

Written submission from the Muslim Council of Britain (CVB0006)

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.
- iv. With evidence showing ethnic minorities are disproportionately impacted by COVID-19 than those of White ethnicity, and Muslim and Jewish communities more than other faith communities, it is imperative that extensive research is conducted to understand the causes of this.
- v. Public Health England launched and has now concluded an inquiry into this, which the MCB submitted evidence to. This inquiry, whilst taking evidence from over 4,000 community stakeholders, initially only published the section of the report which omitted this and instead reiterated that racial and health inequalities intensified the risks of COVID-19. Though the second half of the report which detailed evidence from stakeholders was eventually published, this still neglected to explicitly discuss the need to explore the role of structural racism in the unnecessary loss of life.
- vi. Furthermore, there is considerable feeling, particularly amongst ethnic minority communities, that the UK Government has failed to take sufficient action over the disproportionate toll of COVID-19 on such communities. As a result, The Ubele Initiative has launched legal action against the UK Government, demanding an explanation of what steps the Government has taken to assess the impact on ethnic minority communities of lockdown-easing measures and an immediate independent inquiry to find out why ethnic groups face an increased COVID-19 risk. ²
- vii. As such, it is welcome that the Women and Equalities Select Committee is leading its own inquiry to look more widely at the impact of COVID-19 on BAME communities, not just in terms of mortality rates. In submitting evidence to this review, the MCB hopes a deeper discussion on institutional racism and its impact on society is started, and more impactful recommendations are produced.

- viii. In this submission, we seek to gather relevant information and analyses related to Muslim communities to feed into a broader understanding of impact, drawing upon the limited data available to provide a number of examples of factors which may be contributing to the disproportionate rate of deaths in ethnic communities. 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 high levels of 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.
- ix. This submission seeks to highlight different factors which may help to explain why Muslim communities are disproportionately impacted by COVID-19. 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.
- x. In writing this submission, it is also evident that the COVID-19 pandemic and the associated measures introduced by the UK Government will have unprecedented effects on all communities and all sections of society which may contribute further to structural inequality, and therefore have a negative impact on health outcomes. Further research into this is vital in order to prevent further excess deaths.

2. EXECUTIVE SUMMARY

- i. With data on COVID-19 mortality rates by faith only having been published by the ONS for the first time on 19 June, it has thus far not been possible to accurately know whether Muslims are dying at a disproportionate rate to people of other faith groups. This new data confirms that the highest age-standardised mortality rates of deaths involving COVID-19 were in the Muslim religious group, with 198.9 deaths per 100,000 males, and 98.2 deaths per 100,000 females.³
- ii. As we are still in the middle of the pandemic and measures introduced to tackle this have only been in operation for a few months, 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.
- iii. We believe it is important disaggregated data on COVID-19 mortality rates continues to be collected to better understand whether there are particular factors that put individuals at higher risk, and the extent to which these have an impact, in order to

develop public policy to attempt to mitigate these risks and save lives. Furthermore, consideration should be given to recording ethnicity and faith on death certificates in order to help to learn more about health differences between different groups.

- iv. With high levels of deaths of BAME healthcare workers, and extensive research showing evidence and feelings of structural racism and discrimination in the NHS, PHE should consider exploring this in more detail, and looking into specific measures to put in place to tackle the culture of discrimination and racism. It may also be of value to issue a clear statement from the NHS that this is not acceptable, committing to introducing change.
- v. It is clear that the different measures imposed by the UK Government will impact communities in different ways. It is possible that measures which exacerbate deprivation and poverty in particular communities, especially those who are already disadvantaged, may put them at higher risk of contracting the virus. Our view is that equality impact assessments can be hugely valuable for the UK Government to understand how these measures affect different communities, and that further research will help to understand the impact this has on mortality rates.
- vi. 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, criminal justice, 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.

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. ⁴ 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". ⁵ 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.

