Families and Migration: Older People from South Asia
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Older Gujarat Immigrants in Birmingham, UK

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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 Gujaratis 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 Gujaratis 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 larger 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.

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 heavily on the City template "Birmingham" by Romain Garbaye, prepared for the MPMC Project. This is hereby acknowledged.)* The city has a population of 977,087 (Census 2001), is the second largest city in the United Kingdom and lies in the middle of the Metropolitan Area of

the West Midlands. The 2001 Census shows that 43% of the population in the city centre is of minority ethnic background (http://www.grad.ch/bham.html).

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). Today people from ethnic minorities form just over one fifth of Birmingham's population. Immigrants from India came mostly during the 1960s and 1970s. The numbers of Indians in Birmingham increased ten-fold from 1951-1971 (0.2% to 2.02%) (Ratcliffe 1979). Local statistics do not distinguish between Gujaratis and Punjabis but count these together as Indians, making the distinction only between Indians, Pakistanis and Bangladeshis. Indians make up 5.3% of the total population. By 1991 there were nearly twice as many 'Asians' as 'Blacks' in Birmingham. Ethnic minorities comprised 21.5% of Birmingham's population, but 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 the 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 Gujaratis

Emigration from Gujarat to Africa had been well-established for over a century. By the end of the 19th century, Gujarat had had two thousand years of trading experience in Africa (Coupland 1939, Morris 1968). This was supplemented during the period 1896 to 1901 when the British recruited Indian labourers (predominantly Gujaratis and Punjabis) to build the railways in Kenya and Uganda. The South Asian community in Africa expanded due to the natural growth of the original families and

the migration of friends and relatives to the same area to fill the gap in the African market for certain trades and skills (Morris 1968).

The economic success of the Asians in East Africa prompted restrictions on trading for immigrants. The 'Africanisation' of labour in these countries drove many Asians to leave. Many Gujaratis, who constituted 70 percent of the Asian population in East Africa, sought to settle in the UK (Kalka 1990). A further wave of emigration ensued in 1972 when President Amin's government expelled Asians from Uganda (Kalka 1990).

The Gujaratis from East Africa, in many cases, had been absent from their homeland for over sixty years and had fewer ties with their country of origin than other South Asian immigrants to the UK had. The East African Gujarat migrants often arrived in Britain in family units often consisting of three generations, and in many cases had substantial capital (Bhachu 1986). They have remained cultural traditionalists (Bhachu 1986). These migrants have geographically dispersed settlement patterns, and unlike earlier migrants have tended to be employed in administrative work and professional occupations as well as in factories (Bhachu 1986).

The most prominent caste associated with migration from Gujarat is the 'Patels' or 'Pattidars', the majority of whom are farmers and belong to affluent families. The 'Patels' are a close-knit community, where if one member emigrates others are in line to follow. The 'Patels' are very enterprising and tend to quickly find jobs abroad. The next most numerous migrating group from Gujarat is the 'Shahs', a business class. The main destinations of migrants from Gujarat are the UK or the USA. Few people from the lower socio-economic classes or castes manage to emigrate. When they do, their destination is usually East Africa.

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 minority 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.

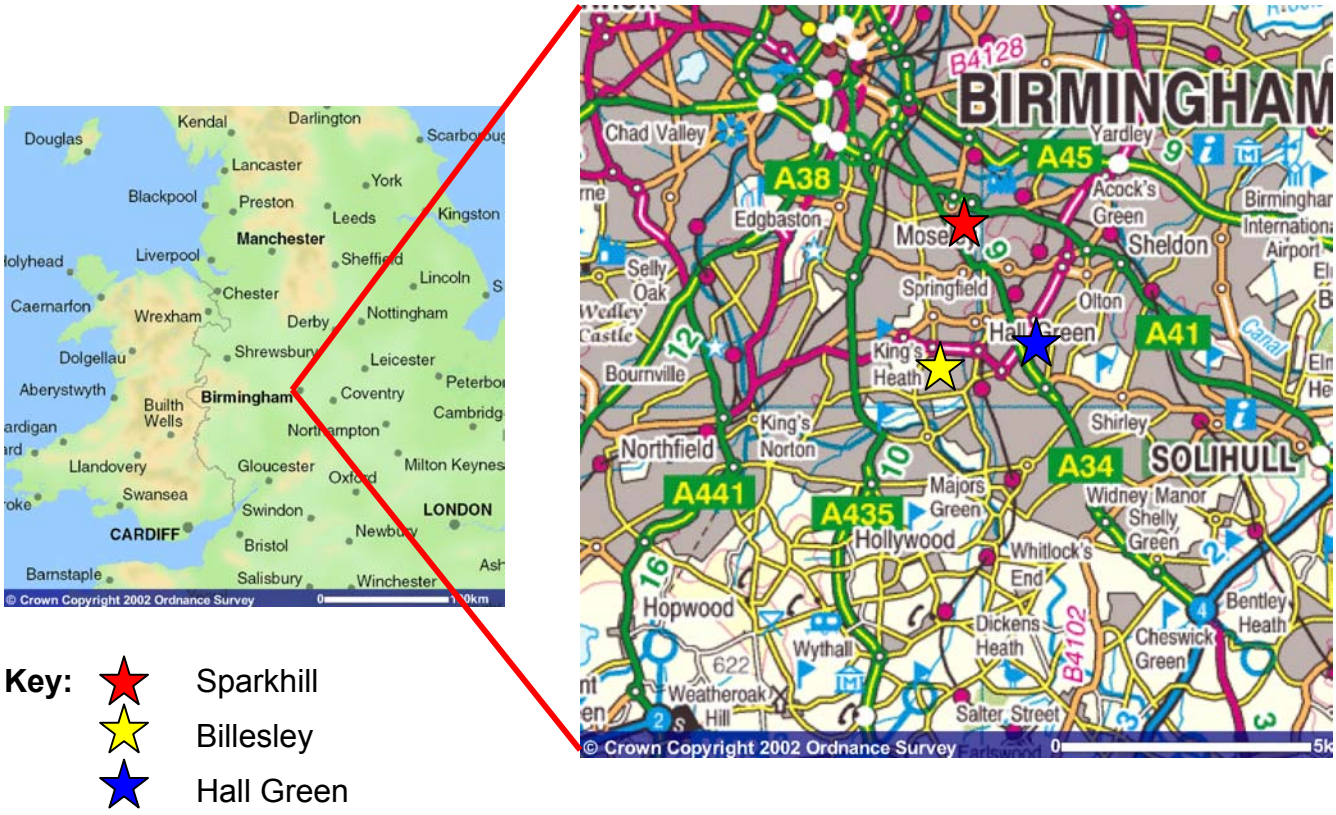
In this study we found that the Gujarati elders lived mainly in the southeast of the city in Sparkhill, Hall Green and Billesley. Sparkhill is situated approximately 4 kilometres south-east of the City Centre and is a typical inner city area (Birmingham City Council 2002). It is an inner city ward of mainly older owner occupier and privately rented terraced housing and a significant amount of housing association accommodation. The population consists mainly of minority ethnic groups, who live in a deprived district characterised by high unemployment and poor quality environment. The area has been granted £30 million of UK and EU funds for urban regeneration (Birmingham City Council 2002). The resident population of Sparkhill in mid 1998 was 29800 people. Over one-tenth (12%) were aged 60 and over (National Statistics Online 2002a).

Hall Green is situated on the southeast boundary of the City approximately 7 kilometres south-east of the City Centre. It is a suburban ward of mainly inter-war owner-occupied family housing. It has a predominantly white population with a slightly older age profile than the City as a whole. The resident population of Hall Green in mid 1998 was 26200 people. Over one-fifth (21%) were aged 60 and over (National Statistics Online 2002b).

Billesley is also situated on the southern boundary of the City, approximately 7 kilometres south of the City Centre. It has a similar profile to Hall Green, that is a suburban ward of mainly inter-war and post-war family housing with a predominantly

white population. The resident population of Billesley in mid 1998 was 27600 people. Over a fifth (21%) were aged 60 and over (National Statistics Online 2002c).

Figure 2. Maps of Birmingham showing areas of Gujarati Settlement



Key: Sparkhill
Billesley
Hall Green

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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 greengrocery 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. Bank, catering for Gujarati customers in Birmingham

Figure 4. Greengrocers, catering for Asian customers in Birmingham

Figure 5. Sari shop, 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, including: the Asian Hindu Cultural Association, Birmingham Pragati Mandal (Krishna Temple) and the Gujarati Hindu Association. Most Gujaratis are Hindus (82%). The city has a Hindu temple and Gujaratis arrange funerals according to their religious beliefs. However, while there are several funeral directors who arrange funeral rites for Muslims, there is only one that attends to the needs of Hindus, Buddhists and Sikhs.

