

Cultural Competence in Health Care: Exploring the Experiences of Muslim Women
within the Ontario Healthcare System

Submitted by

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Abstract

This exploratory study examines the influences of cultural and religious practices of Muslim women within health care settings. Twelve Muslim women, ranging between the ages of 19 to 57, were interviewed. They all participated in a 30 to 60 minute, semi-structured interview, and discussed their personal interactions with health care providers and shared their experiences receiving health care. The research question highlights the role of cultural and religious traditions and practices for Muslim women and how that affects the patient-provider relationship. Knowledge of the difficulties these women face is often unrecognized by providers. These include communication and language barriers, modesty issues, provider gender, translator services and poor provider services. Other significant themes in the study also include characteristics of a ‘good’ provider, main challenges for Muslim women, positive versus negative health care experiences, and key suggestions from participants to improve health services for Muslim patients. Data was analyzed using Denzin’s qualitative framework interpretive interactionism. Analysis suggests that Muslim women patients encounter a wide range of difficulties when obtaining health care services. The women shared some personal stories, where providers lacked the ability to care for them in accordance to their cultural and religious obligations. This reinforces the need for better cultural and religious accommodations for this “unique” population. Cultural competent strategies and protocols must be developed to improve health experiences. However, health care providers must first recognize the gap in the Muslim woman patient-provider relationship in order to change health care processes and experiences for this community.

Dedication

I dedicate this to the greatest gift that is my grandmother, Habiba Hussein,
I am blessed to have you.

To my mother and father, Khadija Ali Farah and Mahdi Muhammed Nur,
Each day I hope to be more and more like you both.

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Introduction

Overview

Over the past decade, there has been a growing change in demographics that enforces the need for culturally competent health care. The growth in various cultural groups has been widely attributed to immigration. These changes have imposed the need for health providers to adopt different communication styles, attitudes, expectations, languages, and worldviews (Fortier & Bishop, 2003). The delivery of culturally competent care has been correlated with the improvement of patient-provider communication, adherence to medical regimens by patients, satisfaction and improved health outcomes (2003). It is important to note that health providers need not be fully competent in every culture and religion, but rather improve their competency of the community and people they service regularly (Schim, Doorenbos & Borse, 2005).

The diversity in culture has become quite apparent in both Canada and U.S populations. People that were non-European made up for 2.9 million (13%) of the Canadian population. First generation Canadians, who are considered individuals who were born outside of Canada, account for almost one-quarter of the population (23%). Interestingly enough, not since 1931 have the proportions of the population that were foreign-born been this high (Statistics Canada, 2003). Canada and the United States have both become aware of the effects of language, religion, and gender on the patient-provider relationship (Fortier & Bishop, 2003). Even if the provider is of the same ethnic background, other aspects of diversity still need to be tackled (Schim, Doorenbos & Borse, 2005).

Cultural competence encompasses personal experience with diversity of culture, knowledge, and sensitivity within daily practices. The best way that cultural competent behaviour is learned is from personal exposure and experience with a diverse community. Also, the understanding of both individual and group similarities and differences improves quality care by attending to the specific needs of patients (Schim, Doorenbos & Borse, 2005).

The research on cultural competence in health has become an essential discourse over the past few years. Specifically, it has received attention as an effective way to combat racial and ethnic disparities and to improve overall quality of care. It is important to understand an individual's ethnic background and how this may or may not play a role in communication between health care providers. Although there are literatures that discuss the role of cultural competence in health, few research studies exist that look at specific ethnic backgrounds and their lived experiences. We must be able to identify and understand problems or barriers that minority groups may face through examining individual experiences. As the diversity of patients continues to grow, this makes it important that cultural competency and the absence of biases become a fundamental professional obligation (Geiger, 2001).

This thesis will highlight some of the key components of cultural competence and its importance within health care. Also, it will address a key model that will help explain the ideas of cultural competence. This research will emphasize and analyze the experiences of Muslim women in the Canadian healthcare system, specifically in Ontario. Language for example, will be looked at as a barrier that may affect the communication process between provider and patient. The data from each interview script will be analyzed using Norman Denzin's (1989) qualitative framework, *interpretive interactionism*. This will allow us to better understand the experiences and interactions of Muslim women with health care providers and grasp the meanings people make of these interactions. Also, it will give us an idea of patients' individual obstacles and how these are related to the broader structures of health.

The main research question explores the role of cultural and religious practices of Muslim women in health care settings and its influence on patient-provider dynamics. This paper uses theoretical insights obtained from the sociology and social-psychology of social relationships from McCall and McCall's *theory of social relationships* (1970). This will assist the study in further examining the patient-provider relationship and trying to provide meaning to the interactions of patients. Sociologists suggest that healthy relationships are an important part of an individual's lifestyle and can have significant impact on their actions and their daily lives. If a poor relationship is developed, it will

have negative effects on a person's health outcome and treatment process (Stokes, Dixon-Woods & Mckinley, 2004).

Some of the topic areas this research will cover include, the background on cultural competence, communication, culture and gender roles, as well as religious competency and immigrant women in Canada. The methodology process and findings will then later be discussed, following the conclusion and future prospects. It is important to understand that this is exploratory research where little literature exists. Much of the existing literature is often U.S. based and very few studies have looked at cultural competence within the Canadian realm. The Muslim community is a unique community that is often misrepresented and where very limited research is conducted. The health experiences of women in the Muslim community, specifically whether poor or appropriate patient-provider interaction exists, may be identified. This may encourage further research on the role of cultural competence in health and perhaps assist in the development of adequate care practices for providers (Simpson & Carter, 2008).

Significance of the Study

It is essential to note that many families across all ethnicities and cultures may face barriers when receiving health care. Although communication strategies have been developed for the general population, the specific needs of Muslim women in Canada need to be recognized. Many Muslim women have immigrated to Canada and in doing so find it difficult to balance their cultural and family dynamics with Western customs (Eiser & Ellis, 2007). Some studies have been conducted in the U.S, which suggest further studies are needed to understand the "unique needs of Muslim patients" (Simpson & Carter, 2008, p.21). Further research will assist in the development of adequate care practices and help outline a Muslim woman's subjective experience, through her own voice (2008).

This research will contribute to the development and implementation of best models of communication practices for Muslim women and health care providers. It is suggested that these practices will also assist professionals and communities in understanding the current research that exists concerning cultural competence, as well as

adding to this body of knowledge that is still in its early stages. Furthermore, with the lack of empirical research, this study will assist in identifying gaps in the knowledge base and may be used as a guideline for further research, to promote positive and effective experiences between patients and providers.

The primary objective of this research is to identify the role of religion and culture in healthcare settings and the effects it has on Muslim women obtaining care. Also, to understand to what extent Muslim women's culture and religion influences patient-provider relationship when receiving care. Finally, to provide insight for health care providers into the experiences and needs of a growing, diverse Muslim population and the importance of cultural and religious knowledge when providing care.

Literature Review

Cultural Competence and Cultural Safety

The concept of culture is referred to as various patterns of acquired belief and behaviour that are often shared amongst a group (Betancourt, 2002). This often involves the way an individual communicates and interacts with others, their relationships, roles, principles and customs (2002). What outlines culture are numerous factors, which include “race, ethnicity, nationality, language, and gender...” (Betancourt, 2002, p. 1). As Canada continues its progression into the 21st century, it is quite evident that cultural and ethnic diversity has grown to be a strong part of its character. In light of this fact, it is important that our healthcare system reflects these diversities and parallels the change. These changes must reflect patients’ wide-ranging perspectives, ideals and behaviour regarding health and wellness. If this does not occur, it may lead to a lack of understanding of socio-cultural differences that may in turn affect the health of minority groups (2002).

The term *cultural competence* did not surface within literatures until the early 1990’s. In 2005, over 1500 journal articles have been written about cultural competence, most of them published at the start of the new millennium. Not until the last decade was it that countless programs, initiatives, and mandates were developed to address increasing needs for culturally competent care. The main reason for the development of these programs in the past decade was reflective of the “widespread racial and ethnic disparities in health care” (Beach, Saha, Cooper, 2006, p.4).

As we try to move towards a healthcare system that incorporates cultural competence into practice, the topic has gained much needed attention by “policy makers, managed care administrators, academicians, providers, and consumers” (Betancourt, Green, Carrillo, et al., 2003, p. 118). It has now been recognized as an effective approach to combat racial and ethnic disparities. However, there has been debate on how to define this vital construct. Various terms have surfaced to better summarize the concept. These include: “cultural sensitivity, responsiveness, effectiveness, and humility” (2003, p. 15), which have been used to flesh out its meaning and the nuances of these words help us arrive at a unique meaning.

The term *cultural safety* was developed in the 1980's as a blueprint for the increase of delivery of appropriate health services for the Maori people who reside in New Zealand. Initially, this concept was used to identify an approach to health care that highlights the “contemporary conditions” of indigenous people from their “post-contact history” (Brascoupe & Waters, 2009, p.6). However, it has been identified as a key tool within all aspects of health care and not just in indigenous communities. A frequently used definition of cultural safety is as follows: “an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together with dignity, and truly listening” (Williams, 1999, p. 213)

Culturally safe practices involve action that distinguish the cultural identities of others and safely meet their needs, expectations and rights. On the contrary, culturally dangerous practices are those that involve the diminishing, or disempowerment of a culture's identity as well as wellness of a person (Nursing Council of New Zealand 2002, p.9).

The term cultural safety is often made in reference to cultural competence, an extension of it rather, to improve and build on competence. Thus, both terms are often characterized as “points on a continuum of cultural approaches” (Brascoupe & Waters, 2009, p. 10). However, the two terms are often used interchangeably, which dilutes the importance of the concept of cultural safety and its origin in New Zealand nursing literature (2009).

Communication, Culture and Gender Roles

Culture and communication are two important concepts that can sometimes influence each other when delivering culturally sensitive care. Poor communication, as a result of language and cultural differences, is considered a major barrier between patient and provider when it comes to the provision of health care services. This ultimately has severe ramifications at all levels of health care. Culture is identified as a social phenomenon with both broad and narrow definitions. It is also described as a deposit of

“knowledge, experiences, beliefs, values, actions, attitude, meanings, religion, notions of time, spatial relations, concepts of the universe of group of people” (Samovar, Porter, & Stefani, 2000, p.112). With that being said, communication is not only a part of culture, but in actuality is culture. Communication between individuals from various cultural and ethnic backgrounds (intercultural communications) is identified as a significant exchange process, where they confer shared meanings in engaging situations. Often, the process of intercultural communication leads people to stereotype other groups based on pre-conceived notions about that particular group. One of the most important intercultural communications is that of the patient-provider relationship, which brings two people together with different communication mechanisms that may not coincide well in a health care setting. It is important that health providers transcend their cultural variations and beliefs in order to effectively communicate with their patients. Effective communication is a crucial component for not only improving the satisfaction of patients, but treatment adherence as well, ultimately improving health outcomes (Degni & Suominen et al., 2011). Previous studies have shown that patients, who have an understanding of their illness and treatment and believe that their provider has a genuine concern for their wellness, have a higher satisfaction. They are also more likely to follow medical regimens (Lowell, 1998).

Communication is culturally significant when it comes to behaviour patterns, attitudes, and beliefs, according to some anthropologists. In health care there are social roles for both patients and providers, in which the provider’s role is often correlative to that of the patient. There is an expectation on the patient to cooperate with providers just as much as doctors are supposed to relay knowledge and expertise that is beneficial for patients. This idea highlights the overall expectations that govern patient-provider behaviour and how these roles assist interaction during visitations, in which both understand each other’s expected behaviour (Scambler, 2003). It is said that the most frequent complaint about providers from patients involves communication issues. Specifically, poor listening skills, lack of information given and absence of respect. This results in patients leaving the consultation, often troubled, without asking any questions. It is important to note that patients can have an influence on a physician’s communication and interaction skills, although they are considered to have less power than physicians.

For example, patients who use passive styles of communications and give limited information to providers affect not only the relationship with them, but also treatment recommendations (Degni & Suomeninen et al., 2011).

It has been known for many years that culture and language obstacles concerning health care providers and patients can disturb the way effective services are delivered (Beach, Saha, Cooper, 2006). It is fundamental to understand patient perspectives regarding their beliefs, which is a key part of providing culturally competent health care. A 2002 article titled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care”, published by the Institute of Medicine, highlighted that racial and ethnic minorities often receive poor health care comparatively speaking to those that fall outside this vulnerable group. This also includes when specific aspects are controlled, such as accessibility factors (i.e. income). It is quite evident that the need for cultural training for providers within the health care realm is critical (Smedley, Stith, & Nelson, 2002). The difficulty with training programs lies within the need to provide important information about various cultures without stereotyping. This is why many programs put forth an emphasis on how to effectively communicate with patients from different backgrounds, or who may have varied beliefs and experiences (Hammound, White, & Fetters, 2005). Although health care workers try to provide quality care to each patient, sometimes they may inadvertently go against individual customs and beliefs. This would ultimately hinder the development of a patient-provider relationship when providers try to get insight into serious issues with patients (2005).

The concept of gender plays a very important role for many Muslim women, not only when it comes to religious values, but also when receiving health care. According to a study on the experiences of Muslim women with health providers conducted in the United States, many women expressed their preference for a female provider—specifically when it came down to problems associated with female related issues and body parts (Simpson & Carter, 2002). Some of the matters included gynaecological related problems, pap smears, family planning, and childbirth. A few of the women emphasized that it was not just simply for religious reasons, but for personal preferences as well. Some stated that they did not mind seeking care from a male provider, but only

for basic health illnesses that could be addressed with limited contact. Some of the women interviewed defined a positive male provider interaction as one that involved less physical contact and less time alone with the provider (2002).

The gender of a provider is quite significant for most Muslim women when seeking care for health needs. The reason for this is due to cultural practices and religious views, which are often intertwined. If patients feel a provider is not an appropriate fit for them, it can hinder the communication process between them. They will feel less inclined to express themselves fully and discuss their needs with a provider if they are male. Communication will be quite limited and may result in fewer visitations from the patient (Simpson & Carter, 2002). Though little research exists that looks at the effects of gender on communication, it is vital for providers to understand the gender dynamics affiliated with Islam and how this plays a role within the care they provide to patients.

There are many other factors that may interrupt the lines of communication between patient and provider other than language and gender. The concept of *ethnocentrism* is often overlooked as a barrier of communication, however can play a major role in the health setting (Purnell, 2002). The term was first developed by American sociologist William G. Sumner in 1906, who defined it as a: “view of things in which one’s own group is the center of everything, and all others are scaled and rated with reference to it” (Neuliep & McCroskey, 1997, p. 210). In relation to health care, it has been reported that the ethnocentrism of providers has contributed to “patient alienation, inadequate treatment, and misdiagnoses (Andrews, 1992, p. 9). It has the ability to reinforce an individual’s idea that if a person’s belief differs significantly from one’s own, then it is deemed strange and incorrect. Many believe that ethnocentrism has a negative influence on a provider’s ability to give adequate care in a way that is culturally sensitive (Purnell, 2002).

When health care providers are learning about approaches to health care in different cultural groups, they often have a strong belief in their own value system with the assumption that they have the most precise approach to health. For example, in some cultures lies a belief that if one talks about death, it speeds up your chances of death. Many Western health providers would most likely view this idea as flawed and

misguided. On the contrary, some cultures may view something like the common practice of braces (forced movement of teeth by metal) as a cruel act (Anand & Lahiri, 2009).

Medical ethnocentrism is a barrier to accessing health because it constrains a provider's understanding of a person's behaviours and beliefs. This idea becomes even clearer when it begins to affect treatment plans for patients. What many people do not realize is that ethnocentrism can actually lead to quite serious circumstances, such as a serious decline in patient health or even death. Another example of medical ethnocentrism is that for many people the idea of God's Will is heavily valued in the way they live their lives. Consequently, they may not believe in taking medication or going through various therapies because it contradicts their beliefs. Thus, their faith-based choices would ultimately cause a regression in their health. If health providers are uninformed of such cultural beliefs, this may result in a patient's eventual demise. On the other hand, if providers are aware of this idea, they can then work with the individual on a solution that not only respects their belief system, but a solution that ensures optimal health and well-being (Anand & Lahiri, 2009).

Ethnocentrism on the part of the health provider may have a negative impact on lines of communication with their patients. Patients might feel that they cannot discuss their values and beliefs because doing so, may cause a negative response from the provider. Sometimes providers might interpret things differently based on their own beliefs, resulting in perceptions that could be completely inaccurate. Or they may unintentionally prejudge patients based on their personal stereotypes of cultural groups (Anand & Lahiri, 2009).

The quality of communication is a key determinant of positive and negative outcomes. Lack of trust, loyalty and understanding are three factors that are being especially looked at, with respect to the patient-provider relationship (Fredericks et al., 2006). These factors often exist due to differences in cultures between both parties (Anand & Lahiri, 2009).

Religious Competency and Immigrant Women in Canada

Islam is the religion of many cultural groups around the world and is the fastest growing religion, with over 1.5 billion followers (Huntington, 1998). The Muslim community, though still considered a minority, has grown tremendously as a population in North America. Health care providers and future providers must prepare for the challenges that may be associated with this unique group. They must be ready to care for their health needs, without dismissing their cultural and religious needs (Carter & Simpson, 2007). According to a pilot study conducted in the United States, out of 32 Muslim women that were surveyed in a rural community, 63% did not obtain professional medical treatment. This was due to the belief that their providers were not familiar enough with them or their faith to provide care in accordance. They felt that their interactions with providers were uncomfortable and did not assist them in anyway (2007).

In the past century, Canada has welcomed over 13.4 million immigrants, with the majority of that number arriving within the last ten to fifteen years. Most of the countries that many are emigrating from are increasingly non-European, mostly Asian and Middle Eastern. It is clear that Canada is becoming “ethnoculturally diverse” (Janhevich & Ibrahim, 2004 p.49). Not only are the numbers of visible minorities rising, but also those individuals who consider themselves part of other religious groups besides Christian. The 2001 Census indicated that eight out of ten Canadians categorized themselves as Christian; however, major changes have occurred that have ultimately transformed the religious make-up within the past ten years (2004). There has been a major growth with the numbers of Canadians who identify themselves adherents of non-Christian religions. For example, the number of individuals that identified themselves as Buddhist increased by 84% and those classified as Sikhs and Hindus increased by 89% each (2004). Though these numbers are significant increases, the number of Muslims actually has seen the most growth. The number of persons that have identified themselves as a part of this community doubled from 250,000 in 1991 to 580,000 in 2001 (2004).

