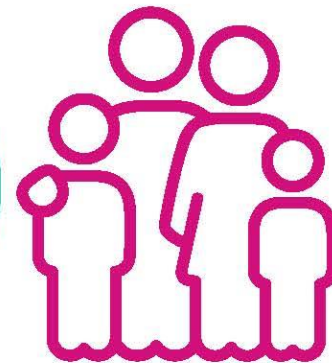




ARAB

COMMUNITY HEALTH PROFILE

2023



A BOLDER HEALTHIER BIRMINGHAM

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Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder	IoD	Indices of Deprivation
A-OHAT	WHO Oral Health Assessment Tool	LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer, and other sexual orientations
ASIR	Arabic-Speaking Immigrants and Refugees	LSOA	Lower Super Output Areas
BCE	Before Common Era (refers to same time period as 'BC')	LTHC	Long-term Health Condition
BMI	Body Mass Index	MBRRACE-UK	Mothers and Babies Reducing Risk Through Audits and Confidential Enquiries
BSOL ICS	Birmingham and Solihull Integrated Care System	MENA	Middle East and North Africa
BTEC	Business and Technology Education Council	MERS-CoV	Middle East Respiratory Syndrome Coronavirus
CAZ	Clean Air Zone	MHCLG	Ministry of Housing, Communities & Local Government
CAZ	Clean Air Zone	MSOA	Middle Super Output Area
CEMACH	Confidential Enquiry into Maternal and Child Deaths	NHS	National Health Service
COPD	Chronic Obstructive Pulmonary Disease	OECD	Organisation for Economic Co-operation and Development
COVID-19	Coronavirus disease	OHID	Office for Health Improvements and Disparities
EU	European Union	ONS	Office for National Statistics
GPPS	GP Patient Survey	PHEBL	Public Health England Birmingham Laboratory
HESA	Higher Education Statistics Agency	TFR	Total Fertility Rate
HPV	Human Papillomavirus	UAE	United Arab Emirates
IMD	Index of Multiple Deprivation	UHI	Urban Heat Island

USA	United States of America
WHO	World Health Organisation
YLL	Yeats of Life Lost

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Community Evidence Summaries

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

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

- To identify and summarise the physical health, mental health, lifestyle behaviour, and wider determinants of health-related issues affecting the specific community 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 ten key priority areas identified in the Health and Wellbeing Strategy for Birmingham 2022 to 2030.
 - 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.
- To empower communities, by providing them with a summary of health inequalities, which can be used to advocate for change across local systems to improve outcomes.

Executive Summary

The Arab Community Health Profile identifies and summarises the national and local evidence concerning the health, lifestyle behaviours and wider determinants of health that affect the Arab community. Although the focus of this report is health inequalities among the Arab community in Birmingham, the limited available information on health inequalities has resulted in data being used from the West Midlands, the UK and internationally where available.

There is limited data for the “Arab” ethnic category used in the census, which makes it difficult to get a clear picture of the health status and of the potential inequalities that UK Arabs may be experiencing. There is, however, information about Arabs from individual countries. Moreover, the majority of UK Arabs follow the Muslim faith. Where data is unavailable for Arabs in the UK on religious beliefs and practices, data on Muslims has been extracted. However, this is presented with suitable caveats because most research studies have sampled primarily South Asian Muslims; hence generalisations may not be accurate.

This report covers health topics throughout the life course from maternity to ageing and dying well and includes chronic health conditions such as diabetes. The report also covers protect and detect topics such as screening and vaccinations, as well as other themes such as knowledge and understanding of health issues affecting the Arab community.

There are long-standing health inequalities between different community groups across the UK, some of which have been exacerbated by the

Coronavirus pandemic. This Community Health Profile aims to unpack some of these issues, with a focus on the Arab community.

Much of the data for examining health outcomes in this profile has been taken from open-source research and health records. It is worth noting that the sample sizes, coverage, and quality for some studies are imperfect. The picture is complex not only between different community groups but also across different conditions. Understanding and knowledge is also limited by a lack of good quality data. This health profile aims to highlight the available health data and the current gaps in our knowledge and understanding.

Arab Community in the UK

Arab migration to the UK predominantly took place after the Second World War.⁽¹⁾ However, the British colonisation of some parts of the Arab world meant that some Arabs came and settled in Britain far earlier, for example, the Syrian and Yemenis merchants in South Wales, Sheffield, Manchester and elsewhere.⁽²⁾ Many of the earliest Arabs who lived, worked, or settled in Britain were merchants and traders from Syria or lascars from Yemen who laboured on the trade ships of the British East India Company.⁽³⁾

The end of the Second World War brought about several migratory waves^(1, 4), including:

- In the 1940s, mainly from Egypt
- In the 1960s, mainly from Egypt and Morocco and for employment opportunities e.g., hospitality, industry, ports, and shipping
- In the 1970s, mainly from the Gulf States and mainly for business opportunities because of the growth of the oil industry

- In the 1980s, mainly from Iraq as political refugees and asylum seekers

In the 2021 UK census, Arab people made up 1.1% of the population of England and Wales (644,232).(5) In the 2021 census, in Birmingham, 44,816 individuals identified as Arab, representing 4.1% of the local population. Within Birmingham, the community is primarily concentrated in Balsall Heath West (15.1% Arab population), Sparkbrook & Balsall Heath East (8.2%), and Bordesley & Highgate (5.6%).(6)

The Arab community in Birmingham is predominantly young: 45% of Arabs were 25 years old or younger (29% of the population of Arabs in England and Wales), 5% of the Arab population was over 65 compared with 19% of the overall population.(7, 8)

People from the Arab nations made up 31% of all asylum seekers to the UK in 2021 (15,264), the largest numbers coming from Iraq, Syria, Sudan and Somalia, countries with armed conflicts, civil unrest, and widespread deprivation.(9)

The key health inequalities identified within this Arab Community Health Profile include:

Getting the Best Start in Life

- From 2000 to 2019, women from MENA (Middle East and North Africa) countries were identified at being at increased risk of gestational diabetes (13% prevalence) compared with the England average (5%).(10)
- The prevalence of obesity and overweight in the Middle East and North Africa for young people aged 20 and under in 2013 was 23% for males and 28% for females.(11)
- Oral health is a major public health concern in Arab countries. In one 2020 study from Saudi Arabia, 80% (n=384) of school-aged children had teeth in poor condition.(12)
- A high proportion of unaccompanied asylum-seeking children come from Arab countries, and they have poor physical and mental health due to their traumatic experiences and lack of support in the UK.(13, 14, 15, 16, 17, 18, 19)

Mental Wellness and Balance

- From 2010 to 2013, Arabs accounted for 28% of admissions among ethnic minority groups to psychiatric wards in North-West London for attempted suicide or self-harm.(20)
- In a 2013 cross-sectional study, UK Arabs were less likely to seek professional help with mental health issues than the White British population.(21)
- In a 2021 cross sectional study of 132,597 UK adults, 18% were identified as regular smokers. Smoking prevalence was higher among Arab/Other ethnic group (20%).(22)

- Waterpipe (shisha) smoking is popular among many Arab countries, with shisha smoking most common in Lebanon (15%), Syria (12%) and the Gulf States (from 4% to 12%).(23)
- Semi-structured interviews with 13 Libyan women in the UK from 2012 to 2013 revealed that 54% (n=7) reported they had been subjected to physical and verbal abuse.(24)
- Hate crime against Muslims, including Arab Muslims, grew considerably after the 9/11 and 7/7 terrorist attacks.(25)

Healthy and Affordable Food

- Vitamin D deficiency levels were high amongst Arab women in western countries who wore veils and did not take vitamin supplements.(26)
- There are no statistics on the prevalence of obesity specifically looking at the UK Arab community, data from Arab countries in 2011 suggested overweight and obesity prevalence to range from 25% to 38% in men and 28% to 83% in women.(27)

Active at Every Age and Ability

- Sport England's Active Lives Survey (2016 to 2018) showed that 52% of people of Arab ethnicity were physically active (150+ mins/week) compared with 62% of all adults in England. Consequently, rates of physical inactivity (less than 30 mins/week) among the Arab population (35%) were higher than people from other ethnic groups, including White (25%), Black (29%), Asian/any other Asian (32%) groups (28)

Living, Working and Learning Well

- In Birmingham, according to the 2021 census, 46% of Arabs were economically active compared with 56% of the local population.(29)
- Roughly half (51%) of the Arab ethnic group population in Birmingham live in the 10% most deprived middle super output areas (MSOAs) nationally, compared with 34% of the White British population.(30)
- The English indices of deprivation (IoD) 2019 also reported on experiences of seven domains of deprivation. It was reported that 18% of Arabs in England lived in the top 10% of income-deprived neighbourhoods compared with 10% of the general population of England.(30)
- The 2017 to 2018 English Housing Survey reported that 17% (n=14,000) of households of Arab origin were homeowners compared with 63% of all households.(31)
- In the 2022 GP Patient Survey (GPPS), only 34% of Arabs in England rated their experience with their GP as 'very good' compared with 40% of the White British population.(32)

Protect and Detect

- 28% of the Arab population in Birmingham in the 65 to 80 and over age range had received the booster dose of the COVID-19 vaccine by December 2021 compared with 87% of the White British population in Birmingham.(33)

Ageing and Dying Well

- According to the EQ-5D index, Arab men (0.71) and women (0.60) in England aged over 55 years of age experienced worse health than

White British men (0.77) and women (0.75). The Arab population were identified as one of the ethnic minorities experiencing the greatest health inequalities.(34)

Green and Sustainable Future

- Balsall Heath West ward contains a high proportion of residents of Arab ethnicity (15%), this ward was classified as the ward with the least environmental justice for its citizens.(35)
- Approximately 15% of people from the Arab ethnic group live in the 15 most polluted MSOAs in Birmingham, compared with 5.4% of the White British population.(30)

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Methodology

An exploratory search was undertaken using a range of national data (e.g., NOMIS, Office for National Statistics (ONS), NHS), electronic databases such as Scopus and PubMed, and generic Google searches to identify information on the Arab community in the UK for this profile. Keyword search terms and subject headings relevant to the themes were identified.

The following avenues were examined:

a. National data sources

NOMIS data:

Data has been extracted by ethnicity from the ONS for the [2021 census](#); data from the 2011 census has only been used as a comparison and/or where 2021 data were not available. Any conclusions based on historical data or information should be considered with caution. The relevant ethnicity category in the 2021 census which has been included in analysis within this report is the 'Other ethnic group: Arab'. In This report, people of 'White: English, Welsh, Scottish, Northern Irish or British' ethnicity are referred to as White British.

National public health, NHS Digital and other government data sources (ons.gov.uk and gov.uk):

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

National voluntary and community sector reports:

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

- [Council for Arab-British Understanding](#)
- [World Health Organisation](#) (WHO)

b. Academic Database Search

In addition, searches on [Scopus](#) and [PubMed](#) were performed. All searches contained the keywords "Arab" as well as terms related to Arabic-speaking countries and nationalities including Middle East, Algeria, Bahrain, the Comoros Islands, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Mauritania, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, the United Arab Emirates (UAE), and Yemen, and keywords related to specific topic themes. Examples of these are included in this Search Strategy (**Appendix 1: Search Strategy**).

c. Grey Literature

Further searching through Google and Google Scholar using topic-specific search terms was also carried out. Resources relevant to the UK were included, e.g., data and information from local or national-level reports and/or surveys.

d. Data consolidation and analysis

Findings from systematic reviews and large-scale epidemiological, and qualitative research studies were also considered for inclusion.

In addition, "snowballing", a technique where additional relevant research studies are identified from the reference list, and citations of the initial search or published article was also applied. Additional papers were

identified from reference lists using this approach, where these additional resources enhanced the knowledge base. Generally, searches were limited to literature from the last 20 years.

The authors reviewed results from the initial searches against the inclusion and exclusion criteria. The team used a 'concept table' to frame the theme and identify search keywords. The articles utilised in this document were then analysed, identified, and cross-referenced with other themes throughout the profile. All resources utilised have also been reviewed against the inclusion and exclusion criteria (**Appendix 2: Exclusion and Inclusion Criteria**). International research findings were included if they were comparable or relevant to the national population.

e. Caveats and Limitations

There is a paucity of data on the Arab population in the UK and Birmingham. Data is often available for people who are not categorised as Arabs but have come to the UK from specific Arab nations and is presented as such in the profile. Many national datasets by ethnicity include an 'Arab' category under 'any other ethnic group', but this does not present outcomes specifically for the Arab community.

Additionally, methodology and ethnicity categories vary depending on which source of health data have been utilised. This inconsistency in data collection can lead to multiple different conclusions being drawn from the same data, creating challenges when interpreting data within this report for healthcare and policy decisions.

The Arab population comprises a heterogenous mix of people with links in different countries across the 'Arab world'. Many British Arabs may not

define themselves under the ethnic category of Arab, instead choosing other ethnic categories and writing in their Arab affiliation.

Where data is unavailable on this population in Birmingham or the West Midlands, the focus has been broadened to the UK context or the broader international context – because UK and British Arabs come from countries of the Middle East and North Africa.

The majority of UK Arabs follow the Muslim faith. Where data is unavailable for Arabs in the UK on religious beliefs and practices, data on Muslims has been extracted. However, this is presented with suitable caveats because most research studies have sampled primarily South Asian Muslims; hence generalisations may not be accurate.

In **sections 2.5.4 and 2.8**, in the absence of much data on deprivation and green and sustainable futures respectively, ward-level deprivation and environmental data have been used to make assumptions about the experiences of people living in that area; this information should be interpreted with caution.

f. Statistics

This report draws on evidence from a variety of research studies with different methodologies and results. Data throughout this report have been presented to two significant figures where possible; proportions may not add up to 100% due to rounding.

Below, is a brief overview of some key statistical terms to aid in interpretation of the findings.

Odds ratio (OR): Indicates the likelihood of an outcome or event occurring in one group compared with another. An OR of greater than one means

there is an increased likelihood compared with the reference group; an OR of less than one means there is a decreased likelihood.

Confidence interval (CI): Indicates the level of uncertainty around an estimate (e.g., a percentage or an OR) taken from a sample of a population. 95% CIs are calculated so that if samples were repeated taken from the same population, 95% of the time the true value would lie between the upper and lower bound of the CI. If the CIs surrounding two estimates overlap, there is no statistically significant difference between these estimates.

In this report, “n” is used to represent the numerator of a percentage (e.g., the number of people with the event of interest) and “N” is used to represent the denominator (e.g., the population from which the numerator was drawn).

1. Introduction

1.1 Overview

1.1.1 Defining the Population

The term “Arab” describes a cultural and linguistic group of people who speak Arabic and, to an extent, have a shared culture and history. Records of Arabs begin with the earliest traces of the Old Arabic language in the 9th century Before Common Era (BCE). It is believed that Arab peoples began settling in the Syrian desert, later migrating to the Arabian Peninsula and North and Lower Mesopotamia.(36, 37)

Nowadays, the term “Arab” relates to a large number and variety of groups and peoples natively descended from territories of the Arab world, encompassing territories that were claimed during early Muslim conquests in the 7th and 8th centuries BCE.(38)

From 1516 to 1918, most Arab territories became part of the Ottoman Empire bordering Europe and Asia.(39) The First World War, however, brought the end of the Ottoman Empire, and with it, a wave of migratory movements began.(40) European colonialism of some of the Arab world began in the late 18th century.(41) Muslims of the Middle East were annexed in the aggressive efforts of the colonialists, which were reduced to dependent blocs by Europe’s most potent powers at the time: Britain, France, Italy, and Germany.

In the modern day, the Arab world can be divided into 22 states encompassing some 456.5 million people.(42) The 22 countries, known as

the ‘Arab League’ which was formed in 1945, include: Algeria, Bahrain, the Comoros Islands, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Mauritania, Oman, Palestine, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, the United Arab Emirates (UAE), and Yemen (

Figure 1). The term MENA is popularly used by academic, economic, social, and international organisations to group countries of the Arab world.(43)

Figure 1: Map of Arabic-speaking Countries



Source: World Atlas, 2018 (44)

The Arab Spring refers to a wave of pro-democracy/anti-government protests and uprisings across the Arab world, beginning in 2010.(45) The Arab Spring led to the overthrowing of long-standing authoritarian regimes in several countries in a call to end mass poverty, corruption, repression, and injustice. Significant social and political upheaval in these countries has

also led to civil wars (e.g., in Libya, Syria, Somalia, Sudan and Yemen) and armed conflicts that forced millions of people to become displaced. In 2021, the UN Refugee Agency estimates that around 16 million people from Arab countries had been forcibly displaced and made stateless.(46)

This report has focused on datasets where ‘Arab’ has been defined as an ethnic group, such as in the 2021 census. Where ‘Arab’ was not included as a self-defined identity, data has been extracted from Arab countries, or used the Muslim faith as an approximate (with caveats).

The current profile will not focus on Arab Somalis, please refer to the [Somali Community Health Profile](#) for an in-depth profile on the Somali community.

1.1.2 Culture and Influence on Health

The Arab identity is typically based on an affiliation with the Arabic language.(47) Arab culture is heterogeneous, comprising diverse countries with different social practices, permissible dress codes, political regimes, and economies. For example, countries such as Saudi Arabia and Kuwait are ‘high-income economies’ whilst Sudan and Somalia are ‘low-income economies’.(48) Political regimes range from parliamentary republics (e.g., Algeria, Lebanon, Egypt), traditional monarchies (e.g., Qatar and Saudi Arabia), and constitutional monarchies (e.g., Jordan and Morocco).(49)

Nonetheless, Arabs share central parts of their culture encompassing language, religion, social norms, political outlooks, and shared cultural practices.(50, 51) Islam, for example, is central to Arab culture and major Muslim festivals such as Eid al-Fitr and Eid al-Adha are celebrated. Alcohol is banned in most Arab states (*see section 2.2.2* for more on alcohol consumption), and Arab Muslims eat “halal” food (that means “lawful” or

“permitted”) and do not eat pork. Arabs place an essential emphasis on gendered roles and relations, modesty, honour, and personal hygiene, as well as on family values, hospitality, and respect. (50, 51) The religious identity of those self-identifying as ‘Arab’ by ethnicity can be seen in *section Religion*.

The position of women is heavily prescribed in most Arab countries, where they are often regarded as less advantaged socially, politically, legally, and/or economically compared with their male counterparts and to women in Western countries (although this varies across Arab states).(49, 52)

The Arab world is rich in its cultural and natural heritage, reflecting diverse values and features and spanning various periods from prehistory to the modern era.(53)

1.2 Migration Patterns

1.2.1 Global Migration Patterns

There are vast socio-economic differences between richer and poorer Arab nations, which has led to a considerable movement of migrant workers within the Arab world and other rich countries worldwide.(54) Within the Arab world, most workers move from poorer states to the rich Gulf states such as Qatar, Bahrain, and the UAE, to send back money to support their families. Socio-political unrest in Arab regions has also been a primary cause of migration producing myriads of refugees and asylum seekers. In 2019, it was estimated that Arab regions hosted around 40 million migrants, of which 9.3 million were refugees and asylum seekers.(55)

Of an estimated population of 13 million Arab migrants in 2000, 45% (5.8 million) lived in the Arab world, and the rest lived outside the Arab region. Most of those living outside Arab regions lived in Europe, and some 60% lived in the developed market economies of the Organisation for Economic Co-operation and Development (OECD) member countries. Around half of Arab migrants in OECD countries lived in France (48%), followed by the USA (12%).(56)

1.2.2 Migration to the UK

Arab migration to the UK predominantly took place after the Second World War.(1) However, the British colonisation of some parts of the Arab world meant that some Arabs came and settled in Britain far earlier, for example, the Syrian and Yemenis merchants in South Wales, Sheffield, Manchester and elsewhere.(2) Many of the earliest Arabs who lived, worked, or settled in Britain were merchants and traders from Syria or lascars from Yemen who laboured on the trade ships of the British East India Company.(3)

The end of the Second World War brought about several migratory waves, including:(1, 4)

- In the 1940s, mainly from Egypt
- In the 1960s, mainly from Egypt and Morocco and for employment opportunities e.g., hospitality, industry, ports, and shipping
- In the 1970s, mainly from the Gulf States and mainly for business opportunities because of the growth of the oil industry
- In the 1980s, mainly from Iraq as political refugees and asylum seekers

The 2021 census provided insight on migration to the UK of Arabs by mapping the country of birth from 19 of the Arab countries. Overall, in 2021 there were 552,683 people in England and Wales who noted their country of birth as an Arab country, with Somali (n=108,921) and Iraq (n=89,394) being the most common (Table 1).(57)

Table 1: Migration to the UK from Arab League countries: England and Wales, 2021

Country of Birth	Population (England and Wales)
Somalia	108,921
Iraq	89,394
Egypt	43,516
Syria	42,875
Sudan	37,393
Morocco	32,646
Saudi Arabia	31,386
Algeria	29,845
UAE	22,611
Kuwait	22,177
Lebanon	19,885
Yemen	19,269
Libya	17,800
Jordan	8,575
Tunisia	8,057
Bahrain	6,102
Occupied Palestinian Territories	4,621
Oman	4,099
Qatar	3,511

Source: ONS, 2023 (57)

According to the latest census data (2021), most people who declared being of the ethnic category “Arab” live in London (42%), followed by the North-West (13%).(58) The West Midlands includes 9.6% of the total Arab population in England and Wales.(50)

Socio-political unrest in Arab countries has led to large proportions of Arab people coming to the UK as refugees and asylum seekers. According to statistics from the Home Office, asylum seekers from 22 Arab countries constituted 31% (n=15,264) of all asylum applications (N=50,042) in 2021.(9) Iraq, Syria, and Sudan were amongst the most common ten countries of origin for all asylum applications in the UK. **Table 2** outlines the most common Arab countries applying for asylum in 2021.

