MUSLIM ADVISORY COUNCIL OF CANADA

Office of Community Engagement | McMaster University

Scoping Review: Research on Islamophobia in Healthcare Settings

Table of Contents

Organizations Behind the Report

Muslim Advisory Council of Canada

The Muslim Advisory Council of Canada is an award winning, non-partisan, not-for-profit organization amplifying cross-country dialogue and policy priorities of Canadian Muslims on the intersectionalities of Islamophobia. Our goal is to equip executives and leaders with information that allows them to be active participants in dismantling Islamophobia.

McMaster University Office of Community Engagement-Research Shop

The McMaster Research Shop works with public, non-profit, and community organizations in Hamilton to provide plain-language answers to research questions. McMaster University is one of only four Canadian universities ranked among the top 80 in the world by the major global ranking systems. As the home to over 70 research institutes and more than 31,000 students, we pride ourselves as a hub for innovation, discovery and growth.

MUSLIM ADVISORY COUNCIL OF CANADA

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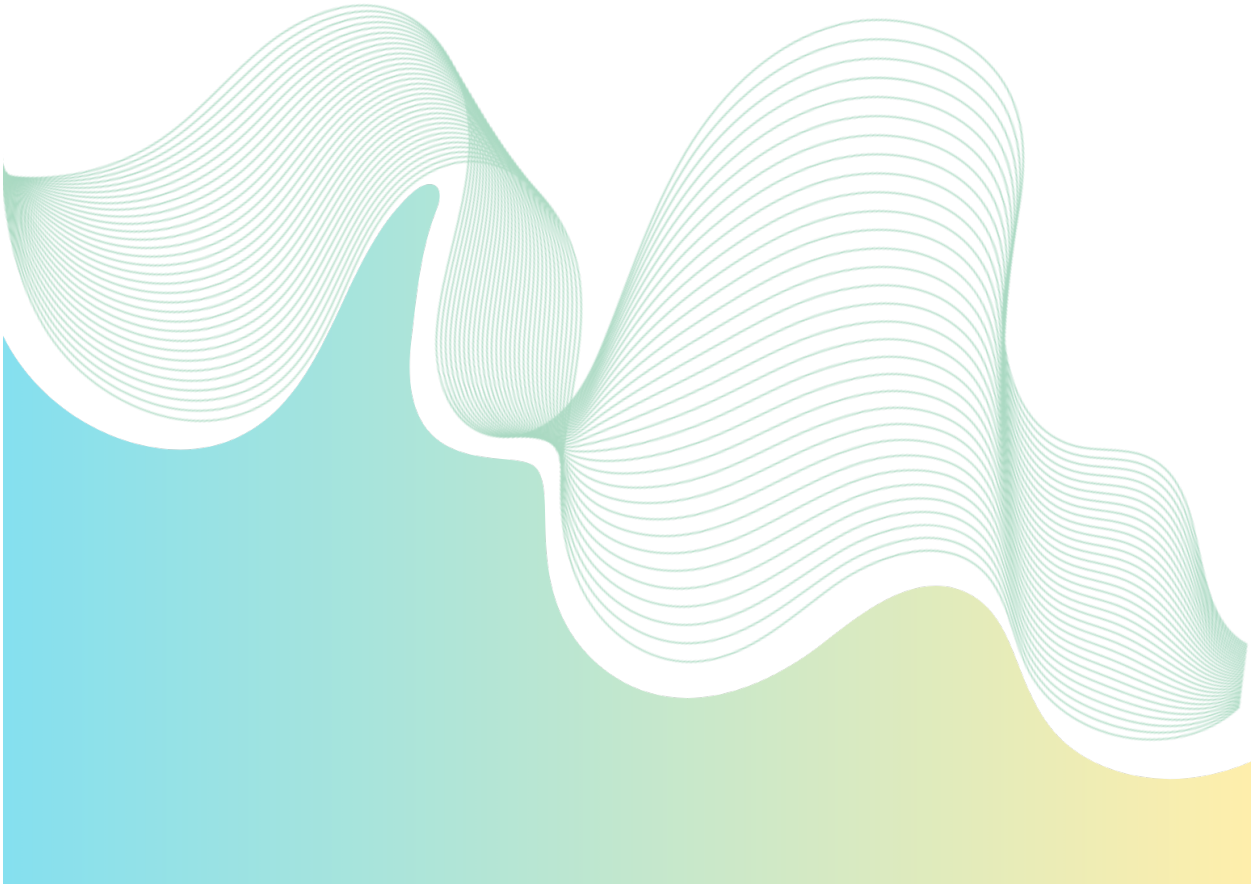
Executive Summary



The Canadian healthcare system is responsible for ensuring appropriate and effective care for all its citizens, yet evidence suggests not everyone is treated equally. In the Fall of 2022, the McMaster Research Shop partnered with the Muslim Advisory Council of Canada to investigate experiences of Islamophobia towards Muslim women and children in the healthcare system. To do this, we conducted a scoping review of published academic literature assessing the extent and impact of discrimination towards the target population in Canadian, U.S., and U.K. healthcare settings. We searched for published studies in 5 academic databases and found 14 articles to include in our review.

Studies used a mixture of qualitative and quantitative research designs to investigate experiences of discrimination towards Muslim patients in a variety of healthcare contexts. These contexts ranged from hospitals and in-home care settings to studies focusing on maternal vs. mental health services. We did not find any studies about children's experiences of Islamophobia in healthcare. Assessments of the extent ofIslamophobia differ according to the kind of discrimination experienced and the healthcare setting in which the study was conducted. Though overt incidences of discrimination were uncommon, several studies suggest other forms of discrimination directed towards Muslim women, such as being treated dismissively by healthcare staff, are commonplace experiences. Moreover, these negative interactions may impact the type and quality of healthcare Muslim women receive as well as increase their fear and distrust towards the healthcare system.

Our review suggests that research on Muslim patient experiences of Islamophobia in healthcare settings is lacking, especially those focusing on women and children in their relevant healthcare settings. To our knowledge, there have been no large-scale Canadian studies quantifying the extent of Islamophobia towards Muslims in Canada using representative samples and validated measures. Moreover, reliance on self-reported measures and other sources of bias in existing studies may undermine their validity.

