November 2016

Promoting Breast Cancer Screening Among Muslim Women in Montgomery County, Maryland

A Qualitative Exploration

Nneka J. Madu, MPH
PRIMARY CARE COALITION

BHQC
National Capital Area
Breast Health Quality Consortium

primary care coalition

Funding for this project was provided by:

susan g. komen.

Acknowledgements

We thank the Muslim Community Center Clinic, who provided logistical support for the focus groups, and made many telephone calls to recruit participants. We would also like to thank Susan G. Komen, whose support for the National Capital Area Breast Quality Consortium made this project possible.

Purpose of the Project

The National Capital Area Breast Health Quality Consortium (BHQC) is a multi-year project, led by the Primary Care Coalition (PCC)'s Breast Health Initiative. The goal of the BHQC is to identify and reduce racial/ethnic disparities in breast health service delivery in the DC Metro Area. Since its inception, the BHQC has convened health care providers, community organizations, and local government entities to commit to a unified vision of improving breast health services throughout the region. This qualitative exploration was conducted to better inform the BHQC's breast health promotion strategy in the National Capital Area.

Introduction

Although diverse in socioeconomic status, race, and ethnicity, Muslim Americans are united in their common religious worldview which inform the way they interact with the healthcare system (Hasnain, Menon, Ferrans, & Szalacha, 2011; Padela & Curlin, 2013). Immigrant Muslim women in the United States represent a unique and fast-growing population whose healthcare behaviors, including breast cancer screening practices, are significantly influenced by past beliefs and experiences (Hasnain, Menon, Ferrans, & Szalacha, 2014; Shaheen, Galal, Salahi, & Aman, 2005). Mammograms may not be part of the routine screening process in public hospitals in their home countries and are usually recommended only as part of the diagnostic workup after an abnormality has been detected (Hasnain et al., 2011; Hasnain et al., 2014). When providing breast health education to recent immigrants, underscoring the importance of regular screening is of utmost importance (Hasnain et al., 2011; Hasnain et al., 2014).

Additionally, the limited research available on the experiences of Muslim women with health care providers suggests there are significant barriers to the provision of culturally appropriate care. In one survey study, 83.3% of responding providers reported encountering challenges while providing care to Muslim women. In the same study, 93.8% of responding patients reported that their healthcare provider did not understand their religious or cultural needs (Hasnain et al., 2011). In this survey, both providers and patients named similar barriers to optimal care, including a lack of providers' understanding of patients' religious and cultural beliefs; language-related patient-provider communication barriers; patients' modesty needs; patients' lack of understanding of disease processes and the healthcare system; patients' lack of trust and suspicion about the healthcare system, including providers; and system-related barriers (Hasnain et al., 2011).

Furthermore, Muslim American women encounter provider bias. Muslim women have reported interacting with healthcare providers that have made them feel unintelligent or unwelcome, interpreted their modesty as shame for their bodies; assumed they were in abusive marriages, and occasionally refused to provide medical care (Padela & Curlin, 2013). Moreover, Muslim patients have reported feeling like their requests for culturally-sensitive accommodation were not treated seriously (Padela, Gunter, Killawi, & Heisler, 2012). Previous studies suggest that Muslim patients are more willing to trust and adhere to the recommendations of a provider they felt acknowledged and respected their religious beliefs (Padela et al., 2012).

Methods

For this project, we implemented a qualitative design to explore the breast cancer screening beliefs and behaviors of Muslim patients among two groups: 1) two English-language focus groups with Muslim women living in Montgomery County, 2) four in-depth interviews with patient navigators that have worked throughout the National Capital Region. Preliminary findings from the two focus groups with Muslim women were presented to the patient navigators.

The focus groups included 17 participants with an age range of 40-67 and a median age of 50. Women were recruited from Muslim Community Center membership and their clinic's patient list. Women with and without recent breast cancer screening experience were sought to participate in the focus groups. Table 1 below describes the demographics of the focus group participants. With the exception of an over-representation of participants born in Pakistan, the focus groups participants are generally representative of the Muslim Community Center Clinic's patient population.

