

Woman of the North: Closing the health gap for minority ethnic women

Understanding the inequalities, barriers
and opportunities for change



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Foreword



Kim Johnson,
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It is an honour to welcome Woman of the North: Minority Ethnic Women in the North and recognise the important contribution this report makes to understanding and addressing inequalities that too often remain overlooked.

As the first Black MP to represent a Liverpool constituency, and as a Black, working-class woman born and raised in the city, I know both the barriers that can shape women's lives and the strength, leadership and solidarity that exists within our communities.

My own experience of working with community organisations has reinforced for me the importance of listening to people with lived experience. Too often, decisions are made about communities without properly listening to the people who know those communities best. That is why this report matters.

It shines a light on the persistent inequalities experienced by minority ethnic women across the North, while equally recognising their leadership, expertise and lived experience. Minority ethnic women contribute to their families, workplaces and communities every day and are often at the forefront of driving positive change. Their voices, experiences and knowledge must be central to the decisions that affect their lives.

The evidence presented in this report shows that inequalities are constant, interconnected and experienced across the life course. Health, employment, poverty, caring responsibilities and access to services cannot be understood in isolation. Racial discrimination remains a significant driver of poor health and economic outcomes, yet its impact is too often unacknowledged within policy and public debate. My own personal experiences mean I know only too well the impact of deeply entrenched institutional racism.

If we are serious about tackling inequality in all its forms, we must first ensure that minority ethnic women are visible in our evidence, our policies and our decision-making. Too commonly, their experiences are missing from the data collected and the conversations that are had about improving outcomes. Better representation in data matters, but so does meaningful engagement. Listening must go beyond consultation; it must lead to progress.

This is particularly essential when we consider women's health. Recent Women's Health Strategies have rightly sought to centre women's voices and improve health outcomes. However, significant ethnic inequalities remain, including in maternal health outcomes, and the concerns of minority ethnic women have often been overlooked. We must ensure that attention is matched by action, with services and policies shaped by the experiences of the women they are intended to support. The report also highlights the many barriers minority

ethnic women face in accessing and progressing in employment. A lack of appropriate employment support, alongside cultural norms and gender role expectations, can influence participation in the labour market and limit opportunities. Addressing these challenges requires tailored and long-term approaches that recognise the realities of women's lives.

The expertise, leadership and commitment found within the voluntary, community and social enterprise (VCSE) sector are among our greatest strengths. Across the North, community and voluntary organisations play a vital role in providing culturally informed, accessible and trusted support. Many are deeply embedded within their communities, giving them an invaluable understanding of local needs and enabling them to help women navigate services, access opportunities and have their voices heard.

Sustained funding for these organisations is essential, enabling them to continue acting as trusted intermediaries and providing advice. They cannot continue providing this vital work on the basis of inadequate funding and uncertainty. If we value the trusted relationships they have built with communities, we must provide the long-term investment and support needed to sustain them. The North has proud traditions of solidarity and collective action. Those strengths are reflected throughout this report and in the work of organisations rooted in, and led by, minority ethnic communities. They demonstrate what can be achieved when communities are empowered to shape solutions for themselves.

But we must be clear: community organisations cannot tackle structural inequalities alone. Lasting change requires continued investment, genuine partnership and shared responsibility. Short-term funding and isolated interventions will not address inequalities that have been allowed to develop over decades.

The challenges highlighted in the report show that success will depend on whether minority ethnic women themselves are at the heart of shaping solutions. This report challenges us not only to understand inequality, but to act on it. The evidence is clear, the voices are clear, and the need for change is clear.

As a proud Scouser and someone who has spent much of my life campaigning for equality and social justice, I understand how communities have the power to demand change. If we are serious about building a fairer North, minority ethnic women cannot remain on the margins of policy, data or decision-making. Their experiences, expertise and leadership must be at the centre.

The challenge now is to match that community strength with political will, sustained investment and meaningful action. That is how we build a stronger North for every woman going forward.

Introduction

This report came about following the original 2024 Woman of the North report and a conversation during a summit on the report. At the summit, Pat Poinen, Chair of the North East of England African & Caribbean Association (NEEA&CA), challenged the panel and Executive Director of Health Equity North, Hannah Davies on the limited focus about minoritised ethnic women from the report.

This was acknowledged by Hannah Davies, and Health Equity North responded by engaging a cohort of academics across the North and beyond, to focus on issues surrounding the experiences of these women. This response recognised the importance of addressing the omission and ensuring that the experiences, contributions and inequalities experienced by minoritised ethnic women were more fully represented. A mix of qualitative and quantitative research has been used by over 50 report authors, predominantly minoritised ethnic women and mostly based in the North of England.

Hannah Davies & Pat Poinen

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Executive summary

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Minority ethnic women in the North of England experience significant health inequalities, yet their experiences often remain hidden and overlooked. Research shows how racial discrimination is a key driver of poor health and economic outcomes, compounded by regional inequalities, underinvestment and a fundamental lack of understanding of the challenges minority ethnic women face. Fragmented data and limited research, which tends to put groups together into broad categories, prevent us from fully understanding the scale of inequalities or how ethnicity, gender and place interact to shape women's lives.

These inequalities affect women across the life course – from maternity care and mental health to employment, housing, gender-based violence and involvement in the justice system. Large gaps persist that negatively affect lives of minority ethnic women and it's clear that meaningful action is needed to reduce these gaps.

However, work happening across the North shows the strength of northern spirit and community. This report contains examples of voluntary, community and social enterprise organisations that are working alongside women and communities to tackle

inequalities, providing trusted support where statutory services can struggle to reach people. The work of these organisations, and the outcomes of their work, shows what is possible when communities are trusted and empowered to develop their own solutions.

These organisations play a vital role in tackling health inequalities, but they cannot address systemic inequalities alone. To maximise their impact, they need sustainable funding, meaningful opportunities to shape decision-making across government, and stronger frameworks for partnership with the NHS. The Government's 10 Year Health Plan focuses on bringing services to the community, but first trust and understanding must be cultivated in order for this to succeed, particularly in minority ethnic groups.

Engagement, collaboration and evidence are key to reducing the health inequalities experienced by minority ethnic women, and this can only be achieved with long-term, sustained policy action. We need concerted action across government, combined and local authorities, and health services – recognising that improving health outcomes for minority ethnic women is essential to building a healthier, fairer and more prosperous North.

Key findings

Poverty and food insecurity

Individuals from Pakistani, Bangladeshi and Black ethnicity were more likely to be living in the 10% most deprived neighbourhoods compared to individuals of White British background. Black people also are 2.5 times more likely to experience food insecurity than White people.



General health and life expectancy

Minority ethnic women in the North of England report substantially lower levels of good health than those in the South and London

77.4% compared to 88.5% and 82.9%, respectively.

Almost 1 in 5 (18.1%) minority ethnic women in the North have a long-lasting limiting illness, compared to 14.2% in the South and 15.8% in London. These conditions include cardiovascular disease, stroke, renal disease, some cancers, and poorer mental health outcomes.



Mental health

There are significant ethnic inequalities in severe mental illness including Schizophrenia, with minority ethnic women being 2–6 times more likely than White women to be diagnosed with nonaffective psychosis.

Minority ethnic women, particularly those of Black ethnicity tend to experience more severe treatment pathways for mental health and higher rates of detention under the Mental Health Act.

Employment and economic activity

Minority ethnic women in the North of England face worse labour market outcomes than women elsewhere, despite more than

70

initiatives over the last decade to boost economic activity in these groups.

Economic inactivity is significantly higher among minority ethnic groups in the North, particularly among Asian women: **44% of Asian women in the North West and 41% in Yorkshire and Humber are economically inactive**, compared with 25% of White women in both regions. **In the North West, 36% of Black women are also economically inactive**, compared with 25% of White women.

Maternal and neonatal health

Stillbirth rates are substantially higher for Black women than for White women in several regions. In the North East and Yorkshire, the highest stillbirth rates were recorded among women from other ethnic groups (9.2 per 1,000) and those whose ethnicity was not stated (9.7 per 1,000), highlighting significant gaps in the data available to understand ethnic inequalities in the North.

Black babies in the North face substantially higher neonatal mortality than White babies. In the North West, neonatal unit mortality was

29.9 per 1,000 babies admitted among babies born to Black women,

compared with **18.4 per 1,000 among babies born to White women** - around 1.6 times higher. In the North East and Yorkshire, the gap was even greater: compared with 17.0 per 1,000 for babies born to White women - almost twice as high.

32.6 per 1,000 for babies born to Black women



Children in care and child welfare

Black and Asian children enter care later than White children, on average at age 7 compared to age 5, and are less likely to have received a child protection plan beforehand.

Once in care, Black and Asian children are less likely to be placed for adoption or receive a Special Guardianship Order. 16.5% of White children and 15.6% of Mixed ethnicity children are placed on adoption orders, compared to 5.8% of Black children and 4.7% of Asian children.

Black children are more likely than White children to be investigated by the police. Adultification also contributes to Black children in particular being viewed as more responsible and culpable for their actions than their White peers.



Ageing populations

Older minority ethnic people are

3.81

times more likely to experience loneliness than their White British peers.

45%

of minority ethnic women report having experienced online abuse, and technology is increasingly documented as a coercive tool deployed within honour-based or community-monitoring contexts.

Minority ethnic women in the North face a double disadvantage from gender-based violence: they experience domestic abuse and other forms of violence, while facing greater barriers to disclosure and accessing support.

7.1%

of women with mixed ethnicity experience domestic violence - the highest of any group and higher than **White women (5.0%)**

Women in the criminal justice system

Women from minority ethnic groups are more likely to be arrested, serve longer sentences and receive disparate treatment in Magistrates' Court decisions including pleas and remand decisions, compared to White people.



Key findings

Poverty and food insecurity



- Women from Pakistani, Bangladeshi and Black ethnicity were more likely to be living in the 10% most deprived neighbourhoods compared to individuals of White British background
- Black and Asian people are twice as likely to be in poverty than White people, with over three times as many experiencing persistent poverty
- Black people are 2.5 times more likely to experience food insecurity than White people

General health and life expectancy



- Minority ethnic women in the North of England report substantially lower levels of good health than those in the South and London – 77.4%, compared to 88.5% and 82.9%, respectively.
- Minority ethnic women have higher mortality rates from cardiovascular diseases (CVD), diabetes and hypertension. CVD risk is highest in Pakistani women followed by Bangladeshi and Indian women. Women from minority ethnic groups are more likely to have cancer diagnosed at a late stage. Women from African, Caribbean and Asian ethnicity have higher odds of being diagnosed late with breast cancer and ovarian cancer.
- Bangladeshi and Pakistani women are almost four times more likely to suffer from asthma than White women.
- The risk of obesity-related non-communicable diseases among Bangladeshi women was three times higher for women living in the North than those living in London.
- Almost 1 in 5 (18.1%) minority ethnic women in the North have a long-lasting limiting illness, compared to 14.2% in the South and 15.8% in London. These conditions include cardiovascular disease, stroke, renal disease, some cancers, and poorer mental health outcomes
- Minority ethnic women in the North have reported a higher prevalence of obesity (64.5%) than those in the South (43.3%) and London (53%) – despite participating in higher levels of physical activity. This prevalence is also much higher than the prevalence among White women in the North (58.2%).
- Women aged 55 and over from 15 of 17 minority ethnic groups surveyed (88.2%) experience poorer

health-related quality of life than White British women.

- Data shows that, despite the health challenges and barriers minority ethnic women face, they have higher life expectancy levels than White people (83.1 years). For Asian women, life expectancy is 86.9 years, 87.3 years for Bangladeshi women, 88.9 years for Black African women, 84.6 years for Black Caribbean and 86.9 years for other minority ethnic groups.
- Roma people in England are estimated to have life expectancy up to 10 years lower than non-Roma populations, with Roma women experiencing particularly poor health – yet reliable, gender disaggregated data on Roma health is limited.

Mental health



- There are significant ethnic inequalities in severe mental illness including Schizophrenia, with minority ethnic women 2–6 times more likely than White women to be diagnosed with non-affective psychosis.
- Minority ethnic women, particularly those of Black ethnicity tend to experience more severe treatment pathways for mental health and higher rates of detention under the Mental Health Act.
- Significant ethnic inequalities persist in access to and treatment for mental health problems, with barriers including limited trust, culturally insensitive services and delayed diagnosis. Evidence shows that culturally competent training for health staff can help improve engagement and build trust with minority ethnic women and their families.

Employment and economic activity



- Minority ethnic women in the North face a significant employment disadvantage - employment among Asian women is as low as 42% in Yorkshire and Humber and around 49% in the North West, while only 56% of Black women in the North West are employed, compared with 64% of Asian women and 67.4% of Black women across the rest of England. In Yorkshire and Humber, more than 14% of Asian women are unemployed, compared with just 2.5% of White women.
- Minority ethnic women in the North of England

face worse labour market outcomes than women elsewhere, despite more than 70 initiatives over the last decade to boost economic activity in these groups.

- In every region of England, unemployment among Asian women was higher than among White women except the East of England, where Asian unemployment was 1.8% compared with 2.1% among White women.
- Economic inactivity is significantly higher among minority ethnic groups in the North, particularly among Asian people: 44% of Asian people in the North West and 41% in Yorkshire and Humber are economically inactive, compared with 25% of White people in both regions. In the North West, 36% of Black people are also economically inactive, compared with 25% of White people.
- Lack of employment support, cultural norms and gender role expectations can influence minority ethnic women's labour market participation. Community and voluntary organisations play a crucial role in improving their skills for employability and sustained funding should be provided to these organisations to act as intermediaries, offering advice, signposting, and tailored employment support.

- Pregnant women from minority ethnic groups are more likely to have an overweight BMI, while a family history of diabetes was reported by 41% of Asian mothers and 25.5% of Black mothers, compared with 18.0% of White mothers.
- Research shows that Black, Asian and Mixed-ethnicity mothers were more likely to live in the 40% of areas with the highest levels of deprivation.

Listening to women's voices and improving maternity care



- Despite the emphasis by 2022 and 2026 Women's Health Strategy to listen to women's voice and improve health outcomes for them, ethnic inequalities in maternal outcomes still exist and minority ethnic women's voices have often been ignored.
- Minority ethnic women from the North shared that specific barriers including financial hardship, transport difficulties and communication challenges significantly limit their access to care. Women commonly experienced racialisation, financial hardship, poor communication, and navigating technology, and the lack of engagement with cultural practices.
- Community networks and continuity of midwifery care were valued by women as protective factors, while stigma and a fear of being a 'burden' could prevent them from raising mental health concerns. Women reported that comprehensive, family-centred perinatal mental health assessments with longer-term follow-up, alongside systemic changes to ensure equitable access to maternity services, is key to meaningful support.

Maternal and neonatal health



- Women and their babies from minority ethnic groups experience significantly higher rates of stillbirth, infant mortality and neonatal unit mortality than White women, and these inequalities are most pronounced in the North of England, with the risk increased for those in the most deprived areas.
- Stillbirth rates are substantially higher for Black women than for White women in several regions. In the North East and Yorkshire, the highest stillbirth rates were recorded among women from other ethnic groups (9.2 per 1,000) and those whose ethnicity was not stated (9.7 per 1,000), highlighting significant gaps in the data available to understand ethnic inequalities in the North.
- Black babies in the North face substantially higher neonatal mortality than White babies. In the North West, neonatal unit mortality was 29.9 per 1,000 babies admitted among babies born to Black women, compared with 18.4 per 1,000 among babies born to White women - around 1.6 times higher. In the North East and Yorkshire, the gap was even greater: 32.6 per 1,000 for babies born to Black women compared with 17.0 per 1,000 for babies born to White women - almost twice as high.

Children in care and child welfare



- Black and Asian children enter care later than White children, on average at age 7 compared to age 5, and are less likely to have received a child protection plan beforehand. This suggests that risk and vulnerability are being identified too late for many minority ethnic children.
- Once in care, Black and Asian children are less likely to be placed for adoption or receive a Special Guardianship Order. 16.5% of White children and 15.6% of Mixed ethnicity children are placed on adoption orders, compared to 5.8% of Black children and 4.7% of Asian children. Nationally, Black children wait longer for adoption – an average of 10 months longer than White children.

- Evidence suggests that professionals are more likely to report Black children to children's services compared to White children, and Black children in families with lower socio-economic status were more likely than their White peers with a similar socio-economic status to be subject to reports.
- Black children are more likely than White children to be investigated by the police. Adultification also contributes to Black children in particular being viewed as more responsible and culpable for their actions than their White peers.

- 45% of minority ethnic women report having experienced online abuse, and technology is increasingly documented as a coercive tool deployed within honour-based or community-monitoring contexts.

Ageing populations



- Older minority ethnic people are 3.81 times more likely to experience loneliness than their White British peers.
- Older minority ethnic women in the North East are largely invisible in the data: a study of 14 women from African, Caribbean and South Asian communities highlights a major evidence gap in understanding how ethnicity, gender and place shape ageing.
- Compared with the South, women valued the North's affordability, natural environment and slower pace of life, but also highlighted its relative lack of diversity, fewer cultural opportunities and lower levels of investment. Research shows that strong bonds within ethnic and religious communities provided support, but fear, exclusion and limited wider social integration could deepen isolation.

Women in the criminal justice system



- Women from minority ethnic groups are more likely to be arrested, serve longer sentences and receive disparate treatment in Magistrates' Court decisions including pleas and remand decisions, compared to White women.
- Across the North, whilst the majority of the female prison population (which makes up just 4% of the overall prison population) are White, other ethnic groups continue to be disproportionately represented compared to the general population.

Gender based abuse and violence



- Minority ethnic women in the North face a double disadvantage from gender-based violence: they experience domestic abuse and other forms of violence, while facing greater barriers to disclosure and accessing support. 7.1% of women with mixed ethnicity experience domestic violence - the highest of any group and higher than White women (5.0%)
- Research shows minority ethnic women face more barriers to disclosing abuse, including language barriers, fear of stigma and dishonour, immigration insecurity, poverty, housing insecurity and concerns about children being removed.
- Minority ethnic women are also disproportionately affected by forms of abuse including coercive control, economic and immigration-related abuse, sexual violence, forced marriage, so-called honour-based abuse, FGM and technology-facilitated abuse.



Key recommendations

The following recommendations require a coordinated response across national government, regional leaders, and the NHS. The NHS 10 Year Health Plan emphasises shifting the focus from treatment to prevention, moving care from hospitals to local communities, and improving the use of digital technologies. The Women's Health Strategy aims to reduce inequalities and listen to women's voices to shape care. However, no single organisation can address the deep-rooted inequalities experienced by

minority ethnic women alone. Success will depend on shared accountability, sustained investment, strengthened community engagement, and partnership working at every level, with government setting the policy and funding framework, regional systems driving local implementation, and NHS organisations embedding equitable and culturally competent care in practice. Together, these actions can help deliver meaningful and lasting improvements in health outcomes for minority ethnic women.

01 **Make minority ethnic women visible in the data**

Government, the NHS and other public services should improve the quality, consistency and availability of ethnicity-disaggregated data, so that inequalities affecting minority ethnic women can be properly identified and addressed. Particular attention should be given to consistent ethnicity recording including sub-group categories within Asian or African ethnicities and smaller ethnic groups, including Roma women, whose experiences can be hidden within broad ethnic categories. This can provide crucial insight for targeted strategies in achieving the shift from analogue to digital records.



02 **Put lived experience at the heart of decision-making**

Minority ethnic women should be meaningfully involved in the design, delivery and evaluation of policies, research and services that affect them. Co-production should take place from the outset, rather than women being consulted only after decisions have been made.



03 **Make health and care services culturally competent and anti-racist**

Health and care organisations should embed culturally competent, anti-racist and intersectional practice throughout services, with clear accountability for delivering change. This should include appropriate training for healthcare and other frontline professionals, action to address structural racism and stronger expectations around culturally responsive care. This is an important component for improving patient-provider relationships and trust building.



04 **Remove barriers for minority ethnic women accessing healthcare**

The NHS and other public services should identify and remove the practical, financial, linguistic, cultural and digital barriers that prevent minority ethnic women from accessing timely and appropriate care. This should include access to professional interpreting, culturally appropriate information, affordable transport, non-digital routes into services and appropriate support for women experiencing financial or immigration-related barriers. Services should actively engage women who are not currently accessing care, working with trusted community and faith organisations where appropriate.



05 **Invest in targeted prevention and early intervention**

Health inequalities should be tackled earlier through prevention and targeted health promotion designed around the needs of different minority ethnic communities. This should include culturally adapted approaches to cardiovascular disease, diabetes and respiratory disease, alongside targeted action to improve uptake of screening, NHS Health Checks and the NHS Diabetes Prevention Programme. National and local health campaigns should be developed with minority ethnic women and community organisations to ensure that information is accessible, trusted and relevant in order to shift from treatment to prevention.



06 **Deliver equitable, continuous maternity and perinatal care**

Maternity services should take positive action to reduce ethnic inequalities in maternal, pregnancy and infant outcomes, with continuity, cultural competence and women's voices at the centre of care. This should include listening to women's experiences, increasing access to midwifery continuity of care for minority ethnic and disadvantaged women, tackling structural racism through appropriate training and resourcing, and removing financial, transport and language barriers.



07 **Transform mental health support for minority ethnic women**

Mental health services should transform provision to provide culturally sensitive, anti-racist and community-based support that reflects the different experiences and needs of minority ethnic women. This should include consistent collection of ethnicity and gender data, culturally adapted pathways into care, improved communication between services and stronger integration between NHS, social care and voluntary community and social enterprise (VCSE) organisations. Community-led organisations should be recognised as trusted access points and supported through sustainable funding, rather than being expected to fill gaps in statutory provision without adequate resources.



08 Fund community-led and 'by and for' services for the long-term

Government, NHS bodies and local authorities should recognise community and voluntary organisations as essential partners in reducing health inequalities and provide them with sustainable, long-term funding. Funding and commissioning processes should be accessible to smaller, community-rooted organisations, with longer funding cycles and appropriate ring-fenced budgets.



09 Tackle poverty and the wider determinants of health

Action to reduce health inequalities must extend beyond healthcare to address the socioeconomic conditions that shape women's health and opportunities. This should include action on poverty, employment, insecure and informal work, childcare, housing, transport and immigration-related barriers. Employment support should be designed with minority ethnic women and recognise caring responsibilities, community circumstances and existing informal work, while providing routes into secure employment for women who want to make that transition.



10 Target support at women experiencing multiple disadvantage

Policy and services should recognise that some minority ethnic women experience multiple and intersecting forms of disadvantage and therefore require more targeted support. Targeted approaches should recognise the specific circumstances of different communities rather than treating minority ethnic women as a single group. Roma women, for example, should be recognised as a distinct population in data and policy, with their communities involved directly in shaping solutions.



Understanding inequalities affecting minority ethnic women in the North and the broader context

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Ethnic inequalities and the northern context

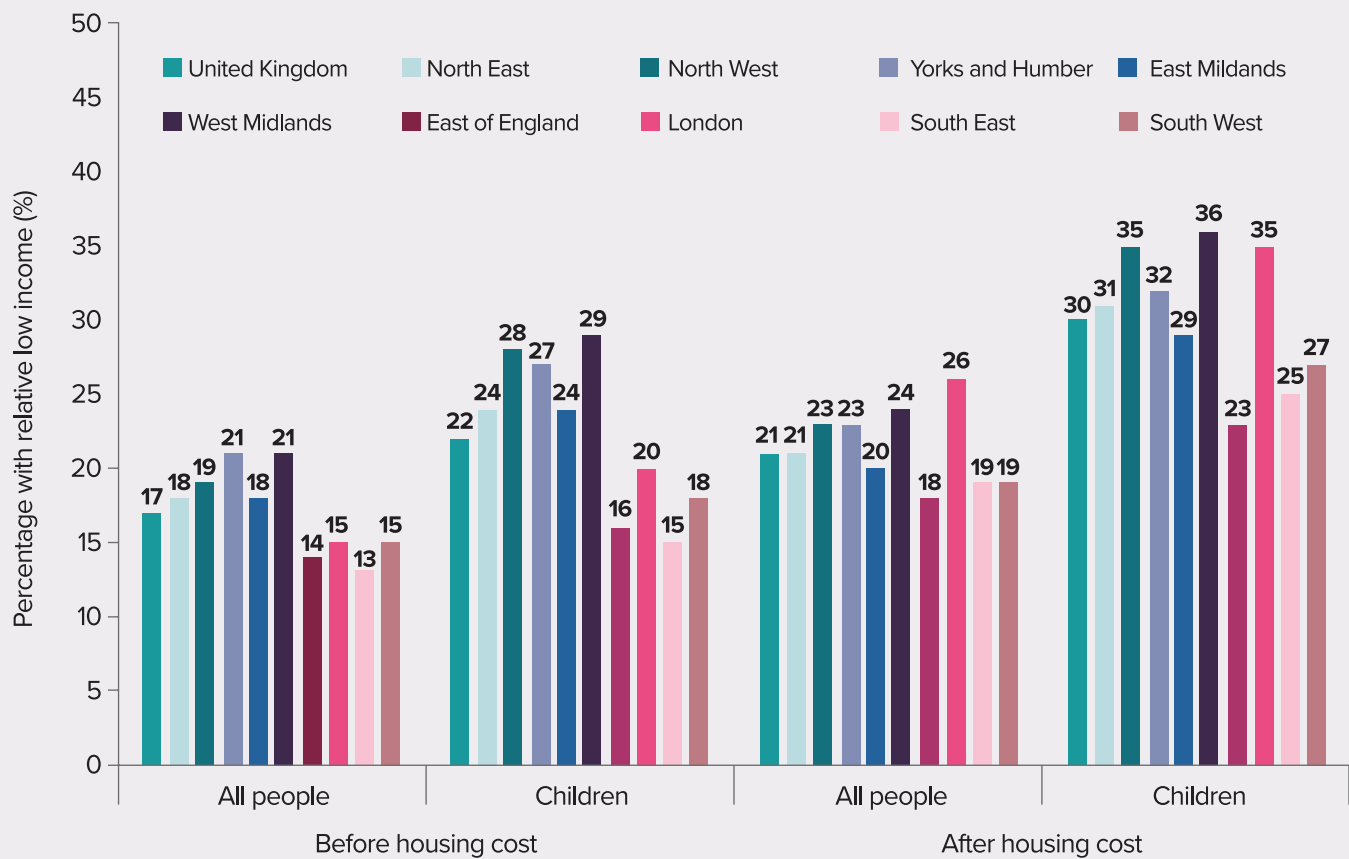
Northern women from minority ethnic groups are simultaneously affected by both ethnic inequalities and regional deprivation. Our Woman of the North report highlighted that women in the North of England face some of the most entrenched health and economic inequalities in the country.¹ They experience lower healthy life expectancy, higher rates of chronic illness, poorer mental health, and a disproportionate burden of unpaid care – providing £10 billion of unpaid care annually. Since the publication of that report, the situation has worsened. Within this context, this report outlines the wide-ranging inequalities facing minority ethnic women, and how recent changes for the worse have amplified these inequalities. (See Box 1.1 for the explanation of terminology adopted in this report).

New ONS data (2022–2024) shows that healthy life expectancy for women has fallen in every region of England except London, reaching its lowest level since the time series began in 2011–2013.² Women in the North East (56.9 years), North West (59.2 years), and Yorkshire and Humber (61.0 years) now have the lowest healthy life expectancy

in the country, widening the North–South divide and reinforcing the urgency of targeted policy action. In addition, although the 21% poverty rate in the UK in 2023/24 appears unchanged (same as in 2010/11, or 2022/2023), nearly half of those (6.8 million people) now experience very deep poverty and it varies sharply by ethnicity and religion.^{3,4} Such widespread poverty has harmful impacts on people’s health, relationships and life chances.⁴ Between 2021 and 2023, 14.2 million people in the UK faced relative poverty after accounting for housing costs.^{5,6} The distribution of income is unequal (Figure 1.1): The northern regions and the Midlands have a higher percentage of individuals living in relative low-income households than the south (excluding London, which has the highest percentage once housing costs are considered).

Along with economic deprivation, a report for the year ending March 2025 showed that over the last 12 months there was an increase in race hate crime (6%) and religious hate crime (3%), though other hate crimes declined (sexual orientation: 2%, disability: 8%, and transgender: 11%).⁷ The increase in racial tension is marked for northern

Figure 1.1. Regional distribution of percentage of individuals living in relative low-income (before and after housing cost), average: 2021/2022 to 2023/2024³



regions, specifically observed in towns and cities with economic loss, likely to be linked with long-term disinvestment in the North.⁸

While existing evidence reaffirms the pattern of persistent ethnic inequalities and their social determinants, understanding the context of health of minority ethnic women in the North deserves special attention.^{3-6,9} Minority ethnic groups commonly experience precarious employment, persistent poverty and high food insecurity (Figure 1.2). Various groups continue to face disproportionate risk in specific areas, with some experiencing multiple axes of disadvantage (Figure 1.3). These varied experiences highlight the critical need to avoid a reductionist approach in describing vastly varied and numerous minority ethnic groups.

“The government wants to ensure that whoever you are, wherever you come from, Britain is a country that will respect your contribution and give you a fair chance to get on in life. No-one deserves to be held back at work because of their ethnicity or disability. Everyone should be able to expect fair pay and progression opportunities for their hard work”.
Seema Malhotra MP, Former Minister for Equalities, 25 March 2026

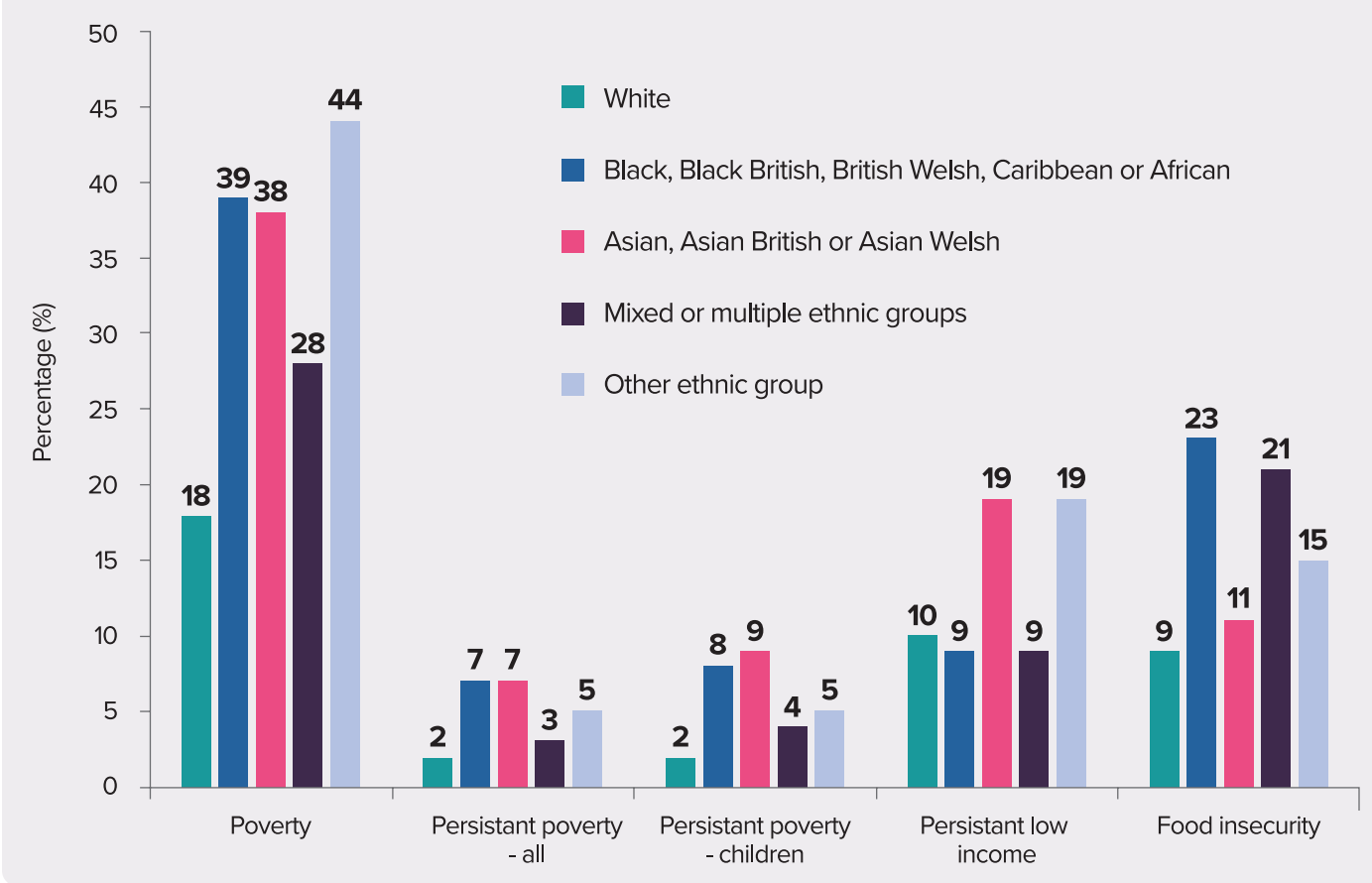
What we know about inequalities facing minority ethnic groups
Health inequalities, though considered unfair and avoidable, remain challenging issues for the NHS and the UK government. Women from minority ethnic groups face inequalities in access to health care, care experiences, and outcomes. Generally, compared to White ethnic women, the rates of obesity, diabetes, and cardiovascular disease are much higher among women of South Asian and Black ethnic background.^{10,11} Despite a disproportionately higher burden, minority ethnic women also experience poorer access to treatment for depression and anxiety disorders.¹² Black women were nearly three times more likely to die during pregnancy, and this gap continues to widen.¹³ While deprivation significantly increases such risk, ethnic inequalities in maternal mortality exist irrespective of social or economic status, indicating the influence of racial biases and systemic

issues.¹³ Undocumented migrant women in England face even more challenges accessing maternity services.¹⁴

To give a specific example, stark inequalities were reported in the UK experience of the COVID-19 pandemic and response to it. Although initially COVID-19 infection or mortality was not expected to have differential racial patterning as the government stated, ‘we are all in this together’, it exposed and exacerbated existing social and health inequalities. It turns out that the experience and exposure were unequal, with the pandemic disproportionately impacting the lives of disadvantaged communities and deprived neighbourhoods.^{15,16} The risk of infection and associated mortality was significantly higher among Bangladeshi, Pakistani, and Black Caribbean men.^{17,18} Ethnic inequalities were also observed for COVID-19 related short- and long-term physical and mental health impacts.^{19,20} Recent research noted that pandemic-related economic consequences, such as loss of income and increased poverty, were higher among those with protected characteristics.^{15,16}

Despite the lack of disaggregated regional level health outcomes data for women from minority ethnic background, we are aware that place amplifies ethnic inequalities.^{8,21} Mirza and Warwick (2024) have emphasised that race and ethnic inequalities are complex, and that a holistic investigation needs to not just assess the impact of area level deprivation but also inspect the inequalities seen between and within ethnic groups (Figure 1.3).²² We have seen that health risks, such as risk of obesity-related non-communicable diseases vary between Bangladeshis in the North and South and between genders and generations, with the risk being three times higher among women living in the North compared to women living in London.²³ This reiterates the importance of applying the intersectionality framework to examine multiple axes of deprivation simultaneously, enabling a more nuanced interpretation of social injustice.²⁴ Since ethnicity, gender, and place interact to form distinctive and compounded forms of inequities, without tackling the structural issues shaping the inequalities all positive efforts would merely reflect hope rather than substance.²⁵

Figure 1.2. Prevalence of poverty, persistent poverty (all, children), persistent low income, and food insecurity by broad ethnic categories^{3-6,9}



Our work was inspired by several connected ideas and conceptual frameworks. Dahlgren & Whitehead's (1991) 'Social Determinants of Health model',²⁶ grounds our starting premise that health inequalities arise from a combination of social and environmental factors, not from individual factors alone. The intersectionality framework then lets us examine how region, gender and ethnicity interact to affect the lives of minority ethnic women, their access to healthcare, and their health outcomes.²⁷ However, ethnic inequalities are more complex than a simple interaction of place and gender, and few frameworks focus explicitly on ethnicity. The modified Diderichsen framework addresses this gap, explaining how social and political structures stratify society and create differential exposures, vulnerabilities, and health outcomes among ethnic groups.²⁸ We also show how culture shapes gender roles and influences health – through personal beliefs, behaviours, relationships, and healthcare interactions²⁹ – while political and economic structures shape these factors across different ethnicities, genders, and social positions. Each of our chapters includes policy recommendations, as differences in political and economic arrangements partly explain why health inequalities vary across populations and places.³⁰

Key ongoing initiatives aiming to reduce inequalities

The UK government has launched several positive initiatives to tackle inequalities. These include the:

- 2022 Women's Health Strategy for England and the renewed 2026 strategy aspiring to address ethnic inequalities in access to services, outcomes and risk factors^{31 32}
- 2025 NHS 10 Year Health Plan, "Fit for the Future" proposing a shift for NHS services to emphasise community-based approaches, introducing "neighbourhood health services", and emphasising prevention rather than cure³³
- NHS Core20PLUS5 framework specifically focusing on addressing the needs of the 20% most deprived areas (core20), and people from minority ethnic groups (PLUS component)³⁴
- 2026 enforcement of mandatory reporting of ethnicity and disability pay gaps³⁵

Despite these efforts, we know that ethnic inequalities and the health of minority ethnic women in the North of England are shaped by a

complex web of factors, including place characteristics, socio-economic context, structural racism, ethnic variation in biological make up that leads to higher risk of non-communicable diseases in particular groups, limited awareness and conceptualisation of mental health, and attitudes and norms relating to patriarchy and culture and their influence on gender roles.

