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# LONDON BANGLADESHI HEALTH INEQUALITIES SUMMIT

# A CALL TO ACTION

#BanglaHealthSummit24

# Welcome and Introduction from Co-Chair

- Riyadul Karim

# LONDON BANGLADESHI HEALTH INEQUALITIES SUMMIT

# A CALL TO ACTION

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# How and why was the London Bangladeshi Health Partnership (LBHP) formed?

Riyadul Karim

Assistant Director, Community Engagement and Vaccine and Screening Equity, COVID-19 and Flu Vaccination Programme, NHS England, London Region.

Co-Chair – London Bangladeshi Health Partnership.

# The key learnings from COVID-19:

The importance of:

- Addressing the communities' healthcare inequalities.
- Building trust and confidence in communities we serve.
- Bringing  people, and place together.
- Working with **Trusted Leaders** (Faith and Community) in their **Trusted Places** and utilising their **Trusted Voices** and channels.
- 3Ts model of engagement used in Enfield forms the foundational pillar of Vaccination & Screening Groups, spanning across London, seeking to address vaccine and screening disparities in underserved communities.

- The 3Ts model also fostered a key network of connections to be made across London of those concerned about Bangladeshi health inequalities, including myself, Dr Sharmin Shajahan V4CE, Khasruz Zaman, Barts Health & Bashir Uddin, Bangla Housing Association (BHA), and other trusted leaders.
- Thanks to funding from London Health Equity and Legacy Partnership (LHEP), we were able to form LBHP, launch last summer, begin to develop this health network and organise today's landmark summit in Tower Hamlets Town Hall.
- LBHP is an interdisciplinary group of health and community development professionals, interested in identifying, addressing principal health needs of the Bangladeshi community in London, and working to develop a strategic workplan.

- LBHP aims to respond to the health priorities of Bangladeshi communities in London and seeks to advance health equity in vaccinations, screening and diabetes.
- Today, we focus on these areas and bring people, place, system together for this first-ever summit on Bangladeshi health inequalities in London.

- Please refer to the special data packs on Bangladeshi health inequalities in London prepared by NHSE PIR team for the summit.
- Thanks to Voice 4 Change England, NHSE PMO team, Tower Hamlets Council, Bangla Housing Association, Barts NHS Health Trust, Diabetes UK, North East and North Central London Cancer Alliances, our speakers, morning and afternoon session chairs, facilitators and scribes. And **thank you** for coming!

Welcome

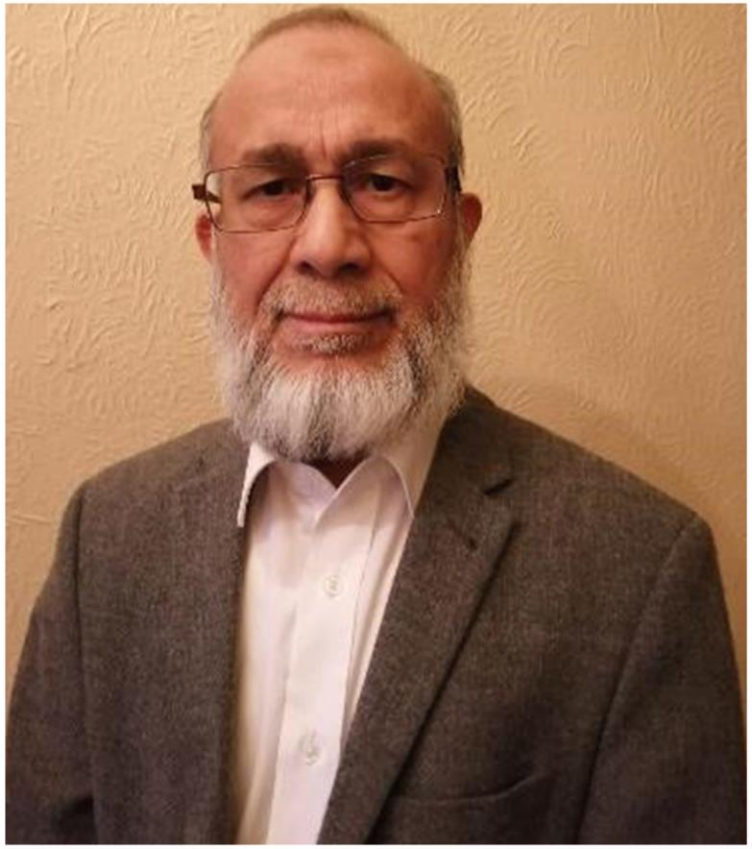
# Khasruz Zaman

Inclusion and Community Engagement Manager, Barts Health NHS Trust & Community Lead,
Vice Chair LBHP

## Welcome

# Bashir Uddin

Chief Executive Officer,
Bangla Housing Association
LHBP Delivery Partner



Welcome

# Dr Sharmin Shajahan

Deputy Director, V4CE & Co-Chair LBHP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# Welcome and Introduction from Co-Chair

- Dr Sharmin Shajahan

# Advancing health equity and access to health services for the Bangladeshi community

Sharmin Shajahan – Deputy Director, V4CE

Co-Chair – London Bangladeshi Health Partnership

# A Successful Initiative Of Advancing Health Equity In Bangladeshi Community in Tower Hamlets

Research in partnerships → Evidence / data 1 in 2 women chewed tobacco in Paan → Bespoke service developed in TH with health authority funding → PH funded & now embedded in mainstream stop tobacco service at QMUL

Trained NHS & Asian Quitline telephone counsellors

London wide Ramadan Campaign 2002 funded by DoH

JOURNAL ARTICLE

## Tobacco dependence in a UK Bangladeshi female population: a cross-sectional study

Get access ›

Ray Croucher ✉, Sharif Islam, Martin Jarvis, Myra Garrett, Rubina Rahman, Sharmin Shajahan, Gareth Howells

*Nicotine & Tobacco Research*, Volume 4, Issue 2, May 2002, Pages 171–176,
https://doi.org/10.1080/14622200210123171
**Published:** 01 May 2002 **Article history** ▾

https://www.researchgate.net/profile/Ruth-Belling/publication/264838413_Evaluation_of_London-wide_Ramadan_Campaign/links/568a271f08ae051f9af9e86b/Evaluation-of-London-wide-Ramadan-Campaign.pdf

https://academic.oup.com/ntr/article-abstract/4/2/171/1013226?redirectedFrom=fulltext


Paan Daan Decoration!!


Zarda
Tobacco leaves
Betel nut
Piper betel leaf


(A) Ordinary Quid
(B) Sweet Quid

# A Qualitative Study Exploring The Process Of Access To Health Services In Tower Hamlets

Factors influencing access to health services for Bangladeshi patients, their help seeking behaviour after heart attack and varying perceptions of health and illnesses between health service users and health service providers

**Social Models**

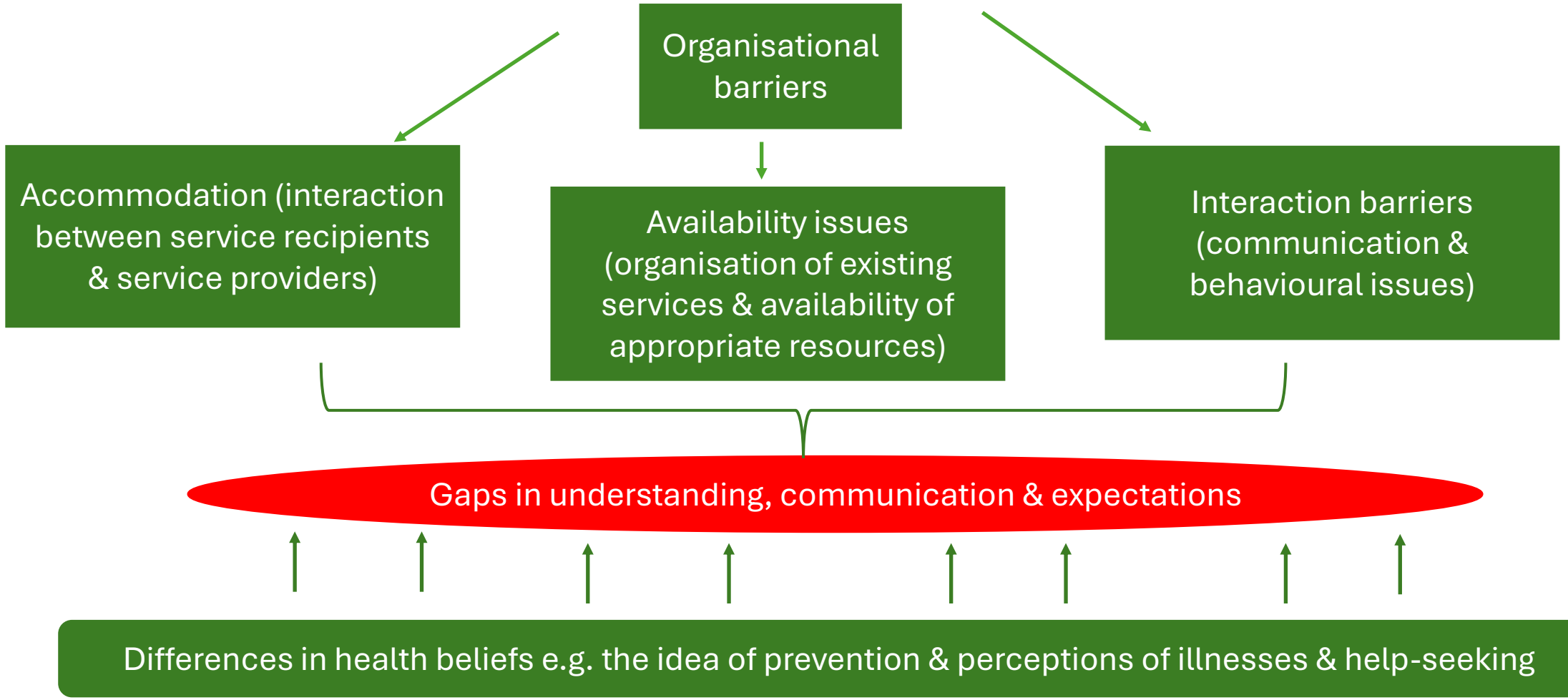
- Physical accessibility; affordability and availability
- **Acceptability** (interaction between service recipients & service providers)
- **Accommodation** (organisation of existing services & availability of appropriate resources)

**Behavioural Models**

Primary determinants of health behaviour is influenced by factors such as:

- How the healthcare system is & external environment
- Patients' predisposing factors (socio-cultural, health beliefs)
- Enabling factors (availability & cost)
- Patient needs (equity context), these factors influence their personal health practice, help-seeking behaviour and the patterns of use of different types of health services (preventative, e.g. vaccination & screening, primary, secondary & tertiary)

# Conceptual Model Of Help-seeking Behaviour And Factors Influencing Access To Health Services by Bangladeshi Patients With Heart Disease



Organisational barriers (accommodation, availability issues & interaction barriers (communication & behavioural issues )

Multi-sectoral partnership working

Increase recruitment & retention of bilingual staff

Gaps in understanding, communication & expectations

**Factors influencing access to health services in the Bangladeshi community in Tower Hamlets**

Differences in health beliefs & perceptions of health & illnesses

Awareness raising campaigns; bilingual & culturally appropriate interventions

Interaction barriers (communication & behavioural issues)

Needs assessment & health equity audits

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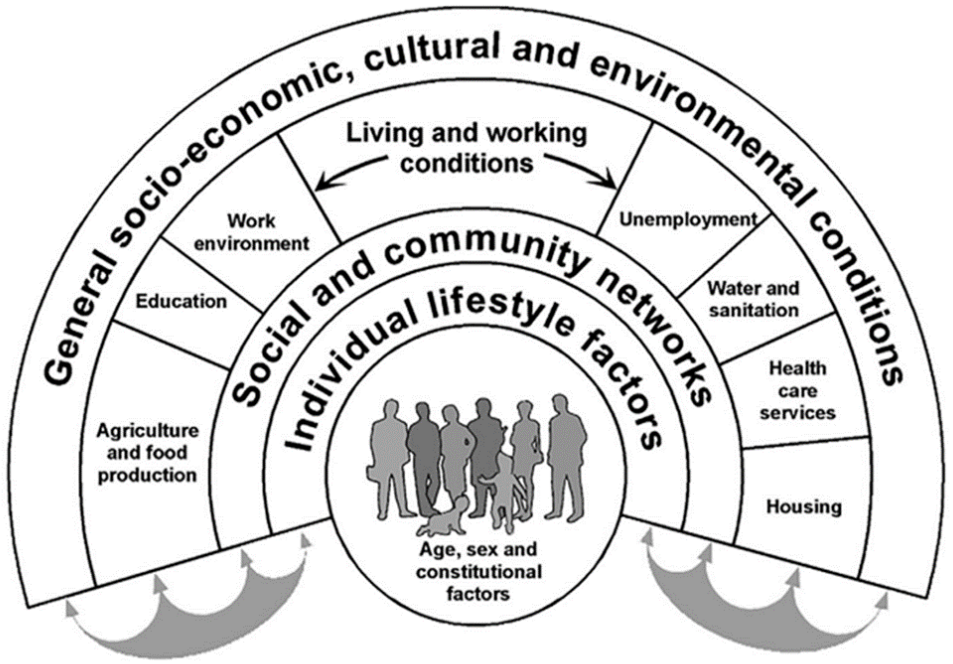
# Health Inequalities & Social Determinants

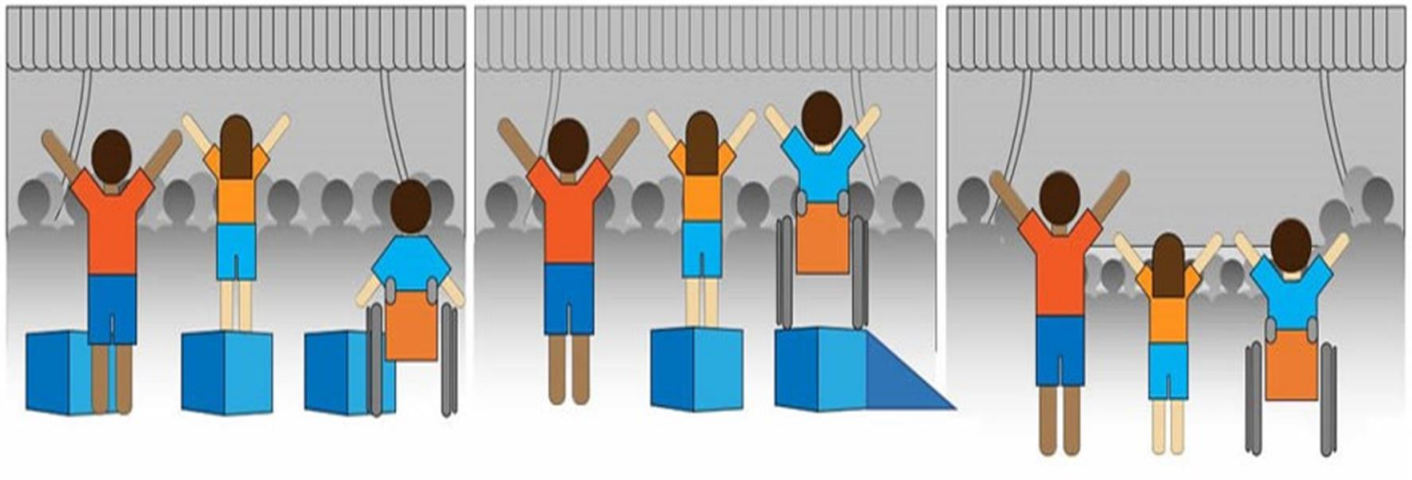



Source: adapted from Dahlgren and Whitehead, 1991

Dahlgren and Whitehead emphasized the relevance of socioeconomic, cultural, and environmental factors as determinants of population health from an equity-in-health perspective.

- Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can impact both our physical and mental health and wellbeing. Within this wider context, healthcare inequalities are about the access people have to health services and their experience and outcomes.
- Socio-economic inequalities are mostly determined by unfair & unjust distribution of money, power and resources, leading to poorer health outcomes such as obesity, heart disease, diabetes and cancer.
- We need to add racism as a social determinant of health, as addressing racism will address the historical barriers leading to health inequalities.

# Equality, Equity and Equal Outcomes



**Equality** – everyone gets the same resources

**Equity** – everyone gets the same outcomes, with resources distributed according to need

**Equal outcomes** – through the removal of structural barriers

- Equity is fair treatment aimed at eliminating systemic barriers
- V4CE aims to advance race equity and strengthen BME voices by addressing structural barriers that can disadvantage BME groups, e.g. V4CE giving grants to BME VCSE sector to improve health and wellbeing
- There are differences between systemic racism, structural racism and institutional racism. There is a need to address these different types of racism and collectively, with multi-sectoral partnerships we can advance health equity.

# Advancing Healthy Equity

- Covid 19 pandemic have shown how the pre-existing health inequalities in the Bangladeshi community impacted them disproportionately and magnified the needs that should be addressed with an equity-in-health approach.
- By addressing the root causes of health disparities, such as poverty, lack of adequate housing, nutrition, issues around access during pregnancy and early years, employment and training opportunities, we can start to rectify these systemic inequities and, in the process, improve individual health outcomes and reduce overall healthcare costs.
- Race Equality Foundation reported that racism is the root cause of ethnic inequalities in health, both directly, and indirectly via socioeconomic disadvantage
- https://raceequalityfoundation.org.uk/wp-content/uploads/2023/02/CC167_REF_Briefing_Paper_vs4.pdf

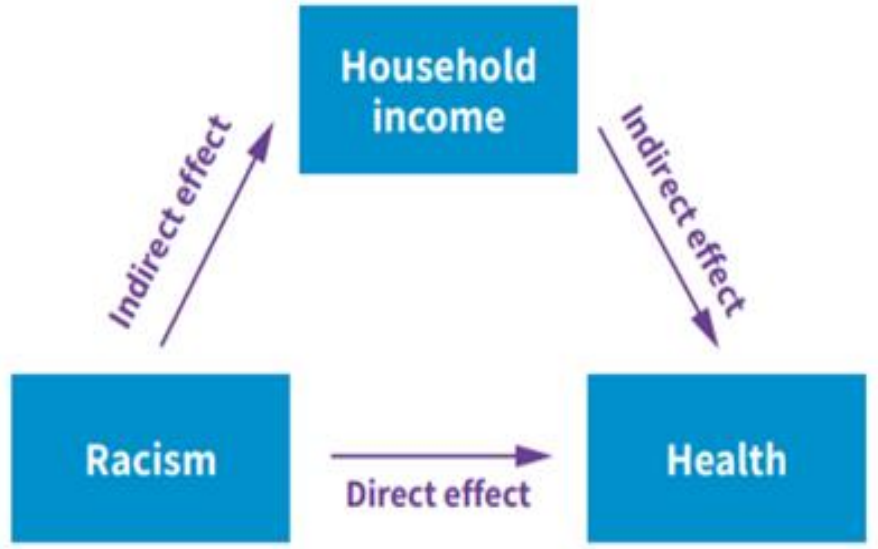



**Figure 1. Direct and indirect effects of racism on health**

# A Strategic Framework to Tackling Ethnic Health Inequalities through an Anti-Racist approach

**Leadership commitment:** to being anti-racist health and care systems and organisations, with Board representation, strategy development and anti-racist approach to all policies.

**Commitment to becoming an anchor institution:** to leverage our positions as anchor institutions to tackle the wider determinants of racial health inequalities.


**Workforce Commitment:** to support our ethnic minority staff and create enabling workplaces.

**Commitment to target health equity**: to prioritise and deliver evidence informed, culturally competent interventions to narrow the gap, by reducing inequities people from ethnic minority groups face in access, uptake, experiences and outcomes of our health and care services

**Commitment to our local communities**: to work with our communities to amplify their voices, in the decision, design and delivery of services, to rebuild trust and confidence

https://www.transformationpartners.nhs.uk/londonpartnership/wp-content/uploads/sites/2/2023/08/20230726_Strategic-framework-to-tackling-ethnic-health-inequalities-through-an-Anti-racist-approach.pdf

# Muti-Sectoral Partnership Working in Action Advancing Health Equity

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# Voice4Change England addressing inequalities

- A national membership organization, advocating for the Black and Minoritised Ethnic Voluntary Community and Social Enterprise (BME VCSE) sector
- Our vision is to build a stronger and more inclusive civil society to meet the needs of BME communities with equity lenses by:
- Give out grants, addressing health inequalities, provide free infrastructure support (capacity building workshops, 121 tailored support with needs assessment) to BME organisations across England through our Catalyst Programme, aimed at tackling race inequalities and building resilience
- Campaign on topical issues, policy and promote democratic rights and participation in wider civic life
- Collaborate in ground-breaking research on racial equality e.g. Home Truths 2, in partnership with ACEVO, addressing a need in the mainstream civil society for clarification and guidance to overcome blockages to progress and to support transformative change on anti-racism and race equity (webinar series)
- Environment strategy – exploring the barriers to BME VCSE participation in the climate justice agenda through the lens of anti-racism and provide support
- Free membership: Full and Associate
- https://www.voice4change-england.org/membership

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# Thank you

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enquiries@voice4change-england.co.uk

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# Chair's Introduction – Welcome to morning session

- Professor Tahseen A. Chowdhury

# Keynote Address

- Professor Kevin Fenton CBE FFPH

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# Racism as a Public Health Issue

**Professor Kevin Fenton CBE FFPH**
**President**
**UK Faculty of Public Health**

# Content

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- Racism is a public health issue
- Racism and health in the UK
- The impact of COVID-19
- Tackling racism: learning from the COVID-19 pandemic
- Anti-racism in public health
- Summary

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# Racism is a public health issue

“Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call “race”), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.”

Camara Jones

@profkevinfenton

# Race and Racism

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- Racism is a “wicked” problem - complex problems that are highly resistant to solutions and that are characterized by high difficulty and disagreement about the nature and cause of the problem and their potential solutions.
- Racism is a system based on race that unfairly disadvantages some individuals and communities, and advantages others.
- Racism also may be considered a fundamental determinant of health because it is a dynamic process that endures and adapts over time, and because it influences multiple mechanisms, policies, practices and pathways that ultimately affect health.
- The health consequences of living in a racially stratified society are illustrated by a myriad of health outcomes that systematically occur along racial lines, such as disproportionately higher rates of infant mortality, obesity, deaths caused by heart disease and stroke, and an overall shorter life expectancy for Blacks in comparison with Whites.

# Racism: A public health issue

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- Racism is common: in one national survey in the United Kingdom, 25-40% of participants said they would discriminate against ethnic minorities; a third of people from ethnic minorities constrain their lives through fear of racism; reported hate crimes have more than doubled between 2013 and 2020, the majority of which were racial (78,991), representing an 11% increase over the previous year.
- Disparities between ethnic minority and majority groups in housing, education, arrests, and court sentencing are believed to be due to racism, not simply to economic sources.
- Although both race and racism are relevant to health, typically only race is included as a research question, variable, or topic in most health studies.
- Race, as it is conventionally conceptualized and operationalized in public health research, is not an adequate proxy measure for racism. In addition, controlling for race in statistical analysis is a common practice in public health research and the research of other health professions.

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# Racism and Health in the UK

# What do we know about racism and its impact on public health?

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**Race Equality Foundation (2023)**

- ‘Experiences of racism and racial discrimination are associated with poorer mental and physical health outcomes for people from minoritised ethnic groups... The enduring effects of racism on health operate over time both directly and indirectly. Repeated exposure to racism severely and negatively impacts the health of people from minoritised ethnic groups.’

**The Health Foundation (2020)**

- ‘Racial discrimination affects people’s life chances negatively in many ways. For example, by restricting access to education and employment opportunities. People from black and minority ethnic groups tend to have poorer socioeconomic circumstances, leading to poorer health outcomes. The stress associated with being discriminated against based on race directly affects people’s mental and physical health.’