Table 1. Focus Group Participant Demographics

Demographic Item	**Response**	**N**	**%**
Country of Birth	Pakistan	7	41%
	Bangladesh	2	12%
	USA	2	12%
	Afghanistan	1	6%
	India	1	6%
	Indonesia	1	6%
	Philippines	1	6%
	Sudan	1	6%
	Sierra Leone	1	6%
Are you of Hispanic, Latino, or Spanish Origin?	No	17	100 %
What race(s) do you identify as?	Asian	13	76%
	African-American	4	24%
Highest level of education completed?	Some high school (9 to 11 grade)	2	12%
	High school graduate or GED	4	24%
	Some college/technical or vocational school	2	12%
	Bachelor's degree	5	29%
	Postgraduate degree/study (Master's degree/PhD/MBA)	4	24%
How much money did you make in 2015?	Less than $25,000	10	59%
	$25,000-$49,999	6	35%
	$100,000 or more	1	4%
In the past 5 years, how often have you gotten a mammogram?	Every year	4	24%
	Most years but not all	4	44%
	Once or twice	5	29%
	Never	4	24%

During the focus groups, the facilitator had participants complete a naming exercise where they generated two lists: 1) motivations for pursuing breast cancer screening and 2) barriers to pursuing breast cancer screening. The items named were written on a large white board. After the naming exercise was completed, participants were giving six stickers and asked to vote for their top three motivations and barriers to screening. If there was a particularly strong motivator or barrier, participants were permitted to dedicate more than one vote to their chosen item.

Findings: Motivations for Breast Cancer Screening Named By Patients

1. **Finding Abnormalities During Breast Self-Exam/Previous Screening** (11 votes received)

When asked to explain how this was a motivation, participants said the following:

- *"I had a lump or cyst that I found during a self-exam. I found something and I wanted to make sure it was benign."*
- *"During my first mammogram, they found something… solid cellular kind of thing. For that, they did everything… biopsy, it exceeded biopsy. Ultimately, the last word was that it's okay but they recommended that they I go every year."*

2. **Family History** (11 votes received)

3. **Receiving Communication from the Physician about Screening** (10 votes received)

When asked to explain how this was a motivation, a participant said the following:

- *"When I turned 40, my doctor recommended that I go."*

4. **Prevention/General Wellness/Annual Physicals** (5 votes received)

When asked to explain how this was a motivation, participants said the following:

- *"Not because it was free. It [my annual exam] is an opportunity since you check up everything in your body. You might as well check that. "*
- *"To live longer."*

5. **Fear** (4 votes received)

When asked to explain how this was a motivation, a participant said the following:

- *"Fear of death. Fear of all this cancer treatment, pain, and the whole procedure. It's very scary. You see someone with cancer after chemotherapy and oh my god."*

6. **Public Education Campaign** (1 vote received)

Findings: Barriers to Breast Cancer Screening Named by Patients*

1. **Pain** (16 votes received)
   When asked to explain how this was a barrier, participants said the following:
   "Looking at the way the procedure is... and having to press and press [your breast]. That's what made me very very fearful and initially go and have it done."
   "Yes, the pain is the real thing."
2. **Ignorance of Importance** (7 votes received)
   When asked to explain how this was a barrier, participants said the following:
   "Because we come from back home, everything that you have in your breast is seen like a cyst. They treat it themselves with their own medications and remedies. They are ignorant about the symptoms and treat everything as a cyst. This is very important."
   In my home country's culture, it's common to think that cancer is "after marriage". "Married women have cancer". Unmarried do not have because nobody touches her."
3. **Husbands** (5 votes received)
   When asked to explain how this was a barrier, participants said the following:
   "Two years ago I went somewhere for a mammogram and my husband was with me. There was a guy there [to conduct the mammogram] and my husband said, "there is no need to do that." After that, I came back but I've only gone once in this country."
   "I think that Muslim men... they so care about their wives. They so care about their privacy. I don't think it's about democracy or being weird. It's because they are so protective."
4. **Shyness** (3 votes received)
   When asked to explain how this was a barrier, participants said the following:
   "To me, the more important [fact] is that we're Muslim and we're shy, even if [the doctor] were a woman. Man or woman, it's a matter of taking off our clothes-- this is embarrassing for us. For a doctor, we know it's okay but we feel shy, so we don't want to do that."
   "I'm telling you that a doctor gave me an appointment. Last week I had the appointment but I didn't go because I was shy."
5. **Need for a Female Mammography Technician** (3 votes received)
   When asked to explain how this was a barrier, participants said the following:
   "Only a female [technician] should be there, I don't agree with male [technicians]."
   Muslim men, they will never agree to a male technician touching you in the way they do it. Holding your breast and pressing it. I wouldn't think that any Muslim husband would agree."
6. **Fear** (2 votes received)
   When asked to explain how this was a barrier, a participant said the following:
   "Fear of the doctor telling you that they may find something."
   "My mom died breast cancer. Three of my cousins died from breast cancer. My sister had breast cancer and she is a survivor. So, I am so scared. I have do to it every year. I make an appointment and then I am so scared that I back out. So I don't want to have some day where I find out."
7. **Lack of Time/Convenient Scheduling** (2 votes received)
8. **Cost** (2 votes received)
9. **Language Barrier for Non-English Speakers** (1 vote received)

