



**Black and Minority Ethnic Health in
Greater Glasgow:
A Comparative Report on the Health and
Well-Being of African & Caribbean,
Chinese, Indian and Pakistani People and
the General Population**

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THIS REPORT PRINTS WELL IN COLOUR. SOME OF THE INFORMATION ON THE GRAPHS MAY NOT BE VISIBLE IN BLACK AND WHITE.

**This report was compiled from the following previous reports
of research:**

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1 Executive Summary

This report summarises findings from three health and well-being surveys conducted in Greater Glasgow focussing on the following populations: firstly, the Chinese community (commissioned by the Chinese Healthy Living Centre, FMR Research, 2004), secondly, the Pakistani, Indian and African & Caribbean communities (also referred to as the PIAC study, Heim et al., 2005) and thirdly the health and well-being survey of the general population (RBA, 2002).

The former two surveys were conducted since the most recent general population health and well-being survey was not designed to yield sufficient data from minority ethnic groups living in Greater Glasgow to allow planning decisions to be made. This report compares findings from these three reports and key findings are summarised below.

General, Oral and Mental Health

Minority ethnic respondents' perceptions of their general health tended to be more positive than those of the general population. However, the younger age profile of minority ethnic groups¹ may be responsible for this finding. African & Caribbean respondents tended to have the most positive perceptions of their general health, whereas Pakistani interviewees were more likely than other ethnic groups to give responses indicative of comparatively poorer health.

Pakistani respondents were more likely than respondents from other minority ethnic groups to report attendance at a dentist in the six months preceding the interview. African & Caribbean respondents, however, were least likely to have been to see a dentist, thus a need for encouraging respondents from these backgrounds to visit dentists was identified.

In terms of mental health, findings suggest that Indian respondents were least likely to report diminished psychological well-being compared to Pakistani and African & Caribbean groups. The Chinese Healthy Living survey did not utilise a specific measure of mental health and the general population survey utilised a clinical measure, rendering comparisons problematic.

Service Provision: Use and Satisfaction

Chinese respondents were less likely than all other minority ethnic groups and the general population to have made use of health services in the year preceding their interview. This is likely to have been the result of a combination of factors. First, Chinese respondents reported using a combination of traditional Chinese and Western medicine. Second, Chinese respondents reported the lowest levels of satisfaction with service providers.

¹ Minority ethnic populations in Greater Glasgow have a younger age-profile than the general population (see page 8).

This suggests a need for consultations with the Chinese community regarding how service provision can be improved to cater for specific community needs.

Pakistani, Indian, African & Caribbean respondents were more positive about service provision, and similar to the general population with regards to their perceptions. Respondents aged 50 years and above were consistently more positive in terms of their perceptions of service provision.

Alcohol Consumption and Smoking

It is possible that alcohol consumption and smoking levels were underreported as a result of interviewees giving socially desirable rather than truthful accounts of their behaviours. Self-reported alcohol consumption was markedly lower amongst all minority ethnic groups in comparison to the general population. Female Chinese, Indian and Pakistani respondents were less likely than their male counterparts to report alcohol consumption.

Smoking appears to be less prevalent in minority ethnic communities in comparison to the general population. However there was a gradient amongst minority ethnic groups, ranging from Pakistani groups who smoke more than African & Caribbean groups to Chinese and Indian groups who smoke the least.

Diet

Around half the Chinese and African & Caribbean respondents were meeting the Scottish Diet Action Plan target of eating at least 5 portions of fruit and vegetables a day, compared to around a third of the general population and Indian respondents and only one fifth of Pakistani interviewees. Future research needs to ascertain whether relatively low levels of fruit and vegetable consumption reported by Pakistani respondents are the result of differences in styles of food preparation.

Average bread consumption was similar for all groups apart from Chinese respondents, who reported markedly lower consumption of bread. Consumption of foods with a relatively high fat content was lower amongst minority ethnic groups than the general population.

The Scottish Diet Action Plan recommends consuming cereal at least five times a week. Very few Chinese participants reported achieving this whereas a fifth of Pakistani and over a quarter of African & Caribbean participant ate cereal at least five times per week. This compares to over a third of Indian participants and almost half of the general population.

It should be noted, however, that the Scottish Diet Action Plan might be culturally insensitive for minority ethnic groups.

Physical Activity and Body Mass Index

Around half of the general population, Indian and African & Caribbean informants undertook the recommended weekly amount of physical exercise whereas around a third of Pakistani and Chinese respondents exercised according to current guidelines.

Chinese respondents were more likely than informants from other minority ethnic groups and the general population to be classified as being of normal weight. Similarly, Chinese and Indian respondents were less likely to be obese than other groups.

Distribution of Health-Related Information

African & Caribbean respondents were more likely than those from Chinese, Indian or Pakistani backgrounds to say that they would like to receive additional information on health issues. Conversely, Pakistani respondents, who were more likely than other minority ethnic groups to be receiving medical treatment, were least likely to say that they required additional information on health related issues. It also emerged that African & Caribbean respondents required general information on the National Health Service.

Whilst the majority of Pakistani, Indian, African & Caribbean respondents said that they would like to receive health related information in English, the distribution of health-related information targeting individuals aged above 50 years could be made available in appropriate languages since respondents in this age group were more likely than younger respondents to request information.

Social Health and Capital

Minority ethnic respondents tended to be more likely than the general population to report a feeling of isolation from family and friends at times.

African & Caribbean respondents, who reported comparatively shorter periods of residency in Greater Glasgow, were more likely than other minority ethnic groups to feel less connected to the local area in which they lived. They were also more likely to report feeling insecure walking alone in their neighbourhood and least likely to feel that their associations and friendships with people in their local area meant a lot to them.

Chinese respondents were more inclined to say they felt less safe using public transport than other minority ethnic groups or the general population. Interviewees from Chinese backgrounds were also more likely than the general population to say that they felt insecure when walking alone in their neighbourhood.

Chinese and African & Caribbean respondents were more likely to say they were members of community groups. Overall there was a significant tendency for respondents above 50 years of age to feel more connected to their local area than younger respondents.

Experiences of Racism and Perceptions of Identity

Experiences of racism were explored differently in the Chinese and the PIAC surveys. Chinese respondents were asked whether they had ever experienced racism and results indicate that over a third of Chinese informants had experienced racism.

Pakistani, Indian and African & Caribbean participants were asked whether they had experienced specific forms of racism and discrimination in the year preceding their interview. Results suggest that African & Caribbean respondents were significantly more likely to experience racism and discrimination than Pakistani and Indian interviewees.

Other findings indicated that African & Caribbean respondents felt less Scottish / British than their Indian and Pakistani counterparts, and that feelings indicative of Scottish / British identity decreased with age. Pakistani, Indian and African & Caribbean interviewees who were aged 50 years and above felt more Scottish / British than their younger peers. This indicates that young people from minority ethnic backgrounds, many of whom were born in the UK, may feel disconnected from the majority culture.

Individual Circumstances

Use of childcare was less common amongst Pakistani and Indian respondents in comparison to Chinese and African & Caribbean informants. Pakistani and Indian respondents, in turn, were more likely to say that they cared for someone on a day-to-day basis, although absolute numbers were very low.

Whilst Internet access decreased with age in all ethnic groups, around two thirds of Pakistani and of Chinese, and around three quarters of Indian and African & Caribbean participants reported having access to the Internet. In contrast, less than half the general population had access to the Internet

Indian and Pakistani respondents rated their English language abilities lower than the other minority ethnic groups participating in the surveys. The self-reported highest level of educational attainment was also comparatively lower for Pakistani respondents.

Financial Well-being

Results relating to financial well-being suggest that African & Caribbean respondents were more likely than those from Indian and Pakistani backgrounds to say that meeting the cost of an unexpected expense would be difficult or impossible. Chinese respondents were also more likely than the general population to say that finding £1000 to pay an unexpected bill would be a big problem or impossible. Overall minority ethnic respondents were less likely than the general population to say that they were in receipt of state benefits.

Conclusions

This summary report has provided an overview of health and well-being issues affecting the largest black and minority ethnic communities in Greater Glasgow. As such it provided a baseline against which future research can measure how the health and well-being of minority ethnic communities in Greater Glasgow develops in the future, and will inform service delivery and planning as well as future research.

2 Introduction and Methodologies

2.1 Background

Greater Glasgow NHS Board commissioned a general population health and well-being survey in 2002 (RBA, 2002). However, the numbers of ethnic minority individuals interviewed were small and did not give a clear enough picture of the health of these communities. It was decided to conduct more detailed research specifically with these groups. The Chinese Healthy Living Centre commissioned research among Chinese populations through FMR, a market research company (FMR, 2004), and NHS Greater Glasgow commissioned University of Strathclyde and University of Stirling to conduct a health and well-being survey with Pakistani, Indian and African & Caribbean communities (also referred to as the PIAC study, Heim et al., 2005). This report compares the health and well-being of specific black and minority ethnic groups to each other and to that of the general population of Greater Glasgow.

2.2 Research Aims

Two of the studies reported here aimed to gather information amongst people from the most common black and minority ethnic groups living in Greater Glasgow, whilst the third aimed to assess the perceived health status of people in general in Greater Glasgow as well as to monitor core indicators and track changes over time. The latter was the first follow-up of the 1999 baseline study. A range of indicators of health and well-being were examined including health needs and service issues, as well as information on a wider range of topic areas such as measures of social capital, perceptions of identity, and financial well-being. Data were collected using questionnaires that were derived from the general population health and well-being survey (see below), and information gathered is to be used to measure progress towards local and national targets and to inform local service delivery.

2.3 Methodologies

This section provides a synopsis of the research methods used in the Chinese Healthy Living Centre study, the PIAC study and the general population study. There were some methodological differences which may limit the extent to which findings are comparable. Moreover, whilst the general population survey utilised a multi-stage stratified random sampling design, with post hoc weighting of the data to ensure a representative sample, both minority ethnic population surveys utilised purposive sampling methods. The latter approach was adopted to address the challenge of accessing appropriate respondents given the lack of appropriate sampling frames for minority ethnic populations. However, recognising the dearth of information on the health and well-being of minority ethnic communities in Greater Glasgow, this comparative report is intended to give a valuable overview of health and well-being amongst the respective minority ethnic communities.

2.3.1 Sample Size and Participant Recruitment

2.3.1.1 Chinese Healthy Living Centre Study

A quota sample of 350 individuals from a Chinese background broken down by age and gender was set. Interviewers were instructed to include respondents who considered themselves to be Chinese and who lived in the Greater Glasgow area. Respondents (n=350) were recruited via various Chinese community groups and organisations (e.g. Chinese church, Wing Hong and San Jai, and student groups), in addition to approaching potential participants in the street in areas such as Chinatown. The sample is summarised by age in Table 2.1.

