Written evidence submitted by the Muslim Council of Britain (MRS0410)

1. INTRODUCTION

i. The Muslim Council of Britain (MCB), founded in 1997, is an inclusive umbrella body of mosques, charities, schools and Islamic associations, representing a large cross-section of Muslims in Britain today. It is pledged to work for the common good of society as a whole.

ii. The MCB's affiliate base reflects the diversity of Muslims in the UK, being made up of a range of ethnic, geographic and theological backgrounds.

iii. Since March 2020, the MCB has been collaborating with a number of Muslim organisations to create a coordinated response to the pandemic, setting up Community Response Groups covering health, burials, mental health, economic support and charity support for Muslim communities. [1] In working with Muslim organisations and in communities, the MCB has been able to gain anecdotal evidence of the different ways in which British Muslims are being impacted by the pandemic.

2. EXECUTIVE SUMMARY

i. With no data being collected on COVID-19 mortality rates by faith, it is impossible to accurately know whether Muslims are dying at a disproportionate rate to people of other faith groups. Additionally, while we are still in the middle of the pandemic and measures introduced to tackle this have only been in operation for just over a month, there has not been sufficient time to collect clear evidence nor has there been data collected to show the myriad of ways this will be impacting different communities, be that faith communities or otherwise. In this submission, we seek to gather relevant information and analyses related to Muslim communities to feed into a broader understanding of impact.

ii. This submission draws upon the very limited data available and seeks to provide a commentary on the different ways in which Muslim communities are likely to be dying at a disproportionate rate. This will likely be due to a number of factors, with social and economic inequalities leading to poor outcomes in health, and therefore making those subject to inequality more susceptible to COVID-19. We are not in a position to determine causation, but this submission seeks to identify outcomes that appear correlated to the death rate that are relevant for Muslims, like ethnicity and inequality for example, and how Muslims are affected by these. It is important that these areas are explored in more depth to gain an understanding of why these factors play a part.

iii. All data on mortality rates and NHS employment is for England only, where the majority of Muslims reside. It has not been possible to collate and analyse data for Muslims in Wales, Scotland and Northern Ireland, though there will undoubtedly have been a huge impact on these Muslim communities too.

iv. This submission also seeks to highlight the impact of working on the frontline in the NHS on Muslim communities, with Muslims being overrepresented in the NHS workforce.

v. Muslim communities are likely to be affected by the COVID-19 and the associated legislation in a number of different ways and to different extents, but with limited data and whilst the impact is still being realised, it is not possible to understand the full extent of this, particularly in areas in which we know there will have been an impact, for example, health, education and civil liberties. Instead, this submission looks at the ways in which Muslims have been impacted in terms of employment and income, as there is data, albeit limited, which can provide some degree of understanding.

vi. In writing this submission, it is evident that the COVID-19 and the associated measures introduced by the UK Government will have unprecedented effects on all communities and all sections of society. It is imperative that data on COVID-19 mortality rates is collected on a more granular level to better understand whether there are particular characteristics that put individuals at higher risk in order to develop public policy to attempt to mitigate these risks and save lives.

vii. With a range of measures and policies having been brought in by the UK Government at short notice, there has been little opportunity to sufficiently scrutinise the impact these measures would have on different aspects of equality. It is therefore essential that further measures, and particularly long term measures, are subject to equality impact assessments, and research is carried out on a rolling basis to understand the different ways in which sections of society are affected by these measures to ensure that no part of society is being disproportionately disadvantaged.

3. BACKGROUND

i. The MCB, in its work with the British Islamic Medical Association, recognised the risk the COVID-19 could have and the impact of Muslim communities continuing religious practice as normal, and took proactive action.

ii. Muslim communities tend to have frequent community congregations for social events like weddings and funerals and for religious purposes like congregational prayers and educational activities. Congregational prayer is a prevalent practice in Muslim communities, with many Muslims attending the mosque regularly – some on a daily basis or multiple times a day – to pray. With individuals being asymptomatic for up to two weeks, it is likely that individuals who may be carrying the virus could be attending the mosque and therefore able to transmit the virus to fellow congregants without realising.

