

# Health Perceptions and Care Preferences Among Muslims: A Mosque-Based Study in Central Ohio

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**Background:** The Muslim population in the United States is rapidly growing, yet this demographic remains largely underrepresented in healthcare research and policy, where religion is often overlooked as a determinant of health.

**Objective:** This study aims to explore the health preferences and needs of American Muslims, with a particular focus on the role of mosques in health promotion and the significance of Muslim healthcare providers.

**Methods:** The study surveyed 193 congregants of Noor Islamic Cultural Center (NICC), the largest mosque in Central Ohio, using an online survey that assessed their healthcare preferences, perceptions of health, and views on the mosque's role in health promotion.

**Results:** Our results indicate that over three-quarters of respondents see mosques as valuable platforms for health promotion, with religious sermons perceived as effective in disseminating health information. Mental health and reproductive health were identified as key areas where congregants preferred Muslim healthcare providers, reflecting the need for culturally sensitive care. The study also highlights significant challenges, including a gap in health literacy, particularly concerning the distinction between health and wellness, and the underrepresentation of Muslim healthcare providers in key areas like mental and reproductive health.

**Conclusion:** These findings underline the importance of integrating culturally and religiously tailored health promotion strategies into healthcare delivery systems and the potential role of mosques as hubs for health education. Future research should explore how to scale these approaches and address the workforce gaps in Muslim healthcare professionals to improve health equity for American Muslims.

## Keywords

health promotion; Muslim health; imam; mental health; reproductive health

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IRB statement:

Our study protocol was reviewed and approved by the OSU Institutional Review Board (IRB) and deemed exempt in 2020.

Conflicts of interest:

None of the authors have any conflict of interest.

## Introduction

The Muslim population in the United States is rapidly growing, yet this demographic remains largely invisible in healthcare research and policy, as religion is not typically recognized as a determinant of health. The absence of reliable indicators for a patient's religious identity has led to the exploration of alternative approaches, such as community-based partnerships and population-centered research, to better understand and serve the Muslim population (Brekke et al., 2019; Brown, 2000; Hasnain et al., 2011; Holdo, 2021; Idler, 2024; Killawi et al., 2015; Kramer et al., 2022; Laird & Cadge, 2010; Navarro & Muntaner, 2004; Rehmani et al., 2023; Spielhaus, 2011).

Muslims are not a monolithic group; their intersecting identities related to race, immigration status, and socioeconomic factors often result in misrepresentation and disparities in healthcare (Abrar, 2023; Hassan, 2017; Mahmood, 2024). Despite this diversity, Muslims share certain religious values that influence their health perceptions and expectations of the healthcare system (Padela et al., 2012). For instance, they may prefer gender-concordant care (Shahawy et al., 2023), be less likely to consent to pelvic exams if not sexually active (Vahabi & Lofters, 2016), and have varying views on contraception, fertility treatments, and end-of-life care (Abdullah et al., 2020; Shabaik et al., 2019).

The health preferences and needs of American Muslim communities are underrepresented in both the literature and policymaking (Lajevardi, 2018; Sinno, 2009). Mosques, as community hubs, have taken on an increasingly progressive role in supporting Muslims by endorsing their traditions, beliefs, and responding to their needs (Abu-Ras et al., 2008; Alaca, 2022; Al-Krenawi, 2016; Padela et al., 2011). As a result, they offer a valuable partnership opportunity for understanding the health preferences and promoting the well-being of the Muslim population.

Collaborating with mosques has emerged as an effective strategy to bridge some of the gaps in Muslim health research and promotion, while giving the community a voice in shaping their care (Hall & Padela, 2021; Mustafa et al., 2017). As mosques continue to grow as non-profit organizations with diverse staff and volunteers, religious leadership remains central. Imams are underrepresented in research compared to leaders of other faiths (Quadri et al., 2024), which may explain their limited involvement in healthcare discourse at a national level. Imams play a pivotal role in the lives of American Muslims by leading prayers, giving sermons, and offering spiritual advice (Ederer, 2020).

