Health Outcomes and the Pakistani Population

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CAMBRIDGE
SCHOLARS
PUBLISHING

Health Outcomes and the Pakistani Population,
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This book first published 2014

Cambridge Scholars Publishing

12 Back Chapman Street, Newcastle upon Tyne, NE6 2XX, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (10): 1-4438-6134-0, ISBN (13): 978-1-4438-6134-2

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CHAPTER ONE

INTRODUCTION

Background

This book examines dietary habits and physical activity among older Pakistani people in Mirpur, Pakistan. It explores how diet has changed over time in Pakistan. It also explores the ways in which older Pakistani people participate in physical activities. This was carried out by conducting in-depth semi-structured interviews with residents in Mirpur, Pakistan.

The research reveals some unique insights into the Pakistani community. By exploring physical activities among Pakistanis, the author was able to explore perceptions held by the 'community'; these include cultural norms and values that dictate whether individuals are allowed to participate or not, for example 'restrictions' placed on females that prevent them from freely engaging in physical activity.

This research shows that, although some older female respondents said they would like to participate in physical activity, the overriding cultural norms dictate that only a very small minority of females were allowed to do so. Practices varied mainly along the lines of socioeconomic background and all the females who said they participated in physical activity were from middle-class backgrounds.

In addition, this book has several chapters on methods, which can act as a reference guide to researchers who wish to examine a minority ethnic community, in this case the Pakistanis.

The researcher

Research is usually conducted by way of personal interest for the author(s). My parents were born in the district of Mirpur and I grew up hearing stories of family 'get togethers' where food played a pivotal role in family life and functions. Food brought individuals and families together. Whilst I was growing up, I heard stories of how meals were cooked on a 'mega scale' for all the 'family' to enjoy ('family' included

parents, siblings, grandparents, uncles, aunts, close relatives and friends), where they would sit together on the floor and enjoy a well-earned evening meal after a hard day's work.

The important link to bringing families and individuals together was food. Food brought everyone together, whether it was for the main evening meal, to celebrate a birth or marriage, or even to mourn a death. Food was served in a celebratory manner and they were thankful for what the family could afford, however much or little.

It was a time to relax and enjoy family life. I also heard stories about the daily struggles and hardships of everyday life for most Pakistanis during and after Independence in 1947, which later provided the impetus to immigrate to the UK when the opportunity arose (discussed later). What little food families had was shared.

During an earlier visit to Pakistan, I observed that most families I visited were consuming traditional foods, e.g. curries (meat and veg) and rotis, mostly due to limited finances. However, during my last visit I observed an increasing number of people were eating out in the bazaar and consuming a vast array of foods, particularly fried foods, sweet desserts and drinking an array of fizzy drinks. Much of this was linked to an increase in the family's financial status. There is a link between an increase in spending on food items and family status. For the purposes of this research, there was a clear division between those families who could afford to eat what they liked, as often as and when they wished, compared to many Pakistani families who were on very limited incomes struggling to make ends meet.

CHAPTER TWO

HEALTH OF PAKISTANIS

This chapter covers a preliminary literature search on dietary habits of Pakistanis and South Asians. Three of the world's ten most populated countries are located in South Asia. The problems seem to be different from those of the developed world, with rapidly changing socioeconomic circumstances, increasing urbanisation and longevity, changes in dietary patterns and a decrease in mortality from infectious diseases, which have made chronic illnesses of old age, such as cardiovascular disease and strokes, an important areas of focus. The risk factors for diabetes are well-established including obesity, smoking, hypertension and family history of diabetes (Fawwad et al., 2013).

The Commission on Health Research for Development (1990) stressed the importance of national health research in developing countries. It estimated that at around 2% of the national budget should be made available for health research, which it considered to be paramount for developing countries (Hyder et al., 2003). A literature search for purposes of this book showed an increasing number of studies being conducted in Pakistan around dietary habits and physical activity. This is important in order to understand health issues and to develop interventions that tackle unhealthy behaviours. There is a need to understand geographical differences because experience suggests that dietary behaviour varies enormously.

Asian diet

The dietary customs of people of South Asian origin living in Britain are important determinants of health (Simmons and Williams, 1997). They found that those of South Asian origin ate fewer meals per day than European participants, but ate more fruit. Further, South Asians had their evening meal 2-3 hours later than their European counterparts.

Research shows that the Asian diet can have an effect on conditions such as coronary heart disease (McKeigue et al., 1985), non-insulin dependent diabetes mellitus (McKeigue et al., 1991), rickets, anaemia

(Robertson, 1982) and eye conditions such as cataracts (Thompson, 1991). Sheikh and Thomas (1994) argue that the Asian population has a diet which differs from the indigenous white population; for example, Asian populations often have a vegetarian diet which has been linked to the development of rickets, iron deficiency B12, folic acid anaemia and, more recently, cataracts.

Råberg et al. (2010) found the most important barriers to healthy dietary changes were preferences of children and other family members and perceived expectations during social gatherings. They found the perceived pressure was strong when women were trying to change to more vegetables, lentils and fish and to use less oil in cooking.

Obesity epidemic

Obesity is considered a global epidemic (Ishaque et al., 2012). It has become a problem of public health magnitude. It is associated with substantial economic burden, not only in the developed countries but also in the developing countries (Afzal, 2004).

