Study of a Needs Assessment of the Bangladeshi and wider Muslim Community

Bangladeshi Women's Association Essex

Full report

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1. Introduction

Bangladeshi Women's Association Essex (BWAE) was established in 2001 in response to feedback from the community, identifying there are no services tailored to meet the needs of Bangladeshi Asians Community that take into account the cultural and religious sensitivity or language barriers that individuals face in getting access to health and social care. BWAE has become an integral part of the community as it is the only organisation meeting the needs of Bangladeshi and Muslim families.

The Founder of the organisation Jahanara Loqueman, one of the first Bangladeshi woman who moved to Colchester, to join her husband in 1965. Jahanara was experiencing difficulties and facing barriers in particularly accessing services and language which was a huge barrier. In the early 1970s, other restaurant workers wives came to join their husbands in Colchester after the Bangladesh Liberation. Her experience of settling in a new country was useful to other women and she became a source of help and support to other members of the community.

The Bangladeshi and Muslim communities are expanding in Colchester and surrounding areas. Currently there is inadequate provision for the culturally specific needs of women and families within our locality. Concerns has been growing amongst the community for the need of community development and better access to services and social welfare. Our outreach work confirmed that everyone agreed 'something needed to be done'.

Primary care services provide the initial point of contact in the healthcare system, acting as the front door for the NHS. These services should therefore notably be a point of equal access for all in the community. However, research over the years has shown inadequate patient access and poor patient satisfaction among patients from ethnic minority backgrounds. COVID-19 has brought health inequalities to the forefront more than ever before. For many, the reality is that these inequalities and disparities are not a new phenomenon.

This study aims to take a deeper look at the problems faced Bangladeshi communities in accessing health and social care services and looks at what changes can be made to overcome these barriers to ensure the provision of equal access to health and social healthcare.

In light of this overarching aim, a set of objectives were created to guide our study:

1. Improve access to the NHS for Bangladeshi Asians.

    ⇒ By conducting a survey in the Bangladeshi community, we aimed to identify high priority medical concerns within the Bangladeshi community. This would indicate the magnitude of health concerns and related services this may affect.

2. Promote information sharing within the community.

    ⇒ A culturally sensitive approach to identify groups of individuals particularly at risk of being overlooked in their health and social care.

3. Improve the design of future health and care services for Bangladeshi Asians.

    ⇒ By gathering data specific to the Bangladeshi community, we hoped to indicate relevant community resources that will be required to develop culturally sensitive health and care services.

This study was designed and completed by the Bangladeshi Women's Association Essex (BWAE), using funding from NHS Charities Together. A full literature review was undertaken by Dr Farzana Chowdhury, and the analysis was completed by Liesel Park and Sharon Rodie, of the Suffolk and North East Essex Integrated Care System's Central Team.

It is hoped that the findings from this report will aim to inform on strategic decision making, improve the design of health services targeted at this group; accessibility to the National Health Service and commission services to ultimately improve health outcomes and social mobility in the Bangladeshi community, and in turn other Muslim communities locally and nationally.

We look forward to working with our partners from the voluntary & community and statutory sectors to explore how the findings and recommendations in this report can be taken forward.

2. Summary of literature on the health needs of people of Bangladeshi and South Asian origin

A detailed literature review is appended to this report, which identifies a range of diseases and conditions where people of Bangladeshi and South Asian origin have a higher prevalence than people of other ethnicities.

2.1 Demographics

In the 2011 census, ethnic minorities in England and Wales represented approximately 14% of the total population. Asian/Asian British people are the largest minority ethnic group in England and Wales, accounting for 7.5% of the total population; the Bangladeshi ethnic group make up 0.8%. Of the population of Essex (1.39 million), 5.72% were of Black Asian and Minority Ethnicity. In Colchester, the Bangladeshi population (0.22%) is close to the average in Essex (0.20%).

Asian communities tend to be younger than the average nationally, with under-18s comprising 38.3% of this population. In contrast, Bangladeshis had the lowest percentage of people aged 65 years and over (8.2%). From the 2011 census, 18.5% of people of Bangladeshi ethnicity were aged 15-24, 48.1% aged 25-44, 10% aged 45-64, and 3.7% aged 65 and over. However, the census figures are now 11 years out of date, and we are currently awaiting the publication of the 2021 census data, which is due to be made public in the autumn of 2022.

2.2 Physical health

Type 2 diabetes

South Asians, particularly Bangladeshis, are 5-6 times more likely to develop diabetes, namely type 2 diabetes (T2D). Incidence (the number of new cases during a specified time period) is also greater in ethnic minorities, with new-onset T2D 2-3-fold higher in British South Asian groups compared to White British people. Comparing more specifically to White British women, the incidence of T2D is 6-fold higher in Bangladeshi women. Bangladeshi men display the highest risk amongst ethnic groups and is 60% greater than that in White British men. T2D also develops 5 to 10 years earlier in South Asians and at a lower obesity threshold in South Asians, compared to White British people.

Cardiovascular Disease (CVD) and Stroke

CVD is one of the leading causes of mortality in the UK. Diabetes increases the risk of developing CVD two-fold. The prevalence of CVD is higher in South Asian groups, who have higher rates of ischaemic heart disease, hypertension and diabetes compared to the White British population. South Asian groups are significantly younger when diagnosed with heart failure (72 years) compared to the White British population (78 years). British South Asians present with 12% more hypertension (high-blood pressure), 24% more diabetes and 11% more anaemia than the White British population. Stroke rates in England and Wales are higher in African-born, Bangladeshi and Pakistani populations.

There are a number of risk factors associated with CVD that, if managed effectively, can prevent further illness or long term conditions:

- ***Hypertension:*** This affects 26.2% of UK adults, with a slightly higher prevalence in Essex, at 27.9%. If it isn't managed well, hypertension can lead to heart disease, stroke and kidney disease.
- ***Cholesterol:*** Generally, a reduction in high density lipoprotein (HDL – or 'good cholesterol') and increase in low density lipoprotein (LDL – or 'bad cholesterol') have been shown to increase the risk of heart disease. While total cholesterol is comparable between British South Asian and White British groups, raised LDLs have observed in South Asians - this is largely genetically determined, and is a potential ethnic-specific risk factor of ischaemic heart disease.
- ***Hyperglycaemia***: Non-diabetic high glucose levels are linked to prediabetes and type 2 diabetes. Compared to White British counterparts, South Asian and African Caribbean groups present with increased glucose intolerance, raised fasting and post-load (an hour after a meal) insulin. It is these metabolic disturbances that can lead to obesity - a British population survey of 3193 South Asians found that mean waist-hip girth ratios and

subcutaneous fat folds were higher in South Asians compared to Europeans. These metrics correlated with glucose intolerance, insulin and blood pressure levels.

Health related behaviours that can create risk of disease

A range of behaviour has been associated with cardio-metabolic disorders:

- ***Tobacco:*** Tobacco causes health problems for all ethnicities, with smoking being the most common form of tobacco use. 2017 data showed that 16% of Asian men smoked, and 3% of Asian women smoked. The use of smokeless tobacco is still also a factor in South Asian Britons, as is the use of shisha pipes. Smokeless tobacco appears to have fewer risks for lung cancer and respiratory diseases than cigarette smoking, but there may be some correlation with higher risk of oral and pharyngeal cancers among South Asian ethnic groups and a link to a range of oral health problems that include tooth staining and wear, periodontal disease, bad breath (halitosis) and tooth loss. Research suggests that shisha use has an effect on respiratory illness, low birthweight and gum disease, as well as metabolic disorders.
- ***Physical activity:*** Nationally, self-reported physical activity has been recorded as lowest for people of Asian ethnicity, compared to White British adults. Bangladeshi men were 45% less likely than the general population to meet the guidelines for physical activity. Lack of physical activity may contribute to an increased risk of obesity, diabetes and cardiovascular disease. In a focus group, British Bangladeshis perceived exercise as worsening illness and adding to physical weakness. In contrast, the actions taken during daily Muslim prayers (which includes bowing to the ground) were viewed as "worthy" and "health-giving" forms of exercise.
- ***Alcohol:*** The consumption of alcohol units by South Asians is significantly lower (0-14%) compared to the general population (7.2-17.5%), with people of Bangladeshi origin at just 5%. However, a survey has found that whilst drinking amongst Pakistani Muslims appears to be low, this may be hiding significant levels of drinking within the group that simply isn't being reported, and official statistics are under-recording what is happening.
- ***Diet:*** There are varying attitudes and cultural beliefs towards foods and the role they play in an individual's lifestyle. The Health Survey for England conducted in 2004 revealed that while 42% of Chinese and 36% of Indian women were most likely to consume the recommended five portions of fruit a day, only 28% of Bangladeshi women reported doing so. British Bangladeshis perceived white sugar, lamb, beef, ghee (derived from butter), solid fat and spices as providing nourishment and strength; despite this, spices and ghee were identified as foods which should be avoided by those with diabetes. The consumption of clarified fat (ghee) plays a role in dyslipidaemia observed in South Asians. In the survey, boiled (pre-fluffed) rice and cereals were observed as "weak" foods and liable to worsening disease in the elderly. A staple crop in Bangladesh, an imbalance of rice intake, rather than the quantity, was understood to be a causal factor of diabetes. Such cultural perceptions may conflict with advice given by healthcare professionals to help manage diet in this ethnic group.

2.3 Mental health

Black and ethnic minorities are at greater risk of mental health problems compared to the White UK-born population. Compared to White British people, Bangladeshi groups record excess levels of stress, which has been associated with migration and settlement, racism and discrimination, poverty and adverse environment. Per 100,000 people, 136.1 Bangladeshis are detained under the Mental Health Act, more so than Indian or Pakistani counterparts (71.9 and 121.1 respectively). They are more likely to report social factors as a cause of deterioration in mental health. Poor interpersonal relationships, stress and negative childhood experiences were reported to contribute to strains on mental health within Bangladeshis, whilst alternative forms of treatment were sought after more frequently from this group rather than conventional medication. Like many cultures, a degree of stigma is also associated around mental health diseases, preventing individuals to talk about it openly. As such, Bangladeshis may be less likely to seek help from professionals and therefore be grossly underestimated and underdiagnosed in having a mental health disorder.

