

Bangladeshi Community Health Profile

Date: August 2021



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Community evidence summaries

As part of the Public Health Divisions work to improve the understanding of the diverse communities of Birmingham, we are developing a series of short evidence summaries to improve awareness of these communities and their needs.

There are common objectives for each of the evidence summaries which are:

- To identify and summarise the physical health, mental health, lifestyle behavioural, and wider determinants of health-related issues that are affecting the specific community both nationally and locally
- To identify and summarise gaps in knowledge regarding the physical health, mental health, lifestyle behavioural and wider determinants of health-related issues that may be affecting the specific community both nationally and locally.
- To collate and present this information under the 10 key priority areas identified in the Health and Wellbeing Strategy for Birmingham 2021
- To engage with the local communities on the evidence found and any gaps
- To promote the use of these summaries for Local Authority and wider system use for community and service development.

Executive summary (infographic)

The Bangladeshi Community Health Profile identifies and summarises the national and local evidence concerning the health, lifestyle behaviours and wider determinants of health that affect Bangladeshi communities in Birmingham. It covers the health topics from maternity to aging and dying well; includes health status risk factors such as diabetes, CVD (cardiovascular disease); protect and detect topics such screening and vaccinations; and other themes such as knowledge and understanding around health issues affecting Bangladeshis.

British Bangladeshis have been migrating to the United Kingdom since the 1940s. During the 1950s and 1960s, Bangladeshi men immigrated to London in search of employment, and most settled in the Tower Hamlets, particularly Spitalfields and Brick Lane. Migration reached its peak in the 1970s, when changes in immigration laws encouraged a new wave of Bangladeshis to come to the UK and settle. Job opportunities were initially limited to low paid sectors, with unskilled and semi-skilled work in small factories and the textile trade being common. Men, mostly originating from the Sylheti region migrated first, before bringing their families to the UK.

Bangladeshis in the UK are largely a young population. In the 2011 census, 451,529 UK residents specified their ethnicity as Bangladeshi, forming 0.7% of the total population. Of all the Bangladeshis who live in the UK, just over 96% of British Bangladeshis live in England. London has the largest proportion with nearly half of all Bangladeshis, followed by the West Midlands with 52,477 citizens identifying their ethnicity as Bangladeshi (11.6%).

Birmingham is home to the majority of Bangladeshis in the West Midlands, with 32,880 citizens - accounting for 3% of Bangladeshis in the UK. The Bangladeshi population

in Birmingham is generally younger than the national Bangladeshi population, with 41.8% of children under 18 years old living in Birmingham compared to 38.3% nationally. Lozells and Aston have the highest densities of British Bangladeshis, with 31% and 21% respectively. 90% of Bangladeshis in Birmingham are likely to be Muslim and over half were born in the UK.

The evidence and understanding of health inequalities faced by Bangladeshis in Birmingham has been identified through this summary report through a variety of information sources.

The key health inequalities identified are:

- Higher risk of maternal mortality, premature and low birth weight babies from mothers born in Bangladeshi, compared to women born in the UK
- Higher prevalence of obesity among Bangladeshi reception and year 6 children, compared to all children and White children in reception and year 6
- Although child poverty for Bangladeshi children has fallen by 2% nationally between 2012 and 2018, a higher proportion remains more likely to live in low-income families. Bangladeshi children have the highest eligibility of free school meals at each key stage compared to other ethnicities in the UK
- Bangladeshi children are more likely to not be school ready, performing significantly worse than White children in terms of key cognitive outcomes at ages three and five
- The prevalence of drug use in Bangladeshis has increased since the 1990s, with a higher proportion of Bangladeshis presenting for treatment than White British in some areas such as London

- Highest prevalence rates of tobacco smoking and Paan use, compared to other ethnicities
- Low levels of physical activity particularly among women, research highlights barriers such as cultural and family expectations
- Qualitative literature consistently highlights the lower levels of awareness on the causes and disease management among patients with long term illnesses
- There are consistent themes across the literature regarding the lack of cultural sensitivity and language barriers experienced by the Bangladeshi community
- Generally compared to the White British citizens, people of Bangladeshi heritage have a lower prevalence of diagnosed mental health conditions and obesity
- The Bangladeshi community also has a lower prevalence of alcohol related conditions compared to the general population.

Promising developments

Educational outcomes for Bangladeshi children who were eligible for free school meals had higher Progress 8 scores than the national average.

The 'Ethnicity, Gender and Social Mobility' report commissioned by the Social Mobility Commission, found that there has been an increase in educational attainment for Bangladeshi origin pupils in the UK and their performance has improved at a more rapid rate than other ethnic groups in recent years at almost every key stage of education. Although minority ethnic women invest heavily in education, they experience obstacles in the labour market. However, there is a strong desire to study

which is evident in the increasing numbers of Bangladeshi women applying to university since 1994.

The infographics below summarise the evidence from all 10 topics:

Bangladeshi Community Profile

International, National and Birmingham Context

451,529  **38,300**

People in the UK identify themselves as Bangladeshi. Bangladeshis in the UK are largely a young population, heavily concentrated in the inner boroughs of London.

People in the West Midlands identify as Bangladeshi, with **32,532** in Birmingham. Birmingham has the largest Bangladeshi community in the west Midlands, and 3rd largest in the UK

57%

Of Bangladeshis in Birmingham were born in England, considerably higher proportion than those in the Middle East and Asia (43%); Africa (0.2%) and other parts of Europe (0.4%).

Bangladeshis in B'ham identify as British, **76%** significantly higher than those identifying as With Non-UK nationalities (11%).

11.7% of Bangladeshis in B'ham compared to **6.0%** of the City's female population,

0-4 yrs

3.6% of Bangladeshis in B'ham compared to **17.9%** of the City's female pop.

>65 yrs

11.1% of Bangladeshis in B'ham compared to **6.5%** of the City's male population.

3.8% of Bangladeshis in B'ham compared to **15.7%** of the City's male population.

With a population exceeding **163 million** people, Bangladesh is the eighth most densely populated country worldwide. Following Bangladeshi, Saudi Arabia has the 2nd largest Bangladeshi population, followed by United Arab Emirates, Kuwait, Malaysia, Oman, the U.K and the U.S.



Overview

Migration

British Bangladeshis are one the most homogenous groups, with most originating from the rural Sylheti region of Bangladesh. Large scale migration in significant numbers first took place in the **1960s** and reached its peak in **1970s**, with most men migrating to work in clothing & restaurant trades.

Bangladeshis speak Sylheti, which is generally considered a dialect of Bengali. **70%** of those who speak Sylheti are proficient in English. **400,000** 

Religion

90% Muslims

1.5% Christian, Other

1.3% No religion

Celebrations

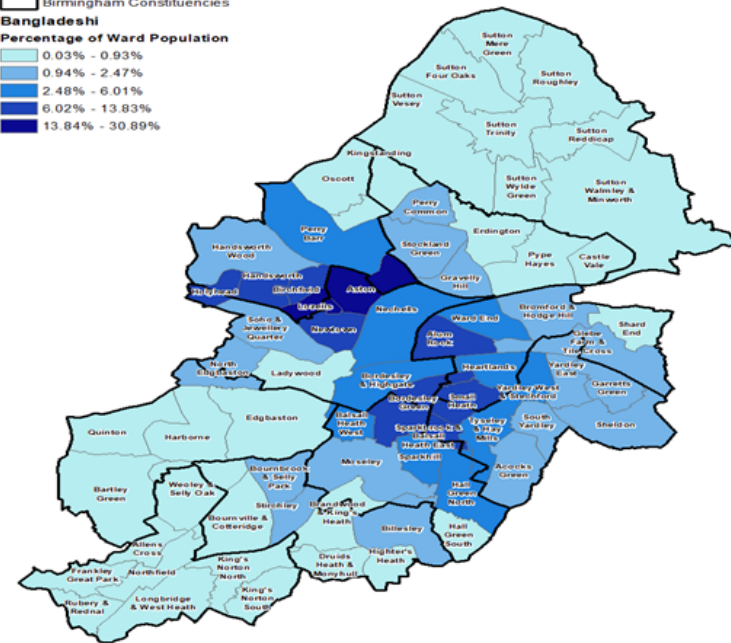
Boishakhi mela Bangladeshi New Year
2nd weekend of May

Independence Day Independence day
March 26th

Data from census in 2011 show that the largest proportions of Bangladeshis live in Lozells (31%) and Aston (21%) wards. No other wards had more than 14% of the Bangladeshi population.

Bangladeshi Ethnic Population 2011 Census by Ward

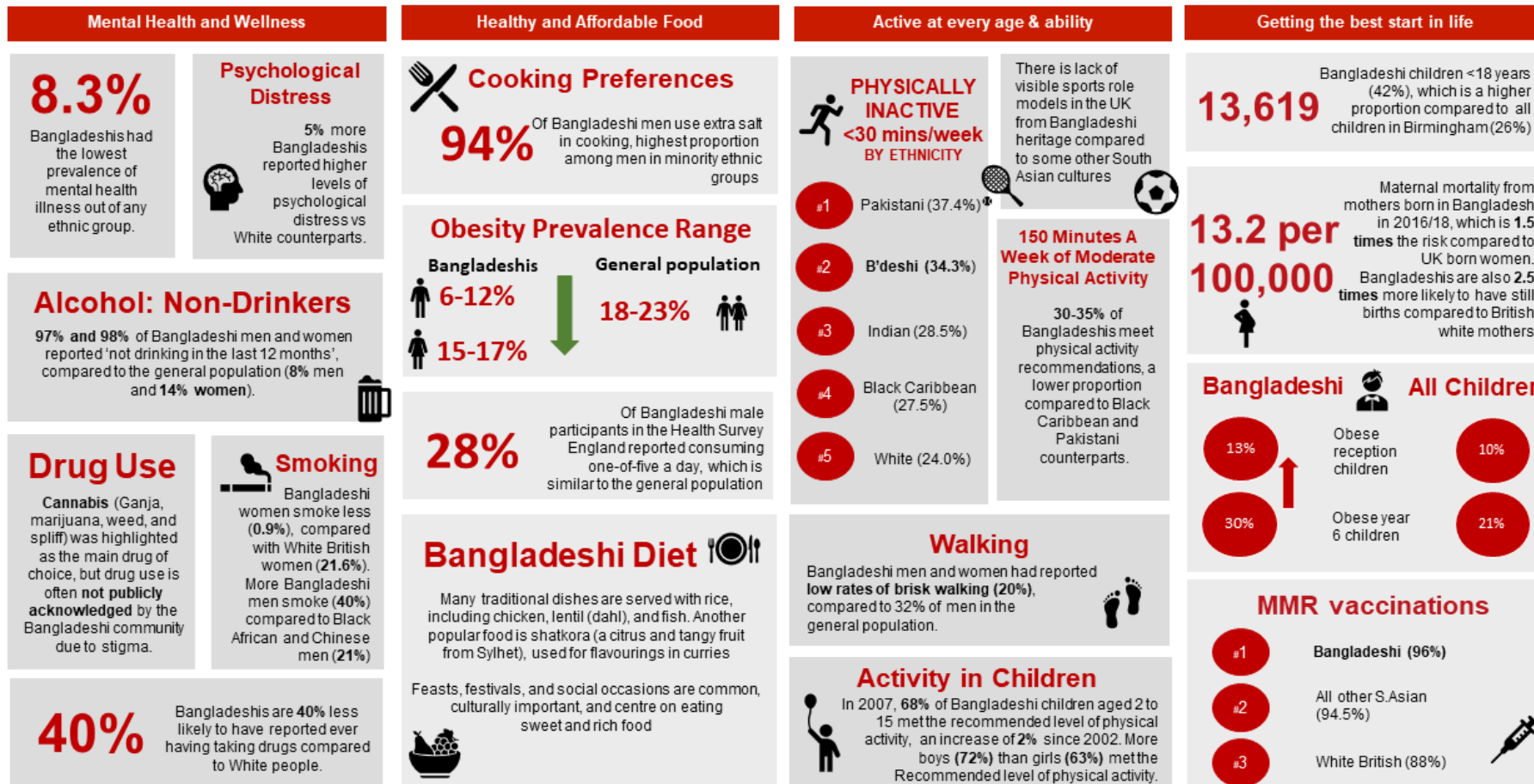
Legend
Birmingham Constituencies
Bangladeshi
Percentage of Ward Population
0.03% - 0.93%
0.94% - 2.47%
2.48% - 6.01%
6.02% - 13.83%
13.84% - 30.89%



Source: ONS Crown Copyright Reserved (2021).
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Please note that the most recent ethnicity data available at ward level is from the 2011 census, so any conclusions from using this data should be made with caution.

Bangladeshi Community Profile



Bangladeshi Community Profile

Working and learning well

Level 5+ Qualification

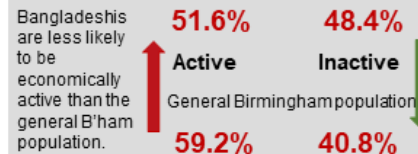


57.3% (60% girls and 54% boys) of Bangladeshi pupils in England got a grade 5 or above in English and maths GCSE, better than the national average (49.9%).

No Qualification



More Bangladeshis reported having no qualifications compared to the general population (35% compared 28%).



Overcrowding



More Bangladeshis (18%) live in overcrowded households compared to the general population (4.2%)



Working

31% Bangladeshis reported having never worked or unemployed long term, twice as likely compared with the general population (12%)



Protect and Detect

FEMALE CANCER SCREENING (NON-ATTENDEES)

- #1 B'deshi (70.6%)
- #2 Indian (66.0%)
- #3 C'bean (62.1%)
- #4 Pakistani (61.0%)
- #5 African (44.0%)

Uptake of breast cancer screening among Bangladeshi women was lower than White population (37% compared to 60%)

Barriers to Cervical Screen



Issue of male doctor or nurse



"Symptoms must be present"



Fitting around family time

HPV Vaccination

Bangladeshi women are around **8x** less likely to accept HPV vaccination compared to White British women.



Sexual Health

Bangladeshis are more likely to be referred to sexual health clinics by GP's, suggesting their knowledge of service provisions is low



43.1 per 100,000 Tuberculosis cases in Birmingham were from people of Bangladeshi heritage, higher compared to White (5.0) and Chinese (17.5) Mixed other (33.7), but lower than Black African (280), Pakistani (142) Indian (112) and Black Other (50)

Ageing and Dying Well

DIABETES 2 X Higher

The risk of developing diabetes is **at least 2 times** higher among British Bangladeshis compared to white counterparts.

CARDIOVASCULAR DISEASE



CVD (cardiovascular disease) prevalence pattern in Bangladeshi men and women follows that of the general population, with an upward trend of age.

CANCER

3x higher



The national cancer intelligence network reported that compared to White people Bangladeshi men had **similar** incidence, rates of lung cancer **3x** higher incidents rates for liver cancer for both sexes

COPD



There is little research on COPD exclusive to Bangladeshis. However, the limited evidence show that Bangladeshis have a lower risk of COPD compared to White people

DEMENTIA



Bangladeshi elderly migrants do not have an increased rate of schizophrenia-like psychosis (SLP) compared to indigenous elders. In the one-year review there was a higher rate of referrals for organic disease in Bangladeshi men compared to Bangladeshi women and British-born men and women



End of Life

87%

A report into end-of-life preferences amongst Oldham's Bangladeshi showed a higher than national rate of those wanting to die at home.

Access to health care

Research across ageing and dying well theme reported perceived barriers to accessing care to be...



Language and communication barrier



Lack of knowledge



Negative experience



Bangladeshi Community Profile

Closing the Gaps

Deprivation

88.2%  **1.0%**

Of all Bangladeshis in Birmingham are living in 20% of the most deprived areas **vs** Bangladeshis in B'ham are less than 1% are likely to be living in 20% least deprived

4 in 5 

Linking deprivation with life expectancy, 4/5 of Bangladeshis in Birmingham can expect to live an average of 74 to 83 years and spend 20 years fewer years in good health

Disability-free life expectancy of British Bangladeshis is lowest compared to White people and all other ethnicities 

Of the 25 leading causes of mortality as measured by years of lost life, and compared to the white ethnic group, Bangladeshis were...

Alcohol cirrhosis
Suicide
All cancers
Stroke
Road injuries
Cirrhosis HepC

Green and Sustainable Future

There is a lack of published research exclusive to British Bangladeshis and their contribution to green and sustainable future or the impact of these topics on them as a population in the UK



Mitigating the impact of Covid

Long-Term Health Conditions

Compared with White British individuals over 60 years of age, people from Bangladeshi backgrounds are **over 60%** more likely to have a long-term health condition that makes them vulnerable to COVID-19

43%

People from Bangladeshi (43%) were the most likely to report loss of income since COVID-19 pandemic, compared to Black African groups (38%) and 22% of White people.

Overcrowding was linked with increased rates of mortality in a hospital-based cohort. **30%** of Bangladeshi households being the highest compared to **16%** of Black African households, **18%** of Pakistani households and **2%** of White British households. 

The provisional analysis for the period 2 March to 15 May 2020 by the Office of National Statistics has shown variation in the rate of death involving the coronavirus between self-identified religious groups, as reported in the 2011 Census, the table below shows that in the second wave of the pandemic, differences in COVID-19 mortality compared with the White British population increased for people of Bangladeshi and Pakistani ethnic backgrounds and decreased for people of Black African and Black Caribbean backgrounds. The table is categorised by susceptibility during the 2nd wave.

Ethnic Group	1 st wave Jan 20- Sep 20	2 nd Wave Sep 20- Mar21
Bangladeshi	2.1x	4.4x
Pakistani	2.2x	3.5x
Indian	2.5x	3.1x
Black African	3.8x	2.9x
Other	2.6x	2.7x
Chinese	2.6x	2.4x
Black Caribbean	2.4x	2.2x
Mixed	2.2x	2.2x

Source: Office for National Statistics – Coronavirus (COVID-19) related deaths by religious group.

Methodology

An exploratory search was undertaken by the Public Health Communities Team using a range of databases such as National Data Sources, NOMIs (Office for National Statistics), and PubMed to identify information on Bangladeshi communities for this report. Keyword search terms and subject headings relevant to the themes were identified. All references used within this report are outlined in the References section.

As an initial exploratory search, the following avenues were examined:

a. National data sources

NOMIS data: data were extracted by religion from the 2011 Census: <https://www.nomisweb.co.uk/>. It should be noted that the most recent ethnicity data available is from the 2001 and 2011 census, so any conclusions from using this data/information should be made with caution.

National Public Health (PHE fingertips) and government data sources (ons.gov.uk and gov.uk) – where relevant Bangladeshi community-level data were available.

National voluntary and community sector reports identified through Google Scholar and national websites – where relevant Bangladeshi community-level data were available:

Alzheimer's Research UK (<https://www.alzheimersresearchuk.org/>)

The British Heart Foundation (<https://www.bhf.org.uk/>)

The British Lung Foundation (<https://www.blf.org.uk/>)

Cancer Research UK (<https://www.cancerresearchuk.org/>)

Diabetes UK (<https://www.diabetes.org.uk/>)

The Joseph Rowntree Foundation (<https://www.jrf.org.uk/>)

Mind (<https://www.mind.org.uk/>)

Sport England (<https://www.sportengland.org/>)

b. PubMed search

In addition, a PubMed search (<https://pubmed.ncbi.nlm.nih.gov/>) was performed. All searches contained the keyword “Bangladeshi,” as well as words that were specific to the specific topic theme. Examples of this are included in this Search Strategy (Appendix 2, below).

c. Grey Literature

Where information sources had not been identified through a or b, further searching through Google, Google Scholar, and PubMed using topic specific search terms were carried out. Papers that were relevant to the UK were included i.e. data and information stemming from local or national-level reports and/or surveys. Findings from international and national systematic reviews and large-scale epidemiological and qualitative research studies were also considered for inclusion. International research findings were included if they were deemed to be comparable or relevant to the national population.