While limited in scope, our investigation suggests that there are obvious gaps in research about experiences of Islamophobia in healthcare settings, particularly for women and children in Canada. The Muslim Advisory Council of Canada should consider conducting studies on the experiences of Muslim women and children in Canadian healthcare settings and include participants from various cultures, ethnicities, races, and socioeconomic backgrounds. Interviews, focus groups, and scales can be used as methods to measure discrimination and should be guided by inclusive and ethical research designs, such as community-engaged research approaches. Finally, the Muslim Advisory Council of Canada may seek to reproduce studies examining the impact of discrimination, as most of these studies took place outside of Canada and were confined to particular healthcare settings.

Background

According to Health Canada,[1] the Canadian healthcare system is responsible for ensuring access to appropriate, effective, and culturally sensitive health services with the overall goal of improving the health of all individuals, including marginalized populations. Despite the emphasis on non-discriminative care, academic studies have captured instances of discrimination in healthcare settings.[2–5]

With nearly 1.8 million Muslims in Canada, Islam is the second most common religion in the country.[6] From 2001 to 2021, the Muslim population in Canada has more than doubled from 2.0% to 4.9%.[6] Unfortunately, along with this increase in the Muslim population in Canada, there has been an increase in Islamophobia. Though the exact number of anti-Muslim incidents varies each year (Figure 1), there was a 16-fold increase in incidents from 2013 to 2019 according to the National Council of Canadian Muslims (NCCM).[7] These incidents included those reported to NCCM, the police, and/or the media. All cases were verified by NCCM.

Given the rise of Islamophobia in Canada, there is concern over the treatment of Muslims in healthcare settings.[2,3] The Muslim Advisory Council of Canada is an independent, non-partisan, not-for-profit organization dedicated to advancing cross-sector policy solutions to address health, education, and employment outcomes for Canadian Muslims, helping to build governmental and partnering organization capacity to deliver equity to marginalized communities. They are interested in examining the health equity issues for Muslims accessing healthcare in Canada, with particular focus on women and children. As part of this endeavor, the Muslim Advisory Council of Canada approached the McMaster University Research Shop (RShop) to conduct a scoping review to explore existing research about the extent and impact of religious discrimination in healthcare settings that Muslim women and children encounter. This plain-language report summarizes our research methods, findings, and recommendations, and seeks to inform the Muslim Advisory Council of Canada on how best to proceed with addressing healthy equity issues for Muslims in Canada. Though the Muslim Advisory Council of Canada's population of interest is Muslims in Canada, we included the experiences of Muslims in the UK and US in this scoping review, as these populations were deemed comparable by both Muslim Advisory Council of Canada and our team.

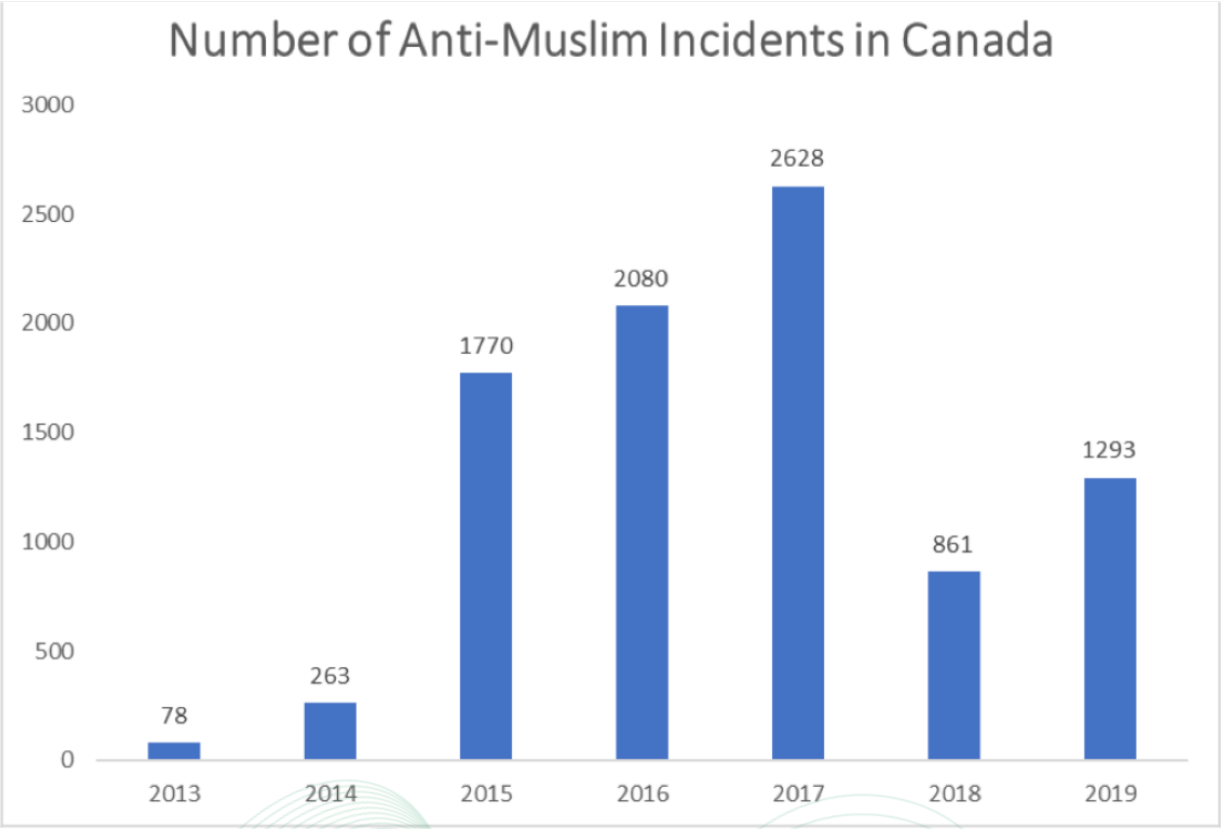


Figure 1. Number of anti-Muslim incidents in Canada by year [7]

