, the pattern of results also differed as a function of a combination of both age and ethnicity. In the youngest age group of 16-29 years Indian (mean=0.12, SD=0.38) participants reported significantly more conditions that interfered with day-to-day activities than their Pakistani (mean=0.01, SD=0.12) and African and Caribbean (mean=0.01, SD=0.11) counterparts. There were no significant differences between ethnic groups in the two older age groups.
3.3 Perceived Effects of Home on Health

Participants were asked whether there was anything about their home that affected their health, and those who felt that there was something about their home affecting their health were invited to give details. Results are summarised by gender and ethnicity in Table 3.4, and indicate that approximately 18% of the sample thought that something about their home affected their health adversely. Analysis indicated no significant differences in response patterns by age (16-29, 30-59, 50+ years age groups) or ethnicity. However, the difference between male and female participants was significant in African and Caribbean sample (see Table 3.4), whilst the Indian and Pakistani male and female participants did not differ in terms of their perceptions regarding whether anything about their home affected their health. Smoking in the home was the most commonly named perceived adverse affect on health, and mentioned by 9% of respondents.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Male % (n)</th>
<th>Female % (n)</th>
<th>Both Genders % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistani</td>
<td>20 (22)</td>
<td>17 (17)</td>
<td>19 (39)</td>
</tr>
<tr>
<td>Indian</td>
<td>15 (11)</td>
<td>21 (17)</td>
<td>18 (28)</td>
</tr>
<tr>
<td>African &amp; Caribbean</td>
<td>10 (13)</td>
<td>24 (28)</td>
<td>17 (41)</td>
</tr>
</tbody>
</table>
3.4 Oral Health

Survey findings regarding the proportion of teeth participants reported as being their own are summarised below. Table 3.5 illustrates that African and Caribbean participants were more likely than Indian and Pakistani respondents to say that all of their teeth were their own.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=211)</th>
<th>Indian (n=153)</th>
<th>African &amp; Caribbean (n=244)</th>
<th>Entire Sample (n=608)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of them</td>
<td>77%</td>
<td>78%</td>
<td>89%</td>
<td>82%</td>
</tr>
<tr>
<td>Some of them</td>
<td>20%</td>
<td>20%</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>None of them</td>
<td>2%</td>
<td>3%</td>
<td>0%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Figure 3.5 illustrates that the proportion of participants reporting to have all of their own teeth decreased with age.

![Figure 3.5](image)

Figure 3.5. Percentage of participants having all of their own teeth by ethnicity and age.

Table 3.6 summarises responses to the question ‘what proportion of your teeth are your own?’ given by participants aged 50+ years. As Table 3.6 illustrates, across the sample, less than 10% of participants in this age group reported that none of their teeth were their own. In comparison, 45% of the Greater Glasgow population, aged 50+ years, reported that none of their teeth were their own. This finding may, in part, be explained by the comparatively younger age profile.
of the current sample. Additionally, the findings regarding the frequency of visits to the dentist (discussed in Chapter 4) may also influence the responses summarised in this section, and vice versa.

Table 3.6. Responses to the question ‘what proportion of your teeth are your own?’ in 50+ years age group by ethnicity (number of participants in brackets).

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Pakistani % (n)</th>
<th>Indian % (n)</th>
<th>African &amp; Caribbean % (n)</th>
<th>Entire Sample % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of them</td>
<td>43 (9)</td>
<td>35 (6)</td>
<td>67 (14)</td>
<td>49 (29)</td>
</tr>
<tr>
<td>Some of them</td>
<td>48 (10)</td>
<td>53 (9)</td>
<td>33 (7)</td>
<td>44 (26)</td>
</tr>
<tr>
<td>None of them</td>
<td>10 (2)</td>
<td>12 (2)</td>
<td>0</td>
<td>7 (4)</td>
</tr>
</tbody>
</table>

3.5 Mental Well-Being

3.5.1 Perceived Stress

Perceived stress was measured by means of a four-item ‘perceived stress’ questionnaire. This short scale was derived from a 14-item measure devised by Cohen et al. (1983) as a measure of self-appraised stress. Five-point scales ranging from 0 (Never) to 4 (Very often) were used to indicate how often in the previous four weeks, participants had, e.g., ‘felt that things were going your way’, ‘felt that you were unable to control the important things in your life’. The aggregate score of the four individual items determined overall perceived stress score.

Across the entire sample, Pakistani participants (mean=6.62, SD=2.62) reported significantly more perceived stress than their Indian (mean=5.54, SD=2.34) and their African and Caribbean (mean=5.05, SD=3.03) counterparts. Moreover, across the total sample female participants (mean=6.04, SD=2.8) reported consistently higher levels of stress than male respondents (mean=5.41, SD=2.8). These findings are illustrated in Figure 3.6.
Further analysis, illustrated in Figure 3.7 below, indicated that in the 16-29 years age group, Indian participants reported significantly lower levels of stress than their Pakistani counterparts (with African and Caribbean participants being in-between). In the 30-49 years age group, African and Caribbean informants reported significantly lower stress levels than both Pakistani and Indian participants. Finally, in the 50+ years age group, there was no significant variation in perceived stress scores as a function of ethnicity.
3.5.2 Feeling in Control About Decisions Affecting Life

Participants were asked the degree to which they felt in control of decisions affecting their lives, such as planning their budget, moving house or changing jobs (see Table 3.7). African and Caribbean participants were most likely to state that they did not feel in control of the decisions affecting their lives, with Indian participants being the least likely to say that they felt that way. There were no gender and age differences in the number of participants saying that they did not feel in control of decisions affecting their lives.

Table 3.7. Responses to the question ‘do you feel in control of the decisions that affect your life?’ by ethnicity.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=207)</th>
<th>Indian (n=151)</th>
<th>African &amp; Caribbean (n=242)</th>
<th>Entire Sample (n=600)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely</td>
<td>52%</td>
<td>62%</td>
<td>50%</td>
<td>54%</td>
</tr>
<tr>
<td>To some extent</td>
<td>34%</td>
<td>31%</td>
<td>34%</td>
<td>33%</td>
</tr>
<tr>
<td>No</td>
<td>14%</td>
<td>7%</td>
<td>17%</td>
<td>13%</td>
</tr>
</tbody>
</table>

3.5.3 General Health Questionnaire

With the aim of assessing participants’ mental well-being, participants were asked to complete the twelve-item General Health Questionnaire (GHQ-12). The GHQ-12 is a screening instrument that is used to detect signs of psychological distress both in community and clinical settings. Participants are asked to think about their general health over the past few weeks, and asked to indicate their agreement with a number of statements (e.g. ‘have you recently lost much sleep over worry?’) on a four-point scale from 0 (Not at all) to 4 (Much more than usual). There are two main methods of scoring the GHQ-12. First, the bimodal method whereby each of the statements is scored as either 0 (Not present) or 1 (Present). This method produces scores from 0–12 and a threshold score of 4 (sometimes 3) or more is usually considered to be indicative of potential psychiatric morbidity. Second, the Likert scoring method, a more differentiated scoring approach, whereby each statement is scored from 0-3. This method produces scores from 0-36, and scores above 15, or so, are usually considered to be indicative of potentially diminished psychological well-being.

The GHQ-12 was not administered in the Greater Glasgow wide health and well-being survey (RBA, 2002). However, it featured in the 1998 Scottish Health
Survey (Calderwood and Park, 2000), which used the bimodal scoring method with a threshold score of 4.

In total 202 Pakistani, 146 Indian and 236 African and Caribbean participants completed the GHQ-12. Analysis using the bimodal scoring method indicated that 16% of Pakistani, 12% of Indian, and 20% of African and Caribbean respondents scored 4 or more on the GHQ-12. There were no significant differences as a function of participants’ ethnicity or age in this pattern of results. The Scottish Health Survey indicates that across Scotland men (13%) are significantly less likely than woman (18%) to have GHQ-12 scores of four or above. In this survey no significant gender differences were found.

Analysis of the GHQ-12 scores utilising the more differential Likert scoring method, outlined above, indicated that Pakistani participants’ (mean=11.01, SD=5.12) scores were significantly higher than those of African and Caribbean respondents (mean=9.64, SD=5.26). The difference between Pakistani and Indian respondents (mean=9.69, SD=5.36) failed to reach statistical significance despite Indian respondents’ mean GHQ-12 score being similar to that of the African and Caribbean respondents. This is likely to be the result of the smaller sample size of Indian respondents in comparison to the African and Caribbean group. Fifteen percent of respondents had a GHQ-12 score of 15 or above and this did not vary to a significant degree as a function of ethnicity, gender or age.

Further analysis indicated that elevated GHQ-12 scores (Likert scoring method) were predicted by:

- Poor perceptions of general health, physical well-being, overall quality of life, and mental/emotional well-being.
- Experience of racism (Schedule of ‘Minor’ Racist Events Scores).
4 Health Services: Use and Satisfaction

4.1 Use of Specific Health Services

Participants were asked to report contacts with specific health services in the past twelve months. Since the present survey utilised different scales than the general population health and well-being survey, this section does not make comparison to the Greater Glasgow population as a whole.

4.1.1 GP

Participants were asked to recall the number of visits they had made to a GP in the twelve months. Responses are summarised by age and ethnicity in Figure 4.1.

![Figure 4.1. Mean number of GP visits in the past year by ethnicity and age.](image)

N.B. Numbers of African & Caribbean participants in the 65+ years age category are very small.

The mean number of GP visits in the past twelve months increased significantly for Pakistani and Indian participants with age, although it would appear that this trend was not significant in the African and Caribbean sample. Seventeen percent (103 respondents) of the sample reported not visiting a GP at least once. This is similar to the Greater Glasgow population, 20% of which reported not seeing their GP once.
The mean number of GP visits across the sample was 3.92 (SD=7.11) and, as can be seen from Figure 4.1, increased significantly with age with participants aged 16-29 years reporting 2.3 (SD=2.39), those aged 30-49 years reporting 4.16 (SD=7.94), and those respondents aged 50+ years reporting an average of 6.56 (SD=10.02) visits in the past twelve months. Mirroring the more negative perceptions of health, outlined above, Pakistani participants (mean=5.41, SD=10.69) reported significantly more visits to their GP over the twelve months preceding the interview than their Indian (mean=3.51, SD=4.93) and African and Caribbean (mean=2.87, SD=2.30) counterparts. In Greater Glasgow, as a whole, informants said that they went saw their GP a mean of 4.3 (6.9) times. This is somewhat higher than in the present survey. RBA (2002) found that respondents aged 16-29 years went a mean 3.4 (6.9), those age 30-49 years reported a mean of 4.4 (8.1) visits, whilst those aged 50+ years reportedly went 4.8 (5.5) on average.

4.1.2 Accident and Emergency

The mean number of visits to an Accident and Emergency (A&E) department did not vary as a function of ethnicity to a significant degree (sample mean=0.34, SD=1.2), with 81% (490 participants) of the sample reporting no visits. As above, the frequency of visits increased with age. Participants’ aged 50+ (mean=0.72, SD=2.34) reported significantly more visits than those aged 16-29 (mean=0.2, SD=0.52) and 30-49 years (mean=0.3, SD=0.76). Moreover, Pakistani men (mean=0.6, SD=2.02) reported visiting A&E significantly more frequently than the African and Caribbean men sampled (mean=0.19, SD=0.52). Indian males reported 0.25 (SD=0.76) visits, and across the sample men reported on average 0.35 (1.32) visits. In contrast, no significant differences in mean frequency of A&E attendance as a function of ethnicity were found amongst women, who reported attending A&E about as frequently as their male counterparts (mean=0.34, SD=1.07).

In Greater Glasgow, as a whole, informants said that they visited A&E a mean of 0.3 (0.9) times. This is very similar to the findings in the present survey.
4.1.3 Hospital Outpatient Department

Respondents were also asked how many times they had been to a hospital outpatient department to see a doctor in the twelve months preceding the interview. Across the sample, 72% (431 participants) had not been to a hospital outpatient department, and participants had, on average, attended 0.69 (SD=1.81) times. This varied as a function of both ethnicity and age. African and Caribbean (mean=0.94, SD=2.16) participants reported significantly more visits than Indian (mean=0.48, SD=1.08) interviewees. Pakistani participants’ mean number of visits was 0.56 (SD=1.76). Participants aged 50+ years (1.22, SD=3.08) were significantly more likely to say they had attended a hospital outpatient department than those aged 16-29 (mean=0.43, SD=0.97) and 30-49 (mean=0.68, SD=1.54) years.

In Greater Glasgow, as a whole, informants said that they went saw their GP a mean of 0.9 (3.1) times. This is similar to the present survey. RBA (2002) found that respondents aged 16-29 years went a mean 0.5 (2.1), those age 30-49 years reported a mean of 0.8 (2.7) visits whilst those aged 50+ years reportedly went to a hospital outpatient department an average of 1.4 (3.9) times.

4.1.4 Day Surgery / Overnight Stay

When asked how many times they had been admitted for day surgery or an overnight hospital stay in the year preceding the interview, the mean number was 0.22 (SD=1.11) across the sample and did not differ significantly as a function of gender or ethnicity. 89% (535 respondents) of the sample reported no such stay. The mean number of reported attendances increased with age with participants older than 50 years (mean=0.59, SD=2.29) reporting significantly more attendances than those aged 16-29 (mean=0.09, SD=0.35) and 30-49 (mean=0.17, SD=0.57) years. In Greater Glasgow respondents had been admitted for day surgery or an overnight hospital stay in the year preceding their interview a mean of 0.2 (0.7) times.
4.1.5 Hospital Attendances of 2+ Days

A similar picture emerged for hospital attendances of two or more days. Thus there was no significant variation as a function of gender or ethnicity with the mean attendance across the sample being 0.19 (SD=0.81). Ninety percent (540 respondents) of the sample did not report any hospital attendance for the duration of two or more days. The mean number of attendances of this nature increased with age and participants aged 50+ years and above (mean=0.37, SD=1.42) reported significantly more attendances than those aged 16-29 years (mean=0.11, SD=0.56). Participants aged between 30 and 49 years reported a mean number of 0.18 (SD=0.58) stays. In Greater Glasgow respondents had been admitted for an overnight hospital stay of two or more days a mean of 0.2 (0.2) times.

4.1.6 Total Number of Times Seeing a Doctor in the Past Year

The overall number of contacts with health services reported by participants was computed, and analysis suggested that across the sample Pakistani respondents (mean=6.78, SD=13.11) reported significantly more contact with health services than did their Indian (mean=4.55, SD=6.64) and African and Caribbean (mean=4.52, SD=5.52) respondents. As Figure 4.2 illustrates, across the entire sample respondents aged 16-29 years (mean=3.08, SD=3.28) reported significantly less visits than those aged 30-49 years (mean=5.42, SD=9.09) and 50+ years (mean=9.29, SD=14.2).
4.2 Satisfaction with Health Services

Participants were asked to think about their recent use and experience of health services (if applicable), and asked the extent to which they agreed with a number of statements gauging perceptions of service delivery and issues relating to language difficulties. A five-point scale measuring the extent to which participants agreed with the statements ranging from 1 (Not at all) to 5 (Definitely) was used. High scores tending towards a score of 5 thus indicate agreement with the statements. Since the parametric scoring method used in this survey was not utilised in the Greater Glasgow wide general population survey, no comparisons between the two surveys are made.

4.2.1 Perceived Adequacy of Information About Conditions or Treatments

The first statement gauged the extent to which participants thought that they were given adequate information about their condition or treatment.
As can be seen from Figure 4.3, responses tended to indicate agreement with the statement. This suggests that, across the sample, participants by and large felt that they were given adequate information about their condition or treatment. There were, however, significant differences as a function of age and ethnicity. Across the sample, participants aged 50+ years felt significantly more satisfied (mean=4.17, SD=1.27) that they were given adequate information than participants aged 16-29 (mean=3.59, SD=1.42) or 30-49 years (mean=3.77, SD=1.42). This suggests that those participants who use the health services most frequently are also the most satisfied with them. The finding may also indicate that older people have lower expectations, or that they are less critical towards service delivery.

Moreover, Pakistani (mean=3.36, SD=1.4) and Indian (mean=3.57, SD=1.5) participants aged 16-29 years agreed with the statement to a significantly lesser degree than those aged 30-49 years [Pakistani: mean=3.83, SD=1.39; Indian: mean=4.19, SD=1.04] or 50 years and above [Pakistani: mean=4.02, SD=1.45; Indian: mean=4.46, SD=1.01]. In contrast, the difference between African and Caribbean participants aged 16-29 years (mean=3.83, SD=1.35) and those aged 30-49 years (mean=3.43, SD=1.56) and 50+ years (mean=4.06, SD=1.24) did not reach statistical significance, indicating that young African and Caribbean participants agreed with the statement to a similar extent to older participants.
These findings suggest that younger Indian and Pakistani people, in particular, feel that they are not given adequate information about their conditions / treatments to the same extent as older Indians and Pakistanis.

### 4.2.2 Extent of Perceived Encouragement to Participate in Decisions Affecting Participants’ Health and Treatment

The second statement assessed the extent to which interviewees thought that they were encouraged to participate in decisions affecting their health and treatment. Across the sample participants aged 50+ years (mean=4.17, SD=1.27) were significantly more likely to agree to a larger degree than those aged 16-29 (mean=3.59, SD=1.42) and 30-49 (mean=3.77, SD=1.42) years. Further analysis suggested that Pakistani and Indian participants aged 50+ years said that they were encouraged to participate in decisions affecting health or treatment to a significantly larger degree than both those aged 16-20 and 30-49 years (see Figure 4.4). African and Caribbean participants did not differ to a significant degree in their response patterns as a function of age.

**Figure 4.4.** Mean agreement with the question ‘were you encouraged to participate in decisions affecting your health?’ by ethnicity and age.
4.2.3 Satisfaction with ‘Say’ in Delivery of Services

Participants were also asked the extent to which they felt that they had a say in how services were delivered. Across the sample there were no significant variations in response patterns as a function of ethnicity or gender (overall mean=3.51, SD=1.48).

As Figure 4.5 illustrates, older participants aged 50 years and above (mean=3.94, SD=1.41) agreed with the statement to a significantly larger degree that did the respondents aged 16-29 (mean=3.37, SD=1.44) and 30-49 (mean=3.42, SD=1.53) years.

4.2.4 Views and Circumstances Understood

When asked about the extent to which participants thought that their views and circumstances were understood and valued, there were no significant differences as a function of age. However, Indian participants (overall mean=4.25, SD=1.14) consistently agreed more strongly with the statement ‘did you feel that your views and circumstances were understood and valued?’ than did Pakistani (overall mean=3.84, SD=1.29) and African and Caribbean (overall mean=3.78, SD=1.44) participants (see Figure 4.6).
4.3 Language Difficulties

4.3.1 Understanding Advice Given

Across the sample participants aged 50+ years agreed to a significantly larger extent with the statement gauging language difficulties in understanding advice given than did participants in the two younger age groups (see Figure 4.7). Pakistani participants (overall mean=2.36, SD=1.66) agreed significantly more strongly than African and Caribbean respondents (overall mean=1.87, SD=1.47).
It is interesting to note that whilst older participants were more likely to feel that they had been given adequate information (see above), they were also the most likely to say that they had difficulty in understanding the advice given.

