Co-Investigator Project Report

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Project Title: ***An Assessment of Health Beliefs among Muslim Immigrant Women in Canada: Implications for Culturally and Religiously Appropriate Health Care Practices***

1. Funding Source

This study was funded by the Social Sciences and Humanities Research Council (SSHRC)-Major Collaborative Research Initiative (MCRI) project: The Religion and Diversity Project.

2. Objectives

The main objectives of this study were twofold: a) to investigate health beliefs among Muslim immigrant women in Canada, and b) to determine the implications for developing culturally and religiously appropriate health care practices for this population group.

3. Background

Health beliefs and health care needs of Muslim immigrants, a rapidly growing minority population group in Canada, are relatively unknown. In addition to highlighting the importance of looking at provider-patient communication in relation to cultural, religious, and socio-economic factors, studies have also reported differences in health care needs between men and women.[1] There is a gap in the literature with regard to examining health care issues faced by Muslim women in general, and Muslim immigrant women in Canada in particular. What literature is available underscores the importance of considering how culture[2] and health care providers' lack of knowledge about Islamic culture,[3] impact the care that Muslim immigrant women receive.[4]

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[1] Tabenkin, H., Goodwin, M. A., Zyzanski, S. J., Stange, K. C., Medalie, J. H. (2004). Gender differences in time spent during direct observation of doctor-patient encounters. *Journal of Women's Health*, *13*(3), 341-349.

[2] Simpson, J. L., & Carter, K. (2008). Muslim women's experiences with health care providers in a rural area of the United States. *Journal of Transcultural Nursing*, *19*, 16-23.

[3] Tsianakas, V., & Liamputtong, P. (2002). What women from an Islamic background in Australia say about care in pregnancy and prenatal testing. *Midwifery*, *18*, 25-34.

[4] Roberts, K. (2003). Providing culturally sensitive care to the childbearing Islamic family: Part II. *Advances in Neonatal Care*, *5*(3), 250-255.

4. Methods

Employing a mixed-methods approach, data were collected using focus group discussions and paper-pencil surveys. Recruited through purposive and snowball sampling and personal networks, immigrant women who self-identified as Muslim, were foreign born, had lived in Ottawa for at least one year, had visited a health care provider for themselves or a family member at least once in the past year, and were able to communicate their experiences in English, were invited to participate in the study.

The research project was carried out in two sequential phases:

Phase One: Four focus groups were conducted with a total of 21 Muslim immigrant women living in Ottawa. Four broad themes emerged from the focus group findings:

Explanatory models of illness. Participants made specific cultural and religious attributions to illness or disease. Their cultural and religious beliefs, views, and values were found to influence their perceptions of causes of illnesses. Interestingly, participants had differences in their beliefs and interpretations of illnesses and in how they expressed certain illnesses.

Intersections between cultural and religious beliefs and health promotion beliefs, health behaviors and practices. Cultural and religious factors were found to play an important role in the health behavior of participants. Interestingly, participants differed in how they understood their illness symptoms and believed in different types of treatment. These factors were likely to shape participants' use of different sources of care for treating their illnesses.

Health care providers' communication skills. Participants emphasized the centrality of communication when providing care for culturally and religiously different patients. Participants underscored the need for communication skills training for healthcare providers, specifically the need to develop knowledge about deeply held religious and cultural beliefs.

Adaptation and accommodation. Participants highlighted the need for adapting to and accommodate culturally and religiously different patients' needs. Participants also underscored the need for patients to be flexible and adapt to the evolving healthcare environment. This mutual adaptation can contribute to culturally and religiously appropriate, sensitive, and competent care for unique population groups.