Table 2: Number of asylum applications lodged by nationality: UK, 2021

Nationality	2021 Asylum Applications
Iraq	6,163
Syria	3,389
Sudan	2,324
Somalia	670
Kuwait	564

Source: Home Office, 2022 (9)

An analysis from the Migration Observatory showed that the decision to grant asylum varied for people seeking asylum from Arab countries.(59) For example, most people from Syria (99%) and Sudan (96%) were granted asylum in 2021 compared with less than half of people from Iraq (47%). Their analysis also illustrates that many refugees who settled in the UK between 2010 and 2021 were citizens from Middle Eastern countries (76%) and sub-Saharan African countries (17%). This included resettled refugees from Syria (68%), Iraq (7%), Somalia (6%) and Sudan (4%).(49)

The variance of events which have resulted in Arabs migrating to the UK can be observed in the 2021 census by investigating ‘year of arrival’ in the

UK. Within the Arab ethnic group, 30% were born in the UK and 40% arrived in the UK from 2011 to 2021 (Table 3).(60)

Table 3: Migration of the Arab ethnic group to the UK by year of arrival: England and Wales, 2021

Year of Arrival in the UK	Arab (Observation)	Arab (%)
Born in the UK	97,925	30
Arrived before 1991	23,075	7
Arrived 1991 to 2000	29,772	9
Arrived 2001 to 2010	46,903	14
Arrived 2011 to 2021	134,170	40

Source: ONS, 2023 (60)

The UK is home to several Arab organisations whose mission is to meet the needs of the Arab community and to promote awareness and understanding of the community. These include the Arab British Centre and the Council for Arab-British Understanding, as well as local organisations in cities across the UK. The Arab British Centre Library is a public borrowing library which houses a wealth of English-language resources about the Arab community.

1.2.3 Migration to the West Midlands

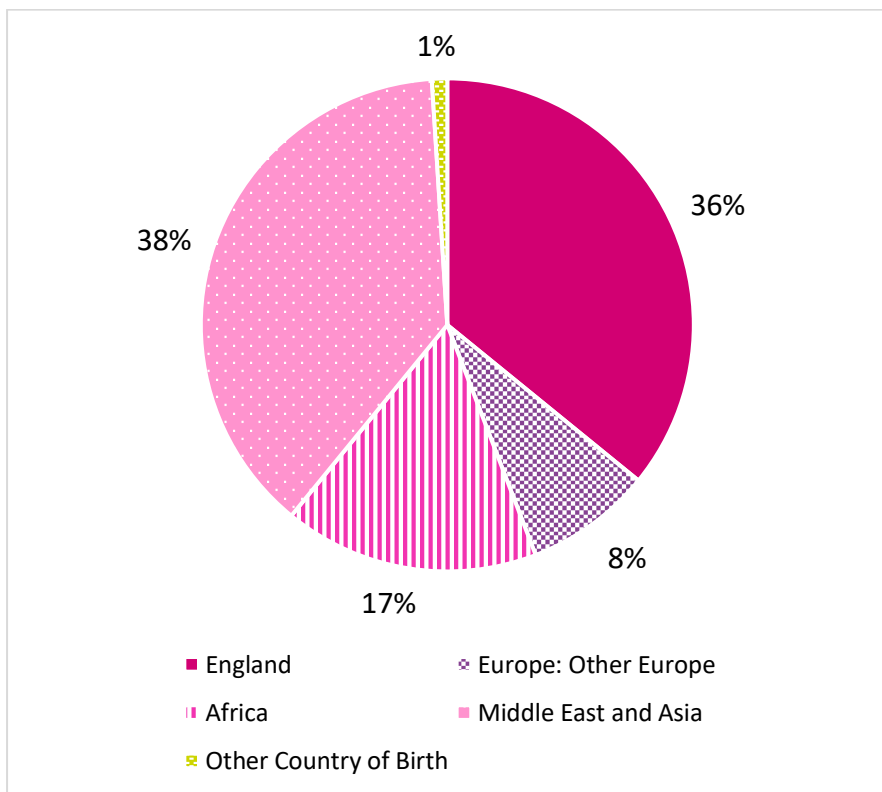
According to the 2021 census, the West Midlands has the third largest population of Arabs by region in the UK (9.6%) comprising around 31,790 people.(5, 58) Furthermore, at the end of March 2022, there were 7,005 asylum seekers in receipt of support in the West Midlands, a third (33%) of whom were from Arab countries.(9) The largest group of asylum seekers receiving support were from Iraq (1,489 individuals).

The Museum of Islamic Arts & Heritage, commissioned by the Arab British Centre, is currently undertaking a project to collect oral histories of Arab communities in the West Midlands and Birmingham through its ‘People, Places, Traces’ project.(61, 62)

1.2.4 Migration to Birmingham

The distribution of country of birth in Birmingham among the Arab ethnic group was similar to that in England and Wales. Overall, 36% (n=6,854) of Arabs in Birmingham in 2021 reported being born in the UK, slightly higher than in England and Wales (see section 1.2.2). Additionally, 38% were born in the Middle East and Asia, and 17% were born in Africa (Figure 2, see Appendix 5.1. Figure 2: Country of birth among Arab ethnic group: Birmingham, 2021 for data table). Specific country of birth by ethnic group data is not currently available from the 2021 census.(63)

Figure 2: Country of birth among Arab ethnic group: Birmingham, 2021



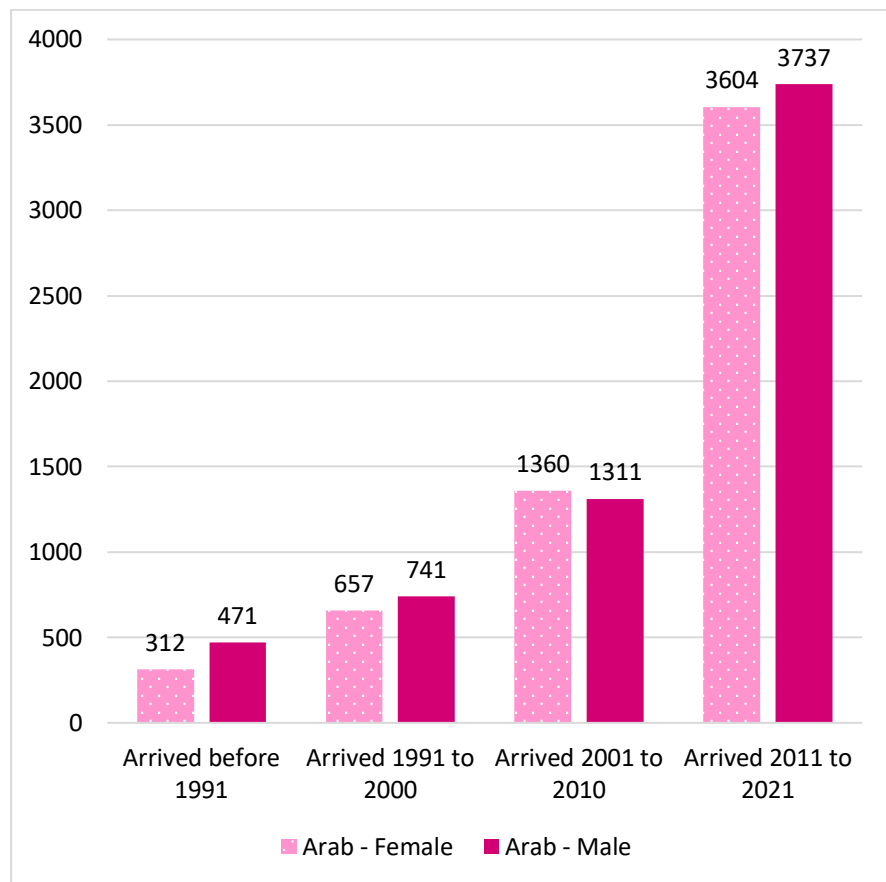
Source: ONS, 2023 (63)

The Yemeni community has the most extended history in the city.(64) In the second half of the 20th century, Arab communities from various countries came to the UK, including Egypt, Syria, Sudan, Somalia, Iraq, Algeria and Morocco, for reasons including study, opportunities and work, and sanctuary. Some 4,000 to 5,000 Sudanese people reside in Birmingham and the wider West Midlands region.(65)

Among the Arab ethnic group in 2021 who were not born in the UK in Birmingham, 60% (n=7,341) noted their year of arrival to the UK as between 2011 and 2021. Within the Arab migrant population to the UK, data on migration by sex is also available. Migration trends typically showed a relatively even split between male and female Arab migrants, with male migrants slightly outnumbering female migrants in the most recent migration period from 2011 to 2021 (Figure 3, see Source: ONS, 2023

Appendix 5.2. Figure 3: Arrival of 'Other ethnic group: Arab' population to the UK by sex: Birmingham, 2021 for data table).(66)

Figure 3: Arrival of ‘Other ethnic group: Arab’ population to the UK by sex: Birmingham, 2021



Source: ONS, 2023 (66)

Some organisations in Birmingham are established to support Arab (and Muslim) communities. These include the Amanah Masjid (the Muath Trust)

established in 1990 by the British Yemeni community; Saint Mary and Saint Mark Coptic Orthodox Centre, offering religious services and community activities for the Egyptian community; and the Birmingham Libyan School (community school offering courses in Arabic).(67)

1.3 Language and Literacy

1.3.1 Arabic Language

The Arabic language first emerged in the northwest of the Arabian Peninsula and dates back to the 8th century BCE.(68) There are more than 300 million Arabic speakers in the world, and Arabic is the official language of the 22 countries that form the Arab League.(69)

The Arabic language connects the Arabic identity and community regardless of race, religion, or region and is central to the identity of many British Arabs.(40, 70) Arabic is also highly valued as the language of the Qur’an, the holy book of Islam, which was revealed in Arabic. The main Arabic dialects include Gulf, Iraqi, Egyptian, Maghrebi and Levantine.(71)

The Colonial past of North Africa and the Arabian Peninsula has resulted in inherited colonial languages, e.g., French in Morocco, Lebanon, and Algeria and English in Lebanon and Jordan.(72)

According to the 2021 Census, 0.4% of the national population in England speaks Arabic as a main language.(73) This figure is much higher for the population of Birmingham, where Arabic is the fourth most common household language and is spoken by 1.2% of the local population as a main language (12,758 people aged 3 and over).(74) The census did not report on the total number of Arabic language speakers.

1.3.2 English Proficiency

The 2021 census reported on how well different population groups could speak English (English or Welsh in Wales). Among the Arab ethnic group in Birmingham, 54% (n=9,860) reported English as their main language and 33% (n=5,942) had English as an additional language that they reported to speak 'well or very well'. This compares to 84% of people across Birmingham who reported English as a first language, and 11% with English as an additional language that could speak English 'well or very well'.(75)

Additionally, 11% (n=1,936) of the Arab ethnic group in Birmingham reported that they could not speak English well, and 2% (n=442) could not speak English at all; compared with the Birmingham average of 4% and 1% respectively.(75)

1.4 Religion

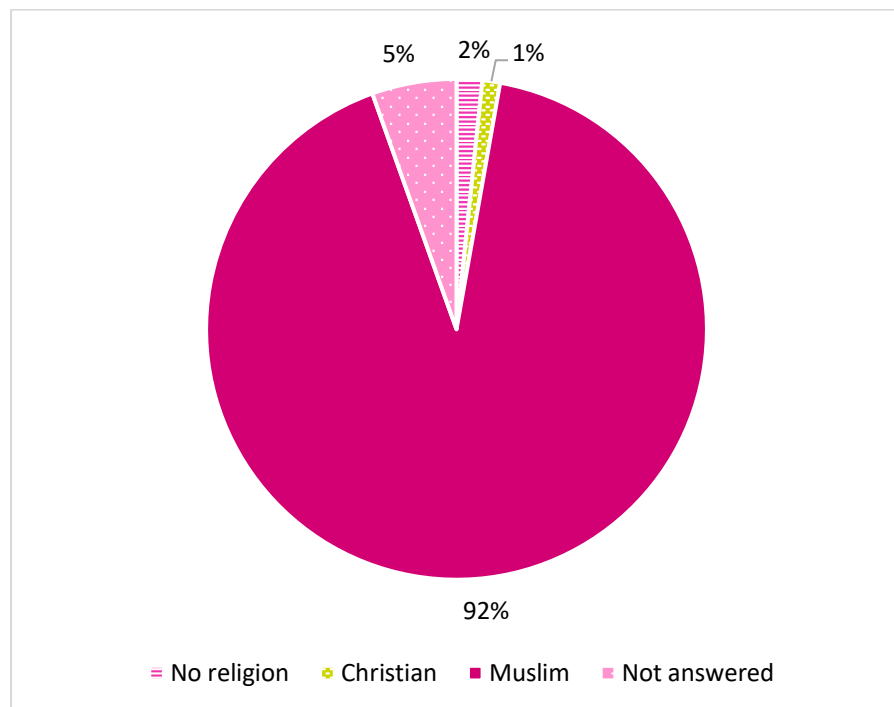
Religion plays a central role in Arab culture. The Arab world includes Muslims, Jews and Christians of different faiths and sects, although most Arab countries declare Islam their state religion.(49)**Error! Bookmark not defined.** Conversely, Arabs comprise around 15% to 18% of the Muslim world. The Qur'an, the central religious text of Islam, is also written in Arabic, which is seen as a central tenet of Arab identity by many British Arabs.(70)

In the UK, according to the 2021 census, the vast majority of Arabs in England and Wales identify as Muslim (84%), followed by no religious affiliation (5%), with a minority declaring Christian faith (4%). Similar figures are found in Birmingham, where the percentage of Arabs identifying as Muslims are higher than the national figure (92%); the Arab

Christian community represents 1% and the non-religious community 2% (Figure 4, see Source: ONS, 2023)

Appendix 5.3. Figure 4: Religious beliefs breakdown by Arab ethnicity: Birmingham, 2021 for data table). Conversely, Arabs comprised only 5% of all Muslims in Birmingham and around 7% nationally.(76)

Figure 4: Religious beliefs breakdown by Arab ethnicity: Birmingham, 2021



Source: ONS, 2023 (76)

1.5 Demographics

1.5.1 Population Size

When counting the Arab population nationally and in Birmingham in the census, the issue of how people identify in pre-existing ethnic classifications is essential. While some Arabs may identify according to the ethnic category ‘Arab’, others may identify under other pan-ethnic groupings, such as Asian, Black, or White (noting their specific affiliation in the open text box). The data below captures people who identified themselves as the ethnic category ‘Arab’ and under other ethnic categories who are affiliated with Arab countries.

In 2021, Arab people made up 1.1% of the total population in England and Wales (637,217 individuals); this included 0.6% (n=331,844) of whom chose the ‘Other ethnic group: Arab’ ethnic category and 0.3% (n=150,649) who identified as ‘Black African Somali’.(5)

Birmingham has a relatively large proportion of Arabs compared with England and Wales. In 2021, 46,391 people in Birmingham identified as Arab (either as an ethnic category or associated with an Arab country), comprising 4.1% of the local population (Table 4). To simplify data, similar ethnic groups have been grouped together e.g., ‘Other ethnic group: Arab’ and ‘Mixed or Multiple ethnic groups: Arab’ have been presented as ‘Arab’ ethnic group.(5)

Table 4: Ethnic groups associated with various Arab populations: Birmingham, 2021

Ethnic Group	Count	Proportion of Birmingham population (%)
Arab	20,485	1.8
Somali	21,584	1.9
Sudanese	1,678	0.1
Other Middle Eastern	1,684	0.1
Other North African	572	<0.1
Moroccan	317	<0.1
Algerian	71	<0.1

Source: ONS, 2023 (5)

Of these, 1.7% (n=19,196) identified as ‘Other ethnic group: Arab’ and 1.5% (n=16,971) identified as ‘Black African: Somali’. The remaining people with affiliations to Arab countries identified themselves under a variety of ethnic categories comprising less than 0.3% of the local population.(5) A full list of the ethnic groups included in the above data can be seen in

Source: ONS, 2023

Appendix 5.4. Table 4: Ethnic groups associated with various Arab populations: Birmingham, 2021

The Arab population in Birmingham has grown by 2% in the last decade. According to the 2011 Census, Arabs and people affiliating with Arab countries comprised 1.7% of the local population (1% of whom ticked the Arab ethnic category).

According to the 2021 Census, among Birmingham wards, Balsall Heath West hosts the largest proportion of population from Arab origin (15.1% of the population self-identify as Arab ethnicity), as seen by **Table 5** and **Figure 5.6**. This is followed by Sparkbrook and Balsall Heath East (8.2% Arab population) and Bordesley and Highgate (5.6% Arab population). The largest Arab population by population numbers can be found in Sparkbrook & Balsall Heath East (2,238).

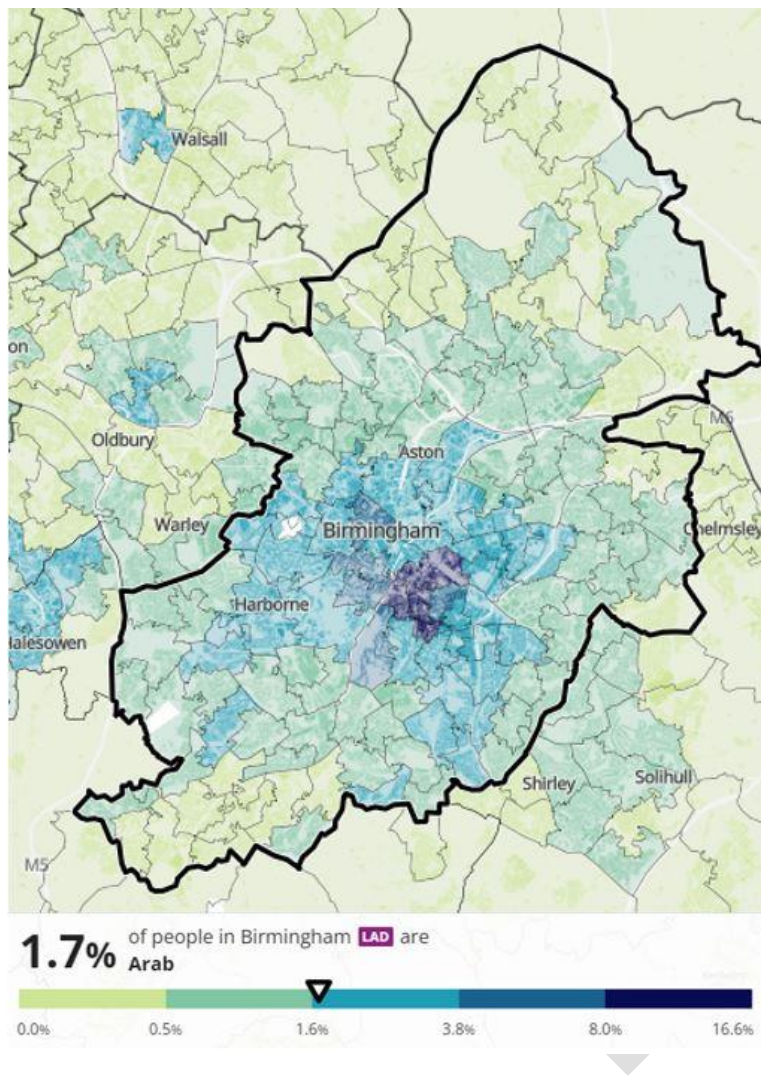
Table 5: Distribution of Arab populations by ward level ethnicity data: Birmingham, 2021

Wards	Total Ward Population	Arab Population	Arab Population (% of Ward)
Sparkbrook & Balsall Heath East	27,328	2,238	8.2
Balsall Heath West	12,153	1,835	15.1
Ladywood	25,738	1,011	3.9
Bordesley & Highgate	15,054	842	5.6
Small Heath	21,969	668	3.0
Moseley	21,840	631	2.9
Edgbaston	18,728	628	3.4

Wards	Total Ward Population	Arab Population	Arab Population (% of Ward)
Sparkhill	21,461	582	2.7
Bordesley Green	12,984	518	4.0
Harborne	23,002	501	2.2
North Edgbaston	23,006	434	1.9
Weoley & Selly Oak	23,519	431	1.8
Hall Green North	24,562	422	1.7
Nechells	16,146	416	2.6

Source: ONS, 2023 (6)

Figure 5: Map of Arab population distribution: Birmingham, 2021



Source: ONS, 2023

1.5.2 Sex Profile

According to the 2021 Census, the proportion of males is larger than that of females in the Arab population. In England and Wales, 53% of the Arab community were men, and 47% were women.(8) In Birmingham, the Census 2021 revealed that the sex distribution of Arab community was slightly more evenly distributed, with 51% being men and 49% being women.

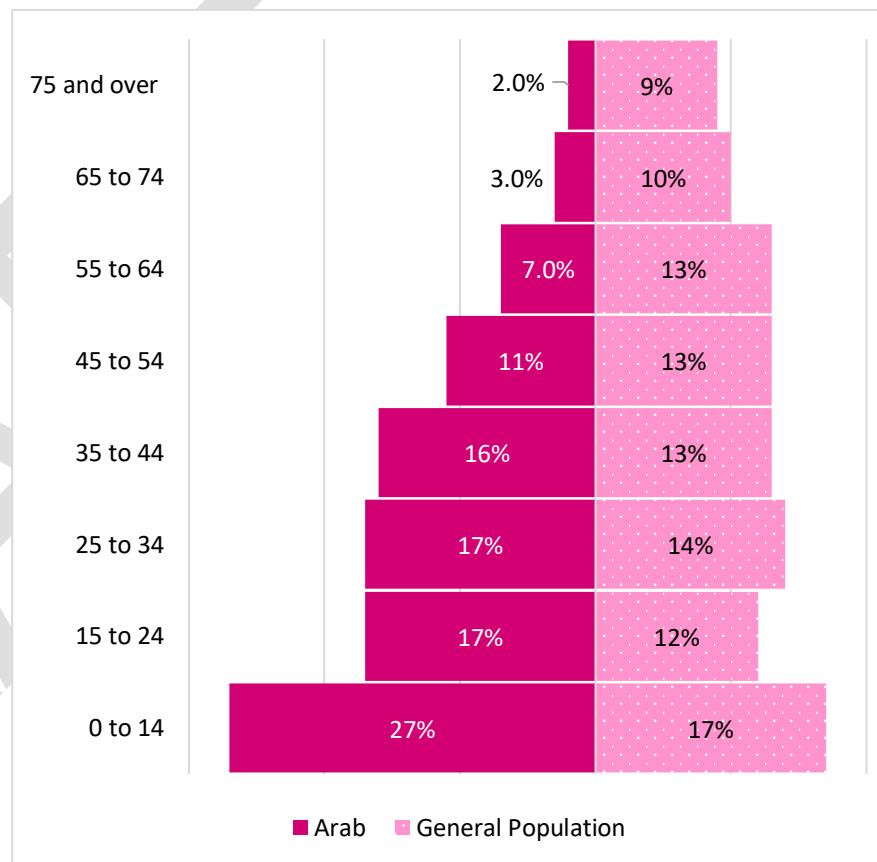
1.5.3 Age Profile

Individuals of Arab origin are generally younger than the general population and compared with many other ethnic groups. According to the 2021 Census, 44% of Arabs were aged 25 and under compared with 29% of the general population in England and Wales; this includes 27% of Arabs aged 0 to 14 compared with 17% of the general population (

Figure 6, see Source: ONS, 2023

Appendix 5.5. Figure 5: Age Breakdown for Arabs and General Population England and Wales (2021) for data table).(7, 8) Conversely, 5% of Arabs were aged 65 and over compared with 19% of the national population (as shown in the 2021 Census).

