Social capital, local community participation and the construction of Pakistani identities in England: implications for health inequalities policies.

*Catherine Campbell, Social Psychology, London School of Economics
Carl McLean, Gender Institute, London School of Economics

*Corresponding author
Dept Social Psychology
London School of Economics
Houghton Street
London WC2A 2AE
c.campbell@lse.ac.uk

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Abstract

Emphasis has been placed on the importance of the participation of socially excluded groups in local initiatives to reduce health inequalities in England, in "partnerships" with government. We examine potential obstacles to such participation through a micro-qualitative case study of factors shaping local participation by residents of a deprived multi-ethnic area in England who describe themselves as Pakistani. We draw on three-hour in-depth interviews with 26 men and women, aged 15-66 years. Assuming that a sense of common identification is a precondition for participation in local community networks, we examine how the construction of Pakistani identities, within conditions of material and symbolic social exclusion, constrains the likelihood of widespread, representative local participation by Pakistani people in our local area of interest. Our interviews highlight the complexities inherent in seeking to translate epidemiological findings into policy directives that implicitly presuppose the existence of cohesive ethnic identities at the local community level. No matter how significant a category such as 'Pakistani' might be in statistical analyses of health inequalities, an epidemiological category of this nature cannot simply be 'mapped' onto policy recommendations - particularly those involving complex and richly textured social-psychological and community-level phenomena such as social identity or participation.

1. Introduction

The concepts of 'community mobilisation' 'grassroots participation' and 'local partnerships' are increasingly being included as articles of faith in health policies and interventions in England and world-wide.[1] This is particularly the case in initiatives targeting excluded or marginalised communities, in the context of efforts to promote health and reduce health inequalities. However, this is an area where research often lags disappointingly behind developments in policy and practice. Much remains to be learned about the mechanisms whereby participation has its allegedly beneficial effects on health. Furthermore much research remains to be done into factors likely to promote or hinder such participation by members of socially excluded groups in particular settings. Because of the lack of systematic research in this area, our understandings of the extent to which participation does indeed lead to health gains is extremely limited. So is our ability to learn lessons from the proliferation of varyingly successful and unsuccessful participatory projects both locally and further afield.

Against this background, this paper seeks to examine potential obstacles to such participation by minority ethnic people, highlighting the challenge facing those who seek to promote minority ethnic group involvement in local partnerships for health, and in 'community strengthening' initiatives to build potentially health-enhancing social capital. We draw on in-depth interviews with Pakistani residents of a deprived multi-ethnic area of a town in south England. Our starting assumption is that a sense of common identification with other minority ethnic group members is a necessary precondition for participation in local community networks or collective action projects seeking to address ethnically defined social inequalities. We examine how the construction of Pakistani identities, within conditions of material and symbolic social exclusion, constrains the likelihood of widespread and representative local participation by Pakistani people in our area of interest.

[1] A global commitment to promoting the participation of local communities in health promotion has been embedded in a range of internationally subscribed declarations spearheaded by the World Health Organisation, including the Alma Ata declaration (1978), the Ottawa Charter (1986) and the Jakarta Declaration (1997).

Policy documents (Department of Health, 1999a, 1999b; Social Exclusion Unit, 2000) emphasise the importance of various forms of minority ethnic participation for reducing health inequalities, in the context of an emphasis on the role of "partnerships" between government and marginalised communities. What are these forms of participation, and what are the mechanisms whereby they have their allegedly beneficial effects on health? Firstly, there is participation in strategic and operational decisions about health service design and delivery, through partnerships between health service workers and user representatives. Such partnerships are considered important for addressing issues such as the differential access, cultural differences, racism and communication difficulties believed to undermine the level of health service provision received by minority ethnic people. Secondly, it is argued that local people should participate in community-based public health projects designed to promote healthy behaviours. People are most likely to perform healthy behaviours (e.g. exercise, the appropriate accessing of health services, compliance with medical treatment) if they see that liked and trusted peers are doing so. Furthermore, grassroots participation in local health projects may increase people's sense of perceived self-efficacy or empowerment, increasing the likelihood that they will feel that they can take control of their health (Israel *et al*., 1994).

Finally it is argued that people are more likely to be healthy in communities with high levels of social capital, characterised by high levels of grassroots involvement in local community organisations and groupings (Blaxter, 2000; Department of Health 1999b). Research in this area is in its early stages, and research findings are still inconclusive. However, it is possible that communities with high levels of local participation might provide their members with the increased likelihood of health-enhancing social support (Yen and Syme, 1999). They might also decrease the likelihood of social anxiety and low perceived self-efficacy, both of which are said to be damaging to health (Wilkinson, 1996; 1999). They might also facilitate the process of health-enhancing peer influence and empowerment which increase the likelihood of health-enhancing behaviours referred to above (Campbell, 2000).

In this paper we highlight factors constraining the likelihood that Pakistani people will participate in local minority ethnic community groups, voluntary groups and faith organisations. It is organisations such as these that are: (i) cited as means of access to participants for consultation forums and local health promotion projects (the first two forms

of participation outlined above); and (ii) which may form a key component of potentially health enhancing social capital (the third form of participation). We do this to support our argument that while health inequalities policies - advocating the promotion of various forms of local community participation - might make good theoretical and political sense, a number of obstacles stand in the way of their implementation. Existing policy guidelines require more specific recommendations for addressing such obstacles to the implementation of policy in real-life social contexts.

