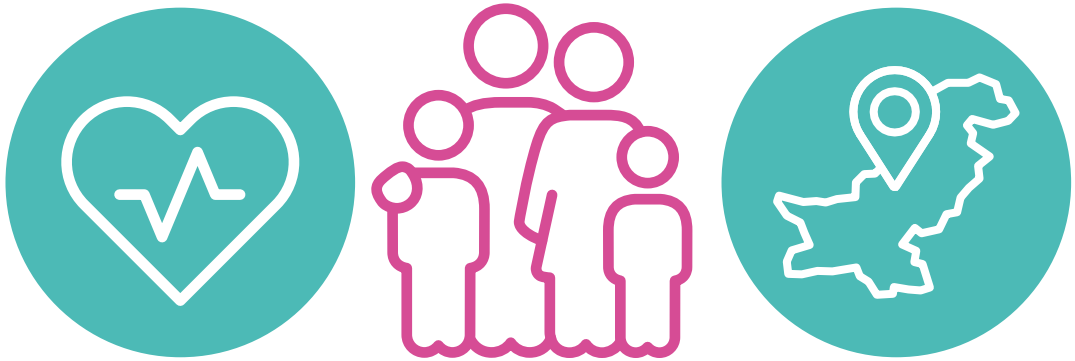
PAKISTANI COMMUNITY HEALTH PROFILE 2022



A BOLDER HEALTHIER BIRMINGHAM

Foreword

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

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

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Community Evidence Summary

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

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

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

Executive Summary

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

There has been evidence of health inequalities between ethnic minority and White groups, and between different ethnic minority groups across the UK for some time. This community profile aims to unpack some of these issues, with a focus on the Pakistani community in Birmingham.

Pakistan and Britain have shared a long-running connection which takes root in history. The British Pakistani community is one of the oldest and largest ethnic minority communities outside of Pakistan. The UK's open-door immigration policy, which was in place until 1962, allowed members of the Commonwealth to apply for work before arriving in the UK; permission to immigrate was granted based on the applicants' employment prospects. This enabled families to be reunified. and for Britain to meet its post war labour needs, with migration increasing significantly in 1961.

The National Health Service (NHS) recruited doctors from Pakistan in the 1960s and many Pakistani immigrants helped solve labour shortages in British industries and were instrumental to the growth of the economy.

At the local authority level, Birmingham has the largest Pakistani population of any local authority, followed by Bradford and Kirklees. There are 144,627 Pakistanis living in Birmingham. This is the second largest Pakistani community within the UK. The community is mainly concentrated in the inner-city wards of Birmingham, with the population having the greatest concentration in Alum Rock (58.6%), Sparkhill (56.9%) and Small Heath (53%).

The key health inequalities and points identified within this Pakistani profile for Birmingham are:

- The Pakistani ethnic group has a young age profile, with those aged 65 and over only accounting for 4.4% of its population.
- Over time the ethnic group's age profile will change, and by 2026, 5.8% of the Pakistani population will be made up of those aged 65 and over.
- Life expectancy of Pakistani women is 84.8 which is slightly less than the Indian women (85.4), but less than Bangladeshi women (87.3)
- Life expectancy of Pakistani men is 82.3 which is same as Indian men, but slightly more than Bangladeshi men (81.1).
- The Pakistani ethnic group consistently had the highest rate of infant mortality of all the Asian subcategories
- Pakistani women are the least active of all ethnicities and men are the one of the least active, with 40.8% of women and 55.6% of men being active for at least 150 minutes per week.
- Men from the Pakistani ethnic group are almost three times as likely as the general population to have type 2 diabetes.
- Women of Pakistani ethnicity are over five times more likely than women in the general population to be diagnosed with diabetes.
- Research has found the Pakistani community has been disproportionately impacted by COVID-19, with poorer areas in England experiencing higher risk of infection; many of these areas have a high proportion of Pakistanis.

Methodology

An exploratory search was undertaken by the Public Health Communities Team using a range of databases such as National Data Sources, NOMIS (Office for National Statistics), and PubMed to identify information on the Pakistani community for this profile. Keyword search terms and subject headings relevant to the themes were identified. All references used within this profile are outlined in the endnotes. As an initial exploratory search, the following avenues were examined:

a. National data sources

NOMIS data:

Data has been extracted by ethnicity from the 2011 Census, available at https://www.nomisweb.co.uk/. It should be noted that the most recent ethnicity data available is from the 2001 and 2011 census, and any conclusions from using this data and information should be made with caution. The next census data will be released in Summer 2022.

National Public Health (PHE fingertips) and government data sources (ons.gov.uk and gov.uk):

Data has been extracted where relevant Pakistani community-level information was available.

National voluntary and community sector reports:

These have been identified through Google Scholar and national websites, specifically where relevant Pakistani community-level data and information were available, such as:

- Diabetes UK (https://www.diabetes.org.uk/)
- Public Health England (now replaced by UK Health Security Agency and Office for Health Improvement and Disparities (https://www.gov.uk/government/organisations/public-health-england)

b. PubMed search

In addition, a PubMed search conducted on https://pubmed.ncbi.nlm.nih.gov/ was performed. All searches contained the keyword "Pakistani" as well as words that were specific to the topic theme. Examples of this are included in the search strategy (Appendix 1). We also used terms such as "South Asian" to refer to the community and other related terms.

c. Grey Literature

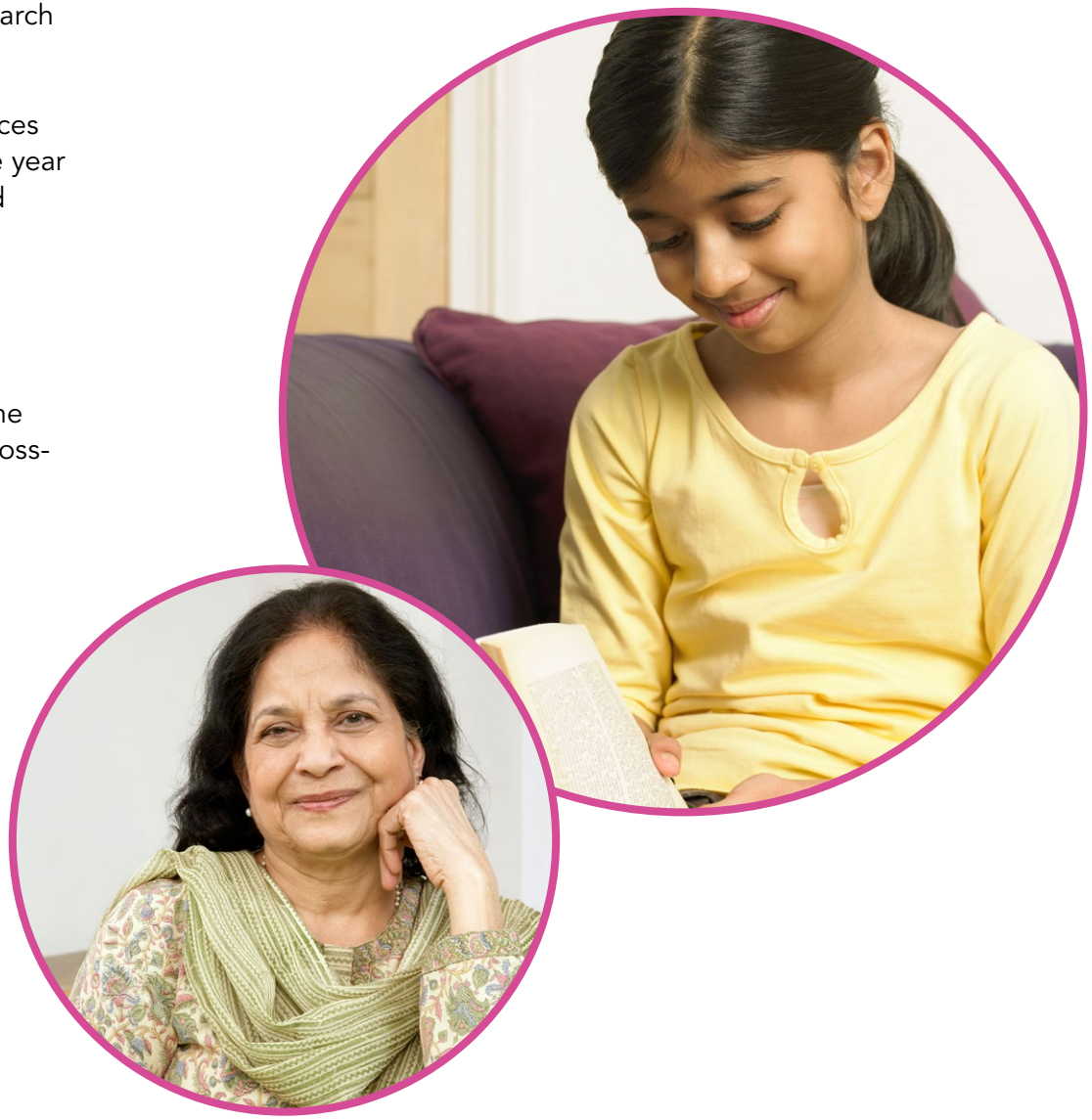
Where information sources had not been identified through a or b, further searching through Google, Google Scholar, and PubMed using topic-specific search terms was carried out. Papers that were relevant to the UK were included i.e., data and information stemming from local or national-level reports and/ or surveys.

Findings from international and national systematic reviews and large-scale epidemiological and qualitative research studies were also considered for inclusion. International research findings were included if they were deemed to be comparable or relevant to the national population.

In addition, "snowballing" - a technique where additional relevant research is identified from the reference list and citations of the initial search or published article - was also applied. Additional papers were identified from reference lists using this approach, where these additional resources enhanced the knowledge base. Generally, searches were limited to the year 2000 onwards, however, older information was occasionally considered where information was scarce.

d. Data consolidation and analysis

Results retrieved from the initial searches were reviewed by the Public Health Communities Team against the search strategy (Appendix 1). The articles utilised in this document were then analysed, identified, and cross-referenced with other themes throughout the report.



1,124,511 PEOPLE IDENTIFIED AS PAKISTANI in England and Wales in 2011. Making up 2.0% of the total population. This is an increase from 1.4% in 2001

Birmingham has the second largest Pakistani community in the UK (144,627 residents) **144,627** MAKING UP 13.5% OF THE CITY'S TOTAL POPULATION

62% For more than half the Pakistani community based in Birmingham the UK is noted as the country of birth (89.981; 62%), reflecting the birth of second and third generation Pakistanis in the UK

According to the 2011 Census the community has a young age profile; 70% of Birmingham's Pakistani community under the age of 35 and 35.6% is under 16 **70%**

THE PAKISTANI COMMUNITY ACCOUNT FOR **12.5%** of the working age group in Birmingham. While in England the community make up 2% of the working age group.

Over 20% of working age Pakistanis are in six wards, and the proportion is over 50% in two - Bordesley Green (53%) and Washwood Heath (57%)

INTERNATIONAL CONTEXT

Pakistan is a cultural melting pot with multiple ethnicities and languages. Pakistan's population can be divided broadly into five major and several minor ethnic groups: Punjabis, Pashtuns, Sindhis, the muhajirs and Ralochis

1.0 Introduction

1.1. Overview of the Pakistani community

Britain's Pakistani community is one of the oldest and largest ethnic minority communities outside of Pakistan. In 2011, there were 1,124,511 people from the Pakistani ethnic group in England and Wales, making up 2.0% of the total population.

Large-scale immigration to Britain from Pakistan began in the 1950s when Britain encouraged migration from the former colonies to meet its post-war labour needs[1]. Migration increased significantly in 1961, prior to the Commonwealth Immigrants Act 1962, which restricted automatic entry to the UK for Commonwealth citizens[2]. During this period most of the Pakistani diaspora were economic migrants from Northern Punjab and the rural Mirpur District of Azad Jammu and Kashmir (AJK). This community began to migrate when their town and its surrounding areas were submerged by the waters of the Mangla Dam[3].

The introduction of the 'voucher system' in the 1960s aided movement from Pakistan as this allowed those who were already in Britain to arrange jobs and vouchers for their relatives and friends[4]. During the 1950s and 1960s, those that migrated were largely single men and were joined by their families a decade later[5]. There are still Pakistani migrants arriving in Britain for marriage purposes, or on temporary student and work permit visas. The latter tend to be highly skilled professionals such as doctors and other health professionals[6].

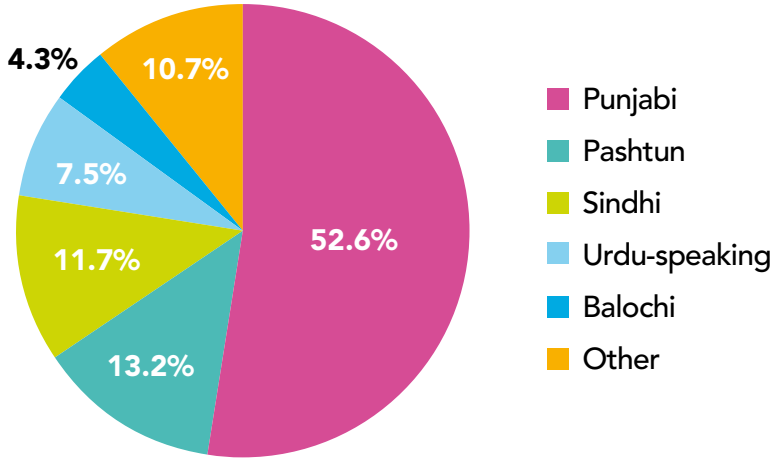
1.2 International context

1.2.1. History of Pakistan

Pakistan was created following the partition of India in August 1947, which also marked the end of the British rule of the Indian Empire.

In its initial years of formation, Pakistan consisted of two parts: West Pakistan (now Pakistan) and East Pakistan (now known as Bangladesh). Bangladesh gained independence from Pakistan in 1971. Pakistan is a cultural melting pot with multiple ethnicities and languages. Modern Pakistan's population can be divided broadly into five major and several minor ethnic groups7. The Punjabis, who constitute roughly half of the population, are the single largest group. The Pashtuns (Pathans) account for about one-eighth of the population, and Sindhis form a smaller group. Of the remaining population, the muhajirs—Muslims who migrated to Pakistan after the partition in 1947—and Balochis constitute the largest groups8 (see figure 1 for Pakistan's ethnic composition).

Figure 1: Pakistan – Ethnic Composition



Source: Britannica[9]

1.2.2 Language

As a linguistically heterogeneous country, there is no single language in Pakistan that is common to the entire population.

Each of the principal languages in Pakistan has a strong regional focus. There are substantial numbers of Urdu and Punjabi-speaking muhajirs. In addition to Urdu and Punjabi, other languages spoken include Sindhi, Pashto, Siraiki, Balochi, Pahari-Potwari and Brahui[10].

1.2.3 Religion

Over 96% of Pakistanis are Muslims11 with majority belonging to the Sunni sect of Islam.

There are also significant numbers of Shiʿi Muslims in Pakistan. Among Sunnis, Sufism is popular and influential[12]. In addition to the two main religious sects, there is also the presence of a small sect called the Aḥmadiyyah[13].

1.3 National context

1.3.1 Demographics

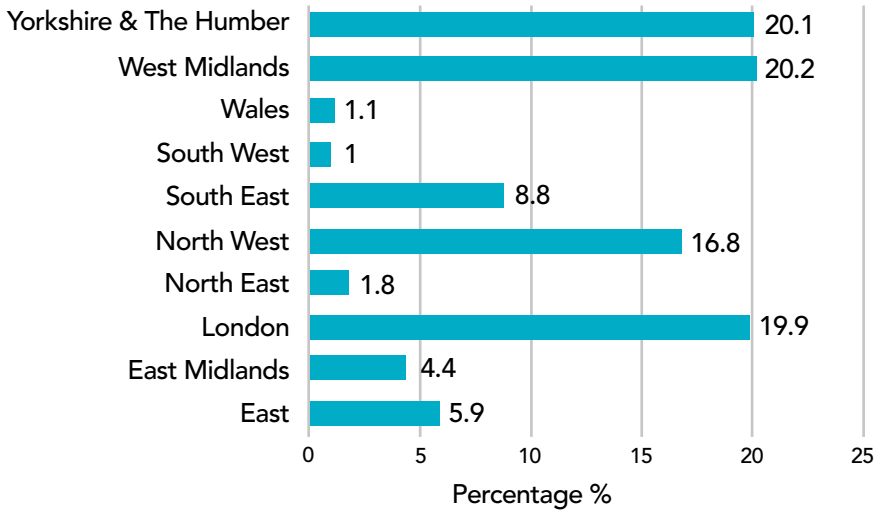
The Pakistani community has a sizeable presence in the UK - in 2011, in England and Wales, 1,124,511 people identified as Pakistani, making up 2.0% of the total population[14].

This figure is an increase since 2001 when the community accounted for 1.4% of the total population[15]. In addition, 141,000 (2.7%) of Scotland's population identified as Asian, Asian Scottish or Asian British, with 50,000[16] people who identified specifically as Pakistani. According to the 2011 Census, there were 1,091 people in Northern Ireland who identified as Pakistani, making up 0.06% of the population there[17].

As shown in figure 2, the Pakistani community is concentrated in the West Midlands (20.2%), Yorkshire and Humber (20.1%), London (19.9%) and the North-West (16.8%)[18]. Greater London overall has the largest Pakistani population, but at the local authority level, Birmingham has the largest Pakistani population, followed by Bradford and Kirklees[19].

Of the three South Asian communities, the Pakistani community is the most evenly spread across the UK, though there are concentrated pockets in Lancashire, Yorkshire, West Midlands and Greater London. More than half of the Pakistani population growth since 1991 is accounted for by UK-born Pakistanis. Bradford has the largest proportion of Pakistanis, accounting for 15% of its total population[20].

Figure 2: Pakistani ethnic group, by area in the UK



Source: England and Wales 2011 Census[21]

It is estimated that 60% of the Pakistani population in the UK is from the Mirpur District of Kashmir and settled mainly in Birmingham, Bradford, Oldham and surrounding towns. The Pakistani community in London is comparatively more mixed22.

Based on the 2011 census, citizens born in Pakistan who now reside in the UK had the eighth highest percentage of holding a UK passport (68.8%) of all "non-UK countries of birth, with the highest proportions holding a UK passport on census day" in 2011. This is the number of people born in Pakistan who have acquired British citizenship23.

1.3.2 Presence in multiple sectors

There are several personalities from the Pakistani community that have gained prominence in multiple sectors in the UK.

This includes a presence in the NHS - members of the Pakistani community are one of the most common nationalities of NHS staff (table 1 below24 – there are almost 5,000 individuals of Pakistani nationality working for the NHS).

Table 1: Selection of the most common nationalities of NHS staff

Nationalities	Number of staff
UK/ British	1,118,116
Indian	32,117
Pakistani	4,902

Source: House of Commons Library – NHS staff from overseas[25]

Within the political system, this includes Sajid Javid (Britain's first British Pakistani home secretary), Sadiq Khan (London's first British Pakistani mayor), and Sayeeda Warsi (the first Muslim to sit in the British cabinet). Within the business sector, this includes Sir Anwar Pervez (founder and chairman of Bestway Group) and the Asda owners Mohsin and Zuber Issa.

From mainstream media, this includes Oscar-winning actor Riz Ahmed and singer Zayn Malik, and Amir Khan in boxing. Malala Yousafzai has also been an influential female figure - an activist for female education who was shot by Taliban gunmen in Pakistan. She is now a resident of Birmingham and the youngest Nobel Prize winner.

1.3.3 Religion

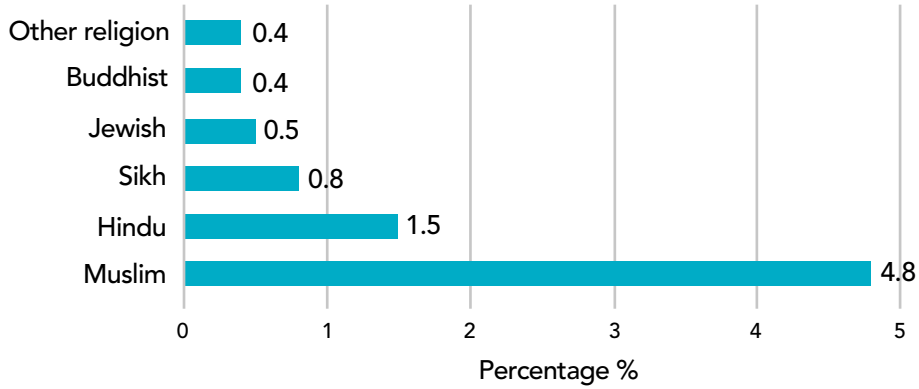
Around 91% of British Pakistanis identify as Muslim and religion forms a large part of the community's identity26.

Of all minority faiths, the Muslim group was the largest minority religious group in the UK, with 2.7 million people identifying as being Muslim (4.8% of the population- figure 3).

The majority of Pakistanis in the UK are Muslim which mirrors the geographic spread of the faith across the country – there was a greater presence of those from the Muslim faith in areas with larger concentrations of the Pakistani community (figure 4).

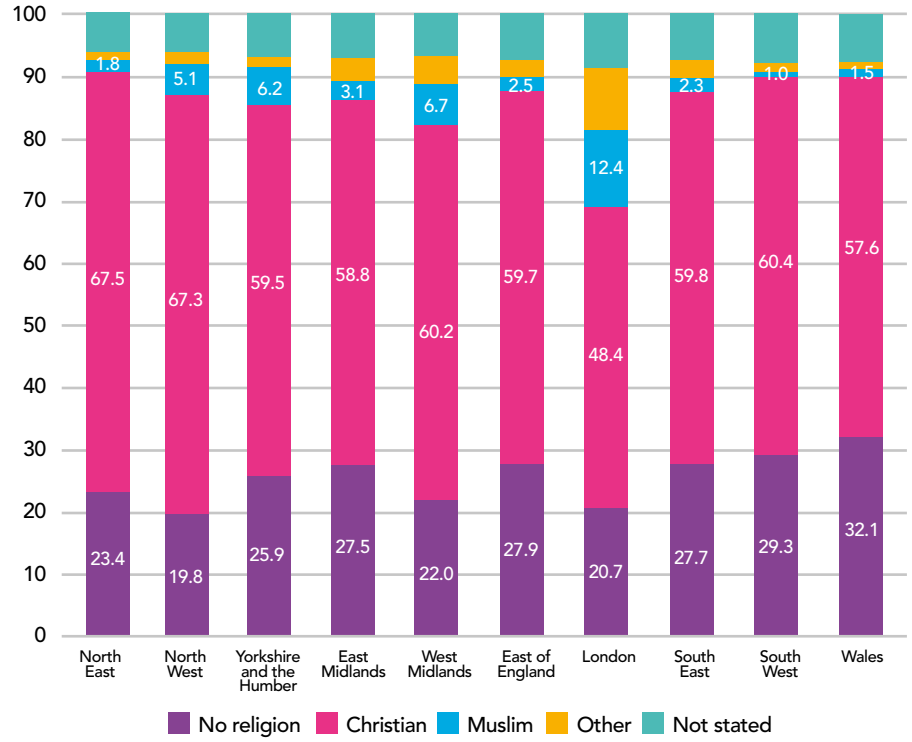
Hajj (Arabic for 'pilgrimage') is a key religious event for Muslims - it is a five-day religious pilgrimage where Muslims make the journey to Mecca. The religious book followed by Muslims is the Quran, which provides guidance on day-to-day living and is the word from Allah (Arabic for God).

Figure 3: Minority religious groups, England and Wales 2022



Source: ONS[27]

Figure 4: Religious affiliation (percentage %), English regions and Wales 2011



Source: ONS[28]

1.3.4 Attire

While usually Pakistanis in the UK wear Western clothing, traditional clothing worn by the Pakistani community is the shalwar kameez, the national dress of Pakistan which is worn by both men and women.

The shalwar kameez is the national dress of Pakistan. It is a pair of light trousers worn with a long tunic, to which women add a shawl. The traditional clothing worn by the Pakistani community reflects the four provinces of Pakistan. The style of shalwar kameez varies by province in Pakistan, and these variations in attire are evident among the Pakistani community in the UK as well.

1.3.5 Food

Pakistani food has Indian, Far Eastern and Middle Eastern influences, and the diet is based on a healthy variety. Pakistani food includes staples such as chapattis and rice eaten with meat dishes and vegetables. Some of the food items involve deep-frying and the use of clarified butter (ghee) which can make Pakistani food less healthy.

Published research[29] on dietary patterns of Pakistani adults has found three dietary patterns: a fat and sweet pattern[30]; a fruit and vegetable pattern[31]; and a seafood and yoghurt pattern[32]. The research found the fat and sweet pattern scores to be low among older Pakistanis, but high among females and those physically active, while the fruit and vegetable intake was greater among younger Pakistanis. Overall, the research identified a distinct dietary pattern within the community with associations to characteristics such as education level, tobacco use, and level of physical activity[33]. This has been explored further in chapter **2.3. Healthy lifestyle**.

1.3.6 Sport

As found in other South Asian countries, of all sports, cricket is the most popular game in Pakistan and one which continues to have prominence among British Pakistanis.

While India was part of the British Empire, the game of cricket was introduced to India and remained within Pakistan following the separation of Pakistan and India. Traditional sports like Kabaddi (a contact sport also known as 'the game of struggle') and Rassa Kashi (tug of war), as well as hockey and football, are played in Pakistan, but cricket is by far the most popular sport.

1.3.7 Festivals

There are several key events celebrated by the Pakistani community in the UK, which include Eid, celebrated twice a year, and Ramadan which is when fasting is observed over a month-long period.

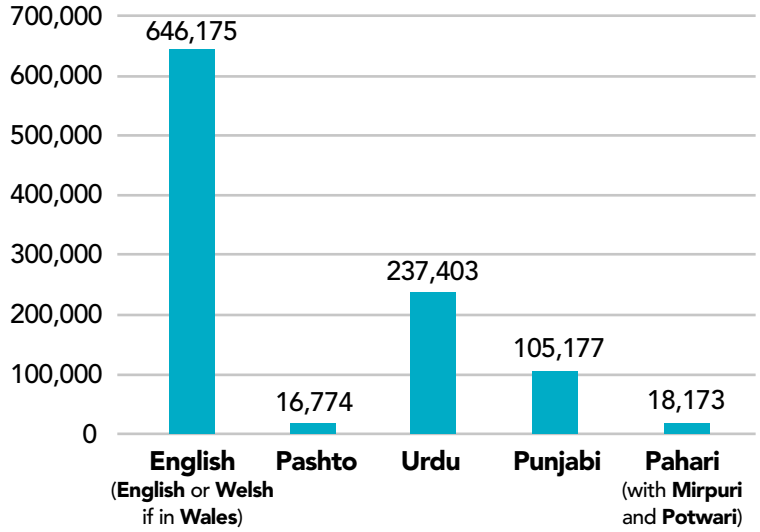
Other events include Muharram which marks the beginning of the Islamic New Year. The month of Ramadan is viewed as the holiest month by Pakistanis. During Ramadan, Muslims fast from dawn to dusk over the duration of a month. There are two Eid festivals in a year: Ramadan ends with three days of festivities called Eid al-Fitr and the second is Eid-ul-Adha which comes at the end of the time linked to the annual pilgrimage of the Hajj.

