NHS
Greater Glasgow and Clyde

2016 Black and Minority Ethnic Health and Wellbeing Study in Glasgow

Final Report

Prepared for NHS Greater Glasgow and Clyde by
Traci Leven Research

April 2017

Foreword

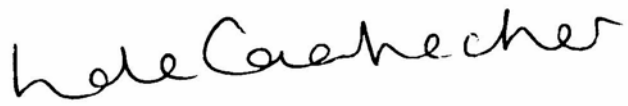
This is an important report of a health and well-being survey of Black and Minority Ethnic (BME) adults living in Glasgow City. It enables comparison with the Glasgow City sub sample of our 2014 adult health and well-being survey.

It is generally a positive report showing that the BME community has positive views of their health and most of the respondents in this survey report healthy behaviours. While it must be acknowledged that we have to see the results in the context of the response rate to the survey, the information still provides useful information for further discussion, examination and planning in Glasgow and across Greater Glasgow and Clyde.

The survey shows areas where we need to work with partners to improve health particularly for Pakistani people, some groups of women and those who haven't had access to or been able to learn English. There are also some key areas that need to be tackled such as feelings of safety and inclusion and freedom from discrimination.

At the end of the report are themes that require further discussion with partners and local communities to use the information to improve service responses and ultimately to improve health. I look forward to working with many of you on these issues.

I am grateful to everyone who worked hard to produce this report.



Linda De Caestecker
Director of Public Health
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Executive Summary

Method

In total, 1,798 face-to-face in-home interviews were conducted in 2016 with adults (aged 16 or over) in Glasgow from the five largest minority ethnic groups – Polish, Indian, Pakistani, Chinese and African. The interviews were weighted to ensure the sample was as representative as possible of the known Black and Minority Ethnic (BME) population by ethnicity, age, gender and deprivation.

Comparisons have been made with the BME survey (2016) with the findings for Glasgow City as a whole from the NHSGGC Health and Wellbeing Survey (2014). The report for Glasgow City can be found at:

http://www.nhsggc.org.uk/media/234847/nhsggc_ph_health_and_wellbeing_survey_2014_glasgowcity_hscp_report.pdf

Health and Illness

Across all BME adults, 80% had a positive view of their general health, 86% had a positive view of their physical wellbeing and 90% had a positive view of their mental/emotional wellbeing. Those in the Pakistani group were the least likely to have positive views of each of these. Although BME groups were more likely than those in Glasgow City to have a positive view of each of these, this can largely be attributed to the younger age profile of the BME population (59% of the BME population was aged under 35, compared to 38% of the Glasgow City population).

Two in three (65%) BME adults said they definitely felt in control of the decisions affecting their daily life. The Chinese group was the most likely to feel in control, and the African group was the least likely. Overall, men were more likely than women to feel in control of the decisions affecting their life and African women were the least likely to feel in control. Those who did not speak English well were less likely than others to feel in control.

More than nine in ten (92%) BME adults overall had a positive perception of their quality of life, which was higher than Glasgow City. The Pakistani group were less likely than other ethnic groups to have a positive perception of their quality of life.

Fifteen percent of BME adults had an illness or condition that limited what they could do, and one in four (26%) were receiving treatment for at least one illness or condition. Overall, BME groups were less likely than those in Glasgow City to have a limiting condition or to be receiving treatment for any illness/condition.

However, the Pakistani group were much more likely than other BME adults to have a limiting condition or illness or to be receiving treatment for a condition/illness. Those who did not speak English well and those who had lived in the UK for 10 years or more were more likely than others to have a limiting long-term condition or illness.

Health Screening and Access to Health Services

Three in five (58%) BME women aged 20-60 said they had been invited for cervical screening; of these, 87% had attended cervical screening. Four in five (79%) BME women aged 50-70 said they had been invited for breast screening; of these, 90% had attended breast screening. Two in three (64%) BME adults aged 50-74 said they had been invited for bowel screening; of these, 68% had completed the home test.

Among the target gender/age groups, Chinese people were among the least likely to say they had been invited for cervical, breast or bowel screening. African people were the most likely to say they had been invited for these.

One in eight (12%) BME adults had used the interpreting service for NHS appointments. Among those who did not speak English well, 44% had used the interpreting service.

Health Behaviours

Three in ten (29%) BME adults were exposed to second hand smoke most or some of the time. Sixteen percent were current smokers, and 9% had used e-cigarettes in the last year. Overall, BME groups were less likely than those in Glasgow City to be exposed to second hand smoke, to smoke or to use e-cigarettes. However, Polish people were the most likely to do each of these things.

Just over a third (36%) of BME adults ever drank alcohol. A small proportion exceeded recommended limits for alcohol consumption – 1.5% exceeded the recommended weekly limit of 14 units; 5.7% exceeded the recommended daily limit of four units for men or three units for women; 2.2% binge drank (eight units for men or six units for women). Overall, BME groups were much less likely than those in Glasgow City to ever drink alcohol (36% BME; 65% Glasgow City), and particularly much less likely to exceed any of the recommended limits for alcohol consumption.

There was much variation across ethnic groups. Hardly any (1%) Pakistani adults ever drank alcohol, and none of them exceeded any of the limits. Polish adults were more likely than those in Glasgow City to ever drink alcohol (80%). However, Polish people were much more likely to drink within recommended limits.

Seven in ten (71%) BME adults met the target of 150 minutes of physical activity per week. Those in the Indian group were much less likely than other BME groups to meet this target.

Four in ten (40%) BME adults met the target of consuming at least five portions of fruit/vegetables per week. Pakistani and African groups were less likely to meet this target.

Half (52%) of BME adults were overweight, and more than seven in ten of those aged 35 or over were overweight. BME adults in each age group were more likely than those in Glasgow City to be overweight.

Social Health

One in eight (12%) BME adults ever felt isolated from family/friends. Feelings of isolation were more common among African and Polish groups.

Seven in ten (72%) felt they belonged to their local area, six in ten (62%) felt valued as members of their community and seven in ten (72%) agreed that local people working together could influence local decisions. The Chinese group were the least likely to feel valued as a member of their community or to feel that local people could influence local decisions.

One in thirty (3.4%) BME adults felt that they had been discriminated against in the last year. Those in Pakistani and African groups were more likely to have experienced discrimination.

One in ten (10%) BME adults had been a victim of one of five types of crime in the last year. Overall, BME adults were less likely than those in Glasgow City to have been a victim of crime. Polish and African groups were more likely than other BME groups to have been victims of crime.

Nine in ten (89%) BME adults felt safe using public transport and two in three (67%) felt safe walking alone in their area even after dark. Polish groups were less likely to feel safe doing either of these things.

One in 20 (5%) BME adults had caring responsibilities. Pakistani adults were the most likely to be carers; caring responsibilities were least common among Polish and African groups.

One in nine (11%) BME adults had gambled in the last month. BME groups were overall much less likely than those in Glasgow City to spend money on gambling. Pakistani adults were the least likely to gamble.

Three in ten (29%) ever had difficulty meeting the costs of rent/mortgage, fuel bills, phone bills, council tax/insurance, food or clothes/shows. African and Pakistani groups were more likely to have difficulty meeting these costs.

One in 11 (9%) said they would have difficulty meeting unexpected expenses of £20; 37% would have difficulty finding £100 and 74% would have difficulty finding £1,000. Three in four (74%) gave a positive perception of the adequacy of their income. The African group was the most likely to have difficulty finding these sums and the least likely to express a positive view of the adequacy of their income.

Half (48%) of BME adults were economically active. The Polish group was the most likely to be economically active and the Chinese group was the least likely to be economically active. Men were much more likely than women to be economically active.

A third (35%) of BME adults said that at least some of their household income came from state benefits. BME adults were much less likely than those in Glasgow City to receive all of their household income from benefits (7% compared to 20%).

Social Capital

Seven in ten (71%) BME adults had a positive view of reciprocity in their area and 59% had a positive view of trust. Just under three in four (73%) valued local friendships and 66% had a positive view of social support. The African group were the least likely to give positive views of each of these four measures.

Sixteen percent of BME adults had volunteered in the last year; 18% belonged to any clubs/associations/groups and 8% had engaged in social activism in the last year. The African groups were by far the most likely to belong to clubs etc, and were more likely than others to have volunteered or engaged in social activism in the last year.

BME adults' views on poverty differed compared to those in Glasgow City. BME adults were more likely to attribute poverty to laziness/lack of will power and less likely to attribute it to lack of jobs or injustices in society.

Contents

1 Introduction

1.1 Introduction[1]

In 2015 NHS Greater Glasgow and Clyde (NHSGGC) embarked on a project to carry out a robust survey of black and minority ethnic (BME) health and wellbeing.

The aim of the survey was to explore the views of adults aged 16 plus from the main black and minority ethnic groups living in Glasgow City on their health and wellbeing. The main groups (in terms of the largest numbers living in the city as measured by the 2011 census) are: Pakistani; Indian; Chinese; Polish and African. The Pakistani, Indian, Chinese and African population accounted for 81% of all non-white ethnic groups in Glasgow City in 2011 (83% when including Polish with the BME groups).

The survey explored the following topics: perceptions of health and illness; health screening; health behaviours; social health; social capital and personal characteristics.

The health of BME groups is of particular interest in Glasgow City where 12%[2] of the population are from BME communities. In Glasgow in 2014 23% of under 5s[3] were BME. The difference in the health of new Glaswegians and people who have lived here for a long time was of relevance and the report shows that, while the health of the BME population is generally considered to be good and often better than the white Scottish population, there are some stark differences between the experiences of different ethnic groups. By comparing the survey responses between people who have lived here for less than ten years and more than ten years it is clear that some people's health does seem to deteriorate once they have lived here for longer. The survey also showed that BME women's health was worse than men's on several indicators combined with other gendered differences between ethnic groups.

The Scottish Government's Race Equality Framework for Scotland for 2016-30[4] states that; "It's right to build communities where minority ethnic people feel safe, protected and included and are given equal and fair access to services and employment".

[1] This section has been prepared by NHSGGC
[2] 2011 Census Figures http://www.gov.scot/Topics/People/Equality/Equalities/DataGrid/Ethnicity/EthPopMig
[3] Understanding Glasgow, The Glasgow Indicators Project http://www.understandingglasgow.com/indicators/population/population_visualisation
[4] Race Equality Framework for Scotland 2016-2030, Scottish Government http://www.gov.scot/Resource/0049/00497601.pdf

The Framework contains key goals in relation to health which are:

- Minority ethnic communities and individuals experience better health and wellbeing outcomes.
- Minority ethnic communities and individuals experience improved access to health and social care services at a local and national level to support their needs.
- Scotland's health and social care workers are better able to tackle racism and promote equality and community cohesion in delivery of health and social care services.
- Scotland's health and social care workforce better reflects the diversity of its communities.

The survey will enable us to develop detailed responses to the health needs of BME people in Glasgow, including our own staff or future employees, to improve the delivery of services and tackle issues of equity, connectedness, social support and belonging. It will also enable us to understand BME peoples' experience of exclusion, poverty and access to employability and other community supports. We hope that the findings will be of wider interest to other health boards, service providers and community planning partnerships in relation to their own BME populations.

The methodology we used, which relied on name analysis to identify possible ethnicity, has already been used in other parts of NHSGGC, for example to understand uptake of screening services by ethnic group. This can be useful where ethnicity data is not available from existing data sources.

Summary of Methodology

In total, 1,798 face-to-face in-home interviews were conducted with adults (aged 16 or over) in Glasgow from the five largest minority ethnic groups – Polish, Indian, Pakistani, Chinese and African. A full account of the sampling procedures, fieldwork and survey response can be found in Appendix A. The survey questionnaire is in Appendix E.

1.2 Sample Profile

The 1,798 completed interviews were weighted to account for under/over representation of groups within the sample to ensure the sample was as representative as possible of the known BME population (across the five ethnic groups) in Glasgow City. A full explanation of the weighting method used can be found in Appendix B.

Ethnicity, Age and Gender

The breakdown of the sample by ethnic group is shown below. The weighting process ensured that the sample is representative of the known BME population in Glasgow for these five groups.

Table 1.1: Sample Profile by Ethnic Group Before and After Weighting

	% Before Weighting	% After Weighting	N (unweighted)
Polish	21%	16%	376
Indian	17%	17%	300
Pakistani	21%	33%	380
Chinese	21%	24%	372
African	21%	9%	370

The sample profile by age and gender is shown below. The weighting process has ensured that the sample is representative by gender. Weighting has also ensured that the sample is representative by age at the level of under 35/35 or over.

Table 1.2: Sample Profile (Weighted) by Age and Gender

Age	Men (% of sample)	Women (% of sample)	Total (% of sample)
16-34	32%	27%	59%
35-54	17%	13%	30%
55+	8%	3%	11%
Total	57%	43%	100%

Deprivation

The Scottish Index of Multiple Deprivation (SIMD) 2012[5] is a relative measure of deprivation used to identify the most deprived areas in Scotland. It is constructed using 38 indicators within 7 'domains' (Income, Employment, Health, Education, Skills & Training, Geographic Access, Housing and Crime) each of which describes a specific aspect of deprivation. The SIMD is a weighted combination of these domains.

[5] The 2012 measure was used for sampling because the 2016 measures were not available at the time of fieldwork.

The SIMD is based on small geographical areas called datazones. The average population of a datazone in NHSGGC is 820 (c.350 households) and unlike previous deprivation measures, which were based on much larger geographies (e.g. postcode sectors, average population 5,000), they enable the identification of small pockets of deprivation. In order to compare the most deprived small areas with other cut-off points, the most deprived 15% datazones are used. There are 6,505 datazones in Scotland. They are ranked from 1 (most deprived) to 6,505 (least deprived). The NHSGGC area contains the most deprived datazone in Scotland and in total 43.2% of the most deprived 15% datazones in Scotland lie within it.

The weighting process ensured that the sample was representative of the known BME population for those living in the most deprived 15% datazones and those living in other datazones. The (weighted) breakdown of those in the most deprived datazones by ethnic group is shown in Table 1.3. Polish and African groups were the most likely to live in the most deprived areas.

Table 1.3: Most Deprived 15% Datazones Versus Other Datazones by Ethnicity

Ethnic Group	Most Deprived 15% datazones	Other datazones
Polish	57%	43%
African	52%	48%
Pakistani	24%	76%
Indian	19%	81%
Chinese	17%	83%
All BME	29%	71%

Length of Residency in the UK

Just over half (53%) of the (weighted) sample had lived in the UK for 10 years or more. As Table 1.4 shows, those in the Pakistani group were the most likely to have lived in the UK for 10 years or more and those in the Chinese group were the most likely to have lived in the UK for less than 10 years.

Table 1.4: Length of Residency in the UK by Ethnicity

Ethnic Group	Lived in the UK for 10 years or more	Lived in the UK for less than 10 years
Pakistani	85%	15%
Indian	49%	51%
Polish	41%	59%
African	35%	65%
Chinese	29%	71%
All BME	53%	47%

How Well Speak English

Four in five (82%) said they spoke English fairly well or very well. Those in the African group were the most likely to speak English well and those in the Chinese group were the least likely. There was no significant correlation between the length of residency in the UK and how well English was spoken.

Table 1.5: How Well Speak English by Ethnicity

Ethnic Group	Speak English Very/Fairly Well	Speak English Not Very Well/Not at all Well
African	96%	4%
Indian	85%	15%
Polish	82%	18%
Pakistani	80%	20%
Chinese	77%	23%
All BME	82%	18%

1.3 This Report

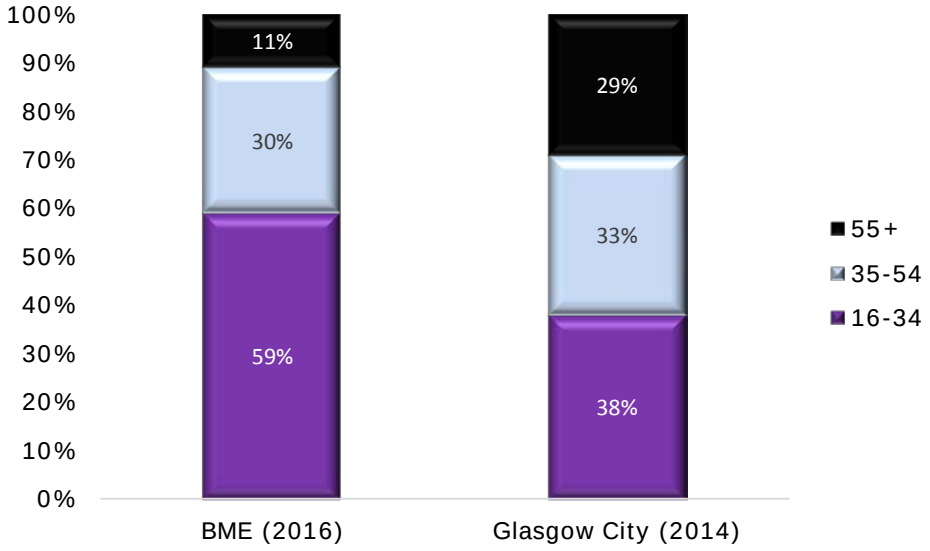
Chapters 2-6 report on all the survey findings, with each subject chapter containing its own infographic summary at the start, and a 'key messages' summary at the end. For each indicator, tables are presented showing the proportion of the sample which met the criteria, with comparisons with Glasgow City population as a whole (from the 2014 NHSGGC Health and Wellbeing Survey), and break-downs by demographic (independent) variables. Only comparisons with Glasgow City and independent variables which were found to be significantly different ($p<0.05$) are reported. The independent variables which were tested were:

- Ethnic Group;
- Age Group;
- Gender;
- Gender and Ethnic Group;
- Deprivation (most deprived 15% datazones versus other datazones);
- How well speak English;
- Length of Residency in the UK

An explanation of how the independent variables were derived is in Appendix C.

When considering the comparisons between the two surveys (The 2016 BME survey and the Glasgow City component of the 2014 NHSGGC Health and Wellbeing Survey), it should be remembered that the BME population differs demographically to Glasgow City as a whole. There are proportionately more young people in the BME population, and fewer aged 55 or over, as *Figure 1.1* shows.

Figure 1.1: Age Profile of BME (2016) and Glasgow City (2014) Surveys (weighted)



Also, BME adults were less likely than those in Glasgow City to live in the most deprived 15% datazones (29% BME; 39% Glasgow City).

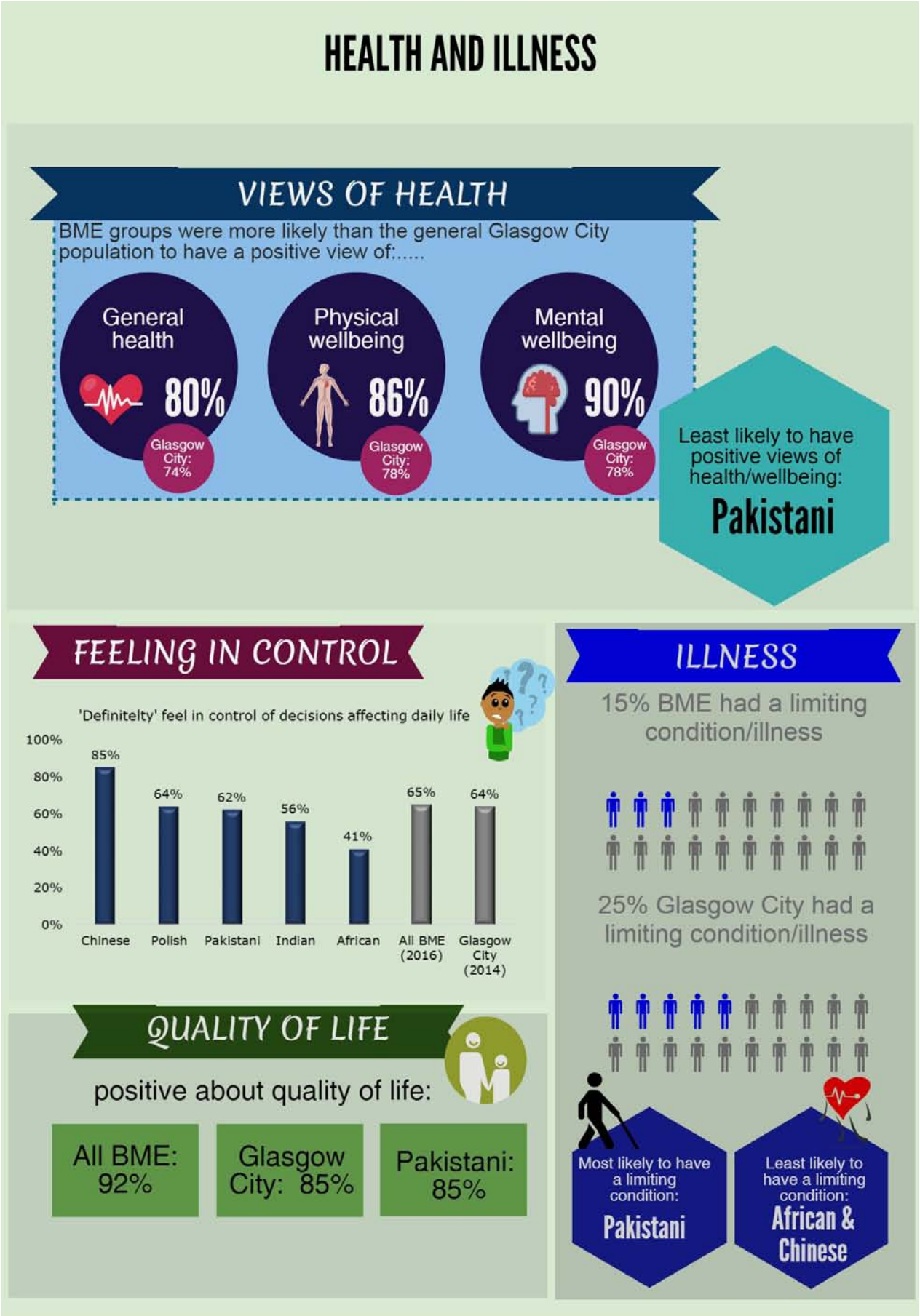
Thus, where differences are observed for BME adults compared to Glasgow City, they could be due – or partly due – to other differences in demography, such as the age and deprivation profile. To make differences between the BME and Glasgow City findings clearer, differences presented in this report include:

- An overall comparison between BME adults and Glasgow City adults;
- Comparison between BME adults and Glasgow City adults for each of the three age groups
- Comparison between BME adults and Glasgow City adults for the 15% most deprived areas and other areas.

Only findings which show a significant difference on any of these three levels are shown.

It should also be remembered that the data for Glasgow City (2014) includes BME adults. The Glasgow City profile includes 1.4% Polish, 1.6% Indian, 6.1% Pakistani, 1.6% Chinese and 2.0% African adults.

Chapter 7 concludes with some comments about the survey findings and a look towards the next steps.


HEALTH AND ILLNESS
VIEWS OF HEALTH
BME groups were more likely than the general Glasgow City population to have a positive view of:.....
General health
80%
Glasgow City: 74%
Physical wellbeing
86%
Glasgow City: 78%
Mental wellbeing
90%
Glasgow City: 78%
Least likely to have positive views of health/wellbeing:
Pakistani
FEELING IN CONTROL
'Definitelty' feel in control of decisions affecting daily life
100%
80%
60%
40%
20%
0%
85%
64%
62%
56%
41%
65%
64%
Chinese
Polish
Pakistani
Indian
African
All BME (2016)
Glasgow City (2014)
QUALITY OF LIFE
positive about quality of life:
All BME: 92%
Glasgow City: 85%
Pakistani: 85%
ILLNESS
15% BME had a limiting condition/illness
25% Glasgow City had a limiting condition/illness
Most likely to have a limiting condition:
Pakistani
Least likely to have a limiting condition:
African & Chinese

2.1 Self-Perceived Health and Wellbeing

General Health

Respondents were asked to describe their general health over the last year on a five point scale (very good, good, fair, bad or very bad). Overall, four in five (80%) gave a positive view of their health, with 27% saying their health was very good and 53% saying their health was good. However, 20% gave a negative view of their health, with 13% saying their health was fair, 5% saying it was bad and 2% saying it was very bad.

Overall BME adults were more likely than those in Glasgow City to rate their health positively (80% BME; 74% Glasgow City). However, this was a consequence of the younger age profile of the BME population, as younger people were much more likely to have positive views of their health.

Those in Polish, Chinese and African groups were more likely than those in Indian and Pakistani groups to give a positive view of their health.

Table 2.1: Positive View of General Health (Q1) by Ethnicity

	General Health Very Good/Good
Polish	92%
Chinese	91%
African	91%
Indian	77%
Pakistani	66%
All BME	80%
Glasgow City (2014)	74%

Positive views of general health were more common among the youngest age group and least common among the oldest age group, as Table 2.2 shows.

Table 2.2: Positive View of General Health (Q1) by Age Group

	General Health Very Good/Good
16-34	90%
35-54	75%
55+	45%
All BME	80%

Those in the most deprived areas were less likely than those in other areas to have a positive view of their general health.

Table 2.3: Positive View of General Health (Q1) by Deprivation

	General Health Very Good/Good
Bottom 15% datazones	75%
Other datazones	83%
All BME	80%

Those who spoke English well and those who had lived in the UK for less than 10 years were more likely than others to give a positive rating of their general health, as Table 2.4 shows.

Table 2.4: Positive View of General Health (Q1) by How Well Speak English and Length of Residency in UK

	General Health Very Good/Good		General Health Very Good/Good
Speak English very/fairly well	84%	Lived in the UK for 10 years or more	72%
Do not speak English well	65%	Lived in the UK for less than 10 years	91%

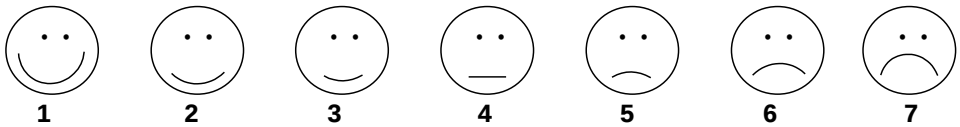
Evidence from other Sources

The findings here mirror the findings of the Scottish Health Survey (2008-2011)[6] which found that Pakistani groups were the least likely to rate their health positively (66%) and Chinese groups were the most likely (91%).

In the 2011 Scottish Census, overall 82% of people in Scotland were said to have very good or good health. However, the proportion was higher for Asian (89%) and particularly African (94%) groups.

Physical Wellbeing and Mental/Emotional Wellbeing

Respondents were presented with a 7-point 'faces' scale, with the expressions on the faces ranging from very happy to very unhappy:



[6] http://www.gov.scot/Resource/0040/00406749.pdf

Using this scale, they were asked to rate their general physical well-being and general mental or emotional well-being. Those selecting any of the three 'smiling' faces (1-3) were categorised as having a positive perception.

In total, 86% of BME adults gave a positive view of their physical wellbeing. BME adults were more likely than those in Glasgow City to give positive views of their physical wellbeing (86% BME; 78% Glasgow City) or their mental and emotional wellbeing (90% BME; 84% Glasgow City). This is only partially explained by the proportionately younger age profile of the BME population (see *Figures 2.1 and 2.2*).

Those in the Pakistani ethnic group were less likely than others to rate their physical wellbeing or their mental/emotional wellbeing positively, as Table 2.5 shows.

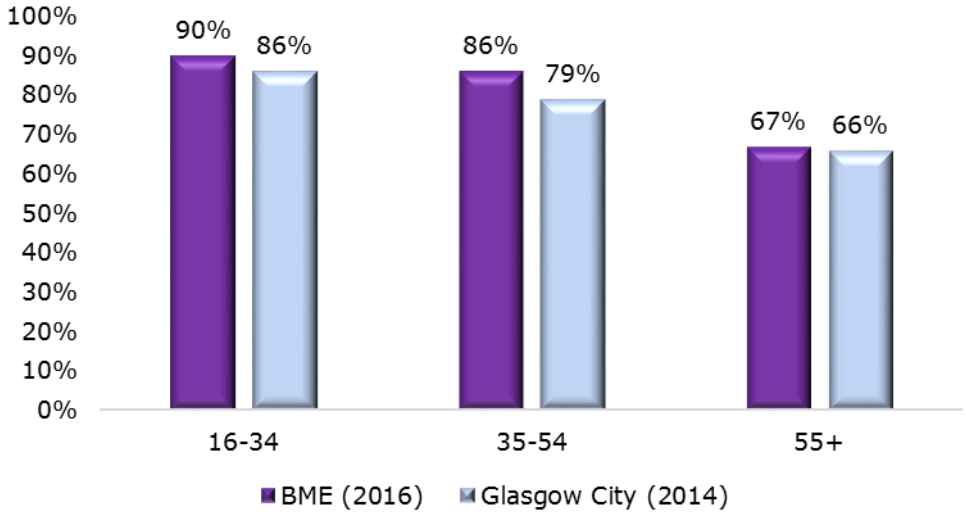
Table 2.5: Positive Perception of Physical Wellbeing (Q29b) and Mental and Emotional Wellbeing (Q29c) by Ethnicity

	Positive Perception of Physical Wellbeing	Positive Perception of Mental and Emotional Wellbeing
Chinese	95%	95%
Indian	92%	97%
Polish	89%	94%
African	87%	93%
Pakistani	75%	82%
All BME	86%	90%
Glasgow City (2014)	78%	84%

Those aged 55 or over were less likely than younger people to give a positive view of their physical wellbeing or their mental and emotional wellbeing (see *Figures 2.1 and 2.2*).

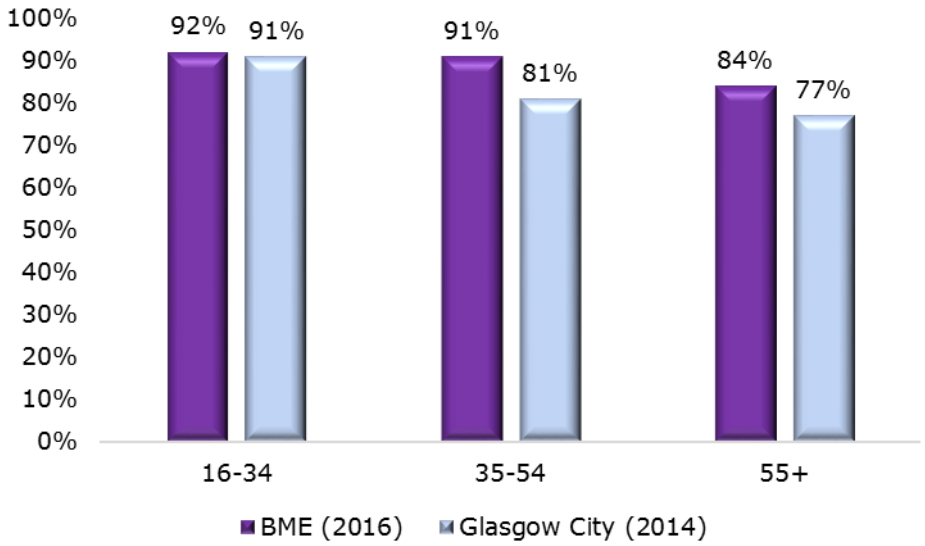
For both the 16-34 and 35-54 age groups, BME adults were more likely than those in Glasgow City to have a positive perception of their physical wellbeing, as Figure 2.1 shows.

Figure 2.1: Positive Perception of Physical Wellbeing (Q29b) by Age Group – BME (2016) and Glasgow City (2014)



BME adults in the 35-54 and 55+ age groups were more likely than adults in these age groups in Glasgow City to have a positive view of their mental/emotional wellbeing, as *Figure 2.2* shows.

Figure 2.2: Positive Perception of Mental/Emotional Wellbeing (Q29c) by Age Group – BME (2016) and Glasgow City (2014)

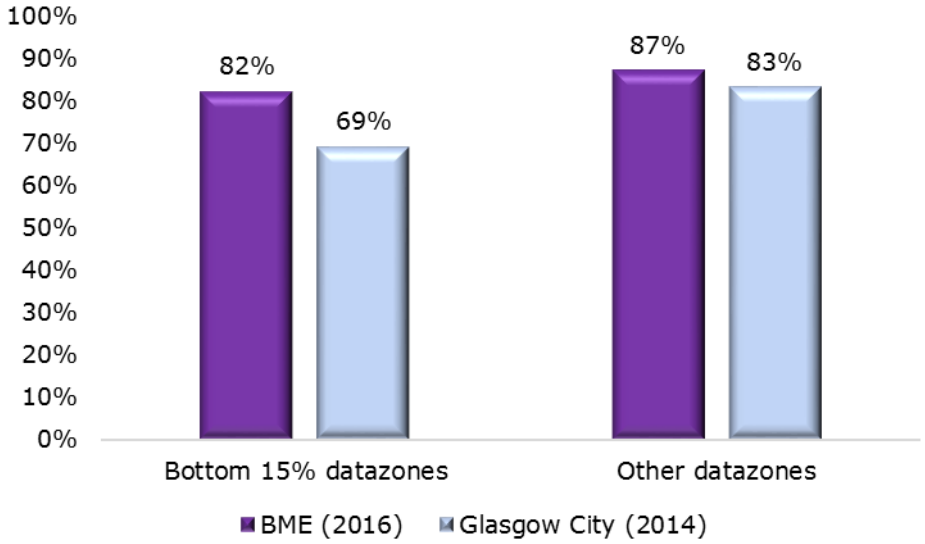


Those in the most deprived areas were less likely than those in other areas to have a positive perception of their physical wellbeing or their mental/emotional wellbeing (see *Figures 2.3 and 2.4*).

BME adults in both the most deprived areas and other areas were more likely than those in Glasgow City to have a positive view of their physical wellbeing.

