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13 Rivers Trust

HEALTH AND SOCIAL INEQUALITIES:

Addressing the Impact on British Muslims

With expert contributions from the industry

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MCB MUSLIM COUNCIL OF BRITAIN

INFOCUS SERIES

Toolkit for Muslim Families and Medical Professionals

The *InFocus Series* toolkit addresses important topics related to End-of-Life care, suicide and assisted dying, health and social inequalities, among other issues affecting Muslim communities in the UK. Each toolkit provides guidance for both Muslim families and medical professionals to bridge the gap in understanding and support.

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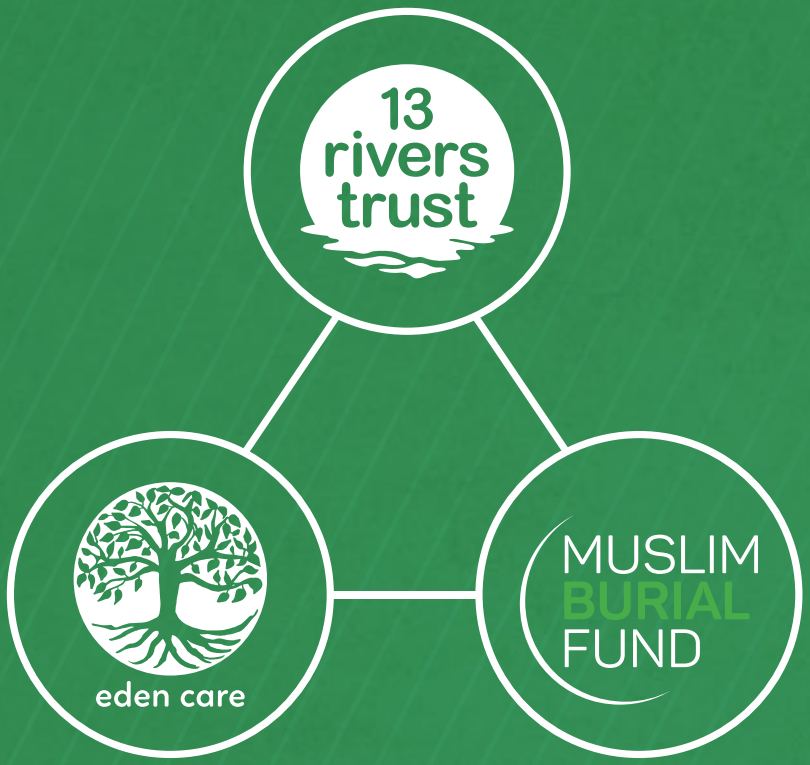


13 Rivers Trust is a charitable organisation dedicated to supporting Muslim communities in the UK through various initiatives. Two of its specialist projects, Eden Care UK and the Muslim Burial Fund, have been particularly impactful in providing essential services to Muslims, including new converts, in their times of need.

Eden Care UK focuses on providing support to terminally ill Muslims and those in their last days. The project offers befriending services, financial assistance, and psychological support to individuals who may lack family support or are struggling with their faith during this challenging time.

www.13riverstrust.co.uk/eden-care-uk

Muslim Burial Fund works to alleviate the financial burden of funeral and burial costs for Muslim families in need. This service has been particularly beneficial for new Muslims and those facing financial hardship. The charity has also extended its support to victims of tragedies such as the Grenfell Tower fire, offering both financial and emotional support during incredibly difficult times.

www.muslimburialfund.co.uk

The 13 Rivers Trust programmes have demonstrated significant impact for the targeted communities, especially for vulnerable members of the Muslim community. By combining practical assistance and emotional support, 13 Rivers Trust has helped large numbers of individuals maintain their faith and dignity during challenging times.

Key Insights

Breaking the Cycle: From Deprivation to Opportunity

Nearly half of British Muslims live in the most deprived areas, leading to significant health disparities and a 19-year gap in healthy life expectancy compared to affluent areas. Targeted socio-economic interventions and improved access to employment are essential for breaking this cycle.

Data Drives Change: Religion-Specific Health Monitoring

The lack of religion-specific health data creates a critical blind spot in understanding Muslim health needs. Incorporating religious affiliation in health data collection will enable more precise interventions and culturally appropriate care delivery.

Trust Rebuilds Health: Ending Institutional Biases

Policies like Prevent have eroded trust in healthcare services among Muslims. Removing institutional biases and developing culturally-sensitive care pathways will rebuild confidence and improve health-seeking behaviours.

Community-led Solutions: From Passive Recipients to Active Partners

Successful initiatives like the British Islamic Medical Association's health campaigns demonstrate the effectiveness of community-led approaches. Government and healthcare providers must engage in full partnership with Muslim organisations, including the Muslim Council of Britain (MCB), moving beyond consultation to genuine co-production of health solutions that serve the community effectively.

Beyond Access: Culturally-Competent Care

Access to healthcare is insufficient without cultural and religious literacy. Training healthcare professionals in faith-sensitive practices and expanding initiatives like health advocates will ensure Muslim patients receive equitable and effective care.

Executive Summary

This toolkit highlights the health and social inequalities faced by Muslims in the UK. Drawing on expert insights and research, the toolkit addresses socio-economic challenges, cultural barriers, and discrimination, offering recommendations to tackle inequalities to improve health and social mobility for the community.

Health and social inequalities are closely linked, with economic disadvantages and cultural factors exacerbating challenges for British Muslims. These inequalities manifest in wealth gaps, limited social mobility, and poorer health outcomes.

Produced by the 13 Rivers Trust charity, the toolkit explains concepts of relative poverty, health inequality, and social determinants of health, emphasising the connection between low income and poor health outcomes. British Muslims often face unmet healthcare needs, especially in mental health, chronic diseases, and end-of-life care. The COVID-19 pandemic intensified these disparities, with higher infection and death rates due to overcrowded housing, low-wage frontline jobs, and limited healthcare access.

Health inequalities are perpetuated by systemic racism, insufficient culturally-sensitive care, and language barriers. Elderly Muslims tend to face worse health outcomes, with poorer self-reported health compared to others. While national data highlights inequalities faced by minority communities (including Muslims), it is crucial to identify whether these gaps are even more pronounced at the local authority level.

Economic inactivity, cultural expectations, and higher unemployment rates among Muslim women compound these challenges, underscoring the need for targeted interventions.

"This toolkit offers a valuable guide to understanding and addressing the health and social inequalities faced by significant numbers within the British Muslim community"

The toolkit offers expert recommendations for policymakers, healthcare professionals, and anyone in a position to tackle the inequalities highlighted, including improved data quality on religion in health studies, promoting cultural awareness in healthcare, and involving British Muslims in policy-making. It also suggests improving socio-economic conditions, expanding education and job opportunities, and supporting community-led health programs. It is imperative to act promptly on available data.

Addressing these barriers is essential for improving social mobility, health outcomes, and civic participation among British Muslims. The toolkit urges healthcare providers, policy-makers, and community leaders to work together towards a fairer society.

13 Rivers Trust hopes that this instalment of the *InFocus* toolkit series offers a valuable guide to understanding and addressing the health and social inequalities faced by significant numbers within the British Muslim community. The 2025 Census summary report, published by the Muslim Council of Britain in April 2025, provides additional relevant statistics and information.[1]

1. WELCOME BY CHAIR

I am pleased to present this important research on health and social inequalities, particularly as they affect British Muslims. This toolkit, by the 13 Rivers Trust, offers a clear look at the challenges faced by the community, from economic disadvantage to barriers in accessing healthcare.

The Muslim community in Britain is diverse, and while there have been improvements in areas like education, significant obstacles remain. Issues such as poverty, limited access to healthcare, and discrimination continue to affect the health and well-being of many British Muslims. These inequalities are closely tied to social and economic factors, as well as cultural challenges, and need to be addressed in a comprehensive way.

The expert insights shared in this toolkit highlight the impact of systemic racism, lack of culturally-sensitive care, and other barriers that contribute to these inequalities. The COVID-19 pandemic also showed how these issues affect communities, with higher rates of infection and mortality among Muslims in Britain.

At 13 Rivers Trust, we believe that addressing these challenges requires both policy changes and community engagement. We support the call for greater involvement of Muslim leaders and organisations in the decision-making process and the development of solutions that are sensitive to the specific needs of this community.

This research is an important step toward understanding the inequalities British Muslims face, and we encourage everyone involved in healthcare, policy, and community work to take note of the recommendations and work together to create a more equal society for all.

Rupina Begum

Chair
13 Rivers Trust

“The expert insights shared in this toolkit highlight the impact of systemic racism, lack of culturally-sensitive care, and other barriers that contribute to these inequalities. The COVID-19 pandemic also showed how these issues affect communities, with higher rates of infection and mortality among Muslims in Britain.”

2. REMARKS BY EDEN CARE UK MANAGER

As the Manager of Eden Care UK, I welcome this important contribution to the ongoing conversation about health and social inequalities affecting British Muslims.