Figure 6: Age profile of Arabs and the general population: England and Wales, 2021



Source: ONS, 2023 (7, 8)

In Birmingham, the age profile of the Arab population is even younger. In 2021, a third of Arabs in Birmingham were aged 14 and under (34%) compared with a fifth of the local population (21%).(7, 8) Over half (53%)

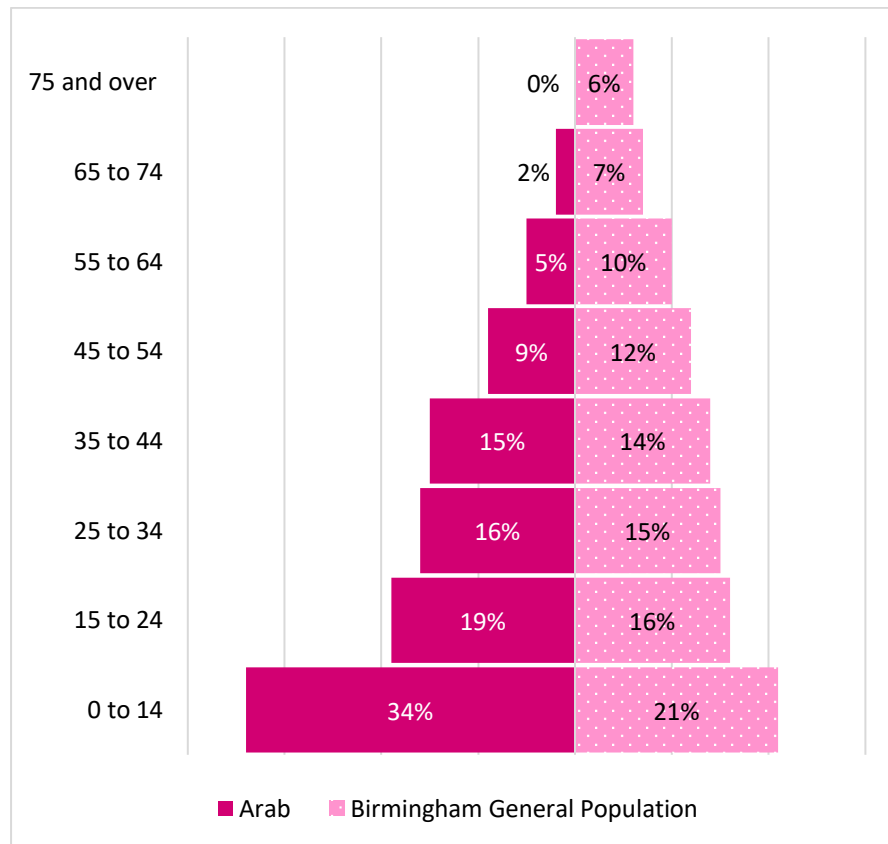
of Arabs in Birmingham were aged 25 and under, compared with 37% of the local population. Only 2% of the local Arab population was aged 65 and over, compared with 13% of the general population (

Figure 7, see **Source:** ONS, 2023

Appendix 5.6. Figure 6: Age Breakdown for Arabs and Local Population, Birmingham (2021)for data table).

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Figure 7: Age profile of Arabs and the general population: Birmingham, 2021



Source: ONS, 2023 (7, 8)

1.5.4 Sexual Orientation

Statistics on the sexual orientation of the Arab community are not yet available from the Census 2021.

The countries of the Arab world mostly share a common thread of cultural and religious conservatism that stigmatizes non-heterosexual identities. In many Arab countries, homosexuality is illegal, and LGBTQ+ individuals are subject to harsh legal penalties, including imprisonment and even death.(77) LGBTQ+ stigma remains a contentious issue, and generally negative attitudes towards homosexuality are shared in many Arab countries.(77, 78) In Saudi Arabia, for example, same-sex sexual activity is punishable by up to five years in prison, while in Qatar, homosexuality is punishable by death.(79) These laws create a hostile environment for LGBTQ+ individuals, forcing many to conceal their sexual orientation and gender identity.

Some UK-based studies show that Arab and Muslim LGBTQ+ people not only face homophobia in their ethnic and/or religious communities but also contend with racism and islamophobia in LGBTQ+ communities.(80) To counter this trend, UK Queer Arabs is a volunteer group to bring together adult queer Arabs. In addition to fostering connections and identity amongst queer Arabs, the group seeks to raise awareness, challenge stereotypes, and build a positive image of the community in the UK.(81) In 2022, UK Queer Arabs marched for the first time at London Pride.

1.5.5 National Identity

According to the 2021 Census, many Arabs identify as British but not English. In England and Wales, 39% of Arabs identified as British compared with 19% of the general population. However, only 10% of Arabs identified with the national identity of English compared with 58% of the general population. Conversely, 43% of Arabs identified with another national identity (not affiliated with the UK) compared with 7% of the general

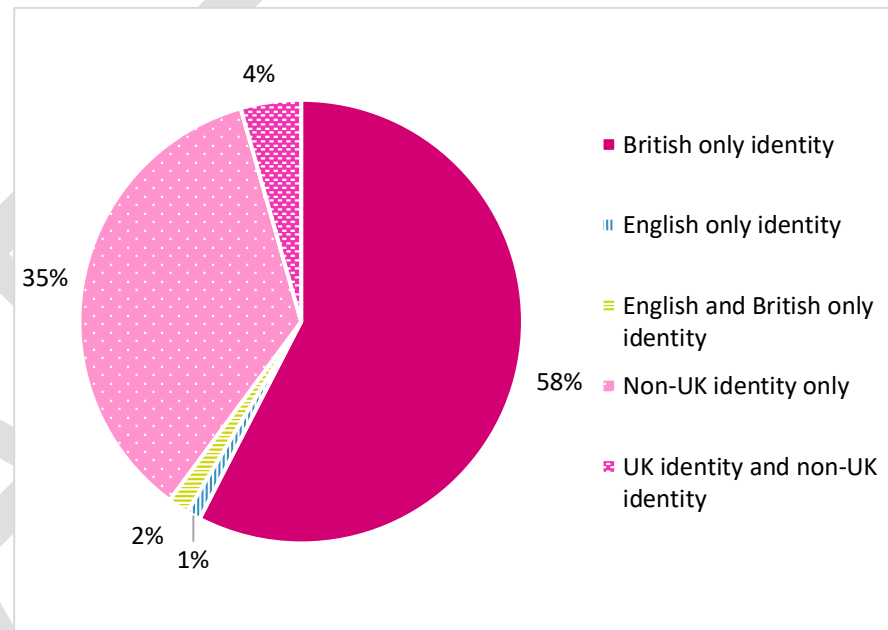
population. Arabs were also more likely to identify as having a dual national identity (4%) than the general population (1%).(82)

In Birmingham, 58% (n=11,026) identified as ‘British only’, compared with 63% of the Birmingham population and 19% of the England and Wales population. A large proportion identified with a ‘non-UK identity only’ (35%, n=6,796) (**Figure 8: National identity among the Arab ethnic group: Birmingham, 2021**, see **Source: ONS, 2023**)

Appendix 5.7. Figure 7: National identity among the Arab ethnic group: Birmingham, 2021 for data table).(82, 83)

This differs to the Arab ethnic group in England and Wales. In 2021, 39% of Arabs identified as ‘British only’ and 43% identified with a ‘non-UK identity only’.(82)

Figure 8: National identity among the Arab ethnic group: Birmingham, 2021



Source: ONS, 2023 (82)

The 2021 census also provided insight on the proportion of ‘non-UK identity only’ by ethnic group across England and Wales, 16% of the Arab ethnic group identified as ‘Other Middle Eastern’ and 10% identified as ‘North African’ (

Table 6).(83)

Table 6: National identity among the Arab ethnic group: England and Wales, 2021

National Identity	County	Arab Ethnic Group (%)
UK identity: British only identity	175,562	53
Other identity only: Middle Eastern and Asian: Middle Eastern: Other Middle Eastern	51,981	16
Other identity only: African: North African	32,501	10
UK identity: Other identity and at least one UK identity	17,563	5
Other identity only: European: EU countries: Other member countries in March 2001	7,732	2
Other identity only: Middle Eastern and Asian: Middle Eastern: Iraqi	7,070	2
UK identity: English and British only identity	5,550	2

Source: ONS, 2023 (83)

2. Community Profile

2.1 Getting the Best Start in Life

Key Findings

- The total fertility rate in 2011 for women from North Africa and the Middle East living in the UK was relatively high, at 3.9 and 2.6 respectively.
- From 2000 to 2019, women from MENA countries were identified at being at increased risk of gestational diabetes (13% prevalence) compared with the England average (5%).
- Barriers to Arab women accessing maternal healthcare include language, discrimination, and a lack of general cultural competency.
- Data from Birmingham in December 2021 indicated lower vaccine uptake of the booster dose of COVID-19 vaccination among Arab children aged 12 to 15 (13%) than White British children (75%).
- The prevalence of obesity and overweight in the Middle East and North Africa for young people aged 20 and under in 2013 was 23% for males and 28% for females.
- Oral health is a major public health concern in Arab countries. In one 2020 study from Saudi Arabia, 80% (n=384) of school-aged children had teeth in poor condition.

2.1.1 Fertility

Fertility among a population can be represented using the 'Total Fertility Rate (TFR)', which can be defined as "the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing years".(84)

The ONS does not report the TFRs by ethnicity; data is only available for the mother's birth country.(85) Whilst the ONS dataset indicates the TFR for women from most Arab countries (grouped as either North Africa or the Middle East), it does not enable a precise estimate due to pre-existing grouping. For example, the following analysis includes Western Sahara (North Africa) and does not include Comoros, Djibouti, and Somalia (East Africa).

In the 2011 census, the TFR for women from North Africa and the Middle East in the UK was 3.9 and 2.6 babies per mother. This figure has declined since 2001 but remained higher than the TFR of UK-born mothers (1.8 babies) and mothers born outside the UK (2.2 babies). Limited research on immigrant fertility in the UK indicates that immigrants from the Middle East share a similar fertility trajectory to White British people over their life course.(86)

Evidence from Arabic-speaking countries indicates that the "Arab world has undergone one of the most dramatic fertility declines in modern history", which scholars attribute to contraceptive technologies and couples' desire for smaller families.(87) Evidence from the USA indicates

that Arabs and minority ethnic people face barriers in accessing infertility and fertility services, similar to minority ethnic groups in the UK.(88, 89)

2.1.2 Maternal Health

There is limited research and information regarding maternal and neonatal health among the Arab community in the UK. MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) is a national audit programme which collects information about all late foetal losses, stillbirths, neonatal deaths, and maternal deaths across the UK. Whilst MBRRACE-UK reports evidence for pan-ethnic groups and particular ethnic groups, there is no data specifically on Arab women.

Evidence from MBRRACE-UK illustrates that some minority ethnic women, mainly black and Asian women from deprived areas, are at a higher risk of maternal mortality than White women.(90) The Confidential Enquiry into Maternal and Child Deaths (CEMACH) also identified disproportionately high maternal mortality and morbidity rates in the migrant population.(91)

In 2015, MBRRACE-UK also reported that having a Middle Eastern ancestry (specifically women whose family origin is Saudi Arabia, UAE, Iraq, Jordan, Syria, Oman, Qatar, Kuwait, Lebanon, or Egypt) was a risk factor for gestational diabetes.(92) The risk of gestational diabetes among women in the MENA region was corroborated in a 2021 study systematic review. Within the review, the pooled prevalence of gestational diabetes was 13% (95% CI 11.5% to 14.6%) and the highest prevalence was observed in Sudan (23%, 95% CI 3.3% to 45.2%) (Table 7). It was estimated in 2019 that gestational diabetes typically occurred in 5% of pregnancies in England.(10)

Table 7: Weighted prevalence of gestational diabetes among pregnant women: MENA countries, 2000 to 2019

Country	Gestational diabetes prevalence (%)	95% CI
Sudan	23	3.3 to 45.2
Qatar	21	15.2 to 26.7
Saudi Arabia	16	12.6 to 18.8
Morocco	16	13.9 to 17.2
UAE	13	9.4 to 18.0
Iraq	12	3.3 to 23.3
Egypt	11	6.2 to 17.4
Iran	11	9.2 to 13.9
Lebanon	11	6.7 to 15.1
Oman	10	6.5 to 14.3
Bahrain	10	8.3 to 11.9
Tunisia	9.3	7.5 to 11.4
Jordan	4.7	3.0 to 6.7
Algeria	3	1.4 to 6.4
Libya	1.4	1.3 to 1.6
Total	13	11.5 to 14.6

Source: Al-Rifai *et al.*, 2021 (10)

2.1.2.1 Access to Maternal Healthcare

A review commissioned by the NHS Race and Health Observatory Unit provides an overview of the literature on ethnic inequalities in maternal, antenatal, perinatal, neonatal, and postnatal UK healthcare. The review presents studies which include but are not limited to Arab participants and indicates that minority ethnic women experience barriers in accessing

maternal health services which impact their maternal health, including the late booking of antenatal classes, missed appointments, being non-English speaking, discrimination and prejudice, pre-existing health problems and wider determinants such as lack of funds.(93, 94)

Some qualitative evidence from UK-based studies explicitly focusing on Arab women corroborates the review evidence. The studies were a study with 24 migrant and second-generation Arab Muslim women(93), a study with 22 Palestinian women in Manchester(95), and an ethnographic study with 8 women from Arab countries in the East Midlands.(96, 97) The qualitative study with 24 Arab Muslim women(97) identified several barriers to accessing maternal healthcare services, including language, discrimination, and prejudice against them, the unfamiliar bureaucracy they had to deal with, the conflict in ideology between what they expected and what was offered, and the unfamiliarity of UK maternity services. The need for culturally competent maternal health services has been another central theme highlighted by the above studies.

For migrant Arab women, a lack of support networks and information about legal entitlement to accessing maternal healthcare and maternity services more generally and frequent relocations after arriving in the UK were raised as additional barriers to services.(98)

Muslim Arab women also reported experiencing a lack of cultural sensitivity from healthcare providers and services, such as not being offered halal food during hospital stays, being given access only to a male caregiver, or being advised by health practitioners who had little understanding of religious-related requirements of Islam (e.g., gendered norms).(97) On the other hand, another study reported that women described relationships with healthcare practitioners as caring, respectful,

confidential, and meeting their emotional, psychological, and medical needs.(98)

Interviews with healthcare professionals indicate that practitioners perceive Arab women as having little autonomy and control over their bodies. Women were regarded as unwilling or unable to make treatment decisions, so professionals provided them with limited information about their conditions.(99)

2.1.2.2 Experiencing Health Services

A qualitative study focusing on the experiences of 18 Muslim minority ethnic women's (including 2 Arabs) accessing perinatal mental health care in South London found that all had been diagnosed with perinatal mental health issues and were supported by specialist services.(100) The study reported three main challenges: first, participants felt ashamed and guilty about not coping well with the first few months of motherhood; second, mental health was associated with stigma and negative beliefs among family and community, which led many to deny it as a medical condition; thirdly, the treatment given by medical professionals did not recognise the cultural dynamics of the patients and did not provide the validation and reassurance that they needed.

Experiencing health care unrelated to mental health can also contribute to mental health issues. Another qualitative study based on interviews with 8 Somali women in 2008 giving birth in England, showed it was a disturbing experience for them, adding to their anxiety because of issues concerning female circumcision, verbal communication, cultural aspects of care and pressures that were a consequence of migration.(101)

2.1.3 Infant Mortality, Stillbirths and Live Births

The ONS does not report the number and percentage of live births for the Arab population; typically subsumed under 'any other' ethnic groupings, in England and Wales. The ONS does report on live births by parents' country of birth (grouped by region).(85) This dataset is subject to the same limitations as the TFR (*see section Fertility*). In 2021, of the 179,726 babies born to mothers who were born outside of the UK, 4,002 babies were born to mothers from North Africa and 8,676 babies were born to mothers from the Middle East, together making up around 7% of births to mothers born outside of the UK.

Evidence on geographical differences demonstrates that Birmingham has nearly the highest rate of infant mortality in the country, nearly twice that of the England average. Pooled data between 2017 and 2019 shows that, in England, the infant mortality rate was 3.4 per 1,000; in the West Midlands it was 5.6 per 1,000; in Birmingham, it was 7.0 per 1,000 (around 112 infant deaths a year).(102) In 2020, the infant mortality rate in Birmingham declined to 6.0 per 1,000 but remained higher than the national average (4.0).(103)

Evidence from MBRRACE-UK and the ONS shows that minority ethnic women, mainly black and Asian women from deprived areas, are at higher risk of infant mortality than White British women.(92, 104) The research literature has focused on the south-Asian community, mainly Pakistani and Bangladeshi, for whom there is a much higher risk of infant mortality and for whom the leading causes of infant mortality were congenital abnormalities.(105, 106)

Whilst socioeconomic factors, such as maternal education, maternal age, deprivation, and health-related factors (obesity and smoking) are important factors in perinatal and infant morbidity and mortality, the contribution of genetic conditions has been highlighted as a particular concern for Muslim communities, which tend to allow consanguineous marriage.(102, 107) Some research indicates that consanguineous marriages are routinely practised in many Arab countries, e.g., 30% to 50% of marriages in the Middle East and 20% to 40% in North Africa, with potentially higher rates in countries such as Egypt, Mauritania, Syria and Saudi Arabia.(108) However, data relating specifically to the Arab community nationally or in Birmingham is unavailable.

2.1.4 Childhood Vaccinations

There is a lack of data on vaccination uptake, specifically amongst Arab children in the UK, with data focusing on pan-ethnic groups or ethnic groups other than Arabs.(109, 110, 111) However, the Census 2021 indicates that some Arabs may identify under South Asian, Black African, and Black Caribbean populations pan-ethnic groupings. Hence some of the following research findings might provide an approximate indication of the views on vaccination among children of Arab origin.

Existing evidence indicates mixed results related to various childhood immunisations among minorities and religious groups. For example, some studies indicate lower uptake of the human papillomavirus (HPV) vaccine amongst Muslim young people compared with young people from Christian and non-religious backgrounds.(112) Other studies report that religion is not an influential factor(113) and others report similar rates of vaccinations for Muslims compared with other minority religious communities.(114) For example, a study across 195 schools in London

analysing aggregated uptake of the HPV vaccine between 2008 and 2010 found no significant differences by ethnicity, although the study included only 1 Arab participant.(115) Another study focusing on children from South Asian backgrounds reported consistently higher HPV vaccine uptake compared with Black African and Black Caribbean populations.(114) Some research indicates that Muslim parent's decision to vaccinate their children is shaped by various factors, including their awareness and understanding of the importance of vaccinations and whether they see it as culturally or religiously permissible.(116) A study with immigrant Arab mothers in the USA reported that 64% of respondents' children had received the HPV vaccine.(117) Most women had not heard of the vaccine (67%), did not have it recommended by a healthcare provider (60%) and desired educational materials in Arabic to aid their decision-making. However, it is unclear how this report will correspond to UK Arabs, due to the differences in healthcare systems from the US.

A review of vaccine hesitancy in Arab countries found high rates of hesitancy in some countries, e.g., in 2009 in Saudi Arabia, more than 80% of parents refused to authorise the vaccination for their child for influenza.(118) .

Concerning COVID-19 vaccinations, evidence published by Birmingham City Council in 2021(33) showed that children of Arab origin living in Birmingham had lower uptake of the COVID-19 vaccine than their White British counterparts and most other minority ethnic groups. Among Arab children aged 12 to 15, 18% had the first dose, and 13% received their booster shot of the COVID-19 vaccine, compared with 47% and 75% of White British children of the same age. For young people aged 16 to 17, 26% of people identifying as Arab had received a COVID-19 vaccination,

and none had a booster shot, compared with 63% and 2% of White British of the same age.

2.1.5 Screening Programmes

There is a lack of data on neonatal screening of children of Arab ethnicity in the UK. Evidence from the Middle East and North Africa region indicates wide variation in neonatal screening for genetic conditions (often resulting from high levels of consanguinity).(119)

2.1.6 Childhood Obesity

There is a lack of data on the prevalence of obesity amongst Arab children in the UK, as evidence is not explicitly reported concerning this community.(120) In 2013, global estimates on the prevalence of obesity and overweight in the Middle East and North Africa for young people aged 20 and under was 23% for males and 28% for females.(11)

A systematic literature review focusing on children in the Middle East and North Africa in 2017 found an increase in the prevalence of obesity in these countries, particularly in the Gulf area.(121) Kuwait had the highest overall overweight and obesity prevalence among male adolescents and children (60%), followed by the Kingdom of Saudi Arabia (44%), Egypt (37%), UAE (36%) and Qatar (32%); the top five countries for females were Kuwait (41%),Libya (37%), Egypt (36%), Kingdom of Saudi Arabia (35%) and Qatar (34%).The main risk factors for obesity were lack of physical activity, longer screen time – also associated with higher consumption of sugar-sweetened food and drinks, a higher socioeconomic standard and parental obesity.

Some older evidence from the UK suggests that Arab children may be at higher risk of developing Type 2 diabetes than their White British

counterparts, due to factors such as being overweight. In 2000, a study of eight British children aged 9 to 16 years in the West Midlands and Leicester children with Type 2 diabetes identified of Arab or South Asian origin (no further ethnic breakdown was reported); all were females, overweight and had a family history of diabetes.(122)

2.1.7 Dental Decay in Children

There is a lack of data on oral health among Arab children in the UK, as evidence is not specifically reported concerning this community.(123)

Evidence from Arab countries shows that improving children's oral health is one of the critical public health challenges in these countries.(124)

A 2020 cross-sectional study conducted in Saudi Arabia using the Arabic version of the World Health Organisation's child oral health assessment tool (A-OHAT) with school-aged Arab nationals (N=478) found that 80% (n=384) had poor teeth conditions and 36% (n=173) had 'often' experienced toothache in the last 6 months.(12) Children with high consumption of sweets were 1.5 times more likely to have poor teeth and 20% higher chances of having poor gums than those with lower sweet consumption. On the other hand, children who regularly used a toothbrush had nearly 50% lower chance of having poor gum condition in contrast to the school children who did not use a toothbrush.