2.3.1.2 Pakistani, Indian and African & Caribbean Survey

The target sample was stratified by age and gender with 200 Pakistani, 150 Indian and 200 African & Caribbean individuals. A quota sampling method was employed to match the sample in terms of age and gender, and a total of 155 Indian, 211 Pakistani and 244 African & Caribbean individuals participated in the survey. As in the Chinese Healthy Living Centre study, participants were recruited through a variety of approaches. Potential participants were thus largely approached 'at random' on the street and recruited via the 'snowballing' method, aided by obtaining contact details about potential participants from community groups and organisations. As a result of difficulties in recruiting sufficient numbers of Caribbean respondents it was decided on pragmatic grounds to combine these groups into an 'African & Caribbean' sample (see Table 2.1).

2.3.1.3 General Population Survey

In contrast to the minority ethnic surveys, the general population survey utilised a multi-staged stratified random sample with post-hoc weighting to ensure that the sample was as representative as possible. A total of 1802 members of the Greater Glasgow general population participated. General population interviews were conducted in the respondents' own homes. Table 2.1 summarises the achieved samples and illustrates the age make-up of the respective populations as measured in the 2002 census. The table illustrates that minority ethnic groups tend to have a younger age-profile than the general population.

Table 2.1. The age make-up of the samples and census data comparison.

Age Group	Pakistani Sample	Greater Glasgow Pakistani Population	Indian Sample	Greater Glasgow Indian Population	African & Caribbean Sample	Greater Glasgow African & Caribbean Population	Chinese Sample	Greater Glasgow Chinese Population	Weighted General Population Sample	General Population
16-24	26	28	23	23	16	22	27	27	15	16
25-34	26	27	31	25	34	33	26	26	20	20
35-44	18	21	19	20	30	25	21	21	19	20
45-54	19	12	19	15	10	12	13	13	14	15
55-64	9	7	7	8	8	5	6	6	12	12
65+	3	5	7	8	1	4	8	8	18	18
Sample Base (n)	211		155		244		350		1802	

2.3.2 Fieldworkers

The Chinese Healthy Living Centre study employed 11 interviewers who were able to speak appropriate Chinese languages such as Cantonese, Hakka and Mandarin. Eight interviewers conducted the bulk of the fieldwork. Fieldwork for the PIAC survey was conducted by 23 individuals who were competent in a mix of relevant languages and exclusively from Pakistani, Indian and African & Caribbean backgrounds. All fieldworkers received comprehensive training.

2.3.3 Questionnaire Design

The survey instruments used in both studies were based on the 2002 Greater Glasgow general population health and well-being survey. Topic 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, and this resulted in some noticeable differences between the two survey instruments. The Chinese survey, for example, included items concerned with traditional Chinese medicine, and the PIAC survey included items concerned with experiences of racism and perceptions of identity. Questionnaires were developed with the support of the Steering Group and were piloted among members of the appropriate communities and revised, as appropriate, to enhance comprehension.

2.3.4 *The Interviews*

The interviews in the surveys of black and minority ethnic communities were conducted in participants' preferred languages. The Chinese Healthy Living Centre study translated the English version of the survey questionnaire into Chinese. This version was then carefully compared to the English version by fieldworkers to help ensure that the translated version was faithful to the original. The PIAC survey used back-translated versions of the questionnaire that were administered by interviewers competent in the respective languages. Thus the original instrument was translated into Urdu, Hindi, Punjabi and French and back translated into English. This helped ensure that the questionnaire was appropriate in terms of use of languages, and helped to ensure that translations were equivalent in meaning and measurement in each of the languages.

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 & Caribbean participants were interviewed in English.

2.3.5 *Recruitment of Participants*

As indicated above, both the studies focussing on black and minority ethnic minority communities utilised purposive sampling strategies. This method, whereby participants are recruited via a number of approaches based on their convenience and availability is common for research in minority ethnic populations since it is often difficult to find reliable sampling frames from

which to draw random samples of Black and minority ethnic communities (McGraw et al., 1992; Hughes et al., 1995).

Whilst respondents from Pakistani, Indian and African & Caribbean, backgrounds were offered £10 remuneration as a contribution towards time and effort involved in participating, respondents were not offered a financial reward for their participation in the Chinese Health and Well-being survey.

2.4 Ethical Issues

The surveys reported here were conducted in accordance with Greater Glasgow NHS Board ethical guidelines. Ethical approval was obtained from the Strathclyde University Ethics Committee for the PIAC survey. 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 respondent'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. Respondents were given the opportunity to respond in their preferred language and could withdraw at any point in the survey.

2.5 About this Report

This report summarises key findings from the surveys of the Chinese population and that of the Pakistani, Indian and African & Caribbean communities in Greater Glasgow and compares them to the general population survey. The summary report is organised into the following chapters:

- Self-Perceived Health and Well-Being
- Health Services: Use and Satisfaction
- Health Behaviours
- Social Health and Capital

Throughout this report reference is made to Chinese, Pakistani, Indian and African & Caribbean participants. However, ethnicity is not treated as an objective or definitive entity. Thus it is not intended to imply that individuals from these backgrounds would not consider themselves (or be considered), for example, to be Glaswegian, Scottish or British. Rather; this categorisation serves as a practical means of discussing the health and well-being of individuals from these respective backgrounds. It should be noted that for pragmatic reasons the African & Caribbean ethnic groups were combined in one sample.

The word 'significant' is used to refer to statistically significant differences in response patterns identified using appropriate inferential statistical techniques.

3 Self-Perceived Health and Well-Being

Participants were asked a number of questions concerning perceptions of health and well-being.

3.1 General Health

African & Caribbean and Indian respondents tended to have more positive perceptions of their overall health than the general population, whereas Pakistani and Chinese participants were very similar to the general population (see Table 3.1).

Table 3.1. Percentage of participants rating their overall health as 'excellent' or 'good'.

	% of Participants
African & Caribbean	86
Indian	76
General Population	67
Pakistani	65
Chinese	62

Positive self-perceptions of general health decreased with age across all ethnic groups.

3.2 Treatment for Medical Conditions

People were asked whether they were currently being treated for a number of medical conditions. Less than half in all sample groups reported that they were being treated, but minority ethnic individuals tended to be less likely to report receiving treatment than the general population.

Table 3.2. Percentage of participants being treated for any medical conditions.

	% of Participants
General Population	44
Pakistani	42
Indian	35
Chinese	27
African & Caribbean	23

The likelihood of individuals saying that they were not receiving treatment decreased with age in all ethnic groups, and the overall figures may reflect the younger age profiles of these samples.

Although statistical comparisons cannot be made, minority ethnic communities appeared less likely than the general population to report receiving treatment for arthritis / rheumatism / painful joints and, apart from

Pakistani respondents, were less likely to report receiving treatment for blood pressure.

Table 3.3. Conditions currently being treated.

CONDITION	Pakistani		Indian		African & Caribbean		Chinese		General Population	
	n	%	n	%	n	%	n	%	n	%
Coronary heart disease	7	3	4	3	2	1	3	1	96	5
Stroke	5	2	2	1	0	0	0	0	32	2
Arthritis or rheumatism or painful joints	13	6	12	8	9	4	19	5	269	15
Clinical depression	7	3	3	2	3	1	6	2	78	4
Diabetes	19	9	8	5	5	2	9	3	71	4
Cancer	0	0	1	1	2	1	2	1	26	2
Asthma, bronchitis, or persistent cough	12	6	9	6	8	3	14	4	134	8
Epilepsy	0	0	1	1	0	0	0	0	22	1
Stress related conditions (e.g. difficulty sleeping or concentrating)	10	5	10	7	8	3	16	5	114	6
Hearing problems*	6	3	5	3	2	1	6	2*	43	2*
Eyesight problems*	17	8	13	8	19	8	8	2*	56	3*
Accident / injury	1	1	6	4	2	1	1	<1	47	3
Gastro-intestinal problems (e.g. peptic ulcer disease, irritable bowel syndrome)	11	5	3	2	8	3	9	3	87	5
High blood pressure	22	11	13	8	18	7	21	6	194	11
Drug or alcohol related conditions	1	1	2	1	2	1	0	0	23	1
Other/s	13	6	6	4	9	4	35	10	91	5
None	121	58	100	65	188	77	257	73	1005	56

*The Chinese healthy living centre and the general population surveys probed for 'severe' eyesight and hearing problems. Question relating to sexually transmitted diseases (0.4% prevalence in the general population) and mental health problems (0.6% prevalence in the general population) not included in minority ethnic surveys.

3.3 Prevalence of Long-Term Condition Interfering with Day-To-Day Activities

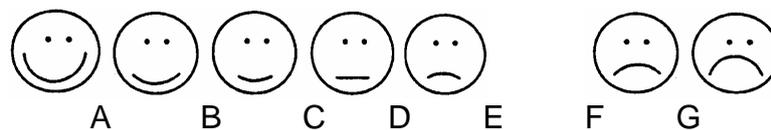
Minority ethnic groups were less likely to report conditions that interfered with their day to day activities than the general population. However, the prevalence of such conditions increased with age in all ethnic groups, and again the younger age profiles may have an effect.

Table 3.4. Percentage of respondents reporting at least one long-term condition or illness substantially interfering with their every day life by ethnic group.

	% of Participants
General population	23
Pakistani	19
Indian	18
Chinese	12
African & Caribbean	8

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

Participants were asked to rate different aspects of their life with the aid of the following 'faces scale', representing different perceptions ranging from very happy to very unhappy. The scale was developed by MRC Social and Public Health Sciences Unit, Glasgow.



When the first three 'smiley' faces were combined into a 'positive perception' category, results did not show much variation among ethnic groups living in Greater Glasgow and the general population as a whole. Over three quarters of all respondents indicated positive ratings of quality of life, physical health and mental and emotional well-being. Pakistani, Indian and African & Caribbean groups gave particularly positive ratings (over 90% gave positive scores in each domain).

3.5 Mental Well-Being

The three surveys utilised a range of measures to assess mental well-being. Indicators of mental well-being that were identical across all three surveys, included the faces rating procedure above (see above), and participants being asked whether or not they were currently being treated for clinical depression or stress related conditions (section 3.2). Other than these general indicators of mental well-being, the Chinese Healthy Living Centre survey did not include any questionnaire items dealing specifically with mental health.

The survey of Pakistani, Indian, African & Caribbean residents of Greater Glasgow utilised General Health Questionnaire 12 (GHQ-12), a measure of psychological distress in community and clinical settings. Findings suggested that 16% of Pakistani, 12% of Indian, and 20% of African & Caribbean attained a score indicative of psychological distress. It is also noteworthy that Pakistani respondents in the same survey reported significantly higher levels of stress than Indian and African & Caribbean respondents. Female participants from all ethnic backgrounds reported significantly higher stress levels than male respondents. Elevated GHQ-12 scores were associated with reports of racism. In contrast, the general population survey utilised the depression sub-scale from the Hospital Anxiety and Depression scale (HAD). Results here indicated that 5% of residents living in Greater Glasgow had a score indicative of clinical depression.

