Diet and Exercise

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Lifestyle and Health Choices of Older Pakistanis in Bradford

By

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For Natasha, Tanya, Hannah and Danyal

TABLE OF CONTENTS

CHAPTER ONE

BACKGROUND OF THE RESEARCH

The context of the study

The diet of South Asians living in the UK has an important influence on their health, but there are few studies in this field (Simmons and Williams, 1997). There is a limited amount of research which explores the physical activity and diet preference of Pakistanis in Bradford. This needs to be addressed in order to develop public health strategies to combat certain high-prevalence conditions, including diabetes and coronary heart disease, and the link these diseases have with a sedentary lifestyle through a lack of physical exercise and poor diet. Limited research has been undertaken around 'South Asian' and diet, while the available research examines cardiovascular disease (McKeigue and Sevak, 1994; Williams, Bhopal and Hunt, 1994). This book fulfils that gap in the knowledge of professionals, healthcare and medical students alike.

Existing health literature and empirical research, particularly in Pakistan, is limited and this book fulfils an important health knowledge gap. This book explores the lifestyle and health choices of older British Pakistanis (49+) living in the city of Bradford through examining food intake (diet) and physical exercise among this group. Through this research we understand the favourite foods among older Pakistanis; how they make their food choices; how much they understand about the food they purchase; how their diet has changed over time and the influence of British cuisine on their life. In terms of physical activity from this research we will understand the way older Pakistanis engage in physical activity; the frequency of exercising; how men and women differ in the way they exercise; the way they fit physical activity around their daily lives and around other commitments such as work and family. These issues were explored through conducting qualitative research through in-depth interviews in the city of Bradford. The information is presented in a qualitative tapestry, allowing the respondents to talk and elicit a richness

of information. The study is important because it can be used as a baseline study which can be built upon by further investigative research into diet and physical activity among older people and into the causes of diseases. At the same time this research should, it is hoped, also increase our understanding of how older Pakistanis spend their leisure time. The continued connection they have with Pakistan (in particular the Mirpur region from where they emigrated), the importance of family life and the importance of one's community to older Pakistanis come out strongly from the data. At the same time this research will be an invaluable book among academics and researchers to learn about the Pakistan community.

Research has shown that Pakistanis have a higher prevalence of certain diseases, including diabetes (see Hanis et al, 1983; Simmons et al, 1992; Abate and Chandalia, 2001) and coronary heart disease (see Gupta et al, 1994; Wild and Payne, 1997; McKeigue, 1997; Shaw et al, 1999). In addition the incidence of cancer among Pakistanis is increasing. Physical activity and diet are seen as having an important influence on these diseases; however it is also clear that given the higher prevalence of such conditions important health messages regarding diet and the need to participate in physical exercise are not been understood by the general public as a whole irrespective of ethnicity and not just by the Pakistani community.

An earlier important paper by Ahmad (1995) highlighted that the limited amount of work around 'race' and 'health' has led to race and ethnicity being marginalised in the area of health research. What little research existed was confined to quantitative studies (Sheldon and Parker, 1992). But this marked an important beginning among academics where 'race' and 'ethnicity' were used as variables in health research. This can allow the understanding of patterns of disease and the use of health services (Pearson, 1989). 'Race' is a biological concept which categorises humanity by means of sets of phonotypical features that appear to distinguish between types of people and are passed on between generations (as stated by Sheldon and Parker, 1992), whereas, 'ethnicity' involves the process of boundary definitions that demarcates one group from another (Wallman, 1986).

There has been a notable change in academic research over the past few decades. Social researchers such as sociologists have begun to show greater interest in health research. They play an important role, for example in helping to understand the occurrence and the geographical

spread of disease. As we will read later, the present study includes in-depth comments about social and environmental factors which a number of respondents highlighted as playing an important role in their general well-being. The overlap and the collaboration between academic fields such as social and medical (research) should be the norm. An appropriate example is studies moving from malnutrition in children towards health-related issues and disease prevention in future adults (Burgess and Morrison, 1998).

The structure and data were carefully put together allowing a clear understanding of the themes to be discussed. 'Quotes' are used sometimes at length, allowing the reader to interpret the material provided. Analysis is kept to the minimum without over-analysis by the author, allowing the respondents to speak for themselves as opposed to the 'academic'. It was left to the respondents to describe events and to provide answers and explanations to the question of 'why' allowing the conversation to flow with the minimum of pause or hesitation, allowing the respondent's story to be told. The respondent has a right to be listened to and to be heard. This is rarely done by researchers; instead in some cases long analysis is made. If the opportunity arises, exploring a largely private community is interesting in the least. It should be explored to levels anticipated by the participant. Being better informed, the reader is then in a position to ask questions. The freshness of the data and the material gathered shows itself in the quotes used. The quotes themselves are representative of the general consensus. A unique feature of this book is that it is set out differently from most other studies.