Figure 6. Birmingham Mandir for Hindus

Figure 7. Shakti day centre

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 which 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 and culturally sensitive meals on wheels tailored to specific dietary and religious requirements, which are delivered to impaired older people in their homes.

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 services 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 organisation 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 1999). It has been noted that voluntary agencies that 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 8. Shakti day centre provides meals for day centre clients and meals on wheels for Gujaratis and other South Asians in the community

Figure 9. Shakti day centre provides exercise classes for older Gujaratis (and other South Asians)

Health care is provided by the National Health Service, which provides neighbourhood 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.

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 minority 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 sending communities in Gujarat. 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.

Family Structures

As noted above, earlier research conducted in the United Kingdom has often focused on 'Asians' 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 member.

For those emigrants who do not speak English, dependency on the family is likely to be intensified. This is particularly true for older women. The evidence of community surveys seems to support the idea of a resilient Asian extended family or of joint family households, which include older members. Earlier research showed that in Birmingham 61% of 'Asians' lived 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). Such differences may result from sampling procedures which did not distinguish between different ethnic groups.

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 (Atkins & Rollings 1993).

METHODOLOGY

This regional report on Gujaratis in Birmingham covers one sample from the larger study. The larger study also includes samples of Punjabis 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 (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 the 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 proportions 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 Gujarati by one translator and then translated back into English by a second translator. Disagreements were then discussed and best forms negotiated and agreed. Although Gujarati questionnaires were available in the UK, only one of the UK interviewers could read Gujarati script. In order to overcome this difficulty, Gujarati interviewers translated the questionnaire from English into Gujarati (or Hindi) 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 Gujarati sample was 103: 50 males and 53 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 Gujaratis in Birmingham. In this report, the data are discussed in the text and tables giving all figures are presented in the Appendix.

Age Distribution

Forty-five percent of the sample was under 65 years of age (Table 2). Over one-fifth (23%) of Gujarati women were below retirement age (<60) and 42% of Gujarati men were under retirement age (<65). Thirty-six percent of all Gujaratis were over 70. The average age was 66.5 (s.d. 8.1). 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 Gujaratis in the population of Birmingham.

Marital Status

Compared with the indigenous population of the United Kingdom, very few Gujaratis (3%) never married (Table 3). Figures for divorce and marital separation (10%) are also low. More than half (54%) were still married and one-third (33%) were widowed. There were significant differences between genders in marital status (level of significance for Pearson Chi Square test $p<.05$). More men than women were currently married (72% vs. 38%) and conversely more women than men were widowed (49% vs. 16%).

The data for the current or last marriage[1] showed that almost half of Gujaratis got married between the ages of 20 and 29 (48%) (Table 4). Over one-third (37%) married between the ages of 16 and 19. A small proportion of the sample (8%) married under the age of 15. On average the duration of marriages was 38.4 years

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

(s.d. 15.8) (Table 5). However, those people who were still married had been married for longer (mean 44.7 years, s.d. 9.5) than those people who were widowed (mean 35.4 years, s.d. 15.4). Overall, men were on average older than women when they were married (mean 23.8, s.d. 8.4, vs. 18.6, s.d. 7.3). In addition, men had been married longer than women (mean 39.3 years, s.d. 15.4, vs. 37.6 years, s.d. 16.2).

Migration History

Only 37% of Gujaratis lived in India before moving to the UK. Over half (55%) lived in Africa prior to the move, with over one-quarter (28%) coming from Kenya and one-tenth (10%) from Uganda. There were no significant differences between the genders in the country of residence before emigration to the UK. Although not statistically significant, it is probably worth noting that a larger proportion of Gujarati men than women moved to the UK from South Africa (17% vs. 0%).

A majority of Gujaratis (42%) moved to the UK between the ages of 20 and 39 (Table 6). However, nearly one-quarter (24%) were aged between 40 and 49 when they moved. One-tenth of Gujaratis (12%) migrated to the UK when they were over 60 years of age. There were no significant gender differences in the age of move to the UK.

Nearly half (46%) of the Gujarati sample arrived in the UK in the 1970s (Table 7). One-third arrived in the UK in the 1960s (33%). Consequently when the length of stay in the UK is examined it is not surprising to find that on average the Gujarati sample had lived in the UK for 29.1 years. Looking at length of stay in 10-year bands shows that over two-fifths (42%) of Gujaratis had lived in the UK between 31 and 40 years and over one-third (36%) had lived in the UK for over 21-30 years (Table 8).

Table 9 shows a summary of the top four reasons for moving to the UK. The most frequently cited reason for moving to the UK given by one-quarter (24%) of the Gujarati sample was the political Africanisation of labour. A further one-fifth (21%) of Gujaratis noted that they moved to the UK to resettle, or that they needed a change. Seventeen of the twenty Gujaratis who responded that they moved to resettle, or

because they needed a change were living in an African country prior to coming to the UK[2]. It appears that for Gujaratis 'need a change' or 'resettle' may have been a euphemism for being compelled to leave Africa. This is also borne out in the language used in the literature describing the exodus of Indians from Africa, which suggests that "for many Asians the major tie to Britain was merely a formal one: the passport which gave them the right to settle" (Kalka 1990). Taking this into account, 42% of the older Gujaratis in this sample may have come to the UK because of political pressures in African countries. Respondents also moved for economic reasons or for work (19%), to live with or near a relative (18%), or for other reasons (19%).

There were significant differences between genders in the reasons given for moving to the UK (level of significance for Pearson Chi Square test $p<.05$). Gujarati men were more likely than women to give political motives for moving (32% vs. 17%). As noted above, 'need a change' or 'resettle' may have been a euphemism for being compelled to leave Africa, but this terminology also seems that have a gender dimension as Gujarati women were more likely than men to give this reason (29% vs. 11%). More Gujarati men than women stated that they came to the UK for economic reasons (30% vs. 10%) and more women than men came to live with or near a relative (23% vs. 11%). Over two-thirds of the women that moved to the UK to live in the proximity of family members were widowed. As more Gujarati women than men were widowed (49% vs. 16%) one could assume that there were fewer Gujarati men who outlived their wives and needed to move to the UK to the proximity of their family for support. Gujarati men would therefore be less likely to give this as a reason for relocation.

Over four-fifths of Gujaratis in this sample settled in the West Midlands when they arrived in the UK (86%) (Table 10). Only 4% lived in Greater London and a further 3% lived in Lancashire on arrival. Very few (14%) made one or more moves after arriving in the UK (Table 11).

[2] In one instance this was 2 years prior to coming to UK (via India).

Living Arrangements

More than half the Gujaratis lived either alone (26%) or with their spouse only (30%) (Table 12). The rest (42%) lived in multi-generational households with members of younger generations. Modal household size was 2 (37%), and mean size was 2.69 (s.d. 1.8). However, 17% of Gujaratis lived in households of 5 or more and 37% in households of 3 or more people.

The figures for Gujaratis living alone are different from those produced by analysis of the General Household Survey (GHS). The GHS shows that only 9% of Indians over the age of 60 lived alone (Evandrou 2000b). In addition, the mean household size for Gujaratis is more similar to the white population average household size (2.43) than the Indian household size (3.8) which was extrapolated from the 1991 Census data (Owen 1993). Taking into account regional differences only makes the distinction more marked. In 1991 the average size of Indian households in the West Midlands was 4.2 and for white households was 2.5 (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 Gujaratis (70%) had been in their current house for more than 11 years (Table 13). Over one-quarter (27%) of the sample had been in the current residence for between 11 and 20 years and a further quarter (26%) of the sample had been in their current house between 21 and 30 years. This pattern is reflected in the age that the respondents came to the current house. Although over one-quarter (27%) of the sample were between 20 and 39 years old, a majority (41%) were between the ages of 40 and 59 (Table 14).

Half of the Gujaratis in the sample were home-owners (Table 15). One-fifth (22%) lived in their child's home, and a further fifth (21%) lived in rented accommodation. The levels of home ownership for Gujaratis in this study were lower than for the

levels for Indians in the GHS and the 1991 Census (50% vs. 84%[3] & 82%) (Owen 1993, Evandrou 2000b). Conversely, the level of people living in rented accommodation was higher for Gujaratis than for Indians in the GHS (21% vs. 11%) and closer to the levels stated for Indians in the 1991 Census (21% vs. 17%) (Owen 1993, Evandrou 2000b). This may reflect distinctions in tenure between Indian Punjabis and Gujaratis which is hidden in the GHS and Census data.

Children

Older Gujaratis typically had larger families of procreation than the indigenous population (T able 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 child-bearing age. This is the lowest post-war TFR (with the exception of 1977) (Williams 1999). One-third of Gujaratis (33%) had 5 or more children. The mean number of children was 3.33 (s.d. 2.0) and the modal Gujaratis family had 5 children. However, thirteen percent were childless.

