Families and Migration: Older People from South Asia
Department for International Development (DFID) Project

ESA315

UNITED KINGDOM REGIONAL REPORT No. 2

Older Punjabi Immigrants in Birmingham

October 2002

By Vanessa Burholt, G. Clare Wenger and Zahida Shah

TABLE OF CONTENTS

BACKGROUND

The second half of the twentieth century saw increased levels of immigration to the United Kingdom from India, Pakistan and Bangladesh. The ageing of this South Asian population will be rapid over the next decade. The research project ***Families and Migration: Older People from South Asia,*** was developed to examine the effect of migration on people as they age in both the United Kingdom and in sending communities in South Asia. In particular, we were interested in the effects of migration on the availability of support for older people. This is a regional report on the findings for older Punjabis in the United Kingdom.

Earlier research, which focused on minority emigrant ethnic groups or 'Asians', did not identify the specific factors associated with particular ethnic groups within that category. This study aimed to move in the direction of differentiation between South Asian ethnic groups within the United Kingdom.

This report is primarily descriptive and covers basic demographic characteristics; migration history; health; education, language and religion; work and income; and, family and social support systems. The earlier research, which *did* differentiate between different Asian groups, did not differentiate between Gujaratis and Punjabis – the two main *Indian i*mmigrant groups, but between Indians, Pakistanis and Bangladeshis. This report focuses on older Punjabis in the UK and seeks to describe their predominant family and social support systems at the beginning of the 21st century.

The Study Area

The City

The UK part of the study was conducted in the City of Birmingham in the West Midlands of England. The West Midlands metropolitan region is largely urbanised and industrialised and is situated about 110 miles (180 kilometres) north west of London. It has been at the centre of the British metal and engineering industry since the beginning of the industrial revolution. It remains a major industrial centre and is recovering from the economic crisis that affected industrial Britain in the 1970s and 1980s.

Figure 1. View of Birmingham skyline

Birmingham is an especially interesting city for an international comparison, because it is large, very diverse and active in the field of ethnic politics, while retaining an essentially English "provincial" aspect that makes it typical of many other British cities (Garbaye 2001). *(Note: Parts of this section rely on the City template "Birmingham" by Romain Garbaye, prepared for the MPMC Project. This is hereby acknowledged.)* The city has a population of 960,970 (Census 1991), is the second

largest city in the United Kingdom and lies in the middle of the Metropolitan Area of the West Midlands.

The climate in the Midlands is generally wet and cool. In 2001 maximum daily temperatures ranged from 5.6 C in January to 21.6 C in July. Minimum temperatures for the same period ranged from -0.1 in December to 12.2 C in July. Mean temperatures range from 2.8 in January to 16.9 C in July. Hours of sunshine per day averaged from 2.21 hours in November to 6.87 hours in May. Rainfall for the year 2001 was 776.5 centimetres, with the most rain in October (112) and the least in December (33) (data supplied by the Met Office). Many older Asian immigrants find the winters cold; some visit South Asia during the coldest winter months. In cold weather fewer Asians are seen outside in the streets.

Immigration

Birmingham did not witness any significant immigration movement prior to the waves of post-colonial immigrants from the late 1940s and early 1950s onwards (Woods 1979). From 1951-1971 the Indian population of Birmingham grew from 0.2% to 2.02% of the total population (Ratcliffe 1979). The 2001 Census is likely to show that people from ethnic minorities form just under one third (30%) of Birmingham's population (Birmingham City Council 2001).

Most of Birmingham's present ethnic minority communities came from the New Commonwealth and are on the whole representative of post-war immigration patterns to Britain. The economic boom of the fifties resulted in a shortage of labour, which attracted a flow of mostly young, single men who came to work in industries in and around Birmingham. This was facilitated by the liberalism of the existing British legislation on nationality and immigration, compared to other post-colonial European states. Any person born on New Commonwealth territory (i.e. newly independent countries that used to form part of the British Empire) was a British subject and could enter British territory without restrictions.

The largest populations of New Commonwealth immigrants came from the Caribbean, then, starting a few years later, from Pakistan and India. During the early

and mid 1960s there were migration streams of immigrants that were initiated by employers, who actively sought to recruit employees from under-developed countries (Piore 1979, Schmitter Heisler & Heisler 1986). Recruitment of foreign workers was considered to be a temporary means of covering labour shortages with the expectation that the employees would return home when there were no more labour shortages in the host country. Temporary immigration has benefits for the Government of the host country, as temporary residents are unable to make claims on the welfare state (Freeman 1986). It has been argued that many immigrants from the commonwealth and especially the “New Commonwealth and Pakistan” came to the United Kingdom with the intention of remaining (Peters & Davis 1986).

The migration streams that had developed over time led to the formation of settlements that contained residents who were more or less permanent (Piore 1979). Once it became apparent that not all immigrants would return to their country of origin the Government felt it necessary to enforce parliamentary Acts that restricted access to the United Kingdom.

In 1961 the United Kingdom made its first application to become a member of the European Economic Community. This signified the diminishing economic and political importance of the Commonwealth and an increase in the importance of European Union (Carter et al. 1996). In the House of Commons a group of Members of Parliament: Sir Cyril Osbourne, Norman Pannell and John Hynd tried to associate ‘coloured immigration’ with notions of national identity. Immigration from the Commonwealth was linked with ‘social problems’ for example, unemployment, poor housing, venereal disease, vice and prostitution (Carter et al. 1993, Carter et al. 1996). The opinions of this group of politicians began to sway public opinion and in July 1962 the Commonwealth Immigration Act came into effect (Carter et al. 1996).

The Commonwealth Immigration Act classified people wishing to enter the United Kingdom into three categories: people with a specific job with a specific employer (Voucher A); people with skills of qualification that were in short demand in the United Kingdom (Voucher B); unskilled workers with no specific employment (Voucher C) (Carter et al. 1996, Juss 1993). The Home Office regulated the number

of people in each category allowed to enter the country. In 1965 'Voucher C' was abandoned which meant that no unskilled workers without specific employment could enter the United Kingdom (Carter et al. 1996).

The 1968 Commonwealth Immigration Act further restricted access of New Commonwealth citizens. Only people with a 'substantial connection with the United Kingdom' were allowed to enter freely (Ben-Tovim et al. 1982, Carter et al. 1996). This prompted many immigrants to have their families join them in Britain while it was still possible to 'beat the ban' - thus starting the diversification of the immigrant population in Britain. The tenets of this Act were further strengthened in the 1971 Commonwealth Immigration Act. This Act defined the terms patrial and non-patrial. Anyone who could not prove the existence of a parent or grandparent born in the United Kingdom were non-patrial and were not allowed to enter the United Kingdom and could be deported once in the country. The Act had the effect of considerably slowing down the rate of emigration. By the 1970s, the immigrant population was on the way to rapid diversification, with many organisations and businesses. Since then, a second generation, born in Britain of parents of the New Commonwealth, has emerged.

Immigration of Punjabis

The literature indicates that Punjabi immigrants mainly came to the UK in the 1960s. The first Punjabi settlers in the UK were members of trading castes and later Sikh soldiers, who remained in the UK after fighting in France during the First World War (Ballard 1986). Military service in the Second World War again offered many young Sikh men the opportunity to emigrate to the UK (Ballard 1986). Many emigrants were from the Jalandhar district, a densely populated area in which our study communities are situated. People in Jalandhar suffered from shortage of land and therefore the means of self-support (Marsh 1967). The partition of India in 1947 meant that some villages' resources came under pressure due to the influx of refugees from Pakistan (Helweg 1986).

A post-war rebuilding programme in Birmingham required much unskilled labour. In addition, Birmingham's industrial base expanded, significantly increasing the

demand for both skilled and unskilled workers. During this time, Sikhs from the Punjab arrived in Birmingham, primarily to work in the foundries and on the production lines in motor vehicle manufacturing.

Emigrants to the UK in the 1950s were predominantly men who settled in inner city areas. During the late 1960s and 1970s families left Punjab to be reunited with men who had settled abroad (Ballard 1986). Some additional Punjabi immigration to the UK from East Africa took place as a result of the Africanisation of labour and the expulsion of Asians by Idi Amin (Kalka 1990).

Residence patterns

Topographically, Birmingham can be characterised as flat. The areas in which the study was conducted were mainly in or near the city centre. Unfortunately, local statistics do not distinguish between Punjabis and Gujaratis but count these together as Indians, making the distinction only between Indians, Pakistanis and Bangladeshis.

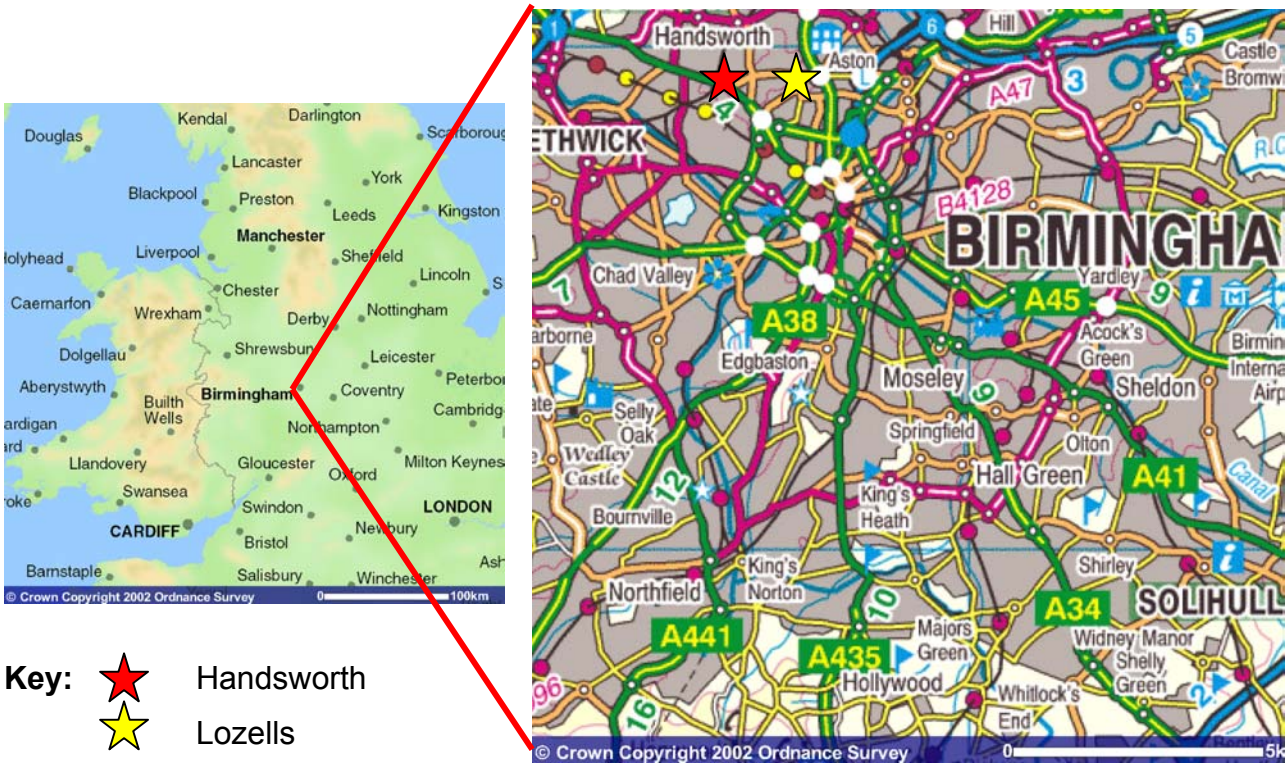
The residential patterns of ethnic groups in Birmingham are typical for British cities, with significant concentrations in inner urban areas, the sites of first settlement in the 1960s. In 1991, 57% of Birmingham's ethnic minority population was to be found in seven of the city's 39 wards (the smallest territorial division). These all had more than 50% of their population made up of people from ethnic minority backgrounds.

In this study we found that the Punjabi elders lived mainly in Lozells and Handsworth. Handsworth is approximately 4 kilometres north of the City Centre. It is an inner city ward of mainly pre-1919 owner occupied and privately rented dwellings but with significant pockets of post-war council redevelopment and housing association accommodation. Over half the residents belong to ethnic minority groups

Handsworth has been the focus of racial tensions and discontent. In September 1985 this escalated. Blanket raids on black and Asian meeting places were conducted and a “stop and search” policy increased the tension between the police

and ethnic minority groups, which spiralled into full-scale riots. However, after the Handsworth riots the community worked together with local authorities to rebuild community relations (Birmingham City Council 2002)

Figure 2. Maps of Birmingham showing areas of Punjabi Settlement



Key: Handsworth

Lozells

Services and Amenities

In those areas of the city where there are concentrations of particular ethnic groups, shops and services have grown up to serve the needs of the local people. Grocery and green grocery stores offer familiar ethnic foods. Shops provide a wide range of ethnic clothing and jewellery. Restaurants cater to a range of non-European diets and cuisines. A high proportion of the people on the streets are Asian, Middle Eastern or Black.

Figure 3. Greengrocers, catering for Asian customers in Birmingham

The ethnic minority communities in Birmingham are characterised by a very dense network of associations, organisations and groups. In the Directory of Black and Ethnic Minority Organisations in Birmingham (1995), 47 Indian organisations are listed. These include: the Punjabi Community Centre, Ramgharia Sikh temple, Guru Nanak Gurdwara and ASRA day centre for older people. Provision of services may have to be culturally specific, particularly in the provision of food (Henly 1979, Shukla 1991), bathing practices (Blakemore & Boneham 1994) and rituals associated with dying (Firth 1993a, 1993b, Gillanshah 1993, Koenig & Gates-Williams 1995, Smaje & Field 1997, Small 1997, Wenger 1998). However, separate provision usually means voluntary provision (Daniel 1988, Klein 1979, Murray 1985, Williams 1986), which has been the case for culturally sensitive services.

The provision and take-up of special service by voluntary and community ethnic groups seems to indicate that ethnic elders accept this type of service (Askham et al. 1995). The successful voluntary organisations tend to be small-scale, catering for between 20 and 50 older people (Brenton 1985), and offer a limited range of

services (Blakemore & Boneham 1994). Although voluntary and community organisations provide services for ethnic elders, studies have shown that they cannot provide for all sub-groups, they are under-resourced and unlikely to be able to sustain services (Bowling 1990, Patel 1990, Jeyasingham 1992, Blakemore 1985, Norman 1985, Bhugra & Bahl 1997). It has been noted that voluntary agencies, which take a holistic approach to their clients can find it difficult to attract funding (Mocroft et al. 1999). Consequently, innovative, relevant and effective services do not get funded. One report quotes a comment from a frustrated self-help group coordinator:

> "The whole point was to get the system to fit the community and its needs, not the other way around. Yet through the grants system they have disempowered black communities. We have to adopt the same bureaucratic structures that they have and it takes our time, skills and expertise away from what we are good at and here for."
>
> (Alexander 1999).