In addition, some “snowballing” (a technique where additional relevant research are identified from the reference list and citations of the initial search or published article) was used where additional papers were identified from reference lists where these added to the knowledge base. Generally, searches were limited to the year 2000 onwards however older information was occasionally used where information was scarce.

E. Data consolidation and analysis

Results retrieved from the initial searches were reviewed by the Public Health Communities Team against the inclusion and exclusion criteria (**Appendix 1**). The Team used a 'concept table' to frame the theme and identify keywords for searches (**Appendix 2**). The articles utilised in this document were then analysed, identified, and cross referenced with other themes throughout the report.

1.0 Introduction

1.1 Overview of the Bangladeshi community

Despite being the most recently settled of the major South Asian communities, Bangladeshi communities in England are well established. Migration in significant numbers first took place in the 1960s. British Bangladeshis are among the most homogenous, with most originating from the rural Sylheti region of Bangladesh. The Bangladeshi community has a younger age profile than other South Asian communities in England.⁽¹⁾

Migration reached its peak in the 1970s, with Bangladeshi men arriving in the UK alone, followed by teenage sons, then by wives and younger children. In Birmingham, most Bangladeshi men worked in heavy industries such as Delta Metal Works, Birmingham Small Arms Company (BSA), and Morris Motors, but later many became involved in clothing and restaurant trades. This pattern has continued to the present day, with many Bangladeshi families running and working in small textile and catering firms.^(1, 2)

The most common language spoken among British Bangladeshis is Sylheti with about 400,000 speakers. It is originally spoken in North India/Bangladesh and is derived from Sanskrit. Sylheti is generally considered as a dialect of Bengali, though linguists mostly view it as an independent language.⁽³⁾

Based on the 2011 census, English is spoken as the main language by nearly half of the Bangladeshi population. For those who considered Bengali or Sylheti as their main language, more than half (70%) were proficient in speaking English. English tends to be spoken among the younger Bangladeshi generation, and Bengali/Sylheti with the older Bangladeshi generation.⁽⁴⁾

Most of the Bangladeshi community are Sunni Muslim (90%), accounting for 1.5% of all Muslims in the UK. 1.5% are Christians; another 1.5% follow other religions and 1.3% have no religion. The 2011 census shows that between 2001 and 2011 the number of Bangladeshi Muslims have grown by 142,000 (from 260,000 to 402,000). The highest proportion of Bangladeshi Muslims was in Tower Hamlets (83 percent).

The sari is considered the ideal attire for women from Bangladesh. However, clothing has become less traditional for British Bangladeshis, as women choose to 'modernise' clothing by mixing ethnic clothing with Western elements.⁽⁵⁾

Many British Bangladeshi citizens celebrate significant culturally specific events throughout the year. Boishakhi Mela (Bengali New Year) is celebrated during the second weekend of May and British Bangladeshis have been celebrating in London Banglatown since 1997. It is the largest open-air event in Europe and the largest Bengali festival outside Bangladesh. There is normally a funfair, music and dance displays on stages, henna body painting, with people dressed in colourful traditional clothes. At festivals, curry and Bengali spices are served throughout the day.⁽⁶⁾

The Nowka Bais (also known as the dragon boat racing) is a traditional boat racing competition celebrated every year, at the end of July. It was first introduced to the United Kingdom in 2007 to commemorate the 1000th birthday of Oxfordshire. Each boat is traditionally 40ft long, painted bright red, white, yellow, and green, and paddled by a 16-man crew in brightly coloured robes who follow the beat of a drummer in the prow of the craft. Since 2015 it has been hosted in Birmingham, where it is the largest cultural event in the West Midlands and the largest boat race in Britain, attracting thousands of people every year. The dragon boat racing forms part of a wider community festival, featuring street food, arts and crafts stalls, a funfair, sports

activities, rowing and sailing taster sessions as well as live music and dance - with the Canal & River Trust a key event partner.^(7, 8)

British Bangladeshis celebrate the Independence Day of Bangladeshi on 26th March each year. Men attend private and public events to celebrate the history and Bangladeshi culture. Independence Day is commonly associated with parades, political speeches, fairs, concerts, ceremonies, and other various private and public events.⁽⁹⁾

Muslim Bangladeshis also observe religious Muslim festivals such as Eid al-Adha and Eid ul-Fitr. They dress for the occasion in traditional Bangladeshi style clothing. Eid prayers are attended by men and women in the morning in large numbers. Typically, Muslim Bangladeshis get together with relatives, where traditional food will be served such as samosa or sandesh.

There are some culturally specific Bangladeshi meals but there is significant overlap with Bengali cuisine. Many traditional Bengali dishes are served with rice, including chicken, lentils (dahl), and fish.⁽¹⁰⁾ Another popular food is shatkora (a citrus and tangy fruit from Sylhet), used for flavourings in curries.

1.2 International context

With a population exceeding 163 million people, Bangladesh is the eighth most densely populated country worldwide.⁽¹¹⁾ 50 years ago, Bangladeshi was known as East Pakistan. The country officially had its status as an independent nation recognised on 16th December 1971, following the liberation war that lasted for 9 months. The UK was one of the first countries to recognize Bangladeshi as a sovereign nation after its liberation where an estimated three million died in a nine-month long war.⁽¹²⁾

Many first-generation Bangladeshi migrants moved abroad for varied reasons, some of which include escaping poverty and seeking better living conditions, and work to financially support their families back home. There is an estimated population of 7.5 million Bangladeshis living abroad, making the Bangladeshi diaspora the largest in the world.¹¹³ According to the United Nations Migrant Stock by Origin and Destination in 2019, the following are the most common countries where Bangladeshi migrants were located; Saudi Arabia (1,377,072); United Arab Emirates (1,044,505); Kuwait (381,669); Malaysia (365,600); Oman (276,518); Great Britain (228,353); United States (279,021).⁽¹³⁾

1.3 National context

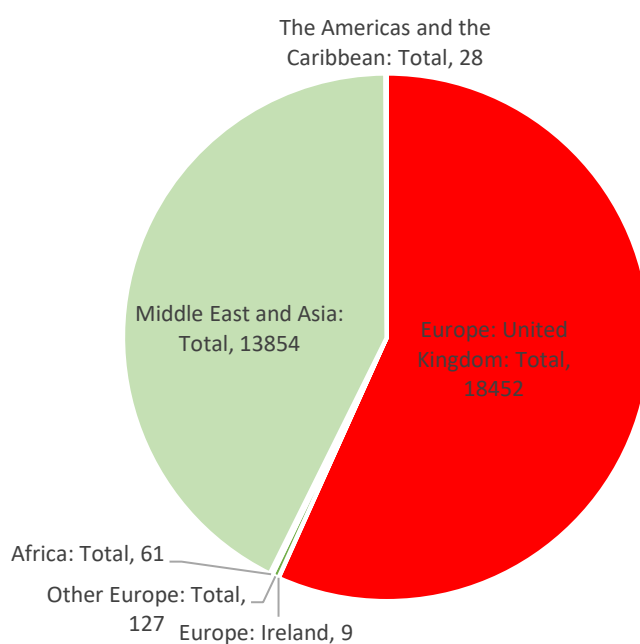
The UK has the largest Bengali population outside of Bangladesh and West Bengal. According to the 2011 census, 0.8% of the UK residents identified themselves as Bangladeshi.⁽¹⁴⁾ 96.7% of British Bangladeshis live in England, and London is home to half of the UK Bangladeshi population. The largest proportion of Bangladeshis is in Tower hamlets where Bangladeshis constitute 32% of the borough population. Other London boroughs with large Bangladeshi populations include Camden, Haringey, Hackney, Newham, Westminster, and Redbridge. Outside of London, 11.7% of the Bangladeshi population live in the Northwest and 10.3% live in the West Midlands.⁽¹⁴⁾ UK areas with the smallest Bangladeshi populations include Mid and West Devon, Christchurch, West Somerset, and the Cotswolds.

1.4 Birmingham context

The 2011 UK census reported that Birmingham is home to the largest Bangladeshi community in the West Midlands, and 3rd largest in the UK, with 32,532 citizens.

Figure 1 below illustrates that of the 32,532 Bangladeshis in Birmingham, 18,452 (57%) reported being born in the UK. Of the Bangladeshis born in the UK, 18,347 were born in England (99.4%), followed by 62 in Wales (0.34%), 15 in Scotland (0.08%), and 8 in Northern Ireland (0.04%).

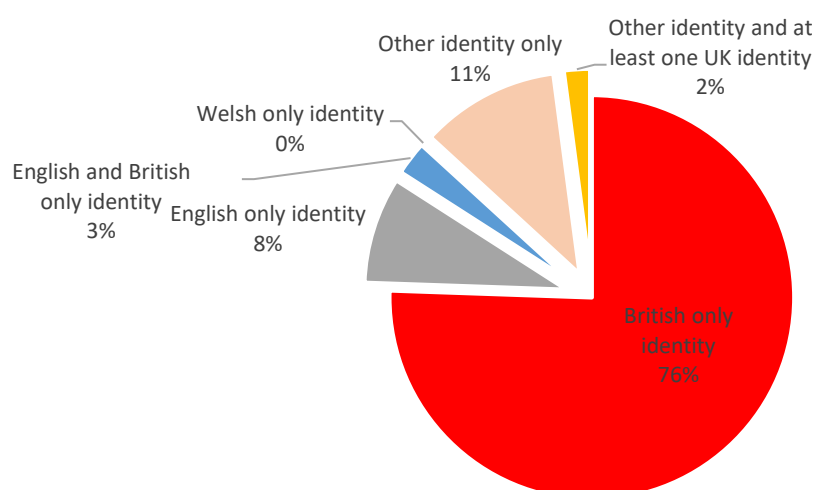
Figure 1: Country of birth for Bangladeshis in Birmingham (n= 32,532)



Source - Census 2011 ONS: DC2205EW

Figure 2, below, illustrates that the largest proportion of Bangladeshis in Birmingham identify themselves as British nationals. 24,551 citizens identify themselves as British nationals (75.5% of those in Birmingham), followed by those who identify as 'other identity' with 3,604 citizens (11%) and English only identity with 2,773 citizens (8.5%). The rest of reported identities account for less than 5% each. Non-UK identities were made up of Irish only and other identities accounting for a total of 3,606 (11%) Bangladeshis citizens in Birmingham.

Figure 2: National identity of Bangladeshis in Birmingham (n= 32,532)

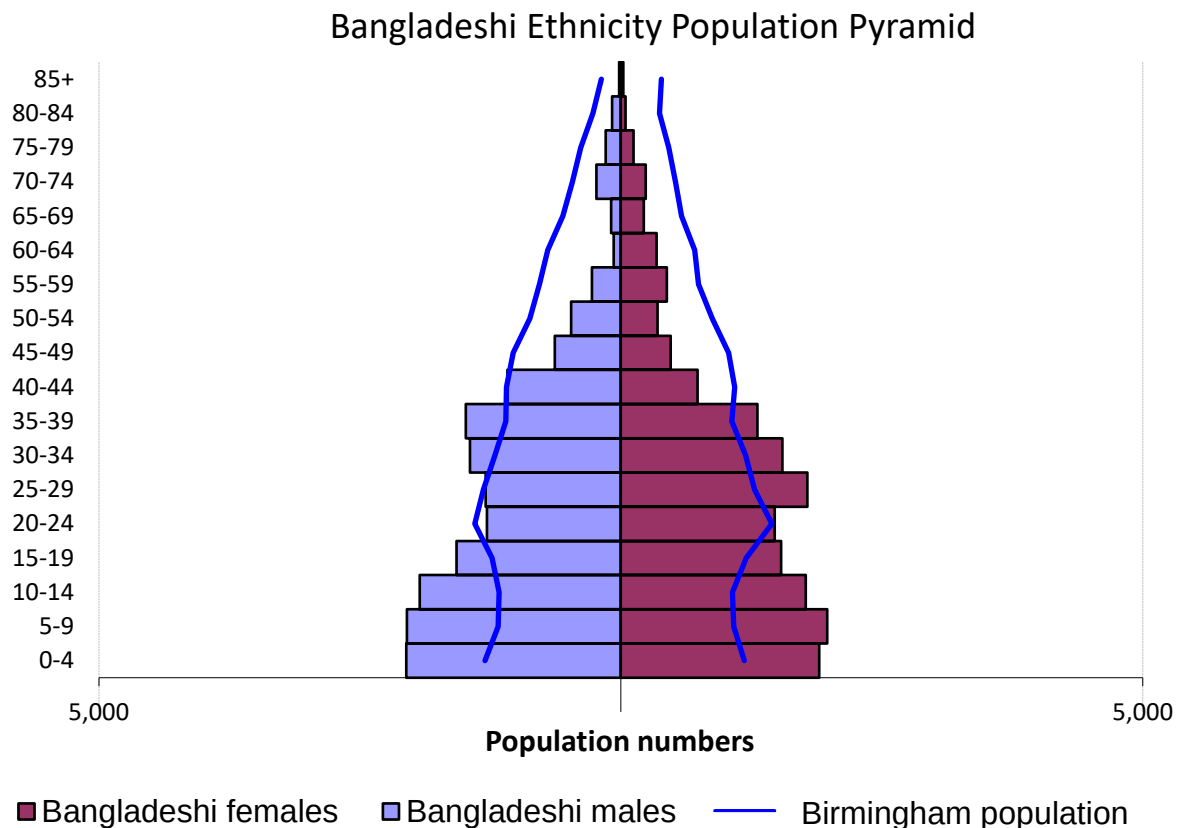


Source - Census 2011 ONS: DC2202EW

In 2011, 30,136 (92.6%) of Bangladeshis in Birmingham were reported to be Muslims, this was the largest proportion compared to all religious affiliations. The second largest proportion are those who did not state their religion, 1,650 (5%) of Bangladeshis in Birmingham. All other religions only accounted for less than 1% each of Bangladeshis in Birmingham.⁽¹⁴⁾

The population pyramid in figure 3 below, shows that the Bangladeshi population in Birmingham is younger than the Birmingham general population, with a higher proportion of children aged under 18 compared to the general population (42% compared to 26%). Bangladeshis aged 65 and over account for 3.8% of all Bangladeshis in Birmingham, a smaller proportion when compared with the general population (12.8%).

Figure 3: Age profile of Bangladeshis in Birmingham, compared to the total Birmingham population

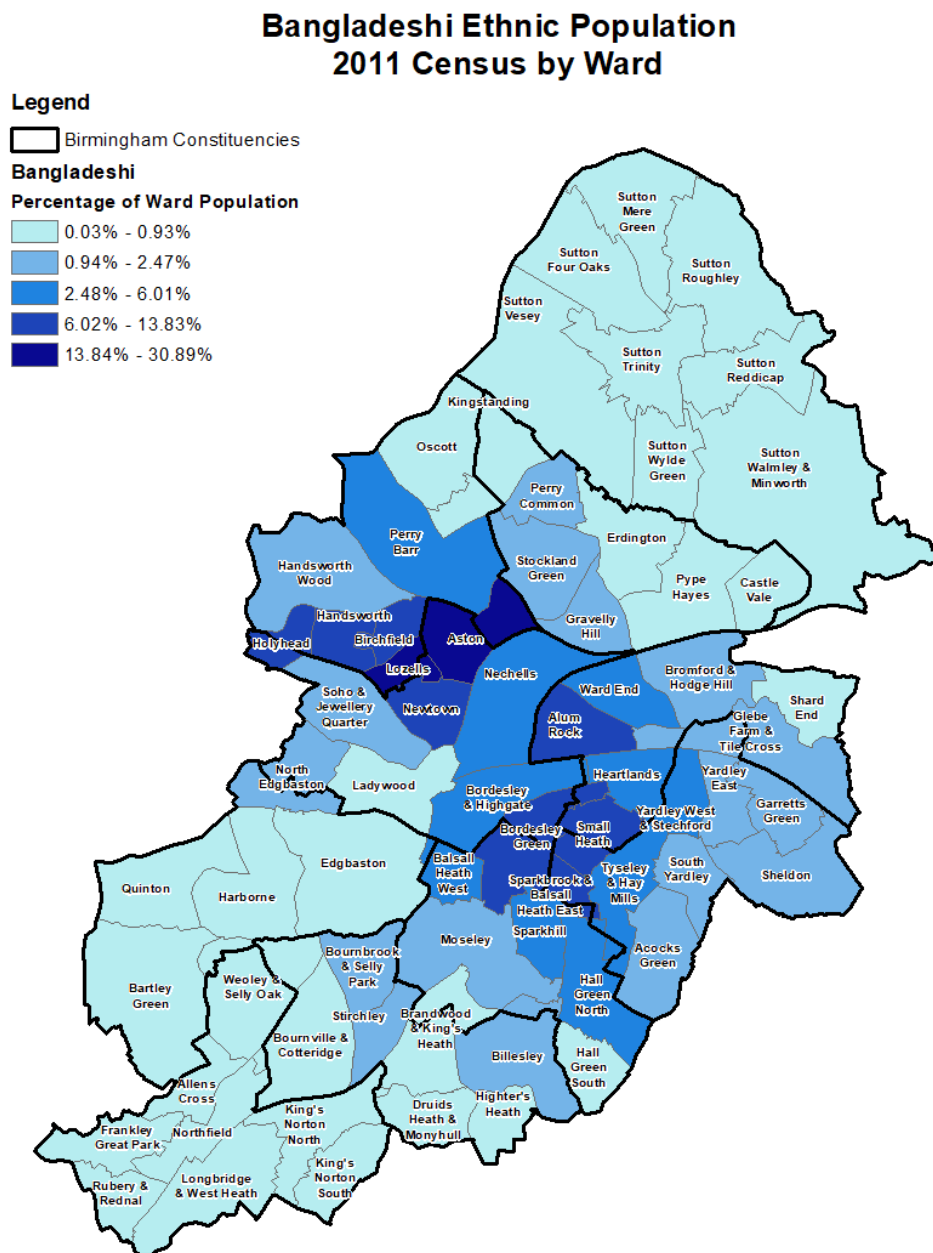


Source: Census 2011 DC101EW

1.5 Bangladeshi population ward level

Figure 4 below shows the percentage of Bangladeshis by Birmingham wards. In 2011, the largest Bangladeshi population in Birmingham lived in Lozells and Aston (31% and 21%, respectively). No other Birmingham ward had more than 14% of their population in this ethnic group, with almost half of all wards (32 out of 69) having a population lower than 1%.

