



Submission to Public Health England’s Review into the Impact of Coronavirus on BAME Communities



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, it is imperative that extensive evidence-driven research is conducted to understand the causes of this. Whilst this review is welcome, the exclusion of identifying the root causes of findings is regrettable. With structural inequality and racism being among key determinants of health, looking at the impact of this would have made this review more robust.
- v. In addition, it is welcome that Public Health England is also reviewing how other factors like deprivation, age, gender and obesity could impact how people are affected by COVID-19, but broadening the scope of the review should not detract from the depth needed to properly understand the impact of each of these factors.
- vi. The MCB has raised concerns about the appointment of Sir Trevor Phillips to support the inquiry, following dangerous assertions he has made about the disproportionately higher mortality rates in BAME communities, and it is important that this concern is taken into account. It is of the utmost importance that this review does not take heed of assertions and speculation which have no basis, and is instead driven by evidence. Examples of dangerous and lazy assertions about race that have been made in the public space, either by individuals and organisations supporting the review or about the issue include, but are not limited to: “campaigners are twisting BAME Covid data to further their ‘victimhood’ agenda” (Civitas)², certain ethnic groups may specialise in different types of crime (Origins)³, Muslims are at lower risk of contracting the virus due to “ritual washing” (Trevor Phillips)⁴. It is imperative that such stereotypes are not considered as part of this review, and that Public Health England clearly shows that such claims are not justifiable.
- vii. 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 very limited data available to provide a number of examples of factors which may be contributing to the

¹ [Coronavirus \(COVID-19\) Guidance for Muslim Communities](#), *Muslim Council of Britain*, 2020

² [Campaigners are twisting BAME Covid data to further their ‘victimhood’ agenda](#), *The Telegraph*, 4 May 2020

³ [Trevor Phillips’ firm Origins software linked ethnic groups to crime](#), *The Guardian*, 6 May 2020

⁴ [We need to solve ethnic puzzle of Covid-19](#), *The Times*, 20 April 2020

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.

- viii. As this review is by Public Health England, all data on mortality rates and NHS employment is for England only, where the majority of Muslims reside. COVID-19 is likely to have had a significant impact on Muslim communities in Wales, Scotland and Northern Ireland too.
- 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 no data being collected on COVID-19 mortality rates by faith, it is impossible to accurately know to what extent Muslims are dying at a disproportionate rate to people of other faith groups. However, it is evident that Muslims are disproportionately impacted, by virtue of most Muslims also being from ethnic minorities.
- ii. We believe it is important disaggregated data on COVID-19 mortality rates is 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.
- iii. 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.

- iv. 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.

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.⁵ 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”.⁶ 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.⁷
- 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,⁸ with the

⁵ MCB calls for the suspension of all congregational activities at UK mosques and Islamic centres, *Muslim Council of Britain*, 16 March 2020

⁶ An open letter to the Muslim community, *British Islamic Medical Association*, 16 March 2020

⁷ KS209EW Religion, local authorities in England and Wales, *ONS*, 27 March 2011

⁸ Q208EW Usual residents in England and Wales by Religion, *ONS*, 2011

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.⁹
- 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. DEATH RATES IN BAME AND MUSLIM COMMUNITIES

- 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 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.¹⁰ 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 almost 300% more deaths than we would expect. Further detail can be seen in the table below.

