LIVING LONG LIVING WELL

THE IMPACT OF ALCOHOL, DIET, EXERCISE AND SMOKING ON THE HEALTH OF AFRICAN PEOPLE IN THE UK
Tackling health inequalities is essential. Health inequalities are a social injustice. The fact that people from ethnic minorities can expect poorer health is a crisis that we all must address. Policy makers must expand efforts to achieve the priorities of reducing health inequalities and improving the quality and equality of our health system.

Efforts have been made in the past to do just this. In 2004, I launched the NHS Race Equality Action Plan, which for the first time committed the NHS and the Department of Health to paying more attention to meeting the needs of people from ethnic minorities and to make race an integral part of their strategy, policies and practices (Crisp, 2004). It is a health issue, a legal and a moral issue. Today, the NHS Commissioning Board, Clinical Commissioning Groups and Health and Wellbeing Boards have new opportunities to take up this cause and pursue it vigorously.

I very much welcome this report and the work done by the African Health Policy Network. Exploring and understanding the connections between ethnicity, health and health inequalities expands our understanding and enables us better to address the problem of inequalities in health.

I hope this report will aid the NHS to redouble efforts to mitigate ethnic health inequalities. The same applies today as I said then: “Success will be judged not on what we say but on what we do.” (Crisp, 2004)

Rt Hon Lord Nigel Crisp KCB
Independent crossbench member of the House of Lords.

From 2000-2006, he was both Chief Executive of the NHS and Permanent Secretary of the UK Department of Health.
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AHPN: Improving Health and Wellbeing

The AHPN is the leading policy organisation that influences policy on the health and wellbeing of Africans in the UK.

We are a network of membership organisations and individuals with a common goal to improve the health and wellbeing of the UK’s African population.

The AHPN acts as a focal point and catalyst for individuals and organisations in the African community, providing platforms to share learning and experience, to influence policy and to speak with a collective voice.

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Health is an outcome, not an accident. That is the principle underpinning this report, and indeed all of the work of the African Health Policy Network. AHPN is concerned with identifying, measuring and reducing health inequalities facing African people and communities in the UK, in order to promote good and equal health for all. Our work is based on the recognition that inequalities in health between different social groups are a product of wider inequity in society, and that promoting equity in health is therefore a question of social justice. This view was the foundation of the work of the Marmot review, instigated by the Secretary of State for Health in 2008 to investigate health inequalities in the UK. The report of this review calls for recognition of the ‘social gradient’ in health, whereby a person’s health is determined proportionately by their socio-economic position, and targeted action to reduce it (The Marmot Review, 2010). Whilst supporting the conclusions of the Marmot review, this report calls for health policy to move beyond Marmot, by embracing a broader and deeper understanding of the causal factors creating and sustaining health inequalities. In particular, it calls for ethnicity to be understood as an independent driver of health and recognised as a causal factor in health inequalities.

In much of the literature and indeed programming considering the issue of health inequalities, the socio-economic determinants of health are prioritised at the expense of other factors such as ethnicity. While it is clear that the social-economic factors which influence health are core drivers of health inequalities, it is also vital to consider wider determinants such as ethnicity and migrant status in order to paint a complete picture of health inequalities and their causes (Ingleby, 2012). Economic status and monetary barriers are not the sole drivers of health inequalities; other factors are also influential including ethnically driven barriers, practices and beliefs. Ethnicity can also be seen as a causal factor contributing to the socio-economic status of the individual, and therefore an important ‘cause of the cause’ in determining health:
"In other words, that being a migrant or a member of an ethnic minority leads to ill-health by lowering one's socio-economic status. There are many ways in which this could happen: discrimination may lower one's chances of getting a good job, education, or housing; legislation may deny one's group many rights and privileges (for example, if one is an undocumented migrant); and one's social capital may be reduced if one moves to a new country" (Ingleby, 2012).

Effectively tackling health inequalities necessarily requires action to address the root causes of those health inequalities – if the causal factors are unchanged, then the outcomes they generate will also resist change. Therefore, the impact of ethnicity in generating and driving inequalities in health must be incorporated as a vital component of an effective health equity programme. This further reaffirms the need to abandon a single risk factor approach in favour of a comprehensive analysis that addresses the multiple and cross-cutting determinants of health including ethnicity, gender, class and social and economic indicators (Ostlin et al, 2011). Ethnicity is a driver and determinant of both health and health inequalities, due to the impact it has on the wider determinants of health. This function operates in the influence ethnicity has on social and economic status, and so is important to recognise in attempts to improve socio-economic status in order to improve health. It can also act to generate health inequalities which the standard socio-economic model struggles to capture and explain, for example creating barriers to access to services that cannot be explained by poverty or deprivation. A picture of health inequalities that excludes ethnicity is therefore an incomplete picture.

In AHPN’s Policy Position 2013, we presented an intersectional interpretation of health that acknowledges the multiple elements of identity and experience that influence health and lifestyles (Stevenson, 2013). These intersecting factors operate across 5 domains:

- **Structural**: access to health services, access to appropriate information and advice
- **Social**: immigration status, social capital, peer support
- **Economic**: poverty, housing, employment
- **Cultural and beliefs**: faith, beliefs about health, symptom recognition and comprehension
- **Individual**: priorities, preferences, psychological factors, explanatory models

For example, whether or not an individual eats a healthy diet and the health outcomes of their diet is influenced by factors on each level, such as:

- **Structural**: ability to access resources on healthy eating and recipes that reflect dietary preferences, access to a GP for support and advice, food resources available in their local area (e.g. if fresh fruit and vegetables are available and at what cost)
- **Social**: dietary norms in their communities, family or peer support to make lifestyle changes
- **Economic**: monetary resources to support a healthy diet, ability to budget for food, facilities to store and cook fresh food.
- **Cultural and beliefs**: cultural norms around healthy weight, traditional diets
- **Individual**: food preferences, knowledge of healthy diets.

As this example demonstrates, the choices a person makes at the individual level are only one part of a far larger causal process determining healthy behaviours, which limit and proscribe the options available to the individual to choose from. Ethnicity and its impacts underpin and influence each of the five domains described above. AHPN therefore calls for an approach to public health that brings the public to the individual and takes account of the impact of ethnicity, whilst targeting interventions to mitigate all five domains of influence on health inequalities, as described in the model:

This approach has many advantages, in terms of supporting public health and enabling effective interventions to mediate lifestyle and behavioural influences on health. The extent to which healthy options are available to people and the extent to which they choose to adopt them, are determined and limited by a range of factors. Too often, interventions targeting the lifestyle determinants of health (alcohol, diet, exercise, smoking) focus on the choices people make.
This approach is necessarily limited. A person living in a large estate on the outskirts of a city, with limited and expensive public transport, in an area overrun with fast food stores and no fresh food, isn’t choosing an unhealthy diet in any meaningful way. Focussing interventions on encouraging them to change a behaviour, to which they have no viable alternative, is simply not going to be sufficient. In some cases, structural interventions are essential to support and enable healthy behaviours. Similarly, addressing the social and economic factors that determine the options available to people is essential in order to make healthy behaviours feasible and accessible to those who may otherwise lack access to them. Finally, embedding culturally competent approaches that recognise why people make the choices they do is essential in supporting people to make different choices.

For example, an individual whose culture perceives a larger size to be aspirational as a marker of health is not going to adopt a weight loss strategy predicated on a thin aesthetic.

In summary, this report calls for a holistic approach to public health that moves focus from specific behaviour and conditions to a focus on the individual. An approach that understands that individuals have one ‘health’, and that improving this necessitates an approach rooted in an understanding of the factors that affect their lifestyle options and choices, as well as the wider determinants outside their control that predict and limit their health outcomes. By recognising the impact of ethnicity and the determining influence it has on health, a richer understanding is enabled of the health of African people, and more meaningful, targeted and effective interventions become possible. Similarly, a model of public health intervention that acts on the structural, social, economic and cultural determinants of health in addition to individual choices and behaviours will facilitate greater and faster improvements in health outcomes. Health inequalities are an injustice. But they are also predictable and preventable, if the right approach is adopted and effective action is taken. Health is an outcome, not an accident.

**Lifestyle options and health inequalities**

“People’s lifestyles - whether they smoke, how much they drink, what they eat, whether they take regular exercise – are widely recognised as affecting their health and risk of dying young” (King’s Fund, 2012b).