Certain minority ethnic groups suffer disproportionately high levels of poor health in England. These groups also suffer the highest levels of material deprivation, and it is generally accepted that poverty plays the greatest role in shaping their relatively poor health (Nazroo, 1997). Thus, for example, Pakistani people experience four times more unemployment than the white population, and four-fifths of Pakistani households have below half average income (Health Education Authority, 2000). However, a number of researchers have commented that poverty and ethnicity cannot simply be collapsed into one another in explaining poor health. There have been calls for increased attention to factors specific to ethnic minority status, such as racism, culture, ethnic identity and factors shaping peoples' participation in local community networks (Nazroo, 1998; Smaje, 1996; Williams *et al*, 1997). Methodologically, this field has been dominated by quantitative epidemiological research. Ahmad (1993, 1995) has long emphasised the need for qualitative research, emphasising how early quantitative explanations of health inequalities tended to reify ethnicity as a risk factor in ways that misunderstands the life worlds of different groups in British society.

Ahmad's call for qualitative research resonates with a growing emphasis on the generative mechanisms whereby health inequalities are perpetuated. Rees-Jones (2000) has argued that while epidemiologists have provided crucial descriptive evidence for a health divide, our understandings of the underlying generative mechanisms are still inadequate. He points to the need to "move beyond concerns about the superficial patternings of inequalities, to look at the social relations that produce them ..... we need to shift the focus to the mechanisms that create inequality". Our research starts from the assumption that an important dimension of the social exclusion which accompanies health inequalities is the way in which both relative material deprivation and various forms of symbolic disadvantage (such as racism, lack of

perceived respect and recognition) limit particular groups' opportunities for participation (Percy-Smith, 2000).

Against this background, our research draws on the concepts of social capital and social identity as conceptual tools which contribute to the development of a "social psychology of participation" which accounts for the social psychological processes shaping the likelihood of community participation (Campbell and Jovchelovitch, 2000). According to Bourdieu (1986), unequal distribution of social capital is one of the key mechanisms whereby social inequalities are perpetuated.[2] Taking Bourdieu's framework as a starting point, we define social capital in terms of peoples' participation in local community networks. If increased participation is indeed one way in which a group of socially excluded people can advance their social interests and improve their health, attention to the way in which the construction of ethnic identity may undermine such participation could contribute to more general understandings of the mechanisms whereby social inequalities are perpetuated.

According to Leonard (1984), social identities are constructed and reconstructed within a range of material and symbolic constraints which limit the extent to which people can construct images of themselves and their claimed group memberships that fully reflect their potentialities and interests. The "institutional racism" (MacPherson, 1999) which characterises English society presents a number of such constraints, both in the form of higher levels of poverty (material exclusion), and lower levels of social respect and recognition (symbolic exclusion). However, at particular historical moments, often through participation in collective projects and networks, members of socially excluded groupings may work together to construct identities that challenge their marginalised status. This may take the form of participation in collective networks which directly or indirectly serves to improve peoples' material life circumstances, or raise the group's levels of perceived empowerment and social recognition by other groups. Within this context, the inter-locking phenomena of social identities and participation are potentially important mechanisms for social change.

[2] Schuller, Baron and Field (2000) locate Bourdieu's work within the context of other leading conceptualisations of social capital, including the work of Putnam and Coleman.

However, a number of studies have shown that participation in local networks is most likely amongst the more privileged members of a community (Baum *et al.*, 2000; Weinberger and Jutting, 2001). Measures to increase local community participation may, unintentionally, increase social inequalities rather than reducing them.[3] For this reason we argue that it is critical that policies advocating participation should not be blind to factors which promote or hinder the likelihood of such participation by socially excluded groups.

2. Methodology: social identities and civic engagement in a multi-ethnic community

We report on a sub-set of findings drawn from a larger study of social capital in a multi-ethnic community in the two most economically deprived wards (administrative districts) of a south English town. In the light of the controversies regarding the notion of community, we must emphasise that we defined 'community' in geographical terms. This decision accords with the fact that most local health and community development resources in our town of interest are targeted at geographically demarcated wards. Furthermore national policy attention to health inequalities often coincides with policies focusing on local neighbourhood renewal (e.g. Social Exclusion Unit, 2000; Home Office, 2001). Our wards, which are geographically adjacent, have the highest percentage of black and minority ethnic residents in the town. Of their 20 000 inhabitants, roughly 45% are white, 5% African-Caribbean and 50% South Asian (30% Pakistani, 15% Bangladeshi and 5% Indian). Our wards of interest fall in the 5% most deprived wards in England and Wales, with levels of unemployment well above national or local averages. Of the Pakistani inhabitants, about half were born in England, and half in Pakistan, with new immigrants often having poor English language skills and relatively low levels of education.

In this paper we report on three-hour in-depth interviews with 26 people who identified themselves as Pakistani. The issue of defining who to include within ethnically demarcated groups is a controversial one. In our area of interest, a significant majority of Pakistani residents' families originate from the Pakistani region of Kashmir, and we focused specifically on this group. People were included in our small sample on the basis of their

[3] Acheson (1998) makes a similar point about health education, which is most likely to change the behaviour of the wealthiest and most highly educated members of a society. (Acheson, D. 1998

answers to two questions, the first relating to self-ascribed identity, and the second to country of family origin. The first question was: 'Do you consider yourself to be a member of the group of people who refer to themselves as Pakistani Kashmiri'? The second question was: 'Do you or your parents originate from the Kashmiri region of Pakistan?' If people answered in the affirmative to both questions, they were included in the study.