# Ethnic health inequalities in the UK

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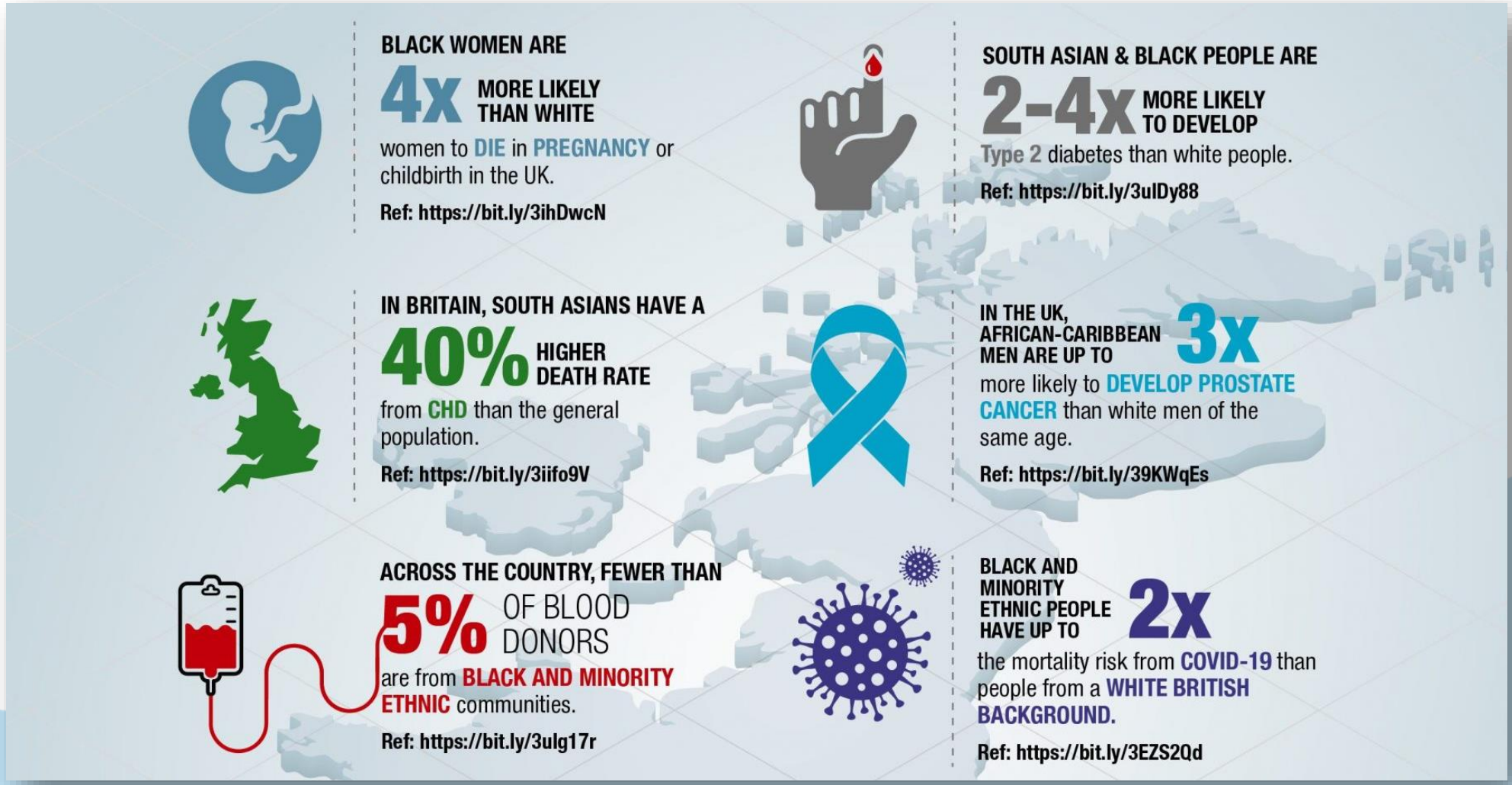

# Structural racism and the health and care system

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| Access barriers to healthcare | Bias in clinical decision-making | Inequities in patient outcomes | Workforce disparities | Lack of diversity in clinical trials |
|---|---|---|---|---|
| Includes **language barriers, cultural differences, migration status, and implicit biases** which impact communication between healthcare providers and ethnic minority patients, leading to delays in diagnosis and treatment. | Structural racism can result in **implicit bias in clinical decision-making**, which can negatively impact patient care including likelihood of referral for further investigations or receive specialist treatment. | Structural racism can lead to **inequities in patient outcomes, with ethnic minority patients experiencing poorer health outcomes, diagnostic delays, receive suboptimal treatment**, and experience worse outcomes for certain health conditions. | Structural racism can result in **workforce disparities - underrepresentation** in senior roles, overrepresentation in lower-paid and lower-status roles, more likely to experience **bullying and harassment** with impacts on the quality of care and worsened ability meet the needs of diverse patient populations. | Structural racism can result in a **lack of diversity in clinical trials**, which can limit the generalisability of study findings and impact treatment options for diverse patient populations. This results **in limited evidence-based treatment options** for diverse patient populations. |

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# The impact of COVID-19

# Excess deaths and mortality from COVID-19 in England since the start of the pandemic were highest in black, Asian and mixed ethnic groups : 21 March 2020 – 14 October 2022

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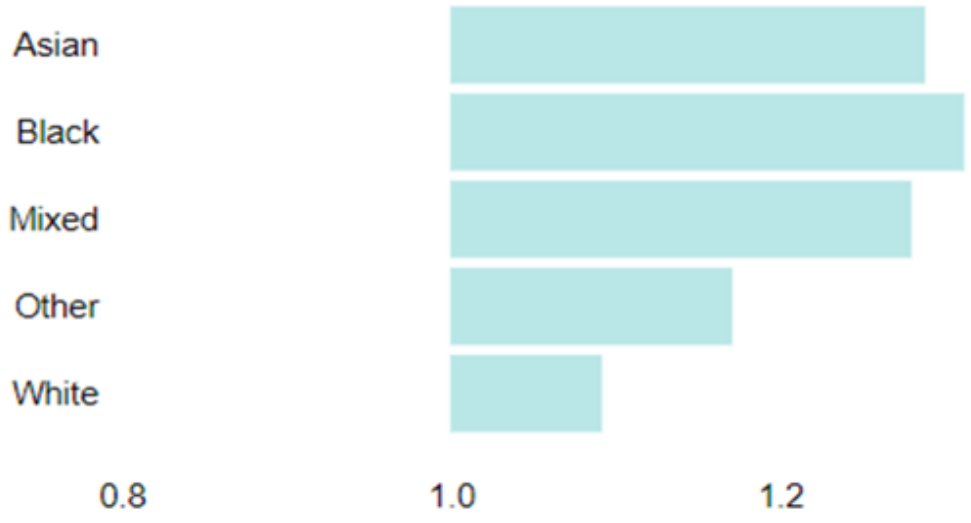
Ratio of Registered Deaths to Expected Deaths in England by Ethnic Group, Persons




Summary of Deaths in England by Ethnic Group, Persons

| Ethnic group ▲ | Registered deaths | Expected deaths | COVID-19 deaths | Excess deaths | Ratio: registered / expected |
|---|---|---|---|---|---|
| All | 1,414,830 | 1,282,070 | 177,151 | 132,760 | 1.10 |
| Asian | 51,297 | 40,016 | 11,925 | 11,281 | 1.28 |
| Black | 27,439 | 20,997 | 5,669 | 6,442 | 1.31 |
| Mixed | 6,326 | 4,937 | 951 | 1,389 | 1.28 |
| Other | 5,192 | 4,445 | 903 | 748 | 1.17 |
| White | 1,324,575 | 1,211,676 | 157,704 | 112,899 | 1.09 |

# The impact of COVID-19

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- COVID-19 highlighted new inequalities in the likelihood of being **infected**, being **admitted**, having **severe disease** and of **dying** from infection.
  - People who lived in **overcrowded** or **multi-generational households.**
  - People who worked in **jobs** with **increased risk** of **coming into contact** with the virus.
  - People who live in **poor areas** were **more likely** to die.
  - People with **low engagement** due to **stigma** and **low trust and confidence** in health service.
  - People with **historic** and **current experiences** of **racism and discrimination.**

# Poverty and racial discrimination

# Multilevel conceptual framework to examine racial/ethnic disparities in severe maternal morbidity and mortality in the context of COVID-19 pandemic

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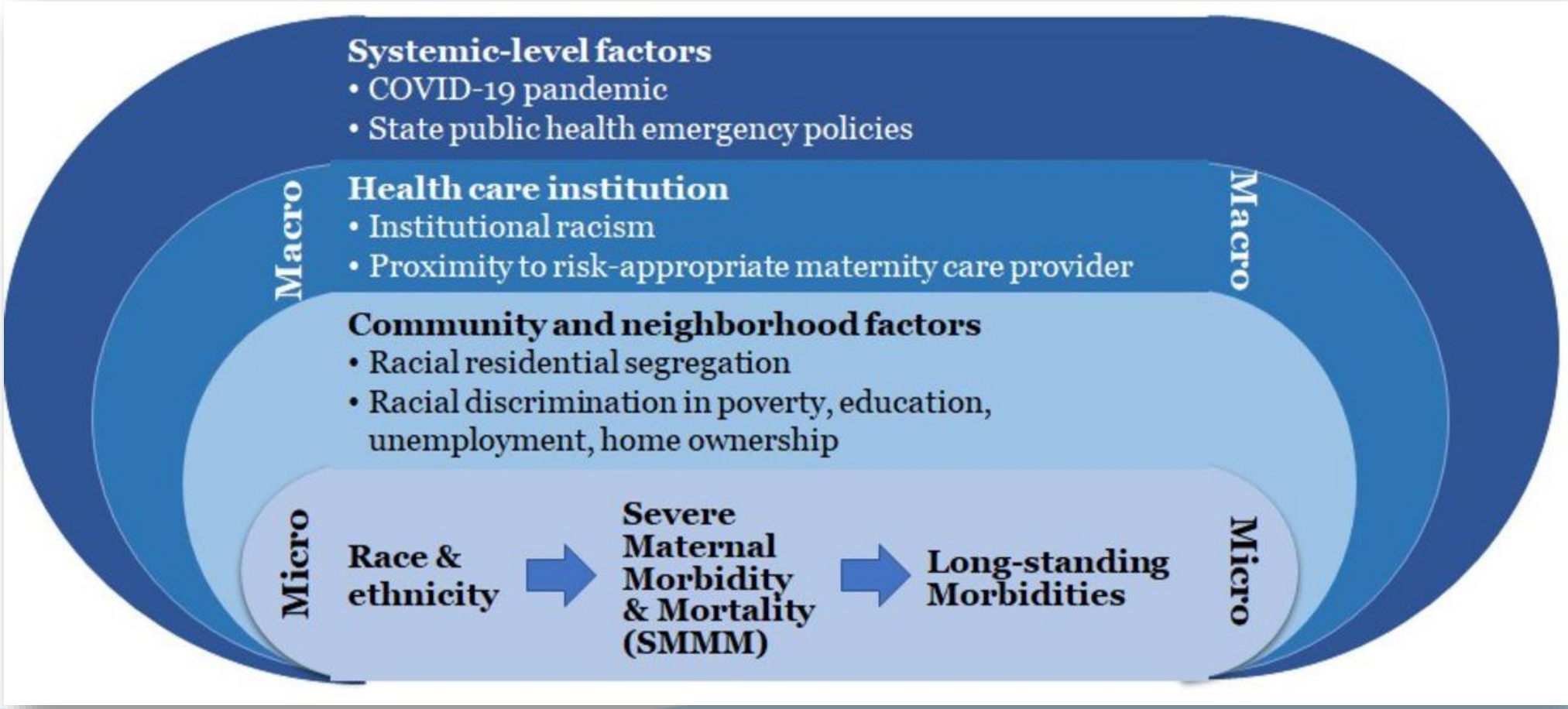

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# Tackling racism: Learning from the COVID-19 pandemic

# Learning and legacies from the COVID-19 pandemic

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**Well-resourced, equity-focused public health, healthcare and pandemic preparedness systems**

**Stronger, innovative and more agile health, care and community partnerships**

**A commitment to high quality, timely clinical and programme data and metrics**

**Pragmatic, mixed-methods programme-relevant and participatory research**

**Strengthened community-centred approaches, outreach and engagement**

# Operationalising the London Approach to Anti-Racism, Structural Discrimination and Racial/Ethnic Health Inequalities

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**1. Leadership**
- Public commitment to being anti-racist organisation with actions
- Board level review of strategy and monitoring objectives indicators, including health outcomes by ethnic groups
- Assure anti-racist approach in all policies


**5. Working with communities: to rebuild confidence and trust**
- Include community voice in decisions, design and delivery of services though participation in governance, funding and integrated delivery structures
- Embed co-production
- Supporting community groups with resources – funding and training to allow meaningful participation

**2. Workforce**
- Monitor and act on ethnic inequities in recruitment, workforce wellbeing and promotion
- Provide training and support to address cultural bias and discrimination, incl safe spaces
- Implement and monitor robust equality, diversity and inclusion policies

**4. Becoming Anchor institutions**
- Address wider determinants of health through anchor actions with a focus on race equity in local populations
- Support education, employment and opportunities to reduce structural determinants of ethnic health inequalities

**3. Health Equity programmes**
- Embed anti-racist lens on health equity programmes such as Core20P5, Marmot framework
- Data-led insights to prioritise areas of work with community groups to improve health and healthcare access
- Integrated and personalised care that is culturally competent.

@profkevinfenton

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# An anti-racist approach

# What is anti-racism?

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- Anti-racism is the practice of identifying, challenging, and changing the values, structures and behaviours that perpetuate systemic racism. Anti-racism is an active way of seeing and being in the world, in order to transform it.
- Being antiracist is based on the conscious efforts and actions to provide equitable opportunities for all people on an individual and systemic level.
- People can act against racism by acknowledging personal privileges, confronting acts of racial discrimination, and working to change personal racial biases.
- Anti-racism is an educational and organising framework that seeks to confront, eradicate and/or ameliorate racism and privilege (Bonnett, 2000).
- An anti-racism approach often includes a structural analysis that recognises that the world is controlled by systems, with traceable historical roots, that batter some and benefit others.

# What is anti-racism?

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- Because racism occurs at all levels and spheres of society (and can function to produce and maintain exclusionary "levels" and "spheres"), anti-racism education/activism is necessary in all aspects of society.
- A person who practices anti-racism is someone who works to become aware of:
  - How racism affects the lived experiences of people of colour within our society
  - How racism is systemic, and has been part of many foundational aspects of society throughout history, and can be manifested in both individual attitudes and behaviours as well as formal (and "unspoken") policies and practices within institutions
  - The role, benefits and damage of “White Privilege” including how white people participate, often unknowingly, in racism and learning how whiteness—often without them recognizing it—shapes their place in society, and its impacts.

# Reducing racial/ ethnic health inequalities

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1. **Robust leadership, governance and accountability** to tackle health inequalities at all levels

2. **Integrating anti-racism and addressing structural discrimination** in our systems and programmes

3. **Reducing poverty and inequality**: Poverty and inequality are the root causes of health inequalities. We need to implement policies and programs that reduce poverty and inequality, such as good wages, strengthening social care and support and providing affordable housing.

# Reducing racial/ ethnic health inequalities

4. **Improving access to healthcare**: We need to ensure that everyone has equitable access to high-quality healthcare, regardless of their income, race, or ethnicity. This means addressing the barriers that people face in accessing healthcare, such as language barriers, trust and confidence, and financial barriers.

5. **Promoting healthy lifestyles, prevention and early intervention**: We need to promote healthy lifestyles, such as eating a healthy diet, exercising regularly, and not smoking and promoting secondary prevention campaigns. This can be done through culturally competent and targeted education and public health campaigns.

6. **Supporting vulnerable groups**: We need to provide support to vulnerable groups, such as people living in poverty, migrants and asylum seekers, people with disabilities, and people with mental health problems. This can be done through a range of services and programs, such as social care and mental health services.

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# Summary

# Summary

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- Racism permeates our everyday lives, even if we do not readily acknowledge its power or pervasiveness.
- Addressing racism is central to eliminating racialised health disparities, and therefore, should be central to health research and practice.
- As health professionals many of us will share the belief that collective efforts can help evoke social change and more generally reduce racialised health disparities and inequality.
- Now is the time for us to develop a reformed health agenda that recognises the connection between structural racism and racialised disparities in health.
- Implementation of this agenda requires a multipronged, multilevel, and interdisciplinary approach.

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www.fph.org.uk

# Presentation

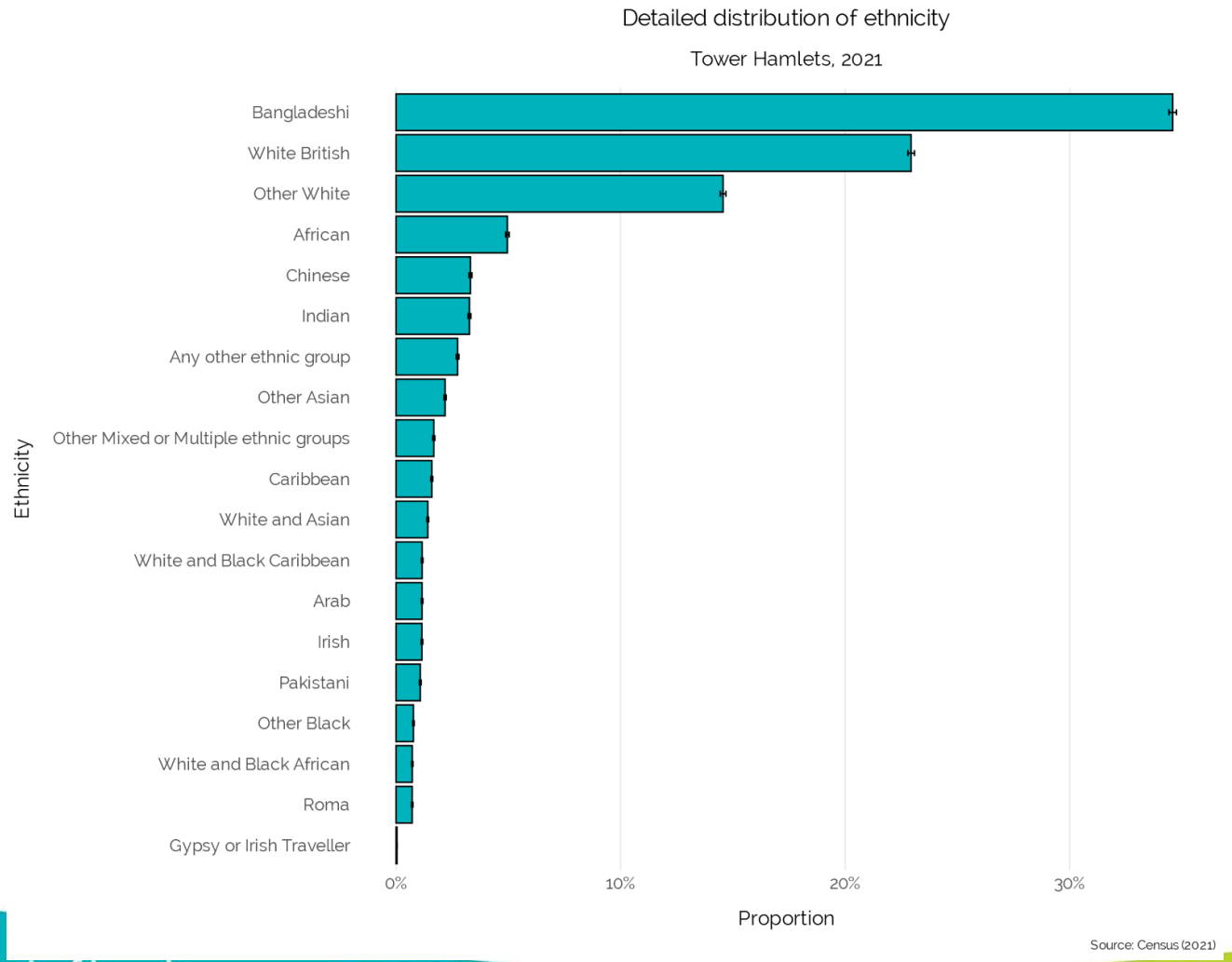
- Dr Somen Banerjee

# Health in Bangladeshi communities in Tower Hamlets

Dr Somen Banerjee
Director of Public Health
London Borough of Tower Hamlets

Presentation to the London Bangladeshi Health Inequalities Summit
24 September 2024

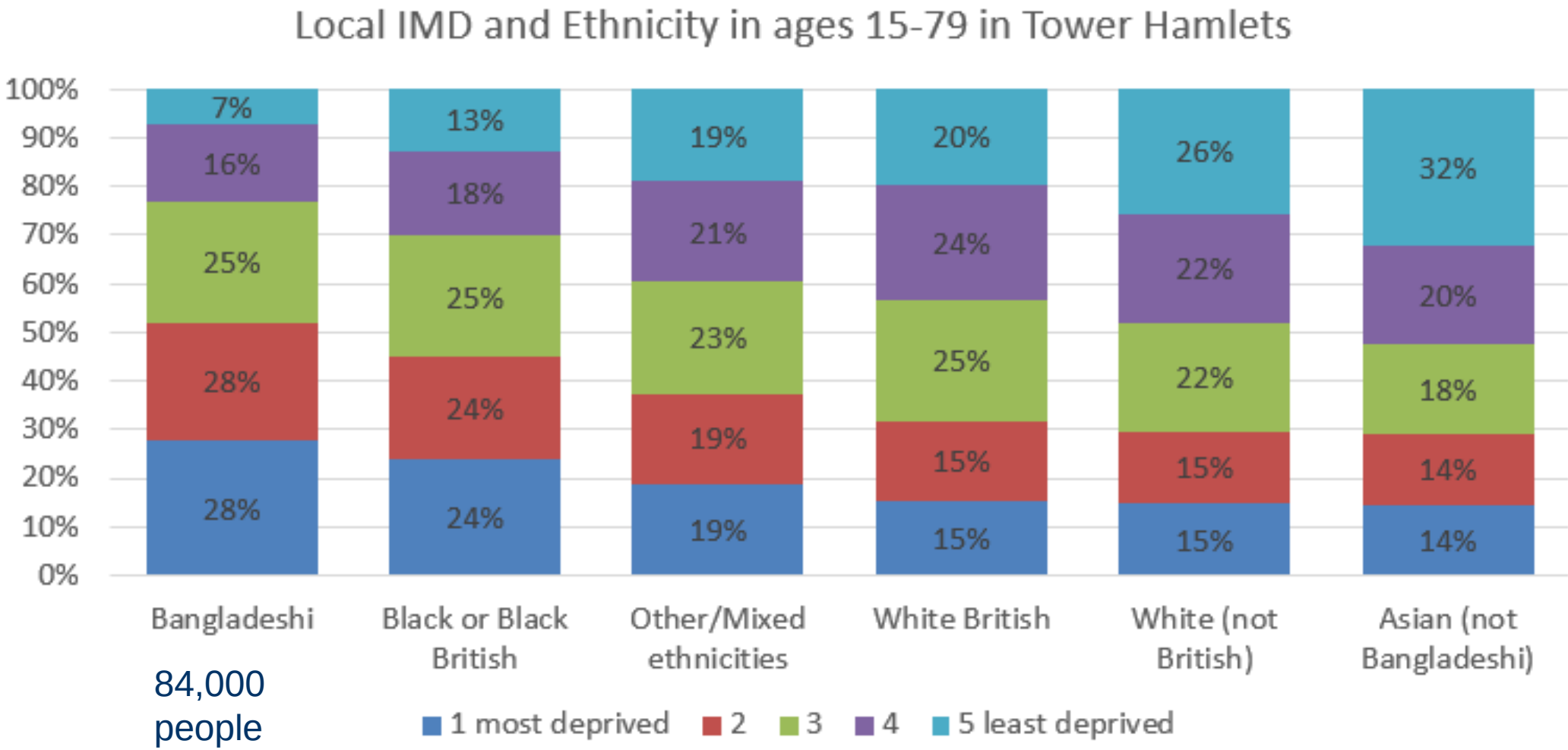
# Ethnic groups in Tower Hamlets




Source: Census (2021)

The largest Bangladeshi community in England reside within Tower Hamlets
- 34.6% of all residents.

# Deprivation and ethnicity

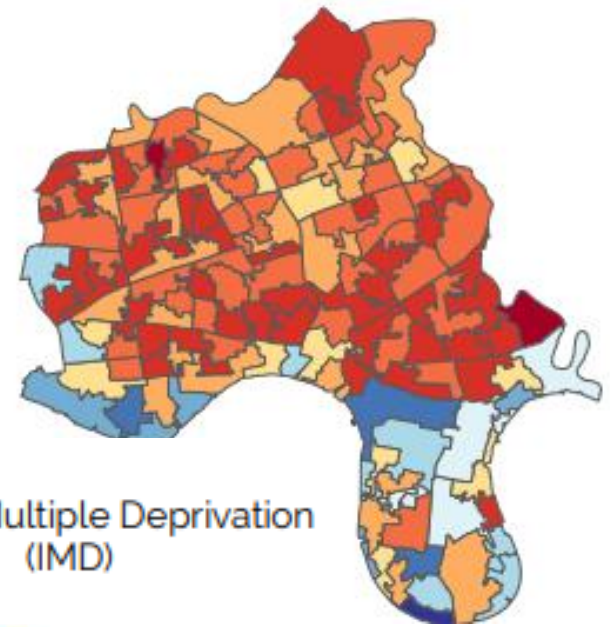



84,000 people

# Bangladeshis in Tower Hamlets are still among most deprived communities nationally

On average, deprivation in Tower Hamlets has decreased slightly in recent decades.

