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AN EXPLORATORY STUDY OF MUSLIM WOMEN’S ATTITUDES TOWARDS AND EXPERIENCES OF CERVICAL SCREENING

A DISSERTATION SUBMITTED TO THE UNIVERSITY OF OTAGO IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR A MASTER OF PUBLIC HEALTH

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Abstract

Cervical cancer is the second most common cancer worldwide in women, yet the cervical screening test is able to detect precancerous cells, improving the prognosis. Internationally, Muslim women have been found to have poor uptake of cervical screening. This study aimed to explore Muslim women’s experiences of and attitudes towards cervical screening in Christchurch, New Zealand. Utilising snowball sampling, eight first-generation immigrant Pakistani Muslim women were recruited to participate in in-depth interviews. Thematic analysis of the interviews revealed two major themes. These were moving from a collectivist to an individualist society and the influence of acculturation. The influence of the community played an important role in the women’s perceptions of cervical screening and the findings from this dissertation suggest that their engagement in promoting cervical screening will enable women to more closely identify with the messages. Findings also revealed that the cultural awareness of the health professional impacted on the doctor-patient relationship and therefore the women’s understanding of cervical screening. Improving cultural awareness of health professionals is, therefore, important. Further research is also recommended which would involve Muslims of various ethnicities and from different generations to inform the National Cervical Screening Programme with the aim of improving the service for this overlooked group.
Chapter 1: Introduction

Cervical cancer is the seventh most common cancer worldwide. However, it is the second most common cancer in women (Parkin, Bray, Ferlay, & Pisani, 2005). Cervical cancer has been found to be much more common in developing countries compared to developed countries, with 83% of cervical cancers occurring in developing countries. Incidence rates in developed countries tend to be fairly low, with age-standardised rates of less than 14.5 per 100,000. In developing countries, the cervical cancer rate has been found to vary. In Bangalore, India, the age-standardised incidence rate of cervical cancer was 28.8 per 100,000 (Nandakumar, Anantha, & Venugopal, 1995). However, the crude rate among Muslims was 7.7 per 100,000 compared to 21.2 per 100,000 among Hindus and 15.9 per 100,000 among Christians. There were no variations in mortality between Hindus and Muslims. In Karachi, Pakistan, the age adjusted incidence rate was found to be 6.81 per 100,000 reflecting a low risk population (Bhurgri et al., 2007). However, the majority of the cancers found had already reached a late stage as no in-situ cases were found: 25.7% were localised, 58.1% had spread regionally and 8.1% had spread to a distant site. In a study in Lahore, Pakistan, only two patients were identified at a pre-invasive stage, whereas 43% were identified in Cervical Intraepithelial Neoplasia (CIN) 3 and 4 (Badar, Anwar, Meerza, & Sultan, 2007). Although the incidence rate of cervical cancer for Muslims may not be inflated, the possibility of screening means that many of the cases have the potential to be detected at an early stage and, therefore, improve the prognosis.
Cervical Cancer Screening

Cervical screening involves the use of a simple test on asymptomatic people to classify them as being likely or unlikely of having cervical cancer. It is therefore not diagnostic of cervical cancer and further tests are required for those who screen positive. The screening test aims to detect precancerous lesions to prevent them from progressing to invasive cervical carcinoma (Sankaranarayanan, Gaffkin, Jacob, Sellors, & Robies, 2005). There are many precancerous lesions that can occur, including: low-grade squamous intraepithelial lesions; atypical cells of undetermined significance; moderate dysplasia or severe dysplasia/carcinoma in situ (CIN2); and high grade squamous intraepithelial lesions (CIN3) (National Screening Unit, 2008). Cell cytology revealing CIN 2 or 3 are associated with a high risk of cervical cancer and require treatment.

Women who undergo regular screening have been found to have a lower risk of late stage diagnosis than those who have had no screening (Brewer, Pearce, Jeffreys, Borman, & Ellison-Loschmann, 2010). Screening has been found to be particularly low in women with squamous cell carcinoma compared to adenocarcinoma. More than half the women diagnosed with cervical cancer in New Zealand between 1994 and 2005 had not been screened more than six months before diagnosis.

In New Zealand, the National Cervical Screening Programme (NCSP) is offered every three years to any woman between the ages of 20 and 69 who has ever been sexually active (National Screening Unit, 2008). A repeat screen should be done in the following year after the first cervical screen and also if a screen is not performed within five years.
There are numerous locations where women can have their cervical smears. These include general practices, the Family Planning Association, sexual health services, Marae-based or Maori health providers and community health service providers (National Screening Unit, 2009a). The cost of a cervical smear is the cost to see the doctor or the nurse; there are no fees for the cervical smear specifically. Some health providers will offer free or reduced prices for the service. The result of the first ever smear is sent directly to the women (National Screening Unit, 2009b). Subsequent smear results are sent to the smear taker but only to the women if the result is abnormal. The results from a cervical smear can be normal, unsatisfactory, show inflammation or infection, atypical cells, mild (low grade changes) and moderate to severe (high grade changes) (National Screening Unit, 2008). Unsatisfactory results, due to inadequate sample, clinical factors (such as bleeding or inflammation) or laboratory technical factors, require a repeat smear within three months. Inflammation or infection requires discussion and treatment with a doctor. Results showing atypical cells, mild or moderate to severe changes will need further investigation.

On introduction of the NCSP in New Zealand, incidence of cervical cancer (adjusted for age) decreased from 12 per 100,000 in 1991 to below 7 per 100,000 in 2002 (Ministry of Health, 2005). This is a fall of approximately 40%. Mortality from cervical cancer has also decreased by 60%, from 5 per 100,000 in 1990 to 2 per 100,000 in 2001. Some of this decrease in mortality will be due to improved treatment during this time in addition to the introduction of cervical screening. There has also been an increase in the detection of high grade precancerous lesions by 40%, mirroring the decrease in incidence of invasive cervical cancer.
The NCSP collects information throughout the screening process to ensure that a high standard of quality is maintained at each step (Ministry of Health, 2005). Coverage, referred to as the number of women who have enrolled in the programme and have had a smear taken in the last three years, is currently estimated to be 73% of women in New Zealand. This, however, varies by ethnicity. Maori coverage varies between 50% and 70%, and Pacific between 45% and 55%. For Asian women coverage is approximately 40%. There were no data collected on religion or more specifically for South Asian women.

Worldwide there is a large variation in the coverage of cervical screening, ranging from approximately 80% in countries such as Austria and Luxemburg to 1% in Bangladesh, Ethiopia and Myanmar (Gakidou, Nordhagen, & Obermeyer, 2008). Developing countries’ rates of cervical screening tend to be lower than those in developed countries. There are also inequalities within countries between the poorest and richest quintiles. This is important to recognise as Muslim women in New Zealand may be originating from these countries and, therefore, may not be aware of cervical screening in New Zealand.

Few countries collect data on religion when screening women. However, many countries do collect information on ethnicity. South Asian women, including those from India, Pakistan, Bangladesh and Afghanistan, have been found to have poor attendance at both breast and cervical screening. In Wakefield, UK, 67% of South Asians had acceptable cervical screening histories compared to 75% of non-Asians (Sutton, Storer, & Rowe, 2001). For breast screening this difference was found to be
even higher; only 53% of South Asians had acceptable breast screening histories compared to 78% of non-Asians. This was repeated in a further study in Manchester, UK, where a study found only 69.5% of South Asians to have been screened in the last five years compared to 73% of others (Webb, Richardson, Esmail, & Pickles, 2004). In addition 14.7% of South Asians had never been screened in this study compared to 10.3% of others.

The United States has also found lower screening rates in South Asian women. In a cross sectional observational study, 73% of South Asian women reported having a cervical smear in the last three years compared to 83% in the National Health Interview Survey for the general US population (Chaudhry, Fink, Gelberg, & Brook, 2003). Women were found to have greater odds of having a cervical smear if they were married, more educated, had a common source of healthcare and were more acculturated. In Canada only 27% of South Asian students reported uptake of cervical screening (Gupta, Kumar, & Stewart, 2002). South Asian women may practice a variety of religions including Hinduism, Islam, Christianity and Sikhism (Chaudhry, et al., 2003) and little is understood about the uptake of screening amongst these different religious groups.

**Muslim beliefs and health behaviours**

Islam is a way of life for Muslims and has a significant impact on all aspects of daily life. Whereas a Western view of medicine is that of dualism of body and mind, Asian-Islamic women’s beliefs reflect a holistic approach to healthcare (Rashidi & Rajaram, 2001). A Muslim believes that God created human beings and that their bodies are
gifts which should be cared for (Yosef, 2008). Through the Quran and Hadith Muslims are taught how to achieve healthy lifestyles. General hygiene is strongly emphasised as prior to each of the five daily prayers a Muslim must wash their hands, face, head and feet. Exercise is also encouraged through the observance of the five daily prayers and through the Prophet Muhammed’s (PBUH) example of walking and working in the fields.

Rashidi and Rajaram (2001) have described five critical beliefs of Islam that relate specifically to health. The five pillars of Islam are the acts of worship and provide the framework for a Muslim’s beliefs, lifestyle and practices (Hadi, 2002). The first pillar of Islam is Shahadah, the belief in one God and Muhammed (PBUH) as his messenger. This is the declaration of faith. It is the first of the pillars as it forms the basis of a Muslim’s actions. Salat refers to praying five times a day. This is the essence of the spiritual life of a Muslim. Through prayers a Muslim is able to establish a personal communication through God, is able to seek God’s help when difficulties arise and to purify themselves. Zakat is the setting aside of a proportion of one’s wealth for those in need. This can protect society from problems occurring due to unequal distribution of wealth through control of national wealth. The fourth pillar of Islam is Sawm; fasting during the month of Ramadhan. This is obligatory on every adult Muslim. However, those who are sick or travelling are exempt from fasting in Ramadhan. Fasting is believed to promote self-discipline and increase human sympathy, promote spiritual elevation and improve physical health. The final pillar is

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1 The Hadith are the sayings and Traditions of the Prophet Muhammed (Peace be upon him). The collection has been gathered into ninety-seven books and is second in authority only to the Quran (Lawrence and Rozmus 2001)
2 Peace be upon him
Hajj or pilgrimage to Mecca. Each Muslim who has safe access and can afford the journey is expected to undertake the pilgrimage once in their lifetime.

Rashidi and Rajaram (2001) also argue that modesty is an important belief in Islam and this has important implications for health services. The Quran has a strong emphasis on modesty between genders. It specifically directs women to veil themselves with head coverings (Padela & Pozo, 2010). In the presence of males (not related or married) women are told that only their hands, feet and face may remain uncovered. However, in the presence of women a Muslim woman may be uncovered except for the area between her naval and knees. Having to expose herself to a health professional who does not show sensitivity to her modesty can be of great discomfort to a Muslim woman.

There is strong importance placed on communities and families in Islam, and that they should be both physically and emotionally close (Rashidi & Rajaram, 2001). The family is the foundation in Islamic culture and as a result there is strong family involvement in caring for those who are sick. Visiting those who are sick is a responsibility placed upon every Muslim. This act can be seen as a sign of love, mercy and empathy resulting in stronger friendships and bonds of brotherhood. The Prophet Muhammed (PBUH) promised great rewards for those who visit the sick. Through visiting the sick, Muslims should try and help forget their suffering and increase their morale and lift their spirit.

The Quran contains many verses that advise on healthy eating and linking this to physical and spiritual health. Moderation of food is recommended, with extremes of
obsession and neglect associated with the inability to fulfil the duty of serving God (Stacey, 2009). Foods that are lawful for Muslims to consume are labelled as halal (Mohammadi, Evans, & Jones, 2007). These are foods that have been slaughtered in the name of God with all the blood drained from it. Foods that are not lawful are labelled as haram. Many verses in the Quran forbid Muslims to eat dead meat, blood and pig meat (Stacey, 2009). Alcohol and other intoxicants are also forbidden. There is an emphasis on Muslims to consume foods in moderation and not to indulge in excesses.

In order to protect dignity and to prevent both accusations and acts of illicit relationships, restrictions are imposed on Muslims (Padela & Pozo, 2010). A man and a woman who are not related or married are not allowed to be alone in a place where sexual contact between them could occur. This regulation extends to physical contact.

In addition to those aspects of Islam that Rashidi and Rajaram (2001) contend are associated with health services, Yosef (2008) also argued that Muslim’s health beliefs may be different from others. Some Muslims may believe that God has already decided on their future and therefore they cannot prevent disease from occurring. This may lead to them not taking part in health promotion activities. However, prophet Muhammed (PBUH) encouraged Muslims to maintain good health and seek medical advice. Some Muslims may also have misconceptions as to how illness occurs. Kulwicki (1991) cited in Yosef (2008) found Muslims to believe in four categories of the causation of illness. These were supernatural causes (for example, God or the devil), social causes (for example, evil eye and stress), natural causes (for example, cold and dirt) and hereditary causes.
Aim and outline of this dissertation

This dissertation aims to explore the attitudes towards and experiences of cervical screening among Muslim women in Christchurch, New Zealand. Through providing an in-depth insight on this important topic, new information will be obtained on a group in New Zealand that has not previously been studied. The information could then inform further research and service development to improve the uptake of cervical screening among Muslim women in New Zealand. Increasing the uptake of cervical screening will allow a greater number of women to be detected with cervical cell changes at an earlier stage and therefore improve the prognosis of cervical cancer in New Zealand.

