

Muslim

Community Health Profile

PROTOTYPE

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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.

The common objectives for each of the evidence summaries are:

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

Executive Summary

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

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

Islam has several denominations and sub-denominations which have significant theological and legal differences from each other. The two largest denominations are Sunni Islam and Shia Islam; the latter focuses on the Prophet's example whereas Shia focus on the lineage of Muhammad's family through a series of Imams. Sufism can be considered to be a separate branch of Islam or to be part of Sunni Islam and Shia Islam in that it represents mystical Islamic belief and practice through which Muslims experience a direct personal and divine connection to God.

Around 50 countries in the world are recognised as 'Muslim countries', with at least 50% of the population identifying as Muslim. These include Saudi Arabia, Turkey, Egypt, Iraq, Pakistan, and Bangladesh). Across Europe, the Muslim population varies greatly. France (9%) and Germany (6%) have one of the largest Muslim populations, for example, compared with Poland (<0.1%) and Portugal (0.4%), which

have one of the lowest total Muslim population. The culture that Muslims practice will inevitably be shaped by their ethnicity and geographical location.

In the early 1950s, the Muslim population in the UK was estimated to be around 23,000¹⁵. In the late 1950s/early 1960s, Muslims, and South Asian , immigration to the UK rose sharply. Muslim immigrants, mostly men, arrived from India and Pakistan after partition, encouraged by the UK government due to labour shortages in Britain (e.g. in steel and textile industries). After partition, the majority of Pakistanis in the UK came from particular villages in Pakistan (e.g. Mirpur district), and Bengali/Bangladeshi immigrants primarily came from the Sylhet district of Bangladesh.

In 2011, there were 234,411 Muslim people recorded as living in Birmingham, making up around 22% of the local population. This is compared with 4.8% of the general population in England and Wales.

Echoing the national picture, Islam is the second largest religion in Birmingham, following Christianity. There was a significant increase in the number of Muslim people living in Birmingham between 2001 and 2011 (+ 8%), which was at a much higher rate than the increase in the Muslim population nationally (+ 1.8%). Over the same period, the Christian community in Birmingham declined from 59% (2001) to 46% (2011).

The main language spoken by Birmingham's resident population in 2011 was English (84.7%). This was followed by Islamic affiliated languages such as Urdu (2.9%), Bengali (with Sylheti and Chatgaya) (1.4%), Pakistani Pahari (with Mirpuri and Potwari) (1.1%).

In 2011, over half (53%) of Birmingham's Muslim population was aged under 25, including over a third were under the age of 16 (37%). This is significantly higher than the proportion of people aged under 25 in Birmingham's Christian, Sikh and Hindu communities (28%-39%) and those with no religion (44%).

Muslim children under the age of 16 made up around a third (35%) of all young people in Birmingham (compared to 22% of the local population). Only 4% of Muslims in Birmingham were aged 65 and over. This was significantly lower than the Christian community (21%) but similar to people with no religion (5%) and Sikhs (9%) and Hindus (8%).

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

- Data is not available on maternal care or infant mortality by religion
- Issues in accessing healthcare and cultural barriers in relation to women's access to healthcare, predominantly in relation to the gendered nature of women's roles in Muslim communities
- Muslims have poorer access to mental health services and poorer treatment outcomes compared to non-Muslims
- The use of cannabis as a recreational drug by Muslim youth in the UK appears to be becoming 'normalised' in common with young people from other groups.
- Lower percentages of Muslims engage in sport or physical activity compared to national rates
- The working-age Muslim population has lower rates of full-time employment, compared to the general population

Methodology

The Community Health Profile for the Muslim community in Birmingham is based on a narrative review of the scientific and grey literature. Below, the search strategy for the review and limitations of the Muslim literature are outlined.

a. Peer-reviewed Databases

Extensive use of a range of academic databases was made to identify relevant literature on the Muslim population. Citation and literature databases which were searched included: EBSCO, SocINDEX, Academic Search Complete, CINAHL, PubMed/Medline, Science Direct and SCOPUS.

Structured searches were undertaken using the terms 'Muslim' and 'Islam' alongside search terms for individual health and well-being indicators and the national and local context (see Appendix 1 for search string). Additional searches were undertaken on these databases using the terms 'Muslim' or 'Islam' and "Birmingham", alongside specific health and wellbeing indicators. The literature search was designed to capture epidemiological, quantitative, and qualitative studies, as well as existing systematic and narrative reviews.

b. Grey Literature

Google Scholar and Google were the main databases used to capture grey literature. Searches were also undertaken on the websites of public bodies, local councils and nationally collected data repositories, including the Office for National Statistics (ONS), NHS Digital, NHS England, Equality and Human Rights Commission (EHRC) and Public Health England (PHE) (accessed via GOV.UK).

National voluntary and community sector websites were also searched, including Alzheimer's Research UK, The British Heart Foundation, British Library ETHOS, The British Lung Foundation, Cancer Research UK, Diabetes UK, The Joseph Rowntree Foundation, Mind, Sport England.

c. Muslim Specific Sources

A search of national and local Muslim specific websites was also undertaken. These included:

The Muslim Council of Britain (MCB), UK Action Committee on Islamic Affairs; Muslim Council of Britain; British Muslim Forum; Muslim Women's Council, Muslim Women's Network, Sufi Muslim Council; Islamic Society of Britain; Muslim Association of Britain; Mosques and Imams National Advisory Board; Federation of Student Islamic Societies.

d. Snowball Searching

"Snowballing" (a technique where additional relevant research is identified from the reference list and citations of the initial search or published article) was used.

Additional literature was identified from reference lists where these added to the knowledge base of the report.

e. Inclusion and Exclusion Criteria

All retrieved literature were subject to the inclusion and exclusion criteria below.

Inclusion Criteria:

- Focus on Muslim people
- UK based population, with a focus on Birmingham and England

- Minimum of 10 Muslim participants for qualitative studies
- Minimum 20 Muslim participants or Muslim participants comprising at least 10% of overall sample for quantitative studies
- Published after 1999

Exclusion Criteria:

- Studies with less than 9 Muslim participants (qualitative studies)
- Studies which do not disaggregate findings for Muslim participants
- Published before 2000
- Less than 20 Muslim participants or Muslim participants as less than 10% of total sample

Only literature specifically related to Muslim people in the UK was selected for inclusion.

Results and Research Synthesis

The findings of the analysis are presented as a research synthesis under each of the key indicators contained under designated chapter themes.

The comparators used for Islam include Christianity (currently the largest religion in the UK), Hinduism and Sikhism (other predominantly South Asian affiliated religions) and people with no religion. Where relevant, studies with smaller sample sizes have been highlighted. Percentages reported in studies have typically been rounded up for the purposes of this report.

f. Limitations and Caveats of the UK Literature on Muslim Communities

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.

Sometimes it has been necessary to use proxy data. The metrics of many health and wellbeing indicators do not include classifications by religion and there are therefore no direct measures for Muslims. In these cases, for example, in relation to school attainment, proxy assessments have been made in this report using data from Pakistani and Bangladeshi communities in the UK or in some cases South Asian communities that include Indian Muslims and other ethnic minorities. A very high percentage of both the Pakistani and Bangladeshi communities in the UK is Muslim. Whenever these proxy assessments are made in this report the sources of data will be described.

Religion is closely entwined with ethnicity. Because, for example, the majority of members of the Pakistani and Bangladeshi communities are Muslim, it is difficult to untangle whether we are observing a religious or an ethnic difference. In these cases, we have reported the overall results for the Muslim community and also reported the data for each ethnic sub-population.

Abbreviations and glossary

Hajj

- This is the name given to the pilgrimage to Makkah that adult Muslims are required to perform at least once in their lifetime.

Iman

- This translates as 'faith'. In Islam, it refers to the belief that Allah is One and that Prophet Muhammad (peace be upon him) is the Final Messenger of Allah.

Shari'ah

- This term refers to the legal rulings laid down for the betterment of society, derived from the Quran and teachings of Prophet Muhammad (peace be upon him).

Jumu'a

- The Day of Friday. Friday is the most religious day of the week, reflected by the fact that non-travelling, healthy, male adult Muslims are required to attend a congregational prayer in the mosque at noon on this day.

Salah

- The ritual prayers that Muslims are required to perform during their adult life. It is one of the five pillars of Islam.

Sunna

- This refers to the sayings, actions and silent approvals of Prophet Muhammad (peace be upon him).

Zakah

- This word literally means 'purification'. In Islam, it refers to the 2.5% financial donation Muslims give annually, to be spent on good causes.

Ummah

- This term refers to the Muslim followers of Prophet Muhammad (peace be upon him)

1. Introduction

1.1. History of Islam

Originating in 7th century in the Arabian Peninsula, near Mecca and in what is known today as Saudi Arabia, Islam translates as 'submission to the will of God'¹. Islam is predominantly centred around the Prophet Muhammad (peace be upon him), an orphan boy born around 570 AD who lived in Mecca. He is said to begin receiving revelations from the archangel Gabriel when he was 40 years old and gathered a small following. These revelations form the basis of the Quran, the Islamic sacred text which is believed by Muslims to be the 'word of God' as revealed by the Prophet. The Hadith is another central text in Islam and is collection of traditions containing sayings of the Prophet Muhammad (peace be upon him), which gives accounts of his daily practice (Sunnah)².

Islam has several denominations and sub-denominations which have significant theological and legal differences from each other³. The two largest denominations are Sunni Islam and Shia Islam; the latter focuses on the Prophet's example whereas Shia focus on the lineage of Muhammad's family through a series of Imams. Sufism can be considered to be a separate branch of Islam or to be part of Sunni Islam and Shia Islam in that it represents mystical Islamic belief and practice through which Muslims experience a direct personal and divine connection to God.

The Five Pillars of Islam represent the key practices in Islam and Muslims' everyday lives. They illustrate the obligatory norms and practices expected of Muslims and the essence of what it means to be a Muslim⁴. The First Pillar is Shahada, the

declaration of faith. It is twofold, with “There is no god but God and Muhammad is his messenger”, promoting a unity of monotheistic faith through the prayer Tawhid. The *Shadah*, combined into a set Arabic statement, is said five times a day during prayer, to new-borns and to those about to die.

The Second Pillar is Salah, or prayer. Praying consists of reciting passages and taking up *sujud*, which is a position of a low bow, in the direction Mecca. Islamic prayers are performed 5 times daily - at dawn, noon, afternoon, evening and night. They can be performed in any location Muslim men gather for prayer at mosques on Fridays at noon. Exceptions to Salah are made for people who may be unable to pray, e.g. women on menstrual cycles or people with physical and mental illness or disabilities.

The Third Pillar is Zakat, the act of giving to charity. Also known as Almsgiving, it is considered an act of purification for a Muslim individual to give a percentage (2.5%) of their surplus wealth to charitable causes⁵. This practice originates from the Hadith and is obligatory for those who are able to do so. The purpose of Zakat is to bring balance to life, eliminate other's economic hardship and strive for equality.

The Fourth Pillar is Sawm, which is the act of fasting, that takes place during Ramadan. Ramadan is on the ninth month of the Islamic calendar (known as *Hijrī*, which is based on lunar cycles) and begins and ends with the appearance of the crescent moon. During Ramadan, Muslims observe a strict month long fast between dawn and sunset, lasting anywhere between 10 to 20 hours depending on where Muslims live in the world. Exemptions to fasting are made for certain groups of

individuals, e.g. children, menstruating, pregnant or breastfeeding women, those in poor health and the elderly.

The Fifth Pillar is Hajj, or pilgrimage. This consists of the journey to Mecca and various prayers and rituals around the Kaaba, Islam's holiest shrine, which is located inside Islam's most important Mosque, the Masjid al-Haram. Muslims are expected to undertake Hajj during the twelfth month of the Islamic calendar, at least once in their life. Those who are unable to make the journey for health or economic reasons are exempt from this obligation.

Muslims celebrate many different holidays, but the most important are generally considered to be *Eid al-Fitr* and *Eid al-Adha*⁶. *Eid al-Fitr* is a celebration to mark the end of Ramadan and translates as the 'holiday/festival of breaking the fast.' It lasts for up to 3 days and includes Muslims gathering for prayer, giving charitable donations, visiting friends and family, gifting presents and money, wearing their finest clothes, decorating their homes, sharing food and sweet treats and remembering loved ones who have passed away. In Muslim majority countries, *Eid al-Fitr* is usually a public holiday. It is also known as the 'lesser Eid'.

Eid al-Adha, also known as the 'the bigger Eid', falls on the 10th day of the twelfth month of the Islamic calendar. It translates as "Holiday/festival of the sacrifice" and honours the willingness of Ibrahim to sacrifice his son Ismaili. *Eid al-Adha* lasts up to 4 days and includes Muslims celebrating the same way as in *Eid al-Fitr*. The act of Qurbani (sacrifice) is also carried out, which involves slaughtering a specified animal,

cutting its meat into three equal parts and sharing these between family, relatives and friends, and poor people.

Islam gives guidance about all aspects of life for Muslims. Sharia is Islam's legal system, but it is not the same as Islamic Law⁷. Sharia Law is derived from the Quran, the Sunnah and Hadith, although different interpretations exist, and it is implemented in Muslim countries to different degrees. Where an answer cannot be derived directly from these, religious scholars may give rulings as guidance on a particular topic or question. Muslims may also look to Sharia for guidance on their everyday life, including family law, finance, business and personal relationships.

Islamic cultural guidance about how Muslims should conduct themselves, what they should eat and what they should wear are central tenants of the everyday life of Muslims. *Izzat* ('family honour') is a cultural concept of honour that is seen across south Asia and within South Asian and Muslim communities⁸. It concerns the maintenance of both individual and familial reputation and avoidance of shame. 'Halal' translates as 'permissible' and is contrasted with *haram* (forbidden). In the context of food, pork and alcohol are expressly forbidden by the Quran. Furthermore, for other meat to be halal, healthy animals must be slaughtered through a cut to the jugular vein, carotid artery and windpipe, and the carcass must be drained of all blood.

Islam's code of modesty refers to all aspects of one's life, including clothing. Both men and women are expected to show modesty in the clothes they wear, including covering parts of the body and clothing material/style. Traditionally, men are

expected to cover the area between the waist and the knees and women are expected to cover their heads and bodies, except for their face and hands⁹. Whilst some Muslim women wear a headscarf (e.g. the Hijab), others Muslim women – especially those from conservative Muslim countries, are more likely to wear a full body and face covering (such as the Niqab or a burka).

Islamic guidelines also stipulate rules in relation to interactions between people of the opposite sex and for each sex. For example, unmarried or unrelated men and women are discouraged from being alone or physically touching¹⁰ and stricter interpretations mandate restrictions on men, and predominantly women's, rights and freedoms.

1.2. International Context

Islam is the second largest religion in the world. Almost a quarter (24%) of the global population, around 1.8 billion people, identify as Muslim. The main regions of the world with a predominantly Islamic population are located in Central, South Asia, the Middle East and Western Asia (except Armenia and Israel), North Africa, and many countries in West Africa¹¹. Islam is the fastest growing religion in the world and is estimated to supersede Christianity as the world's largest religion by 2075¹².

Around 50 countries in the world are recognised as 'Muslim countries', with at least 50% of the population identifying as Muslim¹³. These include Saudi Arabia, Turkey, Egypt, Iraq, Pakistan, and Bangladesh). Across Europe, the Muslim population varies greatly. France (9%) and Germany (6%) have one of the largest Muslim populations, for example, compared with Poland (<0.1%) and Portugal (0.4%), which

have one of the lowest total Muslim population¹⁴. The culture that Muslims practice will inevitably be shaped by their ethnicity and geographical location.

Arabic is the primary language that is associated with Islam and is the language of the Qu'ran. However, it is estimated that the majority of Muslims in the world reside in Asia, where Muslims first languages are Bengali (Bangladeshi), Urdu (India) and Panjabi, Western (Pakistan). Other languages spoken by Muslims include Turkish, Farsi, Sindhi and Malay¹⁵.

1.3. National Context

The first large group of Muslims arrived in the UK from India around the 18th Century¹⁶. The growth of the British Empire led to a large settlement of 'lascars' (sailors and merchant sea men employed by the East India Company) as did the increase in trade through the opening of the Suez Canal in 1869¹⁷. A large proportion of early Muslims who settled in the UK came from North Africa, the Middle East and Central Asia and settled in port towns and cities such as London, Cardiff, Glasgow, Liverpool and Hull. Bangladeshi workers concentrated in London and Birmingham, while Pakistani communities formed in Manchester, Lancashire, West Yorkshire, Birmingham, and the Midlands¹⁸. By the early 20th century, it was estimated that around 10,000 Muslim people lived in the UK¹⁹.

In the early 1950s, the Muslim population in the UK was estimated to be around 23,000²⁰. In the late 1950s/early 1960s, Muslims, and South Asian, immigration to the UK rose sharply. Muslim immigrants, mostly men, arrived from India and Pakistan after partition, encouraged by the UK government due to labour shortages

in Britain (e.g. in steel and textile industries). After partition, the majority of Pakistanis in the UK came from particular villages in Pakistan (e.g. Mirpur district), and Bengali/Bangladeshi immigrants primarily came from the Sylhet district of Bangladesh²¹. The introduction of the Commonwealth Immigrants Act (1962), which introduced restrictions for entry of Commonwealth citizens whilst enabling extended family migration, was also part of this peak in immigration to the UK, although by 1971 this Act was superseded and the right to citizenship was replaced with the 'right to abode'²².

Muslim migration to the UK was declining significantly until the 1980s and 1990s, when Britain saw a different type of migration pattern, with war and political unrest in countries such as Algeria, Libya, Somalia, Iran, Iraq, Afghanistan and Bosnia (predominantly Muslim Countries) leading to an increase in the number of Muslim asylum seekers and refugees.

Islam is now the second largest religion in the UK. The majority of Muslims in the UK are Sunni, but around 10% are estimated to be Shia²³. Most of the Muslim population in the UK today are people who immigrated to the UK between the 1950s-1970s from South Asian (predominantly Pakistan and Bangladesh) and their British-born children. This population mainly settled in industrial cities with textile industries, such as Manchester, Bolton, Bradford, Birmingham, Leicester and London. The range of languages spoken by British Muslims includes Punjabi, Urdu, Bengali/Sylheti, Arabic, Gujarati, Turkish, Somali, Kurdish²⁴.

The growing number of Muslims in the UK meant that Muslims began to self-organise as a social and political force and began to participate more actively within the political sphere of the UK ²⁵. This led to the institutionalisation of Muslim organisations and institutions such as Islamic banks, Muslim schools and mosques. By 1985, Sharia councils (also known as Sharia Courts) existed in the UK²⁶ and there were around 340 registered mosques ('masjids') in the UK²⁷. In 2017, it was estimated that this figure was 1,825²⁸. Representative bodies like The Muslim Council of Britain (an umbrella group representing 500 or so different organisations) and the British Medical Islamic Association are also part of the Islamic political landscape in the UK.

Muslims have become subject to significant public distrust, vilification, discrimination, racism and islamophobia²⁹. Scholars argue that these attacks on Muslims have led to the reinforcing of a Muslim identity amongst Muslims in the UK, in that identity "is constituted through constant struggles and negotiations and needs to be understood as always constructed or imagined, the outcome of political processes (Modood, 2009) ³⁰. 'Muslim' is not a fixed single identity – Muslims are comprised of a variety of ethnic groups, cultures, languages and political beliefs which is fluid and intersectional. British Muslims (74%) are much more likely to emphasise the importance of religion in their lives compared to Hindus (48%) and British Christians (23%), whilst simultaneously holding the view that their national identity is important to their sense of who they are (55% of Muslims compared to 44% of all adults in the general population)³¹.

Number of Muslims in UK

Islam is the second largest religion in the UK, with a population of around 3.3 million Muslims in England and Wales³². Nationally, evidence from the UK Censuses (2001 and 2011) and the Annual Population Survey (2018/19) shows that the Muslim population has been slightly increasing over time. This is compared with the Christian population which has seen a sharp decline and the population of people with no religious affiliation which has seen a sharp increase. Between 2001 and 2011, the Muslim population in England and Wales increased from 3% of the total population (1.5 million people) to 4.8% of the population (2.7 million people). Over the same period, the Christian population – the largest religious group in the UK – declined from 72% (37 million people) to 59% (33 million people) of the total population. The population of people with no religion on the other hand increased from 15% to 25% (more than 14 million people).

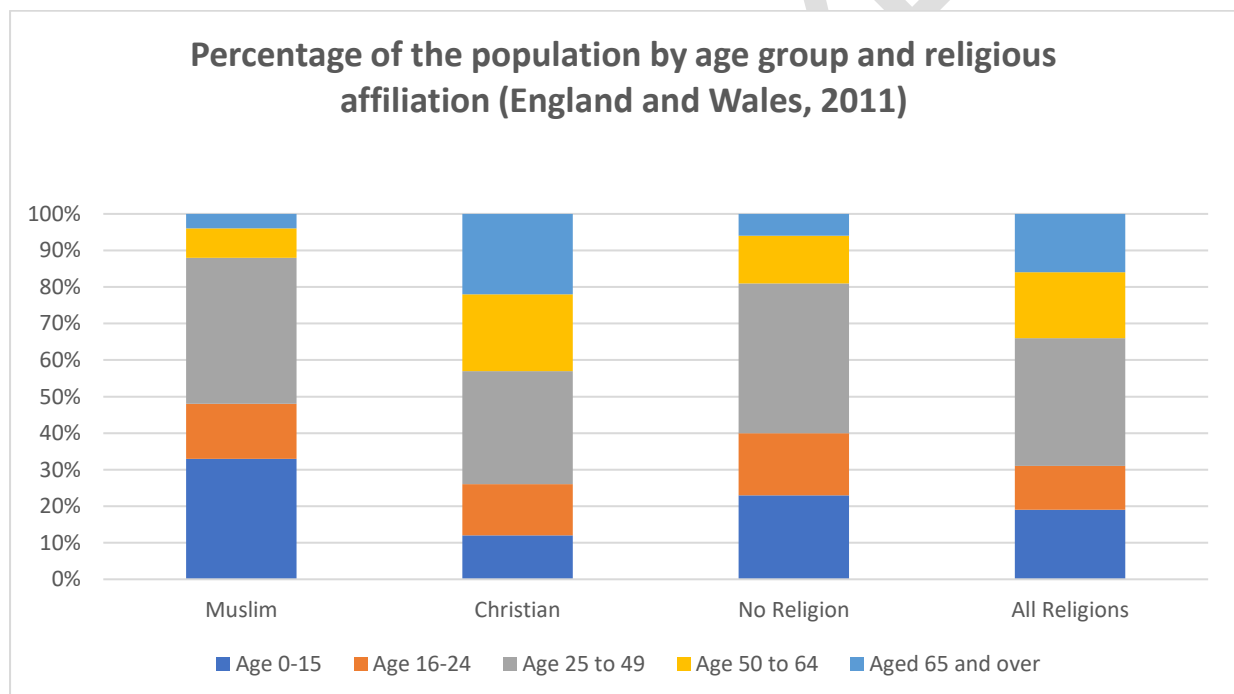
In 2019³³, the Office for National Statistics (ONS) estimated that the Muslim population in England and Wales increased to 5.1% of the population (3.3 million people) whilst the Christian population was estimated to have declined to 50% (29.3 million people). The size of the Hindu (1.7%) and Sikh (0.7%) populations has remained relatively low (ONS- Annual Population Survey, 2018)

Age and Sex Breakdown

Like many of the diverse ethnic minority communities under the Islamic umbrella, the Muslim population has a younger age profile compared to the overall population in England and Wales and to other religious affiliations. Almost half (48%) of the Muslim population in England and Wales³⁴ were aged 24 and under, the majority of

whom were under the age of 16 (33% of the total Muslim population). This is a significantly younger profile when compared with other religious groups. For example, the population of under 16-year olds was less than a quarter in all other religious groupings. Only 4% of the Muslim population was over the age of 65, which is significantly lower than the Christian population (22%), but lower than Hindus/Sikhs (8%) and people with no religious affiliation (6%).

Figure 1 Percentage of the population by age and religious affiliation (England and Wales, 2011)



Source: ONS NOMIS³⁵

According to the 2011 Census, in England and Wales, 52% of the Muslim population were male and 48% female³⁶. The age distribution between males and females were relatively even across all ages. The latest analysis of religion by sex and age-group in 2018-2019 suggests a similar picture to the 2011 Census³⁷.

Country of Birth

In 2011, just under half (47%) of Muslims in England and Wales were born in the UK and just over half (53%) were born abroad³⁸. Of the 53% that were born abroad, around 29% of the Muslim population were born in Southern Asia (e.g., India, Pakistan and Bangladesh) and a significant minority were born in the Middle East (6%) and Southern and Eastern Africa (6%).

Ethnicity

The Muslim population is ethnically diverse, with a significant number Muslims being from a variety of ethnic backgrounds. According to 2011 Census data³⁹, 92% of the Muslim population were from a (non-White) minority ethnic background (this does not include 'other White ' (5%). The majority of Muslims came from Pan South Asian backgrounds (68%), including Pakistani (32%), Bangladeshi (15%), Indian (7%) and 'Other Asian' (7%) ethnicities. A smaller proportion of Muslims were Black African (8%), Arab (7%).

Although Pakistani and Bangladeshi populations jointly made up just under half of all Muslims (47%), over 90% of people in these populations identified as Muslim. Furthermore, just over three-quarters (77%) of Arab people and a fifth (21%) of the Black African population identified as Muslim.

Language

A breakdown of Census data on language (e.g. main household language, English language proficiency) is not available by religious affiliation. Data on ethnicity

provides some insight into the language patterns of Muslim dominant ethnic groups (with over a 75% Muslim population).

Analysis of the 2011 Census⁴⁰ reveals, Bangladeshis had the lowest proficiency of English compared with all other ethnic groups. Around 16% of people from a Bangladeshi background 'could not speak English or 'could not speak English well'. It is important to note here that the vast majority of men and women in these figures 'could not speak English well' rather than 'could not speak English at all'; less than 3% of Bangladeshis reported not being able to speak English at all. Pakistanis and Arabs (both 11% respectively) also had amongst the lowest levels of English language proficiency. This is compared with around 2% of the general population and 7% of Indians (who also fall under the South Asian umbrella).

Significant sex differences also exist in the Bangladeshi, Pakistani and Arab communities' ability to speak English or to speak it well, whereby women had the lowest level of English language proficiency. Bangladeshi women (22%) were significantly less able to speak English well than Bangladeshi men (11%) and compared to all other sub-groups by age and sex. This was also the case for Pakistani women (16%) compared with Pakistani men (7%) and Arab women (15%) and Arab Men (8%).

Age is also a significant predictor of ability to speak English well for Pakistani, Bangladeshi and Arab communities. When looking at Bangladeshi (44%), Pakistani (31%) and Arab (18%) women aged 65 and over, levels of English are significantly lower than for all younger age brackets. For example, 18% of Bangladeshi women

aged 45-64 are unable to speak English well compared with 3% of Bangladeshi women aged 25-44..

Regional disparities in English language proficiency also indicate that the Muslim community residing in the West Midlands, and Birmingham, are likely to have even lower levels of proficiency. The West Midlands, along with the North West, had the highest proportion of Bangladeshis (3.5%) and Pakistanis (2.8%) who could not speak English at all.

Geography

According to the 2011 Census data⁴¹, the Muslim population has been geographically concentrated in particular areas of England. Three-quarters (76%) of the Muslim population in England and Wales lived in 4 regions of England, namely London (37%), West Midlands (14%), the Northwest (13%) and Yorkshire and The Humber (12%).

Nationally, Muslims communities make up less than 6% of the population in over three quarters of local authorities and less than 1% of the population in over half of local authorities. More specifically, most Muslims resided in the London boroughs of Tower Hamlets and Newham (making up a third of the local population in these boroughs) and in regional districts such as Birmingham, Blackburn and Bradford. According to the 2011 Census, there were 376,152 Muslim people in the West Midlands, over half (62%) of whom resided in Birmingham.

