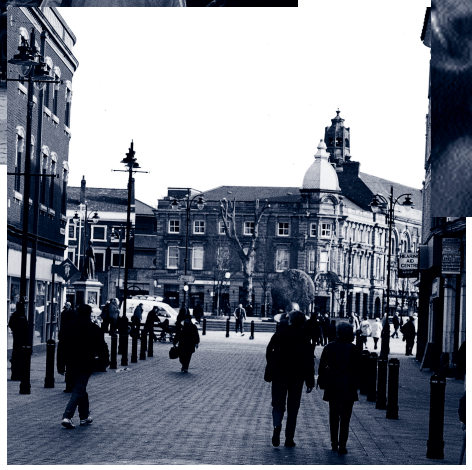
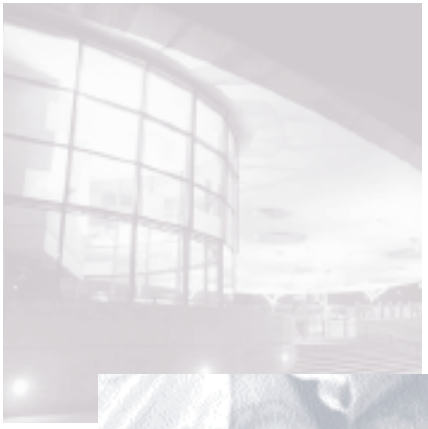
Walsall NHS
Teaching Primary Care Trust

Minority Communities Matter

The 2005 Annual Report of the Director of Public Health

Department of Public Health





Minority Communities Matter

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Glossary of Terms Relating to Ethnicity and Race

Asian
Strictly, this label applies to anyone originating from the Asian continent. In practice, this term is used in the United Kingdom to mean people with ancestry in the Indian subcontinent. In the United States, the term has broader meaning, but is mostly used to denote people of far Eastern origins, for example, Chinese, Japanese, and Filipinos. More specific terms should be used whenever possible.

Asian Indian
A term currently used synonymously with South Asian (see below), but with the important limitation that major South Asian populations such as Pakistani and Bangladeshi may not identify with it. This term is being used in North America to distinguish the population from Native Americans, previously know as American Indians.

African
A person with African ancestral origins who self identifies, or is identified, as African, but excluding those of other ancestry, for example, European and South Asian. This term is the currently preferred description for more specific categories, as in African American, for example. In terms of racial classifications, this population approximates to the group historically know as Negroid or similar terms. In practice, Northern Africans from Algeria, Morocco, and such countries are excluded from this category (see also Black).

Afro-Caribbean/African Caribbean
A person of African ancestral origins whose family settled in the Caribbean before emigrating and who self identifies, or is identified, as Afro-Caribbean. In terms of racial classifications, this population approximates to the group known as Negroid or similar terms (see also Black).

Bangladeshi
A person whose ancestry lies in the Indian subcontinent and who self identifies, or is identified, as Bangladeshi (see also South Asian). Between 1947 and 1971 the land knows as Bangladesh was East Pakistan and before that India. There is no clear cut equivalent in terms of racial classifications, though historically Northern Indians have been classified as white, and some Indian tribes as aboriginal.

Black
A person with African ancestral origins, who self identifies, or is identified, as Black, African or Afro-Caribbean (see African and Afro-Caribbean). The word is capitalised to signify its specific use in this way. In some circumstances the word Black signifies all non-white minority populations, and in this use serves political purposes. While this term was widely supported in the late 20th century there are signs that such support is diminishing.

Caucasian
An Indo-European. This is Bluemenbach's 19th century term for the white race of mankind, which is derived from the people who lived in the Caucasus. This term is usually used synonymously with Caucasoid, European, or White. Alone among terms derived from traditional race classification, Caucasian remains popular in both science and everyday language.

Chinese
A person with ancestral origins in China, who self identifies, or is identified, as Chinese. In terms of historical racial classifications, Chinese approximate to the group known as Mongolian or Mongoloid.

Ethnicity
The social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry, and physical features traditionally associated with race (see race). Increasingly, the concept is being used synonymously with race but the trend is pragmatic rather than scientific.

Ethnic minority group
Usually, but not always, this phrase is used to refer to a non-white population. Alternatively, it may be used to describe a specific identifiable group, for example, gypsy travellers, and less commonly, Irish in the UK. Some people consider the phrase inaccurate and prefer minority ethnic group, but the two phrases are used synonymously.

Ethnocentrism
The tendency to perceive and interpret from the standpoint of one's own culture. In epidemiology the tendency is reflected in the practice of using the White population as the norm or standard (see White).

European
European primarily means inhabitant of Europe, or one with ancestral origins in Europe. Effectively this is used in epidemiology and public health as a synonym for White (see below). Europeans are placed in the racial classification Caucasian, more recently known as Europid (the latter has not proved popular).

General population
Everyone in the population being studied, irrespective of race or ethnicity.

Hindu
An old, now seldom used term, for Indians. A term occasionally used more or less synonymously with South Asian. In some countries such as Holland the term is used to describe the ethnicity of Surinamese of Indian subcontinent ancestry.

Hispanic
A person of Latin American descent (with some degree of Spanish or Portuguese ancestral origins), who self identifies, or is identified, as Hispanic irrespective of other racial or ethnic considerations. In the United States this term, often used interchangeably with Latino, is considered an indicator of ethnic origin.

Indian
A person whose ancestry lies in the Indian sub-continent who identifies, or is identified, as Indian (see South Asian).

Indigenous
This term is usually used to mean a person who belongs naturally to a place in the sense of long term family origins (see Native). This term is sometimes used to identify the majority population, *eg* in the UK as an alternative to the word White.

Institutional racism
See Racism.

Irish
A person whose ancestry lies in Ireland who self identifies, or is identified, as Irish but this label is generally restricted to the White population (see White).

Majority population
When used in race/ethnicity studies this phrase is usually used as a synonym for White or European.

Minority ethnic group
See ethnic minority group. Increasingly used as the preferred phrase and replacing ethnic minority group.

Native
Sometimes this word is used to refer to populations born, or with family origins, in a place (see indigenous). This was also a perjorative term meaning populations belonging to a non-European and imperfectly civilised or savage race, so writers need to take care.

Non-Asian/Non-Chinese etc
This type of term is rarely defined but self evidently implies those not belonging to the group under study. This degree of non-specificity is not recommended.

Occidental
This is a very rarely used term meaning a native or inhabitant of the Occident (West), and effectively a synonym for European, but readers need to be aware of it as the antonym of Oriental.

Oriental
A term meaning a native or inhabitant of the Orient (East). This term is in occasional use in epidemiology, usually referring to Far Eastern populations. It is too general to be useful.

Pakistani
A person whose ancestry lies in the Indian subcontinent who identifies, or is identified, as Pakistani (see South Asian). Some Pakistanis may have birth or ancestral roots in the current territory of India but identify with Pakistan, a country created in 1947.

Race
By historical and common usage the group (sub-species in traditional scientific use) a person belongs to as a result of a mix of physical features such as skin colour and hair texture, which reflect ancestry and geographical origins, as identified by others or, increasingly, as self identified. The importance of social factors in the creation and perpetuation of racial categories has led to the concept broadening to include a common social and political heritage, making its use similar to ethnicity. Race and ethnicity are increasingly used as synonyms causing some confusion and leading to the hybrid terms race/ethnicity (see Ethnicity).

Racism/institutional racism
A belief that some races are superior to others, used to devise and justify individual and collective actions that create and sustain inequality among racial and ethnic groups. Individual racism is usually manifested in decisions

and behaviours that disadvantage small numbers of people. Institutional racism, whereby policies and traditions, sometimes unwittingly, favour a particular race or ethnic group, may be less obvious but may disadvantage large populations.

Racial prejudice
Negative beliefs, perceptions, or attitudes towards one or more ethnic or racial groups.

Reference/control/comparison
This refers to the standard against which a population that is being studied can be compared with to permit an analysis of similarities and differences. The concept is fundamental to epidemiology, and this terminology is preferable to non-specific ethnic or racial terms such as non-Asian, or general or even White population.

South Asian
A person whose ancestry is in the countries of the Indian sub-continent, including India, Pakistan, Bangladesh, and Sri Lanka (in terms of racial classifications, most people in this group probably fit best into Caucasian or Caucasoid but this is confusing and is not recommended). This label is usually assigned, for individuals rarely identify with it. See also Indian, Indian Asian, Asian, Pakistani, Bangladeshi.

Western
A person or populations with ancestry in a region conventionally known as the west, effectively European countries, as distinguished from Eastern or Oriental populations.

White
The term usually used to describe people with European ancestral origins who identify, or are identified, as White (sometimes called European, or in terms of racial classifications, the group known as Caucasian or Caucasoid). The word is capitalised to highlight its specific use. The term has served to distinguish these groups from those groups with skin of other colours (black, yellow, etc), and hence derives from the concept of race but is used as an indicator of ethnicity. There are problems of poverty and excess disease in subgroups of the White population which cannot be unearthed and tackled by using the label White.

Mixed and other race or ethnic group
This glossary omits a clear exposition on these terms, which require fresh thought. The increasing importance of the category mixed (ethnicity or race) is self evident. The increasing acceptance of sexual unions that cross ethnic and racial boundaries is adding both richness and complexity to most societies. The way to categorise people born of such unions is unclear and the current approaches are inadequate, partly because of the number of potential categories is huge. Another category seen in racial classifications is “other”, this permitting those not included to identify themselves, or be identified by the observer. In both instances the solution is, most probably, to offer space for free text response for people to identify themselves. These responses, however, need to be coded, analysed, summarised, quantified, and published.

Glossary adapted from Bhopal R. J Epidemiol Community Health 2004; 58: 441-5.

Foreword

Minority communities matter in Walsall. I refer to communities made up of Black and Minority Ethnic (BME) groups: people of African, Asian, Caribbean or other migrant group heritage or descent. They matter because these groups in the Walsall Borough have grown from 9.6% of the population in 1991 to 13.6% in 2001, representing an increase of almost 39%. This increase continues. Indeed, Walsall has one of the highest ethnic minority populations in England. Only 45 other local authorities, out of a total 376, have a higher proportion of BME groups. In Walsall, they are primarily made up of Indian, Pakistani, Caribbean, and Bangladeshi people. This report largely refers to them and their health needs; with little reference to smaller groups such as asylum seekers, refugees, Chinese, Eastern Europeans, *etc*.

Unfortunately, minority communities also matter in Walsall and elsewhere from a negative perspective, because people are still adjusting to population change. So many migrant BME groups arrived in Britain after the second world war, providing a much needed workforce to build up and sustain the economy. Of course, as immigrant numbers started to increase, along with many other urban areas across the country, Walsall communities started to change. In some neighbourhoods, BME groups now comprise a majority of the local population. Earlier tensions were inevitable, given such a dramatic population change over a relatively short period of a few decades. Although such tensions are lessening with time, the general public may still discriminate against minority communities based on their skin colour, foreign culture or religion.

This report is timely since Walsall Teaching Primary Care Trust has just published its Race Equality Scheme 2005 – 2008, which identifies what actions will be taken in health and social care planning that reflect the diversity of people we serve and employ. In terms of health, it is important to eliminate unlawful discrimination, to provide equality of opportunity, and to promote good relations between people of different ethnic groups. Thus, minority communities matter in terms of health since it is important to ensure equality and equity of access to available services. Also, minority communities have their own specific health needs. For example, they are a generally younger population who have higher risks of diabetes,

cardiovascular disorders, and chronic liver disease; so posing a significant future burden on health.

On an upbeat note, minority communities matter because diversity is enriching society. Witness the cosmopolitan make up of our British sporting idols and media personalities, the choice of restaurants, and the mix of languages. Many young South Asians born in Walsall speak with a Black Country accent, considering themselves no different from the rest of society. Our youth are hope for the future and signify an even better future integration. Still, for some time yet, there will be a need to focus on the health of BME groups. This report is all about maintaining such an awareness and I sincerely hope it will make a significant contribution.

Dr Sam Ramaiah
Director of Public Health
October 2005

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Disclaimer
The names of people used in this report to provide case studies bear no relation to the actual identity of Walsall residents.

Chapter 1

Introduction and Overview

Black and Minority Ethnic groups or BME groups, refer to people of African, Asian and Caribbean heritage or descent, and may also include other migrant communities. The term usually refers to non-Whites and incorporates several different ethnic groups. In Walsall, BME groups largely comprise people of South Asian (Indian, Pakistani, Bangladeshi, and Sri Lankan) and Caribbean origin. Refer to Glossary (Bhopal 2004). These communities may be discriminated against because of their race, ethnicity or skin colour. Associated factors are often culture and religion.

There has been considerable interest in the health of BME communities in Britain since the early 1980s. Under its agenda for change in the mid 1980s, the National Association of Health Authorities and Trusts drew attention to the health needs of BME groups. Marmot *et al* (1984) produced a classic study of ethnicity and health that became a model for others to follow. Balarajan & Soni Raleigh (1993) related work on ethnic variations in health to the Health of the Nation targets. Interest continued into the early 1990s, and became very much a part of the health inequalities agenda from the mid to late 1990s. However, it should be emphasised that while ethnic differentials in health are often strongly related to deprivation and socioeconomic disadvantage, membership of an ethnic minority group does not always result in poor health. For example, in the case of alcohol consumption and smoking, it is the White British group that shows the highest rates. The interest in the health of BME communities in Walsall has been considerable and consistent, as witnessed by a recent report of the Walsall Primary Care Trust (2003), aptly titled: *Walsall: who we are and how we live*.

A useful early bibliography of health among BME groups was provided by Karmi & McKeigue (1993). Incidentally, Paul McKeigue was part of Marmot's group at the London School of Hygiene and Tropical Medicine, and was instrumental in publishing coronary heart disease among South Asians living in London; drawing attention to strong links with abdominal obesity, insulin resistance, and the metabolic syndrome

(McKeigue *et al*, 1988). Coronary heart disease among South Asian populations has recently been described as an epidemic (Patel & Bhopal, 2004).

According to Nazroo (1997), variations in health across ethnic groups appear to have been of interest for three, potentially conflicting, reasons:

1. In an explanation of the position of BME groups in Britain, health is a crucial experience. Health is very much a reflection of the social position of these groups, and so ethnic variations in health are an important part of understanding the disadvantages faced by BME groups.
2. How a disease is socially patterned provides important clues for investigation of its aetiology, so if a particular group is at greater risk of a particular disease, then something about the attributes of that group must be elevating its risk.
3. The planning and provision of appropriate health care services, in that the needs of BME groups have not necessarily been considered.

These issues have been further explored by Modood *et al* (1998) in the social context, by Bhopal (2000) from the standpoint of aetiological investigation, and by Senior & Bhopal (1994) in trying to match the aetiological approach with that directed at health care planning. Many other authors have attempted to tackle these issues.

This report cannot explore such issues around ethnic minorities in depth, no matter how interesting or important. The major purpose has to be that of imparting an awareness of diversity, and how much it may be affected by access to health services, quite aside from issues around discrimination; and that of showing how membership of certain groups can be associated with higher risks of important diseases. Many pieces of work relating to BME groups and health have been carried out in Walsall and this report provides an opportunity to pull it all together.