In 2001, Muslims represented two percent of the total Canadian population. Eight out of ten persons identified as Muslims, where 68% live in Ontario and about 18.7% reside in Quebec. The remaining percentages are spread through British Columbia (9.7%) and Alberta (8.5%) (2004). It is quite evident that immigration plays a key role in the change of religious landscape; however, the aging population and the decline of people identifying themselves as part of a specific religious group also influenced the change (Janhevich & Ibrahim, 2004).

In 2011, the Muslim population officially surpassed the one million mark according to the National Household Survey (NHS) conducted by Statistics Canada. This population has actually doubled for another consecutive decade and has reached 3.2% of Canada's entire population. Experts say that the NHS' findings should be taken with slight discretion, due to individuals that might have not filled out the survey (i.e. new immigrants), which may leave some gaps in data. Still, many experts believe that this data shows an accurate, yet broad picture of Canada (Statistics Canada, 2011).

It is quite clear that limited research exists on how to adequately provide health care that is culturally sensitive. However, current literatures that have been published highlight the idea that Muslim immigrant women have quite similar stories of difficulties, regardless of place of emigration. These difficulties include: "language, communication of cultural understanding, and application of care practices that are insensitive to Islam" (Simpson & Carter, 2007, p. 16).

Language difficulties are one of the main barriers that Muslim immigrants face. Since English may not be a first language, this often leads to negative experiences for many individuals. Many women, who do not speak fluent English, felt that they did not receive the best care or support and felt "rushed" (Small et al., 1999, p. 83). Although some may not distinguish between the concepts of language and communication, Bowes and Domonkos (1995) believe that they are two different ideas. Language involves the technicalities of speech as opposed to communication, which incorporates verbal and non-verbal actions (i.e. attitude). Language used in the patient-provider relationship is quite important; however, it is not considered of high importance for racial minorities. Instead, a health care provider's attitude was a reflective indicator of a patient's compliance. For example, if the provider demonstrated a supportive attitude regarding an

individual's culture and understood the differences, patients would be more willing to adhere to treatments. However, if the provider exemplified any aggressive and dominant behaviour, it was less likely the individual would listen and follow through on any medical recommendations. The best way to effectively communicate with patients and establish a strong patient-provider relationship is to show empathy towards their needs and view them as individuals (Roberts, 2003).

Awareness and understanding of Islamic customs and values are quite important and ultimately stimulate efficient delivery of culturally competent care for Muslim women (Rajaram & Rashidi, 2001). Health providers, who are familiar with their patients' beliefs and traditions, have a better chance at being "co-participants" with them and providing culturally sensitive care. Patients who practiced Islam are more likely to identify a good health provider as someone who recognizes "issues of faith and spirituality as well as biological needs" (Eiser & Ellis, 2007 p. 180). It is reasonable for Muslim patients to expect that some of their concerns regarding religion and health be considered and not just biological issues. As mentioned earlier, if religious concerns are not addressed, this may cause distrust in the provider and defiance of health recommendations. This idea can also be applied to patients in other religious groups as well (Eiser & Ellis, 2007; El-Kadi, 1994).

Within the realm of cultural competency lies the concept of religious competence and often, religion and culture are intertwined when discussed. According to Whitley (2012), religious orientation encompasses a person's "belief, attitude, values and conventions" (p.250) and plays a very significant role in a person's psychological and existential framework. Also, it can affect an individual's behaviour, which in turn can influence specific actions. This includes: alcohol consumption, substance use such as cannabis, diet (i.e. fasting influencing medication use), sleep and sexual activity patterns. Religion often dominates lifestyle and choices and cannot be separated from daily activities (2012).

Though Islam is the religion that bonds all Muslims together, they all come from various parts of the world. According to Janhevich and Ibrahim, (2004), Canadian Muslims are anything but a homogenous group. Similar to Christians, a Muslim person's

culture and traditions are developed within the strong influence of their ethnic background. The heterogeneous Canadian Muslim population can be seen through the wide-spread “ethnic, cultural, linguistic and racial diversity” (2004, p. 53). Furthermore, Canadian Muslims continue to reflect the diversity that is Islam by upholding varying interpretations of Islam. Some continue traditional practices, while others are developing their own idea of a distinct Muslim identity (2004). Also, Islam is divided into two major sects: *Sunni* and *Shi'ite*, in which each sect identifies with a different school of thought. Where one school has a specific ruling on an issue, another can have a completely different belief. This may or may not have influence on a Muslim woman’s ideas and practices in health.

Many immigrants often share, if not the same, similar experiences when moving from one country to another. This often includes the transition process of settling in and most intriguing, identity transformation over a length of time. During this period, many encounter both joyous and stressful situations. These situations often heighten vulnerability, specifically for immigrants’ health and health risks. Although women’s health care needs are unique, they are also quite established, which have contributed to women focused health care centres. With that being said, immigrant women have common characteristics that need “gender-sensitive research and clinical efforts” (Meleis & Lipson, 2006 p. 291). They also share the same vulnerabilities and marginalization as minority groups overall. Immigrant women face many constraints when residing in a new country, which often include language and the burden of taking on a new role. This goes hand in hand with trying to maintain their cultural traditions, while simultaneously adapting to new values to assist them with the integration process. Many of these factors influence the health of immigrant women; however, research studies are limited (2006).

Immigrant women often work in environments that may not be good for their overall health. Often the work, such as working in the home or family business, provides limited benefits. When seeking jobs outside the home, low-income jobs are obtained, usually domestic work. A key factor that also influences the health of immigrant women involves the concept of gender roles. They are often responsible for maintaining the household, childcare, (sometimes) contributing to income, family mediators, amongst many other roles. Many health care providers seldom have knowledge of the various roles

and demands that many of these women have and how it is associated with their health (Meleis & Lipson, 2006).

In 2010, more than 280,000 immigrants came to Canada, which has considerably contributed to the overall growth of the Canadian population (Statistics Canada, 2011). According to the 2006 census, there were over three million immigrant women in Canada (3,222,795), which is about twenty percent (20.3%) of Canada's total female population (Chui, Tran, & Maheux, 2007). The population trend for immigrant women parallels the total immigrant population. This explains why the total immigration population in 2006 also made up approximately twenty percent of the total population (19.8%), which was the highest since 1931. Between 2001 and 2006, the immigrant women population increased by fourteen percent, which was four times faster than women who were born in Canada. If these trends of immigration continue, it is projected by 2031 there will be over eleven million immigrants in Canada. One half would be women (52.3%) and they would make up 27.4% of the female population (Malenfant, Lebel, & Martel, 2010).

The immigrant population in Canada stem from various parts of the world. The 2006 census highlighted that Canada's 3.2 million women immigrants originate from over two hundred countries. Eighteen percent of the total women immigrant population arrived from 2001 to 2006, the majority of which came from the continent of Asia. Over the years, the origin of Canada's immigrants has changed. In the early 1970's, the main birthplace of many immigrants was Europe, which accounted for 61% of recent immigrant women. By 2006, Asia and the Middle East was the main source of recent immigrant women (59%). The reason for the change of origin of the immigrants since the 1970's was a result of various factors that include a change in Canada's immigration programs, as well as global events that affect the move of migrants and refugees (Chui, Tran, & Maheux, 2007). With that being said, this has considerable implications for Canada and its health services, which needs to reflect the makeup of its changing population. A growth and change in population may mean different health needs as well (2007).

A Model of Cultural Competence

The changing demographics and economy of a growing diverse world and increasing health disparities have challenged health care workers to put cultural competence as a priority. There have been several models developed to meet these challenges of a cultural diverse society, however Campinha-Bacote's (1998) model, *The process of cultural competence in the delivery of health care services*, focuses cultural competence as an "ongoing process" (p.3), in which health providers continuously try to work with the cultural context of a patient. This model encourages workers to become culturally competent as opposed to already being culturally competent (Campinha-Bacote, 2002).

The author has borrowed from various fields to help develop this model, such as medical anthropology, transcultural nursing, and multicultural counselling. Campinha-Bacote (2002) highlights five integration constructs of the model that include: *cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire* (p.182).

Cultural awareness refers to self-examination of personal culture and professional background. This will enable the health provider to identify any bias and prejudices that they may have for others that they consider different. If a person does not recognize their own personal biases and assumptions, they increase the chances of interacting with a patient in a way that is insensitive, culturally speaking. This may include implanting personal beliefs and values onto another person's culture (Leininger, 1979).

Cultural knowledge involves the ability to obtain sound information, with an education base about various culture and ethnic groups. There are three specific issues that the health provider must recognize: "health-related beliefs and cultural values, disease incidence and prevalence and treatment efficacy" (Lavizzo-Mourey, 1996, p. 182). By understanding a patient's health related beliefs, this allows providers to learn from the perspective of the patient, how they interpret their health, and how it guides the way they think. For instance, if the incidence and prevalence of a disease is dependent on a particular ethnic group and providers do not have sound epidemiological data, it will influence the outcome of a patient's health. Cultural knowledge can be obtained by

recognizing treatment efficacy. An example of this would be understanding the differences in drug metabolism among various ethnic groups. Though, it is important to note that a person is not just linked to one culture, but in actuality a variation of cultures with different life experiences (Campinha-Bacote, 2002).

Cultural skill refers to the capability of a provider to gather significant cultural data of a patient and then appropriately assessing them based on this culture data. This is also referred to as a cultural assessment, in which cultural skill is required. A provider must understand how persons “physical, biological and psychological variations” (Campinha-Bacote, 2002, p.182) may affect the ability to conduct accurate assessments.

Cultural encounters involve the interactions between a provider and a particular cultural group. The direct engagement with patients will “refine or modify” (Campinha-Bacote, 2002, p.183) the current beliefs about a cultural group and challenge any stereotypes that may exist. However, the author highlights that engaging with a few patients may not depict an accurate picture of a cultural group and that differences may lie within cultural groups as opposed to across groups (2002).

Cultural desire is when a provider has the desire to learn about other cultures and be familiar with cultural encounters as oppose to being forced to. In order to want to know something, it begins with the simple act of caring: “...people don’t care how much you know, until they first know how much you care” (Campinha-Bacote, 1999, p. 183). It is important that health providers show a genuine interest in a patient and focus on the major similarities that they may have as opposed to the differences. Campinha-Bacote (1999) believes that it is important to learn from each other and our cultural influences.

It is significant to highlight that all five constructs are interdependent. This model can be used in all health care practices and more importantly can be used for cultural sensitive research. It can also be used as a tool to develop policies that highlight the issues that many ethnic groups face regarding cultural sensitive care (Campinha-Bacote, 2002). Furthermore, models such as this can be used as a blueprint to develop cultural competence programs and initiatives that may ultimately help put theories and ideas into practice.

As mentioned earlier, the literature on cultural competent care has increased significantly in the last decade. With that being said, initiatives and programs have been developed to help deliver care that is more tailored to a diverse population. In the United States, the *Healthy People 2020* initiative was developed as a ten-year plan to improve health for populations. One of the many objectives highlighted include, eliminating disparities in health care by providing health services in a culturally competent manner (Healthy People 2020, 2014). In Canada, the College of Nurses of Ontario have developed a practice guideline for culturally sensitive care that outlines key elements and real scenarios on how to provide quality care to diverse populations. It also lists behavioural directives for nurses such as: “seek to broaden your understanding of cultural concepts and issues” and “become aware of cultural differences in client’s responses to illness and care needs” (College of Nurses of Ontario, 2009, p. 12). Cultural competence has come a long way and its importance is continually being recognized in health care. However, more initiatives and programs are needed in Ontario that support not only Nurses, but all health professionals as well. As research and literature on cultural competence in health care continue to develop, programs, initiatives and guidelines will likely follow the same pattern.

Theory of Social Relationships: A Sociological Perspective

In order to conceptualize social relationships, such as the patient-provider relationship, they must be seen as a social organization, similar to “small groups, bureaucracies and communities” (Stokes, Dixon-Woods & Mckinley, 2004, p. 507). This concept was developed by sociologist McCall and McCall (1970), who believed that social relationships have a history and career that is continuously redefined by each participant in a specific social encounter. Social relationships encompass rules and rituals that govern its initiation, maintenance, as well as ending. A key characteristic of the concept includes its focus for its members’ activities and the boundary guidelines it sets in order to maintain that focus. Boundaries are quite dependent on societal norms, but also can sometimes be developed. This means that they arise through interactions as opposed to being defined externally (2004).

McCall and McCall (1970) use the concept of marriage to exemplify boundaries and its association to social relationships. In a marriage, intimacy may be the focus and with that rules and limitations are emplaced such as “private terms of endearment” (Stokes, Dixon-Woods, & Mckinley, 2004, p. 508). In comparison to the patient-provider relationship, its focus and boundary rules differ. A rule that may exist may perhaps be an emotional disconnect, which is considered as “affective neutrality” (Parsons, 1951). The purpose of this would be to uphold the professional objective that doctors need to provide care and treatment. This allows providers to act in a manner that is not hostile and to also not become too close with patients. There needs to be impartial grounds when it comes to emotions (Stokes, Dixon-Woods, Mckinley, 2004).

The social relationship between the patient and provider may change overtime, causing one person to become unhappy because of the boundary rules or disconnect from the focus. When a person decides that the focus is no longer significant, alienation takes place. The alienated person may then adopt to break boundary rules to stress the need for the relationship to be defined again. The end of a social relationship can be viewed as a defiance of the rules in an effort to reformulate the relationship (McCall & McCall, 1970).

Social-Psychology: Hayes-Bautista’s Termination of the Patient-Practitioner Relationship

The concept of termination was identified as a phase within the “career” of the patient provider-relationship. Sociologist Hayes-Bautista (1976) developed his work around the ideas of McCall and McCall’s (1970) model of social relationships previously discussed. He used grounded theory to identify theoretical properties of termination, developed from the personal accounts of patient encounters with providers. With respect to the author, termination is defined as the ending of a patient-provider relationship, which can be executed by the patient or the provider. Or it can be due to “over-riding conditions” (Stokes, Dixon-Woods, Mckinley, 2004, p. 508), meaning external factors that are outside the patient and provider’s control. An example of this would be when a patient moves away from the area where the provider practices (2004).

Hayes-Bautista (1976) describes two different types of termination; the first one called *patient-initiated termination*, referring to when a patient encounters a provider and decides that the care that he or she gives is insufficient. This belief by the patient may perhaps come to light when he or she compares two providers, as a result of consulting another doctor. The second type of termination is called *practitioner-initiated termination*, which is perceived by the patient as an outcome of their failure to comply with the provider's medical direction. Or it can also be applied to when a provider is unable to continue care, as the condition has become complex, in which patients are then given a referral and sent to a specialist with more expertise. It is important to note that when patients feel the relationship with their provider is being terminated because they failed to follow through with treatment suggestions, they believed that the termination was permanent or temporary. If the latter, patients believed that the relationship would continue if they yielded to medical treatment (Stokes, Dixon-Woods, Mckinley, 2004).

Box 1 *Methods by which termination of the relationship is accomplished by both practitioner and patient*

Mutual withdrawal: when both parties come to an agreement that the relationship has not worked out as either hoped and termination is the only way forward.

Confrontation: when mutual withdrawal is attempted by one party but the other angrily refuses.

The 'fade-out': when patients, having decided to terminate the relationship, choose not to return to that particular practitioner.

The 'hand-off': when a practitioner refers a patient to another practitioner and does so for the specific purpose of terminating the relationship.

The 'put-off': when a practitioner, seemingly on purpose, refuses to accede to a patient's demands so that the patient loses patience with the practitioner and consults another doctor.

Note. From *Termination of the Patient-Practitioner relationship: divorce, patient style* by D.E Hayes-Bautista, 1976, *American Sociological Association*, 17(1): 12-21

There are various stages of termination that were developed that explain the relationship dissolution between patient and provider, which is initiated by either the patient or the provider. A model of termination, shown in Box 1, developed by Hayes-Bautista (1976) explains the process and can also be tested in various health care settings. The accounts of termination were constructed around the experiences of patients. The perspective of the practitioners regarding the patient-provider relationship was not included in the work of Hayes-Bautista (Stokes, Dixon-Woods, Mckinley, 2004).

The disconnect in care between provider and patient can at times develop a mutual frustration that results in a mutual separation. An example of this would be when patients decide to change doctors because they feel that their current provider has not successfully identified or cared for their health difficulties that they experience (Freeman et al., 2001). The discontinuity of care is an area that requires further research, as it highlights the challenges that both patient and provider face in upholding the boundary rules of a relationship, which may ultimately last for years (Stokes, Dixon-Woods, Mckinley, 2004).

The end of a patient-provider relationship can be a negative experience and quite disruptive. For many patients, it can create new problems as opposed to fixing old ones. Situations that involve dissolution of the relationship, on the part of the provider, may pose more serious problems as oppose to a patient walking out. Because of the impact on patients, there is certainly an important need for studies that look at the relationship and identification of ways that can sensitively deal with issues that affect both patient and provider (Stokes, Dixon-Woods, Mckinley, 2004).

The Hayes-Bautista (1976) termination model is important because it takes a unique look at the end of the patient-provider relationship. It provides a sociological perspective of the way patients and providers may discontinue their relationship with each other. The reason why this relationship is significant is because it is one of the few professional relationships that can last for many years as previously mentioned (Stokes, Dixon-Woods, Mckinley, 2004). Despite this fact, very little research has been done that examines the ending of this relationship. This model may help with recognizing “at risk” (p.513) relationships at an early stage and lead to the development of interventions that

focus on finding a solution (2004). By understanding this model in health care settings, it may help patients and providers build a better connection with each other. If the relationship must end, then it will allow both parties to recognize better ways to move on from each other.