2.4 Socio-economic factors

The workplace

Bangladeshi ethnic minorities have been reported to be disadvantaged in the UK workplace. Between 2011 and 2015, 20% of Bangladeshi workers earnt less than the bottom 10% of White British workers. The proportion of the

population not in the labour force is higher for Bangladeshi women (57.8%) compared to Bangladeshi men (23.2%), which may be driven by cultural differences as 38.1% of Bangladeshi women say "looking after the family" is one of the reasons for their inactivity. 22% of Asians are more than twice as likely to live in households with persistent low income than White British counterparts. In 2018, employees of Bangladeshi and Pakistani heritage earnt the 20.2% less median hourly pay in the UK compared to White British employees. This is of significance since the breadwinners of many Bangladeshi households are hourly waged earners, whose reduced holiday, sick leave and job security can affect their anxiety and stress levels.

Deprivation

Generally, deprived people are diagnosed with heart failure 4 years earlier than affluent groups, and may also experience obesity, diabetes, anaemia, depression and chronic obstructive pulmonary disease.

Housing conditions

Bangladeshis are more likely to live in overcrowded homes compared to the general population. For example, 18% of Bangladeshis live in homes with more than 1 person per room, compared to 4.1% among the rest of the UK population. Children living in overcrowded homes are more likely to contract meningitis and develop respiratory infectious diseases. It has also been linked with slow growth, correlating with an increased risk of heart disease as an adult.

3. Methodology

Scope

The needs assessment survey aimed to explore the range of physical and mental health issues experienced by the Bangladeshi community over the age of 16 who live in Colchester, Essex and surrounding areas; and the barriers they face in accessing health and care services.

Research questions

The needs assessment focused on three main questions:

1. What are the common health issues that the community lives with?
2. How easy is it to access health and care services when they are needed?
3. What are their barriers to accessing help, and where do they arise?

Method

To gather data on the health needs of the Bangladeshi community in Colchester, The Bangladeshi Women's Association Essex (BWAE) devised a detailed semi-structured survey where respondents could record the health issues that they and their family live with, and describe how easy it is to seek help from health and care services. The questions were devised based on the anecdotal knowledge the organisation has regarding the most prevalent issues within their community but 'free text' space was allowed at every stage in order that respondents could add more explanation or share their experiences. This enabled any additional information to emerge as the questionnaire was completed. The content of the questions was therefore intentionally biased in order to draw out known issues, however as the survey was designed within the community itself, reflecting an ethnographic approach to the needs assessment.

The surveys were shared with potential respondents as hard copies that they could complete themselves independently or with support. In total, 125 surveys were completed, 70 of which respondents completed independently and the remainder were completed jointly in conversation with a member of BWAE. These conversations both ensured that surveys were completed as fully as possible, and have enabled issues to surface that respondents may have otherwise not described in any detail.

Respondents were given free choice to complete the surveys, and so are not intended to be a representative sample of the community's demographics.

Analysis

The data gathered is a mixture of qualitative and quantitative, and so a mixed methods approach has been taken. Quantitative data highlights the conditions most commonly recorded by respondents on their health and wellbeing, as well as some ratings regarding health services. Qualitative data comprises respondents' comments and the stories they have shared during completion of the surveys. Our analysis uses a grounded approach which has allowed both common themes and individual stories to emerge.

4. Findings

4.1 Demographics of respondents

The survey was completed by 125 respondents. Although the survey targeted the Bangladeshi community in Colchester, some local respondents identified themselves as Pakistani or simply Asian. The Muslim community in Ipswich expressed an interest in the survey and so the offer was extended to them, and 8 of the 125 surveys were completed by this community. 122 of respondents said they were Muslim, three left this question blank.

Of those who answered the questions on ethnicity and origin, the majority (113 respondents, or 90%) identified that they were from families that originated from Bangladesh. Four respondents identified as 'Asian Pakistani' and six as 'Asian – Other'. One respondent defined themselves as Mauritian, and one left this section blank. Of the 109 respondents who said they originated from Bangladesh, 101 were from the Sylhet Division, two were from Khulna Division, two from Dhaka, one from Chittagong Division, and one from Barisal; two did not name a district of origin.

There are about 39 languages spoken across Bangladesh, with the official language being Bengali (or Bangla). 103 respondents said they spoke Bengali or Bangla with 82 specifying the Sylheti dialect; the remainder did not answer. 18 respondents specifically mentioned that they spoke English, these were aged from 18 to 79. 82 respondents said they could read and write Bengali. It is likely that the majority of respondents speak English at some level, so it may be appropriate to explore in more detail the levels of fluency and literacy in English among the community.

Gender

Although most respondents were female (74), a large proportion were male (50), while one respondent did not specify their gender. It is important to recognise, therefore, that analysis by gender will inevitably be distorted by the higher numbers of female respondents.

Age

This survey was completed by people predominantly aged over 25 and of working age. The number of respondents aged over 65 (approx. 17%) appears relatively low, but data from the last census suggests that there may well be proportionately fewer Bangladeshis in this age range. However relatively few respondents were in the youngest age group (10%), suggesting this group is under-represented in the survey, so it is clear that we need to know more about the health of younger Bangladeshi people.

16-24 years (13 respondents – approx. 10%)

- Of the 7 females and 6 males in this age group, all were single, but for 1 female who was married.
- 6 respondents were educated to GCSE/A level, with 7 being University graduates.
- 7 respondents are in employment, 2 in full time work (1 female, 1 male) and 5 part time (2 female, 3 male); one male was unemployed and looking for work. Five respondents were students (4 female, 1 male).

25-44 years (60 respondents – approx. 48%)

- Of the 38 female and 22 males in this group, 48 were married (of which 31 were female). One was divorced, one separated and one widowed, all women in their 40s. 5 men and 2 women were single and 2 people did not specify.

- 19 had a university education (11 female, 8 male), 18 were educated to GCSE/A Level (12 female, 6 male), 6 were educated to High School level (4 male, 2 female), 12 described themselves as having 'other educational level' (10 female, 2 male); the remainder were unspecified.
- 29 of the respondents were in some form of paid employment: 16 Full time (6 female, 10 male), 13 part time (11 female, 2 male). 10 were self-employed (1 female, 9 male), 3 were students (all female), 4 were unemployed seeking work (all female). 9 females described themselves as homemakers, 5 people did not specify.

45-64 years (27 respondents – approx. 22%)

- Of the 13 females, 13 males (and 1 unspecified) in this group, all were married.
- 5 were university-educated (2 female, 3 male), 7 with GCSE/A levels (3 female, 4 male), 3 were educated to High School level (2 female, 1 male), 7 at 'other educational level' (4 female, 2 male, 1 unspecified), 2 had no schooling (both female), 3 preferred not to say (all male).
- 16 were in some form of paid employment: 3 full time (1 female, 2 male), 4 part time (3 female, 1 male). 9 were self-employed (all male), 8 women said they were homemakers, 2 were unemployed and seeking work (1 female, 1 unspecified), and 1 preferred not to respond.

65 years and over (21 respondents – approx. 17%)

- Of the 13 women and 8 men in this age group, 12 were married (6 female, 6 male), 1 male was divorced, 5 were widowed (all women aged between 69 and 80), 1 male was single, and 2 women did not specify.
- 5 had been to university (1 female, 4 male), 4 educated to High School level (all female), 2 to 'other educational level' (1 female, 1 male), 5 had no schooling (4 female, 1 male) and 3 did not specify.
- 10 of this group were retired (3 female, 7 male), 1 man was employed part-time, 7 women described themselves as homemakers, 1 woman said she was unable to work, while 2 did not specify.

In summary, marriage is the most common status among people in the community, with very few who say they have experienced marriage breakdown, and most wait until after the age of 25 to marry. Higher levels of educational attainment were more common among the younger age groups, with university-level qualifications being gained by half of those aged under 25, falling to a third for those aged 25-44, and around a fifth of those older than this age group. Predictably many in the youngest age group were in education rather than work. Two thirds of the 25-44 age group were employed or self-employed, falling slightly for those aged 45-64; but the proportion of people in employment or self-employment fell in the older age groups, with only one respondent aged 65 still in work, The vast majority of those self-employed were men, while women made up a larger proportion of those in part time work or describing themselves as homemakers.

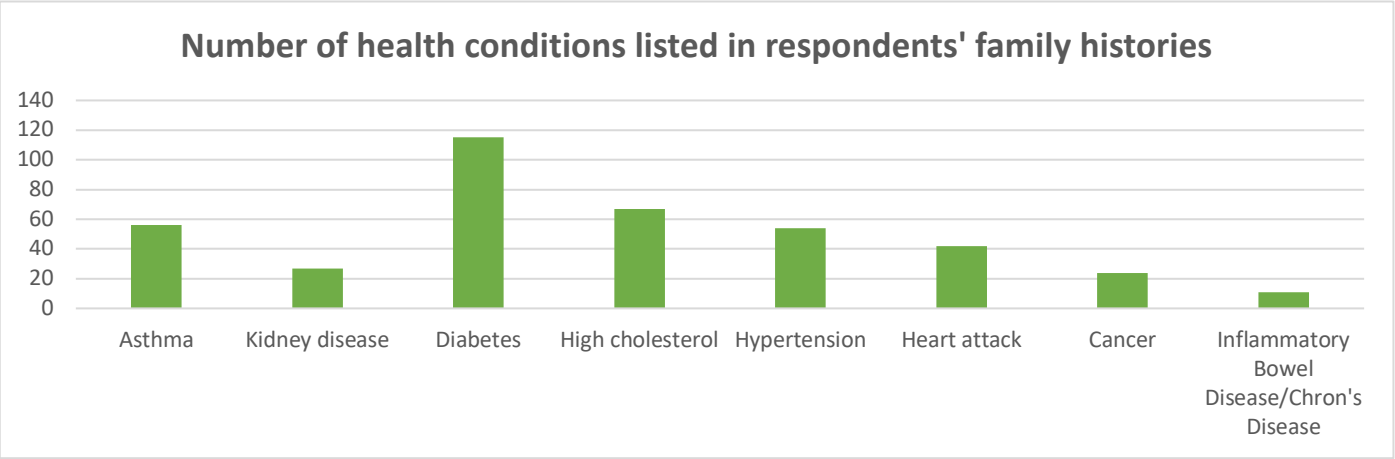
4.2 Health conditions and disability

Respondents were asked about their own health conditions and their family's history.

