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The Nigerian Community Health Profile was commissioned by Birmingham City Council to review the evidence on the Nigerian community in Birmingham and nationally. The report synthesises evidence on the experiences, needs and outcomes of the Nigerian community across a range of health and well-being indicators, including education, employment, housing, mental health, disabilities, substance (mis)use and physical activity. It illustrates the multi-layered barriers and inequalities faced by people with Nigerian backgrounds in relation to their health and everyday lives and highlights gaps in the existing evidence base. The report demonstrates the public health need for comprehensive monitoring, research, and engagement with Nigerian communities at a local and national level.

The Nigerian Community Health Profile is part of a wider series of evidence summaries produced by Birmingham City Council which focus on specific communities of interest.

Authored in partnership with:

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May 2022

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a much larger range of countries of origin than just Nigerians, it is, nevertheless, of some validity as a proxy as the migration of Black Africans to Britain was dominated by Nigerians up to 2011. Moreover, the time when Black African migrants came to live in this country is very similar to the timing of Nigerian migrants.

Even routine health data for the census category 'Black Africans', released by ONS and NHS Digital, is usually for England/England and Wales. While NHS Digital's fingertips database was set up to provide data for Local Authority Profiles, the database largely lacks data on migrant and minority ethnic groups in its inequalities indicators.

A further major drawback of using 'Black African' data as a proxy for the Nigerian population is that many of the NHS Digital, ONS and other datasets are for the five broad ethnic groups ('White', 'Mixed', 'Asian', 'Black', and 'Other'). This is problematic as, in some areas of health/ healthcare, there is substantial concealed heterogeneity in the 'Black' pan-ethnicity (comprising Black Caribbean, Black Other, and Black African groups). Even broader collectivises have come into recent use, such as BME and BAME, that cover all groups that are not 'White', sometimes because of small numbers ("sparse data bias") in the study population[2].

At the fine-grained end of the categorisation scale, the 'Nigerian' population category is, itself, heterogeneous, containing diverse ethnic, religious, and language groups. Fine-grained ethnic data is available in the Department for Education 'Extended Category' codes, including 'BNGN: Nigerian' and codes for Nigerian languages ('Edo/Bini', 'Igbo', 'Hausa', and 'Yoruba'). Apart from the education sector, these are scarcely recognised by officialdom in Britain. The ethno-religious (or ethno-linguistic) groups, the Yoruba, the Igbo, and the Hausa are used in the context of educational attainment in London[3]. Akinlua *et al.* investigated beliefs about hypertension amongst Nigerian migrants to the UK across seven Nigerian ethnic groups (Yoruba, Igbo, Hausa, Tiv, Urhobo, Okpameri, and Ijaw) (see chapter 6)[4]. These fine-grained groups are also important for language provision, the community languages used by the NHS for COVID-19 vaccination communication materials include Igbo and Yoruba.

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1.1 I C

There is substantial diversity in terms of fine-grained ethnic groups. These are meaningful and have significant saliency amongst Nigerians living in Nigeria and may also be part of their personal identity for Nigerians living in Britain.

There are around 250 ethnic groups in Nigeria and similarities between them enable these groups to be aggregated into six major ethno-geographic clusters: the Hausa, Fulani and Kanuri constitute two clusters in the northwest and northeast; the Yoruba in the southwest; the Igbos in the southeast; the 'south-south', composed of Ijaw, Ikwerre, Ogoni, Efik and Ibibio; and the Nupe and Igala in the north-central regions[6, 7, 8]. There is a relationship between ethnicity, geographical location, and religion:

hi85 (l)1.4 (n t)-8.6 (h)1.1 (e(e)4.6 (a)0.6 (s)-21 (t)6.1 (e)-1.1 (r)2)253 nhers92.3 (,inh)1.1 clugbo-3557 (, a)6.5 (j)6.3 (a)6.7 (w)47.7 (, a)-1.6 (n)-2.8 (d E)-323 (fi)0.9 (n)-2.8

arrived in the UK to either get married/form a civil partnership, to seek asylum, as a visitor, or for other stated reasons) (24.4%); work related (19.2%); and formal study (13.9%). With respect to the UK overseas-born population by nationality, an estimated 128,000 were British nationals, 130,000 nationals of Nigeria, and 23,000 of other nationality[11].

Robust estimates of the size of the Nigerian ethnic group population are not available. While the ‘Bll

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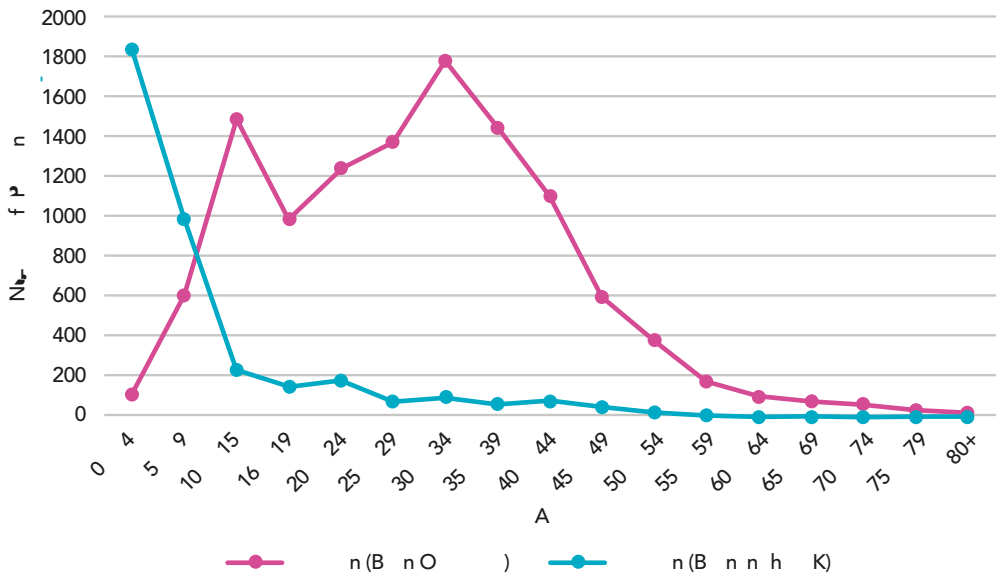


Source: Birmingham LA and Solihull LA combined. (2011 Census).CT0430_2011

Additionally, it can be seen by Table 1 that there is a higher Proportion of the Black African population that has migrated to the UK, compared to those born in the UK.