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. ⁶
- 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, ⁷ 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 43.6% of Muslims being Asian/Asian British, 14.5% being Black/African/Caribbean/Black British, 0.5% being White, 77.1% being Arab, and 8.4% being Mixed or Multi-Ethnic.
- 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. ⁸
- 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. MORTALITY RATES IN MUSLIM COMMUNITIES

- i. Until 19 June, COVID mortality rates were only collected by ethnicity and not faith, so it was not possible to ascertain whether or not Muslim communities specifically – regardless of ethnicity – were dying at disproportionate rates. The Muslim Council of Britain, among others, had been lobbying the UK Government and Public Health England to publish this data by faith and further disaggregated data to be able to better

understand the impact on different communities to tailor public health approaches in order to prevent the unnecessary loss of life.

- ii. This data now shows in England and Wales between 2 March and 15 May 2020, 297 Muslim males aged 9 to 64 years, 584 Muslim males aged 65 and over, 125 Muslim females aged 9 to 64 years and 301 Muslim females aged 65 and over died of COVID-19.

Religious group	Males		Females	
	Aged 9 to 64 years	Aged 65 years and over	Aged 9 to 64 years	Aged 65 years and over
No religion	484	2,068	218	825
Christian	1,261	13,958	863	12,806
Buddhist	15	48	6	29
Hindu	90	271	43	190
Jewish	16	252	7	178
Muslim	297	584	125	301
Sikh	42	119	20	77
Other religion	11	44	13	30
Not stated or required	152	1,344	82	1,087
Total	2,368	18,688	1,377	15,523

Table 1: Death occurrences involving COVID-19 by age, sex and religious group, England and Wales, 2 March to 15 May 2020⁹

- iii. The highest age-standardised mortality rates of deaths involving COVID-19 were of those identifying as Muslim, with 198.9 deaths per 100,000 males and 98.2 deaths per 100,000 females. Males identifying as Muslim had the highest rates of death involving COVID-19, which was statistically significantly higher than that of all groups. Jewish males had the second highest rate of deaths at 187.9 deaths per 100,000 males. For females, it was higher than all other groups, followed by Jewish females who had the second highest rate at 94.3 deaths per 100,000 females. Muslim males had a rate of death involving COVID-19 that was 2.5 times higher than males identifying with no religion, while for females it was 2.1 times higher.

Age-standardised mortality rates involving COVID-19		
Religious group	Males	Females
No religion	80.7	47.9
Christian	92.6	54.6
Buddhist	113.5	57.4
Hindu	154.8	93.3
Jewish	187.9	94.3
Muslim	198.9	98.2
Sikh	128.6	69.4
Other religion or not stated	84.2	49.2

Table 2: Age-standardised mortality rates involving COVID-19 for those aged nine years and over by sex and religious group, England and Wales, 2 March to 15 May 2020 ¹⁰

- iv. Whilst it is useful to have the data to hand to prove that Muslims are dying of COVID-19 at exceptional rates, much more data and research is needed to understand the factors that contribute to this. It is evident that there are a number of factors at play, from socio-demographics, health inequalities and occupational exposure. This report discusses some of these inequalities, but this needs to be explored further and the root causes of these inequalities understood in order to develop effective public policy to tackle this.
- v. As religion is not recorded on the death certificate, this information was retrieved through record linkage of death registrations to the 2011 Census.
- vi. **Recommendation: As standard practice, disaggregated data should be collected, including data on faith, to facilitate a more detailed understanding of the impact of the pandemic on different groups. The UK Government may also consider recording religion on the death certificate going forwards.**

6. MORTALITY RATES IN BAME COMMUNITIES

- i. From the start of the pandemic, mortality rates have been routinely collected and published by ethnicity, with faith data published for the first time on 16 June. Thus far, it has not been possible to know the true impact of COVID-19 on Muslims in the UK. However, with 90% of all Muslims coming from ethnic minorities and clear evidence showing BAME communities are disproportionately impacted, it was assumed that Muslim communities would also be heavily impacted by virtue of the majority of Muslims also being from ethnic minorities. With the data now confirming that Muslims have the highest COVID-19 mortality rates among all religious groups,

it is evident that this is as a result of the structural inequalities that also 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. ¹¹ 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.
- iii. Data published by the ONS on 19 June 2020 with the number and percentage of deaths involving COVID-19 by ethnic group in England and Wales reiterates that BAME communities are disproportionately dying of COVID-19.