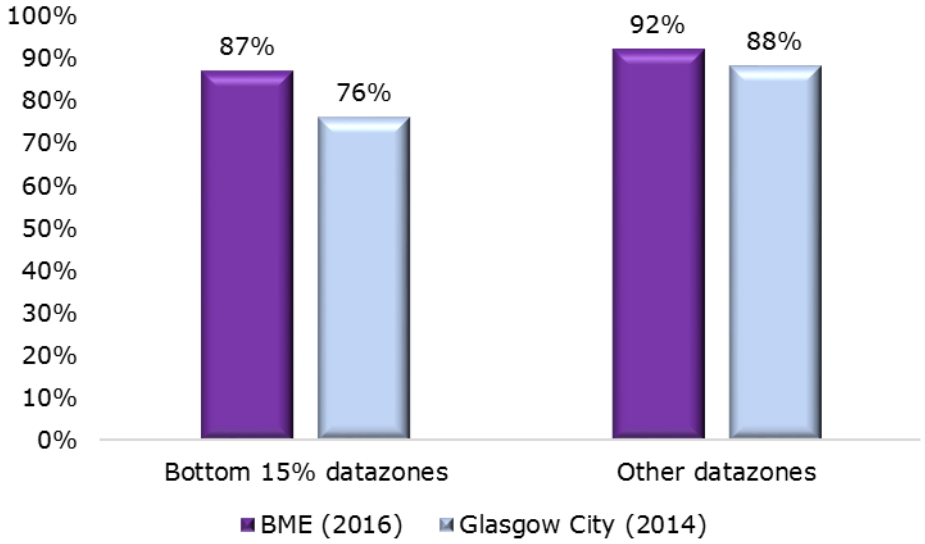
However, the difference between BME and all Glasgow City was most pronounced among those in the most deprived areas, as *Figure 2.3* shows.

Figure 2.3: Positive Perception of Physical Wellbeing (Q29b) by Deprivation – BME (2016) and Glasgow City (2014)



Similarly, BME groups in both the most deprived and other areas were more likely than those in Glasgow City to have a positive perception of their mental/emotional wellbeing, with the greatest difference observed among those in the most deprived areas. This is shown in *Figure 2.4*.

Figure 2.4: Positive Perception of Mental/Emotional Wellbeing (Q29c) by Age Group – BME (2016) and Glasgow City (2014)



Those who spoke English well and those who had lived in the UK for less than 10 years were more likely than others to have a positive perception of their physical wellbeing.

Those who had lived in the UK for less than 10 years were also more likely to have a positive perception of their mental and emotional wellbeing.

Table 2.6: Positive Perception of Physical Wellbeing (Q29b) and Mental and Emotional Wellbeing (Q29c) by How Well Speak English and Length of Residency in UK

	Positive Perception of Physical Wellbeing	Positive Perception of Mental and Emotional Wellbeing
Speak English very/fairly well	88%	(not significant)
Do not speak English well	78%	(not significant)
Lived in the UK for 10 years or more	80%	86%
Lived in the UK for less than 10 years	93%	96%
All BME	86%	90%

Feeling in Control of Decisions Affecting Life

Respondents were asked whether they feel in control of decisions that affect their life, such as planning their budget, moving house or changing job. Just under two in three (65%) said that they 'definitely' felt in control of these decisions, while 26% said that they felt in control 'to some extent' and 9% did not feel in control of these decisions. This was consistent with the findings from Glasgow City (2014).

There was considerably variation by ethnic group. Those in the Chinese group were the most likely to say they definitely felt in control, and those in the African group were the least likely.

Table 2.7: 'Definitely' Feel in Control of Decisions Affecting Life (Q50) by Ethnicity

	Definitely in Control
Chinese	85%
Polish	64%
Pakistani	62%
Indian	56%
African	41%
All BME	65%

Those aged 35-54 were the least likely to say they definitely felt in control of the decisions affecting their life.

Table 2.8: 'Definitely' Feel in Control of Decisions Affecting Life (Q50) by Age Group

	Definitely in Control
16-34	68%
35-54	59%
55+	64%
All BME	65%

Overall, men were more likely than women to say they definitely felt in control of decisions affecting their life (69% men; 59% women). For specific gender and ethnicity groups, African women were the least likely to feel in control (33%) and Chinese men were the most likely to feel in control (90%).

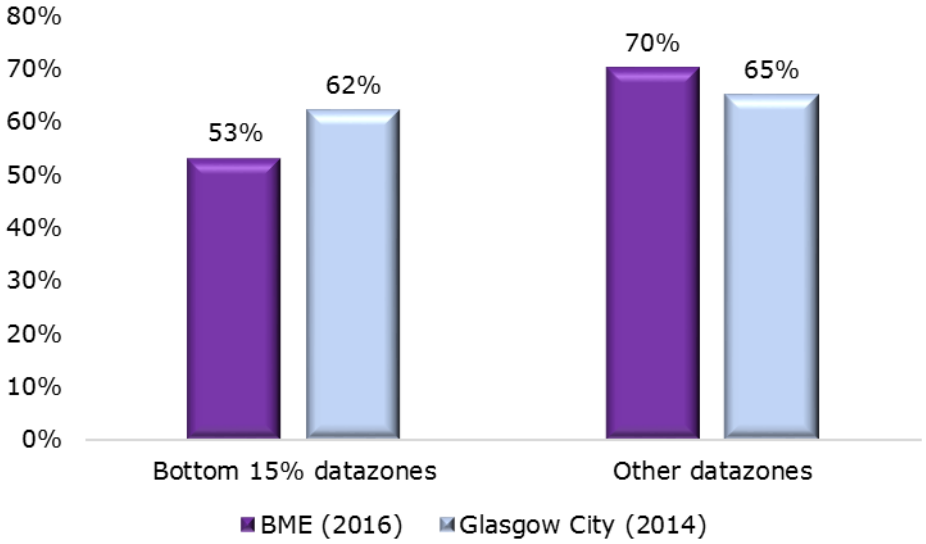
Table 2.9: 'Definitely' Feel in Control of Decisions Affecting Life (Q50) by Gender and Ethnicity

	Definitely in Control	
	Men	Women
Chinese	90%	80%
Polish	70%	58%
Pakistani	67%	54%
Indian	62%	45%
African	47%	33%
All BME	69%	59%

Those in the most deprived areas were less likely than those in other areas to say they definitely felt in control of the decisions affecting their life.

Overall, there was no significant difference between BME adults and those in Glasgow City in the proportion who felt in control of decisions. However, in the most deprived areas BME adults were less likely than those in Glasgow City to feel in control. In other areas, BME groups were more likely than those in Glasgow City to feel in control. This is shown in *Figure 2.5*.

Figure 2.5: 'Definitely' Feel in Control of Decisions Affecting Life (Q50) by Deprivation – BME and Glasgow City



Those who did not speak English well were less likely than those who spoke English well to say that they definitely felt in control of the decisions affecting their life.

Table 2.10: 'Definitely' Feel in Control of Decisions Affecting Life (Q50) by How Well Speak English

	Definitely in Control
Speak English very/fairly well	68%
Do not speak English well	49%
All BME	65%

2.2 Self Perceived Quality of Life

Using the 'faces' scale, respondents were asked to rate their overall quality of life. Just over nine in ten (92%) gave a positive rating of their quality of life. Overall, BME adults were more likely than those in Glasgow City to give a positive rating of their quality of life (92% BME; 85% Glasgow City).

Those in the Pakistani ethnic group were less likely than others to rate their quality of life positively.

Table 2.11: Positive Perception of Quality of Life (Q29a) by Ethnicity

	Positive Perception of Quality of Life
Polish	96%
Indian	95%
Chinese	95%
African	94%
Pakistani	85%
All BME	92%
Glasgow City (2014)	85%

Those aged 55 or over were less likely than younger people to have a positive perception of their quality of life.

BME adults in all age groups were more likely than those in Glasgow City to rate their quality of life positively, although the greatest difference was among those aged 35 or over. This is shown in *Figure 2.6.*

Figure 2.6: Positive Perception of Quality of Life (Q29a) by Age Group – BME (2016) and Glasgow City (2014)

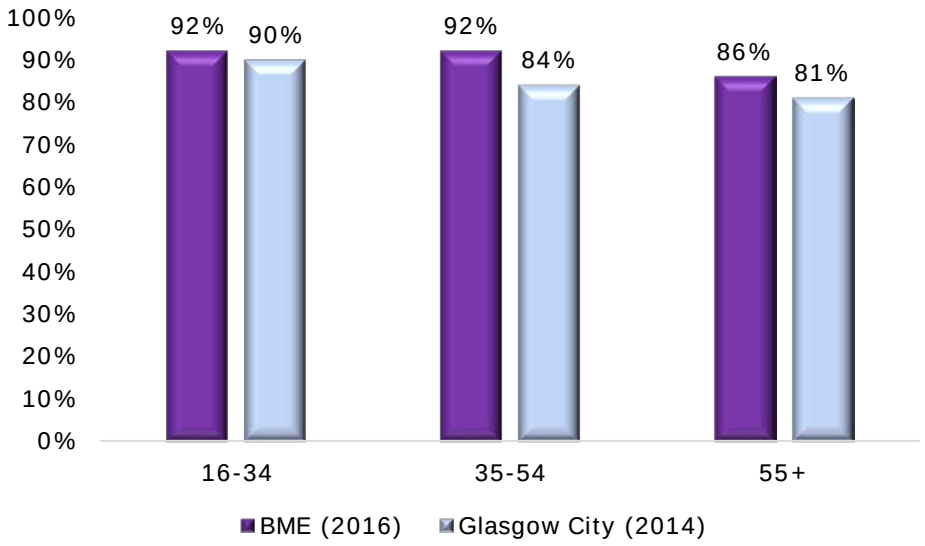
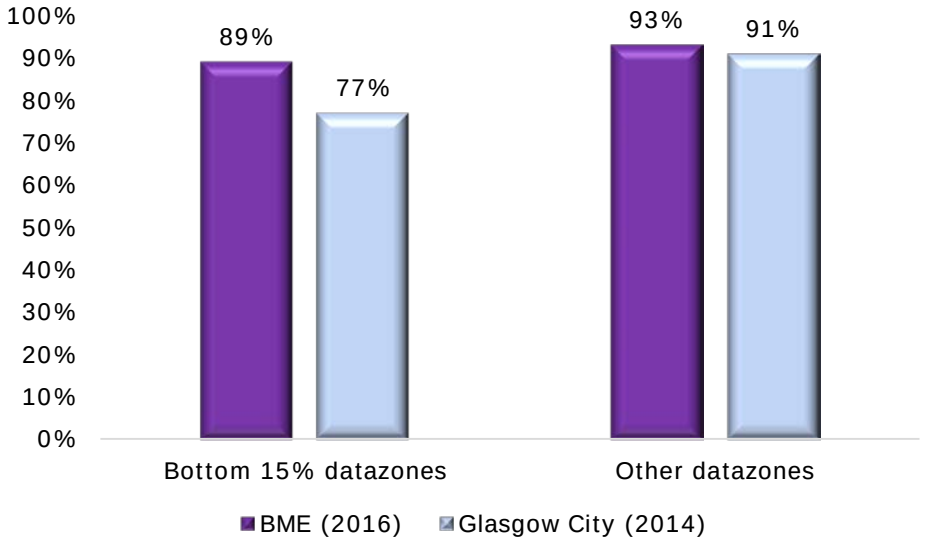


Figure 2.7 shows that those living in the most deprived areas were less likely than those in other areas to give a positive perception of their quality of life.

Although overall BME adults were more likely than those in Glasgow City to have a positive perception of their quality of life, this was only significant for those in the most deprived areas, and not for those in other areas.

Figure 2.7: Positive Perception of Quality of Life (Q29a) by Age Group – BME (2016) and Glasgow City (2014)



Those who had lived in the UK for less than 10 years were more likely than others to have a positive view of their quality of life.

Table 2.12: Positive Perception of Quality of Life (Q29a) by Length of Residency in UK

	Positive Perception of Quality of Life
Lived in the UK for 10 years or more	88%
Lived in the UK for 10 less than 10 years	96%
All BME	92%

2.3 Illness

Fifteen percent of BME adults said that they had a long-term condition or illness that substantially interfered with their day to day activities.

Of those who said they had a long-term condition or illness that interfered with their day to day activities:

- 38% said that they had a physical disability;
- 11% said they had a mental or emotional health problem; and
- 75% said they had a long-term illness.

Overall, BME adults were less likely than those in Glasgow City to have a long-term condition or illness that substantially interfered with their day to day activities (15% BME; 22% Glasgow City). This can partially be explained by the proportionately younger age profile of BME adults.

There was considerable variation by ethnic group, with those from the Pakistani group being the most likely to have a limiting condition or illness, and those in African and Chinese groups being the least likely.

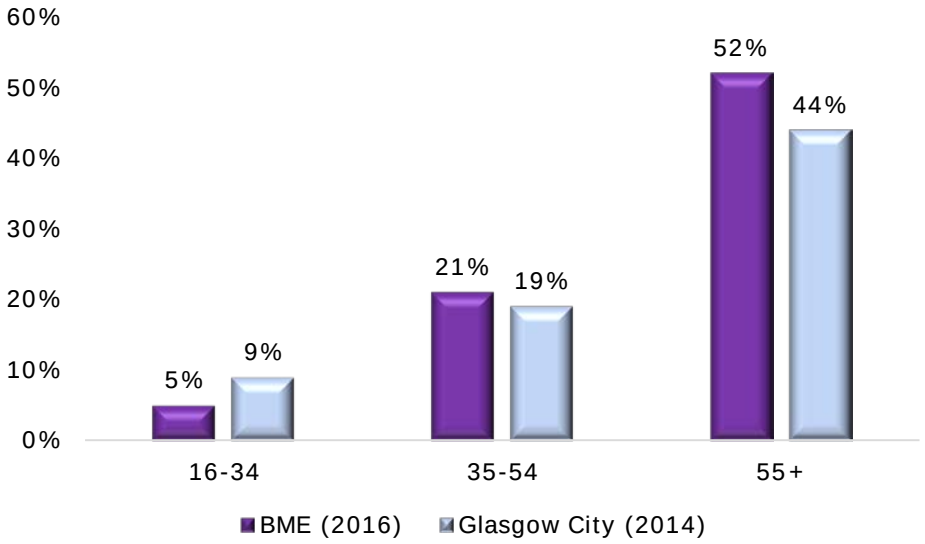
Table 2.13: Limiting Long-Term Condition or Illness (Q2) by Ethnicity

	Long-Term Condition/Illness
Pakistani	27%
Indian	14%
Polish	11%
Chinese	7%
African	6%
All BME	15%
Glasgow City (2014)	22%

The likelihood of having a limiting condition or illness increased with age, ranging from 5% of those aged 16-34 to 52% of those aged 55 or over.

Among those aged under 35, BME adults were less likely than those in Glasgow City to have a limiting condition illness (5% BME; 9% Glasgow City), but there was no significant difference between BME groups and Glasgow City for the other two age groups.

Figure 2.8: Limiting Long-Term Condition or Illness (Q2) by Age Group – BME (2016) and Glasgow City (2014)



Overall, men and women from BME groups were equally likely to have a limiting condition or illness. However, among Indian and African groups, women were more likely than men to have a limiting condition or illness.

By contrast, Chinese men were more likely than Chinese women to have a limiting condition or illness.

Table 2.14: Limiting Long-Term Condition or Illness (Q2) by Gender and Ethnicity

	Long-Term Condition/Illness	
	Men	Women
Pakistani	27%	27%
Indian	10%	20%
Polish	9%	12%
Chinese	8%	5%
African	5%	8%

Those who did not speak English well and those who had lived in the UK for 10 years or more were much more likely than others to have a limiting long-term condition or illness, as Table 2.15 shows.

Table 2.15: Limiting Long-Term Condition or Illness (Q2) by How Well Speak English and Length of Residency in UK

	Long-Term Condition/Illness		Long-Term Condition/Illness
Speak English very/fairly well	11%	Lived in the UK for 10 years or more	23%
Do not speak English well	32%	Lived in the UK for less than 10 years	6%

Illnesses/Conditions for Which Treatment is Being Received

One in four (26%) BME adults were receiving treatment for at least one illness or condition (not necessarily 'limiting' illnesses/conditions). BME groups were overall less likely than those in Glasgow City to be receiving treatment for at least one condition/illness (26% BME; 38% Glasgow City). This, however, can be partially explained by the younger age profile of BME adults.

Responses varied substantially by ethnic group, with the proportion receiving treatment for any condition/illness ranging from 10% of Chinese people to 42% of Pakistani people.

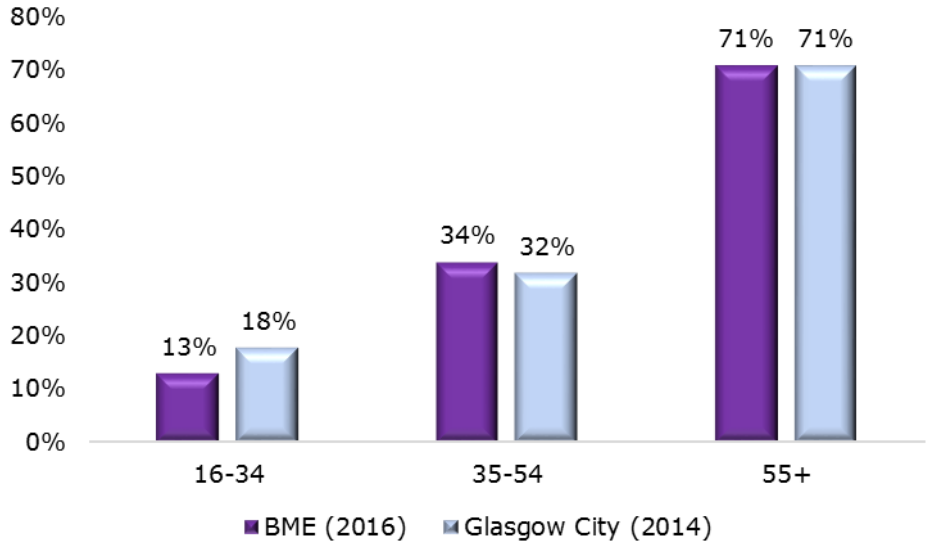
Table 2.16: At Least One Illness/Condition Being Treated (Q5) by Ethnicity

	Being Treated for Condition/Illness
Pakistani	42%
Indian	26%
African	20%
Polish	19%
Chinese	10%
All BME	26%
Glasgow City (2014)	38%

The likelihood of receiving treatment for conditions/illnesses increased very significantly with age – ranging from 13% of those aged 16-34 to 71% of those aged 55 or over.

Among those aged under 35, BME adults were less likely than those in Glasgow City to be receiving treatment for at least one condition/illness. There was no significant difference between BME and Glasgow City for the other two age groups.

Figure 2.9: At Least One Illness/Condition Being Treated (Q5) by Age Group – BME (2016) and Glasgow City (2014)



Overall, men were more likely than women to be receiving treatment for at least one condition or illness (28% men; 23% women).

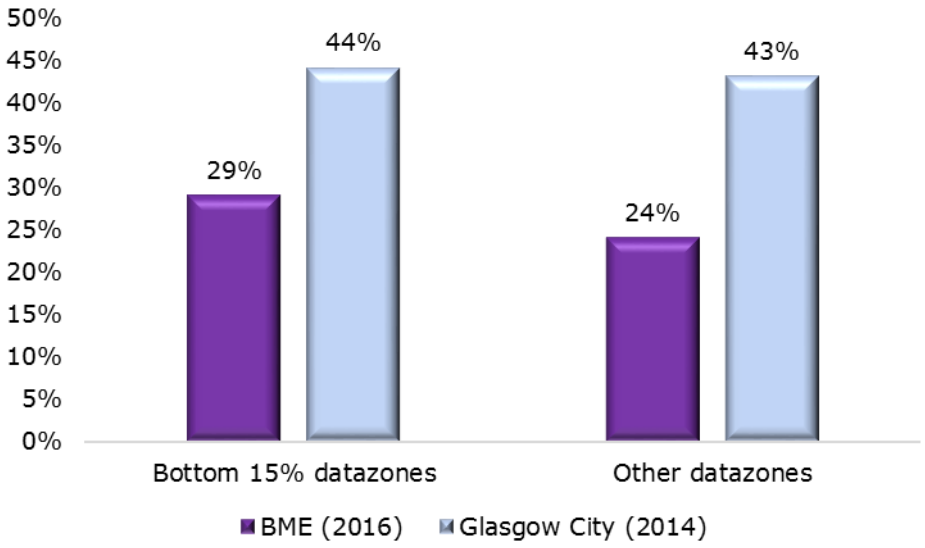
Table 2.17: At Least One Illness/Condition Being Treated (Q5) by Gender and Ethnicity

	Being Treated for Condition/Illness	
	Men	Women
Pakistani	44%	40%
Indian	25%	29%
African	21%	19%
Polish	20%	17%
Chinese	12%	8%
All BME	28%	23%

Overall, those in the most deprived areas were more likely than others to be receiving treatment for an illness or condition. This is shown in *Figure 2.10*.

For both the most deprived and other areas, BME adults were less likely than those in Glasgow City to be receiving treatment for illnesses/conditions.

Figure 2.10: At Least One Illness/Condition Being Treated (Q5) by Deprivation – BME (2016) and Glasgow City (2014)



Those who did not speak English well and those who had lived in the UK for 10 years or more were much more likely than others to be receiving treatment for at least one condition, at Table 2.18 shows.

Table 2.18: At Least One Illness/Condition Being Treated (Q5) by How Well Speak English and Length of Residency in UK

	Being Treated for Condition/Illness		Being Treated for Condition/Illness
Speak English very/fairly well	22%	Lived in the UK for 10 years or more	38%
Do not speak English well	43%	Lived in the UK for less than 10 years	12%

2.4 Mental Wellbeing

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) Scores

The survey used the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[7] to assess positive mental health (mental wellbeing). This uses 14 positively worded questions. Scores are derived by summing responses to each of the 14 questions on a 1-5 Likert scale. Thus, the maximum score is 70 and the minimum score is 14. The scale is designed to allow the measurement of mean scores in population samples. The Scottish Health Survey has consistently shown the mean WEMWBS score for the Scottish adult population to be around 50, with the 2015 survey showing a mean score of 49.9.

The overall mean WEMWBS score for BME adults was 53.9. This was slightly higher than the score for Glasgow City in 2014 (52.5), although this is in part due to the younger age profile of BME adults, as younger people tended to have a high WEMWBS score.

Mean WEMEBS Scores were highest for those in the African ethnic group and lowest for those in the Pakistani group.

Table 2.19: Mean WEMWBS Score (Q7) by Ethnicity

	Mean WEMWBS Score
African	57.1
Indian	54.9
Polish	54.3
Chinese	54.0
Pakistani	52.3
All BME	53.9
Glasgow City (2014)	52.5

[7] http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/

Those aged 55 or over had lower mean WEMBS scores that younger people.

Table 2.20: Mean WEMWBS Score (Q7) by Age Group

	Mean WEMWBS Score
16-34	54.3
35-54	53.9
55+	52.1
All BME	53.9

Overall, men had higher mean WEMWBS scores than women. The gender difference was greatest among the Indian ethnic group.

Table 2.21: Mean WEMEBS Score (Q7) by Gender and Ethnicity

	Mean WEMWBS Score	
	Men	Women
African	57.9	55.8
Indian	56.1	52.7
Polish	54.4	54.2
Chinese	54.6	53.5
Pakistani	52.8	51.4
All BME	54.5	53.1

Those in the most deprived areas had lower mean WEMWBS scores than those living in other areas. This is shown in Table 2.22.

Table 2.22: Mean WEMWBS Score (Q7) by Deprivation

	Mean WEMWBS Score
Bottom 15% datazones	53.0
Other datazones	54.3
All BME	53.9

Those who had lived in the UK for less than 10 years had a higher mean WEMWBS score than those who had lived in the UK for 10 years or more.

Table 2.23: Mean WEMWBS Score (Q7) by Length of Residency in UK

	Mean WEMWBS Score
Lived in the UK for 10 years or more	53.2
Lived in the UK for less than 10 years	54.7
All BME	53.9

Evidence from other sources

The Scottish Health Survey (2008-2011)[8] found that those in the White British ethnic group had the lowest mean WEMWBS score (49.8), significantly lower than the African, Carribbean or Black group which had the highest mean score (53.7).

2.5 Summmary of Key Messages from This Chapter

Views of health

Across all BME adults, 80% had a positive view of their general health, 86% had a positive view of their physical wellbeing and 90% had a positive view of their mental/emotional wellbeing.

- Those in the Pakistani group were the least likely to have positive views of each of these.

- Although BME groups were more likely than those in Glasgow City to have a positive view of each of these, this was explained by the younger age profile of the BME population. The exception was physical wellbeing, with BME adults in each age group being more likely than those in Glasgow City to have a positive perception of their physical wellbeing.

- Those in the most deprived areas, those who did not speak English well and those who had lived in the UK for 10 years or more were less likely to have positive views of their health and wellbeing.

Feeling in control

Two in three (65%) BME adults said they definitely felt in control of the decisions affecting their daily life, although there was much variation between ethnic groups.

- The Chinese group was the most likely to feel in control, and the African group were the least likely.

- Other groups who were less likely to feel in control were women, those in the most deprived areas and those who did not speak English well.

[8] http://www.gov.scot/Resource/0040/00406749.pdf

Quality of life

More than nine in ten (92%) BME adults overall had a positive perception of their quality of life, which was higher than Glasgow City.

- The Pakistani group were as likely as those in Glasgow City to have a positive perception of their quality of life.
- Those aged 55 and over, those in the most deprived areas and those who had lived in the UK for 10 years or more were less likely to have a positive perception of their quality of life.

Illness

Fifteen percent of BME adults had an illness or condition that limited what they could do, and one in four (26%) were receiving treatment for at least one illness or condition.

- Those aged 55 or over were much more likely to have a limiting condition/illness (52%) or be receiving treatment for something (71%).

- Overall, BME groups were less likely than those in Glasgow City to have a limiting condition or to be receiving treatment for any illness/condition. However, the Pakistani group, those who did not speak English well and those who had lived in the UK for 10 years or more were much more likely than other BME adults to have a limiting condition or illness or to be receiving treatment for a condition/illness.

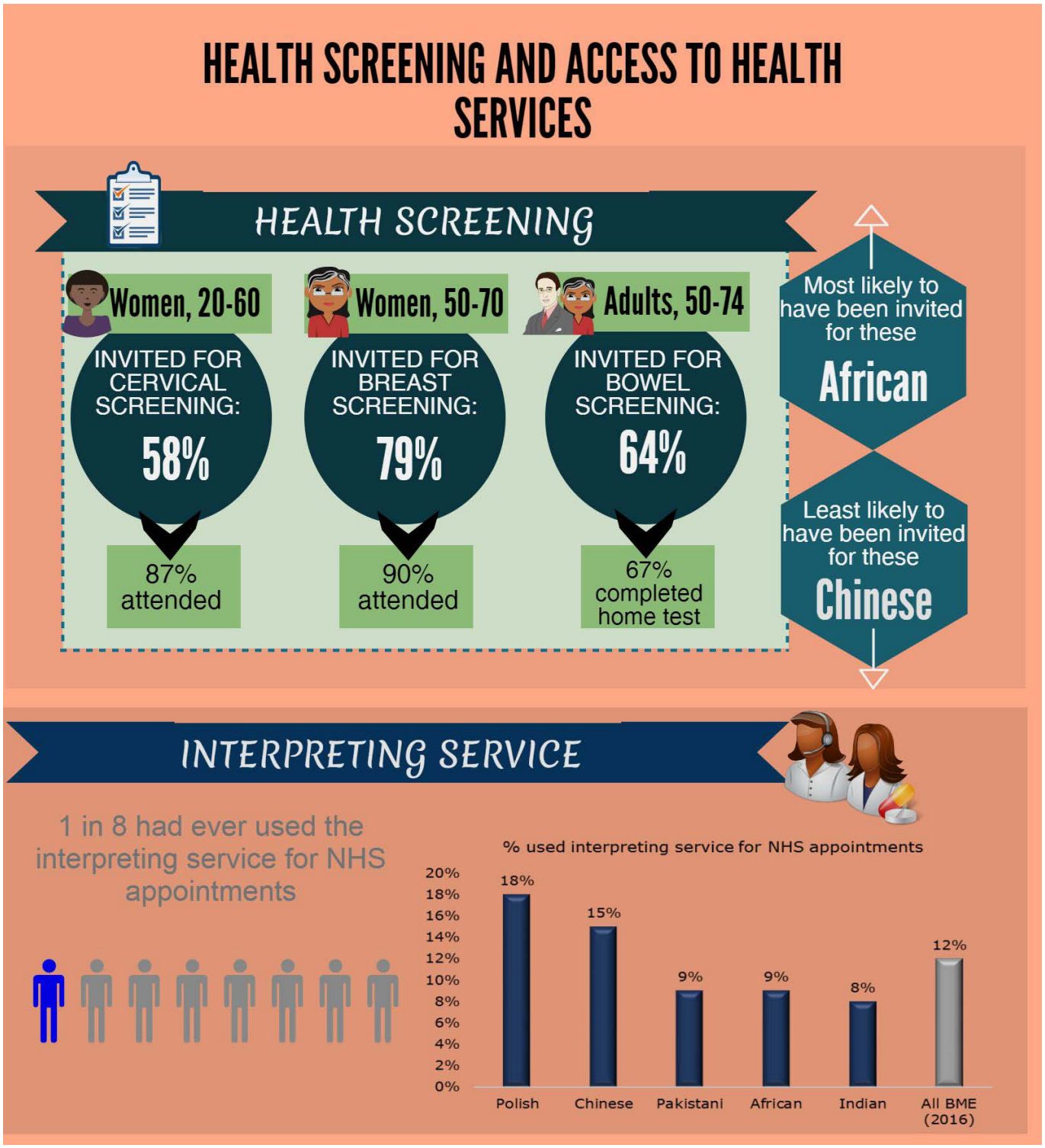
WEMWBS

The mean WEMWBS score for BME adults was 53.9, which was higher than the mean score for Glasgow City, although this can partly be explained by younger age profile of BME groups.

- Mean WEMWBS scores were highest for the African group and lowest for the Pakistani group.

- Overall, men had higher WEMWBS scores than women.

3 Health Screening and Access to Health Services



3.1 Introduction

This chapter presents the findings for questions relating to attendance at health screening appointments and access to health services. These questions were unique to the 2016 BME Health and Wellbeing survey, and therefore no comparisons are made with Glasgow City.

3.2 Health Screening

Cervical Screening

Overall, 58% of BME women aged 20 to 60 said they had ever been invited for a cervical screening (smear test). Of those who said they had been invited for a cervical screening, 87% said they had attended.

Chinese women were much less likely than women on other ethnic groups to say they had ever been invited for a cervical screening. African women were the most likely to report having been invited for a cervical screening. Of those who reported having been invited for a screening, Chinese women were also the group least likely to have attended.

Table 3.1: Whether Ever Been Invited for a Cervical Screening and Whether Attended a Cervical Screening by Ethnicity (Women aged 20 to 60 Only)

	Ever Been Invited for Cervical Screening	Attended Cervical Screening (of those who were invited)
African	90%	93%
Pakistani	72%	81%
Polish	62%	95%
Indian	61%	90%
Chinese	36%	79%
All BME	58%	87%

Currently in Scotland, cervical screening is offered three-yearly to women from the age of 25, and five-yearly to women aged 50-64. It is therefore to be expected that the youngest age group (20-34) would be the least likely to report having ever been invited for cervical screening. However, of those who said they had been invited, the youngest age group were also the least likely to attend.

Table 3.2: Whether Ever Been Invited for a Cervical Screening and Whether Attended a Cervical Screening by Age Group (Women aged 20 to 60 Only)

	Ever Been Invited for Cervical Screening	Attended Cervical Screening (of those who were invited)
20-34	52%	82%
35-54	70%	92%
55-60	67%	94%
All BME	58%	87%

Women aged 20 to 60 in the most deprived areas were more likely than those in other areas to say they had been invited for a cervical screening. Among those who had been invited for a screening, those in the most deprived areas were also the most likely to have attended.

Table 3.3: Whether Ever Been Invited for a Cervical Screening and Whether Attended a Cervical Screening by Deprivation (Women aged 20 to 60 Only)

	Ever Been Invited for Cervical Screening	Attended Cervical Screening (of those who were invited)
15% most deprived datazones	70%	91%
Other datazones	53%	84%
All BME	58%	87%

Those who had lived in the UK for 10 years or more were more likely than those who had lived in the UK for less than 10 years to say they had been invited for a cervical screening.

Table 3.4: Whether Ever Been Invited for a Cervical Screening by Length of Residency in UK (Women aged 20 to 60 Only)

	Ever Been Invited for Cervical Screening
Lived in the UK for 10 years or more	71%
Lived in the UK for less than 10 years	48%
All BME	58%

Among those who did not attend a cervical screening appointment they were invited to, the most common reason was that they did not have time/were too busy (38%).

Breast Screening

Four in five (79%) BME women aged 50 to 70 said they had ever been invited for breast screening. Of those who had been invited for breast screening, nine in ten (90%) said they had attended.

Those in the Polish and Chinese groups were less likely than others to say they had been invited for breast screening.

Table 3.5: Whether Ever Been Invited for Breast Screening (Women aged 50 to 70) by Ethnicity

	Ever Been Invited for Breast Screening
African	100%
Pakistani	86%
Indian	83%
Chinese	58%
Polish	50%
All BME	79%

Those who had lived in the UK for 10 years or more were more likely than others to say they had been invited for breast screening.

Table 3.6: Whether Ever Been Invited for Breast Screening by Length of Residency in UK (Women aged 50 to 70 Only)

	Ever Been Invited for Breast Screening
Lived in the UK for 10 years or more	83%
Lived in the UK for less than 10 years	54%
All BME	79%

Bowel Screening

Just under two in three (64%) BME people aged 50-74 said they had been invited for bowel screening. Of those who said they had been invited for bowel screening, 68% said they completed the home test.

African and Pakistani groups were the most likely to say they had been invited for bowel screening.

Table 3.7: Whether Ever Been Invited for Bowel Screening (Aged 50 to 74 Only) by Ethnicity

	Ever Been Invited for Bowel Screening
African	75%
Pakistani	72%
Indian	56%
Chinese	55%
Polish	42%
All BME	64%

Those who had lived in the UK for 10 years or more were more likely than others to say they had been invited for bowel screening.