As will become evident below, in the course of their interviews, people often described themselves as 'Pakistani' and 'Kashmiri' interchangeably. Our research informants were half men and half women. Each gender group was spread within the 15-20, 21-34, 35-55 and 55+ age groups, with half living in households with at least one person employed and half not, and half involved in at least one local community organisation, with the other half not. Appendix A provides a detailed description of our research informants. Interviewers were matched by gender and ethnicity. Interviewers were fluent in both Urdu and English, and informants were interviewed in their language of choice, 11 choosing Urdu and 15 choosing English. Interviewees were recruited using a purposive snowball sampling technique, beginning with personal contacts of the interviewers (one of whom lived in the area, and the other of whom had conducted earlier research in the community), together with a few names given by local religious and voluntary organisations. These people introduced the interviewers to friends, neighbours or relatives. Interviewers made sure that no more than one informant came from any one household, extended family or street.

The interview topic guide covered each informant's personal life history, their experiences of community life, and their most significant formal and informal networks. Interview participants were encouraged to speak freely on whatever associations the questions elicited, and the interviewers placed as few constraints on people as possible. Interviews, which were three hours long, were conducted in informants' living rooms by an experienced interviewer, with no one else present. They were tape recorded, fully transcribed and analysed using the NUDIST software package for qualitative data analysis (Richards, 1997).

Thematic analysis of the interviews involved total immersion in the coded data for a number of weeks, in order to specifically extract material that threw any light on factors affecting

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Independent inquiry into health inequalities in health report. London: Stationary Office).

informants' participation in three local network types. The first was informal networks of family, friends and neighbours. The second was local voluntary organisations linked to leisure, hobbies and personal or spiritual development. The third was local community activist groups devoted to promoting the quality of local community life. Particularly close attention was paid to the ways in which ethnic identities shaped peoples' involvement in these three network types.

Researchers in the field of ethnicity are often accused of perpetuating inaccurate stereotypes of groups (Hall, 1997), particularly in relation to the frequently constructed so-called 'Asian community' in England, and to generalisations about sub-groups within it such as 'the Pakistani community'. Such generalisations ignore the enormous diversity within these groups resulting from multiple configurations of intersecting axes such as age, gender, class, caste, religion as well as the range of geographical and historical contingencies, and idiosyncratic biographical details (Brah, 1996). The diversity of this group has repeatedly been emphasised in ethnographic studies of a range of South Asian people in England (Ballard, 1994; Modood *et al*., 1997; Modood and Werbner, 1997) and more particularly of Pakistani people in England (Shaw, 1988; Werbner, 1990)

This paper focuses on the social identities of one small group of Pakistani people in one small area of one English town. We by no means seek to perpetuate the notion of some fixed and enduring concept of 'Pakistani identity in England', or even of 'Pakistani identity' in our small local area of interest. Rather, our goal is to provide a case study of the ways in which ethnic identities may sometimes be constructed in ways that undermine the likelihood of participation in local community networks, given the emphasis on such local group memberships in social inequalities policies.

3. Findings: Pakistani identities and local community participation

3.1 Pakistani identities as a potent and sustaining resource at the inter-personal level.

Our informants valued their ethnic distinctiveness, repeatedly referring to their identities as 'Pakistani' or 'Kashmiri'. Even those whose life circumstances, loyalties and interests varied considerably, tended to draw on a stereotypical representation of 'the Pakistani community'

which furnished a central organising metaphor in their interviews. The level of inclusiveness of peoples' expressed ethnic identities varied. In the context of life in England, people sometimes distinguished between Pakistani people, and other south Asian groups (e.g. the Indian or Sikh groups). People also distinguished between a more inclusive category of 'Asian' people, in comparison to white English people. This Asian-white distinction frequently served as a rhetorical device highlighting what people experienced as the ethnically-shaped distinctiveness of their daily lives.

People repeatedly defined their identities in contrast to the white English community, referring to layers of difference relating to factors such as language, dress, culture, the behaviour of women, religion, diet.

> If you give an opinion, and you're a Pakistani, its going to be different to what another religion thinks, the way you live, the way you dress, the way you think, it'll be more related to what your parents think. It will be completely different to what white people think. (15-year-old woman, England born)

> I wouldn't say I'm British. I wouldn't say I'm English. I'd say I'm Kashmiri. People like, even my tutor, he said to me that, "You're born here, you're British". But I'll go, "Just because I am born here, The values I've got and the way I've been brought up, I'm Kashmiri". I don't see myself as being British or being English because I just don't have any desire to see myself that way. (18-year-old woman, England born)

People often spoke of the extended family as the central building block of Pakistani identities. They distinguished this family from 'English families', who were said to be less close and less supportive of one another, and to have less of a sense of responsibility for the well-being and future of their children and their parents. People provided stereotypical accounts of Pakistani family relationships defined by clearly articulated roles and expectations. These included: a strong sense of mutual responsibility for the emotional, financial and practical well-being of other family members; an emphasis on the moral and religious socialisation of young people; assisting them to set up their own families; inculcating young people with a sense of personal ambition in education and employment; and safeguarding the modesty of female family members. The way in which the conduct of

individual family members contributed to the reputation of the collective family unit was repeatedly emphasised.