Most LSOAs are now between the 20th – 50th percentile nationally



Index of Multiple Deprivation (IMD)

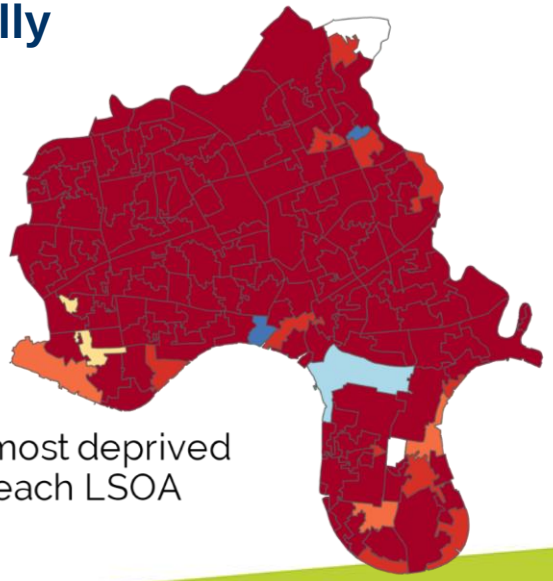
National Decile

1 2 3 4 5 6 7 8 9 10

However this masks inequalities between ethnic groups.

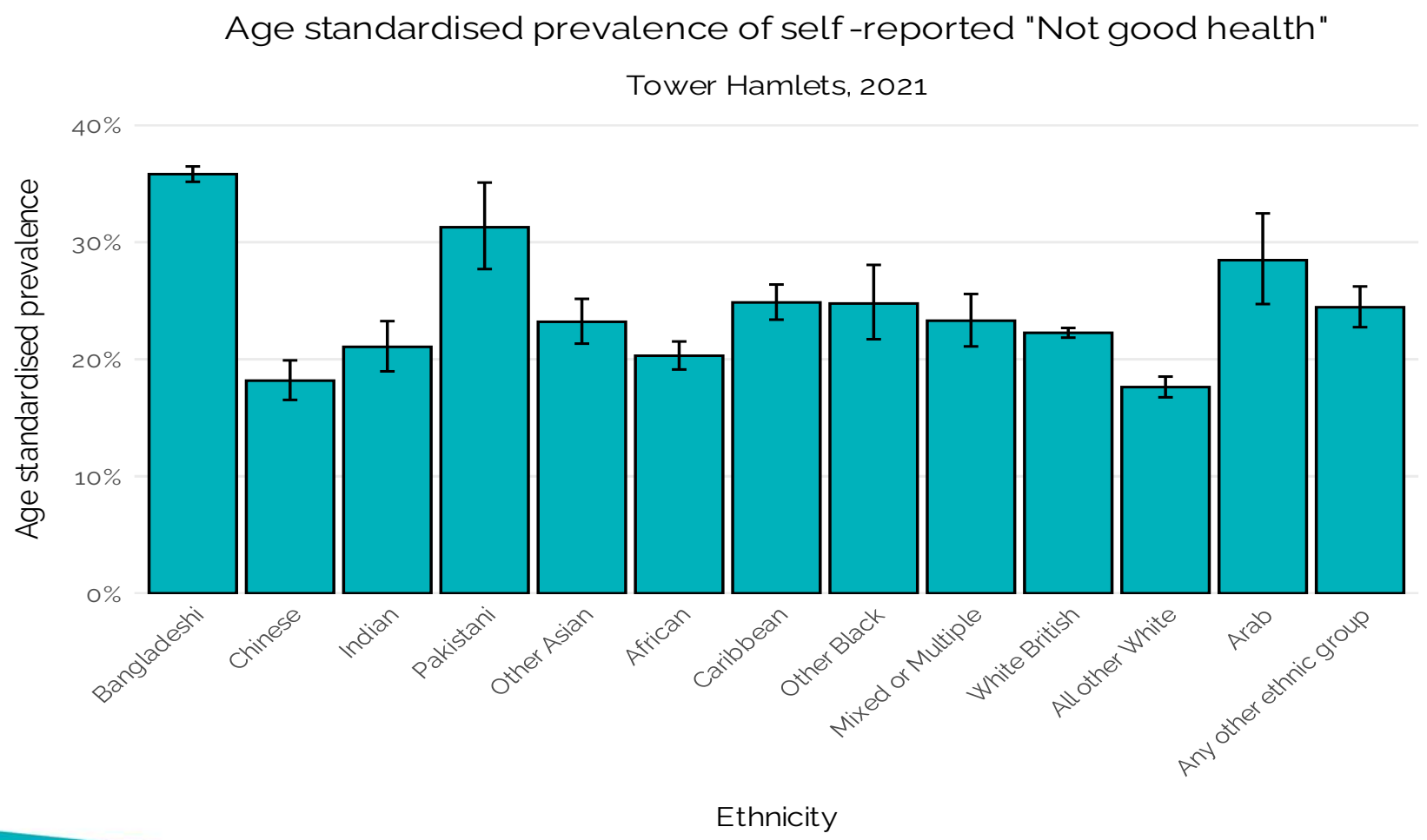
The EGDI measures particular ethnic groups' deprivation across domains.

**In 94% of LSOAs in Tower Hamlets, the most deprived ethnic group is Bangladeshi. And across the borough, these groups are among the most deprived 10% nationally**



EGDI decile of the most deprived ethnic group in each LSOA

# Self-reported poor health



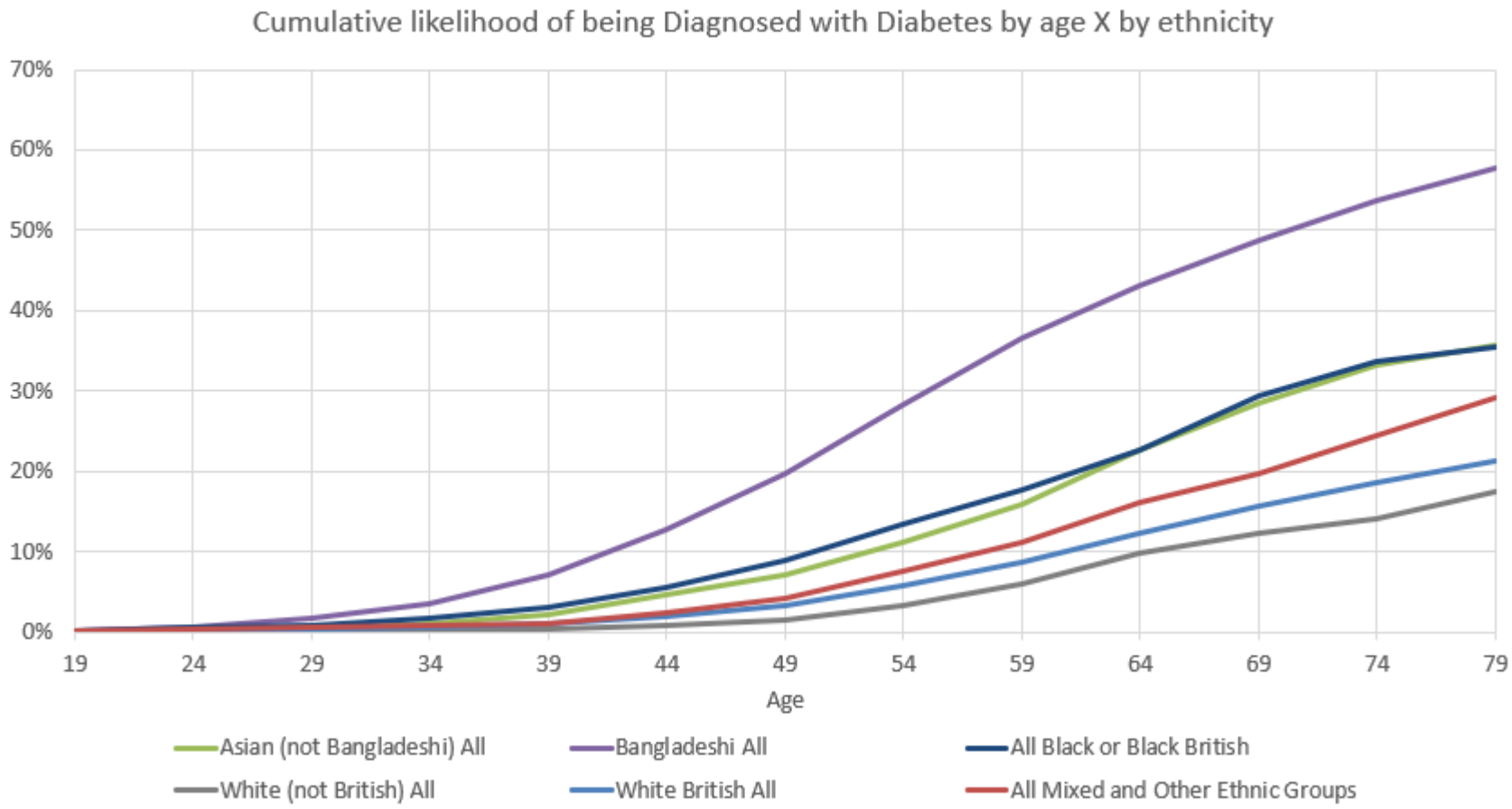

**People from a Bangladeshi background have the worst self-reported health of any ethnic group, in TH.**

1 in 3 report they are 'not in good health'.

In the Bangladeshi population in TH, a **greater proportion of women** than men describe their health as poor (not shown here).

Source: Census 2021

# Diabetes

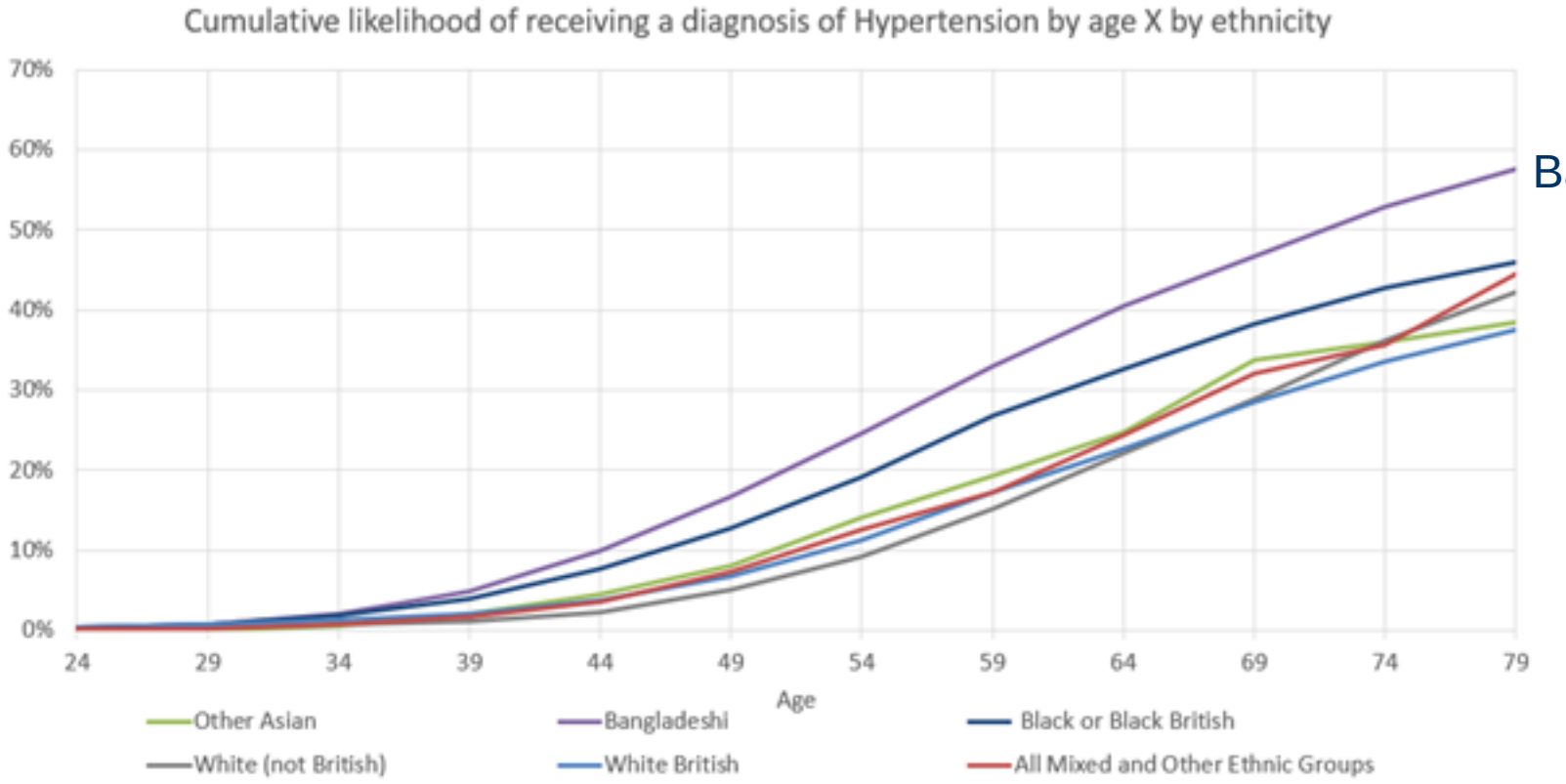



Bangladeshi

The cumulative likelihood of having received a **diabetes diagnosis by age 70 is 1 in 2 among Bangladeshis,** compared to 1 in 4 in rest of population.

NB these are constructed ‘hazards’ made up of age-specific diagnosis rates –these metrics don’t reflect ‘real’ cohorts: they don’t account for mortality or changes in the ASDR over time.

# High Blood Pressure

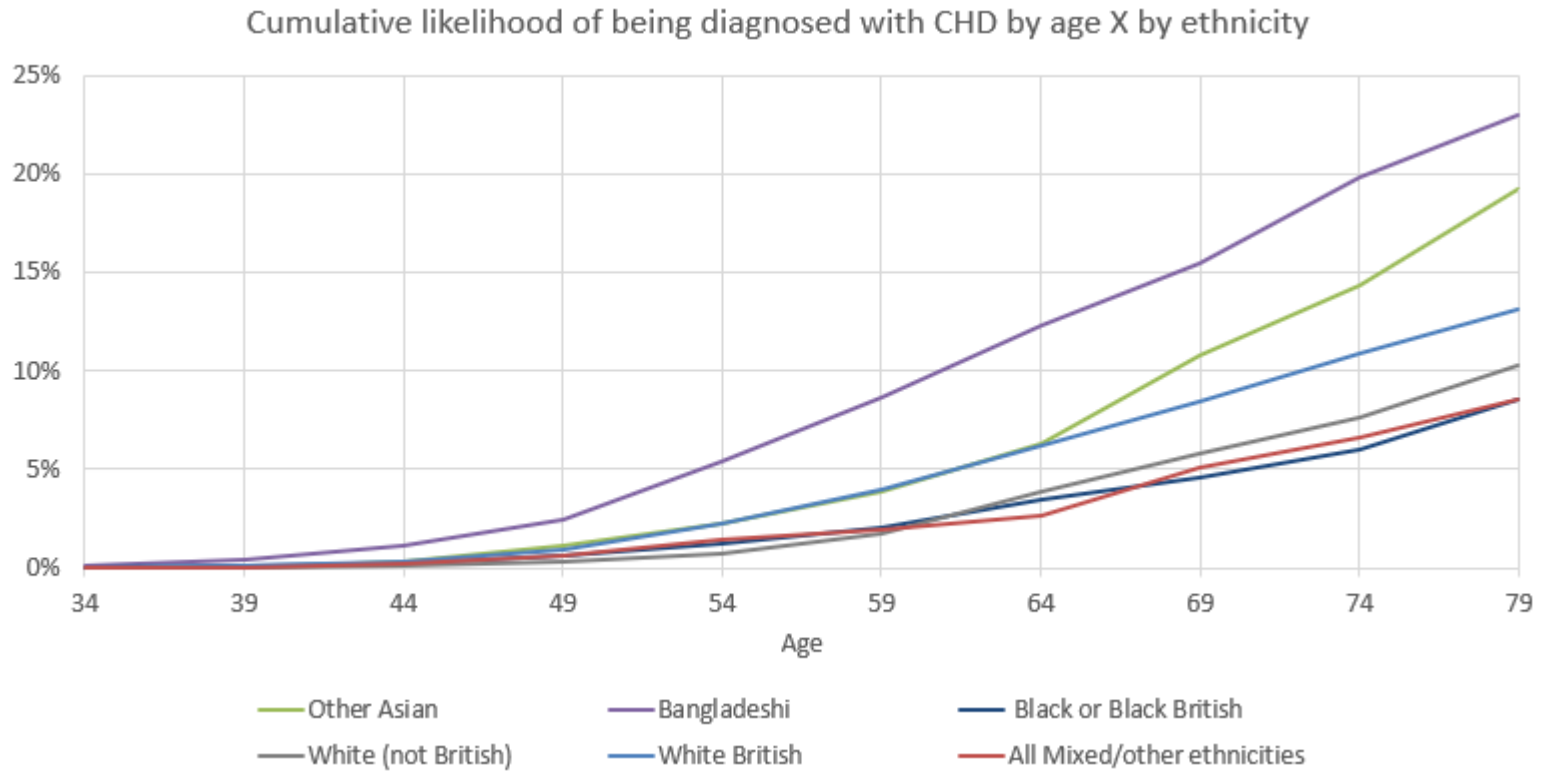



Bangladeshi

The cumulative likelihood of having received a **HBP diagnosis by age 70 among Bangladeshis is 1 in 2,** compared to 1 in 3 for rest of population

NB these are constructed ‘hazards’ made up of age-specific diagnosis rates –these metrics don’t reflect ‘real’ cohorts: they don’t account for mortality or changes in the ASDR over time.

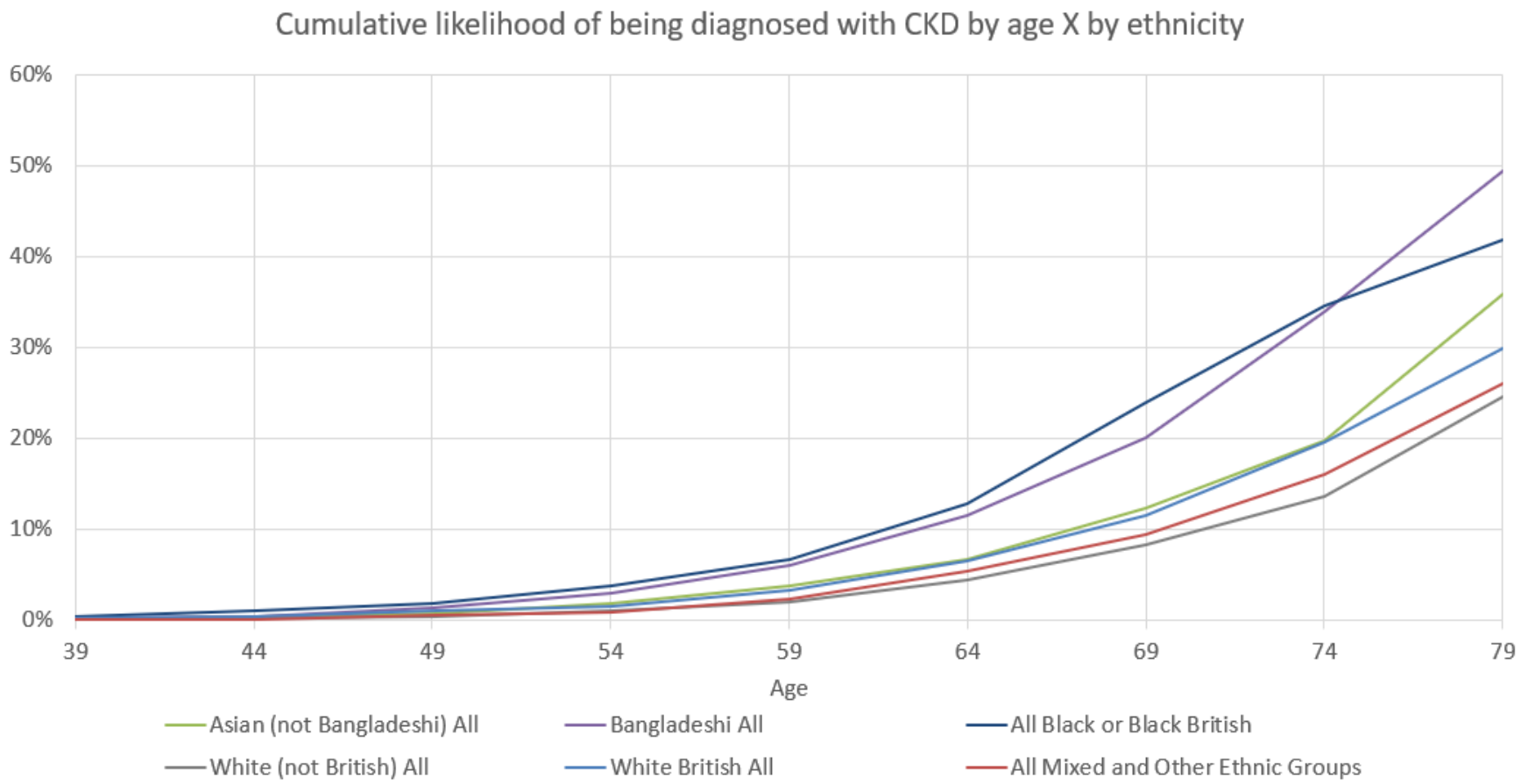
# Heart Disease




Bangladeshi

At age 55 the chance of being diagnosed with heart disease is around 3x rest of population

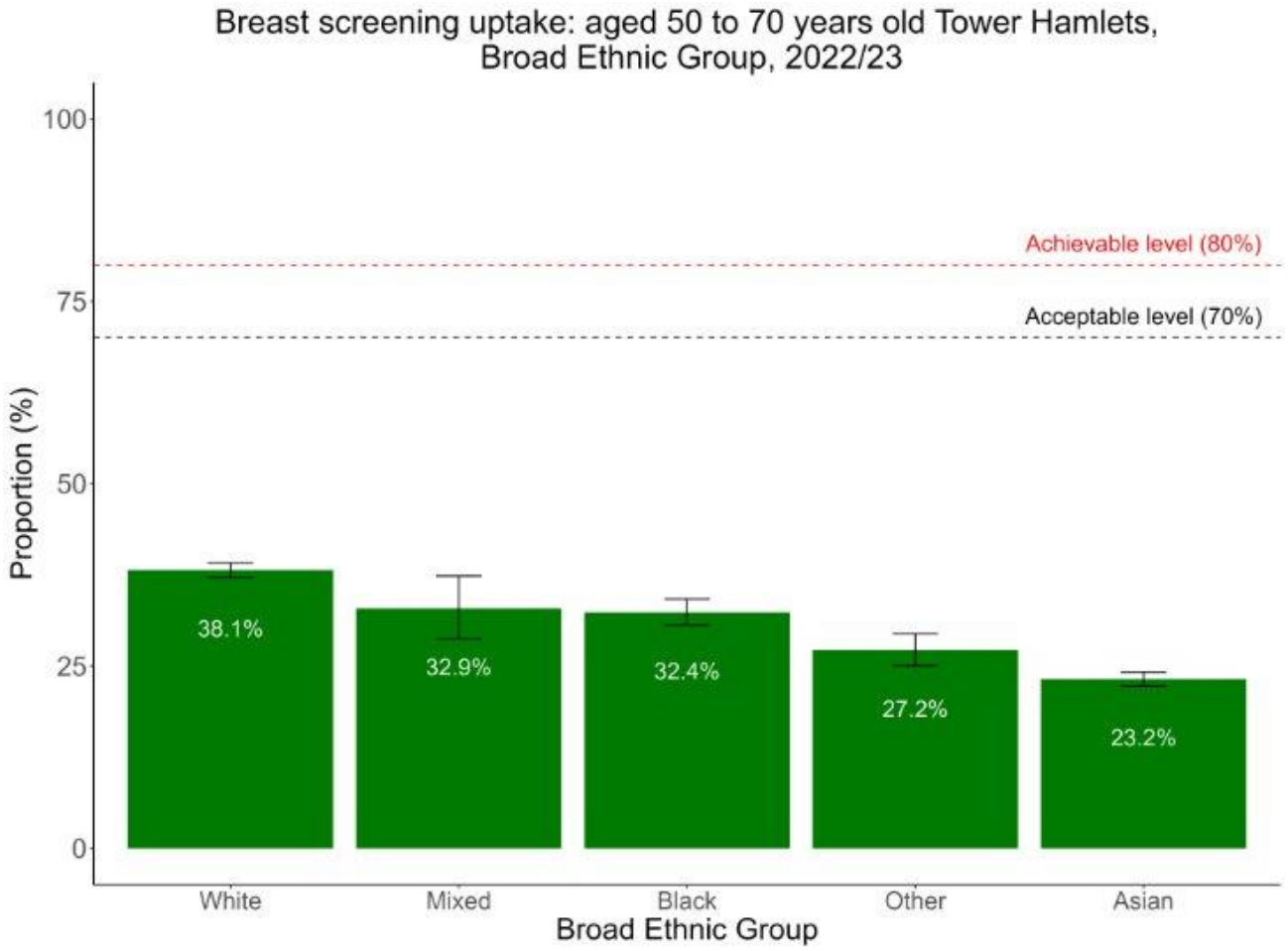
# Kidney disease




Bangladeshi

The cumulative likelihood of having **kidney disease by age 70 is 1 in 5 in Bangladeshis** compared to 1 in 10 for rest of population