Table 3.8: Whether Ever Been Invited for Bowel Screening by Length of Residency in UK (Aged 50 to 70 Only)

	Ever Been Invited for Bowel Screening
Lived in the UK for 10 years or more	67%
Lived in the UK for less than 10 years	33%
All BME	64%

The most common reason for not completing the home test was do not have time/too busy (26%).

3.3 Use of Interpreting Service

One in eight (12%) BME adults said they had ever used the interpreting service for appointments with the NHS. Polish and Chinese groups were the most likely to have used the interpreting service.

Table 3.9: Whether Ever Used Interpreting Service for NHS Appointments (QN12) by Ethnicity

	Used Interpreting Service
Polish	18%
Chinese	15%
Pakistani	9%
African	9%
Indian	8%
All BME	12%

Use of the interpreting service for NHS appointments increased with age – ranging from 7% of those aged 16-34 to 25% of those aged 55 or over.

Table 3.10: Whether Ever Used Interpreting Service for NHS Appointments (QN12) by Age Group

	Used Interpreting Service
16-34	7%
35-54	16%
55+	25%
All BME	12%

Overall, women were more likely than men to have used the interpreting service (17% women; 8% men). Use of the interpreting service was highest among Polish women (28%) and lowest for Pakistani men (5%).

Table 3.11: Whether Ever Used Interpreting Service for NHS Appointments (QN12) by Gender and Ethnicity

	Used Interpreting Service	
	Men	Women
Polish	9%	28%
Chinese	12%	17%
Pakistani	5%	15%
African	8%	10%
Indian	7%	11%
All BME	8%	17%

Those in the most deprived areas were more likely than others to have used the interpreting service for NHS appointments.

Table 3.12: Whether Ever Used Interpreting Service for NHS Appointments (QN12) by Deprivation

	Used Interpreting Service
Bottom 15% datazones	17%
Other datazones	10%
All BME	12%

As would be expected, those who did not speak English well were much more likely than others to have used the interpreting service. However, less than half (44%) of those who did not speak English well had ever used the interpreting service.

Table 3.13: Whether Ever Used Interpreting Service for NHS Appointments (QN12) by How Well Speak English

	Used Interpreting Service
Speak English very/fairly well	4%
Do not speak English well	44%
All BME	12%

Those who had ever used the interpreting service were asked where their appointment was (those who had used the service more than once were asked about the most recent occasion). Most said that it was at their GP practice (55%) or as a hospital/ward inpatient (39%). A further 4% said that it was at a dentist appointment, and 2% said it was somewhere else.

3.4 Summary of Key Messages from This Chapter

Health Screening

Three in five (58%) BME women aged 20-60 said they had been invited for cervical screening. Of these, 87% had attended cervical screening.

Four in five (79%) BME women aged 50-70 said they had been invited for breast screening. Of these, 90% had attended breast screening.

Two in three (64%) BME adults aged 50-74 said they had been invited for bowel screening. Of these, 68% had completed the home test.

- Among the target gender/age groups, Chinese people were among the least likely to say they had been invited for cervical, breast or bowel screening. African people were the most likely to say they had been invited for these.

- Among the target gender/age groups, those who had lived in the UK for 10 years or more were much more likely than others to say they had been invited for cervical screening, breast screening or bowel screening.

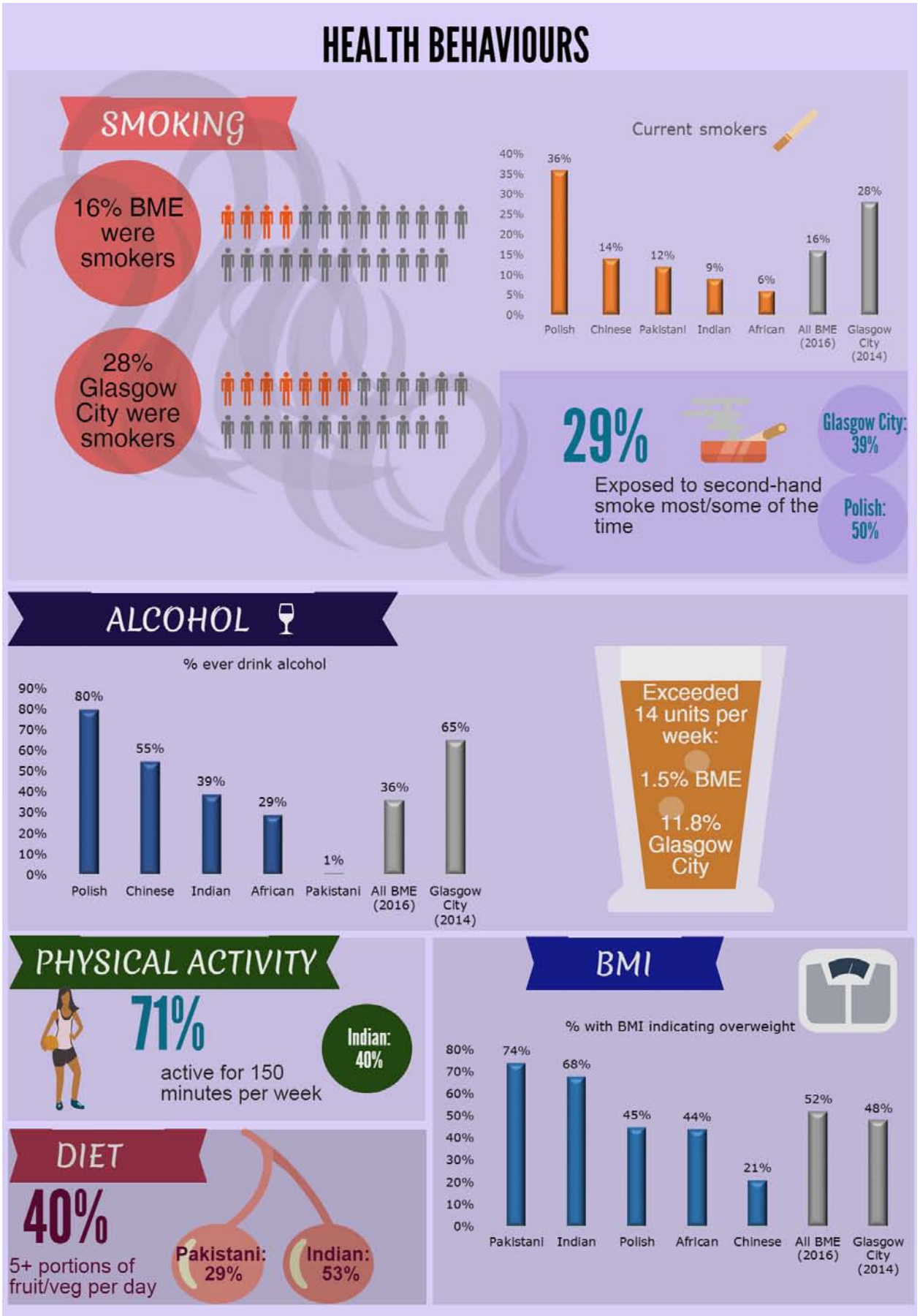
Interpreting Service

One in eight (12%) BME adults had used the interpreting service for NHS appointments.

- Among those who did not speak English well, 44% had used the interpreting service.

- Of those who had used the interpreting service (for any appointment or their last appointment), most said it was at their GP practice (55%) or as a hospital in-patient (39%).

- Those aged 16-34 were the least likely to have used the interpreting service (7%) and those aged 55 or over were the most likely (25%).


HEALTH BEHAVIOURS
SMOKING
16% BME were smokers
28% Glasgow City were smokers
Current smokers
40%
35%
30%
25%
20%
15%
10%
5%
0%
36%
14%
12%
9%
6%
16%
28%
Polish
Chinese
Pakistani
Indian
African
All BME (2016)
Glasgow City (2014)
29%
Exposed to second-hand smoke most/some of the time
Glasgow City: 39%
Polish: 50%
ALCOHOL
% ever drink alcohol
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
80%
55%
39%
29%
1%
36%
65%
Polish
Chinese
Indian
African
Pakistani
All BME (2016)
Glasgow City (2014)
Exceeded 14 units per week:
1.5% BME
11.8% Glasgow City
PHYSICAL ACTIVITY
71%
active for 150 minutes per week
Indian: 40%
DIET
40%
5+ portions of fruit/veg per day
Pakistani: 29%
Indian: 53%
BMI
% with BMI indicating overweight
80%
70%
60%
50%
40%
30%
20%
10%
0%
74%
68%
45%
44%
21%
52%
48%
Pakistani
Indian
Polish
African
Chinese
All BME (2016)
Glasgow City (2014)

4.2 Smoking

Exposure to Second Hand Smoke

Respondents were asked how often they were in places where there is smoke from other people smoking tobacco. Three in ten (29%) said that this happened most of the time (12%) or some of the time (17%). A further 21% said that they were seldom exposed to second hand smoke and 50% said they were never exposed.

BME adults were overall less likely than those in Glasgow City to say they were exposed to second hand smoke most or some of the time (29% BME; 39% Glasgow City). This was despite the BME population profile having proportionately more young people (who were more likely to be exposed to second hand smoke). There was, however, much variation across ethnic groups – the proportion who were exposed most/some of the time ranged from 18% in the Chinese group to 50% in the Polish group.

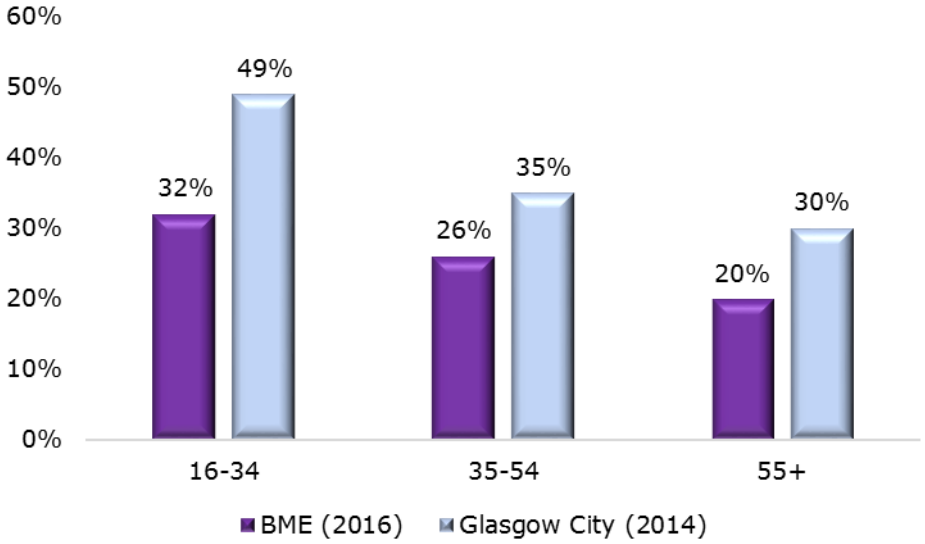
Table 4.1: Exposure to Second Hand Smoke (Q8) by Ethnicity

	Exposed Most/Some of the Time
Polish	50%
African	33%
Indian	27%
Pakistani	27%
Chinese	18%
All BME	29%
Glasgow City (2014)	39%

The likelihood of being exposed to second hand smoke most or some of the time decreased with age, ranging from 32% of those aged under 35 to 20% of those aged 55 or over.

BME adults of all age groups were less likely than those in Glasgow City to be exposed to second hand smoke most or some of the time, as *Figure 4.1* shows.

Figure 4.1: Proportion Exposed Second Hand Smoke Most/Some of the Time (Q8) by Age Group - BME (2016) and Glasgow City (2014)



Overall, men were more likely than women to be exposed to second hand smoke most or some of the time (35% men; 21% women). The gender difference was much more pronounced among the Chinese and Pakistani groups, as Table 4.2 shows.

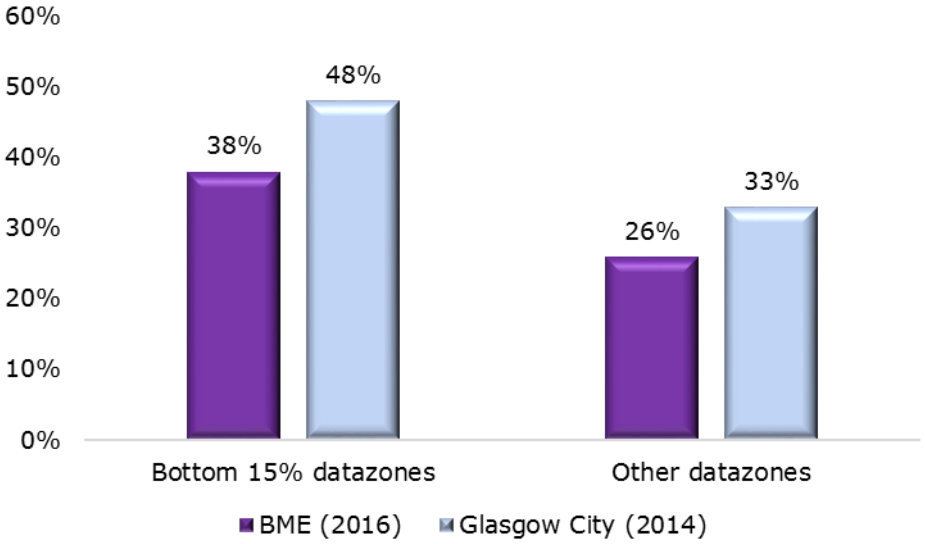
Table 4.2: Exposure to Second Hand Smoke (Q8) by Gender and Ethnicity

	Exposed Most/Some of the Time	
	Men	Women
Polish	53%	47%
African	39%	25%
Indian	27%	26%
Pakistani	33%	16%
Chinese	30%	9%
All BME	35%	21%

Those in the most deprived areas were more likely than those in other areas to be exposed to second hand smoke most or some of the time, as shown in *Figure 4.2*.

A difference between BME adults and those in Glasgow City was observed in both the most deprived areas and other areas, with BME adults being less likely to be exposed to second hand smoke.

Figure 4.2: Proportion Exposed Second Hand Smoke Most/Some of the Time (Q8) by Deprivation - BME (2016) and Glasgow City (2014)



Those who had lived in the UK for less than 10 years were more likely than others to be exposed to second hand smoke most/some of the time.

Table 4.3: Exposure to Second Hand Smoke (Q8) by Length of Residency in the UK

	Exposed Most/Some of the Time
Lived in the UK for 10 years or more	27%
Lived in the UK for less than 10 years	32%
All BME	29%

Smoking

One in six (16%) BME adults were smokers, smoking either every day (11%) or some days (4%). Overall, BME adults were much less likely than those in Glasgow City to be smokers (16% BME; 28% Glasgow City). However, those in the Polish ethnic group were much more likely to be smokers, as Table 4.4 shows.

Table 4.4: Proportion of Current Smokers (Q9) by Ethnicity

	Current Smokers
Polish	36%
Chinese	14%
Pakistani	12%
Indian	9%
African	6%
All BME	16%
Glasgow City (2014)	28%

Overall, men were much more likely than women to be smokers (21% men; 8% women), although this was not the case among Polish people.

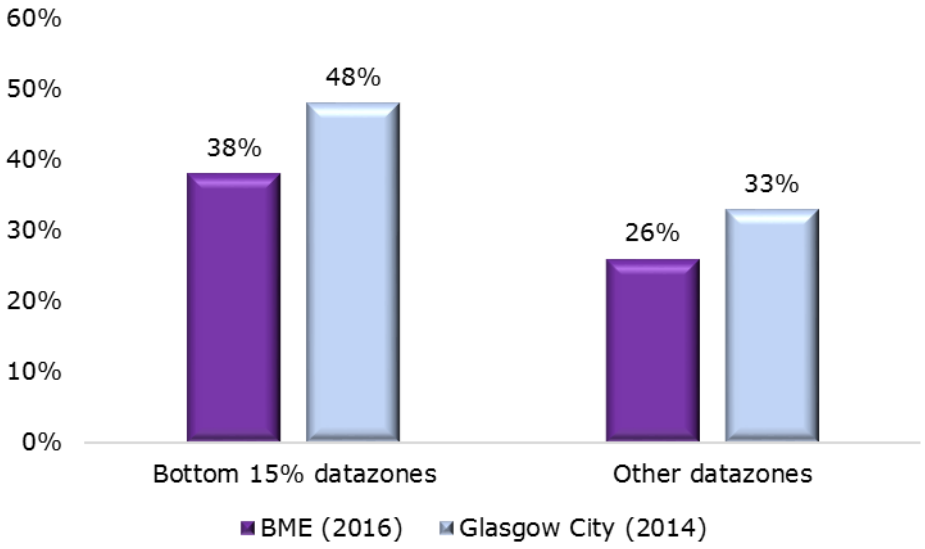
Table 4.5: Proportion of Current Smokers (Q9) by Gender and Ethnicity

	Current Smokers	
	Men	Women
Polish	35%	38%
Chinese	27%	3%
Pakistani	20%	1%
Indian	14%	0%
African	9%	3%
All BME	21%	8%

Those in the most deprived areas were much more likely than those in other areas to be smokers, as shown in *Figure 4.3*.

BME adults were less likely than those in Glasgow City to be smokers, and this was true in the most deprived areas and also other areas.

Figure 4.3: Proportion of Current Smokers (Q9) by Deprivation - BME (2016) and Glasgow City (2014)



Those who had lived in the UK for less than 10 years were more likely than others to be smokers.

Table 4.6: Proportion of Current Smokers (Q9) by Length of Residency in the UK

	Exposed Most/Some of the Time
Lived in the UK for 10 years or more	13%
Lived in the UK for less than 10 years	18%
All BME	16%

Evidence from other Sources

The Scottish Health Survey (2008-2011)[9] showed that the Pakistani ethnic group was the least likely to be smokers.

Intention to Stop Smoking

More than four in ten (44%) smokers said that they intend to stop smoking while 39% said they did not and 17% said possibly.

Among smokers, those in the Pakistani ethnic group were much more likely than those in any other group to say they intended to stop smoking.

Table 4.7: Proportion of Smokers who Intend to Stop (Q10) by Ethnicity

	Intend to Stop Smoking
Pakistani	74%
African	45%
Chinese	38%
Polish	32%
Indian	28%
All BME	44%

Smokers who had lived in the UK for 10 years or more were more likely than other smokers to say they intended to stop smoking.

[9] http://www.gov.scot/Resource/0040/00406749.pdf

Table 4.8: Proportion of Smokers who Intend to Stop (Q10) by Length of Residency in the UK

	Intend to Stop Smoking
Lived in the UK for 10 years or more	54%
Lived in the UK for less than 10 years	36%
All BME	44%

Shisha

Overall one in 14 (7%) BME adults said they had smoked shisha (hookah) in the last year. These comprised 4% who had used it 'once or twice' in the last year, 3% who had used it 'on some days' and less than 1% who used it every day. This question was not included in the 2014 Health and Wellbeing survey, so comparisons with Glasgow City are not possible.

Use of shisha was most common among those in the Pakistani group.

Table 4.9: Use of Shisha in Last Year (QN14) by Ethnicity

	Smoked Shisha in Last Year
Pakistani	13%
Polish	6%
African	5%
Indian	4%
Chinese	2%
All BME	7%

Those aged under 35 were much more likely than those in other age groups to have smoked shisha in the last year.

Table 4.10: Use of Shisha in Last Year (QN14) by Age Group

	Smoked Shisha in Last Year
16-34	10%
35-54	2%
55+	3%
All BME	7%

Overall, men were more likely than women to have smoked shisha in the last year (9% men; 4% women). Pakistani men were the ethnicity/gender group most likely to have used shisha in the last year (17%).

Table 4.11: Use of Shisha in Last Year (QN14) by Gender and Ethnicity

	Smoked Shisha in Last Year	
	Men	Women
Pakistani	17%	6%
Polish	8%	3%
African	5%	5%
Indian	5%	2%
Chinese	2%	2%
All BME	9%	4%

Use of shisha was less common in the most deprived areas than in other areas.

Table 4.12: Use of Shisha in Last Year (QN14) by Deprivation

	Smoked Shisha in Last Year
Bottom 15% datazones	4%
Other datazones	8%
All BME	7%

Those who spoke English well were more likely than those who did not to have smoked shisha in the last year. Also, those who had lived in the UK for 10 years or more were more likely than those who had lived in the UK for less than 10 years to have used shisha. This is shown in Table 4.13.

Table 4.13: Use of Shisha in Last Year (QN14) by How Well Speak English and Length of Residency in the UK

	Smoked Shisha in Last Year		Smoked Shisha in Last Year
Speak English very/fairly well	8%	Lived in the UK for 10 years or more	9%
Do not speak English well	1%	Lived in the UK for less than 10 years	5%

E-Cigarettes

One in 11 (9%) BME adults had used e-cigarettes in the last year. These comprised those who had used e-cigarettes every day (2%) some days (4%) or once or twice (3%). Overall, BME groups were less likely than those in Glasgow City to use e-cigarettes (9% BME; 14% Glasgow City). However, those in the Polish ethnic group were much more likely than any other group to have used e-cigarettes, with more than one in five (22%) Polish adults having used e-cigarettes in the last year.

Table 4.14: Proportion who had used E-Cigarettes in the Last Year (Q11) by Ethnicity

	Used E-Cigarettes in the Last Year
Polish	22%
Pakistani	9%
Chinese	5%
Indian	3%
African	2%
All BME	9%
Glasgow City (2014)	14%

Overall, men were much more likely than women to have used e-cigarettes in the last year (11% men; 5% women). However, this was not the case for the Polish group, among which women were more likely than men to have used e-cigarettes. Indeed, a quarter (25%) of Polish women had used e-cigarettes in the last year.

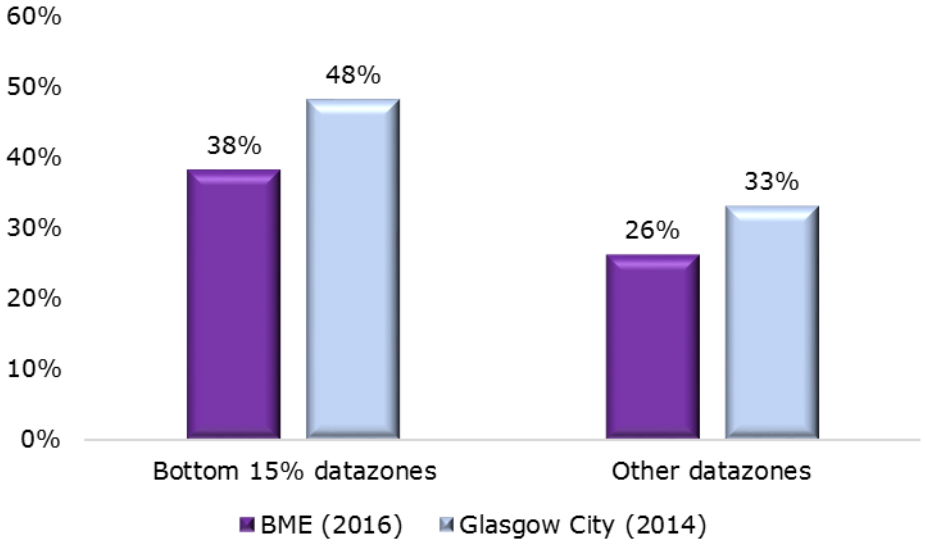
Table 4.15: Proportion who had used E-Cigarettes in the Last Year (Q11) by Gender and Ethnicity

	Used E-Cigarettes in the Last Year	
	Men	Women
Polish	18%	25%
Pakistani	15%	1%
Chinese	8%	1%
Indian	5%	1%
African	4%	0%
All BME	11%	5%

Those in the 15% most deprived areas were more likely than those in other areas to have used e-cigarettes in the last year, as shown in *Figure 4.4*.

BME adults were less likely than those in Glasgow City to have used e-cigarettes in the last year, and this was true for both those in the most deprived areas and those in other areas.

Figure 4.4: Proportion who had used E-Cigarettes in the Last Year (Q11) by Deprivation – BME (2016) and Glasgow City (2014)



Those who had lived in the UK for less than 10 years were more likely than others to have used e-cigarettes in the last year.

Table 4.16: Proportion who had used E-Cigarettes in the Last year (Q11) by Length of Residency in the UK

	Used E-Cigarettes in the Last Year
Lived in the UK for 10 years or more	7%
Lived in the UK for less than 10 years	10%
All BME	9%

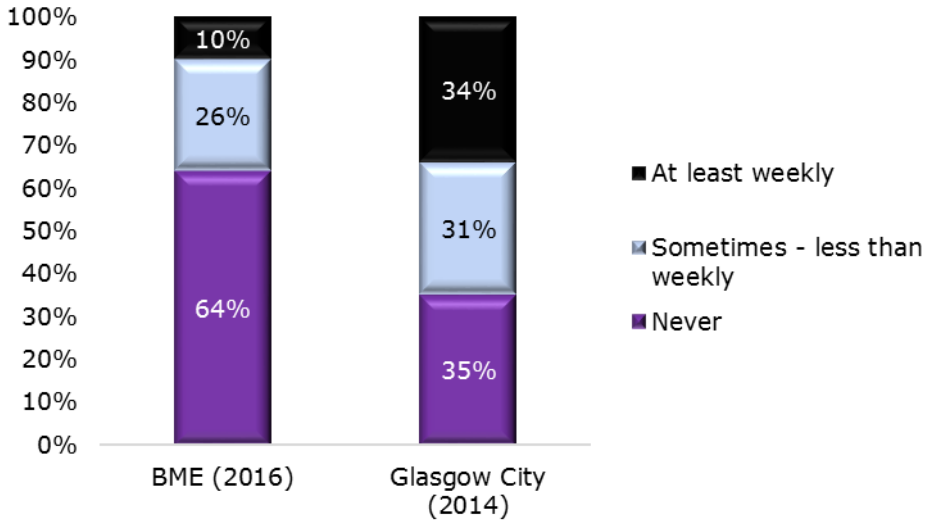
4.3 Drinking

Frequency of Drinking Alcohol

Nearly two in three (64%) BME adults said that they never drank alcohol, 25% drank alcohol sometimes, but less than weekly and 10% drank alcohol at least once a week (including 2% who drank alcohol on three or more days per week).

Overall, BME adults were much less likely than those in Glasgow City to drink alcohol, as *Figure 4.5* shows.

Figure 4.5: Frequency Drink Alcohol – BME (2016) and Glasgow City (2014)



Drinking behaviour differed very considerably by ethnic group. Nearly all (99%) of those in the Pakistani group said they never drank alcohol, but this was true of just 20% of those in the Polish group. Table 4.17 shows the proportion who ever drank alcohol by ethnic group.

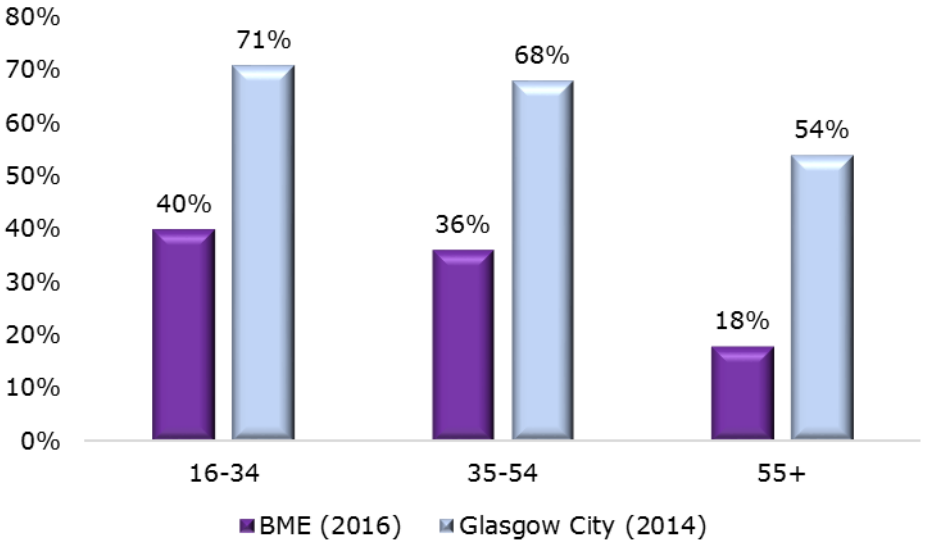
Table 4.17: Proportion who Ever Drank Alcohol by Ethnicity

	Ever Drink Alcohol
Polish	80%
Chinese	55%
Indian	39%
African	29%
Pakistani	1%
All BME	36%
Glasgow City (2014)	65%

Those aged 55 or over were less likely than younger adults to drink alcohol.

BME adults in all age groups were much less likely than those in Glasgow City to drink alcohol, as *Figure 4.6* shows.

Figure 4.6: Proportion who Ever Drank Alcohol by Age Group – BME (2016) and Glasgow City (2014)



Overall, men were more likely than women to ever drink alcohol (40% men; 31% women). The gender difference was most pronounced in the Indian and African groups, as Table 4.18 shows.

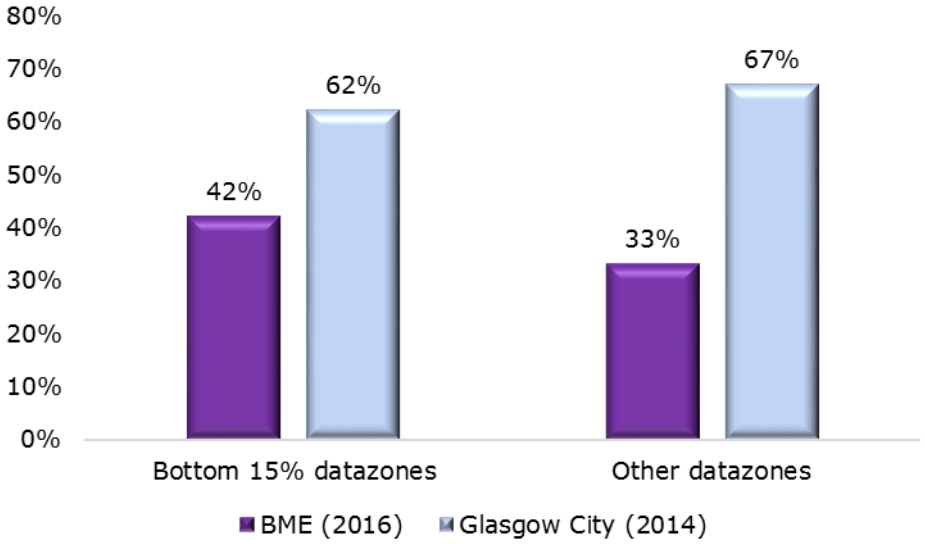
Table 4.18: Proportion who Ever Drank Alcohol by Gender and Ethnicity

	Ever Drink Alcohol	
	Men	Women
Polish	87%	72%
Chinese	63%	48%
Indian	52%	17%
African	39%	15%
Pakistani	1%	<1%
All BME	40%	31%

Those in the most deprived areas were more likely than those in other areas to ever drink alcohol.

In both the most deprived and other areas, BME adults were less likely than those in Glasgow City to drink alcohol. However, the difference was much more pronounced among those in other areas. This is shown in *Figure 4.7*.

Figure 4.7: Proportion who Ever Drank Alcohol by Deprivation – BME (2016) and Glasgow City (2014)



Those who spoke English well and particularly those who had lived in the UK for less than 10 years were more likely than others to ever drink alcohol.

Table 4.19: Proportion of Respondents who Ever Drank Alcohol by How Well Speak English and Length of Residency in the UK

	Ever Drink Alcohol		Ever Drink Alcohol
Speak English very/fairly well	38%	Lived in the UK for 10 years or more	23%
Do not speak English well	26%	Lived in the UK for less than 10 years	51%

Alcohol Consumption in Previous Week

Respondents were asked whether they had had a drink containing alcohol in the past seven days. One in eight (12%) BME adults said they had drunk alcohol in the past week (therefore slightly more than the 10% who had said they drank alcohol weekly).

Respondents were asked how many of each type of drink they had consumed on each of the past seven days. Responses were used to calculate the total units of alcohol consumed on each day, and a total number of units for the week. Appendix D shows the assumptions of units in each type of drink.

There are national guidelines for limits to alcohol consumption. Very few BME adults exceeded any of the limits. Just 1.5% exceeded the weekly alcohol limit of 14 units.

However, 6% exceeded the recommended daily limit of four units for men and three units for women on any day in the preceding week. Also, 2% had binged on at least one day in the previous week (men consuming eight or more units and women consuming six or more units in one day). Just 0.7% of BME adults failed to have two or more alcohol-free days in the previous week.

BME adults were much less likely than those in Glasgow City to exceed any of the recommended limits for alcohol consumption in the previous week. Among BME adults, those in the Polish group were the most likely to have exceeded recommended alcohol limits.

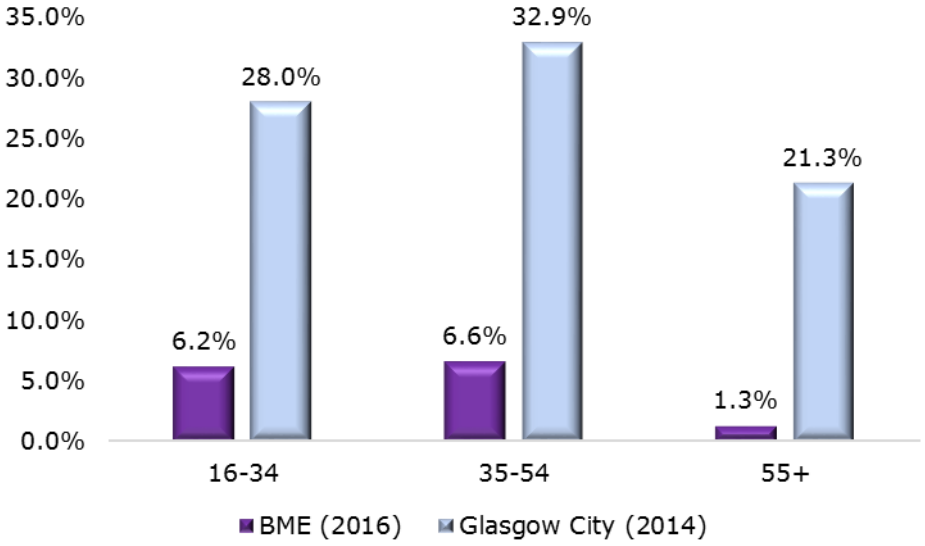
Table 4.20: Proportion Exceeding Recommended Alcohol Limits in Previous Week (Q15) by Ethnicity

	Exceed weekly limit of 14 units	Exceed daily limit of 4 units for men or 3 units for women	Binged on at least one day (8+ units for men; 6+ units for women)
Polish	3.4%	13.3%	5.6%
Indian	2.4%	8.7%	2.7%
Chinese	1.7%	7.2%	2.7%
African	1.7%	3.4%	2.2%
Pakistani	0.0%	0.0%	0.0%
All BME	1.5%	5.7%	2.2%
Glasgow City (2014)	11.8%	27.5%	16.5%

Those aged 55 or over were much less likely than younger people to exceed the recommended daily limit for alcohol consumption.