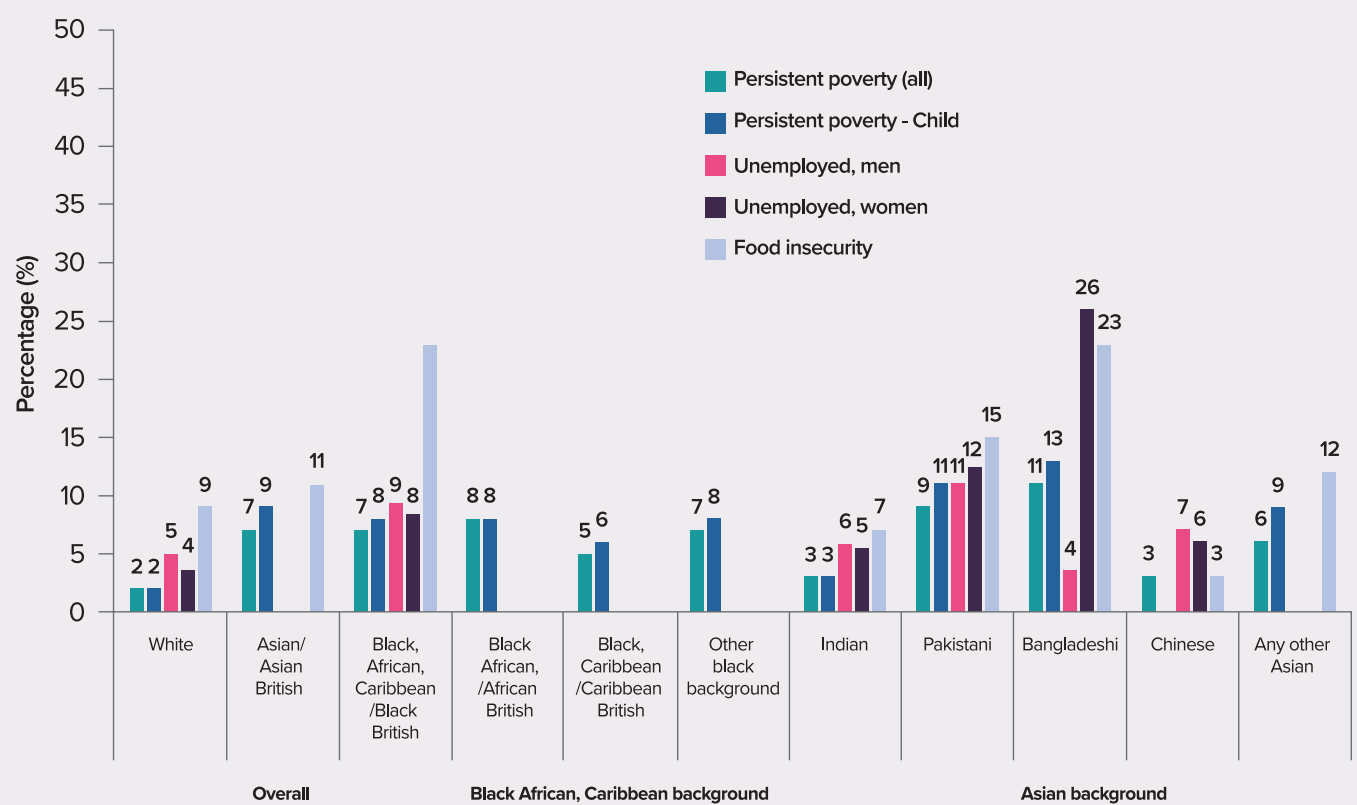
What this report adds

Our previous report noted a significant variation in physical health by gender (women having poorer physical health), region (the North-South gap), and ethnicity, with much worse health status for women from Pakistani, Bangladeshi and other Black or Asian ethnic groups, compared with White women.¹ Health outcomes of minority ethnic women are shaped not only by the regional inequalities, but also by racialised barriers in employment, healthcare access, and social support, as well as limited options for culturally sensitive approaches to health care.³⁶

Building on the picture laid out in the Woman of the North report,¹ we need to focus on the factors underlying inequalities faced by minority ethnic women. We must extend the narrative to include their experiences and the current evidence on the long-standing and entrenched inequalities they often face in more acute and complex ways. This approach supports embracing diversity and having mutual respect for differences – core British values.

The scope of our work is to some extent limited by data availability, particularly as this report focuses on comparing the health and wider determinants of health of minority ethnic women in the North with those of women from majority ethnic groups and from other regions of England. Quantitative data may sometimes lack the power to disaggregate findings by detailed categories of ethnicity for a specific time point, by region, and thus to examine how ethnicity and gender interact to influence findings. Here, we draw on both quantitative and qualitative evidence, integrating lived experience, testimonials, and perspectives from a wide range of stakeholders – including community-based organisations – to build a fuller picture of the landscape and of ongoing efforts to reduce the inequalities minority ethnic women face. Effective, accountable policy responses depend

Figure 1.3. Prevalence of persistent poverty (all, children), unemployment (men, women), and food insecurity by broad ethnic categories^{3-6 9}



on this kind of awareness: awareness of inequalities themselves, and of the different experiences that underlie them. Equally, it must recognise the positive contributions, leadership, and resilience of minority ethnic women, and the community organisations supporting them, contributions that are too often overlooked.³⁶

We present data and contextual information on variation in physical and mental health (chapters 2 and 3), then follow a life course approach to cover outcomes and experiences of maternity, pregnancy and early infant health (chapters 4-5); regional and ethnic variation in employment (chapter 6); ageing (chapter 7); and children in care (chapter 8). This is followed by discussion of vulnerable and multiply marginalised groups: those experiencing gender-based violence (chapter 9); those who are justice-involved (chapter 10); and Roma women (chapter 11). We examine the role of community-led organisations, showcasing examples of their positive contributions (chapter 12) and conclude by illustrating how data limits our exploration of ethnic inequalities and recommend ways for improving ethnicity recording across systems to allow data synchronisation and investigation of ethnic inequalities (chapter 13).

Altogether, this report aims to holistically present ethnic inequalities and the context behind them, and calls for actions leading to the changes needed to close these gaps and deliver more equitable health and social outcomes for minority ethnic women.



Box 1.1. Terminology used in this report

The terminologies used to describe minority ethnic groups are historically and politically situated. In addition to debates around the use of race vs ethnicity which we outline, there are also debates around the collective terms used, for example BME (Black, Minority Ethnic), BAME (Black, Asian and Minority Ethnic), Global Majority, People of Colour etc, all of which signify attempts to find a workable language that either depoliticises race (for the purposes of policy or common expression) or reclaims the politicisation of race by those on the receiving end of racism who want the legacies of oppression to be better understood. None of these phrases or acronyms are adequate in every context. Suffice to say, the terms used matter, and they have ramifications for the communities that sit under them. Given the complexity, nuances, and variable exposure to underlying factors shaping inequalities, it is also clear that in the current context we cannot simply apply a reductionist approach to describe vastly varied and numerous minority ethnic groups. Using a collective term such as BME/BAME (Black, Asian and Minority Ethnic group) that homogenises different ethnicities within a broad umbrella term has this effect.^{37 38} This is illustrated very clearly in Figure 1.3.

The 2021 Commission on Race and Ethnic Disparities proposed changes to reflect inclusivity, build trust and avoid racism.³⁹ They recommended a focus on understanding inequalities across ethnic groups and that aggregate terms like BAME should be dropped. The NHS has also discarded terminology such as BAME and advocates for promoting 'ethnicity' as a self-defined form of identity.⁴⁰

"...the term 'ethnic group' cannot be used solely in relation to those peoples from the ex-colonies of the Caribbean, the Indian subcontinent, continental Africa, and Hong Kong. ... Nevertheless, everyone has an ethnicity, whatever colour, creed or nationality."

Mirza and Warwick (2024)²²

In this report, we chose to use the term 'minority ethnic women' to describe the group that is the focus of this report, and we did so after careful consideration of the legacies of terminology

and language that has been used to describe our communities. Although 'ethnic minority' and 'minority ethnic groups' are used interchangeably, some felt that the term ethnic minority implies that only minority groups come from an ethnic background. We acknowledge that everyone has ethnicity. While some constitute a small portion of the whole population in the UK, they may be considered a global majority. Between the 2011 and 2021 census, the percentage of the White population has decreased by 4.3 percentage points (86.0% to 81.7%), with an accompanying increase in ethnic diversity among the 10.9 million minority ethnic populations and those classed as mixed race or 'other'.⁴¹ Whether this is a true increase or simply that people are more comfortable disclosing their ethnicity is hard to quantify.

The ONS ran detailed consultations on the way it collects data on ethnicity ahead of the 2021 census, which may have impacted these figures.⁴² Race has no biological or scientific basis and is widely recognised as a social construct used to justify racial subordination and hierarchy based on skin colour.^{37 38} Whilst ethnicity is a highly complex phenomenon related to culture, ideology, faith and nationality, it is commonly expressed as a self-defined concept of belonging which lets people describe their identity and their belonging to particular groups.⁴³

"People want to categorise me and they want to put me in a space, and they have not asked me how I identify. They have not asked me what my ethnicity is... We do not want to be categorised. Ask us how we identify. Ask what our ethnicity is... You see race is a social construct, it's an ideal that we created and gave power to and reinforced through actions and behaviours but it's not biological... You see the fluidity of race is not real, we are all ethnic and the sooner that we learn that and we understand and respect one another for that the better off that will be."

Tammy Hodo (2019), President of All Things Diverse LLC.⁴⁴

General health and wellbeing of minority ethnic women in the North

Authors Omotayo Joan Olajide, Fiona Igwe and Faraz Ahmed

Summary

- Minority ethnic women in the North of England experience greater socio-economic deprivation than those in the South. We see a distinct pattern of health disadvantage, with higher prevalence of limiting long-term illness, cardiovascular disease, diabetes and asthma than their counterparts in the South, reflecting the compounding effects of ethnicity, deprivation and place.
- Late-stage cancer diagnosis is a particular concern, with Caribbean, African and Asian women significantly more likely than White British women to be diagnosed with breast, ovarian, uterine and lung cancer at a late stage. This pattern is consistent with lower screening uptake in some minority ethnic groups.
- Available data mask important variation within and between minority ethnic groups, as analysis has had to rely on broad ‘White’ and ‘non-White’ categories due to small sample sizes, making it impossible to identify the specific needs of, for example, Bangladeshi or Pakistani women in the North separately.

Context

Women from minority ethnic backgrounds in England constitute a substantial share of the population (5.6 million).⁴⁵ Although regional data is not often disaggregated by sex, ethnicity and deprivation, available evidence on minority ethnic people living in the North suggests that they are more likely to live in areas of high socioeconomic deprivation, and to experience variation in access to healthcare services, poor housing and environmental conditions that negatively impact general health and wellbeing.

This chapter provides an overview of the health status, some of the clinical risk factors associated with non-communicable diseases and challenges with access to public health preventive services for these groups of women. It highlights the need for health care systems and policies that can facilitate accurate identification of health needs combined with prompt responses to promote equity, improve health outcomes and narrow the longstanding North-South health gap for minority ethnic women.

The health of minority ethnic women – overview

Here we outline the evidence on the variation in health of minority ethnic women at a national level, before discussing the regional evidence in a later section.

Life expectancy and mortality

The Office for National Statistics (ONS) analysis of life expectancy in England and Wales from 2011 to 2014 shows that women from all minority ethnic groups have higher life expectancy at birth than the 83.1 years for women from the White and Mixed ethnic groups (Table 2.1).⁴⁶ In particular, women from the Black African group had a statistically significant higher life expectancy than most groups (88.9 years). This pattern is largely mirrored in recent age-standardised

Figure 2.1 Age standardised mortality rates for deaths from all causes, England:21 March 2021 to 31 January 2023. Source: Public Health Data Asset from the Office for National Statistics, 2024⁴⁷

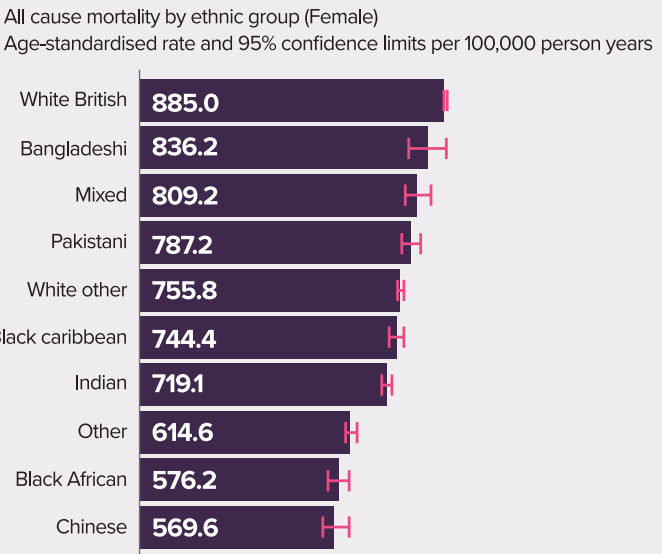


Table 2.1 Life expectancy at birth by sex and ethnic group:England and Wales, 2011 to 2014. Source: Office for National Statistics, 2021.⁴⁶

Ethnic group	Females	Males	Sex gap (years)
Asian other	86.9	84.5	2.4
Bangladeshi	87.3	81.1	6.2
Black African	88.9	83.8	5.1
Black Caribbean	84.6	80.7	3.9
Black other	86.8	82.0	4.8
Indian	85.4	82.3	3.1
Mixed	83.1	79.3	3.8
Other	86.9	84.0	2.9
Pakistani	84.8	82.3	2.5
White	83.1	79.7	3.4
Ethnic group gap (years)	5.8	5.2	

mortality rate data, which shows the highest mortality rate (per 100,000) among women who are White (885), with Mixed ethnic groups having the third highest rate (809) (Figure 2.1). These data show women who are Bangladeshi have the second highest age-standardised mortality rate (836.2).

The patterns in life expectancy and age-standardised mortality rate

Figure 2.2. Age-standardised mortality rates for deaths from diabetes, England: 21 March 2021 to 31 January 2023.⁴⁷

All cause mortality by ethnic group (Female)
Age-standardised rate and 95% confidence limits per 100,000 person years

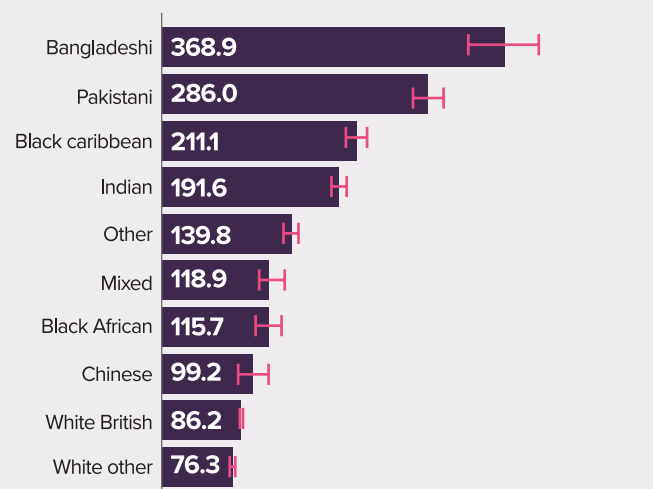
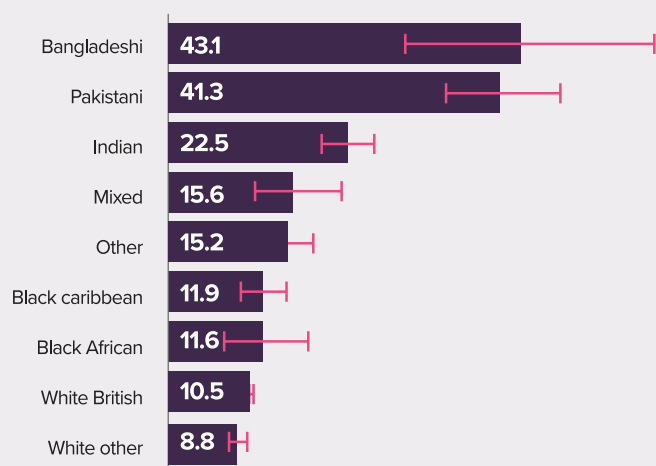


Figure 2.3. Adjusted hazard ratios for CVD incidence among women by ethnicity; White women are the reference with a value of 1.



Figure 2.4. Age-standardised rates of asthma-related outcomes among females by ethnic group, England.⁴⁷

Asthma by ethnic group (Female)
Age-standardised rate and 95% confidence limits per 100,000 person years



are at first glance at odds with data showing poorer health outcomes for minority ethnic women. However, this highlights the need for more disaggregated data. Overall rates are likely to be affected by the 'healthy migrant effect' in which healthier migrants are more likely to migrate but this wanes over time because of environmental and lifestyle changes.¹¹ This may be the case for the Black African minority ethnic group which has a higher proportion of first-generation migrants than the Bangladeshi ethnic group.⁴¹ However, this does not account for socioeconomic status, health-related behaviours – with smoking and drinking prevalence lower in many minority ethnic groups compared to White groups – or condition-specific mortality.

Causes of mortality and morbidity among minority ethnic groups

Factors contributing to mortality vary by ethnicity. Out of all ethnic groups, those of Bangladeshi and Pakistani ethnicity had the highest age-standardised mortality rates for diabetes, chronic kidney disease, ischaemic heart disease, hypertension, stroke, myocardial infarction, asthma, pneumonia, and COVID-19. Those of Black Caribbean ethnicity had the highest age-standardised mortality rates for blood cancer and prostate cancer.⁴⁷ The situation is complex as minority ethnic groups have disproportionately higher rates of cardiovascular multimorbidity – including diabetes, hypertension, heart attack or stroke. Compared to those of White ethnicity, those of South Asian and Black Caribbean ethnicity have more than three and two times higher cardiovascular multimorbidity, respectively.⁴⁸ Below we describe the variation in conditions that are highly prevalent for minority ethnic women.

Diabetes

The ONS report on mortality involving common physical health conditions from 2021 – 2023 shows a striking difference in age-standardised mortality rates from diabetes between women from different ethnic groups. Diabetes mortality rate was the lowest amongst White women (76.3), and highest amongst Bangladeshi (368.9), Pakistani (286.0) and Black Caribbean women (211.1). See Figure 2.2.

Cardiovascular disease

The Commission on Race and Ethnic Disparities report, 2021 indicated that CVD risk is generally higher in women than men from minority ethnic groups, except in the Black African group.³⁹ Across the minority ethnic groups, CVD risk is highest in Pakistani women followed by Bangladeshi and Indian women (Figure 2.3), with implications of strong ethnic and socioeconomic inequalities, particularly in Pakistani women.

Cancer

Whilst the incidence rates for most cancer sites were higher in White groups compared with other ethnic groups,⁴⁹ there is evidence that women from minority ethnic groups are more likely to have their cancer diagnosed at a late stage. The retrospective secondary data analysis by Fry et al., 2023,⁵⁰ using data from NHS Digital's National Cancer Registration and Analysis Service and Hospital Episode Statistics records from 2012 to 2016, found that Caribbean and African women were significantly more likely to be diagnosed with late-stage breast (OR 1.27, 95% CI 1.12 to 1.43); OR 1.71, 95% CI 1.51 to 1.95, respectively), ovarian (OR 1.48, 95% CI 1.02 to 2.14); OR 1.85, 95% CI 1.26 to 2.71) and uterine cancer (OR 2.17, 95% CI 1.74 to 2.71); OR 2.19, 95% CI 1.61 to 2.97), compared with White British women. Asian women had increased odds of late-stage breast (OR 1.12, 95% CI 1.03 to 1.22) and ovarian cancer (OR 1.21, 95% CI 1.02 to 1.44) while Caribbean women had increased odds of late-stage non-small cell lung cancer (OR 1.62, 95% CI 1.20 to 2.19)). These data are consistent with reports on uptake of routine mammographic screening – offered every three years to women aged 50–70 years. Evans (2018) highlighted that screening uptake is likely to be considerably lower in Asian women, particularly women of Pakistani or Bangladeshi origin in the UK.⁵¹

Initiatives that focus on increasing screening uptake among

minority ethnic women should thus be designed to encourage early presentation with symptoms. Lower uptake is not confined to breast screening: participation in the cervical and colorectal cancer screening programmes is also lower among women from minority ethnic groups in England, and South Asian women are particularly affected.¹¹

Asthma

Asthma is a common chronic respiratory condition that contributes significantly to morbidity among women in England and demonstrates notable inequalities across population groups. Age-standardised rates per 100,000 person years of asthma-related outcomes among females in England by ethnicity show clear variation across ethnic groups (Figure 2.4), with the highest rates observed among Bangladeshi (43.1) and Pakistani (41.3) populations. Indian women also show elevated rates (22.5), while Mixed (15.6) and Other ethnic groups (15.2) report comparatively lower levels. The lowest recorded rates are observed among White British (10.5), White Other (8.8), Black Caribbean (11.9), and Black African women (11.6).⁴⁷

These findings highlight marked ethnic inequalities in asthma-related outcomes among women in England. Higher rates among South Asian populations, particularly Bangladeshi and Pakistani groups, may reflect a combination of increased exposure to environmental risk factors, socioeconomic disadvantage, and structural inequalities in access to healthcare.¹¹

Regional analysis

Population

Health inequalities are shaped by place, gender, ethnicity and socioeconomic deprivation – and these factors are deeply interrelated. Here we show the regional distribution in the population of minority ethnic groups across England, focusing on women.

There is a clear variation in the proportion of minority ethnic groups across regions in England (Figure 2.5). ONS census population estimates (2021)⁵² for females show that the Asian, Asian British or Asian Welsh ethnic category accounts for the largest proportion of minority ethnic groups across all regions, with the highest concentration in London – more than double the proportion for England as a whole (20% vs 9.6% respectively). Among the northern regions, Yorkshire and The Humber (8.8%) and the North West (8.3%) have a higher proportion of this group than the South East (7.1%) and

East of England (6.4%), while the North East (3.6%) also has a higher proportion than the South West (2.9%). For the Black, Black British, Black Welsh, Caribbean or African ethnic category, London has by far the highest proportion (14.3%), followed by the West Midlands, which also has a notably high proportion (4.6%) compared with other regions. This patterning reflects historical migration patterns as well as the Immigration and Asylum Act of 1999, with asylum seekers and refugees dispersed to other regions of England to reduce pressure on London and the South East.

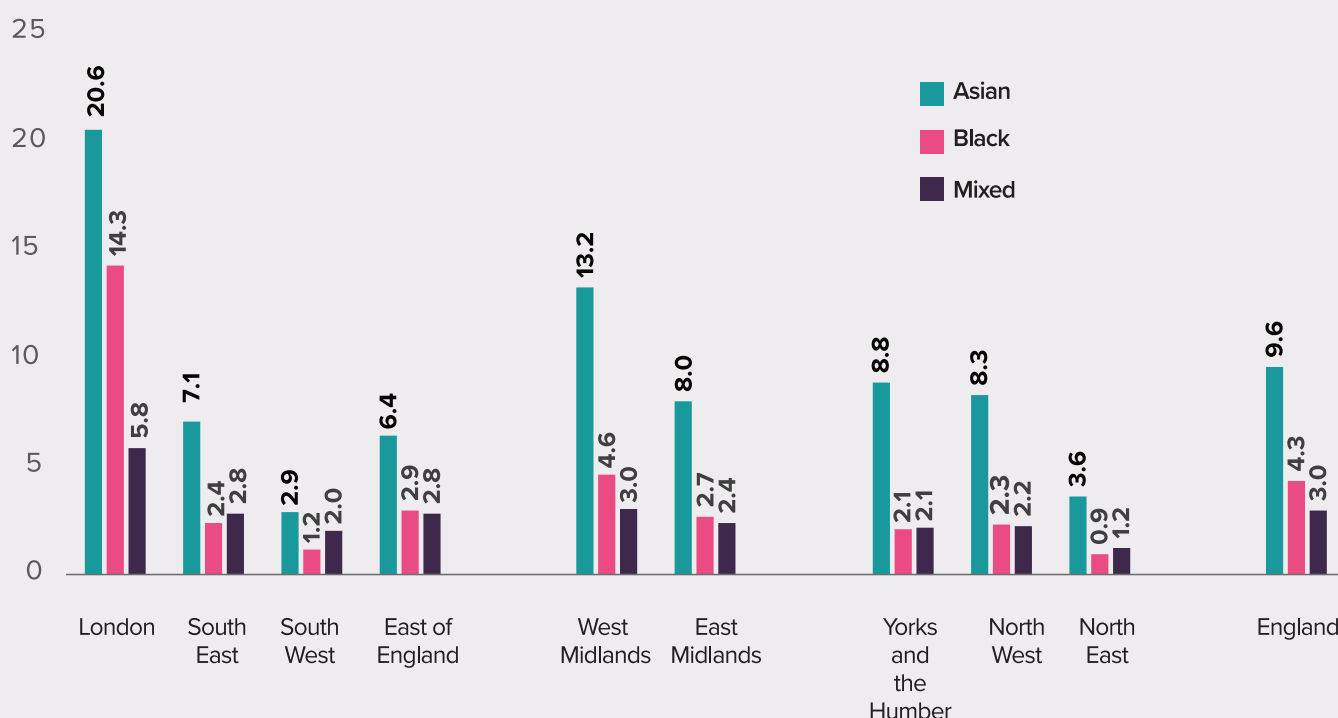
Whilst areas of high socioeconomic deprivation can be found across England, at a regional level, the North West, North East and Yorkshire and the Humber have a higher concentration of areas classified with the highest indices of multiple deprivation (IMD)⁵³. There is also a clear North-South divide in women's health.^{2 54} Women in the North East, North West, and Yorkshire and The Humber have the lowest life expectancy and healthy life expectancy across England, with the North East performing worst. Across the northern regions, average female life expectancy in 2022-2024 was 81.9 years of which 23 - 25 years was in poor health, compared with 84.3 years in the South, with 20 - 22 years spent in poor health.

Ethnic variation in self-assessed general health and non-communicable diseases risk factors

We used the latest available 2022 data from the Health Survey for England (HSE),⁵⁵ which is a cross-sectional survey undertaken by around 8,000 adults annually to monitor trends in health conditions and health behaviours of adults and children in England. We used this data to examine self-reported health status and identify key long-term conditions and behavioural risk factors linked to health outcomes: overweight/obesity, physical activity, hypertension, diabetes. Although responses may be influenced by factors such as culture, environment and people's expectations, the data is valuable in estimating variation in health outcomes and their determinants, which can provide useful information for policy development.

Due to inadequate representation of individual ethnic groups in this dataset, we could only categorise ethnicity into two broad groups: White women and non-White minority ethnic women (combining Asian, Black, Mixed/multiple ethnic and other ethnic background). Although this was not a preferred approach, we felt it would provide some broad-brush indication of difference between White and non-

Figure 2.5. ONS 2021 census population proportion by ethnicity for North and South regions⁵²



White women, which would then require further investigation. For regional focus, we present results for the northern regions combined (North West, North East and Yorkshire and Humber), compared with the South of England (South East, South West and East of England) to enable some useful regional and ethnic comparisons. London was separated out from the southern region analysis because it is a demographic outlier, and its inclusion could mask intraregional variation. Due to small sample sizes, results presented should be interpreted cautiously.

Self-assessed general health

Descriptive analysis of the data revealed a broadly similar self-reported health metric between White and non-White groups in the North. However, a higher proportion of non-White females in the North were experiencing poor health (6%) and were living with limiting long-term illness (18.1%) when compared to the South (Figures 2.6 and 2.7).

Non-communicable disease (NCD) risk factors

The results of a high-level analysis of key clinical risk factors and chronic health conditions among minority ethnic women in North and South England using HSE 2022 data are shown in Figure 2.8. These included prevalence of obesity/overweight, participation in moderate/vigorous intensity physical activity for at least 30 minutes per week, hypertension and diabetes (including undiagnosed cases identified via HbA1c ≥48mmol/mol in blood samples). These conditions are collectively associated with increased risk of cardiovascular disease, stroke, renal disease, some cancers, and poorer mental health outcomes. Data on cigarette smoking and alcohol consumption was incomplete across ethnic and regional categories and were therefore excluded from the analysis.

Across all four conditions, the North showed higher prevalence among non-White women relative to the South, though the picture varied by condition. For hypertension and diabetes, prevalence among non-White women in the North was broadly similar to White women in the same region (hypertension: 4% vs 4.4%; diabetes: 10.5% vs 10.6%), but notably higher than non-White women in the South (hypertension: 2.3%; diabetes: 7.4%). Obesity showed a clearer ethnic gap within the North, with non-White women reporting higher prevalence (64.5%) than White women (58.2%). However, non-White women in the North reported higher participation in physical activity than White women, a counterintuitive finding given the elevated rates of obesity in the same group, highlighting the complexity of the relationship between self-reported activity levels and health outcomes.

The need for culturally tailored interventions for maximised effectiveness

Contributing factors to ethnic inequalities in diabetes and CVD incidence and mortality are fundamentally complex as there is an interplay of factors to consider. These comprise deprivation, behavioural/lifestyle factors, access to healthcare service, genetic, environmental, psychosocial, and cultural factors.⁵⁶ These chronic conditions are further aggravated by economic crisis and social inequalities implying a dire need for appropriately adapted preventative interventions that target specific barriers that may be faced by minority ethnic women and which impact on their health and wellbeing. Global and national guidance recognise the importance of preventing chronic diseases and recommend limiting energy intake from total fats; increasing intake of fruit and vegetables, whole grains and nuts; and limiting simple sugars and salt. The importance of physical activity is also recognised.

Patel et al. acknowledged the role of lifestyle changes through effective lifestyle interventions which can be maximised in minority ethnic groups by engaging with women from minority ethnic groups to identify and understand the barriers and facilitators to healthy lifestyle changes.⁵⁷ These would be particularly helpful in addressing the higher likelihood of cardiovascular disease in non-White women in the North observed in our analysis. However, addressing these inequalities requires integrated and culturally adapted strategies that

Figure 2.6. HSE 2022 Self assessed general health (females)



Figure 2.7. HSE 2022 Limiting long-lasting illness (females)

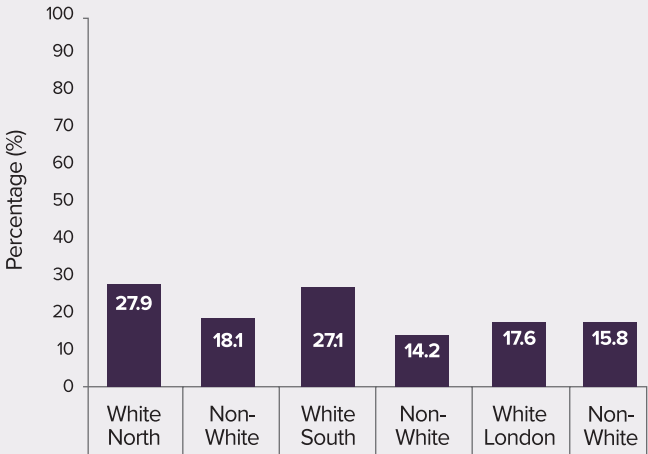
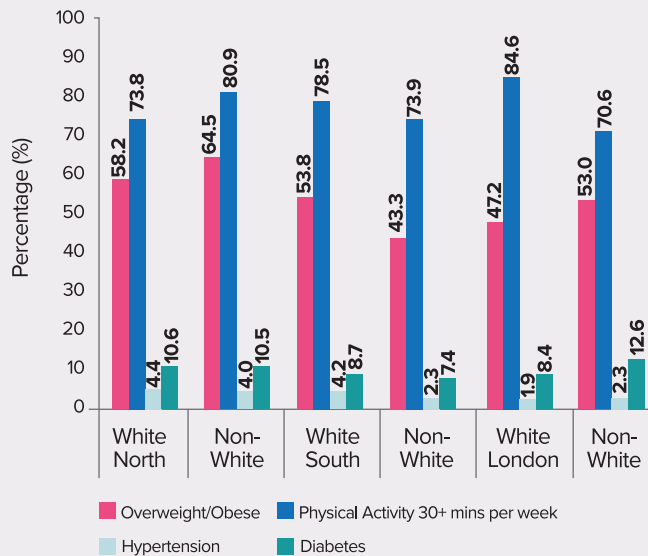


Figure 2.8. HSE prevalence of non-communicable disease risk factors among women by ethnicity and region



go beyond individual risk factors to tackle the upstream underlying social and environmental determinants of health and to target the specific barriers faced by minority ethnic groups.⁵⁸

Box 2.1. Black African and Caribbean Women's experience of breast cancer survivorship and structural inequality

Author Omolade Allen, Senior Lecturer in Global Health Research at the University of Manchester

Findings from an NIHR-funded project led by Dr Omolade Allen on the role of mosques and churches in the experience of Black African and Caribbean women living with and beyond breast cancer in Greater Manchester illustrate how structural inequalities continue after treatment ends.

Women reported receiving excellent care through their GPs and the Breast Cancer Care Pathway. However, they also described anxiety, panic attacks, fear of recurrence, financial strain, immigration status uncertainty, disruption to employment, and concern about the impact of illness on family members.

For some women, their churches and mosques became an important source of support during this period. These organisations provided prayer, pastoral care, visits, meal preparation, transport to appointments, and opportunities to speak with others who had experienced breast cancer. Peer relationships within faith communities were particularly valuable, with survivors acting as informal “buddy navigators” who helped women interpret medical information, manage fear, and feel less alone. This reflects the tenets of Social Support Theory,⁵⁹ which emphasises the importance of emotional, informational, and practical support, and of Social Capital Theory,⁶⁰ which highlights the value of trust, networks, and reciprocity in accessing resources.