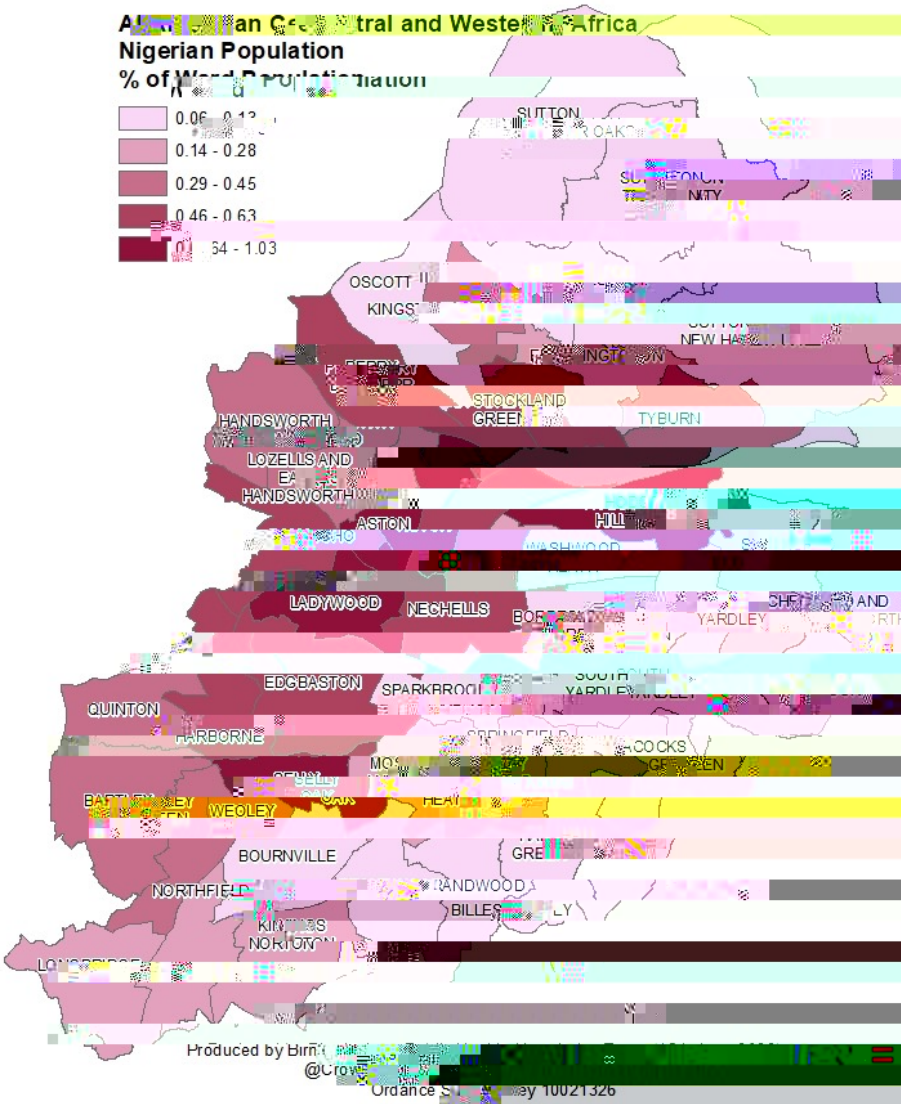
1: B A , , ,
(K,)

	B K	B O	
M	3,983	11,366	15,349
F	3,824	11,670	15,494
	7,807	23,036	30,843

Source: Birmingham LA and Solihull LA combined. (2011 Census).CT0430_2011

Data has been extracted from the 2011 England and Wales Census using NOMIS for Lower-Level Super Output Areas for the Metropolitan Borough of Birmingham. The number of Nigerian migrants in Birmingham in 2011 was 3,399 persons. This relatively small number was widely dispersed across the city. Of 638 Lower-Level Super-Output areas in the city, 150 (23.5%) had no Nigerian migrants, and a further 45.8% had only 1-5 Nigerian migrants. Only 33 LLSOAs had over 20 Nigerian migrants and there was just one outlier with 97 Nigerian migrants. An LLSOA has an average size of 1500 persons. The population of Nigerians in Birmingham can be seen by figure 6 (see Appendix 5 for full data).

F 6: N B



Source: Graph produced using data extracted from 2011 Census[16].

Nigerian students in higher education institutes in Birmingham comprise a significant proportion of Nigerian migrants

TFR of 2.25, the third highest after Bangladeshis (3.96) and Pakistanis (3.16) and higher than the White group (1.76). By 1996-2000 the Black African rate had fallen to 2.05 but increased to 2.37 in 2006-10, remaining third in rank-ordered rates. While there is a trend towards the convergence of fertility rates across ethnic groups, only the Black African group significantly increased its TFR between 1996-2000.

Simpson's findings are broadly consistent with those of other investigators who use the own-child method to calculate average period total fertility for 1996-2000 and 2001-2005 from the Labour Force Surveys[22]. These investigators estimat.2 75y(s)-85BDC BT0 Tc 0 Tw 11 0 0 S9 een-GB-16.660ETEMC /P <</Lang (en-GB)/MCID 791D 793 >>BDC BT0 Tc 0 Tw 11 0 0 11 348.7 (k A)4

1.7 N I H :

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C W C

2.0 C

2.1 G B L

G B L K F :

- The total fertility rate (TFR) of the Nigeria country of birth group (7,476 births, 3.32) was seventh highest in Sub-Saharan Africa, above that for the UK-born (1.84) and more than twice the England and Wales average.
- In 2020 Nigerian-born mothers contributed 5,575 live births (or 3.1% of all live births to mothers born outside the UK, and 0.9% of live births to all mothers).
- 0.82% of all live births in Birmingham from 2012-2014 were to mothers born in Nigeria but 1.72% of all stillbirths.
- There is no Nigerian-specific data on child weight. In 2019-20 Black African children in England, aged 4-5, had the highest rate (15.9%) of obesity across ten ethnic groups, substantially higher than the White British group (9.7%).
- The proportion of overweight or obese boys was highest in the Black African population (42%), and Black African girls were also one of the ethnic groups most likely to be overweight or obese (40%)

2.1.1 M H

Fertility rates for many migrant groups in Britain (including Black Caribbeans) have declined to around the national average, and below it in some cases. However, over recent decades Black African women have had higher total fertility rates (TFRs) than most other ethnic groups and in 2011 women born in several African countries were featured in the top 20 for number of births. Fertility rates are frequently calculated around the time of the decennial census as ethnic group iicr-1.1 EMC /P <<coe de (a)4.5 (f b1-1.2 (i)4.1 (r)-48.6 (t)-8.8 (d)]TJETEMC /P <</Lang (en-GB)/MCI3 919 >>BDC

of White women)[32]. Of these 32 women, 22 were ‘Black Africans’. Thus, Black women have more than five times the risk of dying in pregnancy or up to six weeks postpartum compared to White women, women of Mixed ethnicity three times the risk and Asian women almost twice the risk. The report also noted that Black women (compared to White) are around 3 times more likely to develop pre-eclampsia in their pregnancies. With respect to specific countries of birth, women born in Nigeria had the highest of the listed rates: 10 deaths amongst 20,469 maternities, a rate of 48.85 per 100,000 maternities, a relative risk of 6.13 compared with 1 for women born in the UK. Nair *et al.* report a similar picture for severe maternal morbidity in a national cohort of data collected by the UK Obstetric Surveillance System (UKOSS)100.1 .3 (5.3 (r)-12.ang (.8 (3 ()(r)-28BT/T 0.72es4.3 ()100.1 .3 (5.3 (r)-12.ang (.8[.2y4T9 362.92 .3 m(33)Tj.1 .3 (5.3 (r)-12.ang (.8

natal depression. British mothers were more likely to receive functional

was associated with preterm birth (aOR 1.6, 95% CI 1.1-2.2) and Caesarean section (aOR 2.2, 95% CI 1.5-2.7); no differences were found in rates of instrumental delivery and the Nigerian group had half the risk of genital tears (aOR 0.6, 95% CI 1.1-2.2) with a higher likelihood of undamaged genitals (aOR 1.5, 95% CI 1.3-2.1). Perinatal indicators of neonatal distress were increased among Nigerians, namely a low Apgar score (aOR 2.6, 95% CI 1.4-4.9), new born intensive care unit admission (aOR 1.7, 95% CI 1.1-2.8), and stillbirth (aOR 4.0, 95% CI 1.3-12.8).

Sickle cell disease

2.1.4 C

There is a paucity of data on childhood vaccinations stratified by ethnic group as official vaccination data collections do not include ethnic group, though this is recorded in Child Health Information Systems that include vaccination status and in most GP recording systems. The most robust study is a population-based analysis of routine vaccination uptake patterns among different population groups from the QResearch database, using individual level primary care data[64]. Disparities in vaccination uptake of influenza, meningitis C and rotavirus, and measles, mumps and rubella (MMR) vaccines were assessed in 2,447,875 children aged under 18 years across ethnic groups. Logistic regression models were used to estimate the odds ratios for 8 ethnic groups compared to those of White ethnicity. Variations in vaccination uptake were observed across different ethnicities for children. For influenza (n=1,617,686), the odds ratio (OR) for Black Africans, OR 0.93 (0.87- 0.97) was substantially higher than for Pakistanis (0.72 (0.68- 0.76)) and Black Caribbeans (0.49 (0.46- 0.51)). For Rotavirus (n=497,524), the OR for Black Africans was 0.75 (0.66- 0.86), similar to Indians, Pakistanis, Other Asians, and, again, higher than Black Caribbeans (0.51 (0.45- 0.59)). For MMR (n=1,679,356) Black Africans had an OR of 0.76 (0.68- 0.86), the lowest of the eight ethnic groups and lower than Black Caribbeans (0.88 (0.79- 0.98)). For meningitis C (n=1,679,356), Black Africans had an OR of 0.92 (0.86- 0.99), lower than Black Caribbeans (1.17 (1.09- 1.26)) but higher than other ethnicities (Indians, Other Asians, Chinese, and Other).

