

# PATIENT-CENTERED HEALTH CARE FOR MUSLIM WOMEN IN THE UNITED STATES

Conference Proceedings and Postconference Evaluation Report

Editor  
Memoona Hasnain, MD, MHPE, PhD

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## **Editor's Note**

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## PREFACE

Elimination of health disparities, a national priority, requires a multidisciplinary effort. Essential elements for attaining the goal of eliminating, or at the very least, reducing health disparities include cutting-edge research that informs and guides policies and practices, community involvement, and high-quality programs for patient education and provider training. In terms of overlooked health disparities, American Muslim women are a fast-growing, under-studied, and underserved population. As an initial step in identifying and addressing health disparities for American Muslim women, the Agency for Healthcare Research and Quality funded a research agenda-setting conference titled “Patient-Centered Health Care for Muslim Women in the United States.” The conference was the first step in ensuring that the health-care issues of Muslim women are understood and addressed. It enabled dialogue among key stakeholders, including consumers, health-care providers, medical educators, public health professionals, faith leaders, and scholars, to define key foci for research and action for meeting health needs of Muslim women.

Conducting a comprehensive assessment of health needs of Muslim women is a challenging task given the scope and complexity of the influence of religion and culture on health-care beliefs and practices. To make this task more manageable, we will focus on priority areas identified through conference deliberations. Findings from this conference particularly underscore the urgent need to better educate both providers and patients and tailor health-care provision to meet the needs of Muslim women.

A project like this one would never have been possible without multidisciplinary participation from a multitude of individuals and organizations. We are very grateful to the Agency for Healthcare Research and Quality for providing financial support for the conference. We are indebted to everyone who participated in this endeavor by contributing their time and expertise, including the planning committee members, organizers, volunteers, speakers, facilitators, moderators, conference participants, supporters, and endorsers. We look forward to everyone’s continued involvement.

Findings of this project have laid the foundation for a multistage intervention research program intended to provide high-quality, culturally appropriate, patient-centered care for American Muslim women. In order to move forward with a research and best-practice agenda, the findings from the conference are shaping the next phases of the project. We are working on the critically important next steps of developing empirical studies to address the foci identified at the conference and on organizing future events to support dialogue and dissemination about this developing program of research. We believe that there are exciting new opportunities to involve patients in the development of a new model of care—one in which patients and providers are equal partners. Findings from this ground-breaking research will make significant contributions toward informing health policies and practices that will reduce health disparities among minority and underserved women.

**Memoona Hasnain, MD, MHPE, PhD**

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UIC Center for Research on Women and Gender

UIC College of Nursing

UIC Great Cities Institute

UIC National Center of Excellence in Women's Health

UIC School of Public Health

## EXECUTIVE SUMMARY

Evidence from leading national agencies, such as the National Institutes for Health, Institute of Medicine, and Centers for Disease Control and Prevention, indicate that health-care disparities continue to exist across diverse populations. As a groundbreaking step in identifying and addressing health-care disparities for American Muslim women, a research-agenda setting conference titled “Patient-Centered Health Care for Muslim Women in the United States” was held on March 4 – 5, 2005, at the University of Illinois at Chicago (UIC).

The conference was sponsored by the Department of Family Medicine at the UIC College of Medicine and funded by the Agency for Healthcare Research and Quality of the United States Department of Health and Human Services. Other collaborating UIC colleges and centers included the National Center of Excellence in Women's Health, the Center for Research on Women and Gender, the Divisions of Maternal and Child Health and Community Health Sciences in the School of Public Health, the College of Nursing, and the Great Cities Institute. The Society of Teachers of Family Medicine, American College Health Association, Illinois Department of Public Health, and the Council of American Muslim Professionals also endorsed the conference.

This event drew a national audience of approximately 200 participants, including health-care providers, consumers, and scholars and was the first in a planned series of initiatives aimed at identifying and overcoming barriers to the provision of high-quality, culturally appropriate, patient-centered care for Muslim women.

### **Learning Objectives**

By the end of the conference, participants were expected to be able to:

- Discuss issues related to Muslim women's health care within the context of the religious tenets of Islam
- Recognize the barriers Muslim women experience in obtaining culturally appropriate health care
- Identify challenges and difficulties experienced by primary-care providers in providing culturally appropriate health care to Muslim women
- Make recommendations for a research agenda aimed at addressing the health-care needs of Muslim women

### **Intended Audienc**

Primary-care providers, as well as all interested health-care professionals, scholars, students, and consumers.

### **Continuing Education Credits**

The conference was approved for:

- 10 ACCME Category 1 credits by the University of Illinois at Chicago (UIC) College of Medicine

- 10 Prescribed credits by the American Academy of Family Physicians
- 4.1 Nursing continuing education contact hours by the University of Illinois at Chicago College of Nursing.

## **Focal Points**

The conference was the result of preliminary work by the principal investigator, Dr. Hasnain, to study the health needs of Muslim women, with collaborative multidisciplinary support from several UIC colleges and centers, state institutions, and national professional organizations. The overall goal of this project is to identify and overcome patient, provider and health-care-system related factors to provide high quality, culturally appropriate, patient-centered care to Muslim women in the United States.

The program commenced with a welcome address by Dr. Patrick Tranmer, professor and head of clinical family medicine in the Department of Family Medicine at the UIC College of Medicine. On behalf of the organizers, Dr. Tranmer thanked the participants and described the relevance of the conference to the mission and vision of the UIC Department of Family Medicine. He emphasized the importance of addressing health-care needs of diverse populations as a core value for all health-care providers, particularly family physicians.

The conference overview was presented by principal investigator and conference chair, Dr. Memoona Hasnain, director of research in the Department of Family Medicine at the UIC College of Medicine. Dr. Hasnain explained the background and rationale for the conference and the overall project guiding it. She discussed ways in which religious and cultural beliefs of the many diverse groups of Muslim women can pose significant barriers to their receiving quality health care. She emphasized the importance of keeping in mind that Muslims in America are a diverse group and that it would be a fallacy to assume that all Muslims have the same cultural influences and origins. She also noted the paucity of research in this area and that the conference was the first in a series of anticipated activities to address this issue.

Dr. Asma Barlas, a professor in Department of Politics at Ithaca College, New York, and author of “Believing Women in Islam: Unreading Patriarchal Interpretations of the Qur’an,” gave the keynote address, titled “Women in Islam: Facts and Perceptions.” Her presentation focused on health-care needs of Muslim women within the context of Islamic tenets, dispelling misconceptions about gender preferences, the young age of marriage for girls, views of the wife as her husband’s sexual property, and polygamy. Dr. Barlas reiterated that each of these issues raises practical problems for Muslim women who are burdened by misleading stereotypes and called attention to implications for health-care providers.

Dr. Rosaly Correa-de-Araujo, Senior Advisor on Women's Health, Agency for Healthcare Research and Quality, presented “Patient-Centered Care: Relevance to Muslim Women’s Health.” Dr. Correa contextualized Muslim women’s health care within the broader realm of patient-centered care and provided an overview of key research findings from national studies on minority and underserved women’s health.

Dr. Fauzia W. Lodhi, director of the Palliative Care and Hospice Program at Rush University Medical Center and member of the Board of Directors of the Muslim Community Center in Chicago, presented “Culturally Appropriate Health Care for Muslim Women”. Dr. Lodhi’s talk emphasized the need for health-care providers to respect the customs and beliefs of patients from every religion and culture.

Dr. Nawal M. Nour an assistant professor at Harvard Medical School and the director of the African Women's Health Center at Brigham and Women's Hospital presented “Clinical Perspective: Female Genital Cutting,” a topic of great interest to clinicians. Dr. Nour emphasized that the tradition of female circumcision, though usually ascribed to Muslims, transcends all religions and geographical locations and that people continue the practice of FGC due to a multitude of complex beliefs, fears, and societal pressures that providers may never completely comprehend. She explained that some parents believe that, by not circumcising their daughters, they have done them a great disservice. She also stressed that providers need to continue to help circumcised women in a manner that is supportive and respectful of their personal and cultural values and beliefs.

Dr. Elizabeth A. Burns, chair of the Department of Family Medicine and a professor at the University of North Dakota School of Medicine and Health Sciences presented “Patient-Physician Communication: The Case of the Muslim Woman Patient.” Her talk provided a pragmatic example of an American physician who has worked successfully with Muslim women patients by closely attending to and accommodating their religious and cultural needs.

A panel moderated by Dr. Constance Shabazz, executive director of TCA Health, Inc., discussed specific health-care issues and possible approaches to addressing them. Panelists included Muslim women health-care consumers, health-care experts, and scholars. Panelists agreed that there was a pressing need for addressing system issues, as well as educating both health-care providers and Muslim women to ensure the provision of high-quality care to Muslim women.

Conference attendees also were provided an opportunity to work in small groups to identify specific barriers to culturally appropriate patient-centered health care for Muslim women, and to develop areas of focus for future activities and research.

The conference concluded with closing remarks by Dr. Memoona Hasnain. She thanked all the participants for their input and particularly acknowledged the organizers and volunteers for their help. She outlined next steps, which include convening ongoing forums on the subject; conducting empirical studies exploring health needs of Muslim women; and developing and testing evidence-based, best-practice guidelines and training materials for both providers and consumers.

## **Future Directions**

The conference initiated a much-needed dialogue among multiple stakeholders, including consumers, health-care providers, medical educators, public health professionals, faith leaders and scholars regarding health issues for Muslim women. Review of the conference papers and panel discussions indicates a strong need for continued work on this topic. Several overarching as well as discrete foci have

emerged for future work. Key challenges and recommendations for change involve patients, providers, and the health care system. The need for patient education and enhancing cultural awareness and training for all levels of health care providers emerges as the main theme. Participants strongly voiced the need for developing and conducting empirical research studies to address research questions related to Muslim women's health in the following key areas:

- a. Reproductive health—with special focus on:
  - Screening for breast and cervical cancer
  - Female genital cutting
  - STDs and HIV
- b. Intimate partner violence
- c. Mental health
- d. Acculturation issues

The need for training providers to provide patient-centered care resonates in the Institute of Medicine's report, *Health Professions Education: A Bridge to Quality*, as well as in the "New Model of Practice" proposed by the Future of Family Medicine Project. The latter calls for a "flexible model that trains family physicians to deliver patient-centered care consistently and lead an interdisciplinary team, emphasizing the biopsychosocial model, cultural proficiency, evidence-based practice, quality improvement, informatics, and practice-based research". This model can guide training and practice not only for family physicians but also for providers from all disciplines. Reducing the disconnect between what patients need and what they receive in the current health care system in the US is certainly possible.

A multidisciplinary project team is developing a program of research to address the key areas identified through the conference.

# Expert Forum

# BRIDGING THE QUALITY GAP FOR MUSLIM WOMEN

**Memoona Hasnain, MD, MHPE, PhD**

University of Illinois at Chicago College of Medicine

Department of Family Medicine

The increasing diversity of the U.S. population has implications for all aspects of health-care delivery. Although reducing health disparities is one of two overarching goals of the Healthy People 2010 initiative, they continue to be a challenge to minority and underserved populations. Contributing factors to the well-documented health-care disparities among cultural minority groups include differences in access to and utilization of services, quality of care and services rendered, and perceived satisfaction with the health-care provided.

The Institute of Medicine's report "Crossing the Quality Chasm, A New Health System for the 21st Century," details problems in the current U.S. health-care system and prescribes a roadmap for change. The report notes a serious "quality chasm" that exists between currently available health care in the United States and the health care that patients could have. It states that the gap is attributable, in part, to the fact that, in many instances, patients must adapt to the customs and practices of health-care organizations and professionals, rather than receiving services designed to address patients' needs and preferences. Another IOM report, "Health Professions Education: A Bridge to Quality," concludes that health professions education has not kept pace with, "changes in patient demographics, patient desires, changing health system expectations, evolving practice requirements and staffing arrangement, new information, a focus on improving quality, or new technologies."

Researchers in the United States have acknowledged the importance of the need for health-care professionals to be nonjudgmental and respectful of the traditions of other cultures. Being nonjudgmental and respectful, however, is only part of the tool kit required for ensuring high-quality care. Provision of high-quality health care requires culturally competent care, including attention to the diversity of patient beliefs, perceptions, and expectations across cultural groups.

In terms of overlooked health disparities, American Muslim women are a fast-growing, under-studied, and underserved population. Muslims are followers of the faith of Islam, a monotheistic religion with approximately 1.6 billion adherents globally. Muslims are as diverse as humanity itself, representing about twenty-two percent of the people in the world. Approximately 15 percent of the world's Muslims belong to the Arab countries, while nearly 33 percent of Muslims live in the Indian subcontinent. The largest Muslim nation is Indonesia, with 160 million Muslims among its 200 million people. Muslims represent the majority population in more than 50 nations and they also constitute important minorities in many other countries. Muslims compose at least 10 percent of the Russian Federation's population, three percent of China's population and three to four percent of Europe's population. Islam is the second largest religion in France and the third largest in both Germany and Great Britain.

Although estimates vary widely, Muslims represent approximately two percent of the United States population, with six to eight million people, 47 percent of whom are women, and the population is growing. The Muslim population of the United States grew six fold between 1972 and 1990. By the year 2010, it is projected that Muslims will be the second largest religious group in the U.S. These increases in the number of Muslims in the U.S. are due mainly to migration and, to a lesser extent, to conversion. African-American Muslims, who are indigenous to this country constitute the largest population of Muslims in America. America's immigrant Muslim population, however, is extremely varied coming from remarkably diverse ethnic backgrounds. The single largest group of Muslim immigrants in the U.S. is from South Asia, followed by the Middle Eastern countries.

Muslim women in the U.S. are a population for whom issues in the provision of culturally appropriate, patient-centered care have not yet been fully explored. The literature on health problems of immigrant women reveals a paucity of studies concerning the health-care needs of immigrant Muslim women. Several patient, provider, and health-system related factors contribute to the challenges that Muslim women face in accessing and utilizing health-care services. Some of these challenges are due to common barriers of language, access, insurance, and family pressures faced by other immigrant groups. Compounding the issue, sociocultural barriers, including the lack of culturally appropriate health communication programs and services contribute to health-care barriers for this group.

Due to their religious and cultural beliefs, Muslim women have specific health needs, e.g. same-gender providers, dietary restrictions, special needs during fasting, and personal hygiene needs related to daily prayers. Muslim practices and beliefs have implications for a wide range of health conditions including but not limited to sexual norms, maternal and child health issues, e.g., prenatal care, labor and delivery, post-delivery consultation, care of newborns and breast feeding. Lack of providers' attention to these needs may seriously compromise care.

