SOMALI COMMUNITY HEALTH PROFILE 2022

A BOLDER HEALTHIER BIRMINGHAM

Foreword

The Somali Community Health Profile was commissioned by Birmingham City Council to review the evidence on the Somali community in Birmingham and nationally. The report synthesises evidence on the experiences, needs and outcomes of the Somali 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 Somali 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 Somali communities at a local and national level.

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

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

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

Executive summary

Evidence has been building for many years of health inequalities between ethnic minority and white groups, and between different ethnic minority groups across the UK. This community profile aims to unpack some of these issues in Birmingham, with a focus on the Somali community.

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

Much of the data for examining health outcomes in this profile has been taken from open-source research and health records. It is worth noting that the sample sizes, coverage and quality for some studies are imperfect. Also, data on the Somali community is limited as 'Somali' is rarely recognised as a distinct ethnic category in research and analysis. As a result, our understanding of the nature and extent of the community's needs, particularly how it compares and contrasts with other minority ethnic groups and the White-British population, is incomplete.

Located in the Horn of Africa, Somalia is a Muslim-majority country and home to almost 16 million people. Conflict and violence as well as sudden onset of disasters and food insecurity have driven displacement at a mass scale in Somalia. As a result, the Somali community in the UK, and more broadly in North America and Europe, have migrated either directly from Somalia or from other countries, migrating twice or thrice due to instabilities back home in search of security and opportunities.

The most prominent wave of migration from Somalia to the UK has been from 1991 to the 2000s. Since 2000, the UK has attracted Somalis from across Europe. Between 1985 and 2006, Somalia was consistently one of the top ten asylum applicant-producing countries in the UK.

According to the 2011 Census, around 93% of Somali-born residents in England and Wales are Muslim, and 1.4% Christian. Considering more than 99% of the population in Somalia is Muslim, it is likely a greater proportion of Somalis in the UK are Muslims. It is worth noting, 5% of Somali-born residents have not stated their religion, and it is likely most within this category are of the Muslim faith.

Anecdotal evidence estimates roughly 250k-400k Somalis living in the UK. According to the 2011 Census, there are 9,870 Somali-born people across the West Midlands (0.2%), and 7,765 specifically in Birmingham (0.7%). The Somali community is the largest African diaspora within Birmingham and has a highly young age profile compared to the overall age profile of the West Midlands. According to the 2011 Census, 58.8% of the females and 67% of the males within the Somali ethnic group in Birmingham were aged between 0-19 years.

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

The key health inequalities and points identified within the Somali profile are:

- Children born to women born in Somalia accounted for 0.69 of live births in Birmingham, but 3.10% of all stillbirths in the city.
- More than 8 out of 10 childhood live in a poor household.
- 97% of Somalis eat less than 2 portions of fruit or vegetables per day.
- Khat use is a major issue of substance misuse amongst the Somali community, with around 77% Somalis being a regular khat user.
- Somali women felt that they were more active before they migrated to the UK.
- Statistics in America reveal that Somalis have higher rates of diabetes compared to the general population of America.
- Somalis have one of the lowest employment rates in the country, with only 1 in 10 in full-time employment.
- One of the highest rates of tuberculosis are found in the Somali community (3% of all cases in the UK).
- Overall, the Somali community across the UK experience high levels of poverty, with most living in overcrowded housing, high proportions of economically inactivity, experiencing high levels of unemployment, along with many managing health issues like PTSD.

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 Somali 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 section. 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, so 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 Somali community-level information was available.

National voluntary and community sector reports:

These have been identified through Google Scholar and national websites, specifically where relevant Somali 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 "Somali" as well as words that were specific to the topic theme. Examples of this are included in the search strategy (Appendix 1).

c. Grey Literature

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

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

In addition, "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.

108,000

Somalis in the UK. Anecdotal evidence suggests roughly 250k-400k Somalis live in the UK

THIS IS THE LARGEST SOMALI POPULATION IN EUROPE

UK's Somali community has seen a year-on-year increase

108,000 — 2018

101,370* — 2011

43,515 — 2001

5% of the Somali population living abroad currently live in the UK which accounts for almost **40%** OF THE SOMALI POPULATION IN EUROPE

LOCAL SOMALI POPULATION

Based on data from the 2011 Census

9,870 SOMALI-BORN PEOPLE ACROSS THE WEST MIDLANDS

7,765 SOMALI-BORN PEOPLE ACROSS BIRMINGHAM

16 MILLION

CURRENT POPULATION ESTIMATES FOR SOMALIA

INTERNATIONAL CONTEXT

Conflict and violence as well as sudden-onset of disasters and food insecurity have often displacement at a mass scale in Somalia. The UNHCR estimates there to be around 3 million internally displaced people (IDPs) in the country

1.0 Introduction

1.1 International context

1.1.1 History, migration and displacement

Located in the Horn of Africa, Somalia is a Muslim-majority country[1] and home to almost 16 million people[2]. Conflict and violence as well as natural disasters and food insecurity have driven displacement at a mass scale in Somalia. The search for a secure home and life chances has led to a Somali community in the UK who have migrated either directly from Somalia or via other countries, a feature in common with Somali migrants in North America and Europe.

The conflicts faced by the country have been both internal and external, with intermittent conflicts with neighbouring countries and managing clan-based territorial divisions internally. Following the civil war in 1988, there has been a failure to establish long-lasting stable governments, leading to a politically fragile state which has given way to clan leaders and 'warlords' gaining control over specific territories.

Somalia has also faced numerous environmental challenges. These have included droughts, resulting in mass famine and starvation. It is estimated the famine from 2010 to 2012 cost the lives of around 260,000 people[3], more than the famine in 1992 which killed roughly 220,000 people[4]. Such natural disasters have driven out-migration to neighbouring countries such as Kenya, Ethiopia, Yemen and Djibouti in Africa, and to Europe and the USA. Almost two-thirds of the global Somali diaspora live in neighbouring countries, with Kenya hosting the largest number (488,470), followed by Ethiopia (442,910), see table 1.

According to the UN's figures, the UK accounts for 5.5% of the Somali population abroad and almost 40% of the Somali population in Europe (see table 1). Between 1990 and 2015, the total number of people born in Somalia but living outside the country more than doubled, from about 850,000 to 2 million[5].

Migration to Europe has seen significant numbers. The UN's data of "total migrant stock" estimates that in 2015 approximately 2 million people from Somalia were living outside of the country's borders[67].

Table 1: Somali diaspora communities around the world, December 2015

Country	Population
TOTAL	1,998,764
Africa	1,276,600
Kenya	488,470
Ethiopia	442,910
Libya	104,539
Djibouti	93,042
South Africa	69,688
Asia	262,944
Yemen*	245,683
Europe	279,948
United Kingdom of Great Britain and Northern Ireland	110,775
Sweden	59,213
Norway	27,042
Netherlands	27,115
Germany	7,359
Northern America	170,326
United States of America	145,579
Canada	24,747

**categorised as Western Asia*

Source: UN: Population Division - Trends in International Migrant Stock; Migrants by Destination and Origin, table 16[8]

The UNHCR estimates there to be around 3 million internally displaced people (IDPs) in Somalia[9].

The UN Refugees Agency (UNHCR) estimates that cyclones and floods in 2020 displaced more than 1.3 million Somalis, outnumbering those displaced by drought or conflict[10].

1.1.2 Languages in Somalia

The official languages of Somalia are Somali, which is understood across the country, and Arabic. A small minority also speak Chiwmini, which has also been identified in the UK.

In 1973, Somalia adopted an official orthography based on the Latin alphabet. Prior to this Somali had been an unwritten language[11].

Arabic is also a prominent language in the country - it is the second official language spoken mainly in northern Somalia[12]. Swahili is spoken in the southern part of the country[13].

1.1.3 Tribalism

Somalia is made up of six major clan-families, underpinning the social organisation of the country. Of the six, four families are predominantly nomadic or seminomadic pastoralists, representing around 70% of Somalia's population: Dir, Daarood, Isaaq and Hawiye[14]. Two families are mainly crop farmers and represent approximately 20% of the population: Digil and Rahanwayn[15].

Clans and tribes are an important aspect of Somali culture, forming the foundations of the country's political system. It also provides a system of rights and social support, which continues to have an impact on the community in the UK, often acting as a pre-existing support network, with clan members feeling obliged to assist newly arrived migrants from their own clan[16].

According to qualitative research focusing on the Somali communities across the UK[17], the community feels successful settlement in the UK has resulted in a weakening of links and emphasis on clan affiliation in favour of identities based on local connections in the UK.

1.2 National context

1.2.1 Migration to the UK

Prompted by internal and external conflicts as well as natural disasters, the most prominent wave of migration from Somalia to the UK has been from 1991 to the 2000s. Since 2000, the UK has attracted Somalis from across Europe. Between 1985 and 2006, Somalia was consistently one of the top ten asylum applicant producing countries in the UK[18].

Migration from Somalia can be dated back to the late 19th century, when many Somalis arrived as seaman in the British Merchant Navy, majority settling in port cities like Cardiff, Liverpool and the East London docks[19].

In the 1940s, with demand for labour in the UK's steel industry, Sheffield and South Yorkshire became popular places for the Somali community to settle[20]. There have been further waves of Somali migration since Somalia's independence in 1960.

1.2.2 Demographics

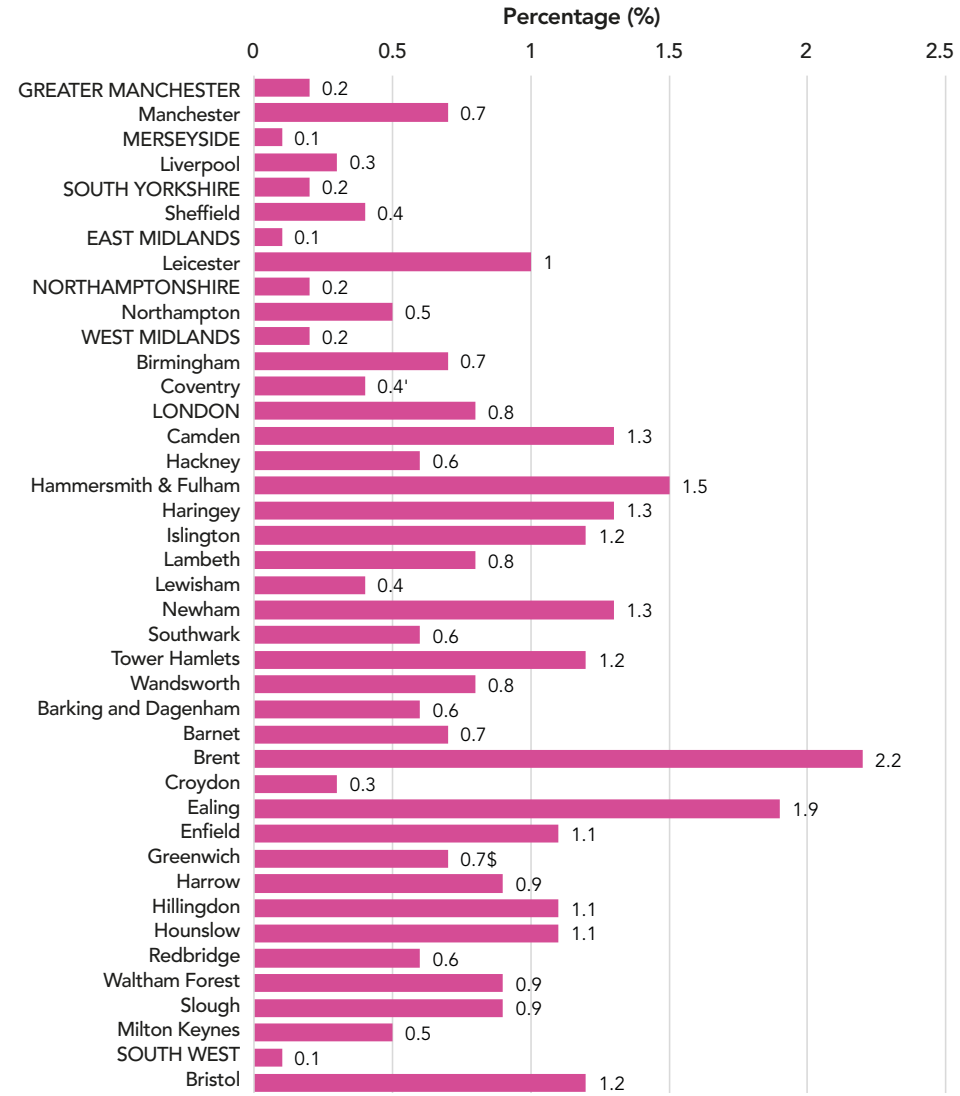
The UK is home to the largest Somali population in Europe. According to the 2018 ONS data[21], there are around 108,000 Somalis in the UK; females account for 60% of this figure.

The Census also shows there are 1,886 (0.1%) Somalis in Wales[22]. Research from the United Nations Development Programme (UNDP)[23] indicates that the community is one of the largest refugee communities in the UK. The community has seen a year-on-year increase; while in 2001 43,515 Somali people were living in Britain (0.08% of the UK population born in Somalia)[24], this increased to 101,370[25] in 2011 (0.2% in England & Wales).

The Somali community is settled in various cities across the UK; areas with the greatest proportion of the community are in London (65,333, 0.8% specifically Brent 6,855; 2.2% and Ealing 6,468;1.9%) and South West (5,218; 0.1%; specifically, in Bristol 4,947; 1.2%).

Research from the UNDP has found[26] that the city of Leicester – a major city with more than 355,000 citizens[27] - has gained a sizeable Somali community over the last decade, majority of whom are Dutch, Danish and Swedish passport holders. Estimates of the Somali-born population are complicated as anecdotal evidence from the community indicates the number of Somalis in the country may be a lot greater than that recorded by the government; based on anecdotal evidence, an estimated 250k-400k[28] Somalis live in the UK.

Figure 1: Proportion of Somali-born people, by local authority in UK



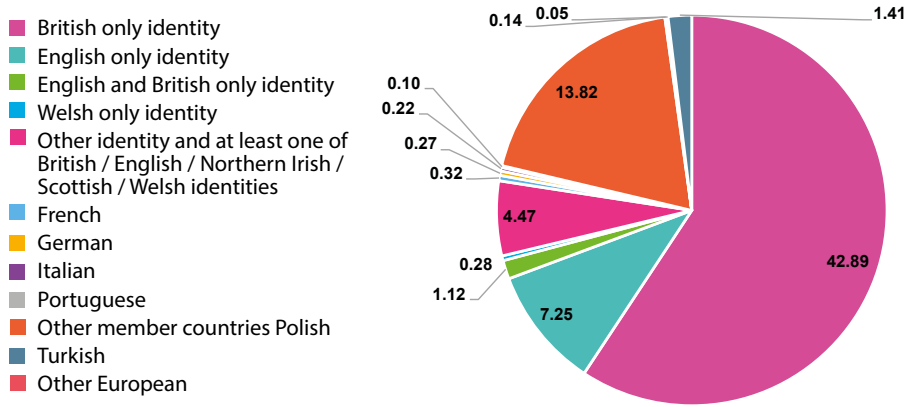
Source: 2011 Census, Table QS203EW

1.2.3 National identity

ONS data based on write-in responses from the community indicates 59% of Somalis in the UK identify as 'British' (within the category covering UK and European national identities. Within the category of 'other' identities which includes Africa, the Middle East and Asia, the 'Somali' national identity accounts for the overwhelming majority (89%).

Figure 2: National identity for all residents with Somali ethnic group, England and Wales; in percentage (%)

Somali ethnic group (write-in response) contains codes: 1330 White Somali; 2330 Mixed Somali; 3330 Asian Somali; 4330 Black Somali; 5330 Other Somali.