There is an enormous amount of literature that examines obesity in Pakistani populations, with an increasing number of studies being conducted in Pakistan. This is essential in order to understand the increasing problem of obesity and the impact this will have on the health budget in Pakistan.

Obesity is an emerging problem in Pakistan. Obesity in childhood and adolescence is of concern because it is an important predictor of adult obesity (Ishaque et al., 2012). The study by Warraich (2009), which examined the prevalence of childhood obesity, found that 52% were found to be overweight and 34% of all children were normal. Of the population, 6% were obese and 8% overweight. Interestingly, of all obese children, 70% were from the higher socioeconomic status and a higher number of them ate meat every day compared to children from lower socioeconomic groups (65% versus 33% respectively). This is similar to the findings by Ishaque et al. (2012), who found the frequency of overweight and obese children was high in children from higher socioeconomic status.

Imam et al. (2000) studied 869 people visiting Lahore General Hospital (Pakistan). They were evaluated for their body mass index (BMI) in a random fashion to determine the prevalence of obesity. They found that 170 subjects had a BMI of 25 to 30 in a pre-obesity range of BMI and 51 subjects were in an obese range of 30 to 40. They suggested that urgent public health measures be taken to prevent a rise in obesity in the suburbs of Lahore.

The study by Nanan (2002), which examined the health outcomes associated with overweight and obesity, suggests that, in South Asia, including Pakistan, social and environmental changes are occurring rapidly, with increasing urbanisation, changing lifestyles, high energy density of diets and reduced physical activity, all contributing to an increase in obesity. Nanan found that the prevalence of obesity in the 25-44 age group in rural areas of Pakistan was 9% for men and 14% for women. By contrast, in the urban areas, the prevalence was 22% for men and 37% for women. For the 45-64 age group, the prevalence was 11% for men and 19% for women in rural areas, and 23% and 40% in urban areas for men and women.

The systematic review by Raza et al. (2013) found only seven studies among the immigrant Pakistani community and 24 studies among the indigenous Pakistani community. They found that studies had limitations such as low participation rates and use of self-reported data. They report a higher prevalence of central obesity among women (42.2%) than among men (14.7%) (National Health Survey of Pakistan). Interestingly, differences were found along the lines of inter-ethnic groups; for example, Muhajir and Baluchis showed a higher prevalence of cardiovascular disease risk factors when compared to other ethnicities in the indigenous Pakistani population.

Health behaviour in Pakistan

Nisar et al. (2008), in her sample of university medical students, found that an unhealthy lifestyle and poor dietary habits were highly prevalent in the overweight study population.

Aslam et al. (2004) looked at the cardiovascular health behaviour of medical students in Karachi, Pakistan. They found that 8% smoked, 9% were overweight, 33% had a family history of coronary artery disease, 32% regulated dietary fat intake and 28% exercised regularly. As regards to developing cardiovascular disease in the future, 62% showed concern but only 54% of the population had adopted preventative practices. Amongst others, poor screening practices and lack of awareness were identified as barriers to changing health behaviours.

Qidwai et al. (2003) found, in their sample of 393 patients, a preference for consumption of fats/oils, sweets, spicy foods, salts and cola drinks. Furthermore, 19% of the sample reported sleeping less than six hours per day, and water consumption of less than one litre was reported by 21% of the sample.

Health information

Ludwig et al. (2011), in their study of social and cultural construction of obesity among Pakistani Muslim women in North West England, found that 55 participants lacked the motivation to address weight gain and were unsure how to do so. There was also a lack of awareness of the link between weight gain and type 2 diabetes.

Physical activity

Regular physical activity plays an important role in improving and maintaining one's health, especially as one ages. They found that, although many older American people are aware of the benefits of exercising regularly, many do not engage in physical activity as recommended by health professionals (Costello et al., 2011). This suggests that, although health messages are reaching individuals, the problem lies around changing behaviours that will increase their participation in physical activity.

A study of patterns of physical activity and the relationship with risk markers for cardiovascular disease in South Asian and European adults in a UK population by Hayes et al. (2002) found Europeans were more physically active than Indians, Pakistanis or Bangladeshis. On the physical activity index, they found 52% of European men did not meet current guidelines for participation in physical activity compared with 71% of Indians, 88% of Pakistanis and 87% of Bangladeshis. Similar findings are reported for women. Further, the level of physical activity was inversely correlated with body mass index, waist measurement, systolic blood pressure, blood glucose and insulin in all ethnic groups, but did not correlate with high-density lipoprotein (HDL) cholesterol.

Sajwani et al. (2009) compared the differences in knowledge and practices regarding healthy lifestyle among medical and non-medical students along with assessment of any perceived barriers. They found that 'lack of time' was cited as the most important reason for skipping meals and as a barrier to exercising regularly among both people

Sedentary lifestyle

Research has shown that a sedentary lifestyle, a diet in saturated fat and cholesterol, smoking and stress, as well as mortality from cardiovascular disease, varies considerably among the ethnic and cultural adult population (Savage and Harlan, 1991). Similarly, Dodani et al. (2004) in their study

of risk factors of coronary heart disease in Karachi found that a very high prevalence of sedentary lifestyle, despite a high literacy rate and awareness regarding CHD risk factors, was low.