iii. Therefore, on 16 March 2020, the MCB took the unprecedented step of strongly recommending the temporary suspension of all congregational activities in Muslim communities. [2] This was following the UK's Chief Scientific Advisers calling for

extraordinary social distancing measures, and the British Islamic Medical Association advising it is "unsafe and harmful to continue business as usual, or even with significant adjustments". [3] Following this call by the MCB, regional Muslim associations and Councils of Mosques mobilised to support efforts to communicate to their communities the importance of needing to urgently suspend congregational activities, which came with a number of ramifications for mosques and communities, not least in terms of mental and emotional health and financial impact. The UK Government then called for the closure of all places of worship and imposed lockdown measures across the UK on 23 March 2020.

iv. In addition, many of the factors which contribute to the disproportionate impact of COVID-19 on BAME communities also apply to Muslims. This is because in a BAME population in England and Wales of about 8 million, 2.5 million are Muslim (2011 Census), i.e. 1 in 3 BAME has a Muslim faith affiliation. Thus, what affects BAME individuals, affects Muslims, with 90% of Muslims also being BAME. The shared factors can include, but are not limited to, health inequalities, inner city population and deprivation.

4. PROFILE OF MUSLIMS IN BRITAIN

i. According to the 2011 Census, there are 2,706,066 Muslims in England and Wales, accounting for 4.8% of the population. [4]

ii. 76% of the Muslim population live in four regions: London, West Midlands, the North West and Yorkshire and The Humber. Muslims make up 12.4% of London's population, [5] with the London Boroughs of Tower Hamlets and Newham having the highest percentages of Muslims by Local Authority District.

iii. One in three members of the Black, Asian and Minority Ethnic (BAME) community are Muslim, with 67.6% of Muslims being Asian/Asian British, 10.1% being Black/African/Caribbean/Black British, 7.8% being White, 6.6% being Arab, 3.8% being Mixed or Multiple Ethnic, and 4.1% belonging to other ethnic groups.

iv. The Muslim population, in common with the BAME population, is younger than the overall population which a much greater proportion aged 15 years or under (33% of the Muslim population compared to 19% of the overall population); and only 4% of Muslims being aged 65 or over compared to 16% of the overall population. [6]

v. For more information on these statistics and on the profile of Muslims in Britain, please refer to the Muslim Council of Britain's landmark report analysing the 2011 Census entitled "*British Muslims in Numbers"*.

5. ETHNICITY

i. With mortality rates only being collected by ethnicity and not faith, it is not possible to know the true impact of the COVID-19 on Muslims in the UK. However, with 90%

of all Muslims Muslims coming from ethnic minorities and clear evidence showing BAME communities are disproportionately impacted, Muslims are likely to be heavily impacted too as a result of the structural inequalities that place BAME groups at much higher risk of severe illness from COVID-19.

ii. Initial analysis by Trevor Phillips in The Times suggested that COVID-19 death rates from Bangladeshi and Pakistani Muslim communities was not significantly higher than the general population and made the implication that this could be because of ritual washing. [7] We would strongly caution against any such superficial analysis that disregards the differing age profile of these communities, which is a major driver of COVID-19 deaths.

For example, looking at the Bangladeshi ethnic group in the UK, the proportion of overall deaths (0.7%) is less than their proportion in the population (0.8%). However, adjusting for age, we see 300% more deaths than we would expect. Further detail can be seen in the table below.

Deaths in Hospital from COVID-19 by ethnicity

Data for England up until 21st April 2020 (published 23rd April 2020)