*Additionally, while not named during the listing exercise, focus group participants concluded that that foreign born Muslim women may be less educated about breast cancer screening than their American-born counterparts.

Outreach Recommendations by Made by Focus Group Participants

Focus group participants were asked "what are the best ways to encourage Muslim women in the National Capital Region to pursue breast cancer screening?" They named the following suggestions:

- **Develop outreach and educational materials in languages spoken by the local Muslim community.** Focus group participants suggested that in addition to English, materials should be printed in Pakistani, Urdu, Amharic, and Arabic to be distributed at local mosques.
- **Community advocates should conduct specialized outreach to the different subpopulations within the local Muslim community.** Focus group participants suggested appointing volunteer advocates that represent the different groups within the local Muslim community (e.g. Pakistani, Sudanese, etc.) to conduct breast health outreach. Often, these subpopulations have their own community events and gatherings. Focus group participants believed that a community advocate that speaks the language and is familiar with the cultural milieu of that group can more effectively craft a message that resonates with their peers.
- **Local mosques should form women's groups to discuss health issues, including their breast cancer experiences.** Focus groups participants suggested forming women's support groups with women that have gone through mammograms and/or breast cancer treatment.
- **Muslim husbands should be brought into the conversation about women's health**. Focus group participants were asked whether or not they care about the gender of the provider in an emergency situation. All responded that the gender of the provider does not matter in the case of an emergency. As a result of this conversation, several participants stated that while both they and their husbands would greatly prefer a female technician, the urgency for gender concordance would be reduced if breast screening was seen as a priority by all family members. Focus group participants agreed that husbands should be educated about the importance of wives to getting regular breast screening. One focus group participant suggested that husbands can even be tastefully presented with the idea that they can assist their wives with their breast self-exam.

Recommendations by Patient Navigators to Optimize Patient Interactions

Patient navigators were asked to reflect on their experience with serving Muslim patients and provide feedback on the motivation and barriers lists developed by focus group participants. They named the following additions:

- **Have Muslim women tell their own stories about breast cancer screening and treatment**. Consistent with the outreach recommendations made by the focus group participants, patient navigators reported that having staff that served as Muslim community advocates effectively motivated Muslim women to get screening. One patient navigator reported that one of her colleagues, often shared her candid anecdotes about breast cancer screening and treatment at local Muslim gatherings. While this colleague was employed, they saw an increase in the number of Muslim women getting screened at her site. Many of these patients cited this employee as their reference.
- **Acknowledge and accommodate the patient's need for privacy and physical space**. One patient navigator stated that she instructed her team to always provide Muslim female patients with both a forward and backward-facing gown. The patient navigator was inspired to do this after a patient had made this request. They reported that they've seen a visible increase in comfort levels when this accommodation is made. Another patient navigator suggested that providers mimic the patient's physical cues, such as how far away the patient stands when speaking and matching the volume of their voice.

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