2.1.6 C

There is a substantial body of evidence for childhood poverty in Asian and Black households, but no granular information on Nigerian children and families in the UK. A report by ONS found that the Black (30%) high-level ethnic groups had a higher percentage of children living in low-income households than the national average[69]. This may be partly explained by the fact that the Black group has an unemployment rate of 9%, higher than the national average (4%). In addition, amongst the high-level ethnic groups, the Black and Mixed ethnic groups were the most likely to have gross household income (the income that a household has available for spending after taxes and benefits are taken into account) of less than £400 per week. The percentage of children in Black households living in persistent low income (2013-17) was six percentage points higher than the percentage of children in White households living in persistent low income. 22% of children living in Black households were living in low income and material deprivation, compared to 10% in White households.

Eligibility for free school meals (FSM) provides another measure of childhood poverty. In January 2020 Black pupils were the most overrepresented group (in absolute terms) in the FSM population (that is, a higher proportion of Black pupils were eligible for FSM compared to their proportion of the general pupil population). Black pupils made up 9% of FSM pupils but only 6% of pupils overall[70]. This compares with White pupils who made up only 68% of pupils eligible for FSM but 73% of pupils overall. Data released by the London Assembly showed that 9% of Black, Asian, and minority ethnic Londoners used food banks in July 2020 compared with just 1% of White Londoners[71].

2.1.7 C L A C C

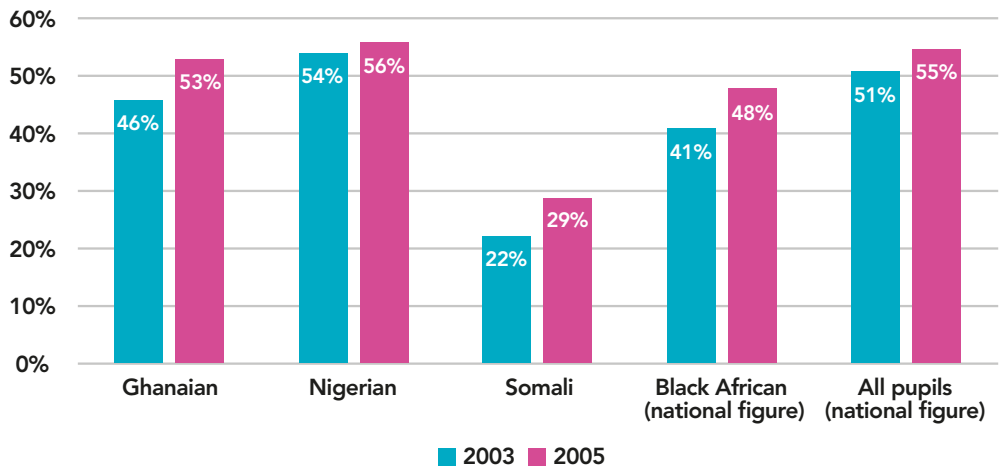
In 2021, 7 in 10 children in need were White and 3 in 10 were from all other ethnic groups combined. The proportion of children in need from all other ethnic groups combined has increased since 2015. In 2021 the number of children in need (defined as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired without the provision of children's social care services, or the child is disabled) in England for the reporting year 2021 was 29,530 Asian or Asian British, 32,640 Black or Black British, 33,750 Other ethnic group, and 264,900 White. Those with known ethnicity numbered 373,810. Data is available for detailed ethnic groups. 7,120 (1.9%) were Black Caribbean, 18,750 (5%) Black African, and 6770 (1.8%) Any Other Black background[72]. The total number of 'Black African' children who were looked after varied from 2,980 (2018) to 2,880 (2021), 4% of all children looked after and higher than the Black Caribbean (2%) and Any Other Black background groups (2%)[73]

school amongst 'Black Africans', around 30%, was close to that for England as a whole and also the Any Other Asian Background, Chinese, and Mixed: White and Black African groups[74].

Public Health England's 'fingertips' Public Health Profiles for 2018/19 provide more recent data[75]. With respect to 'percentage of children achieving a good level of development at the end of reception', the rate for Black children in England was 69.3%, compared with 72.7% for White children (figures were not released for local authorities).

Figure 12 shows older statistics from 2003 and 2005 from a DES report[76]. It highlights that Nigerian pupils achieved above the average for all Black African pupils, and above the average for all pupils; however Somali pupils achieved well below the average for Black African pupils. These statistics do, however, indicate that levels of attainment within the Black African extended codes have improved: the increase in the proportion of Somali pupils achieving 5+ A*-C is aligned with the increase in the proportion of all Black African pupils achieving 5+ A*-C, at 7 percentage points; this is a higher increase than was seen for 'all pupils' nationally[77].

F 7: B A 5+A*-C GC E, 2003 2005



Source: DES report (Department for Education and skills, Ethnicity and Education, 2006)[78].

2.1.9

In 2017/18 in England pupils from the Black African (3.0%, 5.1%) and Chinese (2.5%, 3.0%) ethnic groups had the lowest rates of overall absence and persistent absence, compared with the White British group (4.9%, 11.3%). Rates of overall absence and persistent absence for the 'Black' group in Birmingham were 4.0% and 9.4%, respectively.

Rates of temporary exclusions in England for the school year 2018 to 2019 were 4.13% for the Black African group, compared with 6.01% for the White British group. The rate for the 'Black' group in Birmingham was 6.35%. The rate of permanent exclusions for the Black African group was 0.07%,

2.2 M B

M B K F :

- Black African group had the highest proportion admitted to hospital for mental health (18.2%), higher than for all people (6%) and higher than both Black Caribbeans (13.9%) and Other Black (16.2%) patients.
- The proportion of Black African patients ‘reliably improved’ following treatment for anxiety and depression was 66.2%,

2.2.1 M : , , M H A

(2.9%) and highest for women (4.0%) in the Black group, compared with 2.3% and 1.8%, respectively, in the White group[85]. In 2014, there were no meaningful differences between ethnic groups in the percentage of men who had experienced a common mental disorder (like anxiety, depression or obsessive compulsive disorder) in the week before they were surveyed. The percentage for Black men was 13.5%, the same as for White British men. 29.3% of Black women had experienced a common mental disorder in the past week, a higher rate than for women from White British (20.9%) and White Other (15.6%) ethnic groups.

The percentage of people aged 16 years and over who screened positive for attention deficit hyperactivity disorder (ADHD) in the past 6 months

been developed to help improve service design and delivery to improve access and outcomes for Black and minority ethnic service users, notably, The IAPT Black, Asian and Minority Ethnic Positive Practice Guide (2019), the effectiveness in service delivery and impact have yet to be assessed[90].

The percentage of people aged 16 years and over receiving any treatment for mental or emotional problems, based on the Adult Psychiatric Morbidity Survey, 2014, was lowest in the Black group (6.5%), and substantially below that for the White-British group (14.5%)[91]. Thus, the Black group had the highest percentage (93.5%) across the ethnic groups who were receiving no treatment. With respect to treatment type, 5% of Black persons were receiving medication only, compared with 11.4% in the White British group. For counselling or therapy only, no proportion was reported for the Black group. For both medication and counselling, the proportion for the Black group was 1.5%, below the 1.7% for the White British group. Finally (from the Mental Health Services Dataset for the 2019/20 in England), the number of people per 100,000 using NHS mental health, learning disability and autism services was 5,098 in the Black group); this was lower than in the Mixed and Other groups but higher than for the White and Asian groups. Within the Black group, Black Africans (3,485 per 100,000) had a substantially lower rate than for Black Caribbeans, 5,099, and the Black Other group, 12,440.