	Population	Population (%)	Observed Deaths	Observed Deaths (%)	Expected deaths if distributed by age structure of population	Excess Deaths = Observed Deaths - Expected Deaths	Excess Deaths (% of expected deaths)
White							
British	40,072,756	79.7%	11,354	77.1%	13,487	-2,133	-16%
Irish	507,284	1.0%	161	1.1%	238	-77	-32%
Any other White background	2,443,913	4.9%	544	3.7%	302	242	80%
Total White	*43,023,953*	*85.6%*	*12,059*	*82%*	*14,027*	*-1,968*	*-14%*
Asian							
Indian	1,338,395	2.7%	492	3.3%	188	304	162%
Pakistani	1,020,967	2.0%	332	2.3%	82	250	305%
Bangladeshi	392,762	0.8%	100	0.7%	25	75	300%
Chinese	370,642	0.7%	57	0.4%	36	21	58%
Any other Asian background	775,336	1.5%	245	1.7%	71	174	245%
Total Asian	*3,898,102*	*7.8%*	*1,226*	*8.3%*	*402*	*824*	*205%*
Black							
African	914,359	1.8%	290	2.0%	51	239	469%
Caribbean	554,424	1.1%	460	3.1%	124	336	271%
Any other Black background	253,635	0.5%	146	1.0%	17	129	759%
Total Black	*1,722,418*	*3.4%*	*896*	*6.1%*	*192*	*704*	*367%*
Mixed							
White and Asian	312,874	0.6%	22	0.1%	18	4	22%
White and Black Caribbean	372,676	0.7%	33	0.2%	24	9	38%
White and Black African	155,898	0.3%	12	0.1%	6	6	100%
Any other Mixed background	269,465	0.5%	48	0.3%	17	31	182%
Total Mixed	*1,110,913*	*2.2%*	*115*	*0.8%*	*65*	*50*	*77%*
Other							
Any other ethnic group	521,958	1.0%	439	3.0%	48	391	815%
Total Other	*521,958*	*1.0%*	*439*	*3.0%*	*48*	*391*	*815%*
Total	50,277,344	100%	14,735	100%	14,735		

Analysis by Miqdad Asaria (@miqedup)

Data are from the ONS (ethnicity) and NHS England (deaths)

Expected deaths are adjusted for age structure of ethnic groups and normalised to sum to total observed deaths

Table 1: Deaths in Hospital from COVID-19 by ethnicity [8]

iii. The table above shows an analysis of deaths in hospital from COVID-19 by ethnicity. When comparing the percentage of observed deaths by ethnic group with the percentage of the population these ethnic groups make up, BAME groups have higher mortality rates. 8.3% of deaths were of Asian individuals despite only accounting for 7.8% of the population, 6.1% of deaths were Black individuals despite only making up 3.4% of the population and 3.0% of deaths were of individuals of any other ethnic group, which include Arabs, despite only making up 1% of the population. In contrast, 82% of deaths were of White individuals who make up 85.6% of the population, and 0.8% of deaths were of Mixed-Race individuals despite making up 2.2% of the population.

iv. The analysis goes further and applies age specific mortality rates to each ethnic group to be able to compare the number of expected deaths with the number of observed deaths to understand the number of excess deaths. The total number of Asian excess deaths was 824, Black excess deaths was 704, other ethnic groups excess deaths was 391. There were 1,968 fewer deaths of White individuals than expected, but 50 excess Mixed-Race deaths.

v. As mortality rates are not published by faith, it is not possible to work out the number of excess deaths of Muslims specifically, but it is possible to apply 2011 Census data showing faith by ethnicity to Table 1 to estimate the number of Muslim observed deaths.

Deaths in Hospital from COVID-19 by ethnicity with Muslim estimates

Data for England up until 21st April 2020 (published 23rd April 2020)

	Population	Population (%)	Muslim Population	Muslim Population of Ethnicity (%)	Observed Deaths	Observed Deaths (%)	Estimated Muslim Observed Deaths
White							
British	40,072,756	79.7%	75,088	0.2%	11,354	77.1%	21
Irish	507,284	1.0%	1,872	0.4%	161	1.1%	1
Any other White background	2,443,913	4.9%	130,022	5.3%	544	3.7%	29
Total White	*43,023,953*	*85.6%*	*206,982*	*0.5%*	*12,059*	*82%*	*58*
Asian							
Indian	1,338,395	2.7%	195,952	14.6%	492	3.3%	72
Pakistani	1,020,967	2.0%	1,017,463	99.7%	332	2.3%	331
Bangladeshi	392,762	0.8%	392,636	100.0%	100	0.7%	100
Chinese	370,642	0.7%	7,802	2.1%	57	0.4%	1
Any other Asian background	775,336	1.5%	191,522	24.7%	245	1.7%	61
Total Asian	*3,898,102*	*7.8%*	*1,805,375*	*46.3%*	*1,226*	*8.3%*	*568*
Black							
African	914,359	1.8%	203,774	22.3%	290	2.0%	65
Caribbean	554,424	1.1%	7,294	1.3%	460	3.1%	6
Any other Black background	253,635	0.5%	56,226	22.2%	146	1.0%	32
Total Black	*1,722,418*	*3.4%*	*267,294*	*15.5%*	*896*	*6.1%*	*139*
Mixed							
White and Asian	312,874	0.6%	48,636	15.5%	22	0.1%	3
White and Black Caribbean	372,676	0.7%	5,279	1.4%	33	0.2%	0
White and Black African	155,898	0.3%	15,279	9.8%	12	0.1%	1
Any other Mixed background	269,465	0.5%	31,189	11.6%	48	0.3%	6
Total Mixed	*1,110,913*	*2.2%*	*100,383*	*9.0%*	*115*	*0.8%*	*10*
Other							
Any other ethnic group	521,958	1.0%	280,082	53.7%	439	3.0%	236
Total Other	*521,958*	*1.0%*	*280,082*	*53.7%*	*439*	*3.0%*	*236*
Total	**50,277,344**	**100%**	**2,660,116**		**14,735**	**100%**	**965**