4.3.2 Getting Views Across

Across the sample participants aged 50+ years agreed to a significantly larger extent with the statement gauging language difficulties in getting views across than did participants in the two younger age groups (Figure 4.8). Moreover, Pakistani participants (overall mean=2.37, SD=1.67) reported having significantly more problems getting their views across than African and Caribbean respondents (overall mean=1.88, SD=1.47).
The overall findings regarding language difficulties therefore indicate that older people are more likely to have language difficulties in communicating with health professionals.

### 4.4 Dental Health

Responses to the question asking about the last time participants had been to a dentist are summarised in Table 4.1. The interview schedule did not include a ‘never’ option, however, a number of fieldworkers noted such responses informally. These are included in the table below, and it is therefore important to note that the ‘over 15 months’ category is likely also to include a number of participants who have never been to a dentist.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=200)</th>
<th>Indian (n=150)</th>
<th>African &amp; Caribbean (n=238)</th>
<th>Entire Sample (n=588)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the last 6 months</td>
<td>50%</td>
<td>40%</td>
<td>32%</td>
<td>40%</td>
</tr>
<tr>
<td>Within 6 months to 15 months</td>
<td>17%</td>
<td>17%</td>
<td>21%</td>
<td>19%</td>
</tr>
<tr>
<td>Over 15 months</td>
<td>33%</td>
<td>42%</td>
<td>41%</td>
<td>38%</td>
</tr>
<tr>
<td>Never</td>
<td>1%</td>
<td>1%</td>
<td>6%</td>
<td>3%</td>
</tr>
</tbody>
</table>

From these figures it appears that African and Caribbean participants, whilst reporting the greatest likelihood of having all their own teeth, are the least likely to
have attended a dentist. It is apparent that Indian and African and Caribbean participants appear to visit the dentist less frequently than the general population, 33% of which reported not having visited a dentist in the 15 months preceding their interview.

4.5 Difficulty in Accessing Health Services

Participants were asked to rate the difficulty of accessing health services on a five-point scale ranging from 1 (Great difficulty) to 5 (No difficulty). Findings are summarised below. As outlined earlier, comparisons to the general population survey are not made as a result of differences in methodologies employed.

4.5.1 Arranging Home Visits from GP

Participants were asked the extent to which they thought that arranging a home visit from a GP for themselves was difficult. The results summarised in Figure 4.9 indicate that, overall, Indian participants were significantly less likely to report difficulty than both Pakistani and African and Caribbean participants. Across the sample participants in the 50+ years age group report significantly less difficulty arranging for home visits than those in the 30-49 years old age group.

Figure 4.9. Mean perceived difficulty arranging a home visit from GP by ethnicity and age.
4.5.2 Getting GP Appointment

A similar picture emerged when participants were asked to rate the difficulty of getting an appointment with their GP. As is illustrated in Figure 4.10, participants aged 50+ years felt that it was significantly easier to get a GP appointment than participants in both younger age groups. The pattern of results did not differ to a significant degree as a function of gender or ethnicity.

Figure 4.10. Mean perceived difficulty getting a GP appointment by age.

4.5.3 Getting to GP Surgery / Health Centre

Participants were asked to assess the difficulty of getting to a GP surgery or health centre using the five-point scale, ranging from 1 (Great difficulty) to 5 (No difficulty). Analysis of the findings indicated no significant age differences in response patterns, or differences as a function of ethnicity. However, as is illustrated in Figure 4.11, regardless of ethnic background, women reported significantly more difficulty in getting to a GP surgery or health centre than men.
4.5.4 Accessing Health Services in an Emergency

When asked to rate the difficulty of accessing health services in an emergency, the following picture emerged. Across the sample, there was a significant trend whereby participants aged 50+ years reported less difficulty in accessing health services in an emergency than those aged between 16 and 29 years. Further analysis suggested that Pakistani participants aged 30-49 years reported significantly more difficulty than those aged 50+ years (see Figure 4.12). There were no significant differences in response patterns by age amongst Indian and African and Caribbean participants.
Figure 4.12. Mean perceived difficulty accessing health services in an emergency by ethnicity and age.

4.5.5 Obtaining Hospital Appointment for Self

Participants were asked to rate the difficulty of obtaining a hospital appointment for themselves. Whilst response patterns did not differ significantly as a function of participant ethnicity or gender, older participants (aged 50+ years) across the sample reported less difficulty than those ages 16-49 years. These results are summarised in Figure 4.13.

Figure 4.13. Mean perceived difficulty obtaining hospital appointment for self by age.
4.5.6 Obtaining Appointments with Health Professionals for Family Members

Across the sample participants aged 50+ years reported less difficulty obtaining an appointment with health professionals for family members than those aged 16-29 years and 30-49 years. Moreover, as Figure 4.14 shows, African and Caribbean participants reported significantly more difficulty than Indian participants.

Figure 4.14. Mean perceived difficulty getting an appointment with health professionals for family members by ethnicity and age.

![Chart showing difficulty in obtaining appointments by ethnicity and age]
5 Health Behaviours

5.1 Smoking

5.1.1 Passive Smoking

Table 5.1 summarises responses to the question gauging the amount of time participants thought that they were exposed to cigarette smoking by ethnicity and gender.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani</th>
<th>Indian</th>
<th>African &amp; Caribbean</th>
<th>Greater Glasgow</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Most of the time</td>
<td>(n=109)</td>
<td>(n=100)</td>
<td>(n=73)</td>
<td>(n=81)</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>12%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Some of the time</td>
<td>29%</td>
<td>27%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Seldom</td>
<td>15%</td>
<td>30%</td>
<td>26%</td>
<td>44%</td>
</tr>
<tr>
<td>Never</td>
<td>26%</td>
<td>31%</td>
<td>41%</td>
<td>22%</td>
</tr>
</tbody>
</table>

The analogous figures for the Greater Glasgow general population are summarised in Table 5.1. It appears that the likelihood of participants reporting exposure to cigarette smoking some or most of the time shows similarities between the general population and Pakistani, African and Caribbean participants in this survey. Indian participants appear to report considerably less exposure to smoking.
As Figure 5.1 indicates, there appears to be a trend whereby self-reported exposure to cigarette smoking is highest in the youngest age group and shows a tendency to decrease with age. In the African and Caribbean samples there appears to be a tendency for exposure to cigarette smoking to increase from about the age of 35-55 years. The figures for Greater Glasgow indicate a broadly similar trend with 25-34 year-olds reporting the highest exposure most of the time (49%), and those aged over 65 years reporting the lowest (21%) exposure most of the time. This may be an indication of different lifestyle choices.

5.1.2 Active Smoking

Table 5.2 summarises self-reported smoking behaviours by ethnicity and age. It should be noted, however, that these responses may have been influenced by the fact that the team of fieldworkers were exclusively from black and minority ethnic backgrounds, and that this may have impacted on the responses obtained as a result of respondents giving socially desirable - rather than ‘truthful’ – accounts of their drinking behaviour.
Table 5.2. Self-reported smoking behaviour by ethnicity and gender.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani</th>
<th>Indian</th>
<th>African &amp; Caribbean</th>
<th>Greater Glasgow</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (n=110)</td>
<td>Female (n=97)</td>
<td>Male (n=68)</td>
<td>Female (n=77)</td>
</tr>
<tr>
<td>I have never smoked tobacco</td>
<td>52% (n=97)</td>
<td>93% (n=97)</td>
<td>71% (n=68)</td>
<td>91% (n=77)</td>
</tr>
<tr>
<td>I have only tried smoking once or twice</td>
<td>8% (n=97)</td>
<td>2% (n=97)</td>
<td>6% (n=68)</td>
<td>5% (n=77)</td>
</tr>
<tr>
<td>I have given up smoking</td>
<td>4% (n=97)</td>
<td>0% (n=97)</td>
<td>7% (n=68)</td>
<td>0% (n=77)</td>
</tr>
<tr>
<td>I smoke some days</td>
<td>7% (n=97)</td>
<td>0% (n=97)</td>
<td>6% (n=68)</td>
<td>1% (n=77)</td>
</tr>
<tr>
<td>I smoke every day</td>
<td>29% (n=97)</td>
<td>5% (n=97)</td>
<td>10% (n=68)</td>
<td>3% (n=77)</td>
</tr>
</tbody>
</table>

Overall, 22% of Pakistani, 10% of Indian and 11% of African and Caribbean participants said that they smoked at least some days. This compares to 33% for the Greater Glasgow population. As the above table illustrates, there were marked gender differences with men consistently being less likely to say that they had never smoked tobacco. This gender difference is most marked in the Pakistani sample.

The mean number of cigarettes smoked per day is summarised in Table 5.3 and did not differ as a function of ethnicity to a significant degree. The trend by which men smoked more cigarettes per day than women was also non-significant, probably owing to the low number of female smokers in the sample. Across the sample, however, there was an effect of participant age, with smokers aged 50+ years and above smoking significantly more cigarettes per day than those aged 16-29 years and 30-49 years.

Table 5.3. Mean number of cigarettes smoked a day.

<table>
<thead>
<tr>
<th></th>
<th>Mean number of cigarettes smoked per day (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistani (n=40)</td>
<td>13.95 (22.24)</td>
</tr>
<tr>
<td>Indian (n=13)</td>
<td>7.24 (6.49)</td>
</tr>
<tr>
<td>African &amp; Caribbean (25)</td>
<td>11.09 (10.23)</td>
</tr>
<tr>
<td>Entire Sample (n=78)</td>
<td>11.92 (17.2)</td>
</tr>
<tr>
<td>Entire Sample: men (n=67)</td>
<td>10.60 (8.89)</td>
</tr>
<tr>
<td>Entire Sample: women (n=11)</td>
<td>19.91 (40.92)</td>
</tr>
<tr>
<td>Entire Sample: 16-29 years (n=30)</td>
<td>8.38 (8.84)</td>
</tr>
<tr>
<td>Entire Sample: 30-49 years (n=30)</td>
<td>10.35 (5.52)</td>
</tr>
<tr>
<td>Entire Sample: 50+ years (n=18)</td>
<td>20.41 (32.43)</td>
</tr>
</tbody>
</table>

In Greater Glasgow smokers reportedly smoked 18.5 (SD=17.5) cigarettes per day. This is markedly higher than the responses in this survey. However, in Greater Glasgow, as a whole, smokers aged 30-49 years (mean number of cigarettes=21.2, SD=20.3) smoked significantly more cigarettes than those aged...
16-29 (mean=13.4, SD=12.6). Smokers aged 50+ years reported smoking an average of 18.3 (SD=15.2) cigarettes per day.

5.2 Alcohol Consumption

Participants were questioned about the consumption of alcohol and responses are summarised by gender in Table 5.4 and by age in Figure 5.2. As noted earlier with regards to cigarette smoking, however, that socio-cultural sensitivities with regards to smoking, as well as the ethnic makeup of the team of fieldworkers may have influenced the ‘truth’ of responses given.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>85%</td>
<td>97.0%</td>
<td>91%</td>
<td>34%</td>
<td>79%</td>
<td>57%</td>
<td>56%</td>
<td>64%</td>
<td>60%</td>
<td>70%</td>
</tr>
<tr>
<td>&lt; once a month</td>
<td>8%</td>
<td>2.0%</td>
<td>5%</td>
<td>22%</td>
<td>15%</td>
<td>18%</td>
<td>12%</td>
<td>14%</td>
<td>13%</td>
<td>12%</td>
</tr>
<tr>
<td>&gt; once a month but not weekly</td>
<td>4%</td>
<td>1.0%</td>
<td>2%</td>
<td>20%</td>
<td>5%</td>
<td>12%</td>
<td>6%</td>
<td>9%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>1-2 days per week</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
<td>11%</td>
<td>1%</td>
<td>6%</td>
<td>15%</td>
<td>11%</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td>3-5 days per week</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>8%</td>
<td>0%</td>
<td>4%</td>
<td>9%</td>
<td>2%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>6-7 days per week</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>5%</td>
<td>0%</td>
<td>3%</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Participants who said that they consumed alcohol were asked whether or not they had drunk alcohol in the week preceding the interview. Out of the 20 Pakistani participants who said that they consumed alcohol only 4 participants (20%) said that they had done so in the past week. This figure was substantially higher for Indian and African and Caribbean respondents. Of the 67 Indian participants who drank alcohol 37 respondents (55%) said they had not consumed alcohol in the same time period, with 51 interviewees (53%) of the 97 alcohol consuming African and Caribbean participants saying that they had not had a drink containing alcohol in the past week.
It is noteworthy that a survey of young people from Indian, Pakistani and Chinese backgrounds aged 16 to 25 years conducted throughout Greater Glasgow in 2001 (Heim et al., 2004a) found higher alcohol consumption levels amongst Indian and Pakistani young people than in this survey. In that survey approximately 50% of Indian participants reported drinking alcohol and 30% of Pakistani males and 12% of Pakistani females reported that they consumed alcohol.

The number of units of alcohol that the small number of participants reported drinking in the week preceding the interview was extremely low, and is therefore not analysed in detail.

5.3 Diet

Participants were asked a number of questions gauging their eating behaviours.

5.3.1 Fruit and Vegetable Consumption

Results indicate that 19% of Pakistani, 33% of Indian and 47% of African and Caribbean participants consume five or more portions (the recommended
minimum amount) of fruit and vegetables per day (Table 5.5). The comparable figure for Greater Glasgow is 34%, and therefore, it would appear that only the African and Caribbean participants exceed this amount. Pakistani participants appear to report a considerably lower intake of fruit and vegetables than the Greater Glasgow population.

Table 5.5. Self-reported consumption of fruit and vegetables portions per day by ethnicity.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=210)</th>
<th>Indian (n=155)</th>
<th>African &amp; Caribbean (n=242)</th>
<th>Entire Sample (n=607)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>1-2</td>
<td>49%</td>
<td>43%</td>
<td>29%</td>
<td>39%</td>
</tr>
<tr>
<td>3-4</td>
<td>31%</td>
<td>23%</td>
<td>24%</td>
<td>26%</td>
</tr>
<tr>
<td>5</td>
<td>7%</td>
<td>6%</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>6-10</td>
<td>11%</td>
<td>25%</td>
<td>31%</td>
<td>23%</td>
</tr>
<tr>
<td>10+</td>
<td>1%</td>
<td>2%</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Across the sample females reported higher fruit and vegetable consumption than males, and African and Caribbean participants reported consuming significantly more portions of fruit and vegetables than both Pakistani and Indian participants. This may be the result of African and Caribbean aged 30 years and above reporting significantly higher consumption levels than their Indian and Pakistani counterparts (see Figure 5.3). The mean consumption for the Greater Glasgow population is 3.83.

Figure 5.3. Mean number of fruit and vegetable portions consumed per day by ethnicity and gender.
In the youngest age group (16-29 years) Pakistani participants report significantly less fruit and vegetable consumption than their Indian counterparts. In the 30-49 years and 50+ years age groups African and Caribbean participants report significantly higher mean fruit and vegetable consumption than both Indian and Pakistani participants (see Figure 5.4).

Figure 5.4. Mean number of fruit and vegetable portions consumed per day by ethnicity and age.

5.3.2 Bread Consumption

The mean number of slices of bread consumed per day (see Table 5.6) did not differ as a function of ethnicity with the mean number of slices of bread consumed per day being 2.85 (SD=1.83) across the entire sample. This is almost identical to the mean of 2.87 slices per day for the Greater Glasgow population at large.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=211)</th>
<th>Indian (n=155)</th>
<th>African &amp; Caribbean (n=244)</th>
<th>Entire Sample (n=610)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1%</td>
<td>2%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>1-2</td>
<td>51%</td>
<td>47%</td>
<td>46%</td>
<td>48%</td>
</tr>
<tr>
<td>3-4</td>
<td>40%</td>
<td>39%</td>
<td>34%</td>
<td>37%</td>
</tr>
<tr>
<td>5</td>
<td>2%</td>
<td>6%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>6+</td>
<td>5%</td>
<td>7%</td>
<td>8%</td>
<td>7%</td>
</tr>
</tbody>
</table>
However, across the sample there was a consistent difference in self-reported mean consumption as a function of participant age and gender. Participants aged 50+ years and above consumed significantly less slices of bread per day than those aged 16-29 years. Furthermore, male respondents from all ethnic backgrounds said that they consumed significantly more slices of bread per day than female interviewees (Figure 5.5).

![Figure 5.5. Mean self-reported number of bread slices consumed per day by age and gender.](image)

### 5.3.3 Cakes, Sweets and Pastries

The mean number of times per day that participants said they consumed cakes and sweets was 0.91 (SD=1.14) across the sample (see Table 5.7 for a breakdown by ethnicity) and did not differ to a significant degree as a function of ethnicity and gender.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=211)</th>
<th>Indian (n=155)</th>
<th>African &amp; Caribbean (n=242)</th>
<th>Entire Sample (n=608)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>37%</td>
<td>50%</td>
<td>46%</td>
<td>44%</td>
</tr>
<tr>
<td>1-2</td>
<td>56%</td>
<td>47%</td>
<td>44%</td>
<td>49%</td>
</tr>
<tr>
<td>3+</td>
<td>7%</td>
<td>3%</td>
<td>10%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Across the sample there was a significant difference in the mean portions of sweets, etc. consumed as a function of participant age. Participants aged 16-29
years (mean=1.24, SD=1.15) reported a significantly higher mean consumption than those aged 30-49 years (mean=0.87, SD=1.22) and 50+ years (mean=0.37, SD=0.59).

5.3.4 Breakfast Cereal Consumption

The Scottish Diet Action Plan target for breakfast cereal consumption is five or more times per week. In Greater Glasgow as a whole, 46% of respondents met this target, compared to 20% of Pakistani, 39% of Indian and 28% of African and Caribbean respondents (see Table 5.8).

| Table 5.8. Self-reported consumption of breakfast cereal per week by ethnicity. |
|--------------------------------------------------|-----------|------------|----------------|----------------|
| Pakistani (n=210) | Indian (n=155) | African & Caribbean (n=242) | Entire Sample (n=607) |
| Never | 38% | 27% | 27% | 31% |
| 1-2 | 28% | 24% | 24% | 25% |
| 3-4 | 15% | 10% | 20% | 16% |
| 5 | 5% | 12% | 7% | 8% |
| 6+ | 15% | 27% | 22% | 20% |

Pakistani participants (overall mean=2.17, SD=2.45) report significantly lower mean consumption of breakfast cereal compared to both African and Caribbean (overall mean=2.91, SD=2.67) and Indian (overall mean=3.17, SD=2.77) respondents (Figure 5.6). Across the sample, the difference in mean consumption between participants aged 16-29 years (mean=3.16, SD=2.84) and those aged 30-49 years (mean=2.43, SD=2.44) reaches statistical significance.
The mean number of days on which the Greater Glasgow population as a whole reported eating breakfast cereal is 3.69 and somewhat higher than in this survey.

5.3.5 Oily Fish Consumption

The Scottish Diet Action Plan stipulates that people should eat at least 2 portions of oily fish (e.g. mackerel, tuna, salmon, herring) per week. The Greater Glasgow wide survey indicates that this target is met by 29% of people living in and around Glasgow, whilst 41% of the general Greater Glasgow population report that they do not eat any oily fish. With this in mind, participants were asked how many times per week they consumed oily fish either as part of a meal, or taken in sandwiches.

