Assessing the Health Needs of Muslim Women in the Raleigh/Durham Area

By

Sumera Hayat

A Master's Paper submitted to the faculty of the University of North Carolina at Chapel Hill. In partial fulfillment of the requirements for the degree of Master of Public Health in the Public Health Leadership Program.

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First Reader

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Abstract

Background: The United States population is becoming increasingly diverse, with racial and ethnic minorities projected to represent almost half of the U.S. population by the year 2050. There is compelling evidence that racial and ethnic minorities have experienced health care disparities in the past. The United States government, along with other health care stakeholders, is increasing efforts to evaluate the etiology of these disparities and create interventions to address them. One important initiative to address health care disparities faced by racial and ethnic minorities is to improve cultural competency in order to help health care providers serve a diverse population.

Muslims in America represent the fastest growing religious minority population. Given that religious data is not tracked by the Census, the exact numbers of Muslims living in America, or North Carolina in particular, cannot be obtained. Muslim American women may represent an especially vulnerable population given the double minority status they hold.

Methods: Little research has been conducted on the health needs of Muslim American women. In order to examine the barriers Muslim women experience in obtaining culturally appropriate health care, a qualitative needs assessment was conducted with local Muslim women in the Raleigh/Durham area. Three focus groups were conducted in the span of two months. This data, which was collected at Duke University, provide the basis for a secondary analysis carried out here. Transcripts from the focus groups were reviewed and coded by independent reviewers. These coded data were then compared for similar themes.

Results/Conclusions: The major themes can be divided into two categories: health and well-being concerns and priority services of an ideal health center. The majority of focus group discussion centered on health and well being concerns. The two focus groups of local Muslim women shared similar concerns. Many of the Muslim women felt uncomfortable with preconceived notions that they felt going into their health care encounters. Many participants felt that stressed Muslim women, especially since September 11, 2001, have difficulty finding appropriate services locally. Participants also stressed that factors shared by non-Muslims and Muslims alike, such as poverty and transportation issues, affected ability to access quality health care. Priority services that the focus group participants desired in a health center include: all-female staff; education of non-Muslim health care providers; staff with understanding of Muslim women; cultural sensitivity; comprehensive services; and childcare/children's health care. In the discussion of these findings, this paper identifies future interventions and research the Muslim community has discussed in order to address these local health needs.
INTRODUCTION

The United States is experiencing shifting demographic trends, with the minority population expected to reach 43 percent of the U.S. population by the year 2030.\textsuperscript{1} The increasing diversity of people affects patient care in North Carolina’s health care institutions and with health care providers. Health care providers must learn to navigate different cultural and linguistic communications in order to provide quality health care. The idea of cultural competence bridges the communication barriers that stem from these racial, ethnic, cultural or linguistic differences. The federal government has recently increased efforts to raise cultural competency in health care delivery, recognizing that culturally and linguistically diverse groups typically experience less adequate access to care, lower quality of care, and poorer health status and outcomes. The Institute of Medicine’s recent report, \textit{Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care}, states that, “Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patient’s insurance status and income, are controlled.”\textsuperscript{2}

Cultural competency has been used in relation to religious minorities, in addition to racial and ethnic minorities.\textsuperscript{3} Islam is reported to be the second largest religion in the world. The world-wide Islamic community is reported
to have a following of more than one billion people. Because the United
States Census does not track religion, there is no scientific count of American
Muslims. However, most organizations estimate six million Muslims in
America, making them the largest non-Christian religious minority within the
United States by the year 2010. Given recent international events, there is
urgency in bridging cultural barriers between America and its minority
Muslim community. One way is through evaluating and addressing the health
needs of American Muslims. It has been asserted that “the ‘little that is
known’ about the Islamic community ‘is often misunderstood’, ‘is often
misrepresented in the literature and the popular press’ or both. Yet while the
beliefs and customs of Muslim men and women are a mystery to many health
care professionals, most acknowledge that they appear to have a profound
influence on health behavior”.

This paper will attempt to address the nature of cultural competency, the
importance of cultural competency in U.S. health care, review current
available literature on health needs of Muslim women, describe a needs
assessment of local Muslim women, and finally, discuss future steps to
address the health needs described by local Muslim women. Specifically, the
goals of the needs assessment include:

- To discuss the perceived health needs of local Muslim women.
- To discuss barriers to quality health care of local Muslim women.
- To describe priority health care services for the local Muslim
  population, and brainstorm methods to achieve these services.
- To identify ways to empower the local Muslim community to
  address these health care needs.
Disparities in Health Care

Health care is only one of many contributing factors to health disparities for racial and ethnic minorities. The long and varied list includes culture, social factors, racism, environmental factors, genes, economic factors, neighborhood factors, stress/“weathering”, institutional policies and behavior.6 Citizenship status and language play a large role in disparities in health coverage, access, and quality for racial and ethnic minorities, as evidenced in a Kaiser Commission report. This report found that racial and ethnic disparities exist among citizens, but these disparities are substantially greater among non-citizens. Also, non-citizens and those who do not speak English as a primary language experience greater problems accessing care than other groups, resulting in less connection with the health care system.7

