Title: Engaging Muslim Americans for Research on Community Health [E-MARCH]: Results and Lessons Learned from a PCOR Capacity Building Program

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Abstract

Background: Although racially, ethnically, and socioeconomically diverse, Muslim American communities share a religious worldview that contributes to similar health and healthcare behaviors, and thus common health and healthcare challenges, among its members. Yet, this "Muslim" dimension to health outcomes is largely overlooked in health disparity research and intervention programs. As such, Muslim community leaders have few opportunities to participate in, and shape, research that addresses religion-related factors impacting Muslim community health outcomes.

Objectives: We initiated a community-engaged, capacity-building program to develop a cohort of Muslim community leaders equipped with the knowledge and motivation to participate in Muslim community-relevant, patient-centered outcomes research (PCOR).

Methods: By means of a Learning Institute and webinars, we implemented tailored education focused on research methods, strategies for studying the religious dimensions of health behavior, PCOR tools, and skills for mosque engagement to a cohort of 15 diverse Muslim community leaders. This cohort further participated in a consensus-building activity to identify Muslim community health priorities, and developed project proposals to tackle these community health issues. Finally, we convened a national, multi-stakeholder conference to connect Muslim health researchers and discuss PCOR approaches to combating Muslim health disparities.

Conclusions: A multiple modality capacity-building program can cultivate grassroots motivation and skills for addressing the religious dimensions of health challenges through mosque communities. Yet, for such efforts to translate into specific research initiatives sustained educational programs and strategic partnerships between research funders, healthcare systems, and mosque community leaders is needed. Our experience suggests that holistic approaches to Muslim health concerns are desired by community members, and that, therefore, discussions and consensus-building projects should incorporate a variety of voices and stakeholders.

Introduction

Although, given their minority status, sociodemographic profile, and the current sociopolitical climate, it is likely American Muslims suffer from health disparities, national data on Muslim American health outcomes is largely unavailable. National healthcare surveys and administrative databases typically do not collect religious affiliation data, and Muslim community organizations generally lack the knowledge and resources to conduct high-quality comparative longitudinal health research, contributing to paucity of evidence for health disparities.[1]

In the context of these data gaps, and underrepresentation of Muslim stakeholders within healthcare and policy institutes, American Muslim health outcomes are overlooked in the implementation of community-based health disparity research and intervention programs. For example, American Muslims are not considered a health disparities population by the National Institutes of Health nor by the Agency for Healthcare Research and Quality, and Health Disparities Strategic Plans and funding opportunities do not routinely incorporate the study of religion-related health differences.[2-4]

However, the scant research that is available points to the presence of health differences and healthcare disparities among Muslim American populations.[5-8] Some of these challenges are related to religion-related impacts upon health beliefs and values. For example, Muslim Americans share a theocentric view of illness and healing which may impact the way in which they understand and ameliorate health problems, and in turn their healthcare-seeking behaviors.[7,9] Additionally, religious understandings about the permissibility of consuming pork-based products or certain assisted reproductive health technologies, can impact health behaviors and outcomes in the Muslim community.[10-13] Against the backdrop of Muslim community health being understudied, this "Muslim" dimension to health behavior and outcomes is even moreso, yet arguably is the most salient aspect of identity to a community aggregated along religious lines. Consequently, there are few opportunities for community stakeholders to initiate, or partner in, research to identify and intervene upon Muslim health disparities.

In order to systematically evaluate Muslim health and health disparities, one must first locate American Muslims. Given that healthcare systems unevenly collect data on religious affiliation and national databases do not have religious affiliation data, researchers must work within local communities. American Muslim mosques thus represent a key venue for community health research and intervention work. In addition to worship services, American mosques routinely host educational, social, and civic events, and, as nearly 50% of American Muslims attend mosque once a week, mosques are ideal venues for data collection.[14,15] In fact, the foundation for research activities has already been laid within mosque communities. American mosques routinely host health screening events, e.g. diabetes and hypertension, and prominent mosques also serve as venues for volunteer-run health clinics.[16-19] Hence a culture of health programs already exists within mosque communities. Our project thus focused on building capacity among Muslim community leaders for mosque-based research in order to address the aforementioned knowledge and opportunity gaps.