For nearly half (49%) of the Gujarati sample the nearest child lived in the same household or within a mile (Table 17). If the radius is increased, 76% of Gujaratis in Birmingham had a child living within 5 miles. Over two-thirds (71%) had daily contact with a child (Table 18). A further one-fifth (20%) saw a child at least weekly. Only 6% saw children less frequently than weekly with 2% never seeing a child.

Although many of the respondents' children were living in the UK, a minority had children living outside the UK. Nearly one-third (31%) of Gujaratis had children living in another country, representing 51 children (Table 19). For two respondents their nearest child lived abroad. Most children living abroad were residing in North America (N=16) (Table 20). There were also children in Australia and New Zealand (N=11) and Africa (N=9). Fewer children lived in South Asia (N=6) or other areas of Europe (N=6).

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

Although it might be expected that the children residing in South Asia would be daughters who had married, analysis of the data showed that nearly all of the children living in South Asia were sons (N=5). As might be expected, an overwhelming majority of parents (96%) kept in touch with their children. Contact was maintained by letter in 37% of the relationships; however, a far more popular method of keeping in touch was by telephone. Contact was maintained between parents and children by phone in 88% of relationships. The importance of the telephone is not surprising given the low levels of education and literacy (see below).

Sending gifts and receiving gifts from children was clearly an important means maintaining contact for nearly three-tenths of the Gujarati sample (29%). Gift exchange has been used to explain the reproduction of immigrants' cultural identity in Britain, whilst also maintaining links between the sending and receiving countries (Werbner 1990).

Respondents with children living abroad were asked whether they sent regular remittances to at least one child. No Gujaratis sent remittances to children abroad. However, three Gujaratis received remittances averaging £200 a month, which were spent on household maintenance.

Siblings

Relationships were examined for Gujarati siblings. Almost one-third had no living siblings (31%), on the other hand nearly one-third (30%) had four or more siblings (Table 22). Excluding those respondents without siblings the modal number of siblings was 2 or 3 (28%).

Nearly one-third of the Gujaratis (30%) had a sibling living within 5 miles (Table 23). On the other hand, for over one-fifth (21%) of the sample the 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 afield. Only 11% saw a sibling daily (Table 24). However, a further one-third (34%) of the sample saw a sibling at least weekly. Only 6% of the sample saw *children* less frequently

than weekly, however, this appears to be the norm for contact with siblings as half of the sample (50%) saw a sibling less frequently than weekly.

The respondents were more likely to have siblings than children living abroad (Table 25). Two-fifths of the Gujarati sample had siblings abroad (41%). The respondents' siblings lived in South Asia (N=55), Africa (N=19), North America (N=11) and South East Asia (N=11) (Table 26).

A large majority of Gujaratis with siblings abroad (92%) kept in contact (Table 27). Around two-fifths of relationships between siblings were maintained by letter (44%) and a further four-fifths by telephone (82%). Once again the importance of the telephone in maintaining relationships is highlighted. Around one-tenth sent gifts to siblings (11%) and received gifts from siblings (13%). Only one of the Gujarati respondents sent remittances to a sibling abroad and one received remittances from siblings.

Relatives

A majority of Gujaratis saw a relative[4] daily (60%) and a further 16% saw an 'other' relative at least weekly (Table 28). Nearly one-tenth of the sample never saw a relative, or did not have any relative (9%).

Other than children or siblings, 17% of respondents also had other relatives living abroad (Table 29). Most other relatives lived in South Asia (N=15) (Table 30). In addition some relatives also lived in Africa (N=10), the Middle East (N=8) and North America (N=6). Over nine-tenths (96%) of Gujaratis with relatives abroad kept in contact (Table 31). Two-fifths (42%) maintained contact through letter writing, but 70% kept in contact through telephone calls. 17% sent gifts to relatives abroad and 13% received gifts. Among those with relatives abroad, only one sent remittances. No respondents received remittances from 'other' relatives.

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

Of those respondents with *any* relative[5] living abroad, only 3% of Gujaratis, were sending remittances, which averaged £60 a month. Remittances were received by only those 3 parents mentioned above who received an average of £200 a month from children. The sending and receiving of remittances was clearly not typical among the Gujaratis in Birmingham.

Friends, neighbours and community integration

In addition to maintaining relationships between kin, Gujaratis kept in contact with friends. Nearly two-thirds of the sample (61%) saw friends at least weekly, with one-fifth (20%) noting that they saw their friends daily (Table 32). However, nearly one-quarter of the sample (24%) never saw any friend, or did not have any friends.

Respondents were asked to give the names of up to five friends. Although one third of Gujaratis did not name a friend, 18% named one or two friends, one quarter (24%) could name three or four friends and a further one-quarter (25%) named five friends (Table 33). In addition, thirty percent of Gujaratis 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 more frequent than contact with friends. Although a similar proportion of Gujaratis saw neighbours at least weekly (62%), over one third (34%) saw neighbours daily (Table 34). However, over one-quarter (27%) of Gujaratis did not have any contact with neighbours.

Many of the Gujarati sample also attended social or community meetings (Table 35). Nearly half of the respondents (49%) said that they attended such meetings regularly, that is at least once a month. A further three-tenths (30%) attended meetings occasionally, and one fifth (20%) of Gujaratis interviewed never attended any social or community meetings.

[5] In this instance any relative is a child, sibling or other relative.

A majority of Gujaratis in our sample said that they were rarely alone (Table 36). Around one-half (49%) said they were in the house alone for less than three hours a day. One-fifth of the sample (19%) was only alone for between three and six hours. However, one quarter of the Gujaratis studied was alone for over six hours (27%), this included 16% who were alone for over nine hours. There were significantly more Gujaratis who said they were lonely often, or most of the time spending over nine hours in the home alone (level of significance for Pearson Chi Square test $p<.01$) (Table 37). Conversely over three quarters (76%) of Gujaratis who were in their home alone for less than three hours stated that they were never or rarely lonely.

Religion

Gujaratis are mostly Hindu; 91% of the Birmingham sample stated that they were Hindus (Table 38). Other religions followed by Gujaratis were Jainism (3%), Sikhism (3%), Islam (2%) and Christianity (1%). As Gujaratis are predominantly Hindu access to Mandirs or Ashrams in Birmingham is important. The first formal Hindu temple in Britain opened in Leicester in 1969 (Vertovec 1992). The largest concentration of Hindu mandirs can be found in Greater London (just under 30 per cent). However, between 15 and 20% of Mandirs in England and Wales can be found in the West Midlands (Birmingham), the East Midlands (Leicester) and the North West Manchester) (Peach 2000). The recent Leverhulme survey of Hindu, Muslim and Sikh officially recognised places of worship in England and Wales, lists six places of worship for Hindus in Birmingham. 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 4,559 Hindus per recognised temple in the UK.

Although there are relatively few places to worship in Birmingham nearly one half (48%) of the Gujaratis interviewed said that they attended religious meetings regularly, that is once a month or more (Table 39). A further 41% said that they attended such meetings occasionally. Less than one-tenth (9%) of Gujaratis said that they never attended religious meetings.

Over half of the Gujaratis interviewed said that they would visit places of worship on their own (58%) and just under one half said that they would visit with family members (46%) (Table 40). Although one-fifth noted that they would visit a mandir with members of the community (22%) over three-quarters of the sample did not answer this question. A greater proportion of the sample engaged in prayer; three-quarters (76%) said that they prayed on their own, one-third (33%) prayed with family members and nearly one-quarter (23%) prayed with other members of the community. The latter two findings should be treated with caution as over half of the sample of Gujaratis did not answer the questions (56% and 68% respectively).

Texts called *Puranas* describe numerous sacred places and the merit gained by undertaking pilgrimages to these sites. In particular, bathing at such sites is especially meritorious. The Library of Congress (Heitzman & Worden 1995) country studies note that there has been an increase in the numbers of pilgrims visiting sacred sites since the expansion of public transport in the twentieth century. It has been noted that pilgrimage is the preferred form of tourism for many Indians.

For Hindus, one of the most significant sites for pilgrimage is Varanasi (also known as Banaras, Benares, or Kashi) in southeastern Uttar Pradesh on the north bank of the Ganges. In addition, Hardwar, on the banks of the Ganges in the foothills of the Himalayas (Uttar Pradesh) is also a popular destination for pilgrims and ritual bathing. Other sacred sites in the Himalayas, include Badrinath and Kedarnath, and in southern India, the rivers Kaveri, Krishna, and Godavari and the Ramalingesvara Temple in Ramesvaram (Tamil Nadu), also attract pilgrims. In Maharashtra, Western India, Pandharpur is the site of an incarnation of Vishnu which attracts thousands of devotees of Vitthala (Heitzman & Worden 1995).

