

Review of Dietary Intervention Models for Black and Minority Ethnic Groups

Part 1: An analysis of the BME situation in Wales

Prepared for the Food Standards Agency Wales

by Lynn Stockley

May 2009



Lynn Stockley & Associates
Food and Nutrition Consultancy

Strategic and Policy Development ♦ Communications ♦ Research Advice ♦ Education and Training

CONTENTS

EXECUTIVE SUMMARY	4
1.0 INTRODUCTION	8
1.1 Aim and objectives	8
1.2 Methods	8
2.0 BACKGROUND INFORMATION ON THE BME POPULATION OF WALES	8
2.1 Overview in Wales	8
2.1.1 Background	9
2.1.2 The BME student population	9
2.1.3 Recent asylum seeker and refugee populations	9
2.1.4 Other BME groups in Wales	10
2.1.5 Geographical distribution of the BME population.	10
2.2 Demographics	11
2.2.1 Age	11
2.2.2 Gender	11
2.2.3 Socio-economic status of the BME population	12
2.2.4 Country of Birth	13
2.2.5 Religion	13
2.3 Language and Education Levels	14
2.3.1 Welsh language	14
2.3.2 Ethnic languages	14
2.3.3 Education levels	15
2.4 Employment and Economic Activity	16
2.4.1 Employment	16
2.4.2 Self-employment	16
2.4.3 Gender differences in employment – Males	17
2.4.4 Gender differences in employment – Females	17
2.4.5 Income indicator – car ownership	18
2.5 Family units and housing types	18
2.5.1 Types of family units	18
2.5.2 Housing types	18
2.5.3 Housing conditions	20
2.6 Health	20
2.6.1 Cardiovascular Disease (CVD)	21
2.6.2 Blood pressure	21
2.6.3 Diabetes	21
2.6.4 Obesity in adults	22

2.6.5 Obesity in children	22
2.6.6 Future trends in obesity levels in BME groups	22
2.7 Foods, nutrients and attitudes to diet	23
2.7.1 Foods and Nutrients	23
2.7.2 Attitudes to diet	25
2.7.3 Body image and shape	26
2.8 Future Trends	26
3.0 SPECIFIC CHARACTERISTICS OF THE MAJOR BME GROUPS IN WALES	27
3.1 The South Asian BME Communities in Wales	27
3.1.2 Food beliefs and diet	27
3.1.3 The Indian Community	28
3.1.4 The Pakistani Community	28
3.1.5 The Bangladeshi Community	28
3.1.6 The Future	28
3.2 The Mixed Community	29
3.2.1 Food beliefs and diet	29
3.3 The Chinese Community	29
3.3.1 Food beliefs and diet	30
3.3.2 Future Predictions	30
3.4 The Black Community	31
3.4.1 The African-Caribbean Community	31
Food beliefs and diet	31
3.4.2 The African Community	32
Somali food beliefs and culture	32
REFERENCES	33

Executive Summary

The overall aim of this work was to review dietary interventions in black and minority ethnic (BME) groups and to recommend which interventions and models may be most applicable for piloting with ethnic communities in Wales. The Report of the work is divided into two Parts. This is Part 1, and the specific objective for this was to prepare an analysis of the BME situation in Wales.

History

The BME population in Wales is diverse, coming from a range of different geographical, religious and cultural backgrounds. Some BME communities date back centuries and were the result of a sea faring and colonising past. More recent arrivals have come to Wales from the 1950's onwards, and are a mixture of economic migrants and people fleeing persecution. The most recent arrivals include those reaching Wales through the government policy, begun in 1999, to 'disperse' refugees and asylum seekers, which has further increased the diversity of BME groups in Wales. There is also a 'transient' population, including a fluctuating international student population, illegal workers, and travellers.

Proportions of different BME groups in Wales

The 2001 Census data showed that people of Asian background were the largest group within the Welsh BME population, making 42% of the total, comprising the Indian (14%), Pakistani (13%) and Bengali (9%) populations. The second largest category were the Mixed populations at 29%, where Mixed White / Black Caribbean and Mixed White / Asian were the largest groups at 10% and 8% respectively. The mixed race population in Wales is much higher than that in England (14%), possibly as a result of historic migration patterns and a seafaring past. The Chinese (10%), and 'Chinese and other' (8%) ethnic groups were the third largest group, accounting for 18% of the BME population. The smallest group was the Black/Black-British people in Wales (11%). As a proportion of the population this group is much smaller than in England (26%), and mainly consists of Black African (6%) and Black Caribbean (4%) populations. A high proportion of the Black African community are of Somali origin, and most live in Cardiff.

Geographical Distribution

Geographically, the largest number of people from all of the BME groups lived in Cardiff (42% of the total Welsh BME population). This was followed by Newport with 11%, Swansea with 8%, Rhondda Cynon Taff with 4% and 4% for the Vale of Glamorgan. This means that 69% of the BME population of Wales were found in these 5 areas in 2001. The remaining third are scattered throughout the rest of Wales.

Age

In general the BME groups in Wales have a younger age structure than the White groups. The Mixed ethnic group have the youngest age structure, with over 45% under 16 years old, while the Black Caribbean group has the most people over 65 years (15%).

Gender

Broadly, the genders within each ethnic group are fairly balanced. There are slightly more men than women in the Asian and Black groups, but the reverse is true in the Chinese and “Chinese and other” groups, and in the mixed communities

Socio-economic characteristics

The social composition of BME households is complex. The Indian ethnic group includes both a high percentage of Hindus in high status occupations and Sikhs in lower status occupations. Pakistani, Bangladeshi and Chinese household heads are most likely to be self-employed. On the other hand, the percentage of the BME population who were either long-term unemployed, or who had never worked was much higher than for the white population.

The BME sector shows a range of types of employment, with a tendency for different ethnic groups to work in certain sectors. Around half of Indian people and people from the Other Asian and Other ethnic groups were highly qualified. Amongst people from Black and Black British ethnic groups, African people were much more likely than white people to have higher level qualifications, while Caribbean people were less likely than white people to be highly qualified. People with one Black-Caribbean parent were least likely (12.7%) to have higher level qualifications, but this might reflect their relative youth.

Levels of self-employment are high in some ethnic groups, reflecting the number of BME people operating take-away food outlets and small corner shops, and perhaps also reflecting the difficulty of finding paid employment. Fewer men from the BME population were likely to be in work than white men, and Black-African men are least likely to be in work.

Religion

The Indian group had the most diverse religious backgrounds with 54% Hindu, 19 % Sikh and 9 % Christian. The vast majority of Pakistani and Bangladeshi groups were Muslim, while 54% of Black, and 51% of mixed groups were Christian.

Languages

The languages spoken by the different BME groups vary considerably. For the three main resident South Asian ethnic groups (Indian, Pakistani, Bangladeshi), ability to speak English declines with increasing age, is less for women than men, and much less for those born outside the UK. 1% of the BME population claimed to speak some Welsh. The majority of these were Mixed, with levels around 18% – which is not too far behind the proportion of white people in Wales (21%).

Housing and family structures

- BME households tend to be larger on average than white households. Asian and Muslim households tend to be largest. Asian and Asian British ethnic groups have a higher percentage of married couples, while Black and Black British and mixed parentage households contain a higher percentage of lone parent households.
- BME family sizes are larger than those of white people and are largest for households from the Bangladeshi, Pakistani and mixed parentage ethnic groups.

- BME households are less likely than white households to be owner occupiers, and more likely to rent from private landlords. They are more likely than white households to live in terraced housing and flats.
- BME households are more likely than white households to be overcrowded, but are more likely to live in housing with a full range of amenities.
- BME households experience a higher rate of housing deprivation than white households, irrespective of the social class of the household.
- The share of BME people among the homeless is greater than their share of the population.

Health

In the general BME population:-

- Black African and Bangladeshi women were significantly more likely to have high blood pressure than women in the general population
- Among Black Caribbean men and women diabetes is relatively high (10% and 8%) compared with the general population, 4% men and 3% women respectively
- Diabetes also occurs more frequently in Indian men and women (10%, 6%), Pakistani (7%, 9%) and Bangladeshi (8%, 5%)
- Anaemia was more common among women: it was lowest in Chinese (7.3%) women but otherwise ranged from 16.4% in Black Caribbean women to 29.0% in Indian women

Amongst BME adults aged 55 and over:

- Nearly a third of Pakistani men had angina compared with 13% of men in the general population.
- High prevalence of angina was also found in Indian women (15%), compared with the general population equivalent of 9%
- Prevalence of heart attacks was especially high among both Pakistani men (19%) and women (7%). Among the general population the equivalent rates were 10% and 5% respectively
- Bangladeshi and Pakistani women reported relatively high levels of stroke (12% and 10% respectively compared with 5% in the general population)
- Stroke rates were also relatively high among Black Caribbean men (12%). The equivalent for men in the general population is 6%; Black Caribbean

Obesity levels

The mean Body Mass Index (BMI) of the general UK population was 27.1 kg/m² for men and 26.8 kg/m² for women. The BMI of Chinese (24.1 kg/m²), Bangladeshi (24.7 kg/m²), Indian (25.8 km/m²) and Pakistani men (25.9 km/m²) was lower than in the general population, and particularly so for Chinese women (23.2 kg/m²). Black Caribbean (28.0 kg/m²) and Black African women (28.8 km/m²) had a higher BMI than women in the general population. Black Caribbean men had the highest prevalence of obesity in the BME groups (27.1 kg/m²).