The following chapter will discuss the literature around Muslim women and cervical screening. Chapter three discusses the qualitative methodology and methods used to address the aims of this study. The findings of the study are presented in chapters four and five. Chapter four discusses the influence of Muslim women immigrating from a collectivist to an individualist society on their perceptions of cervical screening. Chapter five examines the role of acculturation in women’s insights of cervical screening. The final chapter provides the overall conclusions and recommendations arising from the findings of the study.
Chapter 2: Literature Review

Introduction

This chapter will focus on the literature that is currently available on Muslim women’s attitudes and experiences of cervical screening. Worldwide there is a large variation in the uptake of cervical screening (Gakidou, et al., 2008). However, studies indicate that the uptake in Muslim women is low (Chaudhry, et al., 2003; Sutton, et al., 2001). In New Zealand no studies have explored Muslim women’s experiences of healthcare or that of cervical screening. Internationally, studies have been performed. However, only a few are specific to Muslim women. Many studies have focused on South Asian women, including those from India, Pakistan and Bangladesh. As some, but not all, women from these countries will be Muslim, both relevant and irrelevant issues may be identified in these studies. Studies have utilised both quantitative and qualitative methods. Quantitative studies have utilised questionnaires and qualitative studies, face-to-face interviews, telephone interviews and focus groups.

Due to the small number of studies exploring cervical screening and Muslim women specifically, studies evaluating the experiences and beliefs surrounding the uptake of breast screening have also been included in this literature review. Breast screening is organised via a national screening programme with similar recruitment techniques to that of cervical screening. It is also comparable in that it involves a private part of the body and can be a sensitive issue. Therefore, factors identified in studies focusing on breast screening may be relevant to that of cervical screening and provide further or reinforcing information. A wide range of issues regarding breast screening have been identified, which highlights the complex nature of making decisions regarding
screening. Remennick (2006) analysed the barriers occurring in the challenge of detecting early breast cancer in immigrant and minority women, identifying these as structural, organisational, psychological and socio-cultural barriers. This framework could also be applicable to cervical screening and I have therefore used this format as a means to discuss the literature reviewed in this chapter.

**Structural Barriers**

Remennick (2006) describes structural barriers as the social factors that determine a woman’s personal resources and opportunities for being able to attend screening programmes. Specific structural barriers identified include travelling a long distance to the screening facility, a lack of transportation, inability to take time off work and inability to pay for childcare to be able to be present for the test.

Transportation was identified by key informants in a study by Matin and LeBaron (2004) to be a significant issue for older women due to their dependence on their family and not wanting to be a burden on them. This qualitative study is particularly relevant as it is one of the few studies to specifically explore the attitudes that Muslim women have towards cervical screening. The study initially used key informant interviews performed via telephone and typed concurrently. This method of interviewing may have been a limitation of this study due to an inability to build sufficiently good relationships with participants over the telephone and distraction of typing whilst interviewing. This may have resulted in important information not being included.
Older Muslim women, especially, may require the assistance of family members in order to attend cervical screening. Bottorff et al (1998) undertook a qualitative ethnoscience study examining breast health practices of South Asian women and found that many of these women prefer to be accompanied by a family member during the procedure. Many reasons were suggested for this including a sense of vulnerability, support in making decisions, ensuring they would not be left alone with the doctor and a sense of duty from the family member. If family members are unable to fulfil this requirement due to their own schedules then older Muslim women may not access the screening programme.

Minority ethnic women have also been found to be very mobile. During a six month community development intervention study in Bradford, UK, a quarter of the participants changed address (Kernohan, 1996). Incorrect addresses on databases has been found to be one of the major obstacles in encouraging women to participate in screening (Fylan, 1998; Hoare, 1996). Women's names have not only been spelt incorrectly on invitation letters but they have also been sent to the wrong woman (Kernohan, 1996). Muslim women also travel to their country of origin for prolonged periods of time (Hoare, 1996; Kernohan, 1996). Kernohan (1996) found that fifteen percent of women in their study were found not to be in the country when the mammography invitation was made. As well as identifying inaccurate screening registers as a reason for poor uptake, Szczepura (2005) also argues that the location of health services can lead to poor access for mobile populations. Bottoroff (1998) identified that many women did not know where the community mammography screening clinics were, and often found them difficult to locate. A study in Scotland, using a questionnaire as its data collection tool, found that reasons women gave for
non-attendance included unsuitable appointment times (Neilson & Jones, 1998).
Similarly, Fylan (1998) identified that women were unable to reach appointments due to them only being available during working hours.

Knowledge of cervical screening in the countries Muslim women originate from appears to be low. In a study in Pakistan, although eighty-five percent of women understood that early detection of cancer improved survival, only thirty-six percent were aware that screening was available for cervical cancer (Imam et al., 2008). Ninety-five percent of women in this study had never been offered a cervical smear by their doctor. This was also found in Israel, where women identified that breast screening was available but they were unaware of cervical screening (Azaiza & Cohen, 2007).

When arriving in developed countries, Muslim women still identify the need for better access to information on cervical screening (Box, 1998; Matin & LeBaron, 2004). Poor understanding of cervical screening appears to be present amongst all minority ethnic women (Chiu, Heywood, Jordan, McKinney, & Dowell, 1999). However, in a study in the UK, South Asian women reported the lowest level of knowledge of cervical screening (Kernohan, 1996). It seems then that minority ethnic women may not access services due to not having the information that they exist (Szczepura, 2005). If a person is a new immigrant then they will be unfamiliar with the health service and how it works. They may also not have the social networks to inform them of the services that do exist. Matin and LeBaron (2004) found that many immigrant women in the United States did not know when a smear was needed, why it was needed and the benefit that the test would have for them. Women appeared interested
in finding out more about the screening and what benefits it would have for them so that they were able to take more control of their own decisions regarding their health.

The level of literacy of the patient can be variable and is an important factor for accessing health services (Szczepura, 2005). In the UK it has been found that less than a third of Bangladeshi and Pakistani women aged 50-75 years can read English. Szczepura (2005) also found that fewer than half of South Asian adults could read a school timetable or telephone directory. If levels of literacy are low then screening invitation letters cannot be understood (Kemohan, 1996). If read by someone else, priority may not be given to screening or thought inappropriate and the women may never know about the opportunity. Although literacy in English is important, studies in the UK have also found that over half of older Bangladeshi and Pakistani women were illiterate in any language (Szczepura, 2005).

Structural barriers do play a role in limiting women’s access to the cervical screening programme. However, organisational barriers may result in women choosing not to take part, even if they are able to access it.

Organisational Barriers

Remennick (2006) describes organisational barriers as the difficulties that women face within the medical encounter itself or within the medical institution itself. Examples include difficulties in being able to find a way through the health system, language barriers, arrogance of staff and lack of female providers.
The importance of modesty of dress and keeping themselves covered when in the presence of any male apart from their husband or relative has been found by Underwood et al (1999) to influence attitudes towards breast screening. This study used three semi-structured focus groups to collect data. Six of the nine women who took part had been brought up as Muslims whereas three had converted five or more years previously. Women in this study described how concerns over having to expose parts of their body led them to avoid physical examinations, especially if no symptoms were present. These concerns were present whether they had been brought up as Muslim or converted.

Gender relations has also been found to play an important role in Muslim women’s experiences of health care (Simpson & Carter, 2008). Due to the Islamic belief that a man and woman should not be alone in the same room, Muslim women tend to prefer female health professionals for conditions involving ‘female problems’. These include obstetric or gynaecological issues, breast exams, pap smears, prenatal and postnatal check-ups, contraception counseling and delivery of children. Many studies have found that the prospect of a cervical smear being performed by a male health professional is a significant barrier to Muslim women attending cervical screening programmes (Abdullahi, Copping, Kessel, Luck, & Bonell, 2009; Fylan, 1998). This is also true in breast screening where a study by Kernohan (1996) found 28% of women not attending breast screening due to the possibility of the test being performed by a man. Although Underwood et al (1999) found that Muslim women prefer to be seen by female health professionals in any situation, Simpson and Carter (2008) found that male health professionals were acceptable for basic illnesses that did not require removal of clothing for assessment. In the presence of a male health
professional an accompanying person was important for the woman. Requiring a female health professional has been found to be as much a personal preference as an Islamic requirement (Tsianakas & Liamputtong, 2002).

Studies have found that a lack of cultural responsiveness and awareness of healthcare professionals can act as a barrier to access of services and experiences of healthcare for ethnic minorities (Elkan et al., 2007; Szczepura, 2005). Matin and LeBaron (2004) utilised focus groups involving fifteen unmarried Muslim immigrants from India, Pakistan, Afghanistan, Palestine, Egypt and Yemen. All participants were either due to start college, were in college or were college graduates. These results were therefore obtained from a very specific population and may not be representative of the entire female Muslim population. However, they found that Muslim women reported that doctors treated all women similarly with no sensitivity to their cultural background. Underwood et al (1999) also found that women felt their beliefs and customs were dismissed by health professionals and there was a lack of understanding by health professionals of their values and customs.

It has been suggested that Muslim women perceive that wearing a Hijab can lead to communication difficulties as health providers presume they are unable to speak English (Tsianakas & Liamputtong, 2002). Tsianakas and Liamputtong (2002) interviewed fifteen migrant Muslim women originating from Lebanon, Jordan, Egypt, Kuwait, Malaysia, Singapore, Morocco and Pakistan. The interviews explored women's perceptions and experiences of prenatal testing in antenatal care in Australia. Thematic analysis found that women perceived a lack of respect and

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3 A Hijab is a covering of a Muslim woman's head, face or body. It is often referred to as a veil and is a symbol of privacy, modesty and morality (Esposito 2003b)
negative reactions from the health care providers. They reported being treated as though they had no knowledge of the issues and were not given information unless they specifically asked for it.

Similarly, in the United Kingdom, the ScanLink Project\textsuperscript{4} found that some minority ethnic women experienced racism by health professionals (Box, 1998). The ScanLink project utilised a variety of methodologies and therefore was able to extract a wealth of information. The first involved two focus groups involving eleven female health advocates who spoke a variety of languages. Individual interviews were then held with the eleven ScanLink facilitators who carried out cancer awareness sessions. Questionnaires were also completed by black and minority ethnic women who were attending the cancer awareness sessions, with seventeen of the women interviewed in greater depth. Lastly, group interviews were held in three different age groups and in one of eight languages. Both advocates as well as the women receiving the cervical smears spoke of being treated unfavourably and that care was not taken to provide them with comfort. Some women felt that they were just fulfilling the practices’ required number of smears and others had experienced offensive behaviour from health professionals.

Another UK study utilised participatory action research involving six mini focus groups with minority ethnic women, as well as one focus group of smear takers (Chiu, et al., 1999). The smear takers perceived the South Asian women as either being ‘westernised’ if they were able to speak English and ‘non-westernised’ if they could

\textsuperscript{4} The ScanLink Project was carried out by CancerLink, a charity providing information and support to people affected by cancer. It aimed to ascertain the views and knowledge levels of black and minority ethnic women about the cervical screening programme, cervical cancer and smear tests, as well as conducting awareness classes on the subject.
‘Non-westernised’ women were seen as problematic. Smear takers constructed stereotypical views of the women as docile and lacking independence and not understanding preventative medicine due to their culture. Smear takers were also reluctant to accept that they should be providing minority ethnic women with further information about cervical screening.

Simpson and Carter (2008) found that the perceived power of the provider played an important role in Muslim women’s experiences with healthcare providers in a rural area in the United States. The phenomenological approach utilised in this study found that a woman’s approach to health care was either passive or assertive. Assertive women tended to ask more questions and wanted more information about conditions or treatment. They also informed the providers of how they wished to be treated as Muslim women. Passive women had lower levels of competency in the English language and gave the provider complete power and trust in decision-making. Assertive women can be forced to be passive due to the actions of the provider and feeling obliged to perform actions that went against their religion (Simpson & Carter, 2008). This includes shaking hands and maintaining eye contact with male providers. Assertive women also used passive language when describing their experiences, suggesting that power was still placed with the provider even though the women still made their decision.

Difficulties in communication can occur due to differences in language (Elkan, et al., 2007; Rajaram & Rashidi, 1999). Szczepura (2005) reviewed research in the UK and found evidence to show that South Asian women’s ability to speak English was lower than South Asian men, was poorer for those born outside the UK, and competence
decreased with increasing age. Interpreters are, therefore, used to overcome this language barrier. However, smear takers have specifically questioned the ability of translators and whether their use results in a true understanding of cervical screening for women (Chiu, et al., 1999). Women have also voiced distrust in interpreters as they feel that they are unqualified in a medical setting (Abdullahi, et al., 2009). An imbalanced power relationship can also result through the misuse of translators, thereby disempowering women (Chiu, et al., 1999). Utilising family members as translators can be difficult if their English is not sufficient and if they lack an understanding of the technical aspects of cervical screening. (Chiu, et al., 1999). Relying on family members for translation can also raise questions of inappropriateness and the censoring of information (Elkan, et al., 2007). Communication difficulties in explaining cervical screening may result in women not having a complete understanding of the test and therefore not having the procedure done. Women may also feel they cannot trust the provider and feel unable to ask questions to increase their understanding.