⁹ British Muslims in Numbers, Muslim Council of Britain, July 2015

¹⁰ We need to solve the ethnic puzzle of Covid-19, The Times, 20 April 2020

Deaths in Hospital from COVID-19 by ethnicity

Data for England up until 12th May 2020 (published 14th May 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	42,279,236	79.8%	17,117	78.8%	19,886	-2,769	-14%
Irish	517,001	1.0%	219	1.0%	351	-132	-38%
Any other White background	2,484,905	4.7%	751	3.5%	445	306	69%
Total White	45,281,142	85.4%	18,087	83%	20,682	-2,595	-13%
Asian							
Indian	1,395,702	2.6%	665	3.1%	277	388	140%
Pakistani	1,112,282	2.1%	448	2.1%	121	327	270%
Bangladeshi	436,514	0.8%	146	0.7%	37	109	295%
Chinese	379,503	0.7%	78	0.4%	53	25	47%
Any other Asian background	819,402	1.5%	366	1.7%	105	261	249%
Total Asian	4,143,403	7.8%	1,703	7.8%	593	1,110	187%
Black							
African	977,741	1.8%	394	1.8%	75	319	425%
Caribbean	591,016	1.1%	601	2.8%	183	418	228%
Any other Black background	277,857	0.5%	199	0.9%	25	174	696%
Total Black	1,846,614	3.5%	1,194	5.5%	283	911	322%
Mixed							
White and Asian	332,708	0.6%	28	0.1%	26	2	8%
White and Black African	161,550	0.3%	14	0.1%	9	5	56%
White and Black Caribbean	415,616	0.8%	44	0.2%	35	9	26%
Any other Mixed background	283,005	0.5%	69	0.3%	26	43	165%
Total Mixed	1,192,879	2.3%	155	0.7%	96	59	61%
Other							
Any other ethnic group	548,418	1.0%	585	2.7%	71	514	724%
Total Other	548,418	1.0%	585	2.7%	71	514	724%
Total	53,012,456	100%	21,724	100%	21,726		

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 ¹¹

- 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. 7.8% of deaths were of Asian individuals, with the same population share, 5.5% of deaths were Black individuals despite only making up 3.5% of the population and 2.7% of deaths were of individuals of any other ethnic group, which include Arabs, despite only making up 1% of the population. In contrast, 83% of deaths were of White individuals who make up 85.4% of the population, and 0.7% of deaths were of Mixed-Race individuals despite making up 2.3% 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, which helps to show the extreme rates of disproportionality in BAME communities. The total number of Asian excess deaths was 1,110, Black excess deaths was 911, other ethnic groups excess deaths was 514. There were 2,595

¹¹ Updated analysis by Miqdad Asaria (@miqedup). Miqdad Asaria is an Associate Professor and Health Economist at the London School of Economics. Original analysis of data until 21st April 2020 published here: [Are there more COVID-19 deaths than expected in BAME communities in England – what does the data say?, Discover Society, 29 April 2020.](#)

fewer deaths of White individuals than expected, but 59 excess Mixed-Race deaths. This, and the implications this has for Muslim communities, is explored in more detail below.

- 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

Data for England up until 12th May 2020 (published 14th May 2020)

	Population	Population (%)	Muslim Population	Muslim Population of Ethnicity (%)	Observed Deaths	Observed Deaths (%)	Estimated Muslim Observed Deaths
White							
British	42,279,236	79.8%	75,088	0.2%	17,117	78.8%	30
Irish	517,001	1.0%	1,872	0.4%	219	1.0%	1
Any other White background	2,484,905	4.7%	130,022	5.2%	751	3.5%	39
<i>Total White</i>	<i>45,281,142</i>	<i>85.4%</i>	<i>206,982</i>	<i>0.5%</i>	<i>18,087</i>	<i>83%</i>	<i>70</i>
Asian							
Indian	1,395,702	2.6%	195,952	14.0%	665	3.1%	93
Pakistani	1,112,282	2.1%	1,017,463	91.5%	448	2.1%	410
Bangladeshi	436,514	0.8%	392,636	89.9%	146	0.7%	131
Chinese	379,503	0.7%	7,802	2.1%	78	0.4%	2
Any other Asian background	819,402	1.5%	191,522	23.4%	366	1.7%	86
<i>Total Asian</i>	<i>4,143,403</i>	<i>7.8%</i>	<i>1,805,375</i>	<i>43.6%</i>	<i>1,703</i>	<i>7.8%</i>	<i>722</i>
Black							
African	977,741	1.8%	203,774	20.8%	394	1.8%	82
Caribbean	591,016	1.1%	7,294	1.2%	601	2.8%	7
Any other Black background	277,857	0.5%	56,226	20.2%	199	0.9%	40
<i>Total Black</i>	<i>1,846,614</i>	<i>3.5%</i>	<i>267,294</i>	<i>14.5%</i>	<i>1,194</i>	<i>5.5%</i>	<i>130</i>
Mixed							
White and Asian	332,708	0.6%	48,636	14.6%	28	0.1%	4
White and Black African	161,550	0.3%	5,279	3.3%	14	0.1%	0
White and Black Caribbean	415,616	0.8%	15,279	3.7%	44	0.2%	2
Any other Mixed background	283,005	0.5%	31,189	11.0%	69	0.3%	8
<i>Total Mixed</i>	<i>1,192,879</i>	<i>2.3%</i>	<i>100,383</i>	<i>8.4%</i>	<i>155</i>	<i>0.7%</i>	<i>14</i>
Other							
Any other ethnic group	548,418	1.0%	280,082	51.1%	585	2.7%	299
<i>Total Other</i>	<i>548,418</i>	<i>1.0%</i>	<i>280,082</i>	<i>51.1%</i>	<i>585</i>	<i>2.7%</i>	<i>299</i>
Total	53,012,456	100%	2,660,116		21,724	100%	1,234