Methodology

This research was conducted through the process of a qualitative methodology with a phenomenological approach. This method was appropriate because qualitative research allows researchers to gain insight into an individual's attitude and behaviour in a particular area of focus (Lester, 1999). According to Lester (1999), phenomenology involves the study of experience from the point of view of the individual. It is a powerful technique for understanding "subjective experience" (p.1) and attaining insight into individual thoughts and actions. Furthermore, the phenomenological approach will capture individual lived experiences, which will ultimately assist in the overall study and give a unique insight into the patient-provider interaction within the Muslim population.

A qualitative study gives way for more flexibility and opens the door for further issues that are derived from participants that may have been overlooked. This may ultimately increase data quality (Tsianakas & Liamputtong, 2002). For example, Simpson and Carter (2008) conducted a study concerning the experiences of Muslim women in rural United States with health care providers. According to the authors, the phenomenological approach was used not only to explore individual experience, but to also identify themes to highlight "positive and negative provider interaction" (p.20), that may ultimately improve care for this population (2008). In another study, Hasnain and Connell et al., (2011), look at patient centered care for Muslim women and also interviewed providers to get their perspective. According to this study, when religious or cultural needs of patients are not met, there exist many challenges for both provider and patient. This may inevitable lead to a greater burden on the healthcare system (2011). There were many reoccurring themes highlighted throughout the authors' research, which included: "communication, attitude, gender, religion and competence" (2011, p.79). The themes were developed based on the participants' responses. Qualitative research is an ideal approach to take when the topic of study is in its infancy stage. As mentioned previously, limited research exists on cultural competence for women in the Muslim community. Thus, studies like this will certainly help build and contribute to the current body of knowledge.

In the world of nursing, qualitative research and the exploration of patient experiences is a very important technique. Often, qualitative methods of inquiry can deliver rich information that assists in practice when taking on research that analyzes the experiences of individuals. This method is significant to health care because it allows health providers to gain knowledge that will ultimately assist them in the recovery process of patients (Tower, Rowe & Wallis, 2012).

Data Collection

The target study population for this research is Canadian Muslim women who are over the age of eighteen. In the inclusion criterion, the women must have some experience using the Ontario healthcare system. Ultimately, the idea is for them to share their personal stories and express themselves openly about their interactions with health providers and using the health system. Only women over the age of eighteen were selected, not only because of possible difficulty retaining parental consent from those under this age, but also older persons may have more experience using the health system as opposed to younger individuals. The women in this study all expressed interest in this research, wanting to share their personal accounts, and also to help limit the gap in knowledge on behalf of the Muslim community. There were no exclusion criteria when it came to specific health providers and all the women that were able to participate discussed seeking health care from various providers, including family doctors, nurses, and more specifically their OBGYN.

The exclusion criteria for this study were women under the age of eighteen, Muslim men, non-Muslim women and also those that did not have any experiences using the Ontario healthcare system. That includes individuals from different provinces in Canada. This exclusion criteria supports the attainment of the appropriate target population for this research.

Twelve Muslim women were recruited for this research who all ranged in age from 19 to 57, with the average age being 31. The target population for this study were recruited from Flemingdon Health Centre (FHC), located in the community of Thorncliffe and non-random sampling was used—specifically purposive. FHC is a registered charity

and an incorporated not-for-profit community health centre that is funded by the Ontario Ministry of Health and the Toronto Central Local Health Integrated Networks (TC-LHIN). FHC provides a wide range of health related services that are based on social determinants of health and community engagement models. Factors that affect community health is one of the major focuses of the health center, which is why most of their programs and services emphasize community involvement, health promotion and disease prevention. FHC tries to tackle issues involving poverty, employment, food security, isolation and newcomer support. Some of the programs offered include, but are not limited to, support programs for seniors, women, youth and newcomers. They also have diabetes prevention programs that specifically target the South Asian population (Flemingdon Health Centre, 2012).

Fliers were posted throughout the health centre that provided information about the research and how to contact the principal investigator (PI). A few of the women that were interested in participating stated in their emails that they were informed about the research through a friend who either visited FHC or someone that was an employee. The recruitment process was somewhat challenging in the earlier stages due to conflicting schedules. For example, one woman in particular stated that she wanted to participate, however she would cancel when a date was arranged. Although the PI was quite flexible with conducting the interview at any time and location, a mutual date and time could not be met. Her reasons were often family related—she was a mother of four young children. This perhaps may be one of many reasons why recruitment was difficult in the early stages of the research. Some of the women simply did not have the time, no matter how flexible the interview dates were.

Out of the twelve participants, only two were born in Canada. The majority of the women migrated with their families to Canada at a young age, whereas only two women came as adults with children. One woman cited that she came to Canada when she was in her early teen years. Eight participants stated they are from Pakistan. Two of the women emigrated from East Africa with their families (Somalia and Eritrea). The last two women stated that they were originally from India and Saudi Arabia. All participants cited some

experience using the healthcare system and wanted to share their personal encounters. Table 2 in appendix B outlines the demographics for participants of this research.

Data was collected through one-on-one in-depth interviews with each participant. The interviews were semi-structured, which allows for openness in conversation and can help generate new ideas. Also, each interview lasted approximately 30-60 minutes in length. An interview guide (see appendix D) was used to help ensure the same general scope of information was collected from each of the women (McNamara, 2007). Participants were told that the interviews were going to be held at the Flemington Health Centre, however they had the option of opting for a location that best suited their needs. Many of the women chose the latter for various reasons, from transportation issues or personal reasons. The purpose for that option was to make sure participants were comfortable wherever they decided to have the interview, which would ultimately benefit the data collected.

At the beginning of each interview, the consent form was read over by the participant and anything that was not understood was explained thoroughly by the principal investigator. Once that was completed, each woman and the PI signed the consent form and the interview was ready to begin.

Data Analysis

The interviews were audio recorded for later transcription and the principal investigator jotted down keynotes throughout the progression of the interview. As mentioned earlier, the interview was designed as a semi-structured interview, which assisted in making the interview more of a conversational-type style. The interview questions were developed based on previous studies conducted on Muslim women in health care, specifically the work of Hasnain and Connell, et al., (2011) as well as Simpson and Carter (2008). Common topic areas and themes were identified in both literatures, such as religion and gender, which helped develop the interview guide for this research.

Participants shared their experiences by expressing detailed thoughts, raw emotions, and sharing opinions of the Ontario healthcare system. The interview began with basic questions about past visitation history with health providers, however later progressed into questions about gender, religion, communication and overall experiences. Twelve themes were developed that were based on the participants' responses to the questions during the interviews. Some of the experiences and comments shared by the women were quite similar to each other, which is how the themes were developed. The principal investigator looked for key words and word repetition that were common in all the interview transcripts. For example, *modesty needs* was identified as a theme because of its frequent use when the women shared their personal health experiences.

The information that was derived from the interviews were all kept anonymous and confidential, in which the participants were reminded at the end of each interview. The name of each participant was not disclosed and instead codes were used to identify each person (i.e. Participant 1, Participant 2, Participant 3 etc.) The audio-recorded interviews were transcribed verbatim. All personal information of the participants retrieved from the interview sessions, such as name and age, were removed to continue to keep the anonymity of the women. The PI kept all original material of the audio recordings in a locked, private cabinet.

Prior to the beginning of each interview, participants were given a basic demographic questionnaire to fill out. The purpose of this was to obtain a characteristic of the population being studied. Questions regarding age, place of birth, and education, were asked to each of the women.

Nvivo, which is a qualitative data analysis package, was originally going to be used to aid in the organization and analysis of each interview script. However, due to the small sample size, it was best that the analysis was completed manually. Also, analyzing the data manually brings a sense of closeness to the data. According to Eben A. Weitzman (2000), for many experienced researchers it is difficult to get through raw data manually, however quite beneficial. The time that is spent sifting through countless amounts of paper work may sound tedious, however leads to "very rich and thorough familiarity" (Weitzman, 2000 p. 816). It is essential to recognize that software programs

are not eliminating this familiarity, however simply altering the process. With that being said, it is very important that new researchers receive hands on experience when undertaking a good analysis as opposed to using such programs (2000).

Researchers must identify possible biases that may surface during any research study. The principal investigator shares some similarities with the participants of this study, but one of the major similarities includes religious beliefs. Islam is a common dominator between both parties and because of this the PI can relate to many of the experiences expressed by the women, with respect to religion. Also, all participants were from immigrant family backgrounds and many of the barriers faced by them are relatable to the PI. These biases were kept in mind during the entire process of the study and although it was sometimes challenging, personal biases were geared away from particularly in the analysis and interpretative section of the research. For example, the interview guide was reviewed for leading questions, which can often influence participants to answer questions in a particular way. If any leading questions were found, it was changed and framed neutrally.

Interpretation

Interpretive interactionism is a qualitative framework coined by Norman Denzin (1989), which is used as a process in research to develop the understanding of everyday people through important issues or turning points. Interpretive interactionism allows researchers to center their attention on the following: “the interactional processes and the meanings people make of them, the turning point moments where the underlying social patterns are most likely to become obvious, and the private troubles of individuals and how these are related to the broader social structures and processes” (Denzin, 1992, p.202).

Interpretive interactionism stems from the major sociological theory of symbolic interactionism, which is based on the idea of putting the individual self in the place of others (Crotty, 1998). It is the simple idea that in order to understand patient-provider interactions, you must try to uncover patient experiences as they live them. Interpretive interactionism also allows researchers to examine experiences that change and mould patient lives and the definition they put on not only themselves, but the relationship with

others as well. By using this approach, it takes into account historical, cultural, and physical aspects that give meaning to such experiences. Ultimately, interpretive interactionism can influence the development and implementation of health policies by relying on the views and experiences of patients, who are the vital core to research (Mohr, 1997).

Denzin (1989) outlines six steps to his concept of interpretive interactionism, in which each process will be explained and then used to analyze the data of the current study.

(1) Framing the research question

The first process emphasizes the use of “how” in terms of framing the question as opposed to “why”, since the primary interest is the experiences of patients. This will assist researchers by understanding the experiences of patients with relevance to the social, cultural, and historical factors that impact these experiences (Tower, Rowe, & Wallis, 2012).

(2) Deconstructing

The second phase is quite an important aspect prior to conducting any research study. A thorough literature review of the topic area must be prepared first in order to get a background understanding on the current research that exists. This will aid in identifying any issues that may be prevalent (i.e. between patient and provider). Deconstruction emphasizes how the phenomenon was studied and entails a continuous review and analysis of the literature as the current study unfolds. This will also allow researchers to compare and contrast various studies and identify any gaps in knowledge in the current study that may have not been identified previously (Mohr, 1997).

(3) Capturing the phenomena

In this phase of interpretive interactionism, participant responses are “captured”; specifically, their experiences and emotions are shared and gathered for interpretation. “Capturing” is often used in the interview phase, where participants have an opportunity to have an open in depth dialogue about their personal experiences, which allows individuals to express themselves freely. This will allow them to create their own definition of their situations. Researchers are also encouraged to probe, to help stimulate “thick description” (Mohr, 1997, p. 282), which provides individuals the opportunity to discuss a range of ideas they deem relevant.

(4) Bracketing

Bracketing involves the separation of the actual phenomena from the context. This process assists researchers in further understanding the experiences of individuals by thoroughly examining the phenomena of interest. Once experiences and emotions are omitted, researchers are able to take apart the components of the context itself, exposing their true meaning. This will allow the interview to stand-alone and isolate any preconceived notions that may exist. Bracketing allows the research to tackle the subject matter on its own terms (Denzin, 2001). Themes will arise through the use of words and experiences of individuals and will ultimately aid researchers to connect and understand the phenomena at hand (Mohr, 1997).

(5) Construction

The construction phase involves classifying, ordering, and most importantly reassembling. (Mohr, 1997). As bracketing focuses on taking apart, construction does the opposite, and actually builds on bracketing. This is where the foundation for interpretation takes place in preparation for the final stage: contextualizing (Denzin, 2001).

(6) Contextualizing

The final phase allows researchers to present and discuss the phenomena in relation to the lives of participants and its relevance to the greater social world. It is important that what has been learned through the accounts of the individuals be thoroughly outlined and its influence on the social environment. Contextualizing uncovers how everyday people experience the phenomena (Denzin, 2001). Also, in this phase other data sources that may shape the phenomena, such as historical or current events, can be examined (Mohr, 1997).

Findings

Twelve Muslim women over the age of eighteen were interviewed from the Thorncliffe neighbourhood in Toronto. Each participant details their experiences based on the questions that were asked by the principal investigator (PI). Their responses are divided and categorized by themes, which emerged throughout the interviews.

To explore the responses of the participants, Denzin's "capturing" and "bracketing" phase from his concept of interpretive interactionism will be used. The capture portion highlights what participants discussed during the interviews and what meaning they give to their personal situations. Whereas the bracket section provides a summary of the major themes discussed with reference to the overall phenomena being studied, omitting emotions and excerpts. This allows the interview to stand-alone. In order to keep the anonymity of the women, codes were used to identify each participant as opposed to their names.

Capturing

Demographics: The participants ranged between the ages of 19 and 57 and had a medium age of 31. Eight of the women were originally from Pakistan, whereas the rest of the women cited India, Saudi Arabia, Eritrea and Somalia as their country of origin. Two of the women were born in Canada and the rest of the participants were born outside of Canada. All the women, with the exception of one, cited English as their second language. Eight of the women have completed post-secondary education and the rest of the participants are either in the process of completing a degree or have no formal education completed in Canada. The two women that cited not having any formal education in Canada stated they did receive some education from their home country of Pakistan. Also, participant twelve (P12), four (P4), and eight (P8) all stated that they held a master's degree.

Visitation Frequency to Health Provider: All the women explained how often they visited a health provider and described different reasons for their visit. Five of the participants stated that they visited a health provider when the medical issue became constant and the severity of it increased. Otherwise, they relied on over the counter medications to solve their problems. Participant one (P1) says she visits her doctor two-three times a year, however she prefers solving her illness with basic home remedies. Whereas participant five (P5) and two state that they both visit health providers frequently because they require more health care. *I go often, I am older now so I get sick often, so I have to visit more now (P2).*

I usually stay at home and use natural remedies to get better like ginger teas and soup. If it gets bad, then I go to the walk-in clinic closest to where I live (P3).

I usually visit walk-in clinics...but I try to just solve the problem on my own with over the counter medications and stuff like that...it's just easier (P1).

Participant eleven (P11) says she does not visit a health provider often, unless the problem is of a serious nature that she cannot solve on her own. She visits her family doctor at least once a year for routine check-ups...*I tend to not go to see the doctor unless*

there is something that is constant and I can't handle through an herbal method (P11).

The participant visits her family doctor and if he is not available, she turns to walk-in clinics where she sometimes encounters issues.

...I don't like it there (walk-in clinics), I feel like they always misdiagnose me because they don't know me as well my doctor. My doctor has treated me for the last twenty-three years, so I feel he knows me better. So, I always try with him first, then if I am very ill, a hospital...and moderately ill, I will go into a walk in clinic. Depends on the situation, but my doctor is number one (P11).

Description of Last Visit to Provider: The descriptions of the participants' last encounters with a health provider were described as "standard" or "routine check-ups" from the women. Participant five (P5), who is 57 years old, often visits her provider because she lives with diabetes. She says she visited a walk-in clinic recently to make sure everything was going well with her illness. She describes it as a basic visit that did not take much of her time. She uses a walk-in clinic because there is either a long waiting list for her family doctor, or her family doctor is not available.

I usually go to a walk-in. I don't like hospitals...the emergency room, it is very uncomfortable. And my family doctor... sometimes it's a long time for an appointment or he is not available that often, so it is just easy for me and my family to go walk-in, even I don't like walk-in because wait times are too long, but a little better than family doctor sometimes... (P5).

My last visit to the doctor's office was terrible. I was feeling very sick and was so fatigued and when I went in, there was a two to three hour wait. I waited about thirty minutes when I realized how drowsy I was and needed to lay down. The receptionist told me to leave and come back, but that was not possible considering how bad I was feeling. I decided to leave and walked twenty minutes to get home, which was awful. I just decided to not go back and stay in bed because it wouldn't make sense to keep going back outside if I wanted to get better (P3).

Well [my last visit]...actually my family doctor wasn't there at the time, so I checked another doctor and he gave me false information and I ended up in the emergency because of that for two days (P9).

Seven of the women stated they mostly visited walk-in clinics because it was either convenient or their family doctors were unavailable. Participant eight (P8) refers to her last visit to her doctor as quite “confusing” because she noticed some changes in the walk-in clinic.

...It's very different now because it is technologically advanced, so everything is technology based. Even when you sign in, so it's very confusing for me who doesn't go very often because things are constantly changing... (P8),

I go to the walk-in clinic. I have a family doctor, but prefer to go to a walk in because it is closer and much quicker (P4).

I usually go to the same provider. Unless it is an emergency and I cannot see my provider right away. I usually find another walk-in clinic. But for the most part, I try to go to the same provider because I don't like to see different providers for my health needs because I feel like that affects the overall care that I receive (P1).

Provider Gender: The gender of a health provider was very important to the participants, where seven of the women specifically highlight a preference for only a female provider. Five of the women stated that they would seek care from a male doctor only for basic health illnesses. Participant one (P1) states she does not mind seeing a male provider, especially when it relates to basic health care needs. She emphasizes that if what she needs is gender specific, then a female provider is important to have (i.e. gynaecologist). She says she understands why many Muslim women do not like to see a male doctor for religious reasons and says she can relate to this. Whereas participant two (P2), who is fifty-five years old, says she only prefers female providers, regardless of the health service required. This is because she is a woman and feels comfortable with a female doctor. She continues to say that she believes her [female] provider understands her issues more, as opposed to a male provider. She also says there is a difference between male and female providers in terms of how they deliver care. This is why many Muslim women favour female providers. She believes Muslim women are able to express themselves more to a female doctor.

I prefer female...because I am female, so I want female doctor. It is easier for me and I feel more comfortable with a female. They understand me, and some of the things that I go through...mostly Muslim ladies they prefer the ladies because they can't express themselves and their feelings in front of the male doctors. It is really hard sometimes to talk to male doctor. I don't feel comfortable...(P2).