The reader will see early on that a number of quotes are used to illustrate the points raised in the research. This is to allow the reader to read much more of the respondents' interviews/transcripts, allowing the reader to follow their journey and their narrative and feel the vibrations of their interviews. From the dissemination point of view the research allows the reader to make analyses of their own. At the same time it is hoped that the reader will gain a greater understanding during their reading. They will also learn about the Pakistani community in Bradford, which has been a focal point of so much media interest over the years, made famous for the Manningham Riots in 1995 and in 2001. To understand the health norms within this community we need to understand the Pakistani community. For an in-depth discussion see my earlier works (Cullingford and Din, 2006; Din 2006).

CHAPTER TWO[1]

PAKISTANIS: POPULATION UNDER STUDY

Migration of Pakistanis to the UK

In order to understand the health outcomes and beliefs of the Pakistani community it is important to understand both the historical and present connection with Mirpur because what becomes clear from the data is that habits formed in Pakistan around food intake and physical exercise are still apparent in many of the British samples. Britain has a long history of White and non-White immigration to its shores. The presence of Asians in Britain can be dated back to the seventeenth century (Fryer, 1984; Visram, 1986). Indians began coming to the UK from the early part of the twentieth century as seamen (Aurora, 1976; Desai, 1963) and settled in areas such as Birmingham (Rose et al, 1969). Others, mainly White people, arrived from Europe and Eastern Europe. The numbers increased dramatically, especially after World War II. Most escaped to avoid to persecution (Jackson, 1963). The mass migration of non-White workers started more slowly, but during the 1950s increased substantially through the number of migrants from the West Indies. Although mass migration from India and Pakistan began from 1945 it also reached a high level from 1960 onwards (Anwar, 1995). The majority of Pakistanis who settled in the UK resided in Bradford and Birmingham (Dahya 1972; Shaw, 1988, 2000; Werbner, 1990). This involved a large-scale movement of people, under arrangements with the British government and Indian and Pakistani leaders (Allen, 1971; Taylor, 1976).

The religious, cultural and socio-economic position of Mirpuri immigrants from Pakistan before their arrival in Britain is essential in understanding many of the attitudes of the community. Despite the geographical and culture distance between the UK and Pakistan, there is still a major and

[1] For further discussion see Din, I. (2006) The New British: The Impact of Community and Change on Pakistanis. Ashgate.

ongoing influence from Pakistan because so many people travel back for visits, thus maintaining ties with relatives. After the separation of East and West Pakistan in 1947 from India, Mirpur became one of the three districts of Azad 'Free' Kashmir (Rose, 1969). An illustration of poverty in Pakistan in the 1940s and the 1950s was the low literacy rate and the poor provision of schooling (Braham, 1992). Due to high levels of poverty within the district of Mirpur only a small number of young children entered secondary schooling, and less than half stayed on at the age of fifteen. Thus, it is not surprising that the majority of the immigrants who came to Britain were illiterate (Khan, 1979; Kannon, 1978; see also Din, 2006).

There were a number of options open to Mirpuri villagers with contacts in the United Kingdom and limited opportunities at home. In reality, there were no economic reasons to encourage Pakistani men to stay in Mirpur (Khan, 1979; Lewis, 1994). Another motive for low-caste families to emigrate was that education could improve the status of an individual as well as that of the family. Kannon argued that low-caste groups had always been subjugated by those higher than them and never had the opportunity to climb up the social hierarchy (Kannon, 1978, p56), particularly in terms of education and health advancement (see also Din, 2006)..

One significant factor that resulted in the migration of Pakistanis to the UK was the Pakistani government's decision to build the world's largest hydroelectric earth dam at Mangla, which was constructed during the late 1950s and early 1960s. As a result it submerged two hundred and fifty villages in the district of Mirpur and displaced approximately one hundred thousand people. As a result of the dam a new Mirpur city emerged at the side of the lake, which replaced the old Mirpur town. It acted as an impetus for Pakistani immigrants to come to Britain. Other displaced families were allocated land in the state of Punjab (Taylor, 1976; Holmes, 1991; Anwar, 1998).

The Pakistani emigration became highly organised and depended upon a system of sponsorship and patronage, which was selective and was confined to certain districts of Pakistan such as Mirpur. Afterwards, as the first migrants became more settled and permanent in terms of employment and accommodation, they sponsored relatives to come to the UK (Rose et al, 1969; Ghuman, 1994). In the early days migrants would fit into the structure and take on their share of responsibilities to help others. Most

early migrants were illiterate and this was even more so among the women who arrived later to join their husbands, but this did not deter the early migrants; nor did it act as a barrier to their aspirations. This is where the biraderi (extended family network) was important because it offered support and laid the foundations for permanency.

