Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)

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Foreword

Birmingham and Lewisham are global communities that thrive from the many cultures and communities, including large, diverse and vibrant Black African and Black Caribbean populations.

For too long our Black African and Black Caribbean populations have experienced health inequalities. These have often been ignored and their voices unheard, with these inequalities often accepted as fact rather than an unacceptable wrong to be addressed.

Although it has been hard, the journey over the last eighteen months has been worth it. It has also underlined the critical need for the work as our Black African and Black Caribbean residents have been disproportionately affected by COVID-19 pandemic, both directly through infections and deaths, and indirectly economically and socially. This review has opened difficult conversations, analysed the published research alongside lived experience, and talked head on about the practical steps needed to make lasting change.

We are grateful for the honesty, passion and commitment of the individuals and groups who have been part of the boards or taken part in the community sessions that have guided our work and offered challenge through every stage of this review. Their personal contributions led to the review identifying not just the challenges, but also important opportunities for action to be taken forward in our local communities and systems; as well as further afield in other local, regional, national and international settings.

The review is the first step in a longer journey of transformation and resolution. It shines a light on the unfairness our Black African and Black Caribbean citizens live with every day which damages their health and wellbeing. This is the reality for too many citizens who live within our communities. They experience racism and discrimination, ignorance and invisibility existing within structural and institutional processes that underpin and perpetuate these inequalities.

This is a reality that must change.

The review sets out clear opportunities for action driven by evidence and it is now for us as leaders to work together through the Health and Wellbeing Boards, new Integrated Care System Partnerships and most importantly with our communities themselves, to take them forward.

We are already implementing some of these opportunities for action locally in our areas, through programmes such as Community Champions and pilots of culturally competent health and wellbeing programmes, and we have begun to engage national partners in responding to these opportunities nationally.

We must be committed to a better future for our citizens, and we must work together to seize every opportunity set out in this report to make our communities fairer and healthier for all.

Councillor Paulette Hamilton

Cabinet Member for Adult Social Care and Health/ Chair of the Birmingham Health and Wellbeing Board

Councillor Chris Best

Leader of the Lewisham Council/ Chair of the Lewisham Health and Wellbeing Board

Executive summary

Health inequalities are not inevitable and are unfair. Many people from different backgrounds across our society suffer health inequalities which can negatively impact the whole community, not just those directly affected. Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) set out to urgently reveal and explore the background to health inequalities experienced by our Black African and Black Caribbean communities.

Birmingham is home to 8% of the Black African and Black Caribbean populations in England and 23% of Lewisham's population is of Black African or Black Caribbean heritage (ONS 2011). Therefore, we are uniquely placed to take on this project to improve the health and wellbeing of our populations.

We recognised the need to think and act differently, looking at not just published data and evidence but also listening professional and lived experiences to better understand health inequalities, the reasons why they exist and identify opportunities for action to address them.

The main aim of the Review is to improve the health of Black African and Black Caribbean people in our communities by listening to them, recognising their priorities, discussing, and reflecting on our findings and coproducing recommended solutions for the Health and Wellbeing Board and NHS Integrated Care Systems to consider and respond to.

Addressing the layers of disadvantage

This Review clearly demonstrates and reinforces the evidence that there are social, economic and environmental reasons that determine significant inequalities in health outcomes amongst Black African and Black Caribbean communities, both locally and nationally.

These reasons lead to growing inequalities which have continued to worsen throughout the course of the COVID-19 pandemic, with many ethnic communities, especially our Black African and Black Caribbean communities, disproportionately impacted by disease and death.

BLACHIR supports previous research into health inequalities such as the Marmot Reviews[1,2], demonstrating that widespread inequality creates barriers to healthy behaviours, as faced by Birmingham and Lewisham's Black African and Black Caribbean communities. The Review highlights that must address the root causes and not just the results of bad health by focusing on fairness, a good start in life, supporting individuals at key stages and planning interventions better in partnership with our communities. We must make sure that we offer appropriate and accessible interventions at critical times in people's lives, whilst also continuously improving the way services work with them in culturally competent ways designed with communities in collaboration.

Poor housing, lack of green spaces, pollution, unemployment, food and fuel poverty, violence and crime and inadequate education all contribute to worse health and inequalities in these must be improved alongside action in health and social care services, otherwise the gaps will persist.

Structural racism and discrimination, and associated trauma is also a negative determinant faced by our Black African and Black Caribbean communities and one that was a clear and

[1] Marmot, M., Goldblatt, P. and Allen, J. (2010) *Fair Society, Healthy Lives, Strategic Review of Health Inequalities in England post 2010.* Institute of Health Equity

[2] Marmot, M. et al (2020) *Build Back Fairer: The COVID-19 Marmot Review*. The Health Foundation

constant theme throughout the Review. This layer of disadvantage cannot be ignored and addressing it must be at the heart of the response.

This Review's purpose is to break down the layers of disadvantage by bringing them to the fore and offering opportunities for actions from the BLACHIR Academic and Advisory Boards made up of volunteer professionals and academics and volunteers from our African and Caribbean communities.

We present key findings from across eight themes and offer opportunities for action to help address them.

Our methodology

"There is an urgent need to do things differently, to build a society based on the principles of social justice" (Marmot 2020).[3]

In line with the need to think and act differently, BLACHIR took a relatively unique approach to collate and analyse data and evidence, taking a balanced approach with proper consideration for published data and evidence, expert knowledge, lived experience and community voice. This helped the review obtain both quantitative and qualitative information over the course of eighteen months.

We identified eight themes related to the health and wellbeing of our populations based on the life course and areas already highlighted in the literature. For each theme a rapid evidence review was conducted to collate the published evidence, in some cases this was done by the local public health teams, in others it was commissioned from external providers. Our board of academics discussed the results from the literature and the evidence review to identify gaps, key issues and opportunities for action. The community advisory board and public engagement events provided an 'expert by experience' perspective to further build the opportunities for action and also provide challenge to the ambition and approaches suggested.

Public engagement activities included four online surveys using the Be Heard and Survey Monkey platforms, six focus groups, five individual interviews and five online community engagement events.

Our main findings

Seven key areas that need to be addressed were identified as cutting across the eight themes explored. These are deemed as being fundamental to closing the inequality gap, providing fairer access to health and social care services, and improving health outcomes for Black African and Black Caribbean communities. The Review calls on the Health and Wellbeing Board and NHS Integrated Care System Boards to prioritise taking forward work to address the seven fundamental areas that need to change.

1. Fairness, inclusion and respect

Across settings and life stages, people of Black African and Black Caribbean heritage are exposed to structural racism and discrimination which accumulates over time leading to chronic stress and trauma. There is a need to recognise, identify, address and mitigate structural racism and discrimination as a driver of health inequalities.

The Review calls for the Health and Wellbeing Board and NHS Integrated Care Systems to explicitly recognise structural racism and discrimination as drivers of ill health, systematically identify and address discrimination within systems and practices, and engage

[3] Marmot, M. et al (2020) *Build Back Fairer: The COVID-19 Marmot Review*. The Health Foundation

with Black African and Black Caribbean individuals and organisations to ensure community voice and their leadership in driving this work.

2. Trust and transparency

Trust is lacking between the Black African and Black Caribbean communities and public sector organisations, and connections with communities need to be built. A long history of discrimination, biases, poor experience and poor outcomes has destroyed trust in statutory services.

The Review calls for cultural competence training of health and social care professionals led by the NHS Integrated Care Systems and the Councils. This will require working with trusted community organisations and partners to coproduce training for professionals and volunteers that includes cultural awareness, is trauma informed and recognises the short and long-term impacts of discrimination and racism, values lived experiences and embeds and delivers inclusion in practices and policies.

3. Better data

Treating all ethnic minority or 'Black' communities as a single 'Other' group does not consider the cultural differences between Black African and Black Caribbean people. This has led to gaps in available data and limits our understanding of our communities and their needs. These communities are often grouped in research and data with other non-White British ethnic communities, denying their visibility and muting their needs to commissioners and service providers.

The Review calls for the Health and Wellbeing Boards to act across their partnerships to strengthen granular culturally sensitive data collection and analysis. Collaboration with professionals who represent these ethnic backgrounds can create a more sensitive, informed and appropriate approach to data collection and commitment that when data is collected it is used to drive better services and outcomes.

4. Early interventions

Investing early in people is essential. Too many children and young people from Black African and Black Caribbean communities are facing additional challenges that could be reduced through evidence-based interventions and this would benefit them through their whole life. Supporting children and young people's key periods of change, from birth and infancy to primary and secondary school, and then to young adulthood in culturally competent ways is essential.

The Review calls for the Health and Wellbeing Board to work with the Children's Trusts and Children's Strategic Partnerships to develop a clear action plan to provide support at critical life stages to mitigate disadvantage and address the inequalities affecting Black African and Black Caribbean children and young people. Investing early in local opportunities and partnerships is key to helping households and improving the lives of local children and young people.

5. Health checks and campaigns

Early detection and diagnosis of disease and identification of risk factors is critical for improving outcomes and empowering people to control their own health and wellbeing. Black African and Black Caribbean populations are at greatest risk of many health conditions but have lower uptake of health checks and screening services.

The Review calls for the Health and Wellbeing Board to act across their partnerships to promote health checks through public campaigns to increase the uptake of

community-based health checks in easy to access locations. This should also include specific work on mental health and wellbeing, working with community organisations and partners to increase peoples' understanding of the different types of mental illness and to encourage self-help, early intervention and self-referral to the NHS mental health services.

6. Healthier behaviours

The awareness about healthier life choices must be increased by using appropriate representation and amplified community voices to help identify and promote better health and reduce stigma. Unhealthy behaviours such as not taking enough exercise, eating an unhealthy diet and use of recreational drugs are a growing concern amongst Black African and Black Caribbean people. As with other ethnic minorities, these unhealthy behaviours can be driven by experiences of discrimination and racism. This is not helped by a lack of quality data, culturally competent resources and services to support healthier life choices.

The Review calls for the Public Health Teams and their partners to assess current service provision and health improvement campaigns through a cultural competency lens to improve support and access for these communities. This should be built on coproducing interventions with supplementary training for professionals such as health education and racial trauma awareness to help understand the psychological reasons for unhealthy behaviours and the role of lived experiences of discrimination in causing unhealthy habits.

7. Health literacy

Increasing people's skills, knowledge, understanding and confidence (health literacy) to find and use health and social care information and services to make decisions about their health is key to achieving healthier communities. Many in the Black African and Black Caribbean communities have not been supported to develop in this area in ways that work with their culture and community.

The Review calls for the Health and Wellbeing Boards and NHS Integrated Care Systems to work with local community and voluntary sector partners to develop targeted programmes on health literacy for Black African and Black Caribbean communities. Improving health literacy has been shown to have a positive impact on reducing health inequalities and helping people to manage long-term conditions effectively and to reduce the burden on health and social care services.

Opportunities for action

There are 39 opportunities for action across the eight themes explored as part of this review summarised below, they are also included in Appendix 1.

In some areas these opportunities are suggested as pilots of approaches as the evidence base and live experience supports action but there is limited evidence on effectiveness. This reflects the lack of detailed and focused research into ethnic communities' specific needs and how best to respond to them. Appendix 4 sets out the recommendations for research questions that could help close some of these gaps for the future.

These opportunities outline the potential next steps proposed to address the findings from the Review and are for the Health and Wellbeing Board and the NHS Integrated Care System Boards to consider and respond to alongside the 7 key areas for action.

Theme 1: Racism and discrimination	
Who	**Opportunities for action**
Local Councils and Health and Wellbeing Board Partners	**1.** Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.
Local Councils and Children's Trusts	**2.** Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.
Local Councils and Health and Wellbeing Board Partners	**3.** Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.
Local Councils and Education Partners	**4.** Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

Theme 2: Maternity, parenthood and early years	
Who	**Opportunities for action**
Local Integrated Care Systems (ICS) and NHS Provider Collaboratives	**5.** Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.
Local NHS Integrated Care Systems (ICS)	**6.** Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.
Local Maternity System Partnerships and Health Child Programme Providers	**7.** Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.
Local Maternity System Partnerships (LMS) working with Local Council Housing Teams	**8.** Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through appropriate support and protecting them from relocation or eviction.

Local Public Health and NHS services	**9.** Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

Theme 3: Children and young people	
Who	**Opportunities for action**
Education settings supported by the Regional Schools Commissioner and local Councils	**10.** Provide guidance and support for Black African and Black Caribbean parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.
Local Integrated Care Systems (ICS), Mental Health Trusts & Council commissioned Healthy Child Programme Providers	**11.** Commission and develop culturally appropriate and accessible services, including schools-based support, for Black African and Black Caribbean young men and women to increase capability, capacity and trust to engage with services. This should be specifically actioned for mental health services and for sexual and reproductive health services and take into account issues around gender exploitation and gender based violence.
Education settings supported by the Regional Schools Commissioner and local Councils	**12.** Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people.
Local Health and Wellbeing Board and NHS Integrated Care System	**13.** Address low pay and associated poverty for frontline workers who are disproportionately of Black African and Black Caribbean heritage.
Local Council Director of Children's Services and Strategic Children's Partnerships	**14.** Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.
Local Councils and climate change and air quality partners	**15.** Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.
NHS Integrated Care Systems and Health and Wellbeing Board	**16.** Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Theme 4: Ageing well	
Who	**Opportunities for action**
Regional NHS England teams and Local Public Health teams	**17.** Provide targeted and culturally appropriate screening services Black African and Black Caribbean older adults.
Local Public Health Teams	**18.** Campaign to raise awareness and increase uptake of community-based NHS health checks in Black African and Black Caribbean older adults.

NHS Integrated Care System Boards	**19.** Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.
NHS England and NHS Integrated Care System Boards	**20.** Support initiatives to improve uptake of vaccinations in older African and Caribbean people, focusing on areas of higher deprivation.
Local Health and Wellbeing Boards and NHS Integrated Care System Partnerships	**21.** Use life course approach and consider relevant findings from this Review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

Theme 5: Mental health and wellbeing	
Who	**Opportunities for action**
Local Public Health and Community Mental Health Trusts	**22.** Coproduce awareness campaigns aimed at Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.
Local NHS providers and Community Mental Health Trusts	**23.** Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.
NHS Mental Health Providers and Commissioners	**24.** Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.
Local Health and Wellbeing Boards and NHS Integrated Care Partnerships Boards	**25.** Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and NHS Integrated Care Systems	**26.** Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

Theme 6: Healthier behaviours	
Who	**Opportunities for action**
Local Directors of Public Health	**27.** Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.
Health Education England	**28.** Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.
Local Councils and NHS Integrated Care Systems	**29.** Provide long-term investment for trusted Black African and Black Caribbean grass roots organisation such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.
Local Directors of Public Health	**30.** Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.
Research funding bodies such as National Institute for	**31.** Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for

Health Research (NIHR)	community providers in 'action research' to concurrently deliver and evaluate interventions.
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	**32.** Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

Theme 7: Emergency care, preventable mortality and long-term physical health conditions	
Who	**Opportunities for action**
NHS England NHS Integrated Care Systems Local Councils	**33.** Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations. This should be supported by clear commissioning that requires data collection and analysis linked to all key relevant performance indicators. A specific example of where this can be rapidly done is through better use of the Friends and Family Test (FFT) and working with African and Caribbean communities so they engage with the tool and understand how it is used. There should also be better scrutiny and use of data from complaints and complements and this should be reviewed as part of contract monitoring and output data reported into system-leaders. This can also be strengthened through undertaking qualitative research to understand and overcome negative perceptions and experiences of health care for Black African and Black Caribbean communities to avoid delays in accessing care, including the influence of structural racism and discrimination. Through this better data and engagement, local areas should develop a more in depth understanding of the needs of communities in relation to emergency care, preventable mortality and long-term physical health conditions.
Local Health and Wellbeing Board and NHS ICS Partnership Board	**34.** Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include: • A team of community advocates who understand the needs and barriers for Black African and Black Caribbean communities, supporting them to 'navigate' and access support (e.g. social prescribing). • Use of faith and workplace settings to increase awareness and understanding of health issues to support informed decisions about health. • Investment in grass-roots organisations to recruit volunteers who can support Black African and Black Caribbean

	communities that may experience structural institutional racism when accessing services.
Local Directors of Public Health and NHS Prevention Leads	**35.** Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy. This could include: • Services considering evidence-based ethnic differences in outcome measures (e.g. BMI versus waist-to-height measures, age of heart disease issue onset for NHS Health Checks, depressive symptoms in childhood and influence on life-time physical health). • Work with communities to co-develop services that are accessible for Black African and Black Caribbean communities (e.g. opening times, location of delivery). • Work with communities to encourage and raise awareness about how to access health services, including investment and development of multi-service hubs and pop-ups based in community locations (e.g. Youth Centres, libraries, leisure centres, faith-based sites, universities, colleges, schools) • Contractual clauses that strengthen support for Black African and Black Caribbean communities when they experience racism while accessing services and offer tiered positive approaches that address reported issues. • Meaningful measurement of change and learning from communities and grass roots organisations being captured and informing service design, monitoring, improvement, and review • Whole system workforces, across all partners and professions including front-line, back-office and system leaders, to complete anti-racism training, with ongoing independent evaluation • Early help provision that supports communities when they do not meet statutory thresholds such as improved investment in grassroot organisations to provide social prescribing support (e.g. befriending, talking therapy, group therapy, forums and general health support).

Theme 8: Wider determinants	
Who	**Opportunities for action**
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**36.** Consider cultural and religious influences when developing interventions to address the wider determinants of health inequalities for Black African, Black Caribbean and Black-Mixed ethnic minority groups.
Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations	**37.** Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.

Local Health and Wellbeing Boards	**38.** Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**39.** Take action to address employment inequalities and issues around racism and discrimination affecting in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high-risk occupations.

Introduction

"Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane"

Dr Martin Luther King Jr

There are clear and significant differences in the health status of Ethnic communities compared with their White counterparts in many local areas across the United Kingdom[4]. These reflect inequalities in the wider determinants of health such as education and housing, in health behaviours such as diet and physical activity, across many health outcomes from birth to premature death and in unequal access to health and social care support when it is needed.

The COVID-19 pandemic revealed how the impact of poverty, ethnicity, health, work and housing led to a higher rate of deaths in Black African and Black Caribbean people.[5] This simply shone a light on inequalities that have persisted for decades. The Black Lives Matter (BLM)[6] movement was also re-energised in 2020 highlighting the longstanding racism, discrimination and inequality experienced by Black people in the UK and internationally.