Studies have shown that Muslim women feel that providers give insufficient information regarding the procedure and some women have had the screening performed with no understanding of what was happening and why (Box, 1998). Through eleven focus groups (each with six to ten women) Naish, Brown and Denton (1994) found that some women had the misconception that a part of the womb is cut away. Many also did not know the exact nature of the procedure and confused cervical smears and vaginal swabs. Some women were also unaware that a laboratory test was performed following taking of the smear and, therefore, were falsely reassured when the smear taker told them that the internal examination was normal.
Other studies have also shown women to mistake cervical smears to be a test of diagnosis rather than of screening (Abdullahi, et al., 2009). Women are also confused as to when and how often screening needs to be performed. As cervical screening is often performed in an opportunistic way, women may not appreciate the need to have them done regularly and it has been found that they believe that it is in some way connected to childbirth (Chiu, et al., 1999).

Minority ethnic women in the UK who have utilised advocates have had more positive experiences of cervical screening and were better informed (Box, 1998). The advocates themselves experienced a lack of respect from health professionals and also felt that there was a lack of clearly defined boundaries of their responsibilities, a lack of training and poor understanding of the health professionals of their role.

The relationship between the health professional and Muslim women is an important factor in women attending the cervical screening programme. However, additional psychological barriers may exist.

**Psychological Barriers**

Psychological barriers have also been implicated in the low uptake of breast screening in multicultural societies (Remennick, 2006). Fear of cancer can often lead to a denial of a person’s susceptibility and therefore early testing or preventative strategies are avoided (Neilson & Jones, 1998). Many women will not talk about breast cancer due to their fear of it and may even choose not to mention the specific word as it may be tempting fate (Bottorff, et al., 1998). Some women also feel that they do not want to go looking for disease but will get treatment if they have symptoms (Remennick,
Women may also fear the treatment that is needed following diagnosis due to lack of knowledge and may also believe that treatment is futile.

Bottorff et al (1998) purposefully recruited fifty South Asian women in Canada to take part in in-depth face-to-face interviews to ensure a diverse representation of age, education, occupation, length of residency in Canada and religion. Women were found to believe that no cure existed for breast cancer and that it caused much suffering and pain. Stories that they had heard or people they knew seemed to be sources that informed the women. Due to the association that women made between cancer and death many women decided that it was pointless in doing anything to prevent, detect or treat breast cancer.

Fatalism is the belief that a higher power is in control of a person’s life and therefore they do not have control over diseases that affect them (Remennick, 2006). Studies have found that Muslim women believe that their lives are ultimately controlled by God (Abdullahi, et al., 2009; Box, 1998; Underwood, et al., 1999). It is argued that Muslim women believe that if somebody becomes sick it is ‘God’s will’. A study of Israeli Bedouin women found that traditional causes of illness, such as the evil eye of envious neighbours, were seen as causes of the disease (Azaiza & Cohen, 2007). They also believed that cancer was a punishment for not adhering to religious rules or due to inappropriate behaviour. Some also perceived it to be a test from God to see how strong their beliefs were. However, Underwood (1999) also found that women placed great importance on health promotion and the prevention of disease and that preventing a disease was better than having to be treated for it. Another study found that if Iranian Muslim women believed that maintaining their health was a part of
their Muslim responsibility, they were more likely to participate in the screening process (Hatefnia et al., 2010).

Studies have also shown women to identify promiscuity as a risk factor, with a consequent perception that cervical cancer is a disease of the West (Box, 1998). Muslim women, therefore, may not see themselves at risk. Women can be hesitant to bring up promiscuity as a risk factor and there is much confusion as to whether a woman who has never been sexually active needs screening (Abdullahi, et al., 2009). Some women identified that a genital infection can cause cervical cancer but were unsure how, and there was no knowledge of the role of human papillomavirus.

Minority ethnic women may not be familiar with the concept of screening and tend to associate illness with symptoms (Hoare, 1996). Therefore, if they feel fit and healthy they do not see any reason to seek medical help. Smear takers also perceive that South Asian women do not understand preventative measures and find them reluctant to receive health education (Chiu, et al., 1999). An invitation or suggestion of undergoing screening can lead to anxiety as they may assume that the medical intervention is due to ill health (Hoare, 1996; Neilson & Jones, 1998).

Minority ethnic women have also found cervical screening to be a negative experience (Abdullahi, et al., 2009; Chiu, et al., 1999; Fylan, 1998). Typical negative experiences include pain, bleeding, inexperienced smear takers and not having the procedure explained to them (Abdullahi, et al., 2009). Many women have feelings of helplessness due to a lack of explanation both in preparation and during the procedure (Chiu, et al., 1999). The speculum can be perceived to be a painful instrument and
some women do not trust the sterilisation process (Abdullahi, et al., 2009). Although they may have a lack of information, women still feel a sense of obligation to have cervical smears (Chiu, et al., 1999).

Minority ethnic women can find talking about the reproductive tract embarrassing and are reluctant to talk about it (Box, 1998). If there is hesitancy to talk about cervical smears within families then this lack of encouragement could also act as a barrier. Some women also feel that only their husband should have access to this private area and the thought of another person doing such a test is highly undesirable.

Similar perceived views have been found with regards to breast screening. A two-centre study of Muslim women's views of breast cancer in Pakistan and the UK found that women in Pakistan described feelings of shyness, modesty and embarrassment associated with breast screening (Banning & Hafeez, 2010). Even between women, mothers, daughters and spouses there was a resistance to talking about issues concerning breasts. This has resulted in breast cancer being a socially unacceptable disease for Pakistani women. This was in contrast to British Muslim's views, where it was found that there was little taboo with breast self examination or any other form of screening. Bottorff et al (1998) found that women were reluctant to talk about breasts due to fears that the conversation would sound sexual, which would not be acceptable.

In Punjabi and Hindi there is no actual word for breast; women refer to their chests. The study also found that South Asian women were reluctant to self-examine their breasts as they believed that it was inappropriate to touch themselves in this way.
Psychological barriers can therefore have an important role to play in a woman’s attitude towards cervical screening yet the impact of culture and society is also influential.

Socio-cultural barriers

In many Muslim societies men are responsible for women’s decisions and actions (Remennick, 2006). Smear takers in the UK have identified the presence of a male dominated culture amongst South Asians and observed that women are rarely present by themselves (Chiu, et al., 1999). Women have a central role in the family structure and often put the family’s needs before their own. Therefore, the priority is not on their own health but their family’s needs (Bottorff, et al., 1998). Their own sense of self worth may lie in their ability to provide for their family and the possibility of breast cancer may jeopardise this role (Remennick, 2006). It is also very important to South Asian women to maintain the reputation and health of their family (Bottorff, et al., 1998). This is important to the family’s standing in the community and the future marriages of their children. Being seen in a screening clinic by another South Asian woman may lead to the belief that she has breast cancer with possible negative effects on the family’s reputation.

Muslim women are more likely to visit health professionals with family members. They may, therefore, not be willing to discuss cervical screening with them present. (Matin & LeBaron, 2004). Parents were also found to answer on their daughter’s behalf, believing that they were protecting them. Muslim women place a lot of emphasis on the views of family and others in the community and will only seek advice when it has been suggested and sanctioned by them (Bottorff, et al., 1998;
Soskolne, Marie, & Manor, 2006). If a woman is unable to discuss cervical screening with her family due to embarrassment she may feel unable to seek help independently. South Asian women also put a lot of trust in the doctor’s advice and if they do not mention the topic of screening then they may feel it unnecessary to attend a screening programme. This has also been found to be the case among Muslim Israeli women (Soskolne, et al., 2006).

Muslim society places great value on virginity before marriage. Matin and LeBaron (2004) found that women felt that Muslims’ values of virginity and bodily privacy conflicted with standards of American health care. For many Muslim women the procedure utilised during the cervical smear test represented a violation of virginity and was therefore inappropriate before marriage. Some women felt that unmarried women should not receive any gynaecological care. Box (1998) also found that unmarried women may be concerned that members of the community will believe that they are involved in sexual relationships if they attend cervical screening. Some Muslim women have been found to consider cervical screening as part of routine health checks. In order to avoid cervical screening women may, therefore, not visit their physician (Matin & LeBaron, 2004). However, once married it is more acceptable to access health care due to no longer needing to be a virgin.

Muslim women have also commented that breast screening programmes are not structured in a way that is consistent with Islam (Underwood, et al., 1999). They do not want to adopt western approaches and are strongly concerned with maintaining their religious beliefs, customs and identity. Some report that breast self examination, clinical breast examination and mammography are not practices they are familiar
with. They perceive that providers overlook their beliefs and that their opinions are ignored. Many South Asian women cannot relate to asymptomatic screening as it is not usual for them (Bottorff, et al., 1998).

Summary

The literature reviewed suggests that the experiences and attitudes that Muslim women have regarding cervical screening are broad and that the reasons for not taking part in cervical screening programmes complex. Remennick’s (2006) classification of barriers to breast screening has been used to try and understand these factors. The barriers were classified as structural, organisational, psychological and socio-cultural. Structural barriers were identified such as lack of transportation as well as a lack of time due to other family commitments and incorrect databases. The gender of the health professional was an important organisational barrier for the women. The level of cultural knowledge and attitudes of the health professional and the resulting relationship between patient and professional was also influential for Muslim women. Communication was also a barrier and could have contributed to the lack of knowledge that many Muslim women had regarding cervical screening. Psychological factors included that of fatalism, the belief that there is a higher power in control of their lives, fear of cervical cancer and previous negative experiences of the procedure. Women find the procedure embarrassing and are uncomfortable discussing the topic. Socio-cultural factors were determined by the dynamics involved within families. Men making decisions in the woman’s life and the central role of the woman in the family can prove to be obstacles for women. Values of virginity are especially important for unmarried women.
The studies reviewed were mainly qualitative. This has the advantage that the contextual exploration of the meanings and interpretations people give to their experiences and behaviours can be explored and allows people to speak for themselves (Kuper, Reeves, & Levinson, 2008) However, few studies explored the relationship between Muslim women and cervical screening. In many studies, women were recruited from a multitude of different ethnicities which may not be relevant. In many of the studies women were South Asian but this does not imply that they will all be Muslim. No studies were found which looked at Muslim women and their attitudes to cervical screening in New Zealand. The international studies reviewed here, may not be relevant in New Zealand due to the different healthcare system, culture and environment. Therefore, a study involving Muslim women in New Zealand would be advantageous to explore their views on this sensitive topic. The next chapter will describe the methodology and methods used in this study.
Chapter 3: Methodology

Introduction

This chapter outlines the methodology and study methods utilised to explore the experiences of, and the attitudes towards cervical screening in Muslim women. A qualitative approach was used to conduct the study. As the study involved a hard to reach population concerning a sensitive topic, care was needed in the methods to approach this appropriately. These and other factors including any potential impact I may have had on the findings are discussed in this chapter.

Methodological Approach

Qualitative research focuses on the meanings, experiences and the views of the study participants (Pope & Mays, 1995). It therefore generates rich data and, through enabling participants to speak for themselves, allows an exploration of their behaviour (Kuper, et al., 2008). Qualitative studies tend to take place in natural surroundings rather than the experimental surroundings of quantitative research (Pope & Mays, 1995). Qualitative research also tends to be inductive which means that attempts are made to create an understanding of the world through the data collected rather than from any prior theory (Dew, 2007). Themes are built from the bottom up with the data organised into more abstract pieces of information (Creswell, 2009). Therefore, for areas of research where minimal information is available, qualitative research can expand the area of interest by identifying relevant emerging issues (Fitzpatrick & Boulton, 1994).
A social constructivist approach was taken in this study. This approach comes from the position that individuals seek an understanding of the world in which they live (Creswell, 2009). In contrast to positivist assumptions, which identify one stable pre-existing reality, social constructionists assume that meanings are formed through social interactions and through historical and cultural norms (Green & Thorogood, 2010). The aim of research carried out within this paradigm is, therefore, to appreciate and reconstruct understandings that are held (Guba & Lincoln, 1994). This is always open to interpretation as the meanings that people form can be altered due to increased information and understanding. As multiple meanings are developed, the researcher must look for the complexities of the views.

Methods

The aim of this study was to gain an understanding of the attitudes and experiences that Muslim women have towards cervical screening in New Zealand. Due to the qualitative nature of the study it was unnecessary for the sample to be statistically representative of the female Muslim population in New Zealand. In contrast, through purposive sampling, I aimed to select cases that would be information rich in order to examine the meanings and interpretations that Muslim women have of cervical screening.