Source: 2011 Census: CT0781 - National identity[29]

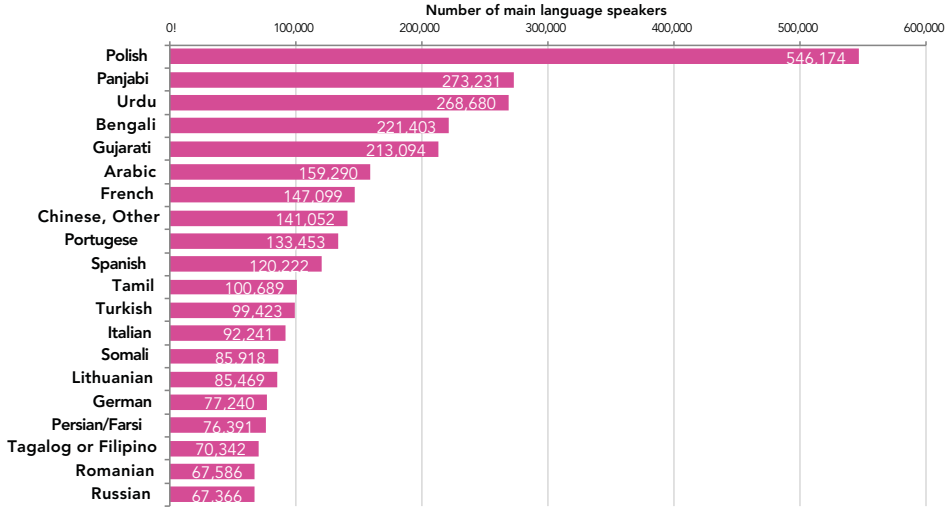
1.2.4 Languages

According to the 2011 Census, of the twenty largest non-English languages, Somali is the 14th largest language spoken in England and Wales[30]. There are more than 85,918 Somali-speakers across England; it makes up 0.16% as a percentage of the population and 2.07% of non-English languages.

The official languages of Somalia are Somali and Arabic, which mirrors the language preferences of the Somali community in the UK, majority of whom speak Somali.

The 2011 UK Census recorded 85,918 people living in England and Wales who spoke Somali as their main language, which represented 0.16% of the population, and 2.06% of speakers of non-English main languages[31].

Figure 3: 20 largest non-English main languages by number of speakers in England and Wales



Source: 2011 Census[32]

According to a report[33], many UK Somalis have limited knowledge of the English language, especially women. It is also worth noting that there is a lack of literacy in the Somali language among many adult members of the community as a result of missing out on schooling. This is largely due to conflicts and natural disasters causing Somalis to migrate during the post-independence years[34].

Somalis who arrived as refugees since the 1990s have shown lower rates of English literacy than other migrant groups. A study[35] has found UK Somali migrants have literacy rates of 41% in English and 75% in Somali. To note, the literacy rate among male youth in Somalia is around 16%, one of the lowest in the world[36].

1.2.5 Religion

The majority of Somalis in the UK and elsewhere are Muslims, with most being part of the Sunni sect[37].

According to the 2011 Census[38], around 93% of Somali-born residents in England and Wales are Muslim, and 1.4% Christian. Considering more than 99% of the population in Somalia is Muslim[39], it is likely a greater proportion of Somalis in the UK are Muslims. It is worth noting, 5% of Somali-born residents have not stated their religion, and it is likely most within this category are of the Muslim faith.

Mosques are the primary centres for religious and social gatherings, and also play an important role in sharing information within the community[40].

In the UK Somalis usually attend mosques established by the more established Muslim communities from South Asian and Arab countries, though there are now a small number of mosques operated by Somalis in the UK such as the Arrahma Islamic Centre in Small Heath, Birmingham.

1.2.6 Festivals

As followers of the Muslim faith, Somalis celebrate Eid which is a religious holiday.

There are two Eid festivals in a year: Ramadan ends with three days of festivities called Eid al-Fitr; Eid-ul-Adha also three days of festivities and comes at the end of the annual pilgrimage of the Hajj.

1.2.7 Sport

There are several prominent sports people of Somali heritage. In the UK, the most prominent Somali athlete is British long-distance runner, Mo Farah.

Sports and athletics are popular within the community. Prominence of role models within the sports sector has helped deepen this interest within the community. Other prominent sportspeople include Abdisalam Ibrahim, a Norwegian-Somali footballer who transferred to Manchester City in 2007.

1.2.8 Somali cuisine

Somali cuisine derives from culinary traditions of the Horn of Africa; it shares many traditional dishes from Eritrean and Ethiopian cuisine, such as stews served with flatbread injera (made of teff grain).

Teff grain is highly nutritious, with high iron, protein and calcium content. It is also gluten-free and has a mild flavour[41].

Somali food also has influences from Italian cuisine due to its colonial history. Some notable Somali delicacies include Kimis/ Sabaayad, Canjeero/Lahoh, Xalwo (Halva), Sambuusa (Samosa), Bariis Iskukaris, and Muqmad/ Odkac[42]. As followers of the Islamic faith, Somalis do not consume pork.

1.3 Birmingham context

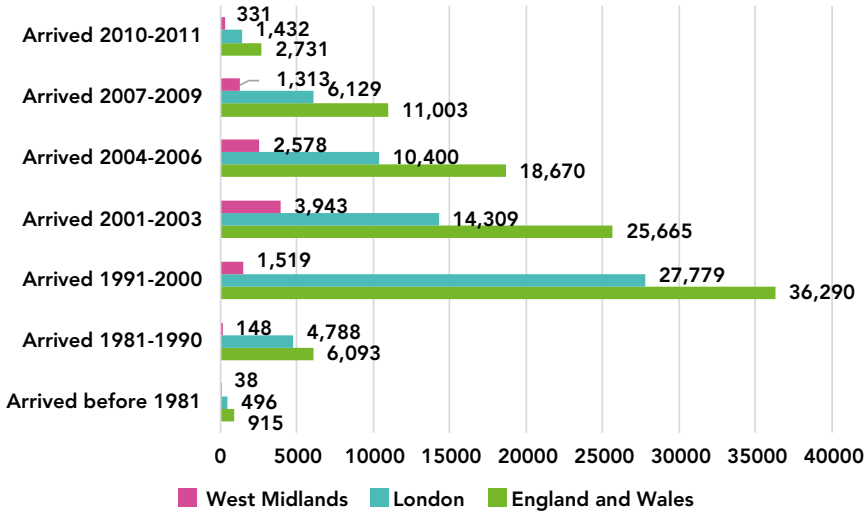
1.3.1 Migration to the West Midlands and Birmingham

While historically Somali migrants' part of the initial waves settled in port cities, others moved to work in heavy industry cities such as Birmingham[43].

As shown in figure 4, the most prominent wave of migration from Somalia to the West Midlands was from 2001 to 2003. This can be compared to England and Wales where the greatest migration wave from Somalia occurred in the decade earlier, from 1991 to 2000.

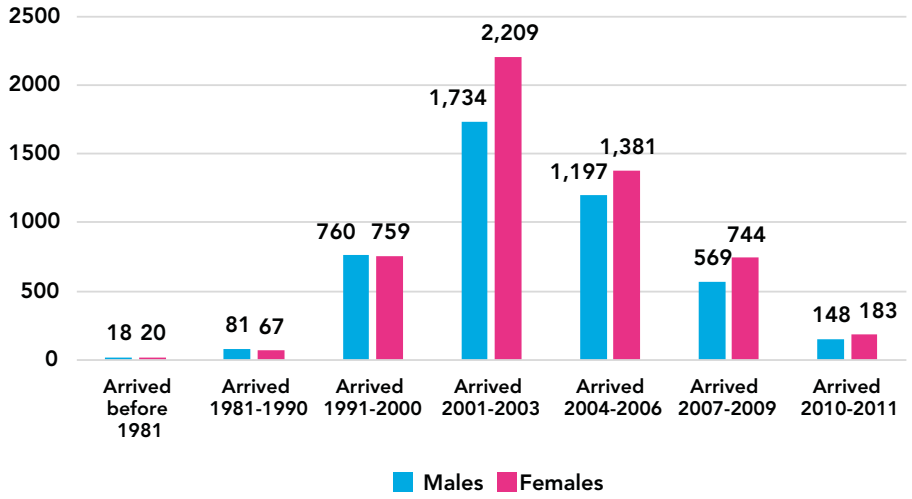
Data on migration from Somalia to the West Midlands by gender (figure 5) shows a higher proportion of females migrating. This indicates that these are likely Somalis who have entered the UK as asylum seekers, majority of whom will be women and children.

Figure 4: Arrivals from Somalia to London, the West Midlands, and England and Wales, by year



Source: Census 2011 Table CT0562

Figure 5: Arrivals from Somalia to the West Midlands, by gender



Source: Census 2011 Table CT0562

1.3.2 Demographics

According to the 2011 Census, there are 9,870 Somali-born people across the West Midlands (0.2%), and 7,765 specifically in Birmingham (0.7%).[44] Anecdotal evidence suggest roughly 250k-400k[45] Somalis live in the UK.

As shown in table 2, within Birmingham the greatest proportion of the Somali community are in Nechells ward (1.2%), Aston ward (0.7%) and Bordesley Green ward (0.7%). Overall, the Somali community accounts for 0.7% of Birmingham's overall population.

Table 2: Top 10 Birmingham wards with the greatest proportion of Somalis

Birmingham ward	Somali population number	Somali population (%)
Nechells ward	1,559	1.2
Aston ward	895	0.7
Bordesley Green ward	918	0.7
Sparkbrook ward	671	0.5
Washwood Heath ward	572	0.5
Lozells and East Handsworth ward	537	0.4
Ladywood ward	328	0.3
Soho ward	362	0.3
Hodge Hill ward	197	0.2
Springfield ward	226	0.2

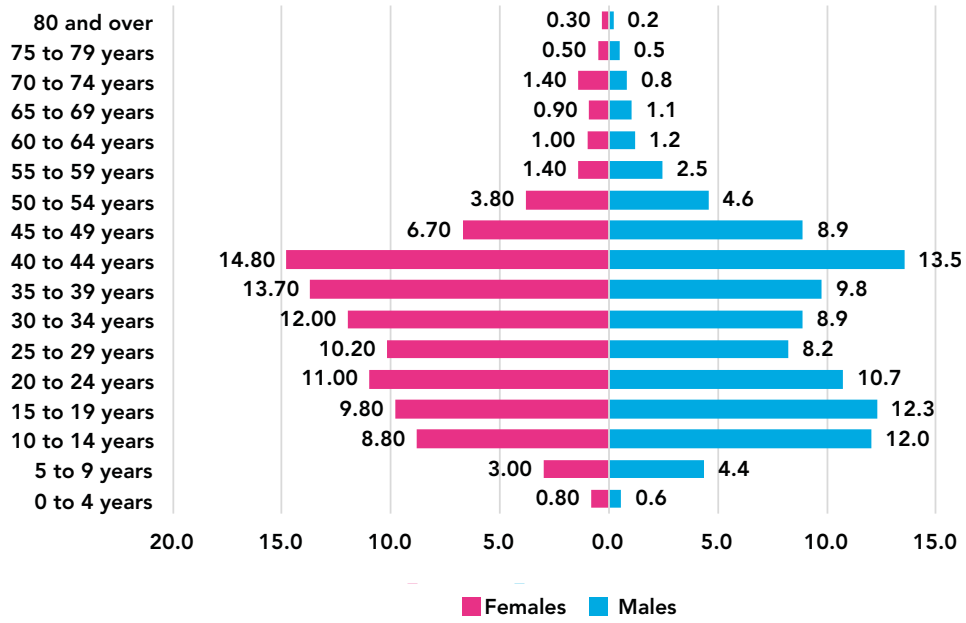
Source: 2011 Census[46]

1.3.3 Age profile

The Somali community has a young age profile; in Birmingham 84.1% of Somali-born males and 80.4% of Somali-born females were between the ages of 0 to 44.

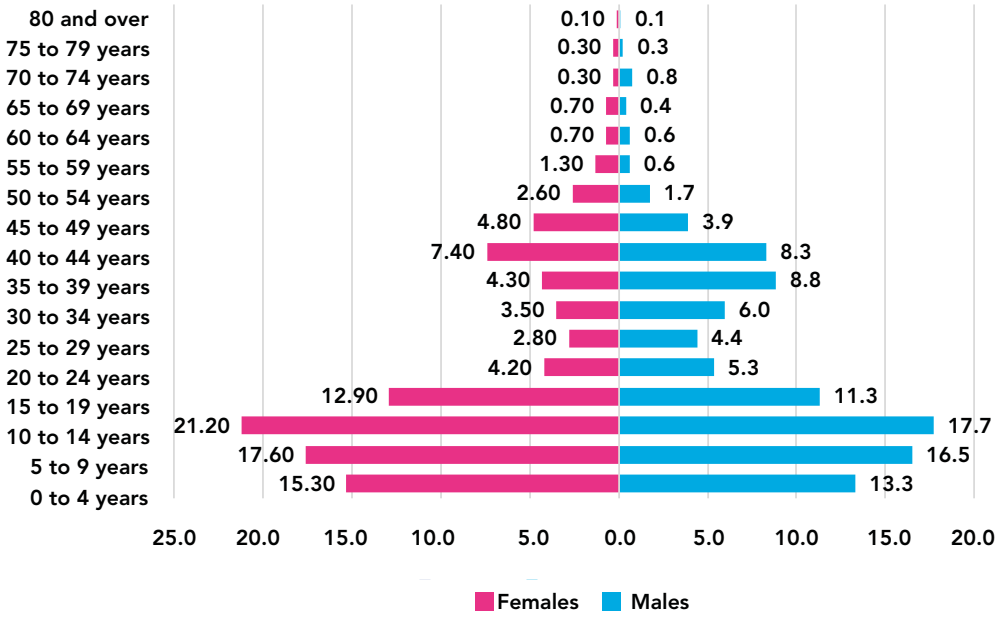
According to the 2011 Census, 58.8% of the females and 67% of the males within the Somali ethnic group in Birmingham were aged between 0-19 years (figure 7). The age profile difference in figures 6 and 7 below is likely a reflection of the community using different ethnic self-categorisation (i.e. Black African).

Figure 6: Small population datasets: population breakdown by 'Somalia' country of birth, by gender, in Birmingham



Source: 2011 Census, SP028[47]

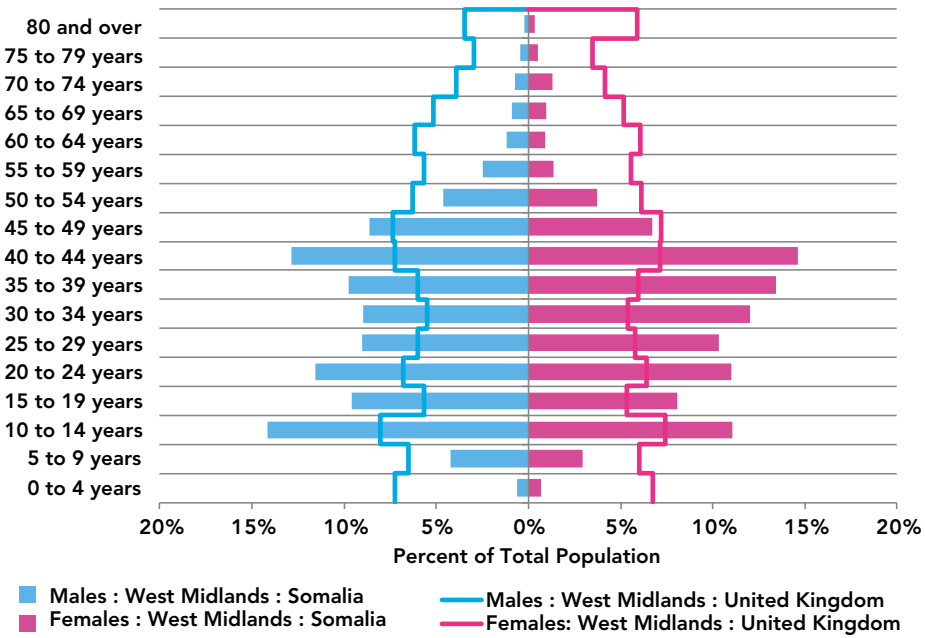
Figure 7: Small population datasets: population breakdown by Somali ethnic group, by gender, in Birmingham



Source: 2011 Census, SP009 [48]

The Somali community has a highly young age profile compared to the overall age profile of the West Midlands (figure 8). For example, Of the Somali population in Birmingham, 14% of males and 11% of females are aged 10 to 15, which compares to 8.6% and 7.4% of the total West Midlands population. 1% of Somali males and 1% of Somali females are aged 60 to 64, which is significantly lower than the total West Midlands population (6.4% and 6.2% respectively). However, this may be due to the varying self-identification used between ages, as highlighted above.

