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Abstract

This paper offers an analysis of the interactions of Muslim women in the US healthcare system in order to unpack challenges and propose potential accommodations. Islam may inform values or considerations in the context of other cultural factors or present Muslim women with specific challenges in seeking healthcare based on Islamic teachings or social constructs. This paper examines these factors by elaborating on an overview of Muslim interpretations of healthcare using religious authorities, text from the Qur'an, and social norms. It then delves into challenges faced by Muslim women in the US healthcare system and the implications of those challenges and finally proposes improvements to help Muslim women to gain access to fair and equal healthcare in the US.

Keywords

Muslim, women, healthcare

Disciplines

Anthropology | Gender and Sexuality | Islamic Studies | Near and Middle Eastern Studies | Public Health | Race and Ethnicity | Social and Cultural Anthropology | Sociology of Religion | Women's Health | Women's Studies

Comments

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Muslim Women and United States Healthcare: Challenges to Access and Navigation

by Dayna M. Seeger

I. Introduction

Adequate healthcare is a vital part of the well being of all humans. Despite this established need, minorities tend to receive lower quality healthcare than non-minorities, even after access-related factors such as insurance and income are controlled for (Smedley, Stith, & Nelson, 2003). In the United States (US), the Muslim population is the fastest growing and the treatment of Muslims in the American healthcare system is, as may be expected, often lacking (Ali, Milstein, & Marzuk, 2005; Salman, 2012). Despite the seven-million-person presence of Islam in the US, there is a sense of misunderstanding and bias associated with the religion and its population because of media portrayal and post-9/11 discrimination (Ali et al., 2005; Padela, Gunter, Killawi, & Heisler, 2012). Because of this misunderstanding and cultural barriers between Islam and the organization of the system, the treatment of Muslim women in US healthcare is insufficient to meet their healthcare needs.

The relevance of Islam to healthcare is well demonstrated by medical anthropologist Dr. Arthur Kleinman, who proposes a cultural construction of clinical reality. He argues that the way that individuals experience health and illness is very much shaped by cultural factors, such as religion, which in part determine when and how they choose to label illness, evaluate its severity, and seek care within a healthcare system. That healthcare system, he states, comprises socially organized responses to illness and culturally informed social realities that legitimize and construct illness and define social roles for both patients and healers (1980). Religion defines those social realities and roles, which then determine how patients and healthcare workers

interact and influence when individuals choose to seek out healthcare. Islam, then, can be a dominant factor in the interaction of Muslim women with any healthcare system. Muslim women's cultural construction of clinical reality presents unique challenges in navigating the US healthcare system, as will be demonstrated.

This paper offers a generalized analysis of the interactions of Muslim women in the US healthcare system in order to unpack challenges and propose potential accommodations. It is important to note that, just like race and ethnicity, Islam does not affect the health-related choices or outcomes of all Muslim women in the same way (Padela & Curlin, 2013). Instead, the religion may inform values or considerations in the context of other cultural factors (Padela et al., 2012). It may also present Muslim women with specific challenges in seeking healthcare based on Islamic teachings or social constructs. I will examine these factors by elaborating an overview of Muslim interpretations of healthcare using religious authorities, text from the Qur'an, and social norms. I will then delve into challenges faced by Muslim women in the US healthcare system and the implications of those challenges. Finally, I will propose improvements to help Muslim women to gain access to fair and equal healthcare in the US.

II. Islamic basis of health and healthcare

In order to understand the challenges faced by Muslim women in the US healthcare system, it is important to have an appreciation of how Islam treats healthcare. Islamic medical ethics are based on several different sources, namely *adab*, *sharī'ah*, *fatawa* (plural of *fatwa*), and *fiqh*. The scope of this paper does not encompass detailed explanations of each of these sources, but a brief description is helpful to recognize the complexity of the interaction between Islam and US healthcare. *Adab* is a form of Islamic etiquette that promotes certain virtues and

conduct. It is not law and may vary among cultures, but is reinforced by social norms. *Shari'ah* is the moral code of Islam and again, though not codified or singularly referenced as law, can be consulted when facing decisions regarding medical care. Other sources of moral guidance are *fatawa*, or fatwas, which are decrees that may be based on regional culture and can be used to regulate issues for Muslims. Although fatwas are non-binding, Muslims and clinicians may look to them for clarification on an issue. *Fiqh*, contrastingly, is the jurisprudence of Islam based on the Qur'an, Sunnah, and Hadith, or the texts of Islam (Padela & Pozo, 2011). Recommendations for Muslim women seeking healthcare may be based on some or all of these sources of authority, but the common core of each of them is the Qur'an.