By means of funding from the patient centered outcomes research institute (PCORI), four organizations came together to create the Engaging Muslim Americans for Research on Community Health (E-MARCH) project. This project primarily sought to develop a diverse cohort of Muslim community leaders equipped with the knowledge, skills, and networks to participate in Muslim community-relevant, patient-centered outcomes research (PCOR). Herein, we detail the activities of, and findings from, the E-MARCH project, and also explore lessons learned from its conduct. In so doing we hope to spur further capacity-building projects focused on Muslim community health and on studying the religion-related factors impacting health and healthcare disparities.

Project Activities & Outcomes

There were four organizational partners on this project each from a different health-related sector, and each represented by an individual(s) on the project steering committee. The Initiative on Islam and Medicine at the University of Chicago, a platform for research, education, and dialogue on Muslim health and Islamic bioethics, was the academic research partner and represented by Aasim I. Padela MD MSc and Stephen Hall MPH. Worry Free Community, a Chicagoland community-based organization dedicated to healthcare navigation and social services provision, was represented by Fatema Mirza MBA. The healthcare services industry was represented by the University Muslim Medical Association Community Clinic located in Los Angeles and its executive director Adel Syed MPPA and its founder Yasser Aman

DrPH. Whitestone Foundation, a Muslim community building organization, was the fourth partner on the project and represented by Harris Ahmad JD. This team brought years of collective experience in mosque-based healthcare, programming, and research to the design and implementation of the E-MARCH project. By means of an in-person learning institute, online webinars, and a multidisciplinary conference, the partners created sought to empower a cohort (details below) of Muslim community leaders with the knowledge, skills, and networks relevant to Muslim PCOR. In what follows we describe these activities in detail and also present the relevant outcomes of each activity. Importantly, survey evaluations were conducted throughout the project to assess the effectiveness of the curricula and identify learning needs. Results of these surveys are presented in the appropriate section below.

Cohort Recruitment

We used listservs of our respective organizations, national Muslim health professional organizations (e.g. American Muslim Health Professions), social media, as well as word-of-mouth to recruit Muslim community stakeholders interested in learning skills for mosque-based PCOR. Our inclusion criteria were as follows: individuals with leadership positions in mosque communities or other community organizations, prior experience with championing health causes in community settings, capacity and motivation for learning health research skills through a longitudinal curriculum involving a learning institute and webinars over the course of a fourteen months, and a commitment to presenting a health research project proposal at a national conference. Applicants for the cohort had to write an essay addressing these inclusion criteria and provide a letter of reference from a potential mosque community site where they could implement a future research project.

We obtained over fifty applications for fifteen funded slots. The steering committee independently ranked candidates based on their essays and built consensus around the best candidates via phone conferences. After a list of highest applications was agreed upon, we sought diversity within the cohort. Specifically, we aimed to designate one-third of the cohort to be Imams, chaplains or other religious leaders, another third to be associated with social service or community health organizations, and the final third to comprise patients or academic researchers. We purposively sought social service professionals and religious leaders for this capacity-building project because they play critical roles in helping community members navigate health, religious, and social issues, all of which impact health outcomes.

Ultimately, the final cohort consisted of 16 individuals of diverse racial/ethnic backgrounds, professional roles, and geographical regions. The cohort was nearly equal in male and female representation [See Table 1]. Over the course of project, one member withdrew citing competing personal and professional demands on their time.

Learning Institute

At the initiation of the project, the cohort participated in a two-day Learning Institute (LI) held at the Institute of Knowledge, a hybrid mosque-seminary, in Diamond Bar, California. The LI was designed to energize the cohort to work together towards a common purpose, understand different disciplinary perspectives on Muslim community health dynamics, and lay the foundations for community health research from a PCOR lens. In addition to the educational components of the LI, the cohort participated in a group networking dinner, a community town hall (described below), and had dedicated time to share their own personal and professional narratives on pressing health issues confronting American Muslims.