Family histories

Respondents described a wide range of health conditions within their family history, both among their parents and their adult siblings.

The following table details the number of times that respondents listed conditions among family members. It should be noted that several members of the same families will have completed surveys and therefore there will be some duplication in the responses on family histories. Conclusions cannot therefore be drawn based solely on the numbers, but nevertheless the survey does highlight trends in prevalence of specific conditions within the community.



We know, from the evidence identified through our literature review, that there are certain diseases and conditions where people of Bangladeshi and South Asian origin have a higher prevalence than other ethnicities. The findings from the survey reflected that many of the conditions identified by respondents are consistent with this data.

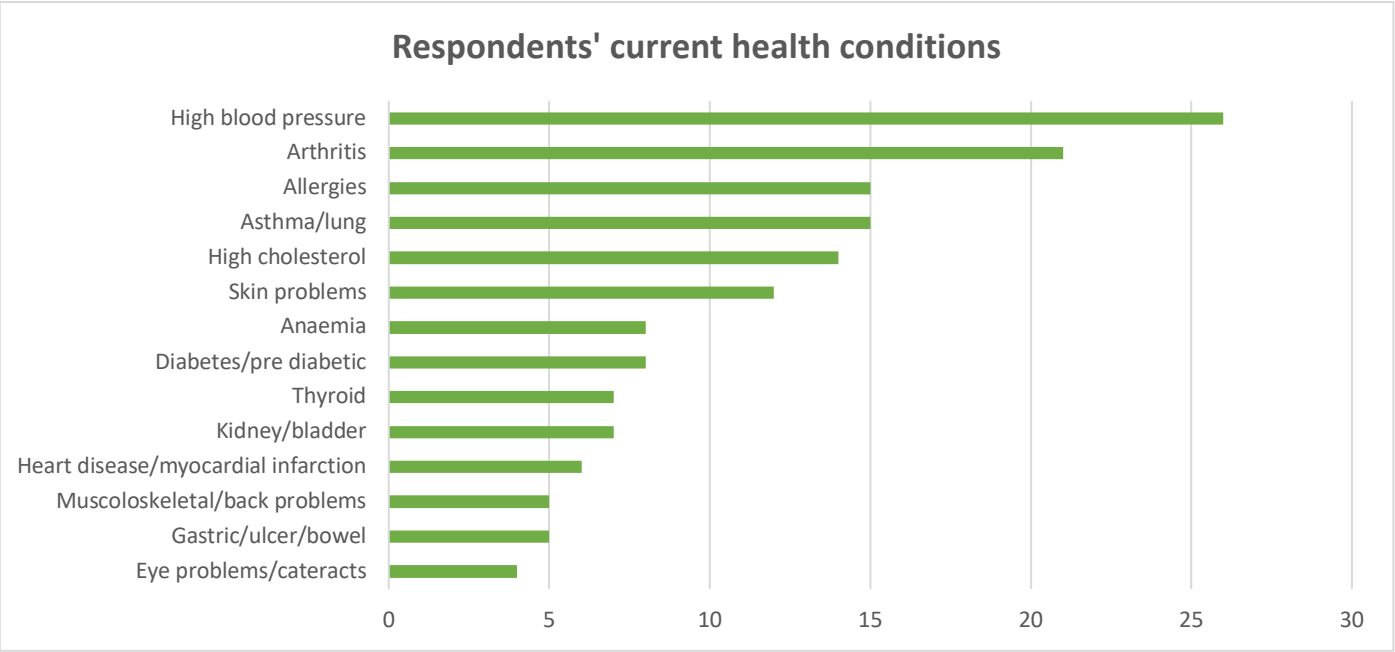
One respondent highlighted many in the community experience intergenerational health issues:

> ***Both my parents were diagnosed with diabetes in their 50s. They ended up taking insulin. My father died from heart failure when he was 70 years old. He had a pacemaker too. My mother died when she was 75 years old. My father also suffered from anxiety and had to give up work in his 40s. This was not recognised or treated. I and my brother have also ended up with taking insulin and other medication.***

Interestingly, there were a number of common health conditions, particularly those prevalent among older people, which were mentioned by very few respondents. Arthritis was only highlighted on 4 occasions, and dementia was mentioned only once. Only 17% of survey respondents were aged over 65, and as the literature review has highlighted, less than 4% of Bangladeshis were aged over 65 at the 2011 census. The lower reporting of age-related conditions could be due to the smaller population of older people in the Bangladeshi community or the fairly small number of respondents in this age group. However, such conclusions should be treated with caution, as the lower numbers could also reflect under-diagnosis of conditions due to lack of access to services which is a common theme throughout this report. Further exploration of the health needs of older people is therefore needed.

Current physical health issues of respondents

Respondents were asked to list their current health issues, and 50 people listed a wide range of conditions, many having multiple health problems. The table below lists the most common conditions and numbers living with them.



Again, most of these conditions are consistent with the national data on prevalence among South Asian ethnicities and reflect many of the conditions in respondent's family histories. A small number of respondents (less than three in each case) highlighted other long term conditions including Multiple Sclerosis, Parkinson's Disease, cancer, sleep apnoea, hypermobility, immune deficiency, pancreatic illness, inflammatory bowel disease, gynaecological issues, diverticulitis, and migraine.

Disability and chronic illness

Of the 125 people who completed the survey, very few identified themselves as having a disability. None in the 16-14 age group said they had a disability, only three of those aged 25-64, and only 7 of the over-65s.

Respondents were also asked whether they had a chronic illness, 37 responded that they did: 13 in the 25-44 age group (10 women, 3 male), 12 in the 45-64 age group (7 women, 5 men) and four aged 65 and over. None of the respondents aged under 25 said they had a chronic illness.

These figures are very low when compared to the range of long term health conditions that respondents also described having (above). This suggests that people in the Bangladeshi community would not tend to describe themselves as being disabled or having a chronic illness. It may be that their impairments do not affect them to a significant degree, or they simply may not use the term 'disability' in the way that health and care professionals do. Further exploration of the reasons for the low response to these questions is needed.

4.3 Oral health

The survey asked a range of questions about oral health; this section was added into the survey after the survey period began and therefore relatively few respondents answered these questions. Of those that did complete this section, 33 said that they had a regular dentist while 16 said they did not. Of those who did not have a regular dentist, all but two respondents said they experienced some level of anxiety. Many of those that did have a regular dentist also reported anxieties, but a third said they had no anxiety at all, so whilst the number of respondents is small, it does appear that anxiety is a factor in access to dentistry.

Of the 33 people that said they have a regular dentist, however, 13 had not visited the dentist for at least one year, and four of those had not visited the dentist for over two years. Only 10 of the 33 respondents to this section had been to a hygienist in the last 12 months. Therefore, it appears that even where people say they use dentistry, many have not accessed services for several years, and anxiety seems to be a significant contributory factor.

However, a further factor was difficulty accessing a dentist. As one respondent explained, this not only relates to the availability of appointments but also delays due to Covid and the challenges in arranging an appointment when a supporter is needed:

> ***'Dental appointments are hardly available. Questioning a receptionist or requesting to be seen quicker, their response would be 'it's not an emergency.' When detailed symptoms described then the response is 'we are not trained clinically.' I am an elderly [my] daughter reported my anxiety/problems of broken tooth etc got advised to call in the morning, every morning I was told appointments all gone! … Have only been having soft/liquid food or nothing as too afraid to eat. Yet dentist has rescheduled January appointment to March without our knowledge…. Those who have to accompany to these services have always struggled with affordability of time. Children are all in full time employment – need time out. Arranging children time and appointment availability delays the patient being seen quicker.'***

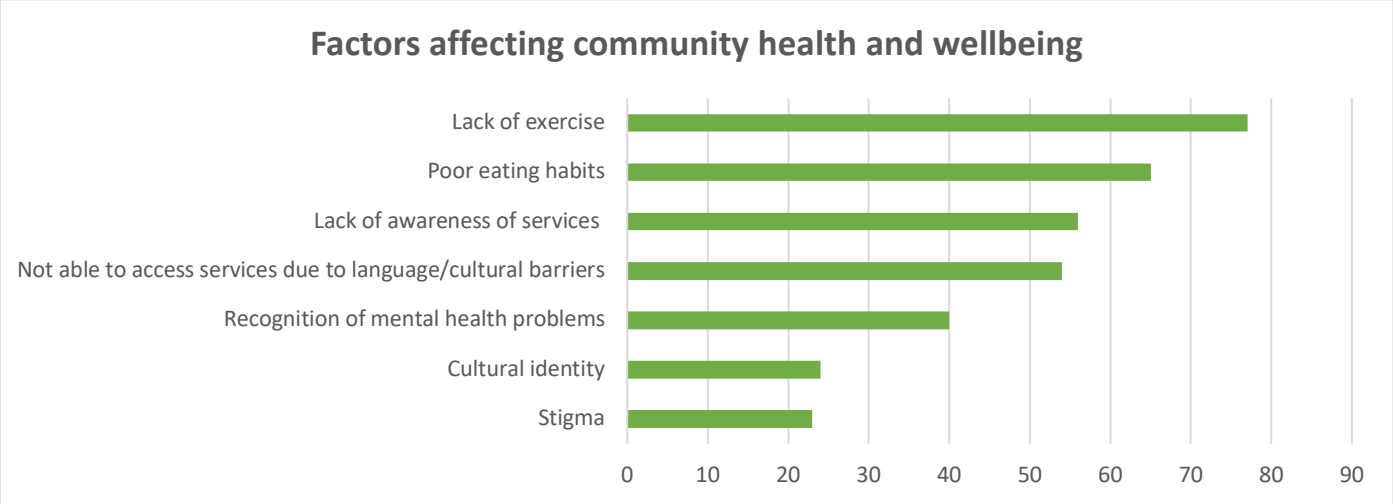
18 of the respondents in this section of the survey stated they used betel nut, shopari or paan, with 10 saying they used it daily or several times a week. Although the ages of users ranged from late 20s to people in their 80s, of those that shared their age, eight were aged 25-44 and 7 were aged 65 or over. 13 of the users were female, five were male. Although the numbers responding are small, there was a strong correlation between those that used these products and anxiety about visiting the dentist (only one reported no anxiety). Half of the 18 respondents said they had either not visited a dentist in over two years or had never been at all, and 8 shared that they had never been to a hygienist. Four of the 18 respondents, 9 reported tooth pain, decay or affected gums. This group of respondents is small, but they appear less likely to use dentistry services despite the clear impact of using these products on their oral health.