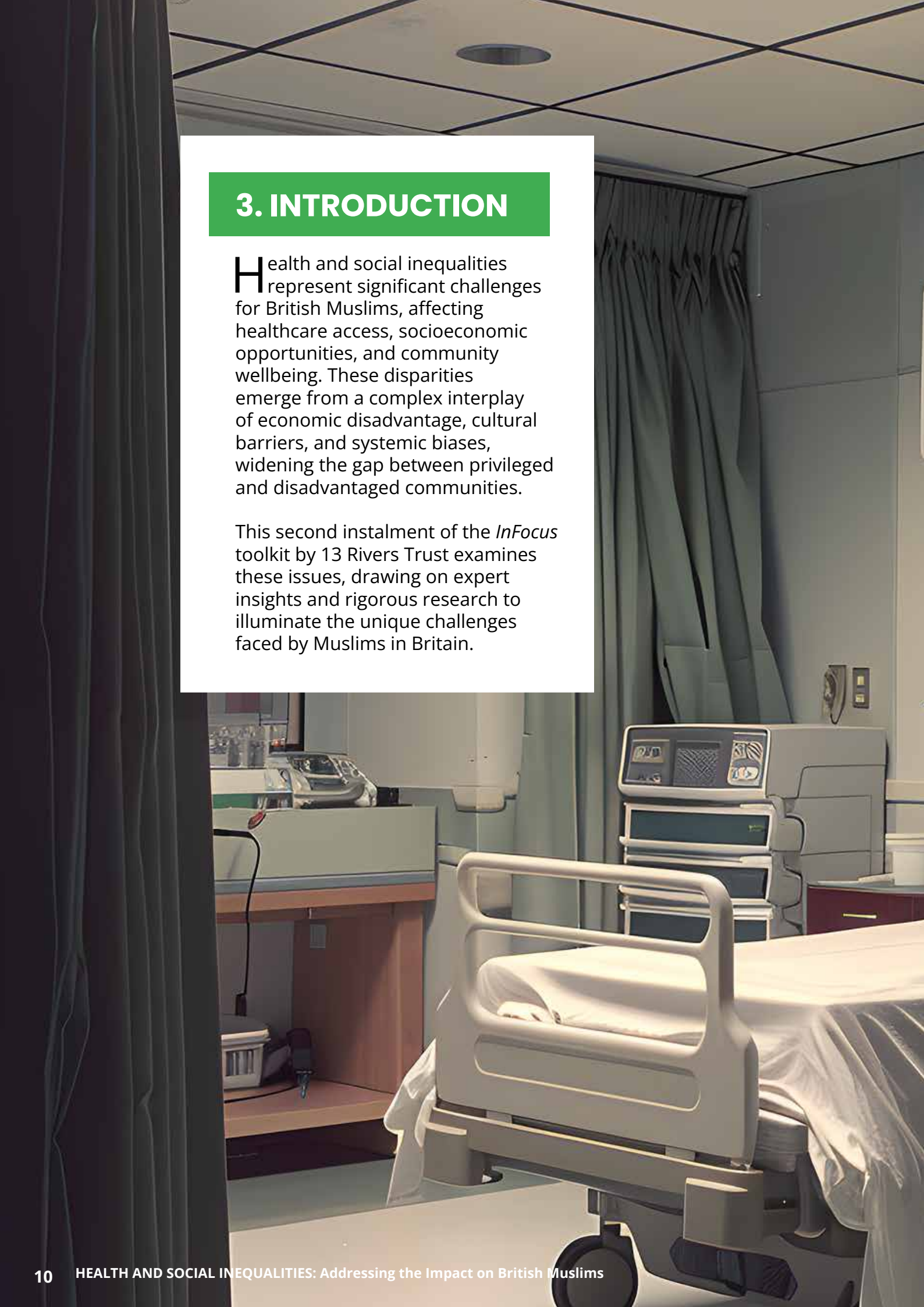
The findings in this toolkit closely reflect the realities we encounter every day in our work with individuals facing terminal illness, chronic health conditions, and isolation.

At Eden Care, we see first-hand how economic hardship, poor access to culturally-appropriate healthcare, and a lack of support at the end of life disproportionately affect members of our community. The issues raised — particularly around mental health, chronic disease, and end-of-life care — are not abstract to us; they are the lived experiences of the people we serve.

This toolkit is timely and necessary. It provides a framework not only for understanding these disparities, but also for responding to them through informed, community-based action. We hope it will guide professionals, policymakers, and community leaders to make meaningful changes that improve the lives of British Muslims – so that dignity in life and in death is not a privilege, but a right.

Nadira Huda

Manager
Eden Care UK



3. INTRODUCTION

Health and social inequalities represent significant challenges for British Muslims, affecting healthcare access, socioeconomic opportunities, and community wellbeing. These disparities emerge from a complex interplay of economic disadvantage, cultural barriers, and systemic biases, widening the gap between privileged and disadvantaged communities.

This second instalment of the *InFocus* toolkit by 13 Rivers Trust examines these issues, drawing on expert insights and rigorous research to illuminate the unique challenges faced by Muslims in Britain.

4. EXPERT CONTRIBUTORS

Dr Asma Khan

Dr Asma Khan is a Research Associate in British Muslim Studies at Cardiff University's Centre for the Study of Islam in the UK. She is a mixed methods (QUANT-QUAL) researcher, with research interests in labour market inequalities, migration, and mental health. Khan has been co-producing projects with third sector groups to help people to live healthy, happy and productive lives.

She is the author of (amongst other titles):
Khan, A. S. (2024). How Do Religious Beliefs Impact Economic Inactivity Among British-Pakistani Muslim Women? *Ethnic and Racial Studies* 47(4), pp.763-784.

Khan, A. S. (2023). Muslim Identities and Mental Health. *Healthcare Counselling and Psychotherapy Journal* 23(4)., pp.8-13.

Dr Shuja Shafi

Dr Shuja Shafi has led a lifelong career in medicine. As former director of Pathology and Public Health Laboratory, he has served in the NHS, the Public Health Laboratory Service and Health Protection Agency as Consultant Medical Microbiologist with an interest in infection prevention and community health protection.

Shafi has undertaken research in clinical and aspects of public health medicine with over 90 publications in professional, peer-reviewed journals. Currently he is Director of the Mass Gatherings & Global Health Network (MGHN).

As former Secretary-General of the Muslim Council of Britain, he has been associated with its reports, including: "Elderly & End of Life Care for Muslims in the UK" (2019), and "Muslim Voices The palliative care needs of British Muslims during the Covid-19 pandemic and beyond" (2024) – the latter jointly with Marie Curie, University College London (UCL) and University of Leeds.

Dr Kambiz Boomla

Dr Kambiz Boomla is a retired GP in the London Borough of Tower Hamlets and Senior Lecturer at Queen Mary University of London, School of Medicine and Dentistry.

His research interests have included equitable delivery of quality improvement programmes in primary health care. He has been chair of the GPs Local Medical Committee, and is currently an officer of Tower Hamlets Stand Up to Racism.

In 2021, Boomla was a commissioner in the London Borough of Tower Hamlets Black, Asian and Minority Ethnic Inequalities Commission. A report and recommendations by the commission was produced in 2021, which called for concerted effort and a leadership approach to close the inequality gap, in particular race inequality, in the borough.

Dr Anna Eleri Livingstone

Dr Anna Eleri Livingstone is a retired GP having worked as a Clinical Lead for the P-RESET service.

Following hospital and GP training, she became a partner at the Gill Street Health Centre in Limehouse, London, in 1983 where she worked until 2012.

Having seen first-hand the impact of language barriers affecting Bangladeshis, especially accessing health, Livingstone studied Bangla, and in particular the Sylheti dialect to better understand the community's needs. She visited Bangladesh several times.

During Livingstone's Sabbatical MSc in Epidemiology (1993-1994) at the London School of Hygiene & Tropical Medicine, she taught medical students and trained GPs. She also conducted public health research as an Honorary Senior Lecturer.

Dr Muhammad Wajid Akhter

Dr Muhammad Wajid Akhter is the Secretary-General of the Muslim Council of Britain (MCB). Prior to being elected as the head of the MCB, he served as an Assistant Secretary-General.

He works as a medical doctor in Essex. He is the founder of a variety of multi-national projects including Charity Week for orphans and children in need; FIMA Lifesavers; and is the co-founder of the Islamic History Channel.

Akhter is also a founding member of the British Islamic Medical Association (BIMA) and the Faculty of Medical Leadership and Management. His passions include history, public speaking, building teams, and travelling. He is the author of *Istanbul: An Islamic History Guide* (Jan 2024, Troubador Publishing).

5. DEFINITIONS AND DISTINCTIONS

Relative Poverty

Relative Poverty is defined by the Organisation for Economic Co-operation and Development (OECD) as a condition in which individuals or families have significantly less income and resources than the average for the society in which they live. This makes it difficult to maintain the standard of living considered normal in that society. It is typically measured as having an income below a certain percentage (often 50% or 60%) of the median income of the population.

The United Nations defines relative poverty as a lack of income or resources compared to other people within a society, which results in the inability to fully participate in everyday activities or to access services that are considered normal for others. This concept emphasises the social and contextual nature of poverty, as opposed to Absolute Poverty, which focuses on basic subsistence.

In the UK, poverty is generally measured and discussed in terms of Relative Poverty rather than Absolute Poverty. Data shows that while absolute poverty is less prevalent in the UK, a substantial portion of the population experiences relative poverty.

The King's Fund and Marmot Review[2] (particularly the landmark study, "Fair Society, Healthy Lives") extensively document poverty as a significant social detriment to one's health, both physical and mental.

- *Direct impact on health:* increased rates of illness and poorer health outcomes due to poor diet, inadequate housing, limited access to healthcare.

- *Social gradient:* residents in deprived areas tend to have significantly lower life expectancy and experience more health problems.

Data from January 2024 reveals that 49% of people in the most deprived areas report that the cost-of-living squeeze is impacting their physical health, compared with 27% of people in the least deprived areas.[3] According to the Centre for Mental Health (CMH), Muslims in Britain are more likely than the general population to face a range of social and economic risk factors and determinants for poor mental health, including poverty, financial insecurity, and inadequate housing. This can be linked to social gradient whereby 40% of British Muslims in England live in the most deprived areas, and a third live in overcrowded homes.

When it comes to getting help, Muslims face stigma, discrimination, and a lack of faith-responsive services.[4]

Therefore, given British Muslims' experience of high levels of poverty rates, we can conclude they are more likely to suffer from poor health outcomes. Muslims are distributed throughout the country, with concentrations in certain local authority areas where, according to Muslim Council of Britain analysis of Census 2021 data, the impact is likely more severe than indicated by national statistics.

Health inequality

To provide clarity, here are definitions of health inequality from key national and international organisations:

National Health Service (NHS) England

Health inequalities refer to the unjust and avoidable differences in people's health across the population and between specific population groups. These differences are often shaped by factors such as socioeconomic status, geographic location, race and ethnicity, gender, and disability.

The definition emphasises that health inequalities are inextricably linked to social determinants and systemic factors, underlining the necessity of addressing these broader social issues to improve health outcomes for all.

World Health Organisation (WHO)

Health inequalities are the avoidable and unfair differences in health status seen within and between countries**.** These disparities are often due to social, economic, and environmental conditions that are unequal and unjust. WHO emphasises that health inequalities arise from the conditions in which people are born, grow, live, work, and age, including the health systems in place.

Centres for Disease Control and Prevention (CDC)

The CDC defines health inequalities as differences in health outcomes and their determinants between segments of the population, which are often associated with social, demographic, economic, and geographic attributes.

The King's Fund – Health Inequalities UK

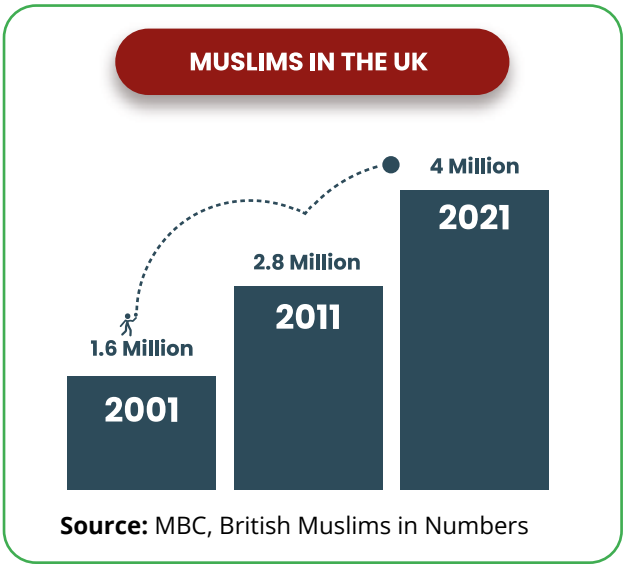
Health inequalities are preventable, unjust, and systematic differences in health among various groups. Since there are different types of health inequalities and ways the term 'health inequality' is used, it is important to specify which measure is unequally distributed and between which groups.