With respect to the educational curriculum of the LI, didactic sessions and group activities targeting learning in study design, PCOR, the social determinants of health, and project management

methodologies. Session topics also covered the "known knowns, unknown knowns, and unknown unknowns" related to Muslim American health disparities and the intersection of religion and community health [See Appendix 1 for the LI program agenda]. The community town hall featured a panel presentation followed by group discussion on the pressing health challenges facing the Muslim community. Expert panelists included Umar Hakim, Executive Director of ILM Foundation which targets economic inequities through housing and educational programs, Wali Hanifzai, Director of Mental Health at Access California Services, Ahmad Al Kurdy, a Community Chaplain at IOK, and Sundus Kholaki, a healthcare chaplain serving the Muslim community in Los Angeles. Insight from these diverse "on-the-ground" stakeholders served to foster fruitful exchanges on the knowledge and resource gaps impacting Muslim community health research and intervention work.

At the conclusion of the LI, the cohort reported overall increases in general health research knowledge and the social determinants of health. They also gained in their understanding of PCOR, community-based participatory research (CBPR), and comparative effectiveness research (CER) [See Table 2].

E-MARCH Webinars

To facilitate continued learning, and to address the gaps in confidence and knowledge observed following the LI, [See Table 2], we designed three tailored 90-minute webinars spaced out over several months. Webinars topics were specified based on cohort feedback, and addressed the "Muslim Dimension" of community health research, strategies for overlaying PCOR and project management tools and techniques within mosque-based health projects, and on linking health research with policy action.

Based on a surveys conducted at the close of the project, the cohort's general research, PCOR, CBPR, CER, and the SDOH knowledge gain remained significantly increased above baseline. Furthermore, the cohort reported having acquired the skills needed to carry out a Muslim health research projects [See Table 3].

Online Modified Delphi Discussions

Given the integral role that the E-MARCH cohort members play in their mosque communities, and their diverse personal and professional experiences, we sought to elicit their views on the most pressing Muslim community health issues. Thus we employed a three-step modified Delphi technique involving asynchronous facilitated group discussions (FGD) to identify and prioritize health topics that are amenable to mosque-based PCOR. We adapted the Whitestone Foundation's online platform, the Idea eXchange, for this purpose and cohort members were de-identified on the forum to allow for free exchange of ideas without concern for stigmatization or backlash.

Prior to the first online discussion, each member was asked to list up to 10 pressing Muslim health challenges and their accompanying rationale onto the platform (Delphi Round 1). These data were compiled and summarized by project staff in preparation for the first FGD [See Table 4]. During the first FGD, as well as each subsequent FGD, project staff solicited the cohort's views during a two week discussion period on the common health concerns and whether they agreed or disagreed with various rationale. An online survey listing all the health topics from Round 1 and asking cohort members to re-rank their top 3 mosque-based PCOR amenable health issues (Delphi Round 2) preceded FGD 2. Data from Round 2 was fed into the next FGD where the cohort discussed the five highest ranked health issues and considered whether, and how, religious values impact these health challenges. They further deliberated over how these issues may be addressed through mosque-based PCOR. A subsequent survey

elicited the cohort's view on the three pressing health concerns amenable to mosque-based PCOR and these topics framed the conference agenda (see below).

The cohort overwhelmingly identified mental health (77%) as the primary health concern for Muslim Americans which had both religious dimensions and was amenable to mosque-based PCOR. Other issues included reproductive and sexual health (46%), Islamophobia-related health impacts (38%), and the need for religiously sensitive/culturally appropriate healthcare in hospitals (38%).