As Table 5.9 indicates, over one third of both Pakistani and African and Caribbean participants reportedly consume the recommended amount of oily fish, whilst Indian interviewees appeared considerably less likely to report eating oily fish at least twice a week.
Table 5.9. Consumption of oily fish per week by ethnicity (number of participants in brackets).

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=206)</th>
<th>Indian (n=149)</th>
<th>African &amp; Caribbean (n=239)</th>
<th>Entire Sample (n=594)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Never</td>
<td>22 (46)</td>
<td>56 (84)</td>
<td>27 (65)</td>
<td>33 (195)</td>
</tr>
<tr>
<td>Once</td>
<td>40 (83)</td>
<td>28 (41)</td>
<td>30 (71)</td>
<td>33 (195)</td>
</tr>
<tr>
<td>Two or more times</td>
<td>37 (77)</td>
<td>16 (24)</td>
<td>43 (103)</td>
<td>34 (204)</td>
</tr>
</tbody>
</table>

A more detailed account of the number of times oily fish is consumed per week as a function of ethnicity is provided in Table 5.10.

Table 5.10. Self reported weekly consumption of oily fish by ethnicity.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=206)</th>
<th>Indian (n=149)</th>
<th>African &amp; Caribbean (n=239)</th>
<th>Entire Sample (n=594)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Never</td>
<td>22%</td>
<td>56%</td>
<td>27%</td>
<td>33%</td>
</tr>
<tr>
<td>1-2</td>
<td>60%</td>
<td>38%</td>
<td>46%</td>
<td>49%</td>
</tr>
<tr>
<td>3-4</td>
<td>15%</td>
<td>3%</td>
<td>20%</td>
<td>14%</td>
</tr>
<tr>
<td>5</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>6-10</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Across the entire sample Indian (mean=0.76, SD=1.25) participants reported a significantly lower consumption of oily fish than their Pakistani (mean=1.44, SD=1.3) and African and Caribbean (mean=1.67, SD=1.64) counterparts. More specifically, in the 16-29 years age group Indian participants reported a significantly lower consumption of oily fish than both Pakistani and African and Caribbean participants, in the 30-49 years age group the difference in consumption is only significant between Indian and African and Caribbean respondents, and in the 50+ years age group the mean consumption by African and Caribbean participants was significantly higher both in comparison to Indian and Pakistani respondents (see Figure 5.7).
Figure 5.7. Mean self-reported consumption of oily fish by ethnicity and age.

The general population of Greater Glasgow reportedly eat a mean of 1.08 oily fish portions of per week.

5.4 Body Mass Index

Participants were asked whether they knew their height and weight. In total 531 (87%) of participants said that they knew their weight and 540 participants (89%) said that they knew their height. Overall 488 respondents (80%) knew both their height and weight, allowing their Body Mass Index (BMI) to be calculated. BMI is classified into the following categories:

- Underweight: <18.49
- Normal: 18.5-24.99
- Overweight: 25-29.99
- Obese: 30-39.99
- Extremely Obese: >40

Figure 5.8 summarises the BMI classifications in this survey by ethnicity. There were no significant differences as a function of ethnicity in terms of the percentage of participants who were classified as overweight, and overall 46% of participants had BMI score of 25 or over. This indicates that the percentage of
participants classified as overweight in this survey is slightly higher than that of the Greater Glasgow population, where 43% of people were classified in this way.

Figure 5.8. BMI classification scores by ethnicity.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Entire Sample (n=488)</th>
<th>African &amp; Caribbean (n=187)</th>
<th>Indian (n=135)</th>
<th>Pakistani (n=166)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Obese (%)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Obese (%)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Overweight (%)</td>
<td>50.0</td>
<td>40.0</td>
<td>55.0</td>
<td>51.0</td>
</tr>
<tr>
<td>Normal (%)</td>
<td>44.0</td>
<td>50.0</td>
<td>40.0</td>
<td>48.0</td>
</tr>
<tr>
<td>Underweight (%)</td>
<td>6.0</td>
<td>0.0</td>
<td>5.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

5.4.1 BMI: Classified as Overweight

In the Greater Glasgow population survey men (46%) were found to be significantly more likely than women (40%) to be classified as overweight (BMI>25). In this survey, however, no significant difference between men (45%) and women (47%) across the entire sample was found to this regard (Figure 5.9). Further analysis indicated an exception to this in the 45-54 years age group where female participants (86%) were significantly more likely than male participants (61%) to be classified as overweight. This trend is the opposite of that found in the Greater Glasgow population as a whole where analysis indicated that in the 45-54 years age group men (65%) were significantly more likely than women (48%) to be classified as overweight. Analogously to the findings summarised here, the Greater Glasgow population survey did not find any other significant gender differences in terms of being classified as overweight in any of the other age groups either.

Across the entire sample, participants in the youngest and oldest age groups were less likely to be classified as overweight than those in the middle age group
(16-29 years: 18%; 30-49 years: 52%; 50+ years: 30%). Figure 5.9 illustrates this age trend, which broadly mirrors that found in the Greater Glasgow population survey.

Figure 5.9. BMI scores classified as overweight (BMI>25) by age and gender.

5.4.2 BMI: Classified as Obese / Extremely Obese

Further analysis indicated that Pakistani (13%) and African and Caribbean (12%) respondents were significantly more likely than Indian (4%) interviewees to be classified as either obese or extremely obese (see Figure 5.8). As is illustrated in Figure 5.10, participants in the youngest age group of 16-29 years (3%) were significantly less likely than those aged 30-49 years (12%) and 50+ years (16%) to be classified as obese or extremely obese. Ten percent of the entire sample was classified as being obese or extremely obese. Moreover, across the sample men (7%) were significantly less likely than women (13%) to be classified as obese or extremely obese. This finding is similar to that found for the Greater Glasgow as a whole where 9% of men and 13% of women were classified as obese / extremely obese. The trend illustrated in Figure 5.10 by which classification as obese or extremely obese also appears to vary as a function of a combination of gender and age, fails to reach statistical significance.
5.4.3 BMI: Mean Scores

Analysis of BMI score as a continuous variable indicates that there were no significant differences in mean BMI scores as a function of ethnicity (overall mean across the sample=24.8, SD=4.14). Across the sample, male participants (mean=24.71, SD=3.64) had a slightly (and significantly) lower BMI score than female respondents (mean=24.9, SD=4.64). Moreover, as Figure 5.11 illustrates, participants in the 16-29 years age group (mean=22.57, SD=3.72) appeared to have significantly lower BMI scores than those aged 30-49 (mean=25.83, SD=3.72) and 50+ (mean=26.57, SD=4.01) years. Figure 5.11 also illustrates that this was likely to be due to female (mean=27.95, SD=3.87) participants appearing to have significantly higher BMI scores than their male (mean=25.34, SD=3.75) counterparts in the 50+ years age group. There were no significant differences in mean BMI scores as a function of gender in either of the younger age groups.
The Greater Glasgow general population survey found a similar age trend whereby respondents aged 16-29 years (mean BMI=23.03, SD=3.3) also had a significantly lower mean BMI than those aged 30-49 years (mean BMI=25.71, SD=4.63) and 50+ years (mean BMI=25.61, SD=4.2).

Further analysis indicated that high BMI scores were related to:

- Receiving treatment for medical conditions.
- Comparatively lower positive perceptions of physical well-being.
- Reports of stress.
- Eating sweets, cakes, etc. and not eating breakfast cereal.
- Not undertaking much moderate physical activity.

5.5 Physical Activity

The minimum recommended amount of physical activity is either i) five or more days on which people undertake at least thirty minutes of moderate physical activity such as taking a brisk walk, or ii) doing vigorous physical activity, defined as twenty minutes of activity vigorous enough to make people sweaty and out of breath, three or more times a week.
5.5.1 Moderate Physical Activity

As is illustrated in Table 5.11, 26% of Pakistani, 41% of Indian and 28% of African and Caribbean participants meet the target of undertaking moderate physical activity at least five times per week.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=211)</th>
<th>Indian (n=153)</th>
<th>African &amp; Caribbean (n=243)</th>
<th>Entire Sample (n=607)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 days</td>
<td>24%</td>
<td>18%</td>
<td>12%</td>
<td>18%</td>
</tr>
<tr>
<td>1 day</td>
<td>21%</td>
<td>25%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>2 days</td>
<td>12%</td>
<td>8%</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>3 days</td>
<td>10%</td>
<td>3%</td>
<td>13%</td>
<td>9%</td>
</tr>
<tr>
<td>4 days</td>
<td>6%</td>
<td>5%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>5 days</td>
<td>11%</td>
<td>12%</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>6 days</td>
<td>2%</td>
<td>2%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>7 days</td>
<td>12%</td>
<td>28%</td>
<td>13%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Pakistani participants (mean=2.58, SD=2.4) report significantly less days doing moderate physical activities in comparison to both Indian (mean=3.33, SD=2.81) and African and Caribbean (mean=3.38, SD=2.32) participants. Additionally, with the exception of African and Caribbean interviewees, the mean number of days participants report doing moderate physical activity appears to significantly decrease with age with both Indian and Pakistani participants aged 30-49 years reporting significantly less periods of moderate physical activity per week than those aged 16-29 years, and participants from both the 16-29 years and 30-49 years age groups reporting significantly more moderate physical activity in comparison to the 50+ years age group (see Figure 5.12).
5.5.2 Vigorous Physical Activity

Table 5.12 illustrates that 16% of Pakistani, 29% of Indian and 17% of African and Caribbean participants reported meeting the target of twenty minutes of vigorous activity three or more times a week.

Pakistani participants (mean=0.93, SD=1.49) reported spending significantly less time doing vigorous physical activities than both Indian (mean=1.75, SD=2.33) and African and Caribbean (mean=1.10, SD=1.73) participants. Additional analysis showed that Pakistani participants aged 16-29 years reported doing significantly more vigorous physical activity than those aged 50+ years (see Figure 5.13). There were no significant age differences in the other ethnic groups.
5.5.3 Physical Activities: Meeting the Target

As was outlined above, the recommended minimum amount of physical activity per week is either five times doing moderate physical activity for at least thirty minute, or doing three sessions of at least twenty minutes of vigorous physical activity three times per week. The Greater Glasgow population survey indicated that 58% of the general population met this target in 2002. The results of this survey indicate that participants from the respective backgrounds are less likely to meet the physical activity target. Thus only 32% of Pakistani respondents reported undertaking the recommended amount of physical activity, compared to 50% of Indian and 45% of African and Caribbean informants.

5.6 Oral Health Behaviour

5.6.1 Frequency of Brushing Teeth

With none of the participants reported brushing their teeth less than ‘about once a day’, Table 5.13 summarises how often participants reported brushing their teeth per day. 67% of the Greater Glasgow population reportedly brush their teeth at least twice a day.
Table 5.13. Responses to the question ‘how often do you brush your teeth?’ by ethnicity.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=208)</th>
<th>Indian (n=154)</th>
<th>African &amp; Caribbean (n=243)</th>
<th>Entire Sample (n=605)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twice or more a day</td>
<td>56%</td>
<td>68%</td>
<td>83%</td>
<td>70%</td>
</tr>
<tr>
<td>About once a day</td>
<td>44%</td>
<td>32%</td>
<td>17%</td>
<td>30%</td>
</tr>
</tbody>
</table>

There were no overall gender differences, although Indian females (58%) were more likely than Indian males (42%) to say that they brushed their teeth twice or more per day. Figure 5.14 illustrates that teeth brushing habits show some variation as a function of ethnicity and age, and it is noteworthy that tooth brushing two or more times daily appears to decrease among Pakistani and Indian participants from the age of 16-29 years to 35-44 years, before slightly increasing again in participants aged 45-54 years.

Figure 5.14. Percentage of participants brushing teeth two times or more times per day by ethnicity and age.

N.B. Numbers of African & Caribbean participants in the 65+ years age category are very small.

5.7 Health Information

Participants were asked if they needed more information on a range of 14 health topics (see Table 5.14). Analysis of the overall number for which health information was needed indicated that African and Caribbean participants (mean number of health issues=2.93, SD=3.47) said that they needed information on more issues than their Indian (mean=1.99, SD=3.35) and Pakistani (mean=1.87, SD=3.12) counterparts. Since this was consistent across most of the categories
listed, further analysis examined the perceived necessity of further information as a function of age and gender.

### Table 5.14. Perceived necessity of further information on health issues by ethnicity (number of participants in brackets).

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Pakistani % (n)</th>
<th>Indian % (n)</th>
<th>African &amp; Caribbean % (n)</th>
<th>Entire Sample % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident Prevention</td>
<td>9 (19)</td>
<td>12 (19)</td>
<td>20 (47)</td>
<td>14 (85)</td>
</tr>
<tr>
<td>Addictions</td>
<td>3 (6)</td>
<td>5 (8)</td>
<td>10 (24)</td>
<td>6 (38)</td>
</tr>
<tr>
<td>Cancer</td>
<td>12 (26)</td>
<td>12 (19)</td>
<td>19 (45)</td>
<td>15 (90)</td>
</tr>
<tr>
<td>Child Health</td>
<td>19 (39)</td>
<td>18 (28)</td>
<td>28 (134)</td>
<td>22 (134)</td>
</tr>
<tr>
<td>Dental Health</td>
<td>12 (26)</td>
<td>15 (23)</td>
<td>22 (54)</td>
<td>17 (103)</td>
</tr>
<tr>
<td>Heart Health</td>
<td>15 (32)</td>
<td>18 (27)</td>
<td>20 (47)</td>
<td>18 (106)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>14 (29)</td>
<td>11 (17)</td>
<td>12 (28)</td>
<td>12 (74)</td>
</tr>
<tr>
<td>Men’s Health</td>
<td>18 (37)</td>
<td>17 (26)</td>
<td>24 (58)</td>
<td>20 (121)</td>
</tr>
<tr>
<td>Nutrition</td>
<td>17 (36)</td>
<td>22 (33)</td>
<td>27 (65)</td>
<td>22 (134)</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>14 (29)</td>
<td>15 (23)</td>
<td>30 (73)</td>
<td>21 (125)</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>9 (18)</td>
<td>17 (11)</td>
<td>22 (52)</td>
<td>14 (87)</td>
</tr>
<tr>
<td>Smoking</td>
<td>6 (13)</td>
<td>5 (7)</td>
<td>6 (15)</td>
<td>6 (35)</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>23 (48)</td>
<td>24 (37)</td>
<td>30 (73)</td>
<td>26 (158)</td>
</tr>
<tr>
<td>Young People’s Health</td>
<td>16 (34)</td>
<td>13 (20)</td>
<td>25 (59)</td>
<td>19 (113)</td>
</tr>
<tr>
<td>None of These</td>
<td>57 (120)</td>
<td>52 (79)</td>
<td>40 (96)</td>
<td>49 (295)</td>
</tr>
</tbody>
</table>

A number of differences emerged. Across the sample men were more likely than women to say that they wanted information on accident prevention. Participants aged 30-49 years were significantly more likely to want information on childcare and dental health than those aged 50+ years. Men were more likely to want information on men’s health and smoking, whilst the reverse was true for women, who also wanted more information than male participants on nutrition. Male participants aged 30-49 years were more likely than female participants to want information on young people’s health.

The finding to emerge informally as part of the research process suggesting that African and Caribbean respondent showed a tendency to say that they required basic information on the National Health Service is also noteworthy.
5.7.1 Format of Information on Health Issues

The most frequently requested formats for the information were: videos (132 participants) booklets (128 participants) leaflets (106 participants), Internet (74 participants), talks/seminars (29 participants), posters (28 participants), and audiotape (27 participants).

5.7.2 Distribution of Information

Participants were also asked to indicate where they would like to receive the information and prompted with the examples of supermarket, surgery and community centre. The prompting is reflected in the answers with these three categories being named with relative frequency. The most commonly named places where participants would like to receive information on the above health issues are as follows: surgery (95 participants), by post (85 participants), community centre (75 participants), supermarket (65 participants), place of worship (7 participants), library (7 participants), workplace (3 participants).

Given the open-ended format of the question and that participants were not prompted with this response, the relatively large number of participants saying that they would like to receive information by post is noteworthy.

5.7.3 Language of Information

Participants were also asked in which language they would like to receive the above information (multiple responses were possible).

Across the sample the vast majority (83%) of participants said that they wanted to receive the information in English (89% of African and Caribbean; 77% of Pakistani; 79% of Indian respondents). Thirty five percent of Pakistani and 3% of Indian participants said that they wanted information in Urdu, whilst 8% of Pakistani and 23% of Indian respondents said that they would like the information in Punjabi. Furthermore, 11% of Indian participants said that they wanted to be able to receive information in Hindi and 25% of African and Caribbean
interviewees said that they wanted to receive the information in French. A very small number of participants (not analysed in detail) also said that they wanted information in other languages.
6 Social Health and Capital

6.1 Social Connectedness

6.1.1 Number of Close Friends

Respondents were asked how many close friends they would say they had. The mean number of close friends reported by participants across ethnic groups was 4.47 (SD=4.47) and did not differ as a function of age or ethnicity. Across the entire sample, however, a significant difference between male (mean=5.03, SD=5.69) and female (mean=3.90, SD=2.6) participants was found. This indicates that regardless of their ethnic background, male participants consistently reported having a greater number of friends.

6.1.2 Ethnic Background of Close Friends

Participants were also asked how many of their close friends were from the same ethnic background as themselves. Pakistani participants reported that 76% (SD=30) of their close friends were also from the same ethnic background, and this was a marginally yet significantly higher percentage compared to 72% (SD=29) Indian and to 70% (SD=31) of African and Caribbean participants. There were no significant differences as a function of gender or age.

6.1.3 Isolation from Friends and Family

When asked whether they ever felt isolated from family and friends, 24% of participants across all ethnic groups responded ‘yes’ and this did not vary as a function of participant age and gender. However, African and Caribbean (30%) participants were more likely than Pakistani (19%) and Indian (23%) to say that they felt isolated from friends and family. It is interesting to note that participants from all minority ethnic groups surveyed were more likely to say that they felt isolated from family and friends than the Greater Glasgow population as a whole (15%).
6.2 Perceptions of Local Area

Participants were asked to indicate their feeling towards the local area in which they live. Participants were presented with four statements, and asked to rate the extent they agreed with them on a five-point scale from 1 (Strongly disagree) to 5 (Strongly agree).

6.2.1 Feeling of Belonging to Local Area

African and Caribbean (mean=3.21, SD=1.08) participants said they felt that they belong to their local area significantly less than the Pakistani (mean=4.04, SD=1.08) and Indian (mean=4.11, SD=1.18) participants. The corresponding mean for the Greater Glasgow population is 3.7 (SD=0.93), and, whilst this is slightly lower than that of Indian and Pakistani respondents, it is higher than that of the African and Caribbean participants. Further analysis showed that across the sample the oldest age group of 50+ years (mean=4.12, SD=1.17) felt that they belonged to their local area to a significantly greater degree than did participants aged 16-29 (mean=3.66, SD=1.32) and 30-49 (mean=3.59, SD=1.3) years (Figure 6.1).