1.3.8 Languages

According to the 2011 Census (figure 5), among British Pakistanis, the main language is English (62%). The main 'other' languages spoken by the community are Urdu (23%), Punjabi (10%), Pahari with Mirpuri and Potwari (1.7%), and Pashto (1.6%)[34].

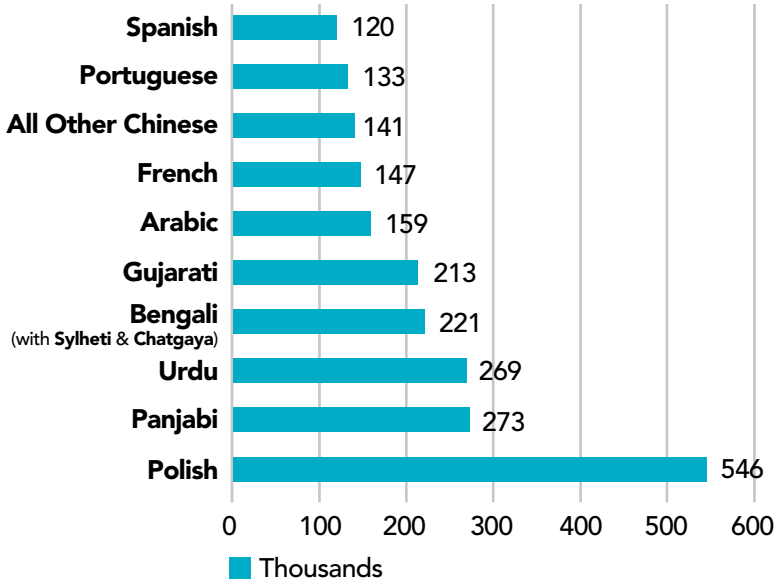
Overall, in England and Wales, Punjabi (spoken by 273,000 people) and Urdu (spoken by 269,000 individuals) were the top second and third most common 'other' languages, likely a reflection of the sizeable presence of the Pakistani community in the country (figure 6). The Urdu script is the most widely used for reading and writing in the community[35]. Other main languages and dialects include Sindhi, Saraiki and Balochi. It is worth noting that young British Pakistanis communicate mostly in English[36]. Half (10,800) of those who reported Pakistani Pahari (with Mirpuri and Potwari) as their main language lived in Birmingham[37].

Figure 5: Main languages spoken by British Pakistanis



Source: ONS[38]

Figure 6: Top ten main 'other' languages in England and Wales, 2011



Source: ONS[39]

1.3.9 Multigenerational households

The community maintains strong ties with their family and many Pakistanis live in multigenerational households – in the UK around 35% of Pakistani households are multigenerational.

The tight family unit means that many Pakistanis live in multigenerational households, which means three or four generations live together. A multigenerational household is defined as one that contains at least one person aged 19 or under, at least one between the ages of 20 and 69, and at least one who is 70 or older.

Around 35% of households of Pakistani heritage are multigenerational; this is less than the Bangladeshi households of which 56% are multigenerational, whereas only about 1.5 per cent of white households are multigenerational[40]. This has been discussed further in section **3.5.3 Housing**.

1.3.10 Other cultural aspects

Each generation within the Pakistani community has a different self-identity. The elders from the first generation feel a strong connection towards their country of birth, compared to the second and third generations who see themselves primarily as British while maintaining a connection with Pakistan[41].

The majority of Pakistani community members of all ages and generations unequivocally describe themselves as British Muslims[42].

1.4 Birmingham context

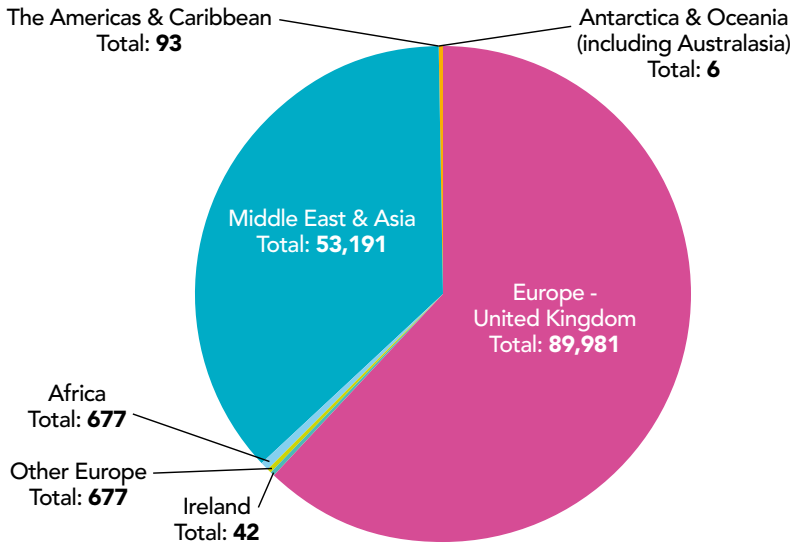
1.4.1 Demographics and identity

Birmingham has the second largest Pakistani community in the UK (144,627 residents), accounting for 13.5% of the city's total population[43].

There were 55,922 usual residents in Birmingham with Pakistan registered as the country of birth[44]. For more than half the Pakistani community-based in Birmingham, the UK is noted as the country of birth (89,981; 62%), likely reflecting the birth of second and third generation Pakistanis in the UK (figure 7). In terms of the national identity for Pakistani residents based in Birmingham, around 69% note a "British only" identity, followed by "English only" by around 16%, and lastly "other identity only" noted by around 10% (figure 8).

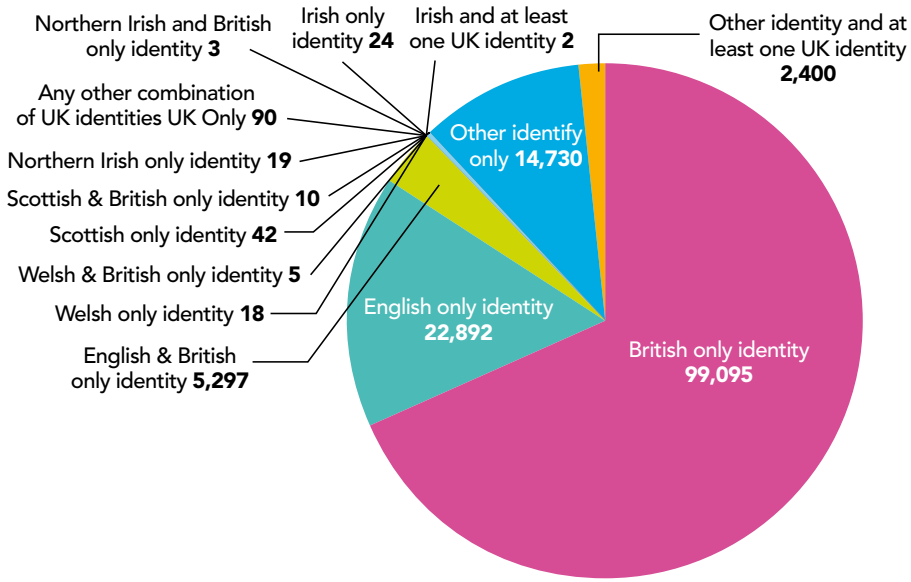
Ward-level data based on the population census shows the top 10 wards with the highest proportions of Pakistani community are inner-city wards of Birmingham (table 2 and figure 9). The community has the greatest concentration in Alum Rock (58.6%), Sparkhill (56.9%) and Small Heath (53%).

Figure 7: Country of birth for Pakistanis in Birmingham (n=144,627)



Source: Census 2011 ONS DC2205EW[45]

Figure 8: National identity by ethnic group for Pakistanis in Birmingham (n= 144,627)



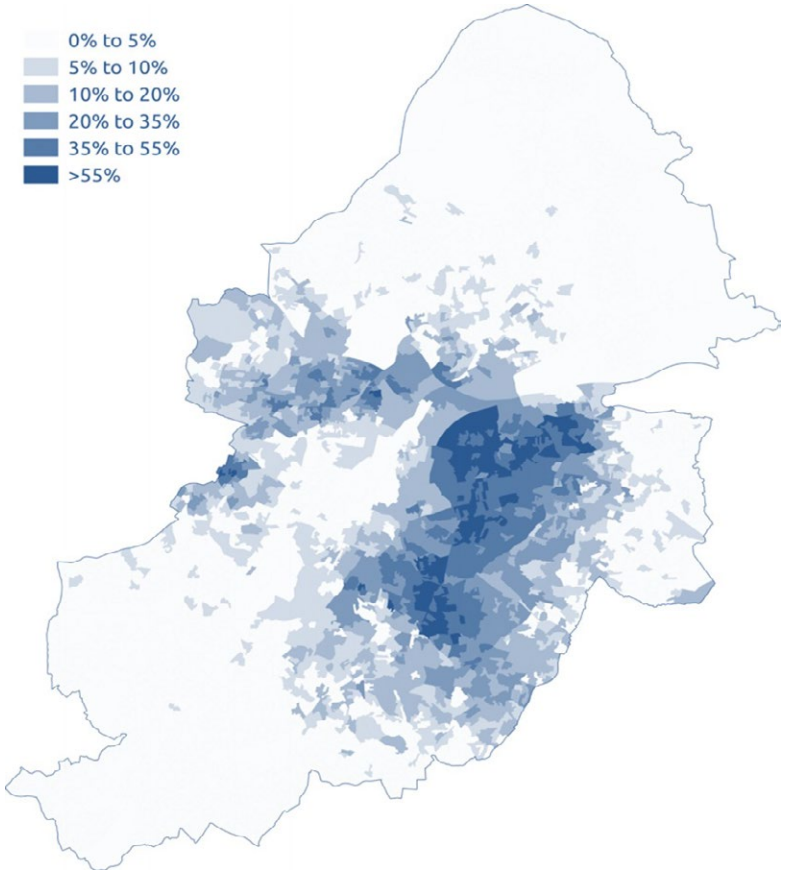
Source: Census 2011 ONS DC2202EW

Table 2: Top 10 Birmingham wards with highest populations of Pakistanis

Ward	Total ward population	Pakistani population (%)
Alum Rock	25, 487	58.6
Sparkhill	20,309	56.9
Small Heath	20,403	53
Ward End	12,255	51
Heartlands	12,287	46.3
Sparkbrook & Balsall Heath East	25,211	46.3
Bordesley Green	11,796	41.1
Aston	22,636	30.9
Lozells	9,153	30.8
Hall Green North	21,509	28.1

Source: Census 2011 KS201

Figure 9: Map of Birmingham and concentrations of the Pakistani community



Source: 2011 Census ward-level data[46]

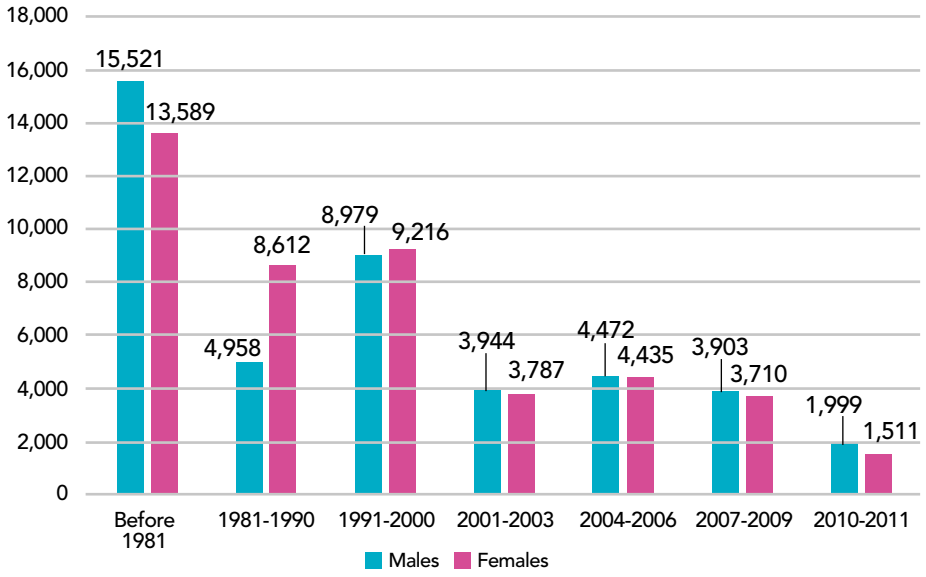
1.4.2. Arrival to the West Midlands

The majority of the arrivals of the Pakistani community to the West Midlands were before 1981.

From 1981 to 1990, females accounted for 63% of the arrivals from Pakistan to the West Midlands, likely to join Pakistani men who migrated in the previous years.

As shown in figure 10, migration from Pakistan has been declining year on year, with only around 3,500 arriving from 2010 to 2011, compared to over 29,000 before 1981.

Figure 10: Arrivals from Pakistan to the West Midlands, by gender



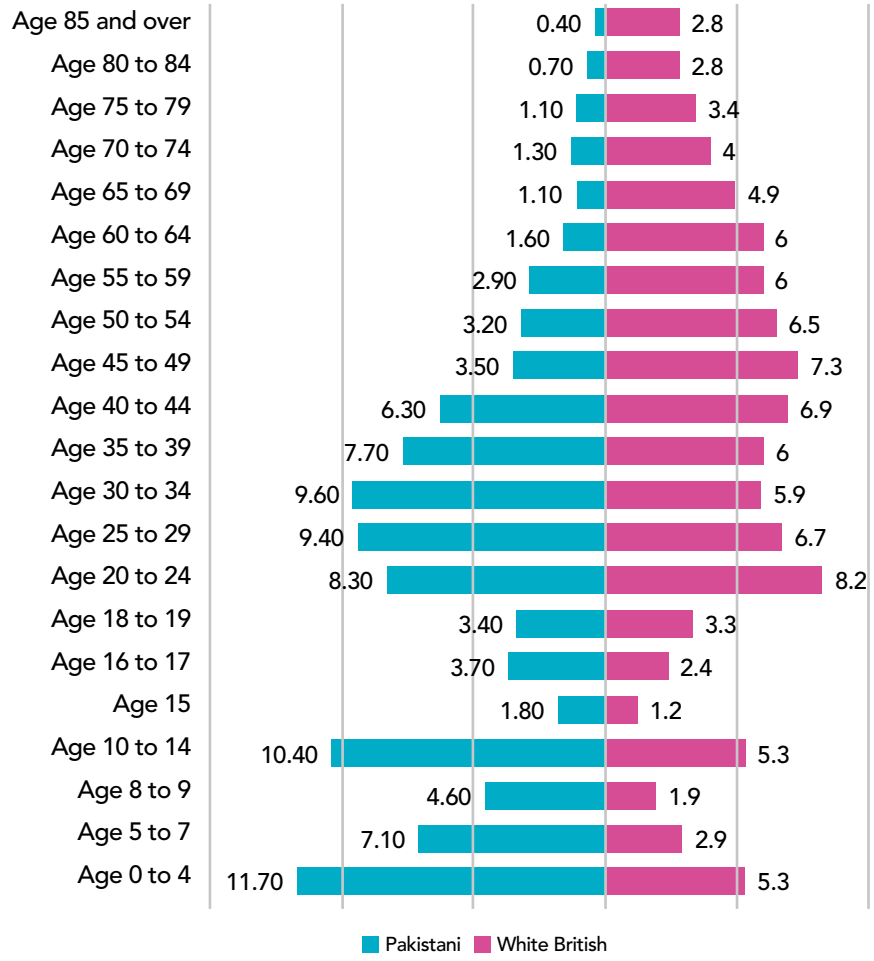
Source: Census 2011 Table CT0562

1.4.3. Age profile

According to the 2011 Census, 70% of Birmingham's Pakistani community is under the age of 35 and 35.6% is under 16, indicating the community has a young age profile. The Pakistani community account for 12.5% of the working age group in Birmingham, while in England the community make up 2% of the working age group. Over 20% of working-age Pakistanis are in six wards, and the proportion is over 50% in two – Bordesley Green (53%) and Washwood Heath (57%).

This can be compared with the White British community in the city of which 43.1% are under 35 and 16.6% are under 16 (figure 11). In addition, as shown in figure 12, under 35s makeup 37% of West Midlands' residents born in Pakistan.

Figure 11: Age profile in percentage (%) of Pakistani and White British people in Birmingham



Source: Census 2011 Table DC2101EW

Figure 12: Population pyramid image: Age profile of population born in Pakistan, by gender within West Midlands, with age profile of West Midlands as comparator

Source: Census 2011 Table CT0561[47]

The Pakistani working age population in Birmingham is mainly concentrated to the north-west, east and south-east of the city centre. While the proportion is over 50% in two wards, it is less than 5% in 21 wards.

As shown in table 3, apart from White British and Other White, Birmingham has a higher proportion of all ethnic groups compared to England. The three largest minority groups in Birmingham are Pakistani (12.5%), Indian (6.9%) and Black Caribbean (4.6%). In contrast, the three largest minority groups in England are Other White (5.6%), Indian (3.0%) and Pakistani (2.0%)48.

The difference is most apparent for the White British group which comprises 54.1% of the Birmingham working age population, but 78.5% of the population in England, and the Pakistani group, which comprises 12.5% of the Birmingham working age population, but only 2.0% of the population in England.

Table 3: The ethnic composition of the working age population in Birmingham compared to the England, sorted by number of Birmingham residents 2011

Ethnic Group	Birmingham no.	Birmingham %	England %	Difference
White British	373,231	54.10%	78.50%	-24.40%
Pakistani	86,260	12.50%	2.00%	10.50%
Indian	47,484	6.90%	3.00%	3.9%
Bangladeshi	18,932	2.70%	0.80%	2.00%

Source: Ethnic Groups in the Labour Market: statistical analysis for Birmingham, based on the 2011 Census[49]

CHILDHOOD POVERTY

Children in Pakistani households were 2.8x as likely to live in low-income households

47% of children living in Pakistani households were living in low-Income households 30 percentage points higher than children living in White British households and 27 percentage points higher than the national average

56,974
CHILDREN REGISTERED AS PAKISTANI IN BIRMINGHAM

21% of the overall population under the age of 18

OBESITY

	Pakistani	White British
Obese 4-5 year old children	11%	10%
Obese 10-11 year olds	26%	19%

89.8%
VACCINE TAKE-UP

The Pakistani community have one of the highest vaccine take up rates, particularly vaccine coverage or the completed course at one year of age for babies (89.8%)

7.48
PER 100,000

maternal mortality among mothers born in Pakistan in 2015/17; this is 0.94 times the risk compared to UK born women. Pakistanis have the highest risk of congenital anomalies as the most common cause of death, accounting for 3.4 infant deaths per 1,000 live births

2.0 Community Health Profile

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

2.1 Getting the best start in life

Getting the best start in life key findings:

Maternal health

- Mothers from Pakistan have a similar relative risk of maternal mortalities compared to those born in the UK. From 2015 to 2017, there were 7.48 per 100,000 maternal mortalities in the UK among mothers born in Pakistan, compared to 7.97 deaths per 100,000 of women born in the UK.
- From 2012 to 2014, of the West Midlands live births to mothers born outside the UK, 49% were from Pakistan, Poland, India and Bangladesh, of which Pakistan accounted for the greatest proportion at 4.92% (10,666 births).

Infant mortality, stillbirth and low birth weight

- Combined data for 2017, 2018 and 2019 on infant mortality by cause of death shows for babies of Pakistani ethnicity congenital anomalies are the most common cause of death.
- Between 2012 and 2014 in the West Midlands, the highest proportion of low-birth-weight babies were born to mothers from the Caribbean (13.7%), Pakistan (12.0%) and India (12.0%), compared to a proportion of 8.4% low birth weights to mothers born in the UK.
- Pakistani, Bangladeshi and Indian infants were 280–350g lighter, and 2.5 times more likely to be low birthweight compared with White infants.
- Within the Asian subgroup, stillbirths and infant mortality rates in England and Wales are highest among Pakistani babies (stillbirths are 6.1 per 1000 total births, 2017-2019) and infant deaths (6.8 infant deaths per 1000 live births, 2017-2019).

Breastfeeding and childhood vaccinations

- According to the 2011 Census, the Pakistani community has a young age profile, with a higher percentage of under 18s compared to the general population in Birmingham.
- Research examining patterns of breastfeeding among ethnic minority mothers found that Pakistani mothers had consistently lower rates of breastfeeding initiation and continuation, similar to white mothers. However, of those mothers who were breastfeeding their infant at 3 months, the largest proportion who did so predominantly were Pakistani (49%).
- The Pakistani community have some of the highest vaccine take up rates, particularly vaccine coverage of the completed course at one year of age for babies (89.8%).

Childhood obesity

- Pakistani children of the ages 10 and 11 have higher prevalence of obesity (26.2%) compared to White British (19%) and White other groups (22.5%).
- Similarly, Pakistani children of four and five years of age have much higher prevalence of obesity (10.8%), compared to children of White British (9.7%) and White other (9.1%) communities.

Child poverty

- Children in Pakistani households were 2.8 times as likely to live in low-income households, compared with children living in White British households. That is 47% of children living in Pakistani households were living in low-income households.
- This was 30 percentage points higher than children living in White British households and 27 percentage points higher than the national average.

Social care

- Statistics for children looked after in England, including adoptions, indicates from 2018 to 2020 that Pakistani children accounted for a small proportion (roughly 1%). This is far smaller than White British children who account for roughly 70%, but similar to other South Asian groups (Indian: less than 1%; Bangladeshi: 1%).

School readiness and educational attainment

- Pakistani pupils achieved above average Progress 8 scores (0.24) – despite being one of the ethnic groups most likely to experience low income, high poverty rates and be living in some of the most deprived areas of the country.

2.1.1 Maternal health

Live births

The Infant and Perinatal Mortality in the West Midlands report50 has found from 2012 to 2014 live births to mothers born outside the UK, 49% were from Pakistan, Poland, India and Bangladesh, of which Pakistan accounted for the greatest proportion at 4.92% (10,666 births).

Table 4 shows the ten most common countries of birth for mothers in the West Midlands.[51] The report also states the country of birth of the mother is an important category to note as the information can be used to understand whether there is consanguinity. Consanguineous marriages are within couples who descend from the same ancestors. This is particularly useful as data pertaining to births from consanguineous marriages in the West Midlands are not currently collected[52].

Information from a study of 85,735 births in Birmingham (2006 to 2010) found that congenital anomaly-related deaths contributed to 29.3% of stillbirth and infant deaths, with significantly higher mortality rates in Pakistani and Bangladeshi mothers compared to White Europeans[53]. A proposed causal factor for this is the higher rates of consanguineous relationships in the Pakistani community - it was found that 49.9% of Pakistani mothers were in consanguineous relationships, compared to 15.9% across the whole cohort[54].

A recent study from the West Midlands with a specific emphasis on Birmingham found mortality from congenital anomalies was also statistically significantly higher in Pakistani and Bangladeshi mothers. Linking mortality to clinical genetic cases, linkage rates were highest in deaths to Pakistani and Indian mothers, which could suggest a higher rate of mortality due to genetic causes in these groups[55].

A published research[56] has found British Pakistani families at-risk for recessive disorders have a limited understanding of recessive disorders. It highlights receiving two explanations of the cause of recessive disorders (cousin marriage and recessive inheritance) leads to confusion among British Pakistani families. It also found that the realisation that couples in non-consanguineous relationships have affected children has led to mistrust of professional advice. The research suggests local commissioning groups and service providers should address the health service needs of consanguineous communities by forming multidisciplinary groups in areas where consanguinity-related recessives are a health concern.

Table 4: Selection of the most common countries of birth of mothers born outside the UK (West Midlands; 2012 to 2014)

Country of Birth of Mother	No. of births in West Midlands	% of live births in West Midlands	% of stillbirths in West Midlands	p value
Pakistan	10,666	4.92	7.29	0
India	5,202	2.4	3.21	0.06
Bangladesh	2,744	1.27	1.36	0.66
Total mothers born outside the UK	50,509	23.34	27.11	-
Total mother born in UK	165,770	76.66	72.89	base

Source: ONS - analysis LKIS (WM), data from the Infant and Perinatal Mortality in the West Midlands report[57]

Maternal mortality

Mothers from Pakistan have a similar relative risk of maternal mortalities compared to those born in the UK. From 2015 to 2017, there were 7.48 per 100,000 maternal mortalities in the UK among mothers born in Pakistan, compared to 7.97 deaths per 100,000 of women born in the UK.

The MBRRACE-UK Saving Lives, Improving Mothers' Care 2019 report[58] has found women born in Pakistan have a similar relative risk (0.94 times the risk) of maternal mortalities when compared to those born in the UK (table 5). This was slightly less than mothers born in India who had 9.43 per 100,000 maternal mortalities during the same time period, 1.18 times the risk compared to women born in the UK. The report has found women who died who were born abroad were from various regions, including Asia which accounted for 30% of the cases, mainly from Pakistan, India and China[59].

Nearly a quarter of women who died in 2015-17 (23%) were born outside the UK; 42% of these women were not UK citizens and overall 10% of the women who died were not UK citizens[60]. Women who died who were born abroad and who were not UK citizens had arrived in the UK a median of 3.5 years before they died (range is 3 months to 18 years)[61]. Specific disaggregated data for mothers born in Pakistan for these categories is not available.

*Estimates based on proportions of births to UK and non-UK born mothers applied to a number of maternities

‡Estimates based on the ratio of maternities to births applied to the number of births recorded to mothers born in the stated country

Table 5: Maternal mortality rates according to mother's country of birth (selected countries)

Woman's country of birth	Maternities 2016-18	Total Deaths	Rate per 100,000 maternities	95% CI	Relative risk (RR)	95% CI
UK	1,669,097*	133	7.97	6.67 to 9.44	1 (Ref)	
Outside UK	611,354*	48	7.85	5.79 to 10.41	0.99	0.69 to 1.38
India	42,399‡	4	9.43	2.57 to 24.15	1.18	0.32 to 3.10
Pakistan	53,491‡	4	7.48	2.04 to 19.15	0.94	0.25 to 2.46

Source: MBRRACE-UK - Saving Lives, Improving Mothers' Care 2019[62]

Other characteristics - Mother's country of birth and height

ONS data shows since 2010, Pakistan has remained the second most common country of birth for mothers not born in the UK.

Analysis from ONS found in 2019, 34.3% of all children born in England and Wales had either one or both parents born outside of the UK; up from 33.8% in 2018[63]. The percentage of live births to women born outside the UK has generally been increasing[64].

Statistical analysis conducted for research published in 2009[65] found that maternal height, lone parenthood and education have different effects on birthweight across ethnic groups. Mothers from Pakistani, Bangladeshi and Indian groups were on average up to 8 cm shorter than White mothers.