The King's Fund explains that differences in health status disparities can affect people based on various characteristics. In England, health inequalities are typically analysed and addressed through policies that focus on four key factors, collectively known as the Social Determinants of Health (SDH):

1. Socio-economic factors (e.g., income)
2. Geography (for example, region or whether urban or rural)
3. Specific characteristics including those protected in law, such as ethnicity or disability
4. Socially excluded groups (for example, people experiencing homelessness)

6. KEY STATISTICS REGARDING BRITISH MUSLIMS

- Of the UK 67 million UK population, 4 million are Muslim (6%).
- All the minority faiths are growing in population, but the fastest rate is for Muslims. There are more Muslims than all the other minority faiths put together.[5]



Source: MBC, British Muslims in Numbers

- In England and Wales, the proportion of Muslims under the age of 16 is nearly double that of the overall population. The majority (51%) are British-born, with 75% identifying as British, and over 90% speaking English as their main language fluently.
- The Muslim population is ethnically diverse, predominantly of South Asian and African descent, but also includes a wide range of other ethnic groups.
- A Muslim newborn is nearly three times more likely to be born into the most deprived 10% of local authorities in England and has less than a quarter of the chance of being born in the most affluent 10% of local authorities, compared to other newborns.
- Muslims predominantly live in deprived urban areas across the UK, with the highest concentration in London.[6]
- Almost half of the Muslim population lives in the most deprived areas. A staggering reality of living in deprivation is the dire impact on one's quality of life and life expectancy.
- People face a 19-year gap in healthy life expectancy between the most and least deprived areas.[7]
- Residents in deprived areas die seven years earlier, on average, than those in affluent areas.

DIE 7 YEARS EARLIER

- Residents of deprived areas spend an additional 17 years living with disability compared to those in affluent areas.[8]

17 YEARS LIVING WITH DISABILITY

A new report published by the Muslim Council of Britain, titled, *British Muslims in Numbers: Census Report Summary 2025,* provides additional statistics and information about the Muslim community.[9]

- Muslim educational attainment is improving significantly, with 32.3% holding degree-level qualifications in 2021, up from 24.0% in 2011 – growth largely driven by the increasing participation of Muslim women in higher education.

- In some local authority districts, the ratio of Muslim women in education is greater than Muslim men.

- 8.1% of all school-aged children in the UK are Muslim.[10]

- The qualification gap is significant, however, with 26% of the Muslim population have no qualifications. This hinders employment opportunities and integration.

- Social mobility indicators, such as occupational classification, show Muslims progressing more slowly than the general population over the past decade, particularly in higher-level occupations. While the latest Census shows some improvements, these have not translated into the expected positive impacts.

- There is a lack of awareness and uptake of palliative care services among British Muslims.[11] This is partially a direct consequence of the inequalities some Muslims face in palliative and end-of-life care access. This is not helped by lack of research on the experiences of British Muslims with palliative care needs, especially exacerbated by the COVID-19 pandemic.[12]

- The COVID-19 pandemic significantly impacted Muslim communities by exacerbating existing challenges in accessing health and palliative care. Family members experienced the cumulative impact of supporting people with palliative needs while also advocating for and supporting them to access needed care. Language barriers and digital exclusion, amongst other issues, added to their plight, with many stating they feel neglected and deliberately left out

- The self-reported health of British Muslims is broadly in keeping with the overall population, except for the older age group of Muslims, where health deteriorates more markedly. Strikingly, 38% of Muslim women over 65 report bad or very bad health compared to 16% for all women in England.[13] There are similar trends in the case of self-declared disability.[14]

- Mental health needs remain a concern, with 19% of Muslim patients reporting their mental health needs had not been recognised, compared to 8% of the general population.[15]

- British Muslims experience unmet needs towards the end of life. Challenges can include limited training of healthcare professionals regarding faith and cultural values and their implications on care plans. In addition, there is a lack of awareness of palliative care services among British Muslims.[16]

Bangladeshis are the poorest ethnic group and live in London's most deprived areas

Source: Health Inequity Bangladeshi Health Profiles Sep 2024, PIR Team London, London Bangladeshi Health Partnership

CASE STUDY 1

London Borough of Tower Hamlets

Overview

- Fastest growing population in England (22% rise between 2011-2021)
- Most densely populated area in England (15,695 residents per sq km)
- Youngest median age of any area (30 years)
- Disproportionately comprised of working age adults (71% of all residents aged 20-64)
- Ethnically diverse and ranked 16th most ethnically diverse local authority in England out of 325 local authorities
- Largest Bangladeshi population in the country (107,333 residents, 34.6% of the population)
- Somalis make up the borough's largest Black group
- Lessening deprivation but highly deprived populations of older people & children
- Healthy life expectancy at birth increased by 11 percentage points for males and 2 percentage points for females between 2011-13 and 2018-2020, although this data pre-dates the pandemic
- A larger economy than the cities of Birmingham, Manchester, or Leeds, with more jobs (291,000) than working age residents
- Unemployment is higher than the national average for residents (4.6% compared to a national average 3.7%)
- Women are much less likely to be employed (59.7% compared with 72% in Great Britain). While half of adult residents in the borough are highly qualified, 16% have no qualifications at all

Findings of BAME Inequalities Commission 2021 (Tower Hamlets)

Key findings

- Racism is a key barrier in accessing services and progression in life and employment.
- Black, Asian and Minority Ethnic (BAME) residents do not have access to the same social capital as their White peers and this impacts them detrimentally.
- The collection of comprehensive, disaggregated ethnicity data remains largely inadequate, and is needed to better understand service delivery and progress.
- Lack of representation in many areas of public life, or ambitious targets to increase representation, has a profound impact on the way residents perceive, interact, and experience services.
- Structural racism is most apparent in health outcomes of BAME residents which are worse than those of White residents, with the former group suffering a higher burden of multi-morbidity.
- Lack of emphasis on improving the partnership approach to tackle wider determinants of health, including poorer employment and housing.
- Digital exclusion is a prevalent access barrier, exacerbated by the COVID-19 pandemic, alongside ineffective communication and inadequate translation services.

Source: Black, Asian and Minority Ethnic Inequalities Commission 2021, Tower Hamlts Council.

7. WEALTH INEQUALITY AND POVERTY

The history of poverty among British Muslims is intricately linked to migration patterns and socioeconomic challenges. Muslims have been in Britain since the 16th century, with significant migration waves occurring in the 1950s and 1960s from South Asia. This was followed by migrations from conflict zones such as Somalia, Iraq, and Afghanistan. Many settled in industrial towns, where they faced limited job opportunities and discrimination, which contributed to persistent poverty and limited social mobility within these communities.[17]

An increasing number of young British Muslims are growing up in environments characterised by poverty and limited opportunities, which greatly affects their social mobility. According to the Muslim Council of Britain (MCB), areas where Muslims comprise 20% or more of the population rank among the most deprived in the country. MCB's analysis reveals around 400,000 children are growing up in 14 such local authority districts, underscoring the significant challenges faced by young Muslims in impoverished neighbourhoods.

Dr Shuja Shafi, former Secretary-General of the Muslim Council of Britain, author, and expert on health inequalities in minority communities, noted that the connection between health and poverty is most comprehensively documented in the landmark Marmot Review (2010), commissioned by the coalition government. The follow-up publication 'Marmot 10 Years On' assessed progress and revealed conditions had stagnated or worsened, largely attributed to austerity measures. As this updated review coincided with the COVID-19 pandemic but did not capture its impact, a supplementary report was published later that year.

8. THE LINK BETWEEN HEALTH INEQUALITY AND SOCIAL INEQUALITY

Health inequality is inextricably linked to social and wealth inequality, with profound implications for public health outcomes. Research demonstrates that income and wealth disparities lead to unequal healthcare access, different health behaviours, and varying exposure to environmental risks, all significantly affecting health outcomes.

In societies with high income inequality, disadvantaged community members typically have restricted access to quality healthcare, nutritious food, and safe living environments. These disparities result in higher rates of chronic diseases, mental health issues, and mortality. The landmark Whitehall Studies – longitudinal health surveys of British civil servants begun in 1967 – conclusively demonstrated that lower socioeconomic status correlates with poorer health outcomes, including higher rates of heart disease and mental illness.[18]

The COVID-19 pandemic starkly illuminated these inequalities in the UK, exposing significant health outcome disparities that disproportionately affected low-income and minority communities. Nearly all ethnic minority groups, including Black, Asian and Minority Ethnic (BAME) populations, experienced higher rates of infection, hospitalisation, and mortality compared to the White British population. Contributing factors included higher prevalence of pre-existing health conditions and overcrowded housing, which increased transmission risk.[19]

9. HEALTH INEQUALITY AMONGST BRITISH MUSLIMS

Health inequalities affecting British Muslims represent a significant concern highlighted by numerous recent studies. This community faces distinctive challenges resulting in poorer health outcomes compared to the general population. These disparities stem from multiple intersecting factors, including socioeconomic deprivation, racism, and Islamophobia.

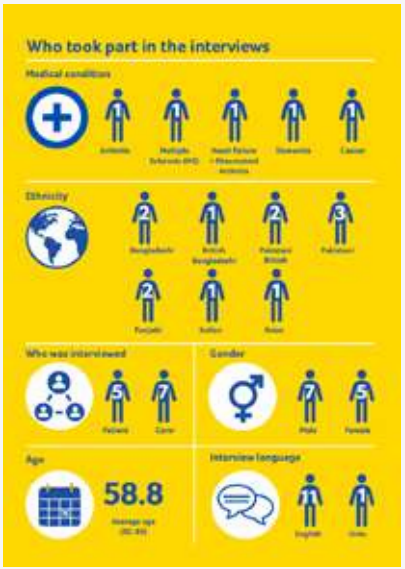
A report, *Muslim Voices: Inequities in Access to Palliative and End of Life Care,*[20] led by the MCB, revealed that British Muslims experienced significant barriers to healthcare access, particularly during the COVID-19 pandemic. The findings identified systemic healthcare issues, including insufficient culturally appropriate services and limited awareness among healthcare providers about Muslim patients' specific needs. Additionally, limited knowledge about available services further compounds these inequalities.