However, this support was not universal. Women who had weaker connections to faith communities, were newer members, or experienced stigma around cancer often received less support. The protective role of faith-based organisations, therefore, depended heavily on the strength of existing social ties and the inclusiveness of the group.⁶¹

Recommendations

1. Preventative interventions for diabetes, cardiovascular disease and respiratory conditions should be culturally adapted and co-designed with minority ethnic women to identify and address the specific barriers they face.
2. Targeted campaigns should be developed to increase uptake of cancer screening programmes among minority ethnic women, including reinforcing that mammograms are performed by female staff, raising awareness of NHS interpretation and translation services, and involving community members in developing accessible information materials.
3. Uptake of NHS Health Checks and the NHS Diabetes Prevention Programme among minority ethnic women should be monitored and actively promoted, with targeted outreach to reduce the risk of cardiovascular disease and diabetes going undetected in this group.
4. Active participation by minority ethnic women in national health surveys and research should be encouraged and facilitated, to address the substantial gaps in sample sizes that currently limit the ability to analyse health data by region, ethnicity and gender simultaneously.
5. Disaggregated health data by region, gender and ethnicity should be made more readily available to enable accurate assessment of health needs, support evidence-informed planning and improve the commissioning of targeted services for minority ethnic women in the North.



Women from minority ethnic groups and mental health

Authors Jordan Mullard, Ghazala Mir, Amina Razak, Ola Demkowicz, Nasima Akhter, Donna Franklin

Summary

- The North of England reports higher rates of mental ill-health than many southern areas, particularly among women.
- There are ethnic variations in prevalence of severe mental health conditions and mixed evidence for variation in common mental health conditions, but data quality and ethnic categorisation hinder deeper exploration of these inequalities.
- Targeted intersectional research by ethnicity, gender and place is needed to understand the important differences, experiences and needs of various ethnic populations.
- Racial discrimination is a key cause of poor mental health outcomes for minority ethnic women. Other factors are deprivation, social and cultural stigma, lack of awareness of mental health issues and difficulties navigating treatment pathways.
- Significant ethnic inequalities exist in the receipt of treatment for mental health problems. Barriers to accessing mental health care, together with late diagnosis, delay treatment for people from minority ethnic groups.
- Minority ethnic groups, particularly those of Black ethnicity, tend to experience more severe treatment pathways and higher rates of detention under the Mental Health Act, alongside additional stressors including racialised violence and hate crime.
- Voluntary, community, and social enterprise (VCSE) organisations play a critical role in developing and providing culturally sensitive mental health care for minority ethnic women, despite remaining chronically underfunded and under pressure from increasing demands.
- Data on the mental health of minority ethnic women in the North remains limited, making it difficult to understand the important differences, experiences and needs of various ethnic populations: targeted intersectional research by ethnicity, gender and place is needed.
- Culturally adapted mental health interventions are more effective than standard approaches for women from minority ethnic communities and can be delivered by both mainstream and voluntary sector services.

Context

The social, economic and environmental determinants of health are well established and documented. The NHS 10 Year Health Plan's proposed shift towards community mental health provision reflects a growing recognition that mental health and wellbeing are shaped and determined by wider societal and structural conditions.³³ To support the gradual movement of care from hospitals into communities the NHS is piloting six neighbourhood mental health hubs bringing together integrated crisis care, home treatment, early intervention, rehabilitation, community, and inpatient care. Of these, three are in the North of England in recognition of higher need.³³

⁶² These regional inequalities reflect how ethnicity, gender, and social determinants of health, such as employment and deprivation intersect.⁶³

The scale of the problem

Nationally, women are more likely than men to have a common mental health condition, such as depression, generalised anxiety disorder, panic disorder, phobias and obsessive compulsive disorder. The nationally representative NHS Digital Adult Psychiatric Morbidity Survey covering 2023/24 found that 24.2% of women and 15.4% of men were identified with a common mental health condition in the past week.⁶³ Specific conditions that were more common in women than men were generalised anxiety disorder (8.9% in women compared with 5.7% in men) and depression (4.5% in women compared with 3.1% in men).

Mental health by region

From a regional perspective (Figure 3.1a), the survey found that the North East had a much higher prevalence of common mental health conditions compared to the South East or South West (24.6% vs. 16.3% and 18.7%, respectively).⁶³ It also found that the lifetime prevalence of suicidal thoughts among women living in the North East (31.7%) was the highest of any English region, above both the range for other regions (22.9%- 31.2%) and the England average (25.9%) (Figure 3.1b). Similarly, when the prevalence of lifetime suicide attempts for women was compared across regions, it was second highest in the North East. The likelihood of having a common mental health condition is also associated with deprivation: those living in the most deprived areas of England are more than twice as likely to be in contact with mental health services as those in the least deprived areas.⁶⁴

The COVID-19 pandemic caused an increase in mental health challenges for many, however a larger deterioration in mental health (assessed by General Health Questionnaire – GHQ12 scores) was seen for those living in the North.⁶⁵ Between 2019 and September 2021, the decline in average GHQ12 scores was larger for northern regions (average decline in the North: 0.5 points; the rest of England: 0.3 points).

Mental health and ethnicity

The COVID-19 pandemic also had a greater deteriorating impact on mental health of minority ethnic women. Minority ethnic women living in the North faced heightened mental health challenges throughout the pandemic, and their mental health scores were on average 4% lower than those of minority ethnic women living in the rest of England.⁶⁵

Findings on the prevalence of common mental health conditions in different minority ethnic groups are mixed. We note that small sample size and limited geographical representation make it difficult to analyse such differences adequately. The NHS Digital Adult Psychiatric Morbidity Survey covering 2023/24 found no statistically significant ethnic variation in prevalence of common mental health conditions in women (Figure 3.2).⁶³ In contrast, the 2007 Adult Psychiatric Morbidity Survey reported that, after standardising for age, South Asian women had significantly higher prevalence of common mental health conditions compared with White women (a grouping

comprising White British and White other categories).⁶⁶ Another study found that in women aged 55-74 years, the prevalence of common mental health conditions was significantly higher among Indian and Pakistani women, lower among Bangladeshi women, and did not vary significantly for Black Caribbean women compared with White women.⁶⁷

When both sexes are considered, Ahmad et al.⁶⁸ observed that differences in prevalence of common mental health disorders were attenuated when demographic and socioeconomic factors were accounted for. A study attempting to decompose gender and ethnic inequalities suggests that the impact of socioeconomic conditions may vary for minority ethnic women and that they may also have higher socioeconomic adversity.⁶⁹ When assessed using the SF-12 Mental component summary (SF-12 MCS), an indicator of general psychological functional wellbeing, this study found that minority ethnic women had a significantly lower (1.83 units lower) mental health score than White women. Using the GHQ-12 score – an indicator of psychological distress, with higher score indicating higher distress – the score for minority ethnic women was 0.81 points higher than for White women. The gap in mental health was explained by age, home ownership, marital status, and neighbourhood cohesion, with neighbourhood cohesion and experience of discrimination having a larger influence. The role of education was less a protective factor for functional wellbeing, but it reduced distress better. The role of home ownership was opposite, home ownership protected functional wellbeing but had a less prominent role in reducing distress (GHQ-12). Neighbourhood cohesion also showed a large protective role for reducing distress.

In relation to severe mental health conditions, the Adult mental health and wellbeing profile (April 2026)⁷⁰ observed that the prevalence of severe mental health conditions and Schizophrenia was particularly high for those of Black ethnicity, though a breakdown by sex was not available in this report (Figure 3.3). Higher ethnic density may act as a protective factor to reduce the risk of early death among ethnic minority people with severe mental illness. A study by Munshi et al reported that in areas with more people from the same ethnic minority group, people with severe mental illness had a lower risk of death compared with White British people with severe mental illness.⁷¹ This may be because higher ethnic density can provide greater social support, reduce loneliness, and encourage healthier behaviours. A systematic review by Halvorsrud et al also reported significant ethnic inequalities, as well as data disaggregated by sex.⁷² Compared to White women, minority ethnic women had significantly higher relative risk of being diagnosed with psychoses, for both affective psychoses (occurring with mood disturbances such as depression) and non-affective psychoses (occurring independently of mood disturbance). Black African women had the highest risk of being diagnosed, with significant differences also found for Black Caribbean, Mixed, White other and South Asian women compared to White women (Table 3.1). However, data were not available to examine how ethnicity and region intersect in this context.

Access to mental health care for minority ethnic groups

Studies have consistently reported a delay in access to treatment by minority ethnic groups, attributed to a range of factors including the lack of acceptance and conceptualisation of mental health among these groups. Stepanova et al.⁷³ highlighted that minority ethnic men and women tend to access mental health support when the condition has deteriorated, with a cultural lack of conceptualisation of mental health often causing prolonged suffering in silence. Cultural stigma, fear of discrimination, lack of information on how to seek support or limited availability of culturally sensitive support, and preference for community-initiated support act as barriers in seeking mental health care. Many are also uncomfortable seeking support from a provider from the same ethnic background fearing a breach of confidentiality, and because mental health is not widely recognised by the community.

Figure 3.1a. Percentage of adults identified with a common mental health condition in the past week by region;

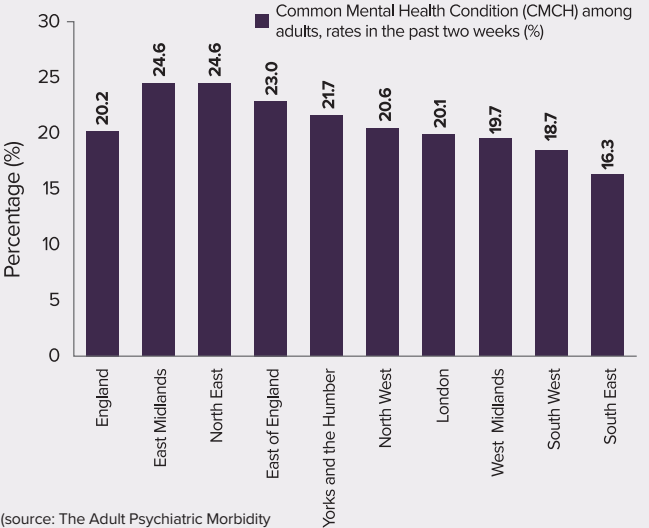


Figure 3.1b. Percentage of women with suicidal thoughts and suicide attempts over their lifetime by region

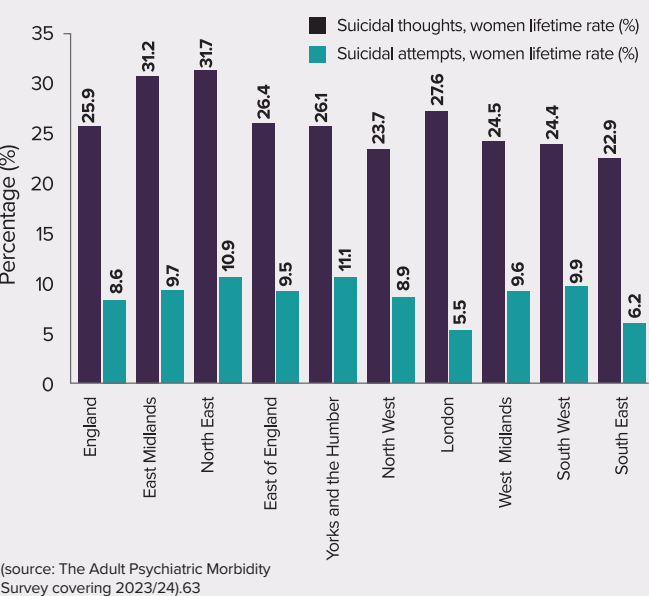


Figure 3.2. Percentage of women identified with a common mental health condition (CMHC) in the past week by ethnicity (source: The Adult Psychiatric Morbidity Survey covering 2023/24).⁶³

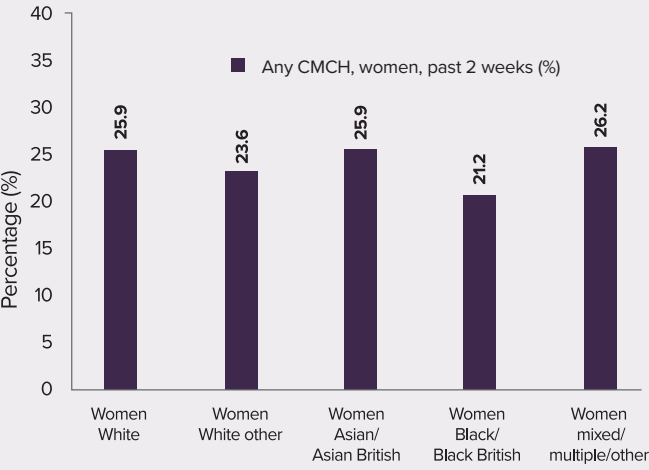


Figure 3.4 shows that in 2014, receipt of treatment for men and women was significantly lower among Black, Asian, and ‘White Other’ ethnicities, compared to the White British group.⁶⁸ This finding was consistent across two models, the first adjusted for age, gender, and interaction of ethnicity and survey year, the second additionally adjusted for socio-demographic factors (marital status, education, tenure, social class, and survey year), indicating that treatment inequalities were not explained by socioeconomic differences. This analysis was not done separately for women.

The intersections of race, ethnicity, religion and culture

Identity-based discrimination is increasingly recognised as a major driver of mental health inequality,⁷⁵⁻⁷⁸ with minority ethnic communities often experiencing more severe pathways into care, psychiatric diagnoses and treatment. For example, those from minority ethnic groups and migrants are more likely to access mental health services through compulsory admission to hospital under the Mental Health Act,⁷⁹ with individuals from African and Caribbean heritages being disproportionately diagnosed with high rates of schizophrenia and subjected to compulsory hospitalisation.⁸⁰

Racial discrimination experienced by women as a determinant of mental health is far reaching and exacerbated by threats of racialised violence. In 2023–24, police recorded over 140,000 hate crimes in England and Wales, with 42% involving violence. Nearly one in six people from minority ethnic communities reported experiencing racist physical assault.⁸¹ The 2024 far-right riots targeting asylum seekers and refugees further increased emotional strain among racially minoritised communities and many women bore the brunt of that strain with self-imposed curfews and concern over the welfare of children.⁸²

Data capture on ethnicity and gender in the North of England remains limited, making it difficult to assess the mental health experiences of minority ethnic women accurately. Racial discrimination, language barriers, economic inequality, lack of knowledge of services, and mistrust of services continue to shape poor access to care across a range of mental health conditions.⁸⁰⁻⁸³ Cultural stigma, experience of service use, acculturation, and gendered aspects of mental health influenced by prevailing patriarchal culture for minority ethnic group can also shape their help-seeking behaviour.⁸⁴ People from minority ethnic groups also reported that limited understanding of religious

Table 3.1. Ethnic variation in women being diagnosed with non-affective and affective psychoses⁷²

Ethnicity	Relative risk of diagnosis of non-affective psychoses (95% Confidence intervals)	Relative risk for diagnosis of affective psychoses (95% Confidence intervals)
White women (reference group)		
Black African	5.76 (3.59 – 9.25)	4.90 (1.81 – 13.27)
Black Caribbean	4.57 (2.99 – 6.99)	2.29 (0.90 – 5.80)
South Asian	2.41 (1.63 – 3.58)	1.50 (0.20 – 11.07)
White others	2.81 (2.01 – 3.94)	1.40 (0.91 – 2.14)
Mixed	4.08 (1.57 – 10.63)	3.39 (1.29 – 9.49)

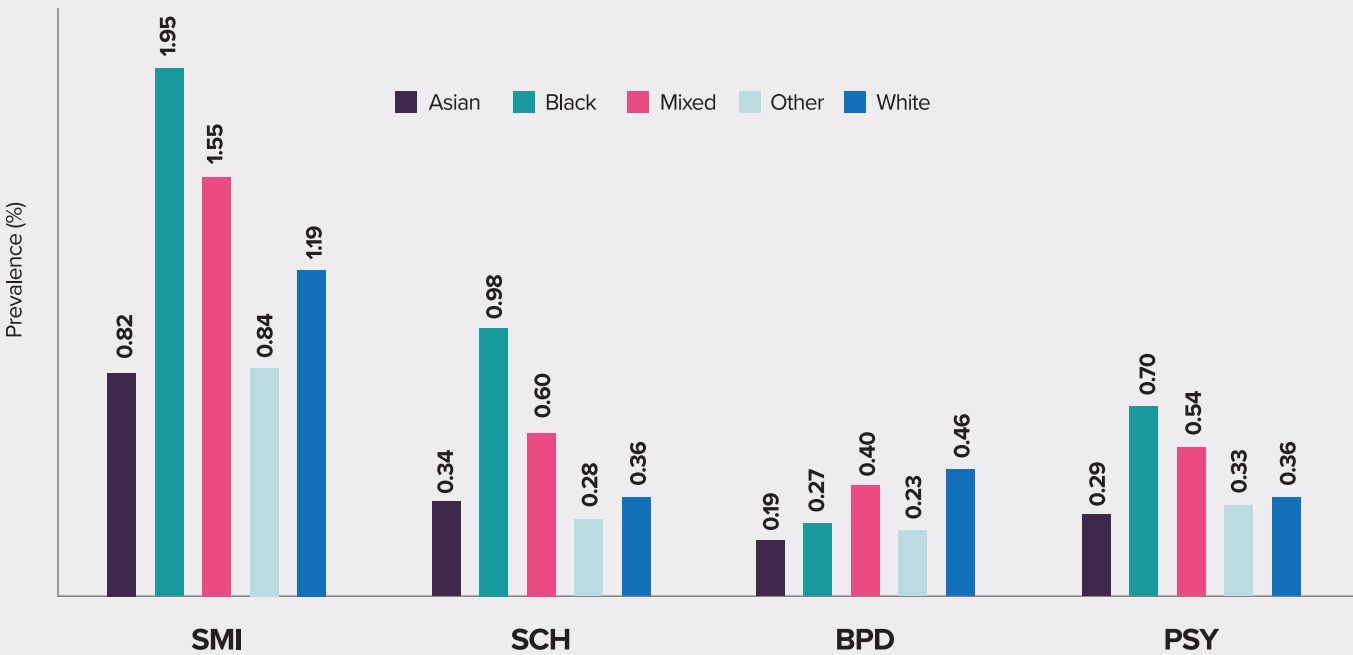
or cultural views of mental health among health professionals acts as a barrier to using available mental health services. A 2024 study gathering perspectives of minority ethnic women service users suggested that awareness of cultural differences among service providers, reduced waiting times, an ethnically diverse workforce, flexible service offerings, and provision of outreach services can improve service experience for this group. There were mixed views regarding ethnic or cultural matching as a patient-provider equity strategy, but those with negative experience with males preferred engaging with a female therapist.¹²

The role of the voluntary, community, and social enterprise sector in mental health support

The VCSE sector has long been addressing discrimination and its impacts on mental wellbeing. With an established presence, they can be a vehicle to reach proactively into communities to promote awareness of mental health issues and dispel stigma. However, this work remains underfunded. Rising demands, funding pressures and changing policy priorities have reduced the sector’s capacity despite its importance for marginalised communities.¹⁹

VCSE organisations often provide more culturally trusted support than mainstream services for minority ethnic communities, with particular strengths including the ability to incorporate cultural and linguistic expressions and experiences of mental health, and to handle fears

Figure 3.3. Percentage of severe mental illnesses by condition groups* by ethnicity (source: Adult mental health and wellbeing profile: April 2026 update).



*SMI: severe mental health illness; SCH: schizophrenia; BPD: bipolar disorder; PSY: other psychosis

of racism and discrimination.^{80 85 86} In addition, these community organisations are often first responders to these experiences and how they are made sense of, handling fears regarding perceived racism and discrimination.^{86 87} VCSE organisations frequently provide peer support, safe women-only spaces and informal wellbeing activities that mainstream services are less likely to offer.⁸⁸⁻⁹⁰ Culture plays a key role in enhancing utilisation of mental health services among minority ethnic groups in the UK, and tailored service with circumstantial understanding of culture can thus be beneficial.⁸⁶ For example, research on culturally adapted therapy for Muslims with depression, who have the worst access to services and treatment outcomes of all minority faith groups,⁹² showed that religion was an important resource for health for many Muslims and should be accepted as a legitimate value framework. Collaboration between primary care and VCSE organisations improved antiracist practice in primary care as well as engagement and outcomes in both sectors for service users, most of whom were women. VCSE staff achieved outcomes comparable to NHS therapists when provided with adequate supervision and resources. However, current national performance measures do not adequately support this type of partnership working.^{77 78 87 91}

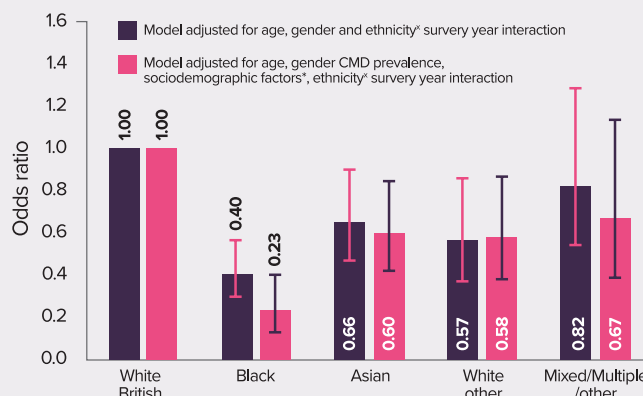
Refugees and asylum seekers often experience intersecting trauma before and after migration, alongside housing insecurity, poverty, isolation and discrimination.⁹² Women may additionally face gender-based violence, language barriers and poorer physical health. This group may face additional challenges in accessing services due to their experience of complex trauma, further aggravated by language barriers and limited availability of interpreters, health professionals not being fully aware of regulations and service entitlements for this group, and the overall hostile political environment.⁹² The U-CARE project aims to understand what aspects of asylum seeker and refugee peer support delivered by VCSE organisations work to prevent mental health problems.⁹³ Provisional findings from U-CARE suggest that, for some, women-only spaces can reduce exclusion through shared lived experience. These spaces provide access to support and guidance, enable self-expression, and strengthen confidence, belonging and resilience. Female sanctuary-seeking research participants, VCSE leads and Local Authority representatives suggest that mixed-gender groups may have the potential to reproduce existing gender hierarchies which restrict female engagement and equal participation. However, funding instability threatens continued access to these culturally sensitive forms of support.^{88 89}

A race equity and accountability framework for mental health

Responding to the longstanding challenges of mental health service provision experienced by minority ethnic communities in the UK, the recently launched Patient and Carer Race Equality Framework (PCREF)²⁴ attempts to improve the access and experience of racialised and minority populations within the mental health statutory services. As NHS England's first race equity and accountability framework, PCREF is an anti-racist organisational competence requirement that mandates for a seismic shift for demonstrable race equality and collaboration between services and voluntary and community (VCSE) organisations who are often the forefront responders to mental health crises in the community. Launched nationally in November 2023 across all mental health trusts in England, and made mandatory from April 2025, PCREF is now a statutory requirement of Care Quality Commission (CQC) inspection criteria. Through the implementation of its three-parts components : representative leadership; organisational competence and the creation of feedback accountability mechanisms, the framework seeks to strengthen inclusion and partnership working.

It is now a requirement for all mental health trusts to produce and operationalise a PCREF Plan, and to plan and develop actions in collaboration with communities served. Through such efforts, trusts are expected to forge towards stronger relationships with the populations that they serve. With gradual implementation, PCREF aims to challenge the historical mistrust that has existed between communities and mental health providers, which can then improve

Figure 3.4. Treatment inequalities by ethnicity, represented by the Odds ratio where 1 = same as White British women and <1 indicates lower receipt of treatment.⁷⁴



local capacity for knowledge-informed pathways and help-seeking behaviour, and the sharing of culturally appropriate information aiding better mental health outcomes.

As a PCREF early adopter, the Sheffield Health Partnership Trust has collaborated with the Sheffield Pakistani Muslim community to develop a community-based mental health reintegration project called 'The Being There Project'. Through embedding cultural knowledge within clinical teams via advocacy workers, they provide a culturally-appropriate wrap-around discharge and re-integration service for those leaving statutory care to receive care at the community level. Prioritising the cultural needs of often underserved Muslim families, the women involved are supported and empowered to navigate the cultural dynamics and emotional challenges that often impact the transition of care from in-patient back into the community.

Recommendations

1. Ethnicity and gender data need to be collected consistently across mental health services and national databases to enable better monitoring of inequalities and inform targeted action.
2. Culturally sensitive and anti-racist pathways into better mental health care need to be developed and incorporated as part of routine care. Community level awareness raising sessions and outreach through safe spaces, such as women's groups, are needed to address stigma, fear, and such barriers to seeking care.
3. Healthcare providers must now include cultural competency training as part of their service development and provide Patient and Carer Race Equality Framework plans. We must ensure that these plans are effectively implemented to improve patient-provider communication and experiences and thereby improve uptake and adherence to mental health treatment among minority ethnic populations.
4. NHS, social care, and VCSE services should be formally integrated to reduce fragmentation and improve access for minority ethnic women.
5. VCSE organisations should be recognised and resourced as important access points for communities, acknowledging the cultural knowledge and trusted role they provide in delivering safer mental health care.
6. Sustainable, long-term funding models for community-led mental health provision that influences mainstream care should be established, protecting and promoting services that are disproportionately relied upon by minority ethnic women.

Centring women's experiences of maternity care in the North of England to address inequalities

Authors Judith Rankin, Maria Raisa Jessica Aquino, Kerry Brennan-Tovey, Ania Couchinho, Nicola Heslehurst, Gina Nguyen, Caitlin Thompson

Summary

- Listening to women's voices is essential to understanding and addressing inequalities in maternity care. Although this principle is widely acknowledged and prioritised in the Women's Health Strategy, it is rarely acted upon meaningfully.
- Women from minoritised ethnicities in the North of England report experiences of racialisation within maternity services, where care is shaped by assumptions rather than their individual needs – insights that would be missed without actively seeking their perspectives.
- Practical barriers including financial hardship, transport difficulties and communication challenges significantly limit access to care, and women themselves are best placed to identify the solutions needed.
- Community networks and continuity of midwifery care were consistently valued by women as protective factors that formal services should seek to replicate and support, rather than allow to decline.
- Systemic change across institutional, professional and individual levels is needed to ensure equitable access to maternity services. Co-production with women from minority ethnic communities must be central to designing that change.

Background

Regional inequalities in maternal health are extensive and persistent, with mothers living in the North having worse outcomes than those living elsewhere in England. The North East of England has a higher prevalence of maternal obesity, preconception diabetes and history of gestational hypertension, compared to those in England (overall). These factors are all associated with poorer outcomes.

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK – set up to investigate the deaths of women and babies during or shortly after pregnancy – also consistently reports poorer maternal and infant outcomes for women from minoritised ethnicities.^{96 97} The scale and wider determinants of inequalities in pregnancy and early infant outcomes are discussed in detail in Chapter 5. Here we focus on listening to women's experiences of maternity and perinatal care to inform the changes needed.

The 2022 Women's Health Strategy for England aimed to improve how the health and care system listens to women's voices and to improve health outcomes for women and girls.³¹ This has been reinforced in the 2026 renewed strategy.³² Here, we center women's voices by presenting data from three qualitative studies exploring experiences of maternity care within the North of England, as case studies. Data were collected via one-to-one semi-structured interviews, audio-recorded and transcribed. For this chapter, we undertook a secondary analysis of the interviews with women from minority ethnic groups.

Case study 4.1. Black women living in the North's experiences of maternity care

Two participants described how they approached maternity care with anticipatory vigilance, informed by previous experiences of racialisation across predominantly White institutional settings. They felt that clinical encounters were shaped by racialised assumptions around Black women's physiology, risk, and capabilities, which constrained autonomy and limited meaningful consent. "Strength" was internally mobilised as a culturally grounded resource for resilience and self-advocacy; externally, within care practices, it was assumed to justify minimisation of need. Place-based dynamics were found to be important: where communities were small, more fragmented and isolating experiences were reported; in locations with denser communities, networks functioned as protective infrastructures, offsetting gaps in formal care. Participants commented on the dismissal or absence of engagement with cultural practices which, combined with age, migrant status, and racial identity, led them to interpret their care as shaped by racism. This was more pronounced in northern settings, where "buffering factors" such as greater diversity, cultural familiarity and pluralism, representation, and relational forms of care, were less commonly experienced.



Case study 4.2. Supporting Engagement with and Access to Maternity Services (SEAMS)

Interviews were conducted with ten women living on low income and from minoritised ethnicities living in Newcastle to explore barriers to accessing maternity care, as part of a larger study.⁹⁸ Women reported having to budget income to afford the essentials, while also planning for additional pregnancy-related costs including travel to appointments. Women with no recourse to public funds faced additional financial barriers. Travel difficulties were also identified: the financial burden and time needed for public transport left women reporting walking to appointments, and in one case, fainting on her way to an appointment. Some VCSE organisations provided free transport vouchers for women to assist them with attending appointments.

Some women reported not being provided with an initial booking appointment, while others reported waiting for extended periods at their appointment and subsequently feeling rushed during appointments by healthcare professionals. Women faced additional barriers with communication where English was not their first language. Some reported having had little experience with interpreters during appointments, while others reported not trusting interpreters.

Women required input and assistance from healthcare professionals to use and troubleshoot the app that gives women real-time access to their maternity records. Some women reported that the app never worked for them. However, for those where the app worked, women reported the benefits the app provided them, such as the ability to book appointments and receive reminders of upcoming appointments.

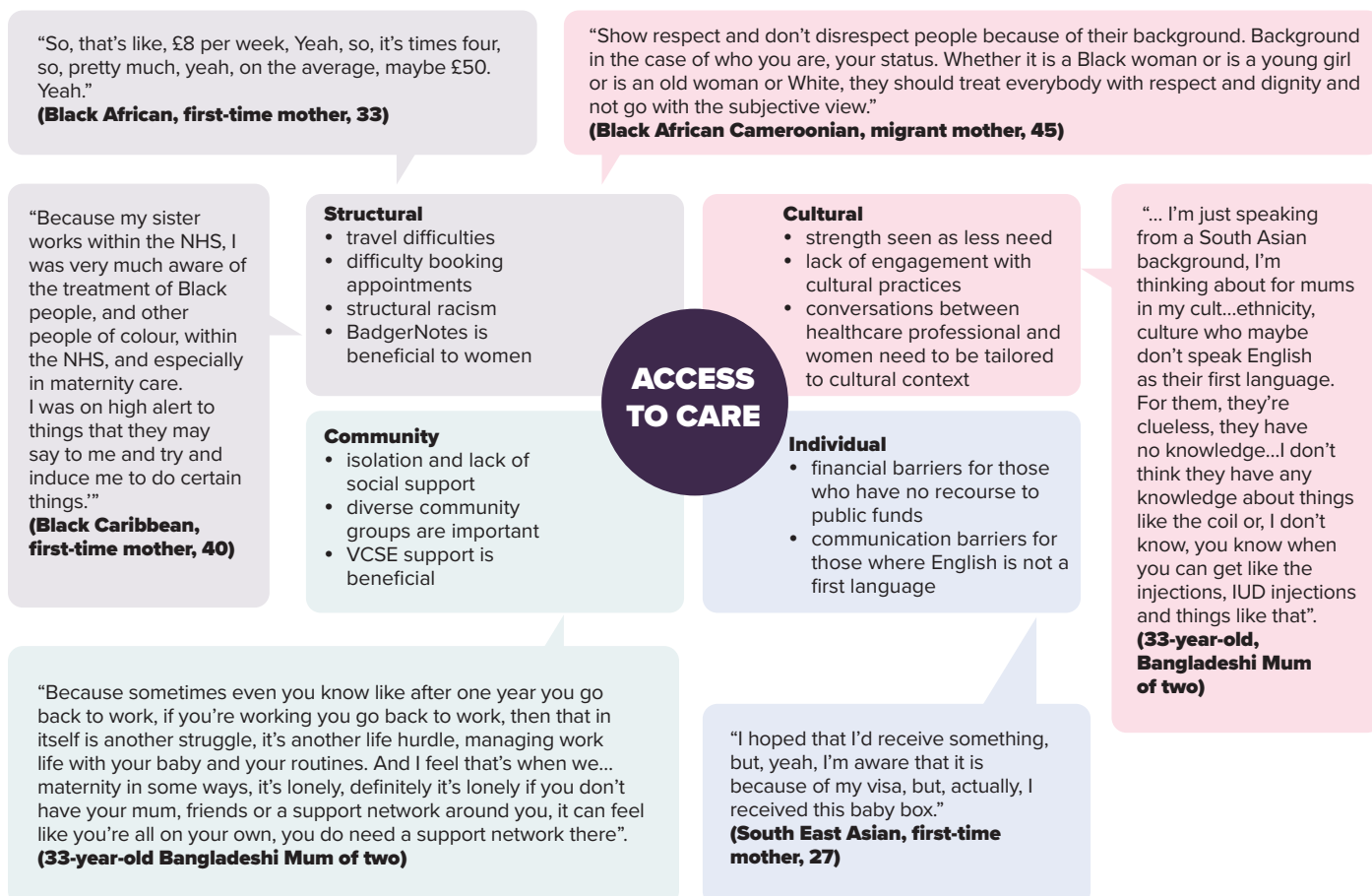
Case study 4.3. Evaluation of a public health prevention programme in maternity in the North East and North Cumbria

Seven women aged 28-36 from different minoritised ethnicities who had given birth between 2021 and 2024 shared their experiences of accessing care.⁹⁹ This evaluation focused on weight management, perinatal mental health, and postnatal contraception. Continuity of midwifery care was valued by women, as trust and rapport facilitated discussions about perinatal mental health.

Women, however, reported feeling an expectation to raise mental health concerns themselves, and often refrained from doing so due to feeling like a 'burden'. This impaired access to appropriate treatment and support. Women highlighted needing a family-centred, comprehensive perinatal mental health assessment, including long-term follow-up, especially for those with longstanding mental health diagnoses. The accessibility of diverse community social groups for pregnant and postpartum women was important for mental health and offered safe spaces for peers to discuss concerns and exchange advice.

Regarding postnatal contraception, participants felt that conversations needed to be tailored around family planning whilst respecting individuals' cultural context (e.g., religion, prior knowledge). Women felt that partners needed to be involved in conversations throughout the perinatal period. For weight management, women reported wanting information on accessible, free exercise groups/classes in the community. Weight was generally seen as a sensitive topic best managed through non-judgemental conversation.

Figure 4.1. Schematic summarising the experiences of women from minority ethnic groups living in the North when accessing maternity services



Discussion

Understanding and addressing the drivers of maternity inequalities is essential to breaking the cycle of inequality and to understanding why women from some groups do not access services. By presenting qualitative data from three case studies, we have centred women's voices and highlighted barriers and facilitators to accessing maternity care from their perspectives. The importance of listening to women's voices has often been highlighted, but is also often ignored. The findings presented in this chapter highlight common experiences, including: experiences of racialisation, the lack of engagement with cultural practices, the value of community, financial hardship, poor communication, and navigating technology (Figure 4.1, including illustrative quotes). To ensure equitable access to maternity services, changes are needed to address intersecting and complex challenges at the institutional, professional and individual levels so that women can more easily access services and that their experience when they do is optimal.

Recommendations

1. Further research is needed to capture women's experiences of all aspects of maternity care (preconception through to postnatal) and these voices should be heard and acted upon.
2. All statutory organisations should collect data on ethnicity using standardised ethnic group categories and make these data accessible to researchers.
3. Continuous cultural competency training should be offered to professionals working within maternity services so that an understanding and appreciation of the practices and values of people from different cultural backgrounds is achieved.
4. The NHS should fully support women to harness the digital shift in maternity care so they have access to, and are competent in, using maternity apps.
5. The government should give its full and forthright support to the Renewed Women's Health Strategy and enact the recommendations made in it.

Box 4.1. Healthcare providers' perspective – Dr Nicola Tempest MBChB PhD MRCOG; Senior Lecturer, Subspecialist in Reproductive Medicine and Consultant Gynaecologist, University of Liverpool and Liverpool Women's Hospital.

