

**UNDERSTANDING HEALTH BELIEFS AND LIFESTYLE PRACTICES IN
RELATION TO SOCIAL SUPPORT IN THE PAKISTANI COMMUNITY, WEST
MIDLANDS, UK.**

by

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ABSTRACT

South Asians, specifically Pakistanis, living in areas of socio-economic deprivation across the UK, have an elevated risk of cardiovascular disease (CVD). The purpose of this research was to explore how social networks function as a source of support and information (social capital) in creating lifestyles associated with CVD prevention in a migrant, minority-ethnic Pakistani population.

Semi-structured qualitative interviews were carried out using an interview guide and the convoy model diagram to elicit participant's responses on social networks, community interactions and lifestyle choices (diet and exercise). A total of 42 participants across three migrant generations, diverse educational and occupational backgrounds, men and women aged 18 years and above participated. Framework analysis was used to analyse transcripts and organise codes, themes and categories. Findings distinguished a diverse narrative amongst men and women with regards to making lifestyle choices and gaining access to social support within or outside of the Pakistani community.

Conclusively, engagement beyond familiar community contexts could provide greater or novel sources of support and information for pursuing (at times) non-traditional, healthier lifestyles. Understanding shifting perceptions of health in relation to religion, culture and ethnic-identity could provide primary care practitioners with a better understanding of how to treat high-risk patients.

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List of abbreviations

ASSIA	Applied Social Sciences Index and Abstracts
BME	Black and minority ethnic
BMEG	Black and minority ethnic groups
BVS	Birmingham Volunteering Services
CAQDAS	Computer-Assisted Qualitative Data Analysis Software
CASP	Critical Appraisal Skills Programme
CHD	Coronary heart disease
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CVD	Cardiovascular disease
DESMOND	Diabetes Education and Self-management for Ongoing and Newly Diagnosed
EM	Explanatory Model
EMBASE	Excerpta Medica dataBASE
GP	General Practitioner
IBSS	International Bibliography of Social Sciences
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
PA	Physical activity
PPI	Patient and Public Involvement
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
QOL	Quality of Life
RCTs	Randomised Control Trials
SA	South Asian
SES	Socio-economic status

UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

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CHAPTER 1

1.0 INTRODUCTION

1.1 RESEARCH FOCUS

The findings of a qualitative exploration of social capital in forming lifestyle choices associated with the prevention of cardiovascular disease (CVD) are presented in this thesis.

The population taking part in this research contains members of the migrant Pakistani community, in the West Midlands, UK. The research was funded by the University of Birmingham College of Medicine and Dentistry.

The research is presented from a first person active voice, as this perspective can be used in medical sociology and qualitative research to show the reflective process as a researcher completing analysis and interpretation (Patton, 2001; Paterson, 2008:89).

1.2 BACKGROUND

The risk of CVD and associated illnesses has been increasing in the UK over the last decade, with more than 27% of deaths being attributed to CVD (Townsend *et al*, 2015). Prevalence of CVD can vary across ethnicity, socio-economic status and constituency (Townsend *et al*, 2012). CVD risk is higher in minority-ethnic populations from socio-economically deprived backgrounds (Gill *et al*, 2007). As a multi-factorial condition, CVD is affected by health and lifestyle factors including diet and exercise (Shah, 2006). Health campaigns have encouraged healthier lifestyles to prevent the onset of CVD, however, the effectiveness of these initiatives is debatable (Lang and Rainer, 2003).

Individuals from lower and middle-class socio-economic groups, or from under-developed countries, in particular South Asians, are at greater risk of CVD (Chandola, 2001). In comparison to European ethnic groups, Black-Caribbean and South Asian populations

have an increased risk of developing CVD, with the latter having a 50% higher risk of death caused by CVD (Scarborough *et al*, 2010).

The South Asian population is heterogeneous, where members of the community have different social, cultural and religious beliefs and lifestyle practices. The Pakistani Muslim community in the UK is prominent amongst the other South Asian sub-set groups e.g. Indian (Sikh or Hindu) or Bangladeshi (Muslims). Pakistani men have a greater propensity of CHD (8%) than Indian men (6%), where Pakistani and Bangladeshi groups have a higher morbidity rate for CVD compared to Indian men and are more likely to report lower self-reported health (Nazroo, 1998; Chandola, 2001).

The Pakistani community encounters greater levels of income deprivation (Kenway and Palmer, 2007), lower levels of education (Modood *et al*, 1998), and is more likely to live with obesity, hypertension (Smith *et al*, 2012) and poor emotional well-being than their White, British counterparts (Gater *et al*, 2010). Social and healthcare inequalities amongst Pakistanis in the UK can be attributed to differences in lifestyle. As a result of migration, members of the Pakistani community have been exposed to novel social and environmental factors that have shaped their identity, including limited networking opportunities for women (Tolia-Kelly, 2004). There are differences based on generation (Fazil *et al*, 2006) and gender that may influence lifestyle choices (Babakus and Thompson, 2012).

It is an assumption that individuals from minority groups have the appropriate social or familial support to manage or prevent health conditions (Katbamna *et al*, 2004), and a lack of social capital could influence the health inequalities experienced by the Pakistani community. Social capital is the access to available social resources including support and information, based on social networks, trust and cultural norms (Lin, 2001). Social capital could compensate for socio-economic deprivation; yet, the complex structure of social

networks challenges this potential and requires further investigation (Wierzbicki, 2004; Griffiths *et al*, 2005).

Research has focused on the health and social care of first-generation migrants as mixed-cohorts, compared to White British populations, or second-generation British Pakistanis.

There remains potential for research with regards to social support for the prevention of CVD amongst first, second, and third-generation Pakistanis.

1.3 RESEARCH DESIGN

The aim of this research was to explore how social networks function as a source of support and information (collectively, social capital) in developing behaviours associated with CVD prevention in a migrant, ethnic-minority community.

A qualitative approach was used by conducting in-depth, semi-structured interviews using a piloted interview guide, as well as the convoy model diagram to elicit responses on social networks. An interpretative epistemological approach was applied during analysis to understand perceived social capital as a phenomenon through meanings assigned by the individuals (Yanow and Shwartz-Shae, 2015: 138). The process was reflexive in order to limit subjective bias. Social capital was used as a guide to collect data and a theoretical lens for analysis.

1.3.1 Research characteristics

It is important to detail the context of the research study, but also the perspective of the researcher. I have a background in Psychology (BSc Psychology, University of Birmingham, 2010), Health Psychology (MSc Health Psychology, Aston University, 2011), and Social Research (MA Social Research [Social Policy], University of Birmingham, 2012). As a

researcher, I have an interest in qualitative methodology to explore health beliefs and behavioural change.

A proactive approach to recruitment and data collection was applied due to my cultural background. I was born and raised in a migrant, Pakistani family, and feel I can acknowledge and understand the different cultural and religious practices of the British Pakistani community. I grew up in Birmingham with an awareness of diverse multi-ethnic and multi-faith communities. I recognise myself as British, Pakistani, and Muslim. My background helped to identify participants in my research in terms of having a socially, culturally and religiously diverse identity.

Despite an increased awareness of socio-cultural practices in the Pakistani community, there were methodological challenges towards recruitment and data collection regarding cultural etiquette and behaviour. Issues included communicating with elders, dressing appropriately in front of men and women from different generations, choice of language (Urdu) amongst first and second-generation participants, translating medical and research terms, and being explicit about socio-culturally specific idioms.

1.4 OUTLINE OF THESIS

Chapter 2 is an overview of the available literature on the prevalence and development of CVD, health inequalities amongst minority-ethnic groups, and theories surrounding social support (social capital, convoy model of health, goal pursuit and instrumentality). Chapter 3 is a qualitative synthesis of literature on social support for CVD prevention in the migrant Pakistani community. Chapter 4 describes the methodological approach used in the study, including novel recruitment techniques, the methods chosen to collect data, analysis, interpretation and presentation of findings.

The findings of this research are organised into two chapters based on emerging narratives from tri-generational male and female participants. Chapter 5 presents findings from interviews carried out with men, and Chapter 6 presents findings from interviews with women. Both chapters (5 and 6) are an inductive exploration of health beliefs and status within local and personal social networks as a unique method of data analysis and interpretation.

Finally, Chapter 7 is the conclusion of the research. The main results are discussed in relation to relevant literature, the strengths and limitations of the methodology and data, and contextualising the findings within British health policy and providing recommendations for further research.

CHAPTER 2

2.0 BACKGROUND

2.1 INTRODUCTION

I will outline the context of the research with an emphasis on cardiovascular disease (CVD) and associated lifestyle behaviours in the South Asian community residing in the United Kingdom. Consequently, behavioural interventions designed to prevent and manage CVD and associated illnesses will be outlined, followed by a discussion of the socio-cultural needs of minority-ethnic groups. A focus will be maintained on the heterogeneity within the South Asian community, for whom behavioural patterns and lifestyle choices are influenced by ethnic variation, age, gender and generational differences. Finally, concepts surrounding health and social support will provide a greater understanding of how social networks can function as sources of support (and information) in communities facing deprivation.

I will summarise findings from the literature, identifying key concepts, strengths, limitations, and gaps in the research. An overview of the chapter will be provided.

2.2 RESEARCH IN CONTEXT

2.2.1 Prevalence of cardiovascular disease

CVD can present itself in the form of high blood pressure, hypertension and arteriosclerosis, which increases the individual's risk of a fatal heart attack or stroke (Shah, 2006). Diabetes and obesity are also associated with CVD risk (Dyakova *et al*, 2013). It is estimated that the European economy spends €196 billion through direct health care (54%), productivity losses (22%) and the informal care of people with CVD (22%) (Nichols *et al*, 2012). In the UK, up to 65 000 deaths were the result of coronary heart disease (CHD); linked to poor health

outcomes, and has cost the National Health Service (NHS) approximately £3.2 billion, with a total of £9 billion dedicated to healthcare provisions (Townsend *et al*, 2012).

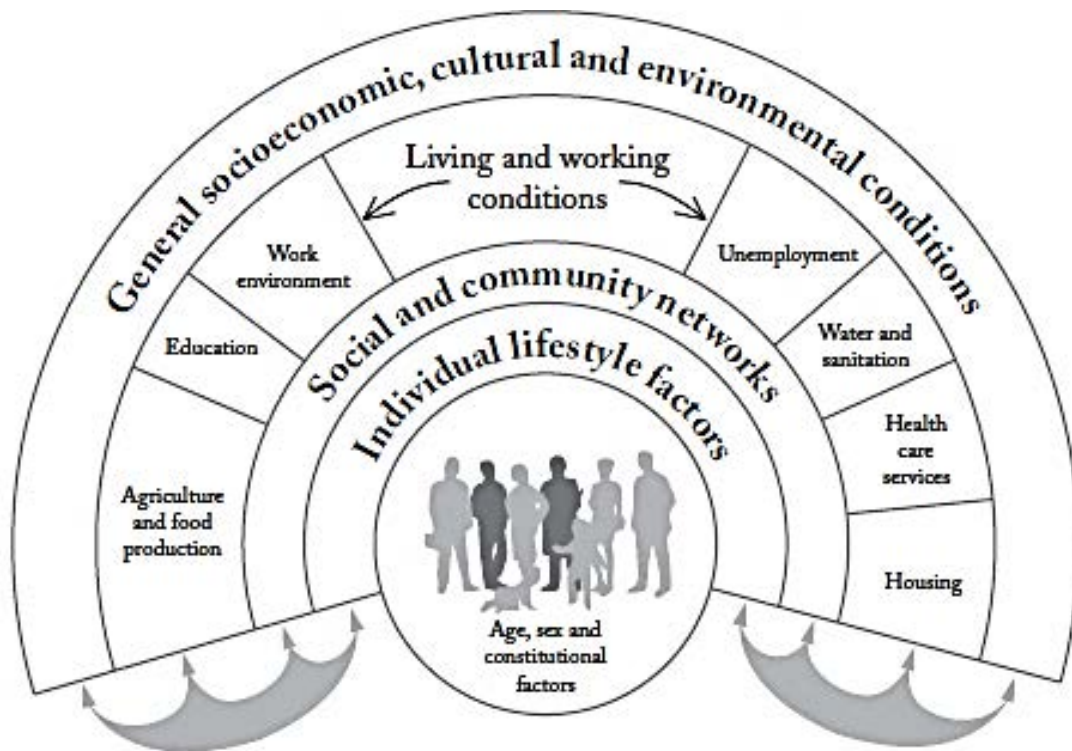
Mortality from CHD has more than halved since 1961 from 166 000 to 80 000 in 2009 (Scarborough *et al*, 2011), but CVD continues to have relevance as a cause of premature mortality (Townsend *et al*, 2015). According to the British Heart Foundation (Townsend *et al*, 2012), CVD is the most common cause of death across all ages for men (26%) and women (18%), second only to cancer.

The World Health Organisation (WHO) defines health as:

“State of physical, mental and social well-being, and not merely the absence of disease or infirmity” (WHO, 2015)

As a multi-faceted illness, CVD encompasses a variety of health and lifestyle factors that determine its outcome. Both environment and genetic factors play a role in the development of the disease and its prognosis. These risk factors include age, sex, ethnicity, high blood pressure, cholesterol levels, smoking, alcohol intake, obesity, family history of CHD, levels of physical activity and diabetes, as well as the psychosocial and environmental features (Shah, 2006; Gill *et al*, 2007). Dahlgren and Whitehead (2007) provide a framework for understanding how social, environmental and behavioural factors determine health outcomes (Figure 1).

Figure 1: The main determinants of health



(Dahlgren and Whitehead, 2007)

With CVD being one of the main causes of mortality, its prevention and management is high on the agenda for healthcare service providers and requires investigation of causal factors. Subsequently, addressing healthcare issues at a national level is a fundamental target of healthcare policy, in order to lower future cases of CVD and the associated costs and demand on resources (Smith *et al*, 2009; Dyakova *et al*, 2013).

The effectiveness of these health campaigns and initiatives is often debated, as there have been reports of both positive and neutral effects on individual health outcomes and cost effectiveness (Anderson, 2000; Lang and Rayner, 2003; Hastings *et al*, 2005). A potential factor influencing the success, or lack of, with health interventions, could be based on the epidemiology of CVD. Individuals belonging to lower and middle class socio-economic status (SES) groups, or from under-developed countries are at a higher risk of developing

CVD and associated illnesses (Chandola, 2001; Shelton, 2005). Individuals from the aforementioned communities are at a higher risk of developing heart disease, diabetes and obesity as a result of lifestyle factors which are not closely monitored and can, affect the ability to address any potential unhealthy behaviours (Millett *et al*, 2007; Smith *et al*, 2012).

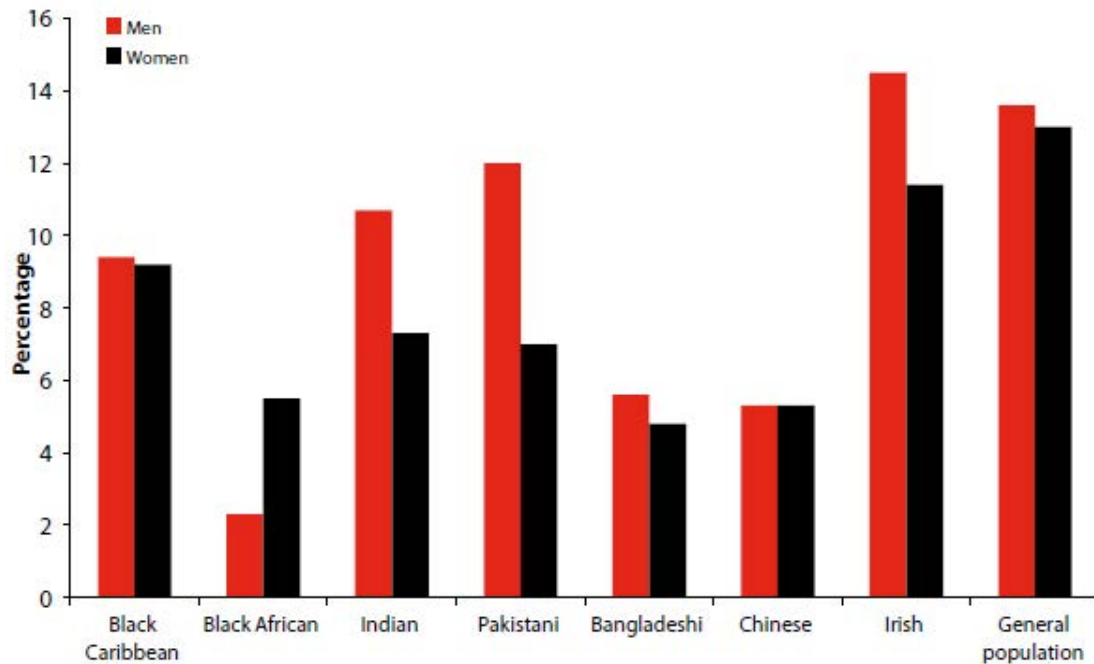
Although CVD is a cause of premature death across the UK, prevalence can vary based on ethnicity, socio-economic status and region (Townsend *et al*, 2012). For example, mortality rates are highest in Scotland and lower in England (Townsend *et al*, 2012).

Neighbourhood deprivation is associated with increased risk of CVD (Ramsay *et al*, 2015). South Asian communities are more likely to live in areas of socio-economic deprivation compared to their European counterparts (Netto *et al*, 2011), with Indians being more socio-economically advantaged than Pakistanis or Bangladeshis (Bhopal *et al*, 2002).

South Asian men and women have a higher rate of myocardial infarction than non-South Asians, with the highest prevalence of CHD in Pakistani (8%) and Indian (6%) men (Scarborough *et al*, 2010). When comparing Black and minority ethnic (BME) groups to the general or White British population, Pakistani men have the highest prevalence rates of CVD (Figure 2) (Scarborough *et al*, 2010).

The health gap between men and women is also great amongst South Asians than that of the general population, with men reporting higher prevalence of diabetes, and more women reporting angina problems (Williams *et al*, 1993; Williams *et al*, 1994).

Figure 2: Prevalence of CVD by sex and ethnic group, England 2004



There has been a smaller decrease in mortality rates from CHD amongst Pakistani women (14%) compared to Indian (53%) and East African women (55%) since 1979 (Scarborough *et al*, 2010).

2.2.2 Associated lifestyle factors for CVD development

Lifestyle choices and modifiable risk factors are associated with an increased risk of CVD including smoking, having a diet that is rich in sugars and saturated fats, physical inactivity, and high alcohol consumption (Buttar, Timao and Ravi, 2005) (Table 1). For instance, high cigarette consumption has multiple, adverse physiological effects, and is associated with raised blood pressure, and can increase the risk of stroke (Townsend *et al*, 2014). The proportion of people smoking in the UK has fallen by over a half from 46% in 1974 to 19% in 2013 (Office for National Statistics, 2014). Although prevalence of smoking remains lower in people of South Asian descent (Indian, Pakistani, Bangladeshi) than the majority of the

population, 43% of Bangladeshi men smoke compared to the national average 27% (Zaman and Mangtani, 2007).

Refraining from unhealthy behaviours, such as smoking, can reduce the risk of developing CVD. Regular physical activity alongside a healthy diet consisting of low saturated fats, and a regular intake of a variety of fruits and vegetables is also important (French *et al*, 2010). The percentage of the population who carry out 30 minutes of moderate intensity exercise was 36%, and only 24% of men and 29% of women consumed the recommended 5 portions of fruit and vegetables a day (NHS health and social care information, 2005; National Obesity Observatory, 2011).

Due to cultural and religious disapproval, Bangladeshis and Pakistanis have high levels of alcohol abstinence compared to individuals from Indian, Black and Chinese communities, or the general population (where a quarter of men and 15% of women consume greater units of alcohol than the recommended levels) (Office for National Statistics, 2012; Lifestyle Statistics, Health and Social Care information Centre, 2014).

European people are reported to be more physically active than South Asian men and women, where low levels of physical activity could be contributing to higher levels of diabetes and CVD risk (Hayes *et al*, 2002). Non-White ethnic groups show lower rates of participation in physical activity (Eyeler *et al*, 2003). In 2004, physical activity levels for South Asian communities in England were considerably lower compared to other ethnic groups. Bangladeshi and Pakistani men engaged less frequently in physical activity, sports and exercise, and activities such as walking (Hayes *et al*, 2002). Similar trends are displayed by Pakistani women, who fail to meet the recommended 30 minutes of moderate to vigorous physical activity a day (Pollard and Guell, 2012). South Asian families have reported a low likelihood of physical activity and limited awareness of cholesterol or dietary content (fibre, sugar, salt).

According to the Health Survey of England, levels of obesity have been increasing overall for women living in areas of high deprivation (Public Health England, 2014). Obesity places an unnecessary and excessive amount of strain on the heart and other internal organs, making the individual vulnerable to developing diabetes and other chronic diseases (Akabas *et al*, 2012). The world health organisation has recommended using lower thresholds to define overweight and obesity in South Asians who have higher body fat compared to White Europeans (Bryant *et al*, 2014). Obesity is more common in Pakistani and Indian women than Bangladeshis, indicating variation in coronary risk factors in the South Asian population (Bhopal *et al*, 1999; Raza *et al*, 2013).

The 2004 prevalence of doctor-diagnosed-diabetes, 4% of men and 3% of women diagnosed with type 2 diabetes were from Black Caribbean, Indian, Bangladeshi and Pakistani men. Amongst women, Black Caribbean (8%) and Pakistani (9%) women had the higher prevalence (Scarborough *et al*, 2010). Migrant South Asian groups have the highest susceptibility to type 2 diabetes in the UK (11-33%), followed by Norway (14-28%) and the United States (18%) (Garduno-Diaz and Khokar, 2012).

Table 1. Non-modifiable and modifiable risk factors for CVD

Non-modifiable risk factors	Modifiable risk factors
<ul style="list-style-type: none">• Age• Gender• Family history• Ethnicity	<ul style="list-style-type: none">• Smoking• Hyperlipidaemia (cholesterol and triglyceride)• Hypertension• Obesity• Diabetes• Lack of physical activity

(Kohl and Murray, 2012: 77)

Despite genetic predisposition, reasons behind an increased risk for CVD amongst Black and minority ethnic groups (BMEGs) are not fully understood. However, an increased prevalence of obesity, hypertension and diabetes, alongside economic deprivation could contribute to the disproportionate incidence of CVD (Bhopal *et al*, 2002).

The South Asian community includes individuals from India, Pakistan, Sri Lanka and Bangladesh, encompassing a myriad of cultural and religious beliefs (Aspinall, 2003). It is an assumption that members of the South Asian community display homogeneity, as there are differences in prevalence of illnesses, access to services, and prognosis (Johnson, 2000; Ingram *et al*, 2003; Grewal *et al*, 2004; McCormack *et al*, 2004). Members of the South Asian community have diverse attitudes towards diet, physical activity and lifestyle practices associated with cardiovascular risk (Farooqi *et al*, 2000). Bhopal *et al* (1999) highlighted the need for sub-group analysis to provide a nuanced reflection of health beliefs and lifestyle choices in the South Asian community.

Culturally and religiously different lifestyle choices could be influencing the levels of diabetes and obesity in the South Asian diaspora. Self-reported CVD in people aged over 55 years was highest in the Pakistani sub-group, with a comparatively larger percentage of men and women with obesity (15% and 28%) than Indian (14% and 20%) and Bangladeshi (6%

and 17%) (NHS Health and Social Care Information Centre, 2005; National Obesity Observatory, 2014). The prevalence of CVD, associated illnesses and lifestyle factors (e.g. deprivation) prompts further research.

2.2.2 Prevention and management of CVD

Primary care services provide facilities for routine check-ups to monitor the development of CVD (such as blood pressure monitoring or weight loss clinics), but prevention is a cost effective measure (De Backer *et al*, 2003). Primary care facilities can monitor these intermediate risk factors and assess the likelihood of an individual developing CVD, however, it remains essential that other lifestyle factors are addressed.

It is possible to reduce the risk of developing CVD /CHD by altering modifiable risk factors, such as diet and exercise (Chow *et al*, 2010; Claassen *et al*, 2012; Qi *et al*, 2012). Consequently, healthcare service providers and policy makers rely on evidence based on health research to make recommendations for CVD prevention, including access to services and health promotion campaigns (Murray *et al*, 2009; Herbert *et al*, 2010; Piggitt and Lee, 2011; Capacci *et al*, 2012). For example, the ‘stop smoking, start living’ (NHS, 2015) campaign highlighted the negative consequences of smoking cigarettes, and individuals were encouraged through multi-media (i.e. TV) to monitor their weekly consumption. The ‘healthy eating’ campaign initiated by the NHS advocates an inexpensive and simple diet, which involves meals limiting the intake of fat, salt, carbohydrates and sugars, as well as promoting physical activity (NHS Choices, 2015).

The aim of these campaigns is to provide public awareness of the health benefits that can be achieved by adopting a healthier lifestyle. An important element of these campaigns is to make information accessible and understandable, whether it is presented by healthcare

staff in primary or secondary care, or discussed between family members and friends (Grilli *et al*, 2001; Smith and Foxcroft, 2009).

UK health policy has paid attention to promoting initiatives to help individuals managing long-term conditions (Department of Health, 1999), including self-management programmes such as the Expert Patient Programme (Kennedy *et al*, 2007) and DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) (Davies *et al*, 2008; Khunti *et al*, 2012). Despite such efforts to raise awareness, it is difficult to assess the impact of educational interventions on South Asian migrants with type 2 diabetes. It is easier to increase knowledge of disease amongst the South Asian community rather than the outcomes (Khunti *et al*, 2008).

2.3 HEALTH SERVICES AND UK POLICY: ADDRESSING ETHNIC SPECIFIC NEEDS

With a growing, ethnically diverse and ageing population there is mounting pressure on the NHS, specifically primary care services, to meet growing challenges (Moriarty and Butt, 2004; Boneham and Sixsmith, 2006; Lievesley, 2010).

The race equality act identifies the need to overcome cultural barriers in providing fair and equal treatment to individuals from all religious and ethnic backgrounds. When developing preventative health care services, it is necessary to consider the many different multi-cultural communities within the UK (Shelton, 2005). Such considerations should be a priority in policy makers' agendas, especially considering the significantly higher rates of CVD /CHD within minority-ethnic groups (Phul *et al*, 2003).

Targeting inequalities would not only benefit minority-ethnic groups in accessing equal healthcare, but can also enable the NHS to reduce costs and pressure on resources.

An attempt has been made to use Urdu or Hindi in campaigns directed at South Asian communities; yet, there are many cultural issues that advertisements fail to consider (Lip *et al*, 1996; White *et al*, 2006; Phul *et al*, 2003). Access to multimedia is influenced by familial relations, for example, second-generation Pakistani Muslim mothers are more likely to be exposed to mainstream culture on television programmes than first-generation mothers who live with their in-laws (Parsons *et al*, 1999). Exposure to healthcare initiatives within the South Asian community is limited to individuals who have access to speciality TV channels and live within communities that watch and discuss multi-media regularly. A minority-ethnic group with an increased risk of developing CVD should have greater access to preventative healthcare information (Szczepura, 2005). Further considerations need to be made in order to take into account the manner in which individuals within minority-ethnic groups have access to sources of support and information.

There is a divergence between reported satisfaction with healthcare services and effectiveness of care and information provided. Smoking cessation research, when taking ethnicity into account, has found little effectiveness of the interventions employed. Limited awareness among the older generation, a sense of apathy from younger individuals, a lack of expressed internal control, and the influence of external forces such as faith or religion have been noted (White *et al*, 2006).

Limited effectiveness could be a result of poorer self-rated health, despite reported high levels of satisfaction with health services in Pakistani and Bangladeshi communities (Madhok *et al*, 1998; Chandola, 2001; Smith *et al*, 2012). Dissatisfaction with healthcare services can vary by ethnicity. In contrast to minority ethnic-groups, British White populations express greater dissatisfaction with community-based services, possibly due to raised expectations of healthcare services (Karlsen *et al*, 2002).

Minority-ethnic communities can be heterogeneous in their healthcare needs. Inequalities are more complex than differences between the general population and individuals from minority-ethnic groups; there are marked variations between and within these groups. Evidence has shown significant social class differences in morbidity and mortality rates within Indian, Pakistani and Bangladeshi communities in the UK, with Bangladeshi and Pakistani men having higher morbidity rates compared to Indian men (Bhopal *et al*, 2005).

High morbidity is common amongst socio-economically disadvantaged Pakistani and Bangladeshi minorities. High morbidity can be explained by low income, duration of working day, crowded housing, and liability to attack, or lack of social support for women (Cooper, 2002). Additional factors include lower educational qualifications amongst Pakistani and Bangladeshis than any other ethnic group (Modood *et al*, 1998).

South Asian Muslim women with limited English language skills reported high levels of distress on psychosomatic measures (Williams and Hunt, 1997; Cooper, 2002). Pakistani women in the UK, suffering from depression, can be misdiagnosed, or treatment can be overlooked as a result of cultural and religious barriers (Chaudhry and Shabana, 1994; Husain, Creed and Tomenson, 2000; Burr, 2002; Gater *et al*, 2010; Chaudhry *et al*, 2012). Therefore, ethnic and gender based differences require greater attention from healthcare service providers targeting inequalities.

2.4 SOUTH ASIAN DIASPORA

Defining ethnicity has been a key issue for health and social researchers as terminology is ever evolving. The use of the term “ethnicity” is favoured over race, as it has fewer racial connotations and includes environmental, behavioural, cultural, social and political experiences of groups and individuals (Lee, 2009; Aspinall, 2003).

The use of terms such as ‘Asian’ or ‘Black and minority-ethnic’ can be simplistic and overlook self-identity and heterogeneity of ethnic groups based on nationality, religion, migrant status and language (Bhopal, 2004). The term South Asian has been more commonly used in UK based applied health research.

For example, the term South Asian is

“Adopted by census, survey and other government instruments to identify the collective ethnicities of migrants and their descendants” (Jepson *et al*, 2012)

“Of first and subsequent generation immigrants originating from the Indian subcontinent (India, Pakistan, Bangladesh, Nepal and Sri Lanka) are referred to as ‘South Asians’” (Misra and Khurana, 2010)

The South Asian community is one of the largest minority-ethnic groups in the UK, with Indian, Pakistani and Bangladeshi communities representing 2.5%, 2% and 0.8% of the whole population, respectively (Office for National Statistics, 2012).

The majority of British South Asians are, by religion, Muslims (two thirds from Pakistan [Kashmir and Punjab] and a third from Bangladesh [Sylhet]), Hindu (majority self-identifying as Indian [Gujarat]) and Sikh (with familial roots in north-west India or Pakistan), and a smaller proportion of Christians, Jains, Buddhists and Zoroastrians (Persian) (Jacobsen and Raj, 2013). Migration of the South Asian diaspora was traditionally a result of fulfilling a post-war labour shortage during the 1950-60’s, and led to concentrated settlements across the UK, such as the West Midlands, Manchester, Bradford and Glasgow (Ali, Karla and Sayyid, 2006:206).

Communities can be defined in geographical terms or common characteristics (Campbell and McLean, 2003). Yet minority-ethnic communities are moving away from the generic identification as South Asian, towards national identification i.e. Pakistani (Chatterjee and Washbrook, 2013).

Nazroo and Karlsen (2003) state “the creation and expression of an ethnic identity relates to self-description, a traditional identity, participating in ‘community’, and being a member of a racialised group”.

2.4.1 Health beliefs of the South Asian diaspora

Lay health beliefs can be defined as practices that are socially embedded and ‘shaped by people’s situations in the social structure, their cultural, personal biography, and social identity’ (Green, Phillips and Fryer, 2004:106). For example, decreased adherence to medication, and hesitation to participate in cardiac rehabilitation has been associated with lay beliefs and cultural attitudes against taking advantage of healthcare services, and a lack of awareness of CHD amongst South Asian groups (Gohar *et al*, 2008; Zaman *et al*, 2009, Babakus and Thompson, 2012; Galdas *et al*, 2012).

Research studies have identified barriers to regular physical activity. These include a lack of time, socio-cultural expectations sustained by individuals’ poor perception, and limited knowledge of the benefits of physical activity (Lawton *et al*, 2006). A systematic review by Babakus and Thompson (2012) on physical activity among South Asian women revealed lower levels of physical activity compared with South Asian men and the White European population. The majority of the themes from the review revealed cultural barriers, for example prioritising time for the family, and structural barriers such as personal safety when unaccompanied in the neighbourhood. Faith and education were perceived as facilitators, however there was a prominent lack of understanding about recommended

amounts of exercise or its benefits (Babakus and Thompson, 2012). The systematic review suggested better understanding of how to utilise existing social resources available to individuals and communities to increase physical activity and overall health of South Asian women. It is an assumption that health practices are being carried out in a social vacuum, and socio-cultural factors should be considered in understanding their development.

2.4.2 Societal environmental concerns

Socio-economic status can play an important role in the development of social, cultural, economic and environmental positions (Bhopal *et al*, 2002; Adamson *et al*, 2003).

Neighbourhood studies in the UK show minority-ethnic groups are over-represented in deprived areas characterised by a disadvantaged physical environment, including poor leisure facilities, transport, housing and primary or secondary healthcare facilities (Macintyre, 1986; Becares *et al*, 2012). *The Joseph Rowntree Foundation* has found higher poverty rates amongst South Asian population compared to the general population, with the highest amongst Bangladeshis (65%) and Pakistanis (55%) encountering income poverty (Kenway and Palmer, 2007). The worst neighbourhood environment for the White majority is comparatively better than that of minority-ethnic groups, as within each work band minority, ethnic individuals earn less than their White counterparts (Becares *et al*, 2012).

Areas of residence with a greater ethnic density, or microcosms (Saggar, 2000: 166), can provide a sense of inclusion, adaptation into the migrant community, and access to cultural and social capital (Becares *et al*, 2011). The ‘ethnic density’ effect can protect community members from racism and create a protective effect on emotional well-being (Becares *et al*, 2009). Area of residence can have a negative influence on the healthcare needs of minority-ethnic individuals due to limited socio-economic resources available in the community or through local social networks (Gill *et al*, 2007; Becares *et al*, 2009).

Local deprivation could be influencing the formation of health goals, or limiting access to suitable resources of information and support.

Ethnic communities are characterised by unique cultural traits and health profiles which present a complex challenge for policy makers and healthcare professionals (Szczepura, 2005; Atkin and Chattoo, 2007).

2.5 PAKISTANIS LIVING IN THE UK

One of the largest South Asian sub-groups in Britain is people of Punjabi descent. This includes individuals from the Punjab province in Pakistan and India, contributing to over two million residents in the UK, recognised as the largest South Asian community outside of South Asia (Ballard and Banks, 1994; Jafar *et al*, 2003; Williams *et al*, 2010).

According to the 2011 census, London is the most ethnically diverse area with only 59.8% of White residents; the second largest diverse area is the West Midlands with 79.2% White and 4.1% Pakistani, 3.9% Indian and 4.2% Black Caribbean residents (Office for National Statistics, 2011). The largest population of Pakistanis reside in the West Midlands (21%), followed by London (19%) (Office for National Statistics, 2005).

Comparatively, Lancashire has the largest White population (90%) with the majority of the minority-ethnic groups (10%) comprising Asian/British Asian (Lancashire City Council, 2011). Similarly, in 2011 Yorkshire had 85.8% White population, with Pakistanis as the second largest (4.3%), and with 25% of Bradford's population identifying as Muslim (Office for National Statistics, 2012).

Members of the immigrant Pakistani community are economically disadvantaged compared to the general population, and live in areas of greater deprivation (Ember, Ember and Skoggard, 2004: 478). Despite Western populations displaying improvements in overall

health, the health of Pakistani immigrants reflects that of the population living in Pakistan, which could be a consequence of shared community views on lifestyle choices, such as diet and exercise (Syed *et al*, 2006; Shaikh, 2008; Agyemang *et al*, 2011).

Epidemiological factors related to the development and occurrence of CVD/CHD amongst minority-ethnic groups, in particular the Pakistani community, could account for some of the differences in prevalence (McMunn *et al*, 2009). Elevated risk of developing chronic diseases is facilitated by the current and continuing socio-economic condition of the Pakistani community (Kenway and Palmer, 2007).

Members of the Pakistani community, at times negotiate between a universally religious or ethnic identity. The latter encompasses a myriad of cultures and traditions based on place of origin (Kabir, 2010). The formation of ethno-religious identity is influenced by ‘modernisation’ and acculturation into the UK; each identity can be associated with different lifestyle choices (Karlsen and Nazroo, 2004). For instance, Muslims follow guidance of Islam that suggests a ‘halal’ diet (permissible to eat animals with a cloven hoof slaughtered in a particular way) (Johnson, 2004).

2.5.1 Religious and cultural impact on health choices

By forming a strong religious or cultural identity, individuals may not perceive general health messages as applicable to them due to ethnic differences. It could also be difficult to incorporate health recommendations within existing cultural or religious influenced lifestyles with limited support to pursue alternative behaviours.

Religious beliefs can limit or enhance access to healthcare treatment. Members of the Muslim community have identified cultural and religious barriers, including veiling for women, specific dietary requirements (halal meat), and a preference for doctors from similar ethnic backgrounds when interacting with healthcare service providers (Lawrence and

Rozmus, 2001; Bhopal *et al*, 2005). The formation of lifestyle choices is an amalgamation of past and present cultural and religious views that should be considered when forming lifestyle recommendations.

Differences in acculturation and adaptation to life in the UK for first-generation Pakistani migrants, and consequently their children, has diversified available lifestyle choices. Where some individuals have adapted to a more “Western” approach, others follow traditional and cultural practices (Bush *et al*, 2003; Ingram *et al*, 2003; Tabassum *et al*, 2000; Atkin and Chattoo, 2007). Research has recognised the potential discordant world views and beliefs within families that have been assimilated into the dominant British culture (Sonuga-Barke *et al*, 1998). Differences in beliefs potentially create an atmosphere of distrust, and limits unity amongst community members regarding support for culturally healthier lifestyle choices (Ingram *et al*, 2003; Sharma and Kemp, 2012).

Barriers to healthcare have the potential to limit engagement with services, and minimise awareness of healthcare programmes for Pakistani individuals (Anwar *et al*, 2012). Limited awareness could explain the increased risk of illnesses such as CVD as a reflection of the weak social structures underlying community engagement with health services (Lip *et al*, 1996). In her study of female carers from four South Asian communities (Hindu Gujarati, Bangladeshi, Pakistani and Punjabi), Katbamna *et al* (2004) encountered difficulties from formal health and social care agencies due to language and communication issues, as well as a lack of knowledge.

Individual behaviour is often influenced by interactions with the environment and those who inhabit it (Amedeo *et al*, 2009). It would be beneficial to understand how sources of social support can influence health behaviours amongst different community members.

Social support can be defined as emotional (feedback and affirmation), appraisal, informational (suggestions, advice and information from others only), and instrumental (labour, money, time obtained from affiliations) (Ritter, 1998:152). Social networks are social structures that provide individuals with ‘companionship, advice, emotional support and practical assistance’ (Gottlieb and Sylvestre, 1996: 153). Social networks in which support may take place should be given greater consideration when trying to understand health behaviours and health status (Ritter, 1998:152).

Social support is also required to overcome barriers towards physical activity amongst South Asian communities. As reported by Johnson (2000), modesty, gender segregation and safety were common issues relating to exercise. Consequently, recommendations were made to pay specific attention to the needs of communities and to increase their confidence (Johnson, 2000).

Healthcare providers have made efforts to minimise barriers to healthcare facilities for minority-ethnic groups by increasing the availability of translators to reduce language issues (Lawrence and Rozmus, 2001; Ingram *et al*, 2003). Cultural adaptation of primary care services can include employment of role models or staff with cultural understanding (Bhopal, 2014), development of language-appropriate educational material, and providing education on cross-cultural issues (Betancourt *et al*, 2003).

Yet, there are low levels of screening, high levels of CVD, diabetes and other health care issues within the Pakistani community (Hoare, 1996; Bhopal, 2000; Hayes *et al*, 2002; Kelaher, 2008).

The Pakistani community is a growing part of the general population, and creates inevitable demands on healthcare services (Moriarty and Butt, 2004). Consequently, further understanding of factors underlying the lack of service uptake and inequalities to access or use should be explored.

2.5.2 Generational and gender based differences in lifestyle

There is a degree to which health inequalities can be transferred from members of one generation to another, especially in relation to socio-economic status and formation of health behaviours. Smith *et al* (2009) analysed health survey data in England from 1999 to 2004 and discovered consistent reports of fair or poor health in minority-ethnic groups compared to the White British population, regardless of upward social mobility or changes in health behaviours between generations. Findings implied a need for investigating intergenerational pathways within migrant populations that show how complex socio-cultural factors influence lifestyle choices leading to increased risk of CVD (Smith *et al*, 2009).

As a result of migration and settlement into the UK, the Pakistani community has a diverse and fragmented identity and role in British society (Tolia-Kelly, 2004). Identity is shaped over time by events that are external and internal to the community, where perception of changes in community and acculturation have been accepted differently by migrants and their descendants (Laird *et al*, 2007).

It is recommended that the South Asian population should not be viewed as a homogenous group, as differences exist between first and second-generation members (Hashmi, 2011; Harding *et al*, 2004). For example, first-generation “Pashtun” (relating to the province of Khyber Pakhtunkhwa [from Pakistan]) have been shown to attribute illness causation to supernatural causes. Older, migrant Pakistanis attribute “Allah” as an external force controlling health behaviours (White *et al*, 2006; Fazil *et al*, 2006). These types of views may not be shared by some of the individuals belonging to second or third-generations. First-generation migrants may have dealt with the “culture shock” and acculturation upon arrival in the UK, but second and third-generation Pakistanis have been facing issues when

trying to balance the culture of the host country with traditions passed on from the previous generations (Nazroo, 1998).

Socio-cultural expectations between members of the same family can vary by age and gender. Although rejection of parent's ethnic and religious identities is not common amongst the second-generation, there is reinterpretation (Modood *et al*, 1998). There is evidence to suggest that economic experiences of migrant and non-migrant generations might be quite different. Non-migrant generations have experienced economic prosperity, subsequently influencing lifestyle choices (Bajekal *et al*, 2004; Platt, 2005).

Research with members of the Pakistani community has revealed differences within multi-generational families that not only impact the stability of relationships, but also health, social, educational and occupational choices (Grewal *et al*, 2004).

Research into smoking habits illustrates disparity in perception of socially acceptable behaviours based on generation and gender (Bush *et al*, 2003; White *et al*, 2006; Begh *et al*, 2011). A common perception within South Asian communities is the acceptance of elders smoking. Although socially undesirable, younger male members of the community often engage in smoking. It is less likely that women smoke, as there is cultural disapproval however, in recent years the number of smokers has been rising (Mukherjea *et al*, 2011).

Discrepancies in socially acceptable behaviours have been highlighted in obesity research. There is a higher incidence of obesity in first-generation migrants where acculturation and limited education were stated as key socio-economic factors; although, second-generation descendants are at a higher risk of becoming obese (Smith *et al*, 2012). This risk was further perpetuated by the mixed patterns of acculturation, diverse profiles of individuals in the community, and socio-economic factors (higher income and qualifications) (Smith *et al*, 2012).

In a review by Fischbacher *et al* (2004), South Asian people were identified as having low levels of physical activity, especially women and the elderly. These findings have been further strengthened in recent research where the rate and desire for participating in physical exercise has been reportedly low (Daniel and Wilbir, 2011).

Concerns over the dietary patterns of South Asian communities have been expressed by researchers, especially in relation to addressing high levels of obesity, hypertension and stroke within the Pakistani community (Smith *et al*, 2000). The main dietary component for Pakistani Muslims is the consumption of chapattis with a variety of curries, often with generous use of oil and red meat (Kassam-Khamis *et al*, 2000). A review by Landman and Cruickshank (2001) noted the ability of younger migrants to adopt a diet consisting of more fruit and vegetables and lower fat content by modifying the dietary practices of the older migrants (Landman and Cruickshank, 2001).

Parsons *et al* (1999) investigated the dietary patterns of young children born to first or second-generation Pakistani Muslims in Bradford. Findings illustrated that first-generation mothers were more likely to adhere to a traditional diet for their infants than second-generation mothers, as first-generation women were more likely to be living with their mothers-in-law. There were no major differences in the food provided by first or second-generation mothers, other than snacks and drinks (Parsons *et al*, 1999). Whether these dietary differences are more beneficial for the infants is debatable, as the second-generation mothers were serving their children more Westernised foods which were not necessarily healthier options (Parsons *et al*, 1999).

A qualitative study carried out by Ludwig *et al* (2011) with first and second-generation Pakistani women in North West England identified a lack of motivation to lose weight, and

an uncertainty about weight gain being related to obesity and the risk of type 2 diabetes. First-generation women consumed more ‘traditional meals’, and second-generation women had more takeaways (English food), especially chips as a popular ‘halal’ option (Ludwig *et al*, 2011). Perceptions were influenced by religion, culture and familial expectations on appearance (weight gain) and prioritising family needs over individual lifestyle. These findings illustrate the importance of a social and physical identity (incorporating religion and ethnicity) when targeting the healthcare needs of Pakistani women (Ludwig *et al*, 2011).

Findings in the literature that support the relationship between dietary patterns and diabetes recommend preventative measures, such as increasing exercise and improving diet to prevent obesity in high-risk ethnic groups such as Pakistanis (Whincup *et al*, 2010).

2.6 CONCEPTS SURROUNDING HEALTH AND SOCIAL SUPPORT

Healthcare frameworks should involve social resources when establishing services in individuals’ social and domestic environments, to try and create a cohesive service (Vassilev *et al*, 2011). Recent research has highlighted the importance of social networks and network-based resources in the management of health conditions and development of self-care support (Rogers *et al*, 2011). Yet, differences in social support between Europeans and South Asians has already been identified, where different forms of social outlets are utilised in relation to the individual’s needs based on their ethnic group (McLean and Campbell, 2003; Pollard and Guell, 2011). There are differences illustrated in the elderly who tend to use religious locations to socialise and seek support (Grewal *et al*, 2004).

2.6.1 The theory of social capital

Social capital can be described as:

“Resources embedded in and acquired from social networks and interactions based on connecting ties, trust and reciprocity, through which members of a collective can attain various ends or outcomes that are of benefit for the individual/collective” (Hyypä, 2010).

Putnam, Bourdieu, Coleman and Lin have made contributions towards the definition and application of social capital, each focusing on differing forms of social ties and interactions (Lin, 2001).

Social capital can be viewed in terms of three dimensions: structural dimensions (network ties), relational dimensions (trust and reciprocity), and finally cognitive dimensions (shared cultural goals) (Nahapiet and Ghoshal, 1998). Social capital can be understood as a phenomenon consisting of trust, network ties, and shared cultural norms.

Putnam focuses on reciprocity within social networks, based on trust, as well as the notion that diversity within and outside communities can lead to distrust and decreased levels of community participation, even with members from a single ethnic group (Putnam, 2007). Individuals from migrant communities seek information through their transnational ties (relatives overseas) for emotional support and local ties (colleagues and members of the locality) for reliable, informational support e.g. making informed medical and educational choices (Lin, 2000; Anthias, 2007).

Coleman and Putnam tend to focus on the stability and continuity of social relationships, where social networks are dynamic and reflect the changing circumstances of an individual (Ryan *et al*, 2008). Vertovec’s notion of super-diversity is where contemporary

socio-political climates are shaped by ethno-cultural backgrounds of individuals within communities creating dynamic social circumstances (Vertovec, 2007).

Coleman and Putnam assume social capital can compensate for low socio-economic disadvantage. Yet the complexity of social networks and the potential to foster 'ghettoization' challenge this concept (Wierzbicki, 2004; Griffiths *et al*, 2005).

2.6.2 Social capital and transnational migration

The beneficial effect of social capital depends on the strength of social ties and gaps in structural networks (Hyypä, 2010). Social ties are connections between people that carry information; they can be strong, weak or absent (Bishop, 2013: 258). The strength of ties between individuals can influence access to potential community resources by maintaining provision of emotional support, companionship and services (Lakon, Godette and Hipp, 2011). The frequency, reciprocity, importance and duration of interactions can help distinguish strong or weak ties (Hjarvard, 2013:145). Strong ties are formed with family members and weaker ties with associates.

Social capital has the potential to serve as a resource (capital) built up of civic associations and dense social connections that offer support (emotional, instrumental, material) and information (provision of informational resources, knowledge) (McLean *et al*, 2002; Kim, Subramanian and Kawachi, 2006). In relation to the productivity of a group, based on accumulated social capital, norms of reciprocity and trust need to be considered (Putnam, 2001).

Strong ties can be understood as a process of 'bonding', where similar individuals relate to each other, whereas 'bridging' occurs amongst weak ties between individuals from different backgrounds (Derose and Varda, 2009). The bridging of weak ties has the potential to increase diversity and information sharing (e.g. employment opportunities), and present an

individual with resources for social mobility which can lead to better social cohesion (Derose and Varda, 2009). Bonding is an essential component of social capital, particularly among homogenous groups, where people share similar interests and characteristics (Larsen *et al*, 2004; Coffe and Geys, 2007). Bridging between heterogeneous communities consisting of different social groups and classes is important when providing novel information and access to resources outside of the group (Grootaert and Van Bastelaer, 2002; Kim, Subramanian and Kawachi, 2006; Laurence, 2011).

Social norms and values tend to be embedded in hierarchical structures of authority, religion and tradition, and are often passed down from one generation to another as a process of socialisation (McLean *et al*, 2002). The role of social capital in transnational migration has been a topic of research but little attention has been directed towards how migrant individuals access existing networks or establish ties with the “host society”. It is an assumption that migrants enter dense networks in close-knit local communities from a similar background (Ryan *et al*, 2008). Granovetter (1983) has suggested the importance of weak ties in communicating information outside of strong ties, which can result in local cohesion, where weak ties can encourage integration and connect sub-groups. For newly migrated individuals, the strength of bonds and ties are affected by geographical strains.

Social capital can provide individuals with protection from racism and encourage the pursuit of non-discriminatory health care within the parameters of their communities’ norms (Becares *et al*, 2009; Elliot *et al*, 2009; Becares and Das-Munshi, 2013). There are also negative consequences of living within a specific community’s protection, as individuals viewed as ‘outsiders’ can be excluded from group activities (Portes, 1998; Hyyppa, 2010).

Social capital has been criticised for failing to recognise the negative outcomes of networking and developing trust in a community. Attaining social capital for economic

reasons (financial and occupational support) as a result of rationalised actions cannot fully explain the fluctuating levels of social capital in different communities.

Social support can influence emotional well-being. The risk of developing psychosis – including depression- is notably high in women from a South Asian background, (Chaudry *et al*, 2001). Dutt and Weber (2010) explored the association between migration statuses, perceptions of social support, and access to social capital for Punjabi women (including Pakistani). The Punjabi women reported having fewer resources compared to the UK general population and the need to enhance social skills in order to create social support for overcoming mental illness (Dutt and Webber, 2010). Pakistani women have higher rates of depression, suicide and self-harm compared to White women, and are more likely to have limited social support, and experience resistance from family members (especially husbands) (Gater *et al*, 2010).

2.6.3 Formation of social networks: ethnicity, ageing and health

There are health and social policies based on the assumption that strong communities with access to social capital can lift the socio-economic burden for funded services and minimise responsibility of care (Leonard, 2004).

Social exclusion can decrease social capital available to minority-ethnic communities. Lower social capital can limit engagement of migrant communities in participating with social or health care projects (Campbell and McLean, 2003).

Pakistanis from Kashmir (Mirpur) distinguished a national identity in sustaining interpersonal resources, and they differentiate themselves from other Pakistanis (Punjabis), South Asian (Sikh, Hindu) and White English groups (Campbell and McLean, 2003). Distinguishing differences in social or cultural groups, Pakistani Kashmiris identify sources

of support and information appropriate to their group values despite opportunities to get involved in wider health and social networks (Campbell and McLean, 2003). Small *et al* (2005) conducted interviews with Bradford Pakistani Muslims and recognised how community members, whether they are professionals or belong to family or kinship, can contribute towards “health systems” for members of their community. Individuals might seek help from healthcare professionals, as well as religious members of the community for explanations of neurological disorders or lifestyle choices (Small *et al*, 2005).

Health seeking behaviour can be shaped by hybrid identities where culture and religion overlap. Pieroni *et al* (2008) recognised a tendency for Mirpuri Pakistani Muslims in Bradford to approach religious members of the community and use traditional therapies in place of (or alongside) Western medicine. Knowledge and advocacy of traditional remedies was limited with the younger generation, and there is a cultural-community effect on seeking healthcare advice and treatment (Pieroni *et al*, 2008).

Derosé and Vrada (2009) found inconsistencies within the effect of social capital on healthcare access. Emphasis was placed on investigating bonding and the potential involvement of cognitive, behavioural and structural factors (Derosé and Varda, 2009).

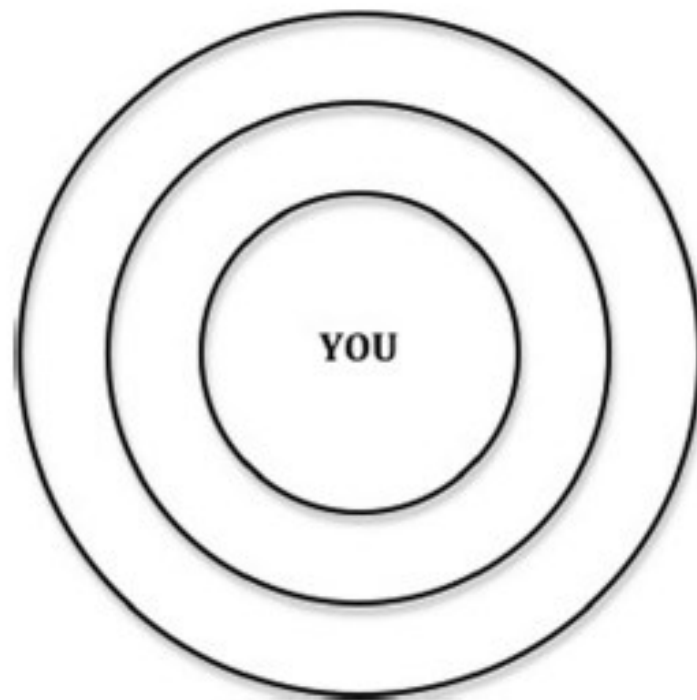
The cognitive component of social capital is based on what people do and feel, which involves various cultural factors. Factors include quantity and quality of social groups, trust and inequality. These factors have an influence on the formation of lifestyle choices and need further exploration (Airaksinen, 2008; Hyyppä, 2010). Some of these cognitive factors will be outlined in the following section.

2.7 THE CONVOY MODEL OF HEALTH

The convoy model of social relationships provides a framework to illustrate the influences of social structures on health and well-being. The convoy model diagram uses a series of

embedded circles to map social connections with the individual at the centre. With each progressive circle the relationship to the individual becomes less important (Figure 3) (Antonucci and Akiyama, 1987; McIlvane *et al*, 2007).

Figure 3: The convoy measure of social network



(Antonucci, 1986 in Shouse *et al*, 2013)

The model can be used as a tool to organise complex networks and identify mechanisms in relation to accessing health information and support. Consequently, well-being is perceived as a varying function of personal, social and situational factors (Fingerman *et al*, 2011).

The convoy model can be used to address an individual's social networks, in terms of close and proximal relationships. Relationships can be compared across generations, age or gender. Individuals from an older generation construct smaller, limited social convoys for providing

support (Antonucci and Akiyama, 1987; Kemp *et al*, 2013). Using such tools can help service providers to understand how individuals form their sources of support through existing or novel social networks.

The model can be used to identify personal and situational characteristics that may define and shape an individual's social network in significant ways. Age, gender, religion, and ethnicity can be experienced differently as individuals grow and mature (Fingerman *et al*, 2011). The convoy can change over the individual's lifetime and can therefore be characterised by constant progress.

Through the use of the convoy model, multiple forms of networks including the variability in size and composition, can be taken into consideration in relation to individual well-being (McIlvane *et al*, 2007). Younger individuals include more friends than family members in their networks in relation to the perceived support (Levit, Guaci-Franco and Levitt, 1994). Research investigating generational differences within social networks based on the convoy model can reveal variation in primary support provided by networks and nominated close family members.

Social, cognitive and possibly ethnically relevant factors can be better understood by using the convoy model diagram to illustrate how social networks develop with age and in relation to health (Fung, Carstensen and Lang, 2001).

2.8 GOAL PURSUIT AND INSTRUMENTALITY

Findings within the field of social psychology have suggested that individuals are more likely to approach someone who facilitates achievement of their goals in day-to-day life. An individual's perception of another person's instrumentality (usefulness) towards their goals can affect the relationship between the two individuals. Research indicates the probability of

maintaining a relationship once a goal has been achieved is low, especially if there are alternative goals present (Fitzsimons and Fishbach, 2010). This implies a cognitive impact on social interactions, where environmental factors can influence the formation of novel relationships and the maintenance of existing ones.

2.8.1 Self-preservation and group membership

A key component of goal pursuit, especially in relation to other social relationships, is self-control. A great deal of self-control has to be exerted in pursuit of specific health goals, or even avoiding unhealthy behaviours (Vohs and Baumeister, 2011). Self-control can be morally guided and requires mental strain and effort (personal resources), thus bringing into question the role of an individual's surroundings and exposure to individuals who motivate certain goals and decisions (Campbell and Mohr, 2011). An example of failure of self-control in Western culture is considered to be succumbing to the temptation of smoking, drinking alcohol, over-spending, gambling, unsafe sex, over eating, and criminal behaviour (Baumeister *et al*, 1989; Baumeister *et al*, 2007).

Alongside an understanding of self-control, it is vital to consider how individuals define their desirable goals and behaviours. Individuals may choose to prioritise social (rather than health) orientated behaviours, and base their rewards on progress within the domain of social goal achievement (Suis and Wallston, 2003). Certain behaviours may not be encouraged or endorsed within a community, and this could affect the level of support.

Research indicates social relationships have the potential for strong and wide-ranging effects on the success of self-control, also known as self-regulation (Vohs and Baumeister, 2011). Self-regulation involves psychological efforts and resources suited to control desired

behaviours, for example resistance to temptation (Leary and Tangney, 2003). There appears to be a social influence on self-regulation as a psychological resource for controlling behaviour, and consequently shaping it.

2.8.2 Cultural norms and goal formation

Social and cultural beliefs can have an influence on individual or community goals and target behaviours. The desire for social inclusion can strongly motivate particular behaviours, in a bid to avoid exclusion and strive for self-protection (Leary and Baumeister, 2000). For example, in a community where racism is present, there can be a sense of solidarity (Putnam, 2007). This can mean accepting common social norms in an attempt to maintain group membership (Rutland, Killen and Abrams, 2010; Giannakakis and Fritsche, 2011). If one is to pursue different or challenging goals, then one may face disagreement from the group (Steinel *et al*, 2010).

Through membership to a particular social group, an individual can adopt stereotyped behaviours associated with that group (Campbell and Mohr, 2011). Stereotype activation can lead people to automatically take on goals associated with the stereotyped group (Aarts *et al*, 2005). Similar behaviour can be seen within the Pakistani community, where individuals have stated their ethnicity and religious affiliations as determining their health outcome; for example, women avoiding care services where predominantly men are present in order to maintain culturally advocated modesty and religious veiling (Lawrence and Rozmus, 2001; Johnson, 2000).

Interpersonal relationships can initiate, operate and monitor goals. Goals can be initiated and influenced by other people however, they can also leave individuals with depleted psychological resources to pursue goals (Fitzsimons and Finkel, 2010). Therefore, in an

environment with minimal support, individuals may seek solidarity amongst family and local community members, by carrying out behaviours viewed as the norm.

The type of relationship an individual has with another person can determine their ability to self-regulate, for instance, where an interaction which may demand a greater amount of effort that is not perceived to be equal to the rewards of reaching a goal. However, being socially excluded has also shown to be an impairment to self-regulation, resulting in unhealthy behaviours, such as the consumption of fatty foods (Baumeister *et al*, 2005).

On the other hand, social interactions can increase an individual's motivation to carry out behaviour by decreasing the gap between goal-relevant intentions and the actual behaviour (Gollwitzer and Sheeran, 2006). It is important within a responsive relationship; support givers provide the adequate amount of support based on the individual's needs in order to avoid negative relationships (Vohs and Baumeister, 2011).

The notion that individuals will grow closer to others who facilitate their goal achievement is contested with the notion that individuals will aim for goals that are socially acceptable. If an individual's personal goals conflict with those of the community or society they belong to, then one can argue that the individual will either move away from the group, or seek individuals who facilitate their goals. Alternatively, the individual will adopt goals that are likely to be facilitated by members of their existing social network, thus providing them with greater support.

2.8 SUMMARY

By outlining the relevant literature and highlighting the context within which the research is embedded, I have illustrated how members of the Pakistani community are marked by health inequalities that are shaped by multiple factors related to CVD prevalence. These factors include complex cultural, social and personal influences. Although we have some

understanding of how and why certain gaps or inequalities exist, there remains uncertainty towards underlying mechanisms, as despite healthcare initiatives, these differences and inequalities persist. By acknowledging possible socio-cognitive features influencing health behaviours, we can explore factors that contribute to certain lifestyle choices that may be detrimental to health. As an individual's lifestyle choices are likely to be influenced by their social environment and those who inhabit it, it is important to consider how these social relationships influence the individual's decision-making process.

This is particularly necessary when considering any socio-cultural differences in forming and pursuing health goals. This will enable us to explore any diversity in engaging with one's social environment when seeking health benefits, especially in terms of proximity to specific, instrumental (professional and communal) individuals in a social network.

CHAPTER 3

3.0 THE EXPERIENCE AND INFLUENCE OF SOCIAL SUPPORT FOR CARDIOVASCULAR DISEASE PREVENTION IN THE MIGRANT PAKISTANI COMMUNITY: A QUALITATIVE SYNTHESIS

3.1 INTRODUCTION

The aim is to synthesise qualitative literature about perceived influence and experiences of social support for behaviours related to cardiovascular risk prevention in the migrant Pakistani community. I identified and critically appraised existing qualitative literature to ensure that this synthesis is robust, and to limit subjectivity. The process for collating literature and analysing emerging themes is systematic, using validated guidelines, and quality assessment and data extraction tools to present data and interpretation of findings. Consequently, manuscripts were filtered at a title, abstract and full text level.

As meta-ethnography is not definitive, and there are multiple possible forms, techniques from this method are applied to provide an interpretation of findings from papers included (Thorne *et al*, 2004). An adaptive meta-ethnography approach is used to synthesise 16 papers meeting the inclusion criteria (Paterson, 2008: 95). Four concepts are identified that reflect participants' perceptions and experiences of social support.

