Professor Kevin Fenton
Public Health England
Wellington House
133-135 Waterloo Road
London
SE1 8UG
Kevin.fenton@phe.gov.uk

21/05/2020

Dear Professor Fenton

Re: Impact on religious minority communities from Covid-19

Thank you for leading a review into the impact of Covid-19 on BAME communities who continue to experience a high burden of morbidity and mortality both in the community and on the frontline. Compounding this is the **increasing concern about the disproportionate impact that Covid-19 has on faith communities, especially the Muslim community**, many of whom belong to high risk BAME groups.

Religion is a protected characteristic in the Equality Act and the lack of data available on faith communities is concerning. While the inquiry into BAME inequalities is encouraging, emerging data demonstrates that **risks are not uniform across ethnic groups** and current aggregated BAME categories fail to consider important **in-group differences in ethnicity and faith**, limiting the scope of understanding and relevant action. **Faith-based organisations have been at the forefront of community efforts**, providing **mental health and spiritual support** through helplines, virtual streaming of congregations and bereavement counselling. They have also been **providing practical support** by organising delivery of food, medicines and essential supplies to elderly, vulnerable and isolated households, **offering guidance** around issues such as end of life care and celebrating religious festivals as all as having to **cope with excess burials and funerals** in the community.

It is well known that **80% of health outcomes are socially and structurally determined**, and **ethnicity and faith are important determinants of health**. Faith beliefs and practices are protective against Covid-19, promoting personal, respiratory and hand hygiene, quarantine practices and mental and social wellbeing. However, **culture, language and literacy barriers** contribute to misconceptions and distortions, communication challenges and discrimination, increasing the risk of adverse outcomes from Covid-19. Religious discrimination including **Islamophobia has intensified during the Covid-19 pandemic**, with Muslim communities experiencing increased blame, stigma and abuse. **50% of Muslim households live in poverty** in the UK and **longstanding intersecting social and structural inequalities** have been amplified by Covid-19 contributing to **adverse health and economic outcomes**; these include hazardous and insecure living and working conditions reported by many Muslim workers, social deprivation, and marginalisation and alienation by politicians, media, and government policies, especially around austerity, security and immigration, which has **undermined trust in advice** from authorities and generated conspiracy theories and harmful alternative facts. **Co-morbidities and nutritional deficiencies** are higher in the Muslim community associated with poorer outcomes from Covid-19, these themselves are rooted in wider structural and social inequalities. It is also concerning that **over 50% of doctors who have died were Muslim**. It is well documented that **Muslim healthcare staff are most likely to experience religious discrimination in the NHS** and those on the front line during Covid-19 have reported bullying, harassment, discrimination, inadequate access to PPE and testing, increased exposure to high-risk patients, and stress, anxiety and burnout.

It is essential that **data is collected and published on key determinants of health** which **includes protected characteristics** as enshrined in the Equality Act 2010 to understand root causes of health inequalities and ensure optimal health for all. In addition to **assessing a range of social, economic, demographic, ecological and medical risk factors,** data on **ethnicity must be disaggregated, and data on faith must be collected and**

published in the UK on a range of outcomes. The risks must be **understood in the context of, and not in isolation of, intersecting inequalities and discrimination**. This is important to continue to **support vulnerable communities, learn from actions and mitigate further risk**.

The reported impact on **faith communities struggling to cope** with excess illness, deaths and burials, mental health disorders, financial hardship and occupational risks requires further investigation. **Government must make sure that the most vulnerable in society are protected and supported**. This can only be achieved if the correct data is collected, published and actioned using an **intersectional, multi-disciplinary and multi-sectoral approach** with stakeholders across public, academic sector institutions including community and faith-based organisations.

We recommend:

- **Collection and publication of data disaggregated by ethnicity and faith** to further understand distribution and impact of risk and protective factors and health outcomes including death, hospital admissions, primary care access and community transmission
- Collection and publication of data on **wider social, economic, demographic, ecological and clinical risk factors** including income, employment, education immigration status, language, disabilities, neighbourhood characteristics, household structures, pollution, social deprivation indices and co-morbidities, as well as **research on healthcare access and discrimination** experienced by Muslim and other faith groups
- **Early multi-sectoral and multi-disciplinary stakeholder engagement and consultatio**n across a range of community, faith, academic, professional and third sector organisations to understand risk and implement mitigation **strategies that are specific, timely, accessible and relevant** to Muslim and other faith and non-faith communities
- **Collaboration and co-production of public health strategies** that are **faith and culturally sensitive** ensuring adequate funding and resources, evaluation of impact, and dissemination of best practice
- **Comprehensive occupational risk assessment** which includes faith and wellbeing as part of psychological safety at work and guaranteed **income, health and safety protection** for all key workers
- Adequate **support and resources for Muslim healthcare staff** to be able to perform their duties in a safe and sustainable way in order to safeguard them both from the high risk of Covid-19 exposure, poorer outcomes and onward transmission to their families, as well as the mental health impact from burnout, stress, abuse and discrimination that they face

I attach as an appendix, the results of our rapid review on the burden of Covid-19 on the Muslim community.