According to this research maternal height may be considered a characteristic of the mother, a marker of socioeconomic status and cultural location over multiple generations, as well as historical and relative economic development of the country of origin for migrants[66]. Tests for interactions showed that there were statistically significant differences for maternal height on birthweight across ethnic groups[67].

Barriers and appreciating complex needs

A published study[68] on maternity care for immigrant women which mentions a research from the National Institute for Health and Clinical Excellence (NICE) provides useful insight into the barriers faced by minority communities. It notes that pregnant women who are recent immigrants, refugees or asylum seekers may have complex social factors which need to be factored when considering access to maternity care. Due to potentially limited English language abilities, lack of knowledge about the health services and/ or poor communication with staff delivering healthcare they may not fully benefit from antenatal healthcare services in the UK. The NICE guidance[69] suggests that 'healthcare professionals should help support these women's uptake of antenatal care services by using a varied of means to communicate [more effectively with them], telling women about antenatal care services and how to use them, and undertaking training in the specific needs of women in these groups', with a further recommendation that healthcare staff be given specific training in meeting the needs of these women. This observation may be applicable to Pakistani women who have recently migrated from Pakistan and / or have limited English language skills and knowledge about Britain's healthcare services.

Another published research[70] based on focus groups and 1:1 interviews with UK-based Pakistani women has found that while women were broadly receptive to discussion of contraception, including antenatally, some explained that the decision on postnatal contraception (PNC) was theirs or made jointly with their husband. It was highlighted that in some marriages the husband made the decision alone, with some women stating facing family expectation to have a baby early in marriage. In addition, maternity staff part of the focus group expressed language as a key challenge and explained utilisation of translation services was important to ensure women received the information they needed on contraception.

2.1.2 Infant mortality, stillbirths and low birth weight

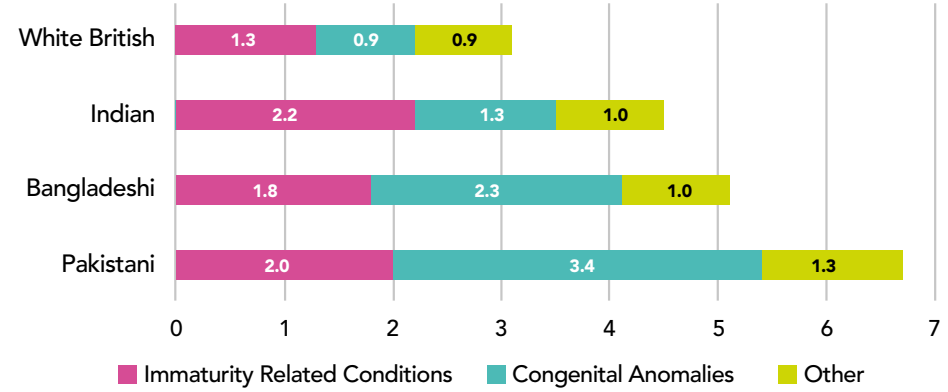
Infant mortality

Combined data for 2017, 2018 and 2019 on infant mortality by cause of death shows for babies of Pakistani ethnicity congenital anomalies are the most common cause of death. The Pakistani ethnic group consistently had the highest rate of infant mortality of all the Asian subcategories[71].

Figure 13 shows combined data for 2017, 2018 and 2019 to assess infant mortality by cause of death. This data indicates among minority communities the Pakistani group has the highest risk of congenital

anomalies as the most common cause of death, accounting for 3.4 infant deaths per 1,000 live births. As discussed, the likely reason for this is consanguineous marriages within the community.

Figure 13: Infant mortality rate by ethnicity of the baby and cause of death, England and Wales, 2017, 2018 and 2019 combined; Infant mortality rate per 1,000 live births (rate)



Source: ONS[72]

Also, in 2014, the Pakistani ethnic group had significantly higher rates[73] of infant mortality than England as a whole, while White British had lower rates.

There has been a slight drop to the infant mortality rate among the Pakistani group when compared to the combined data figures from 2017 to 2019), indicating a positive health outcome, especially when compared to the Bangladeshi and Indian communities which have both seen a slight increase to the infant mortality rate since 2014. It is worth noting, that the data used for 2017-19 is for England and Wales while for 2014[74] is solely for England. According to 2019 data shown in table 6, Pakistanis have a low percentage (4.3%) of live births, especially lower when compared with White British (59.1%) and White Other (11.6%). In comparison to other ethnic minority communities, Pakistanis had a higher percentage of live births than the Bangladeshi group (1.5%) and the Indian community (3.2%).

Stillbirths

Within the Asian subgroup, stillbirths and infant mortality rates in England and Wales are highest among Pakistani babies (stillbirths are 6.1 per 1000 total births, 2017-2019) and infant deaths (6.8 infant deaths per 1000 live births, 2017-2019).

Overall, ONS data indicates a decline in stillbirths and infant mortality rates in England and Wales. As shown in table 6, within the Asian subgroup these cases are highest among Pakistani babies (6.1 per 1000 total births from 2017 to 2019) and infant deaths (6.8 infant deaths per 1000 live births from 2017 to 2019). The community has higher stillbirth and infant mortality rates than both the Indian and Bangladeshi groups.

Table 6: Live births, stillbirths and infant mortality by ethnic group, England and Wales

Ethnic group	Live births 2019	Per cent of live births 2019	Stillbirths per 1000 total births 2017-19	Infant deaths per 1000 live births 2017-19	Relative risk (RR)
Pakistani	27,573	4.3	6.1	6.8	1 (Ref)
White British	377,916	59.1	3.5	3.2	0.99
Bangladeshi	9,505	1.5	5.2	5.0	1.18
Indian	20,627	3.2	4.9	4.5	0.94

Source: ONS in Kings Fund Report[75]

Low birth weight

Between 2012 and 2014 in the West Midlands, the highest proportion of low-birth-weight babies was born to mothers from the Caribbean (13.7%), Pakistan (12.0%) and India (12.0%), compared to a proportion of 8.4% low birth weights to mothers born in the UK[76]. Pakistani, Bangladeshi, and Indian infants were 280–350g lighter, and 2.5 times more likely to be low birth weight compared with White infants[77].

The Infant and Perinatal Mortality in the West Midlands[78] report has also found that birth weight varies considerably by the mother's country of birth. Low birth weight is defined as the number of live and stillbirths occurring in the respective calendar year at under 2500g for all maternal ages; the proportion is calculated as a percentage of all live and stillborn infants. Pakistani infants had one of the lowest mean birth weights at 3.14kg, compared to 3.39 kg among infants of mothers born in the UK[79]. Though it is worth noting that Pakistani infants on average weigh more than those born to Bangladeshi (3.08kg) and Indian mothers (3.10kg)[80].

In addition, the Health Equity Report[81] has found the percentage of babies born with low birth weight varies by ethnic group. In 2015, the Pakistani, Bangladeshi, Indian, Black Caribbean, and Other ethnic groups had significantly higher proportions of term babies born with low birth weight than England as a whole[82].

Overall it also found inequality narrowed between 2006 and 2015[83]. This narrowing mirrors a reduction in the percentage of births with low birthweight in ethnic groups between 2006 and 2015[84]. A national comparison of the percentage of low birth weight in a selection of cities across the West Midlands shows Birmingham fairing "significantly worse than England" (based on the 2012 to 2014 data[85]. Deprivation is a significant risk factor: compared with white groups, higher proportions of mothers from ethnic minority groups, especially Black groups, live in deprived areas[86]. Infant mortality rates are significantly higher in the 10% most deprived compared with the 10% least deprived in England, and this difference has remained relatively constant since 2010[87].

2.1.3 Breastfeeding and childhood vaccination

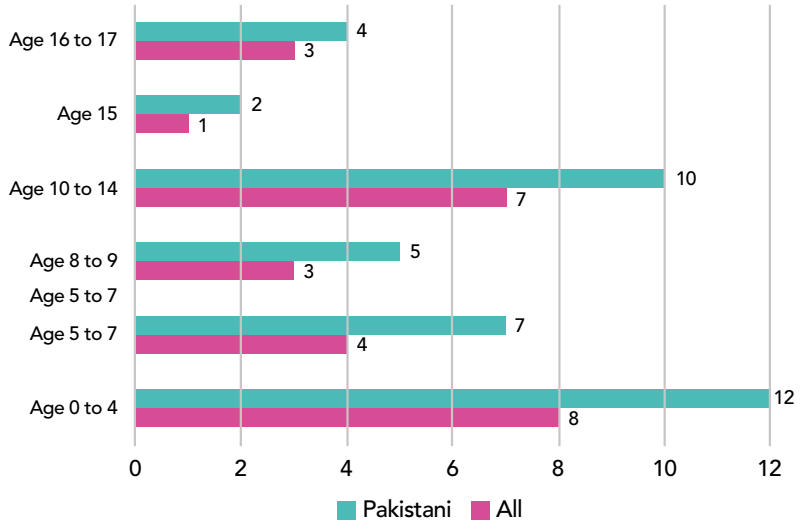
Age profile: under 18s

According to the 2011 Census, Birmingham's Pakistani community has a young age profile, with a higher percentage of under 18s compared to the general population in Birmingham.

In Birmingham, there are 56,974 children registered as Pakistani (2011 Census DC2101EW[88]), representing 21% of the overall children's population aged under the age of 18 (total under 18s in Birmingham: 274,135).

Figure 14 and table 7 below illustrate the proportion of Pakistani children for each age group, compared to the proportion of Birmingham's general population under the age of 18.

Figure 14: Age profile of under 18s within Birmingham's Pakistani ethnic group, compared to the general under 18 population of Birmingham; shown in percentage % (clustered bar format)



Source: Census 2011 DC2101EW[89]

Table 7: Pakistani children's age profile compared to the general population of Birmingham (table format)

Age Group	General Population	General Population (%)	Pakistani Population	Pakistani Population (%)
Age 0 to 4	81,901	8%	16,948	12%
Age 5 to 7	45,952	4%	10,317	7%
Age 8 to 9	28,408	3%	6,686	5%
Age 10 to 14	73,659	7%	15,010	10%
Age 15	14,762	1%	2,645	2%
Age 16 to 17	29,453	3%	5,368	4%
Total	1,073,045 (274,135)	26%	144,627 (56,974)	39%

Source: Census 2011 DC2101EW[90]

Breastfeeding

Research examining patterns of breastfeeding among ethnic minority mothers found that Pakistani mothers had consistently lower rates of breastfeeding initiation and continuation, similar to white mothers[91]. However, of those mothers who were breastfeeding their infant at 3 months, the largest proportion who did so predominantly were Pakistani (49%).

The research[92] found of those mothers who were breastfeeding their infant at 3 months, the largest proportion who did so predominantly were Pakistani (49%) and Black Caribbean (44%) mothers and the lowest proportions were among Bangladeshi (29%) and Black African (24%) mothers[93]. It also concludes that across all racial/ethnic groups breastfeeding initiation was more common among mothers who spoke a language other than English (82%) or in addition to English (82%) compared with English only (63%) at home[94].

In addition, a published research[95] on mothers' experiences of breastfeeding and accessing breastfeeding services in the UK included Pakistani mothers in the study sample. It found the most common barriers to breastfeeding irrespective of ethnicity were perceptions surrounding pain and lack of milk. Among Pakistani mothers it found formula feeding was viewed as a symbol of wealth. Other barriers identified were both physical and psychological barriers, embarrassment of breastfeeding in public, and issues around time and convenience. As Pakistani households tend to be multigenerational, presence of multiple members of the family around breastfeeding mothers may also be a prohibiting factor.

Childhood vaccination

The Pakistani community have some of the highest vaccine uptake rates, particularly vaccine coverage of the completed course at one year of age for babies (89.8%)[96].

The vaccine uptake rate of the Pakistani ethnic group is similar to other South Asian communities (Indian: 92%, and Bangladeshi: 91.4%).

Around 87.4% of Pakistani children completed vaccination by six months, for those fully vaccinated by one year of age. This was slightly higher than the Bangladeshi group (85.8%) but noticeably lower than the Indian community (94.4%)[97].

2.1.4 Childhood obesity

Pakistani children between the ages of 10 and 11 have a higher prevalence of obesity (26.2%) compared to White British (19%) and White other groups (22.5%)[98]. Similarly, Pakistani children between four and five years of age have a much higher prevalence of obesity (10.8%), compared to children of White British (9.7%) and White other (9.1%) communities.

However, obesity prevalence for four- and five-years olds and those aged 10 and 11 among Pakistani children is lower than in the Bangladeshi community (12.6% and 30.1%, respectively)[99]. The finding that childhood obesity rates are higher among Black and Asian children[100], is reflected within the Pakistani community (figure 15 and 16).

According to the Kings Fund report[101], some of these differences may be associated with higher levels of deprivation among ethnic minority groups, as children in deprived areas are twice as likely to be obese than those in less deprived areas.

Health in the early years plays an important role in an individual's future health[102, 103]and these risks are disproportionately high in some racial and ethnic groups[104]. Obesity specifically puts children at increased risk of a range of morbidities, including cardiovascular and respiratory disease, type II diabetes mellitus, hypertension and some cancers[105]. A published research[106] with Pakistani focus group participants identified a range of barriers and facilitators to providing children with a healthy diet.

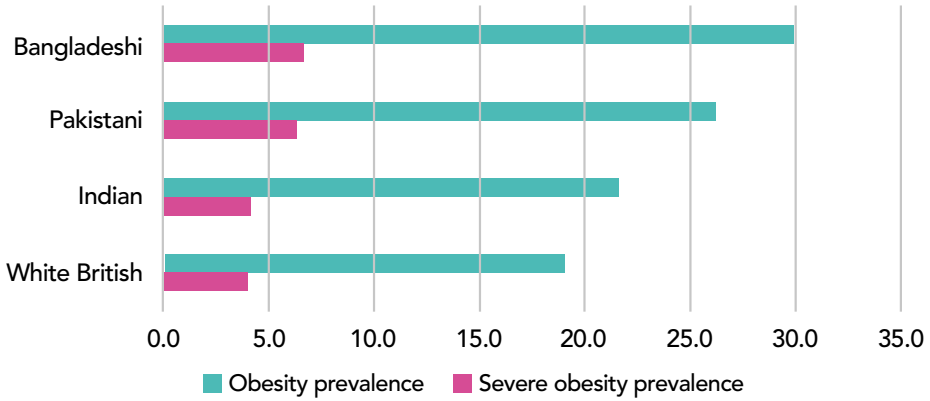
These included knowledge, skills and capability; time and financial constraints, including overexposure of inexpensive, convenient and unhealthy processed food; food environment barriers; influence of cultural identity and upbringing; family influences on eating and food practices; and mealtime routine and practices.

Table 8: Prevalence of obesity among children by ethnic group, England 2019/20

Ethnic group	Ages 4-5 years (%)	Ages 10-11 (%)
White British	9.7	19.0
Pakistani	10.8	26.2

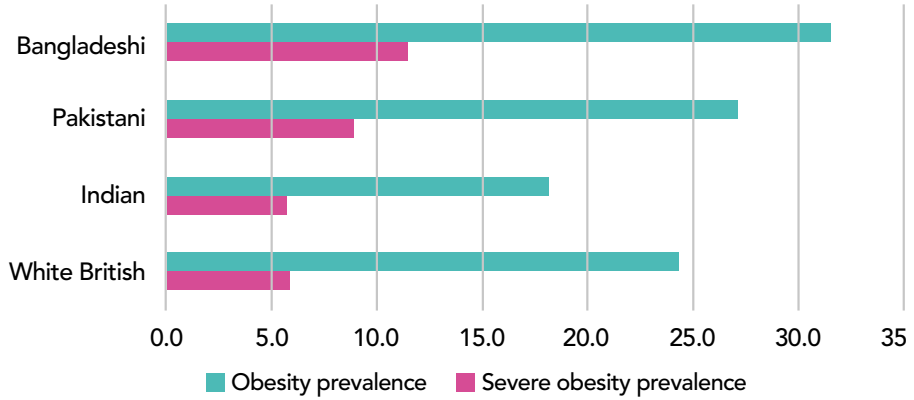
Source: NHS Digital[107]

Figure 15: Obesity and Severe obesity prevalence by ethnic group from the National Child Measurement Programme 2019/20; Children in Year 6 (aged 10-11 years)



Source: NHS Digital, 2020

Figure 16: Obesity and Severe obesity prevalence by ethnic group from the National Child Measurement Programme 2019/20; Children in reception (aged 4-5 years)



Source: NHS Digital, 2020

2.1.5 Childhood poverty

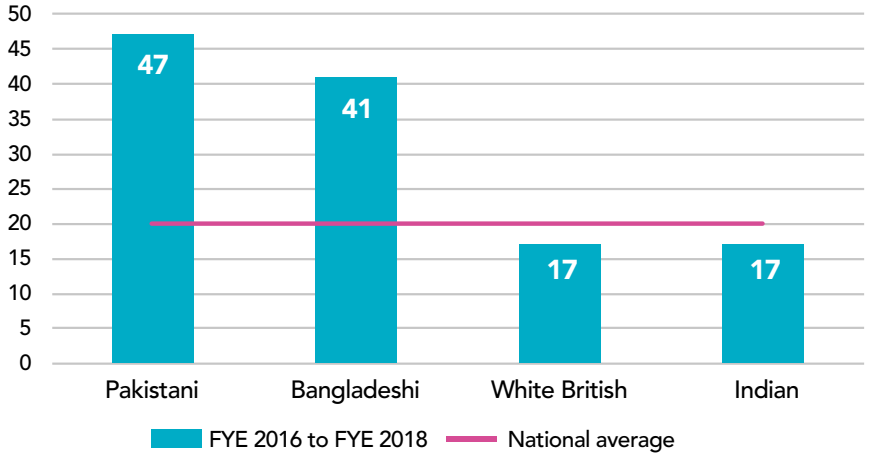
Children in Pakistani households were 2.8 times as likely to live in low-income households, compared with children living in White British households[108]. That is 47% of children living in Pakistani households were living in low-income households. This was 30 percentage points higher than children living in White British households and 27 percentage points higher than the national average[109].

This is similar to children in Bangladeshi households who are 2.4 times as likely to live in low-income households[110] (Figure 17).

Poverty affects more than one in four children in the UK[111] with around 4.3m children living in poverty from 2019 to 2020[112]. Childhood poverty is specifically defined as living in households with income below 60% of the household median. This measure recognises that it is not enough that children's basic needs are met but they also have the resources necessary for them to participate in the same activities as their peers[113].

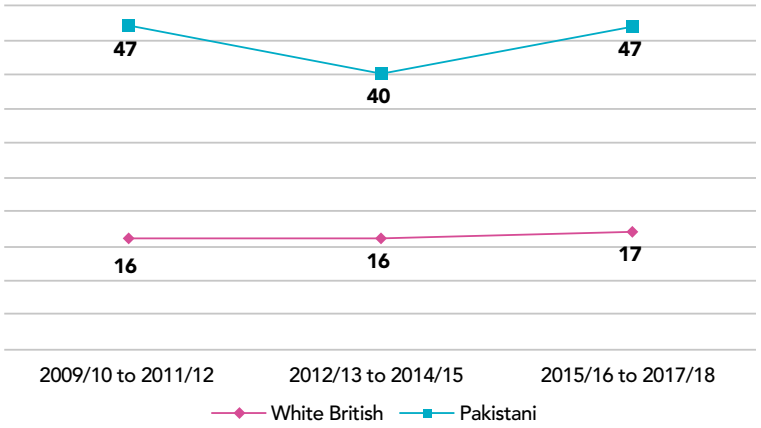
ONS data using three-year average statistics from 2016 to 2018 indicates (in figure 18) that a greater proportion of children from ethnic minority communities live in low-income households. Children in Pakistani and Bangladeshi households were the most likely to live in low income and material deprivation of all ethnic groups, while children in Indian households were the least likely.

Figure 17: Percentage of children living in households in low income, by ethnicity, UK, three-year average, FYE 2016 to FYE 2018



Source: ONS[114]

Figure 18: Percentage of children in households in low income, by ethnicity (Pakistani and White British), UK, three-year average, FYE 2012 to FYE 2018

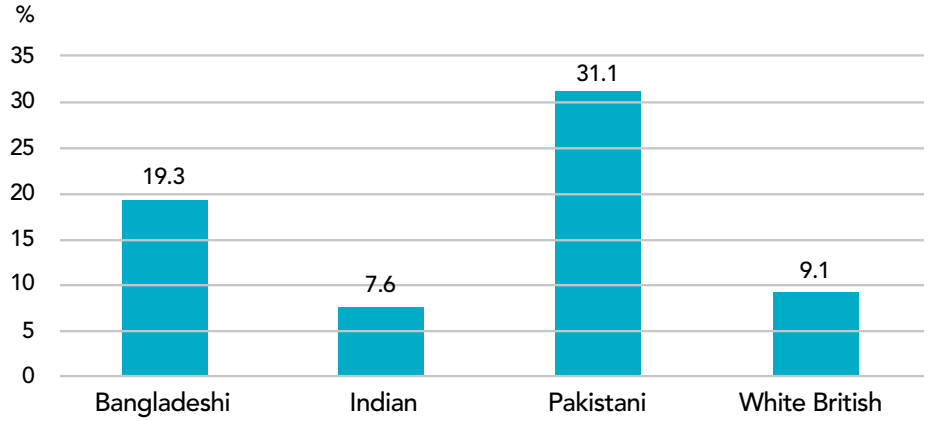


Source: Chart image from ONS[115]

In 2019, 31.1% of the Pakistani community lived in the 10% of the most deprived areas in the country – the highest of all the groups.

In 2019 (figure 19), while all ethnic minority groups were more likely than White British people to live in the most overall deprived 10% of neighbourhoods in England, 31.1% of the Pakistani community lived in the most deprived areas in the country – the highest of all the groups. Similarly, research from the Joseph Rowntree Foundation found the Pakistani community to have some of the highest poverty rates[116].

Figure 19: Percent of ethnic group populations living in the 10% of most deprived neighbourhoods, England, 2019 (%)



Source: English indices of deprivation 2019[117]

2.1.6 Social care

Statistics for children looked after in England, including adoptions (table 9 and table 10), indicate that from 2018 to 2020 Pakistani children account for a small proportion (roughly 1%).

This is far less than White British children which account for roughly 70% but similar to other South Asian groups (Indian: less than 1%; Bangladeshi: 1%)[118]. Published research[119] on ethnic disparities in child maltreatment and out-of-home care has found that Asian children had lower child protection plans and looked after children rates than White children in high deprivation neighbourhoods.

There were substantial differences between Indian, Pakistani and Bangladeshi children - Pakistani children were around four times more likely than Indian children to be on a child protection plan, and twice as likely as Bangladeshi children. But Bangladeshi children were four times more likely than Indian children in high deprivation neighbourhoods to be in out-of-home care, around twice as likely as Pakistani children.

It also found that Indian children had an economic profile not too dissimilar to White British children and, overall, Pakistani and Bangladeshi children were much more likely to be living in disadvantaged circumstances[120]. The research[121] argues that although overall Asian children in England are much more likely than White British children to be living in deprived neighbourhoods, they are much less likely to find themselves on child protection plans or being looked after.

When controlled for a proxy measure of family socioeconomic circumstances, Indian, Pakistani and Bangladeshi children are less likely to be the subjects of children's services interventions across all socio-economic levels, not only amongst the most disadvantaged families[122].

Table 9: Number of children looked after in England including adoptions, by ethnicity

Year	White British	Pakistani	Bangladeshi	Indian
2018	52,830	940	410	320
2019	54,130	1,020	410	310
2020	55,570	1,020	420	300

Source: GOV.UK[123]

Table 10: Children looked after in England including adoptions, by ethnicity (%)

Year	White British	Pakistani	Bangladeshi	Indian
2018	70	1	1	-
2019	69	1	1	-
2020	69	1	1	-

Source: GOV.UK[124]

2.1.7 School readiness and education attainment

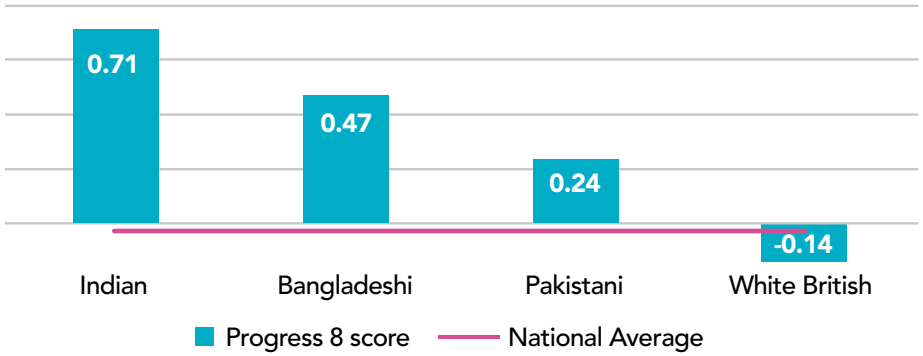
Pakistani pupils achieved above average Progress 8 scores (0.24, shown in figure 20) – despite being one of the ethnic groups most likely to experience low income, high poverty rates and be living in some of the most deprived areas of the country. It is worth noting, that this score was higher than in the Black Caribbean ethnic group (-0.31) but lower than Indian (0.71) and Bangladeshi (0.47) communities.

Progress 8 scores are a useful measure of educational attainment as it measures how much progress students make between 11 and 16 years, compared with other students with similar starting points[125]. Data on patterns of the take-up of free early education[126] shows the use of the

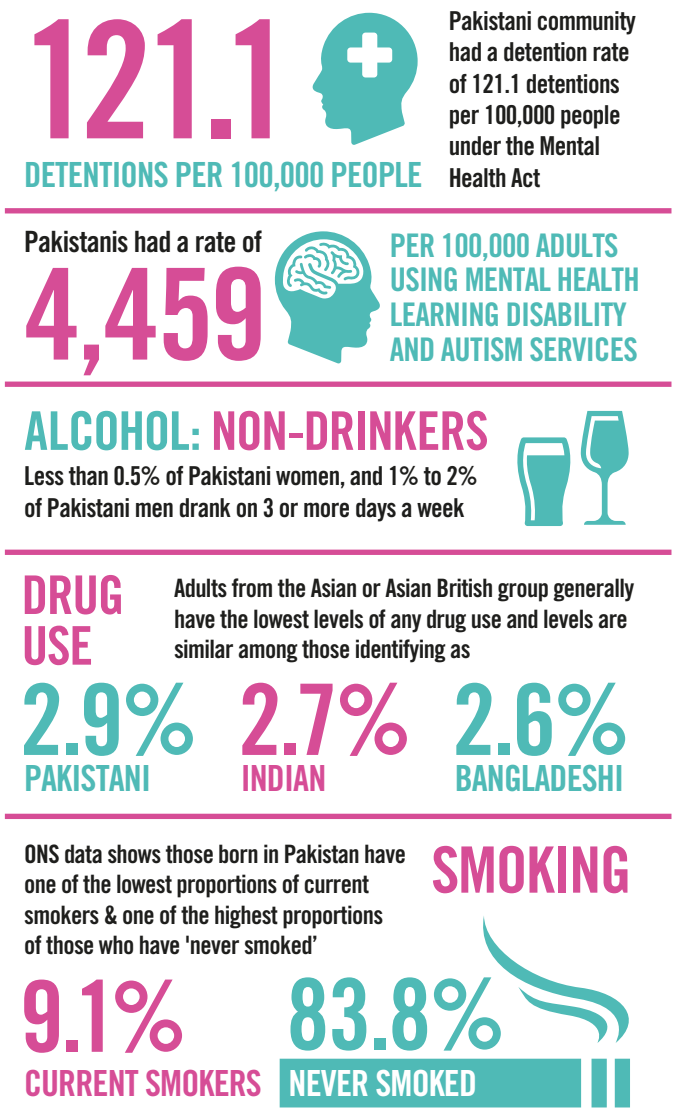
scheme to be lower among children from Pakistani and Bangladeshi backgrounds. In addition, a small-scale qualitative study of Pakistani and Bangladeshi women found that cultural factors and childcare costs help explain differences in uptake, with a preference for mothers to stay at home and the use of family and community networks to meet childcare needs[127].