Qualitative synthesis of literature does not focus on calculating effectiveness, but contextualises behaviour and helps researchers understand how people engage with their surroundings. A synthesis and appraisal of qualitative literature can help recognise previous research, issues, populations, experiences, and provide a wide-range of concepts for interpreting future work (Bearman and Dawson, 2013). An example of broader concepts identified includes socio-cultural barriers affecting women's health behaviours.

3.2 BACKGROUND

Risk of cardiovascular mortality is elevated within the South Asian community where individuals from Indian, Bangladeshi and Pakistani heritage have a greater likelihood of developing the disease and associated illnesses compared to the general White population (Gill *et al*, 2007). Focusing on the health needs of South Asians as a unified group could be counterproductive (Johnson, 2010). For example, the Pakistani community as a sub-population within the South Asian population present an increased risk of developing heart disease, and reside in some of the most socio-economically deprived areas of the UK (Kenway and Palmer, 2007). The risk for developing CVD is exacerbated for Pakistani men and women who have a greater possibility of developing type 2 diabetes than the general population (Liu *et al*, 2012).

Social support can be a form of social capital which individuals can draw upon for encouragement and information on lifestyle choices (Liu, 2001). Perceived social expectations and a lack of familial or community support can negatively affect the uptake of healthier lifestyles (Kousar *et al*, 2008).

Access to social support can present itself as a barrier or facilitator to managing health conditions in the South Asian community (Horne and Tierney, 2012). Lawton *et al*'s (2007) study found perceived stress associated with pressures to fulfil societal roles, support family members, and maintain transnational ties amongst Pakistani and Indian respondents. Social responsibilities were thought to manifest themselves in physiological disorders, as perceived by members of the Pakistani community who felt social stress was the cause of their hypertension and diabetes (Lawton *et al*, 2007). In the absence of familial support, individuals can form social networks outside of their immediate community setting (Bomar, 2004).

The formation and consequent influence of novel social networks for minority-ethnic community members to provide support and information remains unexplained (Vertovec, 2010).

The social psychology theory of instrumental others provides an insight into how individuals may form and manage new relationships to meet a specific target. ‘Instrumental others’ can help individuals achieve an aim by providing some service or assistance e.g. information or support on how to cope with a chronic disease (Fitzsimons and Fishbach, 2010). The formation of instrumental relationships requires cognitive resources, such as self-control to manage the influence of existing social networks on the pursuit of goals (Fitzsimons and Fishbach, 2010). Research into instrumental relationships has been limited to short-term goals (Fitzsimons and Shah, 2008) however, long-term goals could influence social networks differently, especially for minority-ethnic groups maintaining social networks transnationally.

3.2.1 Healthcare policy

Tackling CVD risk is central to UK health policy, which is attempting to reduce health inequalities and lowering death rates caused by CHD in areas of high socio-economic deprivation (Townsend *et al*, 2014). The National Institute for Health and Clinical Excellence (NICE) aims to recognise health changes at population and individual level in order to manage CVD risk factors (NICE, 2010). Policy recommendations and guidelines encourage healthcare providers to assess members of the South Asian community for illnesses such as diabetes at an earlier age (25-39 years) than the wider population (40 and above), due to their increased risk (NICE, 2012). Consequently, individuals with an elevated risk are made aware of lifestyle changes necessary to prevent the onset of diabetes, and are provided with lifestyle recommendations based on weight loss and physical activity interventions targeting the South

Asian community as a whole (NICE, 2011; NICE, 2012). The recommendations may highlight the importance of social support or misunderstanding of CVD causation, but fail to consider the heterogeneity within sub-groups, or cultural and religious nuances (NICE, 2011). Reviews of interventions targeting the South Asian community in the UK note an absence in work related to perceived effectiveness, and the considerable scope to adapt interventions as appropriate for minority groups (Netto *et al*, 2010). It is important to assess the effectiveness of interventions and campaigns by exploring participants' perceptions and views on socially and culturally contextualised health behaviours. Additional information on lay experiences of healthcare interventions and promotion could facilitate development of such campaigns to increase their suitability and help policy achieve their targets.

3.4 AIMS AND OBJECTIVES

The aim of this synthesis is to identify qualitative literature on components of the social capital theory (social networks, trust and cultural norms) in relation to modifiable lifestyle factors related to CVD prevention in the migrant Pakistani community.

The following objectives are used to guide the review process:

- To identify and critically evaluate existing qualitative literature on social capital (social networks, trust and cultural norms) in relation to cardiovascular risk prevention for Pakistanis in the UK (developed countries)
- Interpret how social resources influence the construction of health beliefs

3.3 SCOPING SEARCH: QUALITATIVE LITERATURE REVIEWS

A preliminary search of existing qualitative reviews in relation to social support for CVD prevention in South Asian communities helped address questions regarding quality of research, types of available literature, and identify relevant modifiable behaviours. The search was based on Booth and Fry-Smith's (2003) scoping search questions (Table 2).

Table 2. Questions for guiding the scoping search

Scoping search questions
<ul style="list-style-type: none">• What is the size of the candidate literature review?• What is the likely quality of the literature (e.g. are RCTs common or rare?)?• What are the specific issues with regard to terminology (i.e., definitions or indexing)?• Which databases are likely to provide the highest yield of relevant items?

(Booth and Fry-Smith, 2003 in Jones, 2004).

A systematic review on the effectiveness of dietary change or physical activity interventions delaying the onset of chronic diseases, such as CVD or diabetes, in the South Asian community displayed limited likelihood of change and noted a lack of insight into cultural experiences (Chapman, Qureshi and Kai, 2013). Lay users can provide useful insights into the effectiveness of healthcare campaigns and interventions by highlighting beneficial aspects and areas of improvement (Bamberger, 2000: 152). However, methods of data collection, such as survey data, can be limited to closed-questions and not fully engage participants to respond in detail about their personal views (Boniface and Burchell, 2000). Therefore, perceptions of healthcare intervention delivery, or how they are negotiated into existing socio-cultural frameworks can be overlooked (Ivey *et al*, 2006).

Vassilev *et al* (2011) identified social capital in relation to illness management, and how different forms of social networks assist individuals with the management of chronic conditions. Self-care is seldom limited to the individual, but contextualised within wider community and healthcare frameworks (Katbamna, *et al*, 2004). Links between social capital and self-care in chronic disease management are insufficiently researched, and could indicate a need to develop network-centred approaches for engaging socially and economically deprived groups (Vassilev *et al*, 2011). Minority ethnic communities are often marginalised and come from deprived socio-economic backgrounds that could require greater attention to promoting effective lifestyle changes to promote better health (Hayes *et al*, 2002).

A narrative review of cardiac rehabilitation amongst South Asians has identified poor uptake, attendance, or adherence to programmes where only one study addressed issues underlying such behaviour (Galdas *et al*, 2012). South Asian women in particular faced socio-cultural barriers (Galdas *et al*, 2012).

Systematic reviews of qualitative research within the South Asian community identified barriers to exercise and physical activity in older adults, and highlighted the importance of empowerment, communication, relationships, and the environment (Fischbacher *et al*, 2004; Daniel and Wilbur, 2011; Horne and Tierney, 2012).

Adapting ‘culturally sensitive’ interventions for coronary heart disease in minority-ethnic communities highlights the importance of community resources to publicise interventions and increase access, identify barriers to participation, develop communication strategies to overcome complex linguistic issues, work alongside religious and cultural values, and accommodate cultural identification (Netto *et al*, 2010). Netto *et al* (2010) recommend further verification of these recommendations in order to understand behavioural

interventions, such as diet and smoking cessation amongst Pakistani, Chinese and Indian communities.

The uptake of specific lifestyle changes in BME groups could narrow the identification of barriers and facilitators to lifestyle change. A systematic review of qualitative studies focusing on barriers and facilitators to physical activity amongst South Asian adults acknowledged notions of empowering and disempowering contexts where communication, relationships (social support), beliefs, and the environment had an influence on outcomes (Horne and Tierney, 2012). Horne and Tierney (2012) recognised the influence of group norms when trying to increase physical activity amongst South Asian adults. In their review, Koshoedo *et al* (2015) have identified four main concepts, including individual perceptions, cultural expectations, personal barriers, and factors limiting access to facilities. How group norms form, and social support functions in different minority groups could be of great interest to researchers, as migration history and cultural health beliefs also interact to influence physical activity, at times disempowering BME members (Koshoedo *et al*, 2015).

Synthesising information on a sub-population (e.g. Pakistani) could result in further understanding of complex and varied formation of healthcare beliefs based on migrant experiences, cultural beliefs and social support.

There is limited research exploring social support in relation to CVD prevention in the migrant Pakistani community that considers social network formation and function, and embedded socio-cultural nuances acting as barriers or facilitators to maintaining lifestyle change. The ways in which generation or gender may influence the formation or maintenance of novel relationships (seeking social support or information) when forming health goals for the Pakistani migrant community remains unexplored.

3.5 SYSTEMATIC SEARCH METHODS

The present synthesis and interpretation of findings is guided by Embuldeniya *et al*'s (2013) qualitative synthesis of chronic disease peer support, and Malpass *et al*'s (2009) meta-ethnography of patients' experience of anti-depressants. An adapted meta-ethnography was chosen for data synthesis, as it is a method of interpretation (and not just integration) for understanding how concepts in different studies relate to each other (Embuldeniya *et al*, 2013). A line of argument synthesis was not carried out as papers were divergent and explored different aspects of phenomena, nonetheless, concepts were reciprocal across different studies (Atkins *et al*, 2008; Malpass *et al*, 2009).

3.5.1 Inclusion criteria

A systematic method for including or excluding papers was used, where inclusion criteria were referred to for each title, abstract and full text paper retrieved, as outlined in Table 3.

Due to migration patterns from the South Asian continent, papers from the 1960s onwards were included in the review, as the majority of migrant research was not carried out prior to this period. Searches were carried out from August 2013 to September 2015.

Papers written in English, with an interest in mixed ethnic cohorts were included. Papers with a South Asian sample are included if they specified the number of Pakistani or Urdu speaking participants, and whether the origin of Muslim participants was recognised (e.g. Bangladeshi, Pakistani or other). Only research completed in high income 'developed' countries was included (migrant communities settlement), and if the research topic was health behaviours related to CVD prevention e.g. diet and exercise (Human Development Report, United Nations, 2015).

Only qualitative research was included, as the focus was limited to perceptions, experiences and opinions of preventative lifestyle factors within the Pakistani community. Engagement outside of the health focus, i.e. educational or occupational literature, was not included.

Participants had to be aged 18 years and above. Quantitative studies with empirical evidence and randomised control trials (RCTs) were excluded, or any research in developing countries. Health conditions not related to CVD, including mental health (depression, anxiety etc.) were discounted, as well as the management of chronic conditions or rehabilitation following a cardiac episode or adherence to medication.

An eligibility checklist was developed for the title and abstract stage based on the inclusion/exclusion criteria, and each paper retrieved was measured before being considered to be included (Table 4).

The synthesis focuses on qualitative research based on perceptions of primary care CVD prevention by lay people and healthcare professionals on lifestyle factors associated with the prevention (e.g. exercise) or development (e.g. obesity) of cardiovascular risk; to provide an understanding of how individuals try to manage their health, which factors they think contribute towards ill-health, and how much assistance they seek from social or professional resources within their community.

Table 3. Inclusion criteria for studies in the review

	Inclusion	Exclusion
Language	English	Non-English
Population	Humans Mixed ethnic cohorts with South Asian specifically Pakistani or Urdu speakers	Non-South Asian/ Non-Pakistani Participants only identified as Muslim (vague descriptor could be from any country e.g. Bangladeshi)
Age	Adults aged 18 years or above	Infants Children Adolescents
Field (diseases)	Health and Social Preventative health behaviours Obesity Diabetes High blood pressure Hypertension Coronary heart disease Diet Exercise Smoking	Education Occupation Mental health (depression, anxiety) Management of a chronic condition Secondary care
Study design	Qualitative Interviews Focus groups Life history	Quantitative studies RCT's or embedded qualitative studies Cohort studies Observational studies Reviews Cross-sectional studies Interventions
Date restriction	1960 onwards	Prior to 1960
Country	Developed countries (Human Development Report, United Nations, 2015)	Developing countries

Table 4. Eligibility checklist used to evaluate studies.

Eligibility			
Inclusion criteria	Yes	No	Unknown
Does the study involve participants from the Pakistani/SA community? (If ethnicity of participants is not mentioned, exclude)	Y	N	U
Does the study include any of the key concepts? (social, ethnicity and health)	Y	N	U
Is the study written in English?	Y	N	U
Has the research addressed a health condition? (Predominantly: CVD, CHD, diabetes, obesity, smoking, diet and exercise)	Y	N	U
Are the participants aged over 18?	Y	N	U
Is the research carried out in a developed country?	Y	N	U
Is the research from the 1960s and onwards?	Y	N	U
Is this qualitative research?	Y	N	U
Is the research limited to one case study?	Y	N	U
Does the research focus on perceptions of primary care CVD prevention by lay people or healthcare professionals?	Y	N	U
<ul style="list-style-type: none"> • <i>Only include study if all answers are yes to inclusion criteria</i> • <i>Unsure answers will be discussed with review team</i> 			

3.5.2 Search methods

The synthesis was performed in a robust manner with a refined focus to limit author subjectivity. The method for collating the literature and analysing the emerging themes was outlined in a systematic method drawing on guidelines from CASP, PRISMA and Cochrane (Moher *et al*, 2009; Noyes and Lewin, 2011; CASP, 2013). Standardised reporting of findings could benefit researchers in the field of behavioural medicine (Davidson *et al*, 2003). Peer-reviewed journals were accessed online using databases from relevant research fields, and each search was tracked. Databases from medical, sociological and psychological backgrounds were included. The final list of appropriate databases included Web of knowledge, MEDLINE, EMBASE, ASSIA, IBSS, Science Direct, CINAHL and PsycNet (Appendix 1). A record was kept of the search terms used in each search for every individual database, as well as a record of papers retrieved. Reference lists of retrieved articles were manually searched, and authors were contacted to provide published or unpublished papers that were not available on the databases. EndNote was used to manage references and remove duplicates from the research. Studies were filtered by what is found in each study at title, abstract and full text level by the supervisory team (PG and SG) and myself. We selected the papers to be included in the synthesis by overcoming any uncertainty about inclusion.

3.5.1 Search terms and delimiting

Key terms and phrases were identified in the scoping search of the literature. This helped identify key words, as well as authors and journals of interest. Particular attention was given to words such as “Asian”, that were sensitive enough to draw on South Asian and East Asian populations, as highlighted in a health assessment report (Liu *et al*, 2012). Health assessment reports create individual reports with explanations for individual health and well-being (Ivanov and Blue, 2008: 245).

The key themes (social capital, CVD and the Pakistani community) were disassembled into their various components in order to spread the scope of the search. For example, terms associated with social capital, such as social networks or cultural norms were also searched in order to identify any relevant literature (Appendix 2).

Boolean terms such as ‘AND’ and ‘OR’ were used to combine keywords and produce relevant results by specifying which words to contain, and the relation of each term with the other. Each database had a unique set of filtering options to narrow the scope of the search. For each database, where available, filters that met the inclusion criteria were selected. As there were multiple, and at times lengthy combinations of key words, searches were made for social networks and then combined with searches for health, ethnicity and qualitative studies to refine the focus and draw attention towards papers that were relevant to all the themes (Fink, 2010) (Appendix 3).

I maintained a focus on qualitative research carried out with preventative lifestyle factors in the Pakistani community by developing an inclusion hierarchy. Papers retrieved with key terms were prioritised, whereas papers retrieved using associated terms, such as networks, diabetes or South Asian, were reviewed afterwards. The hierarchy would make the filtering process more transparent between reviewers, and act as an appropriate ranking system.

3.6 QUALITY ASSESSMENT AND DATA EXTRACTION

Referring back to the hierarchical method of prioritising papers retrieved, references were organised into three categories: papers of A) high, B) moderate or C) low relevance based on how closely related they were to the focus of the synthesis at a title level. The papers in category A were reviewed before categories B or C (Appendix 4).

This was a preliminary stage of determining how many papers would be relevant, for example, how likely is it to find papers observing qualitative findings from members of the Pakistani community on preventative lifestyle factors related to CVD. As there were not a great variety of papers in category A, categories B and C were also reviewed at the title stage.

Consequently, the inclusion criteria were broadened to include papers with a South Asian or Muslim population that included Pakistani respondents. Papers were then checked for inclusion or exclusion at the abstract and full paper stages before being quality assessed, and any data was extracted. A broad range of preventative behaviours was included to interpret social support in relation to CVD.

Dixon-Woods *et al* (2007) have provided a similar approach for categorically evaluating the relevance of qualitative literature. Malpass *et al* (2009) used this method to identify ‘key papers’ that were conceptually rich and could make an important contribution to the synthesis, ‘satisfactory papers’, which they were unsure about or wanted to use to supplement key findings, and ‘irrelevant’ or ‘fatally flawed’ methodologies that were excluded. The inclusion of papers is based on a scale of relevance with key papers and others used to supplement interpretation.

A qualitative appraisal sheet based on the CASP qualitative assessment process was formatted and used to assess each study before it was included in the review (CASP, 2013) (Appendix 5). Two reviewers, FK and PG, reviewed the studies and ensured quality checks.

Data extraction was done using a framework adopted from the Cochrane qualitative systematic review, and this provided a uniform method to obtain data (Noyes and Lewin, 2011) (Appendix 6).

3.6 DATA SYNTHESIS

Studies were categorised based on preventative behaviours they explored (Dixon-Woods *et al*, 2006). Papers were organised into five main topics: 1) physical activity, 2) socio-cultural models of CVD, 3) quality of life and decision making, 4) dietary habits, and 5) smoking.

As Seers (2012) outlines:

‘A qualitative synthesis systematically searches for research on a topic, and draws the findings from individual studies together’.

Although systematic reviews of quantitative data are well established, for qualitative research, this is a fairly new field, and methods are still developing. A complete meta-ethnography is possible in areas of research with high levels of interpretation, and due to the diverse conceptual nature of the research included in the synthesis, a modified meta-ethnography interpretation technique was applied (Campbell *et al*, 2003; Thorne *et al*, 2004). Noblit and Hare (1988) developed meta-ethnography not to simply combine data, but to translate findings into one another, and to develop conceptual insights and new interpretations (Noblit and Hare, 1988: 26; Malpass *et al*, 2009). Synthesis was carried out using meta-ethnography techniques including translating findings across different papers and re-interpretation (Malpass *et al*, 2009).

Key themes (1st order interpretations) and authors’ explanations of key themes and recommendations (2nd order interpretations) made from the research were reviewed to synthesise interpretations across papers (Major and Savin-Baden, 2012:67-71). 1st order interpretations (or constructs) are the views of participants in the study, usually found in the results section of the paper, 2nd order interpretations are the main findings identified from the results presented in the discussion, and 3rd interpretation of findings emerges when

reviewer(s) synthesise 1st and 2nd order interpretations (Coughlan, Cronin and Ryan, 2013: 103).

Synthesising information across the literature requires clarity, and had to be written as objectively as possible (Green *et al*, 2006). Information synthesis can be difficult when a variety of data collection and analysis methods are mentioned in the papers retrieved. Based on Britten *et al*'s (2002) findings, including all the studies retrieved in the research (n=16) into a cohesive table could help incorporate new insights, maintain a connection to the original findings, and increase the possibilities for interpretations.

Table 5 includes a summary of 1st and 2nd order interpretations from each paper, which I used to interpret findings in terms of common themes that run across the different papers (Galdas *et al*, 2012).

The themes and authors' interpretations for 3 papers (at random to reduce bias) (Orwin, 2003: 143) were used to form an initial thematic structure. These themes were used to organise the findings from the remaining papers, where categories were added and altered as each paper was included in agreement with the supervisory team.

This enabled translation of findings from one paper to another, in terms of similar issues raised or novel factors identified. The production of these key themes was an iterative process, so that they reflected the different segments within them.

Findings from across the papers included in the review were compared and contrasted continuously until differences and similarities became apparent between different themes discussed in the result sections of the papers (Table 5).

I regularly met with the supervisory team (PG and SG) to discuss these similarities and differences.

Consequently, similar findings from the results and discussion section of each included paper were clustered together into four themes. Themes included i) stereotyping, ii) social influences on decision making, iii) misunderstanding the causes of CVD, and iv) motivation to initiate or maintain behaviour change. To limit selective reporting, the summary of each study's findings were contrasted and where there were insufficient quotes, authors' interpretations were used.

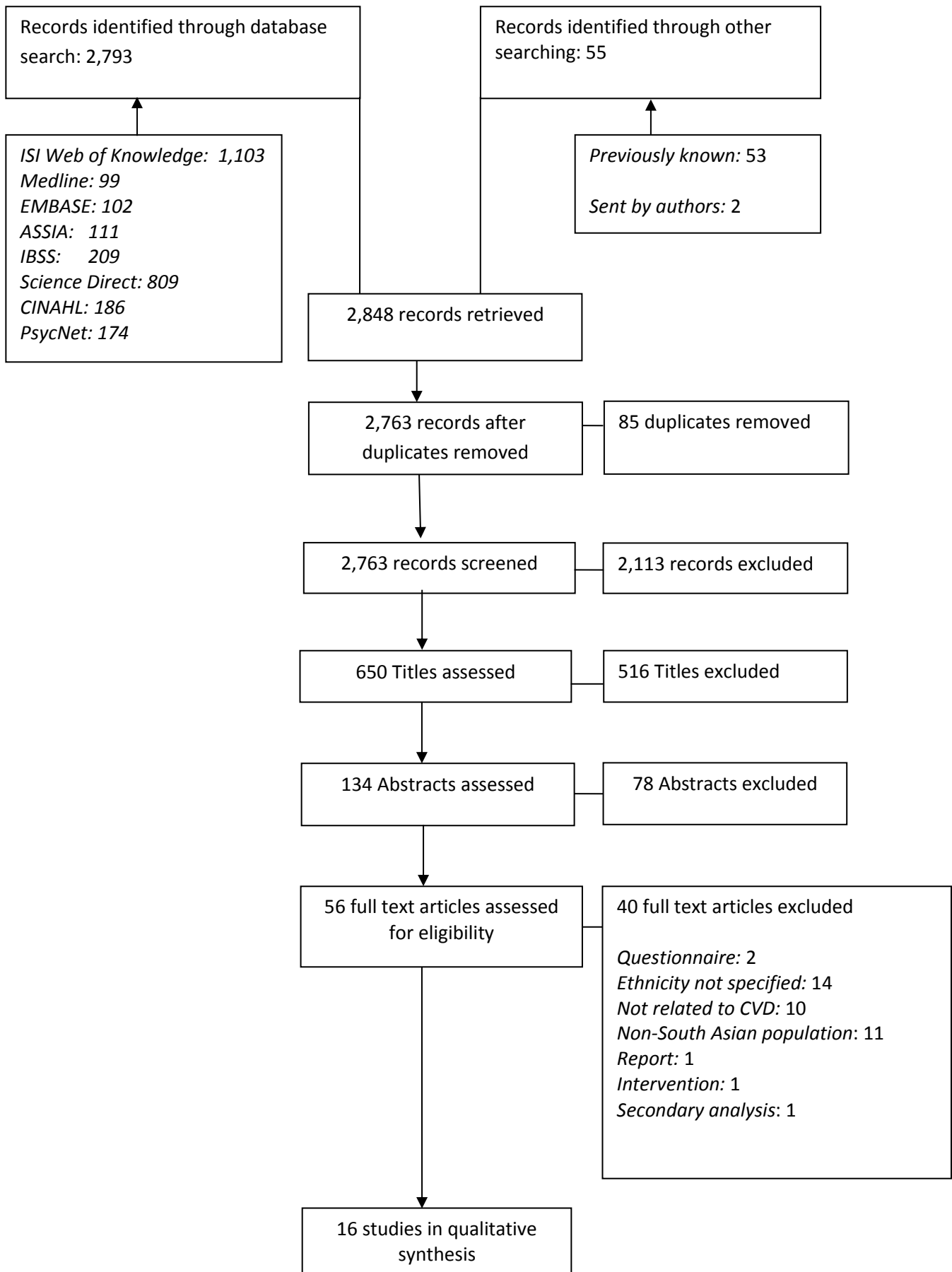
3.7 RESULTS

3.7.1 Identification of literature

The search identified 2,763 citations once duplicates had been removed. Two independent reviewers (FK and PG) manually searched through the retrieved reference lists of articles before determining their inclusion in the synthesis at each stage. This included reviewing titles, abstracts and full text journal articles during meetings to discuss the inclusion (Figure 4).

In total, 40 full text articles were excluded, and 16 papers were included in the synthesis. Reasons for excluding papers were undefined population sample, non-qualitative methodology, and health conditions that did not relate to CVD prevention. Studies included were from developed countries (UK, USA and Norway), and methods used were focus groups and interviews (Tables 5 and 6).

Figure 4: identification of relevant literature



3.7.2 Description of studies

The 16 studies included in the synthesis used thematic analysis (n=5), framework analysis (n=3), grounded theory (n=3), open coding (n=2), content analysis (n=1), constant comparison (n=1), and ethnographic (n=1) methods of analysis (Table 5). The majority of the studies used thematic analysis and noted data collection to saturation.

Study size ranged from focus groups involving 6 participants, to studies with over 40 interviews combined with 15 focus groups. Some of the research groups were mixed ethnic groups, including members of the Indian and Bangladeshi communities, as well as Hindu or Sikh backgrounds. There are a total of 453 Pakistani participants out of a total sample of N= 1,119.

12 studies involved mixed-gendered cohorts, one study focused on South Asian women's views on physical activity (Sriskantharajah and Kai, 2007), two studies focused on Pakistani women's experiences of diet and obesity (Mellin-Olsen and Wandel, 2005; Ludwig *et al*, 2011), and one exploring South Asian men's perceptions of cardiac health (Gany *et al*, 2013).

Table 5. Papers included in the synthesis with a summary of key findings (1st and 2nd order interpretations)

Reference	Country	Participants	Data collection	Analysis	Key findings
1. Explanatory models of coronary heart disease among South Asian immigrants. Patient Education and Counselling Tirodkar, Baker <i>et al</i> (2011)	USA	75 Participants aged 20-75 years. 58 Muslim 19 spoke Urdu (Pakistani)	Interviews	Grounded theory	<ul style="list-style-type: none"> • Self-reported risk factors for CHD including family risk • Definitions of heart disease: good or basic prior knowledge • Explanatory models of CHD aetiology: psychosocial, behavioural and physiological domains. Mainly identified stress as a cause. • Subgroup differences in explanatory models of CHD aetiology: fate mentioned by participants with lower education or interviewed in Urdu or Hindi • Explanatory models of CHD prevention: behavioural factors mentioned more than aetiology, e.g. <i>Namaaz</i> (prayer) as exercise and avoiding stress • Subgroup differences in explanatory models of CHD prevention: women mentioned prayer/positive thoughts more importantly than diet/exercise. Participants interviewed in English mentioned diet/ exercise more. • Perceptions of being at risk: participants with lower education perceived less risk and relied on fate • Participant explanatory models differ from biomedical models • Low levels of knowledge may be linked to poor risk factor control

2. Perspectives on enhancing physical activity and diet for health promotion among at-risk urban UK South Asian communities: a qualitative study

Cross-Bardell, George *et al* (2015)

UK

45 respondents,
34 South Asian
participants
aged 19-67
years

17 Pakistanis

One-to-one
interviews and
family group
interviews

Thematic analysis

- Perceptions and challenges of lifestyle changes: diet is culturally embedded and physical activity is an issue of cost, safety and prioritising time for family
- Preference for spoken information and experience that is tailored to individual needs
- Peer facilitation and motivation including face-to-face support and encouragement
- Informal home-based setting for enhanced cultural access and engagement. Participants had mixed views regarding faith centres
- Walking and pedometer use were seen as feasible activities with peers
- Perceived lack of support for prevention or access to suitable services
- Maintaining social relationships and cultural identity are important factors influencing diet or exercise

<p>3. Social and cultural influences on tobacco-related health disparities among South Asians in the United States</p>	<p>USA</p>	<p>88 participants aged 18-65 years 28 Pakistanis</p>	<p>Focus groups and observations of tobacco products in ethnic outlets/cultural events</p>	<p>Content analysis and thematic analysis</p>	<ul style="list-style-type: none"> • Knowledge of health risks: diverse opinions • Different perceptions on use of products containing tobacco in comparison to others. Some products proposed to have health benefits • The effects of using <i>hookah</i> (water-pipe) is underestimated amongst second-generation • Culturally specific benefits of using certain products containing tobacco and other ingredients • Social and cultural value of tobacco use • Outward representation of ethnicity and maintaining traditions • Used for socialising and distinguishing between different ethnicities and disadvantaged populations
<p>4. Perceived barriers to initiating and maintaining physical activity among South Asian and White British adults in their 60's living in the United Kingdom: a qualitative study</p>	<p>UK</p>	<p>87 participants aged 60-70 22 Pakistanis</p>	<p>40 interviews and 15 focus groups</p>	<p>Framework analysis</p>	<ul style="list-style-type: none"> • Intrapersonal factors: sedentary and less active participants described medical conditions limiting physical activity. Participants experienced anxiety, misunderstandings, and fear of injury • Interpersonal factors: support from family, peers, and healthcare professionals was considered essential • Institutional and community factors: time, gender segregation, and exercise on prescription could have some influence • Cultural sensitivity: within group differences can influence uptake and adherence of exercise
<p>Mukherjea, Morgan <i>et al</i> (2011)</p>					
<p>Horne, Skelton <i>et al</i> (2013)</p>					

5. “Every disease...man can get can start in this cab”: focus groups to identify South Asian taxi driver’s knowledge, attitudes and beliefs about cardiovascular disease and its risks

Gany, Gill *et al*, (2013)

USA

31 Participants
aged 18-40 and
above

10 Pakistanis

Focus group

Thematic analysis

- Stress due to issues of safety, income, and poor facilities. Stress thought to contribute to CVD and stroke risk. Urdu and Hindu-speaking groups believed stress caused hyper-tension.
- Job dissatisfaction: limited opportunities for progress and lack of time for family or health
- Job-related health problems including physical discomfort
- Lack of exercise due to lack of time, exhaustion, and limited safety to exercise at night e.g. walking in certain neighbourhoods due to fear of racial attacks
- Facilitators to exercise: dissemination of leaflets and convenient intervention sites e.g. taxi ranks and airport taxi waiting areas
- Unhealthy diet at work: cheap fast food and irregular meal patterns
- Limited knowledge of heart disease and prevention
- Lack of healthcare access due to insurance issues
- Important to address perceived barriers in order to encourage change

<p>6. Promoting physical activity among South Asian women with coronary heart disease and diabetes: what might help?</p>	<p>UK</p>	<p>15 women aged 20-70 years living in the UK for 15-40 years</p>	<p>Interviews</p>	<p>Constant comparison analysis</p>	<ul style="list-style-type: none"> • Perceived harm threshold limits activity: anxiety in doing exercise and feeling vulnerable to potential harm • Insufficient guidelines from health professionals about suitability of activity • Weight loss, maintaining independence and socialising perceived as main benefits of exercise. Weight loss and improving body image are the main aims for some participants • Participants had some understanding of benefit of exercise to improve and limit illness • Exercise beyond daily work is seen as “selfish” activity, doing ‘Western’ sports, and the cultural importance of keeping busy by doing errands (e.g. housework or chores) • Discomfort with exercising in public, e.g. swimming due to familial concerns about modesty • Some participants felt constrained by not being able to speak English • Participants felt that South Asian women do not share a homogenous identity • Exercises should be easily incorporated into daily routine, such as walking • Main motivation for women is to improve appearance, alongside general health improvements (e.g. relief from ‘stiffness’)
<p>Sriskantharajah and Kai, (2007)</p>		<p>4 Pakistani</p>			

<p>7. Effective heart disease prevention: lessons from a qualitative study of user perspectives in Bangladeshi, Indian and Pakistani communities.</p>	<p>UK</p>	<p>55 participants, aged 16 and above 15 Pakistani</p>	<p>Longitudinal focus group study (2 interviews, 6 month interval)</p>	<p>Grounded theory</p>	<ul style="list-style-type: none"> • Knowledge of heart disease and risk factors: varied amongst participants. Participants acknowledged stress as a result of living in Western society • Knowledge of preventative measures and self-reports of steps taken to prevent CHD: exercise was not always prioritised • There were barriers to adopting a healthier lifestyle including changing own habits and those of others. Occupational (laziness for men), social (cooking for the family for women), and body-image played a role • Impact of the project: participants' need for heart disease prevention and implications for service provision were highlighted • Cultural sensitivity and encouraging change is required to empower service users
<p>Netto, McCloughan <i>et al</i>, (2007)</p>					
<p>8. Inequalities in quality of life among older people from different ethnic groups</p>	<p>UK</p>	<p>203 Afro-Caribbean, Asian, White and Other backgrounds. Aged 55 and above 13 Asian-Pakistani</p>	<p>Interview with open/closed questions</p>	<p>Open coding</p>	<ul style="list-style-type: none"> • Health: gender, occupational, and socio-economic differences in reported health • Income: allocated differently within the household based on ethnic background • Social support: South Asian parents had regular contact with children than other ethnic groups but it was no guarantee that they received additional support • The impact of racism: participants compared arrival in England to present life • South Asian and Black participants may have lower health expectations than White counterparts
<p>Moriarty and Butt, (2004)</p>					

9. "Fasting and prayer don't concern the doctor...they don't even know what it is": communication, decision-making and perceived social relations of Pakistani Muslim patients with long-term illnesses.

Mir and Sheikh, (2010)

UK	104 participants aged 18 and above 76 Punjabi/Mirpuri and 3 Urdu	Longitudinal interviews, ethnographic fieldwork with 13 organisations	Framework analysis	<ul style="list-style-type: none"> • Discussing religious influences on self-care and management: language issues for Pakistani patients and fear of medication use (being addicted). Religious practices gave meaning to experience of illness and decreased anxiety. Religion played an important role for some and not for others in decision-making • Stereotypes and support for decision-making: due to absence of dialogue with healthcare providers, understanding of culture could be drawn from stereotypes including views on oppressed Muslim women (presumed social identity) and fatalism. Perceptions of exclusion affected physical and emotional well-being of participants regardless of age, gender, or socio-economic status. Some participants had an idealised view of their homeland (as a result of social exclusion) that undermined social capital in the immigrant Pakistani community. • Religion should be considered during decision-making and cultural awareness to limit stereotyping patients • Understanding health should shift from a focus on socio-economic status towards acculturation, identity, and community, as well as social relations that produce inequality.
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10. Changes in food habits among Pakistani immigrant women in Oslo, Norway

Mellin-Olsen and Wandel, (2005)

Norway

25 women born in Pakistan in 1955, 1960 or 1970

Focus groups

Open coding

- Meal patterns: shift from eating based on physiological needs towards individual routines and preferences
- Staple foods: some traditional meal items have been replaced, e.g. toast instead of *chapatti*. Time taken by participants to adjust to taste and satisfaction with new meal items
- Factors that have caused dietary changes: status foods, such as meats, eaten more frequently. Two hot meals (in Pakistan) replaced by one (in Norway), where meat is preferred to vegetables or legumes. Children born in Norway had access to Norwegian food and displayed a preference for it
- Physical activity: not investigated as part of the interview guide but mentioned as an important factor for aiding digestion of meals. Smaller houses and easier chores in Norway than in Pakistan perceived as limiting physical activity
- Women were not critical of Norwegian food habits or did not have knowledge about them
- Putting on weight was related to health and status, but the attitude is changing amongst younger community members

11. Social and cultural construction of obesity among Pakistani Muslim women In North West England.

UK

55, 1st and 2nd generation Pakistani women

6 focus groups and 10 interviews

Ethno-graphic, phenomenological and sociological analysis

Ludwig, Cox *et al*, (2011)

- Risk awareness: obesity was not always associated with diabetes
- Urban vs. Rural background: region of origin could affect beliefs and practices, including education and empowerment within marriages. Some women felt rural living was beneficial to health
- Climate: participants blamed cold British weather for gaining weight as they sweat less. Traditional diets were viewed as being more suitable for hotter climates
- Food traditions/expectations: preparing all food items by hand was viewed as being healthier. Breakfast was viewed as an ‘English meal’ with few South Asian items. There was a male dominance on food preparation and consumption. Women were given advice from elders (regardless of asking) and men expected women to maintain traditional cultural practices
- English vs. Pakistani food: English fast food was seen as being processed whereas Pakistani food had better health benefits, e.g. the use of ginger. In comparison to first-generation women, second-generation women consumed fewer traditional meals
- Obesity and health: increased weight may be viewed as good health and status. Modesty also influenced perception of weight as traditional clothes concealed body shape
- Identity was multi-dimensional and religion influenced food choices e.g. *halal* (permitted) or *haram* (prohibited) food
- Familial expectations were prioritised over individual lifestyle choices, e.g. exercising is selfish

<p>12. "I can't do any serious exercise": barriers to physical activity amongst people of Pakistani and Indian origin with Type 2 diabetes</p> <p>Lawton, Ahmad <i>et al</i> (2006)</p>	<p>UK</p>	<p>32 participants aged over 18 years</p> <p>23 Pakistani 1st and 2nd generation</p>	<p>Interviews</p>	<p>Grounded theory</p>	<ul style="list-style-type: none"> • Traditional health belief models focusing on individual self-efficacy may not be suitable for South Asian women • Roles, norms and responsibilities: lack of time and obligations to others. A strong work ethic meant working long and anti-social hours. Cultural norm for women, once married, to stay indoors and attend to domestic chores. Women from abroad were unfamiliar with socialising outside of their home and had limited knowledge of their neighbourhood. Fear and shame, alongside feelings of vulnerability were experienced by women if they left their home. Participants were concerned of being judged by community members for letting elder female members of the family go outside alone • External constraints: lack of culturally sensitive facilities and cold climate limited physical activity • Perceptions and experiences of disease: co-morbidities, lethargy, and perceptions of future health. Participants felt causes of disease were outside of their control and inevitable, based on experiences with older kin, and religious beliefs. Diabetes was thought to trigger irreversible decline in health as it weakened and aged the body. Physical activity can create anxiety. Through encouragement from health professionals, some participants tried to increase
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physical activity but could not maintain it. Symptoms of exercise (e.g. increased heart rate) were not seen as normal

- Activities and active respondents: men made efforts to increase physical activity but women were affected by gendered norms, social rules, and cultural expectations
- Short term goals: health was not a long-term priority. Some participants made an effort to carry out physical activity to avoid insulin injections which are stigmatised. Self-monitoring glucose changes created a sense of achievement. Small minority of participants felt they did enough exercise already
- Complex and interweaving factors influence physical activity for Indian and Pakistani patients that could be shared by other ethnic groups
- A lack of socialisation could be a cause for limited awareness of the benefits of exercise

13. A community and culture-centred approach to developing effective cardiovascular health messages

Kandula, Khurana *et al*, (2012)

USA

58 Hindi or English speaking Indian or Pakistani, all immigrants. Aged 20-75 years

10 Pakistani

Focus groups and interviews

Thematic analysis

- Targeted impact message and perceived susceptibility: a lack of understanding for why South Asians were targeted in awareness videos when everyone is at risk
- Participants felt that community heterogeneity and perceived risk should be reflected in health messages
- Stress and explanatory models of CHD are often based on the experiences of family members and myths around stress that require greater attention. Health messages should acknowledge other risk factors

<p>14. Physical activity in South Asians: An in-depth qualitative study to explore motivations and facilitators</p> <p>Jepson, Harris <i>et al</i>, (2012)</p>	<p>UK</p>	<p>59 participants, middle aged</p> <p>36 Pakistani, 17 Indian (Sikh), 6 Bangladeshi</p>	<p>Focus groups and interviews</p>	<p>Thematic analysis</p>	<ul style="list-style-type: none"> • Perceived benefits of screening and behavioural control: some participants felt heart attacks cannot be prevented and had misunderstandings about heart disease • There appears to be tension between the bio-medical model and the community's explanatory model • South Asian participants did not want to be unfairly targeted for risk awareness as it can create fear amongst community members <ul style="list-style-type: none"> • The types of physical activity people engaged in differed across participants. Some participants went to the gym (for intrinsic motivation reasons). Men talked about having active work in their shops and business. Many enjoyed walks. Men described social activities, such as football and cricket. Some women discussed using the gym (indoor activities), swimming, or exercise classes. Families did little physical activity together due to men having work commitments or spending time at the <i>Mosque</i> • Social interaction and enjoyment were key motivators. There was a preference for participating in activities with friends • Enjoyment of exercise was a motivator for men and women. Dance was viewed as a fun exercise with a social element for women, but inappropriate for Muslim women as it was only permitted in the privacy of their home • Mental and physical benefits seen as motivators for physical activity, such as increased confidence and self-esteem • Participants expressed a desire for leadership and role models in the community to organise
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activities, which could be promoted in religious centres. The influence of sports personalities was debatable as their health was viewed as a consequence of their occupation

- South Asian participants perceived physical activity broadly similar to the general population, such as awareness of health benefits and a sense of enjoyment
- Religion and cross-generation families play a role in how people socialise (especially those with young families)

15. Attitudes and beliefs to the uptake and maintenance of physical activity among community-dwelling South Asians aged 60-70 years: a qualitative study

UK

46 South Asians aged 60-70 years

33 Pakistani

Focus groups and interviews

Framework analysis

- Factors promoting initiation: anticipated health beliefs (benefits of exercise and maintaining independence) and social support (encouragement viewed as key motivator. Muslim women required gender segregation in most facilities)
- Factors promoting adherence: social support (strong motivator to maintain physical activity; avoid embarrassment in doing something alone, and getting confidence from others), psychosocial aspects (sense of accomplishment and achievement. For some South Asian women cultural norms were changing as they exercised for themselves and not their perceived role in society), health (longevity as a goal when keeping active), and integrating physical activity with everyday activities (adherence influenced by incorporating exercise into daily routine. Participants reported a lack of knowledge and associating prayer with exercise)
- The sense of commitment to a group and developing self-confidence were important aspects of regular physical activity

Horne, Skelton *et al*, (2012)

16. Understanding influences on smoking in Bangladeshi and Pakistani adults: community based, qualitative study

Bush, White *et al.*, (2003)

UK	141 participants, 54 Pakistani Aged 18-80 years	Focus groups and interviews	Thematic framework	<ul style="list-style-type: none">• Gender: men felt smoking provided a sense of social acceptance, bonding, and tradition. Macho and fashionable images were reinforced by Indian films and media. Men smoked for stress relief. Women smoking was seen as being taboo and could affect the chances of a women marrying. Fewer opportunities for women to smoke (culturally and economically) Younger participants felt smoking was becoming more Westernised or a form of female ‘rebellion’• Age and generation: it was culturally acceptable for elders to smoke. Elders were viewed as having a lack of knowledge and younger people smoked due to social pressure. A person is less likely to smoke if their peer group is non-smokers• Religion: most participants agreed it is unacceptable to smoke and potentially harmful. There were mixed views on whether smoking is acceptable or not• Tradition, culture, and family: cultural norms and ‘fashion’ around smoking or use of tobacco products• Islam, tradition, and family play a role in influencing attitudes and behaviours
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3.7.3 Risk and bias of studies

Table 6 outlines the assessment of methodological reliability and validity of qualitative studies included in the synthesis. Risk of bias was assessed by observing reliability and validity of findings as a consequence of methodological rigour, including inter-rater reliability and cultural awareness.

3.7.3.1 Inter-rater reliability and attrition

Two studies (Moriarty and Butt, 2044; Horne *et al*, 2012) did not mention inter-rater reliability explicitly, or provide enough detail on how transcripts were checked, or how codes and themes were developed by the research team. Attrition was noted by the three longitudinal studies (Mellin-Olsen and Wandel, 2005; Netto, McCloughan and Bhatnagar, 2007; Mir and Sheikh, 2010), but with limited or no discussion on how factors affected lack of participation, or bias of participants discussing the research topic amongst themselves between sessions.

3.7.3.2 Cultural and religious awareness

Four studies (Bush *et al*, 2003; Sriskantharajah and Kai, 2007; Mukherjea *et al*, 2011; Horne *et al*, 2013) matched participants with researchers on gender or ethnic background. An effort was made by four studies (Moriarty and Butt, 2004; Lawton *et al*, 2006; Mir and Sheikh, 2010; Gany *et al*, 2013) to collect data from participants in their preferred language, and accommodate varying proficiency in English. Two studies (Moriarty and Butt, 2004; Lawton *et al*, 2006) piloted the interview or topic guide in different languages to test efficiency, whereas Jepson *et al* (2012) based the topic guide on focus group outcomes and input from South Asian researchers.

To develop an in-depth understanding of idioms, Mukherjea *et al* (2011) used bilingual researchers, and Horne *et al* (2013) used informal conversations during the data collection process. Trained translators were used by Bush *et al* (2003) and Ludwig *et al* (2011), but only Bush *et al* (2003) provided an outline of the training programme. Single sex, ethnicity, generation, or time of immigration based focus groups were used by four studies (Bush *et al*, 2003; Moriarty and Butt, 2004; Netto McCloughan and Bhatnagar, 2007; Horne *et al*, 2012). Mukherjea *et al* (2011), and Horne *et al* (2013) offered participants the choice of interview or focus group participation.

Sriskantharajah and Kai (2007) and Horne *et al* (2013) increased validity of findings by sending transcripts and a summary of results to multilingual line workers or participants.

Table 6. Quality assessment and risk of bias for included qualitative studies

Authors	Aims and objectives	Methodological and analytical credibility	Research and policy implications
		(recruitment, research relationship, use of interpreters, data saturation, inter-rater reliability)	
Tirodkar, Baker <i>et al</i> (2011)	Investigating SA explanatory models of CHD compared to biomedical model to inform culturally targeted prevention messages	<ul style="list-style-type: none"> • 75 participants from federally qualified health centres (n=48), community centre (n= 27) in SA districts • Interviewer was fluent in Hindi and Urdu • 10 pilot interviews were used to create a coding scheme • Inter-coder reliability: coding discrepancies were resolved via discussion • Codes were modified to reflect outcome of discussion • Reliability coefficient was 99% between coders after discussion of discrepancies 	<ul style="list-style-type: none"> • Interventions should convey knowledge, motivation and skills to engage individuals in healthy lifestyle behaviours • Successful interventions could build on SA EM of CHD
Cross-Bardell, George <i>et al</i> (2015)	Exploring perspectives on enhancing PA and diet among SA in urban deprived communities with high risk of chronic disease and inform culturally appropriate health promotion interventions	<ul style="list-style-type: none"> • GP's identified participants with a high risk for diabetes and focus groups with the families of 6 participants • Researchers were female Muslim or Sikh and bilingual in Punjabi or Urdu • Transcripts were re-checked by bilingual researcher for equivalence of meaning with original audio • Data analysed thematically alongside data generation until saturation was achieved • During analysis, emerging themes were discussed regularly with a multi-disciplinary research team 	<ul style="list-style-type: none"> • Emphasis on spoken interventions using personal stories and peer support • Underline importance of relationships with peers, local and informal settings with easy access and activities involving family • Under investment into prevention compared to management

Mukherjea,
Morgan *et al*
(2011)

Explore and understand key cultural contexts of tobacco use among SA communities in the United States

- Study sites in ethnic enclaves using flyers, community based-organisations, invitations on electronic list servers and announcement on ethnic media
 - Participants proficient in English and using culturally specific tobacco products within previous 24 months
 - Translators present to ensure idioms expressed were accurately captured
 - Transcription by individual who was proficient in multiple SA languages
 - Focus groups based on gender, generation and time as immigrant to acknowledge cultural hierarchies with religious diversity in each group
 - Fieldwork to observe tobacco outlets described by participants
 - Five transcripts were reviewed independently by the three researchers to confirm overarching themes and develop a coding scheme
 - Remaining transcripts were coded by the primary researcher with extensive assessment with other researchers
 - An overarching theme was recognised if the perspective arose in multiple focus groups (in at least two groups)
 - Following initial coding complete data set were reviewed by all three researchers
 - Final evaluation of coding confirmed consistency, evidence of saturation and disconfirming accounts and credibility of data with research question
- Influence of socio-cultural hierarchies on tobacco consumption
 - Inaccurate perceived health benefits, symbolic use of products, health benefits ascribed to different products and use for preservation of identity
 - Inform construction of culturally sensitive surveys to understand culturally framed tobacco use behaviour
 - Need for awareness and accurate information on risk
 - Early screening and treatment with those with heightened risk

Horne, Skelton *et al* (2013)

Exploring barriers to initiate and maintain regular PA among UK Indian, Pakistani and White British adults in their 60's

- Older adults were purposefully sampled from fieldwork observations at local authority leisure centres, voluntary organisations (Age UK) and through informal social groups (walking groups)
- Subsequent sampling was based on emerging themes
- Sample size was based on theoretical saturation
- An interpreter was present during data collection
- For cultural preference, participants were offered FG or individual interview
- SA groups were divided into male or female
- FG were carried out until data saturation
- Saturation was based on no new information emerging from the data, including redundancy in themes or patterns
- Analysis was dependent on self-reported levels of PA, not taking into account life events or PA over life course
- Respondents validation was conducted with some interviews for validity of meaning
- Informal conversations with participants and interpreters occurred during observations, group discussions and interviews
- First author met with other team members who coded independently and compared for similarities and differences
- As a result of discussion amongst the team an indexing scheme was developed
- Charts (framework analysis) were shared and discussed with the research team to identify, interpret and explore data and make constant comparisons
- Respondent validation was carried out
- Regular research team meetings enhanced theoretical sensitivity and uncovered bias and clarified interpretation
- Alternative explanations were explored during the coding process
- Future research is needed to clarify levels of similarity and heterogeneity in ethnic groups
- Similarities and perceived barriers between SA and White British exist but some issues are specific to SA
- Muslim women were deterred by mixed-gender activities
- People's cultural barriers may be perceived by healthcare professionals who may have a tendency to treat all minority-ethnic groups the same. This can effect communication styles
- Healthcare professionals should recognise behavioural nuances and the importance of communication differences among diverse ethnic groups to facilitate the uptake and adherence to PA
- Under-researched area of research that needs more investigation in to how professionals engage with ethnically diverse groups for PA

Gany, Gill *et al*,
(2013)

Investigating SA taxi drivers knowledge, attitudes, and beliefs about general health, CVD and approaches to reduce CVD risk

- Sampling done to saturation per language specific group to reach redundancy in responses
- Drivers were approached whilst they were waiting for passengers in NYC neighbourhoods with largest SA populations
- Focus groups held in preferred language
- Multilingual researchers transcribed and translated audio recordings
- Small sample size and possible participant selection bias as non-participants could have been healthier or less healthy and embarrassed to participate
- Majority of participants were over 40 years under-representing young taxi drivers
- Each research team member generated a list of initial themes which were compared for similarities and differences
- Differences were resolved using group consensus
- All authors reviewed the final themes and results to ensure adequate data representation
- Important to address perceived barriers to encourage meaningful
- change in SA taxi drivers who are at greater risk
- Health beliefs should be incorporated into interventions
- Recommend culturally and linguistically tailored multi-level intervention targeting taxi drivers considering occupational restraints and need for health promotion programmes
- Future research on mental health and stress levels of SA taxi drivers incorporating health of families and other hard to reach occupational groups

Sriskantharajah and Kai, (2007)	Exploring influences on, and attitudes towards PA among SA women with CHD and diabetes to inform secondary-care prevention strategies	<ul style="list-style-type: none"> • Recruitment from 3 GP surgeries • Interviewed by SA female researcher using piloted interview schedule • Bias of using an interpreter with only 3 women facilitating more personal accounts • Emergent themes were explored in subsequent interviews to develop categories and themes • Discussions carried out between multidisciplinary authors during analysis • By the 15th interview no new themes or categories emerged • To check validity of interpretation each participant was sent a summary of results and discussed via telephone to confirm and refine further analysis • Deviant cases were sought to assess integrity of categories • Interpretations were validated by sending participants a summary of the results 	<ul style="list-style-type: none"> • Overemphasis of health promotion strategies on barriers could be creating defeatist attitudes among professionals • Health promotion initiatives need to incorporate social support, awareness of harm thresholds and sensitivity towards cultural norms
Netto, McCloughan <i>et al</i> , (2007)	How service users perspectives can be used to develop effective, culturally focused CHD prevention interventions by addressing identified barriers, including cultural beliefs	<ul style="list-style-type: none"> • Potential participants approached by ‘<i>Khush Dil</i>’ Clinic staff • Information was translated and telephones provided to call home and ask for permission • Community worker fluent in SA languages • FG for Bangladeshi participants carried out with bilingual health workers • Reduction in number of participants over time FG 1 (n= 55) to FG 2 (n=36) • Data was independently coded by all three co-authors to ensure inter-rater reliability 	<ul style="list-style-type: none"> • Noted sub-group variation in behaviours and barriers to healthier lifestyles • Value of targeted CHD interventions that connect clinical lifestyle sessions to increase awareness • Need socio-cultural sensitivity when designing CHD prevention initiatives

Moriarty and
Butt, (2004)

Discussing inequalities
in QOL among older
people from different
ethnic groups using
quantitative and
qualitative outcomes

- Recruitment from Family Resources Survey respondents list, community centre, service settings and snowballing technique
 - Interview schedules were piloted in different languages
 - Interviewer matching: gender and ethnicity using trained interviewers
 - Interviewed until saturation
 - Interviews were conducted in language of choice
 - Literacy and eye-sight issues meant researchers assisted participants with the completion of QOL questions
 - Adequate time had to be provided to participants to avoid fatigue
 - Inter-rater reliability was not reported
 - New cases were added to existing codes until saturation was thought to be achieved, establishing the existence and frequency of concepts with further analysis to establish relationships amongst them
- Minority ethnic groups have lower expectations for health than White counterparts
 - Governmental attention towards income discrepancies in older aged minority ethnic groups is recommended

Mir and Sheikh,
(2010)

Exploring the impact of religious identity and beliefs on self-management of long-term conditions, on patient-professional communication, decision-making and health inequalities

- Purposeful sampling through primary and secondary care contacts
- Community informants helped to develop the topic guide
- Interviews were conducted in participants preferred language
- Patients and professionals were recruited until saturation of themes had been achieved
- Three members of the research team checked coding for reliability
- Two team members independently devised coding themes and categories
- Comparisons were made across themes and categories
- Preliminary analysis was validated by a project advisory group
- Analysis was informed by wider literature
- Diverse range of respondents, settings, and triangulation
- Reliability and objectivity through systematic documented data collection and reflexive approach during all stages
- Deviant cases used to enhance validity
- ‘Shifting subjectivities’ used to balance insider and outsider perspectives within own community and identify assumptions as reflexivity
- Attrition from 25 to 20 participants
- Faith or identity can exclude Pakistani Muslims from health care and arenas known to determine health (work, education and civic participation)
- Personal resources provided by faith and discrimination where Muslim identity triggers in UK society creates dichotomy
- Interventions are needed to engage Pakistani patients with strategies moving beyond health care, taking into account context of social exclusion and disadvantage
- Religious identity is rarely addressed in healthcare policies tackling inequalities
- Requirement for greater dialogue with Pakistani patients due to significance of lay-professional perspectives

Mellin-Olsen and Wandel, (2005)	Provide information on dietary change and factors leading to these changes in Pakistani women post migration.	<ul style="list-style-type: none"> • Women recruited from Oslo health study, using purposive sampling • Recruitment continued until at least 8 women signed up for each of the four focus groups • Attrition from sign up (32) to turn up (25). Four to eight participants per focus group • Use of three different interpreters • Each group met four times, but the Swedish group only met twice • Interpretation of all data was rechecked and discussed by two researchers 	<ul style="list-style-type: none"> • Appearance regarding being overweight created greater concern for participants than diabetes • Health is seen to be the responsibility of health professionals • Potential need to design dietary counselling with access to conventional nutrition information
Ludwig, Cox <i>et al</i> , (2011)	Exploring health perceptions, diet and social construction of obesity and how this relates to initiation and maintenance of healthier diet in Pakistani women	<ul style="list-style-type: none"> • Purposive recruitment from community centres • Trained female Pakistani translator • Use of a non-Pakistani moderator • Sampling until no new themes emerged from the data collected • Emerging themes discussed as a process of triangulation with a sociologist to reduce bias and enhance validity • Use of existing framework to interpret themes (Van Manen themes [phenomenology]) and author themes 	<ul style="list-style-type: none"> • Lack of understanding of diabetes and weight gain • Multiple dimensions of identity exhibited as being Muslim, Pakistani British, female and mother • Tools should be used to assess diet and promotion by healthcare professionals

Lawton, Ahmad <i>et al</i> (2006)	Exploring patient's perceptions and experiences of undertaking PA	<ul style="list-style-type: none"> • Recruitment of clinicians and local community members • Snowballing method for hard to reach participants • Recruitment until saturation: no new themes emerged from interviews (grounded theory approach) • Interviews offered in SA languages • Bilingual researcher used • Topic guide piloted on Punjabi speakers, informed by literature, study advisory group, and preliminary discussion with patients and health-care providers • Translation of interviews was facilitated by casually employed translators from SA background • Team members explored respondents reasoning, deviant cases and reached agreement on themes and findings • Emerging themes were explored with respondents 	<ul style="list-style-type: none"> • Disease perception is a fundamental barrier • Social rules and cultural considerations used in the absence of culturally appropriate exercise • Health promoters and educators need to work with cultural norms, values and individual perceptions e.g. benefits of PA to maintain role within families and fulfil obligations to others • Consider how the term PA is used and understood
Kandula, Khurana <i>et al</i> , (2012)	Key lessons emerging from community and culture-centred approach to developing multimedia CHD patient education programme for medically underserved SA migrants	<ul style="list-style-type: none"> • Theoretical and conceptual framework for collecting and interpreting data • Participants recruited from a federally qualified health centre and two community centres providing non-health care • Snowballing method was used and participants were encouraged to recruit friends and family members • Not all words were translated into English if there was no equivalent • Through consensus an overarching categorical system to describe themes was created • Team reconvened to discuss major themes and inventory of community knowledge and issues related to CHD aetiology, prevention and screening • Team reviewed transcripts together and selected examples to demonstrate major conceptual themes through discussion and consensus 	<ul style="list-style-type: none"> • Heterogeneity within the target populations was overlooked in the education programme • Research is required into particular communities to understand factors influencing health and disease prevention • Incorporate community understanding alongside biomedical model

Jepson, Harris <i>et al.</i> , (2012)	Exploring the motivating and facilitating factors likely to increase PA for SA adults and families to develop successful interventions and services	<ul style="list-style-type: none"> • Recruitment from pre-existing community groups and ‘gatekeepers’ • Purposeful sampling of individuals already involved in PA • Topic guides developed using FG and SA researchers • Data collection iterative until saturation of key themes achieved in final focus group • Mindful of research influence as a form of reflexivity • Analysis was carried out by three researchers who compared and discussed themes • Themes were discussed with wider research team from a range of different perspectives 	<ul style="list-style-type: none"> • Group based activities should be emphasised as SA can have strong community, religious, work or family ties that can make PA as an individual difficult • Use of role models to help motivate and inspire participation
Horne, Skelton <i>et al.</i> , (2012)	Identifying attitudes and beliefs associated with the uptake and adherence of PA among community-dwelling SA aged 60-70	<ul style="list-style-type: none"> • Recruitment through period of fieldwork in several statutory and leisure groups and social settings • Purposeful sampling into gender-separated FG • Sampling until saturation: of emerging themes and theory, e.g. accommodate older adults who were not part of a formal exercise or physical activity group • Translated literature, information sheets and interpreters used • Acknowledged recruitment of older SA from areas where health promotion work had been previously undertaken • Inter-rater reliability not reported 	<ul style="list-style-type: none"> • Independence through the development of physical strength • Social support necessary to motivate start and maintain PA • Older adults able to gauge own activity against others • Allied and health professionals need to develop an awareness of specific motivators for older SA

<p>Bush, Martin <i>et al.</i>, (2003)</p>	<p>Gain a detailed understanding of influences on smoking behaviour in Bangladeshi and Pakistani communities in the UK to inform the development of effective and culturally acceptable smoking cessation interventions</p>	<ul style="list-style-type: none"> • Recruited 13 bilingual community researchers from local SA population to attend a 14 week accredited training programme in qualitative research • Purposeful recruitment from local Bangladeshi and Pakistani communities through existing religious and non-religious organisations, groups and social networks using snowballing • Community researchers matched as closely possible to participant for spoken language, sex and age • Single sex and ethnic focus groups were held • Translations of text were compared for consistency • Data generation until saturation: no new themes or ideas emerged • Interpretations were discussed with local community researchers and members of the research team 	<ul style="list-style-type: none"> • Men smoke to socialise, part of their identity and an antidote for stress • Smoking for women is traditionally disreputable and culturally restricted but carried out covertly • Ethnic minority groups are not given special mention in health (smoking) policies • Appropriate targeting and involvement of ethnic minority groups and respect for cultural norms is needed • Muslim leaders should clarify religious acceptability and support dissemination of agreed policy
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Key* SA= South Asian. CHD= coronary heart disease. PA= Physical activity. EM= explanatory model. QOL= quality of life. SA languages = (Urdu, Hindi, Gujarati, Bangladeshi).

3.7.4 Topics of research

The studies were grouped under five headings based on the topic of research. Table 7 outlines the areas of research.

