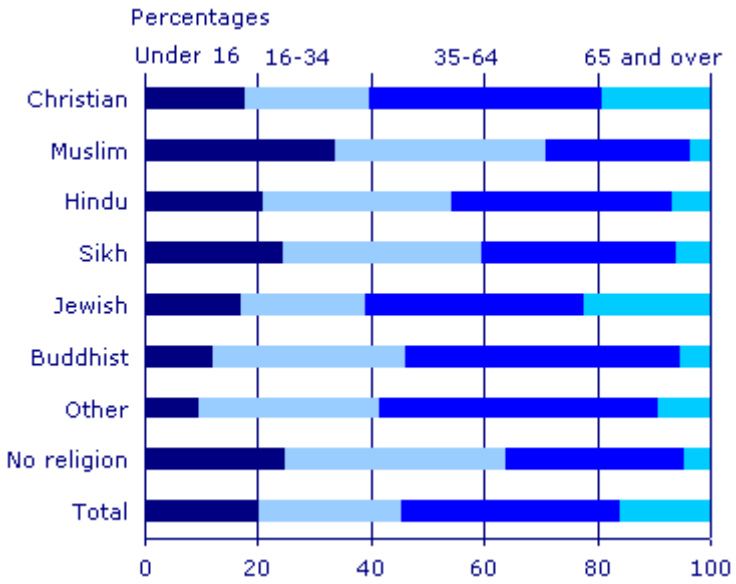
Muslim Statistics

Age and Sex Distribution : Muslim Population is Youngest



Results from the 2001 census, show that Muslims have the youngest age profile of all the religious groups in Great Britain. About a third of Muslims (34%) were under 16 years of age in 2001, that means, 5 years on those under 16's are now 21 and under. 25% of Sikhs and 21% of Hindus were also under 16 in the nationwide survey carried out at that time. It therefore comes as a shock that provisions through the youth work sector are not being specifically made for Muslim young people, when they make the largest faith based youth group.

While other much smaller groups have been well established for youth work with Christian and Jewish young people, the Muslims have had very little support. It is clearly evident that Muslim youth work is going to have to play catch up, if it is to communicate the conversations that are taking place at the grass roots level, working bottom up to influence and inform the myriad of organisations; governmental, statutory and voluntary with regards academia, policy and delivery that affect Muslim young people.

Given the particular social context in which Muslim young people are growing up in Britain, the diversity of forms that youth work takes and the salience of youth work currently to public policy, youth work should provide an entitlement to Muslim young people that will enable them to firstly acknowledge and secondly seek to fulfil their potential.

The statistics also show that there are very few older people in these particular groups – less than one in ten were aged 65 years or over. The Jewish and Christian groups have the oldest age profiles with one in five aged 65 years or over (22%and 19% respectively).

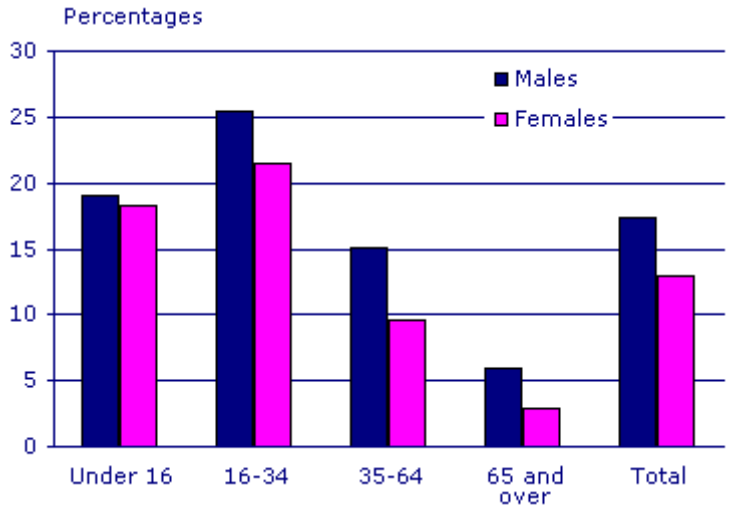
These differing age profiles reflect the ethnic make-up of the different religious groups. Christian and Jewish communities contain predominantly White people who have lived in

the UK all their lives or who migrated here before the Second World War, and have an older age structure. Muslim, Hindu and Sikh communities are predominantly of South Asian ethnic origin and have a younger age profile, reflecting later immigration and larger family sizes with more children.