Defining Islamophobia

The Ontario Human Rights Commission defines Islamophobia as “stereotypes, bias or acts of hostility towards individual Muslims or followers of Islam in general”.[8] Different forms of discrimination exist and not all forms may be intentional. Some researchers distinguish between discrimination and cultural differences or ignorance. For instance, Bawadi et al. interviewed eight Arab Muslim women and categorized their negative experiences related to attitudes and stereotyping as “discrimination and prejudice”, while challenges related to cultural differences (e.g., lack of private rooms, shared toilets) were described in other categories.[9] Michlig et al. distinguished between experiences of “outright discrimination” and reports of “bad vibes” from patients due to cultural differences.[10] Reitmanova & Gustafson distinguished “overtly discriminatory” experiences (e.g., stereotypes and prejudice) from insensitive remarks due to lack of cultural knowledge.[11]

On the other hand, some researchers suggest that cultural ignorance (e.g., culturally inappropriate care) is a form of discrimination, not separate from it. Worth et al. used the term "institutional discrimination" for services that do not meet needs such as halal food options and specific hygienic practices.[12] Duffy et al. categorized a Muslim patient's experience of not having private spaces as a form of discrimination.[13] The Muslim woman described being uncomfortable and having to "cover and ... expect anybody to walk in any minute."[13] Martin developed the Healthcare Discrimination Scale, which includes problems related to prayer rituals and Islamic holidays as part of its list of "discriminatory behaviours".[14] The study did not capture more details about the problems they experienced.[14]

In considering the various ways to frame Islamophobia, and in consultation with our community partner, for the purposes of this project, we define Islamophobia as either direct or indirect forms of discrimination towards Muslims. Direct forms of discrimination align with "outright" discrimination such as harmful treatment and deliberately insensitive remarks based on stereotypes and prejudices. Indirect forms of discrimination align with institutional forms of discrimination and a lack of cultural awareness such as providing a lack of halal food options and prayer spaces in healthcare settings.

Research Questions

1. What research exists, if anything, that explores the extent to which Muslim women and children face religious discrimination in healthcare settings?

a. What are the key findings?

2. What research exists, if anything, that explores theimpact of Muslim women and children facing religious discrimination in a healthcare setting?

a. What are the key findings?

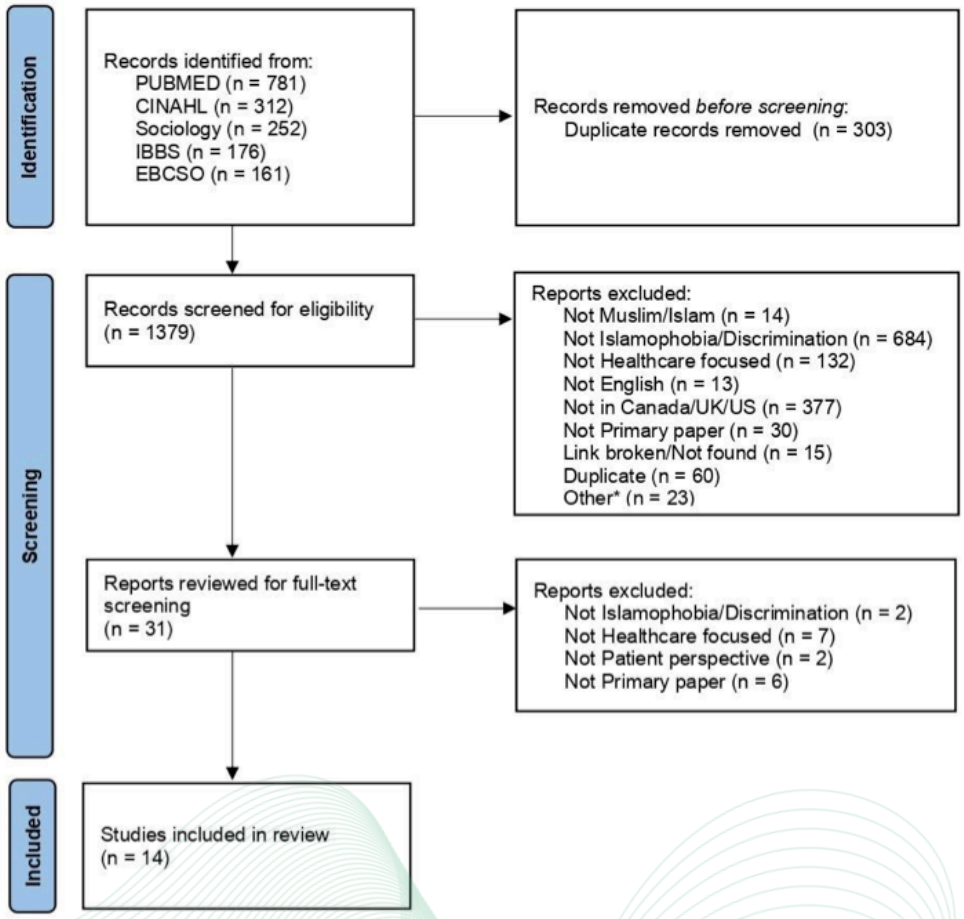


Figure 2. PRISMA flow diagram describing the steps of this scoping review

Methods and Limitations

Methods

We created specific keyword searches using three categories: religion (Islam), discrimination/Islamophobia, and healthcare setting. We used these keywords to search through five academic databases: PubMed, CINAHL, EBSCO, IBSS, and ProQuest Sociology Collection. We ran these searches in October 2022. After removing duplicates, we exported 1379 results for screening. We included studies in our review if they reported on: Muslim participants, perspectives from patients, Islamophobia and religious discrimination specific to a healthcare setting/experience, studies conducted in Canada/UK/US, primary research papers, and papers in English. After screening titles and abstracts, we found 31 articles that met our inclusion criteria and moved onto full text review. After further screening, we fully reviewed and included 14 studies in this report.

We collected four types of information from each study: (1) General, (2) Methods, (3) Outcomes of interest, and (4) Quality assessment. We collected general information such as study title, authors, country of study, and objectives. For methods, we focused on the sample size, target population (specifically, inclusion of women and/or children), data collection period, and type of healthcare setting. In the outcomes of interest, we looked at what the papers reported on the extent and impact of Islamophobia. We defined “extent” as any measure, quantitative or qualitative, of the amount of people who experienced discrimination and the types of discrimination they experienced. We defined “impact” as the resulting effects of discrimination, which can relate to emotions and perceptions, the medical care received, and views on the healthcare system, etc.. For the quality assessment, we considered how the authors measured Islamophobia, extent and impact, and whether these tools were reliable and/or valid. We also considered any conflicts of interest and affiliations reported by the authors as potential bias to the results.