Figure 4. Punjabi men attending ASRA, a drop-in centre

Figure 5. The drop-in centre provide tea and biscuits

Figure 6. Women also attend the drop-in centre

Figure 7. Punjabi men playing cards at the drop-in centre

Figure 8. Transport is provided, to and from the drop-in centre, if required.

The City Council of Birmingham and the surrounding local authorities are responsible for the provision of a wide range of public services on their territory. These are very substantial and include several key areas that are usually of high interest to ethnic minorities, such as housing, some urban regeneration programmes and education. The Birmingham Social Services Department runs Asian day care centres, old people's residential homes, provides home help assistance in a suitable language. They also provide culturally sensitive meals on wheels tailored to specific dietary and religious requirements, which are delivered to impaired older people in their homes.

Health care is provided by the National Health Service, which provides general practitioner surgeries, home nursing services and specialist and hospital care. Many of the health personnel originate from South Asia and interpreters are occasionally provided when a language problem arises.

South Asians in Birmingham arrange funerals according to their religious beliefs. The Punjabis are predominantly Sikhs. There are currently several funeral directors who arrange funeral rites for Muslims, but there is only one that attends to the needs of Sikhs, Hindus and Buddhists.

Elected Representatives

There are 117 elected councillors sitting on the City Council. The city is divided into 39 wards, and each ward elects three councillors. The Council has been controlled since 1984 by the Labour party, which is considered to be the most sensitive party to ethnic minority issues in Britain (Garbaye 2001). However, the Report of the Birmingham Stephen Lawrence Inquiry Commission in March 2001 states that political parties in the UK had failed to support minority ethnic representation, as there were only ten Members of Parliament from minority ethnic backgrounds. Although there were eleven MPs elected in Birmingham none were from minority ethnic groups. Locally of the 117 local Birmingham councillors, 15 are Asian and 7 are Black Caribbean (see Table). The majority were Labour Councillors. There were no Conservative councillors from minority ethnic groups. However, two Liberal Democrat councillors were of minority ethnic origin along with five from the People's Justice Party Group. The report concluded that political parties were not doing enough to increase the minority ethnic communities engagement in the political process (Birmingham City Council 2001).

Birmingham City Council - Composition of Councillors by Ethnicity (January 2001)

		Ethnic Origin		
Party:	**No. of members**	**Black Caribbean**	**Asian**	**Total Black & Asian**
Labour	66	7	8	15
Conservative	28	0	0	0
Lib. Democrat	18	0	2	2
Justice	5	0	5	5
Total	117	7	15	22

Source: Birmingham City Council (2001).

The Labour group in Birmingham includes many of the council's ethnic minority councillors. For the last ten years, the political context has been increasingly favourable to ethnic minorities-related issues. The majority of ethnic minority people in Birmingham have full voting rights and overwhelmingly vote for the Labour party.

Standard of Living

The standard of living is generally higher than in the Indian sub-continent. With very few exceptions, all homes have reliable, potable mains water, electricity and gas supplies. Most also have central heating. The city has a good bus service, is linked to other parts of the UK by train and has a domestic airport with linking flights to international destinations.

Figure 9. Birmingham bus service

Family Structures

As noted above, earlier research conducted in the United Kingdom has often focused on 'Asians' thus aggregating different types of immigrants from South and South East Asia. The evidence of community surveys seems to support the idea of a resilient extended family or of joint family households, which include older members. For those immigrants who do not speak English, dependency on the family is likely to be intensified. This is particularly true for older women. In Birmingham, 61% of 'Asians' had been shown to live in households of six or more people (Bhalla & Blakemore 1981), although 26% were found to have no family outside the household. Although the extended family was common among Asian

groups (Barker 1984), another Birmingham study found that significant proportions of elderly Asians were living alone with few relatives in Britain (Atkin et al. 1989).

It is possible that the dominant culture influences immigrant cultures. It has been claimed that the traditional pattern in many Asian countries of sharing the responsibility for care among a network of family members is not so applicable in Britain (Cameron et al. 1989). It has been pointed out that migration divides extended families (Fenton 1987) and that this has been exacerbated by immigration legislation and the administration of immigration policy (Atkin & Rollings 1993).

METHODOLOGY

This regional report on Punjabis in Birmingham covers one sample from the larger study. The larger study also includes samples of Gujaratis and Sylhetis in Birmingham and parallel samples in sending communities in Indian Punjab, Gujarat and Sylhet. The study was conducted under the overall supervision and co-ordination of Clare Wenger (DFID Project Co-ordinator).

The UK study was conducted under the supervision of Vanessa Burholt as Principal Investigator. She worked closely with a local research co-ordinator, who had a background as a cultural liaison officer at City Hospital in Birmingham, spoke Gujarati and Punjabi and had a working knowledge of Sylheti, and a research assistant, who spoke Punjabi and Urdu and had a working knowledge of Gujarati. The research assistant, Zahida Shah, was responsible for oversight of the data collection.

Interviewers were recruited from within the target ethnic groups in Birmingham and were native speakers of the necessary languages. Interviewers were trained by the research team. The training provided an introduction to the study. Guidelines for professional conduct and guidelines for ethical considerations were circulated to the interviewers prior to the meeting and were reiterated at the training sessions. The interviewers were issued identification cards and were instructed to show these on occasions relating to the project. Interviewers were informed about management of questionnaires and personal safety. A majority of the training was spent going through the interview schedule ensuring that the interviewers were aware of the nature and purpose of the questions.

After training, interviewers understood the necessity of obtaining consent from interviewees, issues regarding confidentiality, contact with respondents and the confounding affect from the presence of other family members or friends during the interview session.

Sampling

As noted above he City of Birmingham was selected as the study area in the United Kingdom as it has a multicultural population. This was important to ensure that there would be large enough proportion of Indian Punjabis, Gujaratis and Sylhetis in the population from which to draw the sample.

The target sample was 100 from each of the study ethnic groups, 50 men and 50 women, aged 55+. The sample for this project included people aged 55 and over, because of lower life expectancy in some of the target groups. The sample of elders was drawn via local ethnic associations. Access was sought through temples, mosques and *gurdwaras*, day centres, various women's groups and other informal meeting places for elders, such as drop-in centres. To supplement the sample and in order to avoid interviewing only those who were in touch with such organisations a 'snowball' technique was used to gain access to a wide range of elders within each ethnic group.

The ‘snowball’ technique has been successfully used previously to identify an ethnic sample in the Health and Ethnicity project undertaken in Liverpool (Boneham et al. 1997). The use of General Practitioner patient lists as a sampling frame has previously resulted in an under-representation of minority ethnic groups in a population sample (Saunders et al. 1993). Therefore, access to ethnic groups via ethnic associations and in conjunction with the 'snowball' technique was likely to be more successful than using GP patient lists. Efforts were made to ensure that the sample included respondents from different social classes with a wide age-range.

Data Collection

Where possible, interviews were conducted in the respondent’s own home, however, many respondents preferred to be interviewed in the ethnic association e.g. in the day centre. In these instances the interviews were conducted in a private room. The interviews were conducted by interviewers in the first language of the respondent (Gujarati, Hindi, Punjabi, Urdu or Bangla), using an interview schedule. All questions

were read to respondents by the interviewers. In addition, 10 in-depth case studies (not discussed in this report) were conducted in each ethnic group.

The interview schedule was written in English by the Project Co-ordinator and the Principal Investigator based on a schedule, which had previously been tested in a pilot project, conducted in Dhaka and Sylhet in Bangladesh and with Bangladeshis living in Tower Hamlets, London in the UK (Burholt et al. 2000). The interview schedule was subsequently edited and refined based on the outcomes from the pilot study.

The interview schedule was translated into Punjabi by one translator and then translated back into English by a second translator. Disagreements were then discussed and best forms negotiated and agreed. The interview schedules used were printed in the appropriate language and script. Although Punjabi questionnaires were available in the UK, none of the UK interviewers could read Punjabi script. In order to overcome this difficulty, Punjabi interviewers translated the questionnaire from English into Punjabi (or Urdu) as they interviewed. Where verbatim responses were asked for, most interviewers recorded responses in English.

The interview schedule included sections on the following topic areas: basic demographic data; health; education and language; work and income; migration; household composition and marital status; family, friends and relatives; sources of support and help; religion; and, funeral rites.

Data Analyses

All completed questionnaires from Birmingham and South Asia were returned to the Principal Investigator who entered (SPSS version 9.0) and cleaned the data. This was facilitated by all questionnaires using the same numbering system irrespective of language used.

Within this report frequencies for variables are reported to provide an overview of the situation of Punjabis living in the UK. Where comparisons are made between genders, Pearson Chi square is used.

FINDINGS

Demographic Characteristics

The achieved Punjabi survey sample was 100: 49 males and 51 females (Table 1). This sample cannot be treated as a representative sample due the gender stratification. Despite the stratification of the sample, we believe that the data presented here is representative of the situation of older Punjabis in Birmingham. In this report, the data are discussed in the text and tables giving all figures are presented in the Appendix.

Age Distribution

Approximately one-third (33%) of Punjabi respondents were under 65 (Table 2). Eighteen percent of Punjabi women were below retirement age (<60) and 13% of Gujarati men were under retirement age (<65). Two-fifths of the Punjabi sample (42%) was over 70. The mean age of Punjabis in the sample was 68.4 (standard deviation (s.d.) 8.48). Given that the samples were not randomly selected and were stratified by gender, these data cannot be interpreted as an accurate description of age distribution of Punjabis in the population of Birmingham.

Marital Status

Compared with the indigenous population of the United Kingdom, a substantial minority of whom never married, not one Punjabi interviewed had remained unmarried (Table 3). Figures for divorce and marital separation are also low; only 2 percent of Punjabis were in this situation. The majority (71%) were still married and approximately one-quarter (27%) were widowed. There were significant differences in marital status between men and women (level of significance for Pearson Chi Square test $p<.01$). More men than women were currently married (86% vs. 60%) and conversely more women than men were widowed (39% vs. 14%).

The data for the current or last marriage[1] showed that half (49%) of the older Punjabis married under the age of 20, of whom half were married before they were

[1] Three respondents had been married twice. In these cases the last marriage has been used in the analysis.

16 (Table 4). Another two-fifths (41%) were married between the ages of 20 and 29. The average age of respondents at last marriage was 19.6 (s.d. 6.5). On average the duration of marriages was 44.7 years (s.d. 13.6). However, those people who were still married had been married for longer (mean 47.3 years, s.d. 10.97) than those people who were widowed (mean 38.8 years, s.d. 16.7). Overall, men were on average older than women when they were married (mean 20.5, s.d. 6.8, vs. 18.8, s.d. 6.1). In addition, men had been married longer than women (mean 47.7 years, s.d. 11.2, vs. 41.7 years, s.d. 15.2).

Migration History

A majority of Punjabis (77%) lived in India before emigration. However, over one-fifth (21%) lived in Africa prior to a move to the UK. The African countries from which Punjabis emigrated were Kenya (14%) and Uganda (5%). There were no significant differences between the genders in the country of residence before emigration to the UK.

A majority of Punjabis (63%) moved to the UK between the ages of 20 and 39 (Table 6). A further one-tenth (10%) were aged between 40 and 49 when they moved to the UK. A small proportion of Punjabis (4%) migrated to the UK when they were over 70 years of age. There were no significant gender differences in the age of move to the UK.

Nearly half (47%) of the Punjabi sample arrived in the UK in the 1960s (Table 7). Around one-fifth arrived in the UK in the 1950s (19%), and the 1970s (21%). Consequently when the length of stay in the UK is examined it is not surprising to find that on average the Punjabi sample had lived in the UK for 34.2 years. Looking at length of stay in 10-year bands shows that over two-fifths (44%) of Punjabis had lived in the UK between 31 and 40 years and three-tenths (30%) had lived in the UK for over 40 years (Table 8).

Table 9 shows a summary of the top four reasons for moving to the UK. For Punjabis the most frequently stated reason for moving to the UK was economic motivation or

for work (39%). The second most frequently cited reason for moving to the UK was to join a spouse (22%). Around one-tenth of respondents also moved to live with or near a relative (12%). A further one-tenth (10%) of the Punjabi respondents came to the UK due to the political Africanisation of labour.

There were significant differences in the reasons for moving to the UK for Punjabi men and women (level of significance for Pearson Chi Square test $p<.001$). Punjabi men were more likely than women to say that they moved to the UK for economic reasons (66% vs. 12%). Only Punjabi women said that they came to the UK to join a spouse (43%) and more Punjabi women than men gave other[2] reasons for migrating to the UK (27% vs. 11%). Examining the data in more detail the 'other' reasons that women gave for moving to the UK were related to marital relationships. Nearly one-fifth (18%) of Punjabi women moved to the UK *with* their spouse and a further 6% moved to the UK to marry.

Over nine-tenths of Punjabis in this sample settled in the West Midlands when they arrived in the UK (91%) (Table 10). Only 3% of Punjabis lived in Greater London and a further 3% lived in Middlesex on arrival. Very few (14%) made one or moves after arriving in the UK (Table 11).

Living Arrangements

More than half of the Punjabis lived alone (14%) or with a spouse only (37%) (Table 12). The figures for those, in this sample aged 55+, living alone are different from those produced by analysis of pooled data from the General Household Survey (GHS) between 1991 and 1996. The GHS shows that only 9% of Indians over the age of 60+ lived alone (Evandrou 2000b). The discrepancy is not likely to be due to the disaggregation of data for Punjabis and Gujaratis, since nearly twice as many Gujaratis(26%) in this study lived alone (Wenger et al. 2002).

[2] The category 'Other' comprised of all reasons excluding economic/for work, to join spouse, to live with or near relative and political Africanisation of labour.

Although the modal household size for Punjabis was two (38%), half (49%) of the Punjabi sample lived in multigenerational households. Almost one-third (31%) lived in households of five or more people. The mean household size for Punjabis was 3.5 (s.d. 2.3), which is similar to the size noted for Indian households (3.8) extrapolated from 1991 Census data (Owen 1993). When regional differences are taken into account the similarity between the data from this study and the Census data disappears (3.5 vs. 4.2) (Owen 1993). This difference in the findings in these studies may represent changes over time, where perhaps children who were co-residing with parents ten years ago (at the time of the last census) may have left home. This may imply that the traditional intergenerational household has begun to shift towards a nuclear household.

Most of the Punjabis (63%) had been living in their current house for more than 11 years (Table 13). The distribution of the sample was fairly even, approximately one-fifth of the sample in each of the three ten year bands (6-10, 11-20, 21-30). In addition, just less than one-fifth of Punjabis had been in their current house for over 30 years. Over one-third (34%) of the sample moved to their current property between the ages of 20 and 39, however, a majority (44%) were between the ages of 40 and 59 (Table 14).