1.4. Birmingham Context

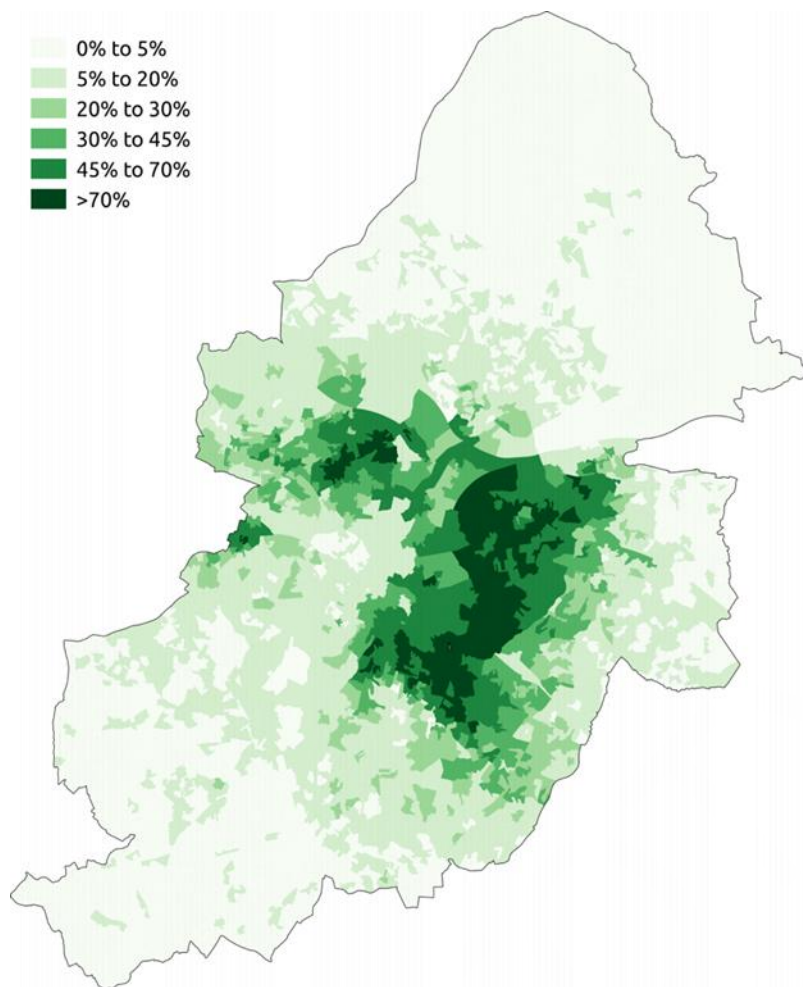
Birmingham has been a central destination for migration from South Asia post the second world war and is home to one the largest Muslim populations in the UK. There are currently around 200 mosques in Birmingham⁴², the first mosque (or 'masjid') having opened in doors in 1942⁴³. Birmingham's Muslim community is a central facet of the city's vibrant, culturally diverse and evolving spaces.

It is worth noting that historically there have been incidents in Birmingham which have been widely perceived as anti-Muslim, for example, 'The Trojan Horse Scandal.'^{44 45 46}. There is recognition that there is a need to repair and strengthen relationships with the Muslim community, particularly in the aftermath of Trojan Horse. More recent collaboration between public services and Islamic Communities, particularly in response to the Covid-19 Pandemic, has demonstrated how relationships are being repaired.

Number of Muslims in Birmingham

In 2011⁴⁷ there were 234,411 Muslim people living in Birmingham, making up around 22% of the local population. This is compared with 4.8% of the general population in England and Wales.

Figure 2 Muslim Population in Birmingham



Source: UK 2011 Census⁴⁸

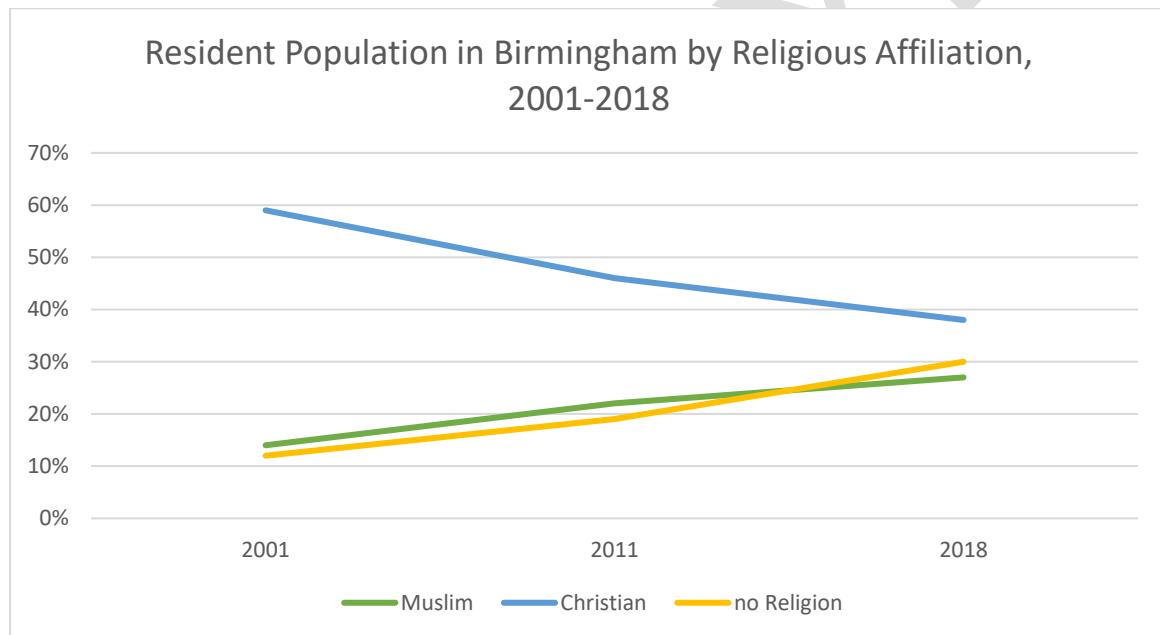
Echoing the national picture, Islam is the second largest religion in Birmingham, following Christianity. There was a significant increase in the number of Muslim people living in Birmingham between 2001 and 2011 (+ 8%), which was at a much higher rate than the increase in the Muslim population nationally (+ 1.8%). Over the same period, the Christian community in Birmingham declined from 59% (2001) to 46% (2011).

Going against the national picture, a higher percentage of people in Birmingham identified as Muslim (22%) in 2011 compared with people who identified with no

religion (19%). Other minority religious communities in Birmingham were relatively small, e.g., Sikh (3%, n=32,376) and Hindu (2%, n=22,362).

More recent estimates by the Annual Population Survey for 2018⁴⁹ suggests a more mixed religious landscape in Birmingham compared with 2011. The Muslim community in Birmingham had slightly increased to 27% of the population (+ 5%), the Christian community declined to 38% (- 8%) and people with no religion rose sharply to 30% of the population (+ 11%).

Figure 3: Resident Population in Birmingham by Religious Affiliation, 2001-2018



Sources: ONS. NOMIS Tables: UV015 and QS210EW; ONS (2019) ⁵⁰

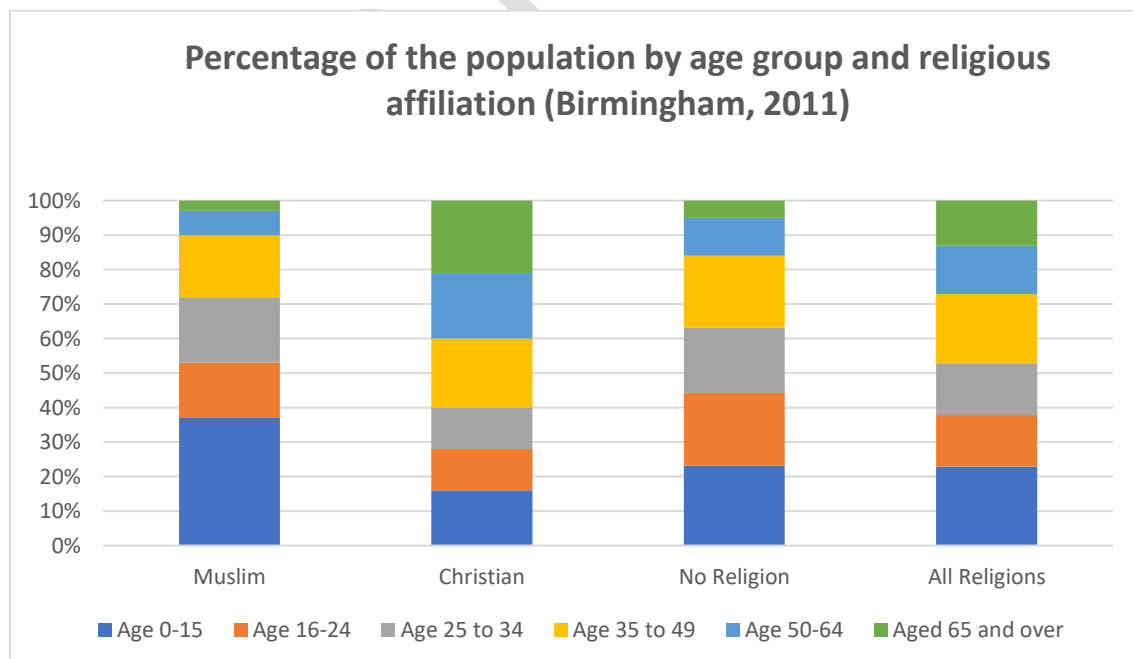
Age and Sex Breakdown

Birmingham has the youngest demographic population of all the UK's major cities (Harris, 2019) ⁵¹, a trend that is reflected in its Muslim communities. The Muslim community in Birmingham has a younger age profile compared to other religious communities in Birmingham.

In 2011⁵², over half (53%) of Birmingham’s Muslim population was aged under 25, including over a third were under the age of 16 (37%). This is significantly higher than the proportion of people aged under 25 in Birmingham’s Christian, Sikh and Hindu communities (28%-39%) and those with no religion (44%). Muslim children under the age of 16 made up around a third (35%) of all young people in Birmingham (compared to 22% of the local population).

Only 4% of Muslims in Birmingham were aged 65 and over. This was significantly lower than the Christian community (21%) but similar to people with no religion (5%) and Sikhs (9%) and Hindus (8%).

Figure 4: Percentage of the population by age and religious affiliation (Birmingham, 2011)



Source: ONS. NOMIS. Table LC2107EW

Around 51% of the Muslim population in Birmingham were male and 49% female⁵³.

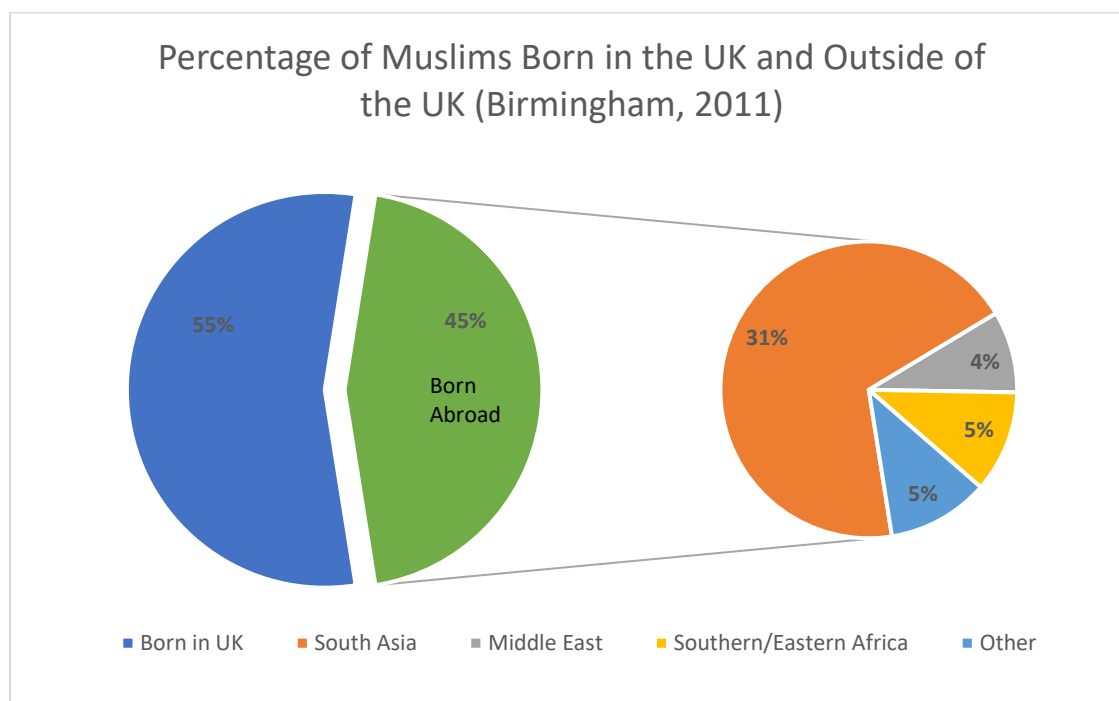
The age distribution between males and females across age groups was evenly distributed.

Country of Birth

In Birmingham in 2011, a higher proportion of Muslims were born in the UK compared with Muslims nationally⁵⁴ (+8%). Over half (55%) of Birmingham's Muslim community was born in the UK. This was higher than the Hindu community (45%), lower than the Sikh community (60%) and much lower than the Christian community (85%) and people with no religion (92%).

Just under a third (31%) of Muslims in Birmingham were born in South Asia and a minority were born in South and East Africa (5%), the Middle East (4%) and other countries in Africa, the Americas and the Caribbean (less than 3% in total).

Figure 5: Percentage of Muslims Born in UK and outside of UK (Birmingham, 2011)

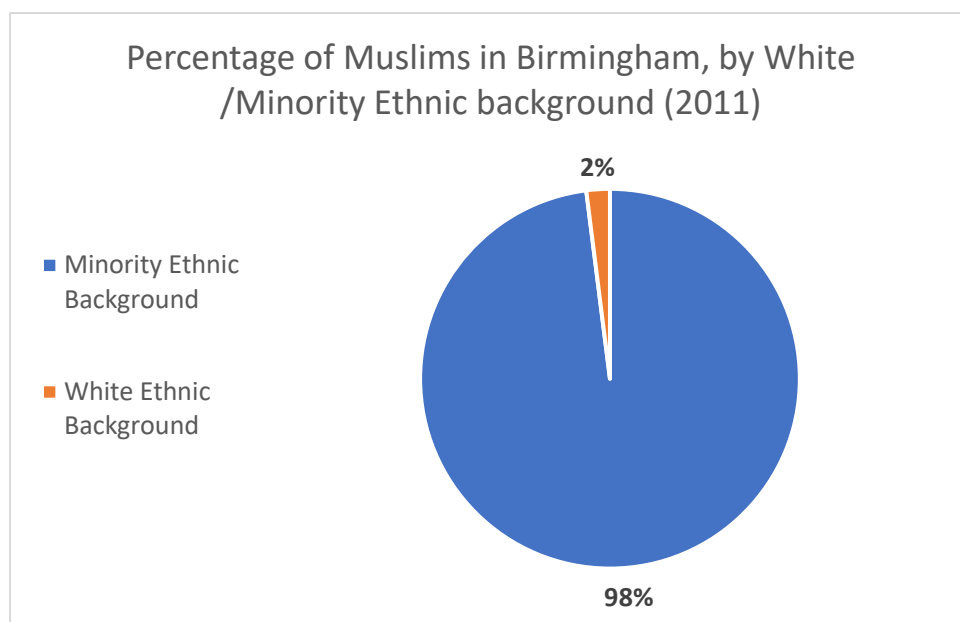


Source: ONS. NOMIS. Table: DC2207EW

Ethnicity

The vast majority of the Muslims in Birmingham according to the 2011 census came from a (non-White) minority ethnic background(98%)⁵⁵, this is higher when compared with the general UK Muslim population (92%). In Birmingham, around half (52%) of minority ethnic people identified as Muslim, compared to 34% nationally. In Birmingham the majority of Muslims identify with non-white ethnic groups, and among the non-white ethnic communities Islam is the largest identified faith.

Figure 6: Percentage of Muslims in Birmingham, by White /minority ethnic background (2011)

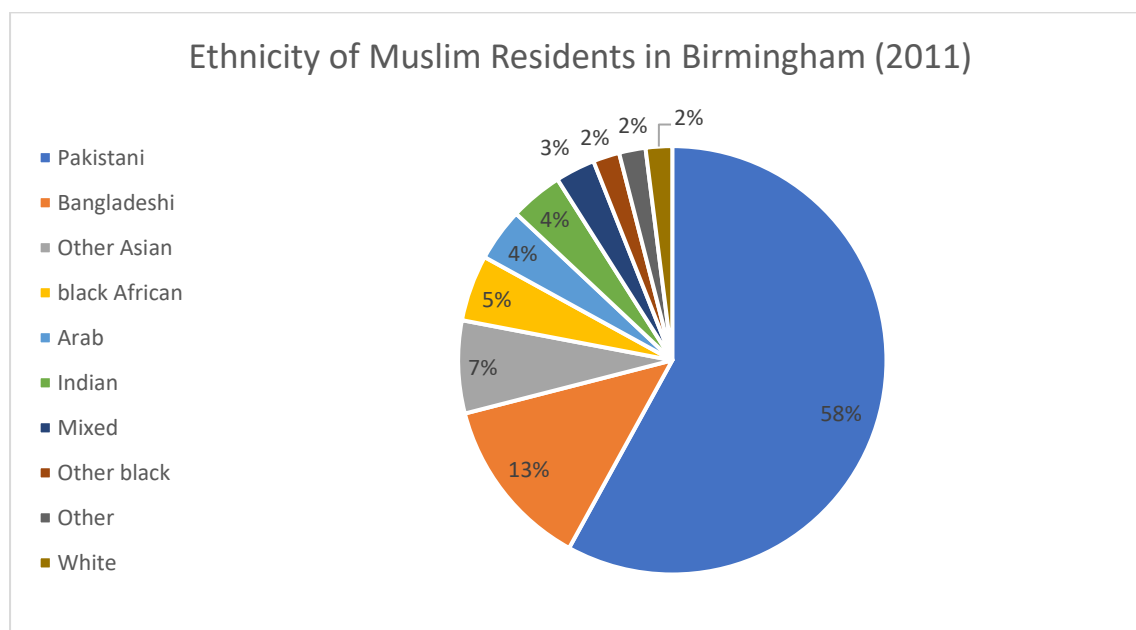


Source: ONS. NOMIS. Table: LC2201EW

The majority of Muslims in Birmingham came from a South Asian ethnic background (81%). This is compared with 68% of the national Muslim population⁵⁶.

Over half (58%) of all Muslims in Birmingham were Pakistani, 13% were Bangladeshi and 7% were from an 'other Asian' background. A minority of Muslims in Birmingham also came from Black African (5%), Arab (4%), Indian (4%), mixed (3%) and less than 2% came from 'other Black', any 'other' and White ethnic backgrounds (respectively).

Figure 7: Ethnicity of Muslim Residents in Birmingham (2011)



Source: ONS. NOMIS. Table: LC2201EW

In terms of religious breakdown by ethnic group, over 90% of Pakistanis and Bangladeshis in Birmingham identified as Muslim⁵⁷. This is similar to the national picture. Furthermore, a large proportion of Arabs (87%), people from ‘other ethnic’ groups (64%), people from ‘other Asian’ backgrounds (52%), Black Africans (42%) and mixed White and Asian people (28%) in Birmingham identified as Muslim.

Languages Spoken

The main language spoken by Birmingham’s resident population in 2011 was English (84.7%). This was followed by Islamic affiliated languages such as Urdu (2.9%), Bengali (with Sylheti and Chatgaya) (1.4%), Pakistani Pahari (with Mirpuri and Potwari) (1.1%)⁵⁸.

Geographical Distribution of the Muslim Population at Ward Level

The majority of Birmingham's Muslim community is geographically concentrated and resides in neighbouring geographical areas.

Muslims make up at least 10% of residents in half Birmingham's 40 wards (2004 wards), as reported by the 2011 Census⁵⁹, and at least 25% of residents in a quarter of these wards. Around a tenth of Birmingham's Muslims resided in the connecting wards of Washwood Heath (n=25,434), Bordesley Green (n=25,066) and Sparkbrook (n=22,755). The Muslim community made up over 70% of the local populations in these wards, with young Muslim people (aged 0-15) making up over 80% of the school age population in these areas.

At least 50% of the population in Springfield (61%) and Aston (54%), and a high proportion of residents in Lozells and East Handsworth (49%), Nechells (44%) and Hodge Hill (42%) were Muslim. At least 60% of school age children in these wards were Muslim.

Table 1: Size and Percentage of Muslim Communities in Birmingham Wards

2011 ward	All categories: Religion	Muslim (No.)	Muslim (%)
Washwood Heath	32,921	25,434	77
Bordesley Green	33,937	25,066	74
Sparkbrook	32,415	22,755	70

Springfield	31,391	19,222	61
Aston	32,286	17,442	54
Lozells and East Handsworth	31,074	15,181	49
Nechells	33,957	14,781	44
Hodge Hill	28,026	11,626	41
South Yardley	30,786	10,358	34
Soho	30,317	8,899	29
Hall Green	26,429	6,435	24

Source: ONS. NOMIS. Table: QS210EW

Social Deprivation at Ward Level

It is well documented that areas with higher concentrations of ethnic minority communities also tend to be among the most deprived^{60 61 62}. Birmingham is ranked as the 7th most deprived local authority out of England's 317 authorities⁶³.

The majority of the city's Muslims (72%) live in seven of the city's most deprived wards: Sparkbrook, Bordesley Green, Washwood Heath, Springfield, Lozells and East Handsworth and, Nechells⁶⁴⁶⁵. The wards in which the most Muslim people reside are the most socially deprived wards in Birmingham and in England^{6667 68} (based on the Index of Multiple Deprivation 2015). For example, Bordesley Green, Washwood Heath and Nechells are also in the top 1% of most deprived Super Output Areas in the entire UK⁶⁹.

A recent analysis of the 2001 Census⁷⁰, which explored internal migration between Birmingham's wards using religious categories (rather than ethnic categories) reported that Muslims were less likely to move into more affluent areas compared with Sikhs and Hindus. The study also reported that Muslims were also less likely to move to wards with a high concentration of Muslims compared to their previous location. This finding has been echoed by national analysis⁷¹.

The author suggests that Muslims are more likely to move to less affluent areas due to property prices and availability of affordable larger properties.

English as a Main Language at Ward Level

According to 2011 Census data⁷² the wards in which Muslim people resided were the least likely to have English speaking household members. Around 1 in 5 (18%-22%) residents in Sparkbrook, Washwood Heath, Aston, Lozells and East Handsworth, Nechells, Soho and Bordesley Green lived in a household where no-one had English as a main language. Furthermore, the wards outlined in the table above were the least likely to have English speaking household members (over 16 years).

2. Community Profile

2.1 Getting the best start in life

Key Findings:

- In England in 2011 8.1% of the school age population were Muslim
- In Birmingham in 2011,33% of the Muslim population were children
- In Birmingham 79% of Muslim children live in nine wards and in three wards they constitute over 80% of the school population
- 46% of Muslim children in 2011 lived in the 10% most deprived local authority districts of England
- In 2019 55.7% of Pakistani and Bangladeshi 3-year olds were ready for school compared with the average for England of 86.3%.
- In school attainments in England Bangladeshi and Pakistani girls perform better than average in school foundation assessments, in assessments at 10 and 11 and in GCSE examinations.
- In school attainments in England Pakistani boys perform less well than the average at all stages of development. Bangladeshi boys are below average at foundation level but perform at the average level at subsequent stages.
- An average of 26.3% of children in the Birmingham wards with over 50% Muslim children were eligible for free school meals. Children eligible for free school meals achieved significantly lower attainment levels at all stages of school development than children not eligible for free school meals
- It is estimated that in 2019 there are 4,500 children in England of Muslim heritage that are looked after by the state. Less than half are fostered by Muslim

families because there is a shortage of registered foster parents in the Muslim community.

- There are fewer school exclusions of Pakistani and Bangladeshi schoolchildren than White or Black children.
- Following Islamic traditions of modesty in dress can make it difficult for Muslim girls to fully engage in physical activities at school.
- Using ethnicity-specific BMI adjustments, half of all South Asian boys – and two in five Asian girls – in Year 6 were overweight or obese. Bangladeshi children, followed by Pakistani children had the highest rates of obesity.
- Bangladeshi women (relative risk ratio 2.1) and women from the Middle East (relative risk ratio 2.9) have significantly higher maternal mortality rates compared to White women
- Birmingham's Pakistani community (7.3 per 1,000) had a higher rate of infant mortality compared to all South Asian s in Birmingham (5.7 per 1,000) and compared to the national infant mortality rate (3.4 per 1,000).

2.1.1 Prevalence and general information

Demography of Muslim Children

The 2011 census ⁷³ reports that 4.8% of the population of England and Wales are Muslim but that 8.1% of the school age population (5 to 15) are Muslim. The number of Muslim children in Birmingham under the age of 16 (35% of the local Birmingham

population under 16, n= 86,266) was higher than the number of Christian children in Birmingham (33%, n=80,884). The prediction from the 2011 census was that there would be approximately 300,000 teenage Muslims in England and Wales in 2021 (based on the number of children who were 5-to-9 years old in 2011).

In Birmingham in 2011 there were 234,411 Muslims of which 76,266 were 15 or under. 33% of the Muslim population of Birmingham are children. 8.5% of the Muslim children of England and Wales are resident in Birmingham.

Table 2: Muslim Children in Birmingham by Age Band

Age	Children in Birmingham
0-4	28,757
5-7	17,179
8-9	10,749
10-14	25,033
15	4,548
Total	76,266

Source: ONS 2011 Census Table DC2107EW

Muslim Children in Birmingham Wards

60,299 of the 76,266 (79%) Muslim children aged 0 to 15 in Birmingham live in nine wards. In three of these wards (Washwood Heath, Bordesley Green and

Sparkbrook) Muslim children are over 80% of the school population and in eight of the wards they are greater than 50% of the school population.

Table 3: Muslim Children in Birmingham Wards

Ward	Age 0-4			Age 5 – 15		
	Total	Muslim	% Muslim	Total	Muslim	% Muslim
Washwood Heath	3,520	2,935	83.4	7650	6547	85.6
Bordesley Green	3,660	2,979	81.4	7798	6531	83.8
Sparkbrook	3,282	2,670	81.4	6715	5526	82.3
Springfield	3,012	2,261	75.1	6020	4510	74.9
Aston	3,190	2,109	66.1	6046	4173	69.0
Lozells and East Handsworth	2,874	1,750	60.9	6012	3749	62.4
Nechells	3,322	2,086	62.8	5677	3710	65.4
Hodge Hill	2,657	1,562	58.8	5363	3136	58.5
South Yardley	2,898	1,427	49.2	5320	2638	49.6
Totals	28,415	19,779	69.6	56,601	40,520	71.6

Source: Analysis of 2011 Census Data by Ali S. et al for the Muslim Council of

Britain 2015 ⁷⁴

2.1.2 Maternal Health

Statistics on maternity care are not currently available by religion. Existing evidence on ethnicity and maternity illustrate that minority ethnic women have poorer experiences and outcomes compared with White British women^{75 76 77 78}, and the specific inequalities and hurdles faced by Muslim minority ethnic women⁷⁹, including Bangladeshi women⁸⁰ Pakistani women⁸¹, Arab women⁸², Somali women⁸³ and Palestinian women⁸⁴. Addressing the ethnic inequalities in maternal healthcare is a focus of the NHS Improvement Maternity Transformation Programme Equity Strategy.

Research illustrated that minority ethnic women have a higher maternal mortality rate than White women. Comprehensive research on behalf of MBRRACE-UK⁸⁵ found that South Asian women were almost twice as likely than White women to die as a result of their pregnancy/childbirth (risk ratio 1.67). The Confidential Enquiry into Maternal and Child Health, which provides a breakdown of data on specific ethnic groups, reported that Bangladeshi women (relative risk ratio 2.1) and women from the Middle East (2.9) have significantly higher maternal mortality rates compared to White women, whereas Pakistani (0.8) women were less likely than White women to die as a result of being pregnant⁸⁶.

Whilst the role of biological and behavioural factors in producing excess unfavourable outcomes among ethnic minority mothers, although indicated, is yet to be fully understood. However, direct associations between socio-economic factors, ethnicity and adverse infant outcomes are evident⁸⁷. Literature reviews of minority ethnic women's access to and experiences of maternity care highlight the multiple

ways in which minority ethnic women, particularly migrant women, have poorer experiences in maternity care and poor perinatal outcomes in the UK compared with White British women^{88 89 90}. An abundance of studies have highlighted the structural and cultural discriminatory barriers that Muslim women face in accessing maternity care (see literature reviews ^{91 92 93}).

A resounding theme in the literature is the differential access to and utilisation of health services among ethnic minority mothers, in particular, for recently arrived migrants, refugees and asylum seekers^{94 95}. Concerns about communication issues and inadequate access to information are also a prevalent theme among ethnic minority women, particularly those who are migrants to the UK^{96 97}. These included difficulties reading written information in English (and sometimes in Urdu), understanding medical terminology, articulating and communicating needs to professionals in English and problems with using interpreters ^{98 99 100 101}

Another common theme is the prevalence of cultural barriers in relation to women's access to maternity care, predominantly in relation to the gendered nature of women's roles in Muslim communities. For example, Muslim women's concerns included the presence of males at antenatal classes, whether hospital food would be 'halal', the gender of healthcare professionals, wearing Islamic clothing and changing and prayer facilities¹⁰².