The report also identified significant social and structural barriers – including lower socioeconomic status and discrimination – that hinder British Muslims' ability to access timely and effective healthcare.[21]

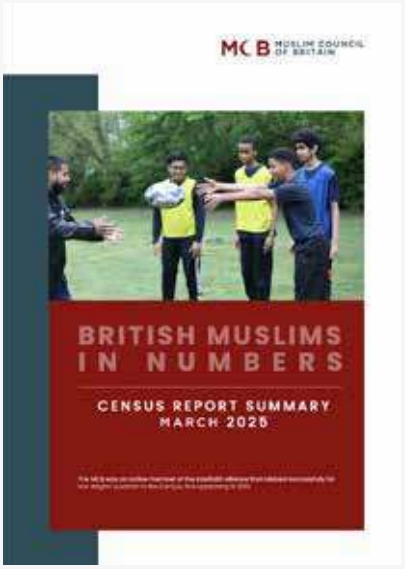
Census data reveals a nuanced picture of health inequalities affecting British Muslims. Historically, a slightly higher proportion of Muslims reported good health compared to the general population, with this positive health perception increasing for both Muslims and the general population between 2001 and 2021.

However, significant disparities emerge in older age groups. Among those 65 and above, only 62.1% of Muslims reported good health compared to 76.3% in the general population – despite Muslims reporting better health across all age groups collectively (91.5%). This 14.2 percentage point gap in self-reported good health among older adults highlights the disproportionate health challenges facing elderly Muslims. For comparison, in the 65-and-over category, those of Jewish faith report the highest levels of good health.

Muslims in his age group report the highest level of bad or very bad health at 24.8%. These findings underscore the broader health inequalities affecting British Muslims and emphasise the necessity for targeted health interventions and policies addressing this community's specific needs.[22]



Source: Muslim Voices: Inequities in Access to Palliative and End of Life Care, MCB & Marie Curie



CASE STUDY 2

Birmingham's Somali community impacted by negative health and social care

A report by Health Watch Birmingham found levels of trust and engagement amongst Somali residents in Birmingham were impacted by negative experiences of health and social care and the challenges and barriers they face when accessing services and experiences of discrimination. It also found the prevalence of dismissive attitudes of health professionals, lack of respect, poor diagnosis and referral to specialist treatment, cultural and language difficulties, stigma and discrimination. The cumulative effect of all this has led to distrust and detachment from health and social care services.[23]

Suad Duale, in her blog, A community in the shadows: experiences of a Somali community in Birmingham, highlights some staggering statics:[24]

- 8 out of 10 Somali children live in 'poor' households with low levels of economic activity and 'high' rates of mental health issues, such as PTSD.
- In the UK, six in 10 (59%) people in the Somali community live in overcrowded accommodation, compared to fewer than one in 10 (8%) of the overall population.
- Many Somali people find it difficult to access health and social care services, due to language and socioeconomic barriers.

"If policy-makers and those in charge were to take action, I would ask that they consider who is sitting at the tables for decision-making and who is advocating for the communities that live in the shadows?"

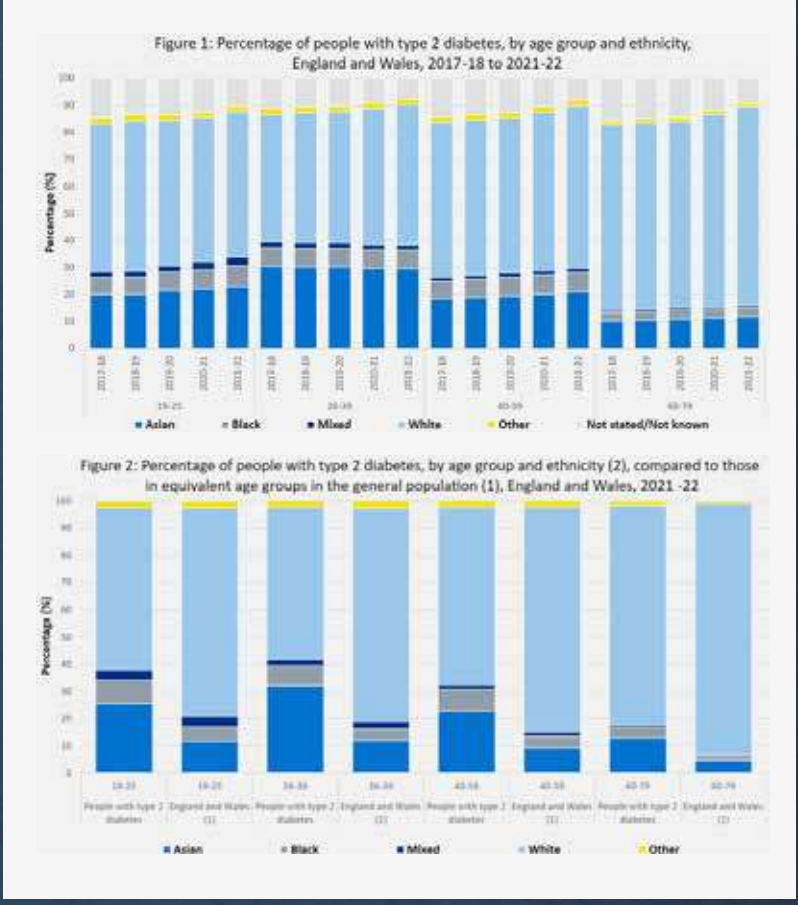
Suad Duale, blogger.

CASE STUDY 3

Bangladeshis face double the risk of Type 2 Diabetes at a younger age

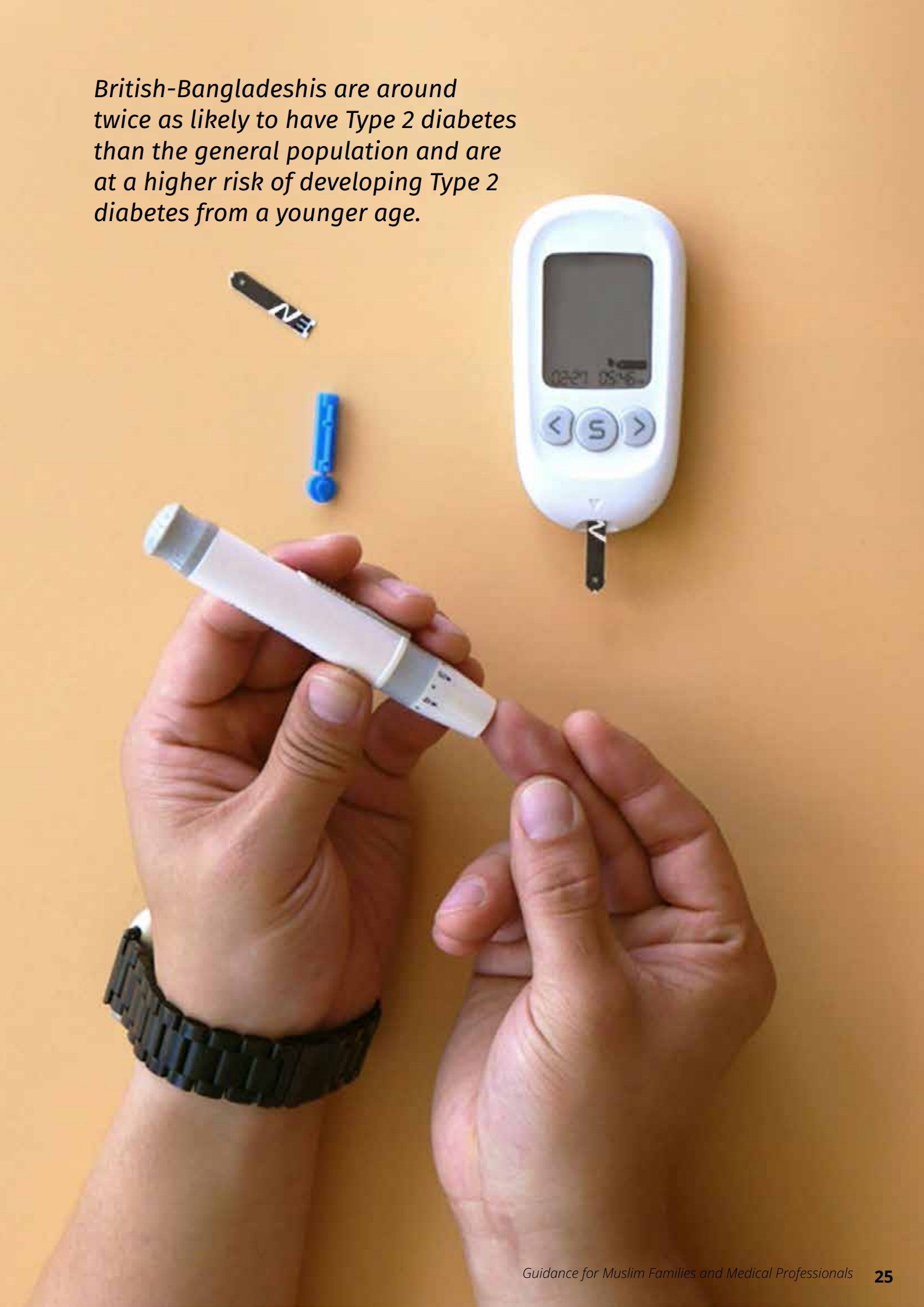
- British-Bangladeshis are around twice as likely to have Type 2 diabetes than the general population and are at a higher risk of developing Type 2 diabetes from a younger age.
- Black and ethnic minority people are not as likely to be prescribed newer medication for Type 2 diabetes and they experience less adequate monitoring of their condition compared to their White peers.

(Above based on epidemiological literature)



Source: Health Inequity Bangladeshi Health Profiles Sep 2024, PIR Team London, London Bangladeshi Health Partnership

British-Bangladeshis are around twice as likely to have Type 2 diabetes than the general population and are at a higher risk of developing Type 2 diabetes from a younger age.



10. SOCIAL MOBILITY

Social mobility is a crucial indicator of progress for disadvantaged communities, reflecting the ability of individuals to transcend their socioeconomic status, access better education and job opportunities, and achieve a better quality of life. The Social Mobility Commission's (SMS) "State of the Nation 2023" report presents an encouraging overview, noting significant upward occupational mobility in the UK, based on the link between parents' and children's job classes.

However, the report also points out that Pakistani and Bangladeshi groups experience the highest rates of downward mobility, potentially attributable due to factors like limited English proficiency, unrecognised foreign qualifications or, simply, discrimination.

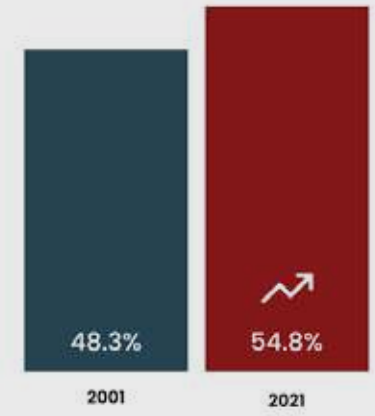
Examining the specific case of the British Bangladeshi population – predominantly Muslim and largely British-born – reveals a paradox. Despite high levels of English fluency (according to the 2021 Census) and increasing participation in further education, downward mobility trends persist within this community. This contradiction points to deeper systemic issues beyond language and immigration status, such as discrimination, limited access to networks and opportunities, and other socioeconomic barriers that obstruct upward mobility.