Limitations

One of the most common limitations for scoping reviews is the possibility of not covering all the available literature due to database selection and inclusion criteria.[15] Our search included five well-known databases containing literature not only covering medical and clinical, but also sociology fields. Although we did our best to capture the breadth of knowledge out there, we might have missed studies that are published elsewhere (e.g., Google Scholar). We also did not search grey literature as we set out to report on primary research articles that have gone through peer review. We chose to only include peer-reviewed literature as it adds credibility to the research we are analyzing.

Another potential limitation to our study may have been our strict inclusion of primary (original) research articles. Our search results had many secondary review articles that may have referenced other original research articles that did not show up in our individual searches. As such, we might have missed some papers on this topic.

Moreover, while our main goal was to find experiences from a Canadian perspective, most of our papers originated from the US and the UK. Therefore, we may not be able to generalize their findings and recommendations to a Canadian context as these countries have different healthcare policies and governance.

A final point about the limitations of our study is the lack of formal quality assessment for the articles. While an in-depth quality assessment may have added more value to this report, our overall goal was to find the breadth of information that is available on this topic. This is typically what scoping reviews are meant for. We did, however, use a less rigorous form of quality assessment by briefly commenting on the methods used and the sampling characteristics of each study in this report.

Results

Study Characteristics

We included 14 studies in this review. All of the studies were published in academic journals except for one report from a community organization that was later summarized in a peer-reviewed journal article. Please see Table 1 for an overview of the study designs

Table 1. Overview of Study Characteristics

Citation No.	Authors, Year	Country	Study Design	Participants	Healthcare Setting	Islamophobia	
						Extent	Impact
9	Bawadi et al., 2020	UK	Qualitative	8 Arab Muslim women	Maternal health (hospital)	✓	✓
10	Michlig et al., 2022	US	Qualitative	168 Somali men and women	Mental health services	✓	✓
11	Reitmanova & Gustafson, 2008	Canada	Qualitative	6 immigrant Muslim women	Maternal health		✓
12	Worth et al., 2009	UK	Qualitative	7 Sikh patients and 18 Muslim patients, their family members, and their primary care providers	Palliative care		✓
13	Duffy et al., 2005	US	Mixed	73 total participants (one focus group with 5 Arab Muslim women)	End-of-life care		✓
14	Martin, 2015	US	Quantitative	227 Muslim men and women	General healthcare services	✓	
16	Alaloul et al., 2021	US	Qualitative	17 male and 15 female Muslim cancer survivors	Oncology		✓
17	Padela et al., 2015	US	Quantitative	240 Muslim women	Oncology	✓	
18	Padela et al., 2014	US	Quantitative	254 Muslim women	Oncology	✓	
19	Tanhan & Strack, 2020	US	Qualitative	118 Muslim students, alumni, staff, faculty, and parents of students at a university	University health centre		✓
20	Vu et al., 2016	US	Quantitative	254 Muslim women	General healthcare services	✓	✓
21	Alzghoul et al., 2021	Canada	Qualitative	19 Muslim women	Maternal health (hospital and in-home care)	✓	
22	Moscovitz et al., 2022	Canada	Quantitative	450 counselors and psychologists (focusing on Muslim woman's experience)	Mental health services		✓
23	Ali & Burchett, 2004	UK	Qualitative	43 Muslim mothers, 22 Muslim fathers, 8 healthcare professionals	Maternal health	✓	✓

The studies were published from 2004 to 2022. We found 8 studies from the US,[10,13,14,16–20] 3 studies from Canada,[11,21,22] and 3 studies from the UK.[9,12,23] The studies used various research designs: 8 studies used qualitative methods,[9–12,16,19,21,23] 5 studies used quantitative methods,[14,17,18,20,22] and 1 study used mixed methods.[13]

All of the studies included Muslim women as participants, though only 7 of them specified Muslim women as their target population.[9,11,17,18,20–22] Other studies explored the experiences of Muslim men and women,[14,16,19,23] included other religions,[12,13] or focused on an ethnic group that included Muslims.[10] We did not find any studies that focused on children's experiences of Islamophobia in healthcare settings.

The studies explored Islamophobia in a variety of healthcare settings, including hospitals,[9,21] in-home care,[21] and a university health centre.[19] Types of healthcare services included oncology, [16–18] maternal health,[9,11,21,23] mental health services,[10,22] palliative care,[12] and end-of-life care.[13] Two studies looked at healthcare services in general.[14,20] Various forms of discrimination were reported in the studies. Most studies focused on perceived discrimination, which is when patients felt they were being treated differently because of their religion.[9,10,12–14,16–18,20] Outright discrimination included rejection, harassment, physical attacks, and verbal abuse.[10,11,14] A subset of studies described healthcare providers' insensitivities towards Islamic religious and cultural beliefs, values, and practices[9,11,12,14,16,21,23]; implicit bias towards Muslim patients[22]; and harmful assumptions and/or stereotypes.[10,14,23] One study reported on the healthcare environment, such as the lack of prayer rooms.[19] None of the studies reported having conflicts of interest.

None of the studies reported having conflicts of interest.

Results

Extent of Islamophobia

Among the studies we included, 8 were related to the extent of Islamophobia.[9,10,14,17,18,20,21,23] Please refer to Table 1 for more information about study designs. We found two scales that were used to measure the extent of Islamophobia in healthcare settings. The Discrimination in Medical Settings scale was used in studies about cervical cancer screening,[18] breast cancer screening,[17] and delayed healthcare seeking.[20] This scale asks about how frequently Muslims are treated with less courtesy, less respect, and poorer service compared to non-Muslims. The Health Care Discrimination Scale was also used to measure the extent of Islamophobia in healthcare settings.[14] This tool includes a yes/no question about feeling discriminated against because of being Muslim, a list of discriminatory behaviours, and a space for participants to describe "other" types of discrimination they experienced.[14] Studies with qualitative approaches describe the extent of discrimination through individuals' perceptions (e.g., word choices like "rare"[10], "some of the women"[9,23]).