However, health disparities can persist even after controlling for socioeconomic and health care factors, as in the case for perinatal health disparities in African Americans. As Hogan states, “In fact, in the summer of 2000, the acting director of the National Institutes of Health stated before the US Senate Subcommittee on Public Health that:

*The causes of health disparities are multiple. They include poverty, level of education, inadequate access to medical care, lack of health insurance, societal discrimination and lack of complete knowledge of the causes, treatment and prevention of serious diseases affecting different populations. The causes (of health disparities) are not genetic, except in rare diseases like sickle cell... The elimination of health disparities will require a cross-cutting effort, involving not only various components of the Federal Government, but the private sector as well....*8
Adding to this, the degree to which health care disparities itself contributes to health disparities is unknown. However, the possibility of reversing the health disparities factor compels policy makers to intervene at this stage.

Increasing scientific evidence in recent years of racial and ethnic disparities in health care led to the congressionally-mandated report by the Institute of Medicine in 2002. "Disparities in the health care delivered to racial and ethnic minorities are real and are associated with worse outcomes in many cases, which is unacceptable," said committee chair Alan Nelson. "The real challenge lies not in debating whether disparities exist, because the evidence is overwhelming, but in developing and implementing strategies to reduce and eliminate them." The racial and ethnic minority populations in the U.S. who are experiencing these disparities include the following: African Americans, Alaska Natives/American Indians, Asian Americans, Pacific Islanders, and Hispanic Americans. Some examples of disparities in health care include:

- Relative to non-Hispanic whites, African Americans, Native Americans, Hawaiians, Indians and Pakistanis, Mexicans, South and Central Americans, and Puerto Ricans had 1.4- to 3.6-fold greater risks of presenting with stage IV breast cancer. In addition, African Americans, American Indians, Hawaiians, Vietnamese, Mexicans, South and Central Americans, and Puerto Ricans had 20% to 200% greater risks of mortality after a breast cancer diagnosis than non-Hispanic whites.

- The rate of surgery was 12.7 percent lower for African American patients than for white patients, and the five-year survival rate was also lower for African Americans (26.4 percent vs. 34.1 percent). However, among the patients undergoing surgery, survival was similar for the two racial groups, as it was among those who did not undergo surgery. Further analysis suggests that the lower survival rate among black patients with early-stage, non–small-cell lung cancer, as compared
with white patients, is largely explained by the lower rate of surgical treatment among blacks.\textsuperscript{11}

For the federal government, the six priority areas with disparities in health care include: cancer (screening and management); cardiovascular disease; diabetes; HIV/AIDS; immunizations; and infant mortality.\textsuperscript{12} The federal government plays a major role in providing and financing health care for minority groups, and thus has a major stake in reducing disparities in health care. For instance, REACH 2010 is a federal initiative which includes the goal of eliminating racial and ethnic disparities in health by the year 2010.\textsuperscript{13}

Some national initiatives to address health care disparities described by the General Accounting Office (GAO) for its Congressional report include:

- Disease management (i.e. asthma management programs)
- Disease prevention (i.e. breast cancer screening programs)
- Health literacy and language services
- Cultural competency
- Education and outreach (for instance, in collaboration with community or religious groups, targeting specific populations)

However, as identified by the GAO, some challenges to initiating beneficial approaches to address health care disparities include:

- Incomplete understanding of nonfinancial causes of disparities
- Targeted programs and interventions are in early stages of implementation
- Limited evaluation of existing programs and interventions
• No overarching approach to address health care disparities. In fact, multiple approaches are perhaps preferred given the diverse etiologies of health care disparities in minority populations.

• Limited health care data on racial and ethnic minorities.

Cultural Competence in Health Care

The U.S. Department of Health and Human Services Office of Minority Health (OMH) and Agency for Healthcare Research and Quality (AHRQ) has sponsored the Cultural Competence Research Agenda project, to examine how cultural competence affects health care delivery and health outcomes. The project used the following definition of cultural competence:

*Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.*

One goal of the federal government was to create national standards for culturally and linguistically appropriate services (CLAS) in health care. The CLAS standards were derived from an analysis of current practice and policy on cultural competence, and further shaped by the input and expertise of health care providers, policymakers, researchers, advocates, and consumers. The 14 standards are organized by themes:
• Culturally Competent Care (standards 1-3).
• Language Access Services (standards 4-7).
• Organizational Supports for Cultural Competence (standards 8-14).

