support your choice of care wherever possible. Your care, and the information you are given about it, should take account of any religious, ethnic or cultural needs you may have (National Institute for Clinical Excellence (2008).

The NHS needs to ensure these guidelines are enforced, so that health care professionals are unable to divert from providing high quality maternity care for all. If these guidelines were followed on the ground, it would completely transform these women's antenatal experience.

AMANI MUGASA

Amani Mugasa is a junior doctor based in Scotland, of mixed Ugandan and English heritage. Dr Mugasa is very passionate about tackling health inequalities after her experiences in the UK and Uganda, and intends to pursue a career in public health Insha'Allah. As well as caring for her young family, Dr Mugasa is involved in activism and charity work in her spare time, and has just agreed to have her first children's book published.

THE IMPACT OF COVID-19 IN BLACK MUSLIM COMMUNITIES

BY AMINA HERSI, ZAINAB GARBA SANNI & RANYA ALAKRAA

INTRODUCTION

The COVID-19 pandemic and its impact on communities across Britain has exposed the enduring inequalities entrenched in the country. Altogether, Britain's COVID-19 death toll passed 100,000 in January 2021, among the highest per capita in the world. However this has been felt disproportionately by certain groups, in particular Black and Muslim communities, that have come out as the most impacted ethnic and religious communities respectively. This suggests the existence of compounded impact amongst Black Muslims and emphasises the importance of intersectionality and the need for further research in this space. At present, data around the impact of COVID-19 on Black Muslim communities is lacking. We review recent research and provide insight into the perspectives of a Black Muslim doctor at a GP surgery.

IMPACT OF COVID-19

A recent report from Public Health England (2020), into the disparities in risk and outcomes of COVID-19 has confirmed that the impact of COVID-19 has not only replicated pre-existing health inequalities but, in some cases, has increased them. The report finds that the risk of dying, among those diagnosed with COVID-19, is higher in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups. Furthermore, this disparity is particularly pronounced among individuals from Black ethnic groups. The Runnymede Trust finds a similar outcome in their recent report into the impact of COVID-19 on BAME groups, stating that Black and minority ethnic people are overrepresented in COVID-19 severe illness and deaths. Nonetheless, there still remains a gap in research and data on the particular impact of the disease on Black Muslim populations. The existing research may provide insights into the exposure of Black African and Black Caribbean Muslim Briton's to COVID-19.

A number of key themes have emerged in recent research exploring some of the main factors why minorities are more likely to be diagnosed and die from COVID-19, and the specific inequalities experienced in British Black Muslim communities.

OVERREPRESENTATION IN FRONTLINE ROLES

BAME community members make up a large proportion of frontline and key worker roles. These roles are both in the NHS and beyond the healthcare sector too. In their stakeholder engagement, Public Health England (2020) found evidence to suggest increased risk of exposure among BAME staff in the NHS and social care settings due to their overrepresentation in these roles. Public Health England (PHE) reports numerous examples of staff not being able to access personal protective equipment (PPE) or appropriate protective measures, as well as feeling reluctant to speak up about these issues due to concerns around bullying and harassment. Beyond the NHS, essential staff in public transport, retail, and education also feature a higher proportion of BAME individuals. These staff also face additional exposure and risk and are often not provided appropriate protection or effective workplace risk assessments. In particular, Black Britons are more likely to be classed as key workers than their other BAME counterparts, with nearly 40% (Runnymede Trust, 2020) of Black African individuals being key workers.

The impact of the pandemic on frontline workers is made apparent by the extent of deaths experienced among NHS Black, Muslim healthcare staff. To name but a few, Raahima Bibi Sidhanee, Gelaluddin Ibrahim, and Dr. Alfa Saadu, of Trinidadian, Sudanese, and Nigerian heritage, respectively.

SOCIOECONOMIC STATUS AND CORRELATION WITH POOR HEALTH

Health inequalities in Britain are stark but not new; they are enduring characteristics of British communities that have been amplified by COVID-19. Evidence clearly illustrates that BAME groups tend to have poorer socioeconomic circumstances, which can subsequently lead to poorer health outcomes. The Office for National Statistics (ONS) (Office for National Statistics, 2020) confirmed a strong association between socioeconomic disadvantage and the incidence and severity of a COVID-19 diagnosis. In addition to this increased socioeconomic disadvantage, those from BAME backgrounds also experience higher incidence of long-term and chronic conditions, which are also impacted by socioeconomic status. Ultimately, the ability to protect one's health and wellbeing from coronavirus is affected by one's ethnicity and socioeconomic status.