Due to the higher rates of infant mortality in Pakistani communities, studies have also sought to explore Pakistani Muslims views of prenatal screening. A qualitative study amongst the Pakistani/Kashmiri community in Birmingham¹⁰³ highlighted that,

although participants had an awareness of still births and genetic conditions, they had a poor understanding of genetics and were reluctant to accept the link between cousin marriages and birth issues. Fatalistic discourses about the 'will of God' as a cause of birth impairments and deaths were noted. In practice, some had declined tests such as Down's syndrome testing as they saw terminating their pregnancy as contrary to Islamic principles. These findings have been echoed by other studies¹⁰⁴

¹⁰⁵ ¹⁰⁶.

However, scholars also recommended that Muslim women's religion was not a proxy for their attitudes for or against termination of a pregnancy. Other factors, such as maternal age, perception of screening and termination, severity of condition and influence of significant others were all found to shape Muslim women's conceptualisation of prenatal screening¹⁰⁷. Studies have typically highlighted the importance for local, culturally sensitive services for Pakistani parents around genetic risk and consanguineous marriage¹⁰⁸.

Some Muslim minority ethnic women reported positive experiences of maternity care, which generally included continuity of care, individualised care and feeling respected by professionals¹⁰⁹. On the whole however, minority ethnic Muslim women reported experiencing negative interactions, dismissive comments, cultural insensitivity, a lack of understanding, disrespect and discrimination from healthcare professionals¹¹⁰ ¹¹¹. Studies with healthcare professionals (mainly midwives) also report that they had poor cultural awareness and were unable to distinguish ways in which the needs of minority ethnic Muslim women might differ from White women's

needs and often relied on cultural stereotypes when seeking to care for Muslim women.

2.1.3 Infant Mortality and Live births

Data is not available on infant mortality rates by religious affiliation. Evidence on geographical differences shows that Birmingham has near the highest rate of infant mortality in the country, near twice that of the national average¹¹².

For the period 2012 to 2014, Public Health England reported that the infant mortality rate in Birmingham (7.2 per 1,000) was significantly worse than the West Midlands (5.5 per 1,000) and England (4.0 per 1,000)¹¹³. A similar picture exists for perinatal mortality. Pooled data from 2017-2019 shows that the rate of infant mortality in England was 3.4 per 1,000 whilst in the West Midlands it was 5.6 per 1,000 and in Birmingham it was 7.0 per 1,000, around 112 infant deaths a year¹¹⁴ (different analysis may prevent accurate comparison with earlier figures).

In relation to ethnicity, the ONS reports that in England (2020) infant mortality rates were significantly higher for South Asian babies (4.1 per 1,000) than for babies from White (2.8/100,000) mixed ethnicity (3.2/100,000) and 'other' (3.7/1,000) ethnic backgrounds, but lower than for Black babies (5.3/1,000)¹¹⁵. For specific ethnic groups, the average rate between 2017-2019 was 4.9 deaths per 1,000 live births¹¹⁶. The Pakistani community had amongst the highest rate of infant mortality (6.7 per 1,000) whereas the Bangladeshi community (5.1 per 1,000) did not show any significant differences with other ethnic groups.

For most ethnic groups, immaturity-related conditions were the main contributor to the overall infant mortality rate, followed by congenital anomalies (average of 1.61 deaths per 1,000 live births across all sub-ethnic groups). However, this pattern was reversed for Pakistani (3.4 per 1,000) and Bangladeshi (2.3 per 1,000) ethnic groups where more infant deaths were caused by congenital anomalies¹¹⁷.

Compared to 2006, when ONS records began, there has been a significant improvement in the infant mortality rate of Pakistani babies from 9.4 per 1,000 in 2006 to 6.7 in 2019 (¹¹⁸). The Pakistani group continued to have the highest stillbirth rate, the highest rate of infant mortality for babies born at 24 weeks and the lowest birthweight¹¹⁹. The Bangladeshi infant mortality rate has seen more fluctuation, which includes a rise from 4.7 per 1,000 in 2006 to 5.1 in 2019.

A recent enquiry by Health and Social Care Overview and Scrutiny Committee in Birmingham City Council reported that in 2017 infant mortality was the highest amongst Pakistani babies (7.3 per 1,000). This was compared to a rate of 5.7 per 1,000 for all South Asian babies in Birmingham¹²⁰. The Committee reported that babies from a Pakistani background were significantly over-represented in all child deaths in Birmingham compared to their presence in Birmingham's resident population (14%). The Pakistani population in Birmingham accounted for 34% of all child deaths, including 45% of chromosomal, congenital and genetic deaths and 21% of perinatal and neonatal deaths¹²¹.

Similar findings have been reported by other studies in the UK¹²² and for Muslim communities internationally¹²³. For example, analysis of 85,735 births in Birmingham

between 2006-2010¹²⁴ found that mortality from congenital anomalies was statistically significantly higher in Pakistani (OR 3.0) and Bangladeshi (OR 2.1) mothers. Based on the Committee's findings, a task force has been set up by Birmingham City Council to tackle the high rate of neonatal mortality in Birmingham¹²⁵.

Socioeconomic factors (such as maternal education, maternal age, deprivation, obesity, smoking) and prematurity are major factors in perinatal and infant morbidity and mortality, however the contribution of genetic conditions is also significant, particularly for Muslim communities^{126 127 128 129}. The main causal factor proposed for the higher rates of infant mortality in babies from Pakistani backgrounds is the higher rates of consanguineous relationships in the Pakistani community^{130 131 132}. In the study by Tonks et al. (2013), 50% of Pakistani mothers were in consanguineous relationships compared to 16% across the whole cohort.

Qualitative studies which have explored Pakistani communities' perceptions of consanguinity and resulting genetic conditions/birth issues report they held strong cultural beliefs about cousin marriage and had poor understanding of genetics^{133 134}. For example, a study with the Pakistani/Kashmiri community in Birmingham highlighted that although research participants had an awareness of still births and genetic conditions they had limited understanding of genetics and were reluctant to accept the link between cousin marriages and birth issues¹³⁵. Furthermore, whilst female respondents were in favour of screening for genetic conditions, in practice some had declined tests such as Down's syndrome testing as they saw terminating their pregnancy as contrary to Islamic principles.

Researchers therefore recommend public health interventions for Pakistani communities, such as timely access to screening services and referral for genetic risk assessment¹³⁶, and local, culturally sensitive campaigns to improve understanding around genetic risk and consanguineous marriage^{137 138}

2.1.4 Childhood Obesity

The National Child Measurement Programme (NCMP) measures the height and weight (BMI) of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) in England to assess overweight and obesity levels in children within primary schools. Data on religious affiliation is not reported. In relation to ethnicity, for the year 2016/17, analysis by NHS Digital reported slight but no statistically significant differences across age groups for Bangladeshi and Pakistani pupils¹³⁹. In 2017/18, an estimated 22% of children aged 4 to 5 in England were overweight and 34% of children aged 10 to 11 were overweight. This is compared with 21% and 44% of Bangladeshi children (respectively) and 20% and 40% of Pakistani children (respectively). Other studies also report no significant differences by Pakistani and Bangladeshi children¹⁴⁰

Another analysis of the NCMP by Public Health England¹⁴¹, which analysed pan-ethnicity by residential deprivation, reported that Year 6 Asian boys in the most deprived quintile have a predicted obesity prevalence that is on average 5.2 percentage points higher than equivalent White boys after adjustment for other factors including height. On the other hand, Year 6 Asian girls in the most deprived quintile have a predicted obesity prevalence that is on average 0.5 percentage points

lower than equivalent White girls after adjustment for other factors including height. The opposite sex pattern was seen in Black children. Deprivation in and of itself was not a predictor of obesity for Asian children.

Another study¹⁴² applied ethnicity-specific BMI adjustments to data from NCMP and reported that the NCMP underestimates obesity levels in South Asian children by around 10 percentage points - and to higher levels than for Black Caribbean/African and White children¹⁴³. According to the adapted measures, the researchers reported that half of all South Asian boys – and two in five Asian girls – in Year 6 were overweight or obese. Bangladeshi children, followed by Pakistani children had the highest rates of obesity.

2.1.5 Childhood Physical Activity

Qualitative studies that have been undertaken in England to explore the issues of Muslim children undertaking physical exercise in the school setting have almost exclusively focused on the experiences of girls. The studies conclude that most Muslim girls are as keen as their classmates to engage in sporting events and other forms of physical exercise but that they have to 'navigate' ¹⁴⁴ the gaps between parental expectations and school regulations and facilities. Parents are not against girls engaging in physical activity but are concerned that they do so in circumstances that conform to Muslim values and traditions.

A qualitative study of Muslim 15-year old girls in two English secondary schools ¹⁴⁵ found that the main concern was the uniform or 'kit' to be worn during physical activities which had to fulfil Muslim requirements for modesty, for example to ensure

there is coverage of arms and legs. The wearing of track suit bottoms during physical activity was one common way of meeting this requirement. There were also concerns that girls after puberty should be enabled to undertake physical activities separately from boys and that changing and showering arrangements should enable privacy to be sustained. Being able to engage in swimming was particularly problematic. There were also specific concerns about arrangements for Ramadan and whether schools would enforce the requirement for regular exercise whilst girls were fasting for the month.

These findings were replicated by a study ¹⁴⁶ situated in a large, urban, co-educational, local authority school in Yorkshire in which 91% of the students were Muslim (76% classed as British Asian of Pakistani origin), and 63% lived in the 10% most deprived neighbourhoods in England. The study also found that the funding necessary to engage in physical activities was a limiting factor, a finding confirmed by a similar study ¹⁴⁷ in a school in the south of England. Funding and arrangements for modesty, safety and privacy were also factors limiting the degree to which girls were able to engage in extracurricular sporting activities. The girls interviewed in the study in Yorkshire also highlighted another tension they had to manage between school and home: Muslim family values emphasised sharing and conforming to cultural norms whereas, in school, physical activities, and especially sporting activities, highlighted competition and individual achievement.

This study also obtained results that challenge what the author describes as a popular stereotype of Muslim girls: that they are passive, frail and oppressed. Many of the girls in the study showed themselves to be active agents in negotiating

Physical Education and physical activity opportunities for themselves that enabled them to participate whilst still abiding by Muslim values and traditions.

These studies include many illustrations of Muslim girls requesting changes to school procedures, regulations and facilities to enable them to participate in physical activities with varying degrees of success. In some cases, schools held fairly rigidly to their existing policies to ensure everybody was treated equally whilst in others every effort was made to encourage Muslim engagement. The authors of the studies conclude that the school reaction was often based upon a lack of understanding of the Islamic values the girls were upholding and that 'gate keepers' from the local Muslim community, people who could mediate between the schools and the children, could often increase understanding in the schools and point to solutions that had worked elsewhere.

2.1.6 Child poverty

In 2011, 46% of the Muslim population of England and Wales lived in the 10% most deprived local authority districts based on the Index of Multiple Deprivation measure. In 2006, 69% of Muslim children in Birmingham lived in areas of poverty¹⁴⁸. In the 2011 Census, three wards in Birmingham which have high numbers of Muslim children are within the 10% most deprived areas of England and Wales: Sparkbrook, Bordesley Green and Lozells and East Handsworth ¹⁴⁹.

The receipt of Free School Meals is often used as an indication of children in poverty. In Birmingham in 2018, the average percentage of children receiving Free School Meals was 25.6%. Of the wards listed in table 2 in which the school

population is more than 50% Muslim, the Free School Meal figures average was 26.3% with the highest figures for Nechells 38%, Sparkbrook 29%, Hodge Hill 27% and Bordesley Green 27%.

The number of children eligible for Free School Meals may be higher than reported. There is evidence ¹⁵⁰ many Muslim parents who are concerned that their children may eat unacceptable food at school, for example, because meat may not be Halal, may not take up the offer of Free School Meals.

Muslim children in deprived areas may have an impoverished start to life in a number of ways ¹⁵¹. They tend to live in overcrowded housing occupied by multiple generations. There is also likely to be a high degree of unemployment. 19% of children are in one-parent families.

2.1.7 Children in care

In 2019, there were 78,150 looked-after children in England, of which it is estimated approximately 4,500 were of Muslim heritage ¹⁵². Both the number of looked-after children and the number of children of Muslim heritage in care are increasing. The reasons Muslim children need looked-after support include all the reasons common to other parts of society, for example, parental death, family breakdown, domestic violence and sexual abuse, but there are also reasons specific to Muslim families. Miller and Igram ¹⁵³ give the example of a cultural stigma attached to children born outside of marriage. There are also a small number of girls who come into care because they get into conflict with their socially conservative families because they do not wish to conform to all the limitations on their freedom that the families expect.

An additional factor in recent years has been the number of Muslim children coming into the country as unaccompanied refugees who need to be cared for. There was a 17% increase in unaccompanied asylum-seeking children in the first quarter of 2018 ¹⁵⁴. The UK refugee council found that Sudan was the top country of origin for the number of unaccompanied children (19% of all applications in Q1 2018). Eritrea accounted for 14% of applications, Iraq for 12%, Vietnam for 11%, Afghanistan for 10%, Albania for 10% and Iran for 9%. Together these seven countries accounted for well over 80% of all applications in Q1 2018. Therefore 64% of all applications in the first quarter came from predominantly Muslim countries which would equate to approximately 384 children likely to be Muslim coming into the care system in the first quarter of 2018.

Ideally, Muslim children needing foster homes would be placed with Muslim families. However, there is a shortage of Muslim foster homes and there are estimates ¹⁵⁵ that less than half of the children needing foster homes get placed with Muslim families. Qualitative research studies ¹⁵⁶ have documented the problems experienced by Muslim children being fostered by White parents. As Pitcher and Jaff ¹⁵⁷ point out, even when a child is not a practicing Muslim, they have grown up in a family setting that follows Muslim cultural traditions and these traditions are a complete 'way of life' extending into diet and meals, dress codes, language, how members of the family are treated, how to behave outside the home and so on. For example, one study ¹⁵⁸ reported the case of Hussain who reacted very negatively to a pet dog owned by his foster parents because he had been taught that dogs are 'unclean'.

Pitcher and Jaff ¹⁵⁹ studied 13 Muslim children who had between them experienced 44 placements only 13 of which were with Muslim families and found that the placements with White families were very unsettling for the children, causing many anxieties and, in the longer-term, confusions about their cultural identities. Foster parents often tried hard to help the children settle down, in some cases buying them copies of the Quran, but the culture exhibited in the living style of the foster families remained foreign and challenging to the children.

Many research studies advocate placing Muslim children only with Muslim families but there is a great shortage of Muslim parents approved to foster children. In a study of foster agencies Miller and Imran¹⁶⁰ found there were many barriers to Muslims becoming foster parents. They found that there was no shortage of applicants to become foster parents, but foster agencies reported that only a small number, perhaps only 3 in every 100, of applicants were successfully registered. The applicants tended to have only a limited understanding of the fostering process and found the bureaucratic nature of the process very challenging. The requirements of the fostering authorities were also often difficult for Muslim families who perceived possible clashes with Islamic values and cultures ¹⁶¹.

2.1.8 School readiness

School attainment and school readiness data are not available by religion but there are records by ethnicity. In the next two sections, the data for Pakistani and Bangladeshi children are reported because the Muslim faith is common to both. An analysis in 2019 of 9487 children from the UK Millennium Cohort wave one data, using the Bracken School Readiness Assessment, found that 55.7% of Pakistani and

Bangladeshi 3-year olds were ready for school compared with the average for the overall sample of 86.3%. The authors¹⁶² identified six factors (social class, maternal education, family income, ethnicity, the sex of the child and the number of children in the household), as the best predictors of school readiness. These factors indicate that the Muslim children least ready for school would be boys in families with low levels of income, with mothers with no qualifications or work history, living in multi-generational housing with many other children.

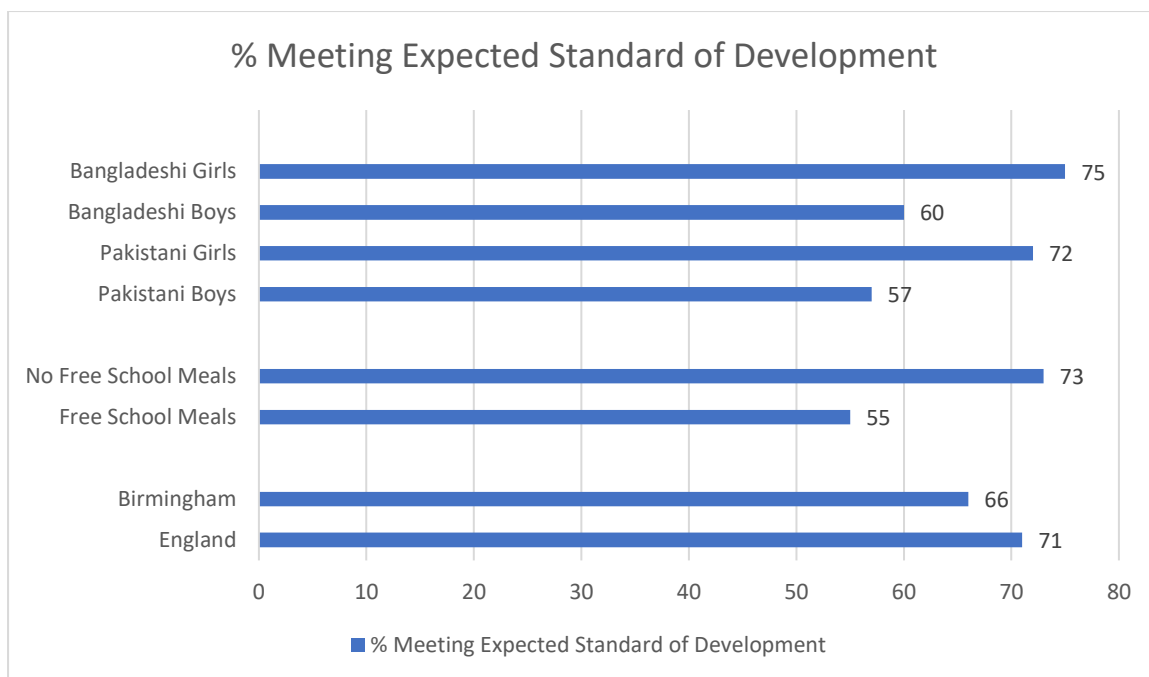
2.1.9 Attainment at School

The attainment of Pakistani and Bangladeshi children at all stages of their school careers can be compared with the average attainment in England and in Birmingham. As an indication of the effect of poverty on school attainment it is also possible to compare the attainment of children eligible for free school meals with those who do not qualify for this benefit.

Children Meeting Expected Standards When Starting Schools

Children are assessed at the end of their first foundation year at school on their development in relation to expected standards of development. In 2018/19, 71% of children in England met the expected standards. In Birmingham 66% met the expected standard.

Figure 8: Children Meeting the Expected Standard of Development in their Foundation Year (2018-19)



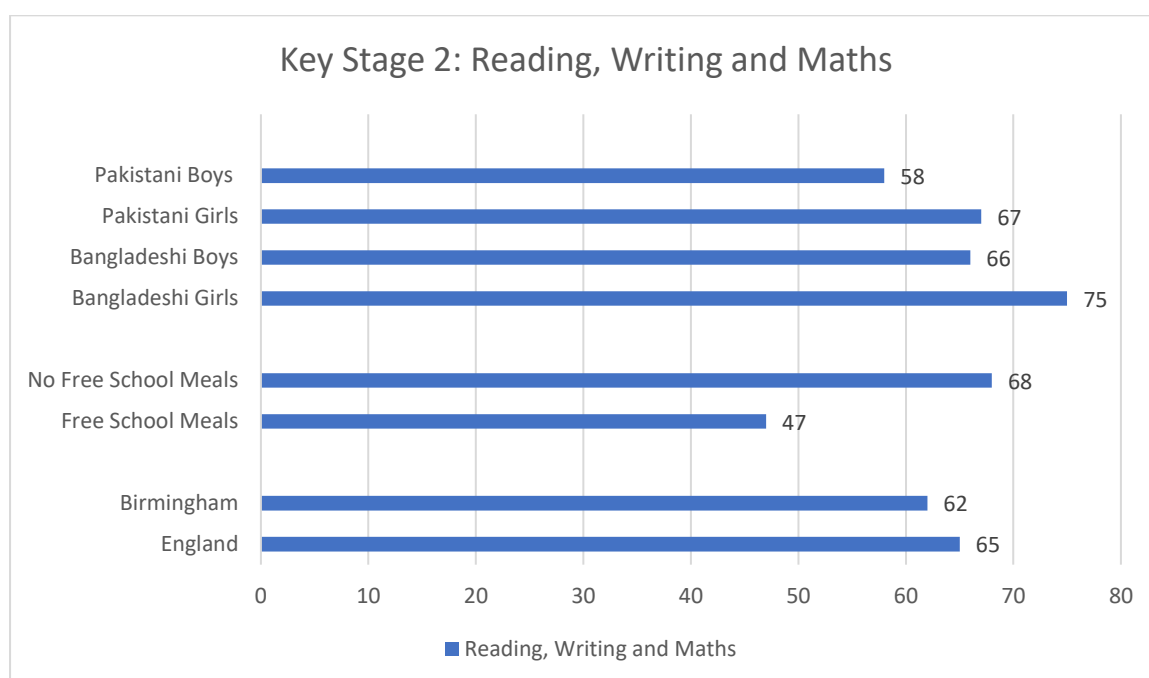
Source: ethnicity-facts-figures service.gov.uk

The Bangladeshi and Pakistani girls both exceeded the average standard of development in England but the boys in both cases were considerably below the national average. There was in each case a 15-point difference between the standard of development of the girls and the boys. There was also a substantial difference between the standard of development of children not receiving school meals (73%) and those eligible for school meals (55%). Eligibility for free school meals is used as an indicator that the child is from a family in poverty and this finding is evidence that poverty is having a significant effect on the preparedness of children for school.

Key Stage 2: 10 and 11 year olds in 2018/19

At key stage 2, all children are assessed to establish whether they have attained the expected standards in reading, writing and maths. In England 65% of children attained this standard. In Birmingham 62% attained this standard.

Figure 9: School Attainment at Key Stage 2 in England (2018-19)



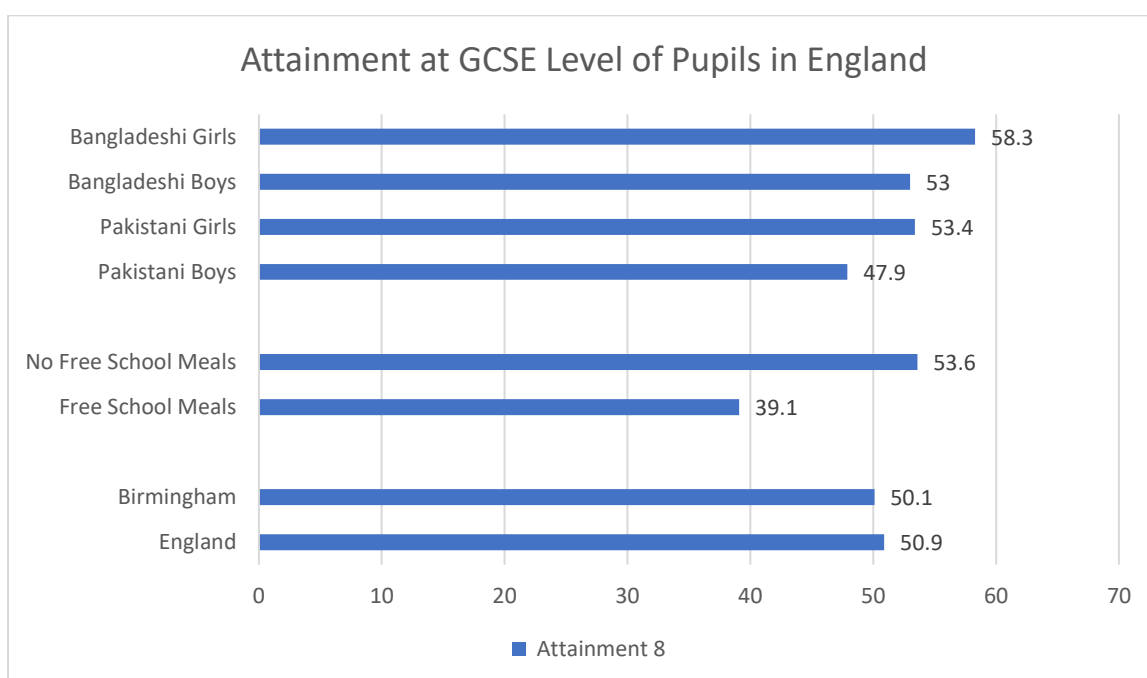
Source: ethnicity-facts-figures service.gov.uk

Bangladeshi girls and boys both exceeded the national average as did the Pakistani girls. The Pakistani boys were 7% below the national average. In both communities the girls outperformed the boys by a considerable margin. There was again a large difference in attainment (21%) between pupils not receiving free meals and those eligible for free meals.

Key Stage 4: GCSE Performance at 16

The assessment of performance at age 16 made by the Department of Education 'Attainment 8' comprises scores in eight subjects including English and Maths and can include three non-GCSE subjects approved by the Department. The highest possible score is 90. The average score in England in 2020/21 was 50.9 and in Birmingham the score was 50.1.

Figure 10: School Attainment at GCSE in England (2018-19)



Source: ethnicity-facts-figures service.gov.uk

Muslim children as represented by Bangladeshi and Pakistani pupils score higher than the country average except for Pakistani boys. The girls in both ethnic groups perform better than the boys. There is a big difference in the scores for pupils eligible for free school means (39.1) and those not eligible (53.6) suggesting that degree of poverty is an important determinant of success at this level.

Attainment by Muslim Children in Birmingham

Muslim children had lower attainment than the average in 2005 in Birmingham at GCSE level than other minority ethnic groups, e.g. Indian and Chinese ¹⁶³. It is worth noting that this data is not routinely reported, so the findings presented are from specific research, which is now historical but may still provide some important areas for consideration.

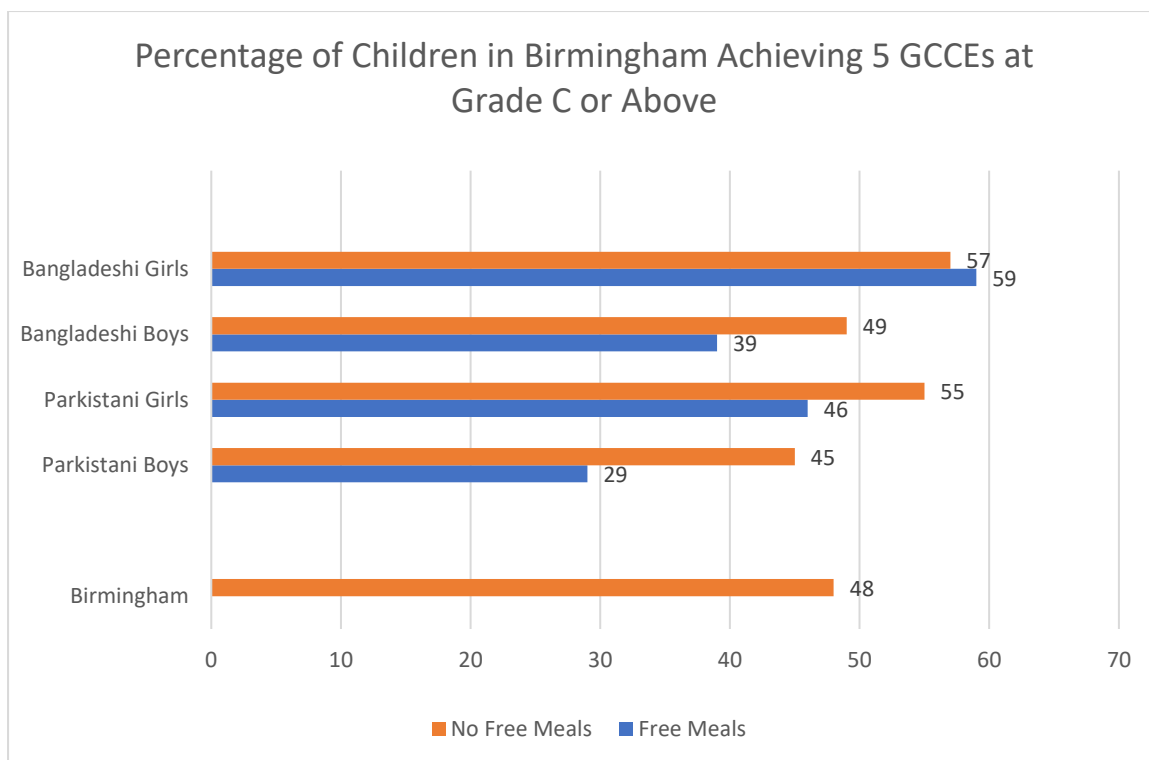
Table 4: Minority Ethnic Groups GCSE Attainment Levels in Birmingham

Achievement at GCSE Level (5 or more GCSEs at grade C or above)	
Birmingham children	48%
Muslim children	40%
Indian children	63%
Chinese children	73%

Source: Abbas, 2006 ¹⁶⁴

Muslim girls in Birmingham outperformed boys in GCSE attainment. In 2005, 48% of all children in Birmingham achieved 5 GCSEs. Of the children not receiving Free School Meals, 55% Pakistani Girls achieved 5 GCSEs compared with 45% of Pakistani Boys. Of Bangladeshi children not receiving Free School Meals 57% of girls achieved 5 GCSEs compared with 49% of boys. 36% of Muslim children left school with no qualifications and 20% of 16-24 year old young people were unemployed ¹⁶⁵.

