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ACKNOWLEDGEMENT, I CONFIRM THAT I HAVE NOT USED ANY AI TOOLS IN THE RESEARCH AND CREATION OF THIS ASSIGNMENT. I CONFIRM THAT I HAVE NOT PRESENTED ANY AI-GENERATED MATERIALS AS MY WORK. I CONFIRM I HAVE COPIES OF MY DRAFTS, NOTES, AND OTHER RESOURCES I USED, WHICH I MAY BE ASKED TO PROVIDE IN EVIDENCE.

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TASK 1

1.0 INTRODUCTION

In the UK, there exist glaring health inequalities that affect ethnic minorities, including Black Africans, Black Caribbeans, South Asians, and mixed ethnicities. These disparities in health are not due to racial characteristics but rather due to a host of factors along the lines of social determinants of health, which include, but are not limited to, lack of income, discrimination, poor housing, and poor access to care.

It is now well evident that there exists a poor relationship between ethnic minorities in terms of their experience of poor health outcomes due to structural racism in their past socioeconomic conditions (Marmot, 2020). Reduction of disparities in ethnic health in the UK is an important issue in public health due to increased diversity (NHS England, 2022).

2.0 CONTEXTUAL BACKGROUND AND UNDERLYING FACTORS

2.1 HIGHER RATES OF TYPE 2 DIABETES

The ethnic minority communities, specifically the South Asian and Black African/Caribbean groups, have a higher incidence of type 2 diabetes in comparison to the White British groups. The relative risk of type 2 diabetes is from two to six times higher in the South Asian groups and three times higher in the Black Caribbean groups in comparison to the White British groups (Diabetes UK, 2024). These are culturally adapted diabetic prevention programs, selective screening, and community-based lifestyle interventions (NHS, 2023).

2.2 INCREASED CARDIOVASCULAR DISEASE (CVD)

Cardiovascular disease has a large presence within the Black African and Black Caribbean communities because of a large prevalence of hypertension. There has been evidence discovered that the prevalence of hypertension is increased by a large margin in Black adults, at a level that is 40-50% higher than that found in the White British population (British Heart Foundation, 2022). The recommendations include blood pressure checks in community environments, as well as appropriate primary health care services (Public Health England, 2021).

2.3 HIGHER MATERNAL MORTALITY AMONG BLACK WOMEN

“Maternal mortality rates are amongst the worst ethnic inequalities known within the United Kingdom ” (Black et al., 2019). For example, Black women are close to four times more likely than White women “to die from pregnancy-related causes during and after pregnancy” (MBRRACE-UK, 2023).

These include racism training for healthcare staff, specialized midwifery schemes, and enhanced early risk assessment tools (NHS England, 2022).

2.4 SOCIO-ECONOMIC DISADVANTAGE

Ethnic minority families are more prone to poverty. The poverty rate in both Pakistani and Bangladeshi families is almost twice that of the White British population (Joseph Rowntree Foundation, 2022). Poverty reduces the availability of healthy food, housing, and access to health care, besides increasing the risk of stress, which has been shown to affect health precariously.

These include income support strategies, employment equity programs, and increased access to affordable housing.

2.5 RACISM, EXCLUSION, AND MENTAL HEALTH

Racism and discrimination play an important role in impacts related to mental health in relation to ethnic minorities. Black individuals are three times as likely to be detained under the Mental Health Act than White individuals (NHS Digital, 2022). Discrimination leads to a person being at risk of depression, anxiety, and psychosis. A lack of trust in mental health care increases the risk of non-adherence.

These include culturally sensitive mental health provision and anti-racist organizational change (Mental Health Foundation, 2021).

2.6 POOR HOUSING AND OVERCROWDING

Ethnic minority families are more often found in overcrowded and poor-quality housing. Overcrowding is experienced by 30-40% of Bangladeshi and Black African families, as opposed to 2% of White British families (ONS, 2021). Poor housing conditions lead to the onset of respiratory disorders and infectious illnesses, as well as psychological disturbances.

3.0 NATIONAL RESPONSES TO REDUCE ETHNIC HEALTH INEQUALITIES

3.1 EQUALITY ACT 2010

The Public Sector Equality Duty enacted under the Equality Act 2010 that required public bodies to take responsibility in addressing discrimination and enabling equality introduced supportive legislation. This is the law underpinning the NHS's responsibilities concerning the monitoring of ethnicity data and reducing disparities in health outcomes.