Figure 4: Map of Bangladeshi population by Ward



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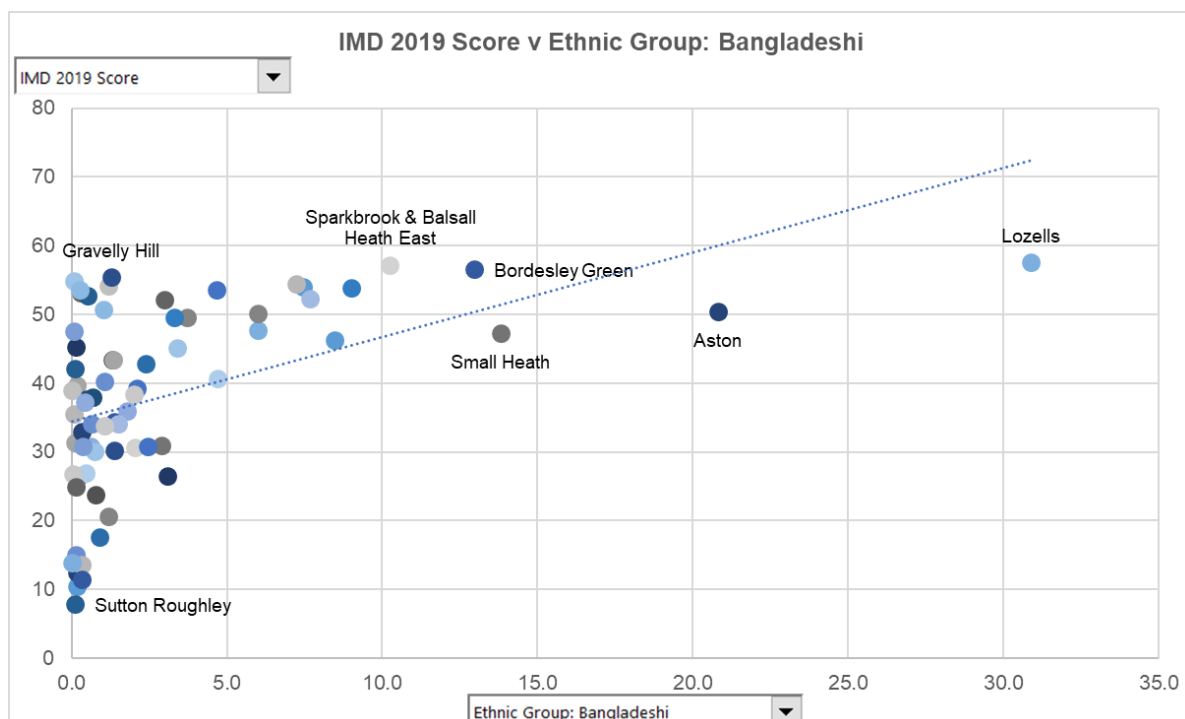
Figure 5 below shows a comparison of the percentage of the Bangladeshi ethnic population against the Index of Multiple Deprivation Scores (IMD) by Birmingham ward.

The IMD is a measure of relative deprivation for small areas. It is derived from 37 separate indicators that have been grouped into seven domains, each of which reflects

a different aspect of deprivation experienced by individuals living in an area. Again, it should be noted that the most recent ethnicity data available at ward level is from the 2011 census, so any conclusions from using this data should be made with caution. Furthermore, IMD 2019 data is originally calculated at LSOA (Lower Layer Super Output Area) level, and then 'averaged-up' to create ward level estimates. LSOAs are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales. They have an average population of 1000 people or 650 households and contain from 4 to 6 output areas. LSOAs do not have names and are referenced by codes identified using the last 3 digits of the code together with the ward name.

Figure 5 below demonstrates a linear pattern of higher levels of IMD for those wards with a higher percentage of Bangladeshi ethnic population although there are some exceptions.

Figure 5: Scatter plot of percentage of Bangladeshi ethnic group against Index Of Multiple Deprivation (IMD) 2019 by Birmingham ward



Source: 2011 Census ethnicity data and average IMD 2019 score by ward.

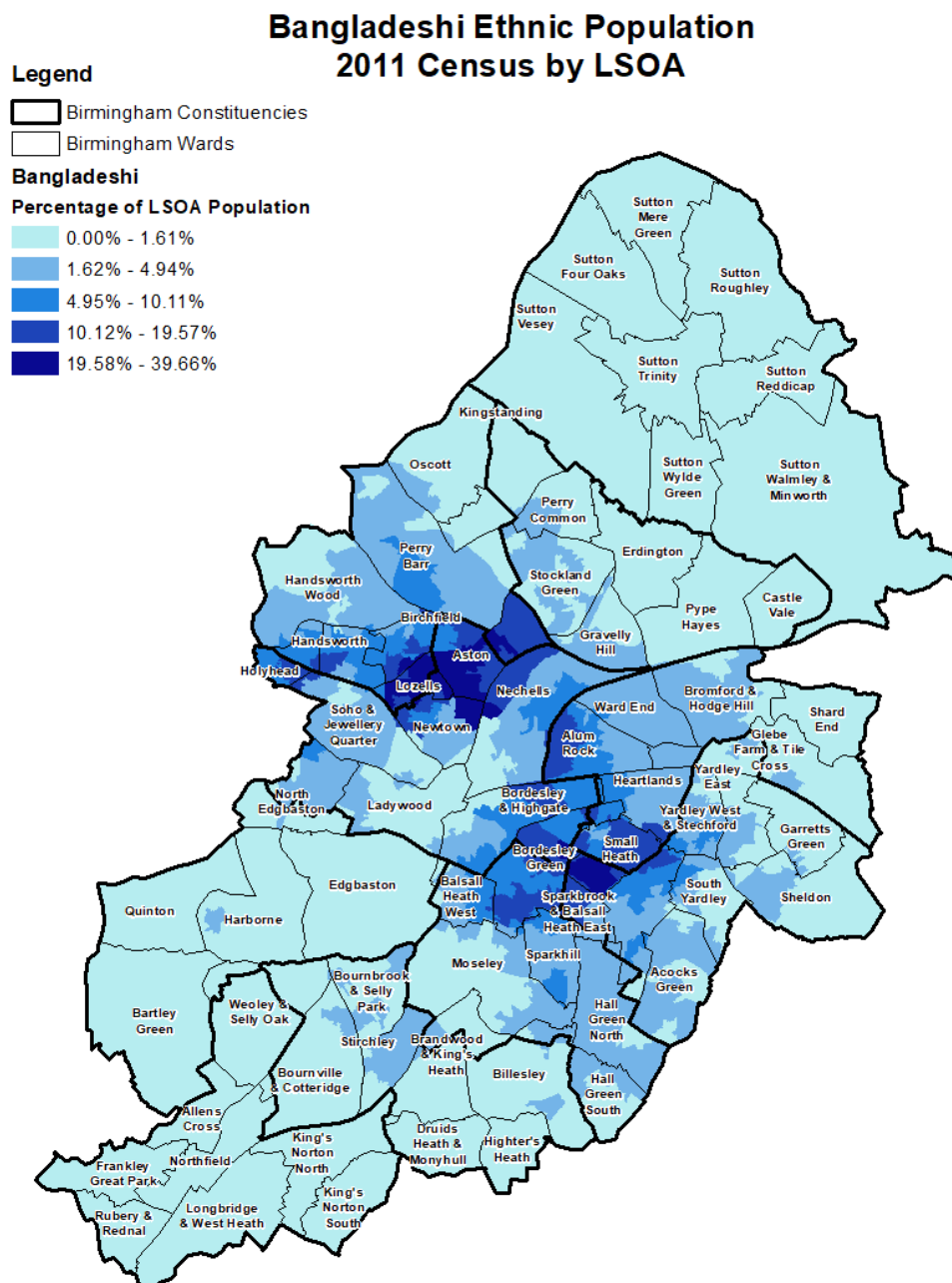
Lozells had the highest percentage of its population in the Bangladeshi ethnic group, and this ward also has the highest IMD score of 57.5. The wards with the second highest IMD scores were Sparkbrook and Balsall Heath East, and Bordesley Green (IMD Scores of 57.1 and 56.5 respectively). These wards also have a relatively high percentage of its population in the Bangladeshi ethnic group (11.6% and %) in 2011. Conversely, the ward with the lowest IMD score, Sutton Roughly (7.8), had one of the lowest percentages of its population in the Bangladeshi ethnic group (0.1%).

However, this pattern is not always consistent, with wards such as Castle Vale, Gravelly Hill, and Garretts Green having relatively low percentages of their populations in the Bangladeshi ethnic group, and some of the highest IMD scores in Birmingham.

1.5.1 Bangladeshi population LSOA level

Figure 6 below shows a map of the percentage of the population in the Bangladeshi ethnic group by Birmingham Lower Super Output Area (LSOA). As with the ward level map in Figure 5, the wards of Lozells and Aston include areas with the highest percentages of their populations in the Bangladeshi ethnic group. However, when examining the data at this lower geographical level, there are also LSOAs within Bordesley Green and Small Heath wards with high Bangladeshi populations.

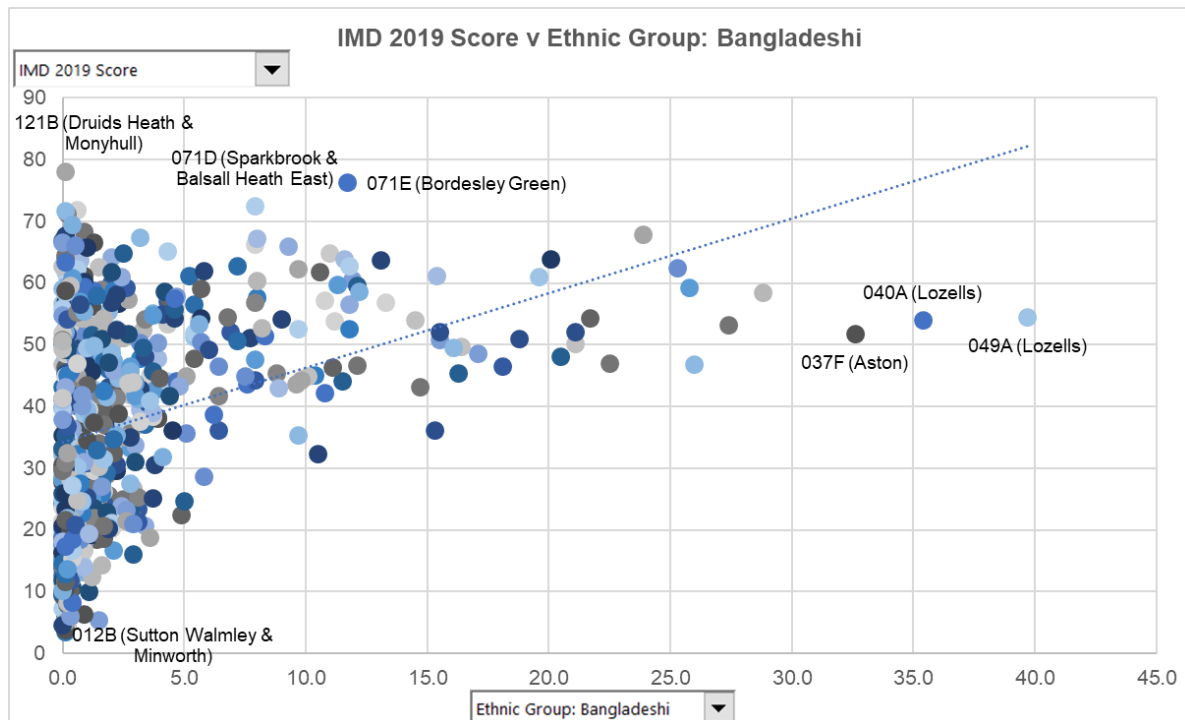
Figure 6: Map of Bangladeshi Population by LSOA



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Figure 7 below shows a comparison of the percentage of the Bangladeshi ethnic population against the Index of Multiple Deprivation Scores (IMD) by LSOA. There appears to be a linear pattern of higher levels of IMD for those LSOAs with a higher percentage of Bangladeshi ethnic population where there are a few notable exceptions.

Figure 7: Scatter Plot of the percentage of Bangladeshi ethnic group against IMD 2019 by LSOA



Source: 2011 Census ethnicity data and IMD 2019 score by LSOA.

The LSOA of 049A in the Lozells ward had the highest percentage of its population in the Bangladeshi ethnic group (39.7%), and this LSOA also has a relatively high IMD score of 54.4. The LSOAs with the next highest percentage of their populations in the Bangladeshi ethnic group, namely 040A in Lozells (35.4%) and 037F in Aston (32.6%), also have relatively high IMD scores of 53.9 and 51.8, respectively.

However, the LSOA with the highest IMD score in Birmingham, namely 121B in the Druids Heath and Monymhull ward has one of the lowest percentages of Bangladeshis (0.1%). LSOAs 071D in the Sparkbrook and Balsall Heath East ward and 071E in the Bordesley Green ward has the next highest IMD scores, they also do not have significantly high percentages of Bangladeshis within their populations (7.9% and 11.7% respectively).

2. Community Profile

Significant health differences exist between minority ethnic groups and White populations, a pattern which is reflected in the Bangladeshi community. The following sections present and highlight key health statistics and data from a collection of sources. Each section features key findings in bullet point format, before presenting detailed evidenced information. All findings are essential for informing policy, which can be used to address health concerns for Bangladeshis within the UK.

2.1 Getting the best start in life

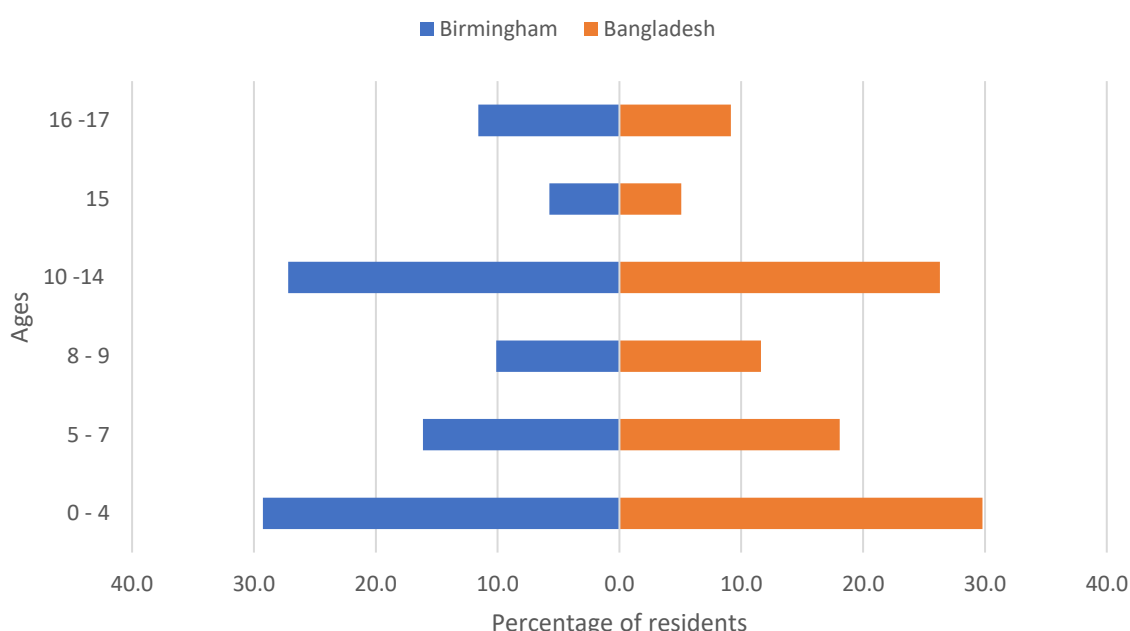
Getting the best start in life key findings

- Bangladeshi women are among the South Asian women who have higher rates of adverse birth outcomes, including perinatal mortality,
- In 2016-18, there were **13.2 per 100,000** maternal mortalities from mothers born in Bangladeshi, **1.50 times** the risk compared to women born in the UK (8.83 deaths per 100,000)
- Bangladeshi women are **2.4 times more** likely to have a stillbirth compared to British White women,
- Generally, Bangladeshis have higher proportions of premature and low birthweight babies than White mothers,
- Bangladeshi infants were on average **280-350g lighter** and **2.5 times more** likely to be low birth weight compared with White infants,
- Bangladeshi uptake on the triple vaccine was **96%**, similar to all other South Asian groups (average 94.5%), but higher than the White groups (92%),
- In Birmingham, obesity prevalence was highest for Bangladeshi children in both reception and year 6 when comparing with all children and White children (**30%** of year 6 Bangladeshi children were obese, and **12.6%** of Bangladeshi children in reception),
- Bangladeshi children are **most likely** to live in low-income and material deprivation compared with White British households,
- Bangladeshi pupils have the highest eligibility for Free School Meals (FSM) at each key stage compared with other groups., **52%** in KS1 and KS2; **62%** in KS3 and KS4
- Conversely, educational outcomes for Bangladeshi children who were eligible for free school meals had higher Progress 8 scores than the national average
- Bangladeshi children are **4 times more likely** to not be school ready than White children.

In Birmingham, there are 167,009 children registered as Bangladeshi, representing 1.47% of the children's population aged under 18yrs. Figure 8 below, illustrates the

proportion of Bangladeshi children at different ages, compared to the proportion of the general population of Birmingham.

Figure 8: Bangladeshi children's age profile compared to the general population of Birmingham



Source: Census 2011- DC2107EW

2.1.1 Maternal health

There is limited research and information regarding maternal health among Bangladeshis in the UK. A report from the Confidential Enquiry into Maternal Deaths in the UK (MBRRACE) found that in 2016-18, there were 13.2 per 100,000 maternal mortalities in the UK from mothers born in Bangladeshi, 1.50 times the risk compared to women born in the UK (8.83 deaths per 100,000)⁽¹⁵⁾

Evidence from published research suggests that:

- Bangladeshi women are among the South Asians who have higher rates of adverse birth outcomes including perinatal mortality, compared with White British or White Other mothers. The prevalence of having a low-birth-weight

infant is high in South Asian mothers in the UK, but the precise measurement of what constitutes low birthweight is unclear⁽¹⁶⁾

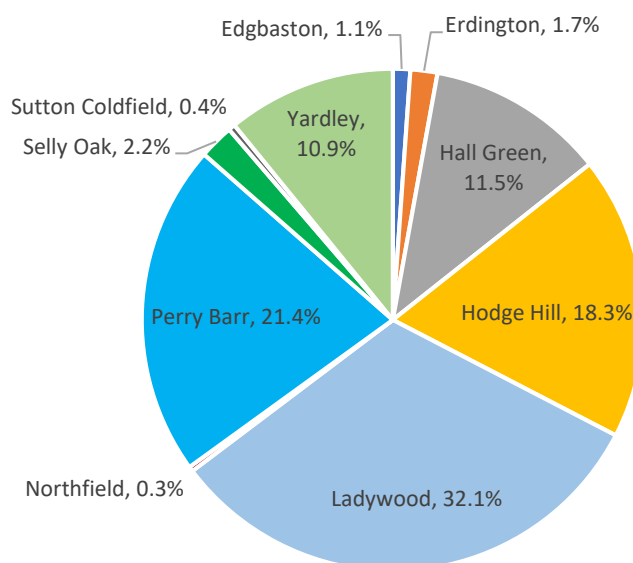
- Using the revised Body Mass Index (BMI) threshold, 24.3% of pregnant Bangladeshi women were obese, compared with pregnant White British women. Bangladeshi women are 2.4 times more likely to have a stillbirth compared to White British women and evidence shows that obesity is associated with increased risks of maternal comorbidity, congenital anomaly, and stillbirth.⁽¹⁶⁾

Because of limited data at an ethnicity level, there is limited evidence to understand trends in infant mortality rates among Bangladeshis in the UK.