Health Leadership Projects

Each cohort member was expected to design of a community health research project proposal that tackled a pressing health issue. This proposal would be presented at the capstone conference to a multidisciplinary panel of experts for feedback and advice (described below). This activity was meant as a co-learning tool as project cohort members were allowed to work in groups and build off of each other's expertise in designing their study. Further, they were advised to utilize concepts and ideas from the learning institute, webinars, and FGDs in their project mapping. In order to prep for the conference, the cohort received a PowerPoint template and delivered mock presentations of their ideas and proposal to other members of the cohort and project leadership during dedicated webinar sessions.

The cohort produced 12 health research project proposals on issues ranging from Islamophobia, to mental health, and sexual health (Table 5), and successfully presented them to an expert panel of "sharks" at the capstone conference (see below). Three cohort members decided to present formal talks at the conference in lieu of a research project proposal (also noted in Table 5).

*A Conference on **A**dvancing **M**uslim **A**merican Health **P**riorities (A-MAP)*

The capstone A-MAP conference, thematically framed around the top three health priorities garnered from the Delphi rounds- mental, reproductive, and sexual health, took place on October 18-20, 2019 at the University of Chicago. As previously noted, Muslim health disparities and community health receive scant attention in health research. As a result, community leaders, health researchers, and other Muslim community health stakeholders from across the nation remain sequestered in their disciplinary or location-based silos. This national conference provided the platform to seed research projects and networks, as well as action-oriented conversations, aimed at addressing Muslim community health challenges through mosque-based PCOR. A-MAP, thus, built upon the E-MARCH's learning from the LI and webinars, broadened their perspectives through multidisciplinary engagement, and connected them with other stakeholders and leaders working in complementary areas.

The conference included round table discussions that focused on i) engaging mosque communities, ii) mental health, and iii) reproductive and sexual health, and featured a Health Research Shark Tank where E-MARCH cohort members presented their project proposals to a diverse panel of experts. This distinguished panel represented funders, researchers, and community organizers: Aminah Abdullah (Susan G. Komen Foundation-Chicago), Dr. Doriane Miller (University of Chicago Center for Community Health and Vitality), Courtney Clyatt (PCORI), Dr. Aziz Sheikh (University of Edinburgh Usher Institute) and Dr. Tariq Cheema (The World Congress of Muslim Philanthropists). Both the presenters and the audience received feedback on research methodology as well as advice on how to prepare their projects for submission to local and national funding opportunities. For greater details on the conference program the reader is directed elsewhere.[20,21]

The conference was marketed broadly on listservs and social media, resulting in our ticket sales page being visited more than 4,400 times. Ultimately, the conference was attended by 97 individuals

including policymakers, community activists, patients, clinicians, religious scholars and health professionals. Attendees represented 20 US states and three countries. Themes emerging from the discussions at the conference emphasized the need for Muslim health research to be patient-centered, and for community health programs to be data-driven and address the broad spectrum of social and structural issues affecting American Muslims.

As noted above, the E-MARCH cohort completed a survey shortly after the conference to assess gains knowledge and confidence over the course of the project. As reported above increases in self-rated knowledge of PCOR, CBPR, CER, and the SODH remained significant over baseline, and the cohort reported increased capability to carry out a Muslim health research project [See Table 3].

Discussion & Lessons Learned

To our knowledge, this is the first project aimed at building capacity for PCOR within American Muslim mosque communities. Our curriculum set mosques as an untapped venue for community health research where PCOR could address the unique "Muslim" dimensions of health and healthcare disparities. Over the course of the project we were successful in creating an effective educational curriculum, recruiting a cohort of diverse community leaders interested in carrying out mosque-based PCOR, and convening a conference focused on Muslim community health research. Despite these many successes, maintaining adequate levels of engagement with the cohort throughout the 14-month duration of the project proved challenging. In the following, we comment on the principle outcomes and lessons learned from our capacity-building project.