First or second generation Indian/Pakistani/Bangladeshi immigrant Muslim women, aged 20-70 years old were eligible to take part in the study. This ethnic group was chosen as it was one that I identified with. I considered that I would be able to recruit such participants into the study and also build a rapport, which would enable them to
talk more openly during the interview on a particularly sensitive topic. The women were required to be conversant in English. Ethics approval was obtained from the Upper South B Regional Ethics Committee, established under the New Zealand Public Health and Disability Act 2000.

A gatekeeper was identified from The Islamic Women’s Council of New Zealand to help recruit women to participate in the study. This gatekeeper identified potential participants and provided them with an information sheet (see appendix 1) giving details about the study. Women who were interested agreed to have their contact details given to me and I made a follow-up telephone call. This gave potential participants the opportunity to ask any questions regarding the study and to ensure that the study was correctly understood. The women were aware that they were not under any obligation to take part in the study. Once a woman indicated her willingness to participate, an appointment time was made at a location of her choice, which was in all cases their own home. The location of the interview is extremely important and many participants may feel more comfortable in their own home (Liamputtong, 2009). It may also be logistically simpler if they have children and no method of transport.

A snowball method of recruitment was also utilised. Already recruited research participants identified further potential participants who were willing to take part (Liamputtong, 2009), resulting in a snowballing effect. This is a useful method when vulnerable or hard to reach populations are being recruited (Rice & Ezzy, 2001). It is also beneficial when potential participants are well networked but may be difficult to approach directly. As a result, however, the characteristics of the initial participant
may reflect the entire sample. Eight participants were recruited to take part in the study. The majority were recruited through the snowballing technique. Written consent was obtained from all participants prior to taking part in the study and women understood that they could refuse to answer or terminate the interview whenever they wished. All women were given a book voucher in appreciation of their time.

Face-to-face, in-depth interviews were conducted. Liamputtong (2009) argues that in-depth interviewing is a valuable tool to collect information from vulnerable or marginalised people. This method of interviewing allowed me to capture the participants’ own words and gave them the power to focus on issues that were important to them (Liamputtong, 2009). The interviews were semi-structured, with open ended questions exploring areas of interest (see appendix 2) (Britten, 1995). This enabled the participants to deviate and discuss alternative topics of interest. This meant that the interviews were flexible and were able to delve below the surface of topics to explore ideas not anticipated at the start of the study. Interviews lasted between thirty-five and ninety minutes. Interviews were all recorded and transcribed verbatim removing all names and identifying material to ensure confidentiality. Recording interviews has the benefits of providing a level of detail and accuracy that is not possible via note taking (Rice & Ezzy, 2001). It also allows the researcher to pay more attention to what participants are saying during the interview (Liamputtong, 2009). Transcriptions were checked for accuracy in preparation of the analysis process.

Researchers are integral to qualitative studies and therefore cannot be objectively distant from it (Liamputtong, 2009). It is imperative that researchers acknowledge
how they will be perceived by the participants and the effect that this may have on the interview (Britten, 1995). As a female Muslim whose family originates from Pakistan, I already had a lot in common with the participants. It was hoped that this enabled the women to feel more comfortable and therefore talk more openly regarding their views. However, recognising me as a health professional, the women may also have felt the need to impress me by finding out information before the interview or by giving responses to please me. Kuper et al (2008) also identify that researchers need to recognize their own contexts, as their views and beliefs can influence the interaction they have with participants, through a process described as ‘situating’ themselves. This is necessary as the research findings are not only influenced by the participants but also by the researchers. Through my own background and Muslim upbringing I already have my own thoughts and ideas as to the attitudes that the women will have towards cervical screening and it was important that I did not impose these ideas on the women during the interviews.

Data analysis

The data collected through the interviews were analysed using a thematic analysis approach. There are many approaches to qualitative analysis, however thematic analysis has been seen as a foundational method that provides core skills useful for performing other methods of qualitative analysis, such as grounded theory (Braun & Clarke, 2006). Advantages of thematic analysis include its freedom from specific theoretical approaches, therefore enabling it to be a flexible and more accessible tool for research. The key to thematic analysis is the production of codes, sorting and organising the data (Rice & Ezzy, 2001). Through this method themes or patterns are identified and reported from the interviews (Braun & Clarke, 2006).
Braun and Clarke (2006) have identified different phases of thematic analysis. However, they also appreciate that analysis is not a linear process but movement forward and backward through the phases may be required. The first phase involves becoming familiar with the data that have been obtained. Transcribing data can be seen as a key element of this and has been described as an interpretive act. Following this, the researcher immerses themselves in the data through repeatedly reading the transcriptions in an active manner to search for meanings and patterns. An initial set of themes or categories can therefore be identified (Pope, Ziebland, & Mays, 2000).

Codes are then produced by working through the data systematically (Braun & Clarke, 2006). Codes used should be explicitly defined so that they are neither interchangeable nor redundant (Attride-Stirling, 2001). The scope should also be limited so that they focus on the object of analysis. Basic segments of the data, which may have been identified in phase one, should be identified and coded for (Braun & Clarke, 2006). Coding was achieved manually through labelling in the margins of transcriptions. The labelling of codes should be inclusive so that they reflect all nuances in the data (Pope, et al., 2000).

Themes are then searched for (Braun & Clarke, 2006). A theme is described by Braun and Clarke (2006) as encapsulating something important in the data with regards to the research question, as well as representing a patterned response or meaning within the data. The judgement of the researcher is therefore heavily involved in determining what a theme is. The themes were identified in an inductive manner, meaning that, the data were coded without a pre-existing coding and the analysis data driven. Themes
were identified through analysing the codes and deciding how these codes may combine to form themes. Themes had to be specific enough so that they were not repetitive, yet also broad enough so that they could summarise a set of ideas from many text segments (Attride-Stirling, 2001).

Attride-Stirling (2001) has suggested that the use of thematic networks aids the organisation of analysis and facilitates the structuring and depiction of themes. Thematic networks are web-like diagrams that illustrate and summarise the main themes contained within a piece of text. The thematic networks are drawn as webs to emphasise the connections throughout the analysis and to remove any concept of hierarchy. Analysis is continued through ongoing refinement of the themes. When the thematic map is satisfactory themes are named and defined to identify the essence of what the theme represents. The final phase involved the final analysis and write-up of the report. With reference to the initial research question, an analysis of the themes was produced with evidence from extracts to support it.

**Summary**

During this chapter I have outlined and justified the methodological approach taken in this study. A qualitative approach using a social constructivist worldview was used in order to explore the views that Muslim women have towards cervical screening. Eight in-depth interviews were held with immigrant Pakistani Muslim women aged between twenty-one and forty-five years old. Seven women had previously had cervical screens and six women had had smears in the last three years. Thematic analysis was used to analyse the data obtained. The following two chapters discuss the findings of these interviews.
Chapter 4: Moving from a collectivist to an individualist society

Two major themes were identified from the thematic analysis of the transcripts. The first theme, which I discuss in this chapter, was the changes women experienced moving from a collectivist culture to an individualised society. An element of the culture that the interviewed women originated from was that of a collectivist society, which had an impact on their perception of cervical screening. One of the characteristics of a collectivist culture is that the individual puts the goals of the collective ahead of their own (Triandis, Bontempo, & Villareal, 1988). The goals of the individual are therefore similar to that of the group. There is also concern for the integrity of the group and there is a strong emotional attachment to the group. This is in contrast to an individualist culture where there is emphasis on personal goals even if this disadvantages others in the group.

New Zealand is a neoliberal society, which emphasises individualism. Individuals will aim to fulfil their own goals rather than those of others in the community. There is a strong emphasis on individual responsibility with individuals deemed responsible for their own health and for making rational choices to benefit their own health. In contrast, although a Muslim may make choices for themselves, they must do this understanding the responsibilities and obligations that they have to their family, to society and God (Altareb, 2008).

Support
When the participants moved from Pakistan to New Zealand they moved from a collectivist to a more individualistic society. Many were concerned at how they would cope without the previous support they had enjoyed. However, they spoke of the formal services available in the community, which were able to provide the support they required in the absence of the informal support they were used to:

"Here I was worried that oh the neighbours we cannot go in their homes or like this without calling them or with booking we have to go but you know here the doctors and the government and everyone, they are looking after you very well, so we don’t worry that we have not good neighbours or like this. They are here for us, it’s good that we are in New Zealand." (Participant 7)

Some even found that extra help from health services relieved them from responsibilities that they may have potentially had to face themselves:

"My mother she is sick, you know, she is diabetic, and the doctor, she is senior citizen so doctors are coming to her and check her in the house and they are providing everything, the you know, the frame and like this so no worries. She is living alone and we are not worried about her because we know that there are more people to care about her, more than us. They are caring about her.” (Participant 7)

This extra support, may therefore, provide potential not only to reduce time pressures on the women so they are able to attend cervical screening, but also increase their
confidence in the health system, which may make them less resistant to screening. As a result, it is important to explore participants’ satisfaction with the healthcare services available in New Zealand as this may be important in their uptake of cervical screening.

The healthcare system

Satisfaction with health care in Pakistani populations tends to be high. In a study in Middlesbrough, UK, 94% of Muslim participants were satisfied with the service from the GP and 97% were satisfied with hospital doctors (Madhok, Hameed, & Bhopal, 1998). However, surveys such as this may not capture the full extent of the experiences of the population. Participants may be more comfortable in a face-to-face situation where rapport can first be established and where they can express their experiences in their own words (Liamputtong, 2009). Indeed, there were different discourses regarding the healthcare system in this study. There appeared to be satisfaction with being able to see a doctor when required:

“But oh they are perfect they are doing their best and I am happy really, I am 110% happy that I have no problems with this. Whenever we are sick we call. If the GP will not be available then we will go 24 hour emergency. They have solutions everywhere, we have no worries, no tension, nothing, all happy here.” (Participant 7)

However, there was frustration at the length of time it took to negotiate the health system and it was felt that patients were suffering as a result:
“The only thing is, in the medical system is good but it’s just slow. They take very, sometime very easy step and from one step they are going slow one, one, one and then later they will say no, this is we have to be on the tenth step, you know that the centre process will be somewhere gone, you have to jump or you then between that the person really suffers.” (Participant 5)

User chargers are common within neoliberal societies and are used in many countries throughout the world. However, user charges also have a detrimental effect on those in lower income groups and therefore increase inequalities in access to healthcare (Oliver & Mossialos, 2004). Many women in this study found that the cost of seeing the GP was an issue for them and as a result they had to budget accordingly. Some also felt that women would not always go to see their GP because of the cost implications. Participants suggested that the government should provide more assistance for people to see their GP:

“With the doctor if I go I will pay the amount of money which is unaffordable for me but because I am earning the money they think I can afford it um. On that week I will probably not buy fruit for my children because I really need to go to the doctor um so I will be budgeting and um.” (Participant 1)

Other women were willing to pay the GP fees as they felt that money was not an issue when it came to their health:

“Firstly we have to see our health, you know, if we, if our health is going to be better so I don’t worry about the money. No that’s not the money. I’m you
know, so I say more comfortable just go and see the doctor and just pay the money whatever it is. Yeah. Because I want to feel better, that's the main thing, yeah.” (Participant 6)

User charges may affect the uptake of cervical screening on a number of levels. If women are unable or unwilling to pay to see their GP then they may not become aware that cervical screening is available. They may also not fully understand what cervical screening is without the GP explaining it to them. If a good relationship with the GP has not been allowed to develop because of user charges, then women may not feel comfortable having the procedure carried out.

**Community connection**

The support provided by the government helped the women to a certain extent. However, in Pakistan women would also have relied on assistance and advice from the local community in all aspects of their lives. The women in this study had formed their own Pakistani community in Christchurch and were closely connected. They would attend many social gatherings as well as going on holidays with each other. This sense of community appeared to be a strong source of support for them:

“Because we have a Pakistani community very small, around I will say hundred people we have, one hundred and fifty people, but mostly the community is linked about twenty-two families always together. So if happiness we are there, if anything you know sadness we are there to help them er around.” (Participant 5)
Immigrants to new countries tend to make strong connections with those who have undergone a similar process of migration (Farahani, 2010). They can offer intense support and act as sources of information. For many Muslims the community is the priority and there is an emphasis on co-operation, caring, equality and interconnectedness (Graham, Bradshaw, & Trew, 2010). Szczepura (2005) found that without social networks in their community, women may not obtain knowledge of health services that are available to them. This may also apply to cervical screening.