Figure 6.1. Mean agreement with the statement ‘I feel I belong to my local area’ by ethnicity and age.

![Diagram showing mean agreement with the statement 'I feel I belong to my local area' by ethnicity and age.]

Pakistani (n=208)  
Indian (n=153)  
African & Caribbean (n=243)  
Entire Sample (n=604)
This age trend whereby individuals aged 50+ years were more likely to say that they felt that they belonged to their local area was also evident in the Greater Glasgow population at large. The population survey indicated that individuals aged 50+ years (mean=4.17, SD=0.54) felt that they belonged to their local area to a significantly greater degree than did participants aged 16-29 (mean=3.69, SD=0.62) and 30-49 (mean=4.02, SD=0.56) years.

### 6.2.2 Significance of Friendships / Associations in Local Area

The above findings concerning the degree to which participants felt they belonged to their local area was mirrored in the responses to the statement 'the friendships/associations I have in my local area with other people mean a lot to me'. Again African and Caribbean (mean=3.38, SD=1.25) participants agreed comparatively less strongly, and those participants aged 50+ (overall mean=4.08, SD=1.14) tended to agree more strongly than those age 16-29 (mean=3.69, SD=1.18) and 30-49 (mean=3.61, SD=1.24) years. The corresponding mean for the Greater Glasgow population is 3.8 (SD=0.82), and very similar to that of Pakistani (mean=3.85, SD=1.08) respondents and slightly lower than that of Indian (mean=4.11, SD=1.18) participants (Figure 6.2).

**Figure 6.2.** Mean agreement with the statement ‘the friendships/associations I have in my local area with other people mean a lot to me’ by ethnicity and age.
Further analysis of the Greater Glasgow population survey results suggested that participants felt that the friendships / associations with other people in their local area meant comparatively more to older participants than younger ones. Thus in the 50+years age group (mean=4.12, SD=0.55), participants agreed more strongly with the above statement than those aged 16-29 (mean=3.79, SD=0.6) and 30-49 (mean=3.96, SD=0.59) years.

### 6.2.3 Trust in People of Local Area

Participants were also asked the extent to which they agreed with the statement ‘I can trust people in my local area’ in the same format as above. As is illustrated in Figure 6.3, the pattern of results mirrors the results obtained in the aforementioned two statements. African and Caribbean (mean=2.93, SD=1.3) reported feeling significantly less trust towards the people living in respondents’ local areas than did Pakistani (mean=3.65, SD=1.24) and Indian (mean=4.05, SD=1.13) informants. The equivalent mean from the Greater Glasgow wide survey is 3.8 (SD=0.2).

![Figure 6.3. Mean agreement with the statement 'I can trust people in my local area' by ethnicity and age.](image)

Figure 6.3 also illustrates that respondents aged 50+ years (mean=4.07, SD=1.10) were significantly more likely to say that they had trust in the people
from their local areas than those aged 16-29 (mean=3.31, SD=1.35) and 30-49 (mean=3.32, SD=1.31) years.

This age trend is also apparent in the Greater Glasgow wide survey in which respondents aged 50+ years (mean=4.05, SD=0.52) were significantly more likely to say that they had trust in the people from their local areas than those aged 16-29 (mean=3.65, SD=0.59) and 30-49 (mean=3.90, SD=0.58) years.

6.2.4 Help with Problems

Once again, responses to the statement ‘if I have a problem, there is always someone to help me’ followed the same pattern of responses (see Figure 6.4). African and Caribbean respondents (mean=3.25, SD=1.36) agreed significantly less strongly with the statement than did Pakistani (mean=3.94, SD=1.14) and Indian (mean=4.21, SD=1.10) participants. For the Greater Glasgow population the corresponding mean is 3.8 (SD=0.82).

As can be seen in figure 6.4, respondents aged 50+ years (mean=4.15, SD=1.17) were significantly more likely to say that they had someone to help with problems than those aged 16-29 (mean=3.75, SD=1.26) and 30-49 (mean=3.53, SD=1.31) years.
This pattern of results is very similar to that found in the general population survey in which respondents aged 50+ years (mean=4.12, SD=0.53) were significantly more likely to say that they had someone to help with problems than those aged 16-29 (mean=3.74, SD=0.61) and 30-49 (mean=3.96, SD=0.58) years.

6.2.5 Perceptions of Personal Safety

Participants were also asked the extent to which they agreed with three statements gauging perceptions about personal safety. As before, agreement with the statements was measured on a five-point scale ranging from 1 (Strongly disagree) to 5 (Strongly agree).

6.2.5.1 Using Public Transport

The first statement was ‘I feel safe using public transport in my local area’ and analysis indicated no significant differences as a function of ethnicity and gender (overall mean agreement=4.21, SD=1). The equivalent mean for Greater Glasgow as a whole is 3.9 (SD=0.74) and somewhat lower, suggesting that participants in this survey felt slightly safer using public transport. The broad agreement with the statement in this survey suggests that respondents felt relatively safe using public transport in their local area. There was, however, an effect of age across the sample with participants aged 50+ years (mean=4.38, SD=1) feeling significantly more secure than those aged 30-49 years (mean=4.08, SD=1.06). Participants aged 16-29 years (mean=4.28, SD=0.9) lay in-between in terms of their strength of agreement. The Greater Glasgow general population survey, in contrast found no significant differences in response patterns as a function of age.

6.2.5.2 Walking Alone

The second statement asked how safe participants felt walking around alone even after dark. Pakistani (mean=3.65, SD=1.34) and Indian (mean=3.78, SD=1.36) agreed with the statement to a significantly greater degree than did their African and Caribbean (mean=3.05, SD=1.42) counterparts. Moreover,
across the sample male (mean=3.64, SD=1.33) participants agreed to a significantly larger degree than did female (mean=3.23, SD=1.46) interviewees. Additionally, participants aged 50+ years (mean=3.89, SD=1.32) agreed more strongly than those aged 16-29 years (mean=3.48, SD=1.41) and 30-49 years (mean=3.2, SD=1.41). These age and gender trends across the sample are illustrated graphically in Figure 6.5 below. Comparison with the equivalent findings from the Greater Glasgow population as a whole (mean=3.4, SD=1.07) indicate that participants in this survey felt roughly as safe walking alone after dark than did the Greater Glasgow population. In the general population survey participants aged 30-49 years (mean=3.97, SD=0.54) said that they felt significantly safer walking around their local area than those aged 16-29 years (mean=3.85, SD=0.57). Then mean agreement for respondents to the general population survey aged 50+ years was 3.91 (SD=0.60) and did not differ to a significant degree from either of the other age groups.

Figure 6.5. Mean agreement with the statement ‘I feel safe walking alone around my local area even after dark’ by gender and age.

6.2.5.3 Feeling Safe in Own Home

The final statement asked participants the degree to which they felt safe in their own home. Responses are illustrated in Figure 6.6 and the comparative mean for Greater Glasgow, as a whole, was 4.3 (SD=0.65) and broadly comparable with the results found in this survey. The pattern of responses in the general population survey did not differ to a significant degree as a function of age.
Across the sample African and Caribbean (mean=4.15, SD=1.05) participants felt significantly less safe than Pakistani (mean=4.67, SD=0.77) and Indian (mean=4.64, SD=0.77) participants. As Figure 6.6 illustrates, in the youngest age group African and Caribbean respondents felt significantly less safe than Pakistani participants; in the middle age group they felt significantly less safe than both Pakistani and Indian participants; and there were no significant differences between ethnic groups in the 50+ years age groups. Moreover, across the sample participants aged 30-49 years (mean=4.31, SD=1.03) felt significantly less safe in their own home than those aged 16-29 years (mean=4.57, SD=0.78) and 50+ years (mean=4.46, SD=0.93).

6.3 Racism

Given that racism can take many forms, and that definitions of racism may differ greatly, racism was measured by means of the schedules of ‘minor’ and ‘major’ racist events developed by Landrine and Klonoff (1996). The first of these probed how often participants thought that nine racist incidents had occurred to them using a seven-point scale (1=Almost never; 7=Very often). The schedule of ‘major’ racist events, on the other hand, asked whether participants had experienced seven events (e.g. ‘have you ever been fired or denied promotion...
because of your ethnic background’) and scored by adding the number of times participants said ‘yes’, as opposed to ‘no’.

### 6.3.1.1 ‘Minor’ Racist Events

Figure 6.7 summarises graphically the responses to the schedule of racist events by ethnicity and age. African and Caribbean (mean=29.21, SD=12.74) participants reported more ‘minor’ experiences of racism than both Pakistani (mean=21.32, SD=11.33) and Indian (mean=20.02, SD=10.64) interviewees. Across the sample, participants aged 30-49 (mean=26.26, SD=13.07) years reported significantly more experiences of racism than those aged 16-29 (mean=23.47, SD=12.42) and 50+ (mean=20.94, SD=10.22) years. There were no significant differences as a function of gender.

![Figure 6.7. Mean schedule of racist events (‘minor’) scores by ethnicity and age.](image)

### 6.3.1.2 ‘Major’ Racist Events

A similar picture emerged when participants were asked about the number of ‘major’ racist events they had encountered. Again, African and Caribbean (mean=1.14, SD=1.47) participants reported significantly more such events than their Pakistani (mean=0.53, SD=1.01) and Indian (mean=0.46, SD=1.02) counterparts.
Across the sample, participants aged 30-49 (mean=0.95, SD=1.42) years reported significantly more ‘major’ experiences of racism than those aged and 50+ (mean=0.49, SD=1.05) years (see Figure 6.8). There were no significant gender differences.

The findings regarding perceptions of racism and discrimination thus illustrate that, whilst present in all minority ethnic groups sampled, it may be particularly marked in the African and Caribbean communities of Greater Glasgow.

6.4 Social Capital

6.4.1 Community Group Membership

Community group membership and volunteering did not differ as a function of gender. However, as is illustrated in Figures 6.9 and 6.10 below, African and Caribbean participants were much more likely than their Indian and Pakistani counterparts to report acting as a volunteer or being a member of a community group.
The finding that African and Caribbean respondents were more likely to report being civically engaged than their Pakistani and Indian counterparts may point to social and cultural and differences with regard to the perceived importance of local and community involvement. Furthermore, the part played by religion in the organisation of the respective communities may also have had a bearing on these findings.

Findings from the Greater Glasgow genera population survey indicate that 20% of the general population belong to a social club.
6.4.2 Acting as a Volunteer

Figure 6.11 also illustrates the finding regarding a greater degree of voluntary civic engagement in the African and Caribbean community. In particular, more than a third of African and Caribbean participants aged 30-49 years appear to display a relatively high degree of voluntary involvement.

6.5 Individual Circumstances

6.5.1 Perceptions of Identity

Perceptions of (ethnic) identity are not only recognised to be an indicator of individuals’ connectedness to the broader social and cultural environment in which they live, they may also bear an influence on mental well-being by buffering individuals’ from the effects of racism and perceived discrimination. According to Branscombe et al. (1999) perceived discrimination may strengthen the extent to which individuals identify with their minority group, which, in turn, influences psychological well-being positively. At the same time recent research carried out in Glasgow suggests that young people who attached importance to Scottish
identity were less likely to report feelings of depression than those young people who did not (Heim et al., 2004).

With this in mind, participants were asked to rate both the extent to which they felt Scottish/British, and also the degree to which participants identified with their ethnic background. This methodology therefore did not juxtapose ethnic and Scottish/British identity, and allowed participants to identify with their ethnic background in addition to feeling Scottish/British.

6.5.1.1 Feeling Scottish/British

Participants were asked to rate on a ten-point scale from 1 (Not at all) to 10 (Very much), how Scottish/British they felt. Results indicated that across the sample, African and Caribbean participants (mean=5.11, SD=2.80) felt less Scottish/British than their Pakistani (mean=6.57, SD=5.59) and Indian (mean=6.24, SD=2.89) counterparts. Moreover, this finding appears to have largely been the result of African and Caribbean participants aged between 16 and 49 years reporting that they felt significantly less Scottish/British than both Pakistani and Indian interviewees. As Figure 6.12 illustrates, there were no significant differences in how Scottish/British respondents felt in the 50+ years age group between ethnic groups.

Figure 6.12. Feeling Scottish/British by ethnicity and age.

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85
Further analysis across the sample suggested a significant impact of participants’ age and gender on how Scottish/British they felt. As Figure 6.13 illustrates, whilst there were no significant differences between male and female interviewees in the 16-29 years and 30-49 years age groups, male participants in the 50+ years age group felt significantly more Scottish/British than female participants.

**Figure 6.13. Feeling Scottish/British by ethnicity and gender.**

![Graph showing mean scores of how Scottish/British do you feel by age group and gender.](image)

### 6.5.1.2 Feeling ‘Ethnic Background’

Utilising the same scale outlined above, participants were also asked the question ‘on a scale from 1 (Not at all) to 10 (Very much) how (ethnic background) do you feel?’ with interviewers tailoring the question to respondents’ respective ethnic backgrounds. Results indicated that across the sample African and Caribbean participants (mean=8.56, SD=1.92) identified more strongly with their ethnic background than both Pakistani (mean=7.42, SD=2.35) and Indian (mean=7.68, SD=2.54) backgrounds. Furthermore, regardless of respondents’ ethnicity and gender, participants aged 50+ years (mean=7.30, SD=2.56) identified significantly less strongly with their respective ethnic backgrounds than participants in the 16-29 years (mean=8.15, SD=2.22) and 30-49 years (mean=8.05, SD=2.19) age groups.
6.5.2 Nationality

Participants were asked in an open-ended format which nationality they were. As is shown in Table 6.1, Indian and Pakistani participants were more likely than their African and Caribbean counterparts to say that they were British. Pakistani participants were also most likely to say that they had dual nationality (e.g. Pakistani/British).

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Pakistani (n=198)</th>
<th>Indian (n=149)</th>
<th>African &amp; Caribbean (n=237)</th>
<th>Entire Sample (n=584)</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>38%</td>
<td>34%</td>
<td>4%</td>
<td>23%</td>
</tr>
<tr>
<td>Dual (including British/Scottish)</td>
<td>26%</td>
<td>8%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>29%</td>
<td>0%</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Indian</td>
<td>4%</td>
<td>54%</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>African Country</td>
<td>0%</td>
<td>0%</td>
<td>80%</td>
<td>32%</td>
</tr>
<tr>
<td>Religious (i.e. Muslim)</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Other (including European or Caribbean countries)</td>
<td>1%</td>
<td>1%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Scottish</td>
<td>1%</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

6.5.3 Place of Birth

Participants were asked whether they had been born in the United Kingdom and analysis of results did not indicate any significant differences as a function of gender. As Figure 6.14 illustrates, in the 16-29 years age group Indian (46%) and Pakistani (65%) participants were significantly more likely to have been born in the UK than their African and Caribbean (6%) counterparts. Furthermore, Pakistani and Indian participants aged 16-29 years were also significantly more likely than Pakistani and Indian participants in the two older age groups to have been born in the UK. There were no significant differences in whether the African and Caribbean participants had been born in the UK as a function of age.
6.5.4 Length of Residency in Greater Glasgow

Participants were asked also for how long they had lived in the Greater Glasgow area and, once again, findings point to marked differences between the Indian and Pakistani participants on the one hand, and the African and Caribbean respondents, on the other.

As Figure 6.15 illustrates, across the sample African and Caribbean participants (mean number of years=6.16, SD=9.48) reported living in Greater Glasgow for significantly less years than did Pakistani (mean=17.25, SD=11.13) and Indian (mean=16.63, SD=13.77) interviewees. There were a number of differences both as a function of age and ethnicity. In the youngest age group of 16-29 years Pakistani (mean=13.71, SD=8.89) participants reported living in Greater Glasgow for significantly longer than both African and Caribbean (mean=3.7, SD=4.6) and Indian (mean=10.94, SD=10.23) participants. Indian participants aged 16-29 years, in turn, reported living in Greater Glasgow for significantly longer than African and Caribbean participants. In the 30-49 years age group Indian (mean=16.56, SD=13.64) and Pakistani (mean=17.11, SD=11.48) participants both reported living in Greater Glasgow significantly longer than African and Caribbean (mean=4.79, SD=7.13) respondents. Finally, in the 50+ years age group only the Indian participants (mean=26.74, SD=13.88), and not the
Pakistani respondents (mean=23.07, SD=11.45), reported living in Greater Glasgow significantly longer than their African and Caribbean (mean=17, SD=6.19) counterparts.

![Figure 6.15. Years lived in Greater Glasgow by ethnicity and age.](image)

6.5.5 Language Knowledge and Ability

6.5.5.1 Languages Spoken

The questionnaire probed specifically whether participants spoke English, Urdu, Punjabi, Hindi, French, Swahili, and Yoruba. Table 6.2 summarises the languages most commonly spoken by participants (multiple responses were possible). Interviewees were also asked in an open-ended format to name any other languages they spoke. 5% of Pakistani participants, 21% of Indian participants, and 57% of African and Caribbean respondents said that they spoke a further language to the ones surveyed. A number of participants (less than 5% of the entire sample, and primarily from African and Caribbean backgrounds) reported speaking two, or more, additional languages.
Table 6.2. Languages spoken by ethnicity (number of participants in brackets).

<table>
<thead>
<tr>
<th>Language</th>
<th>Pakistani</th>
<th>Indian</th>
<th>African &amp; Caribbean</th>
<th>Entire Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>90 (190)</td>
<td>94 (146)</td>
<td>92 (224)</td>
<td>92 (560)</td>
</tr>
<tr>
<td>Urdu</td>
<td>81 (170)</td>
<td>14 (21)</td>
<td>&lt;1 (1)</td>
<td>32 (192)</td>
</tr>
<tr>
<td>Punjabi</td>
<td>85 (180)</td>
<td>57 (88)</td>
<td>1 (3)</td>
<td>44 (271)</td>
</tr>
<tr>
<td>Hindi</td>
<td>13 (27)</td>
<td>62 (96)</td>
<td>1 (3)</td>
<td>21 (126)</td>
</tr>
<tr>
<td>French</td>
<td>7 (14)</td>
<td>6 (9)</td>
<td>25 (60)</td>
<td>14 (83)</td>
</tr>
<tr>
<td>Swahili</td>
<td>3 (6)</td>
<td>1 (2)</td>
<td>29 (71)</td>
<td>13 (79)</td>
</tr>
<tr>
<td>Yoruba</td>
<td>0</td>
<td>1 (2)</td>
<td>7 (16)</td>
<td>3 (18)</td>
</tr>
<tr>
<td>Lingala</td>
<td>0</td>
<td>0</td>
<td>7 (16)</td>
<td>3 (16)</td>
</tr>
<tr>
<td>Arabic</td>
<td>&lt;1 (1)</td>
<td>0</td>
<td>3 (6)</td>
<td>1 (7)</td>
</tr>
<tr>
<td>Maratyi</td>
<td>0</td>
<td>6 (10)</td>
<td>0</td>
<td>2 (10)</td>
</tr>
<tr>
<td>Shona</td>
<td>0</td>
<td>0</td>
<td>4 (9)</td>
<td>2 (9)</td>
</tr>
</tbody>
</table>

6.5.5.2 First Spoken Language

Interviewees’ first language spoken is summarised in Table 6.2. Approximately 1% of Pakistani, 4% of Indian and 11% of African and Caribbean participants reported that their first spoken language was different from the ones listed. However, the comparatively low response rate should be noted (106 missing cases) since this may have impacted adversely on the accuracy of the figures summarised in Table 6.3. Whilst most respondents spoke English, as already noted, it tended to not be the first language spoke, especially among the Pakistani and Indian respondents.