Muslims often seek guidance from Muslim healthcare workers, community leaders, and imams on healthy lifestyles and advocacy for patients within healthcare settings (Abu-Ras, 2011; Khalid et al., 2022; McLean et al., 2012). Considering imams may not possess the medical expertise necessary for health promotion, Muslim healthcare providers are seen as trusted mediators who can bridge the gap between religious beliefs and biomedical practices. Recognizing the crucial role of religious leaders and institutions in Muslim health can foster stronger partnerships and bridge the gaps in healthcare delivery (Abu-Ras et al., 2024; Laird & Abdul-Majid, 2023).

Faith-based health interventions are increasingly being studied across various settings and have shown promising outcomes (Lancaster et al., 2014; Newlin et al., 2012). In the context of American mosques, religiously tailored health programs have been effective, though their generalizability is limited by factors such as age, gender, language, topic preferences, and frequency of mosque attendance (Soldo, 2017).

Our study aims to explore American Muslims' health preferences, needs, and perceptions of mosques as platforms for health education and promotion. Additionally, it examines the importance of Muslim healthcare providers in serving as advisors for population health within the community.

## Methods

Central Ohio is home to a growing Muslim population (Abu-Ras et al., 2024). It is estimated to have more than 100,000 Muslims (World Population Review, 2025), with an average of 250–350 diverse congregants during high-traffic rituals and events (e.g., Ramadan night prayers and Friday congregational prayers) in its large Islamic centers. Muslim congregants frequently approached their Islamic centers to recommend health care providers who are culturally acquainted with Islamic traditions and willing to accommodate their preferences. Our research team partnered with the largest local Islamic center to conduct a needs and preferences assessment.

### *Study Design and Sampling*

We used a cross-sectional online survey-based design partnering with Noor Islamic Cultural Center (NICC), the largest local Islamic center in Columbus, Ohio. NICC is a charitable non-profit religious organization established in 2006 and is known for its diversity and outreach programs in central Ohio. Our initial plan was to recruit participants electronically and utilize Friday congregations for in-person enlistment. However, the COVID-19 pandemic altered our methods and compelled us to rely solely on online recruitment. Our study protocol was reviewed and approved by Ohio State University's Institutional Review Board (IRB) and deemed exempt in 2020.

We used convenience sampling targeting an email listserv of Muslims signed up to receive NICC religious and community services at any point in time. Survey dissemination was managed using Qualtrics per Ohio State University protocol. We shared the survey via NICC's weekly newsletter, Facebook page, and active WhatsApp groups through their leadership network. A summary of the study and instructions were shared in a flyer through the newsletter and Facebook NICC pages.

### *Survey Development and Key Measures*

A 23-item online survey was developed for this study (See Appendix 1). The survey was designed to evaluate the health preferences and needs of Muslim adults in the local community. It included validated measures in the demographics section, and some questions were created de novo. The first question inquired about the frequency of attendance at NICC, followed by six demographic questions, a six-question section on healthcare preferences and health promotion sessions, two questions regarding exposure to health and wellness terms, and eight final questions on perceptions of health.

### *Data Collection*

Between April and June 2020, NICC published the flyer and the survey link on their digital media. Our research team followed the responses and ensured the weekly publication of the survey. We aimed to commence in April 2020 and obtained expedited approval from the mosque to take advantage of the high traffic during the month of Ramadan (April 23rd–May 23rd). However, our data collection was impeded by the onset of the COVID-19 pandemic, mainly due to the discontinuation of in-person sermons, as they are a great tool in increasing congregants' participation in community-engaged research projects. Data was anonymously collected online with no personal interaction with congregants.