3.6 Oral Health

Participants were asked about the proportion of teeth that were their own. As shown in Table 3.5, minority ethnic groups appear more likely than the general population at large to report that all of their teeth are their own.

Table 3.5. Responses to the question ‘what proportion of your teeth are your own?’ All ages (%).

	Pakistani	Indian	African & Caribbean	Chinese	General Population
All of them	77	78	89	76	60
Some of them	20	20	11	20	24
None of them	2	3	0	4	16
Base (n)	211	153	244	350	1774

The Towards a Healthier Scotland target is to reduce the percentage of residents aged between 45-54 years with no teeth of their own to less than 5% by 2010. Approximately 9% of the general population in this age group currently report not having any of their own teeth. No respondents from Pakistani, Indian, African & Caribbean backgrounds reported that they had none of their own teeth.

Indian, Chinese and African & Caribbean respondents were less likely than Pakistani and general population respondents to say that they had been to see a dentist in the six months preceding the interview (see Table 3.6).

Table 3.6. Responses to the question ‘when was the last time you went to the dentist?’ by ethnicity (%).

	Pakistani	General Population	Chinese	Indian	African & Caribbean
Within the last 6 months	50	50	41	40	32
Within 6 months to 15 months	17	17	23	17	21
Over 15 months	33	33	35	42	41
Never	1	0	1	1	6
Base (n)	200	1792	350	150	238

3.7 Perceived Effects of Home on Health

Respondents to the Chinese and the general population surveys were asked whether a number of aspects of their home affected their health adversely. Results are summarised in Table 3.7.

Table 3.7. Aspects of home affecting health (%).

	Chinese	General Population
None of these	68	92
Cold and draughty	9	7
Difficult neighbours	8	7
Damp	7	21
Passive smoking	7	4
Traffic pollution	6	4
Overcrowding	6	4
Dust	5	3
Stairs	3	21
Lack of central heating	3	8
Heating is too hot	3	<1
Base (n)	350	145

The general population were more likely to report living in damp housing than the Chinese population.

In comparison, Pakistani, Indian and African & Caribbean respondents were asked in an open-ended format whether there was anything about their homes that affected their health. The proportion of respondents who identified an aspect of their home that affected their health is summarised in Table 3.8. Smoking in the home was the most commonly mentioned factor perceived to affect health adversely, and was mentioned by 9% of respondents.

Table 3.8. Number and percentage of respondents identifying adverse effects of home on health by ethnicity and gender.

	n	%
Pakistani	39	19
Indian	28	18
African & Caribbean	41	17

4 Health Services: Use and Satisfaction

This section details survey findings in relation to respondents' experiences in using various health services. Participants were asked a number of questions about their use of and satisfaction with specific service providers.

4.1 Use of Specific Health Services

All three surveys asked respondents the number of times they had visited a range of health services. The most commonly used service was the GP as illustrated in Table 4.1

Table 4.1. Use of specific health services at least once in year preceding interview (%).

	Pakistani	Indian	African & Caribbean	Chinese	General Population
Seen a GP	88	79	81	62	80
Been to A&E	21	15	19	10	15
Visited hospital as outpatient	24	26	34	11	25
Hospital stay of 2 night or more	8	10	11	4	11
Day surgery / overnight stay	11	12	11	2	12

Notably, as shown in Table 4.1 the Chinese population of Greater Glasgow appears to use health services to a markedly lesser degree than all other ethnic groups. Previous qualitative research conducted by Gervais and Jovelovitch (1998) in England may help explain this finding. The authors identified:

- The coexistence of Western and Chinese notions of health and illness and the combination of health practices may impact on selective up-take of health-related services (e.g. Chinese practices aim to handle the roots of disease, and Western practices aim to alleviate acute pain, or reduce symptoms).
- A lack of understanding in the Chinese community about the functioning of the NHS, and of services which, until recently, had no equivalent in Chinese cultures.

Indeed, more than half (55%) of Chinese respondents said that they used traditional Chinese medicine, and just under half of these (46%) said that they preferred traditional Chinese medicine to Western medicine.

4.2 Perceived Involvement in Decisions Affecting Participants' Health and Treatment

The extent to which participants were encouraged to participate in decisions affecting their health and treatment was recorded in different ways in the PIAC study compared to the general population and Chinese Healthy Living Centre studies. This difference in assessment limits the extent to which comparisons

between different survey groups can be drawn. With this in mind, the following areas were explored.

(i) Respondents who had received treatment were asked their perceptions of adequacy of information given about a condition or treatment:

- 69% of Chinese respondents felt that they 'were given adequate information about their condition or treatment, compared to 80% of the general population.
- At the same time, however, 10% of the general population felt that they were not given adequate information, compared to only 6% of the Chinese population.
- Pakistani, Indian and African & Caribbean individuals reported relatively high levels of satisfaction with the information they were given about their condition or treatment. Amongst all ethnic groups in this survey, satisfaction levels were highest among older respondents (aged 50+ years).

(ii) People were also asked whether they felt encouraged to participate in health and treatment decisions.

- Only 35% of the Chinese populations said that they had been encouraged to participate in decisions affecting their health or treatment, compared to 70% of the general population. Additionally, 40% of Chinese respondents felt that they were not encouraged to participate in such decisions compared to 18% of the general population.
- In contrast, Pakistani, Indian and African & Caribbean respondents all tended to feel that they were encouraged to take part in decisions affecting their health and treatment. Older participants were more likely to feel encouraged to take part than younger participants

(iii) Having a 'say' in the way services are delivered was also explored.

- 27% of Chinese participants felt that they had a 'say' in service delivery, compared to 65% of the general population. Conversely, 39% of Chinese respondents felt that they had no say, compared to 24% of the general population.

- Pakistani, Indian and African & Caribbean respondents tended to agree that they had a 'say' in the delivery of services. Respondents from these backgrounds aged over 50 years reported significantly more satisfaction with their 'say' in service delivery than younger respondents.

(iv) Survey participants were also asked to which extent they felt that their views and circumstances were understood.

- Results indicate that Chinese respondents (62%) felt their views and circumstances were understood and valued to a slightly lesser degree than the general population (74%).
- Overall, Pakistani, Indian and African & Caribbean respondents tended to be positive about their views and circumstances being understood and valued. Moreover, Indian participants consistently agreed more strongly with the statement 'did you feel that your views and circumstances were understood and valued?' than did Pakistani and African & Caribbean participants.

4.3 Language Difficulties

Respondents were asked about any language difficulties regarding their understanding of advice given and getting their views across to health service providers. Indian and Pakistani respondents were significantly more likely than their African & Caribbean counterparts to report such difficulties. Moreover, Pakistani, Indian and African & Caribbean respondents aged over 50 years were more likely to report language difficulties than their younger peers. The survey of the Chinese population did not ask about language difficulties in this context.

4.4 Accessing Health Services

Respondents (excluding the Chinese sample) were asked if they felt it was difficult to access a range of health services. Responses from the general population survey are summarised in Tables 4.2.

Table 4.2. Difficulty accessing health services (General Population Survey).

INDICATOR	% saying 'some' or 'great' difficulty
Getting an appointment to see your GP	36
Obtaining an appointment at the hospital	28
Arranging for a home visit from your GP	18
Reaching the hospital for an appointment	12
Getting to the GP's surgery / Health Centre	9
Accessing health services in an emergency	9
Visiting others in hospital	7
Obtaining physiotherapy or chiropody	7
Getting an appointment to see the dentist	6
Getting a prescription made up	4
Obtaining other health services such as optometry (optician), stress relief, addiction services, etc	4

Whilst the scoring methods were different, overall, any difficulties identified in accessing services reported among PIAC respondents tended to have a similar focus to the general population. Thus reported problems tended to centre on making appointments with health professionals rather than accessing services. Participants in the PIAC survey aged 50+ years tended to report less difficulty than their younger counterparts in obtaining home visits from their GP, getting an appointment with their GP, accessing health services in an emergency, obtaining a hospital appointment for themselves, and obtaining appointments with health professionals for family members. Further analysis indicated that:

- Regardless of their ethnic background, female respondents reported more difficulties than male participants in getting to their GP surgery or health centre.
- Indian respondents reported less difficulty in arranging home visits from their GP than Pakistani and African & Caribbean respondents.
- Pakistani respondents aged 30-49 years reported more difficulty than those aged 50+ years in accessing health services in an emergency.
- African & Caribbean respondents reported more difficulties in obtaining appointments with health professionals for family members.

The Chinese survey did not include questions on this aspect of the health service.

5 Health Behaviours

5.1 Smoking

Self-reported levels of smoking were found to be markedly lower in all minority ethnic communities than in the general population at large. This difference was particularly marked for females. As Table 5.1 indicates, however, smoking prevalence amongst male Pakistani respondents was found to be nearer to that of the general population. However, all groups showed smoking levels below the national target of 31% smoking by 2010 (Scottish Office, 1999). It is possible, however, that smoking levels (and alcohol consumption, below) were underreported as a result of interviewees giving socially desirable rather than ‘truthful’ accounts of their behaviours.

Table 5.1. Self-reported smoking behaviour by ethnicity and gender (%).

	Chinese		Pakistani		Indian		African & Caribbean		General Population	
	M	F	M	F	M	F	M	F	M	F
I have never smoked tobacco	53	83	52	93	71	91	69	82	42	52
I have only tried smoking once or twice	10	8	8	2	6	5	8	8	4	4
I have given up smoking	13	6	4	0	7	0	7	4	18	13
I smoke some days	6	2	7	0	6	1	3	2	4	4
I smoke every day	18	2	29	5	10	3	13	3	31	28
Base (n)	170	180	110	97	68	77	124	119	846	946

The general population survey found that smokers reportedly smoked 19 cigarettes per day. This is markedly higher than the responses obtained from respondents belonging to minority ethnic groups (see Table 5.2).

Table 5.2. Average number of cigarettes smoked by ethnic group

	Average Number of Cigarettes
General Population	19
Pakistani	14
African & Caribbean	11
Indian	7
Chinese	4

5.2 Passive Smoking

Table 5.3 summarises responses to the question gauging the amount of time participants thought that they were exposed to cigarette smoking by ethnicity and gender.

Table 5.3. Self-reported exposure to cigarette smoking by ethnicity and gender (%).

	Chinese		Pakistani		Indian		African & Caribbean		General Population	
	M	F	M	F	M	F	M	F	M	F
Most of the time	25	16	30	12	7	7	22	19	42	31
Some of the time	29	28	29	27	26	26	42	39	21	21
Seldom	32	36	15	30	26	44	19	26	27	36
Never	14	20	26	31	41	22	17	17	12	12
Base (n)	170	180	109	100	73	81	125	117	845	951

It appears that the likelihood of participants reporting exposure to cigarette smoking by others some or most of the time shows similarities between the general population and Pakistani, Chinese and African & Caribbean participants. Indian participants appear to report considerably less exposure to smoking, especially males.