Another study surveyed parents of children aged 3 to 11 years in five regions in Saudi Arabia in 2021 to explore children's oral health needs and barriers to good dental health(125) found that 72% of respondents (n=1,098) reported their children experiencing toothache. Barriers identified to accessing dental care included parents with lower education

(aOR 1.8, 95% CI 1.4 to 2.4), and parents with a greater number of children (aOR 1.2, 95% CI 1.1 to 1.3).

A systematic review on the determinants of dental caries in children in the Middle East and North Africa region reported that increased age, low maternal education, low overall socioeconomic status, decreased frequency of tooth brushing, low parental involvement, poor oral habits, infant feeding practices and sugar consumption were the most prevalent determinants of dental caries in Arab children.(126)

2.1.8 Children's Mental Health and Wellbeing

Most research on Arab children's mental health and well-being in the UK has focused on unaccompanied asylum-seeking children, a high proportion of whom come from Arab countries.(127)

Some evidence indicates that unaccompanied asylum-seeking and refugee children have poor physical and mental health and well-being outcomes due to their traumatic experiences living in and fleeing their countries of origin. Furthermore, they also experience a challenging and unsupportive environment when relocating to the UK (e.g., experiences of racism, bullying, financial and legal uncertainty and difficulties accessing services to meet their health and social care needs).(13, 14, 15, 16, 17, 18, 19) Some research focusing on Syrian refugee children relocated to the UK highlights the central role of the education system in integrating them into society and in fostering children's health and well-being.(128, 129)

2.1.9 Child Poverty and Children in Care

Poverty rates for ethnic groups in the UK do not typically include a breakdown for the Arab community.(130, 131) Yet, as noted in **section**

Employment and Economic Activity, Arabs are more likely to be economically inactive than the general population and less likely to own a home than all other ethnic groups. They are more commonly live in the top 10% of income-deprived neighbourhoods.

Specific information on the proportion of Arab children in the UK care system is not reported or disaggregated, unlike for many other ethnic groups.(132) However, evidence indicates that a proportion of Arab children in care are unaccompanied asylum seekers. Children who arrive in the UK without their parents or guardians usually go into the care of a local public authority and will often live with approved foster carers or in other care settings.(133)

According to the Department of Education, at the end of March 2022, there were 5,570 asylum-seeking children in care (out of 404,310), representing a 10% increase since 2020.(134, 135) In the year ending June 2022, the UK received almost 5,000 applications for asylum from unaccompanied children under the age of 18(127), which included a high number of children from Arab countries such as Sudan, Syria and Iraq; around 95% of all applicants were male.(136, 137) In 2021, 2,300 unaccompanied asylum-seeking children were granted asylum or other leave to remain in the UK.(138) In 2022, 8,729 care leavers aged 19 to 21 (26%) were formerly unaccompanied asylum-seeking children.(135) In 2021 to 2022, 106 unaccompanied asylum-seeking children were under the care of Birmingham City Council compared with 68 children in the previous year, 2020 to 2021.(139)

2.1.10 Youth Justice

A breakdown of the proportion of young Arab people who have come into contact with the Youth Justice system is unavailable, as figures are typically reported for pan-ethnic groups.(140, 141)

Evidence indicates that minority ethnic young people(142), particularly Black young people(143), fare worse in the youth criminal justice system than their White counterparts. For example, Black youths, who represented up to 4% of the 10 to 17-year-old population in the 2011 Census, made up 18% of all stop and searches, 15% of arrests, 34% custody on remand and 29% in custody. Evidence also shows that Muslim young people make up 22% of people in Youth Offenders Institutions(144) despite comprising 8% of all 5 to 17-year-olds in England and Wales in the 2011 Census.(145)

2.1.11 School Readiness

Evidence on the school readiness of Arab children is not available as, unlike for children from other ethnic groups, data is not disaggregated for Arab children.(146)

According to the UK Millennium Cohort Study (wave 1), school readiness is influenced by parents' socio-economic status, child's ethnicity, maternal education, income band, sex, household number of children, mother's age, low birth weight, mother's mental, health, infant developmental milestones, breastfeeding, parents' employment, and housing type.(147)

Existing data suggest that children from lower socio-economic backgrounds (e.g., eligible for free school meals) are less likely to meet the

Key Findings

- From 2010 to 2013, Arabs accounted for 28% of admissions among ethnic minority groups to psychiatric wards in North-West London for attempted suicide or self-harm.
- In a 2013 cross-sectional study, UK Arabs were less likely to seek professional help with mental health issues than the White British population.
- Alcohol is prohibited in most Arab countries and most UK Arabs are non-drinkers. However, alcohol consumption by young, male Arabs is quite common.
- In a 2021 cross sectional study of 132,597 UK adults, 18% were identified as regular smokers. Smoking prevalence was higher among Arab/Other ethnic group (20%).
- In the same study, Arab smokers had the lowest uptake of nicotine replacement therapy (7.9%) and e-cigarette use (11%) when compared with all ethnic groups (9.2% and 18% respectively).
- Waterpipe (shisha) smoking is popular among many Arab countries, with shisha smoking most common in Lebanon (15%), Syria (12%) and the Gulf States (from 4% to 12%).
- There is limited data on domestic violence in the UK Arab population. A 2015 study of 175 Libyan migrants in the UK found that 52% of the men viewed domestic violence towards women as normal and acceptable.

standard for school readiness at age 3.(146) Poverty, in particular, has been

- Hate crime against Muslims, including Arab Muslims, grew considerably after the 9/11 and 7/7 terrorist attacks.

highlighted as a central factor affecting school readiness.(148)

2.1.12 School Exclusions

Evidence on school exclusions for Arab children is not available. Unlike for children from other ethnic groups, data is not disaggregated for Arab children.(149) The highest rates of permanent rates were for White Gypsy and Roma pupils (0.18%) and mixed White and Black Caribbean pupils (0.12%), whilst Chinese and Indian pupils had the lowest rates of exclusion (0% to 0.01%).

2.1.13 Educational Attainment

Evidence on educational attainment for Arab children is unavailable from the Department for Education. Unlike for other ethnic groups, data is not disaggregated for Arab children.(150, 151)

ONS analysis of the 2011 Census suggests that, where ethnicity was recorded for the academic years 2010 and 2011 to 2014 and 2015, Arabs comprised 0.65% of those achieving below Level 1 qualifications, 0.28% of those achieving Level 1 qualifications, 0.29% of those achieving Level 2 qualifications and 0.41% of those achieving Level 3 qualifications.(152)

2.2 Mental Wellness and Balance

2.2.1 Mental Health

2.2.1.1 Mental Health in the UK Arab Population

Mental health is an increasingly important and common health concern across the country. According to Mind UK, 1 in 4 people will experience a mental health problem of some kind each year in England. The amount of people with common mental health problems went up by 20% between 1993 to 2014, in both men and women, and the percentage of people reporting severe mental health symptoms in any given week rose from 7% in 1993, to over 9% in 2014.(153)

There are no national statistics that report the prevalence of mental health problems in the Arab population in the UK and there is no information about Arabs in Birmingham. There are also very few recent studies of the mental health of UK Arabs. There are, however, older studies of the mental health issues of specific groups that suggest that mental health is a major issue in the Arab population and, in particular, for newly arrived refugees, more so for women than for men.

Two reviews of the mental health of refugees from Arab origin in Western countries reported high anxiety, depression, and post-traumatic stress disorders for those from war and conflict zones. Many brought these mental health conditions with them to their new country.(154, 155) These conditions were confounded by difficulties adjusting to a new culture, financial insecurity, and poor housing. Older refugees tended to have the

most difficulties making cultural adjustments and exhibited the highest levels of anxiety and depression.

Studies of specific groups within the UK Arab community have also found evidence of high levels of depression and anxiety. For example, in a qualitative study with 12 adult Syrian refugees (3 women, 9 men) living in South-East England, researchers found that participants reported a sense of loss from their homeland and loved ones left behind.(156) Although there were migrant communities in England that could offer support, they were newly formed and engaging with them was often problematic; the interviewees were in a strange new culture that they struggled to connect with, and there were taboos and stigmas associated with mental health they had brought with them that meant they rarely engaged with mental health services. Instead, they relied on 'being their own doctor' and on faith, ritual, and nature to provide routes to healing.

A comparison study of Arab women in Cairo and in the UK in 2009 found similar levels of mental illness in both countries that were considerably higher than for Arab men. Women were more likely to suffer various disorders, including depression, anxiety, somatisation, and eating disorders.(157)

A study of 143 Somali refugees in London (72 women and 71 men) in 2006 used a culturally adapted neuropsychiatric interview to assess 10 mental disorders.(158) It found that over one-third were suffering from common mental disorders, including anxiety and depression. 14% of the respondents had symptoms of post-traumatic stress disorder. Lower levels of the mental health disorders investigated were found in people who were in employment or had educational experiences in the UK or Somalia.

Several evaluations have examined the impact of studying in the UK on students from Arab countries. A systematic review found 8 studies of Arabs beginning medical degrees in the UK from 2005 to 2009.(159) These studies concluded that Arab students displayed levels of stress, anxiety, and depression higher than their fellow students. Still, the levels were similar to those of Arab students studying elsewhere in the world.

Another indirect measure of mental health is the admission to psychiatric wards of people who have attempted suicide or have self-harmed. In 2010 to 2013, 996 'Black and minority ethnic' people were admitted to psychiatric wards for these reasons in North-West London; the two most prominent groups were Arabs and South Americans (28% each).(20)

For information on children's mental health, please *see section Children's Mental Health and Wellbeing*.

2.2.1.2 Accessing Mental Health Services

Many studies have found that UK Arabs experiencing mental health problems are reluctant to engage with mental health services. For example, a cross-sectional study conducted in 2013 comparing the attitudes to accessing mental health services among 100 UK Arabs (64% women) with 104 British Caucasians (73% women) found that the UK Arabs were much less likely to seek professional help than the Caucasians.(21) One reason was that the Arabs did not see their mental health problems as biological in nature but more associated with their faith. They were therefore more inclined to turn to spiritual healers than to mental health services. They also had more concerns about confidentiality: they did not wish their mental health problems to become widely known. The authors

of the report commented that other studies have suggested there is shame and stigma associated with mental illness that could bring shame to the family, but that their study did not confirm this association. The authors did find that the longer the person had been in the UK, the less likely they were to be concerned about these factors and the more likely they were to seek professional help.

2.2.1.3 Actions in the Community to Combat Mental Health Problems

Research has been undertaken to examine the degree to which strong neighbourhood cohesion in ethnic minority communities can reduce the degree of mental health problems. A study based on nine waves of the UK Household Survey tracked changes in neighbourhood cohesion and mental health across 42,866 people across the UK.(160) The sample included 17 ethnic minority communities, 165 of the participants were Arab. The study examined whether strong neighbourhood cohesion was linked with good mental health. Over a 10-year period, mental health across the 17 ethnic minority groups showed an improvement with stronger neighbourhood cohesion (-0.76, 95% CI -0.83 to -0.70, $p < 0.001$). A lower score represents better mental health, as defined by the General Health Questionnaire (GHQ-12). The negative overall score in this study represents an improvement (lower score) in the GHQ-12 over the study period.

Compared to the White British sample (reference group) some ethnic groups saw differing levels of improvement in mental health with increased neighbourhood cohesion, including the Arab ethnic group (0.24, 95% CI -0.74 to 1.24). However, the CI overlaps with 0 due to small sample sizes, therefore conclusions cannot be drawn on whether the Arab population experienced better improvements in mental health compared with the White British sample.

Although the evidence is indirect, the Arab community in Birmingham may share similar mental health issues, especially women and recently arrived migrants. It is also likely that Arabs with mental health problems will seek spiritual help rather than support from mental health services.

2.2.2 Alcohol Consumption

There is no research on alcohol consumption by Arabs in Birmingham or the UK. However, many international studies, particularly in the 22 Arabic-speaking countries in the Middle East and North Africa, suggest that alcohol consumption is limited, especially among Muslim individuals.

Alcohol is defined as 'haram' or forbidden in Islam, and in Arab countries with Muslim majorities and Sharia law (e.g., Qatar), prohibition is enforced. However, some other countries of the Arab League (e.g., Lebanon, Egypt) take a more lenient approach to its prohibition than others. According to the WHO estimates on alcohol consumption, in 2003, Saudi Arabia, Libya, Kuwait and Somalia were the top 3 for no alcohol consumption.(161, 162) The UAE and Lebanon were ranked 77th and 95th, with alcohol consumption rates similar to Albania and Turkey. A survey of the Islamic World and Alcohol suggests that Muslims in Western countries tend to follow Islamic teaching and do not consume alcohol.(162) However, this may complicate research on this topic as taboos surrounding consumption of alcohol may lead to reluctance to report alcohol use, therefore providing challenges when trying to obtain accurate data. The survey includes a case study of France in which it was found that many young Muslim immigrants from North African countries adopted the wine-drinking culture of their host country. Furthermore, a systematic review examining alcohol consumption in all 22 Arabic-speaking countries concluded that alcohol consumption is

widespread, especially among the youth and even in countries where prohibition is enforced.(163)

There is no evidence about alcohol consumption by UK Arabs and the small number of non-Muslim Arabs in the UK. However, there has been some research on alcohol consumption by UK Muslims of South Asian origin.(164) This evidence can be used, with caution, as an approximate estimation of alcohol consumption among UK Arabs, most of whom are Muslim. The research shows that alcohol consumption amongst South Asian Muslims is mainly by young males. There is strong pressure on young women to avoid alcohol because it brings shame to the family and affects marriage opportunities. Young males tend to be drawn into alcohol consumption when they seek to participate in the 'night-time economy' prevalent in most cities with Muslim communities. This pattern of behaviour is similar to that found for young Arabs in France, and whilst there is no direct evidence, it may be similar for young Arab Muslims in Birmingham and the UK.

2.2.3 Substance Use

There is no direct evidence of the scale of substance misuse in the Birmingham or UK Arab population. While drug use is prohibited in Arabic-speaking countries, some studies across the Arab World suggest that it is widespread but not on the same scale as the USA.(165, 166) The majority of UK Arabs are Muslims and the use of cannabis by Muslim youth in the UK is reported to be commonplace.(167, 168)

Although there is no direct evidence, substance abuse in the Arab population in Birmingham may be common among youths and males in

particular. It is also possible that there may be the use of particular substances by Arab sub-populations where there is a cultural history of using them.

2.2.4 Smoking

There is no information about the extent of smoking in the Arab population in Birmingham and limited information about smoking by Arabs in the UK. There is extensive international literature, much of it originating from Arabic-speaking countries. Smoking tobacco is considered a dangerous habit in Islam, and many Arab countries, have issued fatwas (legal rulings on points of Islamic Law) to ban it. Despite this, some regional studies report that smoking is still a common practice, especially among males.

A 2021 cross-sectional study of 132,597 UK adults found that 18% were regular smokers; the proportion of smokers was 20% among a small sub-sample of Arabs/Other ethnicities (n=324). The study also reported the prevalence of e-cigarette use (18%, 95% CI 16.3% to 20.3%) or nicotine replacement therapy (NRT) (9.2%, 95% CI 7.2% to 11.1%), among current smokers. The Arab/Other ethnicities in this sample were the least likely of all ethnicities to use these alternatives (11% e-cigarettes, 7.9% NRT). The odds of e-cigarette use for cutting down and temporary abstinence from cigarette use were 42% lower among those of Arab/other ethnicity (OR 0.58, 95% CI 0.40 to 0.83) compared with those of White ethnicity.(22)

A popular alternative to smoking cigarettes in Arab countries is waterpipe tobacco smoking, often referred to as shisha. This practice originated in Persia. In a waterpipe, tobacco is placed on a small ceramic stove, covered with tin foil, and fired with charcoal; the smoke is passed through a water tank before inhaling. A systematic review of 38 studies on waterpipe

tobacco smoking found that many Arab countries had the highest prevalence: Lebanon (15% of the adult population), Syria (12%), and the Gulf States (from 4% to 12%).(169) In many countries, waterpipe tobacco smoking is a social activity: group smoking was high in Egypt (15%) and Lebanon (5%). The cultural practice of waterpipe smoking has been associated with lung cancer and chronic obstructive pulmonary disease (COPD) in another systematic review of 64 studies of waterpipe usage around the world.(163) The authors found that waterpipe smoking was generally regarded as less harmful and less addictive than cigarette smoking, although there is clear evidence that it can injure health.

Around the world, including the UK, waterpipe smoking has become popular, especially among student populations. In a study conducted at Birmingham University in 2008, a random sample of 937 students found that 77% had used waterpipe smoking and 43% made regular use of it.(23) The students in the sample were not typically regular cigarette smokers, and there was a widespread view that waterpipe smoking was less damaging to health than cigarette smoking. Only 16 of the students (1.7%) were Arabic but 81% of them reported using waterpipe smoking.

2.2.5 Domestic Violence

There are no statistics on the prevalence of domestic violence in Birmingham or the UK Arab population. In its absence, a review of the international literature is provided below with a focus on domestic violence in the Arab world.

A review of domestic violence across the Arab World concluded that domestic violence was common as a way in which men 'corrected' women.(24) It was regarded as an internal and private family matter and

was not normally reported. Assessing the level of domestic violence is therefore difficult although studies in several countries have produced varying findings. For example, 33% of Egyptian women have been beaten at least once since marriage and 26% of Syrian women reported being beaten at least once a year.

A systematic review found 29 studies from 10 Arab countries that reported the prevalence of domestic violence.(170) It concluded that 73% of women experienced some form of domestic violence during their lifetime including physical violence (36%), sexual (24%) and emotional or psychological (50%). By contrast the British Crime Survey concluded that 4.2% of British women had been physically assaulted in acts of domestic violence within the last 12 months.(171) However, there are problems making direct comparisons between the Arab studies and the British survey because of the many different methodologies used in the studies and the difficulties of getting reliable data.

A 2015 study of domestic violence in Libyan migrants to the UK is one of the few studies to provide UK Arab data. It included 13 semi-structured interviews from 2012 to 2013 with Libyan women, 7 of whom reported they had been subjected to physical and verbal abuse. The study included a questionnaire survey of 175 Libyan migrants (108 women and 67 men) that found that 52% of men and 61% of women believed that British culture made a difference to Libyan men's attitudes towards women.(24)

In the absence of direct evidence, it is difficult to establish the likely level of domestic abuse in Arab families in Birmingham. Domestic abuse has been a common practice in the Arab World but there is some evidence that it is less acceptable in the UK Arab population, and it may well be diminishing as a behaviour.

2.2.6 Hate Crimes and Discrimination

In a review of developments since the attack on the Twin Towers in 2001 and the 7/7 terrorist attack in London in 2005, attention is drawn to how 'islamophobia' has developed in many Western societies, including the UK.(172) Islamophobia indicates a misconception or fear that Muslims threaten Western societies and Arab male Muslims constitute a significant threat to society. A 2010 report documents many case studies of hate crimes directed against Muslims in London, including terrorist attacks, arson, criminal damage, violence, and intimidation; much of the hatred documented in the report is directed against mosques but it is also against Muslim communities.(173)

A quantitative review of the incidence of hate attacks analysed the records of four areas in England with large Muslim communities (London, the West Midlands, Leicester, and Yorkshire).(25) The analysis covered the periods before and after the 2001 9/11 attack in New York and the 7/7/2005 attack in London. It found that hate attacks on Muslims and Arabs immediately after the attacks rose from an average of 271 a month in the 2.5 years before the 7/7 attack to an average of 367 in the months after the attack. The authors concluded that the level of violence peaked with major, well publicised attacks and then steadily declined. However, in the case of the 9/11 attack, the level remained above the pre-attack level for 6 months, and in the case of the 7/7 attack, it remained higher than the pre-attack level for an entire year. However, the analysis used the category of 'Muslim and Arab' and did not disaggregate data for a separate analysis of attacks on Arabs. The study suggests that hate crimes are directed at Muslims regardless of their ethnic identities.

Hate crimes against the Muslim community in Birmingham have included some well publicised incidents. In 2013, an anonymous letter was sent to a Birmingham Councillor alleging a plot to infiltrate important posts in some Birmingham schools to convert them to the Muslim faith. The letter was treated as a hoax, but it led to reviews of school policies on safeguarding and increased monitoring of pupil behaviour. This created tensions in the community leading to what became known as the “Trojan Horse Affair”.(174) 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, have demonstrated how relationships are being repaired.

A quantitative study conducted among citizens of Leicester and Stoke-on-Trent in 2005, collected responses from 398 people, 50% of whom were Muslims, yet included others of several faiths, including Jewish, Sheikh and Christians.(175) The authors reported a sizable increase in discriminatory practices against Muslims after the 9/11 attack: there was no increase in this period concerning the other religions.

Other incidents have led to unrest between Muslims and other minority communities. The unrest in 2022 between Hindus and Muslims in Leicester has reportedly spread to Birmingham.(176) As many Arabs in Birmingham are Muslims, the Arab community may experience similar discrimination and potential conflicts. The number of hate crimes rises after major national and international incidents that receive widespread publicity and there may be more hate crimes in Birmingham if such incidents occur.

2.3 Healthy and Affordable Food

Key Findings

- There is no evidence on the diet adopted by UK Arabs. Research in other western countries shows some adoption of fast-food culture.
- Vitamin D deficiency levels were high amongst Arab women in western countries who wore veils and did not take vitamin supplements.
- There are no statistics on the prevalence of obesity specifically looking at the UK Arab community, data from Arab countries in 2011 suggested overweight and obesity prevalence to range from 25% to 38% in men and 28% to 83% in women.
- The proposed BMI cut-off for UK Arabs has been proposed at 26.6 kg/m² (30 kg/m² for the White population) because Arabs are at risk from diabetes at a lower body mass.

2.3.1 Diet and Nutrition

There is no research evidence on the food culture of UK Arabs, but the majority follow a Muslim faith food culture.

Some research highlights the growing influence of fast-food culture in the Arab world, particularly among young Arabs. A 2011 review on obesity in Arabic-speaking countries reported that Lebanese children were progressively abandoning the traditional Mediterranean diet in favour of a fast-food diet, similar to Bahrain and other countries of the Gulf, where

fast-food chains are massively present and eating fast food between meals whilst watching television was becoming the norm.(177)

Studies of dietary practices in the UK also showed the influence of fast-food culture, although none focus on the UK Arab population.