Peoples' first choice of friends was generally Pakistani, and their second choice people from other south Asian ethnic groups. Their accounts of the deep and caring nature of their friendships were characterised by a very explicit discourse of love, sharing and compassion, particularly in the interviews with men. Older men spoke of the lifeline that friends offered one another in times of crisis. Younger men spoke of the "influence of friends", where good influence was associated with upholding Pakistani or Muslim traditions.

Despite the strength of peoples' commitment to their Pakistani identities, and the key role these identities played at the inter-personal levels, and (as we shall see below) in their professional identities, these did not automatically translate into a resource mobilising people at the local community level. Our informants' involvement in the types of local faith organisations, minority ethnic community groups, and voluntary groups referred to in health inequalities policies was low.

3.2 Low levels of community participation

Participation in local religious groupings

Faith groups are identified as an important means of accessing minority ethnic people in various social inequalities policy documents. Six of our 26 informants actively participated in local faith networks. The others had a more secular commitment to Muslim values. Whilst often referring to the importance of Muslim values in guiding action and morals, this did not translate into mosque attendance, for several reasons. Some felt formal religious attendance was unnecessary and prayed at home. Others had simply lapsed. One young man found mosque attendance a tremendous chore, and only kept up a pretence of going to please his father. Another elder said that he had given up attending because of his desire to take alcohol occasionally (to the disgust of his devout wife and daughter). Some said they had become alienated from the local mosque which had been mired in a series of on-going political and financial controversies as well as power struggles between people of different "tribes" or

castes. Contrary to the stereotype of religion being a uniting force in the community, it appeared to be a force dividing people as often as it united them.

Participation in other local community and voluntary groupings

Numerous opportunities existed for involvement in formal community consultation exercises and activist networks, relating to the interests of children, young and old people, women's issues, health issues, neighbourhood safety, policing, leisure and entertainment facilities. However, involvement in such networks was low, as was peoples' interest in more informal activist networks such as neighbourhood petitions regarding issues like traffic calming. While Pakistani interests are often strongly articulated in bids for local council funding or for facilities such as local community centres, such initiatives tend to be dominated by a small elite group of older men, excluding women, younger men, and older men falling outside this elite. We have no doubt that the efforts of this small group are of benefit to other community members insofar as they result in a range of ethnic-specific facilities and services of potential benefit to all Pakistani people in the community. However, if widespread representation of *all* members of a particular local community is a central aspect feature of social capital (Campbell 1996, Morrow 1999; 2001), such involvement in our local community of interest is limited.

Some reasons given for low levels of civic engagement were similar to those of white English interviewees in an earlier study in a small English town (Campbell, Wood and Kelly, 1999). People expressed disinterest in becoming involved in political networks, arguing that politicians prioritised personal and party interests over those of grassroots constituents. Others said their social needs were met within close networks of family and friends, and they had no need for community level leisure facilities or voluntary organisations. Most people said that because they were fairly satisfied with neighbourhood council-provided services and facilities there was little motivation to attend local government consultation fora. Many said that family, school or work responsibilities left them with little spare time or energy to get involved in local community affairs. Given the specifically Pakistani focus of this paper, however, we focus on the way the construction of Pakistani identities influences the likelihood of participation.

3.3 The dialectic of unity and difference in ethnic identity construction

As stated above, the category 'Pakistani' has significance as an epidemiological category in studies of health inequalities in England. However, our interviews suggest that one cannot un-problematically assume the existence of a correspondingly coherent Pakistani identity that will serve as a resource for mobilising people in local health initiatives. Despite peoples' generalised commitment to a Pakistani identity, our interviews were characterised by extreme variations in the ways people interpreted such identities - as a function of factors such as age, gender, educational levels and language skills. Such variations made it unlikely that such Pakistani identities would automatically translate into bonds uniting people at the local community level around common interests.

One of many potential illustrations of such variations lay in the comparison between two groups of women in our sample. These women all identified very strongly with the labels 'Pakistani/Kashmiri'. The first group consisted of Pakistani-born women who had come to England to get married. They had poor English language skills and little education, were often isolated from mainstream English life, seldom leaving the family house and totally dependent on their extended families-in-law for their social and material needs. They defined their identities in terms of their children and their husbands. They were conscious of how different their children's lives would be compared to their own.

> The way I am is not the way the children should be. They have been born in this time, I was born in that time. I speak the language of that time, these children are born in this country, they will not learn that language. (27-year-old woman, Pakistan born)

Most lacked education or skills to find work outside of the home, and their inability to speak English also limited their interaction with non-Pakistani people. The likelihood of their participation in local networks was further constrained by a series of norms that located women's primary needs and interests within the context of the extended family, and within the physical space of home, discouraging participation in wider social life.

Several lived in households in which women did not leave home unaccompanied, or have any contact with strangers, particularly men. Unrestrained inter-gender mixing was frowned on as

a social embarrassment by some informants. One 21-year-old man spoke of how, despite his close friendship with a male neighbour, norms of decency meant that he had never spoken to his neighbour's wife. Another man spoke of his annoyance when the council sent male workers to his house, without telephoning to warn him, saying that norms of modesty strongly prohibited his wife from having contact with strange men.