5.3 Alcohol Consumption

As can be seen from Table 5.4, self-reported consumption of alcohol was markedly higher in the general population than among minority ethnic participants.

Table 5.4. Percentage of respondents saying they do not drink alcohol.

	% Don't Drink Alcohol
General Population	30
Pakistani	91
African & Caribbean	64
Indian	57
Chinese	63

There were gender differences in consumption patterns of Pakistani, Indian and Chinese respondents:

- 97% of female Pakistani respondents said that they never drunk alcohol compared to 85% of male Pakistani respondents.
- 79% of Indian female participants said that they never drank alcohol compared to 34% of male Indian informants.
- 73% of female Chinese respondents said no in response to the question 'do you drink alcohol?', compared to 53% of Chinese male respondents.

Moreover, out of the 20 Pakistani participants who said that they consumed alcohol only four participants said that they had done so in the past week. The proportion of Indian and African & Caribbean respondents who had drunk alcohol in the last week was substantially higher, although still in relatively small numbers. Of the 67 Indian participants who drank alcohol 37 respondents said they had not consumed alcohol in the same time period.

With regards to African & Caribbean participants, 51 interviewees out of the 97 respondents who reported consuming alcohol said that they had not had a drink containing alcohol in the past week. By comparison, 70% of the general population say that they drink alcohol at least sometimes.

Self-reported drinking levels may be underreported, as alcohol consumption in Muslim communities, in particular, is not acceptable.

5.4 Diet

Respondents were asked a number of questions about certain aspects of their diet. The aim of these questions was to ascertain whether dietary targets stipulated in the Scottish Diet Action Plan are being met. Findings are summarised below. Separate data for male and female Chinese and general population respondents were not available.

5.4.1 Fruit and Vegetable Consumption

The Scottish Diet Action Plan recommends that individuals consume at least five portions of fruit and/or vegetables (excluding potatoes) per day. Survey results indicate that this target is being met by:

- 54% of Chinese respondents
- 47% of African & Caribbean respondents
- 34% of the general population
- 33% of Indian respondents
- 19% of Pakistani respondents

Further analysis indicated that female Pakistani, Indian and African & Caribbean respondents reported higher consumption levels of fruit and vegetables than their male counterparts. Whilst self-reported fruit and vegetable consumption was found to be particular low in the Pakistani community, future research is needed to explore whether this finding is an artefact of distinct styles of food preparation that may obscure the amount of fruit and vegetables consumed.

5.4.2 Bread Consumption

The dietary targets for Scotland state that current daily bread intake of 106 grams should be increased by 45% by the year 2005. Pakistani, Indian and African & Caribbean survey respondents showed similar behaviour in relation to bread consumption (mean slices per day=2.85) with male respondents from these ethnic backgrounds consistently reporting higher consumption levels than females. Mean bread consumption was found to be lower in the Chinese population (mean slices per day=1.97). In comparison, the mean number of slices of bread consumed per day for the general population was found to be 2.87.

5.4.3 Sweets, Cakes and Pastries

The mean number of times per day that participants from Pakistani, Indian and African & Caribbean backgrounds said they consumed foods with a relatively high fat content (e.g. cakes and sweets) was 0.91. By contrast Chinese respondents reported consuming 0.99 portions per day, on average. Consumption of sweets and pastries was found to be higher in the general population (mean daily consumption=1.25 times).

5.4.4 Breakfast Cereal Consumption

The Scottish Diet Action Plan target for breakfast cereal consumption is five or more times per week. Only 5% of Chinese, 20% of Pakistani, 28% of African & Caribbean and 39% of Indian respondents met this target. In the general population survey a higher proportion, 46% of respondents, met this target.

5.4.5 Oily Fish Consumption

The Scottish Diet Action Plan stipulates that individuals should eat at least two portions of oily fish (e.g. mackerel, tuna, salmon, and herring) per week. Table 5.5 summarises oily fish consumption by ethnicity.

Table 5.5. Oily fish consumption by ethnicity (%).

	Eating recommended amount of oily fish	Saying they do not usually consume oily fish
General Population	29	41
Pakistani	35	22
African & Caribbean	43	27
Indian	16	56
Chinese	23	31

5.5 Body Mass Index

Participants were asked their height and weight, allowing their Body Mass Index (BMI) to be calculated with the aid of the following formula:

$$\text{BMI} = [\text{Weight in Kilograms} / (\text{Height in Meters}) \times (\text{Height in Meters})]$$

BMI is classified into the following categories:

- Underweight: <18.50
- Normal: 18.50-24.99
- Overweight: 25.00-29.99
- Obese: 30.00-39.99
- Extremely Obese: >39.99

Survey findings, summarised in Table 5.6, indicate that Chinese respondents were most likely to report being of normal weight and are also most likely to be classified as underweight. In the general population survey men (46%) were significantly more likely than women (40%) to be classified as overweight. The survey of the Indian, Pakistani and African & Caribbean populations showed similar proportions of individuals at normal weight to the general population. Generally, there were no overall gender differences in BMI classifications; however, there was an exception to this in the 45-54 year age group whereby, regardless of their ethnic background, women (86%) were significantly more likely to be classified as overweight than males (61%).

Table 5.6. Body Mass Index classifications (%).

	Chinese	Pakistani	Indian	African & Caribbean	General Population
Underweight (<18.5)	13	4	4	4	3
Normal weight (18.5-24.9)	71	51	52	49	54
Overweight (25-29.9)	11	33	40	35	32
Obese (30-39)	4	13	4	11	11
Extremely obese (>39)	1	0	0	1	1
Base (n)	350	166	135	187	1758

5.6 Physical Activity

The minimum recommended 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 per week. As Table 5.7 indicates, minority ethnic survey respondents were less likely than general population participants to meet the target.

Table 5.7. Percentage of respondents undertaking recommended amount of physical activity (%).

	% Undertaking Recommended amount of Physical Activity
General Population	58
Pakistani	32
African & Caribbean	45
Indian	50
Chinese	34

5.7 Oral Health: Frequency of Brushing Teeth

Survey results concerning the self-reported frequency of teeth brushing are summarised in Table 5.8. African & Caribbean and Chinese respondents were more likely than the general population, Indian and Pakistani participants to say that they brushed their teeth at least twice per day. Pakistani

respondents were the least likely to say that they brushed their teeth twice or more per day.

Table 5.8. Responses to the question ‘how often do you brush your teeth?’ by ethnicity (%).

	Pakistani	Indian	African & Caribbean	Chinese	General Population
Twice or more a day	56	68	83	87	67
About once a day	44	32	17	11	26
Less than once a day / seldom	0	0	0	1	7
Base (n)	208	154	243	350	1759

5.8 Health Information

Survey respondents were asked if they required more information on a range of health-related topics. As shown in Table 5.9, Pakistani respondents were most likely to say that they did not want further information (57%), whilst African & Caribbean respondents showed greatest interest.

Table 5.9. Perceived necessity of further information on health issues by ethnicity.

	Pakistani		Indian		African & Caribbean		Chinese*	
	n	%	n	%	n	%	n	%
Accident Prevention	19	9	19	12	47	20	63	18
Addictions	6	3	8	5	24	10	27	8
Cancer	26	12	19	12	45	19	54	15
Child Health	39	19	28	18	134	28	60	17
Dental Health	26	12	23	15	54	22	72	21
Heart health	32	15	27	18	47	20	75	21
Mental Health	29	14	17	11	28	12	79	23
Men’s Health	37	18	26	17	58	24	63	18
Nutrition	36	17	33	22	65	27	110	31
Physical Activity	29	14	23	15	73	30	74	21
Sexual Health	18	9	11	17	52	22	30	9
Smoking	13	6	7	5	15	6	24	7
Women’s Health	48	23	37	24	73	30	80	23
Young People’s Health	34	16	20	13	59	25	54	15
None of These	120	57	79	52	96	40	167	48

* Chinese respondents were asked specifically if they would like information in Chinese.

Chinese respondents had been asked specifically if they would like information in Chinese and nearly half (48%) said that they did not require information in that format. Among other ethnic minority groups, when asked their preferred language, the great majority said that they wanted to receive health-related information in English (89% of African & Caribbean; 77% of Pakistani; 79% of Indian respondents). 35% 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 it in Punjabi. Furthermore, 11% of Indian participants said that they wanted to be able to receive information in Hindi and 25% of African & Caribbean interviewees said that they wanted to receive the information in French.

6 Social Health and Capital

Each survey addressed social health and capital issues although not all questions were the same.

6.1 Number and Ethnic Background of Close Friends

Pakistani, Indian and African & Caribbean respondents were asked about the number of close friends they had. The mean number of close friends reported (mean=4.47) did not differ by ethnic group; although male participants consistently said that they had more friends (mean=5.03) than female (mean=3.90) participants. The majority of friends were from respondents' own ethnic background, but not exclusively.

Pakistani participants reported that 76% of their close friends were from the same ethnic background compared to 72% Indian and to 70% of African & Caribbean participants. The general population and Chinese surveys did not ask questions of this nature.

6.2 Isolation from Friends and Family

African & Caribbean (30%) participants were more likely than Pakistani (19%), Chinese (22%) and Indian (23%) respondents to say that they felt isolated from friends and family. Participants from minority ethnic groups were also consistently more likely to say that they felt isolated from family and friends than the general population as a whole (15%).

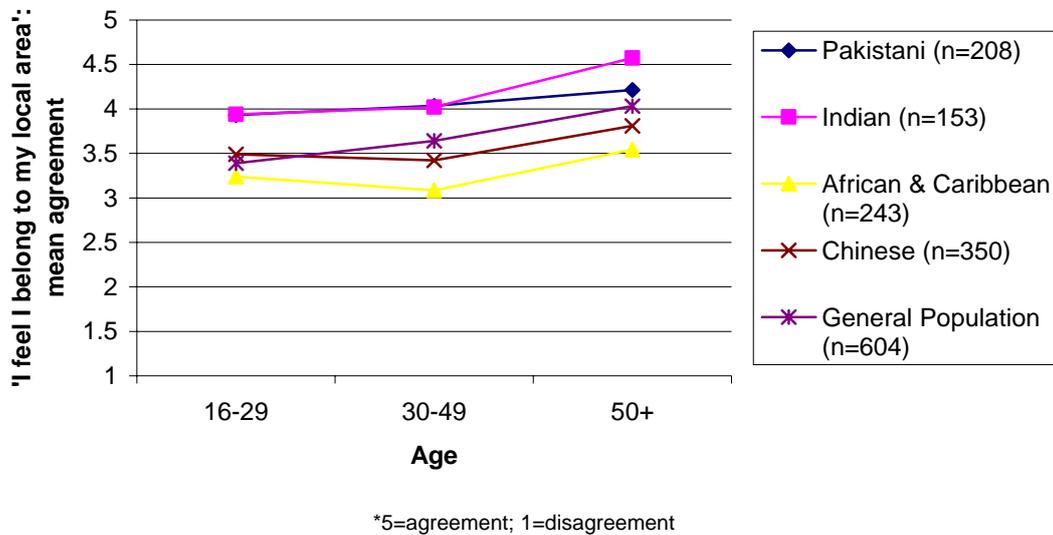
6.3 Perceptions of Local Area

Respondents were asked to indicate their feelings towards the local area in which they live. They were asked the extent to which they agreed on four statements on a five-point scale from 1 (Strongly disagree) to 5 (Strongly agree).