Some verses in the Qur'an promote behaviors that agree with US practice, including breastfeeding and eating in moderation (Padela & Curlin, 2013; Padela, Killawi, Heisler, Demonner, & Fetters, 2011). Other frequently cited verses, though, encourage more challenging practices for women navigating the US healthcare system. The two most frequently referenced issues for Muslim women and healthcare are modesty and separation of gender. The Qur'an states that both men and women should "lower their gaze and guard their modesty" and that women should "not display their beauty and ornaments except (what must ordinarily) appear thereof; that they should draw their veils over their bosoms" (Qur'an, 24:31). There are further writings about *awrah*, or areas of the body that must be covered to protect intimacy (Padela & Pozo, 2011). Modesty is a value frequently held by Muslim women, but modest clothing, including veiling, can prevent healthcare workers from adequately examining the women during appointments. The Qur'an also has references to the issue of *khalwah*, or the situation in which a man and woman are alone together, which provides the opportunity to have sex (Padela & Pozo, 2011). Some religious authorities interpret these and other writings to mean that physical contact

between sexes is forbidden because it may lead to adultery. One Hadith (referring to the words and deeds of Mohammed) says, “It would be better for one of you to have himself stabbed on the head with an iron needle than to touch a woman that is illegal for him” and, because of these inclusions in the religious texts of Islam, Muslim women may be told by religious authorities or social norms to always and only have female healthcare providers (Padela & Pozo, 2011; Laird, Amer, Barnett, & Barnes, 2007).

Despite these recommendations, many argue that Islam does not forbid examination by the opposite gender if absolutely necessary. Most Islamic authorities state that medical necessity overrides the prohibitions and that, if essential, cross-gender examination and undressing are acceptable (Laird et al., 2007; McClean et al., 2012). They cite that *asiyaat*, or lady healers, were responsible for treating soldiers during the Prophet’s life. Therefore, they argue, cross-gender examination must not be prohibited if it cannot be avoided. In such situations, though, Muslim women generally need to be accompanied by another woman (McLean et al., 2012).

A recent study, which investigated how the Islamic treatment of modesty and gender-concordant care translated into the beliefs of Muslim women, found that the concerns about modesty and gendered treatment seem to be most prevalent for intimate examinations. Of the Muslim women in the study, who were all from the United Arab Emirates, 96.8% indicated a preference of female physician for a gynecological exam, but only 46% of them did so for a facial examination scenario (McClean et al., 2012). This difference in preference may be because of the frequent exposure of the face even when a woman is veiled using some styles, or because of the comparison of the facial scenario to the more personal gynecological exam. Interestingly, women with university levels of education were generally less concerned about having a female physician, which demonstrates the interconnectedness of cultural factors outside of religion and

the diversity of Muslim women's views. While it is true that some of the gender preference may be unrelated to religion, similar studies completed in the US and Canada have found that between 60% and 75% of women do not have a strong gynecologist gender preference (Johnson, Schnatz, Kelsey, & Ohannessian, 2005; Fisher, Bryan, Dervaitis, Silcox, & Kohn, 2002).