4.4 Factors impacting on people's health and wellbeing

Respondents highlighted a range of factors that impacted on their general wellbeing, under the following categories:

- Lack of exercise
- Poor eating habits
- Recognition of mental health problems
- Lack of awareness of services
- Not able to access services due to language/cultural barriers
- Stigma
- Cultural identity

Respondents were able to tick as many factors as applied. The table below summarises responses in more detail.



Lack of exercise and eating habits were the most commonly cited factors, both of which are significant issues for those with heart problems and diabetes, conditions very common in this community. Concerns about a lack of awareness of the services available, and finding services inaccessible, were also common issues that are reflected throughout this survey. Recognition of mental health services was mentioned by 40% of those who responded to this section of the survey, which is discussed in more detail in section 4.5 below. it is unclear whether responses relate to a lack of recognition by the community or by services, however in the light of the responses to the mental health section of this questionnaire it is likely that the barriers relate to both. Around a quarter of responses to this question cite stigma and cultural identity as factors, and again this may relate to both experiences within the community and when engaging with health and care services.

The responses indicate that measures are urgently needed to improve the community's levels of physical activity and healthy eating, with the need for services to eliminate the practical and cultural barriers the community faces so that they can access health and wellbeing services when they need them.

4.5 Mental health and wellbeing

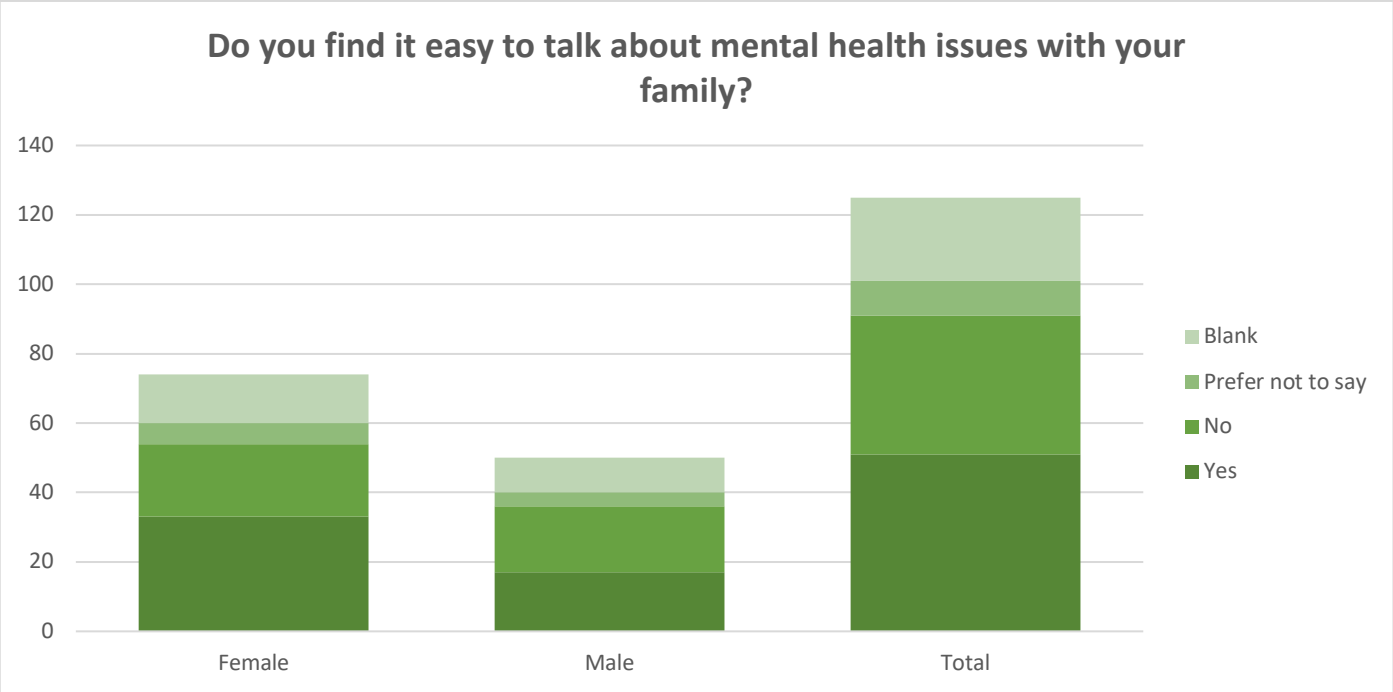
When asked about whether they currently had a health condition, 7 respondents indicated they had anxiety, 6 had depression, one had obsessive compulsive disorder and one had dementia; a total of 12% of respondents. These numbers appear proportionately low compared to the national averages for the whole population.

Family support

Respondents were asked how easy it was to speak to their family about mental health, and how easy it was to access services, whether they had accessed counselling and to share their experiences of mental health services. It should be noted at the outset that a significant proportion of those surveyed did not complete this section, which impacts on analysis of respondents' views.

It is evident that families are a positive source of mental health support for many. Of the 125 respondents, 51 said that they find it easy to talk about mental health issues with their family, with 40 saying they do not find it easy.

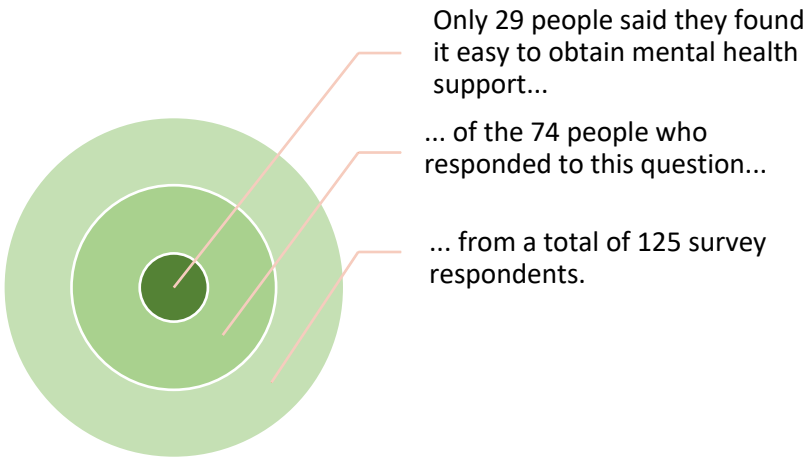
However, 10 preferred not to say, and 24 respondents left this question blank. Female respondents were more likely to say that they found it easy to speak to family, compared to male respondents whose views were more evenly split.



When analysing by age group, those under 65 who responded were evenly split between those who definitely would speak to their family and those who would not. However of those aged 25-64, between one quarter and one third either preferred not to say or left the question blank. Notably, of the 21 respondents to this section aged over 65, just over half would speak to their family, probably reflecting the general greater reliance of this age group on their family for support.

Support from services

Respondents were asked if they found it easy to access support for mental health issues. Of those aged 44 and under, respondents were fairly evenly split between those who found it easy to access support and those who did not. However, a third of 25-44 year olds preferred not to say or left the question blank. Of the 45-64 age group, over half did not answer this question; the numbers of respondents are small, only 18, but it is notable that only two said they found it easy to access support. In fact, across all age groups, only 29 of the 74 respondents who answered this question found it easy to access mental health support.



Respondents listed a number of reasons why they found it difficult to access support, including waiting times. One highlighted that repeat visits to the GP were needed before specialist help could be obtained:

> ***'Only if reported many times to GP re stress or other ailments - then further treatments proceed. i.e referral to psychologist/talking therapy etc'***

Many mentioned cultural barriers both within the community:

> ***'It's … very difficult to talk with families as there are stigma and shame attached to recognising mental health issues.'***
>
> ***"It is not recognised in the community, more awareness and culturally sensitive treatment. Diverse staff/gender.'***
>
> ***'I personally feel there is a lack of awareness in the Asian community.'***
>
> ***'It would be good for this topic to be discussed at mosque. This may help dispel stigma and negative attitude.'***

As well as a lack of cultural understanding within the services available:

> ***'Accessing mental health services has been extremely difficult.'***
>
> ***'Lack of scope and cultural understanding.'***
>
> ***'There is no mental health services available for us as far as I know.'***
>
> ***'Lack of understanding the culture.'***
>
> ***'This has been difficulty to diagnose sooner because of language barriers.'***

One respondent did say that services had been respectful of their community's difficulties and race/religion, while other simply said that their family looked after them.

Just 11 respondents said that they had received counselling, of which 7 were women and 4 men. Some had had poor experiences of accessing, or trying to access services:

> ***'It took a long time to receive my counselling appt.'***
>
> ***'Very poor service.'***
>
> ***'Lack of availability.'***
>
> ***'GP Services need to be improved for getting appointment.'***
>
> ***'I think since covid all the services have delays now and think we need to address illness, mental health is still there and people are struggling.'***

36 respondents expressed that they would like access counselling, two thirds of whom were women, and the largest age group being 25-44, of whom 20 said they would like counselling. Again, a culturally sensitive service, and knowing what is available was seen as vital by many:

> ***'If someone is a trained counsellor from my community and who can understand my Sylheti dialect, religion. If I feel bad and upset about something I will go to someone to talk to or my family. I have no idea of any services here in Colchester.'***
>
> ***'Yes, if we have Muslim counselling services.'***
>
> ***'Face to face interpreting is very much needed.'***
>
> ***'If we have culturally sensitive services we will use it. At present we have nothing.'***
>
> ***'I would like Muslim culturally sensitive counselling. Sometimes I found people who need someone to talk to but there is no services.'***
>
> ***'I have been receiving MH treatment for few years. No cultural sensitivity services available. Need more BAME trained staff.'***

'I received support from family but if any need-wise I would like to have culturally Muslim … services.'