2.1.2 Infant mortality and live births

Figure 9 below shows data from the NHS Digital Show within Birmingham and between 2013 to 2016, a total of 1,610 babies were born from mothers of Bangladeshi heritage. The highest proportions of live births were from Ladywood (32.1%) and Perry Bar (21.4%), and the smallest proportions were from Sutton Coldfield (0.4%) and Northfield (0.3%). In 2018, Bangladeshis in England had 1.5% of live births, which was considerably lower when compared with White British (59.4%), White other (12%) and Pakistani (4.1%).⁽¹⁷⁾

Figure 9: Total live births of Bangladeshis in Birmingham constituencies 2013 – 2016 (N = 1,610)



Source: NHS Digital- Data processed by KEG team Birmingham

Generally, Bangladeshis have higher infant mortality compared to White mothers.^{(17,}
¹⁸⁾ Bangladeshis also have higher rates of low birth weight compared to White mothers.^(17, 18) A King's Fund report found that in England, in 2018, 6.5% Bangladeshis babies had low birth weight compared to White British (2.5%), White Other (2.2%) and Pakistani babies (4.8%).^(17, 18)

From the published research there is evidence that:

- Low birthweight is highest for the Bangladeshi, Indian, and Pakistani groups, but their levels of low birth weight have been improving in recent years.⁽¹⁹⁾ Of all ethnic groups, Bangladeshis had the lowest mean birth weights (3064g to 3378g), 78g - 350g lower than White British⁽²⁰⁻²²⁾
- 6.5% Bangladeshis babies had low birth weight compared to White British (2.5%), White Other (2.2%), and Pakistani babies (4.8%)⁽¹⁷⁾
- Socio-economic, maternal (for example mothers who were on average 8cm shorter compared to white mothers), and infant factors were important in explaining low birthweight differences compared to White ethnicities. There may also be ethnic differences in access to antenatal care reflected by lower reported rates of receiving antenatal care⁽²²⁾
- The highest attributable risk of preterm births in all infants was in Bangladeshi infants (6.3%), compared to White British (5.5%)⁽²⁰⁾
- Bangladeshis have a lower percentage (1.5% to 13.5%) of live births, which was considerably lower when compared with White British (46.1% to 59.4%) and White Other (12%)^(17, 21)
- Per every 1,000 live births in 2015 to 2017, Bangladeshis had 4.9 infant deaths compared with White British (3.2) and White Other (2.4), but lower than Pakistanis (6.8%).⁽¹⁷⁾⁽¹⁸⁾ Infant mortality is linked to Bangladeshis being more likely to live in areas of high deprivation, compared to other minority ethnicities⁽²⁰⁾
- Infant mortality for low birthweight births of Bangladeshi groups increased by 5.5 per 1000 births between 2007 and 2013, compared with White British and

White other that decreased by 8 births per 1000 in 2007 and 7 births per 1000 births in 2013.⁽¹⁸⁾

Both national data and evidence from published research show a higher prevalence of infant mortality among Bangladeshis, particularly women born in Bangladesh compared to mothers of White ethnic groups and other ethnicities in Birmingham and England. However, there is limited qualitative evidence to understand the experiences relating to Bangladeshis in the UK and the role of culture and behavioural factors contributing to differences in birth weight, service uptake, and knowledge of maternal services available.

2.1.3 Childhood vaccinations

No national data or reports were found regarding childhood vaccinations among Bangladeshis in the UK. However, limited evidence from the published research states:

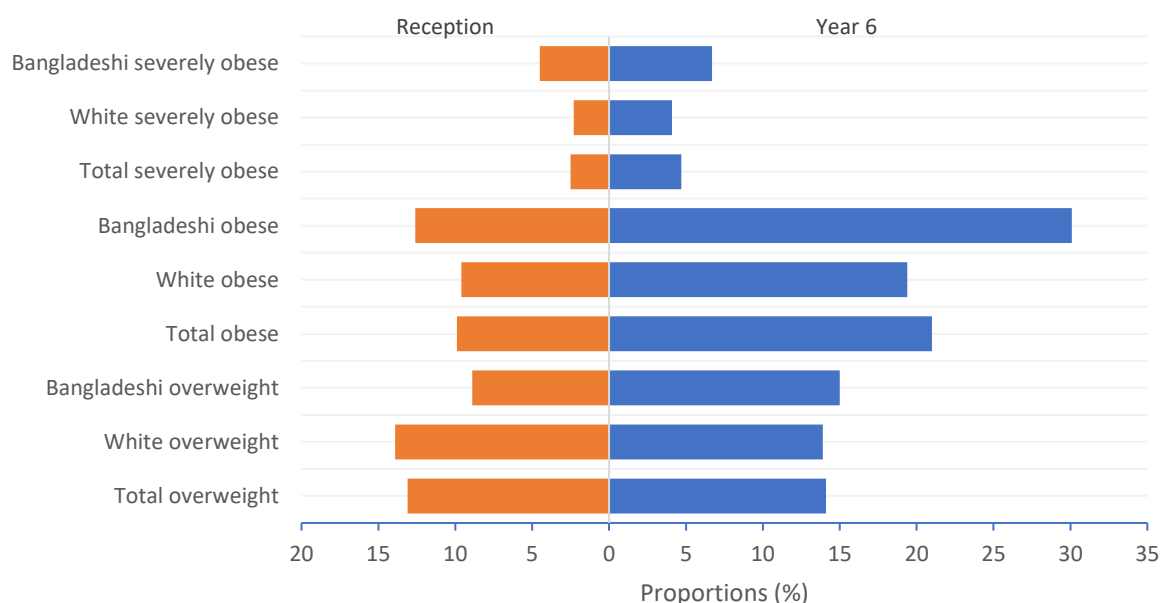
- Uptake of triple vaccinations was higher in Bangladeshi groups (96%). This was similar to all other South Asian groups (average 94.5%), but higher than the White groups (92%). A triple vaccine treats three illnesses within one jab
- Bangladeshi infants were also most likely to be MMR (Measles, Mumps, and Rubella) vaccinated (95%), a similar proportion to other Asian groups, but considerably higher than White British infants (88%)⁽²³⁾
- Conversely, Bangladeshi children were less likely to receive three doses of DTaP (Diphtheria, Tetanus and Whooping Cough), IPV (Inactivated Polio Vaccine), Hib (Haemophilus influenzae type b) by six months of age compared to White British children.⁽²⁴⁾

Due to the lack of published research and national data on an ethnicity level, there is limited evidence to understand the variations in childhood vaccination uptake in the UK.

2.1.4 Childhood obesity

The NCMP (National Child Measurement Programme) is an annual programme that measures the height and weight of over 1 million children per year in reception (aged 4 to 5 years) and year 6 (aged 10 to 11 years) in mainstream state-funded schools in England. The 2019/20 programme found that severely obese and obesity prevalence was highest for Bangladeshi children in both reception and year 6 when compared with all children. Major differences in weight categories were found in year 6 Bangladeshi children who were classified as obese (30.1%), a much larger proportion compared with White only or all children (19.4% and 21% respectively), and Bangladeshi children in reception were obese (12.6), compared with only or all children (9.6% and 9.9% respectively).⁽²⁵⁾ Figure 10 (below) illustrates the prevalence of all weight categories among reception and year 6 aged children in England:

Figure 10: The prevalence of overweight, obese and severely obese among Bangladeshi children compared to White children and all children in reception and year 6 in England, 2019/20



Source: NHS Digital- National Child Measurement Programme

Reports from national data found the following:

- In 2014/15 more Bangladeshi children in England had excess weight compared to the national average (43% compared with 33%)⁽¹⁹⁾
- Physical activity levels are lower than national averages among children from Bangladeshi groups⁽¹⁷⁾
- 21% of Bangladeshi children aged 4-5 years old were classed as overweight. This is slightly lower than the overall population and the White British population (22% and 23%) but was higher than Indian children (14%). Similarly, 44% of Bangladeshi children aged 10-11 years old were overweight, which was significantly higher than all populations (33%), White British (32%), Pakistani (40%), and Indian (37%) children.⁽²⁶⁾

Data and evidence from national sources suggest that more children of Bangladeshi heritage are classified as obese or severely obese, compared to White children and

all other ethnicities. Methods of ‘traditional’ cooking and lower physical activity uptake may be contributing factors to the higher prevalence of obesity among Bangladeshi children.

2.1.5 Child poverty

Statistically, more Bangladeshi children live in poverty compared to White children in England. Low-income and employment rates among Bangladeshi adults may be a contributing factor to high rates of child poverty, material deprivation, and high free school meals uptake rates among Bangladeshi children.

The Office for National Statistics (ONS), Ofsted Survey, and Health Equity national reports explored how child poverty and educational outcomes vary for different ethnic groups and found that, although child poverty fell by 2% for children living in Bangladeshi households between 2012 and 2018 (43% to 41%), the proportion of children living in low-income families remains higher compared to children living in White British households.^(27, 28) 29% of children in Bangladeshi households lived in low-income and experienced material deprivation. Bangladeshi children were the most likely to live in low-income and experience material deprivation out of all ethnic groups (2.4 more likely compared with White British households). This may be explained by the higher rate of unemployment among Bangladeshi adults (31% higher, compared to White adults 12%).⁽²⁷⁾

Bangladeshi pupils have the highest eligibility for FSM (free school meals) at each key stage compared with other groups within the UK. Between Key Stage 1 and 2, 52% of Bangladeshi pupils are eligible for FSM. The figure rises to 62% in Key Stage 3 and 4.⁽¹⁾ Conversely, educational outcomes for Bangladeshi children who were eligible for free school meals had higher Progress 8 scores than the national average.⁽¹⁾ Progress

8 scores measure the amount of progress a child has made from the end of primary school to the end of secondary school. In addition, Bangladeshi pupils make more progress than several other minority ethnic groups, such as Pakistani and Black Caribbean pupils, between Key Stage 3 and GCSE. 71% of Bangladeshi pupils who achieve level 5 at Key Stage 3 achieve five or more A*–C grades at GCSE, compared with 67% of Pakistani pupils and 48% of Black Caribbean pupils.⁽¹⁾

2.1.6 Children in care

There is a lack of data on children in care on sub-ethnic level. As a result, there is a lack of evidence exclusive to Bangladeshi children in care and explanations for varying rates among Asian children in care in the UK.

However, evidence from published research suggests that:

- Asian children overall are almost three times less likely to be in care than White children and almost four times less likely than Black children. In high deprivation areas, Bangladeshi children were four times more likely than Indian children to be in out-of-home care and around twice as Pakistani children.⁽²⁹⁾ Out of home care is defined as the alternative accommodation for children and young people who cannot live with their parents
- The distribution of Asian children subject to state child protection interventions between those of Indian, Pakistani, Bangladeshi, and other origins varied widely. Bangladeshi children are twice as likely to be on a child protection plan compared to Indian children, but half as likely compared to Pakistani children.⁽³⁰⁾

2.1.7 Youth justice

No research could be found on youth justice among British Bangladeshis. However, research and statistics from the Youth Justice Board suggest that South Asian children are under-represented in the youth justice system in the UK, but this is not broken down by individual ethnicities. It is not understood whether the needs of different ethnic groups differ once they enter the system and whether those delivering interventions to BME (Black and Minority Ethnic) offenders have had the necessary training to deliver culturally sensitive services.⁽³¹⁾

2.1.8 School readiness

There is limited evidence exclusively on Bangladeshi children and local data is not available.

However, evidence from published research reported the following:

- Between 2000-2002, Pakistani and Bangladeshi children at three years-old were four times more likely to not be school ready than White children⁽³²⁾
- There are large ethnic gaps in early childhood cognitive development, particularly between White children and Bangladeshi children. (Similar gaps are also present between White children and Pakistani children). Children from all minority ethnic groups perform significantly worse than White children in terms of a key cognitive outcome (BAS Naming Vocabulary Score) at ages three and five. Pakistani and Bangladeshi children have worse academic outcomes at both ages.⁽³³⁾

2.1.9 School exclusions

There is limited exclusive evidence of Bangladeshi children and school exclusions. However, the limited evidence from national government reports state the following:

- The proportion of Bangladeshi children excluded from school is lower than White British and the national average, with 0.07% being permanently excluded compared to 0.14% (White British and national average)⁽³⁴⁾
- In 2003/4, 2.37% of Bangladeshi children were excluded for a fixed period, a lower proportion compared to White British children (4.95%) and the national average (5.2%).⁽³⁴⁾

2.2 Mental wellness and balance

Mental wellness and balance key findings

- Bangladeshis had the lowest prevalence of mental health illness (**8.3%**) in comparison to any ethnic group (White – **17.3%**)
- However, more Bangladeshis reported high levels of psychological distress compared to White British (**25.7%** compared with **20.7%**)
- **136.1 per 100,000** Bangladeshis were detained under the mental health act in 2019/20, a decrease from 2018/19 (**141.7**)
- Majority of Bangladeshis are non-drinkers. **97% and 98%** of Bangladeshi men and women reported 'not drinking in the last 12 months, compared to the general population (**8% men and 14% women**)
- Cannabis (Ganja, marijuana, weed, and spliff) was highlighted as the main drug of choice, but drug misuse is not publicly acknowledged by the Bangladeshi community
- Bangladeshis are **40%** less likely to report ever taking drugs compared to White British
- The prevalence of heroin use among Bangladeshis has increased from negligible levels in the early 1990s to levels proportionally higher than the White population of the same age and sex, with a mean age of **21.1 years**
- Bangladeshi women smoke less (**0.9%**) compared with White British women (**21.6%**). More Bangladeshi men smoke (**40%**) compared to Black African and Chinese men (**21%**)
- Paan chewing is mostly associated with the Bangladeshi population, with more men (**16%**) than women (**9%**) chewing tobacco.

2.2.1 Mental health

Approximately 136 per 100,000 Bangladeshis were detained under the Mental Health Act in 2019/20, which is a decrease of approximately 6 per 100,000 Bangladeshis from 2018/19. This is a higher rate compared to Indian and Pakistani (approximately 72 to

121 per 100,000) and White British (approximately 71 per 100,000), but lower than all Black categories (ranging from 197 to 810 per 100,000).⁽³⁵⁾

From the published research there is evidence that:

- There are lower risks of common mental health disorders and psychotic experiences among Bangladeshi women,^(36, 37) with Bangladeshis having the lowest distribution of mental illness compared to White people⁽⁴⁰⁾
- Bangladeshis admitted to hospitals with mental illness were more likely to be men (77%) and younger mean age compared to other ethnicities. The mean length of illness for Bangladeshis was 4.1 years, this is the shortest length of illness compared to all other ethnicities including White British (6.8 years). The mean length of hospital stay for Bangladeshis (13.4 months) was also shorter than White counterparts (38 months). Bangladeshis also had the lowest proportion of involuntary admissions, being admitted to hospital against your will, compared to all other ethnicities. Bangladeshis were less likely to want treatment of any kind than White patients however Bangladeshis are more likely to want non-conventional forms of treatment, including natural remedies⁽⁴⁰⁾
- In the Bangladeshi ethnic group, there was no gender difference nor socioeconomic gradient in the risk of having a diagnosed mental health illness.⁽³⁸⁾ However, Bangladeshis are at an increased risk of psychological distress, and the risk is higher in men compared to women⁽⁴¹⁾
- Similar to other ethnic minorities, Bangladeshis were more likely to report chronic strains due to relatives compared to White British but were more likely to report severe problems with their relationships, compared with the other minority ethnic groups.^(39, 41) Overall, Bangladeshi groups reported lower social capital levels than the White British group. Bangladeshi men's social capital

level were only 16% and Bangladeshi women's were only 30%.⁽⁴¹⁾ Among citizens aged 65 and over, between 24% and 48% of those from Pakistani, Bangladeshi, African Caribbean, and Chinese groups reported being lonely often or always⁽⁴²⁾. Social capital refers to the networks and shared values that allows individuals to work and live together within a particular community.

- Bangladeshis cited biological factors less frequently as causes for mental illness, and social causes more frequently than White British (such as interpersonal problems, stress, and negative childhood events). Bangladeshis also cited supernatural causes more frequently and either wanted alternative forms of treatment such as religious activities or no treatment at all.⁽⁴⁰⁾

In the UK, research shows that Bangladeshis have the lowest prevalence of a diagnosed mental health illness out of any ethnic group. However, Bangladeshis are more likely to report higher levels of psychological distress and chronic strains due to relatives. This may suggest that the prevalence of mental health illness is higher in Bangladeshis, but not accurately reported as they may be less inclined to seek professional support.

2.2.2 Alcohol

The majority of Bangladeshis living in the UK are non-drinkers, with 97% of men and 98% of women reporting that they had not 'drunk at all in the last 12 months.' 0.5% of Pakistani and Bangladeshi women reported drinking on 3 or more days a week, which is much lower than women in the general population of the UK (26%).⁽⁴³⁾ However, Bangladeshi males are more likely to be regular drinkers than Bangladeshi women, who are more likely to report abstinence than men.^(44, 45)

From the published research there is evidence that:

- People of Bangladesh background are less likely to consume alcohol than other ethnic groups.⁽⁴³⁻⁴⁵⁾ Drinking rates are low amongst British Bangladeshis, contributing to the rates of alcohol-related mortality being lower than the national average
- Bangladeshi people who had migrated to Britain were less likely to be drinkers than those who were born in Britain or had migrated before the age of 11 years old⁽⁴⁵⁾
- Gender differences exist, with Bangladeshi males more likely to be regular drinkers than Bangladeshi females.^(44, 45)

Overall, there is conclusive evidence to suggest a considerably lower prevalence of alcohol intake among Bangladeshis. However, there is currently limited qualitative research that specifically explores other alcohol-related themes such as alcohol service uptake and cultural explanations for differences in alcohol intake between genders.

2.2.3 Drug use

Drug use in Birmingham appears to be proportionately lower in Bangladeshis compared to White populations, but similar to other Asian ethnic groups. According to recent data obtained from Change Grow Live (CGL), Birmingham's local drug services provider, 67 people of Bangladeshi heritage registered for treatment. Bangladeshis make up around 1.4% of the total population registered with substance misuse services in Birmingham. The largest proportion of Bangladeshis accessing services (18%), reported to be living in Aston, and the rest are spread across the city, each area with less than 10% of Bangladeshis registered in drug and alcohol services. Data from the National Drug Treatment Monitoring System (NDTMS) reported for the period

2017-18, that 1,252 Bangladeshis in Birmingham were in treatment for drug and alcohol misuse, representing less than 1% of all clients in treatment during that period. This is a considerably smaller proportion compared to White British (84%), but similar to other Asian ethnic groups such as Pakistani and Indian (both 1%). 928 (1%) Bangladeshis presented at drug services for opiate use only, 137 (1%) for non-opiate use only, and 82 (>1%) presented for non-opiate and alcohol use.