Black African boys were more likely to be obese than boys in the general population. Otherwise the prevalence of obesity was similar among all groups. The prevalence of obesity among Black Caribbean and Bangladeshi boys increased between 1999 and 2004 from 16% to 28%, and 12% to 22% respectively.

A Foresight programme modelling exercise indicates that increases in obesity will be less in BME groups than for the white population, with the exception that black African women and Pakistani men and women appear to share the trend of increasing obesity of the white population, although not to quite the same extent.

Nutrient intakes

- White men had a significantly higher mean percentage of their estimated average energy requirement than Asian men
- Asian men had a lower percentage contribution of non-milk extrinsic sugars (NMES) to food energy (10.5%) than White men (15.0%). Similarly, Asian women had a lower percentage contribution of NMES to food energy (10.0%) than White women (13.2%) and Black women (14.3%)
- The percentage energy from saturated fatty acids in BME households was estimated to be 1.9 percentage points lower than equivalent White households
- 42% of Black women and 36% of Asian women had calcium intakes below the LRNI compared with 8% of White women
- Use of salt in cooking was higher in most minority ethnic groups than among the general population

Attitudes to Diet and Body Shape

- About half in each ethnic group (African-Caribbeans 50%, Indians 47%, Pakistanis 53%, Bangladeshis 54%) perceived their own traditional diets to be healthier than Western diets.
- Knowledge of the links between diet and cardiovascular and other specific diseases was poor in general, particularly among Bangladeshi people
- African-Caribbean women were the only group surveyed who were very likely to feel that they weighed 'a lot more' than they wished, and Bangladeshis, notably men, were rather more likely to feel that they were in fact underweight.

1.0 Introduction

1.1 Aim and objectives

The overall aim of this work is to review dietary interventions in black and minority ethnic (BME) groups and to recommend which interventions and models may be most applicable for piloting with ethnic communities in Wales.

The Report of the work is divided into two Parts. This is Part 1, and the specific objective for this was to prepare an analysis of the BME situation in Wales, including literacy levels in different groups, the languages understood and any specific cultural issues that need to be taken into account when planning an engagement activity.

1.2 Methods

A review of the factors concerned with identifying the opportunities and barriers to dietary change among minority ethnic groups in Great Britain was published 10 years ago (Bush & Williams 1999). This was the first, and to date the only, comprehensive review of this type relevant to the countries of the UK. This review included information on geographical distribution of the different BME groups in the UK, economic situation, income, employment levels, housing tenure, age and gender structure, and family composition as well as nutrition related factors.

Part 1 of this Food Standards Agency Wales (FSA-W) commissioned review has adopted a similar structure to the earlier one, beginning with an overview of the BME population in Wales, and then teasing out specific characteristics of the major BME groups in Wales.

Extensive searches were carried out, using many of the same sources as the earlier review, but identifying updated information. In addition searches were carried out: on the websites of organisations in Wales and the UK who produce statistical and survey data; or are concerned with the BME population; or with nutrition and with health organisations who have carried out work relevant to dietary work with BME groups. Some international web sites carried useful data on cultural practices and beliefs in different ethnic groups, and this information was also used where appropriate.

2.0 Background information on the BME population of Wales

2.1 Overview in Wales

This part of the Report summarises data on BME populations, and focuses in information relevant to Wales. In reading it, it is important to be aware that there are different definitions of 'ethnicity' 'black' and 'minority ethnic'. Also the term 'Mixed' was only introduced into the Census in 2001. In reporting information, we have used the terms used by the authors of source materials.

2.1.1 Background

In the 2001 Census (Statistical Directorate), there were just under 3 million people living in Wales. 2,796,605 were White, and of these 17,689 were 'White Irish', and 37,211 were 'White Other' (from Europe, Australia etc). These latter groups, while being important in their own right, are not within the remit of this work, and are not dealt with further in this report.

The 2001 Census allowed people to 'self-certify' which group they identified. Almost 62,000 people in Wales described themselves as being from a BME group, and they made up 2.1% of the population in Wales.

The BME population in Wales is diverse, coming from a range of different geographical, religious and cultural backgrounds. Some BME communities date back centuries and were the result of a sea faring and colonising past. More recent arrivals have come to Wales from the 1950's onwards, and are a mixture of economic migrants and people fleeing persecution. The most recent arrivals include those reaching Wales through the government policy, begun in 1999, to 'disperse' refugees and asylum seekers, which has further increased the diversity of BME groups in Wales. There is also a 'transient' population, including a fluctuating international student population, illegal workers, and travellers.

2.1.2 The BME student population

According to the Statistical Directorate "of the 154,000 students in Wales, recorded in the 2001 Census, some 8,600 (5.6%) were from minority ethnic backgrounds, accounting for nearly 20% of the total minority ethnic population aged 16 or over.....their presence affects comparisons made between and within the different ethnic groups" (Statistical Directorate 2004). This may not have been taken into account in some of the survey and studies described later in this Report.

The ethnic group described as 'Chinese and Other' forms a large component of the BME population (Welsh Assembly 2005a). The same source goes on to say that nearly half of all BME students live in Cardiff, where they form one in eight of the BME population. Overall 2.4% of BME households are student households. Students (outside communal establishments) were more likely than average to live in private rented accommodation with shared facilities. In Ceredigion (in which Aberystwyth and Lampeter University Colleges are located), students formed 23% of the BME population."

2.1.3 Recent asylum seeker and refugee populations

The Welsh Assembly had also described the asylum seeker and refugee population of Wales, which is very different to that of the rest of the UK. Wales has really only attracted Somali refugees, largely because of prior labour migration to Wales from that country. Asylum seekers are more concentrated into a limited number of cities and towns. The National Asylum Support Service dispersed the great majority to Wales. They are more likely to be single applicants than asylum seekers in England, and they are drawn from a more limited range of nationalities and linguistic groups. The Assembly comments that it is difficult to judge how permanent an addition to the population of Wales these population groups will be (Welsh Assembly 2005a).

2.1.4 Other BME groups in Wales

The 2001 Census data (Statistical Directorate) showed that people of Asian background were the largest group within the Welsh BME population, making 42% of the total, comprising the Indian (14%), Pakistani (13%) and Bengali (9%) populations.

The second largest category were the Mixed populations at 29%, where Mixed White / Black Caribbean and Mixed White / Asian were the largest groups at 10% and 8% respectively. The mixed race population in Wales was much higher than that in England (14%), possibly as a result of historic migration patterns and a seafaring past.

The Chinese (10%), and 'Chinese and other' (8%) ethnic groups were the third largest group, accounting for 18% of the BME population.

The smallest group was the Black/Black-British people in Wales (11%). As a proportion of the population this group is much smaller than in England (26%), and mainly consists of Black African (6%) and Black Caribbean (4%) populations. A high proportion of the Black African community are of Somali origin, and most live in Cardiff.

2.1.5 Geographical distribution of the BME population.

Geographically, the largest number of BME's lived in Cardiff (n=25,729 or 42% of the total BME population in Wales). This was followed by Newport with 11%, Swansea with 8%, Rhondda Cynon Taff with 4% and 4% for the Vale of Glamorgan. This means that 69% of the BME population of Wales were found in these 5 areas in 2001 (Statistical Directorate).

More detailed statistical analyses of the BME population, by area and based on the 2001 Census, can be found through the Black Voluntary Sector Network Wales website¹, and would be a useful source of information for planning more localised interventions.

There are large variations within the BME populations of these 5 areas and some key findings reported from these analyses are:-

- Pakistanis make up 31% of the BME population in Newport, but only 17% in Cardiff and 7% in Swansea;
- Bangladeshis comprised 22% of Swansea's BME population, but only 13% in Newport and 10% in Cardiff - although it appears to be rapidly increasing in Cardiff.
- The Indian element of the BME population in Cardiff was 15%, but only 11% in Swansea and 6% in Newport.
- The Chinese population as a percentage of the BME population is greatest in the Rhondda at 19% compared with only 7% in Cardiff.
- The Mixed population was highest in the Vale of Glamorgan at 43% of the total BME population, 31% in the Rhondda, – and around 25% in the other 3 areas.

¹ http://www.bvsnw.org.uk/census_info.asp

Less than a third of the BME population live throughout the rest of Wales, with somewhere between 500 and 1,200 people from BME groups in each County. In North Wales, the population is largely composed of dispersed individuals or families, and the North Wales Racial Equality Network (NWREN) notes that “the BME population is not a homogenous entity and the potential for isolation and /or ‘Rural Racism’ is evident.” The NWREN website breaks down the counties in North Wales to show the BME population at ward level, and this shows a very small number of people in each group by BME classification.

In summary, the picture is of a long-standing immigrant community from certain ethnic backgrounds in the main towns and valleys of South Wales, while a newer influx of people from a wider range of countries has occurred during the past fifty or so years. Cardiff and Newport have the highest BME populations, with 53% of the total. Slightly less than a third of BME people from a range of ethnic backgrounds are scattered through the rest of Wales, making them fairly invisible to local statutory service providers. Throughout Wales the ‘mixed’ race population is a fairly high proportion of the BME population.

2.2 Demographics

2.2.1 Age

In general the BME groups in Wales have a younger age structure than the White groups. The Mixed ethnic group have the youngest age structure, with over 45% under 16 years old, while the Black Caribbean group has the most people over 65 years (15%). Around three quarters of the Other Ethnic, Indian, Chinese and Black Caribbean groups are of working age (Statistical Directorate 2004).