Health inequalities relate to the social, economic and environmental reasons that shape people's lives and are often called the wider determinants. Recent conversations across social and mainstream media steered by these issues have shown the inadequate support and unfair access to healthcare in our Black communities. This has led us to take action through a different type of partnership.

An innovative partnership

Over 96,000 people living in Birmingham identify with the Black African, Black Caribbean and 'Black Other' ethnic identities in the 2011 Census, and in Lewisham these communities represented over a quarter of all ethnic identities in the population. These are big communities and their health inequalities are reflected in the overall picture for the populations.

The public health divisions of Birmingham City Council and the London Borough of Lewisham Council felt more serious action was needed to understand and tackle health inequalities in their communities but recognised that this needed a different partnership approach which was better done together than individually. Building from these conversations the respective Health and Wellbeing Board Chairs commissioned BLACHIR – the Birmingham and Lewisham African and Caribbean Health Inequalities Review, to be led by the respective Directors of Public Health and their teams to move forward.

Despite the challenges of the last two years of the Pandemic this work has continued to move forward which is testament to the commitment of all those involved to make this happen.

Listening to our communities

Our Councils shared the common goal of addressing health inequalities through a greater understanding and appreciation of, and engagement with, our community groups. We

[4] Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund.
[5] Office for National Statistics (2022) *Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 8 December 2020 to 1 December 2021*
[6] Black Lives Matter (2022) *Home*

created an environment that enabled honest conversations throughout this review. The discussions were held with professionals and members of the public from the Academic and Advisory Boards. Fifteen academic professionals and nine Advisory Board members volunteered and attended five engagement sessions organised by each local authority's public health team. The review took place from July 2021 to January 2022 covering eight themes:

- Racism and discrimination in health inequalities
- Maternity, parenthood and early years
- Children and young people
- Ageing well
- Mental health and wellbeing
- Healthier behaviours
- Emergency care, preventable mortality and long-term physical health conditions
- Wider determinants of health

Our Black African and Black Caribbean Communities

Our Black African and Black Caribbean residents are important members of our community, many of whom were born and raised within our local areas. Irrespective of country of birth, many also have links and heritage with Africa and the Caribbean through cultural, ethnic identities and belief systems. Many Black African communities in the UK and elsewhere have roots in Sub-Saharan Africa with its rich and varied cultures, made up of mainstream and traditional belief systems. Black Caribbean communities also have distinctive cultural and ethnic identities across different Caribbean states with links to sub-Saharan Africa.

Black African and Black Caribbean groups share common ethnicities and cultures (African-Caribbean), and also identify with oppression, discrimination, marginalisation, inequalities and migration. However, there are also differences and we should not make assumptions when people from these groups access services that they all are the same.

The most recent standardised data on our communities locally comes from the 2011 Census as the 2021 Census results have not yet been released. While Birmingham has a much larger population than Lewisham, the ethnic landscape is similar with both being home to a significant proportion of Black African and Black Caribbean people.

There are some differences: a larger proportion of Birmingham's Black African and Black Caribbean citizens were born overseas (48% compared to 46% in Lewisham). The Lewisham's Black African and Black Caribbean population is younger than the general population and although this is similar in Birmingham, it is less pronounced. In general, the African populations are younger than the Caribbean populations and have much smaller proportion of very elderly citizens.

Figure 1: Local communities by ethnicity based on the 2011 Census data

[INFOGRAPHIC]

	Birmingham	Lewisham
Ethnic Identity		
White British	53.1% / 570,217	41.5% / 275,885
Black African	2.8% / 29,991	11.6% / 32,025
Black Caribbean	4.4% / 47,641	11.2% / 30,854
Black Other	1.7% / 18,728	4.4% / 12,063
Total of Black ethnicity	8.9% / 96,360	27.2% / 350,827
Country of Birth		
African Countries	3.2% / 34,549	9.2% / 25,277
• North Africa	0.3% / 2,696	0.4% / 1,180
• Central & West Africa	0.8% / 8,171	6.1% / 16,760
• South & East Africa	2.1% / 23,070	2.6% / 7,201
Caribbean Countries	1.9% / 20,043	4.6% / 12,788
• Jamaica	1.4% / 15,100	3.5% / 9,697
• Other nations	0.5% / 4,943	1.1% / 3,091
Age of arrival in the UK		
• 0 to 15yrs	37.5% / 17,417	29.6% / 10,224
• 16 to 24yrs	25.5% / 11,854	28.9% / 9,989
• 25 to 34yrs	24.3% / 11,310	28.6% / 9,859
• 35 to 49yrs	10.7% / 4,965	10.6% / 3,659
• >50yrs	2.1% / 956	2.3% / 792

Alternative text: Lewisham houses a higher percentage of people of Black ethnicity (27.2% compared to 8.9% in Birmingham). A larger proportion of Birmingham's Black African and Caribbean citizens were born overseas (48% compared to Lewisham's 46%). 37.5% of Birmingham's Black African and Caribbean population arrived between ages 0 to 15, which is higher than Lewisham (29.6%).

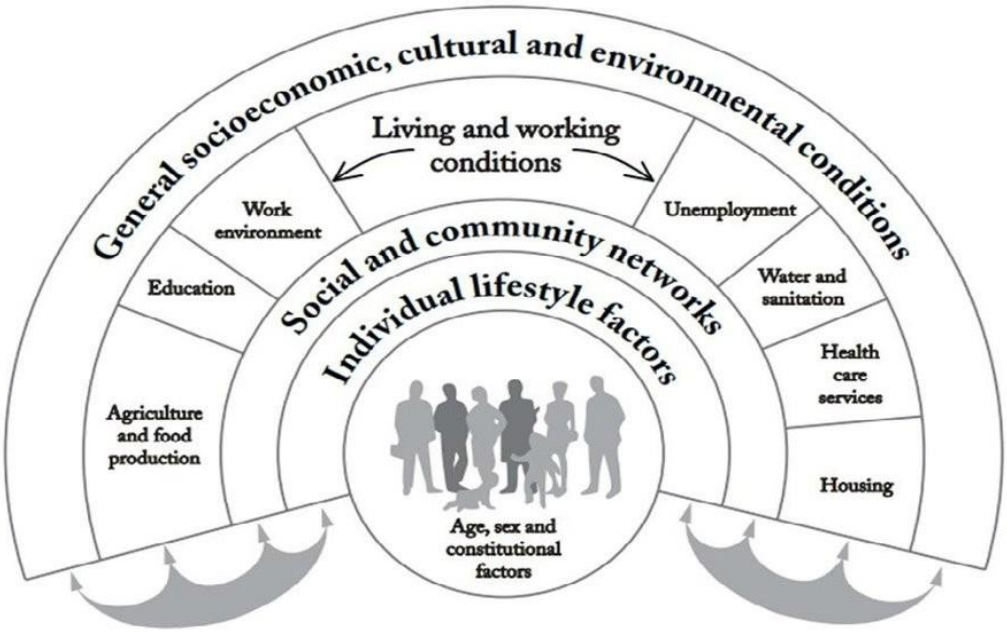
Methodology

The Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) took eighteen months due to the impact of the COVID-19 pandemic. It involved capturing the lived experiences of Black African and Black Caribbean communities alongside exploration of the published data and evidence. The main topic themes were established based on the recognised wider determinants of health (See Figure 2) and initial scoping engagement.

In addition to disproportionate exposure to negative determinants of health, it is increasingly recognised that many ethnic minority populations also suffer from racism and discrimination as an additional determinant of health[7].

BLACHIR wanted to hear from real people and their voices informed our study, revealing what we could do to ensure better opportunities for them now and in the future.

Figure 2: Dahlgren and Whitehead model of health determinants[7]



Alternative text: Dahlgren and Whitehead's model of health determinants shows the many factors that can influence an individual's health. These are:

- personal characteristics that occupy the core of the model and include sex, age, ethnic group, and hereditary factors
- individual 'lifestyle' factors which include behaviours such as smoking, alcohol use, and physical activity
- social and community networks which include family and wider social circles
- living and working conditions that include access and opportunities in relation to jobs, housing, education and welfare services
- general socioeconomic, cultural and environmental conditions that include factors such as disposable income, taxation, and availability of work.

The evidence was collected using the following methods:

[7] Dahlgren, G. and Whitehead, M. (2021) 'The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows', *Public Health* 199, pp 20-24.

- A rapid review of published research and evidence from the past ten years
- Data collation from existing data sources accessible to the Council public health teams
- An appraisal of the outcomes from the rapid review of literature and discussion on its findings by the board of academics
- A discussion on the outcomes from the evidence review and the Academic Board, and feedback from the experts by experience from the Advisory Board
- Public engagement activity including:
    - 4 online surveys
    - 5 online public events
    - 6 focus groups sessions
    - 5 one-to-one interviews.

We listened and we heard

Many groups of people remain under-represented in engagement due to barriers in society. The BLACHIR was important because it heard from people with diverse lived experiences, leading to innovative ideas for better decisions and health outcomes.

We adopted a different way to engage by allowing members of the community to comment on the opportunities for action as they were developed rather than just reading them from the published review.

People from Black African and Black Caribbean communities were invited through targeted engagement to submit responses to an online survey and participate in live Mentimeter© polls at online events. Birmingham City Council opened the last local survey to the wider public on 5 January 2022 and this closed on 20 January 2022. In total, 173 Birmingham citizens participated in the engagement events. In Lewisham, three local grass roots organisations were involved in carrying out local engagement activities. Across Lewisham, a total of 71 people engaged in these activities.

There was specific promotion through targeted media and direct networking to try and engage citizens in these opportunities to comment. As we went through the process we evolved and developed the approach. For example, we captured the ethnicity of participants in digital engagement workshops as a simple step to really understand the voices in the room.

The reality of the COVID-19 pandemic prohibited face-to-face engagement and it has been recognised that this was a significant limitation for the review process.

External boards

External Academic Board

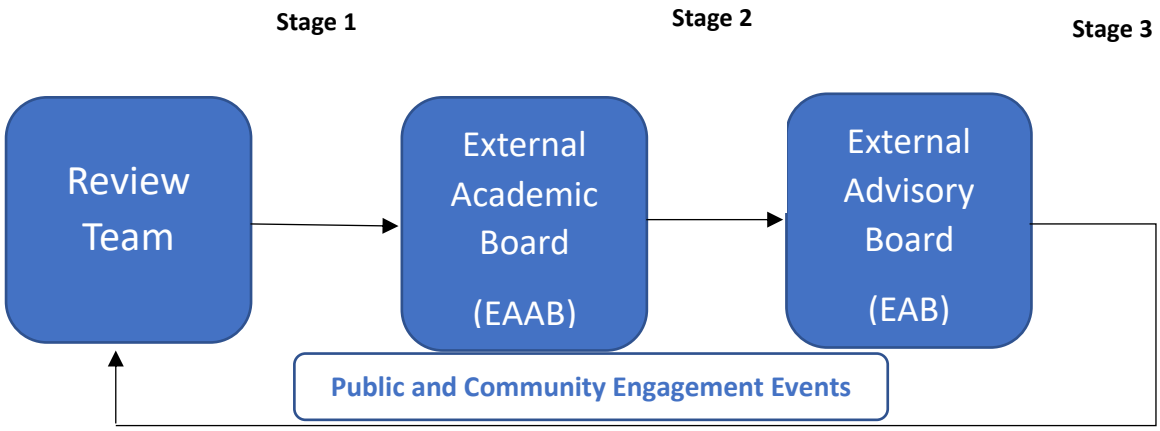
Fifteen academics were appointed as volunteers to the external Academic Board. The main purpose of the external Academic Board was to provide a network of academics who have a research interest in African and Caribbean health inequalities to support and inform the Birmingham and Lewisham review. The Academic Board members represented different aspects of the Black African and Black Caribbean communities in Lewisham, Birmingham and nationwide. They conducted a two-way conversation with communities, not representing individual views and maintained wider community networks to gain and share information relevant to each theme.

External Advisory Board

The Advisory Board consists of five voluntary members from Lewisham and four voluntary members from Birmingham who are actively involved in their communities and live in the local areas. They collected and reported lived experiences from both these local authorities. The external Advisory Board's purpose was to enable regular discussions to inform the

review process from a group of individuals who represented different views of Black African and Black Caribbean communities in Lewisham, Birmingham and nationwide.

Figure 3: Meeting cycle process



Alternative text: decorative (information explained above)

Recruiting participants using internal and external communications

We reached out to relevant audiences using both external and internal communications to find out directly about the issues affecting our Black African and Black Caribbean communities. Both councils' websites and other communication channels were used to provide information to all our targeted stakeholders.

The invitations were created to attract people to our engagement events and the online surveys were used to capture under-represented voices in the workplace.

The methods we applied were:

- email communications to community groups and representatives, including a list of targeted African and Caribbean organisations following a mapping exercise completed by the review team and local media outlets
- promotion of the surveys in all engagement events using slideshows and posting the link in the live MS Teams chats
- advertising using social media channels such as LinkedIn forums, Twitter, and Instagram Healthy Brum accounts.

Figure 4: Information from engagement events and surveys

	Birmingham	Lewisham

	Engagement Events	Survey and Mentimeter© responses	Focus groups and interviews	Survey
Number of participants	129	44	33	38
% of Black ethnicity	50%		100%	
% male	33%		24%	
% female	67%		76%	
Most common age group of respondents	55-64 and 35-44 years		40-59 years	

Alternative text: Birmingham's engagement involved engagement events, featuring a total participant number of 129, and survey and Mentimeter© responses (n = 44). Lewisham's engagement was completed via use of focus groups and interviews (n = 33) and surveys (n = 38).100% of the participants in Lewisham's engagement were people of Black ethnicity, compared to 50% in Birmingham's. Engagement in both councils was completed by a higher percentage of females than males.

Limitations

This review collated and analysed published evidence and available data, collected professional opinion and lived experience evidence, and utilised Academic Board, Advisory Board and community engagement processes to develop and prioritise its findings and proposed opportunities for action.

Each process had inherent limitations and potential biases, e.g. quantity and quality of published evidence and data, lack of available data collection and analyses for ethnicity beyond Black, Asian and Minority Ethnic (BAME), breadth of board membership, reach of community engagement, etc. Findings are not a comprehensive approach to addressing health inequalities for Black African and Black Caribbean communities, and other evidence-based opportunities to address health inequalities and improve health and wellbeing equity for these populations may also be beneficial.

As the Review progressed due to the pressure of the Covid response some of the evidence collation was commissioned from external providers and this led to more variability in the evidence collation.

It should also be noted that long-standing and structural drivers of health inequalities can only be addressed through long-term, progressive action. Therefore, rather than identifying a 'solution', this work represents the start of a new way to co-create action to reduce health inequalities with and by – rather than to or for - the community.

People from ethnic minorities who are not White British are often grouped together as Black, Asian and Minority Ethnic (BAME). The BAME term can mask variations between different ethnic groups and create misleading interpretations of data. The consequences of this are that we don't often get to truly understand the specific different inequalities affecting different ethnic groups or what their specific needs, or issues are.

Due to capacity and also the absence of data and evidence across the general population, this work has not looked at how minority groups within the Black African and Black Caribbean are affected by multiple inequalities ('intersectionality'). For example, evidence suggests LGBT people of Black heritage are more likely to face discrimination from other

LGBT people because of their ethnicity[8], be victims of hate crime[9] and less likely to access services[10] than White LGBT people. There is a need to look at intersectionality for people of Black African and Black Caribbean heritage who have other inequality characteristics or are in inclusive health demographics.

[8] Stonewall (2018) *LGBT in Britain – Home and communities*
[9] Stonewall (2017) *LGBT in Britain - Hate crime and discrimination*
[10] Witzel, T.C., Nutland, W. and Bourne, A. (2019) 'What are the motivations and barriers to pre-exposure prophylaxis (PrEP) use among Black men who have sex with men aged 18-45 in London? Results from a qualitative study,' *Sexually Transmitted Infections* 95(4), pp 262–266. doi: 10.1136/sextrans-2018-053773

Theme: Racism and discrimination

"'Whenever we see racism, we must condemn it without reservation, without hesitation, without qualification."

Antonio Guterres, United Nations Secretary-General

The review into the drivers of health inequality being experienced by Black African and Black Caribbean communities started from a discussion on the role of racism and discrimination.

Racism is "a conduct or words, or practices which disadvantage or advantage people because of their colour, culture, or ethnic origin"[11]. It can happen at both individual and institutional levels, with a collective failure to provide an inclusive environment or detect and outlaw racism termed 'institutional racism'.

Discrimination is treating someone in a negative way because of a personal characteristic such as race, age, sex or disability.

The historical aspect of these issues cannot be ignored. Racism has its roots in colonialism and slavery. A history of hierarchical states with White Europeans at the top and Black Africans and Black Caribbean's at the bottom has resulted in racism becoming embedded into the nation's structures of power, culture, education and identity.

The disproportionate impacts of COVID-19 on people of ethnic minority heritage, especially people from Black ethnic groups, shone a light on persistent and often ignored health inequalities. Recognition is a step in the right direction, but insufficient to create change.

A recent review of the principle of the determinants of health recognised racism as a *"driving force influencing almost all determinants of health"* operating through the mechanisms of racial discrimination and stigma, institutional racism, and structural racism[5].

A position statement from the Association of Directors of Public Health declared *"Racism is a public health issue"*[12]. They set out an action plan based on: trust and cohesion; co-production with communities; improving ethnicity data collection and research; embedding public health work in social and economic policy; diversifying the workforce and encouraging systems leadership.

What did we find from the rapid review?

There has been a steady increase in hate crime, including racially aggravated incidents, over the past 10 years with the number of the crimes rising by 159% since 2012 (Figure 5). The rise can also be attributed to a better recording system and higher reporting rates, as the awareness of hate crime and how to report it increases. Nevertheless, the statistics are worrying and demonstrate deep rooted societal issues[13].

[11] Macpherson, W. (1999) *The Stephen Lawrence inquiry*
[12] The Association of Directors of Public Health London (2021) *Policy position: Supporting Black, Asian and minority ethnic communities during and beyond the COVID-19 pandemic.*
[13] Allen, G. and Zayed, Y. (2021) *Hate crime statistics*. House of Commons Library.

