

JUNE 2011

REPORT



ISPU

MEETING THE HEALTHCARE NEEDS OF AMERICAN MUSLIMS: Challenges and Strategies for Healthcare Settings

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Institute for Social Policy and Understanding



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Acknowledgements

This study was funded by the Robert Wood Johnson Foundation Clinical Scholars Program and the Institute for Social Policy & Understanding. We thank our respondents for sharing their time and insights with us, as well as our community partners and steering committee members for their support and invaluable recruitment assistance: Muzammil Ahmed MD, Hamada Hamid DO MPH, and Shireen Zaman MA (all from the Institute for Social Policy & Understanding); Najah Bazy RN (Islamic Center of America); Adnan Hammad PhD (Arab Community Center for Economic & Social Services); Mouhib Ayyas MD (Islamic Shura Council of Michigan); and Ghalib Begg (Council of Islamic Organizations of Michigan). We also express gratitude to our academic mentors and collaborators for assistance throughout the project: Michele Heisler MD MPA (the Robert Wood Johnson Foundation's Clinical Scholars Program), Michael D. Feters MD MPH MA (Department of Family Medicine, University of Michigan) and Sonia Duffy PhD RN and Jane Forman ScD, MHS (both from the VA Ann Arbor Healthcare System). We also thank Amanda Salih MPH and Heather Tidrick MSW for helping to code manuscripts and qualitative data analysis. Lastly, a note of thanks to our troupe of research assistants, namely, Afrah Raza, Shoaib Rasheed, Ali Beydoun, Nadia Samaha, David Krass, Imen Alem, and Samia Arshad MPH, for their invaluable assistance.

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Executive Summary

The Islamic values and cultural practices of American Muslims can play a role in community health disparities by influencing health behaviors and healthcare-seeking patterns and presenting challenges within the healthcare system. To date, scant empirical research has been conducted in collaboration with this community in order to better understand their beliefs and perceived challenges. This report is based on the analysis of qualitative data from semi-structured interviews and focus groups collected through a community-based participatory project with American Muslims living in southeastern Michigan. Specifically, our aim was to (1) identify key health beliefs and practices within the community, (2) gain a better understanding of these beliefs and practices and how they may impact the seeking of healthcare services, and (3) identify clinical situations that pose cultural challenges within healthcare. This report provides an overview of American Muslim health beliefs, describes how these beliefs impact healthcare-seeking practices, and recommends accommodations that can improve the healthcare experience of American Muslim patients. Understanding the links between Islamic beliefs and practices and their influence on clinical encounters provides opportunities to improve community health and deliver culturally sensitive high quality care.

Introduction

Research has demonstrated that minority patient populations receive a lower quality of care and face significant challenges when trying to access and receive healthcare.¹ Among racial and ethnic groups, health disparities persist due to the confluence of structural, institutional, and interpersonal factors.¹ Overcoming these barriers and disparities requires that the beliefs, priorities, and healthcare needs of minority communities be understood and accommodated. Health disparities among religious minorities merit particular consideration, as religious values are very influential in an individual's and group's development and articulation of the concept of "health." Thus, a better understanding of how religious values influence health behaviors can result in the delivery of more culturally sensitive healthcare services.

American Muslims are a fast-growing, under-studied, and underserved minority. While ethnically and racially diverse, they are bound together by a shared religious tradition that shapes their worldview and informs their behavior. The major ethnic groups within the American Muslim community are indigenous African Americans, South Asians, and Arabs.²⁻⁷ American Muslims may share religiously informed views on health, illness, and the healing process. For example, many aspects of healthcare may be informed by individual and personal practices of Islam- from conceptions of disease and cure to healthcare-seeking patterns and decision-making. When considering the healthcare needs of American Muslim patients, providers must be aware of the wide spectrum of adherence, religious practice, rituals, and traditions within this community. Nonetheless, areas of shared concern between different segments of this population exist and are the focus of our project.

Increasing cultural competence has been cited as part of the solution to reduce health disparities; however, "Muslim patient cultural guides" are predominantly based on provider experiences as opposed to empirical research conducted in collaboration with the community.^{8,9} To better understand the factors that influence American Muslim health barriers and challenges, we embarked on a community-based participatory research project. This report presents an overview of American Muslim health beliefs,

Research has demonstrated that minority patient populations receive a lower quality of care and face significant challenges when trying to access and receive healthcare.

1 Smedley BD, Stith AY, Nelson AR, Institute of Medicine (U.S.). Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, D.C.: National Academy Press; 2003.

2 Muslims American Demographic Facts. <http://www.allied-media.com/AM/>. Accessed January 19, 2010.

3 American Muslims: Population Statistics: Council on American-Islamic Relations; 2005.

4 Ba-Yunus I. Muslims of Illinois, A Demographic Report. Chicago: East-West University; 1997.

5 Obama B. Remarks by the President on a New Beginning. Cairo, Egypt; 2009.

6 Smith TW. The Muslim Population of The United States: The Methodology of Estimates Public Opinion Quarterly. 2002;66:404-417.

7 The World Almanac and Book of Facts 2001: World Almanac Books; 2001.

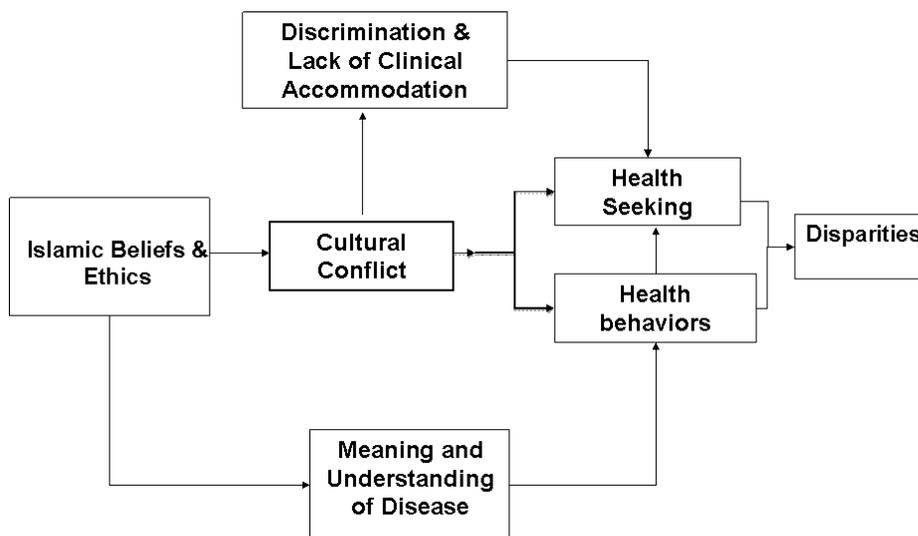
8 Markova T, Broome B. Effective communication and delivery of culturally competent health care. Urol Nurs. Jun 2007;27(3):239-242.