Before launching into a description of the health of Walsall's ethnic minority population, it should be noted from the work of the London Health Observatory (2003) that:

Our understanding of ethnic inequalities in health and health care is seriously compromised by the lack of data collection on ethnicity and by the incomplete collection of ethnicity data that may be of poor quality Within hospitals, where ethnic monitoring has been mandatory since 1995, there is still enormous variation in meeting minimum coding requirements and much work still remains to be done here in Walsall.
Because of the poor quality data, there has been a reluctance to develop tools to help understand what ethnic differentials in access to health care mean for commissioning services.

While there is a commitment to implementing the requirements of the new Race Relations Amendment Act in the NHS, the strategy for doing so is inconsistent.
Bear in mind that London has one of the most ethnically diverse populations in the world, with 40% from BME communities, and 50% or more in nine boroughs. Thus, a complete picture of Walsall's BME communities in terms of health can certainly not be expected at the present time.

Lack of BME data and the challenges

Absence or poor quality ethnic group data precludes even the most basic of audits of access to health care

Need and appropriateness of treatment is difficult to establish since few trials on interventions and disease management contain BME groups

Few attempts have been successful in assessing whether there is equity of access to services based on patient ethnicity, especially since there needs to be an adjustment for the confounding effect of socio-economic status

There has been widespread neglect of the impact of racial discrimination and racism on health and health care disparities across ethnic groups

While ethnic disparities in health continue to be attributed to genetic and non-specific cultural explanations, evidence suggests that socio-economic factors and the experience of racism may be among the most important causes of these disparities.

London Health Observatory (2004)

It is of concern that discrimination and racism in the NHS still need to be tackled some 10 years after efforts were made to take up the challenge; for example, by the King's Fund in developing a toolkit to support health organisations to develop culturally competent services (Chandra, 1996). The aims of the toolkit were to:

- Assess how far progress was being made on culturally competent services and decide priorities for action
- Ensure health needs of BME communities are integral to commissioning
- Identify examples of good practice
- Adopt quality standards
- Point to useful sources of further information.

This was deemed essential to tackle racism, social and economic circumstances, and discrimination.

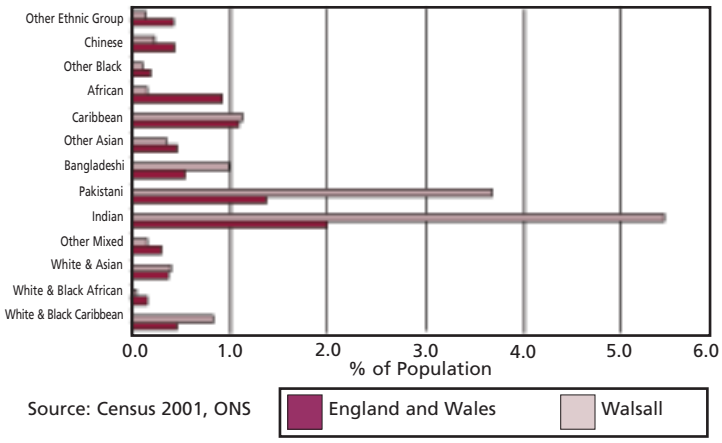
The Population of Walsall

Population issues are further explored in other documents (Griffiths, 1999; Walsall Primary Care Trust, 2003; Neal, 2004).

Four Walsall generations

The BME population of Walsall encompasses a complex range of different language groups, cultures, religions, and geographical regions of origin. The population also stretches across four generations; providing a complex and intricate weave of experiences, characteristics, expectations, values and beliefs, that divide the first generation of Walsall ethnic communities from their grandchildren and great grandchildren. With this has come…a breakdown of family and traditional cultures… a move away from traditional values and beliefs…divorce rates going up…high single parent families.. more mixed race families…. (Bains, 2005)

Figure 1:1 Ethnic diversity in Walsall and England and Wales, proportion of people by ethnic group, 2001.



Source: Census 2001, ONS

Table 1:1 BME populations in the Birmingham and Black Country PCTs

Primary Care Trust	All People	Number in BME Groups	% in BME Groups
Birmingham & the Black Country	2,254,744	447,116	19.83
Dudley Beacon & Castle	111,959	9,785	8.74
Dudley South	193,196	8,346	4.32
Eastern Birmingham	208,570	40,171	19.26
Heart of Birmingham	250,735	172,932	68.97
North Birmingham	160,279	14,137	8.82
Oldbury & Smethwick	87,936	26,706	30.37
Rowley Regis & Tipton	91,126	9,714	10.66
Solihull	199,517	9,57	4.77
South Birmingham	357,503	51,230	14.33
Walsall Teaching	253,502	34,434	13.6
Wednesbury & West Bromwich	103,842	19,979	19.24
Wolverhampton City	236,582	51,173	21.63

Source: Census 2001, ONS, reproduced from the BBC StHA A Strategic Framework for Health and Health Services in Birmingham Solihull and the Black Country, 2004-2010

Table 1.2: The changing ethnic minority composition of Walsall over a decade, proportion of people by ethnic group, 1991 and 2001

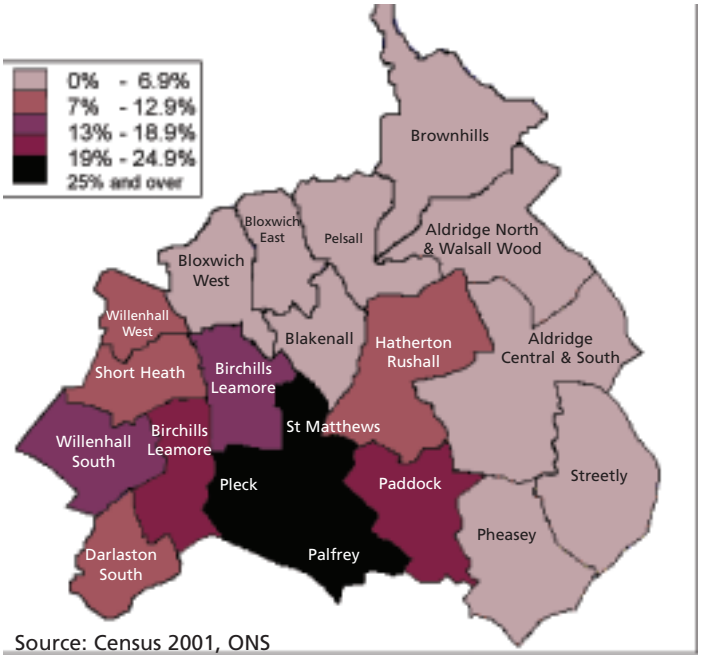
	1991	2001	Change
White	90.4	86.41	-4.0
Black or Black British	1.3	1.4	0.1
Asian or Asian British	7.6	10.5	2.9
Chinese or Other	0.7	0.4	-0.3
Mixed	N/A	1.4	N/A

Source: Census 2001, ONS

Figure 1:1 shows the composition of the BME community in Walsall as defined in this report. In Walsall, the Indian and Pakistani populations are the largest ethnic minority groups, together comprising 9% of the population. Walsall has one of the highest ethnic minority populations in England. In 2001 13.6% of the Walsall population (34,434 people) reported belonging to a BME group. In England and Wales the figure was 8.7% (4,521,050). Only 45 other local authorities, from a total of 376, have a higher proportion of minority ethnic groups.
There are large ethnic minority populations within Birmingham and the Black Country area.

Table 1:1 shows that BME groups are largely concentrated in the Heart of Birmingham, South and East Birmingham, Oldbury and Smethwick (Sandwell), Wolverhampton, and Walsall. A profile of poverty and health in Walsall was produced in the late 1990s (Griffiths, 1999), and drew attention to the distribution of BME groups across Walsall. That data was based on the 1991 Census.

Map 1:1: Ethnic diversity across Walsall wards, proportion of people by ethnic group, 2001

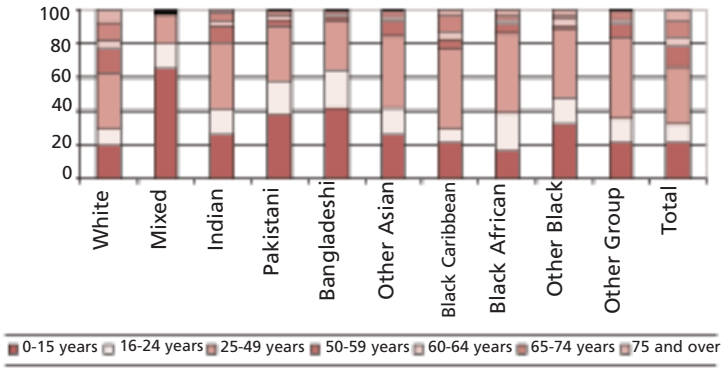


Source: Census 2001, ONS

Since 1991, the BME population of Walsall has grown from 9.6% (24,794) to 13.6% (34,434), compared with 5.9% to 8.7% in England and Wales. This is an increase of almost 39%. The total population in Walsall has fallen by 3.1% since 1991. Table 1:2 breaks down the changing composition of the ethnic groups in Walsall over a decade into more detail. The concentration of Walsall's BME population varies across Walsall. Map 1:1 shows that the wards with the highest ethnic minority population in 2001 were in the south of Walsall, in particular, Palfrey (48%), Pleck (39%) and St Matthews (38%). In addition, over 20% of the populations in Paddock, Bentley and Darlaston North comprise BME groups (Walsall Primary Care Trust, 2003).

The age profiles of each ethnic group are very different. Figure 1:2 illustrates that the Mixed groups have a proportionally younger age population than the profile for the whole population. In Walsall, 80% of the Mixed population are under 25 years compared to 30% of the White population. Only 1% of the Mixed population are over 65 years compared to 16% of the White population. The Pakistani and Bangladeshi groups also have relatively young populations with 60% of their populations being under 25 years of age and around 4% being over 65 years old. The Indian population has an older age profile than the other Asian groups with 40% of the population being under 25 years and 7 % over 65 years. Black groups show marked differences to each other, the Asian and the whole population. The Black Caribbeans have a peak in their profile between the ages of 25-49 years. Other Blacks have a similar peak in the 25-49 age group and an additional peak in the 0-25 age group. These patterns suggest that the BME population, and in particular the Mixed population, will continue to grow in Walsall, in terms of numbers and their health needs over the next 20 years. This report explores these issues in more detail.

Figure 1:2: Age and ethnicity in Walsall, proportiopn of people by age and ethnic group, 2001.



Source: Census 2001, ONS

Asylum seekers

In March 2005 there were over 470 known asylum seekers in Walsall. Of those, 395 were registered with the local authority for housing. These 395 asylum seekers are being housed in over 180 residencies across Walsall. Of those, about 150 are family households with the remainder being single people households. Only 70% of the available housing for asylum seekers is occupied currently. This number is declining. From December 2005 there will be no asylum seekers housed by the local authority. As flats become vacant they are being emptied and returned to the local housing group. No new clients have been received since February 2005. The majority of asylum seekers who were

registered in Walsall Local Authority housing in March 2005 were from the Congo (15.3%), Iran (13.1%), Somalia (13.1%) and Zimbabwe (8.2%). That equates to almost half of asylum seekers; the rest are predominantly from African countries and the Middle East. Of the asylum seeker households in Walsall only 21.3% can speak some English. The major languages spoken are French (15.8%), Farsi by Iranians (11.5%), with the African languages Somali and Swahili being spoken by about 8%.

Wider determinants of health

Table 1:3: No qualifications, proportion of people aged 16-74 years by ethnic group, 2001

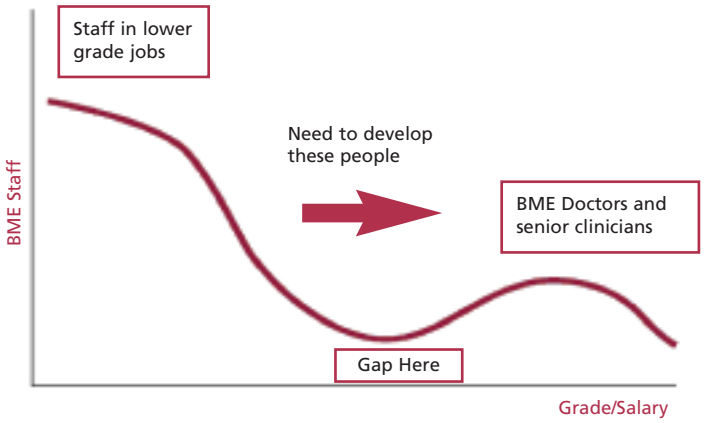
	Wmids	Walsall
White	33.5	42.7
Mixed: White & Black Caribbean	29.1	35.4
Mixed: White & Black African	21.5	12.1
Mixed: White Asian	26.7	29.6
Mixed: Other Mixed	21.6	23.5
Asian or Asian British: Indian	34.7	38.4
Asian or Asian British: Pakistani	51.4	56.5
Asian or Asian British: Bangladeshi	53.6	55.7
Asian or Asian British: Other Asian	35.5	39.0
Black or Black British: Black Caribbean	32.6	34.2
Black or Black British: Black African	15	10.1
Black or Black British: Other Black	23.8	31.4
Chinese	27.1	45.1
Other Group	28.5	22.9
Total	**34**	**42.7**

Source: Census 2001, ONS

Research has shown that educational attainment is strongly related to health status. Historically, Walsall has had poor levels of educational attainment with 43% of Walsall residents aged 16-74 years having no educational qualifications. Table 1:3 shows that, in Walsall, Pakistanis and Bangladeshis have the highest percentage of people aged 16-74 years that attained no educational qualifications, with Black Africans having the lowest proportion. This is likely to be a reflection, in part, of the age structures of these populations.

Health inequalities, race inequality and economic deprivation are closely correlated. However, economic status alone cannot explain inequalities in health and pattern of disease in these groups. People are considered to be economically active, or in the labour force, if they are aged 16 years and over and are either in work or actively looking for work. Figure 1:3 shows that BME staff employed in the NHS predominate in lower grade jobs and there is a further peak among doctors and senior clinicians. However, middle grade and management jobs show a dearth of BME people (Birmingham and the Black Country Strategic Health Authority, 2004).

Figure 1:3: A schematic diagram showing the "gap" in employment for BMR staff in the NHS



Source: Census 2001, ONS, reproduced from the BBC StHA A Strategic Framework for Health and Health Services in Birmingham and the Black Country, 2004-2010[ii]

Employment is positively correlated with good health. The recent report from the Prime Minister's Strategy Unit (2005) - *Ethnic Minorities in the Labour Market* - can be summarised as follows:

- BME groups have lower levels of economic activity than White groups, and also have higher levels of unemployment
- There are variations across age. Younger people from BME groups (aged 16-24 years) have some of the lowest rates of economic activity, especially people of Pakistani and Bangladeshi descent, along with Black people
- BME groups, on the whole, have lower levels of occupational attainment and progression than White groups, particularly Pakistani and Bangladeshi men
- Half of Pakistani and Bangladeshi working households have incomes that are 50% below the national average income
- Even when a range of factors, such as age, gender, and qualifications are held constant, ethnic minority groups still have a worse position in the labour market. This, in part, can be attributed to racism and discrimination.