Muslims are the only religious group in which men outnumber women – 52 per cent compared with 48 per cent. This reflects the gender structure of Pakistani and Bangladeshi groups, in which men slightly outnumber women due to their immigration history. In all other religious groups there are either the same proportions of men and women or slightly more women than men, reflecting the fact that women live longer than men in the general population. However, men formed the majority of the 'no religion' group, with 56 per cent.

There is greater gender variation among the other smaller religious groups in England and Wales. In 2001, women made up more than two thirds of people who gave their religion as Spiritualism (68%) or Wicca (67%). Women also formed just over half of the Pagan and Bahà'ì groups – 54% and 53%. Conversely, among Rastafarians and Zoroastrians, men were in the majority (70% and 54% respectively).

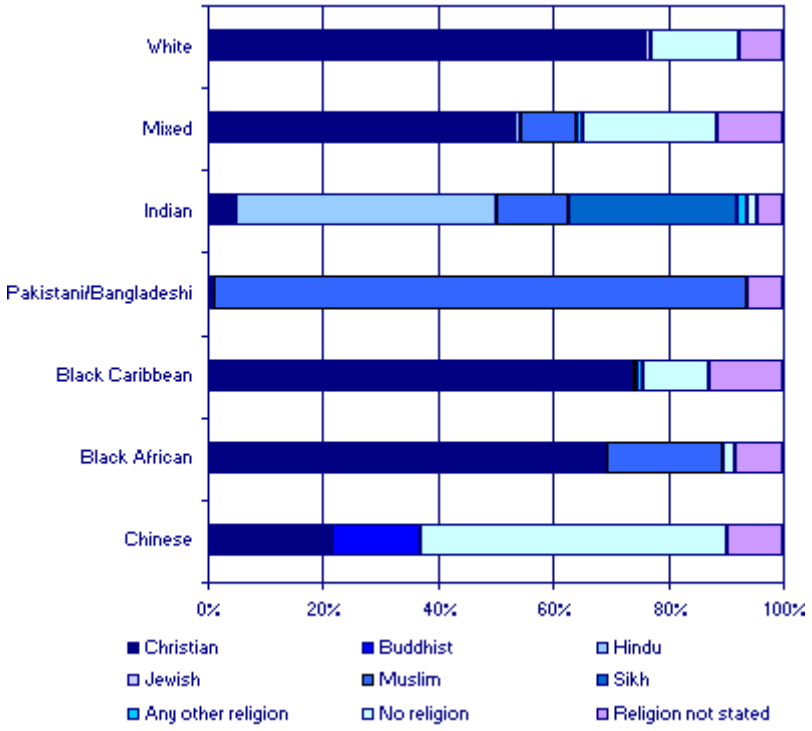
Gender Variation



Percentage with no religion: by age and sex, April 2001, GB

Younger people are more likely than older people not to belong to any religion, reflecting the trend towards secularisation. Among 16 to 34 year olds in Great Britain, almost a quarter (23%) said that they had no religion compared with less than 5% of people aged 65 or over.

Ethnicity and Religion



Information collated about ethnicity and religious identity gave results that while the population is more culturally diverse than ever before, White Christians are by far the largest single group.

Among the remaining faiths, the largest groups were Pakistani Muslims with 658 000, and Indian Hindus forming 467 000, followed by Indian Sikhs who were 301 000, Bangladeshi Muslims at 260 000 and White Jews who were 252 000.

The Indian group was religiously diverse. 45% of Indians were Hindu, 29% Sikh and a further 13% Muslim. By contrast the Pakistani and Bangladeshi groups were more homogenous, with Muslims accounting for 92% of each ethnic group.

Some faith communities were concentrated in particular ethnic groups. For example, 91 per cent of Sikhs were Indian and 97 per cent of Jews described their ethnicity as White. Others faiths were more widely dispersed; significant proportions of Buddhists were found in the White, Chinese, Other Asian and Other Ethnic groups.