I think female providers understand you more sometimes, not all of them but most. And they have more of natural caring aspect to them, kind of like an instinct, whereas males tend to be more aggressive and emotionless, and even though it's not obvious, it's kinda seen through their actions and they mannerism. The good thing about women doctors is that if you explain a women's health issue to them, they will understand way more than the male because they most likely experienced the same thing at one point in their life or another. Whereas a male doctor just reads about it in books and what they learn in medical school. So women, we can relate to each other. That's why many women in general, not just Muslim people, prefer women doctors. It's a comfort thing (P11).

The women had similar commentaries regarding why they prefer a female provider as opposed to a male provider. They were not only comfortable with a female provider, but it followed cultural and religious practices. Participant five (P5) says women understand each other, especially when it comes to their health care needs. It is hard for her to find a family doctor who is a woman and because of that she often visits a walk-in clinic.

...I don't like to see male doctors, I prefer female...because they understand what it is to be a woman and everything we go through. I always try to see a female doctor, but it's hard sometimes. My family doctor is male...it's hard to find a female family doctor. That's why I usually just go walk-ins and ask for a female...(P5).

...Like I said because it's just a general check-up, it doesn't really matter, however I think if they were...if I did have some sort of illness...if it involved a lot of poking and prodding around then I would definitely prefer a female than a male doctor...(P6).

Participant eight (P8) says her current health provider is a female because she feels more comfortable describing her needs to a woman. She feels that Muslim women need a tailored type of care and her female provider meets her needs adequately. She explains

that she rarely sees male providers because she sometimes feels “odd” around them, which may have to do with her cultural background.

...I've only had female doctors, but when I go to a walk-in clinic sometimes there is male doctors. It's uncomfortable for me, I feel uncomfortable... I prefer a female, I just feel more comfortable talking...even regular checkups is more comfortable just for the simple fact that she is a woman (P8).

Though P8 has cited positive experiences when having a female provider, this is not always the case for others according to participant twelve (P12). Her current health provider is female and she says she strongly prefers women. The reason being is because the comfort level is higher with a woman and it is reflective of her religious beliefs. However, she recalls a situation where she encountered a female gynaecologist who was not friendly. She was quite surprised by this experience and did not return to that provider again. She explains how she felt quite sympathetic to the women in the community, which was considered a low-income neighbourhood.

...I wondered how women who were less versed in English language or Western communication styles fared with someone so detached and unpleasant to deal with. I also wonder if her manner was influenced by the income and racial backgrounds of her patients. I don't think her manner would be tolerated in a more affluent neighbourhood (P12).

Modesty Needs: Modesty was a common response for the women when it came to obtaining a female provider. Participant one (P1) says many Muslim women want a female doctor because Islam represents a sense of modesty for them. *In Islam, covering up is a sign of modesty, so that's why many women don't like to take off anything in front of male doctors or don't like to be touched (P1).*

I prefer my doctors to be female because I feel more comfortable when it comes to examine my private parts. I also prefer female for religious reason. As a Muslim woman, we are not allowed to show our bodies to man other than our husband. Therefore, is difficult to be examined by man, it makes me feel uncomfortable (P7).

I prefer to receive health care from a female provider, especially when it is gynaecological or obstetric in nature. It is more comfortable and in keeping with Muslim rules of modesty (P12).

Participant six (P6) believes providers should keep in mind particular patient values when delivering health services to Muslim women, specifically male providers. Many women are not able to express themselves directly to male doctors and modesty rules are a major factor for wanting a female doctor, she says.

...Muslim women do tend to be more reserved. They may not...you know, want to be like touched or grabbed or something as openly. So maybe they could...keep that in mind, I guess that's really it...For example you know when you go for like check-ups, like sometimes their like "okay we need to lift your shirt up so you know...we can like listen to your heartbeat" or whatever...because of that, if we had a male doctor they would definitely feel more uncomfortable you know, whereas if they had a female doctor, they would be like "yeah sure"...(P6).

Participant eight (P8) says the reason why she prefers a female provider is due to her cultural and religious background. There is usually a separation between men and women in the Islamic community in regards to having close interactions, and she cites this as a reason why she does not feel comfortable with a male provider. The participant does not wear a hijab, however regards it as a sign of humility. There can be a feeling of uneasiness for both patient and provider on how to effectively interact, which she believes can be change through education. The hijab is a universal symbol of respect and modesty and if providers were aware of different methods they can use to make a Muslim woman's experience better, perhaps it may help the relationship.

...I can see how someone wearing a hijab can like affect...their doctor who may be Caucasian...there may be some sort of uncomfortable feelings felt by the patient and the doctor right...because the hijab is sorta' like...modesty...you can't touch that woman, you can't nearly be open...talking to that woman because she is covering herself. So maybe the doctor themselves may feel uncomfortable or the patient may feel uncomfortable, so I think again it goes back to knowledge (P8).

Although modesty needs are important, one of the participants explained how important it was for Muslim women not to ignore their own health. She mentions how although some women do not like to see male providers or discuss their issues with them, they may not have a choice at times if it is a serious health matter. She says she understands why they would avoid care from male doctors because of religion, however it

is important that a person's health not be compromised. If the health issue is not serious or life threatening, then it is okay for patients to take the time and look for another provider or care facility that meets their specific needs.

...It is important because when they are assessing you there are certain boundaries, I mean...there are times that you cannot help it, you have to let the doctor assess you. But then, there are times when it is not needed, where your health is not in jeopardy, then you can have someone else that should understand that (P9).

Lack of Provider Understanding of Religious and Cultural Beliefs/Practices: The women explained how important it was for providers to understand cultural and religious beliefs and how it affects overall care. Participant one (P1) believes that health care providers should be familiar with her religious background because it will improve the care that she receives. Not just for her, but for many other Muslim women. She also explains that she does not expect a provider to know every aspect about Islam, however it is important that the details that influence a person's health be understood.

...I think just knowing that every year Muslims all over the world fast from sunrise to sunset for a month would be something important to know. This would be especially important knowledge for health care providers and in turn will be helpful to my father for example, who is a diabetic. You know, if his provider understood his religious obligation, the provider will then be able to assess the situation and provide culturally sound suggestions that ultimately are in the benefit of my father's health. Just to be aware...is very important (P1).

All of the women believed it was an important asset for health care providers to be familiar with the basic practices of the Muslim community. Participant one (P1), two (P2), five (P5), and eight (P8), all use the example of diabetes and believe it would be significant if they understood the influence that Ramadan has on individuals. Participant eight (P8) believes that without this knowledge, it can cause serious health concerns.

...I am diabetic...so nurse and health providers, they ask to go to the doctor and ask permission for the fast ... "are you able to do that fast or not?" so this is the first one...That every provider should know religious background of the people...that is something important to know. As a Muslim, fasting is important, but it can you

know, make problem for our health and make us more sick, if we have some kind of illness. So they should know how to talk to us about it (P2).

...I said before I am diabetic...so that means during Ramadan, I should not fast. I think if they knew more about Ramadan and why people do it, this will help them understand and can give us better direction on what to do...there is still a lot of people that don't know or understand fasting and Ramadan. And there is still a lot of Muslims who have diabetes and they still fast...they (doctors) should know when Ramadan happens so that when a Muslim patient comes in and has diabetes or something else, they can talk to them about it and why they shouldn't, but still respect, you know? (P5).

...There is a lot of things we do in Islam that affects our health so things like fasting right...we don't eat long periods of time and a lot of people who have issues such as diabetes or heart issues still continue to fast because it's there religious spiritually right...so they will continue to do that and if a doctor doesn't understand why we do certain things then there gonna' tell us not to do it, there gonna' say don't fast. They don't know the significance of it and that can create problems because if the patient continues to do that...continues to fast it can affect their health...(P8).

I think that if they did have, you know...some sort of knowledge about my beliefs, then they would...the way they would talk to me and the way they would interact with me, it would obviously be different. But I think that in a sense it would make me feel more comfortable. That's why I would be more willing to come more, (P6).

If providers are not able to connect with their patients, through understanding cultural and religious practices, this can become quite troubling for many older patients. Participant three (P3) recalls a time where her mother visited a doctor's office where she was questioned about her religious attire.

[My mother] has experienced stigma and offensive comments by a health care provider before. Her provider was a male and asked her why she wore the hijab. After answering his question he suggested that she might as well take it off because we're in a "Western" country and was very negative (P3).

She says because of the way her mother was treated, she stopped seeing that specific doctor and did not continue with a follow-up as she was directed to do so. Her focus was more on the negative experience and less on her treatment process to becoming healthier. She was angered by the encounter, which resulted in her mother disregarding

the recommendations given by the provider. She strongly believes that this should have never happened to her mother and expresses how important it is for all providers to recognize their personal biases and separate it from their care practice.

Although many women had a strong belief of providers having some knowledge on a patient's cultural background, participant nine (P9) expressed her concern for providers themselves. She believes they are not equipped with enough information on a patient's culture and religion. It is important for them to grasp the concept of cultural competency because patients seek their knowledge regarding personal health issues. Having the cultural understanding will assist them further when offering treatment regimens, she says. Although this is beneficial, she is unsure of whether this knowledge will improve the overall care for patients. The reason being is because providers do not have the time to research cultural practices of patients. She emphasizes that patients must be more understanding about what providers deal with on a daily basis. When it comes to emergency room care, providers do not have the time to find out the specific ways to deal with a patient's needs, especially if it is a life or death matter.

...It's not gonna' improve the overall care, they are going to get frustrated from what I know....it depends on what sector you are going to. If you are going to a walk-in clinic...that research has to be done before hand from you... but if you are in a hospital or in an emergency...you can't really help it... They are in an environment where they don't have time to make people's needs....so you have to understand the situation too (P9).

Factors that Influence Care Received By Muslim Patients: The women discussed some factors that they believed had an impact on the delivery of care. The most common answer was in regards to the Islamic veil, the *hijab*, which many felt had an influence on the provider. Participant five (P5) says the community she lives in is mostly comprised of South Asian Muslims and many people visit the same local health center. She believes that some nurses do not act appropriately towards visible Muslims and describes them as “rude” and not friendly. She is not sure whether this is attributed to the fact that the patients are mostly Muslim or if that are too detached to provide quality care. This is not the way to act in a health position and will cause many people to seek care elsewhere, she

says. However, she does say most providers are kind and do not focus on her Muslim identity, but still feels the hijab has an impact on the way she is treated.

I think every health person should be nice and open to people. Nobody likes people like that...then the people will stop coming and that's no good. I think mostly though people are kind, they don't care if I am Muslim, they will help, but they are always those people that don't know how to be, or what to do...I don't understand...I think when people can see you are Muslim, by like hijab and covering up, they sometimes might not give care the best...(P5).

The participant also discussed her experiences when she first came to Canada, not just wearing a hijab, but a *Niqab*, which covers the face and only leaves the eyes seen. She says she had a difficult time transitioning to Canadian society and using the health system was not easy.

...The doctors never understood what I was wearing...this was early 1990s, so I don't think many people seen a Niqab or understood Islam...whenever I use to go to the doctors, the doctors use to just rush me. I didn't feel he respected because I was covered up...and you know when I asked for a woman doctor, he was upset...kind of like insult...and I didn't understand...(P5).

Three of the women also highlighted that although they did wear the hijab, they have witnessed poor patient-provider interaction when attending a parent or relative's doctor appointment. Participant ten (P10) says if she were a visible Muslim, she would possibly not have the best encounters or her experiences would be different than what she currently has. She explains that she has noticed some differences in the way her mother receives care versus herself, which has resulted her to attend her mother's doctor appointments. Her mother does not feel comfortable going alone because she is not fluent in the English language and believes that her doctor will not take her seriously. She also adds that people with accents are treated "less" compared to a person who is fluent in English.

...My mother has gone to the doctors many times by herself and she speaks very little English and wears the head-scarf and has complained many times of the type of treatment she received. The doctor did not treat her for her health concerns, or send her for testing, or do any follow ups as my mother had severe chronic coughing that needed to be looked at further and more closely.... I do feel that if I was a visible Muslim the attitudes and interactions that providers give me would be

different from another person who is not a visible Muslim, in the way they would speak to me like an uneducated, non-western immigrant, who doesn't know anything, like I have seen many times with other women from my culture and religion. These visible Muslim women go through being treated badly like idiots and not being cared for properly through the healthcare system. Their care therefore is being compromised because of this negative, prejudice attitudes by some healthcare providers (P10).

I personally do not wear a hijab. However, my mother does and she has experienced stigma and offensive comments by a health care provider before. Her provider was a male and asked her why she wore the hijab. After answering his question he suggested that she might as well take it off because we're in a "Western" country and was very negative. She didn't feel comfortable after those comments and did not want him to go forward with the check-up (P3).

...Anyone can be Muslim right, but you can't really pick apart who's a Muslim or not, but when you are wearing a hijab it's such a big representation that you automatically know okay that person is of this religion. So, I think you know depending on [provider] beliefs and their perspectives you know...it would have some sort of effect (P6).

Similar to P10, participant nine (P9) says doctors may feel reluctant to provide care because they are unsure of how a Muslim would want to be managed. The participant explains that if she wore a hijab, her experiences would be different from her current encounters. *I go with my mom, she wears hijab, so then they know right away that she is Muslim, but I guess the level of interaction is a bit more casual then if I was wearing one (P9).*

However, not all the women believed that being a visible Muslim woman affected the care that they received. Participant two (P2) explains that she has not experienced a time where she felt being a visible Muslim affected the care that she received. She emphasizes that providers respect Muslim patients who wear the hijab because they understand what it means to the individual. Though she has heard of negative experiences from others, she feels "lucky" that she has not gone through those types of issues.

...They respect me and my hijab. Some doctors...they know...and understand what hijab means to me. So my doctor and some other ones that I have visited, they show always respect for me. And I like that and I respect them because of that....you know, I'm sure there are times where some doctors don't respect the patient when

they wear hijab, and I hear stories from friends and family, but me...I am lucky I guess...never happened to me...(P2).

Language Related Patient-Provider Communication Barriers: Communication was believed to be a major issue between patient and provider, especially in relation to language. All of the women discussed how important it was for patients to understand their provider and vice versus. According to participant six (P6), if providers are not able to understand a patient, due to language barriers, this may pose negative consequences for patients. Specifically, it has the ability to cause incorrect treatment regimens from providers or even diagnosis, she says.

...If the doctor doesn't fully understand what is wrong with you, if you can't explain all your symptoms and whatever to your doctor, they might not be able to make the correct diagnosis on the first try. So I think it's a big deal...(P6).

The majority of the women's comments were quite reflective of the above response and they understood how language barriers could affect the health of patients and their experience with health providers. They believed that if providers are unfamiliar with ways to deal with poor communication and language barriers, then it would definitely put a strain on the patient-provider relationship. Communication is not just about relaying information to a patient, but also involves patient understanding and receptiveness to that information. If this does not occur, then there is a clear disconnect in the communication process.

If the [patients] are not vocalizing properly their symptoms then they're not gonna' get the right medication or whatever...so I think language is a huge part. So they should go with someone who either speaks the language...so it doesn't create problems (P8).

If you cannot communicate with the health care provider what your concerns are, it just leads to frustration for both the patient and the provider and it might cause a bad experience (P4)

I think language plays a huge role for patient and provider. I think it is really important for both parties to understand each other, and the only way is through language. How will a doctor understand what a patient needs if language is an issue, or vice versa? How can patients express themselves if they don't know the language? Language is so important in health care (P1).

...When we go to our doctor they explain to us “you have this, this, this”and the person is like... ”okay”they just nod, and they write them the medication and they just take the medication knowing that...,this is going to cure whatever I have. But they need to really understand what is wrong to make it better and if...you don't speak English and if the doctor doesn't speak your language, it will be a barrier (P9).

Use of Translators: The use of translators was described as an effective way to bridge the gap in communication between patient and provider. However, several of the women cited issues with using a translator. Participant four (P4) discusses how difficult it can be for families who need translators. Often people use family members to try to bridge the gap in language between patient and provider, however she believes it can cause issues amongst them. The person might not want to disclose personal information to a third party. She also adds that this may affect the information translated, where only fragments of the health problems are relayed. This sometimes can lead to other issues for the patient.

...Often the person seeking care does not want to share personal information with the translator, but wants to tell the health care provider and in the process things get missed and that may cause issues. Often the patient gets care, but not to their full satisfaction and rating it maybe at a five out of ten experience. It's also hard to explain to the family member what the physician has said, especially if they use medical jargon that is hard to translate or when you don't know what they are talking about (P4).

She says the use of translators can be an effective way to transfer information. However, this is quite dependent on what the medical issues consists of. If the problem is a common cold for example, then a translator is appropriate, she explains. But if it entails “complex” or personal issues, then this may not be the best mechanism.

Six of the women shared their experiences acting as a translator for a family member, while three others discussed actually using a translator. Participant five (P5) explains that because she did not know English very well, she often required a translator. When she first came to Canada, translating services did not exist and she often had to rely on her family or friends, she says. Though this helped, it was difficult at times because she did not understand some of the terms that were being described to her.

...I did not understand some words, you know...like there is not a medical word in my language. So sometimes it would take longer to explain to me...but I think translators are good most times....and me now I speak better English, so I sometimes help some people in my community if they need translation for school or doctor or anything...but I don't do too much because English is still my second language, even though I understand better now...(P5).

...I was more educated now and could research information on health issues my mother was having and ask doctors questions and really be informed and involved, which the doctors also appreciated because it made their job a lot easier. I enjoyed translating for my mom...it is a great feeling for me (P10).

Although P5 has experienced some difficulties with using a translator, she still believes that it is a good way for patients and providers to understand each other. Though services are now frequently offered today compared to her early years in Canada, she says there are still many places that do not provide this important service. This can become an uneasy and stressful situation for new-comers who may have difficulties speaking English. *I think translators is good...it help me a lot when English was hard for me. But not everywhere has translators still...so usually people take their family members or a friend...(P5).*

I do think [translators] are effective, but I don't think we should rely on just like a person just standing there in between you know...translating like it does help a lot, but I think...I mean obviously you can't have some super human doctor who knows every language and everything. I think it's a good starting point and then maybe there should be other things. I don't know exactly what those things are, but there could be other improvements that could help with communication (P6).