Standards 1-7 address interventions that have the most direct impact on clinical care; and standards 8-14 address organizational structures, policies and processes that support the implementation of standards 1-7.15

Many health care providers and policymakers have fundamental questions about the intrinsic and relative value of different cultural competence methods and programs. In Setting the Agenda, the report prepared by the AHRQ, Fortier and Bishop conducted an extensive literature review to identify research that measured the impact of culturally and linguistically competent interventions on outcomes, specifically issues related to access, utilization, and health status. Although limited in scope and depth, the body of existing empirical studies does suggest that several of the proposed interventions have the potential to affect health care delivery and health outcomes. Culturally sensitive interventions such as cultural competence training and racial and ethnic concordance have shown improvements in subjective, self-assessed measures of provider knowledge and patient satisfaction. Health promotion and education programs that utilize interpreters, community health workers, translated materials and other culturally sensitive approaches reported increases in intake, program completion, and knowledge16.
Muslims in America

By some estimates, the first large scale arrival of Muslim in America occurred with African Muslim slaves brought to America: an estimated 12 to 13 percent of African slaves brought to America since the early 16th century were Muslims. Misperceptions about Muslim populations and diversity abound. The majority of Muslims in the world are Asian (including India, Pakistan, Indonesia, etc.). The estimated Muslim population in America is six million. Of the Muslim population in North America, 25 percent are estimated to be South Asian, followed by 23 percent Arab, and 14 percent African American. The majority of Muslims in North America, as well as North Carolina, are racial or ethnic minorities. The estimated population of Muslims in North Carolina in 2000 was 20,137. These estimates were based on mosque attendance estimates, and some estimate that only 20 percent of Muslims are affiliated with a mosque. Rajaram and Rashidi state, “Although Muslims come from different parts of the world with different economic, political and social systems, the practice of Islam and its dominant tenets serve as a unifying bond between these diverse populations”.

Muslim Culture and Beliefs

There is no unifying Muslim culture, given the diversity of the Muslim population around the world. However, Muslims do share common beliefs through their religion, Islam. The word “Islam” in Arabic means “to surrender”, but it is also derived from the word “peace”. A Muslim then is “one who surrenders”. There are
approximately one billion Muslims in the world, inhabiting vast and
diverse cultures and traditions. However, the unifying theme is the
belief in the Quran, and the five pillars of Islam. These include:

- To firmly believe "There is no God but God, and Muhammad is the
  Messenger of God.". This is what is meant by Iman (Belief)
- To pray five times a day (perform Salat).
- To pay charity (Zakat).
- To fast during the month of Ramadan.
- To go on pilgrimage (Hajj) to Mecca once in a lifetime if one can
  afford it.

Central to Islamic teachings is the unity of God in all spheres of life, death
and the hereafter; manifested by the connection between the human mind,
human body and nature. Islamic medicine, in its classical form, used a
holistic approach to health. Nasr summarizes common Muslim thought when
he states, “...in its attempt to view man as a whole, as a single entity in whom
body and soul are united, and in involving man to the total cosmic
environment in which he lives, Islamic medicine has remained faithful to the
unifying spirit of Islam.” Nasr adds, “…to this very day, the theories and
ideas of Islamic Medicine dominate the daily dietary habits of the Islamic
people. They still serve the framework for a unifying vision of man, as an
entity in whom body and soul are closely intertwined, and in whom the state
of health is realized through harmony and equilibrium.” The Islamic
medicine described above had its heyday during the height of Islamic
civilization, and integrated Greek, Indian and Persian medical practices into
relatively standardized systems of health care. Health care providers,
including many well-known Muslim and non-Muslim physicians, practiced in large hospitals (Bimaristans) such as the Mansuri in Egypt and the an-Nuri in Syria. Currently in India and Pakistan, Unani (derived from Greek) medical schools are licensing health care practitioners, and hakeems (those practicing Islamic or Ayurvedic medicine) are consulted alongside allopathic physicians.

North American Muslim women's health issues

A review of the literature shows a rich collection of ethnographic and qualitative data on North American Muslim women’s health issues. Focus groups of Muslim women found that the participants’ religious beliefs and customs significantly influenced their participation in breast cancer screening. Some reasons for not obtaining breast exams and mammograms, elucidated by S. Underwood, include: the value placed on modesty; the belief that the woman’s role as nurturer of the family necessitates always attending to her family’s needs before her own; and the importance of family involvement in health care decisions. Qualitative studies have also been performed evaluating Muslim women’s attitudes towards cervical cancer screening, and American Muslim women’s experiences with domestic violence and polygamy. Rajaram and Rashidi offer an ethnographic review and a framework of African-American Islamic women in the American health system. Overall, however, the values and practices that may contribute to barriers in health care for Muslim women in America have not been well studied.
In light of these issues, key questions still need to be addressed, especially for the local, Raleigh/Durham area Muslim community. Three questions that need to be addressed include:

- Do Muslim women face challenges in obtaining health care within the American health care system due to factors related to their religion and culture?
- What aspects of residing in the Raleigh/Durham area contributes to these health care challenges?
- What are the most beneficial and cost-effective ways of addressing the health needs of this local Muslim community?