Although pilgrimages are clearly important to Hindus, fewer Gujaratis went on pilgrimages than prayed or attended religious meetings. One half (52%) said they never went on pilgrimages alone. However, over around one-fifth of the sample said that they would participate in a pilgrimage on their own (20%), one-quarter said they would undertake a pilgrimage with family (24%) and fewer said that they would go with members of the community (6%). The importance of travelling with family

members is highlighted elsewhere, as it is noted that the process of pilgrimage often involves cooperative efforts among different families and groups (Heitzman & Worden 1995). As with the previous data for participation in religious events, the latter two findings should be treated with caution as due to a high proportion of missing data (48% and 79% respectively).

Hindu festivals are celebrated throughout the year. For example, Makar Sankranti (January); Shiv Ratri (February/March); Holi (the arrival of spring); Rama Navami (April); Raksha Bandhan (August); Janamashtami (August) Ganesh Chaturthi (September); Navrati (October); Karva Chauth (October) Diwali (November) and Best Varash (November) (Shap 2003). This is reflected in the findings in this study, in which less than 3% of the sample said they never attended festivals with members of the community.

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 only 7% of older Gujaratis had not had any full time education (Table 41). However, a further two-fifths (40%) had had less than five years education and nearly one-quarter between six and ten years of education. In total nearly two-thirds (64%) of Gujaratis had less than ten years education. Over one-quarter of Gujaratis had between eleven and fifteen years of education, and 8% had been in full time education for over sixteen years. Very few had been engaged in any part time education (2%) (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 Gujarati was their first language (99%) (Table 44). Most of those who went to school were educated in Gujarati (52%) (Table 43). However, nearly one quarter

(22%) 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 Gujarati. The proportion of Gujaratis taught in English demonstrates the influence that the British had on the schooling system in India and East Africa.

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 nearly 25% of their minority sample spoke no English (Luck et al. 1991). In the sample for this study one-third (33%) of Gujaratis could not speak English (Table 45). Of those who could, only 37% considered that their proficiency at spoken English was good. Although fewer women than men could speak English (56% vs. 76%) the differences were not statistically significant.

Fewer Gujaratis could write English (45%) 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 63% of respondents who were taught in English and 74% of people taught in more than one language could write in English. The proportion of Gujaratis able to write English is significantly greater for those taught in English or more than one language than for Gujaratis taught in other languages (level of significance for Pearson Chi Square tests $p<.001$). Only 50% of these respondents considered that their standard of

written English was good. There were no significant differences between men and women in the ability to write English.

Just over half of the sample of Gujaratis could read English (52%) (Table 47). Analysis demonstrated that only 74% of respondents who were taught in English and 87% of people taught in more than one language could read English. The level of Gujaratis able to read English is significantly greater for those taught in English or more than one language than for Gujaratis taught in other languages (level of significance for Pearson Chi Square tests $p<.001$). Nearly half (49%) of this group considered that they were good at reading the language. There were no differences between genders in the ability to read English.

Sources of Support and Help

In this section we are interested in the sources of informal help and support available to older Gujarati immigrants 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, we discuss the informal support networks available.

Support Networks

Support networks were measured and support network type identified using the Wenger Support Network Typology (Wenger 1991). This typology, based on qualitative and quantitative research conducted in the UK and subsequently tested in Bangladesh (Burholt et. al 2000) and China (Wenger and Liu 1999, 2000), as well as other European countries, identifies 5 types of support networks 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 most 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)

More than three-quarters of the Gujarati sample had family dependent (38%) or locally integrated support (38%) networks (Table 48). These are the two network types that have been identified as providing the highest levels of informal care. We would expect, therefore, that high proportions will be found to receive most informal help and support from family members or friends and neighbours. However, 25%

had less supportive types of networks and we may expect to find that for this minority, support may be problematic.

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).

A sizeable minority said that there is no one or that they do not confide. There is a significant difference between the network types and having someone to confide in (level of significance for Pearson Chi Square test $p<.01$): 77% of Gujaratis with private restricted network types did not have a confidant, on the other hand, 90% of those with locally integrated network type did have a confidant. In other words, those with more robust types of support network are more likely to have a confidant.

Among those who named a confidant the four most frequently mentioned relationship categories are: spouse (16%), son (15%), daughter (13%) and friend or neighbour (11%). Almost one in ten (9%) said that there was more than one person in whom they could confide. The older Gujaratis appear to confide primarily in members of the immediate family. There were no significant differences between men and women.

Person to talk to when Unhappy

Respondents were asked to whom they talked if they felt unhappy (Table 50). Again a substantial minority (28%) said that they spoke to no one. This reflects the findings on the availability or use of confidants. Of those who did mention someone that they would talk to, the most likely person was a friend or neighbour (21%), on the other hand, 16% said that there was more than one person that they could talk to. There were no significant differences between men and women.

Respondents were also asked if anyone came to talk to them when they were unhappy (Table 51). Nearly half (47%) of the Gujaratis said that no-one came to talk to them when they were unhappy. However, nearly one-quarter (24%) said that friends and neighbours came to talk to them if they were unhappy and a further 15% had more than one person come to talk to them when they were sad. There were no significant differences between men and women.

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), but one-quarter (24%) of Gujaratis were unlikely to talk to anyone. The most likely persons to talk to about personal problems were sons (18%), spouses (14%) or daughters (13%).

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. Women were more likely than men to talk to more than one person (16% vs. 4%) or to talk to a son or daughter (42% vs. 21%). On the other hand men were more reliant on spouses than women with 16% talking to their wives about personal problems compared to only 4% of women who would discuss problems with their husbands.

Respondents were also asked if people came to talk to them about personal problems (Table 53). Over one-half (52%) of Gujaratis said that no one talked to them about these issues. Although friends and neighbours do not figure in the people that the respondents would talk to about personal problems, 15% of respondents said that friends would come to talk to them about their personal problems. There were no statistically significant differences between the genders.

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 or being old may be associated with privileges not available to younger people. 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)

At an initial glance this would certainly seem to be the case among the Gujaratis. Although women were more likely than men to say that their health was only fair (49% vs. 16%) when categories of response were collapsed to look at good/excellent or all right for age versus only fair or poor, there were no significant difference in self-assessed health between genders. Overall, only 7% of Gujaratis stated that their health was good or excellent. A third felt it was all right for their age (32%), but three-fifths (61%) felt their health was only fair (33%) or poor (28%). The level of self-assessed poor health is similar to the levels reported in the GHS which shows that 34% of Indians consider that their health is 'not good' (Evandrou 2000a). Elsewhere it has also been demonstrated that age-adjusted prevalence of bad or very bad health for Indian men and women were significantly higher than those of the general population (Erens et al. 2001).

South Asian people have different patterns of mortality and morbidity from the white population in the UK (Marmot et al. 1984, Balajaran & Bulusa1990). Mortality and morbidity are compounded by differences in lifestyles such as diet and socio-economic factors (influenced by racial disadvantage) which may lead to poor educational achievement, unemployment, poverty and poor housing (Daniel 1968,

Smith 1977, DHSS 1980, Townsend & Davidson 1982, Brown 1984, Nazroo 1997a, Beishon & Nazroo 1997, Modood et al. 1997, Acheson 1998, Gordon et al. 1999, Social Exclusion Unit 2000, Evandrou 2000a). Consequently, **the** findings from the current study show that the levels of self-assessed 'poor' health for Gujaratis are higher than for the levels of 'not good' health reported by the white population in the GHS (22%) (Evandrou 2000a).

Our findings suggest that self-assessed health may be based on people's perceptions about the complaints that they suffer from. For example, 70% of the sample said that they had a serious health problem (Table 55). Proportionally more women stated that they had a serious health problem than men (85% vs. 54%) (level of significance for Pearson Chi Square test $p<.001$). In addition, two fifths (62%) said that they had a health condition which limited their activities in some way. There were no differences between men and women in reporting limiting illnesses. It should be noted that the level of limiting illness reported in this study for *Gujaratis*, is much higher than reported in the GHS for *Indians* (20%) (Evandrou 2000a).

The levels of impairment in this study go some way to explaining the high levels of self-assessed poor health. For example, 70% of the sample said that they had a serious health problem, however fewer (28%) reported poor health (Table 55). Over nine-tenths (91%) of those people who reported that their health was only fair or poor had a serious health problem (level of significance for Pearson Chi Square test $p<.001$).

Nearly two-thirds (62%) of Gujaratis said that they had a health condition that limited their activities in some way. There were significant differences between Gujaratis with a limiting health condition and levels of self-assessed health (level of significance for Pearson Chi Square test $p<.001$). 83% of people who considered that their health was fair or poor had a condition which limited their activities (level of significance for Pearson Chi Square test $p<.001$). There were no differences between men and women in reporting limiting illnesses. However, the level of limiting illness reported in this study for Gujaratis, is over three times higher than reported in the GHS for Indians (20%) (Evandrou 2000a).

Research has shown differences in health (morbidity and mortality) 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. 1984, 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 nine-tenths (91%) 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 arthritis (N=29), hypertension (N=29) and diabetes (N=24). Fewer Gujaratis said that they had angina (N=12), impaired vision (N=10), asthma or breathing problems (N=7), coronary heart disease (N=6) or depression (N=6) (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.