9 Miklancie MA. Caring for patients of diverse religious traditions: Islam, a way of life for Muslims. Home Health Nurse. Jun 2007;25(6):413-417.

describes how these beliefs impact healthcare-seeking practices, and recommends accommodations that can improve the healthcare experience of American Muslim patients.

CONCEPTUAL MODEL

For this study, a conceptual model was synthesized from multiple theoretical models in the medical literature. Kleinman’s model of the cultural construction of clinical reality portrays patient-doctor interactions as transactions between competing explanatory models of disease and illness and thus may involve discrepancies in therapeutic goals and values.¹⁰ This model provides the foundation for understanding how Islam influences Muslim patients’ cultural construction of disease and illness, as well as the meanings attached to therapeutics. The Institute of Medicine’s seminal report entitled “Unequal Treatment” cites prior experiences of discrimination, bias, and mistrust of the healthcare system as factors that influence health and healthcare-seeking behaviors. The authors posit that these mechanisms play a role in healthcare disparities of Muslim patient populations. Leiniger’s cultural care theory notes that patients who experience healthcare that is not reasonably congruent



with their beliefs and values may show signs of cultural conflict and/or ethical concern. As a result, the healthcare dynamic may be fraught with non-adherence and tension.¹¹ Together these portions

¹⁰ Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med.* Feb 1978;88(2):251-258.

¹¹ Wehbe-Alamah H. Bridging generic and professional care practices for Muslim patients through use of Leininger’s culture care modes. *Contemp Nurse.* Apr 2008;28(1-2):83-97.

were synthesized into a conceptual model that guided our process of developing interview guides and shaped our approach to data analysis.

Examples that highlight pieces of our conceptual model include the potential challenge of maintaining cervical health for a Muslim woman who may believe that her illness is a test from God and an atonement for her sins. Believing that God has predestined her illness and form of death, she may delay or refuse medical treatment. Another Muslim may distrust western medicine and rely upon such alternative Muslim therapies as holy water, herbal treatments, and prayer. Thus, he may not seek medical care or adhere to the recommended therapies. A Muslim woman may seek healthcare services only from a female gynecologist. If her health plan does not list one, she may choose to postpone or avoid healthcare visits and thus not receive a pap smear for cancer screening. All of these scenarios exemplify healthcare-seeking or health behaviors that may influence healthcare disparities within this community.

METHODOLOGY, SETTING, AND STUDY PARTICIPANTS

Southeastern Michigan is home to one of the United States' longest standing and largest Muslim American communities estimated to number, around 200,000 individuals.¹²⁻¹⁴ We used a community-based participatory research design in partnering with four key community organizations: the Institute for Social Policy and Understanding (ISPU), the Arab Community Center for Economic & Social Services, and two Islamic umbrella organizations representing more than thirty-five Muslim institutions including over twenty-five mosques; the Islamic Shura Council of Michigan and the Council of Islamic Organizations of Michigan.

Members of these organizations, along with an interdisciplinary investigative team, formed part of the steering committee that guided all of the project's phases, from research question and interview guide development to participant recruitment, data analysis, and dissemination.¹⁵ The interdisciplinary investigative team included a Muslim physician-researcher with expertise in Islamic bioethics and experience as an imam and volunteer healthcare chaplain, a social worker active in Muslim advocacy organizations, an experienced qualitative researcher, a senior health services researcher, a nurse-investigator with research experience within the American Muslim community, and several individuals with public health backgrounds. The project, approved by the University of Michigan's Institutional Review Board, consisted of two phases.

Southeastern Michigan is home to one of the United States' longest standing and largest Muslim American communities, estimated to number around 200,000 individuals.

12 Hassoun R. Arab Americans in Michigan. East Lansing: Michigan State University Press; 2005:1-17.

13 Numan FH. The Muslim Population in the United States. 1992; http://www.uga.edu/islam/muslimpop_usa.html. Accessed January 27, 2010

14 Michigan. Arab Americans 2003; http://www.aaiusa.org/page/file/f6bf1bfae54f0224af_3dtmvj4h.pdf/MIdemographics.pdf.

15 Israel B, Eng E, Schultz A, Parker E, Satcher D, eds. Methods in Community-Based Participatory Research in Health. San Francisco: Jossey-Bass Publications; 2005.

Phase 1: Representatives from our partner organizations and steering committee members identified the key informants and community stakeholders to be interviewed and outlined interview protocols and questions. We used a purposive maximum variation sampling method to identify community leaders with a wide variety of experiences and views.¹⁶ Specifically, we attempted to interview both men and women, persons holding various positions within the community (including imams), and persons of different ethnicities, races, countries of origin, and theological branches. During Phase 1, twelve interviews were conducted with community gate-keepers and leaders in order to acquire an initial perspective on Muslim health beliefs and practices, areas of conflict, and challenges within the American healthcare system (Table 1).

Phase 2: Community-based focus groups were conducted at area mosques and segmented by gender and language preference (Arabic vs. English). Sampling was designed to achieve variation on race, gender, and ethnicity as well as to represent the community's main groups (African Americans, South Asian Americans, and Arab Americans). Focus groups explored in great detail the topics that emerged from the semi-structured interviews in Phase 1.