Table 7. Description of studies based on topic of research

Topic of research and papers included	Description
<i>Physical activity (PA)</i> 2, 4, 6, 12, 14 and 15	<ul style="list-style-type: none"> • Largest number of papers included • Research with primary care professionals to encourage the uptake of PA amongst older adults (White and South Asian), motivators and facilitators for exercise, barriers for diabetic patients, and promotion of healthier lifestyle for women with CVD risk • Focus of these papers was to inform services available in the community for individuals to participate in PA as a preventative measure against CVD risk • Two papers looked at individuals who were in their 60's and above and were first-generation migrants from Pakistan (Jepson <i>et al</i>, 2012; Horne <i>et al</i>, 2013) • Focus groups, in-depth interviews and semi-structured interviews as well as observations were carried out with purposefully sampled participants • In some cases a focus was maintained on individuals who participate in regular PA • The level of information available to individuals and community members as well as any support, was the focus of these studies • Benefits, external constraints and prior knowledge on health and exercise were the bases for the themes reported

*Socio-cultural models
of CVD*

1, 7, 11 and 13

- Second largest number of papers included
- Focus groups were a popular method for collecting data and only one paper by Tirodkar *et al* (2011) used interviews
- Other papers used interviews to supplement group data
- Netto, McCloughlan and Bhatnagar (2007) carried out a longitudinal focus group to monitor changes in health beliefs over time
- Religion and culture were recognised as prominent factors determining social behaviour, especially when trying to maintain traditional and cultural beliefs
- Participants often discussed tradition and identity by recognising themselves as Muslim or Pakistani migrants in the UK, such as through the use of religious centres, e.g. *Mosques* for data collection (Netto, McCloughlan and Bhatnagar, 2007).
- A greater understanding of social barriers and awareness of healthcare campaigns within the community context could be established, as this type of research involved participants from diverse backgrounds and not just the elderly or patients with diabetes
- First and second-generation individuals were involved in the research, for example Ludwig *et al* (2011) used social vignettes (body silhouettes) to gauge participant's responses on healthy and unhealthy female figures
- Kandula *et al* (2012) noted stress as an important perceived factor for developing CVD, alongside the differences between the biomedical model and community formed explanations

*Quality of life and
decision making*

5, 8 and 9

- One study included participants from Afro-Caribbean, Asian, White and other ethnic backgrounds. The main topics covered in this study were income levels, social support from family members (particularly for ethnic minority groups) and the effect of racism such as being attacked by drunken groups (Moriarity and Butt, 2004).
- The study by Gany *et al* (2013) involved focus groups with 31 male taxi drivers from a South Asian background. Participants discussed the negative impact of their occupation on their general health and the increased risk of CVD. Job dissatisfaction was one of the major reasons participants felt stressed and had limited time to concentrate on their health. The majority of the participants were first generation immigrants who maintained a focus on supporting their families financially
- One paper contributed towards an understanding of how decision-making is based on communication and perceived social relations for Pakistani-Muslim participants (Mir and Sheikh, 2010)
 - Participants were interviewed in their preferred language of English (n=32), Punjabi or Mirpuri (n=76) and Urdu (n= 3)
 - The study involved a series of interviews with attrition between first, second and last interview
 - Religious influences were highlighted in terms of self-care and management. There was a focus on stereotypes and support for making decisions in relation to practitioners' understanding of cultural differences resulting in inequalities beyond socio-economic status
 - Practitioner's positive perceptions of community groups could increase feelings of empowerment and engage community members in healthcare discussion
 - Pakistani respondents felt relationships with family members and the community were weakening as a result of individualised choices

Use of tobacco products

3 and 16

- These studies reflected the views of individuals from different generations on different tobacco products used in the UK and USA
- In Bush *et al*'s (2003) study, British Pakistani and Bangladeshi participants discussed socio-cultural influences on smoking.
 - There were prominent gender based differences as smoking was viewed as taboo for women, but acceptable for older men within the community
 - Religion also had an influence on the development of lifestyle choices where alcohol was clearly prohibited, yet behaviours such as smoking were only discouraged for being injurious to health
 - Tradition, culture, and family views defined norms around community acceptance of smoking
 - Discrepancies in socio-economic status were noted, especially where men with manual, labour intensive jobs experiencing high levels of perceived stress as an explanation for smoking. Yet, families negotiated cultural norms and any opportunities for women to discuss their smoking behaviour at home were based on cultural restrictions enforced by parents adhering to the positive image of a good family
- The study by Mukherjea *et al* (2011) noted a variety of tobacco products available in areas with a high population of South Asian residents alongside focus group data to explore perceptions on use
 - First and second generation South Asian immigrants differed in their use of tobacco products where younger community members used hookahs (water-pipe) during casual social interactions
 - Tobacco products were also used as a cultural identifier to help distinguish socio-economic and cultural differences
 - Furthermore, certain tobacco containing products that were not explicitly used for tobacco consumption, e.g. betel leaf, had less stigma attached to them and were believed to be beneficial for health

Dietary habits

10

- The study by Mellin-Olsen and Wandel (2005) used purposive sampling to approach women who had migrated to Norway
 - Focus groups were used to explore views and beliefs about dietary changes by using food categorisation where predispositions to particular western foods, social reinforcement and enabling factors played a role
 - Changes in meal patterns, alongside selective staple foods were acknowledged and incorporated into a traditional meal routine alongside social and cultural preferences for engaging with others with food as a socialising medium
 - Although physical activity was not investigated, women noted a decrease since moving to Norway.

3.7.5 Interpretation of themes

The synthesis of 1st and 2nd order interpretations will be presented in the following section as 3rd order interpretation. Concepts extracted from the findings and discussions of each study have been used to develop the following themes of stereotyping, social influence on decision-making, misunderstanding causes of CVD, and motivation to initiate and adhere to lifestyle change. Although raw data was not interpreted for this synthesis (secondary-analysis), and a focus was maintained on 1st (descriptive) and 2nd (explanatory) concepts, quotes were referred to when understanding authors' interpretations (Britten, 2002; Paterson, 2008: 95).

3.7.5.1 Stereotyping

The doctor-patient relationship was identified as presenting a level of misunderstanding that was rooted in the stereotypes doctors have of South Asian patients. Patients felt doctors would not listen or understand their problems, therefore delaying treatment. Additionally, first-generation participants felt health promotions and interventions did not consider religious or cultural differences when designing programmes to increase physical activity.

Mir and Sheikh (2010) identified the lack of confidence practitioners had in discussing health beliefs with their patients, at times underestimating their ability for self-care and management. Their study further identified how stereotyping patients for non-compliance created an atmosphere of exclusion that had an effect on patients, particularly their emotional and physical well-being (Mir and Sheikh, 2010). Advice and support from physicians could encourage health promotion as Sriskantharajah and Kai (2007) highlight; communication between health professionals and patients' needs to be continuous for patient behaviour modification, especially as language can be a barrier to communication (Sriskantharajah and Kai, 2007).

Prejudiced behaviour was experienced by members of the Pakistani community within the professional and general community, which influenced health behaviours. In the study by Netto, McCloughan and Bhatnagar (2007), participants expressed racism creating issues when trying to adjust to a Westernised society, as described by a Pakistani male “We live in fear. Especially when you go to the park and White children call you *Paki*” and this resulted in indulgence in food. More than half of the participants in Moriarty and Butt’s (2004) interview study reported racism, which created a strong internal identity, and participants sought comfort in spirituality and social networks with limited ethnic diversity outside of work. Members of the South Asian community also expressed concerns over sending family members outside unaccompanied, especially children, if the surrounding area was unfamiliar, or neighbours were likely to judge their behaviour negatively (Lawton *et al*, 2006; Jepson *et al*, 2012).

Cross-Bardell *et al* (2015) acknowledged participants frustration with written, even translated health material that did not address the variable levels of literacy in the community; as a Pakistani woman reported, “actually ‘talking’ because literature doesn’t go very far”. Instead, face-to-face and person specific tailored information was preferred (Cross-Bardell *et al*, 2015), as it provided greater personal importance and significance. South Asian participants in the study by Horne *et al* (2013) felt attempts to promote physical activity did not provide suitable times or locations for exercise classes. Initiatives did not take into consideration cultural sensitivities, and assumed women lived in extended families. However, women at times lived alone and were grateful to have opportunities to socialise (Horne *et al*, 2013).

Participants in the focus group carried out by Kandula *et al* (2012) felt images of families used in promotional campaigns were too personal, and preferred health messages

representing various community members in order to reflect heterogeneity within the South Asian groups (Kandula *et al*, 2012).

Participants felt doctors and healthcare service providers should consider pathways to prevention that consider individual barriers to healthy behaviours and lifestyle changes. By grouping community members using a unified set of socio-cultural expectations, service providers could be overlooking changes in community trends and result in feelings of demotivation amongst community members to initiate or maintain behaviour change.

3.7.5.2 Social influence on decision-making

Socio-cultural norms played an important role in determining the lifestyle choices and behaviours that were adopted by members of the community.

Great importance was given to familial support and concerns of family members when considering changes made to improve quality of life (Butt and Moriarty, 2004). Relationships with family members and the community were thought of as weakening, and at times participants felt like they would have to negotiate feelings of exclusion (Mir and Sheikh, 2010).

Interviews carried out by Lawton *et al* (2006) found participants placed an emphasis on prioritising familial obligations and the influence of their socio-cultural environment as a Pakistani female participant noted, “Women cannot go out. You have to cook and provide meals at the right time”. Women wanted to carry out physical activity in segregated facilities from men, and did not want to exercise in front of community members who could gossip, as there was a cultural expectation for women to be homemakers (Lawton *et al*, 2006; Sriskantharajah and Kai, 2007). Social support and encouragement were generally considered key factors in motivating and maintaining physical activity for older South Asians, who

perceived family, friends and peers as important in relation to health choices (Horne *et al*, 2012).

Relationships with family members and the views held by people in the community had the ability to shape health choices. Participants suggested the use of role models that were not just Pakistani athletes (as they exercised for their profession), but a focus on members of the community who were leading a healthy lifestyle (Jepson *et al*, 2012). It is possible that participants recommend community role models, as they are from a similar background and could help justify a change in lifestyle choices. Additionally, privacy and familiarity are important when considering spaces to exercise, where participants would prefer the convenience of their own homes (Cross-Bardell *et al*, 2015).

The pressure to deal with Western influences whilst maintaining socio-cultural expectations presented itself as a challenge for members of the Pakistani community and South Asian participants. Men struggled to adapt to Western norms in the workplace, whilst women faced social isolation as a result of their traditional, South Asian housewife status (Netto, McCloughan and Bhatnagar, 2007). Mellin-Olsen and Wandel (2005) prompted Pakistani women who had migrated to Norway to discuss meal choices. Many women identified the change in eating habits, where meals were not consumed based on physiological needs, but on individualistic and irregular meal patterns of different family members (Mellin-Olsen and Wandel, 2005). Furthermore, cultural gatherings revolved around traditional food prepared according to authentic Pakistani recipes, and a sense of communal eating that is integral to social and cultural lives, often prioritising elders' traditional preferences (Cross-Bardell *et al*, 2015). These dishes were often content rich and no longer reflected the sedentary lifestyle adopted by many immigrants in Norway. However, some participants felt being slightly overweight was a sign of economic prosperity and was acceptable (Mellin-Olsen and Wandel, 2005).

The motivation to adopt a healthier lifestyle is at times in conflict with socio-cultural norms for members of the community. Ludwig *et al* (2011) discovered some generational differences in relation to cooking meals for family members as a social obligation. Second-generation women had fewer traditional meals, and were concerned about *halal* restrictions, limited alternative meal options when eating out, and awareness of unhealthy takeaways (Ludwig *et al*, 2011). Socio-cultural influences on behaviour were not limited to diet and exercise, but extended to smoking as well. When considering influences on smoking behaviour, participants acknowledged the strong social acceptance for men to smoke in social situations and in older age. Women were viewed as being ‘rebellious’ or Westernised if they chose to smoke, as this challenged notions of belonging to a ‘good family’ (Bush *et al*, 2003). Men used tobacco products as a method for socialising. Some tobacco products performed a symbolic function, as it represented heritage and allowed individuals to represent their ethnicity and cultural identity, whilst enabling younger generations to differentiate themselves (Mukherjea *et al*, 2011). It is possible that there are gender based differences in how certain lifestyle behaviours can be used as a social outlet for men in comparison to women, who face greater restrictions.

Socio-cultural restrictions tend to limit women in accessing preventative health behaviours, such as exercise, or seeking smoking cessation advice, as it is a taboo subject in the community. Where time places restrictions on men’s ability to exercise (Gany *et al*, 2013), women struggle to find appropriate activities and social support. Interpersonal factors played an important role for women who required support from family members, peers, and healthcare professionals, to maintain physical activity where the ‘wrong type of support’ could be demotivating (Horne *et al*, 2013). Furthermore, there was a greater concern amongst participants for women to be provided with segregated facilities that were accessible after religious holidays (Horne *et al*, 2013). The cause and consequences of such gender or

generational restrictions could explain why, at times, healthier lifestyle choices may not be pursued.

3.7.5.3 Misunderstanding the causes of CVD

Due to a lack of information, and at times misunderstanding of the cause and prevention of cardiovascular health, participants attributed causality to social and cultural factors. A variety of misconceptions exist with regard to preventing CVD, cardiac events, associated obesity, and diabetes in relation to diet and physical activity. Participants were not always clear on whether a Pakistani diet was a healthier option or not, and which types of Western foods should be incorporated into an existing diet (Mellin-Olsen and Wandel, 2005; Ludwig *et al*, 2011).

Stress was popularly associated with cardiac events, due to culturally embedded perceptions and experiences (Tirodkar *et al*, 2011; Netto, McCloughan and Bhatnagar, 2007; Ludwig *et al*, 2011; Kandula *et al*, 2012). Tirodkar *et al* (2011) discovered participants who gave interviews in Urdu (opposed to English) had a lower educational background, and reported stress as the main psychosocial component affecting cardiac health. Fate was mentioned as a form of managing anxiety, and praying as a form of stress relief (Tirodkar *et al*, 2011). The relationship between mental and physical strain on cardiac health was not considered, but an emphasis was placed on the socio-cultural pressures. Participants in the study by Kandula *et al* (2012) felt information on clogged arteries was insufficient to impact behaviour, and heart attacks were a result of bad news, and were not preventable (Kandula *et al*, 2012). Another misconception was the health benefits of products that contain tobacco, or the underestimation of the negative consequences of hookah smoking (Mukherjea *et al*, 2011).

Some participants reported low levels of physical activity due to a lack of available information on duration and types of appropriate exercise. Participants who were unfamiliar with symptoms of physical exertion, i.e. increased heart rate, considered it to be a negative consequence of exercise (Lawton *et al*, 2006; Horne *et al*, 2012). Consequently, participants were afraid of being vulnerable by being over active and injuring themselves (Sriskantharajah and Kai, 2007).

A misconception surrounding physical activity was that leading a busy lifestyle was adequate exercise, especially amongst Muslim participants who felt praying five times a day was keeping them sufficiently active (Lawton *et al*, 2006; Tirodkar *et al*, 2011; Horne *et al*, 2012; Gany *et al*, 2013). A fatalistic approach to health could be a cause of such behaviour, where well-being is outside of individual control, and lower expectations for health are expected with older age (Butt and Moriarty, 2004; Netto, McCloughan and Bhatnagar, 2007).

A change of climate from hot to cold temperatures was believed to be detrimental to health. Weight gain was perceived to be a consequence of limited sweating, and therefore inability to digest Pakistani cooking, as well as increased sedentary behaviour (staying inside) (Mellin-Olsen and Wandel, 2005; Lawton *et al*, 2006).

Familial responsibilities have been prioritised due to migrating to a new country, and focusing on economic development rather than personal health (Horne *et al*, 2013). Having an individualised approach to health and lifestyle could also ostracise individuals from the community, as they do not share resources within the community (Mir and Sheikh, 2010). Migrants working in labour intensive jobs spent a limited amount of time on care towards their health. A misunderstanding amongst taxi drivers in New York (USA) was occupational stress, lack of prayer, and limited access to healthy food as causation for CVD (Gany *et al*, 2013). Efforts to raise awareness for the biomedical causes of CVD, contextualised alongside

religious and cultural beliefs, could increase engagement in discussions of health behaviour and pursuing change.

3.7.5.4 Motivation to initiate and adhere to behaviour change

Participants in the Lawton *et al* (2006) study felt their health was outside of their control, and was a result of either the will of God, genetics, or the consequences of migrating to a colder climate. This perception of control over health outcomes determined the success of taking up, or continuing any healthy behaviours (Lawton *et al*, 2006; Horne *et al*, 2012).

Exercise instructors with positive personality traits motivated individuals to take part by providing support and helping participants in overcoming any challenges (Horne *et al*, 2012). Enjoyment also played a major role in the maintenance of any physical activity. Socialising with others was related to elevated levels of self-esteem and confidence to continue participating in sports, emotions that transferred into other activities outside of exercise (Horne *et al*, 2012; Jepson *et al*, 2012).

However, this could be problematic for Muslim women who require some privacy when performing certain exercises, such as dancing (Jepson *et al*, 2012). Women expressed a desire for varied exercise classes with greater individual support, and incorporating prayer times (Horne *et al*, 2013). A factor that did promote initiation and maintenance of exercise was ‘exercise on prescription’ from doctors (Mukherjea *et al*, 2011).

Tools such as pedometers and walking groups encouraged participants to take up and maintain physical activity (Cross-Bardell *et al*, 2015). Additionally, promotion and reminders in community spaces, such as restaurants and religious centres, and positive discussions from doctors could serve as a reminder to maintain physical activity (Gany *et al*, 2013). Safe, neutral environments could be important in providing individuals with the opportunity to form networks of support when adopting and maintaining lifestyle changes.

3.8 DISCUSSION

The qualitative synthesis has identified literature addressing socio-cultural factors affecting health behaviours related to the prevention of CVD in the Pakistani community. Although not all of the studies included in the review focused on Pakistani participants, there was sufficient similarity across all of the studies to produce key conclusions.

It was also possible to separate the views of Pakistani communities within some of these mixed-cohorts, as heterogeneity between different South Asian sub-populations was made explicit by the researchers. This was exemplified where Pakistani women talked about their specific, socio-cultural needs in relation to physical activity or diet, or members of different South Asian communities associated their identity with specific tobacco products (Mellin-Olsen and Wandel, 2005; Lawton *et al*, 2006; Ludwig *et al*, 2011; Mukherjea *et al*, 2011).

Social and familial circumstances affected perceived control over adapting an individual, healthier lifestyle. As some of the literature highlighted, participants need to feel confident and have a sense of self-control over their behaviour and management of their health before they can take up physical activity. Confidence is at times rooted within the support received from family members or the community who have the ability to influence lifestyle choices (Horne *et al*, 2012).

Stereotyping by health professionals and members of the general community limited engagement in health behaviours for preventing CVD. Other reasons included social influences, misunderstanding the causes of CVD, and a lack of motivation to initiate or adhere to behavioural change.

Religious identity, such as being Muslim, can exclude individuals from healthcare and arenas known to determine health (e.g. work) (Mir and Sheikh, 2010). When socialising with faith-based groups, individuals could become subject to discrimination from the wider

community and may need to negotiate between multiple identities (e.g. being Muslim, Pakistani, and British, female and a mother) in order to access suitable social resources (Ludwig *et al*, 2011).

First-generation Pakistani women in particular feel a social obligation towards their families when preparing food or considering participation in any form of exercise (Mellin-Olsen and Wandel, 2005). Consequently, it is important for promotional purposes that interventions and health campaigns consider community advocates to promote healthier lifestyles that will be accepted by the group.

Physicians need to develop a greater knowledge of the Pakistani community, and make referrals to diet and exercise by thoroughly informing their patients, rather than drawing on stereotypes or preconceptions that could limit promotion (Mir and Sheikh, 2010). Patients need to feel comfortable enough to discuss their health choices with practitioners, so that there is a sense of trust and security when making positive health changes. Otherwise, participants will continue to feel excluded from engaging in activities that promote better health or fear taking an initiative, as they are unaware of the outcomes for personal physical health (Lawton *et al*, 2006).

It is necessary to make members of the Pakistani community feel empowered by encouraging peer support and clarifying misunderstandings in relation to diet and exercise, especially the cause of cardiac events (Horne and Tierney, 2012). In the case of where educational initiatives have tried to inform participants about the causes of CVD, the study by Kandula *et al* (2012) noted how South Asians might perceive this as a false reflection of the diversity within the community (Kandula *et al*, 2012). It will also require health promoters to address existing explanatory models of health. Health messages need to clarify what type of life changes are required or what causes cardiac events, with a focus on using patients'

explanatory models of illness rather than only relying on the biomedical model (Tirodkar *et al*, 2011).

There have been gender and generational differences acknowledged in the literature included. Pakistani women, who appear to face social isolation, are required to adhere to socio-cultural obligations, and this trend appears to transition from first to second-generation women in developed, ‘Western’ countries (Netto, McCloughan and Bhatnagar, 2007). Where research has identified barriers such as language and religious duties towards the uptake of healthier lifestyle choices, the socio-cultural context within which these activities occur has been neglected (Kandula *et al*, 2010; Kakde *et al*, 2012).

Members of the Pakistani community are willing to listen, learn, and adapt their behaviours if they are given opportunities to combine them with socio-cultural beliefs. Some differences in lifestyle habits have been demonstrated, such as the choice to try different diets, but again with limited information on nutrition and within the context of religiously appropriate food, there are restrictions placed on these efforts (Mellin-Olsen and Wandel, 2005). Information on managing existing routines with socio-cultural expectations when adapting a healthier lifestyle could provide members of the Pakistani community with the internal motivation that is required to persevere with change.

3.8.1 Relevance to health policy

The design and implementation of health services should consider patient engagement with professionals and healthcare services. Kennedy *et al* (2007) developed a whole systems perspective model to understand why interventions for chronic disease patients showed limited improvements. The model identified the role of; patients as recipients of health information, professionals’ responsiveness to patient needs, and improving access to health

services in existing structures (Kennedy *et al*, 2007). Patient's social situation was given greater importance in the model, and recommendations were made for interventions to consider the context within which patients manage their condition and discuss individual background, socio-economic and familial circumstances (Kennedy *et al*, 2007).

Cultural competence programmes may increase practitioners' knowledge, awareness and cultural sensitivity, but are not an indicator for patient health outcomes (Renzaho *et al*, 2013).

Cardiovascular risk assessment of the South Asian population in religious and community settings identified positive experiences due to greater accessibility and community encouragement in comparison to general practice (Eastwood *et al*, 2013). All participants reported making lifestyle changes (diet and exercise), but barriers to change and maintenance included resistance from family members (Eastwood *et al*, 2013). Health interventions may recognise gender differences, and consequently prioritise women as targets and agents of behavioural change, however, motivation for behavioural change needs to consider the individual's role within the family and community (Liu *et al*, 2012).

Culturally appropriate diet and lifestyle interventions can successfully treat metabolic syndrome amongst migrant Pakistani women (Kousar, Burns and Lewandowski, 2008). The use of bilingual facilitators, existing informal networks, peer education on a one-to-one basis, including family members, allowing for limited access to transport, time restrictions, and family commitments helped overcome barriers to health promotion in a culturally and linguistically diverse Pakistani population (Kousar, Burns and Lewandowski, 2008). Cultural differences in understanding the intervention were addressed by bilingual educators with a similar background to the participant and an in-depth knowledge of Pakistani culture and religion (Kousar, Burns and Lewandowski, 2008).

Investigating delivery of health services for minority-ethnic groups in general should not overlook the specific socio-cultural needs of sub-populations, such as the Pakistani community.

3.8.1 Strengths and limitations

A positive feature of the literature included in the synthesis was the awareness of cultural barriers such as language, and the requirement for translators. Additionally, interview schedules and topic guides were often piloted, and interviewers were trained before data collection to make sure the interviews followed some structure and uniformity.

Although factors such as empowerment and understanding of healthcare services have been mentioned by previous reviews, the current literature search has identified specific underlying components, such as the need for community role models, assessing causation of cardiac events, and highlighting the diversity within ethnic minority populations where health choices are affected by specific socio-cultural influences (Fischbacher et al, 2004; Dixon-Woods *et al*, 2006; Jepson *et al*, 2012).

Limitations include some studies failing to include researchers reflections on collecting or interpreting data during the analysis process, or any researcher bias or inter-rater reliability. It is important to place the findings in the context of other literature when reporting findings, but also appreciate and alert readers to any existing biases of their own over the results they have accumulated (Correa, 2013).

There were studies that did not define the analysis method clearly enough, and simply stated text was coded into themes. Although an effort was made to outline the analytical process, it was difficult to understand the theoretical standpoint for interpreting the findings of these studies without knowing details of the analysis to produce findings and

interpretations e.g. Netto, McCloughan and Bhatnagar (2007). Participants could discuss the research outside of its context, actively seek information between focus groups, or become more aware of health messages in their environment. Yet, researchers did not explicitly outline what kind of exposure influenced participants' responses.

3.8.2 Summary

By highlighting the socio-cultural factors that members of the Pakistani community consider when making lifestyle choices, this synthesis identified the need for community led health initiatives. The aims addressed in this synthesis point towards a need to further develop and/or adapt existing healthcare initiatives in order to fully benefit service users from the Pakistani community as outlined in Table 8. Whilst trying to minimise stereotyping behaviour and prejudice is important, the implementation of any intervention would require endorsement from community members en masse. It is not possible to address health inequalities by creating interventions and campaigns that address specific health problems, if they are not fully understood or accepted by community members due to varying socio-cultural needs.

Without understanding how social networks interact in the formation of health goals, or how much individuals get support for the pursuit of less traditional lifestyles, we cannot expect progress towards preventing lifestyle factors related to CVD.

A majority of the studies in the synthesis noted familial and communal influence on lifestyle choice, yet the function of relationships within individual social networks remains unexplored in the migrant Pakistani community.

An investigation of perceived social support and information accessed through professional or personal pathways could lead to a greater understanding of how individuals from minority-ethnic sub-groups negotiate complex identities and shifting social

circumstances in the formation, management and maintenance of lifestyle change.

Specifically, how social networks function to provide access to health resources can vary for men and women across different generations of the Pakistani community.

In the next chapter, I outline the methods used in my research for recruitment, analysis of data, and interpreting findings from qualitative research. I present a reflexive account of the research process, describing rapport with participants, maintaining confidentiality, and presenting the findings.

Table 8. Summary of qualitative synthesis

1) What do we already know?
<ul style="list-style-type: none">• Pakistanis have a high prevalence of CVD and associated diabetes and obesity• Social, religious and cultural factors play a role in determining barriers and facilitators towards accessing healthcare facilities• Social capital based on notions of social networks and communities influence available information and support
2) What this synthesis adds:
<ul style="list-style-type: none">• There is an influence of community opinion over certain lifestyle choices that effect motivation to engage in or adhere to behavioural changes• Discrimination within professional settings and the community are based on ethnicity, gender and generational differences• Misconstrued understanding of what causes CVD and how to prevent CVD are not based purely on biomedical models but psychosocial beliefs• Components of trust and information within the wider community reflect the necessary enquiry into social capital as a resource facilitating the uptake of health goals

CHAPTER 4

4.0 METHODOLOGY, METHODS AND ANALYSIS

4.1 INTRODUCTION

In this chapter, I present the research design, data collection and analysis components of my research as part of a continuous reflexive account. I have placed a great priority in considering my position as a researcher and my role within the Pakistani community to address cultural and religious sensitivity when designing suitable tools for data collection. My background in psychology and social research helped me to contextualise findings from data. The process of reflexivity will be outlined through the different stages of developing the methods for data collection and analysis, as well as my personal epistemological and ontological standpoints. I outline the methods used to recruit participants from a marginalised group who have been described as ‘difficult to engage within health research’ (Din, 2014). Furthermore, I provide an outline of data management and reduction using the framework analysis approach (Gale *et al*, 2013), whilst considering validity and rigour.

4.1.1 Aims and research questions

The primary aim of this research was to explore the level of perceived support for members of the Pakistani community when forming a healthy lifestyle. In order to understand how individuals perceived their social support, the theory of social capital (Putnam, 2001; 201) was used to inform data collection, alongside the convoy model diagram (Pachana and Laidlaw, 2014; 209). Social capital is an all-encompassing theory that helps understand how social resources function to provide an individual with support and information in their community (Putnam, 2001). The convoy model diagram is a life-span model that links attachment and importance to social support (Pachana and Laidlaw, 2014).

4.1.1.1 Research questions

The context behind research questions are presented in the background and qualitative synthesis (Chapters 2 and 3), specifically the prevalence of CVD, socio-economic deprivation, and complex socio-cultural structures within which members of the Pakistani community access support and health information. An understanding of the interpretive standpoint is facilitated by the outline of social support and psychological theories. The research questions addressed in this research are:

- 1) How are networks of support and information accessed by members of the Pakistani community?
- 2) How does the local or wider community influence lifestyle choices?
- 3) What individual health goals exist, and how are they embedded within a community space?

4.1.2 Epistemological position and ontological standpoint

Constructivist and interpretivist perspectives were used to develop an understanding of what (ontology) and how (epistemology) individuals construct knowledge as a process of reflecting on their own life experiences.

The epistemological standpoint I applied to interpret findings was to construct individuals realities through understanding and making sense of their insights and actions by interpreting their meaning subjectively, whilst the ontological position is that individuals perceptions are influenced by social and cultural influences (Ritchie and Lewis, 2003:1-5). This reflects the nature and purpose of this qualitative research on “understanding the world from the

perspective of its participants, and should view social life as being the result of interaction and interpretations” (Phillimore and Goodson, 2004:4). This standpoint enables me to understand how people make sense of their experiences beyond empirical enquiry.

Furthermore, I present a reflexive account of my own position as the researcher to reflect on my approach to research findings.

4.1.3 Research notes and observations

Qualitative researchers should try and present data they have collected and interpreted in a meaningful way, through a comprehensive understanding of participants’ use of language and storytelling (Shaw, 2010). Reflection is necessary for methodological rigour, and enables researchers to review their ontological and epistemological positions during the analysis and interpretive process. Mauthner and Daucet (2003) acknowledge the assumptions surrounding qualitative research, where the method and data are viewed as separate entities, rather than being interdependent and interconnected through reflexivity. Neither data collection nor analysis occurs in a social vacuum; it is influenced by the researcher’s own perceptions and biases. For the purpose of this thesis, I will highlight my own cultural background and reflexive processes surrounding ethnicity, occupation and educational status that may provide rationale for some of the conclusions made.

I considered my position both as a researcher and a member of the Pakistani community from the onset of this research. My parents were born and raised in Pakistan, and moved to New York (USA), before arriving in England and settling down. As a daughter of first-generation migrants, my heritage has provided insight into acculturation and networking within an existing Pakistani community in the UK. Furthermore, being Muslim and British also influences my outlook on life and expectations of other Pakistanis in the community.

Although I am Pakistani, there are numerous factors that affected data collection. Being

Pakistani extends to what city you are from in Pakistan, what caste, which dialect of the language you speak, as well as which religious sect you follow (Kabir, 2010: pg. 25). An individual's physical appearance is a visual marker for the aspects of Pakistani culture that they associate themselves with, i.e. wearing English clothes, or covering your head with a traditional Hijab (Kabir, 2010: pg. 91). Dressing a certain way, or adopting a specific "costume" can create a form of access into the community, as someone who respects the culture (Conner, Peters and Nagasawa, 2009). By dressing in English clothes, I present a non-verbal commentary on my background; presumably my family is from the city, e.g. Islamabad, rather than a village or the rural district of Kashmir and Mirpur, as well as the likelihood that my parents were well educated with a liberal view on culture and religion. Ethnic concordance does not overcome all cultural or religious disparities between researcher and participant. My gender, marital status, religious knowledge, adherence to cultural norms and ability to speak Urdu would be in constant assessment by participants, and I had to make sure I presented myself as respectfully and appropriately as possible to the incredibly diverse range of participants to be recruited in this research. Conducting interviews in second-languages as a community-based researcher can take more time, in order to re-frame questions and consider age, gender, cultural and contextual information (Cortazzi *et al*, 2011).

I was aware of the fact that my gender could have an influence on responses from men and women, but I was surprised to find that my marital status meant older, married women formed a mother-daughter relationship with me when presenting their narrative. It was also made apparent that participants were impressed by my ability to speak fluent Urdu, as it added cultural value however, many words were used in first language for first, second and third-generation participants. It can be enriching for researchers to share a social and ethnic background with their participants, as they can explore issues in more depth through an

understanding of nuances and subtexts (Lewis, 2003: 65). Therefore, I felt I was at an advantage having insight into the community, yet removed from individuals' personal experiences. Participants felt I understood many cultural and religious norms ("you know what I mean"), and they were able to focus more on exploring their experiences, feelings and opinions through the interview. There was a risk that participants could make assumptions about my understanding of cultural or religious concepts being similar to their own. I waited for participants to either describe terms and experiences as the narrative developed naturally or alternatively I asked participants during the interview to provide more information, for example asking if the term "*Biradari*" was used in the context of fraternity (i.e. a group with shared common interests).

4.2 RESEARCH DESIGN

Qualitative research equips researchers with the analytical tools and data collection methods they need to investigate a phenomenon in greater depth and detail than is possible with quantitative methods (Punch, 2014: 115). A community-based interpretative qualitative approach was used and included semi-structured interviews to 1) collect lay accounts of lifestyle practices, 2) the use of talk-based methods (community languages [English and Urdu]), and 3) the application of the convoy model diagram to elicit responses on social networks and community interactions. A community-based interpretative approach is a qualitative study with a sample generated within the community in question using an interpretative approach to address questions around understanding patient meaning and action towards a particular topic of interest (Gregg *et al*, 2009). The approach enabled me to conceptualise the perceptions and practices that lie within the culture of a specific community, by representing views of participants through analytical interpretation (Megyery, 1991).

The study design was piloted with four voluntary participants from the community who were approached to take part in research prior to recruitment on a larger scale. The study was piloted to examine the strengths and weaknesses of a semi-structured interview sheet to collect data, and my ability to translate questions into Urdu (Appendix 7). However, as a result of feedback from participants (discussing the research), and a noticeable amount of dichotomous responses due to closed questions, an interview guide was formatted instead (Appendix 8). An interview guide better suited the nature of this investigation, as they “outline key issues and subtopics to be explored with the participants” (Arthur *et al*, 2014: 149). To increase the length and depth of participants’ responses, I included more open-ended questions organised into four categories, each with a series of sub-questions and prompts to further probe participants during the interview. For example, the following question was asked in the pilot interview; “do you relate to people in the community when you think about your health?”, and was re-phrased into a sub-question within the social capital category as “how informed do you feel as a member of your community about healthcare initiatives?”. By using open-ended questions, I provided participants with the opportunity to develop a story within their response rather than a minimal, categorical answer, i.e. yes/no/maybe (Stake, 2010; 89). This provided a flexible and balanced approach for interviewing participants who had minimal responses, with those who were more actively involved in the interviewing process.

Once the data collection procedure had been refined, individuals interested in the research were invited to take part in a one-to-one interview lasting around one hour. The interview process involved presentation of information about the study (verbally, or as an information sheet), completing the convoy model diagram (Pachana and Laidlaw, 2014), the interview (using the interview guide) and debriefing. In total, interviews lasted between 45 to 120 minutes.

4.2.1 Recruitment strategy: challenges to recruitment

Redwood and Gill (2013) noted how recent migration into the UK has resulted in characteristics such as overlapping ethnicity, resulting in ‘a new kind of diversity which Vertovec has coined “super-diversity”’. Dealing with superdiverse migrant ethnic communities can limit research validity (Redwood and Gill, 2013), produce generalisation, and require personalised approaches to increase recruitment and participation across all communities (Redwood and Gill, 2013).

Members of the South Asian diaspora in the UK are challenging to recruit due to issues surrounding literacy, language, translation, knowledge of research, cultural advocacy of participating in research (trust and sense of belonging), and transportation to research facilities (Hussain-Gambles *et al*, 2006). As a sub-population within the South Asian diaspora, the Pakistani community is viewed as a ‘hard to reach’ community, where further issues such as modesty, lack of awareness, and being ‘housebound’ can limit patient and public involvement (Lawton *et al*, 2005; Banning and Hafeez, 2010). The aforesaid factors should not, however, determine involvement in health research where an understanding of individuals, communities, and the impact on health outcomes should be explored.

Community based research is a novel approach for recruiting members of the Pakistani community who are at times viewed as a marginalised minority-ethnic group (Din, 2014: 22-30). As a Pakistani researcher, ethnic concordance would encourage recruitment from the community by sharing an understanding of spoken languages and socio-cultural backgrounds, with the potential to heighten positive research experiences (Lie, 2006; Cortazzi *et al*, 2011; Ahmed *et al*, 2015).

Traditional recruitment methods might not always be appropriate for targeting minority-ethnic groups. For example, Ejiogu *et al*'s (2011) research with African-Americans utilised a unique community partnership approach in designing research that was beneficial to participants. The study was carried out in safe, community-based research sites where research aims and objectives were made as clear as possible to effectively engage community members (Ejiogu *et al*, 2011). Rooney *et al* (2011) strengthen the argument for community involvement by noting the importance of forming a relationship with participants, or community members to have a greater impact on successful recruitment. In a study using eight South Asian focus groups, Rooney *et al* (2011) found that personal approaches were better received than impersonal; written methods are problematic for poorly educated community members, but are commonly used to recruit from the White, literate populations. Hence, novel-community based approaches to engage non-academic stakeholders can be utilised where traditional methods, such as letters and leaflets for advertisement, may not be as reliable. In order to represent Pakistanis living in the West Midlands, UK, an all-inclusive recruitment strategy targeting participants from varying educational, occupational and migrant backgrounds from first, second and third-generations was applied by exploring diverse recruitment channels.

Although first-generation migrants have been included in health research, there is little known about recruitment methods that facilitate inclusion of second and third-generation migrants. Recruitment strategies tend to rely on recruitment of second-generation migrants from educational institutes, or through parents involved in existing research cohorts (Popkin and Udry, 1998; Splansky *et al*, 2007; Caseir *et al*, 2013). Clearly, these approaches would limit recruitment to very young participants, or require access to data from other research projects. Furthermore, following the acquired ethical guidance and approval, all participants

in this research had to be 18 years and above. In order to avoid biasing recruitment of second and third-generation descendants (children and pre-adolescents), recruitment was limited to higher education, social media and word-of-mouth.

Worth *et al* (2009) argue that there are numerous factors that could be responsible for the deficient number of minority-ethnic participants engaging in research. Challenges to recruitment include low levels of literacy, an increased desire for modesty, feeling vulnerable, and limited understanding of cultural sensitivity (Worth *et al*, 2009). Redwood *et al* (2012) further acknowledge exclusion of minority-ethnic groups based on ethnic specific cultural issues. In the study titled “you give us rangoli, we give you talk”, South Asian women were recruited through voluntary and faith-based organisations, whilst collaborating with a local artist to design a creative data collection task. By recruiting women from community centres, the researchers were able to by-pass traditional methods, such as letter writing, that could place the decision to participate with the male heads of the house (Redwood *et al*, 2012).

Participants are often agreeable to taking part in research once they are aware of the procedures and outcomes of the study however, some researchers can view recruitment as an overwhelming problem and do not attempt to recruit those who are challenging (Sheikh *et al*, 2009). More attempts should be made, when possible, to apply novel and diverse recruitment strategies that could benefit researchers and members of minority-ethnic groups who are willing to participate in research but are limited by circumstances. The present research took this opportunity to apply different recruitment techniques to target a diverse and broadly representative population. I used numerous communal platforms (digital and social) to distribute the research information.

4.2.1.1 Recruitment techniques: social networks and enabling places

The research was promoted through diverse recruitment channels, via enabling places (business districts and community centres) (Soldatic, Morgan and Roulstone, 2014), using word-of-mouth advertising, through third sector organisations, social media (e.g. Facebook) and snowballing (Browne, 2003). I recruited first, second and third-generation Pakistanis living, working or studying in different areas.

There are regions of Birmingham that provide for its vastly diverse minority-ethnic inhabitants. A selection of business districts were scoped for their potential to support recruitment through gate-keepers in established community areas. As a member of the Pakistani community living in the West Midlands, I am well acquainted with areas of high ethnic density that would be suitable for recruitment. These areas included Saltley (Alum Rock), Washwood Heath, Sparkhill (Stratford road), Aston and Bordesely Green (Table 9 and Figure 4).

Table 9. Different locations in Birmingham

Location, (constituency, ward and area)	Description	Population total	Pakistani population
Edgbaston (Bartley Green, Edgbaston, Harborne, Quinton)	Middle-class residential area, Southwest of the city-centre, leafy parks and cricket ground	96,568	2,844
Erdington (Erdington, Kingstanding, Stockland Green, Tyburn)	Largely residential, growing retail centre	97,778	4,709
Hall Green (Hall Green, Moseley and Kings Heath, Sparkbrook, Springfield)	Multi-racial residential area with a diverse range of shops, contemporary restaurants and cafes	115,904	37,653
Hodge Hill (Bordesely Green, Hodge Hill, Shard End, Washwood Heath [Alum Rock, Saltley])	Predominantly Pakistani (Mirpuri inhabitants) characterised by take-away restaurants and ethnic-specific shops	121,678	46,042
Ladywood (Aston, Ladywood, Nechells, Soho)	Alongside Saltley and Sparkbrook one of the main centres for the Pakistani community but trends for moving outwards	126,693	19,484
Northfield (Kings Norton, Longbridge, Northfield, Weoley)	Area of 19 th century industrial development with residential homes, parks and amenities developed for employees	101,422	750
Perry Barr (Handsworth wood, Lozells and East Handsworth, Oscott, Perry Barr)	Majority non-White, close to the city-centre, occupied largely by West Indian and South Asian immigrants	107,090	12,902
Selly Oak (Bourneville, Billesely, Brandwood, Selly Oak)	Close links to Birmingham University, an area for shopping, eating and student residence	104,067	4,323
Sutton Coldfield (Sutton Four Oaks, Sutton New Hall, Sutton Trinity, Sutton Vesey)	Largely village atmosphere and residential development, small number of shops and range of private and public sporting amenities	95,107	1,119

Yardley (Acocks Green, Sheldon, South Yardley, Stechford and Yardley North)	South-eastern edge of Birmingham, few inner-city characteristics, least non-White residents and majority manual workers	106,738	14,801
Dudley	Centre of Industrial revolution in the Black Country	312,925	10,399
Smethwick	Area popular for immigrant settlement since the second world war	55,166	6,939

(Iqbal, 2013; Sandwell trends, 2013; Birmingham City Council, 2014; Dudley Metropolitan Borough Council, 2014)

Figure 5: Map of Birmingham Wards from 2004

Available at: <http://www.birmingham.gov.uk/cs/Satellite?c=Page&childpagename=WT-General%2FPageLayout&cid=1223092626283&pagename=BCC%2FCommon%2FWrapper%2FWrapper>

(Birmingham City Council, 2015)

The owners and managers of established businesses can be perceived as trustworthy by members of the local community, as a result of managing trade and relationships over time (Gonzalez, 2010; 218). Business owners acted as informal gatekeepers in this research, due to their valuable expansive social connections and rapport with the local Pakistani community, particularly as no formal institutes were approached for recruitment (Hatch, 2002: 45; Seidman, 2013: 49). The study was advertised in businesses using three methods: 1) using information sheets (Appendix 9), 2) through oral advertisement by business owners to encourage community members to consider participation, and 3) using lay-led posters that were designed to use terminology that should be accepted by participants who are unfamiliar with research (Appendix 10). The third method helped overcome issues surrounding literacy, and effectively promoted the research to a wider audience by drawing attention to visual material that was supplemented by information from either the business owners or the information sheets.

Community members are valuable non-academic stakeholders who can provide comments on the design and content of research materials, such as recruitment posters and information sheets (Zinnstag, Waltner-Toews and Tanner, 2015: 23). Furthermore, user involvement in the design and application of research can balance power shifts and the agency of control (Godfrey, 2004). Where initially the recruitment poster was black and white with a large amount of text, the Pakistani lay audience (business advocates) suggested the use of colour and increased visual imagery to make the poster more eye-catching. Consequently, the second edition of the poster included images of food, people playing sports and taking part in an interview to visually outline the main components of the research. Community members also suggested the use of sub-headings to organise the text in the information sheet so participants could remember the topic more easily. By incorporating participants' views into

the design of the recruitment material, I obtained a greater understanding of how to engage with the community. As the posters and information sheets were based on lay-led feedback, this helped balance the power distribution, as participants actively contributed to the tailoring of research material to meet community needs (Karnieli-Miller *et al*, 2009).

Getting participants involved in the design of the study is a process similar to Patient and Public Involvement (PPI) (Wilde and Jones, 2014; 190). PPI processes can be pragmatic (outcome orientated) or process based, where the former relates to incorporating participants' perspectives, and the latter about healthcare provider needs (Ives, Damery and Redwood, 2012). Community involvement and effective engagement of participants can positively influence recruitment and retention of minority-ethnic participants (Yancey, Ortega and Kumanyika, 2006).

In essence, the business owners acted as research advocates in a novel approach to provide support for participation in the research through its promotion. As research advocates, the business owners were in a position to inform participants on the different aspects of decision-making, i.e. by answering any questions, clarifying any misunderstandings, and translating material and providing insight into the research process. Therefore, it was important to establish a rapport with business owners and provide them with an appropriate amount of information to cover basic questions that could be asked by potential participants.

Business districts and areas of high ethnic density were viewed as enabling places, as they facilitated discussion of research and recruitment in the locality based on their ability to provide access to existing social networks (Fong, Luk and Ooka, 2005). Enabling places provide individuals with the resources for human development (identity, belonging and

individual biographies), and health and well-being through social, political and cultural resources (Soldatic, Morgan and Roulstone, 2014: 126). Duff (2011) investigated the impact of enabling places on health promotion through social, affective and material resources, where these processes can have a negative or positive effect depending on which resources are available to the individual within their spatial context (Duff, 2011). In areas of high ethnic density, such as popular Pakistani business districts in Birmingham, the socio-cultural landscape provides individuals with networks and resources. Therefore, recruitment was made through these existing networks in areas of social and material resources.

Areas of high ethnic density are considered as ethnic enclaves. Ethnic enclaves are areas with a greater ethnic minority population in residential, business and industrial sectors (Valdez, 2007: 244). Areas of high minority-ethnic populations are characterised by “the spatial concentration” of a particular immigrant group, and “within-group stratification”, with clustered social networks of businesses that are owned by members of that ethnic group offering services primarily to minority-ethnic community members, and then the larger community (Heisler, 2000: 82). Areas of high ethnic diversity are favoured by first-generation migrants, especially women, who view those who venture outside of the area as a target of “othering”, based on their ethnic affiliations, and fear of being excluded from the wider community (Saenz and Morales, 2012; 60). Muslim women in particular experience isolation, and are dependent on close family members as a result of restricted socialising within ethnic neighbourhoods (Joseph and Nagmabadi, 2003; 15). By identifying an area of high ethnic concentration, recruitment can be carried out more effectively by tapping into the existing social networks (Vertovec, 2002). Access can therefore be provided to difficult-to-reach participants who do not have connections outside of their ethnic community.

As a culturally and linguistically diverse population, members of the Pakistani community have varying levels of Urdu or English literacy and spoken English (Kousar, Burns and Lewandowski, 2008). Therefore, oral methods, such as word-of-mouth and snowballing techniques, can increase promotion of research (Rankin and Bhopal, 2001). Word-of-mouth and snowballing techniques were used with business owners in enabling places (business districts) who encouraged friends, family and community members to participate, as well as second and third-generation participants who used messaging applications on their phones and social media to contact members of their social networks. First-generation participants were encouraged to pass on information to younger members of their family who could share the research opportunity amongst their friends. The social media site “Facebook” also provided a platform for communicating with individuals who might be interested in the research. I sent messages to participants’ inboxes if they were interested in the research. Consequently, recruitment through community members became a “referral” process, where participants who were initially recruited or interviewed, passed on research details to members of their social networks (Cottrell and McKenzie, 2011: 225).

Browne (2003) demonstrated the use of the snowballing method as a way to access social networks when seeking entry into a specific population; for example, ‘non-heterosexual women’ who do not wish to be publicly recruited. Some members of the Pakistani community, such as first-generation migrant women, may not be aware of the possibility of research participation, or as easily accessible (Banning and Hafeez, 2010). Therefore the snowballing technique enables researchers to access the interpersonal relations that people use, to recruit participants who may not respond to other forms of advertisement (Browne, 2003). Snowballing can also be a practical method for recruitment in difficult to access populations, where literacy, trust, and/or understanding of research may be limited (Marline

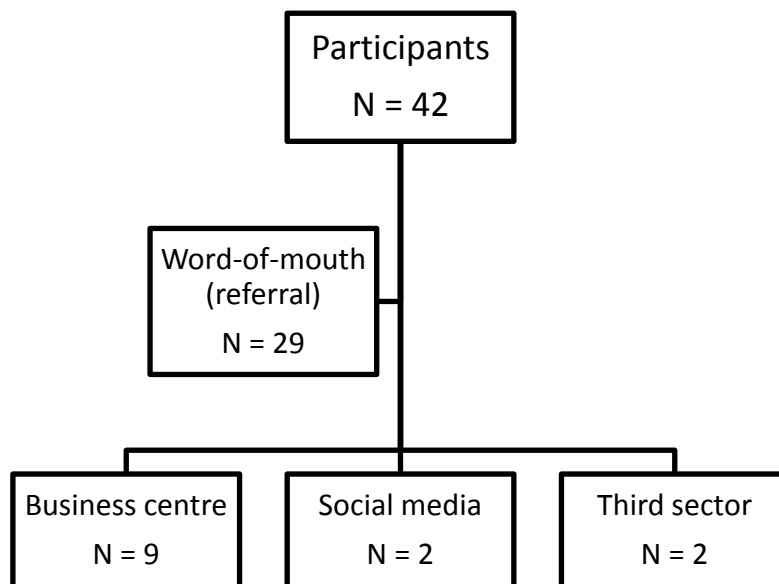
et al, 2003). It can be easier to identify potential participants and lists of communities through a verbal invitation, and generate interest by providing information on the study, and personally drawing attention to it without demanding too much time or effort from individuals (Farmer, 2014: 75). There is also the possibility to tailor the communication to every individual, whilst referring to original instructions from the researchers. By using the snowballing and word-of-mouth technique, recruitment was no longer limited to one form of advertisement, and was thus advertised to a wider target audience and across a diverse spectrum of participants (McManus, Erens and Bajekal, 2006; 127).

An opportunistic sampling approach was adopted to recruit additional participants (Ritchie, Lewis and Elam, 2003; 81). I attended many social and family events, e.g. weddings and funerals, where I discussed my research. This led to people passing information on to prospective participants.

To expand recruitment beyond business and community centres and locate Pakistanis who lived and worked in other places, the Birmingham Volunteering Services (BVS) were approached. The BVS are located in Birmingham city centre, and team members are happy to promote research via a short description written for promoting the study, which is sent out to their extensive mailing list and advertisements on their online noticeboard. As a consequence of this advert, many volunteers, organisers and individuals associated with BVS charities sent an email requesting further information for participating in the research. Consequently, interviews were arranged via phone or email and individuals were encouraged to further promote the research. Individuals working within education, in managerial positions, and in different community organisations took part in the research. These participants were keen to

share their biographies and provide insight into how their health developed whilst living in the Pakistani community.

Figure 6: Recruitment process: participants recruited through different community channels



4.2.1.2 Etiquette and behaviour

Throughout the recruitment process, an active effort was made to consider culturally, religiously appropriate behaviour and etiquette when developing a rapport with participants from the community. This is similar to an ‘auto-ethnographic’ approach that can be used to direct self-reflection as a process for exploring personal experiences in relation to wider socio-cultural and political context (Ives and Dunn, 2010).

Din (2014: 34) notes the importance of learning the custom behaviour of the community under research, and being considerate of what is said when exchanging pleasantries or explaining the research process. Culture and religion play an important role in how Pakistanis have settled in the UK, where hybrid identities have formed as a result of incorporating familial history with socio-economic development (Werbner, 2005). “The appearance and demeanour of the researcher can affect people’s willingness to participate”, where dressing appropriately, or similarly to the participants, can facilitate recruitment into the research (Morgan and Carcioppolo, 2014: 91). The Pakistani community can prioritise cultural and religious beliefs about dressing modestly, and suitable social conduct and appearance should be considered when carrying out one-on-one, face-to-face interviews (Shaw, 2000: 171).

I decided to wear loose, shapeless garments, and a scarf around my neck (not a hijab) to minimise any objection to my appearance, and replicate the traditional Pakistani dress of *shalwar kameez*, whilst maintaining a link with modernised Pakistanis who preferred English apparel. In this manner, I was able to represent the different values in the community regarding socio-economic status, religion and culture, and this helped me establish a relationship of trust, and minimised any potential threat to participant’s internal beliefs about dressing. This was important to participants, which became apparent during the interview process:

“Believe me; my wife dresses better than any (woman). She’ll have a long woolly jumper up to here (indicating knee-length) and her trousers, and you can’t see anything of her. Just like you are dressed”

(Male, 58 years old, first-generation, professional, Dudley)

An attempt was made to acknowledge and protect the researcher-participant relationship through actively monitoring my dress and appearance, to minimise the influence of my personal identity. This is based on Goffman's notion of props, where individuals can represent themselves through visual 'props' and objects (e.g. soldiers and badges) identifying status and self-presentation, as reflexive and active acts of socialising (Goffman, 1959; Goffman, 2009: 57; Smith and Riley, 2007). Dressing can give insight into an individual's socio-economic status (wealthier Pakistani families wear English clothes), and it was best to dress as modestly and as humbly as possible to allow participants to base the interview around themselves, and not be distracted by my appearance and lifestyle (Din, 2006: 148). The power-balance between researcher and participant must be delicately balanced, as close relationships with the researcher during the interview process could trigger notions of exploitation or complicate anonymity, where initially the researcher is the 'expert' as an academic with access to material about the research topic and interpreter of views (Yardley, 2000). 'Shifting subjective' can be used to balance an insider-outsider perspective within the community, and any assumptions about researcher identity (Mir and Sheikh, 2010). With complex elements present in the research process, I tried to minimise the effect of external factors, such as appearance and dress, as much as possible.

I was also aware of the differences between participants and myself, in particular with Pakistani men and older women. Cross-cultural research has highlighted the impact that age can have in research, where respect plays an integral part in forming relationships (Liamputtong, 2010:128). As a researcher, I was aware of the 'shifting subjective-experience' where I cannot obtain complete insider/outsider status, as the participants can alter my status based on my age or gender in relation to their own (Chawla, 2006). I paid particular attention to how questions were worded, and tried to maintain an impartial stance where the

participants could place me either in a role of superior or inferior power within the research dynamic.

4.2.1.3 Research setting

Participants were given a choice of interview locations that were convenient to the researcher and participant, including: their homes, the Primary Care Clinical Sciences Department on the campus of The University of Birmingham, the business location from where they were recruited, or their work place. An environment of privacy and minimal external disturbance was encouraged in order to create a secure and comfortable space during the interview. Only the researcher and participant were present in the room during the interview, and participants were advised to switch off their mobile phones. A notice was placed outside the interview room to alert others not to disturb the interview whilst at participants' homes or business locations, members of the family or business were asked to minimise interruptions.

At times, individuals from minority-ethnic groups can face barriers that make participation in research impractical. For example, issues surrounding transport, suitable interview locations, and consent (Katz, La Placa and Hunter, 2007). The latter became an issue halfway through one of the first interviews, whereby a participant received a phone call from her husband who did not consent to her participation. Only one participant withdrew their information from the study, but it was clear that participants had to be careful about partaking in research, especially with regard to consent.

South Asians and Afro-Caribbean communities are willing to take part in research, but may be restricted due to a number of reasons, including language, and lack of understanding of health research (Gill *et al*, 2013). Interpreters (in the absence of bilingual researchers) can overcome practical issues surrounding communication, where a participant's

preferred language is not English (Plumridge *et al*, 2012). Elwood and Martin (2000) highlight the crucial role of interview sites/locations in determining social relations within geographical spaces, where multiple social relations may intersect, and participants may feel more comfortable sharing their opinions in neutral spaces. The physical and temporal structure of the interview has the potential to influence the power balance between the interviewer and interviewee, and the researcher-participant relationship must be delicately balanced, as often either can exert power and control the direction of the interview (Wengraf, 2001: 43). However, providing participants with a choice of a location gives them greater freedom over the conditions of the interview (Limerick, Burgess-Limerick and Grace, 2006).

I provided participants with the opportunity to discuss their health beliefs in two different languages (English and Urdu). Sidhu *et al* (2016), tried to achieve conceptual equivalence during interviews and transcription to match the understanding of what the person is trying to say, with the interpretation, rather than present the narrative verbatim, as some words can have multiple meanings. During transcription I tried to achieve conceptual equivalence when trying to gather the most accurate depiction possible of the participant's narrative.

4.2.2 Data collection procedure

All participants who had agreed to participate were made to feel comfortable by developing a rapport, by exchanging pleasantries and paying attention to hospitality if the participants had chosen to be interviewed at the University (e.g. offering a hot or cold beverage). Careful consideration was taken to set the scene for the interview, to enable information gathering based on participants' life events, and simultaneously navigate the conversation through the topics based on the theory of social capital (Putnam, 2001; 201).

Participants were provided with the information sheet to read, and verbally informed on the aims of the research and their right to withdraw at any time without reason.

Once written consent was taken (Appendix 11), the interview began with a series of short demographic questions which gathered data on age, gender, time spent in England, generation, postcode, and with whom they lived. By presenting these questions at the start, I did not distract from the main questions in the interview, and helped create a professional atmosphere for the interview to take place in (Flick, 2009; 164). Demographic questions provided important information that was later used to organise data typologically.

Participants then completed the convoy model task; a diagram consisting of a series of concentric circles representing the individual's social network was filled in with the names of relevant relationships (Appendix 12) (Pachana and Laidlaw, 2014; 209).

The interview was based on the structure and content of the interview guide, and a series of response relevant prompts.

At the end of the interview, participants were asked if they had any comments or feedback.

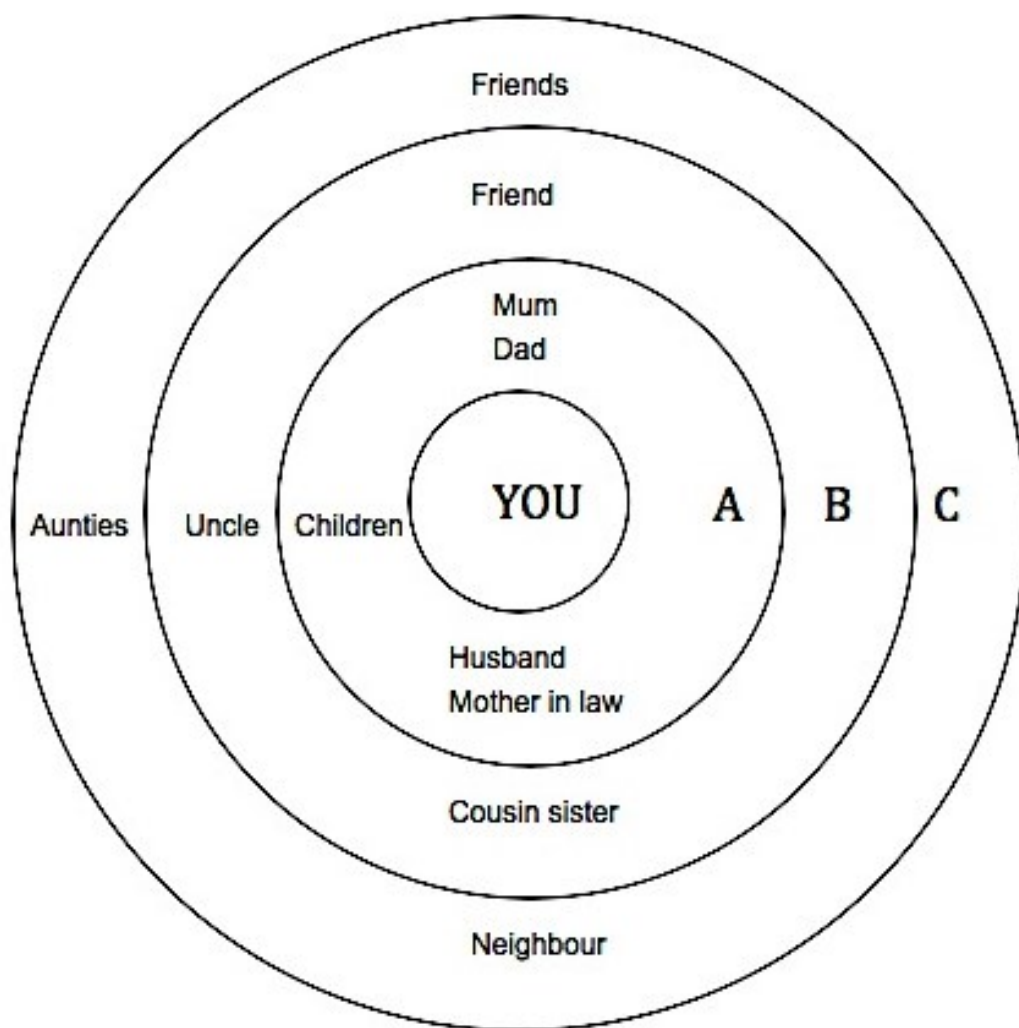
4.2.3 The convoy model task: visualising social networks

All participants were required to complete the convoy model diagram prior to commencing the formal interview. Participants were asked to write the name of a relationship in response to three questions, whilst showing participants a diagram depicting three concentric circles. In the centre of the smallest circle was written the word "you". For each circle, participants were given an instruction. For the inner circle (A), "Beginning with the people you feel closest to, is there one person or persons that you feel so close to that it's hard to imagine life without them?". For the second circle (B), "people to whom you may not feel quite that close, but who are still very important to you", and for the outermost circle (C) "people who you haven't already mentioned, but who are close enough and important enough in your life that

they should be placed in your personal network” (Silverstein, 2004; 231). Participants were asked to name the relationship, not the individual, e.g. sister, colleague, and best friend (Figure 7).

Figure 7: Example of the convoy model diagram filled in with a participant’s responses

(Second-generation, female, housewife, 37 years old, Sparkhill)



(Antonucci *et al*, 2004)

The convoy model diagram can enable data collection on egocentric social networks by allowing participants to visualise their social networks, and place relationships categorically in order of importance. Whilst interviewing, researchers can develop an understanding of the participants' subjective meanings and how they make sense of these relationships (Gamper, Schonhuth and Kronenwett, 2012:197). Perkins *et al* (2012) used the convoy model as part of a qualitative study as a theoretical lens and conceptual framework to interpret the composition of social networks. The convoy model diagram is a useful tool for helping researchers picture participants' social networks, and it became a practical visual aid for participants to discuss their relationships during the interview.

The convoy model was proposed by Kahn and Antonucci (1980) as a framework for observing how social networks develop over time (Astad, 2008: 147). The convoy model is a suitable method for data collection and elicitation, as the diagram has been used in previous healthcare studies to evaluate the effect of social relations on health and well-being (Antonucci, Birditt and Akiyama, 2008: 247).

The diagram can also be used in studies with a theoretical component. De Donder *et al* (2012) applied the convoy model diagram in their study of social capital and safety in later life, where the importance of maintaining close ties within social structures, i.e. most frequent contact groups in social networks, were illustrated. The ability to measure components of social capital were also demonstrated by Ajrouch, Blandon and Antonucci (2005) in a study investigating social networks, age and socioeconomic status. Both studies observed changes over time, and encouraged participants to discuss lifestyle behaviours. Although the convoy model has been used as a measure of different aspects of social capital, the purpose for this research was to use the diagram to help illustrate early relationships in order of importance for each individual.

There are numerous social and psychological theories, such as Bowlby's attachment theory, or Takahashi's affective relationships model theory, which help researchers understand attachment over an individual's lifespan (Berg *et al*, 2010). These theories address the influence of social support on health in childhood attachments (lifespan attachment model) to adult relationships (convoy model) (Rafoth, 2004: 108). Takahashi's model of affective relationships considers multiple figures in affective relationships, and their transformation over the lifespan as measured through self-report scales and frameworks (Takahashi and Sakamoto, 2000). However, the convoy model has been recommended as a suitable model for understanding complex hierarchies in qualitative work (Takahashi, 2014:4).