The Commission for Race Equality has examined this report and concluded that racial discrimination is a significant factor in disadvantaging BME groups. There are still significant disparities between BME groups and others, both in achievement in the labour market, and in income levels. People of Black, Pakistani and Bangladeshi descent suffer particular disadvantage. Although difficult to quantify, one of the factors that research has identified as being responsible for this is racial discrimination. For example, the Commission for Race Equality (1980, 1994) found that White applicants were twice as likely to be accepted for an interview compared to either Black Caribbean or Asian applicants.

HAZ Projects

A number of Health Action Zone (HAZ) projects, particularly in the South of Walsall, have addressed BME issues. For example:

1. **Home-School Liaison Project, South HAZ**
   This project, funded by South HAZ and SRB5, was established as a result of parents, local communities and school staff recognising the need to develop initiatives to bring together schools and families in order to raise educational achievement. The Home School Liaison Team has delivered and supported a number of initiatives including: self esteem sessions, behaviour management courses, positive action programme for Black boys, English Speakers of Other Languages (ESOL) sessions, parent support classes, *etc.*
   A total 265 children have been helped on a one to one basis for whom:
   - 145 had improved attainment levels
   - 56 had improved personal and social skills
   - 34 had increased attendance levels
   over 200 parents and families have been supported.

2. **Speech Therapy Bi-lingual Co-workers, South HAZ**
   Bi-lingual co-workers, covering Gujarati, Bengali, Urdu and Punjabi have been employed within the Speech Therapist Service since 2000. The need for a specialist co-worker was identified by the service when the review of setting up Walsall's own interpreting service was underway. It was clear that an interpreter would not necessarily pick up a speech problem with a child who spoke their mother tongue and that specialist trained workers were required, from within the community of Walsall. By intervening at a crucial age, the service is able to support children who would otherwise been seen as having problems in adjusting from their mother tongue to English.

   The service recruited three local people who have been trained and developed to provide this specialist service. The bi-lingual co-workers are studying the Speech and Language Therapy Course at the University of Central England. In another five or six years time these workers will be fully qualified Speech Therapists. Sure Start in Walsall has picked up and further integrated this work within its programmes. Children going into school are more able and confident in progressing in both their mother tongue and English language.

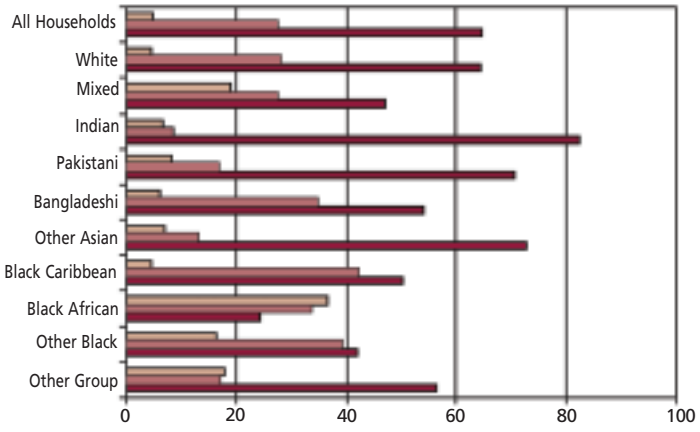
3. **Communication and Translation Service (CATS), South HAZ**
   The project provides a high quality interpretation and translation service which meets the language and communication needs of Walsall's ethnic and linguistic minority communities and public and private sector agencies. Service providers are assisted in achieving their equal opportunities policies by preventing discrimination on the grounds of language.
   - Provision of 26 languages
   - Recruitment of 65 interpreters
   - Production of service information booklet
   - Design of service logo and title.

Factors impacting on health

1. BME groups fare worse on employment, education, burglary and unfit housing and road safety, although Indian pupils have the highest educational attainment.
2. Bangladeshi people are the most deprived of all ethnic groups, having very high levels of unemployment, the worst housing conditions and, along with Pakistani people, the least educational success.
3. There is a high unemployment rate among young Black and Asian people.

4. The growing population of BME pensioners is facing discrimination and less access to public services as they get older.
5. The highest concentrations of BME populations are in deprived areas, although there has been significant movement of certain communities to more affluent areas.
6. Variations in infant mortality and life expectancy have been related to the level of deprivation in an area, with more deprived areas showing the poorest health.

Figure 1:4: Tenure of Walsall households, proportion of people by ethnic group 2001



Source: Census 2001, ONS

Owning your home has been shown to have a positive influence on health, with home owners reporting lower crime and nuisance, less damp, and fewer injuries in the home (Filakti & Fox, 1995). Across the West Midlands, the highest level of home ownership is seen among the Indian population, with 81.4% owning their own home compared to 82.4% overall across Walsall. The lowest level of home ownership is among the Black Africans, who tend to rent privately.

Figure 1:4 shows the breakdown in Walsall. Almost 40% of all Asian households are in unsuitable housing, compared with only 10% of White households. In the West Midlands, over one in four Pakistani homes (27.0%) do not have central heating, compared to less than one in twelve Indian (7.7%) or Chinese (7.6%) homes. In terms of overcrowding, the Census reported that in Walsall only 6% of White people lived in homes categorised as overcrowded, whereas 38.4% of Bangladeshi households are categorised as overcrowded. Overcrowding is defined as having at least one room too few for the number of people living in a household. Asian households have the highest average household size with an estimated 3.77 persons per household, compared with a borough average of 2.47.

There are clear differences in the composition of households by ethnic group. In the West Midlands there are a high percentage of White (15.2%) and Black Caribbean (10.8%) pensioners living alone. The Bangladeshi and Pakistani population tend to be made up of married couples with dependent children, whilst the Black ethnic groups tend to be living alone. White families are more likely to be pensioner households than any of the BME groups.
The Birmingham and the Black Country Strategic Health Authority, 2004 report can be commended for taking a wider view of race equality, as stated in its title for a strategic framework for health and health services. BME groups will grow significantly over the next 20 years; the profile of its members is younger than the population as a whole; and there will be a significant growth in the number of people classifying themselves as Mixed race. Key findings of the report are.

General:

- Those BME people now approaching middle age will use health services significantly more in the next 10 to 20 years
- Race inequality is closely related to health inequality and economic deprivation
- Any action to reduce health inequality will also reduce race inequality, but this should not ignore specific focus on ethnicity, *eg* many groups, especially Pakistanis and Bangladeshis, manifest inequalities in health and patterns of disease that cannot be explained wholly by economic status.

It is important to emphasise race equality because:

- It is important to build up the confidence of BME groups in our health services, to improve access, and attract potential employees
- There is a need to reverse the perception that the NHS is failing the needs of various groups within BME populations
- The Race Relations (Amendment) Act 2000 places a duty on the NHS to eliminate unlawful

racial discrimination and promote equality of opportunity.

Note:

- Heart of Birmingham and Walsall teaching PCTs are jointly looking at ways to make the workforce reflect the populations that they serve.
- It is important to address specific health issues such as diabetes, coronary heart disease, infant mortality rate, and other areas that are not wholly related to social class. Chronic disease, such as diabetes and mental ill health, has a higher incidence among BME groups, and access issues and a healthy start to life are highly relevant here.

Barriers to access:

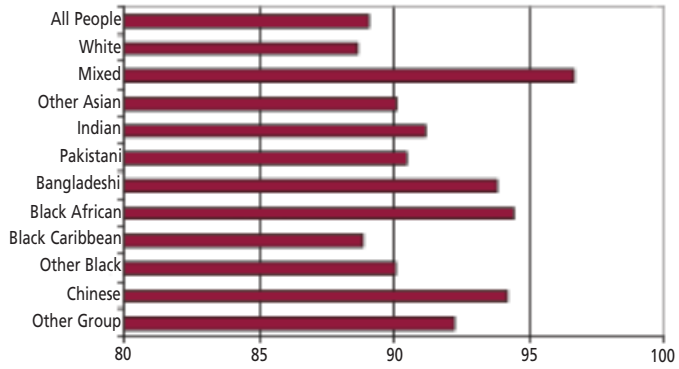
- Although access is fine overall among BME groups, Pakistanis and Bangladeshis experience relatively low levels
- Glaucoma among Africans and Caribbeans tends to be treated later
- Black people with mental health problems are more likely to be given drugs alone rather than counselling
- Bangladeshi women generally show less than half the average rate of cervical screening uptake
- The NHS has generally been slow to target services for sickle cell disease (impacts on BME groups) than for haemophilia
- Problems of language and difficulties in navigating through the NHS system abound among BME groups, who are also slower to demand choice and quality.

There is a need for more BME coding for all diseases, services, *etc* as well as for employees and there is need for more community advocates.

Morbidity

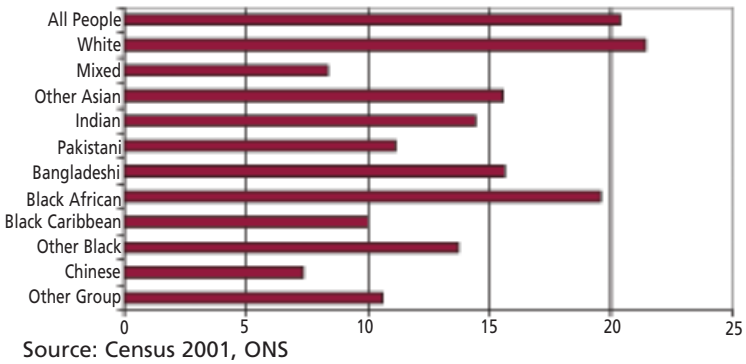
The 2001 Census asked people to state whether their health was good, fairly good, or not good. Figure 1:5 shows the percentages of people who reported their health to be fair or good in Walsall. The Mixed and Black African groups reported the highest levels of fair or good health (96.7% and 91.5% respectively), compared to the West Midlands where the other ethnic groups and Black Caribbeans reported the highest level of fair or good health (96.2% and 95.0%). In Walsall, the White population (88.6%) and the Black Caribbean (89.0%) populations reported the lowest level of fair or good health.
In the West Midlands, 18.7% of people reported a limiting long term illness (LLTI). In Walsall, the figure was 20.4% (Figure 1:6).

Figure 1:5: Walsall residents reporting their health as "fair or good health" in the last 12 months, proportion by ethnic group, 2001



Source: Census 2001, ONS

Figure 1:6: Walsall population with Long Term Limiting Illness, proportion by ethnic group, 2001



Source: Census 2001, ONS

In Walsall, as in the West Midlands, the lowest level of LLTI is reported by the Chinese (7.4% in Walsall and 7.8% in the West Midlands). In Walsall, the Mixed population also reported low levels of LLTI (8.3%). It is certainly the case that the health status of BME groups is related to their younger age profile, compared to the White population, which contains the highest proportion of people with LLTI.

Hospital Admissions

Hospital admissions may also be used as a crude indicator of health status, although there can be significant pitfalls in this. For example, a

common methodology is to compare admissions or admission rates of different ethnic groups with that of the White population. However, such differences may reflect differences in morbidity, differences in accessing services, ethnicity coding gaps and changes, or a combination of all these issues. This should be borne in mind with regard to the exploration of hospital admissions data in this chapter and in Chapter 2.

Table 1:4: Walsall registered patients admitted to hospital total and proportion by ethnicity, 2002-2004

	2002-2004	% of total	% of known	% of Pop
White	136362	69.1	85.5	86.4
Mixed	924	0.5	0.6	1.4
Asian or Asian British	18787	9.5	11.8	10.4
Black or Black British	2670	1.4	1.7	1.4
Other	829	0.4	0.5	0.4
Unknown	37671	19.1	-	
Total	197243	100	100	100

Source Walsall tPCT

In the three years 2002 to 2004, over 197,000 Walsall people were admitted to hospital. However, the ethnicity of almost 19% of this total was not known or recorded. Table 1:4 shows that, of those for whom ethnicity was known or recorded, almost 12% were from the South Asian community, a marginally higher proportion than the South Asian community proportion in the population as a whole (which was 10.4% in the 2001 census). The proportionally higher admissions were concentrated in the Pakistani community and 'Asian Other' groups. Similarly, hospital admissions of people of Black Caribbean ethnicity were disproportionately higher.

Over 2002 to 2004, admissions have grown faster among ethnic minorities than the White population and fastest among people of Pakistani, Bangladeshi, Black African and mixed race ethnicity. Some of this may be attributable to improvements in recording ethnicity of patients and population growth among these groups. In contrast, admissions of people of Indian and Black Caribbean ethnicity were relatively stable. However, deficiencies in the coding of ethnicity in the data make it dangerous to draw any firm conclusions on these changes. Prior to 2002, over one third of ethnicity fields were left blank. Coding has improved since then but in 2004 over 16% of cases were coded "unknown" or inputted incorrectly. Reported increases in admissions by ethnic group may therefore be artificially inflated by improvements in data collection and coding.

Among the South Asian ethnic groups, hospital admissions are concentrated among younger age groups up to age 44 years, which account for 74% of all South Asian admissions compared to 44% of White admissions. Almost 89% of Mixed race admissions are in this younger age group. Moreover, within these age groups the largest proportion of admissions is in infants aged 0-4 years, which account for over 30% of total hospital admissions among Pakistani, Bangladeshi and Mixed race groups compared to less than 10% of White admissions. Amongst the Black population groups, hospital admissions are concentrated particularly among people aged 25-44 years, accounting for 43% of Black admissions, including 47% of Black Caribbean admissions. As with South Asian groups, there is also a relatively high proportion of admissions among Black infants aged 0-4 years, particularly among Black African infants (28% of Black African admissions).

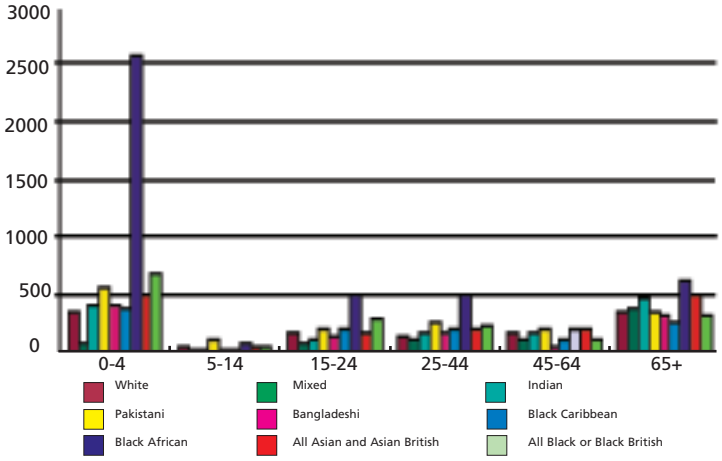
Rates of hospital admission, which take into account population size of the different ethnic groups, indicate that South Asian admissions and Black admissions were 13% and 22% higher respectively than White admissions, whilst admissions of Mixed race groups were 59% lower. Within these groups, however, there are wide variations: Black Caribbean admission rates were marginally lower than White admission rates but Black African and Black Other were 172% and 81% higher than White rates; similarly Asian Other admission rates were 217% higher and Pakistani admission rates 28% higher than White admission rates. Indian admission rates were marginally lower and Bangladeshi rates 19% lower than White admission rates.