Table 6.3. First spoken language by ethnicity (number of participants in brackets).

<table>
<thead>
<tr>
<th>Language</th>
<th>Pakistani</th>
<th>Indian</th>
<th>African &amp; Caribbean</th>
<th>Entire Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>27 (53)</td>
<td>32 (43)</td>
<td>45 (60)</td>
<td>31 (156)</td>
</tr>
<tr>
<td>Punjabi</td>
<td>52 (102)</td>
<td>44 (59)</td>
<td>3 (5)</td>
<td>33 (166)</td>
</tr>
<tr>
<td>Urdu</td>
<td>31 (62)</td>
<td>2 (3)</td>
<td>0</td>
<td>13 (65)</td>
</tr>
<tr>
<td>Hindi</td>
<td>2 (3)</td>
<td>20 (27)</td>
<td>0</td>
<td>6 (30)</td>
</tr>
<tr>
<td>Yoruba</td>
<td>0</td>
<td>0</td>
<td>6 (11)</td>
<td>2 (11)</td>
</tr>
<tr>
<td>Swahili</td>
<td>0</td>
<td>0</td>
<td>23 (39)</td>
<td>8 (39)</td>
</tr>
<tr>
<td>French</td>
<td>1 (2)</td>
<td>0</td>
<td>24 (42)</td>
<td>9 (44)</td>
</tr>
</tbody>
</table>

There was also a clear trend whereby the likelihood of participants saying that English was their first spoken language diminished with age. Thus, across the sample, 44% of participants aged 16-29 years said that English was their first spoken language, compared to 26% of 30-49 year olds and 16% of respondents aged 50+ years. This trend was most marked in the Indian sample with 57% of the 16-29 years age group saying that English was their first spoken language, together with 46% of Pakistani and 32% of African and Caribbean participants in
the same age group. Indeed, in the African and Caribbean sample participants aged 50+ years (48%) were more likely than the younger age groups to say that English was their first spoken language.

### 6.5.5.3 Self-Rated English Language Ability

Participants were asked to rate how well they spoke, wrote and read English on a ten-point scale ranging from 1 (Very poorly) to 10 (Very well).

#### 6.5.5.3.1 Speaking English

African and Caribbean participants aged 50+ years (mean=8.00, SD=2.26) rated their spoken English ability significantly higher than Pakistani (mean=5.11, SD=2.45) and Indian (mean=5.81, SD=2.17) participants of the same age (see Figure 6.16). There were no significant differences in the younger age groups as a function of ethnicity.

![Figure 6.16. Self-rated ability to speak English by ethnicity and age.](image)

Across the entire sample male participants (mean=7.85, SD=2.35) rated their ability to speak English significantly higher than their female counterparts (mean=7.56, SD=2.81). Furthermore, self-rated ability to speak English decreased with age in all ethnic groups. Across the sample, participants in the 16-29 year age group (mean=8.59, SD=1.92) rated their ability as significantly better than those aged 30-49 (mean=7.64, SD=2.52) years. Both the younger
age groups rated their ability to speak English as significantly higher than participants in the 50+ years age group (mean=6.19, SD=2.6).

6.5.5.3.2 Writing English

An almost identical picture emerged when participants were asked to rate their English writing ability on the ten-point scale. Across the sample, male participants (mean=7.66, SD=2.49) rated their ability to write English significantly more highly than female respondents (mean=7.35, SD=2.85).

![Figure 6.17. Self-rated ability to write English by ethnicity and age.](image)

As Figure 6.17 illustrates, African and Caribbean (mean=7.61, SD=2.61) participants aged 50+ years rated their ability to write English significantly higher than both Pakistani (mean=4.21, SD=2.33) and Indian (mean=5.32, SD=2.35) participants.

6.5.5.3.3 Reading English

In contrast to writing and speaking English no significant gender differences emerged for self-rated ability to read English. As with self-rated ability to write in English, African and Caribbean (mean=8.31, SD=2.18) participants aged 50+ rated their ability to write English significantly higher than both Pakistani
(mean=7.09, SD=2.96) and Indian (mean=7.56, SD=2.7) participants (see Figure 6.18).

Figure 6.18. Self-rated ability to read English by ethnicity and age.

6.5.6 Educational Attainment

The self-reported highest level of educational achievement is summarised in Table 6.4. It indicates that the level of educational achievement is markedly lower in the Pakistani sample, when compared to African and Caribbean and Indian respondents.

Table 6.4. Highest level of self-reported highest educational achievement by ethnicity.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=210)</th>
<th>Indian (n=154)</th>
<th>African &amp; Caribbean (n=244)</th>
<th>Entire Sample (n=608)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Education</td>
<td>14%</td>
<td>7%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Secondary Education</td>
<td>31%</td>
<td>26%</td>
<td>14%</td>
<td>23%</td>
</tr>
<tr>
<td>Further Education (e.g. college)</td>
<td>29%</td>
<td>23%</td>
<td>38%</td>
<td>31%</td>
</tr>
<tr>
<td>Higher Education (university)</td>
<td>20%</td>
<td>40%</td>
<td>43%</td>
<td>34%</td>
</tr>
<tr>
<td>No Formal Education</td>
<td>6%</td>
<td>4%</td>
<td>2%</td>
<td>4%</td>
</tr>
</tbody>
</table>

The number of participants with no formal education increases with age (from 0% of those aged 16-24 years to 21% of those aged 65+ years). There are few differences in educational attainment as a function of gender, although women (6%) appear more likely than men (2%) to report that they do not have any formal education.
6.6 Home and Environment

6.6.1 Household Size

It is important to note that the following figures regarding household size are more than likely to underestimate the total number of people living in the same households as the respondents who took part in this survey. This was due to the fact that at the beginning of data collection some fieldworkers did not complete the relevant section in the questionnaire accurately. Attempts were made to obtain missing data via the telephone (where participants had provided contact details). The following data were obtained.

Figure 6.19 illustrates graphically the household composition of the Pakistani sample. Compared to the Greater Glasgow population (household sizes: 20% one person; 31% two people; 23% three people; 26% more than three people) it becomes apparent that Pakistani people living in Greater Glasgow tend to live in larger households of more than three people than do the population at large.

Figure 6.19. Household size (Pakistani sample).

The size of Pakistani participants’ households was also found to be significantly larger than those of Indian (Figure 6.20) and African and Caribbean (Figure 6.21) respondents. The mean number of household members in the Pakistani sample was 3.89 (SD=1.94). This was significantly higher than the household size of
Indian (mean=3.06, SD=1.56) and African and Caribbean (mean=2.25, SD=1.63) respondents. More specifically, African and Caribbean participants reported living in significantly smaller households than both Pakistani and Indian respondents.

Figure 6.20. Household size (Indian sample).

![Household size chart](attachment:image.png)

As Figure 6.20 illustrates, the Indian samples' household makeup showed a less marked but nevertheless noteworthy tendency to be larger than that of the Greater Glasgow population. Indeed, Indian participants were almost twice as likely as the general population to say that they lived in households with more than three members.

The household make-up reported by African and Caribbean participants was remarkably different from both that reported by the Indian and Pakistani participants on the one hand, and that reported previously by the General population of Greater Glasgow, on the other. The majority of African and Caribbean participants thus appeared to say that they lived on their own (see Figure 6.21). This finding is important since lone person households may be more prone to social isolation, which may be associated with diminished mental and emotional well-being.
Across the sample, there was also a significant tendency for participants aged 16-29 years (mean=2.77, SD=1.85) to live with less people than those interviewees aged 30-49 years (mean=3.18, SD=1.85). The mean number of household members in the 50+ years age group was 3.08 (SD=1.86) and not significantly different from either of the other two age groups.

Moreover, a significant interaction between participant gender and age group suggested that male participants aged 16-29 years (mean=2.53, SD=1.95) lived in significantly smaller households than male participants aged 30-49 years (mean=3.16, SD=1.95) and 50+ years (mean=3.34, SD=2.09). Female participants, in contrast did not differ significantly in terms of household size as a function of age, and the mean household size of female interviewees across all age groups was 3.05 (SD=1.70). This finding is illustrated graphically in Figure 6.22.
6.6.2 Marital Status

As is illustrated in Table 6.5 Pakistani and Indian participants were more likely than their African and Caribbean counterparts to be married. African and Caribbean participants, in turn, were more likely to say that they were single / never married. Pakistani and Indian participants were more likely than the Greater Glasgow population (47%), as a whole, to be married. African and Caribbean respondents were slightly less likely to say that they were married. The incidence of divorce and separation across Greater Glasgow is 9% and higher than in the Indian (2%) and Pakistani (7%) communities. Furthermore, in contrast to Greater Glasgow figures (7% of population); participants from all ethnic groups were less likely to report that they were cohabiting with their partner. These trends are likely to reflect broad cultural differences between the majority and minority cultures with regards to interpersonal relationships, and it is important to remember that they may not necessarily be a reflection of qualitatively ‘better’ marriages. Moreover, bearing in mind that, particularly in old age, having a partner is an important determinant of (mental) health and well-being and may impact on the upbringing of children, the findings are of significance.
Table 6.5. Marital status by ethnicity.

<table>
<thead>
<tr>
<th></th>
<th>Pakistani (n=210)</th>
<th>Indian (n=155)</th>
<th>African &amp; Caribbean (n=243)</th>
<th>Entire Sample (n=608)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>60%</td>
<td>65%</td>
<td>41%</td>
<td>53%</td>
</tr>
<tr>
<td>Cohabiting / living with partner</td>
<td>1%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Single / never married</td>
<td>29%</td>
<td>25%</td>
<td>41%</td>
<td>33%</td>
</tr>
<tr>
<td>Widowed</td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Divorced</td>
<td>2%</td>
<td>1%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Separated</td>
<td>5%</td>
<td>1%</td>
<td>6%</td>
<td>4%</td>
</tr>
</tbody>
</table>

When considering the Pakistani sample in more detail a number of trends become apparent (see Table 6.6). Participants in the youngest age group were less likely than respondents in the two older age groups to be married and the incidence of divorce and separation rose with age, as did the incidences of widowhood. Male participants in the 50+ years age group were more likely to say that they were married than women, who, in turn were more likely to report that they were widowed.

Table 6.6. Marital status by age and gender of the Pakistani sample (number of participants in brackets).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Both Genders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>16-29 (n=74)</td>
<td>Married</td>
<td>23 (9)</td>
<td>23 (8)</td>
</tr>
<tr>
<td></td>
<td>Cohabiting / living with partner</td>
<td>0</td>
<td>3 (1)</td>
</tr>
<tr>
<td></td>
<td>Single / never married</td>
<td>77 (30)</td>
<td>69 (24)</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>0</td>
<td>3 (1)</td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td>0</td>
<td>3 (1)</td>
</tr>
<tr>
<td>30-49 (n=89)</td>
<td>Married</td>
<td>87 (40)</td>
<td>84 (36)</td>
</tr>
<tr>
<td></td>
<td>Cohabiting / living with partner</td>
<td>2 (1)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Single / never married</td>
<td>9 (4)</td>
<td>2 (1)</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>0</td>
<td>5 (2)</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>0</td>
<td>2 (1)</td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td>2 (1)</td>
<td>7 (3)</td>
</tr>
<tr>
<td>50+ (n=47)</td>
<td>Married</td>
<td>88 (21)</td>
<td>48 (11)</td>
</tr>
<tr>
<td></td>
<td>Cohabiting / living with partner</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Single / never married</td>
<td>0</td>
<td>4 (1)</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>4 (1)</td>
<td>26 (6)</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>0</td>
<td>9 (2)</td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td>8 (2)</td>
<td>13 (3)</td>
</tr>
</tbody>
</table>

With regards to the Indian sample (see Table 6.7), a trend is apparent by which individuals from an Indian background (and females in particular) get married at a younger age than their Pakistani and African and Caribbean counterparts (see Tables 6.6 and 6.8). A similar finding to that of Pakistani participants, albeit less marked, emerged with regards to male participants in the oldest age group being more likely than females to say that they were married (and less likely to say that they were widowed).
Table 6.7. Marital status by age and gender of the Indian sample (number of participants in brackets).

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Both Genders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>16-29 (n=66)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>28 (8)</td>
<td>46 (17)</td>
<td>38 (25)</td>
</tr>
<tr>
<td>Cohabiting / living with partner</td>
<td>0</td>
<td>3 (1)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Single / never married</td>
<td>69 (20)</td>
<td>46 (17)</td>
<td>56 (37)</td>
</tr>
<tr>
<td>Widowed</td>
<td>3 (1)</td>
<td>3 (1)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>3 (1)</td>
<td>2 (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Both Genders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>30-49 (n=52)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>77 (20)</td>
<td>85 (22)</td>
<td>81 (42)</td>
</tr>
<tr>
<td>Cohabiting / living with partner</td>
<td>8 (2)</td>
<td>12 (3)</td>
<td>10 (5)</td>
</tr>
<tr>
<td>Single / never married</td>
<td>8 (2)</td>
<td>0</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Divorced</td>
<td>4 (1)</td>
<td>4 (1)</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Separated</td>
<td>4 (1)</td>
<td>0</td>
<td>2 (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Both Genders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>50+ (n=37)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>100 (19)</td>
<td>78 (14)</td>
<td>89 (33)</td>
</tr>
<tr>
<td>Cohabiting / living with partner</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Single / never married</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>22 (4)</td>
<td>11 (4)</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

When considering the marital status of the African and Caribbean sample (Table 6.8), it becomes apparent that females appear to get married at a younger age than males. In contrast to both the Pakistani and Indian samples, however, the incidence of divorce and separation appears to increase dramatically with age from 0% in the youngest age group to 12% in the 30-49 years age group and 34% in the 50+ years age group. It is also interesting to note that this age trend was more marked amongst female participants.

Table 6.8. Marital status by age and gender in the African and Caribbean sample (number of participants in brackets).

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Both Genders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>16-29 (n=87)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>12 (5)</td>
<td>20 (9)</td>
<td>16 (14)</td>
</tr>
<tr>
<td>Cohabiting / living with partner</td>
<td>2 (1)</td>
<td>7 (3)</td>
<td>5 (4)</td>
</tr>
<tr>
<td>Single/never married</td>
<td>85 (35)</td>
<td>72 (33)</td>
<td>78 (68)</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>2 (1)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Both Genders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>30-49 (n=120)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>74 (49)</td>
<td>39 (21)</td>
<td>58 (70)</td>
</tr>
<tr>
<td>Cohabiting / living with partner</td>
<td>2 (1)</td>
<td>0</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Single / never married</td>
<td>21 (14)</td>
<td>30 (16)</td>
<td>25 (30)</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>9 (5)</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Divorced</td>
<td>2 (1)</td>
<td>7 (4)</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Separated</td>
<td>2 (1)</td>
<td>15 (8)</td>
<td>8 (9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Both Genders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>50+ (n=36)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>50 (9)</td>
<td>33 (6)</td>
<td>42 (15)</td>
</tr>
<tr>
<td>Cohabiting / living with partner</td>
<td>0</td>
<td>6 (1)</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Single / never married</td>
<td>6 (1)</td>
<td>6 (1)</td>
<td>6 (2)</td>
</tr>
<tr>
<td>Widowed</td>
<td>6 (1)</td>
<td>22 (4)</td>
<td>14 (5)</td>
</tr>
<tr>
<td>Divorced</td>
<td>22 (4)</td>
<td>22 (4)</td>
<td>22 (8)</td>
</tr>
<tr>
<td>Separated</td>
<td>17 (3)</td>
<td>11 (2)</td>
<td>14 (5)</td>
</tr>
</tbody>
</table>
When the gender trends in marital status from all three samples are seen in conjunction, relatively consistent differences between the genders emerge: Men tend to be less likely than women to say that they are widowed, divorced or separated. Considering that the figures for the Greater Glasgow population at large do not indicate this trend, two possible reasons for this gender difference can be identified. First, it is possible that there was a sampling bias by which the male participants sampled happened to be more likely to be in a relationship. Second, these trends may be connected to broader social and cultural practices whereby, regardless of the ultimate ‘truth’ of the statements, men may be less likely than women to admit to an interviewer that a serious personal relationship has been unsuccessful.

6.6.3 Households with Children Under 14 Years and Use of Childcare

Participants were asked whether any children under the age of 14 years lived in their households. Responses for each community are summarised as a function of age and gender in Tables 6.9, 6.10, and 6.11. Regardless of ethnic background a trend whereby female participants have their children at a comparatively younger age than men is apparent.

Table 6.9. Children under the age of 14 years in household (Pakistani sample) by gender and age (number of participants in brackets).

<table>
<thead>
<tr>
<th>Gender (n)</th>
<th>16-29</th>
<th>30-49</th>
<th>50+</th>
<th>All Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (n=110)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, mine</td>
<td>10 (4)</td>
<td>56 (26)</td>
<td>29 (7)</td>
<td>34 (37)</td>
</tr>
<tr>
<td>Yes, others</td>
<td>30 (12)</td>
<td>2 (1)</td>
<td>8 (2)</td>
<td>14 (15)</td>
</tr>
<tr>
<td>No</td>
<td>60 (24)</td>
<td>41 (19)</td>
<td>63 (15)</td>
<td>53 (58)</td>
</tr>
<tr>
<td>Female (n=101)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, mine</td>
<td>29 (10)</td>
<td>63 (27)</td>
<td>0</td>
<td>37 (37)</td>
</tr>
<tr>
<td>Yes, others</td>
<td>23 (8)</td>
<td>7 (3)</td>
<td>13 (3)</td>
<td>14 (14)</td>
</tr>
<tr>
<td>No</td>
<td>49 (17)</td>
<td>30 (13)</td>
<td>87 (20)</td>
<td>50 (50)</td>
</tr>
</tbody>
</table>

It appears that, whilst the findings outlined above concerning marital status indicate that Pakistani (male) participants get married at a comparatively older age than their Indian counterparts, Pakistani men in the youngest age group appear more likely than in other communities to have children at an earlier age.
Table 6.10. Children under the age of 14 years in household (Indian sample) by gender and age (number of participants in brackets).

<table>
<thead>
<tr>
<th>Age</th>
<th>Male (n=74)</th>
<th>Female (n=80)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>16-29</td>
<td>3 (1)</td>
<td>25 (9)</td>
</tr>
<tr>
<td>30-49</td>
<td>65 (17)</td>
<td>46 (12)</td>
</tr>
<tr>
<td>50+</td>
<td>0</td>
<td>11 (2)</td>
</tr>
<tr>
<td>All Ages</td>
<td>24 (18)</td>
<td>29 (23)</td>
</tr>
</tbody>
</table>

When the African and Caribbean figures are considered a discrepancy between male and female respondent becomes apparent by which female participants are more likely to say that the children in their households are their own. This finding suggests that African and Caribbean women may play a more active role in childrearing. This interpretation may also be applicable to the response patterns summarised in the following paragraph below.