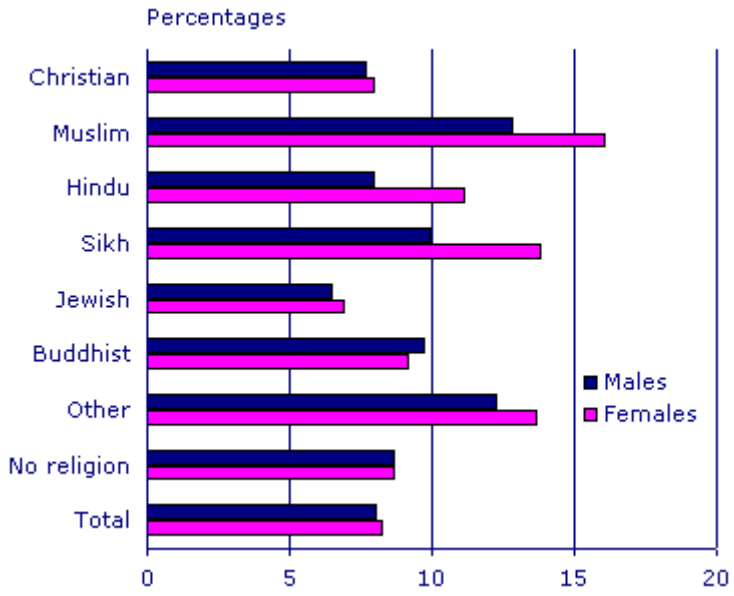
The voice of young people is often rightly questioning or critical. Across and within communities it tends to be differentiated by gender, class, ethnicity and disability. Whether these differentiations are stronger in religious organisational context needs to be considered. This voice of Muslim young people should be encouraged to influence policies and programmes with government and its agencies, local authorities, children's trusts, services and within their own communities and neighbourhoods and religious and other organisations.

There is a powerfully articulated fear that the more Muslim young people become the less British they will be. In the professional youth work context this is translated into the more Muslim they become the more compromised are the values and principles of youth work. This equation needs to be re configured to in order that there is an understanding that the more informed, healthy and safe young Muslims feel about their Muslim identity the greater their comfort with their Britishness and their civic involvement.

Sources :

National Statistics website: www.statistics.gov.uk

Health & Disability : Muslim's Have the Highest Rate of Ill Health



The general health question in the 2001 Census was 'Over the last twelve months would you say your health has on the whole been Good, Fairly Good, Not Good'. Age-standardised rates were then used and staggeringly, a whacking 13% of Muslim males and 16% of Muslim females put themselves forward as having health which was "not good". What does that mean taken out of percentage terms? If the Muslim population stands at about 1.6 million people, then, 13% of men and 16% of women make up 29% of Muslims, that's just less than half a million people, who say their health is "not good" (that's 464 000 to be more precise)!

This can bring forth a barrage of questions;

- Is that because Muslims tend to feel a little more sorry for themselves?

- Is it that they do have poor health, and it's due to their immune systems being different because of their differing their ethnic origin.

- Is it that Muslims tend to live more poverty stricken areas, under harsher conditions than their Non-Muslim counter-parts?

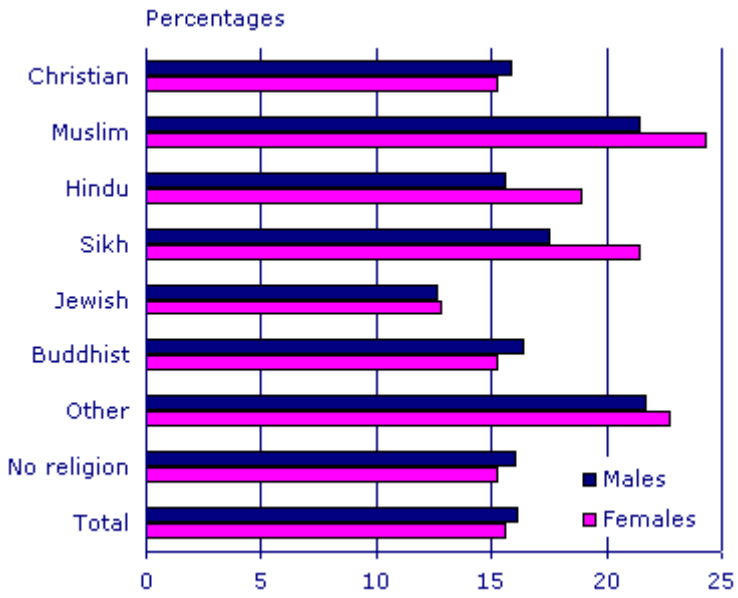
So when there is a statement that comes about saying "Muslim males and females in Great Britain had the highest rates of reported ill health in 2001." One must question where the authority on this is coming from; Is it their GPs and Primary Care Trust reports, or is it the individuals themselves who have complaints about their health, where they create their own yardstick to measure what "good", "fairly good" and "not good" all mean.