Health is an outcome of a range of interrelated factors, including lifestyles, structural influences, heredity and environment. The impact of lifestyle on health is hugely significant: the extent to which individuals eat well, exercise regularly and avoid smoking and alcohol affects their health and wellbeing and impacts on both life expectancy and healthy life expectancy. The lifestyle options available to people, and the choices they make, are amongst the most influential determinants of their health. Differences in the lifestyle options available to different individuals contribute to health inequalities within and between communities.
“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”
(WHO, 1948)

“Health inequalities are systematic and avoidable disparities in the health outcomes of population groups. They are seen in different geographic as well as socio-economic and demographic communities and can become further entrenched when these categories overlap.”
(Public Health England, 2013a)

“Health inequalities have a serious impact on African people and those of African descent, who are affected by lifestyle-related health conditions disproportionately to their population size. According to the 2011 census, people identifying as “Black/African/Caribbean/Black British” make up 3.3% of the England and Wales population, of which 1.8% are African, 1.1% Caribbean and 0.5% Other Black (Office for National Statistics, 2012b). Yet African and African-Caribbean people in the UK are up to three times more likely than the general population to have type 2 diabetes (Diabetes UK, 2012); are twice as likely to have a stroke in comparison to people of European origin (Stroke Association, 2012); and experience higher rates of lifestyle-related cancers (NHS Choices, 2013). Unhealthy behaviours and lifestyles are a driver of these health inequalities.

Health inequalities have a serious impact on African people and those of African descent, who are affected by lifestyle-related health conditions disproportionately to their population size. According to the 2011 census, people identifying as “Black/African/Caribbean/Black British” make up 3.3% of the England and Wales population, of which 1.8% are African, 1.1% Caribbean and 0.5% Other Black (Office for National Statistics, 2012b). Yet African and African-Caribbean people in the UK are up to three times more likely than the general population to have type 2 diabetes (Diabetes UK, 2012); are twice as likely to have a stroke in comparison to people of European origin (Stroke Association, 2012); and experience higher rates of lifestyle-related cancers (NHS Choices, 2013). Unhealthy behaviours and lifestyles are a driver of these health inequalities.

For example, current evidence illustrates that not only do African people tend not to meet the Department of Health’s minimum exercise recommendation, but also show patterns of participation in exercise to be 21% below the national average (Sport England, 2005). At both age 4-5 and 10-11 national statistics suggest Black African children have the highest obesity rates of all ethnic groups (Public Health England, 2013b). Further, African women have the highest rate of obesity of any female ethnic group in the UK (NHS Health and Social Care Information Centre, 2004).

Research has consistently demonstrated the existence of health inequalities between population groups, and in particular that people of Black and Minority Ethnic (BME) backgrounds generally have poorer health than the overall population. Patterns vary for different specific ethnicities and between different health conditions, but the evidence tends to suggest that the poorer socio-economic position of BME people is the main factor driving ethnic health inequalities, including through increasing the risk of unhealthy lifestyle choices and behaviours (Parliamentary Office of Science and Technology, 2007). Health inequalities are linked to and driven by social inequalities, and are influenced by poverty, deprivation, housing conditions, social conditions and employment/education status, issues which have a disproportionate negative impact on African people and families. For example, Black African and Black Caribbean households are more likely to be workless, and individuals are more likely to earn less than the London Living Wage compared to other ethnic groups.
The lifestyle factors most closely associated with disease are all highly influenced by socio-economic status. Individuals affected by poverty and deprivation are more likely to engage in unhealthy behaviours such as poor diet, insufficient exercise, smoking and excessive alcohol. This is not just an issue of the choices made by an individual, the options people have with respect to their lifestyles are limited and dictated by the impact of social, economic, cultural and other factors. In this report, which separately considers the impact of alcohol, diet, exercise and smoking on the health of the African and African descent population in the UK, the existence and impact of both choices and options will be considered, with the former referring to the decisions made by individuals and the latter to restrictions outside their control. For example, individuals living in deprived, obesogenic areas with limited access to fresh food do not have the same healthy lifestyle options for their diet available to them as others who have easy and affordable access to fresh food. There are therefore structural and systemic causes of unhealthy lifestyles, in addition to the choices made by individuals.

‘Clustering’ of unhealthy behaviours

The four unhealthy behaviours considered in this report (diet, exercise, alcohol, smoking) are all linked to high cholesterol, obesity and being over-weight, which in turn lead to conditions such as diabetes and stroke, as well as increasing the risks of other ill health. Almost half of the burden of disease in the UK, and other developed countries, is associated with these four unhealthy behaviours (King’s Fund, 2012b). As well as the impact of smoking, diet, exercise and alcohol as individual health determinants, there is growing recognition of the links between these issues, and the cumulative effect of multiple unhealthy behaviours. The ‘clustering’ of lifestyle risk factors, as termed by the King’s Fund, refers to the co-existence of unhealthy behaviours in individuals (King’s Fund, 2012b). Recent research by the King’s Fund examining this phenomenon found that while the overall proportion of the population engaging in multiple risky behaviours has declined, these reductions are mostly found in higher socio-economic groups, with risks actually growing in those from poorer and most disadvantaged groups.
Therefore, individuals that experience socio-economic disadvantage are more at risk not just of individual unhealthy behaviours, but also of multiple unhealthy behaviours, which in turn increases risks to health and wellbeing exponentially.

The King’s Fund conclude that “The health of the overall population will improve as a result of the improvement in these behaviours, but the poorest and those with least education will benefit least, leading to widening inequalities and avoidable pressure on the NHS”. They call for a holistic approach to policy and practice which addresses multiple unhealthy behaviours, rather than taking a silo approach addressing each factor individually, and an approach which addresses the wider determinants of lifestyle options and choices (King’s Fund, 2012b). In addition to this, in this report AHPN is advocating an equalities-based approach to health promotion which acknowledges the distinct risks, contexts and drivers of behaviours of differing population groups.

A study into the prevalence of multiple lifestyle risk factors, conducted in deprived areas of 20 London boroughs, found different individual and multiple risk associated with different social and demographic characteristics (Renton, 2013). The study ascertained the reported individual risk factors of poor diet, low exercise and smoking as well as the number of risk factors present. The data for Black African respondents (as shown in the table) suggests a high prevalence of poor diet, at 72.8% the third largest prevalence by ethnic group. Rates of low exercise and smoking are lower than for most other groups though as are the percentage with multiple risk factors, though at 24.4% the percentage with two risk factors is still high enough to merit attention given the compounding health impact of multiple unhealthy behaviours.

This ‘Living Long, Living Well’ report is timely and important: minority communities in the UK bear the brunt of health inequalities. As the report notes, African and African-Caribbean people in the UK are twice as likely as the population as a whole to have a stroke, and three times as likely to have type 2 diabetes. Understanding the extent of the risk factors within different communities gives baseline data from which to take action. C3 Collaborating for Health strongly supports this report - we hope that it can be used to enable and support healthy options and choices for improved long-term health.

Christine Hancock, Founder and Director, C3 Collaborating for Health
Professor Mala Rao OBE, Professor of International Health, Institute for Health and Human Development, University of East London

Figure 3 - (Renton, 2013)
Lifestyle risk factors by ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>SD % of sample</th>
<th>Poor Diet</th>
<th>Low Exercise</th>
<th>Smoke</th>
<th>None</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>31.4</td>
<td>76.0</td>
<td>30.9*</td>
<td>42.5*</td>
<td>12.8</td>
<td>36.4</td>
<td>39.8</td>
<td>30.9*</td>
</tr>
<tr>
<td>White Other</td>
<td>13.3</td>
<td>62.4</td>
<td>29.1*</td>
<td>29.7*</td>
<td>21.7</td>
<td>42.1</td>
<td>28.8</td>
<td>7.4*</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>11.1</td>
<td>75.5</td>
<td>33.7*</td>
<td>29.5*</td>
<td>13.2</td>
<td>40.3</td>
<td>40.3</td>
<td>6.2*</td>
</tr>
<tr>
<td>Black African</td>
<td>17</td>
<td>72.8</td>
<td>25.9*</td>
<td>11.5*</td>
<td>21.2</td>
<td>51.7</td>
<td>24.4</td>
<td>2.6*</td>
</tr>
<tr>
<td>Ind Pak Bang</td>
<td>10.5</td>
<td>71.2</td>
<td>26.6*</td>
<td>13.0*</td>
<td>17.4</td>
<td>53.5</td>
<td>28.8</td>
<td>0.3*</td>
</tr>
<tr>
<td>Other Asian</td>
<td>4.5</td>
<td>65.2</td>
<td>43.9*</td>
<td>15.7*</td>
<td>17.7</td>
<td>44.4</td>
<td>33.1</td>
<td>4.8*</td>
</tr>
<tr>
<td>Mixed</td>
<td>4.8</td>
<td>72.4</td>
<td>22.5*</td>
<td>30.4*</td>
<td>21.5</td>
<td>37.6</td>
<td>35.6</td>
<td>5.4*</td>
</tr>
<tr>
<td>Other</td>
<td>7.5</td>
<td>69.5</td>
<td>36.3*</td>
<td>25.0*</td>
<td>14.7</td>
<td>45.2</td>
<td>35.5</td>
<td>4.6*</td>
</tr>
</tbody>
</table>