Communal living was a characteristic of the early immigrants. It offered a number of economic advantages, for example it acted as an insurance policy for fellow countrymen who fell out of work, to those who became ill for any length of time, and also social and environmental advantages for protecting themselves from an alien country. It was understood by most early migrants that economic goals were more likely to be achieved through mutual support than through dispersal into the community, and this helped keep migrant families together (Hiro, 1991; Lewis, 1994).

Similarly, Holmes (1991) showed that immigration was closely linked with village and kinship networks. Roger Ballard mentioned that although a large Asian population may reside in a particular city, internally significant communal aggregation often includes no more than one hundred families (Rapoport et al, 1982). Watney mentioned that Asian immigrants who came to be joined by their wives and families and by other Asians mostly came from the same region, caste or religion, and later formed communities with their own distinct lifestyles. He mentioned that family unity, caste network, religious and social cohesion and the belief in mutual help among the early immigrants were all necessary for social stability and economic success (Andrews, 1991; see also Din, 2006).

There were few economic or social reasons for Pakistanis to stay in Mirpur (Khan, 1979; Holmes, 1991; Lewis, 1994). To those who had relatives or fellow kinsmen who were already settled in the UK, abundance of opportunities proved to be an important deciding factor in chain migration. Another major motivational factor among lower-caste families to immigrate was that free ‘vilayati’ (English) education could improve the status of an individual. This is in the context where historically lower-caste groups had always been subjugated by those higher than them and never had the opportunity to climb up the social hierarchy in Pakistan (Kannon, 1978).

A large number of immigrants who originated from Mirpur came from families who were connected with the land; the majority were small peasant farmers or landless labourers (Taylor, 1976; Lewis, 1994). Dahya

found that two-thirds of the two hundred respondents interviewed had been farming their family's land prior to migration. Furthermore, nearly half had been in the Armed Forces or had served in the Merchant Navy. The survey by John Goodall (1968), of Pakistani men living in Huddersfield, showed that the majority of the men had come from land-owning castes but their holdings had been so small as to make them almost landless (Rose et al, 1969; Lewis, 1994). But not all migrants who came to Britain were small farmers. A small number of urban, educated, middle-class migrants also arrived in Britain in the 1960s (Braham, 1992).

Roger Ballard argued that the early immigrants were drawn from peasant families with limited land holdings who could use overseas earnings to redeem mortgaged land, as well as buy more to provide sisters with dowries, to build new houses and to purchase agricultural implements (Rapoport et al, 1982). This had a cost to those living in Britain since most of the savings were sent to those relatives still left behind. They had to do without material things such as televisions.

As the early years of settlement elapsed, Pakistani-owned shops began to serve their own community because White shops did not stock 'Asian foods'; nor could they cater for diverse and ethnic tastes. This was an opportunity to quickly develop businesses and enterprises that would help to create Asian/Pakistani entrepreneurs who took (often with the help of the biraderi or family) the opportunity by selling anything from lentils to Halal meat, from chapatti flour to spices. This was made possible by a continued and sustained infrastructure of importers, wholesalers and retailers. As this took hold some successful Pakistanis went into manufacturing.

This was made possible by the strong links in Pakistan that could supply goods and materials at the desired price and quality. Bradford was typical of most towns and cities which had a sizeable Pakistani population. For example, in 1967 there were 51 Pakistani greengrocers and butchers shops, compared with two in 1959. There were also 50 Pakistani-owned schools of motoring; the number of cafes rose from three in 1959 to 16; the number of barbers rose from three to 16 and there were five Pakistani banks in Bradford. Other Pakistani-owned businesses included travel agencies and dry-cleaners. The situation was similar in other parts of Britain such as Balsall Heath in Birmingham and Glasgow (Rose et al, 1969; Lewis, 1994). In 1965 105 immigrants owned commercial and business premises in Bradford (Hiro, 1991). This growth was replicated in

other towns such as Glasgow, which at that time had a Pakistani population of 7,000 and had 100 retail grocers and twenty-five wholesale stores (Elahi, 1967; Din, 2006).

Early employment and settlement

There were strong 'push and pull' factors that attracted migrants to Great Britain, namely economic growth and underemployment (Anwar, 1993). The post-war period left Great Britain, especially the industrial areas of the country, with acute labour shortages. The situation was not eased by thousands of servicemen killed during the World War II and the fact that many thousands of families emigrated to countries such as Australia and Canada (Wrench and Solomos, 1993). At the time there was a massive backlog of industrial projects to be completed, plus the restructuring of the country and the public services that had been destroyed during the war and other plans that were in the government pipeline, such as the creation of the National Health Service (NHS) (Hiro, 1991; see also Din 2006).

