YOUR VOICE MATTERS

EXCLUDED ON THE FRONTLINE: DISCRIMINATION, RACISM AND ISLAMOPHOBIA IN THE NHS

PREPARED BY

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Chair MDA

AND

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MUSLIM DOCTORS ASSOCIATION

THE GREY AREA
DECODING INCLUSION

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ABOUT

The Muslim Doctors Association & Allied Health Professionals CIC is an award-winning non-profit organisation that has been working with Muslim, minority ethnic, and marginalised communities in the UK since 2004. It is an independent grassroots organisation based in London working nationally to empower local communities. Its mission is to inspire physical, spiritual, and emotional wellbeing amongst local and minority communities in the UK and to promote inclusive and compassionate workplaces in the NHS.

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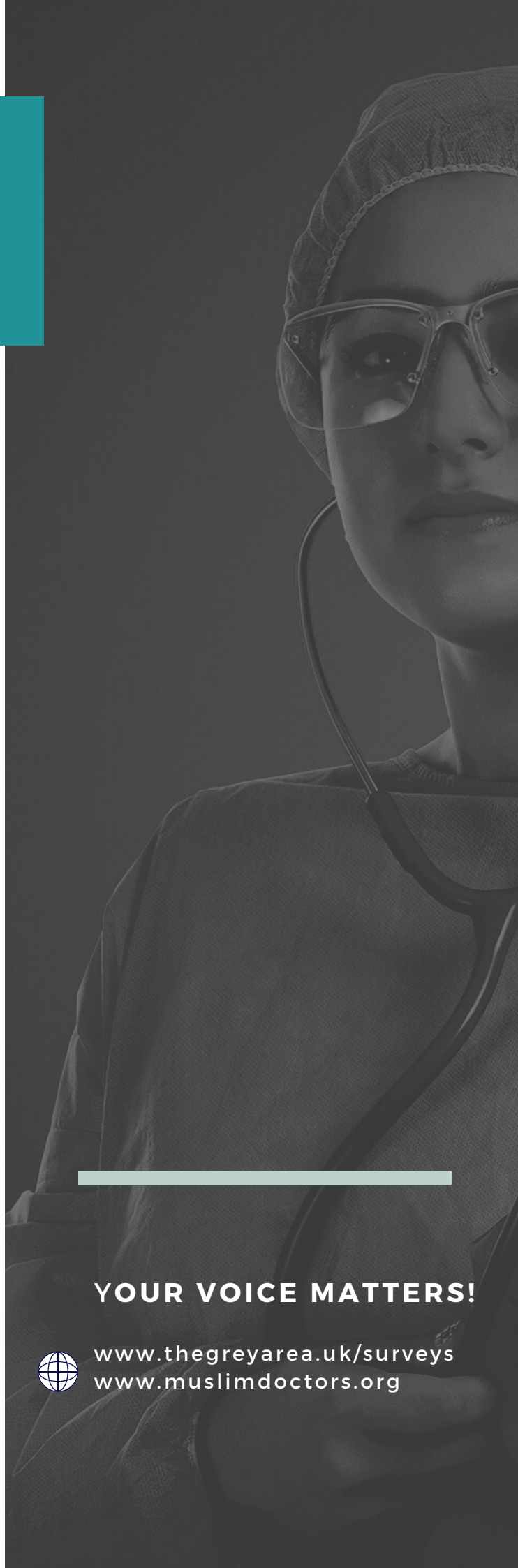
The GREY AREA aims to support employees and employers walking through the GREY AREA by asking those rather difficult questions so that they can understand and realize what inclusion means to them. Their goal is to help Managers re-frame their thought process by helping them recognize this grey area exists and how to dispel the myths and ambiguity around it. This is done via polls and surveys that capture the experience of racially diverse employees working in the public and private sectors.

During Islamophobia Month 2020, The Muslim Doctors Association partnered with The Grey Survey to launch an in-depth survey to understand the perceptions and experiences of Muslim healthcare workers in the NHS to feed into healthcare policy aimed at tackling structural discrimination, Islamophobia, and wellbeing issues affecting Muslim healthcare workers.

Islamophobia Awareness Month (IAM) is a campaign held every November to deconstruct and challenge stereotypes about Islam and Muslims and to raise awareness and encourage reporting of Islamophobic hate crimes. It also showcases the positive contributions of British Muslims to society and provides a platform for people of all backgrounds across society to engage with Muslims.



YOUR VOICE MATTERS!

www.thegreyarea.uk/surveys
www.muslimdoctors.org

MEET THE TEAM

PEOPLE BEHIND THE PROJECT

DR. HINA J. SHAHID

HIRA ALI

Dr Hina J Shahid- GP and Chair at Muslim Doctors Association
Hina is a portfolio GP who also works in research, medical education, public health, and humanitarian medicine. She is a GP Appraiser, tutor at Imperial College School of Medicine, and Chair of the Muslim Doctors Association. Her research interests are the impact of Islamophobia, discrimination and social inequities on health and healthcare systems using participatory approaches. She holds a Masters degree in Public Health with a focus on refugee health and the social determinants of health from the London School of Hygiene and Tropical Medicine and holds diplomas in women's health, children's health, and sexual and reproductive health. She is a consultant to several national and international academic, professional, regulatory, and third sector organisations on health policy, community engagement, diversity and inclusion, and culturally sensitive health promotion. She is a TV presenter and co-producer on Islam Channel's Health Show and is a frequent contributor to the BBC and several mainstream and ethnic media channels on issues around health, faith and the medical workforce.

Hira Ali- Diversity & Inclusion Leader and Co-Founder at The Grey Area
An inspiring leadership trainer and career coach and acclaimed writer and speaker, Hira Ali has been committed to helping others achieve their inherent potential throughout her award-winning career. Her work has been featured in Forbes, Telegraph, BBC, Harper's Bazaar, Independent, CBC, Huff Post, and Entrepreneur, among hundreds of other print, radio, and television outlets, and has earned Hira several prestigious honors and awards. She is passionate about empowering women and ethnic minorities, closing the gender gap, and advocating diversity and inclusion in the workplace. Hira is the author of two books: Her Way To The Top: A Guide to Smashing the Glass Ceiling and—Her Allies: A Practical Toolkit to Help Men Lead Through Advocacy.

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REPORT **SUMMARY**

This report presents findings of a survey jointly conducted by The Grey Area and Muslim Doctors Association & Allied Health Professionals. The survey aims to capture the experiences of Muslim Healthcare Professionals (HCPs) working in the NHS and has evidenced the prevalence of discrimination, racism, and Islamophobia.

Key findings include

- almost 9 in 10 Muslim HCPs do not know Muslims in leadership and management positions and over two thirds can not identify role models whom they can relate to and give them confidence in career progression
- Almost 4 in 10 had received verbal abuse from colleagues around their faith
- Almost 8 in 10 are likely to feel anxious at work due to terrorism related offences reported in the media causing a double joepardy of anxiety around personal safety
- Muslim HCPs experience bias at work from both colleagues and patients
- Muslim HCPs experience bias across their professional lieves begiining at medical school and cmpounded across their career
- The biases and stresses experienced are associated with fear of failure and judgement impacting confidence and self-esteemsuffering from negative impact on wellbeing including depression, stress, anxiety, low self esteem, impostor syndrome, fear of failure
- Almost half have reported they have had thoughts of leaving their profession
- Two-thirds do not feel comfortable raising concerns at work, one third report presenteeism and 4 in 10 have had to compromise on practising their faith at work associated with moral injury and distress
- The majority of Muslim HCPs have experienced othering and stereotype threat associated with identity concealment and inability to bring their full selves to work
- Microaggressions target multiple and specific aspects of religious practice and beliefs

Creating compassionate and inclusive organisations requires:

- Principles that support sustainable intersectional action include multi-level holistic interventions that are culturally and contextually appropriate, co-produced with a focus on empowerment and with transparent processes around data and decision making.
- Active support is built around the 4As of Allyship, Advocacy, Action and Accountability.

Based on the survey findings and recommendations put forward by respondents themselves we have co-created a 12-point action plan and toolkit for allies and advocates with case studies and activities to support them to embed a "Zero Tolerance To Islamophobia" policy in the NHS and better show up and empower their Muslim HCPs.

OUR PURPOSE

- To understand the experiences of Muslim healthcare professionals working in the NHS
- To analyse prevalence and impact of discrimination and exclusion connected to faith identity of Muslim healthcare professionals
- To explore barriers and facilitators to create more inclusive and compassionate workplaces
- To provide practical recommendations that NHS organisations can use to implement effective and sustainable initiatives that address root causes of discrimination, racism and Islamophobia

OUR ALLIES

NHS MUSLIM NETWORK

NHS Muslim Women's Network

BRITISH ISLAMIC MEDICAL ASSOCIATION

APPS UK
Advancing health, changing lives

FAIR PLAY TALKS

BRITISH SOMALI MEDICAL ASSOCIATION

ASKDOC
engage . educate . empower

BACKGROUND

What do we already know about discrimination and racism in the NHS?

The NHS is the fifth largest employer in the world and prides itself on its diverse and inclusive values. Ethnic minority staff makes up 40% of the workforce (Gov.UK 2020) but as the Covid-19 pandemic has demonstrated, not all lives are treated equally; over 90% of doctors who died serving on the frontline were from an ethnic minority background (Kearney et al, 2020) but analysis of media reports demonstrates that over 50% of doctors who died during the first wave were Muslim (Muslim Doctors Association, 2020). An estimated 10% of the medical workforce is Muslim but only 2-3% are in senior leadership positions (NHS Digital, 2016).

Research prior to the pandemic consistently shows that ethnic minority healthcare workers are more likely to experience bullying, harassment, disciplinary procedures and more serious sanctions at work. Inequalities persist in treatment, experiences and opportunities for development for ethnic minority doctors as highlighted by data on unequal attainment in medical education and training, leadership representation, ethnicity pay gap, abuse and complaints by patients and CQC inspections.