Due to their particular religious and cultural beliefs, Muslim women face barriers in accessing and utilizing health care. Many providers also feel challenged in meeting the needs of Muslim patients, especially female Muslim patients. The few studies that have explored Muslim women's health needs in the U.S., Canada, and Australia indicate that the failure of the health-care providers to accommodate the beliefs and customs of Islam influences Muslim women's participation in important programs, such as those for breast and cervical cancer screening and antenatal care. Limitations of these studies include 1) grouping Muslim women with other groups, such as Asian women, 2) using small sample sizes, 3) addressing narrow foci of women's health, and 4) relying heavily on descriptive methods with a glaring lack of intervention research.

With regard to health-care access, Muslim families may face similar hardships to other underserved populations in accessing health care, particularly when it comes to obtaining appropriate employment and health insurance. Health insurance, however, is only a small fraction of the problem impacting the Muslim community. The lack of cultural competency in health-care delivery may be a much greater problem. Examples, from health-care settings, of providers' lack of accommodation of Muslim

women's beliefs and customs include failure of breast and cervical cancer screening programs to accommodate Muslim female patient's needs for privacy and modesty.

I will briefly touch upon cultural competence and patient-centered care, the key concepts, which are the basis of this conference and related work.

Cultural competence consists of a set of behaviors and attitudes that enable professionals to work effectively in cross-cultural situations. In terms of health care, culturally competent care is defined as the knowledge, skills, and attitudes required for providing quality clinical care to patients from different cultural, ethnic, and racial backgrounds. It involves tailoring delivery to meet patients' social, cultural, and linguistic needs in an effort to improve outcomes and eliminate disparities in health care. Culturally competent care improves the quality of care for all patients by treating each patient interaction as a cross-cultural encounter.

Cultural competence recognizes that each individual has a unique cultural identity. This identity is a complex mix. Awareness of a particular culture can provide a useful "short cut" to understanding the general values, beliefs, and behaviors of an individual but there is a danger that it can stereotype that individual. The result is that individual needs are not identified and met. Cultural understanding requires providers to look at their biases, challenge their assumptions, know people beyond labels, and develop a far greater capacity for compassion and respect. Without this appreciation, it is unlikely that health care will be improved.

Cultural competence education has been considered critical in preparing health-care providers to meet the health needs of the growing, diverse U.S. population. As patients present varied perspectives, values, beliefs, and behaviors regarding health and well being, it is important that providers be culturally competent communicators. The Institute of Medicine report, "Unequal Treatment," recommends cultural competence education as a method of improving provider-patient communication and eliminating racial/ethnic disparities in health care. The report states that racial and ethnic minorities receive lower quality health care, even when access to insurance and socioeconomic status are controlled for. In addition to race and ethnicity, lower-quality health care is often associated with a person's national origin, limited English proficiency, religion, age, social class, gender, sexual orientation, physical and mental disability, immigration status, and obesity.

Patient-centered care is increasingly recognized as an important professional attribute. The Institute of Medicine defines patient-centered care as, "health care that establishes a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and solicit patients' input on the education and support they need to make decisions and participate in their own care." Thus patient centeredness is a characteristic of the relationship between the clinician and the patient. In contrast to care that is clinician-centered or disease-focused, patient-centered care customizes treatment recommendations and decision making in response to an individual patient's preferences and beliefs.

Essential components of patient-centered care, described by Anderson and colleagues, include exploring both the disease and illness with the patient,

understanding the whole person, finding common ground regarding management, incorporating prevention and health promotion, providing patients with information about disease management in a patient-friendly manner, and enhancing the doctor-patient relationship. Patient-centered care can result in greater patient satisfaction and improved outcomes without significant increases in time and money for the provider. It can also benefit health-care professionals because many become more fulfilled by the care they provide. Patient-centered care has been shown to influence patients' health through perceptions that their visit was aimed toward their needs and especially that common ground was achieved with the physician. Patient-centered practice also increases the efficiency of care by reducing diagnostic tests and referrals. Provision of patient-centered care is a challenging goal; however, the literature indicates that physicians can be trained, irrespective of years in practice, to provide patient-centered care and increase patient participation and satisfaction with care.

One of the key elements of patient-centered care is an effective and open line of communication between the provider and the patient. There is a wealth of evidence affirming the importance of effective provider-patient communication, as well as the need for improvements in this domain. Physicians' communication styles have also been shown to positively impact participatory decision making and are likely to be an important component of providing culturally competent care. Most research suggests that there are always ample opportunities for health-care providers to improve their communication skills, though few studies have explicitly linked communication skills with care that is culturally and linguistically appropriate. An effective provider-patient partnership should ideally be the product of a relationship in which the clinic makes recommendations based on an informed understanding of the individual patient's needs and the context of his/her life (e.g., home life, job, family relationships) to enhance the patient's ability to act on the information provided. Additional features of an effective clinician-patient partnership include informed, shared decision making and development of patient knowledge and skills needed for self-management of illness. Individuals of different races, cultures, genders, and ages have different preferences and beliefs and providers have been found to vary in the extent to which they demonstrate a participatory decision making style. Patients' trust in their providers and ideally, the provision of culturally competent care are also essential components of patient-centered care.

Both patient-centered care and cultural competence aim to improve health care quality. For Muslim women in the United States, provision of culturally appropriate, patient-centered care has potential for better patient outcomes as well as benefit for health care professionals. With improved provider-patient communication, each could potentially teach the other what it means to be sick, what treatments are religiously or culturally endorsed or otherwise, what factors impact decision making and who makes the decisions. Providers certainly have the need and the capability to enhance their abilities to question patients respectfully and non-judgmentally, while patients can be encouraged to better explain their concerns without hesitation or reservations.

The Institute of Medicine (IOM, 2001) defines quality as, "the degree to which healthcare services for individuals and populations increases the likelihood of desired

outcomes and are consistent with professional knowledge,” and outlines six aims for a redesigned 21st century calling for health-care systems to be safe, effective, patient-centered, timely, efficient, and equitable. The realization of these national priorities requires rigorous intervention research to improve health behaviors and outcomes for all people. Interventions should, not improve access to care and promote health, but should also be tailored to appropriate cultural needs, thus providing a greater likelihood of acceptability, relevance, and improved outcomes.

I have laid a great deal of emphasis on provider education; however, the importance of patient education and awareness should not be underestimated. Muslim women and their families have to take the responsibility of understanding and interpreting their religion accurately to avoid unnecessary and harmful practices. For example, Islam is a very flexible religion that lays emphasis on the sanctity and preservation of life; modesty requirements should not force a female patient not to be seen by a male provider when female providers are not available. Similarly, women who are ill, pregnant, or lactating should avail the waiver from ritual fasting during Ramadan. The negative mental and physical consequences of female genital circumcision compel those who practice it based on religious beliefs to reexamine Islamic injunctions, which do not provide any evidence of this harmful practice being prescribed by Islam. These are only a few examples, but a whole host of other physical and mental health conditions will be positively influenced by patient education and awareness.

The challenge of redesigning processes of care to enhance delivery of patient-centered care is an ongoing dilemma for public and private policy-makers. The Muslim population in the U.S. is continuing to grow. Therefore, health-care professionals can expect to be responsible for providing care to increasing numbers of people from this population. Bridging the quality gap for American Muslim women requires a multidisciplinary commitment and effort. I am confident that this conference and the subsequent research resulting from this work should contribute significantly to the development of practice guidelines, and ultimately, to policy regarding provision of culturally appropriate patient-centered care for Muslim women. It is anticipated that the project findings also will form the foundation for additional research, including development and testing of educational interventions to train patients and providers to use the guidelines developed in this project.

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# WOMEN IN ISLAM: FACTS AND PERCEPTIONS<sup>1</sup>

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I have been asked to discuss women's place in Islam so as to distinguish facts from perceptions. This is such a broad topic and since I have limited time, I am going to be very selective.<sup>2</sup> Rather than recite a list of women's rights, I will focus on four issues—gender preferences, the young age of marriage for girls, views of the wife as her husband's sexual property, and polygamy—all of which impact the well-being of Muslim women and all of which are subject to false stereotypes. My aim in doing this is to help you understand and discuss the health-care needs of Muslim women within the context of Islamic tenets.

Basically, what I want to do is to share with you what Islam's scripture, the Qur'an, has to say about each issue and there are two reasons why I think this is important to do. First, for Muslims, the Qur'an is the word of God that was revealed to the prophet Muhammad over a 23-year period in the seventh century in Arabia. It is therefore the most authoritative source of Islam's teachings.

Second, many people hold that the Qur'an itself oppresses women based on their reading of three or four lines in it. I won't have time to discuss all the lines and nor do I want to pretend that one can settle all disputes by quoting the Qur'an since Muslims disagree on the translations and meanings of certain words. Even so, I think one of the most powerful ways to challenge the abuse of women in the name of Islam is to show that the Qur'an does not, in fact, sanction many ideas and practices that we associate with Islam.

## A. Gender preferences

Perception 1: Islam values men over women and even gives men the right to kill women as evidenced by so-called "honor" killings in some Muslim societies.

*Fact: No.*

The Qur'an teaches that women and men originated in a single self, that they are both God's representatives on earth, and that they are equally capable of moral personality. That is, it does not discriminate against human beings based on their biological sex. Nor does it teach that the woman was created from the man's rib or that she was responsible for the Fall. In fact, the Qur'an does not teach the concept of original sin or the Fall. These are the Qur'an's foundational teachings that we need to keep in mind when examining its position on male-female relationships.

The issue of gender preferences comes up in the Qur'an in two contexts. One is in the context of its criticism of the polytheists (people who worship many gods) who were in the habit of ascribing daughters to God even as they were burying their own new-born girls alive in the sand and abusing those whom they allowed to survive. The Qur'an condemns both practices equally sharply:

And they assign to God daughters; glory be to Him!—and they have their desire [for sons]; and when any of them is given the good tidings of a girl, his face is darkened and he chokes inwardly, as he hides him from the people because of the evil of the good tidings that have been given unto him; whether he shall preserve it in humiliation, or trample it into the dust. Ah, evil is that they judge!<sup>3</sup>

It is clear that what the Qur'an finds contemptible is not daughters, since it refers to their birth as "good tidings," but ascribing paternity to God, and other verses condemn those polytheists who, says the Qur'an,

falsely,  
Having no knowledge,  
Attribute to [God]  
Sons and daughters.  
Praise and glory be  
To [God Who] is above  
What they attribute to Him!<sup>4</sup>

Indeed, the Qur'an even forbids sacralizing God as the father of Jesus. As it says, "Jesus the son of Mary Was (no more than) An apostle of God. . . . God is One God: Glory be to Him: (Far Exalted is He) above Having a son."<sup>5</sup> In fact, in other verses, the Qur'an forbids depicting God even as a figurative father. So, what is at issue here are not gender preferences, since the Qur'an rejects not just ascribing daughters to God, but also the male gender for God. Rather, what is at issue is a rejection of the patriarchal imaginary of God the Father. Significantly, the Qur'an also does not valorize fathers, fatherhood, or the concept of father-rule, which is one of the reasons that I read it as an antipatriarchal text.

The second context in which the issue of gender preference comes up in the Qur'an is in the context of female infanticide. As I noted, many Arabs used to bury their baby girls alive and the Qur'an promises that on Judgment Day "the female (infant) Buried alive [will be] questioned For what crime She was killed."<sup>6</sup> In effect, God will hold men accountable for the murders they commit based on their gender preferences. I have no idea how anyone can read this verse and yet think that a Muslim man can kill any woman in order to protect his "honor!"

Most obviously, gender preferences impact Muslim women's health in two ways. At an extreme, they can lead to outright murder though I should caution against assuming that "honor killings" are as widespread as we sometimes assume them to be because of media sensationalism. Less spectacularly, gender preferences can lead to various forms of discrimination in schooling, upbringing, nourishment, and so on, against girl children. Sadly, these practices are not limited to Muslims alone and girls are at risk in many societies in "Third World" countries today.

## B. Age of marriage

While on the subject of girls, I want to consider the issue of the young age of marriage for girls in some Muslim societies.

Perception 2: Islam enjoins marriage to little girls.

*Fact: No.*

Before I say anything about Muslims, I want to point out the obvious: that all patriarchal societies put a high premium on female youth and virginity. Indeed, even in the U.S., the age of consent for girls was between 7-10 years as late as 1889 and was raised to 18 only as the result of feminist campaigns.<sup>7</sup> An interesting, if horrific, consequence of protecting women in the U.S. and Europe against child marriage and sexuality has been that many U.S. and European men now go to Third World countries to have sex with minors and the fear of HIV/AIDs has led to a thriving sex market in children, both girls and boys, as young as five and six.

I make this point so as to contextualize this discussion and not make it seem that Muslims are aberrant in this respect. However, there is no denying that among Muslims there is religious sanction for marrying young girls because one of the prophet Muhammad's wives, Ayesha, was a young girl when they got married. In passing I should mention that all his other wives were either widows or divorcees and with some, he had no sexual relationship but took them in as a way to offer them protection (I will speak about this notion of protection when I talk about polygamy). Also, his first marriage, to Khadijah, was monogamous. She was twice widowed and 15 years older than him when he married her at age 25.

As for the prophet Muhammad's marriage to Ayesha, we need to keep several things in mind. Most obviously, there was no concept of childhood in the seventh century and such marriages were not unusual. Moreover, Muhammad was allowed to contract certain types of marriages as "a privilege for thee only, not for the (rest of) believers,"<sup>8</sup> and not all the types of marriages he contracted are binding on Muslim men. Furthermore, since all his wives, except one, were widows and divorcees, Muslim men who want to follow his example could just as easily follow the norm rather than the exception.

However, most importantly, there is no conclusive agreement about Ayesha's age. Some people have put it as low as nine because of stories that she was playing with dolls when she got married. But then there are other stories that say that she had "good knowledge of Ancient Arabic poetry and genealogy" and could pronounce the "rules of Arabic-Islamic ethics,"<sup>9</sup> which a child of nine could hardly have done. Based on these stories, as well as what we know of her sister, Asma's age and of Muhammad's migration from Makkah to Madina some people say that she was over 13 and perhaps between 17 and 19 at the time of her marriage.