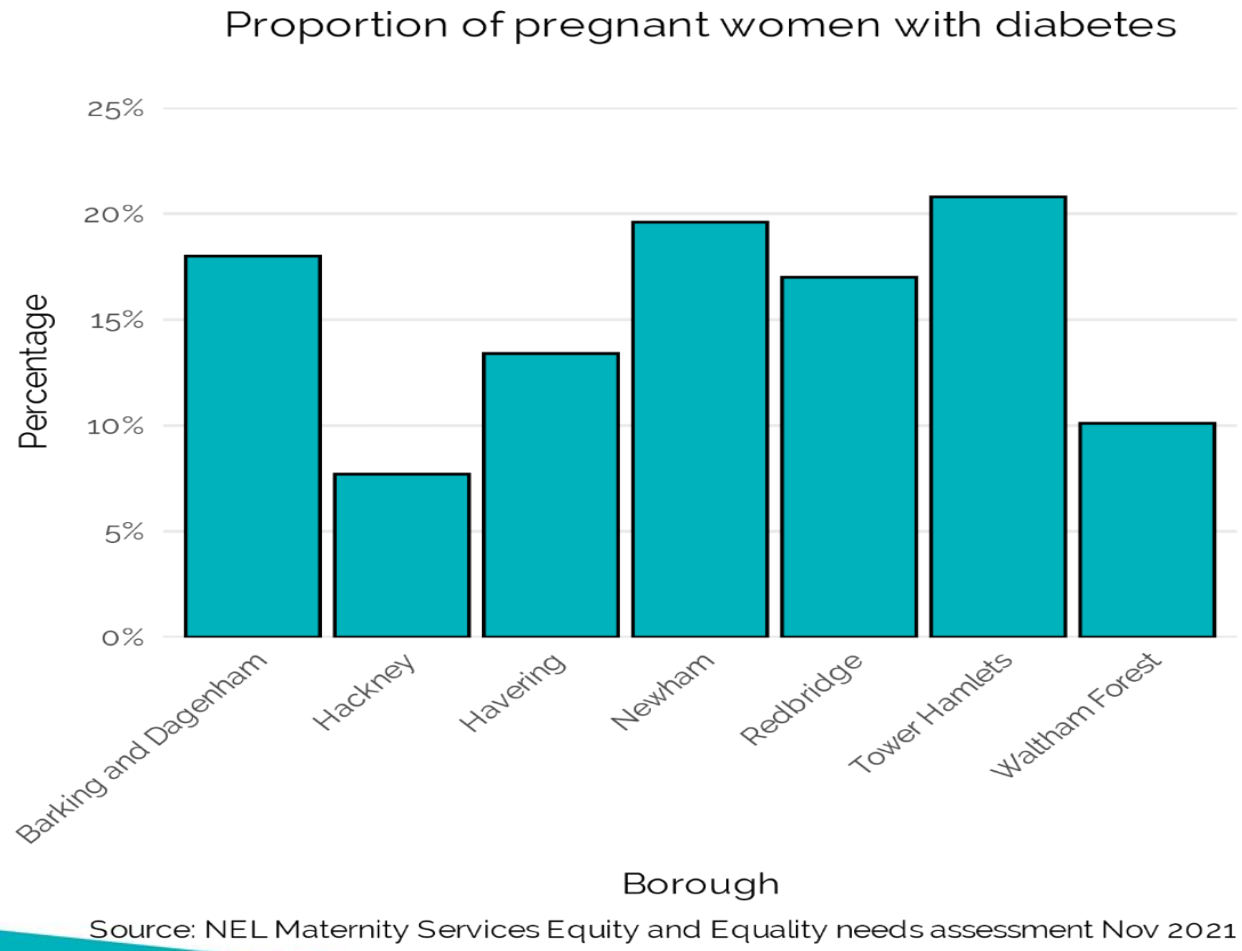
# Breast Cancer Screening




The acceptable level of breast cancer screening is 70%.

Women from an Asian background have the **lowest take up of breast cancer screening** in the borough - around 23%.

# Proportion of pregnant women with diabetes




Source: NEL Maternity Services Equity and Equality needs assessment Nov 2021

1 in 5 pregnant women in Tower Hamlets has diabetes – among the highest rates in North East London.

# 3 reflections from the pandemic

TOWER HAMLETS

- What if we responded to the pandemics of non-communicable disease with the same urgency as we did for COVID?

- If something is not measured it is not truly valued. Our ethnicity monitoring remains poor and patchy across the system, and where it is available it is not used as a matter of routine

- We are only successful in so far as we are connected to the communities we serve to develop solutions together.



# Tower Hamlets Health and Wellbeing Strategy principles

1. Resources to support health and wellbeing should go those who most need it
2. Feeling connected is vital to wellbeing and importance of this should be built into services and programmes
3. Being treated equally, respectfully and without discrimination should be the norm when using services
4. Health and wellbeing information and advice should be clear, simple and coproduced with those who it is targeted at
5. People should feel that they have equal power in shaping and designing services
6. We should all be working together to make the best use of the assets that we already have

# Our long-term conditions prevention strategy

TOWER HAMLETS

**Linking to better support** around 'wider determinants' of health

**Community-centred prevention** and health promotion

**Detection and enabling self-care** to reduce the risks that cause poor health

**Active management and secondary prevention** for those with identified clinical risks / diseases



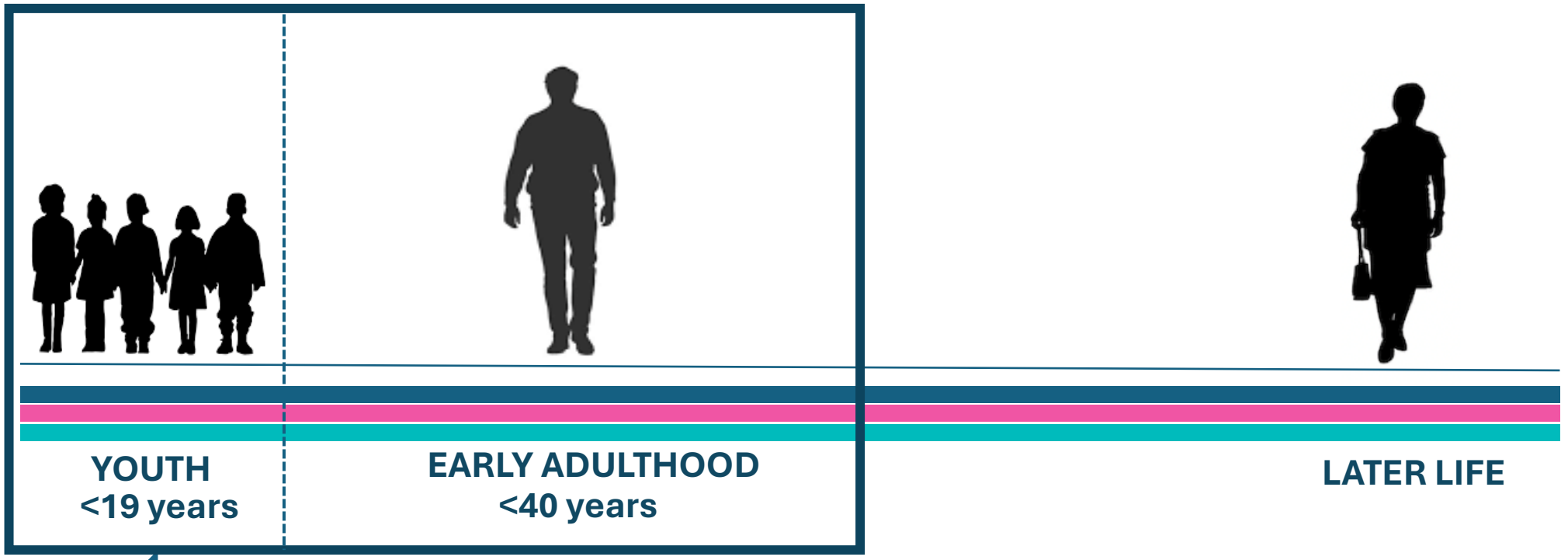
# Presentation

- Dr Shivani Misra

# Rise in early-onset type 2 diabetes in England

Dr Shivani Misra (FRCP, PhD)

Imperial College London



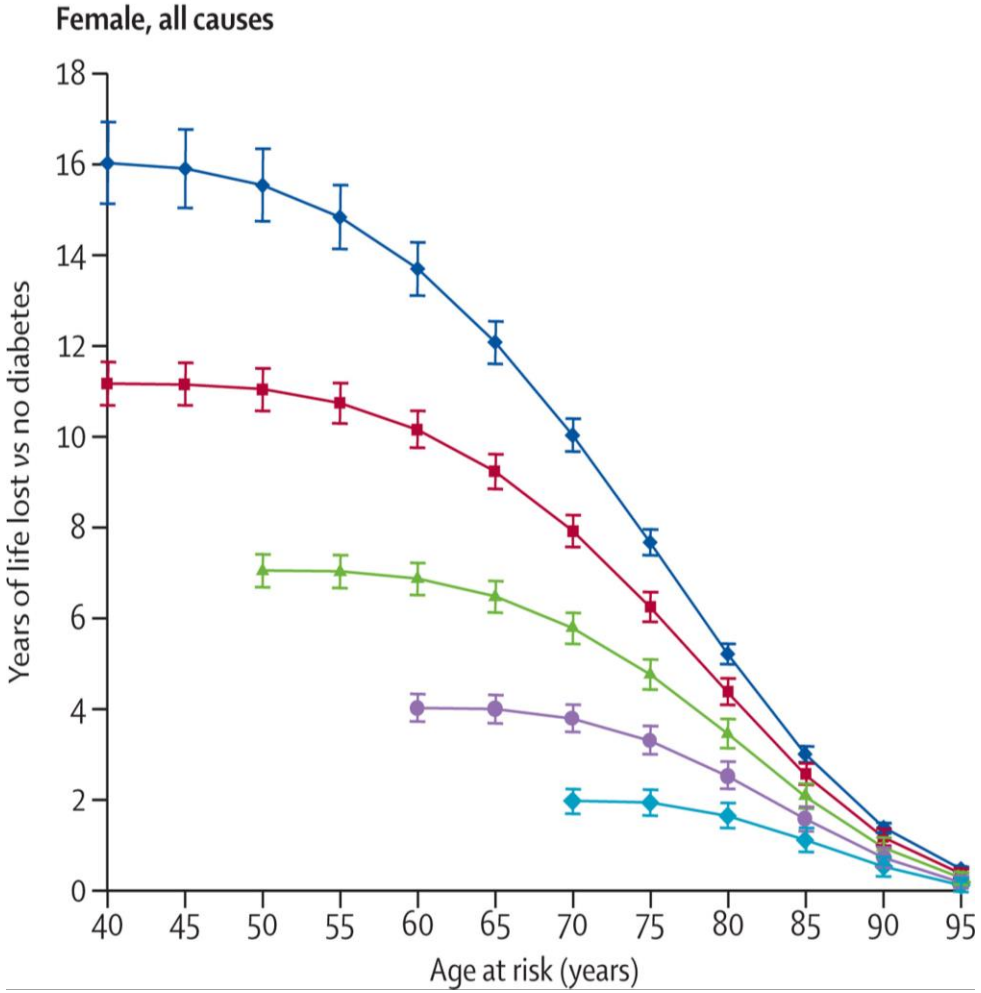

Early-onset type 2 diabetes

Variably described cut-offs
Diagnosis <30 years, <40 years or <45 years

A diagnosis earlier in life is associated with worse outcomes

# Type 2 diabetes presents throughout life

# The earlier you present with type 2 diabetes, the shorter your life expectancy




**People affected….**

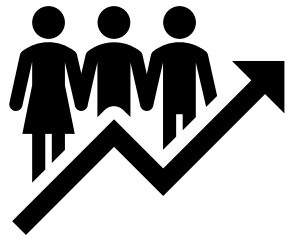
- Progress to end stage kidney disease
- Have poor pregnancy outcomes e.g. neonatal death
- Have greater distress, mental health issues & multiple long term conditions
- Die from heart attacks and strokes
- Die ~15 years earlier than those with type 2 diabetes later in life

# How common is early-onset type 2 diabetes?



| | Audit year | | | | |
|---|---|---|---|---|---|
| **Age group** | **2017-18** | **2018-19** | **2019-20** | **2020-21** | **2021-22** |
| **Under 40** | 117,270 | 123,830 | 129,200 | 132,000 | 139,255 |
| **40 - 79** | 2,488,330 | 2,577,295 | 2,674,395 | 2,705,585 | 2,769,415 |
| **Total** | 2,605,600 | 2,701,130 | 2,803,595 | 2,837,585 | 2,908,670 |

Under 40's with type 2 diabetes rising faster than older age groups



# Characteristics

A 'higher dose' of the typical T2D risk factors

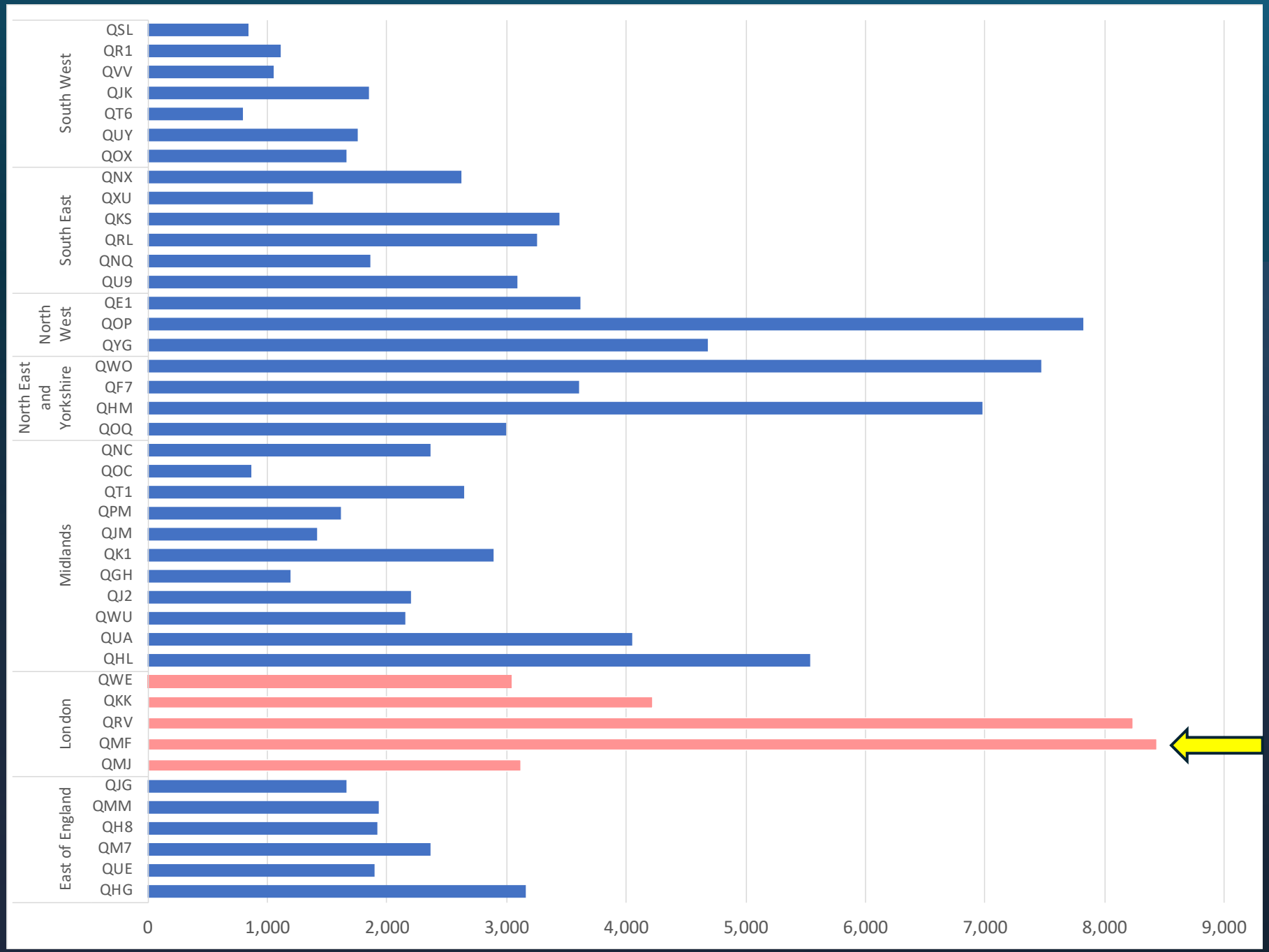
Female preponderance to age 25 years

Strongly associated with obese weight categories

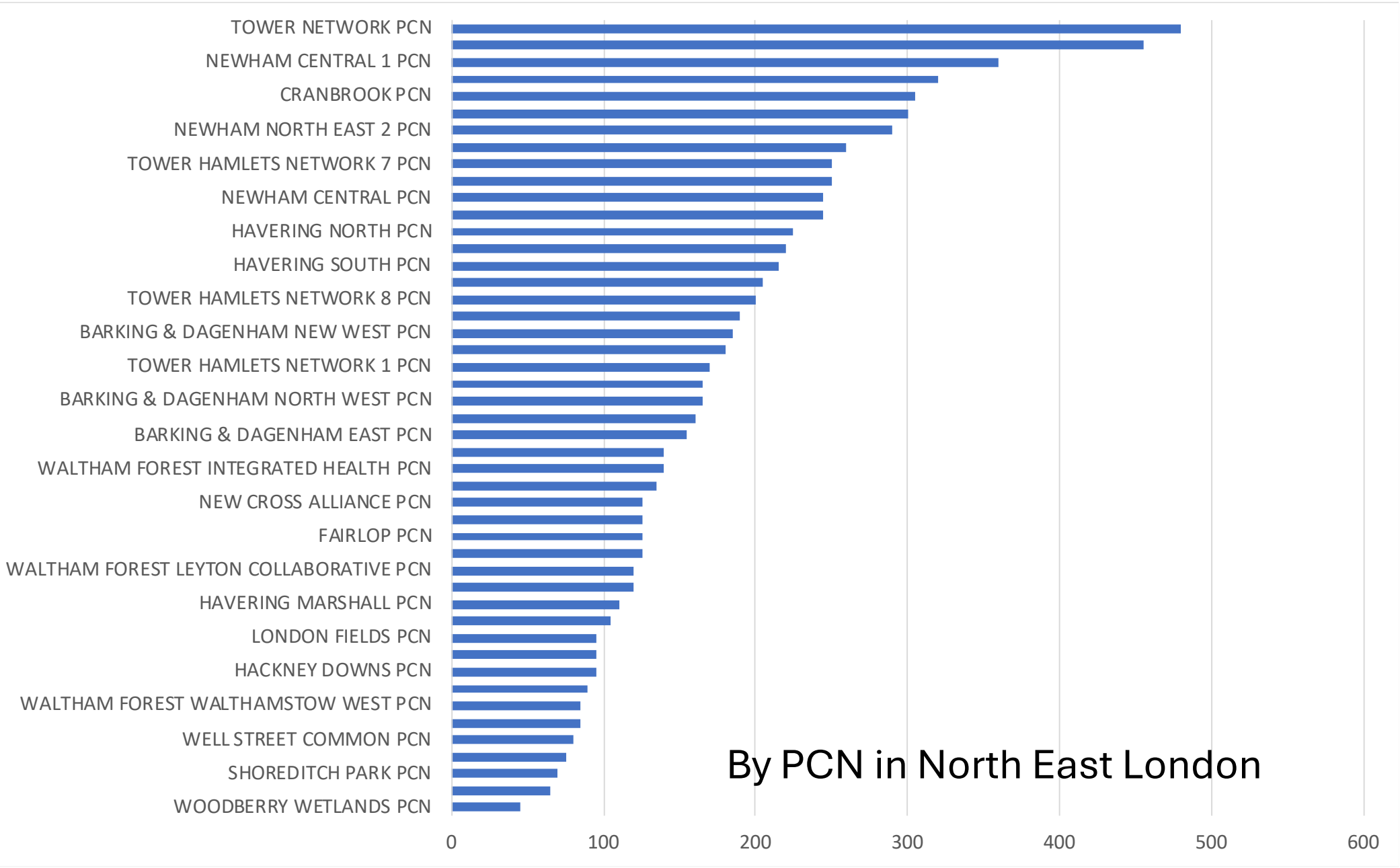
Strongly associated with socioeconomic deprivation

Disproportionate representation of minority ethnic groups, adjusted for population structure

*Misra et al. Diabetic Medicine. 2023;40:e14940*

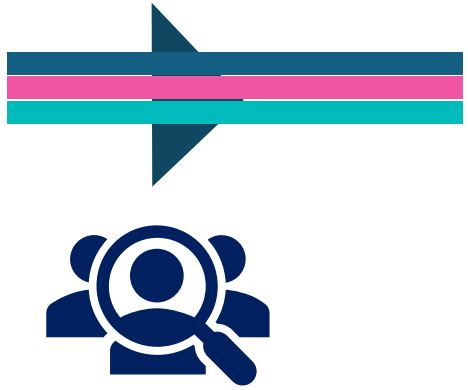



Highest cross-sectional prevalence is in London


TOWER NETWORK PCN
NEWHAM CENTRAL 1 PCN
CRANBROOK PCN
NEWHAM NORTH EAST 2 PCN
TOWER HAMLETS NETWORK 7 PCN
NEWHAM CENTRAL PCN
HAVERING NORTH PCN
HAVERING SOUTH PCN
TOWER HAMLETS NETWORK 8 PCN
BARKING & DAGENHAM NEW WEST PCN
TOWER HAMLETS NETWORK 1 PCN
BARKING & DAGENHAM NORTH WEST PCN
BARKING & DAGENHAM EAST PCN
WALTHAM FOREST INTEGRATED HEALTH PCN
NEW CROSS ALLIANCE PCN
FAIRLOP PCN
WALTHAM FOREST LEYTON COLLABORATIVE PCN
HAVERING MARSHALL PCN
LONDON FIELDS PCN
HACKNEY DOWNS PCN
WALTHAM FOREST WALTHAMSTOW WEST PCN
WELL STREET COMMON PCN
SHOREDITCH PARK PCN
WOODBERRY WETLANDS PCN
0
100
200
300
400
500
600
By PCN in North East London

# A 5-point strategy launched at ICB level “T2DAY”

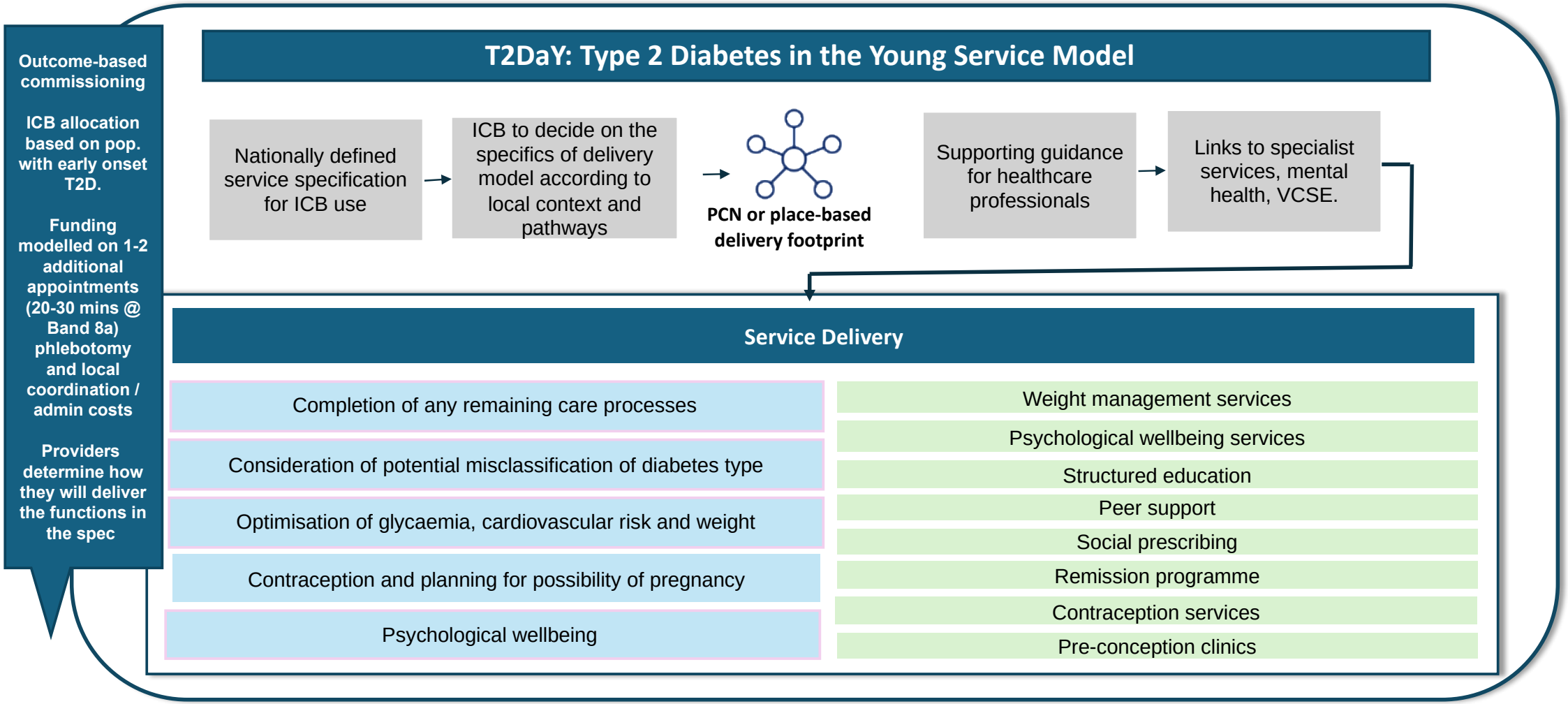
1. Is it definitely type 2 diabetes?