**METHODS**

Estes and Zitzow originally developed a framework for understanding the degree to which one's culture, ethnicity, and religion influence the manner of one's societal interaction. They suggest that a person's lifestyle and behavior is a direct reflection of his or her religion, ethnicity, and culture. Qualitative methodology is well-suited to explore and understand these connections. In order to address the specific questions listed above, researchers at Duke University undertook a process of data collection with the goal of carrying out a qualitative analysis. This data collection process was approved by the Duke University Institutional Review Board and serves as a secondary data source for the analysis presented here. Focus groups were used as the primary mechanism of collecting information about local Muslim women's health needs. Table 1 further delineates the framework for using focus groups.
followed in this study and adapted from Richard A. Krueger’s Focus
Groups: A Practical Guide for Applied Research.33

**Data Collection/ Sample Selection**

In the Duke sampling method a purposefully selected sample of Muslim
women who were patients or potential patients were recruited to participate in
one of two focus groups, one conducted in Raleigh and the other in Durham,
for participants’ convenience. A third focus group consisted of a selected
sample of local Muslim health care providers or community activists. All
focus groups were conducted in the community in a setting deemed to be
suitable to the participants. The focus groups were supported by a grant from
the Trent Foundation. Duke University’s Institutional Review Board (IRB)
allowed for the study’s exemption from full review; University of North
Carolina’s IRB approved the secondary analysis of focus group data. The
secondary analysis contained no identifiable participant markers. Focus group
participants were recruited to represent diverse racial, ethnic, national, and
sectarian segments of the local Muslim population. Many participants knew
each other in the community. All participants were able to speak
conversational English. All of the focus groups continued beyond their
allotted time frame- anywhere from forty five minutes to one hour. Every
participant was noted to have verbalized comments, and only one participant
asked that her comments not be audio-taped (she did agree to have her
comments transcribed by hand).
In the first “patient” focus group of eleven participants, six were reared from birth in accordance with Islamic traditions. The remaining five women had converted to Islam from one to greater than twenty years prior. Four participating women were African American, another four were Asian American, one was Arab American, and the remaining two were Caucasian.

The second “patient” focus group consisted of seven participants, all reared from birth in accordance with Islamic traditions. Two participants were Asian-American, the other five were Arab-American. Although all spoke conversational English, all but one spoke English with an accent.

The third focus group consisted of five participants, with one male Muslim. Four participants were immigrants. Three participants were health care providers well-known in their community, and two were community activists.

All of the focus groups were conducted by the author, whose Muslim background was discussed openly in the introductions. The discussion outline for each focus group consisted of: a brief discussion of the purpose of conducting the focus groups; benefits and drawbacks of having focus groups; and a chance for any questions or thoughts to be aired by the participants.

Then, three open-ended questions were posed to the participants:

- What health issues, if any, have you faced as a Muslim, as a woman, or both?
- What health issues do you see faced by Muslims in the community?
- What services or resources are needed to face the health challenges in our local Muslim community?
Data Coding/Analysis

All of the focus group sessions were audio-taped, and transcribed verbatim. The quality of the recordings was clear. The content of the transcripts was then analyzed by the first author to identify themes and frequency of codes. Standard coding techniques, described in Krueger's *Focus Groups: A Practical Guide for Applied Research, Second Edition* 33, were used. These transcripts were then compared with notes taken during the session to evaluate consistency. The transcripts were also analyzed by an independent coder with experience in evaluating qualitative data, and then discussed and analyzed as a group in order to achieve agreement. The themes were also discussed with key informants from the community who provided advice in organizing the focus group interviews, and their perspectives helped to structure these themes.

RESULTS

All findings presented are specific to the Raleigh/Durham area Muslim community’s health attitudes, behaviors and needs. The major themes can be divided into two categories: health and well-being concerns and priority services of an ideal health center. The majority of the focus group time centered around health and well being concerns. The two focus groups of local Muslim women shared similar concerns. A list of recurrent themes/codes for each focus group is provided in Appendix A, B, and C.
Health and well being concerns

The Muslim women who participated in the first two focus groups expressed very similar concerns about the attitude and behavior of health care providers. Many of the Muslim women felt uncomfortable with the preconceived notions that they felt going into their health care encounters.

"...that's what they think about us, though, when we're saying, I want to keep this on (points to hijab), and you can't see it. They're thinking, "I've seen this a million times and you're not special..." "Why can't you just take it off and show it to me?"

"--Yah-"I'm not attracted to you, I'm a professional. Why do you have this attitude towards me?" They don't see it.

"--"...it's not a sexual thing, it's just purely academic, scientific. I'm not looking at you as a woman, I'm looking at you as a body..."

The doctor was doing a checkup on me, hearing the baby. I had a mosquito bite, and it was so itchy, you know, when you're pregnant, you are so itchy... I wounded myself. She said- what's that? What happened here? You know, you feel like... You know... what do you want? Just something simple happened. You feel like they are investigating... and my husband was standing, and "what happened here?" Things like that. It's weird. It puts you in a very weird situation.

Some of the participants felt that they spent time during the medical encounter deconstructing stereotypes of the health care providers.