The point is that everything we know about her is from stories of her life written a century and a half after her death, so that even the earliest written sources, "already capture [her] life as a legacy, an interpretation." In studying Ayesha, therefore, we are

studying, “male intellectual history, not a woman’s history, but reflections about the place of a woman, and by extension, all women, in exclusively male assertions about Muslim society.”<sup>10</sup> That is why using her example to justify pedophilia is wrong and it also tarnishes the prophet Muhammad’s legacy by obscuring the differences in historical understanding between his time and ours.

The health consequences of marrying young are, I believe, fairly well established and include not just physical and sexual burdens upon the body but also mental and emotional traumas arising from early marriages. Ironically, women are often complicit in young marriages because the younger a bride, the more easily she can be controlled by her mother in law who plays a disproportionately important role in many Muslim cultures and families, sometimes even more important than the husband himself.

### **C. Women as sexual property**

One of the things that I find most troubling about men who want to marry little girls is that they ignore the Qur’anic injunction that an Islamic marriage must be based in chastity not lust. And this provides a good segue into the next topic:

Perception 3: In Islam a wife is her husband’s sexual property and he can treat her as he wills.

*Fact: No.*

Last year, the New York Times published a still from the Dutch film “Submission,” whose director, Theo Van Gogh, was later killed by a Muslim. The picture was of a Muslim bride’s back with a line from the Qur’an written on it saying that, “a man may take his woman in any manner, time or place ordained by God.”<sup>11</sup> I don’t think there’s a more powerful or troubling way to suggest that Muslim women’s oppression is codified in the scripture itself. And, of course, since most people have never read the Qur’an, it’s hard for them to believe otherwise.

I want to place that line in context, by reading the verses from which it is taken:

They question thee (O Muhammad) concerning menstruation. Say: it is an *adan* so let women alone at such times and go not in unto them till they are cleansed. And when they have purified themselves, then go in unto them as Allah hath enjoined upon you. Truly Allah loveth those who turn unto Him and loveth those who have a care for cleanness. Your women are a *harth* for you (to cultivate) so go to your *harth* as ye will, and send (good deeds) before you for your souls, and fear Allah, and know that ye will (one day) meet Him.<sup>12</sup>

First, it’s important to understand that the root meanings of *adan* are “damage, harm, injury, trouble, annoyance, and grievance.”<sup>13</sup> That is, menstruation is hurt, etc., and not pollution. Even if menstrual blood is polluting, it doesn’t follow that the

woman's body is polluting since not a single verse in the Qur'an says that. Moreover, the Qur'an also counsels cleansing after calls of nature, indicating that uncleanness results from biological functions and not from biological differences. I make these points because of the tendency in many religious traditions to view the woman's body as polluting.

These verses are said to have been revealed after some men asked the Prophet as to when and in what positions they could have sex. The Qur'an's response to the "when" is to forbid sex when women are menstruating since it is a time of hurt and trial for them (the Qur'an also forbids sex during the fast in Ramadan). The Qur'an's response to the "how" is to refer to what God "has enjoined." But what precisely has God enjoined? The preceding line says that men are not to go into women until they are cleansed. So, most obviously what God has enjoined is cleanliness.

However, the line following this phrase refers to women as "harth" which Muslims translate as tith or property. Based on this translation and the phrase "as ye will," they assume that a husband may take his wife in any time, manner, or place as he wants since she is his sexual property. But this is an unwarranted conclusion for a number of reasons.

First, at the time that the Qur'an was revealed, there was no concept of property in land and hence no notion of ownership of land. So harth could not have meant property or ownership. (Even when Europeans arrived in North America in the fifteenth century, indigenous peoples did not view land in terms of ownership.) That is why early Muslim scholars understood the Qur'anic reference to harth to mean, not property or ownership, but tillage, or sowing; to put it bluntly, vaginal sex since the concept of tith denotes the sowing of seed.

It is also instructive to look at how the Qur'an uses the word harth in other contexts and in at least one, it uses the word for paradise. Since paradise is not real estate to be parceled out to property owners, it is reasonable to assume that the word harth in the Qur'an does not imply either ownership or property.

Second, the Qur'an repeatedly and categorically instructs that marriage should be based in "chastity, not lust"<sup>14</sup> and it includes chaste women among Jews and Christians, whom it calls the People of the Book. In its words, permitted to Muslim men are "Chaste women among The People of the Book, Revealed before your time,-- When ye give them Their due dowers, and desire Chastity, not lewdness, Nor secret intrigues."<sup>15</sup> Clearly, chastity implies not the absence of sex but, rather a mode of sex that is neither lewd nor lustful. Thus, God is enjoining uncorrupted behavior between spouses and one can assume that violence and rape do not qualify as such behavior.

Third, while the Qur'an does not refer to the wife's consent or will in this verse, it does so in other verses and if we are to have a composite picture of its teachings we need to read all the verses on a particular subject rather than one or two. In 4:19, the Qur'an outlaws the practice of inheriting "Women against their will,"<sup>16</sup> a reference to the seventh-century Arab practice of acquiring a dead father's wives as part of his estate. What is significant is not just that the Qur'an banned this heinous practice but that it did so by imputing a will to women. If the Qur'an acknowledges a woman's will and instructs men to respect it, what reason is there to believe that a wife has no will,

or that her husband has no duty to respect it if she expresses it by declining a certain mode of sexual behavior?

Indeed, the Qur'an clearly states that God created helpmates from ourselves so what "ye might find [sukun] in them, and [God] ordained between you love and mercy."<sup>17</sup> Sukun is often rendered as love but it implies a deeper intimacy that grows from sexual gratification and mental peace.<sup>18</sup> By emphasizing the mutuality of sexual desire, the Qur'an establishes women as sexual beings and affirms that sex is a joyful and purposive activity in and of itself. How could such a view of marriage be compatible with sexual abuse? After all, in the Qur'an's telling, spouses are each others awliya (friends, guides) and garments.

So, for all these reasons, the permission to a husband to go into his wife as he wills and as God enjoins is not as open-ended as it may seem and it is certainly not an incitement to rape as that one line on the bride's back so misleadingly suggests. And, yet, there is no doubt that many Muslim men are misled by such lines and that violence against women in Muslim societies is a real issue that we need to acknowledge if we are to safeguard women's health and, since physical abuse also damages the psyche of the abuser, men's mental health as well.

#### **D. Polygamy**

Of course, at this point some of you may be wondering why, if what I've said about the Qur'an's teachings is true, does it privilege men by allowing polygamy and this brings me to the last issue.

Perception 4: Islam allows all men to marry four wives because men have more sexual needs than women and/or because they need sons to carry on their line, etc.

*Fact: No.*

The Qur'an only speaks about polygamy in the context of orphans:

Give the orphans their property, and do not exchange the corrupt for the good [i.e., your worthless things for their good ones]; and devour not their property with your property; surely that is a great crime. If you fear that you will not act justly towards the orphans, marry such women as seem good to you, two, three, four; but if you fear you will not be equitable, then only one, [aw] what your right hands own; so it is likelier you will not be partial.<sup>19</sup>

This reference to women whom men's "right hands own" is said to be war captives, slaves, and concubines, all of whom were part of the structure of seventh century tribal Arab society and for whose just treatment the Qur'an laid down guidelines. However, some scholars translate "aw" as "that is;" on their reading, the Qur'an is referring to women whom men's right hands possess, that is, their spouses. In other

words, it is encouraging men to remain married to their spouses.<sup>20</sup>

Even if one does not accept this translation, the point is that polygamy is restricted to orphans, and then too only in those cases where the guardian feels that (a) he may be unable to do full justice to his charge outside of marriage (the assumption being that marriage gives the husband a stake in the honest management of his wife's property), and, (b) if the marriage does not do injustice to the wife; if there is such a likelihood then the Qur'an is clear that a man should marry only one wife. Indeed, in another verse the Qur'an says that men in polygamous situations are never "able to be equitable between your wives, be you ever so eager."<sup>21</sup> So, the Qur'an itself makes it clear that men are generally not able to treat more than one wife justly.

So then why did it even permit polygamy? The reason is simple: in a predatory tribal society, marrying a woman, especially someone as vulnerable as an orphan, was the only way to secure her protection. It was thus an ethical concern for orphans that motivated the Qur'anic provisions on polygamy, not the desire to favor men. After all, the Qur'an never presents polygamy as a way for men to fulfill their sexual needs or to acquire offspring.

Lastly, (and I say this for the benefit of those who may not know much about any religion) Islam did not invent polygamy; other than Jesus, none of the Hebrew prophets was celibate or monogamous and some, like David, had 900 wives and concubines. Monogamy is a relatively modern practice and, contrary to popular perceptions, the overwhelming majority of Muslim marriages are monogamous.

However, for Muslims who do not understand the logic or reasoning behind the Qur'anic provisions on polygamy, the very idea that men can marry more than one wife leads them to assume that women have lesser worth than men and, on that basis, to treat them as secondary to men. Naturally this discrimination against women leads to all kinds of problems and difficulties and even to abuse and must therefore be considered a real and potential hazard to women's well-being.

## Conclusion

This has been a long talk, so I will make my conclusions brief.

Basically, I want to say two things. First, for reasons that I hope are clear by now, it is wrong to explain everything that happens to Muslim women in terms of Islam's teachings. Just as there are Jews and Christians whose lives do not reflect Biblical precepts, so there are Muslims whose lives do not mirror the Qur'an's teachings. To put it simply, not everything Muslims do is Islamic. Many of the practices in Muslim communities have less to do with Islam than with patriarchal cultures and prejudices most of which run counter to Islam.

I make this point because I think too often people—and these include Muslims themselves—confuse religion and culture. Clearly, it is not the place of health-care workers to interrogate or try to rectify this confusion; however, they need to be cognizant of it and not to begin from the assumption that everything related to Muslims can be explained solely in terms of Islam.

Second, I think it's obvious that even though Muslims live in our midst, most

people know nothing about our religion and, in some ways, 9/11 has made it even harder for them to approach Islam with an open mind. I know that we like to think of the U.S. as a great “melting pot” of cultures but the truth is that most people are locked into enclaves of mutual ignorance and animosity. And yet, for better or worse, the welfare of different communities is tied together, so we have to find more ethical and sustainable ways to “know one another”—as the Qur’an calls it—in our own self-interest. By dispelling some myths I hope I have provided an incentive to some of you to want to embark on such a journey.

## Notes

1. This is a slightly revised version of the keynote address I was invited to give at the conference by Dr. Memoona Hasnain, Director of Research at the UIC College of Medicine.
2. For a more nuanced and detailed analysis please see Asma Barlas, *∞Believing Women± in Islam: Unreading Patriarchal Interpretations of Islam* (Austin, TX: University of Texas Press, 2002).
3. 16: 55-60; in A.J. Arberry, *The Koran Interpreted*, New York: Allen and Unwin, 1952: 292 (my emphasis).
4. 6:100-01, in Abdullah Yusuf Ali, *The Holy Qur’an*, New York: Tahrike Tarsile Qur’an, 1988: 319.
5. 4: 171 in Yusuf Ali, 234.
6. 81:8-9, in Yusuf Ali, 1694.
7. Stephanie Coontz, *The Way We Really Are*: New York: Basic Books, 1997.
8. 33: 50; in M.M. Pickthall, *The Meaning of the Glorious Koran*, New York, Mentor Books, n.d., 305.
9. Wibke Walther, *Woman in Islam*, Montclair, N.J.: Abner Schram, 1981: 75.
10. D.A. Spellberg, *Politics, Gender, and the Islamic Past*. NY: Columbia University, 1994: 2; 191.
11. Marlise Simons, “Graphic Film of Protest, and Cries of Blasphemy,” NYT, Sept. 27, A4.
12. 2:222-223, in Pickthall, 53.
13. J.M. Cowan, *Arabic-English Dictionary*. Ithaca, NY: Spoken Language Service, 1976: 12.
14. 4:24, in Yusuf Ali, 187.
15. 5: 6, in Yusuf Ali, 241-242.
16. in Yusuf Ali, 185.
17. 30:21, in Pickthall, 291.
18. Mustansir Mir, *Dictionary of Islamic Terms*. NY: Garland Publishing, 1987.
19. 4:1, in Arberry, 100 (my emphases).
20. See, for instance, Muhammad Asad, *The Message of the Qur’an*, Gibraltar: Al-Andalus, 1980.
21. 4:125, in Arberry, 119.

## **PATIENT-CENTERED CARE: RELEVANCE TO MUSLIM WOMEN'S HEALTH**

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*\* The views expressed in this article do not necessarily represent the views of the Agency for Healthcare Research and Quality or the U.S. federal government.*

The population of women in the United States is predicted to grow considerably in the next 50 years, and this growth will reflect a significant increase in minorities. For example, Hispanic women form 11 percent of the current U.S. population, but this proportion will more than double by year 2050. Estimates indicate that Muslim women constitute 51 percent of a total of over seven million Muslims living in the United States. By 2010, the Muslim population will be the largest non-Christian group in this country, and by 2025, the total population of U.S. Muslims will more than double. It is very important that we learn more about Muslim women's health issues, beliefs, and behaviors. This will help us develop strategies to provide quality health care for Muslim women.

### **Disparities in Health Care**

There is still a large gap to be filled to provide the best quality of care to all Americans. This is particularly true for women. Findings from the National Healthcare Quality and Disparities Reports show that 17 percent of pregnant women do not start prenatal care until the third trimester, and that African-American, Hispanic, and Native American women are less likely than Caucasian women to receive any prenatal care at all. Major gaps also occur in preventive care. For example, African-American, Hispanic, and lower-class adults are less likely than Caucasians and members of the upper-middle class to receive colorectal and breast cancer screening and influenza immunization. Disparities in health care are not limited to minorities, the poor, and the uninsured. In many areas, women receive poorer care than men. For example, uninsured women are 20 percent more likely than uninsured men to have difficulties in obtaining care. According to the national reports, women did better than men in some areas of cancer care, such as mortality rates, but did much worse than men in certain areas of health-care safety, in HIV/AIDS care, and in cardiovascular care. As to the latter, our findings showed that women continue to be less likely than men to receive indicated drug therapy (e.g., aspirin, beta blockers) or to have invasive procedures after a heart attack. Only 53 percent of Hispanic women who smoke received advice to quit smoking when visiting a doctor, compared to 66 percent of Caucasian women. Rates for both subpopulations of women are low and should be improved.

To enhance their clinical practice, health-care providers should go beyond their knowledge of epidemiology, disease manifestations, and management to an increased

awareness about disparities and their possible causes.

