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## 1. Statutory Reports

### **Joint Strategic Needs Assessment**

A regularly refreshed snapshot of the health and wellbeing of the citizens of Birmingham and the factors underpinning this.

Highlights the inequalities at a high level across the city.

Draws together data from across the Council and public sector.

### **Annual Director of Public Health Report**

Annual independent report of the Director of Public Health on a specific topic/focus area to shine a light on an issue.

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## 2. Elective Evidence Reports

### Deep Dive Needs Assessments

Structured needs assessments into a specific area/topic/community

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Birmingham has an ambition for a **bolder healthier city**, becoming a city in which, every citizen can live a healthy enjoyable life.

The Community Health Profiles help us understand the gaps (health inequalities) in achieving this ambition in different communities.

The Profiles describe the health inequalities of a specific community of identity or interest or experience.

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- Sikh – (Sept 2021)
- Bangladeshi- (Sept 2021)
- **Muslim**
- Lesbian
- Trans
- d/Deaf & Hearing Loss
- Sight Loss
- Nigerian
- Indian
- Caribbean Islands  
Commonwealth States
- Somali
- Kenyan
- Pakistani

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- Veterans (published)
- End of Life (published)
- Learning Disabilities
- Dual Diagnosis
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# Original Document

A comprehensive review of

- Academic literature, including EBSCO, SocINDEX, Academic Search Complete, CINAHL, PubMed/Medline, Google Scholar, Science Direct and SCOPUS
- Grey Literature, including voluntary and community sector, ONS, NHS, PHE, Google, Muslim specific organisations.

Inclusion criteria: Birmingham/UK population, post- 2000, > 10 Muslim participants (or > 10% of sample)



# Population data used is from the 2011 Census and is likely to have changed since then. Conclusions on populations must therefore be taken with caution.

Often studies fail to recognise the diverse ways of defining difference and the multiplicity of hybrid identities that have come to be associated with the socially constructed category of the British Asian Muslim.

Limitations of findings, e.g. lack of data which classified the religion of participants, conflation between ethnicity and religion, use of ethnicity as a proxy

- Proxy assessments have been made in this report using data from Pakistani and Bangladeshi communities in the UK or in some cases other South Asian communities.