The (Welsh Assembly 2005a) said that the BME population was much younger than the white population of Wales in 2001. The mean age of white people was 39.8 years, compared with 28.1 years for BME people. Among BME people, Black people were oldest on average at 34.6 years, while those of mixed parentage were youngest, aged 23 on average. More than a fifth of white people, but only 6.5% of BME people were of pensionable age. In contrast, 10.1% of BME people were aged 0 to 4 and 21.7% aged 5 to 15, compared with 5.7% and 14.3% respectively for white people. Pensioners living alone represented 10.5% of Black-Caribbean and 10.9% of Black-African households. The more youthful nature of the BME population means that up to the age of 45, each age group forms a larger share of the BME population than the white population, but above that age the pattern is reversed.

2.2.2 Gender

Broadly, the genders within each ethnic group are fairly balanced. There are slightly more men than women in the Asian and Black groups, but the reverse is true in the Chinese and “Chinese and other” groups, and in the mixed communities.

Gender differences are more marked in the over 65 age group. The (Statistical Directorate 2004) explains this by saying that usually, due to differences in mortality rates, women aged 65 or over outnumber men. This is true of the White group, most of the Mixed group and people of Other Black ethnic background. However, there are particular differences in the Black Caribbean group where only 37% of the population aged 65 or over were female. Similarly, Indian and Bangladeshi groups also saw a

surprisingly low proportion of females, with 41% in both cases. It may be that these differences arise from different immigration patterns.

2.2.3 Socio-economic status of the BME population

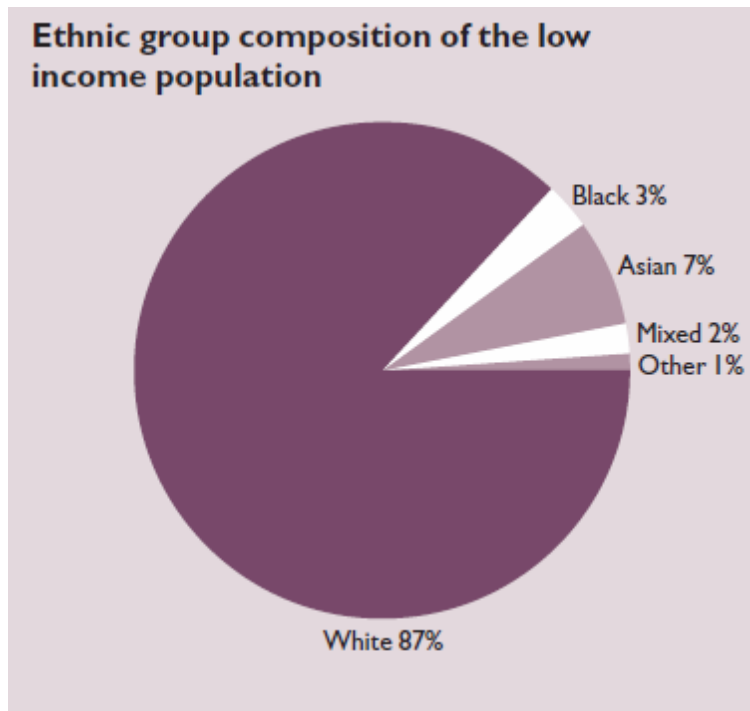
BME households include both highly advantaged and highly disadvantaged households, and there was a greater representation of these extremes than in the white population (Welsh Assembly 2005b). There is a much higher percentage of BME Household Reference Persons (HRPs) from the higher managerial and professional and “small employers” socioeconomic classification groups (SEGs) than white HRPs. On the other hand, the percentage of HRPs who were either long-term unemployed, or who had never worked was much higher for BME than for white HRPs.

A higher percentage of BME households than white were deprived in each SEG. In the small employer and own account workers category, BME households were about twice as likely as white households to be deprived in each SEG. The differential was larger among higher status than lower status HRPs. Among households headed by a person in a lower managerial and professional occupation, 38.1% of Bangladeshi households and 25% of ‘Other’ households were deprived, while 35.9% of Bangladeshi and 27.6% of Chinese households with HRPs from the small employer and own account worker socioeconomic classification group were deprived on the housing domain. Caribbean and Indian households tended to experience lower rates of deprivation in each SEG. Muslim households experienced the highest rates of deprivation in each SEG (Welsh Assembly 2005b).

The Welsh Index of Multiple Deprivation² defines which areas of Wales are most deprived using 8 measures. This, used in conjunction with Census data on ethnicity, can help pinpoint and highlight the most impoverished areas in which some of the BME communities reside.

A dietary survey of low income groups (Food Standards Agency 2007) estimated that non-whites are over-represented in the low income population of the UK, comprising 3% compared with 8% in the general population according to the 2001 census. A diagrammatic representation of this, taken from the survey, is shown below.

² <http://wales.gov.uk/topics/statistics/theme/wimd/?lang=e>



2.2.4 Country of Birth

The mixed community were most likely to be born in Wales, or other parts of the UK, while the majority of all other BME groups were likely to have been born abroad.

2.2.5 Religion

The 2001 Census had a voluntary question about religion. 8% of the Welsh population chose not to answer it. Over half the Chinese population stated they had no religion, while only 3% of Asians said the same. The Indian group had the most diverse religious backgrounds with 54% Hindu, 19% Sikh and 9% Christian. The vast majority of Pakistani and Bangladeshi groups were Muslim (of the Welsh Muslim population of 21,739, 33% are Pakistani, and 23% Bangladeshi and the remaining 44% are from a wide range of ethnic backgrounds), while 54% of Black, and 51% of mixed groups were Christian. Interestingly around 31% of Buddhists were Chinese or other ethnic groups, while most Buddhists were white. Younger people were likely to be less religious, and people born abroad were more likely to be religious than people in the BME population born in Wales.

In 'Religion in England and Wales' (O'Beirne 2004) the author says: "religion and ethnicity are interrelated concepts, so closely associated in some instances that it was difficult to disconnect the effects each one has had on people's behaviour and opinions." Very little research appears to have been done in this area, although there has been some on Muslims, who form the largest religious community after the predominantly white Christian community in Wales. Muslims come from a range of ethnic groups including the Bangladesh, Pakistani and Somali communities (Koestlé 2007, Welsh Assembly 2007). In Wales, there were 21,700 Muslims in 2001, representing half of the people with a non-Christian religion and a third of the BME population (Welsh Assembly 2005a)

2.3 Language and Education Levels

2.3.1 Welsh language

The BME communities in Wales could be at an additional disadvantage, because of the need to know Welsh as well as English. However, the Race Equality Guidelines suggest a different perspective (Ethnic Minorities Foundation 2006) and that in practice, this perception is largely unfounded. They support this by referring to the high percentage of children from BME communities in Welsh language medium primary schools, not only in rural areas but also in the urban centres of South and East Wales. They conclude there is often greater understanding between BME people and Welsh speakers regarding the issues of integration. This is because Welsh speakers can also find themselves marginalised and excluded as a group, and across all regions, both rural and urban, the Welsh language can be a powerful tool for greater understanding amongst a whole host of communities.

The statistics appear to show this may be a rather optimistic interpretation, as in 2001 (Statistical Directorate 2004) only 1% of the BME population claimed to speak some Welsh. The majority of these were Mixed, with levels around 18% – which is not too far behind the proportion of white people in Wales (21%). Between 6 and 7% of the Black and Asian communities speak Welsh, with around 5% of the Chinese groups. Most BME Welsh speakers were under 16 in 2001 – probably reflecting the policy of teaching Welsh in schools.

Surprisingly, (Welsh Assembly 2005a) a higher percentage of BME people over 75 speak Welsh than most younger age groups – possibly reflecting greater prevalence of Welsh speaking when the individuals first settled in Wales.

2.3.2 Ethnic languages

(Szczepura, Ala et al.) looked at language and communication with the health service in the UK, and pointed out there are an estimated 300 languages used by ethnic groups in London. (Wales is unlikely to have such a broad spread of languages). They go on to say that speaking a language, and being able to read and write it are very different abilities. Language and communication are different, and the latter needs to be within the appropriate cultural context; and messages must be specifically tailored to their audience, taking religious and other beliefs and practices into account.

The languages spoken by the different BME groups vary considerably, and provide a major challenge for any interventions with these communities. According to EthnoMed (University of Washington) there are 17 major languages in India, with English as the official language and Hindi the national language; in Pakistan the national language is Urdu, English is the official language, and there are five other principal languages; in Bangladesh Bengali is the national language. China has over 55 different ethnic groups, each with their own dialects, while the Somali population speak Somali, with Arabic a common second language.

(Szczepura et al. 2005) describe the characteristics among the South Asian communities on a UK level. For the three main resident South Asian ethnic groups (Indian, Pakistani, Bangladeshi), ability to speak English declines with increasing age, is less for women than men, and much less for those born outside the UK. However,

there are also variations between ethnic groups. Asian women, especially in Muslim cultural groups are the least likely to speak or read English: they may also not be literate in their 'mother tongue'. Some languages, notably the Sylheti dialect of Bangladesh, do not have an agreed written form. Those who can speak Punjabi or a dialect variety of it, including Kashmiri forms such as Pahari and Mirpuri, may not be able to read it, or only to read in either Urdu or the 'Gurmukhi' (Devanagiri) script. Older people of Bangladeshi origin in particular may have a limited ability either to understand (spoken) English or to read (any language). Even in the early 'middle-age' group (30-49 years), there are significant numbers of Bangladeshi and Pakistani women who will be essentially illiterate in any language, and who also do not speak English. At the same time, those who have acquired English as a second language do get older, and often lose this 'learned' ability.