### **Patient Satisfaction with Health Care**

The national reports also looked at patients' satisfaction with the care they received. It is important for providers to listen to patients, since they must rely on patients for information about symptoms and other information bearing on medical conditions and treatments. It is also important for providers to listen carefully because patients and providers often have different views of symptoms and treatment effectiveness. Clear patient-centered explanations are a key element in patient satisfaction. Overall, 58 percent of adults said their doctor always explained things clearly to them. This percentage remained stable from 2000 to 2001, but there is still room for improvement.

Research has shown that the way in which patients and health-care providers communicate with each other can have an impact on the quality of care they receive, their disease outcomes, and their satisfaction with the care received. This is of particular relevance as our country faces increasing diversity in the background of its population.

### **Improving Health Care through a Patient-Centered Approach**

The Institute of Medicine defines patient-centered care as, "health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care." In addition, patient-centered care "encompasses qualities of compassion, empathy, and responsiveness to the need, values, and expressed preferences of the individual patient."

According to the national reports, scores for providers showing respect for patients' values and preferences are good, and remained stable from 2000 to 2001, but again, there is still room for improvement. Patient-centered care approaches that rely on building a doctor-patient relationship, improving communication techniques, and fostering a positive atmosphere have been shown to improve the health status of patients, to lessen the symptom burden on patients, to stimulate patient compliance and adherence to treatments, and to reduce misdiagnosis due to poor communication.

Patient-centered care has been found to reduce under use and overuse of medical services, to reduce the strain on system resources and/or to save money by reducing the number of diagnostic tests and referrals. Some, although conflicting, evidence in the literature also indicates that patient-centered care may reduce the risk factors that often lead to malpractice suits. Although patient-centered care has the potential to reduce health-care costs, a few studies have shown that providing this type of care may, in the short run, increase costs to providers.

The patient-centered care approach is of particular relevance to women, who constitute the majority of the population seeking medical help, using more health services than men and consuming more medications. Women also live longer than men and are, therefore, more likely to live with chronic conditions. By putting female

patients in the driver's seat, their shared cultural and individual influences will be integrated into their care plan. Improved health outcomes and, ultimately, enhanced quality of life will result.

The bottom line is that providing patient-centered care is critical to providing high-quality care. However, it requires good communication skills and is better achieved through health-care providers who are culturally competent and patients who have a certain level of health literacy. Providers must have the ability to assess the health-care issues applicable to men and women of diverse backgrounds, as well as the issues specific to individuals. In relation to Muslim women, as a first step, providers should be knowledgeable about the different views of the Eastern and Western medical practices.

### **Factors Affecting Patient-Centered Care**

Studies have shown that provider attitudes and ability to communicate, patient socioeconomic status, literacy levels, and English-language proficiency; patient and provider gender, racial, and ethnic concordance; patient trust; and perceived discrimination are all factors that can affect the quality of the doctor-patient relationship. There is, as yet, only limited information from population-based studies that compare multiple variables, such as the perceived quality of the doctor-patient relationship for women versus men and for racial and ethnic subgroups of women. Therefore, there is a broad array of opportunities to develop patient-centered approaches and demonstrate their effectiveness in diverse populations in multiple health-care settings.

Some gender differences in health beliefs and risk behaviors seem to be consistent across several racial and ethnic groups. Generally, women seem to hold more positive attitudes and beliefs regarding their health and health care and they tend to communicate better with their physicians in a patient-centered approach. Women ask more questions in general and are more likely to comply with doctors' instructions.

Men are more likely to adopt a variety of attitudes and beliefs that undermine their health and well-being. They believe in their masculinity, invulnerability to risk, and personal control over health risks. By holding riskier beliefs, men engage in fewer health-promoting behaviors and greater risk-taking behaviors (e.g., alcohol abuse) that contribute to their increased risk of serious chronic disease, injury, and death. In addition, men are less likely to visit physicians, to obtain periodic physicals and screenings, to practice self-examinations, and to restrict their activities or stay in bed when they are suffering from acute or chronic conditions. Men, in fact, are less likely to persist in caring for a major health problem.

Physicians are generally perceived as providing women patients more information in a more comprehensible manner and as communicating more positively, including making more attempts to engage women in the discussion about their health care and asking them more questions about their feelings.

Considerable gender differences exist in communication style in clinical and nonclinical settings. Female physicians are more likely than male physicians to have marked nonverbal expressions, to engage in conversations that convey more

psychosocial discussion, to ask questions and engage in more partnership-building behaviors, to have overall longer visits, and to hold more patient-centered values.

Physicians can also have racial/ethnic bias. They tend to have a more negative perception of African Americans and those with low/middle socioeconomic status, and African-Americans are less likely than Caucasians to receive recommendations for procedures. Studies have shown that physicians seem to use better questioning and more facilitating and empathy skills with Caucasians than Hispanics and that Caucasian patients receive higher technical and interpersonal care. Finally, non-Caucasian physicians tend to have a less participatory attitude with patients than Caucasian physicians do.

One approach to mitigating bias is cultural competence training. A recent systematic review of the literature supported by the Agency for Healthcare Research and Quality showed that cultural competence training can increase providers' knowledge of, attitudes toward, and skills with patients. This training should be offered to all health-care professionals. Also, promoting cultural competence in health-care organizations should be part of total quality management and continuous quality improvement activities. These activities should include analyzing the sociocultural dimensions of one's own practice site and the implications for practice management.

### **Patient-Centered Care for Muslim Women**

Care in the Islamic view is a reflection of the Eastern world view, which emphasizes the whole human being, integrating and balancing the spirit, body, and emotions. It is a holistic approach, addressing the physical, psychological, social, and spiritual dimensions of the patient. In contrast, health care in the United States represents the Western world, which focuses primarily on bodily comfort and cures. In separating body from mind, Western care lacks the holistic emphasis on the integration of all human elements. However, Western care practices are increasingly paying attention to mind-body integration.

The five pillars of Islam refer to beliefs that specifically relate to health and care. They are monotheism, purification, fasting, pilgrimage to Mecca, and prayer. It is very important that physicians respect these beliefs. For example, many Muslims engage in ritual prayer five times a day at specific times. Physicians must respect these prayer time and be considerate while visiting patients at the hospital or when prescribing medications that need to be taken more than once a day.

Modesty addresses restrictions in dress and beliefs concerning privacy of parts of the body. Translating this into clinical practice means that Muslim women may not be comfortable with male providers. Because more Muslim males are physicians, it is more likely that Muslim women will be cared for by a male physician, so the presence of another female in the room may be essential during the doctors' visit. Visiting a sick person, particularly a family member, is an important community or family bond that may affect the patients' recovery. Dietary restrictions also may affect the care of Muslim women. Consumption of pork, drinking intoxicating beverages, or partaking of anything that harms the body is unlawful. Health-care providers should be aware of these cultural aspects to be able to obtain positive treatment outcomes.

Little or nothing is known about the quality of care received by Muslim women in the United States and much less about what Muslim women's preferences are. Gender-based studies should be performed to obtain this knowledge and data about the health services they receive should be collected to help identify disparities and the reasons for disparities. Study results should be disseminated to allow implementation and changes in policy. In this way, we will be able to provide comprehensive quality health care for Muslim women.

## Summary

Providers and policymakers should be committed to helping the health-care system enhance its response to women's needs, and in particular to the needs of Muslim women. Numerous specific questions are still unanswered, providing us with a broad opportunity to further study patient-centered care in general or specifically care that targets women and/or Muslim women. For example, we still do not know how Muslim women's perceptions can be effectively incorporated in efforts to redesign the processes of care; which approach to chronic disease management, disease-focused or patient-centered, is most effective in promoting participation by Muslim women in their health care; by what mechanism—improved patient knowledge, enhanced self-efficacy, and/or other pathways—do shared decision-making approaches work; how can culturally competent communication be reliably assessed; how do access to and use of Web-based technologies and other modalities for health information and education influence what Muslim women need from encounters with their clinicians.

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# CULTURALLY APPROPRIATE HEALTH CARE FOR MUSLIM WOMEN

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First of all, I would like to thank the Department of Family Medicine at the UIC College of Medicine for inviting me to give this talk. I am honored to be a part of such a prestigious panel of speakers. Dr. Memoona Hasnain deserves special praise for her unmatched devotion and commitment to this important issue in health care. I feel extremely fortunate to have gotten this unique opportunity to share my experiences and my views on a topic for which I have a great passion.

My medical experience has taken me from seeing Muslim patients in a Muslim-dominated country to seeing religiously diverse patients, most of whom are of a Jewish, Muslim, or Christian origin. As a provider of health care, and on rare occasions a recipient of medical care, I have experienced low standards of care for Muslim women. My profession as an internist and as a hospice medical director has exposed me to all stages of human life.

On an average day I end up seeing a shy, 16 year old Muslim girl with sore throat, a 26-year-old pregnant Muslim with back pain, a 50 year old Muslim with hot flashes, and an 80 year old Muslim woman faced with end-of-life issues. The common denominator in these cases is trying to provide medical care in the framework of their Islamic beliefs. Like any other religion, Islam has a huge spectrum of believers, starting from the very liberal to the very conservative. As a health-care provider I have learned to respect everyone's faith.

All of my adult life I have heard my father preach modern Islam, according to which Muslim women deserve to have equal rights and are independent to make their own decisions in every aspect of their lives. Yet I was influenced by my maternal grandmother to pray five times a day and wear a veil inside the mosque.

"Today the American Muslim community comprises people drawn from a wide-ranging ethnic and professional mix. Whether they are immigrants, indigenous Americans, or converts, all are united in the unique theistic experience that is Islam. Whether they are physicians, lawyers, entrepreneurs, professors, cooks, or factory workers, all of them are making a contribution to America's future." These observations from a speech given at the 34th Annual Convention of the ISNA in 1997 suggest both the heterogeneity of the American Muslim community and the concern of many of its members and leaders that Islam should be recognized as a legitimate and contributing sector of American society.

Today there are more than 1.3 billion Muslims across the globe, found in virtually every country, and Islam is considered the second largest religion in the world and one of the three major religions in the U.S.

Only recently have many Americans begun to grasp that Islam, along with Christianity and Judaism is a "Western Religion." According to Jane I. Smith author of

“Islam in America” one of her audience members in the near past asked her where Islam is located, supposing it to be a country. Recent statistics show that Islam is the fastest growing religion in America, and it is difficult not to notice the presence of Muslims in American cities and towns. There are between six and eight million Muslims in the U.S., 47 percent of whom are female.

“Islam” in the literal sense means, “surrender to the will of God.” Understanding values of a religion is necessary in providing quality health care.

Religion and science are the most influential forces in our lives. In spite of the important role that religion plays in many people’s lives, approaching a patient only from a perspective of their religious beliefs would be a mistake. Incomplete knowledge is not a safe basis for effective action. Beneficial action stems from sound knowledge. However, the American media is the sole source of most of ones knowledge in this country, a phenomenon unique to American society. The media and the government have their own agenda. We as health-care workers and consumers need to set our goals without political bias.

We as Americans are taught to think of Islam as a culture in which social code and religious law alike force women to accept male authority and surrender to the veil. These misconceptions and judgmental impressions have created a sense of mistrust between Muslim women and the west. We need to clear these misconceptions and start thinking beyond the veil issue and start focusing on other issues important to Muslim women. Contrary to the concept of the general population that Muslim women with veils are uneducated and abused, a majority of the women are highly educated and religiously knowledgeable.

Appropriate dress for women is one of the most controversial subjects in the Muslim world but in Islam, there are two important points on which there is agreement:

1. As the Qur’an makes it clear, both men and women are to dress modestly, though what constitutes modesty is debatable
2. Choice of how to dress is completely the woman’s and cannot be forced on her by her father, husband, or any male relative

Women have the right to marry to their liking.

There is also no doubt that Islam stresses education. Everyone is familiar with the famous saying of the prophet Muhammad, “seek knowledge, even in China.” This falls into line with the Qur’an’s command to. Allah says, “Say: Lord, increase me in knowledge.”

Ayesha, the wife of Muhammad said, “How splendid are the women of the Ansar, modesty did not prevent them from becoming learned in the Deen.” This proves that it is very Islamic for Muslim women to acquire knowledge and education. Depriving females of education is a cultural doing, not an Islamic teaching.

## **Barriers in Providing Health Care for Muslim Women**

The following are some of the barriers in providing health care for Muslim women:

- Insensitivity of the health-care system to the needs of the female Muslim patients. For example, once my 50-year-old Muslim female patient with severe dysfunctional uterine bleeding refused to go into the hospital because according to her, the hospital gowns were not in accordance to her Muslim modesty. Another example is a young, female patient who visited the hospital five times to have her blood drawn by a female lab technician. People at the hospital could not comprehend why she left quietly every day, just to return the following day, until she saw a female technician on duty.
- Most Muslim females are not aware of their rights. Their ignorance stems from lack of education, intimidation, and lack of exposure to the world. We as health-care providers need to educate them about their fundamental rights. Once I had a 48-year-old school teacher, in whom I diagnosed lymphoma. She was referred to see a surgeon for biopsy and an oncologist for chemotherapy. When I would ask her to get results or ask questions for her treatment plans, she would perceive this as disrespectful to those doctors. Yet after every visit to these consultants, she would return to me for explanations. Finally I had to educate her that asking questions and then making educated choices in her treatment was her basic right.
- Another barrier is under representation of Muslim women in every aspect of medicine. Very little research has been done in medicine on social, medical, and psychological problems in Muslim women. Once I had a young Muslim lawyer, unmarried, not sexually active, who asked me to quote her the risk of getting cervical cancer, refusing to accept the numbers taken from studies on Western women with different sexual habits.
- Lack of health-care coverage is an important barrier in providing good preventive medical care to Muslim women. There are multiple reasons for lack of health-care coverage. Common reasons include lower socioeconomic status. Culture is an important factor, since most of the Muslim countries have no concept of medical insurance and have fee-for-service system. Also, in religion, disease is sent by God as a test of your patience and, if you endure pain without complaining, God will ease your suffering. Many first generation immigrants have immigration issues. Fear of deportation prevents them from seeking appropriate health care.
- Mistrust of the system secondary to
  - Media propaganda
  - Racial profiling
- Every time Muslims turn around, they see generalization of their image. This inhabits them from opening up to the world. Most Muslims do not want to trust their lives in the hands of non-Muslims.
- Lack of education of Muslim women on preventive medicine, such as screening mammograms, Pap smears, screening for risk factors for CAD, screening for colon CA, prenatal health care, and postnatal follow-ups makes them very vulnerable to life-threatening diseases being diagnosed at later stages.
- Stories of bad experiences from family or friends also inhibit Muslim women from seeking health care. For example, my female patient requested no male staff. One of the medical students, completely ignorant of her religious beliefs,

insisted on seeing the delivery this incident infuriated the whole family and none of them returned to see me despite my apologies. I represented the health system. They in fact, lost faith in the system, which very often fails to understand the needs of the minorities.