The 13 focus groups (7 female and 6 male) consisted of a total of 102 participants (56 women and 46 men) (Table 2). The number of participants in each focus group ranged from 4 to 12, with a mode of 9 people. Participants ranged in age from 18 to 75, with a mean age of 45 years. Most participants identified as Sunni (N=81, 82%) while 43% of participants were Arab American (N=43), 23% were South Asian (N=23), and 22% were African American (N=22).

DATA ANALYSIS

The detailed content analysis of the data utilized a framework and team-based approach. Analysts immersed themselves in the data by reading and open-coding the transcripts in order to develop a preliminary coding scheme. Disagreements were resolved by team consensus, and emergent themes were discussed via a constant-comparison method during team meetings. Each transcript was assigned to an analyst, who would then develop a summary by code and perform a local integration of codes by grouping them into higher order conceptual themes. These summaries were used in team meetings to perform a global integration of themes across the interviews.¹⁷

¹⁶ Patton M. *Qualitative evaluation and research methods*. Beverly Hills: Sage Publications; 1990.

¹⁷ Weiss RS. *Learning from Strangers: The Art and Method of Qualitative Interview Studies*. New York: The Free Press; 1994.

Table 1: Participants Characteristics (N=12) in Phase 1

Characteristic	N
Age	
mean (SD), y	44.3 (13.6)
< 30 years	2
30-55 years	7
> 55 years	3
Sex	
Male	7
Female	5
Religious Affiliation	
Sunni	8
Shi'ite	1
Prefer Not To Say	3
Ethnicity	
Arab/Arab American	6
African American/Black	2
South Asian	2
European/White	1
Other	1
Education Level	
Associate degree and/or some college	2
4 year college degree	2
Advanced degree (Masters, Doctorate)	8
Country of Origin	
United States	6
Other	6
Africa	1
Europe	1
Middle East	3
South Asia	1
Primary Role in American Muslim Community	
Imam	2
Leadership Role in Community Health Organization	3
Leadership Role in Community Civic Organization	1
Community Organizer	2
Allied Health Professional	4

Table 2: Demographic Characteristics of the Focus Groups (13 Focus Groups with 102 Participants)

Characteristic	Frequency (N= Focus Groups)
Gender	
Female	7 (54%)
Male	6 (46%)
Ethnicity	
Arab American/Arab	4 (31%)
Mixed	4 (31%)
South Asian	3 (23%)
African American/Black	2 (15%)
Language	
English	12 (92%)
Arabic	1 (8%)

In terms of the agents in healing, multiple studies note that Muslims view God as the sole controller of health and illness.

BELIEFS ABOUT HEALTH AND HEALING

As religious values and beliefs are intricately linked to cultural norms and practices, they shape patients' notions of health and illness, influence expectations of encounters with healthcare providers, affect adherence to doctors' recommendations, guide medical decision-making, and influence health outcomes.¹⁸⁻²² Religion and spirituality also directly affect mental and physical health, for they influence coping strategies, health behaviors, and healthcare-seeking attitudes.²³⁻²⁵ To further explore the role of culture in understanding health, illness, and health behaviors, this section relates how American Muslims view health and the agents in healing. After a brief literature review, we present our findings.

18 Johnson JL, Bottorff JL, Balneaves LG, et al. South Asian womens' views on the causes of breast cancer: images and explanations. *Patient Education and Counseling*. 1999;37(3):243-254.

19 Nielsen M, Hoogvorst A, Konradsen F, Mudasser M, van der Hoek W. Causes of childhood diarrhea as perceived by mothers in the Punjab, Pakistan. *Southeast Asian Journal of Tropical Medicine and Public Health*. 2003;34(2):343-351.

20 Nehra A, Kulaksizoglu H. Global perspectives and controversies in the epidemiology of male erectile dysfunction. *Current opinion in urology*. 2002;12(6):493-496.

21 Fukuhara S, Lopes A, Bragg-Gresham J, et al. Health-related quality of life among dialysis patients on three continents: the Dialysis Outcomes and Practice Patterns Study. *Kidney International*. 2003;64(5):1903-1910.

22 Geertz C. *Local knowledge: further essays in interpretive anthropology*. New York: Basic Books; 1983.

23 Koenig HG. Research on religion, spirituality, and mental health: A review. *Canadian journal of psychiatry*. 2009;54(5):283-291.

24 Larson DB, Larson SS, Koenig HG. Mortality and religion/spirituality: A brief review of the research. *The Annals of pharmacotherapy*. 2002;36(6):1090-1098.

25 Koenig HG. *Religious practices and health: Overview*. 2008.

The extant and largely qualitative literature provides a degree of insight into how American Muslims view health and identifies some of the agents in the healing process. In a study of immigrant Pakistani families, conceptions of health were reported to include the social, spiritual, and physical domains. The authors noted that the acceptance of medical treatments was mediated by a sense of concordance within this holistic conception of health.²⁶ In a similar fashion, Afghan American elders residing in California reported their health as tied to their adherence to Islam and thus utilized various religious practices to heal themselves.²⁷ In terms of the agents in healing, multiple studies note that Muslims view God as the sole controller of health and illness.^{28,29} Johnson and Bottorff explored South Asian women's views on breast cancer and its etiology. Among other causative factors, the women reported that God determines who develops breast cancer and who is cured. Their view that breast cancer was a "disease of fate" influenced their healthcare-seeking behaviors, as some believed that they were destined to suffer, while others felt that their fate could be changed through prayer and seeking medical care.^{30,31} Arab-American immigrants in New York also echoed the beliefs that cancer was from God and that modifiable risk factors were only a secondary concern, thereby giving voice to a potentially fatalistic attitude.³²

Our study also offered insight into how religious beliefs and values influence patients' notions of health, illness, and healing. Our research participants opined that health has multiple components: spiritual, physical, and mental. They stated that in order to move from a state of illness to a state of well-being, multiple agents performed one or more ameliorating functions within one or more of these domains. God was said to have the preeminent role in health, as His decree led to disease and feeling ill and to healing and maintaining one's health. Most participants perceived illness through a religious lens as predestined, a trial from God by which one's sins are removed, an opportunity for spiritual reward, a reminder to improve one's health, and sometimes a sign of personal failure to follow Islam's tenets. Participants also remarked that in addition to prayer and supplicating to God, human agents (e.g., imams, family members, healthcare providers, friends, and community members) played important roles. Each actor is viewed as God's instrument and thus assumes various roles within the healing process.