'I personally don't want to discuss it with anyone but if I knew accessing the services was easy then I would certainly use the service.'

The need to overcome language barriers was also highlighted:

'Accessing services for our community is very difficult as there is no hub to go to and ask for help. Especially people who cannot go out or speak English.'

'Difficulty with interpreter and language barrier. My GP said he did not have enough money to employ interpreter.'

It is evident that many in the Bangladeshi and wider Muslim community locally see existing mental health services as not culturally competent. Whilst many people rely heavily on family for support, issues of stigma and a lack of awareness of where and how to access external support results in further barriers when people are struggling with their mental health and wellbeing. The community has clearly stated it needs services that understand their ethnicity and their religion, and greater investment is needed in translation and interpreting services so they can be more widely available. They are also keen to overcome the stigma they know exists in their community about mental health, and want support from within their community, such as training of imams, to help achieve this.

4.6 Carers

23 of the 125 respondents stated that they were carers, and in line with national trends most were women. Three respondents, all women, said that they were paid carers in health or care; the remaining 20 were caring for family members. While most were aged between 25-50, one carer was 75. Nationally, a significant proportion of carers are older, suggesting caring responsibilities fall on more of the younger members of this community.

Only 5 men said they were carers, two saying they cared for a child, and two for a parent (one did not specify). It is unclear if those that said they cared for children were describing their normal parenting role or whether their children had additional needs, but one described a lack of reliable support, so it seems likely that their child does have some specific needs. Of the women who said they were carers, six said they cared for children, and whilst again some may be simply referring to their parenting role, one mentioned being in receipt of carers' allowance and another said they receive respite support, so they evidently have children with additional needs.

Four women said that they care for their partner, generally on a long term basis. Six women said they cared for adult relatives, the majority parents or parents-in-law. All of these had been caring for at least one year, most for over 5 years.

8 of the 20 family carers said they received support. This varied from welfare benefits for themselves or their family (4 respondents), to respite care (3 respondents, one of whom mentioned continuing healthcare funding), and urgent care (1 respondent).

Carers valued the support they did receive:

'Care service enables my mother to stay at home.'

But some did not know where to get help:

' I have no idea how to access services, Where do I go? Many barriers too.'

'Lack of reliable support.'

'I would like to send my kids to swimming and karate club, help me to get some help from Essex Council.'

'Difficult to get information on allowances. Little culturally appropriate help available.'

And two spoke of the impact of caring:

'It takes time and energy to look after someone.'

'There is no respite service care for our community, it is very difficult to find access to home care. Within our community we like to look after our own carers at home however, this can get difficult, and we need support from the service providers.'

It appears therefore that many within this community are carers, starting from relatively young ages, and caring for people across the full age span from children to older adults. Carers need for information on the support available, and they need support that is both reliable and culturally competent.

4.7 Access to health and wellbeing support

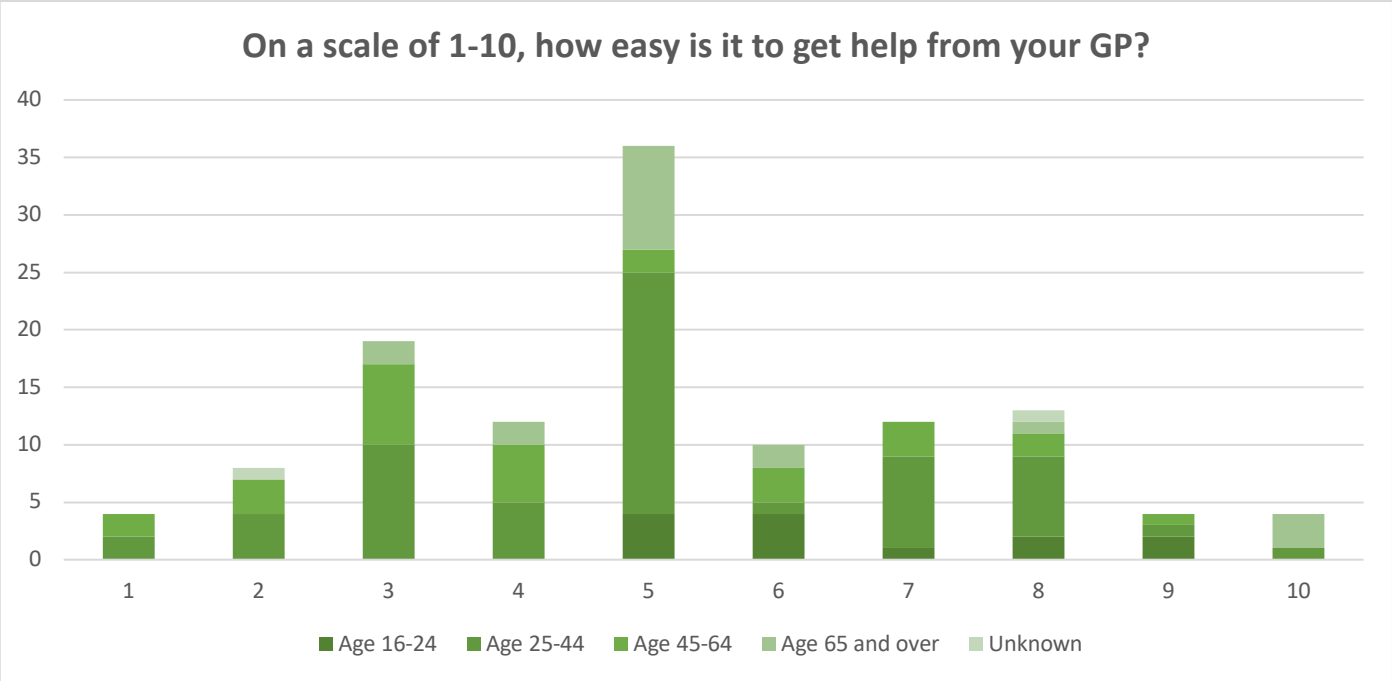
Accessing health services

Respondents were asked if they had any issues with accessing services. Of the 125 respondents, 85 said no, while 33 (26%) said they did; the remainder did not answer the question. Of the 33 people who said they had issues accessing services, 13 were aged over 65, which is almost two thirds of the total number of respondents in this age group.

When you get sick where do you first go for help?

105 would go to their GP, 23 would self-prescribe using over the counter medication, 8 would ring 111 first. A small number (less than 3 on each occasion referred to the emergency services, pharmacist or the internet. Two would use natural or home remedies, one said they would rely on family first and one respondent said they would not seek medical attention at all.

However, although the vast majority of people would access their GP, it appears that many feel it is not easy to do so, as the table below shows.



The 16-24 age group tended to rate access to their GP slightly higher than other age groups, with ratings ranging from 5 to 9. Most of the 25-44 age group rated access at 3 (10 people), 5 (21 people) or 7-8 (15 people in total). The 45-64 age group ratings were more evenly spread, but on the whole were 5 or lower (19 of a total of 28 respondents in this age group). Those aged 65 and over mainly rated access to their GP at 5 (9 people), but of the four people who gave their GP a rating of 10, three were aged over 65.

Overall, 79 people, two thirds of respondents, rated access to their GP at 5 or less, with only 8 (6%) of respondents rating access at 9 or 10.

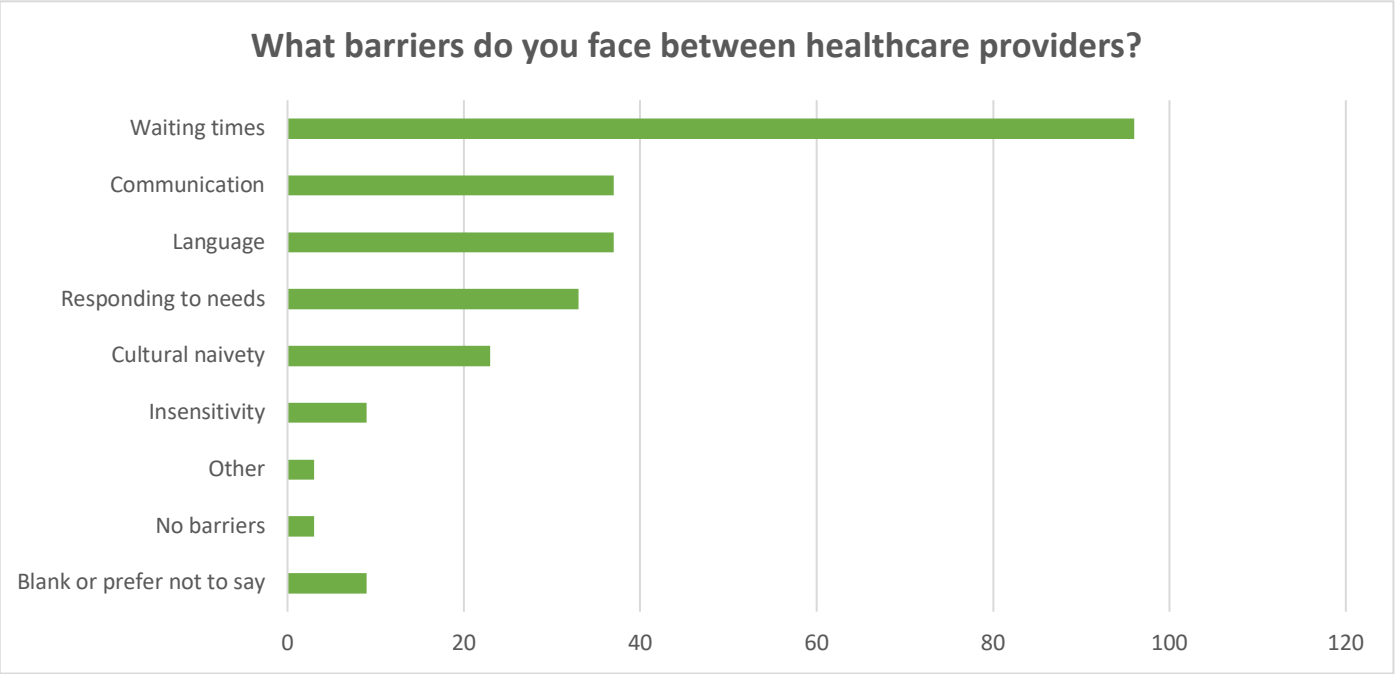
Barriers to access

Respondents were asked what barriers they faced between healthcare providers, with the following choices plus the opportunity to add further issues:

- Language
- Communication
- Waiting times

- Cultural naivety
- Insensitivity
- Responding to needs

The table below highlights the number of times each of these options was ticked, together with those who did not indicate any barriers at all.