Smoking

Smoking is the single most important avoidable cause of premature morbidity and mortality in the world and it is major health problem in Pakistan (Khuwaja and Kadir, 2004; see also Gilani and Leon, 2013).

Almost a fifth of the world's tobacco is consumed in smokeless form and its consumption is common in South Asia and there are many varieties of smokeless tobacco (SLT) (Khan et al., 2014). Tobacco is chewed enormously in Pakistan; for example, paan is a kind of piper betel leaf that contains areca nut, lime, condiment and sweeteners. Another form of common SLT products used in Pakistan is naswar and has been linked to oral and oesophageal cancer (Zakiullah, 2012; see also Bile et al., 2010).

There are regional differences in Pakistan; for example, Bile et al. (2010) found that Urdu-speaking communities had a proportionately higher rate of oropharyngeal cancer (20.4%) followed by Balochis (19.9%), Sindhis (16.8%), Punjabis (11.7%) and Pashtuns (9.6%).

Alam (1998) looked at the prevalence and pattern of smoking in Pakistan from their sample of 9,441 participants, in which a total of 21.6% (36% males and 9% females) were smokers. They found that 20.7% of men in urban areas and 22% of men in rural areas were smokers. Males were more likely to be smokers than females. Further, the number of smokers who used cigarette/beedi were more likely to be males than females, while chillum/huqqa smokers were more likely to be females than males. Socioeconomic differences were found among both males and females; illiterate, and married people who had poor general health were more likely to smoke.

Similarly, a later study by Ali et al. (2008) in Sindh, Pakistan found that 10% of women were smokers and 42% of the 18-24 age group were smokers. The prevalence of smoking increased with age and income and was highest among participants aged 44 and with incomes of more than PKR 4000.

Khuwaja and Kadir's (2004) study of smoking among adult males in an urban community of Karachi found that the majority of smokers (55%) started smoking below the age of 25. Further, 42% of the adult male smokers used tobacco in other forms as well, while 58% of smokers smoked to relieve anger and frustration, or because of friends and peer pressure.

Smokeless tobacco (SLT) is linked to poor oral health and cancers. Ali et al.'s (2009) study into the usage among adult patients who visited family practices in Karachi found that, overall, 52.4% had used SLT at least in one form and more males than females were using SLT than females. They found most of the samples had started using SLT before the age of 15, 40.2% had started using SLT because of media advertisements and 30.8% due to friends/peer pressure.

Health outcomes: Cardiovascular disease

Cardiovascular disease (CVD) has become a major clinical and public health problem (Ramaraj, 2008). Stroke is the most common neurological cause of morbidity and mortality all over the world, being the third leading cause of death (Khan, 2009).

In the developed countries, Zaninotto et al. (2007), using data from the Health Surveys for England, showed that CVD was relatively more common among South Asian populations, with Black Caribbean and South Asian populations having a considerably higher chance of developing diabetes. In particular, migrant South Asian populations residing in the West have one of the highest rates of CAD in the world (Jafar et al., 2005; see also Jafar et al., 2003; Jafar et al., 2008).

Despite improvements in cardiovascular outcomes, coronary heart disease continues to be the major cause of death worldwide. South Asians have an increased risk of atherosclerosis and have the highest mortality rates from coronary artery disease (CAD) than any other ethnic group. The increased susceptibility of South Asians to CAD cannot be explained entirely by conventional risk factors alone. Other factors are involved, for example genetic disposition and high prevalence of the metabolic syndrome and type-2 diabetes. CAD is more severe, extensive and malignant among South Asians. Further, it is often unsuspected and associated with adverse outcomes requiring a more aggressive management strategy (Bainey et al., 2009).

Cardiovascular disease in Pakistan

South Asian countries, India, Pakistan, Sri Lanka, Bangladesh and Nepal not only represent a quarter of the world's population, but also contribute to the highest proportion of CVD burden when compared with any other regions globally (Ramaraj, 2008).

South Asians have a higher than average risk of CHD, although the reasons for this are unclear, but physical inactivity and/or poor responsiveness

to exercise may play a role (Arjunan, 2013). The high prevalence of insulin resistance and type 2 diabetes mellitus in South Asians may be a major cause for their evaluated vascular risk (Tziomalos, 2008).

Dodani et al.'s (2004) study examined the prevalence and awareness of risk factors and risk behaviours of coronary heart disease (CHD) in the lower middle class residing in urban localities of Karachi. They found that the prevalence of hypertension (38.5%), high cholesterol (10.7%) and diabetes (9.1%) and 52.2% of the sample was overweight or obese; 64.8% never exercised and 11.9% had two or more major risk factors of CHD.

The recent study by Nadeem et al. (2013) examining the risk factors for coronary heart disease in patients below 45 years of age found, in their sample of 109 patients, cigarette smoking (46%), hypertension (37%), dyslipidemia (33%), diabetes mellitus (18%) and above normal BMI (63.3%) are the most common risk factors (see also Rafique and Khuwaja, 2003).

Jafar (2006) found that women in Pakistan have an increased burden of clinical cardiovascular risk factors than men. Modifiable factors including obesity and saturated fat intake are associated with increased prevalence of CVD risk factors, hence the urgent need to target this group in CVD prevention.