Figure 11: Children in Birmingham Achieving 5 GCSEs at Grade C or Above (2005)



Source: Abbas, 2006 ¹⁶⁶

In order to explore the effects of deprivation on attainment in Birmingham, Abbas ¹⁶⁷ compared the performance in GCSEs of children receiving and not receiving Free School Meals. There was little difference in the performance of Bangladeshi girls: 59% of those who received Free School Meals achieved 5 GCSEs compared with 57% of those who did not. However, whilst 55% of Pakistani girls who did not receive Free School Meals achieved 5 GCSE's only 46% of the girls receiving Free School Meals achieved 5 passes. The differences were also pronounced for the boys. 49% of Bangladeshi boys not receiving Free School Meals achieved 5 GCSEs compared with 39% of boys who did receive Free School Meals. 45% of Pakistani boys not receiving Free School Meals achieved 5 GCSEs compared with 29% of those receiving Free School Meals.

For many of the Birmingham wards that have a majority Muslim population and are deprived areas, the attainment levels of children in GCSEs were lower in 2005 than the average of 48% for Birmingham as a whole: Hodge Hill 27%, Washwood Heath 33%, Nechelles 38% and Aston 38% and Sparkbrook 42%. Abbas¹⁶⁸ concludes that there is evidence that living in a deprived area in Birmingham in 2005 limited the achievement of Muslim children and in particular Muslim boys.

Wilkinson¹⁶⁹ undertook a mixed-method study to explore the reasons why English Muslim schoolboys in four inner city secondary schools struggled to succeed in their studies. An attitude survey was undertaken with 295 respondents followed by semi-structured interviews with 23 children and 10 of their teachers. The findings demonstrated that the boys struggled to find relevance in many of the subjects they studied, particularly in the humanities. They found it difficult to relate to the history syllabus, for example, when there was no coverage of the history of Islam.

In a series of in-depth interviews with Muslim pupils in Birmingham Suriyah Bi¹⁷⁰ found that the approach of teachers, inspectors and other school officials was leading to anxiety amongst pupils and disaffection from their studies. Many teachers saw Muslim children, particularly the boys, as a problem to be dealt with. In many schools they were required to monitor pupil behaviour to detect signs of extremism and radicalization. The school children were aware of this suspicion which made them guarded in their relations with their teachers.

The relative underachievement of Muslim children in state schools has led to a growing trend for the Muslim community to be proactive in the education of their

children. This can take the form of supplementary education, in some cases in conjunction with Islamic classes taught in the Mosques. There has also been the establishment of private Muslim schools at both primary and secondary levels and requests to establish Muslim state schools akin to Church of England and Catholic state schools.

In 2013, an anonymous letter was sent to a Birmingham Councillor alleging there was a plot to infiltrate important posts in some Birmingham schools with the aim of converting the schools to Muslim faith schools. The letter was condemned as a hoax but it led to reviews of school policies on safeguarding and to increased monitoring of pupil behaviour. This created tensions in the community leading to what became known as the Trojan Horse Affair¹⁷¹.

In 2007, there were 100 independent Muslim faith schools in England and seven state funded schools¹⁷². In 2021 six state funded schools in Birmingham were listed as Muslim faith schools, three primary and three secondary schools¹⁷³. There is some evidence that Muslim children achieve higher levels of attainment in faith-based schools: in 2013/14 three independent Muslim faith schools were in the top 20 highest performing Birmingham schools for GCSEs, the two top performing schools attaining 100% success in pupils obtaining 5 GCSEs at grade C or above. However, these are independent fee-paying schools and the Muslim children attending them probably come from more prosperous families who can afford the fees.

2.1.10 School exclusions

There is a belief that Muslim children are excluded from school more frequently than White children ¹⁷⁴ and, in discussing school exclusions, some authors include Muslim children in the broader BAME category for which school exclusions are four times higher than for White children ¹⁷⁵. However, Government statistics on permanent school exclusions for 2018-19¹⁷⁶ do not support this conclusion. The statistics do not categorise exclusions by religion but ethnicity classifications show that the rate of exclusions for Bangladeshi children in England was 0.04 (4 children in every 10,000) and 0.06 for Pakistani children compared with 0.10 for White British children and 0.11 for Black children.

Although permanent exclusions are low there are specific tensions that can lead to temporary suspensions. There have been cases in England of Muslim girls wearing clothes that conform to Muslim practices but do not conform to school uniform rules. In one case a Muslim 12-year old ¹⁷⁷ at a school in Luton was sent home for wearing the jilbab to school, a case that went to the Court of Appeal which concluded she had been unlawfully excluded from school. In other cases, schoolgirls have been sent home for wearing skirts that are longer than the uniform rules stipulated. In most of these cases the issues were resolved without exclusions being imposed.

2.2 Mental wellness and balance

Mental Health

- A quarter of Muslims (23%) aged 55 and over reported feeling 'unhappy or depressed rather more than usual' compared to 12% non-Muslim
- Muslim females have a higher prevalence of mental illness than Muslim males.
- Muslims have poorer access to mental health services and poorer treatment outcomes compared to non-Muslims

Alcohol

- The Islamic ban on alcohol is largely adhered to by the Muslim population of England

Smoking

- In 2019 4% of Muslim women and 18% of Muslim men in England were current smokers.
- 35% of Muslim adults in England had at some time been smokers compared with 60% of Christians.

Drugs

- The use of cannabis as a recreational drug by Muslim youth in the UK has become 'normalised' as it has in other groups of young people
- In 2011 13% of the prison population of England were Muslims and 19% of them were convicted on drug related charges.

2.2.1 Mental health

Prevalence of Mental Health Problems

Data on the mental health and service use of religious groups is not reported by the Adult Psychiatric Morbidity Survey (which reports on pan-ethnic groups), Limited evidence from large-scale surveys which do report on religious affiliation and mental health present mixed results.

The Household Longitudinal Study (2016-18) measured a Mental Component Summary (MCS) score ranging from 0 (lowest reported state of mental health) to 100 (highest reported state of mental health). Following adjustment for age, sex, broad ethnic group and region, Muslims (50) had a similar mean MCS score as Hindus (50) and Sikh (51) but a lower MCS score than Christians (49) and people with no religion (48)¹⁷⁸. However, no breakdown was reported by age or other socio-demographics. In the previous wave, the Study (2014-16) there was little difference between the self-reported feelings of unhappiness or depression between Muslims (18%) and non-Muslims (17%)¹⁷⁹.

However, differences were starker for older Muslims aged 55 and over, nearly a quarter (23%) of whom reported feeling 'unhappy or depressed rather more than usual' compared to 12% of their non-Muslim counterparts. Furthermore, data from The UK Household Longitudinal Study (2009-2014) showed that Pakistani and Bangladeshi Muslims had poorer wellbeing outcomes (on SWEMWBS and GHQ) compared to Christians and participants with no religious affiliation and poorer GHQ wellbeing outcomes compared to other minority groups¹⁸⁰. The worse wellbeing of Muslims was largely accounted for by ethnicity. Within the Muslim population,

evidence indicates that Muslim females have a higher prevalence of mental illness than Muslim males¹⁸¹.

On the whole, findings from large surveys report that (predominantly South Asian) Muslim adults and Muslim young people^{182 183 184 185} have a similar/lower prevalence of self-reported mental illness than White British people/non-Muslims. Meta analysis of psychosis incidence in England also report that Muslim and South Asian groups have the lowest rates. For example, pool risk ratios showed that the White British population, Kirkbride et al., reported that the South Asian (2.4) population had a significantly lower risk ratio of having a psychotic incidence compared to Black African (4.7) and Black Caribbean (5.6) populations^{186 187}.

In relation to ethnicity and Common Mental Disorders (CMD), The Adult Psychiatric Morbidity Survey (2014) reported that South Asians (18%) had similar rates of observed CMDs as White British people (17%), and lower levels than people from Black African/Caribbean/other backgrounds (29%) and mixed ethnic backgrounds (29%). Furthermore, Asian women (24%) had a higher prevalence of CMD than Asian men (13%). These findings are replicated by other studies, which report that South Asian s report a lower prevalence of mental health problems than White , Black and Mixed Race populations ^{188 189}¹⁹⁰. Within the South Asian Muslim population, Pakistani women appear to have a higher prevalence of mental illness than Bangladeshi women^{191 192}.

Suicide

Meta-analysis of suicides in the UK in 2001 (n=4,848) by South Asian religion, undertaken by Tuck et al.,¹⁹³ reported that the age-adjusted suicide rate for all people of South Asian origin (5.50 per 100,000) and for all South Asian affiliated religious groups (4.39 per 100,000) was significantly lower than the suicide rate for the general population of England and Wales (9.31 per 100,000 for the population of England and Wales). Age standardised mortality ratios (ASMRs) showed that Muslims (0.47) had the lowest ASMRs of all South Asian affiliated religious groups, i.e. compared to Hindus (0.88) and Sikhs (0.85). South Asian females had (3 times) lower rates of suicide than their South Asian male counterparts, although this gap was smaller than for Hindu females (6.4 times lower) compared to Hindu males¹⁹⁴.

The Adult Psychiatric Morbidity Survey¹⁹⁵ also reported that South Asians had the lowest prevalence of suicidal thought and suicidal attempts compared to other pan-ethnic groups. However, other analysis by age and other sociodemographic factors report an elevated risk of suicide for older Asian women (aged 65 and over) and younger South Asian women (aged 15-24)^{196 197 198}.

Factors Shaping Mental Health Problems

In relation to the low prevalence of reported mental health problems amongst South Asian people and Muslims, some researchers highlight the role of religion as a protective coping strategy for coping with mental illness^{199 200 201}. For example, in the Fourth National Survey of Ethnic Minorities more frequent religious service attendance, although not religion in itself, was associated with higher mental wellbeing²⁰². That suicide would be a transgression against Allah, and is a criminal

offence in most Islamic states, has also been suggested to be a protective factor against suicide^{203 204}.

However, it is likely that the low prevalence of mental illness amongst Muslims, particularly South Asian Muslims, is a severe underestimate. International studies, for example, report that Muslim women in Southeast Asia have higher rates of depression than non-Muslim women²⁰⁵, although other context specific factors may also be at play. The tools and cultural interpretations used to assess prevalence of mental illnesses amongst Muslims and South Asians in the UK have been deemed insensitive to conceptualising and translating mental health related terms into South Asian languages²⁰⁶.

In addition to the general factors which are known to negatively impact mental health and wellbeing, such as childhood trauma, deprivation, unemployment, housing conditions, drug and alcohol abuse and poor physical health²⁰⁷, Muslims face additional stresses which severely impact their mental health, such as racism and islamophobia^{208 209 210 211 212}. These problems are compounded for migrants. The cumulative exposure to racial discrimination has incremental negative long-term effects on the mental health of ethnic minority people in the United Kingdom. The problematisation of Muslims and events such as the 'Trojan Horse Scandal' have severely impacted the mental health and wellbeing of Muslims in Birmingham and nationally^{213 214 215 216}. Typical measures of mental health and well-being may therefore underestimate the contribution of racism to poor mental health^{217 218}.

Muslims' conceptualisation of mental health may be influenced by a range of models, including Islamic scholarship, a biomedical model and personal beliefs²¹⁹, which may conflict with Western definition²²⁰. For example, some Muslims believe that the aetiology of mental health problems are associated with the 'Evil eye', 'Black magic' or 'jin'^{221 222 223 224}. The role of Izzat (family honour) and shame has also been highlighted as an additional risk factor poor psychological well-being in South Asian women and young people, highlighting why some South Asian people may not be open about their mental health difficulties ^{225 226 227}.

Whilst living among extended families and having a wider social support network has been raised as a protect mechanism against mental health problems for South Asians, researchers also highlight the juxtaposition of this situation for Asian Muslim women and young South Asian Muslim women in particular. For example, a study exploring the impact of multi-generational households on the mental health of its members reported that whilst Muslim South Asian children and grandmothers were better adjusted in extended families the adjustment of mothers was better in nuclear families than extended families (regardless of acculturation)²²⁸.

Barriers to Accessing Mental Health Services

Evidence indicates that Muslims are less likely to use mental health services and those that do appear to have poorer outcomes than for other religious groups^{229 230}. Use of psychological services among South Asian s and Muslims is low ^{231 232}. In the Adult Psychiatric Morbidity Survey Minority ethnic people (7%) were less likely than White British people (15%) to report receiving mental health treatment²³³. Pakistani women, and particularly Bangladeshi women, are particularly less likely to utilise mental health services²³⁴.

Evidence shows that British South Asian Muslims face a range of cultural, structural and religious barriers when accessing services. As outlined by several reviews²³⁵

²³⁶and individual studies, these include:

- Preserving izzat or embarrassment due to the stigma of mental health ^{237 238}
²³⁹
- Conceptualisation of mental health as having a spiritual cause or being part of Black magic or Jin ^{240 241 242 243}
- Relying on faith healers^{244 245 246}
- Lack of awareness of mental health and mental health services ^{247 248}
- Lack of culturally sensitive treatments and services.^{249 250 251}
- Racism and anticipated discrimination ^{252 253}
- Lack of trust in healthcare professionals and services ^{254 255 256 257}
- Poor communication materials about mental health and mental health services and language barriers ^{258 259}

Researchers highlight the need to adapt mental health services to the needs of Muslims, but also to the needs of specific groups of Muslims from different ethnic backgrounds/nationalities, e.g. Pakistani ^{260 261 262}, Bangladeshi ^{263 264 265}, Turkish²⁶⁶, Black Muslim Somali refugees and asylum-seekers ²⁶⁷, East African²⁶⁸ Muslims.

Treatment Outcomes for Mental Health

Analysis of 2017–2018 outcomes in the UK government’s Improving Access to Psychological Therapies (IAPT) programme reported that Muslim (40%) who underwent IAPT had a poorer recovery rate than Christians (55%)²⁶⁹. A greater disparity was reported for the following year (2018/19); 61% of Muslims were reported as having ‘reliably improved’ and 43% had been ‘moved to recovery’²⁷⁰. This was significantly lower than for Hindus (67% and 52% respectively), Sikhs (68% and 52%), Christians (70% and 56%) and those with no religion (68% and 52%).

Table 5: IAPT Referrals and Outcomes by Religion (2018/19)

IAPT Referrals and Outcomes by Religion, 2018/19			
Religion	Number of Referrals	Reliably Improved	Moved to Recovery
Muslim	44,740	61%	43%
Christian	311,858	70%	56%
Hindu	8,473	67%	52%
Sikh	7,087	68%	52%
Buddhist	4,319	67%	51%
Jewish	3,743	68%	57%
No religion	620,811	68%	52%

Source: Baker (2020). House of Commons Briefing Paper²⁷¹

The lack of culturally sensitive interventions for South Asians, and for Muslims, has led to the development of several culturally adapted/specific interventions delivered in a range of settings^{272 273 274}.

2.2.2 Alcohol

Alcohol is defined as 'haram' or forbidden in Islam and the requirement to avoid alcohol is maintained by young Muslims as they enter adulthood to a remarkable extent²⁷⁵.

A qualitative group study of 47 Muslim Asians in the Midlands²⁷⁶, aged 16–26 years, examined how this prohibition was regulated in Muslim communities. Although the proscription on alcohol was formally gender blind it was strongly enforced in relation to women. Concerns about reputation and future marriage chances, sanctioned by gossip, meant that women's behaviour was consistently more constrained than men's. For men, Muslims' abstinence from alcohol was tightly linked with an Islamic identity in that drinking jeopardised one's claim to being a Muslim.

Although the prohibition is largely adhered to, Valentine et al ²⁷⁷ cite studies which report that a significant minority of Muslim men do drink alcohol but usually in moderation. In a study of alcohol consumption in Southall, although alcohol consumption was lower amongst Muslim men than any other of the other social groups surveyed, 20% of the Pakistani and Indian Muslim respondents reported drinking alcohol at least once a week. Valentine et al. ²⁷⁸ report a questionnaire survey (n=1,139) and 63 in-depth interviews in communities in Cumbria and in Stoke-on-Trent that studied 'the night-time economy'. They found many examples where young Muslims, in order to socialise with friends, had to visit pubs, bars and clubs where drinking alcohol was the norm. For some they were able to refrain from drinking whilst still being part of the social grouping, for others taking alcohol in moderation was the best way of maintaining their socialising. Even not drinking in these settings could have

repercussions in their Muslim communities where being seen to socialise in settings where alcohol was consumed could jeopardise your reputation.

A major questionnaire study²⁷⁹ surveyed 824 Asian 14-15 olds in Glasgow (Muslims, Sikhs and Hindus) and followed up with a sub-sample of 492 four years later when they were 18 -20 years old. The study found that at 14-15 years old the children followed all the traditions of their cultures and abstained from alcohol, smoking and drugs. When they were 18-20 years old the Sikhs and Hindus in the sample were less inclined to follow the guidance on alcohol because they were socialising with friends for whom drinking was a part of the social process. However, the study found that the majority of the Muslim 18-20 year olds continued to abstain from alcohol, especially the females. In a follow-up study questionnaire study²⁸⁰ in 2006, 47 young Asians were questioned about attitudes to alcohol and the influence of cultural traditions. The study found that Muslim men were more influenced by Islamic views of alcohol, citing that drinking jeopardised one's claim to being a Muslim, whereas cigarette smoking was tolerated amongst young men. Amongst Sikh and Hindu men avoidance of tobacco was strongly sanctioned, but smoking did not strongly jeopardise a religious identity

However Muslim men were less affected by traditions than Muslim girls whose behaviour was highly constrained by the expectations of the older generations in their families. The study reports, for example, the experience of a young woman who was no longer considered marriageable in her community because she has been seen on 'nights out' with friends who are drinking, despite the fact that she herself was not drinking.

2.2.3 Drug use

The Muslim doctrine of avoiding harm to oneself or others²⁸¹ means that Muslim's should avoid using harmful drugs. Although it is difficult to obtain accurate figures, there are, however, many indications that drug use, particularly of cannabis, is widespread amongst Muslim youth:

- The use of cannabis is widespread in the Muslim youth of many countries. Nassif²⁸² reports studies in Saudi Arabi, Tunisia, Iran and Egypt that all show increasing use of cannabis amongst Muslim young men in particular.
- In the UK the use of cannabis has become 'normalised' as a lifestyle in younger generations and this development has extended to Muslim youth²⁸³.
- In some communities, notably in the Muslim community in Bradford, Muslim youth gangs have become the main local drug dealers²⁸⁴.
- In 2011 Muslims accounted for 13% of the prison population of England and Wales (but only 4.8% of the population)²⁸⁵. A freedom of information request (Independent)²⁸⁶ found that 2,089 of the Muslim prisoners (18.7%) had been convicted on drug related charges. This number had increased to 3,406 by 2017.

Qualitative studies have been undertaken to examine the place of drug taking in the lives of young Muslims and how and where they seek help with their habits. A qualitative study of 43 Muslim youths in Northern England²⁸⁷ who had accessed professional drug help agencies explored the role of cannabis in their lives. It found that the drug was widely available and shared in friendship groups leading to pressures to conform to the habit. It was much more common amongst young males

although young females were also drawn into what was considered to be normal behaviour.

In a study²⁸⁸ of 66 Bangladeshi drug users (46 males and 20 females) recruited through two Mosques in Leicester the drugs in use were first cannabis and second heroin. The users reported that drug taking was a normal part of socializing with friends, the drugs were easily available and 'everyone was doing it.' The route to taking up drugs usually began with smoking together until drugs were introduced and then there was peer pressure to conform. The respondents felt that the drugs problem primarily affected males.

A four-year study in Bradford²⁸⁹ gained access to young Muslims who were trading in heroin. The study concluded that the reasons for the gangs to engage in drug trading had nothing to do with religion or to their particular cultural roots. The gang members were from some of the most deprived areas of the city and had very limited employment prospects. The gang members were concerned about their status in their communities and the kind of jobs they could take were very low status compared to the status they enjoyed as members of the gangs²⁹⁰.

These studies also examined what happened when drug users began to worry about the negative effects on their health. They faced a dilemma about where to find help. There was a stigma and shame associated with drug use in the Muslim community that would affect not only the young drug takers but also their families so they were reticent to share their problems with their families. In many cases they sought confidential help from professional agencies. In some cases they did seek help from

faith healers within their local Mosque rather than professional agencies. A study of seven faith healers²⁹¹ who were consulted by drug users found that the healers used religious teaching to help the drug users and to guide them on faith-based practices to overcome their habits. The faith healers expressed doubts about the efficacy of the solutions offered by professional drug agencies meaning that drug users could be exposed to two very different potential routes to recovery.

2.2.4 Smoking

Islamic attitudes to smoking vary from country to country²⁹². Many countries, for example, Egypt and Iran, have issued fatwas prohibiting the smoking of tobacco but in many other countries e.g. Saudi Arabia, smoking is commonplace. In South Asian countries smoking is unlawful but is also a widespread practice.

In 2019 the proportion of current smokers amongst Muslim men in England was 18.4%, whereas among Muslim women this was only 3.9%²⁹³. In 2018, 14% of Pakistanis and 16% of Bangladeshis were current cigarette smokers in England²⁹⁴.

The extent of smoking in the Muslim population of England is less than other populations. An analysis using the Health Survey of England 2010-2014 statistics reviewed the smoking behaviours of 39,877 adults and 2,355 youths. 35% of Muslim adults had at some time been smokers compared with 60% of Christians. Only 18.6% of Muslim youths smoked. 50% of Muslim adult smokers were not likely to quit smoking compared with 26% of Christians²⁹⁵.

In a qualitative survey in 2002 ²⁹⁶ 87 men and 54 women aged between 18–80 years, smokers and non-smokers, from the Bangladeshi and Pakistani communities in Newcastle Upon Tyne were asked about the attitudes to smoking in their Muslim communities. There were varied and conflicting interpretations of how acceptable smoking is within the Muslim religion. Smoking was a widely accepted practice in Pakistani, and particularly Bangladeshi, men and was associated with socialising, sharing, and male identity. Among women, smoking was associated with stigma and shame. Smoking in women was often hidden from family members. Peer pressure was an important influence on smoking behaviour in younger people, who tended to hide their smoking from elders.

A number of approaches have been proposed to help Muslim people reduce their smoking habit and in many cases the aim has been to engage local Mosques in the process. One proposal has been to utilise the fasting period of Ramadan as a means of beginning a process of giving up smoking²⁹⁷. For the month of Ramadan Muslims do not eat or drink between sunrise and sunset and this includes not smoking during this period. As a consequence, the fasting period leads to lower levels of smoking and what could be the beginning of a process of ending the habit. It has been proposed that Mosques lead campaigns to encourage heavy smokers to continue the smoking reduction begun in Ramadan after the fasting period has ended.

A second approach that involves Mosques in tackling tobacco addiction has been in relation to passive smoking. The prevalence of male smoking in the home means that women and children are exposed to second-hand smoke which can lead to health problems. A 2008 household survey in a deprived area of the North of England, where

nearly half the population was of South Asian origin, found that smoking took place regularly in front of children in 42% of households with at least one smoker²⁹⁸. The Muslim Communities Learning About Second-hand Smoke (MCLASS) study was undertaken to implement second-hand smoke education in 14 UK mosques²⁹⁹. Mosque staff were trained to deliver advice and support to families where there were smokers. Varied levels of success were reported depending on the degree of engagement by the Mosques and the families and also the degree to which the impact of second-hand smoke was understood and accepted.

2.2.5 Domestic Violence

The Crime Survey for England and Wales³⁰⁰ reported that Muslim women (3%) were more likely to have experienced partner abuse in the last 12 months than Hindu women (2%) but less likely than Christian women (6%). In relation to Muslim majority ethnicities, Bangladeshi women (1%) reported lower levels of partner abuse than Pakistani (4%) and Arab (5%) women; around 3% of women people from South Asian backgrounds experienced domestic abuse. It should be noted that evidence of lifetime experience of domestic violence is likely to be much higher.

Evidence indicates that minority ethnic women often experience 'double victimisation' in domestic abuse, in that they are abused in the home and experience discrimination by state agencies when reporting abuse and seeking intervention^{301 302 303}. British South Asian Muslim women in particular face specific socio-economic disadvantages (including low economic activity, educational attainment and literacy rates) and gendered/racialised islamophobia^{304 305}, which may further exacerbate their risk of

violence and abuse, difficulties in leaving an abusive relation and difficulties in accessing services³⁰⁶.

British Asian Muslims women who experience domestic abuse may also face various challenges from within their own communities, such as cultural and family pressures to preserve 'izzat' (family honour) and avoid shame^{307 308}. Islamic law, which makes it particularly difficult for Muslim women to obtain a divorce compared to men, can also be problematic for Muslim women seeking to leave abusive and forced marriage relationships^{309 310}. Muslim women from immigrant backgrounds, who do not have extended family or support networks, may also be additionally limited their ability to reach out for support outside of their husband's family^{311 312}. These women may also face specific threats of deportation and having their passport withheld in a context of not knowing their legal rights or having recourse to public funds³¹³.

Language and communication barriers and a lack of cultural awareness on the part of service providers may also impact the specific situation of Muslim women who are also from minority ethnic backgrounds^{314 315}. There is some evidence of mosque initiatives to reach out to Muslim women who experience domestic abuse³¹⁶ e.g. Imams Against Domestic Abuse (IADA). However, a lack of female representation within mosques and an avoidance of domestic violence issues by Mosques, have been highlighted as a barriers to Muslim women seeking support for domestic violence through religious institutions^{317 318}. A booklet by the Muslim Women's Network (funded by Birmingham Lord Mayor's charity) provides Muslim women with information about different types of abuse, safety advice and accessing support³¹⁹.

Some authorities have used the Quran to justify domestic violence against women whilst other scholars and imams have pointed to the mutual respect and compassion between husband and wife which is emphasised in the Quran and the contextual nature of the sacred text^{320 321 322}. Since the late 1990s, there has been a shift towards considering practices such as 'forced marriage' and 'honour-based violence' as domestic abuse³²³. Like other minority ethnic women, married Muslim women tend to live in multi-generational households with their in-laws and other relatives. Studies have highlighted the role of family members other than husbands, such as mothers-in-law, in instigating and perpetuating abuse³²⁴.

The resounding recommendation across the literature in this area is for the development of culturally competent, relevant and effective services which taking into account the specific circumstances of Muslim women's lives, including the role of the family³²⁵.

2.3 Healthy and affordable food

Obesity

- The chances of having a high waist hip ratio, were higher for Bangladeshi (OR9.65), Pakistani (OR5.37) and Indian (OR3.30) Muslim women than White British Christian women.
- Pakistani women (23%) had the highest prevalence of a high BMI, followed by White British women (21%), Bangladeshi women (15%) and Indian women (11%)
- A study with Pakistani Muslim women living in deprived inner-city areas found that Muslim women faced multiple barriers in addressing concerns about their weight.

2.3.1 Prevalence of Obesity

Data on obesity and religious affiliation is not available. Evidence on ethnic differences in obesity indicates that, on the whole, Pakistani and Bangladeshi Muslims, particularly women, have a higher prevalence of obesity compared with their religious and non-religious counterparts.

The Fourth National Survey for Ethnic Minorities³²⁶ reported that although the risk of having a high BMI varied between ethnic/religious groups, like most minority ethnic groups³²⁷, South Asian Muslims had a significantly increased risk of having a high waist-hip ratio compared with the White British Christian group (adjusted for age, gender and socio-economic status).

Within the South Asian ethnic group, Pakistani Muslims (1.19) had higher odds of having a BMI of 25 or over compared with White British people (1.00) whilst Bangladeshi Muslims (0.68), and Hindus (0.76), had lower odds of this. The higher odds of Pakistani Muslims were explained by socioeconomic status.