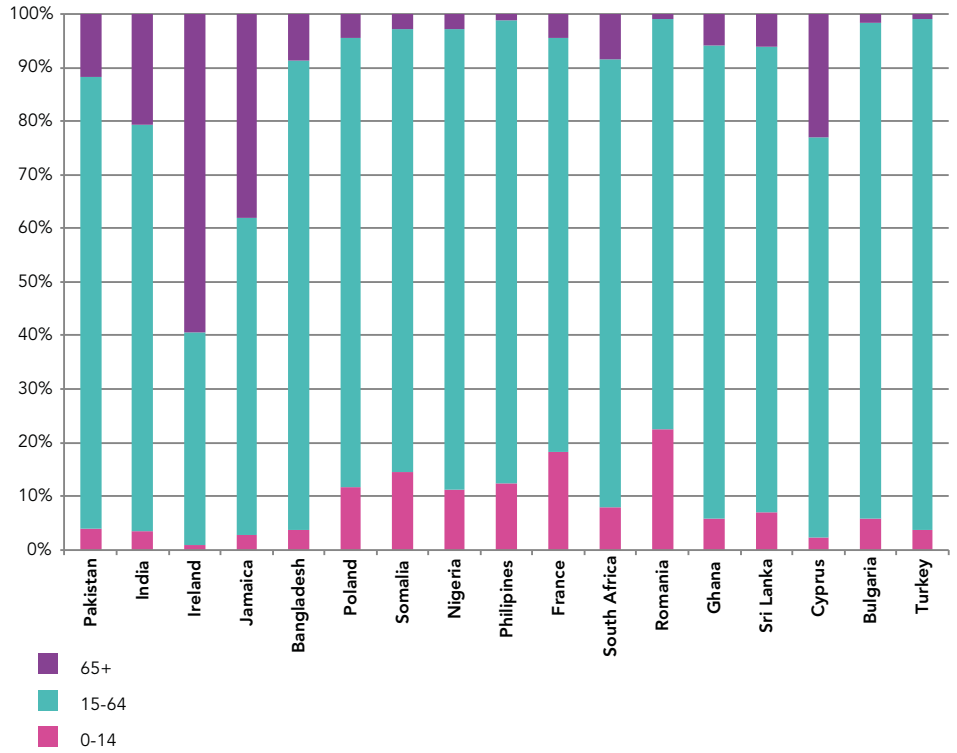
Figure 8: 2011 Census Commissioned Table: Country of Birth Somalia – Population Pyramid Tool



Source: 2011 Census CT0561[49]

Compared to communities from other countries in Birmingham, those from Somalia have the third greatest proportion of those aged between 0 to 14-year olds. Those from Romania and France have the highest proportion of 0 to 14-year olds in Birmingham (figure 9 below).

Figure 9: Country of birth, by age - Birmingham



Source: 2011 Census[50]

1.3.4 Languages

According to the 2011 Census, 8,139 people[51] in Birmingham recorded Somali as their main language. It is worth noting that 6,921 Birmingham citizens[52] noted Arabic as their main language, some of whom are likely to be of the Somali ethnic group.

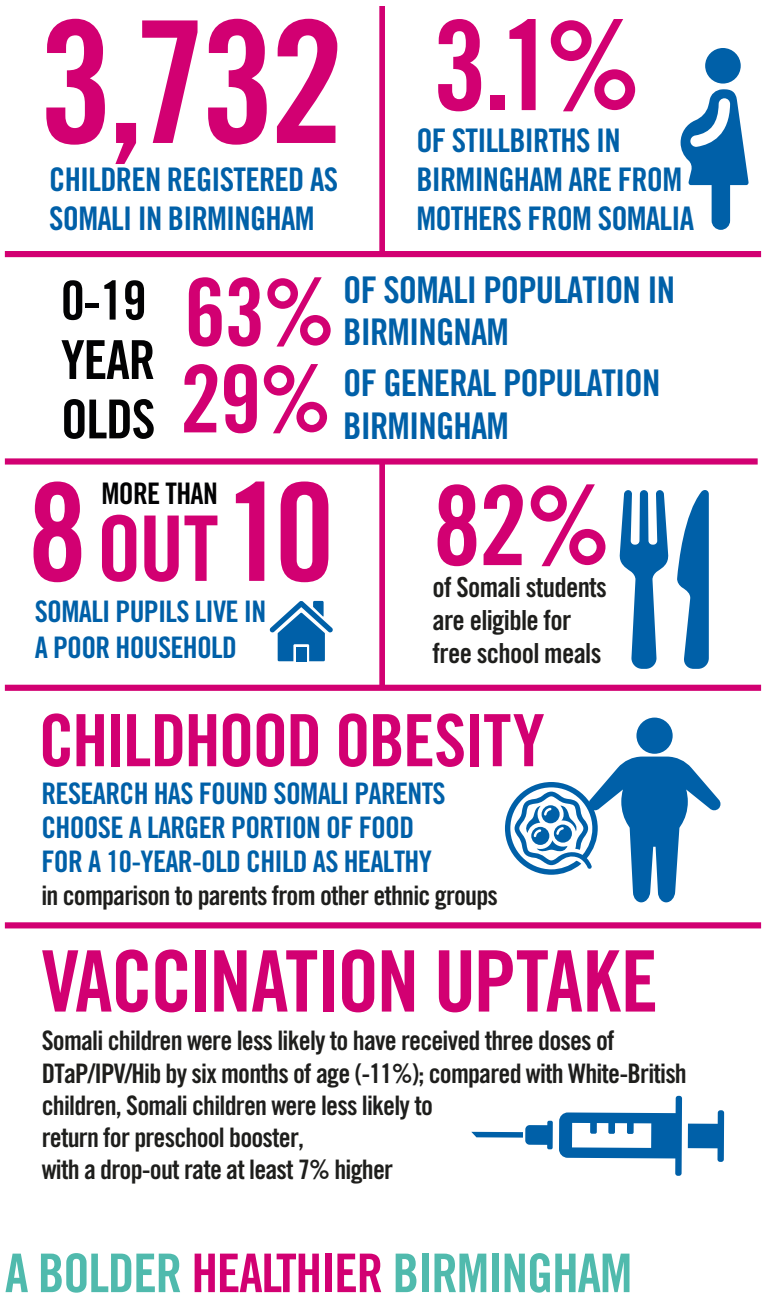
Similarly, as many within the Somali community have migrated from the Netherlands, it is likely that Dutch is their main language; Dutch was noted as the main language by 557 Birmingham citizens.

According to the 2011 Census data, the districts in Birmingham with the greatest proportion of Somali-speakers are outlined in the table below in table 3. At ward-level, the highest number of Somali-speakers are in Nechells (1,680), Bordesley Green (1,177), Aston (959), Washwood Heath (681) and Sparkbrook (654)[53].

Table 3: Top three districts in Birmingham with highest number of people recording Somali as the main language

Birmingham District	Number of people recording Somali as main language
Ladywood	3,242
Hodge Hill	2,101
Hall Green	1,023

Source: 2011 Census QS204, pp.10



2.0 Community Profile

2.1 Getting the best start in life

Key findings

Maternal health

- From 2012 to 2014, the stillbirth rate among Somali-born mothers in the West Midlands was 6.7 per 1,000 births, and 7.2 per 1,000 births in Birmingham.

Children statistics

- The Somali ethnic group has a very young age profile. While 0 to 19 year olds account for 29% of the general population in Birmingham, the age group accounts for 63% within the Somali ethnic group's population in the city.

Childhood vaccinations

- Somali children were 11% less likely to have received three doses of DTaP/IPV/Hib by six months of age compared to White British children.Compared with White-British children, Somali children were less likely to return for preschool booster, with a drop-out rate at least 7% higher.

Childhood obesity

- An empirical study assessing parental perceptions of weight in childhood found Somali parents referred to the absence of illness to judge their child's weight status; underweight was associated with negative attributes such as poverty.

Child poverty

- According to a Department for Children, Schools and Families (DCSF) report from 2010, more than 8 out 10 Somali pupils live in a poor households and the proportion of Somali pupils eligible for Free School Meals (FSM) is 82%.

Children in care

- According to a DCSF report from 2010, more than 8 out 10 Somali pupils live in a poor households and the proportion of Somali pupils eligible for Free School Meals (FSM) is 82%.

School readiness and education attainment

- On average, the educational achievements of Somali pupils are one of the lowest compared to other groups.
- Somali FSM girls outperformed Somali FSM boys (60% achieving 5+ GCSEs A*-C, same as the city average).

2.1.1 Maternal Health and Infant Mortality

Live and stillbirths

The Infant and Perinatal Mortality in the West Midlands report [54]has found from 2012 to 2014 of the live births to mothers born outside the UK in the West Midlands, 52% were from Pakistan, Poland, India, Bangladesh and Somalia, of which Somalia accounted for 3% (1,497 births) among foreign-born mothers.

Table 4 below shows the ten most common countries of birth of mothers in the West Midlands[55]. From 2012 to 2014, mothers born outside the UK accounted for 30% of the live births in the West Midlands (50,509 live births to mothers born outside the UK compared to 165,770 to mothers born in the UK).

The report also found from 2012 to 2014 mothers from Somalia accounted for 0.97% of the stillbirths in the West Midlands. During this period, the stillbirth rate among Somali-born mothers was 6.7 per 1,000 births; this was a lower rate than mothers from Pakistan and Romania, but higher than mothers from India, Bangladesh and Poland and higher than the Birmingham average (5.7 per 1,000 births).

Table 4: 10 most common countries of birth of mothers born outside the UK, West Midlands, 2012 to 2014

	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**	**Stillbirths per 1000 births**
1 Pakistan	10,666	4.93%	7.29%	7.0
2 Poland	6,087	2.81%	2.92%	4.9
3 India	5,202	2.41%	3.21%	6.3
4 Bangladesh	2,744	1.27%	1.36%	5.1
5 Somalia	1,497	0.69%	0.97%	6.7
6 Romania	1,239	0.57%	0.97%	8.1
7 Iraq	1,200	0.55%	0.68%	5.8
8 Nigeria	1,086	0.50%	0.58%	5.5
9 Latvia	973	0.45%	0.29%	3.1
10 Germany	969	0.45%	0.19%	2.0

Source: ONS data used in the Infant and Perinatal Mortality in the West Midlands report[56]

Similarly, from 2012 to 2014, among foreign-born mothers in Birmingham, those from Somalia accounted for 6% of live births (2.37% of all live births in Birmingham); overall mothers from Somalia accounted for 3.10% of all stillbirths in the city (table 5). The stillbirth rate among Somali-born mothers' resident in Birmingham was 7.2 per 1,000 births. This was a lower rate than mothers from India and Nigeria, but higher than mothers from Pakistan and Bangladesh, even though mothers from these two countries accounted for a significantly higher number of births in the city.

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[57].

In addition, a study[58] from Denmark has found ethnic disparity in stillbirth and infant death. It found women of Pakistani, Turkish and Somali origin had a particularly high risk of stillbirth and infant death. Specifically, in relation to Somali females it found that women from recent high conflict areas displayed a pattern with increased stillbirth risk, with more than a doubled risk and high rate of emergency caesarean sections[59]. The study also found mean birth weight of babies born to Somali mothers to be 3391g. The average weight of a baby in a full-term baby is 7.7lb (3493g).

To contextualise, the Infant and Perinatal Mortality in the West Midlands[60] report has 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 finding that mean birth weight of babies born to Somali mothers is 3.39kg is echoed in a UK-based research[61] which found babies of African ethnicity whose mothers were born in Western Africa had a mean birth weight of 3311g. This was significantly higher than the mean birth weight of babies born to UK-born mothers (3257g).

Table 5: 10 most common countries of birth of mothers born outside the UK, Birmingham; 2012 to 2014

Country of birth of mother	No. of births in B'ham	Percentage (%) of all live births in B 'ham	Percentage (%) of all stillbirths in B'ham	Stillbirths per 1000 births
1. Pakistan	6,453	12.31%	14.48%	6.5
2. Bangladesh	1,750	3.34%	3.10%	5.1
3. India	1,407	2.68%	4.48%	9.2
4. Somalia	1,246	2.38%	3.10%	7.2
5. Poland	1,027	1.96%	2.07%	5.8
6. Romania	654	1.25%	1.38%	6.1
7. Jamaica	543	1.04%	1.03%	5.5
8. Nigeria	431	0.82%	1.72%	11.6
9. Yemen	414	0.79%	1.72%	12.0
10. Afghanistan	396	0.76%	1.38%	10.1

Source: ONS data used in the Infant and Perinatal Mortality in the West Midlands report[62]

Maternal health

Female Genital Mutilation (FGM) is practised in many parts of Africa and the Middle East and is widespread in Somalia. Somalia has the highest rate of FGM cases, with more than 90% of the female population aged 15-49 affected[63]. According to data from ONS[64], the estimated number of Somali-born women aged 15-49 with FGM living in England and Wales exceeded 40,000.

A City University London report[65] estimated 103,000 women aged 15-49 with FGM born in countries in which it is practised were living in England and Wales in 2011, compared with the estimated 66,000 in 2001. The represented an estimated prevalence rate of 7.7 per 1,000 women.

Female Genital Mutilation (FGM)

FGM refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons; it is commonly performed by traditional practitioners with no formal medical training and without anaesthetics[66]. FGM is illegal in the UK as is taking a child overseas to have the procedure performed. The procedure carries significant risks of pain, trauma, bleeding and infection as well as long term risks to sexual, gynaecological and obstetric health.

FGM is heavily under-reported in the UK and true numbers are not known. FGM is often performed in the country of origin and can cause serious complications later, especially during pregnancy and childbirth. It is estimated a significant proportion of 15 to 49-year-old Somali women who are permanent residents in England and Wales have undergone FGM. The data available indicates that within England and Wales, the greatest prevalence of FGM among women aged 15 to 49 is in London, followed by the West Midlands.

Researchers at Bristol University report that increasingly, evidence suggests FGM is not as prevalent a problem as previously assumed and therefore needs to be handled proportionately[67].

Findings from a study[68] exploring the experiences and needs of Somali women in the UK during pregnancy and childbirth found that there are major concerns around the mismanagement of care for women who have undergone FGM. The study raises concerns around aspects of communication, continuity of care, and attitudes of health professionals[69].