Yours Sincerely,

Hina Shahid

Dr Hina J Shahid MBBS, MSc, MRCGP, DRCOG, DCH, DFSRH
Chairperson Muslim Doctors Association & General Practitioner

RAPID REVIEW OF EXCESS BURDEN ON MUSLIM COMMUNITIES FROM COVID-19
MAY 2020

Faith as a determinant of health

Faith is an **important and overlooked** determinant of health, mediating risk from Covid-19 on faith communities through various mechanisms and providing unique opportunities for intervention:

- **Decreased vulnerability**- **religious teachings** on healthy lifestyle, hygiene, quarantine, and charity, and **faith institutions** providing emotional, spiritual, social and practical support to elderly, vulnerable and isolated individuals **promote the principles of health protection**, **prevention of illness** and **maintaining wellbeing**.
- **Increased vulnerability**- religious and cultural **misconceptions and misunderstanding** of teachings such as Divine Will, preference for **traditional faith healers** and faith-specific media outlets separate to mainstream **communication channels**, **performing rituals** without specialist consultation such as fasting during Ramadan, communal prayer, burial and grieving practices which allow for adaptation under conditions of necessity and prevention of harm, **facilitate community transmission** and form b**arriers to accessing evidence-based health information and clinical care**

Impact on Muslim communities

Reports from the Muslim community and published data on ethnicity indicate that it is **over-represented in morbidity and mortality.**

- Individuals from **Pakistani and Bangladeshi** backgrounds are 2-3 times more likely to die from Covid-19, with the risk for **Black Africans** being almost 4 times as high[1].
- There are reports from the **British Somali community** being disproportionately impacted as well as Sudanese, Arab, Afghan, Iranian and Turkish communities with large numbers of Muslims, but there is **no published data specifically capturing this**, leading to **misclassification and/or underestimation of the true impact**
- Muslim communities have reported that they have **struggled to cope with excess deaths and burials**. Under-preparation caused by the **delay** in declaring a national emergency and **lack of clear communication by authorities** on funeral and burial rites caused heightened anxiety amongst the British Muslim community at the beginning of the pandemic, undermining trust. Higher deaths increase the risk of **bereavement and other mental health disorder**s, and of developing long term **post traumatic stress disorder** accentuated by restrictions on hospital visitation especially for end of life patients, funerals and isolation of grieving households disrupting cultural and religious norms.
- Muslim community organisations **responded early with insights into risk**, suspending congregational activities and adapting burial and funeral practices ahead of government advice, organising networks **providing mental health support** including bereavement counselling and providing **social support** to elderly, vulnerable and isolated households by delivering food, medications and essential items and running helplines through community volunteers
- Muslim **health and religious organisations have collaborated** on multiple information campaigns and engagement events to provide up to date evidence-based and holistic advice to communities to protect them against the risks of Covid-19
- A large number of Muslim organisations and institutions **depend on donations**, which have declined due to suspension of routine services and economic impact on communities, **pushing many organisations into financial hardship**

Longstanding intersecting inequalities and institutional discrimination

Members from the Muslim community are at the centre of **multiple and long standing intersecting and institutionalised inequalities, marginalisation and discrimination**, placing them at a higher risk of adverse health outcomes from Covid-19:

- **50% of Muslim households live in poverty** and Muslims are more likely to experience insecure employment, income and housing[2]. The Covid-19 crisis has **exacerbated economic vulnerability and occupational hazards**, as Muslims are over-represented in shut-down industries and in the informal sector with **inadequate health and safety protection at work**. This has pushed many Muslim families into **financial hardship and increased stress, anxiety and depression**.
- The **legacy of colonialism and slavery, alienation by politicians and the media** and **marginalisation by policies** especially around security, austerity and immigration[3] have contributed to **mistrust of authorities and public health advice** and the generation of **conspiracy theories,** alternative facts and **fake news**, undermining public health efforts.
- **Increased Islamophobia** (linking Muslims to the spread of Covid-19, anti-Muslim memes and fake news theories [4] threaten social cohesion, safety, security and wellbeing, on a background of a year-on-year increase in hate crimes experienced by Muslims.
- Muslim families are more likely to live in **overcrowded multi-generational households** facilitating transmission to high-risk vulnerable individuals, and the **delay in lockdown** enabled families and communities to continue holding large events and congregations, contributing **to widespread community transmission**.
- A large proportion of **refugees and migrant communities** in the UK are from Muslim backgrounds[5], experiencing difficulties with **accessing healthcare and lower health literacy**. These result in **delayed presentation** to health services and **increased the risk of complications** and death from Covid-19 and other acute medical conditions (collateral health damage).
- There are reports of Muslims experiencing **racial and religious discrimination by care professionals** on structural and interpersonal levels[6], **creating barriers in accessing healthcare**.
- Our research has highlighted that Muslim-majority ethnic communities in the UK are more likely to experience **underlying chronic diseases and nutritional deficiencies**, as well as lower uptake of **preventative health screening services** and **engagement with healthy lifestyle behaviours**, in part exacerbated by structural and social disadvantage; these are all known to increase the risk of serious illness and death from Covid-19.

Impact on Muslim healthcare workers

There is also concern about the **impact on healthcare workers, both physical and mental**. Despite making up 10-15% of the workforce**, over 50% of doctors who have died have been Muslim**. Several factors are thought to contribute to this:

- BAME healthcare workers are more likely to experience **bullying, harassment, disciplinary procedures** and more serious sanctions at work[7].
- A large King's Fund study in 2015 highlighted that **Muslims in the NHS are the most discriminated religious group**. [8]
- From our qualitative work 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 reflected in **under-representation** in senior roles.
- There is documentation of Muslim women facing a "**Triple Penalty" of discrimination** in multiple employment sectors. [9]
- There is emerging evidence of BAME doctors being **pressurised to work in frontline roles without adequate PPE** compared to their White colleagues as reported in a large ITV survey of 2000 healthcare workers, of which 39% were Muslim. [10]
- These factors translate into **difficulties raising concerns at work**, such as around unsafe working conditions and access to appropriate PPE, **increasing infection risk**. This is particularly relevant to

Muslims with specific **dress code requirements**, such as men with beards and women wearing the headscarf.

- Muslim health care professionals report feeling **stressed, anxious and burnt out** both because of their working conditions and risks to themselves, as well as onward transmission to their families, consistent with a large survey on BAME doctors conducted by the Royal College of Psychiatrists. [11]
- Muslim health care professionals have had to go a**bove and beyond their NHS work in a voluntary capacity to support, educate and inform their communities** on health risks from Covid-19, accentuated during Ramadan. Sometimes they have found themselves as **targets of abuse** from the community with wide ranging accusations **undermining their professionalism and integrity**.

References

1. Platt L, Warwick R. Are some ethnic groups more vulnerable to COVID-19 than others. Institute for Fiscal Studies, Nuffield Foundation. 2020 May.
2. Ali S. British Muslims in Numbers: A Demographic Socioeconomic and Health Profile of Muslims in Britain Drawing on the 2011 Census/cSundas Ali, Lead Analyst. MCB; 2015.
3. Elahi F, Khan O. Islamophobia: Still a challenge for us all. London: Runnymede Trust. 2017
4. Awan I, Khan-Williams R: Coronavirus, fear and how Islamophobia spreads on social media. Anti-Muslim Hatred Working Group Report. 2020 April
5. Walsh PW. Migration to the UK: asylum and resettled refugees. The Migration Observatory at the University of Oxford. 2019 November
6. Laird LD, Amer MM, Barnett ED, Barnes LL. Muslim patients and health disparities in the UK and the US. Archives of disease in childhood. 2007 Oct 1;92(10):922-6.
7. 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 [Accessed May 2020
8. West M, Dawson J, Kaur M. Making the difference: Diversity and inclusion in the NHS. The Kings Fund. 2015.
9. Miller M. Employment Opportunities for Muslims in the UK. Report of The Parliamentary Women's and Equalities Committee. London: House of Commons. 2016.
10. ITV News. 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
11. Royal College of Psychiatrists, Impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) staff in mental healthcare settings| assessment and management of risk. https://www.rcpsych.ac.uk/docs/default-source/about-us/covid-19/impact-of-covid19-on-bame-staff-in-mental-healthcare-settings_assessment-and-management-of-risk_13052020v2.pdf?sfvrsn=1068965_2. Accessed May 2020.