EthnoMed³ (University of Washington) gives a flavour of the practical difficulties for non-English speakers (in this case, the Chinese community in Seattle) and this experience is directly transferable to Wales:-

“An English speaking person cannot understand or even imagine how frustrating and frightening it can be for a non-English speaker to answer the phone or door. Quite often they must rely on their children and relatives who speak better English. The children have taken over many of the parents' traditional duties because of their English skills like reading the mail, relaying school news and information, answering the phone, assisting in shopping, making appointments, and interpreting. However, even though the children can speak English fluently they often have a difficult time conveying information completely back to the parents because of their lack of sophistication with the Chinese language or because the subject is inappropriate for a child to interpret. Also, English speaking children or relatives are often busy with their own daily lives to be constantly translating for their non- English speaking family members. The whole issue of language knowledge has created a lot of tension and frustration in Chinese households and has led to power struggles between the parents and the child or family member.”

2.3.3 Education levels

Two-fifths of people in Wales aged 16 to 74 years had no educational qualifications (or qualifications which are unknown) in 2001. While only a third of BME people overall had no qualifications, there was considerable variation between individual ethnic groups. Only a fifth of Indian and a quarter of Other Asian people had no qualifications, but around two fifths of Black-Caribbean and over half of Bangladeshi people had no qualifications. Two-fifths of Muslim people also had no educational qualifications (Welsh Assembly 2005b).

White people were more likely than BME people to have a lower level qualification as their highest educational qualification. However, on average, BME people were far more likely than white people to have higher level educational qualifications (A-levels and above). Around half of Indian people and people from the Other Asian and Other ethnic groups were highly qualified. Amongst people from Black and Black

³ A UK multicultural resource on food and nutrition is planned for publication in 2010. A Multicultural Handbook – Food Nutrition and Dietetics. Published by Blackwell. Editor Aruna Thaker.

British ethnic groups, African people were much more likely than white people to have higher level qualifications, while Caribbean people were less likely than white people to be highly qualified. People with one Black-Caribbean parent were least likely (12.7%) to have higher level qualifications, but this might reflect their relative youth. (Welsh Assembly 2005b).

2.4 Employment and Economic Activity

2.4.1 Employment

The BME sector shows a range of types of employment, with a tendency for different ethnic groups to work in certain sectors. BME people are less likely than white people to work in manufacturing industry, but much more likely to work in hotels and restaurants and in the health and social services. Public sector services employed 30.7% of BME people and 35.7% of Black people. For Asian people, wholesaling and retailing and restaurants and hotels were the major sources of employment. More than a third of Chinese and Other people worked in hotels and restaurants. An above average percentage of people from the Asian and Asian British and Chinese and Other ethnic groups worked as managers and senior officials. The overall percentage of BME people in professional occupations was nearly double that for white people, with over a quarter of Asian and Asian British people in work having this type of job. Doctors accounted for a large percentage of these workers, with 17.9% of Asian and 9% of Muslim people employed as “health professionals” (Welsh Assembly 2005a).

Only Chinese and Other people were more likely than white people to work in skilled trades (working in “textiles, printing and other skilled trades”). Black and Black British people and people of mixed parentage were more likely than people from other ethnic groups to work in personal service occupations, while sales occupations are most important for Asian and Asian British ethnic groups and Muslim people. White people are more likely than people from BME groups to be process, plant and machinery operatives, but a higher percentage of people of mixed parentage, Black and Black British and Muslim people work in ‘elementary occupations’ (Welsh Assembly 2005a).

2.4.2 Self-employment

Levels of self-employment are high in some ethnic groups, reflecting the number of BME people operating take-away food outlets and small corner shops, and perhaps also reflecting the difficulty of finding paid employment. Welsh Assembly data says that a quarter of men from BME groups and an eighth of women were self-employed (compared with 18% of white men and 8% of white women). The percentage self-employed was highest in the Chinese (39%), Pakistani (37.3%), Indian (27.5%) and Bangladeshi (26.4%) ethnic groups. The percentage of men from Black and mixed parentage ethnic groups who were self-employed was lower than that for white men. The percentage self-employed was highest for Sikh men at 39.2% followed by Jewish men (35.3%) and Muslim men (31.1%). Those with no religion were least likely to be self-employed (Welsh Assembly 2005b).

There are similar differences among women, with Chinese and Pakistani women most likely to be self-employed, together with Sikh (28.6%) and Buddhist (21.4%) women. Women of mixed parentage and Black women were much less likely than average to be self-employed (Welsh Assembly 2005b).

2.4.3 Gender differences in employment – Males

About two-thirds of men aged 16 to 74 were economically active in 2001, with the percentage of men from BME groups economically active slightly lower than the corresponding percentage for white men. Indian and Bangladeshi men were more likely than white men to be economically active, while men of mixed parentage, Pakistani, Chinese and Black men were less likely to be economically active (and African men displayed the lowest economic activity rate). The economic activity rate was highest for men with no religion and Hindu men, and lowest for Muslim and Buddhist men (Welsh Assembly 2005b).

More than three-fifths of white men were in work, a higher percentage than BME men. Indian, Bangladeshi and Other-Asian men were most likely to be in work, and Black-African men least likely to be in work. Employment rates were highest for Hindu men and lowest for Muslim men and men with “other” religious faiths.

The male unemployment rate was about half as high again as that for women. Amongst men, the BME unemployment rate was about 1.5 times the white unemployment rate, but the unemployment rate for BME women was more than twice that for white women. The lowest unemployment rates were experienced by Indian and Chinese men, (around 6%) but the highest unemployment rates were experienced by Caribbean, African and mixed white /Caribbean men.(18 – 20%). The male Bangladeshi unemployment rate (7.8%) was just above the white rate (7.3%) and the Pakistani unemployment rate was 12.5%. The unemployment rate for Hindu men was extremely low (3.4%), but around 1 in 10 Buddhist and Muslim men were unemployed. Men with “other” religions experienced the highest unemployment rates (16.4%) (Welsh Assembly 2005b).

2.4.4 Gender differences in employment – Females

Just over half of all women aged 16 to 74 were economically active in 2001- a rate about an eighth below that for men. The differential in economic activity between white women and BME women was much greater than that for men, mainly because of the low economic participation rates of Asian and Asian British women. Nearly half of women of mixed parentage and women from Black and Chinese and Other ethnic groups were economically active, with Caribbean and Chinese women more likely than white women to be in the labour force. Economic activity rates for African, Pakistani and Bangladeshi women were lower than average, with less than a quarter of Bangladeshi women aged 16- 74 in the labour force. Only a quarter of Muslim women were economically active, only half the average for women(Welsh Assembly 2005b).

Two-fifths of BME women aged 16 to 74 were in work, compared to just under half of white women. Black-Caribbean, Chinese and Indian women were most likely to be in work, and Bangladeshi, Pakistani and Black-African women least likely to be employed. Only 21.5% of Muslim women were working (Welsh Assembly 2005b).

Amongst women, unemployment rates were highest for the Bangladeshi (24%), African (15.5%) and Pakistani (15.3%) ethnic groups. Unemployment rates for all BME ethnic groups were higher than for white women, with the lowest rates experienced by the Chinese, Other, Black-Caribbean and Indian ethnic groups. The

unemployment rate for women of mixed parentage was above the BME average and well over double that for white women (Welsh Assembly 2005b).

2.4.5 Income indicator – car ownership

As the 2001 Census did not ask about income, car ownership was used by the Welsh Assembly as a rather crude indicator of wealth and disadvantage. A higher percentage of BME than white households had no car, but the percentage with two cars was only slightly less than that for white households. There was a clear contrast between BME groups. Asian people were most likely to have a car and much more likely than white households have two or more cars. Indian households (39.9%) were most likely to own two cars, but Bangladeshi households (14.6%) were least likely to. Mixed parentage, Caribbean and African households were least likely to own a car. Chinese and Pakistani households displayed similar percentages with no car and with two or more cars. Their rate of car ownership was slightly greater than that of white households. Hindu households were the most likely to own two cars, followed by Sikh households. The percentage with no car was highest for Muslim households (Welsh Assembly 2005b).

2.5 Family units and housing types

2.5.1 Types of family units

In 2001, 43.5% of BME households (compared with 31.4% of all households in Wales) were families with children. However, there were considerable differences between BME groups. Two fifths of Asian and Asian British households and over a third of Chinese and other households were couples with children, but only 21.7% of Black and Black British and 21% of mixed parentage households were of this type. Lone parent families were less common than average among Asian and Asian British households but much more common for Black-Caribbean or mixed parentage (Welsh Assembly 2005a).

Lone pensioners and pensioner couples were about a third as common in the BME population as in the white population. Among BME groups, the percentage of childless couples was higher than average for Indian people, while this percentage was very low for Pakistani, African and (especially) Bangladeshi people. The percentage of households containing adults living alone was particularly high for people from Black and Black British ethnic groups, people of mixed parentage and the “other” ethnic group (Welsh Assembly 2005a).