Despite the large influx of migrants arriving into the United Kingdom from Ireland, the problems of acute labour shortages affected British industry throughout the 1960s. The government looked towards the British colonies in search of extra labour resources. The proposed National Health Service and London Transport employees were largely recruited from the West Indies (Rose et al, 1969; Modood, 1997). This provided Great Britain with a reserve army of labour which was vast and cheap and which was only too willing to meet the needs of the British economy (Bhat and Ohri, 1988; Wrench and Solomos, 1993). It was also the result of the British government's willingness to accept large numbers of Asians into the UK (Allen, 1971). Tomlinson (1984) argued that even well-qualified parents had no guarantee that they would obtain employment equivalent to their qualifications. An early study by Smith (1977) found that many Asian men were working in jobs for which they were 'overqualified'. In addition overseas qualifications were often not accepted. The DES for example insisted that teachers trained overseas must retrain in Britain.

In order to understand the context of settlement and employment patterns of first migrants it is important to note that regardless of their caste, the vast majority of Pakistani males began their working life in factories and other manual related employment, i.e. restaurants, taxis and buses. Modood (1997) argues that the majority of the early immigrants began working in industries which were losing ground in terms of pay and status.

Jobs were taken in public transport or in positions which were considered unpleasant by the host country, such as working in the foundries (Modood, 1997; Brown, 1995). Similarly, Bhatti (1999) found that some fathers who had obtained degrees from Pakistan were offered cleaning jobs, which they regarded as insulting, when they wished to do white-collar jobs (see also Din, 2006).

Sending remittances are habits which are long established and remain standard among many older Pakistanis. Khan (1979) found that the remittances sent to Mirpur improved both the general standard of living and also contributed towards the economy of Mirpur through investment. The early Pakistanis remitted as much as half of their earnings. It was estimated that in 1963 £26 million was remitted, which amounted to more than the whole inland revenue of East Pakistan (Khan, 1979; Lewis, 1994). This demonstrates a dependent connection between kin in Britain and those who remained back in Mirpur. Many large new houses were built in the new Mirpur City with remittances sent by relatives from Britain (Lewis, 1994). This would ensure that close ties with the country of origin would continue (Khan, 1979). Most people build houses to show off their wealth to biraderi but also to non-biraderi members. This gave most a sense of satisfaction that 'they had made it'; but at the same time this created resentment and hostility among biraderi members (see also Din, 2006).

The significance of acquiring this wealth could be seen within the Pakistani community. The izzat increased in accordance with the newfound wealth. For lower-caste families this meant they could purchase land, gain increased access to services such as medical care, electricity and water supplies, and also meant an increase in the prestige of the family. To an extent this new wealth meant an increase in power and authority within one's own biraderi (Raza, 1993).

Economic and social life in Bradford: Present

Bradford has long been a multicultural city with people emigrating into the district from many parts of the world, particularly from Asia and more specifically from Pakistan. Bradford's population is continually changing. This can prove to be a strength as people from different ethnic, racial, religious and cultural backgrounds hopefully learn about each other; but diversity in populations can also pose a problem for service providers because institutions have to understand the various populations and their

norms and values in order to continually improve services. This is particularly relevant for Primary Care Trusts (PCTs) because they are often at the forefront of service provision and at times they feel most challenged as new populations arrive in the district, for example from Europe.

PCTs have to ensure that different populations understand the services which are available to them in their locality but because some of the population are illiterate in English (or indeed in their own 'home' language). For example most Pakistanis resident in Bradford speak Mirpuri or Punjabi, a dialect of Urdu that does not have a written form, thus health information should perhaps be available in various languages and different formats. An alternative format, but perhaps more costly, is to provide information translated into the community languages on audio tape. The latter recommendation was something that came out strongly from the data, as we will see later.

Perhaps often overlooked is the fact that most health service users want a service that is reflective of their immediate and future needs, and, for some, substantial amounts of money spent on language translations might be better spent on medical needs of the individuals concerned. Some would rather see their GP or hospital consultant sooner, and instead take a family member who can act as interpretor for them. This is seen by some as an ethical issue, one of confidentiality and protecting one's privacy, but is nearly always argued for and on behalf of non-White/English patients, particularly Pakistanis. Often overlooked is that on occasions White/English patients take a family member or relative to provide support or to ask questions on their behalf.

It was appropriate to conduct this research in Bradford given the percentage of Pakistanis residing in the district and also because most resident Pakistanis there are from Mirpur (Pakistan). There is a continuing attachment of British Pakistanis to Mirpur, particular among the older Pakistanis, and this is continuing strongly through sending remittances, holidays to Mirpur and through marriage. The total population of Bradford is 467,000, although more people leave than come to Bradford. The district has more births than deaths (88% of Bradford's residents were born in the UK) as well as continuing immigration, particularly from South Asia, which adds to the population. The majority of the population of Bradford is White (78.3%); Asians or Asian-British account for 18.9%, of which 14.5% are Pakistanis.

