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The Pandemic of Islamophobia

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The COVID-19 pandemic has shone a spotlight on pre-existing intersectingand compounding inequalities and injustices. Data shows that Muslims in the UK are more likely to die from COVID-19[1]. However, when social deprivation and ethnicity are controlled for, this excess risk diminishes[1]. This is consistent with structural discrimination and racism being key drivers of health disparities from COVID-19 among Muslims in the UK. A syndemics approach[2] is a useful lens to illustratethe "biosocial complex"that enables the dual pandemics of Islamophobia andCOVID-19 to interact, converge and amplify health inequities.

Islamophobia is often seen through the lens of discrimination or race-based oppression (racism) as expressions of racism move away from biological differentiation to more socially acceptable cultural racism within postcolonial and Orientalist narratives.Islamophobia is, however, more than this; it is a complex intersectional form ofdiscriminationand oppression that operates along and between axes of religion, race, culture, gender, class and citizenship within structures of power and privilege. It produces differential inequities and exclusion, interacts at multiple levels, andmultiple axIes of oppression are simultaneously embodied by Muslims who are racialized by society. Both the Runneymede Trust[3] and the APPG[4] define Islamophobia as an expression of racism.

Although the origins of Islamophobia can be traced back to the Crusades, it has increased in global prominence with a series of "moral panics around British Muslims" [3]. Theseincludes the Satanic Verses affair and Gulf War in the 1980s and 90s and anti-Muslim sentiments havebecome acutely accentuated after 9/11 withdiscourses on the "War on Terror", "home-grown" terrorismand ISIS 'jihadis'[3]. This has led some to portrayIslam as an ideological and cultural pathogen in need of quarantine and elimination.In the UK, these global norms are "glocalised" to reproduce health and social inequities.

In the context of COVID-19, and drawing on Singer's work on syndemics[2], Islamophobia and COVID-19 interact synergistically at the population level and contribute to excess burden of illness in the Muslim community. At the biological level, the convergence of the pathophysiological processes of SARS-CoV-2 and embodiment of Islamophobia produces excess morbidity and mortality.

It is well known that almost half of Muslim households in the UK live in poverty[5], an indicator of structural discriminationagainst Muslims. Social deprivation is one of the strongest risk factor associated with poorer outcomes from COVID-19[6]. Austerity policies therefore disproportionately impact Muslim familiesand the pandemic has further increased financial hardship especially for Muslim-majority Pakistani and Bangladeshi families where individuals are more likely to be working in shut down sectors and in insecure employment[7]. Inequities and exclusion produce socially patterned and trauma-embodied diseases associated with high allostatic load ("weathering")such as diabetes, ischaemic heart disease and obesity[8]as well as increased inflammatory markers[9]. These cardio-metabolic and chronic inflammatory disorders are higher in Muslim-majority ethnic groups[10] and are known to be strong predictors of serious illness and mortality and may be associated with the cytokine storm observed in severe COVID-19[9,11]. Additionally, living in urban areas with high neighbour density[12],poor quality and insecure housing and household overcrowding with multi-generational occupancy[5,13] found among Muslim communitiesincrease exposure, reduce opportunities for self-isolation, and facilitate onward transmission of COVID-19.

The hostile environmentfurther institutionalises Islamophobia and worsens COVID-19 outcomesthrough policies on immigration and security. Just under 50% of Muslims are born outside the UK[10] and are therefore disproportionately impacted by immigration policies which create a barrier to accessing healthcare due to surcharges or fear of deportation[14]. This can lead to a delay in accessing care, with Muslim patients more likely to present sicker and with more advanced disease. Security policies such as Prevent similarly create a climate of suspicion and surveillance[15]and discrimination by healthcare professionals has also been reported by Muslim patients [16]. This may account for lower uptake of preventative health programmes by Muslims essential to optimise health[17].

The media is a particularly important institutional force that entrenches Islamophobia through shaping public perception. During the pandemic, divisive media narratives that blame and scapegoat Muslims for transmitting infection were widespread[18]. This is in addition to fake news and conspiracy theories on social media which have been linked with increased levels of Islamophobia during the pandemic[19].Stereotypes and stigma through the creation of a socially devalued identity of Muslims through public policy and the media not only create a barrier to accessing healthcare but create mistrust in mainstream services and information and are a public health risk for all. They encourage alternative systems of healthcare andinformation, reduce compliance with public health measures, and threaten community cohesion which is essential to successfully manage a pandemic.

Muslims are also more likely to face discrimination and exclusion in the labour market and workplace. They are more likely to work in key worker roles, in insecure employment and in the gig economy[20]. This has increased exposure risk to COVID-19 and in the absence of adequate statutory sick pay creates a financial penalty and deterrent to self-isolate when sick thus increasing individual, household and community risk.

The NHS is a microcosm of social norms and values where Islamophobia is internalised and inequities reproduced.Over 95% of doctors who died from COVID-19 were from an ethnic minority background[21] and the first four doctors to die were Muslim[22]. Muslim doctors have reported difficulty with accessing PPE[23]which increases exposure risk. This is against a backdrop of well-known discrimination against Muslims in the NHS[24], a Triple Penalty affecting Muslim doctors where doctors feel vulnerable, excluded, judged, stigmatised, bullied and discriminated[25], a dress codes policy which discriminates against Muslim doctors, and the Prevent policy which creates a culture of fear and suspicion of Muslim colleagues[27]. A recent survey by the Huffington Post and British Islamic Medical Association showed that over 80% of medics in the NHS have experienced Islamophobia with detrimental impacts on their wellbeing and careers[28]. A large survey conducted by ITV, of which over 50% of respondents were Muslim, highlighted that during the COVID-19 pandemic, ethnic minority doctors havefelt less likely to raise concerns and are more likely to be discriminated and bullied into taking higher risk roles, contributing to stress, burnout, excess illness and deaths[29]. This is consistent with institutional Islamophobia in the NHS which must be addressed.

Muslims have a long history of contributing to British society. Initial migration of Muslims began when workers from the British Empire, which covered 50% of the world's Muslim population at its peak[30], were recruited from the Indian subcontinent to work for the British East India Company [31]. The inequities currently experienced by Muslims in the UKare an embodiment ofnecropolitics, a system of social and political power that determines who lives and who dies [32], and which replicates the colonial legacy of oppression and exclusion. In order toeliminate health inequities among Muslimsfrom COVID-19 and beyond, it is imperative that a multi-level multi-sectoral and interdisciplinary approach is adopted which addresses the "causes of the causes"[33] in a holisticand integrated way.

Action must begin with the government adopting a definition of Islamophobia, committing to addressing its urgent and long term impact, and collecting data on religion, a legally protected characteristic[34], across public health programmes and NHS services to monitor health inequities. Action must include reforming laws and policies on immigration, security, austerity, social mobility and social security, improve media regulation and accountability, provide affordable housing and secure employment, and address discrimination in educational, employment, housing and criminal justice systems against Muslims. Within the NHS, a zero tolerance policy against Islamophobia must be implemented along with a culture of inclusion and compassion, and psychological safe routes for raising concerns. Improved faith literacy and faith networks which support and empower Muslim healthcare professionals and culturally sensitive opportunities for networking and mentoring should be made available.

The hallmark of a civilised society is the protection of its most vulnerable groups and supporting individuals to realise their capabilities[35] and achieve self-actualisation[36] and holistic wellbeing. It is this combined rights-based, social determinants and wellbeing approach centred on core values of justice, equity and compassion that can address the syndemic of COVID-19 and Islamophobia to ensure optimal health, peace, safety and security for all.

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