### *Data Analysis*

Survey responses were summarized as frequencies (percentages). Data transformation then proceeded in the following manner: (i) standalone questions where survey responses yielded less than 5% in a single category were collapsed into adjacent categories; (ii) outcome variables were dichotomized for ease of analysis wherever possible. Relevant subgroup comparisons of survey responses were tested using chi-squared or Fisher's exact tests where appropriate. All hypothesis testing was two-sided and conducted at 5% type 1 error rate ( $\alpha = 0.05$ ). Survey responses were collected using Qualtrics (Qualtrics, 2020). Statistical analyses were conducted using SAS version 9.4. (SAS Institute Inc., 2018)

## Results

### *Descriptive Analysis*

#### Participants

We collected 193 analyzable responses over a two-month period. It is challenging to have an up-to-date count of NICC congregants to identify the response rate. However, its membership committee reported roughly 300–350 members eligible to answer our survey since most of their electronic newsletter's listserv does not utilize NICC congregational services. Among participants, more than 75% attended NICC at least once monthly (Table 1). Most were females (84.9%), fell between 34 and 64 years of age (58.3%), graduated from college (68.9%), partnered (married or in a relationship) (71%), and spoke English as their primary language (53%) (Table 2). Of note, those who were single were more likely to be younger than 34 years old (84% vs. 26%). Those who spoke English as a primary language were also more likely to be younger than 34 years old (58.7% vs. 24.7%).

**Table 1.** How frequently do you attend NICC (or your local Masjid)? Please choose the best answer ( $n = 193$ ).

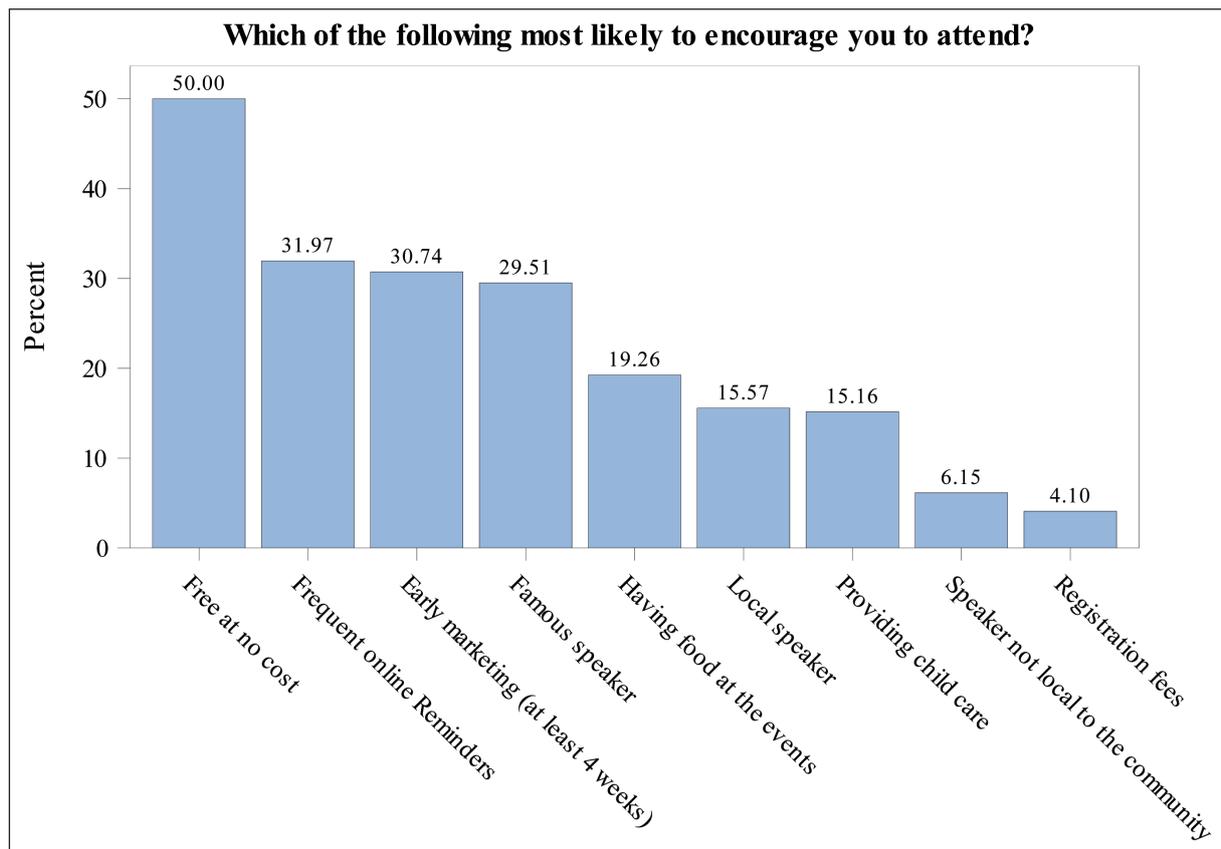
Frequency	<i>n</i> (%)
Daily	23 (11.9)
2–3 times a week	46 (23.8)
Once a week	46 (23.8)
A few times a month	29 (15.0)
Once a month	6 (3.1)
A few times a year	38 (19.7)
I do not attend NICC (or my local masjid)	5 (2.6)