A breakdown of these odds by sex reveals whilst Muslim Bangladeshi (0.40), Pakistani (0.73) and Indian (0.31) men had lower odds of having a BMI of 25 or over compared to White British Christian men. However, Muslim Pakistani (1.94), Bangladeshi (1.09) and Indian (1.53) women had higher odds of having a BMI of 25 or over compared to White British Christian women.

When considering waist-hip ratio, differences were particularly stark for South Asian Muslims of both sexes. Bangladeshi (9.65), Pakistani (5.37) and Indian (3.30) Muslim women had a significantly higher odds ratio of having a high waist-hip ratio compared with White British women, as was the case for South Asian Muslim men from these groups (1.49, 2.07 and 2.51 respectively). The greater risk of South Asian s having a higher hip-waist ratio compared with White British Christians was put largely down to socioeconomic factors³²⁸. Other have also highlighted the role of cultural characteristics, although some differences remain unexplained³²⁹

A retrospective case analysis of maternal obesity between 2008-2013 in the East of England³³⁰ reported that using standard BMI thresholds, Pakistani women (23%) had the highest prevalence of a high BMI, followed by White British women (21%), Bangladeshi women (15%) and Indian women (11%). However, researchers reported that when applying WHO recommended BMI thresholds for South Asian women.

Whilst pan-ethnic analysis from the Active Lives Survey in 2019/20 suggests that South Asians (60%) had a lower than average prevalence of obesity compared with

the average for all ethnic groups (63%)³³¹, recent analysis of the Health Survey for England 2011-2019³³² reports that Pakistani women (74%), along with Black Caribbean/African women, are the most likely to be overweight or obese (differences for men between ethnic groups did not vary widely).

2.3.2 Barriers to Weight Management

Qualitative studies which explore Muslim communities' perceptions of obesity report that individual perceptions, culturally inappropriate services and cultural barriers prevent women from managing their weight. The majority of studies focus on Muslim women.

A review of UK South Asian s³³³ health beliefs related to lifestyle related diseases reported several factors as influencing South Asian s conceptualisation of obesity. These included: not understanding the role of lifestyle (e.g. food and exercise) in certain diseases, fatalistic beliefs about the inevitable nature of diseases, a lack of engagement with and by health professionals, barriers to physical activity and cultural norms and values around food

A study³³⁴ with clinically obese and overweight Bangladeshi Muslim women in East London who had been referred to a gym by their GP to reduce their weight reported that cultural misunderstandings of what constitutes a healthy diet and healthy weight may make some Muslim women reluctant to address medical concerns about their weight. For example, 20% of respondents perceived themselves as being of 'normal' weight and 16% of respondents did not know if they were overweight. Another study with Pakistani Muslim women in Manchester³³⁵ found that there was limited

awareness of the link between weight gain and health issues, such as type 2 diabetes and that women were both unmotivated to address weight gain and unsure how to go about it.

A study with Pakistani Muslim women living in deprived inner-city areas also found that Muslim women faced multiple barriers in addressing concerns about their weight³³⁶. Cultural barriers included the gendered role of women, a lack of culturally appropriate dietary advice, the lack of culturally suitable exercise facilities which conformed to family and community expectations and language barriers, including low literacy levels in English or Urdu. Participants reported a low level of trust in existing offers of women only physical activities.

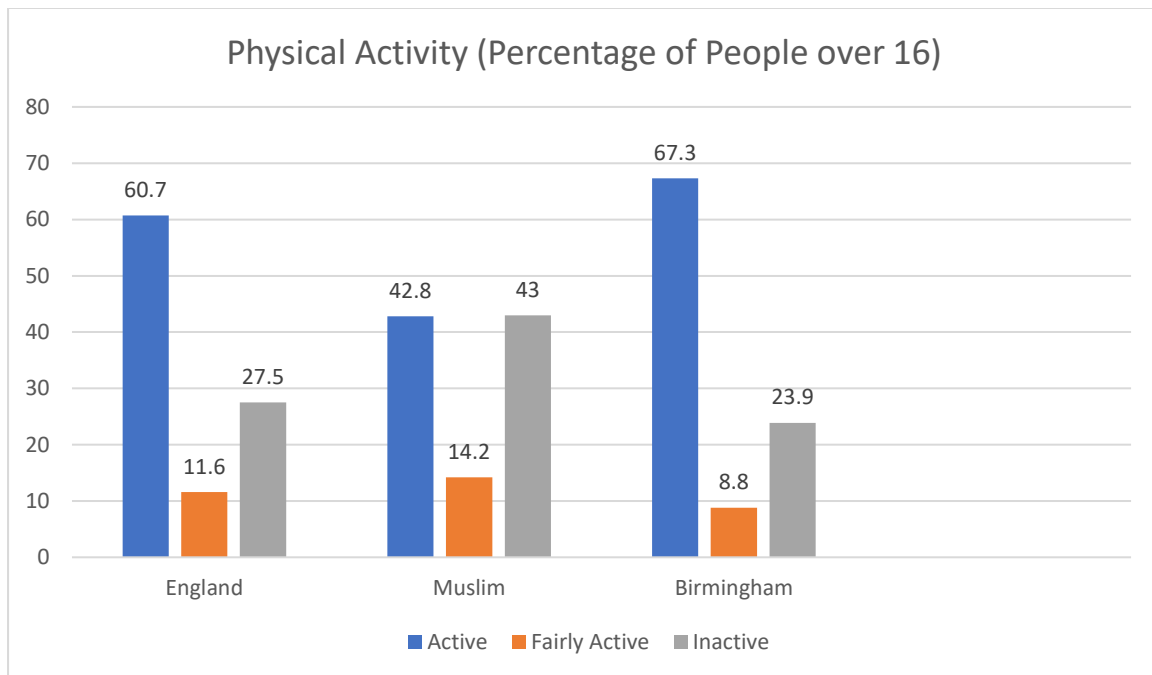
2.4 Active at every age and ability

Physical Exercise

- In 2020/21 **43%** of Muslims were classified as inactive compared with **28%** of people in England.
- In Birmingham **24%** of Muslims were classified as inactive.
- **57%** of Muslims report engaging in sport or physical activity in the past 28 days compared with **75%** of people in England.
- A review of 10 studies found that Muslim women regard mixed-sex sport or physical activity as compromising values of modesty.
- Muslim people's participation in sport in the UK is significantly lower than for the population as a whole.

Sport England ³³⁷classify the amount of physical activity a person takes as *active* (greater than 150 minutes a week), *fairly active* (between 30 and 149 minutes a week) and *inactive* (less than 30 minutes a week). The results of a large-scale self-report survey by Sport England found that in England in 2020/21 60.7% of people over 16 were physically active, 11.6% were fairly active and 27.5% were inactive.

Figure 12: Percentage of People Engaged in Physical Activity by Location and Religion (2020/21)



Source: Sport England Active Lives Data Tables 2020/21

Data from 1,726 Muslims for the same period shows they were considerably less active (42.8%) and that there was a greater percentage of people who were inactive (43%). The data for the population of Birmingham show that there was a greater percentage who were physically active (67.3%) than for the general population of England. Comparing the data with 2018/19 Sport England note that another 1.4 million people in England (a further 2.9%) have become inactive since the beginning of the pandemic. This is mirrored in the Muslim population where a further 2.7% have become inactive.

In a study for the WHO ³³⁸ self-report questionnaires on physical exercise were collected from 163,556 people in 38 Muslim countries. The study found that total physical inactivity prevalence in this Muslim population was 32.3%.

2.4.1 Self-Report and Objective Measures of Physical Exercise

The majority of studies of the amount of physical activity in which a person engages rely upon self-assessment questionnaires. However, objective measures of physical activity can be made by asking a person to wear an accelerometer. Curry et al³³⁹ undertook a study in which 150 South Asian women in Cardiff wore an accelerometer for seven consecutive days. A sub-sample of 24 then completed a self-report questionnaire on physical exercise and took part in a short interview. The findings showed that the questionnaire data significantly underestimated the amount of physical exercise that was taken. Using the interview data, the authors conclude that the underestimation was a product of the difficulties subjects had in recalling their activity, especially the amount of time spent sitting, and problems of understanding the English terminology used in the questionnaire, for example, understanding what was meant by different kinds of physical exercise, for example light exercise and vigorous exercise. The authors warn that self-reporting may underestimate the amount of exercise being taken and that at least some of the differences reported between the physical exercise of the White population and the South Asian population may be a product of the self-completion assessment process.

2.4.2 Muslim Attitudes to Physical Exercise

Many qualitative studies have been undertaken to explore Muslim attitudes to physical exercise in the Muslim communities in major UK cities such as Leicester and Birmingham³⁴⁰. They have also been undertaken with UK Muslims who have health concerns, for example with diabetes or heart disease³⁴¹. A review of ten qualitative studies³⁴² of BME people in the UK over the age of 50 (nine of the studies were of

Muslim communities) found that most respondents considered that physical exercise was important for young people but not for them.

The authors of many studies stressed that Islam is a religion that promotes and encourages physical exercise to improve physical health, to reduce negative feelings, to socialise and becoming a stronger Muslim. However, the results of the studies identified many reasons why British Muslims limit the physical exercise they undertake or limit the kind of physical exercise they are willing to engage in.

Physical exercise often became an issue for Muslims when it was raised by GPs or other health specialists when Muslim patients became overweight or obese or suffered from major medical conditions. Medical professionals proposed physical exercise as a way of improving health and improving fitness. However, rather than adopt a physical exercise regime, many Muslim women adopted a fatalistic attitude and simply accepted that their condition was their fate. For example, some of Pakistani Muslim respondents with coronary heart disease held fatalistic religious beliefs about their condition³⁴³.

There was also in many communities a lack of understanding of the importance of physical exercise in sustaining good health. One study found that many older adults were deterred from outdoor walking because they were unclear what the appropriate distance to cover might be³⁴⁴. In the case of patients with diabetes or heart disease there was anxiety about exceeding the 'body's limit' of physical activity and knowing what sort of activity was appropriate and safe³⁴⁵.

For many female Muslims in these studies physical exercise had to be 'light' rather than 'vigorous'. For some Bangladeshi women brisk walking and running in public was not culturally appropriate³⁴⁶ although slow walking was generally acceptable. Some South Asian Muslim women regarded vigorous physical activity negatively due to perceived sexual connotations from making oneself more attractive³⁴⁷. Women who engaged in exercise beyond housework were at risk of being labelled "a 'bad' housewife or mother"³⁴⁸ and some older South Asian women perceived exercise as damaging to their personal reputation and family honour³⁴⁹.

2.4.3 Muslim Women and Physical Exercise

Most of the studies of Muslims and physical exercise have focused on Muslim women because they are less physically active than men. Sport England³⁵⁰ report that at a national level more men (62%) are physically active compared with 60% of women. The study for the WHO³⁵¹ also found a gender difference: 28.8% of males reported inactivity compared with 35.5% of females.

Many qualitative studies have explored the reasons why Muslim women tend not to take physical exercise. In the study of Cardiff Muslim women³⁵² most of the participants considered they did enough physical exercise because they were primarily busy housewives who spent many hours each day cooking and cleaning following the Muslim tradition in which most women were housekeepers. With 3 to 5 periods of prayer each day in addition, they reported there was very little sedentary time (regarded as being lazy unless you were old). The respondents considered that their normal pattern of activity included sufficient physical activity to meet the guidelines although the researchers, based on the accelerometer data, assessed all the exercise

as 'light'. The respondents did not consider they needed to engage in special periods of more vigorous exercise.

A detailed study of 13 young British Muslim women³⁵³ also concluded that the expectation that they would take on traditional gendered roles around the home meant their physical exercise came from housekeeping tasks and left them with little energy or aspiration to seek other forms of physical exercise.

2.4.4 Participation in Sport and Organised Physical Activity

Sport England³⁵⁴ asked how many people had taken part in sport or physical activity at least twice in the past 28 days: 75.3% of an English sample of 172,970 reported they had, compared with 57.3% of the sample of 1,726 Muslims. Studies that have examined Muslim issues relating to engagement with sport or other organised forms of physical activity have distinguished between female and male concerns.

The review of 10 UK qualitative studies³⁵⁵ found that for the Muslim women in the surveys mixed-sex physical activity or exercise was considered highly inappropriate as it compromised their values of modesty. Although some South Asian women indicated that female-only activities are acceptable, others were concerned that cameras in exercise facilities and the presence of male workers within the facilities were another hindrance to modesty^{356 357}. This was particularly the case with swimming where women identified that even female only sessions did not necessarily preserve modesty, given the presence of cameras or male life-guards³⁵⁸.

The level of in-depth research undertaken with British Asian Muslim male communities around sport participation is more limited. A literature review of Muslim male attitudes to sport ^[11] as well as studying in detail the attitudes of seven Birmingham Asian Muslim males, concluded that for young Muslim men sport is an activity with which they can identify and can even bring them closer to their religion. In some South East Asian countries, sports such as cricket and hockey are very important national pursuits. But in the UK sport participation amongst Muslim males is significantly lower at all levels compared to the majority population ^{359 360}.

Mackintosh and Dempsey (2015)³⁶¹ comment that whilst most literature relating to sport participation by Muslim women focuses on the barriers and challenges they face, the literature on Muslim males and sport participation focuses more on specific aspects such as racism, national identity and masculinity. In a study of British Asian communities and their participation in cricket the authors concluded that religion and faith were not the main barriers. Instead, it was ethnicity, and racialized barriers that limited involvement, belonging to the team and community provision for training and playing³⁶². The exception in this study where the Muslim faith did act as a barrier was the culture of heavy drinking in some northern league cricket clubs. This was incompatible with the Muslim practices and meant that Muslim players could not play a full part in the life of their cricket teams.

2.4.5 Encouraging Engagement in Physical Activity

A number of studies have looked at strategies to encourage more engagement by Muslims in physical exercise. A study in the East Midlands³⁶³ interviewed 34 people of South Asian origin aged between 60 and 70, and 11 health professionals. 16 of the

people interviewed were non-English speakers. The study concluded that successful interventions came from people the community knew and trusted. This 'social' approach to intervention involved health professionals undertaking activities with family or friends and with bilingual community peers to facilitate engagement, motivation and support. Spoken content and delivery of interventions was favoured, including personal stories and multilingual audio–visual information. The interventions that were effective were made within local informal settings, including the home, rather than in provider properties.

Other studies have also highlighted the difficulties Muslims have in understanding and trusting the information that is provided by health professions. Part of the problem is often language difficulties and having a local, bi-lingual translator was often a necessary facilitator. Another significant finding was the important role that local religious leaders could play in explaining the need for physical exercise because they were perceived in the community as influential and trustworthy. They could play a very specific role in helping to overcome the religious fatalism about health matters prevalent in first-generation South Asian Muslim women. This is particularly important as members of the Muslim community perceive Islamic religious leaders to be influential and trustworthy³⁶⁴.

Many of these local 'social' solutions were also important if Muslims, especially women, were to participate in formal physical activity sessions. The inability to communicate in English was perceived as a major deterrent from wanting to attend physical activity classes or walking in public areas^{365 366}. People often lacked confidence in engaging because of their poor English literacy. Some South Asian

Muslim women aged 50 and above who were involved in an intervention to increase community physical activity participation reported that having gym instructors and exercise facility staff from the local community, who could communicate in their local language was a reason for engaging with the intervention³⁶⁷.

PROTOTYPE

2.5 Working and learning well

Education

- In 2018 **35%** of Muslims were degree qualified compared with **30%** of the Christian population.
- **18%** of working age Muslims in the UK were full time students compared with **8%** of the general population.
- There has been a **159%** increase in young Pakistani women starting full-time degrees between 1994–1995 and 2004–2005 compared to a **43.3%** increase for young White women.

Employment

- In 2011 **1 in 5** of the working-age Muslim population were in full-time employment, compared to **1 in 3** of the general population.
- **16%** of Muslims in Birmingham were in full-time employment compared with over **30%** of Christians, Muslims, Sikhs and those with no religion.
- **7%** of UK Muslims were unemployed compared with **4%** of the general population
- **18%** of Muslim women in the 16-74 age band were full time home makers compared to **6%** in the general population.
- **16%** of Muslims in Birmingham were in full-time employment compared to over **30%** of Christians, Muslims, Sikhs and those with no religion.
- In Birmingham **44%** of employed Muslims were in occupational class 3 (semi-skilled manual labour) compared with less than **30%** of Christians, Hindus and those with no religion and **33%** of Sikhs.
- In 2011 there were **480** Muslims out of **88,500** in the Army.
- **39%** of Muslims were economically inactive in 2018 compared with **20-23%** of all other religions, apart from Buddhism.

- In 2018 Muslims in employment had median hourly earnings of **£9.63** at least **£2** per hour less than other employees.

Housing

- In 2011 **27%** of Muslim households lived in social housing compared with **17%** of all households
- Muslim households have a higher number of families with children (**41.0%**) than in the UK as a whole (**25.2%**)
- There is a higher proportion of Muslim 'other households' (**19.3%**), including multigenerational households, than in the general population (**7.9%**).
- **1.22 million** Muslims in the UK (**46%**) live in the 10% most deprived Local Authority Districts.
- In Birmingham **21.8%** of the Muslim population live in the 10% most deprived Local Authority Districts.

2.5.1 Education

In 2011 24% of Muslims over the age of 16 had qualifications at degree level as their highest level of attainment³⁶⁸. This was slightly lower than the general population (27%) but considerably lower than Sikhs (30%) and Hindus (45%). In 2011 26% of the Muslim population had no qualifications, a comparable figure to the Christian population (also 26%). There has been a considerable reduction in the number of Muslims without qualifications since 2001 when it was 39%.

By 2018 the proportion of Muslims whose highest level of attainment was a degree or equivalent had risen to 34.5%³⁶⁹. The proportion of the Christian population with a degree had risen to 30.0%.

In Birmingham 33% of Muslims in 2011 had no qualifications compared with 28% of the local population. 17% of the Muslim population in Birmingham had degree level qualifications compared with 23% of the local population.

18% of working age Muslims in the UK were full time students compared with 8% of the general population. This, in part, may be a product of the relatively young demography of Muslims in the UK. The percentage of Muslims in full-time education in Birmingham (14%) was similar to Hindus (13%) and Sikhs (10%) and those with no religion (12%) but much higher than for Christians (6%)

One of striking changes has been the number of Muslim young women obtaining degrees. Hussain et al³⁷⁰ reported a 158.7% increase in young Pakistani women starting full-time degrees between 1994–1995 and 2004–2005 compared to a 43.3% increase in young White women. Reviewing the literature for the reasons for this increase, the authors note that many Muslim families are giving priority to getting their children into higher education and young women, in particular, see it as their main route to financial independence and being able to follow a career as opposed to the tradition of marrying and assuming domestic duties.

Although the numbers of Muslims in universities and colleges are increasing there is evidence that Muslims experience difficulties in thriving in the higher education environment. An in-depth study³⁷¹ that interviewed Muslim students, non-Muslim students and staff in six UK universities over a 2-year period found that many stereotypes existed about Muslims that were best dispelled by the creation of friendship groups amongst students that included members from a variety of religions.

Unfortunately, many Muslim students continued to live at home and commuted to university or college and this made it more difficult for them to form cross-denomination friendship groups than for students who were based on campus.

The authors also found that there was a strong undercurrent of suspicion about Muslim students and many of them reported feeling under constant surveillance because university authorities were expected to report those expressing extremist views who could be potential terrorists. Many staff rejected this characterisation and said they worked hard to develop good relations with Muslim students but for the students themselves the perception of suspicion remained. Many students shed visible markers of their faith such as veils and beards to 'fit in' more easily.

2.5.2 Economic Activity

Employment

Muslims are less likely to be in full-time employment and more likely to be unemployed than the general population, but they are as likely to be in part-time employment.

The figures below are for working-age people between the ages of 16–74 (2011 Census ³⁷²).

- 1 in 5 (20%) of the Muslim population was in full-time employment, compared to more than 1 in 3 of the general population (35%).
- Levels of part-time employment were comparable with the general population (13%).

- 21% of Muslims reported they had never worked compared with 4% of the general population (excluding full time students)
- 7% of Muslims were unemployed compared with 4% of the general population (excluding full-time students)
- 3% of Muslims were long-term unemployed compared with 2% of the general population.
- 6.3% of Muslims were in Higher Managerial, Administrative and Professional Occupations compared with 9.9% of the general population
- 10% of Muslims were in Lower Managerial, Administrative and Professional Occupations compared with 20% of the general population.
- The proportion of Muslims in the 'Higher professional occupation' category was 5.5%, which is not significantly lower than the 7.6% of the overall population.

Of Muslim women in the 16-74 age band, 18% were 'Looking after home or family', compared to 6% in the general population.

In Birmingham the 2011 Census found that for people aged 16 and over:

- 40% of Muslims were in employment compared with over half of Christians (52%), Hindus (59%) and Sikhs (58%)
- 16% of Muslims in Birmingham were in full-time employment compared with over 30% of Christians, Muslims, Sikhs and those with no religion.
- Part-time employment rates were comparable with other religions
- 9% of Muslims were unemployed compared with 5-6% of Hindus, Sikhs and Christians (excluding full time students). Muslim unemployment rates were similar to those of people reporting no religion (8%).

- A much smaller proportion of Muslims were retired (6%) compared with Christians (26%), Hindus (10%) and Sikhs (12%), but again comparable with people reporting no religion (7%).
- A much higher proportion of Muslims women were looking after family or the home (16%) than other religious groups (less than 6%).

Muslim employment in Birmingham is concentrated in the lower classes of employment:

- There is a similar proportion of Muslims in managerial roles compared to other religions
- Occupation class 1 (all occupations that do not involve manual labour) – 29% of Muslims compared with 51% of Hindus, 41% of Sikhs, 36% of Christians and 43% no religion
- Occupational class 2 (skilled and semi-skilled light manual labour) – Muslims (26%) comparable with Hindus (23%) and Sikhs (26%) but lower than Christians (35%) and no religion (30%)
- Occupational class 3 (semi-skilled manual labour) – 44% of Muslims compared with less than 30% of Christians, Hindus and no religion and 33% of Sikhs.

The ONS Annual Population Survey 2018³⁷³ provides trend information on Muslim employment in the UK since 2012 compared with other religious groups. Between 2012-2018, Muslims were significantly less likely to be in employment than all other religious groups, ranging from 47% being employed in 2012 to 55% in 2018. This is

compared with a range of 72%-76% for Christians, 69%-78% for Hindus, 68%-74% for Sikhs and 72%-77% for those with no religion.

At the end of this period (in 2018) 21% of Muslims were employed in high skill occupations compared with 29% of people with no religion, 41% of Hindus, 30% of Sikhs and 29% of Christians.

Employees who identified as Muslim were the least likely to be employed as a manager (15% in 2018) compared with 25% Hindu, Christian and people of no religion and 21% Sikh.

The relatively low levels of employment, and employment in the highest categories of jobs of Muslims compared with other religious groups has led to questions about there being a 'Muslim penalty' in employment. To address this question a large dataset ³⁷⁴ from the 2005 and 2006 Annual Population surveys comprising over 119,000 men and 118,000 women was analysed to detect where the penalty may be found. The analysis found strong evidence that a penalty existed even when significant variables were discounted such as women not entering the job market and recent immigrants may not have the language skills and local knowledge to compete with comparable others for jobs, promotion etc. The authors used an extensive literature search to identify possible reasons that could contribute. One constraining factor could be that religious and family values may limit the parts of the labour market that Muslims enter, for example, they are more likely to enter hospitality and retail than the Armed Forces. In the 2011 Census fewer than 1% of people in the UK armed forces were Muslim

compared with 4.4% of the UK as a whole. There were 480 Muslims out of 88,500 in the Army.

The authors also identified a set of issues that have become known as the 'chill factor'. Because of their distinctive dress and religious observance practices Muslims are easy to identify and may be subject to 'Islamophobia', defined as the fear of, hatred of, or prejudice against the religion of Islam or Muslims in general especially when seen as a source of terrorism. In employment this may serve as a tendency in some quarters to discriminate against Muslims when appointing people to jobs or selecting people for promotion. The requirement for Muslims to observe the Sabbath, attend prayers frequently and keep other traditions such as the fast of Ramadan, may also mean they are not considered for jobs where there is limited flexibility to support such practices. There could also be more subtle barriers, for example, the difficulty Muslims may have in joining significant social networks that influence who is favoured for particular jobs.

Economic Inactivity

Economic inactivity is defined as people not in employment who have not been seeking work and/or are unable to start immediately. Four out of ten (39%) Muslims were economically inactive in 2018 ³⁷⁵, compared with typical rates of 20-23% of all other religions, apart from Buddhism.

The high rates of economic inactivity seen among those who identified as Muslim were largely driven by the rate of economic inactivity among Muslim women, over half of whom (56%) were economically inactive in 2018 compared with 23% of Muslim men. Across almost all religious groupings, women are less likely to be employed than their

male counterparts, e.g. 25% of Christian women were economically inactive compared with 17% of Christian men, but Muslim women had the highest proportion who were economically inactive and the biggest gap between women and men. The economic inactivity rate of Muslim women can be attributed in part to the greater proportion of this group looking after their family and/or home, 57% of whom stated this as their reason. This is significantly higher than for other religious groups (average of 35% for non-Muslim groups)

The Muslim Pay Gap

In 2018, Muslims who were in employment had the lowest median hourly earnings of any religious group at £9.63. This is at least £2 per hour less than Hindu (£13.80), Sikh (£11.93) and Christian employees (£11.64) and employees with no religion (£12.09).

After controlling for personal characteristics and employment characteristics (e.g. job status, tenure, occupation and industry), the gap between the median pay of Muslims and non-Muslims was reduced. Before controlling for these characteristics, Muslim adults earnings were 17% less than those who identified as Christian but after controlling for these factors their earnings were 4% less than those who identified as Christian.

This gap has led to questions about whether there is a specific 'Muslim penalty' associated with pay rates: whether anyone identifying as a Muslim can expect lower pay than comparable others. To answer this question an analysis³⁷⁶ was made of a large-sample data set obtained from the UK Labour Force Survey (2002–2013). The analysis compared the salary levels of Muslims and non-Muslims in comparable

occupations and controlled for many other variables that could contribute to salary levels. The results of the analysis found that some Muslim groups did experience a pay penalty notably Bangladeshi and Pakistani-Muslims. However, their pay penalty was similar to Christian Black -Africans whilst Indians, regardless of their religious background, fared comparatively well. Moreover, Muslim White -British did not suffer a greater wage penalty than Christian White -British. Additional information regarding pay penalty for all Muslims can be found on page 96.

2.5.3 Housing

According to the 2011 Census 27% of Muslim households live in social housing as compared to 17% of overall households. A much smaller proportion of Muslim households own their own property outright as compared to the overall population - 15% as compared to 31% overall. A much greater proportion of Muslims are living in privately rented accommodation: 30% of Muslim households as compared to 18% overall. 35% of households of the Bangladeshi ethnic group reside in social housing as compared to 13% of the Pakistani ethnic group. 41% of households of the Pakistani ethnic category reside in property that is owned with a mortgage (or loan or shared ownership).

Table 6: Muslim Housing Tenure in the UK (2011)

Type of Housing Tenure	Muslim Households		All Households	
		%		%
Owned Outright	109,404	14.7	7,206,954	30.8
Owned with a Mortgage	211,743	28.4	7,824,960	33.5
Social Rented (Local Authority)	115,853	15.5	2,208,080	9.4

Social Rented (Other Social Rental)	85,386	11.5	1,910,381	8.2
Private Rental (Landlord)	192,350	25.8	3,566,467	15.3
Private Rental (Other or Rent Free)	30,525	4.1	649,202	2.8
Totals	747,261		23,366,044	

Source: Census 2011 ONS Table DC4204EW

The composition of Muslim households in the UK 2011 is summarised in Table 7.

Table 7: Muslim Household Composition in the UK (2011)

Composition of Households	Muslim Households		All Households	
		%		%
One Person	135,959	18.2	7,067,261	30.2
Families:				
Married/Co-habiting No Children	52,317	7.0	4,116,716	17.6
Married/Co-habiting With Children	305,506	41.0	5,936,773	25.2
All Aged 65 or over	7,974	1.1	1,905,393	8.2
Lone Parent	99,679	13.4	2,487,764	10.7
Other Households	143,826	19.3	1,850,137	7.9
Totals	745,261	N/A	23,366,044	N/A

Source: ONS Census 2011 Table DC1202EW

Muslim households³⁷⁷ have a much higher number of families with children (41.0%) than in the UK as a whole (25.2%) which reflects the very young demography of the Muslim population in the UK. For similar reasons there are relatively few Muslim

households where everybody is over 65 (1.1%) compared with 8.2% in the overall UK population.

