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Review

Barriers to healthcare among Muslim women: A narrative review of the literature

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A B S T R A C T

Background: Islam is the world's fastest growing religion and is projected to be the world's most popular religion by the end of the century. The growing population and increased mobility among Muslims make certain that healthcare providers anywhere will encounter Muslim patients in their clinical practice. The intersection of religion, culture, and gender for Muslim women has unique implications for their healthcare provision but remains understudied.

Method: We conducted this narrative review of the literature to describe the known barriers for Muslim women in accessing and receiving high quality healthcare, with an emphasis on what individual providers may do to heighten cultural awareness and sensitivity.

Results: Potential barriers discussed include modesty and privacy among Muslim women, gender preference for providers, family involvement in care, fatalism and predestination, maintaining religious practices during illness, low health literacy and language proficiency, preference for traditional remedies, fear of stereotype and discrimination, and limited healthcare access. Specific advice is included for healthcare providers.

Conclusions: When caring for Muslim women, healthcare providers' awareness of common barriers to effective care and methods of addressing them is valuable. Additionally, an appreciation of the diversity of religious practices, health beliefs, and preferences of Muslim women and their families will enable providers to engage this population with effective and culturally competent care.

Introduction

Islam is currently the world's fastest growing religion with over 1.8 billion people among its followers (Hackett, Cooperman, & Ritchey, 2015). By the end of this century, Islam is projected to be the world's most popular religion (Hackett et al., 2015). While 80% of the world's Muslims live in Muslim-majority countries, Muslims are increasingly migrating for several reasons, including refuge from conflict-ridden areas and opportunities for education and employment, with net immigration occurring to Europe and North America (Lugo, Cooperman, Bell, & Stencel, 2012). International travel specifically for healthcare is increasing (Lautier, 2014). Many patients come from Muslim-majority nations in the Middle East to Western healthcare systems. For example, among patients traveling to the U.S. for care, those from the Middle East comprise more than those from any other region (Johnson & Garman, 2010). The growing number and mobility among Muslims make certain that healthcare providers globally will encounter Muslim patients in their clinical practice.

Religion is increasingly recognized to influence health beliefs and behaviors and interactions with providers and the healthcare system (Karlsen & Nazroo, 2010; Lee & Newberg, 2005; Padela & Curlin, 2013). Large majorities of the world's Muslims report that their religion has a very important role in their lives (Lugo et al., 2012). The influence of Islam on women's health beliefs and behaviors may have special pertinence as care for women's health issues, such as breast and cervical cancer screening, and reproductive and gynecologic care, can pose greater challenges for Muslim women than for other women (Hassouneh, 2017). Describing what is known about caring for the unique needs of Muslim women will facilitate culturally competent care, which can improve patient outcomes (Truong, Paradies, & Priest, 2014).

While there is a growing body of literature on Islam and health (Daniel, De Marrais, & Barnes, 2007), few studies have addressed the barriers that Muslim women face in accessing and receiving high quality healthcare (Hassouneh, 2017). Therefore, we conducted a narrative review to integrate findings from the existing theoretical and

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Table 1
Potential barriers to healthcare for Muslim women and ways to overcome them.

Barrier	Method of addressing barrier
Modesty and privacy requirements	
Physical appearance	• Clarify clothing preference during encounter and physical exam.
Physical touch	• Do not automatically offer handshake. • Limit the physical exam to what is necessary. • Consider deferring sensitive exam elements to female provider.
Disclosure of sensitive information	• Only ask necessary questions. • Sensitive questions may be asked privately or even deferred to a female provider.
Gender preference for provider	• Have a female provider whenever possible, or at least provide female chaperone throughout the encounter.
Family patterns of caring	• Ask patients their preference for family inclusion and engage as appropriate.
Predestination and fatalism	• Provide education and recommendations to engage patients in care.
Maintaining religious practices during illness	• Provide space for prayers. • Expect interruption of the encounter for some patients for prayer. • If food is offered, make sure it is Halal. • Expect a decrease in diet and medication compliance during the month of Ramadan. • Adapt the timing of the medications (e.g. insulin) and meals during Ramadan. • Engage imams when feasible.
Fear of stereotype and discrimination	• Create an open environment of trust and respect.
Health literacy and language proficiency	• Use interpreters during the encounter and provide resources in native languages.
Traditional healing practices	• Engage in discussion of non-medical approaches to healing.
Healthcare access	• Identify payment and transportation barriers and seek to alleviate them.