The imam is a central figure in this process, for he delivers healthcare messages framed within an Islamic worldview, counsels the distressed, provides spiritual support, and facilitates healing through

God was said to have the preeminent role in health, as His decree led to disease and feeling ill and to healing and maintaining one's health.

26 Jan R, Smith CA. Staying healthy in immigrant Pakistani families living in the United States. *Image - the Journal of Nursing Scholarship*. 1998;30(2):157-159.

27 Morioka-Douglas N, Sacks T, Yeo G. Issues in caring for Afghan American elders: insights from literature and a focus group. *Journal of cross-cultural gerontology*. 2004;19(1):27-40.

28 DeShaw P. Use of the emergency department by Somali immigrants and refugees. *Minnesota medicine*. 2006;89(8):42-45.

29 Ypinazar VA, Margolis SA. Delivering Culturally Sensitive Care: the Perceptions of Older Arabian Gulf Arabs Concerning Religion, Health, and Disease. *Qualitative Health Research*. 2006;16(6):773-787.

30 Johnson JL, Bottorff JL, Balneaves LG, et al. South Asian women's views on the causes of breast cancer: images and explanations. *Patient Education & Counseling*. Jul 1999;37(3):243-254.

31 Rajaram SS, Rashidi A. Asian-Islamic women and breast cancer screening: a socio-cultural analysis. *Women Health*. 1999;28(3):45-58.

32 Shah SM, Ayash C, Pharaon NA, Gany FM. Arab American immigrants in New York: health care and cancer knowledge, attitudes, and beliefs. *J Immigr Minor Health*. Oct 2008;10(5):429-436.

communal supplications or prescribing Qur'anic litanies. Within the hospital, his role somewhat overlaps those of healthcare chaplains: he visits Muslim patients, is involved in patient-provider-family healthcare discussions, and serves as a religious "translator" and cultural broker.³³ The family also plays an important role, for its members provide physical care, emotional and spiritual support, and mediate interactions with the healthcare system. Allopathic healthcare providers provide clinical care and are expected to communicate with and educate patients in a respectful manner, as well as facilitate recognition of their religious and cultural traditions. Lastly, friends and community members contribute to the healing process by providing emotional and spiritual support. In this way, the community maintains a holistic vision of healing and recognizes several key agents outside of the allopathic system who influence one's spiritual, physical, and psychological health.

Understanding these perspectives should inform efforts designed to achieve cultural competence and the delivery of culturally sensitive care. At the patient-provider level, the healthcare provider's increased awareness of American Muslim views of healing will help them frame healthcare interventions and enhance partnerships. On a macro-level, healthcare systems and stakeholders can partner with various agents within the healing process to tailor and improve community health interventions. As noted, given that links between Islamic beliefs and practices may affect clinical encounters, culturally sensitive healthcare accommodations should be developed and implemented. As healthcare settings are confronted with adapting to an increasingly racially and ethnically diverse patient population, providers need to respond to a variety of patient perspectives, values, and behaviors about health and well-being. Failure to accommodate the health beliefs and behaviors of American Muslim patients may contribute to healthcare inequalities.

THE NEED FOR CULTURAL COMPETENCE

Cultural competence has been defined as a "set of congruent behaviors, attitudes, and policies that comes together in a system, agency, or amongst professionals and enables them to work effectively in cross-cultural situations."³⁴ Research shows that training in this area can improve the "knowledge, attitudes, and skills" of providers working with diverse patient populations.³⁵ Cultural competence efforts that recognize and accommodate the patients' cultural and religious values can help reduce racial and ethnic healthcare disparities.³⁶ Providing appropriate services can also improve patient

33 DeVries R, Berlinger N, Cadge W. Lost in Translation: The Chaplain's Role in Health Care. *Hastings Center Report*. 2008;38(6):23-27.

34 Cross TL, Bazron BJ, Dennis KW, Isaacs MR. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center;1989.

35 Beach MC, Price EG, Gary TL, et al. Cultural competence: a systematic review of health care provider educational interventions. *Medical care*. 2005;43(4):356-373.

36 Brach C, Fraserirector I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical care research and review*. 2000;57(4 suppl):181-217.

health outcomes and increase client satisfaction.³⁷

In our focus group discussions, participants noted the importance of cultural competency among providers and the healthcare system by using the following various terms interchangeably: “cultural sensitivity,” “cultural awareness,” “education,” and “cultural sensitivity training.” While explaining the rationale for this need, they claimed that cultural competency efforts will (1) lead to a greater understanding of Islam and Islamic culture, thereby improving the patient-provider relationship, and (2) improve Muslim experiences within the healthcare system, resulting in reduced challenges and increased accommodations.

Participants highlighted their experiences with healthcare providers who lacked knowledge about their faith and cultural practices. There was an expectation that providers should have a basic level of knowledge about their patients. As one frustrated participant remarked, “A lot of doctors ask really basic things and you’re kind of like...they should already (know) that stuff.” One participant wished that healthcare providers would have a basic understanding of American Muslims in order to decrease the burden of having to explain their culture and religious beliefs and practices, “That every one of us has to sit, educating her doctor about her beliefs. It’s general information - he can take a two-hour presentation. He can learn this, and that’s it. And then you don’t - each particular patient ha(s) to sit and educate.” Another participant suggested, “It would be good for hospitals to do some, at the hospital they teach other people about our religion and our culture. Because sometimes, people act the way they do out of ignorance. They don’t know...the beliefs and the way Muslims behave.” Additionally, participants asserted that Muslims are often stereotyped and generalized, despite the community’s diversity. As one person remarked, “I think also we get stereotyped or maybe they have a few in-services at the hospital and everyone thinks they know everything about Muslims when we’re all very, very different, so ask.” Consequently, participants said that cultural competency efforts should educate healthcare practitioners about basic Islamic beliefs and practices, thus helping to reduce stereotypical care and discrimination.