NHS workforce race equality standard: 2019 data analysis report for NHS trusts. 2019. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf)

Gov.UK. Ethnicity facts and figures—NHS workforce. Jan 2020. https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest

NHS Digital (2016) Hospital and Community Health Services (HCHS) workforce statistics: equality and diversity in NHS Trusts and CCGs in England. London: NHS Digital.

Kearney, L., Lennane, S., Woodman, E., Kursumovic, E., and Cook, T.M., 2020. At least 23 nationalities among NHS staff killed by covid. Health Service Journal.

Muslim Doctors Association 2020 NHS Heroes Gallery, available online at https://muslimdoctors.org/muslim-nhs-heroes/

Woolf, K., Potts, H.W. and McManus, I.C., 2011. Ethnicity and academic performance in the UK trained doctors and medical students: systematic review and meta-analysis. BMJ, 342.

Humphrey C, Hickman S, Gulliford MC (2011) Place of medical qualification and outcomes of UK General Medical Council 'fitness to practice' process: cohort study. BMJ 342, d1817.

Esmail A, Roberts C (2013) Academic performance of ethnic minority candidates and discrimination in the MRCGP examinations between 2010 and 2012: analysis of data. BMJ 347, f5662

GMC Report 2019: Fair to refer

Snowy White PeakKline, R., Beyond the snowy white peaks of the NHS? Better Health Briefing Paper 39. Race Equality Foundation, 2015.

Experiences during the pandemic and Muslim staff

During the pandemic, evidence from a large media survey in which over 50% of respondents were Muslim demonstrated that ethnic minority doctors felt pressurised and bullied to work in frontline roles without adequate PPE compared to their White colleagues, were less likely to raise concerns, and internalised stress and trauma from excess exposure, infections and mortality among colleagues who looked like them (ITV News, 2020).

A large King's Fund study has previously highlighted that Muslims in the NHS are the most discriminated religious group (West & Kaur, 2015). From qualitative, outreach, and engagement work conducted by the Muslim Doctors Association, there is evidence that Muslim doctors experience discrimination, prejudice, and exclusion at work, through stigma, stereotypes, a lack of belonging, career and workplace support, and limited opportunities to progress in their career (Shahid & Abdulkareem, 2018).

Institutional policies can also be discriminatory against Muslim staff. The Prevent policy has been reported to create a climate of mistrust and fear (Younis & Jadhav, 2015). In a survey by Huffington Post and the British Islamic Medical Association, 80% of Muslim doctors reported that they had experienced Islamophobia. Additionally, dress codes policies form a barrier for women pursuing a career in surgery (Malik et al, 2019) and during the pandemic.

This report is a deep dive that aims to understand underlying drivers of disparities and discrimination in more detail and propose practical recommendations that NHS organisations can implement immediately to address root causes and work towards effective and sustainable interventions to address discrimination, racism and Islamophobia in the NHS.

This report is a deep dive that aims to understand the underlying drivers of disparities and discrimination and propose practical recommendations that organisations can implement immediately to address root causes and work towards effective and sustainable interventions.

Discrimination on frontline of coronavirus outbreak. https://www.itv.com/news/2020-05-13/discrimination-frontline-coronavirus-covid19-black-minority-ethnic-bame-deaths-nhs-racism/. Accessed May 2020)·

West M, Dawson J, Kaur M (2015). Making the difference: Diversity and inclusion in the NHS. London: The King's Fund.

Younis T, Jadhav S (2019) Keeping our mouths shut: the fear and racialized self-censorship of British healthcare professionals in PREVENT training. Culture, medicine, and psychiatry 1–21.

Malik A, Qureshi H, Abdul-Razakq H et al (2019). I decided not to go into surgery due to dress code: a cross-sectional study within the UK investigating experiences of female Muslim medical health professionals on bare below the elbows (BBE) policy and wearing headscarves (hijabs) in theatre. BMJ open 9(3) e019954.

Huffington Post series by Aasma Day, 2020 "'A Me Too Moment': Exposing Islamophobia In The NHS Showed Just How Deep The Problem Is"

Shahid H, Abdulkareem B (2018) The triple penalty: Muslim doctors in the NHS. Muslim Doctors Association.

EQUALITY ACT 2010

Source: Cheshire East Council

Workplace **protections**

The Equality Act protects against discrimination in the workplace when:

- applying for a job
- offered a job on certain terms and conditions
- looking for opportunities for training and promotion
- trying to access work-related benefits
- going through disciplinary or grievance procedures
- dealing with your working environment
- being sacked or made redundant
- looking for, or being given, job references

Source: Advisory, Conciliation and Arbitration Service (ACAS), 2018

EQUALITY ACT 2010

Numerous legislations exist to protect Muslim and minority groups. However, the development of anti-racism legislation in the UK has been reactive rather than proactive. The Equal Pray Act 1970, the Sex Discrimination Act 975, the Race Relations Act 976, the Disability Discrimination Act 1995, and the Disability Rights Commission Act 1999 have been mostly replaced by the more recent Equality Act 2010.

Although the Race Relations Act was passed in 1976, no effort was made to address religious discrimination until much later. Only in 2003 did the Employment Equality (Religion or Belief) Regulations make it unlawful to discriminate against those in vocational training and employment on grounds of sexual orientation and religion or belief. More general provisions were enacted in the Equality Act 2006, now replaced by the Equality Act 2010. The differential treatment could be a one-off action or as a result of a rule or policy and does not have to be intentional to be unlawful. An overview and specific sections are summarised in this section.

Equality Act 2010: **Discrimination**

1 **Direction discrimination** – including ordinary direct discrimination because of a protected characteristic they protect, direct discrimination by association and direct discrimination by perception.

2 **Indirect discrimination** – less obvious than direct discrimination and can often be unintended. It is where a criteria or practices is applied equally to a group of employees' job applications but results in putting those with a shared certain protected characteristic at a particular disadvantage and the employer is unable to justify it.

3 **Harassment** – can be verbal, written or physical and may include nicknames, threats, insults, jokes, 'banter', inappropriate questions, exclusion, inappropriate physical contact.

4 **Victimisation** – where an employee suffers 'detriment' causing disadvantage, damage, harm or loss through raising grievances concerning equality or discrimination.

Source: Advisory, Conciliation and Arbitration Service (ACAS), 2018

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SPECIFIC SECTIONS OF THE EQUALITY ACT 2010

Religion discrimination

The Equality Act 2010 says you must not be discriminated against because:

- you are (or are not) of a particular religion
- you hold (or do not hold) a particular philosophical belief
- someone thinks you are of a particular religion or hold a particular belief (this is known as discrimination by perception)
- you are connected to someone who has a religion or belief (this is known as discrimination by association)

The Equality Act also covers non-belief or a lack of religion or belief.

Race discrimination

The Equality Act 2010 says you must not be discriminated against because of your race. This means

- your colour
- your nationality (including your citizenship)
- your ethnic or national origins, which may not be the same as your current nationality

Race also covers ethnic and racial groups; this means a group of people who all share the same protected characteristic of ethnicity or race.

Public Sector Equality Duty

Section 149:of the Equality Act specficially relates to public authorities

The three aims or arms of the general equality duty are:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Equality Impact Assessments from an important part of the PSED which:

- integrate consideration of equality and good relations into the day-to-day business of public authorities.
- require organisations to consider how they could positively contribute to the advancement of equality and good relations
- require equality considerations to be reflected into the design of policies and the delivery of services, including internal policies, and for these issues to be kept under review.

Source:https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty

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LAWFUL POSITIVE ACTIONS

Positive Action

Positive action is lawful under s.158 of the Equality Act 2010 for an employer to take action to compensate for disadvantages that it reasonably believes are faced by people who share a particular protected characteristic as a proportionate means of achieving, enabling or encouraging persons to overcome or minimise disadvantage. These may include training, mentoring or providing work experience.

Separate provisions allowing positive action in relation to recruitment and promotion in limited circumstances are contained in s.159 of the Act.

Positive action is lawful if it is taken to encourage people from groups sharing a protected characteristic who:

- have a past track record of disadvantage connected to the characteristic;
- have different needs; or
- have a record of low participation

Occupational justification

Objective justification gives a defence for applying a policy, rule, or practice that would otherwise be unlawful indirect discrimination.

To rely on the objective justification defence, the employer, service provider or other organisation must show that its policy was for a good reason – that is 'a proportionate means of achieving a legitimate aim'.

To prove objective justification:

- the aim must be a real, objective consideration, and not in itself discriminatory (for example, ensuring the health and safety of others would be a legitimate aim)
- if the aim is simply to reduce costs because it is cheaper to discriminate, this will not be legitimate
- working out whether the means is ‘proportionate’ is a balancing exercise: does the importance of the aim outweigh any discriminatory effects of the unfavorable treatment?
- there must be no alternative measures available that would meet the aim without too much difficulty and would avoid such a discriminatory effect: if proportionate alternative steps could have been taken, there is unlikely to be a good reason for the policy or age-based rule

Occupational requirement

Where having a protected characteristic is an occupational requirement, certain jobs can be reserved for people with that protected characteristic (for example, women support workers in women's refuges; ministers of religion). The organisation must be able to show that there is a good reason for the occupational requirement (see objective justification above).

Source: https://www.equalityhumanrights.com/en/advice-and-guidance/commonly-used-terms-equal-rights#objective

OTHER LEGISLATION

European Convention on Human Rights

Article 8: respect for private and family life

- The right to live life privately without government interference

Article 9: freedom of thought, belief, and religion

- The right to put one's thoughts and beliefs into action.
- This could include your right to wear religious clothing, the right to talk about your beliefs or take part in religious worship.
- Public authorities cannot stop you practicing your religion, without very good reason – see the section on restrictions below.
- the right to change your religion or beliefs at any time

Article 14 Protection from discrimination

- Protect individuals and groups from discrimination in the enjoyment of those human rights set out in the European Convention of Human Rights.
- Article 14 is based on the core principle that all of us, no matter who we are, enjoy the same human rights and should have equal access to them.
- The enjoyment of the rights and freedoms set forth in the European Convention on Human Rights and the Human Rights Act "shall be secured without discrimination on any ground such as sex, race, color, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Human Rights Act 1998

The Human Rights Act gives effect to the human rights set out in the European Convention on Human Rights. These rights are called Convention rights.
Examples of Convention or human rights include:

- the right to life
- the right to respect for private and family life
- the right to freedom of religion and belief.