The experiences of discrimination and socioeconomic barriers affecting upward mobility is not unique to British Muslims, though other communities face varying challenges. The British Chinese community provides an informative comparison – despite similarly high levels of educational attainment, they do not face the same obstacles to upward mobility as British Muslims. Dr Asma Khan, from the Cardiff University's Centre for the Study of Islam in the UK, notes that while there is no single definitive explanation for persistent labour market inequalities affecting Black, Pakistani, and Bangladeshi groups, "there is pretty robust evidence for discrimination on the basis of both ethnicity and religion for these groups".[25]

Research by Professors Anthony Heath, Stephen Fisher, Jean Martin, and other experts demonstrates that minorities in the UK, particularly children of non-European ancestry, face numerous disadvantages in both education and the labour market. These minorities experience what Heath terms 'ethnic penalties' – with the severity of these penalties often intensifying among second and subsequent generations. Heath and colleagues attribute the difficulty in definitively explaining persistent labour market inequalities for non-White minorities

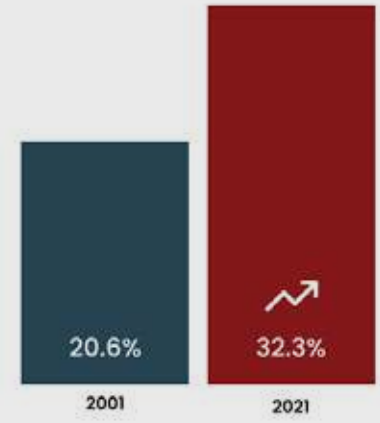
Trends in Social Mobility For England and Wales

(aged 16 years and above)



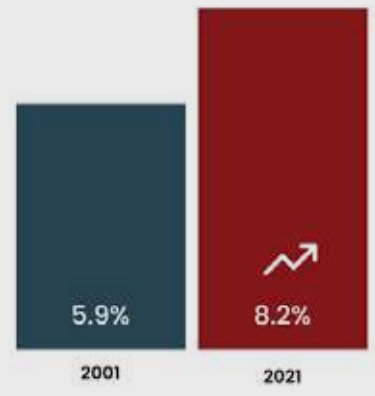
Economic Activity

Muslim population in the labour market



Education & Qualifications

Muslims population qualifying to degree level



Socio-economic Classification

Muslims population in higher managerial occupations

Source: British Muslims in Numbers: Census Report Summary 2025, Muslim Council of Britain

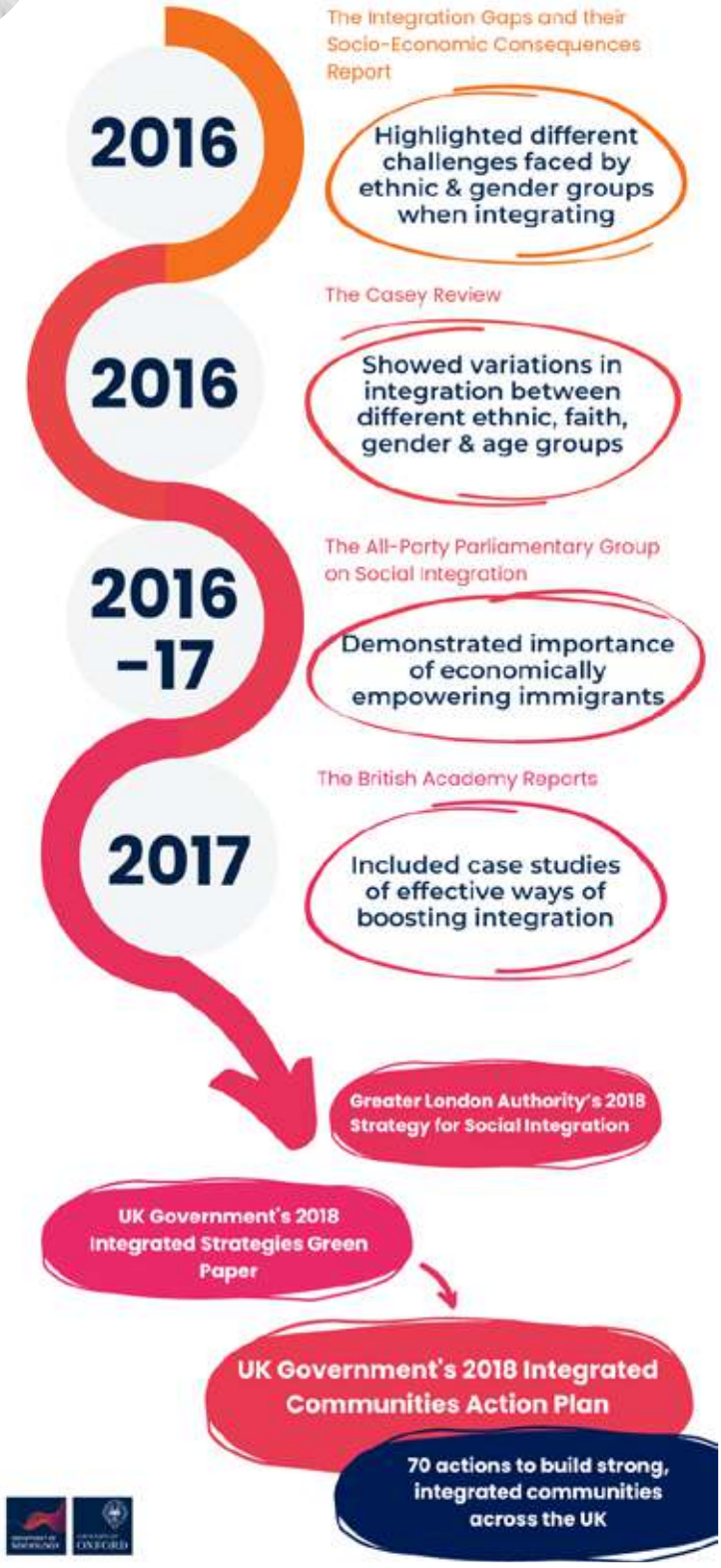
in Britain, as noted by Khan, to conceptual and technical challenges in distinguishing between ethnicity and religion effects, specifically due to what they term the 'identification' problem.[26]

Warning about the discrimination ethnic minorities continue to face in the UK, especially Pakistani Muslims, Heath said:

"The absence of any real decline in discrimination against Black British and people of Pakistani background is a disturbing finding which calls into question the effectiveness of previous policies. Ethnic inequality remains a burning injustice and there needs to be a radical rethink about how to tackle it."[27]

The Rt. Hon. Alan Milburn, chair of the Social Mobility Commission, said: "The British social mobility promise is that hard work will be rewarded. Unfortunately, for many young Muslims in Britain today this promise is being broken." The report by the Mobility Commission states that this trend is predominantly driven by discrimination, particularly against Muslim women, and that "young Muslims are less likely to succeed in the labour market than any other faith group".[28]

Impact of Professor Anthony Heath & team's Research on UK Policy Making



Source: The social integration of ethnic minorities in England, Department of Sociology Oxford University

11. WHY MIGHT MUSLIMS EXPERIENCE POOR HEALTH OUTCOMES?

British Muslims face significant health inequalities due to a variety of socioeconomic and cultural factors. One key issue relates to a large proportion of the Muslim population residing in the UK's most deprived areas, which typically offer limited access to healthcare services, poorer living conditions, and higher levels of environmental stressors. With almost half of the Muslim population living in these deprived areas, their health outcomes worsen considerably, particularly as they age. The opposite is also true, whereby a lack of support for people living with ill health and disability can cause people to be poorer.[29]

Cultural and systemic barriers further compound these challenges. Language barriers and a lack of sensitive healthcare services can prevent British Muslims from accessing appropriate medical care. For instance, older British Muslims report significantly worse health outcomes compared to the general population, with only 62.1% of Muslims aged 65 and above reporting good health, compared to 76.3% in the general population.

High levels of unemployment and economic inactivity among British Muslims further contribute to these health disparities. Unemployment frequently leads to financial stress, poor mental health, and reduced ability to afford healthcare. Additionally, a significant proportion of Muslim women remain outside the labour market, often due to cultural expectations regarding domestic and family care responsibilities, which exacerbates economic vulnerabilities within households.

These factors demonstrate the complex interplay of socioeconomic, cultural, and systemic issues that contribute to health inequalities among British Muslims, underscoring the necessity for targeted health interventions and policies that address these specific challenges. Crucially, while socio-economic deprivation remains the primary determinant of health status across the entire population, its effects disproportionately impact minority groups.

12. INSTITUTIONAL RACISM, PREVENT, AND ISLAMOPHOBIA

Research by Dr Tarek Younis and others, examining the government's Prevent strand of the Counter-terrorism strategy and its impact on mental health, is particularly relevant here, as medical anthropology demonstrates that clinical settings function as microcosms of wider society – with societal discrimination inevitably reflected in healthcare environments. Younis emphasises that the UK stands alone amongst Global North nations in implementing counter-radicalisation as a *statutory duty* requiring compliance from all for all NHS staff members. This widely criticised Prevent strategy disproportionately targets Muslims and, since 2015, officially designates healthcare as a ‹pre-criminal space'.[30]

In practical terms, this statutory duty to undergo counter-radicalisation training is designed to identify and report individuals suspected of extremism or radicalisation. The policy significantly undermines confidence and trust in the NHS among Muslim patients and their families, who often feel reluctant to seek necessary healthcare for fear of unwarranted investigation or compromise of their medical records.

Younis's research on Prevent in the NHS has substantially enhanced awareness of Islamophobia's prevalence in the health sector, particularly as it manifests itself through the framework of 'security'. He argues that the current political climate permeates healthcare settings – thereby institutionalising and legitimising racialised logics in the process. Crucially, Younis asserts that racism extends beyond interpersonal dynamics between patients and staff; the healthcare environment itself becomes racialised through security policies like Prevent.[31]

Younis illuminates the profound ethical dilemmas confronting NHS staff as they attempt to balance patient wellbeing against the prevailing surveillance culture within the healthcare system. The increasingly politicised and securitised environment fundamentally undermines the provision of effective care for Muslim patients and ultimately exacerbates existing health inequalities.

"The UK stands alone amongst Global North nations in implementing counter-radicalisation as a statutory duty requiring compliance from all for all NHS staff members."