Bradford is typical of other cities and regions (for example Birmingham, Tower Hamlets and Slough) which have diverse minority ethnic populations (National Census, 2001). Although Bradford is one of the largest cities in England, Pakistanis tend to be residentially concentrated in 'inner-city', often described as 'deprived', parts of the district, for example the University ward, Great Horton, Lidget Green, Little Horton, West Bowling and Leeds Road. However, an increasing number of more prosperous Pakistanis who once settled in Bradford are moving towards the affluent parts of Bradford such as Heaton, Bingley, Baildon and Saltaire, where property prices are comparable to those in London. In fact Pakistanis have made enormous economic contributions to the both local and national economy, providing services to all its population. However the health of Pakistanis in these districts is similar to the rest of the Bradford district.

Bradford has a young population. Compared to the national trend the Pakistani population is increasing, the major reason being that Pakistanis tend to get married earlier. Information from the National Census 2001 shows that Bradford has 33,240 (7%) of 0–4-year-olds compared to the national average of 6%. This also applies to 5–15-year-olds: the district has 76,097 (16%) compared to the national average of 14% (National Census, 2001). This trend is likely to continue. Nationally, the Muslim population of the UK stands at 687,592 (National Census, 2001) (originated from Mirpur, Pakistan). Further, the UK Muslim population is increasing, with large numbers of young people: 33.8% of Muslims are aged 0–15 years compared to the national average 20.2%; 50% of Muslims are aged 25 years or less compared to the national average of 31% (National Census, 2001).

The ethnic diversity of Bradford can be demonstrated through the fact that the district has one of the highest numbers of individuals who were born outside the European Union. In terms of religion, the majority of those in the district describe themselves as being Christian (60.1%) and Muslims account for 16.1% of the residents. However, a number of those in the district have 'no religion' (13.3%) (National Census, 2001).

Bradford has its particular problems which can have 'knock-on' effects on health outcomes for its populations. Existing research shows that people from minority ethnic communities are more likely to suffer from social exclusion and inequality (Modood et al, 1997; Chahal, 2004) compared to White/English populations. Further, there is a dearth of literature which

shows that minority ethnic populations, for example Pakistanis, are considerably more likely when compared to White groups to live in sub-standard housing in parts of inner cities and more likely to be unemployed (or when employed to be in semi-skilled or unskilled occupations). All respondents in this study made reference to their social environment and their effect it has had on their health. These issues are often overlooked but important determinants of health, for example,

> "I would seriously consider moving from here now I would like to live in a more quiet and clean place. The area that I live in makes me feel stressed out and that is not good for my health" (woman, aged 49)

Similarly, another respondent said,

> "I live in a medium-sized house, we have a small front garden but the back garden is quite big. I have lived here for almost eleven years and I like the people but not the area; there is dirt everywhere and mice. There is an incinerator nearby and the smell makes me ill. I keep the doors and windows closed most of the time, it is worse in summer. I have never got used to the smell; it makes me nauseous the takeaway nearby do not help they throw all their mess and uneaten food out attracting mice. I would like to more I have told my husband he said he would look out for a new property but they cost so much" (woman, aged 53)

More generally, Pakistanis are much more likely to face discrimination and inequality in education (Osler, 2002; Davis et al, 2002), health and social services (Mir, 2000; Vernon, 2002, Mir and Din, 2003)). This deprivation can also lead to poorer health outcomes: for example the actual prevalence of learning disabilities between the ages of 5 and 34 among the minority ethnic groups is three times higher than compared to White groups (Emerson et al, 1997). This is related to social and economic deprivation (Emerson and Robertson, 2002).

A total of 35.1% of the district's population have no qualifications, compared to the English average of 29.1%. Bradford also has a lower than average number of people qualified to degree level or higher when compared to the English average (15.9% and 19.8% respectively) (National Census, 2001). Bradford and district has the region's third largest economy and accounts for 9% of all employment (BMDC, 2003). A total of 56.5% of the district's population is employed, compared to the English average of 60.6%. In total 4.4% of the population are unemployed, which is higher than the English average of 3.4%. In terms of occupation concentration Muslims tend to be found in manufacturing, distribution and

the hotel and restaurant trades and are less likely to be in professional-type occupations compared both to the White British and other minority groups, for example Indians (National Census, 2001). Muslims have lower rates of participation in employment than Whites but are more likely to be self-employed (Annual Local Area Labour Force Survey, 2001/02).