*: p<0.0001 (Rao Scott Chi-squared)
The determinants of health and health inequalities are multi-factional and cross-cutting (Raleigh & Polato, 2004). Some of these factors exist outside the direct control of the health and social care sector, so effective action to reduce health inequalities requires a multi-sectoral approach. The impact of deprivation on health begins at birth and continues and is compounded throughout life, so a life course approach is also needed. Many of the determinants of poor health and health inequalities can be avoided and mitigated, in particular those stemming from differences in opportunity, access to services and material resources and lifestyle options and choices.

The health inequalities considered in this report are those measured against ethnicity, but it is important to also recognise that health inequalities range across multiple dimensions including ethnicity, age, gender, class and geographical area – which supports the intersectional model this report advocates. Different causal factors intersect, exacerbating the impact of each other and contributing to a complex overall picture. Relying on just one element or strand of cause to attempt to understand health inequalities is therefore inherently incomplete. In order to properly establish the causes of health inequalities, a broader, holistic picture is needed.

Determining all the factors contributing to inequalities is not the goal of this report, instead the intention is to identify and discuss specific inequalities that are linked to the four main lifestyle factors determining health of the African and African descent population in the UK. By considering the broader socio-economic inequalities that influence lifestyle options and choices of this group, it is possible to draw out a richer and more helpful understanding of the causes of health inequalities. This provides a strong foundation to build a more holistic model of intervention to mitigate these inequalities. This process is based on the concept of intersectionality, which identifies that an individual and their experiences are influenced and determined by multiple interwoven factors, including structural, social, economic, cultural and individual influences and choices. To illustrate: whether an individual smokes cigarettes is a product of an individual decision. But it is also influenced by their age, gender, ethnicity, cultural beliefs about smoking, economic position, deprivation, educational attainment and employment status. Therefore, reducing the prevalence of smoking cannot be achieved simply by making available more generic smoking cessation services that rely on the individual choosing to stop and seeking out help. Structural, social, economic and cultural factors influence and restrict lifestyle options, and so changing the lifestyle choices that people make requires change in all these domains.
Alcohol consumption plays a role in modern cultures in the UK and internationally. Alcohol is a psychoactive substance and its consumption, in moderation, can lead to feelings of both relaxation and euphoria, but it is also an addictive drug and its misuse can lead to a wide range of negative health and social impacts causing harm both to the individual and wider society. Alcohol misuse is a root cause of ill health, which has been identified as a causal factor in over sixty medical conditions, including suicide, various cancers, high blood pressure, cirrhosis and depression (WHO Regional Office for Europe, 2012). Liver disease, a major consequence of excessive alcohol consumption, is the fifth most common cause of death in England (NHS Information Centre for Health and Social Care, 2011). According to the Office for National Statistics there were over 8,700 alcohol related deaths in the UK in 2010 (Office for National Statistics, 2012a). Alcohol's negative impact on health is most acute in conditions which are otherwise strongly implicated in health inequalities, so alcohol misuse is a significant contributing factor to health inequalities (British Medical Association Board of Science, 2008).

The burden of ill health caused by alcohol misuse is growing. Over the last ten years there has been a sharp rise in the number of alcohol related hospital admissions (NHS Information Centre for Health and Social Care, 2011). Alcohol misuse represents a major burden to the NHS and wider health and social care systems. The Department of Health estimates that nationally 6% of men and 2% of women can be classified as alcohol dependent, which equates to over a million people nationwide. About 1 in 18 (5.6%) alcohol dependent drinkers will enter specialist treatment nationally every year (Alcohol Concern, 2011). Admissions for alcohol-related treatment differ significantly by region and gender. The statistics on alcohol use from 2011 show that hospital admission rates for alcohol-related reasons were 80% higher in North West as opposed to South Central Strategic Health Authorities (King's Fund, 2012a). Such differences indicate the wider determinants underlying alcohol misuse, especially around socio-economic drivers of behaviours.
Alcohol misuse also generates and exacerbates social problems, including anti-social behaviour, crime and domestic violence. Accepted medical advice is not, however, to recommend abstinence from alcohol, but instead to promote restricted consumption. Current advice from the Royal College of Physicians is that men should consume no more than 21 units per week and women 14 units, with 2-3 alcohol-free days a week to allow the liver to recover (Royal College of Physicians, 2011).

Alcohol and the African population

The use of alcohol by African people in the UK is largely under-researched. The statistics that are available indicate that people from most minority ethnic communities, including African, have higher rates of abstention and lower rates of consumption than the majority population (Drink Aware, 2013a). Similarly fewer minority ethnic individuals present to alcohol services for problems related to alcohol misuse. However, the picture is complex with drinking likely to vary greatly within different communities and across age, gender and socio-economic lines.

Existing research tells us that (Sproston & Mindell, 2006):

- 17% of Black African men and 28% of Black Caribbean men consumed more than 4 units of alcohol on their heaviest drinking day of the week, compared to 22% for Indian men, 19% for Chinese men and 45% for the general population.
- 7% of Black African women and 18% of Black Caribbean women consumed 3 or more units on their heaviest drinking day, compared to 12% for Chinese women, 8% for Indian women and 1% for Pakistani and Bangladeshi women). The heaviest consumers were Irish women at 36%. For the general population the figure was 30%.
- Men and women from all BME groups, except the Irish group, reported drinking alcohol less frequently than the general population, were more likely to be non-drinkers and were less likely than the general population to have consumed alcohol on at least one day in the week prior to interview.

This data indicates that Black African people have higher rates of drinking compared to most South Asian ethnicities but lower rates of alcohol use than the general population and white ethnicities. Consumption for Black Caribbean men and women is higher than for Black African groups, though still lower than the general population figures. However, though the data suggests lower consumption, rates are still high enough to cause concern, particularly when considered against the lower rates of access to alcohol-related services. Further, there is a lack of research examining the linked impact of factors that drive and affect alcohol consumption, such as mental health, housing, employment and other socio-economic factors. This paucity of research prevents clear conclusions being reached, beyond the need for further research.

Alcohol and health

Alcohol misuse has serious health implications. Regularly drinking alcohol above the guideline recommended amounts causes long-term damage to health. Alcohol can contribute to chronic long-term health conditions: raised blood pressure, liver disease, cancers – particularly breast cancer and cancer of the gullet, mental health problems such as depression and anxiety, heart disease, stroke and dementia (Drink Aware, 2013c). Alcohol can also have an impact on and exacerbate existing health conditions. Alcohol, both excessive and binge drinking, contributes to diseases that affect the circulation of the blood, such as high blood pressure and diabetes, which in turns raises stroke risk. Type 2 diabetes can also be triggered by heavy drinking as a result of changes caused to how the body responds to insulin. Evidence has shown that people of African origin are twice as likely to suffer a stroke compared to people of European origin (Stroke Association, 2012) and three times more likely than the general population to have type 2 diabetes (Diabetes UK, 2012) and four times more likely to have high blood pressure (Ageymang & Bhopal, 2003).

Specific conditions that disproportionately affect Africans are among those impacted on by alcohol misuse, such as HIV. Black Africans account for 35% of new HIV diagnoses each year in the UK (Health Protection Agency, 2012).
Research conducted in the USA has found that people living with diagnosed HIV who have a history of alcohol problems and are consuming quantities of alcohol whilst receiving highly active antiretroviral therapy, have greater HIV progression than those who do not drink (About.com Guide, 2008).