Seventy-one percent of the Punjabis were home-owners (Table 15). A further eighteen percent lived in their child's home. Only 5% lived in rented accommodation. The levels of home ownership for Punjabis in this study were only slightly lower than the levels for Indians in the GHS and the 1991 Census (71% vs. 84%[3] & 82%) (Owen 1993, Evandrou 2000b). This may be because the GHS did not include a category for people living in a child's property, therefore the category of homeowners may have included respondents who did not pay rent to a landlord. The level of people living in rented accommodation was lower for Punjabis than for Indians in the GHS and the 1991 Census (5% vs. 11% & 17%) (Owen 1993, Evandrou 2000b). This may reflect distinctions in tenure between Indian Punjabis and Gujaratis, which are hidden in the GHS and Census data.

[3] Home ownership in the context of the GHS data includes outright home owners and those with a mortgage.

Children

Older Punjabis typically have larger families of procreation than the indigenous population (Table 16). The total fertility rate (TFR) in England and Wales has changed very little over the last few years and has dropped to just over 1.7 children per women of childbearing age. This is the lowest post-war TFR (with the exception of 1977) (Williams 1999). The modal Punjabi family had 3 or 4 children (26% of each). A quarter (24%) had five or more children. Only two Punjabis were childless, eight had no son and twenty had no daughter.

For over half of the Punjabi sample (57%) the nearest child lived in the same household or within a mile (Table 17). If the radius is increased, 71% have a child within 5 miles. Nearly two thirds (63%) of the Punjabi sample had daily contact with a child (Table 18). A further one-quarter (25%) saw a child at least weekly. Only one-tenth saw children less frequently than weekly.

Although many of the respondents' children were born in the UK, 17% of the Punjabis have children living outside the UK (40 children), and for three respondents this was their nearest child (Table 19).

Most children living abroad were residing in South Asia (N=19) (Table 20). There were also children in North America (N=11) and Southeast Asia (N=9). Two thirds of the children living in South Asia were daughters (N=12), which would suggest that they had perhaps moved for marriage or were married before their parents left India. All parents kept in touch with their children (Table 21). Contact was maintained by letter in one quarter (25%) of the relationships, however, a far more popular method of keeping in touch was by telephone. Contact was maintained between parents and children by telephone in 95% of relationships. The importance of the telephone is not surprising given the levels of education and literacy.

Respondents with children living abroad were asked whether they sent regular remittances to at least one child. A third (6) of those with children abroad sent monthly remittances, which were used for home maintenance and household

expenditure. The remittances were more commonly sent to sons (N=5) (rather than daughters (N=1)) living in South Asia or South East Asia. Respondents (with children abroad) were also asked whether they received remittances from children living abroad. Only 1 was receiving remittances from a child living abroad.

Siblings

Relationships were examined for Punjabi siblings. Thirty-one percent of the sample had no living siblings and 34% had just one or two siblings (Table 22). Excluding those respondents without siblings, the modal number of siblings was 1.

Only just over one-tenth of the Punjabis (12%) had a sibling living within 5 miles (Table 23). However, for nearly three-tenths (29%) of the sample their nearest sibling was in another country. The frequency of contact with siblings is substantially lower than with children. This would be expected given that most siblings live further a field. Only 3% of the Punjabis saw a sibling daily and a further one-tenth (11%) of the sample saw a sibling at least weekly (Table 24). Nearly two-fifths (39%) of the sample saw a sibling only once a year or less.

Punjabi respondents were more likely to have siblings than children living abroad. Forty-four percent had siblings abroad (Table 25). Most siblings living abroad were residing in South Asia (N=70) (Table 26). There were also siblings in North America (N=14), Southeast Asia (N=13) and Africa (N=7). Over two-thirds (69%) of Punjabis with siblings abroad kept in contact (Table 27). Around three-tenths of relationships between Punjabi siblings were maintained by letter (31%) and a further three-tenths by telephone (32%). None of the Punjabi respondents sent remittances to siblings abroad but 2 received remittances from siblings: one from a brother in South Asia and one from a brother in South East Asia.

Relatives

A majority of Punjabis saw a relative[4] daily (60%) and a further 23% saw a relative at least weekly (Table 28). Only 1% of the sample never saw a relative, or did not have any relative.

Other than children or siblings, 14% of Punjabi respondents also had other relatives living abroad (Table 29). Most relatives living abroad were residing in South Asia (N=38) (Table 30). There were also a few other relatives in Africa (N=5) and North America (N=2). Over four-fifths (82%) of Punjabis with relatives abroad kept in contact (Table 31). One-fifth (21%) maintained contact through letter writing, but over one-half (54%) kept in contact through telephone calls. Only one relative was sending remittances. The money was used for household expenditure and upkeep. The average amount sent was £20 per month. No respondents received remittances from 'other' relatives.

When these data are collapsed to look at remittances sent to and received by any relative (i.e. child, sibling or other relative). 11% of Punjabis were sending remittances to family members overseas, averaging £68 a month. All the money was said to be for home maintenance and household expenditure. Only five received remittances. The sending and receiving of remittances is clearly not very common amongst Punjabis

[4] In this instance relative is defined as child, sibling or other relative.

Friends, neighbours and community integration

In addition to maintaining relationships between kin, Punjabis kept in contact with friends. Three fifths of the sample (60%) saw friends at least weekly, with one-fifth (21%) noting that they saw their friends daily (Table 32). However, just over one-fifth of the sample (22%) never saw any friends, or did not have any friends.

Respondents were asked to give the names of up to five friends. Although one third of Punjabis did not name a friend nearly two-fifths (39%) named one or two friends, and one-fifth (21%) could name three or four friends (Table 33). Only 7% of Punjabis named five friends. In addition only one-fifth (19%) said that there was someone who was dependent on his or her friendship. There were no significant differences between genders in the number of friends mentioned or having a person dependent on their friendship.

Contact with neighbours was lower than contact with friends (Table 34). Fewer Punjabis saw neighbours at least weekly (41%), and only 13% saw neighbours daily. Although only 18% of the sample never saw neighbours (which is lower than the proportion which never saw friends) over two-fifths (42%) saw neighbours less than monthly or never compared with one-third (32%) who saw friends less than monthly or never.

Many of the Punjabi sample attended social or community meetings (Table 35). Two-fifths of the respondents (39%) said that they attended such meetings regularly, that is at least once a month. Just under one-third (30%) attended meetings occasionally, and just under one-third (30%) never attended any social or community meetings.

A majority in our sample said that they were rarely alone (Table 36). Nearly three-fifths (59%) said they were in the house alone for less than three hours a day. One-quarter of the sample (25%) were only alone for between three and six hours. Only 14% of the Punjabis studied were alone for over six hours, this included 9% who were alone for over nine hours.

A majority of those who said they were never or rarely lonely spent less than three hours alone in the house (level of significance for Pearson Chi Square test $p<.01$) (Table 37). However, this did not mean that Punjabis who were alone for over nine hours were necessarily lonely. A majority of people alone for over nine house (56%) said that they were only lonely sometimes, whereas only one-third (33%) of this group said they were lonely often or most of the time. These findings should be treated with caution as very few Punjabis (N=9) were alone for more than nine hours.

Religion

Punjabis are mostly Sikh; and 87% of the Birmingham sample said they were Sikh (Table 38). Other religions followed by small numbers of Punjabis were Hinduism (9%), Islam (2%) and Christianity (1%). Muslims form only a minority (and an apparently decreasing minority over time) of Indians (Peach 2000, Modood et al. 1997).

As Punjabis are predominantly Sikh, access to *Gurdwaras* (places of worship) in Birmingham is important. The highest concentration of Gurdwaras in the UK (30%) is found in the West Midlands (Peach 2000). The recent Leverhulme survey of Hindu, Muslim and Sikh officially recognised places of worship in England and Wales, lists fourteen Sikh Gurdwaras. The survey covers only those places that are officially registered with the Registrar General, so that smaller locations may not be included. Peach (2000) calculated that there were about 2,300 Sikhs per Gurdwara and that Gurdwaras are not places of worship only; they are also the main centres for social and cultural activity within the Sikh community (The Council of Sikh Gurdwaras 2001). In addition to religious services, many Gurdwaras also house or support schools, skills training, arts and cultural provision, welfare advice and support, day centres for older Sikhs, community kitchens and libraries (The Council of Sikh Gurdwaras 2001).

Although there are relatively few places to worship in Birmingham nearly one half (47%) of the Punjabis interviewed said that they attended religious meetings

regularly, that is once a month or more (Table 39). A further 46% said that they attended such meetings occasionally. Only 5% of Punjabis said that they never attended religious meetings. There were no gender differences in attendance at religious meetings.

Punjabis said that they would visit places of worship either on their own (90%) or with family members (84%) or members of the community (81%) (Table 40). Slightly fewer of the sample engaged in prayer; 88 percent said that they prayed on their own, four fifths (80%) prayed with family members and the same proportion (79%) prayed with other members of the community.

In the scriptures written by the Sikh Gurus the word used to describe places of pilgrimage is *tirath*. Michaud (1998) notes that:

> "A *tirath* is a sacred ford, a place of crossing between the mundane and the divine usually located, symbolically or actually, along the bank of a river".

The journey to the tirath, know as a *tirath yatra* cannot be directly translated as a pilgrimage, as it carries with it other connotations including merit-giving efficacy of austerities, rituals, vows, purifications, and other practices (Michaud 1998).

Singh (1985) noted that:

> "There are no rivers, mountains or places held sacred by the Sikh faith. 'To worship an image, to make a pilgrimage to a shrine, to remain in a desert, and yet have the heart impure is all in vain,' said Nanak. Although no places are sanctified by the Sikh faith, Sikhs do go on pilgrimage to temples associated with the Gurus."

Historically, dwellings associated with Gurus have received great numbers of visitors. A network of historical shrines, that are traditionally visited by Sikhs, stretch across the Punjab in India and beyond (Michaud 1998). There is a road (Guru Gobind Singh Marg) that connects all of the places visited by the tenth Guru during

his travels in 1705, which is nowadays frequented by Sikh Pilgrims (Randhir 1990, Michaud 1998).

Two of the most sacred shrines in India, to which Sikhs make pilgrimages, are the *Golden Temple* and *Gurdwara Hemkund Sahib* (India Visit Travel Network 2002, Michaud 1998). The Golden Temple (or *Harmandir Sahib*) is situated in the town of Amristsar, Punjab. The temple houses the 'Pool of Immortality', which was constructed by Guru Ram Das and also contains the Sikh holy book the *Guru Granth Sahib* (India Visit Travel Network 2002).

The *Gurdwara Hemkund Sahib* is not situated in Punjab but is located in the Uttaranchal's Garwhal region. Sikhs believe that *Hemkunt Parbat Sapatsring* ('lake of ice' 'mountain' with 'seven peaks') is the place where the tenth Guru meditated in his previous life and became one with God (Michaud 1998).

As would be expected fewer Punjabis went on pilgrimages. One third (33%) said they never went on pilgrimages alone. However, over one half of the sample said that they would participate in a pilgrimage either on their own (61%) with family (57%) or with members of the community (58%).

Birmingham holds a large *Vaisakhi* festival in Handsworth Park every year. In 2001, 40,000 people attended making Birmingham's festival the largest in Europe (The Council of Sikh Gurdwaras 2001). In 2001 the Sikh Community Health Promotion Project (SCHPP) used the *Vaisakh*i festival to promote healthy living for Sikhs (The Council of Sikh Gurdwaras 2001). It has been recognised that *Vaisakhi* provides a good opportunity to offer health care information as a vast majority of Punjabis attend festivals. This is borne out by the findings in this study, in which less than 5% of the sample said they never attended festivals.

Education and Language

Education is important in terms of social inequalities (Evandrou 2000b). Educational attainment is linked to income, health and well-being (Blane et al. 1996). In this respect it is important to note that nearly two-fifths (39%) of older Punjabis had not had any full time education (Table 41). A further 30% had had less than ten years education. Just under one quarter (23%) had been in full time education for over sixteen years. Very few had been engaged in any part time education (5%) (Table 42). The overall level of education is reflected in educational attainment. The 1991 Census showed that only 3.8% of Indians of pensionable age held the equivalent of an A level certificate (or better) which is approximately half the proportion of the white population of the same age (6.6%) (Owen 1994).

In the sample for this study, unsurprisingly almost all the respondents considered that Punjabi was their first language (92%) (Table 44). Most of those who went to school were educated in Punjabi (52%) (Table 43). However, nearly one quarter (23%) were educated in more than one language. As nearly one-fifth (18%) of those who were schooled were taught in English, it might be expected that those respondents who were taught in more than one language were instructed in English and Punjabi. The proportion of Punjabis taught in English demonstrates the influence that the British had on the schooling system in India.

Schools based on the English system were first introduced in India in 1835. After this date, social reformers, such as Raja Ram Mohan Roy, started opening English medium schools, which were given state recognition. Naik (2001) has noted that "this move automatically derecognised the indigenous system and created glaring disparities within the education system." Furthermore, the acquisition of English language was used as a "measure of worth" (Naik 2001). Today, the policy of using English as the medium of education is being implemented in almost all the private schools throughout India (National Council of Educational Research and Training 2000) and knowledge of English is perceived as a means of obtaining a job (Naik 2001).

A study conducted by the West Birmingham Health Authority of Geriatric Medicine in 1991 showed that Punjabi was the most frequently spoken Asian language in the city. In the older sample for this study, just under one half (46%) of Punjabis could not speak English (Table 45). Of those who could speak English, just over half (54%) considered that their proficiency at spoken English was good. Half as many women as men could speak English (35% vs. 74%) (level of significance for Pearson Chi Square test $p<.001$).

Fewer Punjabis could write English (41%) than could speak the language (Table 46). This proportion corresponds with the number of respondents who were taught in English or more than one language. However, analysis demonstrated that only 91% of respondents who were taught in English and 79% of people taught in more than one language could write in English. The number of Punjabis able to write English is significantly greater for those taught in English or more than one language than for Punjabis taught in other languages (level of significance for Pearson Chi Square tests $p<.001$). Of all Punjabis who could write English, only 63% of these respondents considered that their standard of written English was good. Once again, there were significant differences between genders in the ability to write English with fewer women than men able to do so (37% vs. 53%) (level of significance for Pearson Chi Square test $p<.05$).

A similar proportion of Punjabis who could write English, could read English (40%), once again, corresponding with the proportion of the sample who were taught in English or more than one language (Table 47). Once again, analysis demonstrated that only 91% of respondents who were taught in English and 79% of people taught in more than one language could read English. The level of Punjabis able to read English is significantly greater for those taught in English or more than one language than for Punjabis taught in other languages (level of significance for Pearson Chi Square tests $p<.001$). 63% of this group considered that they were good at reading the language. More men than women said that they had the ability to read English (51% vs. 29%) (level of significance for Pearson Chi Square test $p<.05$).

Sources of Support and Help

This section explores the sources of informal help and support available to older Punjabis in Birmingham. In many cases, responses refer to what *would* happen if the need arose, in others the need has already arisen and responses refer to what happened. Before moving on to look at sources of help with particular needs or tasks, the informal support networks available to the members of the sample are discussed.