It is evident that waiting times for care is the most pressing issue for respondents, as well as having their needs met, but a significant proportion also names issues of communication, language and culture. The 'other' issues raised were around difficulties contacting GPs by phone and the lack of face to face appointments, and one person whose hearing loss was a barrier. It is notable that only three of the 125 respondents positively responded to say they faced no barriers between healthcare providers.

> ***'In an urgent situation we do need someone who can help us where to go for help and advice especially in hospital. I have this experience when I went to hospital for a check-up for antenatal care. The doctor says we cannot feel any movement and said 'you have lost the baby' I was 8 months pregnant with the baby girl. They send me home for labour saying that. I have to wait until I get in pain. I devastated and distressed knowing my baby was dead inside. My husband and family comfort me but I was in a very panic state. However community lead intervened and she talked with the ward managers and PALS (which we do not know) and warn them if anything happens to me she will make a "case." At the end they did listen to her and make arrangements for me to deliver the baby. I was very much thankful to her for her intervention. That sort of help and intervention and language support we need in a crisis.'***
>
> ***'My husband was served ham sandwiches and also he went into a diabetic coma because he was not monitored properly and insulin was given. I wanted to complain but my husband withdrew the complaint as he did not want to go through the procedure.'***

Interpreting services

39 respondents said that when they visit a healthcare provider they take someone with them. Of these, almost all (36) take a family member. Two said they would take a community member, and one said that a professional was available at their GP who could support them with communication and understanding of their culture.

Respondents were also asked if they had ever been offered an interpreter, and if so, what their experiences had been. Only 12 respondents said they had been offered an interpreter, with 111 saying they had not, and two not responding to this question.

Of those who had been offered an interpreter, there were positive comments:

'I get interpreting service at back pain clinic.'

'Offered service from a doctor who is from Pakistan and may be more familiar with our culture and language.'

'Arabic, it was good and helpful.'

However, others said they had a poor service or needed more help:

'In Hospital not at GP, I need face to face interpreting.'

'My mother had an emergency visit to the hospital. Due to the pandemic, I was unable to join her. The interpreter used was spoken to via telephone and clearly did not have face-to-face patient experience as she made my mum nervous. The hospital should be able to provide sensible interpreters face-to-face to prevent this sort of thing from happening. Elder Bengalis often refuse medical treatment due to fear and uncertainty.'

'At times I do not go get right language dialect services, this makes it very difficult – no point in having translating services. My son has to take me to my appointments. Language is a huge barrier trying to communicate.'

Finally, respondents were asked if they would prefer an interpreter who understands their culture and dialect. 55 respondents said they would like a culturally sensitive interpreter, whilst 48 said they would not. 22 respondents did not respond or preferred not to. It is evident that the number of people in the community offered an interpreter falls well short of those who want one, and it is also important to them that the interpreter understands their culture and needs.

'As I struggle to speak the language of English, I tend to rely on my children to translate for me. So having a trained translator would be so convenient for me enabling me to communicate with ease and confidence. My children always have to miss time from school, work and their family. I also cannot express everything through my children because I feel shy. Sometimes I take a community member … to help me. She is very comforting and understands my language and culture. I do not feel shy.'

Separate gender spaces

Respondents were asked whether a separate gendered space for a medical examination was important to them. 100, or 80%, said they would prefer a same gender environment for medical examination, which is unsurprising given Bangladeshi culture and religious practices. Six respondents either left this question blank, or said they preferred not to say. However almost one fifth said they did not need separate spaces, 12 of whom were male and 7 female. This group spanned the whole age range from 18 to 79:

- 2 aged 16-24
- 10 aged 25-44
- 4 aged 16-64
- 3 aged 65 and over

It appears therefore that single gender spaces are slightly less likely to be required by the younger age groups, but it is evidently still a very important issue for many in the community.

Access to information and support

Several respondents referred to the importance of an information hub, where they could obtain information and advocacy with health issues.

'If a situation arises whereby I am unable to get in contact with my children or family and need to contact a GP, I believe an essential community hub would be very beneficial for myself and my fellow community members. Having this service would be very essential in Colchester, as it would ease my ability to access all facilities. For example, in the modern day I always ask family members to take me, leaving them to sacrifice their own important time. So please for future purpose, please enable a service which would be convenient for all Asian communities.'

5. Conclusions

This survey was completed by a small but significant number, 125 people, and has provided a rich source of information on the health needs of the Bangladeshi and wider Muslim community in Colchester and, to a lesser extent, in Ipswich. Respondents are not a representative sample of the population, as people volunteered to respond rather than being selected as being from a particular age or gender group, for example. There were fewer male respondents than female, and fewer in the 16-24 age group and the over 65s. However, this does not invalidate the results, the number of respondents overall gives us a good picture of the prevalence of health conditions, the common health concerns of the community, and the range of barriers they face in accessing services. The stories shared by respondents describe the impacts of the health issues they face, and their challenging experiences in trying to obtain culturally sensitive health and care.

Physical health

People in the community live with a wide range of physical health conditions, but as expected, diabetes, heart-related conditions and respiratory conditions are most prevalent in the community, for both respondents and their families. It is important therefore that people living with these conditions can obtain culturally competent information and support. It is also crucial that people have access to early diagnosis of hypertension, high cholesterol, respiratory conditions and diabetes to preventing worsening health and the development of long term conditions, as well as helping to reduce the incidence of stroke and dementia. Measures could include improving understanding within the community of genetic and environmental factors relevant to some of these conditions, so that people can be alert to potential signs and be tested early.

There are a number of other health conditions that were not explored specifically in the survey but where it may be helpful to understand more about how they are affecting the community. These include dementia, which South Asian communities are at higher risk of developing, and eye health, including visual loss and retinopathy as a result of diabetes. Only a very small number of respondents mentioned these conditions, so further research is needed.

Whilst many described living with long term conditions, few respondents described themselves as having a disability or a chronic illness. It is positive that people who live with health conditions do not use labels that might impact their sense of self identity or indicate that they are less capable, as many people with disabilities are made to feel in our society. However, labels around disability and long term conditions can also help identify people who may be eligible for specific health and care services or welfare benefits. This different use of language could therefore contribute to health and care professionals failing to recognise of understand the degree of impact that health conditions are having on people, potentially placing them at a disadvantage in accessing financial or practical support.

Oral health

Questions on oral health were added to the survey after it commenced, so responses are relatively low. Most respondents indicated that they do access dentistry, although it is evident many had not visited the dentist for some years. This will inevitably be due in part to the Covid-19 pandemic, but many respondents also shared they have anxiety about visiting the dentist, so it is important this issue is explored further. Some respondents said they chew products such as betel nut, and although the numbers are small, the impact on oral health can be significant, so health promotion on the issue of chewing products would be valuable, including encouraging accessing dentistry to help manage the pain and mouth decay that results.

Healthy lifestyles

Just over half of the respondents recognised that they did not exercise enough, and a slightly smaller number also highlighted that their eating habits could be improved. Cultural issues were identified as a major factor in accessing help with these issues, but it would also be valuable to explore whether there are other factors, which might include cost, working unsocial or irregular hours, or lack of awareness of the range of options. Both exercise and healthy eating are very relevant to people with heart conditions and diabetes, so access to the right support, co-produced with local people, is particularly important for this community.

Mental health

Only 15 respondents disclosed mental health problems, a relatively low response compared to the prevalence of mental ill-health nationally. Respondents said they would seek support with their mental health from families, but at the same time many did not find this easy to do, particularly men. Very few, particularly in older age groups, found it easy to access services, mainly due to waiting times and a perceived need to go through the GP to access help. Cultural barriers included stigma within the community about mental health, but a lack of cultural awareness and sensitivity in mental health services was a significant barrier, as well as the need for translation support. People who want to access mental health services need them to understand their culture and be fully accessible for those who speak limited English.

Carers

Few respondents identified themselves as carers, possibly due to a lack of full understanding of what types and level of care the term encompasses. Not identifying as a carer could therefore be a barrier to accessing support. Those carers that did receive support valued it, but many did not know where to access help. Support for carers of all ages to be identified is needed, and support should be offered that is reliable and responsive to people's cultural needs.

Access to health and care services

While many respondents said they had no difficulties accessing support, just over a quarter of respondents did. Four in five respondents would see their GP first if they had health issues, but many respondents reported difficulties accessing their GP. Waiting times for care were respondents' biggest concern, but a significant proportion also cited cultural insensitivity, language or communication barriers in access to both physical and mental health services. It is vital therefore that people have meaningful choices about where to access culturally competent support, and have the right information on how and where to access services.

In common with other areas of this survey, the need for interpreting and translation services was a major issue, across the age range but in particular among older people. When people have access to this support they do value it, but many rely on family members, which might not always be the most appropriate if there are confidentiality or sensitive health issues involved. Almost half of all respondents want access to a translator that is culturally competent.

Many respondents, particularly in the older age groups, want access to same gender spaces for health examination, so it is important to offer choice.

Some respondents highlighted how a culturally competent information service signposting to appropriate services would be valuable, in increasing people's knowledge of, and confidence in services. This idea should be explored further.

> ***'Fear, stigma, and lack of culturally sensitive treatment was the reason I did not want to access services. I have used interpreting services many times in health services and social services. I would be given a speaker that speaks a different dialect to my language. How did I communicate when I don't understand her! I would benefit from a signposting and information service to talk to someone in Bengali and get referred the relevant services. I would like more support groups and an activity centre to go to that provides more culturally and religious appropriate activities. So many health problems in the community – need more wellbeing groups and awareness events.'***

Summary

This survey and its analysis have provided a depth of data and shared experiences that will be able to inform the co-production of services for this community that are tailored to their needs. The findings and recommendations can also benefit the wider Muslim community across our local Integrated Care System, regionally and nationally, and help inform action to better support other communities locally and more widely who face similar barriers.