The convoy model acted as a visual tool for communicating research terms that were difficult to conceptualise by some participants in community languages (Banks, 2008). The research focus was not to quantify social networks, but to obtain a personalised illustration of relationship networks, and be a tool to elicit responses.

The diagram facilitated discussion on the existing structure of an individual's social network and importance of placing relationships in their respective categories. Furthermore, the participants referred to the convoy model diagram to illustrate how/why they placed greater trust and/or importance on certain relationships.

4.2.4 Interview guide development and the theory of social capital

Each participant can provide a unique narrative where they may wish to explore personally relevant elements of their biographies. A theoretical lens that was used to design interview questions provided a structure for the data collection process, thereby maintaining a focus on research aims and objectives (Greene, 2010: 18).

The interview guide was a set of questions and prompts that could effectively explore social support in relation to health. Social support encompasses social, cultural, economic and political factors that can be measured in a number of ways, and that can be practically explored through the application of a well-established theory (Garbarino, 1983: 6). As social support can be provided through an individual's formal and informal networks, studies have been carried out to measure the function of this phenomenon using the theory of social capital through standardised quantitative measures across diverse populations, e.g. Belgium and Taiwan (Song and Lin, 2009; Verhaeghe *et al*, 2012). The theory of social capital can be appealing to researchers as it encompasses social support concepts in relation to healthcare (Simon, 2001). Consequently, the theory of social capital, in particular the concepts of social network, trust and cultural norms, were explored and used to develop the interview guide and provide a structure for data collection.

The theory of social capital integrates dimensions of measuring social networks by incorporating culture and community support. Social networks are 'a set of socially relevant nodes connected by one or more relation. Nodes or network members are the units that are connected by the relations whose patterns we study' (Marin and Wellman, 2011; 11). There has been a considerable amount of quantitative research using social capital to collect and analyse data by mapping social structures and calculating the strength of social ties, e.g. social network analysis where social relational units and the allocation of resources are weighted and quantified (Wasserman and Faust, 1999: 7). By attributing values to relational data in a mathematical format, social network analysts measure outcomes for a large cohort of participants (Scott, 2013; 1-10). Granovetter (1973) has long established how this format enables social network theorists to measure the strength of relationships, as weak or strong ties, as well as the dyadic distribution of influence and information between people.

Three of the essential elements of social capital theory that can be specifically explored in this research include social networks, and trust and cultural norms (Nahapiet and Ghoshal, 1998). For example, in a survey tool used by Grootaert *et al* (2004) in developing countries, titled ‘the integrated questionnaire for the measurement of social capital (SC-IQ)’, social capital was divided into 6 categories: groups and networks, trust and solidarity, collective action and cooperation, information and communication, social cohesion and inclusion, and empowerment and political action. Researchers can apply the theory in a manageable and flexible manner by transferring components of the theory into their research. The theory of social capital has been used to investigate phenomena in healthcare research, for example a study by Kawachi *et al* (1997) established the association between income inequalities and mortality. However, their research raised an important point on evaluating the generalisability of such studies on diverse populations (Kawachi *et al*, 1997). By using a qualitative approach, I can explore the understanding of social networks, and trust and cultural norms, as concepts surrounding social capital in a minority-ethnic immigrant community. There is limited research with minority-ethnic groups and social capital measures, which requires an increased amount of validation, especially when translating material into different languages (Grootaert and Bastelaer, 2002). Although the integral concepts of social capital are flexible enough to be incorporated into quantitative measurement, it can be worthwhile to consider the application of this theory in exploratory research designs.

At times, qualitative methods are required for successful exploration of novel phenomena, and they provide insight into perceptions of events. Fukuyama (2001) incorporated qualitative methodology into research relating to social capital in order to further measure the internal cohesion of social groups, where quantitative measures failed to consider non-traditional forms of socialising, e.g. multiple social groups including those formed online.

Similarly, my aim was to explore the influence of social groups and relations, as perceived by members of the community for developing health behaviours and lifestyles using a qualitative approach.

Nonetheless, when developing a novel social capital instrument and methods for data collection, close theoretical underpinning must be maintained, in order to not diffuse the theory and lose its distinctiveness (Lin, Cook and Burt, 2008). Components of existing world bank questionnaires (Grootaert *et al*, 2004) were incorporated into the interview guide, alongside integral components surrounding social networks, and trust and culture, by measuring issues around community space, health beliefs, support for maintaining/changing a healthy diet or lifestyle (e.g. exercise and smoking), notions of reciprocity and civic engagement (Putnam, 2001). The interview guide explored individuals' perceptions of social capital by providing insight into how social capital is perceived by the Pakistani community.

The purpose of the interview was to include a historical account of life in England from migration or birth, to the present, with changes in lifestyle. By discussing changes over time, participants were able to reflect on their health choices, and how/if they had been affected by any changes in social circumstances in a chronological narrative (Seidman, 2013; 84). A general question about participants' life stories was asked at the beginning of the interview, and this approach encouraged participants to build a rapport with the interviewer and become comfortable, before more in-depth questions could be asked.

Following on from introductory questions, participants were asked to provide their views on general health, diet and exercise, social relationships (trust, network ties and cultural norms), and social capital (civic engagement). Each section began with a primary question followed by a series of sub-questions and probes, e.g. "How do you engage with members of the community", with the sub-question "Are there any activities that you think encourage a

healthy lifestyle?”, and probes such as “why do you think that?”, or “how do you do the aforementioned activity and with who?”. This method reflects phenomenological interviewing, where life history interviewing is combined with focused in-depth interviews, based on an existing phenomenon through the application of a series of open ended questions to reconstruct participants’ experiences within the topic of the study (Seidman, 2013: 14). By inviting participants to provide an open narrative on their life history, participants could highlight important events in their life, which could influence their lifestyle, whilst presenting the opportunity to probe participants. The method provided greater flexibility in guiding participants through the interview by giving opportunities to cover areas they perceived as important, whilst navigating through a series of predesigned topics.

4.2.5 Ethical approval and good practice

A research protocol was drafted and used to outline ethical considerations. Ethical standards and guidelines provided by the University of Birmingham helped structure the study, and ethical approval was attained on May 2013 by the Science, Technology, Engineering and Mathematics Ethical Review Committee application number: ERN_13-0450. NHS ethical approval was not obtained, as I did not recruit through healthcare organisations, nor did I approach patients in primary or secondary care (Appendix 13).

It would be unethical to overlook the potential emotional stress of being involved in qualitative research. Information was reviewed within different contexts, issues surrounding privacy, communication with others, and disclosing the nature of the research (Miller *et al*, 2012). Therefore, every effort was made to meet the University standards for carrying out research and ensuring participants were not conflicted or harmed in anyway. Informed consent was acquired from participants who were not suffering from any debilitating mental

conditions by outlining the research aims, providing a debrief, and the right to withdraw their data from the research within two weeks in a manner that could be understood and agreed by all. Contact information was provided if participants had any questions or wanted to report any concerns. Informed consent could be problematic for members of the Pakistani community where some members have low levels of literacy in English or Urdu (predominantly spoken language), so careful considerations were made to verbally translate the material (Creed-Kanashiro *et al*, 2005). All material was tested for readability to a suitable reading level, so that it did not limit participation in any way, and was accessible to a wider audience. I used the Flesch-Kincaid readability test available on Microsoft Office Word to make sure information was suitable for lay individuals (Bernstam *et al*, 2005).

Participants were not identified by their name but given a numbered identifier on the audio file; for example OF0017 would be an older female recording number 0017. Using numbers to identify participants helped conceal identity and prevent participants from being linked to personal or sensitive information.

All information was stored on a password protected University computer and USB drive; only the researcher had access to this material. Any written information (demographic information sheet and convoy model diagrams, observational notes) was kept in a locked cabinet at the University of Birmingham. In accordance with University ethics and guidelines, all information and transcripts were typed, and will be securely stored for 10 years then destroyed.

4.3 DATA ANALYSIS

4.3.1 Participants sampling

As data collection was an on-going and iterative process, purposeful sampling methods were applied, as they provided the ability to continue interviewing participants until saturation had been achieved (Achterberg and Arendt, 2008:67). Unlike quantitative research, qualitative researchers cannot claim that a certain group of participants will reach validity for findings and continue to recruit until saturation (Shi, 2001: 295). Saturation in qualitative research is when all concepts concerning research aims have been attained, and a response pattern emerges where no new novel information, i.e. insights or experiences, are being acquired (Holloway and Wheeler, 2013: 146). Transcribing and coding occurred simultaneously with data collection (Horne *et al*, 2012).

I sought participants per typological group (middle age and older male, younger male, middle age and older female, and younger female) to be equally representative of different generations and genders, and generate enough data to seek difference or similarities as a form of maximum variation sampling (Sandelowski, 1995). I used typological groups to organise participant narratives as functional categories, to seek differences within and between different genders and generations.

Male and female members of the Pakistani community with no acute health conditions, e.g. the flu, were eligible. Participants had to be aged 18 years and over, and take part in the interview lasting between 1-2 hours. Heterogeneity was achieved as participants were first-generation migrants (born in the subcontinent and migrated directly or indirectly to the UK), second-generation descendants (born in the UK or received formal education from the age of 5), and third-generation descendants (born in the UK and at least one parent from the second-generation). The interview could be completed in Urdu or English. In total, forty-two

participants took part in the research, and saturation was achieved. For middle aged and older men, saturation was achieved at 8 participants, however for younger men it was 12 participants. For middle aged and older women saturation was achieved at 13 participants, and younger women at 9. The supervisory team and I agreed saturation was achieved when similar narratives and insights were given by participants of a similar age. For example, middle aged and older women discussed similar concerns and experiences such as socialising in mixed-gendered spaces when engaging with community members.

4.3.1.1 Characteristics of participants

Male and female participants were recruited across three generations and from diverse educational and occupational backgrounds. Alongside cultural and religious features like Muslim, British and/or Pakistani, demographic information such as age and occupation played a major role in how individuals identified themselves. Position and influence within the community will be further explored in the subsequent ‘findings’ chapters.

Participants were recruited from and interviewed in locations across Birmingham and the Black Country including; Alum Rock, Hodgehill, Moseley, Balsall Heath, Yardley Wood, Edgbaston and Smethwick.

4.3.2 Computer-Assisted Qualitative Data Analysis Software (CAQDAS)

When dealing with a large quantity of qualitative data, it can be practical to use computer software to help organise and store data for analysis. The 42 interviews each lasted between 45 to 120 minutes. When the audio recording was transcribed (and translated) verbatim in English, some transcripts were more than sixty pages in length. Transcription and translation was carried out to get conceptual equivalence in meaning, and not to map linguistic structure (Tesch, 1990: 104; Papadopoulos, 2006: 90). As transcripts were very lengthy, with a lot of

rich anecdotal and descriptive detail, NVivo 10 software was used for practical, efficient, and robust data management, organisation for systematic familiarisation and analysis, and storage of all files, and it enabled me to complete the interpretation of the data (Lester, 2015: 196).

As a tool designed for qualitative analysis, NVivo features a framework analysis programme.

All NVivo files were stored on a university password protected computer.

4.4 FRAMEWORK ANALYSIS

Ritchie and Spencer developed the methodological approach known as framework analysis as a suitable tool for research in applied health policy contexts that would provide policy makers with a transparent outline of analysis based on typologies, concepts, and differences and similarities (Ritchie and Spencer, 1994: 305). Table 10 describe the stages of framework analysis.

Table 10. The five stages of the framework analysis method for data management and interpretation

Stage	Description
<i>1) Familiarisation of data</i>	Reading and re-reading transcripts
<i>2) Identification of a thematic framework</i>	Generating codes, concepts and themes based on research aims
<i>3) Indexing</i>	Systematic application of the coding framework
<i>4) Charting</i>	Creating charts with participants across rows and themes down columns to provide a picture of the data to be viewed by others
<i>5) Mapping and interpretation</i>	Filling in the corresponding cells for row x column with quotes, interpretations and/or summaries

(Tiling, Peters and Stern, 2005: 522)

Gale *et al* (2013) effectively outline the application and limitations of using the framework analysis method, in particular its flexibility for researchers with limited qualitative research experience, and for use in multi-disciplinary health research. Framework analysis was considered to be appropriate for this research as it assists the management of in-depth, lengthy qualitative interviews with a community representing diverse socio-cultural beliefs. Data reduction was completed by systematically applying the information into manageable charts. Jahagirdar *et al* (2012) used framework analysis to evaluate the inclusion of people with low levels of literacy and learning disabilities in research. Framework analysis method made it possible to include segments of the interview into a table (chart) under each code, which was integrated into one of the main themes (Jahagirdar *et al*, 2012). Framework analysis has the ability to make findings transparent, a quality that health policy makers' value when making recommendations (Gale *et al*, 2013).

Framework analysis method is a case and theme based approach where analytical observations can be made using cases (by going across the chart) or thematically (going down the chart). The charts enable researchers to organise case notes, and quotes and interpretations that can be interpreted using typological information presented in the rows where participants' information is present (Spencer *et al*, 2013: 285). For example, participant characteristics such as age, gender, and/or generation can be used to analyse views on a specific phenomenon, e.g. views of first-generation men on gym culture. For in-depth explanations, a case and theme based approach can be combined which provides an inductive understanding exploring patterns and developing a theory to explain them (Spencer *et al*, 2003). Mays and Pope (2000) argue that data collection is more structured using the framework approach, which can start off as deductive (based on pre-set aims and objectives), and then become more inductive (through interpretation of original accounts and

observations). Different thematic segments can be linked together to help recognise emerging patterns and form explanations.

Framework analysis is beneficial for data reduction by summarising narratives within charts and condensing lengthy discourses, whilst maintaining a link to the original data where references can be made to the direct quote using a numerical organisation method or NVivo software (Yeo, 2013: 202). The output is a range of charts as part of a matrix, where descriptive or interpretive summaries are presented in cells for corresponding cases (participants) and themes (Spencer *et al*, 2003). Researchers can prioritise their research questions and sift through the information purposefully and uniformly for each enquiry across all stages of analysis.

Charts contained information from different themes and cases that needed to be further organised in to categories based on similarities or emerging patterns. Once categories are formed, researchers can create independent descriptive summaries for each category, and use them as a starting point for further investigation if necessary (Gale *et al*, 2013). Researchers do not use framework analysis with the aim of providing one definitive explanation, but to create a working framework or model to illustrate diversity, and minimise bias through transparency and organisation (Finch, Lewis and Turley, 2013: 220). Framework analysis is beneficial for researchers when discussing the development of codes and themes in a research group where several people would need to be part of the analysis and interpretation (Gale *et al*, 2013; Ritchie and Spencer, 2002: 173). It is an all-encompassing method that maps out codes and themes as a reflection of the researchers' thought processes and interpretation stage-by-stage.

One of the limitations of framework analysis is that it can be very time consuming and labour intensive, as researchers filter and process large amounts of data. A further disadvantage is that application can become very process-driven, with a limited focus and priority on the outcome (Ward *et al*, 2013). Throughout the data management and interpretation process, notes were made as codes, and themes were developed to maintain a focus on the interpretation; as the themes developed, literature searches were conducted to facilitate interpretation of the findings. It was important to have a reflexive approach throughout the data management process with a critical outlook. For this reason the research questions and aims alongside the literature surrounding the developing themes, were taken into consideration as a guide for interpretation.

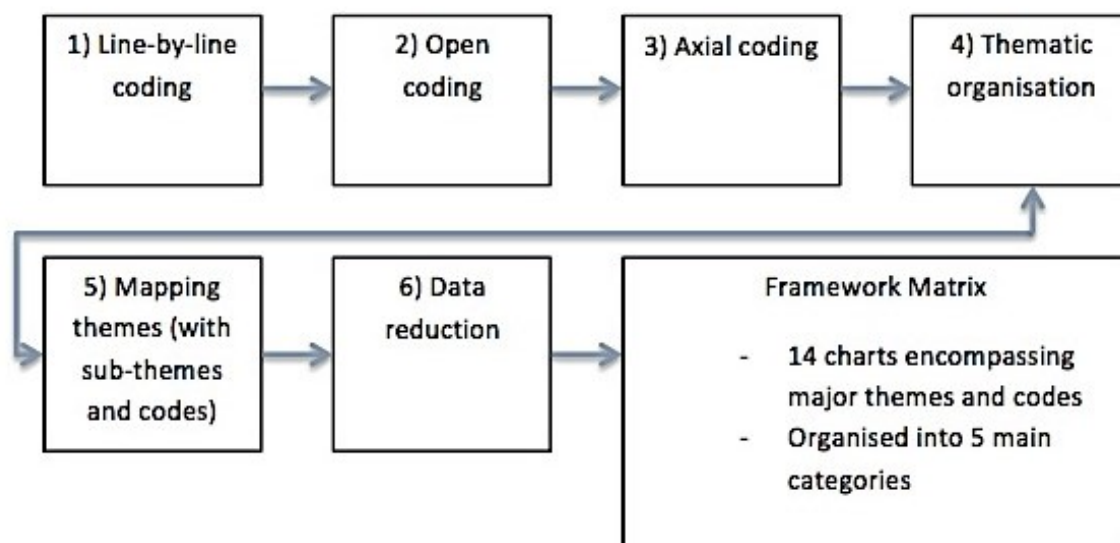
Ritchie and Spencer (1994) suggest that research questions can be investigated in framework analysis once they have been placed into one of the four different categories: contextual (form and nature of what exists), diagnostic (reason for what exists), evaluative (effectiveness), and strategic (identifying new theories, policies, plans or actions) (Srivastava and Thomson, 2009).

4.4.1 Coding: data organisation and generation of themes and charts

The analytical process began with reading each transcript line-by-line, a few times. Transcripts were divided into sections of small text, and an analytical code was applied where necessary. Codes are words or short phrases that capture the essence of data, and are often used in the first cycle of coding, whereas in the second cycle of coding they are developed further. Once codes have been generated, patterns can be identified based on similarities, differences, frequency of a phenomenon occurring, and sequences of codes, correspondences and causations. These patterns can eventually result in the construction of categories and theme structures (Saldana, 2013: 4-6). Glaser, Strauss and Corbin defined the initial stages of

coding as an open-coding approach, where meaning is applied to data in a very detailed form, allowing the researchers to generate concepts (Corbin and Strauss, 2015). Within the second stage of coding, themes were developed using axial coding by forming relationships between codes through a process of relating similar codes, or separating dissimilar ones into clusters, thus forming more manageable sections (Strauss, 1987: 64). Through open and axial coding, theme development, and consequently organisation, can provide structure to otherwise fragmented narratives (Figure 8). Deviant cases were included to strengthen the argument where possible.

Figure 8: Data management and analysis process



4.4.2 Stages of framework analysis

Five stages of framework analysis informed the data management and analysis of codes and themes to form an in-depth understanding of data. I used the Gale *et al* (2013) example of applying framework analysis to data management in healthcare research settings.

1) Familiarity

During the transcription process, each transcript was read and re-read, alongside audio-recordings for Urdu interviews, in order to form a better understanding of interview content, and verify that the transcription had been carried out correctly. Notes were made on initial thoughts about the transcripts, and transcripts were also read in greater detail whilst open-coding, axial-coding, forming themes, and evaluating theme structure to better conceptualise meaning and interpretation.

Open coding was carried out on paper for the first fifteen transcripts, using one margin of the document for analytical notes, and the other margin for interpretation. The transcripts were read line-by-line where descriptive and interpretive codes (phrases or labels) were applied. These interpretative codes were entered into NVivo.

2) Identification of thematic framework

Themes were generated through a process of organising codes into hierarchies. Coding was verified between myself and the supervisory team (PG and SG) who read and familiarised themselves with transcripts during the coding process. Three transcripts were jointly coded, and notes were compared on others. Interpretation incorporated different viewpoints, and one viewpoint did not dominate the data.

Once the research team had read and agreed on the coding for a sample of transcripts, codes were grouped together into mutually agreed themes with definitions and explanations. An effort was made to exhaust every possibility for variation in code organisation, as the themes generated would be the basis for the analytical framework.

Table 11. Example of coding hierarchies

Codes	Thematic organisation	Analytical process
Competition Negative comments Overly critical Secrecy	Jealousy	I chose to summarise the codes under jealousy as participants commented on community members competing with each other for resources, in order to get an advantage. The term “jealousy” was often quoted within narratives
Aged based expectation for physical identity Customise lifestyle to appearance Families focus Prioritise appearance over well-being Stay same level	Appearance	Participants described complex societal expectations on appearance that was best summarised under the umbrella term “appearance”
Body shape Insecurity Male image Appearance Older male role model	Older male influence	A description of social structures was provided by male participants, where older men achieved alpha male status through a masculine physique and managing community resources (money and social connections)

There were over three hundred codes that were arranged into themes through a process of elimination, where similar codes were grouped together, and the quotes were collated.

Segments of data within each code (quotes) were re-read to make sure they complied with the description of the code, or if they were better theorised under a different code. As a result of this process, a few segments were re-coded and re-organised within the hierarchies.

Social capital as a theoretical concept guided the coding and thematic development, but references were made to the wider literature to inform the thematic organisation and further develop interpretation (Mir and Sheikh, 2010). In this manner, reflections could be incorporated into the thematic structure, and influence how the phenomenon could be investigated (Makela and Turcan, 2007: 138). For example, the thematic structure was organised under three components of social capital (social networks, trust and cultural norms) to investigate the data, but as coding was developed, references were made to literature on feminism, agency and control, notions of freedom, and culture and appearance.

3) Indexing

Indexing is the systematic application of the coding framework to the data. Initial stages of data organisation and interpretation, where all transcripts were coded using existing codes and novel codes, were created and added when necessary. These codes were then organised into hierarchies.

NVivo particularly assisted the analytical process by retrieving the data efficiently and organising it within the coding structure, which could be adapted for new codes. The different codes could be managed within hierarchies, and were consequently organised into fourteen major themes (Table 12). These themes were further categorised during interpretation.

Table 12. The fourteen themes identified

- Identity
- Institutions
- Access to health
- Public appearances
- Position and power
- Trustworthy people
- Societal pressure on men
- Exposure through education
- Health Vs. financial prosperity
- Roles of community members
- Microcosm of religion and ethnicity
- Female appearance, education and liberty
- Traditional culture and socio-economic status
- Socio-economic status gradient development

4) Charting

The process of charting involves reducing the data into more manageable proportions, through the production of spread sheets (charts) for each theme that will contain summaries and analytical notes, instead of working with large quantities of text. Charts were made for each theme, with summaries created very carefully to maintain a connection to the original message given by the interviewee. NVivo 10 has a built-in function where charts can be produced using existing codes and participant information (Table 13). The codes and thematic structure is formed by hand before creating charts using NVivo. These charts can be later converted in to an Excel file once the empty cells have been filled in with relevant sections of transcripts (quotes, summaries and interpretive notes) coded in NVivo. Cells are the corresponding empty space on the chart for each participant and code in the spread sheet.

Table 13. Example of a chart for the theme ‘identity’ with incomplete cells that were filled in with long/short direct quotes, summaries and/or interpretations

Column	Row				
	Participant (age, generation, occupation, gender)	Codes			
		Home and work life (different expectations, censorship)	Identity	Racism	Reflecting religion
0035 24, first, technical officer, female					
0029 24, second, pharmacist, male					
0042 52, first, chief executive, female					
0046 35, first, chartered surveyor, male					

Ultimately, fourteen charts were created and completed for the corresponding major themes, with each theme consisting of a series of codes running across the row, and participants’ information running down the column where participant typologies were listed, including age, gender, occupation, and generation.

5) Mapping and interpretation

The mapping and interpretation procedure involved completion of all the charts and categorical organisation. Mapping and interpretation were achieved by filling out each cell in each chart and making notes on the interpretation of ideas that linked different major themes together. An analytical journal was used to keep track of data collection, management, the

analysis process, and ideas and interpretation. These were essentially analytical memos used to discuss the development of themes between the research team, whilst maintaining a reflexive approach through critical thinking, challenging assumptions, and recognising how interpretation is shaping the research (Saldana, 2013: 42). Notes were hand written and also created as memos on NVivo linking data to the interpretative process. As a result of this procedure, the codes, themes and charts were all mapped out to build the framework matrix.

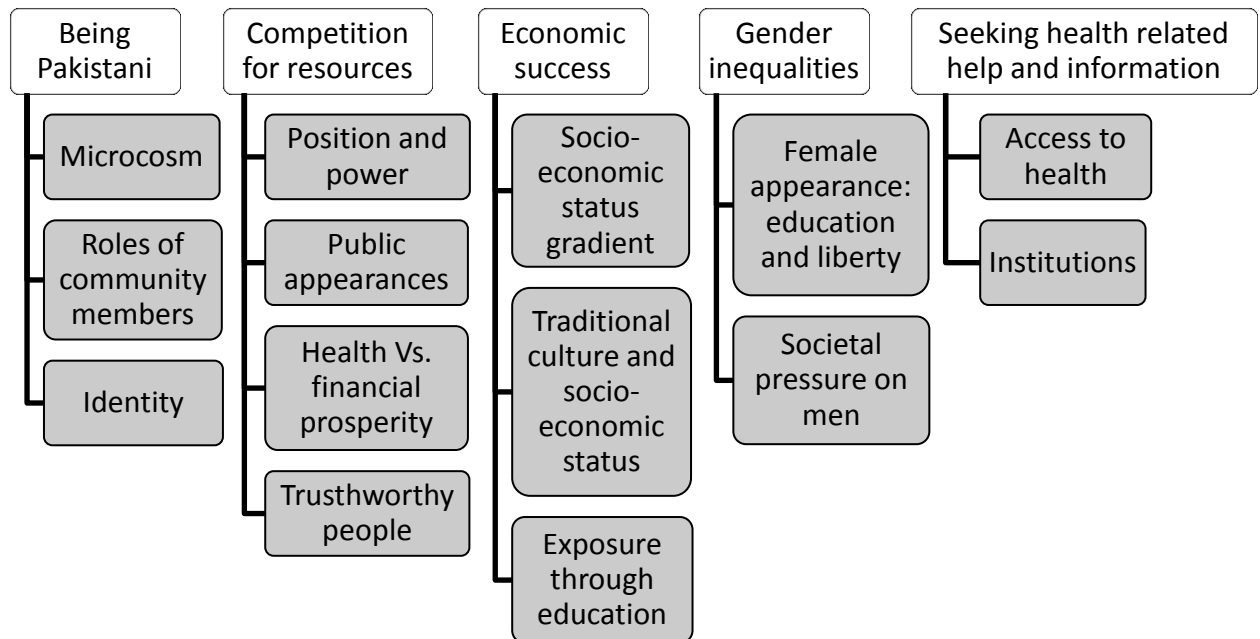
Example of a brief analytical memo from NVivo for “Appearance”

“Men are expected to look strong and are criticised by others. For women, it doesn’t matter if you are a mother you have to look good. There is an assumption that if you look healthy then you are doing well economically, not necessary that you are healthy”

At this stage the typologies became more prominent in interpreting the data, as observations were made about trends and similarities across age, gender, generation, and occupation to map causality. For each theme (chart), a summary was made which helped to seek similarities and differences between corresponding themes. These summaries helped categorise the fourteen themes into five major categories (Figure 9).

An interpretative summary was written for each category. Interpretation involved analysis of participant views across different themes (in each category) to develop a conceptual understanding of perceptions and experiences of social support and health resources, in relation to existing literature (Gale *et al*, 2013). These interpretive summaries were discussed with supervisors PG and SG.

Figure 9: Organisation of themes into categories



The major categories further condensed the material and made it easier to access relevant data to form interpretations. The analysis was top-down, where data was analysed generally until a particular set of conclusions could be made. The data can still be tracked from the specific enquiry to the original interview data. The summaries (description of theme charts and categorical interpretation), written during discussion with PG and SG over the presentation of findings, resulted in the decision to present the findings within themes based around a typological stance.

4.5 TYPOLOGICAL STANCE

The findings of this research will be discussed using gender as a typology to organise and discuss emergent themes. Typologies can lead to the analysis of particular, varying dimensions within a data set where data can be selected based on a typology, such as gender or age, to produce summaries and explanations conceptualising observed patterns (Hatch,

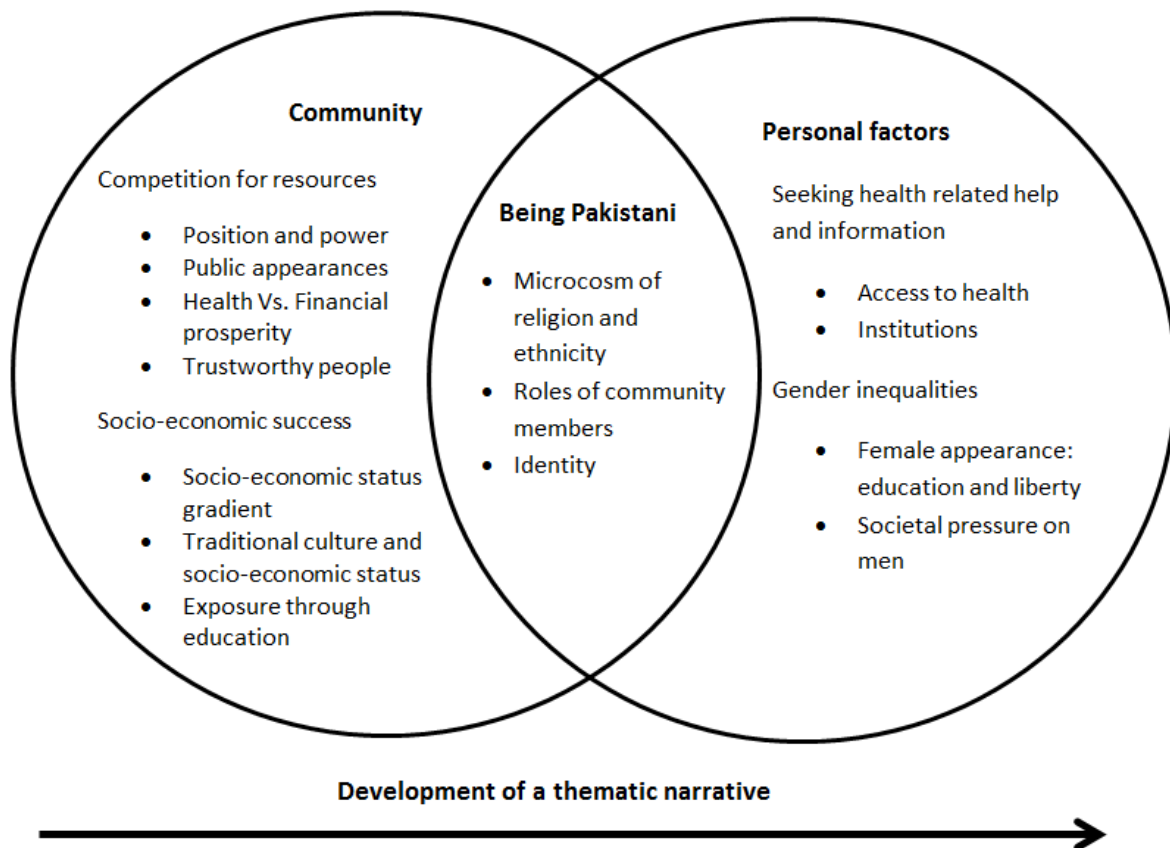
2002: 155). Gender was deemed as being the most appropriate typological stance for this research, as individuals used gender to define self in terms of health messages, recommendations, and lifestyle practices. Men and women formed different social networks that were affected by cultural norms and the formation of trust. Findings will be discussed in greater detail within the following chapters.

4.6 PRESENTATION OF FINDINGS

The aforementioned research questions help explore perceived support for members of the Pakistani community by adopting elements of the theory of social capital (Putnam, 2001) as a theoretical lens. Access to support networks is a reflection of how individuals socialise within, and outside of their ethnic community, where wider community influences could determine the formation of health goals. Consequently, health goals could be further shaped and informed by local facilities and other community members.

The collection of themes have been organised into five major categories presented as a social network organisation (Figure 10); some themes overlapped, as they are multifaceted. Categories are presented as a narrative beginning with the community (relationships, competition for resources and influences [socio-cultural norms]), and shifting the focus to personal factors (e.g. identity, action and agency, individual access to sources of support and information).

Figure 10: Developing the thematic narrative into five categories from a communal to personal perspective



Categories will be discussed in relation to their underlying thematic structure, with direct quotes from participant interviews to illustrate emerging trends. Quotes, interpretative notes and summaries were organised into the framework matrix and used alongside descriptive summaries of each theme and an interpretive summary of each category to illustrate findings. These summaries were written and discussed with the supervisory team (PG and SG) during analysis, and include notes identifying similarities, differences, and patterns across codes and themes.

Due to the depth and breadth of data collected, each section will present an interpretive overview of the category, followed by the encompassing themes. The themes will be

discussed descriptively, with interpretation to link different concepts and quotes to illustrate analysis.

There will be a discussion at the end of each ‘findings’ chapter which relates the findings to existing literature and identifies original contribution to applied health research.

4.7 RELIABILITY

Unlike quantitative work, where measures and statistical figures are used to validate results, qualitative work requires a different level of scrutiny for reliability (Mays and Pope, 2000).

All of this is in effort to maintain credibility of findings and represent participants’ views as accurately as possible, and is related to validity in quantitative research. Qualitative researchers can produce valid and reliable findings by spending time in their field, establishing a relationship with their participants, and interpreting the meaningful interactions within these relationships (Lodico *et al*, 2010).

In order to reduce researcher bias, a number of steps were taken. Qualitative work is open to the subjectivity of the researcher who can use their own existing understanding of the world to form interpretations that are open to bias, and this can only be limited through self-awareness (Gallagher, Truglio-Londrigan and Levin, 2011: 241). An attempt has been made to make all stages of the enquiry as transparent as possible by outlining the way in which data collection, analysis, and interpretation were completed. For example, the data collection guide was piloted to determine the appropriateness of interview questions, and any misconceptions with earlier ways to phrase questions (Walker, 2008: 35). Hence, data collection and analysis was not solely based on the views of the researcher, but a wider, multi-person approach.

Rigour is an on-going part of the qualitative research process where researchers use an iterative process, by going back and forth between data collection and analysis to ensure correspondence between research questions, the literature, recruitment, data collection strategies, and analysis to maintain focus (Morse *et al*, 2002).

The use of language can involve cultural norms that need to be verified conceptually and literally, to determine if they are used in the correct context, i.e. in relation to healthy living (Papadopoulos, 2006: 90; Sidhu *et al*, 2015). A community member and South Asian researcher based at the University of Birmingham verified samples of the transcripts for conceptual equivalence, and to ensure accuracy and quality of translated material. It became apparent that the participants attach different meanings to certain terms which needed to be considered contextually to increase researchers' confidence when working with a minority-ethnic group (Hipwell *et al*, 2008).

To further ensure validity, qualitative researchers can participate in a continuing process of reflexivity, where they discuss the analytical criteria with other researchers, and reflect on their opinions and feelings about the interview process (Walker, 2008: 34). Reflexivity as a validation procedure is strengthened by incorporating views of the research team during analysis, and is known as triangulation where data is crosschecked by multiple investigators to strengthen design and analysis (Merriam, 2009). Again, the data collection and analysis process is not limited to the views and understanding of one researcher, but incorporates a multitude of opinions and experiences.

4.8 SUMMARY

I have used this chapter to discuss the research aims, objectives, and the development of a suitable methodological approach for data collection and management. I have maintained a reflexive approach in managing and analysing data by discussing the development of codes, themes, and the framework with the research team. A series of analytical memos were made during data collection, organisation and analysis that reflect on initial thoughts and the incorporation of literature and theory into the formation of themes and categories. I have further highlighted the ethical considerations that were considered during the research, in particular paying attention to the needs of a minority-ethnic group with diverse socio-cultural beliefs and barriers to participation in research, including issues surrounding literacy. In the following chapters, I will describe participant demographics and discuss findings based on a gender based typology. The first findings chapter will outline men's experiences and perceptions of social support and a healthy lifestyle.

CHAPTER 5

5.0 FINDINGS SECTION A: SOCIAL EXPECTATIONS OF MEN

5.1 INTRODUCTION

I will present participants' accounts with a focus on gender as a typological stance, where characteristics such as age and generation will help organise the discourse.

In the following chapter, I will present the views and experiences of Pakistani men in relation to their community, social and health resources, socio-economic impact on well-being, and identity as factors influencing the prevention of cardiovascular disease.

A categorical summary will be provided with an overview of each encompassing theme. I will then outline each theme in detail with quotes to illustrate participants' perceptions alongside my interpretation. Concepts used to interpret the categories and themes will be examined in relation to the relevant literature in the discussion. The chapter will then be summarised, where I will highlight areas for future research and contextualise findings. Table 14 outlines the characteristics of male participants.

Table 14. Characteristics of male participants

Generation	Participant	Occupation	Age	Locality
First (n = 8) (Born in the subcontinent migrated directly/indirectly to the UK)	0054	Professional	58	Dudley
	0052	Professional	56	Moseley
	0036	Manual	42	Edgbaston
	0061	Manual	71	Moseley
	0047	Unemployed	38	Nechells
	0051	Unemployed	28	Alum Rock
	0033	Retired	48	Washwood Heath
	0034	Retired	70	Alum Rock
Second (n = 11) (Born in the UK or received formal education from the age of 5)	0027	Professional	25	Alum Rock
	0028	Professional	27	Alum Rock
	0029	Professional	24	Alum Rock
	0038	Professional	26	Hall Green
	0043	Professional	22	Hodge Hill
	0046	Professional	35	Hodge Hill
	0057	Professional	44	Moseley
	0062	Manual	45	Moseley
	0059	Student	18	Washwood Heath
	0039	Student	18	Alum Rock
	0032	Student	18	Alum Rock
Third (n = 1) (Born in the UK and at least one parent from the second-generation)	0040	Student	18	Alum Rock

5.2 CATEGORIES AND THEMES

5.2.1 Competition for resources

As a consequence of migrating to the UK, members of the Pakistani community appear to feel pressure to attain material and economic gains to represent successful post-migration settlement. Some participants viewed socio-economic success (i.e. educational, financial mobility) as giving them an advantage over other members of the community, placing them in a position of greater influence and better access to community resources. Therefore, some participants expressed uncertainty about their own social position and competed with other community members, which is apparent within themes. Themes include position and power, public appearances, priorities (health vs financial prosperity), and trustworthy people. Table 15 provides an overview.

Table 15. Overview of category: competition for resources

Overview
<ul style="list-style-type: none"> • Participants appeared to compete for a position of influence, where power is created as a social force for decision-making and authority over other community members (Eysenck, 2004: 719). • There was a presence of a hierarchy where individuals with socially and culturally approved physical appearance (body and clothes) or morals (religiousness and tradition) are given greater priority over others for social resources (Orford, 2004; Orford, 2013: 345). • Men with greater social resources have more opportunities to invest in personal development (physical or economic), particularly amongst second-generation men. • Younger men in particular feel the need to be physically fit as a “rite de passage” into adulthood and gaining independence. A sense of insecurity and fear of being ostracised within their peer groups influenced such behaviour.
Generational differences
<ul style="list-style-type: none"> • Older, first-generation participants felt that competition within the community was affecting the social dynamics negatively by replacing civic engagement with rivalry. • However, second-generation participants felt better suited for leadership positions if they have a masculine, alpha-male physique i.e. broad shoulders and muscular strength. Masculine men can visually dominate their peers and appear to be capable of personal gains and possess skills that could be utilised by other community members (Sussman, 2012; 70).
Lifestyle choices
<ul style="list-style-type: none"> • As a consequence of pursuing masculine physiques, there are changes to lifestyle practices (a greater commitment to the gym) and dietary behaviour. • Wider social influence and responsibility is displayed at the gym where men bond over shared goals to gain muscular strength. At times this results in knowledge exchange and the formation of novel social connections.

5.2.1.1 Position and power

Men's position within the community, and how it determines access to social and monetary resources, was organised under the theme 'position and power'. Men across all generations were similar in their approach to socialising in the community, by using their knowledge and social connections to exert influence. Male participants with greater social connections appear to be better at competing for social resources.

The following excerpt is from an older, first-generation participant who illustrates how well connected he is with members of his local community. He offers assistance to his neighbours who trust him due to his age and outwardly traditional religious values. By helping his neighbours, the participant feels he has been rewarded with trust and social approval that increases his social value:

"I mean even in our neighbourhood, people give us their keys on their holidays and we look after their house. A couple of times house alarms have gone off and I've jumped in the back garden at midnight and had a look and blah, blah. Some of the neighbours-well, one of the neighbours, I won't mention any names, her husband's in prison and I've been over many times in the last years because she's got young boys, teenagers. They've had fights here and they're messing around, and I've always helped out, if you know what I mean, because again Islam says to help your neighbour."

(0034, male, 70, first-generation, retired, Hodgehill)

Men also choose to display their intelligence as a contributing factor towards social influence.

As an educated man in a professional field, the following participant feels accountable for the development of his community. He implies greater importance and consideration should be given to educated community members who should be valued for their informed opinions.

“Of course it does. It...creates harmony in the society. It doesn't give you any mental tension. You don't think about future too much because you know that you are part of this community, this is your home and you live here and work here, but if you don't contribute to...the community as educated person it becomes difficult. Then you're competing with the bottom of the pile”

(0054, male, 58, first-generation, professional, Dudley)

Participants felt obligated to make some attempt to support members of the community, by 're-investing' back into existing social networks, e.g. information on health services or educational prospects. Returning non-tangible resources to the community demonstrates that the individual is in a position to help others.

“And if I'm not gonna, take it upon myself to promote good, and talk about the successes that I've achieved in life then how are these people gonna change? It's not about creating sub-divides or sub-categories, class divides. If you as a person are leading a good lifestyle then why not share with others? You know, there's that famous Islamic saying, you know, wish”

(1300, male, 26, second-generation, professional, Yardley wood)

As a result of acquiring greater resources, the aforementioned participants' viewed themselves in a leadership position within the community. They view themselves as

trustworthy individuals who are willing to help improve the community. What emerges is a downward view of uneducated or physically incompetent community members, who are given lesser social value as their contribution to the community is limited with regard to leadership.

5.2.1.2 Public appearances

Competition for social resources is influenced by individual appearance. Masculine looking men are viewed as role models who can benefit from a stronger position within the community. Participants have the potential to compete for resources through wider community engagement, increased influence, and social approval from male peers. Young men, across second and third-generations, focused on physical appearance as an important factor when pursuing access to wider social networks (for influence as well as support). A muscular 'alpha male' physique provides long-term benefits within the family (i.e. being viewed as a trusted source of health information) and short-term rewards (i.e. the wider community can praise physical attractiveness).

Young men want an image that attracts social approval and 'celebrity' status in the community. However, achieving such a physique would involve personal (to train) and social (support) motivation:

“Keeping the weight off? I’d say...I don’t know, to be fair. Motivation just like, picturing yourself at ideal kind of figure, ideal look. I mean, that would, if you keep on looking at that kind of image that, how you wanna be, that’s it that would motivate you. Celebrities, I guess, if you wanna be like that kinda figure I’d say to have a motivation, impact”

(0040, male, 18, third-generation, student, Alum Rock)

Approval from the community is important for men who want to pursue leadership positions within their social networks. Some participants achieved social approval by performing activities that enhanced self-confidence, e.g. going to the gym.

“I don’t think they do it for health reasons because they’re- people wanna go to the gym and they can do it just-they want to do it to look good in a t-shirt.”

(0043, male, 22, second-generation, professional, Hodgehill)

Participants had to visually demonstrate masculine traits, such as discipline and control through their pursuit of a healthy physique. Physical strength was associated with greater social worth and helped to secure a valuable position within the community. Therefore, the motivation to go to the gym may not always be for health benefits, but to pursue social mobility in the context of the Pakistani community.

Public appearances were not limited to physical attributes, as social behaviours were monitored and criticised by community members, where stigma can be attached to certain lifestyle choices, for example, smoking. Where smoking *Shisha* (water-pipe with flavoured tobacco) is considered a new cultural norm, smoking cigarettes, especially in public, is

viewed negatively by members of participants' social networks. Individuals are particularly concerned by the potential negative impact of community 'gossip' and tarnishing family reputations:

“If I met, say, an aunty and uncle, who was a neighbour, I'll make sure, you know, the way I present myself, the way I speak, it is different. I wouldn't want to be seen smoking, or, with my girlfriend or anything stupid, nothing that's gonna make me, in society, look morally wrong, so I wouldn't go and do that”

(0029, male, 24, second-generation, professional, Alum Rock)

By discussing morality, the aforementioned participant is providing insight into the perceived cultural impact on behaviour. Younger participants have shown caution about being public about their lifestyle choices, and fear of being ostracised for having a 'Western', or non-traditional lifestyle, e.g. having a girlfriend.

Participants feel secure and established in their social networks if they have something valuable or irreplaceable to contribute. Participants have shown how important it is to be valued for physical and socially approved behaviours.

5.2.1.3 Priorities: Health vs. Financial prosperity

When competing for social and environmental resources, such as healthcare or socio-economic success, differences emerged between first and second-generation participants. First-generation participants prioritised allocation of social and monetary resources on material displays of economic success. However, second-generation participants expressed a greater desire to invest in personal and physical growth.

Throughout the migrant period of settlement into the UK, first-generation participants sought financial gains by working long hours in labour intensive jobs and prioritising their children's education. However, second-generation participants want to display trans-generational development through better physical health, and challenge concepts and stereotypes, e.g. unhealthy and overweight Pakistani men. The following quotes are from two second-generation men who express a desire for change within the community by shifting the focus from financial gains towards increasing healthier well-being.

“I think in our people, it's not really seen as the most important thing. I think because our people are so orientated with, what you earn, where you live, how big your house, how's your life, in terms of those things, they, kind of, health and those things second. It's always never on the first priority. That's what I believe, anyway.”

(0029, male, 24, second-generation, professional, Alum Rock)

“They've had their kids, they've bought their properties, they've bought the property in Pakistan; they've done enough now. I don't think they strive to live to 90 years or 100 years. I think if they live to 70 or 80 then they're happy and that's the difference.”

(0046, male, 35, second-generation, professional, Hodgehill)

Older participants, or participants associating with first-generation migrants, maintained an underlying interest in socio-economic development, which at times appeared to dominate social interests. As the following participant illustrates, individuals are competing for leadership positions within the community where they have more control and influence.

“Competition, ‘I want to be, I want to lead’, there’s a guy next to me who wants to lead -laughs- we all want to become leaders, but not followers you see, I think that’s the biggest problem in our society”

(0061, male, 45, second-generation, manual worker, Moseley)

Competition was not limited to social interactions between family members and friends. Participants felt the management of resources at the *Mosque* (Muslim place of worship) did not always prioritise community interests but instead focused on attaining a financial investment from attendees in order to elevate the status of the *Mosque*, e.g. charitable donations for constructing a larger prayer hall. There are competing interests within the *Mosque* where wider community development may be overlooked for the benefit of individual establishments.

“The other thing is the community is not helping, they used to at one time the whole community, the *Mosques* and everybody they used to pay some attention but now even they are just, what I would call it, money making business anyway”

(0047, male, 38, first-generation, unemployed, Aston)

Participants met these views across all generations who felt there was not enough financial support for members of the community where personal gains were prioritised. Community members feel the need to compensate for a lack of communal efforts by making greater individual contributions.

5.2.1.4 Trustworthy people

Several participants listed trust as an important factor when exchanging information or resources within their social networks. As the aforementioned themes have illustrated, participants are competing for social or socio-economic resources. The competition may cause distrust between community members. Male participants felt trust could only be acquired through years of understanding with an individual who provides reliable knowledge and support. For instance, information on healthcare issues, such as diet, or moral and physical care during a turbulent, personal experience.

The following quote illustrates how trust determined the proximity of relationships to the individual, where family members and friends are placed in circles A and B on the convoy model task.

“So in circle A, the closest people to me, I’d say are, obviously family, I think I’m probably closest to my brothers, and then, after that it’s my closest friends, I haven’t got a massive circle of trust but I like to keep it small”

(1300, male, 26, second-generation, professional, Yardley Wood)

Trust was also a justification for small social networks, if the individual has not had the opportunity to form or maintain a wider/larger social network. Difficulty in managing reliable relationships could be a consequence of restrictions, such as time, or opportunities to engage with others.

The next quote is from a first-generation man with a small social network, who justifies his decisions to socialise through religious teachings and personal understanding of who to trust.

Trust in social ties can achieve reciprocity. For these participants, a small social network could be a result of their migrant status and limited interaction with members of the community from diverse Pakistani, or other socio-cultural and religious, backgrounds.

“I think my social circle finishes when I step outside my house –laughs- so it remains very quiet and calm, nobody knows me outside.”

(0033, male, 48, first-generation, retired, Alum Rock)

Another reason that warrants a small social circle is the fear of hearsay about familial affairs within the community. As a consequence of living in an area of high-ethnic density, some participants were aware of the increased risk of being criticised or observed by people in the local area for culturally inappropriate behaviours. The following participants describe how neighbours in one area (Nechells/Hodgehill) are perceived to be discreet about their affairs in contrast to another neighbourhood (Alum Rock) where people take a high level of interest in each other’s daily activities. Alum Rock is well-known amongst community members as an area with a large migrant Pakistani population, with more traditional, culturally and religiously inclined views on what passes for appropriate behaviours. Observing and consequently passing judgement over each other’s behaviours strengthens health beliefs on what the community interprets as suitable and unsuitable lifestyle practices.

“Nechells, I think its people are more, sticking to their own routines and everything, here in Alum Rock they're very, very nosey anyway so they have to tell everybody what they're doing and everything”

(0047, male, 38, first-generation, unemployed, Aston)

“It’s not like it was too lively there (Alum Rock), people mind their own business here (Hodgehill) and just greet you and for me these are good people, right, because they mind their own business and its good and easy, even though majority of our Mirpuri brothers but they are busy driving their taxis and its easy, so I am grateful to Allah”

(0034, male, 70, first-generation, retired, Hodgehill)

School friends and neighbours share common goals or interests which they use to form and maintain strong friendships. Young men avoided discussion on personal choices, such as health, diet, or exercise, in order to maintain group norms and show respect for group members.

“I don’t really say to my friends ‘Oh, let’s be healthy or let’s do this or let’s do that’. When you’re out with your mates you don’t really tend to talk about being healthy or, this come on the news about being healthy or that that come up”

(0039, male, 18, second-generation, student, Alum Rock)

Peers feel uncomfortable or offended by group members discussing formal topics in a casual setting. As trust is viewed as a valuable social feature, participants, at times, felt they were limited in their ability to interact with their peers. Some participants felt rivalry and competition over personal success (or lack of) was a reason why people were reluctant to discuss their appearances. The following participant discussed how he had to defend himself, as other young men challenged his physical strength.

“Because people, when they see you do something, they get jealous then they try to like, argument starts or the young generation at the moment is hot headed I think and once, if they see you in good shape or that you have a good body they get jealous, like look at him he has a good body, we don’t and then even an argument can start over a little petty thing”

(0051, male, 28, first-generation, unemployed, Alum Rock)

There is a complex dynamic emerging from participant narratives which underlies socialising amongst Pakistani men. Although there is a sense of unity over achieving similar health goals (a masculine physique), there is limited discussion on health. Participants can feel vulnerable and susceptible to criticism, as illustrated in the following quote.

“I think amongst the people there is, there is trust, you know, everyone does, kind of, trust you, but it’s a dog-eat-dog world though, isn’t it? You can only trust people so much.”

(0029, male, 24, second-generation, professional, Alum Rock)

Trust is an important aspect of communicating potentially sensitive, personal topics such as health or lifestyle practices. Participants want to avoid being ostracised for adopting a novel health practice or disclosing personal information, although at times they may want to discuss it with others. Community members are careful not to discuss anything that could potentially be misconstrued as inappropriate

5.2.2 Socio-economic success

Socio-economic success as a category developed based on participants' views of familial wealth and individual material growth (Table 16), including a socio-economic status gradient (from migrant to manager), traditional culture and socio-economic success, and exposure (to wider community networks, support and information) through education.

Table 16. Overview of category: socio-economic success

Generational differences
<ul style="list-style-type: none"> • Older and younger men in the community had different priorities as a result of acculturation, changes in occupation and education, and pursuit of different lifestyle choices. • First-generation participants reflected on their hard work and investment into their families, which they anticipated would be further developed by men in the second-generation. • Yet, first-generation participants view the second-generation as having a ‘Westernised’ approach towards independent development at the cost of weakening community ties. • In an apparent dichotomy between first and second-generation participants, where traditional and ‘modern, Westernised’ lifestyle appears to be in conflict, some second-generation participants felt disappointed by healthcare information and support passed down by their parents. • Second-generation participants perceive themselves in a better financial, educational and occupational position to pursue personal development: an opportunity not available to many first-generation individuals. • Younger participants highlighted the negative perceptions of living in an area of socio-economic deprivation, such as criminal influences.
Lifestyle choices
<ul style="list-style-type: none"> • By moving out of an area of high-ethnic density; participants can demonstrate socio-economic progress and live in a ‘healthier’ location.

5.2.2.1 A socio-economic status gradient: from migrant to manager

Since migrating to the UK, first-generation participants find themselves and their families in a better socio-economic situation. The participants viewed socio-economic mobility as success, which second-generation men want to further develop, beyond traditional lifestyle choices and cultural norms.

The change towards better socio-economic status is reflected in dietary changes. Second-generation participants have adopted, at times, non-traditional meals and routines to achieve their personal gains. As the following participant illustrates, first-generation parents are not accustomed to new diets or alternative meals.

“Yeah they don’t believe this technology they’re more like old school and that’s too hard for us. So if they thought that ok they’re not going to have chicken every day and they’re not going to have butter everyday but they’ll have this protein shake then maybe kids will understand that.”

(0032, male, 18, second-generation, student, Alum Rock)

Changing meal patterns, or replacing traditional, natural products with alternatives (e.g. chicken for protein shakes), appears to reflect a shift in cultural norms.

First-generation participants, or those associating with men from this generation, expressed concern over the development of the future generation of Pakistanis. Second-generation men have habits and behaviours that can be different to what first-generation men anticipated.

“I can see a great erm over the next 5-10 years, especially in the 20’s I can see them definitely not following the same lifestyle as us. I think they will lead a very private life as well –laughs- whereas we with our uncles and aunts I talk a lot to them, I think they will have a very private life, so they will have one advantage –laughs- less, but I suppose in one way its selfishness as well”

(0062, male, 45, second-generation, manual worker, Moseley)

First-generation participants feel that young men are not always pursuing cultural norms and expectations. As the aforementioned participant described, younger generations are focusing on their personal preferences and are perceived to be more selfish than his generation who focus on cultural norms. First-generation participants may have expected professional socio-economic development, but believe second-generation men are incorporating contemporary Western habits. The following participant describes young men supporting modern behavioural traits:

“I used to think that once the first-generation immigrants have done their time, the next generation will be better, but unfortunately I see they are actually worse, because, their living style is different, they look distinctly different, if you look at them and their style of, the beard and all that there’s single line running from there and there (gesturing to face), you don’t see that in anybody else so its specific to Asian young men, the look they have. They speak different, it’s not a, a proper language...its slang lingo which they use”

(0054, male, 58, first-generation, professional, Dudley)

What the aforementioned participant describes, appears to be visual demonstration of group membership. The way second-generation men speak, dress, or even groom themselves, could be a reflection of group-membership. Such behaviour could reflect in-group mentality, where members have a uniform appearance distinguishing them from individuals outside of the group.

Appearance continued to be used as a visual identifier for religious and socio-economic beliefs. A second-generation participant, who socialises primarily with first-generation

migrants, described the perceived variation in the level of support available in a ‘modern’ versus ‘traditional’ family based on their financial status.

“Extended families the ones which have Islamic values, they’re fine. Once again the categories as well once you have the secular types the families who are very professional who are you know, earning 40-50k a year, his wife will be also professional as well I don’t think they will be do too much looking after their elders, personally, ones with traditional values, yes! But certainly with modern values, no!”

(0062, male, 45, second-generation, manual worker, Moseley)

Where families with a significant income are viewed as moving away from socio-cultural norms, it seems socio-economic success is achieved by following a less-traditional family model where men and women are employed, although, this is a shift from first-generation beliefs about familial unity, towards professional and personal success. Furthermore, second-generation participants are presented with different opportunities to socialise, either at work, school or university, than first-generation men. The following quotes illustrate the different social lives of first and second-generation Pakistani men, where the latter seek social support and information outside of the home or community setting.

“I mean, ‘cos they (youth) socialise a lot, they socialise a lot, they’re (elders) more into their movies, the dramas”

(0040, male, 18, third-generation, student, Alum Rock)

Second-generation men have the opportunity to socialise and pursue professional development through education and work, as some participants felt there was a shortage of

role models in their community. Areas that are negatively affected by socio-economic deprivation are a cause of concern due to illegal networks.

“Our youth is looking up to successful drug dealers and stuff like that, and, you know, people that are committing fraud and what not.”

(1300, male, 26, second-generation, professional, Yardley wood)

As some participants are worried about exposure to potentially harmful influences, individuals limit socialising to familiar social groups within community spaces. Consequently, the pursuit of leisure activities could develop differently between first and second-generation men who have alternative diets and income. For example, younger men attended *Shisha* lounges to smoke as part of a wider social experience.

“Saturday night I'm out from about seven o'clock, go for a meal with cousins and friends, then end up going to probably a *Shisha* caff, I'll have *Shisha* and a coffee and then back home for 12, one o'clock”

(0046, male, 35, second-generation, professional, Hodgehill)

These activities are suitable for younger members of the community who may refrain from visiting night clubs and drinking alcohol, as they are perceived to be un-Islamic. Additionally, it is an activity associated with younger community members and reflects socio-cultural shifts.

5.2.2.2 *Traditional culture and socio-economic status*

In the previous theme, a dichotomy between first and second-generation men regarding lifestyle choices was identified. Socio-economic success was associated with ‘modern’ lifestyles, and a disregard for traditional values. With increasing monetary capital, community members are perceived as having access to wider, culturally diverse lifestyle choices.

First-generation participants contrasted their life in Pakistan with modern-day, British Pakistani youth. Older men perceived limited influence or control over men from the younger generation, compared to the level of respect they had shown their elders. The concept of youth rebelling is not novel or unique to the Pakistani community, as generational differences can be a consequence of growing up in a different time or environment.

“When we was in Pakistan and everything, we used to go to the *Mosque*, even somebody, even my dad’s friends or anybody sees me going to the *Mosque* or just walking in the street he will slap me and he will say, you know, ‘why didn’t you go’, you know?”

(0047, male, 38, first-generation, unemployed, Aston)

A pattern emerged from the analysis of first-generation participants’ narratives. Older participants felt responsible for their families within their traditional role as heads of the house. The following participant demonstrates this by discussing how flexible he is in incorporating a healthier lifestyle into his family’s routine, especially for women. He sets the underlying attitude for his family’s approach to health and well-being. It is an implication that older men within existing patriarchal perspectives prescribe the norms and acceptable lifestyle choices.

“If I did not have the attitude that you have got to, well, maintain your weight, you have got to be fit, you’ve got to be active, it helps you in your work, my wife would have put on weight like anything. She would have been like any other Pakistani woman, double their size by the time you are 30 and this has to change. That cycle has to be broken, as, somewhere. The healthy eating is part of the...the ethos you have that you will exercise, you will eat, and I told everyone, I said ‘look, you eat whatever you like. If you eat 3,000 calories, burn 3,200, and it’ll be ok’”

(0054, male, 58, first-generation, professional, Dudley)

The quote demonstrates how the participant is confident in his position as informant and decision maker within his home. Furthermore, the participant’s narrative is a demonstration of status. As a professional, he could be in a better position to influence any cultural shifts away from traditional Pakistani lifestyles towards a healthier diet. Similarly, professional, second-generation participants highlighted the importance of looking after their families. However, younger men appear to struggle with changing lifestyle choices at home, such as meal preparation or consumption of unfamiliar food. The following participant has tried to inform others in his family to change their lifestyle choices, for example by informing them about eating healthier meals. However, traditional ingredients, such as oils and spices, continue to be incorporated into the dish.

“They’ve (parents, siblings) probably tried, like, having pasta, but then they’ve started adding Asian ingredients to it, and then it’s not exactly a healthy dish any more, and then you just find that it’s just a curry with the pasta, as well”

(0028, male, 27, second-generation, professional, Alum Rock)

Although second-generation participants note limited influence at home, they take advantage of their socio-economic success by seeking out novel physical activities and diets. It is reasonable to assume that second-generation male participants are willing to try alternative foods and sports in an effort to move away from ‘stereotypical Pakistani’ behaviours.

5.2.2.3 Exposure through education

By studying and working in the UK, second-generation participants have a comparatively wider range of opportunities to broaden their social networks. They have a greater opportunity to learn about alternative lifestyles from people of different ethnic and socio-economic backgrounds.

“I have a diverse range of friends. So I would say that I, me personally, make an effort with everyone and I don’t try and just hang out with people that are highly educated or everything. I try to hang out with all kinds of people”

(1300, male, 26, second-generation, professional, Yardley Wood)

Second-generation participants believe their knowledge about lifestyle choices is a valuable commodity that should be shared amongst community members, and conceivably strengthens their position as informative community leaders. The following quote illustrates the views of second-generation men on using education to help members of the community facing social deprivation.

“Let’s raise the awareness of these people, whether it’s through seminars or whether its conference or people like you, you don’t have to live in this, you don’t have to accept this, this is what you do, what you need to do”

(0057, male, 44, second-generation, professional, Sparkhill)

Younger participants point to the lack of motivation amongst community members to take advantage of local facilities. It is possible that second-generation participants are arguing for educated and determined young community members to encourage others.

“You can’t question the area and say, ‘oh, there’s nothing there’ because there is something there, then you can question the people, ‘cos then it’s just down to the people, ‘cos they’re then just being lazy, aren’t they?”

(0039, male, 18, second-generation, student, Alum Rock)

Participants believed in negative perceptions of living in areas of high socio-economic deprivation. Community members were perceived as being unhealthy as they relied on the local resources, and expressed that moving out of such areas allows access to healthier options.

“Go to Solihull. That’s seen as upper class. So, you will not find a takeaway for a good stretch of a mile or two. Naturally, more likely than not, because of their daily routine, most of the people working there are working 9-to-5, 9-to-6. So most of their food is self-prepared, right, whereas our food, well, if we don’t like it, you’ve got a chip shop just there, ready made for you. Chip shops galore, all fat foods galore and

straightaway; just what's present in the community is having an influence on your health”

(0029, male, 24, second generation, professional, Alum Rock)

‘Environmental’ exposure, e.g. access to takeaways, could lead to excessive food intake and limit physical activity in lower income and deprived communities (Cummins and Macintyre, (2006). Deprived communities live in environments with poor quality food stores, places to exercise, and issues surrounding safety and crime (Lovasi *et al*, 2009).