Other studies have found that some Muslim women incorporate the Islamic teachings about healthcare into their perceptions of their own health. These perceptions could, in turn, influence the manner in which Muslim women utilize the US healthcare system. Many Muslim women, for example, use their faith to reason that God is the final determiner of health regardless of any treatment (Institute for Social Policy and Understanding [ISPU], 2011; Salman, 2012). Several independent studies have investigated Muslim women's views of cancer through a religious lens and found that the disease is often seen as controlled by fate. Muslim women in these studies expressed beliefs that a cancer diagnosis was a reflection of sin, a test from God, or an opportunity for redemption or improvement in following Islam's tenets (Mellon, Gauthier, Cichon, Hammad, & Simon, 2013; ISPU, 2011; Padela & Curlin, 2013; Shah, Ayash, Alarifi Pharaoin, & Gany, 2008). There were also suggestions from the women interviewed that being strong during the diagnosis or, in their words, accepting the cancer, made them more likely to survive the disease (Mellon et al., 2013). Such ideas could result in positive mental responses from the women, such as trying to maintain resolve during treatment (Padela & Curlin, 2013). Conversely, an acceptance of the disease could hinder them from trying to get treatment from the US healthcare system at all. It is important to note, though, that the women interviewed in most of these studies were immigrants living in urban communities and that extensive information about cancer perceptions in larger or non-immigrant Muslim populations is not widely available.

Muslim women may be presented with more barriers when trying to use US healthcare because of the cultural and social aspects of Islam that often define the family as the central unit of citizenship. Muslim culture often includes the entire family in personal medical decisions, which stands in stark contrast to the centering of the US healthcare system on individual choices and strict doctor-patient confidentiality (Hammoud, White, & Fetters, 2005). Muslim patients and their extended families, including spouses, parents, and children, all have a role in making medical decisions (Laird et al., 2007). The involvement of a woman's family could lend support in difficult medical scenarios, but could also prevent her from making independent or perceived shameful decisions, such as asking for birth control or testing for sexually transmitted infections.

Other cultural factors may also influence Muslim women's views of health. Some topics, such as sex education, are considered taboo to talk about in Muslim culture (Hammoud et al., 2005). In a similar vein, many Muslims are offended when asked about sexually transmitted infections during doctor's visits because of the implication of adultery. Muslim women living in the US may be exposed to these topics of conversation in public schooling or in literature published by medical facilities, but there may be some misconceptions about them. Mental illness, for example, is considered taboo because of the belief that a Muslim cannot be depressed if correctly following the tenets of Islam (Hammoud et al., 2005). Muslim women may also utilize the availability of imams, who may promote health in sermons and provide counseling in 74% of mosques in the US, and traditional medicinal treatments such as herbs (Ali et al., 2005; Padela & Curlin, 2013).

III. Challenges faced by Muslim women in navigating the US healthcare system

The previous generalized Islamic view of healthcare presents several challenges when navigating the US healthcare system. The primary issues that this paper will focus on are modesty, lack of understanding about Islam and the US healthcare system, and distanced patient-provider relationships.

The Islamic texts and sociocultural norms regulate recommendations for Muslim women and modesty, which may take the form of hijab or modest clothing and hesitancy to get undressed for medical examination. Although not all Muslim women choose to wear hijab, a 2011 study found that 59% of Muslim Americans wear hijab at least some of the time and 36% wear it whenever they are in public (Pew Research Center, 2011). Modest clothing presents a challenge in that healthcare providers may not be able to adequately examine patients. A lacking examination may then cause some diseases, such as malignancies, to go undetected. Muslim women, as indicated in section II, also may prefer a female healthcare provider because of modesty concerns or the concept of *khalwah* (Padela & Curlin, 2013). They may avoid making requests for accommodations because of the risk of negative reactions from the healthcare facility. There may also be associated frustration of patients from increased waiting time or from the healthcare facility if there is a lack of understanding or ability to accommodate the requests.