Positive Experiences: The women shared their positive experiences with health providers and explained what made those encounters enjoyable. The responses ranged from provider attitude to wait times. Participant eight (P8) believes that the length of time that is spent with a doctor and whether he or she is attentively listening, positively influences the entire experience. If the provider is trying to understand a patient and is thoroughly explaining the details of an illness, then this makes for quality care, she says. Patients do not like to feel rushed and that is why many people label their interactions as a poor experience. This also is a reason why patients do not go back to that specific doctor

once they have a negative visit. The participant also says she has experienced positive encounters with doctors, which was often due the length of time of the appointment and the provider displaying a genuine concern for her health.

Participant nine (P9) experienced many positive interactions with her family doctor and says that most of it is due to the way her provider communicates with her. She says her doctor has developed a rapport with her and often asks questions about her personal life. This makes the experience quite pleasant and the ability for a provider to engage and connect with patients makes for a great doctor, she says.

...My family doctor went to the same university as mine, so it's like...he will give me advice regarding school, so it's not generally health related all the time. So they want to know what else is going on with your life (P9).

Participant two (P2) has encountered many positive experiences when visiting her health provider as well. She believes that some are very kind and have shown much respect to her and community members. She also adds the reason why problems occur is due to the lack of doctors available in some communities, which makes it difficult for others.

...They are very helpful and mostly...they give us free samples and take care of our families and ourselves. But I think it is because of the shortage of doctors here we get the problems. There are not a lot of doctors available. You know it makes harder for us...the doctors they try their best, to help and take care of us, and some are really nice and kind, and I like that...I enjoy very much (P2).

Negative Experiences: The women shared their negative experiences and explained what a poor visit to a health provider entails. They discuss a range of issues from receiving poor medical recommendations to being rushed from doctor appointments by providers. Participant one (P1) and participant three (P3) discuss a time where they received poor service from their provider. When ill, participant one often visits a walk-in-clinic and recalls a time where the doctor gave her and her mother a “strange look” as soon as she entered into the office. The doctor was not respectful and she describes her as “not friendly”. She says it was a bad experience because the doctor had set a negative environment and they did not feel welcomed. *We've gone back to that walk-in...but we*

always make sure we don't see her and see one of the other doctors, who are much better with their patients (P1).

Another poor experience involved a treatment regimen that did not work for participant three (P3). She felt that this was due to the lack of full attention from the provider and her disregard to her as a patient. If the provider had been giving her the care that she needed, which should include undivided attention she says, then perhaps the doctor would have prescribed her a better medication that would have eliminated her illness.

...The prescription she gave me ended up being something off the shelf and didn't even work. I ended seeing my regular walk-in clinic and they prescribed me something that did work and told me they couldn't believe that the previous doctor prescribed me that...(P3).

Participant eleven (P11) recalls a time where she had a severe skin issue that was worsening on a daily basis. She visited a doctor and he provided her with a small dosage of a treatment regimen, which did not last long. She realized that the doctor was not improving the situation. At the height of her skin issue, she was sent to a specialist, who was then able to provide her with a solution. She says this situation was quite disappointing and she did not like the way the first doctor handled it.

...I was very frustrated, as the clinic doctor did not understand that this was spreading and needed to pay more attention to me instead of rushing me for the next patient...(P11).

All the women shared a negative experience, with the exception of participant four and six, who say they have never encountered a poor experience with a provider. Participant four (P4) says the reason being is because she does not visit the doctor's office often. She reiterates that she only sees a doctor about once a year, which means limited interaction with a provider and also less chance of running into a negative situation. Participant six says she is fortunate that she has not had a bad experience with her health providers and hopes that she does not encounter any issues in the future.

...I personally have never had a negative experience because I rarely go see a provider. Get the experience over with as quickly as possible. To just get the care

that I need as soon as possible and deal with the consequences or issues after...(P4).

Dealing With Poor Provider Visits: The women who have encountered a negative experience all explained how they deal with these types of interactions with a health provider. For individuals who did not have any negative experience, they explained what they would do if they were ever confronted with poor provider visits. Participant four (P4) says depending on the situation she would most likely obtain another health provider. *If I am extremely uncomfortable I will probably leave, provided it does not compromise my health even more and seek another provider (P4).*

When participant ten (P10) feels that she has received poor care from a provider, she often finds another doctor that can better assist her. She says she stopped seeing her doctor because of a previous negative situation she had encountered, and ultimately switched family doctors. She believes that something should be done when situations like this occur for patients...*I think there should be a complaint line or something...where when you feel that a doctor is neglecting your care or not doing their job, a board or group can look into it (P10).*

Participant eight (P8) says she often avoids seeing a health provider because of the fear of having a bad experience. She explains that she does not have to deal with her health as often as an older person because she is young. Her solution to negative provider visits is to discontinue care with that provider. However, she sympathizes with those who may not be able to do the same thing.

Honestly, me personally this is why I don't see a doctor. This is why I go once or twice a year because if it's a common cold I can just let it pass and luckily I'm young, I don't have these big health issues...why should I go through all that hassle. But someone who's older, they can't help it, they have to go get their meds...so I can see how it can be frustrating...I just stop going, other people can't do that (P8)

I never go back to that doctor or health care provider where I receive a negative experience. Health care is very serious to everyone and if I don't feel that you're taking the time to understand my concern and you're rushing me, I will never go

back. I think all health care providers should take the time with each patient. That is why I like my family doctor he really takes the time to understand your concern and makes you feel comfortable. He also gives you the feeling that he will try his best to solve your health concern (P11).

Participant nine (P9) briefly discusses media depictions of the Muslim community and believes that if Muslim women were to get upset at a health provider or complain, this will perpetuate the negative stereotype that is already in existence.

[Poor experiences] are frustrating, but you can't be too negative about it. I just feel like how you act represents your community and you don't want that because...[Muslims] already have that misconception from the media that we are angry people. Muslims are angry all the time, you treat them like that and they are angry...So you find out other things along the way too (P9).

All the women shared similar responses in terms of how they would deal with a poor provider experience. They each said they would discontinue their relationship with the doctor and either find another provider or go to a different facility all together.

Obstacles For Muslim Women: When asked about what they considered were obstacles for Muslim women regarding health care, participants provided various responses. The hijab, finding a female provider in close proximity and provider perception of Islam were just a few key comments from the women. According to participant two (P2), language barrier is a major obstacle for many Muslim women. She believes that it stops patients from seeking health care because they may be embarrassed of their level of English skills. She also highlights other factors that influence individuals from seeking care. These include issues in the home that may involve being a stay at home mother, with multiple children, or single parent households.

...And I think [seeking care] is hard, if you have lots problems in the home...like you know kids, or being poor or if you are single mother. It's hard. And that's why sometimes people don't go to doctor when sick, they think they can get better on their own...too many problems the people have sometimes...(P2).

...I myself do not wear hijab yet I'm finding it extremely difficult to find one close to where I live. I can't imagine how far a woman wearing hijab must travel just to see someone she is comfortable with. It is draining especially when you have children... (P3).

Participant five (P5) says Muslim women face many pressures on a daily basis outside of health. She discusses the difficulties that immigrant families face in regards to the changes they go through when coming to a new country. She believes there are a lot of problems that already exists when coming to Canada and not knowing the language makes it challenging.

...I think sometimes Muslim women, we have a lot of pressure because we have to do so much at home, and kids, and many don't understand the language...so it's hard to keep healthy, to go to the doctors, sometimes we don't have the time...or sometimes it's hard to explain what we want to the doctor. We come to the country for better life for our kids and sometimes it is stressful here...too much problems here for us...and we don't know what to do sometimes...it's too much here. When I call my relative back home, they think people here are rich and we live good life...but I tell them no no no it's hard here too....too much stress...and it's not easy. We come, don't know English in a far away country...so sometime this is why people get sick here...a lot of mental problems, you know...they don't understand....it's hard..(P5).

Participant Perspective of a “Good” Provider: The women gave their suggestions on what they believed to be characteristics of a good provider. Eight of the women cited having a positive attitude as an important factor during appointments, ultimately benefiting the patient-provider relationship. Participant six (P6) says providers must recognize their actions when treating patients, which is key to providing good service. She also adds that they should be “easy going” when interacting with patients. Whereas participant five (P5) believes many characteristics exist of a good provider and although not every doctor has these qualities, many should work to strengthen them. *They should be kind and respectful and have lots of compassion for the people you know...it's hard for immigrant family sometimes, not just Muslims, but all people...(P5).*

...There are many things that a provider should have...I think a provider must have good manners, respect and sympathy....that is really key, especially for people who have issues speaking English fluently...its hard (P12).

The three characteristics that a good health care provider should have is respect patients' beliefs, good communicator and caring. Those are the three important things I think a doctor should have and that are important to me (P7).

I believe that patience is definitely key to be a good health care provider. Some people are more expressive and direct with their issues others take probing and figuring out what the issue is. I would say someone who is open minded to different cultures and religions...they would know how to better handle situations with patients and would know when a patient feels a little uncomfortable with things they could re- assure them. Also, knowledge is important too, especially when dealing with a specific community (P11).

Participant Suggestions: At the end of each interview, all of the women provided their suggestions on what would make their experience better and what providers can do to create a better atmosphere for patients. Many of the comments mentioned not only the importance of provider attitude and being friendly, but also having knowledge of a person's cultural and religious practices. Participant nine (P9) says the first interaction between patients and health providers is crucial and providers must always begin an appointment having a positive demeanour. They should be "caring" and "warm" when they talk to patients because this will make them feel that they are being genuinely taken care of, she explains.

...When you have that first interaction with someone that doesn't speak English, it always helps if you greet them in their language....it really does because they will be like "okay I feel kinda' important..."(P9).

...I think all health care providers should have some training every year about diversity. They should learn about racial discrimination, stigmas, diversity...and should be penalized for doing anything of the sort. There should be policies that enforce this training and it needs to be a lifelong learning process, where again they train annually...(P3).

Participant three (P3) suggests that providers should research different religions and cultures to help strengthen their knowledge on specific communities. If a community is made up of a majority Muslims, then a good way to learn about them is to ask patients

themselves. She highlights that people enjoy teaching others about their culture and practices and providers “should not be afraid to ask”. Although many of the women discussed provider knowledge on a patient’s culture and religion, one woman in particular mentioned respect as an important attribute to have. Participant four (P4) says respect is key when it comes to health, especially when dealing with individuals who may not speak English fluently. Often, there is a stigma against those who do not speak English and providers should not follow the same patterns as others and treat them poorly because of it. They should always be aware of their personal biases and ensure that it does not reflect the way they provide care to patients.

...I would suggest that they be respectful to those individuals who have a difficult time expressing themselves and when visiting the doctor’s office or those who do not speak English that well. I mean, I think that there is a lot of negativity towards those who can’t speak English, not necessarily from doctors but in general. People view them differently and treat them different too, even if it’s not intentionally, people tend to respond to them strangely. And often times this can be done unknowingly. So doctors and other health providers have to aware of this and try not to do it. I would want them to be able to understand my cultural and personal wishes...(P4).

I would suggest for them to be kind and show it, to listen and be attentive to their patients. Actually care about the health of their patients by being active and giving them options. Explaining things more, such as risks and benefits, which I noticed providers don't mention unless you ask. And for a person who doesn't speak English well or is a new immigrant, they will put all their trust in any provider because that’s what everyone is told they are supposed to do...that they are doctors and they are there to help you and care for you, which is not always the case (P10).

Bracketing

Twelve Muslim women participated in a one-on-one interview, where they discussed their experiences with health providers and their overall encounters with the healthcare system. Eight of the women were originally from Pakistan and the rest of the women came from varying countries such as, Somalia, Eritrea, India and Saudi Arabia. The women ranged in age from 19 to 57, having a medium age of 31. Eight of the women received post-secondary education, while the rest of the women cited having no formal education or were in the process of completing some form of post-secondary education. Also, three of the women explained that they held master degrees.

All of the women mentioned how frequently they visit their health care provider. However, for five of the participants this was reflective of how often they became ill. The more severe the illness, the more visits they would have to their doctor. Participant five (P5) and two (P2) highlighted that because of their older age, they require regular appointments to the doctor's office and frequently use other health services. Whereas participant six (P6) says she rarely visits a health care provider and vaguely remembers her last visit to her doctor. Some of the women also explained that they often solved their medical issue with over the counter medication or home remedies before taking their concern to a doctor.

The concept of gender was an important aspect for almost all the women and each cited their strong preference for having a female doctor as opposed to a male. A female provider is especially required for procedures that involve any physical contact. However, according to five of the women, when it came to basic health care needs, a male provider was acceptable. Participant nine's (P9) current health provider is male and says she does not have an issue with having a male doctor depending on the service she needs. If an assessment occurred that was invasive, such as a mammogram or Pap smear test, she would go to a female doctor. She would not feel comfortable going to a male doctor for that specific type of care. Although the majority of the responses were similar to that of participant nine, a couple of the women did say that it did not matter whether their health issue was basic or gender specific, they still preferred a female provider regardless of the service. Participant two (P2) says that her provider, who is female, understands her issues

more than a male provider would. She also says there is a difference between male and female providers and this is why women prefer the latter. She believes that many Muslim women are able to express their needs freely to a female provider.

The reason why provider gender is so important to Muslim women is because it is a reflection of their modesty needs. Participant five (P5) explains how important religion is to her and one of the reasons why she does not want to see a male provider is because she does not feel comfortable removing articles of clothing, that is if the medical issue required it. She feels that it is too invasive and she does not like to be touched because of religious reasons. All of the respondents believed that providers should keep in mind patient values when delivering health services to Muslim women, specifically male providers. Participant six (P6) says women are not able to express themselves fully to male doctors and modesty rules are a major factor for wanting a female doctor. The hijab was mentioned as a sign of modesty and how vital it was for all health providers to recognize this. It is also important for provider to respect any religious request of the patient (i.e. limited physical contact) in order to help make the care process comforting for them. The general consensus was for providers to understand and respect the modesty needs of a Muslim woman when caring for her health needs.

All the women believed that it was important for providers to have some knowledge of a person's religious and cultural background, specifically the aspects that affect health. The most common response was regarding the Islamic month of Ramadan, and how fasting influences a patient's health. If providers understood what the religious month entails, this will enable them to deliver care that is culturally sensitive, ultimately satisfying patients. Participant five (P5) believes this will also improve health outcomes for them and improve patient-provider relationship. Having this knowledge will also provide an insight into the daily practices of Muslim patients and allow providers to view things from their perspective. Participant nine (P9) believes that health providers are not equipped with adequate information on a patient's culture and religion. She says it is important for them to know this because patients seek their knowledge regarding health issues. Having that cultural basis will assist them further when offering treatment regimens, she adds. Although this is beneficial, she is unsure of whether this knowledge

will improve the overall care for patients. The reason being is because providers do not have the time to research specific cultural practices and beliefs. She emphasizes that patients must be more understanding of what providers deal with on a daily basis and understand there may be times where they may be unfamiliar with cultural customs.

The hijab was mentioned as one of the major factors that influenced care received by Muslim patients. Participant eleven (P11) says there are times when she feels being a visible Muslim affects the way providers interact with patients. Although she does not wear a hijab, she has witnessed some Muslim women who wear a hijab are treated when using health services. She describes growing up in a working class neighbourhood that was considered at risk and how the community was mostly made up of minorities. This included Muslims and many other cultural groups who did not understand the religious attire of Muslim women, which often led to poor treatment. Participant four (P4) also says because she wears a hijab, she has noticed a difference in the way providers attend to her health needs. She is able to tell whether a provider is comfortable with her based on the way he or she engages with her. Although most of the commentaries were similar to that of P11 and P4, one of the women (participant two) expressed that based on her personal experiences, she did not believe a hijab affected care. Participant two explains that she has not experienced a time where she felt being a visible Muslim affected the care that she received. She emphasizes that providers respect Muslim patients that wear hijab because they recognize its meaning. Though she has heard others discuss their negative experiences, she feels fortunate that she is not familiar with the problems that some Muslim women face. Three of the women believed that providers might be reluctant to provide care because they are unsure of how a Muslim woman would want to be managed. They are not familiar with the specific wants and needs of a Muslim woman, which may affect the care process.

Language barriers were stated as the most common problem for many Muslim women, which resulted in poor experiences with their provider. All the women felt that it was important for patient and provider to understand each other through a common language. Without this, it would be quite difficult for patients to express themselves and their health needs to a doctor. Participant six (P6) explains that if providers are not able to

understand patients because of language barriers, this can pose negative consequences for them. This may cause incorrect treatments or even diagnosis, she says. Language barriers can severely affect older patients who may already be dealing with poor health. Some of the participants share stories of attending a parent or family member's doctor visits because they felt they would not receive adequate care due to language barriers. Participant ten (P10) says she often goes with her mother to help explain her illness to a doctor and believes that without her presence, her mom would receive poor care.

With that being said, the use of a translator was viewed by majority of the women as a solution to language barriers. Participant six (P6) discusses how common the use of a translator is becoming in health care settings. She says many immigrant women, regardless of religion, are able to walk into various health sites and find a translator that speaks their language. Though she has never used or played the role of a translator, she feels that this is a good way to transmit information from one person to another. However, she also adds that providers and patients should not only depend on this mechanism. Participant eight (P8) describes a time where her grandparents used her as a translator. They were recent immigrants to Canada and did not speak English. She would attend their doctor appointments to help explain their medical issues. Also, because they were older, they required frequent medical attention. The participant notes how frustrating this situation was because she did not feel that her grandparents were the focus during the appointment, rather trying to translate correctly was the major concern. Other major issues that were highlighted by the women included information becoming lost through the translator if they were not fluent in the native tongue. Furthermore, six of the participants stated that patients may not want to disclose their personal medical illnesses in front of a third party because of privacy issues or fear of embarrassment.