Figure 1:7 highlights the crude hospital admission rates by age groupings:

- Mixed race admission rates are lower than White rates across all age groups except for people over 65 years, although there is an issue here of small numbers

- Infant admission rates (age 0-4) are substantially higher than White rates for Black and Asian groups; the highest rates are among Black African, 'Asian Other', 'Black Other' and Pakistani groups.
- 'Asian Other', Black African and 'Black Other' admission rates are also substantially higher than White rates in each of the remaining age groupings.
- Indian admission rates are lower than White rates in children and young adults (5-24 age group) but higher in older groups.
- Pakistani admission rates are higher than White rates except for those aged 65 years and over where the rates are the same.
- Bangladeshi admission rates are notably lower than White rates in the younger age groups (aged 5-24 years) and in those aged 45 years and over.
- Black Caribbean admission rates are higher than White rates in people aged 15-44 years but are notably lower in older age groups and in children.

Figure 1:7: Hospital Admission among Walsall registered patients, age specific hospital admission rates by ethnic group and age group, 2002-2004



Source: Walsall tPCT

Another indication of morbidity among Walsall's South Asian communities is provided by the 2000 Asian Health and Lifestyle survey (Pooransingh *et al*, 2001). As in the survey of 1995, overall use of English was still a huge problem. Main points were:

- South Asian females, with 76% having no use of English (especially Pakistanis)
- Compared with 1995 survey, less renting, more heating, and less overcrowding
- Strong correlation between good health and household head being employed
- 10% prevalence of diabetes (especially Pakistanis and Banlgadeshis)
- 28% with diabetes have a family history
- Prevalence of hypertension 18% (up from 14% in 1995)
- Prevalence of raised cholesterol 7% (up from 2% in 1995)
- Less myocardial infarcts and angina among Indians than among Pakistanis and Banlgadeshis
- Obesity 5-12% in men; 5-22% in women (Bangladeshi females, 35%)
- Need for more female GPs
- Breast and cervical screening uptake lower than in general population
- Smoking 23% Bangladeshis, 13% Pakistanis, 9% Indians
- Pakistanis and Bangladeshis least likely to eat fruit and vegetables
- Reduced use of ghee since 1995, with switch to cooking oil
- Indians are highest consumers of alcohol.

These issues have been the focus of Walsall's Asian health festivals (Ramaiah 2001). The second event for example aimed to engage with the local South Asian communities to raise awareness of health issues that are important to these groups and multi agency networks. Specific 'fun' health attractions revolved around diabetes, coronary heart disease, physical fitness, smoking and chewing tobacco cessation, thalassaemia, tuberculosis, drugs awareness, and the importance of influenza vaccination.

An indication of general morbidity among Black groups was provided by an audit of the needs of Walsall's African and African-Caribbean communities, by the Centre for Research in Ethnic Relations, University of Warwick (Harris *et al*, 1999). This project was undertaken on behalf of the African-Caribbean Regeneration Group and Walsall Metropolitan Borough Council. It was done because there was concern regarding

the marked reluctance of African-Caribbeans to engage in meaningful and sustained dialogues with existing institutions in Walsall. Also because African-Caribbeans received only a small proportion of total grant assistance specifically designed for ethnic groups. The key findings of the audit were as follows:

- New phenomenon of Caribbean elderly
- Increasing British-born population, census shift to 'Black other', Mixed', *etc*
- More likely to have lone parents, chronic illness, live in most deprived wards, in rented accommodation, be unemployed, lack training opportunities
- Important health needs of (1) arthritis, eye sight problems, strokes, hypertension; (2) care for sickle cell disease and carriers; (3) concern regarding GP and A&E care for sickle cell crisis; (4) concern regarding quality of care for Mental Health inpatients and those discharged back into the community; (5) late take-up of antenatal care screening
- Disadvantaged in housing and education.

The report recommended that Social Services (with the Health Authority) should develop a unified approach to sickle cell disease by appointing specialist workers to liaise with nurses. The report also recommended help to claim benefits, oversee programme of education in schools and in community venues to provide support for sufferers and carers.

Key points from a conference in 2002 to discuss the audit were:

- Support by ACSERG (African-Caribbean Social and Economic Regeneration Group) who aim to engage and work collaboratively to help their members
- The Group is funded by SRB5 to enable active delivery of training, information and organisational support in target areas (*eg* Caldmore, Palfrey, Pleck, Birchills, Paddock, and Chuckery)
- Long way to go in Education.

Walsall Health Authority also issued a report to address the issues raised by the audit (Ramaiah & Mather, 2001). The following issues were addressed or points noted:

- Consultation report, *Mental health and ethnicity in Walsall*, produced in 2001
- Walsall Manor and Community Trust (CHT) were above average (at 80%) in providing quality of coding on BME populations, *eg* hospital admissions
- Health Improvement Programme 2000 and Mental Health strategy and address Black community needs
- Appointed haemoglobinopathy nurse specialist at the Manor and the CHT
- Information packs and awareness raising of sickle cell disease and thalassaemia sent to all Walsall GP practices; Advisory Group also formed Mainstream funding to Black Sisters scheme (project for Black communities), to support Mental Health strategy
- Improvements to antenatal care screening.

Mortality

This data is difficult to obtain but mortality, especially the infant mortality rate (IMR) is expected to be highest among the South Asians, and especially among the Pakistani population (see also Chapter 3).

Chapter 2

Burden of Disease: How Unequal?

This chapter traces the burden of disease among BME groups and shows that there are some differences when compared to the rest of the population. This is particularly the case regarding chronic diseases such as coronary heart disease and diabetes.

A review of hospital admissions in the Walsall BME population for a range of conditions is outlined in this chapter. However, it should be noted that almost 20% of total admissions during 2002 to 2004 did not have ethnicity recorded (38,500 admissions were coded as 'other and unknown'). The comments and comparisons in this section should therefore be treated with caution as they relate only to those patients for whom ethnicity was recorded. An additional complication is that about 9% of Asian admissions are recorded as 'other Asian'. The data for patients of Indian, Pakistani or Bangladeshi descent may therefore be understated due to inclusion in 'other Asian'. For this reason, and to give a more comprehensive picture, reference is made to 'all Asian' comparisons as well as the distinct Asian ethnic groups. Similarly, 12% of Black patient admissions were coded as 'other Black' and, therefore, a reference is made to the total group of Black patients to include the 'other Black' group.

Cardiovascular disorders: coronary heart disease, hypertension and stroke

The earliest papers linking coronary heart disease among South Asians with central abdominal obesity and the metabolic syndrome came from studies in East London (McKeigue *et al*, 1991). South Asians appeared to have a more aggressive form of myocardial pathology, that also occurred at an earlier age, compared to Europeans. There appears to be a genetic link with the so called thrifty gene, whereby people who originate from more arid areas of the world, where food is more scarce, explode with central abdominal weight gain (previously a 'food store') when exposed to abundant

carbohydrate. This leads to hyperinsulinaemia, Type 2 diabetes and coronary heart disease. This hypothesis was tested among peninsular Arabs, who most definitely originate from arid areas, and they were indeed found to share a tendency with South Asians to insulin resistance, differing from other ethnic groups living in the United Arab Emirates (Pugh *et al*, 1998).

However, risk of coronary heart disease is not uniform among South Asians, and there are important differences between Indians, Pakistanis and Bangladeshis for many coronary risk factors (Bhopal *et al*, 1999). The belief that, except for insulin resistance, South Asians have lower levels of coronary risk factors than Europeans is incorrect, and may have arisen from combining ethnic subgroups and examining a narrow range of factors. Indians are the least disadvantaged and Bangladeshis the most disadvantaged among a range of coronary risk factors. Nevertheless, South Asians have more coronary heart disease than Europeans despite apparently lower levels of risk factors. By contrast, UK-based Chinese groups appear to have a genetic low predisposition to coronary heart disease, in contrast to the situation in South Asian groups (Harland *et al*, 1997).

Table 2:1: Coronary Heart Disease and Stroke, prevalence among South Asians in Walsall, 2000

	1995	2000
Heart Attack	1.4%	1.7%
Angina	3.8%	6.0%
Hypertension	14.3%	18.2%
High Cholesterol	1.9%	7.4%
Stroke	1.4%	1.7%

Source: Walsall Asian Lifestyle Survey 2000

Table 2:1 shows lifestyle survey evidence that events relating to cardiovascular disease have increased significantly among South Asian groups in Walsall over the five-year period between 1995 and 2000.

Table 2:2: Heart Attacks and Angina, prevalence among South Asians in Walsall, 2000

	Heart Attacks	Angina
Indian	1.2%	5.8%
Pakistani	3.0%	6.6%
Bangladeshi	4.2%	6.3%

Source: Walsall Asian Lifestyle Survey 2000

Table 2:2 presents data from the same survey, showing the differences between Indians, Pakistanis and Bangladeshis in Walsall for coronary events; supporting the observation made above by Bhopal *et al* (1999).

Table 2:3 illustrates the proportion of Walsall residents admitted to hospital with an acute myocardial infarction (AMI), or who had a revascularisation procedure, analysed by ethnic group.

Table 2:3: Walsall registered patients admitted to hospital for AMI and revascularisation, proportion by ethnicity, 2001

	2001 Census	AMI	Angio	PCTA	CABG
White	86.4	79.4	64.0	56.6	77.6
Black or Black British	1.4	0.8	1.0	0.9	0.0
Asian or Asian British	10.4	7.2	7.5	6.6	7.1
Other Group	1.4	0.0	0.2	1.9	0.0
Unknown	-	12.5	27.3	34.0	15.3

Source: Walsall tPCT

The table only considers 2001 data because ethnicity recording in the hospital episode (HES) dataset was relatively poor prior to 2001. The table shows the proportion of cases for those whose ethnicity is known. AMI numbers appear to be lower in the minority groups as a proportion of the whole population, but this is undoubtedly due to BME groups having a younger age profile. PCTA and CABG rates, however, appear to be marginally higher than would be expected using AMIs as a proxy for need.

Table 2:4: Walsall registered patients admitted to hospital for AMI and revascularisation, proportion by known ethnicity, 2001

	2001 Census	AMI	Angio	PCTA	CABG
White	86.4	90.8	88.0	85.7	91.6
Black or Black British	1.4	1.0	1.3	1.4	0.0
Asian or Asian British	10.4	8.3	10.4	10.0	8.4
Other Group	1.4	0.0	0.3	2.9	0.0

Source: Walsall tPCT

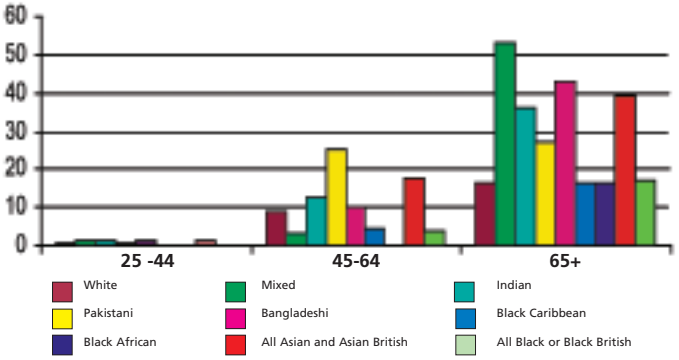
Table 2:4 shows the same data as in Table 2:3 but includes the percentages for those procedures performed where the patient's ethnicity was not recorded. This illustrates some of the problems using ethnicity data and incomplete coding in the HES.

Coronary heart disease

During 2002 to 2004 there were over 5,300 hospital admissions for CHD among Walsall residents but almost 25% of these were not coded for ethnicity. For those patients where ethnicity was recorded, 416 were Asian, 28 Black and 11 Mixed Race. The admission rate for CHD among Asians over age 45 years in Walsall was

more than double that for the White population. For the Black population, the admission rate was similar to the White rate in the older age group. The highest admission rates are among the Mixed race and Bangladeshi populations aged 65 years and over (figure 2:1).

Figure 2:1: Hospital Admissions for CHD among Walsall registered patients, age specific admission rate by ethnic group and age group



Source: Walsall tPCT

Acute myocardial infarction (AMI)

For those patients where ethnicity was recorded, there were 112 admissions for AMI from BME groups during 2002 to 2004. The admission rate among Asians aged 45-64 years was 50% higher than for the White population and 2.5 times higher among Asians over 65 years, the highest rate being among the Indian population. For the Black population, the admission rate was marginally lower than for the White population.

Angina

For those patients where ethnicity was recorded, there were 209 admissions for angina from BME groups during 2002 to 2004. The admission rate among Asians aged 45 years and over was more than double that of the White population, the highest rates being in the Pakistani population. Admission rates among the Black population aged 65 years and over were one third higher than in the White population. The highest admission rate was among the Mixed race population over 65 years, although numbers are small.

Inequalities in uptake of coronary heart disease services in Walsall by BME groups had been noted for some time, but particularly by South Asian women. This was explored by Giles & Laverty (2004), using a structured questionnaire in five languages. The following issues were raised by the survey:

- Use translator known to local community
- Most satisfied with hospital services but not always with GP
- Lack of translator services in primary care
- WALDOC needs answering service in five languages
- Receptionists can be abrupt
- Issue of late referrals from primary care
- More explanation required on medications.

Kuppuswamy & Gupta (2005) conclude that since death rates from coronary heart disease in South Asians have declined at a slower rate than in the indigenous population, more needs to be done, including:

- education about the excess risk of coronary heart disease and its symptoms
- a high index of suspicion of coronary heart disease in South Asians along with more aggressive secondary prevention
- the concept of "well Asian" clinics.

Caribbean groups are known to be at increased risk of hypertension and stroke. However, numbers of this population are relatively low in Walsall and data on hypertension is unavailable to show any effect. The common perception that blood pressure in South Asians is comparatively high is unreliable. Overall, blood pressures are similar but there is stark heterogeneity in the South Asian groups, with slightly higher blood pressure in Indians, slightly lower blood pressure in Pakistanis, and much lower blood pressure in Bangladeshis (Agyemang & Bhopal, 2002).

Stroke

For those patients where ethnicity was recorded, there were 95 hospital admissions for stroke during 2002 to 2004 from Walsall's BME population. The admission rate for people over 45 years was up to 72% higher among the Asian population than among the White population, with the highest rates concentrated in the Pakistani and Bangladeshi groups. Admission rates among the Black population were also higher than among the White population.

Cancers, including screening

Breast and cervical cancer screening is an important issue among BME groups, especially among South Asian women in Walsall. Pooransingh & Ramaiah (2001) found that overall uptake of cervical screening across Walsall was 85% but south Walsall, which has the highest proportion of South Asians (40%), had the lowest uptake of 82%. This was a qualitative study with a 68% response rate. The majority understood the test, but the main reasons for non-attendance were lack of time and not perceiving themselves at risk. Videos were more effective than translated written materials. Husbands mostly encouraged wives to attend but many female relatives did not. It was important to have a female smear taker.