The Human Rights Act means you can take action in the UK courts if your human rights have been breached.

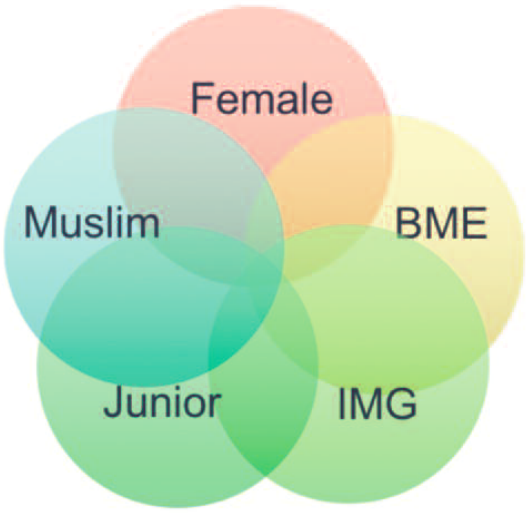
Intersectionality

Intersectionality is an important recurrent theme in literature around the experiences of discrimination and oppression experienced by marginalised groups. It is an analytical framework for understanding how aspects of a person's social and political identities combine to create different modes of discrimination and privilege.

The term was conceptualised and coined by Kimberlé Williams Crenshaw in a paper in 1989. It describes the way multiple marginalised identities overlap and interact to compound and amplify experiences of discrimination and oppression. Using an intersectional lens can help uncover invisible discrimination patterns and approach inequalities from a structural and systemic perspective.

There is documentation that Muslim women face a "Triple Penalty" of discrimination in multiple employment sectors (Miller, 2016), which is also experienced by female doctors in the NHS. A rapid review conducted by the Muslim Doctors Association (Shahid and Abdulkareem, 2018) confirmed the 'Triple p=Penalty' observed in other sectors.

Through the lens of intersectionality, one can see how 'layer after layer of inequality intersect to increase vulnerability and discrimination faced by Muslim doctors who have multiple protected characteristics as defined by the Equality Act 2010 (Wiley, 2018).



Crenshaw, K., 1989. Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. u. Chi. Legal f., p.139.

Shahid H, Abdulkareem B (2018) The triple penalty: Muslim doctors in the NHS. Muslim Doctors Association.

Wiley E (2018). Layer after layer of inequality. London: British Medical Association

Miller, M., 2016. Employment Opportunities for Muslims in the UK. Report of The Parliamentary Women's and Equalities Committee. London: House of Commons.

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ISLAMOPHOBIA

Muslims make up approximately 5% of the UK population. (Office for National Statistics, 2011). The presence of Muslims in Britain spans several centuries, and the influence of the Islamic world even longer in European arts, architecture, science, mathematics, and philosophy. Research indicates that British Muslims feel a strong sense of religious identity, but that they are also more likely than the British public as a whole to say that their national identity as British is important to them. (Kaur-Ballagan et al, 2018).

A recent report shows that Muslims have the highest level of life satisfaction and wellbeing compared with other faith and non-faith groups (Edinger-Schons, 2019). Yet, there is depressing evidence demonstrating discriminatory outcomes faced by British Muslims in housing, education, employment, the criminal justice system, social and public life, and political and media discourse, and that this has enormous social, economic, and health consequences for society (All-Party Parliamentary Group on British Muslims, 2018).

A national poll revealed that 70% of the population perceives Islam as encouraging the repression of women and that wearing a headscarf is widely seen as a symbol of this oppression (YouGov, 2010). These views are mirrored by the rise of nationalism and populism and growing support for far-right and alt-right political groups.

More disturbing still is the increase in violence and hate crimes targeting Muslims in the UK. Muslim adults are more likely to be victims of racially motivated hate crime than other adults including those of other and no faith (Home Office, 2018). This continues to increase year on year with a consistent trend towards targeting Muslim women (Tell MAMA, 2017).

The term "Islamophobia" was first coined by the Runneymede Trust in 1997 but it was only in 2018 that the All-Party Parliamentary Group (APPG) on British Muslims adopted a formal definition, which has since been accepted by the Labour Party and several cities in the UK. Islamophobia recognises that discrimination against Muslims is rooted in racism as a form of cultural racism.

Islamophobia: APPG definition

Islamophobia is rooted in racism and is a type of racism that targets expressions of Muslim-ness or perceived Muslim-ness

All Party Parliamentary Group on British Muslims (2018) Islamophobia defined: the inquiry into a working definition of Islamophobia.London: All Party Parliamentary Group on British Muslims

Office for National Statistics (2011) Religion in England and Wales 2011. Available at: www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/articles/religioninenglandandwales2011/2012-12–11 (accessed 23 April 2019).

Kaur-Ballagan K, Mortimore R, Gottfried G (2018). A review of survey research on Muslims in Britain. London: Ipsos Mori Social Research Institute. YouGov (2010). Exploring Islam: foundation survey results. London: YouGov.

Home Office (2018) Hate crime, England and Wales 2017/18. London: Home Office.

Tell MAMA (2017) Beyond the incident: outcomes for victims of anti-Muslim prejudice. London: Tell MAMA

OUR SURVEY METHODOLOGY

SURVEY LAUNCHED IN NOVEMBER 2020

A self-administered in-depth questionnaire survey was disseminated through the networks of the Muslim Doctors Association and multiple ethnic minority healthcare organizations and networks with significant Muslim membership or following across England between 2020 and 2021 over a four-month period.

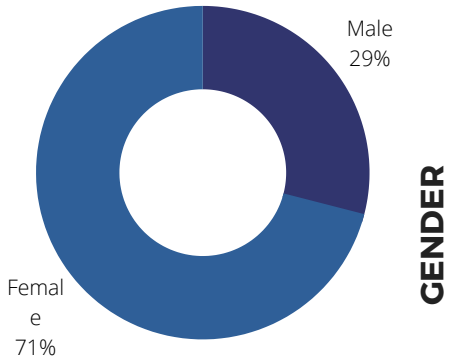
The inclusion criteria were UK-based healthcare professionals currently in practice with a patient-facing role who identified as Muslim. The questionnaire included demographic data and questions on discriminatory experiences at work and wellbeing.

There was some delay in receiving responses owing to the immense pressure faced by NHS workers during the second wave of the pandemic and the survey was paused temporarily between December 2020 and February 2021.

DEMOGRAPHICS

OF SURVEY RESPONDENTS

145 Muslim health care professionals aged between 21 and 59 responded to the survey of which 45 completed responses were analyzed. The majority of respondents were aged 41-50, female, from the urban areas, in permanent employment, and held more than 1 degree qualification



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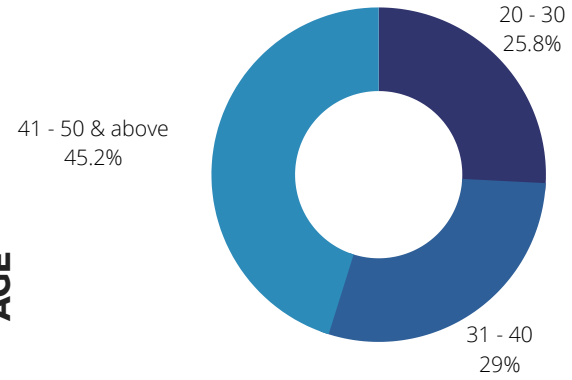

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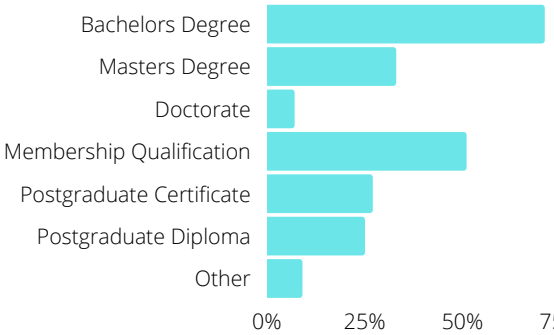

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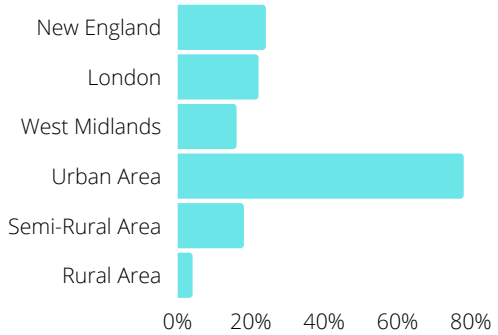

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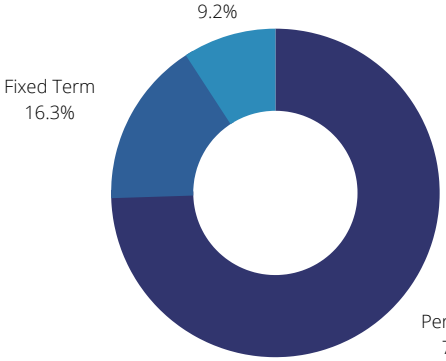

TYPE OF EMPLOYMENT

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OUR KEY FINDINGS

THERE IS WIDESPREAD BIAS, PREJUDICE AND DISCRIMINATION

THE MAJORITY OF MUSLIM HEALTH CARE PROFESSIONALS HAVE EXPERIENCED SYSTEMIC AND INTERPERSONAL BIAS, PREJUDICE AND DISCRIMINATION IN THEIR CAREERS. MANY ARE UNCOMFORTABLE OPENLY PRACTISING THEIR RELIGION WHICH PREVENTS THEM FROM SHOWING UP AUTHENTICALLY.