CASE STUDY 4

Prevent Referral System within the NHS

The following summarises a typical Prevent procedure within the NHS

If a staff member deems a patient vulnerable to radicalisation, they are required to **inform their NHS safeguarding lead** who gauges the need for a Prevent referral.

If a referral is made, the **patient's file is sent to the police** who assess and cross-examine the patient's information with their local database to ascertain if the patient was under investigation.

At this point, the patient's details are stored in a **special police database** for 7 years, even if the referral is closed.

If the patient is **not deemed a threat but still considered vulnerable to radicalisation, the police may forward the file to Channel**. Every borough has a Channel panel composed of various professionals and local community members who devise an intervention strategy, potentially including mental health services, ideological reprogramming, housing assistance, and other supports.

The patient is then informed of Channel's decision and can choose to reject the proposed intervention, although **failure to comply may lead to a police investigation**.

Source: The social integration of ethnic minorities in England, Department of Sociology Oxford University

13. SUMMARY

Health inequality is profoundly intertwined with social inequality, as evidenced by the experiences of British Muslims. Despite growing educational attainment among Muslims, this community continues to experience downward social mobility trends compared to the wider UK population. Discrimination, cultural barriers, and systemic issues persistently contribute to relative poverty for many Muslims. These structural, cultural, and economic inequalities prove especially detrimental to elderly and vulnerable community members, who encounter substantial barriers to accessing quality healthcare.

Addressing these disparities requires concerted action to tackle the fundamental causes of social inequality. By prioritising equal opportunities and actively combating discrimination, the UK can establish foundations for health equality, ensuring all communities – including British Muslims – gain access to essential resources and support for healthier lives.

The development of clear, culturally-sensitive, and targeted healthcare services and socioeconomic support for the Muslim community is essential. This process must meaningfully involve policymakers, healthcare professionals, and Muslim community representatives at all levels – from conception through design to delivery of healthcare services and policies. Fundamentally, there must be explicit acknowledgement of the systematic barriers, including institutional policies like Prevent, as well as racism and Islamophobia, that undermine care and support for Muslims within health and social care settings.

This toolkit concludes with a comprehensive set of recommendations designed to address the specific issues highlighted throughout this publication.

"The development of clear, culturally-sensitive, and targeted healthcare services and socioeconomic support for the Muslim community is essential. This process must meaningfully involve policymakers, healthcare professionals, and Muslim community representatives at all levels ... "

14. INSIGHTS FROM EXPERTS

A group of experts were interviewed for this toolkit on the topic of health and social inequalities facing British Muslims. The sections below summarise the extent of these inequalities within the British Muslim community on a range of different factors.

1. Health Inequalities

British Muslims face significant health disparities, but pinpointing these inequalities remains difficult due to the lack of religion-specific health data. **Dr Asma Khan**, a Research Associate in British Muslim Studies at Cardiff University's Centre for the Study of Islam in the UK with expertise in labour market inequalities, migration, and mental health, explains that "religion is a protected characteristic, yet we don't have the means to identify specific disparities". While health-related data can be inferred from ethnic groups such as Pakistani and Bangladeshi populations, this approach excludes other Muslim groups, highlighting the need for more comprehensive research.

Access to healthcare remains a major challenge. **Dr Kambiz Boomla**, a retired GP and Senior Lecturer at Queen Mary University as well as was a former commissioner in the London Borough of Tower Hamlets' Black, Asian and Minority Ethnic Inequalities Commission, emphasises that although British Muslims receive comparable care once they access secondary health services, the primary challenge lies in delayed access, often due to communication barriers and institutional bias. **Dr Muhammad Wajid Akhter**, a doctor in Essex, an author, and a council member of the British Islamic Medical Association as well as recently assuming the leadership of the MCB, said "there is probably no single area of healthcare in which British Muslims are not significantly underperforming or disadvantaged".

Cultural and linguistic barriers exacerbate these disparities. **Dr Anna Eleri Livingstone**, a retired GP serving as the Clinical Lead for the P-RESET service, notes that "class, educational, language, and cultural differences contribute to institutional racism in terms of both risk reduction and seeking medical care", highlighting the interplay between cultural factors and healthcare access.

2. Impact of COVID-19

The COVID-19 Pandemic disproportionately affected British Muslims due to structural inequalities. Khan identifies several key factors, including language barriers and overcrowded households, especially in South Asian families, that contributed to the higher rates of infection and mortality.

Khan provides further breakdown:

- Language barriers that impacted access to public health information, around half of British Muslims are first-generation migrants
- Socioeconomic disparities including working in manual jobs that didn't allow working from home. High levels of unemployment among Muslim men, and low levels of economic activity among Muslim women, may have meant that these families and communities had less access to resources that facilitated health and wellbeing in constrained circumstances during periods of lockdown (e.g., outdoor spaces such as gardens or home-learning resources)
- Household overcrowding, especially in South Asian families
- Reliance on family and community networks and in-person interactions for support in light of structural disadvantage
- Structural discrimination in health and social care support provision

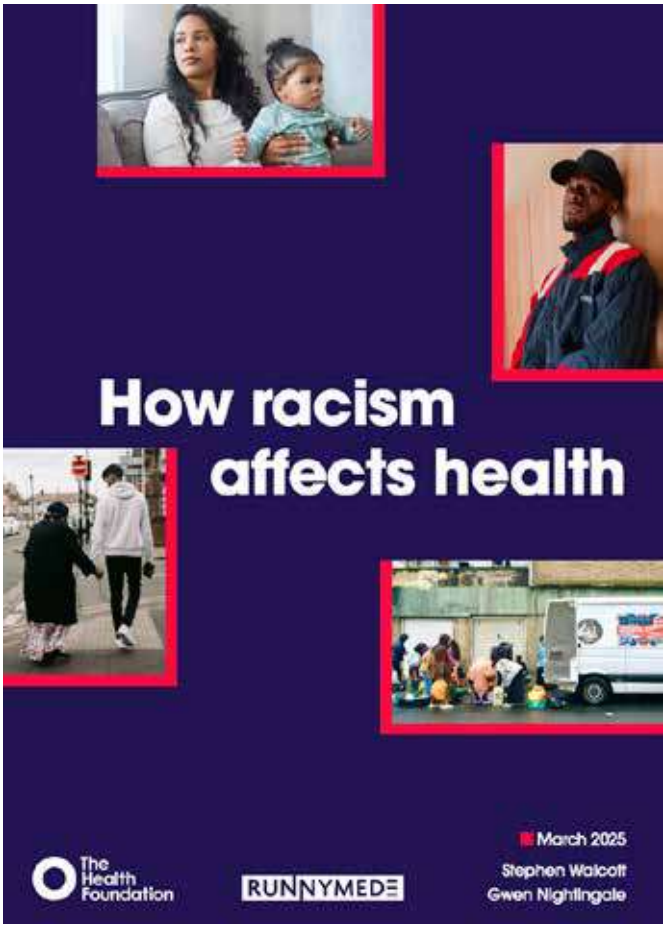
This vulnerability was exacerbated by the types of work many British Muslims engaged in, such as frontline, low-wage jobs, where working from home was not an option. Akhter observed that pre-existing conditions, like high BMI and undiagnosed hypertension, which might have seemed manageable before, became critical risk factors during the pandemic.

Boomla added that it was not greater genetic susceptibility that caused higher infection rates among ethnic minorities, but rather greater exposure due to social and economic factors. He explains, "Ethnic minority healthcare staff were more exposed than their White counterparts, contributing to worse outcomes."

3. Structural Racism

Structural racism in health and social care systems has been a persistent issue affecting British Muslims, both during the COVID-19 crisis and more broadly. Akhter highlighted a stark example during the pandemic when the government refused to engage or collaborate with the Muslim Council of Britain, the largest representative body of Muslims in the UK. This was a decision that "could have saved many thousands of lives", lamented Akhter. Similarly, another former Secretary-General of the Muslim Council of Britain, Dr Shuja Shafi, said the non-engagement with the organisation "very possibly had an impact on how the pandemic impacted our communities".[32] He added that engagement and collaboration is important at the local level.

Welcoming a new report by the Runnymede Trust, *How Racism Affects Health*, its CEO Shabna Begum, explained that the "building blocks of health are experienced unequally by different communities of colour, and that there are patterns of inferior experience and greater hardship that cannot be explained through social class status alone".



"Many of these disparities and experiences Muslims and other ethnic groups face today relate to earlier legacies of exploitation, extraction, and associated migration patterns"

She pointed out how structural racism is a defining factor, not only exacerbating the worst experiences of working-class communities, like many British Muslims, "but ethnic minorities are often locked into that social class status in the first place". Moreover, many of these disparities and experiences Muslims and other ethnic groups face today relate to earlier legacies of exploitation, extraction, and associated migration patterns.

MCB MUSLIM COUNCIL OF BRITAIN


THE TIMES

Minister flouts Whitehall policy to attend Muslim Council event

Sir Stephen Timms, the minister for social security and disability, was at the group's annual leadership dinner despite the 'non-engagement' policy

"MCB'S work [has been] praised by the [government's] Sage science committee's behavioural subgroup, which said the organisation was "more trusted" than the government by some British Muslims."

The disparities are clear in COVID-19 mortality rates. Khan points out that "Asian and Black people were more likely to die from Covid than other ethnic groups, even after controlling for age and health status". British Muslims experienced the highest age-standardised mortality rates among all religious groups during the pandemic, with 198.9 deaths per 100,000 males and 98.2 deaths per 100,000 females.[35] These figures highlight how systemic racism and discrimination, often embedded within healthcare systems, continue to shape outcomes for British Muslims.

Additionally, Boomla observed that ethnic minority health professionals, including Muslims, were less likely to be promoted to managerial positions, leaving them disproportionately exposed on the front lines of care during the Pandemic.

CASE STUDY 5

Government non-engagement with MCB is institutional Islamophobia

As to why the government did not engage the MCB, Akhter replied that this was a question for the government to answer: "Why the government decided not to engage at a time of national crisis, when we are all supposed to work together in the national interest, is a question only the then government can answer." His predecessor and the first female Secretary-General of the MCB, Zara Mohamed, complained that the government's refusal to engage the MCB during the pandemic has had "tragic consequences" and called on ministers to reconsider a policy of non-engagement with it.

The reality is that other faith-based and democratic bodies have not been excluded in the same way at a time when there were concerns about vaccine uptake amongst minority communities. This non-engagement policy was implemented despite the MCB offering regular guidance to the community on safety and other issues during the pandemic, including disseminating detailed guidance for individuals and mosques[33] and had its work praised by the Sage science committee, commending MCB as "more trusted" than the government[34] by some British Muslims.

The fact is that the MCB has been blacklisted by successive governments, on unsubstantiated claims, and without a change in policy by the new Labour government. To many, this policy is an example of institutional Islamophobia and political interference to isolate mainstream Muslim organisations the government does not agree with. This is despite the MCB not found to be guilty of any illegal actions.