> ***'We are not hidden people anymore and they should include and invite us to raise our views how the services should be provided culturally, religiously sensitive way.'***

6. Recommendations for Next Steps

At the outset of this research, we set some specific objectives to improve access to the NHS for Bangladeshi Asians; to promote information sharing within the community; and to improve the design of future health and care services for Bangladeshi Asians.

To achieve this, we recommend that local health and care services across all sectors **co-produce** with the Bangladeshi and wider Muslim community:

1. Greater knowledge and understanding within the community of NHS and social care systems, and entitlements to advice, care, support, and welfare benefits for those living with disability and long term conditions.

- A hub space where people can obtain culturally appropriate information and advice on health, social and financial issues, sources of support, and advocacy where necessary.
- Accessible information on health and care issues and services, available in health and care settings, and other community settings such as mosques, libraries, food retailers and council offices.
- Awareness events initiated by the community to improve people's knowledge about health conditions and in the case of mental health, to help overcome stigma.
- Accessible, culturally sensitive information on how people can self-care.
- Support for the community to help itself, for example training community leaders and volunteers in common health issues and sources of support.

2. Improved access to testing and diagnosis for conditions that the community is at heightened risk of developing, including hypertension, high cholesterol, diabetes and respiratory conditions.

- Accessible information on signs and symptoms of conditions common in the community; genetic, environmental and other relevant risk factors; and the possible risks of these long term conditions including stroke, eye and foot issues, and mental ill-health.
- Advice on where to obtain testing and diagnosis, the procedures and potential results.
- Culturally relevant advice on living well with long term conditions and sources of support.

3. Improved access to advice on oral health, including targeted information for those who chew products such as betel nut, and improved access to dentistry.

- Accessible information materials on prevention and self-care in oral health.
- Culturally competent NHS dentistry services that understand the potential oral health issues for the community and how best to support them.

4. Culturally appropriate advice and guidance on healthier lifestyles including exercise and eating well.

- Better understanding among health and care services of the practical and cultural reasons for lack of exercise and less healthy eating.
- Opportunities to be more active that fit with the community's lifestyles, culture, religion, and personal choice.
- Tailored guidance and opportunities for practical support in healthier eating based on common foods, eating patterns and the availability of healthy ingredients for everyone in the community.

5. Culturally competent physical and mental health and care services.

- Training for staff in GP practices, pharmacies, community health, hospitals and mental health services in Bangladeshi and wider Muslim cultures and lived experiences, and how to develop culturally sensitive practice and services.
- Provision for privacy and dignity, including same gender spaces for health examinations where required.

6. Empowering people to ensure they do not wait longer than necessary to access health and care services.

- Accessible information on how decisions on waits for care are made including how inequality is taken into account, how long people might expect to wait for care, and how people can challenge decisions about them.

7. Translation and interpretation services available as a right for everyone who needs them.

- All written and online health and social care information available in all relevant languages and dialects.

- The opportunity to access a translator or interpreter for all interactions with health and care services, including receptionists, administrators, clinicians and other professionals, both in person and by telephone.

8. Further research where we need more information and understanding of the community's needs.

- Physical health and mental health issues where we need to understand more about prevalence and experiences. This includes dementia, depression, anxiety, and other mental health conditions, eye health and stroke.
- Where and why barriers to treatment and care arise. This includes screening, testing, diagnosis and treatment options across physical and mental health.
- Levels of physical activity and reasons for inactivity, why food and eating patterns might be unhealthy, and causes of the barriers to healthier lifestyles.
- The range of communication methods and information sharing preferred by people in the community, particularly in different age groups and for those with limited English or reading skills.

Appendix: Study of a Needs Assessment of Bangladeshis and the wider Muslim Community in Colchester, Essex: Literature Review

Dr Farzana Chowdhury

Introduction

In this study, we identify high priority health, wellbeing and social care needs in the local Bangladeshi and wider Muslim community in Colchester, Essex. Characterisation of this niche population group will indicate the current magnitude of health-related inequities faced by this community, driven by cultural, socioeconomic factors and wider determinants of health.

It is hoped that the findings from this report will aim to inform on strategic decision making, improve the design of health services targeted at this group; accessibility to the National Health Service and commission services to ultimately improve health outcomes and social mobility in the Bangladeshi community.

Bangladeshi demographic in the UK and Essex

According to the 2011 census, Black Asian and Minority Ethnics (BAME) constituted 13% of the UK population, whereby Asian ethnic groups represented the second largest percentage (7.5%) in England and Wales. Specifically, the Bangladeshi ethnic group amounted to 0.8%[1] and amongst Asian groups were most represented aged under 18 years (38.3%). In contrast, Bangladeshis had the lowest percentage of people aged 65 years and over (8.2%)[2].

Of the total population in Essex (1.39 million), 5.72% were BAME[3]. A breakdown of BAME and specifically Bangladeshi Asians in Essex and its boroughs is shown in Table 1. In Colchester, the Bangladeshi population (0.22%) is close to the average in Essex (0.20%). As of 2011, Harlow had the highest Bangladeshi population in Essex at 0.48% while Tendring had the least at 0.08%[4]. In Suffolk, the Bangladeshi population recorded in 2011 was 0.3%[5].

Table 1: Bangladeshi population in Essex by borough, 2011.

Area	Total population	BAME (%)	Bangladeshi (%)
Essex	**1,393,587**	**5.72**	**0.20**
Basildon	174,497	7.35	0.18
Braintree	147,084	3.40	0.13
Brentwood	73,601	6.43	0.23
Castle Point	88,011	3.11	0.10
Chelmsford	168,310	6.14	0.28
Colchester	173,074	7.95	0.22
Epping Forest	124,659	9.46	0.21
Harlow	81,944	10.92	0.48
Maldon	61,629	1.95	0.15
Rochford	83,287	2.82	0.10
Tendring	138,048	2.45	0.08
Uttlesford	79,443	3.38	0.23

[1] Population of England and Wales – Ethnicity facts and figures.
[2] Age groups – Ethnicity facts and figures.
[3] Joint Strategic Needs Assessment 2019. Essex county wide report.
[4] Essex & District Ethnicity Population 2011 Census – Essex Open Data
[5] Suffolk - Population - UTLA | Suffolk | InstantAtlas Reports (suffolkobservatory.info)

As the only voluntary question in the 2011 census centred on religion, nationally, the largest religious group identified themselves as Christian (59.3%). The second largest religious group were Muslim (4.8%), true for both UK-born (2.6%) and non-UK born (19%) individuals[6]. Between 2001 and 2011, the Muslim population in Essex increased by 78%. Within Colchester, this increased by 133.9%, equating to 1581 individuals[7].

Bangladeshi health outcomes in the UK

Type 2 diabetes

South Asians, particularly Bangladeshis are 5-6 times more likely to develop diabetes, namely type 2 diabetes (T2D) [8]. In 2008, the Bangladeshi population of the London borough of Tower Hamlets had an age-adjusted prevalence of diabetes of 5.9% [9]. Incidence is also greater in ethnic minorities, with new-onset T2D 2-3-fold higher in British South Asian groups compared to British White people. Comparing more specifically to White British women, the incidence of T2D is 6-fold higher in Bangladeshi women. Bangladeshi men display the highest risk amongst ethnic groups and is 60% greater than that in white men. Moreover, T2D develops 5 to 10 years earlier in South Asians and at a lower obesity threshold in South Asians, compared to White people. Interestingly, molecular determinants of diabetes present early on in life, with levels of HbA1c, insulin and triglyceride higher in 9–10-year-olds of South Asian descent compared to their White counterparts. Interestingly, the incidence of such premeditators of diabetes were still higher in South Asian children compared to Black African and Black Caribbean groups. In a focus group of 40 British Bangladeshis, diabetes was generally attributed to factors outside of the body rather than a primary failure of an organ within it. “Too much sugar” was perceived as a primary cause of diabetes and poor diabetic control[10].

Cardiovascular disease and stroke

Diabetes increases the risk of developing cardiovascular diseases (CVD) two-fold, a disease which is already a leading cause of mortality in the UK[11]. This includes myocardial infarction and heart failure. The prevalence of CVD is higher in South Asian groups, who observed higher rates of ischaemic heart disease, hypertension and diabetes compared to the White population. South Asian groups are significantly younger when diagnosed with heart failure (72 years) compared to the white population (78 years). This was reflected in the incidence of co-morbidities, with British South Asians presenting with 12% more hypertension, 24% more diabetes and 11% more anaemia than the British White population. In contrast, they presented with significantly less atrial fibrillation and cancer[12]. Cerebrovascular disease is a major form of CVD and includes stroke and transient ischaemic attack[13]. Stroke rates in England and Wales are higher in African-born, Bangladeshi and Pakistani populations[14]. In contrast, people of Chinese ethnicity have a lower risk of stroke compared to the White population[15].

Modifiable risk factors of disease

A range of proximal, modifiable risk factors have been associated with the development of the co-morbidities described. This includes hypertension, more commonly known as high blood pressure. It affects 26.2% of UK adults, while its prevalence is slightly higher in Essex compared to the UK average, at 27.9%[16]. While half of all CVD cases are related to hypertension, it is no surprise that hypertension is a health priority for the wider public health system. It is sinister in its presentation, often not presenting with any symptoms however ineffective management can lead to

[6] 2011 Census Analysis, Ethnicity and religion of non-UK born population in England and Wales.
[7] Colchester Borough Council – Census 2001 and Census 2011 comparison
[8] Diabetes and heart disease in Bangladeshis and Pakistanis. www.genesandhealth.org
[9] Prevention of type 2 diabetes in British Bangladeshis: qualitative study of community, religious, and professional perspectives
[10] Health beliefs and folk models of diabetes in British Bangladeshis: a qualitative study. Greenhalgh, Helman and Chowdhury 1998.
[11] Fact and Figures – www.bhf.org.uk
[12] Risk factors for heart failure: 20-year population-based trends by sex, socioeconomic status and ethnicity. Lawson et al., 2020.
[13] Fact and Figures – www.bhf.org.uk
[14] Ethnic variations in the incidence and mortality of stroke in the Scottish health and ethnicity linkage study of 4.65 million people. Bhopal et al., 2012.
[15] Age and ethnic disparities in incidence of stroke over time: the South London stroke register. Wang et al., 2013.
[16] Public Health England publications. Reference number GW-1181 ODS.

heart disease, stroke and kidney disease[17]. While it is commonly accepted that high blood pressure prevalence increases with age and poor health, British children of Indian and Bangladeshi descent have raised blood pressure compared to White children. Results from the same meta-analysis describe British Bangladeshi adults to have lower systolic and blood pressure, however. Highlighting the divergence in intergenerational change in hypertension difference in Bangladeshis, this Nature paper has raised concerns that the pattern observed in Bangladeshi children may continue into adulthood[18]. As such, hypertension levels require specific monitoring and managing according to ethnic groups.