Stroke

Stroke is a major public health problem in developing countries of South Asia (Farooq et al., 2009). South Asia has 20 per cent of the world's population and has one of the highest burdens of cardiovascular disease in the world. With an aging population there is the very likely increase in the incidence of stroke in developing countries like Pakistan (Hashmi et al., 2013). Limited data available from Pakistan indicate that stroke epidemiology differs between Pakistan and Western populations. However, they highlight that, in Pakistan, stroke occurs at a younger age, particularly among women, and there is a higher proportion of haemorrhagic strokes (Farooq et al., 2009).

Stroke rates in middle-aged people are five to ten times higher in Pakistan compared with the United Kingdom or United States. There has been limited progress in Pakistan due to a number of reasons, including poor awareness on the part of patients and general physicians on stroke symptomatology, management of stroke risk factors and limited knowledge of physicians on the role of rehabilitation and its different aspects in the management of post-stroke disability (Hashmi et al., 2013).

Diabetes

There is a strong association between diabetes and obesity (Ali et al., 2014).

Type 2 diabetes is highly prevalent among people of a Pakistani background (Mygind, 2013). In addition, Nisar et al. (2008) found that type 2 diabetes mellitus was common among parents and grandparents, making the student population prone to diabetes.

Masood and Afzal (2013) examined the prevalence of diabetes mellitus and its chronic complications along with co-morbidities contributing to atherosclerosis in the diabetic population of Mirpur, Azad Kashmir, with an initial sample of 3,602 patients. Of them, 318 were diabetics, the prevalence rate being 8.83%. Of the 318 patient study subjects, 24 (7.3%) had a history of stroke, 4 (1.3%) had a history of transient ischaemic attack, 17 (5.3%) had history of myocardial infarction, and 27 (8.5%) had a history of angina. Foot ulcers were present in 22 (6.9%) and 3 (.9%) had an amputation. Co-morbid hypertension was found in 153 (48.1%) of cases, whereas co-morbid hypercholesterolaemia was found in 66 (20.8%) and 56.9% had a family history of diabetes mellitus (see Fawwad et al., 2013).

There is also a strong indication that obesity increases over time. Fawwad et al.'s (2013) study into the changing patterns of diabetes in young adults from the rural area of Baluchistan, conducted at two time points in 2002 and 2009, found that obesity had increased significantly from 20 (10.15%) in young adults in the year 2002 to 64 (27.82%).

Diabetes and religious practice

Studies indicate that many Muslims with type 2 diabetes fast during the month of Ramadan but without adequate counselling on how to adjust their medicines. Although Islam allows ill people to refrain from fasting during Ramadan, the study by Mygind et al. (2013) found that all the participants in their sample had fasted during Ramadan and had type 2 diabetes. The study showed that they adapted their use of medicines in different ways, for example changing the time of intake or by skipping morning medicines. Respondents perceived a feeling of improvement in well-being, including physiological, social and religious aspects. However, major changes in dietary habits, daily physical activities and sleeping patterns during Ramadan have significant impact on glycaemic control, lipid profile, weight and dietary intake (Hui and Devendra, 2010). Interestingly, health professionals were rarely included in the decision-

making process; instead, it was friends and relatives, especially in the case of type 2 diabetes, that were considered important to the decision-making process (Mygind et al., 2013).

Hypertension

Akatsu and Aslam (1996) looked at the prevalence of hypertension and obesity among 151 women over the age of 25 in low income/underprivileged areas of Karachi, Pakistan. They found that 42% were overweight and 8% were obese. Most of the overweight/obese females had an upper body type obesity, which is an increased cardiovascular risk. The suggested interventions included diet education and weight monitoring by the community health workers.

Jafar et al. (2003), in their ethnic subgroup differences in hypertension in Pakistan, found that a threefold difference in prevalence of hypertension exists between people of South Asian descent. Interestingly, unlike the rural or urban areas, the difference cannot be accounted for by measured risk factors. Fawwad et al. (2013), in their study of young adults in Baluchistan, found an increase in hypertension increased from 13 (6.6%) in 2002 to 17 (7.39%) in their 2009 sample. Gender differences were highlighted by Ali et al. (2014), who found that females had relatively higher BMI and hypertension was more prevalent in obese diabetic patients.

Cancer

Marlow et al. (2012) explored awareness of cancer risk factors in ethnic minority men and women in England. The most commonly cited cancer risk factors were smoking (55%), diet (20%), genetics (20%) and lifestyle (17%). On average, participants were able to name cancer risk factors (91% of respondents) and cited 2.13 factors. The awareness of risk factors (particularly diet and exercise) was lower in this sample than other representative samples in the UK. They suggested interventions aimed at raising risk factors are likely to prove beneficial to ethnic minority groups. Fawwad et al. (2013) in their study of young adults in Baluchistan found that smoking increased from 8 (4.06%) in 2002 to 49 (21.3%) in 2009.

Access to services

Studies have shown that South Asians face barriers when accessing health services. Deaths from long-term health conditions (LTHCs) are set to

escalate rapidly worldwide over the coming decade. Many people from South Asian backgrounds in the UK face an increased risk of such conditions as a result of severe health inequalities compared with the majority of the population (Hipwell et al., 2008). Studies examining the utilisation of hospital services by South Asian patients in the UK have consistently highlighted levels of dissatisfaction with care in relation to meeting religious and cultural needs (Vydelingum, 2000; Lindesay et al., 1997).