The Index of Multiple Deprivation 2004 shows that Bradford is the fifth most deprived local authority in England. The total number of people unemployed in the district is 8,307 (a rate of 2.9%), which is higher than the national rate of 2.4%. There are gender differences: the number of male claimants in March 2005 was 6,443, showing a rate of 4.3% compared to the national rate of 3.4%. Compare this to 1,864 (1.3%) of females unemployed, which is the same rate as the national average (1.3%). There are significant differences in the unemployment rate by ward. For example the Bowling (5.5%), Little Horton (6.2%), Toller (4.7%), Undercliffe (5.1%) and University wards (4.2%) all have higher unemployment rates than the Bradford district average of 2.9% (BMDC, 2005). These wards also have a high number of minority ethnic populations.

The unemployment rate differs enormously among the Bradford population. Pakistanis are more likely to be unemployed than the White population, but also when compared to other minority ethnic groups. Youth unemployment in Bradford accounts for 33.4% of all unemployment; this is higher than both the regional (32.8%) and UK (30.7%) figures (BMDC, 2005). Bradford also has a higher than the English average of owner-occupied properties (71.7% and 68.9% respectively) (National Census, 2001).

Pakistani households are larger compared to the national picture (4.7 and 2.3 persons respectively). See also my earlier research (Din with Allgar, Atkin 2003) which showed that Pakistani households are often three-generational. This is something that was evident in this present research, for example,

> "I live with my wife, my son and daughter-in-law, one daughter and two grandchildren" (man, aged 72)

Communal living is part of the cultural trait of most Pakistani households, as was evident in this sample. Similarly another respondent said,

> "I live with my wife and two sons and one daughter-in-law and one

grandson" (man, aged 56)

Living in multiple households was also common among the Mirpur cohort, for example,

"I am living with son and his family and my wife" (man, aged 65)

There is considerable evidence that links deprivation to poorer health outcomes for residents in Bradford. For example, life expectancy in Bradford (73.5) is lower than the national average (75.2). Bradford has a significantly higher rate of cancers (142.9 per 100,000 under-75s) than England as a whole (130.6). The mortality rate from circulatory diseases in people aged under 75 per 100,000 population in Bradford (146.4) is also higher than the national average (120.4). The Bradford district has the second highest infant mortality rate, with 8.4 deaths per 1,000 live births compared to the national average of 5.7 (National Census, 2001). Early life circumstances have an important bearing on health in later life (Kuh and Ben-Shlomo, 1997) where in particular birthweight is related both to their own and their parents' cardiovascular mortality (Davey Smith et al, 1997). Indian and Pakistani women had reported having lower birthweight babies than White women (Kelaher et al, 2003).

Household composition of the Bradford sample

All the respondents interviewed lived in privately owned accommodation, commonly residing with offspring; in fact most households had three generations of family living together, which has been borne out by my previous research (see Din, 2006; Cullingford and Din, 2006). This was typical of both the Bradford and Mirpur cohort,

"I live with my husband, son and daughter. I have an elder daughter but she is married and no longer lives at home" (woman, aged 49)

"I live with my husband, two daughters and two sons. My eldest daughter is married and no longer lives at home" (woman, aged 53)

Similarly other respondents said,

"I live with my son, my daughter-in-law left the household two years ago when she married my other son the youngest comes to visit me weekly my daughter-in-law then cooks meals for me" (woman, aged 68)

> "At present I live with my wife and younger daughter. My other two sons and daughters have married and left home" (man, aged 57)

Neighbourhood and community life in Bradford

It is important to understand the social environment respondents are part of because this is an important determinant of health outcomes – for example information about the different communities that reside within their local neighbourhood, including Pakistani, White/English people, as well as new arrivals who had more recently arrived into the area. We need to understand this before we can begin to picture the broader determinants of health and also as a number respondents point to well-being in their neighbourhood. For example, research has shown that social and environmental factors which are known to lead to coronary heart disease include poverty, low income and poor housing (Raphael and Farrell, 2002).

The majority (16/18) of respondents lived in areas which have high numbers of Pakistanis living in close proximity, often kin (*biraderi*) members whom they knew before their emigration, whereas others were non-related. Most had lived in the same neighbourhoods for long periods of time (this was something also typical of the Mirpur sample); knowing one another was an important part of everyday life,

> "I live in a mainly Pakistani community where everyone knows each other. The shops are local, the neighbours some of them I know from Pakistan (woman, aged 68)

All respondents (18/18 Bradford sample and 10/10 Mirpur sample) talked about their immediate neighbourhood in considerable depth, making comments about community life, people and business life in their neighbourhood,

> "I live in a Asian area most of the families at least ninety-five per cent are Pakistani. There is a mosque near by, shops, a school and a community centre and takeaways, a pizza shop, fish and chip shop, a Chinese takeaway and donner kebab shop. There are far too many cars on the streets you can't move for cars ten years ago there were less cars parked out at side of the houses but now each house has at least two or three" (man, aged 72)

There was no sense of a major White/English community in the Bradford sample. White/English people were resident only sparsely in the area.