**Diagnosd <40 years?**

Launched in England “T2DAY” £14 million

# T2Day: Type 2 Diabetes in the Young Programme



# A call to action…

- British Bangladeshi population is distinct
  - Genetically
  - Phenotypically – leaner-onset type 2 diabetes
  - Socioeconomically
  - Environmentally
- Prevention is key
- For those affected
  - Address high risk
  - Engage and mitigate
- This problem is only going to get worse ☹

# Acknowledgements


- Young type 2 diabetes audit team, NHS England

- NHS England diabetes programme
  - Clare Hambling, NCD
  - Karen Kennedy, Manager

- Research team at Imperial College London

# Presentation

- Professor Sarah Finer

Genes Health

# Improving health in British Bangladeshi communities through research


Mohammed Bodrul Mazid
Bilingual Research Assistant
Queen Mary University of London

Sarah Finer
Professor of Clinical Diabetes
Queen Mary University of London
Consultant Diabetologist,
Barts Health NHS Trust

Annum Salman
Communications and Engagement Manager
Queen Mary University of London

Genes & Health

South Asian people have some of the highest rates of heart disease, diabetes and poor health in the UK

genesandhealth.org

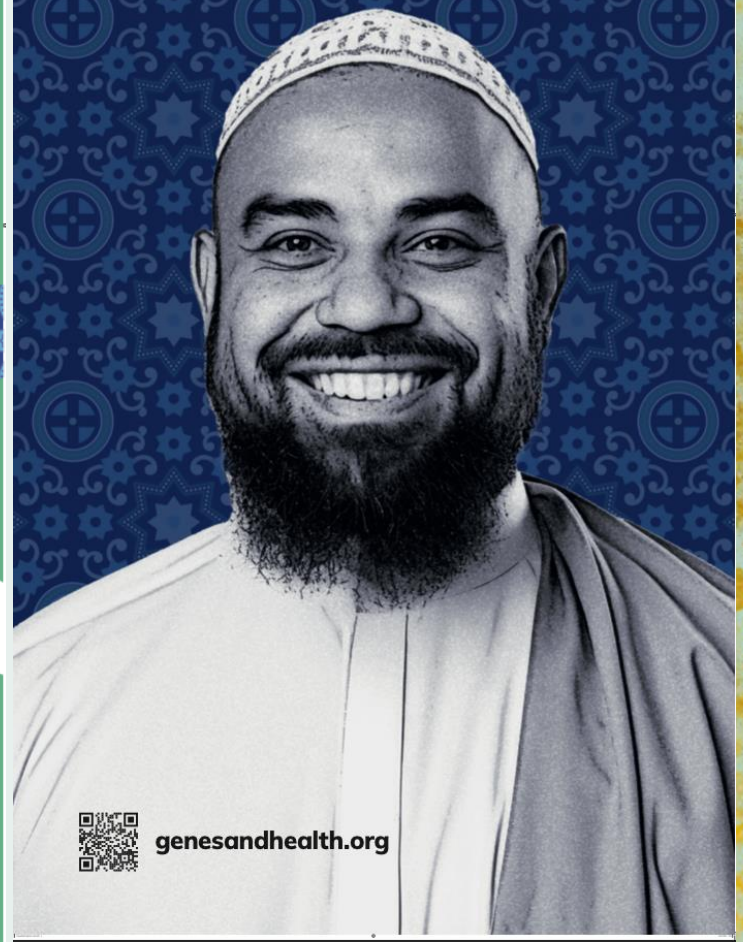
Genes & Health

# Improving the health of South Asian people

genesandhealth.org

Genes & Health

South Asian people have some of the highest rates of heart disease, diabetes and poor health in the UK



genesandhealth.org

LONDON BANGLADESHI HEALTH PARTNERSHIP

# Genes & Health

A large community-based study of the health of British-Bangladeshi & British-Pakistani adults living in the UK

**Who:** British-Bangladeshi and British Pakistani people aged 16+

**Where:** Recruitment in community settings, GP surgeries, hospitals

London, Bradford, Manchester

**What:** Spit sample for DNA (genetic) studies

Consent for health data linkage

Agree to be recontacted in the future for recall studies

**Why:** Health inequalities

Priority areas: diabetes, cardiovascular disease, cancer, mental health

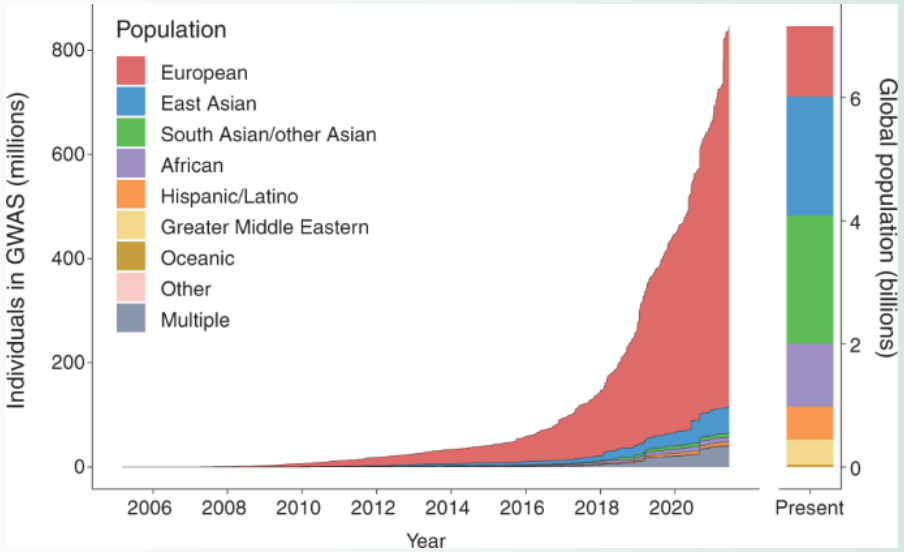
Addresses underrepresentation in other research studies

Equitable advances in healthcare from scientific discovery


Genes Health

biobank uk
Improving the health of future generations

| Category | Count |
|---|---|
| White | 503853 |
| Mixed | 3095 |
| Asian or Asian British | 44 |
| Indian | 6109 |
| Pakistani | 1905 |
| Bangladeshi | 240 |




Fatumo et al, Nature Medicine 2022

South Asians:

23% of the world population

0.8% of participants in genetic studies

Genes Health

Since 2005:

- **Recruited 62,475 volunteers, of whom ~1800 have participated in recall studies**
- Continuous and long-term input from Community Advisory Group, led by Cllr Ahsan Khan
- Publications: Science x1; Cell x2; Nature x11; NEJM x1; Nature Medicine x3; Nat Gen x1
- Partnerships and funding:

## NHS

Barts Health NHS Trust

Bradford Teaching Hospitals NHS Foundation Trust

Manchester University NHS Foundation Trust

East London NHS Foundation Trust

North East London

## Academic

Queen Mary University of London

King's College London

Wellcome Sanger Institute

The University of Manchester

Broad Institute

centre for population genomics

murdoch children's research institute

Garvan Institute of Medical Research

## Community

Social Action for Health

BIMA British Islamic Medical Association

East London Mosque & London Muslim Centre

## Funders

wellcome

UKRI Medical Research Council

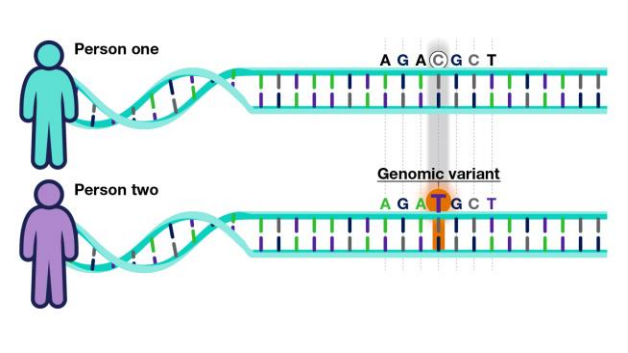
NIHR | National Institute for Health and Care Research

Genes Health

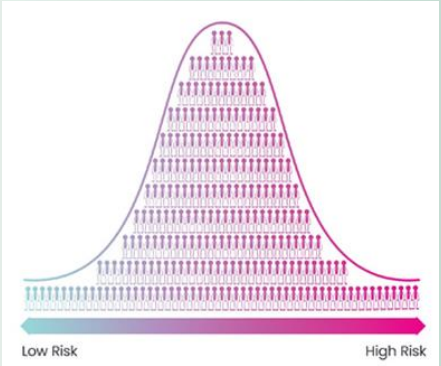
Researching diabetes to improve health outcomes

LONDON BANGLADESHI HEALTH PARTNERSHIP

# Using genetic tools to understand who is at risk of Type 2 diabetes




Polygenic risk scores characterise genetic changes across the genome and can be used to estimate risk of diseases such as type 2 diabetes



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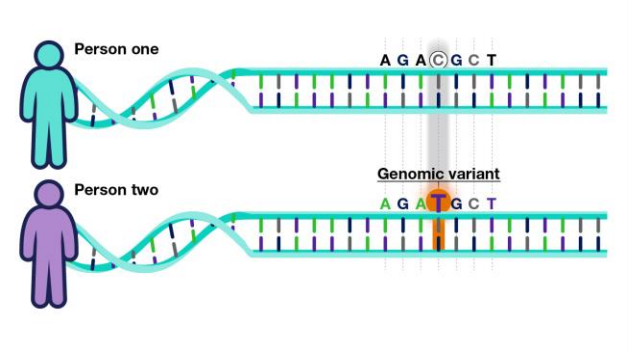


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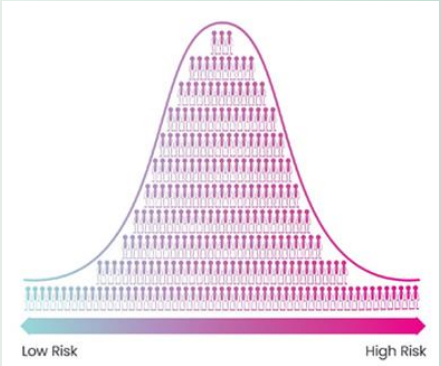
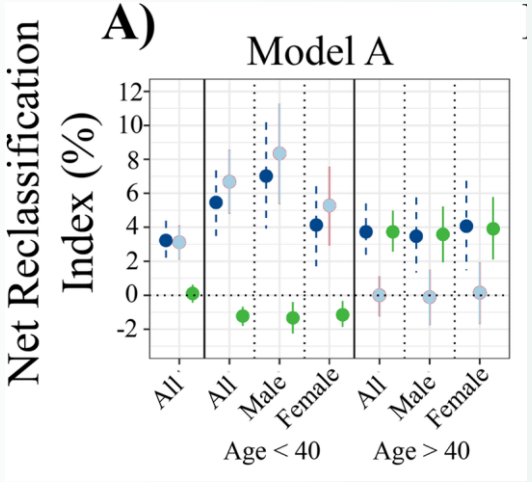



In Genes & Health, we built a polygenic risk score for type 2 diabetes and combined it with QDiabetes used by the NHS



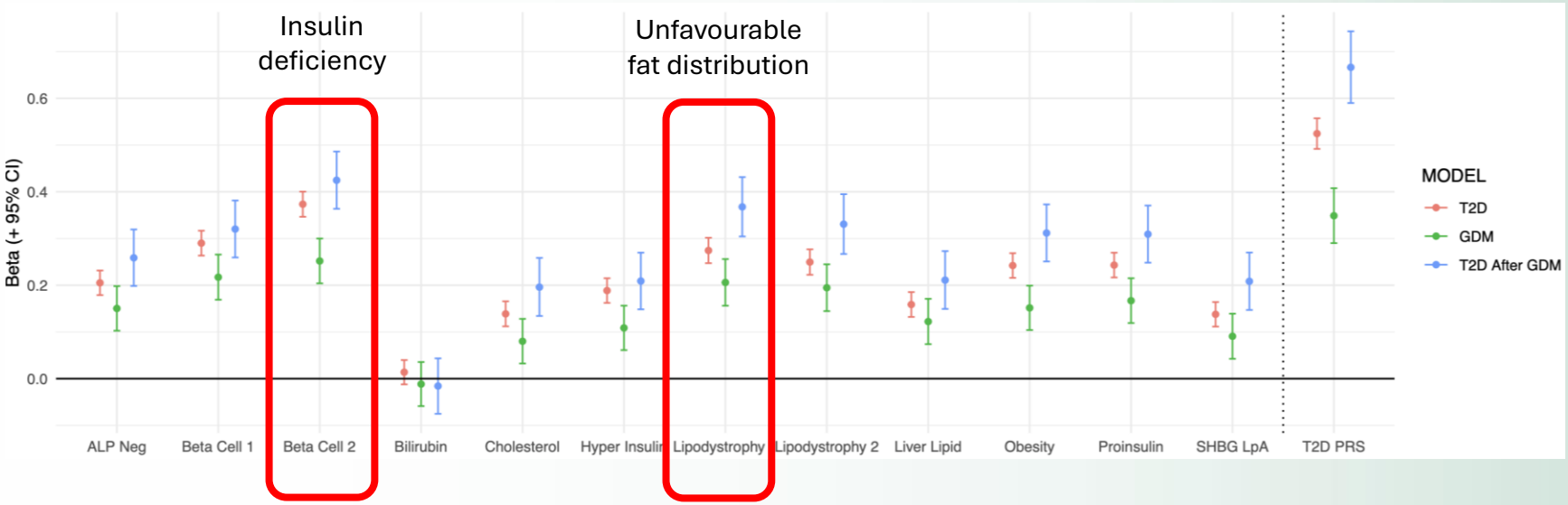

Our combined genetic + QDiabetes risk tool 'reclassified' 6% of young people as being high risk for T2D who would have been missed by Qdiabetes alone

Hodgson et al, PLoS Medicine 2022

# Understanding the genetic cause of early onset type 2 diabetes

A polygenic score can be ‘partitioned’ to uncover different genetic causes of type 2 diabetes.

This tells us that insulin deficiency and unfavourable fat distribution are the key genetic drivers of type 2 diabetes and gestational diabetes in Genes & Health




Hodgson et al, Nature Medicine 2024

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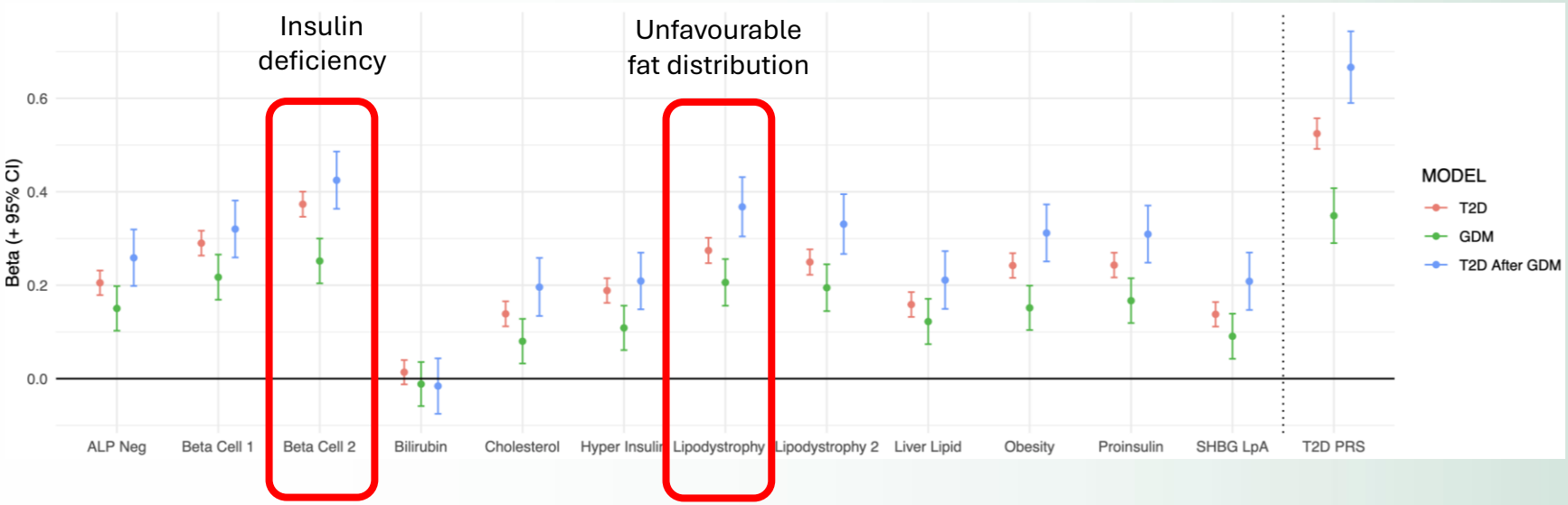


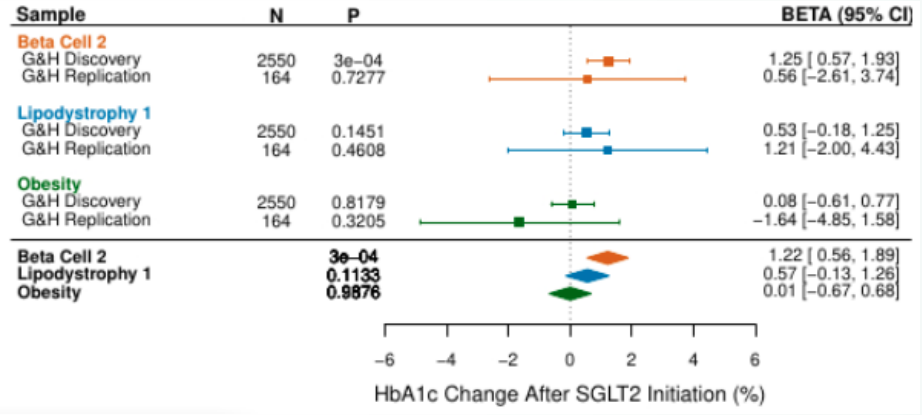

People with the highest genetic risk in both categories are:

- diagnosed 8 years earlier
- slimmer
- progress faster to complications

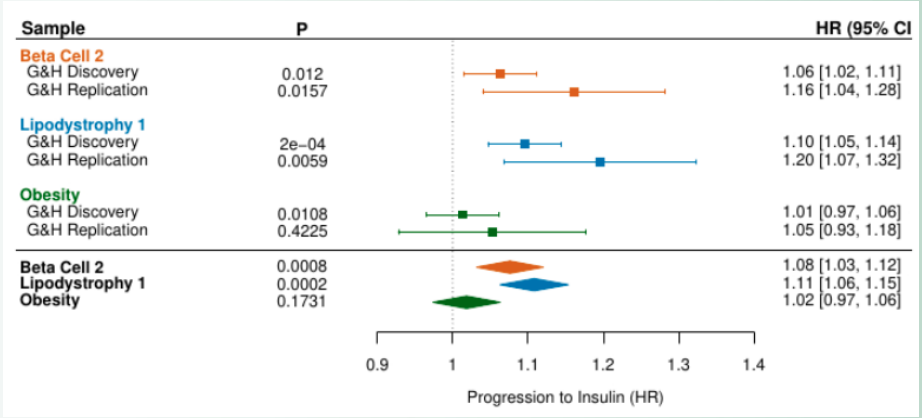
Hodgson et al, Nature Medicine 2024

# Using genetics to guide precision medicine in type 2 diabetes

Response to SGLT2 inhibitors is different according to genetic risk




Progression to insulin treatment is different according to genetic risk




Hodgson et al, Nature Medicine 2024

# Using genetics to guide precision medicine in type 2 diabetes

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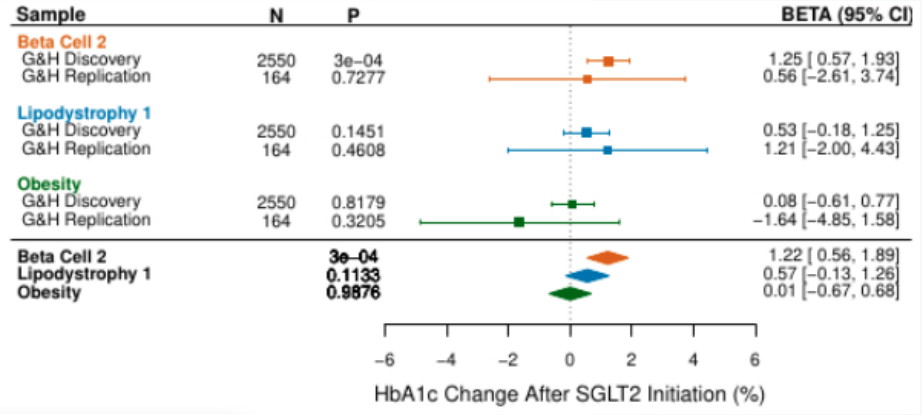


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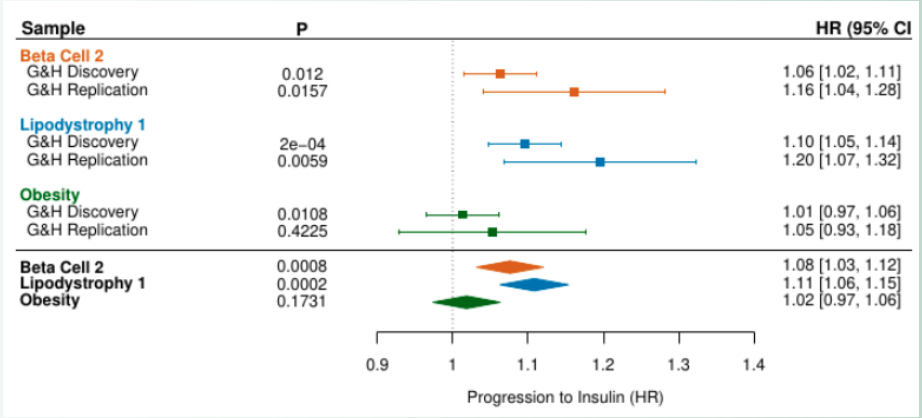


Genetics can guide us towards ‘precision’ medicine in type 2 diabetes, away from one-size-fits-all approaches

Hodgson et al, Nature Medicine 2024

# Understanding misclassification of diabetes

Diabetes diagnoses in young people is often a diagnostic challenge – what type is it?