Ethnic group		COVID-19 deaths	Percentage of COVID-19 deaths
White		33,630	88.6
	English/Welsh/Scottish/Northern Irish/British	32,160	84.7
	Irish	666	1.8
	Gypsy or Irish Traveller	16	0.0
	Other White	788	2.1
Mixed/Multiple ethnic groups		252	0.7
	White and Black Caribbean	86	0.2
	White and Black African	31	0.1
	White and Asian	53	0.1
	Other Mixed	82	0.2
Asian /Asian British		2,355	6.2
	Indian	1,011	2.7
	Pakistani	551	1.5
	Bangladeshi	222	0.6
	Chinese	137	0.4
	Other Asian	434	1.1
Black/African/Caribbean/Black British		1,513	4.0
	African	481	1.3
	Caribbean	911	2.4
	Other Black	121	0.3
Other ethnic group		206	0.5
	Arab	63	0.2
	Other Ethnic Group	143	0.4
Total		37,956	100.0

Table 3: Number and percentage of deaths involving COVID-19 by ethnic group, England and Wales, deaths occurring between 2 March and 15 May 2020 ¹²

- iv. After adjusting for age, Black individuals had the highest mortality rates at 255.7 deaths per 100,000 males and 119.8 deaths per 100,000 females. This is in comparison to White individuals who had the lowest mortality rates at 87.0 deaths per 100,000 males and 52 per 100,000 females. After adjusting for region, population density, socio-demographic and household characteristics, the raised risk of death involving COVID-19 for Black ethnic backgrounds was 2 times greater for males and 1.4 times greater for females compared with those of White ethnic background.
- v. Males of Bangladeshi, Pakistani and Indian ethnic backgrounds also had a significantly higher risk of death involving COVID-19 (1.5 and 1.6 times respectively) than White males once region, population density, socio-demographic

and household characteristics were accounted for, whilst for all groups of Asian females, the risk of death was equivalent to White females.

- vi. Age-standardised mortality rates also showed Black males aged between 9 and 64 had statistically significant mortality rates at 255.7 deaths per 100,000. Males in the Bangladeshi or Pakistani, Indian and Other ethnic groups had rates 2.2 times, 1.8 times and 1.9 times higher than males of the White ethnic group respectively. White males had a statistically lower rate of death involving COVID-19 than all other ethnic groups.
- vii. The pattern for females was largely like that of males, though females in general had a lower rate of death involving COVID-19 than males across all ethnic groups. Black females had the highest rate of death involving COVID-19 at 119.8 deaths per 100,000, 2.3 times higher than White females and statistically significantly higher rate than White males, despite males generally being at greater risk.¹³
- 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.

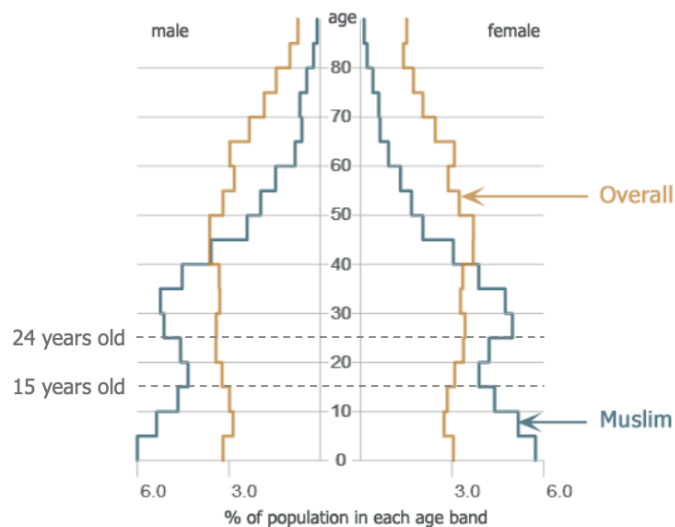


Figure 1: Age distribution of Muslims compared to the UK population¹⁴

- ix. Whilst COVID-19 largely affects older people, when mortality rates are isolated to younger males (aged 9 to 64), the relative differences are larger. Black males under the age of 64 had a statistically significantly higher age-standardised mortality rate than all others at 47.3 deaths per 100,000, 4.7 times greater than those of White males. Additionally, males of Bangladeshi or Pakistani ethnic background had 4.3 times significantly higher rate of death than White males.¹⁵

- x. The Muslim Council of Britain has mapped the latest COVID-19 mortality figures by ethnicity in England and Wales against population figures and Muslim population figures to show the rates at which different ethnic groups are dying of COVID-19 and to understand the makeup of these ethnic groups in terms of religion.