2.1.2 Children statistics

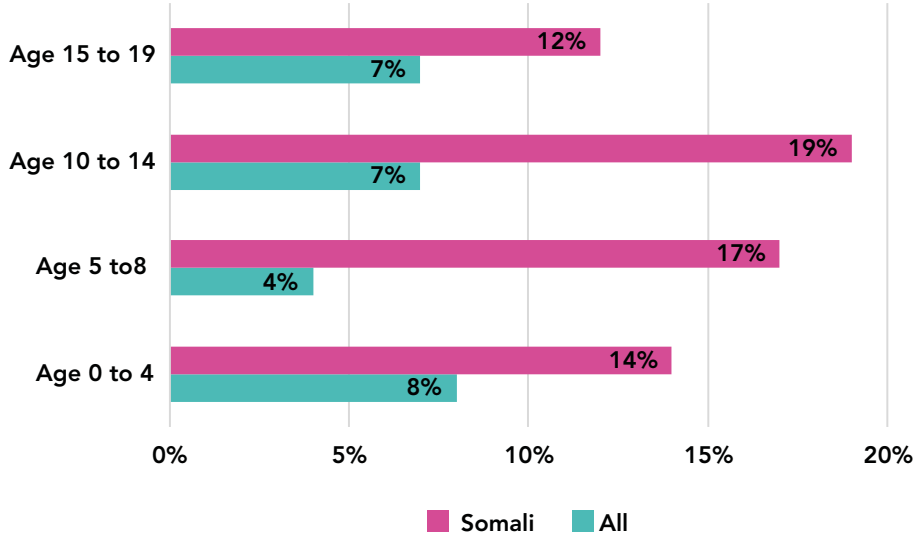
From 2010 to 2019, Somalia has been in the top ten most common country of birth for mothers not born in the UK. Somalia has dropped as the most common country of birth, falling from 6th most common in 2010 to 9th in 2019.

Analysis from ONS has 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[70]. The percentage of live births to women born outside the UK has generally been increasing[71]. Specific health needs of refugees and asylum seekers, such as those from Somalia have been identified in various studies, including issues of language and communication[72, 73, 74], access to health services[75] and mental health service provision[76]. These needs can become more acute for female refugees during pregnancy and childbirth. Additionally, a significant part of the maternity experience is determined by cultural and social aspects of care[77].

The Somali ethnic group has a highly young age profile. While 0 to 19-year olds account for 29% of the general population in Birmingham, the age group accounts for 63% within the Somali ethnic group's population in the city.

According to the 2011 Census[78 79], there are 3,732 children registered as Somali in Birmingham. Somali children account for 1.2% of the overall 0-19-year-old population in Birmingham (information shown in figure 10 on following page).

Figure 10: Age profile of 0-19-year olds within Birmingham's Somali ethnic group, compared to the general population of Birmingham; shown in percentage %



Source: Census 2011 DC2101EW[80] and SP009[81]

2.1.3 Childhood vaccinations

Somali children were less likely to have received three doses of DTaP/IPV/Hib by six months of age (−11%)[82].

Compared with White-British children, Somali children were less likely to return for preschool booster, with a drop-out rate at least 7% higher[83].

A study[84] which explores the health beliefs of Somali women in the UK involved semi-structured interviews at third-sector organisations providing services to Somali women in Birmingham. The study[85] found specific concerns and anxieties about the MMR vaccine, particularly its purported links with autism. It concluded the perceptions of Somali women of the immunisation programme are shaped by culture, religious interpretation and personal experience. It found a reason may be an absence of reliable and culturally appropriate information that addresses the community's concerns about childhood vaccinations[86].

The UK has a universal childhood immunisation programme with overall high vaccine coverage rates[87]. The childhood immunisation programme currently includes a 5-in-1 vaccine that protects against diphtheria, tetanus, pertussis, polio and Haemophilus influenzae type b (DtaP/IPV/Hib) offered at 2, 3 and 4 months of age (primary course) and a preschool booster between 3 years 3 months and 5 years of age (DtaP/IPV or DtaP/IPV)[88].

Data on vaccine uptake in London provides a useful insight as the city has lower rates of vaccine uptake compared to UK-wide vaccine coverage. This is likely due to its increasingly ethnically diverse population, similar to Birmingham which is also a highly multi-ethnic city (vaccine uptake for primary immunisations of DtaP/IPV/Hib/HepB is 87.7% in London, similar to the West Midlands where vaccine uptake for the dose is 87.9%[89]). Uptake of childhood vaccination among Somalis in London between 2006/7 and 2010/11 shows a coverage at 85% and around 88% of the two primary vaccinations, respectively. However, coverage drops to around 60% for the pre-school booster offered at 5 years of age[90].

A study[91] from Norway found that despite overall good vaccination coverage in many countries, vaccine hesitancy has hindered full coverage, increasing the risk of outbreaks. Somali immigrant groups have been known to have low measles vaccination coverage, leading to community outbreaks.

It found that children born to Somali immigrants in Norway had suboptimal measles vaccine coverage at 2 years; for children born in 2016 the coverage was 85%. Coverage declined between 2000 and 2016, and at a greater rate for boys than girls. Children born to mothers residing in Norway for 6 years or more had lower coverage compared to those with mothers residing less than

2 years prior to their birth. Research indicates a general lack of trust in the healthcare system, the use of alternative information sources and inadequate health literacy as contributing factors.

There have been three measles outbreaks affecting the Somali diaspora in Western countries in the last decade, with the largest outbreak in Norway which centred in an under-vaccinated Somali community in Oslo.

2.1.4 Childhood obesity

An empirical study[92] assessing parental perceptions of weight in childhood among UK-based minority communities interviewed parents of children aged 4 to 16 years, including Somali participants. The study found Somali parents referred to the absence of illness to judge their child's weight status; underweight was associated with negative attributes such as poverty. It found Somali parents tended to choose a larger figure for a 10-year-old child as healthy in comparison to parents from other ethnic groups, implying parental readiness to make lifestyle changes for an overweight child may differ by ethnic background[93]. Not all Somali parents had heard of the government's 5-a-day recommendation[94].

The study assessed associations between ethnic background and views of healthy body size in childhood, concern surrounding overweight in childhood and attitudes to perceived causes of overweight in childhood. It found that Somali parents expressed the lowest level of concern for overweight in childhood in comparison to other ethnic groups, believing that overweight children can still be healthy children and that they will grow out of it.

Research on Somali immigrants' resident in other developed countries may also provide a useful insight. A community-based research from the United States which involved three focus groups with the Somali community found Somali adolescents in Minnesota had a higher rate of overweight and obesity compared with the white ethnic group[95]. It also identified useful cultural factors: Somali parents described encouraging their children to finish their food by telling them that the last piece of the food has the 'most reward', referring to religious context of being rewarded for cleaning one's plate[96].

Somali parents in the US-based study aimed to raise healthy-weight children by providing healthy foods and physical activity to their children; however they expressed facing multiple challenges requiring adjustment between the push of dominant culture (i.e. children being exposed to fast-food advertisements), new familial and generational dynamics and preservation or development of their ethnic community identity[97]. The research also provides useful insight into preferred body sizes from the community: some Somali parents said children in the middle of the weight range are likely to be healthier and stronger, with heavy and skinny children likely to be unhealthier and weaker, respectively[98].

2.1.5 Childhood poverty

According to a DCSF report from 2010, more than 8 out 10 Somali pupils live in a poor household and the proportion of Somali pupils eligible for Free School Meals (FSM) is 82%[99].

The free school meals (FSM) indicator is often used as a proxy measure of social deprivation in pupils' backgrounds and has been linked to underachievement in a number of studies.

According to an article from[100] The Economist, over 80% of Somali-speaking pupils qualify for free school meals. It also found more than 50% of British Somalis rent from local councils, the highest proportion of any foreign-born population[101].

According to a Joseph Rowntree Foundation (JRF) research[102] there are higher rates of lone-parent Somali households, which can be used as a proxy for poverty, as single-parent households face around twice the risk of poverty as

two-parent households. Research[103] on the impact of the pandemic on single parent households more broadly has found single parent families were over three times as likely to have relied on food banks during the crisis, compared to coupled families (7% compared to 2%). The findings also showed nearly half (44%) of children in a single parent family were in poverty on the eve of the pandemic, compared to just one in four (26%) of those living in other families.

2.1.6 Social care

There is an absence of research into the number of Somali children in care and adoption in the UK. A research study into the reason for a shortage of Somali foster carers provides useful insight – it found there to be a shortage of Somali carers and adopters meaning the demand in the care population often outweighs the availability of matched placement options[104].

Recent media articles[105] have highlighted the need for more Somali foster carers to help match placement options by cultural, linguistic, religious and ethnic backgrounds.

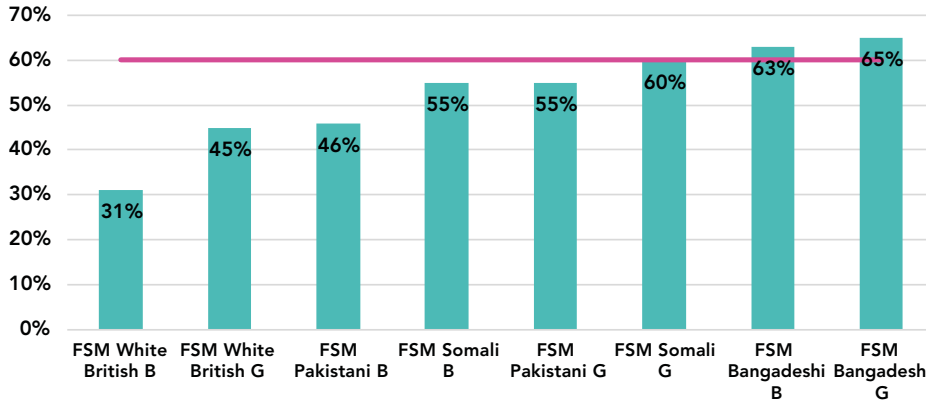
The study[106] from London Borough of Camden conducted focus groups with the community to understand the reason for a shortage of Somali carers. Main findings included that the Somali culture encourages to foster and/or adopt with every participant expressing positive opinions about both options; participants felt it was part of Somali culture to look after extended family, neighbours and/or friends' children, making the concept of caring for a child from outside of the immediate family normal[107]. It also found that many believed they would be rewarded in the afterlife as Muslims, as the Prophet Muhammed was an orphan. The study identified barriers which included: mistrust of social workers; a belief that social workers were too quick to remove Somali children from their parents' care without considering cultural and religious needs; inadequate support for carers; and insufficient accommodation and overcrowding.

2.1.7 School readiness and educational attainment

On average, the educational achievements of Somali pupils are one of the lowest compared to other groups[108]. In 2013, 55% of Somali FSM boys in Birmingham achieved 5+ GCSEs A*-C including English and Maths, below the city average (60%)[109]. Girls out-performed boys for all ethnic groups, with Somali FSM girls outperforming Somali FSM boys (60% achieving 5+ GCSEs A*-C, same as the city average).

Education statistics rarely include a "Somali" ethnic group category, but the limited education data containing the category/ ethnic code indicates that the educational achievements of Somali pupils are one of the lowest. Overall, the educational performance in Birmingham (60%) is only slightly below the national average (61%), and it outperforms other core cities and statistical neighbours[110]. The majority of the ethnic groups below the city average are FSM, the exceptions being non-FSM Black Caribbean, Pakistani and White Other boys[111] (figure 11).

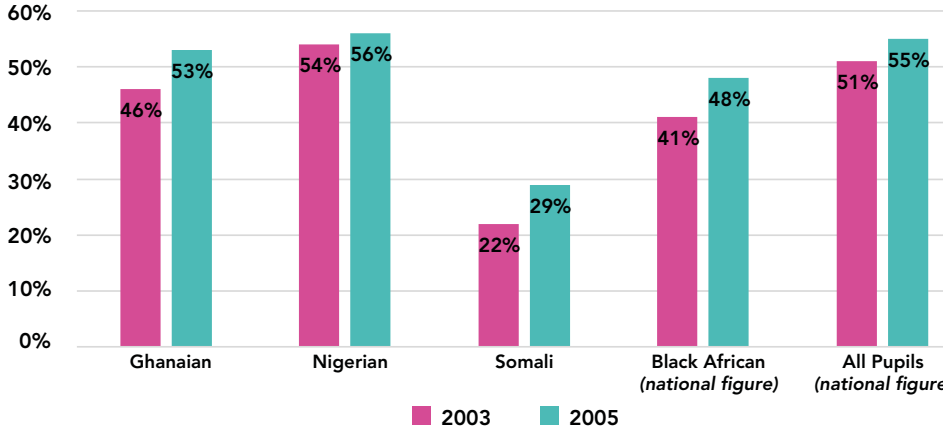
Figure 11: 5+ GCSEs A*-C including English and Maths by ethnicity, gender and free-school meals eligibility Birmingham schools, 2013



Source: From Ethnic Groups in the Labour Market: a statistical analysis for Birmingham, based on Birmingham City Council[112]

Figure 12 below shows older statistics from 2003 and 2005 from a DES report[113]. It highlights that Nigerian pupils achieved above the average for all Black African pupils, and above the average for all pupils; however Somali pupils achieved well below the average for Black African pupils. These statistics do, however, indicate that levels of attainment within the Black African extended codes have improved: the increase in the proportion of Somali pupils achieving 5+ A*-C is aligned with the increase in the proportion of all Black African pupils achieving 5+ A*-C, at 7 percentage points; this is a higher increase than was seen for 'all pupils' nationally[114].

Figure 12: Percentage of Black African pupils achieving 5+A*-C at GCSE, 2003 and 2005



Source: DES report[115]

An article in The Economist found in 2010 to 2011 around 33% of Somali children achieved five good GCSEs, compared with 59% of Bangladeshi pupils and 78% of Nigerian ones[116]. It identifies a few barriers for Somali pupils: overcrowded houses result in children having limited places to complete their homework; limited English language skills of Somali parents; perception of parents that children progress each year at school, creating assumption of achieving well (in Somalia poor performers are held back)[117].

It also found[118] in 2000 just one Somali teenager in the London borough of Camden passed five GCSEs with good grades; to address this the Somali Youth Development Resource Centre was established to mentor students, which in 2012 raised the figure to 59%[119].

Table 6 below shows performance of Somali pupils by FSM status in Lambeth. It shows a noticeable difference in performance between the free and paid meal cohorts, though there is no consistent pattern of one cohort outperforming the other. Specifically, there was a 4% and 3% gap between the free and paid meal cohorts in KS2 level 4+ in 2013 and 2014, respectively, with those paying for meals performing better than FSM-Somali pupils.

Table 6: Performance of Somali pupils by Free School Meal status, 2013 & 2014

Due to the significant changes to GCSE reporting this year, the 2013 results are not shown as they are no longer comparable.

Key stage		2013			2014		
		Free Meals	Paid Meals	Gap	Free Meals	Paid Meals	Gap
KS1 - Level 2B+	Reading	76%	76%	0%	78%	80%	+2%
	Writing	65%	61%	-4%	71%	72%	+1%
	Maths	74%	79%	+5%	80%	81%	+1%
	Average	72%	72%	0%	76%	78%	+2%
KS2 - Level 4+	Reading	88%	92%	+4%	86%	92%	+6%
	Maths	93%	96%	+3%	89%	90%	+1%
	Average	90%	94%	+4%	88%	91%	+3%

Source: Chart image from Lambeth Council report The achievement of Somali pupils in Lambeth school – empirical evidence[120]

58% of Somali respondents to a UK-based survey felt the need for mental health support, but only

14% USED MENTAL HEALTH SUPPORT SERVICES

BARRIERS TO MENTAL HEALTH SERVICES

UNAWARE OF SERVICES AVAILABLE

LACK OF UNDERSTANDING OF THE COMMUNITY

PREFERENCE FOR FRIEND AND FAMILY SUPPORT

ALCOHOL Research has found that the Muslim faith is likely a protective factor against drug and alcohol use within the Somali community

77% of Somali men and women of all ages found to have high levels of regular khat use. Khat use is a major concern within the community

HIGHER SMOKING RATES THAN THE GENERAL UK POPULATION

and higher still among men over 40 years old and those that regularly use khat

A BOLDER HEALTHIER BIRMINGHAM

2.2 Mental wellness and balance

Key findings

Mental health

- A report from a UK-based Somali organisation, found Somali community in the UK have relatively high levels of mental ill-health and low levels of mental health service use.
- It found that while 58% of survey respondents felt the need for mental health support, only 14% have used mental health support services.
- Only 22% expressed turning to the NHS services as the first port of call for mental health support and 45% of respondents would choose family and friends as the first point of contact for mental health support.