There is a higher proportion of Muslim 'other households' (19.3%) than in the general population (7.9%). Although this category includes other types of households, e.g. student houses, this category reflects the number of multigenerational households in the Muslim population. A greater proportion of Muslims live in multigenerational housing than other religious groupings, in properties that are homes, for example, to grandparents, parents and children. Burgess et al.³⁷⁸ report that it is difficult to establish the proportion of multigeneration households in the UK, but their estimate is that it is approximately 7% of UK housing and that it is gradually increasing. One difficulty in getting good estimates is that the ONS report multigenerational households under 'Other' along with other multiple occupancy properties, for example, multi-student occupation. The ONS report this 'Other Households' category as growing from 325,000 in 2001 to 419,000 in 2013. Burgess et al report that Muslim families are usually considered to be a major part of this total, although no good estimates are available. There is a strong, global tradition of multigenerational living in Muslim communities around the world and it is also a tradition in the UK. However, they also report that there is evidence that it is declining in the Muslim community in the UK as children leave home to take up careers and start their own families away from the traditional family home. The authors point out however that there are significant factors that are sustaining the practice: the tradition of caring for the elderly in your own home remains and, where the family is living in poverty, children may continue living at home because there is little prospect of them being able to find separate accommodation.

1.22 million Muslims in the UK (46%) live in the 10% most deprived Local Authority Districts in areas that are characterised by overcrowded housing. In Birmingham 21.8% of the Muslim population live in the 10% most deprived Local Authority Districts. This is the 6th highest in UK Local Authorities (after three London Boroughs, Bradford and Blackburn).

Although Muslims may make up a considerable proportion of the population in many deprived areas, Karner and Parker³⁷⁹ point out that these communities often include equally deprived families from other religious and ethnic groupings. Kaner and Parker undertook a qualitative study in Alum Rock Road in Saltley, East Birmingham to examine how the mixed community there confronted the deprivation that they all experienced. Alum Rock Road, a part of the Washwood Heath Ward, has 65% South Asian residents but also includes Afro-Caribbean working-class families, migrants from East Europe and asylum seekers of East African origin. The authors found many local networks that spanned the ethnic and religious differences in the community and worked together to limit the damage of poverty to human lives. The authors noted in particular 'religiously grounded social capital': that Muslim values about caring and sharing created many 'social actors' who worked together to fight poverty wherever it existed in their community.

2.6 Protect and detect

Cancer Screening

- Muslims (26%), particularly Muslim women, had the lowest uptake of bowel screening compared to South Asian s (33%) and non-South Asian s (61%).
- Muslim women (51%) are less likely to attend breast screening than Hindu (68%) and Sikh (65%) and non-South Asian women (75%)
- Minority ethnic women (12%) were more likely to never have attended a cervical screening appointment than White women (8%)

Vaccination Programmes

- Evidence indicates variable uptake of childhood vaccinations amongst the Muslims community, e.g. MMR, HPV and influenza vaccination programmes
- Muslims (40%) were the least likely to be vaccinated against COVID-19 compared to Hindus (70%), Sikhs (67%), Christians (67%) and people with no religious affiliation (65%)

Sexual Health

- Muslims reported lower awareness of sexual health and sexual health services
- The Muslim population had lower rates of STIs and HIV than the White British population

Domestic Abuse

- Muslim women (3%) were more likely to have experienced partner abuse in the last 12 months than Hindu women (2%) but less likely than Christian women (6%).
- Bangladeshi women (1%) reported lower levels of partner abuse than Pakistani (4%) and Arab (5%) women

COVID-19 Related Mortality

- Muslim males had a COVID-19 mortality rate 2.7 times higher than Christian males whilst for Muslim females this was 2.4 times higher.

2.6.1 Cancer screening

The NHS does not publish data on screening uptake by religious affiliation or ethnicity.

The limited evidence on the Muslim population indicates that Muslims have low uptake of cancer screening, amongst the lowest of all religious groups.

Rates of Screening

A survey undertaken through cancer screening health promotion campaign by the British Islamic Medical Association ³⁸⁰ reported that 37% of participants had not attended their scheduled cancer screening.

Bowel Screening

The NHS Bowel Cancer Screening Programme invites adults aged 60-74 who are registered with a GP to participate in screening every two years. Eligible adults are invited to participate in screening via self-testing kits, i.e. a faecal occult blood test (FOBT) kit sent by post.

Evidence indicates that Muslims have low rates of bowel cancer screening uptake compared with other religious sub-groups and with the wider South Asian population. A study looking at screening attendance for South Asian men and women in the West Midlands between 2000-2005³⁸¹ reported that for round 1 South Asians (33%) had significantly lower rates of bowel screening uptake compared with non-Asians (61%); the Muslim sub-group (26%) had the lowest uptake rate of all sub-groups whilst the Hindu (Gujarati) sub-group had the highest rate (37%). Disparities between religious groups remained for all sub-groups after adjusting for age, deprivation and gender. Using adjusted odds ratios, the study found that the likelihood of Muslim invitees successfully completing FOBT home screening was one third that of non-Asian invitees³⁸² The low uptake of bowel screening amongst Muslim women has also been reported other studies ³⁸³.

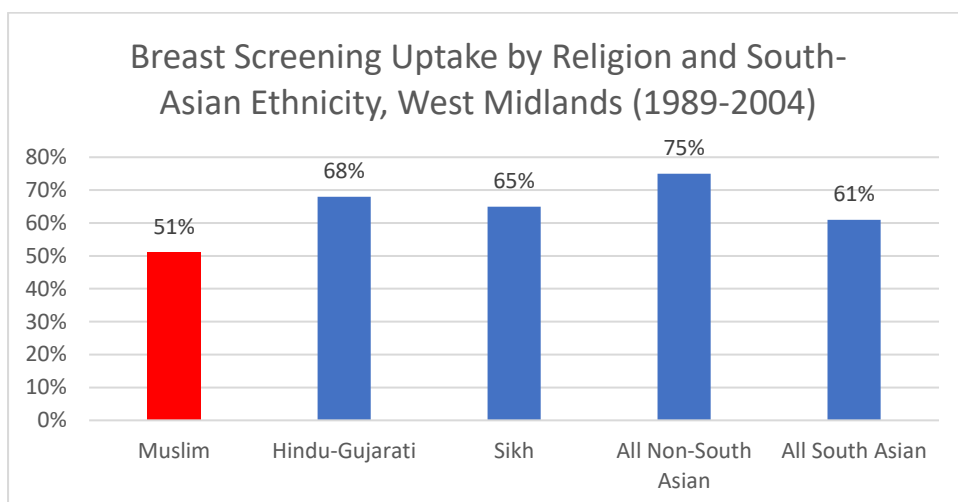
More recently, a retrospective study of 1.7 million people in Scotland found that the Muslim population, and Muslim women in particular, had the lowest rate of bowel screening uptake compared with the reference population (Church of Scotland) and other religious groupings³⁸⁴. Muslim women (58%) had a lower uptake of round 1 bowel screening compared with women from other faiths, e.g. Hindu or Sikh (73%) and Church of Scotland (100%) and compared with Muslim. Muslim men (70%) had a lower uptake of round 1 screening compared with Hindu men (78%), Sikh Men (73%) and men who followed the Church of Scotland (100%).

A non-randomised two group evaluation of The British Islamic Medical Association (BIMA) intervention for bowel cancer screening in the Muslim community is currently being undertaken by researchers at the University of Hertfordshire³⁸⁵.

Breast Screening

The NHS breast screening programme currently invites women aged between 50 and 70, who are registered with a GP, for a mammogram (x-ray of the breasts) once every three years. Evidence indicates that Muslim women have the lowest uptake of breast screening compared with women from other religious, non-religious and ethnic backgrounds. Looking at screening attendance data for women in the West Midlands (1989-2004)³⁸⁶ found that Muslim women (51%) had a lower uptake of breast screening compared to other South Asian affiliated religions, and to all South Asian and non-South Asian ethnic groups.

Figure 13. Breast Screening Uptake, by Religion and South Asian Ethnicity, West Midlands (1989-2004)



Source: Szczepura et al, (2008)

For Muslim women, unlike for some other ethnic and religious sub-groups, differences in breast screening uptake remained after adjusting for age, deprivation and gender (although ethnicity was not just adjusted for). For Muslim women who did attend screening, a slight increase in abnormal mammograms was observed (3% in round 1 to 4% in round 5). These disparities are echoed in another study ³⁸⁷.

Looking at geographical uptake of breast screening in South-West London (2003-2006), Chen et al.³⁸⁸ reported that being Muslim was positively associated with lower screening uptake, although this was variable across region. Overall, Muslim women had significantly lower uptake of breast screening (54%) compared with women from other religious groups, e.g., Sikh (65%) and the majority 'English' resident population (70%) (the religious affiliation of this population was not provided). A qualitative study also found that just under half of minority ethnic women (45%) aged 50-70 reported never having attended breast screening compared to around 9% of the general population sample ³⁸⁹.

Cervical Screening

Data on the uptake of cervical cancer screening by religious background is not available. In relation to ethnicity, limited survey evidence indicates the minority ethnic women (12%) are more likely to never have attended cervical screening than White women (8%)^{390 391}. However, a smaller survey in Manchester with South Asian and White women reported a smaller (not significant) difference between non-attendance rates of minority ethnic women (9%) compared with White women (10%)³⁹².

Screening Continuity and Time lapse

Studies which focus on the screening of Muslims and people from minority ethnic backgrounds highlight the low continuity of screening uptake for Muslim women (and South Asian women more generally) and delays in presenting for screening. Delays in screening can significantly increase risk of death from cancer³⁹³.

For breast screening Price et al.³⁹⁴ found that just over half of Muslim women (55%) who had a mammogram in round 1 went on to participate in rounds 2 and 5 of screening, compared with 70% of Hindu Gujarati women, 67% of Sikh women and compared with non-South Asian women (81%). For bowel screening, Muslims women (28%) were much more likely to be sent 4 FOBT kits or more before successful completion compared to non-Asians (3%)³⁹⁵. For cervical screening, over half (56%) of South Asian women delayed screening compared to 35% of White women, with 16% of women delaying it for more than 3 years³⁹⁶.

Factors Affecting Screening Uptake

Several reasons have been put forward for the low uptake of screening by Muslim men and women. Whilst adjusting for socio-demographic variables may explain some of the disparities between Muslims and other religious groupings, the lower cancer screening uptakes observed for Muslims population cannot be attributed to socio-economic, age or gender population differences alone ³⁹⁷, although ethnicity has seldom been controlled for in studies.

Evidence indicates that the low uptake of screening services by the Muslim population may be due to various structural, cultural and personal barriers. Barriers to Muslims, and particularly Muslim women, accessing screening services include: a lack of awareness, feelings of embarrassment, religious fatalism, communication and literacy barriers, the sex and ethnicity of healthcare professionals and a lack of cultural competence from professionals and services. These factors are reported below.

Poor Awareness

Poor awareness of the purpose of screening, risks and symptoms of cancer, screening programmes and possible treatments has been cited as a primary barrier to screening uptake amongst minority ethnic and Muslim communities^{398 399 400 401 402 403}.

Studies report that minority ethnic groups, and Pakistani and Bangladeshi women in particular, have lower awareness of cervical cancer screening^{404 405} breast cancer screening^{406 407} bowel cancer screening⁴⁰⁸ than the White British group. For example, a study looking at cervical screening found that minority ethnic women (70%) were less likely than White women (91%) to be knowledgeable the purpose of screening and 30% of South Asian women in particular reported not knowing what cervical

screening is ⁴⁰⁹. Another study with South Asian women found that whilst Bangladeshi and Indian women believed that cervical cancer can be treated, 30% of Pakistani women disagreed. Despite this, Indian and Pakistani women had better levels of awareness about what cervical cancer is compared to Bangladeshi women⁴¹⁰.

A survey by the British Islamic Medical Association⁴¹¹ reported that a quarter (26%) of respondents were unaware of national cancer screening programmes. Another survey by the Muslim Women's Network⁴¹² found that participants rated their own knowledge and understanding about cervical screening (smear tests), on average, as just under 4/10. Awareness of the risk factors for cervical cancer was also low. The survey found that 25% of the women said they were not attending or delaying their appointments because they were still a virgin and another 25% of them said they were not attending or delaying appointments because they were no longer sexually active (both of which do not mitigate the need for screening). Muslim women appear reluctant to attend screening in the absence of experiencing symptoms, with reports of some Pakistani and Bangladeshi Muslim women seeing screening as causative rather than as a diagnostic tool for cancer ^{413 414 415}.

Embarrassment and Modesty

Embarrassment has been raised as a particularly important barrier among Bangladeshi and Pakistani Muslim women, particularly in relation to breast and cervical screening^{416 417 418 419}. In their study with minority ethnic groups, Waller et al. (2009) found that 82% of Bangladeshi women felt that embarrassment was a barrier to attending cancer screening compared with 32% of Bangladeshi men. Around 60% of respondents in a survey by the Muslim Women's Network ⁴²⁰ said they may not

attend their cervical screening test or delayed going to their test because of feelings of embarrassment.

With regards to cervical screening, evidence indicates that issues of modesty, embarrassment, community perceptions of the association between screening and being sexually active, and the stigmatisation of Muslim women's sexuality are particularly relevant ^{421 422 423 424}.

Religious Fatalism

Religious fatalism has been highlighted as a central part of Muslim's reasoning for not attending cancer screening, in that illness is seen as 'God's will' ⁴²⁵. The topic of cancer is stigmatised and can be seen as a taboo in Muslim communities, particularly South Asian communities ^{426 427}.

Role of Husbands

The role of husbands in Muslim families has also been identified as influential on women's access to reproductive health, in that men's knowledge and attitudes of screening can facilitate or hinder women's access to cervical screening ^{428 429}.

Communication Materials

Poor communication materials and the low levels of literacy amongst Muslim communities, particularly migrant Muslim women, has been posited as a primary reason for the low levels of screening uptake amongst this community ^{430 431 432 433 434}.

Looking at barriers to bowel screening for South Asian communities in East London ⁴³⁵ reported that language and communication difficulties meant that some South

Asian people overlooked postal communication with FOBTs. For the Bangladeshi Muslim community in particular- the majority of whom spoke Sylheti but did not read in either English or Bengali – written communications were of little use. The study emphasised the centrality of oral culture in the Bangladeshi community, with the consequence that written materials would be inappropriate, and outreach should involve verbal communication.

A large qualitative study by Scanlon and Wood (2005) ⁴³⁶ reported that three-quarters (76%) of minority ethnic respondents said that they did not attend screening because they had never been invited. Whilst this may have been due to participants not having received communication, it may well be the case that information was not adequately communicated.

Gender/Ethnicity of GP

The majority of Muslims who attended screening programmes did so on the advice of their GP ⁴³⁷. A common finding across studies is that Muslim women prefer to have a female GP ^{438 439 440}. This helped them to mitigate embarrassment and adhere to Islamic principles of modesty.

The extent to which the ethnicity of GPs impacts uptake of screening for the Muslim community appears variable. For bowel screening, Muslims registered with an Asian GP (22.9%) had significantly lower uptake than Muslims registered with a non-Asian GP (38%). However, for breast screening, uptake for Muslims with an Asian (vs. non-Asian) GP showed no significant difference during the same period⁴⁴¹.

Lack of cultural competence from professionals and services

A lack of empathy, understanding and cultural sensitivity from healthcare providers has been cited as a central barrier to Muslim women's access to screening^{442 443 444 445}.

Interventions with the Muslim Community

Several organisations have trialled interventions to promote awareness of screening amongst Muslim communities, including community/religious based approaches, bilingual and bicultural approaches and outreach in mosques and other Muslim affiliated organisations^{446 447 448}. In 2019, the British Islamic Medical Association (BIMA), in cooperation with Cancer Research UK (CRUK) and the Muslim Council of Britain (MCB), undertook talks in community centres, mosques, and local radio stations⁴⁴⁹. Evidence indicates that such initiatives would have a positive impact on the screening uptake of Muslim communities^{450 451 452 453}.

2.6.2 Vaccination programmes

Achieving high vaccine uptake is necessary in order to reduce the transmission of infection and to protect the population at large⁴⁵⁴. The UK's vaccination programme targets groups that are at the highest risk of developing severe disease following infection. These programmes are supported by the Department of Health, National Health Service (NHS), Public Health England and other local authority groups⁴⁵⁵. Vaccinations for the programmes outlined below predominantly relate to the immunisation of babies, children and young people.

MMR Vaccinations

Data is not available on the uptake of the combined measles, mumps, and rubella vaccine (MMR) vaccine by religious affiliation.

Evidence in relation to ethnicity suggests that Muslim children have a lower uptake of the MMR than non-Muslim children. A study which looked at a national representative cohort of children born between 2000-2002 in the UK. It was ⁴⁵⁶ found that children who had a mother who was South Asian or Black were the least likely to have received a single vaccine. Children with Pakistani and Bangladeshi mothers (risk ratio 0.13) were the least likely to be vaccinated, e.g. compared with Indian mothers (risk ratio 0.50) and White mothers (1.00).

Conversely, a study which explored analysed data on MMR vaccine uptake for 18–36-month-olds in Brent in 2003 ⁴⁵⁷ reported that coverage was highest in the South Asian population (87%) compared with Afro-Caribbeans (75%) and the White group (58%). Differences remained after controlling for socio-economic status. Within the South Asian group, Pakistanis and Bangladeshis (84%-85%) had similar rates of uptake to Indians (87%).

HPV Vaccinations

The human papillomavirus (HPV) vaccine helps to protect against cancers caused by HPV, including cervical cancer and some mouth and throat cancers, and is offered to girls and boys aged 12-13 years. It is provided in two doses, both of which must be received for proper protection.

An ecological study of HPV vaccine uptake by year 9s in 2016/17 by school type ⁴⁵⁸reported that Muslim/Islamic schools (57%) had significantly lower uptake of the HPV vaccine than schools with no religious affiliation (82%), COE or Christian faith schools (80%) and Hindu/Sikh schools (93%). However, it should be noted that only a

quarter of local authority schools were included in this study, and the number of students in Muslim/Islamic schools (n=178) and Hindu/Sikh schools (n=48) was much lower than the number of students in non-religious schools (n=73,834).

Other studies in this field report a higher HPV vaccine uptake by female Muslim students (70%)^{459 460}, although these rates remain lower than for female Christian students (88%) and students with no religious affiliation (93%), but have also been reported as being slightly higher than for Hindu/Sikh girls (60%)⁴⁶¹. In the study by Marlow et al., for 16–18-year-old college students in the South-East, these differences remained the case even after the effects of ethnicity, language and college were controlled for. In the study by Bowyer et al. (2014)⁴⁶², with year 11 London school girls, after controlling for ethnicity, religion was no longer significantly associated with vaccine status. That is, Muslim girls did not have significantly lower HPV vaccination rates after adjusting for ethnicity⁴⁶³.

A more recent study by Rockliffe et al. (2017)⁴⁶⁴ found that schools in areas with a higher population of Muslims (73%) had a similar vaccine uptake (e.g. for first dose HPV vaccine) to schools located in areas in which the majority of the population did not identify with a religion (74%) and in areas with a higher population of Hindus (71%). This was higher than areas with a higher Jewish population (62%) and lower than areas with a higher Sikh population (83%). Analysis of ethnicity also revealed that schools in areas with a larger South Asian population had consistently high rates of uptake for all doses, with Bangladeshi children having amongst the highest uptake, and consistently low in areas with Black African/Caribbean populations⁴⁶⁵.

MenACWY Vaccinations

The MenACWY vaccine protects against several strains of infections that can cause serious meningitis.

It is routinely offered to teenagers in school Years 9 and 10 and is recommended for students starting college and university (prior to their 25th birthday). In the study by Tiley et al., (2019) ⁴⁶⁶, using aggregated 2016/2017 data from year 9 pupils in 1432 schools, no significant differences in uptake of MenACWY vaccine by religious affiliation of school were reported.

Influenza Vaccinations

Evidence shows mixed results as to the uptake of the influenza vaccine by Muslims but indicates that Muslims have a similar uptake of the vaccine to non-Muslims after adjusting for socio-economic characteristics.

The Childhood Influenza Vaccination Programme Report by Public Health England (2016) reports that in 2015/2016 boroughs in London which had lower than 40% vaccine uptake were based in the top 10% (35/348) of unitary authorities and LA districts in England with the highest Muslim populations. The report highlights the consistency of its findings with previous work from 2014/15 and 2013/14, which has shown that deprivation and Muslim religion are independent predictors of lower uptake ⁽³³⁾. Within the South Asian ethnic group in England, Pakistanis (17%) and Bangladeshis (18%) had a similar vaccination to Indians (19%), which was lower than the White grouping (25%) but higher than all sub-ethnic groups under Black and mixed ethnic categories (13%), except Black Caribbean ⁴⁶⁷.

Other studies however have shown no significant differences in influenza vaccine uptake. A study which analysed national data for 2015/16 and 2016/17 for adults and children in England reported variable uptake by ethnicity and religion amongst different age groups⁴⁶⁸. Adjusted uptake for 2-4 year olds was more than 11% lower in the most deprived populations and more than 3% lower in minority ethnic populations⁴⁶⁹. For 2-4 year olds, areas with the highest Muslim populations (over 6%) had significantly lower adjusted vaccine uptake than non-Muslim areas in 2016/17, although this did not hold true for 2015/16. There was no negative association in vaccine uptake among any of the most populated adult Muslim populations. Amongst 16-65 year olds in a clinical risk group and patients over the age of 65, areas with larger Muslim and minority ethnic populations had a higher uptake of the influenza vaccine than non-Muslim areas and areas with a low number minority ethnic residents.

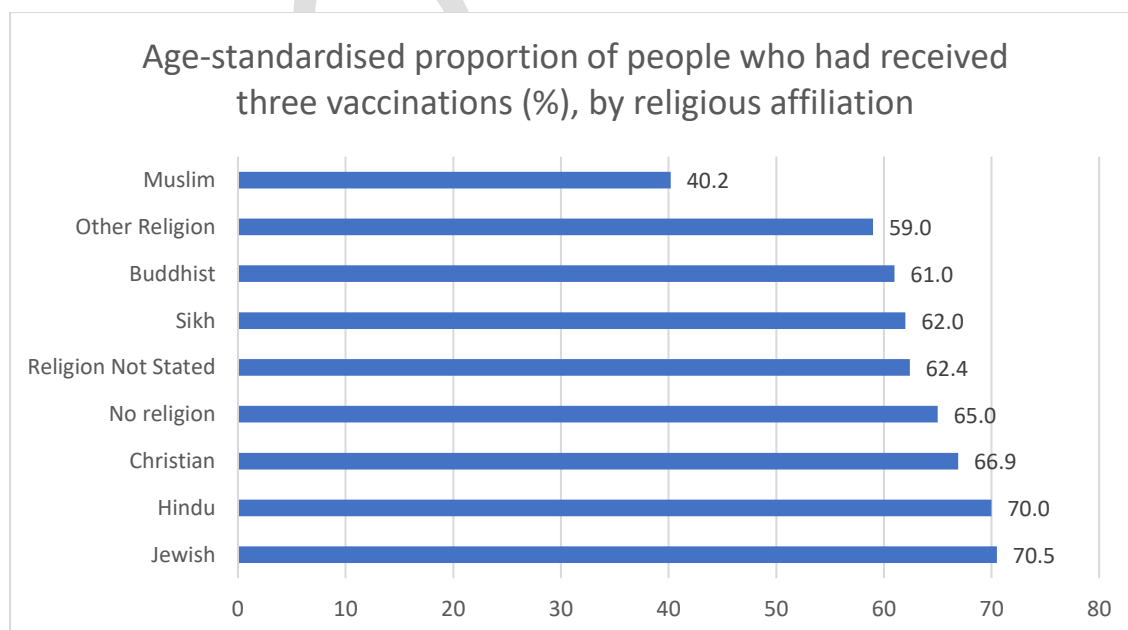
Looking at 2013/14 national data⁴⁷⁰ reported lower uptake of the influenza vaccination in 2-3 year olds and 4-11 year olds in areas of high deprivation, with the highest minority ethnic populations, with the highest Muslim and Jewish communities and rural areas (unadjusted analysis). For example, in local authority areas with more than a 5% resident Muslim population, uptake for 2-3 year olds was 13% lower and for 4-11 year olds was 20% lower and in areas which had more than a 5% resident Muslim population (relative to areas with 0% Muslim population). However, after adjusting for other characteristics (e.g. deprivation, ethnicity), levels of Muslim children's uptake was no longer statistically significant, with a slight difference (3-4%) in 4-11 year olds.

Covid-19 Vaccinations

Muslims have the lowest uptake of Covid-19 vaccinations compared to people in other religious sub-groups. A range of factors influence vaccination rates, including living in more deprived areas, having a disability, not speaking English as a main language, living in rented housing, belonging to a lower socioeconomic group, and having fewer qualifications⁴⁷¹. Religion, being Muslim in particular, is also significantly associated with low vaccine uptake ^{472 473 474}.

By 30th September 2021, Muslim adults (40%) in England had the lowest uptake of all three covid vaccinations compared with adults in all other religious sub-groups, e.g. Sikh (62%), Hindu (70%), Christian (67%) and those with no religion (65%) ^{475 476}. By the end of August 2021, 71% of adults identifying as Muslim had received at least one dose of COVID-19 vaccination, compared with 90% of adults identifying as Hindu or Christian ⁴⁷⁷.

Figure 14. Age-Standardised Proportion of People who received Three COVID-19 Vaccinations (%), by Religious Affiliation



Source: ONS (2022a)

Amongst those over the age of 70, Muslims (79%) had the lowest first dose vaccination uptake of all religious groupings, e.g. compared with Christians (94%), Hindus (92%), Sikhs (92%) and those with no religion (92%)⁴⁷⁸. Uptake by ethnicity corresponded with the above religious breakdown; Pakistanis (38%) and Bangladeshis (46%) had among the lowest third vaccination rates of all ethnic groups, which were just higher than Black Caribbean (34%) and Black African (38%) populations and lower than White British (68%) and Indian (65%) populations.

Factors Affecting Uptake

Several factors are reported to be associated with vaccination uptake, including deprivation of local area, gender, socio-economic status, having English as main language, being born abroad^{479 480 481}. However, Muslims continue to have a lower adjusted uptake of vaccinations (independent of other factors)^{482 483}.

For children's immunisation, parental decision to vaccinate is the primary factor affecting uptake. In relation to minority ethnic groups, parental understanding and attitudes in relation to the importance of immunisation and whether they see it as culturally/religiously permissible have been raised as important concerns^{484 485 486 487 488 489}.

The issue of pork ingredients in some vaccines has been a primary barrier to vaccine uptake amongst Muslim communities worldwide, particularly in relation to the use of porcine gelatine, a stabiliser used in some vaccine brands^{490 491}. Although non-porcine alternatives are available in most cases⁴⁹² some specific brands of vaccines such as 'MMR VaxPro' and 'Zostavax' contain porcine gelatine^{493 494}.

Religious authorities, such as the Muslim Council of Britain, the British Islamic Medical Association, the Muslim Women's Network and Islamic scholars locally, nationally and worldwide have promoted the use of the Covid-19 vaccine, and immunisation more generally, and have sought to debunk myths and disentangle misinformation about the religious impermissibility of certain vaccines⁴⁹⁵. Birmingham mosque leaders have encouraged Muslim communities to get vaccinated and even adapted mosques to enable the provision of community Covid-19 vaccination clinics ⁴⁹⁶.

Some authors suggest that vaccine hesitancy may reflect a broader breakdown in trust between some communities and perceived elites and experts⁴⁹⁷.

2.6.3 Sexual health

There is a lack of data on the perception and use of sexual health services by Muslims, and in particular by Muslim adults. The majority of data focuses on the behaviour and awareness of young Muslims in relation to sexual health awareness and behaviours.

In general, for many South Asian communities, faith and cultural values prohibit premarital sex and therefore dialogues around sexual health are deemed unnecessary, a taboo and shameful within the family and wider community ^{498 499 500 501}.

Young Muslims' Sexual Health Awareness and Behaviours

Evidence indicates that young Muslims, particularly Muslim men, have the lower knowledge and awareness of sexual health than young people from other religious groupings ⁵⁰². A study with 15-18 year old students in London reported that, out of a score of 25, Muslim young men (mean score of 15) reported lower sexual health

knowledge than Christian (16), Hindu (17) and non-religious (19) young men (Coleman and Testa, 2008). Similarly, young Muslim women (16) scored lower in sexual health knowledge than Hindu (17), Christian (20) and non-religious (20) young women.

Muslim students (aged 11-16) reported lower prevalence of sexual intercourse overall as well as lower prevalence of sexual intercourse at an earlier age, compared with young people in other religious groupings^{503 504 505} although there is some indication that this may be an underestimate⁵⁰⁶. In a study by Testa and Coleman (2006)⁵⁰⁷, Muslims from a diverse range of ethnicities shared similar sexual attitudes, and Muslim Asians referred to the Quran frequently and explicitly when describing their personal or community views.