**Table 2.** Sociodemographic Characteristics of Study Participants ( $n = 193$ ).

Sociodemographic characteristic	$n$ (%)
Age ( $n = 187$ )	
18–25	43 (23.0)
26–34	34 (18.2)
34–64	109 (58.3)
> = 65	1 (0.5)
Gender ( $n = 185$ )	
Male	27 (14.6)
Female	157 (84.9)
Prefer not to say	1 (0.5)
Education level ( $n = 177$ )	
Less than high school graduate	5 (2.8)
High school graduate	21 (11.9)
Some college (including Associate's degree)	26 (14.7)
Graduated college (4 year/Bachelor's degree)	59 (33.3)
Graduate school or more (MD, Ph.D., Masters, etc.)	63 (35.6)
Technical school/Other	1 (0.6)
Choose not to answer	2 (1.1)
Marital status ( $n = 173$ )	
Single (never married)	43 (24.9)
In a relationship	3 (1.7)
Married	120 (69.4)
Widowed	1 (0.6)
Separated	1 (0.6)
Divorced	4 (2.3)
Choose not to disclose	1 (0.6)
English as primary language ( $n = 173$ )	
Yes	92 (53.2)
No	81 (46.8)

### Role of the Islamic Center in Health Promotion

More than three-quarters of respondents (77.7%) saw the Islamic center as a good place for health promotion and education, and most of them (60.2%) believed that sermons can be effective in promoting healthy lifestyles. When asked about factors that may encourage Muslims to attend informational health sessions, the top factor was the event being free of cost (50%), followed by frequent online (32%) and early marketing (31%) (see Figure 1).