Figure 5: Number of recorded hate crimes based on Home Office statistics for 2021

Police recorded hate crimes by monitored strand
England & Wales, year ending 31 March

	2012	2013	2014	2015	2016	2017[c]	2018[c]	2019[d]	2020[e]	2021	% Change 2020 to 2021	% Change 2012 to 2021
Race	32,969	33,116	34,874	39,666	45,440	58,294	64,829	72,051	76,158	85,268	+12%	+159%
Religion	1,438	1,421	2,067	3,006	3,962	5,184	7,103	7,202	6,856	5,627	-18%	+291%

Alternative text: The number of recorded racially aggravated hate crimes has risen by 159% from 2012 to 2021. This has risen by 12% from 2020 to 2021. The number of recorded aggravated hate crimes due to religion has risen by 291% from 2012 to 2021, but has reduced by 18% from 2020 to 2021.

Racially motivated hate crime in England spiked following the EU referendum, 2017 terrorist attacks and the Covid-19 lockdown[13].

Between 2017 and 2020, 0.9% of all Black adults aged 16 and over were victims of racially motivated hate crime compared to 0.1% of White adults, 1.0% of Asian adults and 1.1% of other ethnic minority groups, with the White Other group being most affected[13] (Figure 6).

Figure 6: Percentage of adult victims of racially motivated hate crime by ethnicity based on Home Office statistics for 2021

Percentage[a] of adults aged 16 and over who were victims of racially-motivated hate crime, by ethnicity and religion
England and Wales

	2007/08 & 2008/09	2009/10 to 2011/12	2012/13 to 2014/15	2015/16 to 2017/18	2017/18 to 2019/20
Ethnic group[b]					
White	0.1	0.1	0.1	0.1	0.1
Mixed/multiple ethnic groups	3.0	0.9	1.1	0.5	0.3
Asian/Asian British	2.1	1.8	1.0	1.1	1.0
Black/African/Caribbean/Black British	1.7	0.8	0.7	0.6	0.9
Other ethnic group	2.0	1.5	0.8	1.0	1.1

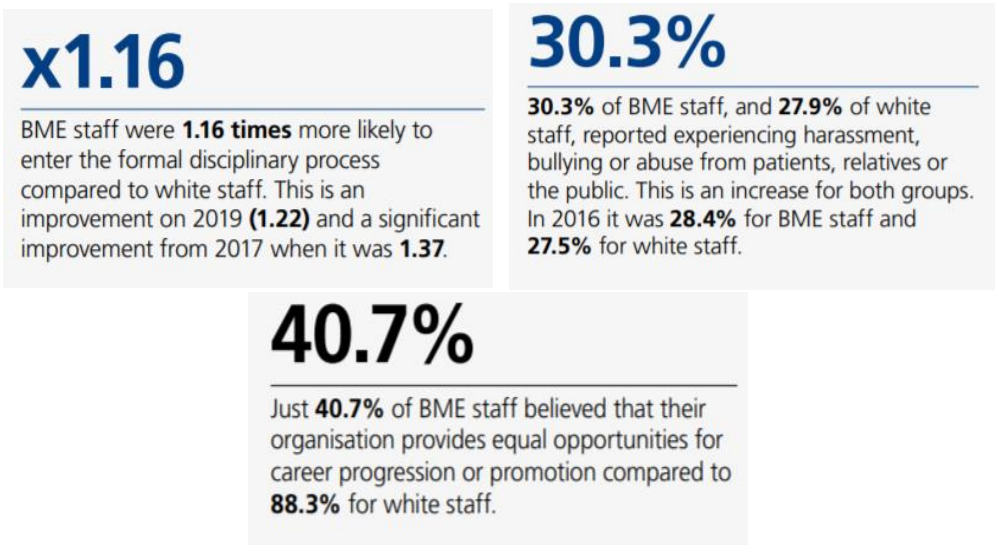
Alternative text: Between 2017 and 2020, 0.9% of all Black adults aged 16 and over were victims of racially motivated hate crime compared to 0.1% of White adults, 1.0% of Asian adults and 1.1% of other ethnic minority groups, with the White Other group being most affected.

There is clear evidence that racism has a detrimental effect on health and those who experience it have worse outcomes across many areas of mental and physical health.[14]People from Black, Asian and Ethnic Minority (BAME) backgrounds are more likely to have a negative experience of health care, which may include insensitivity and racism, and may limit access to those vital services, e.g. racism may cause delays in treatment and mistrust in services.**Error! Bookmark not defined.** Prejudice exists within the NHS staff towards BAME

[14] White, M. (2020) *What are the effects of racism on health and mental health?* Medical News Today

staff and more bullying and harassment has been reported by BAME staff compared to White British staff[15]. (Figure 7)

Figure 7: NHS staff statistics from NHS England 2021[15]



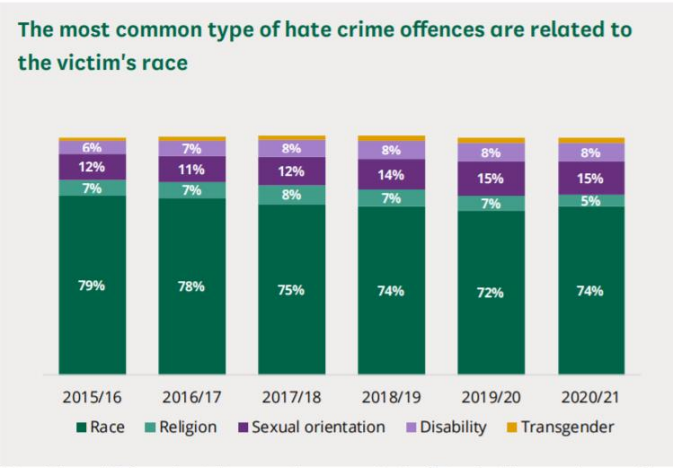
Alternative text: Black and Minority Ethnic (BME) staff were 1.16 times more likely to enter the formal disciplinary process compared to White staff. This is an improvement on 2019 (1.22) and a significant improvement from 2017 when it was 1.37. 30.3% of BME staff and 27.9% of White staff reported experiencing harassment, bullying or abuse from patients, relatives or the public. This is an increase for both groups. In 2016 it was 28.4% for BME staff and 27.5% for White staff. Just 40.7% of BME staff believed that their organisation provides equal opportunities for career progression or promotion compared to 88.3% for White staff.

Key findings [INFOGRAPHICS]

Headline: **West Midlands has the second highest rate for racially motivated crimes across all Police Force Areas in England and Wales**
West Midlands – 269 per 100,000 population
Metropolitan Police – 224 per 100,000 population
England and Wales average – 208 per 100,000 population

Headline: **Proprtion of racially motivated hate crime in England in 2020-21**
74%
[refer to the stats below]

[15] National Health Service (2021) *Workforce Race Equality Standard. 2020 Data analysis report for NHS Trusts and Clinical Commissioning Groups*



Notes: It is possible for a crime to have more than one motivating factor. For this reason the sum of the percentages of the FIVE motivating factors exceeds a 100%.

Headline: **Proportion of British adult (16+ yrs) victims of racially motivated hate crime**
Black adults – 0.9%
White adults – 0.1%

Headline: **Risk of disciplinary action against NHS staff**
BME staff have a 1.16 times higher risk than White staff

What did we find from the community & Board engagement?

"As I entered the surgery the GP said to me: *So many people from your country coming in with HIV!'"*
Lewisham community member

*"*The NHS staff have to be anti-racist, not just less racist."
Birmingham community member

"[Services] take all Black people to be the same."
Lewisham community member

Throughout the review, participants from across the community shared with us their own stories of lived experience of racism and discrimination. Most of these stories reflected on the structural and systemic issues of racism and discrimination present within some areas of public services, such as the NHS and the Criminal Justice System.

Stories about the experiences of racism and discrimination emerged at every discussion and engagement session during the review highlighting their deep and widespread impact on health and wellbeing, particularly on mental health and wellbeing.

The most common issues raised by the communities included:

- Racially charged/discriminatory language from healthcare professionals
- Racial abuse and attacks experienced in childhood having a traumatising effect and potentially lifelong negative impacts on self-esteem and mental wellbeing
- The use of colour language in ethnic coding having the potential to create bias and negative associations from the very first point of contact
- The importance of recognising and understanding the differences in different communities' history and experiences as even within the African and Caribbean

communities there are important and significant differences between different nationalities and cultural identities.

The review welcomed the brave and difficult discussions throughout this segment of the process and highlighted the need for the public sector to invest in creating more spaces for an open and authentic exploration of racism and discrimination in ways that support individuals to be safe in their exploration and learn together from others' lived experience.

Opportunities for action

Theme 1: Racism and discrimination	
Who	**Opportunities for action**
Local Councils and Health and Wellbeing Board Partners	1. Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.
Local Councils and Children's Trusts	2. Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.
Local Councils and Health and Wellbeing Board Partners	3. Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.
Local Councils and Education Partners	4. Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

Theme: Maternity, parenthood and early years

"It's been so bad for so many years, I don't think Black women will ever trust the NHS again."

BLACHIR engagement participant

The physical and mental health of parents are essential for the development of children with mothers playing an important role after conception and then from birth. The way in which they are supported during pregnancy can affect not only the first few years of a child's growth but also their prospects into adulthood.

In the UK, Black women are five times more likely to die in pregnancy or childbirth than White women.[16] During the Covid-19 pandemic, 55% of pregnant women admitted to hospital with coronavirus were from ethnic minority backgrounds.[17]

Prevention and early intervention are most effective when delivered in those early life stages. Prof. Sir Michael Marmot[18] who wrote the study Fair Society, Heathy Lives (The Marmot Review) notes 'giving every child the best start in life crucial to reducing health inequalities across the life course.' The *"first 1,000 days of life"* for lifetime health and wellbeing opportunities and outcomes is now recognised as critical[19].

We present the main findings from the evidence review, community engagement and stakeholder group sessions. The members of the boards suggest Opportunities for action to help improve support for African and Caribbean parents and children.

What did we find from the rapid review?

In local data, there were some interesting differences between the two areas.

Maternity

The outcomes for infant death and low birth weight in Birmingham is consistently poorer compared to England and Lewisham. In Birmingham, the highest infant mortality rates in the BLACHIR communities were found in mothers born in the Caribbean (9.0 deaths per 1000 live births) and Central Africa (8.3 deaths per 1000 live births) and this has remained so over time.[20]

Babies of Black or Black British ethnicity have greater than two times the risk of still birth than those of White British ethnicity.[21]

There are increasingly positive outcomes for continuity of care for Birmingham's Black African, Black Caribbean, and Black Mixed ethnicity mothers.

Pre-term birth rates are higher for Birmingham's Black Caribbean and Black Other women in 2020 compared to Black African and White British women.

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[16] MBRRACE-UK (2021) *Mothers and Babies: Reducing risk through audits and confidential enquiries across the UK*
[17] Royal College of Obstetricians and Gynaecologists (2020) *RCOG and RCM respond to UKOSS study of more than 400 pregnant women hospitalised with coronavirus*
[18] Marmot, M. et al (2020) *Health Equity in England: The Marmot Review 10 Years on*
[19] House of Commons Health and Social Care Committee (2019) *First 1000 days of life*
[20] Public Health England (2016) *Infant and perinatal mortality in the West Midlands*
[21] Office for National Statistics (2021) *Births and infant mortality by ethnicity in England and Wales: 2007 to 2019*

Emergency caesarean rates, from 2019 to 2020 for Black women, show an increase across all groups with higher rates seen in Black African women. However, there is a need to compare to the service standards as this can be an indicator of high-risk pregnancy or underlying medical conditions.

Parenthood and early years

The evidence base around parenting and early years that is specific to Black African and Black Caribbean communities is very limited in a UK context. The academic evidence highlighted the following issues driving inequalities in early years outcomes:

- Socioeconomic factors
- Barriers to accessing prenatal, postnatal, and maternity services
- Lack of culturally competent and sensitive approaches
- Poor perinatal mental health support
- Parental feeding practices such as greater eating pressures and concerns
- Black men and young Black women facing barriers and stigmatisation
- Intergenerational care not being recognised as an obvious aspect of family care.

Fewer children are assessed as being school ready at the end of Reception in Birmingham (68%) compared to England (71.8%) and Lewisham (76.4%)[22]. In 2018-19 only 68% of all Black children achieved the expected standard of development in Reception in comparison with 72% of all White children in England[23].

Key findings [INFOGRAHPICS]

Headline: **Highest infant mortality rates in Birmingham by place of mother's birth**

Caribbean - 9 deaths per 1000 live births

Central Africa - 8.3 deaths per 1000 live births

Headline: **Risk of still birth in the UK**

Black or Black British babies more 2 X more likely than White babies

Headline: **Risk of maternal mortality**

Black mothers 5 X more likely than White mothers

Headline: **Good level of development of children in Reception in England**

All White children – 72%

All Black children – 68%

What did we find from the community & Board engagement?

[22] Public Health England (2022) *Fingertips: Public Health Profiles*
[23] Office for National Statistics (2021) *Development goals for 4 to 5 Year Olds*

"The NHS staff have to be anti-racist, not just less racist"
Birmingham community member

"More people that look like me"
Birmingham community member

"If you are not counted, you do not count"
Advisory Board member

Lack of cultural awareness

Maternity care processes (pathways) do not recognise cultural differences between Black African and Black Caribbean women which can lead to barriers and result in stigmatisation and stereotyping. There is a need to develop and apply a pregnancy needs assessment model inclusive of lived experiences and accounting for cultural traditions. Community led initiatives or models should be considered.

Conscious and Unconscious bias

Communities told us that healthcare professionals tend to have more dismissive attitudes towards ethnic minority women, preventing them from accessing services. The uniting of education, policy and practice through cultural competency (understanding) training could remove bias and stereotypical views which influence assumptions and treatment.

The bias was also visible and present in the way data on ethnicity and culture are collected by services and there seemed to be a conscious bias to not looking at when it was collected. There are significant gaps in collecting and using data about ethnicity to understand the inequalities and underpin needs assessments as well as provision of appropriate services and the discussions with community highlighted the need for this to be much more granular and not lump all communities together.

"Transparency and trust are words that have very little meaning in many deprived areas of Birmingham."

BLACHIR engagement participant

Opportunities for action

Theme 2: Maternity, parenthood and early years	
Who	**Opportunities for action**
Local Integrated Care Systems (ICS) and NHS Provider Collaboratives	1. Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.
Local NHS Integrated Care Systems (ICS)	2. Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.

Local Maternity System Partnerships and Health Child Programme Providers	3. Improve data collection by specific ethnicity in maternity and early years services considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.
Local Maternity System Partnerships (LMS) working with Local Council Housing Teams	4. Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through appropriate support and protecting them from relocation or eviction.
Local Public Health and NHS services	5. Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

Theme: Children and young people

"I had Black teachers who acted as good role models."
Birmingham community member

"[I am] reluctant to go out because I don't feel safe."
Young Lewisham community member

*"Food poverty is caused by **the social exclusion** and spiralling associated costs for many living in these communities."*

BLACHIR engagement participant

Black children in the UK are now the second largest group living in poverty after White children. These are households defined as being below 60% of the median and it is the standard definition for poverty.[24]

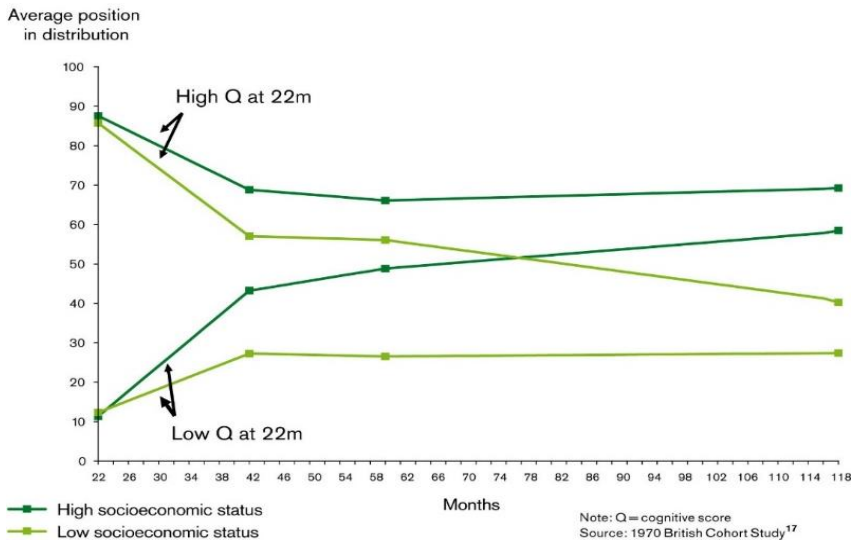
We focused in this review on the data and literature reporting the health inequalities and determinants for Black African and Black Caribbean children and young people (CYP).

So, why are children from these communities missing out on opportunities that lead to better health and life experiences?

Inequality is the main reason and can be seen in the children and young people's wider family and home environment. There is also significant evidence to suggest that these important earlier years can determine health inequalities over a lifetime.

We refer again to the seminal Marmot Review that explains where we sit in society and determines economic benefits. It presents the evidence that those with lower intellectual ability but with higher social status can overtake higher intellectual potential with lower social status in the early years by the time children are 7yrs old as demonstrated in Fig. 13.

Figure 8: The Marmot Review: Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years[16]



Alternative text: decorative (information explained above)

[24] Sparrow, A. (2022) *More than half of UK's Black children live in poverty, analysis shows*. The Guardian

Across both Councils there are clear commitments to reducing the social gradient (being less advantaged) in skills and qualifications, ensuring school, families, and communities work in partnership to reduce the gradient in health, wellbeing and resilience and improving access and use of quality lifelong learning across the social gradient.

We know that children and young people thrive in warm, stimulating, and safe homes with loving and supportive caregivers. But for Black African and Black Caribbean people inequalities often caused by structural racism can impact on being able to access parental help across health and social services when things are challenging and this in turn impacts on children.

One of the ways that we think about challenges to this positive thriving environment is through the ACE framework. The Adverse Childhood Events framework considers things that might happen to a child that have been shown to have impact on their lives in the short term and across the whole of their lifetime.

Adverse childhood events (ACE) are:

1. physical abuse
2. sexual abuse
3. psychological abuse
4. physical neglect
5. psychological neglect
6. witnessing domestic abuse
7. having a close family member who misused drugs or alcohol
8. having a close family member with mental health problems
9. having a close family member who served time in prison
10. parental separation or divorce on account of relationship breakdown.

Exposure to ACE does not automatically mean that children are 'destined' to have worse outcomes but it does highlight the potential risk, especially of negative health behaviours such as smoking, and the risks that come from having less well established personal and social connections and resilience. ACE exposure should not be used to label children but is a prism through which we can identify and consider need and step in earlier to support children and young people to achieve their potential.