Support Networks

Support networks were measured using the Wenger Support Network Typology and support network type identified using the assessment of network type instrument (Wenger 1991). The typology, based on qualitative and quantitative research conducted in the UK and subsequently tested in Bangladesh (Burholt et. al 2000) and China (Wenger & Liu 1999, 2000), as well as other developed countries, identifies five types of support networks. The different types are based on: the availability of local kin, frequency of face-to-face interaction with family, friends and neighbours and community integration (Wenger 1989).

The Local Family Dependent Network – the older person relies for most help and support on relatives living in the same community.

The Locally Integrated Network – associated with helping relationships with local family, friends and neighbours.

The Local Self-contained Network – reflects a more privatised household-centred life style with reliance on neighbours if essential.

The Wider Community Focused Network – is associated with an absence of local kin, primary focus on friends and involvement in community groups.

The Private Restricted Network – is associated with an absence of local kin and low levels of contact with neighbours and the community.

Support network type has been found to be correlated at high levels of statistical significance with demographic variables, social support variables, sources of informal help and support for a range of needs and tasks (such as advice, companionship, household chores, personal care), outcome variables (such as health, morale, isolation, loneliness) and various aspects of formal service use (such as presenting problems, length of time on case loads and reaction to interventions). Research has shown that some network types were better able than others to provide help and support of various sorts, including personal care.

Local family dependent and locally integrated networks were found to be better able to support older people in the community in the face of physical or mental impairment. Nearly all of the aforementioned variables were correlated with network type at the highest level of statistical significance (Wenger & Shahtahmasebi 1990). Network type has been demonstrated to have high predictive value for outcomes in the context of illness or other crises (Wenger 1994, Wenger & Tucker 2002)

In this study, two-thirds of Punjabi respondents had either family dependent (39%) or locally integrated (30%) networks (Table 48). These are the two network types that have been identified as providing the highest levels of informal care. It would be expected, therefore, that high proportions of Punjabis would receive most informal help and support from family members. Fewer Punjabis (17%) had wider community support networks, which are based on friendship and community integration. Almost half (47%), therefore, had types of support networks indicating community integration with friends and neighbours (i.e. wider community focused or locally integrated).

Confidants

Respondents were asked 'Is there someone in whom you can confide or talk to about yourself or your problems?' Responses were coded by the relationship of the confidant to the respondent. At one extreme, respondents said that there was no one and at the other extreme they mentioned more than one person to whom they could talk (Table 49).

Fifteen percent of Punjabis said that they did not have a confidant or did not confide. Among those who named a confidant it is possible to identify the four most frequently mentioned relationship categories from which confidants are drawn: spouse (25%), friend or neighbour (21%), son (15%), or daughter (12%). The fact that more than half of those who do confide name spouse or friend/neighbour as a confidant may indicate a preference for a same generation confidant.

Twice as many women as men had friends or neighbours as confidants (28% vs. 14%). More men than women did not have a confidant (22% vs. 8%), however when a confidant was mentioned men were more likely than women to mention their spouse (31% vs. 20%). These gender differences were not statistically significant but probably reflect the higher proportions of women who are widowed.

Person to talk to when Unhappy

Respondents were also asked to whom they would talk to if they felt unhappy (Table 50). 90% of Punjabis were able to name someone. When Punjabis were unhappy they were most likely to talk to a friend or neighbour (31%), followed by spouse (28%), daughter (13%) and son (9%). Overall, it appears that same generation comforters were preferred. However, when the analysis takes into account gender it becomes apparent that one-fifth (22%) of women would talk to a younger generation (daughters) if they were unhappy. Other differences can be distinguished between genders. Men were more likely than women not to have someone they would turn to for a chat when they were unhappy (16% vs. 4%). When Punjabi men did talk to someone, it was most likely to be a spouse (41%). On the other hand, women were most likely to speak to a friend or neighbour when they were unhappy (39%) (level of significance for Pearson Chi Square test $p<.01$). Again, this is likely to be influenced by the greater proportion of women who are widowed.

Respondents were asked if anyone came to them to talk when they were unhappy. Three-tenths (30%) of Punjabis said that no one came to talk to them when they were unhappy (Table 51). However, one-third (33%) said that friends and neighbours came to talk to them and a further one-fifth (20%) said their spouses talked to them. Again it appears that same generation comforters are preferred. In this instance,

although the pattern remains the same as above (for respondents talking to someone when they are unhappy) the differences between genders are not statistically significant.

Personal Problems

Respondents were asked to whom they would talk to if they had personal problems and 84% were able to name someone (Table 52). Punjabis were most likely to talk to their spouse (29%) but almost as many would talk to a friend or neighbour (25%), followed by daughter (11%) and son (10%). Again, there appears to be a preference for same generation relationships. There were some differences between men and women in the person that they would talk to about personal problems although these were not statistically significant. Three times as many men as women had no-one to talk to about a personal problem (25% vs. 8%) and twice as many women as men would talk to friends or neighbours about a personal problem (33% vs. 16%).

Respondents were also asked if people came to talk to them about personal problems (Table 53). Two-fifths (40%) of Punjabis said that no one talked to them about these issues. The most likely persons to come to talk about personal problems for Punjabis were friends or neighbours (30%), followed by spouse (13%) and son (7%). There were statistically significant differences between the genders. A majority of men did not have anyone who would come to talk to them about personal problems (52%), whereas only 29% of women were in the same position. Over 2.5 times as many women as men would have friends or neighbours coming to talk to them about personal problems (43% vs. 17%) (level of significance for Pearson Chi Square test $p<.05$).

Informal Health Care

Before discussing the sources of help for respondents when they were ill, it is necessary to discuss the health status of the sample. Self-assessed health is a difficult variable to compare. While in the US and UK self-assessed health has been shown to be highly predictive of mortality (Mossey & Shapiro 1982, Kaplan & Camacho 1983, Kaplan et al. 1988, Idler et al. 1990, Lee & Markides 1990, Idler & Kasl 1991, Rakowski et al. 1991, Roos & Haven 1991, Wolinsky & Johnson 1992),

self-assessed health is culturally affected. In cultures where old age is expected to be accompanied by poor health older people are more likely to say that their health is poor. For example, an Indian woman comments:

> "To be a woman in my community and young was often so arduous that many women yearned to reach the status of their mothers and mothers-in-law. So they developed aches, pains and deliberately slowed movements; spoke frequently about their failing bodies and the importance of herbal potions to keep them going. They could then manipulate the guilt of younger members of the family at will and have a wonderful time…"
>
> (Alibhai-Brown 1998)

However, this does not seem to be the case among the Punjabis living in the UK. There were no significant differences in self-assessed health between genders. Nearly three-fifths (58%) of all older Punjabis felt that their health was at least all right for their age, 30% said their health was only fair and 12% that it was poor (Table 54). Comparing findings in this study with the GHS required a manipulation of the data, as categories were not directly comparable. Combining those who said that their health is 'only fair or poor' (42%) and comparing this with the GHS data recorded as 'not good' (34%) it is apparent that the levels of poor health were higher in this study. However, if only those respondents who responded that they had 'poor' health (12%) are compared to the GHS data coded as 'not good' (34%) the health of this sample appears to be better (Evandrou 2000a). The comparison between the two studies is difficult because of the use of different categories for health, and the fact that 'Indians' were grouped together. However, in this study, more than twice as many Gujaratis (28%) reported that their health was poor. This would indicate that we should expect the lower figure for Punjabis when data for the two ethnic groups are separated out.

Elsewhere it has also been demonstrated that that age-adjusted prevalence of bad or very bad health for Indian men and women in the UK were significantly higher than those of the general population (Erens et al. 2001). The findings from the current study show that the levels of self-assessed 'poor' health for Punjabis are

lower than for the levels of 'not good' health reported by the white population in the GHS (22%) (Evandrou 2000a). Not only do these findings suggests that combining Gujarati and Punjabi data together (for a category 'Indian') masks the true levels of self-assessed health for each group, it also hampers any investigation into why Punjabi self-assessed health may be better than the white population. However, again these findings are tentative because of the use of different categories for health in the two studies that are compared.

Our findings suggest that self-assessed health may be based on people's perceptions about the health conditions that they have. For example, 39% of the sample said that they had a serious health problem, however fewer (12%) reported poor health (Table 55). There were significant differences between Punjabis with a serious health condition and levels of self-assessed health (level of significance for Pearson Chi Square test $p<.001$). Over two-thirds (67%) of respondents who reported fair or poor health had a serious health problem, whereas 81% of people reporting good or excellent health did not have a serious health problem. There were no differences between men and women in reporting serious health conditions.

Nearly one third (32%) of Punjabis said that they had a health condition that limited their activities in some way. There were significant differences between Punjabis with a limiting health condition and levels of self-assessed health (level of significance for Pearson Chi Square test $p<.001$). One-half (50%) of respondents who reported fair or poor health had a limiting health condition, whereas 81% of people reporting good or excellent health did not have a limiting health condition. Once again, there were no differences between men and women in reporting limiting illnesses. Regardless of the lower level of reported self-assessed poor health, it should be noted that the level of limiting illness reported in this study for Punjabis, is higher than reported in the GHS for Indians (20%) (Evandrou 2000a). The discrepancy between this finding and the former lower levels of poor self-assessed health probably reflects the difficulty of comparison of self-assessed health between the two studies.

Research has shown differences in health (morbidity and morality) across ethnic groups in the USA (Department of Health and Human Services 1990, Rogers 1992, Sorlie et al. 1992, Krieger et al. 1993, Rogot et al. 1993, Davey Smith et al. 1998, Pamuk et al. 1998) and the UK (Marmot et al. 1oi84, Rudat 1994, Harding & Maxwell 1997, Nazroo 1997a, 1997b). However, there are debates as to the underlying factors which impact on these differences (Nazroo & Davey Smith 2001). Although the levels of impairment in this study go some way to explaining the high levels of self-assessed poor health they do not explain enough, which leads us to believe that there may be other important intervening factors. As noted above, over two-thirds (67%) of those people who reported that their health was only fair or poor had a serious health problem. The most frequently reported health conditions were diabetes (N=14), hypertension (N=13), stroke (N=10), arthritis (N=9) and coronary heart disease (N=8) (Table 56). In an earlier study, the most prevalent conditions suffered by Asians in Birmingham were arthritis, hypertension and back pain (Tinsley et al. 1991). The findings for reported health problems in this current study correspond with data elsewhere and also are consistent with the health problems that are targeted through health promotion by the Sikh Council of Gurdwaras (The Council of Sikh Gurdwaras 2001).

Other studies have looked at the prevalence and severity of the conditions mentioned in our study for ethnic minority groups. Diabetes affects 1-3% of the adult population but is known to be markedly higher in South Asian populations (Williams 1994, Ritch et al. 1996, Raleigh 1997). Death rates from diabetes for people born in India may be 3-6 times higher than national averages (Bardsley et al. 2000). A study conducted in Birmingham found that arthritis was more common in Asian groups than in the UK population (Ritch et al. 1996).

Studies have shown that mortality rates from coronary heart disease are around 40% higher for South Asians than for the white population (Balarajan 1991, 1995). Similar findings have been found for South Asian communities living in different parts of the world (Bardsley et al. 2000). Studies have suggested that the risk factors for coronary heart disease in South Asians are diet, obesity, high blood pressure (13 Punjabis in this study reported hypertension), deprivation in childhood, and insulin

resistance (McKeigue & Sevak 1994, McKeigue 1989, McKeigue et al. 1991, Nath & Murphy 1988, Gupta et al. 1995, Pais et al. 1996, Bhopal et al. 1999). It has also been noted that South Asian women in the UK may require targeted health information regarding coronary heart disease (Beishan & Nazroo 1997). Hypertension is more prevalent among the Asian population in the UK than among the white population (Primatesta et al. 2000, Raleigh 1997). In addition, Asians are more likely to complain of poor vision than the white population (Ritch et al. 1996).

Although the levels of impairment do not explain the levels of self-assessed poor health, there was a relationship between the two variables. This relationship is also seen when limiting conditions are examined. As noted above, 50% of people who considered that their health was fair or poor had a condition that limited their activities. The most frequently reported limiting conditions or the activities they limited were[5]: inability to walk or difficulty with walking (N=12), stroke paralysis (N=7) and arthritis (N=5) (Table 57). A lack of functional ability is considered to be severely limiting by just under one-quarter (23%)of the sample that reported either restrictions in mobility[6], arthritis or stroke paralysis.

In a study conducted in Birmingham in 1991, 58% of Asians aged 65+ were independent, 32% needed help with household tasks (shopping, cooking and housework) and 10% needed help with personal care (dressing, washing and/or feeding) (Tinsley et al. 1991). Those aged 65-74 were more dependent that either UK respondents or West Indian respondents. However, those aged 75+ were less dependent than other groups. In this study, respondents were asked who they needed to look after them. The modal response was no one (44%) (Table 58). Of those who did name someone, the most common person was a spouse (37%) and this was also reflected in terms of the person they would expect to care for them if they were ill.

[5] There was some confusion over the responses to this question. The question stated, "Do you have any condition which limits your activities in some way?" If so, what is it? In some instances the condition was listed, in others the activity that was limited was listed.
[6] Mobility restriction was a collapsed category that included: cannot walk/difficulty walking, cannot go out alone, getting up stairs/steps, housework, in/out of bed and picking things up.

The incidence of ill health is higher amongst older people e.g. coronary heart disease, cerebrovascular disease and stroke, arthritis, osteoporosis (Charles 2000), dementia (Hofman et al. 1991, Lobo et al. 1990, Rocca et al. 1990, Rocca et al. 1991) and depression (Audit Commission 2000). Therefore, having someone to care for one at home if one is ill can be very important. Very few Punjabis (6%) said that there was no one to take care of them when they were ill (Table 59). Spouses were the most common supporters mentioned (35%), followed by son (23%), daughter and daughter-in-law (14% each). There were no significant differences between men and women in the source of help.

Interviewees were also asked if someone needed *the respondent* to look after them. The modal response was that they were not needed to look after anyone (63%) (Table 60). Of those who did name someone, the most common person was a spouse (28%). Once again, this is reflected in terms of the person who would expect the respondent to care for them *if they were ill*. Forty-five percent of the sample did not look after anyone, however, an equal number (45%) stated that they looked after their spouse if they were ill (Table 61).

Earlier research conducted in Birmingham found that members of South Asian groups made less use of health care professionals (other than general practitioners) than the indigenous population and concern was voiced about this. However, Asians were more likely to visit their doctor than all other ethnic groups. The research indicated that when offered the opportunity to consult with a member of their own ethnic group who spoke their language, take up of services was much increased (Tinsley et al. 1991). Birmingham is well served with health professionals of South Asian origins, but some patients still face difficulties related to language or gender.