The published research evidence shows that:

- Generally, the prevalence of heroin use among Bangladeshis has increased from negligible levels in the early 1990s to levels proportionally higher than the White population of the same age and sex with the ratio of Bangladeshi heroin users to White users (in the under 25 age group)^(44, 48). An estimated 13 percent of Asian adolescents reported having used drugs at least once, similar to other ethnic groups, particularly White (14%).⁽⁴⁴⁾ The majority of Bangladeshis report cannabis (Ganja, marijuana, weed, and spliff) as the main drug of choice followed by heroin, cocaine, and speed, with smoking as the preferred method of administering drugs.^(44, 46) Presentations for heroin use in the Bangladeshi sample were highest among younger age groups (mean age: 21.1 years)⁽⁴⁷⁾

The length of drug use within participants ranged from a minimum of five years to a maximum of 21 years.⁽⁴⁹⁾ The mean number of years participants had been using drugs was 13.86 years, with men being users for a much longer time than women (M = 16.6 years; F = 10.7 years).⁽⁴⁹⁾ Despite the evidence of a high prevalence of drug use, Bangladeshis are 40% less likely to report ever taking drugs compared to White British; 50% less likely to report using cannabis in the last month or week; and nearly twice as likely to report ever trying glue, gas or solvents.⁽⁵⁰⁾ Community leaders confirmed that drug-related problems exist

among the Bangladeshi community, especially in the younger age group and are recognised as such but help seeking is often problematic⁽⁴⁶⁾

- Drug use problem is not publicly acknowledged by the Bangladeshi community because stigma affects the status of the family in society and the notion of shame in the family is strong.⁽⁴⁶⁾ Participants' effective utilisation of drug treatment services were impacted by a variety of factors including friendship networks and the embeddedness of drugs in drug-using networks, the structural disadvantages participants experienced, and the need for concealment of their drug use⁽⁴⁹⁾
- Bangladeshi heroin users are nearly all male (96%) and are generally in less advantaged areas compared with White users. They also have much greater contact with their non-drug-using families. Bangladeshis under 25-years old show the most exaggerated gender differences. 96% of Bangladeshi service users were males, a gender ratio of 19:1. This compared with a gender ratio of 3:1 in the White ethnic group.^(47, 48) The prevalence pattern of glue, gas, and solvent use appeared to be different from that for cannabis use; use was higher in younger boys and older girls, and appeared to be higher amongst Bangladeshi than amongst White British (3.9% for year 7 Bangladeshi boys compared with 3.5% for White boys and (5.7% for year 9 Bangladeshi girls compared with 2.6% for White boys). Most started their drug-taking at a relatively young age and men started earlier than women, with an age range at outset ranging from 11 to 25 years (men) and from 15 to 25 years for women⁽⁵⁰⁾
- 88% of the Bangladeshi patients presenting for treatment did so for heroin use, compared to 63% in the White sample.⁽⁴⁷⁾ Young Bangladeshis and Pakistanis are under-represented in the treatment population, currently comprising

2.5%.⁽⁴⁴⁾ Drug consumption is deemed forbidden, bringing shame and stigma upon a family. These may contribute to concealment of drug use, therefore causing there to be a small number of Asians who present at support services with a substance use issue.^(44, 48)

There is limited national data collected on a sub-ethnic level to assess the drug use among Bangladeshis in Birmingham. Also, there is limited qualitative evidence to understand the knowledge of Bangladeshis on service provision and drug related deaths.

2.2.4 Smoking

There are vast gender differences amongst Bangladeshi smokers, with evidence consistently suggesting that males are more likely to be regular smokers than women.^(44, 51) Tobacco is also consumed in the form of Paan chewing, which is widespread throughout the Bangladeshi population and popular with women. Paan is a combination of betel leaf and areca nut, which has been associated with oral submucous fibrosis risk, an oral condition that restricts mouth opening and increases the risk of oral cancer.⁽⁵²⁾

The published evidence shows that:

- 0.9% to 2% of Bangladeshi women are smokers, a much lower rate compared with White British women (21.6%),⁽²¹⁾ while 40% of Bangladeshi men smoked in 2004, higher than the general population in the UK (24%)^(44, 51)
- In 2019, 29% of Bangladeshi adults reported ever having tried tobacco while 12% used tobacco at least monthly. These were both less favourable proportions compared to White populations who reported ever trying tobacco (12%); using at least monthly (1%)⁽⁵³⁾

- The proportion of Bangladeshi men who reported 'never regular smoker' yields inconclusive results with percentages ranging from 47% to 68%. More Bangladeshi women reported 'never regular smoker' compared to the general population in the UK (97% compared with 57% to 86%)(^{43, 53})
- 59% of Bangladeshis using the NHS stop smoking services reported remaining quit 28 days after their quit date, a larger proportion compared to White ethnic groups and all ethnic groups (both 52%)(⁵³)
- Chewing tobacco is predominantly associated with the Bangladeshi community(⁴⁴) with 9% of men and 16% of Bangladeshi women consuming tobacco this way. There was a slightly larger proportion found among men and women aged 55 and over (14% men and 29% women) compared to ages 35 to 54 (10% and 28%)(^{43, 51})
- Comparing Bangladeshi Paan use among adolescents with other ethnicities, 76.5% of all pupils who reported Paan use at any time were Bangladeshi, 10.7% Indian, 6.9% Pakistani, and 5.9% from mixed and Other ethnicities.(⁵⁰) Exploring Paan use by gender and age, more girls than boys in year 7 reported having 'ever chewed Paan' (40.7% girls compared 32.2% boys). The proportion was slightly higher for boys of a year 9 group (49.5% boys compared with 48.9 girls).(50) The median age of Paan chewers among children is 9, with 14% of the sample chewing Paan on most days. Paan chewers were more likely to be from a lower socio-economic background. They reported liking the taste of Paan and they were less inclined to think that it adversely affects their appearance or that it could cause cancer.(⁵⁴)

More evidence is needed on how culture can influence tobacco use, particularly Paan chewing among Bangladeshis. Additional evidence needs to understand

Bangladeshi's knowledge and understanding on health issues caused by using tobacco and the knowledge on stop smoking service provisions.

2.3 Healthy and affordable food

Healthy and affordable food key findings:

- Similar to the general population, only **28%** of Bangladeshi men consume the recommended '5-a-day'
- The use of salt in cooking was highest in Bangladeshi men (**94%**)
- “Strong” foods are perceived as energy giving. These included: white sugar, lamb, beef, ghee (derived from butter), solid fat, and spices
- Bangladeshi adolescents stated that eating rice was perceived as “eating well,” with rice being consumed twice a day
- The prevalence of obesity in Bangladeshi adults varied from **6% - 11.5%** in men and **15.1% - 17%** in women. Both are lower than the general population (**23%** in both).

2.3.1 Diet

Bangladeshi foods are not grouped according to Western notions of nutritional content, but in terms of their perceived strength, nourishing power, and digestibility. “Strong” foods, perceived as energy giving, included white sugar, lamb, beef, ghee (derived from butter), solid fat, and spices. Such foods were considered health giving and powerful, healthy for the body, and suitable for festive occasions. Foods of low digestibility were considered unsuitable for elderly, debilitated, or young people, for example, broccoli, rolled oats and brown rice. Thus, the recommendation for diabetic patients to bake or grill foods rather than fry them may not agree with cultural perceptions of digestibility.⁽⁵⁵⁾

Further published research on a diet within UK Bangladeshi communities evidenced:

- 28% of Bangladeshi men consume the recommended 5-a-day of fruit and vegetables, a similar proportion to the general populations, however, use of salt in cooking was highest in Bangladeshi men (95%) compared to 74% among Black African men⁽⁴³⁾
- There were inconsistent findings for fat intake in the Bangladeshi population. The average fat score for Bangladeshi men ranged from (23%), similar to Irish men (24%), but higher than Indian men (19%). Scores between 12-20% are classed as moderately lean and more than 20-30% are classed as excess fat. However, Bangladeshi men and women in East London reported higher total fat and saturated fat intake than the general population. This is primarily caused by the regular consumption of lamb and beef.⁽⁵⁶⁾ Fat intake may be higher in Bangladeshis due to South Asian cooking techniques (such as deep frying), combined with frequent consumption of fast foods⁽⁵⁷⁾
- Eating rice was commonly associated with “eating well” by adolescents in London with rice being eaten on average twice a day. Most cited that they had been informed that consumption of rice makes them taller and stronger. Children complained about the lack of diversity in their meals at home, which resulted in them seeking alternative options, including energy-dense junk foods. The low cost and accessibility of local fast-food outlets and convenience stores incentivised students to save their school lunch money and spend it on fast food, fizzy drinks, and confectionary.⁽⁵⁸⁾

There is limited evidence on health promotion activities, service provision educating and encouraging healthy eating habits among British Bangladeshis.

2.3.2 Obesity

There is limited research and data regarding the prevalence of obesity among Bangladeshis in the West Midlands. However, one published research study relating to obesity of Bangladeshis in England reported:

- The prevalence of obesity (BMI = 30kg/m²) among Bangladeshi adult men varies between 5.2% and 11.5%, a lower proportion compared to Bangladeshi women (15.1% to 17.8%), and the general population men and women (between 18.7% and 23%). Obesity is consistently reported as being up to three times higher in Bangladeshi women than Bangladeshi men.^(43, 59)

There is a lack of published evidence exclusive to British Bangladeshis, as such, there is limited evidence to understand the variations in weight between the Bangladeshi and the UK general population, BMI levels, or the role of culture on weight and obesity.

2.4 Active at every age and ability

Active at every age and ability key findings

- Sports and games are not generally pursued by adults in Bangladesh or by Bangladeshis in Britain
- **34.3%** of Bangladeshis are likely to be inactive, worse than White British (24.%), Black Caribbean (27.5%); Chinese (26.5%) and Indian (28.5%), but better than Pakistani (37.4%)
- Among Bangladeshis, **men (53%)** are more likely to be active than women (**45.7%**)
- **30-35%** of Bangladeshis meet government physical activity recommendations, a lower proportion compared to Black Caribbean and Pakistani counterparts
- Bangladeshi men and women reported **low rates of brisk walking (20%)**, compared to 32% of men and 27% of women in the general population
- In 2007, **68%** of Bangladeshi children aged 2 to 15 met the recommended level of physical activity, an increase of **2%** since 2002. More boys (**72%**) than girls (**63%**) met the government recommended level of physical activity.

Physical activity rates are consistently reported as being low within the Bangladeshi population, it is estimated that Bangladeshis are 45% less likely to meet government recommendations, compared to the general population.^(51, 60) Of all minority ethnic groups, Bangladeshis and Indians report the lowest levels of physical activity, with Bangladeshis activity being half of those with Indian ethnicity.⁽⁶⁰⁻⁶²⁾ The Sylheti language does not have a directly translatable word for physical activity that has the same connotations of vitality, improvement in body condition, social desirability, and inherent “moral” value as the word “exercise”.⁽⁵⁵⁾

From the published research there is evidence that:

- In 2007, 68% of all children aged 2 to 15 met the recommended level of physical activity, an increase of 2% since 2002. 72% of boys and 63% of girls met the recommended level of physical activity⁽⁵¹⁾
- Low activity levels rates were particularly common among Bangladeshi men and women.^(43, 63, 64) Compared to White and other ethnic groups, fewer Bangladeshis reported walking for at least 150 minutes per week.⁽⁶⁴⁾ Similarly, a lower proportion of Bangladeshis also reported brisk walking for at least 30 continuous minutes.⁽⁴³⁾ Based upon the physical activity index, 52% of European men did not meet current guidelines for participation in physical activity. Comparatively, 87% of Bangladeshi men did not meet physical activity guidelines, inferring that Europeans are more physically active than Bangladeshis⁽⁶³⁾
- About one in seven Bangladeshi men (15%) reported 'bad' or 'very bad health', the highest proportion compared to Pakistani men (10%), Black African and Chinese men (4%), and men in the general population (6%). The proportion of Bangladeshi women reporting "bad health" was also higher (14%) than other ethnicities. In addition, the prevalence of strokes was highest among Bangladeshi women aged 55 and over (11.9%), compared to black and Caribbean men (11.5%) and Pakistani women (10%)⁽⁴³⁾
- Exercise in the context of health and fitness seemed to have limited cultural meaning and is viewed potentially as exacerbating illness or physical weakness. As a result, sports and games are not generally pursued by adults in Bangladesh or by Bangladeshis in Britain.⁽⁵⁵⁾

Published evidence suggests that, generally, the Bangladeshi population in the UK has the lowest rates of physical activity compared to other ethnicities. There is limited qualitative research found exclusive to British Bangladeshis and physical activities. This means that there is limited understanding of the role of culture on physical activity, especially among women with family responsibilities.

2.5 Working and learning well

Working and learning well key findings:

- In the **2019-20** academic year, **57.3%** of Bangladeshi pupils in England got a grade 5 or above in English and Maths GCSE, better than White children, with **60%** being girls and **54%** being boys
- Nearly **50%** of Bangladeshis are eligible for free school meals and attained a grade 5 or above for Maths and English at GCSE, the 3rd highest population after Chinese and Indian pupils
- The rate of Bangladeshi children excluded from school is generally lower than White children and the national average (**2.37%** Bangladeshis compared to **4.95%** White British and **5.2%** national average in 2003/4)
- More Bangladeshis reported having no qualifications compared to the general population (**35%** compared to **28%**), and no level 4 qualifications (**14%** compared to **23%**)
- Fewer Bangladeshis are economically active (**52%**) compared with the general population (**59%**)
- **66%** of Bangladeshi females were economically inactive, which is a considerably larger proportion than Bangladeshi males (**29%**), Birmingham males (**33%**) and Birmingham females (**48%**)
- **31%** of Bangladeshis reported having never worked or being long term unemployed, twice as likely compared with the general population (**12%**)
- **12%** of Bangladeshi elders are in the richest fifth of the income distribution, lower than Other Asian (**25%**), Other White (**26%**), but higher compared to Pakistani (**7.6%**)
- More Bangladeshis (**18%**) live in overcrowded households compared to the general population (**4.2%**)
- Bangladeshi elders aged 60 and over are more than **3 times** likely to report their health limiting typical activities.

2.5.1 Education

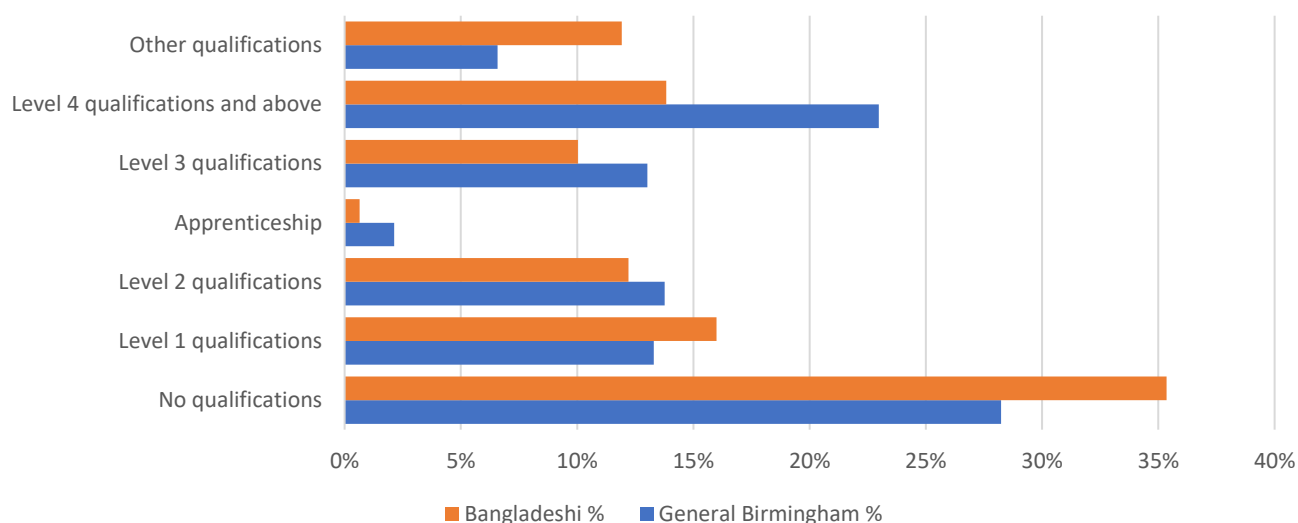
In England and Wales, there are 59,629 Bangladeshis whose highest qualification is level 4 and above, representing 9.8% of the Bangladeshi population. A level 4 qualification is one that is of greater understanding and learning compared with core modules at secondary school, such as the first year of a Bachelor's Degree. This is a smaller proportion than the national average (27% England and Wales).

In Birmingham, 2,789 Bangladeshis highest level of qualification is level 4 and above, representing 13.8% of the Bangladeshi population in Birmingham. Again, this is a smaller proportion than the Birmingham average (23%).

Figure 11 below, is data derived from the 2011 census, which illustrates that:

- In Birmingham, the overall education attainment level of people who identify as Bangladeshi is lower compared to the general population
- Less Bangladeshis reported having level 4 qualifications compared to the general population (14% compared to 23%); level 3 qualifications (10% compared with 13%); level 2 qualifications (12% compared with 14%). Level 3 qualifications are equivalent to 2 A-Levels, whereas level 2 qualifications are equivalent to A* to C grades at GCSE level. Less than 1% reported having an apprenticeship qualification, compared with 2% of the general population
- More Bangladeshis reported having no qualifications compared to the general population (35% compared to 28%), other qualifications (12% compared to 7%).

Figure 11: Level of qualifications among Bangladeshis compared to the general population in Birmingham



Source: Census 2011- DC5209EW

2.5.2 Economic activity

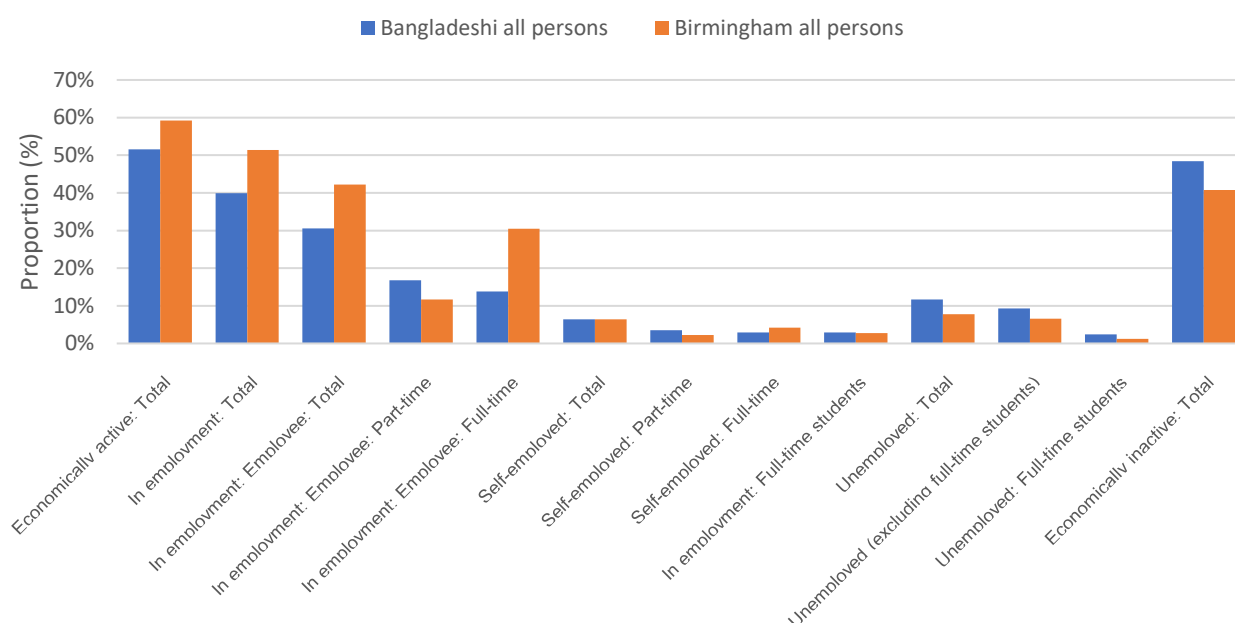
Unemployment, as defined by those not currently in work but seeking employment, in Bangladeshi communities are around double (8%) the national average of 4%.⁽¹⁷⁾ 9,755 Bangladeshis in Birmingham reported being economically inactive during the census 2011. 1,243 (12%) were economically inactive due to retirement; 2,425 were students (25%); 993 (10%) were either disabled or on long term sick pay. The largest proportion of those economically inactive, 3427 (35%) looked after home and family. 51.6% of the 284,767 Bangladeshis aged 16 and over living in Birmingham are economically active. This is a smaller proportion than all Birmingham residents (59.2%).