Alcohol also impacts upon mental health, with evidence suggesting that people who drink heavily are far more likely to suffer from mental illness (Drink Aware, 2013b). Indeed the World Health Organisation has stated that ‘sufficient evidence exists to assume alcohol’s contributory role in depression’ (WHO, 2004). Alcohol can be used by some people as a coping strategy, with one study by the Mental Health Foundation finding that many people in the UK drink alcohol in order to help them cope with emotions or situations that they would otherwise find difficult to manage (Mental Health Foundation, 2013). Mental health is a significant issue in the UK generally and for the black population especially. Mental Health is the largest single cause of disability in the UK contributing almost 23% of the overall burden of disease (Personal Social Services Research Unit, LSE, 2011). Black people are consistently over-represented in compulsory and enforced psychiatric treatment and admissions (Nacro, 2007). It remains an under researched area but the role of alcohol in mental health for the black population requires further interrogation.

Understanding and awareness

Understanding community perceptions about healthy lifestyles is essential to enable effective programming to combat unhealthy behaviours. A survey carried out in the north of England into the perceived impact on health of reducing alcohol consumption of different ethnic groups demonstrated a higher than average rate reported the impact to be “very big” (Keech et al, 2012). This suggests a good level of understanding of the benefit reducing alcohol intake has on health, which may suggest a cause of lower levels of consumption.
Lower consumption and negative attitudes towards alcohol may be affected by generational differences between migrants and second and third generations. Research has been conducted to investigate whether there are any generational differences in the approach and attitudes towards alcohol of people from different BME groups (Orford, Johnson, & Purser, 2004). This concluded that protective factors that might have applied to first generation migrants such as cultural or religious norms did not protect successive BME generations born and educated in the UK, including Africans.

Accessing services

Among those seeking treatment and advice for alcohol-related problems, individuals from BME communities are proportionately under-represented, according to a study that also found that people from BME communities and on lower incomes lacked awareness about where to go to get help (Subhra, 2003). This suggests that health promotion messages around seeking help for problem drinking are either not reaching BME groups or are not as effective if they do reach them (perhaps being perceived as irrelevant) (Bayley & Hurcombe, 2011). Under-use of services due either to reluctance to approach them or lack of awareness about relevant services, may also risk underestimation of the need for such services. Additionally, reluctance to engage with services may also be caused or exacerbated by inappropriate referrals with research suggesting that some people from BME groups have either accessed or been referred to mental health services for problem drinking rather than specialist alcohol services (Bayley & Hurcombe, 2011).

The types of services and support that African people may prefer to access for help with their alcohol-related problems will differ according to a range of factors including age and gender (Heim & MacAskill, 2006). The limited information that exists on the preferences of black people suggests that men identifying as Black and Christian would rather consult a GP about their drinking, whereas Sikh and Hindu men preferred to consult family and friends. Black and Christian women preferred to consult family members about alcohol issues while this was the least preferred option for South Asian women (Alcohol Concern, 2001) (Orford, Johnson, & Purser, 2004).
These differences indicate the need for responsive services that are designed to meet the preferences of all the diverse elements of the local community.

Policy development

Government action to respond to alcohol has included a public consultation and strategy push to reduced binge drinking and the impact of alcohol-fuelled disorder. However, there has been a consistent lack of consideration of the needs of BME groups in relation to alcohol. The 2007 strategy document ‘Safe, Sensible, Social’ although offering practice guidance at the local level, did not attempt to address culturally specific issues (Department of Health, 2007). The subsequent toolkit looks at BME communities generically and fails to address ethnicity separately from other protected groups (Department of Health, 2008). This type of approach, which fails to address the needs of Africans and other ethnicities discretely, makes it more likely that they will fall through the gaps in alcohol service provision.

More recently the Government’s Alcohol Strategy launched in 2012 (Secretary of State for the Home Department, 2012) included commitments to introduce a minimum unit price for alcohol, consult on a ban on the sale of multi-buy alcohol discounting and introduce stronger powers for local areas to control the density of licensed premises including making the impact on health a consideration for this. Again however the strategy offered no discussion of the needs of specific ethnic groups.

Conclusions

Despite lower population consumption, alcohol misuse remains a significant issue in terms of the health impact it has and particularly given the lack of targeted research and interventions. Government initiatives around alcohol, which focus on generic responses and reducing the social impact of alcohol, are necessary but insufficient.

A more targeted approach is needed, recognising that the use of alcohol and beliefs around it are heavily influenced by wider social, economic and cultural factors. Addressing individual misuse of alcohol must take into account these broad factors if it is to be effective. The British Medical Association has stated that ‘Preventing alcohol harm requires the accurate identification of individuals who misuse alcohol and the implementation of evidence-based interventions to reduce alcohol consumption’ (British Medical Association Board of Science, 2008). Successfully identifying individuals who misuse alcohol in African and other black communities requires significant further research, as does developing targeted evidence-based interventions. Patterns of alcohol use, as well as the uptake of alcohol services, should be disaggregated and evaluated against ethnicity and the information gathered utilised in the development of future services.

Greater efforts are also needed to develop targeted health education and promotion programmes in relation to alcohol for African and other black communities. Services including education, health advice and treatment need to be developed with communities and delivered in a culturally competent way that is reflected at all levels including staff selection, education and training. Additionally, based on local data, a need may exist for specialist targeted alcohol services for specific ethnic groups. This approach may become necessary where mainstream services are clearly failing to meet the needs of particular groups. Research has also found that where culturally specific alcohol services have been considered they have acted as a spur to professional training and better understanding of particular groups (Ross, Heim, Bakshi, & Davies, 2004). An observation of the practices of Choices, an organisation that provided services specifically for Black people with alcohol problems in South London, indicates that such a targeted approach has merit (Harrison, Harrison, & Adebowale, 1996). Services at the organisation were heavily oversubscribed, and were largely taken up by individuals who reported negative experiences throughout their interactions with mainstream services and did not know where else to seek help. Such feedback demonstrates the need for targeted services that meet the different needs of diverse communities.
Eating a healthy diet is essential for good health, and reduces the risk of obesity and early mortality. Changes in modern diets including the type and quantity of food consumed have resulted in serious health impacts including increases in the prevalence of obesity and related conditions. Such conditions are especially prominent in the UK where obesity has more than doubled since the 1980s (Government Office for Science, 2007a). If current trends of poor diet continue, it is predicted that by 2050, more than half of the UK’s population could be obese (Government Office for Science, 2007b). In keeping with this extrapolation, NHS spending on tackling overweight and obese conditions is projected to double by 2050 (Government Office for Science, 2007a).

In the UK, obesity is more common among some ethnic groups, African women in particular, compared to the rates experienced by the general population (NHS National Obesity Observatory, 2011). This is caused by a range of factors, including socio-economic factors. For instance, fast food outlets are more common in deprived areas where ethnic minorities most commonly reside (Molaodi et al, 2012). The poorer people are the worse their diet is likely to be, which increases their risk of diet-related diseases and health conditions such as diabetes and coronary heart disease (CHD) (National Heart Forum, 2004). Poor diet is related to 30% of life years lost in early death and disability (National Heart Forum, 2004). Overall, inequalities in diet lead to inequalities in health.

Diet and the African population

A range of social issues cause or compound inequalities in diet for African people in the UK. Broadly, these include socio-economic factors including the availability of food, health status, and level of income, and cultural and migration factors such as beliefs around food and diet, cultural or religious dietary practices, age, length of time in the UK and country or region of origin. Poverty and deprivation have a significant impact on access to good food and
healthy diets. Food poverty, meaning a lack of available and/or accessible healthy, fresh food, is a problem in all deprived areas and particularly in urban areas, where African and other black populations are most likely to live. Economic factors including relying on benefits, unemployment/underemployment or asylum seeker benefits (delivered through a prepaid card system) can pose real barriers to accessing healthy food. Poor housing and facilities can also make it difficult to cook and eat well.

Cultural factors including traditional diets are also an influencing factor. The traditional African diet includes a wide variety of food which is the basis of a healthy diet. However, some cooking methods and certain foods traditionally used are less healthy. For instance, Africans have been found to be most sensitive to the effects of salt and they are at a high risk of associated health conditions such as high blood pressure and stroke (Consensus Action on Salt & Health, 2010). Yet pre-mixed flavouring commonly used in the African diet, including stock cubes and all-purpose seasoning, are high in salt.