Analysis by Miqdad Asaria (@miqedup) and the Muslim Council of Britain

Data are from the ONS (ethnicity and ethnic group by religion) and NHS England (deaths)

Table 2: Deaths in Hospital from COVID-19 by ethnicity with Muslim estimates

vi. The table above shows the estimated number of Muslim observed deaths based on the percentage of Muslims in each ethnic group and the number of observed deaths by ethnic group. This theoretically shows how many Muslims are likely to have died of COVID-19, but does not take into account any external factors and does not account for age specific mortality rates, so is not able to show whether deaths of Muslims are in excess of what is to be expected or not.

vii. Looking at the ethnic groups which had high numbers of excess death: Black, Other and Asian, we can see there has likely been a disproportionate impact on Muslims, who make up large proportions of these groups. The Other ethnic category, which includes Arabs, has had the highest number of excess deaths (815%), with over half of all those identifying as Other being Muslim. The Black group, which has the second highest rate of excess deaths, has experienced the highest mortality rates in the Black African and Any other Black background categories, with Muslims making up almost 45% of individuals in these categories. Almost half of all Asians are Muslim, with the group having experienced excess deaths of 200%. Within this group, the two ethnic categories with the worst rates of excess deaths were Pakistanis and Bangladeshis, almost all of whom are Muslim.

viii. Ethnic minorities are on average younger than the population as a whole, with this being particularly acute for Muslims. In 2011, 33% of the Muslim population was aged 15 years or under, compared to 19% of the population as a whole, and only 4% of the Muslim population was aged over 65, compared to 16% of the overall population.

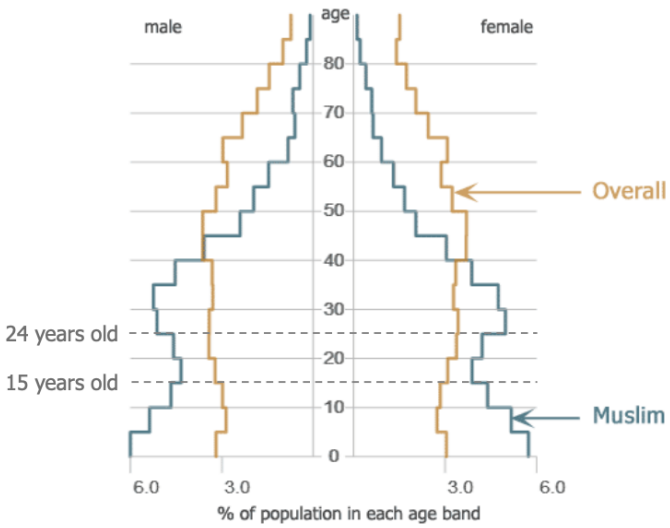

Figure 1: Age distribution of Muslims compared to the UK population [9]

ix. Applying the age standardised mortality rate to Local Authority Districts shows the worst hit areas are those with large populations. Newham had the highest age standardised mortality rate at 144.3 per 100,000 population, a BAME population of 71% and a Muslim population of 32%. The London boroughs of Brent (64% BAME, 18.6% Muslim), Hackney (45% BAME, 14.1% Muslim) and Tower Hamlets (55% BAME, 34.5% Muslim) follow Newham with the worst mortality rates at 141.5, 127.4 and 122.9 respectively. [10]

x. With older people at highest risk from COVID-19, younger people, and by extension Muslims and ethnic minorities, should be less vulnerable to dying of COVID-19.