Participants often described the healthcare system’s atmosphere as unwelcoming, one in which “doctors and nurses...everybody...looks at you like (a) stranger or like you will be a problem for them.” One participant shared, “I think we all know of stories where due to someone having an accent or...appearing Muslim...that sometimes the doctors may be more blunt with you, or they...belittle you, or not...give you the time of day.” Participants also said that Muslim patients run the risk of being treated negatively when requesting accommodations for their religious and cultural beliefs. One participant related her experience with a male doctor who became upset after she requested a female OB/GYN. At times, providers may not take such requests seriously, “think(ing) it’s a big joke...

Participants also said that Muslim patients run the risk of being treated negatively when requesting accommodations for their religious and cultural beliefs.

³⁷ Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Norman J. Culturally competent healthcare systems. *American Journal of Preventive Medicine*. 2003;24(3S):68-79.

or a bunch of old-fashioned foolishness they don't want to be bothered with." Participants clarified that if healthcare practitioners understood why these accommodations were requested, they would be more likely to treat Muslim patients with respect and create a more welcoming atmosphere. Given that negative health care experiences can impact healthcare-seeking patterns, making an effort to accommodate Muslim patients can lead to greater provider-patient trust, which will ultimately impact healthcare-seeking patterns and compliance with the suggested treatments:

When the nurse...tells you...I respect your religion...immediately, I will have trusted her...That's half of the work of being a healthcare giver...to get the trust of the patient. When the patient trusts you, he will do anything you tell him...and he will be compliant with care. So if you take the extra mile, this is (a) very important issue (for) healthcare providers. They have to make the effort to respect and to assess.

Finally, our participants noted that these accommodations could be provided rather easily and required some flexibility and strategic planning, *"Why don't we go the extra mile with...Muslims? ...Their needs are very tiny... What's the big deal..."* In addition, the results of doing so will lead to improved healthcare experiences for both parties. These patient perspectives suggest the need for health systems to utilize cultural competency initiatives and train staff in order to improve interpersonal interactions, thereby enhancing cultural sensitivity and contributing to positive changes in the overall health system culture.

PRIORITY HEALTHCARE ACCOMODATIONS

Given the different conceptions of health and healing, cultural modifications and healthcare accommodations may be integral to providing the highest quality of care. Prior research demonstrates that many hospitalized Muslim patients seek to maintain their religious practices: fasting during Ramadan, adhering to dietary restrictions, and observing the prescribed and optional prayers are just some examples. Within the framework of cultural competence, our focus group participants identified three healthcare accommodations as top priorities: (1) Gender-concordant care (2) Halal food, and (3) Prayer space.

Gender-Concordant Care

Participants requested gender-concordant care based upon Islamic conceptions of modesty and privacy.³⁸ Some of them further described how the lack of female personnel may play a role in delaying or avoiding healthcare services, *"Yeah. I would not even walk into a clinic that I didn't have a choice of the gender."* Gender-concordant care was also discussed in relation to helping patients maintain a secure and private space, such as a hospital room, as well as protecting the body's personal space. In the event that such care was unavailable, participants made some further recommendations, such as more modest hospitals gowns and signs on the doors that requested providers to knock and wait for permission to enter.

38 Padela AI, del Pozo PR. Muslim patients and cross-gender interactions in medicine: an Islamic bioethical perspective. Journal of medical ethics. 2011;37(1):40.

Halal Food

The provision of halal (Islamically slaughtered) food was also identified as an important healthcare accommodation. Some patients requested it for health reasons, and many identified food in general as a priority area in which healthcare providers could take the initiative. One participant stated, *"I would also think that (the) hospital needs to take the initiative to ask every patient, do you have any dietary restrictions or even preferences. Because some people again, not being a very good advocate for themselves aren't going to ask and they're just going to assume...that they get what they get."* This quote speaks to a common theme in our focus groups: patients feel that they are outsiders and thus experience a further degree of stigmatization when asking for or explaining their need for certain accommodations.

Prayer Space

Participants identified prayer space as an important healthcare accommodation due to prayer's role in healing and as a ritual five-time daily obligation. Participants described the challenges they had faced and suggested that a religiously neutral space would be welcomed. Some hospitalized participants mentioned being interrupted while praying and experiencing discomfort. One participant told of her effort to find a suitable place, *"I had knee surgery so couldn't go anywhere, and I was very worried about that...my husband was with me and put me in a wheelchair and wheeled me to the bathroom, I (supplicated) and I came back and prayed."* Another participant described an uncomfortable experience, *"So we were praying but...nurses and...security had come and asked if everything was ok...Doctors were you know, hesitant to come back in the room and...everybody came by after that and kind of looked in the door...we just praying how we pray."*

As previously mentioned, understanding American Muslim perspectives on health and healing requires that the role of religion, cultural beliefs, values, and worldviews of Islam be understood as well. Once this happens, hospital-based barriers to quality care can be identified. Providing culturally appropriate healthcare accommodations is integral to the care of American Muslim patients, and allocating resources that can serve as a source of comfort and fulfill these patients' spiritual needs can help fulfill that goal.