Language

Communication is the greatest barrier in health care provision for people of non-English speaking backgrounds (Lee et al., 2005). For example, Phul et al. (2003) found that, as a result, they have insufficient knowledge about the range of health services available and it is difficult to obtain adequate access to healthcare and health information.

There is a dearth of literature that has reported associations between low literacy and less appropriate access to healthcare services (Easton et al., 2013; Brooks et al., 2000). For example, those who arrive as refugees have experienced poor health and limited access to healthcare services (Riggs et al., 2012). Blignault et al. (2008), in their qualitative study of barriers to mental health services utilisation among migrants, found that, although Chinese-language speakers comprise the largest non-English speaking population in Australia, they have the lowest rates of mental health utilisation. They conclude that mental health services must become more culturally competent in their attempts to engage the target group. The study by Houston and Cowley (2003) showed, through using one vignette, the practical and difficult issues when a formal system is used to assess needs in clients who do not speak English as a first language.

Cultural and language differences between host country and migrants from non-English speaking backgrounds can affect the use of health services (Chan and Quine, 1997). Similarly, the study by Watt et al. (1993) conducted in Hull, UK found that language difficulties is a major barrier in seeking health services. Further, poor communication and attitudes of staff act as an underlying problem between health professionals and service users (Davies and Bath, 2001). ‘Stereotyping’ was negatively affecting the health care received by Asian women in Great Britain (Bowler, 1993). Similarly, Lowe et al. (2007) highlighted considerable institutional barriers to accessing services.

To alleviate and to be inclusive, Yeowell (2010) suggests that a culturally competent health care needs to be provided where health

professionals have some understanding of the culture of their local community, thus enabling them to incorporate the patient's culture into their management. However, Hipwell et al. (2008) highlight the complexity of implementing both culturally-integrated and ethnically-specific public health interventions. Riggs et al. (2012) suggest that there is a need for a systems-oriented approach to improve service utilisation. There is a responsibility to provide equitable services irrespective of a patient's linguistic background, which proactively seek to overcome the disadvantage experienced by minority patients (Gerrish, 2001).

Interpreters

The use of interpreters may provide a solution to helping non-English speakers gain access to health services. However, there are a number of cultural and social concerns; for example, Richters and Khoei (2008) found that females are reluctant to use interpreters because of the lack of faith in their right to confidentiality. Similarly, Wellock (2010) found that female non-English speakers would not ordinarily divulge information to interpreters or relatives because of confidentiality and gossiping in the community.

Dunckley et al. (2003) suggest that translations into appropriate languages can overcome communication barriers and overlook the need for family members to act as interpreters for patients. For some, the problem is one of illiteracy, as is the case in Pakistan. The national language of Pakistan is Urdu and, although Urdu is spoken widely, given the illiteracy levels, much of the population is unable to read or write in Urdu. A further concern is that interpreters who lack appropriate training will fail to interpret accurately (Laws et al., 2004).

Ali et al. (2008) found that, among adult women in a rural district of Sindh, Pakistan, approximately 71% of women were illiterate and 44% of women between the ages of 18 and 24 were illiterate.

CHAPTER THREE

THE PAKISTANIS IN MIRPUR

When we think of 'Mirpur' we think of British Pakistanis who immigrated to the UK and, in particular, to Bradford (as well as other towns and cities such as Birmingham, Manchester and parts of London). Mirpur is a major city in Pakistan with historical links to Bradford. Some authors have labelled the city as 'Bradistan', an affectionate term to describe the existing and continued influence of Pakistan upon its residents in Bradford; examples of these are through maintaining close ties to relatives and through arranged marriages.

There has been an established historical link between Mirpur and Bradford since the late 1950s and early 1960s with the immigration of thousands of Pakistanis arriving from Mirpur and settling in Bradford to seek better financial opportunities. The continued link is seen through the 'keeping up of the traditions', for example the sending of remittances, arranged marriages and the regular visits to see relatives left behind. This continuation of traditions (particularly for older people) is important to maintaining close ties.

History of Pakistanis (Din, 2006)

After the separation of East and West Pakistan (later Bangladesh and Pakistan) in 1947 from India, Mirpur became one of the three districts of Azad 'Free' Kashmir (Rose et al., 1969) and the majority of Pakistanis came from this region (Shaw, 2001). The majority of Pakistanis who settled in the UK resided in Bradford and Birmingham (Allen, 1971; Taylor, 1976; Dahya, 1972-77; Shaw, 1988, 2000; Werbner, 1990).

There were several major reasons for the partition. Robinson (1993) argues that Muslim separatism was fostered both by the political needs of the British and by those of Hindus and Muslims. According to Robinson, this was important because the religious differences that separated Muslims from the Hindus were fundamental. For example, Hindus worshipped idols, whereas Muslims abhorred them. Hindus had many gods, the Muslims have one God. This created tension between the Hindu

population and the Muslims, who were in the minority. In addition, Muslims feared that the Hindu majority would not only interfere with Muslim religious practices, such as cow-sacrifices, but also religious differences would lead to discrimination against them in wider secular fields such as in education and in employment (Robinson, 1993; Brown and Foot, 1994).