Breast cancer

For those patients where ethnicity was recorded, there were 152 hospital admissions for breast cancer from Walsall's BME population during 2002 to 2004. For Asian women these were mainly among women aged 45-64 years. But for Black and Mixed Race women the cases were concentrated in younger women aged 25-44 years. Among Asian women aged 45-64 years the admissions were concentrated almost exclusively among Indian women, where the admission rate was more than 25% higher than among the White population. The Black Caribbean admission rate among women aged 25-44 years (15 cases) was more than 50% higher than in the White population, whilst in Mixed Race women of that age the admission rate (based on 13 cases) was more than twice that of the White population.

Lung cancer

For those patients where ethnicity was recorded, there were 57 hospital admissions for lung cancer from Walsall's BME population during 2002 to 2004. Over 75% of these cases were from the Pakistani population, followed by 16% from the Indian population. The hospital admission rate for the Pakistani population aged 65 years and over was more than 4 times that of the White population in that age group, whilst the admission rate for Indians was almost 50% lower than among the White population. The Black admission rate among those 65 years and over was more than 50% lower than in the White population.

HAZ projects have been important in addressing breast and cervical cancer screening in Walsall.

South HAZ Projects

1. **Picture of Health**
   This project raised awareness around issues connected with breast cancer in the Asian communities. An artist worked with a range of groups of Asian women across the South HAZ to produce images around the issue of keeping healthy. The images then formed the basis for a book which was exhibited in Walsall Art Gallery. Images from the project were also used to produce posters and other publicity materials in community languages to highlight the importance of breast screening.

2. **Breast Screening Awareness**
   This project was to raise the awareness of the Breast Screening Service, especially among the predominantly South Asian population of Palfrey and Pleck. The project provided training by the Breast Screening Unit for the staff at the College of Continuing Education. Three Tutors received the training and will deliver sessions within the communities and to new students that will enrol.

3. **Free Loan Video Scheme**
   The project aimed to raise self-awareness on health issues through Free Loan video cassettes made available in English and five Asian languages (Bengali, Gujarati, Hindi, Punjabi and Urdu) for home viewing. Health topic videos available included Breast Screening and Cervical Smear Tests.

Diabetes and obesity

Reference has already been made to the higher risk of Type 2 diabetes and coronary heart disease among South Asians (McKeigue *et al*, 1991). Again, this is linked to the abdominal form of obesity that is more easily detected by the ratio of waist-to-hip or waist-to-height measurements, rather than the Body Mass Index (BMI). This is borne out by table 2:5 for both forms of diabetes in Walsall, showing a higher prevalence among BME groups (Caribbeans more

than South Asians) compared to the White population. The differences appear to be similar to those across the West Midlands and the rest of the country.

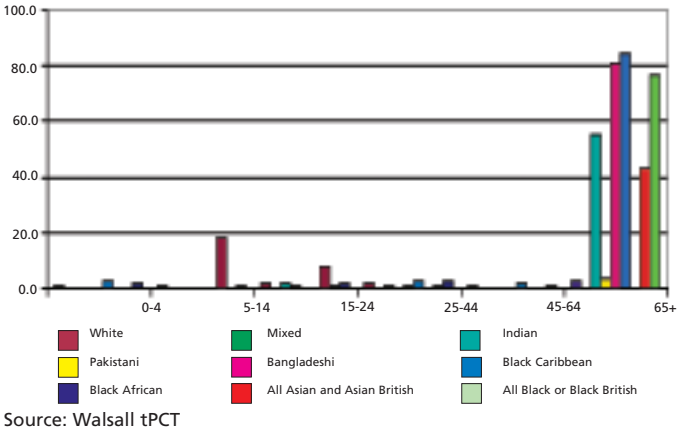
Table 2:5: Estimated Prevalence of Type I and Type II Diabetes amongst different groups in Engalnd, West Midlands and Walsall, 2004

	England	West Midlands	Walsall
Persons	4.41%	4.55%	4.67%
Male	3.61%	3.79%	3.98%
Female	5.17%	5.27%	5.33%
0-29yrs	0.33%	0.34%	0.34%
30-59yrs	3.37%	3.54%	3.69%
60+yrs	13.92%	14.13%	14.18%
White	4.29%	4.36%	4.47%
Black or Black British	5.67%	7.20%	7.03%
Asian or Asian British	6.63%	6.27%	6.19%
Other	2.13%	1.93%	2.28%

Source: Yorkshire & Humber Public Health Observatory, Brent PCT and the School of Health Related Research (University of Sheffield)

For those patients where ethnicity was recorded, there were 325 hospital admissions for diabetes from Walsall's BME population during 2002 to 2004. Figure 2:2 shows that over 80% of these were of people aged 65 years and over. In this age group, with the exception of Pakistani patients, the admission rates for both Asian and Black communities are many times higher than for the White population.

Figure 2:2 Hospital Admissions for diabetes among Walsall registered patients, age specific admission rate by ethnic group and age group, 2002-2004



Source: Walsall tPCT

The highest rates are in Black Caribbean and Bangladeshi populations, where the admission rate was up to 32 times that of the White population, whilst the Indian admission rate was over 20 times the White population rate. In contrast, there were only 4 recorded Pakistani admissions for diabetes, although this represented an admission rate 50% higher than the White population.

Recent work suggests that more needs to be done among BME groups in the monitoring of drug treatment. For example, Lawton *et al* (2005) showed an ambivalent attitude among Pakistani and Indian patients taking oral hypoglycaemic agents for their diabetes, which partly derives from popular ideas about drugs on the Indian subcontinent. Some patients mainly associated drugs with relief of symptoms and disliked the idea of taking a particular medication for life.

Case Study: Diabetes

Abdul, up until recently, was taking medication which had been prescribed by his GP to control his blood sugar levels. However, he had stopped that medication and was drinking the juice of karela (extracted from a bitter vegetable) as a substitute for the tablets. He thought that since the taste of karela is bitter, it counteracts the effects of sugar and therefore balances the sugar levels.

"I have found during visits that patients often don't take medication for numerous reason. They often stop if glucose levels come down or they are trying alternative remedies, Often they do not understand the action of the tablets and the health risks that diabetes possess, they do not appear to understand the progressive nature of diabetes and we often struggle to move patients on to insulin". (Sheila Page: Diabetes Specialist)

South HAZ has been active in developing a Diabetes Awareness Programme. Here, a diabetes support worker is seconded one day a week to lead on developing a campaign to raise the awareness of diabetes, signs and symptoms, and self management. Work has included training a number of volunteers on the diabetes awareness programme, who have then cascaded the information to other people in the community. A team of interpreters has been trained so that they can more efficiently support the diabetes service and staff when dealing with patients from the South Asian communities. A logo is being developed that all involved in promoting diabetes amongst BME groups will adopt, and will enable community members to identify and relate to all information and communication that goes out to them.

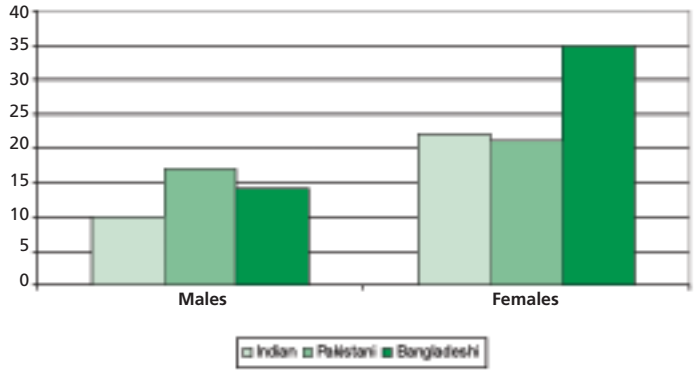
The abdominal form of obesity is a precursor of Type 2 diabetes and so is an important issue

among BME groups, and South Asians in particular. It is of concern that among South Asians in Walsall, being overweight and obese increased from 1995 to 2000, as shown in Figure 2:3. Obesity appears to have increased dramatically among Bangladeshi women living in Walsall (Figure 2:4).

Figure 2:3: Overweight and Obesity among South Asians, by gender, 1995 to 2000

Source: Walsall Asian Lifestyle Survey 2000

Figure 2:4: Obesity by gender and amongst South Asians, 2000



Source: Walsall Asian Lifestyle Survey 2000

Other chronic diseases and mental health

Data is available on chronic obstructive pulmonary disease (COPD) and asthma.

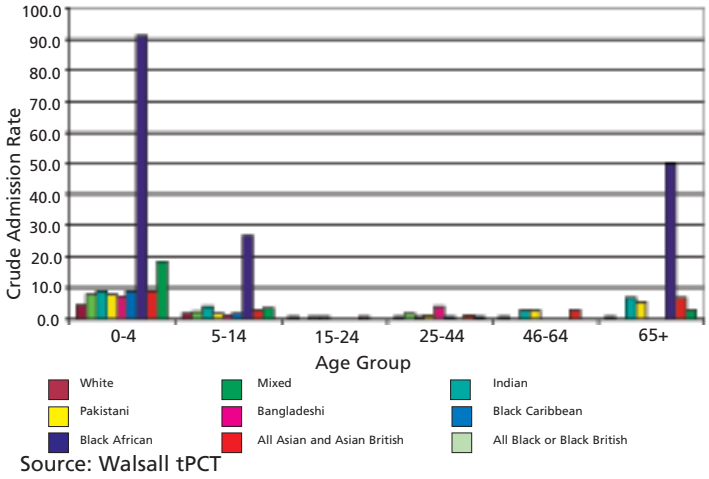
COPD

For those patients where ethnicity was recorded, there were 52 hospital admissions for COPD from Walsall's BME population during 2002 to 2004, of which 45 were from the Asian population. Over 80% of admissions in all population groups are in people aged 65 years and over. The admission rate among the Asian population was over 20% lower than in the White population. Although the admission rate among Black Africans aged 65 years and was almost 3 times that of the White population, this related to 2 admissions only. Conversely the Black Caribbean admission rate (65 years and over) was less than 25% that of the White population (3 admissions).

Asthma

For those patients where ethnicity was recorded, there were 241 hospital admissions for asthma from Walsall's BME population during 2002 to 2004.

Figure 2:5: Hospital Admissions for Asthma among Walsall registered patients, age specific admission rate, by ethnic group and age group, 2002-2004



Source: Walsall tPCT

Figure 2:5 shows that among the Asian and Mixed Race communities the admission rate was up to 3 times that of the White population. Among the Black population the all ages admission rate (based on 21 admissions) was double that of the White population and was concentrated among Black African infants and children. Amongst infants and children up to age 14 years, the highest admission rates (based on 9 admissions) were among Black Africans, although admission rates of Asian and Mixed Race children were also twice that of the White population. Among the older age group (65 years and over) the largest number of non-White admissions were from the Indian community, where the admission rate (based on 19 admissions) was almost 10 times that of the White population. Pakistani admissions were also at a substantially higher rate.

Mental health (excluding alcohol and drug misuse)

During the three years 2002/03 to 2004/05, ethnicity was recorded for 2918 people admitted

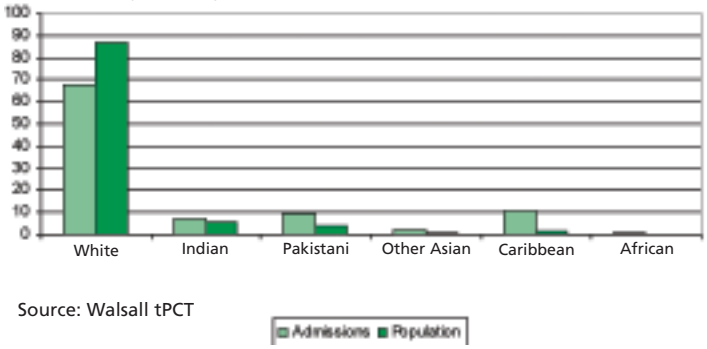
as inpatients to Dorothy Pattison Hospital in Walsall, who were suffering from a range of mental illnesses or conditions. Of these, 370 patients (12.7%) were from BME groups. South Asians were the largest group (over 250 admissions) but for each of the Asian ethnic subgroups the admissions rate in relation to population size was similar or lower than the admission rate for the White population. However, the Black Caribbean inpatient admissions rate (based on 81patients) was 2.5 times greater than admission rate for the White population (Table 2:6). Over three quarters of the Black Caribbean admissions were aged 25-44 years.

Table 2:6: Walsall registered patients admitted to Dorothy Pattison Hospital total and proportion by ethnicity, 2002/03 -2004/05

	2002/03 - 2004/05	% of total	% of known	% of pop
White	2541	80.7	87.0	86.4
Mixed	17	0.5	0.6	1.4
Asian or Asian British	259	8.2	8.9	10.4
Black or Black British	94	3.0	3.2	1.4
Other Groups	Small Numbers	0.3	0.3	0.4
Unknown	228	7.2	-	-
Total	3148	100.0	100.0	100

Source: Walsall tPCT

Figure 2:6: Walsall registered patients admitted to Dorothy Pattison Hospital with a diagnosis of psychotic illness and total population, proportion by ethnicity, 2002/03 to 2004/05



Source: Walsall tPCT

It is recognised that Black people are more likely to present with psychosis than the rest of the population. However, it is also understood that Black people with mental health problems are more likely to be given drugs alone rather than counselling. In the three year period, 2002/03 to 2004/05, 60 patients from BME groups were admitted to Dorothy Pattison Hospital for psychotic illness. The largest group was Black Caribbean, where admissions at 11% of total admissions for psychotic illness are substantially greater than the Black Caribbean proportion of the total population. Pakistani admissions for psychotic illness are also disproportionately high (Figure 2:6).

Communicable disease

Tuberculosis

Each year around 50 cases of TB are reported in Walsall, with the highest incidence in recent years barely exceeding 30 per 100,000 population per annum. In the West Midlands, only Birmingham, Coventry, and Wolverhampton are on a par, although rates have never exceeded 40 per 100,000. This is significant since recent guidance advises that the school BCG vaccination programme against TB will only continue in those areas where TB incidents exceeds 40 per 100,000. Parts of Walsall, where there are concentrations of BME groups, will reach this incidence and so special provisions will remain in place from next year.