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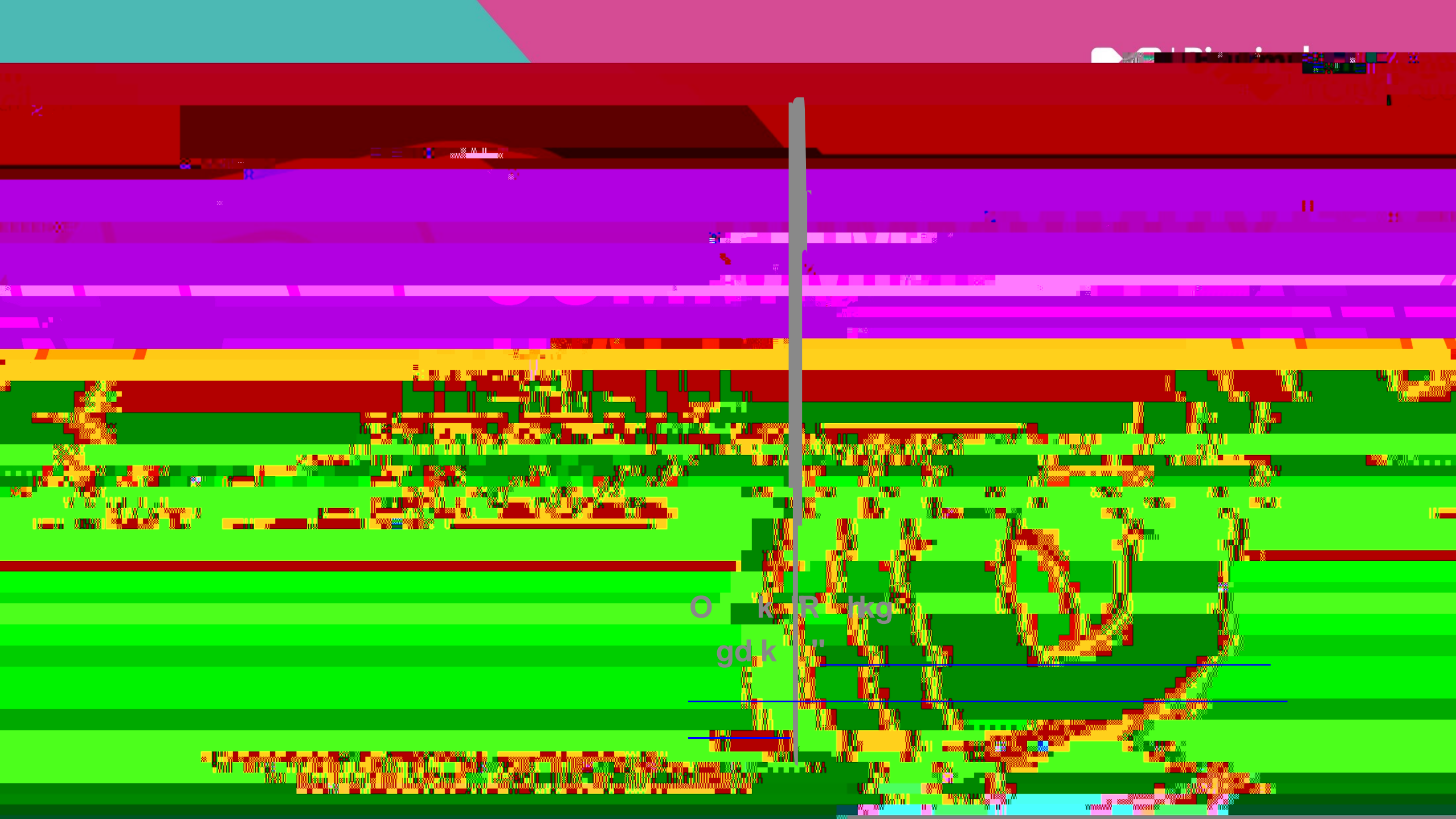
Written report & PowerPoint slide set

Published on the [BCC Communities Pages](#)

YouTube highlights video

Webinars for Muslim community and wider partners

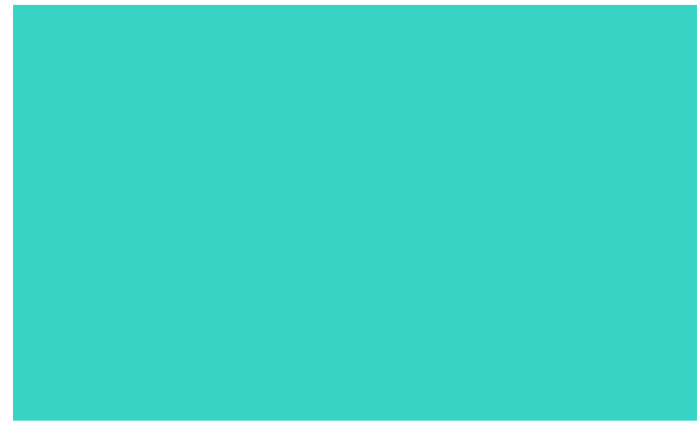
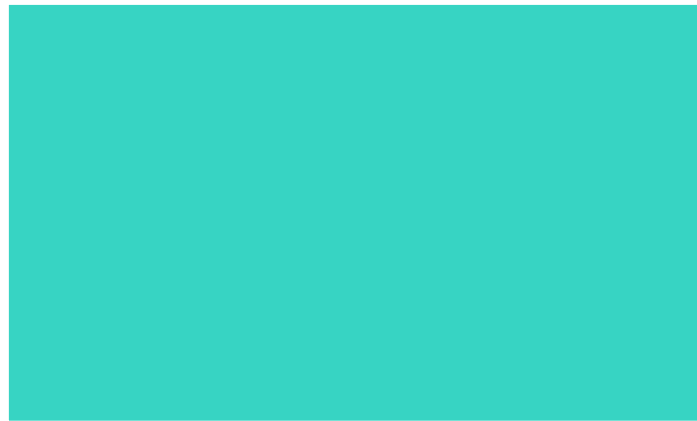