All the women in this study have experienced positive interactions with their health provider. Many of the positive encounters often involved health provider's attitude and his/her ability to listen attentively to the needs of patients. If providers were friendly and caring, this indeed became a gateway to a positive patient-provider experience. For participant twelve (P12), a provider that is able to effectively communicate how they will treat the health concern builds for better health care encounters. Respect for cultural and

religious beliefs also created a better atmosphere for patients, she says. Participant seven (P7) says her male provider makes sure that she is comfortable and understands her modesty concerns regarding physical examinations.

All the participants, with the exception of two, said they had a negative experience with a health provider. These encounters were often related to poor attitude, lack of communication and ineffective treatment recommendations. Another negative encounter briefly discussed involved the rapid technology change that has developed in health care settings. Participant eight (P8) finds them quite confusing and believes it may cause problems for new-comers and older patients who may not be technologically savvy.

When dealing with adversities and negativity with providers, all of the women strongly stated that they would seek care elsewhere. Participant ten (P10) says she switched family doctors because she did not receive adequate care that she needed. Whereas participant eleven (P11) said she usually visits other walk-in clinics to see a new provider. This will in turn allow her to avoid any interaction with her previous health provider. Participant four (P4) and six (P6) are the only two women who stated they did not have a poor experience with a provider. However, they explain that if they ever were to encounter such poor visits, they would also discontinue care from that provider.

There are many obstacles that Muslim women face in health care settings and the women provided various answers on what they felt were major issues for the Muslim community. Participant five (P5) says external pressures exist for Muslim women on a daily basis that influence their health. She discusses the trials and tribulations of immigrant families and the transitions they have to go through when coming to a new country. She continues to say that many problems already exist when coming to Canada, such as communication barriers, which make it quite difficult to navigate through an unfamiliar health system. Others mentioned the hijab as an obstacle because it distinguishes a person's religion, which may cause others to treat them in a different way.

At the end of all the interviews, the women provided suggestions to health care providers and highlighted what they believed to be qualities of a good provider. Attentive listener, kind, empathetic and good communicator, were just a few common attributes

mentioned. Most of the women expressed how important it was for all health care providers to become familiar with their patient's cultural and religious practice that affect health. Participant eleven (P11) believes that if providers have the knowledge base and understand the barriers that Muslim women face, this will prepare them for any situations that may occur, which will ultimately help them become better health providers and strengthen the quality of care for patients.

The overall general message was to urge providers to keep an open-mind when interacting with Muslim patients and try to steer away from any preconceived notions about this community. Health providers should step out of their conventional ways of thinking and try to incorporate a new paradigm into their practice. The women stress how essential it is for all health providers to broaden their views on religions and cultures in a way that allows them to provide culturally sensitive care.

The next section of the thesis will examine the findings, which represents the "construction" phase of Denzin's *interpretive interactionism*, building on "bracketing" and adding interpretations. The "contextualization" phase will be signified by the discussion, which will review the phenomena and participants' experiences in relation to the social environment.

Table 1
Emerging Themes From Data Analysis

Provider Gender	<ul style="list-style-type: none"> • Strong preference for female doctor • Uncomfortable with male doctors, especially for women health issues • Patients able to express themselves more with female providers • Choice of provider gender is reflective of religious and cultural practices
Modesty Needs	<ul style="list-style-type: none"> • Limited physical interaction • More availability of female providers • Respect for religious and cultural attire and needs • Provider not familiar with modesty rules
Lack of Provider Understanding of Religious and Cultural Beliefs/Practices	<ul style="list-style-type: none"> • Ramadan and fasting should be understood by providers and how that affects individual health • Knowledge of modesty needs • Lack of cultural and religious practices leads to poor patient experiences • Reluctant to seek care to a provider that is unfamiliar with cultural needs
Factors That May Influence Care Received by Muslim Women	<ul style="list-style-type: none"> • Being a visible Muslim i.e. hijab • Language barriers • Stereotypes • Provider personal views (ethnocentrism)
Language Related Patient-Provider Communication Barriers	<ul style="list-style-type: none"> • English being a second language for patients • Not understanding terminology, medical treatment regimens, or illness • Poor communication resulting in poor provider experiences • Feeling of embarrassment by patient • Not wanting to return to providers for health need • May result in poor health outcomes • Afraid to speak up to providers. Fear that they will not listen

Use of Translators	<ul style="list-style-type: none"> • Sometimes effective • More translators should be available to those who cannot speak English • Information can get lost in translation • Patient may not want to share personal information in front of third party • Pressure on family member that are translators • Focus is taken away from patient
Negative Experiences	<ul style="list-style-type: none"> • Poor attitude by provider • Provider lack of religious/cultural understanding • Feeling rushed • Unfamiliar with modesty and religious health needs by provider • Poor explanation of illness or treatment • Failure to provide adequate treatment • Lack of listen of listening skills from providers • Feeling afraid to ask questions
Positive Experiences	<ul style="list-style-type: none"> • Provider was kind and had positive attitude • Able to provide effective treatment regimen • Understanding of modesty needs • Efficient length of time with provider during appointments • Familiar with cultural/religious needs
Dealing With Poor Provider Visits	<ul style="list-style-type: none"> • Stop seeing provider • Find a new provider • Writing a negative review online • No options
Obstacles For Muslim Women	<ul style="list-style-type: none"> • Language • Modesty concerns i.e. not wanting to be touched • Availability of female care providers and proximity (especially for maternity care needs)
Participant Perspective of a “Good” Provider	<ul style="list-style-type: none"> • Kind/sensitive • Open • Knowledgeable on patient culture and religion • Attentive listener • Respects modesty needs • Friendly • Sympathetic

Participant Suggestions	<ul style="list-style-type: none">• Providers must gain more knowledge about community• Availability of more female doctors• Cultural competence training in school• Do not make assumptions based on media• Decrease wait times• Improve maternity care needs
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Discussion

In the *capture* and *bracket* section of the analysis, important themes were identified from the interview transcripts of participants. Twelve themes in total were identified to assist in the exploration of the phenomena being studied. Provider gender, Muslim women modesty needs, lack of provider understanding of religious and cultural beliefs/practices, factors that influence care received by Muslim women, language related patient-provider communication barriers and use of translator, were the first six themes developed. The last six themes discussed the overall experiences of the participants as well as final commentaries to providers that will help improve patient overall care process. These included: participant positive and negative experiences, dealing with poor provider visits, obstacles for Muslim women, participant perspective of a “good” provider and final participant suggestions. These themes will be used to analyse the data obtained from the transcripts of the twelve women and provide further insight on their experiences and outline any potential similarities and differences.

Construction

Provider Gender and Muslim Women Modesty Needs

According to Andrews (2006), modesty has been recognized as a factor that may impact health care utilization. It is essential that providers understand the various norms of modesty and how Muslim women feel when modesty is kept. This will allow providers to develop an insight into cultural values and practices, which will improve their ability to provide quality care. Modesty is not specifically about articles of clothing and “covering-up”, however has a great deal to do with respect. A health provider that is able to implement cultural modesty into his or her practice is someone who is respectful and “caring in the highest degree” (Andrews, 2006 p. 444). In Islam, there are specific rules to modesty and the way a woman is dressed is a fundamental aspect of that. Modesty is also one of the many reasons why Muslim women have preferences when it comes to who will provide them care, specifically the gender of a provider. It is said that “gender-concordant care” (p.708) influences the seeking patterns of Muslim women, thus, inhibiting patients to delay their health needs based on availability of same-sex provider (Padela, Gunter, Killawi, et al., 2011).

Out of the twelve participants in the current study, seven participants emphasized that they only preferred a female provider. Also, they emphasized how female providers can be easy to relate to because they too are women, which allows them to express themselves freely. They also cited cultural and religious reasons for their preferences, however almost all participants mentioned the concept of comfort for further explanation of their reasons.

...To me personally, I would feel more comfortable around a female. I've only had female doctors, but when I go to a walk-in clinic sometimes there is male doctors. It's uncomfortable for me, I feel uncomfortable, I feel a little odd...I am not sure why, maybe because of the cultural background I come from...(P8).

I prefer to receive health care from a female provider, especially when it is gynaecological or obstetric in nature. It is more comfortable and in keeping with Muslim rules of modesty (P12).

The remainder of the women in this study also discussed the same reasons for choosing a female health provider as the ones previously cited, however it was also dependent on type of care that they needed. If they were seeking basic care that did not involve close contact, then they were okay with a male provider. If the visit involved a physical interaction with the provider or if they had to remove articles of clothing, they would then find a female provider for that type of care. Similar to the findings of Simpson and Carter (2008), some Muslim women in this study were okay with seeing a male provider—but only for basic health needs that involved minimal physical contact. This is quite important for all health providers to know and understand because this often is the differential factor between a positive and negative patient-provider relationship. A positive experience with a male provider is defined by the absence of “unnecessary touching” (p.20) as well as limited time alone with a male provider (2008).

It's not a big deal to see a male doctor if I just have a sore throat or something minor. However, if something is bothering me where I would need to take off clothes or get checked like a physical, I would prefer a female because I'd be more comfortable (P3).

...Regular healthcare issues such as the flu, cold or regular issues like that, I'll see male or female doesn't matter, but if it's women healthcare issues, I'll have to see a female because it's more comfortable to speak to a female doctor about female health concerns (P10).

The participants also added that religion served as a catalyst to seeking a female provider and explained how they were also more comfortable, as it preserved their modesty needs and adhered to cultural practices. According to Simpson and Carter (2008), the gender of a provider is quite important to Muslim women when health related examination occur. This is due to the combination of cultural and religious beliefs. Though, some Muslim women frequently face obstacles when trying to seek care from a female provider. One of the women explained that it is quite challenging attaining a female family doctor or a female provider in general due to travel and distance issues. This can be problematic for Muslim women when faced with health scenarios that are dire. It is interesting to note that the ability to choose a provider who is female is obtainable when the health care issue is non- life threatening. Patients can take the time

and search for a provider that meets their needs. However, in settings such as hospitals for serious and specialized medical conditions, challenges exist (Padela, Gunter, Killawi, et al., 2011).

Lack of Provider Understanding of Religious & Cultural Beliefs/Practices

Culture and religion are two concepts that are often intertwined and have a significant effect on health-related attitudes, beliefs and practices. If patients' religious and cultural needs are not understood, recognized, or accommodated, this creates a major problem for both patient and provider, also becomes an increased burden on the healthcare system (Hasnain et al., 2011).

Eight out of twelve participants stated that it was critical for all providers to understand a patient's religious and cultural beliefs. The idea was that having this knowledge base would assist them in accurately assessing and providing appropriate treatment regimens. The familiarity of Ramadan was given as an example by some of the women and how recognizing this will improve their health.

...Understanding the things that will help [doctors] with the health of patients can be beneficial. For example, I think just knowing that every year Muslims all over the world fast from sun rise to sun set for a month would be something important to know. This would be especially important knowledge for health care providers and in turn will be helpful to my father, who is a diabetic...(P1)

.... It would make it easier for the doctor to provide me other treatments and care that is appropriate to my religion. And I also would benefit from in terms of comfort and trust. It would make me feel better when knowing my doctor understands my background religion and that he can incorporate in the care that I receive...(P7).

Eleven of the women explain how important it is for their doctor to be acquainted with their religious practices, specifically the aspects that relate to their health. Four participants used the example of fasting (restriction from eating for long hours), which can affect any illness faced by patients. Diabetes has become the most commonly studied

disease in reference to Ramadan because of management complication due to fasting (Kridli, 2011). Many Muslim diabetics tend to not seek medical advice when it comes to managing their health because of fear of providers discouraging the fast, or implementation of strict monitoring of blood glucose. This may then cause irregular consumption of medication and a poor diet, which inevitably may cause severe medical consequences, i.e. hypoglycaemia (Whitelaw, 2005).

It is important to note that Muslim women do not expect health providers to know everything about their religion. They recognize the fact that people may not be familiar with their cultural needs (Simpson & Carter, 2008). Nevertheless, providers can make the experience better for Muslim women by asking questions, education, and generally going by a patient's social cues (Lawrence & Rozmus, 2001).

Being a health clinician, I know why a health care provider would ask certain questions and what they are doing. I would want them to recognize that I am a religious person, but my health should be considered the same priority as anyone else (P4).

Hijab and its Influence On Care

Seven out of twelve respondents stated that being a visible Muslim had some influence when receiving care. They believed that wearing a hijab had an effect on either the provider in terms of attitude and demeanour, or it changed the dynamic of a doctor's visit. Some participants highlighted that although they themselves did not wear a hijab, they recall poor situations with either a friend or family member who did wear the scarf. Participant ten (P10) believes that if she was a visible Muslim, she would indeed have negative encounters with providers.

I don't wear a hijab and if I did, I believe it would have impacted the healthcare I receive, where I probably would have been treated like my mother was. I would have been ignored, passed over and not cared for, as healthcare providers should care for all people (P10).

... You know when I first came to Canada I use to wear the Niqab, because I did not really know what to expect when coming to a new place and I also just came from Hajj so I was use to it...And I felt very uncomfortable when I go outside or going to the doctor...because the doctors never understood what I was wearing...this was early 1990s, so I don't think many people seen a Niqab or understood Islam...whenever I use to go to the doctors, the doctors use to just rush me. I didn't feel he respected because I was covered up...and you know when I asked for a woman doctor, he was upset...kinda you know insulted. And I didn't understand (P5).

All of the women suggested that being a Muslim was quite important to them and Islam defined their interactions with providers. The four women that did wear the Islamic head covering believed that it had somewhat of an impact on the way they were treated. Participant nine (P9) explained that the hijab is indeed one of the strongest symbols of Islam and allows others to identify her automatically with a group, without any verbal interaction. She further elaborated on negative perceptions and stereotypes that are often placed on Muslim women because of media portrayal. However, one participant stated that she did not believe the hijab influenced her doctor visits. She emphasized how providers were respectful to her.

Language Related Patient-Provider Communication Barriers

All respondents considered language and the ability to comprehend information the most important aspect of receiving health care. Many explained this was one of the key tools to effectively express to a health provider needs from a patient. If both parties do not understand a common language, then the ability to give and receive treatment and care becomes compromised. As mentioned earlier, studies have reported that language barriers have been linked to patient dissatisfaction, lack of comprehension and adherence, as well as poor quality care (Betancourt, 2002). Also, according to research, patients believe that when there is a language barrier in existence, their needs are never fully met. Thus, patients who have a lack of ability to communicate with their provider received fewer services in places such as emergency rooms (Bernstein et al., 2002).

...Patients should be able to communicate exactly what the issue is. When there is a language barrier, the patient cannot express exactly how they feel. The doctor may feel the client is talking about one thing, when the issue is a total separate issue (P11).

You know for me, English is hard a little, but I understand when people talk to me and doctors. I can express myself a little, even though I have an accent and maybe sometimes make mistakes, you can still understand me. But for many many people especially this community, English is second language, and some don't speak nothing at all. So I know, it's very hard for them. How can you explain to doctor that you are sick, if you can't understand them and they don't understand you? That no good. I feel sorry sometimes, for people. Especially old people like me, because they are sick and need the most help in health...(P2).

Six of the women felt that language barriers were the beginning of many issues between a patient and provider. Participant two (P2) expressed her concern for older patients that have more health issues and how difficult it may be for them because their health concerns tend to be quite serious. According to Yeo (2004), patients that are “older, poorer, and female” often have serious language barrier issues comparatively speaking to those that are “younger, wealthier, and male” (p. 64). Also, the author emphasized that women have more communication issues such as language barriers than men. This is indeed a major issue in women’s health and serves as a serious health hindrance for immigrant women (2004).

You know, I think [providers] try their best to talk to people who don't understand the language, and try to explain them what is wrong, if they are sick... I think most of them try their best...but they sometimes don't know what to do. And you can tell, you can see in their face, because they kind of get tired to explain...its hard (P5).

Use of Translators

The use of translators was a common solution among the participants to improve health services for those that did not speak English. Eight women cited language and communication barriers not necessarily with themselves, but shared detailed experiences about a parent or family member. According to Giordano (2007), the purpose of a translator is to provide precise translation of information that is not biased between a patient and a provider. Eight of the women said they have played the role of a translator in a health care setting for a family member, however none of the women cited using professional translator services.

I use to translate for my grandmother and the doctor use to communicate her treatment to me and I would explain it to her in my language. It was really great experience to translate for my grandmother. It made me more aware of her illness and the care she required and received (P7).

I have played the translator role for the most part of my childhood for my mother. Anytime we would visit the doctor I would translate what she says to me... I think it is effective if the person translating is fluent in both language. I don't see a problem (P3).

I think translators is good...it help me a lot when English was hard for me. But not everywhere has translators still...so usually people take their family members or a friend...sometimes when I needed to go to the doctors, I use to take my niece...(P1).

The women emphasized how beneficial and practical the use of a translator was and also shared personal difficulties they encountered while translating for someone.

I think it depends on the translator and how well they are able to comprehend the doctor's words, how well they know the patient and how well they can transfer the information. You are really at the mercy of your translator. I am not sure what alternative exists (P12).

I think it is a good way to relay information if the translator can speak both languages well and tell the provider what the patient is saying. But at times information can get lost in translation, so the doctors had to ask many important questions and the translator has to make sure to translate accurately and listen to what the patient is saying (P10).

...Sometimes it is a barrier because someone don't want to express him or herself in front of the third person...there is some secret thing only within their doctor and the patient. So it is a barrier...a big one. Sometimes you don't want to share your medical problems with people, and only you and the doctor know...so what should they do...?(P2).

...I think a lot of parents use their kids as translator for any service, but I think the problem begins when the translator isn't as fluent in their native tongue...It's a lot of pressure for the translator, sometime when I don't know what to say, and the person is looking at me, waiting for me to translate, but I can't...its tough, really hard, and I get stuck...talk about serious pressure...and then I try my best, but it makes it worse sometimes, the words come out wrong or something, and then it takes me time to get back on track....(P1).

Studies have found that family members and friends who are used as translators do not relay medical information correctly and often do not explain the medical gravity of a person's illness in order to protect them. The inaccurate ability to transfer information frequently has to do with the translator not being able to speak the patient's language fluently (Giordano, 2007).

