

Should Muslims have faith based health services?

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YES Muslims have the poorest overall health profile in Britain, but there are few faith centred initiatives aiming to improve health outcomes for our largest minority faith community. This reflects the failure of academics, policymakers, and clinicians to appreciate the needs faith communities may have. There are important moral, political, and legal arguments underscoring the need to ensure equitable delivery of public services to all sections of society. In the short to medium term, these needs will most efficiently be met by faith specific healthcare initiatives. The longer term goals are to mainstream understanding of the importance of religious identity.

A question of faith

There has been a Muslim presence in Britain for almost half a millennium, yet Islam remains something of an enigma to most UK citizens.¹ Even among people involved with health policy and delivery it is common to find Muslims being thought of as synonymous with Asians or Arabs. Such positions reflect a misunderstanding of a faith that has and continues to bind diverse groups of people.

Ethnicity and religion are important markers of self identity, and though often closely intertwined they are not synonymous. For many British Muslims, religious identity is the essential defining characteristic as it represents the prism through which they see and interpret the world.² Offering people only the choice of an ethnicity descriptor, as is the case when registering with a general practitioner or when attending hospital, is therefore inadequate and inappropriate for many Muslims.

Racism—in both its direct and indirect forms—affects all British public services, and there is now a welcome commitment to eradicate this evil.³ What is far less well appreciated is that religious discrimination is also endemic.⁴ In many Western societies, animosity towards Islam dates back many centuries,⁵ but prejudice has risen since the bombing of New York's twin towers.⁶ My experiences suggest that the healthcare profession is still largely in denial about religious discrimination.

One of the main obstacles to making the case for Muslim services has been the lack of any reliable data. A question about religion was included in the 2001 census and a detailed picture of Britain's faith communities has finally begun to emerge.

We now know, for example, that there were 1.6 million Muslims in Britain in 2001 (more than all other minority faith communities combined) and that Muslims are the most ethnically diverse faith grouping in Britain. Muslims are predominantly congregated in the inner city slums, have the lowest household income, poorest educational attainment, and highest unemployment and experience more poverty than any other faith community.⁷ The limited health data show that Muslims are about twice as likely to self report poor health and disability as the general population.

Need for faith specific initiatives

We need to develop a better picture of the health profile and experiences of British Muslims. It is absurd that we do not, for example, know the perinatal mortality or smoking prevalence among Muslims.⁸ To facilitate this we need to encourage recording of religious affiliation in primary and secondary care. The first step would be to make standard codes available. While waiting for the data, several faith services should be initiated.

Male infant circumcision should be available throughout the NHS. Although a handful of NHS trusts provide it, most parents are forced into the poorly regulated private sector. Hospitals also need to accommodate Muslims in other ways. Many Muslims, to maintain modesty, prefer to see a same sex clinician. Such choice is typically unavailable despite the higher numbers of women doctors in the NHS. Better access is required to prayer and ablution facilities for patients and staff in many hospitals.⁹ And Muslim "chaplains" need to be established to provide spiritual care.¹⁰

Another important service is to enable Muslims to avoid porcine and alcohol derived drugs. Currently national or local formularies do not routinely flag potentially objectionable drugs or provide advice on alternatives.¹¹

Despite evidence that many Muslims with long-term conditions modify their treatment

regimens during Ramadan, many people do not get advice on how to do this safely.¹² We need better mechanisms for advising people on avoiding the health risks associated with the Hajj pilgrimage, which is a religious obligation (and not a holiday).^{13 14} General practices should offer consultations before Ramadan and Hajj to inform their patients.

Muslims still often face unacceptable delays in having the bodies of deceased relatives released for burial.¹⁵ Training and reform of coroners' services is needed.

Change is unlikely to occur without adequate and appropriate representation of faith communities in positions of influence—be they government bodies, research charities, or NHS trusts. Such organisations must ensure that they include Muslims on their boards.¹⁶ Firstly, voluntary monitoring should be tried.

There is, as far as I'm aware, currently not one British academic grouping specialising in researching the health needs of Muslims. Long term sustainability of possible service improvements is rightly dependent on rigorously proving that any changes produce the desired effects, and we need the wherewithal to ensure that this can happen.

Competing interests: AS chaired the research and documentation committee of the Muslim Council of Britain from 2002-6. He is currently principal investigator on a Scottish Executive supported grant investigating the end-of-life care needs of South Asian Sikhs and Muslims in Scotland.