6.3.1 Feelings of Belonging to Local Area

General population (mean=4), Pakistani (mean=4.04) and Indian (mean=4.11) participants tended to agree with the statement 'I feel I belong to my local area' to a larger degree than African & Caribbean (mean=3.21) and Chinese (mean=3.53) respondents. As Figure 6.1 indicates, perceptions tended towards the positive end of the scale and there was a trend whereby older respondents reported stronger feelings of belonging than younger ones.

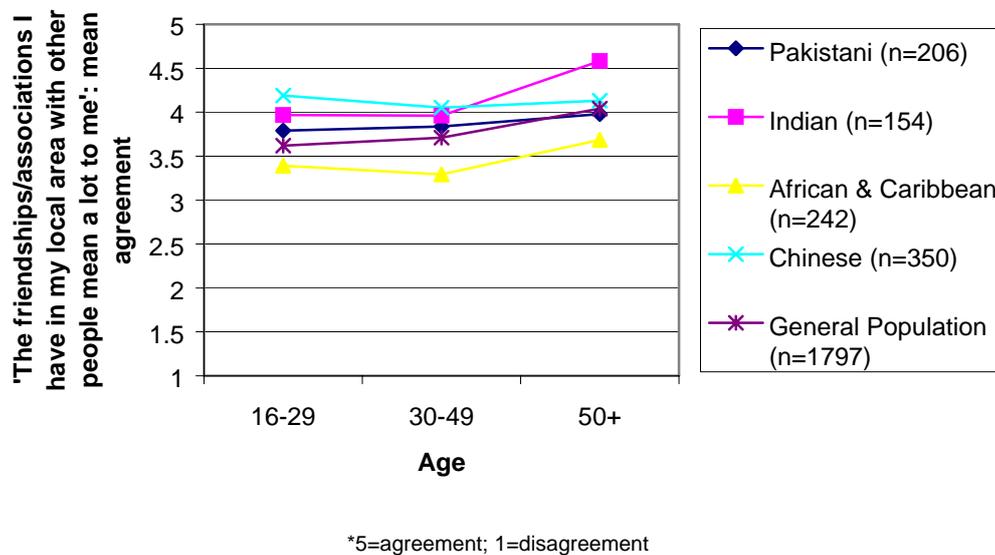
Figure 6.1. Mean agreement* with the statement 'I feel I belong to my local area' by ethnicity and age.



6.3.2 Friendships / Associations

Responses to the statement 'the friendships/associations I have in my local area with other people mean a lot to me' indicated that African & Caribbean respondents (mean=3.38) valued local friendships less than other groups. Thus Pakistani (mean=3.85), the general population (mean=3.99), Indian (mean=4.11) and Chinese (mean=4.13) respondents tended to agree more strongly with the statement. Figure 6.2 illustrates that perceptions regarding meaningful friendships/associations tended towards the positive end of the scale.

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.

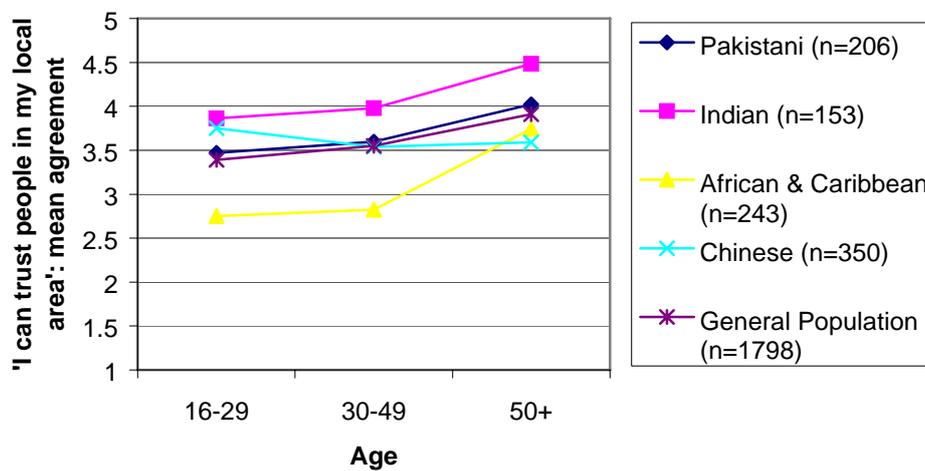


As Figure 6.2 also indicates, response patterns showed some variation with age, with older respondents from Pakistani, Indian and African & Caribbean backgrounds tending to agree more strongly with the statement. This pattern of results was mirrored in the general population survey. Thus further analysis of the general population survey results suggested 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), participants agreed more strongly with the above statement than those aged 30-49 years (mean=3.96) and 16-29 years (mean=3.79).

6.3.3 Trust

Analysis of mean agreement with the statement 'I can trust people in my local area' suggests that African & Caribbean (mean=2.93) respondents agreed to a significantly lesser extent than did Chinese (mean=3.65), Pakistani (mean=3.65), general population (mean=3.8) and Indian (mean=4.05) respondents. With the exception of Chinese respondents, mean agreement tended to increase with age (see Figure 6.3). Whilst perceptions regarding trust in people from respondents' local area tended to be skewed towards the positive end of the scale, African & Caribbean respondents aged 16-49 years tended to be more distrustful towards people in their local areas than other respondents.

Figure 6.3. Mean agreement* with the statement 'I can trust people in my local area' by ethnicity and age.



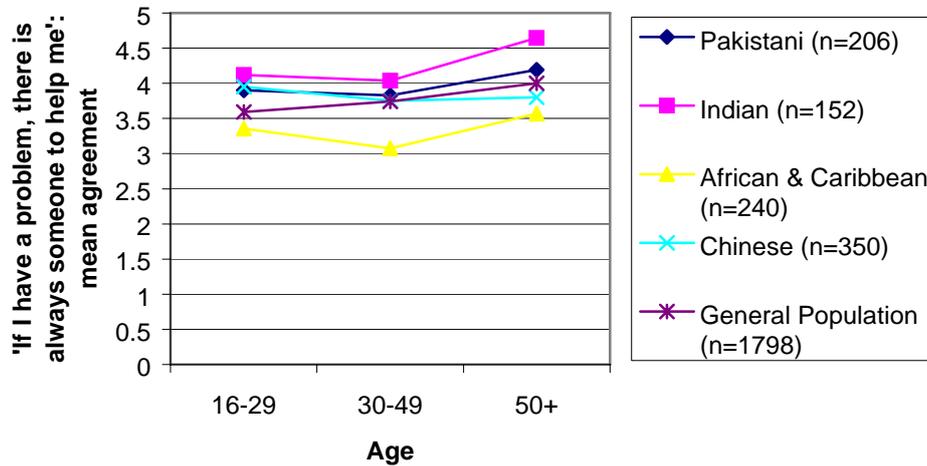
*5=agreement; 1=disagreement

6.3.4 Help with Problems

Responses to the statement 'if I have a problem, there is always someone to help me' followed the same pattern of responses to the above statements (see Figure 6.4). Again, responses tended towards the positive end of the

scale. African & Caribbean respondents (mean=3.25) agreed significantly less strongly with the statement than did Pakistani (mean=3.94) and Indian (mean=4.21) participants. The corresponding means for the general and Chinese populations are 3.8 and 3.85 respectively.

Figure 6.4. Mean agreement* with the statement 'if I have a problem, there is always someone to help me' by ethnicity and age.



*5=agreement; 1=disagreement

6.4 Perceptions of Personal Safety

6.4.1 Using Public Transport

There was broad agreement with the statement 'I feel safe using public transport in my local area'. This did not appear to differ by age group or gender (overall mean agreement=4.21) in the survey of Pakistani, Indian and African & Caribbean populations. The equivalent mean for the Chinese population was 3.85 and 3.9 for the general population as a whole. This suggests that Pakistani, Indian and African & Caribbean participants felt slightly safer using public transport. Participants aged 50+ years (mean=4.38) felt significantly more secure than those aged 30-49 years (mean=4.08). Participants aged 16-29 years (mean=4.28) lay in-between in terms of their strength of agreement. The general population survey, in contrast found no differences in the response patterns among different age groups.

6.4.2 Walking Alone Even After Dark

The second statement was 'I feel safe walking alone around my local area even after dark'. Indian (mean=3.78) and Pakistani (mean=3.65) respondents agreed with the statement to a significantly greater degree than did their African & Caribbean (mean=3.05) counterparts. Moreover, regardless of their ethnic background, male respondents (mean=3.64) agreed to a significantly

larger degree than did female interviewees (mean=3.23). Additionally, participants aged 50+ years (mean=3.89) agreed more strongly than those aged 16-29 years (mean=3.48) and 30-49 years (mean=3.2).

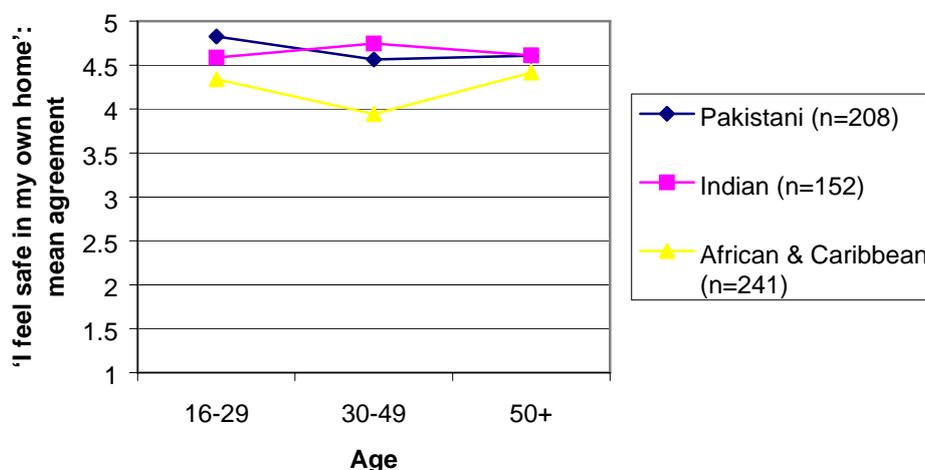
In the Chinese survey, the overall mean agreement with the statement was 3.39 and thus somewhat lower than in the general population. Further analysis suggested that respondents aged 16-29 years (mean=3.21) felt comparatively less safe than respondents aged 50+ years (mean=3.74). The mean for respondents aged 30-49 years was 3.42. Additionally, Chinese female participants (mean=3.24) felt less safe than their male counterparts (mean=3.55).