Migration impacts upon diet in two ways. Firstly, individuals engaged in the immigration system are likely to experience negative impacts on stress levels, empowerment, access to and knowledge of services and financial position, which can all impact upon accessing a healthy diet. Migration also has a direct impact on diet, as people adopting a different diet in a new country have been shown to exhibit changes in insulin-like growth factor, affecting risk of type 2 diabetes and myocardial infarction (NHS National Obesity Observatory, 2011). Many African migrants find it difficult to maintain their traditional eating habits after moving country as familiar foods may be hard to find and more expensive than Western equivalents. This is compounded by lack of access to specialist food shops and markets, restricted by income and availability. A systematic review of the changing dietary habits of minority ethnic groups in Europe concluded that the majority of migrants alter their eating habits following migration, combining part of their traditional diet with some of the less healthy elements of the Western diet (NHS National Obesity Observatory, 2011).

Obesity as a result of poor diet is an issue of significant and increasing concern, and is a particular problem for women in the adult African population, where obesity prevalence against all three measures of obesity is higher than for women in the general population (as shown in the graph (NHS National Obesity Observatory, 2011). For African men, obesity prevalence is lower than the general population (Hirani & Stamatakis, 2003) (NHS National Obesity Observatory, 2011).

Figure 5 - (NHS National Obesity Observatory, 2011)
Obesity measures for women by ethnicity

Childhood obesity is also an issue, with Black African children and those of other black ethnicities more likely to be obese compared to others. Data gathered against the obesity indicators in the Public Health Outcomes Framework for children classified as overweight or obese by ethnicity at ages 4-5 and 10-11 demonstrate highest prevalence in Black African Children (Department of Health, 2012b):

**Figure 6 - (Department of Health, 2012b)**
Children aged 4-5 obesity by ethnicity

**Figure 7 - (Department of Health, 2012b)**
Children aged 10-11 obesity by ethnicity
Diet and health

Unhealthy diets have a significant impact on health, especially through the risks of obesity. Obesity is a risk factor for a range of conditions including coronary heart disease, stroke, type 2 diabetes, hypertension, metabolic syndrome, osteo-arthritis and cancer (Swanton, 2008). Diabetes and stroke are both made more likely by unhealthy diets and obesity, and are also both more common in people of African and African-Caribbean ethnicity. Type 2 diabetes is more prevalent in African-Caribbean people with 1 in 10 men affected with diabetes in their middle years and 1 in 5 women (Stroke Association, 2012). African and African-Caribbean people in the UK are up to three times more likely than the general population to have type 2 diabetes (Diabetes UK, 2012). They are also twice as likely to have a stroke in comparison to people of European origin (Stroke Association, 2012).

One in ten cases of cancer in the UK is caused by an unhealthy diet (Cancer Research UK, 2012c). Africans in the UK experience higher prevalence of some cancers and poorer health outcomes in relation to cancer overall, for example prostate cancer is three times more common in black men than white men (Cancer Research UK, 2012b).

Other conditions linked to diet that disproportionately affect Africans include vitamin D deficiency (which is also linked to physiological factors such as darker skin). As vitamin D aids calcium absorption into the body any lack of this will have an effect on bone health in later life (Leung, 2011). Anaemia is also more common in Black African people, and can be linked to low birth weight in children triggering further problems in later life (see table) (Leung, 2011).

Understanding and awareness

In 2008 a Department of Health survey into attitudes to food found that it played a significant role in Black African communities (Change4Life, 2008). Eating and sharing ‘good’ food is culturally significant and being able to provide and share rich foods is a sign of status. The research also revealed that family meals in Black African communities are less ad hoc than the general population, featuring pre-planned and home-cooked cultural foods that require greater preparation in advance. Generally most parents believed their family was eating a healthy, balanced diet as they were eating traditional food prepared from scratch. However, the research also revealed unhealthy cooking practices such as frying instead of grilling or baking. Some participants in the study did not see alternative cooking methods as appropriate although others adapted cooking practices to produce healthier meals. Another study focusing on women in the Somali community found that their diets were influenced by cultural factors such as the traditional Somali diet of rice, pasta and red meat and an association of fruit and vegetables with poverty (McEwen, Straus, & Croker, 2009). Perceptions of healthy weights and body image are also a factor. In some African societies, obesity is seen as a sign of wealth and success. For instance, focus groups with women of Zimbabwean origin revealed concerns about being overweight were rare in Zimbabwe, but more common in the UK where social pressures to be slim were sometimes adopted (Lawrence et al, 2007).

Accessing services

Targeted services, responding to local demographics, obesity prevalence and need have been recommended at the local level, including for specific ethnic communities (NHS Swindon, 2009). There is though a lack of such programmes. A detailed review of dietary interventions targeted to BME groups found that there were a number of characteristics associated with success in these initiatives: specific tailoring to each group; understanding lifestyles and relationships; using a variety of activities to reinforce changes in knowledge, behaviour and attitudes; and involving a trusted and recognised community worker (Stockley, 2009). Strategies and interventions to prevent or treat obesity are often based on behavioural modification to adopt healthier diets. These programmes are often generic in approach, and so may not be effective for people with cultural beliefs that alter their perceptions of ideal body size and weight. In one study members of the Somali community identified images of larger infant girls as healthy, while members of other ethnicities tended to choose images of a smaller
child. This subjective variation means that obesity prevention strategies need to be targeted to be effective, as generic services may generate de facto inequalities in the effectiveness of prevention services (Liverpool Health and Inequalities Research Institute, 2011).

Policy development

NICE has acknowledged the value of targeting diet and healthy eating information to specific communities, making the following recommendations in its guidance (NICE, 2006) (NICE, 2007):

- Advice needs to be tailored for different groups, particularly for BME people and people at life stages with increased risk for weight gain
- Tailored advice ought to address potential barriers such as cost, personal tastes, availability, time, views of family and community members
- Through working closely with communities over time initiatives will be able to avoid stereotyping or stigmatising groups or individuals, instead tackling prejudice and discrimination in professional practice

Similarly, NHS Scotland in a consultation document on research needs for BME groups, recommends an ethnically boosted health survey and co-ordinated research on the evaluation of interventions to address BME health needs (NHS Health Scotland, 2008).

Government policy around obesity and healthy diets include the programme Change4Life, a public health programme run by the Department of Health to encourage everyone, particularly children, to eat well and live longer. Some of the initiatives include tips on counting calories and cooking healthier food, as well as applications for smart phone users. Ultimately, the programme introduced specific work to target the needs of specific BME communities, including the West African community.

The rationale for this targeting was the increased risk of obesity evidenced in black African children and the existence of specific issues such as perceptions of healthy weight and intergenerational influences such as grandparents ‘treating’ children to unhealthy foods (Department of Health, 2009). Culturally specific materials including posters and leaflets were developed, incorporating specialised dietary advice. However, this targeted work was carried out under the first three year cycle of the programme. In 2011 Change4Life was re-launched with a new marketing strategy, which includes no reference to the specific needs of different ethnic communities and no targeted work (Department of Health, 2011a).

Conclusions

Unhealthy diets results in poor health. For Africans, a range of factors influence the dietary choices they make. Structural factors which limit peoples’ dietary options, linked to the individual’s socio-economic position are a vital determinant, especially through food poverty and access to fresh, healthy and affordable foods. Cultural factors and migration are also relevant, as they influence the choices people make about their diets. Initiatives to promote healthy eating and improve diets should be evidence-based and responsive to all these factors. In particular, targeted information and programmes are needed to ensure that healthy eating advice is appropriate and accessible for those that need it, by for example including information on healthy means of preparing traditional cultural foods. Current programmes tend to be generic, focusing on foodstuffs and recipes that may be common to the majority population but are excluding of those who eat traditional or cultural diets. Community-led programmes which take traditional recipes and ingredients and promote healthier means of preparing and enjoying them are vitally needed. Similarly, existing programmes to promote healthy body image need to become more responsive to the broad range of cultural views of weight and self-image. Cultural norms found in some African communities that excess weight in women is attractive are as harmful as norms of weight loss and ‘size zero’ culture more usually targeted in such initiatives. Overall, food and diet are intricately bound up in community and culture, and initiative to promote healthier diets must reflect this.
Exercise

Physical activity is necessary for good health and should be a part of normal everyday life. Exercise can be structured or unstructured, planned or incidental and need not require significant exertion to be effective. Regular physical activity has significant health benefits and can contribute to the prevention of chronic diseases including obesity, Type 2 diabetes, and chronic heart disease. Insufficient exercise accounts for 6% of deaths globally and is the fourth leading risk factor for global mortality (Department of Health, 2011b). Regular physical activity also impacts on wellbeing, and can be used as a preventative measure to induce various psychological benefits through mood enhancement (Hoffman & Hoffman, 2007).