Table 6.11. Children under the age of 14 years in household (African and Caribbean sample) by gender and age (number of participants in brackets).

<table>
<thead>
<tr>
<th>Age</th>
<th>Male (n=124)</th>
<th>Female (n=118)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>16-29</td>
<td>10 (4)</td>
<td>39 (18)</td>
</tr>
<tr>
<td>30-49</td>
<td>57 (37)</td>
<td>61 (33)</td>
</tr>
<tr>
<td>50+</td>
<td>17 (3)</td>
<td>22 (4)</td>
</tr>
<tr>
<td>All Ages</td>
<td>36 (44)</td>
<td>47 (55)</td>
</tr>
</tbody>
</table>

6.6.3.1 Responsibility for Children Under 14 Years

Participants who said that there were children under the age of 14 years living in their household were asked whether they were responsible for these. Responses showed little variation by gender in the Pakistani (52%=n/a, 32%='yes', 16%='no') and Indian (59%=n/a, 6%='yes', 25%='no') samples. In the African and Caribbean sample female (50%) participants were more likely than male (40%) participants to say that they were responsible for children less than 14 years in the household (overall figures: 48%=n/a, 45%='yes', 7%='no').

6.6.3.2 Use of Childcare

Participants were asked whether they used any form of paid or unpaid childcare. Overall female participants were more likely than males to say that they used
childcare. Across the sample 12% of females said that they used childcare compared to only 6% of male participants. Pakistani participants (4%) and Indian (3%) participants were much less likely than African and Caribbean participants to say that they used childcare (17%). Moreover, across the entire sample participants aged 30-49 years (14%) were more likely to say that they used childcare than those aged 16-29 years (8%) and 50+ years (3%).

When only the 204 participants who said that they were responsible for children under 14 years living in their household are considered, 13% (9 participants) of Pakistani and 14% (5 participants) of Indian said that they made use of childcare. This is significantly lower than the 38% (38 participants) of African and Caribbean respondents who said they used a form of childcare.

6.6.4 Caring Responsibility

In addition to asking about childcare uptake, the interview schedule asked respondents whether they were responsible for caring for someone (e.g. a disabled child or an elderly person) on a day-to-day basis. ‘Ordinary’ childcare was not included in responses. 11% of Pakistani, 7% of Indian and 3% of African and Caribbean participants said that they cared for someone on a day-to-day basis. There was no difference as a function of gender in response patterns, however the likelihood of caring for someone increased with age from 5% in the 16-29 years age group to 8% in the 30-49 years age group to 10% in the 50+ years age group.

On average participants who said that they cared for someone said that they spent 5 hours (SD=3.4) per day caring for the person.

6.6.5 Internet Access

62% of Pakistani, 71% of Indian, and 79% of African and Caribbean participants reported having access to the Internet. There were no significant gender differences in terms of Internet access, indicating that for all ethnic groups male and female participants were equally likely to have access to the Internet.
As Figure 6.23 indicates, there was, however, a significant tendency for the oldest participants being the least likely to report having Internet access.

![Figure 6.23. Internet access by ethnicity and age.](image)

Figure 6.24 indicates that whilst African and Caribbean participants were the most likely to report having Internet access, they were the least likely to report having Internet access in their home.

![Figure 6.24. Places of Internet access (home, elsewhere, or both) by ethnicity.](image)
6.6.6 Perceived Difficulty Paying Unexpected Bill

Participants were asked how much of a problem it would be if they had to pay an unexpected bill (for example for a household repair) since this would give an indication of financial well-being. They were asked to consider having to meet the cost of three bills (£20, £100, £1000), and to rate how much of a problem it would be to pay the bill on a four point scale from 1 (Impossible to find) to 4 (No problem).

6.6.7 £20 Bill

Whilst there was a tendency for all participants to say that it would not be much of a problem to meet the unexpected cost of a £20 bill, African and Caribbean participants (mean=3.62, SD=0.53) perceived this to be a significantly greater problem than Pakistani (mean=3.87, SD=0.41) and Indian (mean=3.9, SD=0.32) respondents.

6.6.8 £100 Bill

When asked how much of a problem it would be to pay an unexpected bill of £100, again, African and Caribbean participants (mean=2.70, SD=0.83) perceived this to be a significantly greater problem than Pakistani (mean=3.18, SD=0.79) and Indian (mean=3.2, SD=0.7) respondents.

6.6.9 £1000 Bill

When asked how much of a problem it would be to pay an unexpected bill of £1000, a similar picture emerged (Figure 6.25). Again, African and Caribbean participants said that this would be a comparatively larger problem for themselves than Indian and Pakistani participants. There was a slight variation in this pattern as a function of participant age. African and Caribbean (mean=1.75, SD=0.73) participants aged 50+ years found it significantly harder to pay the imaginary £1000 bill than their Indian (mean=2.16, SD=0.67) counterparts. In the 30-49 years age group African and Caribbean (mean=1.47, SD=0.76) participants found
paying the imaginary £1000 bill harder than both their Indian (mean=2.49, SD=0.93) and Pakistani participants (mean=2.18, SD=0.83).

Figure 6.25. Perceived problem of paying unexpected bill of £1000 by ethnicity and age.

6.6.10 Proportion of Household Income from State Benefits

Responses to the question gauging participants’ perceptions regarding the proportion of their household income thought to be derived from state benefits are summarised in separate tables for Pakistani (Table 6.12), Indian (Table 6.13) and African and Caribbean (Table 6.14) participants.

Table 6.12. Proportion of household income from state benefits by age and gender (Pakistani sample).

<table>
<thead>
<tr>
<th></th>
<th>16-29</th>
<th>30-49</th>
<th>50+</th>
<th>All Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (n=105)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Very little</td>
<td>10 (4)</td>
<td>22 (10)</td>
<td>19 (20)</td>
<td></td>
</tr>
<tr>
<td>About a quarter</td>
<td>3 (1)</td>
<td>4 (2)</td>
<td>10 (2)</td>
<td>5 (5)</td>
</tr>
<tr>
<td>About a half</td>
<td>0</td>
<td>2 (1)</td>
<td>0</td>
<td>1 (1)</td>
</tr>
<tr>
<td>All</td>
<td>0</td>
<td>4 (2)</td>
<td>0</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>10 (4)</td>
<td>4 (2)</td>
<td>0</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Female (n=95)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>73 (24)</td>
<td>52 (22)</td>
<td>45 (9)</td>
<td>58 (55)</td>
</tr>
<tr>
<td>Very little</td>
<td>12 (4)</td>
<td>38 (16)</td>
<td>30 (6)</td>
<td>27 (26)</td>
</tr>
<tr>
<td>About a quarter</td>
<td>3 (1)</td>
<td>2 (1)</td>
<td>0</td>
<td>2 (2)</td>
</tr>
<tr>
<td>About a half</td>
<td>0</td>
<td>2 (1)</td>
<td>15 (3)</td>
<td>4 (4)</td>
</tr>
<tr>
<td>All</td>
<td>6 (2)</td>
<td>5 (2)</td>
<td>10 (2)</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6 (2)</td>
<td>0</td>
<td>0</td>
<td>2 (2)</td>
</tr>
</tbody>
</table>

The Greater Glasgow population survey indicates that approximately 43% of the general population reported that they were not in receipt of any state benefits,
whilst 28% reportedly received all of their income from state sources. As is illustrated in Tables 6.12 and 6.13, both Pakistani and Indian participants were considerably less likely than the general population to state that they were in receipt of state benefits. There was also a trend in the Pakistani sample indicating that male participants were less likely than their female counterparts to say that a proportion of their household income was derived from state benefits. In contrast, there was little variation as a function of gender in the Indian sample regarding the proportion of household income that was said to be derived from state sources (Table 6.13).

Responses obtained from African and Caribbean respondents follow a somewhat different pattern. As Table 6.14 highlights, African and Caribbean respondents overall were generally more likely than the general public to say that none of their household income was derived from state benefits. However, this was particularly true for male interviewees. Female African and Caribbean participants, 26% of whom said that all of their household income was derived from state sources, were less likely than their male counterparts to say that none of their income was derived from these sources. This may be an indication that female African and Caribbean participants living in Greater Glasgow, in particular, may be relatively dependent on benefits. Indeed, as the findings outlined above concerning the perceived difficulty to pay an unexpected bill suggest, African and Caribbean participants appeared to be comparable worse off financially than both Indian and Pakistani interviewees.
Further analysis suggested that being in receipt of benefits was associated with a comparatively shorter length of residency in Greater Glasgow over and above the ethnic background of participants. In other words, regardless of their ethnic background, participants were more likely to be in receipt of state benefits if they had lived in the Greater Glasgow area for comparatively less time.

### 6.6.11 Types of Benefits

Compared to the general population, 29% of which reported being in receipt of income support, participants from Pakistani and African and Caribbean backgrounds were more likely to say that they received this type of benefit (see Table 6.15). The general population (25%), in contrast, appear much more likely than respondents in this survey to be in receipt of disability-related benefits. Given that participants in this survey were only marginally less likely than the general population to say that they were suffering from a debilitating condition (see Chapter 1), this finding is not necessarily the result of demographic differences between our sample and the wider population. It may, however, be the result of comparatively lower levels of awareness in the populations sampled that incapacity-related benefits are available.
Table 6.15. Types of benefits by ethnicity (and Greater Glasgow comparison).

<table>
<thead>
<tr>
<th>In receipt of</th>
<th>Pakistani</th>
<th>Indian</th>
<th>African &amp; Caribbean</th>
<th>Entire Sample</th>
<th>GG Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>%</td>
</tr>
<tr>
<td>Job Seekers Allowance (JSA)</td>
<td>8 (7)</td>
<td>3 (1)</td>
<td>16 (17)</td>
<td>11 (25)</td>
<td>5</td>
</tr>
<tr>
<td>Income Support</td>
<td>35 (85)</td>
<td>24 (8)</td>
<td>52 (105)</td>
<td>42 (83)</td>
<td>29</td>
</tr>
<tr>
<td>Disability-Related Benefits</td>
<td>11 (9)</td>
<td>3 (1)</td>
<td>6 (6)</td>
<td>7 (16)</td>
<td>25</td>
</tr>
<tr>
<td>Housing Benefits</td>
<td>19 (16)</td>
<td>6 (2)</td>
<td>10 (10)</td>
<td>13 (28)</td>
<td>25</td>
</tr>
<tr>
<td>Child Tax Credit</td>
<td>31 (26)</td>
<td>30 (10)</td>
<td>14 (15)</td>
<td>23 (51)</td>
<td>5 (family tax credit)</td>
</tr>
<tr>
<td>Working Tax Credit</td>
<td>7 (6)</td>
<td>15 (5)</td>
<td>11 (11)</td>
<td>10 (22)</td>
<td></td>
</tr>
<tr>
<td>Disabled Person’s Tax Credit</td>
<td>0</td>
<td>0</td>
<td>1 (1)</td>
<td>&lt;1 (1)</td>
<td>1</td>
</tr>
<tr>
<td>Retirement Pension</td>
<td>9 (8)</td>
<td>24 (8)</td>
<td>4 (4)</td>
<td>9 (20)</td>
<td>38</td>
</tr>
<tr>
<td>Attendance Allowance</td>
<td>2 (2)</td>
<td>6 (2)</td>
<td>3 (3)</td>
<td>3 (7)</td>
<td>5</td>
</tr>
<tr>
<td>Other Pension</td>
<td>2 (2)</td>
<td>3 (1)</td>
<td>2 (2)</td>
<td>2 (5)</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>12 (10)</td>
<td>18 (6)</td>
<td>11 (12)</td>
<td>13 (28)</td>
<td></td>
</tr>
</tbody>
</table>

Indian as well as African and Caribbean participants in this survey were also markedly less likely than the population at large (25%) to say that they were receiving housing benefits (see Table 6.15), ‘other pensions’ (Greater Glasgow figure: 14%).

‘Other’ responses were not analysed by ethnicity owing to their infrequency and missing data. These were as follows:

- ‘child benefit’ (2%, 9 participants)
- ‘scholarship’ (1%, 5 participants)
- ‘widow allowance’ (1%, 4 participants)
- student bursary (1%, 3 participants)
- ‘social work department payments’ (<1%, 2 participants)
- ‘incapacity benefit’ (<1%, 1 participant)
- ‘sickness benefit’ (<1%, 1 participant)
- ‘NASS support’ (<1%, 1 participant)
7 General Conclusions

This report summarised the research findings from a health and well-being survey of people from African, Caribbean, Indian and Pakistani backgrounds living in Greater Glasgow. The research was commissioned because the most recent general population health and well-being survey (RBA, 2002) was not designed to yield sufficient information on the health and well-being of minority ethnic communities in Greater Glasgow. A similar survey of Greater Glasgow Chinese community was also conducted on behalf of the Chinese Healthy Living Centre (FMR Research, 2004). A culturally sensitive methodology, utilising a purposive sample stratified for age, gender and geographic location, was employed to obtain information on a number of indicators of health / mental health and well-being, as well as broader issues relating to service delivery, community involvement, home and environment, personal details, and experiences of racism. Minority ethnic fieldworkers, drawn from the respective minority ethnic populations, collected data with respondents’ informed consent, and informants were reimbursed for participating in the research. Fieldworkers were trained to help ensure standardised data collection.

Key research findings are discussed below in relation to the study aims.

7.1 Health

The report began by outlining respondents’ perceptions of their own health, which tended to be positive and comparable to those reported by inhabitants of Greater Glasgow in the general population health and well-being survey of 2002. At first sight this absence of differences between minority ethnic individuals and the general population may seem remarkable given that minority ethnic communities in the UK are disadvantaged in terms of health (Nazroo, 1997). However, since positive perceptions of health decreased with age, these results may be due to the younger age profile of the population sampled in this survey.

The younger age profile of the sample may explain why informants in this survey were less likely than the general population to say that they suffered from a debilitating condition and were consistently more positive than the general
population about their perceived quality of life, physical, mental and emotional well-being.

The response patterns concerning perceptions of health and well-being of African and Caribbean respondents tended to be more positive than those of Indian participants, the Greater Glasgow population at large, and Pakistani respondents in particular. Pakistani respondents, in contrast, tended to have a more negative perception of their health and were more likely to report that they were receiving treatment for conditions and illnesses, and to say that they suffered from a debilitating illness or condition that interfered with their lives. Respondents from Pakistani backgrounds also reported receiving treatment for a significantly greater number of conditions and illnesses than their Indian and African and Caribbean counterparts. In line with these findings, Pakistani respondents also tended to be most likely to report contact with health service providers in the twelve months preceding the interview.

### 7.2 Mental Well-Being

In terms of mental well-being, Pakistani respondents reported comparatively elevated levels of perceived stress and were also likely to score higher on the general health questionnaire (GHQ-12). The GHQ-12 is a measure of psychological distress that can be scored in both a continuous and a categorical (bimodal) manner - in the aforementioned finding the continuous scoring method was used. In comparison to Indian respondents, who consistently reported the least psychological distress across a range of measures, African and Caribbean respondents also showed a significant tendency to give responses that may be indicative of diminished mental well-being (although perceived stress scores, which were the lowest for African and Caribbean respondents, were an exception to this trend). In this way, for example, African and Caribbean respondents were the most likely to state that they did not feel in control about decisions affecting their lives. Moreover, when using the bimodal scoring method, 20% of African and Caribbean respondents had a GHQ score that may be indicative of psychological distress. This compared to 16% of Pakistani and 12% of Indian respondents.
The finding that self-reported experiences of racism were linked to elevated GHQ scores is also of interest. It serves as a reminder of the negative consequences discrimination can have on individuals’ lives, and points to the need to combat racism so that minority ethnic individuals and communities, who may already be disadvantaged socio-economically (Modood et al., 1999), can also achieve equality in terms of psychological well-being.

7.3 Satisfaction with Service Provision

Regarding satisfaction with health services, participants aged 50+ years from all minority ethnic groups were more satisfied with service provision than younger respondents. Older participants said that they felt more adequately informed about conditions and treatments, that they were encouraged to participate in decisions affecting treatment, and that they felt satisfied with their ‘say’ in the delivery of services. Pakistani and Indian respondents aged between 16 and 29 years were found to be unhappier than their older peers with both the adequacy of information about conditions / treatments and the extent to which they felt encouraged to participate in decisions affecting their health and treatment.

Whilst the aforementioned finding may suggest that health care professionals should be encouraged to show particular sensitivity in consultations with individuals aged between 16 and 49 years from minority ethnic communities, other findings point to significant language barriers to the consultation process, especially among older respondents. Thus, whilst participants aged 50+ years reported the greatest satisfaction with service delivery, including the perceived ease of getting appointments with health care service providers, they also reported the most difficulties in understanding the advice given and communicating their views. This may suggest that the findings regarding age differences in reporting satisfaction levels with service providers signify broader differences in social and cultural norms and expectations regarding health care service provision, as much as differences in actual experiences. For example, comparatively lower expectations regarding desired quality of service provision amongst those aged 50+ years across the population as a whole may help explain these findings.
7.4 Oral Health

Survey findings relating to oral health suggest that African and Caribbean respondents were more likely than their Indian and Pakistani counterparts to say that all of their teeth were their own. Respondents from African and Caribbean backgrounds were least likely to say that they had visited a dentist within the six months preceding the interview, whilst Pakistani respondents were the most likely to say that they had done so. Given that across the entire sample almost forty percent of respondents said that they had not visited a dentist in the fifteen months preceding the interview (compared to about thirty percent of the general population), it is apparent that greater effort is required to encourage minority ethnic individuals living in Greater Glasgow to visit (and/or register with) a dentist. In this context it is also important to note that Pakistani respondents, who were more likely than Indian and African and Caribbean respondents to say that they consumed sweet foods (e.g. sweets and chocolates), were also the least likely to say that they brushed their teeth twice daily. These findings may explain why Pakistani respondents were more likely to have visited a dentist in the months preceding the interview. They also suggest that the distribution of information regarding oral health amongst the Pakistani community in Greater Glasgow should be a priority.

7.5 Alcohol Consumption and Smoking

When considering survey findings summarised in the section, cultural sensitivities with regards to these behaviours, as well as the possibility that participants may have felt particularly uncomfortable disclosing information of this nature to fieldworkers drawn exclusively from respondents’ respective ethnic backgrounds should be borne in mind since these may have affected the ‘truthfulness’ of responses. In particular, this may be reflected in the low levels of self-reported alcohol consumption. In this way, 91% (85% of males and 97% females) of 57% Pakistani (34% of males and 79% of females) and 60% of African and Caribbean (56% of Males and 64% of females) participants said they never consumed alcoholic drinks. Furthermore, the number of participants who said that they had consumed an alcoholic drink in the month preceding the interview was only 7% of the entire sample, and these participants reported very low levels of alcohol
consumptions that were not sufficiently large to be analysed meaningfully in terms of units of alcohol consumed.