"From a consultant gynaecologist perspective, I see the barriers to timely care in sexual and reproductive health services created through the intersection of socioeconomic inequalities with ethnicity, migration status, language, and digital exclusion. Women with heavy menstrual bleeding, fibroids, endometriosis, recurrent miscarriage, infertility, or menopause symptoms often present later, after years of unmanaged symptoms. Delayed diagnosis of endometriosis remains a national challenge, but may be amplified where women struggle to advocate for themselves, cannot access transport, or prioritise family responsibilities over personal healthcare.¹⁰⁰ In some minority ethnic communities, menstruation, fertility, and pelvic pain remain culturally sensitive topics, leading to silence or normalisation of suffering.

"Fertility care is an increasingly important area of inequality. Access to NHS-funded IVF remains variable across England, with some regions reducing the number of funded cycles or applying restrictive eligibility criteria. This creates a postcode lottery in which women and couples in poorer communities, who are least able to self-fund treatment, are disproportionately disadvantaged. Those with financial means may pursue private treatment, while others remain involuntarily childless. Infertility is associated with significant psychological distress, relationship strain, reduced quality of life, and long-term consequences for mental wellbeing.¹⁰¹ A fair Women's Health Strategy should recognise fertility treatment as essential healthcare rather than optional care, and inequitable access risks widening existing North–South health divides.

"Language and cultural barriers are significant. Interpreting services are often reactive rather than proactive. In my view, women should be offered the opportunity to meet or speak with an interpreter before an appointment, allowing explanation of terminology, confidentiality, and process. This could reduce anxiety and increase disclosure of sensitive symptoms. Female interpreters should be routinely available for gynaecology, miscarriage, fertility, and sexual health consultations, as male interpreters may be unacceptable or inhibit discussion for some women.

"There is also a growing role for trusted public education. Many women obtain information through social media before they ever contact official services. However, misinformation is rife. Health professionals should engage more actively with evidence-based digital education using accessible language and culturally competent messaging. Clinician-led platforms, podcasts, and community-facing media, such as our podcast *Between2Ovaries*, can help normalise conversations around miscarriage, fibroids, painful periods, infertility, and menopause while signposting women to care. Clinicians need support and training to provide this highly sought-after information.

"Improving outcomes for women in the North requires services designed around real lives, real barriers, and fair access to reproductive choices."



Pregnancy outcomes and early infant health

Authors Samira Saberian, Natalie Gallagher and Oluwaseun B Esan

Summary

- Women and their babies from minority ethnic groups experience significantly higher rates of stillbirth, infant mortality and neonatal unit mortality than White women, and these inequalities are most pronounced in the North of England.
- Critical gaps in data collection by ethnicity and region limit the ability to monitor and address these inequalities effectively.
- Structural racism, inadequate anti-racist training, and inequities in care delivery contribute to poorer outcomes.
- Barriers to accessing timely and appropriate care, including language, staffing shortfalls, and lack of cultural competency, remain significant, particularly in northern networks.

Context

There are stark socioeconomic inequalities in pregnancy and early child health outcomes in the UK. Women and their babies living in the most deprived areas are at increased risk of stillbirth, neonatal and infant mortality. Data from MBRRACE-UK show that in 2024, stillbirth rates were higher in the most deprived compared to the least deprived areas (4.16 vs 2.19 per 1,000 births), whilst neonatal mortality rates were nearly double in the most deprived compared to the least deprived areas (2.14 vs 1.18 per 1,000 live births).⁹⁷ Similarly, women from minority ethnic groups are at a higher risk of maternal mortality, stillbirth and in-unit neonatal mortality.¹⁰²

Stillbirth rates for babies born to women of Black and Asian ethnicity have been continuously higher year on year between 2019 and 2023 compared to babies born to women of White ethnicity.⁹⁷ A study based on MBRRACE-UK data reported that if the rate of stillbirth for babies of other ethnicity were the same as those for White ethnicity there would have been 1,869 fewer stillbirths over the 6 years from 2014 to 2019: a 12% reduction in stillbirths.¹⁰³ In the latest MBRRACE-UK report on maternal deaths, the risk of maternal death was 2.27 times higher for women of Black ethnicity compared to women of White ethnicity between 2021 and 2023 (Relative risk; 95% Confidence interval [CI] 1.44-3.45).⁹⁶ Understanding the intersectional effects of these socioeconomic and ethnic inequalities is critical to ensuring that every woman has the best pregnancy outcomes.

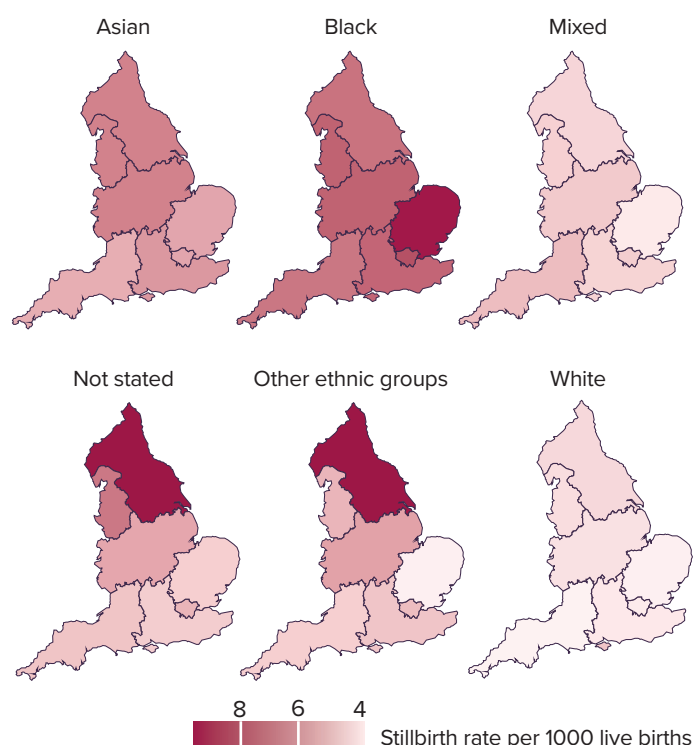
What does the latest data tell us about the North-South divide in pregnancy and infant outcomes in women from minority ethnic groups?

There are important gaps in the data available over the pregnancy and the perinatal period. We are unable to examine inequalities in losses in the first and second trimester, despite calls for improvement in data capture and the high proportion of pregnancies that are lost in the first trimester.¹⁰⁴ There is also a lack of available aggregated data by ethnicity and region. We present findings from the Office for National Statistics (ONS), which is the only open-source data available by region and ethnicity for infant outcomes between 2007 and 2019.¹⁰⁵ Subsequent ONS publications on infant outcomes only include a regional breakdown without ethnicity.

Stillbirths

Regardless of region, women from Asian and Black ethnic groups had high rates of stillbirth. There were 9.4 stillbirths per 1,000 live births for women of Black ethnicity in the East of England (95% CI 8.3-10.7) and 6.8 stillbirths per 1,000 live births for women of Asian ethnicity in the Midlands (95% CI 6.4-7.2). For women of White ethnicity in these regions, the stillbirth rate was 3.8 per 1,000 live births (95% CI 3.7-3.9) in East of England and 4.1 per 1,000 live births (95% CI 4.0-4.2) in the Midlands. Interestingly in the North East and Yorkshire, women who identified as being from another ethnic group or did not state their ethnic group had the highest rate of stillbirths (9.2 stillbirths per 1,000 live births [95% CI 8.0-10.6] for other ethnic group and 9.7 stillbirths per live 1,000 births [95% CI 8.5-10.9] for the 'not stated' group).

Figure 5.1. Heatmaps of stillbirth rates by region per ethnic group, 2007-2019. Data source: Office for National Statistics.¹⁰⁵



Infant mortality

Infants born to women from minority ethnic backgrounds had higher mortality rates than those born to White women across all regions. These rates were elevated further in Northern regions for women of Asian ethnicity (6.5 [95% CI 6.1-7.0] and 7.3 [95% CI 6.8-7.8] infant deaths per 1,000 live births in the North West, and North East and Yorkshire respectively), but less pronounced for other minority ethnic groups. For women of White ethnicity infant mortality rates were 3.7 (95% CI 3.6-3.9) and 3.6 (95% CI 3.4-3.7) per 1,000 live births in the North West, and North East and Yorkshire.

Neonatal unit mortality

Neonatal in-unit mortality also showed variation by ethnicity and region. For babies admitted to NHS neonatal units for neonatal care in England between 2012 and 2022, rates of in-unit mortality were higher in those admitted (defined as first admission) to neonatal networks across the North, and were the highest for babies born to women of Black and Asian ethnicity. In the North West, rates of in-unit mortality were 28.5 (95% CI 24.9-32.5) and 29.9 per 1,000 babies (95% CI 23.5-37.5) admitted for babies born to women of Asian and Black ethnicity, respectively. In the North East and Yorkshire (combination of neonatal networks), rates of in-unit mortality were 30.0 (95% CI 26.1-34.3) and 32.6 per 1,000 babies (95% CI 24.9-42.0) admitted for babies born to women of Asian and Black ethnicity, respectively. For babies born to women of White ethnicity, rates of in-unit mortality in the North West were 18.4 per 1,000 (95% CI 17.2-19.6) babies and 17.0 per 1,000 babies (95% CI 16.0-18.1) admitted in the North East and Yorkshire.

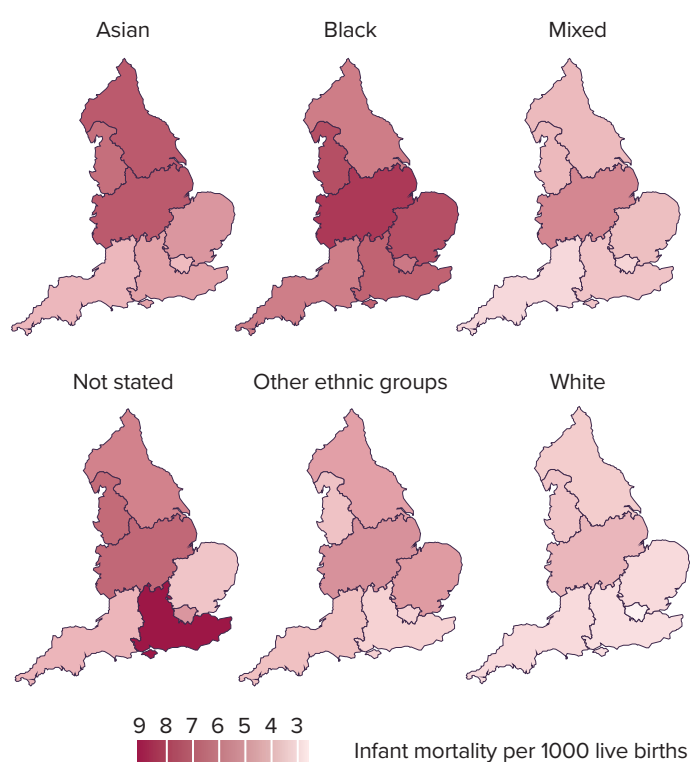
The wider determinants of inequalities in perinatal outcomes

Racism

Addressing ethnic inequalities in perinatal outcomes requires acknowledging the role of structural racism within the healthcare system. There is a lack of national anti-racist policies and implemented training around caring for a population of different skin colour and tones. New infographics on understanding how to recognise jaundice in babies of different skin tones were introduced by the NHS Race and Health Observatory in 2025.¹⁰⁷ As of 2025, all maternity services in England are using diverse skin tone mannequins.

NHS England has also funded some simulators in Black and Brown skin tones.¹⁰⁸ However, the neonatal resuscitation mannequins representing darker skin tones were comparatively limited in functionality and did not meet the same technical standard as the models routinely used in practice. Progress in this specific area is being made with increased ethnically diverse neonatal mannequins expected to be available this year. The recently launched Nursing and Midwifery Council anti-racism principles will now ensure anti-racism healthcare education is consistent across all institutions of the four constituent countries of the UK.¹⁰⁹

Figure 5.2. Heatmaps of infant mortality rates by region per ethnic group, 2007-2019. Data source: Office for National Statistics¹⁰⁵



Other policy initiatives include the need to prioritise women from minority ethnic backgrounds and those living in deprivation through Midwifery continuity of care models.¹¹⁰ These care models have been shown to provide culturally appropriate and individual-level antenatal care, improving engagement and reducing the rate of caesarean section.¹¹¹ However, a policy report in 2023 highlighted a decline in women from minority ethnic and deprived backgrounds receiving continuity of care.¹¹²

Intersectionality of ethnicity and deprivation

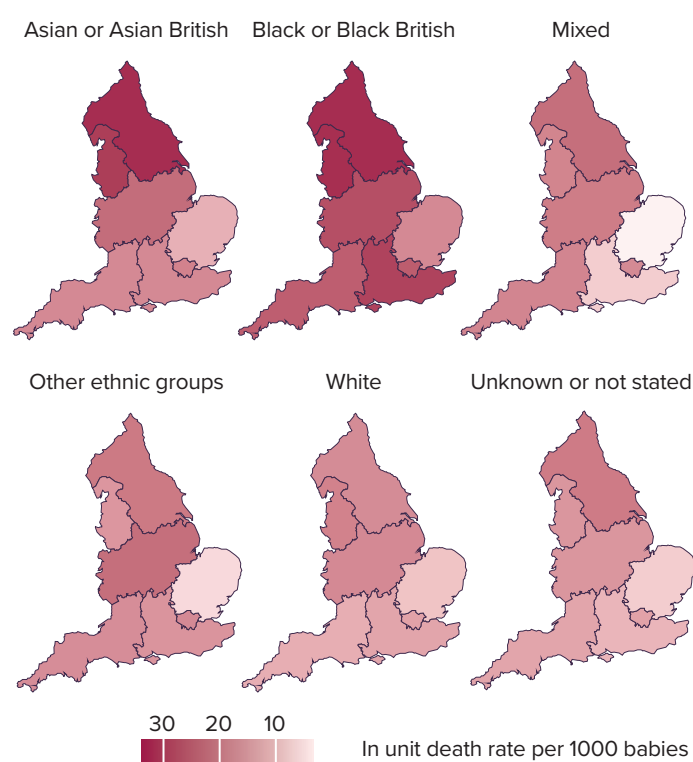
Intersectionality describes the cumulative disadvantage that may be generated for individuals with social identities that may overlap.¹¹³ For example, individuals from Pakistani, Bangladeshi and Black ethnicity were more likely to be living in the 10% most deprived neighbourhoods compared to individuals of White British background.⁴⁵ As a result, the disadvantages experienced by many minority ethnic women in England are interlinked, thus exacerbating inequalities.¹¹⁴

These inequalities are further compounded by geographical location. For example, the proportion of minority ethnic groups living in deprived areas in the Midlands was much higher than that of White ethnic groups, in the South the difference in the proportion living in deprived neighbourhoods between ethnic groups was less.¹¹⁵ Large inequalities in adverse outcomes such as stillbirths and preterm birth were found in Black and South Asian women in the most socioeconomically deprived areas in England,¹¹⁶ highlighting how ethnicity and deprivation interact to exacerbate risk of adverse perinatal outcomes.

Access to care and staffing

Women from minority ethnic groups may experience adversity and issues in accessing timely and appropriate care throughout their pregnancy and during the postnatal period. They are more likely to experience delayed access to antenatal care such as having their booking appointment after 10 weeks.¹¹⁷ Contributing factors include language barriers, lack of access to qualified interpreters, cultural differences and mistrust of health care professionals. The use of informal interpreters, such as male family members, may result in

Figure 5.3. Heatmaps of neonatal unit mortality rates by region per maternal ethnic group, 2012-2022. Data source: National Neonatal Research Database¹⁰⁶



important information being missed and not communicated.¹¹⁸

Differences in care provision have also been identified. Recent studies showed lower performance levels for key neonatal care optimisation measures in babies born to women from Black ethnicity. This included delayed cord clamping,¹¹⁹ and lack of parental inclusion on consultant ward rounds.¹²⁰ Reports from the National Neonatal Audit Programme (NNAP) indicated regional variations of key optimisation measures for preterm infants. The proportion of administrations of antenatal steroids to eligible mothers in 2024 was lower than the average for northern and Yorkshire Humber Networks. However, for the North West Neonatal Operational Delivery Network, this was higher than average. The proportion of shifts with sufficient nursing staff also varies greatly amongst networks in different regions. In the North West, the proportion of shifts sufficiently staffed was lower than the national average of 81.5%.¹¹⁹

Clustering of maternal risk factors and comorbidities

In addition, higher prevalence of certain maternal comorbidities, complex social factors, and congenital anomalies in women from minority ethnic groups¹⁰³ may further contribute to adverse outcomes, particularly where these intersect with deprivation and inequitable access¹¹⁹ to care. Data from a recent cohort study (SHAPES) of 1,425 pregnant women living in the North East (2022-2024),¹²¹ found that mothers from minority ethnic groups (Black, Asian, Mixed) were more likely to be living in the two most deprived quintiles. In addition, fewer Black (18.0%) and Asian (26.7%) mothers reported taking folic acid supplements prior to pregnancy compared with White mothers (34.2%), and were more likely than White mothers to be living with an overweight BMI. Family history of diabetes was higher for Asian (41.0%), Black (25.5%) and Mixed or other ethnic groups (23.3%) than White mothers (18.0%). All of these factors are known to influence pregnancy and infant outcomes. Gaps in the management of comorbidities and social factors disproportionately affect minority ethnic groups and may contribute to inequalities in perinatal outcomes.

Recommendations

1. Socioeconomic conditions before and during pregnancy should be addressed through targeted policy interventions to reduce the structural disadvantages faced by women from minority ethnic backgrounds.
2. Uptake of midwifery continuity of care should be increased, with priority given to women from minority ethnic and deprived backgrounds.
3. Maternity services should commit to addressing structural racism through dedicated resourcing and mandatory anti-racist training for all healthcare professionals.
4. Interventions to improve maternity outcomes for women from minority ethnic backgrounds should be co-produced with those communities to ensure they are culturally appropriate and effective.
5. Statutory organisations and NHS providers should identify and remove barriers to equitable and timely access to maternity care, including those related to language, finances, and transport.
6. Holistic, person-centred approaches should be adopted for women with complex social needs and comorbidities, recognising the compounding effects of ethnicity and deprivation.
7. Ethnicity data should be collected consistently by region and made available in publicly accessible datasets to enable better monitoring of inequalities.
8. The drivers of ethnic inequalities in preterm optimisation measures should be identified and targeted quality improvement interventions delivered to reduce disparities in neonatal care.



Regional ethnic inequalities in employment status

Authors Heather Brown, Koser Khan, Omotayo Joan Olajide, Luke Munford

Summary

- Minority ethnic women in the North of England face worse labour market outcomes than both White women and minority ethnic women elsewhere, despite more than 70 initiatives over the last decade to boost economic activity in these groups.
- Publicly available data enable regional comparison of employment, unemployment and economic inactivity for the broad categories of Asian and White women, however there is insufficient data for a full comparison with Black women, or to break down findings by specific ethnic groups.
- Informal and exploitative forms of work remain largely invisible in official labour market data, meaning current measures likely underestimate the economic activity of minority ethnic women and mask the true extent of workplace inequality.

Context

In 2017, the independent McGregor-Smith Review¹²² highlighted the disparities that minority ethnic groups faced in the labour market. Using data from between 2001-2011, the report clearly showed regional inequalities in unemployment by ethnicity. The highest rates of ethnic inequalities in unemployment were found in

- London (9% for minority ethnic groups compared to 4% for the majority ethnic group)
- the West Midlands (11% for minority ethnic groups compared to 5% for the majority ethnic group)
- the North West (9% for minority ethnic groups compared to 5% for majority ethnic groups).

However, this analysis was not separated by gender, which may mask additional inequalities.

Since the McGregor-Smith Review¹²² we have had the Covid-19 pandemic and the cost-of-living crisis, both of which have long-lasting negative impacts – particularly for those already facing disadvantages and living in deprived areas. We know that there are rising levels of economic inactivity, that there are still strong regional inequalities between the North and the rest of England in employment, unemployment and economic inactivity (see Box 6.1 for definitions of these terms). For example, the North East has the highest share of economically inactive 16-64 year olds, with 15% of this population not participating in the labour market. However, since these shocks to the labour market – which began at the start of the decade – there has been little exploration of if and how they have impacted on labour market participation of minority ethnic women. We address this gap, evaluating regional inequalities in labour market status by gender and ethnicity.

Research Question

What is the distribution of employment rates, unemployment rates and economic inactivity rates by ethnic group and geographical area for women in the UK?

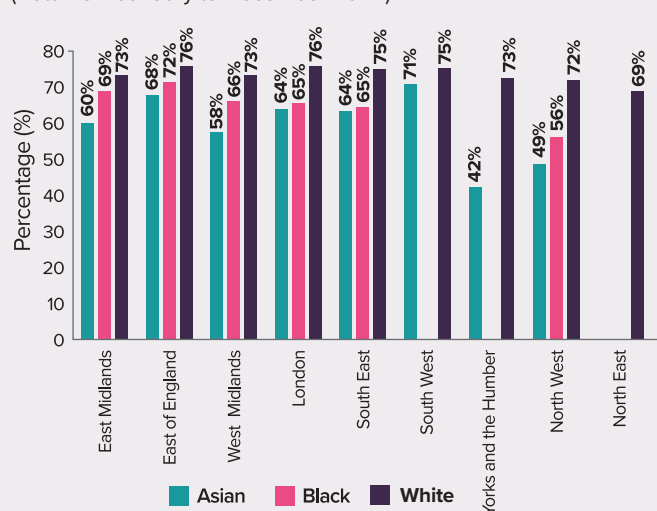
Methods

We used data from the Annual Population Survey ethnicity facts and figures from January 2022 to December 2022 – the most recent publicly available dataset.⁵ We categorised ethnicity according to the Office for National Statistics (ONS) five high-level ethnic groups: 1) White; 2) Asian/Asian British; 3) Black/Black British/Caribbean/African; 4) Mixed/Multiple ethnic groups; and 5) Other ethnic Groups. This means that some ethnic groups within these classifications such as Indian, Pakistani and Bangladeshi are combined. In addition, because of the small number of individuals, we do not report the regional labour market status for women of Mixed/Multiple and Other ethnic groups. Our analysis is thus restricted to the three combined ethnicity categories of: 1) Asian/Asian British; 2) Black/Black British/Caribbean/African; and 3) White. For categorisation by region, we used the ONS definition of the nine Government Office Regions of England: 1) East Midlands; 2) East of England; 3) West Midlands; 4) London; 5) South East; 6) South West; 7) Yorkshire and Humber; 8) North West; and 9) North East. For some regions (South West, Yorkshire and The Humber, and North East), even with the aggregation of the data some ethnicity categories cannot be reported due to insufficient numbers. We report a descriptive analysis in which we present the mean percentage of women of the three ethnic groups for each of the three employment outcomes by region in England.

Results

Across all regions of England, the employment rate for Black and Asian women is lower than for White women (Figure 6.1). Similarly, the employment rate for minority ethnic women living in the North of England is lower than that for the rest of England. Asian women living in Yorkshire and Humber have the lowest employment rate at 42%, whilst approximately 49% of Asian women and 56% of Black women living in the North West are employed. This compares to an average

Figure 6.1. Employment rate by ethnicity for women by region (Data from January to December 2022)⁵



employment rate across the rest of England of 64% for Asian women and 67.4% for Black women.

The regional pattern in women's unemployment rate by ethnic group is more complex (Figure 6.2). Yorkshire and Humber had the highest rate of unemployment for Asian women, at just over 14%, compared with approximately 2.5% for White women. The North West had unemployment rates of approximately 6% for Asian and Black women, which is higher than White women at approximately 3%. Unemployment rates for Asian women were lowest in the East of England at just under 2%, followed by the South East at 2.5%. Except for the East of England, in all regions where data is available unemployment for Asian women was higher than that of White women. As for unemployment, there is variation in economic inactivity rates by both ethnicity and geography. Across all regions, Asian women have the highest rates of economic inactivity, with 41% of those living in Yorkshire and Humber and 44% in the North West economically inactive (Figure 6.3). Black women living in the North West had economic inactivity rates of 36% which is similar to that in the West Midlands but higher than the rate in England overall.

Discussion

Summary of Findings

Descriptive analysis using data from the Annual Population Survey shows that geographical and ethnic variations in employment status persist after the Covid-19 pandemic. Minority ethnic women living in the North of England are more likely to be economically inactive or unemployed than either their White counterparts or women living in other parts of England.

Limitations

We are unable to demonstrate differences amongst specific Asian and Black ethnic groups due to the lack of data. However, it is well documented that variations exist within these groups, particularly for Pakistani and Bangladeshi populations who consistently show higher rates of unemployment compared to their White counterparts.¹²³
^{124 125} This indicates that Pakistani and Bangladeshi women may face multiple disadvantages in the labour market that warrant further exploration.¹²⁴ Future data collection must capture ethnicity adequately.

Implications for Policy and Practice

Over the past ten years the UK government has enacted many initiatives aiming to improve fairness in the workplace and boost employment of minority ethnic groups. Yet inequalities remain, raising the question of why these policy initiatives are not working. One key consideration is whether the interventions consider cultural norms in relation to employment interventions, particularly for minority ethnic women. Evidence indicates that some groups are less active in the labour market than others, and that cultural practices can influence participation. For example, Pakistani and Bangladeshi women are more likely to live with a partner and have dependent children, which may impact employment opportunities and access to suitable work.²² There is also evidence to suggest that women from minority ethnic communities may participate in unregulated forms of work such as homeworking and informal workplaces/organisations defined as 'sweatshops'.^{22 126} Such labour market participation, which in many cases is exploitative, compounds inequalities faced by minority ethnic women. Employment strategies need to look beyond narrow measures of labour participation to protect against exploitation and support more secure work routes for affected minority ethnic women.

Box 6.1. Definitions used in this chapter
Employment: in full or part-time work; Unemployment: not in work and actively looking for work; Economic inactivity: not actively looking for work including homemaking or long-term sickness or disability.

Figure 6.2. Unemployment rate by ethnicity for women by region (Data from January to December 2022)⁵

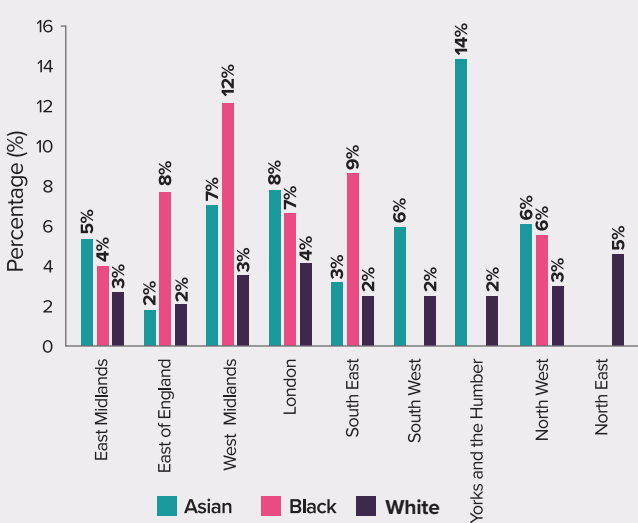
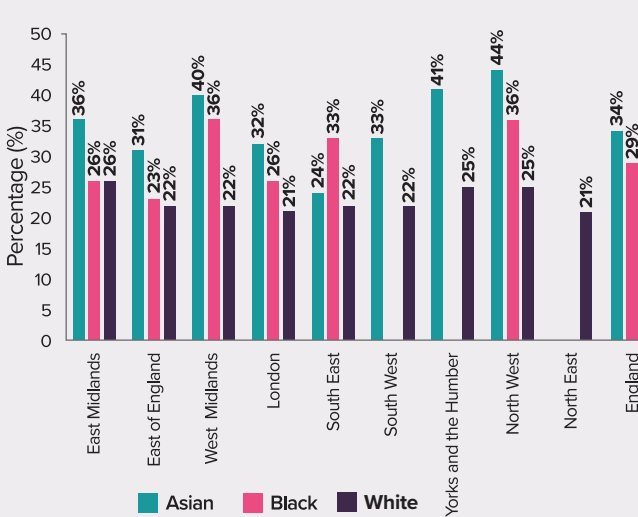


Figure 6.3. Economic inactivity rate by ethnicity for women by region (Data from January to December 2022)⁵



Recommendations

1. Employment initiatives should be co-designed with minority ethnic groups to be inclusive, recognising the role of caring responsibilities, household structures, and community norms in shaping employment decisions.
2. Definitions and measurement of labour market participation should be broadened to capture the economic contributions of women engaged in informal employment to prevent their exploitation.
3. Policy initiatives should support transitions from informal work into formal work for women who want to move into this pathway. This may include tailored skills training and recognition of prior learning in CVs.
4. Along with improved coordination between employment and childcare provision policy, affordable, culturally appropriate, and flexible childcare services should be developed to expand access to employment for minority ethnic women.
5. Community and voluntary organisations play a crucial role in reaching women unable to access traditional employment support. Sustained funding should be provided to these organisations to act as intermediaries, offering advice, signposting, and tailored employment support.
6. Ethnicity-disaggregated employment data should be published more rapidly and at a finer geographic and ethnic group level, to enable timely monitoring of regional inequalities and more responsive policymaking.

Ageing in the North: views from minority ethnic women

Authors Sophia D. Amenyah, Ellie Hayes, Audrey Verma

Summary

- This qualitative study of 14 older minority ethnic women living in the North East contributes towards closing a recognised evidence gap: the lack of disaggregated data on older adults from minority ethnic groups at the geographic level.
- Women in our study describe ageing as a period of continued agency and contribution, but encounter healthcare and public services that treat older people as passive and dependent.
- Participants hold complex, multi-layered relationships with the North East, valuing its affordability and pace of life while navigating a lack of diversity and a sense of regional underinvestment compared to the South.
- Women feel that community life has weakened over time, shifting from open neighbourly interaction towards reliance on organised groups; they have responded by actively building their own networks of belonging.
- Racism persists but has become subtler and more structural, and compounds with gender and age to produce specific vulnerabilities around safety for older minority ethnic women.

Context

Where we live shapes our physical and social environments, and in doing so profoundly influences our health and ageing. Addressing place-based inequalities in healthy ageing is a key UK public health priority.¹²⁷⁻¹²⁸ The recent Ageing in the North report demonstrated that older adults in northern England are more likely to live shorter lives and to be poorer, less healthy, less physically active, and more lonely than their counterparts elsewhere in England.¹²⁹ These disadvantages are further compounded for people from underserved communities, for example older adults from minority ethnic groups are 3.81 times more likely to experience loneliness than their White British peers.¹³⁰ Research with adults aged 55 and older has similarly found that health-related quality of life (HRQoL) was worse for men, for women, or for both in 15 of 17 minority ethnic groups (88.2%) compared with the White British ethnic group.¹³² A clear gap in the evidence base is the lack of disaggregated data on older adults from minority ethnic groups, particularly at the geographic level, owing to small sample sizes and the systematic exclusion of older adults from research.¹³² Addressing these gaps was identified as a key recommendation of the Ageing in the North report.¹²⁹

In response, we conducted a qualitative photo elicitation study to explore experiences of later life and understandings of ageing well among women from minority ethnic communities living in the North of England. Photo-elicitation is a qualitative research method that incorporates photographs into interviews to stimulate culturally relevant reflection and generate rich, narrative data.¹³³⁻¹³⁵ By anchoring the conversation in a visual medium, the technique bridges the gap between conventional verbal questioning and lived experience. In this study,¹⁴ purposively sampled participants recruited from African, Caribbean and South Asian communities were invited to select photographs that captured their experiences of ageing in the North of England, either using existing images or taking new photographs

Table 7.1. Demographic characteristics of participants (n = 14)

Variable	n (%), Mean (SD)
Sex	
Female	14 (100%)
Age	
Mean (SD), years	60.8 (13.1)
Ethnicity	
Bangladeshi	8 (57.1%)
Caribbean	4 (28.6%)
African	1 (7.1%)
Other Asian	1 (7.1%)
Marital Status	
Married	11 (78.6%)
Separated/Divorced	1 (7.1%)
Widowed	1 (7.1%)
Single	1 (7.1%)
Education	
No formal education	1 (7.1%)
Compulsory schooling	4 (28.6%)
Vocational training	3 (21.4%)
Undergraduate degree	0 (0.0%)
Postgraduate degree	6 (42.9%)
Employment status	
Employed full-time	3 (21.4%)
Self-employed	1 (7.1%)
Homemaker	3 (21.4%)
Retired	7 (50.0%)
Annual household income	
Less than £20,000	6 (42.9%)
£20,000–£39,999	2 (14.3%)
£40,000–£59,999	3 (21.4%)
£60,000–£80,000	0 (0.0%)
Above £80,000	0 (0.0%)
Prefer not to say /Not disclosed	3 (21.4%)
Faith/Religion	
Christian	6 (42.9%)
Muslim	8 (57.1%)
Household composition	
Living alone	2 (14.3%)
Living with partner only	2 (14.3%)
Living with partner and children	8 (57.1%)
Living with children only	1 (7.1%)
Living with family, including extended family members	1 (7.1%)
Number of years lived in the UK	
Mean (SD), years	36.9 (16.3)
Data expressed as mean (standard deviation) for continuous variables and frequency (%) for categorical variables. Percentages are rounded to one decimal place.	

of their own. These images then served as a reflexive tool in semi-structured interviews and focus groups, eliciting in-depth insights into participants' experiences of ageing in the region. All interviews and focus groups were audio-recorded and transcribed verbatim. Data, including photos and transcripts of semi-structured interviews, were analysed using NVivo Pro 12.5 (QSR International, 2020), which allowed the coding of both photos and text. Thematic analysis using the process outlined in Braun and Clarke was conducted using an inductive approach.¹³⁶ Ethical approval was obtained from the Northumbria University Research Ethics Committee (Ethics ID: 12587).

The study included 14 female participants with a mean age of 60.8 years (SD=13.1, range 43–83) (Table 7.1). The majority identified as Bangladeshi (57.1%), followed by Caribbean (28.6%), African (7.1%) and Other Asian (7.1%). Most were married (78.6%), living with a partner and children (57.1%), and had resided in the UK for a mean of 36.9 years (SD=16.3). Educational attainment varied, with the largest group holding postgraduate qualifications (42.9%). Half were retired (50.0%) with household incomes below £20,000 per year (42.9%). Participants identified as Muslim (57.1%) or Christian (42.9%).

Emerging themes from preliminary thematic analysis included: (i) Place, identity and belonging; (ii) Community, social cohesion and isolation; (iii) Ageing, health and independence; and (iv) Identity, diversity and cultural experience.

Place, identity and belonging

Participants viewed the North East with a complex mix of pride, attachment, and critique. Compared with the South, they valued its affordability, natural environment, and slower pace of life, an appreciation that was more pronounced among older participants. At the same time, they weighed these benefits against a relative lack of diversity, fewer cultural opportunities, and a sense that the region received less investment than the South. Many saw the loss of industries such as shipyards, coal, and steel as having fractured communities and cast a lasting economic and social shadow. For many participants, identity and belonging operated on multiple levels. Many expressed genuine rootedness in the region while maintaining strong emotional connections to their countries of origin, meaning that "home" rarely functioned as a singular or settled concept. "This house represents... the wealth of the north... things you can get from the North which you can't get from anywhere else." "I feel like I've acquired a certain status for myself... I am entitled to this, and I made it happen." – participant quote

Community, social cohesion and isolation

Participants described a weakening of community life over time, noting a shift away from open, neighbourly interaction towards more insular family units and a growing reliance on organised groups and associations to fill the gap. Participants actively constructed community through joining groups, hosting gatherings, and cultivating friendships that functioned as family. While strong bonds existed within ethnic and religious communities, participants highlighted limited wider social integration and reported that fear, exclusion, and gatekeeping deepened isolation even where local networks existed. Despite this, communities demonstrated clear resilience, developing shared strategies for safety, mutual support and belonging, for example going together to places in groups.

"we go out in groups... so we feel safe" – participant quote.