A report published by Medical research Council Social and Public Health Sciences Unit (1999), did a study on South Asians in the UK, and ascertained that there was a high heart disease mortality rate even though these South Asians originally come from rural areas where heart disease is low. Medically, South Asian heart disease has been linked with abdominal fat, and so the research focused on the role of diet and exercise, and specifically looked at women, as they were most involved in food preparation. Migrant and British-born samples were compared with the general population. But is it that perhaps the imbalanced diet and/or lack of exercise that factors in for the reason of "not good" health? Rates were also high for Sikhs: 10 per cent of males and 14 per cent of females rated their health as 'not good'. These rates, which take account of the difference in age structures between the religious groups, were higher than those of Jews and Christians, who were the least likely to rate their health as 'not good'.

Females were more likely than males to rate their health as 'not good' among most groups. The gender difference was most notable for Muslims, Sikhs and Hindus. Among females, 16 per cent of Muslims, 14 per cent of Sikhs and 11 per cent of Hindus rated their health as 'not good'. These rates were 3 to 4 percentage points higher than their respective male counterparts.

There was little gender difference in the rates for Christians and Jews, and no gender difference for those with no religion. Buddhists were the only group where males were more likely than females to say their health was 'not good'.

If the different age structures of the religious groups are not taken into account, Christian and Jewish groups have the highest proportions of people saying their health was 'not good'. This is a direct result of the older age profiles within each group.



There are marked variations in rates of disability or long-term illness which restrict daily activities between people from different religious backgrounds in Great Britain.

In 2001 the highest overall rates of disability were found among Christians and Jews. However, once age was taken into account, Jewish people had the lowest rates of disability (13% for both males and females). Christians had the second lowest age-standardised rates, at 16% for males and 15% for females respectively.

After taking account of the different age structures of the groups, Muslims had the highest rates of disability. Almost a quarter of Muslim females (24%) had a disability, as did one in five (21%) Muslim males.

It should be noted that the term disability is used to refer to limiting long-term illness or disability which restricts daily activities. It is calculated from a 'Yes' response to the question in the 2001 Census: 'Do you have any long-term illness, health problem or disability which limits your activities or the work you can do?'
Any Muslim reading this should be a little scared, with such a high proportion of individuals being limited in such a way.

In some groups the gender difference in rates of disability was much greater than in others. In Muslim, Hindu and Sikh groups disability rates for females were about 3 percentage points higher than for males. For Buddhists, Christians and those with no religion, disability rates were slightly higher for males than for females.

An organisation called DASH (Determinants of Adolescent Social well-being and health), has been further investigating the relationship between social conditions and health, health related behaviour, and well-being of young people from different ethnic groups living in London, particularly Black Caribbeans.

They are keenly looking at aspects of family life and school life that relate to health, health-related behaviour, and well-being of ethnic minority young people. Researchers have been working with a wide number of respondents. They have been examining how social conditions, family life and school life may work together to influence health, health-related behaviour, and well-being, with real analysis on ethnic differences in health and health-related behaviour between ages 11-13 and ages 14-16. Their hope is to decipher whether this data can help us to understand why some ethnic groups experience higher rates of certain diseases than other ethnic groups in adulthood.

The Medical Research Council (MRC) are also undertaking a variety of projects because very little is known about the reasons for the prevalence of chronic diseases and certain illnesses in ethnic minorities that can quite visibly be observed in the UK. Whether these causes emerge in childhood or through generational transmission is at present unknown, and it is an aim that through the research conducted we will be able to answer this. The major focus of the programme is on UK-born ethnic minorities and whether susceptibility to poor health in later life is discernable in childhood or adolescence.

Another study is focusing on tracking health over the life course and over generations in ethnic groups in different contexts and places necessary for the understanding of the evolution of ethnic disparities in health.

Large numbers of datasets are being used to examine how acculturation occurs and how it is linked to health outcomes at different points of the life course and over different generations. The conventional wisdom is that health outcomes should converge towards those of the host population but there is increasing evidence of a more complex pattern that is possibly influenced by both structural factors and sustained cultural practices. One of the projects included using the Office for the national Statistics Longitudinal Study to examine intergenerational/age cohort changes over the last three decades in family arrangements, area of residence and indices of deprivation. These social trajectories are being examined in relation to a range of health outcomes. Selective migration between areas of different levels of deprivation is another area that is analysed, providing methodological challenges to measuring trends in health inequalities.

Sources:

Census, April 2001, Office for National Statistics
Census, April 2001, General Register Office for Scotland
MRC Annual Report 2006: http://www.msoc-mrc.gla.ac.uk
DASH: http://www.msoc-mrc.gla.ac.uk/DASH/DASH-MAIN.html