empiric scholarship. Articles for the review were selected by our study team based on the evidence that we had encountered in our international patient services activities, searches of PubMed and Google Scholar, and reviews of article references. Our goal was to describe these healthcare barriers and what individual providers may do to heighten their cultural awareness to improve the quality of care for Muslim women. While each individual patient's background and preferences will be unique, and providers will equally come from an array of cultural backgrounds, having general guidance in the care of Muslim women may empower providers to tailor care appropriately. Below we briefly review general characteristics of the global Muslim population, then discuss each barrier and suggest practical steps providers can consider in order to provide more culturally sensitive care (Table 1).

Characteristics of the global Muslim population

Islam, a monotheistic Abrahamic religion rooted in Judeo-Christian traditions, began in the Arabian Peninsula with Prophet Muhammad in the 7th century. Islamic ethico-legal structure that defines Islamic beliefs and practices is called the Shariah and is derived from four sources: the Quran, the sacred Islamic text comprising the Word of Allah as revealed to Muhammad; the Sunnah, comprising sayings and beliefs collected after Muhammad's death in hadiths; Ijma'a, the consensus of scholars; and reasoning by analogy (e.g. qiyas) (Padela & del Pozo, 2011). Shariah is interpreted through fatwas, which are opinions issued by Islamic scholars for emerging matters. In healthcare, fatwas can pertain to the permissibility of medical treatment, and there is great diversity among how clerics and patients interpret and apply fatwas for healthcare (Inhorn & Serour, 2011).

Today Muslim women comprise a heterogeneous population, with a wide variety of convictions and degrees of adherence to the tenets of Islam. A study conducted across 39 countries by the Pew Research Center characterized similarities and differences. The profession that there is one God is nearly universal among those who identify as Muslim (Lugo et al., 2012), although Muslims vary in the extent to which they identify with a specific Islamic sect. Some Shia and Sunni do not recognize each other as fellow Muslims (Lugo et al., 2012), while in other regions, such as Southern-Eastern Europe, majorities of Muslims identify themselves as “just a Muslim”(Lugo et al., 2012).

Certain behaviors are nearly omnipresent, such as fasting during Ramadan (Lugo et al., 2012) and abstinence from drinking alcohol in the belief that it is morally wrong (Lugo, Cooperman, & Bell, 2013). Other beliefs and behaviors are more variable, such as believing that Islam is the one true religion and praying and reading the Quran daily. Muslims in Africa and the Middle East are typically more religious than those in Europe and North America. Older individuals are usually more religious than younger ones (Lugo et al., 2012). Additionally, approximately one-fifth of all Muslims are in Muslim-minority countries, so that the themes that we identified in our literature review, where most studies were from authors at North American institutions, may apply more closely to minority status or to cultural practices in Muslim-majority nations, than to factors specific to Islam.

Modesty and privacy

For many Muslim women, modesty and privacy are at the core of everyday life (Hasnain, Connell, Menon, & Tranmer, 2011). They are considered a cultural norm that influences their public interactions, social behavior, and dress code (El-sayed & Galea, 2009).

Physical appearance

Islamic teaching treats men and women as equals in many respects; however, teachings on modesty and privacy affect women and men differently. While the Quran instructs both men and women to “lower their gaze and guard their modesty,” men are only required to keep covered the area between their navel and knees, while women are expected to cover the torso, arms to the wrists, legs to ankles, and hair (Padela & del Pozo, 2011). The type of clothing worn by Muslim women is an important consideration that reflects their level of privacy. Jilbabs, abayas, and chadors are loose-fitting garments that conceal body curvatures. Hijabs are often worn to cover women's hair, and some add a niqab, which covers the face, permitting only the eyes to show. For many, the hijab is the embodiment of modesty, virtue and respect (Siraj, 2011). In extreme cases, burqas are worn to cover the entire head, neck, torso and limbs (Salman, 2012). When engaging in a physical exam, providers should clarify clothing preferences and level of comfort, and limit the exam to only what is necessary.

Physical touch

Due to concerns about sexual temptation, Islam prescribes that men and women who are not married or immediate family are prohibited from being alone with one another and from touching one another (Padela & del Pozo, 2011). For Muslim women seeking healthcare, one concern is the potential physical intrusion that can be posed by