The Department of Health physical activity guidelines state that thirty minutes of moderate exercise, five days a week is needed to promote good health and help prevent over twenty chronic conditions (Davies, 2012). Though exercise can be accessible, inexpensive, and has significant health benefits, very few people actually fulfil these requirements. According to the British Heart Foundation, 37% of adult men and 25% adult women meet these physical activity recommendations in the UK (British Heart Foundation, 2012). In 2008, it was reported that 56% of women did not spend any time in sports or exercise (British Heart Foundation, 2012).

Social and cultural factors also play a role in influencing physical activity levels. Recent studies have highlighted that low participation levels can be attributed to perceived barriers faced by different socio-economic groups within society, and access can also be negatively affected by the environment, lack of skills and knowledge of positive exercise practices and other psychosocial factors (Gerin & Leslie, 2007).
Exercise and the African population

Evidence suggests that African people in the UK do not tend to meet the Department of Health exercise requirements with only 35% of men and 29% of women meeting the recommended 30 minutes or more of moderate or vigorous activity on at least 5 days a week (British Heart Foundation, 2012). A study by the Centre for Market and Public Organisation investigating exercise rates in different ethnic groups, found that in the four weeks prior to interviewing 27.5% of African women had not undertaken physical activity of a duration of at least 30 minutes (Centre for Market and Public Organisation, 2013). For White British women, this figure was much lower, at 20.7% (Centre for Market and Public Organisation, 2013). This disparity can be partly attributed to the disproportionate rates at which Africans in the UK live in urban, deprived and obesogenic environments, which can pose barriers to leading active healthy lifestyles (NSW Government, 2010).

With respect to structured exercise, 17% of Africans in the UK maintain a club membership, a far lower rate than that for White people of 25.5% (Sport England, 2009a). Reasons for this are under-researched, though cultural, financial or access barriers may be a cause. Attitude studies have found however that high numbers of Africans in the UK do appreciate the value of physical activity and would like to exercise more (Dundas, Ruth; Morgan, Myfanwy et al, 2010). In the Sport and Ethnicity Survey 2000, a significant proportion of the African people surveyed reported that they would like to take up an activity in which they currently do not participate (as shown in the table) (Rowe & Champion, 2000).

Exercise and health

Physical inactivity is a significant causal factor for chronic diseases and is responsible for 23% of deaths from coronary heart disease and 15% of deaths from diabetes in the UK (WHO, 2010). People who are physically active and meet the Department of Health recommended minimum level of activity (30 minutes, 5 days a week) can reduce their risk of premature death by up to 20-30% as well as reducing their risk of developing chronic diseases by up to 50% (Chief Medical Officer, 2004). Despite this, only 43% of people in the UK meet this minimum target.
Lack of exercise contributes to a range of chronic diseases, many of which disproportionately affect Africans, including high blood pressure, type 2 diabetes and stroke (Dundas, Ruth; Morgan, Myfanwy et al, 2010). Reducing levels of physical inactivity and promoting healthy levels of exercise would significantly reduce the burden of chronic disease in the UK (Department of Health, 2011b). The cost of physical inactivity and resulting chronic diseases to the healthcare system in the UK is estimated to be £8.2 billion a year (Chief Medical Officer, 2004). Lack of exercise can also contribute to or exacerbate obesity.

**Understanding and awareness**

African people in the UK tend to be aware of the health benefits of exercise, and yet persistently demonstrate lower levels of participation. This gap between desire to participate and actual participation for Africans has been described as “frustrated demand”, encapsulating the high proportion of Africans who would like to exercise or participate in some form of physical activity but are unable or deterred from doing so by the actual or perceived barriers they face (Rowe & Champion, 2000). Patterns and extent of participation in exercise are affected by individual and community attitudes towards exercise, the perceived value of exercise and barriers to participating. The table below outlines barriers identified by BME survey participants as preventing them from taking part in exercise (Sport England, 2009a). It has also been suggested that widely publicised issues of racism and other negative experiences in sport have a negative impact on regional or local sport participation (Sport England, 2009a).

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples of comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overt racism (17%)</td>
<td>Abuse, called names (at swimming pool)</td>
</tr>
<tr>
<td></td>
<td>People from other religious groups come to cause trouble</td>
</tr>
<tr>
<td></td>
<td>There’s always tension from teenagers in the park...they think they own the parks</td>
</tr>
<tr>
<td></td>
<td>I go out covered and you get nasty comments (park)</td>
</tr>
<tr>
<td></td>
<td>English children (at youth centre) are racist</td>
</tr>
<tr>
<td>Service-delivery barriers (28%)</td>
<td>I need to dress in a certain way so don’t go there (Muslim female)</td>
</tr>
<tr>
<td></td>
<td>Many Muslim women would prefer not to have music to exercise to</td>
</tr>
<tr>
<td></td>
<td>Harder to find women-only facilities</td>
</tr>
<tr>
<td></td>
<td>Hard to communicate when they are only English speaking</td>
</tr>
<tr>
<td></td>
<td>You feel out of place, people look at you</td>
</tr>
<tr>
<td>Political (15%)</td>
<td>Don’t support African-Caribbean events</td>
</tr>
<tr>
<td></td>
<td>More provision in White areas</td>
</tr>
<tr>
<td>Cultural (13%)</td>
<td>Children are more restricted in what they do more than white kids</td>
</tr>
<tr>
<td></td>
<td>It’s frowned on if you go to the park without the family</td>
</tr>
<tr>
<td>General issues not specific to leisure and culture (26%)</td>
<td>Frightened of attacks and muggings</td>
</tr>
<tr>
<td></td>
<td>Poor condition of place</td>
</tr>
</tbody>
</table>

Source: Department of Leisure and Culture - Birmingham City Council 2003 p52
Other research has highlighted higher levels of dissatisfaction with local sports facilities among Africans compared to other ethnic groups (Sport England, 2009b). 26% of Africans participating in the survey reported perceptions of unsafe environments and poor quality outdoor physical activity facilities, which act as barriers to deter recreational physical activity. Additionally, 28% of the African participants suggested that many of the barriers to physical activity they experience in their communities are linked to service delivery and venues for exercise. This included for example the appropriateness of facilities for women, particularly Muslim women. Barriers linked to cultural or religious factors can be overcome by adapting services to suit the needs of diverse local populations, or creating services in community spaces. Adapting community spaces such as places of worship and community centres to deliver physical activity interventions has been shown to successfully improve participation, as well as facilitating the provision of culturally specific support (MRC SPHSU, 2013).

Accessing services
The majority of the African population in the UK live in urban environments. The impact of the built environment on levels of physical activity has not been fully researched, but evidence tends to suggest that labour-saving technology in travel and the environment in urban areas have reduced levels of physical activity (National Academy of Sciences, 2005). Data from the Sports Participation and Ethnicity in England survey, as shown in the table, suggests that a lack of facilities or unsuitable facilities is a significant barrier to participation for Africans, especially African men (Rowe & Champion, 2000). Additional barriers include home and family responsibilities and the demands of work or study. Lack of money is cited by fewer respondents, which suggests that affordability is less of an issue than accessibility in dictating participation levels. Dissatisfaction with facilities and poor experiences of them were also shown to be significant causes of low participation rates amongst African in the Active People Survey (Sport England, 2009b).

Policy development
Successive governments have implemented a number of initiatives to increase participation in sport and raise awareness of the benefits of exercise. Collaboration between government departments, especially the Department of Health and the Department of Culture, Media and Sport has been pursued to ensure the health benefits of exercise are integrated into sports policies (UK Government, 2012). Recent initiatives include investment of £800 million over five years from April 2013 into research by the National Institute for Health Research Biomedical Research Centres to develop lifestyle interventions to prevent chronic diseases (UK Government, 2012). Recent initiatives include investment of £800 million over five years from April 2013 into research by the National Institute for Health Research Biomedical Research Centres to develop lifestyle interventions to prevent chronic diseases (UK Government, 2012). Recent initiatives include investment of £800 million over five years from April 2013 into research by the National Institute for Health Research Biomedical Research Centres to develop lifestyle interventions to prevent chronic diseases (UK Government, 2012). Interventions with a BME specific remit include the Department of Health-funded AIM Project, which works to encourage activity in older people from BME communities (Policy Research Institute on Ageing and Ethnicity, 2012).