Evidence shows this is not the case, and indicates external factors and a range of inequalities play a part in putting people at risk of COVID-19.

xi. Looking specifically at the impact of COVID-19 on Pakistanis and Bangladeshis, of which 99.7% and 100% are Muslim respectively, Pakistanis had 2.5 times more deaths than expected, and Bangladeshis had three times as many deaths.

xii. Further analysis conducted by the Institute for Fiscal Studies shows at-risk underlying health conditions are especially prevalent among older Bangladeshis and Pakistanis, with Bangladeshis being 60% more likely to have a long-term health condition that makes them particularly vulnerable to infection when compared with White British individuals over the age of 60. This may explain excess fatalities in this group. [11]

6. GEOGRAPHY AND SOCIO-ECONOMICS

i. Muslims in Britain are concentrated in urban areas and particularly in London and the West Midlands, the two worst hit regions. London is home to 37.4% of all Muslims, comprising of 12.4% of London's population.[12] London had the highest age standardised mortality rate with 85.7 deaths per 100,000 persons involving COVID-19, 42% of the total deaths in England and Wales, and significantly higher than any other region and almost double the next highest rate.

ii. As discussed in more detailed above, the Local Authority Districts with the highest age standardised mortality rates for COVID-19 deaths between 1 March and 17 April 2020 were all London boroughs with high Muslim populations. Newham, in which Muslims make up 32% of the population, had the highest rate with 144.3 deaths per 100,000 population, followed by Brent with 141.5 deaths per 100,000 population, where 18.6% of the population are Muslim. [13]

iii. The West Midlands is the next most populous Muslim region and the next worst affected region. The West Midlands is home to 13.9% of all British Muslims, comprising of 6.7% of the local population. [14] It has also seen an age standardised mortality rate of 43.2 deaths per 100,000 persons involving COVID-19, 13.7% of the total deaths in England and Wales.[15]

iv. The rate of infection in these areas disproportionately impacts Muslim communities, with 51.3% of Muslims residing in these areas. [16]

v. Data shows COVID-19 has had a proportionally higher impact on the most deprived areas, with 55.1 deaths per 100,000 population, 118% higher than the least deprived areas. [17] General mortality rates are normally higher in more deprived areas, but COVID-19 appears to be taking these rates even higher.

vi. 46% of all British Muslims living in the 10 most deprived Local Authority Districts in England, and evidence also shows both individual and neighbourhood deprivation increase the risk of poor general and mental health. It was found that living in a

deprived neighbourhood might have the most negative effects on poorer individuals. [18] It is therefore evident that the impact of deprivation of COVID-19 mortality rates will disproportionately affect Muslims.

vii. Early advice by the UK Government was for those over the age of 70 to self-isolate to reduce the risk of infection. This is particularly difficult for older BAME individuals due to the prevalence of intergenerational households. Data shows 70% of White households aged 70 and over do not have younger people living with them, compared to just 20% of South Asian and 50% of Black African or Caribbean households. [19] This puts elderly BAME individuals at a higher risk of contracting COVID-19 due to the difficulty to sufficiently self-isolate and the potential for younger generations to bring the infection into their homes.

viii. Even for Muslim households which are not intergenerational, the housing conditions in which Muslims live in mean they are more susceptible to infection. Based on 2011 census data, 35% of Muslim households are overcrowded, lack at least one bedroom, and do not have central heating or have to share a kitchen or bathroom, compared to 13% of the total population. No other faith group has been found to have similar levels of deprivation. [20]

ix. Those with the highest proportion experiencing housing disadvantage are Black African (43%) and Bangladeshi (42%). Muslims within these ethnic groups also have higher levels of housing disadvantage (48% and 55%). Looking at excessive deaths in these two ethnic categories, Black Africans have experienced 467% and 300% excess deaths respectively.

x. With all public health advice requiring infected individuals to self-isolate and not share spaces like kitchens and bathrooms with others, the conditions in which many Muslims live in make this impossible. Overcrowding and the use of shared kitchens or bathrooms make it almost impossible for the virus to not be spread to other members of the household.