A 2013 study compared the lifestyles of British and Saudi adolescents aged 14 to 18 years. The study compared 1,648 children recruited from two Saudi Arabian cities (Riyadh and Al-Khobar) and 1,158 children recruited from Birmingham and Coventry.(178) The ethnic composition of the UK sample was not reported. The overweight and obesity prevalence among Saudi adolescents (38%) was higher than that of British adolescents (24%). Also, British adolescents demonstrated a higher total energy expenditure than Saudi adolescents, with physical inactivity being higher among Saudi adolescents (64%) than British adolescents (26%). Most Saudi and British adolescents did not have breakfast, and their daily intakes of fruit, vegetables, and milk were lower than national guidelines. In both countries, girls were less physically active than boys – a finding aligned with global evidence. The authors concluded that there are many similarities in the diet of children in both countries and the main difference was the amount of exercise taken by British children compared with their Saudi counterparts.

In a 2019 scoping review of 35 interventions to combat obesity in the UK Muslim population, 5 interventions focused on diet behaviours and 28 on physical activity.(179) All these interventions were organised by local mosques and led by faith healers and congregational volunteers. While the religious settings resulted in a high reach, the poor quality of the evaluations of these interventions meant it was impossible to assess their impact on actual dietary and activity behaviours.

Some research, mainly conducted in North America and Europe, has examined the changes in diet and food culture experienced by immigrants and refugees when they leave Arab countries. There are no similar UK studies. The findings of this research allow us to classify individuals according to different levels of acculturation. Low acculturation means Arab people maintain their diet and food culture; high acculturation means they adopt the food practices of the society they are joining. Many Arabs maintain their cultural identities through ethnic Arab food and associated traditions, such as consuming ma'moul (a traditional Arab pastry filled with dates, walnuts, and pistachio) after major religious festivities, such as Lent and Easter for Christians, and the holy month of Ramadan for Muslims - major religious festivities include Eid-al-Adha (feast of the Sacrifice), and Eid-al-Fitr (Festival of breaking fast).(180, 181) Low acculturation among Arabic-speaking immigrants and refugees (ASIR) correlated, in the USA, with healthier nutritional practices.(182) Similarly, in a study in Norway in 2014, low acculturation was associated with higher consumption of healthy vegetable-based Arab dishes (e.g., baba ghanoush) among Arabic-speaking female immigrants and refugees.(183)

The evidence from studies of high acculturation reveals a different picture. Many studies have identified the adoption of fast-food diets by immigrants and refugees. High acculturation was associated with a reduction in the consumption of vegetables, olive oil, lean meat, and whole grains and low consumption of nutritious Arab food items (e.g. Jute mallow leaves "Mulukhiyah") among ASIR university students and mothers following migration to the US.(184, 185, 186, 187) (186) Consumption of convenience foods (pizza, processed meat, and snack foods) was widespread among more acculturated immigrants and refugees in North America.(188) Similarly, high acculturation into the French culture among

Tunisian immigrants in 2007 was associated with increased intake of refined sugars, carbohydrates, higher saturated fats, and lower fibre, compared with Tunisians living in their country of origin.(189, 190)

In contrast, evidence from other US studies found that high acculturation was associated with improved nutritional practices, such as consuming more fruit and vegetables among immigrants and refugees mothers relative to their low acculturated counterparts.(191) Highly acculturated immigrant and refugee university students consumed a more balanced diet.(192) Similar findings were found among immigrants and refugees in Canada, who declared consuming healthy food items such as brown rice, whole grain flour, broccoli, and bagels.(193) Similarly, Iraqi refugees in Canada reported positive changes in their diet since moving to Canada, consuming healthier food, and being more attentive to nutrition labels compared with when they lived in their country of origin.(194)

Refugees and immigrants also reported changes in patterns of eating. Some research with Iraqi refugees in Canada reported avoiding eating before bedtime after their acculturation, contributing to weight loss and improved well-being.(195) In contrast, immigrant and refugee women in Canada declared increased eating out since moving to Canada.(196) Barriers to the ability to eat healthy food in their host countries include personal factors such as lack of nutritional knowledge, limited awareness of good nutrition, mainstream language illiteracy, preventing people from understanding nutrition labels and seeking information about healthy food options, lack of self-efficacy and confidence and low satisfaction with the taste of fruits or vegetables.(197, 198)

Socio-cultural influences such as families' preferences for energy-dense, poor-nutrient foods were key barriers to healthy eating among ASIR in

North America and Europe. A study of 477 Arab mothers of young children from 13 Arab countries found that family responsibilities, family preferences, time pressures, and the cost of fresh produce were major barriers to cooking healthy meals daily.(196) In Canada, the social stigma associated with traditional, homemade ethnic food prevented Iraqi refugee women and their children from consuming it at work and schools.(195) Some other research with immigrants and refugees also reported difficulties obtaining hand-slaughtered (halal) meat that met their religious requirements. Sudanese refugee women in Canada did not know how to cook vegetables such as broccoli and cauliflower.(195) Additionally, the limited availability of ethnic food items, such as biryani spices, was a pivotal barrier to cooking traditional healthy meals in North America.(199)

Economic and food system influences such as financial constraints, unaffordability of healthy and organic foods such as fruits, vegetables, and fish and affordability of processed convenience fast-foods were barriers to following a healthy diet among ASIR in North America. Unfamiliarity with grocery stores' locations and layouts was also cited as a barrier to purchasing healthy food in Canada.(200)^{Error! Bookmark not defined.} Lack of vegetables, fruit, and fresh meat was a major barrier among immigrants of Arab origin in North America and Europe, who were used to obtaining fresh foods in their countries of origin rather than frozen or canned foods.(201)

Facilitators of healthy eating among Arab immigrants in North America and Europe included increased awareness of nutrition health and food literacy. For example, delivery of post-migration nutrition courses in Canada enhanced Iraqi refugee women's nutrition knowledge and helped them make healthy choices.(195) In another US-based study, immigrant women reported they would adopt healthy eating and cooking behaviours, if the

health benefits were clear; those living with diabetes stated they would avoid unhealthy eating if they were convinced about its associated risks.(202)

Facilitators of healthy eating among ASIR in Canada and Europe included socio-cultural influences such as the support from family members who adopted healthy eating practices. Having a nutrition-knowledgeable partner who could help with making healthy food choices while shopping was also a major facilitator.(203) Community dietary programmes which provided information on portion sizing and improved dietary patterns was a strong facilitator for making healthy eating choices. For example, community cooking classes helped immigrants and refugees in North America and Europe learn about healthy cooking and effective shopping, which improved their eating behaviours.(200, 204) Building social networks with people from the mainstream culture also helped these groups navigate the new food systems they encountered and to know about healthy food options.(201)

A specific issue in the diet of people of Arab heritage is the consumption of Vitamin D. Vitamin D is produced by the human body through exposure to sunlight. When this is lacking, humans must intake it from food or dietary supplements. Factors influencing the amount of Vitamin D produced by the body from sunlight are the body's surface area directly exposed to the sun, decreased ambient light, latitude, season, time of day, sunscreen use, and very importantly the amount of clothing worn. These factors can all decrease production and lead to vitamin D deficiency and related health problems.(203, 205, 206, 207, 208, 209, 210, 211, 212)

Vitamin D supplementation is particularly important in climates such as the UK, which has less sunlight and is typically colder than Arab countries.

Wearing clothing appropriate for a sunny climate in a climate with decreased ambient sunlight may further limit endogenous cutaneous vitamin D production.(213) A study from the USA showed that vitamin D levels in the blood stream were uniformly low among Arab women; the highest levels were found among women who did not wear veils; the second highest among those who wore veils but took supplements (e.g., vitamin D-fortified orange juice, milk, or vitamin D pills); the lowest levels were found in Arab women who wore veils and did not take supplements. Vitamin D levels were also low among women with less education.(26)

2.3.2 Obesity

There is no evidence on the incidence of obesity in the Arab population in the UK but there is considerable evidence of an 'epidemic' of weight gain and type 2 diabetes across many Arab nations. A 2011 seminal narrative review of studies on the prevalence of overweight and obesity across 14 Arab countries found that it ranged from 25% to 38% among adult men and 28% to 83% among adult women; among school children (6 to 18 years), the prevalence ranged between 18% to 47% among boys, and between 18% to 47% among girls.(27)

A study of 17,232 Saudi people found that 36% were obese; 44% of females in the study were obese and 26% of males were obese.(214) A national survey of adults in Kuwait found that 48% were obese and 18% diabetic. 77% of obese females were diabetic compared with 48% of obese males.

Research on the reasons for the high levels of obesity in Arab nations has focused on three contributory causes: genetic predispositions, lack of physical exercise, and food culture and diets that lead to weight gain. The standard way of defining obesity is to measure Body Mass Index (BMI),

defined as the weight (in kg) over height in metres squared (kg/m^2); grade 1 obesity corresponds to a BMI equal to or greater than $30 \text{ kg}/\text{m}^2$. A study found that higher levels of diabetes occurred in the South Asian population than in the White population at lower BMI levels.(215) A suggested reason is that Asian people typically have a higher body fat concentration than White people. To ensure BMI is used appropriately to determine the risk of diabetes and related diseases, it has been proposed that different BMI cut-off points be used for different ethnicities. A recent study that set out to determine such cut-off points, used the medical records of 1,472,819 UK patients, including 97,823 (6.6%) diagnosed with type 2 diabetes.(216) The cut-off point calculated for obesity for the White people in the sample remained at $30 \text{ kg}/\text{m}^2$ but for the South Asian people, it was reduced to $23.9 \text{ kg}/\text{m}^2$. The sample also included 2,724 Arabs (0.2%), and the BMI cut-off point for them was calculated to be $26.6 \text{ kg}/\text{m}^2$.

2.3.3 Food Insecurity

No statistics are available on food insecurity experienced by the Arab community in the UK. Most research has focused on food insecurity among asylum seekers and new immigrants. For example, a 2002 qualitative study was conducted among 30 families living in Newham in London, including 10 Somali families.(217) Each family included children under 5 and had resided in the UK for less than 2 years. Interviews concluded that every family suffered from food insecurity: not knowing where the next meal would come from and being unable to feed the children. The most common barriers to food were lack of money or vouchers, knowledge about food shops, and limited facilities for cooking.

In a similar study in Norway in 2022, food insecurity amongst 205 Arabic-speaking asylum seekers, including 42 families with children, was

investigated.(218) Participants came from Syria (25%), Eritrea (18%), Somalia (11%), and Iraq (11%). The study showed that 93% of the sample were food insecure, and 78% were food insecure with hunger. Among the families with children, 20% experienced child hunger. The main barriers were lack of money to purchase food, knowledge about new foods, difficulties with shopping, language challenges, and problems complying with various religious food rules.

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2.4 Active at Every Age and Ability

Key Findings

- Sport England's Active Lives Survey (2016 to 2018) showed that 52% of people of Arab ethnicity were physically active (150+ mins/week) compared with 62% of all adults in England.
- Consequently, rates of physical inactivity (<30 mins/week) were higher among Arab (35%) populations compared with people from other ethnic groups, including White (25%), Black (29%), Asian/any other Asian (32%) groups.
- Some evidence suggests an increase in physical activity among Arabs upon migration to the UK. In one study among undergraduate students from Saudi Arabia, 67% (n=104) reported an increase in physical activity in the UK
- Barriers to participation in physical activity for Arabs include differing definitions of physical activity, a limited accessibility and affordability of facilities, limited English language proficiency, and religion.
- Facilitators to participation include affordable, accessible, and well-equipped local facilities, religion, and support networks.

Regular physical activity provides a range of physical and mental health and social benefits. It can help to prevent and manage over 20 chronic conditions and diseases, including heart disease, type 2 diabetes, and depression.(219)

There is a paucity of research on the Arab community's participation in physical activity and sports in the UK. Some UK studies provide sporadic insight into different sections of the Arab community's engagement with physical activity, whilst international literature reviews on Arab minorities in the West seldom include studies from the UK.

Much research on the Arab community's physical activity experiences has been undertaken in the USA, Canada, Australia, and Europe, focusing on the experiences of Arab migrants and refugees.(220, 221)

2.4.1 Physical Activity

Government recommendations for physical activity state that individuals should complete a minimum of 150 minutes of moderate-intensity physical activity or 75 minutes per week of vigorous-intensity physical activity.(222) According to these UK government recommendations, lower physical activity participation rates amongst minority ethnic and Muslim communities in the UK have been well documented.(223, 224, 225)

The most comprehensive data on the Arab community comes from Sports England's Active Lives Survey (2016 to 2018), which indicated that just over half of the Arab community (52%) were classed as physically active (150+ minutes a week) compared with 62% of all adults in England.(28, 226) Moreover, Arabs had higher rates of physical inactivity (less than 30 minutes a week) (35%) compared with White British (25%), Black (29%), Asian/Any other Asian (32%) backgrounds (**Table 8**). A breakdown of physical activity rates by sex and age was not available.

The table below outlines the national physical activity rates of the Arab community compared with people from broader pan-ethnic backgrounds.

Table 8: Physical activity levels among adults aged 16 and over by ethnic group: England, 2016 to 2018

Ethnic Group	Inactive (less than 30 minutes a week) (%)	Fairly active (30 to 149 minutes a week) (%)	Active (150+ minutes a week) (%)
Arab	35	13	52
White British	25	12	63
Chinese	27	13	60
Black	29	15	56
Any other Asian/ Asian British background	32	13	56

Source: Sports England, 2020 (226)

While the trend suggests that the Arab ethnic community is overall less active than other ethnic groups, the evidence typically demonstrates higher levels of physical activity upon migration to the UK. For example, a study with 12 Saudi female students living in East Midlands suggested that they generally increased their physical activity in the UK compared with their countries of origin.(227) In a 2021 study (N=212) conducted among undergraduate students from Saudi Arabia, 67% (n=104) reported an increase in physical activity in the UK, 20% (n=31) reported a decrease, and 13% (n=20) reported no change compared with when they lived in their country of origin.(228) Another study surveying 212 Saudi Arabian international undergraduates in the UK found that three-quarters (74%) reported undertaking regular exercise, most of which were males (71%, n=111).(228) Some of the barriers and facilitators to physical activity are outlined in **section 2.4.3**.

Nevertheless, dissimilar findings were reported in another study that used objectively-measured physical activity through accelerometers (electric devices used to measure movement) among a sample of 62 Arab fathers and 65 male children living in Liverpool.(229) The study reported that Arab men were more likely to be physically active than their non-Arab counterparts, whilst the results were more mixed for Arab boys. Both men and boys engaged in higher light activity levels rather than moderate or intense activity. However, whilst Arab men performed a cumulative total of 190 minutes of physical activity a week, thus exceeding the 150 minutes guidelines for adults, Arab boys performed around 47 minutes of physical activity daily, which fell short of the recommended 60 minutes daily for young people.

Studies with Arab refugees, asylum seekers and migrants in poor socio-economic circumstances indicate a decline in physical activity rates compared with their home countries for adults and children.(230, 231) A study with parent refugees of 2 to 12-year-old children from Arab countries reported that participants faced substantial changes to their lifestyle and personal contexts, including restrictions to their personal living space and opportunities to participate in neighbourhood and community activities. Parents were also particularly concerned about their children's increased sedentary behaviour and consumption of unhealthy snacks.(230)

2.4.1.1 Sports in Arab Culture

Sports are a significant part of culture and society. Accordingly, they can be powerful agents of social change and sources of entertainment. They can also be vehicles for enhancing mutual understanding.

During colonialism, sports were used by Arabs to promote the national struggle for independence against French and British occupations. In more recent times, Arab leaders have used sport to promote state ideology.(232) The Pan Arab Games, established in 1953, have been promoted as enabling a “cultural unity” across all Arab regions and identities.(233)

Sports have long been ingrained in Arab culture, with football being the most popular sport among the Arab nations.(234) The Arab world has produced numerous footballers who have excelled in the game globally, with a large number coming from countries such as Morocco, Egypt, and Algeria.(235) Arabs also play a significant role in British football, with several UK football clubs currently or previously owned by Arabs, including Manchester City, Sheffield United, Aston Villa, and Newcastle United.(236, 237)

Football has not only been a source of pride and passion for the Arab nations but has also been instrumental in promoting their countries globally. For example, Qatar recently hosted the 2022 FIFA World Cup, which entailed a significant investment in the country in building state-of-the-art stadiums and infrastructure. However, it is essential to note the critique received by Qatar for the lack of worker rights in building this infrastructure and the criminalisation of LGBTQ+ people in the region.(238)

In the UK, the lower physical activity participation rates of Arabs and Muslims have led Sport England to promote campaigns such as ‘Active Sunnah’ and to fund organisations such as the Muslim Women’s Sports Foundation to encourage Muslims to become more active.(239, 240)

2.4.2 Mobility

There is no data available on mobility problems experienced by Arabs in the UK. As reported in **section Living with a Physical Disability**, the 2021 Census shows that few UK Arabs report having a physical disability. The young demography of the UK Arab population means there are relatively few elderly people, the age group that typically has most mobility problems.

2.4.3 Barriers and Facilitators to Physical Activity

Some UK studies highlight several essential facilitators and barriers to Arab men and women’s participation in sports and other physical activities. These factors include different understanding and definitions of physical activity, exercise and sport, availability of open spaces, easy and affordable access to facilities, diet, clothing, weather, language, support networks and awareness of facilities. These issues have been highlighted as particularly pertinent for Arab migrants, asylum seekers and refugees on whom the literature focuses and are similar to those highlighted by Muslim and minority ethnic communities in the UK more generally.(223, 241)

Definitions of Physical Activity

Evidence indicates that the Arab community may have varying definitions of physical activity. For example, Saudi students considered physical activity as all types of activities, including walking, domestic and work activities or going to the gym, whilst Somali women saw it as a structured activity involving high-intensity planned activities like sports.(227, 228, 242) The idea of undertaking physical activity for health was an unfamiliar concept for some members of the Somali community, who understood physical activity to induce sweat (and therefore using a sauna was

considered physical activity).(231) Another study with Arab fathers in Liverpool reported that respondents were unaccustomed to being physically active in their country of origin and did not understand the benefits and guidelines around physical activity.(229)

Easy and affordable access to physical activity resources

The cost and location of physical activity facilities, such as gyms and green spaces, have also been cited as important factors influencing the Arab community's access to physical activity and sports.(220, 227, 229) Limited availability and affordability of facilities were seen as barriers in terms of convenience and cost. On the other hand, affordable, accessible, and well-equipped local facilities were seen as facilitators of participation in physical activity. For example, for some Arab women in the UK, the cost to access facilities was considered reasonable for enabling access to the benefits of physical activity.(227)

Religion

Religion has a dual role in both encouraging and limiting physical activity participation, which has also been highlighted in studies with the Arab community. On the one hand, respondents saw religion as a primary motivating factor for physical activity, referring to the prostrations and movements in Islamic prayer and the promotion of being physically active in religious texts.(220, 241) On the other hand, the requirements of Islam can influence the Arab community's participation in physical activity through stipulations on the types of activities that could be performed and the clothing and settings in which they could be performed.(242)

Gender Roles, Single and Mixed Sexed Spaces

Adherence to the Islamic requirement for gender-exclusive settings was a more prominent concern for Arab women than men and has been consistently highlighted as a central barrier to participating in existing arrangements of physical activity (e.g. gyms and swimming pools).(227, 229, 231) Single-sex spaces, sessions and female instructors were seen as facilitators of participation among women, whereas a lack of these was seen as a barrier to participation.

Clothing

Cultural norms around modesty and culturally appropriate forms of clothing also posed a barrier for some Arab women participating in physical activity. However, this factor was particularly highlighted by Western studies outside the UK, which have different laws and norms regarding Islamic clothing (e.g., France, which prohibits full-face veil coverings).(220, 221) For example, some Arab women were embarrassed or feared judgement when wearing certain types of clothing for physical activity that did not adhere to Western norms.

Arab women in the UK report religious freedom to wear their chosen clothing.(229) For example, a qualitative study with female Arab students in the East Midlands reported that respondents saw the open nature of UK culture as a facilitator to participating in physical activity and did not experience any negative reactions to wearing a hijab during activities such as swimming and working out at the gym.(227)

UK Culture

Studies with Arab migrants in the UK highlight the open and accepting culture and how this facilitates participation in physical activity (e.g., clothing or attitudes towards women). Compared with their countries of

origin, Arab migrants in the UK emphasised the positive influence of encouraging societal norms around physical exercise, the liberal and permissible attitude towards women's participation and the conducive nature of the built and social environment.(227, 228, 229) However, for some Arab migrants, the UK environment hindered their participation in physical activity. For example, a study with Somalis found that respondents saw physical activity as incorporated into their everyday lives in Africa, mainly walking in hot weather. In contrast, in the UK, they saw accessible public transport and the colder weather hindering walking.(231)

Role of Support Networks

The role of family, friends, and the broader community in encouraging or discouraging participation in physical activity and sport was considered an essential determinant of physical activity participation for Arab women in various studies.(220, 221, 227) Family responsibilities and cultural restrictions were central to the discourses of Arab women, as was the support and encouragement of family members.

Lack of awareness about physical activity programmes and facilities

A lack of knowledge or awareness about physical activities and where to access information about programmes and facilities have been highlighted as a barrier for the Arab community, particularly among recent migrants, refugees and older people.(229, 231) For those not proficient in English, language was considered a particular barrier.(220, 221) In this regard, having available and accessible translated and culturally sensitive materials, and engaging physical educators who speak Arabic, were seen as facilitators. The tailoring of health promotion materials and physical activity sessions to different age groups and genders within the Arab

community have also been highlighted as important facilitators of physical participation for these groups.(228, 242)

2.5 Living, Working and Learning Well

Key Findings

- In the 2021 census, 61% of Arabs in Birmingham were of working age compared with 65% of the total population.
- In Birmingham, according to the 2021 census, 46% of Arabs were economically active compared with 56% of the local population.
- Among the Arab population in Birmingham in 2021, 17% stated that they were economically inactive and looking after home or family, much higher than the White British (4%) and Birmingham (8%) averages.
- The 2021 census noted a large student population among the Arab ethnic group in Birmingham (22%), compared with 10% of the Birmingham population.
- In 2017 to 2018, 17% of Arab origin households in England were owner-occupied compared with 63% of households owned by White ethnic backgrounds.
- 51% of Arab origin households in England rented from the private sector compared with 20% of all English households.
- In 2022, 30,205 students enrolled at UK universities came from six Gulf states.