"And it forced me to leave her- I could not move further with her at all, because of that simple issue. Because she did not take my covering (head scarf) seriously. So at that point, I started to search for a Muslim psychologist or psychiatrist, and it was very difficult to find. I did find,... someone
recommended to me a guy, and I just wasn’t really sure I wanted to speak to a man on my issues, especially since it’s PMDD (Premenstrual Dysphoric Disorder), and he doesn’t have a cycle, or period or anything (laughter). I just didn’t feel like I wanted to go that route. So I did find Dr. ___ in Raleigh, and that went well for a while, but now I’m in Winston. So my point being, just from psychological health, it is imperative to me that they be a Muslim. I don’t trust, I don’t think they’ll take me seriously, I don’t know if they’re gonna say it’s her religion. I just don’t know what’s in their psyche. Are they thinking to tell me, “well if you just be a Christian again...” (laughter), I just don’t know. But I don’t want to come face to face with that at all, you know. I just don’t want that issue. So for me, if I could just have a woman who was a psychologist or a psychiatrist it would mean a lot—a Muslim woman..

My mom thought I was mad at her since I was getting married (laughs) she’s like, I want you to get therapy, I’ll pay for you. I was like maybe I’ll take her up on this offer. Maybe I can take this opportunity to learn from this therapist how to have a successful marriage. How can I use this to my advantage? But what ended up happening, for the sessions that I went, was me deconstructing her misconceptions about Islam—about Islam?—exactly. And I was getting charged for it (general laughter). And she’s like—tell me about this, now I remember in 1979... But alhamdullah, you know, that is DEFINITELY there. There’s a woman in a wheelchair who’s a very big activist in the disability community. And she’s getting her degree, her name is ____, she’s from Raleigh. She’s getting her Masters in Psychotherapy with a specialization in dealing with people with disability. Because she felt like, if you had a disability, and you went to go see a therapist about something, they would always bring it back your disability. It’s like, oh, it’s because of this.. They could never see you as a person I think this is kind of similar in that way. Because there’s always stereotypes. Because you’re both educated, and your talking, and you’re having a conversation, but their
still having these thoughts about you.
That’s not neutral...

The participants felt that their modesty concerns are not taken seriously by some health care providers. They also felt that Muslims are not the only group with such concerns. People from other cultures, or from America, have difficulty with some health care system attitudes.

...and I don’t think these are issues particular to just Muslims. I was interviewing a Vietnamese (refugee) family, they are Montegnard, and one of the first things they do when they get off the boat is they go and get a physical exam. And as one woman described to me- she’s like, well, you just have to hold on. These men get off these boats... first of all, it’s shocking because you’re in this new environment. And then people are touching you, and it is totally, culturally, strange. So part of it is just dignity. This is Human.

And there are other people, other than Muslims, who would like the same service that we are talking about. They would really welcome and appreciate the status and principles which we have. It’s kept quiet. They don’t say anything because it’s not available. What are they going to do? Scream and yell? This is what I do, this is what I do. But if it were offered, I think we’d have a line as long as this street every day coming to the clinic.

Although many of the women described specific instances where they felt uncomfortable with their health care experiences, or had specific instances of bias, they did discuss how some changes are being made to improve patients’ comfort levels in health care settings. Participants recognized that there are health care providers who respond to their requests.

...at our hospital, they have signs that say, “Women Only” “No Male Residents”...
-How wonderful-
And they put that outside of the door, so I always got to go in (laughter). But other people didn’t. And a lot of times they can tell that you’re Muslim, and they’ll ask—do you want only females... 

It’s just reassuring them... making them feel comfortable ahead of time if you don’t already have the information. One place that I saw, Triangle Family Practice, did that. They have a sheet where they ask you ahead of time—do you feel more comfortable with a male doctor or a female doctor? So that was a step, a step closer.

Another big concern voiced by participants involved issues surrounding access to medical care in the United States. The major barrier to accessing medical services was the cost of medical care. Women also expressed frustration with insurance issues, transportation concerns, and the ability to obtain health care at off hours (evenings/weekends).

...take care of insurance, for the people who don’t have any insurance. 
-Reasonable price. If I don’t have insurance, I have to pay reasonable price to go see the doctor 
-yah, you’re right. For me, I never went to the doctor because I never had insurance.

Well I was going to say something about a free health clinic. Because when I first came here, I had a problem with my private part (sic). I had to go to a gynecologist, but it was an emergency. Because the weather is different, I just got this high fever, and I had really pain in the stomach (sic). I had to go to this free clinic, because I don’t have a lot of help or money, so I had to go there. “Are there going to be a woman doctor there, because I don’t feel comfortable with a male doctor”, and they said there should be one or two women. But when I went there, they said, well, there’s no woman today, so I don’t know what you’re going to do. My husband said— you just go ahead and see them, because it’s an emergency. But I don’t feel comfortable. These people, they just really want to make me cry.
The level of stress faced by local Muslim women was discussed in depth at the focus group involving community health providers and activists. Many participants felt that stressed Muslim women, especially since September 11, 2001, have difficulty finding appropriate services locally.

Back home, if there’s a problem in the family, the daughter goes to the parent’s house. The problem is solved. At least she doesn’t have to wait outside or find a place to stay. In this country, when there’s a problem with abuse or there’s some problem going on where the family has to stay, there is no place to stay. They end up staying in churches, and places which are not very conducive to Islamic teaching and living. So far, it has run into a lot of difficulties. Not because of lack of funds—it’s a lack of understanding in the part of the community.