7. EMPLOYMENT

i. Whilst it is important to recognise the ways in which different factors impact Muslim communities and expose Muslim communities to greater risk of developing COVID-19, it is also important to look at the way in which the measures introduced in light of the pandemic impact Muslims. This is no more acute than in terms of employment.

ii. In London alone, there are over 13,400 Muslim-owned businesses, with an estimated 33.6% of all Small to Medium Enterprises in London being Muslim owned. [21] The pandemic has meant a number of businesses and venues that are deemed 'non-essential' have had to close to the public. Whilst it is not possible to know how many businesses that have had to close are owned by Muslims, with such a significant proportion of Muslims owning businesses, it is likely that many of these will be subject to a loss of earnings as a result.

iii. With incomes being likely to be especially uncertain for the self-employed, this disproportionately impacts Pakistanis and Bangladeshis, almost all of whom are Muslim, with Pakistani men being 70% more likely to be self-employed than the White British majority.

iv. A tightening of social distancing measures has resulted in the closure of 'non-essential' businesses to the public, with certain industries like restaurants still able to operate but in a different capacity. Research has shown that Bangladeshi men (of whom 100% are Muslim) are four times as likely as White British men to have jobs in shut-down industries, due in large part to their concentration in the restaurant sector. Pakistani men (of whom 99.7% are Muslim) are nearly three times as likely, partly due to their concentration in taxi driving. Black African men (of whom 22.3% are Muslim) are 50% more likely than White British men to be in shut-down sectors. Furthermore, 40% of 30 to 44 year old Bangladeshis are likely to work in shut-down sectors, compared to 14% of the White British population of the same age, meaning this does not just have a disproportionate impact on the individual, but on the family income which has wider implications. [22]

v. Occupational exposure may also help to explain the disproportionate deaths in Muslim communities. There are no conclusive figures which show how many Muslims work across the health and social care sector, the sector most at risk of infection.

vi. Data on ethnicity of NHS staff is available and shows BAME communities are hugely overrepresented in this sector comprising of 44% of all doctors and 20% of all nurses. Despite this, as of 22 April 2020 95% (18 out of 19) doctors and 71% (25 out of 35) of the nurses who died of COVID-19 were from BAME communities. [23]

vii. Without data on COVID-19 deaths by faith and faith data of employees across the health and social care sector, it is not possible to know the true impact working on the frontline has on Muslims. In England, approximately 10% of NHS doctors, excluding GPs, are Muslim, indicating Muslims are overrepresented working on the frontline in the NHS. [24]

viii. The first doctors to die of COVID-19 in the NHS were all Muslim, with Dr Adil El Tayar, an organ transplant consultant dying on 25 March, Dr Habib Zaidi, a GP, passing away on 27 March, Amged El-Hawrani, an ear, nose and throat consultant dying on 28 March and Dr Alfa Sa'adu, a geriatric physician, passing away on 31 March. [25]

ix. Analysis of healthcare staff deaths has found that these have occurred in roles that are not considered high risk of viral exposure and transmission, which could be because these roles are more rigorous with the use of personal protective equipment because of their high risk nature, [26] which indicates that there have been external factors contributing to the high death rates of BAME healthcare staff.

x. It is possible that one such external factor is the role of the issue of discrimination and bullying of BAME and Muslim healthcare staff, and an inability to speak out on key issues because of this. The proportion of BAME staff in the NHS who experienced discrimination at work from a manager, team leader or other colleague was twice as high as White staff, and 29% of ethnic minority staff have also experienced bullying, harassment or abuse from other members of staff. [27] It was also reported in 2015 that Muslims faced the highest levels of discrimination (22.2% compared to 10% of those with no religion), with 8% of Muslims reporting discrimination on the basis of religion. [28]

xi. With the well-documented lack of adequate personal protective equipment provided for staff across the healthcare sector, it is possible that Muslim and BAME members of staff have had high mortality rates due to the lack of personal protective equipment provided to them in their roles, and the inability to speak out about this due to high levels of bullying and discrimination faced, particularly by managers and team leaders. One hospital Trust is now taking the extraordinary step of treating all BAME staff as 'vulnerable and at risk' and prioritising them for fitting of masks in order to make staff more comfortable about disclosing underlying conditions. [29] While it is important that all Trusts work to protect staff, they have a duty to protect all staff, so it is important that all staff with underlying conditions – regardless of their ethnicity – should be prioritised. If Trusts believe BAME staff are fearful and therefore not disclosing underlying conditions, more must be done to tackle the stigma and associated discrimination so that staff feel empowered to be transparent.

xii. With Muslims being overrepresented in the healthcare sector, it is likely that by working in these roles and the other factors associated with working in these roles, that Muslims are at a greater risk of developing COVID-19. Though while it there remains no clear data on exactly how many Muslims work across the health and social care sector and how many Muslims are dying of the virus, it is not possible to understand the true impact.