One UK study showed that communication is still a challenge because the provision of interpreting services is limited, only 3% of Indians, 1% of Pakistanis and 7% of Bangladeshis said their GP provided interpreting services when required (Rehman 1999). In Birmingham it has been noted that communicating with English-speaking health personnel is a barrier to effective heath care (Ritch et al. 1996). The former

chairman of Birmingham Health Authority noted that investment in translation services was inadequate

> "Only £373,000 a year for a population of a quarter of a million ethnic minority people, of whom it is estimated that one hundred and twenty thousand have poor English."
>
> (Birmingham City Council 2001).

Respondents were asked who would accompany them to see the doctor or to the hospital. Almost all Punjabis named someone who would accompany them to see the doctor (94%) (Table 62). They were most likely to name a son (37%) followed by spouse (28%) or less frequently a daughter (15%). People other than the immediate family were rarely mentioned. What is interesting here is the high proportions who would not go to the doctor or hospital alone. It is not possible to know from the data whether this represents the need for transport, companionship or language problems. Although there are no significant differences between genders it is interesting to note that five times more men than women would go to the hospital alone (10% vs. 2%) and twice as many women as men would be accompanied by a spouse (37% vs. 18%) despite the greater proportion of women who are widowed.

Respondents were also asked if *they* accompanied anyone to the doctors or hospital. Nearly three-fifths (58%) of the sample did not accompany anyone (Table 63). However, over one-third (36%) accompanied their spouse to the doctors or hospital. Although there were no significant differences between men and women in accompanying someone to medical facilities, the data show that once again more men accompanied spouses to the doctors than vice versa (47% vs. 26%).

Domestic Help

Respondents were asked about a range of common domestic tasks or situations with which they might need or receive help. These included: borrowing small items (such as food, tools or small sums of money), food preparation, shopping, cooking, receiving prepared food, laundry and other household chores.

Borrowing is clearly not undertaken lightly; 71% of older Punjabis would borrow from no one (Table 64). The only category of people that Punjabis would borrow from that was mentioned by over one-tenth of the sample (14%) was friend/neighbour. Respondents were also asked if anyone borrows from them. Again the findings demonstrate that borrowing is not commonplace for Punjabis; 84% said that no one borrowed from them (Table 65). Once again only friends or neighbours were mentioned frequently enough (13%) to indicate that they borrowed from respondents. There were no significant differences between men and women.

As far as **shopping for food** is concerned, 35% receive help from no one and do their own shopping (Table 66). Help comes mainly from the immediate family: spouse (24%), daughter (15%) or daughter-in-law (14%). A vast majority of respondents did not go shopping for anyone else (77%) (Table 67). However, when help with shopping was received, it was spouses who would undertake this duty (17%). There were no significant differences between genders for either someone shopping for the respondent or the respondent buying food for someone else.

Help with cooking was received primarily from spouse (33%) and daughters-in-law (17%); 38% of Punjabis received no help with cooking (Table 68). Comparing genders it is apparent that significantly more men than women receive help with cooking, whereas 70% of Punjabi women said they did not receive any help, only 4% of Punjabi men were in this situation. Two thirds of Punjabi men get help with cooking from their spouses (67%) compared with only 2% of women who get help with the cooking from their husbands (level of significance for Pearson Chi Square test $p<.001$).

Seventy-one percent of Punjabi elders do not help anyone else with their cooking (Table 69). If they do help with cooking it is most likely to be for a spouse (15%) or for more than one person (8%). Once again the differences between genders are stark. Nearly all of the Punjabi men stated that they did not help anyone with cooking (98%). Women are more likely than men to help a spouse (29% vs. 0%) or more than one person with cooking (16% vs. 0%). In fact, where spouse help was

mentioned 100% of this was wives cooking for their husbands (level of significance for Pearson Chi Square test p<.001).

Respondents were also asked if anyone brought them food that they had grown or cooked. However, 96% of the Punjabis did not receive food from anyone. Likewise, very few respondents (97%) took food that they had grown or prepared to other people.

Laundry is much easier in the UK than in South Asia as most of the Punjabis in the UK sample (98%) had washing machines. Half the Punjabis (50%) did their own laundry and the main source of help was a spouse (28%) followed by daughters-in-law (11%) (Table 70). When gender differences are examined it can be seen that women also mainly undertake laundry. Over three times more women than men had no-one to help them with laundry (77% vs. 22%). On the other hand vastly more men have wives that helped with laundry than vice versa (55% vs. 2%) (level of significance for Pearson Chi Square test p<.001).

An overwhelming majority of the Punjabi sample did not do laundry for anyone else (80%) (Table 71). Where help was given this was to a spouse. Looking at gender differences we can see that (as with cooking) all of this help (100%) was from wives helping husbands and not vice versa (level of significance for Pearson Chi Square test p<.001).

The findings for help with **other household chores** are similar to laundry. Just over half (52%) of the Punjabis said that they received no help (Table 72). Most help comes from spouse (17%) or daughter-in-law (9%). These sources of help are fairly sharply differentiated by gender (level of significance for Pearson Chi Square test p<.05). Men are more likely than women to receive help with household chores from a spouse (29% vs. 6%). On the other hand women are more likely than men to receive help with household chores from a daughter-in-law (16% vs. 2%). In terms of formal help, the same proportions of men and women (4% for each) received help with domestic tasks from a paid helper.

Most respondents did not help anyone else with household chores (85%) (Table 73). However, 6% helped spouses and 4% helped daughters-in-law. The numbers of Punjabis giving anyone help with household chores are too small to make a meaningful comparison between genders.

Work and Income

Indians have high levels of employment and their earnings are comparable with those of whites, however, their overall rates of poverty are higher than for white households and we do not know how this might be different for different groups of Indians (Berthoud 1998). These factors naturally have an impact on economic situations in old age.

Income in later life may be determined by the employment history, pension contributions and to a lesser extent contributions from relatives. From this perspective the prior employment of immigrants to the UK is of prime importance. There is very little data that looks at South Asians in groups other than 'Indian', 'Pakistani' or 'Bangladeshi'. However, one of the rare sources of data is the National Survey of Ethnic Minorities (Modood et al. 1997). These data have been analysed by religious categories: Hindu, Sikh, Muslim, 'Other' (mainly Christian) and no religion (Brown 2000). We know that Punjabis are predominantly Sikh therefore data considering the economic position of Sikhs in the UK are of particular interest. Analysis of these data shows that 38% of Sikh men between the ages of 40 and 64 are likely to be economically inactive (Brown 2000). This would undoubtedly affect income in later life. The reasons that are given for inactivity in these age groups are 'sickness, disability and retirement' (Brown 2000). It has been suggested that this reasoning actually masks pre-retirement due to perceived disadvantage in the workforce (Modood 1997).

Respondents were asked if they currently work for money. Only 12% of the Punjabi respondents were working at the time of the study (Table 74). To a certain extent this

may be affected by the enforcement of a compulsory retirement age in the UK. For those who still work, the average working week is 36.7 hours.

The occupation of respondents is classified using the International Standard Classification of Occupations (ISCO-88) (International Labour Office 1990). ISCO-88 provides a hierarchical framework of occupations that are classified according to the degree of similarity in tasks and duties performed in each job. ISCO-88 identifies occupations in 10 major groups (Table 75). In these analyses housewives have been included in elementary occupations. ISCO-88 also delineates four broad skill levels. These are defined in terms of the educational levels and job-related formal training which may be required for people who carry out such jobs. Skill level is not defined for two of the major groups (Legislators, senior official and managers; and armed forces), as there are aspects of the work that are important as similarity criteria but may represent significant differences in skill levels within each group. Tables 76 and 77 report the highest classification of the married couple (i.e. spouse's occupational classification is used if higher than the respondent's) in addition, the tables report the respondent's own classification displayed for men and women.

Punjabis in the UK were most likely to have Group 7 or Group 8 employment. Those in Group 7 jobs typically worked as carpenters or mechanics and those in Group 8 worked in foundries, in factories as machine operators or as sewing machinists. However nearly one-fifth (18%) of the respondents had been employed in group 2 occupations (typically teachers). There were significant differences in the types of occupation that were undertaken by Punjabi men and women (Table 76). Men were more likely than women to have been employed in Group 7 occupations, whereas women were more likely to be classified in Group 9 occupations. This reflects the large proportion of women who were housewives.

71% of Punjabis in the UK have level 2 skills and over one-fifth (21%) have level 4 skills (Table 77). Once again, there are significant differences in the skill levels of men and women. Nearly two-thirds (63%) of women have skills at level one compared with under one-tenth (9%) of men. Conversely, over two-thirds (67%) of

men have skills at level two compared with less than half as many (29%) women with skills at this level.

Pensioners' incomes are based on combinations of occupational/private pensions and means tested benefits. White pensioners, many of whom have spent a full career building up various entitlements, have relatively high levels of non-state income and low dependence on means-tested benefits. Bangladeshi pensioners are at the opposite extreme with few non-state sources of income and high receipt of means-tested benefits. Indians come somewhere in between (Berthoud 1998).

As with many other surveys, the response rate for the income question was poor, with approximately one-fifth of the sample refusing or unable to answer the question (Brown 2000, Modood 1997). Elsewhere it has been suggested that 'missing' responses are more likely to be high earners and consequently calculated average income may fall short of actual levels (Modood 1997). Analysis of approximately 80% of the Punjabi sample (i.e. those who gave responses) show that the most likely source of income was the state old age pension, which was received by over two-thirds of the sample that responded to this question (68%) (Table 78). Fewer Punjabis received income from other sources. Nearly equal proportions received income from a former employer (27%) or from savings or investments (25%). Approximately one fifth of the sample received income from an 'Other' source (21%), or from the state supplementary pension (18%).

The figures for receipt of state pension in this study were lower than noted elsewhere for Indians as a whole (68% vs. 88%) (Evandrou 2000b), reflecting the fact that the sample included those aged 55 and up, including some who are under pensionable age. However, in order to receive a full entitlement for state pension men have to have paid national insurance contributions for 44 years and women for 39 years when they retired. Other evidence suggests that many Asians would have experienced periods of unemployment (Jones 1993, Brown 1984, Drew 1995). In this study, the Punjabi respondents had lived in the UK for 34.2 years. Consequently some older Punjabis are not likely to have full entitlement to a state pension.

The mean level of income was £147.27 per week (N=70). These findings should be treated with caution, given that almost one-third of the sample refused to state their income. Elsewhere analysis of data for Indians has found that there is a bi-modal distribution of income amongst older Indians. Half of the Indian population are in the bottom quintile of income distribution and one-tenth in the top quintile (Evandrou 2000b).

When respondents were asked to whom they would turn for **financial advice**, the most common answer was no one (38%) (Table 79). Of those who would ask advice the most likely source was son (31%), daughter (11%) or spouse (10%). There were no significant differences between men and women in whom they would ask for advice. Most respondents said that they did not give financial advice to anyone else (79%).

Dying in the United Kingdom

There were also a lot of missing data for questions relating to death, suggesting that Punjabis may have a reluctance to discuss death. Sikhism approaches death with attitudes of resignation and detachment (http://www.sgpc.net/sikhism/antam-sanskar.asp). Whether it is a reluctance to confront the inevitability of death or a cultural difference, only just over a quarter of respondents (27%) had made a will (Table 80).

Respondents were asked about the place of death for the last or a recent death of someone close to them living in Birmingham. More than half (53%) were unable or unwilling to answer this question or any of the other questions about death and funeral rites (Table 81). It is likely that for some or most of these people, no family deaths had occurred in Birmingham or none had occurred recently. Of those who did answer 53% of deaths had occurred at home and 42% in hospital.

Respondents were also asked who had made arrangements for the funeral (Table 82). Most commonly mentioned were son, spouse and other relative. Only in four cases were funerals arranged by female relatives.

Respondents were also asked whether funeral rites for Punjabis in the UK were different from those that they had known in childhood. Of the 59 who responded to this question, 26 said that they were different (Table 83). Qualitative data on these differences will be analysed subsequently.

SUMMARY AND CONCLUSIONS

Immigration of Punjabis to the UK has been well established for decades and was given additional impetus following the First and Second World Wars. Most of today's Punjabi immigrants came to the UK in the 1960s. Most of the Punjabis interviewed in this study had been in the UK for 30 years. Their average age was 68 and 25% were over 75. Half lived in multi-generational households and the other half lived either alone or with their spouse only. Most Punjabis marry and for those interviewed half had married before the age of 20. A majority were still married.

Punjabis have larger families than the indigenous population, with most having four or five children. Most had a child living within 5 miles and saw a child every day. Fewer had living brothers or sisters and most of these lived at a distance, many in South Asia. Contact with siblings was not frequent. However, most saw a relative daily. Most also had frequent contact with friends and neighbours, although contact with neighbours was less frequent than with friends. The majority attended meetings of community groups (at least occasionally). Most Punjabis were rarely alone and were not lonely.

In contrast, there was a minority of the Punjabi sample who lived alone (14%), did not see a child every week (10%), had no living siblings (31%), never saw friends (22%) or neighbours (18%), never attended community meetings (30%) or were alone for more than 9 hours a day (9%). Further analyses will identify whether these Punjabis represent a group with multiple deprivations or if they are a disparate group who are well supported on most other variables.

A vast majority of the Punjabis in Birmingham were Sikhs and virtually all of them attended religious meetings regularly. Most of the Indian Punjabis interviewed had received very little or no formal education and nearly half did not speak English, despite the length of time they had lived in the UK. Fewer than half of the sample of Punjabis were able to read or write English. Overall, those that could read and write English had been taught in English (or more than one language) at school. This

suggests that older Punjabis have been unlikely to undertake English lessons in the UK.

Most Punjabis were typically well supported by their family and community, and in turn played an important role in supporting other family members and friends. Despite fundamental aspects of Sikh theology including implicit gender equality and independence for women (Sikh Women 2002) the analyses showed gender differences in responsibility for domestic work. Women were more likely than men to undertake cooking and laundry for spouses, and wives and daughters-in-law were more likely than men to undertake other household chores. There was a small minority of Punjabis who were without support: 15% did not confide in anyone, 10% had no one to talk to when unhappy, and 16% had no one to whom they can talk about personal problems.

Average incomes were typically low, although one-third refused to divulge their income. Few Punjabis sent remittances to children or other relatives abroad. The sending of money to relatives abroad is not typical and may be related to low incomes. However, the fact that half live in multi-generation households may serve to offset low incomes. Where remittances were sent (by 11%) they averaged £68 a month.

Overall, the majority of the Punjabis are well supported by their families and friends, but do not appear to be well integrated into the host community. Almost half speak no English. On the other hand, the Indian Punjabis appear to be well integrated into the Sikh community in Birmingham. The Sikh community is mentioned here, rather than Punjabi community because, although Punjabi is the most commonly spoken Asian language in Birmingham, most of the speakers are from Punjab in Pakistan and the majority of those are Muslims. It has been estimated that there are 500,000 Sikhs in the UK (Parekh 2000). Sikh Gurdwaras in Birmingham provide more than a place of worship, they also provide a place for cultural focus. The Indian Punjabis in Birmingham may be said to form an ethnic enclave with its own religion, culture, traditions and customs.