In contrast to Box’s (1998) finding that minority ethnic women were embarrassed when talking about the reproductive tract, many of the women in this study spoke of having conversations with other members of the community regarding cervical smears:

“People do talk, to these stuff, but it’s not really about not wanting to talk because you are just telling the information to other women. If something happens like I told you that I had a cervical smear and I told my other friend, she doesn’t have much English so I told her and she, she now understands and wants the cervical smear. Before that she didn’t know what’s the cervical smear.” (Participant 3)

Graham et al (2010) found that the strong social networks within the community have the potential to benefit social agencies as information about services can be spread by word of mouth. As Muslim women were able to relate to each other more comfortably, the women in this study suggested utilising somebody from the community to inform members about the cervical screening programme:
"I think that er the information can easily be supplied by the Pakistani woman or a Muslim woman who is er like telling the other womans because er it will be easier for the other womens to get the information and because she’s from the same culture, she is from the same path which they are going on so I think they, it’ll be easier for them to understand her rather than a Kiwi woman. Because they will think oh she is a Kiwi and how will she know that er this thing can happen to us or stuff like that, if it’s a Muslim woman doing that I think its much much easier for them to understand." (Participant 3)

Strong social networks are also argued to have disadvantages as they could result in social control within the community (Farahani, 2010). In many religious communities, family reputations are very important (Becher, 2008). Reputations are normally dependent on the behaviours of members of the family and their socio-economic success. However, there is also an emphasis on respectability, and the reputation of a family could be diminished if their actions varied from that of accepted cultural norms. Community status can be so important to Muslims that they may put this before their own well being (Graham, et al., 2010). Consistent with findings from other studies (Box, 1998), the unmarried interviewee was particularly concerned about the views of other members of the community if she were to have a cervical smear because it would suggest to them that she was involved in a sexual relationship:

“But if I tell other peoples in my community or like aunties and stuff, how would they react, they will like, why are, they would like try, they would pass
judgement that this girl is so young, but she has have it? Why? She is in a relationship? Or you know why has she done that? So all these factors really prevent them from getting it.” (Participant 2)

The family

The extended family also has an influence on Muslim women. All the women interviewed were immigrants to New Zealand and many had therefore left family members in Pakistan. The extended Muslim family provides a positive form of social capital as they allow practical, emotional and financial support to be exchanged (Edwards, Franklin, & Holland, 2003). Leaving extended family in their country of origin is a common situation5. However, it has been found that geographical distance does not correlate to how close relatives may feel towards each other (Mason, 2004). Some people have found creative ways to support relatives in distant countries utilising technology such as internet shopping. There are still functions and tasks that cannot be achieved from afar and relatives will, therefore, often travel to visit their families. Participants in this study described that when family visited them, it helped them to feel more comfortable in New Zealand:

“When my daughter I think six months old my parents they just arrived here so I was more comfortable and one my I think brother. So we just living together so my parents and husband’s parents and S, I think she just married my brother so we just living together and so feel more comfortable yeah.”

(Participant 4)

5 In Iran 42% of males and 38.5% of females said that they lived in large families but on immigration to Britain this dropped to 3% and 5% (Farahani 2010)
These visits from extended family can be very important for the women in terms of practical support and advice but also as an important emotional support for them (Becher, 2008). The extra support provided may allow more time for the women to attend cervical screening. Mason (2004) contends that visits allow strengthening of links between relatives across long distances and confirm a sense of belonging to their home country. This could influence the process of acculturation, as discussed in the following chapter, and therefore alter views on cervical screening. The visits were also important for the children of the participants as it facilitated the transmission of cultural and religious values and helped them understand their family identity. This could also affect their process of acculturation and their perceptions of cervical screening. However, for extended family to visit New Zealand there are lengthy immigration processes and visas can be difficult to obtain:

“Just my family is there and it’s hard to bring anybody here. That’s the problem, sometime like makes me really, you know because I’m alone, just my children here and I, if I want to call my mum or my like, you know, family parts or the calling procedure is so long that you know it’s hard to.”

(Participant 5)

As a result Muslim families will also travel back to Pakistan. This has been found to be a barrier to attendance for screening as women are frequently not in the country when they are recalled (Hoare, 1996; Kernohan, 1996).

As the community and extended family may have been harder to reach, the nuclear family was seen to grow in importance. This is characteristic of an individualistic
society. The family is thought of as the foundation of Islamic society (Esposito, 2003a). It is considered that this affects a person's morals, ethics, identity, social class and cultural practices. However, in contrast to an individualistic society, Muslims are expected to put their family's needs and well-being ahead of their own desires and requirements. In return, a family is able to provide financial and emotional support, shelter, education and care for the elderly and disabled. The family is also able to raise the future generation with appropriate moral and social responsibilities (Altareb, 2008).

Many conservative Muslims believe that differences between men and women lead to differences in their ability to perform various tasks and, therefore, perform different roles (Haddad, 1998). Men are thought to be strong in body and mind with high intellect and determination and so are designated as the head of the household. They are responsible for providing for the family financially, protecting the family and providing family guidance and discipline (Altareb, 2008). Women are given the responsibility of managing the household, training and bringing up the children (Altareb, 2008). Children also have the duty of respecting and obeying their parents and, when they are older, providing for their own children.

The husbands of the women interviewed were all the main breadwinners and many of the women were full-time housewives. The women interviewed spoke about their husbands providing for them financially making them dependent on their husbands:

"when I am seeing in the malls the husbands are paying and they are buying
everything for her. They have the wallets in their pockets... the womens are walking behind the husbands, childrens are with the mum.” (Participant 7)

However, the roles that men and women have traditionally taken up are changing. This is due to women being given the opportunity of further education and changes in perception of gendered work due to increased opportunities in the labour market. This has led to women being able to renegotiate their personal power and mobility within their family (Weiss, 1998). Men are therefore realising that women do not need them as much as they did in the past and are capable of being self-reliant. This is reflected in this study by many of the women undertaking further education or taking up part-time employment. Despite this, Remennick (2006) argues that men are still responsible for many of women’s decisions. Similarly, in the UK smear takers considered South Asian women to lack independence as they were dominated by males (Chiu, et al., 1999). Women in this study also showed evidence of needing their husbands’ approval when making decisions:

“Whatever we do we need to ask our husband, even though he is interested in it or not, but we have habit to ask him, that oh can we do this or can we go there? Stuff like that, so he plays a big part.” (Participant 3)

Many conservative Muslims see men as being superior to women and, therefore, are able to take charge of them (Haddad, 1998). Women are thought to be emotional in their thought processes, which interferes with their decision-making abilities whereas men are rational. As a husband sometimes still has authority over his wife, he is therefore able to influence whether or not she should get a cervical smear. One of the
women interviewed described the dilemma one lady faced of whether to have the cervical smear or not because of her husband’s disapproval:

“She was confused I think whether she will go or she will not because her husband was stopping her and she wanted to go, so she have to listen to her husband.” (Participant 7)

However, not all husbands appeared to be against cervical screening and some allowed the women to make the decision for themselves:

“He said that if you want to do it, go and do it, if you want to have a check-up but if you don’t want, if you don’t feel like going you can skip it.” (Participant 3)

Due to husbands being involved with the women’s decision, women suggested that their husbands as well as themselves should receive information regarding cervical smears:

“So to tell not even the woman, to the husband as well, so he should encourage her you know. So both must be understand this situation.”

(Participant 5)

For some women this may be difficult to initiate as the topic generates feelings of embarrassment for them and they may consequently prefer to avoid such discussions.
Some participants found it especially difficult to discuss cervical smears with their husbands due to the embarrassment that they felt:

P6: “Once I had done for my second child time and then I receive the letter from the doctor and then he got the letter from the letterbox and then he opened it and what, ‘what the smear thing?’ ‘I don’t know, I don’t know what’s the smear thing’. ‘No you must know that what’s the smear thing, that’s your letter’. I, it was hard for me to explain, you know.”

I: “So it’s embarrassing for you to explain to your husband as well?”

P6: “yeah yeah yeah. So I said I don’t know and then he’s gone and he’s the directory, I mean the dictionary and then found that what’s the meaning, I said ‘oh no’ (laughing). Finally he found it, he said ‘you had your smear because they just want to see if there any disease’, I say ‘yes because you know it’s um mostly they um do like their own people especially girls and womens, like er Kiwi people but they just want to do our one as well so do we have any disease and stuff’. But he doesn’t make us do.”

Many of the Muslim mothers lived very busy lives. Becher (2008) has described many roles of the Muslim woman within the family. These include domestic work, such as cooking and cleaning. Women are also involved in the provision of food, clothes and hygiene of the family and undertake a management role in planning the daily lives of their children. As well as monitoring the children they are involved in the daily disciplining of their children. As children are considered a blessing large families are often encouraged which can increase workloads on the women (Hodge, 2005). Many of the full-time housewives in this study had four or five children to
look after. Others were balancing children with part-time work or further education. They may also be required to maintain social relations such as attending functions associated with marriages, births and deaths (Weiss, 1998). They therefore found that they did not have much spare time:

“When my children want to go for some sports, my son goes for one place and my daughter goes another place and I'm running in between.” (Participant 5)

The demands that are placed upon Muslim women lead them to a process of prioritisation. South Asian women have been found to prioritise their families needs above their own health (Bottorff, et al., 1998). Many of the women in this study also described how the pressure of looking after children prevented them from pursuing things for themselves:

“I want to do some courses but I can't do because my children are small and I don't know when my, I'm out on the road how long it will takes me to come home.” (Participant 5)

The mothers were not only giving up their time in order to accommodate their families' needs but they were also making their own health sacrifices:

“If I take the Macdonald you know and er if I for example have a limited budget ok so my kids are telling me to take them Macdonald so I will try and fit them in but get the best for them, you know, but I will ok never mind I can skip my lunch but they get the best.” (Participant 5)
Being a loving mother and generally being there for your children is a central aspect in Islam (Becher, 2008). Islam views children as a gift from God (Altareb, 2008). Many women in this study described how looking after their children was more important than looking after themselves:

“If our children get the sickness we will take them, run to the doctor but the same problem if we have we don’t go to the doctor because we have so much other things to cope with and we always ignore ourselves.” (Participant 5)

If women have to prioritise their activities then it is important that they are aware of the importance of cervical screening. If they do not understand the importance of the test then they will not attend for screening:

“If they don’t know something you know what is important you know for yourself then how will they go you know? They will be thinking that it’s just they are spending their time for nothing you know. They are going and coming and you know all the ladies are always busy you know, they always busy you know like, then if they know that that’s important they will you know take time and go but if they don’t know they will be thinking oh leave it you know.” (Participant 6)

Hoare (1996) suggests that minority women may not perceive screening as important when they are feeling well. Participants explained that some women may perceive cervical screening as unimportant if they did not have any symptoms. If women were
able to have children they also felt that it was a sign that there was no need to have screening as they were healthy:

“Um I think the mostly the same thing that you don’t know how important it is. You know it’s part of medical check-up, you know, but you don’t know how important it is. So sometime when they come and say oh forget it, it’s not like you know, everything is going nice, we having babies and mostly we think that if we don’t have baby then only have some problems ok, otherwise we are fine, women are fit, you know.” (Participant 5)

The responsibility placed on a woman to look after her family is nurtured from an early age. As a young woman there is an expectation to contribute to the domestic work of the household and an emphasis on one day being a mother. Prioritising others before themselves, therefore, occurs at a young age. Young Muslim women have described how they experience family life and this has been found to be different to that of westernised lifestyles (Kay, 2006). Many young women spend large amounts of their time at home and only travel a small distance away from it:

“You are a daughter mean you have more responsibility…. You know think about everybody everybody in the family, you know, your brothers, your father, people guest is coming you have to look after everybody. Nobody will say you have to look after yourself. So from ourself is gone there, so we don’t care about ourself.” (Participant 5)
Becher (2008) found that many women felt that due to the availability of servants and extended family, life was easier in Pakistan than in the United Kingdom. If women had work outside the house then the demands of domestic work were particularly high. Some of the women reflected back on how life in Pakistan had been easier when they had had support from relatives and employees and how their life in New Zealand was so different:

“I was thinking before that Pakistan is much better than here because (t)here you can get lots of help from your relatives, parents and like the servants can come and they will do for you, you know something but here you have to do everything with your hands you know.” (Participant 8)

Women explained that in Pakistan it was discouraged to discuss sexual matters or topics thought to be taboo in the presence of unmarried women. It was felt that this would protect them from ‘improper’ desires. Women explained that prior to getting married they were not educated regarding sexual matters or topics that were thought to be taboo:

“In Pakistan they say that you are not allowed to talk to the bachelor girl, in front of the bachelor girl if you are a married woman you can’t say your private things in front of those bachelor girls so they don’t get the information and so it’s good for them that they don’t hear these kind of stuff because they will feel, oh I wish I could have this or I wish, like they can have this imagination thing going on with them and they can, they can have a bad or impression, you can say.” (Participant 3)
In not being able to talk to their mothers, many of the women were naïve in their knowledge and understanding of cervical screening services. However, some women felt that they would talk about these matters to their children as they felt that it was important. This may lead to the assumption that the women’s views have been influenced through living in New Zealand and that their views on discussing cervical screening may be changing:

“But I think I will talk to my daughter because I can explain to her, it’s good for her, we just, if we um just avoid this kind of talkings it’s not good for her, how can I think she can understand. So I will I think talk with my daughter but my mum I think she didn’t talk to me at all about this kind of things.”