Healthcare experiences vary from person-to-person and not everyone experiences discrimination. Interviews with Muslim women in the UK found mixed experiences with midwives.[9] Some women felt that they were being treated with less compassion and one participant believed it was "because [she was] a Muslim and [wore] a veil".[9] Other women reported the opposite and that the veil was not an "obstacle".[9] Another study in Ontario interviewed 19 Muslim women about their experiences in perinatal care.[21] Most of the women in the study were pleased with how healthcare practitioners respected their religious and cultural beliefs, values, and practices. They also mentioned that healthcare practitioners were supportive of their requests for modesty and requirement of halal food.[21]

There is no clear estimate of how many Muslim women experience discrimination in healthcare. Only two studies gave a number, but they looked at different populations in different settings. In a study about cervical cancer screening in the US, 60% (145 out of 240) of Muslim women felt that they were *never* treated with less courtesy and 66% (160 out of 242) felt that they were *never* treated with less respect compared to non-Muslims.[18] These numbers were based on responses to a modified Discrimination in Medical Settings questionnaire.[18] Another study asked about discrimination in any US healthcare setting using the Health Care Discrimination Scale[14]. Out of 227 Muslim men and women, 27.6% (62) reported ever feeling discriminated against because of their religion.[14] However, since the study did not report results specific to women, it is unclear what proportion of Muslim women faced religious discrimination.

Some types of discrimination may be more frequently experienced than others. In focus groups with 168 Somali men and women in the US, researchers reported that "while experiences of outright discrimination by healthcare professionals were rare, there were instances where participants reported being treated dismissively by physicians, or looked at strangely by administrative staff".[10] The researchers did not report the number of times these forms of discrimination were mentioned.[10] Another study in the US used the Health Care Discrimination Scale to ask about discriminatory behaviours experienced by Muslims in any healthcare setting.[14] Among 164 participants, 91 (55.4%) reported being excluded or ignored, 60 (36.6%) experienced offensive or insensitive remarks, and 6 (3.7%) reported physical assault.[14] They also experienced problems related to wearing Islamic dress (72 out of 164, 43.9%), prayer rituals (31 out of 164, 18.9%), and Islamic holidays (42 out of 164, 25.6%).[14] The participants reported these discriminatory behaviours using a checklist, so the study did not capture more details about the problems they experienced.[14] There were 30 responses for "other" types of discrimination that Muslims experienced in healthcare. These were related to clothing, diet, prayer, gender issues, lack of knowledge, rejection, stereotypes, harassment, physical threats, and verbal abuse.[14] Note that these responses came from both Muslim men and women and may not reflect results when looking specifically at Muslim women.

Of note, we also found two studies that saw changes in the extent of Islamophobia following specific events. Muslim women in the UK felt that discrimination had become worse in the years following the terrorist attacks on September 11, 2001 due to fears about Islamic fundamentalist terrorism.[23] Scores on the Health Care Discrimination Scale also increased after the Boston Marathon bombing in April 2013, suggesting that Muslim adults experienced more discrimination in healthcare.[14] However, these are single studies and we would need more data over a longer time period to better

understand changes in the extent of Islamophobia.

Results

Impact of Islamophobia

Among the studies we included, 10 were related to the impact of Islamophobia.[9–13,16,19,20,22,23] Please refer to Table 1 for more information about study designs.

Discrimination and mistreatment may not always originate from religious affiliations, but also racial and cultural backgrounds, highlighting the intersectionality of discrimination. We found 6 studies in which patients felt that their race, gender, religion, or combination of those identities may have impacted the **level of care** they received. These include being treated dismissively by healthcare staff in mental health services[10] and healthcare providers disregarding reports of pain from Asian women.[9,23] One study reported that Muslim women are less likely to be offered appointments from mental health professionals, possibly due to gender, religion, race, or a combination of those identities.[22] In an interview about their experiences with palliative care, a Muslim woman felt that healthcare staff only suggested taking her husband home because he was not white.[12] In focus groups with cancer survivors in the US, one Muslim woman commented that racial discrimination made diagnosis difficult:

"[The doctor] had some preconceived notions [about] the colo[u]r of my skin and by looking at my family that I might have traveled to Pakistan, India a lot. He was convinced that I had malaria, and he kept looking at the infectious disease perspective".[16]

During doctor visits, some studies reported people feeling discriminated against as humans and treated poorly by staff. Lack of dignity,[12] stereotypical comments,[23] prejudiced attitudes,[10,11] and aggressive behavior[12] were only some of the experiences of Muslim patients at different healthcare settings. A Muslim woman described her experience of maternity services in an interview: "You see their faces. You feel it that they think you are stupid and you don't know anything about this world".[11] Overall, these patients felt that they were being treated and seen differently than everyone else.[10] As a result, they reported feeling like an outsider,[10] feeling misunderstood,[11] and feeling reluctant to seek help.[12]

Some negative experiences of patients not only presented in how they were treated as humans, but also how they received their medical care. Studies describe instances where discrimination may have led to patients receiving **suboptimal care and services** from healthcare providers. Participants felt that discrimination led to them getting late diagnoses,[16] being considered for discharge early,[12] and not being taken seriously when describing symptoms and pain levels.[9,23] Muslim patients felt they were **not offered services** due to the personal prejudices of their healthcare providers. In focus groups about maternity services in the UK, one Muslim woman mentioned: "I really wanted to go but they [health professionals] don't mention it to you, that's the thing...[they think] Asian people don't want to come to these antenatal classes".[23] Muslim patients might also receive fewer appointments with counselling services due to implicit bias from healthcare providers.[22]

Research is mixed on whether discrimination increases **distrust in the healthcare system** and **discourages people from seeking medical attention**. Although one study did not find any association between perceived discrimination and delayed health seeking behavior,[20] participants in other studies expressed a fear of being judged because of their appearances and being treated differently as a result.[9,16]

Among the studies we included, 7 studies discussed the impacts of institutional discrimination in the form of culturally inappropriate care, which had **harmful emotional effects** on Muslim patients in healthcare settings.[9,11–13,19,20,23] For instance, one study reported that Muslim patients felt discriminated against when their requests for culturally appropriate food and sex-specific staff for personal care were not accommodated.[12]

Lack of awareness of cultural practices in the Islamic tradition, such as lack of prayer rooms,[19,23] privacy for patients,[13,23] halal food options,[9,14,23] or appropriate hygienic services[9,12,19] were also regarded by Muslim patients as **neglectful, "frustrating", "embarrassing" and "uncomfortable"**. Muslim women also reported that the lack of female staff providing care for sensitive health topics, such as antenatal care, made them feel uncomfortable[14,23] and caused them to delay seeking medical care.[20]

Recommendations from Studies

Though outside the direct scope of our investigation, we note that the extent and/or impact of Islamophobia in healthcare settings prompted some researchers to make recommendations for the healthcare system. We have combined these recommendations and summarized them below. It is important to note that these recommendations come from studies conducted in Canada as well as the UK and US, meaning they may not be applicable to the Canadian context.