The study did identify some differences in the findings compared with earlier research that aggregated all Indian ethnic groups together. The study has been conducted with a small sample but it raises questions about differences between different Asian ethnic groups that have not always been seen as important distinctions. The Indian Punjabis in Birmingham do not appear to be disadvantaged by family dispersal as a result of emigration. Most of them have children living nearby and are well supported by family, friends and neighbours. However, low levels of education and a high proportion that do not speak English are likely to lead to disadvantage in the labour market and a low level of integration into UK society. Comparisons with those older Punjabis who remained in India will provide additional information on how or whether those ageing in the UK have benefited from the migration decision.

REFERENCES

Alexander, Z., 1999, *Study of Black, Asian and Ethnic minority issues*. Department of Health, London.

Alibhai-Brown, Y., 1998, Age of respect. *Community Care,* 10-16 December.

Askham, J., Henshaw, L. and Tarpey, M., 1995, *Social and health authority services for elderly people from Black and minority ethnic communities.* HMSO, London.

Atkin, K. and Rollings, J., 1993, *Community care in a multi-racial Britain.* HMSO, London.

Atkin, K., Cameron, E., Badger, F. and Evans, E., 1989, Asian elders' knowledge and future use of community social and health services*. New Community,* **15**(2), 439-46.

Audit Commission, 2000, *Forget Me Not: Mental Health Services for Older People.* Audit Commission, London.

Ballard, R., 1986, Differentiation and disjunction amongst the Sikhs in Britain. In, Barrier, N. G. and Dusenbery, V., (Eds.), *The Sikh diaspora: migration and the experience beyond Punjab*. Pp. 200-234. Chanakya Publications, Delhi.

Barker, J., 1984, *Black and Asian old people in Britain.* Age Concern Research Unit, Mitchum.

Ben-Tovim, G., Gabriel, J., Law, I. and Stredder, K., 1982, A political analysis of race in the 1980s. In, Husband, C., (Ed.), *'Race' in Britain.* Pp. 303-316. Hutchison, London.

Berthoud, R., 1998, *Incomes of Ethnic Minorities.* Institute for Social and Economic Research, University of Essex Press, Colchester.

Balarajan, R., 1991, Ethnic differences in mortality from ischaemic heart disease and cerebrovascular disease in England and Wales. *British Medical Journal*, **302**, 560-4.

Balarajan, R., 1995, Ethnicity and variations in the nation's health. *Health Trends*, **27**, 114-119.

Bardsley, M., Hamm, J., Lowdell, C., Morgan, D. and Storkey, M., 2000, *Developing health assessment for black and minority ethnic groups: Analysing routing health information*. London Regional NHS Executive, London.

Beishon, S. and Nazroo, J. Y., 1997, *Coronary heart disease: Contrasting the health beliefs and behaviours of South Asian communities.* Health Education Authority, London.

Bhalla, A. and Blakemore, K., 1981, *Elders of the Minority Ethnic Groups.* AFFOR, Birmingham.

Bhopal, R., Unwin, N., White, M., Yallop, J., Walker, L., Alberti, K. G. M. M., Harland, J., Patel, S., Ahmad, N., Turner, C., Watson, B., Kaur, D., Kulkarni, A., Laker, M., Tavridou, A., 1999, Heterogeneity of coronary heart disease risk factors in Indian, Pakistani, Bangladeshi, and European origin populations: Cross sectional study. *British Medical Journal*, **319**, 215-220.

Bhugra, D. and Bahl, V., (Eds.), 1999, *Ethnicity: An agenda for mental health.* Gaskell, London.

Blakemore, K., 1985, The state, the voluntary sector and new developments in provision for the old of minority racial groups. *Ageing and Society*, **5**, 175-90.

Blakemore, K. and Boneham, M., 1994, *Age, race and ethnicity*. Open University Press, Buckingham.

Blane, D., White, I and Morris, J., 1996, Education, social circumstances and mortality. In, Blane, D., Brunner, E. and Wilkinson, R., (Eds.) *Health and social organization*. Routledge, London.

Birmingham City Council, 2001, *Challenges for the future. Race quality in Birmingham: Report of the Birmingham Stephen Lawrence Inquiry Commission*. Birmingham City Council, Birmingham.

Birmingham City Council, 2002, *History of Handsworth.* http://www.birmingham.gov.uk/GenerateContent?CONTENT_ITEM_ID=2516&CONTENT_ITEM_TYPE=0&MENU_ID=0

Boneham, M. A., Williams, K. E., Copeland, J. R. M., McKibbin, P., Wilson, K., Scott, A. and Saunders, P. A., 1997, Elderly people from ethnic minorities in Liverpool: Mental illness, unmet need and barriers to service use. *Health and Social Care in the Community*, **5** (3) 173-180.

Bowling, B., 1990, *Elderly people from ethnic minorities: A report on four projects*. Age Concern Institute of Gerontology, London.

Brenton, M., 1985, *The voluntary sector in British Social Services*. London, Longman.

Brown, C., 1984, *Black and White Britain*. Heinemann, London.

Brown, M. S., 2000, Religion and economic activity in the South Asian population. *Ethnic and Racial Studies*, **23**(6), 1035-61.

Burholt, V., Wenger, G. C., Scott, A., Yahya, B. and Roy, S., 2000, Bangladeshi immigration to the United Kingdom: Older people's support networks in the sending and receiving countries. *Quality in Ageing*, **1**(2), 18-30.

Cameron, E., Badger, F. and Evans, H., 1989, District nursing, the disabled and the elderly: Who are the black patients? *Journal of Advanced Nursing,* **14**, 376-82.

Carter, B., Harris, C., and Joshi, S., 1993, The 1951-55 Conservative Government and the racialization of black immigration. In, James, W. and Harris, C., (Eds.), *Inside Babylon: The Caribbean Diaspora in Britain.* Verso, London.

Carter, B., Green, M. and Halpern, R., 1996, Immigration policy and the racialization of migrant labour: The construction of national identities in the USA and Britain*. Ethnic and Racial Studies,* **19**, 135-157.

Charles, J., 2000, *Morbidity and Mortality in Older People: National and local Perspectives.* Health Policy and Public Health, North Wales Health Authority.

The Council of Sikh Gurdwaras in Birmingham, 2001, *Annual Report 2001.* The Council of Sikh Gurdwaras in Birmingham, Birmingham.

Daniel, S., 1988, A code to care for elders. *Social Work Today*, 18th Aug, 9.

Davey Smith, G., Neaton, J. D., Wentworth, D., Stamler, R. and Stamler, J., 1998, Mortality differences between black and white men in the USA: Contribution of income and other risk factors among men screened for the MRFIT. *Lancet*, **351**, 934-939.

Department of Health and Human Services, 1990, *Health status of the disadvantaged: Chart Book 1990*. DHSS, Washington.

Drew, D., 1995, *Race, education and work: The statistics of inequality.* Avebury, Aldershot.

Erens, B., Primatesta, P. and Prior, G., (Eds.), 2001, *Health Survey for England: The health of minority ethnic groups '99. Vol. 1: Findings.* Stationery Office, London.

Evandrou, M., 2000a, Ethnic inequalities in health in later life. *Health Statistics Quarterly*, **8**, 20-28.

Evandrou, M., 2000b, Social inequalities in later life: The socio-economic position of older people form ethnic minority groups in Britain. *Population Trends*, **101**, 11-18.

Fenton, S., 1987, *Ageing Minorities: Black people as they grow old in Britain.* London, Commission for Racial Equality.

Firth, S., 1993a, Approaches to death in Hindu and Sikh communities in Britain. In, Dickenson, D. and Johnson, M., (Eds.), *Death, dying and bereavement.* Sage, London.

Firth, S., 1993b, Cross-cultural perspectives on bereavement. In, Dickenson, D. and Johnson, M., (Eds.), *Death, dying and bereavement.* Sage, London.

Freeman, G., 1986, Migration and the political economy of the welfare state. In, Heisler, M. O. and Schmitter Heisler, B., (Eds.), *From foreign workers to settlers. Transnational migration and the emergence of new minorities.* Pp. 51-63. Sage Publications, Beverly Hills CA.

Garbaye, R., 2001, *City template Birmingham: Basic information on ethnic minorities and their participation.* Worcester College, Oxford University, Oxford. Prepared for UNESCO-MOST Multicultural Policies and Modes of Citizenship in European Cities (MPMC) project. http://www.unesco.org/most/p97city.htm

Gillanshah, F., 1993, Islamic customs regarding death. In, Irish, D. P., Lundquist, K. F. and Neslen, V. J., (Eds.), *Ethnic variations in dying, death, and grief: Diversity in universality.* Taylor and Francis, London.

Gupta, S., de Belder, A. and Hughes, L. O., 1995, Avoiding premature coronary deaths in Asians in Britain. *British Medical Journal*, **311**, 1035-1036.

Harding, S. and Maxwell, R., 1997, Differences in mortality of migrants. In, Drever, F. and Whitehead, M., (Eds.), *Health inequalities: Decennial supplement No. 15.* The Stationery Office, London.

Helweg, A. W., 1986, Indians in England: A study of the international relationships of sending, receiving and migrant societies. In, Rao, M. S. A., (Ed.), *Studies in migration: Internal and international migration in India.* Pp. 363-400. Nomhar, Delhi.

Henly, A., 1979, *Asian patients in hospital and at home*. King Edward's Hospital Fund, London.

Hofman, A., Rocca, W. A., Brayne, C., Breteler, M. M. B., Clarke, M., Cooper, B., Copeland, J. R. M., Dartigues, J. R., Da Silva Droux, A., Hagnell, O., Heeren, T. J., Engedal, K., Jonker, C., Lindesay, J., Lobo, A., Mann, A. H., Mölsä, P. K., Morgan, K., O'Connor, D. W., Sulkava, R., Kay, D. W. K. and Amaducci, L., 1991, The prevalence of dementia in Europe: A collaborative study of 1980-1990 findings. *International Journal of Epidemiology*, **20**(3), 736-748.

Idler, E. L. and Kasl, S. V., 1991, Health perceptions and survival: Do global evaluations of health status really predict mortality? *Journal of Gerontology: Social Sciences*, **46**, S55-S65.

Idler, E. L., Kasl, S. V. and Lemke, J. H., 1990, Self-evaluated health and mortality among the elderly in New Haven, Connecticut and Iowa and Washington Counties, Iowa, 1982-1986. *American Journal of Epidemiology*, **131**, 91-103.

India Visit Travel Network, 2002, *Sikh pilgrimages in India.* http://pilgrimage.indianvisit.com/india/sikh-pilgrimage.html

International Labour Office, 1990, International Standard Classification of Occupations: ISCO-88. International Labour Office, Geneva.

Jeyasingham, M., 1992, Acting for health: Community development and ethnic minorities. In, Ahmad, W. I. U., (Ed.), *The politics of 'race' and health*. Race Relations Research Unit, University of Bradford, and Bradford and Ilkley Community College, Bradford.

Jones, T., 1993, *Britain's ethnic minorities*. Policy Studies Institute, London.

Juss, S., 1993, *Immigration, nationality and citizenship*. Mansell, London.

Kalka, I., 1990, Attachment to the mother country - image and reality. *Ethnic Groups*, **8**, 249-265.

Kaplan, G., Barell, V. and Lusky, A., 1988, Subjective state of health and survival in elderly adults. *Journals of Gerontology*, **43**(4), S114-S120.

Kaplan, G. A. and Camacho, T., 1983, Perceived health and mortality: A nine-year follow-up of the Human Population Laboratory cohort. *American Journal of Epidemiology*, **117**, 292-304.

Klein, R., 1979, The old blacks beat the blues. *Community Care*, **4**, 18-9.

Koenig, B. A., Gates-Williams, J., 1995, Understanding cultural difference in caring for dying patients. *Western Journal of Medicine*, **163**(3), 244-249.

Krieger, N., Rowley, D. L., Herman, A. A., Avery, B. and Philips, M. T., 1993, Racism, sexism, and social class: Implications for studies of health, disease and well-being. *American Journal of Preventive Medicine*, **9**(Suppl.), 82-122.

Lee, D. J. and Markides, K. S., 1990, Activity and mortality among aged persons over an eight-year period. *Journal of Gerontology: Social Sciences*, **45**, S39-S42.

Lobo, A., Saz, P., Dia, J. L., Marcos, G., Morales, F., Perez, M. J., Pascual L. F., Ventura, T., and Gracia, E., 1990, The epidemiological study of dementia in Zaragoza, Spain. In, Stefaniss, C. N., Soldators, C. R., Rabavilas, A. D., (Eds.), *Psychiatry: A world perspective. Proceedings of the VIII World Congress of Psychiatry, Athens, Oct 13-19, 1989*. Elsevier, Amsterdam.

Marmot, M. G., Adelstein, A. M., Bulusu, L. and Office for Population Census and Surveys (OPCS), 1984, *Immigrant mortality in England and Wales 1970-78: Causes of death by country of birth*. HMSO, London.

Marsh, P., 1967, *Anatomy of a strike: Union, employers and Punjabi workers in a Southall factory*. International Race Relations, London.

McKeigue, P. M., 1989, Coronary heart disease in South Asians overseas: A review. *Journal of Clinical Epidemiology*, **42**, 597-609.

McKeigue, P. and Sevak, L., 1994, *Coronary heart disease in South Asian communities.* Health Education Authority, London.

McKeigue, P. M., Shah, B. and Marmot, M. G., 1991, Relation of central obesity and insulin resistance with high diabetes prevalence and cardiovascular risk in South Asians. *Lancet*, **337**, 382-386.

Michaud, H., 1998, *Walking in the Footsteps of the Guru: Sikhs and Seekers in the Indian Himalayas*. MA Thesis, Department of Anthropology, University of Calgary, Alberta, Canada.

Mocroft, I., Pharoah, C. and Romney-Alexander, D., 1999, *Healthy relationships: A survey of London health authorities' and trusts' support to the voluntary sector.* Charities Aid Foundation, West Malling.

Modood, T. 1997, Employment. In, Modood, T., Berthoud, R., Lakey, J., Nazroo, J., Smith, P., Virdee, S. and Beishon, S., (Eds.), *Ethnic minorities in Britain: Diversity and disadvantage*. Policy Studies Institute, London.

Modood, T., Berthoud, R., Lakey, J., Nazroo, J., Smith, P., Virdee, S., Beishon, S., (Eds.), 1997, *Ethnic minorities in Britain: Diversity and disadvantage*. Policy Studies Institute, London.

Mossey, J. M. and Shapiro, E., 1982, Self-rated health: A predictor of mortality among the elderly. *American Journal of Public Health*, **72**, 800-808.

Murray, N., 1985, The central issue is racism. *Community Care,* 28th Feb.

Naik, S., 2001, *Education: A Beautiful Tree – Part 1*. Reprinted by the Society for the Integrated Development of the Himalayas, Mussoorie, Uttaranchal, India. http://www.indiatogether.org/education/opinions/btree.htm

Nath, B. S. and Murthy, R., 1988, Cholesterol in Indian ghee. *Lancet*, **ii**, 39.