(Participant 4)

Summary

In this chapter the impact the move from a collectivist to an individualist society has on women’s perception of cervical screening has been discussed. The participants utilised formal support structures in the absence of the strong emotional attachment and support they received within their native country. In some cases the health services available were seen as beneficial. However, general satisfaction with the health care system was mixed which may impact on screening uptake. Cost was also seen as a barrier to accessing health services and thus on attendance for cervical screening. If user charges to access GPs results in infrequent visits, the opportunity to inform the women on cervical screening may be missed. An understanding
relationship with the GP also may not be developed, leading to avoidance of cervical screening due to feeling uncomfortable with the GP.

In order to be able to retain some elements of a collectivist society the women had strong ties to other Pakistani families in Christchurch. Through these relationships they were able to replicate some of the social support they had in Pakistan. This was especially important for cervical screening as information was being disseminated amongst the women themselves. Women felt more able to relate to members within their own community and were more likely to take their advice. The community support, however, was also a hindrance for unmarried women attending cervical screening as they feared the community would presume they were in a sexual relationship if they attended cervical screening. This would have negative effects on their own reputation and that of their family’s.

The role of the extended family was also important in influencing Muslim women in their uptake of cervical screening. Whilst living in Pakistan, support from extended family lessened demands on women in maintaining the household. On moving to New Zealand the absence of this support may have increased demands on women, which acted as a barrier to screening. Visits from extended family may have provided an opportunity for women to participate in cervical screening due to the additional support available. The strengthening of cultural identity during these visits may have had an impact on the acculturation of the women, which could in turn affect attitudes towards cervical screening, as discussed in the following chapter.
The strongest influence on perception would have come from the nuclear family. Arriving from a paternalistic environment the influence of the husband was very strong for Muslim women. Husbands were seen to vary in their support or discouragement of cervical screening. Some women found talking to their husband about cervical screening embarrassing and tried to avoid the topic. The women also lived very busy lives and sacrificed themselves in order to meet their families’ needs. This attitude develops at a young age for Muslim women due to the influence of a collectivist society. Cervical screening may, therefore, have a low priority for Muslim women and result in poor attendance.

Compared to an individualistic society, where emphasis on individual goals results in women making their own rational decisions regarding cervical screening, the women in this study originated from a collectivist society, where the goals of the community are the first concern. On moving to New Zealand, Muslim women would have experienced varying levels of acculturation. This may have influenced whether they prioritised their own goals or that of the community. Acculturation was the second major theme that emerged. This is discussed in the following chapter.
Chapter 5: Acculturation

The second dominant theme arising from the interviews was that of acculturation. Included in this was the role of religion and culture in the uptake of cervical screening and the cultural awareness of health professionals on both the uptake and experience of cervical screening.

Redfield, Linton and Herkskovits (1936: p149) defined acculturation as a:

"...phenomena which results when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture patterns of either or both groups."

Acculturation affects the culture of a group as well as changing the psychology of an individual (Berry & Sam, 1997). However, individuals within a group will vary in the extent to which they adapt to the changes. Three key factors that have been identified in the process of acculturation are voluntariness (for example, immigrant or refugee), mobility (for example, physical move or colonisation) and permanence (Cabassa, 2003). The women in this study were all immigrants and a physical and permanent move from their native country was involved. This move was, however, a voluntary process. There are a variety of different factors that influence how people acculturate (Padilla & Perez, 2003). These include family structure, religious beliefs and practices, gender, personality characteristics and power relationships between the host and minority group. Changes can be seen to emerge over a number of areas such as attitudes, values, behaviours and a sense of cultural identity (Ryder, Alden, & Paulhus, 2000).
Two theoretical models have emerged to explain the acculturation process. Unidimensional models view the acculturation process as movement along a single continuum (Cabassa, 2003). This ranges from immersion in an individual's culture of origin to the immersion in the host's culture. According to this model, the culture of the acculturating group has no influence on the host culture. This model only permits an individual to have access to one culture and requires loss of the other culture.

Bidimensional models of acculturation recognise two independent dimensions within the process. These are the maintenance of the culture of origin and adherence to the host culture (Berry, 1997). Cultural maintenance is the extent that cultural identity and characteristics are important to individuals and how much they strive to maintain them. Individuals can choose to strongly adhere to their culture or neglect the culture altogether. However, the second dimension encapsulates the level to which the individual has contact and participates with the host culture. The two dimensions, therefore, allow an individual access to both cultures without having to neglect one completely. According to this model, Muslim women can maintain their culture and religion whilst incorporating aspects of New Zealand culture.

A theoretical framework has been conceptualised incorporating the dimensions of cultural maintenance and adherence to host culture to identify four strategies, which may be used to adapt to a new culture. These are separation, assimilation, integration, and marginalisation (Berry & Sam, 1997). Separation is described as the rejection of mainstream culture and identification with their ethnic group only. Conversely, assimilation involves the rejection of their ethnic culture and identification with the
majority group only. Integration allows them to identify with both groups, whereas marginalisation involves the rejection of both cultures.

This theoretical framework assumes that individuals are free to choose the strategy they desire (Cabassa, 2003). However, if the individual is restricted from interacting in the dominant culture, assimilation and integration may not be possible. This model also implies that individuals make a conscious decision on choosing the acculturation strategy they will use. Although some immigrants may be mindful of their approach to cultural maintenance and adherence to host culture, for others this may occur instinctively. Similarly, those who decide to follow a certain acculturation strategy may unconsciously diverge from this due to the circumstances they are in.

Participants in this study described Muslim women acculturating in different ways. Some of the participants talked about how Muslim women changed when they came to live in New Zealand. They discussed how they often changed their appearance, their dress and also seemed to gain confidence:

"Time by time they gain confidence, time by time, they don't live the same. You know when they are seeing the freedom, they are seeing, looking at the other peoples, the other womens who are before here from them so they are looking, they are you know changing their skin or like this, their way of talking they change, their way of living they change, they cut their hairs or like this, they get confident. When most of the womens I have seen they you know when they came in the big gowns, but after three four years you will look at them you will see they cut their hairs and they got confidence in the
talking and involving everywhere, you know they got confidence and its good that their children can get better day by day, they can if their mother will be educated the childrens will be educated and they will learn more than her, its good that they are getting confidence here rather than the Pakistan.”

(Participant 7)

Others did not feel that it was possible to change the way they had been brought up in Pakistan. Subsequently, they rejected mainstream culture and maintained Pakistani culture. They did appreciate that their children would be exposed to both cultures but felt that as they would maintain a Pakistani culture at home this would be the culture that they would retain:

“You can’t change the culture. You can’t change the brought up so it’s just the information you can provide. You can’t like, if I’m brought up I, I’ve had my brought up in Pakistan. Even though I have been living here for about 8 years but I am still following my brought up. I’m not like following the culture here, I am following my culture back home, I want my childrens to get the same culture which I am following. They can get the, they will get the both worlds like, a bit of the culture of me and a bit of like outside culture but it’s like, like I want them to have this culture and I think you can’t change a persons brought up. You can change everything but from the, like he is too young, whatever I tell him to do he will start doing it and then he, it’ll become his habit, throughout his life.” (Participant 3)
Participant 3, however, was able to identify that being exposed to two different cultures would mean that their children had two nationalities and speak two languages and so would be more integrated. Madood (1994) cited in Robinson (2009) found that young Asians sometimes combined the country of origin and the country of settlement with hyphenated symbols to describe their ethnicity. This was in an attempt to retain some heritage, language and family customs, but at the same time not to live segregated social lives. They wanted to live in an ethnically mixed way:

“I told my other little one who is in school, I told him look, he has only got one nationality and you have got two nationalities, you are much much more than him, so look you can speak two languages and he can only speak one language, so stuff like that so just to make them feel better, yeah.” (Participant 3)

As acculturation will affect so many aspects of Muslim women’s life it is important to understand how this will affect women’s decision to participate in cervical screening. It is not only important to understand the acculturation process for the women currently requiring cervical screens but also how acculturation may affect the views of their children. Acculturation has been found to vary from the first generation (immigrant generation) to future generations. Keefe and Padilla (1987) cited in Padilla and Perez (2003) showed that cultural awareness of immigrants’ country of origin declines from first generation to fourth generation. However, they argue that loyalty to the culture of origin remains consistently high throughout generations. It is important to note that all the women in this study were first generation. Future generation’s attitudes and uptake of cervical screening may, therefore, differ from
those of the participants in this study. Cervical screening programmes in the future will need to be sensitive to the values that future generations hold in order to ensure that attendance of cervical screening is maintained.

**Importance of religion and culture in the uptake of cervical screening**

The importance of religion and culture for the women was a major theme that emerged throughout the interviews. Religion and culture are two different aspects of a person's identity. There are over 1.57 billion Muslims throughout the world yet they come from a variety of different cultures (Padela & Pozo, 2010). They may, consequently, have different views on certain issues and may interpret Islam differently. Islam is a way of life for many Muslims and is present in every action and decision that is made. The Pakistani culture played an important role in the worldview of these women. However, they also acknowledged that they were incorporating the Western culture into their life and therefore described integration. Some of the women were able to identify that religion and culture often became blurred and caused confusion not only for them but also for non-Muslims:

"We very much culture we adopt from Indian culture you know and we even adopt the western culture but sometime we try to mix the culture and religion and there we always get confused you know and make other people confused to think about ourself because er when we say we can’t something they will say maybe they are Muslim that’s why but no something is our culture, you know." (Participant 5)
Some Muslim women felt that their culture was not well understood in New Zealand so that they looked to their own communities for support:

“Obviously the other people don’t know our culture well, you know, because um it’s not much information for them, you know, so they will like er think it’s um differently, you know, so they only can see from far, but they don’t come forward to see it like what you will need, you know. So that whatever you will have to manage ourself.” (Participant 5)

However, in contrast, other women found that there was an understanding of their religion and an interest in it. This made them feel more accepted and less ‘othered’ in New Zealand society:

“Lots of people they can understand our even religion you know. Like when that’s our fasting month is coming or Eid celebration they know that, you know. I was really surprised when they told me they know all about Ramadhan and you know about Eid and this and that, they know all the things like when we call school that our Eid celebration is coming then they feel very happy, they also wish you know. Then I am thinking they know our religion and you know our culture. They are good.” (Participant 8)

Other studies have looked at different ethnic groups and the process of acculturation. In the United States (US) it has been found that first-generation Mexican women tended to socialise within their own ethnic neighbourhood (Viruell-Fuentes, 2007). They were, therefore, thought to have less contact with people and institutions that
were delivering 'othering' messages. As a result they felt more positive about their treatment as Mexicans in the US. Similarly, this was reflected in this study where women were very happy with their lives in Christchurch:

“It’s a very peaceful city you won’t believe, here every culture they love religions, we have no tension whether we are going in any conditions, we are wearing clothes or not, it doesn’t matter but you know in our country the main problem was that if we are walking on the road, like, everyone is looking at you and that’s the most embarrassing thing for us, I don’t like this. But in Christchurch, oh I love this country.” (Participant 7)

First-generation Mexicans in the US who did speak about ‘othering’ messages were those who interacted with people outside of their community (Viruell-Fuentes, 2007). In this study, women who had regular contact with people outside of their community, such as in schools, found that being a Pakistani was especially isolating as people assumed that you were Muslim and reactions towards Muslims were generally negative:

“It was different like they used to thought that I am an Indian or a Hindu so they were like, they were ok to talk to me but whenever I told them that, there is, the main question is where are you from and when you say that I am from Pakistan they said oh, oh Pakistan, oh I thought you were an Indian and then they, the discussion just changes and then they just think and speak and like nothing much going on. That kind of stuff, yeah. Even in the schools, in the kindy people are not comfortable talking to me or maybe to the other
Pakistanis, like we are like aliens, we are sitting alone and they are talking alone, so its that kind of stuff.” (Participant 6)

A summary report on Islamophobia cited in Thurfjell (2010) gives clear evidence that Islamophobia is widespread on the continent. Muslims have greater difficulties in the housing and labour markers, vandalism of Muslim property is common and the verbal and or physical assaults on Muslims are frequent. At the same time as Muslims in these ways are systematically discriminated against in almost all social spheres, the image of Islam as an ideology that constitutes a great threat increasingly gains hold.