Other studies have looked at the prevalence and severity of the conditions mentioned in our study for ethnic minority groups. A study conducted in Birmingham found that arthritis was more common in Asian groups than in the UK population (Ritch et al. 1996). Diabetes affects 1-3% of the adult population of the UK but is know 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).

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, 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).

There is little systematic evidence regarding the mental health of ethnic groups (Askham et al. 1995). Studies have shown higher psychiatric admission for older Indian women (Glover 1991). There may be reluctance in the Asian communities to report mental health problems due to the stigmatisation of such conditions (Lin et al. 1978, Mays 1981, Gupta 1992). There may also be less reported mental illness among Asians due to the stigma of being admitted to hospital, and the lack of knowledge about treatments (Henly 1979). There are also problems because of cultural bias in diagnosis of mental health problems (Littlewood & Lipsedge 1982, McCracken et al. 1997).

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, 83% 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[6]: inability to walk or difficulty with walking (N=33) and arthritis (N=14). Fewer people mentioned that asthma or breathlessness (N=5) and stroke paralysis (N=4) limited their activities (Table 57). A lack of functional ability is considered to be severely limiting by nearly half (47%) of the Gujarati sample who reported either restrictions in mobility[7], arthritis or stroke paralysis. More women than men (57% vs. 36%) reported this type of restricted mobility as limiting their activities (level of significance for Pearson Chi Square test $p<.05$).

[6] 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.

[7] Mobility restriction was a collapsed category that included: cannot walk/difficulty walking, cannot go out alone, getting up stairs/steps, housework and picking things up.

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 current study, respondents were asked who they needed to look after them. Two-thirds (65%) of Gujaratis said there was no one needed to look after them (Table 58). Of those who did name someone, the most common person was a spouse (16%) and this is reflected in terms of the person they would expect to care for them if they were ill.

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. However, 18% of Gujaratis were unable to name someone (Table 59). Spouses were mentioned most frequently, followed by adult children (equal proportions of sons and daughters) or daughters-in-law. Few mentioned other categories and only 3% mentioned non-kin.

Although there were no significant differences between men and women it was noticeable that more men were looked after by wives, when they were ill, than vice versa (44% vs. 23%). This probably reflects the greater likelihood of widowhood for women. Over half (56%) of respondents with private restricted network types were unable to name someone who would look after them when they were ill. On the other hand 92% of Gujaratis with locally integrated support networks could name someone who would care for them when ill (level of significance for Pearson Chi Square test $p<.05$).

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 (73%) (Table 60). For those who did name someone, the most common person was a

spouse (15%). Once again, this is reflected in terms of the person who would expect the respondent to care for them *if they were ill*. Over half (54%) of the sample did not look after anyone, however, just over a quarter (26%) stated that they looked after their spouse if they were ill (Table 61). Less than one-tenth of older Gujaratis looked after more than one person when ill (9%) and only 7% looked after a daughter or other relative if they were unwell.

Earlier research conducted in Birmingham found that members of South Asian groups made less use than other groups 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 or whites. Research indicated that when offered the opportunity to consult with a member of their own ethnic group who spoke their ethnic language; take up of services was much increased (Tinsley et al. 1991). Birmingham is well served with health professionals of South Asian origin, 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 one-third of Gujaratis (31%) said that they would go alone but for those who would be accompanied, spouse was mentioned most frequently (21%)

followed by son (13%) or daughter (12%) (Table 62). What is interesting here is the high proportion that would not go to the doctor or to the hospital alone. It is not possible to know from the data whether this represents transport, companionship or language difficulties. Although more men than women (30% vs. 15%) are accompanied to the doctors or hospital by their spouse (probably reflecting the greater incidence of widowhood for women) and more women than men (19% vs. 4%) are accompanied by daughters, this difference is not statistically significant.

Respondents were also asked if they accompanied anyone to the doctors or hospital. Over two-thirds of the sample did not accompany anyone (67%) (Table 63). Seventeen percent of Gujaratis accompanied their spouse to the doctors or hospital and a further 8% accompanied more than one person. There were no significant differences between men and women in accompanying someone to medical facilities.

Domestic Help

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

Borrowing is clearly not undertaken lightly. Nearly three-fifths of older Gujaratis (57%) would not borrow from anyone (Table 64). Among those who would borrow things, the most common person to ask for each group would be a friend or neighbour (13%). Twelve percent named more than one person from whom they could borrow and one-tenth (10%) said they would borrow from sons. There were no significant differences between men and women. Respondents were asked if anyone borrows from them. Again the findings demonstrate that borrowing is not commonplace for Gujaratis. Eighty-one percent said that no-one borrowed from them (Table 65). Although very few, equal proportions of respondents said that more than one person, or friends or neighbours (8%) borrowed from them.

As far as **shopping for food** is concerned, more than half of Gujaratis (52%) shop themselves (Table 66). Help comes mainly from the immediate family: sons (11%), spouse (10%) and daughter (10%). A large majority of respondents did not go shopping for anyone else (84%) (Table 67). 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 spouses (27%) and daughters-in-law (14%); 41% of Gujaratis get no help (Table 68). Comparing genders it is apparent that significantly more men than women receive help with cooking from their spouses (48% vs. 10%) and more women than men get help with cooking from a daughter-in-law (23% vs. 4%). Cooking is primarily undertaken by women, fewer men than women have no-one to help them with cooking (33% vs. 50%) (level of significance for Pearson Chi Square test $p<.001$).

Nearly three-quarters of Gujarati elders do not help anyone else with cooking (74%) (Table 69). If they do help with cooking it is most likely to be for a spouse (13%) or for more than one person (10%). Although not statistically significant, there are differences between the genders. Women are more likely than men to help more than one person with cooking (17% vs. 2%) and men are more likely than women not to help anyone with cooking (86% vs. 62%).

Respondents were also asked if anyone brought them food that they had grown or cooked (this was a custom that we noted whilst in India). However, 81% of the Gujaratis did not receive food from anyone. Similar proportions received food from friends and neighbours (6%), daughters (5%) and more than one person (5%). Likewise, very few respondents (9%) took food that they had grown or prepared to other people.

Laundry is much easier in Birmingham than in Gujarat as most of the respondents in the UK (88%) had washing machines. Approximately half (52%) did their own laundry and the main source of help was a spouse (22%) followed by daughters-in-law (9%) (Table 70). There were gender differences in the source of help for women

and men (level of significance for Pearson Chi Square test p<.001). Men were more likely than women to get help from a spouse (38% vs. 0%). Women were less likely than men to get any help with laundry (45% vs. 12% have no-one to help). This is an important finding. Earlier we noted that 85% of Gujarati women stated they had a serious health problem. However, these findings show that men are more likely than women to get help with laundry. Gujarati women in poor health may need to receive help with laundry that is currently not being met in the community by formal help. Only one Gujarati women received help from a paid helper (2%).

An overwhelming majority of the Gujarati sample did not do laundry for anyone else (90%) (Table 71). Where help was given this was to a spouse (8%). Although three-quarters (75%) of this help was from wives helping husbands and not vice versa, the difference was not statistically significant.

The findings for help with **other household chores** are similar to laundry. Just over half (52%) of the Gujaratis said that they received no help (Table 72). Most help comes from spouses (16%) or daughters-in-law (11%). These sources of help are fairly sharply differentiated by gender (level of significance for Pearson Chi Square test p<.005). Men are more likely than women to receive no help with household chores (65% vs. 41%) or help from a spouse (22% vs. 10%). On the other hand women are more likely than men to receive help with household chores from a daughter-in-law (22% vs. 0%).

Most respondents did not help anyone else with household chores (83%) (Table 73). However, 7% helped daughters-in-law. There were no statistically significant gender differences in helping with household chores.

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 employment history, pension entitlements and to a lesser extent contributions from relatives. From this perspective the prior employment of immigrants to the UK is of prime importance. There are very few data which look at South Asians in groups other than 'Indian', 'Pakistani' or Bangladeshi'. 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. We know that Gujaratis are predominantly Hindu therefore data considering the economic position of Hindus in the UK are of particular interest (Brown 2000). Analysis of these data shows that 41% of Hindu men between the ages of 40 and 64 are likely to be economically inactive. This would undoubtedly affect income in later life. The reasons given for inactivity in this age group are 'sickness, disability and retirement' (Brown 2000). It has been suggested that this reasoning actually masks early-retirement due to perceived disadvantage in the workforce (Modood 1997).

Respondents were asked if they currently work for money. Only 11% of the Gujarati 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, but 42% of men and 23% of women in this sample were under retirement age,. For those who still work, the average working week is 36.8 hours.

The occupation of respondents is classified using the International Standard Classification of Occupations (ISCO-88) (International Labour Office 1990). This 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.