Deaths from COVID-19 by ethnicity compared with Muslim population

Data for England and Wales 2 March and 15 May 2020 (published 16 June 2020)

	Population	Population (%)	Muslim Population	Muslim Population of Ethnicity (%)	Observed Deaths	Observed Deaths (%)
White						
British	45,134,686	79.7%	77,272	0.2%	32,160	84.7%
Irish	531,087	1.0%	1,914	0.4%	666	1.8%
Any other White background	2,543,622	4.9%	131,434	5.2%	804	2.1%
<i>Total White</i>	<i>48,209,395</i>	<i>85.6%</i>	<i>210,620</i>	<i>0.4%</i>	<i>33,630</i>	<i>88.6%</i>
Asian						
Indian	1,412,958	2.7%	197,161	14.0%	1,011	2.7%
Pakistani	1,124,511	2.0%	1,028,459	91.5%	551	1.5%
Bangladeshi	447,201	0.8%	402,428	90.0%	222	0.6%
Chinese	393,141	0.7%	8,027	2.0%	137	0.4%
Any other Asian background	835,720	1.5%	194,485	23.3%	434	1.1%
<i>Total Asian</i>	<i>4,213,531</i>	<i>7.8%</i>	<i>1,830,560</i>	<i>43.4%</i>	<i>2,355</i>	<i>6.2%</i>
Black						
African	989,628	1.8%	207,201	20.9%	481	1.3%
Caribbean	594,825	1.1%	7,345	1.2%	911	2.4%
Any other Black background	280,437	0.5%	57,469	20.5%	121	0.3%
<i>Total Black</i>	<i>1,864,890</i>	<i>3.4%</i>	<i>272,015</i>	<i>14.6%</i>	<i>1,513</i>	<i>4.0%</i>
Mixed						
White and Asian	341,727	0.6%	49,689	14.5%	53	0.1%
White and Black Caribbean	426,715	0.7%	5,384	1.3%	86	0.2%
White and Black African	165,974	0.3%	15,681	9.4%	31	0.1%
Any other Mixed background	289,984	0.5%	31,828	11.0%	82	0.2%
<i>Total Mixed</i>	<i>1,224,400</i>	<i>2.2%</i>	<i>102,582</i>	<i>8.4%</i>	<i>252</i>	<i>0.7%</i>
Other						
Any other ethnic group	563,969	1.0%	290,289	51.5%	206	0.5%
<i>Total Other</i>	<i>563,969</i>	<i>1.0%</i>	<i>290,289</i>	<i>51.5%</i>	<i>206</i>	<i>0.5%</i>
Total	56,076,185	100%	2,706,066		37,956	100%

Analysis by the Muslim Council of Britain

Data are from the ONS (ethnicity and ethnic group by religion) and (COVID-19 related deaths by ethnic group)

*Table 3: Number and percentage of deaths involving COVID-19 by ethnic group, England and Wales, deaths occurring between 2 March and 15 May 2020*¹⁶

- xi. 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.
- 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.¹⁷