Increasing Capacity for PCOR: Improving Knowledge & Intention

Focusing on developing a cohort of community leaders, the E-MARCH cohort, was a key element to increasing community capacity for addressing the Muslim dimensions of community health and for mosque-based PCOR. Indeed we focused on a creating change by honing in on a small group that was best positioned to champion health research projects using accepted methodologies. Once these individuals were equipped with the relevant knowledge and tools, we hoped they would develop project proposals that would begin to tackle pressing community health issues through mosques. By and large the data we collected suggested that knowledge gain occurred, Indeed increases in self-reported knowledge were observed following the LI and they remained until the end of the project 14 months later. Furthermore, the cohort not only felt more knowledgeable, but they felt more capable of carrying out a Muslim health project. While the project proposals evidence this knowledge is being translated into action, longer-term follow-up will be required to see if a stream of Muslim community health research results from the direct contribution of cohort members.

At the same time our data revealed that the cohort did not report increases in intention, likelihood, or confidence in carrying out a Muslim health research project in the next year. While we did not explicitly evaluate why this is the case, it could be that this project provided cohort member's with a better understanding of the time, effort, and funding required to undertake community health research and intervention work. Arguably such learning is also valuable and poorly constructed projects produce poor quality data and involve ineffectual use of human and fiscal resources.

Given that the cohort was selected from diverse professional and geographical backgrounds, we anticipated engagement to be a significant barrier to the project. While the LI sought to ameliorate some of this by providing a venue for relationship building, we found that by and large cohort members opted to work on their project's individually. This lead to tangible areas of oversight in some of the project designs (e.g. theoretical frameworks, budget line items, program evaluation, etc.) Furthermore, attendance

at webinars was inconsistent. Scheduling a time that worked for the entire 15-person cohort proved difficult and recorded sessions were not viewed consistently by those not present. Future projects may need to consider a greater amount of in-person teaching, and mandate team-based projects so that disciplinary silos are broken down and the expertise of different members of the cohort advantaged of.

Increasing Capacity for PCOR: Identifying Muslim Health Priorities

The modified Delphi rounds both i) demonstrated that American Muslims are concerned about a range of health topics and ii) successfully identified three priorities for mosque-based PCOR. However, the asynchronous online platform for discussion and consensus-building was not as useful as we had hypothesized. We had anticipated that given the platform would allow members living in different time zones and with differing availability to engage in the conversations at their convenience. Yet the conversations seemed to be superficial and not content-rich. Through informal feedback mechanisms, we discovered that several participants were concerned about how discussion data would be reported to PCORI (even though de-identified) and some were not comfortable with the Delphi method of defending their views. Additionally, participants reported that they failed to regularly visit the website due to competing demands. As such we could caution against considering the three health issues identified by the cohort as being the one's most pressing and most amenable to PCOR in mosque communities. We might suggest that in-person prioritization exercises, like those used in projects like Choosing Healthplans All Together (CHAT), might be more effective in eliciting robust conversation and health research prioritization.[22]

Increasing Capacity for PCOR: Convening Diverse Stakeholders at a Conference

The A-MAP conference closed the loop for capacity building. Through the A-MAP conference, our diverse cohort was exposed to the current landscape of Muslim health research and programming. The discussion-based approach of the conference allowed for key issues affecting Muslim American mental, reproductive, and sexual health to be brought to the forefront. Changes in immigration policy, social stigma, and discrimination were cited as factors affecting Muslim American well-being. This conference provided a crucial opportunity for the E-MARCH cohort and conference attendees to network with like-minded researchers with diverse experiences and formed collaborations that will impact the future of Muslim health research. On the first day of the conference, patients and stakeholders participated in a a total of four Muslim community research focused panels followed by discussions over best practice methods and tools. The panels were beneficial to conference attendees and offered guidelines for novice researchers in their own work. For example the value of qualitative research to examine the "Muslim" dimensions of health was highlighted, as was the critical role a community advisory board can play in mosque-based research. The Shark's Tank was well-received by attendees, as well as E-MARCH cohort members, as it demystified the process of grant scoring and experts shared critical advice for how researchers and community leaders can design effective projects and get funded. The conference also successfully built connections among diverse stakeholders as multiple cohort members reported planning to work with individuals they met at the conference on grants and health education programs.