Children interpreters have both advantages and disadvantages for both parties. For some children they seem to receive an emotional fulfilment and an increase in self-esteem because they were helping a family member. They also have the ability to speak isolated dialects that a professional translator may not know or understand. However, Giordano (2007) stresses the negative consequences that patients may suffer, due to possible inaccuracy of information given by children. The use of family members and children is discouraged and professional interpreters are seen as a better option for patients because they are trained and continually evaluated for competence (Giordano, 2007).

Although most of the women cite some difficulties with the use of a translator, they still believed it was an effective way to bridge the gap in communication between patient and provider. It was considered the most convenient way simply because professional translators are not available as often. With that being said, it seems that challenges exist with the use of both translator services as well as laypersons. Furthermore, the infrequent use of professional translator services by the women in this study may suggest that they may be unaware of these services or only prefer family members to take on that role.

Positive and Negative Experiences

Almost all the women in this study discussed both positive and negative experiences, when going through the processes of the healthcare system. Ten women stated that they have had a positive encounter with a health provider. The majority of the positive experiences had some relation, if not all, with a provider's attitude, demeanour and ability to explain information. If the provider seemed attentive to the patient and it was clear through body language, many would often cite that as a major factor of a positive experience. Similar to the studies of Roberts (2003), minorities often held a provider's attitude of high importance more so than language. If patients felt that the provider had a poor attitude, they would most likely not follow treatment recommendations.

Six of the women also stated that positive interactions with health providers were a reason why they came back to see the same provider again. Researchers have argued that it is not enough to just design services that function well, but more important to ensure positive experiences for both patients and providers. Positive encounters will motivate patients to visit the same health provider, which helps limit fragmented care (Wensveen, 1999).

...If they're spending a good amount of time with you, listening to your symptoms and actually trying to understand what's happening, it's that interaction. If that interaction is good quality, solid, then I will go back to the doctor. It's a pleasant experience, which I had in the past...(P8).

...I have had great experiences at my local walk-in clinic...the doctors are so knowledgeable and actually teach me things when I go there. They don't only tell me what's wrong and write a prescription they actually explain to me, for example, how a sore throat forms and how it looks, what they see and how the medicine will make it better. On top of that they are super nice and always get me better (P3).

Positive [experiences] a lot, but negative a little. They are very helpful and mostly...they give us free samples and take care of our families and ourselves. But I think it is because of the shortage of doctors here we get the problems. There are not a lot of doctors available. You know it makes harder for us...the doctors they try their best to help and take care of us, and some are really nice and kind and I like that...I enjoy very much (P2).

Ten participants stated they have experienced a poor interaction with their health care provider. These negative experiences varied through each respondent as they detailed their accounts. Some of the women cited they were being rushed and not listened to, while others noted poor results in medication treatments.

...The doctor was very monotone and seemed like she had no interest in me at all. She wrote something on a paper and walked out of the room and left the door open... It was really weird and rude because she didn't even tell me it was my prescription; she didn't explain to me what it was or why I'm supposed to take it...(P3).

...This particular doctor didn't give me the time to ask questions, he always rushed me out of his office. Every time I asked for referral he would be denying me saying that I didn't need it. I found him rude most of the time, when he especially rushed the visit...(P7).

...I was having stomach pains where I would get burning sensation in my stomach and my doctors told me to keep taking antacids as I told him it helped the pain, but did not get rid of it. After baring with this discomfort for over a year and I went back to him many times for the same problem, he didn't do nothing further about it, or take my blood, or send me to any specialist. I was fed up because I noticed he wasn't even trying to help me, or look further into my problem. Therefore, I stopped going to him and asked for another doctor who was new doctors in the same office. She was nice and kind and interested in helping and seeing what my problem was. She did a blood test and found out right away that I had a bacteria in my stomach and she prescribed medication and within a week it was gone! I was really upset at my so-called family doctor...(P10).

Participant ten's (P10) encounter with her provider exemplifies Hayes-Bautista's (1976) *patient-initiated termination*, in which the patient decided to end the relationship because she was not able to receive the care that she needed. As the theory explains, the patient deems the original provider "inadequate" in comparison with the new one because her issue was solved with a new doctor.

Another respondent shared detailed experiences where her doctor was not respecting her religious belief and found it strange that she did not participate in sexual activities prior to marriage, due to religious beliefs. She explains these questions came up as it related to a medical examination and felt that he did not mean any offensive intent.

She notes that her doctor told her he was an atheist and found the concept of religion “silly”.

...When I got married and a pelvic examination became relevant, I explained to him that I would see a female doctor for that kind of care. He was deeply offended by this, feeling that I was questioning his ability to be professional while examining a female patient. I tried to explain that it wasn't about him, but about my own religious views but he was too defensive to accept what I was saying. When he continued to challenge me directly about my perceptions of his professionalism, I told him that my husband was really adamant that my doctor be female when it came to breast and pelvic exams. While this was true, I was also more comfortable with a female doctor, but felt too intimidated to tell him this because he was taking it so personally—as if I was accusing him of being a pervert. So I used the excuse of my husband, which of course plays in to some stereotypes of the oppressed Muslim woman, but I was so uncomfortable with his anger I was just trying to dodge it. I tried to continue using his care because he had been my doctor my whole life but ultimately I left him because when I became pregnant he said he could not offer me any care without examining me fully. But I also left because his resentment of my religious practice was uncomfortable as well as extremely insensitive (P12).

Similarly, in a recent study on health care accommodations for American Muslim women, the participants experienced somewhat of the same encounters with their provider. According to Padela, Gunter, & Killawi, et al. (2011), most of the women in their study stated there was a risk of being treated poorly if they requested any cultural or religious accommodations. Also, one participant explained that her male doctor was angered by her request for a female gynaecologist. If providers are not able to become sensitive to the cultural and religious needs of Muslim women then negative implications will follow that will put them in compromising positions (2012). Although further research must be completed on Canadian Muslim women, it seems that their health experiences parallel that of their American counter parts.

According to Hasnain et al., (2011), a major example of how a provider and the healthcare system can lack sensitivity is through the inability to provide Muslim women a female doctor when delivering intimate physical examinations such as “breast and pelvic examinations” (2011, p. 80). Although these examinations are considered standard in Western society when performed by a male, this is not the case for the Muslim women

population. These are seen as “cruel violations” for Muslim female patients that will cause anger, and ultimately create resentment between health care providers and Muslim patients. The respondent’s example (P12) emphasizes the modesty needs in health care for Muslim women and how health providers should become familiar with these requirements, especially the importance of sensitivity. “Sensitive care must focus on the cultural uniqueness of the client” (Leininger, 2001, p. 258). Studies have shown that Muslim women with an immigrant background find physical examinations of intimate body parts to cause anxiety, which becomes a major health barrier for them. (Hasnain et al., 2011).

The experience outlined by participant twelve (P12) can be described by two methods of Hayes-Bautista’s (1976) *termination of the patient-practitioner relationship theory*. The *confrontation* method was used in which the patient told her doctor that she would no longer see him because she preferred a female doctor for pelvic examination and care of that nature. He was quite angered by her request and although he did not blatantly deny her, his overt anger can be viewed as such. The second method, *mutual withdrawal*, was developed towards the end of the termination, where both parties decided to go their separate ways because the relationship was no longer productive. Her doctor was unable to continue care because of her request and she, as well as the doctor, felt that termination of relationship was the only option forward.

The doctor-patient relationship is subjected to a variety of challenges that often arise from issues “in the focus of the relationship” (Stokes, Dixon-Woods, & Mckinley, 2004, p. 513) or the ability to maintain boundary lines. The ending of a relationship may transpire in numerous ways and is often dependent on who initiates the termination first. Though this experience may be negative for both parties, the dissolution of the relationship can also be considered the most “satisfactory” way of resolving a particular issue. The discontinuity of care is sometimes effective for both patient and provider. This often is because of mutual frustration on the part of patients and sometimes providers, which can lead to mutual separation, exemplified in the experience of participant twelve (2004).

Patients may find importance in the ability of being able to change health providers when they believe that their current provider has been ineffective when dealing with their health issues or any other obstacles they may face. The idea of “sought discontinuity of care” (Stokes, Dixon-woods & Mckinley, 2004, p.513) has become quite a phenomenon, in which further exploration must be continued. It is an important component in the patient-provider dynamic and briefly introduces the difficulties both parties face in a relationship that can potentially last for several years (2004).

Dealing With Poor Provider Visits

All the women who have experienced a negative provider interaction stated they would never return to that specific provider. They either find another doctor to assist them, or completely change health clinics. The two respondents that did not face any poor experiences explained that if they were to have a negative encounter, they would also no longer see the provider. The way the women deal with a negative situation can be viewed as *the fade out* method by Hayes-Bautista (1976), in which patients terminate their relationship with provider by discontinuing visitation to their doctor. Many explain their discomfort to continue to see a health provider is a reflection of their previous poor interactions. One respondent cited some regrets by not vocalizing her concerns and opinions to providers when such incidences occur.

I wished I spoke up for myself at that clinic I just told you about. I know that next time something like that happened I will express my concerns with the doctor directly and file a complaint rather than letting it go and just not going back. If I leave things the way they are she might harm someone in the future and give someone a prescription that doesn't work, what if it's fatal? It would be on my conscience (P3).

Three of the women stated they would complain if they came across any issues with a provider, however they often have reservations with this approach. They felt that perhaps this would further aggravate the situation and may cause strain on future relationships with other providers. For some Muslim patients, they do not have the choice of going to another doctor or finding another health facility because of varying

factors such as distance. External factors such as distance can be categorized as “over-riding conditions” described by Hayes-Bautista (1976) in which the ability to change providers is out of the patient’s control (Stokes, Dixon-Woods, Mckinley, 2004, p. 508).

I might complain or at least post a negative review online. But I think in general I am reluctant to complain seriously about doctors...especially when I have to return to the same place like a hospital...(P12).

...We get upset, talk about it with other people, and just make sure we don’t see that person again. There isn’t much you can really do...at the end of the day, it’s you that needs the care; this is about your health at the end of the day. Sometimes, there isn’t that option of finding another provider, sometimes you are just stuck with the one you have...you have no choice...crumby service in exchange for vital health care information...what would you do? This is your life, you need them more than they need you, so you just gotta deal with the poor attitude that comes with it...(P1).

I never go back to that doctor or health care provider where I received a negative experience. Health care is very serious to everyone and if I don’t feel that you’re taking the time to understand my concern and you’re rushing me, I will never go back. I think all health care providers should take the time with each patient (P11).

Poor provider experiences are one of the main reasons why Muslim women patients, or patients in general, do not seek health care or fail to keep up with their treatment regimens. When patients decide to discontinue service from their provider or delay treatments, this becomes an enormous health issue and can ultimately lead to severe health outcomes. This does not only affect patients, but also long-term difficulties are foreseen for the healthcare system (Hasnain et al., 2011).

Obstacles for Muslim Women

All participants highlighted various responses to what they think are major obstacles for Muslim women in health care. Two of the participants cited the difficulty of being able to find a female family doctor within close proximity. Seven participants mentioned being a visible Muslim woman as an obstacle when receiving care from a

provider. They explained that being a Muslim woman who wears a hijab can sometimes influence the perception of the provider, whether it is intentional or unintentional.

I feel that just being judged before being spoken too is a great obstacle for Muslim women just by wearing a hijab, and then other factors also play a role such as racism, sexism, and prejudice...(P10).

Trying to find a female provider who can take new patients. Finding a female provider in the area, especially if they do not drive and a provider who you are comfortable with. Being with a provider who you are not comfortable with can be a cause for concern...(P4).

One respondent specifically highlighted health care policies as a major issue for Muslim women and the need for policy changes. She believes modesty rules exist in theory, but not when it comes to changing policies that are already in place.

...The rotation schedule followed in most hospitals, even if you have a female obstetrician, she may not attend your childbirth. This policy means that Muslim women are forced to have male doctors deliver their babies against their preference...There should be some kind of system where a female health provider is on call for women whose religious practice requires female health care provision...(P12).

Participant seven (P7) discussed a family member who shared a similar experience when she was going into labour. She explained how the woman was religious and did not want a male provider to deliver her child.

...Her female doctor was not available. The only doctor available was a male doctor, and she refused to be seen by her. The hospital had to page another doctor from her home so that she can deliver her baby. Because she was Muslim woman and she felt that her religious beliefs was being compromised if she allowed the male doctor to deliver her baby...(P7)

Maternity health care needs of immigrant Muslim women are quite similar and they often face the same barriers. In the experience mentioned above (P7), the woman was eventually able to find a female doctor, who was called from her home that would delivery her child. Although there was a solution, the likelihood of finding a female

provider when they are not immediately available on site is quite slim, which poses serious complications for Muslim patients. These examples outline the need to improve accessibility of health services for Muslim women, specifically maternity care. “Changes that address the needs of immigrant Muslim women have the potential to create more inclusive and responsive maternity health services for all Canadian women” (Reitmanova & Gustafson, 2008, p.110).

To respect women’s modesty during physical examinations, few health providers are educated and trained to provide covers if needed. These expectations are quite important for Muslim women, especially when it comes to maternity care. Understanding the modesty needs of Muslim women must become extensive to all providers across Canada. By implementing training and changing policies to reflect the need of a growing, unique population, this will help strengthen cultural competency strategies. The Muslim women population is not a homogenous group, therefore it is important that care is delivered individually and information of patient needs is obtained directly from that person respectfully (Reitmanova & Gustafson, 2008).

Defining a Good Provider and Participant Suggestions

Participants described what they considered to be characteristics of a good provider. Listening skills was cited as the most common response from the women. All the women explained that it was important for the provider to be attentive when they were communicating their health needs. Also, it was essential for providers to have a knowledge base, not just clinical skills, but in terms of culture and religion. If providers had some sort of insight into a person’s background, they believed this would improve the interaction experience for patients.

At the end of each interview, participants were asked if they had any suggestions or comments they would give to health providers to improve their overall experience and receive cultural sensitive care. All shared various responses and touched upon a range of issues. Some mentioned ways to improve provider interaction, such as showing respect and compassion, while others discussed developing training classes for providers to be more competent about patient cultures.

I would recommend to them to have background knowledge of Islam and I would definitely recommend them to view Muslim women issue as a unique, but the same as other women. To respect the beliefs of others, I would recommend the providers to show no interest of religious bias to their patients (P7).

I think all health care providers should have some training every year about diversity. They should learn about racial discrimination, stigmas and should be penalized for doing anything of the sort. There should be policies that enforce this training and it needs to be a lifelong learning process, where again they train annually (P3).

Prioritize the comfort level of your patient...remember that seeing a doctor is a vulnerable act. Don't bring cultural assumptions with you when interacting with a patient and have respect for beliefs different from your own... different doesn't mean backward, just different (P12).

I would want my provider to know that the Muslim community is just like any other community in the sense that we want to be heard, respected, and be able to receive good care. It's that simple. I really don't think it's that complicated. I feel like there are these misconceptions with the Muslim community that a lot of people still have and I think the health world should separate that...me or any other Muslim woman that wants to see a female doctor, that's not a Muslim thing sometimes...most of the time it's just a woman thing, period. I know plenty of people who are not Muslim, but specifically search for a female doctor. It's not just our communities that want these things... (P1).

I would just say [to providers] to keep an open mind, I mean...what you are use to, that doesn't mean that's the only way in what there is. Usually, we are scared of what we don't know, or we just feel uncomfortable. Just like...do research or try to get to know people that are of different backgrounds and different religions and that will kinda expand your knowledge and work-view I guess (P6).

One participant commented on the structure of the patient-provider relationship, emphasizing that it was not her place to suggest to providers what they should do to improve care for patients. She explained that regardless of what she has to say, they will not listen.

...They won't listen to me. I am not the person to tell them do this or do that. You are only allowed to tell one problem at one visit. So they don't care about anything else...My family doctor right away she will say "no I can't do this for you right now, you have to go to another doctor". So I have to go...I can't explain my position to her that I need right now...she will say... "come to the next visit", then I do that one...so they don't listen to us. I fear that I will preach to them... (P2).

Patients often feel a sense of inferiority towards health providers, specifically doctors, which can inhibit them from speaking up or asking questions. This commonly has to do with the imbalance of power between patient and doctor, where doctors tend to hold more power than the patient because of their higher status (Goodyear-Smith & Buetow, 2001). Furthermore, this imbalance can be attributed to the nature of the medical world where historically, a patriarchal system existed. It was considered that doctors held “exclusive knowledge” (p. 132), in which they make decisions for all patients, particularly women (2001). The participant’s comments (P2) above also highlight the medical visit protocols (i.e. one concern per visit), interfering with her ability to receive the holistic and comprehensive care she feels she needs.

According to Steinhart (2002), medicine is a culture on its own, in which exists “unique languages, hierarchy, set of values, practices and expectations” (Steinhart, 2002 p. 444). Consequently, hospitals, health clinics and other elements related to the culture of health are often foreign to patients. Currently, healthcare is moving from less paternalistic and further into a patient-centered approach to increase autonomy for individuals (Steinhart, 2002). It is important that patients are empowered and have the ability to speak on and question health matters concerning themselves. Also, patients must be participants in the decision-making process with providers to improve health and wellness, without disempowering providers (Goodyear-Smith & Buetow, 2001).

Lastly, a significant commentary from one participant briefly shed light on a health topic that goes beyond the scope of this study, however is important for further research. She strongly expressed that all health providers recognize that no beliefs in Islam interfere with medical treatment or cause injury. She uses the example of female genital mutilation/cutting (FGM/FGC) and states it is not an Islamic practice, but in fact cultural. She was adamant that health providers disassociate this “cruel” practice from the religion of Islam.

Some medical providers might feel Muslim beliefs are at issue if they are unsafe. Female genital mutilation is absolutely a cultural practice that has nothing to do with most Muslim communities. Muslims come from hugely diverse ethnic

communities and it is unfortunate that this misogynist cultural practice has become conflated with Islam because it has nothing to do with it...(P12).