8. FINANCIAL IMPACT ON MUSLIM INSTITUTIONS

i. The lockdown measures have had huge financial implications for Muslim institutions, particularly mosques and charities, which then have knock on effects for both the individuals these institutions employ, and the communities they seek to serve.

ii. Mosques are largely funded on donations, with many mosques being registered as charities, depending on daily and weekly footfall, especially on Friday, for donations from congregants. This is particularly true of the month of Ramadan, which begun on 24 April 2020, in which mosques usually have sizable congregations every evening and are able to collect significant donations to fund the running of the institution. With mosques having been closed for a number of weeks and mosques having relatively undiversified income compared to places of worship of other faiths which may have investments they can derive rental income from, they have found

themselves in a difficult financial situation, with many concerned the potential long term sustainability of mosques is at risk. In addition, most mosques are run on a purely voluntary basis, with no formal employees. They are therefore not able to take advantage of UK Government initiatives like the Job Retention Scheme which would lessen the burden.

Initiatives have been set up to help mosques fundraise online, like the #SupportOurMosque initiative by LaunchGood and the Muslim Council of Britain, but mosques are likely to be severely cash-starved for the foreseeable future. Many British Muslims use their mosques not just for prayers, but for pastoral care and social activities too, which will no longer be available if mosques are unable to reopen.

iii. Muslim charities rely heavily on the month of Ramadan for fundraising, with Muslims giving an estimated £100 million to charities in the month along, [30] many organisations depend on the funds raised during this month for their full year's income. This drop in income is expected to fall by 50% this Ramadan, [31] which not only has implications for the projects of the charities, but the people these projects help and the staff employed by the charities. Many will be under increasing pressure to reduce their overall costs, with salaries being the largest cost. Although the UK Government has announced to support 80% of the salaries of furloughed staff, this will have little effect on charities as furloughed staff will not be able to generate income, jeopardising the ability of the charity to continue employing staff after lockdown measures have eased, when the funds are no longer there to support them.

9. END OF LIFE CARE AND FUNERALS

i. The high numbers of Muslims infected with COVID-19 who are in hospital by themselves and are not able to be visited by family makes the role of hospital chaplains all the more crucial. Chaplains are in many cases barred from bedsides to avoid infection being spread, but providing end of life pastoral care is important and must be enhanced as we move through this pandemic. Faith chaplains have been supporting NHS medics who have been giving the emotional and spiritual care, but the provision for faith representatives to provide support for those in hospital should be enhanced to allow for this in a safe way.

ii. The spike in deaths in Muslim communities has led to Muslim funeral directors reporting a huge surge in their work and the demand for burial spaces, with one cemetery reporting going from an average of five burials per week to 50 burials per week.

iii. This sector has faced significant upheaval in light of the pandemic for a number of reasons, including confusion around the need for personal protective equipment when carrying out funeral rites and burials, onboarding new staff to help with the rise in the number of funerals and the restrictions on the number of attendees at funerals. Funeral services are often conducted by volunteers, who may be older and therefore at high

risk, so many funeral directors have had to recruit and train younger members of the community to conduct funerals. [32]

iv. Usually when a Muslim dies the funeral is attended by many within the community to pray the communal funeral prayers which usually take place at the mosque ahead of the burial. Social distancing measures have meant severe restrictions have been put in place with funerals no longer taking place at the mosque, instead only a burial taking place with a few members of immediate family to perform the burial rites and pray the funeral prayers. This has been difficult for cemeteries and funeral directors to police at such difficult times because this restriction clashes so heavily with religious and cultural norms.

v. The surge in the number of Muslims dying, often with family members in self-isolation so not able to take part, the lack of a proper Islamic funeral and the absence of religious gatherings after someone has passed away will have a huge emotional impact on Muslims who have lost loved ones who will already be dealing with grief, particularly in such difficult circumstances with reduced access to a support network.

May 2020

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[1] Coronavirus (COVID-19) Guidance for Muslim Communities, *Muslim Council of Britain,* 2020
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[3] An open letter to the Muslim community, *British Islamic Medical Association,* 16 March 2020
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