It is unlikely that first-generation migrants have similar social (support and information) or financial resources to be influential community members. Post-migration networking compared to second-generation, appears to have produced limited long-term connections for first-generation men, and limited lifestyle choices, including physical activity and a lack of focus on diet.

“The 3 of us friends at the garage, we run the garage, at 2 we eat and then we have *Kewa*-green tea and then we just carry on working, we give parts and so on, other than that its evening, then I pick up the wife and cook, eat and at 9 o'clock watch *Bigg Boss* (Asian reality show) and whatever show around 11 go to sleep”

(0036, male, 32, first-generation, manual worker Balsall Heath)

First-generation participants may have smaller social networks due to time restrictions as a result of work commitments, therefore, they socialise mainly with their colleagues (other migrants) and family.

5.2.3 Being Pakistani

The political and socio-spatial aspects of residing in migrant environments have an effect on members of the Pakistani community (Table 17). Being Pakistani is a notion that may evolve from themes surrounding microcosms, roles of community members, and identity.

Table 17. Overview of category: being Pakistani

Overview
<ul style="list-style-type: none">• Living in areas of high-ethnic density can shape ideas about behaviour, concepts surrounding gender, and personal identity i.e. being British (to varying degrees).• There are socio-cultural codes that result in the formation of strong identities and well-being may be a multicultural concept.• Participants' perceptions of themselves in relation to wider community settings inform access to social resources. For example, a prominent Muslim identity can potentially limit socialising outside of the religious social group.• Participants highlighted perceived levels of racism and political tensions in the media against Muslim communities, including Pakistanis.• Participants differentiated between different caste, cultures and sects within their religious or ethnic social groups. Although Islamic teachings do not decree differences between religions and cultures based on the aforementioned characteristics, they influence relations within the community.• Despite living and socialising in areas with a majority of Pakistani inhabitants, participant's voiced negative connotations of living with members of their own community. In particular, being vigilant of each other's behaviour and reluctance to change community norms.
Gender differences
<ul style="list-style-type: none">• Religion and ethnic affiliation is not the only factor leading to insular networks. Gender-based differences and cultural expectations vary for men and women in the community.• Findings suggest that men are responsible for the cultural and religious adherence of their family and are the main source of income; thus, giving men greater control in households.• It is possible that male participants in this research exerted control by limiting women in their family from working, exercising or socialising outside of their homes.• A sense of 'othering' stems from different expectations placed on women in the Pakistani community compared to 'other non-Pakistani women'.

Socio-cultural expectations and consequences

- Areas with a large Pakistani population means increased social expectations and socio-cultural codes of behaviour.
- Development of strong Muslim or Pakistani identities that can limit engagement with non-Pakistani communities. For example, male participants with professional occupations seldom socialised with colleagues from different ethnic backgrounds.
- There are implications for networking within the confines of the Pakistani community based on shared interests.

5.2.3.1 *Microcosm of religion and ethnicity*

Areas of high-ethnic density, in particular social spaces that are defined by one group's socio-cultural norms and practices, are known as microcosms (Brown and Mussell, 1984).

Participants living in areas of high-ethnic density are exposed to social influences that strengthen civic ideas of being Pakistani:

“My community is Asians, Pakistanis, Bengalis, Pathans (people from North Western Pakistan and Afghanistan), that is because the area we live in just full on. Everyone is a, it's a Muslim area. All Muslims. And you know like Pakistanis, Bengalis and Pathans. All which are very, they keep themselves to themselves. We don't really like to interact with people, as Asians, unless there's a social gathering or joyous occasion”

(0027, male, 25, second-generation, professional, Alum Rock)

However, a concern emerged amongst participants about the negative perceptions of living in an area with a majority Pakistani or South Asian influence. There is limited engagement outside of the community setting, as participants have no purpose to widen their networks.

“So people live in their own bubble. People have their comfort zones and I’m talking about the Asian community of course. People are not necessarily encouraged to get out of that comfort zone.”

(1300, male, 26, second-generation, professional, Yardley Wood)

It is possible that living in a microcosm is limiting exposure to wider communities, and affecting access to other social resources. The aforementioned participant appears to believe community members are not challenging themselves by approaching other groups, and are staying within the ‘comfortable’ restraints of their community.

Through further interpretation and comparison of participant perspectives, it is conceivable that microcosms provide a sense of security. Participants across all three generations expressed greater confidence in living amongst other Pakistanis. For example, a young second-generation participant points to loyalty and safety amongst community members and friends.

“It’s good to have friends around in the local area, if sometimes people don’t know you, they’ll try to pick on you and stuff like that, whereas I know everyone and no one does that”

(0059, male, 18, second-generation, student, Alum Rock)

Comparatively, second-generation participants felt their parents’ decision to live in areas of high-ethnic density resulted in limited exposure to various communities, and associated socio-cultural lifestyle practices. Some participants felt disadvantaged, lacking understanding about British cultural norms.

“The things they lacked were mixing, living the English lifestyle ‘cos they weren’t taught to do that and bringing up their children, English children. You can’t be a Pakistani from Pakistan; your children have to be brought up like the British.”

(0046, male, 35, second-generation, professional, Hodgehill)

Second-generation participants perceive themselves as more British than their first-generation counterparts. Such findings suggest an internal conflict amongst community members and cultural shifts, especially the formation of new, British identities.

The debate regarding cultural norms and lifestyle practices may extend to different castes within the community. First and second-generation participants believe caste plays an important role in defining differences, which were prioritised before socio-economic development or personal health.

“People don’t look at their communities, now they look at the culture, religion and this, they’re not looking at, it’s just community it doesn’t matter if it’s White or Black whatever you should class as the one community whatever. But people class I’m from this area, I’m from this religion, I’m from this background”

(0047, male, 38, first-generation, unemployed, Aston)

Participants’ narratives show an inward looking community system focusing on cultural differences within sub-groups, potentially damaging social cohesion amongst community members, and the flow of resources (knowledge and support) between individuals:

“We’re still very insular people aren’t we really, especially the labour classes, we’re very insular our thinking is very insular, we’re not very broad minded people, we don’t travel a great deal, our place for travel is Pakistan and then of course you go further afield you’ve got Saudi Arabia. You see we’re not ones who travel in Europe or America, where our mind broadens, our thinking it changes our, see, we sort of are in one way in a very small world aren’t we? You know, with our similar type mind-sets”

(0062, male, 45, second-generation, manual worker, Moseley)

Men appear frustrated and limited by living in an insular community which tries to protect itself from perceived external ‘threat’. The threat seems to be the influence of other cultures and religions, with the potential to steer the group away from traditional beliefs.

“And I feel that way about the community we have here, is that we are like June-flies. We live in darkness. We don’t want to enlighten ourselves and we feel that if we educate our children it’ll be anti-religion. They will lose their culture and they’ll lose, they won’t be a Muslim and... which is totally wrong. The billions of people out there who are well-educated normal people who believe in religion and they practice religion”

(0054, male, 58, first-generation, professional, Dudley)

There is experienced ‘threat’ of assimilation emerging from participants’ narratives. Preservation of religious and cultural microcosms that maintain traditional (familiar) values are preferred.

The effects of living in microcosms are possibly more limiting for women. With men acting as potential community leaders, women are often exemplified as cultural bearers and ideal Pakistani Muslims. Such expectations seem to create further tensions between families with different views on female expression:

“My wife, when she took my daughters for a Koran lesson, it was being held just next to a house, and this lady who used to teach, she had told the girls that when my wife comes again to pick the girls up, she must be informed so she assured them ‘Oh, Auntie’s here’, and she came out and she said ‘Look, if you come dressed like this to this place, then please don’t bring your children here’. And she...believe me; my wife dresses better than any (woman). She’ll have long woolly jumpers up to here (indicating knee-length) and her trousers, and you can’t see anything of her. Just like you are dressed I don’t see anything wrong with it, what she wears. *Saris* and *shalwar kameez* (traditional Pakistani dress) where you are going, what you are doing. And which environment you are in and dresses are not religious dresses. There is nothing Islamic, just because somebody wears a dress in Saudi Arabia that doesn’t mean that that’s Islamic dresses. Dresses are cultural, and (she) doesn’t seem to understand that. That is a problem we have in our community, that the religion we have allowed, not religion, but the guys who are the vanguards of religion to have such a big say that women are being treated the same way as they were treated 50 years ago in Pakistan.”

(0054, male, 58, first-generation, professional, Dudley)

Distinctions between religious and cultural practices can overlap and create confusion amongst community members. A lack of clarity between what is religious and what is cultural, suggests a disjointed community narrative on acceptable behaviour, thus questioning

members with greater scrutiny over lifestyle choices. For example, how you choose to dress should indicate whether you are practising your religion simultaneously: how one respects their culture.

Participants commented on the popularity of fast food restaurants, which the local areas are well-known for, but appear to have an adverse effect on the health of the community.

“Asian areas, there’s so many takeaways, and now dessert parlour culture’s kicking in. That’s why I salute places that actually give a healthy alternative”

(1300, male, 26, second-generation, professional, Yardley Wood)

Some of the participants felt they would benefit from having a variety of health-orientated establishments in the vicinity, and blame the availability of cheap, convenient meals for their poor health.

The local area can influence the physical and mental well-being of community members.

“For socio-economic funding in these areas, building youth clubs, building youth centres, building these gyms, the other thing we also need to do is, in our community drug dealing and alcohol is a very taboo subject, we don’t talk about it, if my kids is doing drugs I don’t want help or support I don’t want to talk about it. I want to hide the fact. There’s some research that’s been done that BME communities are less likely to access treatment services for drug and alcohol problems”

(0057, male, 44, second-generation, professional, Sparkhill)

Community members are dealing with drug and alcohol problems, which they refrain from discussing or drawing attention to publicly. As a result, by discussing taboo subjects this may in return help marginalised members of the community seek the necessary support that they need.

5.2.3.2 Roles of community members

Members of the Pakistani community are likely to form lifestyle choices around gender roles within the household and wider community setting. For men, conventional patriarchal gender roles appear to influence a majority of decisions, including responsibilities for other members of their family.

Findings suggest men exert control and dominance over family members by highlighting women as the ‘weaker’ sex. Participants across all generations appeared to demonstrate traditional, culturally appropriate behaviour with women. For example, determining suitable locations to exercise and evaluate the safety of surrounding neighbourhoods. The following participant discusses how it was suitable for his daughters to go outside when they were younger. The word ‘independent’ is used as a pejorative term by community members for women who are viewed as being bold, or rebellious to community norms.

“Before, anybody could go outside and everything it used to be safe and everything even for the girls, they used to go out and play out until 11, 12, 10 but now there’s too many things happening out there so it’s not very, unless the girl is very, very independent and she knows, she's aware of how to self-defend”

(0047, male, 38, first-generation, unemployed, Aston)

With limited influence in wider community settings, i.e. at work, participants might show greater assertion in their homes instead. Male participants inform women about safety to protect their role within the home and consolidate their position as ‘leaders’.

Comparatively, second-generation participants also expressed patriarchal opinions regarding the behaviour of Pakistani women. Men appeared distrusting of women’s behaviour, even in relation to diet or exercise. Some participants felt women were only making an effort to lose weight to become more attractive and draw male attention.

“A girl might wanna be skinny and stuff to impress boys or attract boys, just better looking basically. They might, some girls, in their minds have like their mind-set ‘if I’m this size or I’m this skinny this is gonna be the perfect size’ or ‘everyone’s gonna love me if I look like this’ so that’s why they might wanna just be really skinny ‘cos of that”

(0039, male, 18, second-generation, student, Alum Rock)

Women wanting approval from members of the opposite sex and ‘free mixing’ are frowned upon in the Pakistani Muslim community.

In the following quote the participant provides a community contextualised vignette in which a woman shows limited efforts to attract members of the opposite sex, despite vocalising concerns over her weight and seeking assurances from her female peers.

“It’s good news for the guys, and like I say it’s different for the girls, girls they (like) being skinny. They love to go out of their way to be skinny. You get the odd fat one, and she doesn’t care about no guys looking at her, or asking her friends out, she says

‘Oh, I wish I could be like you’, while she’ll be chomping on a chocolate bar and eating donuts and you’re like ‘all right, hippo, calm down’. You know. Nobody likes a fat girl. It’s true, nobody likes a fat girl. I hope no fat person hears this. I’m a fat person as well.”

(0027, male, 25, second-generation, professional, Alum Rock)

Men and women are expected to focus on appearance and financial status when seeking partners for marriage. Findings demonstrate participants’ awareness of gender discrimination, with female members of the community experiencing a greater societal burden to achieve an attractive appearance in order to find a suitable partner. It is possible such behaviour is a defence mechanism, where men may feel insecure about themselves and might be reassured by the idea of women seeking their approval and not vice-versa. Strong-independent women who exercise for their own well-being, might question the purpose of men as ‘protective alpha males’ in the community.

“There’s more pressure on girls and I think that’s what causes them to be more health conscious. I’m not saying its good pressure, but that is one of the ways, ‘cos unfortunately society, you know...a girl gains a bit of weight she's seen as unattractive or whatever, whereas a guy, even with a bit of weight if he’s doing alright in life, he’s very much attractive”

(1300, male, 26, second-generation, professional, Yardley Wood)

The participant’s narrative acknowledges and to a degree disapproves of the imbalanced gender expectations for women to maintain a slim physique. Women might be under greater pressure to meet community ideals, e.g. for appearance, than men. Based on these findings,

men are placed higher on the social hierarchy than women, or are expected to meet different requirements. For example, men who are financially secure may be viewed as respected members of the family and community, whereas women's priority should be physical attractiveness.

Based on the available evidence, male participants justify gender-based roles by highlighting apparent environmental risk. Men appear to be defending the community from external threats they perceive to be a danger to current social structures. Showing physical strength may be an attempt to maintain gender roles that suggest men should work to provide and protect their family.

“The weaker you are the more vulnerable you are to other people, the more prone you are to being attacked, so the more healthy you are you can protect yourself, you can protect your family, if you get in to a fight or something and you are weak, its most likely that the person that's fighting you will be stronger than you... protection, protecting yourself, protecting your women, protecting children, I think that is a big motivation”

(0051, male, 28, first-generation, unemployed, Alum Rock)

Men are under the impression that they need to defend their families against societal dangers. It appears to be a responsibility that requires effort and attention. However, some male participants seem to have concerns regarding stereotyped behaviour.

The following quote highlights community views on gender based roles within the family or home.

“There’s a greater responsibility on the female population than the male population, especially when they have obviously children, role will always be greater”

(0062, male, 45, second-generation, manual worker, Moseley)

However, some participants want wider community audiences to limit stereotyped perceptions in other domains, such as work and education.

“Those of us that are successful need to encourage the rest of us to all follow suit and not give anyone any excuse to stereotype us, because there’s a lot of stereotyping going on out there. And we have ourselves to blame, but I think those of us that are doing well need to share that success.”

(1300, male, 26, second-generation, professional, Yardley Wood)

Participants might be trying to differentiate themselves as progressive individuals, and want to protect themselves from assimilation.

5.2.3.3 Identity

Identity develops as a concept of self within the migrant community where individuals can associate with wider community networks, such as Muslim or British over Pakistani.

By being associated with a larger population, such as British, participants considered themselves better supported through positive discrimination. Findings suggest a sense of pride over shared group achievements, cultivated within their network.

“I developed the association of Muslim police, so we’ve got the association of Muslim police with issues that Muslim officers...that were being deprived of,

recruiting, retention and progression so I used to meet home office commissioners, senior officers, and we formed like 12 at the time associations each country doing that and I think that every public institute should reflect the communities it serves, if we don't then people don't understand your problems and issues, so hopefully there's recruitment going on. Saying that, I'm trying to recruit you now, that's an option for you, that we've said that West Midlands police are going to recruit 450 officers, we've told that or I've been consulted we put a draft proposal which has been accepted now but 25 of those recruits should be BME, you know Muslims, Black whatever but visible non-White, so we're trying to work through that gender and stuff like that so police roles"

(0057, male, 44, second-generation, professional, Sparkhill)

"We had loads of money, £40,000 I had in my pocket to spend and all these medications and we came back and we set up an organisation called Midland Office Association and it started collecting funds to build hospital in Kashmir in the next few years or so, they were spent doing that travelling every three months or four. I was in Pakistan in December and I'm going again in March"

(0054, male, 58, first-generation, professional, Dudley)

Associating with a religious community, with members from different ethnic backgrounds, appears to create its own problems.

An emerging issue was the struggle to combine religious teachings into daily life, whilst dealing with racial tension in the local vicinity.

“Yes, we need to change their viewpoint, but what we’ve got here is some uneducated *Maulana* (man valued for religious learning or piety). I’ve always said that your religious leaders, they’re not scholars, gone are the days where we really had scholars to hold these debates, they’re not. They’re your *Mullahs* (Islamic teaching and law) and that’s all they are, they’re not scholars who can actually say that this in Islam is acceptable, this isn’t. You know what we’ve done in Islam? We’ve chosen the things that we like, and what we don’t like we’ve distorted.”

(0057, male, 44, second-generation, professional, Sparkhill)

Participants appear to be distressed by the state of current social and religious communities. However, some participants seem to have adopted Western and Eastern viewpoints, enabling them to form identities that reflect successful acculturation into UK life.

“So integration has never been an issue, we have maintained the good qualities of our cultural background. We have adopted lots of very, very good things, which is in this culture. So I would say that it is a hybrid”

(0054, male, 58, first-generation, professional, Moseley)

Based on participants’ accounts, it is possible to incorporate different religious and social identities to increase access to wider social networks. However, participants may need to be discreet about which aspects of their lives they choose to share within their social network(s), especially amongst family members.

“More difference would be, like, amongst your family, your cousins and stuff, there are certain things you can say or talk about, and certain things you can’t, whereas your friends, everything is, you know, a go-go area.”

(0029, male, 24, second-generation, professional, Alum Rock)

Developing an identity that includes contemporary British or Western qualities appears to create barriers for inter-generational bonding. First-generation participants are likely to face communication difficulties with younger community members, as they have limited English fluency. Findings suggest first-generation participants had greater difficulty in interpreting social and cultural views that might create a distance between them and wider community networks.

“Asian, elderly it’s hard for them. Main problem is the language, if they don’t understand the language then they think that they are being under treated or being racially abused so the main barrier I think is the language between the elderly, if they don’t understand the language then they think that they are being racially abused and being looked at lower than other race people”

(0051, male, 28, first-generation, unemployed, Alum Rock)

Some participants may find it easier to keep their lives private, and limit interaction with the wider community. Limiting social engagement due to issues of privacy can result in a lack of clarity amongst men in the community, especially regarding the acceptability of social trends. Consequently, community members start questioning the nature of each other’s behaviour. Identity develops as a factor with meaningful influence over men in the community, yet there

is uncertainty over the socio-cultural norms associated with either religious or cultural affiliations.

5.2.4 Seeking health-related help and information

Analysis of participants' accounts revealed potential differences in individual pursuit of health information (diet and exercise) and support through diverse institutional channels.

The gym, *Mosque* and GP surgery can be the main sources of support and information (Table 18).

Table 18. Overview of category: seeking health-related help and information

Overview
<ul style="list-style-type: none"> • Findings suggest a noticeable trans-generational difference amongst male participants when seeking health advice or support from professionals or community members. • Based on age, generation and associated formation of identity and health views, participants may have reduced or increased likelihood to approach medical professionals. • Unlike the GP surgery, the <i>Mosque</i> has the potential to accommodate Pakistani Muslims across generations. • The <i>Mosque</i> is a social space designated for praying and sermons are held for men every Friday after mass prayer. • Participants identified the potential for <i>Mosques</i> to act as community centres that promote health and neighbourhood cohesion. • There is a potential to socialise with like-minded others, develop social skills and take responsibility for health, for example at the <i>Mosque</i>, that may not be possible in other community venues.
Generational differences
<ul style="list-style-type: none"> • First-generation participants in particular seem to rely on information available at GP surgeries or the <i>Mosque</i>. • Second-generation participants believe insufficient efforts are made at the <i>Mosque</i> to communicate with the community about health and well-being. • GP surgeries can provide medical information and reassurance in a professional setting. For first-generation migrants, this support could compensate for small or limited social networks. • Second-generation participants might be dissatisfied by healthcare facilities as they have comparatively greater expectations than first-generation migrants (Sidhu <i>et al</i>, 2016). Younger participants believe they are more independent and better suited to look after their own health.

- Conversely, second-generation participants prefer the gym. The gym, as a social space, could help develop existing or novel social connections.
- Young men thought the gym was the most suitable place to focus on social development and gain information on how to achieve a masculine physique.
- Younger participants were likely to find additional information online, if social connections or GP surgeries did not provide adequate support.

5.2.4.1 Access to health

There are generational differences in the way men from the Pakistani community access healthcare services in their communities. Second-generation participants were more likely to be dissatisfied with the bio-medical approach utilised by GP and health services, compared to first-generation migrant men (Garrett *et al*, 2012). The following quote illustrates a greater preference with regard to a GP service the participant would like to receive.

“If I went to a GP now, he’d say ‘Okay, what’s your problem? What’s wrong?’ Do you get it? That’s the problem. ‘What’s wrong?’ Do you get it? It’s not ‘Okay, shall we do some checks? Let’s see if there’s anything wrong’ (instead) ‘what’s wrong?’ ‘Oh, I’ve got a headache’ ‘Okay, you need this medication’, ‘what’s wrong?’ ‘Oh, my back’s hurting’ ‘Oh, just put this cream on’. Which is fair enough they’ve gotta do a hell of an amount of diagnosis. They’ve got about 10 minutes per patient. They’re busy. My point is, if they had some sort of service where you could go in once a year for a regular check-up, just to see how your fitness is, then people might actually learn something”

(0029, male, 24, second-generation, professional, Alum Rock)

Participants believe health organisations, e.g. general practices, make limited efforts to raise awareness of health concerns. Participants relied on self-education, especially where socio-cultural issues could directly or indirectly influence access to healthcare.

An example of external factors likely to alter behaviour are the changes associated with socio-economic development. The following participant believed purchasing a car has direct implications upon well-being.

“Before I started driving and stuff I was a really active person. Because I would be walking everywhere I went. If I wanted to go to town I’d have to walk to the bus stop, catch the bus, then walk around in town and get to where I wanted to go, with my friends I used to walk and cousins house walk, now it’s like if I want to do anything I just, in my car and I’m off, let’s go.”

(0027, male, 25, second-generation, professional, Alum Rock)

Older, first-generation participants believed the GP services are a reliable source of support and information. Findings suggest first-generation participants are more satisfied with the healthcare they receive than younger participants, and are not reluctant to ask for more information.

“When I went to the doctor to get my regular check-up he said that my cholesterol level was too high, so I asked him what is the best thing you know apart from medicine?”

(0033, male, 48, first-generation, retired, Alum Rock)

“The doctor that I know he treats me very well, gives me medicines, anything I need to get I get it in a nice way”

(0061, male, 71, first-generation, manual worker, Moseley)

Participant accounts suggest there are psychosocial concerns that preoccupy some patients and influence their health. These concerns affect patients’ ability to initiate or adhere to lifestyle changes:

“I think people have that, they have depression they have other things you know...most of the people who are overweight I think it’s depression and other things, either financially or either they in some sort of problem with alcohol, drugs or gambling or any of that...The people who are working and everything, they have their routine lifestyle, they will automatically be healthy”

(0047, male, 38, first-generation, unemployed, Aston)

First-generation migrants have limited exposure to alternative healthcare options, and there is a lack of information available from social contacts. Migrants place increased demand for GP care and attention, to compensate for the inadequate support and information available in their social networks.

Where numerous lifestyle factors influence health, participants might not be able to incorporate complex or culturally unfamiliar lifestyle changes. These changes could include diet management and exercise techniques that may appear to be complex, or involve novel technologies.

5.2.4.2 Institutions

The gym or *Mosque*, provide social space and information for participants. Based on findings, Pakistani men may choose these religious and social spaces to develop their social networks.

For some participants, institutions appeared to play an important role in shaping their support systems.

“Are we talking people or institutes as well, because mine would be my local *Mosque*, I think in (circle of convoy model) B and C as well and again when I ask that question, local shops in C, banks ok, now and again. Now because for me it isn't that clear, but going to the gym that's important too so that's why I ask you if that's people or institutes as well so that would fit there”

(0057, male, 44, second-generation, professional, Sparkhill)

Gyms are viewed as a social space specifically for second-generation men. It is an environment that might not accommodate first-generation men or women. Some participants can become territorial about their workspace as a place for potential social and personal development, limited to regular attendees. The following quote describes the participant comparing his gym ('my') to other places a woman may feel more comfortable in.

“If she takes that first step, she goes in, and there's a lot of sweaty guys training, making all sorts of noises, it's uncomfortable. Whereas, if you went to Virgin Active (brand gym), it's normal to have people of all ranges of ages and colour, everyone's training, it's all that you know, fitness Zumba going on. It's so comfortable to be

there. Whereas you come into my gym and you see fat, hairy, hairy guys, and you're sweating 'Aargh' 'What's that?' 'Aargh', the girls are not gonna want to be there. She's not gonna take that first step...I know, it's natural, of course."

(0029, male, 24, second-generation, professional, Alum Rock)

A distinction is made between men and women's exercise beliefs, where men are believed to train for societal benefits in comparison to leisure pursuits. The following participants understood that women have different motives when carrying out physical activity. In comparison to going to the gym, women may do activities such as yoga or swimming.

"I think my wife goes to the gym, does she go to the gym, I think, I know she goes for a swim occasionally, but she would do it on her own"

(0052, male, 56, first-generation, Moseley)

"Spin cycling is currently a trend among girls, but I think I, guys, just generally weight train, they (guys) don't really do much cardio and girls do a lot of cardio, and they don't do much weight training, and so there's a constant trend...I think women aren't generally viewed as, it's hard for the community to see women go to the gym. I think they're just expected to not really concentrate on their health much. In some cases guys get food cooked for them from the family they want to go to the gym and work out, but if that was a girl I don't think that would be the same case"

(0028, male, 27, second-generation, professional, Alum Rock)

“I know girls that do stuff like yoga and stuff and that’s just for themselves to feel better. That’s not to have, impress anyone that’s not for society sense that’s just keeping them busy and attracts them away from other stuff, like they say that girls are busy doing make up and stuff but it’s a chance to take your make up off, wear your loose clothes”

(0032, male, 18, second-generation, student, Alum Rock)

Second-generation participants feel independent, and use ‘self-education’ to expand their understanding of health and well-being. Self-education involves self-awareness and reflection on personal understanding of physical and emotional well-being (Mensinga, 2013).

Individuals actively seek health information (such as online), when information is not available from health services (Bourn, 2006). However, participants continued to suggest participation in group activities, such as going to the gym, as necessary for comprehensive understanding of health.

“I think going to the gym has been a big contributing factor with that, because you meet other individuals who you see, they’ve achieved good physical shape and you ask them for tips. You go online you do research, and obviously they just do that at work, in a lot of things that I’ve learned through academia made me aware of what things I need to look out for, what diseases there are out there and how they develop. So I think, obviously self-education is key but all that comes through participating in these kind of activities, i.e. going to the gym, playing sports and, that’s how you come across things”

(1300, male, 26, second-generation, professional, Yardley Wood)

Findings suggest participants learn more through active participation in a variety of social activities and access to wider social networks, than they do online, or through one organisation. An individual who seeks knowledge by channelling different social resources, could be better informed than someone who relies on one group of people.

Participants might seek alternative sources of support in addition to the gym, as the gym might not always provide a suitable atmosphere for knowledge exchange. Local gyms, in comparison to well-known branded centres, could be intimidating for new or unfamiliar attendees.

“I just didn’t feel good in that environment. Like, there was a lot of people, the way they just talked to each other, there was a lot of bad words being said, and you could sometimes smell them doing drugs or, it just wasn’t a nice environment”

(0028, male, 27, second-generation, professional, Alum Rock)

Although, the gym can provide the opportunity to form novel social connections, men may prefer support from existing contacts. First-generation participants in particular struggle to establish a supportive social group at the gym, and a lack of support could limit motivation to initiate or maintain exercise routines:

“What kind of friends am I meant to make at the gym? The one day I see someone, he’s not there the next day, he changes his timing and I am there by myself, so that’s it, if I had one friend that said to me every day ‘ok work done lets head to the gym’, but since there isn’t anyone to suggest that then when I work I don’t know what time it is and I get misplaced”

(0036, male, 32, first-generation, manual worker, Balsall Heath)

Social isolation at the gym can make first-generation men feel unwelcome and uncertain about exercising in public spaces. Participants seem to blame their busy routine for their inability to change their lifestyle, especially as they cannot find appropriate social encouragement.

The *Mosque* can provide a free and open space for worship and recreation for all members of the community. However, community members believed limited effort is made by the *Mosque* to address community needs, in particular for women’s healthcare.

“If we can go alongside *Mosques*, have cultural centres and then make it part of that or they then provide information and say ‘yes for the ladies in their forties we can, you got two hour slot or four hour slot twice a week’ ...and make it such that it doesn’t sort of interfere with picking up the kids from school and things like that. But then I suppose it all comes with a cultural centre, if there’s a culture centre then access to that information will be a lot easier”

(0062, male, 45, second-generation, manual worker, Moseley)

The *Mosque* is understood as a culturally appropriate environment for women to exercise and develop social networks, as all activities can be conducted in a religious communal space. Findings suggest a joint community effort may be required to create health and social changes in social spaces often accessed by the Muslim Pakistani community.

“Baby steps, Rome wasn’t built in a day, we need to, but it’s about investing that time in individuals and not as a cattle or herd, do you know who’s got a big role to play in all this? Our own community, you and I know that public services and strategy organisations aren’t funding and sources are very limited, our *Mosques*, our *Gurdwaras* (Sikh place of worship) our Hindu temples have got a big role to play in this, I think *Mosques* is not there to just go pray, *Mosques* are based on the model that they are community centres, that’s what they are, praying is a part of, we should have people in the *Mosque* who are offering this support, offering this help, going through and working with these people, people have the time and effort to do this”

(0057, male, 44, second-generation, professional, Moseley)

Second-generation participants think *Mosques* do not incorporate contemporary ideals towards integrated social development. Younger community members felt they are not the target audience, as *Mosques* tailor messages to first-generation, older men.

“I don’t know I just, I don’t understand when I go ‘cos they’re speaking Asian languages and I don’t understand it, so I don’t know what they talk about”

(0059, male, 18, second-generation, student, Alum Rock)

By referring to ‘Asian languages’, participants are referring to Pakistani and Muslim identities, as religious concepts are discussed in Mirpuri, Urdu and Arabic. The *Mosques* appear to make their target audience very evident, and unintentionally exclude youth groups.

Men across all three generations view the GP surgery, gym and *Mosque* as multi-purpose platforms with the potential for community development. For example, the *Mosque* is a religious centre but participants suggest adapting the location into a community space.

Although the aforementioned spaces can be utilised as social hubs, their potential is currently reduced by the influence of dominant groups, i.e. young men in the gym and older men in the *Mosque*.

5.2.5 Gender inequalities

Gender differences influence how participants form relationships within community networks. The thematic basis for this category includes female appearance (grounded within education and liberty) and societal pressure on men (Table 19). There are a series of gender inequalities that have the potential to shape social interaction and the formation of lifestyle choices.

Table 19. Overview of category: gender inequalities

Overview
<ul style="list-style-type: none">• Participants expressed a need to protect women in the community from perceived racial or sexual abuse. Hence, male participants strengthen their position in the community, by suggesting male guidance is needed to steer potentially vulnerable community members.• Gendered views appear to be prominent in microcosms, where men support women who exercise or socialise in segregated spaces.• However, participants with a professional background felt women should have equal rights for education and be empowered to make their own lifestyle choices without facing any social obstacles (e.g. verbal threats of violence).• Men face pressure from community members to be physically strong, provide for their families and establish a variety of social connections.

5.2.5.1 Female appearance: education and liberty

Findings identify gender inequalities for women in the Pakistani community. The way in which women present themselves through dress, educational attainment and social choices appears to be under criticism from men. Male participants seem to prefer a high level of modesty from Pakistani women, which could present itself as a barrier to exercise.

“The most important thing in Pakistani culture is that women have to be covered. So most sports women are not fully covered, so that is a big decision for the family to take. So as long as the woman who is playing, if she is playing some sport and she is fully covered then I think she should be allowed to play”

(0051, male, 28, first-generation, unemployed, Alum Rock)

The need for permission could stem from a sense of responsibility that men have for women in the community. Based on participants' accounts, Pakistani men feel that Pakistani women should socialise within the boundaries of their own community. Seeking approval from their families could negatively influence women's ability to have independent lifestyles.

“This is upon the Asian population and it's the women, they suffer because they are not allowed to go anywhere, do anything”

(0054, male, 58, first-generation, professional, Dudley)

By limiting women's exposure outside of the community, participants felt they were protecting them.

There was a heightened sense of fear surrounding 'attacks' on women and men believe women may not be able to defend themselves in unfamiliar circumstances.

“My sister was racially attacked years ago. My elder sister, she used to cover and some Black guy came and attacked her. She phoned me, I didn't get there in time but my friends did though. My friends did that for me because I've done it for them; I've handled situations for them. We live in that society, unfortunately, and it can all blow up any time, and it has blown up quite a few times, so you need to be ready physically and mentally.”

(0046, male, 35, second-generation, professional, Hodgehill)

Men's roles as guardians and advocates for appropriate behavior could be explained by the socio-political debates surrounding the practice of Islam in UK communities.

The following participant believes that other Asian men think women should exercise in the home.

“In the Asian community, if they see a girl jogging down the road, she’ll be frowned upon. They will look at her, ‘what are you doing? Don’t you have respect? You shouldn’t be jogging around? If you want to jog, go get a treadmill. Do it at home’. If she goes to the gym, ‘what are you going to the gym for? You’re an Asian girl, come home’ it’s the Asian community”

(0027, male, 25, second-generation, professional, Alum Rock)

Men believed cultural practices result in psychological stress for women. There is recognition for South Asian women having poor emotional well-being, in particular those from the Pakistani community.

“Depression is high in women, because men give them depression”

(0033, male, 48, first-generation, retired, Alum Rock)

Male participants acknowledge that gender inequalities exist within the community. Cultural issues such as marriage increase emotional pressure on Pakistani women:

“Domestic violence and forced marriage is a big issue, it’s for you (community) to sort out, and they would say ‘no, it’s not an issue’, now the same *Mullahs* coming to me saying ‘you’re right’. ‘Cos I said if you don’t sort it out then the government will and the government has. It is now criminal to force somebody into marriage”

(0057, male, 44, second-generation, professional, Sparkhill)

Therefore, it emerged from participants' narratives that women should be provided with support to address community pressures:

“And unless we come out of that mould nothing will change, the health of women in our community will not change. As a consequence, the health of men will not change because the driving force behind every community is actually females. Women are the driving force and very, very few men are such strong that they (women) will have the major say in any household. So, if it comes from a woman in the house then everything will be all right but at the moment, they haven't got the power. Even if they had the power they have not been trained and educated in a way that they will use it for right reason and I feel very strongly about this issue.”

(0054, male, 58, first-generation, professional, Dudley)

It seems as though men are reluctant to support women with personal development, as it may challenge their role as providers.

“You have a lot of women in Asian households who are not encouraged in learning, even English, and it's because men do all the hard work and everything. But that's all fine men do the hard work and everything. But a woman shouldn't be sitting at home like a tool. But that's sort of become the norm”

(1300, male, 26, second-generation, professional, Yardley Wood)

It appears as though a cultural shift might be taking place where men want to encourage women in the community to take up roles outside of the household. However, men and women with such progressive views seem to be restricted by their socio-spatial environment.

“The more you move out of a congested and compacted area like Alum Rock and Aston and Perry Barr. There’s a lot of stigma attached to the housewife and the working husband model. Unfortunately, that stigma attached and the woman has to wake up, tidy the house up, feed the kids. It’s all about everybody else but not themselves”

(0046, male, 35, second-generation, professional, Hodgehill)

The change in cultural norms is emerging from a greater sense of awareness that men have about their position within the home. By recognising gender inequalities within the community, women’s health could be given greater priority.

“Possibly due to inferiority complex, I mean not complex, I mean, girls are viewed as probably inferior, in terms of, when it comes to health and fitness, to men”

(0028, male, 27, second-generation, professional, Alum Rock)

Yet by acknowledging such differences, there is no guarantee that change may occur and that men’s health will be prioritised compared to women’s in order to preserve traditional social hierarchies. Within these hierarchies, women appear to come second, as it is more important for men to be healthy as they are perceived to be providers and protectors of the community.

5.2.5.2 Societal pressure on men

Community expectations, formation of contemporary identities, and access to sources of social support create high social expectations upon Pakistani men.

A trend which developed across themes amongst young, second or third-generation participants, was an interest in developing physical strength. Consequently, participants appear to spend a lot of time at the gym developing a masculine physique.

“Health wise? Well, we’re not fat b*****s so we don’t talk about it much, but no, I think just, a few of my mates, I mean, we all, like, go to the gym, and stuff and we all train and stuff because everyone’s into it now. I think, so we talk about it quite a lot now”

(0029, male, 24, second-generation, professional, Alum Rock)

Often, training seems to happen in local gyms where like-minded individuals gather to train. Training tends to involve a lot of weight lifting and minimal time and attention on cardio-respiratory exercise.

“If you go to a White persons gym everything is in the same room, if you go to an Asian man’s gym, you’ve got weights and weights and weights and you’ll have a little room in the corner with the- it’ll have like three treadmills”

(0027, male, 25, second-generation, professional, Alum Rock)

It is possible that with greater physical strength, participants may feel they have acquired more responsibility. By physically dominating their social space, men may achieve leadership roles within their families.

“I’ve got the broad shoulders to make decisions, whether the family likes them or not, and that’s the role that I play in my family.”

(0046, male, 35, second-generation, professional, Hodgehill)

Findings suggest that becoming the male lead at home or in the community is something passed down from generation to generation. In order to become an adult, younger participants believed they would need to train with their older family members.

“I go with my cousin and like, he’s more serious about it and if I go, if I mess about he shouts at me and stuff so I have to train properly with him”

(0039, male, 18, second-generation, student, Alum Rock)

Men from the second-generation might be trying to display responsibility and influence over community members by physically dominating members of their social groups. By ensuring they are the strongest in their immediate surroundings, young Pakistani men view themselves as a valuable commodity amongst peer groups and friends. The following participant describes occasions where his strength and willingness to help has created opportunities to socialise and be appreciated.

“It’s like little things that people don’t notice but if you can’t open a drink bottle people will come up to me and say ‘can you open this for me’ ‘cos I, it’s just one of those things. It sounds funny but it makes you feel better when everyone’s coming to you for everything”

(0032, male, 18, second-generation, student, Alum Rock)

However, exercising and training appears to have protective properties and young men might be keen to find opportunities to gain advantage over others. Such findings imply participants may sense some threat in the environment that they want to be prepared to defend themselves against.

“If you’re walking on the road and if someone sees you and you’re skinny and that like they may wanna try something like bully you whereas if you are big and intimidating they wouldn’t try that”

(0059, male, 18, second-generation, student, Alum Rock)

The social implications for being strong and appearing physically capable of protecting others, can mean participants seek knowledge on how to gain physical advantages over their peers. The sense of achievement associated with being more aware of training needs and abilities could be perceived as being as beneficial as actual strength.

“When they're not training, I'm like, look he's not training. I'll do it myself. If he doesn't want to do it, I'll do it. Because it just gives me that reason- look if I do something now today, I'll know something that he doesn't know by tomorrow. So I know something more than him. It's a bit cheeky but that's the way I see it”

(0043, male, 22, second-generation, professional, Hodgehill)

Physical strength appears to be associated with men and their social expectations. For example, men's gyms are not viewed as places for women's health, as they might only cater to men's socio-cultural needs.

“‘Meatheads’ meaning the big bulky guys who actually, more of a guy’s gym rather than the normal health club that you’d expect, like women or stuff like that. They wouldn’t be there. It’s normally a guy’s gym”

(0040, male, 18, third-generation, student, Alum Rock)

Participants appear to prefer space away from their families and responsibilities where they can express their masculinity amongst other men.

Such behaviour could be to compare potential masculine abilities with other men, or possibly to relax amidst like-minded others away from responsibility.

“If you’re cocooned in one aspect of life then you don’t have a life. I don’t agree with sticking at home 24/7 and you’re cocooned. You need to have a release. So Friday night I’m out and Saturday night I’m out, which consists of, in the day time, any house chores that need doing, shopping, anything that the wife needs doing or I’ll babysit and the wife will go out and do her things so we balance that out”

(0046, male, 35, second-generation, professional, Hodgehill)

Gender inequalities are also apparent in relation to the health and well-being of women in the community. Opportunities to exercise are limited by men’s views on safety and appropriate dressing.

“I wouldn’t be bad to a random girl because I have a sister, but not everybody would think like that. They would just say, ‘she’s not my sister. It doesn’t matter’. But

everybody thinks like that...I wouldn't feel comfortable with my sister running around here or in Alum Rock'

(0043, male, 22, second-generation, professional, Hodgehill)

"Well it all depends on if they're playing (sports) with the females, which female that they are playing with and they are covered and no male can join in to the game then it shouldn't be a problem"

(0051, male, 28, first-generation, unemployed, Alum Rock)

Participants noted unequal opportunities for men and women, in particular from a patriarchal viewpoint as brother or father. The following participant uses satire to illustrate this point;

"Of course there's gender differences in the, there is this joke which it may be construed as very flippant of me to say this, that in our community the women use to walk ten paces behind men. Now they walk ten paces in front. You know why? Landmines"

(0054, male, 58, first-generation, professional, Dudley)

The aforementioned themes in the chapter have illustrated how health expectations appear to be different for migrant, first-generation men who do not appear to engage in gym going or muscle-making behaviour. It could be a result of limited social influence or socio-economic resources, and over-reliance on close familial networks. First-generation migrant community members may be limited to lifestyle options as consequences of limited exposure to alternative diets or exercise regimes.

“I can only look after myself and not anyone else, I tell my missus, she's lost a bit of weight, she goes to Pakistan and she loses weight, otherwise we start that we control ourselves from meat and avoid fried things”

(0036, male, 32, first-generation, manual worker, Balsall Heath)

However, some older participants might be beginning to consider the potential health benefits of attending institutes with selected health spaces for both men and women. Such changes seem to be maintained within the traditional socio-cultural framework, i.e. expectations for women to remain segregated from men.

“When it comes to your health, no. You can't compromise on your health. If my wife wants to join a club with other Asian ladies you know by all means there are places there they can join a club, where I think that two hours is designated for, their own people, their own community or their own age group. If I'm not taking advantage of these facilities and then you can't blame the system”

(0062, male, 45, second-generation, manual worker, Moseley)

Based on the available evidence, there are generational-based differences in how gender roles are perceived. Second or third-generation participants appear to focus on gaining physical strength as a traditionally male characteristic. On the other hand, older married participants might appreciate the need to try and improve their family's health as whole and sharing responsibilities. Health for men in the community appears to be an independent venture for younger participants who might develop a focused workout routine in a suitable environment. On the other hand, older or migrant participants may not be able to devote that time to physical achievements as they have other (marital or familial) responsibilities.

5.3 DISCUSSION: INTERPRETATION OF FINDINGS

Findings from this chapter reveal generational differences amongst men with regard to their social position and preference for lifestyle choices. There are issues surrounding the distribution of power, control and agency for allocating health and social resources. Conclusively, there are cultural shifts negotiated amongst men from different generations.

5.3.1 Cultural shifts in power

Power was defined as the ability to make independent choices and have control over environmental and personal resources (Boudet, Petesch and Turk, 2013; 1-3). Findings were broadly compatible with concepts of masculinity within the context of community; though several views differed. First and second-generation men expressed varying views on whether health or socio-economic success should be prioritised. First-generation migrants had maintained a focus on work and educational attainment for their children, which meant they overlooked health behaviours such as diet and exercise. Consequently, second-generation men felt they were at a disadvantage compared with peers who had benefitted from information on alternative lifestyle choices from White or British born parents. Second-generation participants are dealing with contesting South Asian and Western identities, along with an increased desire for positive self-representation within wider community contexts (Campbell and McLean, 2003). Sweet (2010) explored African American adolescents' consumption behaviours alongside blood pressure and found an association. High blood pressure was linked to limited parental economic resources where participants felt peer pressure to obtain symbolic material goods (Sweets, 2010). The second-generation might be pressured to display financial success associated with educated or financially stable parents and participate with shifting cultural trends.

More second-generation Pakistanis are completing higher education in the UK and pursuing professional careers. As a result, Pakistani descendants are working with diverse groups of people, hence second-generation men are more exposed to alternative lifestyle choices and greater sources of information and support. Crul and Doornik (2003) examined the socio-economic and socio-cultural status of second-generation Turkish people in the Netherlands, and discovered a growing proportion of second-generation migrants with better education and career opportunities. However, participants continued to express dissatisfaction and felt they were at a disadvantage to their White peers, as their parents were less educated. Comparably, Dustmann, Frattini and Lanzara (2012) commented on the disparity between first and second-generation migrants, where second-generation youths feel at an educational disadvantage to the wider population, especially if parents speak a foreign language at home. Parents may play an important role in developing an understanding of healthy lifestyle choices, but first-generation men believe health is less important compared to income.

5.3.1.1 Second-generation men

First-generation men appear to be influenced by their migrant status. Migrant labourers traditionally worked long, labour-intensive jobs in order to provide for their families in England and Pakistan (Ballard, 2003). Yet, second-generation Pakistani men used knowledge and greater financial resources to exert influence over their family, friends, and acquaintances within their wider social network.

These findings are similar to those of Picot and Hou (2003), and Montazer and Wheaton (2011), who identify the socio-economic gradient shifting from low-income status towards higher-income between the first, second and third-generations. Second-generation Pakistanis are more likely to pursue higher education, as a shared cultural norm ‘ethnic capital’ amongst Pakistani families (Shah, Dwyer and Madood, 2010). Pursuing higher education is a

plausible explanation for the disparities between first and second-generation men on the social and economic resources available and the competition between members of the community to attain and distribute these assets effectively.

There are complex internal struggles between first and second-generation men on how resources should be allocated. Second-generation men want to support personal development, and at times familial prosperity, rather than community interests. For example, second-generation participants expressed a desire to develop local resources such as healthy shops and restaurants, or more gyms.

Pingali (2007) and Gilbert and Khokar (2008) note the rapid economic growth, urbanisation and globalisation of Western communities influencing a dietary shift amongst South Asians away from traditional foodstuffs. Fast-food restaurants are not only a reflection of the cultural shift towards Westernised food, but an example of spatial and socio-economic relations within the community.

Second-generation men felt strongly about moving away from fast food as they acknowledge the negative consequences of high fat, processed, convenience diets (Grace *et al*, 2008).

Although fast-food restaurants and Pakistani businesses may benefit community members, second-generation men are beginning to acknowledge the socio-economic and health consequences of shifting cultural norms and trends.

These patterns are not unique to the Pakistani community, as generational differences often cause second-generation migrants to negotiate cultural or religious ambiguity amongst other ethnic communities. Generational differences can influence a shift in cultural norms, but also influence engagement and citizenship where alternative social and political opportunities are available (Dalton, 2015). For example, second-generation Swedish-Sikh immigrants have contested with different arenas of power (religious, traditional and cultural) to adopt religious norms and individual interpretations into networking opportunities, e.g. self-help activities

for the youth at the *Gurdwara* (Myrvold and Jacobsen, 2013; 84-87). Therefore, shifting power, control and access to resources could be a consequence of ageing, where the newer generation can try and incorporate past ideals into contemporary practices.

5.3.1.2 Health and social priorities

Cultural shifts can include greater self-indulgence and individualism amongst second-generation immigrants that affect the distribution of financial and social resources (Parekh, 2000: 25).

Second-generation men expressed health concerns regarding the prevention of illness and diseases associated with ageing in the South Asian population, and were more likely to cook and eat meals independently and/or request family members to adapt existing recipes. Yet studies have discussed acculturation in diets, due to incorporating Western food items into a daily routine; regardless of this, there is limited information on shifts towards healthier diets, or the impact of individual meal preferences on familial dynamics (Parsons *et al*, 1999).

Researchers have reported the increased consumption of processed foods with second-generation immigrants in Europe, which increased the risk of chronic diseases, especially in the South Asian population (Anderson *et al*, 2005; Gilber and Khokar, 2008). Where community members might be incorporating unhealthy Western meal items into an existing diet, second and third-generation participants seem to express a desire to shift cultural norms towards healthier, individualised dietary practices.

First-generation men had a tendency to use GP surgeries for support and information in the management of illness and disease, whereas second-generation men benefitted from using the Internet or social resources. Surprisingly, first-generation migrants, including Pakistanis, are known for having low response rates for attending doctors' surgeries and screening

(Norredam, Nielsen and Krasnik, 2009). Different post-migration social networks have formed, where second-generation participants have developed stronger social bonds over a longer period of time with fewer people, whereas first-generation migrants tend to socialise with other migrants and rely on transnational ties.

5.3.1.3 Masculine capital

The gym was perceived as the perfect location for young men to socialise and form strong bonds with other men who had similar health goals. Perceived masculinity has been associated with traditional masculine behaviours, health benefits, and stronger gender identity to accumulate ‘masculine capital’ (deVisser and McDonnell, 2013). ‘Masculine capital’ can be viewed as the skill sets and cultural competences for men to fulfil social expectations in society (Vasquez del Aguila, 2013: 67).

Second-generation men dominated their social networks through displays of physical strength. Men with masculine physiques were approached for advice and support because their size was an indicator of i) access to wider community resources e.g. the gym, ii) being able to afford an expensive, high protein diet, and iii) having knowledge of health, i.e. nutrition and exercise techniques.

The gym was not viewed as a mixed-gender environment, as women were not considered to have the same health goals as men. Rabiee, Robbins and Khan (2015) piloted a free gym scheme in Birmingham, where by quantitative and qualitative measurements identified increased self-esteem, social support and lifestyle behaviour change with an increase in physical activity for members of the Pakistani community, especially women. For young Pakistanis in the UK, who were born to migrant parents, social spaces can be areas in which they can develop their identities away from the influence of religious or cultural influences

(Michael, 2011). The findings of this research contribute to the existing literature on social motivators for going to the gym, where previously it was understood that men went to pursue better health (Crossley, 2006). The gym maintains spatial significance in a Pakistani community as the local hub for social support and interaction for young men. First-generation participants struggled to socialise at the gym or attend during regular hours.

5.3.1.4 Women's position in the community

Men across all generations viewed themselves as the breadwinners and felt women should maintain their roles as homemakers. Also, men defined socio-culturally and religiously appropriate behaviours for women in their families. An example of such behaviour is how men permitted wives and/or sisters to exercise in the local area, at the gym, or only with a group of women from the community. Keeler (2008) discusses the impact of strong 'hegemonic masculinity' within the home during a decline in professional status at work. Furthermore, Wang (2000) and Macey (2010) identify the role of race, ethnicity, and cultural and social influences on the formation of masculine identities, where men from minority communities acquire power to dominate, through responsibility and physical strength, women within the community. Such socio-cultural influences contribute to the subordinate treatment of women in the community. Similarly, Dion and Dion (2001) studied the influence of gender roles on immigrant families and the renegotiation of these roles where there are different social expectations on sons compared to daughters. Sons have fewer restrictions in heterosexual relationships, including choice of marriage (Dion and Dion, 2001). The findings of the current research contribute to the existing literature by emphasising the limited development in the attitude of men towards women in the community; where individuals continue to compete for influence and control over others, whereby having experience within

the domains of male physical fitness places an individual at a greater advantage over his peers.

Similar to first-generation men, second-generation male participants held expectations for women's physical and moral appearance. Such values were evident in the themes 'roles of community members' and 'female appearance'. Placing women in an inferior position to men in the community is a characteristic of migrant communities with limited social and financial resources (Wrigley and Dreby 2008; 271; Garcia-Ramirez *et al*, 2013: 189). Such concepts were evident in men's accounts, where women were expected to exercise in their homes, dress modestly (to preserve cultural values), while men should be able to socialise outside of the familial 'cocoon'. Power is often unequally distributed between men and women in the household as men are often perceived to be the main breadwinners (Boudet *et al*, 2013; 1-3). Second-generation participants expected women to focus on their appearance by looking attractive, yet covering themselves up modestly, thus exhibiting the potential to be a domesticated and culturally disciplined wife.

5.3.1.5 Moral panic

Participants commented on racist behaviour, incidences of violence and a heightened sense of awareness regarding potential crime or physical threats in the environment. These concepts relate to a sense of 'moral panic' about a perceived increase in violence when actual crime rates have decreased since post-war migration during the 1970-80s, but Black community members were used as 'scapegoats' (Baker, Anderson and Dorn, 1993: 163). Moral panic can also emerge when individuals deviate from cultural norms. The deviation is viewed as a 'threat' by influential members of society as it conflicts with their interests (Lynch, 2004; 183). By creating hysteria amidst community members, men can create an atmosphere of

perceived risk, where women may be perceived physically and morally weaker and need men to defend them. Also, such behaviour creates a hierarchical structure in the community, where greater agency is given to men for how women should behave.

Phillips (2004) commented on British Muslims and ethnic segregation and stated that withdrawing from wider community interactions may create ethnic-divisions in the community. Yet, by being in close proximity to similar others, participants felt they were constantly judged for following culturally acceptable behaviours, or therein the lack of. As members of the Pakistani community tend to live in ethnically clustered areas with a high concentration of ethnic minorities and polarised enclaves, there is a greater tendency for conflicts to arise (Johnston, Forrest and Poulsen, 2002; Webster, 2003).

‘Ghettoization’/Segregation are a further adverse effect of living amongst communities with limited social capital and exposure to wider community settings (Lan, 2011). Noticeably, second-generation migrants with greater exposure to alternative lifestyles and behaviours have a better understanding of how living in ethnic enclaves or microcosms affect the behaviours of community members.

5.3.2 Microcosm

Microcosms can be areas of high ethnic-density defined by one group’s socio-cultural norms (Brown and Mussell, 1984). There is greater pressure in Pakistani areas to uphold traditional values and behaviours, especially in close proximity to community members from a similar background. Thomson and Crul (2007) comment on the challenges to integration for Muslims in the UK, where the Muslim identity plays a significant role despite ‘socio-economic indicators (such as a good education and job prospects) suggesting that particular individuals are integrated’. Furthermore, regular visits to Pakistan amongst community members can be overlooked and have a significant influence on British Pakistanis’ identity and behaviours.

Intercontinental marriages and regular visits to Pakistan are viewed as mechanisms for protecting Pakistani youth from being overly influenced by Western ideals, to strengthen ties with their kinship, and even for health-related visits (Bolagnani, 2013). Community members maintain a strong sense of identity across all generations where they feel the need to protect their socio-cultural beliefs from exposure to other, at times, Western values.

A detrimental effect of competition between community members due to limited trust emerged from the analysis. There is context of fear, where community members feel restrained by assumed common attitudes about practices. Participants commented on factors such as jealousy and hearsay that limited their interaction with members of their own community. Bachkaniwala, Wright and Ram (2001) highlighted issues surrounding communication, rivalry and failure to accommodate different opinions in family businesses that affect the success of such ventures. Furthermore, Tyler (2011) explored class distinction in contemporary Britain and found discrepancies between individuals who classed themselves differently in terms of respectability, social ambition and mobility that create jealousy and trust issues. The aforementioned studies differ from the findings, as they did not explore the effects of such issues on the formation and maintenance of relationships. Although literature highlights the need to improve healthcare support for individuals managing illness and disease (alongside the importance of familial support), there is limited information on the potential to develop strong communal bonds to supplement familial resources (of support and information) (Astin, Atkin and Darr, 2007). For example, despite access to wider social networks in the community, the majority of the Pakistani men relied on members of their family to support (where applicable) the pursuit of a healthy lifestyle, or the management of illness or disease, and provide information on health behaviours (diet and exercise). Consequently, participants had limited access to information and support as they were reluctant to approach individuals outside of their immediate social circle.

5.3.2.1 Asian spaces and languages

The local area provided community members with three key sources of support and information. These are the gym, the *Mosque*, and the GP surgery. At times the aforementioned social spaces were designated a role to meet the needs of specific sub-groups in the community.

Male community members had a unique identity based on where they lived, as they were influenced by the socio-cultural beliefs of their neighbours, school friends and peers. A sense of unity was used to protect community members from perceived racial discrimination in educational institutions or professional organisations. Some Pakistani men have shown to have interests in establishing Muslim organisations which aid welfare needs. Similarly, Werbner (2006) has commented on the conflicted diaspora within the Muslim ‘public sphere’ that is dominated by male community leaders, suppressing the pluralistic sub-identities of younger men, and in particular women. As older men in the community feel a sense of responsibility to maintain traditional cultural and religious values within their homes and community, this results in a cultural-based conflict amongst first-generation men and second-generation youth who prioritise different values (Giguère, Lalonde and Lou, 2010). Second-generation men are reluctant to vocalise their opinions on how the community should socialise based on caste or religious sects, as different opinions regarding the classification of community members could result in them being ostracised from the already limited support network.

Men in the community relied on the caste system and religious sects to identify and interpret different people living in the local area. The findings could add to existing literature on the effects of the caste system on consanguinity, where marriage and even employment is affected by an individual’s caste; a reflection of placing family interests before personal

preferences (Waughray, 2009; Dale and Ahmed, 2011). The research shows that caste and religion play an important role in how individuals socialise within the constraints of their own community, but provides insufficient information for why second and third-generation community members continue to harbour such inclinations.

The *Mosque* presented itself as the ideal location for older men to congregate, particularly on Friday prayer ceremonies, and to socialise with members of their own community. Younger men felt the *Mosque* was unaccommodating to their needs, which was reflected in the lack of effort made to advertise events or pass on information in English. The *Mosque* is viewed as an ideal location for promoting social support and development, which members of the community feel is being overlooked. Gale (2004) denotes the increased number of *Mosques* in the UK as an architectural representation of community space and identity, rather than a focus on function. Furthermore, Elahi (2014) noted the potential for *Mosques* to promote health messages and effectively target Muslims via *Mosque* leaders. Other South Asian places of worship, such as the *Gurdwara* (Sikh place of worship) or the *Mandir* (Hindu temple), have demonstrated their ability to incorporate social services into their infrastructure and effectively support members of the community (Peach and Gale, 2003; Koehn *et al*, 2014). The *Mosque* can be utilised for multiple purposes and satisfy the requirements of a diverse community, yet it continues to insufficiently support local social and/or health initiatives.

The gym, community spaces and the *Mosque* have been noted by participants for creating environments that appealed to specific sub-populations. For example, fast-food restaurants particularly catered to local inhabitants, the *Mosque* advertised events in non-English languages, and the gym appears to be a male only arena.

Multilingualism can be an indicator of superdiversity in large urban spaces where ideologies of language are historically embedded and used to associate cultural and social identities (Myrvold and Jacobsen, 2013; 194). Participants commented on the integration of Arabic and Eastern influences in the community, as Pakistan and Saudi Arabia were common holiday destinations. Therefore, developing an understanding of the languages, accents and styles used (e.g. ‘meatheads’) can reveal material, social and environmental effects and views when using such language (Blommaert and Backus, 2013; 60-61). A complex use of languages can imply a cultural shift within ethnic spaces, as languages and dialects overlap to form new forms of verbal and non-verbal communication. In relation to the findings, there is potential to recognise how religion and gender play a role with language for distinguishing access to certain social spaces.

There is potential to develop existing social spaces to meet community members needs and reflect local aspirations. Across all generations, men felt that the *Mosque* had the greatest potential to become a social hub that addressed community issues surrounding crime, support for youth, and the negative impact of external and internal social factors on health. *Mosques* have been used to host temporary ‘health fairs’ to raise promotion of illnesses such as CVD (Ghouri, 2005). Whether *Mosques* can facilitate permanent social and healthcare services is something that requires further development and community support.

5.4 SUMMARY

Throughout this chapter five categories have been presented, as well as the underlying themes related to perceived levels of social capital (support and information) available for cardiovascular disease prevention for men in the Pakistani community. Participants expressed a number of views on how lifestyle choices are formed and maintained within the jurisdiction of cultural and religious belief systems within the Pakistani community.

There were generational differences in the manner in which participants determined the allocation of social and monetary resources, and at times where health goals were viewed as a luxury, not a necessity. Notably, many of these views were influenced by the formation of traditional or ‘Westernised’ identities, drawing on a range of socio-cultural beliefs and traditions.

In this chapter, participants illustrated views on managing social resources for men and women based on a patriarchal system. Men with a traditionally masculine physique demonstrated their ability to acquire social, information-based, and monetary resources that open pathways to leadership in the community and home. Women in particular were persuaded to seek male approval before adopting, at times, non-traditional diets or exercise. There is a gradual shift in the management of community resources towards local health promotion, better utilisation of existing community spaces such as the *Mosque*, and efforts to unite different castes, religions and sects within areas of high Pakistani density.

The following chapter will provide insight into the five major categories and underlying themes from the perspective of women in the Pakistani community. Subsequently, findings for men and women will be discussed in an overall discussion including reflections on the research, implications of the findings, limitations, and recommendations for policy and research.

CHAPTER 6

6.0 FINDINGS SECTION B: WOMEN'S LIBERTY TO PURSUE THEIR OWN LIFESTYLE

6.1 INTRODUCTION

I will outline and discuss the views and experiences of Pakistani women in relation to their community, health resources, education, well-being, and identity as factors influencing the prevention of cardiovascular disease. I will continue to use gender as a typological stance supported by characteristics such as age and generation. The aim of this chapter is to address the research questions outlined in the methods chapter.

A categorical summary will be provided with an outline of each encompassing theme. Each theme will then be presented with quotes to illustrate interpretations. The themes will explore experiences surrounding influence and access to social resources for women in the Pakistani community in greater detail. The chapter will end with a discussion on the findings specific to female participants, by relating to existing literature and highlighting areas that may not have been previously explored. This will be followed by a summary of chapter findings.

Table 20 outlines characteristics of female participants.

Table 20. Characteristics of female participants

Generation	Participant	Age	Occupation	Locality
First (n = 13) (Born in the subcontinent migrated directly/indirectly to the UK)	0037	23	Professional	Yardley
	0041	38	Professional	Perry Barr
	0042	52	Professional	Edgbaston
	0048	26	Professional	Yardley
	0022	39	Manual	Springfield
	0025	46	Manual	Springfield
	0026	40	Manual	Springfield
	0060	29	Manual	Washwood Heath
	0017	35	Housewife	Springfield
	0018	49	Housewife	Hall Green
	0019	46	Housewife	Hall Green
	0031	42	Housewife	Springfield
	0050	21	Student	Yardley
Second (n = 7) (Born in the UK or received formal education from the age of 5)	0024	28	Professional	Hodge Hill
	0035	24	Professional	Bordesley Green
	0021	34	Housewife	Springfield
	0030	37	Housewife	Hall Green
	0049	19	Student	Smethwick
	0055	20	Student	Handsworth Wood
	0056	20	Student	Aston (Ladywood)
Third (n = 2) (Born in the UK and at least one parent from the second-generation)	0058	25	Professional	Bordesely Green
	0053	19	Student	Soho (Ladywood)

6.2 CATEGORIES AND THEMES

6.2.1 Competition for resources

Competition for local social and monetary resources emerged as a category from analysis and interpretation of participants' interviews. Female participants focused on their position within their social networks, where education and occupational status could be advantageous (Table 21).