On average, BME households were larger than white households (3.6 persons compared to 2.8 persons). Family sizes were largest in families with a family head of mixed parentage, while Black and Black British families were smaller than white families. Lone parents of mixed parentage headed large families, with an average family size of 5.4 persons (Welsh Assembly 2005a).

2.5.2 Housing types

In 2001, BME households were less likely than white households to own their own homes (58.2%, compared with 71.5% of white households), but were also less likely to live in local authority rented accommodation (11.6% compared with 13.8%).

BME households were more than twice as likely as white households to live in private sector rented accommodation and were also more likely to live in accommodation provided by housing associations and other social landlords (Welsh Assembly 2005a).

There were substantial differences between the different BME groups (Welsh Assembly 2005a):

- Two-thirds of Asian and Asian British households owned their dwellings, while only half of those with heads from Black or Black British or mixed parentage ethnic groups owned their homes.
- Black or Black British or mixed parentage ethnic groups were more likely than other broad ethnic groupings to live in rented accommodation, especially local authority and other social landlord rented housing.
- Households from Asian or Asian British ethnic groups were less likely than those from other ethnic groups to live in social rented housing, but more likely to live in private sector rented accommodation.
- Pakistani and Chinese households were more likely than other BME households to be owner-occupiers (a similar percentage to white households).
- Households headed by people from the “Other”, Black-African and Other Asian ethnic groups are most likely to live in private sector rented accommodation.
- Among BME households, 38.9% of those living in social rented accommodation were lone parent families.
- In the private rented sector, BME people (37.3%) are over twice as likely as white people to be living in married couple families with dependent children.

There were large variations in the housing tenure of BME households between unitary authorities in Wales (Welsh Assembly 2005a):

- In Monmouthshire, Flintshire, Caerphilly, Conwy and the Vale of Glamorgan, over two-thirds were owner-occupiers.
- The percentage renting from local authorities was highest in Blaenau Gwent and Torfaen.
- The percentage renting from other social landlords was highest in the three south Wales cities (9.5% in Cardiff) and Wrexham
- BME households were most dependent upon private sector landlords for housing in Ceredigion, where 51.1% lived in private sector rented accommodation, and rural areas such as Denbighshire and Powys, followed by Wrexham.

Households from BME groups were more likely than white households to live in terraced dwellings (33.8% compared with 29.2%) and flats (12.6% compared with 7.8%) and less likely than white households to live in detached (21% compared with 27.1%) and semi-detached (23.5% compared with 32.5%) dwellings.

Black and Black British and mixed parentage households were the most likely to live in flats, and Black, Pakistan and Bangladeshi households were more likely to live in terraced housing. On the other hand, Indian, Other-Asian, “Other” and Chinese households were more likely than white households to live in detached dwellings (Welsh Assembly 2005a).

2.5.3 Housing conditions

Welsh Assembly statistics (Welsh Assembly 2005a) also show that:-

- BME households were much more likely to experience housing deprivation than white households (20.3% compared with 11.3%).
- Rates of housing deprivation were highest for Bangladeshi (31.7%) and Black-African (27.6%) households.
- Overall, 4.4% of all households lived in dwellings where there were fewer rooms than the household required. Overcrowding was much more severe for BME groups than for white households, with 15.5% of BME households living in dwellings in which there were too few rooms.
- Chinese and Other ethnic groups experienced the greatest degree of overcrowding, with nearly a fifth of households living in dwellings with too few rooms.
- Mixed parentage or Caribbean households were least likely to be overcrowded. Overcrowding was more severe for Black-African and Asian ethnic groups
- Nearly a third of Bangladeshi and a quarter of Black-African people lived in dwellings without sufficient rooms, while a fifth of Pakistani and Other-Asian people lived in overcrowded conditions.
- Muslim and Sikh households were most likely than those from other religious groups to live in dwellings with too few rooms for the household.
- Overcrowding was most common in the private rented sector, where a quarter of BME households live in dwellings where there are fewer rooms than required; a fifth of BME households in social rented accommodation are overcrowded.
- BME households (5.6%) were less likely than white households (7.5%) to live in dwellings without central heating. Pakistani, Bangladeshi, Black-African and Black Caribbean households were more likely than other BME households not to have central heating in their homes.
- The percentage of white households experiencing housing deprivation was highest in Gwynedd (24.6%) and lowest in Caerphilly (6.6%). The percentage of BME households deprived was highest in Ceredigion (31.1%). Rates of BME housing deprivation tend to be high in unitary authorities with Universities (e.g. Aberystwyth and Lampeter in Ceredigion and Bangor in Gwynedd), where students form a high percentage of the BME population.

2.6 Health

The first Welsh Health Survey was carried out in 2003-4. This makes it a relatively new survey, and searches did not reveal any information specifically on BME groups. This is not surprising because BME groups form a relatively small proportion of the Welsh population. To get meaningful information for small groups one must 'over-sample' the groups. This was done in England in 2004 (Department of Health 2006, Sproston & Mindell 2006) when the first survey since 1999 was carried out to look exclusively at the health of ethnic minorities. The sample was boosted to permit analysis of information collected from adults and children from Black Caribbean, Black African, Pakistani, Indian, Bangladeshi, Chinese and Irish groups.

The main findings are summarized below.

2.6.1 Cardiovascular Disease (CVD)

- Black African men and Chinese women were significantly less likely than the general population to have any CVD condition. Black African informants reported the lowest prevalence of ischaemic heart disease (IHD) (0.7% men and 0.5% women) and of IHD or stroke (0.7% men, 1.0% for women).
- Prevalence of CVD increased significantly between 1999 to 2004 in Pakistani men (from 4.8% to 9.1%) and Indian women (from 2.3% to 4.2%).
- Among males aged 35 and over no significant difference was found in age-standardised mean or prevalence of raised low-density lipoprotein (LDL) cholesterol (≥ 3.0 mmol/l) between minority ethnic groups and the general population.
- After adjustment for age, Chinese women had a lower mean LDL-cholesterol and lower prevalence of raised LDL-cholesterol. Black Caribbean women showed significant increases over time in both mean LDL-cholesterol, from 3.1mmol/l in 1999 to 3.4mmol/l in 2004, and in the prevalence of raised LDL-cholesterol, from 49% to 68%. High-density lipoprotein (HDL) cholesterol is protective against CVD.
- The prevalence of low HDL-cholesterol (< 1.0 mmol/l) was significantly higher than in the general population in Pakistani men and Bangladeshi men and women, and significantly lower in Black African men.
- Amongst adults aged 55 and over:-
 - Nearly a third of Pakistani men (31%) had angina compared with 13% of men in the general population. High prevalence of angina was also found in Indian women (15%), compared with the general population equivalent of 9%.
 - Prevalence of heart attacks was especially high among both Pakistani men (19%) and women (7%). Among the general population the equivalent rates were 10% and 5% respectively.
 - Bangladeshi and Pakistani women reported relatively high levels of stroke (12% and 10% respectively compared with 5% in the general population). Stroke rates were also relatively high among Black Caribbean men (12%). The equivalent for men in the general population is 6%.

2.6.2 Blood pressure

- Bangladeshi men were significantly less likely to have high blood pressure than men in the general population. Prevalence did not vary significantly among men in other ethnic groups. However, Black Caribbean, Black African and Bangladeshi women were significantly more likely to have high blood pressure than women in the general population.

2.6.3 Diabetes

The survey confirmed that diabetes is more common in people from Black Caribbean and many Asian communities.

- Among Black Caribbean men and women diabetes is relatively high (10% and 8%) compared with the general population, 4% men and 3% respectively.
- Diabetes also occurs more frequently in Indian men and women (10%, 6%), Pakistani (7%, 9%) and Bangladeshi (8%, 5%).

- After adjusting for age, doctor-diagnosed diabetes was almost four times as prevalent in Bangladeshi men and almost three times as prevalent in Pakistani and Indian men as in men in the general population.
- Doctor-diagnosed diabetes was more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women compared with women in the general population. This was similar to the findings in 1999.
- Levels of glycated haemoglobin indicate the average blood glucose levels over the preceding three months. It is used to monitor control of blood sugar in diabetics: high levels indicate individuals at higher risk of micro- and macro-vascular complications. It has also been suggested as a screening test for diabetes. Raised levels are taken as 7% or above. Age-standardised prevalence of high glycated haemoglobin was very considerably raised in Bangladeshi men and women and Pakistani women, compared with the general population. With the exception of Pakistani women, mean glycated haemoglobin was lower in 2004 than in 1999 in each black minority ethnic group and in the general population.

2.6.4 Obesity in adults

- The mean Body Mass Index (BMI) of the general UK population was 27.1 kg/m² for men and 26.8 kg/m² for women. The BMI of Chinese (24.1 kg/m²), Bangladeshi (24.7 kg/m²), Indian (25.8 kg/m²) and Pakistani men (25.9 kg/m²) was lower than in the general population, particularly so for Chinese women (23.2 kg/m²). Black Caribbean (28.0 kg/m²) and Black African women (28.8 kg/m²) had a higher BMI than women in the general population
- Black Caribbean men had the highest prevalence of obesity in the BMEG groups. Bangladeshi men were almost five times, and Chinese men almost four times, less likely to be obese than men in the general population.
- Pakistani and Bangladeshi men and women, and Black Caribbean and Black African women were more likely to have raised waist-hip ratio (WHR) and raised waist circumference than informants in the general population.
- Overall, the patterns for BMI, overweight and obesity, WHR and raised waist circumference in HSE 2004 were similar to those in 1999, although for most groups the absolute levels of overweight and obesity, raised WHR and raised waist circumference increased between the years.