Alcohol

- While statistics of alcohol consumption by the Somali community in the UK are not available, research from Lambeth Council has found that the Muslim faith is likely a protective factor against drug and alcohol use among the Somali community.

Drug use

- One of the key challenges within the Somali community across the UK is the use of khat. Khat is a leafy plant which acts as a stimulant when chewed and is assumed to be commonly consumed by the community, potentially with damaging effect.
- While exact statistics are unavailable, research from London Borough of Lambeth found high levels of regular khat use (77%) among Somali men and women of all ages.

Smoking

- Smoking rates in the Somali population (based on London's Somali community) appear to be higher than in the general UK population, and higher still among men over 40 years old and those that regularly use khat.
- A study on smoking in various communities, including the Somali community in London, found that participants' attitude to smoking in the country of origin, for example in Somalia, affected the attitudes and smoking behaviour of the migrant community in the UK.

2.2.1 Mental health

A report from a UK-based Somali organisation, Anti-Tribalism Movement, found Somali communities in the UK have relatively high levels of mental ill-health and low levels of mental health service use[121]. It found that while 58% of survey respondents felt the need for mental health support, only 14% have used mental health support services. 67% were not aware of mental health service in their area[122] and 78% felt that available mental health service do not understand the Somali community. Only 22% expressed turning to the NHS services as the first port of call for mental health support and 45% of respondents would choose family and friends as the first port of call for mental health support.

Published research has found a high prevalence of Post-Traumatic Stress Disorder (PTSD) within the Somali community, with high prevalence of depression and anxiety[123] [124] [125]. Research has found the incidence of PTSD in Somali women seems to be equal to men[126] and continuing immigration and discrimination-related pressures have been identified as predictors for PTSD in Somali adolescents[127].

A research study which surveyed 428 Somali and Oromo women found high levels of trauma, with over 90% of participants having lost their home, been persecuted by the military or local militia, and/or experienced life-threatening starvation[128].

Published research has found[129], migration and seeking asylum can increase the risk rates of mental illness. Refugees and migrants have higher prevalence rates of mental illness, with 48.1% of Somali refugees meeting the criteria for PTSD[130].

Research studies[131] have found Somali communities in London and the United States have a relatively high level of mental ill-health need but a low level of mental health service use[132]. It found, Somali adolescents also have low rates of service use, but access alternative sources of help (school and religious leaders) more frequently[133]. Higher suicide rates have been anecdotally reported in Somali communities in London, with mental illness a known risk factor for suicide[134].

A published research found[135] that Somali women explained that mental illness and feelings of distress start with and would be described to a GP as a "headache", illustrating the way mental illness symptoms in the community are described differently. Physical symptoms of mental illness have been described in Somali adults, such as dizziness, poor vision and heat coming out of the head[136].

2.2.2 Alcohol

While statistics of alcohol consumption by the Somali community in the UK are not available, research[137] from London Borough of Lambeth has found that the Muslim faith is a protective factor against drug and alcohol use amongst Somalis and it is therefore likely alcohol consumption by the community are low.

A study[138] from Finland which involved a sample of 512 Somali people, found binge drinking was less prevalent among Somali men (2%). The main reason cited for the alcohol abstention by the community is prohibition of alcohol in Islam.

A mixed methods research study[139] has been conducted by the London Borough of Lambeth's Drug and Alcohol Team; more than 350 participants completed questionnaires within the community (one of the largest data sets of any khat study conducted in the UK), literature review, focus groups and interviews. It found for polydrug users' alcohol was consumed along with khat (exact proportions are not known). Khat users generally felt that it is an important cultural practice integral to Somali identity, unlike alcohol.

2.2.3 Drug use

One of the key challenges within the Somali community across the UK is the assumed common consumption of khat. Khat is a leafy plant which acts as a stimulant when chewed and has potentially damaging effect. While exact statistics are unavailable, research[140] from London Borough of Lambeth found high levels of regular khat use (77%) among Somali men and women of all ages. It found significant economic impact of khat on users, their families and the community: according to the survey approximately 50% of respondents were unemployed and the average amount spent by each user was around £780 per year.

While the khat leaves are legal in the UK, the two main active ingredients found in the leaves, cathine and cathinone, are Class C controlled substances, under the Misuse of Drugs Act (1971)[141].

Research[142] has found while in Somalia chewing khat is a traditional social activity among Somali men, in the UK there is a pattern of those who are unemployed or suffering from depression consuming the substance, often leading to dependence.

A key finding from a literature review[143] on substance use in the Somali community is that substance users and their families encountered difficulties in accessing services and the need for culturally sensitive services.

A literature review[144] found among khat using communities, men are more likely to use the substance than women. For example, in a study of khat use among 602 Somalis in London, Birmingham, Bristol and Sheffield it found that 14% of female respondents reported having used khat recently (16% 'ever used') compared with 51% of male respondents (58% 'ever used'). Analysis in the report suggests that because of the stigma attached to drug used, women are likely to deny their khat use and may use it alone rather than in social settings. Women also appear more likely to regard their khat use as problematic[145]. 40% of the respondents' part of the study reported socialising as the most common reason for using khat[146]. 'For fun and enjoyment' was the second most popular reason identified by the sample (17%).

Another study[147] on khat use consisting of 45 interviews and 11 focus groups with Somali, Yemeni and Ethiopian community members cited khat as providing a reason for friends to come together and discuss issues concerning their communities[148]. Stress relief was another reason for use identified by 11% of respondents. These respondents tended to feel that chewing khat was an effective distraction from the range of problems they faced[149]. A study[150] which assessed use and perceptions of khat among young Somalis in the UK interviewed 94 young Somalis. 83 of the respondents reported that Somalis faced more challenges which increased their susceptibility to using khat, including unemployment, lack of knowledge of the British health, social and education systems, frustration as a result of cultural and language barriers and feelings of homesickness and statelessness due to their refugee status[151].

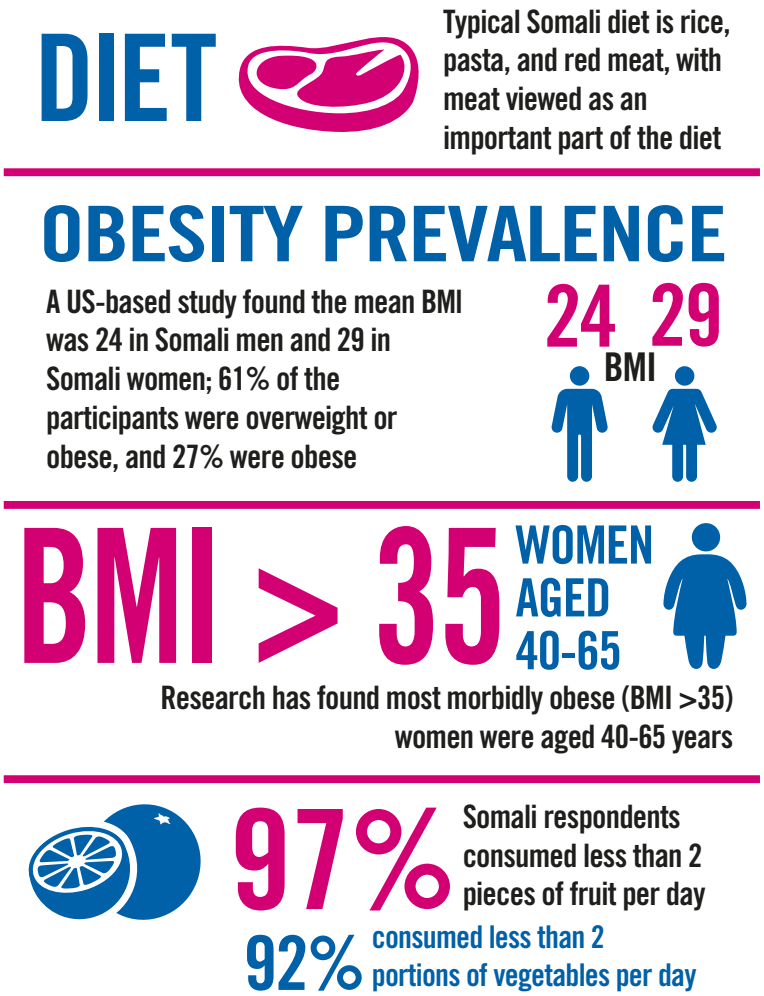
2.2.4 Smoking

Smoking rates in the Somali population (based on London's Somali community) appear to be higher than in the UK general population, and higher still among men over 40 years old and those that regularly use khat[152]. A study[153] on smoking in various communities, including the Somali community in London, found that participants' attitude to smoking in the country of origin, for example in Somalia, affected the attitudes and smoking behaviour of the migrant community in the UK. This is particularly useful for recent migrants, especially for those from countries with higher smoking rates and where different legal and cultural frameworks are taken to tobacco use[154].

A study completed by Cancer Research and University College London on Smoking Attitudes and Prevalence of a Somali Population in London[155] found limited knowledge within the community of local smoking cessation services. The main feedback included the format and ineffective promotion of the NHS' Stop Smoking Services, and ambivalence towards preventative health behaviour.

The study also found, of current smokers surveyed in a study[156], just over half Somalis reported at least one quit attempt, far lower than estimates of 80% among the general population of smokers. It found a strong relationship between khat use and smoking: 71% of those that chewed khat also smoked, but only 10% of non-khat users smoked. It identified greater nicotine dependency among the Somali community. Half of the Somali smokers in the study smoked less than 10 cigarettes per day. However, 76% of Somali smokers had their first cigarette within 30 minutes of waking, a significantly larger proportion compared to the general UK population of smokers (40% smoke within 30 minutes after waking)[157]. Smoking within 30 minutes of waking indicates a high level of nicotine dependency and implies that dependency among the Somali population is higher than the national average[158].

A study from Finland, mentioned earlier, used a sample of 512 Somalis and assessed attitudes and prevalence of cigarette smoking within the community[159]. It found the prevalence of daily smoking was lower in Somali men (10%) and even lower in Somali women (1%) compared with the general population (15%). It also found the prevalence of lifetime regular smoking was lower within migrant populations than in the general Finnish population. The prevalence of lifetime regular smoking and current daily smoking were higher in men than in women in all the studied populations, including the Somali community.



2.3 Healthy and affordable food

Key findings

Diet

- A series of studies have found fresh fruit and vegetable intake among Somalis to be minimal, with reasons cited including financial constraints, cultural association of fruit and vegetables with poverty, and the absence of fresh produce in neighbourhood stores.
- A UK-based study has found around 97% Somali respondents consumed less than 2 pieces of fruit per day and 92% consumed less than 2 portions of vegetables per day.

Obesity

- A US-based study found the mean BMI was 24 in Somali men and 29 in Somali women.
- 61% of the participants were overweight or obese, and 27% were obese. Of obese subjects, 67% were women; only 2 were men.
- It found most morbidly obese (BMI >35) women (60%) were aged 40–65 years.

2.3.1 Diet

A series of studies[160] [161] have found fresh fruit and vegetable intake among Somalis to be minimal[162], with reasons cited including financial constraints, cultural association of fruit and vegetables with poverty, and the absence of fresh produce in neighbourhood stores[163]. A UK-based study has found around 97% Somali respondents consumed less than 2 pieces of fruit per day and 92% consumed less than 2 portions of vegetables per day[164].

This section provides insights from various qualitative studies into the diet of the Somali community and the likely health implications. A London-based study from 2009 involved 8 focus groups with 62 Somali participants and a survey with 77 Somali respondents. It found uncertainty from the community about what constitutes a healthy diet, a general opinion within the community that Somali diet was unhealthy and that this has an adverse effect on health[165]. It highlighted the need to learn how to prepare healthy food, with only 60% surveyed agreeing that they have a healthy diet[166]. It was reported that fruit and vegetable consumption was an irregular part of daily diet, with a significant minority of survey respondents consuming less than 2 portions per week of fruit and vegetables (29% fruit; 24% vegetables)[167].

The study found a typical Somali diet comprised rice, pasta, and red meat, with meat viewed as an important part of the diet. The eating pattern was one main meal per day at lunchtime or early afternoon with 64% reporting large gaps between meals, and 51% not snacking between meals[168]. Takeaway meals were popular amongst men, particularly those living alone. A large amount of sugar (4-6 teaspoons) was taken in tea[169].

Similarly, research from United States has found that some Somali women and men in Minnesota were knowledgeable about what constitutes a healthy diet[170], while other studies including those from the UK found they had limited knowledge[171].

A study[172] from the United States has found Somali immigrants maintain a traditional diet, supplemented with Western fast food. The study has found that national data on diet from Somalia and the United States linked more distal influences on food consumption, such as the food environment/ the availability of certain types of food: it showed comparisons between Somalia where 93% of calories came from vegetables whereas in the United States only 72% did[173, 174].

2.3.2 Obesity

There is currently an absence of data on obesity rates among the Somali community in the UK, however, a US-based study provides useful insight into this topic. The study found[175] the mean BMI was 24 in Somali men and 29 in Somali women; 61% of the participants were overweight or obese, and 27% were obese. Of obese subjects, 67% were women; only 2 were men[176]. Among morbid obesity (BMI >35), most morbidly obese women (60%) were aged 40–65 years[177].

A study compared the body mass index (BMI), waist-to-hip ratio (WHR), and physical fitness levels of Somali women (n=31) to those of white women in New Zealand, with 36% of Somali women having a BMI>30 kg/m2 as compared to only 19% of white women[178, 179]. When the overweight BMI> 25 kg/m2 and obese categories were combined, 71% of Somali women were in this group[180, 181]. The study also found there to be no difference between the groups in WHR. It also highlighted limitations of using BMI to assess health risk and obesity in ethnic minorities and emphasised the comparative advantage of using WHR.

According to another study[182, 183], the Western cultural preference for slenderness has generally been adopted by British minority ethnic communities. Obesity is perceived as a symbol of affluence and success in some traditional, non-Western societies: a qualitative study of young Somali women in England[184] found that, whilst they were aware of what constitutes a healthy body size, they were constrained by older Somalis' cultural attitudes favouring larger body sizes.

A research[185] conducted jointly by Kensington & Chelsea and Westminster councils on the Somali community found there to be a limited understanding about healthy eating. The study's finding included that Somali people expressed greater freedom to eat as they pleased in Somalia without the risk of unhealthy weight gain. The change of environment and lifestyle associated

with migration to the UK has led to a need to eat healthier, with many Somalis unaware that some of the health conditions now prevalent in the community (i.e. heart disease, high blood pressure, high cholesterol, type 2 diabetes, stroke etc) are directly linked to obesity[186].

A comparative study[187] of the Somali community in Norway and Somaliland[a] found that while prevalence of high-BMI was greater in Somali women in Norway than women in Somaliland, both groups had the same prevalence of central obesity (waist circumference, WC ≥ 88 cm)[188]. In Somali men, the prevalence of central obesity (WC ≥ 102 cm) was lower in Somaliland than in Norway[189]. The prevalence of obesity (body mass index ≥30 kg/m2) was 44% and 31% in Somali women in Norway and Somaliland, respectively. In contrast, the prevalence of obesity was low in men (9% in Norway; 6% in Somaliland)[190].

A study[191] from the United States on the prevalence of overweight, obesity, and associated diseases within the Somali migrant community used a sample of around 250 people within the community. It found Somali immigrants in Minneapolis not only adopted Western eating habits but also reached the same epidemic rate of overweight and obesity[192]. However, obesity in Somalis was not associated with diabetes or hypercholesterolemia. The study found the mean BMI was 24 in men and 29 in women. 61% of the participants were overweight or obese, and 27% were obese. Of obese subjects, 67% were women; only 2 were men[193]. Twenty-two subjects (20 women and 2 men) had morbid obesity (BMI >35). Most morbidly obese women (60%) were aged 40–65 years[194]. The prevalence of diabetes mellitus was only 6% and the prevalence of hyperlipidemia was 5%[195].