Figure 12 below illustrates an overview of the economic activity in Birmingham:

- 14% of all Bangladeshis are in full time employment, a considerably lower proportion compared with the general population in Birmingham (30%). The proportions of self-employed Bangladeshis are similar to the Birmingham

general population, with 3% of all Birmingham Bangladeshis being full-time self-employed, compared to 4% of all Birmingham citizens being full-time self-employed.

Figure 12: Economic activity of Bangladeshis compared with the general population in Birmingham.



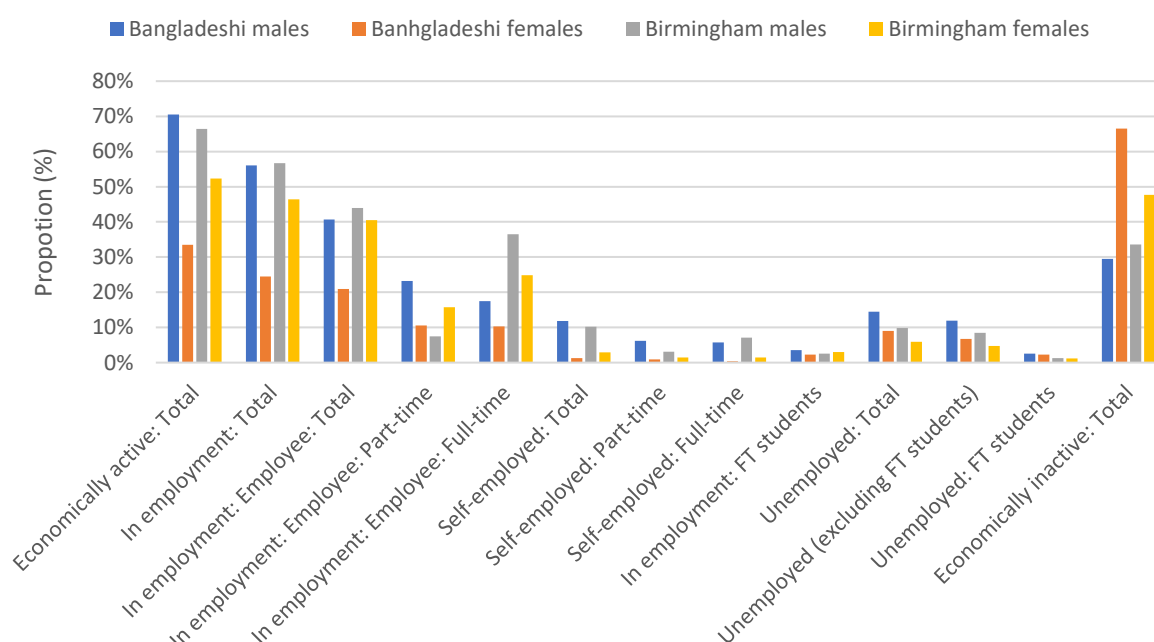
Source: Census 2011- DC 6201EW

Exploring economic activity by gender in Figure 13 below shows that women of Bangladeshi origin had the lowest proportion across all 'In employment' categories, compared to Bangladeshi males, and Birmingham males and females. 66% of Bangladeshi females were economically inactive, which is a considerably larger proportion than Bangladeshi males (29%), Birmingham males (40%), and Birmingham females (48%). Exploring the reasons for economic inactivity, both Bangladeshi females (47%) and Bangladeshi males (35%) who were economically inactive cited “looking after home or family” as the main reason for economic inactivity; compared to 41% of White British females and 31% Black/African/Caribbean/Black British who cited

“retirement”; and 40% Other ethnic groups who cited “being a student” (including full time students) as the reason for being economically inactive.

More than 14% of Bangladeshi males were unemployed but currently seeking work, which is a higher proportion compared to both male and female gender categories, Bangladeshi females (9%), Birmingham males (10%), and Birmingham females (6%), but more than double the national average.⁽¹⁷⁾

Figure 13: Economic activity of Bangladeshis by gender compared to the general population in Birmingham

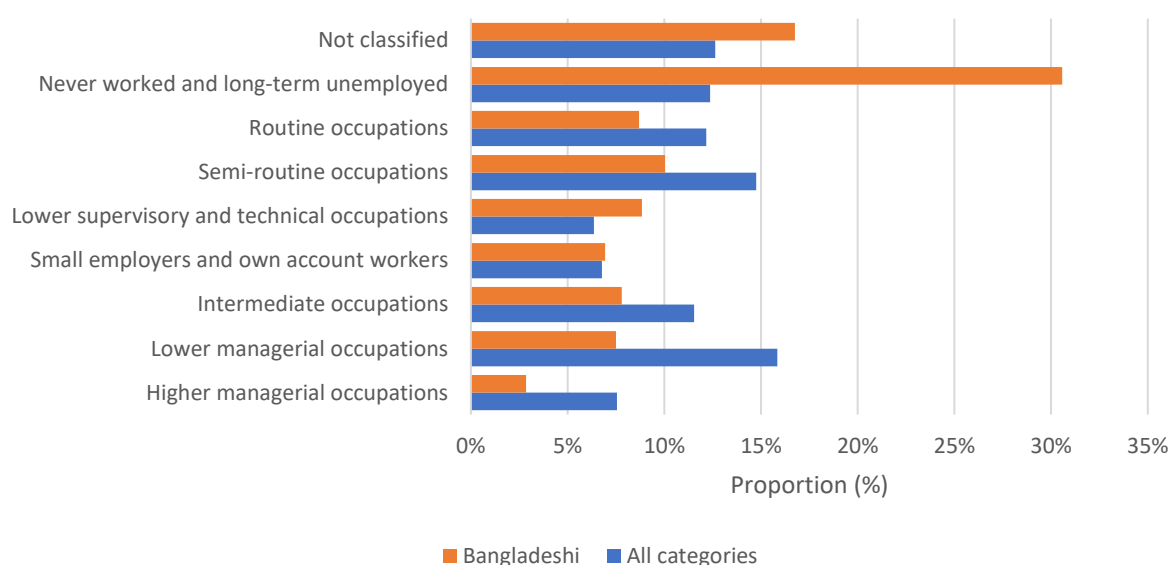


Source: Census 2011- DC6201EW; FT=Full-time

Figure 14 below, shows that people from the Bangladeshi ethnic group are more likely to report either having never worked or being unemployed long term, twice the rate compared with the general population (31% compared with 12%) in Birmingham. The proportion of Bangladeshis in high managerial (2%), lower managerial (8%) and intermediate occupations (8%), was lower compared to the general population in Birmingham (8%, 15% and 12% for higher and lower managerial and intermediate

occupations respectively). Bangladeshis were more likely to work in semi routine occupations (such as postal worker or security guard), routine occupations (such as bar staff or bus driver), and lower supervisory and technical occupations (such as a mechanic, plumber, or electrician).

Figure 14: Social-economic employment classification of Bangladeshis compared to the general population in Birmingham



Source: Census 2011 DC6206EW

Reports from national research sources evidence that:

- In the UK, the gap in employment between Bangladeshi and White ethnic groups had decreased over the past 20 years, the employment rate for the Bangladeshi ethnic group increased by 20.6% from 2001 to 2019, while the rate for the White ethnic group increased by 4.0% in the same period⁽⁵²⁾
- Households in the Bangladeshi (35%) and Chinese ethnic groups (35%) received the highest percentage of their income from other sources, including pensions and benefits. Bangladeshis were the least likely to rely on self-

employed income and the second least likely, after Pakistanis to rely on wages and salaries as sources of household income⁽³⁵⁾

- Out of all ethnic groups, households in the Bangladeshi ethnic group consistently had the lowest percentage of income from employment, although it increased from 60% to 65% during the period 2017-19. As such, Bangladeshi households consistently received the highest percentage of their income from benefits and tax credits (between 24% and 27%)⁽⁵²⁾
- Bangladeshis' hourly median pay gap was 15% less than White British. Men earned a higher hourly median wage than women.⁽⁵²⁾ Cultural-religious reasons may contribute to substantial differences between men and women in employment.⁽⁵²⁾

Although enough data is suggesting the low level of economic activity and employment/unemployment rates among Bangladeshis, there is not enough research evidence to understand potential cultural explanations for low economic activity and low rates of employment in Bangladeshi females in the UK.

2.5.3 Housing

In Birmingham, people who identify as Bangladeshi are more likely to live in overcrowded homes compared to the general population. This is summarised in Table 1 below.

Table 1 Number of persons per room in a household by ethnic group

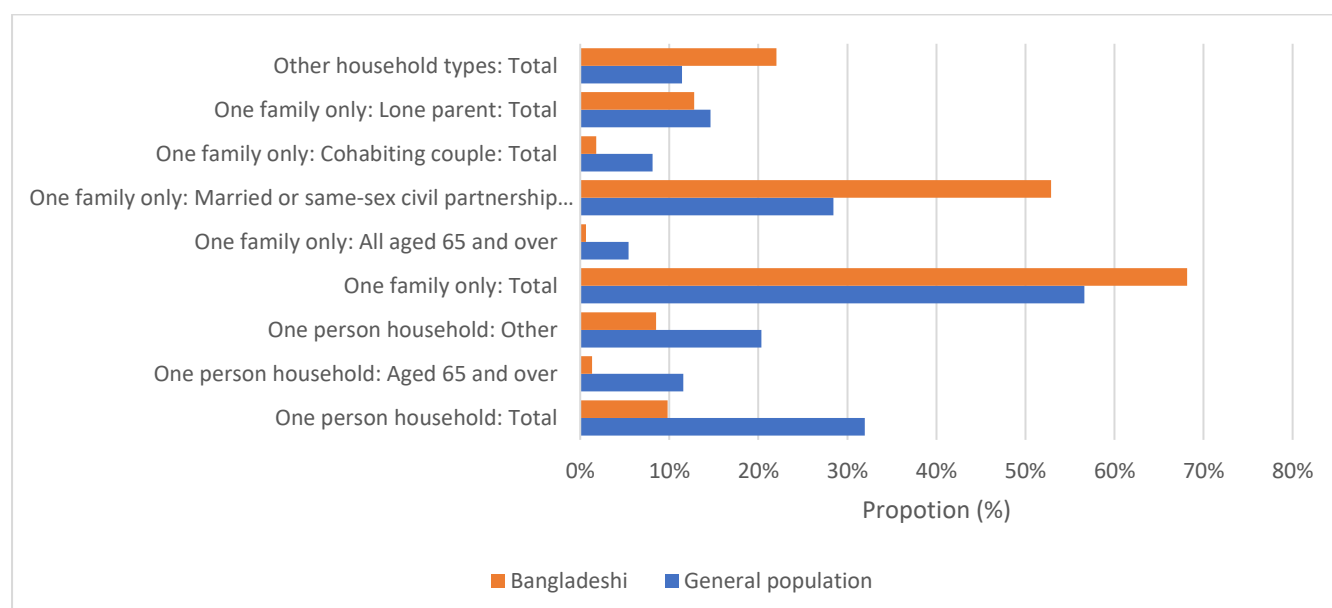
Ethnicity	Up to 0.5 persons per room	Over 0.5 and up to 1.0 persons per room	Over 1.0 and up to 1.5 persons per room	Over 1.5 persons per room
All	64.4%	31.5%	3.2%	0.95%
Bangladeshi	25.6%	55.6%	14.8%	3.7%

Source: Census 2011- DC4209EW

More than 18% of Bangladeshis live in households with more than 1 persons per room, a larger proportion compared to the general population (4.1%)

25.6% of Bangladeshis live in households 'up to an average of 0.5 person per room' (least overcrowded), a lower figure compared to the general population (64.4%). 0.5 persons per room could be comprised of 2 people living in 4 rooms, for example.

Figure 15: Household composition (HRP) of Bangladeshis compared with the general population in Birmingham



Source: Census 2011- DC1201EW

Data from the 2011 census, figure 15 above, found that more Bangladeshis reported living as families compared to the general population in Birmingham (68% compared with 57%).

Larger proportions for Bangladeshis reported living with their spouse or a partner (52.9%) compared with the general population (28.4%) and those living in 'other household type' (22% compared with 11.5%).

The percentage of households containing only one person was lower within Bangladeshis compared to the general population of Birmingham across all 'one family' categories (9% compared with 32%). The percentage of Bangladeshis with one person households with a person aged 65 and over was also lower than the general population in Birmingham (1% compared to 12%).

Cohabiting couples and lone parent households were 2% and 13% respectively, which was both lower than the general Birmingham population. Within the general Birmingham population, parents and cohabiting couples made up 8% and 15% of the sample, respectively.

Evidence from published research also found that:

- The rates of overcrowding in the UK are higher in ethnic minority households than White British households (2 percent), and highest in Bangladeshi (24 percent), Pakistani (18 percent), Black African (16 percent) and Arab (15 percent) households^(17, 65)
- 68% of Bangladeshis live in low-income, often overcrowded households, that rely more on benefits more than any other ethnic group. Just over 40% of Bangladeshi men under 25 years of age are unemployed, compared with 12% of young White British men.⁽¹⁾

2.5.4 General health

In 2001, the census captured information on general health and disability among Bangladeshis in the UK. The census asked respondents to rate their general health

over the last 12 months; the possible responses were 'good,' 'fairly good,' and 'not good.' In general, a larger proportion of Bangladeshis reported their health status as being in 'good or fairly good health overall' compared to the all-ethnic category in Birmingham.

Table 2: Health status by age group comparing Bangladeshis in Birmingham with the general population of Birmingham

Ethnicity	Age group	Good or fairly good health (%)	Not good health (%)
<i>All</i>	All Ages	89.1	12.2
	Age 0 to 15	23.1	0.4
	Age 16 to 49	44.1	3.8
	Age 50 to 64	11.6	3.3
	Age 65 and over	10.4	46
<i>Bangladeshis</i>	All Ages	91.8	8.2
	Age 0 to 15	40.0	0.8
	Age 16 to 49	45.2	3.6
	Age 50 to 64	4.5	2.4
	Age 65 and over	2.2	1.4

Source: Census 2001- ST107

Exploration of 'not good' health status by gender shows that generally the proportion of Bangladeshi men reporting 'not good' health status is slightly larger than that of women. Both male and female Bangladeshis aged 50 and over have lower levels of self-reported 'not good' health status.

Table 3: 'Not good health' - health status by age group and gender comparing Birmingham Bangladeshis with all-ethnic population of Birmingham

		Males (%)	Females (%)
<i>All</i>	All Ages	10.0	11.6
	Age 0 to 15	0.4	0.3
	Age 16 to 49	3.3	3.5

	Age 50 to 64	3.0	2.9
	Age 65 and over	3.4	4.9
<i>Bangladeshis</i>	All Ages	8.3	8.1
	Age 0 to 15	0.8	0.7
	Age 16 to 49	3.4	3.9
	Age 50 to 64	2.1	2.7
	Age 65 and over	1.9	0.9

Source: Census 2001- ST107

2.5.5 Long-standing health impairment, illness or disability

Of those who reported having a limiting long-term illness, the proportion of Bangladeshis reporting a 'good' or fairly good' health or 'not good' health status was similar to all-ethnic category in Birmingham.

Table 4: Impact of long-standing health impairment, illness, or disability on 'Good health' in Birmingham population

Ethnicity	Good or fairly good health (%)	Not good health (%)
All	53.2	46.8
Bangladeshis	54.0	46.0

Source: Census 2001- ST107

The published research evidence that:

- 1 in 7 Bangladeshi men (15%) reported 'bad' or 'very bad' health, this is a higher proportion compared to men in the general UK population (6%). There is mixed evidence that poor self-rated health is higher in Bangladeshi women⁽⁴³⁾⁽⁶⁶⁾
- A similar proportion of Bangladeshi women also reported 'bad' or 'very bad' health⁽⁴³⁾
- Bangladeshis, like most people from ethnic minority groups, are more likely than White British groups to report long-term illness and poor health^(17, 66)

- Bangladeshi elders aged 60 and over are more than 3 times likely to report that health limits typical activities, such as walking. This is a higher proportion than any other ethnic group, of whom nearly twice reported the same
- More than 35% of Indian, Pakistani, and Bangladeshi elders are in the lowest 20% of the income distribution. This compares with 19% of White British individuals⁽⁶⁶⁾
- 12% of Bangladeshi elders are in the richest fifth of the income distribution in the UK, lower than Other Asian (25%), Other White (26%), but higher compared to Pakistani (7.6%)⁽⁶⁶⁾
- By contrast, more than 50% of Pakistani, Bangladeshi, Caribbean, and African elders are found in the highest quartile of deprivation (the top 25% most deprived)⁽⁶⁶⁾
- A randomised controlled trial of lay-led self-management found Bangladeshi people with chronic disease to benefit from a 6-week chronic disease self-management programme. The programme was delivered by trained and accredited lay Bangladeshi tutors, who themselves had a chronic disease. The programme improved participants' confidence (self-efficacy) to control chronic disease and altered their behaviour, increasing their use of self-management skills⁽⁶⁷⁾
- Qualitative interviews with attenders and non-attenders to a self-management education programme for Bangladeshis with chronic disease suggested that there were social and spiritual barriers to attendance, which included social and family responsibilities.⁽⁶⁷⁾

The 2011 census did not collect general health data at an ethnicity sub-group level. Therefore, there was no data exclusive to Bangladeshis as a sub-group population of

South Asians. As such, the latest data available is derived from the 2001 census, meaning the report may be limited in understanding the current and up to date general health status among Bangladeshis.

2.6 Protect and detect

Protect and detect key findings:

- Bangladeshi women had the highest rate of not attending cancer screening (**70.6%**) compared to all minority ethnic groups, Caribbean (**62.1%**), African (**44%**), Indian (**66%**), Pakistani (**61%**)
- Compared to White women, Bangladeshi women were nearly **nine times** more likely not to attend cervical cancer screening
- Uptake of breast cancer screening among Bangladeshi women was lower than the White population (**37%** compared to **60%**)
- Perceived barriers to lower uptake included not being at risk of cervical cancer, do not need to attend if no symptoms are present, not being sexually active, concerns around seeing a male doctor or nurse, fitting an appointment around family time
- Compared to the White Scottish population, Bangladeshi men were **23%** less likely to uptake bowel cancer screening (Other White British **10%** more likely), overall Bangladeshi uptake rates were **41%** less likely compared to other ethnic groups.
- Bangladeshi women are around **8 times** less likely to accept Human papillomavirus (HPV) vaccination compared to White British women
- Compared to the general population, Bangladeshi men are less likely to report having a casual sexual partner in the past 3 months (**21%** compared with **28%**), Bangladeshi women (**4%** compared with **14.2%**)
- Bangladeshis are more likely to be referred to sexual health clinics by their GP's, suggesting their knowledge of service provisions is low
- **43.1 per 100,000** tuberculosis cases in Birmingham were from people of Bangladeshi heritage, this is higher compared to White (**5.0**) and Chinese (**17.5**) Mixed other (**33.7**), but lower than Black African (**280**), Pakistani (**142**), Indian (**112**) and Black Other (**50**) ethnic groups.