But besides the physical thing, my emphasis will also be on the psychological factors. Because currently what we Muslims are going through—it is really unimaginable. Because I came on September 10, 2001. And this was 11th, that happened. And ever since I came, it was so traumatic. And I have seen a lot of Muslims going through the trauma. Even now they are going through a lot of trauma. I think this is the real thing we need to understand. Because we give so much emphasis to the physical needs. I mean, the mental needs, the psychological needs are just pushed aside, you know, I mean most of the time. And when these two are combined, then you have the total well-being of a person considered, if you have both these put together.

I know through my work (as a massage therapist), actually, I realize how much women, especially in our community, are really stressed. And they love what I do. I didn’t expect it. I thought that Muslim women are not my target population. I was targeting rich people. But I found Muslim women coming to me, asking for my service. They are really stressed, as you mentioned. They need some space to go to relax, and to get what they’re problem is, out.
For the last 9 years, I’ve been running our food pantry through the IAR (Raleigh Mosque). And because I’m the only woman, I, by default, got to be the person who is very much in touch with women who are not only needy, but women with social issues. Domestic issues. As you said, when the husband is gone, the wives are left in a very bad situation. I didn’t realize you had tried (speaking to MB), but we had also tried 2-3 years ago to establish a shelter for women. And the task is just too great. And very expensive. But the other part is also the medical need. And even with the fifty some odd families I have in the food pantry right now, a lot of them don’t have the papers, or the money, or for whatever reason, they’re not able to avail themselves of the medical assistance.

**Priority services of an ideal health center**

All of the focus group participants felt that there exists a need for a health center that can address the broad health needs of patients in a culturally competent way. In all three discussions, the importance of mental, emotional, nutritional as well as physical health of patients, especially minority patients, was repeatedly mentioned. Also, the focus groups of Muslim women described the importance of educating non-Muslim health care providers about their religion. Listed below are the priority services that the focus group participants discussed:

- All-female staff
- Education of non-Muslim health care providers
- Staff with understanding of Muslim women, cultural sensitivity
- Comprehensive services
- Childcare/children’s health care

So for there to be a Muslim women clinic, with women doctors and nurses, it would just be like an amazing thing, and like ___ was saying I think you have women of all stages and walks of life, lining up just because of the Woman Clinic, staffed by women
But for those of us who are Muslim, it would be like, the icing on the cake, because all the women there working with you understand your ideology, your sensitivities at a whole different level.

A lot of Muslim women need a center where they can go freely, to feel comfortable. When they are woman to woman, they can talk freely. They feel comfortable. The things they don’t want to discuss with the male doctor. It’s not only doctors- the nurses, if they are female over there- or dentists, dietitians- that’s going to be a more comforting environment for the Muslim woman.

But if we establish an international clinic with Muslim principles, I would think that that would assure that there would be some humane treatment there. That the people they are interviewing to be doctors and nurses are told ahead of time, you know, we are looking not only for good professionals, but empathetic people, people that are gonna really be a full doctor as far as practicing from the heart and the mind and everything. That would cover that. If you could at least have reassurance that the female doctors there would have some level of morality, not just trying to get a paycheck-right-And you would feel comfortable. That’s the place you could go and bring your daughters one day, you know.

One of the participants summarized her concerns about community health needs, and discussed a way to address these needs. She felt that education and empowerment are key to improving community health. She summarized the thoughts of many participants.

I’m a nurse. I work at Duke. My specialty is adult medicine. My passion- my patients and my community as well. My concern- being a nurse for as long as I have- many of the challenges that people have in the community- whether it’s domestic violence, AIDS, drugs, and all these things that affect us. And if it affects our patient
population, ultimately it affects us. I do believe that the greatest strength that we have is each other. And many people in the community who need help don't know that yet. They don't know that there are places they can go to be educated. They can go to get preventative care as well as help them in their emergent or acute situation. And I think the biggest gift we can give the people is to help them help themselves. I think you can do that by education, resources, but I think that's such a helpless feeling not to know that there are things out there for you, or that there are people out there who really care. Our challenge is to put it all together. To make something that's viable—after we're long gone. You know, have communities that can hopefully benefit way beyond our lifespan. I think that's it in a nutshell.

DISCUSSION

The main goals of the data collection and analysis based on focus groups that has been presented here was to learn about perceived health needs of the local Muslim population in the Raleigh / Durham area and to discuss barriers to achieving quality health care for this population. There are some limitations to consider with the information from this qualitative study. Given that the focus groups represent the views of purposefully selected local Muslim participants, the data obtained cannot be extrapolated to the wider needs of Muslim women in America. Also, with the diversity of the local Muslim population, there is a possibility that major viewpoints held by segments of the local Muslim population are missing. However, the level of agreement in the major themes that emerged from all three focus groups is reassuring. The key findings of the focus groups identify common health related issues. There
are health needs described by the Muslim participants which are common to many Americans, and also others which are specific to Muslim women’s health concerns. These include:

- Physical barriers to accessing quality health care. This includes the cost of health care, transportation issues, appointments on weeknights/weekends, etc.
- Local Muslim women felt uncomfortable with the preconceived notions that they felt going into their health care encounters.
  - They note how this can be an issue for non-Muslims as well
- Changes are being made individually by health care providers responding to the needs of minority populations
- Muslim women, especially since September 11, 2001, have faced increasing and worrisome amounts of stress, with few avenues for culturally appropriate stress reduction.
- Education and empowerment are key to improving the community’s health.
- The priority health services discussed by the focus group participants include: an all female staff; education of non-Muslim health care providers; staff with an understanding of Muslim women’s culture; comprehensive services; childcare; and children’s health care.