Table 21. Overview of category: competition for resources

Overview
<ul style="list-style-type: none">• Participants recognised themselves in positions of limited influence within their families or homes.• For many women, their appearance played an important role in securing social approval, especially from family members.• Despite an apparent shared goal amongst women to lose weight and appear physically attractive, there was minimal discussion about diet or exercise.• Any attempts to discuss weight or appearance could be misinterpreted as an indirect, negative remark about an individual's physical identity.• Furthermore, social interactions seem to be a product of feelings of jealousy and rivalry amongst female community members who strive to look more physically attractive than each other.• Some participants struggled for social support within their homes or public spaces to pursue an ideal physique.
Generational differences
<ul style="list-style-type: none">• In particular, first-generation women exhibited limited social interaction, restricted within the boundaries of their homes and communities.• Older, migrant women interacted with few acquaintances whilst conversing on topics such as fashion and cooking. The majority of the healthcare information was accessed via the GP, who is viewed as a reliable and unbiased resource. Some participants used alternative sources of information, such as the Internet.• Social restrictions also emerged for younger participants, who were careful about whom they interacted with in case they were overstepping cultural restrictions.• Second-generation women appeared to be limited by opportunities to discuss health practices with each other, in case they offended friends who may be sensitive about their weight or other health issues.

Lifestyle choices

- Women who pursue a healthier lifestyle might be criticised by members of the community for prioritising their own well-being over their role as caretakers.
- There can also be stigma attached to women who try to look young and healthy, whereas most women are expected to focus on traditional roles.
- Although physical appearance may play a pivotal role in the formation of social resources, many women are limited to the information passed down by older generation men and women.
- Additionally, the pressure to look slim, healthy and physically attractive might place women in rivalry with each other, which could further limit any social exchange of healthcare information.

6.2.1.1 Position and power

A woman's position in the home and community may be greatly influenced by family dynamics and patriarchy. Men influence the majority of the decisions regarding diet, exercise and socialising, and women can struggle to compete for resources. Female members of the community seem to be given greater respect and responsibility with older age, as they become respected elders within the community. However, mothers may still be expected to prioritise their children's upbringing rather than their own health.

First-generation women can be overlooked for their efforts to lose weight and can be criticised by their peers. Any influence they may have over personal health or the health of others, is consequently limited. The following excerpt is from a participant who has made a comparison between herself and other women in the community. However, as a mother, she may not expect herself to be as healthy in comparison to younger women.

“‘How the hell do you look so good?’ But then I think back and think ok I have had four kids and maybe that’s why, when I wasn’t married I was like that as well so its ok so you pick yourself up but for a moment you can be like that”

(0021, female, 31, first-generation, housewife, Sparkhill)

Some participants considered it offensive to discuss dietary habits amongst friends, especially as Pakistani women can be conscious about their weight. Issues surrounding diet, exercise and health could be viewed as a criticism of someone’s lifestyle choices.

“ So I think with the girls, yeah girls of course want nice figures and stuff but in social networks you do say yeah, ‘I wanna eat good food’, you’re like yeah, you support, don’t turn around tell someone ‘I think you need to change your lifestyle’, ‘cos it’s a very touchy topic”

(0037, female, 23, first-generation, professional, Yardley Wood)

Some second-generation women said they are willing to accept their parents’ dietary choices in order to avoid conflict at home. Family members can be offended by individual lifestyle choices if children reject their choice of food. As a result, women felt isolated if they chose to pursue different diets.

“No, I don’t. I’d feel like it would be offensive to be like- they would- silence is gratitude. To be like, ‘Okay, you don’t want the food.’ Humbly take my portions of it or whatever. Anything- preferences that I have, that is what I buy myself or should be responsible for buying myself, if they’re- whatever they're getting isn’t good enough.

Again, it would be offensive to not eat what they buy, because then it's like, 'Well, what's wrong with what I bought you?'"

(0035, female, 24, professional, second-generation, Bordesley Green)

Women acknowledged the amount of time and effort they spend considering other people's opinions before forming their decisions that could stem from a fear of being ostracised and losing existing support. Often, women must draw on themselves for motivation to change their lifestyle.

"If we do this then what will people think? It is because those people have a lot of pressure on them, they want to do lots of things for their health but they have some restrictions and no one supports them like no one appreciates their efforts so I think there are many ladies who just stay like that, like me once I got it in my mind then I had to make myself strong that I will do this!"

(0022, female, 39, first-generation, housewife, Sparkhill)

There appears to be a paradox, as women seek support for their alternative lifestyle behaviours through confirmation from disapproving community members. However, women receive limited feedback on any improvements they make in their lifestyle, which can result in anxiety and a greater likelihood of discontinuing any new behaviour, as they have not been socially affirmed. Participants can feel insecure about their lifestyle choices and making recommendations. Unless peers take up similar behaviours, participants feel uncertain about their choices and how accepted they are:

“But some say like, ‘ah, you're too picky you just, you know, you're so fussy with your food’, but, I just wanna eat healthy, I just don’t wanna have junk.”

(0053, female, 20, third-generation, student, Handsworth)

Women seldom feel confident enough to be vocal about their lifestyle choices in detail, apart from at the gym. The gym is one place where women can find themselves discussing health topics without feeling self-conscious about their opinions.

“I’ve seen girls in the gym looking and talking and that’s the best place to pick up these kind of things to be honest with you attending one of those looking and thinking, whatever they're thinking in their heads”

(0021, female, 31, first-generation, housewife, Sparkhill)

How women are viewed in the community appears to determine their self-confidence and ability to influence family members and friends. Clearly, appearance plays an important role in determining participants’ social position.

6.2.1.2 Public appearances

Lifestyle choices are influenced by obtaining social approval. An individual’s impression of community members’ views, on both physical appearance and morality, has important social consequences. When women have a socially desirable appearance, they are placed in positions of greater influence and can contend with others for social resources. For example, social approval may provide first-generation women with the motivation to lose weight.

“I think everybody said I looked good. That’s it. And that sort of encourages you in every way”

(0041, female, 35, first-generation, professional, Edgbaston)

The current trend amongst community members (in the sample) is to prioritise physical appearance, which may have negative health consequences. Some professional first-generation women felt frustrated about peers placing greater importance on their appearance rather than their health. The following participant noted the socio-economic success of some families resulted in young women being more fashionable.

“The girls are all...balloon-y. Young, pretty, good skin, and lots of makeup because they’ve really got into grooming, whereas we weren’t into grooming ‘cos we didn’t have the products or the money 30 years ago, or the know-how. These girls are very groomed, threaded eyebrows, lovely lashes, lovely grooming, lots of makeup, not necessarily good skin sometimes really bad skin. A lot of them’ve got, because it’s the bad diet I think as well.”

(0042, female, 52, first-generation, professional, Edgbaston)

Yet, some participants refrain from drawing attention towards themselves in order to avoid shame culture (Thiara and Gill, 2010; 45). Shaming is where community members highlight each other’s physical inadequacies, such as a previously heavier appearance or unexpected weight loss. In the next quote the participant discusses the cultural obstacles she had to consider, challenge, and overcome in order to commit to and implement a process of losing weight, which once achieved was commented on by female members of the community.

However, the context within which this scenario occurred was in a public sphere i.e. a wedding, in front of other members of the community.

“But it’s like ‘Oh, she runs’, like recently I had a friend who messaged me on Facebook in front of everyone, she saw me at a wedding recently and she was like ‘where’s your stomach? You look fantastic’, literally, I walked into the wedding and she held on to my stomach and went ‘where has your stomach gone?’ and I was like ‘Oh, yeah’, and she was like ‘how did you do it?’...she said ‘your face has gone proper like that’ (sucks in cheeks)’ and I said thanks, she said ‘how’d you do it?’ I go ‘it’s not easy, I ran 10k’ and she started laughing and the other girl next to her, and I said ‘no, I really did run 10k before coming to this wedding’, so it’s not easy and she messaged me after that and she said ‘I want to start running’ and I said ‘ok go for it, start doing a race’...then it’s the whole concept of covering whilst you’re running and she said ‘if I want to run, I’ll have to go to a place where no one is going to see’...to be honest I deleted the comment from my Facebook (account) because I’ve got friends who will see that as offensive because if you’re going to run, because I would never say to a Muslim girl its Islamic to run ’cos when I used to run I used to cover, I would wear a cap because of the sweat and stuff but it’s hard for me to say to a girl that wears a hijab that go running because it’s not, I can’t take that sin off you”

(0024, female, 28, second-generation, professional, Washwood heath)

Members of the same community can be very critical of one another, especially when making comparisons about appearance, weight gain or loss. Women can even experience scrutiny over their behaviour and appearance at the gym. First-generation women noted how their daughters felt critiqued by the other South Asian women.

“They look. They don’t go to an Asian gym. They go to a White one, or a gym in a White area where there aren’t many Asians going, they go there because it’s firstly, all the women you know. They (daughters) don’t say ‘why are they staring? Why are they looking like this?’ They don’t like it, so they want to go somewhere where no one knows them, so they go there.”

(0031, female, 42, housewife, first-generation, Sparkhill)

Unlike first-generation migrants, some second-generation women have greater exposure to diverse social networks (through work and higher education). Nonetheless, women remain aware of their physical appearance in social and professional settings. The community places an emphasis on young women having petite and feminine physiques, which diverts attention away from educational or occupational achievements. Mothers can become competitive over the eligibility of their daughters by comparing their physical attributes in the context of finding suitable marriage partners.

A focus on appearance may be a reflection of women’s position in Pakistani society, where their role is not to contribute financially towards the household income, but to attain social approval for culturally appropriate etiquette and feminine beauty (Kabeer, 2002: 251-258; Ahmar, 2013: 73).

“It’s just I kind of know because being Pakistani and being part of that culture they have this set image of this pretty, good-looking perfect girl who has to have that height, who has to have that colour, that attitude and that size you know, like, let me give you an example, someone I know they were talking about how amazing this girl is, and explaining her education, like my mum would talk about me and how good I

am in what I've achieved in life, in the sense like my education, work wise and different things that I've tried, whereas there is another lady who was talking good about her daughter, from a Pakistani background, her good things, she was highlighting the fact that how pretty she is, she's got straight brown hair she is really fair, has blue eyes and weight 47 kilos, so, yeah that's the difference kind of thing and that's what I've seen from the Pakistani culture or the Asian culture and the image like to be a certain person you have to have all the things"

(0048, female, 26, first-generation, professional, Yardley Wood)

Subsequently, some second-generation women struggled to influence members of their community who ignore their advice or don't take their suggestions seriously. It can be easier to influence women from the same age or generation group.

"I think I'm a good influence. And health-wise, diet-wise I try and encourage my friends to eat healthier. I'll be like 'oh, you don't want that, it's got this and that'. I've tried telling her you know, you should go to the gym, you should join the gym with me. I've made an influence obviously on one of my friends who's joined with me. I like to think that I have a good influence on people. Encourage them to do good instead of 'eat this, eat that'. And other ways as well, like 'don't do this, don't do that', it's not...do you know what I mean? But it's like we support each other, me and my friends, I'd say"

(0055, female, 20, third-generation, student, Handsworth)

6.2.1.3 Priorities: Health vs. Financial prosperity

The health of female community members is linked to their financial status, where the latter is prioritised in order to compete with rivals in the community. Participants highlighted the

need to make socio-economic progress in order to move out of traditional communities, with intimate social circles bound by rigid socio-cultural guidelines.

Living within inward-looking communities creates limited room for social development beyond one's immediate social groups. A narrow social group increases competition amongst community members to use available social or economic resources for their personal growth.

“Come along, yeh and everyone no matter how good friends or family doesn't matter how good at some point you have to do your individual things and everyone has to move away from there, otherwise you will always be caught up in that circle and you never, and they'll be the first people to move out of that circle and they'll just leave you in there and you will just be moving round and around so the best thing is that at some point everyone has to do their own thing, so that's the best thing, so the quicker you move away the better”

(0021, female, 31, first-generation, housewife, Sparkhill)

However, the desire to make financial gains can conflict with women's responsibilities towards their families. First-generation women are under pressure to maintain high domestic standards at home.

“Yes, that the food should be good. If the food isn't good and that if there is even a slight difference in the taste of the food then ‘what is this? That you have made?’”

(0031, female, 42, first-generation, housewife, Sparkhill)

Consequently, women in the community are reluctant to take steps towards change and are waiting for others to set an example. These socio-cultural restrictions can result in women relating to others in a similar position with whom they make small lifestyle changes.

“Oh, I mean I haven’t been. I mean, how can I say this...like there is a gate and its closed, it is shut and once you open it and get out then that’s it, then everyone will follow through and not enough people go, like we don’t go swimming a lot or to the gym. We just go to the park and if we bring a machine home then that’s a separate thing and yes, we look less after ourselves”

(0019, female, 46, first-generation, housewife, Sparkhill)

A lack of community support is further reflected in the perceptions of some first-generation women. It can be impractical to spend money and time on health products if there are limited social benefits.

“You just listen to it and you don’t act upon it and I have never acted upon it to be honest with you and most of its just money and you have to spend money to buy products and use them and it’s just a waste of money so what’s the point?”

(0021, female, 31, first-generation, housewife, Sparkhill)

Second-generation women wish to invest their finances for better health though their lifestyle choices continue to be influenced by the community values regarding women’s appearance and beauty. A focus on physical appearance can be demotivating and inhibit discussion on health and well-being.

“Yeah, or they say ‘I knew this person who was big as you’ and you think ‘I’m not big!’ ‘Oh, they were bigger than you, but half your size now’ and you think, ‘I’m fat? I’m not fat!’ I think talking to someone from an Asian background, or talking to someone because I’m an Asian, that’s going to be the people I talk to, as soon as you talk about your diet or you want to watch what you want to eat automatically think you want to lose weight and you think oh forget that! Let’s not talk about it!”

(0048, female, 26, first-generation, professional, Yardley Wood)

Some women highlighted the circumstance in which people from the first-generation, including their parents, prioritised educational, monetary and materialistic gains over health benefits. They identified this as having potentially detrimental effects on the pursuit of health goals:

“Asian parents don’t encourage some kids, like, ‘oh, go for a run, go for this’ it’s like, ‘what you playing sports for? You should be concentrating on doing this, become a lawyer, become a doctor, become...’ you know? All the stereotypical views, like become this become that. And I think it’s in their...they don’t say to the kids ‘go out, go do sports, go do active’ like my brothers, they play football. Even my little brother’s ten years old, he’s part of football club. So from day one he’s been told go out and...‘Cos my dad used to play cricket...”

(0055, female, 20, third-generation, student, Handsworth)

Older members of the community seem to have different priorities. First-generation migrants appeared to follow popular trends in the community, especially when competing with their

neighbours on materialistic gains. Families would be less concerned with healthy lifestyles, but rather concentrate on financial achievements.

“If someone has to say something then it’s good otherwise, stay quiet and don’t do it in front of them. The uneducated people, don’t do it in front of them as they will pick it up quickly these things, that he did it, he got a big TV so meaning the money he has for something important in his house he will go and copying the other person she will spend all that money, not thinking they have to pay the kids fees or get something for the kids or something, no, the person next door has a TV so they have to get a bigger TV as well”

(0060, female, 29, first-generation, manual worker, Alum Rock)

Younger third-generation women had a stronger personal identity which at times enabled them to justify their lifestyle choices. Women had to maintain a strong sense of self-awareness in terms of their behaviour in relation to the wider community norms.

“To be honest I don’t, I’m not a person that will do it (follow community norms) because everyone else is doing it. Like, I don’t know I’m just a weird person, I’m really weird”

(0053, female, 19, third-generation, student, Smethwick)

Volunteering in charitable organisations provides a suitable platform for women from all generations to socialise. Community members viewed volunteering for Islamic charities as a positive use of time. However, these fundraising activities centred on selling food items rather than campaigning through sporting events.

“I think they won’t be very open to that idea of like, a race, or if it is they’ll just probably be guys. Yeah, I think they’re more of like; let’s throw a party and raise money, bake cakes and make money. It is different. They’re not very...or even, like, a football match, I don’t think they’d be down to do it. They probably wouldn’t, they probably wouldn’t get, that many volunteers as well. Like, you know, like party at this place, tickets for this, this much pounds.”

(0050, female, 21, first-generation, student, Yardley)

Women’s use of financial resources, particularly for the pursuit of personal health, is conflicted by many socio-cultural trends and norms. In the aforementioned text, women have highlighted their struggle to redirect capital towards health investment.

6.2.1.4 Trustworthy people

Trust is a major underlying component for developing and maintaining relationships within the Pakistani community. Women across all generations were protective of their social status, and anxious about offending community members or being judged by them. Consequently, women kept their social circles small, with close friends and immediate family members.

“I tend to get along with people like trust- like with the term trust it depends. Like, I wouldn’t go and tell them my whole life story and expect them to be faithful to me but, just making that, that secure bond, that okay, I’m not going to kill you or anything. I’m just being friendly.”

(0049, female, 19, second -generation, student, Smethwick)

Women are careful about whom they build a relationship with and whom they can trust.

Some women felt they cannot rely on how individuals chose to present themselves, as social interactions can contain hidden meanings.

“Bad friends get jealous, you don’t realise what you are saying to someone at what time and you don’t know what their nature is like”

(0018, female, 49, first-generation, housewife, Sparkhill)

There is a degree of paranoia surrounding jealous community members who may try to jeopardise social or socio-economic development. Women were aware of how community members closely observe each other’s behaviours for any sudden or unacceptable changes.

“All we do is spy into each other’s homes to see what is happening and that’s it, that’s why I say Pakistanis otherwise, I have no other reason, we are proud to be Pakistani but there is jealousy amongst us”

(0018, female, 49, first-generation, housewife, Sparkhill)

A lack of trust developed as a result of unreliable information being passed on between community members, which led to community members verifying health information they received from anyone in their social groups before applying it. There was greater suspicion surrounding new social connections.

“You think are you sure it (weight loss information) worked for you or are you just giving me the wrong advice?”

(0021, female, 31, first-generation, housewife, Sparkhill)

Some second-generation women feel health issues are too private or outside of the socio-cultural norm to be discussed within the home. The following participant in particular felt reluctant to discuss going to the gym with her family. The stigma attached to an independent healthy lifestyle was comparable to smoking (cultural taboo).

“I wouldn’t feel comfortable- like at home, because it was, like I was saying, I wouldn’t trust telling them that I go to the gym or that I smoke because of all the other connotations around it. But with food I’d be comfortable sharing that with my family. Then anyone other than family, close, immediate or extended, I wouldn’t tell them about going to the gym or exercising, but I’d tell everything to everyone else. So to friends I wouldn’t mind sharing food habits, eating habits, dieting, exercising, all that. Everything I would talk about with everyone else, it’s just family that there’s kind of restrictions there.”

(0035, female, 24, second-generation, professional, Bordesley Green)

Second-generation women feel they have better confidentiality amongst their peers at work who will not judge them according to Pakistani norms. The reluctance to discuss health with other Pakistani women might limit awareness of health problems.

“How trust is built? Well, I think with professions, the trust i.e. built ‘cos of the security that you have in England. Whatever you speak to them is gonna stay between you, and if it does come out the job is at risk. So I think that way is good trust, for the people. I think with your friends and your families, the trust, how is it built? I think it’s when you... when you see, I dunno how trust is built. I think for me it’s like, yeah, you’ll be seeing someone and you see how you’re like, how they’re like. I’m

very big on feelings, like if my heart is content with someone, like yeah, you could get a feeling. And it sounds so bizarre, but I think that's how it is. Trust is built. Like if I, you can, I think, as you grow up, you're able to judge someone's character, you get a feeling, how someone's like. So I think that how it is, and you just... I actually never thought about it, how trust is built, but yeah."

(0037, female, 23, first-generation, professional. Yardley Wood)

For some women, the pressure to find people they can trust is beyond their control or tolerance, and they prefer to disengage from socialising. The following participant thought people with insecurities are attention seeking by constantly talking about themselves.

"Trust? I'm one of those people the more you talk about it, the less, the shallower it gets and an empty box makes a loud noise, that's how I build it, if someone gets me, if someone is, I unconsciously, if I care for someone or if I like someone, I automatically have this bond with them, I don't have to keep on reminding them, I don't have to keep doing stuff to them to build their trust, if they know it they know it, if they don't then it's their take and I just accept it and take it like that, I have never gone around and talked or discussed or shown how trust should be or I trust you or you can tell me, I trust you or I'm telling you because I trust you, I have never done that"

(0048, female, 23, first-generation, professional, Yardley Wood)

The manner in which women in the Pakistani community form or expand their social network is influenced by numerous factors, such as appearance and the ability to trust each other.

Where there is a lack of trust, women have expressed their reluctance to discuss health or

lifestyle choices, thus limiting their access to information and support from within their community and families.

6.2.2 Socio-economic success

Work and education appeared to provide first and second-generation women with the opportunity to expand their social networks and access novel sources of support and information outside of their own community. Resources can include support through discussion and recommendation of alternative and complementary medicines (Table 22).

Economic success as a category will be discussed in greater detail in the forthcoming major themes, including socio-economic status gradient, traditional culture and socio-economic status, and exposure through education. These themes will elaborate issues surrounding managing familial responsibilities with work, and socio-cultural trends surrounding home and work life balance.

Table 22. Overview of category: socio-economic success

Overview
<ul style="list-style-type: none"> • Despite access to different sources of support and information, women tried to maintain lifestyle changes within the domains of socio-cultural and religious boundaries. • Family members can be unfamiliar with norms outside of their own community, which places restriction on women’s ability to express themselves within their homes. • Participants highlighted the detrimental effects of strict socio-cultural norms on emotional well-being. An individual’s emotional state appears greatly influenced by cultural perceptions of women’s role within the home.
Generational differences
<ul style="list-style-type: none"> • Younger women encounter a range of people from diverse socio-economic backgrounds and have access to better resources i.e. hobbies, diet and clothing. However, women are aware of the socio-economic differences within and outside of the community that can influence behaviour. • Women in professional occupations have access to a wider array of lifestyle choices, which they encourage family members to adopt. • Negative health consequences are often associated with a South Asian diet and lifestyle that women from a younger generation want to prevent. • Older female participants relied on family members to provide financial and social support, as they have been dutiful and completed responsibilities at home. Yet, staying at home seems to limit the resources available for women to look after their physical or emotional well-being.

6.2.2.1 A socio-economic status gradient: from migrant to manager

A growing number of women in the Pakistani community are pursuing professional careers or manual work to supplement their family’s income. There are associated lifestyle changes for younger women who work in corporate or professional settings. Some women struggle to manage these lifestyle changes within their family’s cultural and religious boundaries.

Developing a healthier lifestyle, which incorporates regular exercise, requires determination and strength especially in a community that has a dining out culture.

“Right, so it’s quite contradictory because I eat (out) a lot but it’s a hobby for me, but the younger generation and the older generation have took it in different ways, a lot of girls are like ‘yeah, I want to do it too because you look fit’, because you do look good after you do it, but they don’t understand the hard work and the effort that goes in to it so they give up, it’s a commitment”

(0024, female, 28, second-generation, professional, Washwood heath)

Trying to balance familial obligations alongside work can be problematic for women. As more women work, there appears to be cultural shift taking place within families with women managing several responsibilities.

“When it comes to the husband’s, it’s not the same story. They expect you to do all that and it’s... relationships are not relationships and what you see in the community is like, men want their women to go out and earn and then what they want them to do is pay half of their mortgages and bills and everything and you see some marriages- what is it? You see that in people, ‘Oh, I’ve got to do the...’ the women go, they expect to work, keep their living, look after their children, but what does a man do? He just goes out, does his work, comes home, puts up his feet.”

(0041, female, 35, first-generation, professional, Edgbaston)

Cultural norms are challenged in families where both men and women pursue professional employment opportunities. It can be difficult to negotiate women’s role within the home

alongside their role at work. Shifting gender roles can result in disapproval and conflict between families.

“It was forced. Against our other relations. We still hear from our other relations ‘don’t you think you’ve got enough money to make your mum stop working’, ‘why does your mum have to keep working?’”

(0042, female, 52, first-generation, professional, Edgbaston)

Women are taught about their roles as homemakers at an early age, and this is rarely challenged as they become older. Traditional roles can limit women’s independence and ability to progress beyond gender based restrictions.

“What your father’s like will have an impact on the son or what your mother’s like will have an impact on the daughter. If they bring you up like I was brought up, not with the dolls but doing other things- DIY, this, that, etc....so we do that. But if you’re mother’s brought you up playing with the dolls, playing house, playing etc....they-it’s completely- it’s showing you your duties, isn’t it?”

(0041, female, 35, first-generation, professional, Edgbaston)

The classic view of women relying on each other for support and information is beginning to be challenged. A sedentary lifestyle and need to retire in middle age can place pressure on daughters and daughter-in-laws to provide extra care at home.

“So now they’ve got daughter-in-laws and so they don’t do any work at all now!”

(0042, female, 52, first-generation, professional, Edgbaston)

An inactive lifestyle is typically associated with first-generation migrant women, and younger members of the female community want to avoid it. Younger women had raised concerns for health problems that are associated with the South Asian community, where a lack of knowledge on disease causation persists.

“I don’t want that to happen to me, I want to be the exception, so yeah media, my best friend and also like I said, my mums got diabetes and I don’t, ‘cos diabetes has got a lot to do with your diet isn’t it? And I don’t want to end up like that because I can see what that’s doing to her and I don’t want that”

(0055, female, 20, third-generation, student, Handsworth)

First-generation women with more traditional views believe young Pakistanis are not investing their finances sensibly. Second-generation women’s apparent empowerment is evidenced by social behaviours. Young women are more likely to spend money on social pursuits, such as going to *Shisha* lounges, showing a changing spectrum of what is acceptable or not. The *Shisha* culture is associated with social pressures and trends, but women also highlight the potential risk of this hobby. Smoking *Shisha* is a leisure activity for young male and female Pakistanis, nevertheless, the following participant outlined the growing health concerns.

“A lot of my friends smoke *Shisha* and I smoked *Shisha* for quite a long time, I was an addict, not the point that I was dying, but I would smoke it every day, but recently for the past 8 months I’ve stopped because of this new thing where I want to be really fit and healthy and I’ve sort of looked up into *Shisha* and its worse than fags, I think 45 minutes is a 100 fags or something really ridiculous like that, so there’s no point if

I'm going to work out and then do that, I was just in the other room and my friends were saying 'are you not smoking' and I was like, 'No way'. So I think I'm strong enough not to be influenced by other people"

(0056, female, 20, second-generation, student, Handsworth)

Furthermore, women expressed a desire for greater education at school and increased community awareness surrounding a variety of culturally contextualised health issues, such as sex education.

"We didn't get it either and I went to a girls school and you'd think we would get it because there's no guys to get it either, it was so awkward it was a 2 minute thing like 'does everyone know about the birds and the bees?' And we don't so, it was really like, we didn't get sexual education, we didn't get health. I know at school you're constantly doing sports but no one tells you that continue it after, you, that you turn into a fat person"

(0056, female, 20, second-generation, student, Handsworth)

Younger women are voicing their health concerns, and in particular their dissatisfaction with community, institutional and personal networks. Higher expectations could be a result of exposure to lifestyle choices and greater awareness of health concerns, which women might want addressed.

6.2.2.2 Traditional culture and socio-economic status

Despite any personal or familial socio-economic success, women are expected to follow cultural practices. For example, first-generation women may be reluctant to change their

existing lifestyles, as it could be a reflection of moving away from community norms. For example, some women in the community have started to go for walks in order to be healthier:

“Well, I am trying to start going for walks and go daily and once or twice a week I do and to reduce my food a lot to lose weight”

(0018, female, 49, first-generation, housewife, Sparkhill)

Where women lack control or influence over monetary capital, they can share information to maintain social ties. As women might not be expected to work or have a steady income, they can socialise using food to demonstrate generosity and hospitality.

“Yeah, on Eid day we get lots of food from everyone, our neighbourhood is based on sharing food; it’s a community and culture of giving”

(0024, female, 28, second-generation, professional, Washwood heath)

However, younger women are making attempts to follow healthier dietary recommendations by replacing some unhealthy foods with healthier alternatives.

“Well I’m sort of doing it now, like I’m sort of cutting junk food out but I do, I have it like now and again. But what I’m thinking is just substituting it, so...instead of chocolate I have nuts ‘cos I like nuts as well. Or just have fruit, ‘cos they’re sweet.”

(0055, female, 20, third-generation, student, Handsworth)

Younger women who are concerned about health may view sharing traditional food as unnecessary. Women associated traditional Pakistani food with obesity and ill health.

“Fat aunties who like to drink tea and eat cake rusks, that’s what they do, samosas and pakoras”

(0024, female, 28, second-generation, professional, Washwood heath)

To prevent obesity or ill health, some women use extreme dieting methods that can be detrimental to health.

Weight loss could be achieved by having different food choices instead of drastically reducing calorie intake.

“I want you to eat; every 3 hours eat something healthy, gym. If you don’t want to go gym, and starve, well then eat healthy things than starve, don’t give up food altogether. If you are leaving roti then have fruit or salad, things that you are getting calories from because your body needs everything like water, good, and if these things. First of all, your skin, and then all this dieting you will faint at work, what’s the use of such dieting? You should look after your health, eat something healthy, instead of eating so many chips and oil cooked things it’s better to eat something healthy that will give you strength”

(0060, female, 29, first-generation, manual worker, Alum Rock)

However, dieting may be the only option for women who are restricted by their families to use the gym or exercise in public.

“The thing with Pakistanis is that they spend a lot of their time within their homes, doing their homework, making food and eating it and they don’t know about anything

else about how to change or improve their life and how to enjoy it, our Pakistani women, these are their conditions and how they live”

(0026, female, 40, first-generation, manual worker, Sparkhill)

Women expressed a lack of support from community members when trying to balance cultural expectations with lifestyle changes. Women expect their communities to provide encouragement through unity, but instead discover divisions.

“Surely, I don’t know, isn’t that to some extent why culture exists? So, that groups of people feel supported and unified in one way or another. To look within your own and not see that-or feel like there are too many variants”

(0035, female, 19, third-generation, student, Smethwick)

One situation, in which community members can be alert to take action about lifestyle change, is when the GP or doctor recommends it.

“I think once you get a reality check, as in go to the doctors and telling you that your diet is really bad, I think that’s when most people would be ‘Okay, I need to take action””

(0049, female, 19, second-generation, student, Smethwick)

The GP can provide a medical justification for changing behaviour which neither culture or tradition can contest. The GP’s opinion may be given greater importance than recommendations from family or friends.

6.2.2.3 *Exposure through education*

As a consequence of going to work and studying for higher-level qualifications, women are exposed to a greater variety of support and information on healthier lifestyles. Personal socio-economic success appears to be linked with more options for lifestyle choices, health practices and social support.

“My friends never said anything but my colleagues they told me and gave me good support that you can do this (lose weight)”

(0022, female, 39, first-generation, housewife, Sparkhill)

The ability to adopt such changes is determined by family members and views of the wider community. For example, first-generation women are concerned about the views of immediate family members, and whether they support their lifestyle choices. The immediate family seems to be dominant in the nature of influence.

“I do what I think suits me and my family. And as my thing has always been- as long as it doesn't upset my immediate family, which is my mum and my brothers, then I'm not really, after that, to my extended family- I'm not really concerned what they think or what they don't think”

(0042, female, 52, first-generation, professional, Edgbaston)

The views of both immediate and extended family members can influence women's behaviour. Potentially critical comments from family members can inhibit individuals from freely expressing their desired behaviours or lifestyle choices.

“Too much, more than necessary, the people who think will think, if you go to your family and they aren’t educated then the way you sit and where you sit, the society isn’t educated and they say things that sting you, irritate you, then you can’t sleep and if you can’t sleep then your health will be disturbed and your whole system will be messed up, so it has a great (effect) I think”

(0060, female, 29, first-generation, manual worker, Alum Rock)

Changes to lifestyle could question the existing traditional and socio-cultural frameworks within which members of the community currently function. Furthermore, there could be repercussion for anyone challenging existing cultural norms. Therefore, some women incorporate small personal changes into their routine, i.e. making different meals to suit everyone or exercising.

“Last year, before this I would just eat and relax in front of the TV but since last year I realised I am over weight and I am getting closer to my 40’s and this will create problems in later life obviously so the thing is I am an educated person but sometimes you get too relaxed but I think a person should, especially in regards to their health have some control. So in my opinion, as a person, I mean food is good but your health so then I started doing exercise and began eating healthier food, plus exercise like walking”

(0022, female, 39, first-generation, housewife, Sparkhill)

Older first-generation women have a greater desire to maintain a lifestyle that respects cultural and religious guidelines. At times, women make comparisons between religious and

health behaviours to justify lifestyle changes, e.g. comparing the discipline required to diet or exercise with the regular, compulsory prayer, *Namaaz*.

“Then it is very difficult to get it back, like reading *Namaaz* if you stop reading for a few days you stop paying attention to what time it is and that whether you need to read or not and this happens, similarly every other routine is a routine. You shouldn't drop it; like we don't drop our homes or uni routines it is for our health so we shouldn't drop that either”

(0018, female, 49, first-generation, unemployed, Sparkhill)

Younger women have diverse networks of friends with whom they can try different diets and exercises. Institutions for further education, e.g. universities, can provide a shared social space within which individuals from different backgrounds can discuss culture, traditions and lifestyles.

“I think it just depends on the occasion and stuff, like obviously in uni I can't, like sometimes we do get a bit, get our friends together, like the ones who are, they're Welsh and they're Geordie and whatever, and we put on our Bhangra routines and they're like, 'ooh, is this what you do?' and I'm like yeah, sure, we move our shoulders –laughs-”

(0050, female, 21, first-generation, student, Yardley)

Younger women are concerned about looking after their emotional well-being, as they recognise the burden of stress from work and families. Issues surrounding mental health are

not always acknowledged within the community, and therefore responsibility is placed on the individual addressing their own needs.

“I think, maybe, if you’re not just talking about physical health, if you’re talking about mental health, in the Pakistani community, mental health isn’t acknowledged, it’s not. It’s not something that’s ever talked about. If you’re depressed, you’d never go to a doctor, or get antidepressants or anything like that, because it’s a problem that doesn’t exist”

(0058, female, 25, second-generation, professional, Bordesely Green)

Mental or physical health issues are not openly discussed with family members or friends, and women look for ways to de-stress and relax away from their families and work, e.g. by exercising at the gym.

“I do a 12 hour shift, I need to go to the gym to get all the c**p out of my head. It’s just to have a break from everything before going out and facing my family, I’ve had some me time, its more, maybe I could put some music on and sit in a room and it could be the same, it is, but I need to go and work out, sweat a little bit and have a shower and it’s like yeah, I’ve had my bit”

(0024, female, 28, second-generation, professional, Washwood heath)

Furthermore, second-generation women are aware of the limited support available for dealing with non-traditional health behaviours and emotional issues. Some women choose to limit socialising and maintain privacy.

“By talking you understand what someone is like, anyway you shouldn’t discuss things in your family but if you have ‘hi’ and ‘hello’ with people then to that limit its ok”

(0031, female, 42, first -generation, housewife, Sparkhill)

Healthcare information from male family members or friends is greatly appreciated, as men are viewed as being more knowledgeable than women in the community. Obtaining permission or approval can be an indication of advocacy, as men are likely to recommend culturally suitable practices for women to practise.

“He actually said two things, I remember two things. He said sleep and diet and the rest is workout. But he goes, the first two things you need to get in order is your diet and your sleep, then, you know then worry about your workout, because the results of your workout depends not on how hard you work out but it depend on how you eat and how you sleep.”

(0049, female, 19, second-generation, student, Smethwick)

Although women have an increased awareness of health and well-being, there are socio-cultural consequences for pursuing non-traditional lifestyles.

6.2.3 Being Pakistani

Many of the Pakistani women interviewed for this study lived in areas with a large Pakistani population. A consequence of living in such areas is the constant debate over global, national and local ethno-religious political agendas surrounding membership to a specific ethnic group (Table 23).

Conflicts between personal and communal identity will be discussed in the following themes in greater detail: microcosms, roles of community members and identity. There will be a particular focus on how members of the Pakistani community distinguish expectations for Pakistani women and women belonging to other communities.

Table 23. Overview of category: being Pakistani

Overview
<ul style="list-style-type: none">• A topical issue for members of the Pakistani community is seeking unity amongst Muslims from different ethnic backgrounds.• Hence, many women have adopted a British Muslim identity rather than Pakistani, and bonding with people from a similar religious background.• Transnational identities are dependent on social spaces, structurally founded on religious beliefs.• It is important for women to form pluralistic identities at home and in the wider community.• Women try to differentiate between behaviours that are acceptable at home or within specific social circles. Such actions stem from the need to censor certain aspects of individual lifestyles.• At times, Pakistani women choose not to disclose aspects of their life if they are uncertain of the public response.• There are certain lifestyle choices that are distinguished as unacceptable by religious clerics; therein, the responsibility lies with family members to set an example for appropriate behaviour. Therefore, women often reflect on the health practices of family members in relation to their own.
Gender differences
<ul style="list-style-type: none">• Male heads of the family, such as fathers, can be criticised by community members for promoting women's education. Men appear to have culturally bound views of women in the community.• Some women acknowledge the greater level of freedom and independence granted to men in the community.• Although second-generation women are given more freedom to pursue their own lifestyle choices, community members still view women who are 'too independent' negatively.• Community members, especially men, continue to maintain a focus on women's physical appearance rather than other characteristics.

6.2.3.1 Microcosm of religion and ethnicity

Members of the Pakistani community tend to live in areas with a large Pakistani or South Asian population. These areas tend to be defined by the traditional and cultural beliefs of the dominant group.

One of the participants expressed a desire to live in a place that was not so strictly defined by one community's religious and cultural norms.

“No, not at all. I do not like Asian areas, I like English areas, it's quiet and peaceful. Here I feel as though I am living in Pakistan, there is a lot of noise and kids are always running around, and saying this, like this and women opening doors and sitting having a chat, doesn't feel like England, feels like I am in Pakistan, people walking around all night, chatting and kids playing around easily”

(0060, female, 29, first-generation, manual worker, Alum Rock)

Feeling dominated by one set of social norms can result in feelings of isolation for individuals who believe they are living in an insular community.

There can be socio-cultural trends that further limit exposure to the wider community setting, for example, through marriage.

“I think it depends where they are. Because if you go to like, Alum Rock, they're very, just about their bubble there and they're not getting that much, you know interaction with other people and stuff, or even other families, especially families which have marriages within people they know. And I think once that happens then

they don't get an opportunity to change, or like, see what's going on in the world around them. So yeah, I think it's about where you are and who you're with"

(0050, female, 21, first-generation, student, Yardley)

Living in areas where the majority of the population is Pakistani or Muslim can also result in a dichotomy between orthodox and secular practices. The religious dichotomy has an effect on how members of the community interact with each other and the type of social connections they form. One participant commented on how difficult it can be to interact with religious community members, as they can be very critical of whether certain behaviours are socio-culturally appropriate, which can also be a reflection of socio-economic differences between community members.

"I think the religion, and then we've got the other part which was the Orthodox part. So we've got one part of the community, that is starting to value going out, how you look, materialistic stuff, and then you've got the other part that's becoming isolated and insular from the rest of the community because it's really gone into the religion. So you've got that two parts of the community. And the one part of the community which has become very orthodox it's even more difficult to talk to them because then you've got these, 'oh, you can't do this, you can't do that'."

(0042, female, 52, first-generation, professional, Edgbaston)

Furthermore, there are differences on a familial level for interpreting socio-cultural norms. Some families are more traditional than others with regard to issues such as marriage, appearance and socialising with the wider community, which can result in fragmented social networks.

“Attitudes to marriage, attitudes to socialising, attitudes to personal fulfilment, to work-life balances. What should matter more? I think there are a lot of things that vary in-between that, and I think that can have an effect as much as anything because there isn’t that sense of unity.”

(0035, female, 24, second-generation, professional, Bordesley Green)

There are sub-cultural differences within the Pakistani community where some families value traditional health and social practices more than others (Din, 2014). Women acknowledged the cultural differences for educating women amongst Mirpuris from Azad Kashmir, in contrast to those from cosmopolitan cities such as Islamabad or Lahore. Certain communities within the Pakistani diaspora ostracised women for being independent (Bowen, 2016):

“Our Mirpuri community is very defamed, we are not educated, we are not anything, that’s it, if their mothers, it’s all about upbringing, about freedom, my father said that the more you tie someone up, the more they will yearn for freedom”

(0060, female, 29, first-generation, manual worker, Alum Rock)

Traditional practices are exercised with greater rigour for women in the community, male fraternity systems are in place to ensure men and women respect the moral and religious development of the community. The following participant discusses how the community looks for differences between members based on caste, and creates boundaries for socialising.

“Our nose would be cut off in the community, the *biradari*-ism that they will be from a different caste, that they are *Chaudhry*, that they are *Rajput*, that they are whatever, so if she marries in to a different *biradari* (fraternity), then our nose will be cut off,

that's the biggest thing that affects our community, it's like rust, it is eating away at us, that caste, marrying outside of the caste, that she will cut our nose off in the *biradari* that other people's women listen to them but ours doesn't"

(0060, female, 29, first-generation, manual worker, Alum Rock)

Traditional systems of belief continue to be practised across multiple generations of the Pakistani community living in England. Participants noted socio-cultural nuances, such as socialising with different communities.

"Because, at the moment, if you think, the majority of people who are from, for example, they came to Pakistan in the 1960's. So they were, maybe, in their 20s-30s, so they were the first-generation. So that would have been people like my grandparents. They would have come to England and they will have known English. And the second-generation were people like my parents, who, either they spent some time in this country, growing up when they were young, or, I dunno, and possibly not born in this country, and then, myself, will be the third-generation? So, I would have been born and brought up here, so obviously that's a massive change, and I've only been to Pakistan once. Some people that, who are, who are third-generation, have probably never been to Pakistan at all"

(0058, female, 25, second-generation, professional, Bordesely Green)

These generational differences translated into views about lifestyle choices such as exercise, where older community members may be reluctant to work out. Projects have been organised in areas of high density in Birmingham to try and promote cultural and generational integration using exercise.

“They just will not exercise. I mean, one of the projects that I recently did last year, was get some money for a project which was a inter-generational project called Lozells, which is trying to get people to walk, but walk, as generations like the grandchildren, parents, parents and children, but also other communities because they didn’t know their neighbours either, a lot of these people, so trying to get a walking route that people did three times a week that they all met at one point in Lozells. So that was a really successful thing and it was led by a walking leader who is one of my teachers, so that she would be the walking leader and she would then pick up the community and she’d go along and they got talking and people share ideas and people get to know neighbours and different communities come together and different generations”

(0042, female, 52, first-generation, professional, Edgbaston)

Community members display concern about in-group and out-group membership. Sub-cultural nuances can limit an individual’s engagement between different groups, as one can be ostracised for displaying non-characteristic behaviour of the group, e.g. different diet. Group membership can change very quickly, and members need to be attentive of lifestyle choices in order to preserve their position within the community.

“People start forming groups then, and you become like without even knowing or without even the knowledge you become the outsider and it can happen, it’s a sad fact of life it can happen you wake up one day and you think, how did that happen? How on earth did that happen? But it can happen. It happened to me in earlier life when I was a bit fuller when I was younger when I was 16-17 and I lost all my weight through starvation which is the worst way but it was then and it can happen, they

think to themselves ‘what are you doing? How have you done it?’ They prefer you bigger for some reason and it gives them confidence”

(0021, female, 31, first-generation, housewife, Sparkhill)

Moving from one area to another limited participants’ ability to socialise with Pakistani sub-groups. The following participant describes her apprehension towards integrating into a tight-knit, established social circle that is embedded within a different neighbourhood. Such behaviour is a defence mechanism of the group, where differences between insider and outsider group norms influence membership:

“We moved here about 3-4 years ago, and because a lot of the people have been living there, they didn’t like, no, not many people like anyone new. Like, you make your friends and someone new comes into the class and it takes them a bit of time to get, so I kept myself to myself through that, then I don’t really interact with anyone down there to be honest with you, my family doesn’t and my both sisters don’t live that far so that’s about the most interaction I do is that’s it”

(0021, female, 31, first-generation, housewife, Sparkhill)

Living in an area with ethnic diversity can have a detrimental effect on residents’ health. There appears to be an increase of fast food consumption in areas of high ethnic diversity and population. The growing number of fast food restaurants concerned women across all generations.

“The shops and fast food that are around. If you’re living a few minutes away from a local chippy then you’re more likely to eat from there quite a lot. You can go there or-

it depends like now there's loads more shops opening and stuff, then more people tend to go. "

(0049, female, 19, second-generation, student, Smethwick)

A large number of fast food restaurants in the local area could decrease the likelihood of individuals making healthier meal choices. The safety of the local area can also influence well-being.

"It's just seen as a bad area. So if it feels like there's a lot of burglaries going on in the area, or there's a lot of drug use or dealings- like at times it feels like that on our street. I think it contributes to sort of bad health because it means that people don't wanna go out as much"

(0035, female, 24, second-generation, professional, Bordesley Green)

Areas that provide limited safety and security for its female residents negatively influence their pursuit of a healthy lifestyle. Some women were reluctant to exercise in public spaces, as they felt it would be disrespectful towards their culture, religion and families.

For some women, thinking about their health is embedded within their perceptions of their community and evokes emotions such as fear of social disapproval regarding the inappropriate use of public spaces for exercise.

"Those girls have started running and they go to Ward End park, an Asian park like at least I still have respect for my culture and I won't do it there, one, because my brothers would say 'what the flip are you doing?' And two, I just wouldn't 'cos I'd

get in to trouble because it's not socially accepted but those girls have actually started running this year, right –laughs-they have!”

(0024, female, 28, second-generation, professional, Washwood heath)

Norms surrounding healthcare are different for men and women living in areas defined by Pakistani customs, and dominated by patriarchal values. Young men receive support from their peers to work out at the gym and pursue masculine physiques; women lack subsequent peer-to-peer ties.

“Of course you get it in those areas, have you noticed you get groups of boys, like my younger brother whose gotten in to body building and the whole group would look like The Rock (wrestler), it's like a conformity thing”

(0024, female, 28, second-generation, professional, Washwood heath)

Yet women found it difficult to find social support and motivation to exercise due to a perceived lack of role models, but they provided little detail and description about the nature of the person from whom they would accept health advice:

“What changes? If someone told me what to change then maybe I would change it, but if no one tells me, if you don't know anything, than how can you change it?”

(0031, female, 42, first-generation, housewife, Sparkhill)

Although professional women have access to support and health information outside of the Pakistani community, they interact with other Muslim groups constructed by shared understanding of religiously influenced social boundaries for women.

“All Pakistani girls. After that it was, they were all different. I think with college, JC (Joseph Chamberlain), they’re...majority of them are Asian, like South Asian, and then, it was like a new-not a new- but there was like a growing community of Somalians and Arabs, and, I found myself hanging out with them because of a friend I made in maths class, through her and then another friend and then it was like this one time that through me that three, four people of like different races just kind of came together”

(0050, female, 21, first-generation, student, Yardley)

6.2.3.2 Roles of community members

Family members expect men and women to behave according to the cultural norms assigned to their gender. Being a Pakistani woman within the existing social structure, there are many expectations. For example, taking on a homemaker role, caring for immediate family members, as well as being respectful of the extended family:

“Yes, especially when, as far as I have seen that in the extended family, what do you call it, the joint family system where you live with your father-in-law and mother-in-law and your relatives, then brothers and sisters, there are a lot of responsibilities to look after the house and there is a bit of, you can’t go certain (places), these things, even though they are not bad, I don’t know why they are not encouraged to do this”

(0022, female, 39, first-generation, housewife, Sparkhill)

Women belonging to the Mirpuri-Pakistani community discussed restrictions surrounding education and work opportunities. Young women appear to be concerned about being taken to Pakistan and being married to relatives, so that more family members can move overseas. In these circumstances, women are encouraged to work, so they can provide for their migrant husbands. Some female community members function within transnational family support networks, which restrict their professional and personal development.

“They will take her to Pakistan and get her married off to some illiterate person and he will come and what life will he have? And to bring him over, these people, look at their mentality, to call over her husband, he (father) will send her out for work but not for her education, they have to call over their son-in-laws from Pakistan then they will send their daughters to work, no matter what they have to do so they can get pay-slips and make them and get them from Pakistan. Teach her as well so that from her the next generation can study as well, if your parents are educated then.”

(0060, female, 29, first-generation, manual worker, Alum Rock)

Women may not receive support within their homes to pursue education or employment for personal interests, but rather to serve some purpose for their families. One of the unique situations in which first-generation women have access to external support is for advice from women who are suffering a similar illness:

“It is reassuring that someone else has it (hyperactive thyroid) not just me and beforehand I had never heard of the illness”

(0018, female, 49, first-generation, housewife, Sparkhill)

Second-generation women are aware of what men expect from their prospective wives, based on physical appearance and duties towards the home. The next excerpt is from a participant who discussed the pressure to fulfil this criterion.

“They (Pakistani men) want a *desi* (indigenous to South Asia) wife who stays at home and doesn’t go to the gym and is naturally slim, but it’s like you can’t be naturally slim unless you’ve got the genes, we’ve got to work out, especially”

(0024, female, 28, second-generation, professional, Washwood heath)

Women give less importance to their own health or well-being in order to protect their position within their family as the primary care taker, and fulfil traditional Pakistani female values:

“I look after everyone who’s in the house –laughing-. I look after...most, my kids and my husband. Because he works and I’m the housewife, so I’m doing everything around the house and I try to help my mum out as well. On Saturdays I’ll be there, at my mum’s”

(0030, female, 37, second-generation, housewife, Sparkhill)

As mothers, women have to balance the requirements of different family members within the same home within their conjugal role. At times, women have to cook several meals in order to accommodate the diverse needs of their children, and cooking becomes central to completing the ‘mother role’.

“He does it mainly for himself and he should be here! Like, he says things he wants grilled chicken and with that he wants boiled vegetables or mashed and he says ‘mum make jacket potato for me today’ and then tomorrow he told me that how fish, he got it he wants it boiled with vegetables and like this morning he wanted beans and toast and then he went to work and he took some rice and chicken with himself and others don’t”

(0019, female, 46, first-generation, housewife, Sparkhill)

Whereas the previous quote illustrates a mother’s role to provide healthy meals for her son, women show great concern over their daughters’ physical appearance. Weight gain for a young single woman can have negative social consequences, and mothers try to monitor their daughters’ appearance in the context of community opinion.

“My mum’s really honest when it comes to these kind of things. If whatever I’m doing, say ‘Mum, do I look nice?’ ‘Yes, you do’. If I’m wearing something stupid she’ll be like ‘go back upstairs and get changed’. If I’m wearing a ridiculous colour and it doesn’t go with my jeans or doesn’t go with my shoes, she’ll just tell me. If my hair’s messed up she’ll tell me. If it’s not she’ll be like ‘oh, yeah, go on’. And especially about weight. If I’ve put on weight she’s like, ‘what’s that?’ –laughs- and I’m like ‘ooh, it just happens’ and she’s like ‘no, it doesn’t happen. Eat less’. She’ll always tell me whether I’ve put on weight, or not or whether I’ve just lost too much weight and I need to eat more, and yes. There was a time, when, me and her both decided we’ll like not bring Coke in the house, not bring chocolates in the house anymore, and, that’s when the apple juice thing started.”

(0050, female, 21, first-generation, student, Yardley)

Older women are not expected to look attractive in the same way that younger women are, and this socio-cultural norm to justify their weight lessens with age:

“I think they’re thinking ‘you’re young, you’re single and you’re free you should be looking good’ - laughs- ‘you should be looking good’ and then you think to yourself, ‘I’ve had a few kids is it alright if I’m not looking good’, but no, it’s not ok, I think with age its ok”

(0021, female, 31, first-generation, housewife, Sparkhill)

The expectation for women to have an age appropriate and culturally suitable appearance, i.e. slim when young, can affect women’s confidence.

Some women experienced internal conflict regarding their self-representation in their own community and that of wider British female expectations.

“You’re always going to be confused because like I’ve said we’ve got lots of pulling forces, like, British, female, and then the community talking, but I think I just lost my confidence because I had faith in myself that I would lose it, but then when you lose it you change, you’re not comfortable with it, you’re like ‘Oh my God, I look so different and maybe I shouldn’t wear tight clothes’, it just goes, the body confidence, I don’t know what it is, maybe you think I don’t want people to know I’m that skinny, it’s true but then, yeah”

(0024, female, 28, second-generation, professional, Washwood heath)

In addition to maintaining a culturally acceptable physique, young women are under pressure to adhere to their family’s rules on social behaviour. Women are expected to behave

respectfully and adhere to the guidelines set out by, at first their fathers, and consequently their husbands.

“The other thing is in us Asians is that once you are married. Your parents won’t let you do many things, if you want to do something your parents will say ‘no, you can do it once you’re married and you ask your husband for permission’, and if you are lucky you have a good husband, then you get a bad husband then you will long to do that thing forever”

(0060, female, 29, first-generation, manual worker, Alum Rock)

Community members tend to correlate choice of clothing with social behaviour, and prefer women to respect their family’s reputation by dressing modestly. Fathers appear to play an important role in young women’s lives, outlining appropriate appearance and behaviour. Young second-generation women struggled with the concept of dressing in a culturally appropriate manner and were not comfortable with the strict dress codes that were chosen for them by their fathers.

“I think to be honest, they’ve just learnt to deal with when I was very young my dad was, he was trying to get me into a scarf, he was trying to get me to wear the Asian dress of *shalwar kameez* and things like that, but it wasn’t working, it wasn’t happening”

(0056, female, 20, second-generation, student, Handsworth)

Choosing to wear contemporary, Western clothes can expose women to derogatory comments from community members. The following quote is from a participant belonging to the *Chachi*

caste, where women are culturally expected to cover their entire bodies using a *Niqaab* (full veil with only the eyes visible).

“I’m a ‘complete h*e’, because of the way I dress, when I wear English clothes.

Chachi girls wear long things, the *Niqaab*s everything at my age”

(0053, female, 19, third-generation, student, Smethwick)

Family members fail to appreciate the conditions in which women try to socialise and seek social support. Consequently, young women share social and health beliefs only amongst close friends who can relate to their circumstances.

“They’re (family members) supportive and stuff, but they say ‘ah, you shouldn’t go to the gym so often’ and ‘it’s not good’, but it is, it’s just, a bit of like exercise every day. I go to people in the outer circle (of convoy model diagram) and stuff, ‘are you going?’, ‘You go gym too much’ and all this, like ‘ah, you don’t see us, you’d rather go to the gym than hang around with us’ blah, blah. Days I do go to it in the evenings, so...But I’m not really bothered, they can think what they like. As long as my, I’ve got my friends’ support and stuff”

(0055, female, 20, third-generation, student, Handsworth)

Trying to pursue an independent lifestyle can be difficult for young women when they are managing numerous roles at home. Having a professional career and a growing number of responsibilities associated with living in a joint-family system persists for Pakistani women. As older women in the family rely on their daughters and daughters-in-law to share their family duties, second-generation women feel obligated to help.

“I feel like there’s an element of guilt that my mum places on us, even though she’s the primary person looking after him (nephew), that she wishes she was-we were helping with it more, so anything I do for myself feels selfish in that way and I feel like it’s either- it’s like almost being in another job. How can I assist to this job?”

(0035, female, 24, second-generation, professional, Bordesley Green)

Furthermore, the socio-cultural norm amongst many Pakistani families is for daughters to be married at a young age. The need to find a suitable partner cannot be overlooked for work or higher education. Some women choose to socialise outside of the community in order to avoid competition and pressure to get married.

“Oh, I was just gonna say I’ve noticed, like one of my friends, she’s at university and, she’s just saying how girls at 22, 23, are getting married, ‘cos she has all these Asian friends and they say to her like, ‘oh, you know, let’s get you hooked up with someone as well, as, you know, get you engaged as well’. And then when she was talking to me and she was like, ‘us two, you know, we’re like, I know we’re good friends, we’re the only two single ones’. And I’m like, ‘yeah’. And then she was saying how in her uni they’d all like, ‘it’s just you’. I’m like, ‘it’s not annoying’ and she’s like, ‘why’, and I’m like ‘‘cos I don’t care; nobody cares in my uni because they’re not the same race. They don’t think of that biological expiry date and stuff like that and it’s never, I dunno, I’ve never seen it as an issue, and my parents have never seen it as an issue. So I think it’s different and I think it’s because I’m not so, I don’t have that many, you know, Asian friends and that, stuff like that, so probably, that’s why”

(0050, female, 21, first-generation, student, Yardley)

There are more opportunities for women in social networks outside of the Pakistani community.

6.2.3.3 Identity

First-generation women feel obligated to conceal aspects of their identity from non-immediate family members who can be critical, therefore stifling development towards healthier lifestyles.

“My White friends, if I say to my best friend who’s White ‘you’re gonna bugger your knees up jogging round the reservoir 20 times’ Yeah? ‘You’re gonna bugger your knee up’ and she’ll go ‘I know. But I’m so addicted. I get such a head rush, I am gonna’, you can have that conversation, can’t you? But you can’t have a lot of those honest conversations in the Asian family. I mean, I can do it with my immediate family, like with my mum and my brothers”

(0042, female, 52, first-generation, professional, Edgbaston)

Second-generation women are also reluctant to display certain aspects of their personality at home, which shows conformity to Pakistani customs.

The following excerpt is from a participant who feels more confident at work but is expected to behave submissively at home.

“I am doing a job where I have to be very upfront and very direct and very straightforward in a sense so I take all of my personality and approach out on them and influence them in a way that they’re doing their job properly, whereas in my

social circle and home I'm like, whatever, so my personality comes out where I work because I have to use it whereas at home I'm really chilled out"

(0048, female, 26, first-generation, professional, Yardley Wood)

Being self-aware of culturally appropriate mannerisms and behaviours has implications for lifestyle choices. Second-generation women have to take their Pakistani identity into consideration when forming health or lifestyle choices.

"With the gym, because I'm a girl and I'm a Pakistani girl, there's a, like morals that people expect you to abide by, like if there's guys working out I don't think my dad would be very happy that I'm working out in that sort of place so the gym I'm joining I think they have a female bit to it and I think he would want me to go the female bit"

(0056, female, 20, second-generation, student, Handsworth)

Such restrictions effect numerous aspects of young, second-generation Pakistani women's daily lives, limiting their freedom, independence and ability to express their personalities.

"There are social expectations, even in normal general life as well, like you can't be out late at this time, you can't wear certain clothes, it's not that I would want to but its certain expectations you can't do this, you can't do that, if you're going to ever go out anywhere what time will you be home and it's like that, it's always been like that"

(0056, female, 20, second-generation, student, Handsworth)

Some first-generation women felt their daughters had a greater range of social and lifestyle choices, by recognising themselves as Muslim rather than Pakistani. The rights of women are

often mentioned in Islamic literature as being equal or greater to those of men, and by identifying themselves as Muslim, rather than Pakistani, frees women from the cultural and traditional expectations of the community. The following first-generation participant identifies the shift in identity between herself and her daughters. The participant's daughters are moving away from the traditional roles of women as a daughter-in-law towards a life independent of cultural beliefs. She starts by discussing the traditional expectations of a mother-in-law to expect care from her son's wife.

“Because it's my inherited right that I have to have that. I've got two children; two girls so I ain't gonna have a daughter-in-law. You know what I mean? So, and my children probably won't marry into the culture. Or they won't marry to Pakistanis. I think they'll marry Muslims but they won't marry Pakistanis, because they don't like the Pakistani culture. So I think, but they like to be Muslims. They wanna be Muslims. They like being Muslims but they don't wanna be Pakistanis, you know what I mean?”

(0042, female, 52, first-generation, professional, Edgbaston)

However, being Muslim can limit social interactions with members of other ethnic and religious communities. Lifestyle choices can be affected by the limited number of halal opportunities to socialise, e.g. in single gender environments, unless learning about Islam. Socialising in mixed-gender situations or activities that are prohibited in Islam, such as drinking alcohol, can be viewed negatively.

“Because we live in a very White area, what's it called? You know, being a Muslim and being Asian you can't eat certain food and you can't drink and stuff, whereas my

neighbours have a lot of house parties and they tend to, I wouldn't say it has influenced me, but because you live in a certain area people expect you or they think you're going to be doing the same as well, but I don't think it has influenced me or affected me because I have seen that around, so my neighbours when they have a house party they have a lot of drinking, they have music like all night and stuff, not that I want to do it, but because you're in that area and they think like 'oh, you live there!' and that kind of stuff"

(0048, female, 26, first-generation, professional, Yardley Wood)

Living in a microcosm that enforces gender-based community roles defines women's identity, and consequently lifestyle choices. As a community, Muslims behave differently based on their cultural group. Behaviours of Pakistani Muslims are differently influenced by cultural norms than, for example, Arabic or Bangladeshi Muslims.

6.2.4 Seeking health-related help and information

Women in the Pakistani community relied on two formal institutes for social support and information; the GP surgery and the gym.

Although there are two local sources of support and information, they are influenced by social and cultural restrictions (Table 24). The ability to access different institutes will be discussed in the following section as access to health and institutes.

Table 24. Overview of category: seeking health-related help and information

Overview
<ul style="list-style-type: none"> • Sources of information and support highlighted by women included the gym, which was viewed as a place to socialise, relieve stress and gain better mental and physical health. Older women found this space as the perfect location to connect with women from similar backgrounds. • Some women expressed apprehensions about joining mix gender gyms, as they felt uncomfortable exercising in unisex areas. • Women felt they would be criticised for working out in socio-culturally unacceptable circumstances, and choice of clothing by community members.
Generational differences
<ul style="list-style-type: none"> • There are generational differences amongst Pakistani women’s approach to healthcare and advice seeking behaviour. • First-generation women relied on their GP surgery (GP and nurses) for healthcare information and support on the maintenance and prevention of illness and disease. • They had an increased level of trust in GP advice and some first-generation women felt inspired and empowered by the healthy eating interventions their GPs recommended and referrals they made for the gym. • Women use the GPs advice to justify going out to exercise rather than being expected to stay at home. • Second-generation women recognise how much women from the first-generation rely on the GPs advice, and are more likely to pursue a healthier lifestyle if a doctor gives validation. • Second-generation women relied on an array of healthcare resources including self-education e.g. advice from their colleagues and peers, alongside information from the Internet. • One of the main reasons for using informal sources of information was the lack of satisfaction second-generation felt with NHS services. • There were issues surrounding the ethnic concordance with GP, where young women felt doctors from the same ethnic background were more likely to stereotype Pakistani women as being submissive and less likely to implement health changes.