2.6.1 Cancer screening

Research evidence suggests that screening uptake across different cancer screening programmes is lower in Bangladeshi populations compared to other minority groups and White populations.⁽⁶⁸⁾ Reasons for lack of attendance includes: language and cultural barriers, believing they do not need an appointment if they do not have symptoms, embarrassment, fitting an appointment around family time and concerns around seeing a male doctor or nurse.⁽⁶⁸⁻⁷⁰⁾

From further published research there is evidence that:

- Bangladeshi women had the highest cervical screening non-attendance rates (70.6%) compared to all minority ethnic groups, Caribbean (62.1%), African (44%), Indian (66%), Pakistani (61%), and were nearly nine times more likely not to attend cervical screening.⁽⁶⁸⁾ Similarly, when compared to a White Scottish population, Bangladeshi men had a significantly lower uptake of bowel cancer screening⁽⁷¹⁾
- Oral cancer screening is usually completed by dentists, who check for red or white patches or sores in the mouth. Of those who attended oral cancer screening, a considerably larger proportion of Bangladeshis, who were likely to be Paan chewers, were likely to be referred for further investigation. Only 73% of those referred to further investigation attended. Reasons for non-attendance included language barriers, non-receipt of referral letters, and perceived difficulty in attending hospital⁽⁷²⁾
- Like all other ethnic minority groups, awareness of breast and cervical cancer screening among Bangladeshis was lower compared to White ethnic groups.⁽⁷³⁾ A larger proportion of Bangladeshis than White British were most likely to say “don’t know” when asked about perceived causes of colorectal cancer (65%

compared with 11%). Many cited embarrassment, shyness, shame, screening equipment being off-putting, pain, lack of time due to family commitments as the reasons for not attending screening⁽⁷⁰⁾

- Community outreach worked well within the Bangladeshi community to increase breast cancer and oral screening uptake.^(69, 72) One study improved outreach by calling women who did not attend appointments, rebooking their appointments, and providing transport. This led to 69% of women attending a rescheduled cancer screening appointment.

There is limited data to understand the extent that Paan chewing contributes to oral cancers among Bangladeshis.

2.6.2 Vaccination programmes

There was no national data on adult vaccinations programmes among people of Bangladeshi heritage in the UK. However, the limited published research found that:

- Vaccination uptake is lower amongst the Bangladeshi community compared to the White British population. Bangladeshi women were 89% less likely to be aware of the Human Papilloma Virus (HPV) vaccine and 87% less likely to accept the HPV vaccine than White British women⁽⁷⁴⁾
- 66% of Bangladeshi women reported a shared decision to vaccinate against HPV, a higher proportion compared to White British women; 16% reported fathers would take the leading decision, compared to none among White women; only 8% of Bangladeshi women reported taking the leading decision, much lower proportion compared to White British women (64%).⁽⁷⁴⁾

2.6.3 Sexual health

STI (Sexually Transmitted Infection) prevalence in Bangladeshis attending GUM (sexual health) clinics are similar to other populations, although patterns of presentation and referral show variation.⁽⁷⁵⁾ Generally, the epidemiology of STIs among Bangladeshis is unknown, likely due to sex outside the marriage being generally perceived as shaming and bringing stigma to a family.^(76, 77)

The published evidence suggests that:

- Syphilis was significantly more common in the Bangladeshi men compared to the general population (10.9% compared with 4%), and bacterial vaginosis was an infrequent diagnosis in Bangladeshi women compared to the general population (3.5% compared with 22.4%). Bangladeshi men were also more likely to present with sexual dysfunction (12.5% compared with 2.5%).⁽⁷⁵⁾ Compared to the general population, Bangladeshi men are less likely to report having a casual sexual partner in the past 3 months (21% compared with 28%), as are Bangladeshi women (4% compared with 14.2%)
- Bangladeshis are less likely to attend sexual health clinics,⁽⁷⁷⁾ but more likely to be referred to sexual health clinics by their GP. Bangladeshi men are more likely to be referred than women^(75, 76)
- Current knowledge and use of existing sexual and reproductive health services varied across the community.⁽⁷⁷⁾ Barriers to accessing sexual healthcare services were: the local hospital was perceived as culturally insensitive and antagonistic towards community values; ⁽⁷⁶⁾ lack of representation of BME (Black and Minority Ethnic) staff and the staff having the same gender as the patient, fear of judgement, embarrassment, perceived lack of confidentiality and

privacy, language barriers, awareness of where sexual health services are located⁽⁷⁷⁾

- Knowledge of contraception prior to sexual intercourse was poor amongst Bangladeshi women. For many, their first discussions about contraception were following the birth of their first child⁽⁷⁷⁾
- Culture plays a role among Bangladeshis, particularly women and young people, contributing to the lack of knowledge and awareness of sexual health and sexual health service provision. Sex outside marriage brings shame and stigma to the family, therefore sex and sexual issues are generally not discussed. Traditionally grandmothers or a sister-in-law would be expected to take a role in educating Bangladeshi women about sexual issues before marriage. It was reported that it was inappropriate in Bangladeshi culture to be examined by or discuss sexual issues with someone of the opposite sex or where the clinician was of a younger generation⁽⁷⁶⁾
- Cultural factors such as the amount of socialising, the role of religion, parental attitudes and beliefs, and peer-group adhesion and norms, are strong influences on young people within Bangladeshi communities. Bangladeshi young people rarely discussed sex and relationships at home, so SRE (Sex Relationship Education) classes at school are often their only source of information. Knowledge about sex was poorest amongst Bangladeshi young people.⁽⁷⁷⁾ It is “haram” (forbidden or inhibited by Islamic law) to teach sex education to young people and reported that Bangladeshi parents might choose to have their children opt out of this at school⁽⁷⁶⁾
- Key factors contributing to the risks of infection and unwanted pregnancies among young Bangladeshis included inadequate parental understanding about

sexual health and limited parent delivered SRE (sexual relationships education); and inconsistent provision of culturally appropriate school based SRE⁽⁷⁸⁾

- Factors affecting SRE provision included culturally rooted perceptions of sex/sexuality and limited participation of stakeholders such as religious leaders and parents in developing and delivering SRE.⁽⁷⁸⁾

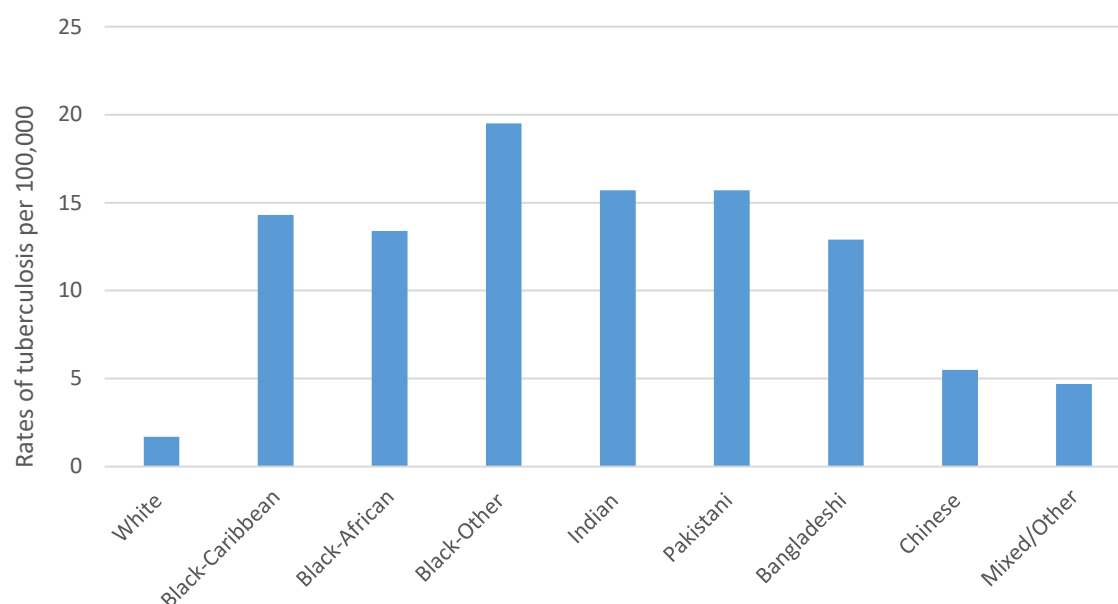
ONS surveys do collect information about sexual identity and HIV (Human Immunodeficiency Virus) rates amongst British citizens, however, when categorising sexuality by ethnicity, there is no specific information about British Bangladeshis. Evidence does suggest that the proportions of individuals who identify as gay, lesbian or bisexual are the lowest in Asian or British Asian ethnicities.⁽⁶⁸⁾

2.6.4 Tuberculosis

According to the Birmingham local TB (Tuberculosis) strategy (2012), 43.1 per 100,000 TB cases in Birmingham were from people of Bangladeshi heritage, higher compared to White (5.0) and Chinese (17.5) Mixed other (33.7), but lower than Black African (280), Pakistani (142) Indian (112) and Black other (50) ethnic groups. 70% of those with diagnosed TB had not been born in the UK.⁽⁷⁹⁾

Latest reports in England show that the prevalence of tuberculosis among Bangladeshis in the UK is lower (12.9 per 100,000) compared to Black-Other ethnic group (19.5), Indian and Pakistani (both 15.7), Black-Caribbean (14.3), and Black-African (13.4), but considerably higher compared to White British (1.7).⁽⁸⁰⁾ Conversely, English-born Bangladeshi's childhood rates were higher than most ethnic groups, except for Pakistani and Black African children, see figure 17 below:

Figure 16: English-born Bangladeshi tuberculosis notification rates compared to other ethnicities within England



Source: Public Health England 2020

From the published research and national local reports, there is evidence that:

- 12.8% of active cases among Indian, Pakistani and Bangladeshi ethnic groups were acquired through travel, with cases occurring within 3 years of revisiting the Indian subcontinent. In addition, TB cases were 7.4 times more likely to have recently received visitors from abroad⁽⁵⁸⁾
- In England, the rate of TB among the Indian, Pakistani, and Bangladeshi ethnic groups increased from 117.7 to 122.0 per 100,000 population between 1999 and 2003,⁽⁸¹⁾ while reports in Yorkshire show that incidence of TB among the Bangladeshis declined from 57 per 100,000 population in 2011 to 17 per 100,000 population in 2017 but remained higher than the White groups (1.8 per 100,000)⁽⁸²⁾
- In 2015, Bangladeshis in London were 1.17 times more at risk of having TB compared to White people and Bangladeshis outside London were 1.04 times more at risk. Most cases were distributed across the most deprived quintiles in London⁽⁸¹⁾

- There could be an association between deprivation and TB treatment delay in some population groups, with one study showing longer intervals observed among the most deprived Black Africans, Indians, Pakistanis, Bangladeshis and recent UK entrants.⁽⁸³⁾

2.7 Ageing well and dying well

Ageing well and dying well key findings

- Prevalence of doctor-diagnosed diabetes was significantly higher in Bangladeshi men and women (**8.2% and 5.2%**) compared to the general population (**4.3% men and 3.4% women**)
- Barriers to healthcare included poor housing, unsafe streets, financial hardship, language barriers, and the inability to read leaflets
- **24%** of Bangladeshi men and **21%** of women aged 55 and over had Cardiovascular Disease (CVD), both slightly lower than the general population
- However, Bangladeshi men had a **14%** greater risk of heart failure than White men
- Bangladeshis are **40%** less likely to be diagnosed with Chronic Obstructive Pulmonary Disorder (COPD), compared to White people, but there are **no differences** in COPD-related mortality
- Bangladeshis experienced the lowest rate of four female-related cancers (breast, ovarian, cervical, and endometrial cancer)
- Bangladeshis are **3 times** more likely to be carers for relatives of dementia than White British counterparts. However, most carers have a lack of knowledge and awareness of the symptoms of

2.7.1 Diabetes

The prevalence of Type 1 and Type 2 diabetes for Bangladeshi men and women are reported at around 8.2% and 5.2% respectively, compared to the general population

(4.3% and 3.4% respectively). British-Bangladeshis are around twice as likely to have Type 2 diabetes than the general population.^(43, 51, 86)

The published research evidence that:

- Respondents cited physical or psychological stress as a perceived cause of diabetes and saw a diagnosis as devastating and a chronic, incurable condition.⁽⁵⁵⁾ Absence of sweating (due to the cold British climate and lack of physical labour) on immigration to Britain was commonly cited as a cause of diabetes and a reason the condition improved or disappeared on return to hot countries⁽⁵⁵⁾
- There are structural and socio-economic barriers to improving health. Poor housing, unsafe streets, and financial hardship were the least important factors in preventing certain outcomes (such as taking regular exercise). Religious restrictions or ethnic customs were the largest barriers to certain health outcomes. Other barriers included language barriers when speaking to professionals and the inability to understand leaflets⁽⁵⁵⁾
- Informants generally tested their urine regularly, and all patients with diabetes understood the importance of a change in the colour of the test strip. However, people reported they didn't think they needed regular surveillance if they didn't have symptoms. Preventive care was also not well understood.

Limitations in ethnic sub-groups data shows that there is limited evidence to understand the experiences of the Bangladeshi communities in the context of prevalence, trends, disease management, service provision and access to health services relating to diabetes in Bangladeshis.

2.7.2 Cardiovascular disease

Cardiovascular disease (CVD) prevalence pattern in Bangladeshi men and women follows that of the general population, with rates of CVD increasing as individuals get older. 24% of Bangladeshi men and 21% of women aged 55 and over had CVD, both slightly lower than the general population. However, Bangladeshi men had a 14% greater risk of heart failure than White men.⁽⁸⁷⁾

Further published research evidence that:

- Contributing factors for CVD could be the high rates of cigarette and tobacco chewing in Bangladeshi communities and shisha smoking is popular among some South Asian groups. Flavoured shisha can be misleading for younger people who do not realise it is often tobacco-based⁽⁸⁷⁾
- 18% of Bangladeshi men had CHD (coronary heart disease), similar to the general population (18%), while men from a Bangladeshi group had a 14% greater risk of heart failure and around twice the incidents of CVD than White men.^(87, 88) Among women aged 55 and over, Bangladeshis are more likely to have a stroke compared to the general population (11%)⁽⁴³⁾
- More Bangladeshi women had CHD compared with the general population (13% compared with 11%)^(87, 88)
- The highest CHD death rates occur in Bangladeshi communities in East London, which has many pockets of deprivation. Compared with the White British population, Bangladeshi populations in the UK are more likely to report poor oral health, work part-time, suffer infant mortality, and live in overcrowded households⁽⁸⁷⁾
- For those born in Bangladesh but dying in England and Wales, coronary artery disease causes 25% of all deaths⁽⁸⁹⁾

- For interventions, a short video on issues causing coronary artery disease in the Bengali language significantly improved the knowledge and attitudes of viewers in the community setting in inner-city London within Elephant and Castle.⁽⁸⁹⁾

More evidence is needed to understand Bangladeshis uptake to health services and knowledge and understanding of the cardiovascular disease.

2.7.3 COPD (Chronic obstructive pulmonary disease)

There is little research on COPD (chronic obstructive pulmonary disease) exclusive to Bangladeshis as an Asian sub-category ethnic group. However, the limited evidence shows that Bangladeshis have a lower risk of COPD compared to White people⁽⁴³⁾ and there was no difference with COPD related mortality between Bangladeshis and White British people.⁽⁵²⁾

2.7.4 Cancer

Generally, compared to White British people and non-Asians, the incidence of cancer among Bangladeshis is lower within most cancer types, except for lung and liver cancers.

In 2011, reports on ethnicity and lung cancer found that lung cancer is most common in White and Bangladeshi men. The ratio of lung cancer incidence rate for Bangladeshi men was similar to those of White men; and for women were 97%, significantly lower than White women.⁽⁹⁰⁾ Between 2001-2007, Bangladeshi men had an incidence rate three times higher for liver cancer compared to White men. Bangladeshi women had the highest rates of all ethnic groups, around 3 times higher rates compared with White women.⁽⁹¹⁾

From the published research there is evidence that:

- Colorectal cancer is uncommon in Bangladeshi patients compared to the non-Bangladeshi population. Between 1998-2002 the reported prevalence among Bangladeshis in London was 27 per 100,000, considerably lower compared to non-Bangladeshis (342)⁽⁹²⁾
- Bangladeshi women had the lowest incidence rates for breast cancer.^(93, 94) They were 0.23 times less likely to be diagnosed with breast cancer than White women,⁽⁹³⁾ had lower incidences on ovarian (6.3 compared with 11.6 per 100,000); cervix (4.0 compared with 7.0 per 100,000); endometrial (2.0 compared with 5.3) cancer⁽⁹⁴⁾
- In terms of presentation at health services, Bangladeshi patients with colorectal cancer present at a young age and with advanced cancers. 61% of Bangladeshis were aged less than 40; median 40 years compared to 69.5 years in non-Bangladeshis. 22% presented with locally advanced disease compared to 11.3% of non-Bangladeshi patients and all died within 9 months.⁽⁹²⁾ Conversely, for breast cancer, Bangladeshi women were least likely to have a stage recorded at diagnoses compared with White women (55% compared with 75%)⁽⁹³⁾
- Bangladeshis reported the worst experiences across the entire healthcare pathway compared to all patients. There were particularly low ratings to 'understanding answers to important questions,' meaning that language and communication were barriers to healthcare for Bangladeshi patients. Bangladeshi patients also were the least satisfied with communication and information provision on diagnoses (55.3% of Bangladeshis compared with 72% all patients) and on treatment (55% compared with 70.6% all patients). Bangladeshis were more likely than White patients to report that they had received an explanation of side effects to treatments that they could understand from staff (45.7% compared with 75.3%). Bangladeshis also

reported difficulty in understanding written information about the effects of treatment (40% compared with 55.2% White British)⁽⁹⁵⁾

- Bangladeshis showed a low level of awareness about the development of oral cancer. Compared to White British, Bangladeshis were nearly twice less likely to be aware that a small lesion in the mouth can develop into oral cancer (18% Bangladeshis compared with 29.6% White British). They were also nearly twice less likely to be aware that treatment can prevent a lesion in the mouth to develop into oral cancer compared with White British (31% compared with 45%).⁽⁹⁶⁾

2.7.5 Dementia

Bangladeshis are 3 times more likely to be carers for relatives with dementia than White British counterparts. Most carers have a lack of knowledge and awareness of the symptoms of dementia, as well as service provisions available.^(97, 98) While there is no evidence of stigma and prejudice to the belief that dementia is caused by God, there seems to be a strong sense of stigma attached to being a carer of somebody with dementia within the Bangladeshi community.^(99, 100)

Published research shows that:

- Bangladeshi elderly migrants do not have an increased rate of schizophrenia-like psychosis (SLP) compared to indigenous elders⁽¹⁰¹⁾
- In a one-year review there was a higher rate of referrals for organic disease in Bangladeshi men compared to Bangladeshi women and British-born men and women.⁽¹⁰¹⁾ An organic disease is one where there is a measurable disease process, such as inflammation of tissue damage
- Bangladeshi caregivers show a practical attitude towards dementia which is acknowledged as a medical symptom, and for which family caregivers voluntarily

seek healthcare support.⁽¹⁰⁰⁾ The religious beliefs of Bangladeshi caregivers' intertwine with their knowledge, perception, and attitudes toward caregiving for their relatives with dementia. Most of the family caregivers said they were unlikely to obtain practical and emotional caregiving support from extended family members because they did not live near the person who needed care or the family caregivers and had responsibilities with their own families^(98, 100)

- Several Bangladeshis have discussed their excruciating experiences when caring for people with or without dementia and the practical challenges in dealing with psychological, physical, and financial factors that had a profound impact on their personal lives⁽⁹⁸⁾
- Familism was a major barrier, particularly for those caregivers representing as husbands, wives, adults, children, and grandchildren of the wider Bangladeshi community. There was a strong belief that family should be the first choice when providing care for people with dementia and that it should be provided in the family home⁽⁹⁸⁾
- Help would be sought when caregivers felt they could no longer cope by themselves or when hospital doctors recommended it and referred them to social workers⁽⁹⁸⁾
- There were a few barriers to accessing service provision for Bangladeshis. Many had negative experiences of care homes and they were sceptical about sending their relatives with dementia to live in a residential care home. Religious beliefs and cultural emphasis on caring for the family also contributed to a reluctance to care home services as a choice⁽⁹⁸⁾
- A negative experience of healthcare in the past was also cited to influence the caregiver's decision against seeking medical help. There were issues with a

culturally inappropriate assessment and care; a shortage of culturally appropriate support and services, including the unavailability of Bangladeshi Muslim same-sex carers; a lack of cultural and religious knowledge among agency respite carers; a lack of flexibility and choice in home-based respite care services; and family caregivers feeling that respite services were insufficient or inadequate in meeting their caregiving need⁽⁹⁸⁾

- Respondents felt that current healthcare services did not meet the religious needs of Bangladeshi Muslim older people, and subsequently could hinder or deter Bangladeshi people living with dementia and their carers' willingness to seek and use appropriate health and support services.⁽⁹⁹⁾

2.7.6 End of life

Little is known about the numbers of care home residents from Black and minority ethnic groups, nor about the extent to which their end-of-life care needs are addressed in line with their specific cultural requirements.⁽¹⁰²⁾

From the published research, there is evidence that:

- Bangladeshis are more than 2.5 times as likely to have a poorer experience of primary care, such as a General Practitioner, and had 3 times the risk of not getting sufficient support from local services and organisations to manage long-term conditions, and nearly 4 times as likely to lack the self-confidence to manage their condition⁽¹⁰³⁾
- Carers felt it was their duty and an act of love to help look after their family and relatives during illnesses or times of need. 65% stated they were offered access to specialist support and information if asked, 34% had not been offered any type of specialist support, 87% carers had their role as carers acknowledged by staff, as

compared to 13% who did not feel their role was acknowledged. The majority of carers cited the GP (62%) as the key person, followed by the palliative nurse (35%) and district nurse⁽¹⁰⁴⁾

- Emotional support and spiritual support scored the lowest in terms of overall support received, whilst the relief of pain and symptoms scored the highest for overall support given. However, pain control was reported to be poor in 11 out of 18 patients in palliative care. Language and communication were often a barrier to asking for or receiving support and information^(104, 105)
- 87% preferred to die at home, which was higher than the national average. Reasons cited were comfort, wanting to be close to family, and privacy. Out of 14 deceased Bangladeshi patients from palliative care, 13 of them were buried in Bangladesh.^(104, 105) Being with family, relatives and loved ones was another category that scored high in terms of what was important to respondents during the end-of-life stages⁽¹⁰⁴⁾
- Lack of knowledge and information about hospices; fear of being treated unfairly, language barriers; cultural barriers; perceptions of not being able to get privacy and to say prayers, and inadequate specialist staff were some of the reasons why no one chose the hospice as the place for the end of life. ⁽¹⁰⁴⁾

There is limited evidence regarding palliative or end of life services for people of Bangladeshi heritage in terms of access to services, knowledge of the available services, uptake of services when offered, or cultural or other influences on the uptake of services.