- In the 2021 census, 87% of Arabs reported being in good health compared with 76% of the White British population in Birmingham.
- In the 2021 census, 89% of Arabs in Birmingham had no physical disabilities census compared with 76% of White British people.

2.5.1 Education, Qualification, Skills, and Training

2.5.1.1 Higher and Further Education

The latest data from Higher Education Statistics Agency (HESA), the UK-based body which collects education-related data, has found that there were 30,205 students from the six Gulf States in higher education instituted in the UK in the academic year 2021 to 2022, as seen by

Table 9. Of these students, 1,840 were enrolled in universities in the West Midlands, with the most common university locally being University of Birmingham (580 students).(243) The number of students from the Gulf States has increased within the last decade, in 2013 there were 18,102 students from the six Gulf States in UK universities.(244)

Table 9: Numbers of students from the Gulf States enrolled in university: UK, 2021 to 2022

State	Numbers of students
Saudi Arabia	8,750
UAE	8,085
Kuwait	6,630
Qatar	2,900
Oman	2,390
Bahrain	1,450
Total	30,205

Source: HESA, 2023 (243)

There have been several evaluations of the impact of studying in the UK on students from Arab countries. A 2010 systematic review identified 8 studies on Arabs beginning medical degrees in the UK.(122)^{Error! Bookmark not defined.} These studies concluded that Arab students displayed higher levels of stress, anxiety, and depression than their fellow students, but the levels were similar to those of Arab students studying elsewhere. The authors conclude that little is known about the reasons for these high stress and anxiety levels. Similar findings were reported in qualitative studies. For example, a 2011 qualitative study of 16 nurses from Jordan, looking back at the doctoral programme they had taken at various UK universities, found that they were initially very anxious and frustrated by the lack of structure to the programmes.(245) They had been used to a fixed timetable of study and regular examinations, and they found the need to create a research programme very unsettling. In retrospect, they realised this enabled them to grow as independent scholars and to be able, when back in Jordan, to take responsibility for their work programmes. However, participants felt

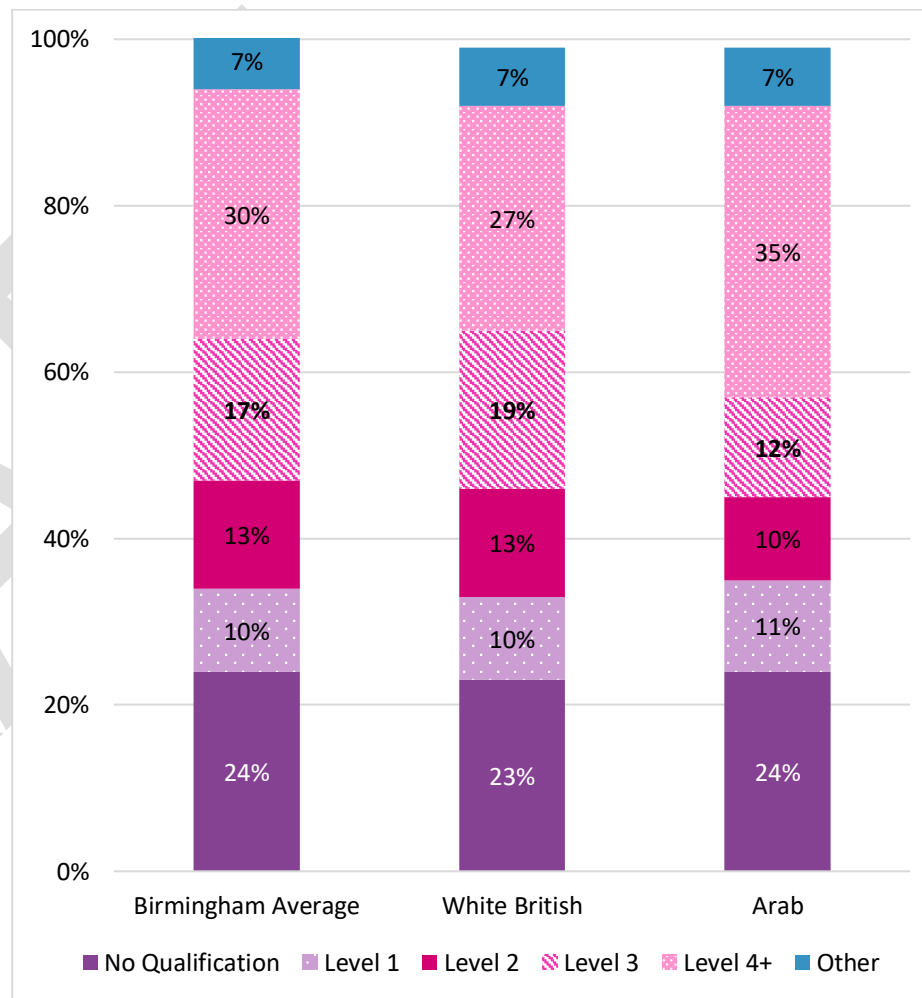
quite restricted in what they could do in their home country and that many of their newly developed capabilities were being wasted.

2.5.1.2 Highest Level of Qualification

The 2021 census reported on the highest level of qualification obtained by ethnic group. Around 30% of people aged 16 years or over in Birmingham had obtained a higher-level qualification (level 4 or above). This equates to a university degree, higher level BTEC or equivalent. This increases slightly to 35% for the Arab ethnic group, as seen in **Figure 9** (see **Source:** ONS, 2023)

Appendix 5.8. Figure 8: Highest level of qualification by ethnic group: Birmingham, 2021 for full data table). The Arab ethnic group has approximately the same percentages as the Birmingham average for those with no qualifications, level 1, level 2, and other qualifications (definitions of each qualification level can be found in Appendix 5.8).(246)

Figure 9: Highest level of qualification by ethnic group: Birmingham, 2021



Source: ONS, 2023 (246)

However, it is important to note that there may be variance of highest level of qualification by specific Arab country that will not be captured by the census data shown in **Figure 9**.

2.5.2 Employment and Economic Activity

In the 2021 census, 61% of the Arab population of Birmingham was of working age compared with 65% of the total population of Birmingham.(249) The Arab community had lower rates of economic activity in Birmingham (46%) than the White population (56%) (**Table 10**). Being economically active involves making, providing, purchasing, or selling goods or services. Slightly higher figures were found across England and Wales (50% of Arabs were economically active compared with 57% of the White British population).(29)

Table 10: Economic activity by ethnic group: Birmingham, 2021

Economic Status	Arab (%)	White British (%)	All ethnic groups (%)
In Employment (excl. students)	34	49	47
Unemployed (excl. students)	7	4	5
Economically active students	5	3	4
Total	46	56	56

Source: ONS, 2023 (29)

2.5.3 Economic Inactivity

Of those who were economically inactive, 22% of the Birmingham Arab community were students compared with 7% of the White British population. This difference is also found in England, where 19% of Arabs were students compared with 4% of the White British population. This is likely a consequence of the young demography, and migration for education, of the Arab population which is also indicated by the retirement statistics: only 4% of the Arab community in Birmingham were retired compared with 24% of the White British population. The statistics are similar for England, where 5% of the Arab population were retired compared with 26% of the White British population. In Birmingham, 17% of the Arab population who were economically inactive were taking care of their families at home compared with 4% of the White British population. In England, 14% of Arabs cared for their families compared with 4% of the White British population. These statistics are summarised in **Table 11**.(29)

Table 11: Economic inactivity by ethnic group: Birmingham, 2021

Economic Status	Arab (%)	White British (%)	Birmingham (%)
Retired	4	24	16
Student	22	7	10
Looking after home or family	17	4	8
Long-term sick or disabled	5	6	5
Other	8	4	5
Total	56	45	44

Source: ONS, 2023 (29)

According to the 2021 Census, the highest percentage of Arabs who were in employment in Birmingham were employed in professional occupations (28% compared with 21% of the White British population), including teaching and other educational professionals, information technology professionals; nursing and midwifery professionals. Similarly, 18% of Arabs were in Elementary occupations, compared with 11% of the White British population (Table 12).(250) The numbers in these categories were different across England and Wales, where 30% of Arabs were in professional occupations compared with 19% of the White British population; 11% were in elementary occupations compared with 9% of the White British population.(250)

Table 12: Occupation by ethnic group: Birmingham, 2021

Occupation	Arab (%)	White British (%)	Birmingham (%)
Managers, directors and senior officials	8	11	9
Professional occupations	28	21	21
Associate professionals and technical occupations	8	13	11
Administrative and secretarial occupations	6	10	9
Skilled trades occupations	7	10	8
Caring, leisure and other service occupations	8	10	10
Sales and customer service occupations	8	8	8

Occupation	Arab (%)	White British (%)	Birmingham (%)
Process, plant and machine operatives	9	7	9
Elementary	18	11	13

Source: ONS, 2023 (250)

When looking at specific occupation in Birmingham from the 2021 census, the most common occupations for the Arab ethnic groups were medical practitioners (n=390), elementary storage occupations (e.g. loading, picking goods and cargo in warehouses and ports) (n=303) and teaching and other educational professionals (n=284).(250)

2.5.4 Deprivation

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England and is calculated using outputs from the IoD domains. There are seven distinct domains of deprivation, including income, employment, crime, barriers to housing and services and living environment. An IMD decile output of 1 demonstrates a neighbourhood which is in the 10% most deprived in the country.(30)

In Birmingham, the Arab ethnic group is more likely to live in the most deprived areas compared with the average citizen. Roughly half (51%) of the Arab ethnic group population in Birmingham live in the 10% most deprived MSOAs nationally, compared with 34% of the White British population. All populations in Birmingham are more likely to experience deprivation than the national average. Additionally, 18% of the Birmingham Arab ethnic group population (n=3,074) live in the top 10

deprived MSOAs in the city, compared with 5.4% of the White British population (Table 13).(30)

Table 13: Deprivation among the Arab ethnic group by MSOA: Birmingham, 2019

MSOA	Total Population	Arab Population	IMD Rank (MSOA)	IMD Decile
Balsall Heath West & Kingswood Road	7,200	1,188	123	1
Balsall Heath East	8,300	1,102	108	1
Sparkbrook North	8,600	893	24	1
Attwood Green & Park Central	9,400	538	778	2
Bordesley	15,700	516	230	1
Five Ways South & Calthorpe Park	6,700	509	1131	2
Moor Green & Cannon Hill	7,100	506	1103	2
Sparkbrook South	8,100	454	118	1
Yardley Fields	11,600	423	263	2
Small Heath Park	10,200	377	311	1

Source: Ministry of Housing, Communities & Local Government (MHCLG), 2019 (30)

Note: IMD Rank is comprised of all MSOAs nationally, with 1 being the most deprived neighbourhood nationally.

It is also important to note that while some MSOAs are more deprived than others, some people can live in the most deprived areas and not be

deprived themselves, while some can experience deprivation despite living in the least deprived areas.

Data from the English IoD 2019 also provides an overview of the domains of deprivation experienced by ethnic group. The Arab ethnic group experienced high levels of deprivation by health deprivation and disability, crime, barriers to housing and services, and living environment. 17% of the Arab population lived in the 10% most deprived neighbourhoods by living environment, this domain is only higher among the Pakistani (28%) population. The IoD also reported that 18% of Arabs live in the top 10% of income-deprived neighbourhoods (the highest level is Pakistanis at 31%: White British is 8.7%) (Table 14).(251)

Table 14: Percentage of citizens living in the most deprived 10% of neighbourhoods, by type of deprivation and ethnicity: England, 2019

Indices of Deprivation Domain	Arab (%)	White British (%)	England (%)
Education, training and skills	9.4	9.7	9.8
Health deprivation and disability	12	9.7	9.8
Crime	17	8.9	10
Barriers to housing and services	22	8.2	11
Living environment	17	9.2	10
Income	18	8.7	10

Source: MHCLG, 2019 (251)

2.5.5 Housing

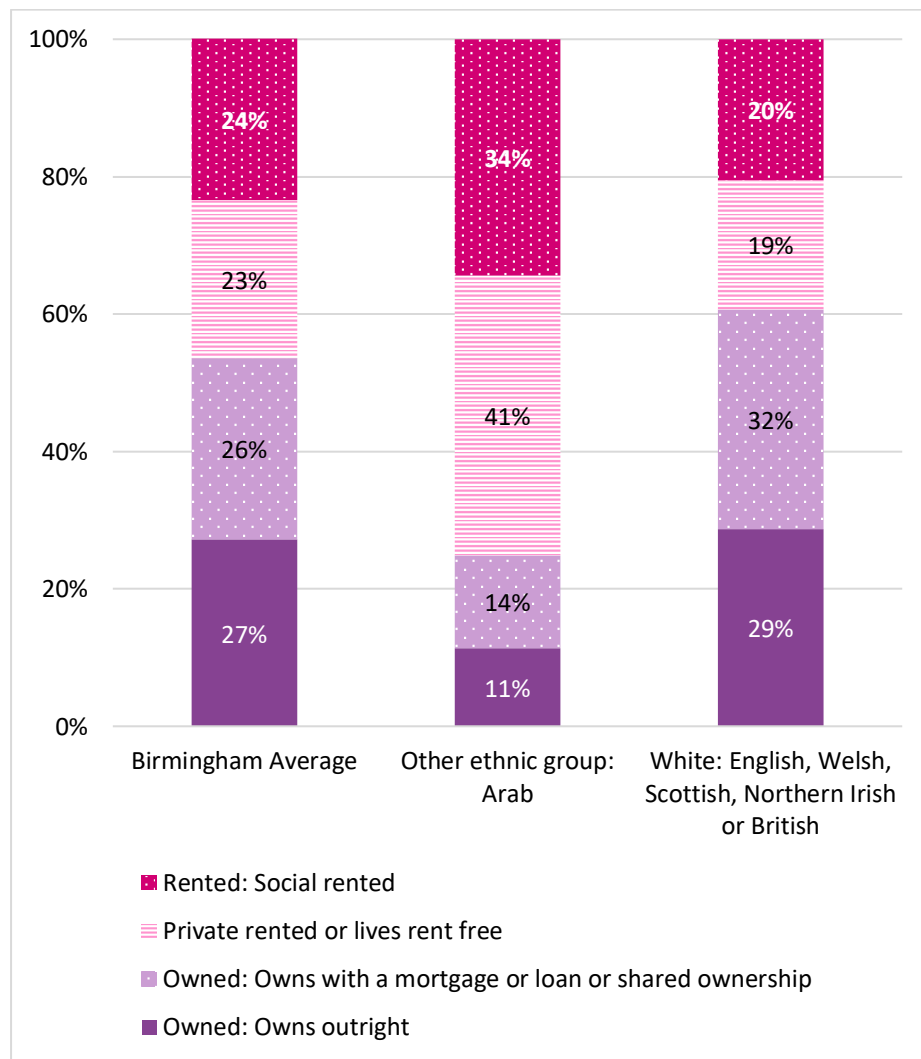
Information on housing type by ethnicity is available from the English Housing Survey 2017 to 2018 and the 2021 census. Sample sizes for the

English Housing Survey are typically smaller, and therefore 2021 census figures may be a more reliable estimate. It is important to note that the below figures from the census do not include Arab residents in communal establishments, such as university halls of residence or care homes.

2021 census data reported that the Arab ethnic group had a higher proportion of people living in privately rented or rent-free properties (41%, n=7,687) than the White British population (19%) and the Birmingham average (23%). Additionally, people from the Arab ethnic group had a larger proportion of their population living in socially rented properties (34%, n=6,510) than the White British population (20%) and the Birmingham average (24%) (Figure 10, see Source: ONS, 2023

Appendix 5.9. Figure 9: Housing tenure by ethnic group: Birmingham, 2021 for data table). Living in privately rented accommodation is more common in Birmingham than across England and Wales (21%); whereas living in social rented properties is less common nationally (17%) than in Birmingham (24%).(252)

Figure 10: Housing tenure by ethnic group: Birmingham, 2021



Source: ONS, 2023 (252)

The 2017 to 2018 English Housing Survey found that 11% of Arabs lived in non-decent homes i.e., without effective heating or insulation and in a state of disrepair, compared with 17% of the households in England. Also, 2% of Arabs lived in damp properties compared with 3% of households in England. 15% of the properties occupied by Arab households were overcrowded (assessed by the size of the household and the number of bedrooms), the highest levels of overcrowding being in Bangladeshi (24%) and Pakistani (18%) households. Overcrowding is generally associated with low levels of hygiene and the spread of infectious diseases.(31)

The 2017 to 2018 English Housing Survey reported that 17% (n=14,000) of households of Arab origin were homeowners compared with 63% of all householders who owned their homes. Arabs had the lowest level of home ownership of all ethnic groups (for example, Indians were 74% and Pakistani 58%). However, it should be noted that the Arab population in the UK is younger than the national average. According to the 2021 Census, 44% of Arabs were aged 25 and under compared with 29% of the general population in England and Wales; this includes 27% of Arabs aged 0 to 14 compared with 17% of the general population.(7, 8)

In the West Midlands, 68% of White British households were owner-occupiers compared with 50% of all non-White British households. Homeownership was strongly correlated with age. 69% of non-White British, where the average householder was over 65, owned their own homes, compared with 23% of non-White British householders aged 25 to 34.(31)

The average time White British householders had lived in the same property was 15 years. The average for Arab households was 6 years, the shortest period of any ethnicity but similar to the Chinese ethnic group.

According to the same survey, 51% of Arab households in England rented their home privately compared with 20% of all households. In the West Midlands, 32% of non-White British households rented privately compared with 14% of White British households. Of new social housing lettings, 78.9% were let to White British households and 0.6% to Arabs. Of these lettings, 653 (37%) were made to Arab households earning less than £200 weekly. Arab households had the highest percentage of those earning less than £200 per week (60.3%) of any ethnicity. Arab households spent 46% of their income on rent, the highest percentage of all ethnic groupings after people of Chinese ethnicity (72%).(31)

2.5.6 Physical Health

There are no statistics on the prevalence of specific physical diseases in the UK Arab community. However, there have been studies of cultural practices associated with the risk of some physical diseases.

2.5.6.1 General Health

The 2021 census provided a breakdown of self-assessed general health on a regional level. In Birmingham, 87% of the Arab ethnic group rated their health as “good or very good”, compared with 76% of the White British population and 77% of the average Birmingham population. The Arab population also reported lower rates of “bad or very bad health” (5%) than the Birmingham average (7%) and White British population (8%).(252)

2.5.6.2 Diabetes

Diabetes is prevalent in Arabic-speaking countries, particularly among old female community members. People who are obese are at heightened risk of developing diabetes (*see section Obesity*). Although there is no direct evidence of the extent of obesity in the UK Arab community, it is a noted problem in many Arab countries. There is evidence that Arabs may be genetically predisposed to developing obesity, and further causal factors may be a lack of physical activity and a fatty diet. Female Arabs do less physical exercise than males, which may increase their risk of obesity and diabetes.

Saudi Arabia had the fifth highest incidence of type 2 diabetes globally, affecting 20% of the population. Type 2 diabetes usually develops among adults; however, some global evidence demonstrates that it can occur in children. Some studies conducted in the UK showed that Arab children may be at higher risk of developing type 2 diabetes than their White British counterparts, however data is limited.(122)

2.5.7 Living with a Physical Disability

Disability was self-reported on the 2021 census. People are considered disabled if they reported being limited “a little” or “a lot” in their day-to-day activities by a long-term health condition (LTHC). Under the 2010 Equality Act, disability is classified as having a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on your ability to do normal daily activities.(253)

In the 2021 census, 89% of Arabs in Birmingham reported that their day-to-day activities were not disabled under the Equality Act. This is a higher

proportion than the 76% of the White British population were not disabled under the Equality Act (Table 15). Across England and Wales, 88% of Arabs reported no disabilities compared with 80% of the White British population.(254) The lower rates of disability among the Arab ethnic group may be due to the overall younger demographic profile of Arabs living within England and the West Midlands, with younger populations less likely to live with a physical disorder.

Table 15: Disability status by ethnic group: Birmingham, 2021

Disability	Arab %	White British	Birmingham %
Disabled under the Equality Act: Day-to-day activities limited a lot	5	11	10
Disabled under the Equality Act: Day-to-day activities limited a little	6	13	10
Not disabled under the Equality Act	89	76	80

Source: ONS, 2023 (254)

2.5.8 Neurodivergence

There are no available statistics on the prevalence of neurodivergent conditions in the UK Arab population, for example, the extent of autism or attention deficit hyperactivity disorder (ADHD). A 2019 national population survey reported the experiences of Arab parents with autistic children.(255) In this study reported in 2022, a survey was undertaken with 100 Arab families in the UK that had an autistic child living with them. The parents reported a high level of psychological stress and anxiety, higher

levels associated with the more extreme forms of autism. However, the parents also reported that their bonds were strong and positive. The authors report that the psychological stress experienced by Arab parents was greater than that experienced by other UK families with autistic children and surmised that this may be related to the stigma attached to having a disability in the family in Arab cultures. The parents needed information and support networks to help them manage their child’s behaviour and plan for their development and education.

2.5.9 Quality of Life

The Annual Population Survey of 2017 to 18 reported that UK Arabs’ life satisfaction was, on average 7.6 out of 10, similar to the national figure of 7.7.(256) There has been a steady improvement in this rating by UK Arabs from 7.1 in 2012 to 2013, tracking closely the improvement shown in the population.

The same survey assessed how participants felt about doing worthwhile things in life. A higher score would indicate that they thought the things they did in life were more worthwhile. UK Arabs scored 8.0 out of 10, slightly higher than the UK average of 7.9 and above all other ethnic communities. In the 2012 to 2013 survey, the score was 7.2, one of the lowest ethnic groups. However, the compilers of these statistics caution that it is impossible to draw firm conclusions from this data ‘because of wide variations in responses’.(256)

2.5.10 Access to Health and Social Care Services

There is evidence that some members of the Arab community have difficulty accessing and using UK health services and that, as a result, physical health problems may go undiagnosed and poorly treated. For example, a study with 1,611 attendees at A&E and walk-in centres in South London – including 720 migrants (44.7%), of which 13 (0.9%) were from Somalia, Morocco, Algeria, Jordan, and Egypt, reported difficulties making themselves understood, due to their limited ability to speak English.(257) As a result, Arab immigrants struggled to get a good, speedy service, and they represented an extra workload on NHS staff, often needing translation services, for example.

A mixed-methods study conducted in Scotland examined the experiences of 20 Arabic-speaking university students in accessing primary care services.(258) In general, they were satisfied with the GP services they received. They could be seen by medical professionals of a gender of their choice. They felt that more Arabic translations of health information would have been helpful and that the medical staff needed a deeper understanding of the cultural needs of people with an Arabic background.