Table 2:7: Tuberculosis in Walsall and West Midlands populations, incidence rate by ethnic origin, 2003

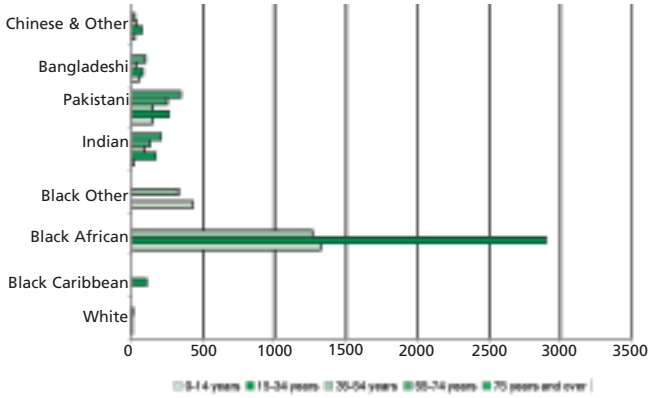
Ethnic Group	Walsall			West Midlands		
	No	%	Rate	No	%	Rate
White	Small Numbers	24.0	5.5	228	29.4	4.9
Black Caribbean		0.0	0.0	13	1.7	15.8
Black African		0.0	1078.2	91	11.7	759.3
Black Other		0.0	0.0	2	0.3	20.5
Indian		30.0	109.0	204	26.3	114.2
Pakistani		34.0	123.5	190	24.5	122.9
Bangladeshi		0.0	0.0	14	1.8	44.6
Chinese & Other		4.0	37.5	34	4.4	32.6
Total	50	100	19.7	776	100	14.8

Source: Enhanced TB Surveillance in the West Midlands, HPA, Regional Surveillance Unit

Table 2:7 and Figure 2:7 show that the highest reported rates of TB are amongst the Black African population, which in 2003 was more than 6 times the rate of any other ethnic group. There is an association here with HIV infection among the African people, acquired in their countries of origin. Walsall follows a similar pattern to the whole of the West Midlands. However, numbers of African people living in Walsall are relatively small (around 500 persons), and so numbers of TB cases predominate among the South Asians, especially the Pakistani population. Small numbers mean the rates in ethnic minority groups fluctuate over time. However, overall, the rates in the White, Black African, Indian and Pakistani populations have been relatively stable over the last four years.

Tuberculosis is more common in men among all ethnic groups, with the exception of Black Caribbean women (Table 2:8).
TB rates vary significantly by age group.

Figure 2:7: Tuberculosis in Walsall, incidence rate by ethnic origin and age, 2001-2004



Source: Walsall TB Services, Moat Road Clinic

Table 2:8: Tuberculosis in Walsall, incidence rate by ethnic origin and gender, 2001-2004

Ethnic Group	Rate per 100,000 population		
	Male	Female	Persons
White	7.7	5.6	6.6
Black Caribbean	18.1	34.3	26.4
Black African	1941.3	786.5	1347.7
Black Other	179.9	170.0	174.8
Indian	123.3	102.5	112.5
Pakistani	220.4	203.1	211.5
Bangladeshi	61.7	58.3	60.0
Chinese and Other	48.2	27.4	37.5
Total	26.4	20.7	23.5

Table 2:9: Tuberculosis in Walsall, incident rate by ethnic origin and age, 2001-2004

Ethnic Group	Rate per 100,000 population				
	0-14yrs	15-34yrs	35-54yrs	55-74yrs	75yrs & over
White	5.1	4.0	6.0	10.6	11.4
Black Caribbean	0.0	103.5	0.0	0.0	0.0
Black African	1325.7	2902.7	1267.0	0.0	0.0
Black Other	429.9	0.0	328.7	0.0	0.0
Indian	17.9	170.7	88.8	132.8	206.9
Pakistani	144.8	262.1	151.0	247.9	343.2
Bangladeshi	49.1	78.3	37.6	97.4	0.0
Chinese and Other	23.1	73.4	35.3	22.8	0.0
Total	14.1	30.1	18.9	26.9	33.7

Source: Walsall TB Services, Moat Road Clinic

Table 2:9 shows that in the Black African and Black Caribbean populations, the highest rates are in the 15-34 year old group. In the Indian, Pakistani and Bangladeshi populations there are two peaks in the incidence of TB; in the 15-34 year age group and the 55 years and over group. The neonatal BCG vaccination programme is active in Walsall, whereby the babies of mothers originating from areas with a high TB prevalence are offered the vaccine. The TB Clinic cooperates with Maternity services in this venture, and is further active in raising the awareness of tuberculosis in communities containing BME groups at risk. This has been achieved by cooperation with South HAZ, which has actively supported the TB team in undertaking an awareness raising campaign. TB leaflets and information packs have helped raise awareness of the disease and service available. The leaflet is available on www.southhazwalsall.org.uk. The campaign has increased the profile of services; has resulted in an increase in enquiries and referrals; has promoted open days and community events; and has provided a community outreach role.

Viral hepatitis

The two most important infections in this category that affect BME groups are hepatitis B and hepatitis C virus.

Laboratory notifications grossly underestimate the true incidence of acute infections and prevalence of chronic infections in the UK.

In the UK, acute hepatitis B infection is predominantly acquired through injecting drug use and through sexual transmission. However, this only occasionally results in long lasting, chronic infection. The potential for blood borne transmission requires that all medical staff are now required to take up the full course of the vaccine prior to employment.

The UK, along with Scandinavian countries, has among the lowest prevalence rates of chronic hepatitis B infection in the world (around 0.2%); which is the reason why a universal vaccination programme is not currently available in this country. The risk of chronic infection is greatest when the virus is acquired at or shortly after birth, and this can signify the later development of chronic liver disease (usually cirrhosis) or hepatocellular carcinoma later in adult life. Thus, people with chronic infection have, in the majority, acquired hepatitis B virus in their countries of origin where there is a high prevalence (affecting most developing countries of the world). It follows then that the majority of chronic hepatitis B infections, and cases of cirrhosis arising from this virus, are to be found in BME groups. This is of such concern that all mothers originating from high prevalence areas

are screened for hepatitis B. If necessary, their babies are offered a course of the vaccine and in a few cases every year, when the mother is infectious with the "e" antigen, the baby is given B immunoglobulin.

Similar comments can be made for hepatitis C, except that sexual transmission is not so efficient, and there is currently no vaccine available. Again in the UK, injecting drug use is the leading risk factor for acquiring this virus. Previously, blood transfusion was also a risk (as it was for acquiring hepatitis B). In many developing countries, there is still a risk of acquiring both viruses through contaminated needles or blood transfusions.

The UK is again a low prevalence area for hepatitis C (less than 0.5%) and so most chronic infections are to be found among BME groups, among people who have been brought up in high prevalence areas. As with hepatitis B, the danger of chronic hepatitis C is the later development of cirrhosis.

In summary, both viruses among BME groups in the UK represent a significant disease burden, since as the affected population ages, increasing numbers of cases of cirrhosis will emerge. We are starting to see cirrhosis emerge in the UK as a leading chronic disease, especially given the fact that chronic high alcohol consumption is another important contributor to this disease burden. Liver transplantation remains the only hope for sustained survival among patients with cirrhosis, and so the significance of this mounting disease burden is only too clear.

HIV infection and sexually transmitted infections (STIs)

The number of cases of human immunodeficiency virus (HIV) infection in Walsall has been rising over the last decade, as it has nationally. The highest rates are in the 25-44 year old age groups. Between 1996 and 1998, there was an average of four new cases a year in Walsall. By 1999 to 2001, this had risen to nine, and the numbers continue to rise. The biggest increase has been in the Black African population, where the rate per 100,000 population is 985.7, compared to 2.0 in the White population in 1998 to 2003 (Tables 2:10 & 2:11; Figure 2:8).

Within the UK, the risk of acquiring HIV infection is highest among men who have sex with men (MSM).

Table 2:10: HIV in Walsall, proportion by ethnic group, 1998/2000 to 2001/2003

	1998-2000	1999-2001	2000-2002	2001-2003
White	50%	39%	29%	25%
Black African	38%	52%	67%	74%
Black Caribbean	13%	9%	2%	1%

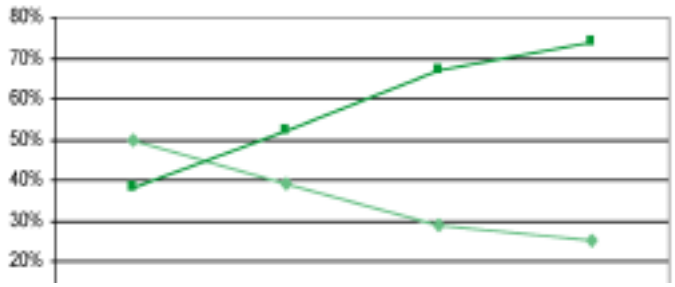
Source: West Midlands Regional HIV Surveillance Project

Table 2:11: HIV in Walsall, incidence rate per 100,000 population by ethnic group, 1998/2000 to 2001/2003

	1998-2000	1999-2001	2000-2002	2001-2003
Black African	537.63	1,164.87	2,688.17	4,032.26
Black Caribbean	23.48	23.48	23.48	11.74
White	1.23	1.39	2.01	2.32

Source: West Midlands Regional HIV Surveillance Project

Figure 2:8: HIV in Walsall, proportion by ethnic group, 1998/2000 to 2001/2003



Source: West Midlands Regional HIV Surveillance Project, population 2001 census based

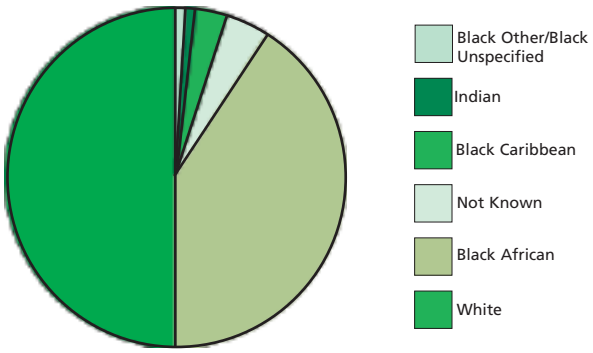
However, although these numbers are being overtaken by heterosexual transmission, principally among African groups, these merely reflect Africans who have arrived in this country from high prevalence areas. Figure 2:9 shows the predominance of HIV positive people among the White population (especially among the MSM population), although there is a disproportionately large population of HIV infection among people of African origin.

A few years ago in Walsall, antenatal screening for HIV infection was introduced, to identify infected mothers. By doing so, mother to child transmission can be prevented, by antiviral treatment, by use of Caesarian section, and by avoidance of breast feeding. A few cases so far have been detected in Walsall.

Walsall tPCT engages the Terence Higgins Trust (jointly with Wolverhampton) in providing a specialist African worker to target people of African origin, especially in the uptake of HIV testing. There is clearly a need here to convey the benefits of testing to detect early disease, amenable to treatment and control, as well as to protect the public health in minimising onward transmission of HIV. Central to all HIV work is the

promotion of condom use and raising the awareness of the dangers of unprotected sex. More recently in Walsall, there has been an ongoing outbreak of syphilis, partly in the predominantly White MSM population.

Figure 2:9: People with diagnosed HIV infections resident in Walsall, proportion by ethnic group, up to date the end of 2003



Source: West Midlands Regional HIV Surveillance Project

The remainder of cases have arisen from heterosexual transmission, and there have been links here with commercial sex workers. It is in these areas that BME groups have been involved, particularly Black Caribbean people and South Asian men. Syphilis is also important since there is often co-infection with HIV, especially among the MSM population. Other STIs show similar trends to syphilis.

Immunisation

Vaccine preventable diseases in childhood are important from the public health perspective. While uptake of childhood vaccines is excellent in Walsall, more can be done among disadvantaged groups and, in some areas, this will include BME groups. Below par uptake of vaccines tends to be synonymous with those areas were uptake of cervical screening also needs to be improved.

As with uptake of cervical screening, South HAZ worked in partnership with primary care to increase uptake of immunisation and vaccinations in GP practices. Nursing staff from a practice with successful uptake were employed to work with other practices in the area. Leaflets were also funded in all community languages, giving equal access to information on immunisations. As a result of this initiative, uptake of immunisation in some practices increased by up to 100%.

Travel medicine

There is a widely held belief among many BME people that immunity to malaria is inherent. Indeed, Wallis (1997) found in a Walsall study that such beliefs of immunity to malaria and other illnesses were held by 40-50% of respondents. This is important since most South Asian travellers stay with friends and relatives when they visit the Indian subcontinent, and especially in rural areas, may be exposed to malaria. It is important for primary care professionals to remind such travellers of the need to take malaria chemoprophylaxis. Ray et al (1999) suggest that the withdrawal of NHS provision of malaria chemoprophylaxis may have led to a transient increase in malaria notifications in Walsall. A campaign of public and GP education on protective measures in Walsall was credited with reducing notifications down again.

Travellers from minority groups in the UK are less likely to take prophylaxis despite higher risk from travel to more rural areas and staying longer than the average British tourist. There is need to target groups for prevention also regarding typhoid, hepatitis A, and dysentery. Also a need for multi-lingual media among travel agencies, community pharmacists, and primary care teams.

Summary

There does appear to be an unequal burden of certain disease among BME groups, as opposed to the rest of the population. In the case of chronic disease such as cardiovascular disorders and diabetes, this is largely due to inherent or predisposing factors. However, these are amenable to a preventive approach, and we need to do more to raise awareness. National Service Frameworks have begun to ensure a great deal of this, and further improvements can be expected following the White Paper, Choosing Health.

In terms of communicable disease, particularly in the case of tuberculosis, hepatitis B virus infection, and HIV infection, the increased burden among BME groups reflects origin from countries where prevalence is significantly higher.

Chapter 3

Population Groups: What Specific Problems?

Many of the general comments in this and the next chapter are derived from the London Health Observatory (2004).

Mothers and babies

Although not comprehensive, the recording of births by ethnicity has improved substantially in Walsall in the last five years, including the start of recording Mixed race ethnicity during 2002. A total 989 babies born in Walsall in 2004 were recorded as being of Asian, Black or Mixed race ethnicity. Of these, more than 75% were Asian, 15% Mixed race and 7% Black. Reflecting the growing young BME population, the number of BME births has increased by over 40% in the last five years and in 2004 accounted for 30% of total (3,300) births in Walsall.

Many areas in the UK have shown that the babies of mothers born in Pakistan had an infant mortality rate higher than babies of mothers born elsewhere. Similarly, stillbirth and perinatal rates were significantly higher for these mothers. Other data have shown lower adjusted birthweight rates in South Asian babies born in the UK. Confidential enquiries into maternal deaths have shown that the rate for South Asian women has reached three times that of White women, with Black women having a rate in between.

Low birthweight, still births and infant mortality

In Walsall, 11.6% of all births during 2002-2004 were babies with low birthweight. Among the White population the proportion of babies born with low birthweight was almost 10% but among BME groups the proportion was over 15% (Table 3:1). The highest rate was among African Caribbean babies, where 18.7% had low birthweight. Among the South Asian population the low birthweight rate was 15.8%, rising to 17.5% among the Bangladeshi group. Over 14% of Mixed race babies also had low birthweight.

Table 3:1 Births below 2500gms, proportion by ethnic group, 2002 to 2004

Ethnic Group	2002	2003	2004	Total
White	10.1	9.8	10.0	9.9
Mixed	12.8	13.6	15.2	14.2
Asian or Asian British	18.8	14.4	14.5	15.8
Black or Black British	10.6	9.8	16.9	13.0
Walsall	12.4	11.0	11.6	11.6

Source: Walsall tPCT

Stillbirths and infant mortality are not routinely recorded by ethnicity. Data based on a South Asian name recognition programme (Nam Pehchan – developed by Bradford Health Authority and Bradford Council) suggests that 12 out of a total of 50 stillbirths in Walsall during 2002-2004 were to parents of South Asian origin. Similarly, 18 out of 70 infant deaths (up to one year old) were to parents of South Asian origin. These proportions (24-26%) are marginally higher than the proportion of total births to South Asian parents as a percentage of all births in Walsall (22%).