2.6.5 Obesity in children

- Black African boys were more likely to be obese than boys in the general population. Otherwise the prevalence of obesity was similar among all groups. The prevalence of obesity among Black Caribbean and Bangladeshi boys increased between 1999 and 2004 from 16% to 28%, and 12% to 22% respectively.

2.6.6 Future trends in obesity levels in BME groups

In 2007 the Foresight programme undertook a modelling exercise, as part of the to project the growth, or otherwise, of obesity rates through to 2050 (McPherson *et al.* 2007). This included ethnic groups although the data sets for some ethnic groups in the survey are relatively small. The report includes a detailed table, and the main findings only are reported here:-

- Black Caribbean and Chinese groups appear to be becoming less obese, with trends suggesting a proportion of just 3% being obese by 2050.
- Bangladeshi men are also becoming less obese. This is not the case with Bangladeshi women, although the increase is estimated to be modest.
- Indian men and women demonstrate very slight increases in the modelling.
- Black African women and Pakistani men and women appear to share the trend of increasing obesity (though slightly attenuated) of the white population (for the general population the modelling indicates that 60% of adult men and 50% of adult women could be obese by 2050)

2.7 Foods, nutrients and attitudes to diet

2.7.1 Foods and Nutrients

In 2007 the Food Standards Agency published a survey of diet and nutrition in Low Income groups (LIDNS) (Food Standards Agency 2007). Since low income groups include a relatively higher proportion of BME people, this means that there is more data for BME groups in this survey than the rolling National Diet and Nutrition Surveys. However, the sample bases for some ethnic groups is still small. The LIDNS report cautions that the analyses that could be carried out were limited, and the results must be interpreted with caution. Statistical comparisons were only carried out between White and Asian men and between White, Black and Asian women. The other relevant survey is the annual Family Food Survey from the Department for the Environment, Food and Rural Affairs.

The main results for consumption of different foods from LIDNS, supplemented by information from the 2007 Family Food Survey (Department for the Environment Food and Rural Affairs 2008), were:-

- White women consumed more bacon and ham, peas and green beans (cooked), carrots (cooked) and ‘other potatoes’ and less rice than Black and Asian women.
- Asian women consumed more white fish dishes and white fish (not coated or fried) than women in all other ethnic groups and more ‘other vegetables’ than White women.
- Black women consumed more fruit juice than women in all other ethnic groups.
- Black women consumed more portions of fruit but fewer portions of vegetables per day compared with White and Asian women .
- Asian women consumed more portions per day of fruits and vegetables combined than women in the other ethnic groups.
- There were no significant differences between fruit or vegetable consumption between White and Asian men. Of the 1.9 portions of vegetables that Asian men consumed per day, a half portion came from meat dishes, representing just under one-fifth of their total portions of fruits and vegetables eaten per day.
- The average purchases of fruit and vegetables are significantly higher in households with a Chinese HRP, over 900 grams per person per week higher than households with a White British HRP. (DEFRA)

The main results for consumption of nutrients were:-

- White men had a significantly higher mean percentage of their estimated average energy requirement than Asian men (86% vs.77%). The same pattern was seen in women but it did not reach statistical significance. There were no differences in

the mean body weight or physical activity scores between these groups to explain these differences.

- Asian men had a lower percentage contribution of non milk extrinsic sugars (NMES) to food energy (10.5%) than White men (15.0%). Similarly, Asian women had a lower percentage contribution of NMES to food energy (10.0%) than White women (13.2%) and Black women (14.3%). Conversely, Asian men and women had a higher percentage contribution of intrinsic and milk sugars plus starch to food energy (38.1% and 42.5%, respectively) than White men and women (32.6% and 35.0%, respectively).
- Households with a non White British HRP tend to have a lower percentage of their energy intake coming from consumption of NMES; the exception being households with a Black HRP which have an intake 0.6 percentage points higher than a household with a White British HRP. Percentage of energy intake from NMES is lowest in households with a Chinese HRP at 2.9 percentage points lower than households with a White British HRP (Department for the Environment Food and Rural Affairs 2008).
- There were no differences in mean daily non starch polysaccharide (NSP) intake between White and Asian men. Black women had a lower mean daily intake of NSP than Asian and White women. Only 14% of Black women achieved an intake of 12g/day compared with 31% of White women and 34% of Asian women.
- White men had higher contributions to energy intake from saturated fatty acids (13.9%) than Asian men (12.1%). White women had higher contributions to energy intake from fat (35.5%) than Black (30.7%) and Asian (31.4%) women. Similarly, White women had higher contributions to energy intake from saturated fatty acids (14.0%) and trans fatty acids (1.3%) than Black (10.8% and 1.0%) and Asian (11.7% and 0.9%) women. White women also had higher contributions to energy intake from cis monounsaturated fatty acids (11.7%) than Asian women (10.3%). This is supported by the finding from (Department for the Environment Food and Rural Affairs 2008) that the percentage energy from saturated fatty acids in households with a Black Household Reference Person (HRP) is estimated to be 1.9 percentage points lower than equivalent households with a White British HRP.
- For men and women, mean and median daily intakes of all vitamins from food sources were above or close to the reference nutrient intake (RNI) in all ethnic groups with the following exceptions.
 - There was evidence of lower intakes of vitamin A, riboflavin and folate in Black and Asian women compared with White women.
 - Black and Asian women had median intakes of vitamin A, folate (and for Asian women) riboflavin below the RNI.
 - They were also more likely to have intakes below the lower reference nutrient intake (LRNI) for riboflavin than White women.
 - Median intakes of vitamin A were below the RNI for Black and Asian men and they were more likely to have intakes below the LRNI for riboflavin than White men.
- There was evidence of lower intakes of calcium in Black and Asian women compared with White women. 42% of Black women and 36% of Asian women had calcium intakes below the LRNI compared with 8% of White women. Asian men were also likely to have lower intakes of calcium than White men.
- The prevalence of anaemia (defined as haemoglobin <12.0 g/dl) was very low among men, ranging from 0% in Chinese men to 4.4% in Black Caribbean men. Anaemia was more common among women: it was lowest in Chinese (7.3%)

women but otherwise ranged from 16.4% in Black Caribbean women to 29.0% in Indian women. The prevalence of anaemia decreased between 1999 and 2004 in Black Caribbean and Pakistani women.

- The pattern of salt use in cooking was similar in both men and women (Sproston & Mindell 2006). Use of salt in cooking was higher in most minority ethnic groups than among the general population. There were more modest ethnic differences in salt use at the table, with men and women in the general population more likely to report that they generally add salt without tasting than other groups. More Chinese and Black Caribbean men and women said they rarely or never add salt at the table (50% and 49% respectively among men, 53% and 64% among women). Between 1999 and 2004, there was a reduction in the proportion of Chinese men who used salt in cooking, though little change among other groups. The proportion of women who used salt in cooking decreased slightly over the same period in all minority ethnic groups, with the greatest falls among Chinese, Black Caribbean and Pakistani women. Salt use at the table also decreased between 1999 and 2004 among adults in most minority ethnic groups, particularly in Indian men and women and Pakistani men. There was little change among Bangladeshi and Black Caribbean informants.

2.7.2 Attitudes to diet

A Health and Lifestyles Survey of BME groups carried out by the Health Education Authority sheds some light on attitudes to traditional foods, and current health messages (Johnson *et al.* 2000). The key findings are shown below:-

- About half in each ethnic group (African-Caribbeans 50%, Indians 47%, Pakistanis 53%, Bangladeshis 54%) perceived their own traditional diets to be healthier than Western diets.
- Only small numbers in each ethnic group (African-Caribbeans 13%, Indians 17%, Pakistanis 13%, Bangladeshis 10%) said that they preferred eating British or European style foods to their own traditional foods.
- Traditional foods constituted a major component of the diets eaten at home by Indian, Pakistani and Bangladeshi people, with 8 in 10 Pakistani people (79%) and Bangladeshi people (83%) and 7 in 10 Indian people (71%) reporting that all or most of the foods they consumed at home in the last week consisted of traditional foods. Eating traditional foods at home was less common among African-Caribbean people, with only 1 in 3 respondents reporting that all or most of the meals eaten at home during the last week consisted of traditional foods of some kind. For both African-Caribbean people and the South Asian respondents, eating traditional foods away from home was less common.
- Dietary restrictions for cultural or religious reasons were uncommon among African-Caribbean people (22% reported restricting their diets) but widespread among Indian people (80%), Pakistani people (97%) and Bangladeshi people (97%).
- Perceived understanding of key terms used in healthy eating messages varied widely across groups and between terms. Large proportions (three-quarters or more) of African-Caribbean people reported understanding the terms 'starchy foods', 'dietary fibre' and 'fat', with a smaller proportion (about half) reporting an understanding of the term 'saturated fat'. Indian, Pakistani and Bangladeshi people reported lower rates of understanding of each term.

- Among those who said they understood individual dietary terms, knowledge of foods high in starch, dietary fibre, fat and saturated fat was patchy and often poor across all ethnic groups.
- Knowledge of the links between diet and cardiovascular and other specific diseases was poor in general, particularly among Bangladeshi people.

