Reviewer’s report

Title: Muslim Women's Use of Contraception in the United States

Version: 0 Date: 11 Jun 2017

Reviewer: Karen Hardee

Reviewer's report:

This paper is on an interesting topic, but the purpose of the paper isn't entirely clear. The data are so skewed towards highly educated and possibly high income women in the US who identify as Muslim, that it is not clear what conclusions can be drawn by comparing this group to all American women, or to Muslim women in other countries. Contraceptive use among Muslim populations in countries around the world range considerably as the authors note, but country averages hide differences by age, education, income, etc. Given the sample of women that self-selected into this study, perhaps comparing contraceptive use of highly educated women in the regions of origin to this sample would make more sense. 79.5% of the women in the sample reported using contraception - that is much higher than national averages in countries mentioned in the introduction - but is it higher than women living in those countries who are college graduates/graduate school/professional school - 86% of the sample? With data like these, the argument that these are difficult-to-reach populations (with generally means hard to reach by programs) that suffer from stigma and lack of ability to decide to use contraception doesn't hold up. Also, because of the breadth of topics covered in the survey (in a short time), the authors were not able to probe about stigma, autonomy in decision-making and other factors associated with contraceptive use in countries of origin that hold in the US as well. That those identifying as Sunni Muslim report lower contraceptive use than women who report as Shia is interesting, although that difference does not hold up in the multivariate analysis.

One angle could be looking at patterns of contraceptive use among this sample (e.g. who uses the pill, condom and withdrawal) compared to similarly highly educated American women - or to delve deeper into the characteristics of the women using the various methods since there are some interesting patterns. One is the link between contraceptive use and insurance - note that compared to those who are uninsured, fewer women with private insurance reported using withdrawal. Also, note that compared to foreign born women, women born in the US were far more likely to be using withdrawal, although there was not a significant difference between contraceptive use overall between those born in the US and those born elsewhere.
Some specific comments:

The manuscript for review does not have page numbers - I am starting my comments assuming the abstract is page 1.

Page 3 (Introduction: It would be useful to define what is meant by American Muslim earlier in the paper.

Page 3: "American Muslim women's outcomes may not be comparable considering their unique cultural identities" - comparable to what? And cultural and religious identity interact - there is no one "Muslim" identify.

Page 4: When you mention stigma, are you suggesting that married American Muslim women might also experience stigma related to contraceptive use or would that just be unmarried women?

Page 5: To suggest that contraceptive use is like other "preventive health care utilization" ignores that contraceptive use is related to sexual activity and reproduction, which is sensitive and related to gender, culture and power norms.

Page 5: Why is this population considered hard-to-reach? It is because the background characteristics are not collected in most surveys so it is not possible to analyze data on Muslim Americans from other data sources? Or that these women are hard to reach by programs? Those are very different things. If the first argument is right, then this data set is useful - and should be mentioned as such in the paper, even though it is not necessarily representative of Muslim women living in the US.

Page 6: 15 minutes to complete the survey seems very short to cover so many topics listed on page 5: cardiovascular health, healthy lifestyle behaviors, reproductive health, mention health, experience with adverse life events, utilization of preventive health services, religious practice, and demographic information. Was it a very short questionnaire or did respondents skip sections?

Page 6: Outcome measures - given how many topics were covered in the survey, it would be good to say, "Our primary outcomes for this paper…"

Page 6: Was there a reason you did not ask about female or male sterilization when asking about contraceptive use?

Page 7: the relationship variable was binary: married or not married, but for contraceptive use, teen sexual activity and contraceptive use is likely perceived differently than that among divorced or widowed women. Please explain why these groups were merged.
Nativity is important, but so is time lived in the US (in terms of acculturating to the behavior of the country of residence. Someone who moves to the US as a child is going to be different from one who moved as an adult. Do you have data on length of time living in the US?

Page 8 RESULTS: I suggest not presenting percentages with 2 decimals points - at least in the text. One decimal point is sufficient and easier to read.

Discussion: As I noted at the beginning of my comments, the argument that these women are hard to reach and face stigma in contraceptive use does not hold up - this paper would be more interesting if it had a different focus, as I suggested at the beginning of this review.

Table 1 is missing South Asian origin.

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