POOR ACCESS TO HEALTH

Both economically disadvantaged communities and BAME communities experience poorer access to health services. Research has shown that those from BAME backgrounds also have poorer past experiences of health care (Public Health England, 2020). This may act as a discouraging factor when these individuals need to seek care. Furthermore, BAME individuals experience less access to timely preventative care/services. Mental health services are one example. The reduced access and scarcity of culturally appropriate services has increased the impact of the pandemic on BAME communities (including restrictions such as lockdown and social distancing) and puts those with pre-existing mental health conditions at an even higher risk. Additionally, access to healthcare is also deeply affected by communication barriers experienced by BAME communities. These include language barriers but also barriers in understanding the complexity of the NHS and how to apply messaging from the NHS to their own health.

HOUSING AND SPACE

BAME communities may face specific challenges due to the nature of their housing situations and overcrowding. In comparison to white British households, BAME households tend to be larger (in terms of the number of people living under one roof) but not necessarily larger in terms of physical space. This leads to an increased likelihood of overcrowding and thus may impact a household's member ability to self-isolate. Larger household sizes are most common among those of Pakistani, Bangladeshi, Indian and Black African backgrounds (Runnymede 2020). Additionally, BAME households are often intergenerational, more so than white British households, thus increasing the likelihood of spread of COVID-19 between young, healthy household members to older, more at risk individuals, in particular if households are overcrowded. Given that a large proportion of these communities are also key workers, they are likely to be leaving their homes, potentially using public transport, and so are more exposed. This puts those in their homes at higher risk.

CASE STUDY

My name is Amina Hersi and I am a newly qualified GP. I currently work 6 sessions a week in a busy Reading surgery. I am Muslim, Black and female and getting to where I am today has not been easy. I was actively discouraged from becoming a doctor, by career counsellors, family friends and even members of my own family. There was very little representation in the NHS of people from my background when I was growing up. I don't think this is because they weren't there, more because they weren't being shown. I really relate with the line "You cannot be what you cannot see."

I love the NHS, I love what it stands for because it is about healthcare, free at the point of access to anyone who needs it, regardless of gender, race, religion. This is the epitome of inclusion, diversity and equality. Unfortunately, there is a dark underbelly. 2020, a year for the history books, placed society under a magnifying glass and all its flaws were made apparent. Pandemics have a way of highlighting the true nature of things. Furthermore, this year has been the year the Black Lives Matter movement went mainstream. I want to highlight that it has been around for years. What is interesting is people who only a few years ago used to reply with "all lives matter" are now Blacking out their social media pages in support of this movement. But we need more than blank posts on social media. We need to sustain the momentum of getting people to accept that racism is real.

Coronavirus has devastated the world. As cases went up, deaths did too. Then the studies highlighted something; COVID IS RACIST. This virus was twice as likely to infect Black people, we were more likely to be hospitalised and more likely to die. Two of my siblings have had COVID 19 and it has been frightening because as a medic I know just how high risk they are. I had a risk assessment at work, to find that I was just 1 point away from being asked to work from home.

Some argue that GPs are not frontline but I have seen Covid positive patients with nothing but a surgical mask and a plastic apron (in a time where we were not even sure this was enough). I very much felt frontline when on March 12th I ran a busy clinic with patients in my office, coughing near my face and not a single mask to be seen: only for lockdown to be announced the next day.

So Covid was definitely something I became fearful of, it was a massive source of anxiety and sleepless nights for me. I worried because I was convinced that I was going to infect and kill my family. Especially as it was affecting ethnic minority groups more severely. Eventually, I realised that I could encounter this virus from anywhere be it public transport, the supermarket, the post office or from my own family.

Because of how prevalent cases were, telephone triage became the new normal and I often speak to patients before inviting them for an examination. It has been an interesting experience because where I work is quite affluent and not very diverse. I have been told, "you sound white on the phone." I'm not sure how you can sound like a race. But I found that some of my patients were shocked to learn that I, the Black hijab wearing lady was indeed who they spoke to on the phone. I've had people walk past my room because they thought I was the nurse (this isn't a slight about nurses) but why is it so shocking that I went to medical school looking the way I do? I like to think I'm doing my part by exposing this part of suburbia to Islam and being an ambassador for Black, female, Muslim medics.