There are already calls in academic papers racism to be considered *"an ACE exposure risk factor, a distinct ACE category and a determinant of post-ACE mental health outcomes among Black youth"*[25]. This reflects the sustained and long term impacts of racism on young people that can persist into adulthood and was a discussion that was reflected strongly in the Review.

What did we find from the rapid review?

We included data analysis of outcomes for children and young people locally and nationally, and a literature review of 65 sources.

Children and young people in Black ethnic groups have higher proportions of:

- excess weight[26]

[25] Bernard, D. L. et al (2021) 'Making the "C-ACE" for a culturally-informed Adverse Childhood Experiences framework to understand the pervasive mental health impact of racism on Black youth,' *Journal of Child & Adolescent Trauma* 14, pp 233-247. doi:10.1007/s40653-020-00319-9

[26] Office for National Statistics (2020) *Overweight children*

- living in low-income families[27]
- low birth weight[28].

Children and young people in Black Caribbean groups have significantly worse levels of:

- readiness for school[29]
- not (being) in Education, Employment or Training (NEET)[30].

The recent national YMCA research report: *Young and Black, The Young Black Experience of Institutional Racism in the UK* (October 2020)[31] emphasised four main issues:

- Racist language (school & workplaces) – 95% & 78%
- Stereotypes & pressure to conform – 70% & 50%
- Employer recruitment prejudice – 54%
- Distrust in police & NHS - 54% & 27%.

Black African and Black Caribbean children and young people often suffer the greatest inequalities resulting in Black Caribbean children and young people being 2.5 times more likely than a White British child to be permanently excluded.[32]

However, it must be noted that limited data by specific ethnicities and the lack of evidence doesn't mean inequalities are absent. We must avoid assumptions in the shared outcomes between Black Caribbean and Black African communities.

We are all in it together?

"Healthcare workers have been exposed to risk for years long before COVID."
BLACHIR engagement participant

As we have discussed in the introduction and will continue to reference in this review, Black ethnicities are more likely to be diagnosed or die from COVID-19. Statistics revealed that Black Caribbean and Black Other ethnicity categories have a 10-50% increase in deaths compared to other groups.[33]

The COVID-19 pandemic and our response to the virus had an unfair impact on minority ethnic households. People from these groups have reported greater financial impact leading to an increased use of food banks because their basic needs were not being met. For example, the IFS found that Black African and Black Caribbean men were both 50% more likely than White British men to work in shutdown sectors (areas that had been closed due to the initial lockdown).[34]

Whether the virus's impact is on an individual, or indirectly through a family member, the negative result of COVID-19 is likely to be greatest on Black children and young people given increased exposure to five risk factors:

- Negative financial impacts
- Unemployment
- Bereavement
- Mental health issues

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[27] Birmingham City Council (2022) *Supporting healthier communities*
[28] Office for National Statistics (2021) *Births and infant mortality by ethnicity in England and Wales*
[29] Office for National Statistics (2021) *Development goals for 4 to 5-year olds*
[30] Powell, A. (2021) *NEET: Young people not in education, employment or training. UK Parliament: House of Commons Library*
[31] YMCA (2020) *Young and Black. The young Black experience of institutional racism in the UK*
[32] Office for National Statistics (2021) *Statistics: Exclusions*
[33] Public Health England (2020) *Disparities in the risk and outcomes of Covid-19*
[34] House of Commons. Women and Equalities Committee (2020) *Unequal impact? Coronavirus and BAME people*

- Widening educational gap related to socioeconomics (status in society).

Black and minority ethnic young people have shown more increases in seeking help for mental health during the first wave of the pandemic than White young people.[35] While not identified by the literature, disproportionate COVID-19 deaths in Black and minority ethnic communities are likely to have created unequal levels of bereavement in children and young people.

Physical health
There are limited indicators for physical health in children and young people which can be reviewed in the context of ethnicity.

Black African and Black Caribbean girls have a higher body mass index (BMI) than White girls at age 11-13 (data for boys it was unclear with variation between studies). However, BMI was shown to overestimate the negative health effects of being overweight or obese in Black children because it fails to account for body composition. The body fat on average is lower in Black children and their increased height plays a part too.

The overweight and social economic status (SES) patterning varied by ethnicity with lower SES awarding higher risk of being overweight or obese for White children than Black children. However, for adolescents having overweight or obese parents could suggest they may be on the path of following suit.

Mental health and emotional wellbeing
Black African and Black Caribbean children and young people generally reported higher levels of mental wellbeing than White participants in the same studies. However, one study found that Black Caribbean children described higher levels of social difficulty at seven years old. Family activities and cultural integration (identified as ethnically diverse friendship circles) were also shown to have a protective 'bubble' effect.

Risky behaviours
White and Mixed ethnicity young people reported higher levels of substance misuse than Black young people, and Black Caribbean young people were most likely to report having unprotected sexual intercourse. Black African young people generally had fewer risky behaviours than Black Caribbean young people.

Physical activity levels were not lower in Black children, but cultural factors may affect parents' engagement with out-of-school sporting and exercise activities.

Educational attainment
Black African and Black Caribbean children on average report higher levels of aspiration than White children in areas including school. However Black Caribbean pupils on average have lower levels of academic attainment, including after adjustment for socioeconomic status (SES). The determining factors such as status in society and family achievement explain some but not all the reasons for poorer results. Black Caribbean and Black African children are less likely to be entered into higher-tier examinations by teachers compared to White children even where prior academic attainment is the same, so this is limiting their grades.

The high achievement by Black children was associated with a range of individual, family and school factors. Individual factors included good attendance at school, completing homework, aspiration to attend school beyond GCSE and the development of resilience, protecting against negative school experiences. Family factors included maternal education and employment with parental involvement in education. The education factors included the

[35] Campbell, D. (2020) *Covid-19 affects BAME youth mental health more than White peers – study*. The Guardian

recognition and celebration of cultural diversity especially the cultural identities of Black pupils in the school setting.

Social inclusion
Black young people in contact with Youth Offending Services may not have equal access to healthcare, with mental health needs less likely to be identified and supported. Young Black men's early exposure to 'adult' styles of policing may create feelings of unsafety and social exclusion.

Black children's on-average over-representation in the care system is heavily characterised by SES, locality, and type of intervention. The variation includes under-representation in more disadvantaged areas compared to White children, but over-representation in less deprived areas compared to White children.

In Black African and Black Caribbean populations engagement with a variety of health services may be lower, including immunisation, Child and Adolescent Mental Health Services (CAMHS), and being registered with a dentist. The causes of variation will be noted to sub-populations, with culture, language and prior experience of health services affecting individuals' engagement.

Key findings [INFOGRAHPICS]

Headline: **Black children and young people are more likely to:**

- be overweight
- live in low-income families
- be identified as NEET (Not in Employment, Education or Training)

Headline: **Child poverty in the UK**
Black children are now **more than twice** as likely to be growing up poor as white children

Headline: **Black child poverty in the UK**
The proportion of Black children living in poverty went up from 42% in 2010-11 to 53% in 2019-20

Headline: **Permanent exclusions in the UK**
Black Caribbean children and young people are 2.5 times more likely to be permanently excluded than White British children

What did we find from the community & Board engagement?

In Birmingham, Black young people were consulted as a group, whilst in Lewisham, we conducted one-to-one interviews. This gave us the opportunity to understand their overall experiences including those in education, physical environment, family, social environment, money, employment, and activities that influenced health.

Positive changes in health behaviour

The conversations being heard in our engagement activities with local communities were very different. We discovered that the participants all took part in physical exercise and had access to healthy food. Young people's primary school educational experience was positive, and they had lots of support. Inevitably, as the participants became older, they encountered more social and emotional challenges in life.

What did young people say?

Physical environment and family

"Having to move from my family to foster care was very scary, not knowing where I was going at the time affected me mentally."

Food

"Chicken and chips after school, for a lot of people is a trendy thing to do and I am not sure if people generally want it."

Belonging

"Especially in university because I felt like I no longer fit into Lewisham (and with friends I had growing up) and neither did I fit in the university context."

Opportunities for action

Theme 3: Children and young people	
Who	**Opportunities for action**
Education settings supported by the Regional Schools Commissioner and local Councils	1. Provide guidance and support for Black African and Black Caribbean parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.
Local Integrated Care Systems (ICS), Mental Health Trusts & Council commissioned Healthy Child Programme Providers	2. Commission and develop culturally appropriate and accessible services, including schools-based support, for Black African and Black Caribbean young men and women to increase capability, capacity and trust to engage with services. This should be specifically actioned for mental health services and for sexual and reproductive health services and take into account issues around gender exploitation and gender based violence.
Education settings supported by the Regional Schools Commissioner and local Councils	3. Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people.
Local Health and Wellbeing Board and NHS Integrated Care System	4. Address low pay and associated poverty for frontline workers who are disproportionately of Black African and Black Caribbean heritage.
Local Council Director of Children's Services and Strategic Children's Partnerships	5. Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.
Local Councils and climate change and air quality partners	6. Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.

NHS Integrated Care Systems and Health and Wellbeing Board	7. Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Theme: Ageing well

"Black people in their 50s and 60s have significantly lower weekly income than their White peers, are less likely to own their home outright and are more likely to live in deprived areas".

Centre for Ageing Better[36]

One of the ways of considering how well people are living in later life is to look at healthy life expectancy, this is a measure of the number of years and individual living in a particular area can expect to live without chronic disease or disability and it is calculated at birth and at 65yrs.

Within the UK, males at age 65 in the least deprived areas could expect to live 7.5 years longer in "Good" health than those in the most deprived areas. For females, the difference is 8.3 years.[37] Within Birmingham, the difference in life expectancy when comparing the most deprived and least deprived areas is 8.9 years for males and 6.6 years for females.[38] Between the most and least deprived areas in Lewisham, there is a difference in life expectancy of 7.4 years for males and 5.6 years for females.[39] People living in the most disadvantaged areas of England spend nearly a third of their lives in poor health.[40]

According to the Office for National Statistics, a disproportionate percentage of those living in the ten per cent most deprived neighbourhoods are from ethnic minorities. 15.6% of Black African people and 14.1% of Black Caribbean people live in the most 10% of deprived areas.[41] This correlation between ethnicity and place is particularly important for older adults who are less likely to move between areas in later life, this makes 'place based approaches[42]' even more important for older adults from ethnic communities.

The British Medical Journal (BMJ) discusses in an article: "older people from ethnic minorities are one of the most disadvantaged and excluded groups in society. Understanding the pathways leading to ethnic inequalities in older age requires research on these complex processes and how they link different life experiences to health and social outcomes in later life. This nuanced understanding would allow us to develop responses to these inequalities."[43]

We discussed several themes and trends relating to the health inequalities experienced by Black African and Black Caribbean older adults:

- Life expectancy
- Chronic conditions
- Suicide
- Loneliness
- Mental Health
- Frailty falls and hip fractures.

[36] Centre for Ageing Better (2020) *Ethnic inequalities among over 50s revealed in new research*
[37] Office for National Statistics (2016) *Population, People and the Community: Healthy life expectancy at birth and age 65 by upper tier local authority and area deprivation: England, 2012 to 2014*
[38] Public Health England (2018) *Protecting and improving the nation's health*
[39] Lewisham Health Inequalities Toolkit (2021)
[40] Public Health England (2018) *Chapter 5: Inequalities in Health*
[41] Office for National Statistics (2020) *People living in deprived neighbourhoods*
[42] Public Health England (2021) *Place-based approaches for reducing health inequalities: Main report*
[43] Bécares, L., Kapadia, D. and Nazroo, J. (2020) 'Neglect of older ethnic minority people in UK research and policy', *British Medical Journal* 368, doi:10.1136/bmj.m212

Health behaviours influences include:

- Smoking
- Physical activity
- Diet
- Drugs
- Alcohol
- Vaccinations.

Wider health determinants include:

- Income and debt
- Housing
- Education and skills
- Natural and built environment
- Access to goods and services
- Racism and discrimination.

What did we find from the rapid review?

Smoking: The rates remain high for White British and Black Caribbean men. Elderly smokers are twice as likely as non-smokers to develop certain cataracts, and smoking can double the likelihood of developing advanced diabetic retinopathy.[44]

Indicators of wellbeing: In older people aged 65 to 74 it was revealed that Black people are more likely to report life satisfaction and happiness compared to White people. However, some were also likely to report anxiety compared to other groups.

Depression: There is some evidence of a higher prevalence of depressive symptoms within the Black Caribbean communities than people of White ethnicity; in addition, being aged 75 and above combined with being from an ethnic minority community is a risk factor for loneliness.[45] [46]

Dementia: Black African and Black Caribbean communities have a higher prevalence of dementia (9.6%) than in White groups (6.9%). They are also at risk of developing vascular dementia nearly eight years earlier than their White British counterparts[47].

Cancer: While the overall rate of emergency colorectal cancer surgery is reducing, elderly patients, those from a lower income background and Black African and Black Caribbean patients remain at high risk of emergency attendance.[48]

Falls: Black women are at higher risk of death after a fall compared to White women. Exploring frailty, falls, and hip fractures by gender, older black Caribbean women are more at risk of frailty than men of the same age.[49] [50]

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[44] National Health Service (2022) *Smoking and your eyes*

[45] Scharf, T. et al. (2002) *Growing older in socially deprived areas: Social exclusion in later life*. Help the Aged.

[46] Victor, C. R., Burholt, V. and Martin, W. (2012) 'Loneliness and ethnic minority elders in Great Britain: an exploratory study,' *J Cross Cult Gerontol* 27(1), pp 65-78. doi: 10.1007/s10823-012-9161-6.

[47] Adelman, S. et al. (2011) 'Prevalence of dementia in African–Caribbean compared with UK-born White older people: Two-stage cross-sectional study,' *British Journal of Psychiatry*, 199(2) pp 119-125. doi:10.1192/bjp.bp.110.086405

[48] Askari, A. et al. (2015) 'Elderly, ethnic minorities and socially deprived patients at high risk of requiring emergency surgery for colorectal cancer,' *Gut*

[49] Klop, C. et al. (2017) 'The epidemiology of mortality after fracture in England: variation by age, sex, time, geographic location, and ethnicity,' *Osteoporos Int*. 28(1), pp 161-168. doi: 10.1007/s00198-016-3787-0.

[50] Williams, E. D., Cox, A. and Cooper, R. (2020). 'Ethnic differences in functional limitations by age across the adult life course', *The Journals of Gerontology* 75(5), pp 914–921

Cardiovascular: The risk factors are higher in Black Caribbean populations compared to the White population.[51]

Death at home: This was significantly less likely in Black African and Black Caribbean individuals. Compared to the White population, Black Africans and Black Caribbean's are less likely to die at home (52% and 22%, respectively). The evidence suggests that African and Caribbean older adults make end-of-life decisions with a significant emphasis on family structure, religion and spirituality, cultural identity, migration, and communication. Other research suggests the differences become barriers when trying to access specialist care in various settings.

The main causes of inequalities in this age group are:

- poorer mental health for people of Black ethnicity
- higher deprivation levels
- barriers in accessing specialist care in different healthcare settings
- lack of culturally competent and sensitive approaches
- lack of culturally and religiously sensitive services to support with end-of-life care.

Key findings [INFOGRAHICS]

Headline: **Scores of wellbeing in older people (65-74 years) by ethnicity (out of 10)**

- Life satisfaction – Black (7.9), White (7.7)
- Happiness – Black (8.0), White (7.7)
- Worthwhileness - Black (7.9), White (7.9)
- Anxiety - Black (3.2), White (2.7)

Headline: **Dementia prevalence by ethnicity**
Black people – 9.6%
White people – 6.9%

Headline: **Risk of developing cardiovascular dementia**
Black African and Black Caribbean 10 years earlier than other ethnic groups

Headline: **Proportion of deaths at home by ethnicity**
White population – 52%
Black Africans and Black Caribbean's - 22%

[ADD IMAGE BELOW AS INFOGRAPHIC]

[51] Birmingham City Council (2021) *What is the impact of health inequalities on Black African and Black Caribbean older people in the UK?*

What did we find from the community and Board engagement?

"Sense that care homes are uncaring and prefer end of life being at 'home'. Elderly feel they are not getting the care they deserve in care homes"
Lewisham community member

Accessibility
We need to gather further research on the accessibility issues older Black African and Black Caribbean individuals face when accessing good quality care and health screening opportunities. We can consider topics such as othering (not fitting in with the norms of a social group) and deprivation. Surveys will help us to obtain the information about the lived experience using focus groups from this community.

Cultural expertise
Cultural expertise needs to improve through providing cultural awareness training in care homes and hospitals. The needs of older Black African and Black Caribbean individuals must be met in an institutional setting. This can be achieved by using a peer development support model.

Unpaid care
To achieve better understanding through a specialised focus group with older Black people and their unpaid carers. This will help us to understand the experience older adults face within social care services and the reasoning for opting to care at home rather than in an institutionalised setting.

End of life treatment
A personalised end of life care treatment programme needs to be put in place for older Black African and Black Caribbean people based upon better cultural understanding. This will be co-developed with the individual and their carer to appreciate family practices and the importance of culturally sensitive issues.

Training
Elderly Black African and Black Caribbean people have different cultural attitudes to care and support needs. It is important to think beyond faith settings to engage with older Black African and Black Caribbean adults appropriately. There is a need to provide training to ensure expertise in cultural awareness for health care professionals.

Community
Black African and Black Caribbean older adults frequently suffer from loneliness and isolation. However, there is a lack of evidence to suggest whether interventions offering tailored support for elderly Black African and Black Caribbean adults effectively reduce loneliness and isolation.

Opportunities for action

Theme 4: Ageing well	
Who	**Opportunities for action**
Regional NHS England teams and	1. Provide targeted and culturally appropriate screening services Black African and Black Caribbean older adults.

Local Public Health teams	
Local Public Health Teams	2. Campaign to raise awareness and increase uptake of community-based NHS health checks in Black African and Black Caribbean older adults.
NHS Integrated Care System Boards	3. Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.
NHS England and NHS Integrated Care System Boards	4. Support initiatives to improve uptake of vaccinations in older African and Caribbean people, focusing on areas of higher deprivation.
Local Health and Wellbeing Boards and NHS Integrated Care System Partnerships	5. Use life course approach and consider relevant findings from this Review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

Theme: Mental health and wellbeing

"There are still strong religious connections and thoughts about mental health and these needs changing and tackling as does the perception [of mental health] within the community and shame in the family."

Birmingham community member

"[Mental health is] not spoken about. Awareness raising is needed within the community as well as in the health care services."