Comparison with the equivalent findings from the general population (mean=3.4) indicate that Pakistani, Indian and African & Caribbean participants felt similar levels of safety in relation to walking alone after dark to the general population. In the general population survey participants aged 30-49 years (mean=3.97) said that they felt significantly safer walking around their local area than those aged 16-29 years (mean=3.85). The mean agreement for respondents from the general population survey aged 50+ years was 3.91 and did not differ to a significant degree from either of the other age groups.

6.4.3 *Feeling Safe in Own Home*

The final statement 'I feel safe in my own home' asked participants the degree to which they felt safe in their own home. African & Caribbean (mean=4.15) participants felt significantly less safe than Pakistani (mean=4.67) and Indian (mean=4.64) participants. As Figure 6.5 illustrates, in the youngest age group African & 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) felt significantly less safe in their own home than those aged 16-29 years (mean=4.57) and 50+ years (mean=4.46).

Figure 6.5. Mean agreement* with the statement 'I feel safe in my own home' by ethnicity and age (Pakistani, Indian, African & Caribbean samples).



*5=agreement; 1=disagreement

The comparative mean for the general population was 4.3 and 4.31 for the Chinese population, which are broadly comparable with the results found in the survey of Pakistani, Indian and African & Caribbean residents. The pattern of responses in the general population and Chinese surveys did not differ to a significant degree as a function of age.

6.5 Racism

Experiences of racism and discrimination were measured differently in the Chinese Healthy Living Centre survey and in the Pakistani, Indian and African & Caribbean survey. The Chinese survey gave respondents the following definition of racism:

“Racism is a hatred or intolerance of another race or other races. It can take the form of verbal comments, exclusion, and or physical attack and can happen anywhere, e.g. in work, school, college, university, or the street.”

Chinese respondents were then asked if they had experienced racism in the last year and 38% (133 respondents) said they had. There was no gender difference in the experience of racism, although respondents aged 55+ years were slightly less likely to say that they had experienced racism.

The PIAC survey used a different methodology to assess experiences of racism by utilising two standardised questionnaires that asked whether respondents had experienced specific forms of racism and discrimination in the past year. The first of these probed how often participants thought that nine ‘minor’ racist incidents (e.g. how often do you receive worse service because of your ethnic background?) 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 was scored by adding the number of times participants said 'yes', as opposed to 'no'.

6.5.1 'Minor' Racist Events

African & Caribbean (mean=29.21) participants reported more 'minor' experiences of racism than both Pakistani (mean=21.32) and Indian (mean=20.02) interviewees. Across the sample, participants aged 30-49 years (mean=26.26) reported significantly more experiences of racism than those aged 16-29 (mean=23.47) and 50+ years (mean=20.94). There were no gender differences in the experience of racism.

6.5.2 'Major' Racist Events

When participants were asked about the number of 'major' racist events they had encountered a similar picture emerged. African & Caribbean (mean=1.14) participants reported significantly more racism than their Pakistani (mean=0.53) and Indian (mean=0.46) counterparts.

Regardless of their ethnic background participants aged 30-49 years (mean=0.95) reported significantly more 'major' experiences of racism than those aged and 50+ years (mean=0.49). There were no gender differences in the experience of racism.

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 & Caribbean communities of Greater Glasgow.

6.6 Perceptions of Identities

Questions relating to perceptions of identity were only asked in the survey of Pakistani, Indian and African & Caribbean populations. In this way, participants were asked to rate, on a scale from 1 (Not at all) to 10 (Very much), how Scottish / British they felt.

Results indicated that across the sample, African & Caribbean participants (mean=5.11) felt less Scottish / British than their Pakistani (mean=6.57) and Indian (mean=6.24) counterparts.

Results indicated that across the sample African & Caribbean participants (mean=8.56) identified more strongly with their ethnic background than both Pakistani (mean=7.42) and Indian (mean=7.68) respondents. Furthermore, regardless of respondents' ethnicity and gender, participants aged 50+ years (mean=7.30) identified significantly less strongly with their respective ethnic backgrounds than participants in the 16-29 years (mean=8.15) and 30-49 years (mean=8.05) age groups.

6.7 Languages Spoken

Table 6.1 summarises the languages most commonly spoken by participants from Pakistani, Indian and African & Caribbean backgrounds (multiple responses were possible). Additionally, 5% of Pakistani participants, 21% of Indian participants and 57% of African & 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 & Caribbean backgrounds) reported speaking two, or more, additional languages.

Table 6.1. Languages spoken by ethnicity (number of participants & %).

	Pakistani		Indian		African & Caribbean	
	n	%	n	%	n	%
English	190	90	146	94	224	92
Urdu	170	81	21	14	1	<1
Punjabi	180	85	88	57	3	1
Hindi	27	13	96	62	3	1
French	14	7	9	6	60	25
Swahili	6	3	2	1	71	29
Yoruba	0	0	2	1	16	7
Lingala	0	0	0	0	16	7
Arabic	1	<1	0	0	6	3
Maratyi	0	0	10	6	0	0
Shona	0	0	0	0	9	4

As is illustrated in Table 6.2 which summarises the most commonly spoken languages reported by Chinese participants, Cantonese appears to be the most commonly spoken language by the Greater Glasgow Chinese population.

Table 6.2. Languages spoken - Chinese sample (%).

	Chinese
Cantonese	79
English	64
Mandarin	49
HAKKA	30
Malay	9
Hokkien/Fujian	7
Teochew	1
Other	2
Base (n)	350

6.8 First Spoken Language

Interviewees' first spoken language is summarised in Table 6.3. Whilst most respondents spoke English, as already noted, it tended not to be their first language spoken, especially among the Pakistani and Indian respondents.

Table 6.3. First spoken language by ethnicity (Pakistani, Indian, African & Caribbean samples).

	Pakistani		Indian		African & Caribbean	
	n	%	n	%	n	%
English	53	27	43	32	60	45
Punjabi	102	52	59	44	5	3
Urdu	62	31	3	2	0	0
Hindi	3	2	27	20	0	0
Yoruba	0	0	0	0	11	6
Swahili	0	0	0	0	39	23
French	2	1	0	0	42	24

There was also a clear trend whereby the likelihood of participants saying that English was their first spoken language diminished with age in all ethnic groups: 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 & Caribbean participants in the same age group. African & Caribbean sample participants aged 50+ years (48%) were more likely than the younger age groups to say that English was their first spoken language. Approximately 1% of Pakistani, 4% of Indian and 11% of African & Caribbean participants reported that their first spoken language was different from the ones listed.

The Chinese Healthy Living Centre survey found Cantonese to be the most common first spoken language in the Chinese community in Greater Glasgow (see Table 6.4). However there were clear differences amongst different age bands. For example, Mandarin tended to be the first spoken language for respondents aged 16-34 years, whilst Hakka was the most common first spoken language amongst respondents aged 65+ years.

Table 6.4. First spoken language - Chinese sample (%).

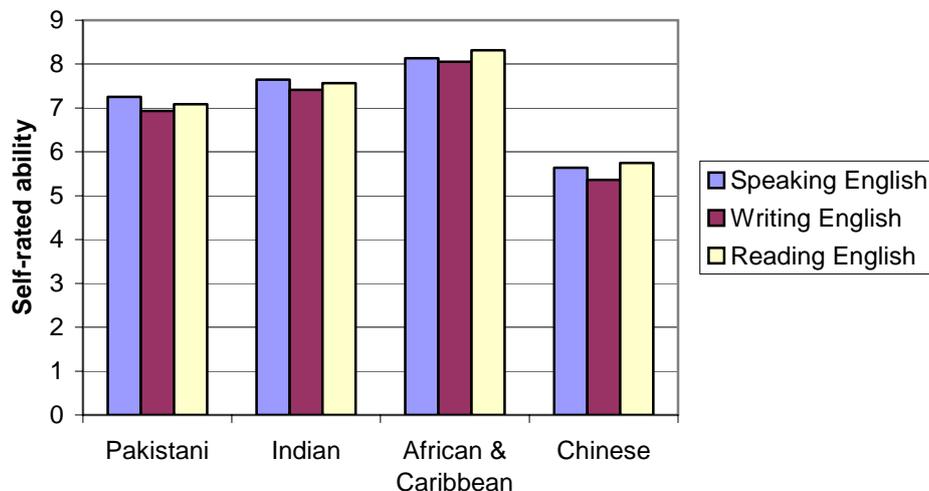
	Chinese
Cantonese	41
Mandarin	26
Hakka	16
English	11
Fujian/Hokkien	2
More than one language	2
Other	1
Base (n)	350

6.9 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).

As Figure 6.6 indicates, overall ratings for English language abilities were lower amongst Chinese respondents than in the other minority ethnic groups.

Figure 6.6. Self-rated English Language Ability by ethnicity.



The PIAC report further analysed responses concerning self-rated English language ability as a function of gender and age and these findings are summarised below.

6.9.1 Speaking English

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

Regardless of their ethnic background, male participants (mean=7.85) rated their ability to speak English significantly higher than their female counterparts (mean=7.56). Furthermore, self-rated ability to speak English decreased with age in all ethnic groups. Thus participants in the 16-29 year age group (mean=8.59) rated their ability as significantly better than those aged 30-49 years (mean=7.64). 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).

6.9.2 Writing English

An almost identical picture emerged when participants were asked to rate their English writing ability. African & Caribbean (mean=7.61) participants aged 50+ years rated their ability to write English significantly higher than both Pakistani (mean=4.21) and Indian (mean=5.32) participants. Male participants (mean=7.66) rated their ability to write English significantly more highly than female respondents (mean=7.35).

6.9.3 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 & Caribbean (mean=8.31) participants aged 50+ rated their ability to write English significantly higher than both Pakistani (mean=7.09) and Indian (mean=7.56) participants.

6.10 Educational Attainment

Respondents were asked about their highest level of educational achievement. Responses are summarised in Table 6.5. The level of self-reported educational achievement is markedly lower in the Pakistani sample, in comparison with the African & Caribbean and Indian samples.

Table 6.5. Highest level of self-reported highest educational achievement by ethnicity (%).

	Chinese	Pakistani	Indian	African & Caribbean	General Population
Primary Education	34	14	7	3	14
Secondary Education	27	31	26	14	<i>not available</i>
Further Education (e.g. college)	<i>Not asked*</i>	29	23	38	7
Higher Education (university)	30	20	40	43	14
No Formal Education	8	6	4	2	26
Base (n)	145	210	154	244	1778

* The Chinese Health living survey did not distinguish between further and higher education.