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- 23% of Muslims aged 55 and over





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43% of Muslims were classified



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# Range of findings

## Screening

- Muslims (**26%**) had the lowest uptake of bowel cancer screening compared to South Asians (**33%**) and non-South Asians (**61%**).<sup>[40]</sup>
- Muslim women (**51%**) are less likely to attend breast screening than Hindu and Sikh women.<sup>[40]</sup>



## Barriers to Screening<sup>[41-45]</sup>

- Lack of awareness to services.
- Feelings of embarrassment.
- Communication and literacy barriers.
- Sex and ethnicity of healthcare professional and a lack of cultural competence from services.

## COVID-19

- Muslims (**40%**) were the least likely to be vaccinated against COVID-19 compared to other religions.<sup>[46]</sup>
- Muslim males had a COVID-19 mortality rate **2.7** times higher than Christian males (**2.4x** higher for women).<sup>[47]</sup>

# Cultural Differences

Muslim women over 65 report more bad health (**38.2%**) than other women (**16.1%**) and more bad health than Muslim men over 65 (**38.2% vs 26.7%**).<sup>[48]</sup>

Older Muslim patients have difficulty accessing and understanding medical advice because of language and cultural barriers.<sup>[49]</sup>

Muslim families make less use of hospices and care homes as they may not receive cultural support than is in line with the Muslim faith.<sup>[51]</sup>

Cultural Differences [6: 72]



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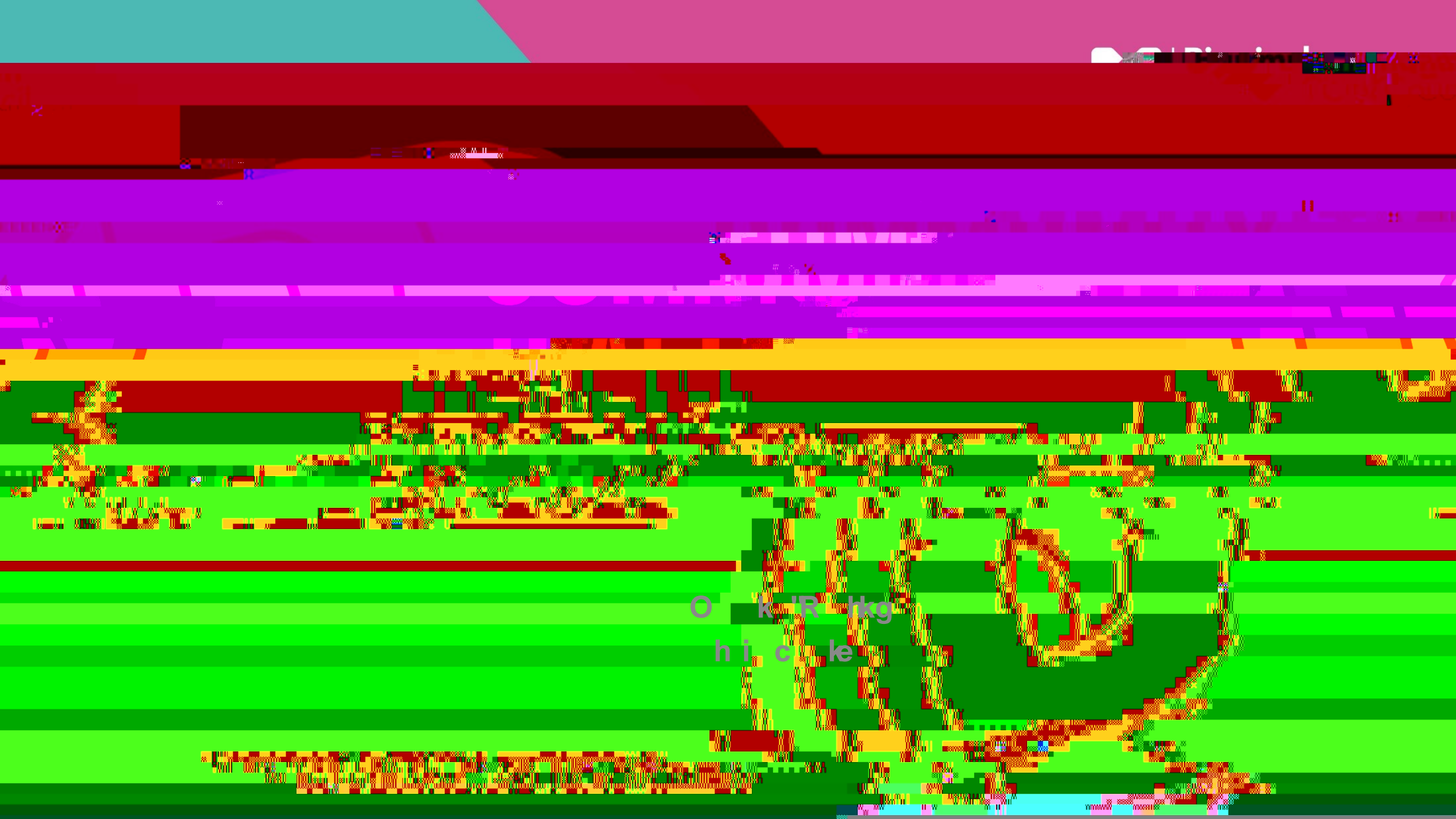
Data on life expectancy by religious affiliation is not available.  
Limited data on many areas of health specific to Muslims.