While this group of women was aware of the existence of women's groups and English classes, they did not attend any themselves. Some cited poor health. One said she was exhausted by the combination of family duties and part time work. Every mother in our sample expressed an interest in matters relating to schooling. However, apart from one woman who had attended school meetings with her husband, this interest did not translate into participation in local community meetings. Women were divided over whether language constituted a constraint. Some said that meetings were often conducted in Asian languages to accommodate non-English speakers, while others said they didn't attend because of their poor English skills. Some women referred to gender modesty as a constraining factor, others to lack of education.

> Only our men participate, discuss in groups. Us women don't participate. We don't like it. If it is your brother or father - that is okay to discuss things with them, but not with other men. (27-year-old woman, Pakistan born).

> (Are you a member of any voluntary organisations?) No. No one does that sort of thing around here, we are all uneducated women, we just pray and that's all. (41-year-old woman, Pakistan born)

The situation of our second group of women - England born to Pakistani parents and currently at school or college - was in many ways deeply different. They spoke of how their families had encouraged them to get educated, find good jobs and "stand on their own feet" economically and professionally. They were more likely to be involved in local community organisations than their Pakistani-born married counterparts, describing involvement in sports activities, charity work, and in current efforts to set up an all girls' youth club. They had accessed such organisations through their schools or colleges, or through individual neighbours or relatives who worked for the local council. This group of women were

confident, socially skilled and at ease with life in England, drawing inter-changeably on the resources of what they described as a mainstream identity and a Pakistani one - and planning a life which they hoped would involve far greater emotional and financial independence from their families.

Interviews with young women reflected different parental attitudes to their upbringing. One impatiently described her parents' generation as "backward" and out of touch. However, another spoke of her parents' willingness to achieve compromises acceptable to both generations. She and her mother had an implicit understanding about her telephone friendships with young men. Young men would call her mobile, rather than the family phone; and she would switch off the mobile at night when she was with her mother. Another also spoke of older family members who actively encouraged her independence.

> My auntie, she taught us that education is the best thing, that's the only way a woman can get out of the society we are in. She goes, otherwise, women, they've got no way to get out of it. So she used to take me to London on the tube to teach us to be independent. So, she goes, when you want to go somewhere, you don't have to rely on a brother or an uncle to take you, you just go, yourself. (20-year-old woman, England born)

In this section we have highlighted a dialectic of unity and difference in the identity construction of two groups of women, resident in one small geographical area of one small town. We have illustrated that despite both groups' expression of strong allegiance to a 'Pakistani/Kashmiri' identity, they have little in common. One cannot simply assume that strongly held ethnic identities will automatically translate into a sense of common concerns which might facilitate involvement in ethnically defined local groupings.

3.4 Negotiating inclusion/ exclusion from the English mainstream

Much has been written about the social exclusion of visible ethnic minorities in Britain (e.g. MacPherson, 1999). Another key source of difference in our informants' accounts of their ethnic identities lay in their varying understandings of the possibility and desirability of various forms of inclusion and exclusion from what informants described as mainstream

English culture. While several people spoke of how racism had been a feature of life in the past, when Asian people were a small minority in the local area, most said that now that Asian people formed over half of the local population, they felt relatively shielded from such experiences. As one 39-year-old woman said: "There probably is still racism nowadays but we don't notice it because there's so many of our own people here that you don't really mix with the whites that much, you know, the English." A 15-year-old woman spoke laughingly at a white English friend's indignation when a young Asian man had called on her to "go back to her own country" as they walked down the local high street. The exception to this trend was among teenage men, as will be discussed below.

Most people described a selective participation in mainstream English life, often choosing participation at the level of education and work, and non-participation in the private spheres of life. Variations in negotiating differing possibilities of social inclusion or exclusion, and the extent to which these possibilities were regarded as positive or negative, resulted in different styles of engagement with local community life. We highlight a number of specific ways in which this selective participation constrained the likelihood of local involvement. This selective participation was less of an option for younger men than older people or women, and it was younger men who had the greatest first-hand experiences of overt racial hostility. These experiences of social exclusion were involuntary, and more psychologically alienating than the more selective and voluntary forms of exclusion.

Selective participation: private exclusion; public inclusion

Several people made a strong distinction between the private sphere (the inter-personal sphere of family and friends) and the public sphere (particularly the educational and professional arenas) in relation to their ethnic identities. In the private sphere, exclusion was often actively sought and valued, and non-integration was seen as positive, binding and strengthening Pakistani or Asian people in England. People often spoke of the Pakistani or Asian communities as self-contained units, with little interest in engagement with non-Asian people except in the educational and professional spheres. Several interviewees actively worked towards non-integration in their inter-personal interactions with family and friends. Older people often had little interaction with white people, other than limited contacts with neighbours, or particular friendships with single white colleagues at work e.g. fellow taxi

drivers. This was particularly so amongst those with poor English language skills, or women subject to norms limiting their socialising beyond the family. Younger people had far more contact with white people through work, school and leisure, enjoying these casual contacts to a certain extent, but preferring the company of other Asian people whom they "trusted" more, and who could "understand their culture". They referred to the incompatibility between Asian lifestyles and other ethnic groups, especially relating to dating and drinking. People also placed much value on what they referred to as the independence and self-sufficiency of the Asian community. In short, informants communicated a sense of belonging to an autonomous community, "with a strong sense of values which everyone follows" (15-year-old woman), with these values standing in sharp contrast to those of the majority white community.