Reports show that women from BME groups use antenatal services less frequently and that a higher proportion book too late for screening to be effective. Reference has already been made to sickle cell disease and the importance of awareness raising and screening regarding the Caribbean community. This is also relevant to thalassaemia, important to all BME groups. As mentioned, work in Walsall has progressed in these areas, and has been reinforced by the appointment of haemoglobinopathy nurses. More work is required to improve this aspect of antenatal screening.

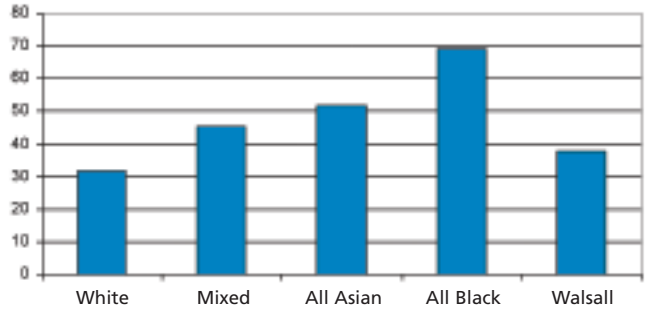
Walsall Teaching PCT employs a Haemoglobinopathy Specialist Nurse to facilitate the Neonatal Screening Programme. This became universal last year as part of a government initiative outlined in the NHS Plan . She also provides support to sickle cell and thalassaemia clients, their families and carers, and raises awareness of the conditions to the general public, either in groups or on a one to one basis. She has been actively working within the community targeting African Caribbean and South Asian communities.

Breast feeding and post-natal depression

Many surveys suggest that women of BME groups are more likely to breastfeed, and for a longer duration, than women belonging to White groups. Nevertheless, as younger women belonging to BME groups become more in tune with other women overall, there is a need to reinforce the traditional recommendation of breastfeeding. South HAZ has been active in this respect. An Arts into Health Project undertook a consultation and raising awareness around the benefits of breast feeding. Local women and children at the Luqman Medical Centre and Brace Street Health Centre, painted fabric panels and talked about their experiences and feelings about feeding their babies. When pieced together, the fabric they painted formed a sumptuous tent representing the nurturing space that women need when they have given birth. This provided support to women around this important and special time. Following this, a Walsall wide breastfeeding network is being developed.

Breastfeeding among mothers of BME groups is substantially higher than among White mothers in Walsall. For the two years 2002/03 to 2003/04, almost 70% of Black mothers, 52% of South Asian mothers and 46% of Mixed race mothers were breastfeeding on transfer of care from midwife to health visitor. Among South Asian mothers, the highest breastfeeding rate was amongst Indian mothers (59%) and the lowest was among Pakistani mothers (45%). In contrast, however, only 32% of White mothers were breastfeeding (Figure 3:1).

Figure 3:1: Mother's breastfeeding on transfer to health visitor at 10 days, proportions by ethnic group, 2003/04 to 2004/05



Source: Walsall Hospitals NHS Trust

Another South HAZ project identified issues around post natal depression and services that were on offer. Women in Theatre were appointed to produce a Baby Blues DVD to record these experiences through motherhood and worked closely with groups from Sure Start in Palfrey, Alumwell, Pleck, Birchills, and North

Walsall. In addition, a jewellery project emerged Gift of Motherhood - which again worked with the above Sure Start groups, enabling at least 60 women to make their own bracelet and charm symbolising the challenge and gift of motherhood.

Other issues

Other issues such as teenage pregnancy, termination of pregnancy, and smoking in pregnancy tend to be closely identified with White women from more deprived areas. However, a lack of data by ethnic group cannot show how strong this correlation is with respect to the indigenous population. It should also be noted that teenage pregnancies among BME groups are not necessarily unwanted, especially among households with extended families. Also that unwanted pregnancies may be dealt with outside the Borough of Walsall.

Finally, there is existence of consanguinity as a result of first cousin marriages within the traditions of some BME groups. This is still responsible today for the high frequency of congenital malformations among the Peninsular Arabs of the Middle East. Previously in the UK, reports have been linked with people of Pakistani origin, but not always with a proportionately significant increased incidence of congenital malformation.

Children and young people (including drug misuse)

The following comparative data are known from various surveys:

- South Asian children are less likely to have chronic illness compared with children from the general population, but just as likely to have similar psychological health scores.
- South Asian children are less likely to have ever smoked cigarettes.
- South Asian children (especially of Pakistani or Bangladeshi origin) are less likely to have drunk alcohol, and any reported rates are lower.
- South Asian children have marginally lower rates of physical activity compared to the rest of the child population.
- Compared to the general population: Caribbean girls are more likely to be overweight; Caribbean and Pakistani girls are more likely to be obese; Indian and Pakistani boys are more likely to be overweight.

These are generally lifestyle issues, further discussed in the next chapter, regarding all age groups. In addition, with regard to children:

- The general child population and Caribbean children are more likely to have respiratory symptoms; South Asian (especially Bangladeshi) children are less likely.
- South Asian children are less likely to have major and minor accidents than children from Caribbean and White groups.

The following section on drug misuse is not confined to children and young people.

Drug misuse

Drug misuse is a major problem nationwide and it has historically been difficult to obtain an accurate picture of its pattern and extent, let alone details of misuse according to ethnicity. However, it is known that a substantially higher proportion of crack-cocaine users are from Black ethnic groups, based on police arrest. Yet this same high proportion is not reflected in crack and cocaine users accessing treatment. Indeed, at least 75% of people accessing specialist drug agencies are White; less than 10% are Black. This needs to be placed into context, since most drug users accessing treatment seek substitute medication for their heroin use, which in the UK has historically been the domain of White groups. More recently, there has been a growing trend towards heroin use among young South Asian men. It is clear, therefore, that ethnic data relating to serious and problematic drug misuse needs to be categorised by the type of drug used.

During 2003/04, a total of 512 people entered into drug treatment services in Walsall. Of these, 56 (11%) were from BME groups. Pakistani, Black Caribbean and Indians accounted for 70% of the BME group total, with Mixed race a further 18%. An acknowledgement of the increasing problem

of drug misuse among South Asian communities is reflected in the activities of South HAZ initiatives, which frequently target this population. Following the successful impact of video productions, over 150 local people received training, and widespread consultation on drug issues affecting BME groups was set in motion.

HAZ drug misuse initiatives

1. **Effective Responses to Drug and Alcohol Abuse**
   A partnership group was established to deliver HAZ and Single Regeneration Budget 5 (SRB5) drugs projects. Partners include Walkways, DEAL, National Association for the Care and Rehabilitation of Offenders (NACRO), Street Teams, and the tPCT. The projects, delivered in consultation with the Drug Action Team, included delivering basic drugs awareness sessions, working with young people to develop leaflets and resources, and employing staff to provide support advice to young people.

2. **Breaking the Silence**
   This explored the use of drugs within the Asian communities of Walsall. A video operator worked in partnership with drugs education agencies and workers to involve young people in the production of the video, to be used as a resource to raise the issue within groups. The video was distributed with the backing of the Walsall DAT. One stunning aspect of this project was that it documented drug misuse within the South Asian community, and tackled the denial of use voiced by many parents. Thus, a further video - *It couldn't happen to us* – was produced for use within the community.

3. **Asian Drugs Resource**
   This follow up to the video project examined issues of drug use in the South Asian community. Young people worked with arts workers to produce culturally appropriate drugs education materials and resources. Young people took part in a number of workshops to contribute to the development of these resources.

   Based on some concern that drug misuse may involve the South Asian female community, a needs assessment was undertaken.

Older people (including accidents)

This has commanded little attention, due to the widely held perception that BME older people are few in numbers and that they are looked after within the context of extended BME family groups. This is a mistake given a predicted significant expansion in the first decade of the 21st century. Moreover, BME older people have comparatively lower incomes and are generally disadvantaged in their housing. This is especially the case with regard to older Caribbean men, who are more likely to live alone than men from other ethnic groups. There are already issues around access to mental health services and discrimination around access to services in general, as highlighted by the Older People's National Service Framework.

South HAZ engaged to some extent with older people from the standpoint of physical disabilities, visual and hearing impairment. The project consulted and engaged with people from disadvantaged communities, commissioning four pieces of participatory appraisal to train and skill up South Asian women, young people, people with physical disabilities, and the visual and hearing impaired community. Following this: 200 people have been trained across the borough; 20 young people trained 10 people with physical disabilities; and professionals working in the area trained the visual impaired.

Accidents

For all the BME age groups, data is notoriously deficient because hospital evidence on injuries and accidents tends to have a very low rate of ethnic coding. This is further compounded by lack of such data obtained by the Fire and Police services.

Summary

Specific problems among BME population groups appear to be: poorer birth outcomes; poorer access to antenatal care; higher frequency of childhood obesity; increasing drug misuse among young adult men; and poorer access to services among older people.

Chapter 4

Lifestyle Factors: Any Big Differences?

The recent White Paper *Choosing Health* addresses lifestyle factors together with health inequalities, and so it may be expected that progress will be made on BME health matters.

Tobacco

Smoking is a widely accepted practice among Pakistani, and particularly Bangladeshi, men and is associated with socialising, sharing and male identity (Bush *et al*, 2003). Among women, smoking is associated with stigma and shame, but may often be hidden from family members. However, among younger adults, there are strong similarities with White people. As with many lifestyle surveys, caution should be exercised over their limitations. For example, there may be wide discrepancies and inconsistencies, because there is need for linguistic equivalence of survey questions (Bhopal *et al*, 2004). Nevertheless, the issue of smoking among Bangladeshi men has also been borne out by HSE self reported prevalence. It should be noted that there is a high prevalence of paan or betel use among both Bangladeshi men and women. More needs to be done on the specific targeting of smoking cessation services.

These general comments on smoking appear to be borne out in Walsall, according to lifestyle survey information summarised in Tables 4:1, 4:2 & 4:3.

South HAZ has tackled the issue of smoking in line with other approaches nationally. One HAZ project was entitled: *Smoking today's taboo; tomorrow's addiction*. This was an exploration of the smoking habits of young South Asian people in Walsall. The locally produced video focused on young people's early introduction to smoking through to tobacco addiction in later years. The video acted as a guided resource and came with an information and resource pack. It is intended for use with groups aged 12 years and upward. This led to the creation of an Asian communities smoking post to reinforce and follow up health promotion messages.

Another project was the *Ramadan Quit Smoking Campaign*. This was targeted at the Muslim community prior to and during Ramadan. It involved distributing posters, leaflets and utilising available resources such as the "Smoking" video to the community. Staff were recruited to represent the three main Muslim communities in Walsall. They worked together with the Walsall tPCT Smoking Reduction group to produce a Ramadan calendar. As well as showing prayer and fast breaking times, the calendar also had smoking information translated into appropriated Asian languages. During Ramadan, 15 mosques in Walsall were targeted with promotional material giving information about smoking harms and quit smoking support.

Table 4:1: Smoking Prevalence amongst South Asians by Gender, 1995 and 2000

	1995	2000
Males	24%	23%
Females	1%	1.2%

Table 4:2: Smoking Prevalence amongst South Asians, 1995 and 2000

	1995	2000
Indian	8%	9%
Pakistani	15%	13%
Bangladeshi	24%	23%

Source: Walsall Asian Lifestyle Survey 2000

Table 4:3: Stop Smoking Services in Walsall, Number of people setting a quit date by ethnicity and gender, 2004/2005

	Males	Females	Total
White	1,377	1,736	3,113
Mixed	11	21	32
Indian	24	10	34
Pakistani	30	8	38
Bangladeshi	14	0	12
Black Caribbean	10	12	22
Black African	5	0	5
Other Groups	8	1	9
Not Stated	29	32	61
Total	1,580	1,820	3,328

Source: Walsall Stop Smoking Service

Alcohol

Generally, rates of alcohol consumption are highest among White and Caribbean men, but lower among South Asian men (substantially lower among Pakistani and Bangladeshi men). However, there are cultural differences. For example, among Indian groups, Sikh men are generally reported to have very high rates. Table 4:4 shows lifestyle survey data for Walsall. _

Table 4:4: Alcohol consumption amongst South Asians, proportion of people who said they drank alcohol, 2000

	1995	2000
Indian	30%	40%
Pakistani	2%	5%
Bangladeshi	2%	-

Source: Walsall Asian Lifestyle Survey 2000

Case studies

'Fitastic' Asian Women's Project profiles

Saima Kauser is 16 years old, of Pakistani descent and attends the Abu Bakr School, an all girl Islamic school in Walsall. Her initial reason for joining the 'Fitastic' project was for weight loss as she had been advised by her doctor to lose weight. However, she is quite a shy girl and needed to be persuaded of the benefits.

Once she joined the group, Saima's confidence grew, partly as she knew most of the other girls and therefore felt comfortable. She attended all sessions and gained considerable information about healthy eating, weight management and exercise. She also developed her own fitness programme, which boosted her confidence further. The girl's group and the atmosphere generated of being able to wear head scarves or bring their own music, made her feel more comfortable. She was both happy and proud to receive her certificate of achievement after 8 weeks. As a result of this project, other family members have shown interest and are keen to join in future sessions. Saima achieved her goal of maintaining good health and is committed to staying healthy in the future.

Hannah Tariq is 17 years old, of Pakistani descent and a student at a local school. The project appealed to her as it overcame barriers such as not being able to attend mixed classes due to cultural reasons. Prior to this project, there were no other similar activities running, and where there were some, they were usually for older women.

The healthy messages given were taken on board as the girls often walked the short distance to the gym rather than take the taxis that were offered to them. Hannah has since shown interest in becoming a fitness instructor. She felt that being able to participate has given her the confidence to develop a career.

Physical activity

Available UK information suggests that age-standardised physical activity levels are higher among Black groups compared to South Asian groups (lowest among Bangladeshi men and women). These differences are consistent with parameters of overweight and obesity already discussed.

South HAZ has been active in addressing this issue by supporting and facilitating the development of a primary prevention programme for South Asian Communities with a focus on smoking cessation, physical activity, and healthy eating activities. Another initiative was the Fitastic Young Asian Women's Project. The aim of this project is to engage young Asian females from the community in cardiovascular physical activity and issues relating to obesity. This was conducted in partnership with Walsall tPCT, NACRO, and other Community groups. A group of young Asian females, aged 12-18 years, participated in weekly sessions at the NACRO gym. These involved how to utilise equipment and develop personal fitness programmes with a trained fitness instructor. After successfully completing an eight week course, they were presented with a certificate of achievement.

The Fit4Life Boundary Cricket Club project, promoted health related issues surrounding young men from minority ethnic communities. It was decided to promote cricket, as it is a popular sport amongst South Asian communities. A promotional leaflet was designed that highlighted key areas such as the 5-a-day campaign, physical and social benefits of becoming a club member. The project aims to gain the support of the national governing body of cricket (English Cricket Board) in recognising the use of the sport as a vehicle of engagement for promotion of health related issues.

Diet and nutrition

The consumption of fruit and vegetables is especially low among Pakistanis and Bangladeshis, the latter having high red meat consumption and low fibre scores.

