SOAS COP Policy Briefings

To Inform Government and Parliamentary Debate

Keeping faith during Covid-19: protecting religious minorities experiencing disproportionate impact by Dr Hina J Shahid and Professor Alison Scott-Baumann SOAS (28th May 2020)

Covid-19 related morbidity and mortality has disproportionately impacted faith communities in the UK, which makes the **lack of data available on faith particularly concerning**. For many people in these groups, **faith is a central part of their identity and way of life**, impacting their health beliefs, and personal, household, and community practices. **Religion is a legally protected characteristic** in the Equality Act. Furthermore, members of minority religious groups are more likely to be from Black, Asian and Minority Ethnic (BAME) backgrounds, and **experience multiple intersecting risk factors simultaneously**.

More Muslim doctors have died from Covid-19 than all other religious groups combined, making up over 50% of medical worker deaths**.** BAME doctors, nurses and carers report that they **find it difficult to raise concerns about inadequate access to personal protective equipment and testing or unfair redeployment as they feel pressurised and bullied** at work**.** The **government needs to urgently collect and publish data by faith** and needs to consider a **whole system intersectional approach** to fully understand and contextualise risks, which include:

- **Socioeconomic factors:** 50% of British Muslims live in poverty, and are more likely to live in poor quality overcrowded housing. This relates to many being employed in the less-protected informal sector and gig economy, which have higher occupational hazards and poorer health and safety protections.
- **Structural stigma:** a history of alienation by media and politicians, and especially policies around austerity, immigration, and security contribute to mistrust of government public health advice
- **Disruption to social, cultural and religious practices: suspended** congregational prayers, curtailed grieving and burial practices, and cessation of the right to visit the sick has increased mental health and post-traumatic stress disorders. During Covid faith institutions dependent on donations have suffered a loss of income
- **Barriers to accessing healthcare:** delayed presentation with more advanced disease due to language barriers and cultural and religious misconceptions about illness and treatment, and documented discrimination by healthcare professionals.
- **Religious discrimination:** Religious minorities have been targets of abuse and blame during Covid-19, in particular Muslim and Jewish communities.
- **Increased prevalence of underlying disorders:** Muslims, Hindus and Sikhs have a higher prevalence of cardio-metabolic disorders and nutritional deficiencies associated with high morbidity and mortality from Covid-19.

Faith-based organisations have been **at the forefront of community efforts**, providing **mental health and spiritual support** services such as bereavement counselling. Failure to consider the important role of faith beliefs, practices, institutions and discrimination risks **missing important lessons and opportunities to prevent a second wave of infection and inequality**. Government must **engage early with faith-based community and medical organisations** to collaborate and co-produce interventions that are evidence-based, timely, relevant, accessible, and sustainable. Government must **go beyond current statistics**, disaggregating BAME data by expanding ethnic groups and including immigration status and information on a range of social, demographic, ecological and clinical risk factors that work together to increase overall risk. This also involves analysing **issues around discrimination and access to healthcare** to understand the excess risk that BAME groups face both on the frontline and in the wider community.

Please contact CoP to speak to Dr Shahid who has the evidence

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