ASSUMPTIONS, STEREOTYPES, BIAS AND DISCRIMINATION

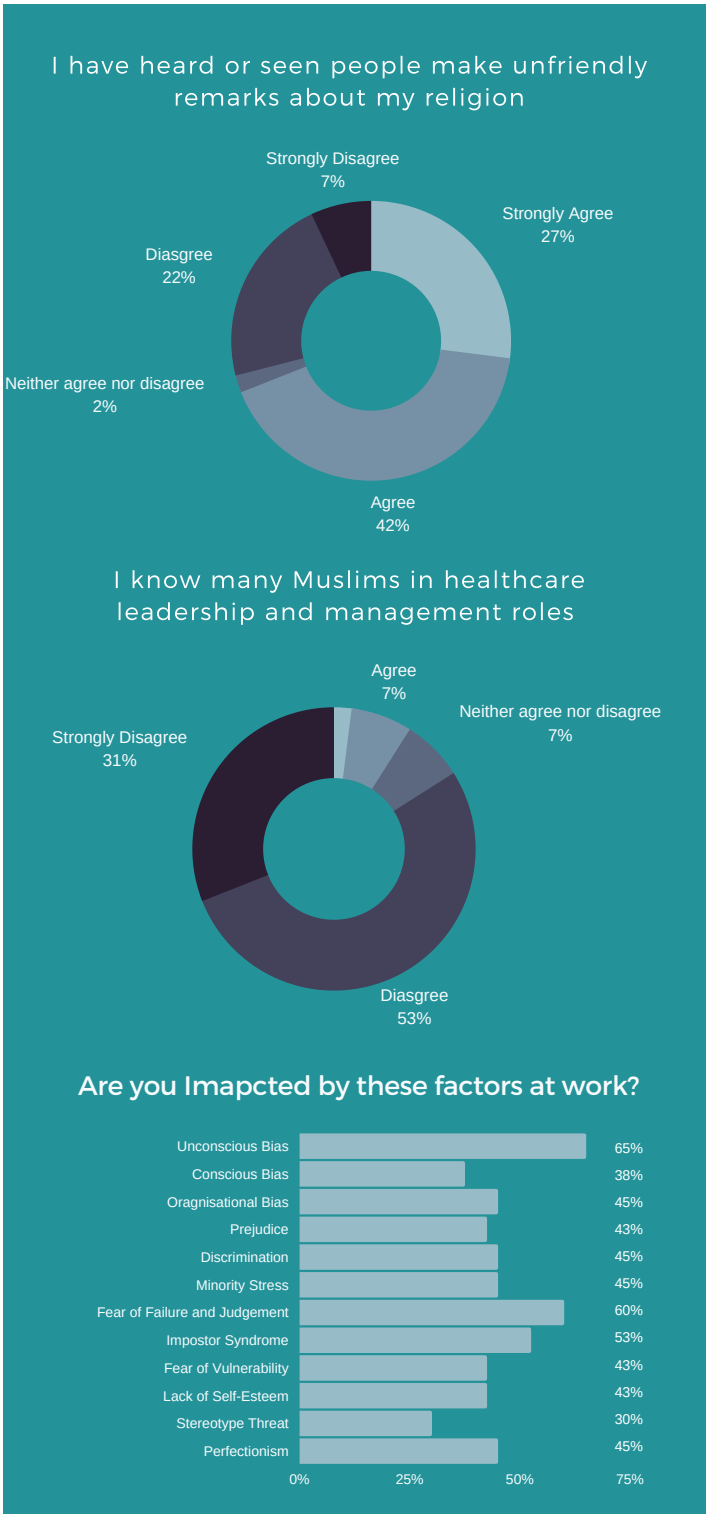
- Almost **8 in 10 experienced negative assumptions** related to their religion.
- **7 in 10 reported negative stereotypes** about Muslims either perceived or through comments heard in the workplace.
- **6 in 10** reported being impacted by **unconscious bias.**
- **Almost half** have experienced **discrimination**.

MENTORING AND LEADERSHIP

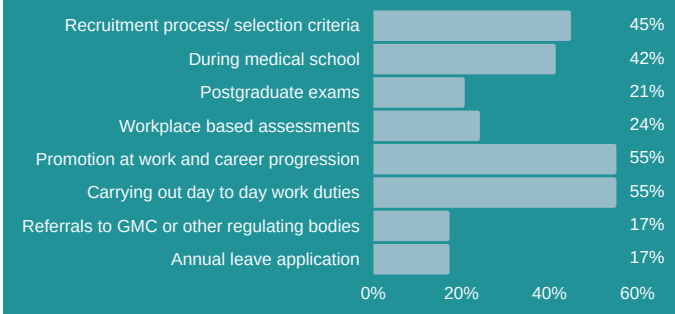
- **Two-thirds** felt there is a **lack of senior representation** and Muslim **role models**.
- **Two-thirds** report a lack of **access to mentors**.
- Almost **9 in 10 Muslim** healthcare professionals **do not know many Muslim colleagues in leadership and management positions.**

IMPACT

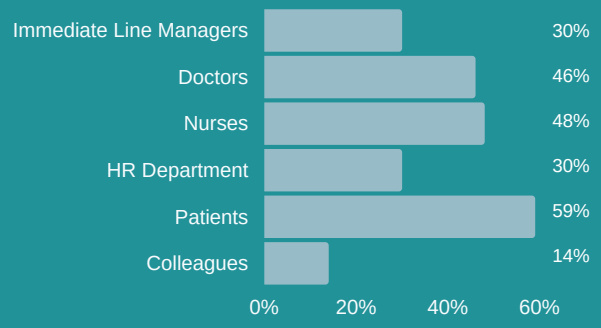
- Almost **half** have been impacted by **organisational bias, discrimination, and minority stress.**
- Almost **half** reported that sometimes they want to **leave healthcare.**
- Over **1 in 5** reported that they have felt **disrespected** because of their faith.
- **1 in 4** reported they have felt **socially avoided**
- **1 in 4** have **felt ignored** because of their religion



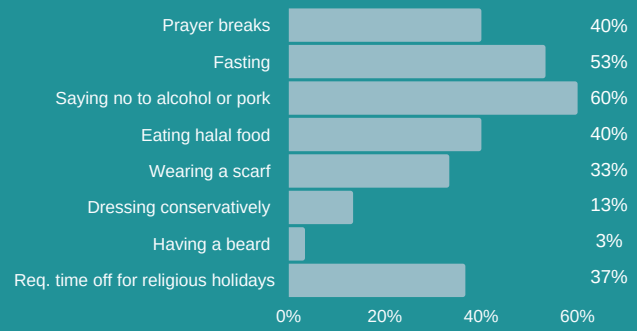
Have you experienced prejudice or bias or felt singled out in the following ? Tick all that applyIf you can, please offer any examples in the comments box



Where have you experienced bias? Select all that apply



Were you ever made to feel different or a victim of microaggression as a result of your faith for the following?
Tick all that apply & give examples if any



ORGANISATIONAL BIAS

- **1 in 5** felt they had been **passed over for promotion** because of their religion.
- Over **2 in 5** felt there was bias during the **recruitment process**.
- **2 in 5** had experienced bias in **medical school**.
- Over **half** felt that they experienced bias when it came to **career progression and day-to-day work duties**.

SOURCES OF BIAS

- Muslim HCPs felt that most biases were from **patients** who had made **openly hostile comments**.
- Almost **3 in 5** reported that they had experienced **bias** from **patients**.
- Almost **half** had experienced bias from **nurses**
- Almost **half** had experienced bias from **other doctors**.
- Almost **3 in 10** had experienced bias from direct **line managers**.

Given the percentages, it would appear that some respondents had experienced bias from more than one source.

HOSTILITY AND ABUSE

- **3 in 10** reported having faced **hostility** aimed at them **specifically because of their religion**.
- Almost **4 in 10** reported **verbal abuse** because of their religion.
- Less than **10%** reported **physical abuse**.

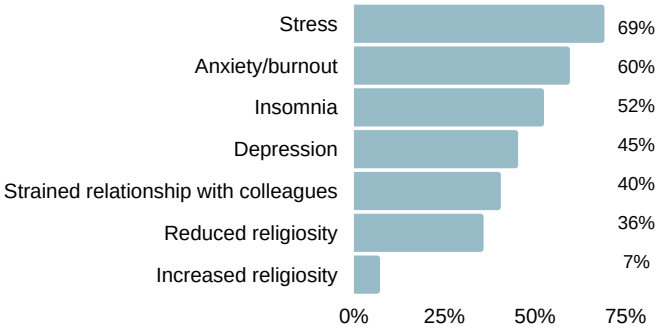
Many issues seem to arise around **fasting during Ramadan** or taking **prayer breaks**. Muslim healthcare professionals can find it difficult to take prayer breaks or to pray on time.

In spite of all the challenges that Muslim healthcare professionals face, approximately **6 in 10 remain optimistic** about the future.

WELLBEING IMPACT ON MUSLIM HEALTHCARE PROFESSIONALS

The **majority** of Muslim HCPs experienced **negative impacts on psychological and emotional wellbeing**.

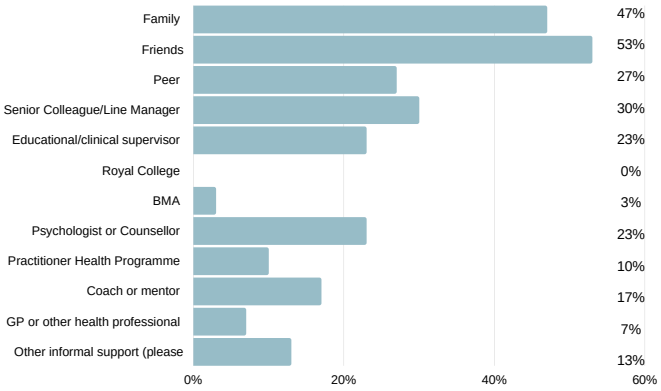
Four in ten reported **strained relationships** with colleagues and a similar proportion used **identity concealment** as a coping strategy for stereotype threat.