3.2 NHS CORE20PLUS5 FRAMEWORK

The framework of NHS England's Core20PLUS5 focuses on the most deprived population and ethnic minority groups across five clinical areas, including maternity care and hypertension. The framework will reduce health inequalities through targeted, place-based interventions.

4.0 ORGANISATION SUPPORTING ETHNIC MINORITY HEALTH

4.1 RACE EQUALITY FOUNDATION

The Race Equality Foundation focuses on narrowing the gaps that exist between the white population and ethnic minorities regarding health, housing, and social care services. It is involved in research and professional development and running community-driven health projects. The objective of the organisation is the abolition of institutional racism and enhanced healthcare for ethnic minorities (Race Equality Foundation, 2023).

5.0 CONCLUSION

The issue of ethnic inequalities in the health of the people in the UK is embedded in social, economic, and structural factors. The differences found in the prevalence of chronic illnesses, the state of mother and baby care, mentally healthy conditions, and living environments establish the imperative in pursuing an eternal state of healthy approaches. Despite the strategies in place, the gaps in inequalities cannot be closed through competent health approaches.

TASK 2

1.0 INTRODUCTION

Type 2 Diabetes Mellitus can be defined as a non-communicable chronic disease that results from insulin resistance and an inability to control blood sugar. The condition is closely linked to other conditions such as obesity, a sedentary lifestyle, age, racial factors, and deprivation. When left untreated, diabetes results in cardiovascular diseases, renal failure, blindness, and early death (WHO, 2023). Socially, diabetic disorders can affect the working abilities, mental health, and quality of life of an affected subject.

In addition to its medical sequelae, T2DM also carries important social and economic aspects. People with diabetes may be affected by impaired quality of life, work limitations, psychological morbidity, and dependence on health and social care. From the health perspective, diabetes is an important source of disease burden within the NHS, accounting for about 10% of the health budget, mainly due to preventable complications (Diabetes UK, 2024). An important consideration is that the disease does not affect the population equally but affects deprived areas in higher proportions and certain ethnic groups.

Tower Hamlets, a London borough characterised by high levels of deprivation and ethnic diversity, particularly within its Bangladeshi community, experiences disproportionately high rates of T2DM. This makes it an appropriate case study for examining how social determinants of health, ethnicity, and public health interventions interact in shaping disease prevalence and outcomes.

1.1 EPIDEMIOLOGICAL CONTEXT: GLOBAL, NATIONAL, AND LOCAL

Globally, diabetes is regarded as the fastest-growing public health issue. According to the International Diabetes Federation, “More than 530 million adults were living with diabetes in 2021, and this number is projected to rise to 783 million by 2045.” Additionally, “Currently, 90-95% of people living with diabetes have Type 2 diabetes.”

In the UK, the incidence of people with diabetes has steadily risen over the last two decades. There are 4.3 million people with diagnosed cases of diabetes, with another 850,000 living with undiagnosed type 2 diabetes. Minority ethnic groups, including people of South Asian and African Caribbean origin, are more commonly affected by developing type 2 diabetes at

younger ages and lower body mass indexes compared to those from the White British population.

Locally, Tower Hamlets has one of the highest levels of diabetes cases in England as a whole. It is estimated that 8-10% of the population are affected with diabetes, as opposed to 6%, which stands as a national average (London Borough of Tower Hamlets, 2023).

2.0 PUBLIC HEALTH ACTIONS USING THE 3 Ps

2.1 PRIMARY PREVENTION

It aims at minimizing the chances of developing T2DM through modifiable lifestyle and environmental risk factors before the onset of the disease. In Tower Hamlets, community-based public health strategies include improving dietary habits, improving physical activity levels, and reducing the problem of obesity, mainly in children and high-risk communities.

These include school-based physical activity interventions, healthy eating campaigns, and community-based weight management schemes. These interventions work in partnership with local schools, mosques, community centers, and voluntary organizations to promote greater engagement with ethnic minorities. Health promotion that is culture-sensitive, for example with eating advice that is appropriate for Bangladeshi food, have been demonstrated to be more effective.

The role of the NHS Health Check programme is also prominent in the primary spheres for the assessment of people aged 40 to 74 for the risk of developing diabetes. The assessment for risk testing incorporates measurements for BMI, blood pressure, and blood glucose, making way for early lifestyle changes to take place (NHS, 2023). The accessibility for these services in the deprived areas, such as Tower Hamlets, is inconsistent.