THE ROLE OF IMAMS

A logical starting point for recognizing Islam's influence upon its adherents' health may be to understand the roles an imam is expected to assume. For the purpose of this report and within the American context, we define an imam as the man who leads the prayers, gives the sermon, and advises the congregation on spiritual matters. His community-based role is analogous to that of a priest, a minister, or a rabbi (Table 3). While medical literature is replete with studies describing rabbi-priest partnerships to improve their community members' health, respectively, and while chaplaincy programs have effectively incorporated them within the hospital system, few imams have been included in such initiatives. Therefore, further research is needed to delineate their multiple

roles in American Muslim health.³⁹⁻⁴¹ Surprisingly, few studies have examined the imam's importance in the Muslims' medical decision-making processes.⁴²⁻⁴⁴ Non-Muslim chaplains, however, have recognized that imams should be available to minister to Muslim patients.⁴⁵

The scant international literature suggests that imams and mosque-based interventions can enhance community health and reduce healthcare disparities. For example, educating imams about tuberculosis resulted in sermons on the topic and increased detection and treatment in Bangladesh.⁴⁶ Mosque-based lecture series on cardiovascular disease risk factors have helped advance health in Austria.⁴⁷ A similar approach has recently been adopted by USAID's Bureau for Global Health: imams are mobilized to be "champions" of reproductive health and family planning in multiple Muslim-majority nations.⁴⁸ Imams also serve as religious "translators" and cultural brokers while visiting hospitalized Muslims, provide ethical consultation for both staff and patients, and are involved in patient-provider-family healthcare discussions.⁴⁹

Imams also play key roles in their community's health, as they are perceived as counselors and a source of spiritual cures.^{50,51} Our participants identified four central healthcare-related roles for imams: (1) encouraging healthy behavior through scripture-based messages in sermons; (2) performing religious rituals around life events and illnesses; (3) advocating for Muslim patients and delivering cultural sensitivity training in hospitals; and (4) helping Muslims make healthcare decisions.

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51 Padela A, Killawi A, Heisler M, Demonner S, Fetters M. The Role of Imams in American Muslim Health: Perspectives of Muslim Community Leaders in Southeast Michigan. *Journal of Religion and Health*. 2010:1-15.

Table 3: A Brief Taxonomy of Imams

Type	Description	Comment
Imam = Prayer-leader	The most general definition of an imam is a congregational prayer leader.	This individual leads prayers at a mosque at specific times formally or informally. The term can also be used for an individual who leads prayer once for a group of people and may not do so on a regular basis.
Sermon-Giver = Imam and/or Khateeb	Gives sermons that are a requisite part of Friday (Jumma) prayer services and Holiday services (Eid).	This individual often, but not always, has some level of Islamic educational attainment and is asked to give sermons by the mosque leadership.
Spiritual Guide = Imam and/or Shaykh	Sought out by Muslims for spiritual guidance around life events, the esoteric sciences related to purifying one's character and belief, and "spiritual cures."	This individual is often referred to as a Shaykh which is also a ubiquitous term in the Islamic tradition. Such an individual is often associated with Sufi paths in the Islamic tradition.
Islamic Law Expert = Imam and/or Shaykh	Studied Islamic law and ethics extensively through formalized Islamic seminaries and colleges. Specialized in Islamic law and is authorized to issue religious edicts (sing. Fatwa, pl. fatawa).	The legal theorists of the classical era who promulgated the dominant extant schools of Islamic law (Maliki, Hanafi, Shafi, Hanbali, and Jafari) are all accorded the honorific title imam.
Director of Mosque = Imam and/or Shaykh	A mosque-based imam who is hired by the mosque administration to serve multiple roles for congregants, including religious ceremonies and prayers.	This individual may fulfill some or all of the types of imams listed above.

Participants discussed how imams may deliver health-based messages through sermons and lectures, especially during the congregational Friday prayer (*jum'uah*). Held at all mosques, *jum'uah* is obligatory upon all Muslim men and is often a family activity. In areas with large Muslim populations, multiple prayer sessions and sermons may be conducted at a single mosque, lending variety to both the message

and the messenger. Participants related that by framing disease and healing as coming from God, imams help Muslims cope with illness by helping them maintain hope in the Divine. Participants also alluded to imams' messages about moderation and health promotion, for example, *"to take care of our health...that (the body)...is a trust (from God)"* and to be moderate in eating, for the Qur'an states: *"Eat and drink and don't go beyond the limit"* (7:31). Participants remarked that imams sometimes use healthcare messages from the Qur'an to guide the audience's health and that some congregants expect to receive (and may desire more) health-focused sermons.

Participants also provided insight into how imams perform religious rituals connected with important life events and illnesses: blessing births, visiting the sick, overseeing funeral services, and many others. When asked about these responsibilities, one imam related, *"(Being an) imam entails...first and foremost, guiding the community...and also visiting a sick person...if somebody dies...either you get involved in the washing of the body or directing...people how to do that and...praying for the deceased person."* Thus, imams serve important ritualistic functions associated with life and death. In fact, hospitalized Muslims may even request their presence. In addition to these functions, participants noted that imams are often requested to make special prayers for sick congregants and/or their relatives. Participants shared that some Muslims believe that reciting certain Qur'anic verses and certain prayers over food can have healing qualities, and thus they may request imams to do so. Some imams may serve a more direct therapeutic role as counselors and alternative mental healthcare providers.

Participants illustrated how imams can take on larger roles within the hospital and healthcare system as part of their religious duty to visit the sick. One healthcare worker said, *"Maybe a sheikh (imam) comes from the masjid (mosque) (to educate healthcare workers about) when you come across these Muslims, this is the kind of belief...that you might encounter."* The goal here is to provide staff with a cultural knowledge base and tools that can help healthcare professionals understand and facilitate care that is attuned to Muslim beliefs. As one of our imams noted, *"Many of the staff...have no idea what Muslims believe...once they know that, they are more sensitive and they know how to approach (Muslims)...and how to respect them and not offend them."* Our respondents noted that few imams have formal hospital appointments, and thus *"many patients are surprised when they know that (t) here is (an) imam on...staff to visit them, and to take care of them, and make sure that their traditional beliefs are respected."* This illustrates how imams can serve as cultural brokers.