We can use type 2 diabetes and type 1 diabetes polygenic scores to understand how many people are ‘misclassified’ with the wrong type of diabetes

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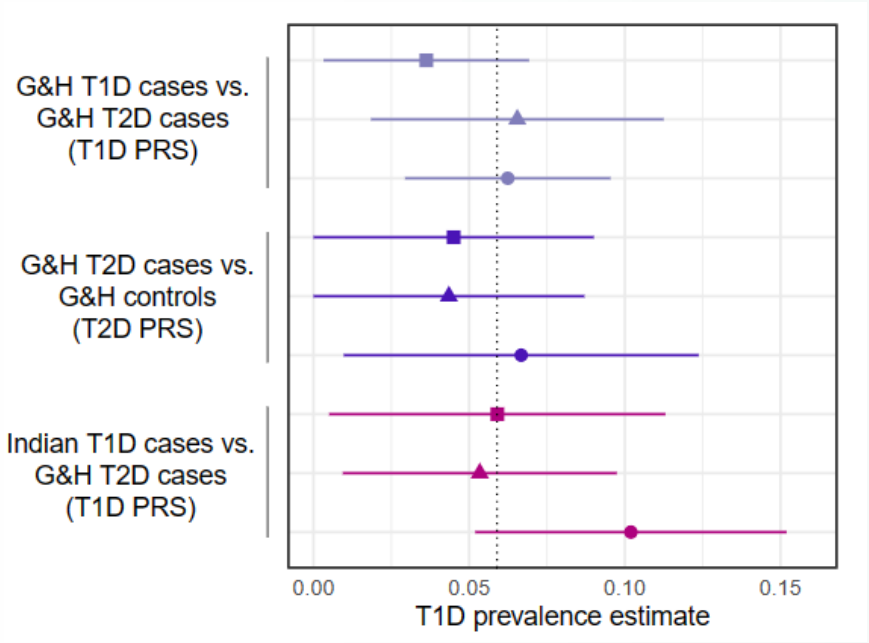


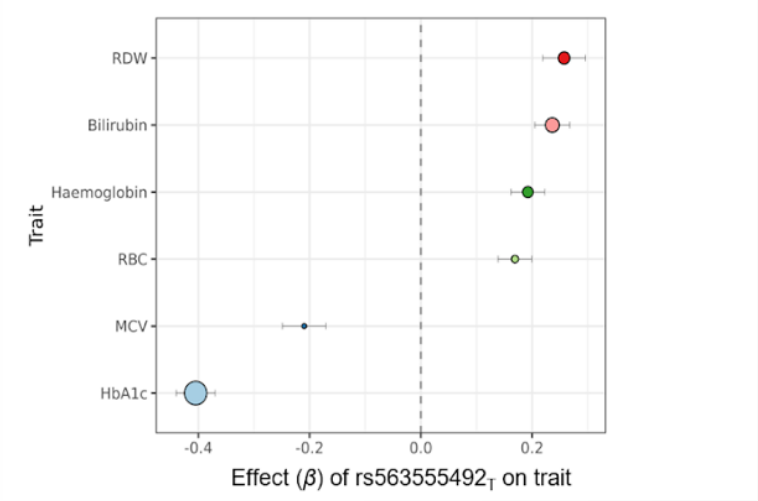

We estimate that 6% of insulin-treated south Asians with diabetes are misclassified as having type 2 diabetes, when in fact they have type 1 diabetes

Liu, Sankareswarn, Paterson, under review, Scientific Reports

# Understanding misdiagnosis of diabetes

HbA1c is a blood test used to diagnose and monitor diabetes

HbA1c is measured ~50 million times per year by the NHS




HbA1c is ~6mmol/mol lower in people with genetic changes in the PIEZO1 gene, irrespective of glucose levels

This leads to a 2.5 year delay in the diagnosis of type 2 diabetes in Genes & Health volunteers carrying two copies of the gene change

These genetic changes are common in south Asians but not White Europeans

Jacobs, Nature Comms, accepted 2024

Genes Health

LONDON BANGLADESHI HEALTH PARTNERSHIP

**Thank you to our incredible volunteers and partners**

**Please let us know how we can work with you**

# Presentation

- Yesmin Begum
- Farzana Khanom
- Aoife Slattery
- Bashir Uddin

# Living with diabetes

Aoife Slattery, Diabetes UK Tackling Inequality Engagement Lead

Yesmin Begum, Public Patient Representative, NIHR Academy.

Farzana Khanom, Community Health Facilitator, Tower Network PCN Limited.

Bashir Uddin, CEO, Bangla Housing Association (BHA)

#BanglaHealthSummit24

# Aoife Slattery

## Diabetes UK Tackling Inequality Engagement Lead

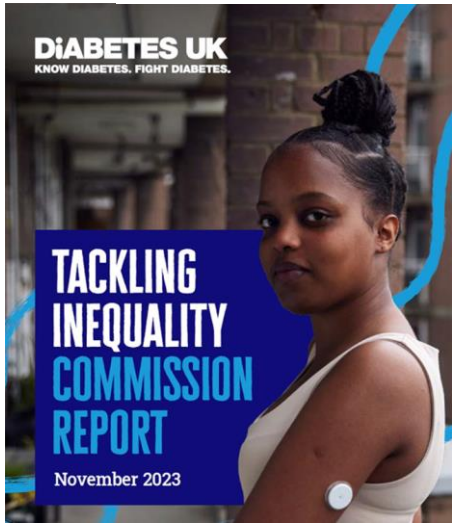
- Driving change through lived experience

- Lived Experience themes:
- Inevitability
- Assumptions
- Representation

"Diabetes in our family is very prevalent. Anybody with the same surname as myself has a high susceptibility of diabetes on this planet."
**Lived experience testimony**

"[community] knowledge needs to be integrated early on into the design of services and materials to ensure they will be fit for purpose for those furthest away from service access"
**Walsall housing group Director**

Report available here:
https://www.diabetes.org.uk/professionals/resources/tackling-inequality-commission



# Yesmin Begum

## Public Patient Representative, NIHR Academy

- Gestational Diabetes during 4 out of my 5 pregnancies
- Borderline diabetes since last pregnancy 11 years ago
- 2 years ago developed type 2 diabetes and started metformin
- I also have other health conditions which make managing diabetes more complicated
- Although I have lots of knowledge about diabetes now, I still find it hard to find time to look after myself

# Staying motivated and accountable in managing diabetes

- 1. Importance of Motivation
- 2. Role of Support
- 3. Accountability
- 4. Building a Routine
- 5. Overcoming Challenges
- 6. Encouraging Self-Care

# Farzana Khanom

## Community Health Facilitator, Tower Network PCN Limited

- Gestational Diabetes during first 2 pregnancies
- No diabetes in 3rd pregnancy after changing diet and exercise
- I remain at high risk due to my family history and past history of gestational diabetes
- I have continued the diet and lifestyle changes and use my experience in my role as a community health facilitator

# Communities Keeping Well Programme

- Type 2 diabetes
- Heart and Lung conditions
- Awareness raising events
- Prevention work through walking and gardening activities


#BanglaHealthSummit24

# Bashir Uddin

## CEO, Bangla Housing Association (BHA)

- BHA has been working for the community in East London for 32 years
- Bangla Covid-19 Advice Project (BCAP) reached over 40,000 people
- Now acting as the Anchor for the London Bangladeshi Health Partnership
- Recent work included working with Diabetes UK to run focus groups on new resources for diabetes check ups



# Diabetes in our community

- Type 2 Diabetes is a serious,  life threating disease and is a health emergency for our community.
- With good healthy living awareness, it's preventable and if managed well people can live with it for long time

- We have heard how much more can be done in our community to raise awareness, improve understanding and ensure access to better care for all types of diabetes
- BHA is committed to support our community and to continue to work in partnership with LBHP, the NHS and others to do this.

' In my community you are an exception if you don't have diabetes by the age of 60'.
BHA resident.

#BanglaHealthSummit24

# Presentation

- Rehan-Uddin Khan
- Ferha Saeed

# Pregnancy and Diabetes
# The Journey for the Bangladeshi women

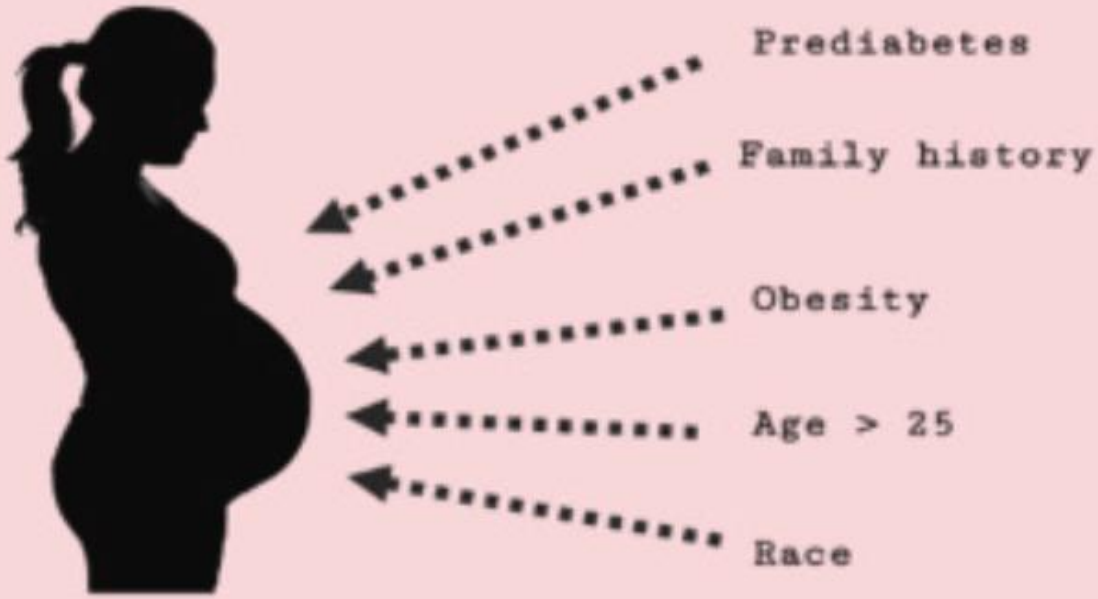

## Ferha Saeed

Consultants Obstetrician & Gynaecologist

Barts Health

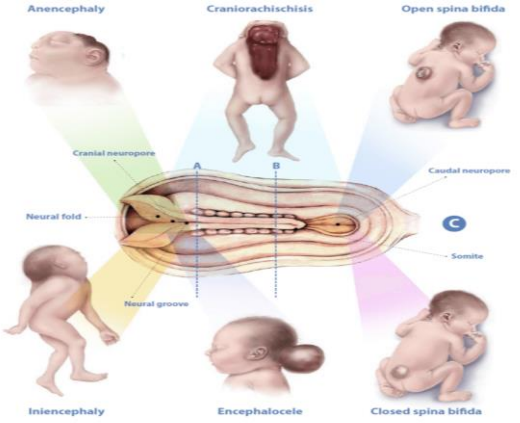
# Risk factors for Diabetes and Bangladeshi women

# The perfect match

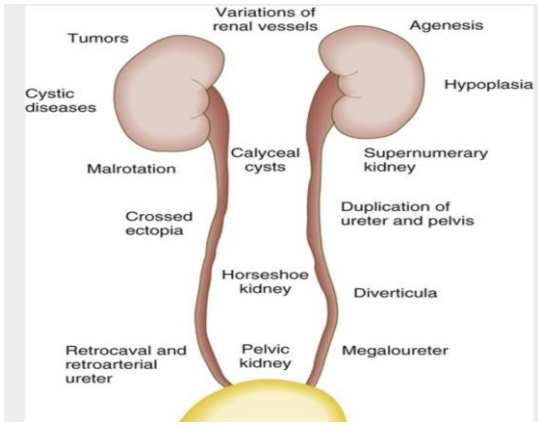


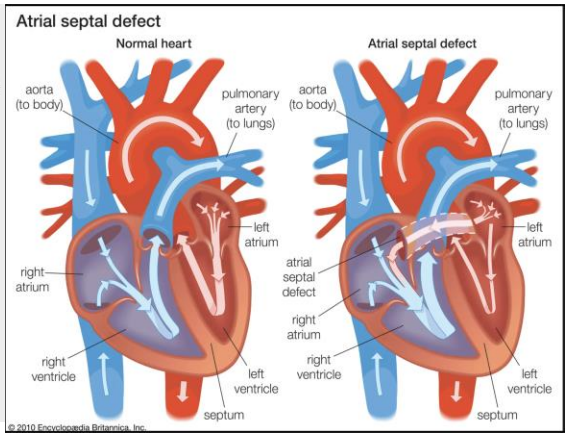
# Conception with Uncontrolled Diabetes : Abnormalities in the baby

- Termination of pregnancy
- Long term neonatal morbidity
- Psychological morbidity for the couple and the extended family



Source: adapted from: Botto et al. (1999) (27). Reproduced with permission from the publisher.



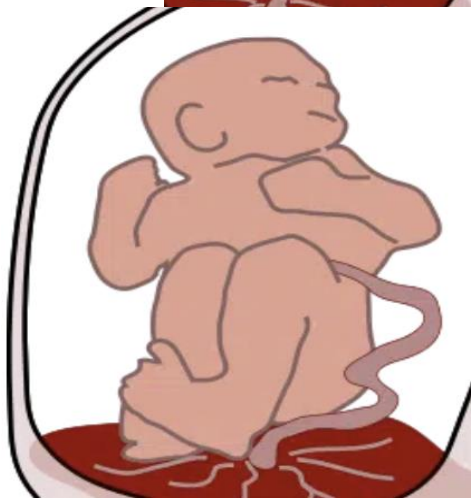



Long term diabetes with vasculopathies

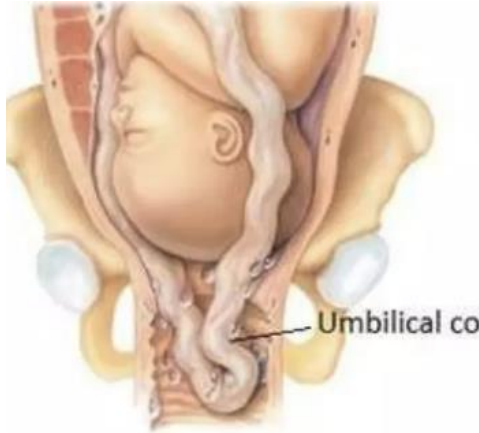
**Small babies**; Risk of intrauterine death. Risk of preterm birth

Poorly controlled diabetes

**Large babies ;** Risk of intrauterine death Birth trauma, physical handicap



**Polyhydramnios.** Cord prolapse, baby's brain damage




Umbilical Cord Prolapse

**Preterm Deliveries :** Huge burden in east London ( Being Bangladeshi living in deprived area with diabetes multiply the risk)

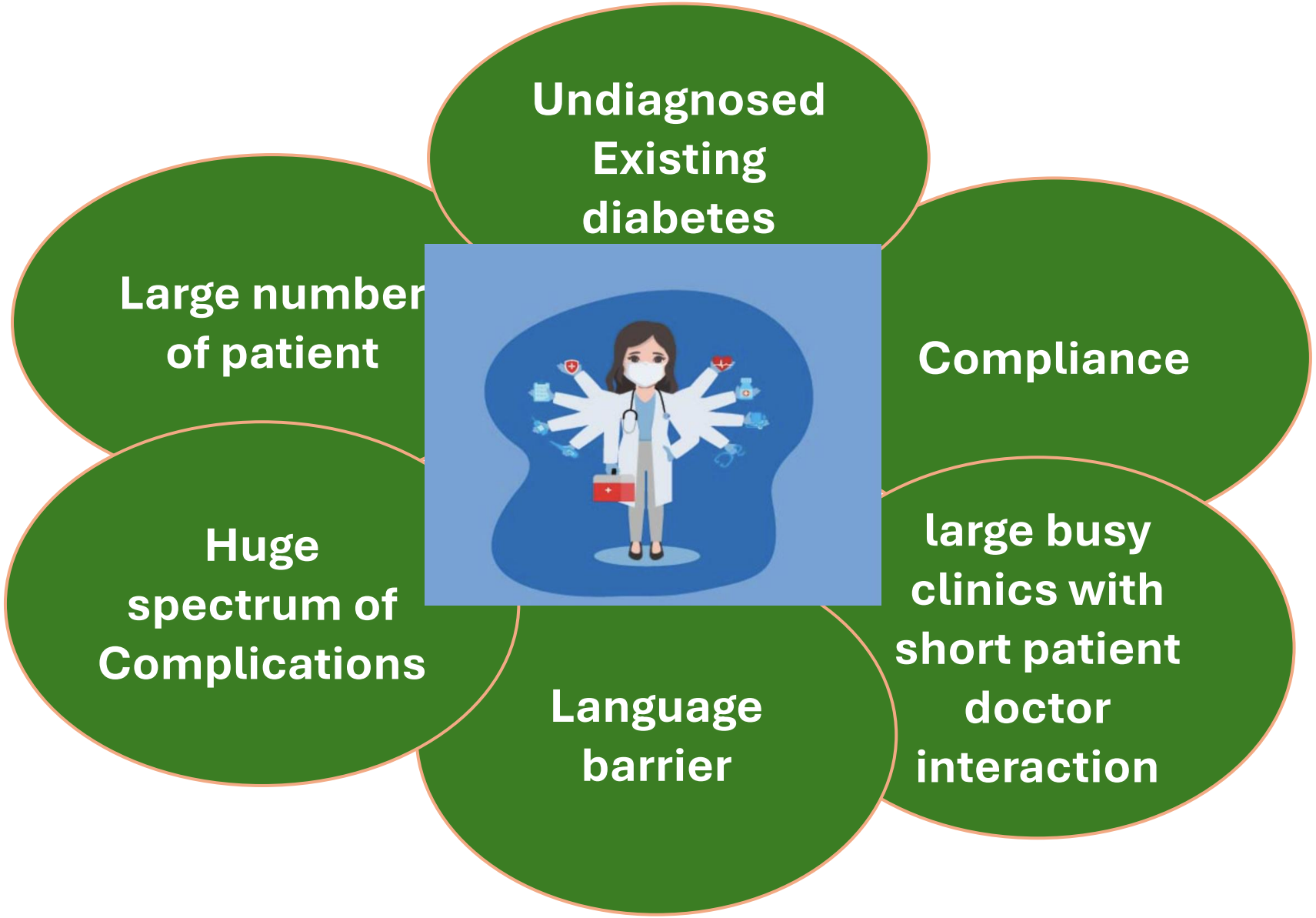
# Risk and Complications for Diabetic mothers

- Higher incidence of C section.
- Excessive bleeding. Risk of anemia; fatigue slow recovery
- Deterioration of  Preexisting Diabetes
- Physical and psychological burden of;
    - Termination of pregnancy and Stillbirth
    - Babies with congenital abnormalities
    - Preterm neonates
- GDM to Type 2 DM

# Barriers to improving maternal health with Diabetes in Bangladeshi women

- Hospital resources / time spent with women
- Community feedback mechanisms and follow-up systems;
- perceptions and practices related to pregnant women's diet;
- societal negligence of women's health
- Women Empowerment
- And so on and so forth….

# The Hospital journey in reality : Fire fighting



# Ideal journey

- Preconception counselling. Contraception and  timed conception
- Effective GDM screening
- Optimal glycaemic control
- Reduced risk of maternal complications, promoting favourable fetal outcomes, and reducing the long-term health risks for both the mother and the child
- Adequate hospital resources

# Life course management of Diabetes in Women

**Rehan Khan**

Consultants Obstetrician & Gynaecologist

Barts Health

# Thank you


**Diabetes in Pregnancy Model of Care Health service executive  Ireland 2024**

# Presentation (Verbal Update): What this means for Tower Hamlets

- Councillor Maium Talukdar
- Councillor Abdul Wahid

# Coffee / Tea Break

# Panel Discussion:
# Diabetes and Health Equity in Bangladeshi Community

Chair: Professor Tahseen A. Chowdhury

- Dr Haroon Rashid
- Dr Imrul Kayes
- Adeola Agbebiyi
- Minara Chowdhury
- Dr Joan St John
- Dr Tammy Hibbert
- Ajit Abraham
- Dr John Ford
- Ana Correia
- Nure Alam

# Table Discussions: Diabetes Health Equity World Café Session

- What is already happening that we can build on?
- Where have we found gaps or barriers?
- How can we work together to change and improve this?

# Feedback Session

Professor Tahseen A. Chowdhury and facilitators

- Feedback session
- Next steps
- Call to action
- Pledges
- Closing remarks

# Lunch

# Chair’s Introduction: Afternoon Session

- Martin Machray

# Presentation and Q&A

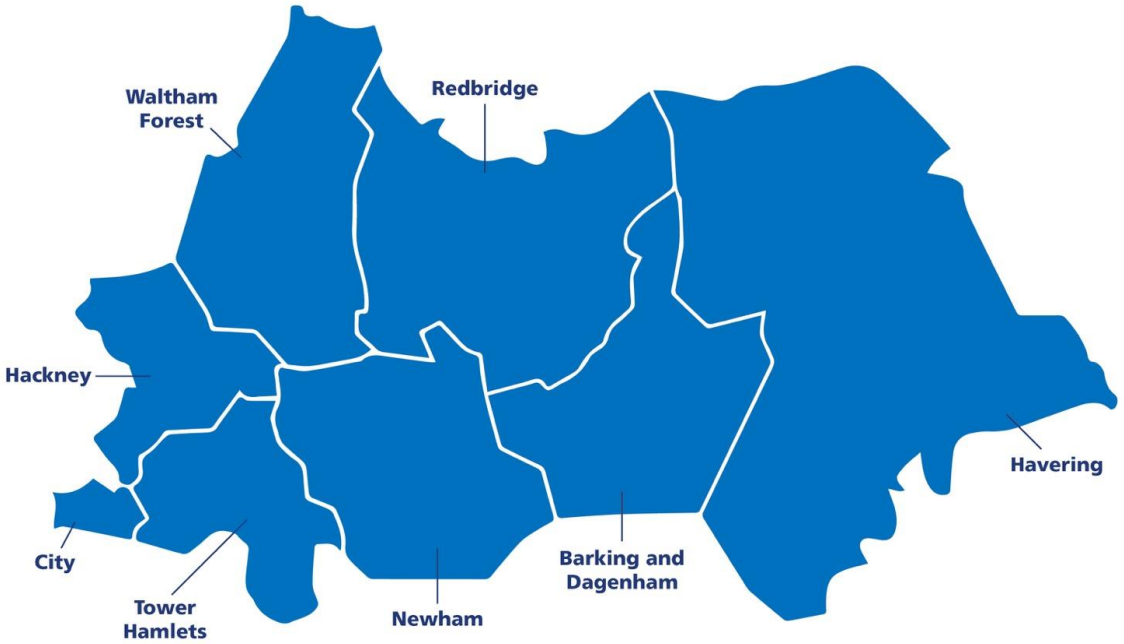
- Femi Odewale
- Caroline Cook
- Fanta Bojanj
- Clare Mabena
- Josephine Ruwende
- Tasnuma Binta Haque
- Regina Maduekeh

# Breast Screening Uptake in Women from the North East London Bangladeshi Community – Insights from a Focus Group

Caroline Cook – Early Diagnosis Programme Lead, North East London Cancer Alliance
Regina Maduekeh – Public Health Programme Officer, London Borough of Newham

# Introduction to the Cancer Alliance

- Committed to improving cancer outcomes and reducing inequalities for local people. Our aim is that everyone has equal access to better cancer services so that we can help to:
  - Prevent cancer
  - Spot cancer sooner
  - Provide the right treatment at the right time
  - Support people and families affected by cancer
- We work with patients, residents, carers, hospitals, GP practices, health and care professionals, local authorities and community and voluntary organisations across north east London.



# Our work programmes

**Operational Performance**
Supporting the local healthcare system to maximise performance and achieve targets for faster diagnosis and time to treatment

**Early Diagnosis**
Increasing the earlier diagnosis of cancer to support the ambition to diagnose 75% of cancers at stage I or II by 2028.

**Diagnosis and Treatment**
Implementing national best practice pathways and improving access to diagnostic services.

**Personalised Cancer Care**
Improving patient experience throughout the whole pathway and supporting the patient and carer voice in developing services.