1. All healthcare providers and staff at healthcare institutions should receive regular training programs about religion, culture, and ethnicity to develop cultural competence and minimize perceived discrimination. This should include details about Islamic cross-gender boundaries, modesty requirements, moral and dress code expectations, halal food/dietary practices, and cleanliness. Collaborating with local Muslim organizations would ensure the authenticity of the training material [9,14,17,19,21,23]

2. Healthcare providers and staff at healthcare institutions should consult with patients to determine their individual preferences and then provide appropriate care.[13,21]

3. Hiring more Muslim healthcare providers and female healthcare providers would improve the healthcare experiences of Muslim patients.[23]

4. Healthcare providers should actively provide information about available services to support patients in their decision-making, as they may be unfamiliar navigating the healthcare system.[21,23]

Discussion

Overall Findings

We found 14 studies that described Muslim women's experiences of Islamophobia in healthcare settings. These studies varied in the number and types of participants they recruited, their study designs, and the healthcare settings they explored. We did not find any studies that focused on children's experiences of Islamophobia in healthcare settings.

Eight studies provided information on the extent of Islamophobia,[9,10,14,17,18,20,21,23] though these estimates diverge according to the *kind* of discrimination experienced and the healthcare settings it's experienced in. Some of the largest-scale studies and best sources of data come from the U.S. where, for instance, overt discrimination such as physical assault constitutes a small number of experiences, while less obvious forms of discrimination like being excluded and ignored are reported as being experienced by over half of all Muslim patients.[14] Two studies suggest rates of discrimination are influenced by the timing of world events that perpetuate Islamophobia among the general population,[14,23] such as the September 11 terrorist attacks.[23]

Like the studies estimating the extent of Islamophobia, studies investigating the impact are isolated and somewhat divergent in their findings. Of the 10 studies relating to the impact of Islamophobia,[9–13,16,19,20,22,23] 6 used an intersectional lens [9,10,12,16,22,23] to highlight experiences of prejudice towards Muslim patients of various racial and cultural backgrounds. Concerning interactions with healthcare providers range from stereotypical comments[23] and prejudiced attitudes[10,11] to not being taken seriously.[10,11- 20] Consequences of these interactions may impact the level and quality of care received[16,22,23,9,16,12] as well as cause harmful emotional effects on Muslim patients relating to fear and distrust of the healthcare system.[14,23] Most of these studies took place outside of Canada, so further research is needed to better understand their applicability to the Canadian context.

Gaps in Research

Research on patient experiences of Islamophobia in healthcare settings is lacking. While searching through academic databases, we found many articles that talked about the health consequences of Islamophobia and how healthcare workers could be more culturally sensitive. However, very few studies described how patients experience discrimination in healthcare settings. This was also rarely the sole focus of the research studies we found.[14,22] Researchers typically studied discrimination along with other topics,[13,17,18,20,23] or it came up organically in participant responses without asking them specifically about discrimination.[9–12,16,19,21] In addition, the majority of these studies were conducted in the UK, with a lack of research conducted in Canada. This lack of focus on Islamophobia could explain why there is little information about it.

There are gaps in the populations studied. We did not find any studies about Islamophobia when children are receiving care. Though all our studies included Muslim women, some combined their responses with other groups (e.g., Muslim men).[10,12,14,16,23] This makes it difficult to interpret the findings because Muslim women may experience discrimination differently compared to other groups.

The studies looked at discrimination in very different settings. Two studies looked at healthcare services in general.[14,20] Conducting more studies using this approach could tell us about Islamophobia across the entire healthcare system. On the other hand, most of the studies we found were examining the problem in specialized services, such as maternal health,[9,11,21,23] mental health,[10,22] and oncology.[16–18] Since women and children are more likely to use some services over others, it would be helpful to focus on areas of the healthcare system that are most likely to impact them. More research is needed in specialized healthcare settings to make comparisons and identify where Islamophobia is most prevalent.

Most of the studies also used qualitative research methods,[9–12,16,19,21,23] which gave rich descriptions of how patients experience Islamophobia but did not paint a clear picture about its extent. There could be more studies that are designed to count the number of people who experience Islamophobia in healthcare. A clear gap in this literature are large-scale Canadian studies quantifying the extent of Islamophobia towards Muslim women and children in healthcare settings.

Quality of Existing Research

The existing research relies on self-reported measures of Islamophobia. Participants shared their past experiences through focus groups,[10,13,23] interviews,[9,11,12,16,20,21,23] and questionnaires.[13,14,17,18,23] This can sometimes bias the results because participants might have trouble remembering instances of discrimination.[24] In focus group settings, participants might also be reluctant to share information in front of others.[24] However, self-reporting is important for hearing about discrimination from the perspective of Muslim patients. More inclusive and ethical research designs, such as community-engaged research approaches,[25] can further empower future research participants to share these narratives. Future studies could also support self-reported findings by using observational designs and other methods that document instances of discrimination as they occur.