Gujaratis in the UK were most likely to have jobs classified as Group 7 or Group 8 occupations. UK Gujaratis in these groups typically worked as carpenters, tailors, mechanics, drivers (Group 7), machine operators or assemblers in a factory (Group 8). There were significant differences in the types of occupation that were undertaken by Gujarati 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 greater proportion of women who were housewives.

Two-thirds (68%) of Gujaratis in the UK have level 2 skills, and just over one-tenth of the sample have level 3 skills (12%) and level 4 skills (13%) (Table 77). Once again, there are significant differences in the skill levels of men and women. More women than men (63% vs. 13%) have skills at level one. Conversely, more men than women (64% vs. 23%) have skills at level two.

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 receipts 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 over half of the sample refusing or unable to answer the question (Brown 2000, Modood 1997). Elsewhere it has been suggested that 'missing' data are more likely to be high earners and consequently mean income may fall short of actual levels (Modood 1997). Analysis of approximately half of the Gujarati sample (i.e. those who gave responses) show that the most likely sources of income were 'Other' (24%), state old age pension (19%) and state supplementary pension (10%) (Table

78). The figures for receipt of state pension in this study were considerably lower than noted elsewhere for Indians as a whole (19% vs. 88%) (Evandrou 2000b). However, in order to receive a full entitlement for state pension men have to have paid national insurance contributions for 44 year and women for 39 years. As we noted earlier most Gujaratis arrived in the UK in the 1970s, and other evidence suggests that many Asian men would have experienced periods of unemployment (Jones 1993, Brown 1984, Drew 1995). Consequently Gujaratis are not likely to have full entitlement to a state pension. Periods of unemployment also make it less likely that they would receive a pension from a former employer (Evandrou 2000b).

The mean level of income was £143.17 per week (N=29). These findings should be treated with caution, given the large proportion of missing data. 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 asked to whom they would turn for **financial advice,** two-fifths (41%) said they would ask no one (Table 79). Of those who would ask advice the most likely source was sons (22%). Most respondents also said that they did not give financial advice to anyone (85%).

Dying in the United Kingdom

The Hindu ideal is to spiritually prepare for death throughout life (Firth 1991, p.55) However, preparation in practical terms does not seem to be a priority as only just over one-third of respondents (35%) had made a will (Table 80).

There were a lot of missing data for questions relating to death, suggesting either that Gujaratis or Hindus have a reluctance to discuss death or that the majority had not experienced a family death in the UK. Respondents were asked about the place of death for the last or a recent death of someone in their family living in Birmingham. Two-fifths (40%) 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 most of these people, no family deaths had occurred in Birmingham or none had occurred recently.

Of those who did answer 34% of deaths had occurred at home and 58% in hospital (with a small proportion occurring somewhere else). This finding is important in terms of practice in hospital. Most Hindus have similar attitudes towards death and believe that death should take place on the floor with members of the family present (Firth 1991). While most reported that hospitals had been helpful, it is not usually possible for the dying to be placed on the floor. In Birmingham, nursing staff try to accommodate the needs of different ethnic minorities and to make it possible for family members to be allowed to stay with patients. Private rooms may be used for this purpose.

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

Respondents were also asked whether funeral rites for Gujaratis in the UK were different from those that they had known in childhood. Of the 70 who responded to this question, around one third (34%) said that they were different (Table 83). Qualitative data on these differences will be analysed subsequently.

SUMMARY AND CONCLUSIONS

In the 1970s the economic success of the Asians in East Africa prompted trading restrictions on immigrants. The 'Africanisation' of labour in these countries drove many Asians to leave. Nearly half of Gujarati immigrants in this study came to the UK in the 1970s. The largest proportion of the Gujaratis interviewed had been in the UK for over 30 years. Their average age was 66.5 and more than a third were over 70. Over two-fifths lived in multi-generational households, one quarter lived alone and three-tenths lived with their spouse only. Most Gujaratis marry and for those interviewed half had married between the ages of 20 and 29. Over half were still married and one-third were widowed.

Older Gujaratis had larger families than the indigenous population, with most having five children. Nearly half had a child living in the same household or within a mile and over two-thirds saw a child every day. Fewer had living brothers or sisters. Most Gujaratis saw a relative daily. Most also had frequent contact with friends and neighbours. The majority attended meetings of community groups (at least occasionally). Most Gujaratis were rarely alone and were not lonely.

In contrast, there was a minority of the Gujarati sample who lived alone (26%), did not see a child every week (6%), and had no living siblings (31%), never saw friends (24%) or neighbours (27%), never attended community meetings (20%) or were alone for more than 9 hours a day (16%). Further analyses will identify whether these Gujaratis 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 Gujaratis in Birmingham were Hindus and virtually all of them attended religious meetings regularly. Around two-fifths of the Gujaratis interviewed had received very little education, however, only one-third did not speak English. Fewer than half of the sample was able to write English and just over one half could read 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 Gujaratis have been unlikely to undertake English lessons in the UK.

Most Gujaratis were typically well supported by their family and community, and in turn played an important role in supporting other family members and friends. The analyses showed gender differences in responsibility for domestic work. Women were more likely than men to undertake cooking for spouses, and wives and daughters-in-law were more likely than men to undertake laundry and other household chores. Around one quarter of Gujaratis was without personal support: 25% did not confide in anyone, 28% had no one to talk to when unhappy, and 24% had no one to whom they can talk about personal problems. Further analysis will be undertaken to ascertain whether this represents multiple deprivation or reflects a disparate of respondents.

The income data were unreliable as 70% refused to divulge their income. The sending of money to relatives abroad is not typical and may be related to low incomes. Where remittances were sent (by 3%) they averaged £60 a month.

Overall, the majority of the Gujaratis were well supported by their families and friends and appear to be well integrated into the host community. Almost two-thirds speak English. Gujaratis also appear to be well integrated into the Hindu community in Birmingham. It has been estimated that there are 559,000 Hindus in the UK (National Statistics Online 2003). However, there are only six Mandirs registered in Birmingham.

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 Gujaratis in Birmingham do not appear to be disadvantaged by family dispersal as a result of emigration. Most of them have children and siblings living nearby and are well supported by family, friends and neighbours. However, three-fifths of Gujaratis reported that their health was only fair or poor. In addition, 70% said they had serious health problems and over three-fifths had a health condition that limited their activities. These figures are three times higher than

reported elsewhere (Evandrou 2000a). In this context it is important to note that 18% of the Gujaratis interviewed were unable to name someone who would care for them when they were ill. This flags up a possible need or shortfall of culturally sensitive domiciliary social care services.

In this study over three-quarters of the respondents had Family Dependent (38%) or Locally Integrated (38%) support networks. These types are the most robust networks in terms of the availability of informal care and support and those which make it most likely that impaired older people will remain living at home. The other three network types (Local self contained, Wider community focused and Private restricted) are less robust and in the face of declining health and mobility are less able to provide support. Although the number of Gujaratis with private restricted network types was small (9%), over half of this group were unable to name someone to care for them when they were ill. In the absence of relatives living in the area, older people may rely on support from friends and neighbours. Neighbour relationships have on the whole been treated primarily instrumentally (Chatters et al. 1985, James & Davies 1987, Petchers & Milligan 1987, Stoller & Pugliesi 1988, Wenger 1990). At low levels of dependency, older people are likely to receive help from neighbours with undemanding tasks. In some instances, neighbours may become friends as impairment increases but care is not part of the host country's cultural expectations for neighbours (Wenger et al. 1999).

Use of hospital services by Asians is low (Blakemore 1982, Bhatia 1986), however, there are very few large-scale studies to corroborate this evidence (Patel 1993). There are however, several problems associated with health service use. Definitions of illness in ethnic minority groups may be different from the indigenous population and health beliefs may be incongruent with those of professional health providers (Zola 1966, Zborowski 1969, Schwartzman 1982, Bhopal 1986, Donovan 1986, Bates 1987, McGoldrick 1989, Krause 1989). It is sometimes assumed by service providers in the UK that ethnic minority families are better at taking care of their elderly members than are Western families. This approach has been criticised as an over-simplified stereotype (Patel 1993, South Thames RHA 1994, Atkin & Rollings 1996). This study has highlighted the fact that a majority of Gujaratis experience

serious health problems, or limiting illnesses, but in addition to this, there are a small minority who are unlikely to be supported by family, friends or neighbours in times of illness. Although family contact for a majority of Gujaratis is high, this does not mean that there are not care deficits or problems (Mays 1981, McFarland et al. 1989, Sastry 1981). Comparisons with older Gujaratis who remained in India will provide additional information on how or whether those ageing in the UK have higher levels of care provision than in India, and whether the UK Gujaratis have benefited from the migration decision.