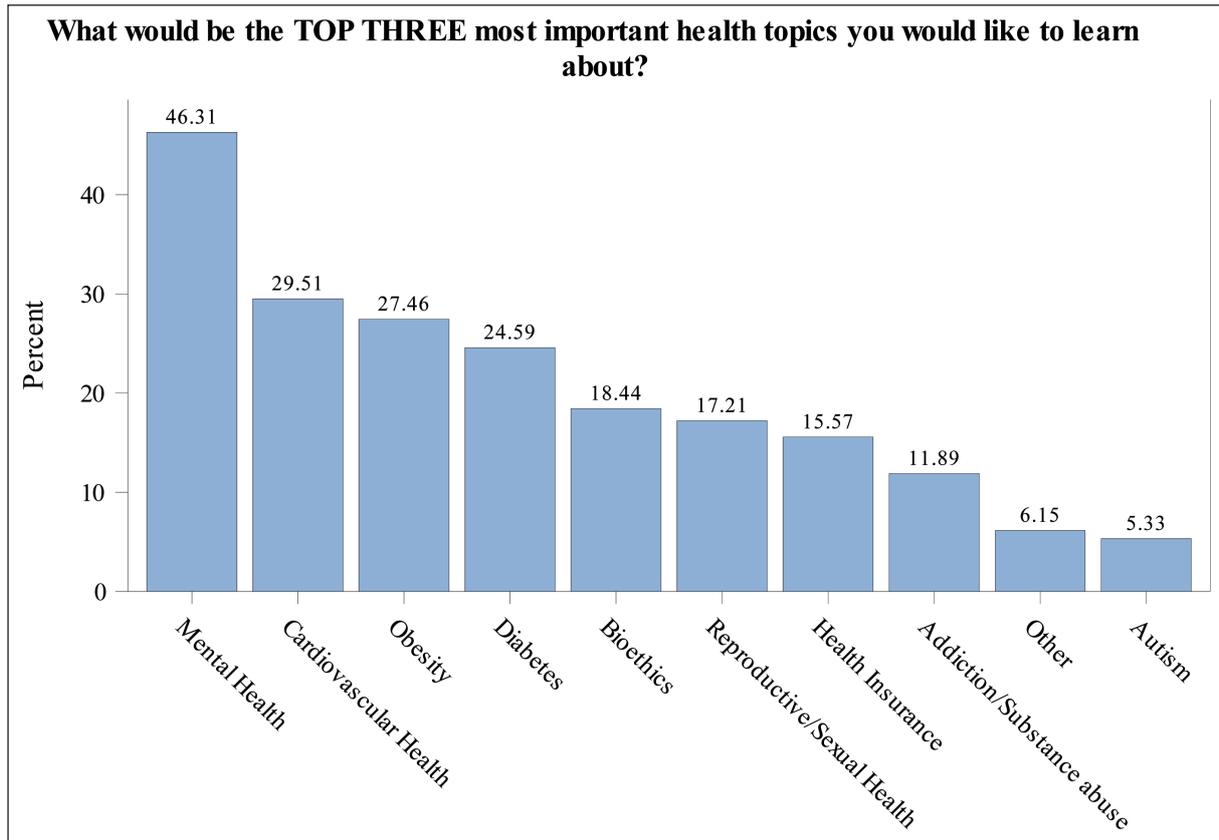
**Figure 1.** Which of the Following Will Encourage You to Attend.

### Health Preferences and Perceptions

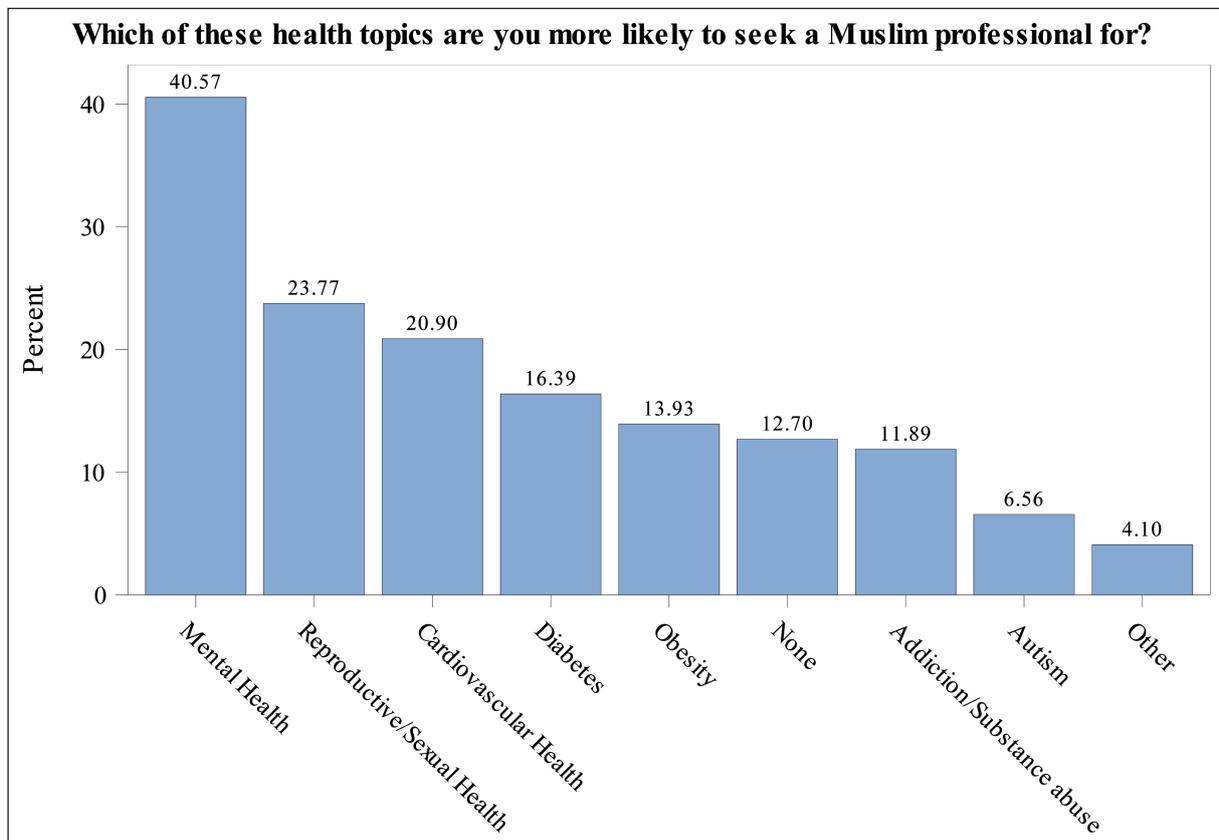
Participants reported mental health (46.3%) as the top subject of interest to learn about, followed by cardiovascular health (29.5%) (see Figure 2). Other topics mentioned under “other” were neuropsychiatric or behavioral in nature (e.g., bullying, wellness, seizures, vaping). More than two-thirds preferred informational sessions on weekend evenings (71.2%). About one-third of respondents (35.93%) were unsure of the distinction between health and wellness. Among respondents, 90% agreed it is important for them to be in good shape, and a higher percentage of participants agreed that maintaining good health year-round is important for them (94.48%). Most survey participants believed their health was either equivalent to or better than individuals of the same age (88.96%) and that their health was good overall (88.34%).