4. Mental Health Challenges

Mental health challenges are stigmatised in many communities, and British Muslims face unique barriers in accessing mental health support. According to Khan: "Mental health carries stigma in all communities, but attention has disproportionately focused on Muslims, drawing attention away from structural issues that need urgent attention." She emphasised that "public health bodies have a role to play in making information about identifying mental health problems and signposting to sources of support more accessible to diverse communities". Mosques are one, but not the only, location where this information might be effectively shared, she added, and other local grass-roots community organisations can also be effective in dealing with mental health challenges affecting Muslims.

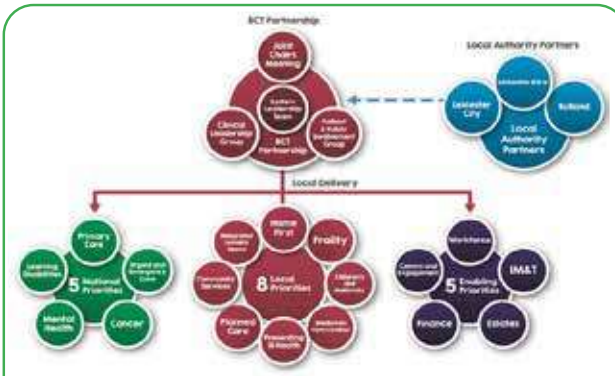
Low levels of mental health literacy within British Muslim communities, compounded by social and economic factors, such as language barriers and low education levels, impede help-seeking behaviour. Akhter stressed the need for culturally-sensitive approaches, praising initiatives like MindSavers, which teaches mental health and First Aid in mosques. He noted that services are more effective when "designed with Muslim communities rather than imposed as a one-size-fits-all solution".

Livingstone pointed out that mental distress in older Muslim women often manifests physically, describing how "depression of isolation, lack of language, is often expressed as 'pain all over'". This makes diagnosis and treatment more complex in a healthcare system that may not be equipped to recognise these presentations.

Khan highlighted further two barriers that can prevent Muslims accessing or receiving mental health support. These relate to *firstly*, some Muslims viewing mental health challenges as a punishment from God which impacts on how an individual, and the community around them, views their mental health problems. The second barrier relates to the close-knit nature of many British Muslim communities, commonly on the basis of ethnic belonging, meaning that families and households can be dependent on their local ethnic communities for social, and sometimes socioeconomic, support.

Elaborating, Khan argues that the largely close-knit composition of Muslim family structures can mean "deviance from ethnic cultural norms can be the subject of community-level scrutiny and can lead to a loss of essential support systems". It can also impact long term life chances, she adds, such as gaining employment or finding a suitable marriage partner. This may lead to individuals not seeking support when needed.

Whilst acknowledging there may be evidence of close-knit family and community structures within the Muslim communities increasingly breaking down, Khan asserts that, in comparison to other groups, Muslim ethno-religious groups still display high levels of co-ethnic density both in terms of area of residence and social networks.



Source: Better Care Together

5. Social Determinants of Health

The social determinants of health, such as housing, employment, and education, play a significant role in the health disparities experienced by British Muslims. Overcrowded, multi-generational housing is identified as a significant factor to the higher rates of COVID-19 in Muslim communities. Akhter highlighted that "low incomes, being from a minority, and having multiple caring responsibilities create the perfect storm where health slides down the priority list".

Housing conditions in densely populated urban areas exacerbate these challenges. Livingstone discussed how the pandemic exposed the limitations of poor housing, where many lacked the privacy and resources needed for activities like online schooling, which had repercussions for both mental and physical health.

"Greater involvement of Muslims in public spheres, through work and employment, will create greater and more positive representations of British Muslims as valuable members of British society".

Khan emphasised that poverty and employment discrimination significantly impact health outcomes, explaining that "poverty and deprivation are major risk factors for poor physical and mental health". She stressed the need for equal access to jobs and adult education to help improve the socioeconomic conditions of British Muslims.

6. Impact on Families and Communities

Health and social inequalities have long-term consequences for British Muslim families and communities. Akhter illustrated the personal impact of broken families, elderly suffering from uncontrolled diabetes, and mental health issues spiralling out of control. "The burden is felt by real people and cannot be hidden by statistics," he remarked.

On a broader scale, social inequalities disrupt community cohesion. Livingstone pointed out that the ongoing housing crisis and deteriorating infrastructure in many areas, particularly in the London Borough of Tower Hamlets, have left families isolated and disconnected from essential support systems. This further contributes to mental health issues and long-term social dislocation.

Meanwhile, Boomla warned that political scapegoating of Muslims, particularly by Far-Right groups, adds to these challenges. He explained that: "The Far-Right scapegoats Muslims for being responsible for the lack of housing and healthcare, exacerbating the inequalities they already face."

Khan stressed the need to improve the socioeconomic circumstances of Muslims, which she views as key to improving their health. "Poverty and deprivation are major risk factors for poor physical and mental health. This means removing barriers and challenges to accessing good employment." She further adds, "Muslims need to have equal access to jobs, and there is ample evidence of discrimination in hiring practices." She also highlighted that British Muslims lack proper access to adult training and education because this is poorly funded across the UK.

Currently, there can be waiting lists of up to two years or more for access to ESOL classes and this is a significant

problem for recent migrants who are seeking to join the labour market. She argues that accessing information about the state welfare system, particularly Universal Credit, will allow families to make decisions about how employment will improve the financial circumstances of the household. This will allow greater social and geographic mobility for Muslim families.

Greater involvement of Muslims in public spheres, through work and employment, will create greater and more positive representations of British Muslims as valuable members of British society who are contributing to its social, economic, and cultural wellbeing, and effectively challenge negative stereotypes.

CASE STUDY 6

How can we dismantle health inequality together?

Based on a workshop facilitated by National Voices on the future of better health provisions for the community

What should a fairer health alliance or network prioritise?

Mentimeter interactive results

Source: How Can We Dismantle Health Inequity Together? National Voices' conference to realise the power of the voluntary sector, March 2021

7. Improvement Examples

Despite these challenges, there are examples of community-driven initiatives that have effectively addressed specific health and social inequalities faced by British Muslims. Akhter highlighted grassroots programs like LifeSavers, a CPR training initiative in mosques, and the Healthy Ramadan campaign, both of which use culturally appropriate education and trusted community spaces to spread health awareness. This could include healthy Ramadan campaigns, and so on.

In Tower Hamlets, Livingstone discussed the role of health advocates in bridging the language and cultural gaps between healthcare providers and patients. "Health advocates have played a crucial role in improving access to healthcare for Bengali and other Muslim communities," she remarked.

Boomla emphasised the importance of countering Far-Right narratives and uniting communities through collective action, adding that these movements demonstrate solidarity and resilience.

8. Culturally-Competent Care

The role of culturally-competent care in improving health outcomes for British Muslims cannot be overstated. Khan explained that culturally sensitive care creates more meaningful assessments and treatment plans, allowing healthcare practitioners to understand how religious beliefs and ethnic norms may influence a patient's wellbeing. She noted that: "Culturally competent care is essential in creating holistic and meaningful assessments of health problems."

"Health advocates have gone beyond simple translation to help[ing] Muslim patients articulate their needs in ways healthcare professionals can understand. This has helped bridge the gap between patients and providers, ultimately leading to better care."

Boomla added that health advocates have gone beyond simple translation to help Muslim patients articulate their needs in ways healthcare professionals can understand. This has helped bridge the gap between patients and providers, ultimately leading to better care.

Livingstone also shared her own experience learning Sylheti (Bangladeshi dialect) to communicate better with Bangladeshi patients, reflecting on the importance of building trust through language and cultural understanding.

9. Ethnic Comparisons

Many of the health inequalities found in the Muslim community also exist in other ethnic minority groups and even in the White working-class population. Akhter observed that "there is a large overlap between Muslim health inequalities and those of other minorities and the white working-class population", suggesting that poverty and socioeconomic status are key drivers of these disparities.

Livingstone pointed out that health challenges like smoking, obesity, and poor diet are not unique to Muslims, but are common among disadvantaged groups. "It isn't religion that creates the main differences, but poverty and structural factors," she added.

10. Community Involvement

Empowering local communities and leaders to create solutions for these inequalities is vital. Khan stressed the importance of long-term, meaningful engagement, stating that: "The work of meaningful engagement with marginalised communities requires partnership approaches that take time and resources."

Akhter called for a unified national plan to address inequalities at all levels, from legislative to individual, emphasising that "strong, authentic partnerships need to be developed from the start, not as an afterthought".

Boomla highlighted how collaboration between the NHS and Muslim organisations, such as vaccine outreach at the East London Mosque, has shown the potential for positive outcomes when communities and health services work together. Shafi also welcomed the recent public consultation process initiated by the Health Secretary Wes Streeting which seeks to gather feedback on the future of the healthcare system and develop a new 10-year plan for the NHS in England. It is important Muslims engage with this process and make their views known.

Shafi further pointed out that there are a number of changes and developments that if pursued properly will make an improvement which involves community contribution and consultation. There has been a phenomenal amount of excellent work done by Muslim communities – especially during the COVID-19 pandemic led by the likes of Muhammad Wajid Akhter through the British Islamic Medical Association. All of this, Shafi pressed, needs to be publicised more widely and to the wider community.

He further added: "The government, policy makers and service providers realise the need for civil society input – they talk about a culturally-appropriate, faith-sensitive approach to addressing health inequalities. There is a genuine realisation that without meaningful community engagement, equitable care cannot be achieved.

"We have the will and passion to play our part but this is not enough – there is an urgent need to capacity-build our organisations and institutions to respond to our challenges of the day."

15. RECOMMENDATIONS

To address the structural and systemic factors contributing to health inequalities impacting Muslims in Britain, our experts propose the following actionable recommendations:

1. **Better Data Collection**
   Implement standardised recording of religious affiliation across NHS and social care services, particularly in areas with high Muslim populations. Fill critical gaps in longitudinal health studies by including religion as a mandatory demographic indicator alongside ethnicity. Include standardised questions on religious affiliation in all health and social care data collection systems. Use comprehensive, disaggregated ethnicity data to identify and address inequalities and effectiveness of services and provisions.

2. **Connect Government to Muslim Communities for Better Health Outcomes**
   Establish formal consultation channels with diverse Muslim organisations, including the Muslim Council of Britain, without preconditions. Create regional health advisory boards with Muslim representation to inform policy development and service design.

3. **Mental Health Focus**
   Redirect attention from stigmatising narratives about Muslim mental health toward addressing structural barriers to care. Fund research into effective, culturally appropriate mental health interventions while training healthcare professionals on cultural sensitivity.