2.2.4 N /

The Care Programme Approach (CPA) is a national system which sets out how mental health services should help people with mental illnesses and complex needs[92]. National guidance exists though each provider of mental health services has their own CPA policy. According to NHS Choices it is recommended that the person who needs CPA support is involved in the assessment of their own needs and in the development of the plan to meet those needs. The person should be informed about their different choices for care and support available to them, and they should be treated with dignity and respect. Of the 13,847 Black Africans in contact with services 41.3% had Care Programme Approach (CPA) status, in common with Other Black/Black British subgroups (Black Caribbean, 39.9%; Other Black, 40.2%)[93]. This compared with 20.5% amongst all people and 22.3% in the White British group. Rates were also lower in the pan-ethnic Mixed (31.3%) and Asian or Asian British group (26.8%). This su eop(s)-2589 Tm[(a)-1.6 (nt)-1.3 9.3 (,

2.8 (2.1–3.6) and the ‘Mixed’ group from 2.7 (1.8–4.2) to 1.4 (0.9–2.1). In the Black African group, there was a negligible difference from 4.1 (3.2–5.3) to 3.5 (2.8–4.5).

In a longitudinal record linkage study in Scotland (Scottish Health and Ethnicity Linkage Study (SHELS), ‘African origin’ women had higher risk of any psychiatric disorder (139.4, 95% CI: 119.0-13.2), ‘Africpan origin (me)-5.1 (f)]TJETEMC /P <</Lang (en-GB)/MCID 64.6 (a)-2.2 (d h)8.3 (i)6.3 (g (y)10 (c)-8.7[(a)-1.6 (

2.2.8 A N B A

There is only limited evidence on the attitude of Nigerians and other Black Africans towards mental health and services. A qualitative study of 10 students who had migrated from the Niger Delta to the UK for study provides insights into an immigrant population[103]. The study explored the perceptions of stigma and mental disorders. The findings showed an overall limited understanding of the causes of mental disorders, though respondents with relatives with a disorder expressed fewer stigmatizing attitudes. Respondents attributed such disorders to a variety of causes, including witchcraft, evil practices of individuals/parents, spells from an enemy and other supernatural forces, use of India-hemp (cannabis), hard drugs (cocaine and heroin) or other noxious substances, and also hereditary. In Nigeria stigma is ingrained in the local culture, leading to non-diagnosis or the prevention of seeking early treatment. Mental disorders were reported to impact specifically on relationships with others, maintaining secrecy of the illness, and poor marriage prospects. The negative portrayal of what are described as 'mental disorders' in films (home videos) in Nigeria was reported to strongly contribute to the continuing stigmatization of these disorders.

Some similar findings were reported in a Birmingham-based qualitative study by Rabiee and Smith, involving interviews and focus groups with 97 service users, carers, etc. (including 51 Black Caribbeans and 21 Black Africans)[104]. Stigma related to mental illness was highlighted by a number of informants and examples were offered of people trying to hide mental illness or explain it in more favourable terms. Some talked of the fear of being permanently labelled as mentally ill and about the impact of mental illness on marriage prospects. Other concerns were insufficient provision of psychological therapies and concerns about high dosage of medication. Africans tended to rely on support from family, friends, faith-based sources of help and GPs, compared with Black Caribbeans' use of voluntary and statutory services such as hospital care, community-based early intervention, day care services, and assertive outreach. Participants talked directly or indirectly about their spiritual beliefs (including obeah, juju, spirits, magic and curses). One person commented that these beliefs were neither understood nor respected by mental health services staff. The authors conclude that there is a need to expand professional education that promotes an understanding of the diverse cultures and traditions of Black African and African Caribbean peoples.

Finally, understandings of depression were explored in the Yoruba ethnic group in Southwark (where 7.5% of school children speak Yoruba or a Benuic language), South London through qualitative, semi-structured interviews with 20 Yoruba people recruited from primary care. The Yoruba were mostly Christian, but some of their Christian churches also merged into traditional religious practices, with soothsayers as part of the church community. Fourteen Yoruba said that they had been depressed. Curses, black magic, evil spirits and the devil were mentioned frequently amongst the Yoruba people as causes of depression. Some Yoruba people explained that families could suffer mental illness because of misdeeds of their ancestordl were 21 (t)6.1 (o)-(e)-4.3cr6iramomieined thequenta Ba

2.2.9

Smoking is a major cause of preventable morbidity and premature mortality and a risk factor for several diseases including chronic obstructive pulmonary disease (COPD), heart disease and many cancers.

Prevalence rates for Black African self-reported cigarette smoking have been consistently amongst the lowest across ethnicities and have been declining over the last two decades[106]. According to the 2004 Health Survey for England, Black African men (21%) had one of the lowest rates of current cigarette smoking and below the general population (24%)[107]. Amongst Black African women, only 10% were current cigarette smokers, compared with 23% of women in the general population. These rates are in broad accord with those estimated from the General Household Survey pooled data for 2001-2005 for Great Britain, in which rates for Black African men and women were reported as 18% and 5%, respectively. Similarly, Karlsen *et al.* calculated rates for pooled Health Survey for England data for the years 2006-8. 12% of Black African men and 4% of Black African women were current cigarette smokers[108].

A more recent analysis (Aspinall and Mitton 2014) used the GP Patient Survey and Integrated Household Survey to provide estimates[109]. According to the GP Patient Survey for 2012, 12% of Black African men were regular or occasional smokers compared with 3% of Black African women. Analysis of the Integrated Household Survey for England and Wales, pooled for the years 2009/10-2011/12, showed that Black African men born outside the UK had lower smoking rates than the UK-born (14.3% vs 18.5%), a prevalence ratio (UK born: non-UK born) of 1.29 (95% CI 1.06-1.57). The difference was even larger for Black African females: 4.4% of the non-UK born were current cigarette smokers compared with 11.1% of the UK-born, a prevalence ratio of 2.54 (1.97-3.28). There is only slight evidence of a social class (NS-SEC) gradient in smoking prevalence for Black African men and none for Black African women.

One of the drawbacks of routinely reported data for cigarette smoking by ethnic group is that such reporting uses the five pan-ethnicities (White, Mixed, Asian, Black, Other) rather than the granular census categories. The Race Disparity Audit reports such data for all adults by the 5 pan-ethnicities (plus Chinese) for England, 2019[110]. Given the marked differences by gender and granular ethnic group, such data has little value for policy makers. Similarly, ONS's report and reference data for 2019 for the UK is for the pan-ethnicities (plus Chinese), but at least these data are broken down by gender.

Two population groups merit particular attention: pregnant women and children. Smoking amongst women in early pregnancy in England in 2019

There is limited data on interventions to address smoking and their outcomes by ethnic group. The Nuffield Trust published data on the variation in quit rates by ethnicity and gender. The percentage of adults on the NHS stop smoking service who quit smoking after 4 weeks varied from 56.1% for Pakistanis to 34.4% for the Any Other ethnic group, with Black Africans occupying a middle position (48.6%). Amongst males the range was 55.7% (Pakistanis) to 37.6% (Any Other ethnic group), with Black Africans again occupying a middle position (49.4%). The respective proportions for females were 57.8% (Pakistanis), 30.3% (Any Other ethnic group), and 46.7% (Black Africans)[115].