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

ESA315

UNITED KINGDOM REGIONAL REPORT No. 1

Older Gujarat Immigrants in Birmingham, UK: Appendix – Data Tables for UK Gujarati Sample

October 2002

By Vanessa Burholt, G. Clare Wenger and Zahida Shah

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Demographic Characteristics

Table 1. Gender distribution

Gender	**Gujarats (UK) (N=103) %**
Male	48.5
Female	51.5

Table 2. Age distribution

Age bands	**Gujarats (UK) (N=103) %**
55-59	22
60-64	23
65-69	18
70-74	18
75+	18

Table 3. Marital status distribution

Marital status:	**Gujarats (UK) (N=103) %**
Never married	3
Married	54
Widowed	33
Divorced/separated	10

Table 4: Age at current (or last) marriage

Age:	**Gujaratis (UK) (N=98) %**
<10	1
10-15	7
16-19	37
20-29	48
30-39	2
40-49	5
50-59	1

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

Number of years:	Gujaratis (UK) (N=98) %
<10	4
10-19	7
20-29	8
30-39	24
40-49	26
50-50	26
60+	4

Migration history

Table 6. Age at move to the UK

	Gujaratis		
Ageband:	***All***	***Male***	***Female***
10-19	2	4	0
20-29	30	35	28
30-39	12	20	28
40-49	24	26	25
50-59	5	4	6
60-69	11	11	11
70+	1	0	2
Missing	4		
Level of significance for Pearson Chi Square test2		ns.	

Table 7 .Decade of move to the UK

Decade	Gujaratis (UK) (N=99) %
1940s	1
1950s	5
1960s	33
1970s	46
1980s	6
1990-present	9

Table 8 . Length of stay in the UK

Length of stay:	Gujaratis (UK) (N=99) %
Less than 10 years	8
11-20 years	6
21-30 years	36
31-40 years	42
40+ years	7

Table 9. Reasons for emigrating to the UK

Reasons:	All (N=96)	Men (N=44) %	Women (N=52) %
Political Africanisation of labour	24	32	17
Resettle, need a change	21	11	29
Economic/for work	19	30	10
Live with or near relative	18	11	23
Other	19	16	21
Level of significance for Pearson Chi Square test		p<.05	

Table 10. First county of residence in the UK

County:	Gujaratis (UK) (N=102) %
West Midlands	90
Greater London	4
Lancashire	3
Somerset	1
Middlesex	1
Northumberland	1

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

Number of moves:	Gujaratis (UK) (N=103) %
0	86
1	11
2	2
3	1

Living Arrangements

Table 12. Household composition

Household composition:	Gujarats (UK) (N=103) %
Lives alone	26
Lives with spouse/partner only	30
Lives with younger (2) generation	23
Lives in 3 or 4 generation household	19
Other	1

Table 13. Length of time living in current house

Number of years:	Gujarats (UK) (N=103) %
< 1	5
1-5	14
6-10	19
11-20	27
21-30	26
30+	7
Missing	2

Table 14. Age came to live in current house

Age:	Gujarats (UK) (N=103) %
Under 20	2
20-39	27
40-59	41
60-69	12
70+	4
Missing	1

Table 15. House tenure

Owned by:	Gujarats (UK) (N=103) %
Self or spouse	50
Child	22
Landlord	21
Other	66
Missing	1

Children

Table 16. Number of living children

	Gujaratis (UK) (N=103) %		
Number of living:	**Children**	**Sons**	**Daughters**
0	13	17	26
1	5	33	30
2	18	28	16
3	18	14	14
4	13	6	12
5	21	2	2
6+	12	1	1

Table 17. Distance from nearest child

Distance of nearest childen:	**Gujarats (UK) (N=103) %**
No children	13
In the same household/within 1 mile	49
1-5 miles	27
6-15 miles	3
16-50 miles	3
50+ miles	3
In another country	2
Missing	1

Table 18. Most frequent contact with any child

Frequency of contact:	**Gujaratis (UK) (N=89) %**
Daily	71
More than once a week	10
Once a week	10
2-3 times a month	3
Once a month	2
Less than once a year	1
Never	2

Table 19. Number of children living abroad

Number of children living abroad:	Gujarats (UK) (N=103) %
0	70
1	16
2	10
3	5

Table 20. Where children abroad live

Child living in:	Gujaratis (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:	Gujaratis (UK) (N=51) %
Yes	96
By:	
Letter	37
Phone	88
Sending gifts	29
Receiving gifts	29
Other means	0

Siblings

Table 22. Number of living siblings

Number of living siblings:	Gujarats (UK) (N=103) %
0	31
1	12
2	14
3	14
4	5
5	13
6+	12
Missing	1

Table 23. Distance of nearest sibling

Distance of nearest sibling:	Gujarats (UK) (N=103) %
No siblings	31
In the same household/within 1 mile	3
1-5 miles	27
6-15 miles	7
16-50 miles	0
50+ miles	8
In another country	21
Missing	3

Table 24. Most frequent contact with any sibling

Frequency of contact:	Gujaratis (UK) (N=64) %
Daily	11
More than once a week	14
Once a week	20
2-3 times a month	13
Once a month	14
3-11 times a year	14
Once a year	2
Less than once a year	8
Never	5

Table 25. Number of siblings living abroad

Number of siblings living abroad:	Gujarats (UK) (N=103) %
0	59
1	10
2	9
3	11
4	1
5	2
6+	5
Missing	4

Table 26. Where siblings abroad live (N).

Sibling living in:	Gujaratis (UK) N
Other Europe	2
North America	11
Middle East	4
South Asia	55
South East Asia	11
Far East	1
Africa	19

Table 27. Keeping in touch with siblings abroad

Keep in touch:	Gujaratis (UK) (N=108) %
Yes	92
By:	
Letter	44
Phone	82
Sending gifts	11
Receiving gifts	13
Other means	0

Relatives

Table 28. Frequency of contact with any relative

Frequency of contact:	Gujaratis (UK) (N=103) %
Every day	60
2-3 times a week	13
At least once a week	3
< weekly, but > monthly	4
Less Often	9
Never/no relatives	9
Missing	3

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

Number of relatives living abroad:	Gujarats (UK) (N=103) %
0	72
1	6
2	5
3+	8
Missing	10

Table 30. Where other relatives abroad live (N)

Relative living in:	Gujaratis (UK) N
Other Europe	1
North America	6
Latin America	2
Australia	3
Middle East	8
South Asia	15
South East Asia	2
Far East	2
Africa	10

Table 31. Keeping in touch with relatives abroad

Keep in touch:	Gujaratis (UK) (N=53) %
Yes	96
By:	
Letter	42
Phone	70
Sending gifts	17
Receiving gifts	13
Other means	0

Friends, Neighbours and Community Integration

Table 32. Frequency of contact with friends

Frequency of contact:	Gujaratis (UK) (N=103) %
Every day	20
2-3 times a week	24
At least once a week	17
< weekly, but > monthly	8
Less Often	7
Never/no friends	24

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

Number:	Gujaratis (UK) (N=103) %
0	33
1	8
2	10
3	13
4	12
5	25

Table 34. Frequency of contact with neighbours

Frequency of contact:	Gujaratis (UK) (N=103) %
Every day	34
2-3 times a week	13
At least once a week	16
< weekly, but > monthly	1
Less Often	9
Never/no friends	27
Missing	1

Table 35. Attendance at social or community meetings

Attend:	Gujaratis (UK) (N=103) %
Never	20
Regularly[1]	49
Occasionally[2]	30
Missing	1

Table 36. Hours per day at home alone

Number of hours:	Gujaratis (UK) (N=103) %
<3	49
3-5hrs 59mins	19
6-8hrs 59mins	11
>9	16
Missing	6

Table 37. Feels lonely

Frequency:	Gujaratis (UK) (N=103) %
Never	49
Rarely	15
Sometimes	26
Often	3
Most of the time	7
Missing	1

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

Religion

Table 38. Religion

Religion:	**Gujaratis (UK) (N=103) %**
Christian	1
Hindu	91
Jain	3
Muslim	3
Sikh	2

Table 39. Attendance at religious meetings

Attend:	**Gujaratis (UK) (N=103) %**
Never	9
Regularly	48
Occasionally	41
Missing	3

Table 40. Participation in religious events

Religious activity & frequency:	Gujaratis (UK) (N=103) %		
	Individually	**With family**	**With community**
Prayer:			
Never	12	11	10
Regularly	53	18	11
Occasionally	23	15	12
Missing	12	56	68
Festival:			
Never	11	5	3
Regularly	34	34	15
Occasionally	21	18	13
Missing	34	57	30
Going to place of worship:			
Never	14	7	4
Regularly	40	35	12
Occasionally	18	11	10
Missing	29	48	75
Pilgrimage:			
Never	52	27	16
Regularly	7	2	1
Occasionally	13	23	5
Missing	28	48	79

Education and Language

Table 41. Length of time in full time education

Number of years:	**Gujaratis (UK) (N=103) %**
None	7
1-5	40
6-10	22
11-15	15
16+	17