SEEKING SUPPORT

Over one-third of Muslim healthcare professionals have **sought psychological or emotional support** because of **work-related stress**.

This was from a **variety of sources** such as friends, family, colleagues, and professional counselling.

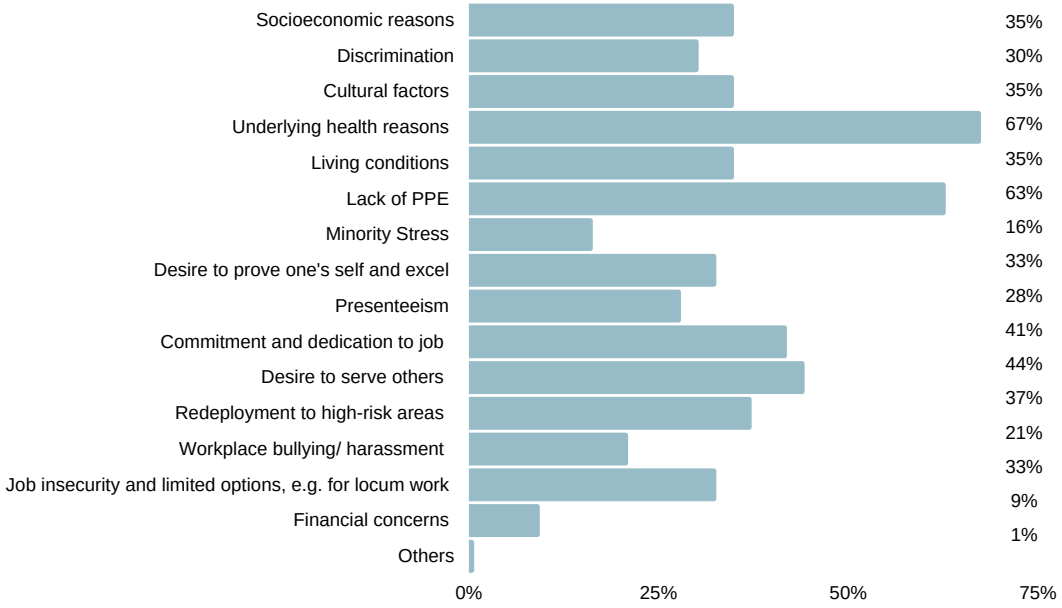


FEARS OF BEING SCAPEGOATED OWING TO MINORITY STATUS

Almost **8 in 10** Muslim HCPs suffer **anxiety** at work on **hearing news about any Muslim-related terrorism** consistent with **stereotype threats of supporting violence and extremism.** Many believe it is important that they openly express their disassociation and/or denounce terrorism.

COVID-19 AND DISPROPORTIONATE IMPACT ON MUSLIM HCPS

The main factors believed to contribute to a higher number of Muslim doctors losing their lives during COVID-19 are **underlying health reasons, lack of PPE** and a **desire to serve others**. Other notable factors include **commitment and dedication to their jobs**, **socioeconomic reasons** and **job insecurity**, **cultural factors** and **living conditions** (multi-generational households).



WHAT COULD HELP

- **4 out of 5** felt that there is a need for **good mentors** to help Muslim HCPs tackle disadvantages or discrimination at work.
- **7 out of 10** felt that it would help to have a **faith network at work**.
- **6 out of 10** felt that **self-empowerment and leadership training** could help.·
- **5 out of 10** wanted **unconscious bias training** for managers and **bystander training** for themselves on how to tackle bias and micro-aggression at work.

OTHER COMMENTS ON WHAT COULD HELP

*I Whilst it is true that more carefully chosen mentors and leadership training will be useful, I think there is **only so much the individual can do to improve their situation**. Drs, nurses, and managers all will **benefit from training** in various forms of bias, discrimination, and microaggressions. It really should be made **mandatory** as I have **experienced much more racism as a patient in the NHS than as a doctor**. Or at least the racism was **more overt and ugly** as a patient anyway.*

*I think Muslim doctors often don't bother to **sign up to a defence union** when they practice medicine in this country, which is actually a standard thing all doctors here do. It may be because in their country of origin this is not a usual thing, or indeed they may not even have defence unions there. a serious complaint (eg GMC) can lead to **huge legal costs** if the doctor is not insured by a defence union. and sometimes I think unions won't accept complaints you already have once you sign up. They will only deal with complaints that come in after you are a member.*

*Even if Muslim doctors have a defence union, they **need proper guidance, support, and mentoring to traverse the potential minefield that is medical regulation in this country**. It is not openly discussed (as everyone wants to keep their head down and keep out of trouble!) but **medical regulation in the UK is often punitive and over-zealous, disproportionately so to ethnic minority doctors**. Due to many factors, mentioned above, ethnic minority doctors are considered **easy targets to sanction and keep the public 'safe' and confident in the regulator (GMC) even if confidence in (ethnic minority) doctors is damaged.***

*''I"There should be **strong networks/ associations** like BMA who could represent Muslim healthcare professions properly.*

*I think Muslim Doctors Association should **exert its influence more assertively** and should make sure voice is heard properly and should try to **make a proper pressure group**.*

***Racism and discrimination is everywhere but employees don't raise it** as it can affect badly retrospectively."*

DIFFICULT INTERPERSONAL EXPERIENCES & MICCROAGGRESSIONS

*" **Racism is rife** and it makes it **hard to progress** in ways one wants."*

*"Colleagues from **another minority** openly make **derogatory comments about my religion** and **stereotype** it."*

*"Putting **extra effort** in and **no recognition**."*

*"Asking to be put through for **projects but told not available**, and then hear a **white person got it** "*

*Asking to have **reduced workload and being told that is not possible,** the **white person asks the same and gets it** no questions asked."*

*"I had **0 days sick leave in 3 years. I took 1 day sick** and I got a call from a colleague saying **people including my boss were talking about me behind my back that I was faking it**. I went back to work the next day despite not being ready."*

*"Most discrimination encountered is from **patients**, not from workplace staff."*

*"Heard directly from patients that **I am not to be trusted as I am a Muslim**."*

" Sarky comments from patients. HR forcing their bullying tactic upon me because I seem to be a focus for their frustrations."

*"Despite being from the UK, I have been **asked umpteen times which country I'm from**. Been told to **get the F*** out the country** and nursing staff who witnessed this saying the patient isn't in their senses."*

*"I **have experienced every kind of microaggression that can be thought of. I** have a record of at least **20 racist incidents involving NHS staff alone**. Many of these **revolve around Ramadan where the supervisor was not happy I requested leave** then in another job the consultants **were not happy I was taking time out to pray.***

FAITH RELATED CHALLENGES

*I would **never make it obvious I need to go to pray**. I would **avoid trying to put myself in a place where I might have to say no to a social outing** because I **did not want to disappoint other**s and did not want to make things worse for myself. It is **always harder when wearing a scarf**, you **have to be more extroverted** than one's introverted nature might allow.*

I often wonder what difficulties would have been avoided if I hadn't worn a scarf from aged 21. But wearing it, opened my eyes to all sorts of situations that I also never wanted to cast a blind eye to. But it is hard, wearing this mantle. Carrying this mantle. It is hard. For example, how can a man know what it's like to be a woman, how can a white-skinned person know what it's like to be black-skinned, and how can a Non-Muslim know what it's like to be a scarf-wearing Muslim. I've had generally positive experiences, but I faced more classist issues, on top of everything else.

*A so-called **Muslim consultant** once said how can water be holy and do miracles in a **morning handover**. Meaning Zamzam. Thought I may have an **arranged marriage**.*

*I have always kept my religious views quite private, perhaps because I knew in the UK Muslims are not regarded in the best light. On one particular occasion at work, I felt uncomfortable voicing my opinion on **male circumcision** when a colleague was saying quite aggressively that she was opposed to this for religious reasons. I do not think she was aware I was Muslim as I do not dress in a way that would openly show my faith either.*

FAITH IMPACT ON CHOICE OF JOB OR SPECIALITY

*''Due to the racism in the **surgical specialty, I was in. I left and chose GP** so that I can pray and perform my religious duties as suited to me."*

*" I made sure **I went and worked I'm a predominantly Muslim GP surgery** I **left hospital medicine** as found racism."*