BME adults in all age groups were much less likely than those in Glasgow City to exceed the recommended daily alcohol limits, as *Figure 4.8* shows.

Figure 4.8: Proportion who Exceeded Daily Alcohol Limits (Q15) by Age Group – BME (2016) and Glasgow City (2014)



Men were more likely than women to exceed any of the recommended limits for alcohol consumption, as Table 4.21 shows. The small number of respondents who exceeded the limits prohibits analysis at the gender and ethnicity level.

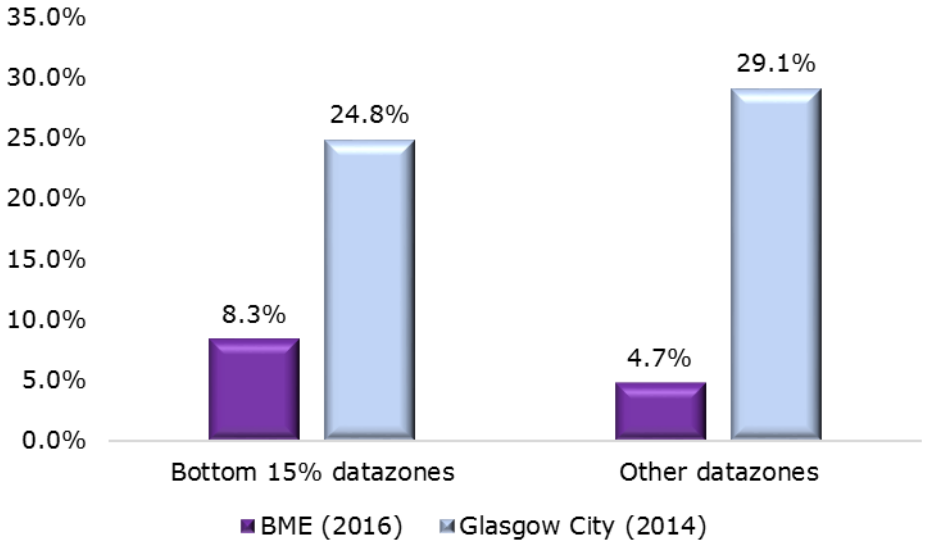
Table 4.21: Proportion Exceeding Recommended Alcohol Limits in Previous Week (Q15) by Gender

	Exceed weekly limit of 14 units	Exceed daily limit of 4 units for men or 3 units for women	Binged on at least one day (8+ units for men; 6+ units for women)	Did not have 2 alcohol free days in last week
Men	2.4%	7.8%	2.9%	1.2%
Women	0.2%	3.2%	1.3%	0.0%
All BME	1.5%	5.7%	2.2%	0.7%

Those in the most deprived areas were more likely than those in other areas to exceed the recommended daily alcohol limit.

BME adults in both the most deprived and in other areas were much less likely than those in Glasgow City to exceed the recommended daily limit of alcohol, although the greatest difference was observed in other areas, as *Figure 4.9* shows.

Figure 4.9: Proportion Exceeding Recommended Alcohol Limits in Previous Week (Q15) by Deprivation – BME (2016) and Glasgow City (2014)



Those who had lived in the UK for less than 10 years were more likely than other to exceed the recommended daily limit for alcohol consumption or to have binged in the last week, as Table 4.22 shows.

Table 4.22: Proportion Exceeding Recommended Alcohol Limits in Previous Week (Q15) by Length of Residency in the UK

	Exceed daily limit of 4 units for men or 3 units for women	Binged on at least one day (8+ units for men; 6+ units for women)
Lived in the UK for 10 years or more	3.3%	1.1%
Lived in the UK for less than 10 years	8.6%	3.5%
All BME	5.7%	2.2%

Evidence from other sources

Although the Scottish Health Survey (2008-2011)[10] used different measures of harmful levels of alcohol, it similarly found that Pakistani and Chinese groups were much less likely to drink at harmful levels than the national average (Pakistani 3%; Chinese 4%; national average 23%).

[10] http://www.gov.scot/Resource/0040/00406749.pdf

4.4 Physical Activity

Frequency of Physical Activity

Respondents were asked on how many days in the last week had they taken a total of 30 minutes or more of physical activity which was enough to raise their breathing rate. One in three (33%) said that they had not done this on any day in the last week. One in four (26%) had done so on five or more days in the last week. The mean number of days for all BME adults was 2.6.

Subsequently, respondents who had been active for 30 minutes or more on fewer than five days were asked whether they had been physically active for at least two and a half hours (150 minutes) over the course of the last week. Finally, those who answered no to this were asked to include all types of physical activity such as brisk walking (including housework and physical activity that is part of their job). The physical activity target is to be physically active for at least 150 minutes per week. Combining responses to the questions on physical activity (i.e. those who were active for 30 minutes or more on five or more days per week or who otherwise were active for at least 150 minutes per week), shows that seven in ten (71%) BME adults met this target.

Those in the Indian group were much less likely than those in other groups to meet the target for physical activity. The African group had the highest proportion who met the target.

Table 4.23: Proportion Who had Been Active for 150 minutes or More in Past Week (Q25-27) by Ethnicity

	Meet Target (Active for 150+ minutes per week)
African	88%
Chinese	83%
Pakistani	74%
Polish	73%
Indian	40%
All BME	71%

Those aged 55 or over were less likely than younger people to meet the target for physical activity.

Table 4.24: Proportion Who had Been Active for 150 minutes or More in Past Week (Q25-27) by Age Group

	Meet Target (Active for 150+ minutes per week)
16-34 35-54 55+	75% 71% 54%
All BME	71%

Those who spoke English well and those who had lived in the UK for less than 10 years were more likely than others to meet the target for physical activity.

Table 4.25: Proportion Who had Been Active for 150 minutes or More in Past Week (Q25-27) by How Well Speak English and Length of Residency in the UK

	Meet Target (Active for 150+ minutes per week)		Meet Target (Active for 150+ minutes per week)
Speak English very/fairly well Do not speak English well	74% 59%	Lived in the UK for 10 years or more Lived in the UK for less than 10 years	68% 75%

Evidence from other sources

The Scottish Health Survey (2008-2011)[11] which measured physical activity in different ways, found different findings to this study. This showed that the Pakistani group were the least likely to meet recommended physical activity levels (27% compared to a national average of 38%).

4.5 Diet

Fruit and Vegetables

The national target for fruit and vegetable consumption is to have at least five portions of fruit and/or vegetables per day. Respondents were asked how many portions of fruit and how many portions of vegetables they had consumed on the previous day. Responses indicate that two in five (40%) adults in BME groups met this target. Four percent had no fruit or vegetables.

[11] http://www.gov.scot/Resource/0040/00406749.pdf

Those in the Pakistani and African groups were less likely than those in other groups to meet the target for fruit/vegetable consumption.

Table 4.26: Proportion Who Consume Target Amount of Fruit/Vegetables (Q21/Q22) by Ethnicity

	Meet Fruit/Veg Target
Indian	53%
Polish	45%
Chinese	45%
African	32%
Pakistani	29%
All BME	40%

Overall, women were more likely than men to meet the target for fruit/vegetable consumption. However, this gender difference was not observed among Pakistani or African groups.

Table 4.27: Proportion Who Consume Target Amount of Fruit/Vegetables (Q21/Q22) by Gender and Ethnicity

	Meet Fruit/Veg Target	
	Men	Women
Indian	49%	59%
Polish	42%	49%
Chinese	42%	48%
African	33%	31%
Pakistani	28%	30%
All BME	37%	43%

Those in the most deprived areas were less likely than those in other areas to meet the target for fruit/vegetables consumption, as shown in Table 4.37.

Table 4.28: Proportion Who Consume Target Amount of Fruit/Vegetables (Q21/Q22) by Deprivation

	Meet Fruit/Veg Target
Bottom 15% datazones	34%
Other datazones	42%
All BME	40%

Evidence from other sources

The Scottish Health Survey (2008-2011)[12] showed somewhat different findings for fruit/vegetable consumption. This survey found that White British people were the least likely to consume five portions per day (21%) while Chinese (49%) and Pakistani (48%) were much more likely to consume five portions per day than the national average of 22%.

4.6 Body Mass Index (BMI)

Respondents were asked to state their height and weight, from which their Body Mass Index (BMI) was calculated.

BMI classification points are generally defined as follows:

Underweight	BMI below 18.5
Ideal weight	BMI between 18.5 and 24.99
Overweight	BMI between 25 and 29.99
Obese	BMI between 30 and 39.99
Very obese	BMI 40 or over

However, advice from the World Health Organisation and the National Institute for Care and Excellence[13] is that British South Asian ethnic groups should have different BMI classifications, with the threshold for being at increased risk (overweight) being a BMI of 23 rather than 25, and the threshold for being at high risk (obese) being a BMI of 27.5 rather than 30. Therefore, the proportions of people reported in each category is specific to ethnic groups, with Indian and Pakistani groups having the revised South Asian classifications applied.

Altogether, just over half (52%) of BME adults had a BMI which indicated that they were overweight or obese. Seventeen percent were classified as obese.

Pakistani and Indian groups were the most likely to be overweight. Those in the Chinese group were the least likely to be overweight.

[12] http://www.gov.scot/Resource/0040/00406749.pdf
[13] https://www.nice.org.uk/guidance/PH46/chapter/1-Recommendations

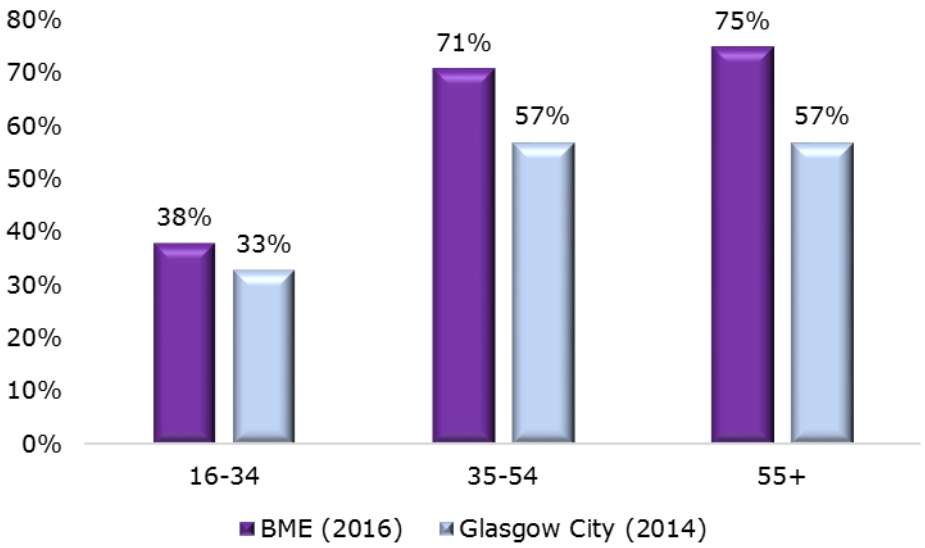
Table 4.29: Body Mass Index Indicating Overweight (Q23/Q24) by Ethnicity

	Overweight
Pakistani	74%
Indian	68%
Polish	45%
African	44%
Chinese	21%
All BME	52%

Those aged under 35 were much less likely than others to be overweight, as *Figure 4.10* shows.

Although overall around half of BME adults and half of those in Glasgow City were classified as overweight, the different age profile masks a difference in the BMI profile between BME adults and the overall population in Glasgow. BME adults in all age groups were more likely than those in Glasgow City to be overweight, but this was particularly true for those aged 35 or over. This is shown in *Figure 4.10*.

Figure 4.10: Body Mass Index Indicating Overweight (Q23/Q24) by Age Group – BME (2016) and Glasgow City (2014)



Men were much more likely than women to be overweight (62% men; 38% women), and this was true for four of the five ethnic groups. However, African women were more likely than African men to be overweight.

Table 4.30: Body Mass Index Indicating Overweight (Q23/Q24) by Gender and Ethnicity

	Overweight	
	Men	Women
Pakistani	77%	68%
Indian	76%	53%
Polish	65%	24%
African	38%	53%
Chinese	33%	10%
All BME	62%	38%

BME adults in the most deprived areas were more likely than those in other areas to be overweight.

Table 4.31: Body Mass Index Indicating Overweight (Q23/Q24) by Deprivation

	Overweight
Bottom 15% datazones	57%
Other datazones	50%
All BME	52%

Those who did not speak English well and those who had lived in the UK for 10 years or more were more likely than others to be overweight.

Table 4.32: Body Mass Index Indicating Overweight (Q23/Q24) by How Well Speak English and Length of Residency in the UK

	Overweight		Overweight
Speak English very/fairly well	50%	Lived in the UK for 10 years or more	64%
Do not speak English well	62%	Lived in the UK for less than 10 years	39%

4.7 Unhealthy and Healthy Behaviour Indices

An Unhealthy Behaviour Index

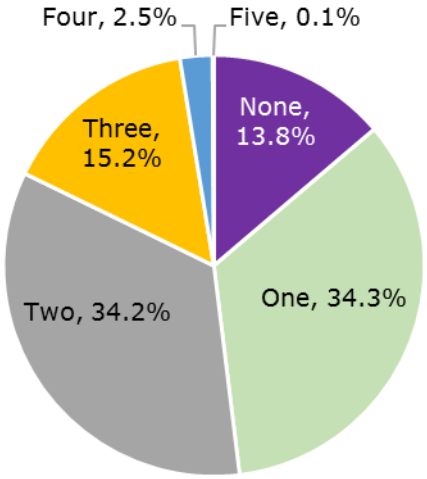
This section examines the extent to which multiple 'unhealthy' behaviours are exhibited by the same people. An 'unhealthy' behaviour index has been derived from the following five unhealthy behaviours:

- Smoking;
- Having a BMI of 25 or over (23 or over for Pakistani and Indian groups);
- Not meeting the target for physical activity (150 minutes per week);

- Not meeting the recommended level of fruit and vegetable consumption; and
- Binge drinking.

Figure 4.11 shows that 86% of BME adults exhibited at least one of these behaviours, but few (3%) exhibited more than three. The mean number of unhealthy behaviours was 1.58.

Figure 4.11: Number of Unhealthy Behaviours Exhibited



Overall, BME groups had a lower mean number of unhealthy behaviours than those in Glasgow City (1.58 BME; 1.85 Glasgow City). However, Indian and Pakistani groups had the highest mean number of unhealthy behaviours, similar to Glasgow City. The Chinese group had the lower mean number of unhealthy behaviours. This is shown in Table 4.33.

Table 4.33: Mean Number of Unhealthy Behaviours by Ethnicity

	Mean Number of Unhealthy Behaviours
Indian	1.86
Pakistani	1.84
Polish	1.68
African	1.35
Chinese	1.09
All BME	1.58
Glasgow City (2014)	1.85

Those aged under 35 tended to have fewer unhealthy behaviours than others.

The overall lower number of mean health behaviours among BME adults compared to Glasgow City is not explained by the different age profile.

Indeed, BME adults in all age groups had a lower mean number of healthy behaviours than those in Glasgow City. This is shown in *Figure 4.12*.

Figure 4.12: Mean Number of Unhealthy Behaviours by Age group – BME (2016) and Glasgow City (2014)

Overall, men had a higher mean number of unhealthy behaviours than women (1.75 men; 1.35 women). Indian men had the highest mean number of unhealthy behaviours (2.02) and Chinese women had the lowest mean (0.87).

Table 4.34: Mean Number of Unhealthy Behaviours by Gender and Ethnicity

	Mean Number of Unhealthy Behaviours	
	Men	Women
Indian	2.02	1.54
Pakistani	1.92	1.69
Polish	1.82	1.51
African	1.31	1.39
Chinese	1.34	0.87
All BME	1.75	1.35

Those in the most deprived areas tended to exhibit more unhealthy behaviours than those in other areas.

BME adults in both the most deprived areas and in other areas had a lower mean number of unhealthy behaviours than those in Glasgow City.

Figure 4.13: Mean Number of Unhealthy Behaviours by Deprivation – BME (2016) and Glasgow City (2014)

Those who did not speak English well and those who had lived in the UK for 10 years or more tended to exhibit more unhealthy behaviours than others.

Table 4.35: Mean Number of Unhealthy Behaviours by How Well Speak English and Length of Residency in the UK

	Mean Number of Unhealthy Behaviours		Mean Number of Unhealthy Behaviours
Speak English very/fairly well	1.52	Lived in the UK for 10 years or more	1.72
Do not speak English well	1.88	Lived in the UK for less than 10 years	1.44

4.8 Summary of Key Messages from This Chapter

Three in ten (29%) BME adults were exposed to second hand smoke most or some of the time. Sixteen percent were current smokers, and 9% had used e-cigarettes in the last year.

- Overall, BME groups were less likely than those in Glasgow City to be exposed to second hand smoke, to smoke or to use e-cigarettes.
- Polish people were the most likely to do each of these things.
- Men were more likely than women to be exposed to second hand smoke, to be smokers or to use e-cigarettes. The gender difference for each of these indicators was greatest among the Chinese and Pakistani groups.

- Those in the most deprived areas were more likely than others to be exposed to second hand smoke, smoke or use e-cigarettes.

Seven percent of BME adults used shisha.

- The Pakistani group was the most likely to use shisha, particularly men.

Just over a third (36%) of BME adults ever drank alcohol. A small proportion exceeded recommended limits for alcohol consumption – 1.5% exceeded the recommended weekly limit of 14 units; 5.7% exceeded the recommended daily limit of four units for men or three units for women; 2.2% binge drank (eight units for men or six units for women).

- Overall, BME groups were much less likely than those in Glasgow City to ever drink alcohol (36% BME; 65% Glasgow City), and particularly much less likely to exceed any of the recommended limits for alcohol consumption.
- There was much variation across ethnic groups. Hardly any (1%) Pakistani adults ever drank alcohol, and none of them exceeded any of the limits. Polish adults were more likely than those in Glasgow City to ever drink alcohol (80%). However, Polish people were much more likely to drink within recommended limits.
- Drinking alcohol was more common among those aged under 55 and men. The gender difference was most pronounced among Indian and African groups.

Seven in ten (71%) BME adults met the target of 150 minutes of physical activity per week.

- Those in the Indian group were much less likely than other BME groups to meet this target.
- Groups more likely to meet the physical activity target were those aged under 55, those who spoke English well and those who had lived in the UK for less than 10 years.

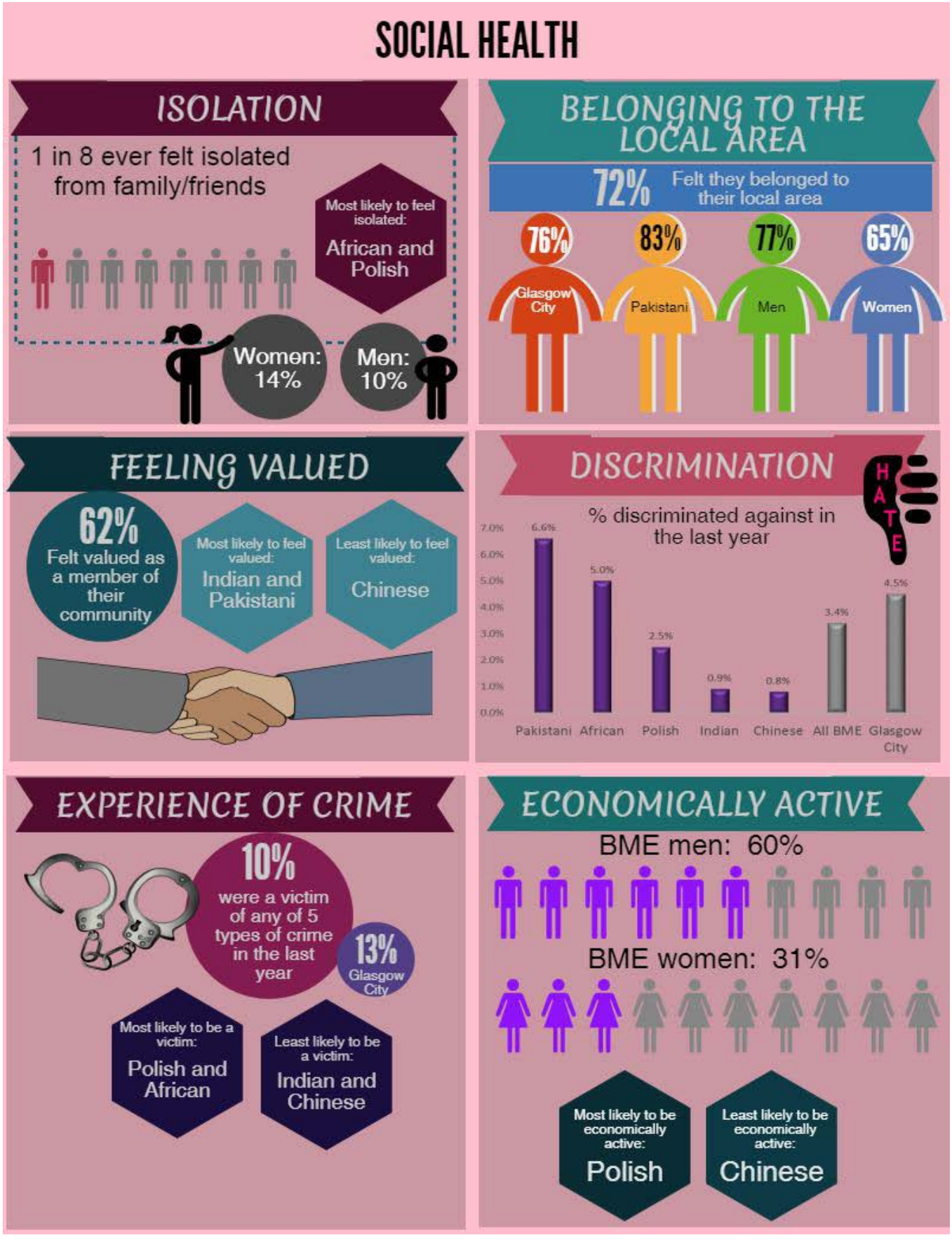
Four in ten (40%) BME adults met the target of consuming at least five portions of fruit/vegetables per week.

- Pakistani and African groups were less likely to meet this target.
- Men and those in the most deprived areas were less likely to meet this target.

Half (52%) of BME groups were overweight.

- More than seven in ten of those aged 35 or over were overweight.
- BME adults in each age group were more likely than those in Glasgow City to be overweight.

- Men were much more likely than women to be overweight.
- Those in the most deprived areas, those who did not speak English well and those who had lived in the UK for 10 years or more were more likely to be overweight.


SOCIAL HEALTH
ISOLATION
1 in 8 ever felt isolated from family/friends
Most likely to feel isolated:
African and Polish
Women: 14%
Men: 10%
BELONGING TO THE LOCAL AREA
72% Felt they belonged to their local area
76%
Glasgow City
83%
Pakistani
77%
Men
65%
Women
FEELING VALUED
62% Felt valued as a member of their community
Most likely to feel valued:
Indian and Pakistani
Least likely to feel valued:
Chinese
DISCRIMINATION
HATE
% discriminated against in the last year
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
6.6%
5.0%
2.5%
0.9%
0.8%
3.4%
4.5%
Pakistani
African
Polish
Indian
Chinese
All BME
Glasgow City
EXPERIENCE OF CRIME
10% were a victim of any of 5 types of crime in the last year
13% Glasgow City
Most likely to be a victim:
Polish and African
Least likely to be a victim:
Indian and Chinese
ECONOMICALLY ACTIVE
BME men: 60%
BME women: 31%
Most likely to be economically active:
Polish
Least likely to be economically active:
Chinese

5.1 Social Connectedness

Isolation from Family and Friends

One in eight (12%) BME adults said they ever felt isolated from family and friends. Feeling of isolation was much higher among African and Polish groups than those in other groups, as shown in Table 5.1.

Table 5.1: Ever Feel Isolated from Family and Friends (Q33) by Ethnicity

	Feel Isolated from Family and Friends
African	22%
Polish	19%
Pakistani	9%
Chinese	9%
Indian	8%
All BME	12%

Overall, women were more likely than men to say they ever felt isolated from family and friends (14% women; 10% men). African and Polish women were the most likely to say they felt isolated, with just under one in three (30%) African women and one in four (24%) Polish women saying they felt isolated. A difference between men and women was observed for all groups except for those in the Pakistani group.

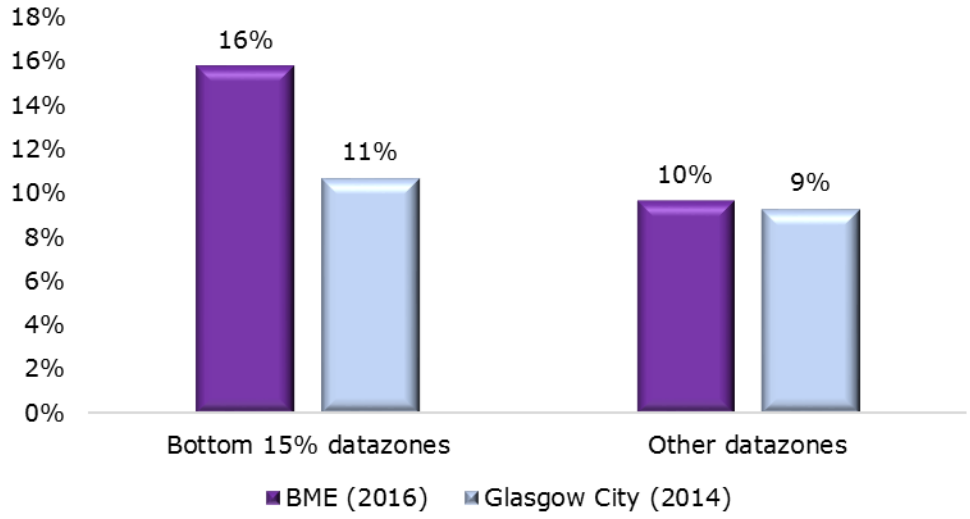
Table 5.2: Ever Feel Isolated from Family and Friends (Q33) by Gender and Ethnicity

	Feel Isolated from Family and Friends	
	Men	Women
African	16%	30%
Polish	14%	24%
Pakistani	10%	8%
Chinese	6%	12%
Indian	6%	11%
All BME	10%	14%

Those in the most deprived areas were more likely than those in other areas to say they ever felt isolated, as shown in *Figure 5.1*.

Although overall the BME population did not differ significantly from Glasgow City for the proportion who felt isolated from family and friends, there was a significant difference among those living in the most deprived 15% areas. In the bottom 15% most deprived areas, BME groups were more likely than those in Glasgow City to say they felt isolated (16% BME; 11% Glasgow City).

Figure 5.1: Ever Feel Isolated from Family and Friends (Q33) by Deprivation – BME (2016) and Glasgow City (2014)



Those who had lived in the UK for less than 10 years were more likely than those who had lived in the UK for 10 years or more to say they ever felt isolated, as Table 5.3 shows.

Table 5.3: Ever Feel Isolated from Family and Friends (Q33) by Length of Residency in UK

	Feel Isolated from Family and Friends
Lived in the UK for 10 years or more	9%
Lived in the UK for less than 10 years	14%
All BME	12%

Sense of Belonging to the Community

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement "I feel I belong to this local area". In total 72% of BME adults agreed with this statement (19% strongly agreed and 53% agreed), 11% disagreed and 17% neither agreed nor disagreed.

Overall, BME groups were less likely than those in Glasgow City to feel that they belonged to their local area (72% BME; 76% Glasgow City). However, this was largely a function of the BME sample having proportionately more younger people. Analysis by age group showed very similar findings for the BME and Glasgow City surveys for each age group.

Those in the Pakistani group were much more likely than those in any of the other ethnic groups to agree that they belonged to the local area.

Table 5.4: Belong to the Local Area (Q32b) by Ethnicity

	Belong to the Local Area
Pakistani	83%
Indian	69%
Polish	66%
Chinese	65%
African	63%
All BME	72%
Glasgow City (2014)	76%

Feelings of belonging to the local area increased with age, from two in three (65%) adults aged 16-34 to nine in ten (90%) of those aged 55 or over.

Table 5.5: Belong to the Local Area (Q32b) by Age Group

	Belong to the Local Area
16-34	65%
35-54	78%
55+	90%
All BME	72%

Overall, feelings of belonging to the local area were higher among men (77%) than women (65%). Pakistani men were the most likely to feel they belonged to the local area (86%) and African women were the least likely (53%).

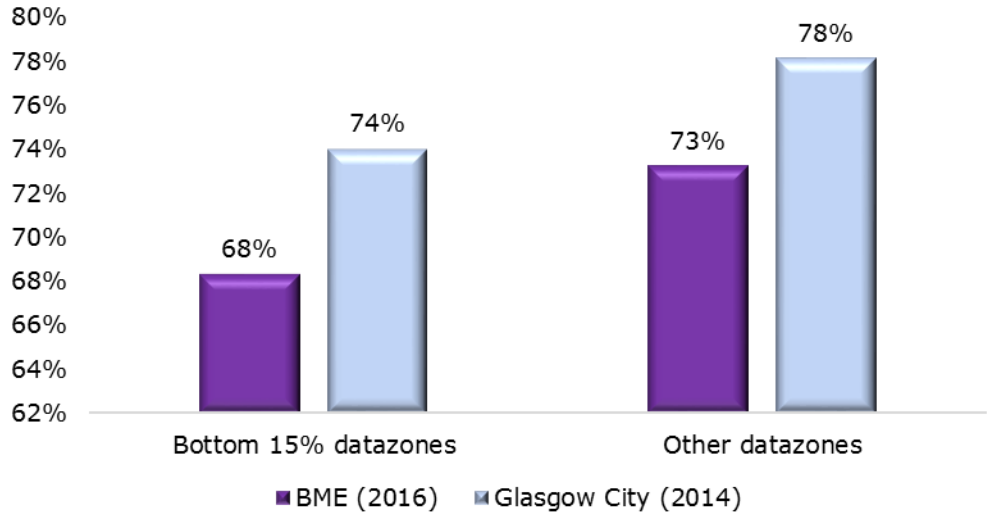
Table 5.6: Belong to the Local Area (Q32b) by Gender and Ethnicity

	Belong to the Local Area	
	Men	Women
Pakistani	86%	78%
Indian	72%	63%
Polish	73%	59%
Chinese	71%	60%
African	70%	53%
All BME	77%	65%

Those in the most deprived areas were less likely than those in other areas to feel they belonged to their local area.

BME groups were less likely than those in Glasgow City to feel they belonged to their area, for both bottom 15% deprivation areas and other areas, as *Figure 5.2* shows.

Figure 5.2: Belong to the Local Area (Q32b) by Deprivation – BME (2016) and Glasgow City (2014)



Those who did not speak English well and those who had lived in the UK for 10 years or more were more likely than others to feel that they belonged to their local area.

Table 5.7: Belong to the Local Area (Q32b) by How Well Speak English and Length of Residency in UK

	Belong to the Local Area		Belong to the Local Area
Speak English very/fairly well	70%	Lived in the UK for 10 years or more	84%
Do not speak English well	82%	Lived in the UK for less than 10 years	58%

Feeling Valued as a Member of the Community

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement "I feel valued as a member of my community". Three in five (62%) BME adults agreed with this statement (11% strongly agreed and 51% agreed); 12% disagreed and 26% neither agreed nor disagreed. This did not differ significantly to those in Glasgow City.

Indian and Pakistani people were the most likely to feel valued as members of the community, and Chinese people were the least likely.

Table 5.8: Feel Valued as a Member of the Community (Q32d) by Ethnicity

	Feel Valued as a Member of the Community
Indian	69%
Pakistani	68%
African	60%
Polish	59%
Chinese	50%
All BME	62%

Feeling valued as a member of the community increased with age – ranging from 59% of those aged 16-34 to 70% of those aged 55 and over.

Table 5.9: Feel Valued as a Member of the Community (Q32d) by Age Group

	Feel Valued as a Member of the Community
16-34	59%
35-54	66%
55+	70%
All BME	62%

Those who had lived in the UK for 10 years or more were more likely than others to say they felt valued as a member of the community, as Table 5.10 shows.

Table 5.10: Feel Valued as a Member of the Community (Q32d) by Length of Residency in UK

	Feel Valued as a Member of the Community
Lived in the UK for 10 years or more	69%
Lived in the UK for less than 10 years	54%
All BME	62%

Influence in the Neighbourhood

Respondents were asked the extent to which they agreed or disagreed with the statement, "By working together people in my neighbourhood can influence decisions that affect my neighbourhood". Just over seven in ten (72%) agreed with this statement (16% strongly agreed and 56% agreed), while 10% disagreed and 18% neither agreed nor disagreed. This was similar to the findings for Glasgow City (2014).

Chinese people were less likely than those in any of the other ethnic groups to agree that people in their neighbourhood could influence decisions affecting their neighbourhood, as Table 5.11 shows.