Findings regarding smoking indicate smoking is relatively more prevalent in the Greater Glasgow Pakistani community (23% smokers) compared with the Indian (10% smokers) and African and Caribbean (11% smokers) communities. Overall however, all communities were less likely to report that they smoked cigarettes than the general population of Greater Glasgow (33%). The tendency for smokers aged 50+ years to report being the heaviest smokers suggests generational differences in smoking behaviour. In terms of exposure to passive smoking, no clear differences emerged between the general population and respondents in this survey concerning their likelihood of reporting exposure to cigarette smoke some or most of the time. Moreover, exposure to smoking was the most frequently given response to the open ended question of whether respondents felt that there was something about their home that affected their health.

7.6 Diet

In terms of diet, the results suggest that self-reported intake of fruit and vegetables showed much variation as a function of ethnic background, and was particularly low amongst Pakistani respondents. Thus only 19% Pakistani reported consuming the recommended amount of five, or more, portions of fruit and vegetables per day. This compares to 34% of the general population, 33% of Indian and 47% of African and Caribbean participants. The comparatively low fruit and vegetable consumption reported by the Pakistani community may also reflect distinct styles of food preparation which may obscure the total amount of fruit and vegetables consumed. From this perspective, cooking practices may render it difficult to measure fruit and vegetable consumption in terms of ‘portions’, especially vegetables, since these may traditionally be associated with western styles of food preparation.

Breakfast cereal consumption was lower than in the general population, with Indian respondents reporting the highest consumption levels followed by African and Caribbean and Pakistani respondents. With regards to oily fish consumption,
Indian participants, in particular, were the least likely to meet the target set by the Scottish Diet Action Plan of eating oily fish at least two times per week.

However, promotion of the aforementioned diet action plan, which also stipulates how much bread and breakfast cereal people should eat, may be a problematic strategy to adopt when aiming to help minority ethnic individuals to improve their diets since, by being based on the general eating habits of the white population, it may be culturally insensitive and inappropriate.

7.7 Physical Activity

Pakistani (32%) respondents were less likely than Indian (50%) and African and Caribbean (45%) respondents to undertake the recommended amount of physical activity, defined as either moderate activity at last five times per week or twenty minutes of vigorous physical activity three or more times per week. These findings indicate that the general population (58% of which met this target in 2002) appear to be more physically active than the minority ethnic groups participating in this survey.

7.8 Body Mass Index

Results relating to the Body Mass Index (BMI) suggest that the likelihood of respondents in this survey being classified as overweight was similar to that of the general population, and Pakistani and African and Caribbean respondents were significantly more likely than their Indian counterparts to be classified in this way. Further analysis indicated that across the entire sample participants between 30-49 years were more likely to be classified as overweight than those aged between 16-29 years and over 50 years.

Comparatively high BMI scores were linked to receiving treatment for medical conditions, reports of stress, taking comparatively low amounts of moderate physical exercise and eating comparatively larger amounts of sugary foods amongst other factors. The increased likelihood of Pakistani respondents to be classified as overweight may therefore be linked to health behaviours since Pakistani informants reported the highest intake of sweet foods and lowest levels
of both moderate and vigorous exercise, as well as the highest stress levels. This suggests that it may be particularly worthwhile to target healthy lifestyle campaigns at the Pakistani community in Greater Glasgow.

7.9 Distribution of Information Relating to Health

Pakistani and Indian participants were significantly less likely than African and Caribbean respondents to say that they wanted further information on a number of health issues, in spite of the lower uptake of recommended health behaviours reported above. Whilst this may reflect lower levels of concern or awareness regarding issues relating to health in the Pakistani and Indian communities, it also suggests that African and Caribbean participants feel a particular need for additional health related information. This finding also emerged in other parts of the research with a number of African and Caribbean respondents, who tended to have lived in the Greater Glasgow area for the least amount of time and were most likely to have been born outside the UK, saying that they required general information on the National Health Service.

Other survey findings suggest that the perceived need for further health related information was perceived as being best met by distributing videos, booklets and leaflets, and making information available on the Internet. However, participants aged 50+ years were the least likely to have access to the Internet and also reported the most difficulties with reading and writing English. This suggests that information targeted at this age group should be distributed in appropriate (language) formats.

The vast majority of respondents said that they wanted information in English with Urdu and Punjabi also being mentioned by a sizable proportion of respondents. A relatively large number of participants said that they would like to receive information relating to health issues via the post, suggesting that this might be an effective strategy for distributing health-related information. Interestingly, as noted below (2.11) African and Caribbean respondents were the most likely to report having access to the internet.
7.10 Perceptions of Local Area and Identity

Perceptions relating to the local area in which participants lived and personal safety suggested that African and Caribbean individuals living in Greater Glasgow feel a comparatively lesser sense of belonging to their local area, as well as feeling less secure and safe than their Pakistani and Indian counterparts. In this context it is also significant that African and Caribbean respondents reported being subjected to racism more frequently than both Indian and Pakistani participants, and that respondents from African and Caribbean backgrounds were the least likely to say that they felt Scottish / British and identified most strongly with their ethnic background. This may also reflect the comparatively shorter average length of residency in Greater Glasgow of African and Caribbean participants (6 years compared to 17 years for Pakistani and Indian respondents) which may have had a bearing on the extent to which these respondents had established roots. Across all ethnic groups, older participants showed a greater tendency than younger informants to say that they felt connected to the area in which they lived. Moreover, across all ethnic groups participants in the oldest age groups (50+ years) identified less strongly with their ethnic background than those aged between 16 and 49 years.

The findings that African and Caribbean respondents were the most likely to report experiences of racism and feelings of isolation, and the least likely to feel connected to the area in which they lived may, in part, explain why community group membership and volunteering were more common in the African and Caribbean communities than in the other two. From this perspective, elevated community group membership may be a means of providing and attaining social support, in addition to being influenced by religious and socio-cultural practices of the three communities sampled. Moreover, retaining (and/or building) strong minority ethnic community links may help buffer adverse effects of racism and discrimination, and therefore be an advantageous strategy to adopt (Heim et al., 2004). This notion may also help explain the tendency for younger participants to identify more strongly than their older peers with their ethnic background.

7.11 Individual Circumstances and Financial Well-Being
The finding, hinted at above, that African and Caribbean respondents were the most likely to say that they sometimes felt isolated from friends and family may also be related to the demographic characteristics of the sample. Thus Indian and Pakistani respondents were more likely than their African and Caribbean counterparts to live in larger households, with more than half of African and Caribbean respondents saying that they lived alone. As mentioned above they were also likely to report much shorter periods of residence in Glasgow. Participants from African and Caribbean backgrounds were also the least likely to be married, and female African and Caribbean respondents were more likely than their male counterparts to say that they were responsible for children under the age of fourteen years in their household.

Finally, research findings relating to a range of indicators of financial well-being indicate that African and Caribbean respondents considered themselves to be worse off than both their Indian and Pakistani counterparts. African and Caribbean participants reported the most perceived difficulty of meeting the cost of an unexpected bill, and were also comparatively more likely to state that a proportion of their household income was derived from state benefits. African and Caribbean respondents were more likely than their Indian and Pakistani equals to have access to the internet, although they were least likely to say that they had access to the internet in their own home. This may also be an indication of comparatively lower levels of affluence in the African and Caribbean community in Greater Glasgow. The survey also found that, regardless of their ethnic background, participants who had lived in Greater Glasgow for a comparatively longer length of time were less likely to be in receipt of state benefits.

7.12 Research Limitations

A few general points regarding the limitations of the research are appropriate. Whilst care was taken to stratify the sample with the aim of making it as representative of the minority ethnic populations as possible, the extent to which it is representative remains difficult to determine owing to a lack of appropriate sampling frames as well as the purposive nature of the sampling methodology.
Moreover, since participation was voluntary and the recruitment of respondents was opportunistic there is the possibility of sampling biases.

Some caution also needs to be brought to bear on comparisons drawn across the minority ethnic communities surveyed in this research since significant differences as a function of ethnic background may also have reflected differences in sample characteristics (e.g. in terms of age), although the analysis by age and gender may have controlled for this to an extent. For example, since the age profile of the minority ethnic populations surveyed is somewhat younger than that of the Glasgow general population not all of the findings from the current survey and that of the general population are readily comparable. Moreover, the research instruments utilised in the current survey differed to some extent from those used in the general population survey.

Whilst the methodology of exclusively employing fieldworkers from minority ethnic backgrounds may have impacted adversely on the ‘truthfulness’ of responses (see 5.1.2), this practice may also have enriched the data to a degree. By interviewing respondents in their preferred language, as well as using - and building upon - existing links with minority ethnic community groups and individuals the research team was able to involve individuals in the survey who may otherwise have been excluded from taking part.

In addition, the flexible nature of the data collection process and the inclusive fieldworker recruitment process enabled a number of fieldworkers to gain employment in the UK and / or research experience for the first time. This opportunity, as did the perceived importance of the research, helped ensure that fieldworkers were highly motivated and is likely to also have combated the problem of fieldworker fatigue to some degree.

7.13 Further Areas for Research

In conclusion, this study provided an overview of health and well-being issues affecting the Pakistani, Indian, and African and Caribbean communities in Greater Glasgow, encompassing the highest numbers of people from minority ethnic backgrounds living in Scotland. Bearing in mind health inequalities affecting minority ethnic communities, and explicit linkages between health and social
inclusion agendas this research identified areas of concern as well as positive factors, which will inform planning as well as suggest areas for future research. It also provided a baseline against which to measure the impact of initiatives aimed at improving the health and well-being of minority ethnic communities in Greater Glasgow.

Given the relatively broad aims of this research, covering amongst other issues indicators of health and well-being, satisfaction with services, and perceptions relating to identity and local areas, future research should explore some of the key findings in more depth. For example, whilst this research identified a relationship between experiences of racism and diminished psychological well-being, future research could aim to identify factors that may mediate this link. Given that this research identified differences between minority ethnic groups with regards to specific health behaviours (e.g. diet and physical activity); future research should endeavour to identify possible underlying reasons for such discrepancies. In particular, findings in this study point to a need for developing culturally sensitive measures of dietary behaviours that may inform local and national dietary guidelines for minority ethnic groups. Information needs of minority ethnic communities and possible communication approaches and routes could also be explored further, as well as identifying barriers in terms of access to services encountered by minority ethnic communities.
8 References


attitudes to service provision: Results from a survey of Indian, Chinese and Pakistani young people in Greater Glasgow, Scotland, UK. *Alcohol and Alcoholism, 39*, 220-226.


9 Appendix

Health and Well-Being Study Questionnaire

INTERVIEWER: Ensure that participant has read the information sheet, has had the opportunity to ask questions about the study and signed the consent form.

Screening Questions

1. As outlined in the information sheet, this survey is interested in the views of people from Pakistani, Indian, African or Caribbean backgrounds. Can I confirm that you are from one of these backgrounds?

   Yes / No

   If no, thank and close
   If yes, continue with survey

2. Are you aged 16 or over? Yes / No

   If no, thank and close
   If yes, continue with survey

3. Can I please check whether you have already been interviewed for the Health and Well-being Survey? (EXPLAIN IF NECESSARY) Yes / No

   If yes, thank and close
   If no, continue with survey

<table>
<thead>
<tr>
<th>Full Post Code</th>
</tr>
</thead>
</table>

Participant ID (Interviewer Initials and Number of Interview): ______________

INTERVIEWER DECLARATION:
I declare that this interview was carried out according to instructions.

<table>
<thead>
<tr>
<th>Interviewer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
</tr>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Interviewee Ethnicity</td>
</tr>
<tr>
<td>Gender and Age M F (circle) Age:</td>
</tr>
<tr>
<td>Interview duration</td>
</tr>
<tr>
<td>Area</td>
</tr>
<tr>
<td>Recruitment Details</td>
</tr>
<tr>
<td>Back-checked by</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>
SECTION 1 – YOUR HEALTH

Q1 I’d like to start by asking you some questions about your health. How would you describe your health over the past year? (READ OUT AND CODE ONE ONLY)

Would you say it was...

Excellent .......................................................................................................1
Good .............................................................................................................2
Fair................................................................................................................3
Poor ..............................................................................................................4

SHOWCARD A

Q2 Are you currently being treated for any of the following conditions?

(CODE ALL THAT APPLY, CHECK THAT PARTICIPANT IS CURRENTLY BEING TREATED)

Coronary heart disease ................................................................................1
Stroke ...........................................................................................................2
Arthritis or rheumatism or painful joints.........................................................3
Clinical depression.......................................................................................4
Diabetes ........................................................................................................5
Cancer ...........................................................................................................6
Asthma, bronchitis, or persistent cough........................................................7
Epilepsy .........................................................................................................8
Stress related conditions, e.g. difficulty sleeping or concentrating ...............9
Hearing problems .......................................................................................10
Eyesight problems ......................................................................................11
Accident / injury ..........................................................................................12
Gastro-intestinal problems, e.g. peptic ulcer disease, irritable bowel syndrome...........................................................................13
High blood pressure ....................................................................................14
Drug or alcohol related conditions ...............................................................15
Other/s (PLEASE SPECIFY) .......................................................................16

None ...........................................................................................................17

Q3 Do you have any long-term condition or illness that substantially interferes with your day to day activities?

Yes ..............................................................................................................1

No ...............................................................................................................2

GO TO Q4

GO TO Q5
Q4 Thinking of these conditions and/or illnesses, would you describe yourself as having…?
(READ OUT AND CODE ALL THAT APPLY)

A physical disability ....................................................................................... 1
A mental or emotional health problem .......................................................... 2
A long-term illness ........................................................................................ 3
Other/s (PLEASE SPECIFY) ........................................................................ 4
None of these ............................................................................................... 5

And now, thinking about your experiences of health services.

Q5 Thinking about the past 12 months and your own health:
(PUT A NUMBER IN EACH BOX. IF ‘NEVER’, WRITE IN ‘0’. IF DON’T KNOW, PROBE FOR ESTIMATE. IF CAN’T GIVE ESTIMATE, WRITE IN ‘DK’ REPEAT ‘PAST 12 MONTHS’ AND ‘YOUR OWN HEALTH’)

a) How many times have you seen a GP? ..................................................

b) How many times have you been to an accident and emergency department? ...........................................................

c) How many times have you visited a hospital out-patient department to see a doctor? (Do not include visits for an X-ray or other tests)

d) How many times have you been admitted to hospital for either day surgery or an overnight stay?

e) How many times have you been admitted to hospital for a stay of two nights or more?

f) How many times have you seen a dentist ...............................................

SHOWCARD B

Q6 Thinking about your recent use and experience of the Health Services such as GP, dentist, or hospital, please rank the following statements on a scale from 1 (not at all) to 5 (definitely).

(READ OUT AND CODE ONE FOR EACH)

In general…

a) Were you given adequate information about your condition or treatment? ...................................................... 1......2 .....3 .....4 .....5 7 8
b) Were you encouraged to participate in decisions affecting your health or treatment? ........................................ 1 ......2 .....3 ..... 4 ..... 5 7  8

c) Did you feel that you had a say in how these services were delivered? ........................................ 1 ......2 .....3 ..... 4 ..... 5 7  8
d) Did you feel that your views and circumstances were understood and valued? ........................................ 1 ......2 .....3 ..... 4 ..... 5 7  8
e) Did you have any problems understanding the advice given because of language difficulties? ........................................ 1 ......2 .....3 ..... 4 ..... 5 7  8
f) Did you have any problems getting your views across because of language difficulties? ........................................ 1 ......2 .....3 ..... 4 ..... 5 7  8

SHOWCARD C

Q7 Please rank the following statements on a scale from 1 (Great difficulty) to 5 (No difficulty).
(READ OUT AND CODE ONE FOR EACH)

<table>
<thead>
<tr>
<th>How much difficulty do you have...</th>
<th>Great</th>
<th>No</th>
<th>Don’t</th>
<th>Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Arranging for a home visit from your GP for yourself ........................................ 1 ......2 .....3 ..... 4 ..... 5 7  8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Getting an appointment to see your GP for yourself ........................................ 1 ......2 .....3 ..... 4 ..... 5 7  8</td>
<td></td>
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<tr>
<td>c) Getting to the GP’s surgery/Health Centre for yourself ........................................ 1 ......2 .....3 ..... 4 ..... 5 7  8</td>
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<tr>
<td>d) Accessing health services in an emergency for yourself ........................................ 1 ......2 .....3 ..... 4 ..... 5 7  8</td>
<td></td>
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</tr>
</tbody>
</table>
e) Obtaining an appointment at the hospital for yourself  ................................ 1......2 .....3 .....4 .....5  7  8
f) Getting appointments with health professionals for family members?  .................................... 1......2 .....3 .....4 .....5  7  8
f1) If experiencing difficulty, please specify: family member(s) & health professional(s) ..........................................................

Q8 What proportion of your teeth are your own?
(CROWNS ARE REGARDED AS ‘OWN TEETH’.) (READ OUT. CODE ONE ONLY)

All of them...................................................................................................1
Some of them.............................................................................................2
None of them..............................................................................................3

Q9 When was the last time you went to the dentist?
(READ OUT. CODE ONE ONLY)

Within the last 6 months .............................................................................1
Within 6 months to 15 months ....................................................................2
Over 15 months..........................................................................................3

Q10 How often do you brush your teeth?
(CODE ONE ONLY)

Twice or more a day ...................................................................................1
About once a day........................................................................................2
Less than once a day ...................................................................................3
Seldom or never .........................................................................................4

I would now like to ask you few questions concerned with tobacco and alcohol consumption.

Q11 How often are you usually in places where there is smoke from other people smoking tobacco? Would you say most of the time, some of the time, seldom or never?
(CODE ONE ONLY)

Most of the time ..........................................................................................1
Some of the time .......................................................................................2
Seldom .......................................................................................................3
Never.........................................................................................................4
SHOWCARD D

Q12 Which of the following statements best describes you at present?
(CODE ONE ONLY)

I have never smoked tobacco.................................................................1
............................................................................................................GO to Q13
I have only tried smoking once or twice.................................................2
............................................................................................................GO to Q13
I have given up smoking.......................................................................3
...........................................................................................................GO to Q12a
I smoke some days................................................................................4
...........................................................................................................GO to Q12b
I smoke every day ..................................................................................5
............................................................................................................GO to Q12c

Q12a On average, how many cigarettes a day did you smoke?
(WRITE NUMBER OF CIGARETTES IN THE BOX)
GO to Q13
(INCLUDE ROLL YOUR OWN; CODE AS ‘995’ IF THE PERSON
ONLY SMOKES CIGARS / PIPE)

Q12b On average, how many cigarettes a week do you smoke?
(WRITE NUMBER OF CIGARETTES IN THE BOX)
GO to Q13
(INCLUDE ROLL YOUR OWN; CODE AS ‘995’ IF THE PERSON
ONLY SMOKES CIGARS / PIPE)

Q12c On average, how many cigarettes a day do you smoke?
GO to Q13
(WRITE NUMBER OF CIGARETTES IN THE BOX)
(INCLUDE ROLL YOUR OWN; CODE AS ‘995’ IF THE PERSON
ONLY SMOKES CIGARS / PIPE)

Q13 Do you take tobacco in any other way apart from cigarettes or cigars?

Yes ........................................................................................................1
............................................................................................................GO TO Q13a

No .......................................................................................................2
............................................................................................................GO TO Q14

Q13a If YES, what ways do you take tobacco?