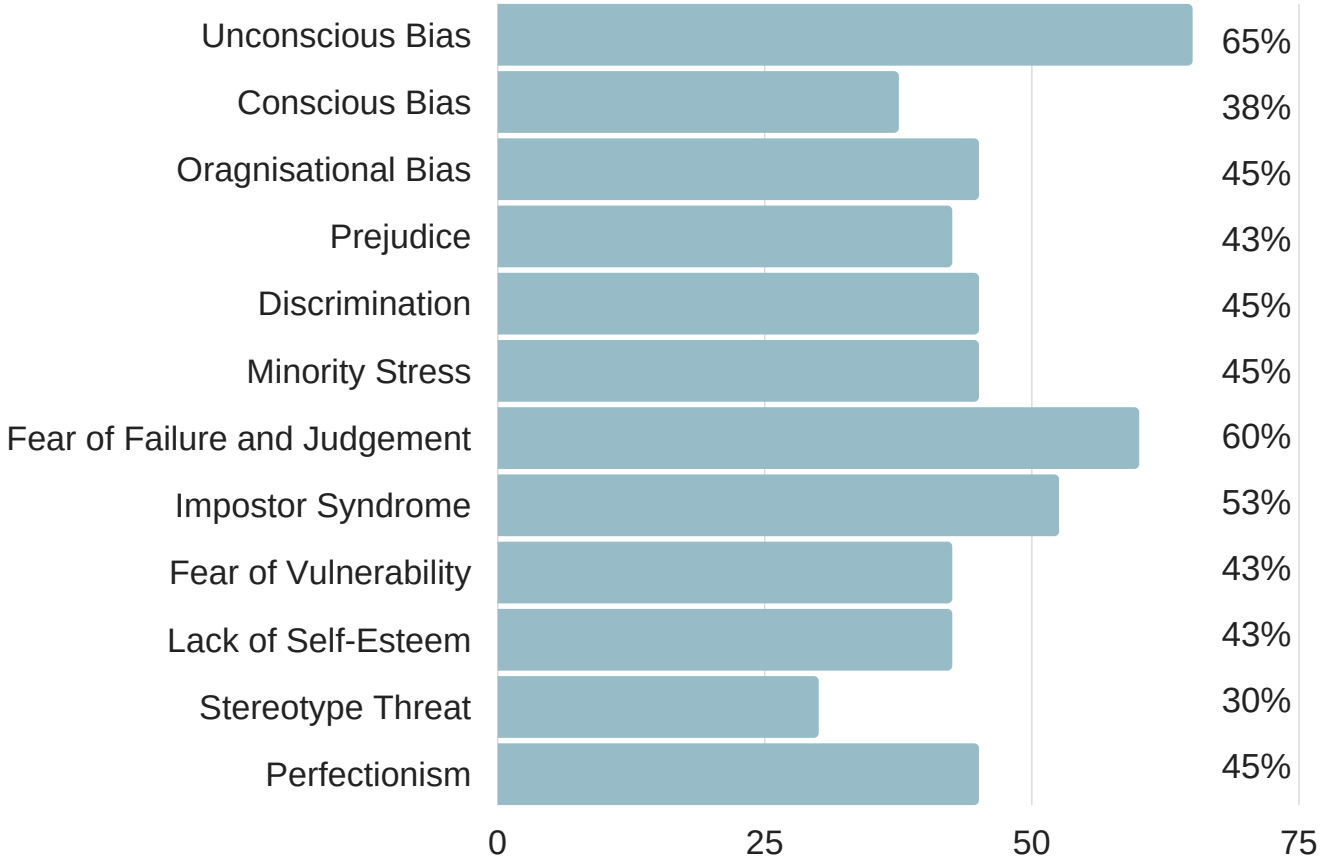
MUSLIM DOCTORS ASSOCIATION

THE GREY AREA
DECODING INCLUSION

SUMMARY OF TYPES OF EXPERIENCES

- ***Conscious Bias**: overt negative behaviour(s) that can be expressed through physical and verbal harassment or through more subtle means such as exclusion.*
- ***Unconscious Bias:** are social stereotypes about certain groups of people that individuals form outside their own conscious awareness. Unconscious bias occurs when people favour others who look like them and/or share their values. Examples include preferring candidates with certain names, ageism, sexism, homophobia, and ableism.*
- ***Organisational Bias** occurs when factors such as culture, senior leadership, strategic focus and team organisation are used to support particular outcomes.*
- ***Prejudice:** these are preconceived attitudes and/or judgements that can be cognitive, affective and/or behavioural.*
- ***Discrimination:** describes differential treatment on the basis of perceived difference.*
- ***Minority Stress:** describes chronically high levels of stress faced by members of stigmatised minority groups. It may be caused by a number of factors, including poor social support and low socioeconomic status, but the most well-understood causes of minority stress are interpersonal prejudice and discrimination.*
- ***Acculturative Stress:** refers to the feeling of tension and anxiety that accompany efforts to adapt to the orientation and values of the dominant culture. These can have an influence on physical and mental health disparities, such as hypertension and depression.*
- ***Impostor Syndrome:** syndrome (also known as impostor phenomenon, impostorism, fraud syndrome or the impostor experience) is a psychological pattern in which an individual doubts their accomplishments and has a persistent internalized fear of being exposed as a "fraud" or not feeling good enough.*
- ***Perfectionism:** striving for flawlessness and setting excessively high-performance standards, accompanied by overly critical self-evaluations and concerns regarding others' evaluation.*
- ***Fear of Failure and Judgement:** fear of not living up to or achieving what you or others expect you to achieve.*
- ***Fear of Vulnerability:** ultimately this is a fear of rejection or abandonment resulting in holding back and not taking risks or putting yourself forward. The idea of exposing your true feelings and thoughts, opening yourself up or sharing any weaknesses can seem dangerous and risky.*
- ***Self-Promotion Gap:** not promoting your unique ideas, talents and strengths to further your own growth, advancement, or prosperity.*
- ***Lack of Self-Esteem:** lack of a sense of worth or self-confidence resulting in feeling awkward, incompetent, or bad about oneself.*
- ***Stereotype Threat:** is a situational predicament in which people are or feel themselves to be at risk of conforming to stereotypes about their social group. Stereotype threat is purportedly a contributing factor to long-standing racial and gender gaps in academic performance.*
- ***Tokenism:** is the practice of making only a perfunctory or symbolic effort to be inclusive to members of minority groups, especially by recruiting a small number of people from underrepresented groups in order to give the appearance of racial or sexual equality within a workforce.*
- ***Colourism/Shadeism Discrimination:** based on skin colour, also known as colourism or shadeism, is a form of prejudice or discrimination usually from members of the same race in which people are treated differently based on the social implications from cultural meanings attached to skin colour.*
- *Other (please specify):*

SUMMARY OF TYPES OF EXPERIENCES



DISCUSSION OF RESULTS

The report revealed that the **majority of Muslim HCPs have experienced systemic bias and interpersonal prejudice** in their careers. At an organisational level, Muslim healthcare professionals have been passed over for **promotions** and face bias in their **day-to-day work**. Bias, prejudice, discrimination, and racism are in fact evident **across the entire professional spectrum** of a Muslim healthcare professional—from medical school to job applications and recruitment to workplace-based assessments, postgraduate exams, and career advancement. Muslim HCPs also reported **differential treatment** around career opportunities such as project allocation as well as flexibility around work times and workload.

These are similar to racialised disparities documented in the literature but Muslim HCPs experience an **additional dimension of faith-based discrimination** that includes hostility and verbal abuse specifically related to their religious identity. The Grey Area Research conducted in 2019-2020 to capture the workplace experiences of multi-ethnic professionals working in the public and private sector revealed similar findings wherein participants reported bullying and harassment on account of their **faith and cultural practices**. This is consistent with **structural Islamophobia** spanning across institutions. However, as an organisation committed to placing people at the centre as outlined in the Long Term Plan and NHS People's Plan, the **NHS has a greater responsibility to create inclusivity and compassion** in its organisations.

Muslim HCPs shared how they were **uncomfortable openly practising their religion** which, in turn, prevented them from showing up authentically and bringing their whole selves to work. This creates a **false dichotomy between professional and religious identity** which can lead to **moral distress and injury** and impact **workforce retention**; indeed half of the respondents reported they had had thoughts of leaving their profession. Eight in 10 experienced **negative assumptions** about their religion and 7 in 10 reported perceived or overheard negative **stereotypes** about Muslims in the workplace. 8 in 10 Muslim healthcare professionals reported having suffered **anxiety** at work upon hearing news of Muslim-related terrorism indicating **stereotype threat** around being violent or extremist and report they need to actively denounce such acts as though they are guilty by (group) association. Others have felt **socially avoided, ignored, bullied, ridiculed, and disrespected** because of their faith (including comments from patients such as: 'I am not to be trusted as I am a Muslim' and 'Get the f… out of my country.' Participants shared that 'racism was rife' and widespread throughout the NHS **across multiple leadership levels**. Open-ended survey answers exposed **several traumatic incidents of abuse, microaggressions, and discrimination**.

DISCUSSION OF RESULTS

Respondents also reported **difficulties practising their faith** through prayer, fasting, time off for religious festivals, alcohol-related social events, and networking opportunities. These **compound experiences** of discrimination and exclusion and are consistent with **institutional Islamophobia**. Furthermore, where concerns are raised, employers **do not accommodate reasonable requests** to practice their Muslim faith.

The survey findings reveal **double jeopardy** at an interpersonal level whereby bias, prejudice, and discrimination can originate from **patients *and* colleagues** including clinical staff, managers, and Human Resources. When Muslim HCPs experience racial and religious discrimination from patients in the presence of other white or non-Muslim colleagues, they report that they **do not receive bystander support** or intervention from their colleagues.

These collective and cumulative experiences have a **profoundly negative psychological and emotional impact**, with respondents reporting symptoms of stress, burnout, anxiety and depression, insomnia, and **strained relationships with colleagues**. While the majority have reported a negative impact on wellbeing, only one-third have sought **psychological or emotional support** due to work-related stress, which has been mainly informal from friends, family, colleagues. This may be as a result of shame and guilt and/or lack of appropriate support.

During **Covid-19**, many of these factors contributed to **excess morbidity and mortality** among Muslim HCPs as indicated by the survey responses and comments.

"A workforce that has a supportive working environment is more productive. Many organisations have also found it beneficial to draw on a broader range of talent and to better represent the community that they serve. It should also result in better-informed decision-making and policy development. Overall, it can lead to services that are more appropriate to the user, and services that are more effective and cost-effective. This can lead to increased satisfaction with public services." (EHRC)

Shahid H, Abdulkareem B (2018) The triple penalty: Muslim doctors in the NHS. Muslim Doctors Association.

RECOMMENDATIONS

SURVEY RESULTS

AWARENESS, DIALOGUE, CELEBRATIONS, TRANSPARENCY, CULTURAL REVAMP

The report findings validate the **need to prioritise and address discrimination, racism, and Islamophobia across NHS organisations**. Muslim HCPs do not fit neatly into one category of the Equality Act 2010, thus we must explicitly recognise Islamophobia as a type of discrimination and oppression that goes beyond race and religion, and often includes a gendered component that affects professionals differently, including in secondary versus primary care settings. The Muslim Doctors Association's qualitative work reveals penalties faced by Muslim healthcare workers go "Beyond the Triple Penalty;" this necessitates an **intersectional lens** to explore their different experiences at the individual, subgroup, and organisational levels.