After independence, Pakistan went through a number of social changes. This included, for example, the spread of primary school education, especially Islamic education and ideas of nationalism with reference to Kashmir. However, progress on the whole was slow, and unemployment was high (Rose et al., 1969; Taylor, 1976; Holmes, 1991). An illustration of poverty in Pakistan in the 1940s and the 1950s was the low literacy rate, as well as the poor provision of schooling (Braham, 1992). Due to high levels of poverty within the district of Mirpur, only a small number of young children entered secondary schooling and less than half stayed on at the age of 15. Thus, it is not surprising that the majority of the immigrants who came to Britain were illiterate (Khan, 1979; Kannon, 1978). It was estimated that unemployment was 7.4 million at the end of 1964 (Economist Intelligence Unit, 1966). According to the speech made by the President of Pakistan, Ayub Khan, at the time the per capita income was only £30 per annum (Rose et al., 1969).

To increase electrical output, the Pakistani government made a decision to build the world's largest hydroelectric earth dam at Mangla, which was constructed during the late 1950s and the early 1960s. As a result, it submerged 250 villages in the district of Mirpur and displaced approximately 100,000 people. As a result of the dam, a new Mirpur city emerged at the side of the lake, which replaced the old Mirpur town. Other displaced families were allocated land in the state of Punjab (Taylor, 1976; Holmes, 1991; Anwar, 1998).

Most families living in Mirpur were connected with the land; the majority were small peasant farmers or landless labourers (Taylor, 1976; Lewis, 1994). Dahya found that two-thirds of the 200 respondents interviewed had been farming their family land prior to migration. Furthermore, nearly half had been in the Armed Forces or had served in the Merchant Navy.

Family life

The village household is often three-generational, comprising of grandparent(s), married son(s), their wives(s) and children and unmarried son(s) and daughter(s). Property is communally owned, whether the source

of this is through work, land or wage labour, and decisions are communally made. The final decision rests with the head of the family, the eldest male, and authority is allocated according to gender and age (Khan, 1979). It is important to bear in mind that the izzat of the family is crucial for parents and biraderi elders.

Beyond the household, there are biraderi members (kin groups) whose members claim descent in a paternal line from a common male ancestor. Raza (1993) argued that, in village society, the individual forms part of a complex network of rights and obligations, which extend outwards from his/her immediate family to that of kin and fellow villagers. He defined biraderi as, 'it includes all men who can trace their relationship to a common ancestor, no matter how remote'.

Individualism and independence, so revered by the West, appears selfish to Pakistanis, who expect and value dependency and loyalty to kin members and kin groups. Within the Pakistani family, individual rights are dictated by age, sex and the order of birth. One of the main characteristics of village life is that everyone knows each other: close friends are classified as 'brothers' and 'sisters'. This network of friends and family also ensures conformity and deviants are 'pulled back' into line by the community (Khan, 1979; Rapoport et al., 1982). The family is the vehicle for conveying the group norms to ensure its survival is sustained by a religious ethos, and it is the religious element that gives these norms the strength and enforces the values of the biraderi (Basit, 1997). Individualism fostered by the white culture is almost unknown to people from rural Pakistan, who work and live together and where individuals are expected to be loyal and respectful to fellow kin members. In cases of disobedience, social pressure is exercised on its members to conform to traditional values (Hiro, 1991). This still holds true today.

In terms of biraderi relations, Raza argued that the individual does not act on his own behalf, but his/her reputation depends upon theirs and the fulfilling of obligations ascribed to him which, as a result, keeps the family 'bound' together (Raza, 1993). Wilson (1978) defined izzat as 'the sensitive and many faceted male identity which can change as the situation demands it – from family honour to self-respect and sometimes to pure male ego' (in Adams, 1978). Ballard argued that, in its narrow sense, 'izzat' is a matter of male pride (Rapoport et al., 1982).

Caste

In order to understand this community, it is important to explain their belief in the caste system. Before the independence of Pakistan from India

in 1947, Muslims, Hindus and Sikhs lived together in towns and villages across India, although each of these communities had their own traditions, norms and beliefs. Over a period of time, some of the traits of Hinduism and Sikhism became fused into the culture of Pakistanis/Muslims. This fusion between the Hindu and the Pakistani culture can be seen from examining marriage rituals and the practice of dowry. In Hinduism, the family of the bride must give a dowry to the groom, which can include a combination of money, gold and land (especially in Pakistan).

Singh (1959) found that, before the separation of Pakistan, Muslims, Sikhs and Hindus commonly visited one another's shrines and that many Muslim holy men had Hindu followers (Taylor, 1976). Caste plays an important part in the lives of Hindus, which determines the life chances of every individual. The highest caste in Hinduism is Brahman (Pardesh, 1994). Men born in this caste become priests and scholars and provide the spiritual leadership of their community. At the bottom of the caste hierarchy, and those deprived of caste affiliation, are the outcasts who are labelled as engaging in demeaning or polluting occupations by the society. The origins of the caste system can be dated as far back as 1500 BC to the ancient sacred writing of Rig-Veda (Skjonsberg, 1982).

Social stratification in Pakistan is based on the caste system. Unlike the Hindu system, the Pakistani caste system is not religiously based, but cultural. The highest caste in Pakistan is the Rajah or Jats, who are the landed gentry, the traditional ruling class in Pakistan. The lowest castes are Kamini, landless labourers, for example the Majaar caste, who may be shoesmiths, blacksmiths, etc. (Ranger et al., 1996). The social structure of the villages from which migrants are drawn closely parallels that of a Hindu caste system made up of a number of largely endogamous and nominally occupationally-linked descent groups (Shaw, 1994).