Table 5.11: Can Influence Decisions that Affect Neighbourhood (Q32f) by Ethnicity

	Can Influence Decisions that Affect Neighbourhood
Polish	78%
African	76%
Indian	74%
Pakistani	74%
Chinese	61%
All BME	72%

Those aged under 35 were less likely than older people to agree that people working together could influence decisions that affect their neighbourhood, as shown in Table 5.12.

Table 5.12: Can Influence Decisions that Affect Neighbourhood (Q32f) by Age Group

	Can Influence Decisions that Affect Neighbourhood
16-34	68%
35-54	76%
55+	80%
All BME	72%

Table 5.13 shows that those who did not speak English well and those who had lived in the UK for 10 years or more were more likely to agree than local people could influence decisions that affect their neighbourhood.

Table 5.13: Can Influence Decisions that Affect Neighbourhood (Q32f) by How Well Speak English and Length of Residency in UK

	Can Influence Decisions that Affect Neighbourhood		Can Influence Decisions that Affect Neighbourhood
Speak English very/fairly well	71%	Lived in the UK for 10 years or more	75%
Do not speak English well	78%	Lived in the UK for less than 10 years	67%

Experience of Discrimination

Respondents were asked whether they had been discriminated against in the last year. In total 3.4% of BME adults felt they had been discriminated against (2.4% said this had happened occasionally and 1.0% said that it had happened on several occasions). This was not significantly different to those in Glasgow City (2014).

Experience of discrimination was more common among those from Pakistani and African groups

Table 5.14: Discriminated Against in the Last Year (Q60) by Ethnicity

	Discriminated Against
Pakistani	6.6%
African	5.0%
Polish	2.5%
Indian	0.9%
Chinese	0.8%
All BME	3.4%

Those aged 35 or over were more likely than younger people to have experienced discrimination in the last year.

Table 5.15: Discriminated Against in the Last Year (Q60) by Age Group

	Discriminated Against
16-34	2.5%
35-54	4.9%
55+	4.0%
All BME	3.4%

Those from BME groups who were aged 16-34 were less likely than those in Glasgow City from the same age group to have experienced discrimination (2.5% BME aged 16-34; 5.7% Glasgow City aged 16-34).

Experience of discrimination was more common among those in the most deprived areas (4.9%) than other areas (2.8%).

Table 5.16: Discriminated Against in the Last Year (Q60) by Deprivation

	Discriminated Against
Bottom 15% datazones	4.9%
Other datazones	2.8%
All BME	3.4%

Those who had lived in the UK for 10 years or more were much more likely than those who had lived in the UK for a shorter period to have been discriminated against in the last year, as shown in Table 5.17.

Table 5.17: Discriminated Against in the Last Year (Q60) by Length of Residency in UK

	Discriminated Against
Lived in the UK for 10 years or more	5.1%
Lived in the UK for less than 10 years	1.4%
All BME	3.4%

Of those who felt they had been discriminated against (unweighted n=69), the most common types or people/agencies who had treated people offensively were:

- Unknown person in a public place (61%);
- Employer (26%);
- Social services (11%);
- College/school (10%);
- Police/judicial system (9%);
- Known person in a public place (9%);
- Health care services (8%).

The most commonly perceived reasons for being discriminated against were:

- Ethnic background (91%);
- Religion/faith/belief (36%);
- Appearance (15%);
- Accent (10%).

Evidence from other sources

Removing Barriers: race, ethnicity and employment (2016)[14] by the Scottish Parliament provided some evidence that BME people face discrimination from employers. This reported that although ethnic minorities largely performed better academically than white Scots, they were more likely to be unemployed or in low-paid work and were under-represented in senior management roles.

14 http://www.parliament.scot/S4_EqualOpportunitiesCommittee/Reports/EOS042016R01Rev.pdf

5.2 Experience of Crime

Respondents were asked whether they had been a victim of specific types of crime in the last year. Overall, one in ten (10%) BME adults had been a victim of any of the five types of crime listed. The most common type of crime was anti-social behaviour. This is shown in Table 5.18.

Table 5.18: Experience of Being a Victim of Crime in the Last Year (Q40) (all BME Groups)

	Victim of Crime in Last Year (all BME)
Anti-social behaviour	5%
Any type of theft or burglary	4%
Vandalism	3%
Domestic violence	1%
Physical attack	1%
Any of the above 5 types of crime	10%

BME groups in 2016 were less likely than those in Glasgow City in 2014 to report having been a victim of one of the five types of crime (10% BME; 13% Glasgow City).

Experience of crime was highest among Polish and African groups and lowest among Chinese and Indian groups.

Table 5.19: Experience of Being a Victim of Crime in the Last Year (Q40) by Ethnicity

	Victim of Crime in the Last Year
Polish	18%
African	15%
Pakistani	10%
Indian	6%
Chinese	6%
All BME	10%
Glasgow City (2014)	13%

Those aged 35-54 were the age group most likely to have been a victim of crime in the last year, with 15% in that age group having experienced at least one of the five types of crime.

Table 5.20: Experience of Being a Victim of Crime in the Last Year (Q40) by Age Group

	Victim of Crime in the Last Year
16-34 35-54 55+	8% 15% 4%
All BME	10%

The overall difference in the levels of experience of crime between BME groups and Glasgow City was attributable largely to an observed difference among those aged 16-34 only. Eight percent of BME 16-34 year olds reported having been the victim of a crime in the last year, compared to 15% of 16-34 year olds in the Glasgow City survey in 2014.

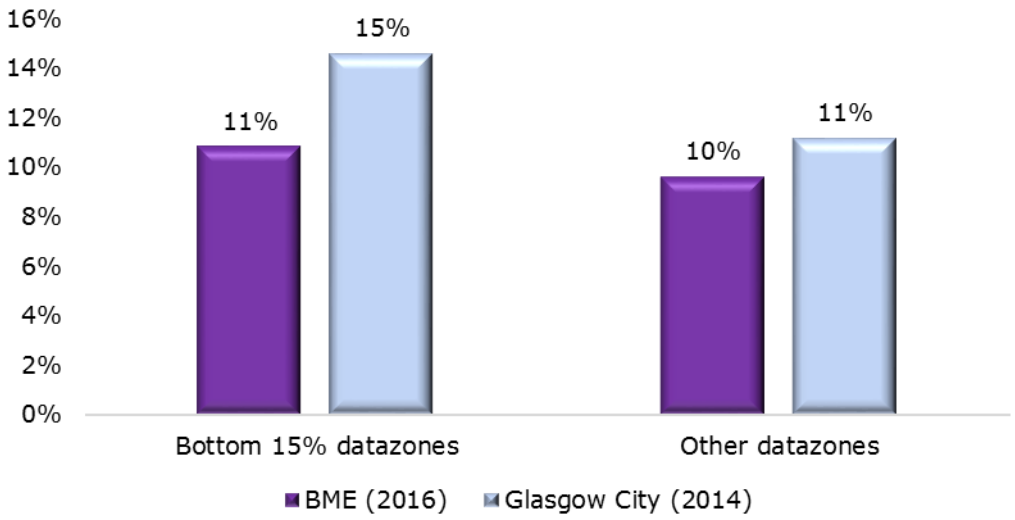
Overall, women were more likely than men to have been a victim of crime (12% women; 9% men). Gender differences were more pronounced among those in African, Chinese and Indian groups.

Table 5.21: Experience of Being a Victim of Crime in the Last Year (Q40) by Gender and Ethnicity

	Victim of Crime in the Last Year	
	Men	Women
Polish African Pakistani Indian Chinese	17% 11% 9% 4% 4%	19% 20% 11% 9% 7%
All BME	9%	12%

As shown in *Figure 5.3*, BME groups were overall less likely than those in Glasgow City to have been a victim of crime. However, this difference was significant only among those in the most deprived areas. Overall, experience of crime among BME groups did not differ by deprivation. By contrast, among the whole Glasgow City population, experience of crime was more common in the most deprived areas.

Figure 5.3: Experience of Being a Victim of Crime in the Last Year (Q40) by Deprivation – BME (2016) and Glasgow City (2014)



Those who had lived in the UK for 10 years or more were more likely than others to have been a victim of crime in the last year.

Table 5.22: Experience of Being a Victim of Crime in the Last Year (Q40) by Length of Residency in UK

	Victim of Crime in the Last Year
Lived in the UK for 10 years or more	12%
Lived in the UK for less than 10 years	8%
All BME	10%

Evidence from other sources

The Experience of Civil Law Problems in Scotland 1997-2004[15], showed that one in three people from an ethnic minority in Scotland experiences civil law problems over a five year period, compared to one in four people in Scotland as a whole.

The 2000 Scottish Crime Survey: Analysis of the Ethnic Minority Booster Sample[16] found that compared to people from a White ethnic background, those from ethnic minorities were more at risk of experiencing household victimisation (vandalism, housebreaking, vehicle theft), but at a slightly lower risk of experiencing personal victimisation (assault, robbery, theft from the person).

Racist Incidents Recorded by the Police in Scotland, 2013-14[17] showed that people from a Pakistani ethnic background were the most likely to be the victim/complainer of a racist incident recorded by the police (rate or 244.2 victims/complainers per 10,000 population). Across all ethnic backgrounds in Scotland, the rate of reported racist incidents was 10.6 victims/complainers per 10,000 population.

5.3 Feelings of Safety

Feeling Safe Using Public Transport and Walking Alone After Dark

Respondents were asked the extent to which they agreed or disagreed with the statement "I feel safe using public transport in this local area". In total nine in ten (89%) agreed with this (29% strongly agreed and 60% agreed), while 4% disagreed and 7% neither agreed nor disagreed.

Respondents were also asked the extent to which they agreed or disagreed with the statement "I feel safe walking alone around this local area even after dark". In total, two thirds (67%) agreed with this statement (20% strongly agreed and 47% agreed), 19% disagreed and 14% neither agreed nor disagreed.

The proportion of BME respondents who felt safe on public transport or walking alone was similar to the findings for Glasgow City.

Polish people were the least likely to feel safe using public transport or walking alone in their area, as Table 5.23 shows.

[15] http://www.gov.scot/Publications/2010/11/15095623/0
[16] http://www.gov.scot/Publications/2002/05/14693/4196
[17] http://www.gov.scot/Publications/2015/11/7911

Table 5.23: Feel Safe Using Public Transport and Walking Alone Even After Dark in Local Area (Q39) by Ethnicity

	Feel Safe Using Public Transport in Local Area	Feel Safe Walking Alone
African	95%	64%
Chinese	94%	75%
Indian	92%	66%
Pakistani	85%	70%
Polish	81%	55%
All BME	89%	67%

Those aged 35-54 were the least likely to feel safe walking alone in their area even after dark, as Table 5.24 shows.

Table 5.24: Feel Safe Walking Alone Even After Dark in Local Area (Q39b) by Age Group

	Feel Safe Walking Alone
16-34	69%
35-54	62%
55+	72%
All BME	67%

Men were more likely than women to feel safe using public transport (92% men; 85% women), and particularly more likely to feel safe walking alone in their area (77% men; 55% women). Polish women were the ethnic/gender group least likely to feel safe using public transport (76%). African and Polish women were the least likely to feel safe walking alone (42% and 43% respectively).

Table 5.25: Feel Safe Using Public Transport and Walking Alone Even After Dark in Local Area (Q39) by Gender and Ethnicity

	Feel Safe Using Public Transport in Local Area		Feel Safe Walking Alone	
	Men	Women	Men	Women
African	96%	93%	79%	42%
Chinese	94%	94%	84%	66%
Indian	94%	88%	71%	58%
Pakistani	90%	77%	80%	54%
Polish	86%	76%	65%	43%
All BME	92%	85%	77%	55%

Those in the most deprived areas were less likely than those in other areas to feel safe walking alone in their area.

Table 5.26: Feel Safe Walking Alone Even After Dark in Local Area (Q39b) by Deprivation

	Feel Safe Walking Alone
Bottom 15% datazones	62%
Other datazones	70%
All BME	67%

Those who did not speak English well were less likely than those who spoke English well to feel safe walking alone in their area.

Table 5.27: Feel Safe Walking Alone Even After Dark in Local Area (Q39b) by How Well Speak English

	Feel Safe Walking Alone
Speak English very/fairly well	69%
Do not speak English well	62%
All BME	67%

Those who had lived in the UK for less than 10 years were more likely than others to say they felt safe using public transport in their area.

Table 5.28: Feel Safe Using Public Transport in Local Area (Q39a) by Length of Residency in UK

	Feel Safe Using Public Transport in Local Area
Lived in the UK for 10 years or more	85%
Lived in the UK for less than 10 years	93%
All BME	89%

5.4 Social Issues in the Local Area

Using the 'faces' scale (See Section 2.1 of this report for full explanation of the scale), respondent were asked to indicate how they felt about a range of perceived social problems. Faces 5 to 7 are classified as negative perceptions and indicate that people are concerned about these issues.

The social issues which most frequently caused concern were the level of alcohol consumption and the amount of drug activity as shown in Table 5.29. This table also shows that for three of the issues, BME adults were less likely than those in Glasgow City to have a negative perception.

For each of the five social issues, those in the African group were by far the most likely to express a negative perception. Indian and particularly Chinese groups were the least likely to express negative perceptions.

Table 5.29: Negative Perception of Social Issues in the Local Area (Q30a-e) by Ethnicity

	Level of Alcohol Consumption	Amount of Drug Activity	Level of Un-employment	Harassment because of skin colour, ethnic origin or religion	Amount of troublemsome neighbours
African	72%	60%	48%	25%	17%
Polish	42%	38%	26%	17%	14%
Pakistani	39%	45%	34%	14%	13%
Indian	32%	28%	20%	13%	2%
Chinese	24%	19%	10%	5%	4%
All BME (2016)	38%	36%	27%	13%	10%
Glasgow City (2014)	(not significant)	44%	40%	17%	(not significant)

5.5 Environmental Issues in the Local Area

Again, using the 'faces' scale (See Section 2.1 of this report for full explanation of the scale), respondents were asked to indicate how they felt about four perceived environmental problems. Faces 5 to 7 are classified as negative perceptions and indicate that people are concerned about these issues.

Table 5.30 shows the proportion who were concerned about each issue, together with the proportion from Glasgow City (2014) who were concerned about each issue. Overall, BME groups were less likely than those in Glasgow City to be concerned about the amount of dogs' dirt, availability of safe play spaces and the availability of pleasant places to walk. However, BME groups were more likely than those in Glasgow City to be concerned about the amount of rubbish lying about in their area.

Table 5.30 also shows the proportion in each ethnic group who had a negative perception of each environmental issue. The Chinese group had a relatively low proportion expressing a negative perception of each of the four issues.

Table 5.30: Negative Perception of Environmental Issues in the Local Area (Q31a-d) by Ethnicity

	Amount of Rubbish Lying About	Amount of Dogs' Dirt	Availability of Safe Play Spaces	Availability of Pleasant Places to Walk
Pakistani	48%	43%	19%	16%
Polish	41%	41%	19%	14%
African	36%	44%	20%	15%
Indian	30%	19%	11%	8%
Chinese	21%	15%	13%	7%
All BME (2016)	36%	32%	17%	12%
Glasgow City (2014)	31%	38%	23%	15%

5.6 Perceived Quality of Services in the Area

Respondents were given a list of seven local services and asked to rate each (excellent, good, adequate, poor or very poor). Table 5.31 shows the proportion who rated each service positively (excellent or good). 'Don't know' responses have been excluded. Overall, BME groups were more likely than those in Glasgow City to have a positive view of local food shops, police, leisure/sports facilities, childcare provision and activities for young people.

The Pakistani group was much less likely than other BME groups to have a positive view of leisure/sports facilities, childcare provision and activities for young people.

Table 5.31: Positive Perception of Quality of Local Services (Q38a-g) by Ethnicity

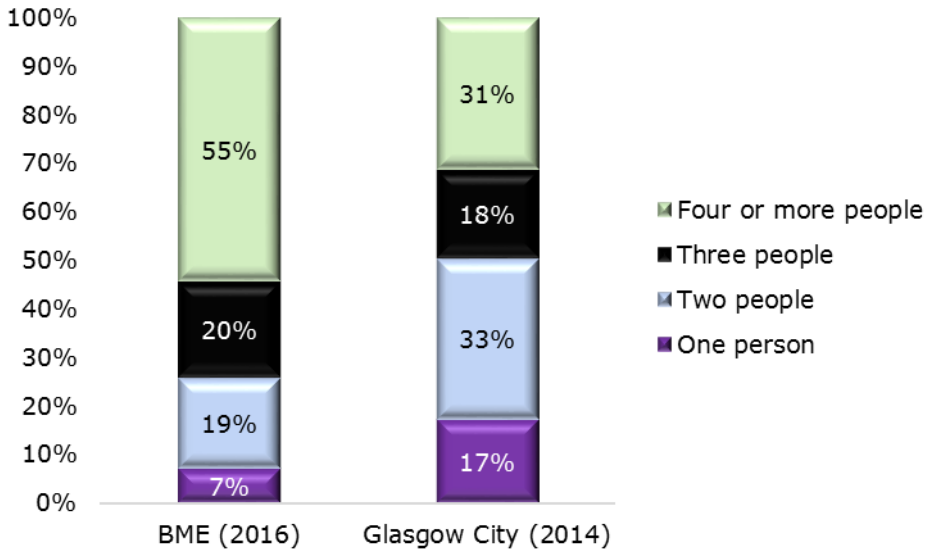
	Public transport	Food shops	Local schools	Police	Leisure/ sports facilities	Childcare provision	Activities for young people
Indian	85%	83%	73%	76%	63%	65%	70%
Pakistani	81%	71%	76%	62%	38%	34%	34%
Polish	80%	71%	72%	77%	67%	57%	54%
Chinese	68%	87%	79%	63%	63%	65%	62%
African	65%	66%	75%	70%	47%	55%	38%
All BME (2016)	77%	76%	75%	68%	54%	53%	50%
Glasgow City (2014)	Not significant	69%	Not significant	57%	46%	47%	38%

5.7 Individual Circumstances

Household Size

Seven percent of BME adults lived alone. Figure 5.4 shows the breakdown of household size for the BME population compared to Glasgow City (2014). BME adults were much less likely to live alone and much more likely to live in households of four or more people.

Figure 5.4: Household Size: BME (2016) and Glasgow City (2014)



People in the African ethnic group were more likely than those in other BME groups to be living alone.

Table 5.32: Proportion who Live Alone (Q41) by Ethnicity

	Live Alone
African	13%
Chinese	8%
Polish	7%
Pakistani	6%
Indian	5%
All BME	7%
Glasgow City (2014)	17%

Overall, BME men were twice as likely as BME women to be living alone (8% men; 4% women). This gender difference was observed in each of the groups except the Polish group. Pakistani women were the least likely to be living alone (2%) and African men were the most likely to be living alone (19%).

Table 5.33: Proportion who Live Alone (Q41) by Gender and Ethnicity

	Live Alone	
	Men	Women
African	19%	4%
Chinese	10%	6%
Polish	7%	7%
Pakistani	7%	2%
Indian	6%	3%
All BME	8%	4%

Those who spoke English well and those who had lived in the UK for less than 10 years were more likely than others to live alone.

Table 5.34: Proportion who Live Alone (Q41) by How Well Speak English and Length of Residency in the UK

	Live Alone		Live Alone
Speak English very/fairly well	7%	Lived in the UK for 10 years or more	4%
Do not speak English well	4%	Lived in the UK for less than 10 years	10%

Caring Responsibilities

Five percent of BME adults said that outside work they were responsible for caring for someone on a day to day basis. Caring responsibilities were most common in the Pakistani group and least common among African and Polish groups.

Table 5.35: Proportion with Caring Responsibilities (Q58) by Ethnicity

	Caring Responsibilities
Pakistani	8.5%
Chinese	4.3%
Indian	3.3%
African	1.7%
Polish	1.5%
All BME	4.9%

Those aged under 35 were less likely than those in older age groups to be carers.

Table 5.36: Proportion with Caring Responsibilities (Q58) by Age Group

	Caring Responsibilities
16-34	2.8%
35-54	7.9%
55+	7.1%
All BME	4.9%

Those in the most deprived areas were less likely than those in other areas to have caring responsibilities.

Table 5.37: Proportion with Caring Responsibilities (Q58) by Deprivation

	Caring Responsibilities
Bottom 15% datazones	2.8%
Other datazones	5.7%
BME	4.9%

Those who had lived in the UK for 10 years or more were much more likely than others to have caring responsibilities.

Table 5.38: Proportion with Caring Responsibilities (Q58) by Length of Residency in the UK

	Caring Responsibilities
Lived in the UK for 10 years or more	7.4%
Lived in the UK for less than 10 years	2.0%
All BME	4.9%

Evidence from other Sources

The 2011 Scottish Census showed that nationally the proportion of people (of all ages) who were carers was similar for minority ethnic groups (5.1%) and White Scottish/British/Irish groups (5.4%). However, Census data show that in Glasgow City, BME groups were less likely than White Scottish/British/Irish groups to be carers (5.3% BME; 9.8% White Scottish/British/Irish).

Educational Qualifications

Just over one in four (27%) BME adults said they had no qualifications. BME adults were more likely than those in Glasgow City to have no qualifications (27% BME; 19% Glasgow City).

It is acknowledged that although the list of qualifications included 'others', some respondents may not have mentioned qualifications obtained in other countries.

There was considerable variation across ethnic groups. African adults were the least likely to have no qualifications (8%) and those in the Indian group were the most likely to have no qualifications (43%).

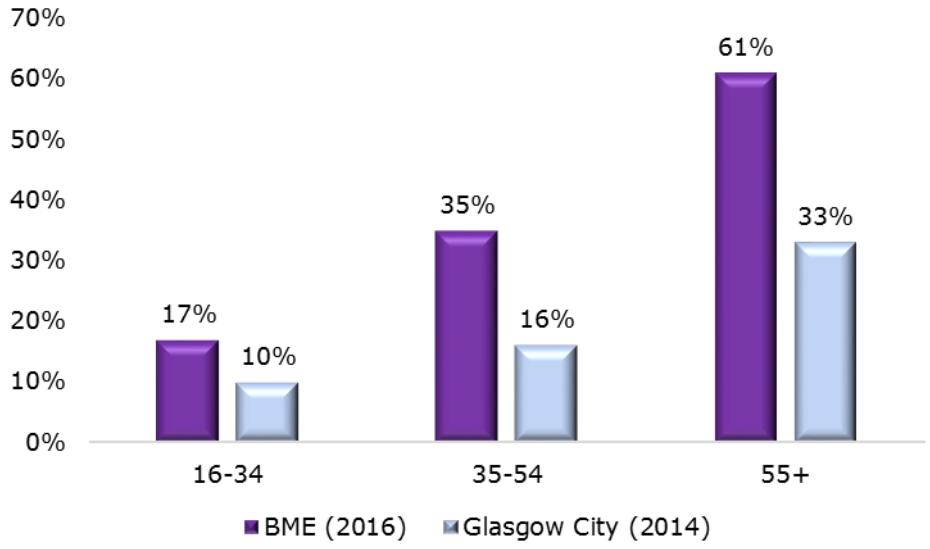
Table 5.39: Proportion with No Qualifications (Q47) by Ethnicity

	No Qualifications
Indian	43%
Polish	32%
Pakistani	28%
Chinese	21%
African	8%
All BME	27%
All Glasgow (2014)	19%

The likelihood of having no qualifications increased sizably by age, ranging from 17% of those aged 16-34 to 61% of those aged 55 or over.

BME adults in each age group were more likely than those in Glasgow City to say they had no qualifications, although the difference was more pronounced among those aged 35 or over, as Figure 5.5 shows.

Figure 5.5: Proportion with No Qualifications (Q47) by Ethnicity – BME (2016) and Glasgow City (2014)



Overall, men were as likely as women to say they had no qualifications. However, among Indian and Pakistani groups, women were more likely than men to have no qualifications; among Chinese and African groups men were more likely than women to have no qualifications.

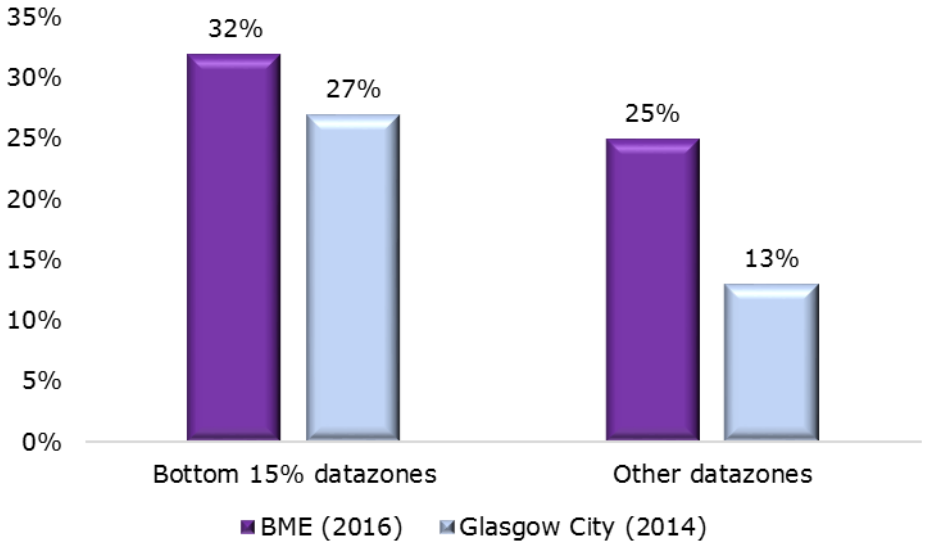
Table 5.40: Proportion with No Qualifications (Q47) by Gender and Ethnicity

	No Qualifications	
	Men	Women
Indian	40%	48%
Polish	33%	32%
Pakistani	24%	33%
Chinese	25%	17%
African	9%	5%

Those in the most deprived areas were more likely than those in other areas to have no qualifications.

The difference between BME adults and those in Glasgow City in the proportion with no qualifications was less pronounced in the most deprived areas than in other areas. This is shown in *Figure 5.6*.

Figure 5.6: Proportion with No Qualifications (Q47) by Deprivation – BME (2016) and Glasgow City (2014)



Those who did not speak English well were greatly more likely than others to have no qualifications.

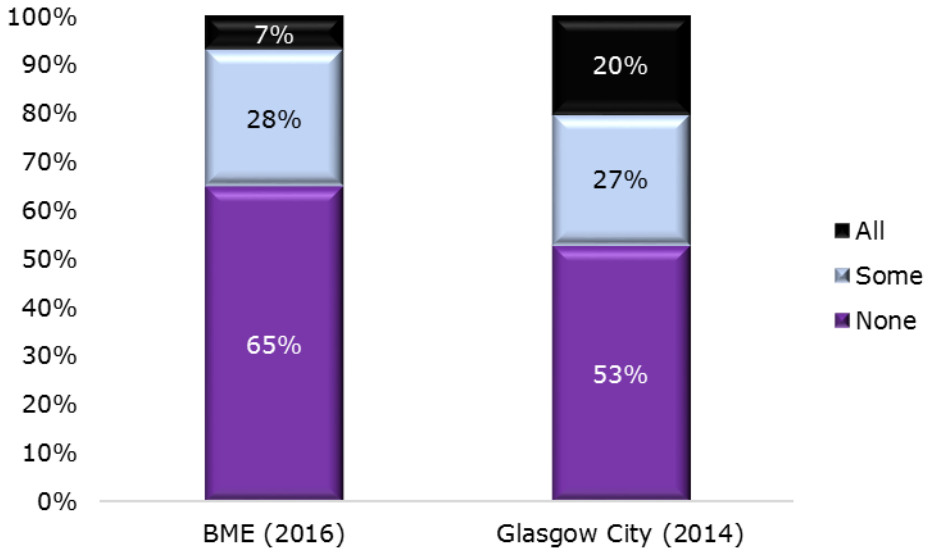
Table 5.41: Proportion with No Qualifications (Q47) by How Well Speak English

	No Qualifications
Speak English very/fairly well	18%
Do not speak English well	71%
All BME	27%

Proportion of Household Income from State Benefits

Just over a third (35%) of BME adults said that at least some of their household income came from benefits, and 7% said that all household income came from benefits. As *Figure 5.7* shows, BME adults were much less likely than those in Glasgow City to receive all income from benefits.

Figure 5.7: Proportion of Household Income from State Benefits



Those in the Pakistani ethnic group were the most likely to be in receipt of any benefits and those in the African group were the most likely to say they received all household income from benefits. The Indian group were the least likely to receive benefits.

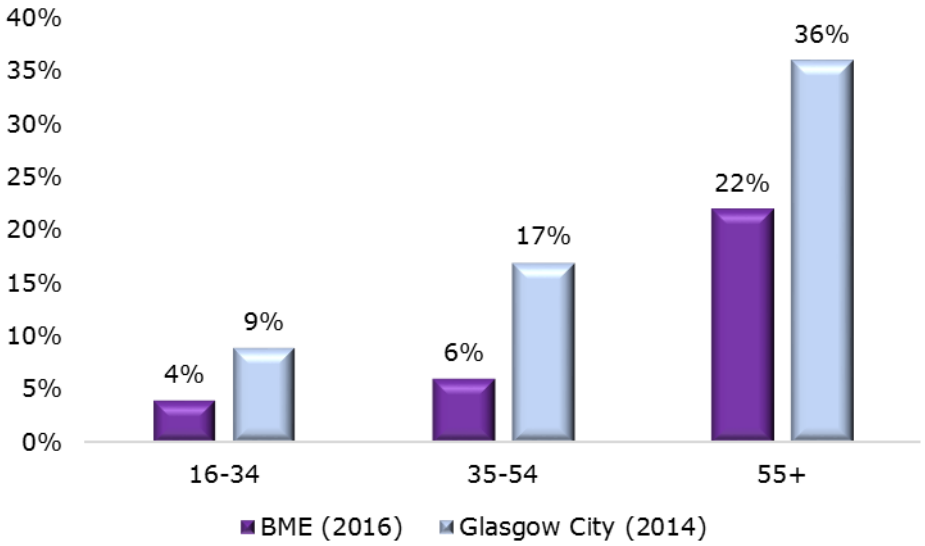
Table 5.42: Proportion of Household Income from State Benefits (Q56) by Ethnicity

	None	Some	All
Indian	87%	10%	3%
Chinese	78%	19%	3%
Polish	66%	31%	3%
African	50%	29%	21%
Pakistani	45%	44%	11%
All BME	65%	28%	7%
Glasgow City (2014)	53%	27%	20%

Those aged 55 or over were the most likely to say that all household income came from benefits.

BME adults in each age group were less likely than those in Glasgow City to receive all household income from benefits, as *Figure 5.8* shows.

Figure 5.8: Proportion of Household Income from State Benefits (Q56) by Age Group – BME (2016) and Glasgow City (2014)



Overall, women were more likely than men to say they received state benefits. This gender difference did not exist in the Chinese group, but was most pronounced in the Pakistani group.

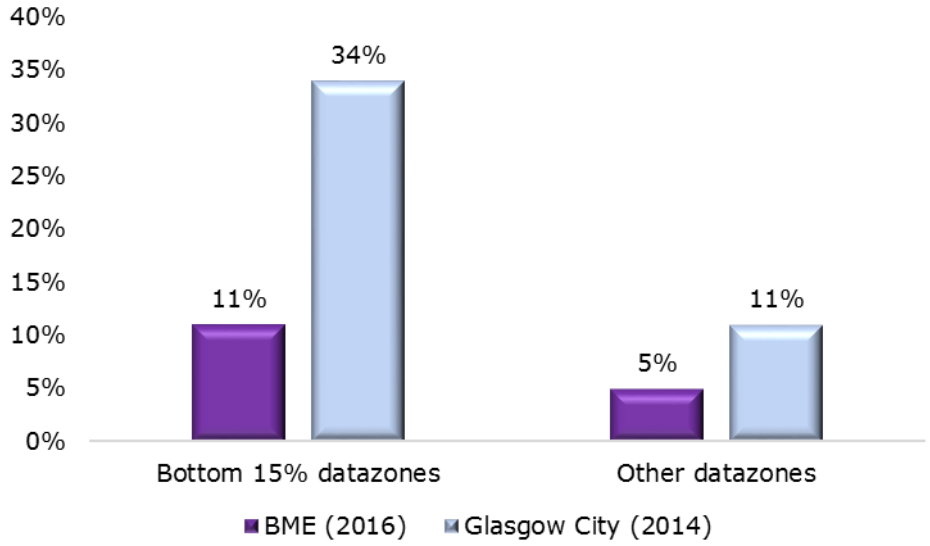
Table 5.43: Proportion of Household Income from State Benefits (Q56) by Gender and Ethnicity

	None		Some		All	
	Men	Women	Men	Women	Men	Women
Indian	89%	83%	9%	14%	2%	3%
Chinese	78%	79%	17%	20%	5%	2%
Polish	69%	62%	30%	32%	1%	6%
African	59%	37%	22%	40%	19%	24%
Pakistani	54%	30%	39%	54%	7%	16%
All BME	69%	60%	25%	32%	6%	8%

Those in the most deprived datazones were more likely than others to receive benefits.

In both the most deprived areas and other areas, BME adults were less likely than those in Glasgow City to receive all income from benefits. The greatest difference was observed in the most deprived areas, as shown in *Figure 5.9*.

Figure 5.9: Proportion of Household Income from State Benefits (Q56) by Deprivation – BME (2016) and Glasgow City (2014)



Those who did not speak English well and those who had lived in the UK for 10 years or more were more likely than others to receive state benefits.

Table 5.44: Proportion of Household Income from State Benefits (Q56) by How Well Speak English and Length of Residency in the UK

	None	Some	All
Speak English very/fairly well	69%	25%	5%
Do not speak English well	44%	43%	14%
Lived in the UK for 10 years or more	54%	37%	10%
Lived in the UK for less than 10 years	77%	19%	4%
All BME	65%	28%	7%

Welfare Reform

When asked whether they or their household had been affected by welfare reform, 18% of BME adults said they did not know. Of those who were able to say, 3% said they had been affected by welfare reform. This was lower than the 7% of adults in Glasgow City (2014) who said they had been affected by welfare reform.