- Fear of lack of respect for female modesty is a huge barrier in providing culturally appropriate health care for our Muslim patients.
- Another barrier, which I experienced in providing health care, is strict teachings of females not to share their family problems with the outside world. This usually leads to underdiagnosis of social and psychological problems in females, resulting in unnecessarily prolonged suffering. Once my 45-year old Muslim patient had multiple admissions to the hospital for severe chest and abdominal pains. Her million-dollar work up including cardiac angiogram to CT scan was negative. Finally after ruling out everything I confronted her to tell me what was going on in her personal life. By this time she felt that I really cared and I wanted to help. She started by saying that her religious beliefs did not allow her to talk about her marital problems.
- Muslim females from many cultures are taught to put their husbands and families before themselves. They understate their pain and suffering—spending money or time on their well-being is a waste—so when we teach them to exercise and spend time and money on their preventive screening tests, they have great internal conflicts, leading to anxiety and depression.
- Muslim females who I see in my practice come from different cultures. Many of them live in a combined family system. When a young Muslim girl gets married, many times she has to live with her in-laws. She is expected not only to please her husband but also her in-laws. This often leads to negative criticism of the young girl, resulting in low self-esteem and lack of decisional capacity. So health-care workers should provide compassionate and integrated social and health-care services.
- The most important barrier is lack of knowledge about the basic teachings and values of Islam. We should carefully separate Islamic and cultural values. This conference is the first step in the right direction. This leads me to a quick review of some health practices our female Muslim patients observe. Islam means “peace and submission to the will of God”. Muslims believe in one God (Allah swt) and that his last messenger is the prophet Muhammed (may peace be upon him). They also believe in the other prophets, from Adam through Moses and Jesus until the Day of Judgment. They firmly believe in the five pillars of Islam:
  - Faith in one God, Allah, and Muhammad (s) as His last prophet
    - Prayer five times a day
    - Charity for the poor
    - Fasting in the month of Ramadan
    - Pilgrimage to Mecca

## **How Muslims View Health and Illness**

- Muslims receive illness and death with patience and prayers. They consider an

illness as a test for their sins. They consider death a part of a journey to meet their lord. However, they are strongly encouraged to seek health and care.

- Hygiene is very important in Islam. Cleanliness is considered “half of the faith.” As stated in the holy Qur’an, Islam prohibits eating pork and pig products, meat of a dead animal, blood, and intoxicants.
- Alcohol is prohibited because it affects one’s judgment and also because it is addictive. Any addictive product that takes over one’s mind is prohibited in Islam.
- Blood transfusion is allowed.
- Autopsy is not routinely allowed except if required by law.
- Sanctity of life is highly regarded.
- Circumcision of males is recommended.
- Abortion is not permitted except to save a mother’s life.
- Muslims can have a living will.
- Maintaining a terminal patient on life support for prolonged period with no hope of meaningful recovery is prohibited.
- Islam opposes homosexuality but does not prohibit Muslim physicians from caring for AIDS patients.
- Transplantation is generally allowed.
- Artificial reproductive technology is permitted between husband and wife during intact marriage.
- Genetic engineering to cure a disease is acceptable but not cloning.

### **Steps Needed to Break Down Barriers for Providing Health Care for Muslim Females**

- As health-care workers we are held to the highest moral and ethical codes. Patients trust their lives in our hands. To live up to this trust we have to be respectful and compassionate, knowledgeable and understanding. Respect, dignity, knowledge, and patience are required to gain mutual trust in every relationship especially patient and doctor relationships.
- The most important aspect of providing health care to Muslim women in the U.S. is respecting their modesty and privacy.
- Many times during my first few visits with a Muslim female patient, I examine them over the gown until a mutual trust develops.
- Always ask if she wants another family member to be present during interview or examination.
- Try to breakdown cultural and religious barriers by talking about Muslim friends, coworkers, or neighbors. Or talk about a religious awareness class that you may have taken.
- Encourage Muslim females to ask questions. Take time to explain the procedures and treatments, since many patients may have language barriers.
- Assure them that same-sex staff is available.

- Asking about sexual activity and alcohol consumption is humiliating to most Muslims; if medically appropriate, try to avoid these questions in your first encounter with a Muslim female patient.
- Ask about religious beliefs and preferences, documenting them to assure them that they will be respected.
- If the Muslim female is hospitalized, respect the following
  - Identify the Muslim patient with the letter “M” on the nametag—I work on an inpatient hospice unit. Here, for spiritual and religious preference, we make “J” for Jewish, “C” for Christian, “H” for Hindu, however, when we made “M” for Muslim, very few health-care workers were familiar with Islamic values.
  - Provide Halal or kosher meals.
  - Allow for proper arrangements to pray five times a day make sure a copy of the Qur’an is available on request.
  - Services of Imam should be available if requested by a Muslim patient.
  - Allow family to bring food from home if is is not medically counter indicated.
  - Same-sex physicians and staff should always be offered to Muslim females.
  - No males should be allowed in the female’s room before she is modestly covered or without permission.
  - Option of no males in delivery room should be provided to Muslim females.
  - Always involve family in discussions about health care for female patient in hospital.
  - As a patient faces the end of her life, consult her Imam, face the patient towards the Kabah. The Qur’an should be read aloud to the dying patient. Allow the family and the Imam to prepare the body according to Muslim laws. The female body should be respected with modesty and privacy just like it was during her life.

We are all thinking in our minds, “Is this practical in our culture?” Riverview Hospital in Detroit, Michigan, in collaboration with Islamic Health and Human Services Organization in 1996–97, made an unprecedented decision to provide for Islamic practices as a regular part of its hospital services. The Adhan, or call to prayer, is whispered in the ear of a new born baby, Halal food is prepared in the hospital kitchen, Muslim patients and caregivers offer Salat (prayer) in the meditation room, copies of the Qur’an are available by request, and female hospital personnel are allowed to go about their work in their full hijab if they so choose. Lists of patients contain the reference “Muslim” by their names, as appropriate. Riverview is the first to offer total Islamic care to Muslim patients, but it will certainly not be the last.

Living in isolation leads to the fear of others. The pluralistic society of America presents a unique opportunity for people of different faiths to live together, to better understand one another, and to work together for peace with respect and understanding of each other’s faiths.

# CLINICAL PERSPECTIVE: FEMALE GENITAL CUTTING

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## **Introduction**

One culturally determined practice that has gained international attention in recent years is female genital cutting (FGC). Female circumcision is estimated to have affected over 228,000 women and girls in the United States. (1) Because of recent immigration patterns, health practitioners in the United States will increasingly encounter patients who have undergone this practice. It is therefore imperative that we understand the health and social issues involving FGC. This talk will describe the various types of circumcision, the reasons behind this tradition, its immediate and long-term complications, and the optimum way to care for these patients.

## **Classification**

Female circumcision, female genital mutilation, or female genital cutting (FGC) are terms that describe the practice involving the manipulation or removal of external genital organs in girls and women. The World Health Organization classifies FGC into four types. Type I involves clitoridectomy, which is partial or total excision of the clitoris. Type II involves clitoridectomy and partial or total excision of the labia minora. Type III or infibulation involves clitoridectomy, partial or total excision of labia minora, incision of labia majora and reapproximation of the remnant labia majora, leaving a small neointroitus. Type IV involves other forms of incisions, burns and manipulation of the external genitalia. (2)

## **Origins of FGC**

This practice represents an extremely important rite of passage for girls into womanhood. FGC is a tradition, unrelated to Islam, which is reinforced because of customary beliefs such as: maintaining girls' chastity, preserving fertility, ensuring ability to marry, improving hygiene and enhancing sexual pleasure for men. The origins of FGC are unknown. There are theories that it dates as far back as the fifth century BC. Other theories hypothesize origins in pre-Islamic Arabia, ancient Rome, and Tsarist Russia. (3-5)

## **The Procedure**

Nonmedically trained operators usually perform FGC. During this procedure, anesthesia and antibiotics are rarely administered. Instruments used are old, rusty knives, razors, scissors, or heated pebbles. Girls' legs are then bound around the ankles and thighs for approximately one week while they remain on bed rest. Cases

performed in major cities can be performed under more sterile and anesthetic conditions.

Circumcision is performed between the ages of five and twelve during a celebration where the girl receives gifts of money, gold, and clothes. Invited families and friends often bring food and music to the festivities. In other regions however, girls are abducted in the middle of the night to be circumcised.

## **Understanding FGC**

A frequently asked question is why this is performed and perpetuated. Being a wife and a mother is a considered woman's livelihood in some cultures, thus not circumcising their daughter can be seen as equivalent to condemning her to a life of isolation and preventing her from possible marriage. Infibulation safeguards her virginity, preserves her chastity, and ensures her eligibility for marriage, thus protecting her future.

A large number of women who have undergone FGC do not consider themselves to be mutilated. This ritual occurs to the majority of women in their community, and as a result, they do not believe that they are selectively being tortured. Therefore, many women will be offended if they are referred to as having undergone female genital mutilation. Using the term circumcision or the exact word they use in their language is preferable.

Women who have undergone FGC have voiced concern that we are not sensitive when broaching this subject. Many patients have seen physicians gasp in horror and question the patient as to whether she has been burnt or tortured. Others have been told that they have to undergo a cesarean section because of this scar. Women have carried the responsibility of educating their providers about this practice. Our primary responsibility is to educate ourselves, become culturally competent, and provide the best possible care for our patients. We must address our own shock, pity, or judgment regarding this practice before entering the patient's room. We must also be aware that patients present to us with a variety of complaints and their circumcision may not necessarily be one of them.

## **Immediate and Long-Term Complications**

Immediate complications vary from hemorrhage, infection, oliguria or sepsis. (6) Health providers will predominantly be addressing the long-term complications of FGC. Those women who have undergone type II or type III FGC tend to suffer more long-term complications than those who have undergone type I or IV. However, it is important to stress that not all women suffer complications. The most common long-term complications are dysmenorrhea, dyspareunia, chronic vaginal infections, and chronic bladder infections. (7-9)

## **Obstetric Difficulties**

Women who have undergone type III FGC with a persistent infibulated scar may be more likely to experience prenatal, intrapartum, or postpartum difficulties.

Infibulated women are at an increased risk of complications during vaginal deliveries, such as perineal tears, perineal wound infection, separation of episiotomy scar, and postpartum hemorrhage and sepsis. (10) Other challenges include placing a fetal scalp electrode, an intrauterine pressure catheter, performing fetal scalp pH, or placing a foley catheter. The infibulated scar has been documented to prolong only stage II of labor probably because the defibulation is delayed and the scar obstructs crowning and delivery. (11) To prevent this dilemma, a defibulation procedure during the second trimester is strongly recommended. (12)

### **Defibulation Counseling**

Defibulation can be performed under spinal or general anesthesia. The optimum time to defibulate a woman is prior to coitus to prevent dyspareunia or prior to pregnancy to prevent obstetric complications. However, what is medically more beneficial to the patient may not necessarily be the most optimum time for her.

As a result, defibulation is more commonly performed during pregnancy. Performing it during the second trimester under regional anesthesia has decreased obstetrical and fetal risks. Patients may require multiple prenatal visits before they finally consent to the procedure. (12) Counseling the patient about the risks of delivery with an infibulated scar is critical. The risks and benefits must be reviewed and the patient should be aware that her urinary stream would feel different.

### **Reinfibulation**

There are times when a woman has just delivered and requests an immediate reinfibulation. Reinfibulating her may create the long-term complications previously mentioned and is strongly discouraged. However, given that she may only feel comfortable being infibulated, her request must be respected. The U.S. law passed in March 1997 has made performing any medically unnecessary surgery on the genitalia of a girl younger than 18 years of age a federal crime, but reinfibulation is not included as a federal crime, and therefore, if the patient strongly insists, this should be performed with absorbable sutures in a running fashion. (13)

### **Conclusion**

The number of African immigrants and refugees are increasing, bringing renewed interest in unique cultural traditions. The most important aspect in caring for circumcised women is to develop a trusting relationship. By understanding the issues of FGC, obstetrician-gynecologists should move beyond the scar and address their patients' health needs. Like every woman, she needs the annual Pap smear, pregnancy test, mammogram, and hormone replacement recommendations. But unlike other women, cultural awareness and sensitivity regarding FGC is crucial. One of the vital things we can do is listen, understand, reassure and provide her with the best care she can obtain.

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# PATIENT-PHYSICIAN COMMUNICATION: THE CASE OF THE MUSLIM WOMAN PATIENT

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I became a provider of Muslim Women's health care by serendipity. I was fresh out of a family practice residency and had moved to Iowa City, Iowa to start my fellowship in academic family medicine. At the same time, the University of Iowa was busy recruiting and educating graduate students from around the world. Some of those students were newly married men from Saudi Arabia who brought their wives with them.

Although I was at the university, our FM inpatient service was at the local community hospital, Mercy Hospital, where I joined as an attending physician. I was the first woman family physician in some years to provide maternity care and in 1979, there were no women obstetrician-gynecologists at Mercy. We had a number of women in our residency program, so the largest concentration of women physicians was at the family practice centers we had, two of which were soon consolidated to an on-campus location where my faculty practice had always been located. The women residents in family practice also agreed to cover me if needed, and it was an easier setting to reassure patients they would have a female provider. The women at the university hospital had their practices set up with a group cross-coverage, so they would not always be there at the birth. Now, for the rest of the story.

Soon, I was visited at the FPC (Family Practice Center) by a Saudi couple who interviewed me about providing care for the wife during her pregnancy. Would I be the only care giver? How did it work here in Iowa City? What was family practice? I answered their questions and assured them that I expected to be there for the delivery. As a new faculty member, I needed to manage and deliver my own patients for a while to gather clinical experience, so I did not usually involve the residents in the labor and delivery of my patients. I explained about family practice as a specialty: how we provided care for the whole family, how we thought about the patient in the context of community and family, taking a holistic approach to patient care. They seemed satisfied with my answers and soon enough, they showed up on my appointment schedule for prenatal care.