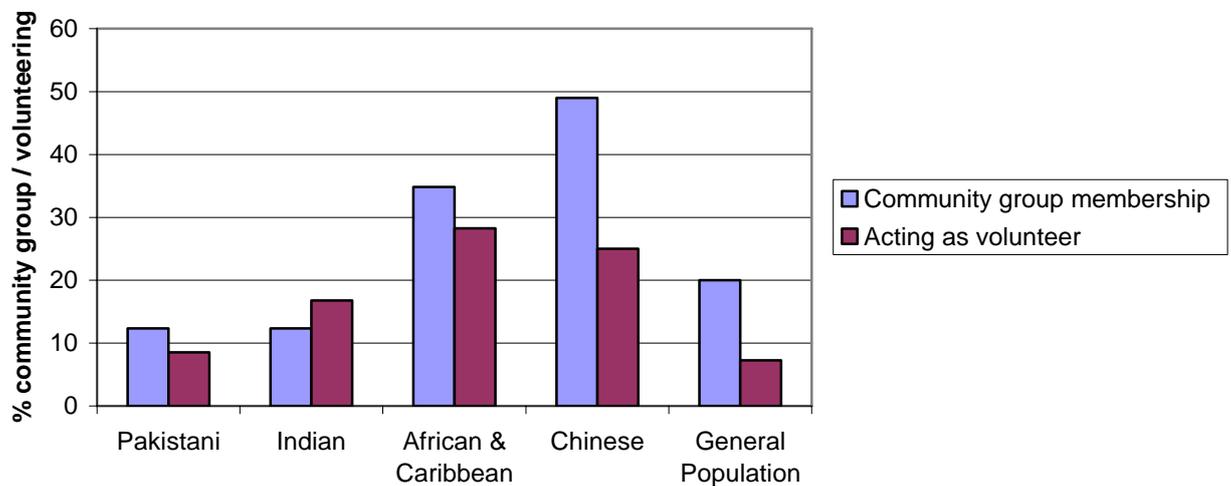
The number of participants with no formal education increases with age (from 0% of those aged 16-24 years to 21% of those aged 65+ years). There are

few gender differences in educational attainment although, regardless of their ethnic background, women (6%) appeared more likely than men (2%) to report that they did not have any formal education.

6.11 Community Group Membership

In order to gauge levels of civic engagement, respondents were asked whether or not they were members of community groups, or acted as volunteers. As Figure 6.7 illustrates, community group membership varied as a function of ethnicity. A higher proportion of Chinese and African & Caribbean respondents thus reported belonging to a social club, association or similar than among the general population and the other minority ethnic groups. It is possible that this pattern of results is a function of comparatively more Chinese respondents being recruited via social clubs and associations.

Figure 6.7. Community group membership / volunteering.



6.12 Use of Childcare

Respondents who said that they were responsible for children under the age of 14 years were asked if they used any paid or unpaid childcare. Results suggest that 38% of African and Caribbean, 21% of Chinese, 14% of Indian and 13% of Pakistani respondents said they used a form of paid or unpaid childcare. By comparison, 35% of general population respondents with children under the age of 14 years say that they use childcare facilities.

6.13 Caring Responsibility

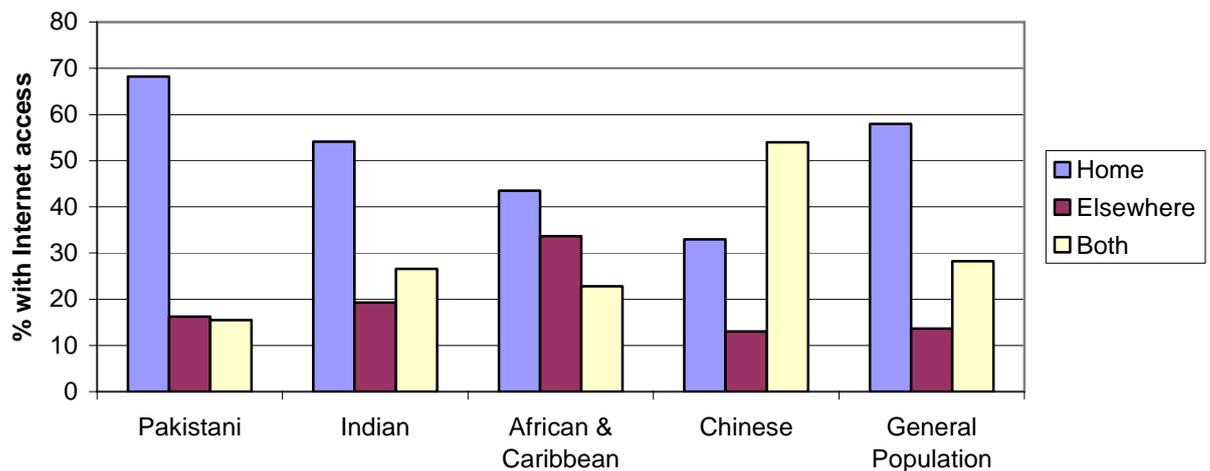
Respondents were also asked whether or not they cared for someone (e.g. a disabled child or an elderly person) on a day-to-day basis, excluding ordinary childcare. 11% of Pakistani, 7% of Indian, 5% of Chinese and the general population and 3% of African & Caribbean participants said that they cared for someone on a day-to-day basis.

On average, participants from African & Caribbean, Pakistani and Indian backgrounds who reported that they cared for someone said that they spent 5 hours per day caring for the person. Chinese respondents who reported caring for someone, on average, said that they spent 6.3 hours per day caring. The general population survey found that of those who care for someone, 37% said that they spent up to eight hours per day caring, and 51% of respondents said that spent between nine and twenty four hour per day caring.

6.14 Internet Access

As Figure 6.8 indicates, 62% of Pakistani, 65% of Chinese, 71% of Indian, and 79% of African & Caribbean participants reported having access to the Internet. This proportion is substantially higher than that found in the general population (43%). Access to the Internet decreased with age in all age groups self-reported.

Figure 6.8. Location of access to the Internet (includes only respondents with Internet access).



6.15 Perceived Difficulty of Paying an Unexpected Bill

To give an indication of financial well-being participants were asked how much of a problem it would be if they had to pay three unexpected (for example a household repair) bills (£20, £100, £1000). Respondents had 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). The method of scoring differed slightly between the general population and Chinese surveys on the one hand and that of Pakistani, Indian and African & Caribbean individuals on the other. Thus the latter survey utilised a continuous scale from 1 to 4, whilst the other two surveys utilised a discrete four-point scale (1=Impossible to find; 2=A big problem; 3=A bit of a problem; 4=No problem).

Results indicate similarities between the general and Chinese populations in terms of the perceived difficulty of paying a £20 or £100 bill. Chinese respondents (67%), however, were much more likely than the general

population (46%) to say that finding £1000 to pay an unexpected bill would be a big problem or impossible to find.

In the PIAC survey, African & Caribbean respondents consistently reported more perceived difficulty in having to pay an unexpected bill (irrespective of its amount) than Pakistani and Indian respondents.

6.16 Proportion of Household Income from State Benefits

The general population survey indicated that approximately 43% of residents of Greater Glasgow said that they were not in receipt of any state benefits and 28% of the general population reportedly received all of their income from state sources. In comparison, respondents from both minority ethnic surveys were more likely to say that they were not in receipt of state benefits, and less likely to say that all of their income was derived from these sources:

- 63% of Pakistani participants said that they were not in receipt of any state benefits and 4% said that all their income came from this source.
- 80% of Indian participants said that they were not in receipt of any state benefits with 3% saying that all of their income was derived from state sources.
- 59% of African & Caribbean participants said that they were not in receipt of any state benefits, although 20% of this sample said that all of their income came from state benefits.
- 70% of Chinese participants said that they were not in receipt of any state benefits whilst 9% of Chinese respondents said that they derived all of their income from state sources.

Respondents in receipt of financial support were asked about the types of benefits they received. Responses are summarised in Table 6.6.

Table 6.6. Types of benefits by ethnicity (and Greater Glasgow comparison).

	Pakistani		Indian		African & Caribbean		Chinese		General Population	
	n	%	n	%	n	%	n	%	n	%
Job Seekers Allowance (JSA)	7	8	1	3	17	16	5	1	49	5
Income Support	85	35	8	24	105	52	30	9	288	29
Disability-Related Benefits	9	11	1	3	6	6	13	4	253	25
Housing Benefits	16	19	2	6	10	10	34	10	252	25
Child Tax Credit	26	31	10	30	15	14	30	9	50	5
Working Tax Credit	6	7	5	15	11	11	8	2		
Disabled Person's Tax Credit	0	0	0	0	1	1	2	1	8	1
Retirement Pension	8	9	8	24	4	4	26	7	381	41
Attendance Allowance	2	2	2	6	3	3	5	1	50	5
Other Pension	2	2	1	3	2	2	1	0	139	15
Other	10	12	6	18	12	11	16	5	126	14

7 General Conclusions

This report provided a summary of key indicators of health and well-being in the Greater Glasgow, Pakistani, Indian, Chinese and African & Caribbean populations. The data underpinning this report were collated in a survey of the Chinese community that was conducted by the Chinese Healthy Living Centre and a survey of the Pakistani, Indian and African & Caribbean (PIAC) communities conducted by Strathclyde / Stirling Universities. Comparisons are drawn with the health and well-being survey of the general population of Greater Glasgow (RBA, 2002). Key findings are summarised below.

7.1 Health

Indian and African & Caribbean respondents' perceptions of their health were more positive than those of Pakistani, Chinese and general population respondents. However, the younger age profile of minority ethnic communities compared to the general population should be noted since positive perceptions of health tend to decrease with age. The younger age profile of minority ethnic groups may also help explain the finding that participants from all minority ethnic backgrounds were also less likely than the general population to be suffering from long-term conditions interfering with day-to-day activities.

General population and Pakistani informants were more likely to report being in receipt of treatment for medical conditions than Indian, Chinese and African & Caribbean respondents.

7.2 Mental Health

Findings of the PIAC survey, which utilised the General Health Questionnaire 12 (GHQ-12) as a measure of well-being, suggested that 16% of Pakistani, 12% of Indian and 20% of African & Caribbean attained a score indicative of psychological distress. Pakistani respondents also reported significantly higher levels of stress than Indian and African & Caribbean respondents, with female participants from all ethnic backgrounds reporting significantly higher stress levels than male respondents. Elevated GHQ-12 scores were associated with reports of racism.

The Chinese Healthy Living Centre study did not include a specific measure of mental health, and the general population survey utilised the depression subscale of the Hospital Anxiety and Depression scale, making comparison problematic. However, findings suggested that 5% of the general population obtained a score indicative of clinical depression.

7.3 Service Provision Use and Satisfaction

Chinese respondents were less likely than the other ethnic groups, including the general population, to have made use of health services in the year preceding the interview. This relatively lower uptake of health-related services by the Chinese community may be the result of a variety of factors.