Second generation immigrants are exposed to ‘othering’ messages at an early stage in their life and these messages can be more explicit and pervasive (Viruell-Fuentes, 2007). One of the women interviewed in this study, found that the negative attitudes towards Pakistanis were also being exhibited by children at school:

“All of the culture kids so um there was another Kiwi friend of him and he told him that “oh you know that I am going to tell all your buddy readers that you are a Pakistani and they are not going to talk to you anymore and they won’t be your buddy”. And I told this to the teacher and she said “oh I will try to talk to that little one’s mum but we can’t do anything because definitely you guys are different from the other kids so kids just think for themselves. It’s not like their mums or dads are doing it with them or stuff like that.” She didn’t take any action actually. But this teacher, this one is really really good. She always like protects my little one, always look for him and what’s he saying, trying to listen to him yeah.” (Participant 3)
Despite experiencing greater difficulties due to being Muslim, religion still plays a major role in Muslim women’s lives and therefore it is important to understand how cervical screening may be perceived from an Islamic point of view. Although in Islam there is the belief that ultimately the cure lies in God, there is a personal responsibility placed on Muslims to seek remedies for ailments (Ahmed, 2008). This is due to the body being seen as having certain rights, which must be respected. Muslims are encouraged to seek the advice of trained health professionals for physical diseases of the body. The women interviewed agreed with this, expressing that they felt Islam placed great emphasis on protecting the body and that it was, therefore, important to look after themselves:

“So Islam is just a way of life and the God tell you everything about your body and and he said look after your body very well. If we read our holy book and after I think every Surah they have mention you know that you have must look after yourself.” (Participant 5)

For some women the Islamic requirement to look after your body and believing that cervical screening was good for their health meant that they were willing to participate in cervical screening:

“I’m I think I always care about the health so I really I don’t mind. Because when I heard it’s good for my health so I just do it so I didn’t avoid to do

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6 Surah is usually translated as chapter. The Quran is divided into 114 Surahs which are arranged in order of descending length. (Esposito 2003c)
smear. If it’s good for my health it’s good for me, it’s useful for me so why not. Why I’m just say no I don’t want and something like that.” (Participant 3)

Women identified themselves as being different to other New Zealanders due to their views on sexual relationships. Muslim women are not expected to enter sexual relationships until after marriage and Islam places a strong emphasis on the family and prohibits adultery. Many Muslim women felt that this was in contrast to other women in New Zealand who they felt did not share these values. Hosper et al. (2007) found that behavioural risk factors in non-Western migrants do not all change to mimic that of the host population. The women in this study’s views around sexual relationships had not changed as a result of acculturation:

“Because we are confident in our own self that we are not that like people. Because like other Kiwi people, like um New Zealand people then when the girls just grown up they just started doing like the things you know, like different different males you know so it’s our one is different you know. We have to start the things when our normally age is like twenty or twenty-one or twenty-two you know. So I think we are quite like age are like old enough to understand what the things are. Yeah so I think we are lucky anyway.”

( Participant 6)

Box (1998) found that women associated promiscuity with cervical cancer and thought of it as a disease of the West. Many of the women in this study shared this view. They perceived New Zealand women as promiscuous and consequently
requiring cervical screening. As they were only having sexual intercourse with one partner, cervical screening was unnecessary for them:

“It’s not I think um compulsory for the Muslim womens because just maybe live only one person. This is good for our um like a Kiwi ladies because every weekend they are different boyfriend, going a different I think mans so they I think need to do smears so why I think we do because we just living I think with one man or something like that. Something discussing sometimes.”

(Participant 4)

Language is also an important factor in acculturation. If a Muslim woman is unable to speak English then she is also likely to see herself as different to other New Zealand women. South Asians in the UK have been found to speak English poorly and this is seen as a major barrier to accessing screening services (Szczepura, 2005). In this study, an inclusion criterion was that all participants spoke English, but for many on arrival in New Zealand their English had also been poor. It was felt that the language barrier still existed for Muslim women in New Zealand:

“They are not really, some womens can’t speak really good English, maybe that’s the reason why they are not aware of this thing um because it’s a language barrier is the main problem. If you want somebody to understand something you need to like have the same language as well so maybe it’s, I think the language is the main barrier.” (Participant 3)
Although translators may seem like a good solution to language barriers, there have been a number of issues identified by other studies. Whilst Abdullahi et al (2009) felt that participants lacked trust with interpreters, Elkan et al (2007) raised the issue of the appropriateness of family members acting as translators. Women in this study also identified problems with translators in not fully translating all the details:

“There are like so many language barriers, like, every time you see these women they need a translator, you know. I think that’s the biggest problem here. They should at least learn English language because the translator, with the translator, I have personal experience that the doctors is telling something else but the translator is like shortening it even less than a summary and that’s the reason the person cannot understand.” (Participant 2)

Others described that using a translator did not allow the patient to express themselves as they wished and misunderstandings could occur:

“We can’t say is interpret wrong. I think it’s er like myself is a, if I can speak English so I its more easy for me to um tell my GP what’s wrong with me, what I feel about, ok and then er if I say to you I feel like oh I feel a pain in my leg, I don’t know sometimes I feel like pain in my bone so you can’t feel pain in your bone but you can feel around your bone, you know like in your knee or stuff. But that’s little bit difficult I think, yeah, little bit difficult, it’s hard for me to explain that but it’s difficult, yeah.” (Participant 6)
If a Muslim woman is unable to speak English but does not have confidence in translators then it will be difficult for a GP to explain properly what cervical screening is. As a result Muslim women may have incorrect perceptions of cervical screening. Box (1998) found that there are disparities in how much cervical screening is understood. Some women in this study understood that the cervical smears were performed to prevent cervical cancer:

“They don’t want you to get like that cervical cancer or stuff like that so they just keep checking you.” (Participant 3)

However, other women were unsure of the implication of abnormal smear tests and were keen to be told information. Other studies have also found that some women do not have good understandings of smear tests (Chiu, et al., 1999):

“That’s sort of things I want to know, what will be abnormal if it’s not right. If it’s not normal the abnormal will mean what, you know? Yeah so they don’t give you this information.” (Participant 5)

The lack of explanation exists not only for the test but of the procedure itself. Many studies have reported a lack of information provided prior to the test (Box, 1998; Chiu, et al., 1999). This has been found to instil fear in some Muslim women due to feelings of helplessness. In this study not being given sufficient information about the procedure caused a lot of distress and shame for one woman:
“She did once when I done like you know and the first time I went that time I was not married and they started. So I went to the, I didn’t even know what’s going to happen because it was so shame for me to go and see doctor to do that. But er I didn’t ask why the reason for that but um when I got my children then the doctor explain me that what we are going to do, what’s happen.”

(Participant 6)

The religious beliefs and the cultural values that women hold will, therefore, affect their perception of cervical screening. Religion was found to be a positive influence on the uptake of screening, whereas an inability to speak English and perceived sexual values were negative influences. The cultural understanding of health professionals also had an influence on Muslim women’s perceptions of cervical screening.

**Cultural understanding of health professionals**

Szczepura (2005) has identified cultural differences that may influence the delivery of healthcare to minority populations. These include: patients’ health, healing and wellness belief symptoms; how illness, disease and their causes are perceived; the behaviour of patients seeking healthcare and their attitudes towards healthcare providers; the views and values of those delivering healthcare. As a result, the attitude and understanding that a health professional has regarding participants’ religion and culture may affect the relationship and, consequently influence their perceptions of cervical screening:
"You don’t know how much time you have with the doctor, so you just quickly finish your job, you say dadada and they quickly tell you dadada so its not why its happening, what your lifestyle is, whereas back at home they know where you eat, they know what you do, so they give you advice straight away, don’t eat things like that, um better to do walk and then so they give you prescription as well as advice straight away so you feel that trust or that kind of like they know you, your background.” (Participant 1)

The participants felt that there were a number of aspects of their religion and culture that were different to that of New Zealand women. The awareness of health professionals to these differences is important in allowing Muslim women to feel comfortable with cervical screening. One woman described how she felt that health professionals respected her religion and culture so that she felt more at ease with them. This was in contrast to other studies where women felt that there was no sensitivity given to their culture and a lack of understanding of health professionals existed (Matin & LeBaron, 2004):

“That’s why I’m thinking they always respect, even like er changing clothing and this and that they know that we are Muslim, we can’t, you know like the men if the men will come in we can’t change our dress or then I am thinking they always respect. When we are Muslim they will respect us, you know. Like not racist people they are. They are good, you know. Even the ladies doctor they are always. Like when we are fasting, they are not teasing us and not telling us why you are, you know, fasting and this and that. They know
that that’s our religion, you know. I think they are good in this case, you know.” (Participant 8)

The dress of Muslim women is a very visible difference that can easily identify them. The Quran as well as the actions of the Holy Prophet Mohammed describe Islamic dress code (Padela & Pozo, 2010). These specify specific areas of the body that should remain covered depending on the people present. The intention behind this is to reduce the temptation of extra-marital relationships occurring. The difference in dress culture in New Zealand was especially uncomfortable for many of the women when they first arrived in the country. However, through the acculturation process they seemed to have become more accepting of the difference in dress culture:

“So here um when I came in New Zealand it’s summer, you know, it’s different dress and erm it’s very open I think atmosphere so I am, I’m not feeling good, but now I think I’m used to when I just see any flyer and I’m just saw the pictures and bra and underwear, something like that, so erm maybe first time I’m just maybe er wrap it and put it in the rubbish, something I feel so maybe shame or something like that.” (Participant 4)

The women felt that the clothes that they wore led to misperceptions regarding their knowledge of the English language and therefore the attitudes that people had towards them. This issue has also been found in Australia where pregnant women felt that health professionals assumed they could not speak English because of their dress (Tsianakas & Liamputtong, 2002):
“They think that you can’t speak English, they think that you can’t talk, or they won’t understand you or you don’t understand them, or the clothes doesn’t matter, I mean, the people matters but they don’t think like this. I know sometimes its hard to understand English because of the accent and because of our brought up as well but it’s not really that bad that nobody can speak English.” (Participant 3)

If there are misperceptions that Muslim women cannot speak English then health professionals may not fully explain cervical screening to them. It may also increase ‘othering’ messages to the women and as a result they may struggle to integrate, which may have an effect on uptake of cervical screening.

Rajaram and Rashidi (1999) contend that health care providers are unaware of the discomfort caused by exposing the body and are not always sensitive of modesty requirements for Muslim women. Having to remove clothing for the cervical smear to be performed was a daunting prospect for many of the women interviewed. For some women, having to expose their body brought up feelings of shame and sometimes this feeling was so strong that they did not attend cervical screening:

“For us because we don’t show our body very, even not our shoulder and arms, and you know, legs to anybody, don’t expose ourselves to outside people so it’s bit hard for us to you know go in front of doctors and say ok, you going to check us, no.” (Participant 5)
"I have one Somalian friend, she was from Somalia, Muslim, she was wearing very long gown and scarf and before that she had a letter, she was talking to our friend that they ask me for this test and she says ‘I don’t want to go’, and I says ‘why you don’t want to go?’ She says ‘oh its no good, they will ask us to take off the, you know, trousers or like this and its no good’.” (Participant 7)

Muslim women perceive themselves to have different attitudes to sexual relationships, compared to other New Zealand women. Intercourse between an unmarried couple, be it pre-marital or post-marital, is a grave sin that is punishable. Extramarital sexuality threatens family stability and ultimately peace in society because the activity causes strife for individuals, families and societies (Altareb, 2008). Many studies have found that cervical screening is embarrassing for Muslim women (Abdollahi, et al., 2009; Box, 1998; Fylan, 1998) as the idea of being touched in this area is distressing. Women feel that only their husbands should have access to this private part of their body. One woman found it especially embarrassing:

"Never had that and I think when I had my first smear and then I was so shamed because my brother gone with me and my sister-in-law and then I said ‘what’s she going to do it?’ he says to me ‘what’s the smear like?’ I didn’t want to do it and when I came back and then I was so um I feel shame in front of my brother because our culture is different, they was different because they are totally open people but we are not, that’s another thing, so I never talked to my brother and then next time I said to my sister I don’t want to go.” (Participant 6)
The issue of virginity was also raised for younger women in terms of how the test would affect this:

"Like we are not doing the sex before marriage you know and er the only thing is I am thinking that’s if they are using the stick you know that and if they hurt that you know like the part then little bit I am thinking you know maybe the misunderstanding after marriage you look and you know they will think about that but that’s the only fact I am thinking. Otherwise I am thinking no problem. If they safe then no problem." (Participant 8)

The issue of virginity is a major theme in Matin and LeBaron’s (2004) study. In this study women felt that a smear test could be seen as a threat to a woman’s virginity due to its possible effect on the structure of the hymen. These participants did, however, acknowledge that not all women may remain virgins prior to marriage but due to privacy concerns they may still not attend cervical screening until after marriage.