Respondents also noted that traditionally they lived in ethnically 'mixed' areas, for example where once White/English people also resided but recently have moved out of the area. This trend was typical of most areas around Bradford as people and communities locate and then relocate themselves to be close to services such as school or work or family,

> "I live in a semi-detached house, it is quite big and we have a large garden. The neighbourhood is mainly Pakistani and Indian it used to be White but they have all moved out now. It is quite clean there is lots of greenery and bushes. One of my Pakistani neighbours cut three trees down in his garden and was fined by the council. Some Pakistani people do not understand the importance of greenery and concrete everything. My next door neighbour is my butcher and I get on well with him we work together. The other neighbours are OK we mostly keep ourselves to ourselves. I like where I live I would not move" (man, aged 54)

These areas were often dense in terms of residential and business properties in close proximity to each other. This sometimes meant that the neighbourhood was constantly changing where new families moved into the area, but also other undesirable things such as crime,

> "I live on a busy street in a terraced house. There are a few shops around, a takeaway, a newsagents and a chemist. I used to really like this area but there is too much crime around here these days. I have known my neighbours for many years and we get on really well but there are a few new families who have moved here in the last three or four years, one in particular is very noisy and leaves rubbish everywhere on the pavements (woman, aged 49)

It soon became clear and consistent that a number of respondents (Bradford sample in particular) believed that their immediate environment, especially untidy 'mess' and 'noise' coming from the street, has an important knock-on effect on their well-being and health. This was something that they would find impossible to get rid of, particularly as they got older, as the following elderly woman explains,

> "Lots of cars are parked on the street and a neighbour has a business fixing cars, the mess and noise gets me angry, sometimes my neighbours parks their car outside my house" (woman, aged 68)

There were other comments made of their neighbourhood which could have an impact on health. Some issues the council could intervene in, for example removing old unwanted furniture (as they do with prior notice), whereas other issues such as dog litter needed tighter controls or fixed penalties. These issues were commented on in some detail,

> "I like immediate neighbours but just down the road there is a neighbour who owns some dogs he lets them run riot they are never on a leash and soil the ground and the gardens that makes me angry. Dog faeces contain harmful bacteria which is harmful to humans. There is a lot of household rubbish like mattresses in people's gardens inviting mice and rats it is quite dirty. I would actually move away from here I need to find a reasonably priced house" (man, aged 56)

Another concerned respondent explained that although the local council provides bags some individuals living in the area show examples of inappropriate behaviour,

> "The front street of my house is quite clean but the back street is very dirty as that is where people leave all their garbage. We have been given big green bins by the council to put all our rubbish in but lots of people around here leave bin bags lying around and rats and other animals like stray cats and dogs tear them open leaving dirt and mess. My neighbours leave food they have not eaten like chapattis and stale bread for the birds but they throw it on the ground attracting all kinds of vermin. Mice come into the house from outside and it makes me feel ill they carry all manner of diseases. I wish the council would clean up the streets more and provide skips at least once every three months so people do not have to dump their rubbish in the street attracting vermin and diseases" (woman, aged 51)

This should be read in the context of available research. An American study showed that lower socio-economic status and poor living conditions in youth, which is typical of inner city regions of UK, has contributed to an increased mortality and morbidity from ischemic heart disease in adult life (Weber et al, 1983) as well as poor health behaviours among the youth (Fardy, 1994, 1996)). Litter was not only thrown out of households in the area but also came from nearby businesses; for example takeaway wrappers and food were found frequently where people simply discard rubbish onto the ground,

> "The only problem around here is litter people throw wrappers and tins and takeaway food on the ground. People from out of the area are the worst the food creates bacteria and rats feed on it. It is the only problem the council needs to clean up more, rats carry diseases I worry for my grandchildren" (woman, aged 55)

Changes in lifestyle, financial barriers and social isolation often act as markers that lead to stress and high blood pressure (Brown and James, 2000). Pollution in the air was also commented on by a number of respondents in both study locations (7/18 Bradford sample and 10/10 of the Mirpur sample). Increasing traffic was becoming common; given that

all respondents lived in inner city areas of Bradford this made the situation even more personal,

> The car fumes are no good for breathing, the fumes can cause a sore throat and make you sick. I like my neighbours but there needs to be less cars around so the air can be cleaner. The streets are often littered and the council needs to sweep them up more" (man, aged 72)

On another level, equally worrying was the issue of crime, and drug-dealing in their local neighbourhood and environment was a constant issue that added to their stress and the fear that most parents have of their child falling prey to the wrong type of people in their neighbourhood, as the following father explained in some detail,