2.7.3 Body image and shape

The same survey (Johnson *et al.* 2000) asked questions about body image and body shape found that:-

- African-Caribbean women were the only group surveyed who were very likely to feel that they weighed ‘a lot more’ than they wished, and Bangladeshis, notably men, were rather more likely to feel that they were in fact underweight. In general, men were more likely than women to believe they were underweight.
- Very few people, despite objective measures showing considerable levels of obesity, reported that they had been actively advised to lose weight.
- Reasons for wanting to lose weight were very general and mostly health related: very few people in the survey referred to issues of personal appearance.
- One in three men and more than half the women, most notably the African-Caribbean females, stated that they would like to alter their body shape in some manner. The body area giving rise to most concern was the stomach, but women were also interested in changing their bottoms and hips.

2.8 Future Trends

The Welsh Assembly used available data to assess what future trends might be expected in the BME population (Welsh Assembly 2005a). One of the predictions was that the BME population will increase by nearly a half from 62,000 to 91,000 in 2011. Its percentage of the Welsh population is likely to rise to over 3% by 2011. Rapid growth of the BME population is set to continue over the period 2001-2011. This will come about through both migration and natural increase but probably more from the latter than from the former. Natural increase will predominate over migration for the Pakistani, Bangladeshi and Mixed populations. The reverse probably will be the case for other BME groups.

The BME population aged 60 and above is expected to increase by 33% between 2001 and 2011. The extent of the change will differ significantly between groups. The Indian, Chinese and Other Asian groups are more likely to experience the largest increase, while the Caribbean and African cohorts will be relatively little affected. The impact of the ageing of the BME population, while not numerically large will be geographically concentrated in the largest towns: Cardiff, Swansea and Newport and in the main industrialized regions.

3.0 Specific characteristics of the major BME groups in Wales

3.1 The South Asian BME Communities in Wales

42% of the Welsh BME community in 2001 were of South Asian background, and this represents people with a range of cultures, religions, languages, characteristics and life experiences in Wales (Statistical Directorate).

EthnoMed (University of Washington) describes South Asian cultures as strongly rooted in the family and extended family. The role of each family member is well-defined. Elders are respected. Elderly parents quite often live with and are looked after by their children. A strong system of support and co-dependency develops naturally in families. Most decisions are made in light of what is best for the family. South Asians generally do not discuss personal, physical or mental problems with anyone outside the family.

3.1.2 Food beliefs and diet

According to (Bush & Williams 1999) the region of origin helps determine the diet of different South Asian groups. For Bangladeshis the staple food is rice, for Punjabis it is wheat, and for Gujaratis it is wheat and rice.

The South Asian BME Muslim populations are primarily from Bangladesh and Pakistan, and they follow dietary rules from the Koran, which means only ritually-slaughtered meat (halal) can be eaten, and pork or pork products are prohibited. Over the Ramadan fast, which lasts for a month, no food or drink is consumed between dawn and dusk. Certain groups, such as pregnant women, very ill people and children can be excluded from the fast.

Orthodox Hindus are strict vegetarians, rejecting meat, fish, eggs, cheese made with animal rennet, and animal gelatine (Bush & Williams 1999). The less strict will eat meat, but beef and its products are not eaten since Hindus esteem the cow as sacred; dairy products are permitted however, because they do not involve the taking of life. Ghee (clarified butter) is believed to sanctify food prepared with it. Milk and yoghurt are also valued (Ganatra, 1989). Pork is thought unclean and generally not eaten (Shukla, 1991). If fish is taken it is usually white. Hindus also fast, often to mark religious days; their fasting ranges from total abstinence to restriction of quantity and type of food (to those which are considered pure, such as milk, fruit, yoghurt, nuts and potatoes).

Lastly, the Sikh religion originates from a reform which sought to combine Muslim and Hindu beliefs in a fresh synthesis. Sikhs have few dietary taboos, but some Sikhs are vegetarian, and beef and pork may also be avoided. Meat, fish and eggs are never served at the regular communal meals in Sikh temples to avoid giving offence to vegetarian Sikhs. Butter and ghee are the most commonly used fats in Sikh cooking, with occasional use of oil (Ganatra, 1989).

As to gender differences in food consumption, (Bush & Williams 1999) note a study in Glasgow among Punjabi Muslims, Sikhs and Hindus: "the data indicate that more

women than men eat salads/raw vegetables in summer on a daily basis, eat biscuits three or more times a week, and never eat red meat or eggs."

(Bush & Williams 1999) further note some of the cultural beliefs which may affect the diet of the South Asian BME community: belief in the Ayurvedic and Unani medical systems which "emphasise the role of food in the causation, prevention and treatment of disease, especially as part of the 'hot/cold' theory of nutrition and disease; the practice of fasting; breastfeeding; weaning foods; the role of food in hospitality and in maintaining the family's honour; and food's religious connotations.

3.1.3 The Indian Community

People of Indian background made up 14% (8,261 people) of the total BME population in Wales, and 15% of the BME population of Cardiff. The British Indian community has been in Cardiff since the late 1940s, when young men came to the UK as economic migrants. Most of the Indian community came from India, but in the 1980s many people came from East Africa. The British Indian community of 3,829 people is widely spread throughout Cardiff, with the majority of people living in Grangetown, Riverside, Cathays, Canton, Heath and Gabalfa (Hughes & Mahil 2007).

3.1.4 The Pakistani Community

At 14% of the BME total, Pakistanis are the second largest Asian group in Wales. The Pakistani community is well established, with most people coming to Cardiff as economic migrants in the 1950s. The community experience very high levels of employment and self-employment, with low incomes. The population of 4,264 people live mainly in Grangetown, Plasnewydd, Riverside, Cathays and Penylan (Hughes & Mahil 2007).

3.1.5 The Bangladeshi Community

People from Bangladesh form the smallest of the main Asian groups in Wales, making up 9% of the BME total. Bangladesh experienced intense political upheaval in the early 1970s when Bangladesh became independent from Pakistan, and many Bangladeshi families came to the UK during this time in search of stability and work and encouraged by changes in immigration laws. There were 2,546 Bangladeshi people in Cardiff recorded in the 2001 Census, mostly living in Riverside, Plasnewydd, Grangetown and Canton (Hughes & Mahil 2007).

3.1.6 The Future

Among the BME groups, the Indian population is expected to have the largest increase in the >60 years cohort. This growth is also likely to be geographically concentrated in Cardiff, Swansea and Newport. Indian people in Wales are predominantly Hindu, with a high socio-economic profile and less dependent on social housing (6.8% versus the Welsh average of 11.8%) than all other ethnic groups except the Chinese (6.5%). Extended families are a significant feature of Indian, Pakistani and Bangladeshi housing profiles, and it is likely that families will be largely responsible for the care of this generation of elderly people. Demands on the social rented sector will be small, but likely to increase further into the 21st century (Welsh Assembly 2005a).

3.2 The Mixed Community

The mixed community is the second largest BME grouping in Wales at 29% of the BME population, comprising of the Mixed White / Black Caribbean (10%) and Mixed White / Asian (8%) groups, the Mixed White / Black (4%) and Mixed White / Other (7%). The mixed community is more than twice that in England, and probably results from early past migration, when single men connected to shipping settled along the south coast of Wales (Statistical Directorate).

3.2.1 Food beliefs and diet

There was very little research relating to the food and diet beliefs of the Mixed community. However, (Bush & Williams 1999) provide an insight that suggests this group are likely to have similar view and diets to the majority White Welsh population, as they start with at least one relative from the white population. When talking about the Asian community (Bush & Williams 1999) say:

"Adherence to these traditional foods is affected by exposure to the ethnic majority culture and by decline in religious observance. Kassarn-Khamis, Thomas and Judd (1996) found that having white friends, eating in non-Asian homes, and being born in Britain were associated with reduced consumption of traditional foods and increased consumption of Western foods. The second generation were also less observant of halal prohibition and of food prescribed for religious festivals. The implications of this obviously vary according to the healthiness of the traditional diet."

(Bush & Williams 1999) go on to say, in relation to the varying levels of adherence to religiously-prescribed food practices by school pupils in Harrow:

"The primary reason reported was a difference of opinion from that of parents regarding the desirability of religious influence upon daily life, while in other cases respondents followed one or both parents' example of not following the dietary restrictions of their religion, or else they received no opposition to their rejection of them (Sheik and Thomas, 1994b). The rejection of such dietary restrictions and adoption of a more Western diet could have serious health consequences, depending on their degree and extent"

This suggests a gradual erosion of traditional food patterns among the Asian community, and it seems plausible that this process would occur more quickly in mixed households, where there is greater mixing with the white community.

3.3 The Chinese Community

Some Chinese people are reputed to have settled in Cardiff 150 years ago, and these were often seamen. From the 1920s to the 1960s Chinese restaurants and laundries spread throughout the UK, including Wales. The laundries have disappeared, but many towns still retain their Chinese take-aways. From the 1950s many Chinese people came from Hong Kong, and others were economic migrants from other ex-colonies and South Asian countries. In the 1990s more Chinese people arrived from mainland China, and more recently people from the rural areas of China have been emigrating to the UK.

These immigration patterns could provide extra challenges to interventions in Wales. The Chinese population within China is very diverse (including variations within the

Han group, who make up 95% of the Chinese population, and at least 55 different ethnic groups within the remaining 5% of the population). Also many Chinese settlers in Wales have come from intermediary countries. A useful summary of the Chinese populations and languages can be found in EthnoMed (University of Washington).