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)
Expected deaths are adjusted for age structure of ethnic groups and normalised to sum to total observed 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, Black, Other and Asian groups had the highest numbers of excess deaths as per Table 1. Considering most Muslims belong to these ethnic groups, Muslims will therefore also be disproportionately impacted.
- viii. The Other ethnic category, which includes Arabs, has had the highest number of excess deaths (724%), 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 over 40% of individuals in these categories.
- ix. Almost half of all Asians are Muslim, with the group having experienced excess deaths of 187%. Within this group, the two ethnic categories with the worst rates of excess deaths were Pakistanis and Bangladeshis, who are 91.5% and 89.9% Muslim respectively. Pakistanis have experienced 270% deaths in excess and Bangladeshis experiencing 295% deaths in excess. In particular, males in the Bangladeshi and Pakistani ethnic groups were 1.8 times more likely to have a COVID-19 related death than White males when age and other socio-demographic characteristics and measures of self-reported health and disability were taken into account. For females, the figure was 1.6 times more likely.¹²
- x. 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.

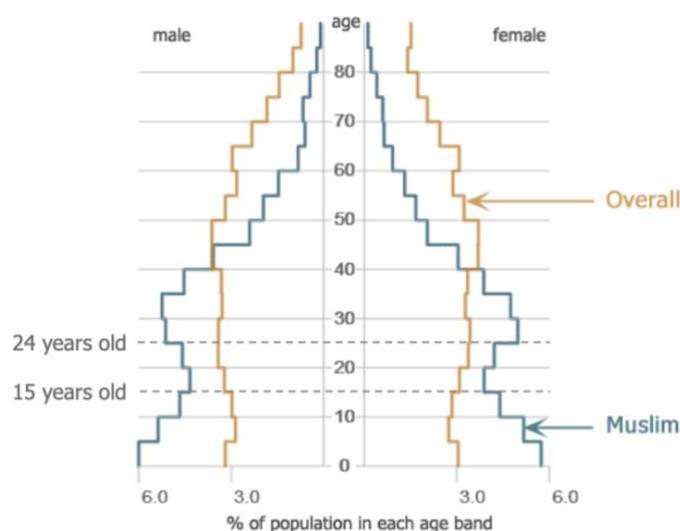


Figure 1: Age distribution of Muslims compared to the UK population¹³

- xi. Applying the age standardised mortality rate to Local Authority Districts shows the worst hit areas are those with large BAME and Muslim 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),

¹² Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020, ONS, 7 May 2020

¹³ British Muslims in Numbers Briefing: Britain’s Muslim population is relatively young, Muslim Council of Britain, 1 June 2015

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. ¹⁴

- xii. 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.
- xiii. Looking specifically at the impact of COVID-19 on Pakistanis and Bangladeshis, of which 91.5% and 89.9% are Muslim respectively, Pakistanis had 2.5 times more deaths than expected, and Bangladeshis had three times as many deaths.
- xiv. 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. ¹⁵
- xv. **Recommendation: Without having a clear picture of mortality rates by faith, it is not possible to understand whether Muslim communities are suffering excess levels of death because of COVID-19, and therefore it is not possible to truly understand the extent to which external factors contribute to this. Whilst it is welcome and important that this data is available by ethnicity in order to explore how different ethnic groups are affected by different external factors which could explain the high mortality rates, disaggregated data collection would provide more detailed insights.**

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 British Muslims, comprising 12.4% of London’s population.¹⁶ 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. ¹⁷

¹⁴ List of local authorities by age standardised mortality rates from COVID-19 between 1 March and 17 April, via Twitter, @miqedup, 1 May 2020

¹⁵ Are some ethnic groups more vulnerable to COVID-19 than others?, Institute for Fiscal Studies, 1 May 2020

¹⁶ British Muslims in Numbers, Muslim Council of Britain, July 2015

¹⁷ Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 17 April 2020, ONS, 1 May 2020

- 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 6.7% of the local population. ¹⁸ 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.¹⁹
- iv. The rate of infection in these areas disproportionately impacts Muslim communities, with 51.3% of Muslims residing in these areas. ²⁰
- 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. ²¹ 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. ²² It is therefore evident that Muslims are disproportionately impacted by virtue of living in deprived areas.
- 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. ²³ 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. ²⁴
- 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 425% and 295% excess deaths respectively.