4. **Reverse Austerity**
   End budget cuts to public health services in deprived areas with high Muslim populations. Restore community health programmes, preventative care initiatives, and local support services that have faced significant funding reductions. Health and care system leaders must work proactively to understand and respond to the cost-of-living crisis in their area.

5. **Address Institutional Biases**
   Address the crippling effects of structural racism and Islamophobia in health and social care systems (e.g. the statutory duty on NHS staff to report Muslim patients suspected of extremism and radicalisation). Remove institutional biases and develop culturally-sensitive care pathways to foster trust and confidence, and improve health-seeking behaviours. Initiate and showcase anti-racist pledges to include tangible actions to drive improvement in health, employment, services, and procurement.

6. **Foster Economic Opportunity**
   Remove employment barriers through anti-discrimination enforcement, anonymous job applications, and targeted skills development. Implement employer education programmes to combat hiring bias and establish mentorship schemes connecting Muslim professionals with young job seekers.

7. **Make Welfare Accessible to the Most Vulnerable**
   Create multilingual resources explaining Universal Credit and benefits entitlements. Fund community advocates to provide guidance on navigating the welfare system and train Job Centre staff on cultural sensitivity.

8. **Enhance Cultural Intelligence**
   Develop mandatory training for healthcare professionals on faith practices and the cultural needs of Muslims and others. Create healthcare environments that accommodate religious requirements including prayer spaces, same-sex care options, and Halal food choices.

9. **Better Engagement with Muslim Organisations and Experts**
   Position Muslim organisations at policy planning stages rather than just implementation. Provide funding for Muslim community organisations to develop and deliver health initiatives shaped by local needs and expertise. Muslims need to be engaged in the design and delivery of services which impact them.

10. **Expand Training**
    Fund accessible mental health first aid training specifically for mosque leaders, imams, and community workers. Develop certified programmes on health inequality delivered through community venues with flexible timing to maximise participation.

11. **Foster Sustainable Partnerships**
    Establish long-term partnerships between health authorities and Muslim communities with shared decision-making power. Compensate community members for their expertise and time when contributing to health service development.

12. **Showcase a Representative and Diverse Health Service**
    Create media partnerships to highlight positive Muslim contributions to British healthcare and society. Support Muslim healthcare professionals through leadership development programmes to increase visibility in senior positions.

13. **Support Research**
    Establish scholarships and mentorship programmes for Muslim students pursuing careers in public health, social care, and health policy. Fund research positions focused on health inequalities affecting British Muslims at leading universities.

14. **Target Poverty**
    Implement targeted poverty reduction strategies in high-deprivation areas with significant Muslim populations. Address housing quality, fuel poverty, and food insecurity through coordinated local authority and NHS partnerships.

15. **Accessible in English Primarily, and Other Languages When Needed**
    Expand accessible English language provision with vocation-specific courses for healthcare and social care settings. Develop professional interpretation services with staff trained in medical terminology and cultural sensitivity.

16. **Proactive Muslim involvement**
    Constructive and proactive engagement by Muslims and Muslim organisations to promote community health awareness and literacy through mosques, community centres, and Muslim media channels. Support and get involved with initiatives to represent and facilitate access to hard-to-reach populations and provide valuable cultural expertise to

SIGNPOSTING

Below are useful support groups, organisations and resources.

Eden Care UK
Helping people who are terminally or chronically ill, or feel isolated. Eden Care's trained team members are here to listen to you.

13riverstrust.co.uk/eden-care-uk

Muslim Burial Fund
Helping Muslim families in need, especially anyone experiencing financial difficulties to pay for funeral and burial costs.

muslimburialfund.co.uk

Muslim Council of Britain
As the UK's largest Muslim representative body, MCB has produced a series of reports, toolkits, and guidelines on health and social inequalities. It works closely with affiliate medical bodies, recognising the importance of bringing together medical expertise with community representation to effectively advocate for the health needs of British Muslims. mcb.org.uk

MindSavers
A national initiative designed especially for Muslims to learn how to improve their own mental health and support others. britishima.org

British Islamic Medical Association
BIMA works to engage on health inequalities, advocating for equitable care, and building bridges between communities. britishima.org

Muslim Youth Helpline
A national helpline offering free and confidential faith and culturally sensitive support services targeted at vulnerable young people in the UK.

myh.org.uk

The Lantern Initiative
A Muslim-run Social Enterprise, based across Peterborough and Leicester, addressing mental health issues in the Muslim community, to help break down the associated stigma and to empower communities in seeking and accessing relevant support.

thelanterninitiative.co.uk

Stand Up to Racism
A trade union network that campaigns against racism and the Far-Right.

standuptoracism.org.uk

Keep Our NHS Public
A campaign committed to calling for health equity, reversing the privatisation of the NHS and its services. keepournhspublic.com

British Board of Scholars and Imams
A national assembly of Imams and scholars, that promotes intra-Muslim dialogue and provides guidance to the community on pertinent issues, including community health and mental wellbeing. bbsi.org.uk

FutureLearn short course, Cardiff University
Understanding Mental Health in Muslim Communities
Explore the distinctive mental health experiences of Muslims and how mental health support can be improved in Muslim communities.

bit.ly/4m50dAk

Better Care Together
Working to enable clinicians, NHS and local authority staff, patients and carers to improve the way we care for local people. The partnership includes the six NHS organisations working alongside the three principal local authorities in Leicester, Leicestershire and Rutland. bit.ly/4dgT385

FURTHER READING AND RESOURCES

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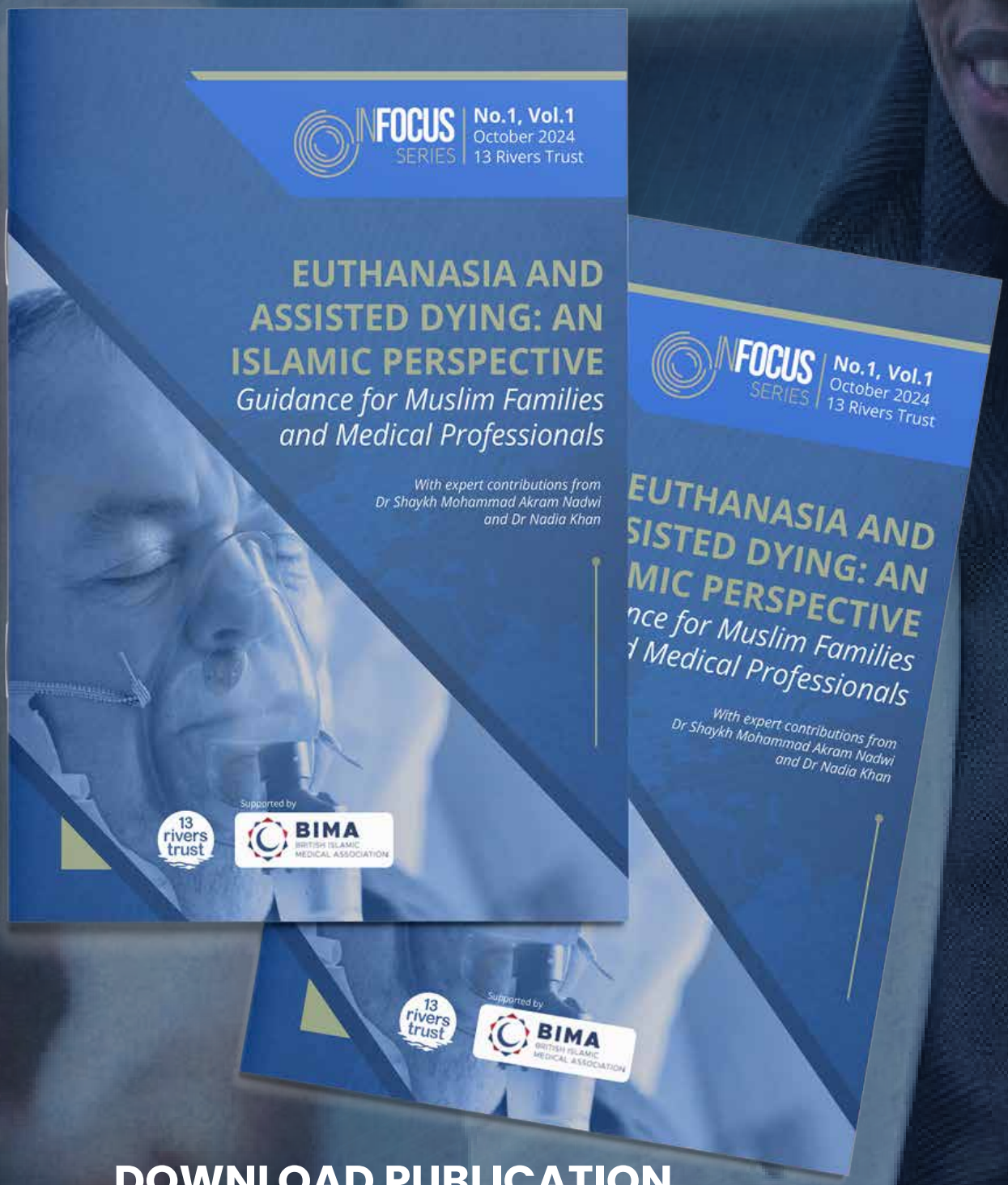

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HOW EDEN CARE UK CAN HELP TERMINALLY-ILL PATIENTS?

Befriending and Advocacy

Our Befriending and Advocacy Service engage terminally ill people and those reaching End-of-Life and enhance their quality of life. We provide a 1-1 person-centred approach.

People referred to our project are paired with a Befriender to support them with their personal, social and spiritual needs.

Befrienders offer friendship and advocacy support to help the service-user overcome issues and difficulties.

Creative Arts

We use Creative Arts sessions to help reduce anxiety and stress amongst people who are socially isolated and those reaching End-of- Life.

We help improve cognitive and physical wellbeing. We also use artistic expression to improve mental health and wellbeing.

We deliver Creative Arts sessions from hospitals, nursing homes, hospices and day care centres.

eden care

We befriend people who are terminally ill and those reaching End-of-Life

We provide dignity, care and sense of self-worth through friendship.

We advocate for quality of care and enhanced life choices

We tackle social isolation for older people through befriending and social activities

Rapid Response

Our Rapid Response Team provide speedy support to people and their families reaching End-of-Life. Our intervention includes providing advice and guidance as well as practical help with food and transport during their hour of need.

A designated group of trained volunteers respond quickly to the needs of people and their families. We visit them in their home, hospital, care homes or hospices.

Raising Awareness of End-of-Life

We promote awareness of End-of-Life issues within BAME communities and create platforms through seminars and workshops as well as through dialogue between the community, practitioners, mainstream provisions and service users.

We are committed to improving existing End-of-Life Care to meet the needs of the BAME community and promote greater partnership working between voluntary sector organisations and the statutory sector.

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