Compliance with the Equality Act is a **legal obligation**, but it also makes good **business sense**. An organisation that is able to provide services to meet the diverse needs of its patients and users will be able to provide its core business, in this case, **patient care** through improved experience, outcomes, and quality of care, that is delivered more efficiently, effectively and safely.

However, there is also a **strong moral and ethical case** for improved diversity, inclusion, and equity, and organisations, especially the NHS, which looks after the vulnerable in society, There is an **imperative for the NHS to be more values-driven,** centring compassion, fairness and justice.

RECOMMENDATIONS

An **organisation's culture** has a strong influence on whether people acknowledge the existence of any type of disparities. Management teams need to **actively take stock** and check if their organisational cultures and values unconsciously encouraging bias. Are employees penalised or not supported for taking time off from work for prayer or breaking fast? Is religious leave difficult to secure but misplaced humour and micro-aggressions targeting marginalised groups are a dime a dozen? Are employees working late and contacted outside of office hours? Are minority groups experiencing cultural taxation for trying to champion Equality, Diversity, and Inclusion (EDI)? Is working culture rife with locker room talk? Does the work ambiance seem divisive—are employees always on the edge, pitted against each other? **If the answer is yes to any of the above, then it's time for a change**.

A robust EDI plan is now more important than ever. While the strategic budget is proportionate to an organisation's size and resources, the good news is many organisations can implement several changes at zero or minimum cost. **Most of the impactful changes begin with one simple step: creating awareness**. However, for sustained and impactful change, EDI work must be adequately resourced and funded.

Multi-level and holistic interventions are necessary that are tailored and personalised, consider cultural and contextual particularities and preferences, and centre co-production and empowerment with agency of marginalised voices and accountability of those in power.

"Decision making must be open, consultative, deliberative and participatory"

Sustainable intersectional action: **Principles**

1 Multi-level and holistic – an examination of how policies impact individuals and marginalised groups across protected characteristics and at different levels: organisational, interpersonal and individual

2 Tailored and personalised – considering cultural and contextual particularities and preferences and how these can be addressed and supported

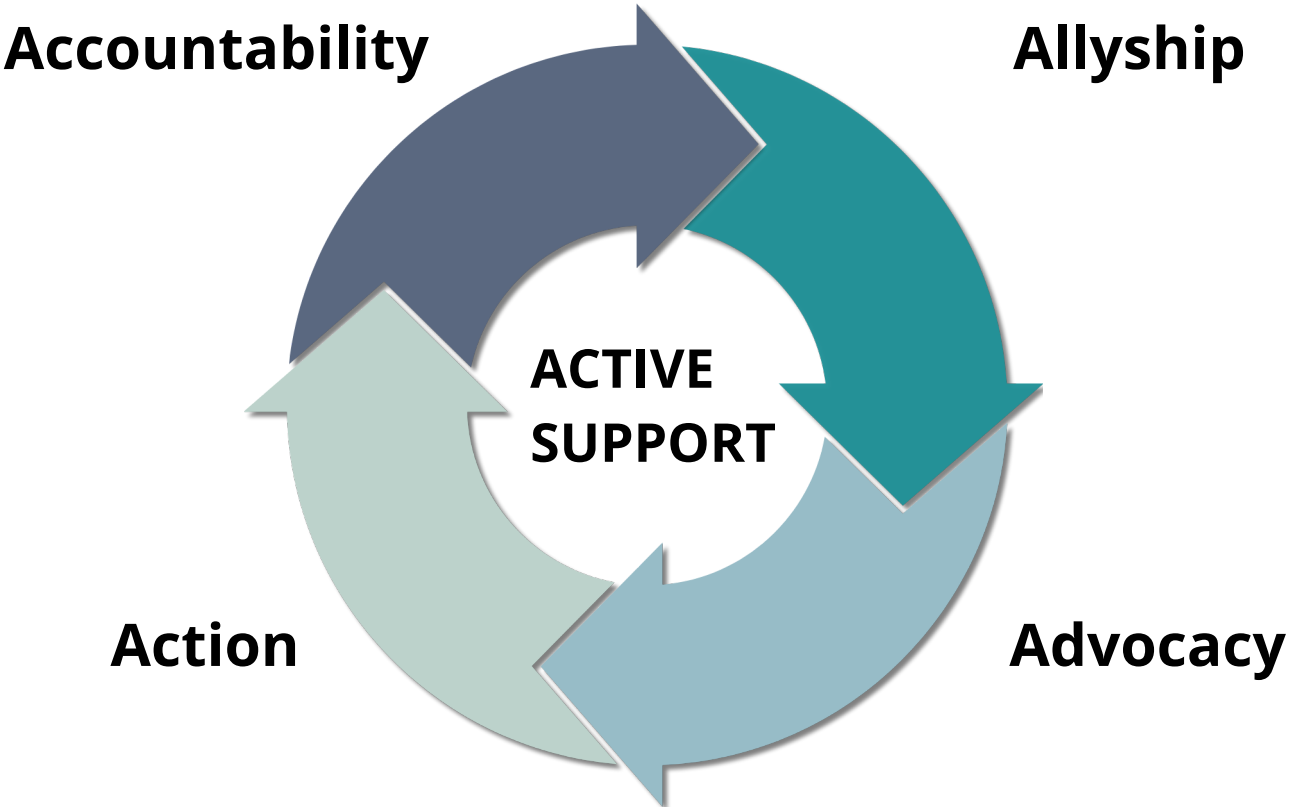
3 Co-production - with agency of marginalised voices and accountability of those in power to empower Muslim and other marginalised groups

4. Transparency- with data collection, publication and sharing across protected characteristics, fair processes around recruitment, selection, and open, consultative, deliberative and participatory decision making around disciplinary referrals, conflict in EDI policies and decision making

Supporting Muslim Healthcare Professionals

We recommend a twelve-point plan built around **"The 4As of active support**":

- Authentic allyship
- Advocacy
- Action
- Accountability



RECOMMENDATIONS

12 POINT ACTION PLAN FOR ALLIES & ADVOCATES

1. START ON AN INDIVIDUAL LEVEL

To truly promote belongingness, we need to **start with each one of us**. We need to encourage allies to **question their assumptions** regarding any aspect of their values and belief system around their Muslim colleagues.

This may begin with **self-reflection and further inner work** to identify blind spots and a commitment and action plan to build awareness and knowledge.

A **spirit of curiosity, cultural humility and compassion** are vital. As an ally, you are not expected to understand what it feels like to go through the experiences of Muslim HCPs, what is asked is that you take a genuine interest in the experiences of your Muslim HCPs, seek permission to ask questions and do so with the **intention to take action** and provide **support and solidarity**.

A simple checklist is shown below. **Getting comfortable with feeling uncomfortable** is crucial to developing authentic allyship and advocacy,

Checklist: **checking assumptions**

- What do I know about this?
- How do I know this is true? Is this a valid and legitimate source?
- How could this not be true?
- Do I need to find out more information about this?
- Where can I find more information?
- What questions could I ask someone to better understand their values and perspectives?
- What is my sphere of influence where I can make a difference to actively support Muslim HCPs?

Her Allies: A Practical Toolkit to help Men Lead through Advocacy by Hira Ali

2. CHANGE MUST INITIATE FROM THE TOP: REPRESENTATION AND ROLE MODELS NEED TO BE VISIBLE

Change must come from the top. Respondents stated that they would like to see **more people who look like them at the top** and that they would like more **mentorship opportunities** and **role models** who give them confidence that they belong and are valued and that career progression is possible.

Leadership and representation in senior roles must be **authentic** and not tokenistic, based on competency, capability, and credibility. Senior minority and Muslim leaders must have the necessary **resources** and **agency** to carry out their roles effectively.

Spotlight events for role models and initiatives highlighting personal stories of success within organizations **create a narrative and culture of inclusion and optimism**.

3. MOVE BEYOND STANDALONE TRAINING TO CONSTRUCTIVE DIALOGUE, LEARNING, AND REFLECTION

Muslim HCPs stated that they felt that **bystander training** and **unconscious bias** training for managers and colleagues would be helpful. However, on their own, these are unlikely to lead to meaningful or sustainable change. Culture and institutional change require **safe spaces** for ongoing learning, reflection, and constructive dialogue to **co-create inclusive work environments**.

What do safe spaces look like?

- Wearing your PPR—Being positive, present, and respectful
- Clarifying what you didn't understand or like there and then
- Acknowledging responsibility
- Contributing to the agenda
- Avoiding interruption and allowing everyone to speak.
- Listening with an open mind
- Respecting privacy and not sharing what is discussed outside that space.
- Staying on point and on time
- It's okay if you feel emotional
- It's okay to not know everything
- It's okay to make mistakes
- Recognizing that every experience is unique-it's not always either/or there may be grey are areas

Her Allies: A Practical Toolkit to help Men Lead through Advocacy by Hira Ali

RECOMMENDATIONS

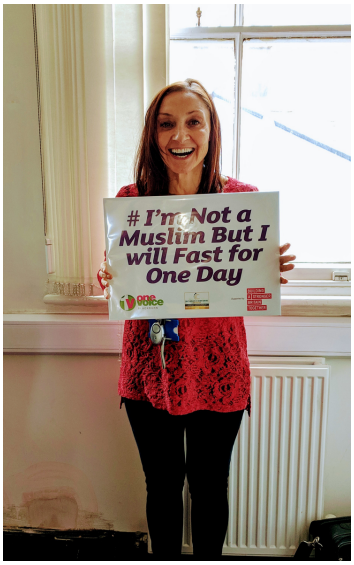
SURVEY RESULTS

4. CELEBRATE THE DIVERSITY IN DIVERSITY

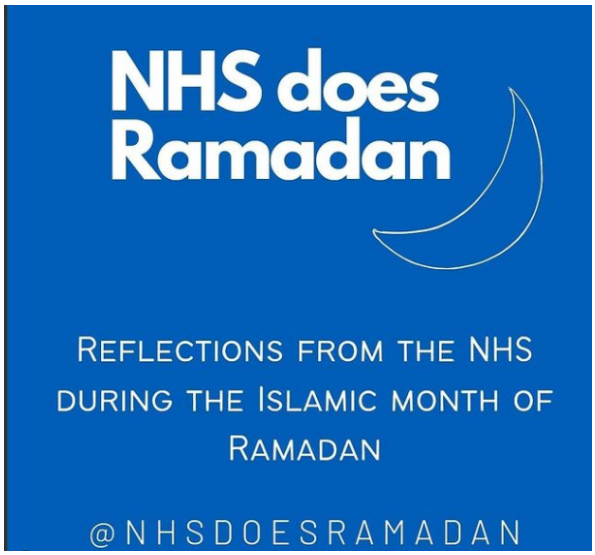
Creating awareness and constructive dialogue will also help **normalise mainstream religious practices** such as praying, fasting, and wearing the hijab so that they are not perceived as negative, extreme, or threatening. This will help r**e-humanise Muslim professionals** as multidimensional beings and enable them to be supported to bring their whole selves to work.