7. 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.¹⁸ London had the highest age standardised mortality rate with 137.6 deaths per 100,000 persons involving COVID-19, statistically higher than any other region in England and more than a third higher than the region with the next highest rate.¹⁹
- ii. Applying the age standardised mortality rate to Local Authority Districts shows the worst hit areas are those with large populations, with 26 out of the 22 London boroughs having a higher age-standardised mortality rate than the England and Wales average. Brent is the area in England and Wales with the highest overall age-standardised mortality rate with 210.9 deaths per 100,000, followed by Newham with a rate of 196.8 deaths per 100,000, and Hackney with a rate of 182.9 deaths per 100,000 population.²⁰ Brent has a population which is 64% BAME and 18.6% Muslim, Newham has 71% of its population BAME and 32% Muslim and Hackney has a BAME population of 45% and Muslim population of 14.1%.²¹
- iii. The West Midlands is the next most populous Muslim region and the third worst affected region. The West Midlands is home to 13.9% of all British Muslims, comprising of 6.7% of the local population.²² It has also seen an age-standardised mortality rate of 92.6 deaths per 100,000 persons involving COVID-19.²³
- iv. The rate of infection in these areas disproportionately impacts Muslim communities, with 51.3% of Muslims residing in these areas.²⁴
- v. Data shows COVID-19 has had a proportionally higher impact on the most deprived areas, with 128.3 deaths per 100,000 population, 118% higher than the least deprived areas.²⁵ 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.²⁶ 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. There are 150,200 households that contain residents of school age (0-15), working age (16-64) and old age (65+), with the Bangladeshi ethnic group having the highest proportion of three generation households.

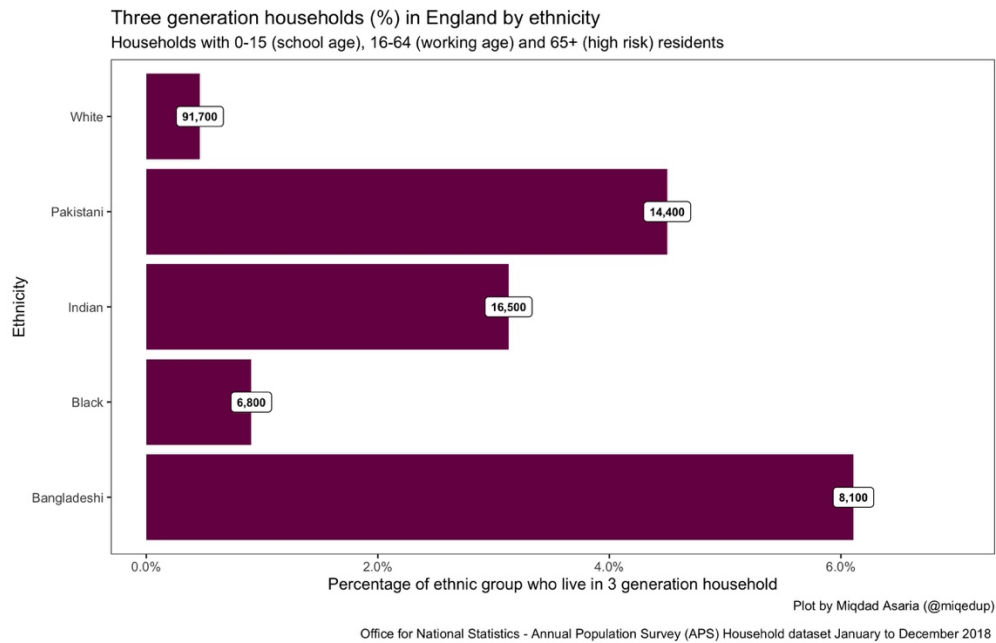


Figure 2: Three generation households in England by ethnicity ²⁷

- viii. Additional 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. ²⁸ As schools, workplaces and leisure facilities begin to open in England, 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.
- ix. 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. ²⁹
- x. 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.
- xi. 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.

- xii. The racial wealth gap in the UK will only be exacerbated by the pandemic, with falling household wealth impacting on poverty levels. The percentage of households having trouble paying their bills since the outbreak of the pandemic has increased faster among BAME households than White households, with 16% saying they are now behind on their bills, compared to 7% of White households. They are also more likely to have borrowed money or applied for Universal Credit, with 13% of BAME households having applied for welfare support and 16% having taken on debt, approximately double that of White households.
- xiii. Children of ethnic minority households are also much more likely to be living in poverty than their White counterparts, with one in four children from Asian families and one in five from Black families in persistent poverty. This is in contrast with one in 10 of White families. This has long-term implications on development and contributes further to health inequalities.³⁰
- xiv. **Recommendation: With a number of external factors likely to contribute to the high mortality rates by COVID-19 in BAME communities, we believe it is important that factors like socio-economics, poverty and deprivation are explored in more detail to understand what impact these may have, and the development of public policy to seek to reduce this will be valuable. In looking at the ways in which such factors affect health, we believe it is also important to understand why such inequalities exist in the first place, the impact of racism and structural discrimination on different facets of people's lives, and how this has contributed to the disproportionate rate of deaths in BAME communities.**