Concluding Remarks

American Muslim communities likely suffer from health and healthcare disparities, yet community leaders lack the capacity to conduct research, and build programs, that address these issues. In the absence of national metrics, and national attention to religion-related disparities, it is essential that grassroots capacity is built, and multi-sectoral collaborations are developed, such that American Muslim community health can be advanced. This project sought to do just that by developing a diverse cohort of Muslim community leaders equipped with the knowledge, motivation and networks to participate in

Muslim community-relevant, patient-centered outcomes research (PCOR). Our project was largely successful in increasing knowledge and capacity for such research, yet faced challenges in consistent engagement from participants. Since stakeholder engagement is vital to PCOR and critical for learning, we suggest that community capacity-building projects of similar scope in minority communities utilize more in-person education modalities less online methods so that engagement and learning is enhanced.

Tables:

Table 1. The Engaging Muslim Americans for Research on Community Health Cohort*

Name	State	Stakeholder Group
Heba Abolaban	Massachusetts	Clinician
Sameera Ahmed	Michigan	Social Services
Yasser Aman	California	Community Health
Mohammad Aref	Indiana	Clinician
Alia Azmat	Indiana	PhD Student/Social Services
Mona Elgohail	Pennsylvania	PhD Student
Amal Killawi	New Jersey	PhD Student/Social Services
Angelica Lindsey-Ali	Arizona	Social Services
Nasir Malim	New York	Clinician
Fatema Mirza	Illinois	Community Health
Sharif Mohamed	Minnesota	Imam
Samaiya Mushtaq	Texas	Clinician
Nancy Romanchek	Illinois	Community Health/Clinician
Muhammed Sackor	Nebraska	Imam
Michael Van Keulen	Minnesota	Community Health

*This table notes all members who completed the entire E-MARCH project.

Table 2. Changes in Self-Reported Measures Pre-Post the Learning Institute, N = 14

Measure	**Pre-LI Scores**	**Post-LI Scores**	**p-value**
	Mean ± Standard Deviation		
Self-Rated Knowledge about…[*]			
General Health Research[‡]	29.3 ± 8.5	32.8 ± 7.4	0.017
PCOR	1.9 ± 0.9	3.0 ± 0.7	0.001
CBPR	2.4 ± 1.2	3.2 ± 0.7	0.028
SDOH	2.9 ± 0.7	3.5 ± 0.7	0.014
CER	1.6 ± 1.0	2.8 ± 0.9	0.003
Self-Rated Agreement with the statement…[§]			
I have the necessary skills to carry out a Muslim-focused health research project[§]	3.1 ± 0.6	3.3 ± 0.7	0.336
I intend to carry out a Muslim health research project in the next 12 months	3.8 ± 0.4	3.7 ± 0.5	0.594
It is likely that I will carry out a Muslim health research project in the next 12 months	3.7 ± 0.5	3.4 ± 0.5	0.169
I am confident that I am able to carry out a Muslim health research project in the next 12 months	3.4 ± 0.7	3.4 ± 0.6	1.000

[*] Items rated on a 4-point Likert scale from "None" to "A lot"

[‡] 11-item scale assessing self-rated knowledge of general research methodologies, Cronbach's $\alpha = 0.93$

[§] Items rated on a 4-point Likert scale from "Strongly Disagree" to "Strongly Agree"

Table 3. Changes in Self-Reported Measures Prior to the Learning Institute and at the Close of the Project, N = 10