A robust analysis for London, based on pooled individual records from PCT-level stop smoking services for 2005-6 and 2006-7, found that the Black groups had the lowest access to the stop smoking services and within the Black ethnic groups the poorest access was from the Black African group. The ethnic group significantly less likely to quit smoking at 4 weeks was the Black ethnic group (African, Caribbean, Mixed White and Black African) along with the Pakistani ethnic group[116, 117]. The quit rate analysis showed they have significantly lower quit rates (44.5%) compared to other groups (50.1%) (x^2 233.1 df2 $p<0.001$). Pregnant women in the Mixed ethnic group were the only ethnic group significantly more likely (62%) to quit at 4 weeks than all other ethnic groups (48%) (x^2 8.4 df2 $p<0.05$) and pregnant women in the Other ethnic group are the only ethnic group significantly less likely to quit (32%) compared to all other ethnic groups (49%) (x^2 7.8 df2 $p<0.05$). The proportion for the Black group was 50%. All broad ethnic

in the HSE 2004 report: Normotensive-untreated (SBP <140mmHg and DBP <90mmHg and not taking medicine prescribed for high blood pressure; and 3 hypertension levels (Hypertensive-controlled: SBP <140mmHg and DBP <90mmHg and taking medicine prescribed for high blood pressure; Hypertensive-uncontrolled: SBP ≥140mmHg or DBP ≥90mmHg and taking medicine prescribed for high blood pressure; and Hypertensive-untreated: SBP ≥140mmHg or DBP ≥90mmHg and not taking medicine prescribed for high

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the five-a-day recommendation, similar to Black Caribbean men (32%), with somewhat higher rates in the Indian and Chinese groups. Similar patterns were found in the mean number of portions consumed. In the

2.3.4 F

Prayogo *et al.* investigated the use of foodbanks in the London Trussell Trust network and found that 39.6% (107/270) were 'Black', 47.0% (127/270) 'White', and 13.3% (36/270) 'Mixed, Asian, and Others'[138]. Given the concentration of the Black African community in London, this finding is important. This is clearly a substantial over-representation of the Black group. At the national level, and of British-born people referred to food banks, data from the Trussell Trust, a charity that supports food aid eoy4-1.2 faort s

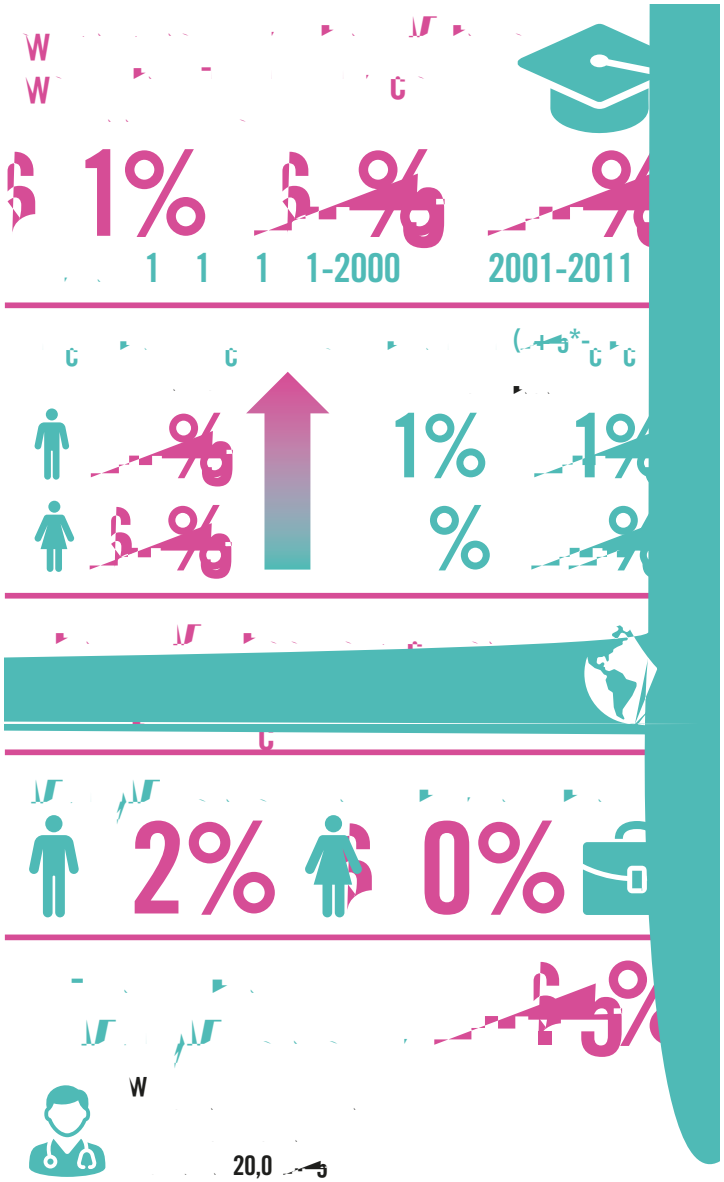
Two thirds of men in the general population reported regular participation in any physical activity (at least once a week on average). Regular participation was also reported by about two thirds of those in the Irish, Black Caribbean, Black African minority ethnic groups. Six in ten women in the general population participated regularly in physical activity, the proportion amongst Black African women being 57%.

The 2004 HSE showed that there were few differences across ethnic groups in the proportion of children aged 15 or under who participated in any physical activity.

More recent reports of physical activity are only stratified by the pan-ethnicities. Levels reported for 2018/19 show the relative position of the 'Black' group to the 'White' group to have deteriorated. People from Asian and Black groups, and women in particular, were reported to be most likely to report being physically inactive and least likely to report being active[141].

The percentage of males aged 16 years and over who were physically active in England, 2018/19, was highest in the Mixed group (71.3%), followed by White British (66.4%), Other (66.1%), Chinese (65.1%), and White Other (65.0%). Lower percentages were found in the Black (63.8%) and Asian (57.9%) groups. Rates were lower in all the female groups except White Other (65.5%): Mixed (65%), White British (63%), Chinese (57.4%), Other (56.6%), Black (52.9%), and Asian (49.1%).

The percentage of males aged 16 years and over who were physically inactive in England, 2017/18 is the inverse of these proportions. Amongst males the most physically inactive were 'Black' (29%) and 'Other' (29%), followed by 'Asian' (27%) and 'Chinese' (26%) males. The Mixed and White groups had rates of 19-23%. Amongst women the highest rate of physical inactivity was found in the 'Asian group' (36%), followed by the 'Other' (31%) and 'Black' (29%). The 'White Other', 'White British', and 'Chinese' groups had lower rates, 24%, 25%, and 26%, respectively, while the 'Mixed' group (18%) had the lowest rate.



A BOLDER HEALTHIER BIRMINGHAM

standardised limiting long-term illness is also examined by country of birth using 2001 Census data.

Limiting long-term illness

Two measures of generic health status are available in the decennial census:

of limiting long-term illness (after Chinese and Other Asians). Only Black African women had a somewhat different ranking of illness ratios, being the fifth ranking ethnic group in 1991 (with a ratio of 1.05 and therefore slightly worse than White British and also Chinese, Other Asian, Other, and Other Black).

One major drawback of these data is that they yield findings for the highly heterogeneous Black African group as a whole and not for national origin or other subgroups. Only limited information on generic health is available at this finer level of granularity. In the 2011 Census only one table

in 2011 are compared with those in 2001. Black African men and women

With respect to gender, a slightly higher proportion of Black African men (62%) were in employment (62%) but lower than Black Caribbean men (65%).