Respondents also provided examples of how imams play an integral role in healthcare decision-making for Muslims within hospital and mosque settings. For example, one participant observed how they function at his hospital in family meetings: *"[W]e have (had) to invite local imams to sit in on family meetings with physicians to help the family make the decision with, as far as considering the faith and the rulings because...they just had the medical advice so...(the family) wanted religious advice."* One

imam explained that imams seek to “*try to close the gap between physicians and family*” and “*inform them (the healthcare staff and patient family) what can be done and what cannot be done according to religion.*” This reveals how imams can function as interpreters and cultural brokers. Healthcare partnerships with imams and their mosques may be an important way to enhance this community’s health. Moreover, some participants described how imams may facilitate cultural competency efforts for the healthcare system. Our project also identified the need for further research related to the challenges of involving imams in healthcare settings.

CHALLENGES IN PROVIDING CULTURALLY SENSITIVE HEALTHCARE

Many factors pose challenges to providing culturally sensitive healthcare and accommodations to American Muslim patients. These challenges are discussed in this section, with a particular focus on patient-provider interactions, the limitations of non-Muslim chaplains in healthcare settings, and the benefits and limitations of imams in healthcare settings.

American Muslim patients who have to deal with physicians who will neither accommodate their religious and cultural traditions nor fulfill their duty to communicate with and educate them may rely more heavily on folk medicine and spiritual cures in lieu of allopathic treatment. This pattern has been suggested in other studies of the American Muslim community and is not unique to it.⁵²⁻⁵⁵ Patient-provider communication difficulties, mistrust, and perceived discrimination all play a part in minority healthcare disparities and contribute to a poorer quality of healthcare in general.⁵⁶⁻⁵⁸ Furthermore, poor patient-provider dynamics influence patients’ decisions not to consume allopathic medicine and to conceal their use of alternative medicines. Such a situation contributes to delaying healthcare efforts.^{59,60}

Given that allopathic providers are only one source of healing for American Muslims, a strong patient-doctor alliance is important. Some of our participants expressed concern that physicians sometimes did not accommodate their religious and cultural needs and exhibited distant communication styles. For example, some providers may see ritual fasting as harmful to the body or the rejection of porcine-based products as zealotry. Yet our participants affirmed how these practices can be essential to maintaining their faith

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identity and are of primary importance to them. Such misunderstandings have important implications for healthcare utilization, given that a variety of healing patterns emerged within our focus groups. Some participants held religious cures to be primary and so used allopathic medicines as secondary sources of healing, while others used them as integrative choices. Further work is needed to explore the linkages between the quality of patient-doctor relationships and community members' utilization patterns for alternative and spiritual therapies. Our findings suggest that there is a continuing need for healthcare providers to improve their cross-cultural communication skills and enhance their level of cultural sensitivity.

The importance of religion and spirituality in supporting individuals and families within hospital settings is often facilitated by professional chaplaincy organizations.⁶¹⁻⁶³ From the healthcare system perspective, chaplains provide spiritual support to patients.. While these chaplaincy and pastoral care programs have largely emerged from the Judeo-Christian healing traditions, efforts to incorporate other faith traditions are underway. Little attention has been paid to the role of Muslim chaplains within healthcare settings.⁶⁴ Pastoral care and chaplaincy training programs rarely include education on Islam, and it is not clear if non-Muslim chaplains feel morally comfortable counseling Muslims.^{65, 66} For example, a study of directors and chaplains associated with New York City pastoral care departments revealed that non-Muslim chaplains had a limited awareness and understanding of the needs of Muslim patients.⁶⁷ Thus, hospital chaplains may not be able to meet them. On the other hand, hospitals may lack the financial resources or perceive Muslim patient volumes as insufficient to justify hiring a Muslim chaplain. A further barrier may be that hospitals often require chaplaincy credentials, and there are only a few Islamic chaplaincy programs in the United States.⁶⁸⁻⁷⁰

As noted earlier, imams and chaplains have similar functions, such as providing spiritual support and religious advice for Muslim patients and their families. Research within the United States notes the beneficial role imams can play in promoting mental health through counseling and healthcare initiatives. Our research also

61 Chaplains AoP, Education AfCP, Education CAfPPa, Chaplains NAoC, Chaplains NAoJ. A White Paper. Professional chaplaincy: Its role and importance in healthcare. *Journal of Pastoral Care*. Spring 2001;55(1):81-97.

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70 Islamic Chaplaincy Program. <http://macdonald.hartsem.edu/chaplaincy/index.html>. Accessed January 19, 2010.

suggests several tangible benefits with respect to American Muslim health behaviors.⁷¹⁻⁷⁴ In our experience and that of other researchers, even in areas with large Muslim populations, few imams have formal chaplaincy roles in the hospital.⁷⁵ This might be due to a lack of time given their mosque-based responsibilities, feeling uncomfortable about assuming such a role due to their limited medical knowledge, and viewing chaplaincy as alien to their understanding of supporting the sick as a communal, not an individual, obligation.^{76,77}

The imams in our sample felt uneasy about making medical decisions for patients, due to the uncertainties of medical science, and expressed discomfort with being asked to convince them to pursue physician recommendations through religion-based argumentation. Some of these ethical conflicts may also stem from imams' lack of familiarity with the healthcare system and medicine in general. The barriers and potential limitations to their involvement in the healthcare system must be delineated more thoroughly, and the types of ethical challenges they face have to be explored as well. Ensuring culturally sensitive care is a multi-faceted challenge and merits a consideration of American Muslim patient beliefs and preferences regarding healthcare accommodations and spiritual support in the hospital. For example, a clearer definition of the core competencies required to become a Muslim chaplain and an increased focus on the spiritual needs of minority religious groups in chaplaincy programs may help address such concerns. Finally, it is critical to consider how these challenges manifest themselves at the individual level, within the patient-provider relationship, and in response to the system-level constraints that limit spiritual support for hospitalized Muslims.

RECOMMENDATIONS

Several changes in policies and healthcare delivery may provide tangible solutions to the above-mentioned concerns. Based on our project's findings, we recommend the following:

- Healthcare providers can better situate medical interventions within an American Muslim cultural framework by increasing their understanding of how American Muslims view health and healing. Assessing

71 Ali OM, Milstein G, Marzuk PM. The Imam's Role in Meeting the Counseling Needs of Muslim Communities in the United States. *Psychiatr Serv*. February 1, 2005;56(2):202-205.