> "There is a lot of crime in the area and drug-dealers it has got worse over the last five years. The police are always patrolling the area before it would shock us and was something new but now it is almost normal. The police have been so worried about crime around here that we are now a neighbourhood watch area. Young people, particularly the boys are being caught up in the wrong crowd this causes their parents stress. I worry that my young son is mixing with the wrong crowd" (man, aged 56)

Economic and social life in Mirpur

After the separation of East and West Pakistan (later Bangladesh and Pakistan) from India in 1947, Mirpur became one of the three districts of Azad 'Free' Kashmir (Rose et al, 1969). Most Pakistanis who settled in the UK came from this region of Pakistan (Shaw, 2001). After independence Pakistan went through a number of social changes. These included, for example, the spread of primary school education. Progress on the whole was slow (this was natural given the recent independence) and unemployment was high (Rose et al, 1969; Taylor, 1976; Holmes, 1991). An illustration of poverty in Pakistan in the 1940s and 1950s was the low literacy rate, and the poor provision of schooling (Braham, 1992).

Due to high levels of poverty within the district of Mirpur only a small number of young children entered secondary schooling and less than half stayed on at the age of fifteen. Thus, it is not surprising that the majority of the immigrants who came to Britain were illiterate (Khan, 1979; Kannon, 1978). It was estimated that unemployment was 7.4 million at the end of 1964 (Economist Intelligence Unit, 1966). According to the President of Pakistan, Ayub Khan, at the time the per capita income was only £30 per annum (Rose et al, 1969). Since the early years of partition, Mirpur has

changed enormously, both socially and economically. Much of this has been partly due to foreign investment, particularly from British Mirpuris. This has meant major lifestyle changes for British Mirpuris, most noticeably in diet.

Household composition and community life in Mirpur

Like the Bradford sample all respondents (10/10) in Mirpur lived with their immediate family members, including married and unmarried offspring,

> "I am living with my wife and other members of my family are abroad" (man, aged 65)

Similarly, another elderly respondent said,

> "I live with my family my sons and my daughter-in-laws and grandchildren" (man, aged 60)

On the one hand life in Mirpur was similar to the experiences of the Bradford sample, for example, although most respondents (8/10) said they liked where they lived but highlighted some of the common pitfalls of city life, such as pollution from traffic,

> "The area I am living is environmentally good this area is a little further from town so it is environmentally friendly so I can I say it is the only air pollution affecting my health. Our neighbours are good and very cooperative because we have been living together for many years. I like the area because it is environmentally friendly and we have no problems here so I like the area" (man, aged 65)

Again another elderly female points out the congestion problem and the fumes that are produced from high volumes of traffic coming into the area, coupled with the high temperature in the district generally,

> "The area where we live is very congested and due to this there is a lack of fresh air so we have to go on to the roof for fresh air and the temperature gets high because of the overpopulation" (woman, aged 65)

Traffic fumes was particularly a problem arising from older vehicles and also the fact that there were few emission controls on vehicles,

> "To some extent there are some factors which affects health there is heavy traffic load in this area. The old vehicles release smoke that affects our health. All the community residing here are rich and they are cooperative

> as well we meet during prayer times or when there are some programmes or ceremony on" (man, aged 60)

Mirpur has become a cosmopolitan city and a hub of business and entrepreneurial activity. Most Pakistanis who had emigrated to the UK were residents of the city and most still have relatives that were left behind. Mirpur has quickly grown into the 'most happening' region in Azad Kashmir. This created its own problems, perhaps as a victim of its own success leading to overpopulation and a lack of coordinated planning of residential and business property, as remarked on by a number of interviewees,

> "The area we are living [in] is overpopulated this meant that when people started living here then there had been no considered planning. The streets are very narrow and the homes are constructed together very closely. Due to the lack of planning its suffocation and the area is dusty the factors which affect health here are pollution, water and air" (man, aged 62)

All the respondents had a personal story to tell of their neighbourhood. For example another respondent remarked on the lack of permanent pavements leading to the market or facilities (health) in the area, and on not having the financial resources to move to another area. Typically most people in Pakistan would remain in the same house or district all of their lives and where their children and grandchildren will remain unlike those living in the UK who tend to move at least on several occasions throughout their lives,

> "There are no facilities for example no permanent pavements or passages to go to the town or bazaar and this is far from town it takes about half an hour or more in reaching the town as there are no proper roads coming to this area so it is a dusty area so it affects our health otherwise here is less polluted due to less traffic. I do not like the area because of the lack of facilities but despite of this I have to live here because I cannot afford to move or live in another place" (man, aged 63)

However, those living further from the inner city of Mirpur saw considerable improvement in their immediate environment, particularly in terms of more sparse population, and also the newer more modern areas being constructed according to systematic planning rather than on an ad hoc basis, as was the case in the early years of partition in 1947,

> "It is not overpopulated and it is a very calm area. This area is constructed according to planning so the streets are wide and there is no problem for living here" (man, aged 65)