High cholesterol is another modifiable risk factor associated with CVD. Generally, a reduction in high density lipoprotein (HDL) and increase in low density lipoprotein (LDL) have been shown to increase the risk of heart disease. While total cholesterol is comparable between British South Asian and White British groups, raised LDLs have observed in South Asians. The latter is largely genetically determined, highlighting a potential ethnic-specific risk factor of ischaemic heart disease. Hyperglycaemia, or non-diabetic high glucose levels, represent a modifiable risk factor of insulin resistance. Compared to White counterparts, South Asian and African Caribbean groups present with increased glucose intolerance, raised fasting and post-load insulin [19]. Such metabolic disturbances can lead to obesity, as demonstrated in a British population survey of 3193 South Asians: mean waist-hip girth ratios and subcutaneous fat folds were higher in South Asians compared to Europeans. These metrics correlated with glucose intolerance, insulin and blood pressure levels[20]. The most recent systemic review on ethnic differences in the UK did not, however, find a relation between determinants of obesity among South Asians relative to Caucasians among children or adults. It was noted that the lack of consensus and the paucity of studies concerned with differences in obesity aetiology by ethnicity warrant further research in this area[21].

Behavioural risk factors of disease

A range of behaviour has been associated with cardio-metabolic disorders, including smoking, tobacco, alcohol consumption, diet and physical activity. A biennial survey of secondary school pupils in England revealed lower smoking rates in Asian groups (8%) compared to White, Mixed and Black groups (18%, 17% and 9% respectively)[22]. Such differences in smoking behaviour among ethnicities may be reflected in adults in due course. Consumption of smokeless tobacco is common within ethnic minorities. Although smokeless tobacco (such as chewing of tobacco, arecra nut/betel quid) is associated with a lower risk of developing lung cancer compared to cigarette smoking, it is highly associated with developing oral cancer. Higher incidence was observed in South Asians, particularly in females. While a positive trend was observed between increasing incidence of oral cancers and socioeconomic deprivation, this was only shown for non-South Asians.

The consumption of alcohol units by South Asians was significantly lower (0-14%) compared to the general population (7.2-17.5%), however tobacco chewing was significantly higher among Bangladeshi males and females[23]. Oral and pharyngeal cancer rates observed in the UK were lower than that reported in countries of origin in the Indian subcontinent[24], suggestive of changes in behaviour. More research is required for the risk that the commonly chewed snack betel quid, or paan, alone has on the incidence of oral cancers in ethnic minority groups. More recently, a YouGov survey conducted nationally to investigate the use of shisha by ethnicity found Bangladeshis most likely to have ever tried the smokeless tobacco. By suggesting South Asian groups are more likely to engage in non-cigarette forms of tobacco, their exposure to the carcinogen may be grossly underestimated in studies that focus on cigarette smoking alone. Thus, more research on the effect of ethnicity-specific consumption of tobacco, which is

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[22] Smoking, drinking and drug use among young people in England. Digital, N. 2018.
[23] Oral and pharyngeal cancer in South Asians and non-South Asians in relation to socio-economic deprivation in South East England. Moles et al., 2008.
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reflective of cultural behaviours, is required. Alcohol consumption is five times lower in South Asian ethnic groups (10%) compared to White people (52%), with even lower trends observed in the younger population[25]. Similar trends are observed when harmful alcohol consumption is measured[26]. As such, this behavioural trait may not be linked with the development of cardiometabolic diseases within the South Asian community.

Physical activity is being increasingly linked as a preventative measure of developing chronic illnesses. Regular physical activity such as daily brisk walking is associated with a 30-50% reduction in the risk of coronary heart disease[27], obesity[28] and stroke[29]. More vigorous activity has been associated with protective HDL[30]. Self-reported physical activity has been recorded as lowest for people of Asian ethnicity, compared to White British adults shown to be most active. Bangladeshi men were 45% less likely than the general population to meet the guidelines for physical activity, and as such, lack of physical activity may contribute to an increased risk of obesity, diabetes and CVDs[31]. In a focus group, British Bangladeshis perceived exercise as worsening illness and adding to physical weakness. In contrast, the actions taken during daily Muslim prayers (which includes bowing to the ground) were viewed as "worthy" and "health-giving" forms of exercise. Compared to White British and Afro-Caribbean groups, Bangladeshis generally lacked associating exercise with good health[32].

Interestingly, there are differing attitudes and cultural beliefs towards foods and the role they play in an individual's lifestyle. The England Health Survey conducted in 2004 revealed that while 42% of Chinese and 36% of Indian women were most likely to consume the recommended five portions of fruit a day, only 28% of Bangladeshi women reported doing so[33]. Foods perceived to provide nourishment and strength, were identified by British Bangladeshis as white sugar, lamb, beef, ghee (derived from butter), solid fat and spices. While they were also observed as liable to worsening disease in the elderly, "weak" foods were identified as boiled (pre-fluffed) rice and cereals. Baked and grilled food were perceived as "indigestible" including vegetables grown under the ground. Despite this, spices and ghee were identified as foods which should be avoided by those with diabetes. As a staple crop in Bangladesh, an imbalance of rice intake was understood to be a causal factor of diabetes, rather than the quantity[34]. The consumption of clarified fat (ghee) plays a role in dyslipidemia observed in South Asians, with a dose-response relation between increasing ghee consumption and raised levels of trans fatty acids[35]. Such cultural perceptions may conflict with advice given by healthcare professionals to help manage diet in this ethnic group.

Mental health in South Asians

Black and ethnic minorities are at greater risk of mental health problems compared to the White UK-born population. Comparing against a White British reference, Indian, Pakistani, Bangladeshi and mixed ethnic minority groups record excess levels of stress. Such vulnerability has been associated with migration issues, settlement and experience of racism and discrimination, poverty and adverse environmental conditions[36]. Per 100,000 people, 136.1 Bangladeshis are detained under the Mental Health Act, more so than Indian or Pakistani counterparts (71.9 and 121.1 respectively)[37]. Those Bangladeshis admitted into hospital were more likely to be men with younger mean age compared to other ethnicities. Bangladeshis and African-Caribbean's were more likely to report social factors as a cause of deterioration in mental health, which is in contrast to White populations who cite biological causes more

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[35] Ethnic differences in cardiovascular disease. Chaturvedi 2003.
[36] Social capital and mental health among black and minority ethnic groups in the UK. Bamford et al., 2021.
[37] Ethnicity facts and figures: detentions under the mental health act. UK Government 2021.

often. Poor interpersonal relationships, stress and negative childhood experiences were reported to contribute to strains on mental health within Bangladeshis, whilst alternative forms of treatment were sought after more frequently from this group rather than conventional medication[38]. Like many cultures, a degree of stigma is also associated around mental health diseases, preventing individuals to talk about it openly. As such, Bangladeshis may be less likely to seek help from professionals and therefore be grossly underestimated and underdiagnosed in having a mental health disorder[39]. More research is required, in a culturally-sensitive manner, not only to determine the true prevalence of mental health disorders within the community, but to fight stigma and educate the communities themselves about how help can be sought.

Socio-economic determinants of health

Bangladeshis in the UK workplace

Bangladeshi ethnic minorities have been reported to be disadvantaged in the UK workplace. Between 2011 and 2015, 20% of Bangladeshi workers earnt less than the bottom 10% of White British workers[40]. Furthermore, inactivity rates, or the proportion of the population not in the labour force, is higher for Bangladeshi women (57.8%) compared to Bangladeshi men (23.2%) and Indian women (27.9%). Cultural differences may drive this difference, since 38.1% of Bangladeshi women say "looking after the family" is one of the reasons for their inactivity. 22% of Asians are more than twice as likely to live in households with persistent low income than White British counterparts[41]. While forecasts predict Bangladeshis will be overrepresented in low paid-intermediate sectors [42], second generation individuals earn higher wages than the first generation[43]. The inequalities described can affect the health of disadvantaged workers. In 2018, employees of Bangladeshi and Pakistani heritage earnt the lowest median hourly pay in the UK compared to White British employees, at 20.2% less[44]. This is of significance since the breadwinners of many Bangladeshi households are hourly waged earners. Hourly waged earners tend to have reduced benefits package, holiday, sick leave and job security. This can in turn have an effect on an individual's anxiety and stress levels.

Generally, deprived people are diagnosed with heart failure 4 years earlier than affluent groups, observe significantly more co-morbidities and present with higher BMI. Such co-morbidities include obesity, diabetes, anaemia, depression and chronic obstructive pulmonary disease. In contrast, affluent groups had higher annual growth rates of cancer compared to deprived groups[45].

Housing conditions

Bangladeshis are more likely to live in overcrowded homes compared to the general population. For example, 18% of Bangladeshis live in homes with more than 1 person per room, which is relatively higher than the rest of the UK population (4.1%). Generally, overcrowded living in the UK is reported moreso in ethnic minority households compared to White British households, presenting highest in British Bangladeshis (24%) followed by Pakistani, Black African and Arab households (18%, 16%, 15% respectively)[46]. Children living in overcrowded homes more likely to contract meningitis[47] and develop respiratory infectious diseases[48]. It has also been linked with slow growth, correlating with an increased risk of heart disease as an adult. Such evidence highlights a need to integrate housing, health and social care when considering health inequalities. This approach would ultimately reduce demand on health and care services.

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