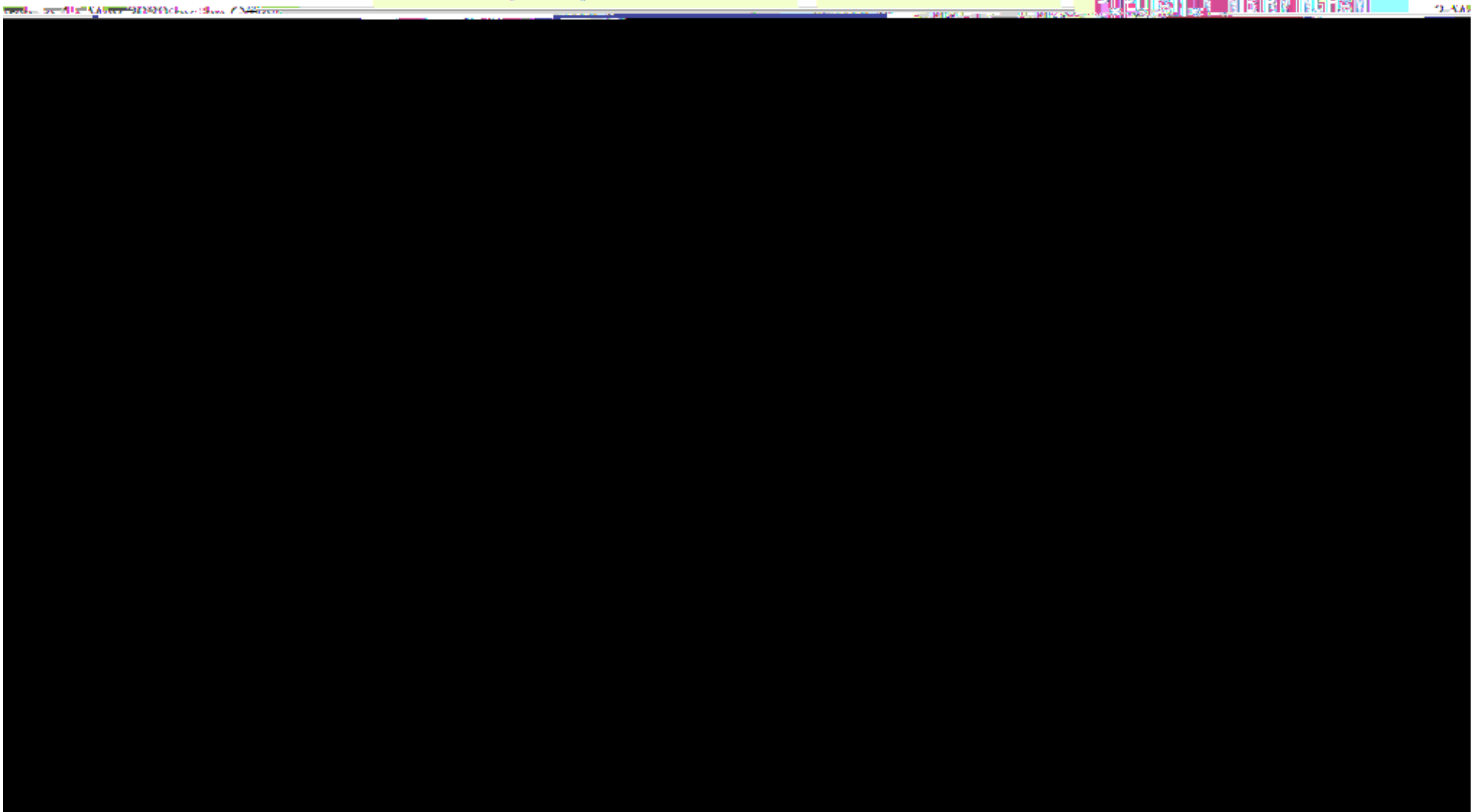
Very few official statistics use a classification by religion and as a consequence most of the data available refers to the largest communities of Muslims in the country who have Pakistani or Bangladeshi heritage.