2.4 Active at every age and ability

Key findings

Physical activity

- Overall levels of physical activity are low within the Somali community, and as with most ethnic minority communities, levels are lower for Somali women than men.
- According to research, Somali women felt their physical activities have reduced and that they were more physically active before immigration.
- Barriers cited for physical activity include the lack of transportation to gyms, financial constraints for membership, limited choice of suitable outdoor winter clothing, and absence of women-only facilities.

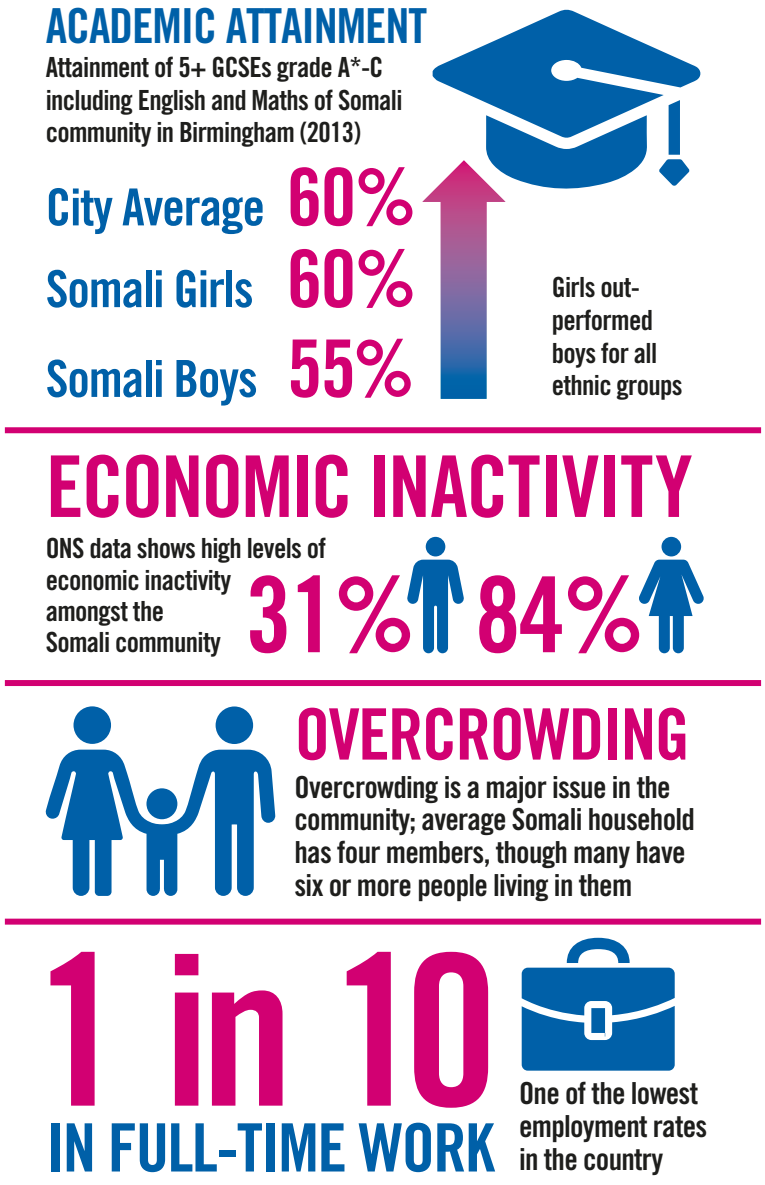
2.4.1 Physical activity

Overall levels of physical activity are low within the Somali community, and as with most ethnic minority communities, levels are lower for Somali women than men[196]. According to research, Somali women felt their physical activities have reduced and that they were more physically active before immigration[197].

Studies have found Somali women demonstrated awareness of the health risks of sedentary living; barriers to physical activity included lack of transportation to gyms, financial constraints for membership, limited choice of suitable outdoor winter clothing, and absence of women-only facilities[198].

Research has found[199] a correlation between higher levels of physical activity with years since immigration and education level. A study[200] argues this connection may mean the knowledge of the benefits of exercise may prevail over traditional societal norms.

A study conducted in the UK[201] in which Somali women were interviewed about experiences of childhood provides interesting insights into physical activity and use of outdoor spaces. Somali mothers described life in Somalia as shaped by the environment - rising at sunrise, home for a siesta at midday, and children returning home to eat and sleep when the call comes from the muezzin at sunset. They shared that children are allowed to roam outside as soon as they can crawl or walk with one mother commenting: '...people live in houses like bungalows, most of them and there are no flats... so you just open the door in the morning... as soon as kids start walking, they are let outside'. They compared this to their life in the UK which involves living in flats in more restricted environments and interaction with outdoor spaces requiring greater effort.



2.5 Working and learning well

Key findings

Qualifications, skills and training

- According to the Home Office, 64% of Somali refugees had low level English language skills at the time of their asylum decision in the UK, with this likely hindering their ability to find employment; 28% had medium fluency, and 8% had high proficiency.
- Home Office statistics found employment rates increase over time, with 20% of the refugees finding employment 8 months after the asylum decision, 28% being in employment after 15 months, and 39% in employment after 21 months.

Economic activity

- The Somali community has one of the lowest employment rates in the country with just one in ten is in full-time work. A study has found unemployment, including part-time work, among Somalis has remained high – in excess of 70%.
- ONS data show high rates of economic inactivity and unemployment among the Somali community, particularly Somali females (84%).

Housing

- Many Somali households live in severely overcrowded circumstances. According to a research study over half Somali households in the study lived in overcrowded conditions.
- It found the average family size of a Somali household was four, however more than a quarter of dwellings had six or more people living in them.

General health

- In terms of general health, 86% of Somali-born residents surveyed in the West Midlands felt they have very good or good health, higher than Somali-born residents in England and Wales (82%).
- In the West Midlands 4.8% Somali-born residents felt they have bad or very bad health, lower than those living across England and Wales (7%).

Long-standing health impairment, illness or disability

- According to the Long-term Health Problem or Disability survey, 89% of Somali-born residents 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 11% who felt it did.

2.5.1 Qualifications, skills and training

According to the Home Office, 64% of Somali refugees had low level English language skills at the time of their asylum decision in the UK, with this likely hindering their ability to find employment[202]; 28% had medium fluency, and 8% had high proficiency.

Home Office statistics found employment rates increase over time, with 20% of the refugees finding employment 8 months after the asylum decision, 28% being in employment after 15 months, and 39% in employment after 21 months[203] (see table 8).

Table 7: English language skills of refugees at the time of the asylum decision, 2005-2007

(sweep 1) by country of origin; Respondents: 5,535

Country of origin	English language skills		
	High	Medium	Low
Zimbabwe	87%	11%	2%
Ethiopia	37%	46%	18%
Pakistan	30%	29%	41%
Democratic Republic of Congo/Congo	22%	42%	37%
Eritrea	20%	53%	26%
Sudan	12%	41%	47%
Somalia	8%	28%	64%
Turkey	5%	21%	74%

Source: Home Office[204]

Table 8: Employment rates of new refugees 8, 15 and 21 months after the asylum decision, 2005-2007

	Months after the asylum decision		
	8 (sweep 2)	15 (sweep 3)	21 (sweep 4)
	Percentage of each group in employment		
Age at baseline			
18-24	28	40	50
25-34	36	45	50
35-44	36	42	46
45+	25	31	35
Sex			
Male	41	53	61
Female	18	22	24
Area of origin			
Eritrea	18	36	43
DRC/ Congo	26	32	47
Somalia	20	28	39
Sudan	25	28	49
Zimbabwe	60	68	62
Pakistan	20	29	43
Ethiopia	19	33	19

Source: Home Office[205]

A reason cited for low employment levels among Somali women was limited English language skills. A research from Joseph Rowntree Foundation (JRF) found language skills are a major barrier for Somali women's access to the labour market. While many interviewees part of the JRF research expressed a desire to learn English and acquire more education and training, many found childcare responsibilities made this difficult[206]. It also found Somali women are more likely to be caring, with some mothers preferring to look after their own children and live below the official poverty line than to use formal childcare.

The report also found[207] there was recognition by the community that the lack of qualifications and skills were a barrier to finding work, with an understanding that those with a limited education and lack of skills are at risk of suffering recurrent poverty, including single parents, the unemployed, economically inactive and skilled manual and lower-skilled workers.

2.5.2 Economic activity

The Somali community has one of the lowest employment rates in the country with just one in ten is in full-time work[208]. A study has found unemployment among Somalis remains high – in excess of 70%[209]. ONS data show high rates of economic inactivity and unemployment among the Somali community. In the three months to June 2008, ONS found the largest male unemployment rates were for Somalia, at 41%. Similarly, Somali females had the largest inactivity rates, at 84%[210].

ONS data also shows 31% of Somali men and 84% of Somali women were economically inactive. Of those economically active, 41% of men and 39% of women were unemployed. Employment rates were 40% for men and 10% for women. The male employment rate in 2008 rose from 21.5% in 1998 (see table in ONS report, pp.7[211]).

Similarly, a study[212] has highlighted that from 2003 to 2013, the employment rate of the Somali-born population has rarely been above 20% among the

working population of 16–64-year-olds. It also found that the Labour Force Survey data indicates disproportionately high levels of unemployment among under-25s from some countries, including Somalia. This is even when education as a reason for economic inactivity is considered: just 17% of Somalia-born 20–24-year-olds were in work in Q3 2012[213].

Some of the barriers cited to securing employment by studies[214] include lack of recognition of pre-migration qualifications, insufficient contacts in the UK and loss of transferable skills caused by migration.

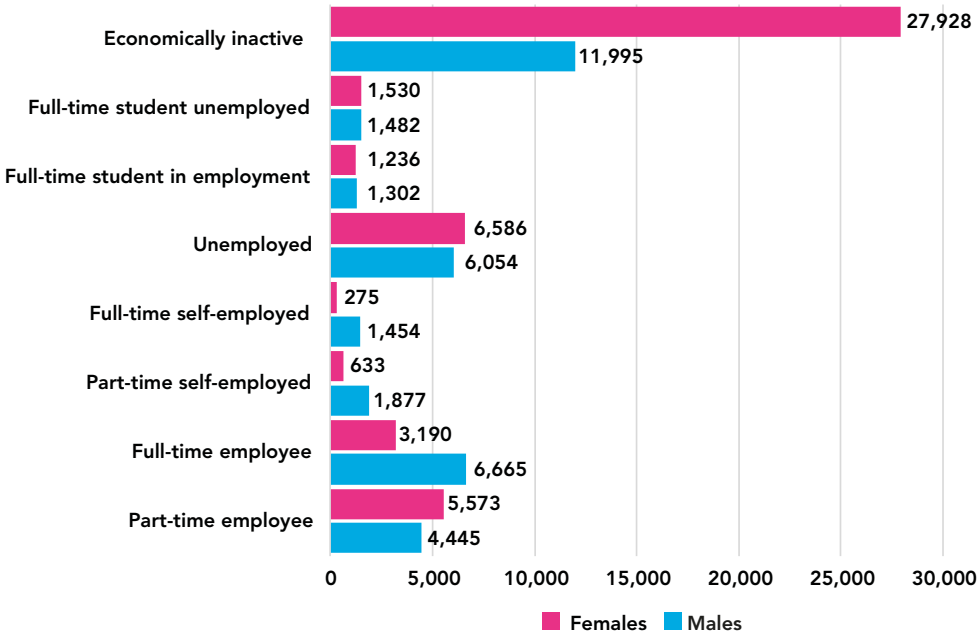
Table 9: Working age (16-64-year olds) unemployment and inactivity rates by country of birth & sex

	Male		Female	
	Unemployment rates	Inactivity rates	Unemployment rates	Inactivity rates
UK	5.7	16.7	4.7	24.5
Kenya	4.4	11.4	2.8	21.7
Nigeria	4	11.4	9.8	22
Zimbabwe	5.3	13.8	4.3	20.4
Somalia	41.4	31.4	39.1	84.2
Uganda	12.9	14.6	0	38.9

Source: ONS Labour Force Survey[215]

According to the 2011 Census data, within the working age population in the West Midlands, of those born in Somalia, 9% were in full-time employment and 13% were in part-time[216]. Within the working age population in England and Wales, of those born in Somalia, 12% were in full-time employment, the same as those in part-time employment (12%)[217].

Figure 13: Economic activity by gender, as recorded in 2011 Census for those born in Somalia; data for West Midlands



Source: 2011 Census Table CT0566

2.5.3 Housing

Overcrowding

Many Somali households live in severely overcrowded circumstances. According to a research study by Sheffield Hallam University[218] which studied the Somali community in Sheffield, Tower Hamlets, Ealing, Liverpool and Bristol found over half of their sample of Somali households lived in overcrowded conditions. It found the average family size of a Somali household was four, however more than a quarter of dwellings had six or more people living in them.

The study from Sheffield revealed over a third of households as part of the research sample contained more than one family unit, with over half of Somali households living in overcrowded conditions[219]. The impact of overcrowding in Somali households is manifold, with young Somalis expressing challenges with completing homework and studying for exams in overcrowded conditions.

Other issues identified in the research by Sheffield Hallam University include housing conditions such as damp and condensation, ineffective heating systems, poor quality repairs and maintenance and inadequate security measures[220]. It also found many Somali households rely on family or friends to report repairs.[221]

Tenure

According to the 2011 Census, majority of Somali-born in the West Midlands either rent privately (28%) or rent housing from the Council (Local Authority) 38%[222].

This mirrors the situation across England and Wales where 27% or Somali-born residents rent privately, and 37% rent from the Council (local authority)[223].

2.5.4 General health

In terms of general health, 86% of Somali-born residents surveyed in the West Midlands felt they have very good or good health, higher than Somali-born residents in England and Wales (82%). In the West Midlands 4.8% Somali-born residents felt they have bad or very bad health, lower than those living across England and Wales (7%).

Of those from Somalia in the West Midlands, 20% of 55 to 64-year olds felt they have bad or very bad health, compared to 24% across England and Wales in that age group. 25% of those over the age of 65 felt they have bad or very bad health, compared to 33% across England and Wales[224].

2.5.5 Long-standing health impairment, illness or disability

According to the Long-term Health Problem or Disability survey, 89% of Somali-born residents 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 11% who felt it did.

In slight contrast, in England and Wales, 84% of Somali-born residents living with a long-term health problem or disability felt it did not impact their day-to-day activities, lower than in the West Midlands; 16% felt it did impact their day-to-day activities, more than in the West Midlands[225].

According to the Institute for Public Policy Research (IPPR), of data collected amongst ethnic groups, Somalis are the most likely to claim Income Support, likely due to the high incidence of poverty among the group (table 10)[226]. The IPPR report[227] has also found that as Child Benefits are available to households with children, the proportion of each country-of-birth group in receipt of this benefit is affected by the groups' age and family structures. Therefore, unsurprisingly, the group with the highest proportion claiming Child Benefit is the Somali-born, the youngest of the country-of-birth groups featured in the table below[228] (table 11).

At 7%, the Somali group had a greater tendency to claim benefits available to people with a long-term sickness or disability, compared to other ethnic groups (table 12).