Again, South HAZ has been active by establishing an Asian and African Caribbean Healthy Cookery Club, whereby local community members are trained to become Cookery Club tutors. These tutors then run six week healthy cookery courses to the local community groups. The tutors are supported by a Community Dietician and Palfrey Community Association. Achievements include: 41 community members trained as tutors; 168 community members attended the courses; and reported increased fruit and vegetable intake, with a reduction to mono-unsaturated fats.

Summary

There are big lifestyle differences, with issues around smoking, physical activity, and diet among Bangladeshis; and alcohol among Caribbeans and (reportedly) Sikhs.

Chapter 5

Access to Services: Is it Getting Better?

Reference has already been made in earlier chapters to access to preventative services. Generally, South Asian groups, especially Bangladeshi women, have lower uptake of cervical cancer smears and breast cancer screening. However, in Walsall, these differences against the White groups are not marked, and are as much to do with levels of deprivation. This is certainly the case regarding uptake of childhood immunisation.

Primary care

Again, there is a lack of ethnic recording. However, national surveys have indicated that BME groups are more likely than Whites to consult their GP. Despite this, respondents on issues of patient satisfaction suggest that BME groups experience poorer care compared to White groups. This was particularly expressed by South Asian respondents.

Although there is evidence to suggest that such differences in access do exist (Christopher & Kendrick, 2004), this could be attributed to deprivation. Practices in areas of high deprivation and high ethnicity were less likely to have measures of diabetic control recorded than those in more affluent communities with low ethnic minorities (Hippisley-Cox *et al*, 2004). This supports the findings of an earlier study in the Black Country that there were no significant systematic differences in the level of diabetic care given to Asian and non-Asian groups, as practices tend to treat all their patients alike and that observed differences were more likely due to variations in clinical practice between general practices (Stewart & Rao, 2000).

Hospital care

The above comments relating to primary care can also be applied to hospital care. South Asian patients specified lower standards of care with respect to prompt access, involvement, and choice of care. These same differences also applied with regard to experiences in Accident and Emergency departments.

Much inpatient data to highlight ethnic differences has analysed admissions for revascularisation (angiography, percutaneous transluminal coronary angioplasty; and coronary artery bypass graft). Walsall data on this topic has already been referred to, although not in sufficient depth to untangle age factors, and subgroups within an ethnic grouping. For example, data from elsewhere has been able to demonstrate better access among White groups; but also, among South Asians, poorer access by Bangladeshis compared to Indians and Pakistanis. Recent evidence, however, suggests that access to hospital care may be more equitable than is widely thought. When adjusted for confounding variables such as age and deprivation, general practices in London with a higher proportion of South Asian patients were shown to have higher rates of angiography (Jones *et al*, 2004).

Other services

BME groups are less likely to visit the dentist compared to White groups, although this does not necessarily imply poorer dental health (the exception may be Bangladeshis). Again, Bangladeshis are least likely (along with Caribbeans) to have visited the optician.

Many of these issues can be addressed by interpreting skills or similar facility. However, once in place, they should be widely publicised to promote better uptake of services.

There is a perception that many people from BME groups, who do not access conventional services, may turn to traditional remedies. This has been investigated in Walsall by Howell (1998). He found that the use of complementary and Asian traditional medicine by South Asians in Walsall is varied and complex. The younger group of South Asians have more characteristics in common with the White population. There is a decline in use of traditional remedies, which even then is additional, not alternative, to conventional remedies. Use is pragmatic, not ideological. There was no suggestion that use is related to ethnicity.

Summary

Access to services by BME groups in Walsall is improving. Certainly, there is an immense amount of work to be done on ethnic coding. However, awareness of services available has certainly been enhanced by information provided in the main South Asian languages. It would appear from evidence elsewhere that the quality of services provided to BME groups has also got to improve.

Chapter 6

Conclusions and Recommendations

The proportion and numbers of black and ethnic minority groups within the population has grown considerably in Walsall. This necessitates the careful planning and organisation of services to cater for their health needs, especially for the growing elderly population and increasing numbers of young people.

Conclusions

There is a lack of ethnic information in many key areas, including cancers and primary care. This lack of information hampers monitoring, and so makes it difficult to ensure equitable access to services in relation to the needs of BME groups.

It is difficult to unearth certain instances of racism in relation to health in Walsall, as elsewhere. However, disadvantage in access to services experienced by BME groups in general, and even by people of ethnic sub-groupings (*eg* preferential uptake or services experienced by Indians compared to Bangladeshis, or by South Asians compared to Caribbeans), can be interpreted as a proxy for racism. It follows that experience of racism has an adverse effect on indicators of health.

Socioeconomic factors clearly account for a large proportion of ethnic differences, especially given that the majority of the BME population in Walsall reside in the most deprived wards. However, they do not explain all the differences, as exemplified by inherent risks of coronary heart disease among South Asians and risks of some communicable disease among the BME communities.

Examples of good practice in the community are provided by HAZ initiatives. These are to be applauded in Walsall, and they have done much to address the needs of BME groups (especially South Asian communities) in the south of the borough. However, despite the positive impact of South HAZ in particular, in relation to BME issues, there are concerns:

- The future of HAZ is uncertain.
- Many initiatives are of a short term nature,

with no guarantee of entry into the mainstream.

- Projects, by their very nature, are not usually widespread, and so the main beneficiaries tend to be those populations living where there is an existing high concentration of BME groups.

We need to understand the perceptions of the younger members of BME groups, especially the youth who consider themselves totally integrated into society, not to mention people who classify themselves as Mixed ethnicity. This is an area of research that could be implemented in Walsall, principally from the standpoint of physical and mental health issues.

Recommendations

Specific actions that need to be worked on to address some of the health equality issues outlined in this report include:

- Ethnicity coding. There is need to promote and intensify ethnicity coding, especially in secondary and tertiary care, to enable identification and monitoring of service needs and gaps.
- Primary Health Care. Primary care practices serving areas with a high proportion of ethnic minorities and in areas of deprivation need to be supported to achieve good clinical indicators and outcomes for all their patients, so that access to health care is not just equitable, but of a high standard. The new GMS2 contract and the Quality and Outcomes Framework could help facilitate this process.
- Deprivation, lifestyle and cultural issues underpin some of the poor health outcomes experienced by minority ethnic communities. It is therefore important to have services that engage them and are targeted at them, whilst remaining part of mainstream health care provision.
- Members of the BME communities with English language difficulties should be encouraged to learn and become fluent in English. Not only would this improve their likelihood of accessing care but also enable them to integrate more easily into the wider community. In the interim it remains important for health service providers to continue offering efficient and effective interpreting services in order to overcome language barriers in accessing healthcare services.
- Increasing awareness of issues affecting BME groups and promoting equity in staffing among health care professionals.

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General Glossary

Abdominal obesity
The amount of abdominal fat measured by waist circumference. For non-pregnant women abdominal obesity is defined as waist measurement of 88cm or above and for men 102cm or above. This measurement is then usually related to a measurement of hip girth or height, to obtain a ratio that is more discriminatory than the Body Mass Index (BMI) in predicting risk of developing diabetes. Abdominal obesity is a precursor of Type 2 diabetes

Acute infection
A short and severe infection

Acute Myocardial Infarction (AMI)
Heart attack

Aetiology
The systematic investigation into the cause of diseases.

Angiography
A test using injection of a liquid dye to make the blood flow through arteries visible via X-rays. The test is used to assess whether blood vessels are narrow, irregular or blocked.

Antenatal Care Screening
A series of examinations and tests on pregnant women in order to detect any likely birth complications or abnormalities in the unborn child.

Asylum Seeker
A person seeking refugee status in order to be granted protection by the UK authorities not to be sent back to the country from which they fled. A refugee is a person with a well-founded fear of persecution because of his or her nationality, race or ethnic origin, political opinion, religion or social group, who is unable or unwilling to seek protection of the authorities in his or her own country.

BCG
Vaccination against tuberculosis (TB).

Betel
Fruit of the areca palm which is chewed together with lime and betel powder as a stimulant.

Breast screening
A method of detecting female breast cancer at an early stage.

Cardiovascular Disease
Disease relating to the heart and blood vessels.

Cervical Screening
A method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer of a woman's cervix (the neck of the womb).

Chronic infection
A long lasting infection

Cirrhosis
A condition where normal liver tissue is replaced by scar tissue (fibrosis). Liver cells become damaged and die as scar tissue develops and the liver gradually loses its ability to function properly. The most common causes of cirrhosis are excess alcohol drinking and infection with hepatitis B or C virus.

Consanguinity
A situation in which a couple are 'blood' relatives, ie they share a common ancestor. An example is a couple who are first cousins.

Coronary Heart Disease
Damage to the heart. Not enough blood flows through the vessels because they are blocked with fat or have become thick and hard. This harms the muscles of the heart.

Culturally competent services
Services taking account of cultural differences between ethnic groups.

Diabetes
A condition in which the amount of glucose (sugar) in the blood is too high because the body cannot use it properly. Insulin produced by the pancreas helps the glucose to enter the cells, where it is used as fuel by the body. There are two main types of diabetes: *Type 1* is known as insulin dependent diabetes, where the body is unable to produce any insulin. It is treated by insulin injections, diet and regular exercise. *Type 2* is known as non-insulin dependent diabetes, where the body produces insufficient insulin or when the insulin that is produced does not work properly (insulin resistance). Type 2 diabetes usually appears in people over the age of 40, though in South Asian and African-Caribbean people often appears after the age of 25. It is treated by diet and exercise alone or by diet, exercise and tablets or by diet, exercise and insulin injections. People with diabetes are at greater risk of heart disease, stroke, nerve damage and damage to the kidneys and eyes.

Epidemic
Affecting many people in an area at the same time.

Equality and equity of access
Equality means the degree to which a resource is equally distributed. Equity is concerned with how fairly resources are distributed throughout a group of people according to population need, not individual need. Equity can be defined as equal resource (access, use or quality) for equal need. It may sometimes be necessary to increase inequality to reduce inequity.

Haemoglobinopathy
A disorder caused by the presence of abnormal haemoglobins in the blood, e.g sickle cell disease.

Haemophilia
A deficiency of a blood clotting factor leading to susceptibility to bleeding and bruising.

Health Action Zones (HAZ)
Multi-agency partnerships between the NHS, local authorities, the voluntary and business sectors, and local communities. Their aim is to tackle inequalities in health in the most deprived areas of the country through health and social care modernisation programmes.

Hepatitis B and C
Hepatitis is an inflammation of the liver caused by a virus. Hepatitis B and hepatitis C are the types most commonly affecting BME groups.

Hepatocellular Carcinoma
A primary malignant disease of the liver.

Hyperinsulinaemia
A syndrome with excessively high insulin levels in the blood.

Hypertension
High blood pressure, a major cause of heart attacks and strokes

Infant Mortality
Death in the first year following live birth.

Infant Mortality Rate
The number of deaths under the age of 1 year following live birth, per 1000 live births per year.

Insulin Resistance
A condition where insulin produced by the body does not work effectively and the body cells cannot take up enough glucose. This results in high glucose levels in the bloodstream and type2 diabetes.

Life Expectancy
An estimate of how long someone is expected to live based on current mortality rates for an area.

Low Birthweight
A child born weighing less than 2.5kg

Malaria
A serious infection (which can be fatal) caused by a parasite that lives in mosquitoes and is passed to humans from a mosquito bite. Malaria infection is prevented by taking steps to avoid mosquito bites and by taking anti-malarial medication before visiting a country where malaria is present.

Maternal Death
Death occurring during or within one year of pregnancy, childbirth or abortion which is directly or indirectly related to these conditions.

Metabolic syndrome
A condition where people have at least three of the risk factors (high blood sugar, high waist circumference, high triglycerides, high blood pressure or low HDL cholesterol) for diabetes and heart disease.

Mono-Unsaturated Fats
A type of fat found mainly in olive oil, rapeseed oil, canola oil, nuts and seeds. Healthier than saturated fats.

Mortality
The number of deaths caused by a disease that occur in a defined population within a specified time, usually a year.

NACRO
National Association for the Care and Resettlement of Offenders. An independent voluntary organisation working to prevent crime by developing and implementing effective approaches to tackling crime and dealing constructively with offenders.

MSM
Men who have sex with men: this includes bisexual as well as homosexual men

Obesity
A chronic disease characterised by an increase of body fat stores. Body fatness is commonly assessed by the body mass index (BMI), which is calculated as measured body weight (kg) / measured height (m^2). Adults are classed as obese if their BMI is equal to or greater than 30 (see Abdominal obesity).

Older People
Differently interpreted as people over 50 or people over state retirement age of 60 for women and 65 for men.

Paan
A chewing tobacco mix comprising tobacco, betel nut, lime paste and perfume wrapped in a leaf.

Participatory Appraisal
A method of soliciting the views and priorities of people on issues affecting them. Used for health needs assessment and service planning.

Perinatal
Period of infancy between 24 weeks gestation and six completed days of life.

Perinatal Mortality Rate
Number of stillbirths together with deaths up to six completed days of life per 1000 total births per year.

Post Natal Depression
A depressive illness in a woman following soon after she has given birth.

Ramadan
Annual Muslim religious festival lasting 29/30 days during which all adult Muslims must give up food, drink, smoking and sexual activity during the hours of daylight.

Revascularisation
Reestablishment of the blood supply to the heart. The two most widely used techniques are coronary artery bypass surgery (CABG) and percutaneous transluminal coronary angioplasty (PTCA).

Screening uptake
The percentage of eligible women who attend for screening.

Secondary prevention of coronary heart disease
Prevention of progression of coronary heart disease in people who have survived a heart attack, people with angina and those who have had a revascularisation procedure, or patients with any other manifestation of atherosclerotic disease such as stroke, peripheral vascular disease or diabetes. Secondary prevention is implemented through lifestyle changes (eg stopping smoking, healthy eating, and taking more exercise) and various drug treatments.

Sickle Cell Disease
A group of inherited disorders of abnormal haemoglobin, which is more common in certain ethnic groups. It is characterised by anaemia and acute exacerbations called 'crises'.

SRB5
The fifth tranche of the Single Regeneration Budget allocated to local authorities for urban regeneration.

Sure Start
A Government programme to help disadvantaged children under the age of four to develop physically, intellectually, and socially.

Syphilis
A sexually transmitted infection that can cause serious damage to body systems and organs if left untreated.

Thalassaemia
A group of inherited disorders of haemoglobin metabolism. In severe form regular blood transfusions are needed.

Tuberculosis (TB)
An infectious disease caused by the bacterium Mycobacterium tuberculosis. TB commonly affects the lungs, but can reach any part of the body. It is usually spread by coughs and sneezes of an infected person. TB is curable with a course of special antibiotics taken for at least six months. The most important part of controlling TB is identifying and treating those who already have the disease, to shorten their infection and to stop it being passed on to others.

Typhoid
A potentially life threatening illness caused by bacteria and acquired by the ingestion of food or water contaminated by the bacteria, or by food and drink that have been handled by a person carrying the bacteria.

WALDOC
Walsall Doctors On Call out-of-hours GP service for Walsall.