### Preference for Muslim healthcare providers

More than half of the respondents (58.8%) preferred to have a Muslim healthcare provider, and more than 88% were interested in learning about local Muslim healthcare providers. When participants were asked, “Which of these health topics are you more likely to seek a Muslim professional for?” more than a quarter chose mental health (26.6%), followed by reproductive health (15.38%) (Figure 3).



**Figure 2.** Top Three Most Important Health Topics Participants Would Like to Learn About.



**Figure 3.** Healthcare Topics Congregants Will Most Likely Seek a Muslim Professional For.

### *Bivariate Analysis*

#### **Mental Health**

Partnered Muslims were less likely to rank mental health among their top three health concerns compared to single Muslims (54% vs. 76%,  $p = 0.0086$ ). Additionally, English speakers were more likely to consider mental health an important issue (73% vs. 47%,  $p = 0.0005$ ).

Similarly, partnered Muslims were less likely to prefer a Muslim healthcare provider for mental health compared to non-partnered Muslims (48% vs. 66%,  $p = 0.0312$ ). English speakers were also more likely to prefer a Muslim provider for mental health services (64% vs. 41%,  $p = 0.0021$ ).

#### **Reproductive Health**

Partnered Muslims were less likely to rank reproductive health among their top three health concerns compared to single Muslims (18% vs. 32%,  $p = 0.0421$ ). English speakers were more likely to consider reproductive health an important issue (30% vs. 20%,  $p = 0.0041$ ).

Additionally, partnered Muslims were less likely to prefer a Muslim healthcare provider for reproductive health compared to non-partnered Muslims (24% vs. 48%,  $p = 0.0016$ ). English speakers, however, were more likely to prefer a Muslim provider for reproductive health (39% vs. 21%,  $p = 0.0098$ ).

#### **Role of Mosque and Muslim Healthcare Providers**

Interestingly, only 7.9% of non-English speakers preferred health literacy sessions to be offered in their primary language, compared to 74% of English speakers ( $p < 0.0001$ ). Partnered individuals were more likely to prefer a Muslim healthcare provider than single individuals (65.7% vs. 45.6%,  $p < 0.0200$ ).

The preference for a Muslim physician as a healthcare provider was not statistically associated with gender, education level, primary language, or frequency of attending religious services. Additionally, factors such as education level, frequency of mosque attendance, perceived current health status, and the importance of maintaining health year-round were not statistically linked to perceptions of the role of Islamic centers in health promotion, the effectiveness of sermons, or the preference of a Muslim healthcare provider as a primary care provider.