During the course of that pregnancy and the two that followed before they left for home, they became my guides for providing care to Muslim women and their families. I spend a lot of time with my patients and the majority of any prenatal visit is education. I was grateful that the husband was able to stay for most of the visits and translate (making sure that there was good communication and understanding among the three of us). Of course, he left the room during the physical exam, so every step was gone through before he left. Even then, an occasional pantomime was needed to get through the exam. I learned to ask about their traditions of birth and tried to figure out how to best accommodate them in a U.S. hospital with its first birthing

room. In the U.S., it is expected that the husband will stay with the wife and help out during the labor. This was a new role for this Arab father-to-be, but one that he rose to as the usual support system was simply not there for his wife. I explained that I was concerned about any emergencies that might come up during the delivery and needed to have him there during the delivery. He would leave as soon as the baby was born (and he did). He faced his wife during the delivery as I kept up the encouraging delivery chat and reported what was happening with each contraction. Today, we might have more success finding a woman who knew Arabic, but 25 years ago, in a small Midwestern university town of 50,000, there were none to be had (as I remember). I was grateful that they were willing to put their child's safety above their own concerns and allow the husband into the delivery room. Additionally, my own practice of staying with a woman in active labor, a luxury afforded by my academic schedule, and the fact that all the nurses were female and we often had one-to-one staffing helped duplicate some of the support system the woman would have had at home.

During the next five years, I was privileged to provide care for two more pregnancies (two girls and a boy) and care for her friend's pregnancies as well. During that time, I learned about Ramadan and fasting (from which pregnant women could be exempted), the birth dance that gave rise to what we now call "belly" dancing (we never did try that, but it was good for a laugh), the rules about food, which we got around by bringing food to the hospital (not usually done in those days), their method of contraception (withdrawal), and the overarching modesty of the Muslim woman. I delivered one of those babies under a sheet, as the modern U.S. method of draping for a delivery was more than one of my subsequent patients could tolerate. You do what you have to for the sake of the patient.

Throughout the prenatal visits, I asked and learned and marveled at the brave couple who moved around the world for an education. I realized their isolation (this was before the internet took hold) and their sense of being in a foreign place. Fortunately, the university had special programs for foreign students, designed to make them feel like they belonged. We developed a special relationship during the prenatal and well-child visits, and I believe this led to an openness that allowed me to learn and provide quality patient-centered care to the family.

Thinking back, I'm sure there were things I could have done better. But as a new family physician, I was willing to listen and try things that my older colleagues wouldn't have. Respecting the modest dress and the cultural and religious ways of living and finding out what values and traditions we had in common built our relationship through the years. Having patients who prayed regularly and followed dietary rules did not surprise me, since I came from a traditional religious background. That was who they were, and my role was to figure out how to help them with their health-care issues, not impose my way of doing things on them.

As the years have gone on, I've cared for many Muslim women. I've learned customs and traditions along the way. I've also learned from my Muslim students, especially those who keep with the religious and cultural traditions. One student in particular gave me a good opportunity to learn as she shadowed me in her

introduction to clinical care sessions. She wore a head scarf and modest dress. She requested time to pray during the afternoon sessions, so we were aware of the time and made sure she had a private spot for this. We were challenged, however, the first time a male patient offered to shake her hand during the introductions. We teach our students to do this and apparently her reluctance to shake hands had never been shared with a faculty member before that day. She explained to the patient that she didn't shake men's hands for religious reasons and the patient was fine with that. At the end of that session we spoke about this practice and why Muslim women did not shake hands. Did this apply to social settings, professional settings or both? I certainly did not know the answer, but framed the question within her desired role of becoming a physician. What were the issues that would challenge her as a religious Muslim woman? Would she be able to provide the care a patient required when the time came? From my standpoint, it seemed logical to separate the social proscriptions from the professional expectations. I shared with her my experiences in dealing with physicians who, for religious reasons, had to deal with the tension between medical practice and their personal belief system. This happens most often around issues of sexuality, contraception, and abortion. A physician must be able to fulfill his/her responsibility to a patient by taking a professional role. The patient's health issues must be foremost and that means, in this country at least, the Muslim woman medical student and physician must learn to examine male genitalia, for example, if the need arises.

The hand-shaking issue was handled by posing the question to her father, who was supportive of her medical education. When viewed as a professional interaction, it seemed that it was permissible.

A review of the literature regarding Muslim women's health care reveals several issues that I do not recall being important in my patient interactions. Care must be taken to not misinterpret avoidance of eye contact in the medical setting. This is not necessarily a sign that the patient is lying, depressed, or has a low self-image. A woman cannot be in office setting with a male health-care provider unless she has another person with her. A woman may also be accompanied by a family member, who may assist with translation or transportation. (1)

Family medicine's underlying biopsychosocial philosophy is a good match to the holistic way Muslims approach health care. They do not separate the mind and body and are open to nutrition, herbs, exercise, meditation, and music as healing modalities. (1,2) Rashidi and Rajaram (3) discuss this holistic world view, as well, and identify the following as critical concepts in the Islamic Belief System that pertain to health matters. The Pillars of Islam are: monotheism (Shahadah); prayer (Salat); purification (Zakat), which requires almsgiving; fasting (Siawm) during Ramadan; and pilgrimage (Hajj) to Mecca. Other concepts include modesty (Hejab), visiting the sick (Hadith), dietary restrictions (Hallal or lawful foods; Haram prohibited food/drink), and gender restriction.

It is important for the health-care provider to understand these concepts and advocate for the Muslim woman patient in the health-care setting. One example might be the issue of the vaginal exam in an unmarried woman. If an evaluation by pelvic

ultrasound is necessary, it is incumbent on the physician or provider to order only an abdominal view. The patient should not be put in the position of refusing the vaginal probe part of the exam or worse, have an ultrasound technician attempt this exam in an unsuspecting patient.

According to some authors, living an Islamic way of life is supportive of promoting preventive practices such as breast cancer screening. However, if the patient's modesty is not respected or the male in the family does not believe such screening to be important, there will be significant cultural barriers to screening. Preventive practices may fall victim to poor patient-physician communication or the belief that this is not important. Health-care providers must remember that the patient's perspective may place more importance on treatment of infections, due to the overwhelming importance and impact of infectious diseases in her country of origin. (4) Education and understanding the background health beliefs will help Muslim women understand the importance the U.S. health system places on preventive practices.

There are many unanswered or incompletely answered questions regarding the optimal health care of Muslim women. These include:

- How does living in a foreign culture, perhaps with loss of social support, contribute to health outcomes?
- What are the health-care beliefs, values, practice, and expectations of Muslim women? Do they vary by age, country of origin, and/or length of time in the U.S.?
- Are there cultural barriers to using health and preventive services?
- Do certain health beliefs prevent use of effective contraception, health education information, and/or preventive practices?

Additionally, as an educator, I would propose talking with Muslim women health-care providers to discover their concerns and issues as they study to take on a professional identity in the U.S. Cultural competency is not just trying to understand where the patients come from, but also how the provider's background impacts the patient-provider interaction.

Caring for and learning about Muslim women has added a scope and understanding to my practice that enhanced my ability to care for all of my patients. It is something I will always value and appreciate.

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# Working Groups

## FACILITATORS

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# WORKING GROUP DELIBERATIONS

## Barriers to Culturally Appropriate Care to Muslim Women— Factors that Translate into Negative Experience or Poor Care

### Patient or consumer challenges

1. Language barrier; a family member not the best translator, but privacy must be respected
2. Modesty
3. Lack of acceptable (halal) food
4. Low literacy and education related to Islam and health issues
5. Perceived negative reception to patient education by providers
6. Cultural isolation
7. Lack of knowledge of appropriate services

### Provider challenges

1. Provider rushed by large patient load and lacking in time to fully explain health issues to patient
2. Attitude of providers is often negative when provider is stressed
3. Lack of communication about challenges faced by patients
4. Failure to distinguish between religion and culture
5. Conflict between patriarchy and patient-centered care
6. Lack of awareness of taboo health issues for Muslim women (i.e. infertility, mental health, HIV, etc.)
7. Inability to dispel cultural myths
8. Insensitive providers
9. Lack of respect of patient's modesty

### System challenges

1. Lack of medical insurance
2. Patient's lack of access to services
3. Patient's immigration status/issues
4. Rigid system creates time constraints in practice settings
5. Lack of access to female OB/GYNs and female translators
6. Long wait times
7. Lack of culturally appropriate information and services

## RECOMMENDATIONS FOR ENSURING CULTURALLY APPROPRIATE CARE FOR MUSLIM WOMEN

### Patient changes

1. Educate patients about issues of preventive health their rights
2. Partner with the provider in order to play an active role in care
3. Communicate effectively what is important to them
4. Differentiate between Islamic cultural beliefs and practices

### Provider changes

1. Enhance communication with consumer - understand Muslim women's health needs and expectations; dispel cultural myths and be knowledgeable about patient's cultural practices
2. Be holistic and nonjudgmental - providers should provide patients with a sense of safety and an apolitical climate and they should honor patients' preferences and create a safe place for patients to discuss concerns (e.g., does the patient want a male or female provider?)
3. Understand that family involvement is important to Muslims - involve and recognize the family; delineate between autonomy/self-determination and spousal consultation while considering the question of respect
4. Accommodate religious practices, educate providers in basics of Islam, and distinguish between religion and culture
5. Develop religiously appropriate guidelines for care
6. Empower women with information about health care and rights
7. Develop cooperative team environment with social workers, nutritionists, and interpreters
8. Institutionalize cultural competency training for providers
9. Enhance networking among Muslim health providers

### System changes

1. Provide affordable access that women can choose to use
2. Establish community linkages, (e.g., identify doctors or particular hospitals suitable for Muslim women)
3. Improve diversity among providers
4. Ensure continuity of care
5. Provide medical interpreters
6. Provide appropriate ablution and prayer areas
7. Provide halal or kosher food (halal/kosher meat and poultry, vegetables, seafood, pasta)
8. Community institutions provide resources for patients and providers

9. Increase access to preventive care, (e.g., health fairs, screenings, promotions, use of translators)
10. Follow care up with client surveys to solicit the experiences and opinions of Muslim patients
11. Create a research agenda that focuses on the needs of Muslim women

# Program Evaluation

A confidential program evaluation survey was administered to all conference participants. There were 112 evaluations (approximately 60 percent) completed and returned to program organizers.

Participants evaluated different aspects of the conference and provided feedback on:

- Overall effectiveness of the conference in terms of content, organization (facility, audiovisuals, environment, setting), level, and attainment of objectives
- Overall effectiveness of individual speakers in terms of expertise, presentation, ability to engage and respond to the audience, use of audiovisuals, and attainment of objectives
- Appropriate financial disclosure
- Most important impact on participants
- Most effective aspects of the conference
- Suggestions for improving future activities.

The findings from the conference program evaluation are divided into subsections, highlighting what worked, what did not and making suggestions for improvement.

### **Conference Impacts**

Reported impacts of the conference fall into four main categories:

1. Enhancing education/awareness
2. Networking/collaboration
3. Motivation/inspiration for patient care
4. Acting as a catalyst for research

### **Enhancing Education / Awareness**

Respondents provided input on the importance of the conference in terms of bringing about awareness of and enhancing education in the following areas: health-care issues related to Muslim women's health, knowledge of differences between Muslim culture and Muslim religious beliefs, similarities and differences between Islam and other religions, specific practices (religion) that affect care-seeking behavior, myths about Islam and practices attributed to Islam, e.g., female circumcision.

### **Networking/Collaboration**

Several respondents highlighted the benefits of networking as the most notable impact.

### **Motivation / Inspiration**

Respondents indicated that after participating in this conference, they felt they were reenergized to address cultural competency issues, not only for Muslim women but for patients from all religions and cultures and they were excited that a research agenda may develop to build on work done so far and to further identify gaps in

health care that need attention.

## **Catalyst for Research**

Several participants noted that the conference helped jump start new ideas for future research and indicated strong interest in continuing this line of work. Several overarching and discrete areas of focus have emerged for future work. The need for enhancing cultural awareness and training for all levels of health-care providers emerges as the main theme. Participants indicated the need for developing and conducting empirical research to address research questions related to Muslim women's health in the following key areas:

- Reproductive health, including screening for breast and cervical cancer
- Female genital circumcision
- Intimate partner violence
- Acculturation issues
- Mental health issues

## **Most Effective Aspects of the Conference**

The most effective reported aspects of the conference concerned both content and format/process:

1. Dynamic, knowledgeable expert speakers
2. Focus on the diversity of Muslims, the importance of culture vs. religion
3. Outstanding organization
4. Appropriate participant mix
  - a. incorporation of both providers and consumer perspectives
  - b. multiple views from different cultural groups
5. Interactive nature of the variety of instructional methodologies used (opportunity for Q & A and comments during all activities)
  - a. Plenary talks
  - b. Working groups
  - c. Panel discussion

## **Recommendations**

Recommendations are divided in into two parts:

1. Format (including participants)
2. Content

### **1. FORMAT**

- a. Continue to ensure adequate time for both formal and informal networking
  - i. Include time for a social event
  - ii. Build in additional breaks between sessions
- b. Continue to include additional plenary talks with expert speakers
  - i. More Islamic scholars
  - ii. More nurses and allied health professionals as speakers

- c. Smaller working groups to enhance participation
- d. Longer duration of conference
- e. Encourage participation from all cultural groups, including African Americans, who constitute a large proportion of American Muslims, and ensure an ethnically diverse planning committee
- f. Encourage more men to participate in future events
- g. Continue the interdisciplinary focus and try to draw more consumers
- h. Improve audiovisual equipment/support and cordless microphones for speakers
- i. Provide handouts of speaker talks

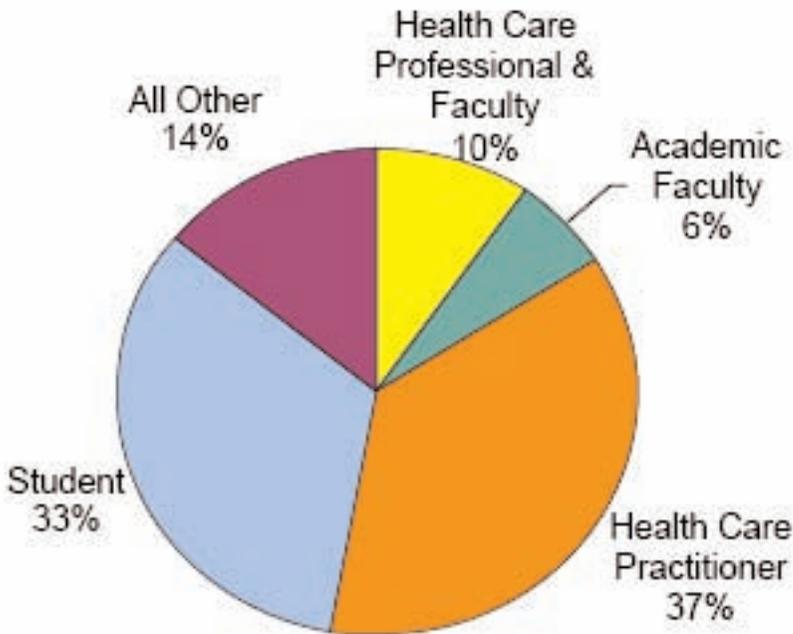
2. CONTENT

Participants strongly indicated the need for continued work on this topic

Recommendations for future work included:

- a. Continue to work on this line of inquiry
- b. Develop and disseminate research related to the subject
- c. Organize annual conferences on the subject

**Respondents' Professional Background**



## ATTAINMENT OF PROGRAM OBJECTIVES

Participants were asked on a five-point scale from 1(Strongly Disagree) to 5 (Strongly Agree) to rate attainment of conference objectives:

By the end of the conference, I was able to:

- Discuss the issues related to Muslim women’s health care within the context of the religious tenets of Islam.
- Recognize the barriers that Muslim women experience in obtaining culturally appropriate health care in the US.
- Identify challenges/difficulties experienced by primary-care providers in providing culturally appropriate health care to Muslim women
- Make recommendations for a research agenda aimed at addressing the health-care needs of Muslim women.