2.2 SECONDARY PREVENTION

Secondary prevention involves the earlier diagnosis and management of the disease. In Tower Hamlets, the NHS Diabetes Prevention Program works towards the screening of high-risk ethnic populations. Organized education programs like the DESMOND program support patients in managing the disease effectively (NICE, 2023).

2.3 TERTIARY PREVENTION

The primary goal of tertiary prevention is to minimize the complications that may arise in those who already have diabetes. The care provided by the local authority includes the establishment of diabetes care teams, annual eye checks, foot clinics, and management of

cardiac risk. These help to cut down the number of people admitted to the hospital and enhance the quality of life of the patient (NHS Digital, 2021).

3.0 KEY DETERMINANTS AND RISK FACTORS

The prevalence of T2DM in Tower Hamlets is not only because of individual lifestyle factors. Social, economic, environmental, and biological determinants all play an important part in the high prevalence of T2DM.

Socioeconomic deprivation is an important factor that influences diabetes risks. Most of its citizens suffer from low incomes, precarious employment, and food insecurity, making it difficult for them to enjoy healthy food choices and exercise opportunities. In Tower Hamlets, an unhealthful environment that lacks green spaces and densely inhabited homes further reduces opportunities for a healthy lifestyle.

In addition, ethnicity also plays a role. The Bangladeshi population demonstrates a greater genetic predisposition to insulin resistance and can also develop T2DM at a lower level of BMI compared to others (Public Health England, 2021). Further, their typical food practices, such as high consumption of refined carbohydrates and saturated fats, may also pose risks to their health.

3.1 DETERMINING AT-RISK GROUPS

The health needs assessment report the following groups as high risk: adults aged 40+, Bangladeshi and Black African communities, low socioeconomic groups, and obese individuals. Epidemiology-level results for GP practices demonstrate a concentration of diabetes cases within deprived wards, including Whitechapel and Stepney Green, in the London Borough of Tower Hamlets (London Borough of Tower Hamlets, 2023).

4.0 MONITORING AND SURVEILLANCE SYSTEMS

4.1 MONITORING AND SURVEILLANCE

The monitoring systems that exist include the Care Quality Commission's Quality and Outcomes Framework for the NHS, the National Diabetes Audit Compendiums, Public Health England's Fingertips database, and the use of patient records in the healthcare system. These platforms make use of the following aspects for monitoring and tracking the specified areas for improvement in the healthcare system for people with diabetes in

5.1 PUBLIC HEALTH IMPACT

The short-term effects may include more attendance at general practitioner sessions, tiredness, and lowered productivity. The long-term effects include cardiovascular disease, renal failure, amputations, and lower life expectancy. Diabetes contributes largely to the cost of the NHS and, further, to deprived neighborhoods specifically, according to Marmot, 2020.

The financial burden on the NHS is substantial, with most costs arising from treating preventable complications. Deprived areas such as Tower Hamlets bear a disproportionate share of this burden, reinforcing existing health inequalities (Marmot, 2020).

6.0 THE INTERVENTION PROGRAMME PROPOSAL

6.1 TOWER HAMLETS DIABETIC ACTION PLAN (2025-2030)

Such a program would comprise community-managed lifestyle learning programs, mobile screening programs, eHealth assistance, and cultural competency training of workforce staff. Outcomes of this program will address the reduction of prevalence, better control of HbA1c levels, strategies to decrease admission rates to hospitals, and enhanced patient satisfaction (NICE, 2023).

The programme's objectives would be to reduce diabetes incidence, improve glycaemic control, lower hospital admission rates, and enhance patient satisfaction. Partnership working between the NHS, local authority, and voluntary sector would be central to its success.

7.0 ADVANTAGES AND DISADVANTAGES OF EPIDEMIOLOGICAL METHODS

Epidemiological tools are extremely valuable for the assessment of disease distribution patterns, high-risk groups, and the evaluation of interventions. Epidemiology offers sound information for resource utilization and formulation.

However, the following are considered potential shortcomings: There may be a tendency toward underreporting. There may be a lack of qualitative understanding. Structural factors like racism and poverty may not be adequately explored. Thus, a gap exists between the practices followed by epidemiologists and a more social/community-based model.

8.0 CONCLUSION

Type 2 diabetes in Tower Hamlets is an important public health issue, contrastingly impacted by ethnicity, disadvantage, and underlying inequalities. Although there is existing evidence from epidemiology regarding the effectiveness of targeted interventions, a holistic approach that considers both diabetes control and the underlying social determinants is important for achieving sustainable outcomes. Only planning can ensure that inequalities associated with diabetes is reduced.

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