In the public arena (including business and politics), while first generation Pakistanis were seen to have been disadvantaged in various ways, people said that successive generations were overcoming this disadvantage with increasing education and success in England. They often compared the Asian and white communities in terms of the former's superior commitment to education for example.

> I know a lot of white people who just don't go on to further education. A majority of Asian families now would say "Yes, go to college, university. Become something - a doctor, accountant, make something of yourself". Like even my doctor, he's an Asian, a Muslim, I went to get an injection. It's like, "Make sure you get a good job." I'm sure if white people go up to their doctor, they don't talk about things like that. (15-year-old woman)

Informants communicated a clear sense of having a stake in society in England, despite their commitment to maintaining connection with Pakistan/Kashmir. Most were adamant that they were not ‘English’ – saying that this label referred to white people only. Some were willing to describe themselves as ‘British’, though usually with qualification - ‘British Pakistani’ for example. Even so, there was a clear sense in which people felt they belonged in England, albeit if this involved a degree of self-imposed isolation from the mainstream culture. This sense of confidence belies the fact that levels of unemployment and poverty are high amongst Pakistani people. Rather than seeing such problems as the result of social inequalities,

however, interviewees ascribed them to individuals or families who failed to understand the importance of education, or who failed to work hard enough.

Pakistan as emotional 'home'

Many informants of all ages regarded Pakistan as their emotional 'home', despite feeling comfortable in England. For example a 33-year-old woman commented wryly on her father's insistence that when he died his body should be sent back to Pakistan, although he had lived happily in England for 50 years, only returning to Pakistan for five short visits. She described this as one key reason why people didn't identify with local community groupings and issues: "They don't think that England is their home, so they're not bothered, always waiting to go back to Pakistan."

This close identification with Pakistan was evident in a greater likelihood of identifying with Pakistani or Kashmiri political controversies than with English ones. Virtually every informant said that s/he had no interest in English politics. However, several spoke of how Pakistani and Indian people had trashed one another's shops at the time of the India-Pakistan nuclear controversy, and of how local violence arose in response to different positions on the Kashmiri question. Community divisions were also said to emerge around differences in caste, or "tribal" differences characteristic of society in Pakistan/ Kashmir.

Community involvement by the 'white English Other'

Local involvement was often typified as a 'white thing'. People said that Pakistan had no tradition of widespread involvement in community networks. Several said that there was far greater participation in Neighbourhood Watches, generating petitions or attending local meetings in predominantly white areas. Pakistani people who did seek to involve themselves in local community networks might be criticised for "acting white". One woman in her 30s, Pakistani born, England educated, and with a husband who was supportive of her voluntary involvement in a local welfare organisation, said her involvement had made her the object of negative gossip "..... for thinking I can class myself as British. They whisper that they all know where my mother and father come from; that I am still Pakistani, no matter what I try to think".

Integration as a source of stress?

Some informants found the issue of integration a stressful one. Women were generally more accepting of the inevitability of integration and synthesis between the two metaphorical spaces of 'England' and 'Pakistan'. In comparison, men were more preoccupied with maintaining and policing the boundaries between the two, expressing dismay at increasing Pakistani integration into mainstream lifestyles. They portrayed England as their material and professional home, and Pakistan as their spiritual and moral home - trying to keep the two worlds separate.

Several men said that compared to life in Pakistan, life in England had given people access to material possessions, individualistic values and a relatively easy life. This experience had served to undermine the social care, compassion and collective responsibility associated with Pakistani culture in general, and the Muslim religion in particular. They spoke of how the relative poverty and struggle associated with life in Pakistan, and the difficulties faced by the earliest Pakistani migrants to England, had humanised people, giving them a deep sense of compassion for the suffering of others.

Several men said the morals of the host culture were often incompatible with their own, with mainstream English culture described as potentially corrupting. Whilst this view was most common amongst older men, the most religious of the younger men in our sample also saw integration as a slippery slope. Thus, while several people referred to the need for safe and healthy sports facilities to keep young men out of trouble, one devout 21-year-old man was particularly opposed to community centres. He spoke of young Pakistani people being corrupted by the bad language used by white university students who frequented a local council-funded table tennis facility. He said that community centres promoted unnecessary contact between the incompatible English and Pakistani cultures. He spoke of how as young Pakistani peoples' school grades went up, so their morals went down, with school failing to restrict or police contact between boys and girls, or to police their behaviour in terms of Islamic traditions. Some men also spoke of how the individual freedoms accorded to women in England undermined the traditional control their families had over them. One 46-year-old

man spoke regretfully of "the problem of the law" in England, where social workers could take away women "if any mistake was made".

We cannot exaggerate the strength of feeling that some men associated with the loss of their roots on moving to England.

> What did we gain coming to this country? For earning a few quid, I destroyed my life, we lost ourselves. (49-year-old man)

However this view was by no means common to all men, or even to all older men. One 67-year-old interviewee regretted that more efforts were not made to integrate young Pakistani mothers into "English culture". He said children were disadvantaged both educationally and professionally by mothers who spoke little English and could not teach their children how to fit into mainstream English society. Another older man expressed relief that life in England had freed him from crippling responsibilities for large numbers of family members - compared to his brothers in Pakistan.