The 2022 GPPS investigated how different ethnic groups described their experiences of their GP practice (Table 16). Overall, the Arab ethnic group less frequently rated their experience as ‘very good’ (34%) compared with the general population (38%).(32) There is no information on GP practice experience by ethnic group in Birmingham.

Table 16: GP practice experience by ethnic group: England, 2022

GP Experience	Arab (%)	White British (%)	General Population (%)
Very Good	34	40	38
Fairly Good	35	34	35
Neither Good nor Poor	16	13	14
Fairly Poor	8	8	8
Very Poor	6	5	6

Source: GPPS, 2022 (32)

In summary, although there is relatively little information about the physical health of Arabs in Birmingham and the UK, it can be hypothesised that the physical health and quality of life of this group is generally good because it is primarily a young community. Specific physical health issues may be associated with obesity and the relative lack of physical exercise. When there is a need to access health and social care services, there may be problems, particularly for new immigrants, because of a lack of information, cultural misunderstandings, and communication difficulties.

2.6 Protect and Detect

Key Findings

- It is estimated that uptake of breast cancer screening in the UAE among women over 40 is only 10%; compared with 62% uptake (women aged 50 to 70) in England.
- By December 2021, 28% of the Arab population in Birmingham in the 65 to 80 and over age range had received the booster dose of the COVID-19 vaccine; compared with 87% of the White British population.
- A 2021 Manchester study found low uptake of the influenza vaccine among eligible Arab populations (43%) compared with the White British population (57%).
- There is limited information on HPV vaccine uptake among the UK Arab population. A New York study of Arab women and children (N=162) showed a 37% uptake of the HPV vaccine, compared with 75% among the US general population.

2.6.1 Cancer Screening

Cancer is one of the major causes of death in the UK, with more than 1 in 4 deaths in the UK being attributed to cancer in 2019.(259) Diagnosis at an early stage of cancer development can improve survival chances and health interventions, such as screening programmes, are an important part of efforts to reduce cancer mortality.

There is very little information about the uptake of screening services by UK Arabs, although evidence from Arab countries shows that it is very low.

For example, in the UAE, the uptake of breast cancer screening, free for women over 40, is only 10%; more than 65% of breast cancer patients only present when the cancer is in an advanced state.(260) This is compared with a 62% uptake of NHS England breast cancer screening (women aged 50 to 70) from 2021 to 2022.(261)

A 2005 qualitative study (N=135) on the barriers to cancer screening among black and minority ethnic groups in the UK, including an unspecified number of Arabs, found low uptake was associated with poor knowledge of cancer, underlying health and cultural beliefs, and the attitudes, language, and unhelpful attitudes of health professionals.(262) The authors recommend developing community-based cancer awareness education interventions sensitive to religious and cultural needs.

2.6.2 Vaccination Programmes

2.6.2.1 COVID-19 Vaccine

There is minimal information on the uptake of various vaccination programmes by the UK Arab population except for COVID-19.

According to national data, as of 14 December 2021, 89% of people in England aged 12 years and over had had their first vaccine dose, 81% their second dose, and 41% their booster dose. In Birmingham, the vaccination rates were lower than the national average, with 66% for the first, 59% for the second, and 25% for the booster doses.(33)

The Arab community residing in Birmingham showed stark differences from the White British segment. The uptake of the booster dose in the 65 to 80 and over age range was 87% for the White British and 28% for the Arab population. For the age range 30 to 64, the White British population

average was 48% compared with 10% for the Arab population. Similar disparities were found in a smaller segment classified as “vulnerable”: for the 65 to 85 and over age range, 97% of the White British had received their booster compared with 71% of the Arab population. For the vulnerable in the age range 30 to 64, 88% of White British were covered, compared with 64% of the Arab population.(33)

A similar finding was obtained from an analysis undertaken of the 1,235,117 people in the Greater Manchester area who were eligible for the first dose of the COVID-19 vaccination (over 50 years of age or vulnerable because of medical conditions) in the period December 2020 to April 2021.(263) Of the sample, 79% were White British, and 0.13% were Arabs (n=1,414). Overall, 15 of the 16 minority ethnic groups assessed in the study achieved much lower vaccination levels than the White British group (88%, 95% CI 87.9 to 88.0). The Arab population had one of the lowest levels of vaccination (64%, 95% CI 61.7 to 66.7). The greatest level of inequality was for the oldest and most clinically vulnerable people and those most income deprived. The study also found a 56% influenza vaccine uptake amongst the eligible population, the highest among the White British population (57%, 95% CI 56.9 to 57.2), with the Arabs reporting lower uptake (43%, 95% CI 39.6 to 46.0).

One survey from 2021 investigated COVID-19 vaccine hesitancy across several African nations (n=5,416) including Egypt, Sudan and Morocco.(267) It found an overall level of 37% vaccine hesitancy, the highest being in Cameroon (67%), whereas around the average for Egypt (35%), Morocco (34%), and Sudan (28%). The most frequently mentioned reason for hesitancy was the misbelief that there was a high risk of infection or sickness if the vaccine was taken. Additionally, an online survey from 2020 of the general populations of the UK (N=1,088) and Turkey

(N=3,936) that assessed attitudes to taking up the COVID-19 vaccine found that 14% of UK respondents were hesitant compared with 31% of Turkish respondents.(268)

2.6.3 Sexual Health

There are no studies on the sexual health of UK Arabs to report. Still, there have been studies in Arab countries and the USA on the sexually transmitted HPV. Cervical cancer is one of the most common cancers affecting females worldwide, and HPV infection is its main risk factor. In addition to sexually transmitted HPV leading to cervical cancer it can also lead to cancers of the vulva, vagina, penis, anus, and oropharynx and genital warts are also caused by it. An estimated 92% of cancers caused by HPV could be preventable with vaccines.

A 2021 study conducted in four Arab countries (Jordan, Qatar, UAE, and Iraq) concluded that there are no public awareness and national immunisation programs in most Arab countries.(269) Very poor knowledge was found about the virus, its link to cancer or its vaccine. Higher levels of knowledge were found amongst a young minority with a postgraduate degree, career, or medicine-related education.

In a study conducted in New York with a sample of 162 Arab women with children, 37% of them reported that their child (aged between 9 through 26 years) had received the HPV vaccine. This was lower than the US average, where 75% of adolescents (aged 13 to 17 years) had received at least one dose of the HPV vaccine.(117) The authors hypothesised that the low level of vaccination might be due to cultural factors, including the shame associated with discussing sexual health. However, 43% of the

women reported limited knowledge about the disease or the vaccine, attributing this to limited vaccine availability in the Arab countries of origin.

2.6.4 Viral Respiratory Diseases

Respiratory infections or diseases are an umbrella term for conditions which affect the airways and other structures of the lungs. Respiratory disease affects one in five people and is the third biggest cause of death in England; they include pneumonia, influenza, Coronavirus disease (COVID-19) and COPD.(270)

In 2012, an epidemic of Middle East respiratory syndrome coronavirus (MERS-CoV) started in Saudi Arabia. An analysis was made in Birmingham of Arabs suspected of contracting MERS-CoV.(271) Over 25,000 pilgrims from the UK (Arabs and other ethnic Muslims) visit Saudi Arabia annually for the Umrah and Hajj pilgrimages. Active surveillance for MERS-CoV in returning pilgrims or travellers from the Middle East was initiated. Public Health England Birmingham Laboratory (PHEBL) was one of the institutions responsible for MERS-CoV screening of returning travellers to the UK from the Middle East who presented to hospitals with severe respiratory symptoms. From 2013 to 2015, 214 UK Arabs were tested for MERS-CoV on return from the Hajj, but no cases were detected; 50% of the sample had a viral infection, with rhinovirus and Influenza A being the most common viruses detected. In Manchester, the Public Health Laboratory tested 264 patients returning from the Hajj from 2013 to 2019 and found no MERS-CoV cases.(272)

2.6.5 Oral Health

There are no reports of the oral health of UK Arabs, but as a 2021 narrative review reported there is a 'silent epidemic of common oral diseases in the Arab world'(273). The study identified 39 dental health reports in most Arab nations, highlighting dental caries, periodontal disease, tooth loss, oral cancer, and dental trauma. The most frequently reported causes of poor oral health were the consumption of a high-sugar diet, particularly by the young and those who follow poor dental hygiene.

2.7 Ageing Well and Dying Well

Key Findings

- In 2021, only 3% of the Arab population in Birmingham was aged over 65, compared with 13% of the Birmingham average population.
- According to the EQ-5D index, Arab men (0.71) and women (0.60) in England experienced worse health than White British men (0.77) and women (0.75).
- There is very little information about the specific health concerns of older Arabs nationally or in Birmingham.

2.7.1 Health Inequalities and Older UK Arabs

In the 2021 census, only 5% of Arabs in England and Wales were over 65 compared with 19% of the national population.⁽⁵⁾ In the 2021 census, 3% of Arabs in Birmingham were over 65 compared with 13% of the local population. The relatively small number of Arabs over 65 means there is limited information about them at the national and local levels.

A recent study investigating health inequalities among people aged 55 or above in the UK, compared UK Arabs and 16 other minority ethnic groups with a White British group.⁽³⁴⁾ The study used data from the GPPS from 2014 to 2017, including a sample of 1,394,361 patients, 152,710 (11%) belonging to one of the 17 minority ethnic groups, 1,285 (0.1%) of which were Arab. Health inequalities were measured by the EQ-5D-5L index and its domains (mobility, self-care, usual activities, pain or discomfort, and anxiety or depression). The index ranges from -0.594 (poorest health) to 1

(perfect health) in the UK, where the value of death is 0 and negative index values represent health status valued worse than death. Health inequalities were apparent in all the ethnic groups compared with the White British group. Still, the greatest inequalities were for the Arab community (together with the Gypsy or Irish Traveller, Bangladeshi and Pakistani communities) (Table 17).

Table 17: Age-standardised mean EQ-5D index by ethnic group and gender: England, 2014 to 2017

Ethnic Group	Male [95% CI]	Female [95% CI]
White British	0.77 [0.77 to 0.77]	0.75 [0.75 to 0.75]
Arab	0.71 [0.69 to 0.74]	0.60 [0.56 to 0.64]
Pakistani	0.67 [0.67 to 0.68]	0.53 [0.52 to 0.54]
Bangladeshi	0.64 [0.61 to 0.67]	0.54 [0.50 to 0.57]
Gypsy or Irish Traveller	0.54 [0.40 to 0.67]	0.48 [0.40 to 0.57]

Source: Watkinson *et al.*, 2021 (34)

Ethnic inequalities were accompanied by increased prevalence of long-term conditions or multimorbidity, poor experiences with primary care, insufficient support from local services, low patient self-confidence in managing their own health, and high social deprivation, compared with the White British group.⁽³⁴⁾

2.7.2 Life Expectancy and Healthy Life Expectancy

There is no information about the life expectancy or healthy life expectancy of older Arabs in the UK.

2.7.3 Dementia

Dementia and Alzheimer's disease represented 13% of all death registrations in England and Wales among the general population (200,111) between the period of 2017 to 2019. There is no information about the prevalence of dementia in the older members of the UK Arab population.

However, since the majority of UK Arabs are Muslims, there is information about the religious and cultural practices of taking care of the elderly in the Muslim community. South Asian respondents dominate many surveys and research studies of the Muslim community but often include a minority of Arabs. These studies suggest that some Islamic beliefs and practices apply across different national identities. In the absence of direct evidence of the care of elderly Arabs in the UK, the findings of studies of UK Muslims are reported below as they may apply to many elderly Arabs in the UK.

A 2021 systematic review of 17 qualitative studies on dementia in the UK Muslim population concluded that the prevalence is likely high.(274) Another 2021 systematic review of the risk factors leading to dementia identified seven main contributing factors, such as diabetes, mid-life hypertension, mid-life obesity, smoking, depression, low educational attainment, and physical inactivity.(275) Given that these factors are common in the Muslim population, many older UK Muslims may suffer from dementia.

The review drew the following conclusions about how the Muslim community treated people with dementia. There was 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. As a result, family members were often slow to engage with the medical services to seek treatment for their elderly. For many Muslim families, there was also stigma and shame associated with dementia.

In some cases, families with a relative with dementia shut themselves off from contact with their community because of the shame.(274) Muslim families felt they had a religious and moral obligation to take care of a relative with dementia, no matter how distressing and difficult it may be. The principal caregiver was nearly always a woman and was often the wife of the eldest son. The behaviour of the person with dementia could often be disruptive and difficult to control. 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, spiritual guidance, and traditional herbal remedies to help their relatives.

To support Birmingham residents living with dementia, the Birmingham and Solihull Integrated Case System (BSOL ICS) have launched a Dementia Strategy for 2023 to 2028. The Strategy aims to enable all people with dementia and those who care for them, to have the best possible health and social care support through their dementia journey. This will be achieved through 4 key priorities(276):

1. Information which focuses on prevention of dementia, early intervention and support.
2. Access to a timely diagnosis with support before and after.
3. Supporting people with dementia, their loved ones, carers, and communities to prevent crisis.

4. Improving the quality of personalised care and support planning for people with dementia, including planning for the end of life

2.7.4 Frailty

There is limited evidence on the prevalence of frailty amongst the elderly of the UK Arab population.

The NHS defines frailty as “the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long term care”.(277) The GPPS reviewed fall outcomes among patients, which can be used as a predictor of frailty. When asked “Have you experienced two or more falls that have needed medical attention over the last 12 months” the Arab population reported higher rates of falls (6%, n=248) than the average survey respondent in England (2%, n=17,162).(32) Therefore, based on this predictor, the Arab ethnic group may be more likely to be classified as frail. More data is needed to gain a comprehensive understanding of the factors contributing to frailty among the Arab population.

2.7.5 Loneliness and Isolation

There is no evidence of the degree to which the older members of the UK Arab population experience loneliness and isolation. There is, however, evidence of the experiences with loneliness and isolation among elderly Muslims. A 2019 Muslim Council of Britain survey of 75 families found that there was a belief and expectation that an elderly person will be cared for by their family and many families set out to honour that commitment(278). However, respondents found it increasingly difficult 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 living alone in their home and becoming isolated and lonely.

2.7.6 Care Homes and Domiciliary Care

From March 2021 to February 2022, there were an estimated 360,792 care home residents in England. Data on care home residents by ethnic groups is not available. However, data from the Adult Social Care Activity and Finance Report provided an overview of the number of Arab adults receiving long term adult social care support. In 2021 in England, it was noted that 515 adults of Arab ethnicity were in receipt of long-term support.(279) This figure encapsulated those in the following support settings: nursing, residential, community or prison.(279, 280)

The 2021 survey of 17 studies of dementia in Muslim communities found that very few families explored the option of moving their relative to a care home.(34) This was partly because of the obligation to look after them at home and partly because of concerns about the appropriateness of the care in the care home, e.g., ‘would the food be suitable, would Muslim carers be available or would care be given by opposite-sex care staff?’ Similarly, families did not seek domiciliary care believing it was their responsibility to provide care in the home.

2.7.7 End-of-life and Palliative Care

Palliative care, encompassing end-of-life care, is an approach that aims to provide optimal quality of life to people with life-limiting incurable diseases and their families. There is no evidence of the extent to which UK Arabs receive end-of-life or palliative care.

There are reports that the take up of palliative care by Muslims in the UK is much lower than for elderly people in the country, and Arabs who are Muslims may also make little use of palliative care.(281) This is attributed to beliefs in the Muslim population that the practices involved in palliative care do not follow Islam's spiritual teachings. This is partly related to the distinction made in palliative care between 'cure' when a medicine is used to help a person recover from illness, and 'care,' when a 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 strictly prohibited by Islamic teachings, including opioids, brain stimulants, and cannabinoids.

There are, however, substantial analyses in Islamic teaching that conclude that the palliative care approach is entirely compatible with spiritual and cultural approaches to caring for the dying.(282) Some authors 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.(283) Several examples are available to show what these approaches are like in practice.(284)

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 the care of elderly patients because of the stigma and shame 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 their doubts about some of

the practices involved. However, the reasons for reluctance include doubts 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.(285)

As Muslims near the end of life, many rituals 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, the authors have called for the staff of hospices and care homes to receive training in the cultural practices of Muslims so that they can offer people at the end of their life holistic treatment commensurate with their beliefs and expectations.(281)

A 2009 survey of elderly Muslims and Sikhs, their families, and health professionals in Scotland explored the issues of accessing appropriate services.(286) The study was based on 96 interviews, 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, including 11 with cancer. 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 Muslim people of the role of hospices; and difficulty discussing death. The patients at most 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 Sikh and Muslim patients and their families were, in many respects, similar to one another.

Many Muslim practices are observed when a person dies.(282) 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.

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2.8 Contributing to a Green and Sustainable Future

Key Findings

- Balsall Heath West ward contains a high proportion of residents of Arab ethnicity (15%), this ward was classified as the ward with the least environmental justice (0.43) for its citizens.
- In Birmingham the wards with the highest concentration of Arab people are amongst the wards that are more than 15 minutes away from parks and green spaces.
- Approximately 15% of people from the Arab ethnic group live in the 15 most polluted MSOAs in Birmingham, compared with 5.4% of the White British population.
- The Arab population in Birmingham is likely vulnerable to the Urban Heat Island (UHI) effect due to high concentrations of the population living in central areas of the city.

The Environmental Justice map combines 5 indicators, namely, the index of Years of Life Lost (YLL), Urban Heat Island (UHI) effect, the Indices of Multiple Deprivation (IMD), Public green spaces access and flood risk. The indicators are combined and scaled in a range of 0 to 1, with 0 being the most preferred and 1 being the least. The wards in Birmingham vary from scores of 0.12 in Sutton Roughley to 0.43 in Balsall Heath West.(35)

The largest concentrations of the Arab community in Birmingham are in the wards of Balsall Heath West, Sparkbrook, Balsall Heath East, Bordesley & Highgate.(5) The Birmingham City of Nature Plan proposed that all citizens should live within 15 minutes of parks and green spaces. In an

analysis of access in the 69 wards, these wards were among the 13 being further away from parks and green spaces.(287) These wards also had some of the highest scores for measuring Environmental Justice in Birmingham (Table 18). This demonstrates that many Arabs living in Birmingham live in areas of the city with the least environmental justice for citizens. Access to green spaces is lowest, the areas are UHIs, at risk of flooding, have high levels of deprivation and people have worse health and wellbeing.(35)

Table 18: Environmental Justice Map scores showing areas with the largest Arab communities: Birmingham, 2021

Wards	Index Mean Value	Arab Population (% of Ward)
Balsall Heath West	0.43	15
Sparkbrook & Balsall Heath East	0.39	8.2
Bordesley & Highgate	0.40	5.6
Bordesley Green	0.39	4.0
Ladywood	0.33	3.9
Edgbaston	0.21	3.4
Tyseley & Hay Mills	0.35	3.2
Small Heath	0.34	3.0

Source: Birmingham City Council, 2022 and ONS, 2023 (35)

2.8.1 Access to Green and Blue Space

Green spaces are defined as “any area of vegetated land, urban or rural. This includes both public and private spaces”. Examples of green spaces include parks, gardens, playing fields, wood and other natural areas.(288)

Access to green spaces can contribute to a multitude of health and wellbeing benefits such as stress reduction, reduction in crime, increased physical health and reduction in UHI effect.(289)

Birmingham has been named one of the greenest cities in Europe, with over 600 publicly accessible green and blue spaces across the city. 60% of Birmingham residents visit green spaces on a weekly basis, with 72% choosing to visit the green space closest to their home. However, there is an observed inequality in access to good quality green spaces across the city.(287)

The environmental justice map defines access to a green space as “within 1,000m and at least 2 hectares”.(35) ONS data for 2020 provides insight into the average combined size of parks or public gardens and playing fields within 1,000m radius of residents by MSOA.

Encouragingly, all MSOAs in Birmingham have at least 2 hectares of combined green space within 1,000 metres; however, these two hectares may be split into smaller parks and playing fields. For example, in the Balsall Heath East MSOA, with an Arab population of 1,102, the average size of the nearest green space is 1.62 hectares, below the definition for access to green space. However, this dataset does not indicate the size of the next nearest green space, which may meet the requirements listed above.(290)

There is no data on the extent to which Arabs in Birmingham or the UK can access and use blue spaces.

2.8.2 Air Pollution

Air pollution is a major public health risk. A review by the WHO concluded that ambient (outdoor) air pollution can reduce life expectancy and cause

premature deaths. In 2019, it was estimated that 37% of premature deaths caused by air pollution globally were due to increased incidence of ischaemic heart disease and stroke, 18% from COPD, 23% from acute lower respiratory infections and 11% from respiratory tract cancers.(291) The effects of air pollution disproportionately affect vulnerable communities such as children, pregnant people, older adults and those with pre-existing conditions.(292)

It is estimated that in Birmingham 900 deaths annually are linked to air pollution.(292) Additionally, Office for Health Improvements and Disparities (OHID) Public Health data estimated that in 2021, 6.2% of mortalities in Birmingham were attributable to particulate air pollution. This is compared with 5.5% nationally.(293)

2019 data from the IMD estimated the concentration of four main air pollutants: nitrogen oxide, benzene, sulphur dioxide and particulate matter across Birmingham. The overall pollution levels were calculated and given an associated score. A higher score indicates a higher level of air pollution; across England scores range from 0.32 to 1.90. In Birmingham, lower super output area (LSOA) pollution scores ranged from 0.91 to 1.59.(30) **Table 19** maps the 15 most polluted MSOAs in Birmingham and the corresponding Arab (ethnic group) population.

Table 19: Average air pollution of four main air pollutants by MSOA, correlated to Arab population by MSOA: Birmingham, 2020

MSOA	Pollution Score	Arab Population (no.)
Central	1.55	257
North Central and Dartmouth Circus	1.52	347
Nechells	1.51	159

MSOA	Pollution Score	Arab Population (no.)
Digbeth	1.49	196
Aston Park	1.48	107
Brookvale	1.47	139
Five Ways North	1.46	291
Ladywood – Summer Hill	1.45	147
Middlemore	1.45	68
Washwood Heath	1.45	105
Lozells East	1.42	123
Hockley & Jewellery Quarter	1.41	167
Attwood Green & Park Central	1.41	538
Saltley West	1.41	248
Perry Beeches East	1.41	30

Source: MHCLG, 2019 and ONS, 2023 (30)

From this dataset it can be estimated that 15% of the Arab ethnic group in Birmingham live in the 15 most polluted MSOAs in Birmingham. This is in comparison to approximately 5.4% of the White British population in Birmingham.