**Table II**

Conference Goals		<i>Issues related to Muslim women's health care</i>	<i>Barriers Muslim women's experience</i>	<i>Challenges/difficulties</i>	<i>Recommendations for a research agenda</i>
N	Participant Profession	Mean Ratings			
112	Overall	4.33	4.42	4.43	4.22
11	Health Care Professional & Faculty	3.89	4.22	4.33	4.22
7	Academic Faculty	4.33	4	3.57	4
41	Health Care Practitioner	4.32	4.39	4.46	4.16
37	Student	4.37	4.56	4.51	4.25
16	All Other	4.41	4.42	4.54	4.29

**Summary:** Overall, the participants strongly agreed felt that the conference objectives were met.

## OVERALL EFFECTIVENESS

Participants were asked to rate the overall effectiveness of the conference:

**Table III**

Overall, the Conference...		<i>Engaged my attention</i>	<i>Level of discussion was appropriate</i>	<i>Objectives were clear</i>	<i>Content was comprehensive</i>	<i>Content was balanced</i>
N	Participant Profession	Mean Ratings				
112	Overall	4.78	4.58	4.52	4.51	4.44
11	Health Care Professional & Faculty	4.8	4.78	4.67	4.33	4.33
7	Academic Faculty	5	4.86	4.86	4.71	4.83
41	Health Care Practitioner	4.68	4.46	4.49	4.53	4.47
37	Student	4.83	4.49	4.38	4.41	4.39
16	All Other	4.83	4.55	4.48	4.51	4.38

**Table IV**

Overall, the Conference...		<i>Environment Conducive to learning</i>	<i>Setting Acoustics, lighting, room size, and temperature—was conducive to effective learning</i>	<i>Educational impact I learned something new from the conference</i>
N	Participant Profession	Mean Ratings		
112	Overall	4.46	4.34	4.72
11	Health Care Professional & Faculty	4.50	4.50	4.70
7	Academic Faculty	4.57	4.43	4.71
41	Health Care Practitioner	4.45	4.38	4.58
37	Student	4.41	4.24	4.78
16	All Other	4.45	4.26	4.83

**Summary:** Overall, participants were highly satisfied with the facility and the quality of speakers.

## OVERALL IMPACT

Participants were asked to rate the overall impact of the conference on their understanding of the health-care dilemmas faced by Muslim women and anticipated modification in patient-care practices.

**Table VIII**

In Summary, on a scale of 1 (strongly disagree) to 5 (strongly agree)....		<i>The conference significantly raised my consciousness about the health care dilemmas that Muslim women face.</i>		<i>As a result of the conference, I will modify my patient care practices (for health care providers only).</i>	
N	Participant Profession	Mean Ratings			
112	Overall	4.62		4.44	
11	Health Care Professional & Faculty	4.3		4.44	
7	Academic Faculty	4.86		3.33	
41	Health Care Practitioner	4.5		4.53	
37	Student	4.71		4.55	
16	All Other	4.75		4.46	

**Effectiveness of Speakers:** All presenters were very well received and rated highly on their presentations.

**Disclosure:** The disclosure statement given below was printed on the conference program and also stated verbally by Dr. Memoona Hasnain.

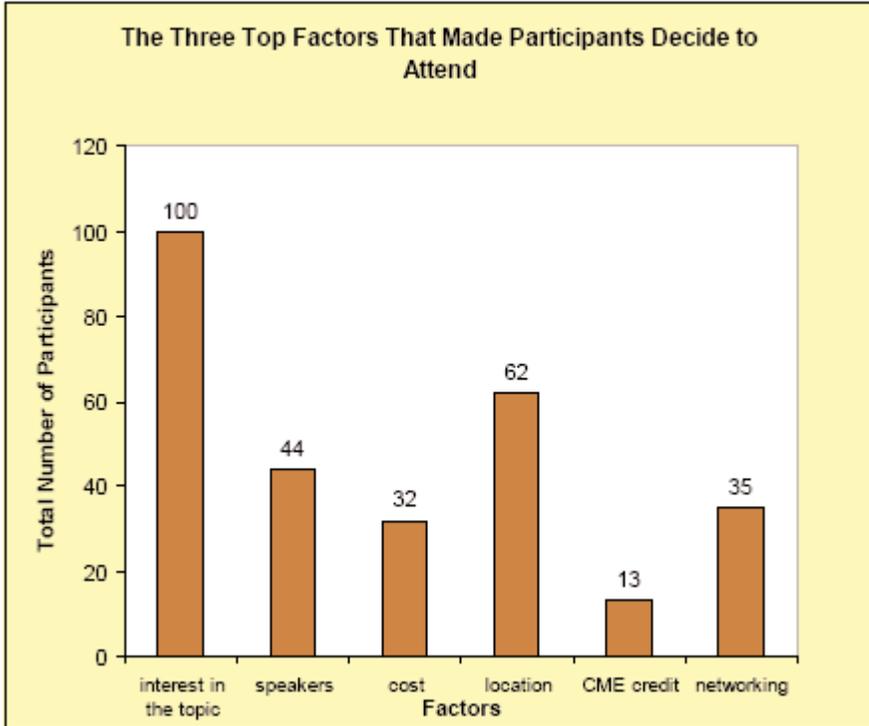
**Disclosure Statement:** Please note that the UIC College of Medicine Department of Family Medicine is committed to disclosure of any commercial entity that provides financial support for the program, as well as speaker financial interests as reported by those individuals. None of the speakers have disclosed any financial interests and no commercial entities have provided financial support for this program.

**Audiovisuals:** Generally, participants felt that although the audio visuals used by the speakers were well integrated in the presentations and facilitated the presentations, A/V equipment and support needed to be improved.

## FACTORS THAT ATTRACTED PARTICIPATIONS

Participants were asked to select up to three factors that made them decide to attend this conference:

**Fig II**



**Summary:** The top three factors that influenced participants to attend the conference were:

- Interest in the topic
- Location
- Speakers

# Postconference Evaluation

A post conference survey was sent to the participants after six months to assess long-term impact of the conference on participants' knowledge, attitudes and practices. A Web-based survey program, Survey Monkey, was used to conduct this voluntary evaluation. Responses were received from September 25 to October 21, 2005. Forty participants completed the survey. The following report summarizes participants' responses to the survey.

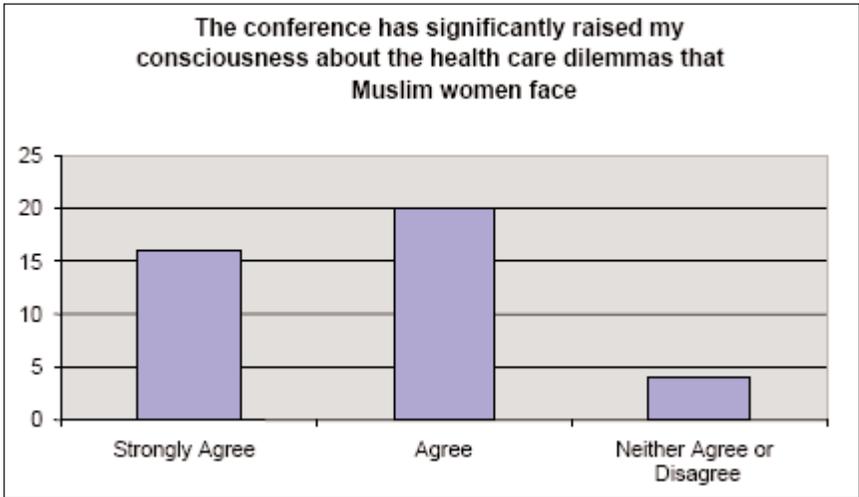
### **1. How has participation in the conference impacted your knowledge, attitudes and/or practices?**

- I have educated people on female genital mutilation.
- It was an opportunity to meet with others who are interested in working on FGM.
- I am much more aware of Muslim health-care practices and feel more comfortable when they are in the clinic.
- The conference discussion, keynotes, etc., have helped me think about new directions with my research, some of which will be implemented this fall in the form of grant proposals.
- I am a provider and an educator. I have not yet had any patient contact to report my experiences. However, as an educator, I have started to develop a course on cultural diversity practices in health care for our first semester nursing students. The initial presentation was to be done by one of our faculty, who is a Muslim woman and who teaches surgical technology students. Unfortunately, she was unable to do the first presentation but we hope she can do one in the spring semester. In the meantime, we are going to do a session on health care for women from India who are also Hindu. That session should be on October 12.
- I'm more of an activist in field of cultural competence for South Asians in the U.S., and in general, cultural competence. Mostly, it has stimulated my continuing curiosity to learn more and my commitment to keep up the work I'm doing. I added a single reading on social work with Muslims and one with Hindus to my Integrative Practice Seminar for social work students, which concentrates on social work in health care.
- The conference taught me to be open-minded and to become culturally aware and respectful. It also allowed me to open up to my provider so that we both would be more comfortable.
- As a provider, I utilize the knowledge I gained at the conference by making no assumptions whatsoever about Muslim women patients, as I know now that their beliefs and health practices may fall anywhere on an extremely broad spectrum.
- Though I haven't been able to put into direct practice what I learned at the conference (my clientele is currently all Hispanic), I know that in the future I will be able to practice and implement strategies/knowledge from the conference.
- The conference definitely helped me better understand the problems that exist

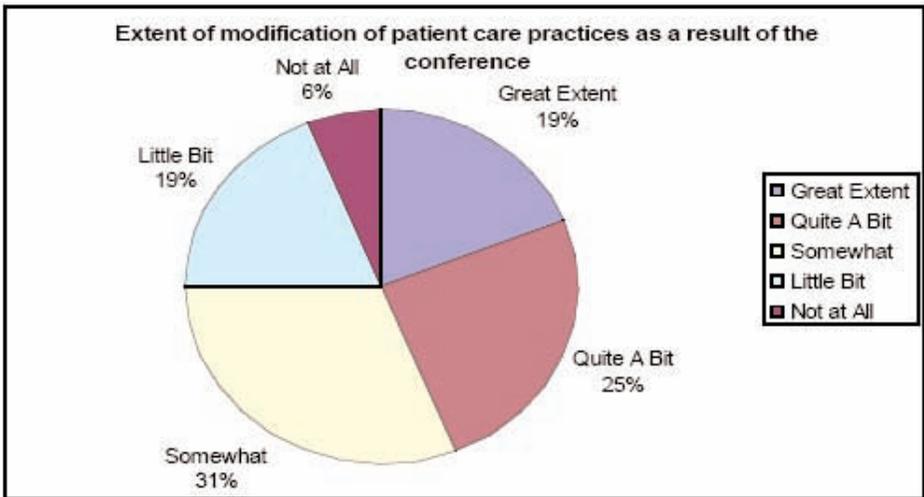
with patients and their physicians, along with understanding the cultural biases that exist.

- I was very aware of the issues facing Muslim nursing home residents and patients. This affirmed my training and also raised my awareness of issues facing Muslim women educators and researchers dealing with the conservative Muslim world.
- It has allowed me a greater understanding of some of the issues faced by my friends and colleagues who are Muslim.
- I became more aware of the differences within Islam and the variety of issues that Muslim women in the U.S. face. This will help me as a provider of care.
- Being a Muslim woman and consumer, attending this conference was an extremely helpful experience because not only could I share my negative/positive experiences with other participants, I also had a chance to actually brainstorm practical and applicable solutions with the providers. I also understood the provider side of the story better. I feel like I am not the only one dealing with these issues and that is reassuring.
- I think I am more sensitive to privacy issues.
- I am Muslim and it was nice to be aware of resources in regards to providing health care to Muslims.
- Understanding the roots of Muslim women's health beliefs that contradict western health beliefs.
- I met other health professionals interested in the field of female genital cutting, and we have formed the Midwest Coalition on Female Genital Cutting with regular meetings.
- As an educator, I learned that the care of Muslim women requires a complex social, cultural, and spiritual set of skills.
- I have become more alert and more sensitive to all my patients since this conference, more available for questions regarding family issues, and more alert and aware of individual needs. I now do not assume anything and am more private with both my women and male patients who practice Islam. I am not afraid; I am educated and sensitive.

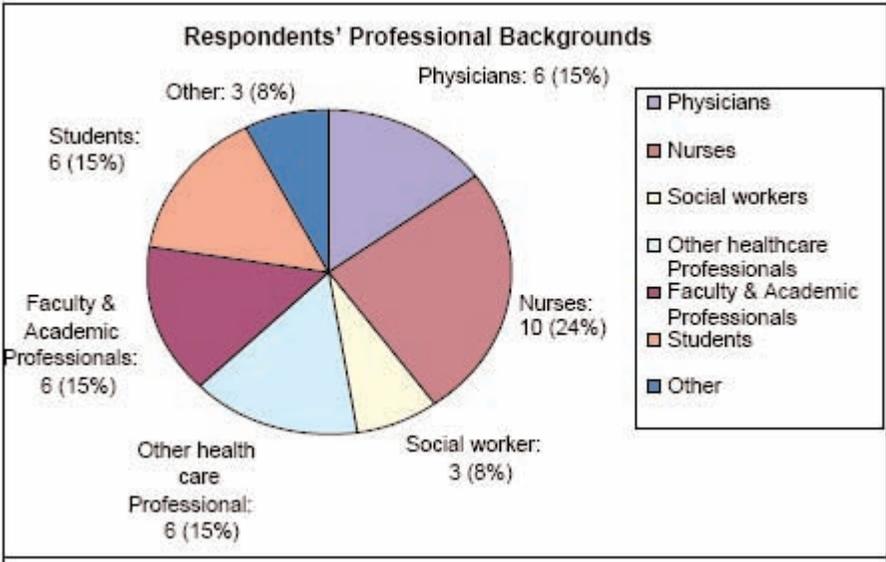
2. Consciousness-raising about the health-care dilemmas faced by Muslim women.