National Council of Educational Research and Training (NCERT), 2000, *National Curriculum Framework for School Education*. NCERT, New Delhi, India.

Nazroo, J., 1997a, *The health of Britain's ethnic minorities: Findings from a national survey*. Policy Studies Institute, London.

Nazroo, J., 1997b, *Mental health and ethnicity: Findings from a national community survey.* Policy Studies Institute, London.

Nazroo, J., and Davey Smith, G., 2001, The contribution of socio-economic position to health differential between ethnic groups: Evidence form the United States and Britain. In, Macbeth, H. and Shetty, P., (Eds.), *Health and Ethnicity.* Taylor and Francis, London.

Norman, A., 1985, *Triple jeopardy: Growing older in a second homeland*. Centre for Policy on Ageing, London.

Owen, D., 1993, *Ethnic minorities in Great Britain: Housing and family characteristics.* National Ethnic Minority Data Archive, Centre for Research in Ethnic Relations, University of Warwick.

Owen, D., 1994, *South Asians in Great Britain: Social and economic circumstances.* National Ethnic Minority Data Archive, Centre for Research in Ethnic Relations, University of Warwick.

Pais, P., Pogue, J., Gerstein, H., Zachariah, E., Savitha, D., Jayprakash, S., Nayak, P. R. and Yusuf, S., 1996, Risk factors for acute myocardial infarction in Indians: A case-control study. *Lancet,* **348**, 358-363.

Pamuk, E., Makuc, D., Heck, K., Reuben, C. and Lochner, K., 1998, *Socioeconomic status and health chartbook. Health, United States, 1998.* National Centre for Health Statistics, Hyattsville, MD.

Parekh, B., 2000, *The future of multi-ethnic Britain. The Parekh Report.* Profile Books, London.

Patel, N., 1990, *A 'race' against time? Social services provision to Black elders.* The Runnymede Trust, London.

Peach, C., 2000, *The cultural landscape of South Asian religion in English cities*. Paper presented to New landscapes of religion in the West, Oxford University, School of Geography and the Environment, 27-29 Sept 2000.

Peters, G. and Davis, P. K., 1986, Migration to the United Kingdom and the Emergence of a New Politics. In, Heisler, M. O. and Schmitter Heisler, B., (Eds.), *From foreign workers to settlers. Transnational migration and the emergence of new minorities.* The Annals of the American Academy of Political and Social Science, 485. Sage Publications, Beverly Hills CA.

Piore, M., 1979, *Birds of passage: Migrant labor and industrial societies.* Cambridge University Press, Cambridge.

Primatesta, P., Bost, L. and Poulter, N. R., 2000, Blood pressure levels and hypertension status among ethnic groups in England. *Journal of Human Hypertension*, **14**(2), 143-8.

Rakowski, W., Mor, V. and Hiris, J., 1991, The association of self-rated health with mortality in a sample of well-elderly from the Longitudinal Study of Aging (1984-1986). *Journal of Aging and Health*, **3**, 527-545.

Raleigh, V. S., 1997, Diabetes and hypertension in Britain's ethnic minorities: Implications for the future of renal services. *British Medical Journal*, **314**(7075), 209-13.

Randhir, G.S., 1990, *Sikh Shrines in India*. Publications Division, Ministry of Information and Broadcasting, Government of India, New Delhi.

Ratcliffe, P., 1979, *Racism and Reaction: A study of Handsworth*. Routledge and Kegan Paul, London.

Rehman, H., 1999, *Inequalities in the Health of Black and Minority Ethnic Groups*. Health Education Authority, London.

Ritch, A. E., Ehtisham, M. Guthrie, S., Talbot, J. M., Luck, M. and Tinsley, R. N., 1996, Ethnic influence on health and dependency of elderly inner city residents. *Journal of the Royal College of Physicians of London*, **30**(3), 215-20.

Rocca, W. A., Bonaiuto, S., Lippi, A., Luciani, P., Turtu, F., Cavarzeran, F. and Amaducci, L., 1990, Prevalence of clinically diagnosed Alzheimer's disease and other dementing disorders: A door-to-door survey in Appignano, Macerata Province, Italy. *Neurology*, **40**, 626-631.

Rocca, W. A., Hofman, A., Brayne, C., Breteler, M. M. B., Clarke, M., Cooper, B., Copeland, J. R. M., Dartigues, J. R., Da Silva Droux, A., Hagnell, O., Heeren, T. J., Engedal, K., Jonker, C., Lindesay, J., Lobo, A., Mann, A. H., Mölsä, P. K., Morgan, K., O'Connor, D. W., Sulkava, R., Kay, D. W. K. and Amaducci, L., 1991, Frequency and distribution of Alzheimer's Disease in Europe: A collaborative study of 1980-1990 prevalence findings. *Annals of Neurology*, **30**(3), 381-390.

Rogers, R. G., 1992, Living and dying in the USA: Socio-demographic determinants of death among blacks and whites. *Demography*, **29**, 287-303.

Rogot, E., Sorlie, P. D., Johnson, N. J., and Schmitt, C., 1993, *A mortality study of 1.3 million persons by demographic, social and economic factors: 1979-1985. Follow-up, US National Longitudinal Mortality Study*. National Institute of Health, Washington DC.

Roos, N. P. and Haven, B., 1991, Predictors of successful aging: A twelve-year study of Manitoba elderly. *American Journal of Public Health*, **81**, 63-68.

Rudat, K., 1994, *Black and minority ethnic groups in England: Health and lifestyles.* Health Education Authority, London.

Saunders, P.A., Copeland J.R.M., Dewey, M.E., Gilmore, C., Larkin, B.A., Patherpekar, H. and Scott, A., 1993, The prevalence of dementia, depression and neurosis in later life: The Liverpool MRC-ALPHA study*. International Journal of Epidemiology,* **22**, 838-847.

Schmitter Heisler, B. and Heisler, M. O., 1986, Transnational migration and the modern democratic state: Familiar problems in new form or a new problem? In, Heisler M. O. and Schmitter Heisler, B., (Eds.), *From foreign workers to settlers. Transnational migration and the emergence of new minorities*. The Annals of the American Academy of Political and Social Science, 485. Sage Publications, Beverly Hills CA.

Shukla, K., 1991, Nutrition and dietetics. In, Squires, A., (Ed.), *Multicultural heath care and rehabilitation of older people*. Edward Arnold, London.

Sikh Women, 2002, *Equality*. http://www.sikhwomen.com/equality/

Singh, K., 1985, *The Sikhs Today*. Orient Longman, New Delhi.

Smaje, C. and Field, D., 1997, Absent minorities? Ethnicity and the use of palliative care services. In, Field, D., Hockey, J. and Small, N., (Eds.), *Death, gender and ethnicity*. Routledge, London.

Small, N., 1997, Death and difference. In, Field, D., Hockey, J. and Small, N., (Eds.), *Death, gender and ethnicity.* Routledge, London.

Sorlie, P., Rogot, E., Anderson, R., Johnson, N. J. and Backlund, E., 1992, Black-white mortality differences by family income. *Lancet*, **340**, 346-350.

Tinsley, R. N., Luck, M., Ehtisham, M., Guthrie, S., Hickling, J., Ritch, A. E. S. and Talbot, J., 1991, *Health Needs of Elderly People in the Inner City, Report No. 4: Dependency.* West Birmingham Health Authority Department of Geriatric Medicine, Birmingham.

Wenger, G. C., 1989, Support networks in old age – constructing a typology. In, Jefferys, M., (Ed.), *Ageing in the 20th Century.* Pp.166-85. Routledge, London.

Wenger, G. C., 1991, A network typology: from theory to practice. *Journal of Aging Studies,* **5**(1), 147-62.

Wenger, G. C., 1994, *Understanding Support Networks and Community Care*. Avebury, Aldershot.

Wenger, G. C., 1998, *Ethnic elders in the UK – A review of the literature.* Working Paper. Centre for Social Policy Research and Development, Institute of Medical and Social Care Research, University of Wales, Bangor.

Wenger, G. C. and Tucker, I., 2002, Using network variation in practice: Identification of support network type. *Health and Social Care in the Community,* **10**(1), 28-35.

Wenger, G. C. and Liu, J. M., 1999, Support networks in Beijing (China) and Liverpool (UK): Differences and similarities. *Hallym International Journal of Aging,* **1**(2), 47-57.

Wenger, G. C. and Liu, J. M., 2000, Family support in Beijing (China) and Liverpool (UK): Differences and similarities. *Hallym International Journal of Aging,* **2**(1), 85-91.

Wenger, G.C. and Shahtahmasebi, S., 1990, Variations in support networks: Some policy implications. In, Mogey, J., (Ed.), *Aiding and Aging: The coming crisis.* Pp. 255-77. Greenwood Press, Westport, CT.

Wenger, G. C., Burholt, V. and Shah, Z., 2002, *Older Gujarat Immigrants in Birmingham, UK.* Report to the Department for International Development, London.

Williams, D., 1999, Population review of 1998: England and Wales. *Population Trends,* Winter 1999.

Williams, R., 1994, Diabetes mellitus. In, Stevens, A. and Raftery, J., (Eds.) *Health care needs assessment*. Radcliffe Medical Press, Oxford.

Williams, V., 1986, Caribbean company. *Insight*, 6th Sept.

Wolinsky, F. D. and Johnson, R. J., 1992, Perceived health status and mortality among older men and women. *Journal of Gerontology: Social Sciences*, **47**, S304-S312.

Woods, R., 1979, Ethnic Segregation in Birmingham in the 1960s and 1970s. *Ethnic and Racial Studies*, **2**(4).

Families and Migration: Older People from South Asia
Department for International Development (DFID) Project

ESA315

UNITED KINGDOM REGIONAL REPORT NO. 2

Older Punjabi Immigrants in Birmingham: Appendix – Data Tables for UK Punjabi Sample

October 2002

By Vanessa Burholt, G. Clare Wenger and Zahida Shah

TABLE OF CONTENTS

Demographic Characteristics

Table 1. Gender distribution

Gender	**Punjabis (UK) (N=100) %**
Male	49
Female	51

Table 2. Age distribution

Age bands	**Punjabis (UK) (N=100) %**
55-59	14
60-64	19
65-69	25
70-74	17
75+	25

Table 3. Marital status distribution

Marital status:	**Punjabis (UK) (N=100) %**
Never married	0
Married	71
Widowed	27
Divorced/separated	2

Table 4: Age at current (or last) marriage

Age:	**Punjabis (UK) (N=100) %**
<10	1
10-15	24
16-19	25
20-29	41
30-39	6
40-49	1
50-59	1
Missing	1

Table 5: Number of years married for current (or last) marriage

Number of years:	Punjabis (UK) (N=100) %
<10	2
10-19	2
20-29	5
30-39	24
40-49	31
50-50	17
60+	14
Missing	5

Migration history

Table 6. Age at move to the UK

	Punjabis		
Ageband:	***All***	***Male***	***Female***
10-19	8	6	10
20-29	41	46	40
30-39	22	21	25
40-49	10	10	10
50-59	6	8	4
60-69	5	6	4
70+	4	2	6
Missing	4		
Level of significance for Pearson Chi Square test2		n.s.	

Table 7. Decade of move to the UK

Decade	Punjabis (UK) (N=96) %
1940s	1
1950s	19
1960s	47
1970s	21
1980s	6
1990-present	6

Table 8. Length of stay in the UK

Length of stay:	All (N=96) %
Less than 10 years	5
11-20 years	7
21-30 years	14
31-40 years	44
40+ years	30

Table 9. Reasons for emigrating to the UK

Reasons:	All (N=96)	Men (N=47) %	Women (N=49) %
Economic/for work	39	66	12
To join spouse	22	0	43
Live with or near relative	12	15	8
Political Africanisation of labour	10	11	10
Other	18	9	27
Level of significance for Pearson Chi Square test		p<.001*	

* 1 cell had expected frequencies <5.

Table 10. First county of residence in the UK

County:	Punjabis (UK) (N=99) %
West Midlands	91
Greater London	3
Middlesex	3
Warwickshire	1
Leicestershire	1
West Yorkshire	1

Table 11. Number of moves made after moving to the UK.

Number of moves:	Punjabis (UK) (N=100) %
0	86
1	12
2	2
3+	0

Living Arrangements

Table 12. Household composition

Household composition:	Punjabis (UK) (N=100) %
Lives alone	14
Lives with spouse/ partner only	37
Lives with younger (2) generation	24
Lives in 3 or 4 generation household	25

Table 13. Length of time living in current house

Number of years:	Punjabis (UK) (N=100) %
< 1	3
1-5	13
6-10	20
11-20	22
21-30	23
30+	18
Missing	1

Table 14. Age came to live in current house

Age:	Punjabis (UK) (N=100) %
Under 20	2
20-39	34
40-59	44
60-69	11
70+	8
Missing	1

Table 15. House tenure

Owned by:	Punjabis (UK) (N=100) %
Self or spouse	71
Child	18
Landlord	5
Other	5
Missing	1

Children

Table 16. Number of living children

	Punjabis (UK) (N=100) %		
Number of living:	**Children**	**Sons**	**Daughters**
0	2	8	20
1	9	40	25
2	13	26	23
3	26	20	22
4	26	3	4
5	8	3	4
6+	16	0	2

Table 17. Distance from nearest child

Distance from nearest child:	**Punjabis (UK) (N=100) %**
No children	2
In the same household/ within 1 mile	57
1-5 miles	14
6-15 miles	9
16-50 miles	3
50+ miles	12
In another country	3

Table 18. Most frequent contact with any child

Frequency of contact:	**Punjabis (UK) (N=98) %**
Daily	63
More than once a week	10
Once a week	15
2-3 times a month	3
Once a month	5
Twice a year	1
Less than once a year	1

Table 19. Number of children living abroad

Number of children living abroad:	Punjabis (UK) (N=100) %
0	83
1	5
2	4
3	5
4	3

Table 20. Where children abroad live

Child living in:	Punjabis (UK) N
Other Europe	6
North America	16
Australia	11
Middle East	2
South Asia	6
Far East	1
Africa	9

Table 21. Keeping in touch with children abroad

Keep in touch :	Punjabis (UK) (N=40) %
Yes	100
By:	
Letter	25
Phone	95
Sending gifts	10
Receiving gifts	5
Other means	0

Siblings

Table 22. Number of living siblings

Number of living siblings:	Punjabis (UK) (N=100) %
0	31
1	21
2	13
3	14
4	11
5	5
6+	5

Table 23. Distance of nearest sibling

Distance of nearest sibling:	Punjabis (UK) (N=100) %
No siblings	31
In the same household/ within 1 mile	0
1-5 miles	12
6-15 miles	10
16-50 miles	5
50+ miles	13
In another country	29

Table 24. Most frequent contact with any sibling

Frequency of contact:	Punjabis (UK) (N=69) %
Daily	3
More than once a week	9
Once a week	2
2-3 times a month	2
Once a month	8
3-11 times a year	4
Once a year	17
Less than once a year	17
Never	5
Missing	2

Table 25. Number of siblings living abroad

Number of siblings living abroad:	Punjabis (UK) (N=100) %
0	56
1	18
2	7
3	9
4	4
5	3
6+	3

Table 26. Where siblings abroad live (N).