Lewisham community member

Mental health and wellbeing are fundamental parts of our overall health, there is no physical health without mental health and we cannot be fully well without being in a positive state of wellbeing. While this is an incredibly important part of our overall health there is very limited data available on wellbeing or on mental health in African and Caribbean communities.

Stereotypes create a misconception of how people are and how they live in other cultures, religions, or countries causing problems such as discrimination and fuelling hate crimes. Negative and even positive stereotyping can lead to prejudging others based on interpreting one side of the story. These can damage individual and community wellbeing and also lead to mental health issues. Stigma is also a major barrier within communities to seeking help and support when mental health issues are developing and this can lead to worse outcomes for individuals and a vicious downwards spiral of isolation and marginalization.

We explored in this theme research literature reporting on mental health inequalities for men and women from Black African and Black Caribbean communities in the UK. As well as disproportionately high rates of mental health need, these groups face, in some circumstances, stigmatised views held by mental health service providers that Black people are dangerous, leading to misinterpretations of the nature and degree of their illnesses.

The evidence highlighted that Black African and Black Caribbean people have less access to effective and relevant support for their mental health. Where support is accessed, the experiences and results for Black individuals are often less effective and, in some circumstances, can cause harm. Therefore, BLACHIR considered mental health inequalities for topical research including collaborative community participation.

We identified evidence of inequalities in mental health experiences and results for African and Caribbean communities. The findings were reinforced by qualitative evidence from their lived experiences shared by representatives of the communities through local engagement and observations from members of the Advisory Board.

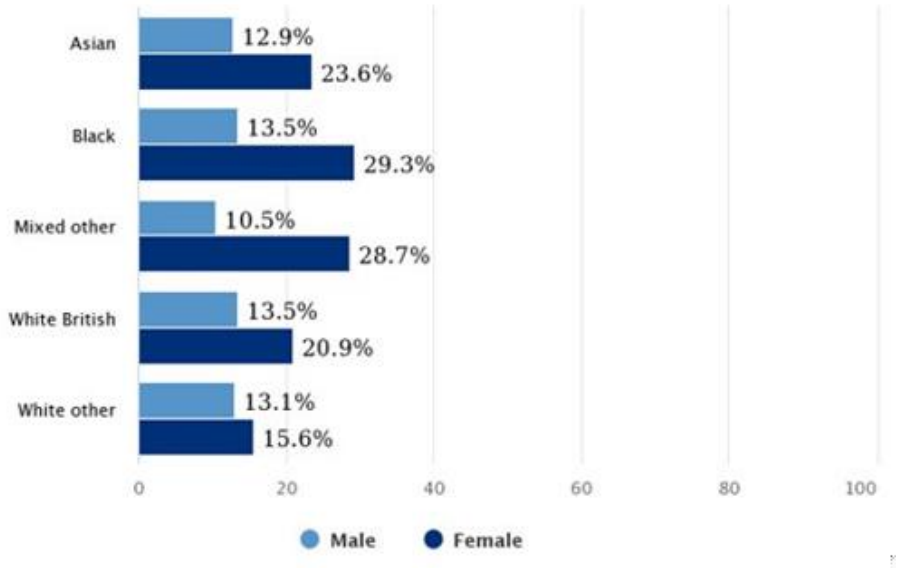
What did we find from the rapid review?

Insight was obtained from the evidence review, community engagement and stakeholder group sessions. It provides opportunities for action to improve African and Caribbean populations' access to support and services.

According to a national survey completed in 2014, 29% of Black women had experienced a common mental disorder in the past week, a higher rate than for women from all other ethnicities including Asian, White British and White other ethnic groups[52] (Figure 14).

[52] NHS Digital (2014) *Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014*

Figure 9: The percentage of adults who experienced a common mental disorder in the past week by sex and ethnicity



Alternative text: According to a national survey completed in 2014, 29% of Black women had experienced a common mental disorder in the past week, a higher rate than for women from all other ethnic groups including Mixed Other (28.7%) Asian (23.6%), White British (20.9%) and White other (15.6%) ethnic groups. Black men (13.5%) also had high rates of a common mental disorder, compared to White British (13.5%), White Other (13.1%), Asian (12.9%) and Mixed Other (10.5%).

Black Caribbean young men are three times more likely to have been in contact with mental health services before committing suicide, compared to their White counterparts.[53] Psychosis was consistently higher in Black populations, in particular males; findings were less conclusive regarding depression and anxiety.**Error! Bookmark not defined.**

Despite this evidence of increased mental health need, Black African and Black Caribbean people of all ages reported to under use mental health services due to social stigma, language barriers, poor mental health literacy and reluctance to discuss psychological stress.[54]

White British people are more likely to have received treatment for emotional and mental health problems compared to all other ethnic groups (14.5%). In comparison, Black adults had the lowest treatment rate (6.5%).[55]

Looking specifically at talking therapy treatment, in the NHS Improving Access to Psychological Therapies (IAPT) there is a lower rate of Black African and Black Caribbean people being offered IAPT services, and where services are offered individual drop out is more likely.[56]

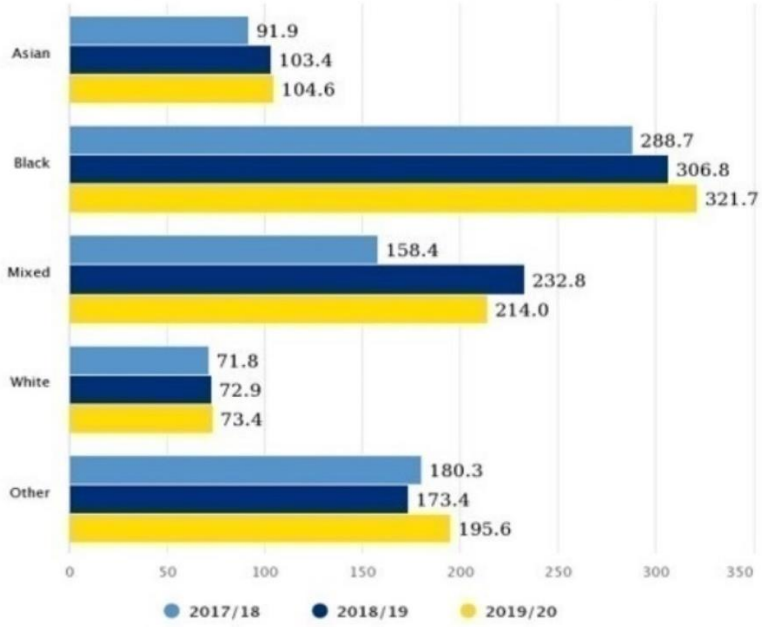
Black populations were less likely to access mental health support through traditional services. Black Africans found help from community leaders, particularly those associated with religion.**Error! Bookmark not defined.** Seeking help elsewhere, I.e. not from clinical increased the likelihood of accessing treatment at the point of crisis or breakdown. This increased risk of

[53] Lankelly Chase Foundation, Mind, The Afiya Trust and Centre for Mental Health (2014) *Ethnic inequalities in mental health: Promoting lasting positive change*
[54] NHS Digital (2014) *Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014*
[55] NHS Digital (2014) *Mental health and wellbeing in England Adult Psychiatric Morbidity Survey 2014*
[56] Public Health England (2022) *Fingertips: Public Health Profiles*

being detained under the mental health act and through the Criminal Justice System. Black populations were also more likely than British White populations to experience re-admission.[Error! Bookmark not defined.]

Hospital admissions for Black Caribbean and Black African patients were more frequent, longer, and often involved the police, when compared to White patients.[Error! Bookmark not defined.] One of the most serious forms of intervention for people who are mentally unwell is to detain them under the Mental Health Act. Black people are four times more likely to be detained under the Mental Health Act than White people.[57] Black Caribbean people had the highest rate of detention out of all ethnic groups (excluding groups labelled 'Other'), with 275.8 detentions per 100,000 people in the year ending March 2020. The highest rates of detention were for the Black Other, Any Other, and Mixed Other ethnic groups – but these are overestimates because 'Other' categories may have been used for people whose specific ethnicity wasn't known[58] (Figure 10).

Figure 10: The number of detentions under the mental health act, per 100,000 people, by aggregated ethnic group



Alternative text: In the year ending March 2020, the number of detentions under the mental health act, per 100,000 people was highest in people of Black ethnicity (321.7), followed by Mixed (214.0), Other (195.6), Asian (104.6) and people of White ethnicity (73.4).

There is very little data on wellbeing that can be analysed by ethnicity, the national adult population survey is not published routinely with ethnicity data. However, the Sport England Active Lives survey includes wellbeing questions for adults, but the sample size means that looking at this by ethnicity in Lewisham is not possible in individual years. The most recent data from the May 2020-2021[59] survey found that:

- Nationally the average anxiety score was lower for Black participants (3.19) than for White British participants (3.51). In Birmingham the gap was even more pronounced 2.10 compared to 4.02.

[57] NHS Digital (2020) *Mental health act statistics, annual figures*
[58] NHS Digital (2021). *Detentions under the mental health act*
[59] Sport England (2022) *Active Lives survey data*

- Life satisfaction scores were similar nationally between Black (6.90) and White British (6.89) participants but in Birmingham Black participants had a higher level of life satisfaction (7.74 compared to 6.51).
- The average Happiness scores were higher nationally for Black participants (7.16) than in White British (6.97) and a similar pattern was reflected in Birmingham (8.17:6.63).
- The final dimension looked at feelings of being Worthwhile. Nationally levels were similar between Black (7.28) and White British participants (7.16), but in Birmingham there were higher levels of positive responses in Black participants (8.23) than in White British(6.79).

Key findings [INFOGRAPHICS]

Headline: **29% of Black women had experienced a common mental disorder in the past week**

Headline: **Black Caribbean young men are 3 times more likely to have been in contact with mental health services before committing suicide compared to White young men**

Headline**: Black people are 4 times more likely to be detained under the Mental Health Act than White people**

Headline: **Black adults have the lowest emotional and mental health treatment rates (6.5%) compared to White adults (14.5%)**

What did we find from the community and Board engagement?

"Racism, stigma and culture play a role in the way our communities view mental health services. Sometimes, they cause more harm than good."

Birmingham community member

"Too quick to label black children as mentally disturbed" with "many ending up with the wrong diagnosis and put in inappropriate places"

Lewisham Community member

"When I step out my door, I do not see the greenery I once used to see. I see a decision made by privileged White men to surround my home with large warehouses and business. Nobody thought it would affect my mental health or wellbeing, not even gave the opportunity of consultation."

Birmingham community member

Inclusion and mental health

Structural issues, such as poverty, deprivation, and racism, must be recognised as key factors contributing to African and Caribbean communities' poor mental health. Addressing this at both institutional and societal levels will create a sense of belonging in the community. The role of urban governance, including the Integrated Care System (ICS) must be explored further and strengthened. Media coverage is largely negative and stigmatising which contributes to poorer mental health outcomes.

Cultural expertise in mental healthcare

There is a lack of or limited understanding of cultural needs and backgrounds with different Black communities. Health professionals must develop better cultural understanding in mental health services when caring for Black African and Black Caribbean patients.[60]

Community support

Grassroots and faith organisations are often unfamiliar to health professionals and for that reason they are not well engaged with community assets. We must use the assets and collaborate with mental health services to provide effective support in the communities. Working with peer, personal support networks and professional networks is essential. We can skill-up more young people and community groups in mental health first aid to reduce stigma, increasing opportunities to help.

There were concerns whether the services are appropriate and provide formal training. One individual stated that commissioned services must be "formally regulated and evaluated."

Health literacy and early intervention were addressed as being important in mental healthcare. For that reason, mental health champions could play a vital role in community inclusion improving mental health delivery.

Opportunities for action

Theme 5: Mental health and wellbeing	
Who	**Opportunities for action**
Local Public Health and Community Mental Health Trusts	1. Coproduce awareness campaigns aimed at Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.
Local NHS providers and Community Mental Health Trusts	2. Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.
NHS Mental Health Providers and Commissioners	3. Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.
Local Health and Wellbeing Boards and NHS Integrated Care Partnerships Boards	4. Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and NHS Integrated Care Systems	5. Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

[60] Birmingham and Lewisham Black African and Black Caribbean Health Inequalities Review (BLACHIR) (2021) *Mental Health Theme: Systematic Review (sharepoint.com)*

Theme: Healthier behaviours

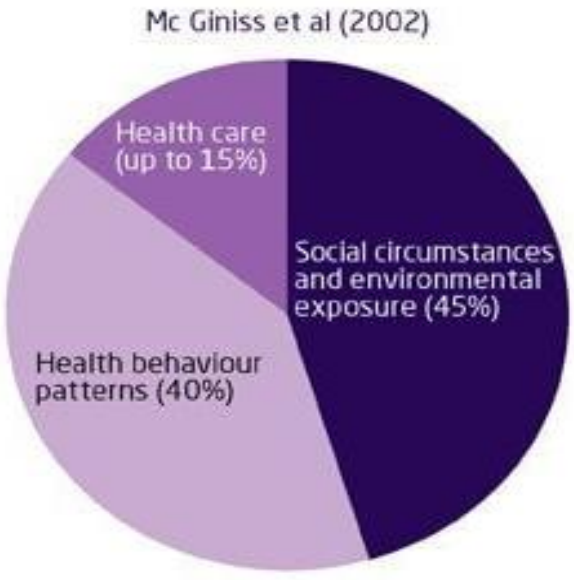
"Stop opening up fast food chains in areas of deprivation where you can get chicken and chips for £1.99 or feed a family for £9.99. Why would you sit and cook a meal for a family of five when this is on offer across the road?"

BLACHIR engagement participant

Many of the things we do each day have an impact on our health, from our diet to the amount of physical activity we take, these behaviours reduce our risk of developing conditions like diabetes and dementia and when we have illness and disease we can often improve our quality of life and reduce complications through positive health behaviours as well as clinical treatment.

Health behaviours don't happen in isolation, they are a reflection of our upbringing, our culture and heritage, our environment and social circumstances as well as our understanding of our own bodies and the health benefits of doing them. Health behaviours are a significant driver of health outcomes and the health of a population (Figure 11).

Figure 11: Broader determinants of health on population health[61]



Alternative text: McGiniss et al (2002) found that the drivers of health outcomes on population health could be broken down into the following proportions. Social circumstances and environmental exposure was the largest determinant at 45%, followed by health behaviour patterns at 40% and healthcare up to 15%.

The key behaviours that impact on the risk of death and disease are:

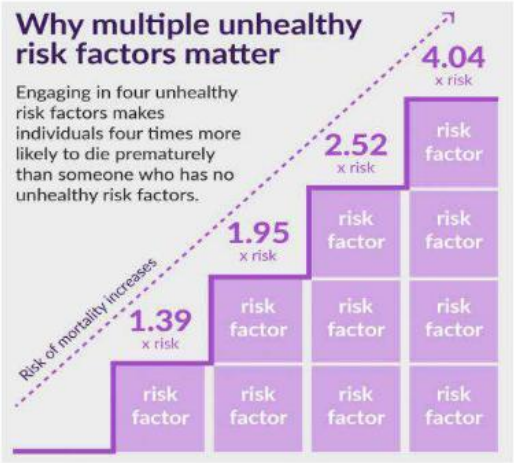
- Physical Activity
- Diet and nutrition
- Smoking, drugs and alcohol

[61] McGinnis, J. M., Williams-Russo, P. and Knickman, J.R. (2002) 'The case for more active policy attention to health promotion,' *Health Affairs* 21(2) pp 78-93.

Other behaviours such as social connection are increasingly being understood as risk factors as well through the evidence of the negative impacts of loneliness on mortality risk.

Research shows that clustering and compounding unhealthy behaviors contribute to inequalities. The number of unhealthy behaviours a person has creates a multiplier effect. After 11 years, an individual with all four risk factors had a four-fold risk of dying compared with someone who ate well, exercised and didn't smoke or drink to excess.[62]

Figure 12: The risk of mortality from engaging in unhealthy risk factors[62]



Alternative text: The risk of premature mortality increases in an upward trajectory with a higher participation in risky behaviours. Engagement in one risk factor increases the risk of premature mortality by 1.39 times compared to those who engage with no unhealthy risk factors. The risk is 1.95 times greater with engagement of two risk factors, 2.52 times at three risk factors and 4.04 times the risk in those who engage with four risk factors.

Understanding the health behaviours of Black African and Black Caribbean people in the UK, and what creates them, will help in planning effective interventions that reduce health inequalities.

Alcohol harm paradox

Disadvantaged groups can suffer greater harm with similar exposure when consuming alcohol. This has been identified as the 'Alcohol harm paradox' in a study by Alcohol research UK entitled: *Understanding the alcohol harm paradox to focus the development of intervention*.[63]

People from deprived areas who have the same or a lower level of alcohol consumption suffer greater alcohol-related harm than those from more affluent ones. Lower individual and neighbourhood socioeconomics are associated with higher rates of alcohol-related conditions and death or hospitalisation.[64]

[62] Khaw, K. T. et al (2008) 'Combined impact of health behaviours and mortality in men and women: The EPIC-Norfolk Prospective Population Study,' *PLOS Medicine*, 5(3) pp 70. doi.org/10.1371/journal.pmed.0050070
[63] Alcohol Research UK (2015) *Alcohol Research UK reports: The alcohol harm paradox, intuition school programme, social networks and alcohol identities, sight loss - Alcohol Policy UK*
[64] Bloomfield, K. (2020) 'Understanding the alcohol-harm paradox: what next?', *The Lancet Public Health*

A similar relationship can be seen in harms related to gambling where lower rates of gambling by people in poorer areas had higher rates of harm compared to people in more affluent areas.[65]

Unfair odds

"Poundland and off licences are higher in deprived areas while the healthy areas get all the fancy foods and they get the bike lanes too."
BLACHIR engagement participant

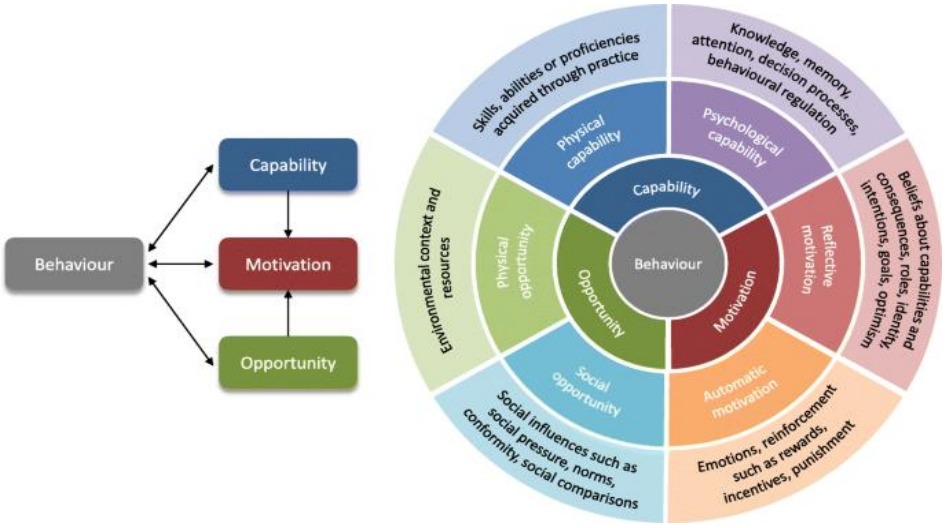
The decisions we make are often influenced by our peer group, family, social status, and the wider community. A sense of belonging is important for many people and the way we behave can be shaped by the environment in which we live.