Young men and racism

To a certain extent older men were able to construct lives involving little contact with the white English mainstream. However, younger men's lives made it more necessary for them to engage with this social group. Even those who were not devout practising Muslims placed much emphasis on the "influence of friends" in their interviews. Good friends were committed to what people referred to as Muslim or Pakistani traditions and customs. Bad friends encouraged young men to drink, smoke and have white girlfriends. However, despite frequent reference to the potentially corrupting influence of English culture and norms when speaking generally, most younger men appeared keen to integrate in wider English society, expressing envy of what they regarded as the relative sexual and social freedoms of their non-Asian counterparts. Yet contact with young white people, either voluntarily in a leisure context or necessarily through attendance at mixed race schools and colleges, also brought them into contact with racism from teachers and fellow pupils.

> White boys, don't wish to be with us, they think bad things, and don't befriend us. (Why not?) Because we are different colour, that's why. (16-year-old man)

> A lot of the Pakistani people don't like the English people, and the English people don't like the Pakistani people, a lot of fights happen because they are of different colour. Some white people probably think 'Why are they living in our country, they should be going back'. But we have got right to live here as well. (15-year-old man, England born)

Another echoed this sense of exclusion from English society more broadly, emphasising that despite being England born, and despite his view that minority ethnic people currently had "equal rights" in England, he never forgot that he was a "foreigner". For this reason he was determined not to lose contact with relatives in his parents' village in Pakistan.

> If Great Britain was coming under some crisis and like if they done ethnic cleansing here, too many things can happen. Where would be go? Its good to build something back home, just in case. (23-year-old man, England born)

While this sense of exclusion could certainly - in principle - form the basis for the political mobilisation of young men, our particular interviews pointed rather to a sense of personal disillusionment and alienation.

3.5 Identities as a source of strain?

Above we highlighted the way in which people spoke of the extended family as the central building block of Pakistani identity, and how extended family norms sometimes served as invaluable support networks for informants. We also highlighted some informants' accounts of ways in which such families sometimes failed to provide this stereotypical support. In this section we point to ways in which certain family norms actively prevented people from looking outside of the family for meeting their needs for help, support or companionship - the types of needs which might potentially be met in local community networks or voluntary organisations. One norm, frequently mentioned by men and women alike was that of 'keeping things in the family'. This issue was emphasised particularly strongly by the young woman who worked as an Urdu interpreter at a local centre providing support and counselling for

Pakistani women. She referred to the veil of silence covering issues like drug addiction and domestic violence, which she described as serious problems in this particular area. While women might occasionally be persuaded to confide about their problems in a one-to-one counselling setting, they would never do so in group contexts. This was partly motivated by a fear of gossip, or fear that their confidences might be reported back to their husbands. She spoke of the particular reluctance of many husbands to take up family counselling for fear that the counsellor would challenge their authority as the male head of the family.

> I mean if we say to him 'Respect your wife, respect her feelings as well, listen to what she has to say,' the husbands always agree while they are there. But afterwards they would say to her: 'Don't you dare take your foot out of the house, or I don't want to listen that you get connected with that counselling woman again.' They think that we inspire their wives.

In some of our interviews with men, the importance of 'keeping things in the family' was linked to a culture of independence. When asked if they had ever approached the council for help, while younger men spoke of visiting job centres or accessing benefits, older men answered emphatically that they had never needed any help, and that when they had problems they sorted them out for themselves.

However the key reason for both men and women for 'keeping one's problems in the family' was to avoid gossip, which every informant without exception referred to as a serious and extremely damaging community problem. Younger, English-born women were particularly vocal about the strains of living in a community of "evil gossipers", describing it as "stifling" and "claustrophobic". The worst culprits were said to be women from Pakistan, often isolated at home with few social contacts, who "gossip to pass the time". People said that no aspect of their lives went un-commented on by neighbours, who peered out of windows, forming judgements on "what you wear, or making up bad reasons for why you walked up and down the same road twice in one day" (15-year-old woman). This group of young women portrayed gossip as an ethnically specific thing.

> A typical Pakistani family is just the ones who are really nosey - and they like to gossip about other people. (18-year-old woman)

Within this context, the local community was often seen as a source of strain rather than support, especially for mothers with problem children. In our sample, two such women said they chose not to seek support from local community welfare organisations for fear that their childrens' 'failings' would reflect badly on them as mothers, and on the family. A 41-year-old woman whose son took drugs and stayed out all night, dreaded leaving her house. She spoke of her fear that "people will say I can't control my own children", and how this resulted in persistent headaches and body pains People went to great lengths to avoid being gossiped about. Several women referred to fear of gossip as one reason for avoiding involvement in community affairs, particularly controversial ones.

4. Conclusion

In this paper we have sought to highlight factors constraining the participation of Pakistani people in local community networks. We have done so in the light of the lag between health inequalities policies which emphasise grassroots participation as a means of reducing health inequalities on the one hand, and the dearth of parallel research by medical social scientists on the other. To what extent did our interviews provide evidence for a sense of common ethnic identity that might unite people in local community networks and collective action projects to address ethnically defined social problems? Our findings pointed to a dialectic of unity and difference in the process of identity construction by our interviewees. There were strong common denominators in peoples' accounts of their ethnic identities. Everyone assertively identified him or herself as 'Pakistani/Kashmiri', with such identities often serving as key resources in the inter-personal and professional spheres. At one level, evidence for an ethnically defined common identity would seem to point to the viability of promoting community-level action for health. Such action could build directly on epidemiological findings that highlight ethnicity as a significant determinant of health inequalities.