Measure	Pre-LI Scores	Post-Conference Scores	p-value
	Mean ± Standard Deviation		
Self-Rated Knowledge about…[*]			
General Health Research[‡]	30.9 ± 8.4	34.8 ± 5.9	0.083
PCOR	2.0 ± 0.9	3.5 ± 0.5	0.002
CBPR	2.5 ± 1.2	3.4 ± 0.7	0.041
SDOH	3.1 ± 0.6	3.5 ± 0.5	0.037
CER	1.8 ± 1.1	3.1 ± 0.9	0.022
Self-Rated Agreement with the statement…[§]			
I have the necessary skills to carry out a Muslim-focused health research project	3.3 ± 0.5	3.7 ± 0.5	0.037
I intend to carry out a Muslim health research project in the next 12 months	3.8 ± 0.4	3.6 ± 0.7	0.443
It is likely that I will carry out a Muslim health research project in the next 12 months	3.6 ± 0.5	3.4 ± 1.0	0.443
I am confident that I am able to carry out a Muslim health research project in the next 12 months	3.4 ± 0.7	3.6 ± 0.7	0.343

[*] Items rated on a 4-point Likert scale from "None" to "A lot"

[‡] 11-item scale assessing self-rated knowledge of general research methodologies, Cronbach's $\alpha = 0.93$

[§] Items rated on a 4-point Likert scale from "Strongly Disagree" to "Strongly Agree"

Table 4: The Top 10 Muslim Community Health Issues From the Perspective of the E-MARCH Cohort

Rank	Unique Responses	Issue	Subtopics
1	13	Mental Health	Stigmatization, lack of community education, underutilization of services, community trauma, untreated depression
2	10	A lack of culturally appropriate or religiously sensitive healthcare in hospitals	Need for Gender concordant care and medical interpreters, Discrimination and stereotyping in health encounters
3	7	The Underutilization of Preventative Healthcare by the Muslim Community	Low rates of breast cancer screening, cervical cancer screening, and HPV vaccination
3	7	Reproductive and Sexual Health Issues	Lack of access to information, stigmatization, the need for infertility treatment and decision-making support
5	5	Substance Abuse	Stigmatization and lack of education,
6	4	A Lack of Islamic Bioethics Knowledge in the Community	The need for religious ethics guidance on organ transplantation, end-of-life care, and other topics
6	4	Interpersonal Trauma in the Community	Prevalence of domestic violence, sexual violence, and emotional abuse
6	4	Islamophobia-related health impacts	Impact on Muslim identity formation, and health behaviors
6	4	A Lack of Elder Care	The underutilization of elder care facilities/hospice
10	3	Immigrant Healthcare	Need to address health issues related to xenophobia, social isolation and segregation, and stress/PTSD among immigrants in the community

Table 5. E-MARCH Community Health Research Project Proposals & Conference Talks

Project Title	Author
Project Proposals	
Increasing Breast Cancer Screening Rates Among Foreign-Born American Muslim Women in South Bay Area, California	Heba Abolaban
Positive Youth Development: A Pilot Intervention with American Muslims	Sameera Ahmed
Studying Religion Associated Disparities in the Mental Health of American Muslims	Mohammed Aref
The Burden of Sexual Violence and Sexual Dysfunction in Muslim Communities	Alia Azmat
An Innovative, Internet-Based Treatment to Reduce Depressive Symptoms in Muslim Women Experiencing Infertility: Preliminary Results and Next Steps	Mona Elgohail
Exploring the Experiences of Muslim American Women with Sexual Health Issues	Amal Killawi
Developing an Islamically-Centered Sexual Health Curriculum for Black Muslim Women	Angelica Lindsey-Ali
The Impact of a Pre-CPE Training Program for Muslim Faith Leaders Upon Minnesota Healthcare Systems	Sharif Mohamed & Michael Van Keulen
An Analysis of a Community Psycho-Education Intervention for Nashville Muslims	Samaiya Mushtaq
Islamophobia on Facebook and Identity Formation Among US Muslim Youth	Nancy Romanchek
Mosque Vandalism and its Health Impacts	Muhammed Sackor
Conference Talks	
Lessons Learned and Moving Forward with Mosque-Based PCOR	Yasser Aman
Islamic Bioethical Perspectives on Gender Identities for Intersex Patients	Nasir Malim
Mosque-Based PCOR: Identifying gaps and discovering best practices to conducting patient-centered research on mosque communities	Fatema Mirza

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