We should also consider the scales used to quantitatively measure discrimination. The Discrimination in Medical Settings scale was used in three studies,[17,18,20] and it is known to be reliable and valid.[26] This means that participants will likely get the same results every time they take the questionnaire and that it measures discrimination accurately. On the other hand, the Health Care Discrimination Scale is relatively new and has issues with validity.[14] Revised versions of this scale may provide more accurate measures about the extent of Islamophobia. Quantitative methods, such as questionnaires, also have limitations in the depth of information they can provide.[27]

Interviews and focus groups may provide more detailed insights and capture relevant information that researchers may not have anticipated.[28]

Lastly, there were concerns about the generalizability of current research. Several studies were worried about sampling bias,[13,17,18,20] meaning that the participants in the study do not represent all Muslims. Other studies also had small sample sizes[9,11,21] and focused on specific communities or subpopulations.[12,23] This makes it difficult to generalize the study findings to all Muslims, especially those who are part of communities other than the study's focus. To ensure generalizability to Canadian Muslims, future research can use large sample sizes and recruit participants who are representative of the Muslim population in Canada.

Conclusion

Our scoping review found 14 published studies that examined the extent and/or impact of discrimination faced by Muslim women within healthcare settings in the US, UK, and Canada. While the extent of religious discrimination in healthcare settings remains unclear, studies suggest that certain forms of discrimination were more common than others. Studies also suggest that discrimination increased after global tragedies, such as the September 11 terrorist attacks and Boston Marathon bombing. As a result of discrimination, Muslim patients reported having negative experiences with healthcare providers, receiving lower quality care, and feeling distrustful towards healthcare settings. This scoping review also demonstrates that Muslims receive culturally inappropriate care due to healthcare staff's lack of awareness of Islamic practices, such as the need for prayer spaces, modesty and privacy for patients, halal food options, and hygienic services. While this is not always considered a form of discrimination, patients describe having negative healthcare experiences because of it.

Looking forward, we perceive a need for future research to investigate the extent and impact of Islamophobia towards Muslim women and children in Canadian healthcare settings. Our scoping review identified only three primary studies that examined religious discrimination or lack thereof against Muslim women in Canadian healthcare settings; however, these studies did not include children and focused on specialized services (e.g., maternal health, mental health). Other studies included in this review involved Muslims in the UK or US, which demonstrates the lack of studies focusing on this topic in Canada.

Based on these findings, researchers should conduct high quality studies to characterize both the extent and impact of Islamophobia in Canadian healthcare settings. Future research should consider:

Based on these findings, researchers should conduct high quality studies to characterize both the extent and impact of Islamophobia in Canadian healthcare settings. Future research should consider:

- Inclusion of women and children, given their greater vulnerability to discrimination
- Inclusion of participants from various cultures, ethnicities, races, and socioeconomic backgrounds
- Use of scales, questionnaires, or surveys designed to measure Islamophobia or religious discrimination in healthcare settings (e.g., Discrimination in Medical Settings Scale)
- Use of interviews and/or focus groups to gain a richer understanding of Islamophobia in Canadian healthcare settings
- Impact of discrimination on access to care (including delayed care seeking), quality of care, and health/well-being outcomes
- Intersectional nature of discrimination
- Inclusion of other religious groups to facilitate comparisons with Muslims

Appendix: Summary of Study Findings

Studies are list based on publication year, from newest to oldest.

Study	Main Findings
"Whatever you hide, also hides you": A discourse analysis on mental health and service use in an American community of Somalis Michlig et al., 2022	• Focus groups with 168 Somali men and women in the Phoenix or Tucson metropolitan areas • They were not asked specifically about Islamophobia in healthcare settings, but it was a theme that came up in the responses. • A middle-aged Somali woman reported that healthcare staff assumed she was illiterate and shared her internal thoughts during the encounter: "You don't have to talk slow to me." • Overall, experiences of outright discrimination by healthcare professionals were rare. Participants talked about being treated dismissively by physicians or looked at strangely by administrative staff. • Participants brought up intersectional marginalization because of their identities as Muslims, immigrants, and persons of colour.
Examination of perceived religion in Muslim women's access to counseling and psychotherapy services: An audit study Moscovitz et al., 2022	• Researchers created fictitious emails as a Muslim woman and as a religious non-Muslim woman. They sent an email request for an appointment to 450 registered/certified counselors and psychologists in independent practices in the metropolitan area of Vancouver (225 as the Muslim woman and 225 as the non-Muslim woman). • Counsellors and psychologists were more likely to respond and were faster to respond to the Muslim woman, but a lower proportion offered an appointment to the Muslim woman compared to the non-Muslim woman. Researchers interpreted this as implicit bias and results in Muslim women having more difficulty accessing counselling and psychotherapy. • Intersectionalities might be at play. Researchers were unsure which characteristic (Muslim, Arabic/Middle Eastern, woman) or combination of

	characteristics triggered implicit bias.
Experiences of Muslim cancer survivors living in the United States Alaloul et al., 2021	• Interviews with 17 male and 15 female Muslim cancer survivors to understand their experiences • Key themes: cancer experience based on their belief in God, hiding cancer diagnosis, perceived strong social support, making an effort to keep up with religious practices, *perceived discrimination in healthcare settings*, importance of religion and cultural awareness • Recommended that healthcare providers partner with Muslim chaplains and community leaders, encourage discussions about cancer stigma, and focus on the needs of Muslim cancer survivors
Perinatal care experiences of Muslim women in Northwestern Ontario, Canada: A qualitative study Alzghoul et al., 2021	• Interviews with 19 Muslim women about their perinatal healthcare experiences • Islamophobia was not the focus of this study, so the participants were not asked specifically about it. • Majority of women were generally pleased with the level of respect their healthcare providers showed to their religious and cultural beliefs, values, and practices. The healthcare providers were supportive of their request for modesty and requirement for halal food.
Needs of migrant Arab Muslim childbearing women in the United Kingdom Bawadi et al., 2020	• Interviews with 8 Arab Muslim women during the third trimester of pregnancy, 2 weeks postpartum, and 1 to 3 months later • Some women reported that their clothing caused problems. • There were positive and negative experiences with midwives. Some women never felt discriminated against, while others felt they were treated with less compassion and that midwives were less willing to communicate. • All participants were not offered halal food, which limited their ability to eat nutritious food after giving birth. • Participants were frustrated about the lack of cleaning and shared rooms. • The women noticed cultural differences about childbirth between the UK and Arab countries. They felt ignored and frightened by the care they received in the UK.