In this analysis 'fast food' refers to energy dense food that is available quickly, covering a range of outlets that include burger bars, kebab and chicken shops, chip shops, and pizza outlets. The number of fast-food outlets in local authorities across the UK ranges from 26 to 232 per 100,000 population.[66]

The UK's most deprived areas have almost 10 times more the number of betting shops than the most affluent parts of the country.[67]

What can be done to enable behaviour change?

Figure 13: Behaviour change is a complex landscape: COM-B model of change[68]



Alternative text: The COM-B model of change proposes a bi-directional relationship between behaviour and capability, motivation and opportunity. In addition, it proposes that both capability and opportunity influence motivation.

The behavior change wheel suggests that capability includes psychological (skills, abilities or proficiencies acquired through practice) and physical capability (knowledge, memory, attention, decision processes, behavioural regulation).

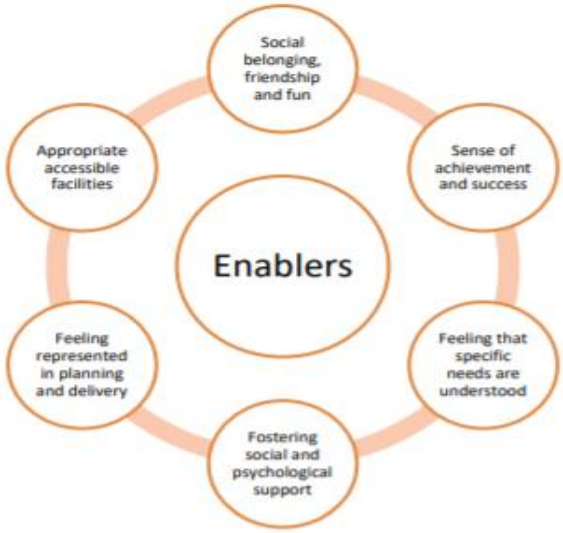
[65] Public Health England (2021) *Gambling-Related Harms: Evidence Review*
[66] Public Health England (2018) *Fast Food Outlets: Density by Local Authority in England*
[67] Russon, M-A. (2021) *Gambling: Poorer UK towns found to have the most betting shops, study shows BBC News*. BBC News
[68] Michie, S., van Stralen, M. M. and West, R. (2011) 'The behaviour change wheel: A new method for characterising and designing behaviour change interventions,' *Implementation Sci* 6(42) doi.org/10.1186/1748-5908-6-42

Opportunity includes physical opportunity (environmental context and resources) and social opportunity (social influences such as social pressure, norms, conformity, social comparisons).

Motivation includes automatic motivation (emotions, reinforcement such as rewards, incentives, punishment) and reflection motivation (beliefs about capabilities, consequences, roles, identity, intentions, goals, optimism).

For example, there is a call to address inequalities in the uptake of physical activity by tackling several enabling factors which contribute to behaviour change in relation to exercise.

Figure 14: PHE enablers of behaviour change



Alternative text: PHE enablers of behaviour change include:

- social belonging, friendship and fun
- appropriate accessible facilities
- sense of achievement and success
- feeling that specific needs are understood
- fostering social and psychological support
- feeling represented in planning and delivery

What did we find from the rapid review?

The rapid review looked at survey data across our populations and in the national data sets. Often national surveys do not present or analysis ethnicity at the level of local authorities for behavioural factors which limits our understanding.

The survey data highlighted the most significant inequalities are in physical activity and diet and nutrition behaviours whereas in many other areas Black populations have healthier behaviours.

Exercise

The evidence from national data analysis in the Active Lives Survey 2019/2020[69] revealed that physical activity is lower in the Black population than the White British population. This pattern was reflected in local data in the Nov 2019/20 survey %[70] for Birmingham but there

[69] Sport England (2021) *Active Lives Adult Survey November 2019/20 report*
[70] Sport England (2022) *Active Lives Survey Data*

were some differences for Lewisham, and overall rates of physical activity in Lewisham are higher than in Birmingham:

- Nationally the percentage of people (White British vs. Black) aged 16 years and over who were physically active between November 2019 and November 2020 were 63.1% vs. 53.3%[71].
- The percentage of Black people, aged 16yrs and over, achieving the recommended 150 minutes of physical activity every week in Birmingham was 54% compared to 53.3% nationally but in Lewisham it was much higher at 66.3%.
- The percentage of Black people achieving 30 minutes of less of physical activity, and classified as inactive, in Birmingham was 29.2% compared to 26.0% nationally but there was not a large enough sample in Lewisham to report on this.
- Nationally the percentage of physically active children and young people in Black communities (35.7%) was lower than in White British (47.7%) communities[72]. The sample of the survey is too small to provide data at a local area by ethnicity.
- Percentage of adults walking for travel at least three days per week (White British vs Black) – 14.7% vs 16.1% between 2019 and 2020[73].
- Percentage of adults cycling for travel at least three days per week (White British vs Black) – 2.2% vs 1.0% between 2019 and 2020[72].

Smoking

The national data for 2020 on smoking suggests that rates of current smoking are lower in Black communities than in White communities but are highest in those who identify with a Mixed ethnicity:[74]

- Mixed ethnicity – 17.1%
- White ethnicity – 12.6%
- Black ethnicity - 7.8%

Diet

We monitor dietary habits in population surveys through asking about the average daily consumption of five portions of fruit or vegetables, known as '5-a-day'. In 2017/18 nationally, the lowest percentages of those achieving '5-a-day' across ethnic groups was seen amongst Black adults (44.2% vs. 55.9% of White British adults).[75]

Alcohol

Data from 2014 showed nationally rates of those with hazardous, harmful or dependent alcohol levels was lower amongst people of Black ethnicity. 6.6% of Black men were featured in this category, compared to 30.8% of White British men. A similar pattern was observed amongst women (Black women = 7.4%; White British women = 14.8%)[76]

Sexually transmitted infections

The population rates of STI diagnoses is high among people of Black ethnicity nationally but varied amongst Black Caribbean and Black African ethnic groups. For example, in 2020, people of Black Caribbean ethnicity had the highest diagnosis rates of gonorrhoea and

[71] Department for Digital, Culture, Media and Sport (2022) *Ethnicity facts and figures - physical activity*
[72] Public Health England (2022) *Fingertips: Physical activity*
[73] Department for Digital, Culture, Media and Sport (2020) *Ethnicity Facts and Figures – Physical Activity*
[74] Public Health England (2022) *Fingertips: Local tobacco control profiles*
[75] Department for Digital, Culture, Media and Sport (2020) *Ethnicity Facts and Figures - Healthy Eating Amongst Adults*
[76] NHS Digital (2018) *Ethnicity Facts and Figures – Harmful and Probable Dependent Drinking in Adults*

trichomoniasis, while people of Black African ethnicity had relatively lower rates of these STIs.[77]

There are also significant differences in HIV infection between Black African and Black Caribbean communities. In the 2020 data on people newly diagnosed with HIV and accessing HIV care in England there were 526 new cases in Black African people with almost 60% of these being in women compared to only 55 in Black Caribbean and 62 in Black Other ethnic groups. In Black African (42%) and Black Other (53%) the percentage of people diagnosed with HIV late was higher than for White British (38%) but it was similar for Black Caribbean (37%), it is important to note that this difference is consistent when looking just at HIV diagnosis in people most likely exposed in the UK, suggesting that late diagnosis in Black African and Black Other communities is not just due to migration factors.[78]

Adult obesity

The percentages of adults who are overweight or obese is highest in people of Black ethnicity. In 2019/2020 the national data shows that 67.5% of Black adults were overweight/obese which is higher than White British (63.7%). The rates over excess weight in Black communities has decreased from 73.6% in 2018/19.[79]

Literature review

For this theme we were able to commission an academic provider to undertake a literature review. In the literature review, a total of 66 articles on Birmingham and 51 on London were included in research. Studies were dominated by the themes of mental health (n=77, 24.6%) and HIV/sexual health (n=53, 17%). There were 63 studies (20%) addressing the four areas of principal behavioural risk: physical activity (n=22, 7.1%), alcohol (n=17, 5.5%), smoking (n=16, 5.1%), diet/feeding practices (n=15, 4.8%).

This review has established that health behaviours result from a complex mix of individual and social factors. We often present individual behaviours in the context of the social circumstances in which they occur. Help seeking behaviour means, quite simply, admitting a need for support and relying on others for assistance. However, because of getting help from family, peers or the community this meant that health care was not being used as much.

More noticeable finding was, consistent to sociocultural factors (wider forces in cultures that affect the thoughts, feeling and behaviours), creating barriers to using health care services. These factors are obvious when looking at people being able to access mental health services. This is more heavily detailed in the mental health theme.

Cultural norms (the standards we live by) perceptions and practices among Black African and Black Caribbean people influenced behaviour risks to health. We could see this in people's choice of diet, how they fed their babies and young children, childhood weight and physical activity. Exposing parts of the body can be cultural and result in a barrier to seeking care because of feeling embarrassed.

Key findings [INFOGRAPHICS]

Headline: **Percentage of physically active adults by ethnicity**
White British – 63.1%
Black – 53.3%

[77] Public Health England (2020) *Sexually transmitted infections and screening for chlamydia in England, 2020*
[78] UK Health Security Agency (2021) *Official Statistics. HIV: Annual data tables*
[79] Sport England (2021) *Ethnicity Facts and Figures – Overweight Adults*

Headline: **Percentage of adult smokers by ethnicity**
White British – 14.4%
Black – 9.7%

Headline: **Percentage of adults achieving '5-a-day' in their diet by ethnicity**
White British – 55.9%
Black – 44.2%

Headline: **Harmful or dependent alcohol consumption by ethnicity and gender**

Black men – 6.6%
White British men – 30.8%

Black women – 7.4%
White British women – 14.8%

Headline: **Obesity in adults by ethnicity**
White British – 63.7%
Black adults – 67.5%

What did we find from the community and Board engagement?

The following quotes provide a summary of key findings from the engagement with members of the local Black African and Black Caribbean communities.

"Develop a positive health behaviours programme that does not require pharmaceutical intervention - this is fundamental".

"The 'big and Black is best' belief is very preached - trying to change the thoughts and attitudes towards being overweight and obese will require an entire cultural shift through populations - with the anti-establishment feelings/attitudes that exist I don't hold out much hope."

"Representation at the decision-making levels will not only help to create more appropriate strategies for our communities but also help to improve levels of trust in the system which is one of the fundamental issues."

The engagement highlighted the need for more culturally appropriate approaches to behaviour change in Black African and Black Caribbean communities and there were several discussions about how these need to recognise the barriers of trust and the need for recognition of culture and heritage in the approaches.

Opportunities for action

Theme 6: Healthier behaviours	
Who	**Opportunities for action**
Local Directors of Public Health	1. Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health

	behaviours, including health literacy training, social prescribing initiatives and group interventions.
Health Education England	2. Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.
Local Councils and NHS Integrated Care Systems	3. Provide long-term investment for trusted Black African and Black Caribbean grass roots organisation such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.
Local Directors of Public Health	4. Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.
Research funding bodies such as National Institute for Health Research (NIHR)	5. Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for community providers in 'action research' to concurrently deliver and evaluate interventions.
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	6. Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

Theme: Emergency care, preventable mortality and long-term physical health conditions

"[Information]…to be in a format that is understood."
Lewisham community member

"… services just want to give out medication and I find I can't relate to the service professionals."
Lewisham community member

The important principle behind public health is the prevention of ill health through the promotion of healthy behaviours. In this review, we have established the worrying trends in health inequalities leading to lower life expectancy for some groups, especially those from Black African and Black Caribbean deprived communities. The impact of these inequalities is played out in people becoming unwell and requiring emergency care, developing long term physical health conditions and dying prematurely.

We focused on exploring research literature that reported on the inequalities in 'Emergency Care and Preventable Mortality, and Long-Term Physical Health Conditions' for men and women from these African and Caribbean communities in the UK. When considering the inequalities (access, experience and outcomes) we were focusing on evidence of differences in the results that we could measure between the community groups.

Higher rates of acute disease and emergency care were experienced by Black African and Black Caribbean communities compared to their White equals. For example, there are higher numbers of bad outcomes and preventable deaths across these groups relating to COVID-19, maternity and stroke.

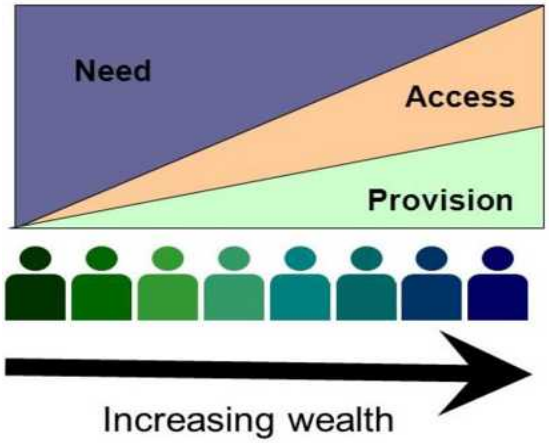
Inverse care law

The inverse care law was suggested 30 years ago by Julian Tudor Hart in a paper for *The Lancet*, to describe a relationship between the need for health care and its actual use. In other words, those who most need medical care are least likely to receive it. On the other hand, those with least need of health care tend to use health services more effectively.[80]

There is limited exploration of how this applies specifically to Black African and Black Caribbean communities but the evidence looked at by the Review strongly suggests it is applicable and needs to be addressed by services.

[80] Hart, J. T. (1971) 'The inverse care law', *The Lancet* 297(7696), pp 405-412. doi.org/10.1016/S0140-6736(71)92410-X

Figure 15: Summarising the Inverse Care Law



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Reducing Premature Mortality

The pathway of someone with a disease can be complicated and there are many opportunities for intervention to reduce the risk of someone dying from the disease. Early detection is important but also improving health behaviours can make a big difference as well to premature mortality. The Vital 5 (King's Health Partners) model is used to improve the population's health and reduce health inequalities by focusing on the Vital 5 areas which can reduce premature mortality (Fig 16). In the context of this Review these Vital 5 approaches could have a major impact in reducing the inequalities in death and disease affecting Black African and Black Caribbean communities if done in culturally competent ways.

Figure 16: The Vital 5 – Addressing the Front-End of the Complete Pathway of Care

The Vital 5 – addressing the front-end of the complete pathway of care

Overall Aim: Improve the population's health and reduce health inequalities by focusing on the Vital 5 to support prevention, detection, health promotion, management and treatment wherever there is an opportunity to do so.

Vital 5	Aim	Measured through
Blood pressure	to reduce stroke and heart attack, and improve well being	BP recording
Obesity	to reduce diabetes, renal dialysis, liver transplants, amputations and other comorbidities, and improve well being	BMI from height/weight recording
Mental health score	to reduce the burden of mental illness, improve physical health, recovery and well being	GAD or PHQ-9 score
Alcohol intake	to reduce liver transplants and malignant disease, to improve well being	volume and frequency questionnaire
Smoking habits	to reduce respiratory and malignant disease, and improve well being	volume and frequency questionnaire

Alternative text: The Vital 5 have been identified as the key 5 areas which can reduce premature mortality. These 5 with the aims and measurements are as follows:

- Blood pressure – aim to reduce stroke and heart attack and improve wellbeing, measured by BP recording

- Obesity – aim to reduce diabetes, renal dialysis, liver transplants, amputations and other comorbidities and improve wellbeing, measured by body mass index measurements taken by height and weight recordings
- Mental health score – aim to reduce the burden of mental illness, improve physical health, recovery and wellbeing as measured by use of GAD or PHQ-9 questionnaires
- Alcohol intake – aim to reduce liver transplants and malignant disease and improve wellbeing, measured through volume and frequency questionnaires
- Smoking habits – aim to reduce respiratory and malignant disease and improve wellbeing as measured by use of volume and frequency questionnaires

We set out the main findings from the evidence review, community engagement and stakeholder group sessions. The opportunities for action are given to improve Black African and Black Caribbean citizens' access to support and services.

What did we find from the rapid review?

In relation to preventable death we focused on two questions:

I. What are the health inequalities associated with emergency care and preventable mortality experienced by Black African and Black Caribbean people in Birmingham, Lewisham and the UK?