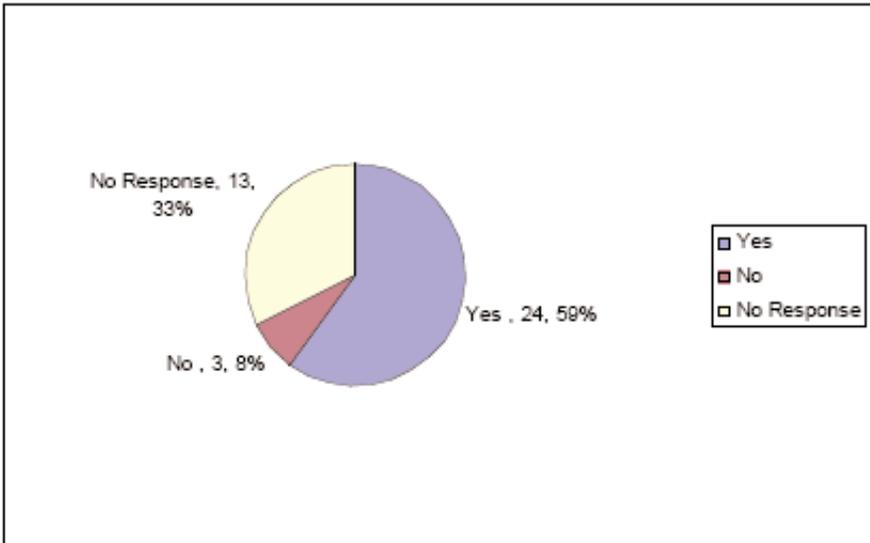
3. Modification of patient care practices as a result of participation in the conference (only for health-care providers, 16 respondents).



4. Respondents' Professional backgrounds



5. Interest in joining a listserv devoted to the continued discussion of Muslim women's health issues?



## 6. Suggested topics for future conferences on Muslim women's health.

- Female empowerment. The Qur'an and its implications for females.
- Domestic violence.
- How best to intervene to help women overcome barriers; use of advanced technology for patient and provider education.
- Nuggets of information on practical tips when interviewing for history taking, assessing for physical and emotional status.
- How men can provide health care to Muslim women (involving family members vs. patient's privacy, parent-child relationship issues, e.g. mental health, child development).
- Addressing contraception, infant circumcision decisions among Muslims, dietary restrictions which may affect pregnancy, e.g., Ramadan fasting (I know there is an exemption for pregnant women, but many of the women I've spoken with choose to fast during their pregnancies anyway).
- Any and all topics. Those presented at the conference were excellent. Perhaps material on differing views between foreign-born versus U.S.-born Muslim women health providers and how that has impacted care/services.
- Muslim women's health-care issues in other cultural backgrounds other than the Asian/Pakistani culture. New concerns and issues that exist with second-generation Muslims, in particular to ones that have predominately had their upbringing in the U.S., since their beliefs and practices tend to be different from the generation of their parents.
- Long-term care, family dynamics, religious influences on health care treatments.
- I enjoyed the speakers who provided a more global perspective on Muslim issues. I would like to learn more about the various groups of Muslims throughout the world and the concerns specific to each unique population.
- The idea of how you practice to provide best care for your patients, even though you practice a religion. This tension should be explored further.
- Screening for domestic violence and depression.
- Female genital cutting.
- Children's needs. I would recommend that someone discuss the birthing process and what the Muslim women would like from their caregivers during their pregnancy, as well as information regarding sexual education. I have many young patients that I instruct on what to expect with their loved one and I have been honest and forthright...but I am not sure if I was correct. I am a Catholic by faith, not by any other instruction.
- I am very interested in cultural competence in general and for Muslim women, in particular.
- More generational information between younger women and older women, including differences in views.
- It would be interesting to have a portion of the conference devoted to follow-up measures taken by patients, providers, and educators that resulted from the conference. For example, have physicians changed their practices and

interactions with this group of patients? Have patients themselves discussed aspects of their care relative to their beliefs and practices? Have educators incorporated this important aspect of health care in teaching their students? Discussion (perhaps a panel discussion) of such follow up measures among these groups would be enlightening, perhaps even inspiring.

- Religious concerns related to abortion and contraceptive usage and informing women on the safety and proper usage of contraceptive measures.
- Unsure at this time; was impressed with the range of topics addressed at the conference.
- More about mental health.
- Needs of young Muslim women in America among immigrants, new members, and second generation.
- Psychological disease and how it is best dealt with in Muslim culture.
- Improved models of care.
- Advocacy strategies on making health-care services and facilities responsive to the needs of Muslim women.
- Discussion about intergenerational attitudes and needs of Muslim women.
- Funding opportunities for research with immigrant populations.

## 7. Additional thoughts

- It was a very interesting and enlightening conference.
- We need to reach out to African-American Muslims.
- I would love to see a simple “Cultural Do’s and Don’ts” card that can give guidelines for health-care providers in the areas of assessment, communication, or physical examination.
- The field of people who should be interested cannot be so simply divided into “providers” and “recipients” of health care. I am of course a recipient; we all are; or consumer; but not Muslim, so that category doesn't quite work. I am an educator, but that is not the same as provider. Yet I have worked as a social worker in health care (hospitals, clinics, community) for more than 20 years. Are social workers not providers? I think the categorization should be nonexclusive that could then be searched for responses in a survey like this for input and benefit at the next conference.
- Thank you for the conference.
- The conference was excellent; I can’t wait for the next one!
- I felt that the conference was a great success and am looking forward to future meetings of such a diverse group of people to discuss similar issues.
- It was great to participate in the conference.
- Very valuable conference. Please continue the series.
- I was so impressed with your program, I used the concept to teach my third year students all about my area, blood borne pathogens, and had them separate and create; the idea was so well-liked that the students let all the other professors know...I have master’s and postgraduate certificate, so all the PhDs

were surprised. A little knowledge went far. Your program changed my practice. Actually the students taught me not to be afraid; just practice and be myself.

- It was a fantastic conference. I wish you would organize another one.
- I think there should be discussion about Muslim women in the context of culture and ethnic differences among various race/countries and also among Muslims who are within the Nation of Islam.
- Thank you for organizing the conference. I hope this can become a yearly event.

# Appendices

## APPENDIX A

### BIOGRAPHICAL SKETCHES\*

\*Information reflects professional positions at the time of the conference.

#### Principal Investigator

**Memoona Hasnain, MD, MHPE, PhD.** Dr. Hasnain is currently the Director of Research and Assistant Professor of Public Health in Family Medicine in the Department of Family Medicine at the UIC College of Medicine. She holds adjunct faculty appointments in UIC's Department of Medical Education and the School of Public Health. Dr. Hasnain received her medical degree from Dow Medical College, Karachi, Pakistan, and practiced medicine before transitioning full-time to medical education and public health. She earned a master's degree in health professions education and a doctorate in public health, both from the University of Illinois at Chicago (UIC). Dr. Hasnain is a medical educator and researcher. Her foci of research interest include women's health, health disparities, HIV/AIDS, clinical reasoning and evidence-based medicine, quality improvement, and patient-centered care. Dr. Hasnain's work has received recognition through media coverage and awards, her work has been presented at scientific meetings and published in peer-reviewed journals. She is currently developing a program of research focusing on identifying and addressing patient, provider, and health system related barriers to patient-centered health care for Muslim and South Asian women in the United States.

#### Speakers

**Asma Barlas, PhD.** Dr. Asma Barlas is a Professor of Politics at Ithaca College, New York. She earned a PhD in international studies from the University of Denver, an MA in journalism from the University of the Punjab, Pakistan, and a BA in English literature and philosophy from Kinnaird College, Pakistan. Dr. Barlas was one of the first women in Pakistan to join the Foreign Service. Her career was cut short, however, by General Zia ul Haq who had her services terminated for her criticism of him and his military regime. She left for the U.S. in 1983 and eventually received political asylum here. Her books include *Islam, Muslims, and the U.S.: Essays in Religion and Politics* (India: Global Media, 2004), "Believing Women" *In Islam: Unreading Patriarchal Interpretations of the Qur'an* (University of Texas Press, 2002) and *Democracy, Nationalism, and Communalism: The Colonial Legacy in South Asia* (Boulder, CO: Westview Press, 1995). In addition, she has written several book chapters, journal articles, and op-eds on issues pertaining to Muslim women's rights in Islam. Dr. Barlas is the recipient of numerous awards and honors including from the United Nations Department of Public Information and the American Association of University Women. In 2003, she was recognized as a Woman of Distinction by the State Senate of New York.

**Elizabeth A. Burns, MD, MA.** Dr. Elizabeth A. Burns is the Verrill J. and Ruth Fischer Professor and Chair of the Department of Family Medicine at the University of North Dakota School of Medicine and Health Sciences. Dr. Burns earned a BA

(chemistry), magna cum laude, from Marygrove College, Detroit, Michigan and an MD from the University of Michigan. She did a flexible medicine internship at Henry Ford Hospital (Detroit) and a family practice residency at Harrisburg Hospital (Pennsylvania). Dr. Burns was a Robert Wood Johnson Foundation Faculty development fellow at the University of Iowa, where she also earned an MA in the Division of Instructional Design and Technology. Following this fellowship, she joined the faculty in family medicine at Iowa, where she was promoted with tenure. She served as a residency program director in family practice at the University of Iowa Department of Family Medicine. Dr. Burns became professor and chair of the Department of Family Medicine at the UIC College of Medicine in 1992, serving for eight years in that capacity. In 2002, she accepted the position of professor and chair of the Department of Family Medicine at North Dakota. During 1999 and 2000, Dr. Burns served as president of the Society of Teachers of Family Medicine. She is currently a Bishop/ACE fellow in academic administration and leadership and is the director of the National Center of Excellence in Women's Health Region VIII Demonstration Project at the University of North Dakota School of Medicine and Health Sciences.

**Rosalyn Correa-de-Araujo, MD, MSc, PhD.** Dr. Rosalyn Correa-de-Araujo, is a cardiovascular pathologist trained at the National Heart, Lung, and Blood Institute, NIH. As AHRQ's Senior Advisor on women's health, Dr. Correa oversees the development of a national research agenda for women in consultation with prominent members of the research community and other government agencies. She has been involved in numerous interagency work groups and committees addressing issues related to the management of chronic diseases in women. In the past, Dr. Correa worked with AHRQ's Evidence-based Practice Centers Program and oversaw the development of various systematic reviews on topics of clinical relevance to women's health and managed a portfolio of research grants targeting geriatric issues.

Prior to joining AHRQ, Dr. Correa acquired a vast experience with the safe use of medications in the elderly through numerous years of work in the development and maintenance of a database on evidence-based geriatric pharmacotherapy for clinical decision support; she studied medication errors in the elderly and developed principles to improve medication use outcomes in this population. Dr. Correa also played an important role in making medicines safe and effective. Her work in this field continues through the activities she performs as member of advisory committees of numerous professional medical and pharmaceutical societies. Dr. Correa has numerous scientific publications in peer-reviewed journals, as well as chapters in pharmacology books, including *Principles of Evidence-Based Pharmacotherapy* and *Drug Interactions in the Elderly*. Her main areas of interest include gender-based research and analysis, disparities, and/or quality of care for minorities, cardiovascular disease, diabetes, and medication use outcomes and safety, particularly in women and older adults. Dr. Correa also holds positions of adjunct associate professor at the School of Medicine at George Washington University and clinical assistant professor at the School of Pharmacy at the University of Maryland.

**Fauzia W. Lodhi, MD.** Dr. Fauzia W. Lodhi is an internist who has practiced in Chicago for the last 10 years. She is the Director of Palliative Care and Hospice of Rush, North Shore. Dr. Lodhi earned her BS from Kinnaird College, Lahore, Pakistan, and her MD from Fatima Jinnah Medical College, Lahore, Pakistan. She completed her residency training at Weiss Memorial Hospital in Chicago. Dr. Lodhi is a firm believer in education and human rights, especially pertaining to Muslim women. She is currently a volunteer at the Muslim Education Center in Chicago and is an active member of the Board of Directors of the Muslim Community Center in Chicago. Aside from her community-based work, Dr. Lodhi has served as a guest speaker at various community health seminars.

**Nawal M. Nour, MD, MPH.** Dr. Nawal M. Nour is a board-certified obstetrician/gynecologist. She is an Assistant Professor at Harvard Medical School and Director of the Obstetric Resident Practice at the Harvard-affiliated Brigham and Women's Hospital in Boston, Massachusetts. Dr. Nour was born in Sudan and raised in Egypt and England. She came to the United States to attend Brown University, received her medical degree from Harvard Medical School in 1994 and completed a chief residency in obstetrics and gynecology at the Brigham and Women's Hospital, Boston, MA, in 1998. She received the Commonwealth Fund/Harvard University Fellowship in Health Policy and earned an MPH at Harvard School of Public Health in 1999. Dr. Nour has established an African Women's Health Practice that provides appropriate health and outreach programs to the African community in Boston. Dr. Nour was recipient of the H. Richard Nesson Fellowship from the Brigham and Women's Hospital for her community work and outreach. She was honored as a 2003 MacArthur Foundation fellow for creating the country's only center of its kind that focuses on both physical and emotional needs of female circumcision victims. This work has been covered by the Associated Press, New York Times, Washington Post, NPR, O and Essence magazines, and CNN Espaniol. Committed to the eradication of FGC, Dr. Nour continues to actively research the issues regarding this practice, both locally and internationally. She has spoken at numerous conferences regarding the medical management of women who have undergone FGC and conducts nationwide workshops to educate African refugees and immigrants on the medical complications and legal issues of this practice. She has served on an FGC task force for the American College of Obstetrics and Gynecology (ACOG). She is the primary author of *Female Genital Cutting, Clinical Management of Circumcised Women*, published by ACOG. This slide-lecture kit aims to educate obstetricians/gynecologists on the medical management of circumcised women in the United States and Canada.

## APPENDIX B PARTICIPANTS

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