18 British Muslims in Numbers, Muslim Council of Britain, July 2015

19 Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 17 April 2020, ONS, 1 May 2020

20 British Muslims in Numbers, Muslim Council of Britain, July 2015

21 Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 17 April 2020, ONS, 1 May 2020

22 British Muslims in Numbers, Muslim Council of Britain, July 2015

23 Coronavirus UK: The government wants over-70s to self-isolate but what about Asians who live with their families?, Metro, 23 March 2020

24 Our Shared British Future, Muslim Council of Britain, March 2018

- 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 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.
- xi. **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.**

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. 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.²⁵
- 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.²⁶ 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

²⁵ Equality and diversity in NHS Support Organisations and Central Bodies, NHS, March 2019

²⁶ Exclusive: deaths of NHS staff from covid-19 analysed, *Health Service Journal*, 22 April 2020

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. ²⁷

- vii. 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, ²⁸ which indicates that there have been external factors contributing to the high death rates of BAME healthcare staff.
- viii. 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. ²⁹ 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. ³⁰
- ix. 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 behavior 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. ³¹
- x. 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. ³² 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

²⁷ MCB and BIMA express gratitude to all NHS staff, and pay tribute to physicians who have lost their lives, *Muslim Council of Britain*, 31 March 2020

²⁸ Exclusive: deaths of NHS staff from covid-19 analysed, *Health Service Journal*, 22 April 2020

²⁹ Ethnic minority deaths and Covid-19: what are we to do?, *The King’s Fund*, 30 April 2020

³⁰ Making the difference, Diversity and inclusion in the NHS, *The King’s Fund*, December 2015

³¹ ‘Discrimination’ on frontline of coronavirus outbreak may be factor in disproportionate BAME deaths among NHS staff, *ITV News*, 13 May 2020

³² Trust treating all BAME staff as ‘vulnerable and at risk’, *Health Service Journal*, 27 April 2020

not disclosing underlying conditions, more must be done to tackle the stigma and associated discrimination so that staff feel empowered to be transparent.

- xi. 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.
- xii. 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, ³³ 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%). ³⁴
- xiii. 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. ³⁵ 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.
- xiv. 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.
- xv. In London alone, there are over 13,400 Muslim-owned businesses, with an estimated 33.6% of all Small to Medium Enterprises being Muslim owned. ³⁶ 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.
- xvi. With incomes being likely to be especially uncertain for the self-employed, this disproportionately impacts Pakistanis and Bangladeshis, the overwhelming majority of whom are Muslim, with Pakistani men being 70% more likely to be self-employed than the White British majority.
- xvii. 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 almost 90% are

³³ [Coronavirus related deaths by occupation, England and Wales: deaths registered up to and including 20 April 2020](#), ONS, 11 May 2020

³⁴ [Employment by sector](#), GOV.UK, 15 May 2020

³⁵ [Black and minority ethnic workers make up a disproportionately large share of key worker sectors in London](#), The Health Foundation, 7 May 2020

³⁶ ‘British Muslims: economic contributions and challenges’, in Media Portrayals of Islam and Muslims: Engage Islamophobia awareness exhibition guide, 2012-13, pp.20-21

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 91% are Muslim) are nearly three times as likely, partly due to their concentration in taxi driving. Black African men (of whom 21% 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.³⁷

- xviii. 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 the COVID-19 mortality rates by faith, and employment in key worker sectors by faith, it is not possible to know to what extent Muslims are impacted by these factors.
- xix. **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.**
- xx. **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.**
- xxi. **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.**

³⁷ Are some ethnic groups more vulnerable to COVID-19 than others?, *Institute for Fiscal Studies*, 1 May 2020

- xxii. **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.**

- xxiii. **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.**