Among those who said they had been affected by welfare reform, 66% said they were worse off as a result of welfare reform, 10% said they were better off and 24% said it made no difference.

The small number of BME adults who had been affected by welfare reform prohibits demographic breakdown.

Money Spent Gambling

Respondents were asked whether they had spent money on different types of gambling activities in the last month (lottery, bingo, bookmakers, casino, online gambling or any other type of gambling). One in nine (11%) had participated in any type of gambling. Lottery was by far the most common type of gambling (8%). Among those who had gambled in the last month, half (50%) had spent £5 or less on gambling activities in the last month; 31% had spent between £5.01 and £20; 9% had spent between £20.01 and £100 and 10% had spent more than £100 on gambling in the last month.

BME adults were much less likely than those in Glasgow City to have gambled in the last month (11% BME; 32% Glasgow City).

Among BME adults, the Polish group were the most likely to have gambled in the last month and the Pakistani group were the least likely to have done so.

Table 5.45: Proportion Spent Money on Any Gambling Activity in the Last Month (Q51) by Ethnicity

	Any Gambling in Last Month
Polish	19%
Indian	13%
Chinese	12%
African	11%
Pakistani	4%
All BME	11%
Glasgow City (2014)	32%

Overall, BME men were much more likely than BME women to have gambled in the previous month (15% men; 5% women). Polish men were the most likely to have gambled (27%) and Chinese and Pakistani women were the least likely (3%).

Table 5.46: Proportion Spent Money on Any Gambling Activity in the Last Month (Q51) by Gender and Ethnicity

	Any Gambling in Last Month	
	Men	Women
Polish	27%	9%
Chinese	22%	3%
Indian	17%	8%
African	14%	5%
Pakistani	5%	3%
All BME	15%	5%

Those in the most deprived areas were more likely than those in other areas to have spent money on gambling in the last month.

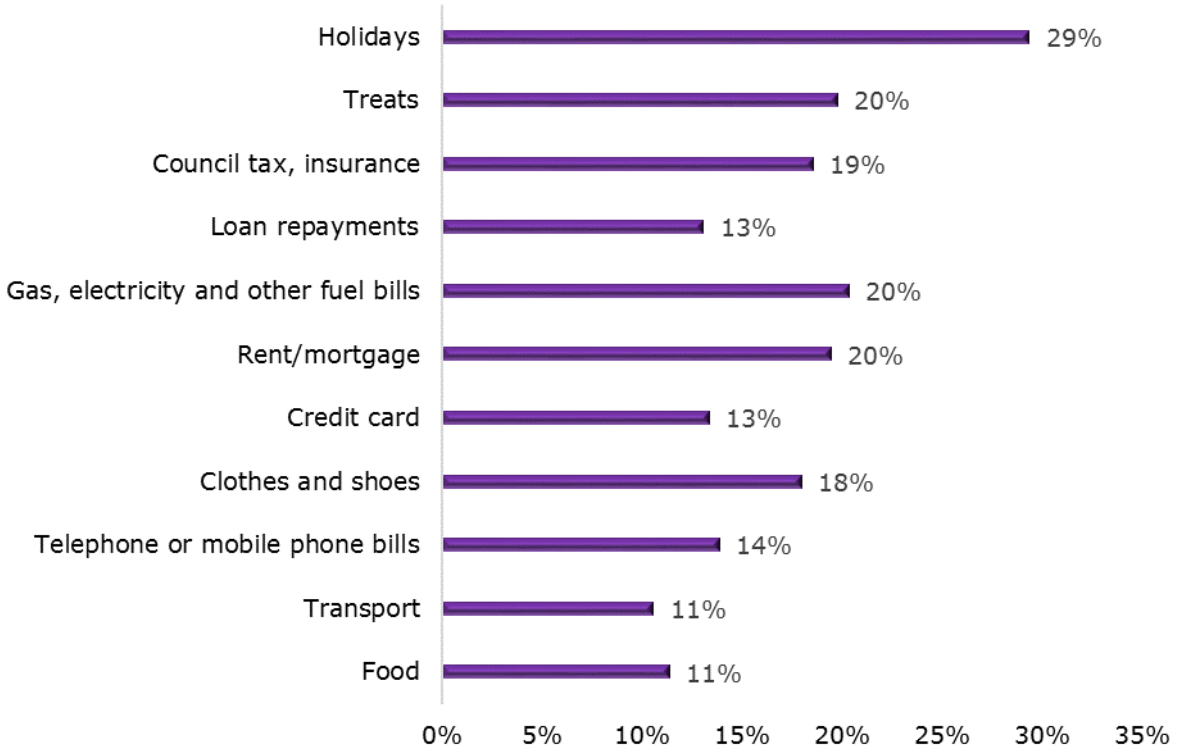
Table 5.47: Proportion Spent Money on Any Gambling Activities in the Last Month (Q51) by Deprivation

	Any Gambling in Last Month
Bottom 15% datazones	13%
Other datazones	9%
All BME	11%

Difficulty Meeting the Cost of Specific Expenses

Figure 5.10 shows the proportion of BME adults who said they ever had difficulty meeting specific expenses.

Figure 5.10: Whether Ever Have Difficulty Meeting the Costs of Specific Expenses (Q53)



Altogether, three in ten (29%) said that they ever had difficulty meeting the costs of rent/mortgage, fuel bills, telephone bills, council tax/insurance, food or clothes/shoes.

Overall, BME groups were less likely than those in Glasgow City to ever have difficulty meeting these costs (29% BME; 33% Glasgow City). However, African and Pakistani groups were more likely to have difficulties meeting these costs, as Table 5.48 shows.

Table 5.48: Proportion Who Ever Have Difficulty Meeting the Cost of Rent/Mortgage, Fuel Bills, Phone Bills, Council Tax/Insurance, Food or Clothes/Shoes (Q53) by Ethnicity

	Ever Have Difficulty
African	49%
Pakistani	40%
Polish	23%
Chinese	20%
Indian	19%
All BME	29%
Glasgow City (2014)	33%

Those aged 35-54 were the most likely to ever have difficulty meeting the costs of rent/mortgage, fuel bills, phone bills, council tax/insurance, food or clothes/shoes.

Figure 5.11 shows that among those aged 16-34, BME adults were less likely than those in Glasgow City to ever have difficulty meeting these expenses. However, for those aged 35-54 there was no significant. BME adults aged 55 or over were **more** likely than those in Glasgow City to have difficulty meeting these expenses.

Figure 5.11: Proportion Who Ever Have Difficulty Meeting the Cost of Rent/Mortgage, Fuel Bills, Phone Bills, Council Tax/Insurance, Food or Clothes/Shoes (Q53) by Age Group – BME (2016) and Glasgow City (2014)

Those in the most deprived areas were more likely than others to ever have difficulties meeting these costs.

Table 5.49: Proportion Who Ever Have Difficulty Meeting the Cost of Rent/Mortgage, Fuel Bills, Phone Bills, Council Tax/Insurance, Food or Clothes/Shoes (Q53) by Age Group

	Ever Have Difficulty
Bottom 15% datazones	36%
Other datazones	27%
All BME	29%

Those who had lived in the UK for 10 years or more were more likely than others to ever have difficulties meeting these costs.

Table 5.50: Proportion Who Ever Have Difficulty Meeting the Cost of Rent/Mortgage, Fuel Bills, Phone Bills, Council Tax/Insurance, Food or Clothes/Shoes (Q53) by Length of Residency in the UK

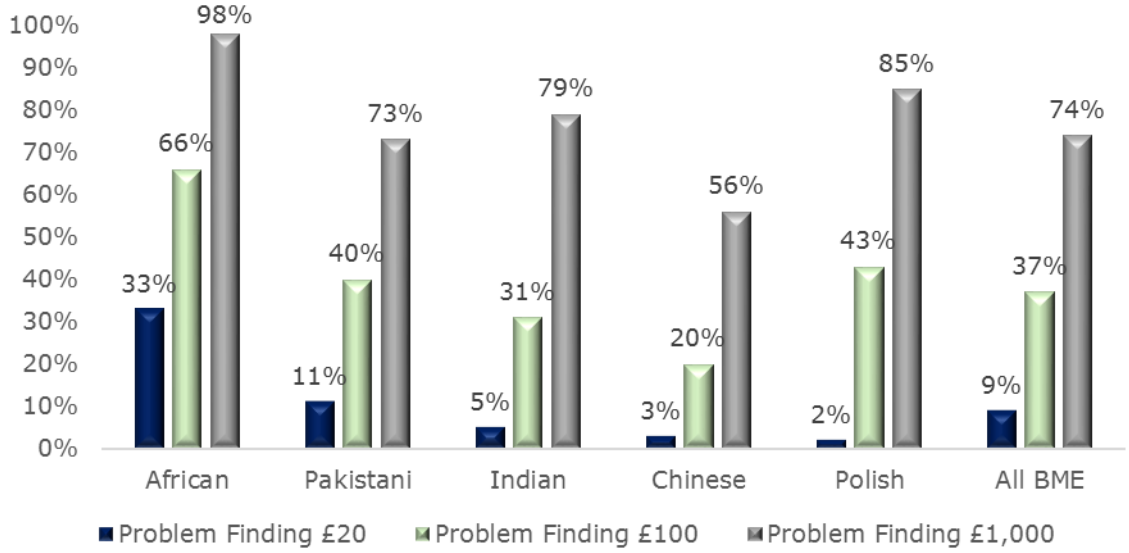
	Ever Have Difficulty
Lived in the UK for 10 years or more	32%
Lived in the UK for less than 10 years	26%
All BME	29%

Difficulty Finding Unexpected Sums

One in eleven (9%) said that they would have a problem meeting an unexpected expense of £20; 37% said they would have a problem meeting an unexpected expense of £100 and three in four (74%) would have a problem finding £1,000 for an unexpected expense.

African groups were the most likely to have a problem finding unexpected sums of £20, £100 or £1,000, as *Figure 5.12* shows.

Figure 5.12: Proportion Who Would Find it a Problem Meeting Unexpected Expenses of £20, £100 or £1,000 by Ethnicity



Those aged 55 or over were less likely than younger BME people to have a problem meeting unexpected expenses of £100 or £1,000.

Table 5.51: Proportion Who Would Find it a Problem Meeting Unexpected Expenses of £20, £100 or £1,000 by Age Group

	Problem Finding £100	Problem Finding £1,000
16-34	37%	74%
35-54	38%	80%
55+	28%	60%
All BME	37%	74%

Those in the most deprived areas were more likely than those in other areas to have a problem meeting unexpected expenses of £20, £100 or £1,000.

Table 5.52: Proportion Who Would Find it a Problem Meeting Unexpected Expenses of £20, £100 or £1,000 by Deprivation

	Problem Finding £20	Problem Finding £100	Problem Finding £1,000
Bottom 15% Datazones	12%	50%	84%
Other Datazones	7%	31%	70%
All BME	9%	37%	74%

Those who had lived in the UK for 10 years or more were less likely than others to say it would be a problem to meet unexpected expenses of £20, £100 or £1,000.

Table 5.53: Proportion Who Would Find it a Problem Meeting Unexpected Expenses of £20, £100 or £1,000 by Length of Residency in the UK

	Problem Finding £20	Problem Finding £100	Problem Finding £1,000
Lived in the UK for 10 years or more	7%	32%	71%
Lived in the UK for less than 10 years	11%	42%	78%
All BME	9%	37%	74%

Adequacy of Income

Using the 'faces' scale (see Section 2.1), respondents were asked how they felt about the adequacy of their household income. Three in four (74%) gave a positive view of the adequacy of their income, while 14% gave a neutral view and 12% gave a negative view. This was similar to the findings for Glasgow City as a whole (2014).

Positive perceptions of household income were most common among Indian and Chinese groups and least common among African and Polish groups.

Table 5.54: Positive Perception of Adequacy of Household Income (Q57) by Ethnicity

	Positive Perception
Chinese	82%
Indian	80%
Pakistani	77%
Polish	61%
African	55%
All BME	74%

Those aged 35-54 were the age group least likely to have a positive perception of the adequacy of their household income.

Table 5.55: Positive Perception of Adequacy of Household Income (Q57) by Age Group

	Positive Perception
16-34	77%
35-54	68%
55+	75%
All BME	74%

Economic Activity

Respondents were asked which category best described their employment situation, with the option of selecting more than one category. Responses, from most to least frequent were:

- Employee in full-time job (31%);
- Full-time education at school, college or university (26%);
- Looking after the family/home (14%);
- Employee in part-time job (12%);
- Wholly retired from work (5%);
- Self employed - full or part time (5%);
- Unemployed and available for work (5%);
- Permanently sick/disabled (3%);
- Part-time education at school, college or university (1%);
- Employed on a zero hours contract (<1%);
- Government supported training or employment (<1%);
- Other (<1%).

In total, just under half (48%) of all BME adults were employed (in full-time or part-time employment, self-employed or on a zero hours contract). There was much variation across ethnic groups, with the Polish group being the most likely to be in employment (77%) and Chinese the least likely (22%).

Table 5.56: Proportion Economically Active (Q45) by Ethnicity

	Economically Active
Polish	77%
Indian	59%
African	52%
Pakistani	44%
Chinese	22%
All BME	48%

Two thirds (67%) of those aged 35-54 were economically active, as Table 5.57 shows.

Table 5.57: Proportion Economically Active (Q45) by Age Group

	Economically Active
16-34	41%
35-54	67%
55+	31%
All BME	48%

Across all BME adults, men were twice as likely as women to be in employment (60% men; 31% women), with the biggest gender difference being observed in the Pakistani and Chinese groups.

Table 5.58: Proportion Economically Active (Q45) by Gender and Ethnicity

	Economically Active	
	Men	Women
Polish	88%	63%
Indian	69%	41%
African	55%	49%
Pakistani	59%	22%
Chinese	32%	13%
All BME	60%	31%

Those in the most deprived areas were more likely than those in other areas to be economically active, as 5.59 shows.

Table 5.59: Proportion Economically Active (Q45) by Deprivation

	Economically Active
Bottom 15% datazones	53%
Other datazones	45%
All BME	48%

Those who spoke English well and were more likely than those who did not speak English well to be in employment. Also, those who had lived in the UK for 10 years or more were more likely than those who had lived in the UK for a shorter period to be in employment.

Table 5.60: Proportion Economically Active (Q45) by How Well Speak English and Length of Residency in the UK

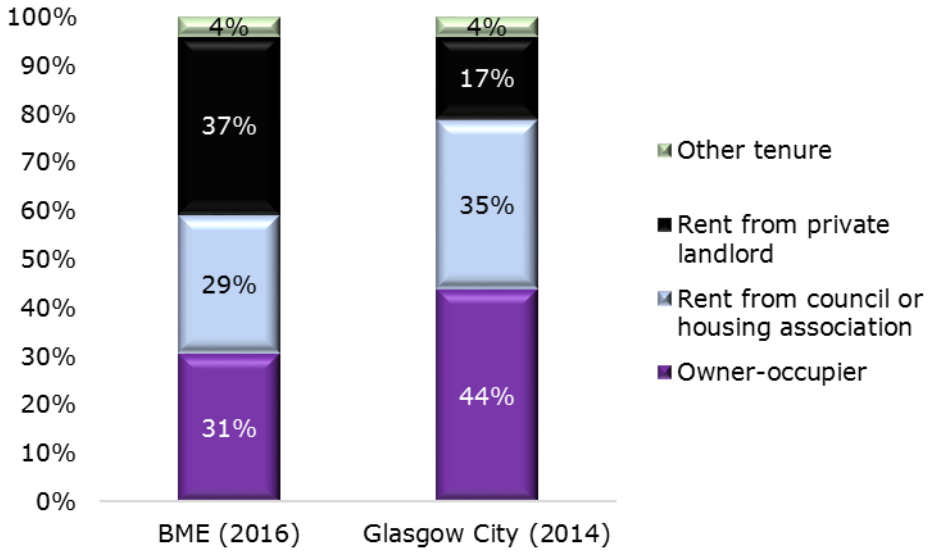
	Economically Active		Economically Active
Speak English very/fairly well	49%	Lived in the UK for 10 years or more	51%
Do not speak English well	41%	Lived in the UK for less than 10 years	44%

Tenure

Three in ten (31%) BME adults lived in owner-occupied homes (either owned outright or buying with a mortgage), three in ten (29%) rented their homes from the council or a housing association, 37% lived in privately rented homes and 4% lived in homes with some other tenure.

As *Figure 5.13* shows, BME adults were less likely than those in Glasgow City to live in owner-occupied homes and much more likely to live in privately rented homes.

Figure 5.13: Household Tenure - Glasgow City and NHSGGC



Pakistani and Indian groups were much more likely than those in other BME groups to live in owner-occupied homes, as Table 5.61 shows.

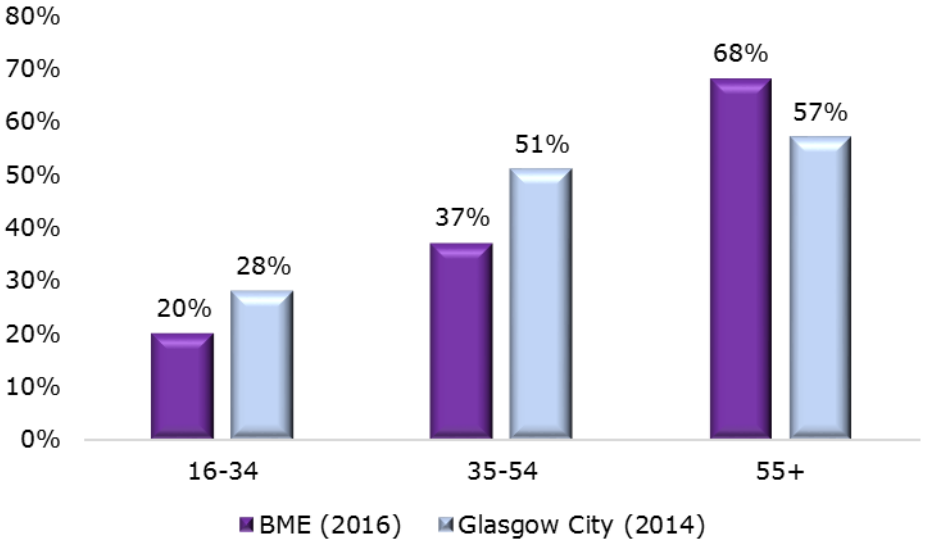
Table 5.61: Proportion in Owner-Occupied Homes (Q55) by Ethnicity

	Owner-Occupier
Pakistani	51%
Indian	44%
Chinese	17%
Polish	9%
African	8%
All BME	31%
Glasgow City (2014)	44%

The proportion of BME adults living in owner-occupied homes ranged from 20% of those aged under 35 to 68% of those aged 55 or over.

Among those aged under 55, BME adults were less likely than those in Glasgow City to live in owner-occupied homes. However, among those aged 55 or over, BME adults were **more** likely than those in Glasgow City to live in an owner-occupied homes.

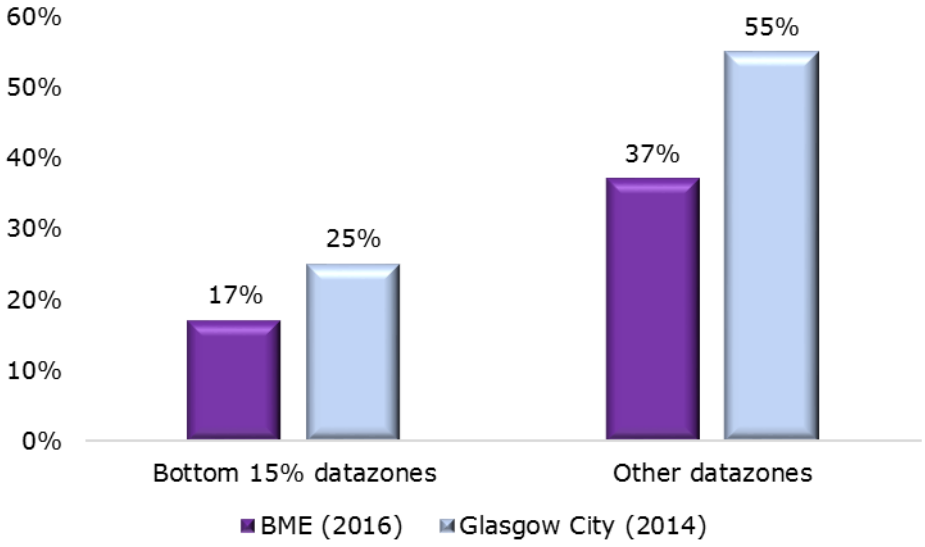
Figure 5.14: Proportion in Owner-Occupied Homes (Q55) by Age Group – BME (2016) and Glasgow City (2014)



One in six (17%) BME adults in the most deprived areas lived in owner-occupied homes compared to 37% of those in all other areas.

BME adults in both the most deprived areas and other areas were less likely than those in Glasgow City to live in owner-occupied homes, as *Figure 5.15* shows.

Figure 5.15: Proportion in Owner-Occupied Homes (Q55) by Deprivation – BME (2016) and Glasgow City (2014)



More than half (52%) of those who had lived in the UK for 10 years or more lived in owner-occupied homes compared to just 7% of those who had lived in the UK for less than 10 years.

Table 5.62: Household Tenure (Q55) by Length of Residency in the UK

	Owner-occupier
Lived in the UK for 10 years or more	52%
Lived in the UK for less than 10 years	7%
All BME	31%

5.8 Summary of Key Messages from This Chapter

One in eight (12%) BME adults ever felt isolated from family/friends (which was not significantly different to the proportion in Glasgow City).

- Feelings of isolation were more common among African and Polish groups, women, those in the most deprived areas and those who had lived in the UK for less than 10 years.

Seven in ten (72%) felt they belonged to their local area, six in ten (62%) felt valued as members of their community and seven in ten (72%) agreed that local people working together could influence local decisions.

- The Chinese group were the least likely to feel valued as a member of their community or to feel that local people could influence local decisions.
- Those aged 35 and over and those who had lived in the UK for 10 years or more were more likely to agree with each of these three sentiments.

One in thirty (3.4%) BME adults felt that they had been discriminated against in the last year.

- Those in Pakistani and African groups, those in the most deprived areas and those who had lived in the UK for 10 years or more were more likely to have experienced discrimination.
- Among those who had been discriminated against, the most common sources of discrimination were unknown person in a public place (61%) followed by employer (26%).
- Among those who had been discriminated against, the most commonly perceived reasons were ethnic background (91%) and religion/faith/belief (36%).

One in ten (10%) BME adults had been a victim of one of five types of crime in the last year.

- Overall, BME adults were less likely than those in Glasgow City to have been a victim of crime.
- Polish and African groups were more likely to have been victims of crime.
- Women, and those who had lived in the UK for 10 years or more were more likely to have been victims of crime.

Nine in ten (89%) BME adults felt safe using public transport and two in three (67%) felt safe walking alone in their area even after dark.

- Polish groups were less likely to feel safe doing either of these things.
- Those aged 35-54, those in the most deprived areas and those who did not speak English well were less likely to feel safe walking alone.

One in 20 (5%) BME adults had caring responsibilities.

- Pakistani adults were the most likely to be carers; caring responsibilities were least common among Polish and African groups.
- Caring responsibilities were more common among those aged 35 or over, those not in the most deprived areas and those who had lived in the UK for 10 years or more.

Just over one in four (27%) BME adults said they had no qualifications (compared to 19% in Glasgow City).

A third (35%) of BME adults said that at least some of their household income came from state benefits. BME adults were much less likely than those in Glasgow City to receive all household income from benefits (7% compared to 20%).

Three in ten (29%) ever had difficulty meeting the costs of rent/mortgage, fuel bills, phone bills, council tax/insurance, food or clothes/shows.

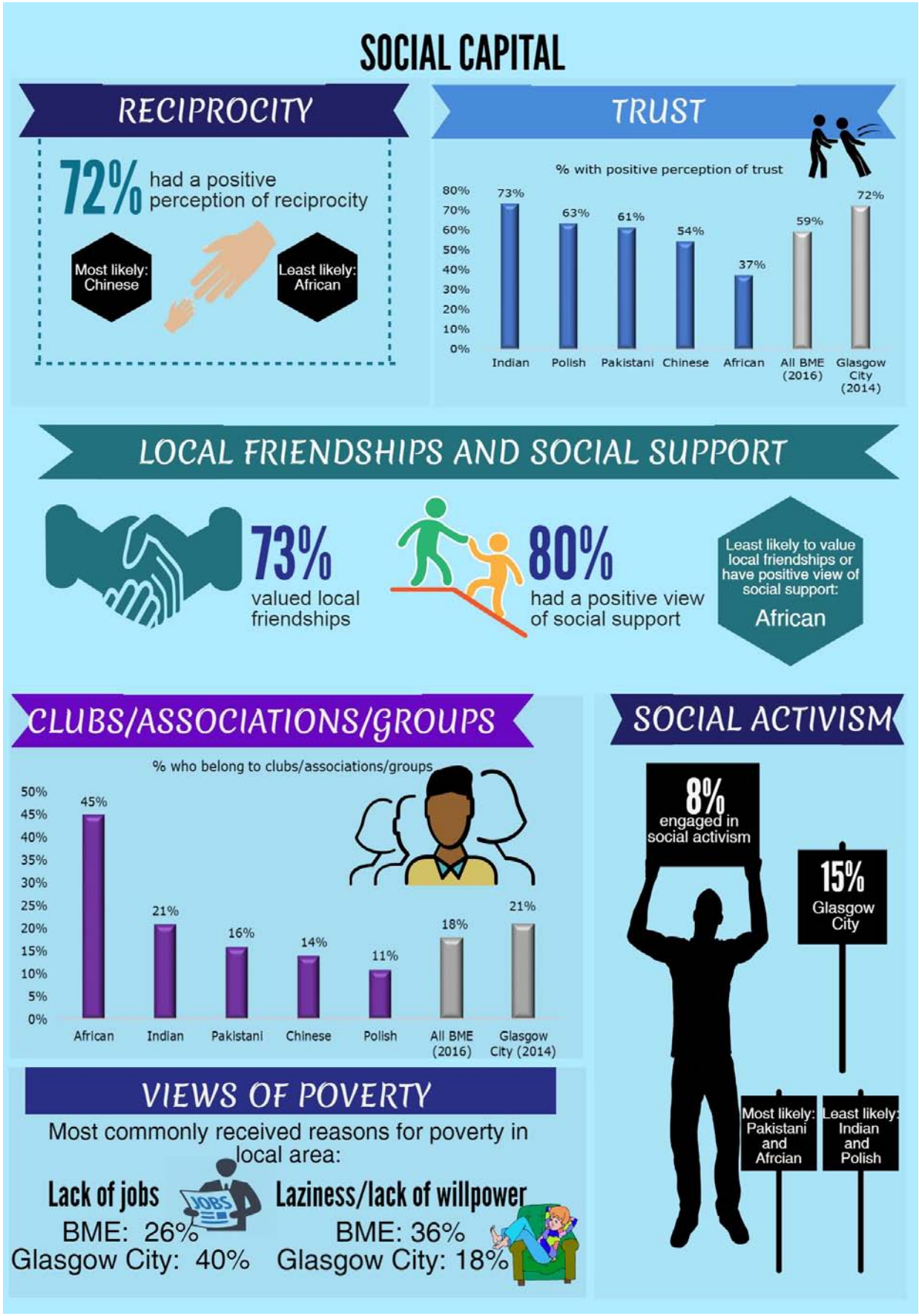
- African and Pakistani groups were more likely to have difficulty meeting these costs.
- Those in the most deprived areas and those who had lived in the UK for 10 years or more were more likely to have difficulty meeting these costs.

One in 11 (9%) said they would have difficulty meeting unexpected expenses of £20; 37% would have difficulty finding £100 and 74% would have difficulty finding £1,000. Three in four (74%) gave a positive perception of the adequacy of their income.

- The African group was the most likely to have difficulty finding these sums and the least likely to express a positive view of the adequacy of their income.

Half (48%) of BME adults were economically active.

- The Polish group was the most likely to be economically active and the Chinese group was the least likely to be economically active.
- Those aged 35-54, men and those in the most deprived areas were the most likely to be economically active. Men were twice as likely as women to be economically active.


SOCIAL CAPITAL
RECIPROCITY
72% had a positive perception of reciprocity
Most likely: Chinese
Least likely: African
TRUST
% with positive perception of trust
80%
70%
60%
50%
40%
30%
20%
10%
0%
73%
63%
61%
54%
37%
59%
72%
Indian
Polish
Pakistani
Chinese
African
All BME (2016)
Glasgow City (2014)
LOCAL FRIENDSHIPS AND SOCIAL SUPPORT
73% valued local friendships
80% had a positive view of social support
Least likely to value local friendships or have positive view of social support: African
CLUBS/ASSOCIATIONS/GROUPS
% who belong to clubs/associations/groups
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
45%
21%
16%
14%
11%
18%
21%
African
Indian
Pakistani
Chinese
Polish
All BME (2016)
Glasgow City (2014)
SOCIAL ACTIVISM
8% engaged in social activism
15% Glasgow City
Most likely: Pakistani and Afrcian
Least likely: Indian and Polish
VIEWS OF POVERTY
Most commonly received reasons for poverty in local area:
Lack of jobs
BME: 26%
Glasgow City: 40%
JOBS
Laziness/lack of willpower
BME: 36%
Glasgow City: 18%

6.1 Reciprocity and Trust

Respondents were asked to indicate the extent to which they agree or disagree with the following statements:

"This is a neighbourhood where neighbours look out for each other", and "Generally speaking, you can trust people in my local area".

Those agreeing with the first statement were categorised as having a positive view of reciprocity, and those agreeing with the second were categorised as having a positive view of trust. Overall, 71% were positive about reciprocity and 59% were positive about trust.

Although BME groups were overall as likely as those in Glasgow to be positive about reciprocity, they were less likely to be positive about trust (59% BME; 72% Glasgow City).

Those in the African ethnic group were the least likely to have a positive view of reciprocity and were also by far the least likely to have a positive view of trust, as Table 6.1 shows.

Table 6.1: Positive Perception of Reciprocity (Q32a) and Trust (Q32e) by Ethnicity

	Reciprocity	Trust
Chinese	76%	54%
Pakistani	73%	61%
Polish	71%	63%
Indian	66%	73%
African	58%	37%
All BME	71%	59%
Glasgow City (2014)	(not significant)	72%

Those aged 55 or over were more likely than younger people to have a positive perception of reciprocity.

Table 6.2: Positive Perception of Reciprocity (Q32a) by Age Group

	Reciprocity
16-34	69%
35-54	69%
55+	85%
All BME	71%

Those in the most deprived areas were less likely than those in other areas to have a positive perception of reciprocity.

Table 6.3: Positive Perception of Reciprocity (Q32a) by Deprivation

	Reciprocity
Bottom 15% datazones	66%
Other datazones	73%
BME	71%

Those who did not speak English well were more likely than others to have a positive view of reciprocity, but less likely than others to have a positive view of trust.

Table 6.4: Positive Perception of Reciprocity (Q32a) and Trust (Q32e) by How Well Speak English

	Reciprocity	Trust
Speak English very/fairly well	68%	61%
Do not speak English well	82%	54%
All BME	71%	59%

6.2 Local Friendships

Respondents were asked to indicate the extent to which they agree or disagree with the statement: "*The friendships and associations I have with other people in my local area mean a lot to me*". Overall, 73% of BME adults agreed with this statement. This did not differ significantly from the finding for Glasgow City.

Those in the African ethnic group were less likely than others to value local friendships, as Table 6.5 shows. This (and other measures of social capital for the African group) may be partly explained by the African population being more dispersed in Glasgow than other ethnic groups.

Table 6.5: Proportion Value Local Friendships (Q32c) by Ethnicity

	Value Local Friendships
Pakistani	79%
Indian	73%
Polish	72%
Chinese	72%
African	61%
All BME	73%

Those aged 55 or over were more likely than younger adults to value local friendships.

Table 6.6: Proportion Value Local Friendships (Q32c) by Age Group

	Value Local Friendships
16-34	72%
35-54	74%
55+	81%
All BME	73%

Those who did not speak English well and those who had lived in the UK for 10 years or more were more likely than others to value local friendships, as Table 6.7 shows.

Table 6.7: Proportion Value Local Friendships (Q32c) by How Well Speak English and Length of Residency in the UK

	Value Local Friendships		Value Local Friendships
Speak English very/fairly well	72%	Lived in the UK for 10 years or more	78%
Do not speak English well	78%	Lived in the UK for less than 10 years	68%

6.3 Social Support

Respondents were asked to indicate the extent to which they agree or disagree with the statement: "*If I have a problem, there is always someone to help me*". Those agreeing with this statement were categorised as having a positive view of social support. According to this definition, four in five (80%) BME adults were positive about social support. Those in the African group were the least likely to be positive about social support, as Table 6.8 shows.

Table 6.8: Positive View of Social Support (Q32g) by Ethnicity

	Positive View of Social Support
Indian	88%
Polish	84%
Chinese	80%
Pakistani	77%
African	66%
All BME	80%

Those aged 55 or over were more likely than younger BME adults to have a positive view of social support.

Table 6.9: Positive View of Social Support (Q32g) by Age Group

	Positive View of Social Support
16-34	78%
35-54	80%
55+	87%
All BME	80%

Those who did not speak English well were more likely than others to have a positive view of social support, as Table 6.10 shows.

Table 6.10: Positive View of Social Support (Q32g) by How Well Speak English

	Positive View of Social Support
Speak English very/fairly well	79%
Do not speak English well	84%
All BME	80%

Volunteering

One in six (16%) BME adults said they had given up time to help clubs, charities, campaigns or organisations in an unpaid capacity in the last year.

Overall, BME groups were less likely than those in Glasgow City to volunteer (16% BME; 19% Glasgow City). However, Pakistani and African groups were much more likely than others to have volunteered, as shown in Table 6.11.