Sibling living in:	Punjabis (UK) N
North America	14
South Asia	70
South East Asia	13
Africa	7

Table 27. Keeping in touch with siblings abroad

Keep in touch :	Punjabis (UK) (N=109) %
Yes	69
By:	
Letter	31
Phone	32
Sending gifts	13
Receiving gifts	2
Other means	0

Relatives

Table 28. Frequency of contact with any relative

Frequency of contact:	**Punjabis (UK) (N=100) %**
Daily	60
2-3 times a week	6
At least once a week	17
< weekly, but > monthly	12
Less Often	3
Never/no relatives	1
Missing	1

Table 29. Number of relatives (other than children or siblings) living abroad

Number of relatives living abroad:	**Punjabis (UK) (N=100) %**
0	82
1	3
2	2
3+	9

Table 30. Where other relatives abroad live (N)

Relative living in:	**Punjabis (UK) N**
North America	2
South Asia	38
Africa	5

Table 31. Keeping in touch with relatives abroad

Keep in touch :	**Punjabis (UK) (N=57) %**
Yes	82
By:	
Letter	21
Phone	54
Sending gifts	0
Receiving gifts	0
Other means	0

Friends, Neighbours and Community Integration

Table 32. Frequency of contact with friends

Frequency of contact:	Punjabis (UK) (N=100) %
Every day	21
2-3 times a week	13
At least once a week	26
< weekly, but > monthly	7
Less Often	10
Never/no friends	22
Missing	1

Table 33. Number of friends named (up to five)

Number:	Punjabis (UK) (N=100) %
0	33
1	16
2	23
3	16
4	5
5	7

Table 34. Frequency of contact with neighbours

Frequency of contact:	Punjabis (UK) (N=100) %
Every day	13
2-3 times a week	9
At least once a week	19
< weekly, but > monthly	16
Less Often	24
Never/no neighbours	18
Missing	1

Table 35. Attendance at social or community meetings

Attend:	**Punjabis (UK) (N=100) %**
Never	30
Regularly[1]	39
Occasionally[2]	30
Missing	1

Table 36. Hours per day at home alone

Number of hours:	**Punjabis (UK) (N=100) %**
<3	59
3-5hrs 59mins	25
6-8hrs 59mins	5
>9	9
Missing	2

Table 37. Feels lonely

Frequency:	**Punjabis (UK) (N=100) %**
Never	12
Rarely	42
Sometimes	34
Often	8
Most of the time	1
Missing	3

[1] More than or equal to once a month
[2] Less than once a month

Religion

Table 38. Religion

Religion:	**Punjabis (UK) (N=100) %**
Sikh	87
Hindu	9
Muslim	2
Christian	1
Missing	1

Table 39. Attendance at religious meetings

Attend:	**Punjabis (UK) (N=100) %**
Never	5
Regularly	47
Occasionally	46
Missing	2

Table 40. Participation in religious events

Religious activity & frequency:	Punjabis (UK) (N=100) %		
	Individually	**With family**	**With community**
Prayer:			
Never	3	8	7
Regularly	43	37	37
Occasionally	45	43	42
Missing	9	12	14
Festival:			
Never	4	3	4
Regularly	39	38	37
Occasionally	49	48	45
Missing	8	11	14
Going to place of worship:			
Never	2	2	3
Regularly	43	39	38
Occasionally	47	45	43
Missing	8	86	16
Pilgrimage:			
Never	33	28	27
Regularly	13	11	12
Occasionally	48	46	46
Missing	6	15	15

Education and Language

Table 41. Length of time in full time education

Number of years:	**Punjabis (UK) (N=100) %**
None	39
1-5	11
6-10	19
11-15	8
16+	23

Table 42. Length of time in part time education

Number of years:	**Punjabis (UK) (N=100) %**
None	88
1-5	3
6-10	1
11-15	0
16+	1
Missing	7

Table 43. Language of schooling (for those who went to school)

Language:	**Punjabis (UK) (N=62) %**
More than one	23
English	18
Gujarati	2
Hindi	3
Punjabi	52
Urdu	3

Table 44. First language

Language:	**Punjabis (UK) (N=100) %**
More than one	1
Gujarati	1
Hindi	5
Punjabi	92
Urdu	1

Table 45. Spoken English

	Punjabis (UK) (N=100) %
Yes	54
Proficiency:	**(N=54) %**
Good	54
Fair	37
Poor	9

Table 46. Written English

	Punjabis (UK) (N=100) %
Yes	41
Proficiency:	**(N=41) %**
Good	63
Fair	29
Poor	7

Table 47. Reading English

	Punjabis (UK) (N=100) %
Yes	40
Proficiency:	**(N=40) %**
Good	63
Fair	33
Poor	5

Sources of Support and Help

Table 48. Support network distribution

Support network type:	Punjabis (UK) (N=100) %
Family dependent	39
Locally integrated	30
Local self-contained	8
Wider community focused	17
Private restricted	4
Inconclusive	2

Table 49. Relationship of confidant

Relationship:	Punjabis (UK) (N=100) %
No-one	15
More than one	5
Spouse	25
Son	15
Daughter	12
Daughter in law	2
Other relative	4
Friend or neighbour	21
Missing	1

Table 50. Relationship of person to whom respondent talks when unhappy

Relationship:	Punjabis (UK) (N=100) %
No-one	10
More than one	2
Spouse	28
Son	9
Daughter	13
Daughter in law	2
Other relative	5
Friend or neighbour	31

Table 51. Relationship of person who talks to respondent when they are unhappy

Relationship:	Punjabis (UK) (N=100) %
No-one	30
More than one	4
Spouse	20
Son	3
Daughter	6
Daughter in law	0
Other relative	3
Friend or neighbour	33
Missing	1

Table 52. Relationship of person who respondent talks to about personal problems

Relationship:	Punjabis (UK) (N=100) %
No-one	16
More than one	3
Spouse	29
Son	10
Daughter	11
Daughter in law	2
Other relative	3
Friend or neighbour	25
Professional	1

Table 53. Relationship of person who talks to respondent about personal problems

Relationship:	Punjabis (UK) (N=100) %
No-one	40
More than one	2
Spouse	13
Son	7
Daughter	4
Daughter in law	1
Other relative	2
Friend or neighbour	30
Missing	1

Table 54. Self assessed health

	Punjabis (UK) (N=100) %
Good or excellent	17
All right for age	41
Only fair	30
Poor	12

Table 55. Health problems

	Punjabis (UK) (N=100) %
Serious health problems:	
Yes	39
Limiting condition	
Yes	32

Table 56. Reported serious health conditions

Condition:	**Punjabis (UK) (N)**
Diabetes	14
Hypertension	13
Stroke	10
Arthritis	9
Angina	8
Coronary Heart Disease	4
Impaired vision	3
Back pain/sciatica	3
Pain (non-specific)	3
Kidney problems	2
Hip problems	2
Migraine	2
Depression	1
Asthma/breathing problems	1
Gout/foot problems	1
Alcoholic	1
Parkinson’s disease	1
Knee problems	1
Hearing impairment/deaf	1
Cancer	1
Anaemia	1

Table 57. Reported limiting condition (or activity)

Condition:	Punjabis (UK) (N)
Cannot walk/difficulty walking	12
Stroke/paralysis	7
Arthritis	5
Angina	2
Back pain/sciatica	2
Pain (non-specific)	2
Coronary Heart Disease	2
Getting up stairs/steps	1
In/out of bed	1
Asthma/breathlessness	1
Diabetes	1
Leg pain	1
Parkinson's	1

Table 58. Relationship of person who respondent needs to look after them

Relationship:	Punjabis (UK) (N=100) %
No-one	44
More than one	1
Spouse	37
Son	5
Daughter	8
Daughter in law	2
Other relative	1
Friend or neighbour	0
Professional	2

Table 59. Relationship of person who would look after respondent if ill

Relationship:	Punjabis (UK) (N=100) %
No-one	6
More than one	3
Spouse	35
Son	23
Daughter	14
Daughter in law	14
Other relative	4
Friend or neighbour	1

Table 60. Relationship of person who needs respondent to look after them

Relationship:	Punjabis (UK) (N=100) %
No-one	63
More than one	6
Spouse	28
Son	0
Daughter	2
Daughter in law	0
Other relative	1
Friend or neighbour	0

Table 61. Relationship of person who needs respondent to look after them when they are ill.

Relationship:	Punjabis (UK) (N=100) %
No-one	45
More than one	4
Spouse	45
Son	0
Daughter	3
Daughter in law	1
Other relative	1
Friend or neighbour	0
Missing	1

Table 62. Relationship of person who would accompany respondent to the doctors or hospital

Relationship:	Punjabis (UK) (N=100) %
No-one	6
More than one	6
Spouse	28
Son	37
Daughter	15
Daughter in law	2
Other relative	5
Friend or neighbour	1

Table 63. Relationship of person who respondent accompanies to doctors or hospital

Relationship:	Punjabis (UK) (N=100) %
No-one	58
More than one	3
Spouse	36
Son	1
Daughter	2
Daughter in law	0
Other relative	0
Friend or neighbour	0

Table 64. Relationship of person respondent would borrow from

Relationship:	Punjabis (UK) (N=100) %
No-one	71
More than one	1
Spouse	0
Son	6
Daughter	5
Daughter in law	0
Other relative	3
Friend or neighbour	14

Table 65. Relationship of person who borrows from respondent

Relationship:	Punjabis (UK) (N=100) %
No-one	84
More than one	1
Spouse	0
Son	0
Daughter	0
Daughter in law	0
Other relative	2
Friend or neighbour	13

Table 66. Relationship of person who goes shopping for respondent

Relationship:	Punjabis (UK) (N=100) %
No-one	35
More than one	1
Spouse	24
Son	8
Daughter	15
Daughter in law	14
Other relative	0
Friend or neighbour	0
Professional	3

Table 67. Relationship of person who respondent shops for

Relationship:	Punjabis (UK) (N=100) %
No-one	77
More than one	5
Spouse	17
Son	0
Daughter	1
Daughter in law	0
Other relative	0
Friend or neighbour	0

Table 68. Relationship of person who cooks for respondent

Relationship:	Punjabis (UK) (N=100) %
No-one	38
More than one	1
Spouse	33
Son	0
Daughter	7
Daughter in law	17
Other relative	1
Friend or neighbour	0
Professional	2
Missing	1

Table 69. Relationship of person who respondent cooks for

Relationship:	Punjabis (UK) (N=100) %
No-one	71
More than one	8
Spouse	15
Son	0
Daughter	3
Daughter in law	3
Other relative	0
Friend or neighbour	0

Table 70. Relationship of person who does laundry for respondent

Relationship:	Punjabis (UK) (N=100) %
No-one	50
More than one	0
Spouse	28
Son	0
Daughter	8
Daughter in law	11
Other relative	2
Friend or neighbour	0
Professional	1

Table 71. Relationship of person who respondent does laundry for

Relationship:	Punjabis (UK) (N=100) %
No-one	80
More than one	5
Spouse	15
Son	0
Daughter	0
Daughter in law	0
Other relative	0
Friend or neighbour	0

Table 72. Relationship of person who helps respondent with household chores

Relationship:	Punjabis (UK) (N=100) %
No-one	52
More than one	5
Spouse	17
Son	5
Daughter	6
Daughter in law	9
Other relative	1
Friend or neighbour	0
Professional	4
Missing	1

Table 73. Relationship of person who respondent helps with household chores

Relationship:	Punjabis (UK) (N=100) %
No-one	85
More than one	1
Spouse	6
Son	1
Daughter	2
Daughter in law	4
Other relative	0
Friend or neighbour	0
Professional	0
Missing	1

Income

Table 74. Currently working for money and average hours worked per week (for those still working)

Relationship:	**Punjabis (UK) (N=100) %**
Yes	12
	N=11
Mean number of hours per week	36.7 (s.d. 11.8)

Table 75. ISCO-88 major occupational groups and skill levels

	Major group	**ISCO skill level**
1	Legislators, senior official and managers	
2	Professionals	4th
3	Technicians and associate professionals	3rd
4	Clerks	2nd
5	Service workers and shop and market sales workers	2nd
6	Skilled agricultural and fishery workers	2nd
7	Craft and related workers	2nd
8	Plant and machine operators and assemblers	2nd
9	Elementary occupations	1st
0	Armed forces	

Table 76. Major occupational groups

ISCO major group:	**Punjabis (UK) household (N=100) %**	**Punjabi men (N=49)**	**Punjabi women (N=51)**
1	14	5	3
2	18	10	4
3	0	-	-
4	0	-	-
5	6	2	10
6	0	-	-
7	34	22	2
8	30	35	16
9	6	8	60
0	2	1	0
Significance level of Pearson Chi Square		P<.001	

Table 77. Skill levels

ISCO major group:	Punjabis (UK) household (N=84) %	Punjabi men (N=43)	Punjabi women (N=48)
1	7	9	63
2	71	67	29
3	0	-	-
4	21	23	8
Significance level of Pearson Chi Square		P<.001	

Table 78. Sources of income

	Punjabis (UK) (N=100)	
Source of income:	**% Yes**	**% Missing**
Work	9	21
Spouse's work	2	21
Business	0	22
Children residing in home	2	21
Children elsewhere	0	22
Other relatives	1	22
Other agency[3]	2	22
Former (spouses) employer	20	21
Savings, investments etc.	21	22
State old age pension	56	17
State supplementary pension	14	21
Attendance allowance	2	23
Housing benefit	5	23
Rent or council tax reductions	3	23
Other source	17	18

[3] Not including retirement benefits

Table 79. Relationship of person who respondent would ask for financial advice for all ethnic groups in the UK.

Relationship:	Punjabis (UK) (N=100) %
No-one	38
More than one	1
Spouse	10
Son	31
Daughter	11
Daughter in law	1
Other relative	3
Friend or neighbour	5
Professional	0

Death and Dying

Table 80. Written a will

	Punjabis (UK) (N=100) %
No	73
Yes	27

Table 81. Place of death for the last (or recent) death of someone in family living in Birmingham

	Punjabis (UK) (N=100) %
In their home	24
At the home of a family member	1
Hospital	20
Somewhere else	2
Missing	53

Table 82. Relationship and gender of person who arranged the funeral

Relationship:	**Punjabis (UK) (N=100) %**
More than one	2
Spouse	12
Son	19
Daughter	2
Other relative	10
Professional	2
Gender:	
Male	41
Female	4
More than one	2
Missing	53

Table 83. Difference in funeral ritual from childhood

	Punjabis (UK) (N=100) %
No	33
Yes	26
Missing	41