### **Discussion**

Our study reveals that Muslim congregants perceive their mosque as a valuable platform for health promotion, with religious sermons serving as a potential tool for disseminating wellness information. This aligns with existing literature demonstrating the effectiveness of faith-based interventions in health promotion across various communities (Padela et al., 2018). This perception of the mosques' and sermons' role in health promotion was positive irrespective of respondents' demographics and health awareness, which foregrounds the acceptability of religiously tailored messaging among diverse Muslim congregants.

The demographic profile of our respondents largely mirrors national data from similar studies, showcasing a younger-than-average, multilingual population, reflective of the ethnic diversity within American mosques (Bagby, 2020; Bagby et al., 2001). Notably, American Muslim women were highly active in mosque programming (Zahedi, 2011). This is reflected in their

prevalent response rate, which is consistent with other findings that Muslim women play a central role in community health initiatives (Vu et al., 2018).

We observed an underrepresentation of college-aged participants, likely due to their engagement with university-based organizations like Muslim Student Associations (MSAs) and their focus on early career pursuits. This suggests a need to explore alternative venues, such as MSAs, for delivering health promotion messages tailored to younger Muslims. This challenge is shared by other religious institutions in the US, where engagement with faith congregational spaces may be lower among the youth (Mustafa & Javdani, 2016; Packard & Ferguson, 2019).

Our finding that over two-thirds of respondents had completed college reflects similar educational attainment rates in previous studies of Muslim communities and is higher than the general US public (Bagby, 2013; Foner & Alba, 2018). While not necessarily generalizable to all US mosques, these findings are likely comparable to those from larger, more established mosques (Bagby, 2013).

The strong interest in health education sessions, coupled with a preference for weekend evening schedules, suggests that timing and accessibility are crucial factors for engagement. These preferences, including the desire for free sessions, reflect broader trends in health promotion within religious institutions, where congregants often expect services to be free of cost. However, funding mechanisms for these initiatives remain underexplored, particularly for Muslim communities. Further research into how preferences for health education might vary across socio-demographic groups could inform resource allocation strategies to sustain such programs.

Despite high self-reported health status among participants, existing research suggests that this perception may not align with actual health outcomes. Studies indicate that American Muslims face several risk factors, including low health literacy (Khalid et al., 2022), health disparities (Padela & Raza, 2014), Islamophobia (Abu Khalaf et al., 2023), discrimination (Johnston & Lordan, 2012; Martin, 2015), and access challenges to healthcare (Rashoka et al., 2022), which can impede their ability to advocate for their health. The discrepancy between self-reported health and actual health risks highlights the importance of targeted health education, particularly given the finding that two-thirds of respondents did not distinguish between health and wellness. This discrepancy may hinder participation in preventative screenings, such as vaccinations and cancer screenings.

A significant portion of respondents expressed a preference for Muslim healthcare providers, particularly in the realms of mental and reproductive health. This aligns with research showing that cultural and religious congruence between patients and providers enhances trust and engagement (Iranmanesh et al., 2018; Saadi et al., 2024). Younger, single participants, especially those who primarily spoke English, were more likely to seek Muslim healthcare providers, particularly for mental health services. This preference for culturally sensitive care reflects ongoing concerns in the literature regarding the stigma and barriers to accessing mental health services among Muslim populations (Aggarwal et al., 2016; Salman & Zoucha, 2010).

Moreover, our study supports the growing recognition that mental health issues are prevalent in the Muslim community, with research showing that American Muslims report higher rates of mental health challenges, including suicide attempts, compared to other religious groups (Awaad et al., 2021). However, they are often underserved in this area, partly due to perceived cultural dissonance between Muslim patients and non-Muslim healthcare providers (Padela et al., 2012). The integration of imams and Muslim healthcare workers into mental healthcare programs could offer a culturally appropriate solution to addressing these disparities (Syed et al., 2020).