Online photovoice to explore and advocate for Muslim biopsychosocial spiritual wellbeing and issues: Ecological systems theory and ally development Tanhan & Strack, 2020	• 118 students, alumni, staff, faculty, and parents of students at a university in the US submitted photos of their experiences as Muslims. They also included captions and identified a theme or metaphor related to their photos. • One participant wrote about the university health centre: ○ "I think we need a place for prayer and water in restrooms at the health center because many Muslims go there. They miss prayers [because of the lack of facilities], including myself and a few of my friends. I will be happy to see a place for prayer for women and water in restrooms as well as a place where we can feel secure to practice ablution. I do not want to have to think a hundred times before I leave home; it is stressful and unjust. I will be very happy if the health center would know about this issue. What we ask for, I think, goes perfectly with health: being clean, physical exercise, and praying. Muslims' prayer consists of physical movements and meditation, so it is a perfect activity for good health."
Predictors of delayed healthcare seeking among American Muslim women Vu et al., 2016	• Interviews with 254 Muslim women, with equal representation of Arab, South Asian, and African American women • 129 respondents (53%) reported a delay in healthcare seeking due to a perceived lack of female clinicians • Perceived discrimination did not play a significant role in delaying healthcare. Sociodemographic characteristics (e.g., age, ethnicity, country of origin) might play a role in Muslim women delaying healthcare. • Recommends that future studies look at other groups and identify patterns of disparities due to the lack of same-sex providers.
Perceived discrimination of Muslims in health care Martin, 2015	• 227 Muslim men and women in the US answered questions on the Health Care Discrimination Scale • 27.6% (62 out of 225) responded "Yes" to the question: Did you ever feel that you were discriminated against in the health care setting because you are Muslim? • Out of 164 participants, the following experiences of discrimination in the

	healthcare setting were reported: ○ 91 (55.4%) being excluded or ignored ○ 72 (43.9%) problems related to wearing Islamic dress ○ 60 (36.6%) offensive or insensitive verbal remarks ○ 6 (3.7%) physical assault ○ 31 (18.9%) problems related to prayer rituals ○ 42 (25.6%) problems related to Islamic holidays ○ Other types of discrimination include harassment, lack of knowledge, stereotypes, and problems related to diet. ● Recommendations include cultural sensitivity training for healthcare professionals and accommodating cultural needs.
Associations between religion-related factors and breast cancer screening among American Muslims Padela et al., 2015	● Survey of 240 Muslim women in Greater Chicago to explore how religion-related factors influence breast cancer screening ● Perceived discrimination did not influence whether Muslim women ever had a mammogram, but it did make them less likely to have had a mammogram in the last 2 years. ● Recommended that religious sensitivity and cultural competency programs should focus on decreasing perceived discrimination
Associations between religion-related factors and cervical cancer screening among Muslims in Greater Chicago Padela et al., 2014	● Questionnaires with 254 Muslim women to explore how religious and cultural factors influence the number who get a Papanicolaou (PAP) test ● Compared to non-Muslims, 60% (145/240) of Muslim women felt that they were *not* treated with less courtesy and 66% felt that they were *never* treated with less respect. ● Perceived discrimination did not affect how likely Muslim women were to get a PAP test. Sociodemographic characteristics (e.g., age, ethnicity, marital status) might play a role in how likely Muslim women are to get tested. ● Recommended that future studies look at beliefs about the virus and vaccination, as well as the trust towards physicians based on race, ethnicity, or sex.

Vulnerability and access to care for South Asian Sikh and Muslim patients with life limiting illness in Scotland: Prospective longitudinal qualitative study Worth et al., 2009	• 92 interviews with 7 Sikh patients and 18 Muslim patients who had life limiting illness, their family members, and their primary care providers • Participants and their family members perceived prejudice and discrimination from service providers. They did not know if it was due to their religion or outward appearance. This resulted in participants being reluctant to seek help, particularly financial support and personal care. • End-of-life care for many Sikh and Muslim patients was substandard. It did not meet their needs and there was a lack of services.
''They can't understand it'': Maternity health and care needs of immigrant Muslim women in St. John's, Newfoundland Reitmanova & Gustafson, 2008	• Interviews with 6 immigrant Muslim women about their experiences during pregnancy, labour, and the postpartum period • During pregnancy, Muslim women received very little information and prenatal classes were not widely accessible. • During labour, Muslim women mentioned a lack of cultural sensitivity (no female attendings, little to no respect for cultural/religious practices) and they received little information on labour and pain management. • During postpartum, Muslim women did not receive adequate support, privacy, and information. Prayer facilities were not available and they experienced challenges with dietary requirements. • Participants generally felt very embarrassed and that they were treated poorly during these periods, except one participant who reported having a positive experience with a nurse. • The study highlights the need for greater cultural and religious awareness in healthcare and recommends further qualitative and quantitative studies to better understand the barriers Muslim women face.
Racial/ethnic preferences, sex preferences, and perceived discrimination related to end-of-life care Duffy et al., 2005	• Focus groups and questionnaires with five racial/ethnic groups in the US, including one focus group with 5 Arab Muslim women. • When asked about discrimination/prejudice related to end-of-life care, they mentioned feeling uncomfortable in the hospital. • Quote from one participant: "I can't sleep or be comfortable. I have to cover and just sit there and expect anybody to walk in any minute." • Racial and ethnic groups have different preferences about end-of-life care.

	These can be used to inform culturally sensitive care, but healthcare workers should prioritize what individual patients prefer.
Experiences of maternity services: Muslim women's perspectives Ali & Burchett, 2004	• Focus groups with 43 Muslim mothers, questionnaire responses from 22 Muslim fathers, and interviews with 8 healthcare professionals in the UK • Some Muslim women received good quality care, but many did not. Facilities and services were insensitive to their needs. Healthcare workers did not understand how Islamic beliefs and practices affect women's experiences of maternity care. • This poor quality of care may be caused by discriminatory attitudes among some healthcare workers. Many Muslim women received stereotypical and racist comments during their care. • The full report contains quotes from Muslim women about their experiences. • Key recommendations: professional training about religious, cultural, and ethnic issues; having a designated midwife for every woman; increasing the availability of community-based services for new parents; improving the content and accessibility of information; hiring more female and Muslim health professionals

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