8. 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. Occupational exposure may also help to explain the disproportionate deaths in Muslim communities, with an over-representation of Muslims frontline roles, both in healthcare and other sectors.
- iii. There are no conclusive figures which show how many Muslims work across the health and social care sector, though 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.
- iv. Although analysis by the ONS does not show healthcare workers having higher rates of death involving COVID-19 when compared with the rate amongst the general public, there is overwhelming evidence to show BAME healthcare workers are dying at significantly higher rates than their White colleagues.

- v. 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.³¹
- vi. 63% of the total COVID-19 deaths among NHS staff have been of BAME individuals: 71% of nurses and midwives, 56% of healthcare support workers, 94% of doctors and dentists and 29% of other staff who have died.³² 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.³³
- vii. In April, NHS England advised all health trusts that BAME staff were at “greater risk” from COVID-19 and advised risk assessments of BAME staff to take place and appropriate arrangements made accordingly to prevent the further unnecessary loss of life amongst NHS staff from ethnic minorities.³⁴ Sky News investigated this further and found two months after this advice, only 34 out of the 149 NHS trusts that responded to the Freedom of Information request confirmed risk assessments of BAME staff had been carried out, whilst 91 trusts said they were still “in the process” of carrying this out.³⁵ Despite the overwhelming evidence proving BAME communities are disproportionately dying of COVID-19, and the number of BAME healthcare workers who have passed away thus far, there appears to be a lack of action by NHS trusts to sufficiently protect their staff who are at greater risk.
- viii. 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,³⁶ which indicates that there have been external factors contributing to the high death rates of BAME healthcare staff.
- ix. 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. Looking at research conducted before the pandemic, 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.³⁷ 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.³⁸
- x. Since the pandemic, further research has been conducted to understand the views of BAME healthcare workers as to why more of their BAME colleagues were dying than their White counterparts. “Systemic discrimination” was cited as one of the potential

contributing factors. The survey, which included responses from more than 2,000 BAME NHS staff found they feel fearful in the most at-risk frontline roles, feel unfairly deployed, and at an increased risk of infection, with many feeling unheard. Half of all respondents felt discriminatory behaviour played a role in the high death toll. Anecdotal evidence from the survey also found BAME staff being allocated or deployed to the most at risk wards, with their White counterparts remaining in the safer areas. This discrimination indicates a culture of racism within the NHS which is leaving BAME staff more exposed to the virus, and thus dying at higher rates.³⁹

- 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.⁴⁰ 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 impact of the racism and discrimination faced by working in these roles, that Muslims are at a greater risk of developing COVID-19. Though while 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.
- xiii. Looking at other sectors of employment and occupational exposure, data shows high COVID-19 death rates among taxi drivers and bus drivers in particular at 36.4 deaths per 100,000,⁴¹ with the Annual Population Survey from 2018 to 2019 also showing the highest percentage of transport workers being from the Bangladeshi and Pakistani ethnicity group (17.8%).⁴²
- xiv. Furthermore, BAME workers also make up a disproportionately large share of key worker sectors in London, meaning they are not able to work from home during the pandemic and so are exposed in their places of work and when travelling to their places of work. The Health Foundation found only 31% of BAME workers in London were classified as ‘non-key workers’. 54% of staff in food production, process and sale are BAME, 48% across the health and social care sector, 44% in the transport sector, 37% in key infrastructure and utilities, 30% in childcare and teaching and 24% in key public services.⁴³ Whilst there is no data to show the number of Muslims in

each of these sectors, by virtue of BAME individuals being disproportionately represented, Muslims will be too.