Phase Two: Surveys were administered to 101 Muslim immigrant women in Ottawa. In addition to drawing from existing literature and scales, the phase one focus group findings also helped

to inform the survey questionnaire. The survey included a total of 53 questions along with 9 demographic questions and 2 questions with multiple items. The survey findings can be categorized into 10 themes:

Perceptions of doctors' cultural competence in healthcare. Reflecting on their most recent doctor's visit, participants rated their perceptions of the doctor's: (1) development of cultural knowledge, e.g., "My doctor wants to know about my religious practices related to health issues;" (2) understanding of the space and time dynamics of cross-cultural differences, e.g., "My doctor wants to know if time is a concern for me with regard to medical treatment;" (3) awareness and recognition of patient's cultural and linguistic differences, e.g., "My doctor considers using the help of an available translator;" and (4), adaptation to patient's cultural plurality, e.g., "My doctor wants to know my viewpoint on illness. " Cultural competence in healthcare may not be exclusive of religious sensitivity.

Patient satisfaction with the direct clinical encounter. Reflecting on their most recent doctor visit, participants rated their satisfaction the direct clinical encounter, e.g., "The personal manner of the doctor you saw." Patients' perceptions of the quality of interpersonal interactions with their doctors can influence how they perceive the overall medical encounter.

Fear of Physician. Participants expressed their opinion about how they feel when they communicate with a doctor. Religious and interpersonal aspects of care can compound mistrust and fear of doctors.

Healthcare accessibility. Participants reported if, in recent years, they faced any challenges in accessing healthcare related to cost, transportation, trust of doctors, linguistic barrier, cultural and/or religious differences, and so on. Participants also reported that when they fell ill, the primary sources they used included medical doctor, family/friend/neighbor, hospital emergency room, among other sources.

Seeking professional help for emotional health. Participants shared their viewpoints of/attitudes toward seeking professional help if they had emotional problem in terms of seeing a professional, being comfortable talking about it with a psychologist or psychiatrist, feeling embarrassed if friends/neighbors knew about it.

Cultural and religious beliefs informed health beliefs, behaviors, and practices. Participants expressed their opinions about health promotion practices in Islam such as general hygiene, diet, exercise, prayer, and so on.

Importance of doctor's understanding of patient's religion, beliefs, and practices. Participants shared their opinion about the importance of doctors having an understanding of their religious

background and practices. Some of these considerations included doctors' effort to appreciate religious differences, being knowledgeable about patients' religion and specific characteristics, and possessing the necessary skills to treat patients of different religious background.

Perceptions of ethical issues in healthcare. Participants' perceptions of ethical issues in health care interactions are shaped by their particular religious and cultural beliefs. It is important for healthcare providers to be sensitive to these cultural and religious differences, acknowledge patients' personal preferences related to treatment issues, and engage patients with respect to help avoid ethical dilemmas in healthcare and thus provide quality health care for all.

Use of the Internet technology to seek health information. Participants reported that they used the Internet to seek health related information to: (1) become informed, (2) get tips, and (3) get a second opinion. Participants used the Internet to search a variety of health information such as specific disease or conditions, treatments or procedures, lifestyle factors. The challenges participants faced when they navigate the Internet include: (1) information overload, (2) linguistic divide, (3) deeply held health beliefs.

Opinions about preventive care and risk reduction measures. Participants reported whether they adopted preventive and risk reduction measures such as consulting doctors for diet and weight management, reproductive healthcare (PAP test and breast examination), and if they did exercise to stay healthy.

5. Anticipated Outcomes

Findings from this research project will contribute to our understanding of the role of culture and religion in healthcare. They bring to our attention the blurred lines of intersection between cultural and religious practices in the context of healthcare. The findings are expected to raise diversity awareness within Canadian health care settings, contribute to a better understanding of the health care needs of Muslim immigrant women, as well as the need for improved communication between culturally and religiously diverse healthcare providers and receivers.

6. Knowledge Transfer and Mobilization

Although I am continuing with data mining, several conference presentations have been and are scheduled to be made. I am developing these conference presentations into potential journal article and book chapter publications. Finally, I am drawing on the findings from this study to prepare for upcoming grant applications such as the CIHR Foundation Grant (2015) and the Religion and Diversity Project's annual Innovation Grant competition (2014-2015).