'The land of dreams'

Britain has a long history of white and non-white immigration to its shores. The presence of Asians in Britain can be dated back to the seventeenth century (Fryer, 1984; Visram, 1986). Indians began coming to the UK from the early part of the twentieth century as seamen (Aurora, 1976; Desai, 1963) and settled in areas such as Birmingham (Rose et al., 1969). Others, mainly white people, arrived from Europe and Eastern Europe. The numbers increased dramatically, especially after World War II. The mass migration of non-white workers started more slowly but, during the 1950s, increased substantially in the number of migrants from

the West Indies. Although mass migration from India and Pakistan began from 1945, it also reached a high level from 1960 onwards (Anwar, 1995).

In reality, there were few economic reasons to encourage Pakistani men to stay in Mirpur or indeed Pakistan (Khan, 1979; Holmes, 1991; Lewis, 1994). To those who had relatives or fellow kinsmen who were already settled in the UK, unlimited opportunities proved to be an important deciding factor in chain migration. Another motive for lower-caste families to immigrate was free 'vilayati' (English) education, which could improve the status of an individual as well as that of the family, whereas lower-caste groups had always been subjugated by those higher than them and never had the opportunity to climb up the social hierarchy (Kannon, 1978).

Roger Ballard argued that the early immigrants were drawn from peasant families with limited land holdings who could use overseas earnings to redeem mortgaged land, as well as buy more to provide sisters with dowries, to build new houses and to purchase agricultural implements (Rapoport et al., 1982). This was at a cost to those living in Britain, since most of the savings were sent to those relatives still left behind. They had to do without material things such as televisions. However, not all migrants who came to Britain were small farmers. A small number of urban educated middle-class migrants also arrived in Britain in the 1960s (Braham, 1992).

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

The money sent to Pakistan was used to pay off debts and to support family and relatives. Some early successful Pakistanis living and working in Britain invested large amounts of money in Mirpur. Dahya (1973), for

example, found that, in the district of Jehlum, Pakistani migrants had built a cinema, petrol station and flats (Khan, 1979).

Diet after Independence

The diet, especially after Independence, was pretty ‘simple’ (due to lack of affordability) compared to the present day. The ‘basics’, including roti and curry (vegetable, lentils), were served every day and meat was served once a week or on special occasions such as on Eid or when the family was entertaining special visitors, often those from overseas, for example from the UK. Pakistanis with all their ingenuity to survive made the most of staple ingredients; for example, potatoes are a versatile vegetable and, when cooked as a curry with a few spices, make it appetizing for hungry mouths. Most vegetables such as potatoes, carrots, aubergines and okra were grown at home in the vegetable patch, which allowed the family to survive, but flour had to be purchased from the bazaar (market). All the money earned by family members was spent on buying flour. In fact, the wealth of the Pakistani family was judged by the amount of flour they had in the home (it was gold dust).

Other staple foods such as milk were luxury products. If the resources allowed, then the family would purchase a small quantity of milk from a neighbour who could afford and keep a cow. Most often, the family would have black tea and, again, if resources allowed, they would have tea with cardamom seeds which would give black tea some flavour. Tea in Pakistan is made differently to the Western version. Most Pakistanis make tea with milk (few add a small quantity of water); it is a filling drink that, even on its own, could keep a stomach filled until lunchtime. Another rarity was sugar, which was expensive and only those with good incomes could afford to have it in Pakistan.

CHAPTER FOUR

RESEARCHING THE BRITISH PAKISTANIS

Introduction

This chapter examines research methods helping researchers to think about the way in which they go about collecting fieldwork data. Firstly, to understand minority communities (in this case, the Pakistanis). Secondly, the appropriate methods that help them to reach the desired goals and outcomes of data collection. How you reach the decision as regards to the methods that will be employed will depend upon one's epistemological background embedded in the theoretical perspective in the methodology.

Increasing participation of South Asians in research studies

The increasing culturally diverse groups in the UK have meant that barriers such as language need to be addressed. The recruitment of respondents with English as a second language to research studies is essential if their unique and valid perspective is to be acknowledged (Marshall and While, 1994).

Families from socioeconomically deprived and ethnic minority groups are less likely to participate in health services research and those who are likely to take part in research are more likely to be white British and from higher socioeconomic groups (Rahi et al., 2004).

The failure to include and/or identify subgroups of the population can undermine the value of research. This can have an impact on needs assessments and service delivery (Yildiz and Barnett, 2011).

Including participants from diverse backgrounds has a number of advantages for participants; for example, the evaluation by Fudge et al. (2007) on involving older people in health research focussed on the impact on participants and highlighted a number of benefits to participants, including increased knowledge, awareness and confidence, meeting others in a similar situation, as well as empowering older people in health research.

In their 2004 study, Hussain-Gambles highlighted a number of effective strategies that can be used to recruit South Asians to clinical trials, including ensuring the eligibility criteria are set as wide as possible, determining the most effective mass media to use in study promotion, and the recruitment and consulting of representative community members to provide assistance in the study. The latter involves asking the help of community leaders and elders to help in recruitment and publicising the study. Although elders would generally like to help researchers, they need to ensure that elders communicate the correct information to potential participants. However, the pitfall is when the researcher does not speak the language of the elder's community and there is no way of checking whether the study information is correctly translated to participants.