First, more than half of Chinese respondents said that they made use of traditional Chinese medicine, in addition to Western medicine. Second, Chinese respondents reported the lowest satisfaction levels with services. In this way, Chinese respondents were less likely than the general population to say:

- That they had been given adequate information about their condition.
- That they had been encouraged to participate in decisions affecting their health or treatment.
- That they had a 'say' in the delivery of services.
- That they felt that their views and circumstances were understood.

The comparative dissatisfaction with service provision reported by Chinese respondents indicates a need for consultations regarding the specific health service needs of the Chinese community.

Pakistani, Indian and African & Caribbean respondents, on the other hand, were more positive about their satisfaction levels than Chinese interviewees and thus more similar to the general population sample. The PIAC survey also found that informants aged 50 years and above tended to be more satisfied with service provision than their younger peers.

7.4 Oral Health

Minority ethnic respondents were consistently more likely to report that all of their teeth were their own than were the general population interviewees. At the same time Indian, Chinese and African & Caribbean respondents were less likely than Pakistani and general population respondents to say that they had been to see a dentist in the six months preceding the interview

The finding that African & Caribbean respondents were the least likely to report that they had been to a dentist suggests that there is a need for a concerted effort to encourage visits to the dentist in this community in particular.

7.5 Alcohol Consumption and Smoking

Respondents from all minority ethnic groups reported markedly lower levels of alcohol consumption than the general population. Overall, self-reported levels of alcohol consumption were very low even for participants who said that they did drink alcohol on occasion, with Indian, Chinese and Pakistani females being less likely than males to report any alcohol consumption. It is possible, however, that respondents underreported alcohol consumption levels for religious and cultural reasons. The possibility of respondents giving socially desirable, rather than accurate, responses might have been increased by the fact that interviewers tended to be from the same ethnic group as respondents.

Smoking related findings indicate that smoking is less common in minority ethnic communities than in the general population (33% smokers). At the

same time, findings indicated that in minority ethnic communities smoking is more prevalent in the Pakistani community (23% smokers) compared with the Chinese (10% smokers), Indian (10% smokers) and African & Caribbean (11% smokers) communities. It is possible that respondents may have given socially or culturally desirable responses as with reported alcohol consumption.

With regards to passive smoking, it emerged that Indian respondents were the least likely to self-report exposure to smoking by others.

7.6 Diet

Findings relating to self-reported consumption of fruit and vegetables indicated that 54% of Chinese, 47% of African & Caribbean, 19% of Pakistani, 33% of Indian and 34% of general population respondents were meeting the Scottish Diet Action Plan target of consuming at least five portions of fruit and vegetables per day. Future research is needed to ascertain whether relatively low levels of fruit and vegetable consumption reported by Asian respondents are the result of differences in styles of food preparation and hence lower recognition of amounts included in dishes.

Average bread consumption was similar for respondents from African & Caribbean, Indian and Pakistani backgrounds and the general population. Chinese respondents, on the other hand, reported markedly lower consumption of bread. Consumption of foods with a relatively high fat content was lower amongst minority ethnic groups than the general population at large. With regards to breakfast cereal consumption, findings indicated that 5% of Chinese, 20% of Pakistani, 28% of African and Caribbean and 39% of Indian participants are currently meeting the Scottish Diet Action Plan target of consuming cereal at least five times per week, compared to 46% of the general population.

It should be noted, however, that the Scottish Diet Action Plan may be culturally insensitive for minority ethnic groups.

7.7 Physical Activity

The recommended amount of physical activity was met more readily by the general population (58% meeting the target of moderate activity at last five times per week or twenty minutes of vigorous physical activity three or more times per week) than minority ethnic groups. Thus only 32% of Pakistani respondents reported undertaking the recommended amount of physical activity, compared to 34% of Chinese, 50% of Indian and 45% of African & Caribbean informants.

7.8 Body Mass Index

Respondents who knew both their height and weight were classified as a function of their Body Mass Index (BMI) into being underweight, normal weight, overweight, obese and extremely obese. Findings suggest that

Chinese respondents were most likely to be classified as being of normal weight (71%). Respondents from other ethnic backgrounds were similar to the general population in terms of being classified as being of normal weight (around 50%).

Further findings suggested that African & Caribbean (12%), Pakistani (13%) and general population respondents (11%) were more likely to be classified as obese or extremely obese than Chinese (5%) and Indian (4%) respondents.

7.9 Distribution of Health-Related Information

African & Caribbean respondents were more likely than those from Chinese, Indian or Pakistani backgrounds to say that they would like to receive additional information on health issues. Conversely, Pakistani respondents, who were the more likely than other minority ethnic groups to be receiving medical treatment, were the least likely to say that they required additional information on health related issues. It is possible that the perceived need for information expressed by African & Caribbean respondents is related to the fact that these respondents tended to have lived in Greater Glasgow for comparatively less time than respondents from other ethnic backgrounds. In this way, it also emerged that African & Caribbean respondents required general information on the National Health Service.

The great majority of Pakistani, Indian, African & Caribbean respondents said that they would like to receive health related information in English. However, the distribution of health related information targeting individuals aged above 50 years should be made available in appropriate languages, given the comparatively lower levels of confidence in reading English reported by minority ethnic respondents aged above 50 years.

7.10 Social Health and Capital

A number of marked differences in terms of social health and capital between the minority ethnic groups participating in the surveys emerged. Overall, African & Caribbean respondents, whose average length of residency in Greater Glasgow tended to be shorter than that of other ethnic groups, were more likely than other minority ethnic groups to express higher dissatisfaction with regards to social connectedness.

For example, minority ethnic respondents tended to be more likely than the general population to say that they felt isolated from family and friends at times. Only 15% of the general population said that they felt this way, compared to 30% of African & Caribbean, 23% of Indian, 22% of Chinese and 19% of Pakistani respondents.

African & Caribbean respondents also tended to feel less connected to the local area in which they lived and to say that they felt more insecure walking alone in their neighbourhood and in their own home, were less likely to report that the associations and friendships with people in their local area were

meaningful to themselves, least likely to say that they trusted people in their local area, and to say that if they had a problem there would be someone to help them. Additionally, there was a significant tendency for respondents above 50 years of age to feel more connected to their local area than younger respondents.

Chinese respondents, on the other hand, were inclined to say that they felt less safe using public transport than the other minority ethnic groups and the general population. They were also more likely than the general population to say that they felt insecure when walking alone in their neighbourhood.

Both Chinese and African & Caribbean respondents were more likely than Pakistani and Indian respondents and the general population to say they were members of community groups and these may be a valuable means of building social support networks.

7.11 Experiences of Racism and Perceptions of Identity

Minority ethnic respondents' experiences of racism were assessed differently in the Chinese and the PIAC surveys. Chinese respondents were asked whether they had ever experienced racism. Results indicate that 38% of Chinese informants said that they had experienced racism.

Pakistani, Indian and African & Caribbean participants, on the other hand, were asked whether they had experienced specific forms of racism and discrimination in the year preceding their interview. It was found that African & Caribbean respondents reported significantly more experiences of racism and discrimination than Pakistani and Indian interviewees.

Further findings from the PIAC survey indicated that African & Caribbean respondents felt less Scottish / British than their Indian and Pakistani counterparts. It also emerged that feeling of Scottish / British identity decreased with age. Thus participants from Pakistani, Indian and African & Caribbean who were aged 50 years and above said they felt more Scottish / British than their younger peers. This suggests that young people from minority ethnic backgrounds, many of whom were born in the UK, may feel disconnected from the majority culture.

7.12 Individual Circumstances

Use of childcare was less common amongst Pakistani and Indian respondents in comparison to Chinese and African & Caribbean informants. Pakistani and Indian respondents, in turn, were more likely to say that they cared for someone on a day-to-day basis, although absolute numbers were very low. These findings may be an indication of differences in the way family life is organised in Indian and Pakistani communities compared to the general population, African & Caribbean and Chinese communities.

Whilst Internet access decreased with age in all ethnic groups, minority ethnic respondents were significantly more likely than the general population to have

access to the Internet. This may be related to the fact that minority ethnic groups have a younger age profile than the general population.

With regards to self-rated ability to speak, read and understand English, survey findings suggest that Chinese respondents rated their English language abilities as markedly lower than that of the other ethnic groups participating in the surveys. The self-reported highest levels of educational attainment however, were comparatively lower for Pakistani respondents.

Respondents were asked to say how much of a difficulty it would be to meet a number of unexpected bills (£20, £100, £1000) and results suggest that African & Caribbean respondents were more likely than those from Indian and Pakistani backgrounds to say that meeting the cost of an unexpected expense would be difficult or impossible. Chinese respondents were also more likely than the general population to say that finding £1000 to pay an unexpected bill would be a big problem or impossible. Overall minority ethnic respondents were less likely than the general population to say that they were in receipt of state benefits.

7.13 Research Limitations

It is well documented that surveys of black and minority ethnic communities face a number of methodological challenges that limit the extent to which findings can be generalised. First and foremost, the purposive nature of the sampling methodologies employed in the minority ethnic surveys must be noted. Thus minority ethnic respondents were recruited opportunistically and participation was voluntary which may have resulted in sampling biases. The three surveys were also conducted at different times and it is therefore possible that this may have affected response patterns. Additionally, remuneration was only offered to respondents in the PIAC study and this may have had an impact on response rates.

There is also the need for some caution when interpreting differences found in response patterns between different minority ethnic groups and in relation to the general population. As was highlighted in the introductory chapter, the age profile of minority ethnic communities is somewhat younger than that of the general population and it is therefore possible that this may have obscured or accentuated differences between the populations.

In addition to differences in the make-up of the samples, the research instruments utilised in the three surveys differed from each other to some extent. Furthermore, the methodology of employing fieldworkers from the respective minority ethnic communities may have impacted adversely on the 'truthfulness' of some responses, in particular in relation to self-reported alcohol consumption. At the same time, however, the practice of employing interviewers from the respective minority ethnic communities may also have had a positive effect on response rates, making it possible to reach individuals that may otherwise have been excluded from taking part in this research.

7.14 Further Areas for Research

In conclusion, this summary report provided an overview of health and well-being issues affecting the main black and minority ethnic communities in Greater Glasgow. As such it provided a baseline against which future research can measure how the health and well-being of minority ethnic communities in Greater Glasgow develops in the future, and will inform both service delivery and planning.

The relatively broad realm of the research reported in this report as well as the discrepancies in the methodologies employed future research should explore some of the findings in more detail. For example, whilst the research summarised in this report points to differences between minority ethnic groups on a whole range of indicators of (mental) health and well-being, dietary behaviours, and satisfaction with service provision, the underlying reasons for these differences remained largely unexplored, and should be the focus of future research. In relation to dietary behaviours, it was also highlighted that future research needs to utilise culturally sensitive measures that may inform local and national dietary guidelines for minority ethnic groups. Finally, while a relationship between racism and diminished psychological health was identified by research summarised here, future research needs to identify factors that may mediate this link.

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