While there are some targeted policy initiatives to increase participation in exercise, many of these are take an overall BME focus rather than addressing the needs of specific communities.
It has also been suggested that some targeted approaches are based on limited representations of racism and so do not address equality fully (Sport England, 2009a). Given the vast diversity encapsulated by the umbrella term ‘Black and Minority Ethnic’, interventions taking this broad approach may be no more successful than generic policies in mitigating barriers to participation. Despite this, such approaches are frequently adopted, as demonstrated for example in the figure below presenting the targeting of approaches in exercise initiatives in Scotland (REACH Community Health, 2008).

**Figure 11 - (REACH Community Health, 2008)**

**Target of Community Organisations – BME**

Source: Mapping exercise of initiatives to increase physical activity amongst Black and Minority Ethnic (BME) groups by REACH Community Health for NHS Health Scotland, March 2008

Conclusions

More research, funding and active engagement with African communities is needed to develop strategies to increase participation in physical activity. Africans in the UK experience an increased risk of chronic diseases, and so effective prevention strategies incorporating physical activity are urgently needed, and must respond to the unique needs of these communities.

Current policies to increase participation in physical exercise do not sufficiently take account of or address the barriers faced by African communities living in the UK. This can be partially attributed to the failure to treat ethnicity as a distinct driver, with recent research arguing that the tendency to conflate ethnic and socio-economic factors in explaining lower exercise rates is unhelpful, as ethnicity is an independent determinant of physical inactivity in itself and therefore increasing exercise rates cannot be achieved solely through financial access: “...it is also clear that education and ethnicity are independent associates of physical inactivity, so that lowering price barriers will not be enough to tackle these disparities: other more targeted policies are likely to be needed” (Centre for Market and Public Organisation, 2013). Though the evidence tends to suggest that the health benefits of regular exercise are known and accepted within the African community, levels of participation in sport and other physical activities amongst Africans continues to be low (Rowe & Champion, 2000). More research is needed to both understand why existing interventions are ineffective in increasing physical activity for African people, and to explore how these barriers can be overcome. Such research-based evidence is needed to develop new and more effective ways of encouraging healthy behaviours around exercise in African communities.

The Deal study brought forward innovative and valuable suggestions on how physical activity programmes in more familiar environments, for example churches and other places of worship, can encourage the uptake of physical activity amongst Africans (MRC SPHSU, 2013). More emphasis should be placed on developing community based programmes in an environment that is conducive to the target population and culturally specific, such as creating female only gyms in areas that have a high percentage of African Muslim residents.
Additionally, new targeted programmes are needed to reach the needs of Africans in older age groups, as most existing BME programmes focus on younger people.

Lack of access to good quality open areas and recreational facilities has been shown to negatively impact an individual’s physical activity choices. Development of safe ‘green gyms’ in areas of economic deprivation and/or population diversity could help increase the opportunity for exercise and encourage more people to take up physical activity. Targeted advice on easy ways to increase activity levels, in accordance with the individual’s abilities and preferences, should also be implemented at all available opportunities in primary care.
In 2009 an estimated 102,000 people in the UK died from smoking-related diseases, making tobacco consumption the UK’s single greatest cause of preventable illness and early death (Peto et al, 2012). Smoking is a major cause of cancer, Cardiovascular Chronic Obstructive Pulmonary Disease (COPD) and can contribute to other cancers and conditions, such as asthma and high blood pressure. Research indicates that tobacco smoking is responsible for more than a quarter of cancer deaths in the UK (Cancer Research UK, 2012a).

Smoking is an issue of particular concern for minority ethnic communities in the UK, and is a major driver of health inequalities. Overall smoking rates in the UK have declined. There was a 7% fall from 27% in 2000 to 20% in 2012 - which means almost a third fewer smokers by the end of the decade (Office for National Statistics, 2008). But this pattern is not reflected among black and minority ethnic communities (Race Equality Foundation, 2011). Rather, combined data from the Health Surveys for England 2006, 2007 and 2008 found fewer self reported ex-smokers among these groups, suggesting that interventions to tackle tobacco use are not reaching minority ethnic communities. Key issues for these groups include high rates of smoking linked to lower socio-economic status, greater use of a range of different tobacco products including shisha and waterpipes and lower understanding of the health implications of smoking (Race Equality Foundation, 2011).

Smoking and the African population

The best available data to assess the extent of smoking in the African population is the Health Survey for England taken in 2004 (Health and Social Care Information Centre, 2006). The data showed 21% of African men were current smokers, lower than the general population figure. A high percentage of African men also reported never having been a smoker. However, the percentage of reported ex-smokers is joint-lowest for this group, and much lower than for other population groups, suggesting perhaps an unmet need in terms of smoking cessation. Differences also exist in smoking rates between African men and women, with African women much less likely than the general population to be a current smoker. This may reflect attitudes in sub-Saharan African societies that it is socially unacceptable for women to smoke (Agyemang et al, 2009). The percentage of smokers is though higher than most other ethnic minorities except Irish and Black Caribbean. For both men and women in the Black Caribbean group, current smoking rates are very high, and higher than the general population figures.

Figure 12 - (Health and Social Care Information Centre, 2006)
Self-reported smoking status by ethnicity

<table>
<thead>
<tr>
<th>Cigarette smoking status</th>
<th>Minority Ethnic Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black Caribbean</td>
</tr>
<tr>
<td>Current cigarette smoker</td>
<td>%</td>
</tr>
<tr>
<td>Ex-regular cigarette smoker</td>
<td>16</td>
</tr>
<tr>
<td>Never regular cigarette smoker</td>
<td>59</td>
</tr>
<tr>
<td>Women</td>
<td></td>
</tr>
<tr>
<td>Current Cigarette smoker</td>
<td>24</td>
</tr>
<tr>
<td>Ex-regular cigarette smoker</td>
<td>13</td>
</tr>
<tr>
<td>Never regular cigarette smoker</td>
<td>63</td>
</tr>
</tbody>
</table>
With respect to the number of cigarettes smoked by current smokers, Black African men are the least likely to be heavy smokers with 5% smoking 20 or more cigarettes a day compared to 31% of the general population (Health and Social Care Information Centre, 2006). The differences in smoking rates between different ethnic groups can be largely explained by socio-economic differences between those groups. In 2010, it was reported that those working in manual and routine jobs had the highest prevalence of smoking (27%) whilst those in professional households were the most likely to have never smoked a cigarette (Health and Social Care Information Centre, 2011). Along with other BME groups, Africans in the UK are more likely to live in low-income households and in areas of high deprivation than the general population, mostly as a result of higher rates of unemployment (Higgins & Dale, 2009). The London Health Observatory has stated that “People in deprived circumstances are not only more likely to take up smoking but generally start younger, smoke more heavily and are less likely to quit smoking, each of which increases the risk of smoking-related disease.” (London Health Observatory, 2013). The economic burden of smoking also works to further impoverish the poorest households. It is estimated that among these households, 15% of weekly income is devoted to purchasing cigarettes (Policy Studies Institute, 1994).

**Smoking and health**

Smoking increases the risk of developing a number of diseases, especially those related to the lungs such as lung cancer and COPD. A Department of Health public information campaign launched in December 2012 encouraged smokers to quit, based on the message that every 15 cigarettes smoked causes a mutation that can lead to cancer (Department of Health, 2012c). These mutations can lead to cancer even if cigarettes are smoked in small amounts.

The lifetime risk of death attributable to tobacco in a cohort of people who started smoking in their early 20s was 24.4% for men and 18.6% for women who were currently smoking five or more cigarettes per day (Brennan et al, 2006). 85-90% of people who die from lung cancer were smokers. (Cancer Research UK, 2013). Lung cancer is not yet treatable, with five year survival of only 9.3% for women and 7.8% for men (Cancer Research UK, 2013). Research has estimated that each day in which an individual smokes 15-24 cigarettes will reduce their lifespan by five hours (Koebler, 2012).

Smoking causes a wide variety of adverse health conditions, one of the most important families of which is COPD. These diseases consistently result in reduced lung capacity, leading to a significant decrease in energy, mobility and quality of life. Over 25,000 deaths in the UK are caused by it and the single most important contributing factor is cigarette use (Health and Safety Executive, 2013).

Smoking is also directly related to an increased risk of diabetes. Recent evidence has suggested that smoking can increase blood sugar levels and is a risk factor for insulin resistance, a precursor for diabetes (Action on Smoking and Health, 2011). This is particularly significant for African and African-Caribbean people who are already up to three times more likely to be diagnosed with type 2 diabetes than the general population (Diabetes UK, 2012). Moreover, the combination of tobacco use and diabetes produces 14 times the risk of complications compared to either smoking or diabetes alone (Cockram et al, 2005). People who smoke and that have diabetes therefore have twice the risk of premature death, compared to non-smokers with diabetes.