- xv. With poverty and deprivation a key health determinant, it is important to look at the impact of the lockdown measures on the employment and income of Muslims.
- xvi. 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. ⁴⁴ 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.
- xvii. 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. Furthermore, a quarter of BAME workers have zero-hour “gig economy” jobs, compared to just 14% of the general population, meaning they are less able to benefit from the UK Government’s emergency coronavirus support packages, which concentrate support for full-time employees. ⁴⁵
- xviii. 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 90% 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. ⁴⁶
- xix. Whilst the UK Government has introduced a range of emergency measures to support employees, including the furlough scheme, this has not adequately protected all workers. Ethnic minorities have been found to be more likely than white workers to have lost their jobs rather than be put on the furlough scheme. With approximately 4,000 workers having lost work because of COVID-19, 21% of those from ethnic minorities said this was because they had lost their job, compared to just 7% of White people. Almost half of White workers whose hours have been cut said this was because they had been furloughed, so continue to receive up to 80% of their usual pay and will still have a job to come back to when the scheme ends. This is in comparison to less than a third of ethnic minorities who have been furloughed upon losing work. ⁴⁷

- xx. It is evident that BAME communities are overexposed to the virus and are less able to socially distance in order to reduce the risk of catching the virus due to concentrated employment in sectors deemed essential. Furthermore, while poverty and deprivation impact health outcomes, it is clear that the impact of the lockdown measures on those who are self-employed or work in shut-down industries will greatly impact Muslims. While there is insufficient data collected on employment in key worker sectors by faith, it is not possible to know to what extent Muslims are impacted by these factors.
- xxi. **Recommendation:** In order to truly understand the impact on Muslim communities to then better explore the factors which have resulted in a high number of deaths, more disaggregated data should be collected on faith of NHS staff. While existing data may be incomplete, releasing this data may prove useful in order to help build trust and transparency.
- xxii. **Recommendation:** Public Health England, NHS England and the Department for Health and Social Care should take heed of the overwhelming evidence and feeling of structural racism, discrimination and Islamophobia within the NHS that has come to light. It is important that BAME staff are properly consulted and heard on the issues that have been raised, and the impact of discrimination on the high death rates be explored. A strong statement acknowledging the problems within the NHS of racism and discrimination, with a clear action plan of how to tackle this and a commitment to implement change would be welcome.
- xxiii. **Recommendation:** We believe NHS England should look at changing the way in which BAME staff are represented and included in decision-making and that consideration should be given to the impact a lack of representation at high levels in the NHS has on the workforce. Key advocacy groups working in the health and social care sector, like ethnicity and faith-based professional networks and charities like The King's Fund that have done research into the levels of inequality would be valuable in consulting, with their views and recommendations considered. Such recommendations include but are not limited to more robust diversity training, improving faith literacy, fostering a culture of valuing diversity, better recruitment selection and promotion policies, coaching and mentoring of under-represented groups and encouraging staff participation in decision-making.
- xxiv. **Recommendation:** Public Health England should consider the advantages of expanding the Workforce Race Equality Standard which is already in place to not only look to tackle racial inequalities, but also the impact of racial inequalities on health outcomes.
- xxv. **Recommendation:** While it is evident that BAME communities are over-represented in key worker industries, and also in terms of COVID-19 mortality rates, it is our view that key worker industries having an understanding of the

risks to the health of its workers is important to put sufficient protections in place to mitigate such risks.

9. 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. Most mosques are largely funded on donations from worshippers, 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 was observed between 24 April and 24 May 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 many mosques having relatively undiversified incomes compared to other places of worship (e.g. income from investments, trust and foundation grants for projects), they have found themselves in a difficult financial situation, with many concerned that the potential long term sustainability of mosques is at risk.

Initiatives have been set up to help mosques fundraise online, like the #SupportOurMosque initiative by LaunchGood and the Muslim Council of Britain, but many mosques are likely to face challenging cash flow positions in the coming months. 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, ⁴⁸ 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, ⁴⁹ 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.
- iv. **Recommendation: The UK Government could consult and work closely with Muslim charities and mosques to understand the issues they are facing and consider whether any additional financial measures could be introduced to support the organisations which are not covered by the current measures.**

10. 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.⁵⁰
- 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.

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