Ageing, health and independence

Participants framed ageing not as decline but as a stage that demanded continued agency, meaningful contribution, and adapted ways of living. They navigated physical limitations creatively through garden design, walking, hosting, and daily routines and placed strong emphasis on maintaining independence and self-worth. However, participants identified healthcare systems as a significant barrier, particularly for older adults from minority backgrounds who encountered cultural incompetence, language and digital exclusion,

Figure 7.1. Participants' photos depicting life in the North of England



Figure 7.2. Participants' photos illustrating community and social cohesion

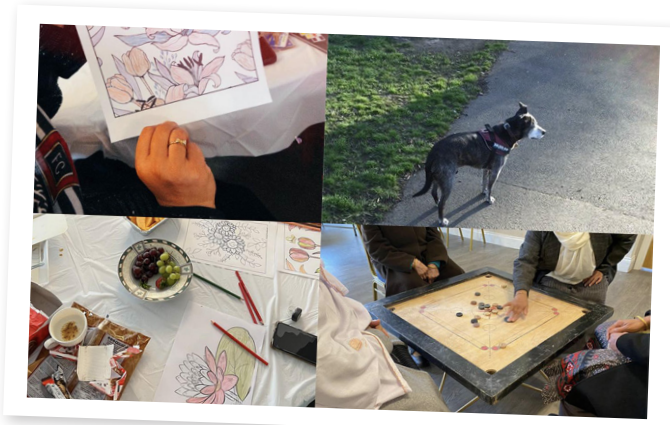


Figure 7.3. Participants' photos on ageing, health and independence



Figure 7.4. Participants' images on identity, diversity and cultural experience



and fragmented or inaccessible services.

“5-minute appointments... you can’t explain everything” “you need more time... especially when you’re older” – quote from participant

Participants also expressed a broader concern that policy and provision treated older people as passive and dependent, failing to account for the diversity of their needs and experiences.

Identity, diversity and cultural experience

Participants described race, culture, and faith as shaping daily life in later years in profound and often difficult ways. Limited ethnic diversity across the North East meant minority individuals frequently navigated spaces where they stood out. While overt racism shifted in form over time, participants emphasised that it had not disappeared, becoming subtler and more structural rather than less present. Participants described compounded vulnerabilities where gender intersected with ethnicity and religion, affecting their safety, mobility, and access to services.

“older people... not able to run away... more vulnerable... we go out in groups... so we feel safe” – quote from participant

At the same time, participants drew on faith and cultural practice as important sources of meaning, community, and resilience. However, many also described a sense of loss and adjustment, with religious and cultural life feeling diminished compared to their countries of origin.

Conclusions

This research highlights the complex and interconnected experiences of older adults from minority ethnic communities living in the North East. Participants demonstrated deep attachments to the region while navigating significant structural inequalities rooted in industrial decline, regional underinvestment, and persistent racial exclusion. Community life, once characterised by openness and collective solidarity, weakened over time, placing greater pressure on individuals and voluntary organisations to construct and sustain networks of belonging. Ageing was understood not as withdrawal but as continued engagement, yet participants encountered healthcare and public service systems ill-equipped to reflect this reality or to meet the distinct needs of those from minority ethnic backgrounds. Experiences of racism, gendered vulnerability, cultural invisibility, and faith-based adjustment shaped daily life in ways that remained largely unacknowledged by mainstream institutions. At the same time, participants demonstrated remarkable resilience by actively building community, maintaining identity, and drawing on faith and culture as sources of strength. Taken together, these findings point to the urgent need for policy that is place-sensitive, intersectional, and genuinely responsive to the diversity of older adults living in the North of England.

This work was funded by the Northumbria University Women’s Sport & Wellbeing Interdisciplinary Research Theme.

Recommendations

Our Ageing in the North report issued broad-ranging recommendations on the actions needed by government and regional authorities to address persistent regional inequalities. These highlight the need for sustained and targeted investment in infrastructure, cultural provision, and economic opportunity across the North, with place-based regeneration strategies that attend to social and community recovery alongside economic goals. Here we focus on recommendations arising directly from this study.

1. Policy frameworks should reframe ageing as a period of active contribution, moving decisively away from deficit-based models that position older people as passive recipients of care.
2. Local authorities and commissioners should provide sustained and ring-fenced funding for community organisations serving older adults from minority ethnic groups, whose role in reducing isolation and building social cohesion is significant but frequently under-resourced.
3. Investment in accessible community spaces and cross-community programmes should be prioritised, treating social isolation as a structural issue requiring systemic responses. Where communities have already developed strategies for resilience and mutual support, policy should seek to strengthen these existing capacities rather than replace them.
4. Health and social care providers should embed cultural competency as a core requirement, ensuring access to professional interpretation services and non-digital alternatives for those excluded by online-only systems, with commissioning frameworks requiring demonstrable responsiveness to the needs of older adults from minority backgrounds, including longer appointment times, culturally appropriate care, and proactive outreach to those at risk of disengagement.
5. Policy should adopt an explicitly intersectional approach to equality, recognising that race, gender, religion, and age interact to produce distinct and compounding experiences of exclusion and vulnerability, particularly for older women from minority ethnic backgrounds.
6. Local authorities should develop diversity and inclusion strategies that move beyond surface-level representation to actively create conditions in which minority communities feel safe, valued, and able to participate fully in public life. Faith organisations and cultural associations should be recognised as significant community assets and supported through funding, partnership, and meaningful involvement in the design and delivery of public services.



Children in care: focus on minority ethnic groups in the North

Authors Hayley Alderson, Ruth McGovern

Summary

- Children in the North are disproportionately represented in the care system, with the North East having the highest rate in England at 113 per 10,000 children, closely mirroring the region's higher levels of poverty and deprivation.
- Black and Asian children enter care later than White children, on average at age 7 compared to age 5, and are less likely to have received a child protection plan beforehand. This suggests that risk and vulnerability are being identified too late for many minority ethnic children.
- Once in care, Black and Asian children are less likely to be placed for adoption or receive a Special Guardianship Order, pointing to persistent inequalities in outcomes that extend beyond the decision to intervene.
- Data on ethnicity within children's social care in the North is limited, and the region's lower ethnic diversity means that issues disproportionately affecting minority ethnic children can be harder to detect. This means these children are at risk of being overlooked in both practice and policy.

Context

Local authorities initiate public law proceedings when children are judged to be at risk of significant harm. Entry into care is one of the most serious state interventions in a child's life and most often involves a child being removed from their family home. These decisions do not take place in a social vacuum. They are shaped by poverty, place, and long standing structural inequalities.¹³⁷

Ethnicity and inequality in the North

The North accounts for just over a quarter of England's child population but more than a third of all children in care. The North East has the highest rates of children in care in the country, 113 per 10,000 compared with the national average of 70 per 10,000 children.¹³⁸ These patterns closely mirror levels of poverty and deprivation, which are substantially higher across many Northern communities and are strongly associated with child welfare intervention.¹³⁹

The North East is the least ethnically diverse region in England, with over 90% of the population identifying as White.⁴¹ Consequently, most care proceedings in the North involve White children. However, evidence consistently shows that children's social care does not affect all ethnic groups equally.^{140 141}

When ethnicity is considered relative to local population composition, children from Black, Asian and Mixed ethnic backgrounds remain disproportionately involved in the family justice system across all regions, including the North.^{137 142 143} This indicates that ethnic disproportionality is not simply a feature of diverse urban areas but is evident even in regions with smaller minority ethnic populations. These patterns do not reflect differences in need alone but point to unequal pathways into support, protection and state intervention.

Pathways into care for children in the North

Black and Asian children tend to enter care later than their White peers: on average at age 7, compared with age 5 for White and Mixed ethnicity children.¹⁴⁴ Over 37% of Black children and 40% of Asian children became known to children's social care aged older than 10 years, compared to less than 30% of White children.¹³⁷ In the North, this pattern raises particular concern given the high prevalence of adolescent-onset harms, including criminal and sexual exploitation, which are more common in areas experiencing high levels of deprivation. The later identification of risk also suggests that harm may be recognised too late for many minority ethnic children, despite evidence that risks outside the home are more prevalent for Black and Asian children who become looked after.¹⁴⁵

Children from Black, Asian and minority ethnic communities frequently experience racism, stereotyping and cultural misunderstanding, which can influence their interaction with child welfare services. Structural factors such as poverty, substance abuse, single-parent families and maltreatment make Black families more vulnerable to child welfare involvement.¹⁴⁶ Evidence suggests that professionals are more likely to report Black children to child welfare compared to White children¹⁴⁷ and Black children in families with lower socio-economic status were more likely than their White peers with a similar socio-economic status to be subject to reports.¹⁴⁸ Additionally, Black children are more likely than White children to be investigated following a referral by a law enforcement agency.¹⁴⁹ A recent scoping review identified that the inequalities Black children experience in the child welfare system begin at the referrals stage. Focusing on the reporting practices of school personnel and police officers, the review identified several factors that may influence referral decisions, including fear of liability, lack of cultural sensitivity in beliefs around parenting and practices, lack of culturally appropriate resources, racism and bias, poverty and lack of diversity and training.¹⁵⁰

Further evidence from a systematic review found that racial discrimination is a major contributor to the persistent over-representation of Black children in out-of-home care.¹⁴⁸ Of the 31 studies included in the systematic review, 27 reported disproportionate representation of Black children within child welfare systems. This disproportionality was evident across various stages of intervention, including the investigation of reports, substantiation of allegations, placements in out-of-home care, re-entry to foster care, lower reunification rates and exits to permanency.¹⁴⁸ Additionally, child welfare cases involving Black children considered fewer alternative response paths resulting in Black children experiencing out-of-home care more frequently than their White counterparts.^{142 151 152} These experiences shape both how families are perceived and how risks are interpreted by professionals.

Unequal preventative intervention before care proceedings

Children in the North also experience ethnic inequalities in support prior to care entry. National data show that 65% of White children and 62% of Mixed ethnicity children had previously been on a child

protection plan, compared to 39% and 36% for Black and Asian children respectively.¹⁴⁰ This suggests that some children are less likely to receive any form of support from children's social care prior to being escalated in the care system compared to others.⁷⁴ Under-resourced northern local authorities face high caseloads and workforce pressures, further constraining preventative practice. These pressures compound inequalities by reducing opportunities for sustained early intervention.

Children from Black, Asian and Mixed ethnic backgrounds in the North often experience a paradox of being both 'hyper-visible' and overlooked. These children may be subject to increased surveillance or punitive responses when displaying behaviours perceived as risky or antisocial, while their vulnerability and need for protection are minimised.¹⁵³ Adulthood contributes to Black children in particular being viewed as more responsible and culpable for their actions than their White peers.^{154 155} Adulthood is 'a form of bias that denies children the right to be seen, valued and protected as children'.¹⁵⁶ Adulthood bias is most likely experienced by Black children due to race, ethnicity and racism acting as compounding factors. This can hinder child protection responses and suppress professional curiosity, and has been repeatedly identified in safeguarding and exploitation contexts.^{157 158}

Care placements for children in the North

Once in care, ethnicity continues to shape children's experiences and outcomes. Regarding Adoption and Placement Orders, 16.5% of White children and 15.6% of Mixed ethnicity children are placed on adoption orders, compared to 5.8% of Black children and 4.7% of Asian children.^{144 159} Nationally, Black children wait longer for adoption – an average of 30 months from entry into care, compared to 20 months for White children.¹⁶⁰ This may be attributable to the fact that children from minority ethnic groups have lower likelihood of identifying a trusted adult compared with White children,¹⁶¹ and that Black adults are more likely than White adults to adopt a child of the same ethnicity (63% v 50% respectively).¹⁶⁰

Special Guardianship Orders show similar disparities: 18% of White children and 17% of Mixed ethnicity children receive these orders, compared to 13% for Black children and 7% for Asian children.¹⁴⁴ In the North, these disparities intersect with placement shortages and

market pressures, increasing the likelihood of inappropriate residential placements and instability.

Social Care Practitioners

Safeguarding reviews highlight gaps in social care practitioners' understanding of how race, ethnicity and culture intersect with poverty.¹⁶² Serious case reviews indicate that racism remains present within social care settings, and that structural racism is embedded within social work practice.¹⁶³⁻¹⁶⁵ These issues are magnified in Northern regions where services face sustained financial pressure, and families experience higher levels of socioeconomic hardship.

Discussion

Differences in outcomes by ethnicity within children's social care are often shaped by the interaction of ethnicity and poverty. Socio-economic disadvantage, ethnicity and age all influence access to early help, likelihood of child protection intervention and chances of entering care.¹⁵⁹ Without action to address poverty, structural racism and regional inequality, the North will continue to experience high rates of children in care and unequal outcomes for children.

Recommendations

1. Children's social care practice across the North should embed culturally safe, poverty-informed approaches that recognise the compounding effects of ethnicity and socioeconomic disadvantage on families' pathways into the care system.
2. Mandatory training on race, ethnicity, adulthood bias and structural racism should be provided to all children's social care practitioners, to reduce inequalities in how risk and vulnerability are identified and responded to.
3. Northern local authorities should be supported to deliver sustained early intervention and preventative family actions with particular attention to closing the gap in child protection planning rates for Black and Asian children before care proceedings are initiated.
4. Regional placement sufficiency should be addressed to reduce reliance on inappropriate residential placements, with priority given to matching children from minority ethnic backgrounds with culturally appropriate placements.



Gender-based violence

Authors Chinyere Ajayi, Michaela Rogers, Parveen Ali

Summary

- Gender-based violence is a public health crisis disproportionately affecting women in the North. In the year ending March 2025, 2.2 million women experienced domestic abuse nationally, with 72.1% of all police-recorded victims being female.
- Every northern police force except North Yorkshire exceeds the national average of 21.8 domestic abuse incidents and crimes per 1,000 population.
- Minority ethnic women face a double disadvantage: comparable or higher actual rates of domestic abuse combined with far greater barriers to disclosure and help-seeking. In South Yorkshire, 70% of domestic abuse crimes closed due to evidential difficulties do so because the victim does not support police action, the highest rate in England and Wales. This is not a measure of victim reluctance; it is a measure of systemic failure.
- Gender-based violence extends far beyond domestic abuse. Minority ethnic women are affected by sexual violence, honour-based abuse, forced marriage, female genital mutilation and technology-facilitated violence, shaped by intersecting factors of gender, race, religion, immigration status and poverty.

Context

Gender-based violence is defined by the United Nations as any act of violence directed against a person because of their gender. It encompasses intimate partner violence, domestic abuse, sexual violence, stalking, forced marriage, so-called honour-based abuse, female genital mutilation, trafficking, religious and spiritual abuse, and technology-facilitated abuse such as threatening to share intimate images.¹⁶⁶ All forms are rooted in gender inequality and the exercise of power and control. Domestic abuse is the most common manifestation of gender-based violence.

The Domestic Abuse Act 2021 defines domestic abuse as abusive behaviour between people aged 16 and over who are, or have been, intimate partners or family members, encompassing physical, sexual, psychological, economic and coercive or controlling abuse.¹⁶⁷ The National Police Chiefs' Council described violence against women and girls as an 'epidemic' in 2024.¹⁶⁸ The scale of this epidemic is vast: in the year ending March 2025, 3.8 million people aged 16 and over experienced domestic abuse in England and Wales, of whom 2.2 million were women. Police recorded 816,493 domestic abuse-related crimes, with 72.1% of victims being female.¹⁶⁹ Women in the North of England face the epidemic of violence at rates well above the national average. The most recent data looking at gender-based violence across police force areas (year ending March 2025) shows that North Yorkshire is the only one of the northern forces whose records fall below the national average of 21.8 recorded domestic abuse incidents and crimes per 1,000 population.¹⁷⁰

The Government's Violence Against Women and Girls (VAWG) strategy,¹⁶⁶ presented to Parliament in 2025, commits to halving this

violence within a decade. Given this national policy, this chapter synthesises current evidence on the scale of different forms of gender-based violence with a focus on the northern context and minority ethnic groups where possible. Data availability for disaggregated minority ethnic groups by region and sex for gender-based violence prevents intersectional analysis.

Forms of Gender-Based Violence: Scale and Northern Context

Minority ethnic women may experience all forms of gender-based violence. However, these women are specifically and disproportionately affected by particular forms of violence that mainstream data systems are ill-equipped to capture. The distinct forms of gender-based violence are shaped by the intersection of gender, race, religion, immigration status and structural disadvantage.¹⁷¹⁻¹⁷⁴ These intersecting drivers are compounded in the North, where poverty, deprivation and housing insecurity create conditions in which violence is more likely, less likely to be disclosed, and less likely to be met with an adequate response. Here we summarise each form with northern-specific evidence, updated from the most recent available sources.

Domestic abuse

Domestic abuse rates in Northern England are markedly elevated compared with the rest of England and Wales. The most recent data looking at patterns across police force areas (year ending March 2025)¹⁶⁹ shows Cleveland recording 33.9 domestic abuse incidents and crimes per 1,000 population – the highest rate in England and Wales. West Yorkshire, Humberside, Durham and Northumbria all exceed 29 domestic abuse incidents and crimes per 1,000 population. In Blackpool specifically, domestic abuse was a contributing factor in 18% of all recorded crime, with women comprising 73–75% of victims and a reoffending rate of 29.3%.

The North West reports a domestic abuse prevalence of 9.7% against a 7.8% national figure, while the North East recorded 87,566 domestic abuse incidents in 2023–24. The Crime Survey for England and Wales (CSEW) is considered by the Office for National Statistics a more reliable source for measuring domestic abuse than police recorded crime data, albeit with important limitations. The most recent data (year ending March 2025)¹⁷⁵ records lower apparent prevalence of domestic abuse among Asian or Asian British women (3.0%) and Black or Black British women (3.4%) compared to White women (5.0%). Women with mixed ethnicity, by contrast, record 7.1%, the highest of any group.¹⁷⁰ This suggests that where barriers to disclosure are partially overcome, the true burden becomes visible.¹⁷⁶ It also illustrates how population-based surveys like the CSEW offer valuable insight into trends but are limited in illuminating the complexities shaping minority ethnic women's disclosure and help-seeking. Large-scale data on experiences of specific minority ethnic groups are extremely limited. Research conducted with Pakistani and British South Asian women in Sheffield identifies coercive control, economic abuse, immigration-related abuse, and sexual violence as the predominant forms of abuse experienced by this group.¹⁷²⁻¹⁷³ The

work also confirms that lower reported rates reflect lower disclosure, not lower incidence, driven by structural and cultural barriers.¹⁷⁷

Sexual violence

Sexual violence shows a similar regional concentration: the North East, and Yorkshire and the Humber rank among the regions with the highest rates of police-recorded sexual offences in England and Wales, with a recorded rate of 3.9 sexual offences per 1,000 population for both regions.¹⁶⁹ So-called honour-based abuse stands out for its collective nature: victims are seven times more likely than victims of other forms of abuse to face multiple perpetrators, and extended family involvement is a well-documented feature of these cases. Systemic police failures in responding to honour-based abuse have been documented in Tees Valley.^{173 178}

Forced marriage

The Forced Marriage Unit supports 1,200–1,400 people per year nationally, with women and girls accounting for 75% of cases.¹⁷⁹ Victims are predominantly of South Asian and Middle Eastern backgrounds. Spousal role expectations and family honour dynamics are identified as structural conditions that enable forced unions.¹⁷¹

Female genital mutilation

Female genital mutilation shows pronounced geographic concentration in the North. In Manchester the prevalence of female genital mutilation is 12–16 per 1,000 women, while Sheffield’s prevalence exceeds 7 per 1,000. In 2024–25, 1,680 women were newly recorded on Northern England’s NHS FGM records, distributed across Greater Manchester (500), Cheshire and Merseyside (395), and the North East and North Cumbria (310). Northern England as a whole accounts for 21.4% of all FGM attendances recorded in England.¹⁸⁰

Technology-facilitated abuse

Technology-facilitated abuse is a rapidly growing concern, with specialist referrals increasing by 205% between 2018 and 2024. Some 45% of minority ethnic women report having experienced online abuse, and technology is increasingly documented as a coercive tool deployed within honour-based or community-monitoring contexts.^{176 181} Taken together, these figures point to a consistent pattern: official statistics are likely to understate the true scale of gender-based violence among minority ethnic women across all forms of gender-based violence given the structural and cultural barriers to disclosure that recur throughout this evidence base.

Barriers to Disclosure and Help-Seeking

Minority ethnic women face intersecting barriers at individual, community, structural and criminal justice levels (Table 9.1). Their

cumulative effect is prolonged abuse, delayed help-seeking, and systematic underrepresentation in every data source used to plan services.

Impacts

Gender-based violence has severe health consequences which include mental health disorders, physical injury, chronic pain and increased risk of suicide and homicide.¹⁸⁶ Domestic abuse has profound personal and emotional impacts including loss of identity, self-blame and denial, internalised shame, ongoing emotional and psychological distress, worthlessness and conflicting loyalty between personal safety and community belonging.¹⁷⁷ In addition, domestic abuse increases the risk of pre-term birth and low-weight birth.¹⁸⁷ A research study examining the associations between area-level ethnic density and health for Pakistani and White British residents of Bradford, England reported that higher ethnic density among Pakistani women was linked to slightly lower birth weight, while no clear link was found between ethnic density and birth outcomes among White British women.¹⁸⁸ Health consequences of female genital mutilation include chronic pain, complications in childbirth, urological problems, mental health difficulties and sexual dysfunction.^{189 190} Technology-facilitated abuse causes significant psychological harm and, in the context of minority ethnic women in the North, is frequently used to enforce honour-based coercion: perpetrators threatening to share intimate content within family or community networks.¹⁸¹

Service Landscape: Fractured and Underfunded

The most effective models for minority ethnic survivors of gender-based violence are ‘by and for’ services, designed and led by the communities they serve. Despite this, 67% of Black and minoritised survivors who want ‘by and for’ support cannot access it due to the predominance of generic providers and chronic underfunding for ‘by and for’ specialist services.^{191 192} Specialist service provision for minority ethnic survivors across northern England is even more fragmented compared to London and the South-East of England, where nearly half of all such specialised national organisations are concentrated.¹⁹³ See Box 9.1 for the perspective from a specialist advisor. The scale of unmet risk is evidenced by Multi-Agency Risk Assessment Conference (MARAC) data. Humberside records 116 MARAC cases per 10,000 adult females and Greater Manchester records 98, compared with the England and Wales average of 50.2. More strikingly, 52% of Humberside’s MARAC reports discuss repeat cases.¹⁷⁰ For minority ethnic women, structural barriers to leaving, including visas with No Recourse to Public Funds restrictions, community pressure and the absence of specialist accommodation, make this cycle more likely. This fragmentation or lack of specialist services results in data gaps across all aspects of gender-based violence for northern minority ethnic women.

Level	Key barriers
Individual	Fear, shame, self-blame; language barriers; religion or prayer as a first resort before formal help-seeking; loyalty to partner or family; community pressure not to report; fear of child removal. ^{172 177 182}
Community	Fear of dishonour (izzat); social ostracism; pressure from in-laws and extended family including active in-law involvement in abuse; victim-blaming by community/religious leaders; misuse of religious norms to reinforce male authority. ^{173 174 183}
Structural	Visas with restrictions specifying No Recourse to Public Funds (NRPF); fear of deportation and immigration enforcement; police stereotyping; lack of professional interpreting; low awareness of specialist services; racism from mainstream services. Women with insecure immigration status are less likely to be protected by injunctions or arrests than UK nationals. ^{184 185}
Criminal justice	Many minority ethnic women withdraw support for police action following initial reporting, in the face of the structural and cultural pressures. In South Yorkshire, 70% of domestic abuse crimes closed due to evidential difficulties do so because the victim does not support police action. This is the highest percentage of cases in England and Wales and 14 percentage points above the national average of 56%. Merseyside records 67%. These figures measure systemic failure, not victim reluctance. ¹⁷⁰

Recommendations

1. Northern police and crime commissioners, local authorities and Combined Authorities should commission ethnicity-disaggregated data on all forms of gender-based violence. The ongoing data gaps must be addressed.
2. Mandatory training on the full spectrum of gender-based violence should be introduced for all NHS professionals across the North. Training must address how ethnicity, immigration status, poverty, interpreting and extended family dynamics intersect with this issue. Faith-based resources and appropriate referral pathways to religious and community leaders should be developed as part of every local gender-based violence strategy.
3. Northern England Integrated Care Boards should ringfence funding for 'by and for' gender-based violence services for minority ethnic women.
4. To address victim withdrawal rates, specialist Independent Domestic Violence Advisers with cultural competency in working with minority ethnic and migrant women, should be commissioned by Northern Police and Crime Commissioners, local authorities and Combined Authorities with particular attention to supporting victims through the criminal justice process.
5. The No Recourse to Public Funds condition must be reformed nationally. Northern local authorities and ICBs should develop interim provisions so that migrant and asylum-seeking women can access gender-based violence support regardless of immigration status.

Box 9.1. Raising awareness of domestic violence/abuse and honour-based violence/abuse in local mosques

Author Ms Farheen Anwar, Independent Domestic Violence Advisor and Independent Sexual Violence Advisor and Service Manager at Independent Choices Greater Manchester

Over the past 25 years, through community-based work across Greater Manchester, I have created a strong network of local professionals and trusted relationships within Black Asian Minority Ethnic Refugee communities. This foundation of trust has been essential in enabling open conversations with mosque staff/trustees and volunteers in addressing sensitive issues such as domestic- and honour-based violence and abuse in the communities.

During the COVID-19 pandemic, as incidents of domestic violence and abuse began to rise and national awareness campaigns were highlighted by the government, I utilised my existing community connections to engage with local mosques across Greater Manchester. I supported these efforts through Facebook posts tailored for mosque audiences which included signposting to local domestic violence and abuse agencies.

During the 16 days of activism against gender-based violence from 25th November to 10th December 2020, I worked closely with the local Imams, priests and community leaders to deliver a coordinated domestic- and honour-based violence and abuse social media campaign for Independent Choices Greater Manchester. This initiative helped raise awareness within marginalised communities that may otherwise face barriers to accessing mainstream support and information.

Over the past year, I have been invited to deliver domestic- and honour-based violence and abuse awareness training to mosque staff, trustees, and women's groups. These sessions focused on understanding the definition of domestic- and honour-based violence and abuse; the impact and barriers victims face; responding to disclosures; and what options are available for victims.

A significant milestone in this work has been training members of the Sharia Council. Establishing trust and strengthening links between the Sharia Council and voluntary support services has been essential to safeguard victims. Many women experiencing domestic- or honour-based violence and abuse who want to end their marriage, may choose to apply for the Sharia divorce (khula), which must be processed by the Sharia Council. This is an Islamic divorce, which is important to a vast majority of Muslim women. It is crucial that this pathway is informed, safe, and connected to appropriate safeguarding measures, and through building these relationships, I have helped ensure this is in place.

This work has also enhanced my own professional knowledge and practice. Through closer collaboration with Imams and community leaders, I have deepened my understanding of the cultural and religious contexts that may influence victims' experiences and decision-making. This enables me to provide more informed, culturally sensitive support in my role within the domestic abuse sector.

I am continuing to work with local mosques to deliver domestic- and honour-based violence and abuse training. This ongoing engagement reflects the commitment from mosques that are deeply embedded and respected within their communities. They are actively working to bridge gaps with statutory services, helping to ensure that victims of domestic- and honour-based violence and abuse safely access the support they need.



Multiply marginalised populations: Women who are justice-involved

Authors Steph Scott, Sofia Buncy, and Michelle Addison

Summary

- Minority ethnic women are marginalised within an already-marginalised population of women in the criminal justice system, facing disproportionate rates of arrest, longer sentences and disparate treatment in court decisions compared with the ethnic majority.
- The health needs of minority ethnic women in the criminal justice system are acute and interconnected, with high rates of mental health problems, trauma, domestic abuse and substance use compounded by systemic racism, language barriers, immigration status and stigma within their own communities.
- Regional-level data on justice-involved individuals disaggregated by both gender and ethnicity is absent, making it impossible to fully assess the scale of inequality in the North for these women.

Context

Minority ethnic women experience inequity at every stage of the criminal justice system in England and Wales, exposing them to significant harm, both as victims and defendants.¹⁹⁴ They are more likely to be arrested,¹⁹⁵ serve longer sentences¹⁹⁵ and receive disparate treatment in Magistrates' Court decisions including pleas and remand decisions compared to White people.¹⁹⁶⁻¹⁹⁷

These women acquire criminal records that last longer because rehabilitation periods are contingent on length of sentence and type of offence.¹⁹⁸ A custodial sentence of between 1 and 4 years will mean that a conviction is not classed as spent until 4 years after the completion of the sentence, which impacts a woman's employment opportunities and reintegration into the community.¹⁹⁹ Meanwhile, migrant, Black and minoritised victim-survivors tend to be overlooked on multiple fronts, including police neglect and inaction in rape investigations, ineffective addressing of language needs, and a lack of referral to specialist support services.¹⁹⁹⁻²⁰¹

Despite this, national data disaggregated by both gender and ethnicity remains starkly inadequate, rendering it difficult to accurately identify and address health and care disparities experienced by minority ethnic women in the criminal justice system.¹⁹⁴⁻¹⁹⁹ These limitations are compounded further when trying to glean a regional picture of what is impacting upon health, care and wellbeing specifically for this population group in northern England. Females make up just 4% of the overall prison population and 12% of the population under the supervision of probation nationally in England and Wales,²⁰² and the most common indictable offence for women is shoplifting.¹⁹⁵ Across northern regions, whilst the majority of the prison population are White, other ethnic groups continue to be disproportionately represented compared to the general population.¹⁹⁹⁻²⁰³ Thus at a regional level data granular enough to meaningfully interpret remains lacking.

Minority ethnic women in the criminal justice system

Justice-involved and minority ethnic women in England and Wales are

marginalised within an already-marginalised population. Many women involved in the criminal justice system have experienced emotional, physical and sexual abuse, as well as childhood trauma, poverty, alcohol and substance use (in prison almost half request help with a drug problem), and almost 74% report mental health problems.¹⁹⁹ ²⁰³ For minority ethnic women, this is exacerbated by systemic and institutionalised racism, reduction in government budgets for specialist intersectional support, language barriers, and acute stigma from their own communities.²⁰⁴ Minority ethnic women in prison report direct and indirect discrimination and unfair treatment, including increased adjudications when alleged to have broken prison rules, reduced access to employment within the prison, and fewer opportunities for Release on Temporary Licence (ROTL). This discrimination occurs against a backdrop of widespread racist language, name calling, racial tropes and stereotyping by staff.¹⁹⁹⁻²⁰⁴

In health, the wide-ranging inequalities in accessing care and in outcomes experienced by minority ethnic women are compounded by the prison environment.

NHS England's review of women's prisons in 2023 found that health and social care services across the women's estate are inconsistent and not always gender-specific, trauma-informed or sensitive to protected characteristics.²⁰⁵ In our experience, the prison environment itself can reduce autonomy, privacy and the ability to seek timely care. For pregnant women, this is particularly concerning because all pregnancies in prison are widely recognised as high risk.

Policy and institutional inaction

Despite their clear needs, minority ethnic women who are justice-involved are overlooked even within policy and practice ostensibly designed to address racial inequality. This is illustrated by the Ministry of Justice's 2008 Race Review,²⁰⁶ which examined race across the prison estate but scrutinised no female prisons. The gap was partially addressed the following year, when HM Inspectorate of Prisons published *Race Relations in Prison: Responding to Women from Black and Minority Ethnic Backgrounds*.²⁰⁷ The report acknowledged that women racialised as non-White had been omitted from the 2008 review and documented racialised differences across a range of areas including offence types, sentencing patterns, treatment by staff, health needs, and family and housing needs. It also drew attention to the particular vulnerability of foreign national prisoners, who faced additional layers of marginalisation due to immigration status, language barriers, and distance from family.

Similar patterns are evident beyond the prison estate. HM Inspectorate of Probation's 2021 thematic inspection examining quality and effectiveness of probation services and the impact of delivery models focused on recovery found, across 100 cases of racially minoritised probation service users, a lack of effective work to address legacies of institutionalised racism within Probation Services.²⁰⁸ All minority ethnic women interviewed for the inspection expressed a preference for a non-White responsible officer, pointing to broader

failures to build trust and deliver culturally responsive supervision. A subsequent thematic inspection in 2023 found that the quality of court work and assessments was notably poorer for minority ethnic women, that practitioners were not always aware of specialist support services available to minority groups, and that few providers had arrangements with specialist organisations to support women from minority ethnic backgrounds.²⁰⁹

The lack of visibility for justice-involved minority ethnic women in policy persists: the current Chief Medical Officer's report on the health

of people in prison and on probation says exceptionally little about minority ethnic women. Similarly, the Women's Health Strategy for England does not address the needs and experiences of minority ethnic women at all except in relation to maternal mortality.³²

Case studies of primary research in the North of England

Given the lack of granular intersectional data on justice involved women, we present case studies of research projects with minority ethnic women in the North of England to centre their voices and experience of the criminal justice system.

Case study 10.1. 'The Muslim Women in Prison Project' (Buncy, Bradley et al)

The Muslim Women in Prison Project at the Khidmat Centres, Bradford, has firsthand experience of how some of the dynamics set out in this report operate in practice. Our insights show that a substantive number of our clients have had limited agency in the community when accessing healthcare, often attending a GP or hospital appointments with or through a family member, such as a parent, husband or mother-in-law.

Subsequently, the expectation to seek healthcare alone within a prison setting can impinge on confidence, self-esteem and the ability to describe symptoms or request help independently. In custody, some women have felt even less entitled to push for better healthcare or challenge medical professionals. Shame and stigma can also be significant, particularly where health issues are intimate, reproductive, mental-health related or likely to attract judgement within family, community networks or cultural networks.

Amal

Amal was 21 when she was first incarcerated, marking her initial contact with the criminal justice system. Her offence was linked to wider family circumstances, and she had reported domestic violence and coercion during the lead-up, which went unaddressed by statutory providers. Growing up, she came from a strict cultural background, where her freedom and independence had been limited, restricting her ability to access services or engage fully within her local community.

At the point of imprisonment, Amal experienced significant shame associated with her offence, alongside ongoing coercive control

and manipulation from within her family network. This intensified her distress, particularly through continued contact with them, which she found difficult to manage.

Amal began experiencing flashbacks related to the lead up and circumstances of the offence and struggled to adjust to the prison environment. She approached healthcare services, expressing that she was struggling and felt close to depression. However, her concerns were dismissed and she was told her feelings were a normal part of adjusting to custody.

Unsupported, over time, Amal's mental health deteriorated and she began experiencing intrusive and negative thoughts, including thoughts of self-harm. Despite multiple attempts to seek support, her needs were not adequately recognised nor was the extent of pressure she faced from her family through phone calls and other communication understood.

Unable to cope with both her circumstances and the ongoing familial pressure, Amal began to self-harm in prison, something deeply at odds with her faith and cultural values. She concealed this for a period, but when she eventually disclosed it, the response was limited to increased monitoring through regular welfare checks and an Assessment, Care in Custody and Teamwork document opened (suicide and self-harm prevention folder). Amal felt scrutinised rather than supported both from a mental health and physical perspective, as the underlying causes of her distress were not addressed.

Her emotional state remained heightened for an extended period despite requesting counselling support whilst in custody. Amal spent the remainder of her 2.5-year sentence self-harming and not being given the support she required.

Case study 10.2. 'The OUTCOMES Project' (*Alderson et al)

This case study is based on an N8 Policing Research Partnership-funded study called OUTCOMES: 'Understanding the impact of Outcome 16 on racially minoritised women's participation in Domestic Abuse investigations'.²¹⁰ The study was conducted with three police forces in the North of England.

The study explored racially minoritised women's experiences of police responses to domestic abuse investigations. Three specialist Voluntary, Community and Social Enterprise (VCSE) organisations acted as gatekeepers to identify and recruit eligible participants. The ethnicity of participants was as follows: Caribbean (n=5), British Pakistani (n=5), Indian (n=2), Ukrainian (n=2), Kurdish (n=1), Rwandan (n=1), Algerian (n=1) and 1 White British whose husband was racially minoritised.