Table 42. Length of time in part time education

Number of years:	**Gujaratis (UK) (N=103) %**
None	86
1-5	8
6-10	4
11-15	0
16+	2

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

Language:	**Gujaratis (UK) (N=96) %**
More than one	24
English	20
Gujarati	55
Urdu	1

Table 44. First language

Language:	**Gujaratis (UK) (N=103) %**
Gujarati	96
Punjabi	1
Sylheti	2
Urdu	1

Table 45. Spoken English

	Gujaratis (UK) (N=103) %
Yes	67
Proficiency:	**(N=68) %**
Good	37
Fair	29
Poor	34

Table 46. Written English

	Gujaratis (UK) (N=103) %
Yes	45
Proficiency:	**(N=46) %**
Good	50
Fair	24
Poor	26

Table 47. Reading English

	Gujaratis (UK) (N=103) %
Yes	52
Proficiency:	**(N=53) %**
Good	47
Fair	23
Poor	30

Sources of Support and Help

Table 48. Support network distribution

Support network type:	Gujaratis (UK) (N=103) %
Family dependent	38
Locally integrated	38
Local self-contained	3
Wider community focused	9
Private restricted	9
Inconclusive	4

Table 49. Relationship of confidant

Relationship:	Gujaratis UK (N=103) %
No-one	25
More than one	9
Spouse	16
Son	15
Daughter	13
Daughter in law	5
Other relative	5
Friend or neighbour	11
Professional	3
Missing	1

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	28
More than one	16
Spouse	9
Son	4
Daughter	6
Daughter in law	1
Other relative	10
Friend or neighbour	21
Professional	3
Missing	3

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	47
More than one	15
Spouse	2
Son	2
Daughter	2
Other relative	5
Friend or neighbour	24
Professional	1
Missing	3

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	24
More than one	10
Spouse	14
Son	18
Daughter	13
Daughter in law	1
Other relative	4
Friend or neighbour	9
Professional	4
Missing	5

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	52
More than one	10
Spouse	8
Son	2
Daughter	3
Other relative	3
Friend or neighbour	16
Professional	1
Employees or other non-related	1
Missing	6

Table 54. Self assessed health

	Gujaratis (UK) (N=103) %
Good or excellent	7
All right for age	32
Only fair	33
Poor	28

Table 55. Health problems

	Gujaratis (UK) (N=103) %
Serious health problems:	
Yes	70
Limiting condition	
Yes	62

Table 56. Reported serious health conditions

Condition:	Gujaratis (UK) (N)
Hypertension	29
Arthritis	29
Diabetes	24
Angina	12
Impaired vision	10
Stroke	7
Asthma/breathing problems	7
Coronary Heart Disease	6
Depression	6
Kidney problems	4
Back pain/sciatica	4
Prostrate problems	3
Gastric problems	3
Hip problems	2
Other physical impairment	2
Hernia	2
Pain (non-specific)	1
Stress	1
Gout/foot problems	1
Parkinson’s disease	1
Hearing impairment/deaf	1
Paralysis	1
Spondylytis	1
Bladder problems	1
Piles	1
Polio	1
Insomnia	1
Cognitive impairment	1

Table 57. Reported limiting condition (or activity)

Condition:	Gujaratis (UK) (N)
Cannot walk/difficulty walking	33
Arthritis	14
Asthma/breathlessness	5
Stroke/paralysis	4
Angina	2
Coronary Heart Disease	2
Getting up stairs/steps	2
Picking things up	2
Diabetes	2
Back pain/sciatica	1
Housework	1
Going out alone	1
Memory loss	1
Parkinson's	1
Ulcer limits eating	1

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	65
More than one	2
Spouse	16
Son	5
Daughter	5
Daughter in law	2
Other relative	1
Professional	1
Missing	4

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	18
More than one	10
Spouse	32
Son	13
Daughter	13
Daughter in law	9
Other relative	2
Friend or neighbour	1
Professional	2
Missing	2

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	73
More than one	3
Spouse	15
Son	1
Daughter	3
Other relative	4
Missing	2

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	54
More than one	9
Spouse	26
Daughter	3
Other relative	4
Friend or neighbour	1
Missing	3

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	31
More than one	11
Spouse	21
Son	13
Daughter	12
Daughter in law	5
Other relative	1
Friend or neighbour	2
Professional	2
Missing	3

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	67
More than one	8
Spouse	17
Son	1
Other relative	3
Friend or neighbour	3
Missing	2

Table 64. Relationship of person respondent would borrow from

Relationship:	Gujaratis (UK) (N=103) %
No-one	57
More than one	12
Spouse	1
Son	10
Daughter	4
Daughter in law	1
Other relative	1
Friend or neighbour	13
Professional	1
Missing	1

Table 65. Relationship of person who borrows from respondent

Relationship:	Gujaratis (UK) (N=103) %
No-one	81
More than one	8
Son	1
Friend or neighbour	8
Missing	3

Table 66. Relationship of person who goes shopping for respondent

Relationship:	Gujaratis (UK) (N=103) %
No-one	52
More than one	8
Spouse	10
Son	11
Daughter	10
Daughter in law	6
Other relative	2
Friend or neighbour	2
Professional	1

Table 67. Relationship of person who respondent shops for

Relationship:	Gujaratis (UK) (N=103) %
No-one	85
More than one	6
Spouse	5
Daughter in law	1
Other relative	1
Friend or neighbour	2

Table 68. Relationship of person who cooks for respondent

Relationship:	Gujaratis (UK) (N=103) %
No-one	41
More than one	6
Spouse	27
Daughter	7
Daughter in law	14
Other relative	1
Friend or neighbour	1
Professional	1
Missing	3

Table 69. Relationship of person who respondent cooks for

Relationship:	Gujaratis (UK) (N=103) %
No-one	74
More than one	10
Spouse	13
Son	1
Daughter in law	1
Other relative	1
Friend or neighbour	1

Table 70. Relationship of person who does laundry for respondent

Relationship:	Gujaratis (UK) (N=103) %
No-one	53
More than one	3
Spouse	22
Daughter	5
Daughter in law	9
Professional	1
Missing	7

Table 71. Relationship of person who respondent does laundry for

Relationship:	Gujaratis (UK) (N=103) %
No-one	88
More than one	2
Spouse	8
Other relative	1
Missing	1

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	52
More than one	5
Spouse	16
Son	2
Daughter	8
Daughter in law	11
Other relative	1
Professional	4
Missing	3

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

Relationship:	Gujaratis (UK) (N=103) %
No-one	83
More than one	3
Spouse	7
Daughter	2
Daughter in law	3
Other relative	2
Missing	1

Work and Income

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

Relationship:	**Gujaratis (UK) (N=103) %**
Yes	11
	N=11
Mean number of hours per week	36.8 (s.d. 15.2)

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:	**Gujaratis (UK) household (N=102) %**	**Gujarati men (N=49)**	**Gujarati women (N=53)**
1	11	8	2
2	12	10	11
3	11	10	2
4	5	2	2
5	8	6	4
6	0	-	-
7	28	31	0
8	21	20	17
9	6	12	62
0	0	-	-
Significance level of Pearson Chi Square		P<.001	

Table 77. Skill levels

ISCO major group:	Gujaratis (UK) household (N=91) %	Gujarati men (N=45)	Gujarati women (N=52)
1	7	13	64
2	68	64	23
3	12	11	2
4	13	11	12
Significance level of Pearson Chi Square		P<.001	

Table 78. Sources of income

	Gujaratis (UK) (N=103)	
Source of income:	**% Yes**	**% Missing**
Work	8	42
Spouse's work	5	53
Business	4	53
Children residing in home	0	53
Children elsewhere	1	53
Other relatives	0	54
Other agency[3]	2	53
Former (spouses) employer	9	53
Savings, investments etc.	5	52
State old age pension	19	51
State supplementary pension	10	56
Attendance allowance	9	53
Housing benefit	7	54
Rent or council tax reductions	4	53
Other source	24	38

[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:	Gujaratis (UK) (N=103) %
No-one	41
More than one	7
Spouse	7
Son	22
Daughter	5
Other relative	5
Friend or neighbour	6
Professional	7
Missing	1

Death and Dying in the UK

Table 80. Written a will

	Gujaratis (UK) (N=103) %
No	65
Yes	35

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

	Gujaratis (UK) (N=103) %
In their home	18
At the home of a family member	1
Hospital	38
Nursing home	1
Somewhere else	3
Missing	40

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

Relationship:	**Gujaratis (UK) (N=103) %**
More than one	8
Spouse	5
Son	26
Daughter	1
Other relative	14
Missing	46
Gender:	
Male	41
Female	9
More than one	6
Missing	45

Table 83. Difference in funeral ritual from childhood

	Gujaratis (UK) (N=103) %
No	45
Yes	23
Missing	32