In the academic year 2018 to 2019, the highest percentages of FSM eligibility were seen in White minority groups (56% of travellers of Irish heritage pupils and 39% of Gypsy/ Roman pupils). This is in comparison to South Asian communities – 20% of Pakistani and 26% of Bangladeshi pupils were eligible for FSM, six and 12 percentage points higher than the national average. The Indian ethnic group had the lowest percentage of students who were eligible for FSM, at 7%[128].

Figure 20: Progress 8 score, by ethnicity, England, academic year 2018-19



Source: Department for Education – KS4 performance, from ONS analysis[129]



2.2 Mental Wellness & Balance

Mental Wellness & Balance Key findings:

Mental health

- People from the Pakistani community had a rate of 121.1 detentions per 100,000 people under the Mental Health Act.
- The group had a rate of 4,459 per 100,000 adults using mental health, learning disability and autism services, lower than the Bangladeshi groups but higher than the Indian community.

Alcohol

- Both genders among all ethnic minority groups, except the Irish, were more likely than the general population to be non-drinkers. Less than 0.5% of Pakistani women, and 1% to 2% of Pakistani men drank on 3 or more days a week.
- In 2014/15, there were almost 65,000 alcohol-specific admissions amongst men, and almost 40,000 amongst women – Pakistani men accounted for 0.5% and Pakistani women 0.1%.

Drug use

- Adults from the Asian or Asian British group generally had the lowest levels of any drug use and levels are similar among those identifying as Pakistani (2.9%), Indian (2.7%), or Bangladeshi (2.6%).

Smoking

- ONS data shows those born in Pakistan have one of the lowest proportions of 'current smokers' (9.1%) as well as one of the highest proportions of those who have 'never smoked' (83.8%).
- According to data from ASH, none of the Pakistani adults regularly consumed smokeless tobacco (SLT), with 21% to have ever tried it and 69% to have never tried SLT.

2.2.1 Mental health

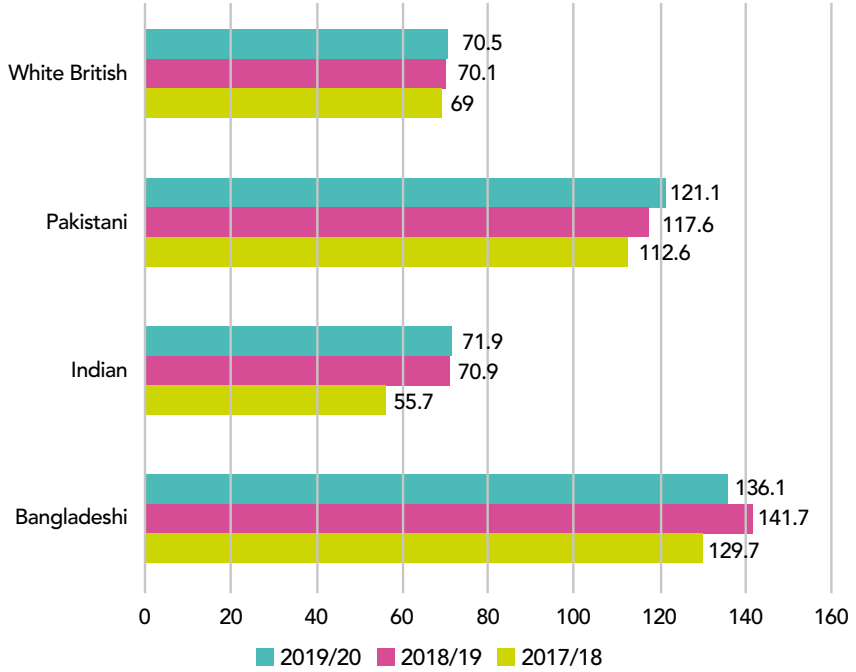
People from the Pakistani community had a detention rate of 121.1 detentions per 100,000 people under the Mental Health Act. The ethnic group had a rate of 4,459 per 100,000 adults using mental health, learning disability and autism services, lower than the Bangladeshi groups but higher than the Indian community.

The Transforming Children and Young People's Mental Health Provision: a Green Paper[130] found that some young people are far more likely than others to experience mental health problems[131]. It found the prevalence of mental health disorders varies by age, with nearly 8% of 5-10-year-olds having a diagnosable mental health disorder, compared to nearly 12% of 11-15-year-olds[132]. It also varies by sex – mental health disorders are more common in boys (just over 11%) than girls (nearly 8%)[133]. In terms of ethnic groups, it found the prevalence of mental health disorders to be around 8% in Pakistani and Bangladeshi children (combined data), compared to 3% in Indian children. South Asian children had a lower prevalence than White (10%) and black (9%) children[134].

In addition, published research[135] on migration, ethnicity and mental outcome used outcome data for women at 9-months and at 5-years after migration. Compared with White British women, Indian and Pakistani women had a two-fold increase in odds of distress. At the 5-year-mark compared with White British women, odds of psychological distress remained statistically significantly increased for Indian women and Pakistani women[136].

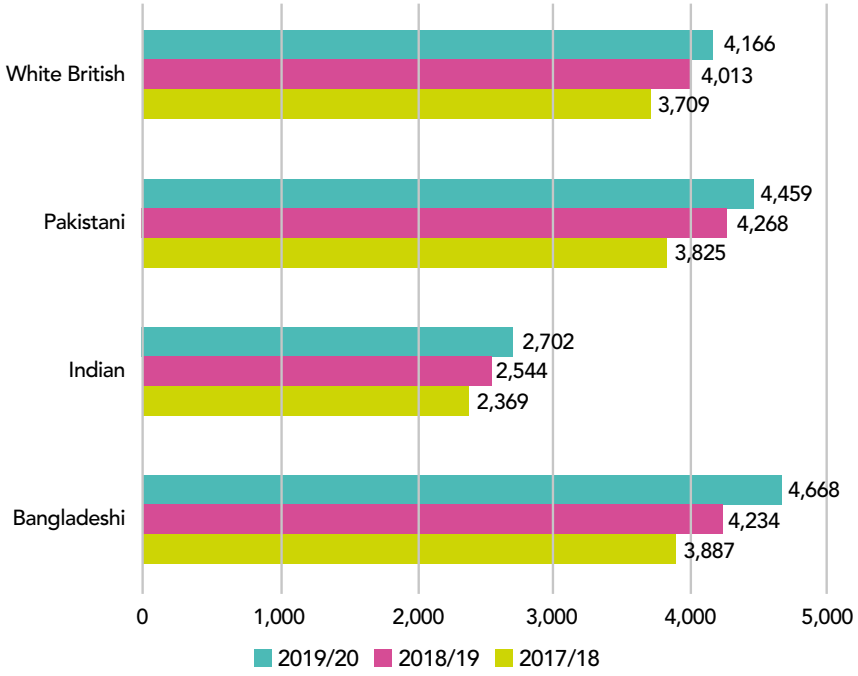
Also, a published research[137] assessing the attitudes of Pakistani families towards mental issues found greater somatisation of symptoms in the Pakistani group and an emphasis on aggressive behaviour as a significant symptom of having a mental health issue. It found expectations of treatment varied with some emphasis on traditional treatments, such as use of faith healers and Hakims (this is a cross between a wise man and a physician), alongside consulting the GP. Language difficulties as well as religious and cultural practices were also identified as barriers, particularly to female treatment. Another study[138] has found Pakistani women's networks display high levels of stigmatising attitudes towards mental health problems and mental health services. This in turn acts as a deterrent to seeking help and using mental health services.

Figure 21: Number of detentions under the Mental Health Act per 100,000 people, by specific ethnic group (standardised rates), England. 2017-20



Source: Mental Health Services Dataset Ethnicity Facts and Figures, image from GOV.UK[139]

Figure 22: Number of adults per 100,000 using NHS mental health, learning disability and autism services by ethnicity, England. 2019 to 2020



Source: Mental Health Services Data Set - Ethnicity Facts and Figures, image from GOV.UK[140]

2.2.2 Alcohol

Both genders among all ethnic minority groups, except the Irish, were more likely than the general population to be non-drinkers. Less than 0.5% of Pakistani women and 1% to 2% of Pakistani men drank on 3 or more days a week.[141] Pakistani men accounted for 0.5% of alcohol-specific admissions in England (2014/15); women from the ethnic group had one of the lowest proportions of alcohol-specific admissions (0.1%).

The PHE Equity Report identifies alcohol-related hospital admissions as a measure of alcohol misuse, with significant personal and societal costs[142]. In 2014/15, there were almost 65,000 alcohol-specific admissions amongst men, and almost 40,000 amongst women – Pakistani men accounted for 0.5% and Pakistani women accounted for 0.1%[143]. For both genders, this was lower than Indian men (2%) and women (0.4%), and higher than Bangladeshi men (0.1%) and the same for Bangladeshi women (0.1%).

The 2004 Health Survey for England (HSE) reported South Asian ethnic groups had high proportions of non-drinkers, with the majority of Bangladeshi and Pakistani adults being non-drinkers. The next highest proportion of non-drinkers were Indian women (59%); Indian men also had one of the highest proportions of non-drinkers (33%).[144]

Most minority ethnic groups were less likely than the general population to report drinking on three or more days a week, especially women[145]. Only 5% to 6% of Indian women drank on three or more days a week, compared to less than 0.5% of Pakistani and Bangladeshi women. More Indian men (18%) drank on three or more days a week compared to only 1% to 2% of Bangladeshi and Pakistani men[146].

2.2.3 Drug use

Adults from the Asian or Asian British group generally had the lowest levels of any drug use and levels are similar among those identifying as Pakistani (2.9%), Indian (2.7%), or Bangladeshi (2.6%)[147].

A published report cites peer pressure and influence as one of the primary reasons given by ethnic minority communities for drug use among young people. Published research[148] on drug issues among young people from Indian, Pakistani and Chinese backgrounds (16-24-year-olds) found that a significant predictor of drug use was having drug-using friends from the same background[149].

Table 11 below from the National Treatment Agency for Substance Misuse (NTA) NHS shows Pakistani young people accounted for around 1% (162 people) of service access in 2007/8, similar to the Bangladeshi group (1%; 161 people) and slightly more than Indian group (0%; 91 people). Those from a White British background accounted for most of the service use access (86%; 20,014 people)[150].

Table 11: Number of young people accessing services, by ethnicity (2007/8)

Ethnicity	Number of people accessing services	% Access by ethnicity
White British	20,014	86%
Pakistani	162	1%
Bangladeshi	161	1%
Indian	91	0%

Source: NTA NHS, pp. 31[151]

Another study[152] reported that the use of Class A drugs and amphetamines was higher among boys from some ethnic minority subgroups compared to other ethnic subgroups, where prevalence was higher among girls; its findings were Pakistani males: 0%, Pakistani females: 2.8% compared to Bangladeshi males: 2.8% and Bangladeshi females: 0.9%. A series of academic literature[153] on minority communities have found stigma attached to drug use is not only directed at the drug users themselves but also at their immediate and extended families. As part of these studies, it has been reported that fear and avoidance of this stigma had an impact on the way families reacted to drug use, with denial being the most common reaction[154].

One study[155] found that Pakistani respondents to a survey on this topic were more likely (56%) to suggest that their community ignores or hides drug use than Indian (38%) respondents.

2.2.4 Smoking

According to ONS data, those born in Pakistan had one of the lowest proportions of 'current smokers' (9.1%) as well as one of the highest proportions of those who have 'never smoked' (83.8%) – shown in figure 46. According to data from ASH, none of the Pakistani participants regularly consumed smokeless tobacco (SLT), with 21% having tried it and 69% having never tried SLT.

ONS data shows that smoking prevalence is lower in most ethnic minority groups than in the white group, and highest in the Mixed group (table 12).[156]

Table 12: Smoking prevalence by country of birth in England, April to December 2020, based on Annual Population Survey (Persons aged 18 years and above)

Selection of the most frequently reported countries by survey respondents.

Country of birth	% Current smokers	% Ex-smokers	% Never smoked	Sample size
India	4.3	8.2	87.5	1,048
Pakistan	9.1	7.1	83.8	539
Poland	20.1	22.8	57.0	615
England	12.3	27.8	59.9	75,428
Northern Ireland	7.6	31.5	60.9	402
UK (but country unknown)	3.4	30.3	66.3	46
Other	11.2	19.8	69.0	7,718

Source: Annual Population Survey, ONS Table 11 [157]

Research from Action on Smoking and Health (ASH), a campaigning public health charity to eliminate the harm caused by tobacco, has found that immigration has had an impact on the use of tobacco in the UK. It found that when people immigrate to the UK many come from countries with higher smoking rates, and many migrants also come from countries with a different cultural approach to tobacco use and legal framework for tobacco control to the UK[158].

However, data on smoking rates (table 13 below) indicates that while Eastern European countries have a higher smoking rate than the UK, South Asian countries have a lower smoking rate. Specifically, Pakistan has a comparatively lower smoking rate (19.8%) than the UK (22.4%).

Table 13: Smoking rates (15+) by country of origin, top five immigrant communities to the UK by size, 2016

Country of birth	Smoking rate in country of origin
Poland	28.2%
India	11.3%
Pakistan	19.8%
Ireland	24.4%
Romania	30.0%
United Kingdom	22.4%

Source: ASH[159]

When considering smoking within the South Asian communities, it is pertinent to assess the consumption of smokeless tobacco (SLT). SLT is consumed by around 350 million people globally, with more than two-thirds of global consumption-based in South and South-East Asia[160].

SLT comprises a range of products that contain tobacco; these are non-consumable but may be chewed, inhaled or placed in the mouth - only products designed to be chewed or inhaled are legal in the UK[161]. As explained by a study by ASH[162], specific types of SLT include:

- Naswar: smokeless tobacco usually containing powdered tobacco, slaked lime and indigo. It is used by sniffing (nasally) or 'dipping' (placing a pinch under the tongue or in the cheek where it is stored).
- Paan (also known as Betel quid): is commonly used in many South Asian communities. It can be prepared in a variety of ways but usually contains sliced areca nut, slaked lime and catechu, wrapped in betel leaf. The quid is then placed in the mouth and sucked or chewed for its psychoactive effects.
- Gutkha: a mixture of tobacco and pan masala
- Khaini: a dried tobacco and slaked lime
- Zarda: a mixture of tobacco, lime, spices, areca nut and flavourings.

Published research by ASH[163] explains that South Asian SLT products are largely produced by a fermentation process and may contain Nicotiana rustica, a species of tobacco-containing higher levels of nicotine and carcinogenic tobacco-specific nitrosamines (TSNAs). As a result, they often have fluctuating pH levels and include heavy metals which contribute to poor health outcomes[164].

Among British South Asian groups, adults of Bangladeshi origin are most likely to use smokeless tobacco, 0% of adults of a Pakistani background regularly use smokeless tobacco, 21% have tried it and 69% have never tried it (table 14). There is also evidence of gender differences with men reporting higher 'ever tried' and 'regular use' of SLT (table 15).

Table 14: Use of chewed or sucked tobacco products by South Asian ethnic group in the UK, 2019

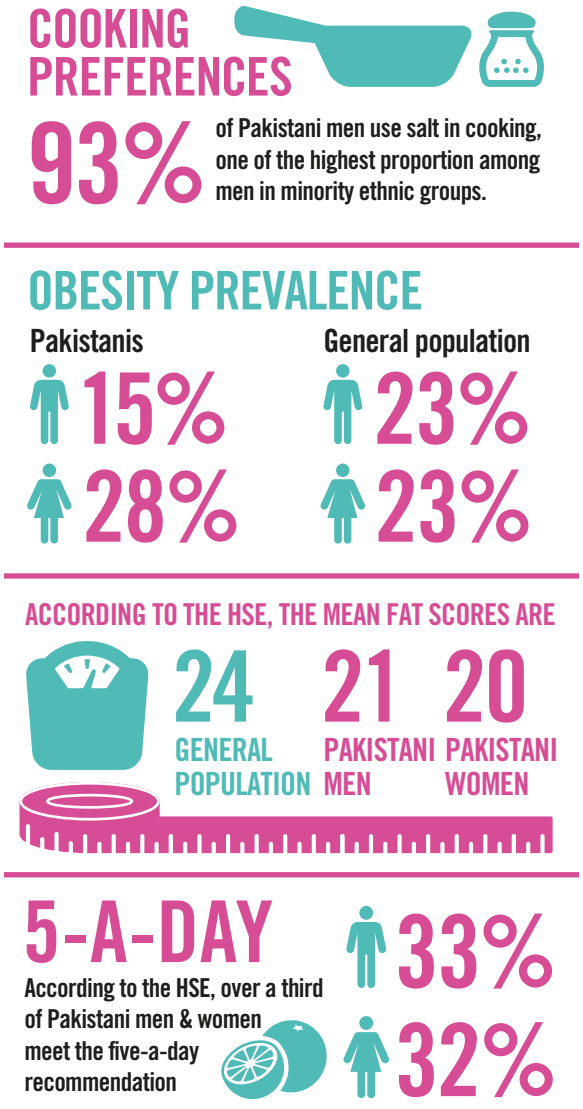
Smokeless tobacco use	Indian	Bangladeshi	Pakistani
Ever tried	16%	29%	21%
Regular use (at least monthly)	5%	12%	0%
Never tried	80%	68%	69%

Source: ASH[165]

Table 15: Use of chewed or sucked tobacco products by gender & ethnic group in the UK, 2019

Smokeless Tobacco Use	All males	All females	South Asian males	South Asian females
Ever tried	15%	11%	24%	18%
Regular use (at least monthly)	2%	1%	7%	6%
Never tried	82%	87%	73%	77%

Source: ASH[166]



2.3. Healthy and affordable food

Healthy lifestyle Key findings

Diet

- Around a third of Pakistani men met the five-a-day recommendation (33%) and slightly less among Pakistani women (32%).
- The Health Survey for England (HSE) found the mean fat score in the general population to be 24; the mean fat scored was lower among men in minority ethnic groups, with it being 21 and 20 among Pakistani men and women, respectively.

Obesity

- According to the HSE, at 15% Pakistani men had one of the lowest obesity rates, though this was higher than Bangladeshi men who had the lowest obesity rate (6%). Pakistani women had a lower obesity prevalence (28%) than Black Caribbean (32%) but higher than Indian (20%) and Bangladeshi (17%) women.
- For Pakistani men the WHR was 0.92, which was the same as Indian men and slightly more than Bangladeshi men (0.91). For Pakistani women the WHR was 0.84, slightly more than Indian women (0.82) and less than Bangladeshi women (0.85). The WHR for the general population was 0.92 for men and 0.82 for women, similar to the Pakistani ethnic group.

2.3.1. Diet

Five-a-day

Around a third of Pakistani men met the five-a-day recommendation (33%) and slightly less among Pakistani women (32%).

In terms of fruit and vegetable consumption (tables 16 and 17), the HSE[167] found the proportion of men meeting the guidelines was significantly higher among all minority ethnic groups. Around a third of Pakistani men met the five-a-day recommendation (33%), slightly less than the Indian men (37%). Similarly, 32% of Pakistani women consumed five portions of fruit and vegetable a day, less than Indian women (36%).

In the general population, a significantly higher proportion of women than men met the five-a-day recommendation (27% and 23% respectively)[168]. Mean daily fruit and vegetable consumption was higher among Pakistani men (4.3 portions per day)[169]. In the general population, fruit and vegetable consumption among men increased with age. Age-related increase in consumption was most marked among Pakistani men[170] compared to women. In comparison to the Indian community within which women aged 55 and over consumed more fruit and vegetables than younger women, there was not a significant age-related increase among Pakistani females.

Table 16: Fruit and vegetable consumption within the Pakistani community, by age and gender (aged 16 & over)

Portions per day	16-34	35-54	55+	All men	16-34	35-54	55+	All women
None	6%	2%	3%	4%	3%	5%	2%	4%
Less than 1	4%	2%	4%	3%	4%	4%	2%	4%
1 or more but less than 2	18%	12%	2%	13%	17%	9%	8%	13%
2 or more but less than 3	11%	18%	18%	14%	16%	19%	18%	17%
3 or more but less than 4	18%	13%	8%	15%	13%	16%	18%	14%
4 or more but less than 5	14%	17%	26%	17%	14%	18%	21%	16%
5 or more	29	37	40	33	33	30	32	32
Mean	3.9	4.4	5.1	4.3	4	3.9	4.1	4.0
Median	3.5	4	4.2	4	3.7	3.7	4.1	3.7

Source: Health Survey for England 2004[171]

Fat intake

The HSE found the mean fat score in the general population to be 24; the mean fat score was lower among men in minority ethnic groups, with it being 21 and 20 among Pakistani men and women, respectively.

The mean fat score was lower among men in minority ethnic groups, ranging from 19 among Indian men to 23 among Irish and Bangladeshi men. Among women in minority ethnic groups, the mean fat score ranged from 17 among Indian informants to 20 among Black African, Irish and Pakistani women, lower than women in the general population (21).[172]

72% of men in the general population had a low-fat score. The proportion of men with a low-fat score was significantly higher for men in minority ethnic groups than those in the general population (ranging from 80% among Pakistani men to 89% among Indian men), with the exception of Irish men (77%) where there was no significant difference from the general population.[173]

Table 17: Fat intake in men aged 16+, by ethnicity (%)

Fat score	Indian	Pakistani	Bangladeshi
Low fat	89	80	83
Medium fat	10	16	12
High fat	1	4	5
Mean fat	19	21	23

Source: Health Survey for England 2004[174]

Table 18: Fat intake in women aged 16+, by ethnicity (%)

Fat score	Indian	Pakistani	Bangladeshi
Low fat	94	87	88
Medium fat	5	11	10
High fat	1	2	3
Mean fat	17	20	19

Source: Health Survey for England 2004[175]

Salt intake

Compared with the general population, the use of salt in cooking was much higher among ethnic minority groups; 93% and 88% of Pakistani men and women used salt in cooking, respectively. This is significantly higher than the general population where 56% and 53% of men and women in the general population use salt in cooking, respectively (tables 19 and 20).

Compared with the general population, the use of salt in cooking was higher among men in minority ethnic groups (93% among Pakistani men, 95% among Bangladeshi men and 93% among Indians).

A similar pattern of salt used in cooking was observed for women. The prevalence of salt used in cooking was higher for women in minority ethnic groups, though it was slightly less among Pakistani women than men (88% among Pakistani women, 91% among Bangladeshi women and 92% among Indian women[176], compared to those in the general population (53%).

Table 19: Use of salt in men aged 16+ when cooking, by ethnicity (%)

Adds salt to food*	Indian	Pakistani	Bangladeshi
Adds salt during cooking	93	93	95
Generally adds salt at table, without tasting	6	15	17
Tastes, generally adds salt at table	14	13	16
Tastes, occasionally adds salt at table	32	25	28
Rarely, or never, adds salt at table	47	47	39

Source: Health Survey for England 2004[177]

Table 20: Use of salt in women aged 16+ when cooking, by ethnicity (%)

Adds salt to food*	Indian	Pakistani	Bangladeshi
Adds salt during cooking	92	88	91
Generally adds salt at table, without tasting	9	12	11
Tastes, generally adds salt at table	14	21	21
Tastes, occasionally adds salt at table	28	22	30
Rarely, or never, adds salt at table	50	46	38

Source: Health Survey for England 2004178

2.3.2. Obesity

Body mass index (BMI)

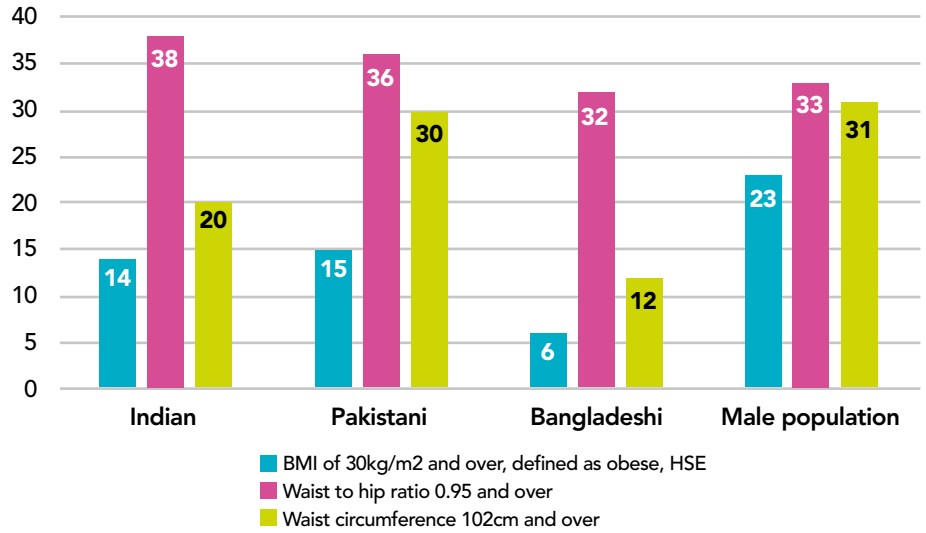
According to the HSE, 15% of Pakistani men had one of the lowest obesity rates, though this was higher than Bangladeshi men who had the lowest obesity rate (6%). Pakistani women had a lower obesity prevalence (28%) than Black Caribbean women (32%) but higher than Indian (20%) and Bangladeshi (17%) women.

Body mass index (BMI) is a measure that uses weight (kg) divided by squared height (m2). 22.7% of men and 23.2% of women in the general population were obese (a BMI over 30 kg/m^2).

15% of Pakistani men had one of the lowest obesity rates, though this was higher than Bangladeshi men who had the lowest obesity rates (6%). Pakistani women had a 20% obesity prevalence rate, higher than the Indian group (20%) and Bangladeshi (17%) groups (figures 23 and 24)[179].