Celebrating Eid and other religious festivals can facilitate **positive representation** and help Muslim colleagues feel included and valued. Some non-Muslims colleagues have participated in the **Ramadan Challenge** and such activities can build solidarity, camaraderie, and compassion.

Celebrating and commemorating faith festivals, interfaith week, and Islamophobia Awareness Week can support Muslim healthcare workers to feel included, heard, valued, and celebrated at work, as well as enable managers and colleagues to understand challenges and commit to addressing them.



Source: Lancastershire Telegraph



'Don't speak for us': How mainstream media misrepresents Muslim women by Hira Ali

5. CREATE AN ISLAMOPHOBIA ZERO-TOLERANCE POLICY

The NHS has a zero-tolerance policy to abuse and discrimination and this must be implemented with perpetrators held accountable. Zero tolerance policies should also **explicitly include Islamophobia**. Where Muslim colleagues report incidents of Islamophobia, these must be taken seriously, with **safe psychological passages for raising concerns**,

There should be the establishment of **clear, consistent, fair and transparent processes** in place for how cases are dealt with, and what support is provided to victims. To effectively counter bullying and other forms of provocations, organisations must **actively deploy mitigation, not just containment, strategies**. They would also need to develop, monitor/track, and review the progress regularly. We recommend that the **NHS recognises Islamophobia as an unacceptable form of discrimination and adopts the APPG policy on Islamophobia**.

In our survey respondents reported that when non-Muslim colleagues witnessed discrimination there was no intervention; **active bystander training** will support the implementation of a Zero Tolerance to Islamophobia policy.

Zero tolerance to Islamophobia: Checklist

1. Do you have a zero-tolerance policy to Islamophobia in your organization?
2. How is this policcy communicated?
3. How is this policy implemented?
4. How is this policy monitored?
5. If you don't have a policy- how will you create one?

https://www.imperial.ac.uk/natural-sciences/education-and-teaching/wellbeing-support/resources-and-support-for-staff/

RECOMMENDATIONS

SURVEY RESULTS

6. ESTABLISH FAITH NETWORKS

Respondents reported that they would like to see more faith networks at work. One-third of respondents stated they sought emotional and psychological support, predominantly from friends, family, and informal networks. This may be due to a lack of **formal support** offered through work. It is important for faith networks to be **adequately resourced and funded** to **avoid cultural taxation** on already marginalised colleagues. There should be faith networks and defence councils with recourse for appeal are set up to provide support to Muslim professionals.

Faith networks: activities

- Inter-Faith Buddies
- Dialogue between people of different faiths and beliefs with safe spaces, coffee mornings and lunch time events, arranging awareness days and commemorating religious festivals
- Peer support for Muslim and staff from other faiths
- Engagement events with chaplaincy services
- Marking Islamophobia Awareness Week
- Providing faith and culturally sensitive support services to staff
- Access to staff survey data by religious affiliation to monitor disparities
- Working with management and leadership boards on issues around inclusion, progression and support for Muslim and staff from other faiths

Source: https://www.interfaith.org.uk/resources/dialogue-1

7. PROVIDE CULTURALLY SENSITIVE PSYCHOSPIRITUAL SUPPORT

During the pandemic, **faith-sensitive counselling** was offered for the first time to Muslim NHS staff through an initiative spearheaded by the NHS Muslim Network; this needs to be more widely available as providing psychological support should not be only limited to the pandemic. The results of this survey identified a high proportion of Muslim HCPs experiencing psychological distress and unmet needs around adequate support

8. DEVELOP AND IMPLEMENT WORKFORCE FAITH EQUALITY STANDARDS

The NHS Workforce Race Equality Standards (WRES) and NHS Workforce Disability Equality Standards (WDES) have been important to bring awareness to the issues of under-representation and challenges of groups with specific protected characteristics and to bring transparency and accountability to NHS Trusts for actions and progress. A similar metric is needed for NHS workers from faith backgrounds to monitor progress and bring accountability to unfair policies and actions.

9. OFFER LEADERSHIP TRAINING, MENTORING, AND COACHING

Career progression needs to be supported as reflected by representation at leadership and senior management levels. Respondents stated they would like more leadership and empowerment training, which is unsurprising given the erosion of self-esteem and confidence reported. The response to this must be protected leadership training and investment into the workforce,

Reverse mentoring in organisations can empower emerging and established leaders, **close knowledge gaps**, and s**upport the career progression of Muslim HCPs**. It can bring **additional benefits** around building trust, empathy, a sense of belonging, workforce retention, and wellbeing.

Her Allies: A Practical Toolkit to help Men Lead through Advocacy by Hira Ali

Reverse Mentoring: principles

Set goals and guidelines- on purpose, values, focus and tracking progress
Set boundaries- on time, resources, interactions and tasks
Authenticity- openly discuss challenges, barriers, failures to promote trust and sincerity
Trust and confidence- clear agreement on what information can be shared and what is private
Respect- in listening, speaking and treatment of eachother
Non judgemental attitude and open mindedness- to promote empathy, understanding and ongoing engagement, use of active listening skills
Giving and receiving feedback- being aware of principles of giving and receiving feedback and being open to accepting feedback from more junior colleagues
Accountability- for both mentor and mentee on commitments, actions, tasks and responsibilities

10. CONDUCT INTERSECTIONAL EQUALITY IMPACT ASSESSMENTS

Any policies that are being proposed in NHS Trusts and organisations must undergo a robust intersectional Equality Impact Assessment that includes an **analysis of the impact on each protected characteristic**. Though Islamophobia is a form of cultural racism, it interacts with religion and gender directly and indirectly with other protected characteristics and beyond (such as citizenship/nationality). This requires a **holistic assessment and tailored response**. There must be **clear processes** for how conflicts are managed and every decision should be informed by a **structured due diligence process**.

11. REFORM RECRUITMENT, APPRAISAL AND OTHER POLICIES

Reform should also include **re-allocation** of existing staff or resources, creating **new policies and procedures** and **discarding old policies** including around dress codes and Prevent, hiring necessary staff, and imparting fresh skills and training aligned with equality regulations. There needs to be **active support** from the top of the organisation and **accountability** established for departments and management that fail to funnel people up the career pipeline while discouraging stereotypes that influence those decisions. A Workforce Faith Equality Standard is vital to monitor progress.

The **recruitment process itself**, including the language, website, and job description, should be gender-neutral. Establishing **objective criteria for reviewing resumés** can help reduce bias, as does using **structured interviews** for recruitment and promotions. At the beginning of the process, interviewers should have a checklist describing biases and actionable advice to mitigate them.

Marginalised groups often get short-changed in reviews and miss out on critical talent assessment discussions. Organisations must **question bias when evaluating performances and doing appraisals** and ensure promotions are not skewed in favor of dominant groups.

12 CHALLENGE WIDER POLICIES

Finally, change is not possible unless the **policy environment** changes. This requires authentic allies to push their **MPs and government** to adopt a definition for Islamophobia and to challenge the **negative media stereotyping** of Muslims which fuels bias, prejudice, and discrimination.

Her Allies: A Practical Toolkit to help Men Lead through Advocacy by Hira Ali

RECOMMENDATIONS

12 POINT ACTION PLAN

1. **Start** on an individual level: challenge assumptions and reflect on privilege and responsibility
2. **Change** must initiate from the top: representation and role models need to be visible
3. **Move** beyond standalone training to meaningful dialogue, learning, and reflection.
4. **Celebrate** the diversity in diversity
5. **Create** an Islamophobia zero-tolerance policy
6. **Establish** faith networks
7. **Provide** culturally sensitive psychospiritual support and eco-spiritual maps
8. **Implement** workforce faith equality standards
9. Offer leadership training, mentoring and coaching
10. **Conduct** intersectional EDI impact assessments
11. **Reform** recruitment, appraisal, and other policies
12. **Challenge** wider policies

LIMITATIONS & FUTURE DIRECTIONS

One of the biggest limitations of this report was the **sample size** due to the pressures of Covid and participation in the vaccination programme. However, the f**ocus needs to now move towards tangible action**; **even one person reporting racism, discrimination or Islamophobia is one too many**.

Routine collection and publication of staff survey data on faith groups and a Workforce Faith Equality Standard will assist with monitoring progress instead of external surveys which are resource-intensive. This needs to be **built into the infrastructure** of NHS organisations.

Additionally, too often **narrative accounts** are ignored, perpetuating testimonial injustice and epistemic racism in communities where oral traditions are an important form of knowledge creation and transmission. When Muslim and other minority staff report adverse experiences, the **response should be validation and action, not verification**.

We hope the in-depth accounts in this survey and solution-centred action points and checklist will be embedded in NHS organisation to enable Muslim HCPs to **flourish and feel empowered with a sense of belonging**.

"When Muslim and other minority staff report adverse experiences, the response should be validation and action, not verification"

DR. HINA J. SHAHID

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YOUR VOICE MATTERS

GOT ANY QUESTIONS OR WANT TO BOOK A SESSION?

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