I absolutely love where I work. My manager is just so aware of my religious needs, she has even got me a special sign to put on my door when I'm praying in my office. They have even offered me adjustments for my working pattern during Ramadan. This is the kind of awareness the NHS needs. I am lucky because I get to choose where I work. My comrades in hospitals may not get the same treatment. I remember from my times in hospital medicine, that it was more acceptable to go on a smoking break than it was to say you're going to pray! Both of these activities take 5 minutes and it should not be taboo.

I think diversity is a beautiful thing and it should be celebrated. I also think we should on a one to one basis try to broaden people's horizons and just by doing what we're doing on the frontlines we can change the way people interact with others. My manager is so clued up because the doctor before me made the time to speak to her about Islam and his needs.

Inequality needs to be addressed wherever it rears its ugly head. This pandemic has highlighted a serious issue of health inequality. It's easy to say things like "Black people have more underlying conditions." That is not enough; we need to ask why are Black people more likely to have underlying conditions. This is where we will find that Black and other minority people are more likely to work frontline, more likely to take public transport , more likely to live in crowded homes and more likely to be from disadvantaged backgrounds.

I hope we learn from this pandemic. Someone mentioned a figure to me that there were an extra 70,000 deaths this year than last year. I thought "that's a lot of grief" each of those 70,000 had friends and family: siblings, cousins, aunts, uncles, partners, children or parents who would grieve for them. The stories of people dying alone in hospital and being buried alone were harrowing. This robbed their loved ones of closure and without closure how can we heal? I worry that Covid 19 will mentally scar this generation and the number of mental health cases I'm seeing are through the roof. Staff morale is lower than ever, we are running on empty, overwhelmed, overworked and underappreciated.

I really want us to pull together to appreciate one another and show gratitude to all the frontline staff who have kept things going for months on end now: to the social workers, teachers, carers, supermarket staff, police, fire brigade and the NHS workers in all roles be that admin, reception, nursing or medicine.

I hope this pandemic can leave a legacy of change in us, to want to treat others better and to stamp out inequality. Race does affect us, it does affect behaviour and you cannot change what you don't acknowledge. We need to address the elephant in the room that has for so long tried to be swept under a rug. Let's be better and do better.

CONCLUSION

The COVID-19 pandemic has impacted Black communities and other minority ethnic communities disproportionately. This is not because the disease targets certain communities or people, this is because of the enduring health inequalities that exist in Britain. In addition to this, Black individuals have experienced overexposure to the disease due to being largely concentrated in frontline roles, a lack of PPE particularly at the start of the pandemic, higher levels of socioeconomic disadvantage and other household factors.

There is a clear need for further evidence around the experiences of Black Muslims in particular, and a need to engage with this community to ensure they are voicing their concerns, and sharing their stories. Greater evidence and engagement will help to lead to robust policy recommendations that are tailored to this community.

The COVID-19 pandemic has impacted Black communities and other minority ethnic communities disproportionately. This is not because the disease targets certain communities or people, this is because of the enduring health inequalities that exist in Britain.

AMINA HERSI

GP based in Berkshire.

ZAINAB GARBA SANNI

Zainab is one of the co-chairs for the NHS Muslim Network: a staff network hosted by NHS England and NHS Improvement which has the following aims: (1) to provide representation for Muslim staff, (2) to provide networking and progression for Muslim staff and (3) to help reduce health inequalities experienced by Muslim communities. Additionally, day-to-day Zainab works in the Innovation, Research and Life Sciences Group leading on an equality, diversity and inclusion programme of work and looking after the NHS Clinical Entrepreneur Programme and the Small Business Research Initiative for Healthcare. Zainab is also Partnerships Lead for TEDxNHS and does patient advocacy and advisory work in her free time.

RANYA ALAKRAA

Ranya is an Economic Analyst at NHS England and Improvement, working on various projects focusing on evidence-based policymaking in the NHS. She is the Head of Member Development at the NHS Muslim Network aiming to support Muslim staff in the NHS in their career development. Ranya is also the equality, diversity and inclusion champion for her team and is the chair of her directorate's wellbeing group.