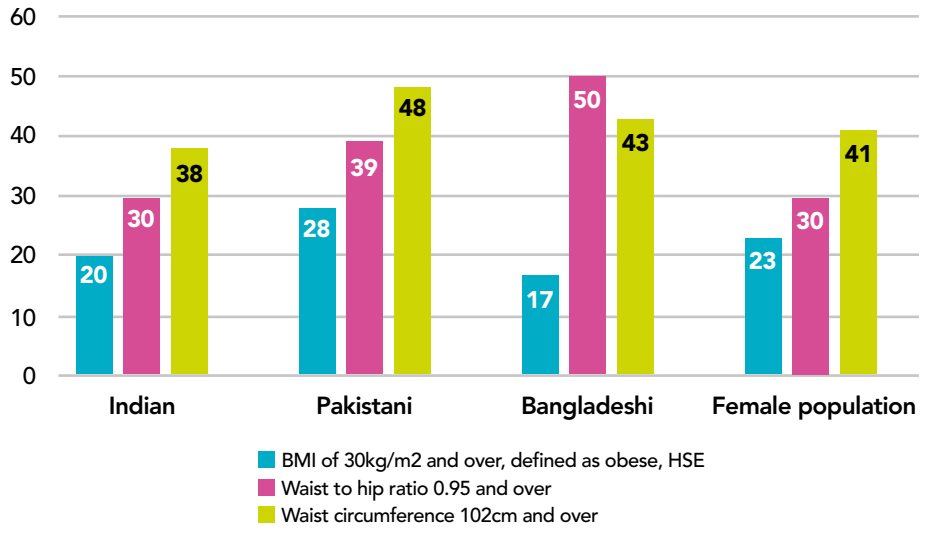
A published research[180] based on a focus group of Pakistani women in Greater Manchester on health perceptions, diet and obesity provides a useful insight into the potential reasons for higher prevalence of obesity among Pakistani women. The study found a lack of motivation to address weight gain and limited awareness of the link between weight gain and type 2 diabetes among the participants. It identified several barriers, including familial expectations on home cooking, perceptions that weight gain is inevitable due to childbirth and ageing, and the prioritisation of family concerns over individual lifestyle changes[181].

Figure 23: Body mass index, waist-to-hip ratio and waist circumference by ethnic group, men, 2004, England



Source: Joint Health Surveys Unit (2005) Health Survey for England 2004. The Health of Minority Ethnic Groups. Department of Health: London.[182]

Figure 24: Body mass index, waist-to-hip ratio and waist circumference by ethnic group, women, 2004, England



Source: Joint Health Surveys Unit (2005) Health Survey for England 2004. The Health of Minority Ethnic Groups. Department of Health: London. [183]

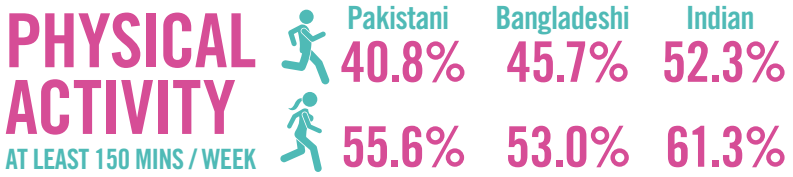
Waist-hip ratio (WHR)

For Pakistani men, the WHR was 0.92, which was the same as Indian men and slightly more than Bangladeshi men (0.91). For Pakistani women, the WHR was 0.84, slightly more than Indian women (0.82) and less than Bangladeshi women (0.85). The WHR for the general population was 0.92 for men and 0.82 for women, similar to the Pakistani ethnic group.

Waist-hip ratio (WHR) is defined as waist circumference divided by hip circumference, i.e. waist girth (m)/ hip girth (m). Among the general population, the mean waist to hip ratio (WHR) was 0.92 in men and 0.82 in women[184].

The mean waist circumference was 96.5 cm for men and 86.4 cm for women in the general population. For Pakistani men, the mean waist circumference was 95.0, which is more than Indian and Bangladeshi men (93.0 and 88.7, respectively). At 87.7 Pakistani women had a higher mean waist circumference, compared to Indian (83.9) and Bangladeshi (85.7) women[185]. 33% of men and 30% of women in the general population had raised waist to hip ratio (WHR) (defined as 0.95 or more for men and 0.85 or more in women). Pakistani men had a higher prevalence of raised WHR than the general population (36%), similar to other South Asian groups (Indian: 38%; Bangladeshi: 32%). The lowest rate in men was found among Black Africans (16%).

Women in the Pakistani ethnic groups had a higher prevalence of raised WHR than the general population (39%), higher than Indian (30%) but lower than Bangladeshi (50%) women. The prevalence of raised WHR increased sharply with age in all ethnic groups and in the general population for both genders[186]. The prevalence of raised waist circumference (102 cm or more in men, and 88 cm or more in women) was 31% in men and 41% in women in the general population. It was recorded as 30% among Pakistani men, which was more than both Indian and Bangladeshi men (20% and 12%, respectively). Similarly, it was recorded at 48% among Pakistani women, compared to Indian women (38%) and Bangladeshi women (43%). The HSE found that the prevalence of raised waist circumference increased with age in all groups and for both genders in the general population[187].



2.4 Active at Every Age and Ability

Active at every age key findings:

Physical activity

- Pakistani women are the least active of all ethnicities and men are the one of the least active, with 40.8% of women and 55.6% of men being active for at least 150 minutes per week.
- Overall, activity levels are the lowest among Indian, Bangladeshi and Pakistani women, with 52%, 46% and 41% being active for the recommended minimum 150 minutes per week.

2.4.1. Physical activity

Pakistani women are the least active of all ethnicities with 40.8% being active for at least 150 minutes per week. Pakistani men are one of the least active, with 55.6% being active for the recommended minimum of 150 minutes per week, which is more than Bangladeshi men (53%) but less than Indian men (61.3%).

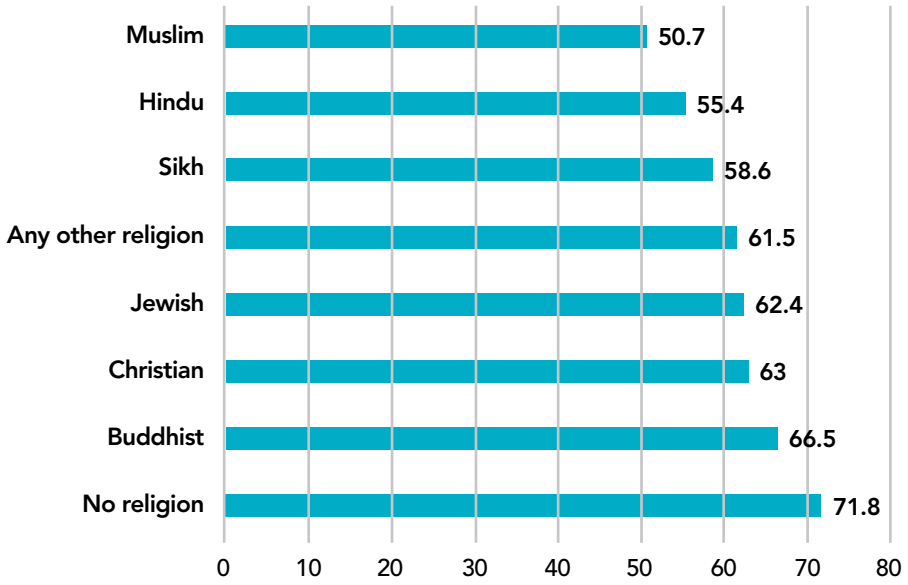
According to survey data from Sports England (figure 25) both Pakistani men and women are among the least active. Overall, activity levels are the lowest among Indian, Bangladeshi and Pakistani women, with 52%, 46% and 41% being active for the recommended minimum of 150 minutes per week.

A published research[188] provides useful insight into the possible reasons for the low physical activity levels among Pakistani men and women. The study included a sample of 23 Pakistani participants and found while all the participants showed awareness of the need for regular physical activity, particularly for diabetes care, few put this lifestyle advice into practice. Of the participants that made a conscious effort to increase or maintain their physical activity, almost all were men. The barriers identified included lack of time (due to working anti-social hours); women felt obligations to others, such as child care; women feared being vulnerable if they left their home, compounded by difficulties speaking English; lack of culturally sensitive facilities, which was felt in particular by women who were reluctant to take up activities that expose their bodies (i.e. swimming); and difficulties caused by poor climatic conditions, which was viewed as a major barrier for both men and women[189].

Figure 25: Adults 16+: Active (at least 150 mins per week)

Source: Sports England[190]

Figure 26: Adults 16+ by religion: Active (at least 150 mins per week)



Source: Data based on Sports England[191] Active Lives Survey (Nov 2016-18)

Findings from data and insights from quantitative and qualitative papers[192] indicate South Asian communities tend to have some of the lowest activity levels in the UK. A study[193] that examines the variations in attitudes, motivations and barriers to physical activity among South Asians found second-generation South Asians were more active than the first-generation but were still less active than the White British. It also found second-generation might have a more favourable attitude towards physical activity than the first-generation, suggesting different strategies may be required to increase physical activity for different generations of UK South Asians[194].

One study[195] used an accelerometer to measure physical activity in South Asian children and White European children, and also examined differences between boys and girls. It found South Asians were less physically active than White European children for all measures, but there were large differences between girls and boys for both ethnic groups. South Asian girls were the least active, spending the largest number of minutes being sedentary and the smallest number of minutes being moderately or vigorously active[196].

Other research conducted in 2008 combined the Pakistani and Bangladeshi groups and found that Pakistani/Bangladeshi girls were the least active compared to the White British and Indian groups. However, almost a third of Pakistani/Bangladeshi boys were in the most active quartile, compared to around a quarter of Indian and White British boys[197].

Only one study examined Indian, Pakistani and Bangladeshi groups separately[198], using accelerometers; in this study the Pakistani group had the highest percentage of children meeting the recommended physical activity levels: Pakistani (45%) compared to both the Indian group (40%) and the Bangladeshi (33%) groups.

50.3% OF PAKISTANI PUPILS ACHIEVED A GRADE 5 OR ABOVE IN ENGLISH AND MATHS GCSE IN 2020 TO 2021

Specifically, 46.8% of Pakistani boys achieved a grade 5 or above in English and maths GCSE, compared to 54% of Pakistani girls

ABOVE AVERAGE PROGRESS 8 SCORES (0.24)

was achieved by Pakistani pupils despite being one of the ethnic groups most likely to experience low income, high poverty rates and be living in some of the most deprived areas or the country

ECONOMIC ACTIVITY

74% 34%

In Birmingham, 74% of Pakistani males are economically active but only 34% of females

OVERCROWDING

18% OF PAKISTANI HOUSEHOLDS WERE OVERCROWDED

The highest rates of overcrowding were in Bangladeshi households (24%)

8% UNEMPLOYED

of Pakistani / Bangladeshi people (combined statistic) were unemployed - the highest unemployment rate of all ethnic groups

2.5 Working & Learning Well

Working & Learning Well key findings:

Education

- In 2020 to 2021, 50.3% of Pakistani pupils achieved a grade 5 or above in English and maths GCSE.
- Specifically, 46.8% of Pakistani boys achieved a grade 5 or above in English and maths GCSE, compared to 54% of Pakistani girls.
- Among those eligible for free school meals, 39.4% achieved a grade 5 or above in English and maths GCSE, compared to 53.8% of those who were not eligible within the ethnic group.
- Pakistani pupils eligible for free school meals (FSM) have the lowest proportion of those achieving a grade 5 or above in English and maths GCSE (39.4%), compared to Bangladeshi (52%) and Indian (52.7%) FSM-eligible pupils.
- Similarly, Pakistani pupils not eligible for FSM have the lowest proportion of pupils achieving a grade 5 or above in English and maths GCSE (53.8%) compared to Bangladeshi (64.4%) and Indian (74.2%) non-FSM pupils.
- 26% of Pakistanis were without any educational qualifications at all, a lower proportion compared to the Bangladeshi group (28%) but more disadvantaged than the White British (24%) group.

Economic activity

- At 8%, the Pakistani / Bangladeshi ethnic groups (combined data) have the highest unemployment rate.
- The Ethnic Groups in the Labour Market: a statistical analysis for Birmingham report has found 35% and 23% of Pakistani males to be in full-time and part-time employment, respectively. This is higher than females of which 11% and 13% of are in full-time and part-time employment, respectively.
- Unemployment rate has reduced over time, with the unemployment rates for the combined Pakistani and Bangladeshi group seeing more than 5 percentage point decline in 2019 than in 2004, the largest decrease of any ethnic group over the period.

Housing

- Housing data from 2016 to 2018 shows 13% of Pakistani households rented social housing. Pakistani families (51%) were one of the most likely to receive a type of state support, which was more than Bangladeshi (49%) and Indian (39%) households.
- The highest rates of overcrowding were in the Bangladeshi (24%) and Pakistani (18%) households.

General health

- In terms of general health, 81.8% of residents from Pakistan surveyed in the West Midlands felt they have very good or good health, slightly lower than residents from Pakistan settled in England and Wales (83.3%). In the West Midlands 6% felt they have bad or very bad health, more than their counterparts living across England and Wales (5.4%).
- According to the Long-term Health Problem or Disability survey, 74% of those from Pakistan living with a long-term health problem or disability in the West Midlands felt it did not impact their day-to-day activities, compared to 26% who felt it did.
- Families from the Pakistani ethnic group (34%) were the most likely to receive Child Benefit. In the 3 years to March 2020, an average of 7% of Pakistani families received the State Pension, 6% received the care component of Disability Living Allowance, and 5% the mobility component.

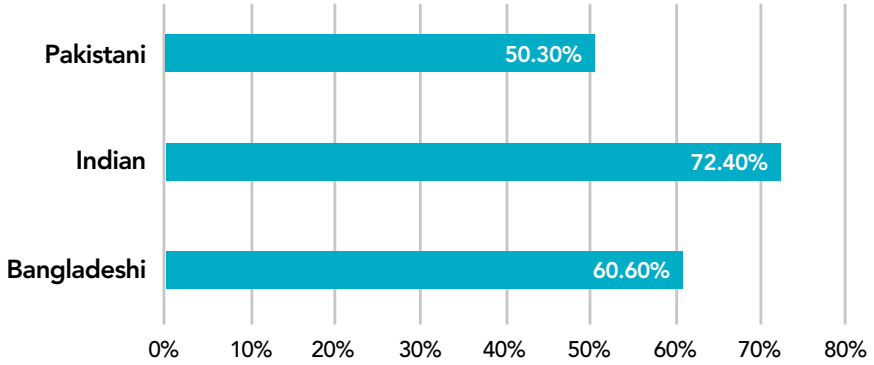
2.5.1 Education

Educational attainment

From 2020 to 2021, 50.3% of Pakistani pupils achieved a grade 5 or above in English and maths GCSE. Specifically, 54% of Pakistani girls achieved a grade 5 or above in English and maths GCSE, compared to 46.8% of Pakistani boys. Among Pakistani pupils eligible for free school meals, 39.4% achieved a grade 5 or above in English and maths GCSE, compared to 53.8% of those who were not eligible within the ethnic group[199] (figures 57-8).

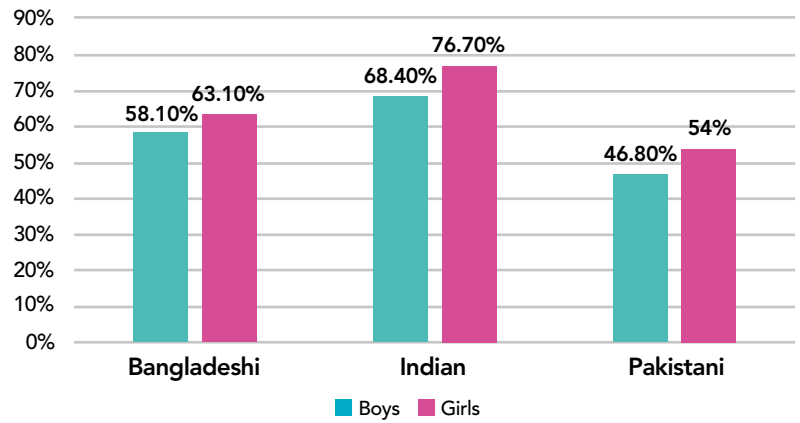
Fewer pupils from the Pakistani ethnic group achieved a grade 5 or above in English and maths GCSE compared to Indian and Bangladeshi pupils (figure 27). As shown in figure 28, fewer Pakistani boys and girls achieved a grade 5 or above in English and maths GCSE compared to their Indian and Bangladeshi counterparts.

Figure 27: Percentage of South Asian pupils achieving a grade 5 or above in English and maths GCSE



Source: Ethnicity Facts and Figures: Key stage 4 performance: academic year 2020/21[200]

Figure 28: Percentage of South Asian pupils achieving a grade 5 or above in English and maths GCSE by gender, 2020-21



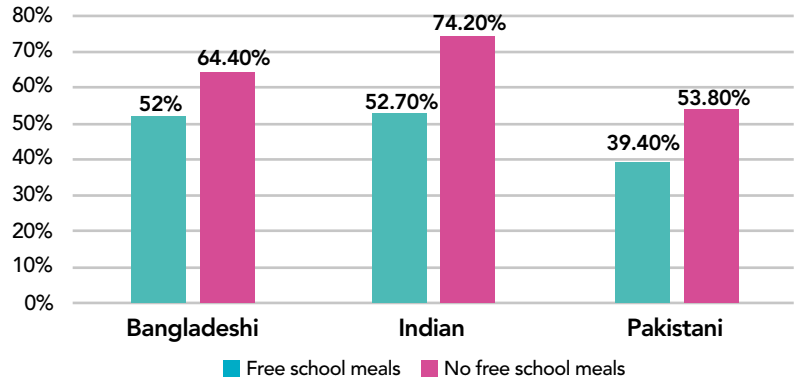
Source: Ethnicity Facts and Figures: Key stage 4 performance: academic year 2020/21[201]

Free school meals (FSM)

Pakistani pupils eligible for free school meals (FSM) have the lowest proportion of those achieving a grade 5 or above in English and maths GCSE (39.4%), compared to Bangladeshi (52%) and Indian (52.7%) FSM-eligible pupils (figure 28). Similarly, Pakistani pupils not eligible for FSM have the lowest proportion of pupils achieving a grade 5 or above in English and maths GCSE (53.8%) compared to Bangladeshi (64.4%) and Indian (74.2%) non-FSM pupils.

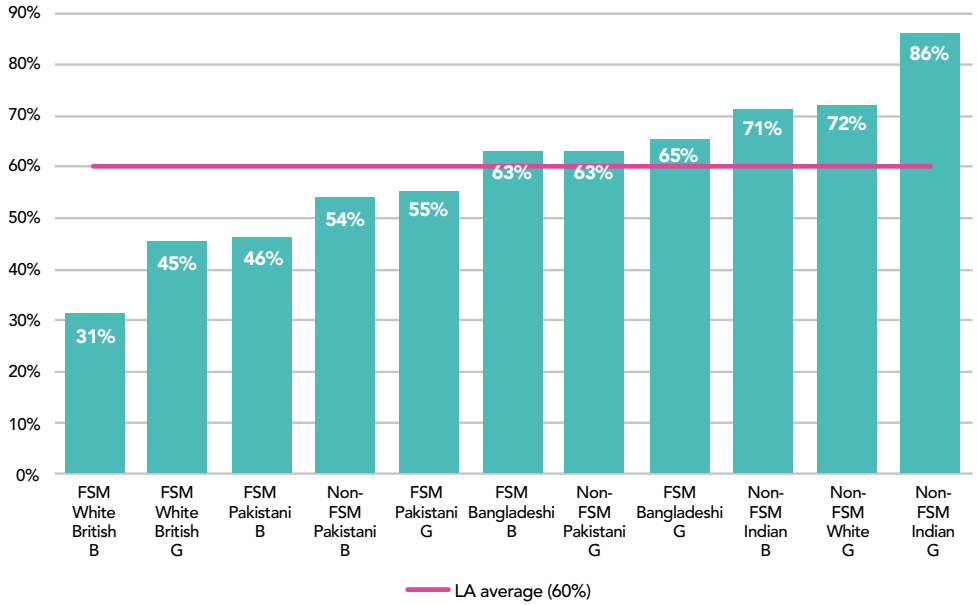
Indicating a similar trend, figure 29 from the Birmingham City Council's Ethnic Groups in the Labour Market report, has found that Pakistani pupils (55%) in Birmingham have the lowest rates of pupils achieving more than five A*-C in GCSEs, including in English and maths. Indian pupils score the highest (76%) and Bangladeshi pupils outperform the city average (66%)[202]. In addition, in terms of gender, the report found that girls out-perform boys for all ethnicities. Also, FSM eligibility has an impact on performance with White boys FSM having the lowest achievement (31%) and Indian girls not eligible for FSM the highest (86%)[203]. As shown in figure 30, Pakistani girls (55%) and boys (46%) eligible for FSM perform below the city average (60%). Non-FSM Pakistani boys also achieve below the city average (54%), and only non-FSM Pakistani girls perform above it (63%).

Figure 29: Percentage of South Asian pupils getting a grade 5 or above in English and maths GCSE by eligibility for free school meals, 2020-21



Source: Ethnicity Facts and Figures: Key stage 4 performance: academic year 2020/21[204]

Figure 30: 5+ GCSEs A*-C including English and Maths by ethnicity, gender and free school meals eligibility Birmingham schools, 2013 (B= boy; G= girl)



Source: Based on data from from Ethnic Groups in the Labour Market: statistical analysis for Birmingham[205]

Qualifications and skills

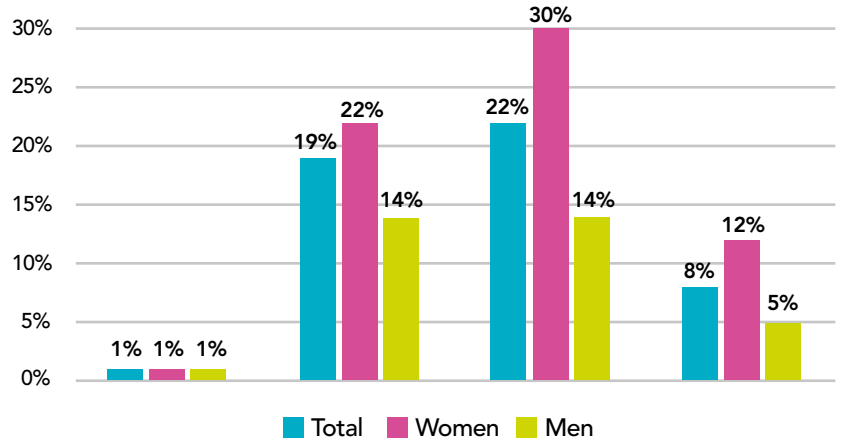
26% of Pakistanis were without any educational qualifications at all, a lower proportion compared to the Bangladeshi group (28%) but more disadvantaged than the White British (24%) group[206].

The local action on health inequalities report from PHE has found the Pakistani community has a slightly lower proportion of people with degrees (25%) than the White British group (26%); this is higher than the Bangladeshi

community (20%) and mixed White and Black Caribbean groups (18%). Similarly, according to the Ethnic Groups in the Labour Market: a statistical analysis for Birmingham report found in Birmingham the Pakistani (35%) and Bangladeshi (35%) groups have the highest proportions with no qualifications and the White Other (15%) and Indian (18%) the lowest[207]. In Birmingham among South Asian ethnic groups, the Pakistani (39%) and Bangladeshi (37%) groups have the lowest proportion educated to NVQ Level 2, and Indian (60%) the highest[208]. The report has found a similar pattern in higher qualifications, with the Pakistani and Bangladeshi groups consistently having some of the lowest proportions.[209]

The Poverty and Ethnicity in the Labour Market report from the Joseph Rowntree Foundation has also found the Pakistani (18.9%) and Bangladeshi (21.9%) groups have the highest proportions of people aged 16 or over with poor English language proficiency[210] (figure 31). Improved levels of English can help minority communities from vulnerabilities as it is likely to hamper their ability to secure employment. Analysis of Census 2011 data[211] shows that those with low proficiency in English were less likely to be employed and more likely to be economically inactive than people with high English proficiency levels.

Figure 31: Percentage of people aged 16+ who cannot speak English well or at all



Source: Based on data from Poverty and Ethnicity in the Labour Market report, Joseph Rowntree Foundation[212]

2.5.2 Economic activity

Unemployment

8% of Pakistani / Bangladeshi people (combined statistic) were unemployed – the highest unemployment rate of all ethnic groups.

Data from the Annual Population Survey shows that in 2019, 4% of the economically active population (these are all people aged 16 and over who were employed or unemployed) were unemployed – just under 1.3 million people[213]. The unemployment rate of the Pakistani/ Bangladeshi group was the highest; 3% of the White Other ethnic group were unemployed – the lowest rate of all ethnic groups.

Similarly, according to the Building Integrated Communities report[214], with unemployment rates of 10% and 11%, Black and Pakistani/ Bangladeshi people are two to three times more likely to be unemployed compared to White people (4%). The unemployment rate for Pakistani and Bangladeshi people aged 16-24 was the highest at 30% in the year to September 2017[215].

It is worth noting, that the unemployment rate has reduced over time. The unemployment rates[216] for the combined Pakistani and Bangladeshi group were more than 5 percentage points lower in 2019 than in 2004, the largest decrease of any ethnic group over the period. The Ethnic Groups in the Labour Market report[217] notes, male economic activity is higher than that of females for all groups, but the difference is more pronounced in some groups. For example, 74% of Pakistani males are economically active but only 34% of females. There is a similar pattern for those of Bangladeshi heritage. The difference between the economic activity of males and females is the least in the Indian ethnic group of all South Asian communities. The report notes, that employment rates broadly follow the same pattern as economic activity rates. The White Other (71%) have the highest rates, and the Pakistani and Bangladeshi groups have the lowest rates; the overall rate is 62%[218]. Employment rates are higher for males than females for most groups and gender differences are greatest for the Pakistani and Bangladeshi groups, where the male rates are around 60% and the female rates around 25%[219].

In terms of employment by industry in Birmingham, the report notes that 25% of White Irish males in employment work in construction compared to 4% of Pakistanis and 2% of Bangladeshis. 26% of Pakistani women who are employed work in education, but only 11% of Black African women; the overall figure is 18%. 22% of Pakistani women in employment are employed in human health and social work activities compared to 5% of Pakistani men. Similarly, 26% of Pakistani women in employment work in education compared to only 4% of Pakistani men[220].

Full-time/ Part-time and Self-employment

The Ethnic Groups in the Labour Market: a statistical analysis for Birmingham report has found 35% and 23% of Pakistani males to be in full-time and part-time employment, respectively. This is higher than females of which 11% and 13% are in full-time and part-time employment, respectively.

For the Pakistani, as well Bangladeshi groups, part-time work constitutes a large proportion of all employment, even for males[221].

According to the 2011 Census data, within the working age population in the West Midlands, of those born in Pakistan almost 16% were in full-time employment and 12% were in part-time[222].

Not in Education, Employment or Training (NEET)

As found in the Health Equity Report[223], young people who are not in education, employment or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood.