In order to address these health needs, further research as well as community interventions are needed. The last part of this paper will present recommendations for future research aimed at addressing the health care needs of Muslim women, as well as possible community-based interventions to address local Muslim women's health care needs.
Future Steps

Research agenda

Based on the findings of national qualitative studies, and our locally conducted focus groups, some important questions emerge that need to be studied further. These include:

- In what way does the world view of Islamic culture in America differ from the U.S. culture?
- What are the multiple levels of integration and practice that might exist between major Islamic principles and the dominant American culture?
- How do these different levels of integration affect the health of Muslim women?
- How do American Muslim women negotiate between these multiple levels in providing a safe social space as well as an identity for themselves? How does this differ between minority American Muslim women vs. Caucasian Muslims? How does this differ between first generation immigrant Muslim women and their more acculturated counterparts?
- What program and policy changes are essential to meet the needs of this population?

There are initial efforts to address these issues on a national level. University of Illinois at Chicago held a first-of-its-kind conference on “Patient-centered Health Care for Muslim Women in the United States” March 4-5, 2005. This event, sponsored by the AHRQ, attracted more than two hundred participants, from policy makers to health care providers. Ongoing qualitative research will hopefully allow the beginning of larger, quantitative research into health care disparities faced by Muslims.
Community intervention

One of the key components of this research from the public health perspective is that it represents a community assessment and improvement process for an important and growing segment of the Raleigh/Durham community. A key to such a process is the involvement of the community in making needed changes. As stated by one of the focus group participants, education and empowerment of the community are essential to improving the community’s health. With this in mind, some members of the Muslim community in the Raleigh/Durham area, spurred on by the results of the focus group discussions and the interest it generated, decided to pursue the health needs local Muslim women face. This group created a presentation entitled “Creating a Muslim Women’s Health Center” based on the results of the focus groups and a compilation of other Muslim-associated health centers from across America. The goal of the presentation is to engage in dialogue with the local Muslim community and decide on a common, mutually beneficial plan to address these health needs. Although most Muslims do not attend mosques regularly, mosques are a focal gathering place. The major mosques in the area will need to be identified, and the support of the imams (religious leader) at each mosque will be needed. The presentation can then be given at each mosque at times of optimal participation by both men and women. Also, key informants will need to be recruited from the Muslim community in order to identify other venues to offer the presentation, such as cultural gatherings. Community organizations offer another important avenue to reach the local
Muslim population, including Women’s groups, Free Health Clinics, Immigrant and Refugee organizations. One challenge faced in achieving a common community plan is the diversity of cultures in the local Muslim population. Especially challenging is reaching some of the more isolated Muslim women in the more conservative Muslim communities. Currently, there is no local Muslim community organization composed of diverse sectarian and ethnic Muslims united to confront health issues. A key step to improving community consensus is through the formation of a new community organization to address local Muslim health needs, especially those of Muslim women. Some key questions that this organization will need to address include:

- Who in the Muslim community needs the most help?
- What services are most important?
- How do we get statistics without invading people’s privacy?
- What is our Muslim community willing and able to start and sustain?

There are major steps that need to be taken, and challenges to address, as the local Muslim community works to address the health needs of the Muslim population, and expands their services to include the health needs of other racial and ethnic minorities. As research continues to be done to further evaluate and address the racial and ethnic health care disparities felt by many Americans, local Muslim are realizing that they can help address these health needs.
CONCLUSIONS

Although the exact number of Muslims in the Raleigh/Durham area is unknown, they do represent an increasing part of the minority population. The health care needs of Muslims, and Muslim women in particular, have not been well studied in the literature. In this joint research effort between Duke University and UNC Chapel Hill, focus groups were conducted of local Muslim women as well as Muslim health care providers and community activists, in order to discuss the health care needs, and barriers to quality health care faced by this population. The major themes that emerged show that Muslim women share some common barriers to accessing health care with other Americans, such as cost, transportation issues, and hours of clinic operation. However, other health care issues specific to Muslim women were voiced in these focus groups. One such specific issue is the significant stress faced by Muslim women currently, heightened after September 11, 2001, and finding appropriate and beneficial stress reduction venues for Muslim women is a major challenge. This challenge includes facing stereotypes by health care providers, and modesty issues.