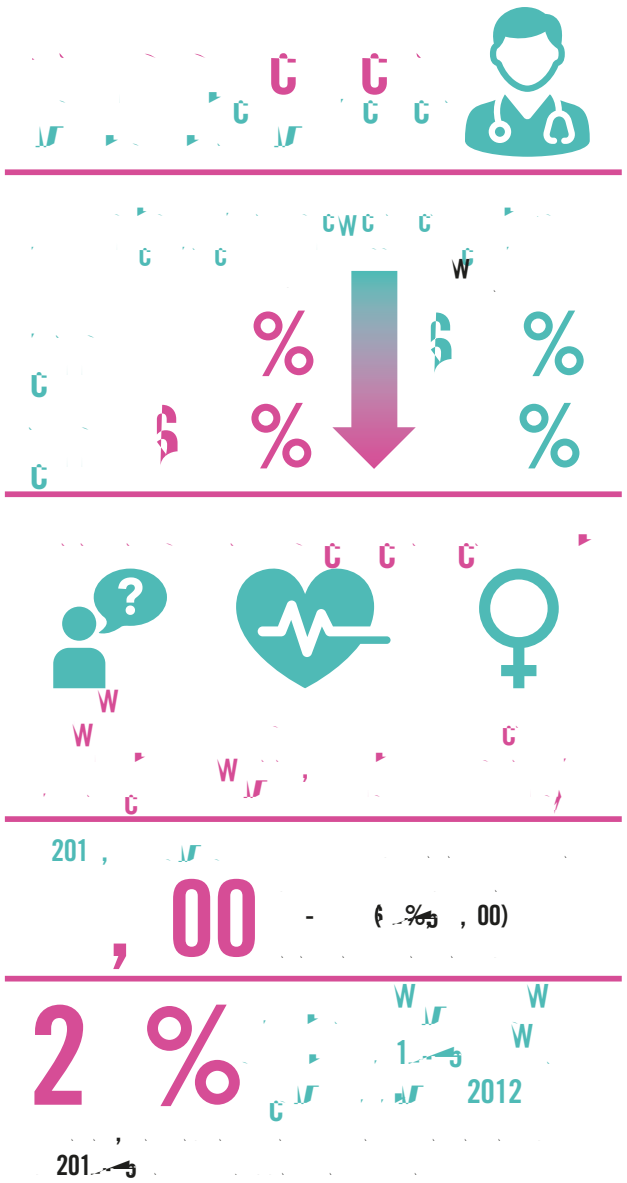
2.5.9 H

Overall 16% of men in the general population worked part-time (up to 30 hours a week) at the time of the 2011 census. Part-time working amongst men is higher in ethnic groups that are not White (apart from Gypsies/ Irish Travellers)

2.5.12 H

A variety of sources, including the decennial census and government social and general purpose surveys, have asked a number of questions on household housing circumstances. The 2011 England and Wales Census asked about the type of accommodation (detached, semi-detached, terraced, flat, maisonette, or apartment, and mobile or temporary structure), whether the accommodation is self-contained; rooms available for use by the household and number that are bedrooms; type of central heating; and housing tenure. The 1991 Census asked a question about household amenities (a bath or shower, an inside flush toilet, and central

2011 England and Wales Census questions on number of rooms convert to measures of under-occupied housing, housing that meets the standard and statutory requirements, and overcrowded housing. Based on the number of bedrooms Black Africans had one of the highest levels of overcrowding (22%) along with Pakistanis, only Bangladeshis having a higher proportion (30%)[187]. Only 31% of Black Africans under-occupied their accommodation, that is, at least one spare bedroom, only Bangladeshis having a lower proportion (30%). By contrast, more than two-thirds of the White British and White Irish ethnic groups under-occupied their accommodation. Moreover, four times as many White British (36%) as Black African (9%) and Bangladeshi (10%) groups lived in accommodation with three or more spare bedrooms. Further, Black Africans had the highest proportion with required bedrooms



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2.6 D .

D K F :

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Breast cancer screening

A study in Scotland found non-attendance at first breast-screening invitation (2002–2008) was higher for Black Africans (162.2, 95% CI 130.8–201.1) (and also for Pakistanis, Indians, and Other South Asians) compared with the White Scottish group (=100)[193]. These disparities persisted after adjustment for rural vs urban residence, long-term illness, area deprivation and education. An investigation of breast cancer screening uptake (as part of the national breast screening programme) among women from different ethnic groups in London during the period 2006-9 reported that White British women attended their first call (67%) and routine recall (78%) invitations most often. Women in minority ethnic groups were less likely to attend these calls: Indians (61% and 74%), Bangladeshis (43% and 61%), Black Caribbeans (63% and 74%), and Black Africans (49% and 64%)[194]. Fully adjusted odds ratios for attendance at their routine call screening appointment in London showed that, compared with the White British group (1.00), Black Africans (0.49 (0.47 to 0.51)) had one of the poorest levels of attendance. Lower levels of attendance may partially account for the fact that Black women are more likely to be diagnosed with breast cancer at late stage compared with White women (Public Health England 2016), a factor which can affect treatment success and mortality.

Amongst factors accounting for the high non-attendance of Black African women, Onyigbuo suggests that the low knowledge of breast cancer-screening services in their countries of origin may contribute[195, 196, 197, 198, 199]. Also, socio-cultural issues surrounding women's health and taboos, secrecy, or the sacred nature of sexuality in Africa may be factors[200, 201, 202].

Cervical cancer screening

Minority ethnicity has also been associated with lower attendance for cervical screening, even when socio-economic position is adjusted for[203], although results were for White British and Other; Webb *et al.* but only for 'South Asian' and 'Other'[204]. A survey of Black women in London which explored their knowledge of cervical cancer and attendance at cervical cancer screening found that being younger, single, African (compared to Caribbean) and attending religious services were more frequently associated with being overdue for screening[205]. Common barriers in the latter group were 'not getting around to it', fear of the test procedure, and low risk perception. In a study by Nelson *et al*., reported experiences of participation and non-participation in cervical screening amongst minority ethnic women in Scotland included difficulties managing competing priorities, including work and care responsibilities; going abroad for more frequent screening; delayed introduction to screening and not accessing primary care services; language difficulties in health-care settings despite proficiency in English; and not being sexually active at screening commencement, and experiences of racism, ignorance and feeling shamed[206].

Again, Onyigbuo suggests the contribution of poor knowledge of cervical cancer screening in migrant women's home countries before migration, also adding: 'the cultural practices of female genital mutilation (FGM) common in Nigeria and other African nations has the potential for influencing women's attitudes towards female-related health conditions such as cervical cancer screening in the UK as in other countries'[207, 208, 209, 210]. Another study assessed the knowledge of cervical cancer in women and current screening practices among female students at the University of Ibadan, Nigeria[211]. 350 respondents were selected using a multi-stage sampling technique. Semi-structured questionnaires revealed that

nearly two-thirds (63%) of respondents had heard about cervical cancer. Knowledge of predisposing factors for the disease was high for early exposure to sex (82%) and sex with multiple partners (70.6%). However, only 15.7% knew that abnormal menstrual bleeding was symptomatic of cervical cancer; 14.9% perceived themselves to be susceptible, while 2.6% had ever screened for the disease. Thus, while awareness of cervical cancer and its predisposing factors was high, the perception of self-vulnerability and utilization of screening services were extremely low. The investigators recommended that intense and integrated educational programs were urgently needed for this group.

Bowel cancer screening

There is limited data on bowel cancer screening as UK bowel screening databases (including Scotland) do not routinely include an ethnic code. However, Campbell *et al.* used data on 1.7 million individuals in two rounds of the Scottish Bowel Cancer Screening Programme (2007– 2013), linked to the 2001 Census using the Scottish Community Health Index number[212]. African origin men (2500/100,000) had a lower rate of returning the completed screening kit than the White Scottish men (3060/100,000), although their rate was higher than Indians and Pakistanis. African origin women had a rate of 1515/100,000, lower than the 1808/100,000 in White Scottish women, and also lower than for Indian and Pakistani women. 'African origin' was a term used for Black Africans, Black Caribbeans, and Black Other persons.

A (AAA)

The review by Davies *et al.*

2.6.2 A NH H C

Although not defined as a screening programme, the NHS Health Check, is a health check-up for adults in England aged 40 to 74, designed to spot risk factors for stroke, kidney disease, heart disease, type 2 diabetes, or dementia.