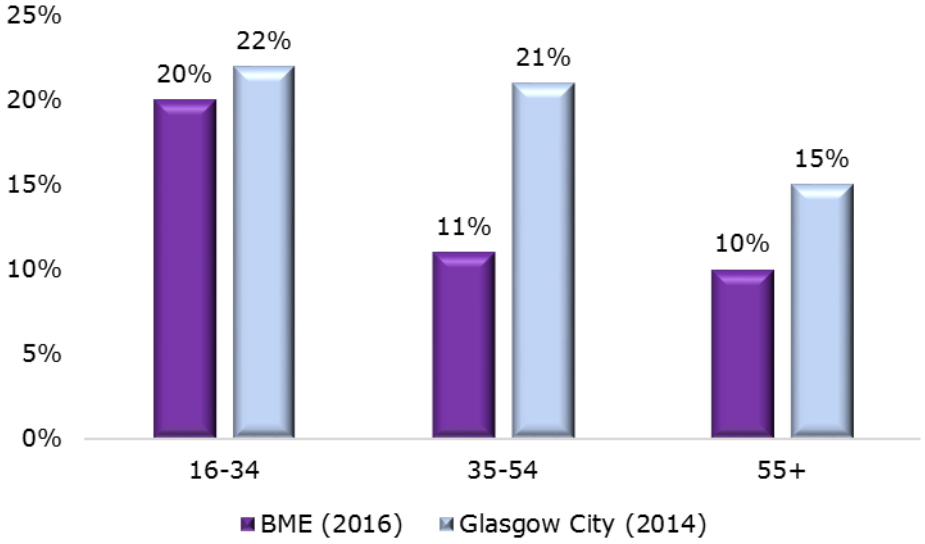
Table 6.11: Volunteering in Last 12 Months (Q34) by Ethnicity

	Volunteer
Pakistani	24%
African	20%
Indian	12%
Polish	11%
Chinese	11%
All BME	16%
Glasgow City (2014)	19%

Volunteering was much more common among those aged under 35 than those in older age groups.

Among those aged under 35, BME adults were as likely as those in Glasgow City to be volunteers. However, volunteering was much less likely among BME adults aged 35 or over compared to those in Glasgow City. This is shown in *Figure 6.1*.

Figure 6.1: Volunteering in Last 12 Months (Q34) by Age Group – BME (2016) and Glasgow City (2014)



Overall, men were more likely than women to be volunteers (18% men; 13% women). However, this was accounted for almost entirely by the gender difference among the Pakistani group, with Pakistani men being almost three times more likely than Pakistani women to volunteer. Indeed, among the Chinese and African groups, women were much more likely than men to be volunteers.

Table 6.12: Volunteering in Last 12 Months (Q34) by Gender and Ethnicity

	Volunteer	
	Men	Women
Pakistani	31%	11%
African	15%	27%
Indian	13%	10%
Polish	10%	12%
Chinese	7%	14%
All BME	18%	13%

Those who spoke English well were much more likely than those who did not speak English well to have volunteered. Also, those who had lived in the UK for 10 years or more were much more likely than those who had lived in the UK for a shorter period to have volunteered. This is shown in Table 6.13.

Table 6.13: Volunteering in Last 12 Months (Q34) by How Well Speak English and Length of Residency in the UK

	Volunteer		Volunteer
Speak English very/fairly well	19%	Lived in the UK for 10 years or more	21%
Do not speak English well	5%	Lived in the UK for less than 10 years	11%

Belonging to Clubs, Associations and Groups

Just under one in five (18%) BME adults said that they belonged to any social clubs, associations, church groups or anything similar. Overall, BME adults were less likely than those in Glasgow City to belong to one of these (18% BME; 21% Glasgow City), but those in the African ethnic group were much more likely than any other group to belong to a club/association/group, as Table 6.14 shows.

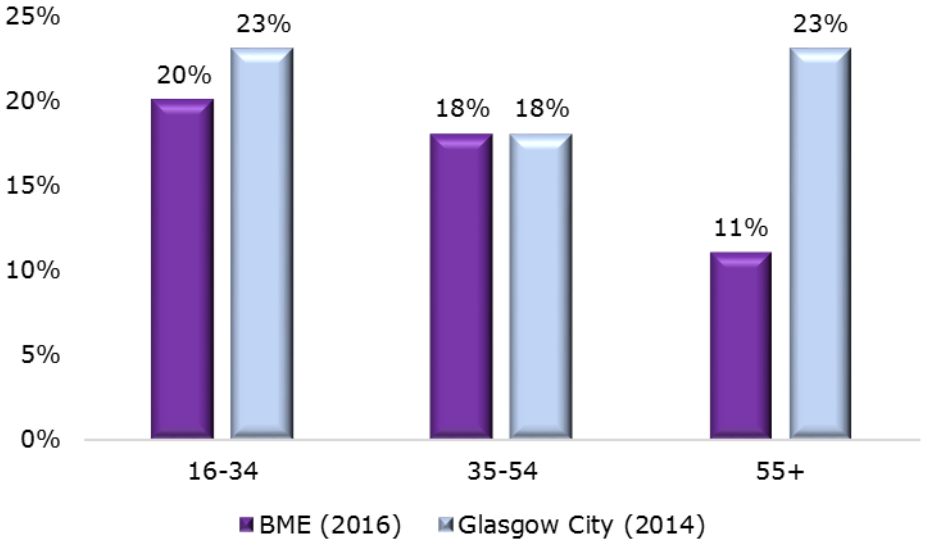
Table 6.14: Belong to Social Clubs, Associations, Church Groups or Similar (Q35) by Ethnicity

	Belong to club etc.
African	45%
Indian	21%
Pakistani	16%
Chinese	14%
Polish	11%
All BME	18%
Glasgow City (2014)	21%

Those aged 55 or over were less likely than younger BME adults to say they belonged to a club, association or group.

Among those aged under 55, BME groups were as likely as those in Glasgow City as a whole to belong to clubs/associations and groups. However, among those aged 55 or over, BME groups were much less likely than those in Glasgow City to belong to clubs etc. This is shown in *Figure 6.2*.

Figure 6.2: Belong to Social Clubs, Associations, Church Groups or Similar (Q35) by Age Group – BME (2016) and Glasgow City (2014)



Overall, there was no significant difference between men and women in the proportion who belonged to groups, clubs or associations. However, among Polish, Indian, Chinese and African groups, women were more likely than men to belong to a club/association/group; but in the Pakistani group, men were much more likely than women to belong to one of these.

Table 6.15: Belong to Social Clubs, Associations, Church Groups or Similar (Q35) by Gender and Ethnicity

	Belong to club etc.	
	Men	Women
African	41%	51%
Indian	16%	29%
Pakistani	22%	7%
Chinese	11%	17%
Polish	8%	15%

Those who spoke English well were much more likely than others to belong to any social clubs, associations, church groups or similar.

Table 6.16: Belong to Social Clubs, Associations, Church Groups (Q35) or Similar by How Well Speak English

	Belong to club etc.
Speak English very/fairly well	20%
Do not speak English well	9%
All BME	18%

Social Activism

Respondents were asked whether, in the last 12 months they had taken any of the following actions in an attempt to solve a problem affecting people in their local area:

- contacted any media, organisation, council, councillor or MP;
- attended a public meeting, tenants/residents group, protest meeting or action group;
- organised a petition on a local issue; or
- some other type of social activism.

Excluding those who said they did not know or that there were no local problems, 8% of BME adults had engaged in any type of social activism. Overall, BME adults were less likely than those in Glasgow City to have engaged in social activism (8% BME; 15% Glasgow City). Those in the Pakistani and African groups were more likely than other BME groups to have engaged in social activism, as Table 6.17 shows.

Table 6.17: Engaged in Social Activism in Last Year by Ethnicity

	Social Activism
Pakistani	12%
African	12%
Chinese	7%
Polish	4%
Indian	3%
All BME	8%
Glasgow City (2014)	15%

Those in the most deprived areas are less likely than those in other areas to have engaged in social activism in the last year, as Table 6.18 shows.

Table 6.18: Engaged in Social Activism in Last Year by Deprivation

	Social Activism
Bottom 15% datazones	5%
Other datazones	9%
All BME	8%

Those who spoke English well were much more likely than those who did not speak English well to have engaged in social activism. Also, those who had lived in the UK for 10 years or more were more likely than those who had lived in the UK for a shorter period to have engaged in social activism.

Table 6.19: Engaged in Social Activism in Last Year by How Well Speak English and Length of Residency in the UK

	Social Activism		Social Activism
Speak English very/fairly well	9%	Lived in the UK for 10 years or more	10%
Do not speak English well	2%	Lived in the UK for less than 10 years	5%

Views on Poverty

Respondents were asked what they felt was the main reason some people in their area lived in poverty. The most frequent responses were laziness or lack of willpower (36%) and lack of jobs (26%). One in five (20%) said there was no one living in poverty in their area.

The profile of views on poverty differed for BME adults compared to those in Glasgow City. BME adults were much more likely to attribute poverty to laziness or lack of willpower and less likely to attribute it to lack of jobs or injustices in society. BME adults were also more likely than those in Glasgow City to say there was no one living in poverty in their area. Table 6.20 shows the responses of BME adults compared to those in Glasgow City.

Table 6.20: Perceived Reasons for Poverty in Local Area – BME and Glasgow City

Perceived reasons for poverty	BME (2016)	Glasgow City (2014)
Laziness or lack of willpower	36%	18%
Lack of jobs	26%	40%
There is no-one living in poverty in this area	20%	14%
An inevitable part of modern life	5%	5%
Because of injustice in society	2%	11%
Because they have been unlucky	2%	4%
Other	1%	2%
None of the above	6%	6%

6.4 Summary of Key Messages from This Chapter

Seven in ten (71%) BME adults had a positive view of reciprocity in their area and 59% had a positive view of trust. Just under three in four (73%) valued local friendships and 66% had a positive view of social support.

Sixteen percent of BME adults had volunteered in the last year; 18% belonged to any clubs/associations/groups and 8% had engaged in social activism in the last year.

Those in the African group were the least likely to:

- have a positive view of reciprocity;
- have a positive view of trust;
- value local friendships;
- have a positive view of social support.

However, African groups were by far the most likely to belong to clubs etc, and were more likely than others to have volunteered or engaged in social activism in the last year.

Those who did not speak English well were:

- more likely to have positive views of reciprocity, social support and reciprocity;
- much less likely than others to belong to clubs etc or to have engaged in social activism.

Those aged 55 or over were the age group:

- most likely to have positive views of reciprocity;
- most likely to value local friendships;
- most likely to have a positive view of social support.

However, younger people were more likely to volunteer or belong to clubs etc.

BME adults' views on poverty differed compared to Glasgow City. BME adults were more likely to attribute poverty to laziness/lack of willpower (BME 36%; Glasgow City 18%) and less likely to attribute it to lack of jobs (BME 26%; Glasgow City 40%) or injustices in society (BME 2%; Glasgow City 11%).

7 The Way Forward[18]

The findings in the report are complex and we would like to talk to partners and voluntary sector agencies who support BME groups to discuss them. We can then use this report to shape our future work with BME communities and partner agencies, involving BME communities in this work.

There are some key areas where we can see that feelings of safety and inclusion, access to services and uptake of interpreters by people who do not speak English well, employment, freedom from discrimination and equitable health outcomes need to be tackled.

Hopefully the report has been able to present some of the facts about BME communities in Glasgow, such as the growing number of young people, and also dispel any myths, such as the view sometimes expressed that BME health is not an issue.

Some of the themes which come across in the report which require further exploration include:

- The different experiences of each ethnic group and how services should respond to their health and wellbeing needs;
- The more negative experience of women and what can be done to address this;
- How language skills affect health and wellbeing indicators;
- Attitudinal differences between the BME and non BME population, for example on the causes of poverty, and how we can have a conversation at local level on understandings of health inequalities for all groups.

In discussion with a wide range of partners and BME communities the survey could form the basis of concrete actions to improve BME health and also the health of everyone in Glasgow.

Finally, we would like to repeat the survey in 2019 to see if there have been any changes as the current report provides a valuable baseline.

[18] This chapter has been prepared by NHSGGC

8 APPENDIX A: SURVEY METHODOLOGY & RESPONSE

8.1 Source

This Appendix has been prepared by BMG Research

8.2 Sampling and Methdology

Introduction

The sampling was a combined effort between NHSGGC and BMG Research. Due to data confidentiality purposes, the addresses supplied to NHSGGC through the Community Health Index (CHI) could not be passed to BMG for sampling purposes. Therefore, a process was adopted whereby NHSGGC shared CHI count information at an output area level, BMG Research then sampled the stratified output areas, which NHSGGC then used to randomly sample addresses. The detailed process is explained in section 2.2.
The overarching objective was to obtain the following number of interviews per ethnic group from across Glasgow City, with the sample as representative as possible in terms of age, gender and deprivation. The target grid is shown below, with an overall target of 1,842 interviews to achieve.

Table A1: Target number of interviews per ethnic group

	Target
Pakistani	375
Indian	365
Chinese	369
African	369
Polish	364
	1,842

Sampling process

Having undertaken a process of collecting names and addresses from the CHI, then mapping this information using software called Onomap, NHSGGC were able to estimate the number of 'people' of each ethnic group living in each output area across Glasgow City, with output area split into SIMD quintile. Using this count of people, BMG Research were able to propose a sampling strategy for each ethnic group, with the strategy dependent on the spread and density of people across the City. The premise was to be able to sample output areas as sampling points, stratified by SIMD quintile, with a set number of interviews to achieve within each output area from a set number of sampled people.

It was agreed that within each output area, 4.15 times the number of people would be sampled in order to achieve the set target number of interviews. This was agreed on the basis of having 2.5 times the number of people (to replicate the process used for the main Health and Wellbeing Survey in 2014), with extra built in to account for the estimated 15% opt out rate from the pre-survey letter, and an estimated 1 times fall-out due to people no longer being resident at the address and/or not being the ethnic group identified through Onomap. It was therefore necessary for there to be sufficient people within each sampled output area to be able to achieve the target.

The following presents the number of output areas sampled per ethnic group, the number of people sampled within each output area (by NHSGGC), and the associated target number of interviews to achieve.

Table A2: Number of sampled output areas and targets per output area

	Number of output areas sampled	Number of addresses per output areas	Target per output area
Pakistani	37	42	10
Indian	73	21	5 (4-6)
Chinese	73	21	5 (4-6)
African	36 cluster of OAs*	42	10
Polish	90	16	4

* There were insufficient African people per output area to allow sampling to be conducted at this level, so output areas were combined into larger clusters.

Once the sample had been finalised, each person received a pre-survey letter on two separate occasions in the post prior to being approached for interview, which gave them the opportunity to 'opt out'. Given the nature of the study being specifically amongst BME groups, it also gave people the opportunity to contact NHSGGC to request for the interview to be conducted in their chosen language. BMG Research were then provided with the list of people minus any opt outs. At this stage, BMG Research cleaned up the addresses and matched them to PAF wherever possible.
The sample was de-duped wherever possible against other survey fieldwork being conducted in the study area (i.e. GoEast).

Fieldwork

Prior to fieldwork commencing, in March 2016, a pilot was conducted to test a number of aspects of the methodology, including sampling, questionnaire content/flow, CAPI script functionality, and contact management in terms of recording call outcomes at addresses. A total of 22 interviews were conducted as part of the pilot, with achieved interviews split as follows:-

- 11 Pakistani (a mix of English and non-English interviews conducted)
- 3 Indian (a mix of English and non-English interviews conducted)
- 3 Polish (all done in English, but the translated materials were tested)
- 1 African (interview done via language line)
- 4 Chinese (all done in English, but the translated materials were tested)

A total of 15 interviewers were briefed and worked on this project. The initial briefing session took place in late July, with NHSGGC in attendance. The maximum number of interviews conducted by any one interviewer was 319, with the average being 120 each. The interviews lasted an average of 28 minutes.

All interviewers were briefed that each person must be attempted up to five times before it is deemed exhausted, although attempts were made up to 6-7 times for the Indian and Chinese groups where the targets were more difficult to achieve.

To effectively manage the attempts, each of the five attempts was to be made at different times of the day and week. This ensures the greatest opportunity for all resident groups to be captured, particularly those in work. The following table provides the breakdown of interviews achieved by time of day and weekday or weekend, and it can be seen that the majority of the interviews were completed at weekends or evenings.

Table A3: Number of achieved interviews by time of day and week

	Number of completed interviews	%
Weekday before 3pm	485	27%
Weekday after 3pm	900	50%
Weekend	413	23%

Evaluation of the methodology and sample

This project utilised an innovative method of identifying people and addresses to specific ethnic groups. NHSGGC are therefore interested in assessing the effectiveness of the method and any lessons that can be learnt for future surveys.

All-in-all it was an effective method, as a large proportion of the people at the addresses were appropriately identified in the chosen ethnic group and were therefore able to be interviewed (where they gave permission). As is shown in below, out of a total of 6,500 people sampled (after the opt out process), 1,953 could not be used for reasons such as:

- Insufficient address information (28)
- Couldn't find the address (17)
- Business or institution (7)
- They were not the chosen ethnic group (743)
- The person no longer lives at the address/or never did (508)
- Couldn't get access to the property (i.e. student accommodation) (650)

There were a number of key issues with the approach that it is important to highlight for any future use:

1. The sampling was conducted at an individual person level, not by address, so the overlap of addresses was very large. Indeed, half of the sample lived in a household with one other sampled person, and 1,700 of the sample lived in households with 3 or more sampled people. In some cases there were 6 or 7 people in one address. What this meant was that if we were unable to get a positive response from the first attempt, it was more likely that this first person would act as a gatekeeper to refuse all occupants of the property, therefore quickly multiplying the refusal rate and reducing the effectiveness of the sample. In addition, it was impractical to be able to interview multiple occupants of one property at the same visit, so this often meant making appointments to return at a later time, which further increases the likelihood of refusals. This issue could be avoided in the future by cleaning up the addresses from CHI ahead of the sampling procedure, so that duplicate addresses are identified and a limit of say 2 people per household is placed on the resulting sampling.

2. Linked to this, it was also found that in a small number of cases, there were multiple occupants of the same address of different ethnic groups. Whilst this was not a key issue given the small number of instances, it did mean that interviewers allocated to specific ethnic groups would find themselves visiting addresses that had been visited by an interviewer at a previous time.

In the future it would just be important to ensure these types of addresses are identified up front and allocated to just one interviewer (albeit across different ethnic groups).

3. By cleaning up the addresses prior to sampling, this would also have avoided an issue whereby interviewers were given part-completed addresses from which to find people – these would have been removed from the list prior to sampling. Anecdotally, interviewers also found that they were approaching an address to speak to a specific person only to find that the person lived in another property close by (i.e. in another flat in the block).

4. A key limiting factor of the method was the sampling of student accommodation, particularly in the African, Chinese and Indian samples. Approximately 10%-15% of the sample was deemed unusable because interviewers could not get access to the student accommodation. In the future, it might be worth NHSGGC engaging with the various institutions across Glasgow to gain permission to access students through the wardens of such accommodation.

5. In terms of the effectiveness of Onomap at identifying the appropriate ethnicity of an individual, a total of 743 of the 6500 people were found to not be the ethnic group they were allocated to through Onomap. This only affected 4 of the Pakistani sample, but was particularly less effective for the Indian sample (257 incorrectly matched). Anecdotally, the interviewers found that Polish names were being allocated where people were from Baltic countries such as Estonia and Latvia.

6. A further limitation was the time lag between acquiring the names/addresses from CHI and the subsequent visit from an interviewer. Clearly, the longer the time lag the more likely the person is to no longer live at the property – this will be more of an issue for transient populations such as Polish and African. A total of 508 of the 6500 people were found to no longer live at the property (or never lived at the property).

Call outcomes and response rates

The following table provides a breakdown of the call outcomes. The response rate can be calculated as the number of interviews achieved from valid people issued (1798 from 4547), which is 40%, or as an adjusted response rate based on the number of achieved interviews where contact was actually made with the person, which is 73% (1798 from 2465).

Table A4: Call outcomes and response rates

Label	AFRICAN	CHINESE	INDIAN	PAKISTANI	POLISH
Interview obtained	370	372	300	380	376
No reply	178	84	14	156	248
Call back/appointment	11	6	3	123	16
Hard refusal	9	3	49	18	16
Refused - doesn't do face to face surveys	3	1	1	1	4
Refused - nature of subject / topic		3	3	1	1
Refused - no time	9	9	15	15	9
Refused - no reason / other	6	5	12	2	7
Refusal given on behalf of selected person	2	5	60	5	6
Refused - Illness			2	6	2
Refused - has dementia					
Broken appointment					
Away/in hospital during survey period	2			3	1
Language required (specify below)		16			6
Insufficient address	19	1	5	2	1
Can't find address	1	1	5	1	9
Not yet built/not yet ready for occupation					
Derelict/demolished	3	6	3	1	1
Empty	19	6	40	4	11
Business premises		4	2		
Institution only		1			
No-one aged 16+	1				
Exhausted contact			32		
Other (specify)	5	2	35	2	11
Unable to interview - not the chosen ethnic group	189	129	257	4	164
Named contact has moved/doesn't live at address	102	65	160	130	51
Call back named contact not home/available	8	4		44	28
Can't get access to property (i.e. student accommodation)	176	181	170	45	78
Five knocks	5	14	25	5	1
Household refusal	36	26	43	60	25
Not Used	164	108	2	428	269
Opt Out					
Parked	45	48	1	1	20

Quality checking overview

In total, 206 of the 1798 cases were back checked (83% of interviews had a valid telephone number recorded for this purpose). The back checking procedure involves, predominantly, telephoning respondents to check the validity and conduct of the interview. The following types of information are checked with respondents:
Name, address and ethnicity.
Conduct of the interviewer (politeness, showed ID badge, whether the interiewer tried to influence the answers).
Other details concerning the interview (were showcards used, was the interview conducted in home or at the doorstep, was a leaflet left behind).
Three pieces of information provided by the respondent during the interview are re-checked for consistency. These were age, disability status and number of people in the household.

9 APPENDIX B: DATA WEIGHTING

Data were weighted to ensure that they were as representative as possible of the known adult BME population in Glasgow City across the five groups.

Data were weighted to the BME population profile from the NHS CHI records (from February 2016) in terms of:

- Ethnicity group (Polish, Indian, Pakistani, Chinese, African);
- Gender (Male, Female)
- Age (Under 35, 35 and over)
- Deprivation (Bottom 15% datazone, other datazones).

The formula for the weighting process was:

$$Wi = \frac{ei}{E} \times \frac{T}{ti}$$

Where:

W_i is the individual weighting factor for a respondent in age/gender/deprivation/ethnic group group i

e_i is the known adult population in age/gender/deprivation/ethnic group i

E is the total adult population in Glasgow City across for the five ethic groups

T is the total number of interviews

t_i is the number of interviews for age/gender/deprivation/Ethnic group i

The resultant weighting factor, when applied to the data returned the achieved sample to be representative of the BME population, as shown in the table below.

	Profile of BME Population (from CHI) across 5 largest BME groups	Unweighted survey sample	Weighted survey sample
Pakistani	33.3%	21.1%	33.3%
Indian	16.8%	16.7%	16.8%
Chinese	24.5%	20.7%	24.4%
African	9.1%	20.6%	9.1%
Polish	16.4%	20.9%	16.4%
Males	56.7%	46.3%	56.7%
Females	43.3%	53.7%	43.3%
Bottom 15% datazones	29.4%	46.1%	29.4%
Other datazones	70.6%	53.9%	70.6%
16-34 years	58.6%	51.0%	58.6%
35+	41.4%	49.0%	41.4%

APPENDIX C: INDEPENDENT VARIABLES

The table below lists the seven independent variables used for the analysis in this report, showing for each the number of categories and how these categories were formed.

Independent Variable	Number of categories	Categories
Ethnicity	5	Polish; Indian; Pakistani; Chinese; African
Age Group	3	16-34; 35-54; 55+
Gender	2	Men; Women
Gender and Ethnicity	10	Polish men; Polish women; Indian men; Indian women; Pakistani men; Pakistani women; Chinese men; Chinese women; African men; African women
Deprivation	2	15% most deprived datazones; Other datazones
How Well Speak English	2	Speak English very/fairly well; Do not Speak English well/not at all well
Length of Residency in the UK	2	Lived in the UK for less than 10 years; Lived in the UK for 10 years or more

10 APPENDIX D: ASSUMPTIONS OF NUMBER OFUNITS OF ALCOHOL IN EACH TYPE OF DRINK (1999-2005 and 2008-2014)

The table below shows the assumed number of units of alcohol in each type of drink that were used for the calculation of unit consumption.

	Unit assumption
Normal strength beer - pints	2.80
Normal strength beer - cans	2.20
Normal strength beer bottles	1.70
Strong beer - pints	3.40
Strong beer - cans	2.60
Strong beer - bottles	2.00
Extra strong beer - pints	5.10
Extra strong beer - cans	4.00
Extra strong beer - bottles	3.00
Single measures spirits	1.00
Single measure martini/sherry/buckfast etc	1.00
Small glass wine	1.75
Large glass wine	3.50
1/2 bottle wine	5.25
Full bottle wine	10.50
Small bottle of alcopops	1.40
Large bottle of alcopops	5.45

11 APPENDIX E: ANNOTATED SURVEY QUESTIONNAIRE

The survey questionnaire is presented here. Where relevant, questions show:

- The number of respondents who answered the question (with "don't know", refused and missing responses removed). These are **unweighted** and shown as "(N=)" after the question;

- The percentage of respondents who gave each response. These are **weighted**.

In some cases, the mean response rather than the percentage giving individual responses is given. These are also weighted.

NHS Greater Glasgow & Clyde 2016
Health and Wellbeing Survey

Good morning \ afternoon, my name is … and I'm from BMG Research. BMG Research is an independent research company who work to the Market Research Society (MRS) code of conduct. We are carrying out research on behalf of the NHS Greater Glasgow and Clyde. The survey is about your health including issues such as diet, exercise and the area you live in and is a follow up to a similar study conducted in 2004.

We are interested in speaking to people of an Indian, Pakistani, Chinese, Polish or African background.

Would you be willing to take part in the survey? The questionnaire will take between 25 to 30 minutes [book appointment if not convenient now].

Can I check if you are able to complete this survey in English? If not, use the crib sheet to agree one of the following options:

- Interviewer is able to conduct the interview in the chosen language
- Another person in the household can help to translate/interpret the interview
- Do they wish to take part at another time if an interpreter could be used
- Agree to conduct the interview there and then using 'language line'

BMG Research will only use your details for the purpose of this survey, and for quality checking the interviews.

The anonymised findings from the survey may be published. The data will only be used for the purposes specified and in terms of the Data Protection Act 1998. Please note that no individual will be identified through the data and findings from the survey, unless your permission is otherwise sought.

IF RESPONDENT REQUIRES FURTHER CLARIFICATION THAT BMG RESEARCH IS A GENUINE MARKET RESEARCH COMPANY THEY CAN CALL MRS ON 0500 39 69 99.

INTERVIEWER NOTE: RESPONDENT MUST BE AGED 16 OR OVER

Section 1: Screening question

We are interested in speaking to people of an Indian, Pakistani, Chinese, Polish or African background.

S1. Firstly, which of the groups on this card best describes you? **SHOWCARD 1 AND CODE ONE ONLY [Q59] ALL S/C N=1,798**

White	
Scottish	-
Other British	-
Irish	-
Gypsy/Traveller	-
Polish	16.4
Other White ethnic group, please specify **LIST**	-
Mixed	
Any mixed or multiple ethnic background, please specify **LIST**	-
Asian, Asian Scottish, or Asian British	
Indian, Indian Scottish or Indian British	16.8
Pakistani, Pakistani Scottish or Pakistani British	33.3
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	-
Chinese, Chinese Scottish or Chinese British	24.4
Other, please specify **LIST**	-
African	
African, African Scottish or African British	8.8
Other, please specify **LIST**	0.2
Caribbean or Black	
Caribbean, Caribbean Scottish or Caribbean British	-
Black, Black Scottish or Black British	-
Other, please specify **LIST**	
Other Ethnic group	
Arab, Arab Scottish or Arab British	-
Other, please specify **LIST**	-
Don't know	-
Refused	-

Only continue if the respondent is from an Indian, Pakistani, Chinese, Polish or African background (Q1/5,8,9,11,13,14).

QN1. Where were you born? TYPE IN BELOW (OR SINGLE CODE) [New] ALL C/F
N=1,796

Other responses	82.5
UK	17.5
Don't know	n/a
Refused	n/a

QN2. How long have you lived in the UK? **CODE ONE ONLY [New]** **QN1/NOT UK S/C**
N=1,556

1	Less than 1 year	15.9
2	1 – 4 years	21.5
3	5 – 9 years	19.0
4	10 years or more	43.6
5	Don't know	n/a

S2. Interviewer to record gender **[Q43]** **ALL S/C**
N=1,798

Male	56.7
Female	43.3

S3. A) Please can you tell me your date of birth? **[Q44]** **ALL LIST & C/F AS BELOW**

DD/MM/YYYY _____
998: Refused

(b**) IF YOU'D PREFER NOT TO ANSWER**: Would you mind indicating which age band you fit into? SHOWCARD 2 **AND CODE ONE ONLY** S3a/REF S/C
N=1,795

16-19	8.7
20-24	18.7
25-29	13.2
30-34	18.0
35-39	10.2
40-44	8.7
45-49	6.4
50-54	4.8
55-60	3.9
61-70	5.2
71-74	0.8
75+	1.5
Refused	n/a

Section 2: General health
ASK ALL

1. I'd like to start by asking you some questions about your health. How would you describe your health? **READ OUT AND CODE ONE ONLY ALL S/C N=1,797**

Very good	27.3
Good	53.1
Fair	13.0
Bad	4.9
Very bad	1.7
Don't know	n/a

2. Do you have any long-term condition or illness that substantially interferes with your day to day activities? **CODE ONE ONLY ALL S/C N=1,796**

Yes	15.1	GO TO Q3
No	84.9	GO TO Q5
Refused	n/a	GO TO Q5

3. Thinking of these conditions and/or illnesses, would you describe yourself as having…? **READ OUT AND CODE ALL THAT APPLY Q2/1 M/C N=1,793**

A physical disability	5.7	GO TO Q4
A mental or emotional health problem	1.7	GO TO Q4
A long-term illness	11.3	GO TO Q5
Don't know	n/a	GO TO Q5

4. How much does it (do they) interfere with the following activities (seriously, moderately, or doesn't)? **SHOWCARD 3, READ OUT AND CODE ONE PER ROW Q3/1-2 S/C PER ROW**

		Seriously Interferes	Moderately Interferes	Does not Interfere	Not applicable
A	Taking up training or education **N=84**	33.5	26.0	40.5	n/a
B	Holding down or obtaining a job **N=98**	46.0	19.7	34.2	n/a
C	Taking exercise/physical activity **N=121**	49.8	30.0	20.2	n/a
D	Socialising **N=121**	37.8	34.7	27.5	n/a
E	Everyday chores **N=123**	44.7	27.7	27.6	n/a

Section 3: Health screening

ASK QN3 WHERE FEMALE AGED 20 TO 60

QN3. Have you ever been invited for a Cervical Screening (smear test)? **CODE ONE ONLY N=833**

Yes	58.4	GO TO QN4
No	41.6	GO TO QN6
Don't know	n/a	GO TO QN6
Refused	n/a	GO TO QN6

QN4. Did you attend the Cervical Screening (smear test)? **CODE ONE ONLY QN3/1 S/C N=539**

Yes	86.7	GO TO QN6
No	13.3	GO TO QN5
Refused	n/a	GO TO QN6

QN5. Why did you not attend the Cervical Screening? **DO NOT PROMPT AND CODE ALL THAT APPLY** QN4/2 M/C N=60

Appointment times inconvenient	8.9
Embarrassment	8.9
Modesty issues	<8.9
Goes against my culture / beliefs	0.0
Gender of the clinician	0.0
Do not have time/too busy	37.5
Do not know how to make an appointment	8.9
Location difficult to get to	0.0
Other (please specify) **BACKCODE AND CLEAN**	28.6
Don't know	n/a

ASK QN6 WHERE FEMALE AGED 50 TO 70

QN6. Have you ever been invited for Breast Screening? **CODE ONE ONLY N=120**

Yes	78.8	GO TO QN7
No	21.2	GO TO QN9
Don't know	n/a	GO TO QN9
Refused	n/a	GO TO QN9

QN7. Did you attend the Breast Screening? **CODE ONE ONLY QN6/1 S/C N=93**

Yes	90.4	GO TO QN9
No	9.6	GO TO QN8
Refused	n/a	GO TO QN9

QN8. Why did you not attend the Breast Screening? **DO NOT PROMPT AND CODE ALL THAT APPLY** QN7/2 M/C N=10

(too few responses for breakdown)

Appointment times inconvenient	
Embarrassment	
Modesty issues	
Goes against my culture / beliefs	
Gender of the clinician	
Do not have time/too busy	
Do not know how to make an appointment	
Location difficult to get to	
Other (please specify) **BACKCODE AND CLEAN**	
Don't know	

ASK QN9 WHERE AGED 50 TO 74
QN9. Have you ever been invited for Bowel Screening? **CODE ONE ONLY N=248**

Yes	63.6	GO TO QN10
No	36.4	GO TO QN12
Don't know	n/a	GO TO QN12
Refused	n/a	GO TO QN12

QN10. Did you complete the home test? **CODE ONE ONLY QN9/1 S/C N=157**

Yes	67.5	GO TO QN12
No	32.5	GO TO QN11
Refused	n/a	GO TO QN12

QN11. Why did you not complete the home test? **DO NOT PROMPT AND CODE ALL THAT APPLY** QN10/2 M/C **N=40**

Didn't understand the instructions	10.2
Embarrassment	<10.2
It is disgusting/dirty	11.2
Goes against my culture / beliefs	0.0
Fear/don't want to know the result	<10.2
Do not have time/ too busy	25.9
I didn't receive (or haven't yet received) the home test	7.2
Other (please specify) **BACKCODE AND CLEAN**	36.3
Don't know	n/a

ASK ALL
QN12. Have you ever used the interpreting service for appointments with the NHS (general practitioner or hospital services)? **CODE ONE ONLY ALL S/C N=1,795**

Yes	11.7	GO TO QN13
No	88.3	GO TO Q5
Don't know	n/a	GO TO Q5
Refused	n/a	GO TO Q5

QN13. Where was your appointment? If you have used the interpreting service more than once, please consider your most recent occasion. **SHOWCARD 4, AND CODE ONE ONLY QN12/1 S/C N=269**

GP Practice	54.6
Dentist	3.8
Optician	<2.2
Outpatient clinic	<2.2
Hospital / ward inpatient	39.2
Mental health service	0.0
Maternity service	<2.2
Other (please specify) **BACKCODE AND CLEAN**	<2.2
Can't remember	n/a

ASK ALL

5. Do you have any illnesses or conditions for which you are currently being treated? If so, please indicate which number(s) from the card. **SHOWCARD 5 AND CODE ALL THAT APPLY ALL M/C N=1,791**

	Coronary heart disease (CHD)/Ischemic heart disease (IHD)/Myocardial Infarction (MI, heart attack)	2.5
	Stroke	0.3
	Arthritis; rheumatism; painful joints	6.7
	Osteoporosis	<0.3
	Chronic pain	2.2
	Clinical depression	1.4
	Diabetes	5.6
	Cancer	0.3
	Asthma, bronchitis, or persistent cough	5.3
	Epilepsy	<0.3
	Acquired brain injury	<0.3
	Stress related conditions, e.g. difficulty sleeping or concentrating	2.7
	Severe hearing problems	0.8
	Severe eyesight problems	0.6
	Accident / injury	0.6
	Gastro-intestinal problems, e.g. peptic ulcer disease, irritable bowel syndrome	2.8
	High blood pressure	6.1
	Drug or alcohol related conditions	<0.3
	HIV	<0.3
	Sexually transmitted infections, e.g. gonorrhoea, syphilis, chlamydia	<0.3
	Chronic Obstructive Pulmonary Disease (COPD)	<0.3
	Other, please specify BACKCODE AND CLEAN	6.6
	None	74.2
	Refused	n/a

6. QUESTION 6 HAS BEEN REMOVED

PASS CAPI MACHINE TO RESPONDENT FOR SELF-COMPLETION OF Q7. ENCOURAGE THE RESPONDENT TO SELF-COMPLETE, BUT DON'T INSIST ON IT IF THEY WOULD PREFER YOU TO COMPLETE IT ON THEIR BEHALF.