Smoking also increases complications in the health of people living with HIV, of which a disproportionate number in the UK are African people. Recent studies have found that those who have HIV and also smoke are more likely to experience side effects from HIV treatment including nausea and vomiting, as well as experiencing an increased risk of heart attack and of developing several opportunistic infections including thrush, bacterial pneumonia and pneumocystis pneumonia (AIDS InfoNet, 2012). Smoking among people living with HIV has also been linked to a higher rate of death.
Understanding and awareness

In 2000, the Health Development Agency reported that ethnic minorities, including Africans, were less likely to understand the health implications of smoking. The data presented considered only ‘African-Caribbean’ as a group, but is nevertheless indicative. For example, the proportion of African-Caribbean men (27%) who argued that smoking had “no effect” on their current health status was above the average rate for the UK (12%) (NHS Health Development Agency, 2000b). While a slim majority of African-Caribbeans respondents reported a link between smoking and lung cancer, only 16% of this group cited cigarette use as a cause of other respiratory diseases.

Studies have shown that for men and women of all minority ethnic groups, greater involvement in the community and higher education levels are positively associated with lower cigarette smoking (NHS Health Development Agency, 2000b). Social capital can play an important role in preventing unhealthy behaviours. Among white people of both genders, improvements in social capital consistently translate into decreased smoking (NHS Health Development Agency, 2000a). The same was true for African-Caribbean men, but for women of this ethnic group it did not hold true. For white men and women, participating actively in their local community was associated with reduced cigarette consumption. However, this was not the case for African-Caribbean men. It did, however, apply to African-Caribbean women (NHS Health Development Agency, 2000a).

Accessing services

Whilst minority ethnic groups in England are just as ready to quit smoking as the general population, fewer have attempted to stop through professional services (Race Equality Foundation, 2011). Yet, evidence suggests that people who use these services are up to four times more likely to quit smoking than those who try to give up alone. Only 6% of the total uptake of NHS provided smoking cessation services reflects individuals from BME backgrounds (Race Equality Foundation, 2011).

A study of smoking among a Somali community in London identified barriers to accessing smoking cessation services including lack of awareness of local services, minimal knowledge of Nicotine Replacement Therapy (NRT) and anxiety about one-to-one stop smoking sessions, with a strong preference to seek counselling in a group context (Straus et al, 2007). All these factors contribute to poor uptake of cessation services.

Usage of differing tobacco products also represents a barrier to accessing services, as people may not perceive the need or relevance of the service. The use of waterpipes (commonly known as shisha smoking) is common in many Northern African countries and especially popular in the African population in the UK. The growing popularity of its use is linked to mistaken beliefs that it is healthier than cigarette smoking and a lack of awareness that most shisha sold in the UK market contains tobacco (Smokefree Islington/Whittington Health NHS, 2012). This lack of perceived harm from the usage of waterpipes discourages users from seeking support to stop, though there is a growing body of evidence to suggest that the harm from using waterpipes is just, if not greater than, smoking cigarettes. For example, 45 minutes of waterpipe smoking doubles carbon monoxide and triples nicotine exposure (Eissenberg & Shihadeh, 2011).

Policy development

Policy developed in relation to smoking has taken some account of inequalities between communities in the prevalence and extent of tobacco use. The Public Health Outcomes Framework, which has an overriding aim to reduce health inequalities, includes indicators relating to smoking prevalence in adults (indicator 2.14) as well as on smoking in pregnancy and mortality from respiratory disease (Department of Health, 2013). Data collected against these indicators should undergo an equalities analysis, including ethnic disaggregation, in order to measure health inequalities. It is too soon however to determine whether this will occur in practice.

The correlation between smoking and deprivation is widely understood, and as a result, policies on smoking have tended to focus on targeting services in order to reduce health inequalities.
The Smoking Kills White Paper published in 1998 aimed to reduce the number of smokers by 1.5 million by 2010 by investing in cessation services (Department of Health, 1998). The paper included the goal “to improve the health of the worst off in society and to narrow the health gap” (Department of Health, 1998). Since poverty is disproportionately common among many ethnic minority groups, they did receive some attention. However, differences in smoking prevalence within such communities (e.g. according to gender and age) were overlooked because ethnicity-specific healthcare strategies were not adopted. More recently the NHS Cancer Plan (2000) and the NHS Plan (2000) set out national targets to reduce smoking rates among manual groups (from 32% in 1998 to 26% by 2010) in order to narrow the gap between manual and non-manual groups (Department of Health, 2000). The Marmot Review into health inequalities also noted that: “Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups” (The Marmot Review, 2010). Smoking-related deaths are two to three times higher in low income groups than in wealthier social groups.

Conclusions
Policies aimed at reducing smoking that do not identify and target the specific differing needs of diverse groups will not meet the needs of these communities. Whilst policies such as Smoking Kills recognise the strong link between tobacco use and economic status, they do not account for the range of other intersecting factors that influence the prevalence of smoking among the UK African population. There is therefore a need to understand the wider socio-economic, cultural and other causes that influence smoking behaviours in order to develop evidence-based interventions that will meet these needs. Smoking cessation services must adapt to the specific needs of African people. Greater recognition of Stop Smoking services could be encouraged through a range of media initiatives, such as targeting ethnic media including media with specific ethnic, racial or national target audiences or published or broadcast in other languages. Given the different preferences of different groups, more group counselling should be provided for those who experience apprehension of one-to-one sessions. Research and interventions are also needed to target the prevalence of smoking in conjunction with one or more other unhealthy behaviours.
POLICY IMPLICATIONS

The evidence presented in this report demonstrates the determining impact of ethnicity in restricting lifestyle options and influencing lifestyle choices. Unhealthy behaviours are a product of the circumstances on the individual, across all levels. Effective action to improve health and reduce health inequalities must address the drivers at all these levels if genuine change is to be achieved. The extent to which an individual adopts and maintains a healthy lifestyle is determined by the circumstances in which they live. Structural, social, economic, and cultural influences can limit their ability to make healthy choices. Therefore, successful public health interventions must focus on identifying these restrictions and disentangling people and communities from them.

The model of public health intervention we propose recognises the causal influence of ethnicity and the chain of determinants that influence health outcomes. Improving public health must necessarily involve action to improve individual health. Through structural change, socio-economic interventions and working with communities, genuine progress towards reducing the impact of lifestyle factors on health and reduction of health inequalities is achievable. Living long and living well is an aspiration shared by individuals and the ultimate goal of the health and public health systems. Understanding health within the framework of the lives people lead is an essential element of this process. People live in communities and cultures and are influenced and restricted by numerous factors within and outside their control, determined by multiple agencies and arms of the state and other actors. All of these therefore have to be active in promoting health.

As points of principle, commissioners, service providers and other actors should accept the following points.

- Ethnicity has a significant role in driving and influencing health and underpinning health inequalities, and should be recognised as a causal factor.
- Public health in relation to healthy behaviours has to function at the individual level to achieve real change.
- A holistic approach, encompassing multiple behavioural factors, is more effective and cost-effective, and facilitates greater targeting to meet specific needs of individuals.
• Health is neither a single goal nor an endpoint, but an ongoing state, varying over time. Consequently, a life course approach is essential.

• Individual health is determined by multiple factors, and so the goal of improving health should be shared by all public services and other actors with influence on the structural boundaries and socio-economic position in which people live.

• Public health interventions should be targeted to individuals and communities in order to meet diverse needs.

Implications for policy and practice: specific opportunities to support African people in living long and living well.

Structural: Improvements in the collection, disaggregation and usage of data, including ethnicity data, is needed, to enable patterns of access to services and health outcomes to be used in commissioning and service development.

Social: The link between social status and poor health has been widely recognised, and now must be addressed. Interventions to support social capital and enable social development at the local and individual levels should prioritise health outcomes as a core goal.

Economic: Interventions to ensure minimum income levels, adequate state support where needed and to mitigate economic inequalities, including in employment levels, are needed. Economic policies and interventions should be assessed and prioritised based on their health impacts.

Cultural and beliefs: Service providers and local authorities must work with communities to understand local needs, through reverse commissioning and service development ensuring interventions are locally designed, responsive and acceptable.

Individual: Adopting a holistic approach to the factors influencing an individual’s health options and choices, and targeted interventions to address them, will better enable all people to live long and live well.
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