Muslim women in America constitute a growing and diverse group of races and cultures. Many Muslim women want health care and community services delivered by those who understand the importance of Islam in their lives. They also desire a forum for education, support services and children’s health care. Education of non-Muslim health care providers is a stated
priority, in order for the providers to better understand the needs of Muslim families in this country. Improving cultural competency for health care providers, a stated goal of the AHRQ, will help in the quest to eliminate racial and ethnic disparities in health care for all Americans.
References


32 Myers, E. Muslim women’s health needs in the Raleigh/Durham area: Results of focus group participation. Unpublished manuscript, Duke University Medical Center. 2005.

Table 1

Determining the Framework of Focus Groups

1) Determine the purpose:
   - Why should such a study be conducted?
     • to focus on perceptions amongst Muslim women in the
       Raleigh/Durham area of their short term and long term health-related
       needs
   - What kinds of information will be produced?
     • experiential data
   - What types of information are of particular importance?
     • priority lists
     • perceived barriers to health care
   - How will this information be used?
     • to shape the direction of future actions (medical, educational, service-
       oriented)
   - Who wants the information?
     • Local Muslim community
     • Local medical community
     • Community and women’s services organizations

2) Why are we using focus groups instead of surveys, observation data, or
   individual interviews?
   • Insights are needed in exploratory studies. Focus groups are hopefully
     the beginning of a larger scale research effort. The goal is to gain
     reactions to areas needing improvement and general guidelines on how
     interventions are prioritized.
   • Further explore the possible communication/understanding gap
     between medical professionals and Muslim women in the area.
   • To uncover factors related to complex behavior/motivation in regards
     to obtaining and maintaining health care.
   • Allow ideas to emerge from the group; capture comments and open-
     ended thoughts of the group
Appendix A

Findings From the Durham Focus Group 1/8/05

Themes - listed in order of frequency and intensity of theme (as measured by repetition)

1. Uncomfortable with male doctor/want female doctor
2. Allopathic world/holistic/primary care
3. We need to educate doctors about what we want
4. Modesty/dignity
5. Willing to travel 1 hour to clinic
6. Not very respectful of women
7. Stereotypes of Muslims
8. Few options to see female Muslim doctors
9. Immigrant experience particularly difficult
10. Insurance issues/costs
11. Children’s play area/childcare
12. Weekend hours
13. Female doctor was not sympathetic/want humane experience
14. Universality/not issues just for Muslims
15. Shuttle service
16. Referral basis
17. Vulnerable
18. Explanations (someone to explain to me what was happening)
19. Totally exposing experience
20. Midwife
21. Open to males at certain times
Appendix B

Findings From Raleigh Focus Group - 1/29/05

Themes - listed in order of frequency and intensity of theme (as measured by repetition)

1. Non-Muslim health care providers don’t understand
2. Not comfortable with non-Muslim health care providers
3. Prefer female physician/staff
4. Do not understand Muslim cultural background (esp. American MD’s)
5. Stereotyping of Muslims
6. Americans are nice, but don’t have outside experience
7. Insurance issues/cost/access issues
8. We need to let them know how we feel/act (educate providers)
9. Alternative therapies/holistic therapies
10. Holistic services (everything there)/nutrition education
11. Muslim counselors
12. Quality health care
13. Immigrant have difficulties
14. Easy location
15. Explain Islam to non-Muslims
16. Skin care
17. Affordable Islamic based education
18. Boys want male health care providers
Findings From Community Leader Focus Group 2/27/05

Themes listed in order of frequency and intensity of theme (as measured by repetition)

Muslim-sponsored outreach to the community:
1. DV/social services issues
2. (half way house) problems
3. Legal issues/restricted sponsorship due to violence concerns
4. Free clinic issues
5. Space
6. Money
7. Free health fair
8. Volunteer issues
9. Open on weekends
10. Malpractice issues
11. Open to everyone, including non-Muslims

Muslim women's health needs:
1. Access to health care/resources
2. Muslim women stressed/overwhelmed
4. Immigrant Muslims need to understand issues affecting them/children
5. Beautiful surrounding
6. Child care
7. Mental health care
8. Women only facility
9. Education/resources (help people help themselves)
10. Muslim girls have health related questions
11. Men/families are overwhelmed
TO: Sumera Hayat  
DEPARTMENT: Family Medicine  
ADDRESS: CB# 7469  
DATE: 07/06/2005  
FROM: Andrea K. Biddle, PhD, Chair  
Public Health IRB, Office of Human Research Ethics  

IRB NUMBER: 05-2658  
APPROVAL PERIOD: 07/06/2005 through 07/05/2006  
TITLE: Assessing the Health Needs of Muslim Women in Raleigh/Durham: Secondary Data Analysis From Focus Group Transcripts  
SUBJECT: Expedited Protocol Approval Notice--New Protocol  

Your research project has been reviewed under an expedited procedure because it involves only minimal risk to human subjects. This project is approved for human subjects research, and is valid through the expiration date above.

NOTE:  
(1) This Committee complies with the requirements found in Part 56 of the 21 Code of Federal regulations and Part 46 of the 45 Code of Federal regulations. Federalwide Assurance Number: FWA-4801, IRB No. IRB540.  

(2) Re-review of this proposal is necessary if (a) any significant alterations or additions to the proposal are made, OR (b) you wish to continue research beyond the expiration date.