Findings demonstrate barriers such as non-recognition of domestic abuse or coercive control and the inability of women to articulate their experiences in the English language. Not being provided with an interpreter by the police influenced the survivor's ability to have a voice within the criminal justice investigation. The quote below shows a lack of support and provision by the police:

"The first barrier is language. Because now I speak a little bit better English, but at that time, even the police in their reports said that I spoke poor language. I wasn't able to express myself, I wasn't able to explain properly what was happening, because my vocabulary simply wasn't good enough. They didn't provide an interpreter. They saw me speaking like this, they never provided an interpreter" (survivor 1)

Survivors discussed how systemic factors such as precarious immigration status influenced their decision making. Survivors felt trapped in abusive relationships due to the perceived power that perpetrators held. Perpetrators were described as weaponising their knowledge of the policy landscape, convincing the survivor they would receive a hostile response due to them being a migrant. Due to survivors' lack of knowledge about their rights, particularly for those with precarious immigration status, they described being fearful of being deported. This impacted on them through not reporting to the police and/or withdrawing support for police action. Perpetrators recognised these vulnerabilities and exerted control over survivors.

"I think initially what my husband was doing was he held my documents, passport, everything. At the same time, he was kicking me out of the house and he said that's so I can leave without my stuff, or just to kick me out really.... So, because of my visa – I was only on spouse's because I missed the date for the indefinite leave to remain

Figure 10.1. Artwork illustrating the themes from The OUTCOMES Project²¹⁰



– he was basically threatening that I can go back to Russia without my son and never see him again” (Survivor 2)

Another factor reported was the lack of awareness of the rights/civil-criminal justice provisions that survivors were entitled to owing to their immigration status, particularly in the context of domestic abuse. Survivors reported that the police failed to recognise the dynamics of coercion/control to which they were subjected. There was a lack of acknowledgement of the potential retribution that survivors might experience, alongside an associated fear of escalated risk which subsequently led to not supporting police action.

This research suggests that, as first responders, police play a central role in responding to domestic abuse and can affect the entire investigation, described by Davies and Barlow as ‘high-stake opportunities’.²¹¹ Policing is further complicated in the case of racially minoritised women, as it is acknowledged that particular forms of domestic abuse (also gender-based violence) - such as forced marriage, ‘honour’-based violence and female genital mutilation may be more prevalent in racially minoritised communities in the UK.^{212 213} Research shows that racially minoritised men and women have been, and continue to be, over-policed and under-protected.²¹⁴

Five members of the research team discussed the themes from the qualitative data with a live artist. Two police forces and two VCSE organisations provided feedback and adaptations were made. The live artwork provided a mechanism to display and share findings in an alternative format to the written word (Figure 10.1).

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Discussion

It is clear that minority ethnic women are subjected to oppressive health and justice systems whose failures are structural, cumulative and intersectional. Whilst the total population of women involved in the criminal justice system in England and Wales is small, it is growing – and the inequalities these women face are deepening rather than narrowing.

Institutional responses have yet to meaningfully reckon with the structural conditions that produce these inequalities. Healthcare and justice systems have historically operated within a biomedical model anchored in colonial knowledge production that obscures the experiences of minority ethnic women, focusing on individual need and presenting behaviour rather than the racism, poverty, trauma and gendered violence that shape women's lives before, during and after contact with the criminal justice system. As the case studies in this chapter illustrate, the consequences of this are tangible: women's distress goes unrecognised, disclosures are dismissed, and the underlying causes of harm remain unaddressed.

Effective responses require health and social care providers to adopt a culturally competent, trauma-informed and proactive approach. Prison healthcare must recognise not only medical need, but also the agency, dignity and voice of women who may have been repeatedly unheard. Much of this will also include prison and healthcare professionals working closely with specialist providers, who understand the intricacy of such dynamics as well as the push and pull factors informing access to healthcare for minority ethnic women. Change requires authentic engagement with minority ethnic women with lived experience of health and justice systems, not superficial methods of involvement and co-production.

Recommendations

1. Linked, disaggregated data on the health and criminal justice experiences of minority ethnic women should be collected and published at national and regional levels, to enable meaningful monitoring of inequalities and inform targeted intervention.
2. The absence of data on the health experiences of minority ethnic women in the criminal justice system should not be interpreted as an absence of need; services should proactively seek to understand why women are not coming forward and address the barriers that prevent disclosure so women feel confident, safe, believed or supported enough to disclose their concerns.
3. Specialist intersectional provision for minority ethnic women in the criminal justice system should be protected and sustainably funded, reducing reliance on overstretched voluntary and community organisations.
4. Minority ethnic women involved in the criminal justice system should have proactive access to appropriate legal and specialist services, rather than being required to identify and source this support themselves.
5. Minority ethnic women with lived experience of health and justice systems should be engaged in the design, delivery and evaluation of services, with continuity of support recognised as essential rather than optional.



Multiply marginalised populations: Roma Women

Authors Lois Orton and Olga Fuseini

Summary

- Roma women in Europe face some of the most severe health inequalities of any group in this report, and in England the overall Roma life expectancy is believed to be up to 10 years lower than majority populations – yet reliable, gender-disaggregated data on Roma health is limited.
- Policy has consistently failed Roma, and particularly Roma women, by overlooking the experiences of Roma people and through the persistent conflation of Roma with Gypsy and Traveller communities whose needs and circumstances only partially overlap.
- Local needs assessments in Sheffield, Manchester and Leeds point to consistent priorities – poverty, housing, language, trust and lack of community services capacity – but these have rarely been acted upon.

Context

'Roma' is a collective, largely political, term used to classify many different populations with varied experiences and health status. People defined as Roma often resist such classification due to well-founded fears of prejudice and violence. Others have started to use the moniker to show solidarity.²¹⁵ Roma should not be confused with Irish Travellers or English Romany Gypsies, who have different cultural and historical origins – even if they are often linked in policy under the construct Gypsy-Roma-Traveller (GRT). Roma people live all across the world and are thought to form the largest racialised group in the European region²¹⁶ with the highest numbers in Central and Eastern Europe and the Balkans.²¹⁷ Most Roma living in the North of England have relatively recently arrived from Central and Eastern Europe and the Balkans – either as refugees or under pre-Brexit freedom of movement. Despite common misconceptions, less than 20 percent of Roma are believed to live an itinerant lifestyle – including seasonal mobility across regional and national borders.^{218 219}

People seen to be Roma (or the previous pejorative 'Gypsy') have faced generations of discrimination and persecution – including enslavement, forced displacement, violence, cultural annihilation, medical experimentation, eugenics and genocide.²²⁰ They face one of the last remaining forms of acceptable racism, sometimes referred to as 'antigypsyism'.²²¹ The effects of intergenerational transmission of trauma are strongly felt,²²² and are arguably the most significant influence on the lives of Roma people.²²³ The UK's exit from the European Union (EU) in January 2020 made the continuing racialisation of Roma people hard to ignore. Popular media discourse during the EU referendum campaign involved scapegoating and demonisation of Roma people to help shape negative attitudes towards Eastern European immigrants.²²⁴

Although not always the case, Roma tend to experience higher levels of poverty, poorer housing and lower access to education and employment than majority populations.^{220 225} Roma women additionally face various forms of gender-based discrimination and violence, including forced sterilisation.²²⁶⁻²²⁸ However, Roma are not victims, with

Figure 11.1. Still from the animation 'Resisting Complicity with Oppression of Roma People' created from the text of a paper by Orton et al. on the health and social inequalities experienced by European Roma populations.²³⁰



many citing the desire for a better life for their children as the main driver for coming to the UK.²²⁹

Within this context, Roma women living in the North of England face a unique combination of inequalities. There are very few policies addressing their specific health and social needs, and Roma voices are seldom heard in policy spheres nationally and globally. Although data are limited, Roma people living in England tend to experience around 10 years lower life expectancy than majority populations, with Roma women experiencing particularly poor health. This chapter provides a brief summary of a highly complex picture that has been pieced together across disparate data sources. We draw on European research; national data; local needs assessments from Sheffield, Manchester and Leeds; and personal perspectives to describe the experiences of Roma women in the North of England and what needs to change.

Policy concerning Roma people in England

Roma people are identified for protection under the Equality Act 2010. Despite this and a growing Roma civil society, Roma have until recently faced very little attention in English health and social policy. Before leaving the EU, the UK was required to produce a National Roma Integration Strategy (NRIS). However, none of the policy measures included were specific to Roma, instead referencing pre-existing equalities and inclusion legislation. Once the UK left the EU the NRIS disappeared and was not replaced with a domestic policy commitment.

A common (but mostly ignored) concern flagged by Roma civil society is that Roma have much in common with other migrant groups (including language and immigration needs), but this is often overshadowed by issues of planning and accommodation associated

with Gypsies and Travellers.²³¹ Over the years, various Ministerial Working Groups and Inquiries have published commitments and recommendations (often under the conflated GRT construct) promoting cross-departmental working to tackle the complex and intersecting inequalities experienced by Roma people. Most have yet to be responded to or acted upon by the UK Government.

Most recently, 'GRT' have been named by National Health Service (NHS) England as an 'Inclusion Health Group', meaning they are seen to require special attention due to their additional health needs. Roma are also included in the work of the cross-government Health and Wellbeing Alliance. Together the Alliance has produced a 'Roma Health Guide', that aims to inform frontline NHS staff to support Roma access and engagement with services. See Orton (2026) for a more complete overview.²³²

The health of Roma women and underlying factors

A growing body of research compares the health of Roma and majority populations across Europe. These data, whilst pertaining to other countries, are relevant to Roma people living in the UK, most of whom have arrived within the last 10 to 20 years. These studies suggest that, despite considerable heterogeneity of circumstances, most Roma populations appear to suffer poorer health and wellbeing relative to non-Roma – including higher rates of communicable and non-communicable diseases, poorer self-rated child and maternal health and higher mortality rates.²³³ Health indicators for Roma are often worse than for other groups in similar socioeconomic positions (e.g. as measured by social class²³⁴) with Roma women experiencing the worst health of all.²²⁷ Reports suggest that gaps in morbidity and mortality rates between Roma and non-Roma continue to widen in most settings.²¹⁷ This threatens people's "Right to Health," a key component of the International Covenant on Economic, Social and Cultural Rights.²³⁵

In England, Roma life expectancy is reported to be up to 10 years lower compared to non-Roma communities.²³⁶ Unfortunately, census

data on the health of people who identified themselves as Roma in England and Wales are distorted by this lower age profile and do not provide a reliable picture. Data disaggregated by gender are not yet publicly available. Explanations for the poor health outcomes that many Roma experience typically focus on a deficit 'culture' and associated lifestyle and behaviour 'choices'.²³⁷

Such explanations ignore the subtle and complex, multi-dimensional and interacting processes linking multiple oppressions (based on racialised and gendered identities) and poverty with health inequalities.²³⁶ Roma, and Roma women in particular, face adverse differential treatment and experiences due to overlapping systems of oppression that increase their exposure to risk factors for poor health beyond those that can be explained by poverty.²³⁸

The underlying causal processes that shape Roma health inequality, including the legacy of past and continuing structural violence, social injustice and the intergenerational transmission of trauma, are left largely unexplored. Further research and data are needed to understand the wide-ranging psychological, social and economic impacts of racism, sexism and poverty that are likely to have the largest impact on the health of Roma women living in the North of England.

Experiences from the North of England

Data from the North of England are patchy, with very little focus on gendered experiences. Some local reports have been produced, but rarely acted upon, and many focus downstream on health indicators and service use, rather than the broader social, economic and political drivers of health inequality.

In 2016, a 75-page Slovak Roma Health Needs Assessment (available on request from Sheffield City Council) was published based on extensive data generation in Sheffield. It concluded with eight specific recommendations focusing on intersectoral working, data requirements, specific health and housing concerns and ways of



engaging better with Roma people (including language support and mediation). In terms of Roma women, the report flagged high teenage pregnancy rates and low access to antenatal care as being of particular concern.

In 2024, Manchester City Council produced a Joint Strategic Needs Assessment for Gypsy, Roma and Traveller Communities concluding that health outcomes for Roma are heavily influenced by living and working conditions, including education, employment and housing, and problems in accessing services.²³⁹ Recommendations include a focus on poverty and high unemployment as an underlying cause of health inequality; closer working with the Voluntary, Community, and Social Enterprise sector; better data collection; and inclusivity and 'cultural awareness' training for health staff.

In 2023, Leeds Health Observatory produced 16 recommendations for improving the mental health and wellbeing of Roma people living in the region.²⁴⁰ These focused on Voluntary, Community, and Social Enterprise involvement; community spaces for Roma; education and employment support; improving housing standards; better data gathering; building trust in services and addressing language barriers. Taken together, these local assessments point to a consistent set of themes – poverty, housing, data, language, trust and the need for increased community organisation capacity – yet progress in acting on their recommendations has been limited, and none has systematically addressed the specific experiences of Roma women.

Box 11.1. Barbora's Story

Context

Barbora's story was developed by Barbora (not her real name) with Roma VCSE staff who have worked directly with her over several years. It was chosen to illustrate the complex drivers of health and social inequality experienced by many Roma women living in (the North of) England. Her story is accompanied by an illustration produced by an independent artist based on the written text.

Barbora's Story

Barbora, who is Slovak Roma, has lived in South Yorkshire with her husband, five children and three grandchildren for many years. She speaks only limited English. She is well known to the local Roma support charity, seeking help with many adverse experiences. Shortly after recovering from surgery for breast cancer, Barbora's children were removed from her care when it was suspected there was an arranged marriage for one of her daughters. Barbora co-operated with Social Care and eventually managed to have her children returned on the condition they do not leave the UK until they are 18 years old.

Recently, Barbora's husband experienced a severe stroke, leaving him temporarily unable to walk and seriously affecting his speech. A misunderstanding led his care home to believe he had discharged himself. Barbora was left to care for him in a small terrace house in great need of repair and with an inappropriate layout to safely accommodate his basic needs (such as using the toilet).

Barbora struggles financially. She is able to claim benefits for herself. However, her husband is still negotiating the complex process of acquiring Settled Status. He cannot claim any support for his care and is facing high NHS bills. Barbora managed to arrange for him to return to Slovakia where he can access the care that he requires but she is unable to join him due to their children's travel restrictions. Throughout all these experiences, Barbora has struggled to access the support and information she has required, causing her significant emotional distress.

Box 11.2. Roma Health Stories

The Roma Health Stories project²⁴¹ conducted two-stage life history interviews with 10 Czech and Slovak Roma women living in Rotherham. Participants were identified to explore a diversity of experiences. Interviews followed a loose topic guide to explore people's life stories in the order and manner that they wished. The second interview followed up on themes mentioned in the first interview, in particular probing in more depth on health and wellbeing experiences. Most interviews were conducted in Czech/Slovak in people's homes. The women who took part in these interviews were then invited to produce 'visual I poems' to allow them to help shape the interpretations of their health and wellbeing stories. For each participant, the project team read through the transcripts relating to the interviews and highlighted the use of the first person 'I' and the seemingly associated text. I-phrases were lifted out of the transcript and arranged into stanzas based on different topics and voices. Once an I-Poem had been created the participant checked and revised the content. They were provided with arts materials and invited to rearrange the text and to visually enhance the poem with illustrations, doodles, etc, to depict important people and places referred to in the poem. Here we show extracts from the visual I poems depicting the experiences of Viktoria and Petra.

Recommendations

1. Data on the health of all Roma people should be presented separately from that of Gypsy and Traveller communities to better understand their unique experiences.
2. Policies to improve the health of Roma women should address racism, poverty, sexism and the intersection of these factors as the root cause of inequality, rather than focusing on lifestyle or behaviour, which are more often consequences of structural disadvantage than causes of it.
3. The considerable diversity of Roma identity and experience across the North of England should be recognised in policy design, avoiding the assumption that Roma communities are homogeneous in their needs or circumstances.
4. Roma women, and Roma more generally, should be involved in policy development from the outset, including in defining and describing the problems that policy seeks to address, rather than being consulted after decisions have been made.
5. Grassroots, community-led action within Roma communities should be formally recognised and sustainably funded, rather than left to operate without resources while statutory services fail to meet need.



Holding the line: Minority ethnic women-led organisations, community impact and the limits of goodwill

Authors Stephanie Ejegi-Memeh, Oluwaseun B Esan and Claire Hart

Summary

- Community-led organisations play a critical but undervalued role in supporting minority ethnic women in the North, bridging gaps left by statutory services through culturally responsive, trust-based provision that mainstream systems consistently fail to replicate.
- The needs met by community-led organisations are complex and wide-ranging: spanning physical and mental health; gender-based violence, housing insecurity, and employment status. Many minority ethnic women experience multiple challenges simultaneously, compounded by immigration status, language barriers and socioeconomic deprivation.
- Community-led organisations achieve outcomes that go beyond crisis response. Many women who first access services as users become volunteers, facilitators and leaders – with many going on to secure employment – demonstrating the transformative potential of grassroots provision when properly supported.
- Chronic funding instability and grant processes which exclude community organisations are the greatest threat to this sector. Organisations are expected to compensate for statutory failures and support those in crisis without equivalent resources or recognition.

Context

Women face overlapping disadvantages across key areas such as health, housing and occupation, and these issues are heightened for women from minority ethnic groups. Statutory systems repeatedly fail these women, often repeating or exacerbating structural inequalities and reducing wellbeing, safety and ability to flourish.^{242 243} This often leaves community organisations to bridge the gap between need and provision.²⁴⁴ In doing so, these organisations prove that the survival and flourishing of women from minority ethnic groups relies not on top-down state benevolence, but on self-determined, radical community solidarity.

In this chapter, we present two case studies and four personal perspectives exploring grassroots service provision for women from minority ethnic groups. These examples explore the power and potential of organisations embedded within communities. They showcase the added value of understanding lived experience, embedding cultural understanding and developing lasting and meaningful relationships that are built on trust.

Case study 12.1. Co-creating organisational responses to equity – perspectives from organisations supporting minority ethnic women in the North of England

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University of Liverpool, Caribbean and African Health Network (CAHN), and Teesside University.

Approach

Voluntary, Community and Social Enterprise (VCSE) organisations play a dominant role in supporting the needs of minority ethnic women living in the North of England, although the contributions are often unrecognised. When creating effective place-based policies, it is crucial to recognise, understand and support the untold contributions of these VCSE organisations by creating a mechanism for future ongoing collaborations.

C.O.R.E. (Co-creating Organisational Responses to Equity) is a participatory action research study conducted in partnership with the Caribbean and African Health Network (CAHN), the University of Liverpool and Teesside University. Here we report on a two-hour online co-creation workshop aimed at understanding how community-led organisations in the North of England support minority ethnic women with their health, housing and employment challenges to identify areas for policy improvement. Eight VCSE organisations from Liverpool, Greater Manchester and Middlesbrough participated in the workshop, which was facilitated using a trauma-informed approach with CAHN peer researchers. Participants were active co-researchers, not research subjects.

Findings

Participating organisations supported a wide range of women from minority ethnic groups (>15), including African, Arab, Eritrean, Ethiopian, Kurdish, Middle Eastern, South American, South Asian, and Ukrainian. Three-quarters of the organisations had been operating for over a decade.

The workshops revealed the profound unmet needs of minority ethnic women in the North. Organisations described women presenting with mental health difficulties rooted in trauma and domestic abuse, maternity fears, safeguarding concerns and an inability to access basic health services, including difficulty registering with a GP on arrival. Being dismissed and encountering culturally inappropriate care were recurring themes. These organisations respond by bringing health professionals into community spaces, accompanying women to appointments, adapting advice to culturally specific contexts and building trust through lived experience. It is this trust, accumulated over years, that enables them to reach women whom mainstream services are failing.

Housing insecurity was identified as a critical and under-addressed issue. This is particularly acute for women whose visas include the

condition 'No Recourse to Public Funds'. On health, participants spoke with pride about NHS partnerships that brought health professionals directly into their spaces, about cervical screening outreach, about the Living Well Bus visiting their premises. On employment, the most striking finding was the depth of transformation organisations achieve with women who, having first accessed support, go on to become volunteers, then facilitators, eventually leading their own workshops and securing employment. Participants' contributions had been recognised through awards by their local councils, as well as nominations for the King's Award for Voluntary Service, but they valued above all the opportunities for women who had once needed support to lead the sessions themselves for other women. This circle of empowerment was, for many, the clearest measure of their impact.

Yet these organisations are struggling. Every participant identified funding as the dominant challenge: its absence, its instability and the structural disadvantage faced in accessing funds by organisations led by minority ethnic groups. Grant processes designed for larger bodies systematically exclude community groups without dedicated fundraising staff. Organisations are routinely expected to cover out-of-hours crises and bridge statutory failures without adequate resources. The need to demonstrate impact in ways funders recognise – but lacking the resources to do so – compounds the problem further.

What must change

The organisations that participated in C.O.R.E. are not filling gaps at the margins of the system, they are holding communities together at its centre. Policymakers seeking to reduce health inequalities in the

North of England should have effective mechanisms for implementing place-based solutions with these organisations as equal partners. To meet this need:

- Grant funding frameworks must be redesigned to be genuinely accessible to small, community-rooted organisations – simplifying processes, weighting lived-experience credibility, providing longer funding cycles and ring-fencing commissioning budgets for VCSE organisations working with underserved communities.
- Housing insecurity for women with No Recourse to Public Funds must be treated as a health and equity priority.
- Local authorities and NHS Integrated Care Boards should develop joint protocols for supporting these women and resource community organisations as navigators within those pathways as a planned and funded part of the system.
- Statutory services must stop treating community organisations as a last resort and invest in them as infrastructure. Peer researcher models, community health navigation roles and co-produced public health initiatives should be funded as core provision, not as time-limited projects that dissolve when the grant ends.

Acknowledgements

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Case study 12.2. Family dynamics and emotional wellbeing

Author Hawa Yatera

From January to June 2025, our organisation United Women Affiliation delivered a community-led research project examining the emotional wellbeing of underprivileged single mothers in Sheffield, with a particular focus on refugees and asylum seekers from Sub-Saharan Africa. This initiative marked a significant achievement in our ongoing commitment to reducing health inequalities and ensuring that underserved communities are meaningfully represented in research and service design.

The project emerged in response to clear community need. Many single mothers attending our organisational events were experiencing profound emotional strain, social isolation, and barriers to essential services, yet their experiences remained largely invisible within mainstream support systems. Establishing this project required building trust, developing culturally safe research environments, and addressing practical barriers such as childcare, food insecurity, and language challenges. Through strong partnerships and the involvement of bilingual community researchers, we ensured that participants felt respected, understood, and able to share their lived experiences openly.

Using a community-based participatory approach we recruited nineteen women for interviews. Six children (aged 10-15) shared their stories under parental guidance, and two focus group discussions (24 women) were conducted. Findings showed that 81% of underprivileged parents that participated in this study were extremely isolated and felt lonely with few activities to engage with; 76% experienced poor emotional wellbeing and had never had access to inclusive mental health services; 19% experienced high pressure in parenting and had no time for self-recovery; 76% were still waiting for therapeutic services for more than two years; and 90% were economically inactive due to parental responsibilities and a lack of skills for flexible jobs. Children felt pity and anger toward their mothers when their needs went unmet and 24% of participants spent most of

the time in the house.

Participants were not simply respondents; they were co-creators who shaped the direction and priorities of the research. Many described this as the first time they felt genuinely heard. Alongside data collection, we provided holistic support including interpretation, advocacy, wellbeing sessions, and culturally appropriate food, helping families navigate GP registration, mental health pathways, and essential services.

The impact of this work has been substantial. The project reduced social isolation, strengthened community connections, and improved access to support. It also generated robust evidence highlighting systemic barriers related to language, service accessibility, and the emotional pressures of parenting in contexts of poverty and displacement.

We are most proud that this project transformed research into healing, creating safe spaces, strengthening confidence, and laying the foundation for more culturally responsive services that reflect the realities of the mothers we serve. It is a clear example of how community-led research can both generate important data and have a powerful impact on women's lives.



Perspective 12.1. The creation of the International Women in Sheffield Group

Author Livia Barreira

The year was 2016. A Brazilian woman in her early 30s had just arrived in Sheffield, northern England. Like many other migrants she was carrying a suitcase full of dreams and expectations. In that initial moment, in a completely different environment, she felt excited as a new chapter of her life was starting. However, as time passed she realised that her journey in a new country would be much more challenging than she thought. The reality is that it can be quite lonely as a newcomer and making friends as an adult is really difficult.

Ten years later she is here writing this piece and sharing how she found her path in the UK, despite all the difficulties. Let me properly introduce myself. My name is Livia Barreira. I am originally from Fortaleza, Brazil. During my time in Sheffield, I have been using my communication and community engagement skills – alongside my best Brazilian energy – to proudly create supportive, safe and joyful spaces for women from our international community.

Writing my book “Living in Sheffield: Our Journeys as Migrant Women”

made me realise how many other migrant women also struggle to find a community where they feel comfortable and genuinely supported. After publishing the book, in 2023 I organised a coffee morning focused on offering a safe, joyful experience. About 25 women turned up to this event, and the International Women in Sheffield community group was born. Since then, this group has grown organically and in 2026 we are a meaningful community of nearly 350 women from across the world, with respect as our key value. I completely believe that when we are together we are much stronger, especially when we face an increasingly hostile environment towards migrants. Building meaningful connections with diverse communities creates not only a safe space for us to connect and socialise, but it also contributes to tackling stereotypes.

I am very proud of every single step I took to open up spaces for other migrants, especially women from the Global South like me, to feel encouraged and proud of who they are and their valuable contributions.

Perspective 12.2. Positive Contributions to Women’s Lives – My journey to setting up “Let Us Speak Out CIC”

Author Nwugo Ugada

Let Us Speak Out is a community-based initiative supporting Black African women across issues relating to sexual wellbeing, mental wellbeing, domestic and sexual violence, menopause, and other interconnected health concerns. The initiative was developed following my lived experiences of domestic and sexual violence while growing up, and my master’s dissertation on the impact of intimate partner sexual violence among Black African women. There is increasing visibility of the extent and impact of domestic and sexual violence and relationship breakdown within some Black African communities in the United Kingdom. However, my work highlighted research gaps and the need for culturally responsive approaches, as well as the need for safe, accessible spaces where women can seek support for their sexual and mental wellbeing without judgment or shame.

Drawing on many years of practice and research-informed insight, the work recognises the intersecting factors shaping women’s experiences, including patriarchal social structures, cultural expectations, and the taboo surrounding women speaking openly, particularly in public, about domestic and sexual violence and mental wellbeing within many African communities. These factors can affect

women’s psychological wellbeing, contributing to emotional distress, anxiety, and reduced self-esteem, and may also impact reproductive and sexual health through stress-related physical symptoms. Let Us Speak Out adopts a holistic and culturally sensitive approach that centres women’s lived experiences, promotes open dialogue, and strengthens awareness of rights, choices, and available support.

A key contribution of this work has been building trust within underserved communities. For example, one woman described prolonged emotional distress linked to menopause and intimate partner violence-related challenges. Still, she had not felt able to seek help due to stigma and fear of not being understood. Through a culturally attuned and non-judgemental space, she was able to access support and begin rebuilding her wellbeing, alongside strengthening her confidence to speak openly about her experiences.

Looking ahead, Let Us Speak Out aims to expand its reach through education, advocacy, and collaboration. A central aim is to build women’s confidence to speak out without fear of judgment, shame, or isolation, and to support them in contributing to decision-making regarding their sexual wellbeing within their relationships.

Perspective 12.3. Bridging Cultural Barriers in Women’s Healthcare Access: A Reflective Perspective

Author Poppy Choudhury-Green

Women’s Community Boutique CIC is a community interest company based in Sunderland, established to tackle poverty, isolation and inequality among women in the North East through a unique blend of sustainable fashion, practical support and skills building. We combine a free shared wardrobe, food pantry and hygiene provision with a bridal wear service that funds our work, alongside workshops in upcycling, cookery, ESOL, digital literacy and dance. With no eligibility criteria, we support whoever needs it, always ensuring women shape that support themselves. Through this, we have helped women facing domestic abuse, hardship, isolation and language barriers, supported many into paid roles, education and self-employment, and built a trusted, dignity-led space recognised across Sunderland. We are now extending our reach through an online store, multilingual

materials and dedicated programmes for domestic abuse recovery and women 45+, working towards becoming a leading North East hub for sustainable fashion and community support.

Access to healthcare for minority ethnic women is often framed in terms of service availability; however, my lived experience suggests that access is more deeply shaped by confidence, cultural norms, language, and trust. Drawing on both my personal background as a British Bangladeshi woman and my work supporting women through a community organisation, this reflection explores how women understand and engage with healthcare, and how current approaches can unintentionally reinforce barriers.

From my experience, many minority ethnic women do not lack access to services in a physical sense, but rather the confidence and agency to use them. Language barriers, unfamiliarity with systems, and cultural expectations around silence and endurance often prevent women from articulating their needs. Health concerns are frequently normalised or dismissed, particularly those relating to menstruation, perimenopause, and reproductive health.

Cultural silence plays a significant role in shaping these experiences. For example, during Ramadan, Muslim women who are menstruating are exempt from fasting, yet many feel a sense of shame and may hide the fact that they are eating. This reflects a broader discomfort around discussing menstruation openly. In my own adolescence, I fasted for the full month, which led to my menstrual cycle temporarily stopping. This was not recognised as a health concern, as I lacked awareness of its significance and did not discuss it. Similarly, my mother experienced menstruation and menopause without ever openly discussing discomfort, reinforcing a generational pattern of silence.

Healthcare services often attempt to engage minority ethnic women through culturally specific groups. While well-intentioned, this approach can reinforce existing norms that discourage open discussion. When women are surrounded by others who share the same cultural beliefs, they may feel less able to raise concerns, as these are often perceived as complaints rather than legitimate health issues.

In contrast, my work has demonstrated the value of inclusive, mixed

community spaces. Bringing together women of different ages, ethnicities, and experiences creates opportunities for shared learning and increased confidence. For instance, a young British South Asian woman in our group once hesitantly raised concerns about a skin condition. Other women, including a British White retired nurse, recognised the symptoms and encouraged her to seek help from a pharmacy. She did so immediately and accessed appropriate treatment. This interaction was only possible because she felt safe within a diverse group where knowledge and experiences were shared openly.

Such examples highlight that healthcare access is not solely dependent on professional intervention, but also on peer support and trust. Women are more likely to seek help when they feel heard, understood, and free from judgement. This suggests a need to rethink current engagement models.

Building trust requires consistent, long-term presence within communities. Healthcare professionals who engage regularly and become familiar faces are more likely to be approached. While this may present logistical challenges, it offers a more sustainable approach to improving access.

In conclusion, improving healthcare access for minority ethnic women requires moving beyond culturally segmented approaches towards inclusive, community-based models. By creating safe spaces, encouraging open dialogue, and building trust over time, healthcare services can better support women to understand and advocate for their health.

Perspective 12.4. Nur Fitness

Author Shazia Noor <https://www.nur-fitness.co.uk/>

Nur Fitness is an award-winning community organisation, based in Middlesbrough, dedicated to the health and empowerment of women and families. They work with all women but specialise in working with minority ethnic communities. They provide awareness, prevention and management programs addressing areas of physical and mental health, and employability and self-confidence courses.

In terms of approaches to reaching women from minoritised ethnic groups, from my experience the most effective ways are through trusted and familiar environments. Faith-based settings such as mosques, Quran classes, and women's gatherings in homes can work well, as women already feel comfortable and safe in these spaces. Similarly, local community groups and organisations, as well as initiatives like NUR Fitness, are helpful because relationships and trust are already established.

Informal, everyday spaces are also really important. Places like local clothing shops and beauty salons often act as social hubs where women speak openly and share information, so they can be valuable for engagement. Word of mouth is particularly powerful within our communities: once trust is built and women have a positive

experience, information spreads quickly through personal networks.

Social media is another useful route, especially platforms like TikTok, where many women access information and learn about opportunities. Schools are also a good point of contact, as they connect directly with mothers and families and can help reach women who may not be involved in other groups.

In terms of gender and cultural aspects, I think it's important to recognise that in some communities, women are more likely to be seen in caregiving roles only. They have a lot of pressure on them and no time, which can affect capacity or confidence to get involved. Some women may not feel comfortable speaking openly, especially in mixed settings, so female-only spaces can really help. Family dynamics can also play a part in whether women feel able to take part. From what I've seen, women engage more when they feel at ease, not judged, and when things are done in a more informal and respectful way. Building that trust over time is key, as it helps reduce any feelings of imbalance and allows women to feel more confident in sharing their views.



Discussion

These studies showcase the undeniable power of grassroots organisations to meet unmet needs in underserved groups. They highlight the breadth of complex health and social care needs, but they also highlight the untold contribution made by voluntary agencies. By tapping into the knowledge and lived experience within communities, agencies can both address gaps left by statutory services and improve the suitability and effectiveness of what is provided.²⁴⁵ They are better able to build culturally responsive services, to act as cultural brokers between communities and external parties, and to respond more effectively to cultural and linguistic barriers.²⁴⁴ To rely on the unpaid and underfunded labour of minority ethnic women to fix statutory failures is not just unsustainable – it is institutional exploitation. True equity requires shifting from a mindset of piecemeal funding to a redistribution of power, recognising that these women are not just service providers, but the architects of their own liberation.

A key foundation for the success of community-led services is their ability to build trust.²⁴⁶ Trust can be hard to achieve within statutory services due to limitations in their understanding of the needs of minority ethnic women, and the focus on short-term provision.²⁴² Trust is largely relational and develops over many years through demonstrations of reliability and understanding. The development of trust within community-led organisations such as these has allowed them to create non-judgmental, trauma-informed spaces. Trust has also supported them in meaningful co-production, which strengthens mutual understanding and allows the agencies to respond more accurately to the needs of their users.²⁴⁷

The case studies also showcase how women enter services requiring help, then move into roles in facilitation or leadership. This captures the transformative power of community engagement to support personal development, harness unused knowledge and skills, and unlock women's potential.²⁴⁸ The case studies describe services which help women to feel safe and supported, but to also experience joy, moving beyond survival, to enable women to live well and flourish.²⁴⁹

Finally, the value of voluntary organisations should be acknowledged in the context of the challenges they face. They have stepped in to

address needs where statutory services fail, but they are not immune to the pressures of meeting complex needs.²⁵⁰ The backdrop of the hostile environment for minority ethnic groups, the ongoing scramble for funding, and demands to provide services alongside existing exclusionary systems all have the potential to undermine voluntary organisations.²⁵⁰ If we continue to expect voluntary community-led agencies to fill gaps that should be met by statutory organisations, then we risk exploiting their energy and goodwill. If we wish to see community-led organisations thrive, we need to employ the same values they do: listening to understand; demonstrating respect for women's capabilities; celebrating achievements; and committing to long-term support.^{242 244} In a world that so often isolates individuals and communities, these grassroots movements offer a masterclass in solidarity. The achievements of community organisations led by minority ethnic women prove that when these women are truly seen and supported, they do not just endure, they lead, transform, and thrive.

Recommendations

1. Grant funding frameworks should be redesigned to be genuinely accessible to small, community-rooted organisations including simplified application processes, longer funding cycles, and ring-fenced commissioning budgets.
2. Statutory services should invest in VCSE organisations as core infrastructure rather than a last resort, with peer researcher models, community health navigation roles and co-produced public health initiatives funded as sustained provision rather than time-limited projects.
3. Faith communities and grassroots networks should be recognised as important sources of support for minority ethnic women, including those living with and beyond serious illness, and should be engaged as partners in the design and delivery of health and social care services.
4. The unpaid and underfunded labour of minority ethnic women and the organisations they lead should be formally recognised and adequately resourced, with commissioning bodies committing to long-term partnerships built on respect, trust and shared power.