However, there is some evidence of higher levels of sex behaviours associated with health risks in Muslim young men and women who do have sexual intercourse compared to young people from other religious and non-religious background. For example, Muslim men and women reported higher levels of anal sex (20%) than the whole sample of respondents (13%), although whether such intercourse was heterosexual or homosexual was not recorded⁵⁰⁸.

Furthermore, Muslim males (24%) and Muslim females (36%) were less likely to use contraception when first having sexual intercourse compared with the whole sample of respondents (83% for males and 85% for females) and compared with other religious sub-groups, e.g. Hindu (20%), Christian (12%) and non-religious (10%) females⁵⁰⁹. Over half (55%) of Muslim females who were sexually active stated that they had never used contraception.

For young people, a lack of culturally appropriate school-based and community-based provision has been highlighted as a barrier to young people's awareness of sexual health and use of sexual health services ^{510 511}. Another barrier for young people accessing sexual health services is the restrictive role of parents and the community, particularly over females, and poor parental knowledge of sexual health ^{512 513 514 515}.

Adult Female Sexual Health

The main focus of the literature on Muslim female adults' sexual health in the UK has been on the use of contraception ^{516 517 518 519 520 521} and reproduction i.e. fertility and infertility ^{522 523 524 525 526 527}. Evidence indicates that Muslim women face cultural and institutional barriers in accessing contraception. Some studies highlight that Muslim women may be reluctant to use family planning methods, such as contraception, because they see it as against the teaching of the Qu'ran and due to religious conceptualisations of sex and reproduction ⁵²⁸.

The stigma associated with talking about sex in minority ethnic communities can also impact Muslim women's access to sexual health knowledge and services ^{529 530 531} ⁵³². Other studies point out the institutional barriers that Muslim women face, such as a lack of information, paternalistic attitudes from some health care professionals, a lack of culturally appropriate care as well as language barriers ^{533 534 535 536 537}.

A literature review of the international evidence on Muslim women's sexual and reproductive health (SRH), including studies from the UK, reported on the multiple and interrelated factors that influence Muslim women's SRH⁵³⁸. Common barriers to

women's SRH which have also been highlighted in the UK literature on Muslim women's SRH include:

Individual/Cultural Barriers

- A lack of knowledge about SRH and SRH Services, including contraception
- Misconceptions about the nature and side-effects of contraception
- Negative attitudes towards contraception
- A lack of female control over SRH, e.g. husband as key decision maker
- The additional stigma in accessing SRH for unmarried Muslim women
- The perspective that SRH education encourages sexual behaviour
- Muslim mothers' restrictive attitudes towards Muslim girls sexual health

Institutional Barriers

- Communication and language
- Male healthcare practitioner
- Paternalistic attitudes from healthcare practitioners (e.g. about role of husband)
- Lack of culturally appropriate and quality services, including educational institutions

Prevalence of Sexually Transmitted Infections (STIs)

Existing evidence indicates that South Asians are less likely or as likely as non-South Asians to be diagnosed with an STI^{539 540 541}. A retrospective case-control study undertaken in two London genito-urinary (GU) medicine clinics in 2003 reported that South Asians were less likely to have an STI (odds ratio of 0.66) or to report risk factors for HIV (odds ratio 0.45) than non-South Asians⁵⁴². Another study of GUM clinics

across England between 2004-2005 reported no significant differences in the proportion of South Asians who had acute STI(s) diagnosed at clinic relative to other clinic attendees⁵⁴³. However, there may be variation with individual STIs.

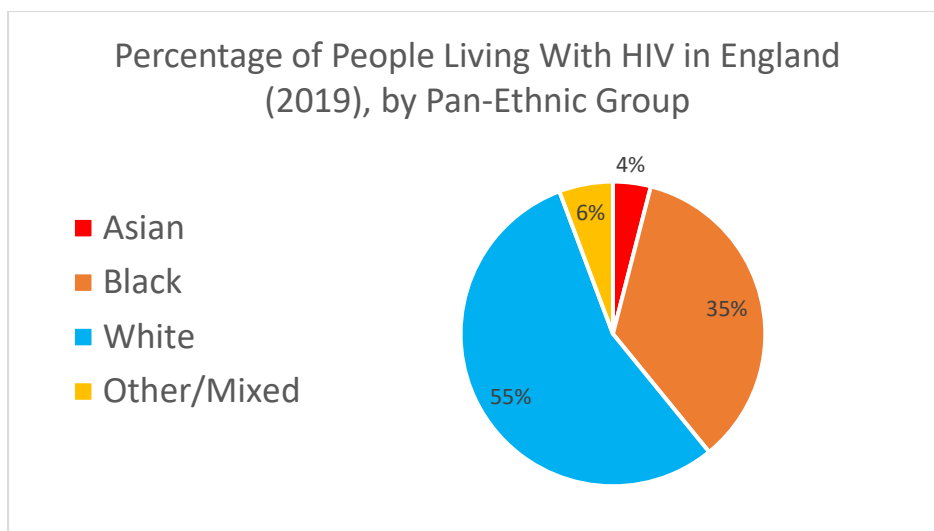
A study with Bangladeshi men attending a GUM clinic in east London found that whilst prevalence of STIs was broadly similar across the study groups, syphilis was significantly more common in the Bangladeshi men (10.9% compared with 4%)⁵⁴⁴. It should also be borne in mind that sexual health attitudes and behaviours are also shaped by sexuality, and so, for example, South Asian Men who have Sex with Men (MSM) may have a different risk profile and face additional barriers to seeking services than other South Asian men ^{545 546}.

A common finding presented across studies is that South Asians were significantly more likely than to have been referred to sexual health services by other medical services rather than self-referred (odds ratio 2.00) ^{547 548 549}.

Prevalence of HIV

Data from the National AIDS Trust (n.d.) suggests that South Asians have a lower incidence and prevalence of HIV than people from Black and White pan-ethnic groups. Of the people living with HIV in England in 2019, 4% were Asian (compared to 8% in the general population), 29% were Black African and 55% were White .

Figure 15. Percentage of People Living with HIV in England, by Pan-Ethnic Group (2019)



Source: National Aids Trust (n.d.)

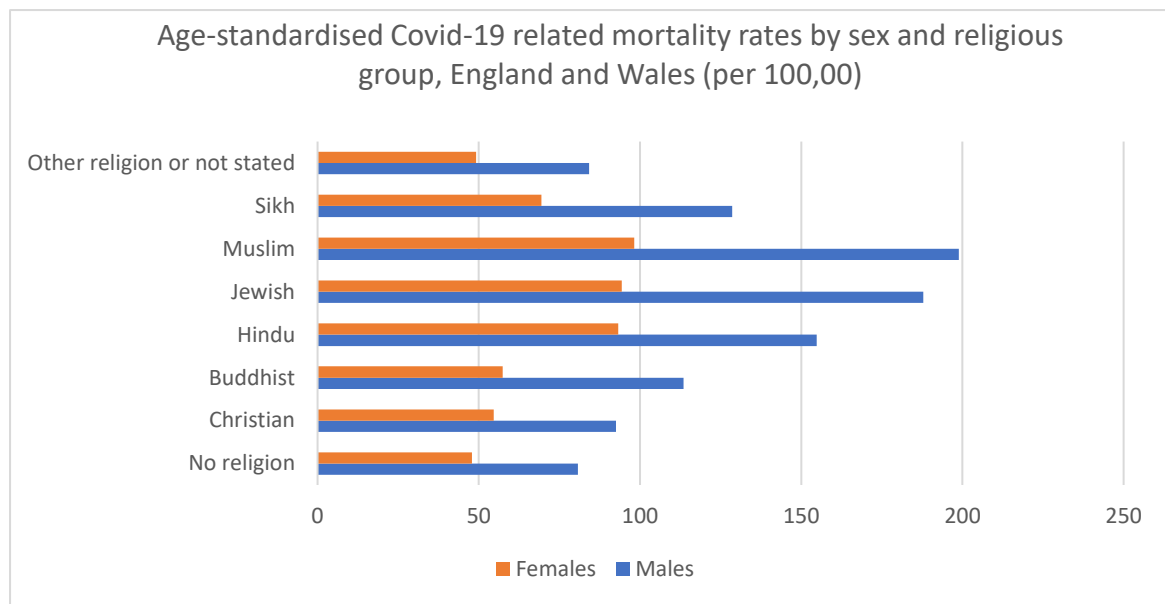
2.6.4 COVID-19 Mortality Rate

Evidence shows that minority ethnic groups have a significantly higher prevalence of Covid infection, higher incidence of Covid disease, a higher rate of Covid-related hospitalisation and higher rate of Covid-related mortality than White ethnic groups⁵⁵⁰⁵⁵¹. The Muslim population has the highest prevalence of Covid-19 related mortality amongst all religious sub-groups, with Muslim males faring the worst.

According to the ONS (2020)⁵⁵², Muslim males (198.9 deaths per 100,000) had higher age-standardised mortality rates (ASMRs) than Hindu males (154.8 deaths per 100,000) and Sikh males (128.6 per 100,000) and significantly higher ASMRs than Christian males (92.6 deaths per 100,000) and males with no religion (80.7 deaths per 100,000). Similarly, Muslim females (98.2 deaths per 100,000) had higher ASMRs compared to Hindu females (93.3 deaths per 100,000), Sikh females (69.4 deaths per 100,000), Christian females (54.6 deaths per 100,000) and females with no religion (47.9 deaths per 100,000). Muslim men and women aged 65 and over also had

amongst the highest Covid-19 related death rates (755 per 100,000), alongside Jewish men and women ⁵⁵³.

Figure 16: Age-Standardised COVID-19 Related Mortality Rates, by Sex and Religious Affiliation, England and Wales (per,100,000)



Source: ONS, 2020. For all residents of England and Wales aged 9 years and above, between 2 March to 15 May 2020.

Thus, Muslim males had a Covid-19 age-adjusted Hazard Ratio (HR) 2.7 times higher than Christian males whilst for Muslim females this was 2.4 times higher. A HR greater than one indicates a greater rate of death involving COVID-19 than the reference group (Christians) while a hazard ratio of less than one indicates a lower rate of COVID-19 mortality than the reference group. This rate was higher than for Hindus (men HR: 1.6, women HR: 1.5) and Sikhs (men HR: 1.6, women HR: 1.5)⁵⁵⁴. After adjusting for other factors, i.e. location, disadvantage, occupation, living arrangements and pre-pandemic health status, Muslim men (HR: 1.7) and women's (HR: 1.3) rates reduced but remained statistically significantly elevated⁵⁵⁵. Breakdown of ethnicity and

religion by binary White and non-White ethnic grouping shows that Muslims from a minority ethnic background (92.2%) made up over 90% Muslim deaths involving COVID-19 compared with Muslims from a White ethnic background (7.8%) (2020). This difference reflects their representation in the 2011 Census.

Analysis of Covid-19 related deaths by ethnic group revealed a similar analysis and illustrated that Bangladeshi and Pakistani men in particular remained at highest risk of Covid-19 related mortality. After adjusting for a range of factors (including location, disadvantage, occupation, housing, pre-existing health conditions and vaccination status), most ethnic groups had a similar risk to the White British group; only Bangladeshi males (HR: 2.2), Bangladeshi females (HR: 2.1) and Pakistani males (HR: 1.2) remained at higher risk of death involving COVID-19 than the White British ethnic group ⁵⁵⁶. For Pakistani females, adjusting for vaccination status eliminated remaining unexplained risks.

A study which analysed Covid-19 mortality risk using national data sets (for adults aged 40 and over) reported that Muslim had lower vaccination uptake across most ethnic groups (compared with Christian, Hindu or no religion), indicating the religion may play an independent factor in determining vaccination uptake ⁵⁵⁷. The lowest uptake was found amongst Black Caribbean Muslims.

The exact causes of the ethnic inequalities seen in COVID-19 are unclear but is likely to be an interplay of social, economic, biological and pre-pandemic health risks that vary across ethnic groups⁵⁵⁸. Minority ethnic groups greater exposure to the virus may be due to occupation (working in high contact/person facing roles), living in

overcrowded housing and poor housing conditions and in urban areas, high levels of socio-economic disadvantage and deprivation, poor access to healthcare, pre-existing co-morbidities, differences in immune response, vaccine hesitancy and institutional racism ^{559 560 561 562 563}.

2.7 Ageing well and dying well

Key Findings:

- In 2011 4% of the Muslim population (110,000) were aged 65 and over compared with 16% of the population of the UK.
- 3% of Muslims in Birmingham were aged 65 and over compared with 21% of the Christian population.
- It is estimated that by 2036 10% of the Muslim population of the UK will be over 65 (450,000).
- Muslim women over 65 report more bad health than other women (38.2% compared with 16.1%) and more bad health than Muslim men over 65 (38.2% compared with 26.7%).
- South Asian Muslims have a 7 to 12% rate of doctor-diagnosed diabetes compared with a 4% rate for British Christians
- Of elderly Muslims with diabetes fasting during Ramadan, 12.6% had to break their fast because of diabetic complications, including serious glycaemic reactions.
- South Asian Muslims have an up to 40% greater risk of coronary heart disease compared with the general population of the UK.
- Elderly Muslim patients have difficulty accessing and understanding medical advice because of language and cultural barriers.

- It is estimated that many elderly Muslims suffer from dementia although there are no agreed figures. In 2013 it was estimated that 25,000 elderly members of the BAME community had dementia.
- Many Muslim families do not realise dementia is a degenerative brain disease and treat it as bringing shame on the elderly person and on the family.
- Concerns to protect privacy and modesty and communication problems in elderly Muslim women can lead to delays in recognizing cancer, low screening rates and problems accepting medical help.
- Muslims have a lower level of organ donations than other groups in the community and more negative attitudes to transplantation because of the violation of the body that it entails.
- Muslim families prefer to take care of elderly people at the end of their lives in their own homes but may be reluctant to accept palliative care, in part because the drugs used may not be acceptable in Islamic teaching.
- Muslim families make less use of hospices and care homes for relatives at the end of their lives because they may not receive the cultural and spiritual support that is traditionally given within the Muslim faith.
- Muslim families may be reluctant to agree to post-mortem examinations because of the body violations that are entailed
- Muslim women aged 65 and over (42%) are significantly more likely to report being in 'bad or very bad health' compared to women in the general population (23%) and compared to Muslim men (31%) of the same age

2.7.1 The Health of Older Muslims

In the 2011 Census ⁵⁶⁴ only 4% of the Muslim population (110,000) were aged 65 and over, compared with 22% of the Christian population and 16% of the general population. The age distribution between males and females was relatively even.

Only 3% of Muslims in Birmingham were aged 65 and over, compared with 13% of Birmingham's local population and 21% of Birmingham's Christian population. The age distribution between males and females across age groups was relatively even.

It is estimated ⁵⁶⁵ that by 2036 10% of the Muslim population will be over 65 (450,000). An extensive review ⁵⁶⁶ of the health of Muslims in England concluded that the older Muslim population of the UK had markedly increased risks of ill health. Using Pakistani and Bangladeshi communities as proxies for the Muslim population the review concluded that in 1999 older Muslims suffered from significantly higher risks of long-standing illness, diabetes, poor self-health assessments, and raised waist-hip ratio. Pakistani and Bangladeshi residents had higher rates of heart disease, stroke, and Type 2 Diabetes and South Asian women over 65 had the highest rate of life limiting and long-term illness (64.5% compared to 53.1% for other women over 65). This trend continued in 2006 with Pakistani women experiencing higher rates of both longstanding and life limited-longstanding illness, at a growing rate. In 1999, both Pakistani and Bangladeshi men and women were 6 times more likely than the general population to have diabetes, and this trend has continued in the past two decades. South Asian Muslims are more likely to die prematurely from coronary heart disease than the general population.

The GP Patient Survey for 2018 ⁵⁶⁷ received responses from 1,919 Elderly English Muslims in a total sample of 150,999 English patients over 65. More of the Muslim respondents over 65 reported themselves in bad health than in the general population over 65. 38% of Muslim women over 65 declared themselves to be in ‘bad health’ compared with 16% of women over 65 in England. 27% of Muslim men over 65 said they were in bad health compared with 15% of men over 65 in England.

For the elderly population three medical conditions – diabetes, a heart condition (such as angina or atrial fibrillation) and high blood pressure – are more prevalent among Muslims than in the rest of the population.

Table 8: Medical Conditions Reported in GP Survey (2018)

Medical Condition	All (%)		Men (%)		Women (%)	
	Muslims	All	Muslims	All	Muslims	All
Diabetes	46	16	47	19	43	13
Heart Condition	24	18	27	21	18	14
High Blood Pressure	53	41	53	41	56	41

Source: GP Patient Survey 2018

The survey also asked two further questions about general health. To the question ‘do these conditions reduce your ability to carry-out day-to-day activities 41% of Muslims over 65 replied ‘Yes a lot’ compared with 21% of the overall sample. More Muslim women (47%) than men ((37%) felt their ability to undertake day-to-day activities had been reduced by poor health. To the question ‘Do you take 5 or more medications on

a regular basis', 65% of Elderly Muslims replied yes compared with 45% of the overall sample. 67% of Muslim women took 5 or more medications compared with 65% of Muslim men.

2.7.2 Diabetes

It is estimated ⁵⁶⁸ that as many as 325,000 of the 2.7 million UK Muslims (12%) may have diabetes. Type 2 diabetes is the older-onset version of the condition and, although figures are not available, it is likely that its prevalence amongst older Muslims is even higher.

A review of the national health surveys of 1999 and 2004 in England ⁵⁶⁹ for ethnic and religious variations found that there was between a three and six and a half times greater risk of having a diabetes diagnosis for men and women in the Pakistani, Bangladeshi and Indian Muslim, Caribbean Christian, Caribbean groups not identifying with any religion, Hindu and Sikh groups compared with White British and other White Christian men and women, after adjusting for age

South Asian Muslims had a 7%-12% rate of doctor-diagnosed diabetes, higher than for White British Christians (4%) and White British people with no religion (3%). However, Indian Muslims (12%) had the highest prevalence of doctor-diagnosed diabetes of all religious sub-groups, e.g. compared with Pakistani Muslims (7%) and Bangladeshi Muslims (7%), Hindus (7%), Sikhs (6%) and Indian Christians (5%).

Diabetes is a condition that requires disciplined self-management, with strict control of medication, diet and exercise, and a number of qualitative studies have identified

the problems older Muslims have in managing the disease. A study ⁵⁷⁰ of 20 older women of South Asian origin in the North East England who had Type 2 diabetes found they had very little understanding of the reasons for the disease, of the risks associated with the disease or the need for careful self-management. When given advice about revising their diet, they found it difficult to follow the advice because they needed to prepare family meals in traditional ways. They regarded the management of the disease as the responsibility of the health professionals who prescribed pills or insulin and not something that they themselves could influence.

A study ⁵⁷¹ of the way 10 Gujarati elderly Muslim men in North West England managed their Type 2 diabetes also found that they had very little understanding of the nature of the disease or of medical advice of how it should be managed. Some of the sample made use of the traditional herbal remedies used in their country of origin. The authors warn against stereotyping all Muslims as following particular cultural patterns because there may be wide variations in the cultural context informing their self-management practices.

These studies also point to language barriers. The management of diabetes involves following complex advice particularly in respect of dietary habits. Most advice is provided in English and many older Muslims may not have sufficient language skills to understand the advice.

A particular problem for Muslims with diabetes is how to manage the disease during the fasting month of Ramadan. A global survey ⁵⁷² of almost 6,000 Muslims with Type 2 diabetes compared the fasting behaviour of over and under 65-year olds. High rates of fasting during Ramadan were found but more over 65s (28.8%) did not fast

compared with 12.7% of the under 65s. 12.6% had to break their fast due to diabetes related illness during Ramadan and glycaemic complications occurred frequently with older adults requiring higher rates of acute hospital care.

A qualitative study of 23 older UK Muslims with diabetes focused on how they managed the condition during Ramadan⁵⁷³. Many were aware that, as they had an illness, they were not required to fast but for both spiritual and cultural reasons they wanted to play a full part in the tradition. However, many were fearful of consulting their GP about how to manage the condition whilst fasting because they might be advised not to fast.

2.7.3 Cardiovascular disease (CVD)

Coronary heart disease (CHD) is a major cause of morbidity and mortality in the UK. The prevalence of CHD in the UK is 3.5% in males and 2.1% in females⁵⁷⁴. However, South Asians (those ethnic groups originating from the Indian subcontinent) have been shown to be at a significantly higher risk from CHD compared with the general population. The overall increased risk of mortality is up to 40%, with evidence that this is even higher for women and for the older generation.

In a study⁵⁷⁵ investigate lifestyle changes within a series of focus groups were conducted with 65 UK patients diagnosed with coronary heart disease. Twenty of the sample were Pakistani Muslims (age range 46 to 72), 12 were Indian Sikhs, 13 Indian Hindus and 20 Europeans. The Muslim patients had the most language problems and were least likely to be able to specify the causes of their CHD, many attributing it to Allah's Will. Nevertheless, they are seeking to live a healthier lifestyle and many of the

Muslims had successfully given up smoking. They recognized that there was too much fat in their diet but were less successful in changing their eating habits. Many thought that stress was a cause of their heart condition, but they did not take up relaxation techniques preferring to get physical exercise by walking more.

In a similar study 43 older people of South Asian heritage in Leicester were engaged in a series of focus groups ⁵⁷⁶ to explore lifestyle risk factors for coronary heart disease. The sample included 11 Muslims, 11 Hindus and 21 Sikhs and had an age range of 40 to 72. A major concern was access to advisory services with language the biggest barrier. The participants identified stress as the most likely risk factor that could lead to heart problems especially the stresses on family life caused by living in a western society. They were also aware that the typical Indian diet could be unhealthy and that they took too little physical exercise. The Muslim women in the sample highlighted the difficulty of protecting modesty if they joined exercise classes. The Muslims in the sample did not see alcohol as a problem and there was only limited recognition that there were risks associated with smoking.

The prevention of cardiovascular diseases and their management when they are diagnosed has been a subject of many qualitative studies. A systematic review of 16 studies of Muslims of Pakistani heritage highlighted the need for both medical and emotional support⁵⁷⁷. Most of the studies were of older populations of Muslims in UK communities and they drew attention to the central role of families and family dynamics in providing emotional support for elderly relatives. The family could support the elderly person in making necessary lifestyle changes or it could provide barriers to change. The review demonstrated the need for the whole family to understand the medical

issues and not just the patient. The studies included many examples of difficulties patients experienced with clinicians, from language problems through to clinicians not understanding Islamic traditions and teachings that were important to the patients.

In relation to mortality from circulatory diseases, Bangladeshi males (451.4 deaths per 100,000) had the highest age-standardised rate of mortality compared to men across all other ethnic sub-groups (329.4 per 100,000) and Pakistani women (276.1 per 100,000) had the highest rate compared with females from all other ethnic sub-groups (237 per 100,000)⁵⁷⁸. As highlighted by the ONS (2011)⁵⁷⁹, the different life expectancy of ethnic groups reveals complex patterns in life expectancy and mortality by ethnic group. These include levels disease prevalence, health-related behaviours and the impact of wider determinants of health, such as living in deprived neighbourhoods.

2.7.4 Cancer

A number of studies have found that Muslim men and women are less likely to be diagnosed with cancer than members of the UK White population, although there are variations according to ethnicity. In a study of ethnic variations in lung cancer diagnosis in South East England,⁵⁸⁰ Bangladeshi men had a similar rate of lung cancer to White men, while rates for Indian and Pakistani men were much lower. Black Caribbean and Black African men have incidence rates around half that of White men, and Chinese men have a rate ratio of 0.75. Compared with White women, women from the other ethnic groups studied have much lower lung cancer incidence rates. The rate ratios ranged from around 0.20 to 0.40.

Although the rates of diagnosis for Muslims may, in general be lower than for other groups, there remain serious issues in cancer screening and treatment for older Muslims. Breast cancer screening is offered to women between the ages of 50 and 70 and in the West Midlands ⁵⁸¹ Muslim women had a lower rate of uptake (51%) than non-South Asian s (75%). The rate of screening of Muslims for bowel cancer is also low ⁵⁸²South Asians had a take-up rate of 33% (Muslims 26%) compared with non-Asians (61%).

When bowel cancer has been diagnosed, one way of treating it is to insert a stoma that opens up the bowel to the surface. A survey of 122 Muslims⁵⁸³ undergoing this operation in Leicester found that they found it had particularly unpleasant consequences and that it reduced the perceived quality of life of these patients more than other groups. In order to counteract avoidance of this procedure a group of cancer specialists ⁵⁸⁴ worked with Islamic faith leaders to develop a series of fatwas regarding the management of stomas for good health. The authors report a growing number of health specific fatwas being developed for other conditions in order to bring health education to the Muslim population in an accessible and authoritative way.

Other studies have identified cultural barriers that may affect the diagnosis and treatment of cancers in older Muslims. In a qualitative study of women with breast cancer in the UK and in Pakistan⁵⁸⁵ the authors found similar cultural issues at each stage of the process in both countries although awareness of cancer was greater in the UK than in Pakistan. Women were slow to recognise a potential cancer because of a Muslim taboo on touching your own body. As a consequence, a lump in the breast

might be quite advanced before it received attention. Women were also anxious about revealing the disease to their families because of a stigma often associated with the disease. As a result, they often got little emotional support from their families. The disfigurement associated with a mastectomy was also a source of shame to be hidden as far as possible.

The process of diagnosis and treatment also meant being subjected to very personal examinations by medical staff. A survey of 75 elderly patients⁵⁸⁶ showed how traumatic this could be for older Muslims, especially because they may have difficulty communicating their concerns. The survey concluded that translation services were often quite poor and that the process was greatly improved if a member of the family could act as both chaperon and translator. Statistics show that only one third of older Bangladeshi and Pakistani women (50–75 years) can read English, and less than two thirds of 50-75 year old men⁵⁸⁷.

2.7.5 Dementia

There are no agreed figures for the number of older Muslims in the UK that have dementia but, following an extensive literature review and a systematic review of 17 qualitative studies, it was concluded⁵⁸⁸ that the prevalence is likely to be high. The review cites an All Party Parliamentary Group on Dementia in 2013 that gives an estimate for the Black and Asian Minority Ethnic population of the UK of 25,000 with dementia that is forecast to grow to 160,000 by 2051. A study of the risk factors leading to dementia⁵⁸⁹ concluded that there are seven main contributors: diabetes, mid-life hypertension, mid-life obesity, smoking, depression, low educational attainment, and physical inactivity. Given that these are all common in the Muslim population the

authors of the review conclude that it is likely that a high percentage of older UK Muslims will suffer from dementia. The authors of the review also cite evidence from a Liverpool study that vascular dementia is more common in the Muslim population than Alzheimer's.

The review ⁵⁹⁰of 17 qualitative studies grouped findings into five categories:

1. Poor awareness and understanding of dementia.

Memory loss and other symptoms of dementia tended to be regarded as part of the ageing process and there was little awareness that it is a degenerative brain disease.

2. Stigma and shame within the family and the community.

The explanation for dementia was that the person was possessed by evil spirits and that the condition brought shame on the individual and the family. In some cases, families with a relative with dementia shut themselves off from contact with their community because of the shame.

3. Obligations of family care.

All the families in the studies accepted that they had a religious and a moral obligation to take care of a relative with dementia no matter how distressing and difficult it may be. The principal care giver was nearly always a woman and was often the wife of the eldest son.

4. Coping with care giving.

The deteriorating condition of relatives with dementia put a considerable

strain on the principal care giver and on the family. The carers found it particularly difficult to sustain the levels of personal hygiene of the person with dementia that was normal in the family. The behaviour of the person with dementia was often disruptive and difficult to control putting a strain on all the other relationships in the family. Without an understanding of dementia, there was a tendency to blame the person with dementia for their behaviour and there were examples of physical abuse towards them. With little understanding of the condition, family members resorted to prayer and spiritual guidance and to traditional herbal remedies to help their relatives.

5. Access to Social Care and Medical Services

Muslim families were slow to seek and to get a diagnosis of dementia. When they did, it reduced the tendency to blame the individual and allowed family members to accept that it was an illness. However, there were many reports that they did not receive the medical help and advice they needed to enable them to care for the person at home. Very few explored the option of moving their relative to a care home, in part because of the obligation to look after them at home and in part because of concerns about the appropriateness of the care in the care home, i.e. would the food be suitable, would South Asian carers be available or would care be given by opposite-sex care staff?

In a follow up study, a review of caregiving in UK Muslim Bangladeshi families⁵⁹¹ confirmed that there was a strong desire to look after elderly relatives with dementia in the family but unlike the other studies it found there was no stigma attached to the condition. Instead, it found that caregivers accepted the condition

was a disease and sought medical advice on how best to support their elderly relatives.