The later study by Hussain-Gambles et al. (2006) found that, although there was no antipathy amongst South Asians to the concept of clinical trials, a number of factors were highlighted that may act as a barrier, including age, language, social class, feeling of not belonging/mistrust and culture and religion. As a result, South Asians may be systematically excluded from trials because of the increased cost and time associated with their inclusion, particularly in relation to language barrier. They report that under-representation might also be due to passive exclusion associated with cultural stereotypes, and that the existence of an exclusionary health care culture continues to affect equity and access for people of a non-English speaking background (Blackford and Street, 2002).

The study by Homer (2000) highlighted that randomised controlled trials exclude women who do not speak English, or are designed in such a way that cultural diversity is not facilitated. This can lead to a sample that is unrepresentative of the population from which it was drawn or to which it will be applied. Homer points out that culturally diverse representation can be achieved through employing a number of strategies, including utilising health-care interpreters, ensuring materials are translated into common community languages and engaging the local community. This should ensure that the sample in a randomised controlled trial is culturally and linguistically diverse.

Similarly, changing population demographics and immigration patterns have resulted in increasing numbers of Canadians speaking a language other French or English. The inclusion of non-English speaking groups is important if disparities in access and use of preventive health care services are to addressed (Thomson and Hoffman-Goetz, 2011).

In the study by Plumridge et al. (2013), which looked at the under-representation of minority ethnic groups in cardiovascular research, it found that few participants had any understanding of the objectives and

nature of research. If this is explained to potential participants, many would describe altruistic reasons for why they would participate in research in the future. The willingness to take part in research as long as participants are approached directly and the reasons for research and potential benefits are explained to them. It is important to build a rapport with participants, but this involves time commitment on the part of the researcher and spending time at the places of recruitment is important.

Researchers face challenges when obtaining consent from participants since the majority of the general population has limited or no familiarity with research studies. This is further problematic when obtaining consent from individuals with low literacy levels and those who speak languages other than English (Cortes et al., 2010). One case in point is that the national language of Pakistan is Urdu; however, there are many dialects which are spoken locally. For example, many Pakistanis living in Bradford speak Mirpuri, Punjabi or Kashmiri and these dialects have no written equivalent, thus information sheets and consent forms cannot be devised. There are alternatives, for example having verbal consents instead of written consents, and the Information Sheets can also be verbally translated. However, one main disadvantage is that, in many cases, participants like to read the information at their leisure and then decide whether they would like to participate. Another problem is that, even if researchers speak the same dialect, they will most likely translate information differently; there is also the possibility of 'glazing' over certain information. Other areas of concern in health research is that medical terms are difficult to translate into a dialect, especially if one is recruiting patients for clinical trials.

A study by Hunt and Bhopal (2004) highlighted a number of potential pitfalls where instruments that are designed for English speakers are simply translated into ethnic minority languages, where measurement error can result from inadequate translation procedures, inappropriate content, insensitivity of items and the failure of researchers to make themselves familiar with cultural norms and beliefs. The latter is paramount in understanding minority ethnic communities, and being aware of such issues allows the research to be transmitted in culturally acceptable terms. The point to remember is that 'one size does not fit all'. These issues should be dealt with at the exploratory or pilot stage and, with careful planning, many of the barriers can be overcome.

The study by Hanna et al. (2012) highlights some of the pitfalls of translating material into community languages. Participants were asked to elaborate on their understanding of the question and meaning of keywords or phrases. For example, the translation for 'chest' was interpreted by

some Pakistani and Chinese women to mean ‘breasts’, and ‘walking up the hill’ was translated in Chinese as ‘walking the hill’, an interpretation pertaining to walking downhill.

Using interpreters for research purposes

For purposes of research, Simon et al. (2006) show that language interpreters mediate a growing number of health care communication events, including the informed consent process which underlies the ethical conduct of clinical research. They highlight the concern around the accuracy of the interpretation, for example the concept of ‘randomisation’, often poorly communicated and interpreted, and that clinicians need to use less technical language and shorter sentences and to be more ‘process driven’. The type of methods used by the research study are important; for example, Twinn (1997) suggests there can be particular problems in using translations in phenomenological research designs.

Fieldwork: arranging interviews (Din, 2008)

The interview is a fluid process allowing the participants the opportunity to ask questions or take a break from answering questions. It also allows participants enough flexibility to change the focus of the interview in order to raise issues or change direction; the researcher should adapt the questions accordingly. To allow for this, there were no pre-set questions, nor was a traditional topic guide written. Most interviews begin with pre-set questions to be discussed with participants, which do not allow or have limited opportunity to allow a participant to steer away from specific questions. These questions are answered in a question-answer session; the participant is guided through the topic guide or an interview schedule. This can lack fluidity.

Research questions develop as the study progresses and may mean that the direction of the research changes. It is practically impossible to predict what participants will say or whether they will raise issues of importance. Research can be preset in other ways. Often, the cohort and the sample ranges are decided before the data collection phase. Practically, it may be difficult to get that precise number of participants recruited for the study, or even interested in taking part. More seriously, there is the issue of reliability; it is difficult to predict that *x* number of interviews will provide a sufficient consistency in the data to stop interviewing, or indeed it may be necessary to conduct further interviews.