Lack of knowledge presents challenges to Muslim women both when they try to access the US healthcare system and when providers try to treat them appropriately. If a Muslim woman has primarily used traditional healthcare, such as imams, or has immigrated to the US, she may not understand the American insurance or health systems, such as the differences between the hospital and an outpatient center (Salman, 2012; Simpson & Carter, 2008). While this issue could be common to all non-native individuals in the US, Muslim women may be discriminated

against because of post-9/11 bias and visual evidence of their religion, if the woman veils. If English is not a woman's primary language, she may not feel comfortable communicating to a healthcare provider about her symptoms or treatment limitations, such as allergies (Salman, 2012). Style of speech may also differ between patient and provider, as Arabic is usually repetitive and flowery, whereas English medical speech is usually straightforward (Hammoud et al., 2005). While Muslim patients may want to establish a new relationship with small talk, the healthcare provider may not. The healthcare provider also may not know that generally, in Arabic, the third person is used to describe negative consequences (Hammoud et al., 2005). Even if patient and provider are communicating in English, then, differences in linguistics could prevent comfortable communication between them. The woman may also be hesitant to describe symptoms related to sexuality because of the taboo associated with discussing them (Salman, 2012). Miscommunications or offenses may, once again, let diseases progress untreated or lead to mistrust between parties.

While these limitations may be specific to non-US native Muslim women, some cultural misunderstandings may apply to a wider majority of Muslim women. Some Muslim women, for example, are not permitted to have physical or eye contact with someone of the opposite sex, though the cited study did not provide information about which populations of Muslim women this permission applies to (Hammoud et al., 2005). These social cues are the norm in American culture and are considered polite to do upon meeting someone new. If a doctor tries to shake hands with a Muslim woman, though, he may alienate or offend her. The woman may not know how to respond or, if she does not reciprocate, could offend the healthcare provider. Though unintentional, cultural violations can prevent the establishment of a close relationship between a Muslim woman and her healthcare provider. Obstetrician-gynecologist and professor of medical

education Maya Hammoud thus suggests that cultural competence based on a basic understanding of culture and customs, though not universal to Muslims, can open cultural doors to relationships with patients and help providers better understand health issues for their patients (2005). Culturally competent care is supported by other literature as well (Chin, 2000).

The relationships between Muslim women and their healthcare providers are challenged further by other health-related differences. As was briefly mentioned in section II, US healthcare providers are generally accustomed to providing healthcare to individuals. Muslim culture, contrastingly, often emphasizes the role of the family in making medical decisions (Hammoud et al., 2005). Providers may not be aware of a woman's desire to include the extended family in medical decisions and may be confused about the inclusion of those family members. Issues might arise, for example, if a woman expects her doctor to consult with her husband and the doctor is concerned about patient confidentiality (Hammoud et al., 2005).

The issue of discrimination has huge implications for Muslim women navigating the US healthcare system. Post-9/11 discrimination has been shown to lead to distress and general mistrust of US healthcare, which may lead to poor treatment or a lack of initiative to seek treatment (Padela et al., 2011; Padela & Heiser, 2010). Muslim women may have visible indicators of their religion, such as hijab, which could elicit reactions from healthcare providers. If Muslim women feel uncomfortable or unwelcome in a healthcare facility, they may avoid using its services. One woman interviewed in a case study of interactions between Muslim women and US healthcare, stated, "Doctors and nurses...everybody looks at you like (a) stranger or like you will be a problem for them" (Padela et al., 2012: 711). Studies have also found that healthcare providers sometimes assume that Muslim women are ignorant, do not speak English, or have abusive husbands (Padela & Curlin, 2013; Shah et al., 2008). That discrimination from

healthcare workers and other patients has led to the marginalization of Muslim women in healthcare and poor health outcomes. Muslim women, for example, are at much higher risk of physical and mental illness than Muslim men (Salman, 2012).

IV. Adaptations and improvements

The challenges to Muslim women in US healthcare and the associated health disparities are reason for adaptations to improve women's experience in the healthcare system. Here I suggest several potential improvements to alleviate some of the stressors and issues faced by Muslim women in attempting to gain access to US healthcare.

Healthcare providers should have a basic understanding of Muslim culture in order to more appropriately treat Muslim women. Several Muslim women interviewed as a part of research studies expressed frustrations about healthcare providers having no knowledge about the accommodations that their patients needed. One woman remarked, "A lot of doctors ask really basic things and you're kind of like...they should already (know) that stuff" (IPSU, 2011: 14). Another woman in the study expressed a similar sentiment: "that every one of us has to sit, educate her doctor about her beliefs. It's general information – he can take a two-hour presentation. He can learn this, and that's it" (ISPU, 2011: 14). Cultural competence training based on Hammoud's model might help to improve healthcare workers' understanding of the needs of their Muslim patients.