2.7.6 Long-standing health impairment, illness or disability

Evidence indicates that, on the whole, the Muslim population report lower/similar levels of health, illness and disabilities as people from other religious groupings. However, the younger age of the Muslim population masks significant differences. When broken down by sex and age, some Muslims report significantly poorer levels of health than their religious and non-religious counterparts.

In Birmingham, data from the 2011 Census⁵⁹² shows that 83% of Muslims rated their health as 'very good or good', 11% rated it as 'fair' and 6% rated it as 'bad or very bad'. This was similar to Hindus (84%), Sikhs (81%) and people with no religion (85%) who rated their health as 'very good or good' but higher than Christians (75%). Similarly, 86% of Muslims in Birmingham said that their day-to-day activities were not limited by a long-term health problem or disability⁵⁹³. This is similar to the national picture in England and Wales in 2011.

Breakdown of the 2011 Census data on self-reported health and disability by age and sex however shows a starkly different picture. Amongst those aged 50 and over, a quarter (22%) of Muslims in Birmingham reported being in "bad or very bad health" compared to between 12-13% of Hindus, Christians and people with no religion and 15% of Sikhs of the same age. When looking at Muslims aged 65 and over and Muslim women (across all age groups) these differences become starker. For example, Muslim women aged 65 and over (42%) were significantly more likely than

women in the general population (23%) and Muslim men (31%) aged 65 and over to report being in 'bad or very bad' health.

With regards to disability⁵⁹⁴, half (52%) of Muslim women aged 65 and over in Birmingham reported having a health problem or disability which limited their day-to-day activities "a lot" compared to 37% their counterparts in the general population. Muslim men (40%) of the same age were also more likely to report this than men in the general population (29%). These disparities are slightly less than in the general population.

More recently, data from the UK Household Longitudinal Study (UKHLS) 2016-2018, reported by the ONS (2020)⁵⁹⁵, showed that after adjusting for socio-demographic characteristics, i.e. age, sex, broad ethnic group and region, Muslims (66%) reported similar levels of satisfaction with their health as most other religious groupings. However, even after adjustment, Muslims (35%) were more likely to report long-standing physical or mental impairment, illness or disability (lasting or expected to last at least 12 months) than Sikhs (22%) and Hindus (27%), although they reported similar levels to Christians (36%), people with no religion (35%) and Jewish people (38%)⁵⁹⁶.

Analysing data from nationally representative data on self-assessed fair or poor health, longstanding limiting illness by religious and ethnic grouping (e.g. Health Surveys for England, 1999, 2004), Karlsen and Nazroo⁵⁹⁷ reported that Pakistani, Bangladeshi and Indian Muslims, alongside Hindus, Sikhs and people from a Black

Caribbean background were significantly more likely than the White British population to report 'fair, poor or very poor' health.

After adjusting for age, gender and socio-economic status, a similar percentage of Muslims from Pakistani (32%), Bangladeshi (37%) and Indian (37%) ethnic backgrounds rated their health as 'fair, poor or very poor' (as opposed to good or very good). These levels were somewhat similar to Sikhs (34%) and Hindus (29%), but higher than for White British Christians (26%) and White British individuals with no religious affiliation (19%). That is, Pakistani, Bangladeshi and Indian Muslims had the highest age-standardised odds (2.26, 2.94 and 2.68 respectively) of reporting poorer health compared with the White British Christian population. Pakistani women (36%) were more likely to report poorer health than Pakistani men (28%).

The study also showed that South Asian Muslims (24%-29%) reported similar levels of activity limiting illness as Sikhs (28%) and Hindus (27%) but higher levels than non-religious White British people (19%) and Hindus (18%). That is, South Asian Muslims were between 1.42 – 1.70 (age-adjusted odds ratio) more likely to report having an activity limiting illness than the White British Christian population. Gender differences were not statistically significant.

2.7.7 End of Life Care

The Muslim Council of Britain⁵⁹⁸ reported a survey of 75 elderly Muslims, their families and medical staff, describing a great 'unmet need' in end of life care. The interviewees describe circumstances in which elderly people remain at home without

the emotional and medical support they need and without access to the many services that may be able to support them.

The survey found that there was a belief and expectation in the Muslim community that an elderly person at the end of their life will be cared for by their family and many families set out to honour that commitment. It was, however, becoming increasingly difficult for families to provide good home care for their elderly relatives. One issue was that more young people, including females who traditionally took on the caring roles, were pursuing careers that took them away from the family home and more elderly people were now living alone at home and becoming isolated and lonely. Another issue was that many Muslims resident in the areas of greatest deprivation lived in overcrowded housing not suited to the care of people at the end of their lives. The frustrations caused by the tensions of this situation have led to reports of abuse being directed at the elderly person. A final issue is that the elderly person and their family carers found it difficult to access medical and other services they needed.

A survey of elderly Muslims and Sikhs⁵⁹⁹ explored the issues of accessing appropriate services. 96 interviews were conducted, 18 with Muslim patients, 7 with Sikh patients and others with family carers and health and social care professionals. The patients all had life-limiting illnesses, 11 with cancer. Six patients died during the research. The survey concluded that most services struggled to deliver responsive, culturally appropriate care. The barriers to accessing effective end of life care included resource constrained services; institutional and, occasionally, personal racial and religious discrimination; limited awareness and understanding among South Asian people of the role of hospices; and difficulty discussing death. The

patients at greatest risk included recent migrants, those with poor English language skills, those with no family advocate, and those dying of non-malignant diseases.

The experiences of South Asian Sikh and Muslim patients and their families were, in many respects, similar to one another.

A particular issue has been access to palliative care. The take up of palliative care by Muslims in the UK is much lower than for elderly people in general in the country⁶⁰⁰. This is attributed to beliefs in the Muslim population that the practices involved in palliative care are not in accordance with the spiritual teachings of Islam. This is partly related to the distinction made in palliative care between 'cure' when medicine is used to help a person recover from illness and 'care', when medicine is used when no cure is available to give pain relief to a person and provide a better quality of life as death approaches. It is reported that in Islamic teaching there is no clear distinction between cure and care and as a result using medicine in this way is treated with suspicion by many Muslim families, especially when the management of symptoms uses agents that are normally prohibited by Islamic teachings, including opioids, brain stimulants, and cannabinoids.

There are substantial analyses of Islamic teaching⁶⁰¹ that conclude that the palliative care approach is entirely compatible with spiritual and cultural approaches to caring for the dying. Some authors⁶⁰² have called for the medical professionals delivering palliative care to do so with sensitivity to the cultural beliefs of the patients and their families and to avoid aspects of palliative care treatment that are deemed inappropriate. Several examples are available⁶⁰³ to show what these approaches are like in practice.

Similar issues help to explain the low level of use the Muslim population make of care home and hospices. There is an additional factor that many Muslim families are reluctant to hand over care of an elderly patients because of the stigma associated with not fulfilling their duty to care for family members in their own homes. The treatment they receive may also be a form of palliative care with all the doubts they may have about some of the practices involved. However, the major reasons for reluctance are that the elderly person, however good the medical care, may not be treated according to the customs and practices of the Muslim faith. They may, for example, not be offered halal food. As Muslims near the end of life there are also many rituals that are observed, for example, helping the person read verses from The Quran, that may not be followed in an institution that does not understand the cultural practices of the Muslim faith. Again, authors have called for the staff of hospices and care homes to receive training in the cultural practices of Muslims⁶⁰⁴ so that they are able to offer people at the end of their life holistic treatment commensurate with their beliefs and expectations.

There are also many Muslim practices that are observed when a person dies. Many of them are observed by family members and are best undertaken in the family home. When a person dies in a hospital, a hospice or a care home it may not be as easy for the family to fulfil these practices, for example, turning the face of the person who has died towards Mecca.

A particular matter that can cause difficulty after death is when a post-mortem examination is required. Islamic law forbids interference with a body in this way and

families may refuse to cooperate although in practice Muslims will obey the law of the land.

In each of these cases, if medical practitioners and other carers are sensitive to the spiritual and cultural concerns of the Muslim community, a way can usually be found of meeting both medical and cultural needs⁶⁰⁵.

2.7.8 End of Life Care

Muslims in the UK make fewer organ donations than other groups in the community and have been found to have more negative attitudes to organ donations and transplantation than other groups⁶⁰⁶. The Islamic position on transplants has been debated for many years and leading scholars have taken different positions. The main argument in favour of organ transplants is the Islamic requirement to help save the lives of others and against is the violation of the body that it entails. Many countries have now approved organ donation and in the United Kingdom, the Muslim Law Council approved organ donation as being entirely in keeping with Islamic principles in 1996⁶⁰⁷.

However, despite the formal acceptance of the practice, many Muslims remain unconvinced. A systematic literature⁶⁰⁸ review identified 53 papers many of which reported the attitudes of members of the Muslim community to organ donation and transplantation. Key factors or concerns identified included: lack of information regarding organ donation, mistrust of the healthcare system, family opinions, sacredness of the body and lack of clear understanding of religious rulings, and

opinions of religious leaders. Mistrust of the health service had a particular focus on criteria that defined when life was extinct and who would make the decision.

A focus group study⁶⁰⁹ asked two groups of Muslims and two groups of White Christians in the north of England about organ donations and Muslim attitudes were more negative than Christian ones. The Muslim groups raised both spiritual issues and practical ones. Spiritually they were concerned about violation of the body and were unsure what their spiritual leaders had to say on the subject. At a practical level they felt it would be difficult to have conversations in their families about it and, for example, discover whether members of the family would be happy to donate their organs. They also took different views on giving organs after you were dead compared with giving organs whilst still alive and many felt they would be happy to donate organs to members of their families but not to others, especially people from other faiths. They were also not happy with the idea of receiving organs from people of other faiths. The White Christians, by contrast, regarded the body as something left behind after death and, if some use could be made of the organs, that would be a good legacy.

2.8 Closing the gaps

Life Expectancy

- Bangladeshi females (87.3 years) and Pakistani males (82.3 years) have higher than average life expectancy compared with females (85.4 years) and males (81.8 years) across all ethnic groups.
- Bangladeshi males (81.1 years) and Pakistani females (84.8 years) have lower than average life expectancy
- Bangladeshi men smoke more and have more lung disease
- 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 with Pakistani or Bangladeshi heritage
- 46% of Muslims live in the 10% most deprived local authority districts
- Many female Muslims have different lifestyles and more family responsibilities than males with consequences for their health and wellbeing
- The age profile of UK Muslims is skewed towards the younger generations: 35% of the Muslim population in Birmingham are children and 4% are over 65

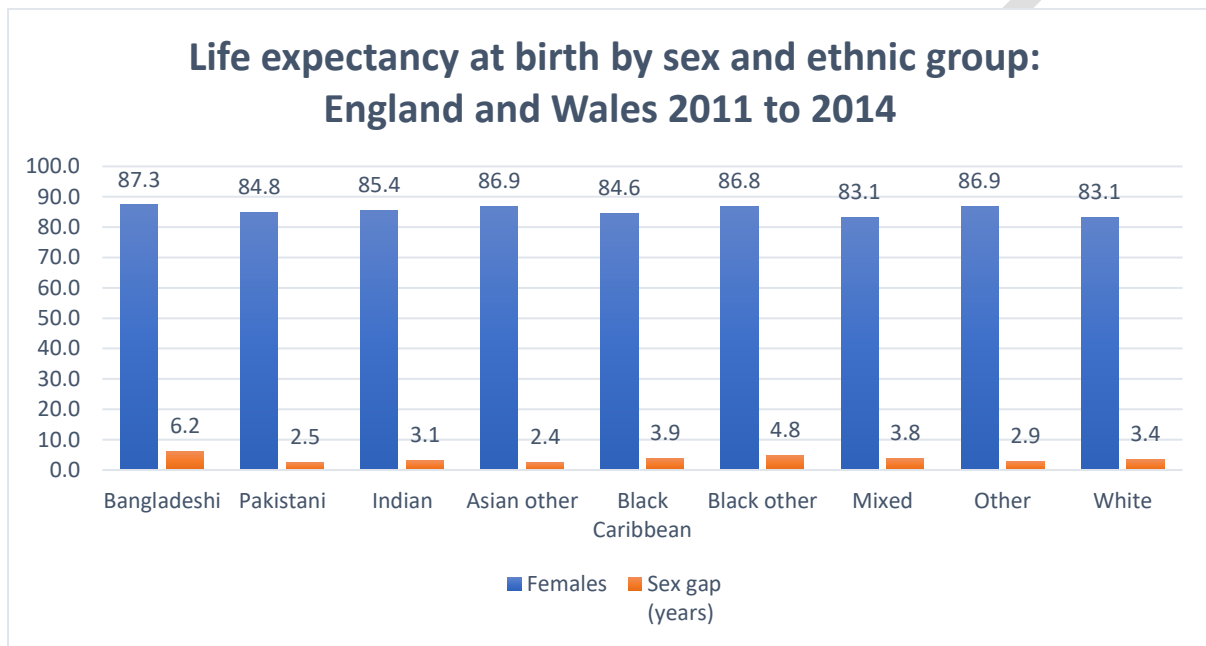
2.8.1 Life Expectancy and Healthy Life Expectancy

Data on life expectancy by religious affiliation is not available. Data on ethnic differences in life expectancy reveal a mixed picture for Bangladeshi and Pakistani communities.

In relation to ethnic and sex differences, evidence reported by the ONS (2011) indicates that Bangladeshi females (87.3 years) and Pakistani males (82.3 years) have higher than average life expectancy compared with females (85.4 years) and males (81.8 years) across all ethnic groups. On the other hand, Bangladeshi males

(81.1 years) and Pakistani females (84.8 years) have lower than average life expectancy⁶¹⁰.

Figure 17: Life Expectancy at Birth, by Sex and Ethnicity (England and Wales, 2011-2014)



Source: ONS (2011)⁶¹¹

In Birmingham, life expectancy for all males (77.2 years) and females (81.9 years) is lower than the national average (79.5 years and 83.1 years, respectively)⁶¹². The other main causes of early death in Birmingham are coronary heart disease, lung cancer and alcoholic liver disease.

2.8.2 Gaps in the Data

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. This means there is little data available about smaller communities of Muslims in the UK who may have other heritage, from, for example, India, Afghanistan, Middle Eastern or North African countries or indigenous White converts to Islam. Similarly, in Islam a major distinction is made between Sunni and Shia Muslims, but official statistics provide no data on whether there are different health issues for these two communities.

There is clear evidence in the data presented that health indicators are strongly linked to ethnicity and many authors point to the danger of drawing conclusions about the Muslim community in general when there are many sub-populations that display different characteristics. The section below identifies some of the main sub-population differences but it needs to be recognised that data about many smaller communities of Muslims in the UK is largely missing from this analysis.

2.8.3 Inequalities within the Muslim population

1. Differences between the Bangladeshi and Pakistani communities

Although there are many similarities in the health indicators for the two main communities of Muslims there are also differences. There are differences in lifestyles and in susceptibility to disease, e.g. Bangladeshi men smoke more and have more lung disease. There are also differences in wider determinants, for example

Bangladeshi children, both girls and boys, achieve higher levels of attainment at school.

2. Muslims living in poverty

46% of Muslims live in the 10% most deprived local authority districts and they score lower on many lifestyle indicators as well as on health indicators, for example, school attainment levels are lower and fewer have good employment records.

3. Gender differences

Many female Muslims have different lifestyles and more family responsibilities than males with consequences for their health and wellbeing. For example, they are less likely to take physical exercise and in later life have more poor health than males.

4. Age differences

The age profile of UK Muslims is skewed towards the younger generations: 35% of the Muslim population in Birmingham are children and 4% are over 65. Many of the most serious health concerns are in the over 65 age group and, because of language issues and other cultural concerns, they have more difficulty accessing and accepting medical services.

2.9 Contributing to a green and sustainable future

The Quran states that nature should be respected as part of God's creation and that all Muslims are stewards entrusted as guardians of nature. An analysis⁶¹³ of the Quran found 88 verses in 42 Quranic chapters that referred to environment and environmental health issues including water resource management and sustainability. An assessment⁶¹⁴ of whether UK Muslims are following this spiritual guidance concluded that the answer is both yes and no.

Very little evidence was found for concerns about green and sustainability issues in the Muslim populations that lived in deprived areas. These, the authors concluded, were likely to be inner city areas of dense housing where most green areas were concreted over with little immediate access to green spaces. The people living in these areas demonstrated little concern for green issues, their priorities being dominated by the immediate needs to deal with poor living conditions.

On the positive side, however, the authors identified Muslim led environmental activist groups across the UK and conducted qualitative interviews of seven of them. Two were based in Birmingham: IFEES (Islamic Foundation for Ecology and Environmental Sciences) and MINE (Midlands Islamic Network for the Environment). These organisations campaign for greater awareness of environmental issues in their local Muslim community and, for example, focus on 'Green Mosques, working towards ensuring that Mosques and all their associated activities are committed to sustainability. IFEES has published a handbook⁶¹⁵ called the 'Green Guide for Muslims' which is available as a free download for all Muslims who want to limit the impact of climate change.

3. Conclusion

This report has highlighted the inequalities that exist within the Muslim community within Birmingham, some of which include the higher rates of maternal mortality, lower rates of physical activity (particularly in women), access to medical advice due to language and cultural barriers. The Community Health Profile is to support the council, communities and partners to better understand the inequalities affecting the Muslim community. The multiple factors that have been identified by the report can be used to inform the work to address inequalities across the city.

PROTOTYPE

Appendix

Appendix 1. Topic Search Terms

Getting the best start in life	Mental wellness and balance	Ageing and dying well	Protect and detect	Behavioural and Lifestyle	Wider Determinants
"children" OR "young people" OR "babies" OR "in care" OR "looked after" OR "social services" OR "children's services" OR "social care" OR "school readiness" OR "school exclusion*" OR "school absence*" OR "Education" OR "qualification*" OR "educational attainment" OR "educational achievement" " OR "GCSE" OR "primary school" OR "secondary school*" OR "level 1" OR	mental health" OR "mental illness" OR "depression" OR "anxiety" OR "psychosis" OR "suicide" OR "eating disorder" OR "eating disorders" OR "Bulimia" OR "anorexia" OR "bi-polar" OR "psychiatric" OR "schizophrenia" OR "disabled" OR "Disability" OR "Disabilities" OR "health" OR "mortality" OR "morbidity" OR "chronic" OR "health" OR "long-term" OR "illness" OR "poor health" OR "life	"ageing" OR "dying" OR "palliative" OR "end of life" OR "death" OR "elderly" OR "dementia" OR "Cholesterol" OR "Alzheimer's" OR "blood pressure" OR "care planning" OR "stroke" OR "residential care" OR "care home" OR "care homes" OR "life satisfaction" OR "quality of life" OR "loneliness" OR "isolation" OR "diabetes" OR "diabetic" OR "cardiovascular disease"	"breast" OR "colon" OR "bowel" OR "cervical" OR "screening" OR "prevention" OR "cancer" OR "smear test" OR "AAA" OR "vaccine" OR "vaccination" OR "vaccine hesitancy" OR "immunisation" OR " OR "cancer" OR "screening" OR "vaccination" OR "sexual" OR "sex education" OR "aortic" OR "HIV" OR "AIDS" OR "HPV" OR "transmission" OR "colonoscopy" OR "health	"smoke" OR "smoking" OR "Tobacco" OR "nicotine" OR "alcohol" OR "drinking" OR "substance abuse" OR "substance use" OR "substance misuse" OR "illicit drugs" OR "illegal drug" OR "addiction" OR "addicts" OR "recreational drug" OR "physical activity" OR "exercise" OR "activity rates" OR "sport" OR "Nutrition" OR "food" OR "eating" OR "diet" OR "nutrition" OR "meat" OR "vegetarianism" OR "Vegetarians"	"quality of life" OR "life satisfaction" OR "career" OR "economic activity" OR "employment" OR "unemployment" OR "occupation" OR "income" OR "employed" OR "housing" OR "homeless" OR "homelessness" " OR "housing conditions" OR "home ownership" OR "Education" OR "qualification*" OR OR "educational attainment" OR "educational achievement" OR "GCSE" OR "primary school" OR "secondary

"level 2" OR "level 3" OR "level 4" OR "educational aspirations" OR "school attendance" OR "literacy" OR "numeracy" OR "speech development" "	expectancy" OR "mortality" OR "healthcare" OR "antenatal" OR "maternal" OR "maternity" OR "mother*" OR "live births" OR "still births" OR "infant mortality" OR "life expectancy" OR "weight" OR "obesity" OR "Cholesterol"	OR "heart disease" OR "stroke" OR "cancer" OR "Chronic Obstructive Pulmonary Disease" OR "COPD" OR "Alzheimer's" OR "dementia" OR "blood pressure" OR "psychosocial" OR "weight" OR "obesity" OR "Cholesterol"	assessment" OR "chlamydia" OR "gonorrhoea" OR "genital warts" OR "genital herpes" OR "syphilis" OR "hepatitis" OR "partner violence" OR "domestic violence" OR "domestic abuse" OR "Covid" OR "coronavirus" OR "sexual health" OR "Tuberculosis" " OR "contraceptio n"	OR "Vegan" OR "obesity" OR "overweight" OR eating OR "bulimia" or "anorexia" OR "Calories" OR "BMI"	school*" OR "level 1" OR "level 2" OR "level 3" OR "level 4" OR "educational aspirations" OR "school attendance" OR "literacy" OR "numeracy" OR "speech development" OR "food" OR "eating" OR "diet" OR "nutrition" OR "meat" OR "Vegetarian" OR "Obesity" OR "vegan" OR "calories" OR "halal" OR "BMI" OR "fasting" OR "poverty" OR "deprivation" OR "deprived" OR "islamophobia" OR "Islamophobic" OR "discrimination" OR "hate crime"
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Appendix:

Appendix 18 *Percentage of the population by age and religious affiliation (England and Wales, 2011)*

Religious Group	Percentage of the population aged 0-15 in England and Wales	Percentage of the population aged 16-24 in England and Wales	Percentage of the population aged 25-49 in England and Wales	Percentage of the population aged 50-64 in England and Wales	Percentage of the population aged 65 and over in England and Wales
Muslim	33	15	40	8	4
Christian	12	14	31	21	22
No Religion	23	17	41	13	6
All Religions	19	12	35	18	16

Appendix 19: Resident Population in Birmingham by Religious Affiliation, 2001-2018

Religious Group	Resident Population in Birmingham 2001 (percentage)	Resident Population in Birmingham 2011 (percentage)	Resident Population in Birmingham 2018 (percentage)
Muslim	14	22	27
Christian	59	46	38
No Religion	12	19	30

Appendix 20: Percentage of the population by age and religious affiliation (Birmingham, 2011)

Religious Group	Percentage of the population aged 0-15 in Birmingham	Percentage of the population aged 16-24 in Birmingham	Percentage of the population aged 25-34 in Birmingham	Percentage of the population aged 35-49 in Birmingham	Percentage of the population aged 50-64 in Birmingham	Percentage of the population aged 65 and over in Birmingham
Muslim	37	16	19	18	7	3
Christian	16	12	12	20	19	21
No Religion	23	21	19	21	11	5
All Religions	23	15	15	20	14	13

Appendix 21: Percentage of Muslims Born in UK and outside of UK (Birmingham, 2011)

Percentage of Muslims in Birmingham Born in the UK	Percentage of Muslims in Birmingham Born Abroad	Percentage of Muslims in Birmingham Born in South Asia	Percentage of Muslims in Birmingham Born in the Middle East	Percentage of Muslims in Birmingham Born in Southern/Eastern Africa	Percentage of Muslims in Birmingham Born in and other location
55	45	31	4	5	5

Appendix 22: Percentage of Muslims in Birmingham, by White /minority ethnic background (2011)

Ethnic Background	Percentage of Muslims in Birmingham
White Ethnic Background	2
Minority Ethnic Background	98

Appendix 23: Ethnicity of Muslim Residents in Birmingham (2011)

Ethnicity	Percentage of Muslim Residents in Birmingham
Pakistani	58
Bangladeshi	13
Other Asian	7
Black African	5
Arab	4
Indian	4
Mixed	3
Other black	2
Other	2
White	2

Appendix 24: Children Meeting the Expected Standard of Development in their Foundation Year (2018-19)

Demographic Group	Percentage of Children meeting the expected standard of development in their foundation year
Bangladeshi Girls	75
Bangladeshi Boys	60
Pakistani Girls	72
Pakistani Boys	57
No Free School Meals	73
Free School Meals	55
Birmingham	66
England	71

Appendix 25: School Attainment at Key Stage 2 in England (2018-19)

Demographic Group	Percentage of Children Key stage 2 achieving Reading, Writing and Maths
Bangladeshi Girls	75
Bangladeshi Boys	66
Pakistani Girls	67
Pakistani Boys	58
No Free School Meals	68
Free School Meals	47
Birmingham	62
England	65

Appendix 26: School Attainment at GCSE in England (2018-19)

Demographic Group	Percentage of Children Achieving attainment 8 at GCSE level
Bangladeshi Girls	58
Bangladeshi Boys	53
Pakistani Girls	53
Pakistani Boys	48
No Free School Meals	54
Free School Meals	39
Birmingham	50
England	51

Appendix 27: Children in Birmingham Achieving 5 GCSEs at Grade C or Above (2005)

Demographic Group	Percentage of Children in Birmingham achieving 5 GCSEs at Grade C or above
Bangladeshi Girls (No free school meals)	57
Bangladeshi Girls (Free school meals)	59
Bangladeshi Boys (No free school meals)	49
Bangladeshi Boys (Free school meals)	39
Pakistani Girls (No free school meals)	55
Pakistani Girls (Free school meals)	46
Pakistani Boys (No free school meals)	45
Pakistani Boys (Free school meals)	29
Birmingham (No free School meals)	48

Appendix 28: Percentage of People Engaged in Physical Activity by Location and Religion (2020/21)

Demographic Group	Percentage of people over the age of 16 considered Active	Percentage of people over the age of 16 considered Fairly Active	Percentage of people over the age of 16 considered Inactive
England	60.7	11.6	27.5
Muslim	42.8	14.2	43
Birmingham	67.3	8.8	23.9

Appendix 29. Breast Screening Uptake, by Religion and South Asian Ethnicity, West Midlands (1989-2004)

Demographic Group	Percentage of Breast Screening Uptake in the West Midlands
Muslim	51
Hindu-Gujarati	68
Sikh	65
All Non-South Asian	75
All South Asian	61

Appendix 30. Age-Standardised Proportion of People who received Three COVID-19 Vaccinations (%), by Religious Affiliation

Religion	Page-Standardised percentage who received three Covid-19 vaccinations
Muslim	40.2
Other Religion	59
Buddhist	61
Sikh	62
Religion Not Stated	62.4
No Religion	65
Christian	66.9
Hindu	70
Jewish	70.5

Appendix 31. Percentage of People Living with HIV in England, by Pan-Ethnic Group (2019)

Pan-Ethnic group	Percentage of People Living with HIV in England
Asian	4
Black	35
White	55
Other/Mixed	6

Appendix 32: Age-Standardised COVID-19 Related Mortality Rates, by Sex and Religious Affiliation, England and Wales (per,100,000)

Demographic Group	Age-Standardised Covid-19 related Mortality Rates in England and Wales (per 100,000)
Other Religion or Not Stated (Females)	49.2
Other Religion or Not Stated (Males)	84.2
Sikh (Females)	69.4
Sikh (Males)	128.6
Muslim (Females)	98.2
Muslim (Males)	198.9
Jewish (Females)	94.3
Jewish (Males)	187.9

Hindu (Females)	93.3
Hindu (Males)	154.8
Buddhist (Females)	57.4
Buddhist (Males)	113.5
Christian (Females)	54.6
Christian (Males)	92.6
No Religion (Females)	47.9
No Religion (Males)	80.7

Appendix 33: Life Expectancy at Birth, by Sex and Ethnicity (England and Wales, 2011-2014)

Demographic Group	Life Expectancy at Birth in England and Wales in Years
Bangladeshi (Females)	87.3
Bangladeshi (Sex Gap)	6.2
Pakistani (Females)	84.8
Pakistani (Sex Gap)	2.5
Indian (Females)	85.4
Indian (Sex Gap)	3.1
Asian Other (Females)	86.9
Asian Other (Sex Gap)	2.4
Black Caribbean (Females)	84.6
Black Caribbean (Sex Gap)	3.9
Black Other (Females)	86.8
Black Other (Sex Gap)	4.8
Mixed (Females)	83.1
Mixed (Sex Gap)	3.8
Other (Females)	86.9
Other (Sex Gap)	2.9
White (Females)	83.1
White (Sex Gap)	3.4

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