Another very useful source of information is (Sproston et al. 1999), a health and lifestyle survey of the Chinese population in England, which is available from the National Institute of Health and Clinical Excellence⁴.

3.3.1 Food beliefs and diet

Chinese food belief systems, dishes and customs are very different to those of the host population. EthnoMed (University of Washington) provides some useful background information, a few excerpts are given below:-

“Chinese people in general are not as concerned about nutrition as Western culture. They are more concerned with the food's texture, flavor, color, and aroma.....Vegetables, fruits, and meats are usually fresh. Some exceptions include preserved vegetables such as snow cabbage or mustard greens, preserved eggs, aka "thousand year old eggs" or salted and dried fish. Other exceptions include snack items such as beef jerky, cuttlefish jerky, sweet and sour preserved plums, or dehydrated mango slices. Canned or frozen foods are seldom eaten.....There is more emphasis on how to eat to balance yin and yang”

“Ethnic Chinese cooking does not involve a lot of deep fried cooking. The reason most of the Chinese restaurants in America have deep-fried dishes such as sweet and sour pork, almond fried Chicken, and deep-fried shrimp is to promote business and to please western tastes. This clearly reflects why there are more overweight and high blood pressure concerns in Western culture than there are in Chinese culture.”

3.3.2 Future Predictions

After the Indian population, the Chinese community in Wales is expected to have the second largest increase in the >60 years cohort between 2001 and 2011. They are similar to the Indian population, in having a high rate of owner occupation and low dependence on social housing and private renting. However, their socio-economic profile is more mixed and less professionalised than the Indians, but nevertheless above average for Wales. Their distribution, presumably because of their presence in the catering industry, is more dispersed than the Indians. Their future demands for social retirement housing seems unlikely to be greater than the age group in Wales in general and less geographically concentrated than those of Indians (Welsh Assembly 2005a).

The ‘Other Ethnic’ groups, whose prospective 60+ cohort is expected to double in size to 450 by 2011, is largely first generation and likely to be a “sojourner” rather than a “settler” population (85% were born outside the UK in 2001). Nearly three quarters were born in the Far East, from a diverse range of countries including Malaysia and Japan. The group has the highest proportion of privately rented

⁴ www.nice.org.uk

accommodation (41%) of any group in Wales. It is also one of the most highly professionalised groups with 60% of its working population in professional or administrative posts. Despite the large proportional increase in its elderly cohort, the group has a very youthful profile (Figure 7.3). In short, the profile suggests a high percentage of short term technical administrators brought in to run companies for overseas corporations and students. Because of the diversity of this grouping, the 60+ cohort may have very different characteristics from those of the Other Ethnic BME population as a whole (Welsh Assembly 2005a).

3.4 The Black Community

The Black community make up 11% of the total BME community, with Black / Black African (4%), Black / Black Caribbean (4%) and Black / Other (1%). This is much smaller than the corresponding proportion of the English BME community (26%) (Statistical Directorate).

3.4.1 The African-Caribbean Community

The African-Caribbean community in Wales tends to be smaller than the African community, nationally as well as in Cardiff and Swansea, although the opposite is true in Newport.

The African-Caribbean community began to arrive in Cardiff in the early 20th Century, with most people arriving as economic immigrants in the 1950s. The population was largely concentrated in Butetown until the 1990s when it began to disperse to other parts of the city. At the 2001 Census most of the 3,500 people lived in Grangetown, Butetown, Pentwyn and Riverside (Hughes & Mahil 2007).

Food beliefs and diet

(Bush & Williams 1999) found very little information available specifically about the diet, food habits and nutritional intake of the African-Caribbean population living in the UK. They reported that: -

The traditional African-Caribbean diet tends to be based on a staple of rice or starchy roots, fruits or tubers such as yam, cassava, and sweet potato usually accompanying a meat (for example curried mutton) or fish dish (for example red snapper, escovitch) (Douglas, 1987; Sharma *et al.*, 1996). Most of these vegetables are purchased from local markets or stores specialising in African-Caribbean foods in areas where there is a sizable African-Caribbean population."

Among African-Caribbeans a greater percentage of energy was provided by carbohydrate and a lower percentage provided by fat than the White UK population, and their diet tended to be healthier than the white population. Gender differences in diet within the African-Caribbean community were minor, with men consuming more alcohol than women.

- There appears to be a gradual change among the African-Caribbean community from eating home cooked food (which can take up-to 3 hours to prepare) to eating more traditional 'fast foods' and eating a more western diet. Older people, and those born in the Caribbean, were less likely to change their eating habits.
- The majority of women breastfeed their babies, but introduced weaning foods early, and often stopped early (possibly because of the need to work).

3.4.2 The African Community

The Somali community is the dominant black African community in Wales, and has been here since the 1880's when sailors, working merchant seaman, settled in Wales and married local Welsh women. The Somali community in Cardiff has the largest British-born Somali population in the UK and is one of the oldest minority ethnic groups in Wales. Most of the Somali community settled in Butetown, Grangetown, Riverside, Adamsdown and Plasnewydd, with a small percentage dispersing beyond these areas. The Somali community comprises 2,189 people in Cardiff according to the 2001 Census (Hughes & Mahil 2007).

More Somali women began arriving in the 1970s, and more Somali asylum Seekers began arriving in the 1980s – including women and children. Many were escaping persecution in Somalia, and included single women whose husbands had been murdered or imprisoned (Hughes & Mahil 2007).

The Commission for Racial Equality⁵ casts some doubt on the size of the Somali community, *“there is some doubt as to whether the Census 2001 data accurately reflect the true size of the black population. For example, the Somali population in Cardiff alone is estimated at anywhere between 4,000 and 10,000 people, and is thought to be the largest concentration of people originating from this country anywhere in Britain. Unlike England, Wales has a majority African black population.”*

Somali food beliefs and culture

A few key points from EthnoMed (University of Washington) are:-

- Somalia is composed of a single, homogeneous ethnic group who share a language, religion and culture
- The Somali language is an Afro-Asiatic language closely related to Oromiffa and more distantly to the Semitic languages Arabic, Hebrew and Amharic. Although written for many years, a uniform written language was not adopted until in 1973. Since the vast majority of the population is Moslem, Arabic is a common second language. Education was conducted in the language of colonial rule until the 1970s, so older Somalis from the north speak English and those from the south speak Italian.
- Almost all Somalis are Sunni Moslems. Attitudes, social customs and gender roles in Somalia are based primarily on Islamic tradition.

⁵ <http://83.137.212.42/sitearchive/cre/diversity/map/wales/index.html>

References

- Bush H & Williams R (1999) Opportunities for and barriers to change in dietary behaviour in minority ethnic groups. Health Education Authority, London.
- Department for the Environment Food and Rural Affairs (2008) Family Food in 2007: A National Statistics Publication by Defra. The Stationery Office, London.
- Department of Health (2006) Health survey for England: health of ethnic minorities.
- Ethnic Minorities Foundation (2006) Race Equality Guidelines 2006. The Ethnic Minority Foundation (EMF) Communities First.
- Food Standards Agency (2007) Low Income Diet and Nutrition Survey.
- Hughes K & Mahil M (2007) Finding Common Ground: Assessing the scope for community mediation as a tool for conflict resolution amongst Black and Minority Ethnic communities Project funded by the Welsh Assembly Government's New Ideas Fund 2006 and hosted by the Vale Mediation Service.
- Johnson M, Seacole M & Owen D (2000) Black and minority ethnic groups in England: the second health and lifestyles survey. Health Education Authority, London.
- Koestlé S (2007) Hard to reach groups - focus on muslim women. In *Ethnic Minority Foundation*.
- McPherson K, Marsh T & Brown M (2007) Tackling Obesities: Future Choices – Modelling Future Trends in Obesity and the Impact on Health. UK Government's Foresight Programme.
- O'Beirne M (2004) Religion in England and Wales: findings from the 2001 Home Office Citizenship Survey. Home Office.
- Sproston K & Mindell J (2006) Health survey for England: the health of ethnic minorities (final). The Information Centre.
- Sproston K, Pitson L, Whitfield G & Walker E (1999) Health and Lifestyles of the Chinese population in England. Health Education Authority.
- Statistical Directorate NAFW 2001 Census: Ethnicity in Wales. Statistical Directorate, National Assembly for Wales,.
- Statistical Directorate NAFW (2004) A Statistical Focus on Ethnicity in Wales. In *SB 53/2004*. Statistical Directorate, National Assembly for Wales, Cardiff.
- Szczepura A, Johnson M, Gumber A, Jones K, Clay D & Shaw A (2005) An Overview of the Research Evidence on Ethnicity and Communication in Healthcare. University of Warwick commissioned by the Department of Health.
- Szczepura. Ala, Johnson. Mark, Gumber. Anil, Jones. Kip, Clay. Diane & Shaw A An Overview of the Research Evidence on Ethnicity and Communication in Healthcare. University of Warwick.
- University of Washington EthnoMed. Available at: <http://www.ethnomed.org/2009>.
- Welsh Assembly (2005a) Housing research summary - A Profile of the Housing and Socio-Economic Circumstances of Black and Minority Ethnic People in Wales in 2001, p. Housing Research Summary 4/05.

Welsh Assembly (2005b) Profile of the housing and socio-economic circumstances of Black and Minority Ethnic people in Wales in 2001. Housing Research Report HRR 4/05.

Welsh Assembly (2007) A social audit of the Muslim community in Wales, Cardiff.