Local demographic statistics on NHS Health Checks attended in England,

Croydon (54%). Outside London the proportions were highest in Thurrock (68%), Luton (67%), Coventry (67%), Southend-on-Sea (67%), and Leicester (65%)[220]

specialist SHS. Compared to people testing through community services, those testing through the national HIV self-sampling scheme were less likely to be Black African (7% vs. 11%). Public Health England recommends that, as many Black African heterosexual women attendees at sexual health clinics are not tested, health promotion services should aim to engage Black Africans who may never have been tested for HIV, while primary and

The 2002 Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) collection showed that Black and minority ethnic groups continue to bear a disproportionate burden of gonorrhoea infections, with Black Caribbeans accounting for 32.55% and 41.2% of the total infections in females and heterosexual males, respectively, and ethnic minorities 47% of the total diagnoses[231]. Data from the ProgrESS surveillance initiative shows a similar distribution by ethnic group for genital Chlamydia infection. The highest diagnostic rates in London were seen in the Black Caribbean and Black-Other groups. Amongst both male and female Black Caribbeans rates were over 900/100,000 population; the male rate in the Black-Other group exceeded 1200/100,000 and reached 1,500 amongst females in this group.

For genital warts, data from ProgrESS for London again show uneven rates of diagnoses across the different ethnic groups. The highest rates for both males and females were seen in the Black-Other group – exceeding 300/100,000 population – and rates were also high in the Black-Caribbean group (around 150 and 200/100,000 in males and females, respectively). Once again, with respect to Genital herpes simplex virus (HSV) infection, ProgrESS data for rates of diagnoses (first attack) in London show highest rates amongst Black ethnic groups: over 300/100,000 population amongst Black-Other females and 150/100,000 amongst Black-Caribbean females; around 175/100,000 and 100/100,000, respectively, amongst males. Enhanced surveillance data for syphilis show that between April 2001 and September 2003 almost half of heterosexual diagnoses of syphilis were attributed to Black or Black-British ethnic groups.

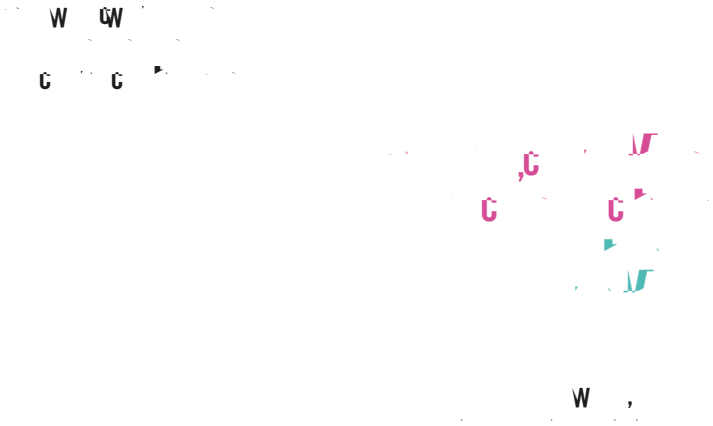
2.6.4

Nigeria is struggling with increasing incidence of tuberculosis cases and suboptimal coverage of diagnostic services. Tuberculosis incidence rose in

since entry of 9 years (4-13). Nigeria had 164 cases, 3.0% of all cases, and a median time since entry of 7 years (3-11). Zimbabwe had 105 cases, 1.9% of all cases, and a median time since entry of 11 years (7-12). Kenya (a country of birth group that includes both Black Africans and East African Asians) accounted for 84 cases, 1.6% of all cases, and a median time since entry of 22 years (8-37). Finally, Eritrea had 62 cases, 1.1% of all cases, and a median time since entry of 4 years (2-7). The numbers of reported cases for people born in Zimbabwe and Somalia have declined due to change in migration patterns and policies.

The number of TB cases in the non-UK born population has been influenced by detection methods. From 2012 the UK rolled out a pre-entry screening programme for migrants from high incidence countries and this programme has seen an increase in the number of cases identified in the pre-entry screening for all countries compared to the programme that targeted migrants from high TB incidence countries. Multi-drug resistant TB is a public health threat, the social factors that can contribute to this including interrupted adherence to treatment and contracting multi-resistant TB. Migrants from Somalia, Nigeria, Sudan and Sierra Leone were amongst the countries of birth for people who had developed drug resistance TB. TB affects children and most cases of TB reported in the 0-14 age group were in UK-born children (69%), with the highest proportion amongst the Black African (23%) and Indian groups.

A recent qualitative research study found that Black African men with a previous diagnosis of tuberculosis suffer a significant burden of stigma[236]. Men were unable to recognise TB symptoms and subsequently made late clinical presentation when they were also diagnosed with HIV. A few were diagnosed when in immigration detention centres. The experience of late diagnosis informed their understanding of the word ‘stigma’. The link between HIV and TB compounded experiences of stigma which led to depression and compromised HIV confidentiality. The investigators recommend that multidisciplinary teams supporting ongoing TB education programmes should include African men’s organ



for cervical cancer was 10.1 and the reported IRR 0.82 (0.66 to 1.01). For endometrial cancer the ASR was 6.2 and the IRR 1.15 (0.92 to 1.45). Thus, relative to the White population, Black Africans had lower rates of breast, ovarian and cervical cancer but higher rate of endometrial cancer (but not significantly so).

Amongst male cancers, the UK studies of prostate cancer incidence rates/ ratios across ethnic groups consistently show that these are higher in the Black group compared with the White group but lower in the South Asian group. Some of these estimates are measured with imprecision because of the small number of cases or limited by the high proportion of cases with ethnicity unknown (37-41%). However, robust evidence indicates that age-standardised rates per 100,000 were 56.4 (95% confidence interval [CI], 53.3 to 59.5) for the White group and 139.3 (95% CI, 110 to 168) for the Black African group, a 2.5-fold difference[250].

With respect to other cancers, Black African men have incidence rates for lung cancer around half that of White men (IRR 0.4), based on Thames Cancer Registry data for 1998-2003. Compared with White women, women from the other ethnic groups studied have much lower lung cancer

3: M : A -

2.7.6

With respect to risks for haemoglobinopathies prior to screening, the chance that the couple are both carriers and require risk assessment is greatest when the family (ethnic) origins of both partners (mother and baby's father) are both Black African (1 in 14) and risks remain high (risks higher than 1 in 100) when one parent is Black African[257, 258]. However, other ethnic, including Mixed, groups are also at risk. While universal antenatal screening takes places in Britain in areas of high prevalence, the Family Origin Question (FOQ) is used as a decision-making tool primarily to identify partners of high risk status in 'low prevalence' areas (a foetal prevalence of 1.5 cases per 10,000 pregnancies or below, where universal screening is n tr6 (o)7es pelow, 3 (b)8 (6 (f 1)624d1 (t)-1.3 (2(o)7e1 (25-5.1 (C.1 (2 (yk37.5(o).3 (c)-1.3 (i6 T2.3 (i)-0.8 (f)-40. (e)-1.1 (2)1.1 .2 (n (n)6 (t)6.1 (e)-5.1 (n)4.6 (a

The investigators suggest that potential reasons for the higher life expectancy found in the Black African and Asian Other ethnic groups include the fact that they contain a higher proportion of more recent migrants than other ethnic groups and that people who migrate tend to be healthier than others (the so-called ‘healthy migrant effect’). However,

2.9 C r G r F r

There is no published literature on a green and sustainable future that can be stratified by ethnic group or country of birth, with respect to the

2.10 M L CO ID-19

M L CO ID-19 K F :

- The risk of COVID-19-related hospitalisation was increased in Black ethnic group.
- Early COVID-19 data suggested that Black Africans had the lowest proportion of people vaccinated (15.9%) compared to other ethnic groups.
-

differences by ethnic group. Vaccine hesitancy was highest in Black or Black British groups, with 71.8% stating they were unlikely/very unlikely to be vaccinated, and 28.2% indicating that they were likely/very likely. Pakistani/ Bangladeshi groups were the next most hesitant ethnic group with 42.3% unlikely/very unlikely to be vaccinated and 57.7% likely/very likely. The Mixed (32.4%) and Any Other White background (including Eastern European) (26.4%) groups also had significant proportions indicating an unwillingness to be vaccinated. This compared with 15.6% in the White British or Irish group.