FGM/FGC and its effects on the Muslim woman receiving care is a vital topic that must be explored within the Canadian context. This practice occurs usually from the countries the women emigrate from, which poses challenges for health providers and patients as they settle in a new country unfamiliar with it. According to Lazar and Johnson-Agbakwu, et al. (2013), studies have shown that many health providers are unsure of how to offer cultural competent care to those that are circumcised. Furthermore, many seem to be providing care without following any protocols or having formal training. This indeed presents severe difficulties for circumcised women and may deter them from seeking care. “Western medical and cultural attitudes towards FGC are generally negative and can provoke moral discomfort and ethical conflict for providers...” (Lazar, Johnson-Agbakwu, et al., 2013, p. 7). By having knowledge and training on FGM/FGC and understanding the cultural context, providers will have the ability to assess the health of patients in accordance, thus improving the provision of culturally competent care for these women. This is indeed an important topic in women’s health and only adds further complexity for Muslim women seeking care. Future studies should examine the experiences of circumcised patients and their interactions with providers and its relationship with providing culturally competent care.

The women in this study have all shared their personal experiences using the Ontario healthcare system. Through this, they have discussed barriers when receiving care and have highlighted many important issues that need to be addressed, all of which points to the need for further research. In order to improve patient experiences, satisfaction and health outcomes, providers must acknowledge the existence of major impediments for Muslim women.

Contextualization

Implications

This study identifies a gap in cultural competent care for Muslim women in Ontario. Not understanding a patient's cultural and religious background limits the ability of providers to connect with their patients and deliver care that meets their needs. When a patient feels that they are unable to receive adequate care that factors in their religious and cultural beliefs, they will become reluctant to seeking care. This will cause them to only obtain care in the advance stages of their illness, as mentioned earlier, and subsequently result in poor outcomes and higher cost (Hasnain et al., 2011). Though this population varies ethnically and racially, their commonality of faith sheds light on challenges within the health care setting.

Finding solutions to barriers linked to communication has become a common issue when it comes to underserved minorities and immigrant patients. These efforts are both challenging and time consuming, as they involve policy changes. There needs to be training for both providers and patients that address the barriers related to patient-provider communication, which must be made a priority (Hasnain, et al., 2011). It is important to note that health care providers are not just "empty vessels" in which knowledge regarding culture and attitude must be dispensed. In actuality, providers are part of two cultures: mainstream society in which biases exist, and the culture of medicine, which also has its own biases. In the latter exist "values, assumptions and understandings" (Geiger, 2001, p.1700) of what must be done and how it can be done within the realm of medicine. The reduction of culturally based inequalities in health care must be viewed as a moral need, especially for the health care of women (2001).

The findings of this study underscore a disconnect between what Muslim women need from what they actually receive and have access to. Strategies must be developed and implemented that help strengthen the communication process between provider and patient that will ultimately improve the overall care process (Hasnain et al., 2011). It is also essential for care providers to be made aware that problems exist with patient-

provider communication. While patients may be frustrated with their health care experience, it is not necessarily true that providers also experience frustration. In some cases, health care providers may not appreciate that they have failed to adequately address patient needs because of the very communication barriers that cause such failure. For providers to prioritize better communication, they must understand just how much poor communication is negatively affecting patients' care experience. Sharing the findings of studies such as this one with health care professionals, offers providers the opportunity to hear frank and open evaluation of provider-Muslim female patient interaction that they might never have access to otherwise. While policy changes and training is integral to improving health outcomes for Muslim women in Canada, understanding that these women are underserved and marginalized is a place to begin for providers.

The women in this study touched upon many topic areas, however they raised a few key concerns about barriers they face in health care. The inability to access a female doctor is a hindering factor that strongly influences the health of Muslim women, especially when involving maternity care needs. This creates a compromising situation, in which these women are forced to have male providers care for them against religious beliefs. It leaves the impression that there is no place for religious accommodations in health care settings, which puts them in a constant struggle between health and religion. Health providers and policy makers must effectively work together to improve the existing structure of health care accommodations for Muslim women. Most importantly, synergies must be created with patients to help identify what is required to develop a unique care process that considers religious practices.

The choice not to have a male provider is not only linked with religious and cultural beliefs, but many of the women cited modesty reasons as well. In order to provide adequate services for Muslim women, providers must have a better understanding of Muslim conceptions of modesty. Acknowledging its relationship with Islam and its vital role in improving health needs is essential to the development of cultural competency strategies and protocols. Furthermore, male doctors are not immune from modesty tenets and it is important for them to understand that just being professional is not enough.

The findings of this study also support existing research and provide more reasons why health care services should be tailored to the needs of patients, in this case Muslim women. Though limited studies have been conducted, there is sufficient amount of literature that recognizes the challenges that exist for this population. Furthermore, this study builds on the knowledge base on Canadian Muslim women, where even fewer studies exist.

Study Limitations

The primary limitations of this study include the small sample size as well as the distribution of participants. They were self-selected Muslim women who decided to share their experiences using the Ontario health care system. Also, the majority of the women held degrees or were in the process of completing some form of post-secondary education. The findings of this study cannot be generalized to every Muslim woman; however they provide readers with a better idea of subjective experiences because its data relies on these particular Muslim women's own voice. If a larger sample were to be used to conduct a broader study, it may not yield similar results. If future studies consisted of a larger sample size, it would allow for in depth exploration of specific issues and how they are associated with particular demographic variables, such as country of origin, education, and religiosity (Hasnain et al., 2011).

Also, the majority of the women were from South Asian countries, Pakistan being the most cited. Muslims are often regarded as one large group, but it is important to remember that Muslims are ethnically and racially diverse, stemming from different countries worldwide. Participants of this research were recruited from a health center located in a predominantly South Asian community. Continuing studies on the Muslim community should reach out and include various cultural groups from different communities, to see whether the same issues occur or vary between ethnic groups.

The researcher's religious beliefs may be viewed by some as a limitation to the study. In actuality, the researcher's Muslim female identity aided the study because it facilitated data collection. During the participant accrual stage, some of the women asked whether a male or a female would be conducting the interviews. Many stated that they had a strong preference for a female interviewer. This may have to do with religious and

cultural beliefs, but ultimately related to comfort level. If a male interviewer had conducted this research, he would potentially be unable to accumulate as many participants. Indeed, the findings of this study support the concern that many Muslim women might hesitate to share personal medical histories with a male interviewer. If the women could not express themselves freely, this would hinder the study significantly. Instead, the women were able to share their stories and experiences without any hesitation or restrictions because they were comfortable with the interviewer. This ultimately helped the researcher capture raw emotions as the women detailed their personal accounts.

Conclusion

Summary of Findings

The current study has uncovered some insights into the experiences of Muslim women in the Ontario healthcare system. These personal accounts make it quite evident that challenges exist for Muslim women, which are bound to affect their health and well-being. One of the main reasons cited as to why participants did not have the best interactions with their provider was a lack of provider understanding of religious and cultural beliefs and practices. Language and communication barriers were also discussed and served as a reason for poor provider visits. Many felt that because it was difficult for them to understand their provider, they were not able to express their needs fully, which was why many labelled their experiences as negative.

Gender was a common theme frequently identified and was found to play a defined role for the Muslim woman in health care. Also, when discussing gender preferences, some of the women had stated that it did not matter if their care provider was male, under the condition that it was for basic health needs. They explained care that required more invasive procedures would without question entail a female doctor. These were also similar to the findings of Hasnain et al., (2011) regarding seeking a male versus a female provider, with some of the women in this study generating the same responses. Nevertheless, this does not mean that all Muslim women are flexible when choosing a health care provider. There are still some women that prefer seeing only a female health provider, regardless of the severity and nature of the health concern.

Although a few of the participants identified patient and health system-related barriers, the overwhelming majority discussed challenges specifically from providers, regarding the failure to understand cultural needs and poor provider attitude. This was often associated with poor patient experience. Subsequently, this hindered the communication process between both parties. The women believed that if a provider was not kind and sympathetic towards them, it became difficult to express their needs fully. A provider's demeanour and attitude had a strong influence on whether the experiences were classified as negative or positive. Furthermore, some of the poor experiences shared by these Muslim women were second-hand, specifically those of parents and other family

members. All of the participants came from an immigrant background and have parents, if not themselves, that do not speak English as a first language. Though most of the health care needs of Muslim women paralleled each other in this study, it seems that their experiences vary depending on demographic. The experiences that involved immigrant parents all shared quite identical stories, often involving language barriers, lack of communication, and poor provider attitude due to being a visible Muslim. Whereas those that were younger did not have as many negative experiences specifically of the same nature. Also, some of the younger participants did not visit a health provider frequently compared to older participants. This could be due to increase of health issues, as patients grow older. This reduces their chances of encountering a poor interaction with a health provider. However, this does not mean that young Muslim women do not have negative experiences, it seems that their encounters simply differ.

The descriptions of the experiences outlined by these women have also shed light on additional subjects that need to be addressed further. Media depictions and perceptions of Muslims and the cultural practice of female genital mutilation were two issues that briefly arose from the interviews. Although it may not appear immediately evident, both have some relevance to the health care experiences of Muslim women. The overall message emerging from the data was a call for health care providers to have respect for and some understanding of the cultural and religious health needs of Muslim women. Also, recognizing some of the barriers that many of these women face during the process of seeking care.

Future Research

Limited studies exist that look at the experiences of Muslim women in health care and according to Simpson and Carter (2008), providers would indeed benefit from an increase of understanding of the health needs of this population. It is important that continuous work be done within the Canadian context that will assist in the development of effective strategies that promote cultural competent care for Muslim women. It would also be beneficial if studies were conducted that compared demographics and see how experiences differ. This will allow health providers to recognize whether the issues the women encounter apply to all Muslim women or vary depending on factors, such as

demographic. Furthermore, comparative studies must be developed that look at the experiences of health providers and explore their personal encounters and perceptions with Muslim women when providing care for them. This will identify any problems that they too may face. With both perspectives studied, this will help reduce the communication gap between patient and provider and improve strategies that promote cultural competence in health care.

Also, it would be of importance for future studies to uncover what role religiosity plays for a Muslim woman seeking care. This may influence their health decisions, such as choosing a male or female provider and give a significant insight about the decision making process. Understanding this unique population can potentially lead to better quality care from providers, and ultimately contribute to combating health disparities (2008). Furthermore, this research may also have great implications for the overall health of immigrants as well as other ethnic groups (Padela, Gunter et al., 2011)

Appendix A

Glossary

Cultural Competent Care: The ability to provide sensitive care, with knowledge base on individual's cultural and religious beliefs, practices and values.

Cultural Safety: an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together with dignity, and truly listening (Williams, 1999, p. 213).

Ethnocentrism: View of things in which one's own group is the center of everything and all others are scaled and rated with reference to it (Neuliep & McCroskey, 1997, p.210).

Fasting (in Islam): Refraining from all foods or drinks during the holy month of Ramadan, from sunrise to sunset.

Hijab: A head covering worn by Muslim women. Unlike the *Niqab*, it does not cover the face.

Islam: The religion of Muslims, which is monotheistic faith that was revealed by the Prophet of Allah, Muhammad.

Niqab: A veil worn by some Muslims in public covering the face, leaving only the eyes.

Phenomenology: Refers to the study of lived experience from the perspective of the individual (Lester, 1999).

Quality Care: Refers to the ability to provide appropriate care and service in a timely manner that encompasses compassion, good communication, cultural sensitivity, and also leaves room for share-decision making (Hasnain, 2011).

Ramadan: The ninth month of the Islamic calendar in which Muslims around the world partake in *fasting*.

Shi'ite (or Shia) Muslim: Followers believe that Ali (Prophet Muhammad's cousin), was the rightful successor of The Prophet and leadership should have remained within the family.

Sunni Muslim: The largest sect of Islam. Followers believe after the death of Prophet Muhammad, his close friend Abu-bakr was his successor as the leader of Muslims.

Appendix B

Table 2: Participant Demographics

Country of Origin (Background)	<ul style="list-style-type: none"> • Pakistan: 8 • India: 1 • Somalia: 1 • Eritrea: 1 • Saudi Arabia: 1
Country of Birth	<ul style="list-style-type: none"> • Canadian Born: 2 participants • Outside of Canada: 10 participants
Age	<ul style="list-style-type: none"> • Youngest participant: 19 • Oldest participant: 57 • Average age: 31
First Language	<ul style="list-style-type: none"> • 1 participant cites English as first language • 11 participants cite English as being a second language.
Education	<ul style="list-style-type: none"> • 2 participants state having no formal education • 2 participants currently completing university degrees • 8 participants hold university degrees • Out of the 8 participants, 3 have Masters degrees

Appendix C

Consent form

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REB File#: 13-023

Title of Research: Cultural Competence in Health Care: Exploring the Experiences of Muslim Women within the Ontario Healthcare System

Introduction

You are invited to participate in research that will look at the experiences of Muslim women in the Ontario health care system. This proposed research will contribute to the development and implementation of best models of communication practices for health care providers. It is suggested that this approach will also assist professionals and communities in understanding the current research that exists concerning cultural competence, as well as adding to this body of knowledge that is still in its early stages. Furthermore, with the lack of empirical research on this topic, this study will assist in identifying gaps in the knowledge base and may be used as a guideline for further research, to promote positive and effective communication flow between patient-provider.

If you decide to participate in this research, a one-on-one, semi-structured, interview will be required for duration of approximately 30-60 minutes in length. These interviews will be audio recorded and the location of the interviews will be held at Flemingdon Health Centre located at 10 Gateway Blvd., Toronto, during a time that is convenient for you. Or if this location is not ideal, a convenient location for you will be arranged.

Risk/benefits

The risks that are associated with this study are quite minimal and do not have a negative impact on participants. Minimal emotional distress such as uneasiness may be experienced due to the discussion of personal negative experiences within the health care system. You do not have to disclose any information about yourself that you wish not to be incorporated in the study. You are encouraged to answer questions that you feel most

comfortable with and will have the option of removing yourself from the interview session at any time.

The benefits that will be gained from this study involve the increase of research on this topic, which current literature is limited. We cannot guarantee that you will receive any direct benefits from this study. However, we hope that it will stimulate conversation and promote awareness on the importance of cultural competence in health care. This study may aid as a guideline for all health care providers in Ontario and may assist in the development of cultural competent strategies that target the needs of Muslim women.

All personal identifying information that is retrieved from the interviews will remain confidential, unless you specifically ask to be identified. All original material of audio recordings will be kept by the lead researcher at the University of Ontario Institute of Technology's (UOIT) department of Health Science, specifically, the graduate office space in a locked drawer. All original audio recordings will be destroyed once interviews are transcribed and coded. Consent forms and transcripts will also be stored at the University within the same department. All data collected through the research will be kept for up to 7 years for reference, that is if future research is needed.

By signing this document, we plan to disclose this information to UOIT, as a written research study document, followed by a final presentation of the research findings. It is important to note that there will not be any identifiers that will expose your identity in any way shape or form. Your decision whether or not to participate will not prejudice your future relations with UOIT. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without any questions asked. If participants decide they no longer want to be a part of the research after the interview is complete, they will have the right to withdraw their data that was retrieved during the interview and any audio recordings that were previously gathered will be destroyed.

Before you complete and sign the form, please ask questions on any aspect of the study that is at all unclear to you. If you have any additional questions, please feel free to contact, Zuhour Nur at 416-797-0480. Or you may contact the Research Ethics Board

(REB) compliance officer at (905) -721-8668 ext. 6393 or you may email them at compliance@uoit.ca

You are making a decision whether or not to participate. Your signature indicates that you have decided to participate, having read the information provided above.

By signing this consent form, I understand the details of this research outlined above and understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below. By consenting, I do not waive any rights to legal recourse in the event of research-related harm:

_____	Print Name _____
Date	
	Signature _____
_____ AM/PM	
Time	
_____	_____
Signature of witness	Signature of principal investigator

I acknowledge that I have received a personal copy of this consent form. Copy received: _____(Initial)

Appendix D

Interview guide

Background

1. When was the last time you visited your health care provider?
 - a. How often do you see your provider on average in a year?
2. How would you describe your last visit to your provider? Explain?
 - a. Are most of your visit experiences similar to the one previously just mentioned?
3. When you are ill, do you visit your family doctor, walk-in clinics, hospital or other?
4. Do you consistently go to the same health provider when seeking basic health needs? Or do you seek care from various providers?
 - a. If you seek care from various providers, why is that?

Gender

5. Is your current health provider(s) male or female?
6. When you visit your health provider, does it matter whether you receive care from a male or female provider? And how is that choice important to you? Explain
 - a. What are the differences between receiving care from a male provider versus a female

Religion

7. Do you think it is important for your health provider to be familiar with and understand your religious beliefs? If so, how would that be beneficial?
 - a. How do you think that knowledge would improve the overall care that you receive? Elaborate
8. Have you ever had an experience where you felt being Muslim had an impact on the care that you received, or know someone that shared this experience? Elaborate.
9. Based on your experience, do you think there are differences between the way a health provider gives care and interacts with a Muslim woman versus someone that is non-Muslim? Please elaborate.
10. Hijab is an important part of being a Woman in Islam, do you think being a visible Muslim influences the attitudes and interactions of providers? If so, elaborate.

Communication

11. What role do you think language plays for a patient, when communicating their needs to a health provider?

12. How do you think providers handle language barriers, for example, where for some patients English may not be a first language?
13. Have you ever played a role of a “translator” for someone, i.e. family member, friend etc....(or used someone as a “translator” when visiting your provider?)
What was the experience like? Explain
 - a. Do you think that is an effective way to relay information from patient to provider? Elaborate.

Positive and negative experiences

14. Can you recall a time where you had a negative experience with a health care provider? Or in general, when going through the health care process? If so, could you explain what made that experience negative?
 - a. What do you do when you have a negative experience? (How do you handle the situation?)
15. Have you ever had a positive experience when dealing with a health provider or in general, when going through the health care process? Please explain what made it a positive experience?

Muslim women population

16. What would you want your health care provider to know about you or the overall Muslim women population?
17. What do you think is a major obstacle for Muslim women receiving health care?

Suggestions and comments

18. What suggestions would you make to your health provider to ensure that you have a positive experience and receive culturally sensitive care?
19. Name three characteristics that a “good” health provider has?
20. Is there anything else that you would like to say or add on to that you did not discuss?

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