The power of data to address health inequalities faced by minority ethnic groups

Authors Akansha Singh, Sophia D. Amenyah, Rizwana Lala, Nasima Akhter

Summary

- Reliable and complete ethnicity data are essential for identifying and tackling inequalities faced by minority ethnic groups. Significant gaps persist across health and administrative datasets, with data quality varying substantially by source and region. This undermines efforts to address the underlying causes of health inequalities, limiting opportunities to address them through policy change, improved service design and equitable resource allocations.
- Critical gaps persist in the availability of data that allow disaggregation of specific ethnic groups. Broad categorisation such as 'White', 'Asian, Black or Mixed' does not capture the variation in health outcomes or lived experiences of specific ethnic groups. Gaps in disaggregated data also obscure and limit analyses of intersecting inequalities – including economic, gender, disability – experienced by different ethnic groups.
- Gaps and poor data quality have multiple complex causes including outdated systems, inconsistent approaches across organisations, culturally incongruent data collection tools, inadequate staff training, and systemic barriers related to trust, language and data governance – all of which disproportionately affect minority ethnic groups.
- Current and historical NHS–Home Office data-sharing arrangements, alongside concerns about third-party access to NHS data, undermine trust among migrant and minority ethnic groups. This can discourage engagement with health services and disclosure of information, further contributing to gaps in ethnicity recording and analysis of health data.
- Data and AI are central to the NHS 10 Year Health Plan. However, significant under-representation of minority ethnic groups in health and genomic datasets – often due to study design, or lack of participation – creates risks that these technologies exclude groups, and reproduce or amplify existing inequalities.
- There is a need to develop processes to integrate qualitative data into quantitative data systems to fully understand lived experiences of multiply marginalised groups such as minority ethnic women in the North.

Context

We cannot effectively tackle health inequalities if we do not understand the scale and types of inequalities experienced by different groups and the social determinants of these inequalities. This is particularly true for minority ethnic women in the North of England, whose experiences sit at the intersection of gender, ethnicity, place and socioeconomic disadvantage. Intersectionality – the recognition that these factors overlap, interact and reinforce one another to shape health outcomes in ways that cannot be understood by examining any one alone – is therefore central to the aims of this report. Yet our ability to apply an intersectional lens is fundamentally constrained by the data available to us.

Reliable data on ethnicity is a prerequisite for adequate and accurate

assessment of health inequalities. Yet gaps in how ethnicity is recorded across NHS and administrative datasets remain a significant and largely unresolved problem.^{251 252} These data gaps undermine our capacity to identify where, when, for whom and to what extent to intervene. They also limit our capacity to understand which factors, such as socioeconomic deprivation or access to care, sit on the pathway between ethnicity and poor health outcomes.

Critically, incomplete, incorrect or unrepresentative ethnicity records also weaken cost-effectiveness analyses, since credible estimates of the cost-effectiveness of an intervention for a minority ethnic group require a sufficiently large and representative sample of that population to appear in the data (National Institute for Health and Care Excellence²⁵³). Without improving the completeness of ethnicity recording – and the consistency of how ethnicity is recorded between different data sets to enable like-for-like analyses – we risk bias in health data.²⁵⁴ A critical limitation running throughout this report is the difficulty or even impossibility of examining the intersecting effects of gender, ethnicity and region due to lack of disaggregated data.

Due to the lack of datasets with adequate representation at ethnic group level, there were instances when analyses have had to rely on broad categories such as 'White' vs 'Asian, Black or Mixed' ethnicity, which masks the differences that exist within and between ethnic groups, and also by region. Furthermore, this has prevented intersectional analysis; this would require adequate ethnically disaggregated regional within regions. As Krieger and Davey Smith remind us, reducing health inequalities demands that we look beyond individual-level risk factors to the structural conditions, including discrimination, poverty, and exclusion, that data systems themselves too often fail to capture.²⁵⁵ In this chapter we describe why data quality matters, the state of the UK data landscape and what needs to change.

Why the quality of ethnicity data matters

The consequences of poor ethnicity data quality are not abstract. Minority ethnic groups already face poorer access to health care services and worse outcomes than the White British population across a range of conditions, and these inequalities are compounded when gender, place and socioeconomic disadvantage intersect, as this report consistently demonstrates. Underlying risk factors for poor health – such as access to resources and healthcare, health behaviours, cultural norms, gender roles and women's empowerment – tend to vary by ethnicity. Good quality data is therefore a cornerstone for understanding and effectively addressing long-standing ethnic inequalities in health.^{256 257}

COVID-19 further revealed the depth of these health inequalities with South Asian, Black and Mixed ethnic groups all facing higher rates of infection and mortality than White ethnic groups.^{28 258-260} The stark inequalities in the UK are further emphasised by the higher maternal mortality among Black women and minority ethnic women from lower socioeconomic background,²⁶¹ and lower access to mental

health services among minority ethnic groups.⁸⁰ Addressing these inequalities requires in-depth investigation and high-quality ethnicity disaggregated data. These data are often inadequate – either poorly recorded (Gypsy, Roma and Traveller and Jewish people not separately recorded), completely absent or inconsistently recorded between organisations²⁶² – in ways that prevent data harmonisation or meaningful comparison of findings. This lack of harmonisation matters because systems of marginalisation – including racism, sexism and class exploitation – do not operate in isolation but act together to create compounded disadvantage in healthcare access and health outcomes. The effects of these limitations are seen throughout this report: authors have often had to rely on broad ethnic categories – grouping together, for example, ‘White’ and ‘Asian, Black, Mixed and Other’ – and on analyses that can describe patterns by ethnicity or by region, but not both together. The specific experiences of minority ethnic women living in the North of England therefore remain only partially visible in the evidence.

Without complete and reliable ethnicity data, assessment of inequalities in access, experience, and outcomes across minority ethnic groups is severely limited, as is appropriate risk stratification and the delivery of equitable, personalised, and compassionate care. This limits the NHS’s ability to design targeted interventions. Gaps in ethnicity data also affect service planning, leading to inefficient resource allocation, overlooked patient needs and misjudgement of demand for healthcare services – ultimately resulting in poorer outcomes and higher costs. In research and digital health, unrepresentative data can weaken evidence and introduce bias

into technologies such as clinical algorithms. While improving data collection is important, it is equally important to use available data effectively, since even incomplete information can highlight potential inequalities and guide further investigation into whether services are meeting the needs of all populations.

Current ethnicity data landscape for England

Ethnicity data in England is extracted from various population surveys and administrative datasets, each collected for different purposes and using partially aligned classification systems,²⁶² see Table 13.1. The 2021 Census remains the gold standard for ethnicity assessment, offering the most comprehensive and granular classification alongside rich sociodemographic information.⁴¹ It plays a critical role in benchmarking and validating health datasets but is limited by its decennial nature, the absence of clinical detail, and the exclusion of undocumented populations – constraining its usefulness for real time service planning and monitoring. Among administrative datasets, GPES/GDPPR: General Practice Extraction Service (GPES) Data for Pandemic Planning and Research (GDPPR) provides the most complete and accurate routine source of ethnicity data for health research and delivery, showing high agreement with Census 2021 for many major ethnic groups. In contrast, ethnicity coding within hospital datasets (HES: Hospital Episode Statistics, and SUS: Secondary Uses Service) is less reliable (Table 13.1), with persistent problems including incomplete recording, inconsistent use of categories, and overreliance on residual codes such as “not stated” or “other”. These issues disproportionately affect recording of minority ethnic groups and vary systematically by region, age and care setting, complicating

Table 13.1. Ethnicity categories across different data sources.

Data source	Primary purpose	Ethnicity categories (approx.)	Strengths for ethnicity analysis	Key limitations
Census 2021 ⁴¹	Population enumeration and planning	~18 high level groups with detailed sub categories	Gold standard for ethnicity measurement; comprehensive coverage; detailed socio demographic context; allows bench-marking and validation of administrative data	Collected every 10 years; no clinical detail; excludes undocumented populations; limited for monitoring short term health trends
General Practice Records (GPES / GDPPR)	Primary care delivery and population health management	NHS ethnicity coding standard (~20+ categories)	Highest completeness and agreement with Census 2021 for many groups (e.g. White British, South Asian, Black African); suitable for defining baseline ethnicity for research and service planning	Excludes people not registered with a GP (e.g. migrants, people experiencing homelessness); quality depends on practice level recording
Hospital Episode Statistics (HES) ²⁶⁵	Secondary care activity and outcomes	NHS ethnicity coding standard	Enables analysis of hospital use, admissions and outcomes by broad ethnic group	Lower accuracy than GP records; poor re-cording for Mixed, Traveller and smaller groups; high use of residual categories (“unknown”, “other”)
Secondary Uses Service (SUS) ²⁶⁶	Commissioning, payment, service monitoring	NHS ethnicity coding standard	Covers multiple care settings (inpatient, outpatient, emergency, mental health, community services)	Inconsistent coding across datasets and providers; reflects access patterns as much as need
Patient experience surveys ²⁶⁷	Service experience and satisfaction	Limited or no ethnicity disaggregated reporting	Rich qualitative insight into access, trust and perceptions	Ethnicity not routinely used in analysis; limited ability to assess inequalities quantitatively

attempts to assess inequalities along patient pathways.^{263 264} Although patient experience surveys provide valuable qualitative insight into trust, access and service acceptability, ethnicity is not routinely or consistently incorporated in quantitative analyses of these aspects.

Ethnicity coding agreement between datasets even varies by region. A 2024 study by the Office for National Statistics assessed agreement between Census 2021 and health-related administrative datasets.²⁶⁸ The report noted in regionally disaggregated data for the North East that agreement between Hospital Episode Statistics recorded ethnicity and Census derived category was very high for White British (98%), and relatively strong for Bangladeshi (94%) and Pakistani (88%) groups. However, agreement drops markedly for several groups: (e.g., Caribbean: 38%, Other Asian: 34%, Irish: 32%, Other mixed: 15%, and Other Black: 9%). In linked GP practice administrative data (GPES/GDPPR), ethnicity agreement in the North East exceeds 90% for White British (99%), Bangladeshi (97%), Pakistani (94%), and Chinese (93%) populations. Nevertheless, structural weaknesses persist for smaller and marginalised groups even in this higher quality data source. Agreement remains substantially lower for Caribbean (64%), Irish (57%), Other White (36%), and White and Asian (51%) populations.

This evidence indicates that quantitative ethnicity disaggregated data requires a consistent recording approach and should be triangulated with qualitative evidence, particularly for racially minoritised communities experiencing intersecting disadvantages related to gender, deprivation or migration status.²⁶⁹

Reasons for gaps and poor-quality data

Gaps and poor data quality have multiple interrelated causes that can be broadly categorised into systemic and operational. Systemic causes – data exchange processes, data governance and AI usage – require higher level policy changes which would be most effective in addressing the underlying causes of gaps in data. Operational causes – such as failing to capture data for specific populations and how ethnicity is recorded, collected and interpreted in practice – can be addressed through improving processes across organisations and systems.

Systemic causes

Data exchange and transparency

The data exchange processes between the NHS and Home Office, particularly in relation to immigration status and NHS charging, alongside wider concerns about transparency about how personal information may be used undermines trust amongst minority ethnic groups. A recent 2025 engagement report by NHS England and Department of Health and Social Care recorded lower levels of trust in the NHS amongst migrants with particular concerns around data sharing between multiple organisations.²⁷⁰ Evidence from Maternity Action gives important insights into the lived experiences of minority ethnic women affected by NHS charges including barriers to accessing maternity care, fear of costs and debt, impact of immigration outcomes through financial data sharing and wider mistrust in health services.²⁷¹ Lack of clarity around data protection, together with language barriers, can aggravate this mistrust further.

Data governance

There are further emerging concerns about the use of patient data extending beyond current NHS–Home Office information-sharing processes. Palantir, the lead provider of the NHS Federated Data Platform, has faced significant scrutiny because of its wider role in surveillance, policing and immigration enforcement, with concerns about its involvement in NHS data systems raised in Parliament and by civil society organisations including the NHS Race and Health Observatory.²⁷² In June 2026, the House of Commons Science, Innovation and Technology Committee published “Rewiring the State” and warned that the UK Government’s growing reliance on US tech firm Palantir across health and defence creates an “unacceptable point of weakness”.²⁷³ It also highlights concerns around public trust, data governance and reliance on a single provider. These

concerns are especially significant for minority ethnic groups and migrant communities who continue to experience disproportionate surveillance and immigration enforcement. Perceptions that health data could be accessed or used beyond healthcare undermine trust, discourage engagement with services and reduce willingness to disclose information.

Artificial Intelligence

The increasing use of AI in healthcare creates additional risks because data used to develop and train systems do not adequately represent minority ethnic groups. AI is a central component of the NHS 10 Year Health Plan, including ambitions to expand AI-enabled personalised medicine.³³ However, the datasets underpinning these technologies are highly unrepresentative. Evidence submitted to Parliament by the NHS Race and Health Observatory highlights that 95% of the 500,000 participants in UK Biobank are White, while only 6.56% of participants across 137 genomic studies reviewed were from minority ethnic groups. This under-representation means that genomic and health data may generate significant scientific and commercial value while failing to adequately represent and serve the communities whose data and health needs are being studied. It also risks producing AI and genomic tools that are less accurate for minority ethnic populations, potentially reproducing and amplifying existing health inequalities. As AI becomes increasingly embedded within NHS services, improving the representation and quality of ethnicity data and ensuring that minority ethnic groups are meaningfully represented in the development and benefits of these technologies is essential.²⁷²

Operational

Hidden populations

Data does not capture people who are excluded from services. Routine NHS datasets are largely generated through contact with health services. People who face the greatest barriers to accessing care can therefore be missing or under-represented in the data. This is particularly relevant for people experiencing homelessness, vulnerable migrants, Gypsy, Roma and Traveller communities, people experiencing domestic abuse and other inclusion-health groups. NHS England acknowledges that these communities are often invisible in health datasets, meaning their needs may be overlooked in service planning and evaluation. This creates a cycle in which those least able to access services are also least visible in the data used to design and resource them.

Recording and coordination across systems

Several factors contribute to the poor recording of ethnicity data. Overreliance on decades-old coding systems and a lack of coordination within and between organisations – including the NHS, Office for National Statistics, and Department for Work and Pensions (DWP) – result in poor-quality data which cannot be compared across sectors. Current challenges include the absence of ethnicity data in essential data sources, such as death registrations, from which mortality statistics are derived; poor coverage in primary care data; outdated ethnicity codes used within the NHS compared with those used in the 2011 and 2021 censuses; and systematic differences in ethnicity coding between White and minority ethnic groups. The lack of synchronicity between datasets in both frequency of data collection and data coding prevents combination of available data and holistic data analysis. Furthermore, poor design for data capture limits the scope to reflect lived, fluid, and plural ethnic/racial identities of people, e.g., one can be Arab, Black and British but cannot tick multiple boxes. Existing systems that include the option ‘mixed’ may not be adequate.^{41 257} Systems need to include the functionality of selecting more than one category due to the fluid and plural character of ethnicity.

Data collection at point of contact

Ethnicity data quality is also shaped by how information is collected in GP practices. Although ‘ethnicity’ can be self-reported based on an individual’s own perceived belonging to an ethnic group and cultural background,²⁵⁴ there are interpersonal barriers to data collection.

Lack of trust between patients and healthcare providers can lead to reluctance to share ethnicity, especially for undocumented migrants and asylum seekers. In addition, staff sometimes lack the confidence and the training to ask patients to identify their ethnicity and record the data.^{274 275} Improving ethnicity data recording and processing is crucial to developing targeted policies aimed at reducing ethnic inequalities.

Culturally incongruent tools and methods

Challenges surrounding the underrepresentation of ethnically diverse populations in health research extend beyond a simple lack of data. They also encompass fundamental shortcomings in the methods and tools used to collect data, as well as in the approaches taken to engage these communities meaningfully in the research process. A fundamental concern is that many standardised data collection tools were developed predominantly within Western, White populations, making them culturally incongruent for individuals from African, Caribbean, and South Asian communities.²⁷⁶ This is the case for several instruments used across clinical, epidemiological and community-based research. For example, the Patient Health Questionnaire-9 (PHQ-9), routinely used in UK primary care to screen for depression, focuses on psychological and cognitive symptoms that may not reflect how distress is experienced or expressed across all cultures. Among South Asian patients in particular, depression is more commonly described through somatic symptoms such as fatigue, bodily pain, and headaches rather than low mood or loss of interest, meaning the PHQ-9 may systematically under detect depression in these groups.^{277 278}

Cultural incongruence is also evident in non-clinical studies, including nutritional or dietary assessment surveys. Food Frequency Questionnaires (FFQs) capturing habitual dietary intake in large-scale epidemiological studies have been predominantly developed and validated in White European populations and are poorly suited to assessing the diets of individuals from African, Caribbean, and South Asian communities.^{279 280} This limitation is also pronounced in large national studies such as the UK Biobank, whose dietary assessment tool asks respondents to quantify vegetable consumption in discrete units such as tablespoonfuls or heaped portions of individual vegetables,²⁸¹ whereas dietary practices of some ethnic groups may not be captured well by such a measure.

Overall, a well-thought-out approach and use of quantitative and qualitative insight, as appropriate, is needed. Minority ethnic groups, by definition, make up a much smaller proportion of the population than the White ethnic group. When broken down by specific ethnic backgrounds it can bring further challenges of representativeness, data presentation or suppression issues, and limitation in quantitative data analysis approaches. In the face of these issues, when data do not allow further disaggregation, we can examine the differences between White and non-White groups as an initial estimation. However, it then requires careful interpretation of the data, and a mixed methods approach could be useful to investigate an issue further.

Discussion

Improving the quality and completeness of ethnicity data is not a technical nicety; it is a prerequisite for equitable healthcare. As this chapter has shown, current data systems are inadequate in multiple respects: recording is inconsistent, coding is outdated, tools are culturally incongruent, and the data that does exist cannot in many cases readily be analysed by ethnicity, gender and region together. The result is that the inequalities faced by minority ethnic women in the North of England are almost certainly underestimated. Addressing this requires action at every level – from national government leadership on data standards, to frontline staff confidence in recording ethnicity, to the redesign of data collection tools that better reflect the diversity of the populations they serve. Without this, the ability to identify need and target interventions will remain severely limited.

Recommendations

1. The UK Government should set clear, narrow limits on NHS data sharing with other organisations, explicitly defining what can and cannot be shared with government departments, immigration authorities, private companies and technology providers. They should ensure that data collected for healthcare is never used in ways that could deter people from accessing care, particularly immigration enforcement.
2. Accessible patient-facing materials should be developed and shared, explaining why ethnicity data is collected and how it is used to monitor progress on health inequalities and design targeted services. This will encourage more patients to self-report their ethnicity and improve the completeness of ethnicity records.
3. Data-sharing arrangements should be reviewed on a regular basis to assess their impact on trust, service access and inequalities, with provision for arrangements being suspended or amended where there is evidence of harm.
4. AI and third-party data platforms used within the NHS should be subject to mandatory ethnic and intersectional bias assessments before and after deployment, strict controls on third-party access and commercialisation of NHS data, transparent publication of how such platforms access and process NHS data, and meaningful involvement of minoritised communities in decisions about the use of their health and genomic data.
5. The UK Government should take leadership on ethnicity data quality by developing coordinated, updated guidance on consistent approaches to data collection, coding and reporting across health and administrative datasets, aligned with emerging standards such as the Unified Information Standard for Protected Characteristics, and should set clear targets to reduce missing, unknown and residual ethnicity codes.
6. NHS, ONS and other relevant organisations should work to harmonise ethnicity data collection and coding so that data can be reliably linked, compared and analysed across care settings, datasets and over time.
7. Data collection tools and methods used in clinical and research settings should be reviewed and updated to be culturally appropriate and inclusive, ensuring they adequately capture the experiences of minority ethnic communities. Quantitative ethnicity data should be routinely complemented with qualitative evidence and meaningful patient and public involvement, particularly for communities experiencing intersecting disadvantages related to gender, deprivation and migration status.
8. The UK Government should continue to monitor ethnicity data quality through clear indicators at provider, regional and national level, including reductions in missing data, increases in valid ethnicity recording and improved consistency across datasets, with findings reported publicly as part of broader equality, diversity and inclusion frameworks.

Lipid Profile	
Cholesterol	1.0
Triglyceride	1.5
HDL-Cholesterol	2.50
LDL-Cholesterol	
Non-HDL-Cholesterol	3.50
Total/HDL Ratio	
Clear S	
Ref. Ra	

References

- Health Equity North. Northern Health Science Alliance. Woman of the North: Inequality, Health and Work., 2024.
- Office for National Statistics. Life expectancy for local areas of the UK: between 2001 to 2003 and 2022 to 2024., 2025.
- Francis-Devine B. Poverty in the UK: Statistics: House of Commons Library, 2026.
- Joseph Rowntree Foundation. UK Poverty 2026: The essential guide to understanding poverty in the UK., 2025.
- Department for Work and Pensions. Ethnicity facts and figures: Persistent low income 17th September 2025, 2025.
- Department for Work and Pensions. Family Resources Survey: financial year 2024 to 2025, 2026.
- Office for National Statistics. Hate crime, England and Wales, year ending March 2025, 2025.
- Barbulescu R, Favell A, Khan O, et al. Class, race and inequality in Northern Towns.: Runnymede Trust, 2019.
- Office for National Statistics. Labour market status by ethnic group 17th February, 2026.
- Goldblatt P, Raleigh V. Ethnic inequalities in all-cause mortality in the UK: the importance of evidence in shaping health policy. *The Lancet Regional Health – Europe* 2025;59 doi: 10.1016/j.lanep.2025.101530
- Raleigh V. The health of women from ethnic minority groups in England: The King's Fund, 2025.
- Arundell L-L, Saunders R, Barnett P, et al. Exploring perspectives on how to improve psychological treatment for women from minoritised ethnic communities: A qualitative study with service users. *International Journal of Social Psychiatry* 2024;70(8):1481–94. doi: 10.1177/00207640241270800
- Adesina M, MacDonald M, McKelvin G, et al. Maternal health inequalities: focusing on Black pregnant women. *British Journal of Midwifery* 2025;33(4):227–33. doi: 10.12968/bjom.2024.0096
- Nellums LB, Powis J, Jones L, et al. "It's a life you're playing with": A qualitative study on experiences of NHS maternity services among undocumented migrant women in England. *Social Science & Medicine* 2021;270:113610. doi: <https://doi.org/10.1016/j.socscimed.2020.113610>
- Bernard K, McGowan VJ, Bamba C. "Power, control, strain": Lay perceptions of health inequalities across England's 'North South divide'. *Social Science & Medicine* 2024;355:117089. doi: <https://doi.org/10.1016/j.socscimed.2024.117089>
- Munford L, Khavandi S, Bamba C. COVID-19 and deprivation amplification: An ecological study of geographical inequalities in mortality in England. *Health & Place* 2022;78:102933. doi: <https://doi.org/10.1016/j.healthplace.2022.102933>
- Pan D, Sze S, Minhas JS, et al. The impact of ethnicity on clinical outcomes in COVID-19: A systematic review. *eClinicalMedicine* 2020;23:100404. doi: 10.1016/j.eclim.2020.100404
- Platt L. COVID-19 and Ethnic Inequalities in England. *LSE Public Policy Review* 2021 doi: 10.31389/lseppr.33
- Kapilashrami A, Bhui K. Mental health and COVID-19: is the virus racist? *The British Journal of Psychiatry* 2020;217(2):405–07. doi: 10.1192/bjp.2020.93 [published Online First: 2020/05/05]
- Van Bortel T, Lombardo C, Guo L, et al. The mental health experiences of ethnic minorities in the UK during the Coronavirus pandemic: A qualitative exploration. *Frontiers in Public Health* 2022;10 doi: 10.3389/fpubh.2022.875198
- UK Health Security Agency. Health inequalities in health protection report 2025 (27th May), 2025.
- Mirza HS, Warwick R. Race and ethnic inequalities. *Oxford Open Economics* 2024;3(Supplement_1):i365–i452. doi: 10.1093/ooec/odad026
- Akhter N, Begum K, Nahar P, et al. Risk factors for non-communicable diseases related to obesity among first- and second-generation Bangladeshi migrants living in north-east or south-east England. *International Journal of Obesity* 2021;45(7):1588–98. doi: 10.1038/s41366-021-00822-5
- Hudson S-KTJ, Myer A, Berney EC. Stereotyping, prejudice, and discrimination at the intersection of race and gender: An intersectional theory primer. *Social and Personality Psychology Compass* 2024;18(2):e12939. doi: 10.1111/spc3.12939
- Alderwick H. Government's 10 year plan for the NHS in England. *BMJ* 2025;390:r1396. doi: 10.1136/bmj.r1396
- Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Background document to WHO - Strategy paper for Europe.: Arbetsrapport 2007:14, Institute for Futures Studies. 1991.
- Crenshaw K. Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum* 1989;1989:8.
- Katikireddi SV, Lal S, Carrol ED, et al. Unequal impact of the COVID-19 crisis on minority ethnic groups: a framework for understanding and addressing inequalities. *Journal of Epidemiology and Community Health* 2021;75(10):970–74. doi: 10.1136/jech-2020-216061
- Blau FD, Kahn LM, Comey M, et al. Culture and gender allocation of tasks: source country characteristics and the division of non-market work among US immigrants. *Review of Economics of the Household* 2020;18(4):907–58.
- Bamba C, Smith KE, Pearce J. Scaling up: The politics of health and place. *Social Science & Medicine* 2019;232:36–42. doi: <https://doi.org/10.1016/j.socscimed.2019.04.036>
- Department of Health and Social Care. Women's Health Strategy for England., 2022.
- Department of Health and Social Care. The Renewed Women's Health Strategy for England., 2026.
- Department of Health and Social Care. 10 Year Health Plan for England: fit for the future., 2025.
- NHS England. Core20PLUS5 (adults) – an approach to reducing healthcare inequalities.
- Office for Equality and Opportunity, Seema Malhotra MP, The Rt Hon Sir Stephen Timms MP. Government commits to introducing mandatory ethnicity and disability pay gap reporting for large employers., 2026.
- Wang S. The Role of Gender Role Attitudes and Immigrant Generation in Ethnic Minority Women's Labor Force Participation in Britain. *Sex Roles* 2019;80(3):234–45. doi: 10.1007/s11199-018-0922-8
- Race Disparity Unit. Why we no longer use the term 'BAME' in government., 2022.
- Race Equality Matters. Umbrella Terms and Identity in the Workplace: What terminology should your organisation be using.
- Commission on Race and Ethnic Disparities. The report of the Commission on Race and Ethnic Disparities, 2021.
- NHS Race & Health Observatory. Survey finds 'BAME', 'BME' and 'Ethnic Minority' not representative, 2021.
- Office for National Statistics. Ethnic group, England and Wales: Census 2021., 2022.
- Office for National Statistics. Ethnic group tick-box prioritisation report for Census 2021 in England and Wales, 2020.
- Borkowska M, Nazroo J, Finney N, et al. Ethnic identities. In: Nazroo J, Finney N, Bécaries L, et al., eds. *Racism and Ethnic Inequality in a Time of Crisis*. 1 ed: Bristol University Press 2023:30–53.
- Tammy Hodo. The social implications of race TEDxJacksonville, 2019.
- UK Government Ethnicity Facts and Figures Service. UK population by ethnicity, 2025.
- Office for National Statistics. Ethnic differences in life expectancy and mortality from selected causes in England and Wales: 2011 to 2014., 2021.
- Office for National Statistics. Inequalities in mortality involving common physical health conditions, England: 21 March 2021 to 31 January 2023., 2024.
- Ng Fat L, Patil P, Patil P, et al. Ethnic differences in multimorbidity after accounting for social-economic factors, findings from The Health Survey for England. *Eur J Public Health* 2023;33(6):959–67. doi: 10.1093/eurpub/ckad146
- Delon C, Brown KF, Payne NWS, et al. Differences in cancer incidence by broad ethnic group in England, 2013–2017. *British Journal of Cancer* 2022;126(12):1765–73. doi: 10.1038/s41416-022-01718-5
- Fry A, White B, Nagarwalla D, et al. Relationship between ethnicity and stage at diagnosis in England: a national analysis of six cancer sites. *BMJ Open* 2023;13(1):e062079. doi: 10.1136/bmjopen-2022-062079
- Evans DG, Brentnall AR, Harvie M, et al. Breast cancer risk in a screening cohort of Asian and white British/Irish women from Manchester UK. *BMC Public Health* 2018;18(1):178. doi: 10.1186/s12889-018-5090-9
- Office for National Statistics. Census 2021: Ethnic group, 2022.
- Ministry of Housing, Communities and Local Government. English indices of deprivation 2025, 2025.
- Office for National Statistics. Healthy life expectancy, UK: between 2011 to 2013 and 2022 to 2024., 2026.
- National Centre for Social Research. Health Survey for England, 2022. UK Data Service, 2024.
- Zaninotto P, Mindell J, Hirani V. Prevalence of cardiovascular risk factors among ethnic groups: Results from the Health Surveys for England. *Atherosclerosis* 2007;195(1):e48–e57. doi: <https://doi.org/10.1016/j.atherosclerosis.2007.02.017>
- Patel N, Ferrer HB, Tyrer F, et al. Barriers and Facilitators to Healthy Lifestyle Changes in Minority Ethnic Populations in the UK: a Narrative Review. *Journal of Racial and Ethnic Health Disparities* 2017;4(6):1107–19. doi: 10.1007/s40615-016-0316-y
- Katangwe-Chigamba T, Kantilal K, Hartley-Palmer J, et al. Diet and Physical Activity Interventions for People from Minority Ethnic Backgrounds in the UK: A Scoping Review Exploring Barriers, Enablers and Cultural Adaptations. *Journal of Racial and Ethnic Health Disparities* 2025;12(5):3024–68. doi: 10.1007/s40615-024-02112-y
- Feeney BC, Collins NL. A New Look at Social Support: A Theoretical Perspective on Thriving Through Relationships. *Personality and Social Psychology Review* 2015;19(2):113–47. doi: 10.1177/1088868314544222
- Hepworth C, Stitt S. Social Capital & Faith-based Organisations. *The Heythrop Journal* 2007;48(6):895–910. doi: <https://doi.org/10.1111/j.1468-2265.2007.00348.x>
- Gordon T, Lee LJ, Tchangalova N, et al. Psychosocial protective interventions associated with a better quality of life and psychological wellbeing for