2.8 Closing the gaps

Closing the gaps key findings:

- **88.2%** of all Bangladeshis in Birmingham are likely to be living in areas classified as the **20%** most deprived while less than **1%** are likely to live in areas classified as **20%** least deprived areas.
- Linking deprivation to life expectancy, **4 in 5** Bangladeshis in Birmingham can expect to live an average of **74 to 83** years and spend **20 fewer years** in good health
- Premature mortality aged **under 75** among Bangladeshi men's and women was significantly greater compared with the White ethnic group
- There was **no significant difference** between men and women's life expectancy of Bangladeshis and White ethnic groups in England and Scotland.

2.8.1 Life expectancy and healthy life expectancy

Table 5 below shows that in 2011, 88.2% of all Bangladeshis in Birmingham are likely to be living in areas classified as the 20% most deprived, some of which are Bordesley Green, Lozell, Birchfield and Small Heath.

Table 5: Bangladeshis living in 20% of most and least deprived areas of Birmingham

	20% most deprived areas n (%)	20% least deprived areas n (%)
All	28,685 (88.2)	83 (0.3)
Males	14,281 (88.0)	41 (0.3)
Females	14,404 (88.4)	42 (0.3)

Source: Census 2011- LC2101EW

Linking deprivation with healthy life expectancy, more than 88% of Bangladeshis can expect to spend nearly 20 fewer years in good health and can expect to live an average of 74 years compared to 83 years for the 0.3% of Bangladeshis living in the 20% least deprived areas of Birmingham.

Further research shows that:

- There was no significant difference between men and women's life expectancy of Bangladeshis and White ethnic group in England and Scotland⁽⁵²⁾
- Life expectancy for those without a disability is estimated to be the lowest among people of Bangladeshi origin, compared with White and all other ethnic groups⁽¹⁷⁾
- Premature mortality aged under 75 among Bangladeshi men and women was significantly greater, compared with the White ethnic group in England and Scotland. Of the 25 leading causes of mortality measured by years of lost life, Bangladeshis were significantly better on deaths caused by all cancers, suicide, alcohol related liver cirrhosis; and significantly worse on death rates caused by stroke, neonatal preterm birth, hepatitis c, liver cirrhosis, compared to the White population in England.⁽⁵²⁾

2.9 Contributing to a green and sustainable future

There is no evidence found exclusive to British Bangladeshis and their contribution to a green and sustainable future or the impact of these topics on them specifically as a population in the UK.

2.10 Mitigating the legacy of COVID-19

Mitigating the legacy of COVID-19 key findings:

- Unlike other ethnic groups where disparities have improved from the first wave, Bangladeshis have worsened
- COVID-19 death was **over two and half times** more likely in Bangladeshi men and **two times** more likely in Bangladeshi women during the second wave
- Bangladeshi men are **four times** as likely as White British men to have jobs in shut-down industries, due to their concentration in the restaurant sector
- UK Bangladeshis (**43%**) were the most likely to report loss of income since the COVID-19 pandemic, a higher proportion compared to Black African groups (38%) and White ethnic groups (22%).
- Overcrowding was linked with increased rates of mortality in a hospital-based cohort. **30%** of Bangladeshi households being the highest compared to 16% of Black African households, 18% of Pakistani households, and 2% of White British households.

There is clear evidence that people of ethnic minorities are at higher risk of dying from COVID-19 than the rest of the population, with estimates that people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity.⁽¹⁰⁶⁾ Unlike other ethnic groups where disparities have improved from the 1st wave, Bangladeshis have worsened.⁽¹⁰⁷⁾ Evidence from The Office for National Statistics (ONS) found that COVID-19 related mortality remained elevated among Bangladeshis, with men nearly 3 times the risk and women nearly twice the risk of dying from COVID-19.⁽¹⁰⁸⁾

From the published research there is evidence that:

- Geographical and social-demographic factors explained more than half of the differences in COVID-19 mortality risk⁽¹⁰⁸⁾

- UK Government statistics show that the highest rates of overcrowding are in Bangladeshi households(24%), with households having more residents than rooms.^(109, 110) Like most BAME (Black and Asian Minority Ethnicity) households, Bangladeshis are more likely to be intergenerational, and particularly likely to have people over the age of 65 living with children under the age of 16.^(106, 109) Over-crowding and multi-generational housing challenges can make it difficult for ethnic minority communities to shield or self-isolate effectively.⁽¹⁰⁹⁾ Older people living in larger households may have found it more difficult to shield, particularly Bangladeshi and other Asian ethnicities.⁽¹¹⁰⁾ In addition to overcrowding, Bangladeshis are also most likely to live in deprived neighbourhoods⁽¹¹⁰⁾ and like other ethnic minorities such as Chinese, Indian, Pakistani, Bangladeshi, Black African and Black Caribbean, they were over twice as likely to use public transportation to travel to work compared with people from a White background⁽¹⁰⁹⁾
- Compared with White British individuals over 60 years of age, people from Bangladeshi backgrounds are over 60% more likely to have a long-term health condition that makes them vulnerable to COVID-19⁽¹⁰⁹⁾
- Differences in occupational exposure could also account for some of the differences, with more Bangladeshi men working as taxi drivers, shopkeepers and proprietors than any other ethnic background.^(106, 108-110) In addition, working in sectors shut down by the pandemic and being self-employed is particularly prevalent among Pakistani and Bangladeshi men, which brings uncertainty of income in households who also typically have fewer savings to rely on. Existing evidence suggests UK workers from Black African, Black Caribbean, Pakistani and Bangladeshi backgrounds are not just at higher risk

of unemployment but face longer lasting scarring effects when they have been unemployed.^(110,111) Compared with White British men, Bangladeshi men were four times more likely to have jobs in industries forced to close during lockdown^(109, 111)

- The potential for buffering incomes within the household depends on partners' employment rates, which are much lower for Pakistani and Bangladeshi women. As a result, 29% of Bangladeshi working-age men both work in a shut-down sector and have a partner who is not in paid work, compared with only 1% of White British men.⁽¹¹¹⁾ People from Bangladeshi (43%) and Black African groups (38%) were most likely to report loss of income since COVID-19, compared with White people (22%).⁽¹⁰⁹⁾ Bangladeshis, Black Caribbean, and Black Africans are the most likely to have limited savings to provide a financial buffer if laid off. Only around 30% of Bangladeshis live in households with enough savings to cover one month of required expenditure. In contrast, nearly 60% of the rest of the population have enough savings to cover one month's expenditure⁽¹¹¹⁾
- Despite the higher risk of income and employment loss, people from ethnic minority groups were less likely to know about changes to financial support as a result of COVID-19 compared with White people. This included the furlough scheme, new allowances around universal credit and claiming statutory sick pay while self-isolating (61% compared with 93%)⁽¹⁰⁹⁾
- When looking at actual versus expected hospital deaths, the number of deaths exceeded expected deaths. Bangladeshis, alongside Pakistanis and Black Caribbean's, were nearly three times as likely to die from COVID-19 related complications. This was higher than mixed and Indian ethnicities (twice likely),

but lower than Black African (four times as likely) and other ethnic groups (eight times as likely)

- Exploring COVID-19 vaccinations among Bangladeshis, a UK survey in December 2020 found that a person of Bangladeshi heritage is 2.31 times more likely to not have the COVID-19 vaccine, compared to a White British counterpart.⁽¹¹²⁾ Compared with all people (18%) Bangladeshis were more hesitant to take up the COVID-19 vaccine (42%). Reasons for hesitancy include concerns about side effects, lack of trust in vaccines and the spreading of misinformation.⁽¹¹²⁾

3.0 Conclusion

This report has highlighted the inequalities that exist within the Bangladeshi community within the UK, some of which include the higher rates of maternal mortality, childhood poverty and childhood obesity, and lower rates of physical activity (particularly in women). The Community Health Profile is to support the council, communities and partners to better understand the inequalities affecting the Bangladeshi community. The multiple factors that have been identified by the report can be used to inform the work to address inequalities across the city.

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5.0 APPENDICES

Appendix 1: Inclusion and exclusion criteria

Age group	Language	Publication type	Availability	Time limit
Any age groups	English Language	Pieces of peer reviewed and high-quality grey literature academic or scientific literature, whether a journal article, report or documents relating to the specified health and wider determinants issues among Bangladeshis in the UK Publications with at least 25% Bangladeshi representation, where there is a comparison	Full text articles include DOI/HTML links	Published literature from the year 2000

		with other ethnicities		
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Appendix 2: Searching key words

Getting the best start in life	Mental wellness and balance	Healthy and affordable food	Active at every age and ability	Working and learning well
General: “Bangladeshi” and “children” or “young people” or “youth” or “child” or “babies” or “childhood” Specific: “Bangladeshi” and “vaccination” or “measles” or “obesity” or “health check” or “maternity care” or “breast feeding” or “home visits” or “rituals” or “vaccine” or	General: “Bangladeshi” and “mental health” or “mental” or “health” or “wellbeing” or “wellness” or “access” or “balance” Specific: “Bangladeshi” and “mental illness” or “depression” or “suicide” or “shame” or “stigma” or “stress” or “racial harassment” or “honour” or	General: “Bangladeshi” and “food” or “diet” or “obesity” or “meat” or “vegetarian” Specific: “Bangladeshi” and “common food” or “festival food” or “dietary laws” or “food practices” or “traditional food” or “obesity” or “physical activity” or “overweight” or “BMI” or “weight”	General: “Bangladeshi” and “physical activity” or “activity” or “exercise” Specific: “Bangladeshi” and “vigorous exercise” or “moderate exercise” or “walking” or “running” or “sports” or “cardiovascular” or “elderly exercise” or	General: “Bangladeshi” and “working” or “education” or “housing” or “living” or “economic activity” or “general health” or “health” or “illness” or “disability” or “long term disability” or “long standing health” Specific: “Bangladeshi” and “apprenticeships” or “Level 1,2,3,4”

pertussis vaccine" or "belonging" or "bullying" or "fostering" or "care"	"disability" or "alcohol" or "drinking" or "abstention" or "drinking frequency" or "drinking intensity" or "alcohol problem" or "alcohol support" or "alcohol consumption" or "substance abuse" or "addiction" or "tobacco" or "cannabis" or "recreational drugs" or "drugs" or "smoking" or drug use"	"Waist Height Ratio"	"health promotion"	qualifications" or "degree" or "NEET" or "secondary school" or "primary school" or "full time education" or "profession" or "career choice" or "household income" or "home ownership" or "Bad health" or "learning disability" or "hearing impairment" or "communication impairment" or "PCOS"
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Appendix 3: List of Bangladeshi communities and organisations

Name of Organisation	Organisational details	Contact details
Bangladeshi Welfare Association	Advice, information and counselling on benefits, housing, employment, health, racial harassment. Interpreting and translation service. Nursery, mother and children's club, older people's coffee morning. Muslim girls social club, youth development and training project, access	Phone number: 0121 328 4746

	to work, IT, mother tongue and supplementary education classes, homework club.	
Bangladesh High Commission	Primarily provides helpful information regarding Bangladesh, and about the functions and services of this Assistant High Commission.	Phone number: 0121 622 3650
Legacy WMC	Legacy WM was established in 2010 and has Charitable Incorporated Organisation (CIO) status. Inspired by the heritage of post-war migrant communities in Birmingham, Legacy WM celebrates their relationship with the industrial, architectural, and cultural fabric of the city.	Phone number: 0121 348 8159
Purbanat	Purbanat works collaboratively with partners to create theatre that works across cultures, specialising in producing new plays and also adaptations of existing international written works.	Phone number: 07432 716868
Bangla Connection	Bangla Connection was formed in the year 2000. In 2002-4, Bangla Connection ran a programme titled 'A son of the Empire', which was funded by Award for All and also The Birmingham City Council Art Team. Bangla Connection was registered as a CIC in February 2021	Phone number: 07932 015335
Kashmiri Arts	A forum for Kashmiri Arts and South Asian creatives found within the midlands and wider UK. Kashmiri champion artists, outreach programs and arts organizations.	Email: kashmiriartsheritage@gmail.com
Bangladeshi Women's Association	Provides access to advice, information and training whilst providing two local venues (Tipton Muslim Community Centre & Jubilee Park centre) for all communities to get more connected, empowered and confident to have a real stake in the sustainable regeneration and renewal of their neighbourhoods.	Phone number: 0121 557 6766 (Tipton) / 0121 520 0234 (Jubilee Park)
Bangladesh Islamic Centre Smethwick	The Bangladeshi Islamic Centre (BIC) is a formally constituted, community led, independent charitable organisation, committed to the alleviation of disadvantage, inequality and deprivation	Phone number: 0121 558 8204/8261 Email: contact@bicentre.org.uk

	through a targeted range of services to the communities of Sandwell and with a particular focus upon the Bangladeshi community.	
Bangladesh Multipurpose Centre	Centre for the local Bangladeshi community. Advice and information on benefits, education, training, employment, health and housing rights. Careers guidance	Phone number: 0121 3269500
Sreepur Village	UK based charity that runs and funds a women and children's village in rural Bangladesh. The Sreepur Village works with mothers (without male support) and their children to increase their chances of remaining a family, by taking a holistic, residential approach including livelihood and literacy training	Phone number: 020 8658 7585 Email: emma@sreepurvillage.org
Bengali Society UoB	Promote and inspire the younger local Bengali generation to follow through to higher degree level education as well as forming a networking opportunity between future Bengali graduates.	Email: bengali@guild.bham.ac.uk

Appendix 4: People registered with the drug and alcohol services in Birmingham by ward and ethnicity

Ward	Alcohol	Non-Opiate	Non-Opiate and Alcohol	Opiate	Grand Total
Acocks Green	12	5	6	103	126
Allens Cross	3	0	0	29	32
Alum Rock	6	1	2	86	95
Aston	19	6	9	172	206
Balsall Heath West	2	0	2	60	64
Bartley Green	18	0	3	85	106
Billesley	10	0	2	61	73
Birchfield	8	1	3	94	106
Bordesley & Highgate	6	3	5	69	83
Bordesley Green	1	2	1	46	50
Bournbrook & Selly Park	8	0	1	65	74
Bournville & Cotteridge	12	0	2	51	65
Brandwood & King's Heath	6	1	1	58	66
Bromford & Hodge Hill	5	5	1	59	70
Castle Vale	5	3	2	35	45
Druids Heath & Monyhull	2	2	2	43	49
Edgbaston	3	1	1	32	37
Erdington	20	6	4	74	104
Frankley Great Park	8	3	1	46	58

Garretts Green	7	3	1	44	55
Glebe Farm & Tile Cross	5	6	6	66	83
Gravelly Hill	9	7	3	93	112
Hall Green North	9	5	2	30	46
Hall Green South	4	0	1	9	14
Handsworth	7	3	4	90	104
Handsworth Wood	6	2	4	57	69
Harborne	4	1	4	83	92
Heartlands	0	2	0	32	34
Highter's Heath	5	0	1	21	27
Holyhead	5	1	2	83	91
King's Norton North	2	0	1	34	37
King's Norton South	3	0	2	51	56
Kingstanding	11	5	5	96	117
Ladywood	15	3	5	140	163
Longbridge & West Heath	10	2	5	87	104
Lozells	5	1	0	79	85
Moseley	11	2	5	110	128
Nechells	9	1	4	41	55
Newtown	7	3	3	78	91
North Edgbaston	18	2	4	139	163
Northfield	2	0	1	21	24
Oscott	17	0	3	45	65
Out of Area	1	0	0	43	44
Perry Barr	10	1	2	49	62
Perry Common	7	5	2	44	58
Pype Hayes	4	1	4	43	52
Quinton	5	1	1	66	73
Rubery & Rednal	3	1	2	30	36
Shard End	5	3	2	74	84
Sheldon	6	2	3	30	41
Small Heath	2	1	2	62	67

Soho & Jewellery Quarter	12	5	6	148	171
South Yardley	3	1	0	26	30
Sparkbrook & Balsall Heath East	5	2	0	129	136
Sparkhill	6	0	0	84	90
Stirchley	8	1	1	24	34
Stockland Green	30	5	10	171	216
Sutton Four Oaks	3	1	0	7	11
Sutton Mere Green	6	1	0	19	26
Sutton Reddicap	3	0	0	24	27
Sutton Roughley	4	1	0	9	14
Sutton Trinity	5	1	0	9	15
Sutton Vesey	7	0	1	21	29
Sutton Walmley & Minworth	5	1	0	16	22
Sutton Wylde Green	4	0	0	4	8
Tyseley & Hay Mills	2	2	1	65	70
Ward End	2	1	3	51	57
Weoley & Selly Oak	7	2	2	69	80
Yardley East	5	1	1	32	39
Yardley West & Stechford	5	1	4	41	51
Grand Total	490	129	161	4187	4967