72 Padela A, Killawi A, Heisler M, Demonner S, Fetters M. The Role of Imams in American Muslim Health: Perspectives of Muslim Community Leaders in Southeast Michigan. *Journal of Religion and Health*. 2010:1-15.

73 Abu-Ras W, Gheith A, Cournos F. The Imam's role in mental health promotion: A study of 22 Mosques in New York city's Muslim community. *Journal of Muslim Mental Health*. 2008;3:155-176.

74 Taylor JY, Holtrop TG. Yemeni families and child lead screening in Detroit. *Journal of Transcultural Nursing*. 2007;18(1):63-69.

75 Abu-Ras W, Laird L. How Muslim and non-Muslim chaplains serve Muslim patients. Does the interfaith chaplaincy model have room for Muslims' experiences? *Journal of religion and health*. 2010;50(1):46-61.

76 Abu-Ras W, Laird L. How Muslim and non-Muslim chaplains serve Muslim patients. Does the interfaith chaplaincy model have room for Muslims' experiences? *Journal of religion and health*. 2010;50(1):46-61.

77 Dudhwala IY. Building bridges between theology and pastoral care <http://www.eurochaplains.org>. Accessed January 19, 2010.

and understanding their views on healing will enable healthcare providers to establish trust, enhance patient-provider relationships, avoid issues of non-disclosure, and reduce patient non-adherence to recommended therapies. Providers may also consider engaging structures and agents outside of the allopathic system who can better meet patient needs and enhance health.

- All patients, regardless of their religious beliefs or practices, want to receive care in a welcoming environment. Hence, health systems should train staff to enhance cultural sensitivity, reduce discrimination, and highlight intra-group differences.
- Health systems should ask patients if they prefer same-gender providers and make good-faith efforts to do so when requested. Our data suggests that this accommodation, above all others, can influence healthcare-seeking patterns. Further delineation of the import, significance, impact, and extent to which this accommodation is necessary is warranted. Our participants suggested that efforts to accommodate and respect patient privacy and modesty can be addressed in several ways:
 - o Knocking and waiting for permission to enter, so that patients can dress appropriately. For example, some Muslim women may want to don the headscarf.
 - o Providing hospital gowns and clothing that accommodate patient preferences for modesty and privacy.
 - o Placing, at the patient's request, or offering the option of a sign designating the room as a same-gender provider only.
 - o Informing a patient in advance that a person of the other gender may need to enter the room.
- Hospitals should provide halal foods and medications to alleviate the stress and discomfort caused by being confronted with substances that violate their religious beliefs.
- Health systems should consider allocating space for Muslims to pray. As some patients may pray in their hospital rooms, staff should be made aware of this practice and told not to disturb praying patients.
- Healthcare institutions should reach out to American Muslims by initiating religiously and culturally sensitive healthcare awareness campaigns through partnerships with mosques. This will allow healthcare systems and imams to explore how sermons and educational venues may be used to disseminate health messages regarding disease prevention.

- Health systems should consider implementing educational programs in healthcare settings so that hospital pastoral care and chaplaincy staff, as well as healthcare providers, can become more aware of the spiritual needs of American Muslim patients. Imams and Muslim healthcare providers may serve as potential resources and sources of support for patients.

LIMITATIONS

The examples and recommendations cited within this report underscore the need for increased cultural competence on the part of health systems and healthcare staff, as well as the need to address cultural and religious accommodations within the healthcare system. Given that we sought to uncover how Islam influences health and healthcare decisions, we looked for participants among those who regularly attended their local mosque on the grounds that they provided a first-cut for identification with Islam and for personal religiosity. While our data legitimately represent the voices of a key community segment, the participants do not represent a full cross-section of the community in that those who did not go to the mosque were not sampled. Given that our participants were from a large and well-established community, we believe that their views offer invaluable insight into the American Muslim community at large. We also note that other communities may hold different priorities and views.

Conclusion

The paucity of research and published data on the healthcare needs of American Muslim patients suggests that ongoing research into the above-mentioned barriers to optimal health and healthcare delivery is necessary. Studying American Muslim health is quite a challenge, for the lack of accurate population statistics and capturing of religious affiliation within national databases affects sampling frames and research designs. The quantification of mechanistic relations between Islam, health practices and behaviors, and population health requires a concerted, systematic, and sustained engagement on multiple levels involving community, state, and national actors. This report highlights several areas of research that may inform and augment healthcare services to American Muslims. For example, their healthcare-seeking patterns may be influenced by the provision or absence of cultural accommodation in healthcare settings that, in turn, may cause them to delay seeking care or to adopt alternative healing practices. Understanding the relationships between Islamic beliefs and practices and how they affect clinical encounters provides an opportunity to improve community health and deliver culturally sensitive, high quality care.

The qualitative literature captures some of Islam's influences upon American Muslim health values and behaviors; however, these studies often focus on only one ethnic group.⁷⁸ Hence, the strength of our work lies in its incorporation of African Americans, South Asian Americans, and Arab Americans, as well as Sunni and Shi'ite groups. We advocate for additional studies that give voice to patient perspectives on health and healing and highlight their experiences in healthcare settings.

An additional challenge is how to inform healthcare providers of this community's perspectives on health and illness while explaining its heterogeneity. Developing and validating Islam-based measures of religiosity, which are integral to exploring associations between religion and health behaviors, remain in the preliminary stage.⁷⁹ Thus, future research should include studies that capture perspectives and experiences from multiple Muslim communities, as well as from Muslims with varying levels of religious adherence, and should reflect the diversity of their members' socioeconomic status and level of acculturation. Our work represents a critical first step in setting such research agendas. Further studies in collaboration with American Muslim communities across the country are required to address current gaps in our knowledge about how they utilize healthcare services and the challenges they face in healthcare settings, while also exploring potential resources, policies, and practices that can enhance cultural competence and accommodation.

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