6.2.4.1 Access to health

For many first-generation women, access to better health was determined by their GP. An example of this is the quote from the following participant who has placed a greater importance on the advice given to her by her doctor compared to friends. Listening to the doctor meant the participant had a justification for her behaviour when dealing with negative comments from the community, or learning about new lifestyle choices.

“Some people, I think do get angry but I ignore it as long as I am happy, I follow my GP’s advice the most and what I know is right for me and what I know about my diet”

(0022, female, 39, first-generation, housewife, Sparkhill)

Some women felt healthcare services used unsuccessful non-verbal communication methods to address healthcare issues, resulting in low levels of awareness amongst first-generation women regarding alternative lifestyle choices.

“You get a lot of leaflets even like gyms and stuff to tell you that you are well informed, whether you want to take up that information or not is up to you but a lot of the women, they don’t read English and stuff so that’s probably why they don’t, they wouldn’t know”

(0021, female, 31, first-generation, housewife, Sparkhill)

Participants with professional qualifications had greater expectations from their service providers and expressed dissatisfaction with doctors ignoring their requests.

The following participant felt their GP was beginning to cluster patient symptoms based on trends in the community.

“I don’t rely on my doctors, because I feel that what’s normal for them is not normal for me. And I’m slightly up and the doctor was saying, ‘Oh. No, really it’s fine’, and I’ve gone, ‘Oh, print it out’ (blood test). So when he printed it out, I realised how high it was and everything. But it was a concern for worry. They think it’s normal because they see it every day”

(0041, female, 35, first-generation, professional, Edgbaston)

Younger women were particularly distressed by the limited healthcare advice they received at their GP surgery.

“‘Oh, I’m fat are you going to refer me to a dietician?’ Er, no. So, I don’t bother. I find the resources myself and I go to my GP and ask them to refer me and I think that’s the best anyone can do, ‘cos the GPs are just like, I know it sounds bad, glorified administrators”

(0024, female, 28, second-generation, professional, Washwood heath)

Second-generation women felt independent and confident to find suitable healthcare support and advice, thus women are becoming more pro-active in their healthcare decisions, and questioned the skills of health professionals.

“But she literally went on Google, typed in what was wrong, print out five pages and said, ‘Oh, basically this and this’. I just said ‘like, really. You just Google-d my

problem' you don't know if it's right. I was so angry with GP now. She Google-d me, I can Google myself –laughs- I was like, I could have done that. And then she wouldn't prescribe me anything.”

(0049, female, 19, second-generation, student, Smethwick)

Some women felt healthcare advice could be more efficiently accessed online or from close friends, rather than having to approach a healthcare professional. There appears to be a greater degree of dissatisfaction with current healthcare practices, and a tendency to go online for health resource and information.

“No, I don't think I've ever gone to my GP just about my health. I hate going to the doctors so whenever I go, it's when I absolutely have to go. So there's...yeah. I, never to, spoken to a healthcare supervisor either. Think I just stick to, whoever's closest to me and just talk about it like that, and if I'm desperate I'll look online. So that's it”

(0050, female, 21, first-generation, student, Yardley)

There are distinct generational differences in how likely women are to approach their GP as a source of support or information. First-generation women have relied on their GPs to provide information and justification for lifestyle changes. Second-generation women felt more independent, but met with stereotypical culturally defined views that deterred them from approaching, or trusting formal service providers. Instead, they relied on close friends or the Internet.

6.2.4.2 *Institutions*

An alternative source of support to GPs was the gym. There are, however, generational differences in the approach used by women to develop a social network with other women as an informational resource.

There is a degree of stigma attached to women socialising at the gym. As the gym is a culturally unfamiliar domain, elders in the community can find it difficult to understand the social conduct that takes place between individuals who attend. A need for gender specific services emerges, as mixed-gender spaces raise concerns around appropriate dressing and presentation.

“Because their mind is still back there, they will think a million things! ‘*Haye!* (Exclamation) she is going to the gym! What clothes does she wear? How must she be? What gym does she go to? Do boys go there?’ Those things happen, non-education, no education, no literacy”

(0060, female, 29, first-generation, manual worker, Alum Rock)

Consequently, women across all generations felt comfortable attending women only gyms as it is culturally more acceptable. Swimming was also favoured by many women, but they were again concerned by the controversy surrounding swimming attire. Further, women may be insecure about their physical appearance and how culturally appropriate their attire is, as wearing a swimming costume is perceived as a bold cultural statement.

“See, if it was swimming, it would come round to what you were wearing again. And what you were wearing would be, that would be a bit of a fuss, I know if you go to a

swimming pool they have certain rules and regulations of what you're allowed to wear. And I wouldn't really feel comfortable wearing a swimming costume, anyway. So, I guess, yeah, that would come into it"

(0058, female, 25, second-generation, professional, Bordesely Green)

For some second-generation women, the gym is an integral part of their lifestyle and identity that they are comfortable to share with others. The following participant justified her indulgent meals by working out regularly.

"I'm not saying it's a secret society, but it's a code that everyone has to lead a happier and healthier life, and I'm not saying, like I said I had a take-out in the morning and in the evening but I'm allowed because I work my a** off at the gym, but if I don't work out for more than 3 consecutive days I feel like my energy levels are dropping"

(0024, female, 28, second-generation, professional, Washwood heath)

There is an emerging 'living healthy lives' culture in UK society that is reflected in the aforementioned quote (Marmot *et al*, 2012). Furthermore, women take a holistic approach to exercise by incorporating yoga and a variety of different exercises into their routine.

Professional workspaces provide younger women with greater opportunities to work out, but maintaining motivation plays a key role in attendance.

"I work out because they have a company gym downstairs in the basement, so they're always encouraging people to go and making them aware"

(0037, female, 23, first-generation, professional, Yardley Wood)

Access to different fitness classes and the gym can greatly impact the likelihood of attending, or even considering working out on a regular basis. Some women noted the difference in going to affordable gyms in their local area to avoid cost and travel.

“I know there’s a gym nearby. When it first opened up ...I actually thought about joining there but it was quite expensive, and that’s the only gym I know that’s like nearby. There’s a few in town but I don’t wanna take the trips into town”

(0050, female, 21, first-generation, student, Yardley)

The type of gym in local areas played an important role in whether women were likely to attend or not. Young, professional women were reluctant to exercise in gyms that were popularly accessed by first-generation Pakistani women, or young girls trying to lose weight.

“Look, thinking about it, the cultural differences, I went to a gym in a very Asian area, ladies only gym, fantastic gym just for Asian ladies, and all the ladies that would go there would be fat aunties who’ve been told to go there by their doctors to go there because they’ve got health problems, there were very few young girls, the girls that would come were, would come for 6 months because they’re getting married”

(0024, female, 28, second-generation, professional, Washwood heath)

Conversely, older first and second-generation women were satisfied with the opportunity to socialise and learn about their health at the gym. For some women, this was a preferred alternative to strict diets.

“I know people who’ve taken *Slimfast* (supplement) but when the, my doctor told me I need to lose weight, I thought I’d try *Slimfast*, but then I decided I’ll go to the gym, because that won’t work for me, so I just decided to go to the gym. I enjoy it there.”

(0030, female, 37, second-generation, housewife, Sparkhill)

Older, first-generation women prefer women only gyms where they can work out and socialise with women from a similar background. In contrast, second-generation women, prefer to work out in fashionable gyms, or in their own health space. Clearly, there are generational differences in the approach used by Pakistani women to access social support and health information.

6.2.5 Gender inequalities

Access to social support in public and private spheres, is affected by gender for members of the Pakistani community. As mentioned in the previous categories and themes, identity and gender based roles outline appropriate lifestyle choices for men and women. Consequently, there are gender-based inequalities between men and women accessing healthcare information and/or support (Table 25).

In order to work out independently, women have to be strongly motivated or seek support from close friends. Further, women fail to disclose their personal opinions to family members due to the socio-cultural standards of the community. These factors will be discussed in greater detail in the following section dealing with female appearance and societal pressure on men.

Table 25. Overview of category: gender inequalities

Overview
<ul style="list-style-type: none">• Women have to pay careful attention to how they socialise, in order to respect their families and subsequent cultured values.• Patriarchal structures influence lifestyle choices and health behaviours for women in the home including dietary choices.• Traditional roles can place pressure on married women to look after their husbands and children. Mothers in particular are worried about instilling traditional, cultural and religious values.• Women rely on support from other women in the family, i.e. mothers looking after their daughters and vice versa.• The level of safety and discrimination against women in the local area influences a woman’s ability to practice healthier lifestyle choices freely.• Women displayed fear and concerns over their safety in the local community. Consequently, women felt more comfortable working out at home but these activities can result in feelings of isolation and women failed to mention group sports or activities.
Generational differences
<ul style="list-style-type: none">• Pakistani women are beginning to notice a cultural shift amongst second-generation men and women who are working towards a more balanced relationship.• Any gender-based differences are thought be a result of men’s insecurities about their position in their home and wider community. Moving away from community values relates back to the men’s chapter about communal dissonance.

6.2.5.1 Female appearance: education and liberty

Traditionally, Pakistani women are expected to spend their time and resources on looking after their children. Such gendered roles can limit women’s ability to form social networks, or

practise independent health choices. Older women are often responsible for helping their children with education, which they count as a personal accomplishment.

“Their achievement is their breeding of their children, and healthy children that have done well, so if they’ve all been educated and got to university and they’ve got jobs, that’s their achievement, isn’t it?”

(0042, female, 52, first-generation, professional, Edgbaston)

Young women are trying to break away from such traditional norms, but having a different lifestyle can have social consequences in the context of family membership.

“Yeah, it’s too independent to buy food for myself in that way”

(0035, female, 24, second-generation, professional, Bordesley Green)

Second-generation women experienced difficulty finding suitable places to exercise because of cultural restrictions on how to dress and socialise in mixed gender spaces. Further, women’s gyms are not supported by the community as they challenge traditional gender based roles.

“There’s loads of lads gyms in the area, there’s no facilities for ladies because ladies are meant to be at the home to cook and clean”

(0024, female, 28, second-generation, professional, Washwood heath)

However, women with their own independent monetary and social capital try to encourage others to take up a similar lifestyle by presenting themselves as an ideal role model.

“My work, I try and struggle, all the time to make sure that the women are empowered enough and if they say, ‘Oh, I can’t do it’ and I go, ‘no, don’t tell me you can’t do it, because if my mum could do it and bring five children up, with no husband, no English and can learn to drive and at 50, none of you women cannot do it’. Nobody cannot do it, because yes, I’ve got an education so I’m a great role model for those girls”

(0042, female, 52, first-generation, professional, Edgbaston)

By having a diverse network of friends and colleagues, women could develop existing social circles comfortably to discuss their health beliefs without worrying about socio-cultural norms, traditional guidelines and stigma:

“I had an older social circle and then I went and met lots of new women who are health conscious as well and we met and we discussed these things then I felt it was nice making new friends and sharing experiences and taking each other’s advice, so it made a big difference that I had new friends and a new community circle”

(0022, female, 39, first-generation, housewife, Sparkhill)

Having different groups of friends enabled women to make comparisons between Pakistani culture and the norms of different communities.

“I think the White community, they are more good at communication, especially as I have seen that the English ladies at school they are good friends of mine, they are happier to talk about health issues than the Pakistani ladies”

(0022, female, 39, first-generation, housewife, Sparkhill)

Some women recognised different cultural restrictions placed on the female Pakistani population. The following participant noted the difficulties Pakistani women encountered when trying to exercise in public, especially if they came from strict families.

“I have a friend and she is Pakistani but she doesn’t feel comfortable coming out in the morning to go for a run but with Ari (Indian friend), she’s like. ‘You’re here. Let’s go for a run. Come on. Our 8 o’clock window’. I don’t know if she’s being lazy or she just doesn’t want to go but, yeah. So I don’t know about that. When I rang her (Pakistani friend) she was like ‘Oh, my God. I can’t even go jogging’. And I was like, ‘I go jogging every morning’. And she was, ‘wow, really?’ it was like ‘yeah’. But I think with her (Pakistani friend) she had cousins and families around. With me it’s just literally our family like our cousins are all over the place. So she found it hard to go and do things. I said, ‘maybe you just move around’”

(0049, female, 19, second-generation, student, Smethwick)

Relationships between Pakistani women are affected by sub-cultural differences, especially religious or socio-cultural guidelines. Some women found it easier to socialise with women in other Muslim communities, with contemporary views on women’s ability to work and socialise outside of their own community.

“Because, I think a lot of them are very, I think that’s what I come across, because, I’m not speaking from my family or anything, people surrounding me. I think it depends what part of Pakistan you come from, a lot. So a lot of the people surrounding me they come from Mirpur, part of Pakistan where they’re quite strict, they don’t like their ladies to be working and my friends, who are Arabic I think I

could relate to them because family-wise we're on a level. Our mentality match them compared to the Pakistanis surrounded by me"

(0037, female, 23, first-generation, professional, Yardley Wood)

Women trying to adopt a healthier lifestyle face discrimination from family members who can be unsympathetic towards their choices. Having a different or unique lifestyle decreases involvement in family meals, and free time is not used for shared activities. Family members are reluctant to share these new experiences or support them, which can lead to feelings of low self-worth.

"I do think about that sometimes and I think that's the sort of thing that causes me like the most depression. I just think that if I was to change my lifestyle, then would it mean that my family wouldn't want anything to do with me? It's one of those worries of how can I change my lifestyle but still maintain the relationships I've got?"

(0035, female, 24, second-generation, professional, Bordesley Green)

Young women who chose to exercise in public are viewed as being disrespectful by showcasing their desire to be healthier and physically attractive bypassing cultural norms. Such bold behaviour can be met with discrimination from men in the community.

"It's a taboo though for us Pakistani girls to go running, the amount of times that I have gone out running and Pakistani taxi drivers have been 'oh, you want a lift? Shall I take you somewhere?' and stuff like that, because a brown girl running is wrong, you shouldn't be doing it"

(0024, female, 28, second-generation, professional, Washwood heath)

Female empowerment was an emerging theme across women's narrative, yet women face discrimination from within and outside of their community. The next excerpt is from a participant who covers herself with a *Niqaab*. In the following quote, the participant is describing an incident that took place whilst exercising in the park.

“It's only once, this Black guy was like ‘I can see you!’ –Laughing- and I go to him ‘can you see me?’ and he goes ‘yeah, I can see you’ I go ‘good for you then!’ yeah. Then I go to him ‘you're not meant to see me because I'm covered up’, but he goes ‘I can see you though’ I go ‘good for you then’.”

(0030, female, 37, second-generation, housewife, Sparkhill)

Gradually, more first-generation women are trying to incorporate a healthier lifestyle into their existing routines and within cultural norms; this is often achieved by strengthening social ties with like-minded women in the community.

“I've seen in the park-I see middle-aged men and women running together and I think it's so adorable. These Pakistani women in their *shalwar kameez* but trainers, Nikes, gently jogging along”

(0035, female, 24, second-generation, professional, Bordesley Green)

Taking part in exercise is not just a lifestyle change, it is also influenced by many socio-cultural nuances that prescribe appropriate behaviour. Women find it difficult to expand their social networks beyond the boundaries of their family and community without struggle.

“I’d say if I was going to give a percentage, 50 per cent. It is like a-it is a notable change. I do feel like I’m fighting-I feel like I’ve always had to fight anyway, to have a sort of a social life because of what culture dictates, or my family’s sub-micro-culture dictates, but I feel like I’m having to fight it even more now and have to fight for myself in that way”

(0035, female, 24, second-generation, professional, Bordesley Green)

First-generation women are aware of the need to empower and educate Pakistani women so that they can support other women in the community.

Pakistani women rely on each other in public and private social spaces for care and support, but this support may not exist in professional settings if women are denied opportunities to pursue further education. Professional roles may be perceived as non-traditional constructs of women’s roles in British Pakistani society.

“We won’t get them, unless our daughters step forward and we then have the right to ask for a lady doctor, when our own are not going forward then how will we get this, a lot of people stop us and say ‘don’t do this’, there is no difference other than our minds have stayed behind”

(0018, female, 49, first-generation, housewife, Sparkhill)

Some participants felt that first-generation women, who pursued dependent lifestyles, had selfish motives to exploit family members for their personal benefits:

“They don’t wanna be strong women, because they wanna be weak women. Because when you’re a weak woman your sister, your daughter-in-law will work for you, this one would, your sons are all rallying round you, it’s almost attention-seeking in some kind of perverse way, I think.”

(0042, female, 52, first-generation, professional, Edgbaston)

Conclusively, Pakistani women who want to exercise outside of their homes can face discrimination from family members and the wider community. However, some women are pursuing healthier lifestyle choices independently whilst trying to encourage other women.

6.1.5.2 Societal pressure on men

The socio-cultural norms surrounding men and women in the Pakistani community have an influence on the relationships within families.

Gendered roles and relationships are affected by generational differences. Women acknowledged that men have patriarchal views of women despite British culture. In the following excerpt the participant describes how her husband expects her to make traditional meals at home, as Westernised foods are viewed as a sign of acculturation and deviation from traditional Pakistani norm

“Apart from my husband, they will all be happy; he will say ‘I want chapatti and curry!’ ‘You can make whatever you want to make, make it, eat whatever you like, do whatever exercise you want’, kids will be happy too and eat what I eat, they like healthy eating and we make it as well, it’s not like we don’t, but curry and roti are a

must! My husband will not eat anything, rice, pasta, lasagne, whatever you make he will eat it and say, ‘I haven’t had a roti today’”

(0025, female, 46, first-generation, manual worker, Sparkhill)

In traditional Pakistani families, men are expected to provide social care and health information to their family members. Consequently, women with small social circles can be dependent on their husband’s knowledge of health. If husbands have strict cultural views, they encourage their wives to exercise at home.

“Well, I’ll try to, like my husband’s joined a gym as well, so I talk to him as well. He’ll tell me what to do. He’s telling me to do like, stuff at home like sit-ups and stuff. We’ve got that ball as well. The exercise one that you can do lots with that as well”

(0030, female, 37, second-generation, housewife, Sparkhill)

Married women have to consider how their husbands’ will react to any changes in lifestyle choices and the pursuit of social opportunities outside of their home. Women also justify their socialising behaviour by stating whether a male head of their family, i.e. husband, endorses it.

“My friends are open minded like me and family obviously aren’t going to feed you or clothe you, they are busy as well, so no one has an objection to me working, my husband either, he doesn’t mind if I work or not, he will not force me, so it’s like that and my family has presented no obstacles, all my siblings work so it’s nothing like that”

(0060, female, 29, first-generation, manual worker, Alum Rock)

Some Pakistani men exert physical dominance in their homes. Women who are not financially or socially independent of their husbands may find it difficult to escape domestic violence in their homes despite support from other women in the community.

“The next door neighbours, the girl she is nice, poor thing, but her husband won’t let her go anywhere or let anyone come over, he used to beat her up a lot and I would call the police, several times, and I said, ‘I will beat your husband on the road if he beats you up again’, so then thankfully there’s been a difference and she said when she sees the lights are on at my house or she can hear some noise then she feels like she doesn’t have to worry anymore because her bodyguard is here now, she doesn’t need to. This one time I heard her crying at half past 2 in the morning and I felt like calling the police”

(0025, female, 46, first-generation, manual worker, Sparkhill)

There are values and norms in the Pakistani community that dictate culturally taboo actions that should be hidden from public view.

There is a strong perception about male expectations of women to be homemakers that fulfil a series of socially desirable criteria. Male identity is strengthened in the community if men maintain traditional family structures within the home.

“The main thing in Asian families is that women stay at home and have kids, take them to school and take them back home, feed them and take them to the *Mosque*, the thing is all of the men, the thing about all Asian men is they are told that they have 5 digits. They want a 5 digit salary, 4 wheel car, 3 bedroom house, 2 kids and 1 wife

that looks like Sheila (pop culture reference- attractive, young woman) and works like *massi* (maid) Haseena, that's what they want for an Asian man, and that's true"

(0060, female, 29, first-generation, manual worker, Alum Rock)

Men from younger generations can be competitive with each other regarding personal appearance, as well as that of their partners. Competition places pressure on women to change their lifestyle so they can achieve a socially desirable appearance.

"No, because a lot of guys do want their girls to work out, like, look at my brother, he got married and she never used to work out but he's like 'you need to go to the gym' because he said he wants a 'fit' wife, whether its physically fit"

(0024, female, 28, second-generation, professional, Washwood heath)

Women felt that men invested time and effort into their appearance, traits which men may want to find in their partners as well.

"He's actually happy that I used to go running. He was, 'Wow, you go running. Wow, you're so good. Oh, you wake up in the morning and you go?' And I was like, this was last year summer. He used to go-he goes gym but in like say in a week I'll go two times, 'Oh, I'm going to give up now' 'well you can't just give it up like'"

(0049, female, 19, second-generation, student, Smethwick)

Consequently, women who exercise regularly tend to impress men. Physically attractive appearances may be popular amongst younger Pakistani men.

‘Boys are not healthy, well Pakistani boys are healthy in the sense that they do a lot of weights, its more about appearance, because the bigger a guy is the stronger he is, right, so I don’t think it’s not health conscious its looks conscious so they can have street cred. So it’s like, the alpha male thing isn’t it, like you know lions when they go to fight, the bigger mane they have, it’s like the bigger the physique they have, it’s usually biceps and triceps they work on like one of my work colleagues is an Irish anaesthetist and he says, ‘whenever I go to the gym, why are the Pakistani boys always pumping weights for their arms’ because it’s like, instead of asking a girl for her number, it’s like ‘look at that! Yeah, look at them biceps’ it’s a means of attraction and scaring other boys away. It’s true! There’s always theory behind all this”

(0024, female, 28, second-generation, professional, Washwood heath)

Young men may be competing for female attention by pursuing strong masculine physiques.

“I find a guy that plays football much more attractive than a guy who doesn’t; I like a guy with a nice body, like a six-pack, broad shoulders”

(0053, female, 19, third-generation, student, Smethwick)

6.3 DISCUSSION: INTERPRETATION OF FINDINGS

Throughout this chapter, the findings have shown women’s perceived access to support and information related to the prevention of cardiovascular disease. Issues surrounding gender inequalities, lack of social support, and socio-cultural barriers towards forming or creating a healthier (independent) lifestyle emerge which challenges existing Pakistani cultural values.

6.3.1 Lack of support and influence

Competition between women over inadequate social and economic resources was ever present throughout findings. Women in the Pakistani community were in a position of limited influence, as they lacked the necessary social or financial capital to exert authority. As part of Pakistani tradition, women were expected to prioritise their role within the home.

These findings are similar to those of Dale *et al* (2002) regarding young South Asian women pursuing higher education only after facing boundaries created by complex socio-cultural norms. Similarly, Afshar (2010) identified the limited progress made by second or third-generation Pakistani women as authority figures in their households. Despite access to better education and economic independence, cultural ties and moral values maintain a firm influence over women (Afshar, 2010). Factors which affected women's ability to work within patriarchal structures included male opinion being given precedence, limited spatial mobility, and social capital resulting in poor local, regional social networks (Roomi and Parrott, 2008). However, Ahmad (2001) found that agency could be a key factor for how women expressed their desires for personal development, albeit within the restrictions of familial duty.

Limited male support could be a consequence of traditional, cultural and gender based roles or norms that limit male engagement within the home. A lack of direct involvement within the family (in comparison to a mother) could be an accepted and traditionally familiar subservient role amongst new fathers (Ives, 2014). Women's narrative about cooking and fulfilling the majority of childcare responsibilities reflects gender based roles.

6.3.2 Rivalry: Westernised beauty

Findings from the analysis show increasing pressure amongst young women to follow cultural ideals of feminine beauty. Women viewed each other as rivals for social approval and were reluctant to discuss methods that they used to lose weight, as they felt other women

would be jealous of their achievements, or offended by their better understanding of health. However, social circles are small, so the opportunities to share better understanding are limited.

Wray (2002) discovered slim images as representing the feminine norm, and that these are often internalised by women in the South Asian community. However, researchers have noted the popular Orientalist view of comparing South Asian women to Westernised ideals (Van Der Veer, 1993; 23), where they are perceived as subordinate (Shaw, 2014:5) and passive when negotiating shifting identities (Wray, 2002; George and Rail, 2005; Samie, 2013).

George and Rail (2005) examined body image in relation to discourses related to health amongst South Asian women in Canada using a post-colonial stance. They noted how ‘looking good’ played a crucial role in how women engaged with family members and friends (to parallel womanliness and cultural norms), whereas health was placed as a personal issue rather than a social pursuit (George and Rail, 2005). Similarly, using a post-colonial feminist approach, Samie (2013) researched views of British Muslim Pakistani women in sports. These women progressively displayed attributes that are used to identify their Western counterparts, but within social atmospheres that endorse the Pakistani notion of classically feminine traits (Samie, 2013). There is a conflict between independent ideologies of beauty compared to the Western standards endorsed by the Pakistani community.

Generational differences can create tensions between younger and older women. First-generation women, specifically mothers, are critical of their daughters’ weight, and question their social conduct. A woman’s social identity was determined largely by her appearance and attire.

Dwyer (1999) draws on interviews with British Pakistani women who viewed their dress as an important indicator of Muslim identity. Researchers discovered a binary

difference between women's self-representation at home and outside that creates a debate on the practice of secular and traditional paradigms (Dwyer, 1999). Women from the Pakistani community can encounter a great deal of inequality based on ethnic and gender based differences. Evidently, appearance plays a key role for women in the Pakistani community, and attractive women are more likely to get marriage proposals. These trends are based on cultural ideals of women's beauty which are universally advertised in South Asian and Muslim media (Siddiqui, 2014). McLoughlin (2013) examined the content of a popular British Asian magazine '*Asiana*' that propagates a 'universal aesthetic of female beauty which is persistently White, Western and wealthy' and parallels South Asian norms surrounding femininity and women's sexuality. Furthermore, having fair skin and a slender physique has been found to be associated with a cultural superiority over indigenous physical attributes (McCloughlin, 2013). Analysis indicates community pressure for women to pursue cultural norms of beauty in order to attain social approval. Traditionally, beautiful women are more likely to be valued for their health and beauty, thus acquiring a social network within which other women sought information on how they achieved a slender or attractive physique.

Younger women have greater access to social and financial resources to achieve an attractive appearance, but some older women view this as a poor use of capital. At times, women who lose weight or appear attractive are targets of shame culture. These are contradictory standards, as young women must be physically attractive, but within the constraints of Pakistani ideals surrounding modesty and tradition (culture and patriarchy). A tendency towards Westernised attitudes towards body shape can lead to dissatisfaction and affect attitudes towards diet and exercise (Mumford and Choudry, 2000). Studies indicate a higher prevalence of bulimia amongst Indian, Pakistani and Bangladeshi schoolgirls compared to their White counterparts as a result of such pressures (Nasser, 2009). As Mussap

(2009) identified, an emphasis on ‘outwards appearance and attractiveness in women is inconsistent with Islam, a woman’s internalisation of the thin ideal, as well as her efforts to reduce her body weight, can remain entirely private’. Religious guidelines would discourage eating disorders, as they are the endorsement of unhealthy attitudes (Mussap, 2009). Women that have a preference for Muslim identity may struggle between cultural expectations of feminine appearance with religious guidance on health and well-being.

Although the existing literature has recognised the role of culture and identity in shaping such views, findings suggest that women can become competitive over physical appearance, where physical attributes can be viewed as a valued social commodity.

Occidentalism, in opposition to Orientalist beliefs, plays a role in shaping Pakistani women’s views of how South Asian women should form their physical identity, in order to protect themselves from modernised Western views that may be ‘morally corrupt’ (Amara and Henry, 2010). Such beliefs surrounding women’s internalisation of South Asian or Western concepts have been studied using quantitative approaches. In a study exploring body satisfaction and veiling, Swami *et al*’s (2013) findings suggest that women who covered themselves using a hijab reported a more positive body image, and were less reliant on a media portrayal of beauty or thinness than those who did not wear a hijab. It is possible that the use of a hijab acts as a buffer towards societal pressures on body image.

A woman’s position within her social group can be determined by her physical attributes rather than her financial status or qualifications. Participants felt their eligibility for marriage, or a position of influence within the community, was based on how much their appearance conformed to South Asian ideals of beauty, rather than their professional, educational, or family achievements.

6.3.3 Patriarchal structures

Ali and Gavino (2008) commented on the Pakistani society as a patriarchal system where men held the decision-making role as heads of the family, and where women feel vulnerable without their guidance. In the present findings Pakistani families had a patriarchal structure, where the husband or father, as head of the house, uses their position to determine the appropriateness of social behaviours, which is further enforced by younger men in the family, i.e. brothers and sons. Often, men made recommendations for food preparation and passed on healthcare information to women in their homes.

Additionally, patriarchal family structures use social constructs of honour and cultural norms to justify violence, as well as reinforcing gender roles (Gill, 2009). A Joseph Rowntree report on Pakistani men in Bradford outlines the spatial division of migrant men settling into the UK according to internal religious and cultural boundaries (Alam and Husband, 2006). These microcosms create boundaries that are based on fraternities regulated by men, which maintain socio-cultural norms.

Female participants felt there are greater restrictions placed on women living in microcosms that are defined by traditional Pakistani values. Men display elements of control over women belonging to their society where there were numerous, at times sensationalised, stories of women being forcefully kept at home. Many young women commented on the verbal abuse they received from community members and outsiders if they deviated from the cultural norms, especially when exercising in the public sphere.

It can become difficult for young women to practise personal lifestyle choices within rigid familial structures and environmental complications. Even purchasing their own food can cause offence within households. Choice of food consumption can be a reflection of acculturation in the context of migration, and is usually the last aspect to be changed. First-generation men can be reluctant to change their diet compared to women and children, as a

Western diet is viewed as a deviation from traditional culture (Jamal, 1998). Furthermore, women who create their own space within the community are criticised for being too independent and moving away from traditional norms (Bhimji, 2009).

6.3.4 Female empowerment

There were elements of female empowerment emerging from the findings. A greater number of women are partaking in professional or manual work, where they can discuss health choices with women from other communities and increase their social capital and networks. A woman going to work is a major cultural shift that questions existing familial dynamics. However, men continue to expect women to maintain their familial responsibilities whilst making a financial contribution. Afshar, Aitken and Franks (2005) and Dale, Lindley and Dex (2006) found Pakistani women were more likely to manage full time responsibilities for their home compared to women from other communities.

Employment presents the opportunity for women to discuss health ideals that were noted as being taboo. Living in an insular community that limits socialising outside with non-community members, reduces exposure to alternative lifestyle choices and health practices.

6.3.4.1 Transnational support networks and patriarchy

A strict characteristic of the socio-cultural practice of insular Pakistani communities is consanguinity, where family members are pressurised into marrying their relatives. Marital practices that involve consanguinity with relatives overseas have been noted as a method of maintaining transnational ties (especially with siblings), and overcoming negotiation of complex socio-cultural factors associated with marriage in the UK (Shaw, 2006; Shaw and Charsley, 2006). Such marital practices are common amongst the Mirpuri Pakistani communities that are largely resident in Bradford and Birmingham (Dwyer, 2000; Shaw,

2001). Younger members of the community believed such marriages into the family would be unsuccessful, even if husbands were encouraging their wives to work and providing support (Dale and Ahmed, 2011). Findings illustrated the fear of consanguinity amongst participants who wanted to pursue an independent lifestyle, as it is a serious example of enforcing traditional practices on women. Individuals from the second-generation are more empowered which is evident in their behaviour. Women reported going to the gym, socialising at *Shisha* lounges and becoming role models in their own community.

6.3.5 Religious interpretation

There were tensions arising between community members from different socio-economic or caste groups. Secular and orthodox interpretations of Islam caused confusion amongst community members regarding the appropriateness of certain behaviours, e.g. running in public spaces. Some women identified the cultural differences between different caste members, and the sub-cultural differences of Mirpuri families, where many cultural practices were upheld by male fraternities in which women were rarely given the permission by men to practise alternative lifestyles.

Ijaz and Abbas (2010) explored inter-generational changing of attitudes in working-class Mirpuri Pakistani women in the UK. Parents held similar views regarding daughters and sons pursuing higher education, if women maintained segregation from the opposite sex and avoided ‘Western values’ associated with secular groups (Ijaz and Abbas, 2010).

6.3.5.1 Emotional well-being

As a consequence of cultural, traditional, religious, and familial obligations to behave and socialise in a particular way, many women experience internal conflict. Women choose to

ensor different aspects of their personal life from family members and friends with regard to traditional or religious attitudes.

Although the present research noted women's hesitation to discuss behaviours surrounding diet and exercise, other social beliefs were censored. Marital choice is an important decision for Pakistani women who would prefer to choose their partner based on 'love marriage' rather than arranged (Zaidi and Shuraydi, 2002). At times women can create 'hybrid' identities which they can use to negotiate their choice of dress and lifestyle choices. These identities transcend traditional ideas of women's behaviour and shift between cultural and 'modern' British values (Ratna, 2011). However, women still find themselves hiding aspects of their identities from their parents (Mishra and Shirazi, 2010).

At times, pursuing personal health goals can be stigmatised (Lawton *et al*, 2006). Therefore, second-generation women preferred to discuss their health beliefs with women from other non-Pakistani Muslim communities, as they would be less judgemental in the context of cultural restrictions surrounding diet and exercise. Younger Pakistani women are more likely to embrace a British Muslim identity and widen their social networks, yet this may restrict them from socialising with different religious groups due to varying beliefs. Muslim communities have been noted to limit integration, compared to non-Muslim groups (Besin *et al*, 2010). British Pakistani Muslims are negotiating more than two cultures, where Islam is reported to have an important influence on lifestyle compared to South Asian communities (Robinson, 2005). However, when making lifestyle choices, the ability of second-generation Pakistanis to negotiate religious influences with ease or difficulty remains to be explored in greater detail.

Many second-generation women discussed the importance of positive mental health in the context of emotional well-being, and in view of the levels of apparent depression amongst first-generation women. The younger women associated depression with limited social

networks, socio-cultural restrictions, and managing multiple identities. Symptoms of depression are visible amongst women living with men who may perpetrate violent behaviours (Ferrari *et al*, 2014; Hester *et al*, 2015). A review by Anand and Cochrane (2005) on the mental health status of South Asian women in Britain identified cultural conflict as having an impact on mental and emotional well-being. Muslim Pakistani women who were home bound were recognised as having higher rates of anxiety and greater vulnerability to depression than Bangladeshi and Indian women, highlighting the need for sub-group research (Anand and Cochrane, 2005). Furthermore, migration itself can cause depressive emotional states amongst South Asian women due to limited awareness of coping strategies and a lack of resources (Gilbert, Gilbert and Sanghera, 2006; Ahmad *et al*, 2008).

Female participants were distressed by the contradictions surrounding men and physical health. Family members were more likely to encourage young men to work out at the gym and pursue a strong, masculine physique. There were facilities, such as women only gyms, that provided females with a source of support and information to pursue health goals. However, there were generational differences in how women made use of social and health spaces. First-generation women used gyms as a platform to socialise with women from a similar socio-cultural circumstance, whilst using this for personal development.

South Asian men with traditional beliefs prioritise cultural norms, such as the taste of food over its nutritional value, and expectations of women's appearance (Patel *et al*, 2011). The latter focuses on ideal female silhouettes where women should 'fill out' after marriage to reflect maternal or domestic roles (BMI over 28 indicating a stress free marriage, healthy diet and children) over a slender physique (suitable for work and finding a spouse) (Patel *et al*, 2011). Women are expected to manage their appearance and roles within their homes based on such expectations. Additionally, Jepson *et al* (2012) identified the importance of social support, role models, and in particular friendship groups, to pursue physical activity.

Attending a ladies only gym has also been noted as an important factor encouraging women's attendance through inclusivity (Penn *et al*, 2014). In comparison, migrant Punjabi Sikh women noted issues surrounding weakness and fatigue, preferences for 'informal exercise', levels of diversion, and migration challenges (language) can limit physical activity (Galdas *et al*, 2012). There appear to be differences between South Asian women from different cultural backgrounds and generations when attending the gym or doing physical activity. Cultural and religious differences, e.g. Muslim Pakistani women from first and second-generation requesting segregated gym space, imply cultural heterogeneity affected by generational factors.

Second-generation women preferred to exercise in isolation and away from judgemental, older Pakistani women. There were numerous issues surrounding appropriate gym attire, and women exercising in mixed gender environments. Young women preferred to exercise in single sex environments, or outside of their community, to prevent discrimination by Pakistani men. However, exercising at home by themselves can lead to feelings of low self-worth. Younger women are often negotiating multiple identities that influence their ability to exercise in public, such as young women who face harassment when participating in sports (Walseth, 2006). In particular, parents' beliefs meant they were more likely to prevent their daughters from participating in group activities (Walseth and Strandbu, 2014). Bhatnagar, Shaw and Foster's (2015) review of generational differences in physical activity of UK South Asians discovered second-generation women were more active than first-generation women, but had limited evidence concerning the different attitudes second-generation South Asian individuals have towards exercise.

There are generational differences that influence women's ability to exercise. First-generation women are inhibited by migrant factors, whereas second-generation women are conflicted by shifting attitudes and identities they negotiate in different social networks. Such

complications can affect motivation to exercise, as individuals would prefer to avoid isolation and being criticised or discriminated against for their behaviour.

It is clear that physical appearance plays an important role in how members of the Pakistani community socialise. For women, trying to have control over their lifestyle choices is informed by tradition, culture, religion and patriarchal familial structures. Furthermore, there are generational differences in the resources available for women to pursue a healthier lifestyle.

6.4 SUMMARY

In this chapter I have identified five major categories and underlying themes related to the perceived levels of social capital (support and information) available for women in the Pakistani community.

There are generational differences between women in the community when accessing sources of support. First-generation women are moving beyond traditional roles such as mother and wife. Second-generation women are trying to manage multiple identities and shifting trends surrounding culture and religion.

The findings demonstrate the societal pressure for young women to achieve a desirable appearance within familial constraints on diet and exercise. Despite greater access to work and education, young women have limited agency over their lifestyle choices or influence over family members. Restrictions on socialising limit women's sources of information, where seeing the GP, and searching on the Internet are acceptable methods for acquiring health knowledge. Furthermore, women are trying to negotiate control over themselves and others in a competitive, insular community with limited access to internal or external support.

The next chapter will provide a conclusion which discusses issues mentioned in the findings chapters of this thesis. The conclusion will include reflections on the findings in relation to existing research, with greater critique, implications of findings for future work, strengths and limitations, and recommendations for policy.

CHAPTER 7

7.0 CONCLUSION

7.1 INTRODUCTION

This chapter summarises key findings of the study, including attitudes towards perceived social capital for the prevention of cardiovascular disease in the Pakistani community in the West Midlands, UK. I discuss how findings support or build upon existing literature, as well as, limitations. This includes a critique of methodology and assessing the robustness of using a theory-based approach for data collection and analysis. Implications for practice and policy, as well as recommendations for further research are outlined. The chapter ends with personal reflections with regard to the production of this thesis.

7.2 SUMMARY OF KEY FINDINGS FOR MEN AND WOMEN

Findings have identified key gender and generational differences for members of the Pakistani community in relation to accessing health information and support. Gender in particular has been a useful perspective to approach each aim and objective in turn. I will now outline how each research question has been answered (Table 26).

Table 26. Summary of findings in relation to the research questions

Research question	Summary of findings		
	Men	Women	Men and women
<i>1. How are networks of support and information accessed by members of the Pakistani community?</i>	<ul style="list-style-type: none"> • First-generation men have a preference for socialising and seeking health guidance at the <i>Mosque</i> • Second-generation men have opportunities to socialise, e.g. at local gyms • Second-generation men have more opportunities to gain knowledge and financial support through work and education compared to first-generation men • Younger men supplement healthcare information from the GP with online resources, e.g. for nutritional information 	<ul style="list-style-type: none"> • First-generation women rely on healthcare advice from their GP, colleagues, husband or children • Second-generation women struggle with socio-cultural and religious barriers to accessing social networks outside of the home • Second-generation women feel stereotyped by their GP as having limited social or personal resources 	<ul style="list-style-type: none"> • First-generation men and women are limited to the information available from their peers • Second-generation participants develop social ties outside of home or communal settings • Second-generation community members are less likely to approach the GP for healthcare • First-generation are satisfied by local GP as resource for health information

Research question	Men	Women	Men and women
2. How does the local or wider community influence lifestyle choices?	<ul style="list-style-type: none"> • Younger men are encouraged to adopt health practices learnt at the gym and share them with their male peers • There is communal pressure for young men to physically display masculine traits in order to influence other community members • Older men reinforce socio-cultural norms and establish segregation in public places e.g. <i>Mosque</i> • First-generation men view change in diet as deviation from traditional norms 	<ul style="list-style-type: none"> • Young women deal with verbal disapproval and stigma for unconventional lifestyle choices • Women attempt, but struggle to empower each other • There is community pressure for young women to look slim and feminine • Women experience mental fatigue and symptoms of depression as a result of negotiating numerous socio-cultural norms • Women feel inhibited by patriarchal structures to pursue unorthodox social or health ventures 	<ul style="list-style-type: none"> • There are patriarchal structure where men are provided with more support to pursue what is perceived as healthier lifestyle choices (going to the gym) • Younger men and women try and move away from traditional roles but are dominated by the views and ideals of older first-generation community members

Research question	Men	Women	Men and women
<p>3. <i>What individual health goals exist, and how are they embedded within a community space?</i></p>	<ul style="list-style-type: none"> • Men attend local community gyms together in groups or pairs to pursue a culturally endorsed masculine physique • Men take pride in their traditional community but are aware of negotiating cultural shifts 	<ul style="list-style-type: none"> • Younger women are reluctant to exercise in local areas due to community stigma and often exercise in the privacy of their home • At times women resort to extreme dieting where food intake is decreased • Younger women feel restricted by their choice of attire to exercise • Older women who wore traditional attire (hijab or <i>Niqaab</i>) felt more comfortable exercising in public (park) or private (ladies gym) • There is a lack of suitable women only exercising facilities 	<ul style="list-style-type: none"> • Participants health goals are to appear physically attractive especially amongst second-generation community members • Trust develops as a result of familiarity with local Pakistani community members • Small changes were incorporated into an existing routine by first-generation community members e.g. going for walks • Older community members criticise second-generation individuals for making changes to lifestyle • Large number of takeaways and restaurants in some areas influence community food choices

For the first research question, I discovered that participants' access to networks of support and information was largely shaped by gender, age and affiliation with a particular generational group.

First-generation men and women were limited to information they sought from peers, however first-generation men had a clear preference for socialising at the *Mosque* to seek further health related guidance, yet first-generation women relied on GPs and colleagues at work. Alternatively, some women relied on their husbands and children to provide them with healthcare information.

In contrast, there was a tendency for second-generation men and women to develop bonds outside of their home and at times, communal settings. Men were particularly liberated in their approach to social activities, and relationships also developed by attending the gym, yet women had limited access to suitable gyms and were provided with fewer opportunities to exercise. Women from the second-generation struggled for equality, as there were many cultural, religious and traditional barriers to women accessing social networks and resources outside of the home. As a result, women struggled to identify as Pakistani, but adopted a greater Muslim persona to increase access to resources outside of the community.

There were greater opportunities for second-generation men to expand their social networks and sources of knowledge and financial support. Ijaz and Abbas (2010) identified the shifting trend for second-generation Pakistani men and women to pursue higher education, although women are expected to adopt more traditional norms and values for social conduct and lifestyle choices. Furthermore, second-generation men have greater socio-economic resources to exert influence over the first-generation (Picot and Hou, 2003; Montazer and Wheaton, 2011).

Although men and women may have access to different social resources, views on GP services and healthcare providers are similar amongst second-generation Pakistanis in this

research. Unlike first-generation community members, second-generation men and women were less likely to approach their GP for healthcare information due to dissatisfaction with treatment, lack of time or personalised care, and stereotyping. Exposure to wider community networks and higher education increased second-generation participants' awareness of healthcare expectations.

Second-generation women felt stereotyped and judged by Pakistani GPs who assumed socio-cultural restrictions. For example, GPs may not provide sufficient advice for dietary changes or exercise, as South Asian women are perceived to be limited by social, cultural and spatial factors. There is a distinctive increase in the demand for a higher quality of care and health education by female, second-generation patients (Durham, 2007; Puthussery *et al*, 2008; Cross-Sudworth, Williams and Herron-Marx *et al*, 2011). Second-generation men also preferred to use online resources or social connections to find support for healthcare needs rather than discussing it with their GP, for example, researching nutrition, recovery from sports injuries, and exercise regimes with peers at the gym. Clearly, younger generations of migrants have greater expectations from healthcare providers than their predecessors and are keen to vocalise their concerns.

Yet, first-generation community members were satisfied with local GP services and healthcare advice in general (Khanam and Costarelli, 2007). Older generations have greater age-associated healthcare needs and are more likely to access healthcare services.

In relation to the second question, participants described competition amongst men and between women to be physically superior to their peers.

In my findings, young men were encouraged to adopt new health practices that they learnt at work or the gym. Conversely, younger women were the targets of verbal abuse and ran the risk of being ostracised if they practised unconventional lifestyles according to

Pakistani society. This reflects the community's patriarchal structure in which men are given greater social support and informational resources than women to practise their lifestyle of choice (Roomi and Parrott, 2008). Women try to empower each other through shared awareness, but continue to face socio-cultural restrictions and limited access and support.

Younger male and female participants seemed to alter their lifestyle in order to reflect social expectations, especially in relation to physical and principled appearances. Women felt pressure to look feminine, slim and fair, whilst maintaining an element of modesty. Men, felt they had to show masculine traits through strong physical attributes and influence over peers. Exercising to achieve a slim or strong physique was not necessarily for health purposes, but at times to fulfil societal needs.

The pressure for Pakistani women to adhere to slim feminine norms has been established in existing research where the pursuit of such an appearance can result in eating disorders (Mumford and Choudry, 2000; Wray, 2002). This is often a consequence of negotiating complex internal conflicts, where women must adhere to religious, cultural, traditional, and modern 'Western' ideals (George and Rail, 2005; Samie, 2013). These conflicts could restrict women from accessing local health resources, such as spaces to exercise, or discussing their health beliefs (Dwyer, 1999). Similar to the present findings, Lawton *et al* (2006) noted greater levels of anxiety displayed by women when adopting a routine that did not prioritise their familial obligations. This could be due to patriarchal structures that enforce traditional roles for men and in particular women who must negotiate their lifestyle choices around strict guidelines.

Women expressed symptoms of mental fatigue and depression as a consequence of balancing numerous socio-cultural ideals and norms (Gilbert, Gilbert and Sanghera, 2004; Ahmad *et al*, 2005). This echoes the findings of Shaw and Charsely (2006), and Dale and Ahmed (2011), where the anxiety to maintain traditional ties can inhibit women from

pursuing social ventures that are not endorsed by men in the family. These restrictions can limit socialising to culturally suitable platforms, such as Muslim charity organisations.

Older men in the family reinforce socio-cultural norms within the home in a framework of patriarchy, and these norms were often discussed and established in segregated social spaces such as the *Mosque*. De Cordier (2008) and Besin *et al* (2010) support this notion, as they noted religious organisations enforce traditional and religious norms through segregation from non-Muslim communities.

First-generation male family members view changes in dietary behaviour or exercise as acculturation and deviation from traditional norms (Bhimji, 2009). Furthermore, Ryan and Webster (2008) distinguished the “hegemonic masculinity” of men at home, where rights and views of male family members are superior to those of women. Consequently, any changes made to the lifestyle should be supported by family and community members, otherwise the individual could be ostracised.

Men try and reflect their social position in the home and community through masculine physical attributes. These findings are consistent with existing research where race, ethnicity and socio-cultural influences direct the formation of masculine identities; where going to the gym and exercising was viewed as an acceptable norm for male participants (Wang, 2000; Macey and Carling, 2010).

Although second-generation men and women try and move away from traditional models of externally ascribed behaviour, appearance and choice, living in a ‘public sphere’ dominated by male community leaders can conflict with youth priorities and values (Giguère, La Londe and Lou, 2010). Clearly, first-generation men try and enforce traditional value systems on younger members of the community, in particular women, who consequently face a greater struggle to pursue an independent lifestyle.

Answering the third research question, social and cultural motivation to appear physically attractive shapes individual health goals, especially for second-generation community members. These health goals would be achieved within the constraints of the local environment and according to cultural norms for socialising.

Community members paid particular attention towards socio-cultural norms when developing social networks that served a specific purpose, e.g. going to the gym with Pakistani friends.

First-generation men and women were more successful in incorporating small changes into their daily routine, whereas younger members faced criticism in trying to make bigger changes.

Although a slender, fair and feminine physique is praised by community members, women are reluctant to pursue such endeavours publically due to community stigma. They often exercise and diet within the privacy of their own homes, at times by drastically limiting their food intake. Similarly, George and Rail (2005) noted the difference between looking good as an important social issue, and health as a personal choice. Where societal views are prioritised, sacrifices to personal well-being could be made. In particular, researchers have identified social restrictions for dress and marital choices on women in the community (Zaidi and Shuraydi, 2002; Mishra and Shirazi, 2010; Bolognani, 2013). However in this research, first-generation women wearing the hijab were more confident about doing exercise in public (at the park) and private spaces (ladies only gyms). Comparably, Swami *et al* (2014) identified hijab wearing as a confidence booster that buffered societal views amongst wearers, which could explain how non-hijab wearing women mentioned criticism regarding their choice of gym apparel as affecting their ability to attend the gym. Consequently, many women preferred to stay at home rather than seek consent, or became empowered (Afshar *et*

al, 2005; Dale *et al*, 2006). Hence, trying to incorporate lifestyle changes can be overwhelming for many women who find it easier to adhere to traditional roles.

Trust also played an important role when forming relationships with people with whom individuals could discuss personal health experiences. This was due to the variety of sub-cultural beliefs within the Pakistani community, and a level of uncertainty surrounding secular or traditional practices in each family. Many men continued to express pride in their residential community, but were aware of negotiating cultural shifts towards Western practices (Pingali, 2007; Gilbert and Kohkar, 2008). This could be a challenging time for community members where negotiation between multiple ethnic identities and acculturation continues to affect the pursuit of better health.

7.3 ORIGINAL CONTRIBUTIONS AND CONTEXTUALISING FINDINGS IN EXISTING LITERATURE

An original contribution from this research was insight into three generations of Pakistanis living in the West Midlands, their approach to forming social networks, and interpreting perceptions of how community spaces and norms influence health behaviours through the theoretical lens of social capital. Specifically, personal needs, in contrast to individual's views on health and social resources, which are differentiated by gender and generational differences.

Birmingham and the surrounding West Midlands region is a diverse, multi-ethnic location that relies on policy and clinical research teams to identify relevant healthcare practices for its constituents (Gill *et al*, 2007). I have contributed to this understanding by exploring views on social networks and preventative health beliefs in the Pakistani community as a group, whilst shifting the view towards gender, and beyond the ethnic categorisation.

There is an assumption that individuals from minority ethnic groups or marginalised populations overly rely on familial help to supplement support from social and healthcare services. Researchers have identified the role of family members to facilitate public health care teams, such as translating information or providing transport services (Katbamna *et al*, 2002; Dixon-Woods *et al*, 2005; Dixon-Woods *et al*, 2006). Researchers should consider the socio-cultural influence over the level and type of support and information available. My findings have demonstrated gender and generational differences in the perceived level of available social capital (support and information) for the prevention of cardiovascular disease (diet, exercise and knowledge). Participants appeared to be segregated at work, university and the gym in Asian areas resulting in further segregation and limited exposure to non-ethnic, or religiously, culturally neutral lifestyle choices. Social capital could be increased for men and women through wider community engagement, especially for women through work and social activities.

Masculine identity and patriarchy combined with cultural norms and values formed a system within which men and women form different social ties.

Men can successfully pursue leadership roles within the community by strengthening existing networks. Members of the Pakistani community are segregated, with stronger patriarchal structures than other South Asian groups. For example, the Sikh community has assimilated with British middle class educational values and moved more fluidly within and between different cultural fields, e.g. choosing when to behave Indian or British (Hall, 2010). Pakistani men were more empowered within the community where they operated within insular and patriarchal networks.

Being physically attractive was viewed as a priority for younger single community members through culturally and religiously approved methods. Research has noted British

women from Asian backgrounds felt pressure from their husbands to limit involvement with people outside of their community due to religious reasons (Wood, Davidson and Fielden, 2012; 88). Female Turkish migrants in London tried to balance patriarchal structures and cultural norms with the ability to make economic gains and have equal control at home, and some women resorted to leaving the community (Dedeoglu, 2014; 111). Women from minority ethnic and/or migrant communities may face greater societal pressure to appear as though they follow cultural-norms, by limiting engagement outside of community networks and maintaining traditional practices.

Acquisition of native or majority society language can be an indicator of similarities between different generations, and a likelihood of intra-community engagement (Franz, 2015; 37). Younger participants noted the language used by *Mosques* did not engage their interests or speak out to them. Therefore, first and second-generation migrants may have conflicting views on how social resources are accessed and distributed. For example, second-generation men might prefer the gym, and both men and women use *Shisha* to socialise.

First-generation male participants displayed strong feelings about Pakistan as their home and travel destination. Building a strong connection to Pakistan could be a 'safety net' when trying to adapt to the host country and maintain transnational loyalties (Erdal, 2012).

Preserving these transnational ties is also reflected in the marital customs within second-generation Pakistani migrants and relatives overseas (Shaw, 2006; Shaw and Charsley, 2006). First-generation Pakistani men could be under pressure to maintain traditional values in their families, if they are to form or maintain multinational relationships.

Unlike Pakistanis, Hindu and Sikh communities are not encouraged or permitted to carry out close-kin marriages and do not display a similar emotional attachment for

transnational relationships (Harvey, 2001; 19). Second or third-generation Pakistanis may be increasingly diverse and less motivated to travel to Pakistan (Mock *et al*, 2012: 114). This implies a shifting experience of identity and transnational ties amongst the new generation of British Pakistanis.

The emerging narrative on female empowerment or patriarchy was an unexpected consequence of investigating social networks and health. Gender differences appeared to play a key role in men's and women's access to social and healthcare resources. Cultural norms and structures were in place that, at times, prevented women from pursuing independent personal or health goals. Participants also felt Pakistan and Saudi Arabia were popular holiday destinations. The continuing Eastern influence alongside post-colonial migrant experiences could account for the existence of a perceived threat from 'Western' and 'anti-religion' influences for living in the West (Richards and Omidvar, 2014). The expectation for women to dress a certain way could be a reflection of such views.

Female participants in my research began to display greater confidence and ownership of their bodies by exhibiting leadership qualities in non-communal settings (e.g. work or university), making dietary changes and going to the gym. Control appears to be better in non-Pakistani (male) orientated spaces.

Generational differences in healthcare could be a reflection of health seeking behaviour, as one of the major overall findings was a hesitancy of young men and women to approach GPs. Older people may expect to be treated according to the biomedical model, where treatment is disease oriented and focuses on the illness and body (Scambler, 2008; 57). Migrants may also have a consumerist approach to healthcare based on a perceived need for additional or alternative medicine (Rhodes *et al*, 2008). Yet contemporary ideals surrounding health

incorporate a holistic approach to individual mental and physical well-being (Fawcett and DeSanto-Madeya, 2012; 130-131).

Generational differences between understanding of healthcare, prevention, management and treatment could conflict with discussion on well-being and allocation of community resources. Younger members might be keen to develop facilities such as the gym, but older migrants might believe healthcare services should take greater responsibility.

7.4 THEORETICAL LITERATURE

The research was informed by different concepts but social capital was used as a lens to structure the interview and interpret and frame findings. Social capital as a theory informed the interpretation and critical analysis of data in this research. I used three integral concepts proposed by Putnam (Brian, 2007; 32) to structure the interview guide, and as a lens to interpret and organise the information. These components were social networks, trust and cultural norms.

7.4.1 Putnam's concepts of social capital

I will now discuss the three underlying concepts of social capital (and how I have used each) as outlined by Robert D Putnam, and reciprocity as a parallel component (Putnam, 2001). I found Putnam's body of work to be a useful aid in designing the interview guide and developing a critical and interpretive stance for analysing data.

7.4.1.1 Social networks

In social capital theory, social networks have value that can increase or decrease the productivity of individuals. Ryan *et al* (2008) argue that researchers assume migrant communities have dense, close-knit networks. The findings of their work indicated Polish

migrants hold strategies for networking amongst small similar groups based on ethnicity and familial ties where networks served an instrumental purpose (Ryan *et al*, 2008).

I related the concept of social networks to the social psychology theory of ‘instrumental others’ and goal pursuit in which individuals prioritise relationships with people who may help them to achieve some personal benefits and obtain a goal, i.e. recruiting friends to reduce stress if they provide positive emotional support (Fitzsimons and Shah, 2008). I used instrumentality, goal pursuit and social network concepts in unison to help distinguish the types of bonds that participants formed. This was evident amongst second and third-generation men, who socialised with men who had a masculine physique. By going to the gym with experienced body builders, young community members gained information and social benefits. They learnt about exercises and nutrition, but also how to become responsible heads of their family and consequently community. However, participants could benefit from engaging in health dialogue with a wider community audience in order to learn about a multitude of health behaviours and lifestyle options such as exercise regimes for cardiac fitness, without focusing solely on muscle building.

7.4.1.2 Trust

I investigated how participants felt that they had developed trustworthy relationships with members of their local and wider community. Putnam (2007) has noted the potential shift in empirical research towards ‘conflict theory’, where diversity creates out-group (trust) and in-group (solidarity) differences. Based on this theory, we become more distrustful of other communities and more reliant on members of our community group (Putnam, 2007).

In my findings, participants consistently mentioned the lack of trust amongst community members and its detrimental effect on knowledge sharing and support.

Participants felt that they could not discuss their health beliefs with members of their

community (sub-group variation), and at times their family members, in case they were met with criticism. Many of the participants, especially first and second-generation men, were reluctant to socialise outside of their cultural and religious domains due to unfamiliar lifestyle practices. Therefore, participants felt conflicted in their ability to adhere with in-group behaviours or try to satisfy out-group standards of behaviour, and preferred to limit socialising with familiar others.

7.4.1.3 Cultural norms

The intention with cultural norms was to explore whether shared norms existed and whether they influenced or helped, or formed or divided social networks, as the norms tend to reflect values of the majority of the community (Arneil, 2006; 32).

Participants focused on their personal identity when discussing cultural norms, and were often negotiating different cultural and religious identifiers. Ultimately, gender influenced the cultural guidelines within which individuals constructed their social networks (community norms) and lifestyle practices (personal norms). Community members felt that they had to tailor their lifestyle choices to suit community views on such behaviours in order to obtain social support.

7.4.1.4 Reciprocity

Reciprocity develops between individuals where social support (advice, courtesy or assistance) is exchanged through social ties based on the notion that it will be returned in a similar or different form (Putnam, 2001).

Social and political activities are involved in the formation of such reciprocal networks, where civic engagement, for example charity and religious attendance, encourages members of the community to engage with each other (Putnam, 2001; 37).

A key finding from my research was the importance of Muslim charitable organisations and the *Mosque* as a platform for socialising. However, as these organisations were managed and attended by Muslim volunteers, this limited the development of social networks outside of the religious community and instilled traditional, cultural and religious views. Furthermore, regular attendance at religious institutions, i.e. the *Mosque*, was a pastime of first-generation men, whereas women or young men felt unwelcome (Chapters 5 and 6).

7.5 LIMITATIONS OF THE RESEARCH

Research questions were designed to gain a better understanding of behaviours related to the prevention of cardiovascular disease. For this I used an interview guide that was based on elements of the social capital theory, alongside the convoy model diagram to elicit participants' responses. A number of methodological and theoretical issues arose during data collection, and these influenced the findings.

7.5.1 Methodological considerations

There were numerous barriers and facilitators surrounding data collection: drafting material for recruitment, developing a rapport with participants, and managing a large amount of data.

My research involved recruitment of a minority-ethnic, poorly educated community.

Therefore, interviews were an appropriate form of data collection and suitable talk-based method for a BME community (Squires, 2009; Sidhu, *et al*, 2016). Findings were interpreted against a theory (social capital) (Putnam, 2001), and a mixed-method approach was used to collect data (interviews and convoy model) (Pachana and Laidlaw, 2014).

Bhopal *et al* (1999) identified differences in the prevalence of illness and disease in different South Asian groups, where Bangladeshi and Pakistanis had a greater risk of developing CVD alongside the varying effects of numerous socio-cultural factors. A focus on behaviours associated with preventing CVD in the Pakistani community as an ‘at-risk’ population to highlight sub-group variations was maintained.

I present a ‘snapshot’ of the Pakistani community living within Birmingham and The Black Country from October 2013 to February 2014. As a ‘snapshot’, these findings can present themselves as a case study, and certain conclusions should not be drawn from this research, such as how local health facilities are catering for male health trends in the Pakistani community (Thomas, 2011; 146-149). My findings provide an insight into a migrant community in Britain which may be transferable to other populations in the UK.

Prior to data collection, my qualitative skills were limited to conducting semi-structured interviews. Consequently, I carried out a series of pilot interviews to help develop an understanding of in-depth data collection. Completing a Master of Arts in Social Research and Social Policy prior to the start of the thesis provided training that became beneficial to this process. Condensing and organising themes into a series of frameworks involved complex data management, where data had to be descriptive, and related to the original text, whilst providing an interpretation (Gale *et al*, 2013). I attended an NVivo workshop on the practical uses of framework analysis prior to creating the framework where I learnt how to plan and manage different matrices which captured the richness of data and made the participants’ experiences transparent. I understood that moving backwards and forwards between different matrices and taking breaks between analyses would help provide a fresh perspective (Smith, 2011). Furthermore, supervisory meetings were a monthly occurrence with PG and SG during the analysis process, where field notes, codes, and the formation of

themes and categories into matrices were discussed in great detail to determine an accurate representation of data.

Another limitation was the multi-media data presented during interviews. Participants provided extra material, such as photographs or websites, to help make sense of their lifestyle choices. Some participants emailed images and gave consent for their use on posters as a means to illustrate their quotes (Appendix 14). Images included food that they had prepared, and charity events organised to raise funds for recent natural disasters, e.g. earthquakes in Pakistan. However, some images were of women without their hijab on, and due to issues of confidentiality I could not use this information. Researchers have used participants' photos to elicit responses in previous research as it has helped to develop a dialogue on social exchange and rich real-life experiences using a 'Photovoice' or 'photo-elicitation' method (Castleden, Garvin and Nation, 2008; Sandhu *et al*, 2013). Although I did not actively apply photo-elicitation methods, photos provided by participants were an illustrative method for participants to elicit conversation. It would have been interesting to include the images as part of the narratives, as well as choice of dress. Some participants chose to wear traditional Islamic or Pakistani clothing, in particular the hijab or *Niqaab*, which could further conceptualise findings.