______________________________________________________________
Q14  How often do you drink alcohol?  
(READ OUT. CODE ONE ONLY)

Never........................................................................................................1
............................................................................................................GO to Q16
Less than once a month...........................................................................2
............................................................................................................GO to Q15
More than once a month but not weekly ..............................................3
............................................................................................................GO to Q15
1-2 days per week....................................................................................4
............................................................................................................GO to Q15
3-5 days per week....................................................................................5
............................................................................................................GO to Q15
6-7 days per week....................................................................................6
............................................................................................................GO to Q15

Q15  Have you had a drink containing alcohol in the past 7 days?  
(CODE ONE ONLY)

Yes ........................................................................................................1
............................................................................................................GO to Q15a
No ........................................................................................................2
............................................................................................................GO to Q16
### SHOWCARD E

**Q15a** Using the card, please tell me how much alcohol you drank on each day in the past week.

(START WITH THE PREVIOUS DAY AND WORK BACK THROUGH THE WEEK, RECORD HALF PINTS AS WELL AS PINTS)

<table>
<thead>
<tr>
<th>Normal strength beer/lager/stout/cider (eg McEwan’s lager, heavy)</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
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<tbody>
<tr>
<td>Pints</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Cans</td>
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<tr>
<td>Bottles</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Strong beer/lager/cider (eg Guinness, Murphy’s, Budweiser)</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
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<tbody>
<tr>
<td>Pints</td>
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</tr>
<tr>
<td>Cans</td>
<td></td>
<td></td>
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<tr>
<td>Bottles</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Extra strong beer/lager/ cider (eg Tennant’s super lager)</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
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<tbody>
<tr>
<td>Pints</td>
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<tr>
<td>Cans</td>
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<tr>
<td>Bottles</td>
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</table>

<table>
<thead>
<tr>
<th>Single measures of spirits (eg whisky, gin, vodka) (a bottle contains 28 measures)</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small glass</td>
<td></td>
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<tr>
<td>Large glass</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Single measures of Martini/sherry/buckfast/Mad Dog 20/20 (a bottle contains 14 measures)</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
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<tbody>
<tr>
<td>½ bottle</td>
<td>Full bottle</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Glasses of wine at pub or restaurant</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small glass</td>
<td>Large glass</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Bottles of wine at home</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>¼ bottle</td>
<td>½ bottle</td>
<td>Full bottle</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Bottles of alcoholic carbonate (alcopops, such as Smirnoff Ice and Bacardi Breezer)</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (please describe)</td>
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</tbody>
</table>

None on that day

**Q16** Now I’d like to ask you some questions about the food you eat.

**Q16** On average, how many portions of fruit do you eat EACH DAY?

On average, how many portions of fruit do you eat EACH DAY?

Examples of a portion are one apple, one tomato, 2 tablespoons canned fruit, one small glass fruit juice.

(WRITE NUMBER IN BOX. IF LESS THAN ONE, WRITE ‘0’)

**Q17** On average, how many portions of vegetables or salad (not counting potatoes) do you eat EACH DAY? A portion of vegetables is 2 tablespoons.

(WRITE NUMBER IN BOX. IF LESS THAN ONE, WRITE ‘0’)

---

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Q18 How many slices of bread or rolls do you usually eat PER DAY? (Please include the bread taken in sandwiches, and other breads such as chapattis & naan.)
(WRITE NUMBER IN BOX)

Q19 How often PER DAY do you usually eat items such as cakes, pastries, chocolate, biscuits and crisps?
(WRITE NUMBER IN BOX. IF LESS THAN ONE, WRITE '0')

Q20 What types of sweets and snacks do you usually eat?
..........................................................................................................................................
...........................................................................................
..........................................................................................................................................
...........................................................................................

(NOTE Q21-Q23 refer to the amount per week)

Q21 How many times PER WEEK do you usually eat breakfast cereal?
(WRITE NUMBER IN BOX)

Q22 How often PER WEEK do you usually eat oily fish, taken in sandwiches or as part of a meal? (e.g. kipper, herring, salmon, trout, mackerel, tuna, sardines or pilchards.)
(WRITE NUMBER IN BOX)

Q23 Do you know your approximate weight?
Yes .................................................................1
.........................................................................................GO TO Q23a
No ...............................................................................2
.........................................................................................GO TO Q24

Q23a What is your weight?
(WRITE IN WEIGHT IN STONES/POUNDS OR KILOGRAMS)

.........................................................................Stones  ................................................................Pounds
Or
............................................................................................Kilograms

Q24 Do you know your height?
Yes .................................................................................................1
.................................................................................................GO TO Q24a
No .................................................................................................2
.................................................................................................GO TO Q25
Q24a  What is your height?  
(WRITE IN HEIGHT IN FEET/INCHES OR CENTIMETRES)  

<table>
<thead>
<tr>
<th>Feet</th>
<th>Inches</th>
</tr>
</thead>
</table>

Or  

<table>
<thead>
<tr>
<th>Centimetres</th>
</tr>
</thead>
</table>

Q25  Thinking now of the exercise you take. In an average week, on how many days do you take at least 30 minutes of moderate physical exercise such as brisk walking? It doesn’t have to be 30 minutes all at once.  
(WRITE NUMBER OF DAYS IN BOX)  

Q26  In an average week, on how many days do you spend at least 20 continuous minutes doing vigorous exercise (enough to make you sweaty and out of breath)?  
(WRITE NUMBER OF DAYS IN BOX)  

SHOWCARD F  
Q27  Looking at the faces on the card:  

a. Which face best rates your overall quality of life? ...........................................
   (WRITE LETTER IN BOX)  

b. Which face best rates your general physical well being? .........................
   (WRITE LETTER IN BOX)  

c. Which face best rates your general mental or emotional well being?  
   (WRITE LETTER IN BOX)  

SHOWCARD H  
Q28  Using the statements on this card, please indicate how often you have felt or thought a certain way during the last four weeks.  

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>never</td>
</tr>
</tbody>
</table>

In the last four weeks, how often have you…  

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) felt that you were unable to control the important things in your life?</td>
<td></td>
</tr>
<tr>
<td>(2) felt confident about your ability to handle your personal problems?</td>
<td></td>
</tr>
<tr>
<td>(3) felt that things were going your way?</td>
<td></td>
</tr>
<tr>
<td>(4) felt difficulties were piling up so high that you could not overcome them</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 2 – COMMUNITY INVOLVEMENT

Now I’d like to ask about your general activities.

Q29 What do you usually do in your spare time?

…………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………

Q30 Are you a member of any community groups?

Yes ............................................................................................................. 1

............................................................................................................. GO TO Q31

No ............................................................................................................. 2

............................................................................................................... GO TO Q32

Q31 What community groups are you a member of?

…………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………

Q32 Do you act as a volunteer?

(CODE ONE ONLY)

Yes ............................................................................................................. 1

............................................................................................................. GO TO Q32a

No ............................................................................................................. 2

............................................................................................................... GO TO Q33

Q32a If Yes, give details

…………………………………………………………………………………………………………………………

SECTION 3 – HOME AND ENVIRONMENT

Q33 Do you have access to the Internet?

(CODE ONE ONLY)

Yes ............................................................................................................. 1

............................................................................................................. GO TO Q33a

No ............................................................................................................. 2

............................................................................................................... GO TO Q34
Q33a Where do you have access to the internet?
(CODE ONE ONLY)

Home ......................................................................................................... 1
Other ........................................................................................................... 2
Both ........................................................................................................... 3

If other, please specify: ________________________________________________

Q34 In your opinion, is there anything about your home that affects your health?

Yes ............................................................................................................ 1
................................................................................................................. GO TO Q33a
No ............................................................................................................... 2
................................................................................................................. GO TO Q35

Q34a Please give details of what about your home affects your health?

..................................................................................................................

..................................................................................................................

SHOWCARD I

Q35 On a scale from 1 (Strongly disagree) to 5 (Strongly agree), how much do you agree or disagree with the following statements about living in this local area?
(READ OUT AND CODE ONE FOR EACH)

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

a. I feel I belong to my local area. ....................................................... 1......2 .....3 ..... 4 ..... 5

b. The friendships and associations I have in my local area with other people mean a lot to me. ....................................................... 1......2 .....3 ..... 4 ..... 5

c. I can trust people in my local area ............................................... 1......2 .....3 ..... 4 ..... 5

d. If I have a problem, there is always someone to help me. ....................... 1......2 .....3 ..... 4 ..... 5

Q36 How many close friends would you say you have?  


Q37  On a scale from 1 (none of them) to 10 (all of them), how many of your close friends are from the same ethnic background as yourself?  
(CIRCLE NUMBER)

None of them       All of them

1  2  3  4  5  6  7  8  9  10

Q38  Do you ever feel isolated from family and friends?  
(CODE ONE ONLY)

Yes  ........................................................................................................1
No   ........................................................................................................2

Q38a  Do you feel in control of decisions that affect your life, such as planning your budget, moving house or changing job?  
(CODE ONE ONLY)

Definitely ....................................................................................... 1
To some extent ............................................................................. 2
No .............................................................................................. 3

SHOWCARD J

Q39  Please look at Showcard J and let me know the number that corresponds to your answer to the following statements.

Almost never      Sometimes       Very often

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often are you treated with less courtesy because of your ethnic background?</td>
<td></td>
</tr>
<tr>
<td>2. How often are you treated with less respect because of your ethnic background?</td>
<td></td>
</tr>
<tr>
<td>3. How often do you receive worse service because of your ethnic background?</td>
<td></td>
</tr>
<tr>
<td>4. How often do people act as if they think you are not clever because of your ethnic background?</td>
<td></td>
</tr>
<tr>
<td>5. How often do people act as if they are afraid of you because of your ethnic background?</td>
<td></td>
</tr>
<tr>
<td>6. How often do people act as if you are dishonest because of your ethnic background?</td>
<td></td>
</tr>
<tr>
<td>7. How often do people act as if they are better than you because of your ethnic background?</td>
<td></td>
</tr>
<tr>
<td>8. How often are you called names or insulted because of your ethnic background?</td>
<td></td>
</tr>
<tr>
<td>9. How often are you threatened or harassed because of your ethnic background?</td>
<td></td>
</tr>
</tbody>
</table>
Q39a  Please indicate if any of the following events below have occurred to you. (TICK THE CORRECT RESPONSE)

<table>
<thead>
<tr>
<th>Statement</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever been fired or denied a promotion because of your ethnic background?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you ever not been hired because of your ethnic background?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever been treated unfairly by police because of your ethnic background?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever been discouraged from seeking further education because of your ethnic background?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you ever been discouraged from seeking a job because of your ethnic background?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Has a landlord or estate agent ever refused to sell or rent to you because of your ethnic background?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Have neighbours ever made life difficult because of your ethnic background?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SHOWCARD K

Q40  Thinking about safety in your local area, on a scale from 1 (Strongly disagree) to 5 (Strongly agree), please rank how much you disagree or agree with the following statements? (READ OUT AND CODE ONE FOR EACH)

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

a. I feel safe using public transport in my local area
b. I feel safe walking alone around my local area even after dark
c. I feel safe in my own home

SECTION 4 – ABOUT YOU

SHOWCARD L

Q41  What level of education have you achieved?
(ASK FOR AND CODE HIGHEST)

Primary education........................................................................................................1
Secondary education...................................................................................................2
Further education (e.g. college)................................................................................3
Higher education (university)...................................................................................4
No formal education .................................................................................................5

Do you have any trade-related apprenticeships, professional qualifications, etc? (If so, specify) 6
Q42 Greater Glasgow NHS Board is reviewing the information it provides on health issues. Do you need any information on the following? (READ OUT & CODE ALL THAT APPLY)

Accident prevention .............................. 1
Addictions ........................................ 2
Cancer .................................................. 3
Child health ......................................... 4
Dental health ....................................... 5
Heart health ........................................ 6
Mental health ...................................... 7
Men’s health ....................................... 8
Nutrition ............................................. 9
Physical activity ................................. 10
Sexual health ..................................... 11
Smoking ............................................. 12
Women’s health ................................. 13
Young people’s health ....................... 14
None of these ...................................... 15   GO TO Q43 if none

Do you need information about anything not mentioned here? If so, please specify:

_____________________________________________________________

Q42a In which language would you like the information?

...........................................................................................................

Q42b In what format would you prefer the information? (READ OUT & CODE ALL THAT APPLY)

Leaflet ................................................. 1
Poster ................................................. 2
Booklet ................................................. 3
Video .................................................. 4
Audiotape ........................................... 5
Talks/seminars ................................. 6
Website/internet ............................. 7
Other ................................................. 8

Q42c Where or how would you like to receive this information (for example, supermarket, surgery, community centre, etc)?

...........................................................................................................

...........................................................................................................
Q43  Which of the following languages do you a) speak b) class as your first spoken language?

<table>
<thead>
<tr>
<th>Language</th>
<th>a) languages spoken</th>
<th>b) first spoken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urdu</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Punjabi</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hindi</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Yoruba</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Swahili</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>French</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>English</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Other(s) (please specify below) [INDICATE IF (a) or (b)]

(a) ____________________________________________

(b) ____________________________________________

Q44  On a scale of 1 to 10 with 1 being very poor and 10 being very well, how well would you say you a) speak English, b) write English and c) read English?

<table>
<thead>
<tr>
<th></th>
<th>very poor</th>
<th>very well</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) speak English</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>b) write English</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>c) read English</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>

SHOWCARD M

Q45  Using this card, please tell me how much of a problem would it be if you had to pay an unexpected bill (for example, for a household repair) of £20? or £100? or £1000? (READ OUT AND CODE ONE FOR EACH)

<table>
<thead>
<tr>
<th>Amount</th>
<th>Impossible to find D/K</th>
<th>A big problem</th>
<th>A bit of a problem</th>
<th>No problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. £20</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. £100</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. £1,000</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q46  What proportion of your household income comes from state benefits?
(READ OUT & CODE ONE ONLY)

None ........................................................................................................1
Very little.................................................................................................2
About a quarter .....................................................................................3
About a half ............................................................................................4
About three quarters ............................................................................5
All ..........................................................................................................6
Don’t know............................................................................................7

Q47 Are you or any member of your household in receipt of each of the following?

(READ OUT & CODE ALL THAT APPLY)

Job seekers allowance (JSA) .................................................................1
Income support .....................................................................................2
Disability-related benefits ..................................................................3
Housing benefits ..................................................................................4
Child tax credit ....................................................................................5
Working tax credit ................................................................................6
Disabled person’s tax credit .................................................................7
Retirement pension .............................................................................8
Attendance allowance .........................................................................9
Other pension .....................................................................................10
Other (PLEASE WRITE IN) .................................................................11

Q48 Are there any children under 14 in your household?

Yes, mine........................................................................................... 1
Yes, others ............................................................................................ 1
No ....................................................................................................... 2

Q49 Are you responsible for the children under 14 in your household?
(CODE ONE ONLY)

Yes ....................................................................................................... 1
No ....................................................................................................... 2
Q50  Do you use any form of childcare (paid or unpaid)?
(CODE ONE ONLY)
Yes ....................................................................................................... 1
No ....................................................................................................... 2

Q51  Apart from work, are you responsible for caring for someone on a day to
day basis?
e.g. a disabled child, elderly person, etc. (Do not include ‘ordinary’
childcare).
Yes ........................................................................................................1
...................................................................................... GO TO Q52
No ........................................................................................................2
...................................................................................... GO TO Q53

Q52  On average, how many hours per day do you spend looking after this
person(s)?
(WRITE NUMBER OF HOURS IN BOX)

Q53  Can you tell me which of these descriptions applies to you?
(CODE ONE ONLY)
Married .......................................................................................................1
Cohabiting/living with partner .....................................................................2
Single/never married ..................................................................................3
Widowed .....................................................................................................4
Divorced .....................................................................................................5
Separated ...................................................................................................6

Q54  Were you born in the UK?
Yes ............................................................................................................ 1
No.............................................................................................................. 2

Q55  How long have you lived in the Greater Glasgow area?
(WRITE IN YEARS AND/OR MONTHS)

Q56  Are you seeking asylum?
Yes ............................................................................................................ 1
No.............................................................................................................. 2

Q57  On a scale from 1 (Not at all) to 10 (Very much), how Scottish / British do
you feel?

Not at all 1  2  3  4  5  6  7  8  9  10 Very much
Q58 On a scale from 1 (Not at all) to 10 (Very much), how (ETHNIC BACKGROUND) do you feel?

Not at all               Very much
   1  2  3  4  5  6  7  8  9  10

Q59 What nationality (or nationalities) are you?

........................................................................................................
........................................................................................................

Q60 INTERVIEWER: Please record the appropriate details in the first row to tell us about the respondent. Then record details for each other member in the household (including children). Record the gender, age and working status for each. (Please provide details of ALL members of the household in the grid below. Remember to give respondent's details first.) [TICK MAIN WAGE EARNER]

<table>
<thead>
<tr>
<th>A Household members</th>
<th>B Gender M</th>
<th>C Write in actual age</th>
<th>D Working status See codes D below</th>
<th>E Industry sector See codes E below</th>
<th>F Main Wage Earner (TICK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
D Which of these apply to you and the main wage earner?
Enter code under Column D – WORKING STATUS
[IF CURRENTLY OFF WORK OR ON MATERNITY LEAVE, CODE AS EMPLOYED FULL- OR PART-TIME. WRITE ‘MWE’ BEHIND DETAILS OF MAIN WAGE EARNER.]

Employed full-time ........................................................... ......................................1
Employed part-time.......................................................... ......................................2
Unemployed for less than
    six months ............................................................. ......................................3
Unemployed for more than
    six months ............................................................. ......................................4
Unable to work due to
illness or disability............................................................ ......................................5
Retired ................................................................. ......................................6
Looking after home/family................................................ ......................................7
In full-time
    education/training .................................................. ......................................8
In part-time
    education/training .................................................. ......................................9
E  What industries do the respondent and major wage earner work for?
(WRITE ‘MWE’ BEHIND DETAILS OF MAIN WAGE EARNER)

<table>
<thead>
<tr>
<th>Industry</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturing and mining</td>
<td>1</td>
</tr>
<tr>
<td>Construction</td>
<td>2</td>
</tr>
<tr>
<td>Transport</td>
<td>3</td>
</tr>
<tr>
<td>Health service</td>
<td>4</td>
</tr>
<tr>
<td>Local or national government</td>
<td>5</td>
</tr>
<tr>
<td>Service industries (e.g. banking, insurance, travel, entertainment)</td>
<td>6</td>
</tr>
<tr>
<td>Retail services</td>
<td>7</td>
</tr>
<tr>
<td>Catering/food preparation</td>
<td>8</td>
</tr>
<tr>
<td>Professional services (e.g. teaching, legal, surveying services)</td>
<td>9</td>
</tr>
<tr>
<td>Voluntary or community sector</td>
<td>10</td>
</tr>
<tr>
<td>Not applicable</td>
<td>11</td>
</tr>
<tr>
<td>Other (PLEASE WRITE IN)</td>
<td>12</td>
</tr>
</tbody>
</table>

CLOSE INTERVIEW BY READING OUT STATEMENT:

"Thank you very much for your help. Can I assure you once again that the information you have given will be treated as absolutely confidential as stated on the information sheet"