Section 4: Wellbeing

7. Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks. **SHOWCARD 6, AND CODE ONE PER ROW ALL S/C PER ROW**

	None of the time	Rarely	Some of the time	Often	All of the time	Not provided
I've been feeling optimistic about the future **N=1,796**	6.7	8.5	27.2	36.9	20.7	n/a
I've been feeling useful **N=1,795**	2.4	5.6	23.0	42.9	26.1	n/a
I've been feeling relaxed **N=1,795**	1.9	9.5	31.2	38.8	18.6	n/a
I've been interested in other people **N=1,795**	3.5	7.7	30.3	39.4	19.1	n/a
I've had energy to spare **N=**	3.2	11.4	34.1	34.5	16.9	n/a
I've been dealing with problems well **N=1,795**	2.3	6.7	23.7	46.0	21.4	n/a
I've been thinking clearly **N=1,795**	0.9	4.1	18.4	44.4	32.3	n/a
I've been feeling good about myself **N=1,795**	0.9	5.5	20.0	44.8	28.8	n/a
I've been feeling close to other people **N=1,795**	1.4	6.2	22.5	42.8	27.1	n/a
I've been feeling confident **N=1,796**	1.2	4.3	23.5	42.5	28.5	n/a
I've been able to make up my own mind about things **N=1,796**	0.8	2.6	16.6	46.1	33.8	n/a
I've been feeling loved **N=1,796**	0.9	2.7	15.6	42.7	38.2	n/a
I've been interested in new things **N=1,794**	1.0	5.3	21.1	42.8	29.8	n/a
I've been feeling cheerful **N=1,796**	0.8	4.3	19.3	48.3	27.3	n/a

PLEASE CAN YOU NOW PASS BACK THE COMPUTER TO THE INTERVIEWER. THANK YOU.

Section 4: Lifestyle

READ OUT: Now I would like to ask you some questions about your lifestyle.

8. How often are you in places where there is smoke from other people smoking tobacco? **READ OUT AND CODE ONE ONLY ALL S/C N=1,796**

Most of the time	11.9
Some of the time	17.3
Seldom	20.8
Never	50.1
Don't know	n/a

9. Which of the following statements best describes you at present? SHOWCARD 7 AND CODE ONE ONLY ALL S/C N=1,798

I have never smoked tobacco	73.6	GO TO QN14
I have only tried smoking once or twice	2.9	GO TO QN14
I have given up smoking	7.9	GO TO QN14
I smoke some days	4.3	GO TO Q10
I smoke every day	11.3	GO TO Q10

10. Do you intend to stop smoking? **CODE ONE ONLY Q9/4-5 S/C N=277**

Yes	44.5
No	38.8
Possibly	16.7

ASK ALL

QN14. Have you smoked shisha (hookah) in the last year? **READ OUT AND CODE ONE ONLY ALL S/C N=1,796**

	Yes – every day	0.4
	Yes – some days	2.5
	Once or twice	3.9
	No	93.2
	DNRO: Don't know	n/a

11. Have you used an e-cigarette in the last year? **READ OUT AND CODE ONE ONLY ALL S/C N=1,797**

	Yes – every day	2.3
	Yes – some days	3.6
	Once or twice	2.6
	No	91.4
	DNRO: Don't know	n/a

12. To what extent do you agree or disagree with the following statements? **SHOWCARD 8 AND CODE ONE PER ROW ALL S/C PER ROW**

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
e-cigarettes encourage people to stop smoking **N=1,276**	5.8	35.4	21.1	27.6	10.1	n/a
e-cigarettes encourage people to start smoking **N=1,203**	4.4	29.8	23.0	33.7	9.1	n/a
e-cigarettes are harmless to health **N=1,159**	4.1	23.9	25.1	32.7	14.2	n/a
e-cigarettes are just as harmful to health as normal cigarettes **N=1,155**	5.5	27.3	27.8	34.3	5.1	n/a
e-cigarettes are helping smoking to become more acceptable **N=1,179**	5.3	41.5	28.9	19.3	5.0	n/a

13. How often do you drink alcohol? SHOWCARD 9 AND CODE ONE ONLY ALL S/C N=1,797

Never	64.0	GO TO Q18
Less than once a month	17.1	GO TO Q14
More than once a month but not weekly	8.7	
1-2 days per week	8.1	
3-5 days per week	0.9	
6-7 days per week	1.1	
Refused	n/a	

14. Have you had a drink containing alcohol in the past 7 days? **CODE ONE ONLY Q13/2-7 S/C N=1,095**

Yes	34.5	GO TO Q15
No	65.5	GO TO Q16

15. Please tell me how much, if any, of the following on this card you drank on each day in the past week. **SHOWCARD 10, START WITH THE PREVIOUS DAY AND WORK BACK THROUGH THE WEEK Q14/1 LIST**

	MON		TUES		WED		THURS		FRI		SAT		SUN	
Normal strength beer/lager/stout/cider (e.g. McEwan's lager, heavy)														
Pints														
Cans														
Bottles														
Strong beer/lager/cider (e.g. Guinness, Murphy's, Budweiser)														
Pints														
Cans														
Bottles														
Extra strong beer/lager/ cider (e.g. Tennant's super lager)														
Pints														
Cans														
Bottles														
Single measures of spirits (e.g. whiskey, gin, vodka) (a bottle contains 28 measures)														
Single measures of Martini/sherry/buckfast/Mad Dog 20/20 (a bottle contains 14 measures)														
Glasses of wine														
Small Glass														
Large Glass														
½ bottle														
Full bottle														
Small bottles (300ml) of alcoholic carbonate (alcopops, such as Smirnoff Ice and Bacardi Breezer)														
Large bottles (1.5litre) of alcoholic carbonate (alcopops, such as Smirnoff Ice and Bacardi Breezer)														
Have you drank any other alcoholic drink in the past week? Yes/No If Yes, Interviewer write what it is and how many each day														

ASK Q16-17 OF THOSE WHO ANSWERED 2-6 AT Q13.

READ OUT: For the next few questions I will be referring to a night out and by this I mean an evening with family or friends away from home (or their home).

16. Do you ever drink alcohol (either alone or with others) before going on a night out?
READ OUT AND CODE ONE ONLY Q13/2-6 S/C N=702

	Yes	17.8	GO TO Q17
	No	82.2	GO TO Q18

17. What are the reasons you have a drink before a night out? **READ OUT AND CODE ALL THAT APPLY Q16/1 M/C N=109**

	It makes the night better	27.6
	It makes the night cheaper	44.9
	It provides a chance to socialise with friends and family	36.2
	Other, please specify BACKCODE AND CLEAN	4.0
	Don't know	n/a

ASK ALL

18. I'm going to read out some statements, please tell me how much you agree or disagree with each of them? **READ OUT AND ONE CODE PER ROW ALL S/C PER ROW**

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
Getting drunk is a perfectly acceptable thing to do **N=1,767**	1.9	6.8	8.3	30.6	52.4	n/a
It is easier to enjoy a social event if you've had a drink of alcohol **N=1,747**	2.3	21.1	11.1	21.7	43.8	n/a

19. Have you ever had alcohol delivered to your home from any of the following places? **READ OUT AND CODE ALL THAT APPLY ALL M/C N=1,791**

	A supermarket	2.1
	A food takeaway	<0.3
	24 hour alcohol delivery service (e.g. dial-a-booze)	<0.3
	A taxi firm	0.0
	Other (please specify) BACKCODE AND CLEAN	<0.3
	None of these	n/a
	Don't know	n/a

20. Thinking about the number of places you can buy alcohol in your local area (for example, off-licences, local grocers, supermarkets, pub, restaurants, etc) in your opinion are there...? **READ OUT AND CODE ONE ONLY ALL S/C N=1,546**

	The right amount	60.1
	Too many	27.9
	Too few	12.0
	Don't know	n/a

21. Now I'd like to ask you some questions about the food you eat. Yesterday, how many portions of fruit did you eat? Examples of a portion are one apple, one tomato, 3 tablespoons of canned fruit, one small glass of fruit juice.

(WRITE NUMBER IN BOX. IF LESS THAN ONE, WRITE '0'; IF DON'T KNOW CODE AS 997) ALL LIST

WRITE NUMBER IN THE BOX: N=1,779 | | |

Mean=2.08

22. Yesterday, how many portions of vegetables or salad (not counting potatoes) did you eat? A portion of vegetables is 3 tablespoons.

(WRITE NUMBER IN BOX. IF LESS THAN ONE, WRITE '0'; IF DON'T KNOW CODE AS 997) ALL LIST

WRITE NUMBER IN THE BOX: N=1,783 | | |

Mean=2.03

PASS CAPI MACHINE TO RESPONDENT FOR SELF-COMPLETION OF Q23-24. ENCOURAGE THE RESPONDENT TO SELF-COMPLETE, BUT DON'T INSIST ON IT IF THEY WOULD PREFER YOU TO COMPLETE IT ON THEIR BEHALF.

23. What is your weight?

(WRITE WEIGHT IN STONES/POUNDS OR KILOGRAMS. IF UNSURE, ASK FOR ESTIMATE. IF DON'T KNOW CODE AS 997, IF REFUSED CODE AS 998.) ALL LIST

a. Stones / pounds | | | | Stones | | | | Pounds

Or

b. Kilograms | | | |

24. What is your height?

(WRITE IN HEIGHT IN FEET/INCHES OR CENTIMETRES. IF UNSURE, ASK FOR ESTIMATE. IF DON'T KNOW CODE AS 997, IF REFUSED CODE AS 998.) ALL LIST

a. Feet / inches | | | | Feet | | | | Inches

Or

b. Centimetres | | | |

Section 5: Physical activity

Moving on, we're now going to discuss issues relating to physical activity.
READ OUT: Physical activity is a broad term. It can be as simple as walking. There are many types of physical activity: exercise, sport, play, dance and active living such as walking, housework and gardening.

25. In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate?

The 30 minutes can be obtained by adding smaller bouts of not less than ten minutes.
The activity may include sport, exercise, and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that may be part of your job.

(WRITE NUMBER OF DAYS IN BOX, IF DON'T KNOW CODE AS 97) ALL LIST

WRITE NUMBER IN THE BOX: N=1,788

0	1	2	3	4	5	6	7
33.3	6.9	11.8	13.8	8.4	9.3	4.5	11.9

ASK Q26 IF CODED 4 DAYS OR LESS AT Q25

26. Have you been physically active for at least two and a half hours (150 minutes) over the course of the past week? **CODE ONE ONLY [Q27] Q25/LESS THAN 5 S/C N=1,375**

Yes	61.5
No	38.5

ASK Q27 IF CODED 4 DAYS OR LESS AT Q25 AND CODED NO (2) AT Q26

27. Including **ALL** types of physical activity you take. In the past week, on how many days have you done at least 30 minutes of moderate physical exercise such as brisk walking? It doesn't have to be 30 minutes all at once. **(INCLUDE YOUR HOUSEWORK AND PHYSICAL ACTIVITY THAT IS PART OF YOUR JOB) (WRITE NUMBER OF DAYS IN BOX, IF DON'T KNOW CODE AS 97) [Q26] Q25/LESS THAN 5 AND Q26/2 LIST**

WRITE NUMBER IN THE BOX: N=477

0	1	2	3	4	5	6	7
28.2	8.5	16.7	18.2	8.2	5.5	1.7	13.0

28. QUESTION 28 HAS BEEN REMOVED

Section 6: Yourself and your local area
I'd now like to ask you some questions about yourself and your local area.

29. Looking at the faces on the card...? SHOWCARD 11, READ OUT A-C AND CODE ONE FOR EACH ROW ALL S/C PER ROW

		1	2	3	4	5	6	7	Don't Know
A	Which face best rates your overall quality of life? **N=1,792**	36.0	40.4	15.3	5.5	1.8	0.5	0.5	n/a
B	Which face best rates your general physical well being? **N=1,792**	33.9	36.0	16.1	6.4	4.0	2.4	1.3	n/a
C	Which face best rates your general mental or emotional well being? **N=1,791**	40.8	39.2	10.5	5.0	2.3	1.3	0.9	n/a

30. I'm going to ask you some questions about various things that may or may not be a problem in your local area. Which face best describes how you feel about…? **SHOWCARD 11, READ OUT A–E AND CODE ONE FOR EACH ROW ALL S/C PER ROW N=1,792**

		1	2	3	4	5	6	7	Don't Know
A	The level of unemployment in your area **N=1,347**	7.4	24.0	20.0	27.7	12.9	7.6	6.4	n/a
B	The amount of drug activity in your area **N=1,472**	9.0	22.7	16.8	15.2	11.7	12.3	12.3	n/a
C	The level of alcohol consumption in your area **N=1,596**	6.5	20.7	17.9	17.2	14.4	11.8	11.6	n/a
D	People being attacked or harrassed because of their skin colour, ethnic origin or religion **N=1,700**	20.4	39.8	17.2	9.2	6.7	2.6	4.1	n/a
E	The amount of troublesome neighbours in your area **N=1,737**	27.2	41.6	14.3	7.0	5.1	2.0	2.8	n/a

31. Now I'd like to ask you about environmental issues that may or may not be a problem in your area. Which face best describes how you feel about…? **SHOWCARD 11, READ OUT A–D AND CODE ONE FOR EACH ROW ALL S/C PER ROW**

		1	2	3	4	5	6	7	Don't know
A	The amount of rubbish lying about in your area **N=1,785**	11.4	24.6	14.7	13.1	12.5	11.3	12.3	n/a
B	The amount of dog's dirt in your area **N=1,774**	11.3	26.0	18.3	12.5	13.0	9.8	9.1	n/a
C	The availability of safe play spaces in your area **N=1,669**	14.8	32.7	21.5	14.3	6.8	4.7	5.2	n/a
D	The availability of pleasant places to walk in your area **N=1,780**	16.9	37.3	21.7	12.0	5.8	3.9	2.5	n/a

32. How much do you agree or disagree with the following statements about living in this local area? **SHOWCARD 12, READ OUT A-G AND CODE ONE FOR EACH ROW ALL S/C PER ROW**

		Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
A	This is a neighbourhood where neighbours look out for each other **N=1,743**	14.2	58.6	16.9	10.3	2.0	n/a
B	I feel I belong to this local area **N=1,777**	18.7	53.1	16.8	10.0	1.4	n/a
C	The friendships and associations I have with other people in my local area mean a lot to me **N=1,772**	17.8	55.6	15.7	9.8	1.2	n/a
D	I feel valued as a member of my community **N=1,714**	10.9	51.1	25.7	10.5	1.8	n/a
E	Generally speaking, I can trust people in my local area **N=1,752**	8.9	50.5	24.5	12.5	3.6	n/a
F	By working together, people in my neighbourhood can influence decisions that affect my neighbourhood **N=1,640**	15.7	55.9	18.5	6.5	3.4	n/a
G	If I have a problem, there is always someone to help me **N=1,777**	19.5	60.3	11.4	6.8	2.0	n/a

33. Do you ever feel isolated from family and friends? **CODE ONE ONLY ALL S/C N=1,789**

Yes	11.5
No	88.5

Refused	n/a

34. Thinking back over the last 12 months, have you given up any time to help any clubs, charities, campaigns or organisations in an unpaid capacity? **CODE ONE ONLY ALL S/C N=1,798**

Yes	16.0
No	84.0

35. Do you belong to any social clubs, associations, church groups or anything similar? **CODE ONE ONLY ALL S/C N=1,798**

Yes	18.0
No	82.0

36. In the last 12 months, have you taken any of the following actions in an attempt to solve a problem affecting people in your local area? **SHOWCARD 13 AND CODE ALL THAT APPLY ALL M/C N=1,763**

	Contacted any media, organisation, council, councillor or MP	5.1
	Attended a public meeting, tenants/residents group, protest meeting or action group	3.0
	Organised a petition on a local issue	1.0
	There are no local problems	12.9
	Other, please specify BACKCODE AND CLEAN	<0.3
	None of the above	92.1
	Don't know	n/a

37. What would you say is the main reason some people in this area live in poverty? **SHOWCARD 14 AND CODE ONE ONLY ALL S/C N=1,448**

	An inevitable part of modern life	5.1
	Laziness or lack of willpower	36.4
	Because they have been unlucky	2.4
	Because of injustice in society	2.2
	Lack of jobs	2.2
	There is no one living in poverty in this area	26.4
	Other, please specify BACKCODE AND CLEAN	19.9
	None of the above	1.1
	Don't know	6.4

38. Please look at the card I've given you and tell me what you think of the quality of services in your area? **SHOWCARD 15, READ OUT AND CODE ONE PER ROW ALL S/C PER ROW**

		Excellent	Good	Adequate/OK	Poor	Very Poor	Don't know
A	Food shops **N=1,788**	18.9	57.8	17.4	4.8	1.1	n/a
B	Local schools **N=1,521**	16.5	58.9	20.2	3.7	0.7	n/a
C	Public transport **N=1,708**	21.2	55.8	16.1	5.2	1.7	n/a
D	Activities for young people **N=1,509**	7.5	42.7	32.1	13.3	4.4	n/a
E	Leisure / sports facilities **N=1,597**	10.0	44.5	29.0	11.5	5.0	n/a
F	Childcare provision **N=1,102**	9.9	42.6	37.8	7.7	2.0	n/a
G	Police N=1,691	12.2	55.6	26.2	4.8	1.1	n/a

39. How much do you agree or disagree with the following statements about safety in this local area? **SHOWCARD 16, READ OUT AND CODE ONE PER ROW ALL S/C PER ROW**

		Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know
A	I feel safe using public transport in this local area **N=1,674**	29.0	60.0	6.8	3.7	0.4	n/a
B	I feel safe walking alone around this local area even after dark **N=1,773**	20.0	47.4	13.8	13.9	4.9	n/a

40. Could you tell me if you have been a victim of each of these crimes in the last year? Just to reiterate, your responses to this survey will remain confidential unless your permission is explicitly given. **SHOWCARD 17, READ OUT AND CODE ONE PER ROW. DO NOT ASK 'DOMESTIC VIOLENCE' IF THE PARTNER IS IN THE ROOM TOO – CODE AS REFUSED. ALL S/C PER ROW**

	Yes	No	Don't know	Refused
Anti-social behaviour **N=1,777**	5.2	94.8	n/a	n/a
Any type of theft or burglary **N=1,775**	3.6	96.4	n/a	n/a
Vandalism **N=1,774**	3.4	96.6	n/a	n/a
Domestic violence **N=1,764**	0.6	99.4	n/a	n/a
Physical attack **N=1,777**	1.3	98.7	n/a	n/a

Section 7: About you and your household

These questions explore some details about you and your household.

41. Now I'd like to ask you about the members of your household. How many people are there in this household (including yourself)? **ALL LIST**

WRITE NUMBER IN THE BOX: N=1,777 | | |

Mean = 3.84

42. How many people living in your household are aged under 16? **ALL LIST**

WRITE NUMBER IN THE BOX: N=1,781 | | |

Mean = 0.94

43. QUESTION 43 HAS BEEN MOVED
44. QUESTION 44 HAS BEEN MOVED

45. Which of the following best describes your employment situation? **SHOWCARD 18 AND CODE ALL THAT APPLY ALL M/C N=1,789**

	Employee in full-time job (35 or more hours per week)	30.5
	Employee in part-time job (less than 35 hours per week)	12.2
	Employed on a zero hours contract	0.4
	Self-employed – full or part time	5.1
	Government supported training or employment	0.4
	Unemployed and available for work	5.3
	Full-time education at school, college or university	25.8
	Part-time education at school, college or university	0.9
	Wholly retired from work	5.3
	Looking after the family/home	14.0
	Permanently sick/disabled	3.0
	Other, please specify _**BACKCODE AND CLEAN**_____	0.5
	Refused	n/a

ASK Q46 WHERE CODED 3 AT Q45

46. How long ago did you commence working on a zero hours contract? **CODE ONE ONLY Q45/3 S/C N=9**

(too few responses for breakdown)

In the past couple of days	
In the past week	
In the past month	
In the past 3 months	
In the past 6 months	
In the last year	
Over a year ago	
Don't know	

ASK ALL

47. What is the highest level of educational qualifications you've obtained? **SHOWCARD 19 AND CODE ONE ONLY ALL S/C N=1,782**

A	School leaving certificate, National Qualification Access Unit	3.2
B	'O' Grade, Standard Grade, GCSE, GCE O Level, CSE, National Qualification Access 3 Cluster, Intermediate 1 or 2 Senior Certificate or equivalent, National 4 or 5	10.4
C	GNVQ/GSVQ Foundation or Intermediate, SVQ Level 1 or 2, SCOTVEC/National Certificate Module, City and Guilds Craft, RSA Diploma or equivalent	3.8
D	Higher Grade, Advanced Higher, CSYS, 'A' Level, AS Level, Advanced Senior Certificate or equivalent	10.6
E	GSVQ/GSVQ Advanced, SVQ Level 3, ONC, OND, Scotvec National Diploma, BTEC First Diploma, City and Guilds Advanced Craft, RSA Advanced Diploma or equivalent	1.7
F	HNC, HND, SVQ Level 4, RSA Higher Diploma or equivalent	6.4
G	First Degree, Higher Degree, SVQ Level 5	28.5
H	Professional Qualifications e.g. teaching, accountancy	2.9
I	Other school examinations not already mentioned	4.1
J	Other post-school but pre-Higher education examinations/ Higher education qualifications not already mentioned, please specify BACKCODE AND CLEAN	1.0
K	No qualifications	27.3
L	Refused	n/a

QN15. Compared with most English speakers, how well do you feel you speak English? **READ OUT AND CODE ONE ONLY ALL S/C N=1,794**

Very well	51.0
Fairly well	31.0
Not very well	14.4
Not at all well	3.7
Don't know	n/a

Section 8: Welfare reform and the current economic situation

READ OUT: The UK government is making big changes to benefits and the way that they are paid.

48. Have you or your household been affected by welfare reform? **CODE ONE ONLY ALL S/C N=1,505**

Yes	3.3	GO TO Q49
No	96.7	GO TO Q50
Don't know	n/a	GO TO Q50

49. Is your household...? READ OUT AND CODE ONE ONLY Q48/1 S/C N=57

Financially better off under welfare reform	9.9
Financially worse off under welfare reform	65.9
Made no difference	24.2
Don't know	n/a

ASK ALL

50. Do you feel in control of decisions that affect your life, such as planning your budget, moving house or changing job? **READ OUT AND CODE ONE ONLY ALL S/C N=1,781**

Definitely	64.7
To some extent	26.2
No	9.1
Don't know	n/a

51. Have you spent money on any of the following in the last month? If so, when? **SHOWCARD 20, READ OUT AND CODE ONE PER ROW ALL S/C PER ROW**

	Yes in the last 24 hours	Yes more than 24 hours ago but within the last week	Yes, more than a week ago but in the last month	None	Refused
Any Lottery/scratchcard **N=1,792**	1.6	2.0	4.5	91.9	n/a
Bingo (not online) **N=1,794**	0.0	0.0	<0.3	>99.7	n/a
Bookmakers **N=1,794**	<0.3	<0.3	0.6	99.2	n/a
Casino N=1,793	<0.3	0.3	1.2	98.4	n/a
Any online (internet) gambling (including bingo, poker etc) **N=1,793**	<0.3	<0.3	0.5	99.1	n/a
Any other gambling – please specify **N=1,792** BACKCODE AND CLEAN	0.0	0.0	<0.3	>99.7	n/a

ASK Q52 WHERE CODED 1-3 AT Q51

52. How much money have you spent in the last month on these activities? **CODE ONE ONLY Q51/1-3 S/C N=185**

Less than £1.00	<2.3
£1.01 to £5.00	1.4
£5.01 to £20.00	49.1
£20.01 to £50.00	31.1
£50.01 to £100.00	3.9
£100.01 to £250.00	5.1
£250.01 to £500.00	4.4
£500.01 or more	2.7
Don't know	2.3
Refused	n/a

ASK ALL

53. How often, if at all, over the past year have you found it difficult to meet the cost of the following? **SHOWCARD 21 AND CODE ONE PER ROW ALL S/C PER ROW**

		Very Often	Quite Often	Occasionally	Never	Don't know	N/A	Refused
A	Rent/mortgage **N=1,494**	0.8	4.6	14.1	80.5	n/a	n/a	n/a
B	Gas, electricity and other fuel bills **N=1,553**	0.8	4.9	14.7	79.6	n/a	n/a	n/a
C	Telephone or mobile phone bill **N=1,641**	0.6	3.8	9.6	86.1	n/a	n/a	n/a
D	Council tax, insurance **N=1,462**	1.1	5.2	12.3	81.4	n/a	n/a	n/a
E	Food N=1,695	0.8	2.9	7.8	88.6	n/a	n/a	n/a
F	Treats N=1,665	2.5	6.3	11.0	80.2	n/a	n/a	n/a
G	Holidays **N=1,620**	5.5	8.0	15.9	70.6	n/a	n/a	n/a
H	Clothes and shoes **N=1,718**	0.8	4.4	12.8	82.0	n/a	n/a	n/a
I	Transport **N=1,693**	0.4	3.4	6.8	89.4	n/a	n/a	n/a
J	Credit card **N=819**	0.9	4.4	8.0	86.6	n/a	n/a	n/a
K	Loan repayments **N=548**	1.8	4.3	7.0	86.9	n/a	n/a	n/a

54. How would your household be placed if you suddenly had to find a sum of money to meet an unexpected expense such as a repair or new washing machine? How much of a problem would it be if it was £20? Or £100? Or £1,000? **SHOWCARD 22 AND CODE ONE PER ROW ALL S/C PER ROW**

		No Problem	A bit of a Problem	A big Problem	Impossible to Find	Don't know
A	£20 N=1,758	91.3	7.6	0.9	<0.3	n/a
B	£100 N=1,755	63.4	25.3	9.3	2.1	n/a
C	£1,000 N=1,720	25.8	24.5	33.2	16.6	n/a

55. Which of the following applies to your household? **SHOWCARD 23 AND CODE ONE ONLY ALL S/C N=1,779**

	Owner occupier / owned outright	13.4
	Owner occupier / buying with a mortgage	17.4
	Rented from council	1.9
	Rented from housing association	26.9
	Rented from a private landlord	36.7
	Shared ownership	<0.3
	Accommodation comes with the job	<0.3
	Other (please specify)__BACKCODE AND CLEAN_____	3.3
	Don't know	n/a

56. What proportion of your household income comes from state benefits? **SHOWCARD 24 AND CODE ONE ONLY ALL S/C N=1,635**

None	65.0
Very little	15.2
About a quarter	5.7
About a half	5.0
About three quarters	2.2
All	6.9
Don't know	n/a
Refused	n/a

57. Thinking of the total income of your household, which face on the scale indicates how you feel about the adequacy of that income? **SHOWCARD 25, IF DON'T KNOW PLEASE ENTER 997. IF REFUSED PLEASE ENTER 998. ALL LIST N=1,719**

WRITE NUMBER IN THE BOX: ☐

1	2	3	4	5	6	7
19.1	25.4	29.7	13.6	5.9	4.1	2.1

58. Outside work, are you responsible for caring for someone on a day to day basis? – e.g. a disabled child, elderly person. (Do not include 'ordinary' childcare.) **CODE ONE ONLY ALL S/C N=1,798**

Yes	4.9
No	95.1

59. QUESTION 59 HAS BEEN MOVED

60. Have you been discriminated against in the last year? **READ OUT AND CODE ONE ONLY ALL S/C N=1,788**

No	96.6	GO TO Q63
Yes, occasionally	2.4	GO TO Q61
Yes, on several occasions	1.0	
Prefer not to say	n/a	GO TO Q63

61. Who discriminated against you? SHOWCARD 26 AND CODE ALL THAT APPLY Q60/2-3 M/C N=68

Health care services	7.9
College/school	9.8
Employer	25.6
Police/judicial system	9.1
Social services	10.9
Shops/restaurants	<7.5
Bank/insurance company	<7.5
Landlord/housing office	<7.5
Close relative	<7.5
Unknown person in a public place	61.0
Known person in a public place	9.2
Other, please specify BACKCODE AND CLEAN	12.3
Prefer not to say	n/a

62. Why do you think you were discriminated against? SHOWCARD 27 AND CODE ALL THAT APPLY Q60/2-3 M/C N=67

Ethnic background	91.2
Gender	<7.6
Sexual orientation	<7.6
Age	<7.6
Disability	<7.6
Religion / faith / belief	35.8
Because of the neighbourhood I live in	<7.6
Accent	9.8
Appearance	14.8
Other, please specify BACKCODE AND CLEAN	<7.6
Don't know	n/a
Prefer not to say	n/a

ASK ALL

63. Does your property have a working smoke alarm? **CODE ONE ONLY ALL S/C N=1,778**

Yes	87.4
No	12.6
Don't know	n/a

INTERVIEWER TO COMPLETE:

64. Was the interview conducted in another language (other than English)? **CODE ONE ONLY ALL S/C N=1,798**

No	85.2
Yes – by the interviewer (specify language)…LIST……	11.5
Yes – through an interpreter (specify language)…LIST……	3.1
Yes – through language line (specify language)…LIST……	<0.3
Yes – with the help of a friend/relative (specify language)…LIST……	0.0

Scottish Health Records

- The National Health Service (NHS) maintains routine medical and other health records on all patients who use their services. These records include:
  - Inpatient and outpatient visits to hospital, length of stay and waiting time.
  - Information about specific medical conditions such as cancer, heart disease and diabetes.
  - Details about registration with a general practitioner, and when people pass away, the date and cause of their death.
- We would like to ask for your consent to link your NHS health records with your survey answers.
- To link this information we need your name, address and date of birth to match up with other NHS Scotland records.
- By linking this information with the interview data the research is more useful as we can look at how people's lifestyle and circumstances can have an impact on their future and use of hospital services.
- This information will be confidential and used for statistical and research purposes only. The information will not identify you so it cannot be used by anyone treating you as a patient.
- By checking this box you are only giving permission for the linking of this information to routine administrative data and nothing else.
- You can cancel this permission at any time in the future by contacting BMG Research on 0800 358 0337. You do not need to give a reason to cancel this.

By checking this box, I give consent to BMG Research to pass my name, address and date of birth to NHSGGC:

ASK ALL – RECODE TO NO CONSENT IF DATE OF BIRTH IS NOT GIVEN AT S3a.

65. May we have your permission to give NHS Greater Glasgow & Clyde or its partners your name and address so they can contact you in the future about similar research studies in relation to health and wellbeing? The partners are the Glasgow Centre for Population Health and the University of Glasgow. Should you agree, this follow-up research could take the form of a postal, telephone or face to face interview/questionnaire within the next 24 months. **ALL S/C N=1,798**

Yes, permission given		63.1
No, permission not given		3.69

READ: Thank you, those are all the questions I have.
If you are concerned about whether BMG is a genuine market research agency you can call the Market Research Society on 0500 396 999 during office hours. Finally I need you to verify that you have taken part in this survey and that I have accurately recorded your comments, by signing the following statement:

As part of BMG Research's quality control process, my employer will wish to contact some of the people I have interviewed. This is to confirm that I have undertaken the interview in an appropriate manner, and according to market research practice. Could you please provide me with your name, your address and provide me with a contact telephone number. This information will not be passed on, or used for any purpose other than our quality control processes unless you provided permission. Your details will be deleted as soon as our quality controls process ends.

IMPORTANT: TAKE CARE TO RECORD RESPONDENT NAME AND ADDRESS DETAILS ACCURATELY.

RESPONDENT'S NAME:	
ADDRESS: (Address Line 1)	
(Address Line 2)	
(Address Line 3)	
(Postal Town)	
(County)	
POSTCODE:	
TELEPHONE: (INCLUDING **STD**)	
EMAIL ADDRESS	