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# Breast Screening in North East London

| | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sept-23 | Oct-23 | Nov-23 | Dec-23 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Barking and Dagenham** | 62.9% | 63.3% | 63.2% | 63.7% | 64.0% | 64.6% | 64.7% | 64.8% | 64.5% | 64.1% | 63.2% | 62.5% |  |
| **City of London** | 49.0% | 47.3% | 43.8% | 44.2% | 44.6% | 47.2% | 45.0% | 46.8% | 51.3% | 49.3% | 46.6% | 46.9% |  |
| **Hackney** | 45.2% | 46.8% | 47.2% | 47.5% | 46.9% | 47.9% | 48.5% | 49.8% | 50.7% | 50.9% | 50.6% | 50.3% |  |
| **Havering** | 77.7% | 78.0% | 77.5% | 77.2% | 77.7% | 77.2% | 76.1% | 76.0% | 75.4% | 74.6% | 73.7% | 73.1% |  |
| **Newham** | 43.9% | 44.6% | 45.1% | 45.7% | 45.7% | 47.0% | 48.1% | 49.9% | 51.1% | 50.7% | 52.4% | 52.1% |  |
| **Redbridge** | 54.2% | 52.5% | 52.9% | 52.7% | 60.6% | 63.7% | 65.8% | 68.6% | 70.1% | 70.7% | 71.0% | 71.0% |  |
| **Tower Hamlets** | 45.0% | 47.0% | 48.0% | 48.3% | 47.7% | 48.2% | 49.4% | 50.2% | 53.6% | 53.2% | 52.3% | 51.8% |  |
| **Waltham Forest** | 54.6% | 57.0% | 58.6% | 59.7% | 60.1% | 62.5% | 64.2% | 65.6% | 65.4% | 64.7% | 65.8% | 65.9% |  |

Data source: Open Exeter; NHS Futures [FutureNHS Home - FutureNHS Collaboration Platform]

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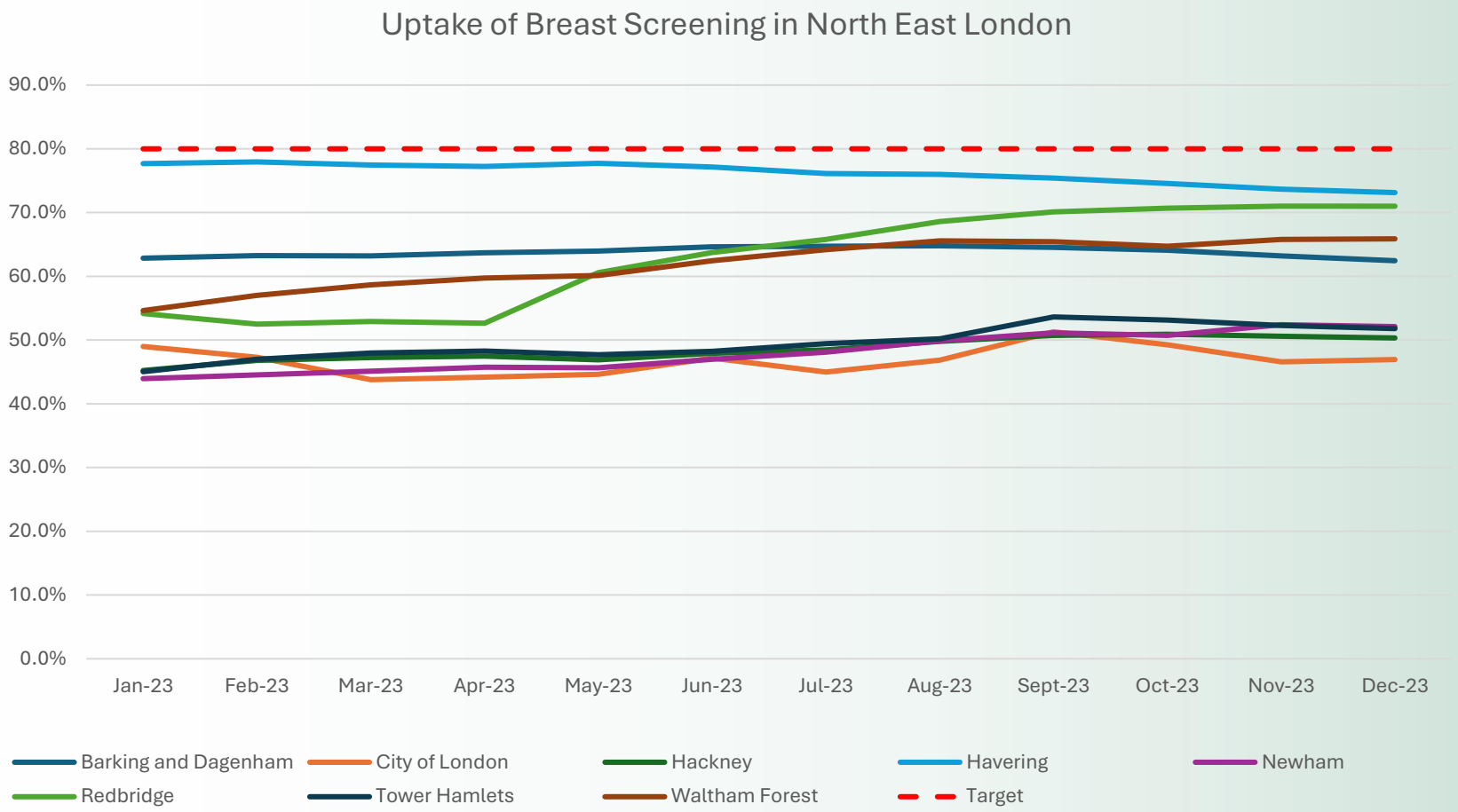
# Breast Screening in North East London




Data source: Open Exeter; NHS Futures [FutureNHS Home - FutureNHS Collaboration Platform]

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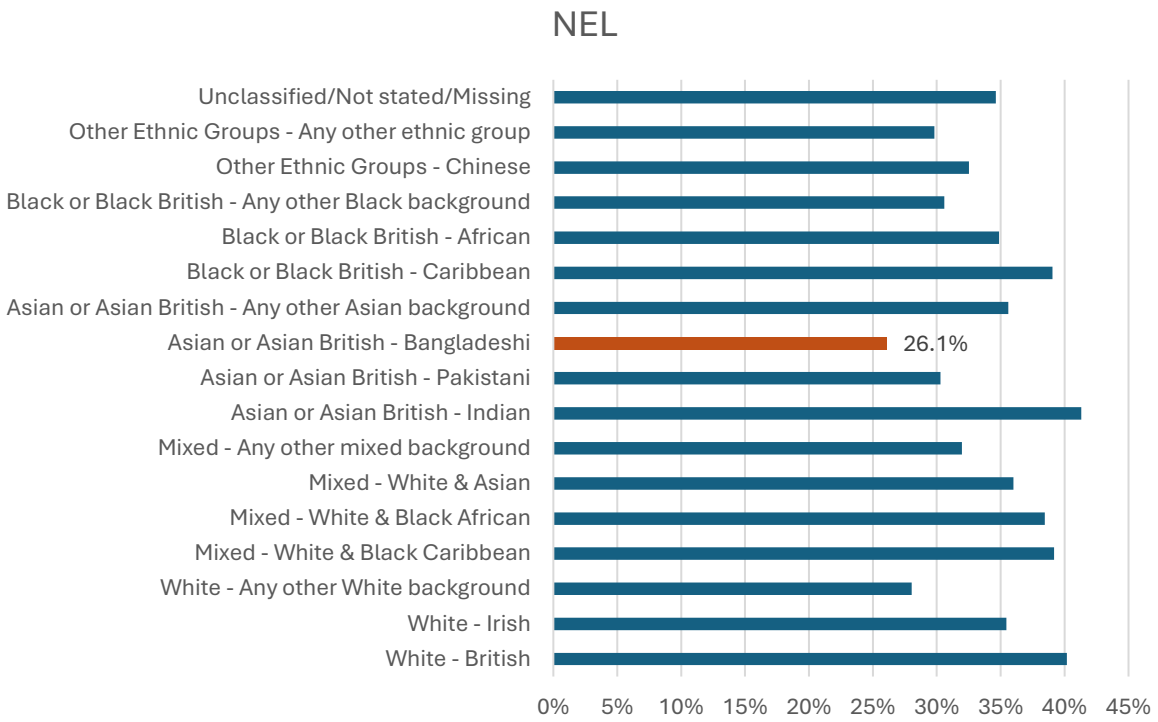
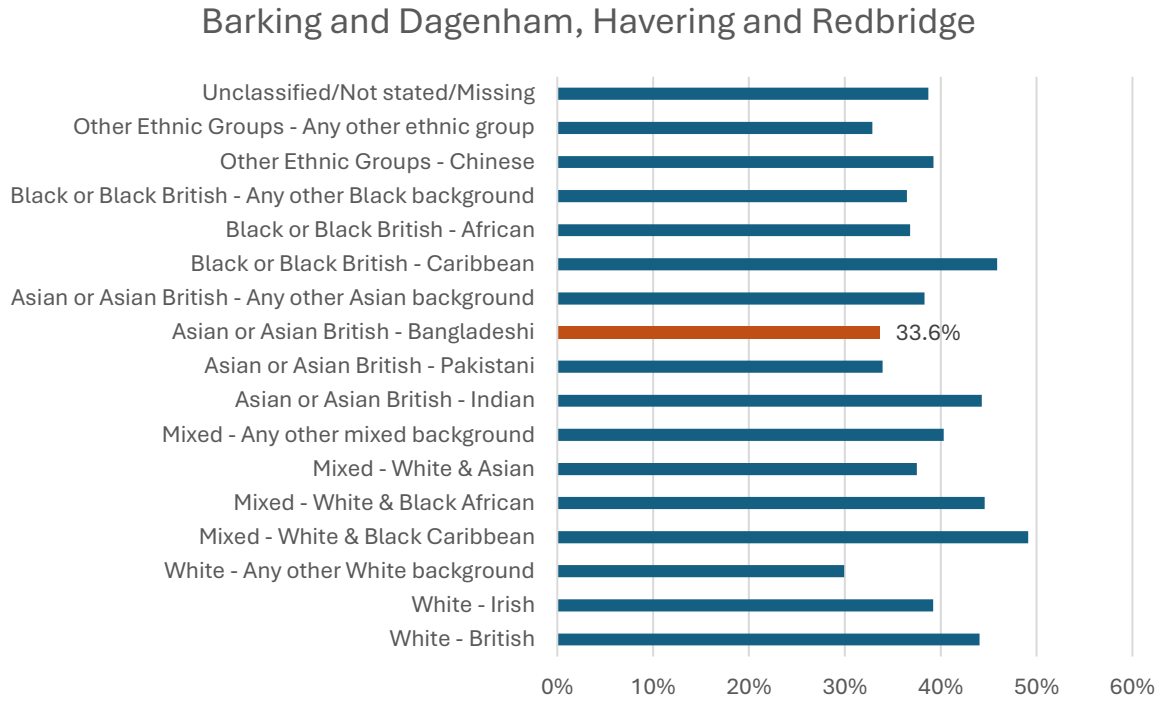
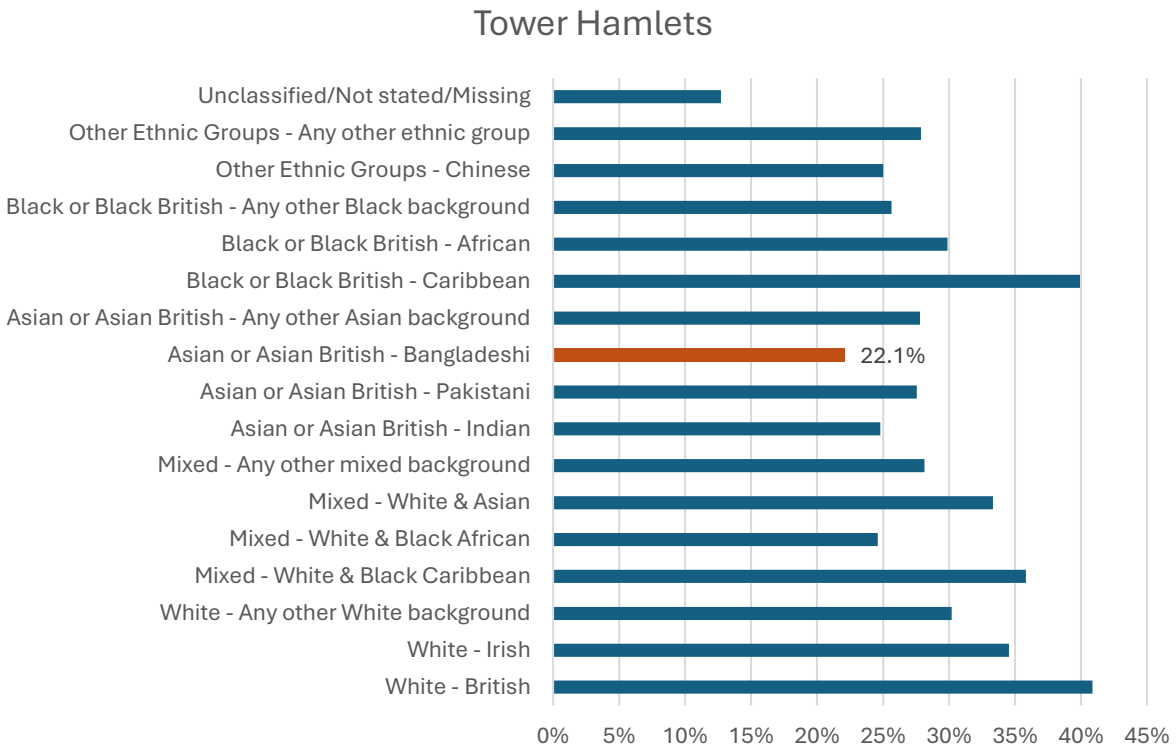
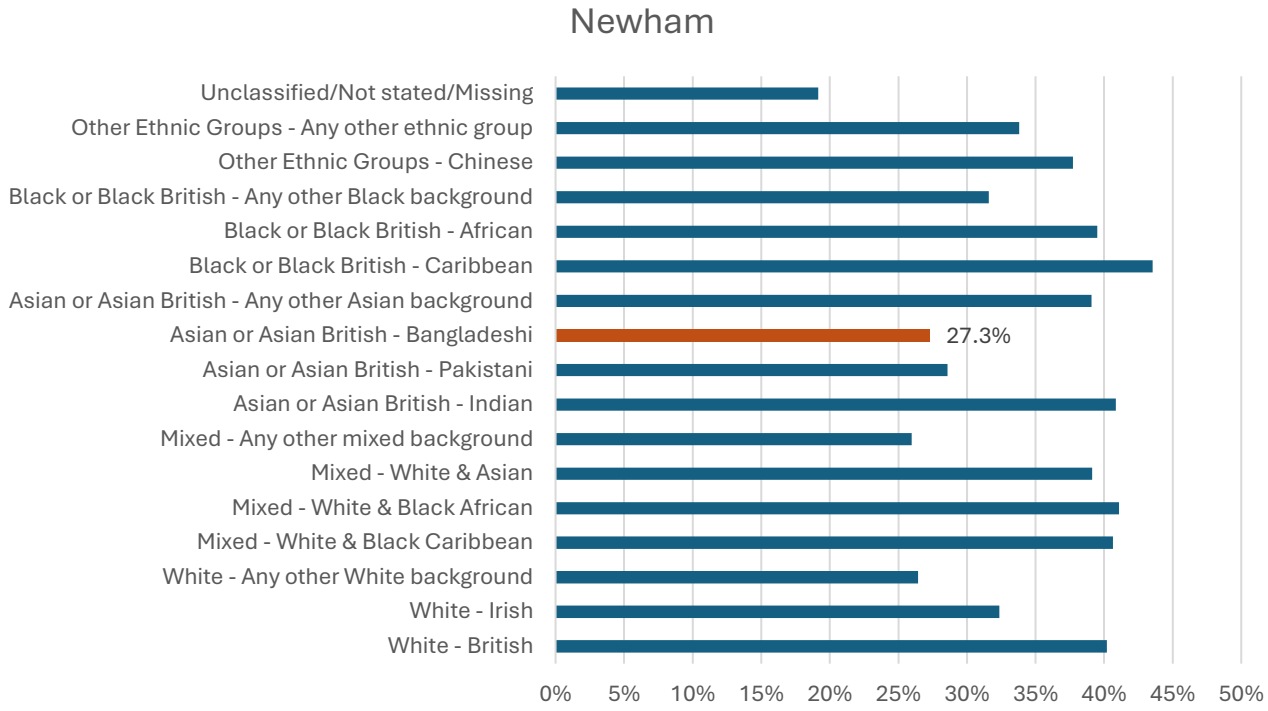
# Breast screening by ethnicity



# Breast screening by ethnicity



# Defining the problem

- Why is the uptake of breast screening so low in Bangladeshi women in NEL?
  - Assumptions:
    - Language barriers
    - Embarrassment
    - Fear – of pain, of having cancer
- What are the consequences of the low screening rates for Bangladeshi women in NEL?
  - 74% unscreened, equates to 10, 401 women
  - Later diagnosis
    - Evidence of the links between ethnicity and late diagnosis[1]
  - More invasive treatments
  - Poorer outcomes.

1. Fry A, White B, Nagarwalla D, et al. (2023). Relationship between ethnicity and stage at diagnosis in England: a national analysis of six cancer sites. BMJ Open 2023;13:e062079. doi: 10.1136/bmjopen-2022-062079 later diagnosis and poorer outcomes amongst women from minority ethnic groups

# Gaining insights

- Focus group held with support from the Bangla Housing Association (BHA).
- Led by the creative agency.
- Purpose to understand:
  - Bangladeshi women's experiences of breast screening and barriers to attending breast screening appointments.
  - The reaction to current campaigns and messaging,
  - How to develop an engaging, relevant and motivating campaign, which addresses the diverse needs of Bangladeshi women.

# Screening appointments

**Communication**

- All of the women had received invitation letters and attended screening appointments, with some attending more than once.
- Most required help from a family member in translating the information received.
- The follow up letter confirming everything was OK was reassuring
- The information was clear for most.

**Appointments**

- Some were concerned that the procedure would be conducted by a male.
- They appreciated having a choice about where the screening took place
- Although the nurses were English speaking, they were respectful and made them feel comfortable throughout.

**The procedure**

- Many found the procedure more painful than they expected, although it was over quickly.

# Barriers and motivations

## Barriers

- Uncertainty or fear around the procedure
- Absence of symptoms
- A lack of understanding of the importance
- Not making it a priority

## Motivators

- Encouragement from family/ friends
- Reassurance from those who have attended
- A reminder that breast cancer can affect anyone
- Encouragement to take care of yourself and put yourself first

# Messaging to increase participation

- Save yourself for your family
- Emphasise importance
- Put yourself first
- Clear focus on breast cancer screening
- Focus on the impact of cancer
- Don’t ignore your letter

# Implications for a campaign

- All key information should be in the poster
  - They are unlikely to engage with a QR code or visit a website
- Clarity on what to expect:
  - An explanation/ diagram of the procedure
  - Reassurance that it will be carried out by a female.
- Imagery:
  - Use vibrant colours.
  - Relatable family scenes e.g. cooking with grandchildren, different generations together preferred.
  - Authentic imagery
  - Positive story
- Language:
  - A clear, simple message that can be easily translated will be most impactful – around putting yourself first and not ignoring the letter

# Limitations and what next?

- Focus group looked at barriers, motivations and messaging – will help us to design a campaign.
- Did not address practical or social reasons for non-attendance, e.g:
  - unable to get childcare,
  - cannot afford transport,
  - services are not easily accessible by public transport.
- Is increasing rates of breast cancer screening the only priority?
  - Raising awareness of signs and symptoms of breast cancer could help to increase earlier recognition.
  - Focus on breast awareness – encourage regular breast checks

# Acknowledgements and thanks

We would like to extend heartfelt thanks and gratitude to the participants of the focus group who gave up their time to join the discussion, and for their contributions which will help to take the project forward.

We would also like to acknowledge and thank Bashir and the team at the Bangla Housing Association for supporting this important work and making it possible at such short notice.

# Cancer Screening Project

NHS North East London

Newham London

## Area of Focus

**Health Priorities**

- Mental Health Project for Asian Women age 18years and above.
- Mental Health Project for Young Black men age 16 – 30 years.
- Cancer Screening Project for Romanian Women & Bengali Women who do not speak English.

## Aims and Objective of the Project

- ✓ Addressing health inequalities through co-design with residents, focusing on areas where participation is lower than others and staying low.
- ✓ To target communities where engagement and participation to cancer screening services are currently and remain persistently low, specifically Bengali and Romanian communities.
- ✓ To increase willingness to attend/participate in cancer screening appointments/invitations in the future.
- ✓ To identify the barriers to accessing cancer screening services by Romanian and Bengali women in Newham.

## The Main Areas Of Focus Include:

- ✓ Bowel cancer – Bengali women ages 54 and above.
- ✓ Breast Cancer- Women age 50 and above.
- ✓ Cervical Cancer – Younger women age 24 and above

## Project Approach

# Main Preliminary Findings:

- **Bengali Community**
- Confidence recognising signs and symptoms of Cervical Cancer and the purpose of the screening was around 20%
- There are significant misconceptions regarding the purpose of the Cervical Screening ; which suggests that some Bengali women hold inaccurate beliefs or lack clear understanding about the reasons behind undergoing cervical screening. This lack of accurate information can serve as a barrier to the uptake of cancer screening services among this population.
- Language barrier is a great obstacle in attending the Cervical Screening, especially within the elderly population who do not speak English. Even if educational/promotional material were written in Bengali, a lot of the older screening age patients may not be able to read. Written Bengali language is a different dialect to the one spoken by most of the community within in Newham, which is Sylheti Bengali.
- Cervical Cancer is a topic that is not discussed with family and friends or in Community and is considered embarrassing
- An average of 60% of the respondents face difficulties in speaking with the Health Care providers and signal a lack of translation services
- Relevance of the Screening & the fear of Cancer.

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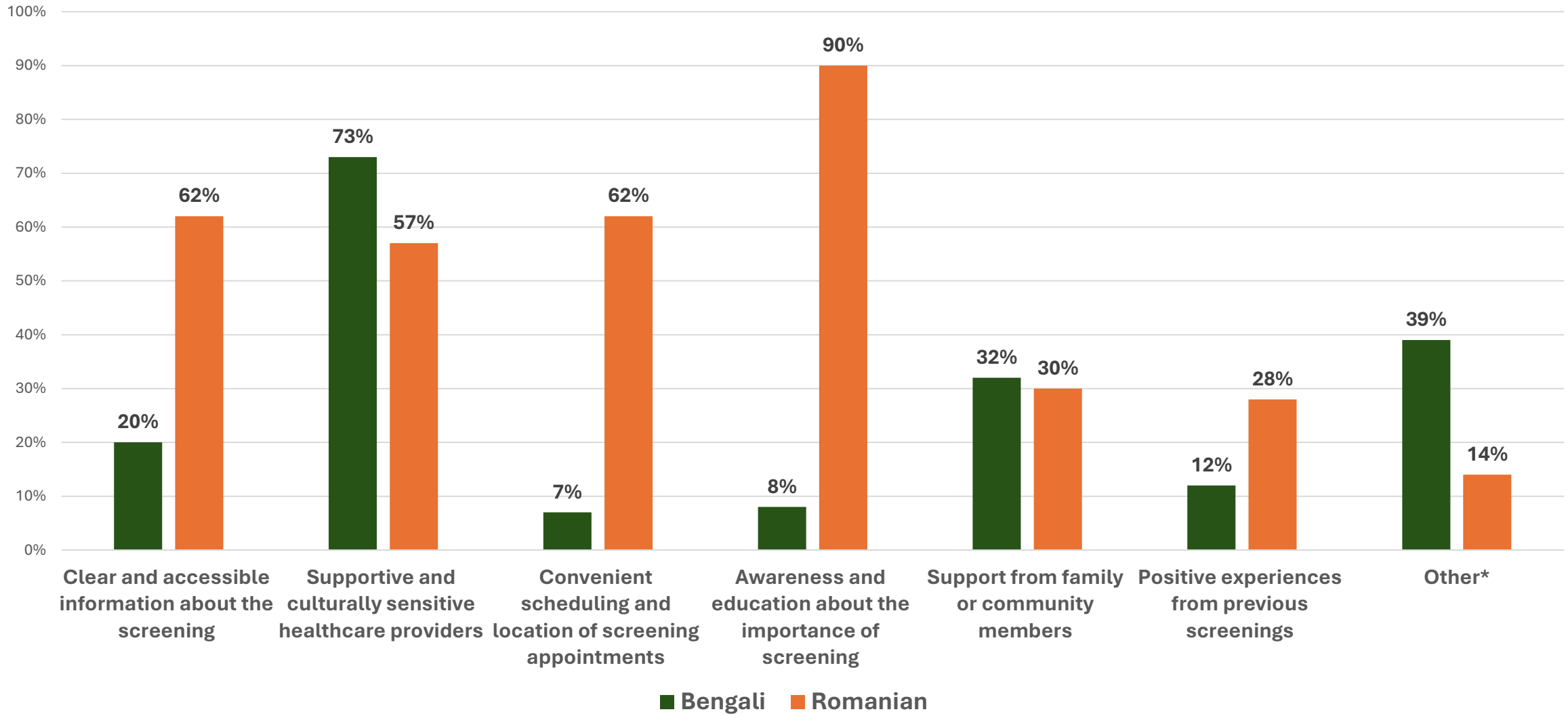
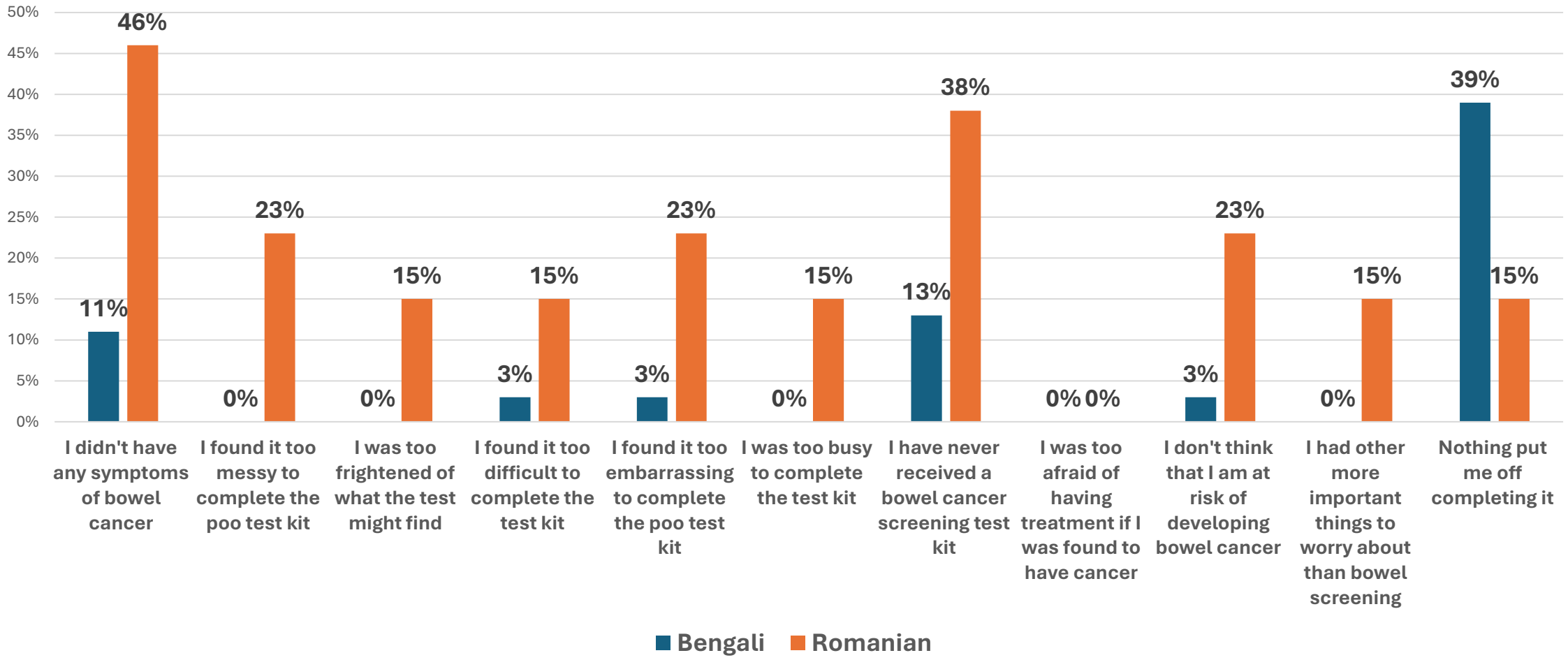
# Factors that led to participation Breast & Cervical



# Factors that put off from participation - Bowel



# Thank You


## Regina Maduekeh

Regina.Maduekeh@newham.gov.uk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# Presentation and Q&A

- Jacqueline Walker
- Susan Elden
- Jo Inskip

# Improving vaccination and reducing inequalities in London's Bangladeshi communities

Susan Elden, Consultant in Public Health, NHSE-London

Jacqueline Walker, Operational Director – Covid 19 and Influenza, NHSE-London

Jo Inskip, Senior Comms and Engagement Manager, NHSE-London

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# Intro

- NHS **vaccination across the life course** (available for London Bangladeshi communities)
- Vaccination **coverage and equity** in  London Bangladeshi
- **Community engagement** and co-production
- **Feedback**- how can we further improve access and vaccination uptake?