- African American/Black female breast cancer survivors: an integrative review. *Supportive Care in Cancer* 2022;30(2):1093–114. doi: 10.1007/s00520-021-06425-0
62. Royal College of Psychiatrists. Briefing from the Royal College of Psychiatrists: 10 Year Health Plan for England., 2025.
 63. NHS Digital. Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4., 2025.
 64. Vriend M, Rocks C, Finch D. Mental health trends among working-age people. In: The Health Foundation, ed., 2025.
 65. Bamba C, Munford L, Khavandi S, et al. The Parallel Pandemic: COVID-19 and Mental Health., 2022.
 66. NHS Digital. Adult Psychiatric Morbidity Survey, 2009.
 67. Weich S, Nazroo J, Sproston K, et al. Common mental disorders and ethnicity in England: the EMPIRIC Study. *Psychological Medicine* 2004;34(8):1543–51. doi: 10.1017/S0033291704002715 [published Online First: 2004/11/04]
 68. Ahmad G, McManus S, Cooper C, et al. Prevalence of common mental disorders and treatment receipt for people from ethnic minority backgrounds in England: repeated cross-sectional surveys of the general population in 2007 and 2014. *Br J Psychiatry* 2022;221(3):520–27. doi: 10.1192/bjp.2021.179
 69. Herrera F, Migali G, Mateus C. Decomposing mental health inequities: an Oaxaca-Blinder analysis of ethnic and gender disparities in the UK. *International Journal for Equity in Health* 2026 doi: 10.1186/s12939-026-02980-2
 70. Office for Health Improvement and Disparities. Adult mental health and wellbeing profile: April 2026 update, 2026.
 71. Das-Munshi J, Schofield P, Bhavsar V, et al. Ethnic density and other neighbourhood associations for mortality in severe mental illness: a retrospective cohort study with multi-level analysis from an urbanised and ethnically diverse location in the UK. *The Lancet Psychiatry* 2019;6(6):506–17.
 72. Halvorsrud K, Nazroo J, Otis M, et al. Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses. *Social Psychiatry and Psychiatric Epidemiology* 2019;54(11):1311–23. doi: 10.1007/s00127-019-01758-y
 73. Stepanova E, Croke S, Yu G, et al. "I am not a priority": ethnic minority experiences of navigating mental health support and the need for culturally sensitive services during and beyond the pandemic. *BMJ Mental Health* 2025;28(1):e301481. doi: 10.1136/bmjment-2024-301481
 74. Ahmed N, James D, Tayabali A, et al. Ethnicity and Children's Social Care. London: Department for Education, 2022.
 75. Jaspal R, Lopes B. Discrimination and mental health outcomes in British Black and South Asian people during the COVID-19 outbreak in the UK. *Mental Health, Religion & Culture* 2021;24(1):80–96. doi: 10.1080/13674676.2020.1871328
 76. Maletta RM, Daly M, Goodwin L, et al. Prevalence of perceived discrimination and associations with mental health inequalities in the UK during 2019–2020: A cross-sectional study. *Psychiatry Research* 2023;322:115094. doi: https://doi.org/10.1016/j.psychres.2023.115094
 77. Maletta RM, Daly M, Goodwin L, et al. Changes in the prevalence of perceived discrimination and associations with probable mental health problems in the UK from 2015 to 2020: A repeated cross-sectional analysis of the UK Household Longitudinal Study. *SSM - Population Health* 2024;26:101667. doi: 10.1016/j.ssmph.2024.101667
 78. Stuart J, Robinson L, Ward C. Rejection identification or disidentification? The association of discrimination on depressive symptoms via religious and national identity among British Muslims. *International Journal of Intercultural Relations* 2020;77:38–45. doi: https://doi.org/10.1016/j.ijintrel.2020.05.003
 79. Barnett P, Mackay E, Matthews H, et al. Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *The Lancet Psychiatry* 2019;6(4):305–17. doi: 10.1016/S2215-0366(19)30027-6
 80. Bignall T, Jeraj S, Helsby E, et al. Racial disparities in mental health: London: Race Equity Foundation, 2019.
 81. Office for National Statistics. Hate crime, England and Wales, year ending March 2024, 2024.
 82. Van der Geest KA, Pervaz A, Lolansen C. 'It's Very Hard to Feel Accepted When a Whole Country Screams That They Don't Want You Here': Minorities' Experiences of the UK 2024 Summer Riots. *Journal of Community & Applied Social Psychology* 2026;36(2):e70244. doi: https://doi.org/10.1002/casp.70244
 83. Mullard J, Mir G, Herbert C, et al. 'You're just a Guinea pig': Exploring the barriers and impacts of living with long COVID-19: A view from the undiagnosed. *Social Health Illn* 2024;46(8):1602–25. doi: 10.1111/1467-9566.13795 [published Online First: 20240608]
 84. Jacobs L, Penraris P. Factors affecting the help-seeking behaviour of Black Asian minority ethnic (BAME) groups for mental health services in the UK: A literature review. *Greenwich Social Work Review* 2021;2(1):156–70. doi: 10.21100/gswrv.21.1251
 85. Mir G, Sheikh A. 'Fasting and prayer don't concern the doctors...they don't even know what it is': communication, decision-making and perceived social relations of Pakistani Muslim patients with long-term illnesses. *Ethnicity & Health* 2010;15(4):327–42. doi: 10.1080/13557851003624273
 86. Nwokoroku SC, Neil B, Dlamini C, et al. A systematic review of the role of culture in the mental health service utilisation among ethnic minority groups in the United Kingdom. *Global Mental Health* 2022;9:84–93. doi: 10.1017/gmh.2022.2
 87. Newbigging K, Rees J, Ince R, et al. The contribution of the voluntary sector to mental health crisis care: a mixed-methods study. 2020;8:29. doi: 10.3310/hsdr08290
 88. Kilicoglu Z. Coming back to life from "social death": creating and regulating women-only/feminist spaces with/for women refugees in the UK. *International Feminist Journal of Politics* 2026;28(2):339–61. doi: 10.1080/14616742.2026.2633982
 89. Lewis R, Sharp E, Remnant J, et al. 'Safe Spaces': Experiences of Feminist Women-Only Space. *Sociological Research Online* 2015;20(4):105–18. doi: 10.5153/sro.3781
 90. Mayblin L, James P. Asylum and refugee support in the UK: civil society filling the gaps? *Journal of Ethnic and Migration Studies* 2019;45(3):375–94. doi: 10.1080/1369183X.2018.1466695
 91. Mir G, West R, Anik E, et al. Treating depression in Muslim communities: Meta-analysis of three trials of culturally adapted behavioural activation for Muslims (BA-M). *Cambridge Prisms: Global Mental Health* 2026;13:e137. doi: 10.1017/gmh.2026.10245 [published Online First: 2026/06/11]
 92. Pollard T, Howard N. Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers. *International Journal of Mental Health Systems* 2021;15(1):60. doi: 10.1186/s13033-021-00473-z
 93. U-CARE. Understanding the role of voluntary sector-led peer support for mental health and wellbeing amongst asylum seekers and refugees.
 94. NHS England. Patient and carer race equality framework, 2023.
 95. Rob PA. The Journey of Collaboration: The Pakistan Muslim Centre (PMC) and Sheffield Health and Social Care Foundation Trust (SHSC-FT) in the 'Being There' Project Reflecting the Patient and Carer Race Equality Framework (PCREF).
 96. Felker A, Patel R, Kotnis R, et al. Saving Lives, Improving Mothers' Care Compiled Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23., 2025.
 97. Gallimore ID, Matthews RJ, Page GL, et al. MBRRACE-UK Perinatal Mortality Surveillance, UK Perinatal Deaths of Babies Born in 2023: State of the Nation Report., 2025.
 98. Brennan-Tovey K, Sarma K, Lima D, et al. Professional perspectives on barriers to accessing maternity care in England: a qualitative study. *BMC Pregnancy and Childbirth* 2026;26(1):334. doi: 10.1186/s12884-026-08745-7
 99. Aquino MRJ, Rankin J, Ngongalah L, et al. Evaluating the Public Health Prevention in Maternity Programme in the North East and North Cumbria., 2025.
 100. Nnoaham KE, Hummelshoj L, Webster P, et al. Impact of endometriosis on quality of life and work productivity: a multicenter study across ten countries. *Fertil Steril* 2011;96(2):366–73.e8. doi: 10.1016/j.fertnstert.2011.05.090 [published Online First: 20110630]
 101. Rooney KL, Domar AD. The relationship between stress and infertility. *Dialogues Clin Neurosci* 2018;20(1):41–47. doi: 10.31887/DCNS.2018.20.1/krooney
 102. Saberian S, Gale C, Subhedar N, et al. Inequalities in neonatal unit mortality in England and Wales between 2012 and 2022: a retrospective cohort study. *The Lancet Child & Adolescent Health* 2025;9(12):857–67. doi: https://doi.org/10.1016/S2352-4642(25)00243-3
 103. Matthews RJ, Draper ES, Manktelow BN, et al. Understanding ethnic inequalities in stillbirth rates: a UK population-based cohort study. *BMJ Open* 2022;12(2):e057412. doi: 10.1136/bmjopen-2021-057412
 104. Sands & Tommy's Policy Unit. Counting Miscarriages in the UK., 2024.
 105. Office for National Statistics. Births and infant mortality by ethnicity in England and Wales: 2007 to 2019., 2021.
 106. Neonatal Data Analysis Unit. [Available from: https://www.imperial.ac.uk/medicine/research-and-impact/groups/neonatal-data-analysis-unit/neonatal-data-analysis-unit/.
 107. NHS Race & Health Observatory. 10 Steps to spot Jaundice in Black & Brown Babies [Available from: https://nhs.uk/wp-content/uploads/2025/01/10-Steps-FOR-SPOTTING-JAUNDICE-POSTER.pdf.
 108. NHS Race & Health Observatory. Review of Neonatal Assessment and Practice in Black, Asian and Minority Ethnic Newborns [Available from: https://rcm.org.uk/wp-content/uploads/2025/10/Neonatal-Infographic-October-2025.pdf.
 109. Nursing & Midwifery Council. New principles will support universities to tackle Black maternal health crisis. 2026 [Available from: https://www.nmc.org.uk/news/news-and-updates/new-nmc-anti-racism-principles-will-support-universities-to-tackle-black-maternal-health-crisis/.
 110. NHS England. Core20PLUS5 – An approach to reducing health inequalities for children and young people.
 111. Esan OB, Adjei NK, Saberian S, et al. Systematic review of interventions to reduce ethnic health inequalities in maternal and perinatal health in the UK. *BMJ Public Health* 2025;3(2):e001476. doi: 10.1136/bmjph-2024-001476
 112. Dodsworth E. "Inequalities in midwifery continuity of care during pregnancy" QualityWatch: Nuffield Trust and Health Foundation. 2023 [Available from: https://www.nuffieldtrust.org.uk/news-item/inequalities-in-midwifery-continuity-of-care-during-pregnancy.
 113. Shannon G, Morgan R, Zeinali Z, et al. Intersectional insights into racism and health: not just a question of identity. *The Lancet* 2022;400(10368):2125–36. doi: https://doi.org/10.1016/S0140-6736(22)02304-2
 114. Elumogo DC, Rayment-Jones DH. Addressing socioeconomic inequalities in perinatal outcomes in the UK: a critical discussion. *Midwifery* 2026;152:104649. doi: https://doi.org/10.1016/j.midw.2025.104649

115. Jivraj S, Khan O. Ethnicity and deprivation in England: How likely are ethnic minorities to live in deprived neighbourhoods?: Centre on Dynamics of Ethnicity (CoDE), Manchester, 2013.
116. Jardine J, Walker K, Gurol-Urganci I, et al. Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study. *The Lancet* 2021;398(10314):1905–12. doi: 10.1016/S0140-6736(21)01595-6
117. Public Health England. Health of women before and during pregnancy: health behaviours, risk factors and inequalities, 2019.
118. Singal K, Cruickshank M, Ekong A, et al. Experiences of women from ethnic minorities and underserved, marginalised and disadvantaged groups in communicating with health professionals during antenatal care: An overview of qualitative systematic reviews. *NIHR Open Res* 2026;6:2. doi: 10.3310/nihropenres.14096.2 [published Online First: 20260602]
119. National Neonatal Audit Programme (NNAP). 2024 data: Extended analysis report.. Royal College of Paediatrics and Child Health., 2025.
120. Pettinger K, Pons Perez S, Legge H, et al. Does neonatal care delivery in England and Wales vary by deprivation and ethnicity: a retrospective cohort study. *BMJ Paediatrics Open* 2025;9(1):e003585. doi: 10.1136/bmjpo-2025-003585
121. Heslehurst N, Vinogradov R, Nguyen GT, et al. Study of How Adiposity in Pregnancy has an Effect on outcomes (SHAPES): protocol for a prospective cohort study. *BMJ Open* 2023;13(9):e073545. doi: 10.1136/bmjopen-2023-073545
122. McGregor-Smith R. Race in the Workplace: The McGregor-Smith Review.: Department for Business, Energy and Industrial Strategy, 2017.
123. Jivraj S, Alao C. Are ethnic employment penalties mitigated in deprived neighbourhoods and in ethnically dense neighbourhoods? *Population, Space and Place* 2023;39:e2646. doi: 10.1002/psp.2646
124. Li Y. Class and Ethno-Gender Differences in Education and Labour Market Position—An Intersectional Analysis of Ethnic Integration in the UK. *Societies* 2024; 14(1).
125. Li Y, Heath A. Persisting disadvantages: a study of labour market dynamics of ethnic unemployment and earnings in the UK (2009–2015). *Journal of Ethnic and Migration Studies* 2020;46(5):857–78. doi: 10.1080/1369183X.2018.1539241
126. Labour behind the Label. From exploited to unemployed: The women in Leicester left behind by fast fashion outsourcing: Oxfam., 2025.
127. Department of Health and Social Care. Chief Medical Officer's Annual Report 2023: Health in an Ageing Society., 2023.
128. Holman D, Bell A, Green M, et al. Neighbourhood deprivation and intersectional inequalities in biomarkers of healthy ageing in England. *Health Place* 2022;77:102871. doi: 10.1016/j.healthplace.2022.102871 [published Online First: 20220801]
129. Health Equity North. Northern Health Science Alliance. Ageing in the North, 2025.
130. Joshi M, Finney N, Hale JM. Loneliness and social isolation of ethnic minority/immigrant older adults: a scoping review. *Ageing and Society* 2025;45(7):1395–425. doi: 10.1017/S014686X24000205 [published Online First: 2024/06/04]
131. Watkinson RE, Sutton M, Turner AJ. Ethnic inequalities in health-related quality of life among older adults in England: secondary analysis of a national cross-sectional survey. *The Lancet Public Health* 2021;6(3):e145–e54. doi: [https://doi.org/10.1016/S2468-2667\(20\)30287-5](https://doi.org/10.1016/S2468-2667(20)30287-5)
132. Banks J, Nazroo J, Oskala A, et al. The dynamics of ageing: evidence from the English Longitudinal Study of Ageing 2002-2016 (Wave 8). London: The IFS 2018.
133. Harrison A, Hall M, Money A, et al. Engaging older people to explore the age-friendliness of a rural community in Northern England: A photo-elicitation study. *Journal of Aging Studies* 2021;58:100936. doi: <https://doi.org/10.1016/j.jaging.2021.100936>
134. Kyololo OBM, Stevens BJ, Songok J. Photo-Elicitation Technique: Utility and Challenges in Clinical Research. *International Journal of Qualitative Methods* 2023;22:16094069231165714. doi: 10.1177/16094069231165714
135. Rose G. Visual Methodologies: An Introduction to Researching with Visual Materials. Fifth Edition ed: SAGE Publications Ltd 2023.
136. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology* 2006;3(2):77–101. doi: 10.1191/1478088706qp063oa
137. McHale P, Filipe L, Hodgson S, et al. What factors are associated with children being taken into care by the state after initial contact with services? A survival analysis of Children's Social Care data in Liverpool. *BMJ Public Health* 2024;2(e001130) doi: 10.1136/bmjph-2024-001130
138. Bennett D, Lee P, Doebler S, et al. Children in Care in the North of England: A report prepared for the Child of the North All-Party Parliamentary Group. London, 2024.
139. Webb C, Bywaters P, Scourfield J, et al. Cuts both ways: Ethnicity, poverty, and the social gradient in child welfare interventions. *Children and Youth Services Review* 2020;117 doi: 10.1016/j.childyouth.2020.105299
140. MacAlister J. Independent review of children's social care: final report: Department for Education, 2022.
141. Bywaters P, Scourfield J, Webb C, et al. Paradoxical evidence on ethnic inequities in child welfare: Towards a research agenda. *Children and Youth Services Review* 2019;96:145–54. doi: 10.1016/j.childyouth.2018.11.042
142. Bywaters P, Kwhali J, Brady G, et al. Out of sight, out of mind: ethnic inequalities in child protection and out-of-home care intervention rates. *British Journal of Social Work Practice* 2017;47:1884–902. doi: 10.1093/bjsw/bcw165
143. Alrouh B, Hargreaves C, Cusworth L, et al. What do we know about ethnicity in the family justice system in England? London: Nuffield Family Justice Observatory, 2022.
144. Edney C, Alrouh B, Abouelenin M. Ethnicity of children in care and supervision proceedings in England. London: Nuffield Family Justice Observatory, 2023.
145. Hood R, Goldacre A, Jones E, et al. Intervention Pathways following a Social Work Assessment: An Analysis of National Administrative Data for Children's Social Care in England. *The British Journal of Social Work* 2024;54(7):2937–56. doi: 10.1093/bjsw/bcae070
146. Dettlaff A. The evolving understanding of disproportionality and disparities in child welfare. In: Korbin J, Krugman R, eds. *Handbook of child maltreatment*. Netherlands: Springer 2014:149–68.
147. Laverne C, Dufour S, Trocmé N, et al. Visible minority, Aboriginal, and Caucasian children investigated by Canadian protective services. *Child Welfare* 2008;87(2):59–76.
148. Cénat J, McIntee S, Mukunzi J, et al. Overrepresentation of Black children in the child welfare system: A systematic review to understand and better act. *Children and Youth Services Review* 2021;120:105714. doi: 10.1016/j.childyouth.2020.105714
149. King B, Fallon B, Boyd R, et al. Factors associated with racial differences in child welfare investigative decision-making in Ontario, Canada. *Child Abuse & Neglect* 2017;73:89–105. doi: 10.1016/j.chiabu.2017.09.027
150. Antwi-Boasiako K, Sanders J, Baird S, et al. A scoping review of child maltreatment reporting by school personnel and police officers concerning Black families. *Child Abuse & Neglect* 2026;173(107932)
151. Huggins-Hoyt K, Briggs H, Mowbray O, et al. Privatization, racial disproportionality and disparity in child welfare: Outcomes for foster children of color. *Children and Youth Services Review* 2019;99:125–31. doi: 10.1016/j.childyouth.2019.01.041
152. Summersett-Ringgold F, Jordan N, Kiesel C, et al. Child strengths and placement stability among racial/ethnic minority youth in the child welfare system. . *Child Abuse & Neglect* 2018;76:561–72. doi: 10.1016/j.chiabu.2017.09.014
153. Davis J. Adultification bias within child protection and safeguarding. Manchester: HM Inspectorate of Probation, 2022.
154. National Society for the Prevention of Cruelty to Children. Safeguarding children who come from Black, Asian and minoritised ethnic communities: NSPCC; 2024 [Available from: <https://learning.nspcc.org.uk/safeguarding-child-protection/children-from-black-asian-minoritised-ethnic-communities>].
155. Child Safeguarding Practice Review Panel. Annual report 2022-2023. London: Department for Education, 2024.
156. CoramBAAF. Adultification aware - Information brochure. Adultification aware information brochure (2025), 2025.
157. Davis J, Marsh N. The myth of the universal child. In: Holmes D, ed. *Safeguarding Young People: Risk, Rights, Relationships and Resilience*. London: Jessica Kingsley Publishers 2022.
158. Davis J, Marsh N. Boys to men: the cost of 'adultification' in safeguarding responses to Black boys. *Critical and Radical Social Work* 2020;8(2):255–59. doi: 10.1332/204986020X15945756023543
159. Bywaters P, Child Welfare Inequalities Project Team. The Child Welfare Inequalities Project: Final Report.: The Nuffield Foundation, 2020.
160. Adoption and Special Guardianship Leadership Board. Ending racial disparity in adoption. <https://www.coram.org.uk/wp-content/uploads/2024/06/Ending-Racial-Disparity-in-Adoption.pdf>: Adoption and Special Guardianship Leadership Board., 2022.
161. Suh E, Selwyn J. Exploring Local Authority Variation in Looked After Young People's Subjective Well-being. *The British Journal of Social Work* 2023;53:177–97. doi: 10.1093/bjsw/bcac117
162. The Child Safeguarding Practice Review Panel. "It's Silent": Race, racism and safeguarding children. London: The Child Safeguarding Practice Review Panel., 2025.
163. Gurao O, Bacchoo A. Anti-Racism Report. London: What Works for Children's Social Care, now Foundations, 2022.
164. Pollock S, McCaughan S, Scholar H. 'Race', Ethnicity, and Experiences of Practice: Perspectives of Child and Family Social Workers Working in England. *Practice: Social Work in Action* 2024;36(4):251–68. doi: 10.1080/09503153.2024.2339393
165. Cane T, Tedam P. 'We Didn't Learn Enough about Racism and anti Racist Practice' Newly Qualified Social Workers' Challenge in Wrestling Racism. *Social Work Education* 2022;42(8):1563–85. doi: 10.1080/02615479.2022.2063271
166. United Nations Committee on the Elimination of Discrimination Against Women. CEDAW General Recommendation No. 19: Violence against women., 1992.
167. UK Public General Acts. Domestic Abuse Act, 2021.
168. National Police Chiefs' Council. Violence Against Women and Girls. National Policing Statement, 2024.
169. Office for National Statistics. Domestic abuse victim characteristics, England and Wales: year ending March 2025, 2025.
170. ONS Centre for Crime and Justice. Domestic Abuse Statistics Data Tool (November 2025 release, year ending March 2025). 2025.
171. Ali PA, McGarry J, Maqsood A. Spousal Role Expectations and Marital Conflict: Perspectives of Men and Women. *Journal of Interpersonal Violence* 2022;37(9-10):NP7082–NP108. doi: 10.1177/0886260520966667
172. Ali PA, O'Cathain A, Croot E. Not Managing Expectations: A Grounded Theory of Intimate Partner Violence From the Perspective of Pakistani

- People. *Journal of Interpersonal Violence* 2019;34(19):4085–113. doi: 10.1177/0886260516672939
173. Ali PA, O'Cathain A, Croot E. Influences of Extended Family on Intimate Partner Violence: Perceptions of Pakistanis in Pakistan and the United Kingdom. *Journal of Interpersonal Violence* 2021;36(9-10):3965–93. doi: 10.1177/0886260518785378
 174. Sharifnia AM, Bulut H, Ali P, et al. Muslim Women's Experiences of Domestic Violence and Abuse: A Meta-Ethnography of Global Evidence. *Trauma Violence Abuse* 2025;26(4):694–711. doi: 10.1177/15248380241286836 [published Online First: 20241018]
 175. Office for National Statistics. *Crime in England and Wales: year ending March 2025*, 2025.
 176. Refuge. *Facts and Statistics*.
 177. Femi-Ajao O, Kendal S, Lovell K. A qualitative systematic review of published work on disclosure and help-seeking for domestic violence and abuse among women from ethnic minority populations in the UK. *Ethnicity & Health* 2020;25(5):732–46. doi: 10.1080/13557858.2018.1447652
 178. Bates L. Honor-Based Abuse in England and Wales: Who Does What to Whom? *Violence Against Women* 2021;27(10):1774–95. doi: 10.1177/1077801220952168
 179. Foreign, Commonwealth & Development Office and Home Office. *Forced Marriage Unit Statistics*.
 180. NHS England. *Female Genital Mutilation Enhanced Dataset, Quarters 1-4, 2024-25*, 2024–25.
 181. Rogers MM, Fisher C, Ali P, et al. Technology-Facilitated Abuse in Intimate Relationships: A Scoping Review. *Trauma Violence Abuse* 2023;24(4):2210–26. doi: 10.1177/15248380221090218 [published Online First: 20220510]
 182. Ajayi CE, Chantler K, Radford L. The Role of Cultural Beliefs, Norms, and Practices in Nigerian Women's Experiences of Sexual Abuse and Violence. *Violence Against Women* 2021;28(2):465–86. doi: 10.1177/10778012211000134
 183. Lowe PE, McManus S, Asadi Zeidabadi P, et al. Black and Minoritized Women's Experiences of Specialist Domestic Violence Services in the United Kingdom (UK): A Scoping Review. *Trauma, Violence, & Abuse* 2026;27(3):1026–41. doi: 10.1177/15248380251335038
 184. House of Commons Library. *Criminalisation of victims of violence against women from ethnic minority and migrant communities*, 2023.
 185. Women's Aid. *No Woman Turned Away project report 2024*, 2024.
 186. White SJ, Sin J, Sweeney A, et al. Global Prevalence and Mental Health Outcomes of Intimate Partner Violence Among Women: A Systematic Review and Meta-Analysis. *Trauma, Violence, & Abuse* 2024;25(1):494–511. doi: 10.1177/15248380231155529
 187. Guo C, Wan M, Wang Y, et al. Associations between intimate partner violence and adverse birth outcomes during pregnancy: a systematic review and meta-analysis. *Frontiers in Medicine* 2023;10 doi: 10.3389/fmed.2023.1140787
 188. Uphoff EP, Pickett KE, Crouch S, et al. Is ethnic density associated with health in a context of social disadvantage? Findings from the Born in Bradford cohort. *Ethnicity & Health* 2016;21(2):196–213. doi: 10.1080/13557858.2015.1047742
 189. Ajayi CE, Ajayi S. A Listening Guide Analysis of Bisi's Story of Living with Female Genital Mutilation. *Journal of International Women's Studies* 2023;25(7):Article 3.
 190. Women and Equalities Commission. *More action needed to tackle FGM in the UK*, 2024.
 191. Domestic Abuse Commissioner. *Submission to the HM Treasury Spending Review: Phase 2*, 2025.
 192. Women's Aid. *The Annual Audit*, 2025.
 193. Domestic Abuse Commissioner. *A Patchwork of Provision. How to meet the needs of victims and survivors across England and Wales*, 2022.
 194. Prison Reform Trust. *Counted Out: Black, Asian and minority ethnic women in the criminal justice system*, 2017.
 195. Ministry of Justice. *Statistics on Women and the Criminal Justice System 2023*, 2025.
 196. Johnstone J, Chistyakova Y, Cole B. *Experiences of Minority Ethnic Women Defendants in English Criminal Courts*, 2024.
 197. Lammy D. *The Lammy Review: An Independent Review into the Treatment of, and Outcomes for, Black, Asian and Minority Ethnic Individuals in the Criminal Justice System*, 2017.
 198. UK Public General Acts. *Rehabilitation of Offenders Act 1974*, 1974.
 199. Working Chance. *Worst-Case Scenario How Racism In The Criminal Justice System Harms Women's Chances Of Finding Work*, 2021.
 200. Lopes Heimer RdV, Hardiman M, Dalton CT. Intersectional injustices: police responses to migrant, Black and minoritised victim-survivors of rape and other sexual offences in England and Wales. *Policing and Society* 2024;34(8):763–80. doi: 10.1080/10439463.2024.2347655
 201. Office of the Victim's Commissioner. *2023/24 Annual Report: Victims' Commissioner for England and Wales*, 2024.
 202. Prison Reform Trust. *Bromley Briefings Prison Factfile: February 2026*, 2026.
 203. Office for Health Improvement and Disparities. *Inclusion health data and intelligence resource for England*, 2026.
 204. Criminal Justice Alliance and Independent Monitoring Boards. *Towards Race Equality: Report 1, A survey of Black, Asian and minority ethnic prisoners, including Gypsy, Roma and Traveller individuals and foreign nationals across the women's estate in England*, 2022.
 205. NHS England. *A review of health and social care in women's prisons*, 2023.
 206. Ministry of Justice. *Race Review*, 2008.
 207. HM Inspectorate of Prisons. *Race relations in prisons: Responding to adult women from black and minority ethnic backgrounds*, 2009.
 208. HM Inspectorate of Probation. *Annual report: inspection of probation services (2021)*, 2022.
 209. HM Inspectorate of Probation. *Annual report 2022/2023*, 2023.
 210. Alderson H, Smiles C, Sarma K, et al. Understanding the impact of Outcome 16 on racially minoritised women's participation in Domestic Abuse investigations, 2025.
 211. Davies P, Barlow CF. Policing domestic abuse: the onus on first responders. *Policing and Society* 2024;34(7):627–40. doi: 10.1080/10439463.2024.2328173
 212. Gangoli G, Gill A, Mulvihill N, et al. Perception and barriers: reporting female genital mutilation. *Journal of Aggression, Conflict and Peace Research* 2018;10(4):251–60. doi: 10.1108/JACPR-09-2017-0323
 213. Gill AK, Anitha S. *A Matter of Trust: Improving Police Responses to Violence Against Women and Girls in Racially Minoritised Communities*, 2024.
 214. Schclarek Mulinar L. Over-policed but under-protected:: Advancing a critical research agenda. *Nordisk Tidsskrift for Kriminalvidenskab* 2022;109(1):63–69. doi: 10.1746/ntfk.v109i1.130289
 215. Surdu M. Why the "real" numbers on Roma are fictitious: Revisiting practices of ethnic quantification. *Ethnicities* 2019;19(3):486–502. doi: 10.1177/1468796819833424
 216. World Health Organisation. *Roma Health*, 2017.
 217. European Commission. *"Roma health report", Health status of the Roma population Data collection in the Member States of the European Union*, 2014.
 218. Donert C. Creating 'citizens of gypsy origin': ethnicity, planning and population control in socialist Czechoslovakia. In: Brenner C, Schulze-Wessel M, eds. *Zukunftsvorstellungen und staatliche Planung im Sozialismus: Die Tschechoslowakei im Ostmitteleuropaischen Kontext*. Munich: Oldenbourg 2010:89–114.
 219. Matras Y. *The Romani Gypsies*. Boston: Harvard University Press 2015.
 220. Sigona N, Vermeersch P. Editors' Introduction. The Roma in the New EU: Policies, Frames and Everyday Experiences. *Journal of Ethnic and Migration Studies* 2012;38(8):1189–93. doi: 10.1080/1369183X.2012.689174
 221. Van Baar H. Neoliberalism and the spirit of nongovernmentalism: Toward an anthroposociology of Roma-related engagement and activism. In: Beck S, Ivasiuc A, eds. *Roma activism: Reimagining power and knowledge*. Berghahn, 2019.
 222. Donert C, Rosenhaft E. *The Legacies of the Romani Genocide in Europe since 1945*. London: Routledge 2021.
 223. Powell R. Understanding the Stigmatization of Gypsies: Power and the Dialectics of (Dis)identification. *Housing, Theory and Society* 2008;25(2):87–109. doi: 10.1080/14036090701657462
 224. Breazu P, McGarry A. *Romaphobia in the UK Right-Wing Press: racist and populist discourse during the Brexit referendum*. *Social Semiotics* 2024;34(4):593–614. doi: 10.1080/10350330.2023.2165907
 225. Tanner A. *The Roma of Eastern Europe: Still Searching for Inclusion: Migration Policy Institute*, 2005.
 226. Bollini P, Pampallona S, Wanner P, et al. Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature. *Social Science & Medicine* 2009;68(3):452–61. doi: https://doi.org/10.1016/j.socscimed.2008.10.018
 227. European Union Agency for Fundamental Rights. *Analysis of FRA Roma survey results by gender*, 2013.
 228. Zampas C, Lamačková A. Forced and coerced sterilization of women in Europe. *International Journal of Gynecology & Obstetrics* 2011;114(2):163–66. doi: https://doi.org/10.1016/j.ijgo.2011.05.002
 229. Orton L, Fuseini O. In my own words and pictures. *Migration Matters Festival*, 2024.
 230. Orton L, Fuseini O, Kóczé A, et al. Researching the health and social inequalities experienced by European Roma populations: Complicity, oppression and resistance. *Sociology of Health & Illness* 2022;44(S1):73–89. doi: https://doi.org/10.1111/1467-9566.13411
 231. House of Commons Women and Equalities Committee. *Tackling inequalities faced by Gypsy, Roma and Traveller communities*, 2019.
 232. Orton L. Constructing (post)-race in English health and social policy: The case of Roma people. In: Parma A, Saar M, Sojka B, eds. *Social Policy Review 38*. Bristol: Policy Press, imprint of Bristol University Press 2026.
 233. Cook B, Wayne GF, Valentine A, et al. Revisiting the evidence on health and health care disparities among the Roma: a systematic review 2003–2012. *International Journal of Public Health* 2013;58(6):885–911. doi: 10.1007/s00038-013-0518-6
 234. La Parra Casado D, Gil González D, de la Torre Esteve M. The social class gradient in health in Spain and the health status of the Spanish Roma. *Ethnicity & Health* 2016;21(5):468–79. doi: 10.1080/13557858.2015.1093096
 235. United Nations Economic and Social Council. *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 2000.
 236. European Public Health Alliance. *Closing the life expectancy gap of Roma in Europe*, 2018.
 237. Orton L, Anderson de Cuevas R, Stojanovski K, et al. Roma populations and health inequalities: a new perspective. *International Journal of Human Rights in Healthcare* 2019;12(5):319–27. doi: 10.1108/IJHRH-01-2019-0004
 238. European Union Agency for Fundamental Rights. *Inequalities and multiple discrimination in healthcare*, 2012.
 239. Manchester City Council. *Joint Strategic Needs Assessment for Gypsy, Roma and Traveller Communities*, 2024.
 240. Leeds City Council. *Roma Mental Health and Wellbeing*, 2023.

241. Orton L. Roma Health Stories.
242. Banga B. Structural Inequality, Women's Safety and the Funding Cliff Edge: The Impact of the New Funding Policy in Meeting the Needs of Black and Minoritised Women. *Women, Power and Autonomy: Rights, Respect and Representation in Law and Society Switzerland*: Springer Nature 2025:451–81.
243. Thomson G, Cook J, Crossland N, et al. Minoritised ethnic women's experiences of inequities and discrimination in maternity services in North-West England: a mixed-methods study. *BMC Pregnancy and Childbirth* 2022;22(1):958. doi: 10.1186/s12884-022-05279-6
244. Scott S, McGowan VJ, Wildman J, et al. "I'll meet you at our bench": adaptation, innovation and resilience among VCSE organisations who supported marginalised and minoritised communities during the Covid-19 pandemic in Northern England - a qualitative focus group study. *BMC Health Serv Res* 2024;24(1):7. doi: 10.1186/s12913-023-10435-5 [published Online First: 20240103]
245. Brenner S, Lok V. "We assist the health system doing the work that should be done by others" - a qualitative study on experiences of grassroots level organizations providing refugee health care during the 2015 migration event in Germany. *BMC Health Serv Res* 2022;22(1):309. doi: 10.1186/s12913-022-07683-2 [published Online First: 20220307]
246. Essex R, Kalocsányiová E, Rummyantseva N, et al. Trust Amongst Refugees in Resettlement Settings: a Systematic Scoping Review and Thematic Analysis of the Literature. *Journal of International Migration and Integration* 2022;23(2):543–68. doi: 10.1007/s12134-021-00850-0
247. Krasniqi E. Engaging Refugee Volunteers in Co-creation: The Role of Non-profit Leadership. *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations* 2024;35(6):1131–42. doi: 10.1007/s11266-024-00675-2
248. Dimitriadis C. Humanitarian helper wellbeing: A psychosocial refugee care approach [Doctoral Thesis]. University of Essex, 2025.
249. Mirzaei V. How Does Volunteering Support Refugee Integration? Positive Psychology Perspectives [Doctoral Thesis]. Anglia Ruskin University, 2023.
250. Cookingham Bailey E, Terry V. What about the migrants? An exploration of organisational change in an asylum seeker and refugee voluntary sector organisation. *Voluntary Sector Review* 2026;17(2):250–67. doi: 10.1332/20408056Y2025D0000000045
251. NHS England. Ethnicity Recording Improvement Plan: NHS England, 2025.
252. Shaw RJ, Harron KL, Pescarini JM, et al. Biases arising from linked administrative data for epidemiological research: a conceptual framework from registration to analyses. *European Journal of Epidemiology* 2022;37(12):1215–24.
253. National Institute for Health and Care Excellence. Support Document: Health Inequalities: NICE, 2025.
254. Pineda-Moncusí M, Allery F, Delmestri A, et al. Ethnicity data resource in population-wide health records: completeness, coverage and granularity of diversity. *Scientific Data* 2024;11(1):221. doi: 10.1038/s41597-024-02958-1
255. Krieger N, Davey Smith G. The tale wagged by the DAG: broadening the scope of causal inference and explanation for epidemiology. *International Journal of Epidemiology* 2016;45(6):1787–808. doi: 10.1093/ije/dyw114
256. Scobie S. Ethnic inequalities in health and care show diversity in need and disadvantage. *BMJ* 2023;381:p1281. doi: 10.1136/bmj.p1281
257. Kapadia D, Zhang J, Salway S, et al. Ethnic Inequalities in Healthcare: A Rapid Evidence Review: NHS Race and Health Observatory, 2022.
258. Bentley GR. Don't blame the BAME: Ethnic and structural inequalities in susceptibilities to COVID-19. *American Journal of Human Biology* 2020;32(5):e23478. doi: 10.1002/ajhb.23478
259. Public Health England. Disparities in the risk and outcomes of COVID-19. Public Health England, 2020.
260. Mathur R, Rentsch CT, Morton CE, et al. Ethnic differences in SARS-CoV-2 infection and COVID-19-related hospitalisation, intensive care unit admission, and death in 17 million adults in England: an observational cohort study using the OpenSAFELY platform. *The Lancet* 2021;397(10286):1711–24. doi: 10.1016/S0140-6736(21)00634-6
261. MBRRACE-UK. Saving Lives, Improving Mothers' Care report 2023, 2023.
262. Scobie S, Spencer J, Raleigh VS. Ethnicity coding in English health service datasets: Nuffield Trust London, UK 2021.
263. Office for National Statistics. Quality of ethnicity data in health-related administrative data sources, England: November 2023: Office for National Statistics, 2023.
264. Razieh C, Powell B, Drummond R, et al. Understanding the quality of ethnicity data recorded in health-related administrative data sources compared with Census 2021 in England. *PLoS Medicine* 2025;22(2):e1004507. doi: 10.1371/journal.pmed.1004507
265. NHS England. Hospital Episode Statistics (HES), 2025.
266. NHS England. Secondary Uses Service (SUS), 2024.
267. NHS England. National Patient and Staff Surveys, 2026.
268. Office for National Statistics. Quality of ethnicity data in health-related administrative data sources by sociodemographic characteristics, England: May 2024, 2024.
269. Magadi JP, Magadi MA. Ethnic inequalities in patient satisfaction with primary health care in England: Evidence from recent General Practitioner Patient Surveys (GPPS). *PLoS ONE* 2022;17(12):e0270775. doi: 10.1371/journal.pone.0270775
270. NHS England. National engagement on data. Cohort 2 report., 2025.
271. Maternity Action. Health and maternity care in a hostile environment., 2022.
272. NHS Race & Health Observatory. Written evidence from NHS Race & Health Observatory (PMA0087), 2026.
273. Science, Innovation and Technology Committee. Rewiring the state: Delivering digital government, 2026.
274. Akbari A, Khunti K. Diversity in Data: Ethnicity Coding Working Group Workshop Report, 6 April 2022. Health Data Research UK. 2022 [Available from: <https://ukhealthdata.org/wp-content/uploads/2022/05/FINAL-Diversity-in-Data-Ethnicity-coding-working-group-06.04.22-Workshop-report.pdf>].
275. Annan-Callcott G. The problem with ethnicity categories in UK health data 2023 [Available from: <https://wellcome.org/insights/articles/ethnicity-categories-uk-health-data>].
276. Bhui K, Bhugra D, Goldberg D, et al. Assessing the prevalence of depression in Punjabi and English primary care attenders: the role of culture, physical illness and somatic symptoms. *Transcultural Psychiatry* 2004;41(3):307–22. doi: 10.1177/1363461504040456
277. Jacob K, Bhugra D, Lloyd K, et al. Common mental disorders, explanatory models and consultation behaviour among Indian women living in the UK. *Journal of the Royal Society of Medicine* 1998;91(2):66–71. doi: 10.1177/014107689809100204
278. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine* 2001;16(9):606–13. doi: 10.1046/j.1525-1497.2001.016009606.x
279. Sharma S, Cade J, Riste L, et al. Nutrient intake trends among African-Caribbeans in Britain: a migrant population and its second generation. *Public Health Nutrition* 1999;2(4):469–76. doi: 10.1017/S1368980099000658
280. Vyas A, Greenhalgh A, Cade J, et al. Nutrient intakes of an adult Pakistani, European and African-Caribbean community in inner city Britain. *Journal of Human Nutrition and Dietetics* 2003;16(5):327–37. doi: 10.1046/j.1365-277X.2003.00461.x
281. Bradbury KE, Young HJ, Guo W, et al. Dietary assessment in UK Biobank: an evaluation of the performance of the touchscreen dietary questionnaire. *Journal of Nutritional Science* 2018;7:e6. doi: 10.1017/jns.2017.66

NHSA members