Table 10: Proportion of population claiming Income Support by country of birth, 2005/06

Country of birth	Income support
Somalia	39%
Zimbabwe	3%
Jamaica	6%
Nigeria	5%
Ghana	3%
Kenya	3%
Uganda	7%

Source: LFS and ippr report pp27; LFS and ippr calculations[229]

Table 11: Proportion of population claiming Child Benefit by country of birth, 2005/06

Country of birth	Child benefit
Somalia	40%
Zimbabwe	16%
Jamaica	16%
Nigeria	22%
Ghana	24%
Kenya	24%
Uganda	25%

Source: LFS and ippr report pp29; LFS and ippr calculations[230]

Table 12: Proportion of population claiming sickness or disability benefits by country of birth, 2005/06

Country of birth	Sickness or disability benefit
Somalia	7%
Zimbabwe	1%
Jamaica	8%
Nigeria	1%
Ghana	2%
Kenya	8%
Uganda	5%

Source: LFS and IPPR report pp28; LFS and IPPR calculations[231]

A Healthwatch Birmingham Health Inequalities Report identified the challenges and barriers that impact experiences of health and social care for Somali people in Birmingham both prior to and during the Covid-19 pandemic. As found by the BLACHIR report, the interaction of various inequalities of religion and ethnicity impacts access to care, the quality of care and health outcomes. It is also essential to understand people's experiences of health and social care on a case by case basis and a move away from grouping people under the broad term of BAME.

The report also revealed that stigma, discrimination and issues around stereotypes tend to guide the interaction between Somalis and health and social care services. Discrimination has also made people more reluctant to access services. Some participants said they have become accustomed to the discrimination they face and fail to raise it as an issue due to fear of affecting access to services for themselves and their families. Trust between Somali people and health and social care services in Birmingham is lacking, leading to caution in seeking treatment and a reliance on alternative sources of care and advice.

Culture and language barriers have considerable impact on how care is delivered and accessed. The Somali participants stated that many healthcare professionals lack cultural sensitivity and the ability to communicate in a manner easily understood by diverse audiences including persons with limited English and low literacy skills. They also cited a need to examine the views and values of those delivering services. Face-to-face interaction with health and social care professionals are important for Somali people. Digital delivery of services has the potential to exclude them, but also there needs to be adequate access to interpreters/translators that are knowledgeable, reliable and able to explain medical terminology in simple terms.

CANCER SCREENING

The limed data and information on the take up of breast and cervical cancer screening by Somali women shows that screening is infrequent for both types of cancers

BARRIERS TO SCREENING

Hesitancy to use male practitioner

Perceived low susceptibility to HPV and cancer

Embarrassment of FGM

Distrust of health care system

SEXUAL HEALTH

A Birmingham-based study found limited knowledge within the community of sexual health services; barriers in accessing services included

SHAME, STIGMA AND TABOO, LANGUAGE BARRIERS AND ABSENCE OF CULTURALLY AWARE AND SENSITIVE HEALTHCARE PROFESSIONALS

One of the highest rates of TB in the UK are found among people of Somali ethnicity. People born in Somalia account for

3%

OF THE UK'S TB CASES, WITH A MEDIAN TIME OF 10 YEARS FROM ENTRY TO NOTIFICATION SINCE ARRIVAL TO THE UK

2.6 Protect and detect

Key findings

Screening

- Screening uptake data for the Somali community for most cancers is unavailable.
- The limited data and information on the take up of breast and cervical cancer screening by Somali women shows that screening is infrequent for both types of cancers.

Sexual health

- There is scarce information and data on sexual health of the Somali community in the UK.
- A study sponsored by Birmingham City University explored the sexual health needs of the local Somali community. It revealed limited knowledge within the community of sexual health services. Barriers included issues relating to shame, stigma and taboo, and absence of culturally aware and sensitive healthcare professionals.

Tuberculosis (TB)

- For those born outside the UK who were notified with TB in 2020, the most frequent countries of birth were India, Pakistan, Romania, Somalia and Eritrea.
- 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%).

Domestic violence

- Data on domestic violence within the Somali community is scarce; a survey found 68% of the respondents expressed that if they experienced domestic violence they would first seek help from community leaders in the UK or another country before seeking help from authorities like the police in the UK.

2.6.1 Screening

Screening uptake data for the Somali community for most cancers is unavailable. The limited data and information on the take up of breast and cervical cancer screening by Somali women shows that screening is infrequent for both types of cancers[232].

It is worth noting that while statistics are not systematically collected on breast cancer in Somalia, according to the World Health Organization (WHO) statistics of May 2014[233] show cancer claims the lives of at least 3,200 women in Somalia each year. Breast cancer accounts for majority of this statistic making up 19% of the deaths, followed cervical cancer and cancer of the oesophagus.

A study from the United States provides a useful insight into this topic. A study[234] from Minnesota assessed what Somali immigrant women know about breast and cervical cancer, their attitudes toward screening, explored cultural barriers to screening as well as cultural factors that would facilitate screening (n=29 women; four focus groups). The study identified the need to address cultural misperceptions to develop culturally-appropriate interventions. It also highlights the requirement for a more nuanced response to address barriers specific to younger and older Somali groups, with the potential for culturally informed beliefs to be integrated into intervention development, preventive care and screening promotion.

Another published study from the United States, again with a focus on Somali migrants in Minnesota[235], found Somali women had higher rates of mammogram use but lower rate of cervical smear testing when compared to other African immigrant women in the study.

A qualitative study[236] from the Netherlands may also help provide some insight; the study assessed the perceptions of Somali women in the Netherlands about the prevention of cervical cancer. It notes participation in Human Papillomavirus (HPV) vaccination and cervical smear testing is low among ethnic minorities in the Netherlands, which may because information about the cervical cancer prevention methods is not available in the appropriate languages to make it appropriate and informative for Somali women living in the diaspora.

It identified several issues including distrust of the Dutch health care system; embarrassment regarding cervical smears due to Female Genital Mutilation (FGM); hesitation to be checked by a Dutch, male practitioner; and a perceived low susceptibility to HPV and cancer because of the religious norms that prohibit sex before marriage. The study also found for some Somali mothers, FGM forms a barrier to cervical smear testing[237].

2.6.2 Sexual health

There is scarce information and data on sexual health of the Somali community in the UK. An 8-month long study[238] sponsored by Birmingham City University explored the sexual health needs of the local Somali community by understanding their perspective of what they know about sexual health services, the challenges that may prevent them taking up these services and how services could be adapted to best meet their needs. The study revealed limited knowledge within the community of sexual health services; barriers included issues relating to shame, stigma and taboo; the influence of gender, religious and cultural norms; language barriers; and absence of culturally aware and sensitive healthcare professionals[239].

As a broader context the study established that many refugees have significant health problems related to their experiences of war and migration, including HIV and other notifiable diseases[240]. It is thought that many Somalis might not be aware that they are infected and that not accessing treatment may raise the risk of the infection being spread.

The study also found that there is stigma around sexuality and sexual health, resulting in the topic rarely being discussed within the community. It recommends the need to raise awareness among the Somali community about local sexual health services, including creating resources which can help the community access information with greater ease[241].

2.6.3 Tuberculosis

For those born outside the UK who were notified with TB in 2020, the most frequent countries of birth were India, Pakistan, Romania, Somalia and Eritrea[242]. 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%)[243].

Overall, in 2020, 40.6% (1,098 out of 2,708) of people with TB born outside the UK were notified less than 6 years since entering the UK, with 18.9% (511 out of 2,098) being notified within 2 years. For people born in Somalia the median time from entry to notification was over 10 years[244].

It is worth noting that the incidence of TB is growing faster in Birmingham[245]. Cases grew by 107% between 1999 and 2009 in Birmingham, whereas in England as a whole, where it grew by 57% between 1987 and 2008[246]. TB admissions in Birmingham have been concentrated in wards with a higher proportion of ethnic minority groups, particularly South Asian communities[247].

2.6.4 Domestic violence

Data on domestic violence within the Somali community is scarce; a survey conducted by Women's Inclusive Team (WIT) – a support group for Somali women in Tower Hamlets – found among its members, 68%[248] expressed that if they experienced domestic violence, they would first seek help from tribal leaders in the UK or another country before seeking help from authorities like the police.

WIT has found[249] tribal community leaders are often the first point of contact if there are domestic issues related to marriage or family.

12.1% HIGHER PREVALENCE OF DIABETES AMONGST SOMALI POPULATION IN THE U.S COMPARED WITH THE GENERAL POPULATION **5.3%**

CARDIOVASCULAR DISEASE

Research from Finland has found Somali men were less likely to have more than one cardiovascular risk factor compared with men from the general Finnish population. Conversely, Somali women were more likely to have two or more cardiovascular risk factors

DEMENTIA

The risk of dementia increases with age, particularly after the age of 65; Birmingham's over 65 Somalis account for only **1.5%** OF THE COMMUNITY'S POPULATION

INDICATING PREVALENCE OF DEMENTIA WILL LIKELY BE LOW

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

There is an absence of statistics on the prevalence of COPD within the Somali community in the UK

40% OF KHAT CHEWERS HAD RESTRICTIVE PATTERNS OF LUNG DISEASES

Research on chronic consumption of khat in Ethiopia reveals its impact on lung function, which may be applicable to the Somali community

END OF LIFE

US study found it is likely Somali children prefer to look after their elderly; in Somalia parents raise children and children care for parents in their old age. Studies suggest treatment plans should allow for Somali children to care for the terminally ill and elderly instead of prolonged hospitalisations or placement in a nursing or hospice facility

2.7 Ageing well and dying well

Key findings

Diabetes

- A published study from the United States has found the prevalence of diabetes mellitus was significantly higher among Somali patients (n= 1007) compared to the non-Somali (n=1010) patients (12.1% vs 5.3%).

Cardiovascular disease

- There is limited research on CVD risk within the Somali community in the UK.
- Research from Finland has found Somali men were less likely to have more than one cardiovascular risk factor compared with men from the general Finnish population. Conversely, Somali women were more likely to have two or more cardiovascular risk factors.

Respiratory Health/Disease

- While there is an absence of statistics on the prevalence of COPD within the Somali community in the UK, research on chronic consumption of khat in Ethiopia reveals its impact on lung function, which may be valid for the Somali community as well.
- The study reveals that for majority of khat chewers, 40.1%, had patterns of restrictive lung disease.

Dementia

- The risk of dementia increases with age, particularly after the age of 65.
- While statistics on the prevalence of dementia within the community are unavailable, as the Somali community in the UK has a young age profile, with those aged 65 and over within Birmingham's Somali ethnic group accounting for only 1.5% (2011 Census, SP009) of the community's population in the city, the prevalence of dementia at present likely remains low.

End of life

- There is limited information on uptake of end of life care by UK Somalis.
- Research from the United States has found it is likely Somali children prefer to look after their parents. It suggests a treatment plan that allows for children and the community to care for terminally ill parents or elders at home and Islamic prayers and conventions to be carried out, would likely be favoured over a prolonged hospitalisation or placement in a nursing or hospice facility.

2.7.1 Diabetes

A published study[250] has found the prevalence of diabetes mellitus was significantly higher among the Somali patients (n= 1007) compared to the non-Somali (n=1010) patients (12.1% vs 5.3%).

Somali patients also had a higher prevalence of prediabetes (21.3% vs 17.2%). It also found the Somali community to have more patients who were obese (34.6% vs 32.1%), and overweight (33.2 vs 30.4 %). The prevalence of hypertension (17.0% vs 15.5 %) and uncontrolled hypertension (5.0% vs 6.2%) was similar in both groups, and the prevalence of dyslipidemia among the Somali patients was lower than that of the non-Somali cohort (18.1% vs 21.6%)[251].

Another study[252] [253] from Minnesota examined medical records (n=584) from 1993 to 2006. It found that Somali women who delivered their babies in the latter half of this period had a rate of gestational diabetes that was three times higher than those delivering in the first half of the period (5.2% vs 15.1%).

2.7.2 Cardiovascular disease (CVD)

There is limited research on CVD risk within the Somali community[254] in the UK. However, research from Finland[255] has found Somali men were less likely to have more than one cardiovascular risk factor compared with men from the general Finnish population. Conversely, Somali women were more likely to have two or more cardiovascular risk factors.

The research found Somali migrants had a notably lower prevalence of hypertension but significantly higher prevalence of several other risk factors, including impaired glucose metabolism, low HDL cholesterol and abdominal obesity.

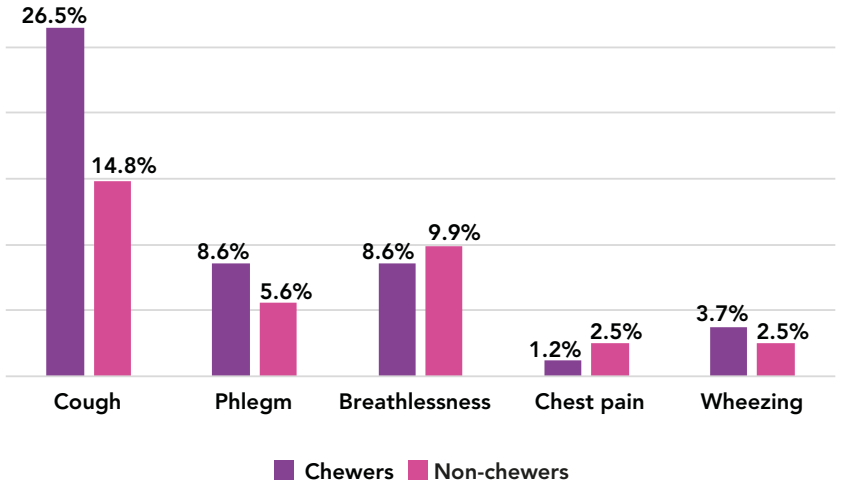
A research[256] from the United States conducted in 2015 surveyed 1156 Somalis and found prevalence of diabetes and low physical activity among men and women was high. It also found overweight, obesity, and dyslipidemia were also particularly prevalent. Levels of calculated CVD risk across the community were greater for men than women, however overall CVD risk was found to be lower among Somalis than the general U.S. population.

2.7.3 Chronic Obstructive Pulmonary Disease (COPD)

While there is an absence of statistics on the prevalence of COPD within the Somali community in the UK, research on chronic consumption of khat in Ethiopia reveals its impact on lung function. This study reveals that for majority of khat chewers, 40.1%, had restrictive patterns of lung diseases. In light of this finding it would be valuable to investigate impact of chronic khat chewing on lung function within UK's Somali community.

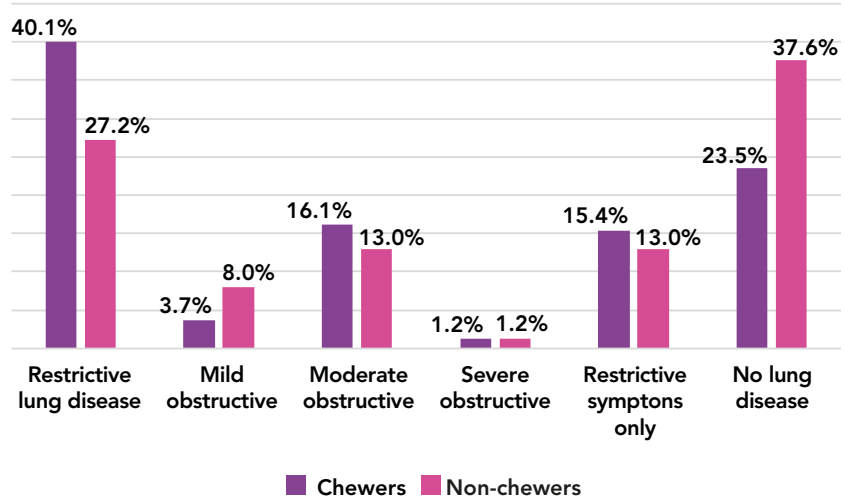
A published study[257] on the impact of chronic khat chewing on pulmonary function parameters and oxygen saturation among chronic khat chewers in Ethiopia found the percentage prevalence of cough was 26.5% for khat chewers compared to 14.8% for non-chewers. It also concluded obstructive pattern of lung function impairment was found in 21.6% participants; of these, 10.5% were khat chewers and 11.1% were non-chewers. Among the khat chewers, 3.7%, 16.1% and 1.2% had mild, moderate and severe obstructive lung diseases, respectively. Similarly, 8%, 13% and 1.2% of non-chewers had mild, moderate and severe obstructive lung diseases, respectively (see figures 13 and 14).