II. What evidence-based approaches are effective at preventing and addressing these health inequalities?

Acute disease and emergency care prevalence

- Males with chronic obstructive pulmonary disease (COPD) in the Black African and Black Caribbean population are more likely to seek emergency care, but less likely to be prescribed medication than similar White people.[81]
- Diabetes and poor glycaemic control lead to emergency care admissions and has higher rates in this population.[82]
- Dominant endocrine disorders for these groups are sickle-cell disorders and these frequently require urgent care for acute events.[83]
- There are higher rates of asthma in UK born Black and minority ethnic groups.[84]
- There are higher rates of strokes in Black African and Black Caribbean population due to hypertension, although other risk factors (smoking, coronary heart disease) are less common.[85]

Emergency care access

- People from an ethnic minority group (excluding non-White minorities) are 25% more likely to be a casualty than White pedestrians in trauma road accidents.
- Violent crime although has uneven reporting suggests high rates of gun and knife crime in areas of deprivation often involving young Black males.[86]

[81] Gilkes, A. et al (2016) 'Does COPD risk vary by ethnicity? A retrospective cross-sectional study,' *Int J Chron Obstruct Pulmon Dis* 11, pp 739-746. doi:10.2147/COPD.S96391
[82] Haw, J. S. et al. (2021) 'Diabetes complications in racial and ethnic minority populations in the USA,' *Curr Diab Rep* 21(1) doi:10.1007/s11892-020-01369-x
[83] Petersen, J., Kandt, J. and Longley, P.A. (2021) 'Ethnic inequalities in hospital admissions in England: an observational study,' *BMC Public Health* 21, pp 862 doi.org/10.1186/s12889-021-10923-5
[84] Asthma UK (2018) *On the Edge: How Inequality Affects People with Asthma*
[85] British Heart Foundation (2022) *How African Caribbean Background Can Affect Your Heart Health*
[86] Stott C, et al (2021) *Understanding ethnic disparities in involvement in crime – a limited scope rapid evidence review, by Professor Clifford Stott et al*

- There is an increased risk of admission observed for patients of Black or Black British ethnicity linked to poor management of chronic disease.
- General practices with higher proportions of Black or Black British patients were associated with higher rates of Accident and Emergency admissions. [87]

Preventable mortality (death)

- Poor outcomes for stroke were noted in Black African and Black Caribbean populations related to a limited awareness of symptoms and reduced health literacy, causing pre -hospital delay.
- The maternal death rate among Black women in England is growing and the gap between Black and White women in terms of their mortality rate is increasing.[88]
- Mortality rates remain exceptionally high for babies of Black and Black British ethnicity: stillbirth rates are over twice of those for babies of White ethnicity and neonatal mortality rates are 43% higher.[89]
- There is a significant difference among Black and other minority ethnic communities and the White population regarding deaths from Covid-19.[90]

Disparities in healthcare services

- Where Black and minority ethnic groups live in our cities' links to poorer quality primary care[91].
- Patients often head directly to hospitals and accident and emergency departments, either because of difficulties in gaining access to general practice or a lack of understanding of the processes and systems.
- Delays in seeking treatment cause complications, poorer outcomes or avoidable mortality[92].
- Criticisms of elements of the healthcare workforce exist and relate to maintaining institutional racism, lacking cultural and religious understanding, or recognising diversity.

What is preventable mortality?

Preventable mortality can be defined as the mortality rates for causes of death which are considered preventable. These are causes where all or most deaths could potentially be prevented by public health interventions in the broadest sense (subject to age limits if appropriate).

The trends observed across the populations are described below based on the data from the Public Health Outcomes Framework, Office for Health Improvement.[93]

- There are higher rates of preventable mortality in under 75-year olds in both Lewisham and Birmingham than the England average.

- There are higher mortality rates from all cardiovascular disease per 100,000 in the under 75-year olds in both Lewisham and Birmingham compared to the England average.

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[87] Scantlebury, R. et al (2015) 'Socioeconomic deprivation and accident and emergency attendances: Cross-sectional analysis of general practices in England', *British Journal of General Practice* 65, e649-e654. doi:10.3399/bjgp15X686893

[88] Government Equalities Office, Race Disparity Unit, and Badenoch, K. (2020) *Press Release: Government working with midwives, medical experts, and academics to investigate BAME maternal mortality*

[89] MBRRACE-UK (2021) *UK Perinatal Deaths for Births from January to December 2019*

[90] Public Health England (2020) *Beyond the data: Understanding the impact of COVID-19 on BAME groups*

[91] Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund.

[92] Gov.UK (2021) *Independent Report: Health. Commission on Race and Ethnic Disparities*

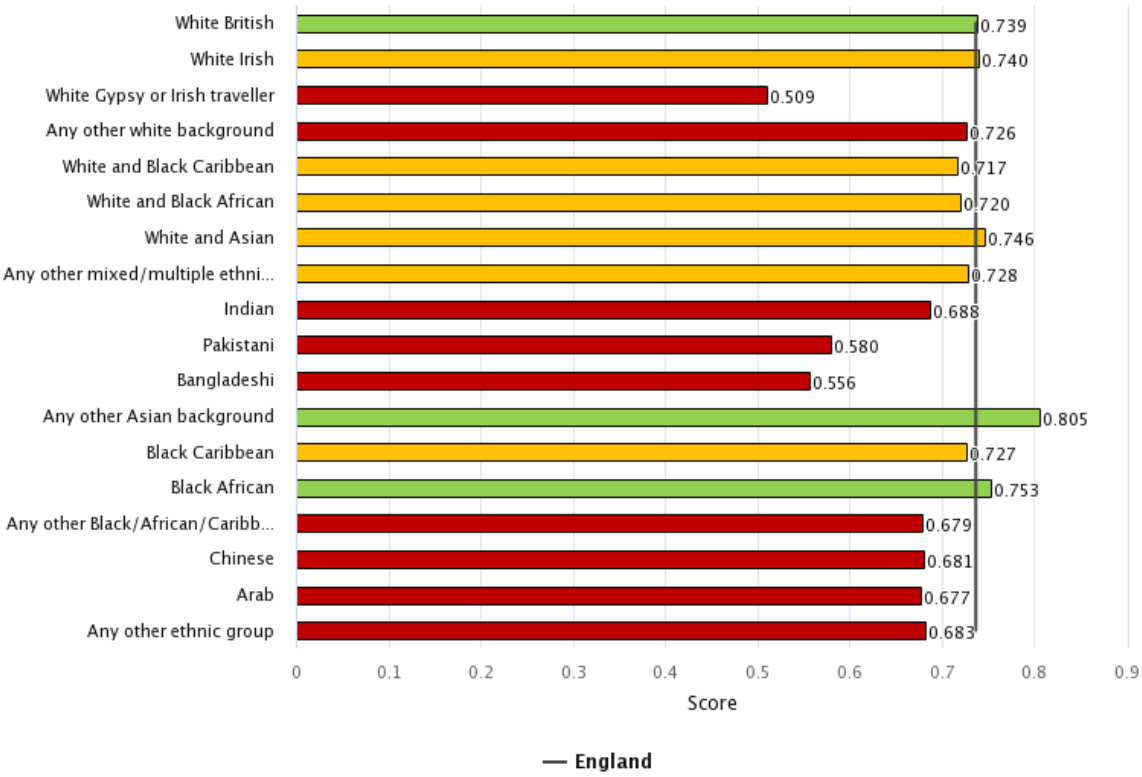
[93] Public Health England (2022) *Fingertips: Mortality Profile*

- The patterns observed in the death rates per 100,000 from ischaemic heart disease are lower in males of Black African and Black Caribbean ethnicities than White males in England and Wales.

- The patterns observed in the death rates per 100,000 from ischaemic heart disease are lower in females of Black African and Black Caribbean ethnicities than White females in England and Wales.

- The average health status score for adults aged 65 and over based on the GP Patient Survey showed similar scores reported for Black Caribbean and White older adults and better scores for Black African compared to the average score in England[94] (Figure 17).

Figure 17: Health related quality of life for older people (2016/17) – England, Ethnic Groups



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Long term conditions

According to the King's Fund,15 million people in England have at least one long-term condition. They affect wellbeing, social relationships and employment. Supporting people with long-term conditions uses 70% of the NHS budget and they are more common in older populations and those from disadvantaged backgrounds.[95]

In this review we considered the health inequalities associated with long-term physical health experienced by Black African and Black Caribbean people. We also wanted to know the evidence-based approaches that are effective at preventing health inequalities.

[94] Public Health England (2022) *Fingertips: Productive Healthy Ageing Profile*
[95] Raleigh, V. and Holmes, J. (2021) *The Health of People from Ethnic Minority Groups in England*. The King's Fund

We assessed the evidence from reviewing a wide-ranging selection of published material on health conditions and multimorbidity (the presence of two or more long-term health conditions).

We found:

- Higher rates of multimorbidity, polypharmacy and earlier onset
- Increased prevalence of diabetes mellitus, poorer glucose regulation[96]
- Earlier onset of cardiovascular and chronic kidney diseases
- Higher risk and earlier onset of some cancers.[Error! Bookmark not defined.] For example, the risk of being diagnosed with prostate cancer is approximately 1 in 4 for Black men and 1 in 8 for White men, within the UK[97]
- Lower rates of COPD[98] and Multiple Sclerosis[99]
- Inequitable change in healthcare.

Some of these inequalities have been well established for many years in research but there is very little evidence of evaluated interventions or evidence-based approaches to address these inequalities.

Healthcare:

- Increased hospital use associated with long-term conditions
- Fewer admissions with Alzheimer's disease[100]
- Increased referral delays and longer period of sickness absence
- Poor patient satisfaction[101]
- Reduced access to hospice care
- Barriers to engagement with services including communication difficulties, lack of resources, cultural and family dynamics and lack of awareness

There is some encouraging data in some areas, but inequalities remain higher with the burden of long-term health conditions for our Black communities.

Key findings [INFOGRAPHICS]

Headline: **Black African and Black Caribbean populations are more likely to seek emergency care**

Headline: **There are higher rates of asthma in UK born Black and minority ethnic groups**

Headline: **There are higher rates of strokes in Black African and Black Caribbean populations**

Headline: **The risk of being diagnosed with prostate cancer is approximately 1 in 4 for Black men and 1 in 8 for White men**

Headline: **Black communities carry a bigger burden of inequalities relating to long-term conditions**

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[96] Public Health England (2016) Diabetes *Prevalence Model*
[97] Lloyd, T. et al (2015) 'Lifetime risk of being diagnosed with, or dying from, prostate cancer by major ethnic group in England 2008–2010,' *BMC Medicine*. doi 10.1186/s12916-015-0405-5
[98] Gilkes, A. et al (2016). 'Does COPD risk vary by ethnicity? A retrospective cross-sectional study*', Int J Chron Obstruct Pulmon Dis*. 11, pp 739-746. doi:10.2147/COPD.S96391
[99] Amezcua, L. and McCauley, J. L. (2020) 'Race and ethnicity on MS presentation and disease course,' *Mult Scler*. 26(5), pp 561-567. doi:10.1177/1352458519887328
[100] Alzheimer's Society (2018) *Research suggests fewer Black men receiving dementia diagnosis*
[101] NHS Digital (2021) *Ethnicity facts and figures – patient satisfaction with hospital care*

What did we find from the community and Board engagement?

The following concerns and suggestions were shared with us by members of the local Black African and Black Caribbean communities.

"There should be more linked services within the NHS that is aimed directly at this ethnic group."

"Get a proper grasp of the barriers to accessing healthcare. Work with faith leaders to get the correct important out into the community."

"As previously stated, the environment in relation to long term physical health and preventable mortality. But to do this it exposes institutional racism and bias within areas of Authority particularly Planning Enforcement Highways and the police."

"Equality a word used by many organisations, but actions witnessed in these communities means inequality. It's just a nice word but has no meaning for many as the actions we experience does not imply Equality in Birmingham."

"Work on the locality model to ensure fairness and use organisations rooted in communities."

"Gateway receptionists need to more responsive and respectful"

"Undocumented slipping through the system", with "many die for fear of being reported"

"Social media becoming a 'source' for information and not necessarily good information 'misinformation'. Lack in confidence to 'challenge' GP's and healthcare professionals where they feel that they are not given sufficient information"

Through this engagement there was significant discussion of both structural and institutional barriers as well as issues of awareness and understanding of risk and these inequalities within communities themselves. Communities shared their frustration that solutions are often focused at patching up problems rather than addressing the root causes and were keen to see a step change in the approach.

Opportunities for action

Theme 7: Emergency care, preventable mortality and long-term physical health conditions	
Who	**Opportunities for action**
NHS England NHS Integrated Care Systems Local Councils	1. Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations. This should be supported by clear commissioning that requires data collection and analysis linked to all key relevant performance indicators. A specific example of where this can be rapidly done is through better use of the Friends and Family Test (FFT) and

	working with African and Caribbean communities so they engage with the tool and understand how it is used. There should also be better scrutiny and use of data from complaints and complements and this should be reviewed as part of contract monitoring and output data reported into system-leaders. This can also be strengthened through undertaking qualitative research to understand and overcome negative perceptions and experiences of health care for Black African and Black Caribbean communities to avoid delays in accessing care, including the influence of structural racism and discrimination. Through this better data and engagement, local areas should develop a more in depth understanding of the needs of communities in relation to emergency care, preventable mortality and long-term physical health conditions.
Local Health and Wellbeing Board and NHS ICS Partnership Board	2. Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include: • A team of community advocates who understand the needs and barriers for Black African and Black Caribbean communities, supporting them to 'navigate' and access support (e.g. social prescribing). • Use of faith and workplace settings to increase awareness and understanding of health issues to support informed decisions about health. • Investment in grass-roots organisations to recruit volunteers who can support Black African and Black Caribbean communities that may experience structural institutional racism when accessing services.
Local Directors of Public Health and NHS Prevention Leads	3. Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy. This could include: • Services considering evidence-based ethnic differences in outcome measures (e.g. BMI versus waist-to-height measures, age of heart disease issue onset for NHS Health Checks, depressive symptoms in childhood and influence on life-time physical health). • Work with communities to co-develop services that are accessible for Black African and Black Caribbean communities (e.g. opening times, location of delivery).

	• Work with communities to encourage and raise awareness about how to access health services, including investment and development of multi-service hubs and pop-ups based in community locations (e.g. Youth Centres, libraries, leisure centres, faith-based sites, universities, colleges, schools) • Contractual clauses that strengthen support for Black African and Black Caribbean communities when they experience racism while accessing services and offer tiered positive approaches that address reported issues. • Meaningful measurement of change and learning from communities and grass roots organisations being captured and informing service design, monitoring, improvement, and review • Whole system workforces, across all partners and professions including front-line, back-office and system leaders, to complete anti-racism training, with ongoing independent evaluation • Early help provision that supports communities when they do not meet statutory thresholds such as improved investment in grassroot organisations to provide social prescribing support (e.g. befriending, talking therapy, group therapy, forums and general health support).

Theme: Wider determinants of health

"We can't ignore the barriers that ethnic minority communities are facing"
BLACHIR engagement participant

Where we live, how we learn, what we do and when we earn all play a part in keeping us healthy. The wider determinants term describes the factors that can influence health outcomes and include education, housing, poverty, employment and the environment in which we live. These impact on our lives both directly as we experience them but also in the longer term driving the inequalities in health outcomes we have seen throughout the Review.
This Review highlighted the evidence on inequalities caused by wider determinants of health experienced by the African and Caribbean populations. Social determinants of health are summarised in the model by Dahlgren and Whitehead[7] which is highlighted in the methodology section of this report (see Figure 2).

In 2010, The Marmot review highlighted the need to make better progress on the social determinants of health. This is because social, economic and environmental factors can impact on health, influenced by the local, national, and international distribution of power. This progress has to be invested in more for communities that experience more inequalities including the Black African and Black Caribbean communities.

What did we find from the rapid review?

We found that poverty and the wider environment has influenced Black African and Black Caribbean's health.

We identified the main causes of inequalities:

- Higher levels of deprivation, overcrowded homes, higher unemployment rates and lower education level attainment
- Racism and discrimination
- Lack of cultural expertise and sensitive methods
- Higher rates of mental health issues.

There are ten wider determinants highlighted and included as part of this review.

Housing

Within England, more Black African and Black Caribbean communities live in overcrowded homes compared to White communities (16% and 7% respectively compared with 2%).[102]

Education

National data shows that temporary exclusions across various ethnicities show differences between students: White: Gypsy/Roma (21.26%) and Irish Traveller (14.63%), Mixed White/Black Caribbean (10.69%), Black Caribbean (10.37%), Black Other (5.91%), Black African (4.13%), Mixed White/Black African (4.13%). Permanent exclusions were similar.[103] [104]

In 2019/20 the percentage of students getting 3 A Grades at A Level in England was lower amongst Black Caribbean (9.1%), Black Other (11.2%) and Black African (12.7%) students compared to White British students (20.2%).[105]

Unemployment

Black people are more likely to be unemployed compared to England average in 2019, 8% of people of Black ethnicity were unemployed which is higher than rates of White British people (4%).[106]

Income

Nationally, Black households were most likely, out of all ethnic groups, to have a weekly income under £600.[106]

Stop and search

Within England and Wales, Black people are over three times as likely to be arrested as White people.[107] In 2020, there were 54 stop and searches for every 1000 Black people, compared to six for every 1000 White people.[108]

Crime

Among juveniles sentenced in 2017 within the UK, the Black ethnic group had a high percentage of offenders sent to a young offenders institution.[109] The evidence shows the disproportionate presence of Black people in the criminal justice systems is linked with racism and discrimination, worsening the negative impact on Black people's health and wellbeing, in particular their mental health.[110]

Deprivation

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[102] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures – Overcrowded Houses*
[103] Department for Education (2021) *Ethnicity Facts and Figures – Temporary exclusions*
[104] Department for Education (2021) Ethnicity Facts and Figures – Permanent exclusions
[105] Department for Education (2021) *Ethnicity Facts and Figures – A level grades*
[106] Department for Work and Pensions (2021) *Ethnicity Facts and Figures – Household Income*
[107] Home Office (2020) *Ethnicity Facts and Figures – Arrest Data*
[108] Home Office (2021) *Ethnicity Facts and Figures – Stop and Search Data*
[109] Ministry of Justice (2020) *Ethnicity Facts and Figures – Young People in Custody*
[110] Ministry of Justice and Youth Justice Board for England and Wales (2020) *Ethnicity Facts and Figures - Youth Justice Statistics: 2018 to 2019*

Nationally there are higher levels of deprivation among the Black African and Black Caribbean groups compared to White groups.[111]

Benefits and financial support

23% of people from Black ethnic groups within the UK receive income-related benefits such as help with the cost of housing. This is the second highest group after people of Bangladeshi origin.[112]

Cultural factors

Nationally, cultural factors such as family support, connectedness, sense of community, the influence of religion and ethnic density are viewed as protective factors. However, some research found these can also become barriers to accessing health and social care.

It is important not to assume and stereotype. While there have been a small number of faith leaders who have been against vaccination, many Christian denominations have no theological opposition to vaccines. Churches from different denominations have come together to help reassure Black members about the Covid-19 vaccine. [113]

Homelessness and fuel poverty

Lewisham has a higher percentage of homeless households from people of Black ethnicity compared to people in these groups in Birmingham and the rest of England.[114]

Figure 18: Percentage of those who live in overcrowded households and experience fuel poverty in England, Birmingham and Lewisham

	England	**Birmingham**	**Lewisham**
Overcrowded households (2011) [115]	4.8%	9.1%	12.4%
Fuel Poverty (2018) [116,117]	10.3%	14.2%	12.1%

Alternative text: The percentages of those who live in overcrowded households (2011) was higher in Lewisham (12.4%) than Birmingham (9.1%) and the England average (4.8%). The percentage of those who experience fuel poverty was higher in Birmingham (14.2%) compared to Lewisham (12.1%) and the England average (10.3%).