I had to navigate numerous customs whilst carrying out interviews, including being aware of Islamic beliefs such as the *Sunnah* (teachings of the prophet [peace be upon him]) (Abdul-Rahman, 2-7: 131-139). Individuals' raise awareness for religious mannerisms and encourage others to follow. Religious awareness was brought to my attention as participants were monitoring my behaviour; for example, one participant corrected me for holding a glass of

water in my left hand, whereas food and drink are consumed with the right (Hashimi, 1997: 347).

Determining the point at which saturation had been achieved was a difficult process as it required careful consideration of participants' narratives in conjunction with answering research questions and topics outlined in the interview guide. The supervisory team and I discussed the degree to which participants, per age bracket, had discussed topics to a similar extent and there were no new ideas or concepts emerging from narratives. There was a potential for continuing to interview participants on themes and concepts, such as patriarchy, but this would have diverted the direction of the interview away from the topics of interest and limited uniformity of data collection across participants.

7.5.2 Reliability and validity

I will address each of Angen's (2000) principles on evaluating interpretative inquiry to establish the level of validity of my research. This involved considering ethical (reflexive) and substantive (interpretive) validity (Table 27).

Table 27. Addressing the criteria for effective and valid research

Angen's (2000) criteria
<p>1) <i>Careful consideration of research questions</i> The origin of the present qualitative research has been outlined in literature contextualising the research and through a synthesis of relevant qualitative literature (Chapter 2, pg,6 ; Chapter 3, pg, 40)</p>
<p>2) <i>Carrying out the qualitative inquiry with respect to participants</i> Careful cultural and religious considerations were made prior to data collection in order to develop rapport with participants, acknowledge and address any issues of modesty and consent, and understand barriers to participation, e.g. language (Chapter 4, pg 109-138).</p>
<p>3) <i>Awareness of subjectivity during data collection and interpretation</i> I have provided a detailed and descriptive exploration of my position within the community and relationship with different participants based on age and gender. I have also outlined the involvement of community members, academic supervisory team and South Asian researchers in the department (Chapter 4, pg, 109-156; Chapter 7, pg, 333-345).</p>
<p>4) <i>Development of persuasive argument</i> The qualities and abilities of the researcher can determine the level of involvement in the research process and the conclusions they have come to. I have outlined my personal and professional development during this research as well as my academic background, the theoretical background, and literature used to interpret the findings (Chapter 4, pg, 109-125; Chapter 5 pg, 216 and Chapter 6, pg, 305).</p>
<p>5) <i>Evaluating dissemination of findings</i> Findings have been contextualised within research carried out with other migrant populations. Policy recommendations and potential for future research have highlighted areas of relevance (Chapter 7, pg 345-357).</p>

As a member of the Pakistani Muslim community, there were many advantages to conducting recruitment, data collection and analysis process. My position as the primary researcher enabled me to provide greater insights into the data, which at times discussed Pakistani and Muslim paradigms in great detail. Therefore, I had a better understanding of the differences

between sub-groups and religious sects that can influence participants' lifestyle choices which are often discussed in the interviews, or etiquette during the research procedure.

Members of the Pakistani community take time to develop trust with individuals outside of their social or cultural groups (Din, 2014: 37). Rapport was built as I have an understanding of diverse 'Pakistani etiquettes' surrounding social interactions within sub-groups; for example, using the appropriate customary greeting for older or younger, men or women (Din, 2014: 51). Young men (aged 18-22) were of particular interest when navigating the interview as they struggled to contextualise my position as a young, female researcher. Over time the young men understood that the dynamics of the research were not as formal or intimidating as they had anticipated (authoritarian interview setting), but not too casual or awkward to be talking one-to-one with a stranger of the opposite sex about personal topics (health beliefs, family and tradition). Archer (2001) noted that adolescent Muslim males discussing hegemonic masculinity were negotiating the boundaries of Western and Islamic societies during the interview process, and were less explicit about religious boundaries for dress in front of a South Asian interviewer wearing a skirt. These adolescent men viewed Westernised Muslim women as unauthentic, yet positioned themselves as their necessary protectors (Archer, 2001). I had taken precautions to dress in a culturally and religiously appropriate manner, whilst using a series of open-ended questions to enable participants to discuss their views freely. Unlike Archer's study (2001), I was not targeting identity and masculinity from a feminist stance, but conducting research surrounding social networks and health. For these topics, participants felt more comfortable to vocalise some of their personal views regarding women's choice to exercise in parallel to their own belief systems.

Working with members of a migrant, minority-ethnic group presented a series of challenges. Participants switched between Urdu and English to emphasise their points. This led to some

difficulties during transcription, as external transcription had to be re-read to correct any mistakes and acknowledge how questions were framed (Sidhu *et al*, 2016). My proficiency with the use of Pakistani idioms, fluency in Urdu and other linguistic nuances, was beneficial when designing recruitment material.

However, there were two issues related to participants' limited use of the English language. First, participants found it difficult to grasp some academic or medical terms used to explain the purpose of the research. Second, it was difficult to translate the word 'convoy' into Urdu or the dialect spoken by some participants. Nonetheless, linguistic issues did not require an interpreter from an external translating service (Squires, 2009). This strengthened the rapport between participants and myself as we could communicate with each other directly. Furthermore, I was able to oversee the entire data collection, analysis and presentation process.

As part of the inter-rater reliability process, community members and the supervision team and South Asian colleagues provided feedback on the recruitment material, including the interview guide, verification of translated transcripts, and the coding process (Long and Johnson, 2000; Pope, Zeibland and Mays, 2000).

It is well noted that individuals from a minority-ethnic background have lower levels of participation in healthcare research (Hussain-Gambles, Atkin and Leese, 2004; Wendler *et al*, 2005). Some participants reported that this was their first experience of being interviewed and discussing their healthcare beliefs in depth. Limited participation could be due to the concentration of community members within a particular geographical location (Nazroo, 1998). Furthermore, Pakistani participants can display cultural heterogeneity from spoken language to the unique socio-cultural norms that require significant considerations during research and its implications (Culley, Hudson and Rapport, 2007). As such, a greater effort

was made to recruit participants through diverse recruitment channels, including social media, word-of-mouth, gatekeepers, third sector organisations, and posters in South Asian business districts.

Researchers tend to rely on written invitations, or questionnaires or letters of invitation to promote participation, but this can limit recruitment to White, middle-class populations (Swanson and Ward, 1995; Poynton, Wood and Greenhalgh, 2004). Consequently, minority-ethnic participants can be under-represented due to issues surrounding literacy or comprehension of complex concepts when consenting to research (Hussain-Gambles, Atkins and Leese, 2004). As Lloyd *et al* (2008) note, minority-ethnic participants can comprehend complicated academic research ideas if they are presented in an alternative manner. Therefore, I made a conscious attempt to use a recruitment method to target a diverse a population and increase representation of the Pakistani community.

Gatekeepers can draw on ‘different axis of the researcher’s identities- religion, ethnicity, gender and age-in ambiguous and contradictory ways’ during the recruitment process (Sanghera and Thapar-Bjökert, 2008). At times it was difficult to identify potential gatekeepers, but my previous role as a member of the Pakistani Society at The University of Birmingham enabled me to communicate with a variety of people. Additionally, social media and the use of third sector volunteering services provided access to Pakistani communities I was unfamiliar with.

Furthermore, whilst using gatekeepers, we cannot be certain of the number of participants who showed interest in the research or refused to participate, but can use theoretical sampling methods to recruit for pre-determined characteristics (Jepson *et al*, 2012).

In order to reflect the diversity of participants taking part in this research, deviant cases were included in the analysis. Not all participants agreed with each other on certain topics and expressed their opinions in different ways (Holloway and Wheeler, 2013; 143). For example, although most participants placed greater importance on women's physical appearance as suitability for marriage, one female participant openly discussed her desires for an athletic, handsome partner, and an attraction to men from other ethnicities.

Although an effort was made to recruit an equal number of male and female, and older and younger participants, it would have been worthwhile to recruit more participants from the third-generation and Sikh and/or Christian Pakistani individuals. This could be a reflection of how members of the community identified themselves as being suitable for this research, or the formation of social networks, or how gatekeepers identified suitable participants.

Views expressed by third-generation participants could be explored in greater detail, and illustrate the socio-cultural shifts amongst younger Pakistanis and their effects (if any) on health. With a growing population of second and third-generation descendants in the UK, the effects of 'cycle of disadvantage' regarding social inequalities and social exclusion contributing to poorer health should be evaluated further (Landman and Cruickshank, 2001). Furthermore, some second and third-generation participants identified with more than one ethnic group, i.e. Pakistani with Punjabi-Sikh relatives on their paternal side. The concept of mixed South Asian identities is potentially a reflection of developing superdiverse personalities (Vertovec, 2007), and could provide insight into multi-ethnic and multi-faith social networks.

7.5.3 Rigour

7.5.3.1 Credibility

There was a large volume of data collected from a range of participants. Interviews lasted from 45 to 120 minutes. The quotes were heavily detailed and content varied depending on the language that the participants spoke. Some participants spoke more quickly than others or at greater length, providing a richer, more insightful interview.

One participant withdrew from the research after consenting. The participant had described the study to her partner who immediately disagreed with her participation. The aforementioned participant was the first to take part in the study, and consequently I took greater caution to evaluate the participant's position to exercise choice, despite initial recommendations from the gate-keeper on ability to participate (Miller *et al*, 2012; 62). I made sure that participants had a clearer understanding of the research, their involvement, withdrawal, and the consequences of taking part, before any data collection took place.

Also, I discussed issues regarding consent with my supervisors in our monthly meetings and sought advice from colleagues with similar research backgrounds. I made sure that issues surrounding confidentiality were maintained, and that only methodological rigour was discussed in the latter circumstance. Feedback from community members shaped the formation of the interview guide, and the recruitment material. Even during the interviews, some participants highlighted the issue that older members of the community may have difficulties with the terminology. Consequently, an Urdu speaking colleague (social scientist) verified the translation from Urdu to English during transcription.

7.5.3.2 Transferability

The findings of this study offer a perspective on a particular phenomenon whilst reflecting on the researcher's involvement (Leung, 2015). The aim of analysing and interpreting data from

the Pakistani community was not to generalise findings, but to be transferable to other research settings and populations (Pope and Mays, 2013). I have identified the use of multiple recruitment pathways (social media, volunteering services and business advocates), as well as interviews and the convoy model task (Pachana and Laidlaw, 2014) completed in Urdu as a novel approach to discuss social capital in relation to CVD amongst three generations of Pakistani individuals in the West Midlands, UK. Within this context, migrant status (generation), role as family member, values influencing behaviours, gender, attitudes towards food and exercise, as well as integration amidst other Muslim and/or South Asian communities have influenced the formation of support networks.

As there is a shortage of qualitative research focusing on obesity in the South Asian, especially Pakistani community, due to their limited awareness of research (Jethma *et al*, 2012; 52), the findings and methodological approach used in my research create a unique dialogue on i) participation through diverse recruitment channels, ii) the use of the convoy model diagram (Pachana and Laidlaw, 2014) as a visual aid during an interview, and iii) the formation of lifestyle practices associated with CVD prevention in ethnic social spheres.

The use of visual aids has been reported in research with minority groups to help overcome issues around communication, involvement in trials, and completion of questionnaires (Brown *et al*, 2000; Fouad *et al*, 2000). The convoy model task (Pachana and Laidlaw, 2014) helped participants understand research terms such, as social networks, social circles, friendship groups, and relationships with varying proximity to the individual. Participants could reliably discuss members of their social network as they had a ‘visual aid’ to guide them (Rubin and Babbie, 2010; 107). The use of the diagram as a visual aid could be effective in eliciting a narrative on health care and social networks, especially amongst poorly educated or minority-ethnic participants.

Previous research has demonstrated the effectiveness of using verbal methods with minority-ethnic communities (Flory and Emmanuel, 2004), which enables participants to discuss their experiences in more detail (Leykoff, Levy and Weitzman, 2000; 37). In addition to the convoy model task, the interview guide proved to be a useful tool in prompting participants to discuss their social norms and lifestyle practices.

The methods and approaches used can be transferred to other South Asian communities, and help develop an understanding of migrant support networks in the UK (Ryan *et al*, 2009) and newer migrant groups settling in other Western countries, such as Canada (Stewart *et al*, 2008).

Although I sought a sample that was representative of the Pakistani community, the views expressed about health and social networks are not exclusive to this population. By contextualising features of the research, we can develop an understanding of a particular phenomenon in different research settings (Lincoln and Guba, 1990; Ritchie and Lewis, 2003: 264). For example, as Mand (2006) describes, South Asian lifestyle practices contribute to the wider debate on social capital and ethnicity, especially in relation to gender norms and South Asian households influenced by migration trends. The manner in which South Asian migrants form social networks could be a reflection of acculturation and access to local, as well as international resources.

Appearance was a consistent underlying concept across most categories and themes. Participants wanted to appear as suitable role models in order to access wider community resources. Often, identity was related to contemporary notions of being British or Muslim, especially amongst second-generation Pakistani community members, as demonstrated in chapters 5 and 6. Forming an individual identity within a migrant community appeared to be in conflict with national beliefs about being Pakistani. Creating or maintaining a Pakistani,

Muslim or British appearance created access to particular sources of support. For example, a stronger Muslim identity might form connections at the *Mosque*.

First and second-generation men seemed to access different institutions and community networks to provide support for their preferred identity, and consequently lifestyle choices, including health behaviours. For African-Caribbean Canadians, the immigration cycle has resulted in the formation of hybrid identities where physical appearance and proximity to a dominant group can influence social and cultural capital (Plaza, 2006).

Findings of the present research can be applied to second and third-generation migrant Indian (Sikh and Hindu) and Bangladeshi descendants to develop our understanding of settlement and acculturation in the UK, and the consequent effect of social network formation on cardiovascular health (Netto, McCloughlan and Bhatnagar, 2007; Horne and Tierney, 2012).

7.6 POLICY IMPLICATIONS

The findings of my research can be used to make research and policy recommendations for migrant populations, the influence of the socio-economic environment on health, the role of family members as providers of support and information, and the impact of wider social structures on access to healthcare (Table 28).

Table 28. Policy implications

Findings	Policy recommendations
<ul style="list-style-type: none">• Migrant communities report poor GP experiences• Familial or community support can be inappropriate or insufficient for information on preventative lifestyle changes or access to healthcare services• Second and third-generation migrants have different social, cultural and health experiences compared to first-generation• Younger community members may rely on health information available in social networks (friends, colleagues and institutes) or online• There are intra-group differences in the South Asian community on how different sources of support are used or accessed e.g. relationships that serve the purpose of providing emotional support or natural remedies• Women may be limited to engagement outside of their home due to culturally based familial and communal expectations• Ethnic labels such as South Asian or Pakistani can fail to account for nuances in individual lifestyles	<ul style="list-style-type: none">• Healthcare providers can adopt greater sensitivity towards socio-cultural barriers• Healthcare provider should incorporate an understanding of personal identity and lifestyle choices alongside community beliefs• GP services should acknowledge type and level of support an individual has access to• Healthcare providers should be aware of acculturation amongst second or third-generation migrants and their use of community and online health resources• GP services can raise awareness for using reliable online resources such as NHS websites• Healthcare providers should understand that traditional models of CVD prevention used with White majority may not be applicable to migrant community groups• Social and healthcare providers can encourage wider community engagement by clarifying purpose of health goals to community members, establishing trustworthy relationships with relevant authority figures and developing individual's confidence in managing personal health• Healthcare providers could benefit from a holistic approach to care provision that engages family members and locally recruited staff to develop social capital. Such approaches can reduce isolation and increase confidence to make or maintain change

My findings support an argument for exploring how socio-cultural differences that encompass further discrepancies based on gender and generation can influence the use of medical services by minority ethnic groups from high-risk backgrounds. Participants could benefit from wider community engagement when the GP service may be an insufficient source of support and information to make significant lifestyle change.

Men and women in the South Asian community are willing to seek immediate health-care support and information for acute or chronic heart disease, similar to their White counterparts (Chaturvedi, Rai and Ben-Shlomo, 1997; Sekhri *et al*, 2012). Yet, there is a notable difference between South Asian and White patients on reported GP experience, where older Pakistani and Bangladeshi female patients rated their experience poorly (Burt *et al*, 2015).

The patient experience can be improved for Indian, Pakistani and Bangladeshi migrant groups if the GP language is concordant with that of the patient, yet only 19.7%, 14.5%, and 3.0% respectively of practices offer this service (Ahmed, Burt and Roland, 2014).

Minority-ethnic patients could benefit from healthcare providers adopting a greater level of sensitivity towards socio-cultural barriers that influence individual lifestyle choices. This is not necessarily as a reflection of the socio-cultural or religious trends of their ethnic community, but as a result of their personal identity and lifestyle choices.

These requirements are reflected in the outcomes of behavioural change interventions that consistently highlight the role of family members, advocates, and cultural or religious identification as important, at times pivotal factors, for initiating and maintaining change (Stolley and Fitzgibbon, 1997; Greenhalgh, Collard and Begum, 2005; Netto *et al*, 2010).

GP services could acknowledge the type and level of support that an individual has access to before they rely on family members. Healthcare professionals have reported frustration when communicating with patients from different cultures, especially when

interpreting with third parties (family members), as assessment of needs or negotiating treatment (Kai *et al*, 2011). For example, Green, Lewis and Bediako (2005) interpreted young people's accounts of acting as bilingual interpreters for family members, where translation is a complex activity, negotiating familial, communal and health system agendas. Family members may provide additional support, but not necessarily overcome the dissatisfaction or lack of knowledge surrounding healthcare facilities; consequently, practices have to be readdressed to incorporate such circumstances (Griffiths *et al*, 2001; Lindsay *et al*, 2010).

Additionally, it is an assumption that second or third-generation migrants are experiencing the same socio-cultural or socio-economic constraints as their predecessors. Individuals who are accustomed to different healthcare systems (migrants) may have lower expectations of general services to provide access to specialist care (Lamkaddem *et al*, 2012), or have a higher degree of satisfaction with services (Madhok, Hameed and Bhopal, 1998), but this cannot be generalised to individuals born and raised in the UK. Consequently, practitioners who treat second and third-generation migrants with the same approach used with first-generation patients are making assumptions about healthcare requirements, and displaying a limited appreciation of acculturation. This creates a social and knowledge vacuum that informants must fill with the use of online resources or social groups without guidance.

McMullan (2006) identified a trend amongst the general population who sought help online for specific health concerns before evaluating their need to see a professional, or after the appointment, for reassurance and further information. Younger, better-educated women are more likely to search online than others, which was reflected in my research (Hesse *et al*, 2005). Similarly, in my findings, second and third-generation participants expressed a greater likelihood for solely relying on online information and support from close friends. This trend amongst younger immigrants should be considered in greater detail, where misinformation on

the Internet, poor search methods, limited online recommendations from health professionals, and limited community awareness could be detrimental.

Culturally competent GP services should provide patients with the right access to appropriate healthcare, i.e. through the provision of appropriate translators, but also provide guidelines to access further online or web-based support and information (Beach *et al*, 2007).

Trends amongst younger members of the wider population can also be a reflection of changing health practices, with the GP no longer the primary source of health support or gatekeeper of information (Hesse *et al*, 2005). A study by Sidhu *et al* (2016) evaluated the management and prevention of non-communicable diseases amongst the Punjabi Sikh population of Birmingham; multiple support systems, including family members for emotional support and traditional medicines or online sources (Internet) for symptom support were identified. Although this research draws on the experiences of the Sikh community, it highlights the importance of recognising diversity through intra-group differences surrounding age, gender, generation and caste. Such research challenges assumptions about research and practice designed for majority White British populations, and contributes towards development in health policy (Sidhu *et al*, 2016).

Expected roles and responsibilities can negatively impact on women's health (Grewal, Bottorff and Hilton, 2005). As in my findings, family members supported first-generation women to maintain their role as primary care-providers, or provide second-generation women with exercise routines limited to the home.

A community-based approach could complement and sustain social support efforts to provide women with greater opportunities to pursue health. For example, social and health care services can try and promote wider community engagement for patients from high-risk

backgrounds. This involves, but is not limited to, characterising the knowledge of the community and its shifting diversity, clarifying purposes and goals to community members, providing information, establishing trustworthy relationships with relevant authority figures, mobilising relevant community assets, maximising opportunity for ownership, and shared control by the community through developing citizen councils (Lavery *et al*, 2010). Health interventions, awareness campaigns, and incorporating lay informants to promote prevention and self-management could facilitate the development of such schemes and overcome social isolation (Greaves and Farbus, 2006).

Ethnic labels such as South Asian, or even Pakistani, fail to encompass the myriad of nuances impacting on daily life and the prevention of illness and disease, greater attention should be given to the heterogeneity and use of labels during research and practise to help narrow inequalities and better contextualise health care delivery (Bhopal.2014: 58-59).Using ethnic labels can limit healthcare providers and patients, as providers may overlook the influence of ethnic diversity, especially hybrid identities, in forming individual lifestyle choices. By clustering minority-ethnic groups, service providers undermine cultural heritage, opportunities to empower patients, and patient confidence to manage lifestyle changes within existing socio-cultural frameworks (Page and Whitting, 2007). Patients and providers can benefit from a holistic approach to care provision that engages family members to participate in care, use of staff recruited from local communities, and developing social capital to reduce segregation or lack of confidence (Page and Whitting, 2007).

7.7 RECOMMENDATIONS FOR FURTHER RESEARCH

The methods and participants involved in this research helped identify the need for further research across a number of areas, and it would be worthwhile to pursue certain aspects of the research findings in other contexts or in greater depth. Amongst these aspects, sources of support and information within community networks could be evaluated, as well as the importance of identity, as these factors were often prioritised over health (Table 29).

Table 29. Recommendations for future research

Key recommendations
<p>Community development to support lifestyle change</p> <ul style="list-style-type: none">• Raising awareness for sources of social support, healthcare information and lifestyle choices could help recognise potential areas for health improvements e.g. feasibility of lifestyle changes in an existing routine.• Faith centred locations such as the <i>Mosque</i> could address social and healthcare issues by outlining culturally and religiously appropriate lifestyle choices. The suitability of <i>Mosques</i> for health service delivery needs evaluation.• Community organisations such as drop in centres could provide a religiously and culturally neutral space to reflect on health needs.• Research should explore education and engagement with wider communities for women with perceived lack of social support or negative emotional well-being.
<p>General practice and healthcare providers</p> <ul style="list-style-type: none">• Service providers can consider the effect of ethnic, gender and generation based differences in access to social and health resources.• Healthcare providers may benefit from promoting lifestyle change within homes, the <i>Mosque</i>, or local health facilities.• First-generation women may seek GP approval to justify healthier lifestyle choices and provide support. This might be influenced by cultural concordance and should be further explored.
<p>Generational differences</p> <ul style="list-style-type: none">• Longitudinal research with second or third-generation community members could highlight shifting community health trends.• Researchers can explore how identifying with a particular sub-group, e.g. British Muslim, could affect the formation of social networks of support and information in the wider community.• How online resources such as social media shape individual identities and access to associated social networks can be evaluated in relation to health seeking behaviour.• Younger men and women pursue different leisure activities than their predecessors, e.g. going to the gym, eating out more often, or smoking <i>Shisha</i>. The consequences of these practices on health remain unexplored.

Awareness of health behaviours within a socio-cultural context can benefit individuals by recognising potential areas for health improvements. Feedback from health research can help community members to become cognisant of their socio-cultural and economic environment, and of access to suitable health resources (Blumenthal and Yancey, 2004: 15). As a process of reflecting on sources of social support and health information, participants in this research

acknowledged discrepancies in certain aspects of their care, e.g. lack of support at home or within the community. Assumptions should not be made about how members of the Pakistani community modify existing routines to incorporate healthier lifestyle choices. Faith centred locations, such as *Mosques*, are important social institutions that provide the opportunity to address some of these issues surrounding support and knowledge. Not all members of the community go to the *Mosque*. As the findings of this study indicate, first-generation men can utilise their position of authority at the *Mosque* to address and advocate social and health issues. If alternative, culturally appropriate lifestyle choices are promoted, then community members could have greater opportunity to pursue a healthier lifestyle, especially Pakistani women, for whom socio-cultural and religious norms define access to suitable public or health spaces. Campbell *et al* (2007) identified how church based interventions could target a wider population and reduce disparities for African-Americans who responded positively to spiritually and culturally contextualised health interventions to impact behaviour. This approach holds the potential to be translated into other religious organisations, and use of community assets (Riley *et al*, 2015). An example of such an endeavour is the Sikh community on Soho road, Birmingham, who have invested in developing the ‘*Niskham*’ centre to promote well-being (Jacobsen and Kumar, 2004; 351). However, there remains an issue in engaging with foreign Imams (Muslim leaders) who may not consider UK health policies and community needs beyond social or traditional viewpoints; thus, religious places have limitations (Van Bruinessen and Allievi, 2013). Therefore, researchers need to evaluate the suitability of *Mosques* or religious locations for health service delivery carefully.

It is not the sole responsibility of religious institutions, but also of community organisations such as work agencies to play a role in developing community strength (Slaght, 2009: 95). Drop in centres could provide a unique balance of health and social care advice for

members of the community (McDonnell, 2014:162). Members of the community could benefit from religiously neutral community spaces to reflect on health needs and lifestyle choices.

In contrast to men, women networked with limited influence, and this had a negative effect on their emotional well-being, yet women were becoming empowered through education, employment and interaction outside of the community. South Asian women have reported increased self-confidence and personal autonomy as a consequence of further education and becoming more aware of their own community's norms in contrast to other cultures (Bagguley and Hussain, 2007). Pakistani women with a broader range of networks were more likely to attain health goals and have greater access to a wider range of health resources. For women to limit community influence, they need opportunities to network and form social ties beyond the Pakistani community.

Health care professionals should consider differences in access (based on ethnicity, gender and generation), equality and socio-cultural contexts (economic circumstances and employment) when promoting preventative lifestyles (diet and exercise) (Green, Lewis and Badiako, 2005). Healthcare providers may benefit from promoting lifestyle change with women (or high-risk groups in general) within their homes, the *Mosque* (community spaces), or local health facilities, e.g. the gym, to increase access to health related resources.

First-generation women in my research sought social approval to motivate them to exercise or diet, but, due to perceived limited support within the family and community, older women can be reluctant to approach peers and rely on the GP as the main source of support and information. GPs could also justify participants' uptake of exercise at the gym or health classes. Sidhu *et al* (2015) note the importance of cultural concordance for discussing health

experiences with minority-ethnic patients, including linguistic and contextual understanding (patient attitudes, behaviours and environment). Khanam and Costarelli (2008) noted numerous cultural beliefs affecting the likelihood of women doing regular exercise, such as restrictions placed on them by men. Bangladeshi women in the UK reported a greater likelihood of going to the gym if they were referred by their GP, as they did not get encouragement from other sources (Khanam and Costarelli, 2008). Nevertheless, underlying mechanisms remain unknown about the degree to which traditional and cultural norms restrict women from socialising within the wider community.

Health beliefs in Pakistan could be shaping views of personal well-being in migrant communities overseas. Although health views may be changing in Pakistan at a different rate to the UK, the influence of transnational ties may create greater influence on the migrant community (Mumtaz and Salway, 2005; Victor *et al*, 2012). Migration of Pakistani physicians to the UK could also influence practice and treatment based on Pakistani ideals (Jamsheer and Gregory, 2006). The views on women's health and education could be affected by overseas South Asian physicians and should be further explored.

Future research could explore social network dynamics in greater depth, i.e. considering the behaviours, cognitive, and social factors influencing access to social and health resources for one generation over time, rather than inter-generational comparisons. It could be worthwhile to observe one sub-group in the Pakistani community in further detail, i.e. women.

The present findings are a case study, or snapshot of the Pakistani diaspora in the West Midlands. Longitudinal research with the second or third-generation could provide greater understanding of shifting trends and belief systems. As the first-generation of migrants ages, and the population size decreases, it would be useful to consider the impact of acculturation once the influence of community elders reduces. Traditional patriarchal

structures may no longer serve the purpose of leadership, and alternative authority figures may be sought (Finklestein and Dent-Brown, 2008: 170). Observations can also be made on how first-generation men have instilled traditional beliefs into their family members, whether these beliefs last, or are balanced with more contemporary viewpoints. Greater gender equality could exist in the Pakistani community with the second and third-generation whilst accessing health services.

Amongst these findings, I have highlighted the cultural nuances amongst different generations of Pakistani South Asian individuals that impact their access to healthcare. As members of a heterogeneous community, second and third-generation participants are negotiating between different identities, such as British, Pakistani, South Asian and Muslim. Identification with a social group could be integral to creating networks of support and information within a local and wider community.

Several participants, especially from the second-generation, listed the use of online support and information as a major resource. Third and/or fourth-generation members of the Pakistani community are growing up in a technologically advanced social atmosphere where individuals have the opportunity to document almost every aspect of their lives (Boyd, 2014: 22). A shared consensus of self and well-being is constantly viewed and evaluated by themselves and their peers. Consequently, individuals can establish strong identities and may have shaped their social networks appropriately. Here, different socio-cultural or religious identities could have an impact on health information seeking behaviour, for example women may be cautious of advocating exercising in public or online (i.e. Facebook) as it raises concerns around modest dressing. An evaluation of online social networks accessed by second, third or fourth-generation BME groups could inform researchers on how networks can be cultivated based on identity and personal needs.

Younger men and women in the Pakistani community spent their income on pursuing leisure activities that differed to the previous generation, such as smoking *Shisha*, going to the gym, and eating out to socialise. Smoking *Shisha* has been on the rise globally, with a misconception surrounding how safe or healthy it is to use (Ishtiaque *et al*, 2014). Consumers include university students looking for cheaper alternatives than alcohol for socialising, and an overall novel communal experience (Roskin and Aveyard, 2009; Maziak *et al*, 2011). The uptake of novel leisure activities reflects a shift in consumerist behaviour between first and second-generation migrants, where the latter have access to greater socio-economic resources. Future research could explore how consumer and social behaviour is changing within ethnically diverse communities and its possible effects on health and well-being.

7.8 AUTOBIOGRAPHICAL REFLECTIONS

I have maintained a reflexive approach throughout data collection, analysis, interpretation and presentation of findings. I will now provide an overall insight on my research experience in the production of this thesis.

Learning to understand individual perceptions of social networks and health has been an enjoyable experience, albeit one with many challenges. These challenges have taught me to adapt my beliefs, attitudes and approaches to both professional and academic issues that researchers face during any research.

Although qualitative research can be intense, time consuming and cyclical, it can be rewarding in its ability to expose novel schemes and processes of thinking about certain phenomena. The richness of data overlapped across a series of themes and categories, and

amongst the chaos of vivid quotes was a framework of belief systems, and a consortium of emotions related to social support and personal well-being.

There are a number of processes a researcher must undertake before exploring the impact of any given phenomenon. These include considering my own influence on the outcome of findings, contextualising the findings into a broad framework, and negotiating with competing theories of understanding human behaviour. Framework analysis (Tilling, Peters and Sterne, 2005; 522) provided a rigorous, yet complex system to manage the extensive amount of data collected. Narrowing down the material became more systematic over time as I learnt to efficiently use matrices and developed keys to identify segments of text using numbers. I was surprised by the amount of confidence a researcher can develop in acknowledging their subjective stance when interpreting narratives by using tools and theoretical lenses to elicit a response.

Given the opportunity to repeat this research, I would take a generational approach to the study and evaluate the impact of first and second-generation networks on third-generation behaviour. As this was not the aim of the research, it was a fortunate discovery of how shifting trends in acculturation move between traditional and contemporary viewpoints. I would make comparisons between other health issues, not just CVD, to establish whether individuals form separate health networks for different conditions.

It was at times intimidating meeting new people to interview, liaising over the phone and email whilst maintaining a professional approach. The level of emotions and commitments expressed by some participants to provide their experiences was unexpected, and it was refreshing to interact with participants on a face-to-face basis. The impact of using the

convoy model to help elicit responses and understand complex concepts was especially of interest to me, as it helped generate a rapport with many participants.

7.9 CONCLUDING REMARKS

As a consequence of undertaking this research, I have made an attempt to provide a greater understanding of how a hierarchy of socio-cultural factors influences the formation of lifestyle choices where health may not be a priority.

Minority-ethnic populations, though culturally diverse and at times multi-ethnic, can be insular and limited in terms of the sources of support available to their members. I have acknowledged how access to networks of support is influenced by gender where appearance is a strong motivational factor for making lifestyle changes, which consequently shape the formation of health goals (if any). I have also illustrated how these findings contribute to the existing literature, but also towards the delivery of health and social services in a UK context.

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APPENDIX 1

Databases searched

Online database	Description	Internet site
Web of Knowledge	Citation indexing software with access to science, social sciences, arts and humanities literature. Multiple database search	http://wok.mimas.ac.uk/
MEDLINE	Resource for journal citations and abstracts from international biomedical literature.	http://www.nlm.nih.gov/bsd/pmresources.html
EMBASE	Database covering international biomedical literature	http://www.elsevier.com/online-tools/embase
ASSIA (Applied Social Sciences Index and Abstracts)	Indexing and abstracting tool covering health, social services, psychology, sociology, economics, politics, race relations and education.	http://www.csa.com/factsheets/assia-set-c.php
IBSS (International Bibliography of the Social Sciences)	Resource for social science and interdisciplinary research. Topics covered include: anthropology, politics, sociology, economics, health, education, psychology, philosophy, law and more.	http://www.proquest.co.uk/en-UK/catalogs/databases/detail/ibss-set-c.shtml
Science Direct	Scientific, technical and medical research.	http://www.sciencedirect.com/
CINAHL	Nursing and associated health journals covering biomedicine, health sciences, alternative medicine and more.	http://www.ebscohost.com/academic/cinahl-plus-with-full-text
PsycNet	American Psychological Association approved research database on behavioural science content	http://www.apa.org/pubs/databases/psycnet/

APPENDIX 2

Search words used

Social capital	Ethnicity	Health	Qualitative
Social*	Ethnic*	CVD/CHD	Interview
Social environment	Ethnic groups	Cardiovascular disease	Focus group
Social network	Ethnic diversity	Coronary heart disease	Ethnography
Social Capital	Divers*	Diabetes	Narrative
Sociability	Cultural diversity	Diabetes type 2/II/two	
Social relations	Acculturation	Obese	
Social isolation	Super diversity	Obesity	
Social support	South Asian /British South Asian /Asian	Hypertension	
Family support	Punjab*	Health*	
Famil*	Pakistan*	Health attitude	
Community	Minor* /Minority groups	Health behaviour	
Trust	Ethnic minority groups	High blood pressure	
Neighbourhood*	Ethnic*	Heart disease	
Cultur*	Ethnic density	Diet*	
Cultural norms	Ethnic enclave	Exercise	
Collective*	Ethnic segregation	Eating habits	
Inter/intra personal	Inequalit*	Physical exercise/activity	
Structural influences	Race /Racial	Cardiovascular disease	
Relation*	Racial identity	Cardiovascular risk	
Network ties	Race relations	Health inequalities	
	Racism	Healthy lifestyle	
	Inclusion/ exclusion	Lifestyle	
	UK/Birmingham	Life choices	
	Multicultural*	Smok*	
	Identity	Preventative	
	Ethnic identity	Primary care	
	Islam/Muslim/Punjab*		

APPENDIX 3

An example of search strategies used for online databases

EMBASE				
Search number	Date	Boolean term and Refinement category	Search term used	Total retrieved references
1	13.08.13		“Social environment” OR “social support” OR trust OR “social capital” OR “network ties” OR social OR “family support” OR community OR “social relations” OR sociability OR neighbourhoods or “cultural norms” OR collectives OR “social isolation” OR interpersonal OR intrapersonal OR “structural influences” OR relations	15,506
		AND	“ethnic groups” OR ethnic* OR “ethnic diversity” OR diversity OR “cultural diversity” or culture or acculturation or “superdiversity” OR Pakistan* or “South Asian” OR “British South Asian” OR Asian OR minority OR “minority groups” OR “ethnic minority groups” OR “ethnic density” OR “ethnic enclaves” or inequality* or race or “racial identity” OR “ethnic segregation” OR inclusion or exclusion or Birmingham OR multicultural or “race relations” OR identity OR “ethnic identity” OR racism or Islam OR Muslim OR Punjab*	
		AND	health* OR CVD OR CHD OR diabetes OR “diabetes type 2” OR obes* OR hypertension OR “health attitude” OR “health behaviour” OR “high blood pressure” OR “heart disease” OR diet* OR exercise* OR “eating habits” OR “physical activity” OR “physical exercise” OR “cardiovascular disease” OR “cardiovascular risk” OR “health inequalities” OR “healthy lifestyle” OR lifestyle OR “life choices” OR smok* OR preventative OR “primary care”	
		AND	qualitative OR interview* OR narrative OR “focus groups”	
2	13.08.13	Refine	Limiters: evidence based medicine or meta-analysis OR “systematic review” and English and Year “1960-current” and article OR conference abstract OR conference paper OR journal OR “review” AND Adult 18 years to 64 years OR aged 65+ years	102

APPENDIX 4

An example of the hierarchy of relevant papers

Category	Reference title	Key points
A	Tirodkar, M.A., Baker, D.W., Khurana, N., Makoul, G., Paracha, M.W. and Kandula, N.R (2011) ' <i>Explanatory models of coronary heart disease among South Asian immigrants. Patient education and counselling</i> ', Patient Educ Couns, 85(2), pp. 230-236.	<ul style="list-style-type: none"> • Prevention of CVD • South Asian community • UK: developed country
B	Aarabi, M., Skinner, J., Price, C.E., <i>et al.</i> (2008) <i>Patients' acceptance of anti-hypertensive therapy to prevent cardiovascular disease: a comparison between South Asians and Caucasians in the United Kingdom.</i> European Journal of Cardiovascular Prevention & Rehabilitation, 15 (1), pp. 59-66.	<ul style="list-style-type: none"> • Prevention of CVD • South Asian and UK community • Anti-hypertensive
B	Akhtar, A., Rahman, A., Husain, M., <i>et al.</i> (2010) <i>Multidimensional scale of perceived social support: Psychometric properties in a South Asian population.</i> Journal of Obstetrics and Gynaecology Research, 36(4), pp. 845-851.	<ul style="list-style-type: none"> • Perceived social support • South Asian population • Gynaecology
C	Sandberg, T. and Conner, M. (2011) <i>Using self-generated validity to promote exercise behaviour.</i> British Journal of Social Psychology, 50(4), pp. 769-783.	<ul style="list-style-type: none"> • Physical activity • No defined population

APPENDIX 5

The formatted quality assessment form

This checklist involved an evaluation of aims, appropriate use of methodology and recruitment strategy, consideration of ethical issues, rigorous data-analysis, value and clarity of research findings, and the use of interpreters where necessary.

	Y	N	U
Clear statement of aims? (Goal, importance)			
Is qualitative methodology appropriate? (Research to interpret/illuminate)			
Appropriate research design? (Justified how decision was made)			
Recruitment strategy appropriate for aims? (How participants selected, why, discuss strategy)			
Data collected in manner to address research issue? (Setting justified, clear method i.e. FG, topic guide, explanation for modification, collection clear e.g. tapes? Video? Saturation discussed?)			
Relationship between researcher and participants been adequately considered? (Formulation of RQ, data collection, response to events in study)			
Ethical issues been considered? (Explain research to participants, discussed issues raised, consent and confidentiality, approval from ethics committee)			
Data analysis sufficiently rigorous? (In-depth, clear derivation of categories, sufficient data presented to support findings, what extent contradictory data taken into account, has researcher critically examined own role? Potential bias and influence during and selection of data for presentation?)			
Clear statement of findings? (Explicit, adequate discussion of evidence for/against, discuss credibility of findings, discuss findings in relation to original RQ)			

<p>How valuable is the research? (Contribution to existing knowledge/understanding-policy, practice. Identify where new research necessary, discussed whether or not findings could be transferred to other populations? Or other ways to use research?)</p>			
<p><i>Additional: Interpreter used where necessary</i> <i>(as multi-lingual population, Urdu, Punjabi and English)</i></p>			

APPENDIX 6

The data extraction form for qualitative studies

The data extraction form organised information on the theoretical background, aim of research, ethical issues and how they were addressed, urban or rural setting of research, socio-demographic information of participants, recruitment context, participants' characteristics, and analysis approach.

Extraction Item	Details
Citation	
Country	
Theoretical background	
Aims	
Ethics-issues addressed	
Urban/Rural setting	
Socio-demographics	
Recruitment context	
Participant characteristics	
Analysis approach	
Key themes (1st order interpretation)	
Author explanation key themes (2nd order)	
Recommendations	
Assessment of quality	

APPENDIX 7

The pilot semi-structured interview guide

INTERVIEW SCHEDULE
(Phase 1: developing topic guide)

Opening statement

Hello. Firstly, I would like to thank you for taking time to be part of this research. Now that you have given your consent you will be asked to complete the convoy task where I will ask you a few basic questions and then we will progress with the main interview.

Can you confirm that I have given you the opportunity to read/hear the information sheet, collected your consent and given you time to ask questions?

(Pause for response)

- **Complete convoy task**

Now that you have completed the convoy task, during this interview I will be asking you some questions about the relationships you noted, your health goals and how you engage with members of your community and health care services. The interview will last roughly about an hour. To clarify this I will begin by defining some of these topics.

Social relationships and networks are the people you interact with. This can be family and friends who you see on a daily basis, as well as colleagues. However, they can also be people that you might encounter from the community at religious, social or health centres.

In terms of health goals, these are targets that you want to achieve in relation to your well-being e.g. how healthy you would want to be and specifically what actions you take to in relation to this. I will also ask you about which people you rely on when thinking about these health aims.

Before we begin, I would like to remind you that you don't have to answer questions if you do not wish to and you can take as long as you like before each response.

Basic questions:

- 1) What is your age?
- 2) How long have you been living in England?
- 3) Who do you live with?

General health:

- 4) Can you please describe what your health is like at the moment?
- 5) How satisfied are you with your health?
- 6) In what ways would you try and improve your health?
- 7) Do you have any ideals for your health?
- 8) Is there anything you do to make sure you are healthy/maintain your current health?
- 9) Can you please tell me what you specifically do in relation to this?

Diet and exercise

- 10) What are your current health targets?
- 11) What are your perceptions of a healthy diet?
- 12) Can you please describe your diet?

- 13) In what ways, if any, are you currently monitoring your diet?
- 14) If possible, in what ways would you change your diet?
- 15) How do you engage in physical activity?
- 16) Would you change this in any way?

Social relationship (goal pursuit)

- 17) Who do you relate to when thinking about your health?
 - Why?
 - Would you prefer to talk to family/friends about your health goals or someone from health/social care?
 - Any particular reason why?
- 18) Please tell me about how this person/these people are related to your health?
- 19) What does this person/these people do in particular that you go to them for your health goals?
- 20) Could you please tell me more about the kind of activities you take part in with these individuals when pursuing these health goals?

Measuring social capital (civic engagement)

- 21) From the people you know, who would you approach to discuss these goals?
- 22) Are there certain people you can trust more than others when discussing your health goals?
 - Who are these individuals?
 - What are the reasons for trusting these people not others?
- 23) Can you describe which community activities you think would relate to your health goals?
- 24) How informed do you feel about local health care initiatives?
- 25) Can you describe the ways in which you think you can influence these initiatives?
- 26) What are your views about the facilities in the area?
- 27) If anything, what would you change?

Finally, are there any points you would like to elaborate on?

Thank you. The research is now over and I would like to ask you if you wish to be contacted with the results. If you do then I need your contact details/alternatively you can collect information from the –insert name of community centre-

APPENDIX 8

Interview guide

Interview guide

(Information in brackets are my thoughts/points to raise during the interview to engage with participants)

- Introduction: What we will be discussing (relationships, health goals, engagement with community and health services)
- Definitions: Social networks, health goals
- Demographic: Age, occupation, time spent in England, who do you live with, postcode

General health

- 1) How would you describe your health at the moment?
(How participants view their health and if they are satisfied)
Sub-questions:
 - Please describe/outlines your daily routine/normal health practices?
 - What is your current/future/ ideal health like?
 - How do you engage with services/community in relation to health?
 - What are your desired improvements for your health?
 - Are there any social (family/community) facilities that are affecting your health? (If yes – in what way?)

Diet and Exercise

- 2) How do you monitor your diet and exercise?
(Personalised approach or based on lifestyle or routine of others)
Sub-questions:
 - In your opinion what is a healthy lifestyle? Which people play a role in it?
 - Do your friends and family agree or have different views?
 - What kind of support do you receive/need to make health choices?
 - What do you think affects your current/ future/ ideal diet or exercise plan?
 - Any health targets/goals/ways in which you would change your diet?

Social relationships (trust, network ties, and cultural norms)

(What your relationship is like with people within/outside of your social circle and how they impact your lifestyle choices i.e. places you go to eat, activities you do together)

3) Who do you relate to when you think about your health?

Sub-questions:

- Who looks after you/ who do you look after?
- Which people do you approach about health? Why these people?
- How do people treat food or their diet?

- How does your social circle provide support or information you need when making lifestyle choices?
- How would these people react if you were to change your current lifestyle?
- Which activities would they like/not like you to do? Why?

- How do you accommodate certain social expectations when creating a daily routine? Which activities do you avoid?
- How likely is the opinion of others to influence your food or exercise choices?

Social capital (particularly civic engagement)

4) How do you engage with members of the community? Where? How often?

(How trust is built with others, do people share their lifestyle routines openly? Do they actively look up any diet/exercise programmes?)

Sub-questions:

- Are there any social activities that you think encourage a healthy lifestyle?
- How comfortable would you be in carrying out exercise or changing your diet around people in your community?
- Can you describe any community activities related to diet and exercise?

- From the people in your social circles who would you approach to discuss health goals?
- Are there certain people you rely on more than others?

- How informed do you feel as a member of your community about health care initiatives?
- What kind of views do you have about the facilities in your area?
- What influence do you think you have?
- What in your neighbourhood do you think contributes to good or bad health?

APPENDIX 9

Participant information sheet

Research carried out by University of Birmingham Doctoral Researcher

Participant information sheet

Does social capital support the pursuit of health goals in a Pakistani community?

Please pay careful attention to the following information and take your time in making a decision to take part. If you feel something is unclear please ask the researcher.

Current research

There is a high level of cardiovascular disease, diabetes and obesity within the Pakistani community. Although the government has made efforts to highlight the importance of a healthy diet and regular exercise in avoiding these illnesses, members of the Pakistani community continue to be at risk.

The aim of this research is to try and understand how/why social relationships in the Pakistani community effect health choices, especially for diet and exercise. As individuals from the Pakistani community are rarely involved in this type of research, this study will give you the chance to voice your opinions with the aim of developing health care that represent the needs of different individuals.

Your involvement

The research will involve completing a task outlining your relationships and answering a series of questions in an interview that will last around an hour. The researcher will ask you for permission to take part and you will be interviewed in a private room with only the researcher present.

Benefits and potential risks

This research will not include tasks that try to change or control your behaviour or show you sensitive material. Risk as a result of taking part in this research is low.

Confidentiality and data storage

The University has a strict policy on the storage of private information. Information collected in this research will be kept securely and will only be accessed by the researcher and supervisors. Data that can reveal you as a participant will not be used or published. False names will be used to hide your identity. The results of the research will be written up for a doctoral thesis and possibly published in a journal. Once the research is complete, the information will be stored safely at the University of Birmingham before being destroyed responsibly.

Decision to participate

Taking part in this research is entirely by choice. Once you have read and understood the information and have given your consent to take part, the researcher will give you more details. If however, you do not wish to take part then you are free to refuse and this will not affect you in any way. If during the research, or interview, you feel that you no longer wish to take part you can remove your information/interview within 2 weeks.

Contact information

In the unlikely nature of any problems occurring or concerns about taking part, you can contact the researcher and supervisors of this research. You can also use these contact details to get more information or ask any questions.

Researcher: Farina Kokab [REDACTED]

Supervisors: Dr Paramjit Gill [REDACTED]
Dr Lynda Tait [REDACTED]

Thank you for reading this information and considering participation in this research, your time is valuable and appreciated.

APPENDIX 10

Lay-led poster to advertise study

WHAT HELPS YOU LEAD A HEALTHY LIFE?

Research carried out by a doctoral researcher at the University of Birmingham.

HEART DISEASE AND DIABETES ARE MORE COMMON IN THE PAKISTANI COMMUNITY THAN IN THE GENERAL POPULATION.



WE STILL DO NOT UNDERSTAND WHY THE HEALTH OF THIS COMMUNITY CONTINUES TO BE AFFECTED BY THESE ILLNESSES.

THIS IS WHY WE WANT TO KNOW ABOUT WHAT HELPS YOU LEAD A HEALTHIER LIFE.



TALK ABOUT YOUR HEALTH AND WHAT OR WHO HELPS YOU TO BE HEALTHY AT ONE OF THE FOLLOWING SETTINGS: THE UNIVERSITY OF BIRMINGHAM/LOCAL COMMUNITY CENTRE/YOUR HOME



IF YOU ARE INTERESTED PLEASE CONTACT:

FARINA KOKAB on [redacted] or at [redacted]

APPENDIX 11

Consent form

CONSENT FORM

Does perceived social capital support pursuit of health goals in a Pakistani community?

Participant number:

Name of researcher: Farina Kokab

Please initial inside each box

- 1) I can confirm that I have read/heard and understood the information sheet dated 04/13 (version 1) for the above study and have had the opportunity to ask questions.

- 2) I know that my participation is voluntary and that I am free to withdraw at any time without any reason and without my medical care or legal rights being affected.

- 3) I agree for the information collected in the interview to be analysed and presented anonymously for present/future research where it is appropriate and ethical.

- 4) I understand that my information will only be accessible to the researcher and supervisors in the research team. I give permission for these individuals to view my information as I have been assured that confidentiality will be maintained and all information will be stored securely.

Name of participant

Date: dd/mm/yy

Signature

Name of researcher

Date: dd/mm/yy

Signature

(1 copy for researcher, 1 copy for participant)

APPENDIX 12

Convoy model diagram

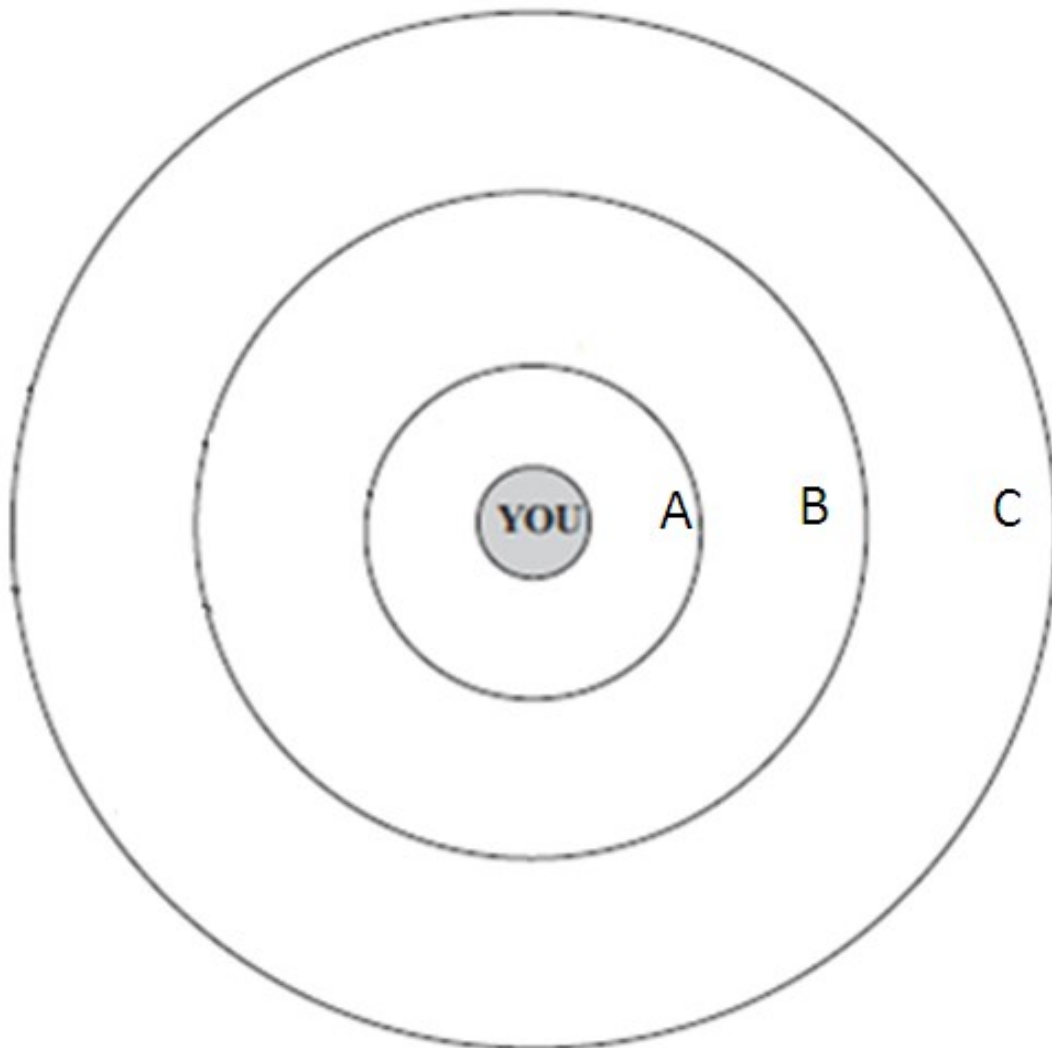
Convoy model: Diagram task

Participant number:

Date:

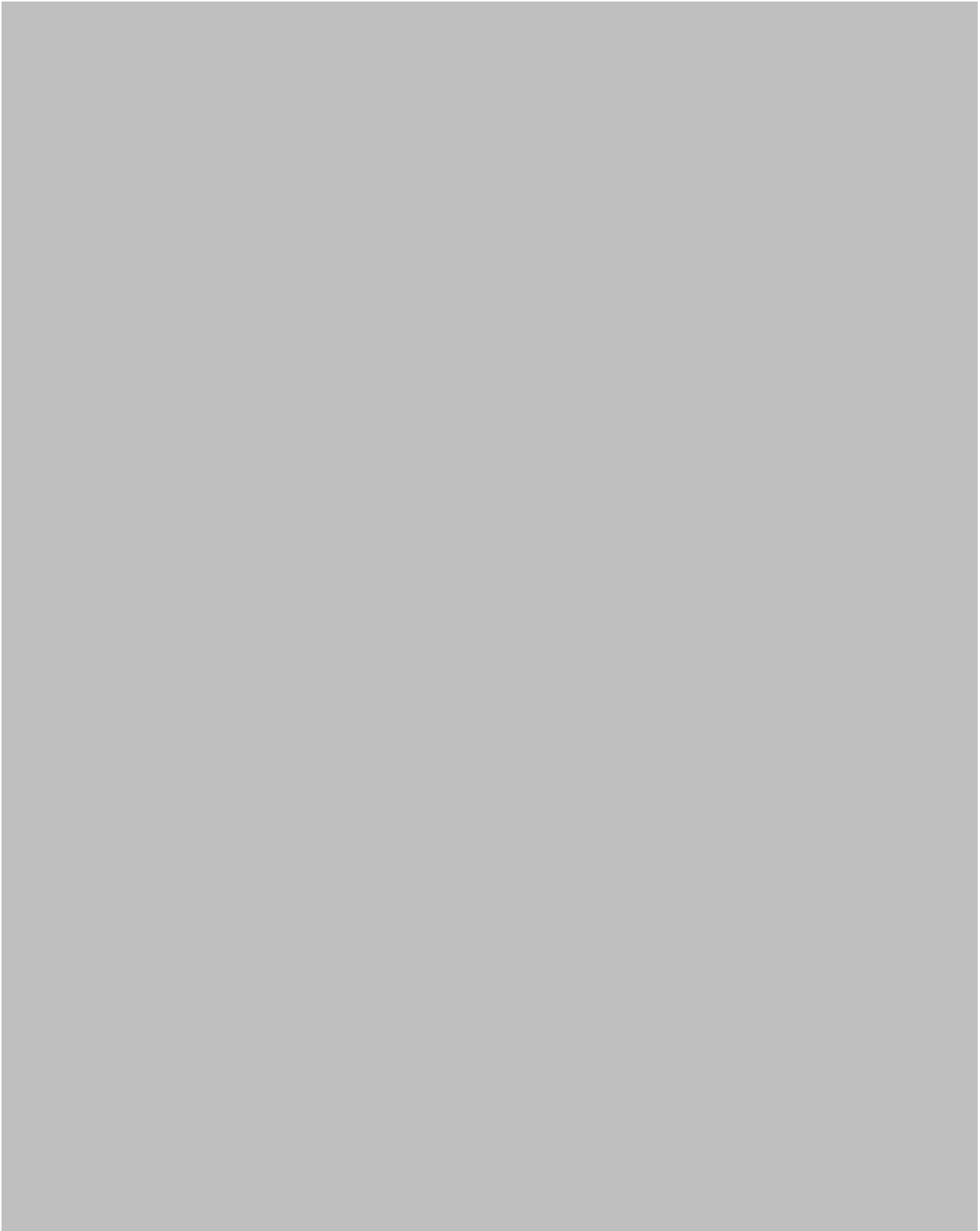
Please complete the following diagram using the following instructions.

- State as many people as you like and feel free to mention the same relationship more than once
- 1) In circle “A” write the relationship (**not name**) of people you feel so close to that it is hard to imagine life without them
 - 2) In circle “B” write the relationship (**not name**) of people you may not feel quite that close to but are still very important to you
 - 3) In circle “C” write the relationship (**not name**) of people whom you haven’t mentioned but who are close enough and important enough in your life that they should be placed in your personal network



APPENDIX 13

Ethical approval



APPENDIX 14

Dissemination of research

Publication

1. Sidhu, M.S., Kokab, F., Jolly, K., Marshall, T., Gale, N.K. and Gill, P (2016).
Methodological challenges of cross-language qualitative research with South Asian communities living in the UK. Family Medicine and Community Health, 3 (3).

Oral presentations

1. Kokab, F., Greenfield, S. and Gill, P. *Narrative review of socio-cultural factors related to cardiovascular risk prevention in the Pakistani community, UK*. South West conference for the Society for Academic Primary Care, Bristol, UK, March, 2014.
2. Kokab, F., Greenfield, S. and Gill, P. *The methodological challenges associated with recruitment of members from the Pakistani community*. 1st Annual conference for the Institute for Research into Superdiversity. Superdiversity: Theory, methods and practice. University of Birmingham, Birmingham, UK, June 2014.
3. Kokab, F., Greenfield, S. and Gill, P. *Trust, cultural norms, networks and the economy: factors that affect cardiovascular risk prevention in the Pakistani community, UK*. 43rd Annual conference for the Society for Academic Primary Care, University of Edinburgh, Edinburgh, UK, July, 2014.
4. Kokab, F., Greenfield, S. and Gill, P. *Socio-cultural factors associated with cardiovascular risk in the Pakistani community: a narrative review*. 43rd Annual conference for the Society for Academic Primary Care, University of Edinburgh, Edinburgh, UK, July, 2014.

5. Kokab, F., Greenfield, S. and Gill, P. *Recruiting members of the Pakistani community: using social networks and culturally sensitive material to overcome gender differences, generational gaps and language issues*, British Sociological Association (BSA) Medical Sociology Group Annual Conference, Aston University, Birmingham, UK, September 2014.

6. Kokab, F., Greenfield, S. and Gill, P. *Gender inequalities in the context of social support for cardiovascular risk prevention in the Pakistani community, UK: a qualitative study*. South West conference for the Society for Academic Primary Care, Birmingham, UK, March, 2015.

7. Kokab, F., Greenfield, S. and Gill, P. *Gender inequalities in social support and access to healthcare for cardiovascular risk prevention in the Pakistani community, UK: a qualitative study*. 44th Annual conference of the Society for Academic Primary Care, University of Oxford, Oxford, UK, July, 2015.

Poster presentations

1. Kokab, F., Gill, P. and Tait, L. *Does social capital support the pursuit of health goals in a Pakistani community?* Graduate poster conference, University of Birmingham, Birmingham, UK, June, 2013.

2. Kokab, F., Greenfield, S. and Gill, P. *Recruitment strategies for engaging members of the Pakistani community: overcoming gender differences and generational gaps beyond work and education*. Graduate poster conference, University of Birmingham, Birmingham, UK, June, 2014 [Winner: first place for College of Medical and Dental Sciences]
3. Kokab, F., Greenfield, S. and Gill, P. *Social capital and the pursuit of cardiovascular health: interviews with Pakistani migrants in the UK*. Annual meeting of the North American Primary Care Research Group (NAPCRG), New York, USA, November, 2014.

Video

1. Kokab, F. *Social capital in the Pakistani community and how it relates to forming health goals associated with cardiovascular disease*. Doctoral Researchers Diversity Network (DRDN), University of Birmingham, Birmingham, UK, November, 2013. URL: <https://www.youtube.com/watch?v=1oNNkXBUa34> Accessed: March 2016.

Blog

1. Burt, J. *Conference report: NAPCRG (North American Primary Care Research Group) Annual meeting 2014*. Cambridge Centre for Health Services Research. University of Cambridge, Cambridge, UK, November, 2014. URL: <http://www.cchsr.iph.cam.ac.uk/2157>, Accessed: March 2016.

APPENDIX 15

Involvement of colleagues

Involvement of colleagues

An initial study proposal in relation to social networks and transnational minority-ethnic groups maintaining social relations with age was developed by Dr Paramjit Gill, Dr Lynda Tait and Professor Sheila Greenfield. However, I refined the research focus in terms of the research outline, population of interest, recruitment strategies, and methods to be carried out. Dr Paramjit Gill and Dr Lynda Tait provided feedback on the initial design and selection of methods, and Professor Sheila Greenfield helped develop analytical and interpretive frameworks. Under the supervision of Dr Paramjit Gill and Professor Sheila Greenfield, I undertook data collection, analysis and interpretation. All data collection, development of coding and themes as part of framework analysis was carried out alongside the supervisory team. Systematic searches and reading titles and abstracts were conducted independently, yet simultaneously, with Dr Paramjit Gill. Dr Paramjit Gill; Professor Sheila Greenfield and I determined inclusion at the full text stage. Appraisal and data extraction were conducted with Dr Paramjit Gill and Professor Sheila Greenfield. I and the supervisory team reviewed the complete qualitative synthesis. I outlined and wrote the present study alongside guidance from Dr Paramjit Gill and Professor Sheila Greenfield. Any causes for concern were discussed amongst the supervisory team and appropriate members of the staff at the Institute of Applied Health Research and the University of Birmingham, as and when necessary.