There is only limited data available on the characteristics of 16- to 18-year-olds who are NEET. A Longitudinal Study of Young People in England in

2010 assessed the characteristics of 19-year-olds who are NEET. It found that being a member of the Black Caribbean, Pakistani, Bangladeshi, or Mixed ethnic groups was one of the key risk factors for young people becoming NEET post-compulsory education[224].

A higher proportion of young people who were not in NEET lived in more deprived areas. In 2015, there was a 2.1%-point gap between the most and least deprived[225]. The report notes that this absolute gap has narrowed since 2011.

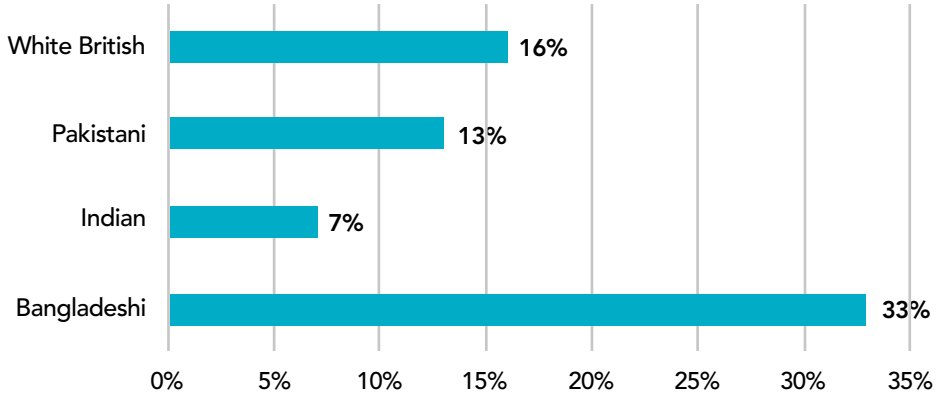
2.5.3 Housing and state support

Housing data from 2016 to 2018 shows that 13% of Pakistani households rented social housing. Pakistani families (51%) were one of the most likely to receive a type of state support, which was more than Bangladeshi (49%) and Indian (39%) households.

Data on housing below shows that from 2016 to 2018, 17% of households (3.9 million) in England lived in social housing (they rented their home from a local authority or housing association); 13% of Pakistani households rented social housing which was less than Bangladeshi households (33%) but more than Indian households (7%).

Data from the Family Resources Survey in the 3 years to March 2020 shows on average 52% of families received a type of state support (table 21). Families from the Bangladeshi (23%) and Pakistani (22%) ethnic groups were the most likely to receive a tax credit. Pakistani families were one of the most likely to receive an income-related benefit (18%), which was less than the Bangladeshi ethnic group (26%) who were the most likely to receive an income-related benefit.

Figure 32: Percentage of households that rented social housing, by select ethnicities



Source: English Housing survey 2017-18[226]

Table 21: Percentage of families receiving state support, by select ethnicities and type of support, England and Wales

Ethnicity	Any state support (%)	Any tax credits (%)	Any income-related benefit (%)	Any non-income-related benefit (%)
Bangladeshi	49	23	26	45
Indian	39	6	9	37
Pakistani	51	22	18	47
White British	54	6	16	51

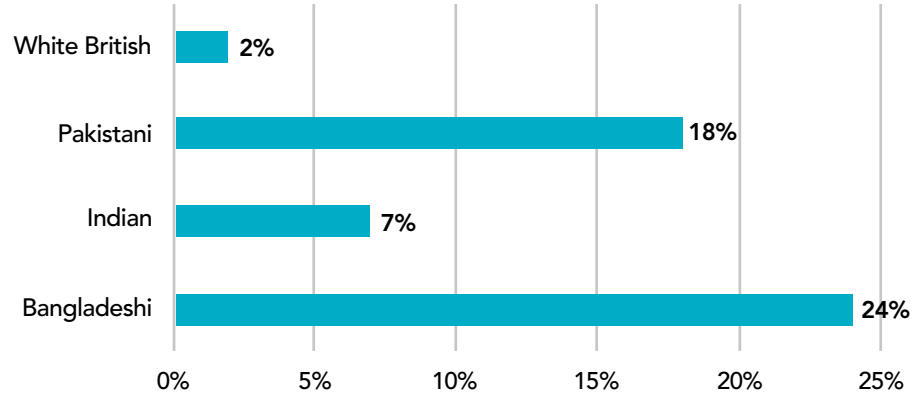
Source: Family Resources Survey: financial year 2019 to 2020 [227]

Overcrowding

The highest rates of overcrowding were in the Bangladeshi (24%) and Pakistani (18%) households.

Data from the English Housing Survey shows that from April 2016 to March 2019, 3% of the 23 million households in England were overcrowded. Overcrowded housing is defined as having fewer bedrooms than needed. The households with the highest rates of overcrowding were in the Bangladeshi (24%), Pakistani (18%), Black African (16%), Arab (15%) and Mixed White and Black African (14%) ethnic groups[228].

Figure 33: Percentage of households that were overcrowded, by ethnicity April 2016-March 2019, England



Source: English Housing Survey[229]

Tenure

According to the 2011 Census, the majority of those from Pakistan (72.8%) in the West Midlands own a property, either the property is owned outright or with a mortgage/ loan or shared ownership.

The 2011 Census shows in the West Midlands 31.8% of residents born in Pakistan own their property outright, and 41% own their property with a mortgage/ loan or shared ownership[230].

This can be compared to England and Wales where residents from Pakistan 24.6% own their property outright and 39.4% own their property with a mortgage/ loan or shared ownership[231]. In the West Midlands around 12.8% lived in properties owned by a private landlord or letting agency, and 21% from Pakistan lived in such properties in England and Wales.

2.5.4 General health

In terms of general health, 81.8% of residents from Pakistan surveyed in the West Midlands felt they have very good or good health, slightly lower than residents from Pakistan settled in England and Wales (83.3%). In the West Midlands, 6% felt they have bad or very bad health, more than those living across England and Wales (5.4%).

Census data[232] shows that 81.8% of residents from Pakistan surveyed in the West Midlands felt they have very good or good health, slightly lower than residents from Pakistan settled across England and Wales (83.3%).

Of those from Pakistan in the West Midlands, 26.3% of 55 to 64-year-olds felt they have bad or very bad health, compared to 23.2% across England and Wales in that age group. 36.9% of those over the age of 65 felt they have bad or very bad health, compared to 32.1% across England and Wales[233].

Table 22: DC3204EWr - General health for Pakistani ethnic group (regional)234

General Health	England & Wales	West Midlands
All categories: General health	1,124,511	227,248
Very good or good health	936,626	185,982
Fair health	126,865	27,579
Bad or very bad health	61,020	13,687

Source: 2011 Census Table CT0563

2.5.5 Long-standing health impairment, illness or disability

According to the Long-term Health Problem or Disability survey[235], 74% of those from Pakistan living with a long-term health problem or disability in the West Midlands felt it did not impact their day-to-day activities, compared to 26% who felt it did.

In slight contrast, in England and Wales, 77.7% of those from Pakistan living with a long-term health problem or disability felt it did not impact their day-to-day activities, higher than in the West Midlands; 22.3% felt it did impact their day-to-day activities, less than in the West Midlands[236].

Families from the Pakistani ethnic group (34%) were the most likely to receive Child Benefit. In the 3 years to March 2020, an average of 7% of Pakistani families received the State Pension, 6% received the care component of Disability Living Allowance, and 5% the mobility component.

The Disability Living Allowance (DLA) figures include the Personal Independence Payment (PIP), which was introduced in 2013. Because of rounding, the figures shown here may not match the sum of published DLA and PIP figures[237]. The data shows that in the 3 years to March 2020 an average of 24% of families received the State Pension, 18% received Child Benefit, 7% received the care component of Disability Living Allowance, and 6% the mobility component. Families from the Bangladeshi and Pakistani ethnic groups (both 34%) were the most likely to receive Child Benefit – families from the Chinese (13%) and White British (17%) ethnic groups were the least likely to[238].

Table 23: 'Long-term health problem or disability' survey in 2011 Census for those born in Pakistan, England and Wales

Ethnicity	Child Benefit (%)	State Pension (%)	Disability Living Allowance (care component) (%)	Disability Living Allowance (mobility component) (%)
Pakistani	34	7	6	5
Bangladeshi	34	6	8	4
Indian	20	12	3	2
White British	17	28	8	6

Source: Census 2011 Table CT0563

CANCER SCREENING

(% of early, late and unknown stage diagnosis)

TYPE	EARLY	LATE	UNKNOWN
Breast*	70%	15%	15%
Colorectal	38%	52%	10%
Prostate	48%	32%	21%
Lung	14%	75%	11%

*Combined data for Pakistani & Bangladeshi ethnic groups

61% of Pakistani participants were non-attenders at cervical screening

SEXUAL HEALTH

MEDIAN AGE FOR PAKISTANI MEN & WOMEN AT FIRST HETEROSEXUAL INTERCOURSE IS

20 **22** YEARS OLD

Research has found Pakistani female respondents were highly unlikely to report using emergency contraception (2.1%) compared to white British women (23%)

TUBERCULOSIS (TB)

ONE OF THE HIGHEST RATES OF TB IN THE UK ARE FOUND AMONG PEOPLE OF PAKISTANI ETHNICITY

10.7% of the TB cases in the UK, with a median time of 10 years since arrival to the UK

2.6 Protect and detect

Protect and detect key findings:

Cancer screening

- **Breast cancer:** For breast screening, a published research has found 63% of Pakistani respondents were most aware of the breast screening programme. Pakistani women were less likely to attend their first call (52%) or routine recall (67%) appointments, than Indian (61% and 74%, respectively), but more than Bangladeshi women (43% and 61%, respectively).
- **Cervical cancer:** According to a qualitative study, 61.7% of Pakistani participants were non-attenders at cervical screening. 30% of Pakistani respondents agreed with the statement that they were not at risk of cervical cancer and therefore do not need a smear test. A large proportion of South Asian respondents agreed with the statement that smear tests were embarrassing: Pakistani (75.6%), Indian (71%), and Bangladeshi (90.8%).
- **Colorectal cancer:** Research on attitudes to and interest in Flexible Sigmoidoscopy (FS) screening has found embarrassment or shame as one of the key barriers to screening uptake, with 96% of Pakistani respondents expressing this as a barrier. NCIN data shows, 38% of Pakistani patients had their diagnosis of colorectal cancer at an early stage, 52% were late stage and for 10% the stage was unknown, similar to other South Asian communities.

- **Prostate cancer:** 32% of Pakistani patients had their diagnosis of prostate cancer at a late stage, which was similar to both Indian (30%) and Bangladeshi (30%) patients.
- **Lung cancer:** NCIN data has found for both genders the Pakistani community had one of the lowest incidence of lung cancer compared to all major ethnic groups. It has also found Pakistani patients had a significantly higher proportion of lung cancer cases diagnosed at a late stage, compared with the White British group.

Vaccination programmes

- While lower than that of the White British group (93.7%), the COVID-19 vaccination rates among people identifying as Indian (90.9%) have been high - the highest vaccination rates of all ethnic minority groups.

Sexual health

- Published research has found the median age for Pakistani men and women at first heterosexual intercourse to be 20 and 22 years old, respectively.
- 7.7% of Pakistani male respondents reported to be under 16 at first heterosexual intercourse.
- Pakistani female respondents were highly unlikely to report using emergency contraception (2.1%) compared to white British women (23%).

Tuberculosis

- One of the highest rates of tuberculosis in the UK are found among people of Pakistani ethnicity, particularly those born outside the UK.
- People born in Pakistan account for 10.7% of the tuberculosis cases in the UK, with a median time of 10 years since arrival to the UK.

Domestic violence

- The data on domestic abuse shows that more Pakistani women reported domestic abuse (5.3%) than men (2%).

2.6.1 Cancer screening

Cancer is one of the major causes of death in the UK, with more than 1 in 3[239] people likely to develop it at some point in their life. A recently published study[240] from Cancer Research UK has found in all broad minority ethnic groups, lung, bowel, breast and prostate cancers were the four most common cancer types[241]. Diagnosis at an early stage of cancer development can improve survival chances and health interventions, such as screening programmes, are an important part of efforts to reduce cancer mortality.

Breast cancer

For breast screening, published research has found that 69% of Indian respondents were had the highest awareness of the breast screening programme[242]. Pakistani women were less likely to attend their first call (52%) or routine recall (67%) appointments than Indian (61% and 74%, respectively), but more than Bangladeshi women (43% and 61%, respectively).

Breast screening prevents 1,300 women from dying of breast cancer every year[243]. Uptake of breast cancer screening is defined as the proportion of women invited who attend for screening within 6 months of their invitation.

A published study that examined the awareness of cancer screening programmes by ethnic group using the Ethnibus™ survey found for breast screening, 63% of Pakistani respondents were most likely to know about the programme. This was less than the Caribbean participants (85%), Bangladeshis (75%) and Indians (69%), but more than Africans (62%) and Chinese (57%)[244].

Another published study[245], which uses self-assigned ethnicity information to study variation in breast cancer screening uptake for women from different ethnic groups, found Pakistani women were less likely to attend their first call (52%) or routine recall (67%) appointments, which was less than Indian (61% and 74%, respectively) but more than Bangladeshi women (43% and 61%, respectively)[246]. It found there was less variation between ethnic groups in some screening areas.

In addition, a study[247] from the National Cancer Intelligence Network (NCIN) studied the proportions of patients in each stage group of cancer and its associations between stage and ethnicity. It found that after adjustment for age, sex and deprivation status, among Pakistani / Bangladeshi patients (combined data) with known stage, 70% were diagnosed with breast cancer at an early stage, 15% were late stage, and 15% were unknown[248]. This is similar to the Indian ethnic group: 69% were diagnosed with breast cancer at an early stage, 15% were late stage, and 17% were unknown. The study states that the stage at diagnosis may be related to a patient's route to diagnosis, including whether the cancer was detected by screening[249].

A study[250] has found British-Pakistani women face unique challenges when accessing breast screening. It suggests to promote breast screening uptake, the service needs to address the translation of screening literature and avail community networks to disseminate knowledge. Similarly, another study[251] found difficulties associated with women's limited English language skills, which impacts access to information, as well as limited I.T proficiency.

A study[252] on barriers faced by ethnic minority communities in accessing cancer genetics services also sheds some light on this topic. In assessing levels of awareness and understanding of familial cancer risk among minority ethnic communities, it found stigma about cancer or inherited risk of cancer. It also identified taboos among the community such as refraining from using the word 'cancer', and limited knowledge of cancer with many equating cancer with death. Importantly some of the participants reported feeling some service interpreters make decisions on their behalf, or selectively choose what information to translate to them.

Cervical cancer screening

According to a qualitative study, 61.7% of Pakistani participants were non-attenders at cervical screening. 30% of Pakistani respondents agreed with the statement that they were not at risk of cervical cancer and therefore do not need a smear test. A large proportion of South Asian respondents agreed with the statement that smear tests were embarrassing: Pakistani (75.6%), Indian (71%), and Bangladeshi (90.8%).

Cervical screening helps identify pre-cancerous cell changes in the cervix. These changes can be treated, preventing cancer from developing. Cervical screening is believed to have saved up to 5,000 lives a year[253].

Research[254] has found that women from ethnic minority groups are less likely to attend cervical screening compared to White British. Qualitative research on attitudes towards cervical screening interviewed 120 female participants from Indian, Pakistani, Bangladeshi, Caribbean, African and White British ethnic groups. It found 61.7% of Pakistani participants were non-attenders at cervical screening, meaning the ethnic group had fewer non-attenders than the Indian (66%) and Bangladeshi (70.6 %) groups[255].

30% of Pakistani respondents felt they were not at risk of cervical cancer and therefore do not need a smear test. This was higher than the Indian group (22%) and the same as the Bangladeshi respondents (30%)[256]. 20% of women from the Pakistani ethnic group were worried about seeing a male doctor/ nurse, less than the Indian respondents (26%) but more than Bangladeshi (18.8%) respondents[257]. A large proportion of South Asian respondents agreed with the statement that smear tests were embarrassing: Pakistani (75.6%), Indian (71%) and Bangladeshi (90.8%)[258].

Colorectal cancer screening

Research on attitudes to and interest in Flexible Sigmoidoscopy (FS) screening has found embarrassment or shame as one of the key barriers to screening uptake, with 96% of Pakistani respondents expressing this as a barrier. NCIN data shows, that 38% of Pakistani patients had their diagnosis of colorectal cancer at an early stage, 52% were late-stage and for 10% the stage was unknown, similar to other South Asian communities.

Published research on the awareness among British ethnic minority men and women of the causes of colorectal or bowel cancer, and attitudes to and interest in Flexible Sigmoidoscopy (FS) screening[259] found embarrassment or shame as one of the key barriers to screening uptake. 96% of Pakistani respondents expressed "embarrassment or shame" as a barrier to screening uptake among the community, compared to 97% in the Indian and 98% in Bangladeshi responses[260].

More than half (65%) of Bangladeshi, and 50% of Pakistani respondents, could not suggest a single cause of bowel cancer, compared with 38% among Indian respondents and only 11% among White British respondents[261]. The study suggests that it is possible that because White British people have a higher objective risk of cancer that they knew more people with the disease and were therefore, more able to suggest causes[262].

According to another study[263], Bangladeshi respondents (53%) reported the greatest awareness of the bowel screening programme and Chinese respondents (0%) the least, with Caribbean (51%), Indian (46%), African (31%) and Pakistani (18%) falling between[264].

Data[265] from the National Cancer Intelligence Network (NCIN) shows, after adjustment for age, sex and deprivation status, 38% of Pakistani patients had their diagnosis of colorectal cancer at an early stage, 52% were late-stage and for 10% the stage was unknown[266]. This is similar to other South Asian communities: 40% of Indian patients had their diagnosis of colorectal cancer at an early stage, 48% were late-stage and for 11% the stage was unknown; 32% of Bangladeshi patients had their diagnosis of colorectal cancer at an early stage, 57% were late-stage and for 11% the stage was unknown.

Prostate cancer

32% of Pakistani patients had their diagnosis of prostate cancer at a late stage, which was similar to both Indian (30%) and Bangladeshi (30%) patients.

Data[267] from the National Cancer Intelligence Network (NCIN) shows, after adjustment for age, sex and deprivation status, 48% of Pakistani patients had their diagnosis of prostate cancer at an early stage, 32% were late-stage and for 21% the stage was unknown[268]. This can be compared to other South Asian communities: 52% of Indian patients had their diagnosis of prostate cancer at an early stage, 30% were late-stage and for 18% the stage was unknown; 55% of Bangladeshi patients had their diagnosis of prostate cancer at an early stage, 30% were late-stage and for 15% the stage was unknown[269]. This suggests that Pakistanis are typically diagnosed with prostate cancer at a later stage than other South Asian communities.

Men living in England and Wales who were born in the Indian subcontinent, including those from Pakistan, have 30% to 80% lower rates of prostate cancer deaths than the overall population in England and Wales[270].

Lung cancer

NCIN data found that for both genders the Pakistani community has one of the lowest incidences of lung cancer compared to all major ethnic groups. It has also been found that Pakistani patients had a significantly higher proportion of lung cancer cases diagnosed at a late stage, compared with the White British group.

Using data from the NCIN covering South East England on patterns of lung cancer incidence for major ethnic groups found Bangladeshi men have a similar rate of lung cancer to White men, while rates for Pakistani and Indian men are much lower[271]. For both genders, the Pakistani community have one of the lowest incidences of lung cancer compared to all major ethnic groups.

NCIN data has also found, after adjustment for age, sex and deprivation status, among patients with known stage, Pakistani patients had higher proportions diagnosed at a late stage, compared with the White British group. In comparison, Indian patients had significantly lower proportions of late-stage lung cancer diagnoses compared with the White British group[272].

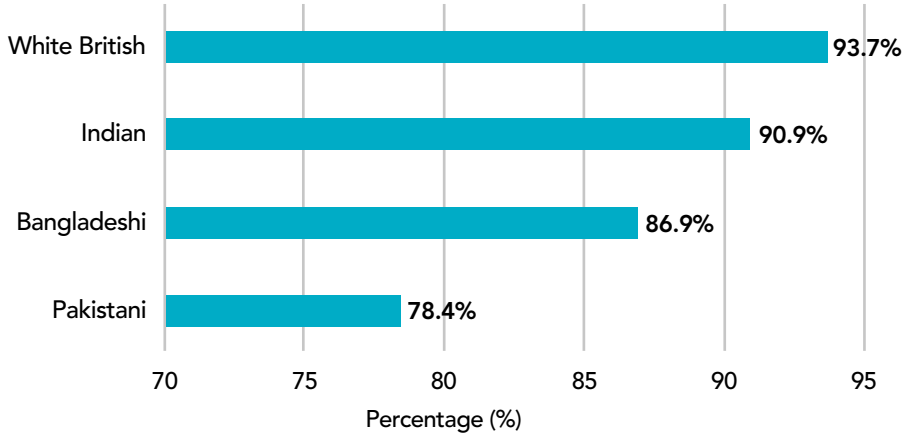
According to lung cancer screening data for England from 2012 to 2013[273] , 14% of Pakistani patients had their diagnosis of lung cancer at an early stage, 75% at a late stage, and for 11% the stage was unknown. This can be compared to 24% of Indian patients who had their diagnosis of lung cancer at an early stage, 61% were late-stage and for 15% the stage was unknown; for Bangladeshi patients: 26% were early-stage, 61% late-stage and 12% stage unknown.

2.6.2 Vaccination programmes

Among adults over the age of 50, the Pakistani ethnic group had one of the lowest COVID-19 vaccination rates (78.4%).

According to ONS data (figure 33), Among adults over the age of 50, the Pakistani ethnic group had one of the lowest COVID-19 vaccination rates (78.4%)[274]. In comparison, vaccination rates were highest among the Indian (90.9%) and Bangladeshi (86.9%) ethnic groups, but lowest for those identifying as Black Caribbean (66.8%) and Black African (71.2%).

Figure 34: COVID-19 vaccination rates of adults aged 50 years and over, by self-reported ethnic group, 8 December 2020 to 12 April 2021, England (percentage %)



1. Figures based on first dose of a vaccine administered between 8 December 2020 and 12 April 2021 for residents in England who could be linked to the 2011 Census and General Practice Extraction Service Data for Pandemic Planning and Research.

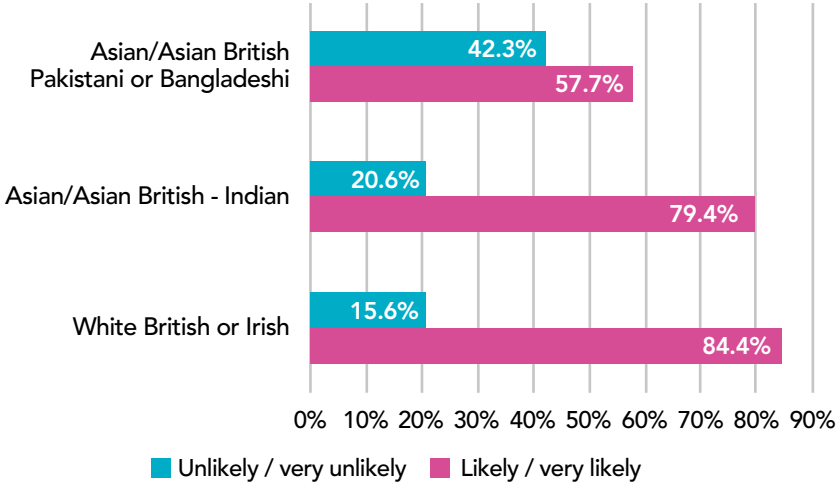
2. Self-reported ethnic group is derived from the 2011 Census. Other ethnic group encompasses Asian other, Black other, Arab and Other ethnic group categories in the classification.

Source: ONS, National Immunisation Management Service[275]

The UK Household Longitudinal Study (figure 35), is a nationally representative longitudinal household panel study, which interviews participants annually. During the COVID-19 pandemic, the survey included questions to understand the impact of the pandemic on UK individuals, families and wider communities. Data from 11,708 participants aged 16 years+ included ethnic minority groups.

In assessing willingness to be vaccinated, Pakistani / Bangladeshi respondents (combined data) had one of the highest levels of vaccine hesitancy, with 57.7% likely or very likely to be vaccinated and 42.3% expressing unlikely or very unlikely to be vaccinated. The survey found vaccine hesitancy highest in Black or Black British groups, with 72% stating they were unlikely/very unlikely to be vaccinated. The Indian respondents had one of the lowest vaccine hesitancy with 79.4% likely or very likely to be vaccinated and 20.6% expressing unlikely or very unlikely to be vaccinated.

Figure 35: Willingness to be vaccinated in the UK Household Longitudinal Study by ethnic group



Source: UK Household Longitudinal Study

2.6.3 Sexual health

Published research has found the median age for Pakistani men and women at first heterosexual intercourse to be 20 and 22 years old, respectively. 7.7% of Pakistani male respondents reported being under 16 at first heterosexual intercourse. Pakistani female respondents were highly unlikely to report using emergency contraception (2.1%) compared to white British women (23%).

Sexual health is the absence of disease and the ability to lead a pleasurable and safe sex life[276]. Published research[277] on ethnic variations in sexual behaviours and sexual health markers used findings from the third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3). It found age and sexual competence at sexual debut varied significantly by ethnicity and sex. Within the study, participants as sexually competent at first intercourse if they reported the following four criteria: contraceptive protection, autonomy of decision (not due to external influences), that both partners were equally willing, and it happened "at the right time." The study found both Pakistani men and women to be more likely to have been sexually competent at sexual debut than their white British counterparts.

The age for Indian men at first heterosexual intercourse was 22, older than Pakistani men (20). 7.9% of Indian male respondents were under 16 at first heterosexual intercourse, compared to 7.7% of Pakistani male respondents. 4.7% of the Indian male. 4.7% of Indian male respondents said they had condom-less sex with more than one partner, compared to 3.9% of Pakistani male respondents. 9.5% of both Indian and Pakistani respondents paid for sex in the past five years.[278]

Among Pakistani female respondents, it found the median age at first heterosexual intercourse was 22, the same as for Indian female respondents. 1.1% of Pakistani female respondents were under the age of 16 at their first heterosexual intercourse, similar to Indian females (0.1%). None of

the Pakistani female respondents reported paying for sex in the past five years; the same was reported for Indian females. 0.5% of female Pakistani respondents reported having condom-less sex with more than one partner, which was less than Indian female respondents (1.6%)[279].

The research also found the proportion of women having had a same-sex experience was significantly lower in Indian (3.5%) and Pakistani (2.2%) women than in white British women (12.2%). Indian (11%) and Pakistani (2.1%) women were less likely to report having used emergency contraception than white British women (23%)[280].

2.6.4 Tuberculosis

One of the highest rates of tuberculosis in the UK is found among people of Pakistani ethnicity, particularly those born outside the UK. People born in Pakistan account for 10.7% of the tuberculosis cases in the UK, with a median time of 10 years since arrival to the UK.

Tuberculosis (TB) is a serious infectious disease and is currently one of the key priorities of Public Health England. While there are signs of a decreasing trend in new TB cases, the UK still has high rates compared to most other European countries. The highest rates of disease are found among people of South Asian ethnicity, particularly those born outside the UK[281].