Finally, the preference for Muslim providers in reproductive health care, particularly among younger and single respondents, reflects concerns about reproductive health disparities within the Muslim community (Taaseen, 2020). Existing studies suggest that Muslims, particularly

women, face significant barriers in accessing reproductive health services, often due to perceived discrimination and cultural sensitivities (Eksheir & Bowling, 2020). Our findings echo similar concerns reported by other minority groups in the US, further highlighting the need for culturally aware healthcare providers in this domain (Sutton et al., 2021). Muslims are underrepresented in the obstetrics field in the US, even in areas with large Muslim populations (Boulet et al., 2020), which stresses the importance of addressing these workforce gaps through targeted recruitment and training programs in medical colleges and residency programs.

In conclusion, our study emphasizes the importance of culturally and religiously tailored health promotion strategies for the Muslim community. The integration of Muslim healthcare professionals into health education initiatives, particularly in mental and reproductive health, holds promise for addressing existing disparities and improving health outcomes. Future research should explore the scalability of these approaches and the role of mosques as enduring venues for community health promotion.

## Strengths and Limitations

One of the key strengths of our study is that it addresses an underexplored area by examining the role of mosques in promoting health education and preferences for Muslim healthcare providers, offering valuable insights that could inform future community health initiatives.

However, our study also has several limitations. Recruitment was negatively impacted by the COVID-19 pandemic, which limited in-person activities and sermons at NICC that would typically support engagement in collaborative research projects. This likely reduced overall participation and diversity within our sample. One notable limitation is the underrepresentation of male respondents, who comprised only approximately 15% of the total sample. This gender imbalance may not accurately reflect the broader mosque-attending population, where men often outnumber women, particularly during congregational events such as Friday prayers. The low male response rate may reflect differential availability, interest, or outreach success during data collection, as well as possible gender dynamics affecting survey participation. As a result, the perspectives captured in this study may more strongly reflect female experiences and preferences. Future studies should consider targeted strategies to increase male participation to ensure a more representative sample of mosque communities.

Furthermore, the survey was conducted exclusively in English, potentially excluding non-English-speaking community members and limiting the generalizability of our results to English-speaking Muslims.

Another limitation is related to survey design. While the survey's introductory statement clarified that we aimed to tailor health education programs to NICC's community needs, this focus was not reiterated in every question. This could have influenced participants' interpretations and responses, affecting the accuracy of the findings regarding health promotion through the mosque. Additionally, the study did not collect data on important variables such as ethnicity, the impact of health insurance on healthcare access, or participants' awareness of health allies (e.g., social services, case management, or chaplaincy), which could have enriched our understanding of the factors influencing health practices in the community.

Considering these limitations, future research should expand on our findings to explore behavioral health models among Muslim minorities in the US, particularly by incorporating these additional variables. Further studies could also examine the role and characteristics of Muslim healthcare providers in fostering engagement within their religious communities, which may enhance healthcare exchanges and outcomes.

## Conclusion

Our study demonstrates that mosque-based health promotion is not only promising but also positively received by Muslim congregants, who view their religious spaces as trusted venues for health education. The strong preference for Muslim healthcare providers, particularly in mental and reproductive health, further highlights the importance of culturally congruent care in addressing the healthcare needs of this community. These findings align with existing literature, which suggests that faith-based institutions, including mosques and religious leaders, can be effective in promoting health and well-being within Muslim populations.

Moreover, fostering partnerships between community and faith-based organizations presents an opportunity to bridge the gap between underrepresented Muslim communities and the broader US healthcare system. Such collaborations could enhance knowledge about Muslim health needs, promote healthier lifestyles, and build trust—an essential factor for improving healthcare access. Importantly, the community's desire for Muslim providers suggests a pathway toward reducing healthcare disparities through workforce development and culturally tailored healthcare interventions.

Further research is needed to explore the role of chaplaincy and other religious leaders in health promotion, as well as strategies for leveraging public funds to support mosque-based health initiatives. Investigating how these religious spaces can be sustainably utilized for promoting healthy behaviors, particularly in underrepresented communities, could have a lasting impact on health equity and access to care.

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