These differences persisted after adjustment for differences in age and gender. The outcome (odds ratio) for a very likely/likely response, where the reference group is White British/White Irish, was 0.072 (0.039-0.134) for the Black group. The adjusted odds ratio was also low for the Asian or Asian

2.10.5 I

Based on a rapid review, QResearch recommends a multifaceted and multimodal approach and targeted interventions that are designed to meet the specific needs of minority ethnic communities. These include: the use of trusted general practitioners and community health centres recommending and offering vaccines, including community leaders, community champions, and community forums as partners; clear information on how the vaccines work and on potential vaccine side effects; use of a range of educational resources - educational videos and narrative films - in multiple languages to increase awareness of risk, efficacy of vaccine and to tackle disinformation; engagement work to identify the appropriate settings

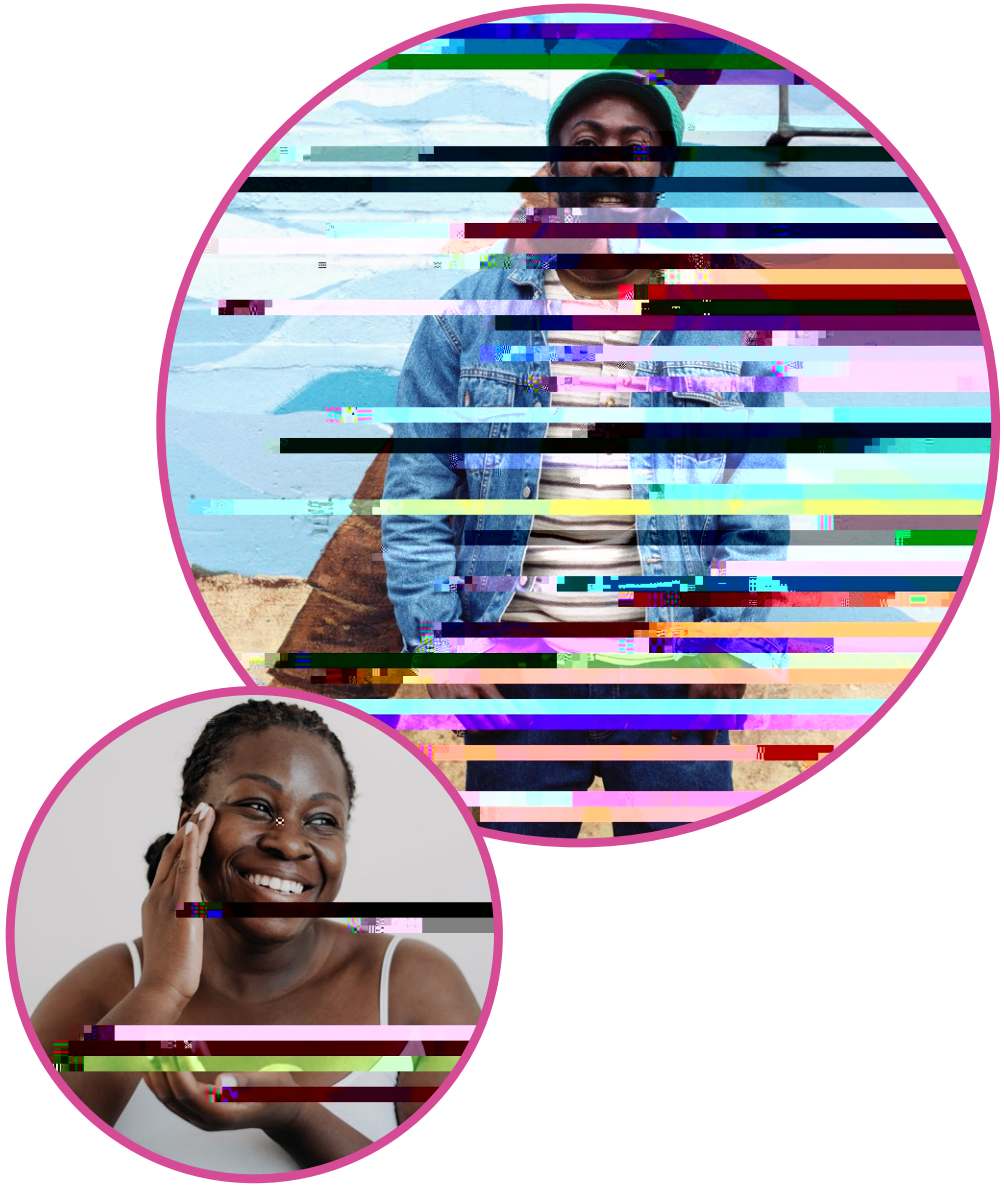
3.0 C

There are no reliable estimates of the Nigerian ethnic group in England and Wales. Yet there is likely to be a significant (but unknown) second generation as Nigerians have had a long history of migration to the country. 10,358 Nigerians migrated to England and Wales before 1981 and a further 56,833 during the period 1981-2000. However, it remains likely that the majority of the Nigerian ethnic group are still migrants. Moreover, in the 2011 Census 60% of Nigerian migrants were recent migrants (2001-2011). This demographic picture makes the experiences of first generation migrants in their country of origin particularly relevant to the health and healthcare experiences of Nigerians in this country. An understanding of the cultural context of the lives of people from minority ethnic groups is essentially to the delivery of culturally competent healthcare.

Two studies, based on qualitative research involving ten participants, have investigated factors that affect health-seeking behaviour and

There is some evidence on the experiences of Black Africans (rather than Nigerians) in using services, including the NHS Patient Experience Surveys and the GP Patient Survey.

Clearly, the cultural encounter between patients and clinicians or other care providers is only one set of factors that may contribute to inequalities in health and healthcare. Central amongst these mechanisms is the role of structural racism and disadvantage which plays a major role in the social determinants of health. This report has shown how Black Africans are disadvantaged in almost every characteristic of the housing market, discrimination having consistently impeded their progress over several decades. Similarly, although Black Africans in 2011 had higher educational attainments than almost all other minority ethnic groups and the White British group, they have experienced consistently high levels of unemployment and a disproportionate presence in low-skilled jobs. This situation is generally regarded as an 'ethnic penalty' accounted for by direct and indirect discrimination of employers. In the last few years, these inequalities have been exacerbated by the COVID-19 pandemic. Black Africans have almost without exception experienced the worst outcomes whatever measure of risk is taken.



A 3: B A ☛ (M), ,
☛ (K,).

A	M (B O)	M (B K)
0 to 4	209	1914
5 to 9	661	1040
10 to 15	1489	211
16 to 19	1000	137
20 to 24	1018	169
25 to 29	1136	116
30 to 34	1548	100
35 to 39	1465	79
40 to 44	1123	100
45 to 49	723	70
50 to 54	432	30
55 to 59	227	7
60 to 64	122	2
65 to 69	79	2
70 to 75	69	3
75 to 79	36	3
80+	29	0

A 4: B A ☛ ( ),
, ☛ (K,).

A 5: N B

2011	A : C	A : C A : N	N (%)
E05001178 : Acocks Green	28,378	19	0.07%
E05001179 : Aston	32,286	249	0.77%
E05001180 : Bartley Green	24,967	78	0.31%
E05001181 : Billesley	26,536	25	0.09%
E05001182 : Bordesley Green	33,937	23	0.07%
E05001183 : Bournville	25,938	33	0.13%
E05001184 : Brandwood	25,708	36	0.14%
E05001185 : Edgbaston	24,426	153	0.63%
E05001186 : Erdington	22,828	63	0.28%
E05001187 : Hall Green	26,429	18	0.07%
E05001188 : Handsworth Wood	27,749	94	0.34%
E05001189 : Harborne	23,001	110	0.48%
E05001190 : Hodge Hill	28,026	205	0.73%
E05001191 : Kings Norton	24,380	47	0.19%
E05001192 : Kingstanding	25,334	93	0.37%
E05001193 : Ladywood	30,133	309	1.03%
E05001194 : Longbridge	25,410	42	0.17%
E05001195 : Lozells and East Handsworth	31,074	140	0.45%

5.0 A

C :

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6.0

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