Figure 14: Respiratory symptoms of khat chewers (n=162) and non-chewers (n=162) in Wolkite, Ethiopia, 2018.



Source: Woldeamanuel GG, et al[258]

Figure 15: Percentages of khat chewers (n=162) and non-chewers (n=162) stratified by lung function category in Wolkite, Ethiopia, 2018.



Source: Woldeamanuel GG, et al[259]

2.7.4 Dementia

The risk of dementia increases with age, particularly after the age of 65. While statistics on the prevalence of dementia within the community are unavailable, as the Somali community in the UK has a young age profile, with those aged 65 and over within Birmingham's Somali ethnic group accounting for only 1.5% (2011 Census, SP009) of the community's population in the city, the prevalence of dementia at present remains low.

Research[260] from Healthwatch Islington found a general reliance on family and local community networks for support for those managing family members with dementia. Somali participants in the focus group expressed mistrust of health services in general, which made them less likely to access dementia services. It is worth noting, there are a number of Somali organisations in the UK which provide advice and support services for dementia awareness and management.

2.7.5 End of life

There is limited data and information on end of life care with a focus on Somali community members in the UK. Research[261] from the United States has found it is likely preferred by Somali children to look after their parents as in Somalia the expectation is that parents raise children, and children care for parents in their old age. The study suggests a treatment plan that allows for children and the community to care for terminally ill parents or elders at home, with Islamic prayers and conventions to be carried out, would likely be favoured over a prolonged hospitalisation or placement in a nursing or hospice facility[262].

The study found that as Somali immigrants have a high prevalence of PTSD and other psychiatric or depressive disorders, it is especially important for care providers to address emotional as well as physical causes of suffering[263].

2.8. Closing the gaps

Key findings

Deprivation

- The Somali community across the UK experience high levels of poverty, with most living in overcrowded housing, majority being economically inactive, experiencing high levels of unemployment, along with many managing health issues like PTSD.
- As aforementioned, the Joseph Rowntree Foundation (JRF) has found higher rates of lone-parent Somali households, and research on the impact of the pandemic on single parent households has found it is likely nearly half (44%) of children in a single parent family were in poverty on the eve of the Coronavirus pandemic, compared to just one in four (26%) of those living in other families.

2.8.1 Deprivation

The Somali community across the UK experience high levels of poverty, with most living in overcrowded housing, majority being economically inactive experiencing high levels of unemployment, along with many managing health issues like PTSD. As aforementioned, the Joseph Rowntree Foundation (JRF) has found higher rates of lone-parent Somali households and research[264] on the impact of the pandemic on single parent households has found it is likely nearly half (44%) of children in a single parent family were in poverty on the eve of the Coronavirus pandemic, compared to just one in four (26%) of those living in other families.

In light of this broader context, the Coronavirus pandemic has especially impacted the Somali community. According to research[265] from the Anti-Tribalism Movement (ATM), many Somali women work in the care industries and had been on the frontline of the pandemic, and many Somali men work in the gig economy and likely faced high rates of virus exposure along with job insecurity. ATM's research also highlights that the overcrowded housing of the Somali community would likely make shielding vulnerable community members more challenging.

With already high levels of PTSD in the community, the sudden loss of family and community members to the virus likely further burdened Somalis, particularly the inability to mourn the loss of loved ones due to burial restrictions during the pandemic.

2.9. Contributing to a Green & Sustainable Future

Key finding

- The largest populations of Somalis in Birmingham are found in Nechells, Aston, Bordesley Green, Sparkbrook and Lozells; these wards have some of the highest mean value on the environmental justice mapcompared to just one in four (26%) of those living in other families.

The Environmental Justice map[266] 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 Somalis in Birmingham are found in Nechells, Aston, Bordesley Green, Sparkbrook and Lozells; these wards have some of the highest mean value on the environmental justice map (listed below).

Table 13: Wards with greatest proportion of Somali population with Birmingham City Council's Environmental Justice Index

Birmingham ward	Index – mean value	Somali population (%)
Nechells ward	0.42	1.2
Aston ward	0.42	0.7
Bordesley Green ward	0.39	0.7
Sparkbrook ward	0.39	0.5
Lozells ward	0.40	0.4
Ladywood ward	0.33	0.3
Soho ward	0.36	0.3

Source: Birmingham City Council[267]

3.0 Conclusion

This report has highlighted the inequalities experienced by the Somali community within the UK and Birmingham, some of which include increased risk of stillbirths to Somali mothers, higher levels of mental ill-health and low levels of mental health service use, higher levels of drug (khat) use, and greater prevalence of diabetes. This Community Health Profile is to support the council, communities and partners to better understand the inequalities affecting the Somali community. The multiple factors that have been identified by the report can be used to inform the work to address inequalities across the city.

However, as identified within the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR), measurements of Black ethnic people may not always consider the needs of Black African individuals. Services could consider evidence-based ethnic differences in outcome measures, such as using BMI versus waist-to-height measures. By ensuring that data collection is more reflective of the communities' needs and with help of this community health profile, we will have a greater understanding of the inequalities that exist within individuals from the Somali community, which may strengthen the methods that we use to address such inequalities.

4.0 Appendix

Appendix 1: Search strategy

Getting the best start in life	Mental wellness and balance	Healthy and affordable food	Active at every age and ability	Working and learning well
"Somali" and "children" or "young people" or "youth" or "child" or "babies" or "childhood"	"Somali" and "mental health" or "mental" or "health" or "wellbeing" or wellness" or "access" or "balance"	"Somali" and "food" or "diet" or "obesity" or "meat" or "vegetarian"	General: "Somali" and "physical activity" or "activity" or "exercise"	General: "Somali" 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: "Somali" 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"	Specific: "Somali" 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"	Specific: "Somali" 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"	Specific: "Somali" and "vigorous exercise" or "moderate exercise" or "walking" or "running" or "sports" or "cardiovascular" or "elderly exercise" or "health promotion"	Specific: "Somali" 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: Raw Data Table for Figure 1: Proportion of Somali-born people, by local authority in UK

UK Local Authority	Percentage of Somali Born People
Greater Manchester	0.2
Manchester	0.7
Merseyside	0.1
Liverpool	0.3
South Yorkshire	0.2
Sheffield	0.4
East Midlands	0.1
Leicester	1
Northamptonshire	0.2
Northampton	0.5
West Midlands	0.2
Birmingham	0.7
Coventry	0.4
London	0.8
Camden	1.3
Hackney	0.6
Hammersmith and Fulham	1.5
Haringey	1.3
Islington	1.2
Lambeth	0.8
Lewisham	0.4

UK Local Authority	Percentage of Somali Born People
Newham	1.3
Southwark	0.6
Tower Hamlets	1.2
Wandsworth	0.8
Barking and Dagenham	0.6
Barnet	0.7
Brent	2.2
Croydon	0.3
Ealing	1.9
Enfield	1.1
Greenwich	0.7
Harrow	0.9
Hillingdon	1.1
Hounslow	1.1
Redbridge	0.6
Waltham Forest	0.9
Slough	0.9
Milton Keynes	0.5
South West	0.1
Bristol	1.2

Appendix 3: Raw Data Table for Figure 2: National identity for all residents with Somali ethnic group, England and Wales; in percentage (%)

National Identity	Percentage
British only identity	59%
English only identity	10%
English and British only identity	2%
Welsh only identity	0%
Other identity and at least one of British, English, Northern Irish, Scottish, Welsh identities	6%
French	0%
German	0%
Italian	0%
Portuguese	0%
Other member countries	19%
Polish	0%
Turkish	0%
Other European	2%

Appendix 4: Raw Data Table for Figure 3: 20 largest non-English main languages by number of speakers in UK

Language	Number of Main Language Speakers
Polish	546174
Panjabi	273231
Urdu	268680
Bengali	221403
Gujarati	213094
Arabic	159290
French	147099
Chinese, Other	141052
Portuguese	133453
Spanish	120222
Tamil	100689
Turkish	99423
Italian	92241
Somali	85918
Lithuanian	85469
German	77240
Persian/Farsi	76391
Tagalog or Filipino	70342
Romanian	67586
Russian	67366

Appendix 5: Raw Data Table for Figure 4: Arrivals from Somalia to London, the West Midlands, and England and Wales, by year

Time Period of Arrival	Number of Arrivals in West Midlands	Number of Arrivals in London	Number of Arrivals in England and Wales
Before 1981	38	496	915
1981-1990	148	4788	6093
1991-2000	1519	27779	36290
2001-2003	3943	14309	25665
2004-2006	2578	10400	18670
2007-2009	1313	6129	11003
2010-2011	331	1432	2731

Appendix 6: Raw Data Table for Figure 5: Arrivals from Somalia to the West Midlands, by gender

Time Period of Arrival	Males Arriving in West Midlands from Somalia	Females Arriving in West Midlands from Somalia
Before 1981	18	20
1981-1990	81	67
1991-2000	760	759
2001-2003	1734	2209
2004-2006	1197	1381
2007-2009	569	744
2010-2011	148	183

Appendix 7: Raw Data Table for Figure 6: Small population datasets: population breakdown by 'Somalia' country of birth, by gender, in Birmingham

Age Range	Percentage of Females born in Somalia Living in Birmingham	Percentage of males born in Somalia Living in Birmingham
80 and Over	0.3	0.2
75-79	0.5	0.5
70-74	1.4	0.8
65-69	0.9	1.1
60-64	1	1.2
55-59	1.4	2.5
50-54	3.8	4.6
45-49	6.7	8.9
40-44	14.8	13.5
35-39	13.7	9.8
30-34	12	8.9
25-29	10.2	8.2
20-24	11	10.7
15-19	9.8	12.3
10-14	8.8	12
5-9	3	4.4
0-4	0.8	0.6

Appendix 8: Raw Data Table for Figure 7: Small population datasets: population breakdown by Somali ethnic group, by gender, in Birmingham

Age Range	Percentage of males of Somali Ethnic group Living in Birmingham	Percentage of Females of Somali Ethnic Group Living in Birmingham
80 and Over	0.1	0.1
75-79	0.3	0.3
70-74	0.3	0.8
65-69	0.7	0.4
60-64	0.7	0.6
55-59	1.3	0.6
50-54	2.6	1.7
45-49	4.8	3.9
40-44	7.4	8.3
35-39	4.3	8.8
30-34	3.5	6
25-29	2.8	4.4
20-24	4.2	5.3
15-19	12.9	11.3
10-14	21.2	17.7
5-9	17.6	16.5
0-4	15.3	13.3

Appendix 9: Raw Data Table for Figure 8: 2011 Census Commissioned Table: Country of Birth Somalia – Population Pyramid Tool

Age Range	Percentage of Males born in Somalia living in the West Midlands	Percentage of Females born in Somalia living in the West Midlands	Percentage of Males born in the United Kingdom living in the West Midlands	Percentage of Females born in the United Kingdom living in the West Midlands
80 and Over	0	0	3	6
75-79	0	1	3	4
70-74	1	1	4	4
65-69	1	1	5	5
60-64	1	1	6	6
55-59	2	1	6	6
50-54	5	4	6	6
45-49	9	7	7	7
40-44	13	15	7	7
35-39	10	13	6	6
30-34	9	12	5	5
25-29	9	10	6	6
20-24	12	11	7	6
16-19	10	8	6	5
10-15	14	11	8	7
5-9	4	3	6	6
0-4	1	1	7	7

Appendix 10: Raw Data Table for Figure 9: 2011 Census: Country of birth, by age – Birmingham

Country of Birth	Percentage living in Birmingham aged 65 and over	Percentage living in Birmingham aged between 15-64	Percentage living in Birmingham aged between 0-14	Percentage of Females born in the United Kingdom living in the West Midlands
Pakistan	11.80%	84.30%	3.90%	6
India	20.64%	75.84%	3.53%	4
Ireland	59.46%	39.73%	0.81%	4
Jamaica	38.13%	59.15%	2.73%	5
Bangladesh	8.58%	87.83%	3.59%	6
Poland	4.43%	83.95%	11.62%	6
Somalia	2.83%	82.60%	14.57%	6
Nigeria	2.91%	85.82%	11.27%	7
Philippines	1.09%	86.48%	12.42%	7
France	4.44%	77.32%	18.24%	6
South Africa	8.46%	83.55%	7.99%	5
Romania	0.91%	76.55%	22.54%	6
Ghana	5.89%	88.32%	5.79%	6
Sri Lanka	6.16%	86.76%	7.08%	5
Cyprus	23.09%	74.68%	2.24%	7
Bulgaria	1.53%	92.69%	5.78%	6
Turkey	1.00%	95.26%	3.74%	7

Appendix 11: Raw Data Table for Figure 10: Age profile of 0-19-year olds within Birmingham's Somali ethnic group, compared to the general population of Birmingham; shown in percentage %

Age Group	Percentage of Somali population in Birmingham	Percentage of general population of Birmingham
15-19	12	7
10-14	19	7
5-9	17	4
0-4	14	8

Appendix 12: Raw Data Table for Figure 11: 5+ GCSEs A*-C including English and Maths by ethnicity, gender and free-school meals eligibility Birmingham schools, 2013

Demographic Group	Percentage achieving 5+ GCSEs A*-C in Birmingham
White British Boys eligible for free school meals	31%
White British Girls eligible for free school meals	45%
Pakistani Boys eligible for free school meals	46%
Pakistani Girls eligible for free school meals	55%
Somali Boys eligible for free school meals	55%
Somali Girls eligible for free school meals	60%
Bangladeshi Boys eligible for free school meals	63%
Bangladeshi Girls eligible for free school meals	65%
Local Authority Average	60%

Appendix 13: Raw Data Table for Figure 12: Percentage of Black African pupils achieving 5+A*-C at GCSE, 2003 and 2005

Demographic group	Percentage achieving 5+ GCSEs A*-C (2003)	Percentage achieving 5+ GCSEs A*-C (2005)
Ghanaian	46%	53%
Nigerian	54%	56%
Somali	22%	29%
Black African (National Figure)	41%	48%
All Pupils (National Figure)	51%	55%

Appendix 14: Raw Data Table for Figure 13: Economic activity by gender, as recorded in 2011 Census for those born in Somalia; data for West Midlands

Economic Activity	Females born in Somalia Living in the West Midlands	Male born in Somalia Living in the West Midlands
Economically Inactive	27928	11995
Full-time Student unemployed	1530	1482
Full-time student in employment	1236	1302
Unemployed	6586	6054
Full-time self-employed	275	1454
Part-time self-employed	633	1877
Full-time employee	3190	6665
Part-time employee	5573	4445

Appendix 15: Raw Data Table for Figure 14: Respiratory symptoms of khat chewers (n=162) and non-chewers (n=162) in Wolkite, Ethiopia, 2018.

Respiratory problem	Khat Chewers	Non-Khat-Chewers
Cough	26.5	14.8
Phlegm	8.6	5.6
Breathlessness	8.6%	9.9%
Chest Pain	1.2%	2.5%
Wheezing	3.7%	2.5%

Appendix 16: Raw Data Table for Figure 15 Percentages of khat chewers (n=162) and non-chewers (n=162) stratified by lung function category in Wolkite, Ethiopia, 2018.

Lung Function category	Khat-Chewers	Non-Khat-Chewers
Restrictive Lung Disease	40.1%	27.2%
Mild Obstructive	3.7%	8%
Moderate Obstructive	16.1%	13%
Severe Obstructive	1.2%	1.2%
Respiratory Symptoms Only	15.4%	13%
No Lung Disease	23.5%	37.6%

5.0 Acknowledgements

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Barques Design – Production of Artwork/Typesetting

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