However, our findings sound a number of cautionary notes for health policies and interventions seeking to promote local participation. Despite expressing strong allegiances to their Pakistani identities, interviewees interpreted these identities very differently as a function of factors such as age, gender, educational levels, language skills and marital status.

One cannot assume that people who stress an allegiance to a particular ethnic group will automatically have common needs and interests of the kind that would unite them in common local health initiatives. Furthermore, despite the salience of these identities in the interpersonal and educational/ professional dimensions of peoples' lives, they did not automatically translate into resources linking people at the level of local community networks. Participation in local voluntary organisations, faith groups or community activist groupings was minimal, and the community level involvement that did occur was often dominated by older men rather than mobilising a representative group of people across both genders and all age groups.

Finally, our micro-qualitative interviews have pointed to numerous ways in which various dimensions of social exclusion undermined the likelihood that people would regard local community networks as representative of their needs. Thus for example, all of the younger men in our sample spoke of being at the receiving end of blatant racism from their white English counterparts. This had led to a sense of alienation from their local communities, rather than a sense of confident inclusion that might have fostered their enthusiastic participation in local networks and activities. By the same token one cannot also assume that all members of a community will have equal opportunities to become involved in local networks. Our interviews suggested that ethnicity was not the only dimension of social exclusion limiting peoples' local community involvement. Language skills restricted some men and some women. Gendered restrictions on the freedom of movement and association of some women (although not others) also served as a limiting factor, both directly and indirectly. Directly, our interviews suggested that compared to married men, a range of factors limited the freedom of some married women to engage in social networking beyond the spheres of family and home. Indirectly, our interviews suggested that such restrictions on women also served to restrict them to small, inward-looking social circles in which gossip flourished. High levels of scrutiny had resulted in a context where many people spoke of attention from the local community as a source of strain and symbolic danger, rather than a source of social support. Within such a context many said they would be unwilling to seek help or support outside of their immediate families.

What are the implications of our findings for the three forms of allegedly health-enhancing participation which we outlined on page 5? The first was the participation of minority ethnic

people in consultation fora regarding the design and delivery of health services, with local voluntary groupings and faith networks being regarded as a key means of accessing grassroots representatives for such consultation. Caution needs to be exercised in assuming that the membership of such groups and networks will automatically serve to identify representatives who are qualified to articulate the needs and interests of their minority ethnic group across dimensions such as age, gender, educational levels and language skills. In our particular sample, a range of constraints limited women, particularly Pakistani-born married women with poor English language skills, from networking freely beyond the sphere of family and household. It cannot be assumed that information about the views and interests of such women are best relayed to health workers via representatives of local formal voluntary networks and organisations that seldom contain members of this group. Yet it this very group of women who might be particularly disadvantaged in English-language health-care settings staffed by professionals who may not always be familiar with their cultural needs, or with their understandings of health and illness. To cite another example, health inequalities policies often mention faith groups as a particularly important arena for mobilising the participation of grassroots people. Yet in our particular sample, few people participated actively in mosque activities, saying that mosque networks in their area were dominated by a small group of powerful people - again mostly men - with particular political and economic interests.

We do not seek to dispute that local voluntary organisations and faith groups should form *one* means of access to minority ethnic group members to work in partnership with health professionals in improving services. However, we argue that they should not be regarded as the *only* means of access to members of marginalised ethnic groupings. Our interviews have highlighted the way in which Pakistani identities are far more likely to unite people in informal face-to-face networks of extended families, neighbours and friends, than in the more formal voluntary networks referred to in social inequalities policies. This finding points to a number of important areas for future research and policy development. In the *research* arena, much room remains for systematic investigation of the extent to which particular local voluntary networks do or do not succeed in mobilising a representative range of local people. There is also much room for further research into the nature of the informal face-to-face networks which featured so prominently in our interviews, and which have not to date been cited as a resource for health promotional interventions. In the area of *policy and practice*,

there is a need to develop and share creative methods for accessing such people who are excluded from participating in more formal voluntary associations. We suspect that numerous creative strategies of this nature may already have been developed in the array of small local community health projects which exist all over England. However, because of the dearth of formal research in the area of grassroots participation for health, and the relative dearth of collaborative research between health academics and health activists working at the community level, these experiences have yet to be documented and systematised in a body of formal research studies. Yet such documentation is essential if social scientists are to contribute to the development of theoretical frameworks for the design and evaluation of participatory health strategies. Such frameworks would facilitate the development and communication of generalisable lessons from the successes and failures of the proliferation of existing community development projects in England and abroad.

Our material highlights the complexities inherent in seeking to translate epidemiological findings about ethnic health inequalities into policy directives outlining measures to reduce such inequalities. We have no doubt that increased levels of participation at all levels of society are an important precondition for reducing social exclusion of marginalised groups. We would argue, however, that it is insufficient simply to assert that such participation should take place in the vague and general way found in the policy documents we have cited. No matter how significant a category such as 'Pakistani' might be in statistical analyses of health inequalities (in the work of colleagues such as Nazroo, 1997, for example), such epidemiological categories cannot simply be 'mapped' onto policy recommendations. This is particularly the case in relation to policy directives that presuppose relatively complex psycho-social and community-level phenomena and processes such as social identity and participation.

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