# Vaccination across the life course

| Cohort | Immunisation Programme | Who we commission | National Target |
|---|---|---|---|
| Routine 0-5 imms | Diphtheria, Tetanus. Poliomyelitis, Pertussis, Hib and Hepatitis B (DTaP/IPV/Hib/HepB) | General Practice, Essential Service in GP Contract | 95% |
| | Meningitis B (Men B) | General Practice, Essential Service in GP Contract | 95% |
| | Rotavirus | General Practice, Essential Service in GP Contract | 95% |
| | Pneumococcal | General Practice, Essential Service in GP Contract | 95% |
| | Hib/Men C | General Practice, Essential Service in GP Contract | 95% |
| | Diphtheria, tetanus, pertussis and polio dTap/IPV (pre-school booster) | General Practice, Essential Service in GP Contract | 95% |
| | Measles. Mumps and Rubella (MMR) | General Practice, Essential Service in GP Contract & opportunistic catch up via School Aged Immunisation Providers | 95% |
| Routine | Seasonal Influenza Immunisation for children - Eligible age or risk group | School Aged Immunisation Providers – 8 in London | 70% |
| Routine School-aged | Human Papillomavirus (HPV) | School Aged Immunisation Providers | 95% |
| | Td/IPV (Teenage Booster) | School Aged Immunisation Providers | 90% |
| | Meningitis ACWY (Men ACWY) | School Aged Immunisation Providers | 95% |
| Routine | Seasonal Influenza Immunisation for adults | General Practice (Enhanced Service), Maternity Units, Acute& Community Trusts, Community Pharmacy | Adults under 65 years - 75%<br>Over 65 years & HCW - 85% |
| Routine Older adults | Pneumococcal | General Practice, Essential Service in GP Contract<br>Pharmacy | 75% |
| | Shingles | General Practice, Essential Service in GP Contract | 65% |
| | RSV vaccine (older adults aged 75 to 79) | General Practice, Essential Service in GP Contract | TBC |
| Selective | Hepatitis B for babies born to hepatitis B infected mothers | General Practice, Essential Service in GP Contract | 100% |
| | BCG for at risk newborns | Community Providers – 11 in London | 80% |
| | HPV for Men who have sex with men | Acute Trusts | No Target |
| | Pertussis for pregnant women | Maternity Units and General Practice, Essential Service in GP contract | London ambition is 70% |
| | RSV for pregnant women to protect infants | Maternity units and General Practice, Essential Service in GP contract | TBC |
| TBC | COVID-19 Immunisation Programme in Development | GPs, Community Pharmacies, Acute Trusts, | 100% universal offer |

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# London vaccination

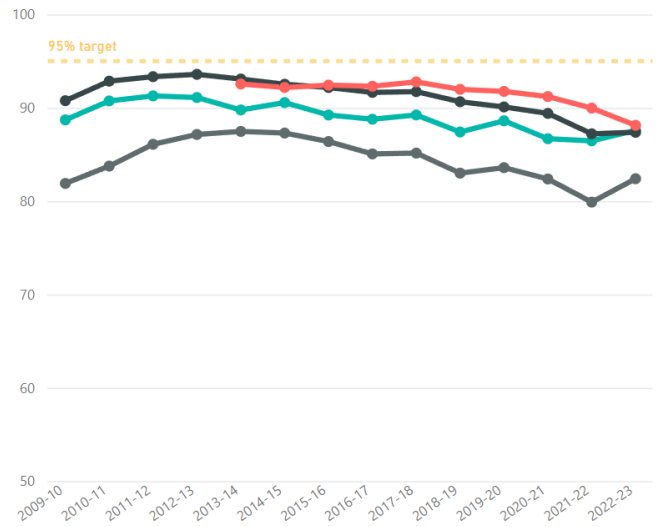
## Childhood Vaccination Coverage Statistics - Regional Time Series

NHS England

| Vaccination Selected | Earliest Year | Latest Year | Years Shown |
|---|---|---|---|
| Multiple Vaccinations Selected | 2009-10 | 2022-23 | 14 |

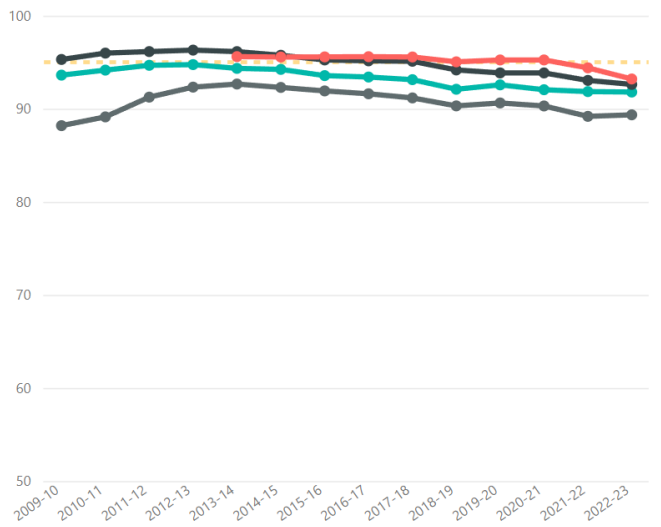
Region: London

Region coverage (%)




Country: England

Country coverage (%)




DTaP-IPV-Hib-(HepB) at 12m ● DTaP-IPV-Hib-(HepB) at 24m ● MMR1 at 24m ● DTaP-IPV-Hib at 5y

Note: Data has been combined for these Local Authorities: Leicestershire & Rutland; Hackney & City of London; Cornwall & Isles of Scilly. From 2019-20, for the 12 month cohort, coverage reported is for the DTaP/IPV/Hib/HepB (6-in-1) vaccination, which replaced the DTaP/IPV/Hib (5-in-1) vaccination. In 2020-21, for the 24 month cohort, coverage reported is for the DTaP/IPV/Hib/HepB (6-in-1) vaccination, which replaced the DTaP/IPV/Hib (5-in-1) vaccination. See Appendix G in the appendices for more details on this change. In 2020-21, for the 12 month cohort, coverage data is not available for PCV. See Appendix L in the appendices for more details.

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EXEC SUMMARY

# VACCINATION UPTAKE ACROSS LONDON

## AND THE CORRELATION BETWEEN ETHNICITY AND DEPRIVATION

### COVID-19 VACCINE

**Deprivation**

COVID-19 vaccine **uptake is lower in areas of higher** deprivation (IMD deciles 1-4) compared to less deprived areas (IMD deciles 7-10)

**Ethnicity**

COVID-19 vaccine uptake is **lowest among those whose ethnicity is unknown, Black Caribbean, Black African, White Other and Black Other** communities.

### WINTER FLU VACCINE

**Deprivation and ethnicity**

As we observe with COVID-19, Flu vaccine uptake **is lower in areas of higher deprivation compared to less deprived** areas

### CHILDHOOD IMMS

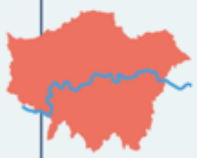
**Deprivation**

**The relationship between increased deprivation and reduced vaccine uptake** that was observed in the covid-19 vaccination programme and winter flu vaccination programme, **also appears to be applicable to most childhood immunisations.**

PCV uptake at 12 months, is an outlier where uptake levels appear to be less closely correlated with deprivation compared to other childhood immunisations.

**Across all ethnicities, higher uptake is related to lower deprivation**

Uptake is higher in the most deprived deciles for the White British, Indian and Irish communities, than the least deprived (most affluent) Chinese, Black African, White Other, Black Caribbean, Mixed and Black Other communities.



Boroughs that are generally **less deprived** (eg. Sutton, Richmond), **have higher uptake in areas of high deprivation,** compared to areas of high deprivation in boroughs that are generally more deprived (e.g. Hackney, Tower Hamlets)

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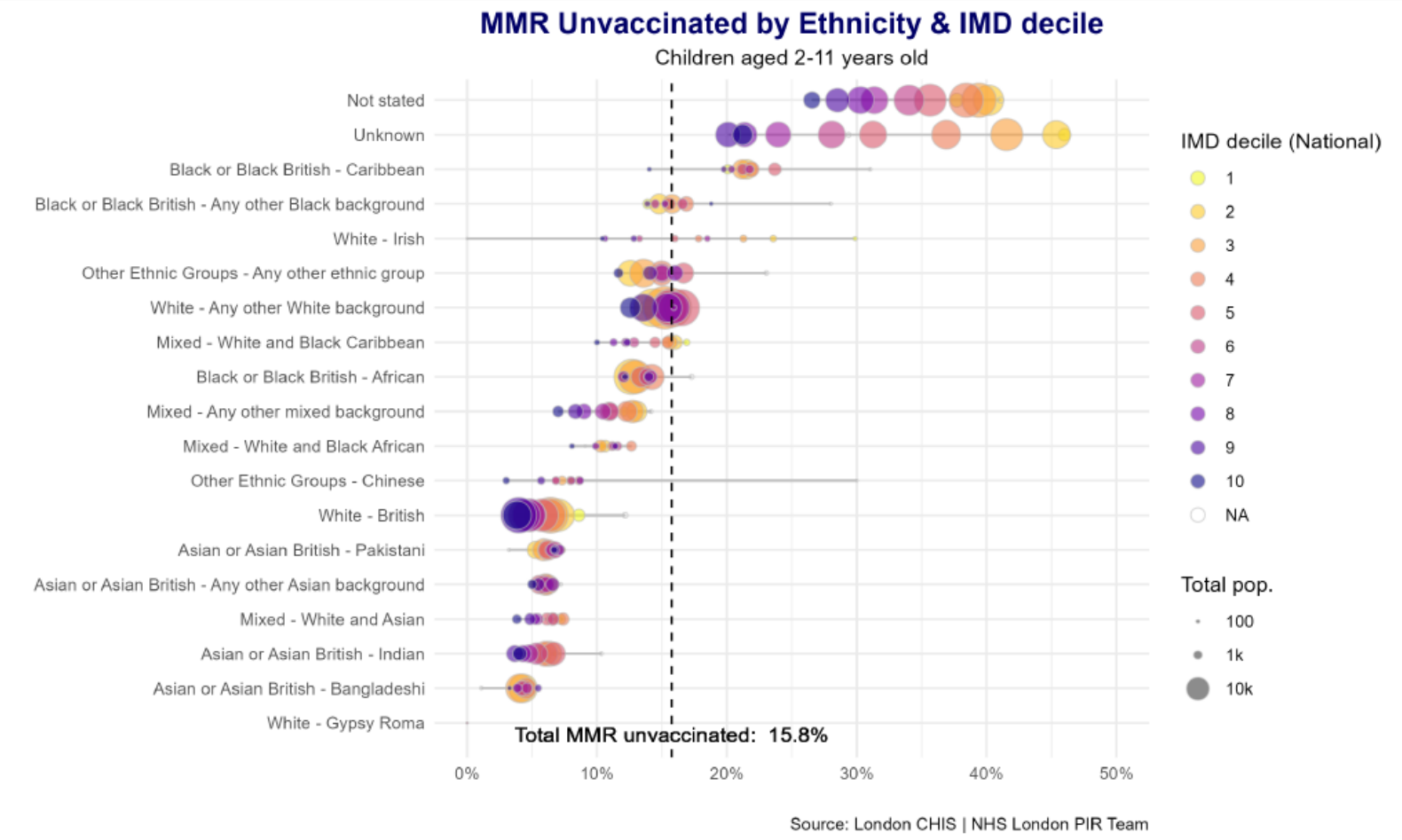
# London Bangladeshi Immunisation: MMR

## MMR Unvaccinated – Ethnicity & IMD




- The bubble chart shows MMR unvaccinated children aged 2-11 years by Indices of Multiple Deprivation (IMD) and ethnicity. The bubble colour represents the IMD with 1 being most the most deprived and 10 the least deprived. The bubble size indicates the total number of children within the IMD decile and ethnicity.
- The not stated, unknown, mixed and white ethnic groups have a higher proportion of unvaccinated children in more deprived IMD deciles and a lower proportion of unvaccinated children in least deprived deciles. However, for Black, Bangladeshi, Pakistani and 'any other' ethnic groups this is not apparent, with higher proportions of unvaccinated children in the least deprived deciles.
- Within the not stated, unknown and white Irish ethnic groups there is a large gap between the high proportion of unvaccinated children in the more deprived IMD deciles and lower proportion of unvaccinated children in the least deprived deciles.

** Note that deprivation is an area-based metric. The ecological fallacy should be kept in mind when interpreting IMD based inequalities.*

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# COVID-19 and Flu Vaccinations

**What is the data telling us?**

COVID-19 vaccination uptake (Spring campaign): England 56.5%, London 37.9%. Uptake is low across all black/mixed black ethnic groups as well as in Bangladeshi and Pakistani groups. Across ethnicity groups in London, we see a clear gradient of lower uptake in more deprived IMD deciles to higher uptake in less deprived deciles.

| Ethnicity | IMD and Vaccination Uptake |
|---|---|
| White British | IMD 1 - 39.1%; IMD 10 – 64% |
| Bangladeshi | IMD 1 - 9.6%; IMD 10 – 30.1% |

- Significant variation across London for our Bangladeshi community - 8.1% uptake in NEL, compared to 24.9% in SWL, 17% in NWL. Tower Hamlets and Newham fall within the lowest fifth of all England boroughs when looking at average level of deprivation.
- London has lowest flu vaccination uptake rate at 37% among all regions in England, and significantly lower than the national average, which stands at 50%. NEL, NCL and NWL are among the lowest performing ICSs nationally.
- NEL and NCL, where many Bangladeshi communities are located, have uptake rates below the London average. Bangladeshi populations have lower flu vaccine uptake (32%) compared to White British (51%), and as low as 17%  in the 30-39 age group, with significant variations across deprivation levels, ranging from 6.8% to 30.1%, highlighting the need for targeted interventions in London's Bangladeshi communities.
- The Bangladeshi group had some of the highest age-standardised mortality rates for COVID-19. During the third wave, mortality rates for Bangladeshi men were 4.43 times higher and for women, 5.23 times higher than their White British counterparts.
- Although adjusting for vaccination status reduced the mortality risk for many ethnic groups, the Bangladeshi group still had elevated hazard ratios even after full adjustments, suggesting that while lower vaccine uptake partially explained the higher mortality, other factors such as socioeconomic inequalities and health disparities also played a role.

# National and Regional Strategy

## What?

- **Improve access - a** service, which is simple to understand, which is convenient and easily accessible.
- **More joined-up prevention and vaccination offer -** vaccination services and activities should be holistic, offering multiple vaccinations for the whole family and offer wider health advice and interventions.
- **Improve Understanding and Motivation** - Help people understand why they or their families need a vaccination and how to access it, and we need to work to build trust and confidence. Clear and balanced communications, tailored to individual needs, explaining value, what is available and addressing hesitancy.

## How?

- **More joined-up, collaborative working** – between NHS providers and the wider NHS, local government, and voluntary organisations to plan engagement activities and outreach services that meet the needs of their underserved populations and address wider health inequalities.
- **Build on partnerships -** with underserved communities developed during the COVID-19 pandemic to ensure service delivery models and communication strategies are informed by community insight.

## Vaccination and Screening Groups

- NHSE London has established several VSGs and through the Assistant Director of Vaccine Equity role, we are adding support to these emerging community networks and supporting established networks e.g. London Bangladeshi Health Partnership.
- VSGs are designed to implement a community first and community driven approach, supporting the wider health inequalities workstream, recognising the importance of engaging with communities around wider health concerns, where vaccination is an integral part of the health conversation.
- VSGs are helping to build trust, confidence with low uptake and underserved communities and by bringing VCSE, public health and NHS partners, so people, places, systems and region together, this is fostering development of emerging community partnerships that will collaborate to address health, vaccine and screening challenges for each underserved community in a more tailored, bespoke and culturally authentic way.

#BanglaHealthSummit24

# Co-produced communications

Co-production is an essential part of addressing health inequalities and we hope that embracing working with people with lived experiences, has created authentic partnerships - such as the one we have with LBHP.

For NHS London communications, the co-production of communications **with** communities has made them more meaningful, accessible and culturally appropriate.

Co-production is a process of working together which I feel should be respected. There's more to do and a way to go but together I am confident we can.

**LBHP co-production AND CO-DELIVERY right from the start….**

- August 2023: Inaugural LBHP event to mark South Asian Heritage Month - *Reflecting on Bangladeshi history and recognising the contribution of the British Bangladeshi diaspora to London and the NHS* - attracting over 100 delegates from across the health, statutory and voluntary sectors in London
- September 2023, LBHP partnered with Capital Kids Cricket, the Redbridge roving team and North East London ICB to deliver a health stand at the annual Bangladesh District Cricket Cup.
- October 2023: LBHP teamed up with South Asian Health Action and the NHSE national vaccine equalities team to deliver a health stand at Diwali in the square, and
- April 2024: LBHP teamed up with NHS London and BIMA to provide a health stand at Eid in the square. Both times providing tailored resources and health promotion materials including fridge magnets and leaflets.


# COVID-19 & FLU Vaccination

LBHP has worked closely with NHS London Comms Team to share trusted factual information to enable Bangladeshi communities to have the right information to make a choice about vaccinations through co-produced NHS and LBHP communications.

**Paid for media**

- Bangla Sanglap, Bangla Post, Muslim News, and Asian Standard – London in both English and translated into Bengali

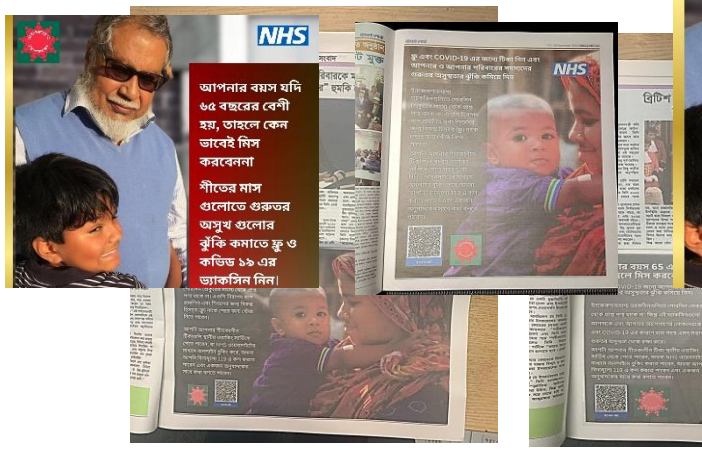
**Radio**

- Paid for radio ads on Asian Star Radio, reaching around 80,000 listeners a week.

**Social media**

- Translated easy to share assets concentrating on the non pork gelatine choice of MMR vaccine shared via LBHP and was very well received.
- Bangla audio cards produced by Nicole, Roopal, Riyad and his wife, shared with NHS London comms team for wide distribution.

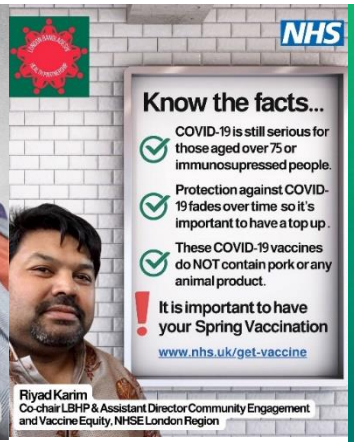
## WINTER 2023 VACCINATIONS WITH LBHP

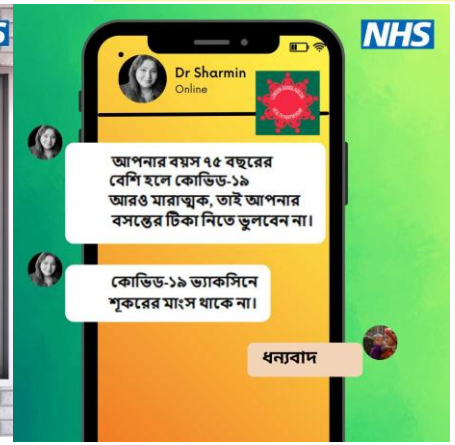






## SPRING 2024 VACCINATIONS WITH LBHP





# MMR

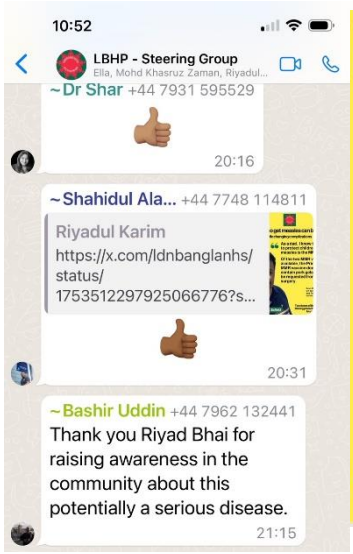
Health partners including UKHSA London, NHSE, ICBs, the Association of Directors of Public Health and Local councils have been working together to support activities to improve uptake in under-vaccinated communities.

LBHP worked closely with NHS London Comms Team to ensure the message reaches Bangladeshi communities in London appropriately.

- Co-produced NHS and the London Bangladeshi Health Partnership – at the request of the co-chair who agreed to be ‘the face’ of the campaign, along with his family.

- Social media asset – concentrating on the non pork gelatine choice of MMR vaccine already shared via LBHP and were very well received.

- Plus paid for advertising in Bangla Post.







More than 3 million unvaccinated children are at risk of measles. Measles is highly infectious and can be passed on even before a rash appears.

rotect your child from becoming se
nwell by making sure they are up to
ith their MMR (measles, mumps an
ubella) vaccinations.

https://lnkd.in/eUsF8M8f

lease note there are 2 different bran
MR vaccine available in the UK. Th
rand does not contain pork gelatine
an be requested from your GP surg

মিলিয়নেরও বেশি টিকাবিহীন শিশু হামে
য়েছে

নুগ্রহ করে মনে রাখবেন UK-তে 2টি ভিন্ন
MR ভ্যাকসিন পাওয়া যায়। Priorix ব্র্যান্ড

# What's next…

**Winter Vaccinations 2024**

Street advertising positioned near community places of interest (mosques, South Asian cafes and food stores etc) in areas with largest Bangladeshi population 07/10 for 2 weeks and 04/11 for 2 weeks.



Community media - Bangla Post Full on 29/09 plus radio adverts on Lyca Radio at the same time as the street ads.

**How can WE work with YOU to make sure health communications work for YOU?**

# Feedback

How can we further improve access and vaccination uptake with our Bangladeshi Communities?

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# Coffee / Tea Break

# Table Discussions: Vaccination and Screening Equity World Café Session

- What is already happening that we can build on?
- Where have we found gaps or barriers?
- How can we work together to change and improve this?

# Feedback Session

Martin Machray

- Feedback session
- Next steps
- Call to action
- Pledges
- Closing remarks

# Close