SOAS ICOP Policy Briefings

To Inform Government and Parliamentary Debate

Coronavirus: creating a syndemic by Dr Hina J Shahid (14 October 2020)

COVID-19 is not a pandemic that affects everyone equally; rather, it is a syndemic that brings together the concurrent pandemics of coronavirus, discrimination and disadvantage**.** In the UK, **Muslims have the highest risk of dying from COVID-19**: that most of this excess risk is explained by social deprivation and ethnicity, highlights **Islamophobia** being an intersectional form of structural discrimination and racism which COVID-19 has amplified. Previous briefings have emphasised the **longstanding inequities faced by Muslims in the UK** shaped by historical and contemporary structural factors, occupational risks, healthcare provider and workplace based discrimination, and socially patterned cardio-metabolic diseases that **increase vulnerability, exposure, transmission, and adverse outcomes from COVID-19**.

Additionally, mixed public health messaging, barriers to accessible healthcare, and constrained opportunities for social distancing and self-isolation lead to **reduced protection**. These structures and processes coupled with an **inefficient centralised public health surveillance system** with **capacity constraints** and **digital exclusion** are disproportionately impacting minority communities. Recent outbreaks - despite contrary evidence - have led to **Muslims and mosques being blamed for transmission**, and **anti-Muslim hate crime has also increased**.

A recent report highlights the **detrimental role of the Prevent policy in the NHS** in undermining trust and worsening health inequities amongst Muslim patients. **Multi-level Islamophobia is creating further stigma and exclusion.** Muslim doctors report feeling **bullied and pressurised** into taking on high-risk roles, face **barriers in accessing appropriate PPE, testing and risk assessments**, and **exclusion from decision making roles**. These conditions place them at unacceptable risk and also **negatively impact mental health and wellbeing**. This replicates pre-existing **discrimination of Muslim NHS workers,** reported **widespread Islamophobia from colleagues and patients**, and **under-representation at senior levels**.

With an impending second wave, we recommend a **whole system, multi-sectoral approach** supported by **local contextualised community-led action** with **transparent governance and reporting systems** and **independent monitoring and accountabilit**y. This includes:

1. **Government re-establishing trust and transparency** by engaging with grassroots Muslim organisations to urgently **co-produce and implement immediate and long term risk mitigation strategies** with adequate funding, resources and community ownership.
2. **Data collection and reporting of outcomes by religion as a protected characteristic must be made mandatory as this is essential to monitor health inequalities. This information must be available** at surveillance, prevention, primary and secondary care levels and death certification to monitor for equality and effectiveness of interventions.
3. **Ensure all healthcare workers have personalised and culturally and faith sensitive risk assessments, access to PPE, priority access to testing and occupational health and wellbeing support**.
4. **Improve access and quality of healthcare for Muslim patients** through provision of linguistic, cultural and faith sensitive positive public health messaging, with **awareness, dialogue and training**. on anti-Islamophobia among healthcare providers.
5. **Supporting the development of diverse, inclusive and representative NHS organisations** with resourced and funded **faith networks and initiatives**, **psychological safe routes** for raising concerns and rigorous implementation of **zero tolerance policies** against Islamophobia in every NHS organisation.
6. **Elimination of policies that entrench structural inequalities** e.g. austerity, immigration, security.
7. Increased **media accountability** with robust action against reports that misrepresent, blame and stigmatise vulnerable and marginalised communities and increase public health risk for all.

Visit our website for further briefings (https://blogs.soas.ac.uk/cop/). If you would like a personal briefing or clarification on any of the issues raised here, please contact the author at chair@muslimdoctors.org. Do contact Professor Alison Scott-Baumann and her team for further briefings and access to other experts as150@soas.ac.uk