Key findings [INFOGRAPHICS]

Headline: **Black people in England are twice as likely to be unemployed as White people**

Headline**: Black households are more likely to have low income and live in deprivation**

[111] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures - People Living in Deprived Neighbourhoods*
[112] Department for Work and Pensions (2021) *Ethnicity Facts and Figures – State support*
[113] The Voice (2021) *UK's Black Majority Churches Want Their Congregations to Consider Taking the Covid-19 Vaccine*
[114] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures – Statutory Homelessness*
[115] Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures - Overcrowded households*

[116] LG Inform (2021) *Fuel poverty in Lewisham* - *LG Inform*

[117] Department for Business, Energy & Industrial Strategy (2020) *Ethnicity Facts and Figures – Fuel Poverty*

Headline: **Black people are over 3 times as likely to be arrested as White people and 9 times more likely to be stopped and searched**

Headline: **Overcrowding, homelessness and fuel poverty are more likely to be experienced by Black households**

What did we find from the community and Board engagement?

"All black areas even were my wider family live experience the same issues that have long term implications on long term health inequalities. It's not about more access or testing it's our environments that start many of these illnesses."

BLACHIR engagement participant

Community issues

Black African and Black Caribbean people often have strong family and community networks where they live. These are positive characteristics and can provide important individual and social connections, but they can also hinder help outside of the community bubble.

Protective factors

Cultural differences, especially those in family life, may be responsible for influencing Black African and Black Caribbean communities' health and wellbeing. Culture can also impact on how they seek health advice, achieve a healthier lifestyle and access health and social care services. It is evident from the findings that social, community and familial networks act as protective factors for Black communities. Protective factors act as a buffer for those at high risk of developing health and social problems.

Social, economic and environmental factors

Wider determinants of health have major influence on the wellbeing of our communities. Therefore, it is important to understand cultural identities, health beliefs and behaviour of the UK's diverse population.

Population diversity

Population diversity is complex and understanding it can be at best uneven. Health professionals can have poor cultural expertise with lack of language, underlying racism resulting in unfair treatment that can prevent access to health and social care.

.

"They have put us in a box, and I was thinking how we get out of it?"

Council elected member

The BAME and BME terms can present a standardised view of Black and ethnic communities. According to the UK government (GOV.UK) BAME (Black, Asian and Minority Ethnic) and BME (Black and Minority Ethnic) are not helpful descriptors because they emphasise certain ethnic minority groups (Asian and Black) and exclude others (Mixed, Other, and White ethnic minority groups). The terms can also mask differences between different ethnic groups and create misleading interpretation of data.

The Office for National Statistics (ONS) will have the most up to date national and local data on population diversity for the Black African communities in Spring 2022.

Our communities have said:

"*Root cause of health in many Black communities is environmental. My blood pressure is constantly high, kids have asthma, and some have neurological conditions which many have put down to accumulation of toxic fumes of industry and pollution."*

"Healthcare workers have been exposed to risk for years long before COVID. Along with many other gig economy workers who are exposed to risk daily but keeps the wheels turning. Many of the environments we live exposes us to many risks daily. Many know friends and family who have lost their positions due to vaccine mandates. Clap when it suits and dispose of when it does not."

"Food poverty is an issue that will grow in many areas, whether to eat or heat currently."

"Councils in the deprived areas of Birmingham seem to be doing the opposite if being truthful. Development plan for this area about twelve years ago spelt out the health inequalities. Twelve years later with all the data available studies and environmental laws, many residents now have chronic illnesses due to ever increasing exposure to exceeding air and noise pollution."

"Poor housing and traffic congestion adding to people's anxiety and stress levels"

Opportunities for action

Theme 8: Wider determinants	
Who	**Opportunities for action**
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	1. Consider cultural and religious influences when developing interventions to address the wider determinants of health inequalities for Black African, Black Caribbean and Black-Mixed ethnic minority groups.
Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations	2. Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.
Local Health and Wellbeing Boards	3. Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	4. Take action to address employment inequalities and issues around racism and discrimination affecting in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high-risk occupations.

Conclusion

Out of the huts of history's shame
I rise
Up from a past that's rooted in pain
I rise
I'm a black ocean, leaping and wide,
Welling and swelling I bear in the tide.

Leaving behind nights of terror and fear
I rise
Into a daybreak that's wondrously clear
I rise
Bringing the gifts that my ancestors gave,
I am the dream and the hope of the slave.
I rise
I rise
I rise.

An excerpt from 'I Rise' by Prof. Maya Angelou

The BLACHIR process allowed us to explore the evidence using a unique compilation of rich local data and intelligence as well as co-exploration with communities to better understand the challenges of persistent inequalities affecting Black African and Black Caribbean people in Birmingham and Lewisham.

The findings from the review clearly demonstrate that the system does not take enough notice of the needs and issues affecting Black African and Black Caribbean people as communities of identity in the UK. We are publishing alongside the Review report a more detailed data pack that we hope to evolve into a dashboard to track progress and impact following this report. We have also included in Appendix 2 recommendations for research that could help to close some of the clear evidence gaps identified through the Review.

These needs include fairness, inclusion and respect, trust and transparency, better data, early interventions, health checks and campaigns, healthier behaviours and health literacy.

This deficit is against a background of historical oppression, racism and discrimination and a clear and consistent repeating pattern of inequalities. This should not be allowed to continue.

This journey to address the needs has begun in our local areas with this review, working together to coproduce opportunities for action (see Appendix 1) for each of the eight themes explored. We commit to publish in a companion document case studies that demonstrate our work so that this can be shared and learnt from by other areas.

The review is submitting these opportunities for action to the respective local Health and Wellbeing Boards for their consideration and for the two local areas to take forward this work with their communities to build a better future and to break these cycles of inequality and disadvantage for African and Caribbean communities.

Acknowledgements and Credits

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The Voice (2021) *UK's Black Majority Churches Want Their Congregations to Consider Taking the Covid-19 Vaccine*

Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures – Statutory Homelessness*

Ministry of Housing, Communities and Local Government (2020) *Ethnicity Facts and Figures - Overcrowded households*

LG Inform (2021) *Fuel poverty in Lewisham - LG Inform*

Department for Business, Energy & Industrial Strategy (2020) *Ethnicity Facts and Figures – Fuel Poverty*

Appendix 1: Opportunities for action

Led by research and evidence with community feedback, our review has put forward a series of detailed opportunities for action that we determined will improve the lives and experiences of Black African and Black Caribbean communities across the UK.

7 key areas that need to be addressed across the 8 themes

Fairness, Inclusion and Respect ~ Trust and Transparency ~ Better Data ~ Early Interventions ~ Health Checks and Campaigns ~ Healthier Behaviours ~ Health Literacy

Theme 1: Racism and discrimination	
Who	**Opportunities for action**
Local Councils and Health and Wellbeing Board Partners	**1.** Pilot the removal of the colour language from ethnic coding and evaluate the impact on participation and experience of data collection.
Local Councils and Children's Trusts	**2.** Pilot the integration of discrimination and racism into the approaches to adverse childhood experiences and recognise this both in the assessment of children's needs and in the design of interventions to mitigate these adverse impacts.
Local Councils and Health and Wellbeing Board Partners	**3.** Review staff equality and diversity training to ensure that this is a core part of the delivery of training, co-delivered by diverse individuals with lived experience.
Local Councils and Education Partners	**4.** Work with education partners for all ages and local communities to explore how ethnic diversity can be further integrated into education to reflect the diverse cultures and various perspectives of history and experience.

Theme 2: Maternity, parenthood and early years	
Who	**Opportunities for action**
Local Integrated Care Systems (ICS) and NHS Trusts	**5.** Address any gaps in existing Maternity and Paediatric Health Professionals' training including topics on cultural awareness, learning from lived experience, awareness of inclusion practices and policies, and awareness of trauma caused by racism and discrimination and how to deliver sensitive care.
Local Integrated Care Systems (ICS) and NHS Trusts	**6.** Co-design online tool with communities to collect information on beliefs, cultural practices and traditions from ethnic groups. This resource could then be used for training to inform practice and communication with patients and service users.
Local, regional and national government, health organisations, care providers and advocates	**7.** Improve data collection by specific ethnicity considering the differences in ethnic background and nationality. Work with professionals who represent the ethnic minority groups to ensure a sensitive approach when collecting data.
Local, regional and national government, health, housing, voluntary	**8.** Support all women who are migrants, refugees, and asylum seekers, particularly those with no access to public funds, to access appropriate care during and post pregnancy, through

organisations and advocates for national protocols	appropriate support and protecting them from relocation or eviction.
Local Public Health and NHS services	**9.** Develop culturally specific and appropriate weaning support initiatives for Black African and Black Caribbean parents.

Theme 3: Children and young people	
Who	**Opportunities for action**
Local Councils, schools, colleges, universities, community groups	**10.** Provide guidance and support for parents and young people on applications and transition to secondary school and further education, including online information, support liaison officers, summer schools on core subjects and finance advice.
Local Integrated Care Systems (ICS), NHS Trusts	**11.** Develop culturally appropriate and accessible mental health services, including schools-based support, for young men and women to increase capability, capacity and trust to engage with services.
Local Councils, schools, regional and national government, and education organisations	**12.** Review educational approach and opportunity for targeted intervention to increase academic achievement for Black African and Black Caribbean children and young people. This should include support on sexual and reproductive health services for young people, sexual exploitation, gender specific interventions and rape culture.
Local Councils, Local Integrated Care Systems (ICS), NHS Trusts, care providers, and advocates	**13.** Address low pay and associated poverty for frontline workers who are disproportionately of Black African and Black Caribbean heritage.
Local Councils, Health and Wellbeing Boards, community and voluntary sector organisations	**14.** Work with trusted community centres and spaces to provide violence-free, accessible and attractive youth provision for access to wider opportunities, including through existing contracts and partnerships with Black-owned businesses and leaders.
Local Councils and climate change and air quality partners	**15.** Collaborate with African and Caribbean communities and their leadership on addressing air quality issues and continue with the in-depth work already in place with explicit consideration of these communities.
NHS Integrated Care Systems	**16.** Put in place interventions for Black African and Black Caribbean children and young people that address specific inequalities (e.g. sickle cell disease services), ensuring proportionate targeting and equality assessments of whole population interventions for issues they are disproportionately impacted by (e.g. low traffic neighbourhoods and school streets).

Theme 4: Ageing well	
Who	**Opportunities for action**
Local Public Health	**17.** Provide targeted screening services for chronic conditions in Black African and Black Caribbean older adults.
Local and national organisations, ICS, NHS Trusts	**18.** Campaign to raise awareness and increase uptake of community-based health checks in Black African and Black Caribbean older adults.

Local and national organisations, NHS Trusts, Mental Health services, First Aid England	**19.** Assess the availability of culturally aware services for mental health and evaluate current services to determine how they meet the needs of older Black African and Black Caribbean adults.
NHS England and NHS Integrated Care System Boards	**20.** Support initiatives to improve uptake of vaccinations in older African and Caribbean people, focusing on areas of higher deprivation.
Local Councils, local, regional and national organisations and advocates	**21.** Use life course approach and consider relevant findings from this review to develop interventions that help to mitigate health inequalities experienced by Black African and Black Caribbean older people.

Theme 5: Mental health and wellbeing	
Who	**Opportunities for action**
Local Public Health and Community Mental Health Trusts	**22.** Co-produce awareness campaigns aimed at Black communities to promote a better understanding of different mental illnesses, facilitate early interventions and self-referral in collaboration with carers, families, health services, community and faith centres.
Local NHS providers and Community Mental Health Trusts	**23.** Ensure practitioners use culturally competent (cultural understanding) trauma informed patient-centred engagement styles and interventions.
NHS Mental Health Providers and Commissioners	**24.** Ensure mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention.
Local Health and Wellbeing Boards and NHS Integrated Care Partnerships Boards	**25.** Promote cultural competency training within healthcare services, the criminal justice system, and the police force.
Local Health and Wellbeing Boards and NHS Integrated Care Systems	**26.** Apply the use of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

Theme 6: Healthier behaviours	
Who	**Opportunities for action**
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	**27.** Work with Black African and Black Caribbean communities and organisations to co-create and deliver culturally appropriate and accessible support on positive health behaviours, including health literacy training, social prescribing initiatives and group interventions.
Health Education England/ NHS England	**28.** Explicitly recognise racism and discrimination as a driver of ill health and put in place training and systems to enable trauma-informed practice and services.
National Government Departments and Local Councils and NHS Integrated Care Systems	**29.** Provide long-term investment for trusted Black African and Black Caribbean grass roots organisation such as faith groups, schools, voluntary and community sector organisations to deliver community-led interventions.
Local Directors of Public Health and	**30.** Work with faith settings to understand and utilise the positive role faith plays in healthier behaviour decision making.

Nationally the Office of Health Improvement and Disparities (OHID)	
Department of Business, Innovation and Skills and research funding bodies such as National Institute for Health Research (NIHR)	**31.** Address the evidence deficit in interventions for Black African and Black Caribbean communities through targeted investment in research, including capacity and skills development for community providers in 'action research' to concurrently deliver and evaluate interventions.
Local Directors of Public Health and Nationally the Office of Health Improvement and Disparities (OHID)	**32.** Undertake insight research with members of smaller Black African and Black Caribbean populations (e.g. Somali, Ethiopian and Eritrean) to understand health literacy needs.

Theme 7: Emergency care, preventable mortality and long-term physical health conditions	
Who	**Opportunities for action**
NHS England NHS Integrated Care Systems Local Councils	**33.** Ensure culturally appropriate data collection and analysis for service planning, monitoring and evaluation that distinguishes by ethnicity and gender for Black African and Black Caribbean populations. This should be supported by clear commissioning that requires data collection and analysis linked to all key relevant performance indicators. A specific example of where this can be rapidly done is through better use of the Friends and Family Test (FFT) and working with African and Caribbean communities so they engage with the tool and understand how it is used. There should also be better scrutiny and use of data from complaints and complements and this should be reviewed as part of contract monitoring and output data reported into system-leaders. This can also be strengthened through undertaking qualitative research to understand and overcome negative perceptions and experiences of health care for Black African and Black Caribbean communities to avoid delays in accessing care, including the influence of structural racism and discrimination. Through this better data and engagement, local areas should develop a more in depth understanding of the needs of communities in relation to emergency care, preventable mortality and long-term physical health conditions.
Local Health and Wellbeing Board and NHS ICS Partnership Board	**34.** Ensure that the engagement of Black African and Black Caribbean communities is meaningful and valued. This should include direct engagement and collaboration with representative organisations that is done in a way which is respectful, transparent and accessible, and considers and values participants' time and commitments. Mechanisms for doing this could include:

	• A team of community advocates who understand the needs and barriers for Black African and Black Caribbean communities, supporting them to 'navigate' and access support (e.g. social prescribing). • Use of faith and workplace settings to increase awareness and understanding of health issues to support informed decisions about health. • Investment in grass-roots organisations to recruit volunteers who can support Black African and Black Caribbean communities that may experience structural institutional racism when accessing services.
Local Directors of Public Health and NHS Prevention Leads	**35.** Ensure prevention services are fair, appropriate and consider the needs of Black African and Black Caribbean populations, and there is proactive work to address issues with health literacy. This could include: • Services considering evidence-based ethnic differences in outcome measures (e.g. BMI versus waist-to-height measures, age of heart disease issue onset for NHS Health Checks, depressive symptoms in childhood and influence on life-time physical health). • Work with communities to co-develop services that are accessible for Black African and Black Caribbean communities (e.g. opening times, location of delivery). • Work with communities to encourage and raise awareness about how to access health services, including investment and development of multi-service hubs and pop-ups based in community locations (e.g. Youth Centres, libraries, leisure centres, faith-based sites, universities, colleges, schools) • Contractual clauses that strengthen support for Black African and Black Caribbean communities when they experience racism while accessing services and offer tiered positive approaches that address reported issues. • Meaningful measurement of change and learning from communities and grass roots organisations being captured and informing service design, monitoring, improvement, and review • Whole system workforces, across all partners and professions including front-line, back-office and system leaders, to complete anti-racism training, with ongoing independent evaluation • Early help provision that supports communities when they do not meet statutory thresholds such as improved investment in grassroot organisations to provide social prescribing support (e.g. befriending, talking therapy, group therapy, forums and general health support).

Theme 8: Wider determinants	
Who	**Opportunities for action**
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**36.** Consider cultural and religious influences when developing interventions to address the wider determinants of health

	inequalities for Black African, Black Caribbean and Black-Mixed ethnic minority groups.
Local Councils, NHS Trusts, ICS, advocates for national standards, Criminal Justice System, community organisations	**37.** Collaborate with government agencies and institutions to remove issues ethnic minorities face when in contact with the justice system and ensure these agencies work to address health inequalities.
Local Health and Wellbeing Boards	**38.** Conduct more research to understand the impacts of the food environment and food poverty on health and wellbeing of Black African and Black Caribbean communities, and devise strategies to address the structural issues at a community level.
Local Health and Wellbeing Boards and NHS Integrated Care Partnership Boards	**39.** Take action to address employment inequalities and issues around racism and discrimination affecting in the public sector. Offer more protection for key workers from Black African, Black Caribbean and Black-Mixed ethnic backgrounds in health or other high-risk occupations.

Appendix 2: Research opportunities

Throughout the review there have been clear evidence gaps in the research, at times we have had to look at international evidence, which is not necessarily transferable to a UK context.

There remain significant data gaps in national collection and analysis of both NHS and Local Government data and these need to be urgently addressed in order to visualize and respond to the needs of ethnic communities. There may be a need for specific research to understand why, despite decades of policy initiatives, ethnic data collection and analysis remains so poor in the public sector.

The following are some of the research gaps that have been identified from this review's work:

- Understanding of the impact of culturally competent equality training on behaviours of professionals and on outcomes for patients/clients
- Understanding of the interventions that are most effective to improve health behaviours in different Black African and Black Caribbean communities
- Understanding of the linguistic barriers to health literacy for non-English speaking communities, especially in relation to mental health and wellbeing.

Pilots and research

Pilots and commissioned research will help to address knowledge gaps across the themes and may help identify the most effective culturally sensitive interventions to address health inequalities affecting Black African and Black Caribbean populations in Birmingham, Lewisham and the UK. In many areas the evidence is weak. Pilot schemes and small projects should guide further large-scale research and support the implementation of the opportunities of action identified as part of BLACHIR.