The wards occupied by the Arab community in Birmingham are subject to the air pollution levels experienced in many large cities in the UK, especially from traffic emissions.(273) The wards in the centre of the city in particular should benefit from the introduction of a Clean Air Zone (CAZ) in Birmingham.

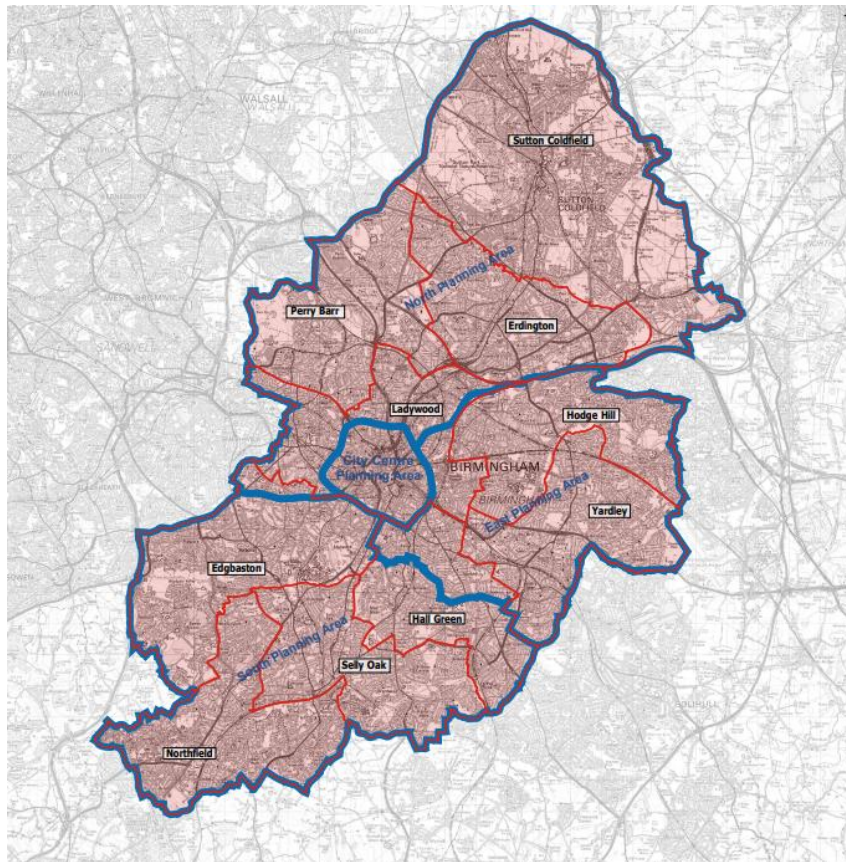
2.8.3 Flood Risk

Most Birmingham postcodes are medium flood risk, with some low, high, and very low flood risk postcodes. Flood risk mapping identifies areas that are at significant risk of flooding.

Figure 11 illustrates the inland waterways in Birmingham which are associated with increased flood risk.

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Figure 11: Map of inland waterways: Birmingham, 2009



Source: Birmingham City Council, 2009 (294)

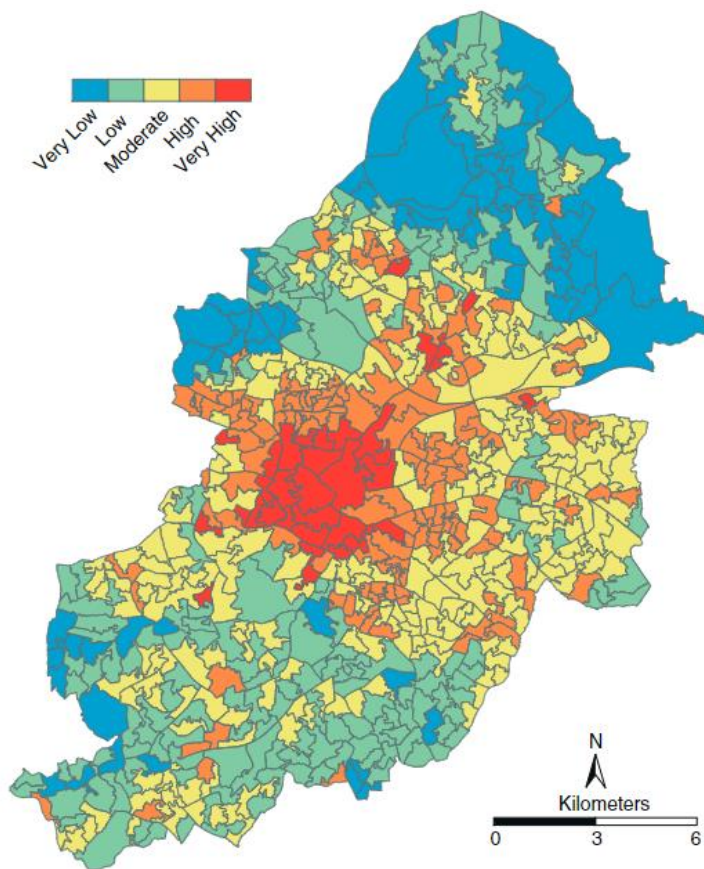
The Birmingham wards that the highest percentage of Arab populations do not have substantial flood risks (294).

2.8.4 Urban Heat Island Effect

The UHI effect refers to areas of high building density, usually the cores of the cities, where temperatures are typically higher than the outer areas of the city. In Birmingham, for example, Sutton Park was recorded as having a surface temperature almost 8 degrees cooler than the city centre during a heatwave. During periods of extended high temperatures, such as heatwave conditions, the UHI can cause excess deaths of citizens in these areas. Some groups are more vulnerable to the UHI effect, including older adults, those with LTHCs, people living in high-rise buildings and in high density areas.(295)

A study from 2011 produced a spatially assessed heat-health risk map for Birmingham (Figure 12). By overlapping this map onto the census data, it can be understood that there are high populations of the Arab ethnic group located in the 'very high' risk areas e.g., Balsall Heath East and Sparkbrook & Balsall Heath East. Therefore, the Arab population in Birmingham is likely vulnerable to the UHI effect.

Figure 12: Spatially assessed heat-health risk: Birmingham, 2011



Source: Tomlinson *et al.*, 2013 (295)

3. Closing the Gaps

There is some understanding of the intersectional experiences of Arab people where ethnicity data is available alongside other key variables, used in multivariate analysis. This data is typically found in the census, NHS digital data etc. However, there are some limitations to fully understanding the health inequalities experienced by the Arab community, with many UK reports grouping the Arab ethnic group into the 'Other ethnic groups' category. These inconsistencies in ethnicity collection make it difficult to make clear conclusions about the health and wellbeing of the Arab population. Additionally, in many aspects of health and wellbeing only small qualitative research studies and international data is available.

There is some data to suggest that the health of Arab migrants is associated with acculturation, such as observed increase in physical activity after migration. Therefore, it is important to interpret international data presented throughout this report with caution as health data may not be applicable to the current health and wellbeing of the UK Arab population.

Research on the Arab community has suggested that intersectionality between ethnic group and other aspects of identity, such as gender and age are associated with poorer health outcomes, and it is important that this is explicitly considered in responding to this profile. For example, women experienced higher rates of domestic violence, were likely to be deficient in vitamin D and generally had lower levels of education than men. There is limited data available, but it is also likely that the Arab population who have a disability or identify as LGBTQ+ experience compounding health inequalities.

Finally, this report highlighted experiences of racism among people of Arab backgrounds in the UK. Individuals of Arab background may also experience discrimination for other factors aside from race, including religion, nationality, having a foreign accent, or having a lower proficiency in English language. For example, many Arabs are Muslims, and this report highlighted how hate attacks and experiences of Islamophobia on Muslims and Arabs in the UK increased after events such as 9/11 and 7/7.

To effectively tackle inequalities the Arab population may experience it is important to decrease discrimination and barriers to accessing services, to accurately map Arab's experiences with health and wellbeing and understand how their health interacts with other aspects of their identity e.g., age, disability, sexual orientation and faith.

4. Conclusion

This Community Health Profile clearly demonstrated a significant breadth of health inequalities affecting the Arab population. Often, there has been limited data on the Arab community living in Birmingham, so data has been reported from national or international studies.

At the heart of some of these inequalities are the impacts of discrimination and racism which impact on health behaviours, access to services and health outcomes. Sadly, much of the evidence demonstrates persistent and consistent inequalities, and often reflects the wider landscape of societal and environmental factors which influence health.

It is important to acknowledge that there are also some positives highlighted in this report and that in some areas such as attainment of

higher education qualifications, self-reported health and experiences of disability or LTHCs, Arabs have more positive outcomes than other ethnic groups. We should also recognise the vibrant and varied culture and heritage of people from Arab countries or heritage within the UK. However, these assets are often overshadowed by the negative inequalities highlighted throughout this report.

The Community Health Profile provides an evidence summary for communities and partners to start to co-produce solutions and better address these long-standing inequalities to create better environments and services to support UK Arabs to live healthier, longer and happier lives.

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4. Appendices

Appendix 1: Search Strategy

Topic Area	General Search Terms	Specific Search Terms
Getting the Best Start in Life	"Arab*" or "Algeria*" or "Bahrain" or "Comoros" or "Djibouti" or "Egypt*" or "Iraq*" or "Jordan*" OR "Kuwait" or "Lebanon" OR "Lebanese" or "Liby*" or "Mauritania*" or "Morocc*" or "Oman" or "Palestin*" or "Qatar" or "Saudi" or "Somalia*" or "Sudan*" OR "Syria*" or "Tunisia*" or "United Arab Emirates" or "UAE" or "Yemen" and "young*" or "youth" or "child*" or "babies" or "infant*" or "adolescents" or "parent*" or "mother*" or "father*"	"Arab*" or "Algeria*" or "Bahrain" or "Comoros" or "Djibouti" or "Egypt*" or "Iraq*" or "Jordan*" OR "Kuwait" or "Lebanon" OR "Lebanese" or "Liby*" or "Mauritania*" or "Morocc*" or "Oman" or "Palestin*" or "Qatar" or "Saudi" or "Somalia*" or "Sudan*" OR "Syria*" or "Tunisia*" or "United Arab Emirates" or "UAE" or "Yemen" and "maternity care" or "obesity" or "measles" or "obesity" or "health check" or "maternal" or "breastfeeding" or "fostering" or "care" or "social care" or "child poverty" or "educat*" or "school" or "bullying" "dental" or "birth" or "fertility" or "vaccin*" or "immunisation" or "refugee" or "asylum"
Mental Wellness and Balance	"Arab*" or "Algeria*" or "Bahrain" or "Comoros" or "Djibouti" or "Egypt*" or "Iraq*" or "Jordan*" OR "Kuwait" or "Lebanon" OR "Lebanese" or "Liby*" or "Mauritania*" or "Morocc*" or "Oman" or "Palestin*" or "Qatar" or "Saudi" or "Somalia*" or "Sudan*" OR "Syria*" or "Tunisia*" or "United Arab Emirates" or "UAE" or "Yemen" and or "mental*" or "wellbeing" or "wellness"	"Arab*" or "Algeria*" or "Bahrain" or "Comoros" or "Djibouti" or "Egypt*" or "Iraq*" or "Jordan*" OR "Kuwait" or "Lebanon" OR "Lebanese" or "Liby*" or "Mauritania*" or "Morocc*" or "Oman" or "Palestin*" or "Qatar" or "Saudi" or "Somalia*" or "Sudan*" OR "Syria*" or "Tunisia*" or "United Arab Emirates" or "UAE" or "Yemen" and "mental illness" or "depression" or "suicide" or "anxiety" or "eating disorder" and "prevalence" or "service" or "access" or "hospital admission" or "shame" or "stigma" or "stress" or "racial harassment" or "alcohol*" or "drinking*" or "abstention" or "substance misuse" or "substance abuse" or "addiction" or "tobacco" or "cannabis" or "cigarette" or "drugs*" or "smoking" or "shisha" or "discriminat*" or "hate crime" or "violence" "illegal" or "hate crime" or "treatment" or "domestic abuse" or "domestic violence" or "partner abuse" or "hate crime" or "discrimination" or "racism" or "islamophobia"

Healthy and Affordable Food	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “food” or “diet” or “obesity” or “meat” or “vegetarian” or “nutrition” or “vegan” or “halal”</p>	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “food*” or “dietary” or “obesity” or “overweight” or “BMI” or “weight” or “waist-height ratio” or “food insecurity” or “food poverty” or “eating” or “cholesterol” or “calories”</p>
Active at Every Age and Ability	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “physical activity” or “activity” or “exercise” or “inactivity”</p>	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “vigorous exercise” or “moderate exercise” or “walking” or “running” or “sports” or “cardiovascular” or “elderly exercise” or “health promotion” or “mobility” or “barrier*” or “facilitator*” or “musculoskeletal”</p>
Living, Working and Learning Well	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “working” or “education” or “qualification” or “training” or “skill” or “housing” or “living” or “economic” or “health” or “illness” or “disability” or “long standing health” or “depriv*” or “poverty”</p>	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “apprenticeships” or “level 1,2,3,4 qualification” or “degree” or “NEET” or “secondary school” or “primary school” or “full-time education” or “profession” or “career choice” or “household income” or “home ownership” or “accommodation” or “bad health” or “learning disability” or “physical disability” or “neurodivergence” or “ADHD” or “autism” or “ASD” or “diabetes” or “cardiovascular disease” or “CVD” or “Chronic Obstructive Pulmonary Disease” or “COPD” or “Hypertension” or “cancer” or “quality of life” or “access”</p>
Protect and Detect	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR</p>	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or</p>

	<p>“Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “protect” or “detect” or “screening” or “vaccin*” or “sexual health” or “infectious disease” or “communicable disease*” or “oral health”</p>	<p>“Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “STI” or “sexually transmitted infection” or “sex education” or “transmission” or “sexual health services” or “genitourinary medicine” or “HIV” or “Hepatitis” or “Tuberculosis” or “TB” or “COVID-19” or “coronavirus” or “SARS-CoV-2” or “lockdown” or “bowel” or “HPV” or “Human Papilloma Virus” or “dental” or “teeth”</p>
Ageing Well and Dying Well	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “ageing” or “aging” or “dying” or “dementia” or “end of life” or “palliative” or “frailty” or “lon*” or “isolat*” or “care”</p>	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “social networks” or “or “Alzheimer’s” or “stigma” or “death” or “advance care planning” or “falls” or “domiciliary” or “life expectancy” or “mortality” or “morbidity”</p>
Contributing to a Green and Sustainable Future	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “sustainability” or “green future” or “sustainable” or “environment”</p>	<p>“Arab*” or “Algeria*” or “Bahrain” or “Comoros” or “Djibouti” or “Egypt*” or “Iraq*” or “Jordan*” OR “Kuwait” or “Lebanon” OR “Lebanese” or “Liby*” or “Mauritania*” or “Morocc*” or “Oman” or “Palestin*” or “Qatar” or “Saudi” or “Somalia*” or “Sudan*” OR “Syria*” or “Tunisia*” or “United Arab Emirates” or “UAE” or “Yemen” and “recycling” or “environmentally friendly” or “tree planting” or “sustainable development” or “energy consumption” or “green space” or “blue space” or “White space” or “pollution” or “flood” or “climate” or “heat” or “heat stroke” or “urban”</p>

Appendix 2: Exclusion and Inclusion Criteria

Age group	Language	Publication type	Time limit
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Any	English Language	<p>Peer reviewed or grey literature from reliable sources, academic or scientific literature, whether a journal or article, report or documents relating to the specified health and wider determinants issues amongst Arabs in the UK.</p> <p>Publications with at least 25% of the Arab population sample representation (e.g., studies reporting on sample group of 'Muslims' where at least 25% of Muslim population identified as Arab).</p> <p>[with caveats, the Islamic religion was sometimes used as a proxy for Arabs, as 92% of Arabs in Birmingham identify with the Muslim faith]</p>	From 2013 to 2023 but older literature was used in the absence of available data.
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Appendix 3: Glossary and Definitions

Arabic: The language that is common to all the nations of the Arab League.

Arab League: The Arab League, formerly the League of Arab States, is a regional organisation in the Arab world.

Qur'an: The Qur'an (also the Qur'an or Koran) is the central religious text of Islam believed by Muslims to be a revelation from God.

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Appendix 4: Birmingham and National Arab Organisation Contact Details

Organisation Name	Target Audience	Contact Information
Birmingham Public Health Communities Team	All Birmingham based communities	communitiesteam@birmingham.gov.uk <i>Sign-up to our mailing list to get all the latest updates on community health profiles and engagement opportunities</i> <i>Email sign up to the email included above.</i>
Council for Arab-British Understanding		info@caabu.org
Arab Advice Bureau	Arab community	info@arabadvicebureau.org.uk
The Arab British Centre		info@arabbritishcentre.org.uk
University of Birmingham Arab Society	Arab students in Birmingham	arabsoc@guild.bham.ac.uk
Arab British Chamber of Commerce	Arab businesses, countries and British ministries and bodies	info@abcc.org.uk

Appendix 5: Raw Data Tables

Appendix 5.1. Figure 2: Country of birth among Arab ethnic group: Birmingham, 2021

Country of Birth	Arab (count)	Arab (%)
Middle East and Asia	7,277	38
England	6,854	36
Africa	3,199	17
Other Europe	1,584	8
Other Country of Birth	284	1

Source: ONS, 2023

Appendix 5.2. Figure 3: Arrival of 'Other ethnic group: Arab' population to the UK by sex: Birmingham, 2021

Year of Arrival	Arab: Female (count)	Arab: Male (count)
Arrived before 1991	312	471
Arrived 1991 to 2000	657	741
Arrived 2001 to 2010	1360	1311
Arrived 2011 to 2021	3604	3737

Source: ONS, 2023

Appendix 5.3. Figure 4: Religious beliefs breakdown by Arab ethnicity: Birmingham, 2021

Religion	Arab (count)	Arab (%)
Muslim	17,580	92
Not answered	1,046	5
No religion	317	2
Christian	218	1

Source: ONS, 2023

Appendix 5.4. Table 4: Ethnic groups associated with various Arab populations: Birmingham, 2021

Ethnic Group	Count
Other ethnic group: Arab	19,196
Black, Black British, Black Welsh of African: Somali	16,971
Black, Black British, Black Welsh of African: Somalilander	2,261
Black, Black British, Black Welsh of African: Sudanese	1,678
Other ethnic group: Somali	1,526
Other ethnic group: Other Middle East	807
Asian, Asian British or Asian Welsh: Other Middle East	707
Black, Black British, Black Welsh or Caribbean: Somali	579
Asian, Asian British or Asian Welsh: Arab	443
Mixed or Multiple ethnic groups: Arab	372
Other ethnic group: North African	309
Black, Black British, Black Welsh of African: Arab	295
Other ethnic group: Somalilander	247
Black, Black British, Black Welsh of African: Other North African	196
Other ethnic group: Moroccan	161
Mixed or Multiple ethnic groups: African/Arab	117
Black, Black British, Black Welsh of African: Moroccan	105
White: Other Middle East	94
Mixed or Multiple ethnic groups: Other Middle East	76
White: Other North African	67
White: Arab	62
Mixed or Multiple ethnic groups: Moroccan	51
Other ethnic group: Algerian	51
White: Algerian	20

Source: ONS, 2023

Appendix 5.5. Figure 5: Age Breakdown for Arabs and General Population England and Wales (2021)

Age Group	Arabs (%)	General Population (%)
0 to 14	27	17
15 to 24	17	12
25 to 34	17	14
35 to 44	16	13
45 to 54	11	13
55 to 64	7	13
65 to 74	3	10
75 and over	2	9

Source: ONS, 2023

Appendix 5.6. Figure 6: Age Breakdown for Arabs and Local Population, Birmingham (2021)

Age Group	Arabs (%)	General Population (%)
0 to 14	34	21
15 to 24	19	16
25 to 34	16	15
35 to 44	15	14
45 to 54	9	12
55 to 64	5	10
65 to 74	2	7
75 and over	0	6

Source: ONS, 2023

Appendix 5.7. Figure 7: National identity among the Arab ethnic group: Birmingham, 2021

National Identity	Arab (count)	Arab (%)
British only	11,026	58
Non-UK only	6,796	35
UK and non-UK	843	4
English and British only	291	2
English only	196	1

Source: ONS, 2023

Appendix 5.8. Figure 8: Highest level of qualification by ethnic group: Birmingham, 2021

Highest Level Qualification	Birmingham Average (%)	Arab (%)	White British (%)
No qualification	24	24	23
Level 1 (1 to 4 GCSEs grade A* to C, Any GCSEs at other grades, O levels or CSEs (any grades), 1 AS level, NVQ level 1, Foundation GNVQ, Basic or Essential Skills)	10	11	10
Level 2 (5 or more GCSEs (A* to C or 9 to 4), O levels (passes), CSEs (grade 1), School Certification, 1 A level, 2 to 3 AS levels, VCEs, Intermediate or Higher Diploma, Welsh Baccalaureate Intermediate Diploma, NVQ level 2, Intermediate GNVQ, City and Guilds Craft, BTEC First or General Diploma, RSA Diploma	13	10	13

Highest Level Qualification	Birmingham Average (%)	Arab (%)	White British (%)
Level 3 (2 or more A levels or VCEs, 4 or more AS levels, Higher School Certificate, Progression or Advanced Diploma, Welsh Baccalaureate Advance Diploma, NVQ level 3; Advanced GNVQ, City and Guilds Advanced Craft, ONC, OND, BTEC National, RSA Advanced Diploma)	17	12	19
Level 4+ (degree (BA, BSc), higher degree (MA, PhD, PGCE), NVQ level 4 to 5, HNC, HND, RSA Higher Diploma, BTEC Higher level, professional qualifications (for example, teaching, nursing, accountancy)	30	35	27
Other (apprenticeships, vocational or work-related qualifications, other qualifications achieved in England or Wales, qualifications achieved outside England or Wales (equivalent not stated or unknown))	7	7	7

Source: ONS, 2023

Appendix 5.9. Figure 9: Housing tenure by ethnic group: Birmingham, 2021

Tenure	Birmingham Average (%)	Arab (%)	White British (%)
Rented: Social rent	24	34	20
Rented: Private or rent free	23	41	19
Owned: Mortgage or loan or shared ownership	26	14	32
Owned: Outright	27	11	29

Source: ONS, 2023

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Authors

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