Research has found that reactivation of latent infections acquired outside the UK accounts for much of the disease burden, though there is also evidence that transmission within communities in the UK may be an increasing challenge, particularly among the South Asian communities[282].

For those born outside the UK who were notified of TB in 2020, the most frequent countries of birth were India, Pakistan, Romania, Somalia and Eritrea[283]. Between 2018 and 2020, the number of notifications declined among people born outside the UK in the 5 most frequent countries of birth; India by 1.1%, Pakistan by 6.3%, Romania by 11.8%, Somalia by 13.3% and Eritrea by 3.1%)[284].

For people born in Pakistan or Somalia, the median time from entry to notification was over 10 years, if born in India, it was 8 years (a reduction from 2019 when it was 10 years), and for people born in Romania and Eritrea, the median time frame was 4 years and 2 years respectively[285]. It is worth noting that the incidence of TB is growing faster in Birmingham[286]. Cases grew by 107% between 1999 and 2009 in Birmingham than in England (grew by 57% between 1987 and 2008[287]). TB admissions in Birmingham have been concentrated in inner city wards, with a higher proportion of ethnic minority groups, particularly South Asian communities.

In 2013, there were 8,751 cases of TB reported in the UK with the highest rates of disease found in UK residents from South Asian countries[288]. Incidence rates were 10-fold greater in Indian (132/100,000) and Pakistani (114/100,000) ethnic groups compared with the UK average (12.3/100,000)[289]. The majority of cases of TB in these ethnic groups are thought to be largely due to reactivation of latent infection acquired in their country of origin. The proportion of UK-born cases of TB in South Asian ethnic groups increased from 18% in 2004 to 27% in 2012[290].

A study[291] on influence of socio-economic deprivation on tuberculosis treatment also provides some useful insight. It found recent UK entrants, including Pakistanis, may experience language barriers, have limited knowledge of health services including difficulties registering with a general practitioner, and / or face issues related to immigration status. There was an overall median interval to start of treatment for the group of around 67 days. It identified deprivation as a key factor in the epidemiology of TB in England and the overall median delay of 67 days.

2.6.5. Domestic violence

The data on domestic abuse shows that more Pakistani women reported domestic abuse (5.3%) than men (2%).

This is more than women of Bangladeshi (3%) and Indian (4.6%) groups, but less than White British (8%). Overall the Pakistani group reported more domestic abuse cases (3.5%) than Bangladeshi (1.4%) but less than the Indian (4.9%) community.

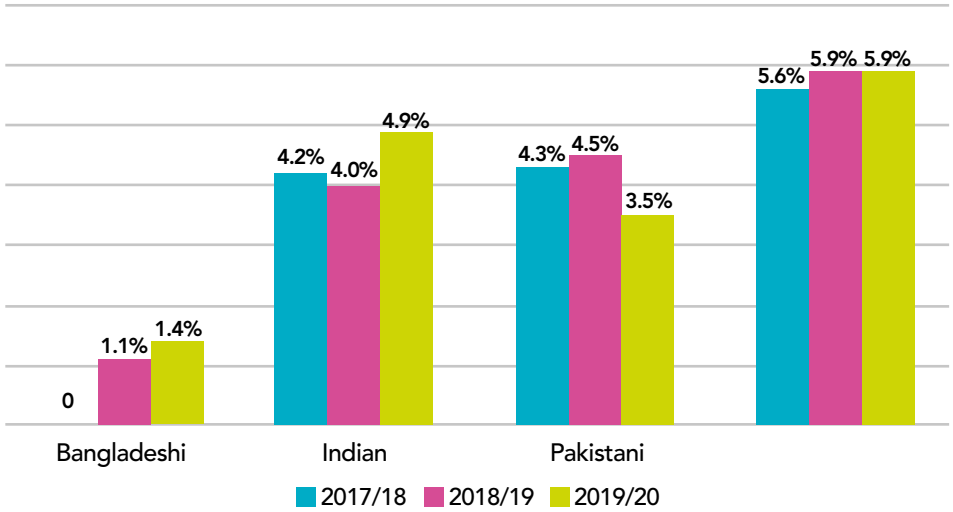
Table 24: Percentage of 16 to 74 year olds who reported being victims of domestic abuse in the previous 12 months, and number of people surveyed, by ethnicity and sex. The data shows that, in the year ending March 2020.

Ethnicity	Male (%)	Male (Sample Size)	Female (%)	Female (Sample Size)
Bangladeshi	0.4	74	3.0	56
Indian	5.2	333	4.6	276
Pakistani	2.0	181	5.3	170
White British	3.7	9,222	8.0	10,793

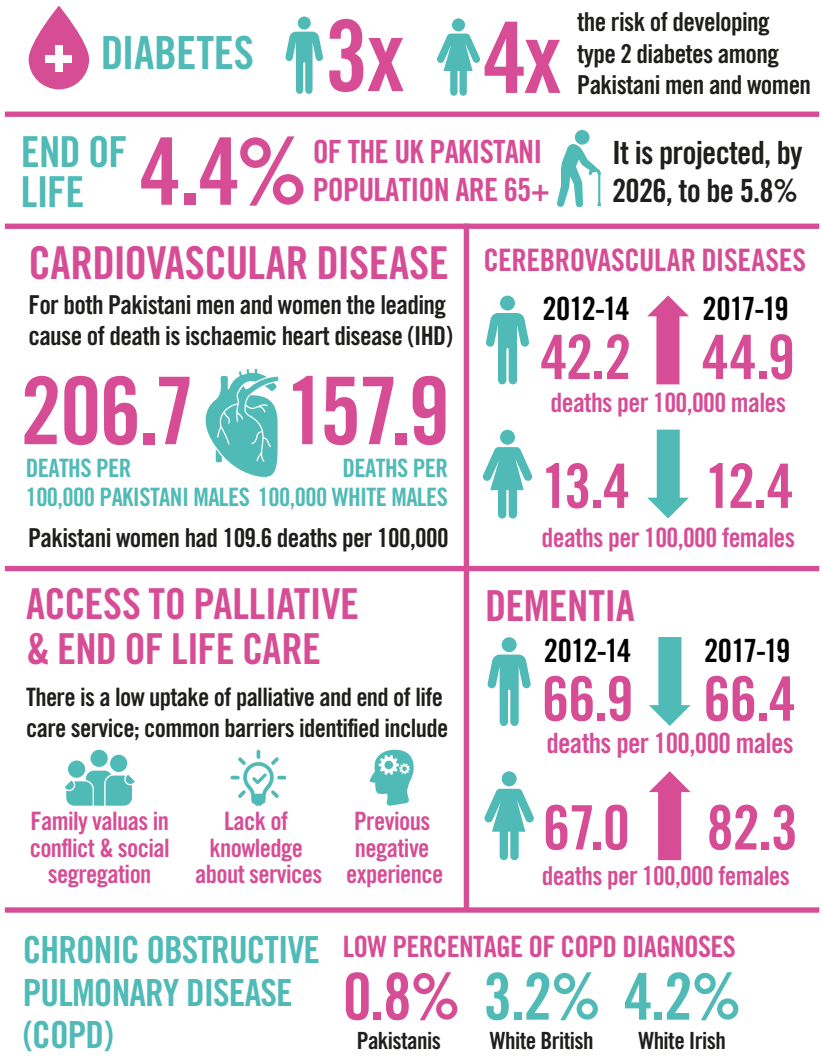
Source: Crime Survey for England and Wales: victims of domestic abuse, year ending March 2018 to year ending March 2020[292]

Figure 36: Percentage of 16 to 74 year olds who reported being victims of domestic abuse in the previous 12 months, by ethnicity over time

Note: Data for Bangladeshi ethnic group for 2017/18 has been withheld to protect confidentiality



Source: Crime Survey for England and Wales: victims of domestic abuse, year ending March 2018 to year ending March 2020 [293]



2.7 Ageing well and dying well

Ageing well & dying well key findings:

Diabetes

- Men from the Pakistani ethnic group are almost three times as likely as the general population to have type 2 diabetes.
- Women of Pakistani ethnicity are over five times more likely than women in the general population to be diagnosed with diabetes.

Cardiovascular disease

- Data from 2017 to 2019 shows for both Pakistani men and women the leading cause of death is ischaemic heart disease (IHD). IHD accounted for 10.5% (162,804 deaths in 2017 to 2019) of death registrations in the UK. The highest mortality rates in males have been in the South Asian ethnic group.
- In the latest period, Pakistani ethnic group had a rate of 206.7 deaths per 100,000 males, which is statistically significantly higher than the rate in the White group (157.9 deaths per 100,000). Similarly, Pakistani women had a rate of 109.6 deaths per 100,000 females.

COPD

- A published research on the ethnic differences in smoking intensity and COPD risk found the sample of the Pakistani ethnic group had a low percentage of COPD diagnoses (0.8% compared to 3.2% in White British group and 4.2% in the

White Irish group, both of which had higher percentage of current smokers).

- Within the sample of the Pakistani group (sample size: 34,415) it found 74% had never smoked, 15% were current smokers, and 0.8% had recorded COPD diagnosis.

Dementia

- Among Pakistani males the rate of dementia and Alzheimer's disease is 66.4 deaths per 100,000 males in 2017-19, a slight decline from 66.9 deaths per 100,000 males in 2012-14.
- The rates are higher among Pakistani females which have seen an increase from 67.0 deaths per 100,000 in 2012-14 to 82.3 deaths per 100,000 females in 2017-19.

Cerebrovascular diseases

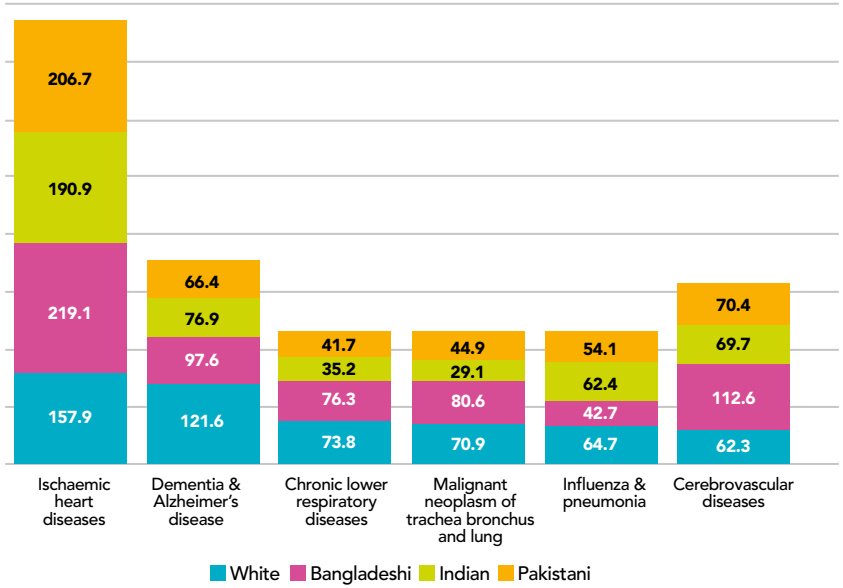
- According to ONS data on mortality from leading causes of death, among Pakistani males the rate of death from cerebrovascular diseases has increased from 42.2 deaths per 100,000 in 2012-14, to 44.9 deaths per 100,000 males in 2017 to 2019.
- Among Pakistani females the rate of death from cerebrovascular diseases has seen a slight drop, from 13.4 deaths per 100,000 females in 2012-14, to 12.4 deaths per 100,000 females in 2017 to 2019.

End of life

- The Pakistani ethnic group has a young age profile, with those aged 65 and over only accounting for 4.4% of its population.
- Over time the ethnic group's age profile will change, and by 2026, 5.8% of the Pakistani population will be made up of those aged 65 and over.
- A literature review on palliative care services found that low uptake of palliative and end of life care services was commonly reported among minority ethnic groups.
- It found this to be due to lack of referrals, the lack of knowledge about services, religious traditions and family values in conflict with the idea of palliative/ hospice care.
- In structural barriers it identified geographical location of inpatient hospices, social segregation and previous negative experiences of care.

For males in all ethnic groups, except Black Caribbean, the leading cause of death was ischaemic heart disease[294] - for both Pakistani men and women the leading cause of death was heart disease (as shown in figures 37 and 38 below). After heart disease, the leading cause of death among Pakistani men was cerebrovascular disease, followed by dementia and Alzheimer's disease.

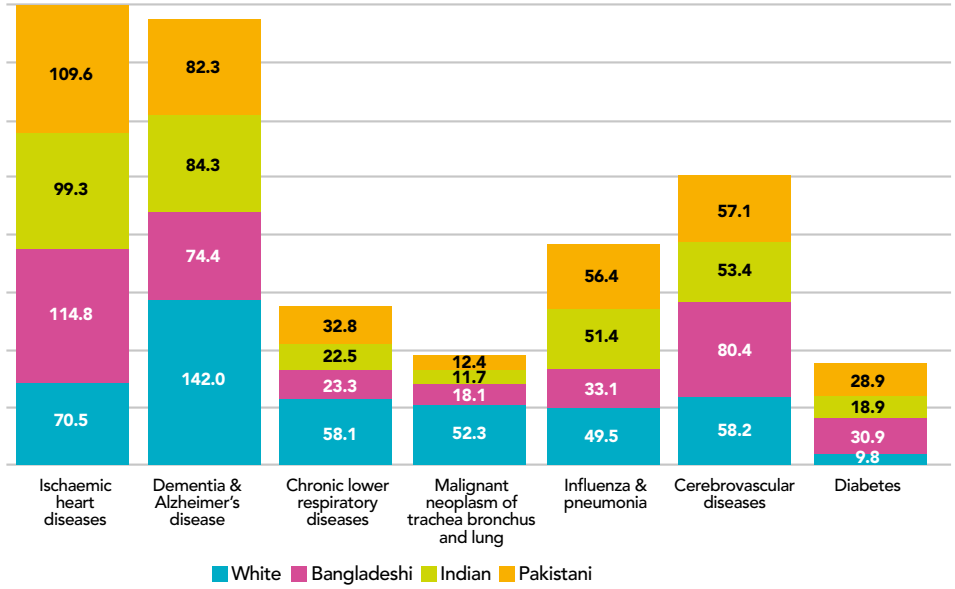
Figure 37: Deaths registered in England and Wales, 2017-19, age-standardised mortality rates per 100,000 for the most common leading causes of death for each ethnic group, males aged 10 years and above



Source: ONS - Mortality from leading causes of death by ethnic group[295]

As shown in figure 38, for Pakistani females the leading cause of death was heart disease, which was the same for both Bangladeshi and Indian females[296]. After heart disease, the leading cause of death among Pakistani women was dementia and Alzheimer's disease.

Figure 38: Deaths registered in England and Wales, 2017-19, age-standardised mortality rates per 100,000 for the most common leading causes of death for each ethnic group, females aged 10 years and above



Source: ONS - Mortality from leading causes of death by ethnic group[297]

2.7.1 Diabetes

Men from the Pakistani ethnic group are almost three times as likely as the general population to have type 2 diabetes[298]. Women of Pakistani ethnicity are over five times more likely than women in the general population to be diagnosed with diabetes[299].

The number of adults with diabetes in the UK has risen from 2.3 million (1980) to 4.7 million[300] (2019), with 1 million people undiagnosed[301], of which type 2 diabetes contributes to 90.4% (prevalence, 4.5%)[302].

A cohort study of 1.9 million individuals extracted data from the CALIBER programme found people with type 2 diabetes were twice as likely to be of either Black or South Asian origin compared to those without diabetes[303].

The HSE found the prevalence of doctor-diagnosed diabetes increased noticeably with age, in both men and women. It was more common in men than women for each minority ethnic group and age group, except Pakistani women aged 55+, who had a significantly higher prevalence of diabetes than Pakistani men[304]. Type 2 diabetes accounted for the majority of cases[305]. Pakistani, Indian and Bangladeshi men had a higher prevalence of type 2 diabetes aged 35-54 and aged 55+ than the general population. Among women, type 2 diabetes was more common in participants from Pakistani, Indian and Bangladeshi groups (aged 35+)[306].

The UK-based NHS Health Check Programme revealed a higher prevalence of diabetes among South Asian men (9.0% vs. 3.9%), and women (7.4% vs. 3.3%) compared to their White European counterparts[307]. According to this research[308], at present, there is insufficient evidence to suggest that there is an increased genetic susceptibility of South Asians to diabetes. Most studies demonstrate that the genetic factors conferring susceptibility to diabetes are not significantly different to other ethnic groups.

There are various risk factors for type 2 diabetes, which include family history, obesity, central fat deposition and ethnicity. The HSE has found that type 2 diabetes was approximately three to four times more common in Pakistani, Indian and Bangladeshi men. As found by Diabetes UK, the risk of developing type 2 diabetes for minority ethnic groups is higher at a younger age (from 25 onwards) compared with the White population (from 40 onwards).[309]

The increased prevalence of type 2 diabetes among adult minority ethnic groups may be tracked from childhood. In a study of 129 14-to-17-year-olds in Birmingham, South Asian adolescents were observed to be less insulin-sensitive than White European adolescents and had a higher percentage of body fat[310].

A study[311] on perspectives of British Pakistani women on their behaviour change to prevent type 2 diabetes identified several factors of why changing their lifestyle is difficult. This included domestic responsibility including hospitality - healthy food is perceived as undesirable; reluctance to go to the gym; environmental reasons such as rain and cold; and faith-related preferences such as absence of music during exercise.

2.7.2 Cardiovascular disease

Data from 2017 to 2019 shows for both Pakistani men and women the leading cause of death is ischaemic heart disease (IHD). IHD accounted for 10.5% (162,804 deaths from 2017 to 2019) of death registrations in the UK. The highest mortality rates in males have been in the South Asian ethnic group. In the latest period, the Pakistani ethnic group had a rate of 206.7 deaths per 100,000 males, which is statistically significantly higher than the rate in the White group (157.9 deaths per 100,000). Similarly, Pakistani women had a rate of 109.6 deaths per 100,000 females.

Cardiovascular disease (CVD) is a leading cause of death nationally and in ethnic minority groups, causing 24% of all deaths in England and Wales in 2019. CVD is the collective term for diseases affecting the circulatory system, such as the heart, arteries and blood vessels. Diabetes increases the risk of CVD almost two-fold.

HSE found among men aged 55 and over, Pakistani males had the highest prevalence (35.1%) of ischaemic heart disease (IHD), which is a heart problem caused by narrow heart arteries (angina or heart attack)[312]. It found the prevalence of CVD was lowest among those aged 16-34 and increased with age in both sexes in the general population and in all minority ethnic groups.

The highest prevalence of these conditions was observed in those aged 55 and over: the prevalence of angina was highest in Pakistani men (30.9%) and Indian women (14.7%), while the prevalence of heart attack was highest in the Pakistani group (19.0% men, 6.9% women)[313].

IHD accounted for 10.5% (162,804 deaths from 2017 to 2019) of death registrations in the UK. The highest mortality rates in males have been in the Bangladeshi, Pakistani, and Indian ethnic groups. In the latest period, these groups had rates of 219.1, 206.7, and 190.9 deaths per 100,000 males, respectively, all of which were statistically significantly higher than the rate in the White group (157.9 deaths per 100,000)[314].

In females, the same ethnic groups tended to have the highest rates (Bangladeshi, Pakistani, Indian), and in the latest period, the rates for these ethnic groups (114.8, 109.6, and 99.3 per 100,000 females, respectively) were statistically significantly higher than the rate in the White group (70.5 deaths per 100,000 females)[315]. For both genders, there has been a decline in the rates of death from IHD within the Pakistani ethnic group.

A study[316] provides some insight into the reasons for greater prevalence for cardiovascular disease in the Pakistani community. It reported the community having significantly lower levels of habitual physical activity than Europeans. This is likely to contribute to the higher levels of diabetes and cardiovascular risk within the community. Another study[317] also hypothesizes the community's susceptibility to CHD may partly be attributable to high-heat treated foods (i.e. deep frying) which produce toxic products called NFCs (such as trans-fatty acids, TFAs, and advanced glycation end-products, AGEs), though there is currently a lack of evidence to support this theory[318].

2.7.3 Chronic Obstructive Pulmonary Disease (COPD)

Published research on the ethnic differences in smoking intensity and COPD risk found the sample of the Pakistani ethnic group had a low percentage of COPD diagnoses (0.8% compared to 3.2% in White British group and 4.2% in the White Irish group, both of which had a higher percentage of current smokers). Within the sample of the Pakistani group (sample size: 34,415) 74% had never smoked, 15% were current smokers, and 0.8% had recorded COPD diagnosis.

Chronic Obstructive Pulmonary Disease (COPD) accounts for 30,000 deaths a year. Published research[319] on COPD shows there was a significantly lower risk for all other ethnic groups compared to the white British group. The study has found that smoking status and smoking intensity had almost identical influences on the COPD risk of individual ethnic groups. Within the study's sample only a fifth of the Indian ethnic group had ever smoked and they had a low percentage of COPD diagnoses (0.8% compared to 3.2% in White British group and 4.2% in the White Irish group, both of which had a higher percentage of current smokers)[320].

Within the sample of the Indian community (sample size: 58,082), 78% had never smoked, 11% were current smokers, and 0.8% had recorded COPD diagnosis. This was similar to the Pakistani community (sample size: 34,415): 74% had never smoked, 15% were current smokers and 0.8% had recorded a COPD diagnosis. In comparison, 65% of the Bangladeshi community (sample size: 95,356) had never smoked, 21% were current smokers and 0.9% had recorded a COPD diagnosis[321].

2.7.4 Dementia and Alzheimer's disease

Among Pakistani males, the rate of dementia and Alzheimer's disease is 66.9 deaths per 100,000 males in 2017-19, an increase from 66.4 deaths per 100,000 males in 2012-14. The rates are higher among Pakistani females which have seen an increase from 67.0 deaths per 100,000 females in 2012-14 to 82.3 deaths per 100,000 in 2017-19.

Dementia and Alzheimer's disease are leading causes of death in the general population and featured in the five most common causes for most ethnic groups and for both sexes since 2012 to 2014. This cause represents 12.9% (200,111 deaths from 2017 to 2019) of death registrations in the latest period[322].

In comparison, among Indian males, the rate of dementia and Alzheimer's disease is 76.9 deaths per 100,000 in 2017-19, an increase from 59.8 deaths per 100,000 in 2012-14. The rates are higher among Indian females which have seen an increase from 67.8 deaths per 100,000 in 2012-14 to 84.3 deaths per 100,000 in 2017-19. This can be compared to Bangladeshis (male: 97.6 and females: 74.4 deaths per 100,000).

2.7.5. Cerebrovascular diseases

According to ONS data on mortality from leading causes of death, among Pakistani males, the rate of death from cerebrovascular diseases has seen a slight increase from 42.2 deaths per 100,000 in 2012-14, to 44.9 deaths per 100,000 males in 2017 to 2019. Among Pakistani females, the rate of death from cerebrovascular diseases has seen a slight drop, from 13.4 deaths per 100,000 females in 2012-14 to 12.4 deaths per 100,000 females in 2017 to 2019.

From 2017 to 2019[323], cerebrovascular diseases, which are conditions that affect the blood supply to the brain such as stroke, appeared in the five most common leading causes for all ethnic groups and for all sexes except the White male group. Cerebrovascular diseases represent 5.8% of deaths registered from 2017 to 2019 (90,106 deaths)[324].

Among South Asian groups for both sexes, from 2012 to 2014, the Bangladeshi group had the highest rate of death from this cause. From 2017 to 2019, the male and female rates for the Bangladeshi group were 112.6 deaths per 100,000 males; 80.4 deaths per 100,000 females. The Indian community had one of the lowest rates of death from cerebrovascular diseases with 29.1 deaths per 100,000 males from 2017 to 2019, a decline from 36.4 deaths per 100,000 males in 2012-14. Among Indian females, the rate of death from the disease dropped from 14.4 deaths per 100,000 females to 11.7 deaths per 100,000 females from 2017 to 2019. In addition, according to HSE, the prevalence of IHD or stroke increased with age in both sexes. Among those aged 55 and over, the prevalence was highest in Pakistani men (41.1%) and Indian women (18.9%), and lowest in the Chinese group (8.7% men, 9.0% women).[325]

A study[326] has found that the incidence of stroke appears to be excessively higher in South Asians, when compared with the white ethnic group, and this difference in risk continues to increase. One of the contributory factors compounding poor standards of stroke care, particularly among South Asians, is the existence of barriers to communication, which can delay treatment as a result of an inability to express symptoms or communicate effectively. The study argues this results in an inability to establish a medical history of the event. In addition, another study[327] highlights the incidence of first-ever-stroke is higher in the Pakistanis compared with the White group in Bradford. Etiology and vascular risk factors vary between the ethnic groups. This information should be considered when investigating stroke etiology and when planning prevention and care provision to improve outcomes after stroke.

2.7.6 End of life

The Pakistani ethnic group has a young age profile, with those aged 65 and over only accounting for 4.4% of its population. Over time the ethnic group's age profile will change, and by 2026, 5.8% of the Pakistani population will be made up of those aged 65 and over.

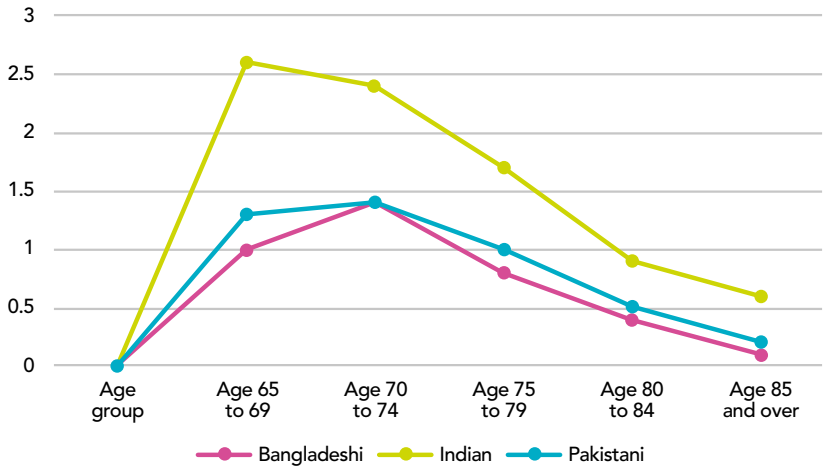
In contrast, the Indian ethnic group had the highest percentage of people aged 65 years and over (8.2%). The Bangladeshi group had the lowest percentage, 3.7%.

A study[328] applied the Alzheimer's Society's Expert Delphi Consensus findings on the prevalence of dementia in the UK to different ethnic groups. Among ethnic minority groups, the Indian community are expected to have the highest expected numbers, which reflects the community's long history of having been resident in the UK. The study states, that the numbers of people likely to experience dementia across all groups will represent a larger proportion of older people.