Greater understanding could reduce the stigmatization and frustration associated with Muslim women requesting accommodations (Padela et al., 2012). With the knowledge that their healthcare providers do not think that their religion is completely foreign, Muslim women might subsequently feel more comfortable trying to access healthcare. It will be important to note in

these hypothesized educational in-service sessions, though, that not all Muslims will fall into neat categories. But if a healthcare provider has questioned or concerns, as one interviewed woman suggested, “we’re all very, very different, so ask” (ISPU, 2011: 14). A general understanding of the Islamic religion can help Muslim women to feel respected, too. Such respect helps Muslim women to more willingly trust their healthcare providers, which may then improve patient compliance (Smedley et al., 2003; ISPU, 2011). As one Muslim women said in her interview, “When a nurse tells you I respect your religion...immediately, I will have trusted her. That’s half the work of being a healthcare giver, to get the trust of the patient. When the patient trusts you, [s]he will you do anything you tell [her]” (ISPU, 2011: 15).

In response to cultural and religious recommendations regarding modesty and gender concordant care, Muslim women should be given the option of choosing the gender of their healthcare provider without any stigmatization. Doctors Aasim Padela and Pablo Rodriguez del Pozo (2011) make a compelling point about these accommodations:

Service companies, such as airlines – and hospitals – routinely ask customers about their religion-based eating preferences (kosher, vegetarian). A similar ethos can be brought into the clinical encounter when the tenor of cross-gender interactions or choice of medical therapeutics may be influenced by religion. In addition, an effective communication tool for providers would be to begin, or end, clinical dialogue by asking “Is there any way I can help make you more comfortable?” (43).

Simple solutions may also be employed to accommodate gender-concordant care and modesty. Muslim women might feel more comfortable with more modest hospital gowns, for example (Padela & Pozo, 2011). They might also appreciate a knock, wait policy in which a healthcare provider announces their arrival before entering the examination room, allowing women time to

cover themselves (Hammoud et al., 2005; Padela & Pozo, 2011). Instead of removing hijab to use an ear thermometer, providers can accommodate by using an oral thermometer (Padela & Pozo, 2011). Modifications can be made if a female healthcare provider is not available, too, such as using a female staff member as a chaperone or leaving the door ajar (Hammoud et al., 2005; Padela & Pozo, 2011).

There might also be some value in incorporating imams into US healthcare. Imams can be hired by American hospitals to begin the education process about Islam. Learning from these religious authorities can begin a partnership between facilities to educate healthcare providers about rituals, cultural tools, and sensitivities (Padela et al., 2011). They may also be used for language interpretation services (Smedley et al., 2003). Imams work within mosques to motivate healthy behavior and help Muslims make medical decisions, so their presence in a more uncomfortable American hospital can help to relieve Muslim women and give them a familiar base on which to make their decisions. In the past, imams have been used during consultations and have been asked by US healthcare providers to convince patients to do something because of the already established trust (Padela et al., 2011).

V. Conclusion

Concepts of health are culturally constructed and religiously influenced. The health-related beliefs of Muslim women are no different. A generalized Islamic view of health is based on Islamic texts and social norms, such as God- and family-centered values of health. While some of these beliefs promote healthy behaviors, others present challenges for Muslim women living in the US and navigating its healthcare system. Muslim women might value modesty and therein be hesitant to remove clothing for full medical examination. They could request gender-

concordant care or face discrimination and language barriers. The healthcare providers that they interact with, too, may not have an adequate understanding of Islam or Muslim culture. Because of these challenges, Muslim women often do not receive adequate care from the US healthcare system or fail to seek care at all. There is a significant need for improvements to alleviate the challenges faced by Muslim women, including education of healthcare providers, simple modesty accommodations, and the incorporation of imams into the healthcare system. While challenges to these accommodations, such as staffing and budgets, do exist, it is important to acknowledge that the changes are important to meeting the needs of Muslim women in the US.

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