Consequently, there is little data available about smaller communities of Muslims in the UK who may have other heritage.

Official statistics also do not differentiate between health of Sunni and Shia Muslims.



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# MUSLIMS HAVE PRODIGER

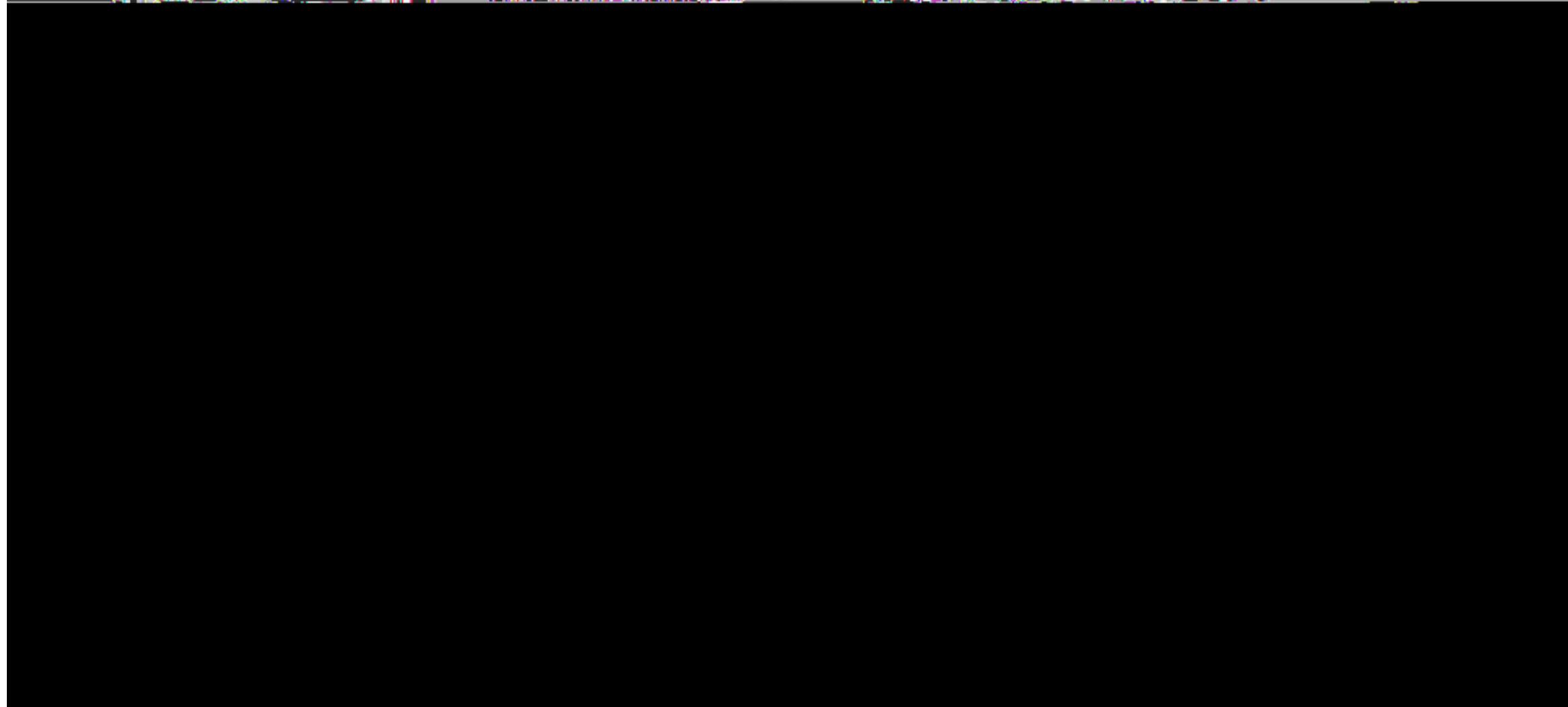
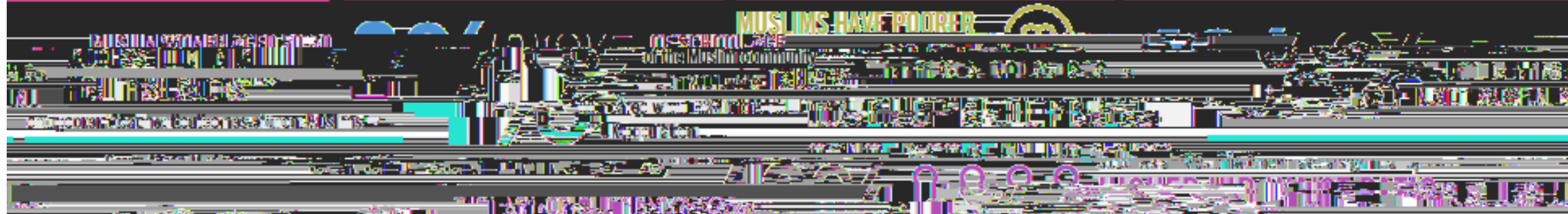
of the Muslim community

Regulation

THESE ARE THE DAYS OF THE MUSLIM COMMUNITY



THESE ARE THE DAYS OF THE MUSLIM COMMUNITY







NEWS

2018

Muslim men and women

1.50 billion

TO BREAK THE

OF MUSLIM MEN

MUSLIMS AT THE

1.50 billion

1.50 billion

of 28% of people in

MUSLIM MEN

1.50 billion

1.50 billion

1.50 billion

1.50 billion

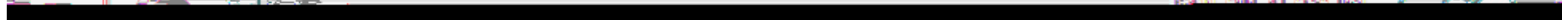
1.50 billion

1.50 billion

VACCINATIONS

1.50 billion

1.50 billion





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[28]



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[36] Census 2011 ONS Table DC4204EW

[37] ONS Census 2011 Table DC1202EW

[38] Office for National Statistics (2020). Religion, education and work in England and Wales: February 2020. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/articles/exploringreligioninenglandandwales/february2020>

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[https://figshare.com/articles/journal\\_contribution/Taboos\\_Concerns\\_and\\_Multicultural\\_Experience\\_Engagement\\_with\\_Cervical\\_Screening\\_among\\_Second-generation\\_British\\_Muslim\\_Women/10008236/2](https://figshare.com/articles/journal_contribution/Taboos_Concerns_and_Multicultural_Experience_Engagement_with_Cervical_Screening_among_Second-generation_British_Muslim_Women/10008236/2)