A literature review[329] on palliative care services found that low uptake of palliative and end of life care services was commonly reported among minority ethnic groups. The review argues this to be due to a lack of referrals, the lack of knowledge about services, religious traditions and family values in conflict with the idea of palliative/ hospice care. It also found other factors to be structural barriers such as the geographical location of inpatient hospices, social segregation and previous negative experiences of care[330]. Published research[331] has found amongst non-White BAME groups, East Midlands, West Midlands and the South-East together accounted for almost four out of ten older Indian, while the West Midlands, Yorkshire & the Humber and the North West together accounted for half of all older Pakistani.

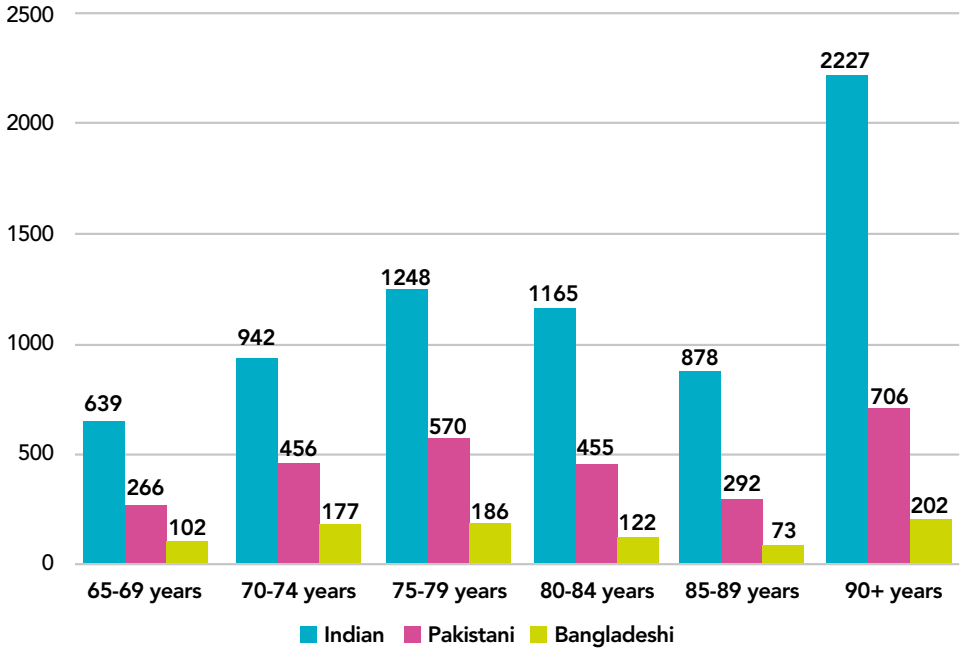
In England and Wales, it is predicted[332] that by 2026 there will be over 1.3 million people from Black, Asian and Multi-Ethnic groups aged 65+ (compared to over half a million in 2001); in 2026 almost half a million people from Black, Asian and Multi-Ethnic groups will be aged 70+[333]. 5.8% of the Pakistani group are predicted to be over the age of 65 by 2026[334] (figure 40 and table 25).

Figure 39: Percentage of people aged 65+ from Bangladeshi, Indian and Pakistani ethnic groups, in England and Wales



Source: England and Wales 2011 Census[335]

Figure 40: Number of cases of people with late-onset dementia by ethnic-group and age based on consensus estimates of population prevalence



Source: Based on data from the Race Equality Report Dementia and end of life care for black, Asian and minority ethnic communities, original data source: Alzheimer's Society[336]

Table 25:Ageing of South Asian ethnic groups in England and Wales (2026 estimates)

Ethnicity	Population (% of total)	% aged 65+
Indian	2,199,270 (3.6)	10.60%
Pakistani	1,701,099 (2.8)	5.80%
Bangladeshi	756,559 (1.2)	4.20%
Indian	91	0%

Source: Adapted from Lievesley (2010). Table 14. Ethnic Minority population projections to 2051. Chart 34. Age structure of ethnic minority groups, England and Wales, 2016. Chart 36. Age structure of ethnic minority groups, England and Wales, 2026. In: The future ageing of the minority ethnic population of England and Wales. Older BME People and Financial Inclusion Report.

2.8. Closing the Gaps

LIFE EXPECTANCY 82.3 84.8

Closing the gaps key findings:

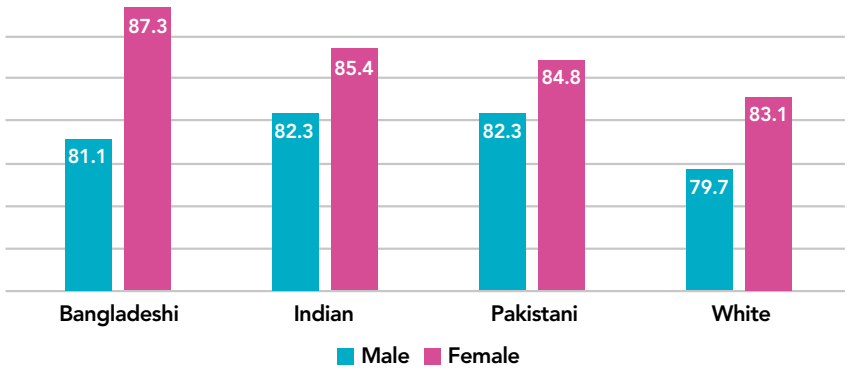
Life expectancy

- Life expectancy is similar across British South Asian communities.
- Life expectancy of Pakistani women is 84.8 which is slightly less than the Indian women (85.4), but less than Bangladeshi women (87.3).
- Life expectancy of Pakistani men is 82.3 which is same as Indian men, but slightly more than Bangladeshi men (81.1).

2.8.1. Life expectancy

Life expectancy is similar across British South Asian communities. The life expectancy of Pakistani women is 84.8 which is slightly less than that of Indian woman (85.4), but less than Bangladeshi women (87.3). The life expectancy of Pakistani men is 82.3 which is the same as Indian men, but slightly more than Bangladeshi men (81.1).

Figure 41: Life expectancy at birth by sex and ethnic group: England and Wales 2011 to 2014



Source: ONS[337]

2.9. Contributing to a Green & Sustainable Future

Contributing to a Green & Sustainable Future key finding:

- The largest populations of Pakistanis in Birmingham are found in Alum Rock, Sparkhill, Small heath, Ward End and Heartlands - wards with some of the highest mean value according to the environmental justice map.

The Environmental Justice map[338] combines 5 indicators, namely, the index of Years of Life Lost (YLL), Urban Heat Island effect (UHI), the Indices of Multiple Deprivation (IMD), Public green spaces access and Flood Risk. The indicators are combined and scaled in a range of 0-1, with 0 being the most preferred and 1 being the least.

The largest populations of Pakistanis in Birmingham are found in Alum Rock, Sparkhill, Small heath, Ward End and Heartlands; these wards have some of the highest mean value on the environmental justice map (listed in table 26).

Table 26: Birmingham City Council's Environmental Justice Map

Ward	Index – mean value	Pakistani population (%)
Alum Rock	0.39	58.6
Sparkhill	0.35	56.9
Small Heath	0.34	53
Ward End	0.38	51
Heartlands	0.39	46.3
Sparkbrook & Balsall Heath East	0.39	46.3
Bordesley Green	0.39	41.1
Aston	0.42	30.9
Lozells	0.40	30.8
Hall Green North	0.30	28.1

Source: Birmingham City Council[339]

2.10. Mitigating the legacy of COVID-19

Mitigating the legacy of COVID-19 key findings:

- Research has found the Pakistani community has been disproportionately impacted by COVID-19, with poorer areas in England experiencing higher risk of infection; many of these areas have a high proportion of Pakistanis.
- Pakistani hospital fatalities were 2.9 times those of the white British group. The fact the Pakistanis have much higher rates of diabetes and cardiovascular disease is likely to also be relevant.

Research has found the Pakistani community has been disproportionately impacted by COVID-19, with poorer areas in England experiencing higher risk of infection; many of these areas have a high proportion of Pakistanis[340]. Pakistani hospital fatalities were 2.9 times those of the white British group[341]. The fact the Pakistanis have much higher rates of diabetes and cardiovascular disease is likely to also be relevant[342].

While researchers found that deprivation played a bigger role in COVID-19 incidence in the first wave of the pandemic, until October 2020, ethnicity played a larger part in the second wave from December 2020 until January 2021 and again from May until June 2021[343]. According to the British Medical Association (BMA)[344], 21% of all healthcare staff are BAME (Black and Minority Ethnic) but 63% of healthcare workers who have so far died from COVID-19 were also BAME.

Research findings suggest that the disproportionate impact of COVID-19 on Black and Asian communities is mainly attributable to increased risk of infection in these communities. Some of the explanations for the increased risk include greater likelihood of living in larger household sizes comprised of multiple generations; having lower socioeconomic status, which may increase the likelihood of living in overcrowded households; and being employed in frontline roles where working from home is not an option – all of which are true for the Pakistani community[345].

In addition, the ONS has found In April 2020 in the UK, 13% of Pakistani or Bangladeshi ethnic groups reported finding it very or quite difficult to get by financially; this was significantly higher than the Indian (8%) ethnic group[346]. It also found in April 2020, respondents in the Pakistani or Bangladeshi ethnic groups (35%) were less likely to report working from home for some of the time over the previous four weeks than several other ethnic groups[347].

3.0 Conclusion

This report has described the status of health and wellbeing and highlighted the inequalities experienced by the Pakistani community within the UK and Birmingham. These include higher rates of childhood poverty, childhood obesity, lower rates of physical activity (particularly in women) and greater prevalence of diabetes and cardiovascular disease.

This Community Health Profile aims to support the council, communities and partners to better understand health and wellbeing and health inequalities affecting the Pakistani community. The multiple factors that have been identified by the report can inform the design and implementation of work to address inequalities and improve health and wellbeing across the city.

4.0 Appendices

Appendix 1: Inclusion and exclusion criteria

Getting the best start in life	Mental wellness and balance	Healthy and affordable food	Active at every age and ability	Working and learning well
General: "Pakistani" and "children" or "young people" or "youth" or "child" or "babies" or "childhood" **Specific**: "Pakistani" and "vaccination" or "measles" or "obesity" or "health check" or "maternity care" or "breast feeding" or home visits" or "rituals" or "vaccine" or pertussis vaccine" or "belonging" or "bullying" or "fostering" or "care"	**General**: "Pakistani" and "mental health" or "mental" or "health" or "wellbeing" or wellness" or "access" or "balance" **Specific**: "Pakistani" and "mental illness" or "depression" or "suicide" or "shame" or "stigma" or "stress" or "racial harassment" or "honour" or "disability" or "alcohol" or "drinking" or "abstention" or "drinking frequency" or "drinking intensity" or "alcohol problem" or "alcohol support" or "alcohol consumption" or "substance abuse" or "addiction" or "tobacco" or "cannabis" or "recreational drugs" or "drugs" or "smoking" or drug use"	**General**: "Pakistani" and "food" or "diet" or "obesity" or "meat" or "vegetarian" **Specific**: "Pakistani" and "common food" or "festival food" or "dietary laws" or "food practices" or "traditional food" or "obesity" or "physical activity" or "overweight" or "BMI" or "weight" "Waist Height Ratio"	**General**: "Pakistani" and "physical activity" or "activity" or "exercise" **Specific**: "Pakistani" and "vigorous exercise" or "moderate exercise" or "walking" or "running" or "sports" or "cardiovascular" or "elderly exercise" or "health promotion"	**General**: "Pakistani" and "working" or "education" or "housing" or "living" or "economic activity" or "general health" or "health" or "illness" or "disability" or "long term disability" or "long standing health" **Specific**: "Pakistani" and "apprenticeships" or "Level 1,2,3,4 qualifications" or "degree" or "NEET" or "secondary school" or "primary school" or "full time education" or "profession" or "career choice" or "household income" or "home ownership" or "Bad health" or "learning disability" or "hearing impairment" or "communication impairment"

Appendix 2: Data tables for figures

Figure 1: Pakistan – Ethnic Composition

Ethnicity	Total percentage
Punjabi	52.6%
Pashtun	13.2%
Sindhi	11.7%
Urdu-speaking	7.5%
Balochi	4.3%
Other	10.7%

Figure 2: Pakistani ethnic group, by area in the UK

Area	Total percentage
Yorkshire and The Humber	20.1%
West Midlands	20.2%
Wales	1.1%
South West	1%
Sound East	8.8%
North West	16.8%
North East	1.8%
London	19,9%
East Midlands	4.4.%
East	5.9%

Figure 3: Minority religious groups, England and Wales 2011

Religious Group	Total Percentage
Other Religion	0.4%
Buddhist	0.4%
Jewish	0.5%
Sikh	0.8%
Hindu	1.5%
Muslim	4.8%

Figure 4: Religious affiliation (%), English regions and Wales 2011

Region	No Religion	Christian	Muslim	Other	Not stated
North East	23.4%	67.5%	1.8%	1.2%	6.1%
North West	19.8%	67.3%	5.1%	1.7%	6.2%
Yorkshire and the Humber	25.9%	59.5%	6.2%	1.6%	6.8%
East Midlands	27.5%	58.8%	3.1%	3.7%	6.8%
West Midlands	22%	60.2%	6.7%	4.5%	6.6%
East of England	27.9%	59.7%	2.5%	2.6%	7.3%
London	20.7%	48.4%	12.4%	10%	8.5%
South East	27.7%	59.8%	2.3%	2.9%	7.4%
South West	29.3%	60.4%	1%	1.5%	7.9%
Wales	32.1%	57.6%	1.5%	1.2%	7.6%

Figure 5: Main languages spoken by British Pakistanis

Language	Total
English (English or Welsh if in Wales)	646,175
Pashto	16,774
Urdu	237,403
Punjabi	105,177
Pahari (with Mirpuri and Potwari)	18,173

Figure 6: Top ten main 'Other' languages in England and Wales, 2011

'Other' Languages	Total
Spanish	120,000
Portuguese	133,000
All Other Chinese	141,000
French	147,000
Arabic	159,000
Gujarati	213,000
Bengali (with Syllheti and Chatgaya)	221,000
Urdu	269,000
Panjabi	273,000
Polish	546,000

Figure 7: Country of birth for Pakistanis in Birmingham

Country	Total
The Americas and the Caribbean	93
Antarctica and Oceania (including Australasia)	6
Middle East and Asia	53,191
Africa	637
Europe- United Kingdom	89,981
Other Europe	677
Ireland	42

Figure 8: National identity by ethnic group for Pakistanis in Birmingham (n=144,627)

National Identity	Total
British Only Identity	99,095
English Only Identity	22,892
Other Identity and at least one UK Identity	2,400
Irish and at least one UK Identity	2
Other Identity only	14,730
Irish only Identity	24
Northern Irish and British only Identity	3
Any other combination of UK Identities	90
Northern Irish Only Identity	19
Scottish and British only Identity	10
Scottish only Identity	42
Welsh and British only Identity	5
Welsh Only Identity	18

Figure 10: Arrivals from Pakistan to the West Midlands, by gender

Date	Male	Female
Before 1981	15,521	13,589
1981-1990	4,958	8,6112
1991-2000	8,979	9,216
2001-2003	3,944	3,787
2004-2006	4,472	4,435
2007-2009	3,903	3,710
2010-2011	1,999	1,511

Figure 11: Age profile in percentage (%) of Pakistani and White British people in Birmingham

Age	Pakistani	White- British
0-4	11.79	5.3
5-7	7.10	2.9
8-9	4.60	1.9
10-14	10.40	5.3
15	1.80	1.2
16-17	3.70	2.4
18-19	3.40	3.3
20-24	8.30	8.4
25-29	9.40	6.7
30-34	9.60	5.9
35-29	7.70	6
40-44	6.30	6.9
45-49	3.50	7.3
50-54	3.20	6.5
55-49	2.90	6
60-64	1.60	6
65-69	1.10	4.9
70-74	1.30	4
75-79	1.10	3.4
80-84	0.70	2.8
85 and over	0.40	2.8

Figure 12: Population pyramid image: Age profile of population born in Pakistan, by gender within West Midlands, with age profile of West Midlands as comparator

Age	Males: West Midlands: Pakistani	Females: West Midlands: Pakistani	Male: West Midlands: United Kingdom	Females: West Midlands: United Kingdom
0 to 4	1%	1%	7.25%	6.73%
5 to 9	2%	1%	6.49%	6.03%
10 to 15	3%	2%	8%	7.44%
16 to 19	2%	2%	5.69%	5.32%
20 to 24	6%	6%	5.32%	6%
25 to 29	10%	11%	6.1%	5.80%
30 to 34	14%	14%	6%	6%
35 to 39	11%	13%	14%	8%
40 to 44	8%	11%	11%	9%
45 to 49	8%	8%	8%	10%
50 to 54	8%	8%	6.26%	11%
55 to 59	3%	7%	6.18%	5.55%
60 to 64	2%	5%	5.14%	6.08%
65 to 69	3%	3%	3.92%	5.16%
70 to 74	3%	3%	2.98%	4.18%
75 to 79	2%	3%	3.48%	3.50%
80 or over	2%	3%	3.48%	5.92%

Figure 13: Infant mortality rate by ethnicity of the baby and cause of death, England and Wales, 2017, 2018 and 2019 combined; infant mortality per 1,000 live births (rate)

Ethnicity	Immaturity Related Conditions	Congenital Anomalies	Other
White British	1.3	0.9	0/9
Indian	2.2	1.3	1.0
Bangladeshi	1.8	2.3	1.0
Pakistani	2.0	3.4	1.3

Figure 14: Age profile of under 18s within Birmingham's Pakistani ethnic group, compared to the general under 18 population of Birmingham; shown in percentage % (clustered bar format)

Age Range	Pakistani Children Living in Birmingham (%)	All Children Living in Birmingham (%)
16-17	4	3
15	2	1
10-14	10	7
8-9	5	3
5-7	7	4
0-4	12	8

Figure 15 and 16: Obesity and Severe obesity prevalence by ethnic group from the National Child Measurement Programme 2019/20; Children in reception (aged 4-5 years) & Children in Year 6 (aged 10-11 years)

Ethnic Group	Obese 4-5 year olds (%)	Severely Obese 4-5 year olds (%)	Obese 10-11 year olds (%)	Severely Obese 10-11 year olds (%)
Bangladeshi	12.6	4.5	30.1	6.7
Pakistani	10.8	3.5	26.2	6.3
Indian	7.2	2.2	21.6	4.2
White British	9.7	2.3	19	4

Figure 17: Percentage of children living in households in low income, by ethnicity, UK, three-year average, FYE 2016 to FYE 2018

Ethnic Group	Children Living in Low Income Households (%)
Pakistani	47
Bangladeshi	41
White British	17
Indian	17
National Average	20

Figure 18: Percentage of children in households in low income, by ethnicity (Pakistani and White British), UK, three-year average, FYE 2012 to FYE 2018

Year	Pakistani	White British
2008/9 to 2011/12	47	16
2012/13 to 2014/16	40	16
2016/17 to 2017/18	47	17

Figure 19: Percent of ethnic group populations living in the 10% of most deprived neighbourhoods, England, 2019 (%)

Ethnic Group	Percentage living in the 10% of most deprived neighbourhoods
Bangladeshi	19.3
Indian	7.6
Pakistani	31.1
White British	9.1

Figure 20: Progress 8 score, by ethnicity, England, academic year 2018 to 2019

Ethnic Group	Progress 8 Score
Indian	0.71
Bangladeshi	0.47
Pakistani	0.24
White British	-0.14
National Average	-0.03

Figure 21: Number of detentions under the Mental Health Act per 100,000 people, by specific ethnic group (standardised rates), England. 2017-20

Year	Bangladeshi	Indian	Pakistani	White British
2017/18	129.7	55.7	112.6	69.0
2018/19	141.7	70.9	117.6	70.1
2019/20	136.1	71.9	121.1	70.5

Figure 22: Number of adults per 100,000 using NHS mental health, learning disability and autism services by ethnicity, England. 2019 to 2020

Year	Bangladeshi	Indian	Pakistani	White British
2017/18	3887	2369	3825	3709
2018/19	4234	2544	4268	4013
2019/20	4668	2702	4459	4166

Figure 23: Body mass index, waist-to-hip ratio and waist circumference by ethnic group, men, 2004, England

Ethnic Group	Obese men (%)	Men with a Waist to Hip ratio of 0.95 and over (%)	Men with a waist circumference of 102cm and over (%)
Indian	14	38	20
Pakistani	15	36	30
Bangladeshi	6	32	12
Male Population	23	33	31

Figure 24: Body mass index, waist-to-hip ratio and waist circumference by ethnic group, women, 2004, England

Ethnic Group	Obese women (%)	Women with a Waist to Hip ratio of 0.95 and over (%)	Women with a waist circumference of 102cm and over (%)
Indian	20	30	38
Pakistani	28	39	48
Bangladeshi	17	50	43
Female Population	23	30	41

Figure 25: Adults 16+: Active (at least 150 mins per week)

Ethnicity	Women (%)	Men (%)
Pakistani	40.8	55.6
Bangladeshi	45.7	53.0
Indian	52.3	61.3
Other Asian Background	53.8	56.5
Black African	54.8	62.6
Black Caribbean	58.2	58.3
Chinese	58.7	62.0
White British	60.9	65.3
Other White	65.1	67.0
Mixed	71.1	72.5

Figure 26: Adults 16+ by religion: Active (at least 150 mins per week)

Religion	Physically Active >150 mins/week (%)
Muslim	50.7
Hindu	55.4
Sikh	58.6
Any other religion	61.5
Jewish	62.4
Christian	63.0
Buddhist	66.5
No religion	71.8

Figure 27: Percentage of South Asian pupils achieving a grade 5 or above in English

Ethnicity	Grade 5 or above (%)
Pakistani	50.3
Indian	72.4
Bangladeshi	60.6

Figure 28: Percentage of South Asian pupils achieving a grade 5 or above in English and maths GCSE by gender, 2020-21

Ethnicity	Grade 5 or above: Boys (%)	Grade 5 or above: Girls (%)
Bangladeshi	58.1	63.1
Indian	68.4	76.7
Pakistani	46.8	54.0

Figure 29: Percentage of South Asian pupils getting a grade 5 or above in English and maths GCSE by eligibility for free school meals, 2020-21

Ethnicity	Grade 5 or above: Free School Meals (%)	Grade 5 or above: No Free School Meals (%)
Bangladeshi	52	64.4
Indian	52.7	74.2
Pakistani	39.4	53.8

Figure 30: 5+ GCSEs A*-C including English and Maths by ethnicity, gender and free school meals eligibility Birmingham schools, 2013 (B= boy; G= girl)

Table A: 5+ GCSEs A*-C including English and Maths by ethnicity, gender and free-school meals (percentage %)

Ethnicity	Males (%)	Females (%)
Bangladeshi	63	65
Pakistani	46	55
Indian	-	-
White British	31	45

Table B: 5+ GCSEs A*-C including English and Maths by ethnicity, gender and non-free-school meals (percentage %)

Ethnicity	Males (%)	Females (%)
Bangladeshi	-	-
Pakistani	54	63
Indian	71	86
White British	-	72

Figure 31: Percentage of people aged 16+ who cannot speak English well or at all in England by ethnicity, 2011 Census

Gender	Bangladeshi (%)	Indian (%)	Pakistani (%)	White and Mixed (%)
Men	14	5	14	1
Women	30	12	22	1
Total	22	8	19	1

Figure 32: Percentage of households that rented social housing, by select ethnicities

Ethnic Group	Rented Social Housing (%)
Bangladeshi	33
Indian	7
Pakistani	13
White British	16

Figure 33: Percentage of households that were overcrowded, by ethnicity April 2016-March 2019, England

Ethnic Group	Overcrowded Houses (%)
Bangladeshi	24
Indian	7
Pakistani	18
White British	2

Figure 34: COVID-19 vaccination rates of adults aged 50 years and over, by self-reported ethnic group, 8 December 2020 to 12 April 2021, England (percentage %)

Ethnic Group	COVID-19 Vaccination Uptake (%)
Bangladeshi	86.8
Indian	90.9
Pakistani	78.4
White British	93.7

Figure 35: Willingness to be vaccinated in the UK Household Longitudinal Study by ethnic group

Vaccine Acceptance	Pakistani or Bangladeshi (%)	Indian (%)	White British (%)
Likely/very likely to get vaccinated	57.7	79.4	84.4
Unlikely/very unlikely to get vaccinated	42.3	20.6	15.6

Figure 36: Percentage of 16 to 74 year olds who reported being victims of domestic abuse in the previous 12 months, by ethnicity over time

Year	Bangladeshi	Indian	Pakistani	White British
2017/18	0	4.2	4.3	5.6
2018/19	1.1	4.0	4.5	5.9
2019/20	1.4	4.9	3.5	5.9

Figure 37: Deaths registered in England and Wales, 2017-19, age-standardised mortality rates per 100,000 for the most common leading causes of death for each ethnic group, males aged 10 years and above

Cause of Death	Bangladeshi	Indian	Pakistani	White
Ischaemic Heart disease	219.1	190.9	206.7	157.9
Dementia and Alzheimer's disease	97.6	76.9	66.4	121.6
Chronic Lower Respiratory diseases	76.3	35.2	41.7	73.8
Malignant Neoplasm of Trachea Bronchus and Lung	80.6	29.1	44.9	70.9
Influenza and Pneumonia	42.7	62.4	54.1	64.7
Cerebrovascular diseases	112.6	69.7	70.4	62.3

Figure 38: Deaths registered in England and Wales, 2017-19, age-standardised mortality rates per 100,000 for the most common leading causes of death for each ethnic group, females aged 10 years and above

Cause of Death	Bangladeshi	Indian	Pakistani	White
Ischaemic Heart disease	114.8	99.3	109.6	70.5
Dementia and Alzheimer's disease	74.4	84.3	82.3	142.0
Chronic Lower Respiratory diseases	23.3	22.5	32.8	58.1
Malignant Neoplasm of Trachea Bronchus and Lung	18.1	11.7	12.4	52.3
Influenza and Pneumonia	33.1	51.4	56.4	49.5
Cerebrovascular diseases	80.4	53.4	57.1	58.2
Diabetes	30.9	18.9	28.9	9.8

Figure 39: Percentage of people aged 65+ from Bangladeshi, Indian and Pakistani

Age Group	Bangladeshi	Indian	Pakistani
65-69	1	2.6	1.3
70-74	1.4	2.4	1.4
75-79	0.8	1.7	1
80-84	0.4	0.9	0.5
85+	0.2	0.6	0.2

Figure 40: Number of cases of people with late-onset dementia by ethnic-group and age based on consensus estimates of population prevalence

Age Range	Indian	Pakistani	Bangladeshi
65-69	639	266	102
70-74	942	456	177
75-79	1248	570	186
80-84	1165	455	122
85-89	878	292	73
90+	2227	706	202

Figure 41: Life expectancy at birth by sex and ethnic group: England and Wales 2011 to 2014

Gender	Bangladeshi	Indian	Pakistani	White
Male	81.1	82.3	82.3	79.7
Female	87.3	85.4	84.8	83.1

5.0 Acknowledgements

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