In order to prevent extramarital relationships from occurring there is marked segregation of the sexes from an early age. This segregation can lead to women feeling uncomfortable with the opposite gender in everyday situations:

"In our culture we don’t get to have much interaction with the opposite gender and its only the ones that are in your own family like your fathers and stuff and although I am like, I I do not ever went to co-education, like in Holland to I think year four I was going to co-education but when I went to Pakistan I"
just always went to girls high schools, even here when I came here I went to
girls high schools so it was never that much interaction, you know, and so like
its like a psychological thing you know, its not anything, I know that they are
all very nice but its just like a psychological thing. You can’t control it, you
just start getting nervous, so that’s how it happens. That’s the reason.”
(Participant 2)

As modesty and the privacy of the pubic area is important to Muslim women, the
gender of the health professional will play an important role in whether they attend
cervical screening. This is increased by the varying levels of segregation that is
thought to be necessary between the sexes. Many believe that although absolute
separation is not necessary, interaction should be limited with unrelated males. In
Islam unrelated members of the opposite sex are prohibited from having physical
contact with each other (Padela & Pozo, 2010). This is to remove any temptation for
either party to engage in sexual activity. This was reflected in this study by some of
the women being willing to see a male GP as long as no examination that required
removal of clothing was performed:

“If I’ve just got a flu and fever then I think it’s ok but I think during delivery
and I think some other maybe he just check like ECG and in this area, you
know so I’m not comfortable, I’m just avoid maybe the male I think GP or
doctor just um consult with me or maybe examine me really I don’t like
because we just brought up a different er atmosphere in Pakistan and in
Pakistan or maybe India is a male society.” (Participant 4)
Many studies have found that Muslim women prefer female health professionals, especially if examination in private areas will be required (Abdullahi, et al., 2009; Simpson & Carter, 2008; Underwood, et al., 1999). Women in this study also identified that they would prefer to have female doctors, especially for cervical smears:

“Yes with I think female GPs more comfortable talking and if I think just touching us something so is feel more comfortable. And if I think the smear doing for me, if I think it’s a male is doing so I’m just feel uncomfortable and I’m just feeling so embarrassed and I’m not talking I think um openly with him so I prefer I think female.” (Participant 4)

It was important for the Muslim women in this study that health professionals understood their need for female doctors. Being questioned regarding this made them feel uncomfortable:

“Some people they understand you but some people say, oh why do you want, a male doctor, oh a lady doctor, I mean its alright to check, he’s a doctor but they cant understand that it’s your cultural thing and you feel shy about it.” (Participant 3)

Other women, whilst they felt that they would prefer a female doctor, were willing to be treated by a male doctor if a female doctor was unavailable. In Islam deviance
from rules is permitted in a case of need and emergency (Padela & Pozo, 2010). In these cases it is felt that necessity allows for that which is prohibited to occur:

“The religion, no it's not kind of a hindrance because um in Islam when you have some problem you go to the doctor, when you deliver a child you go to the doctor. It doesn't matter if it's not a woman, we prefer to have a woman if not, man is fine but because you know that this is what supposed to happen, you know, and you need it, the child needs it, it’s for your life, for your child’s life, for the family. So when it comes to the practical thing the Islam actually tells you to be practical. They don’t say it’s a man, it’s a woman, in our holy book nothing is anything written like the man is not going to see you, when you are his patient, you know, they don’t say anything like that. They say go and find knowledge men and women both, so can be anyone, so it’s not like Islam is hindering anything, you to do anything good, or for your betterness, or for the other people’s betterness.” (Participant 1)

However, for some women the thought of a male doctor touching them was unacceptable even though they understood it was purely a procedure:

“I think only husband can touch women so we not used to maybe other people can touch our body. So that’s why we just avoid, that’s the only reason but I know, I know I think the doctor, he is a doctor, he’s not a male, he’s not er aim like touching womens, he just like examining and helping in health and things but even we know, I know he’s a doctor but he’s a man, you know what
I mean, so that's only way so we just Muslim, me prefer only female doctor.”

(Participant 4)

Requiring a female health professional has been found to be problematic. Tsianakas and Liamputtong (2002) found that in the public health care system a female gynaecologist could not be assured and male doctors had been required to carry out procedures which Muslim women were unhappy with. Under the private system a female doctor could be arranged. Participants found this to be the case and one woman had decided to use the private health system for this reason:

“Then in this case if you have problem then you will get the male doctor because we don't have I mean women doctor very much and then you have to get some male or whoever on duty, you know your own risk. So then um I can I have then I said how to get the women, then she said you have to book privately.” (Participant 5)

Differences in communication were found between the health professionals in Pakistan and those in New Zealand. Women described that in New Zealand health professionals would fully inform the patient of any possible issues, whereas in Pakistan a lot more information was withheld. There did not appear to be a consensus between the women as to how much information they would like to be given. Some women who were able to integrate into a Western culture more preferred a Western style of communication:
“You know in our country they hide everything from the patient, but here they tell if the patient is on the die bed, they will tell him the truth that what’s happening to him and it’s good because if they will hiding him and all of a sudden he will die then the family and they will say that he didn’t let us know, he didn’t told us that this will happen to him. But you know it’s good that they are telling each and everything, even the worse they are telling that this could happen to him, this patient. And that’s good they, after that if this doesn’t happen to that patient and the bit happened then we are happy that oh thank God that didn’t happen to him, so its good they are telling to the patient and to the family each and everything.” (Participant 7)

Other women, less integrated into New Zealand culture, preferred the Pakistani style of communication:

“And the thing is here in New Zealand one more like, they are good, they are very open but I think for our country this kind of serious patient we don’t straight away tell them this kind of tell them off, you know that you have no life left and you only three months and then you, we don’t have any medication to offer you and you are better go and spend your time with your family. So I will think just how they can be so cruel suddenly, you know. Even they don’t have anything they should tell him maybe we will find out something for you. They know they can’t do anything for them, at least they can give them a hope, you know. So that the things like, you know, they tell him straight away.” (Participant 5)
It is important that health professionals have an understanding of cultural communication differences. This will influence the understanding a Muslim woman has regarding cervical screening. Chiu et al (1999) has suggested that women’s inability to communicate and the way they come into contact with the screening service may result in them feeling obliged to accept the screening test. A doctor’s explanation as to why the smear was being done reassured women that there were good reasons behind doing the test and so they felt more comfortable accepting it:

“Yeah I felt better about it yeah because the doctor explained that why we are going to do. Um we have smear because we just want to see that is any disease or because is most of the um woman have that disease like cancer or so we want to send this to um the laboratory and then if we find something so we can treat you. So if it is like normal so then you don’t need to anything, you just yeah.” (Participant 6)

Despite the cultural differences, most women described having overall good experiences with health professionals. Health professionals were thought to be caring and very supportive:

“They are caring you know, very caring you know. They are after five minutes they will come and have a look what’s happening you know. And looking after you properly, they will explain you, you know, things what will be happened and this and that.” (Participant 8)
However, some women felt that they were not always listened to by health professionals which resulted in them feeling that their symptoms were not justified:

"Now I was having pain and I tell the midwife I am having pain and she didn’t believe me, because she thought I’m just not in the real pain at the moment and she say no, you are not crying, you know (Laughing). You are not crying when you are not in labour and I just laugh at her, you know, that I said. This is not reason I should cry, I mean if I can take it I can take it, doesn’t mean if I’m crying, making noises that’s the only way I’m going in the labour pain, you know." (Participant 5)

It was unclear as to whether the women felt that these situations were a result of discrimination or occurred due to the stresses of the health professional’s job. However, Box (1998) has found racism to exist in the health care profession. Experiences women have with health professionals will affect their overall satisfaction with health services. If they have bad experiences it could lead to an element of distrust and to them not attending cervical screening.

Many of the women described that they had built up good relationships with their general practitioners. This relationship was very important for them as the GP knew and understood them, rather than another GP who would not understand. Their own GP may have developed an awareness of the women’s culture as their relationship had developed:
“He’s such a good person but I only have problem when I don’t get him (Laughing) I get somebody else you know. And that doctors, yeah, sometimes they have a new doctors in the practice and they don’t know your record or anything, you know and maybe they are new so they don’t know how to deal the, you know, the people.” (Participant 5)

Although the women in this study generally had good relationships with their GPs, they still described difficulties in expressing their reluctance to have the cervical smear test. The perceived power of the health professional may thus have a role to play. Simpson and Carter (2008) argue that even assertive women can be forced to be passive due to the actions of the health professional. As a result the women may feel obliged to participate in screening when they do not wish to do so:

“With the doctors it’s a difficult part because you can’t let them understand that why don’t you want to have the cervical smear. Um you can’t say that sometimes a person like me, I’m a bit shy with the doctor, I can’t talk to the doctor like openly. Can talk to the lady doctor openly but can’t talk to the male doctor openly but I can’t say to the doctor that I don’t really want to do it, just because I don’t like it or I don’t want to have it.” (Participant 3)

The relationship that a woman has with her GP is important in accessing cervical screening. One woman described that if an understanding relationship was formed with a female GP then the smear test may be less embarrassing. However, as a result of her GP being male, she rarely visited the female GP and had not, therefore, established a relationship with her:
“If you are easy with your doctor, if you are relaxed with your doctor and you have known your doctor for a couple of years and you know that she good and I’m talking about a female doctor, not the male doctor, she is good then she is like, you know her for quite a long time now, so then I don’t think that it will be a problem because that’s a check up which you have to have. But if it’s like, what I do, I go to the doctor sometimes but all the time I’m going to that male doctor so I’m not really having that relationship with her, that I’m not really really easy with her so that’s why maybe it’s embarrassing for me to do it, to have it. But I think if you know the doctor for quite a long time.”

(Participant 3)

The cultural understanding of health professionals is, therefore, also important in facilitating Muslim women’s access of cervical screening. There are many parts of their culture that make them different to other New Zealand women such as their dress, views on sexual relationships, preference for female GPs and ways of communication. In order for a good relationship to be built with Muslim women, health professionals should be sensitive to the cultural differences.

Summary

In this chapter acculturation and its effects on Muslim women’s perceptions and uptake of cervical screening have been discussed. Acculturation will occur differently for all Muslim women and does not remain static but will vary depending on the woman’s circumstances. Religion and culture were important influences on cervical screening for Muslim women. The women in this study emphasised that religion and
culture are often confused, not only by others but also by themselves. This could have the effect of stereotyping women incorrectly. Some women found that there were negative reactions when others knew they were Pakistani. This contributed to ‘othering’ messages making women feel different to other New Zealanders.

Religion was a major influence on the Muslim women. Many women felt that, because Islam requires you to look after your body, they were willing to take part in cervical screening. However, due to identifying cervical screening with promiscuity and seeing promiscuity as prevalent amongst New Zealand women, Muslim women felt that cervical screening was unnecessary for them. Although language was not an issue for the women in this study, it was felt that a number of Muslim women were unable to speak English. This could lead to difficulties in understanding health professionals and being able to express themselves as they would wish.

The cultural understanding of health professionals was also found to be important for Muslim women. If a health professional had respect and understanding for the woman’s religion and culture they felt more comfortable with them. There were a number of areas where sensitivity was required. The Muslim women in this study found that people assumed they could not speak English due to the style of clothing they wore. Women felt uncomfortable in having to remove their clothes and being touched by somebody other than their husband during the screening procedure because of the importance of modesty in their culture. Preference for a female GP was voiced throughout the interviews. In Pakistani culture there is segregation of the sexes, which can lead to some women feeling uncomfortable in the presence of the opposite sex and they may be unable to talk to them freely. If they have a male GP it
could make discussions on cervical screening particularly difficult. There was also a reluctance to be examined by a male health professional, unless it was a case of emergency. There was also a need for health professionals to understand differences in the style of communication. Depending on the acculturation of the Muslim women they may require different amounts of information or require it to be phrased differently. This is important not only for women's understanding of cervical screening but also their relationship with GPs. The relationship with the GP was a major influence on the women attending cervical screening. The GP’s understanding of Muslim women’s religious and cultural background is essential for this to occur.

The next chapter will provide a conclusion to the dissertation and outline the recommendations based on the findings of this study.
Chapter 6: Conclusion and Recommendations

The aim of this study was to explore Muslim women’s attitudes towards and experiences of cervical screening. Although there is no data on Muslim women’s uptake of cervical screening, internationally uptake has been found to be low. Understanding the perceptions of Muslim women is, therefore, essential in informing improvements to cervical screening services. The study involved in-depth interviews with eight first generation Pakistani Muslim immigrants. Six of the participants were up to date with their cervical screens. One participant had never had a cervical screen and one, although having previously had a cervical smear, was now unwilling to continue with the screening process. In the previous two chapters the two major themes emerging from the interviews were described. These were the influence of moving from collectivist to individualist societies and acculturation. In this chapter conclusions from the interviews will be drawn and recommendations outlined.

Influence of local community

Triandis, Bontempo and Villareal (1988) have described two types of society: individualist and collectivist. Labeling a society as individualist or collectivist is problematic as it represents two extreme sides. There will be countries whose societies lie in between these two extremes. Societies thought to be collectivist may be found to have different characteristics, or communities within a country may differ compared to the majority. Hui (1984), cited in Triandis et al (1988), also argues that individuals may be collectivist in relation to one in-group but not to another. Therefore, the individualist-collectivist construct has its limitations and needs further development.
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Nevertheless, the women in this study can be described as originating from a collectivist society and immigrating to New Zealand’s individualist society. On making this transition they attempted to restore the idea of collectiveness through forming a Pakistani community. The women interviewed all had strong ties to this community. As described by Triandis et al (1988), relationships in a collectivist society tend to be intensive and interdependent. The strong social network had a number of important influences on their uptake of cervical screening. Information on the screening programme was often relayed between women in the community.

Although some studies have suggested that women may be embarrassed talking about cervical screening, this did not appear to be the case in this study. As found in Matin and LeBaron (2004), women were keen for more information on cervical screening.

Recognising the influences of the community is important when delivering information. Suggestions received in Matin and LeBaron’s (2004) study were that the community should come together to openly discuss the topic. Other studies have also suggested that information about services can be spread through community networks (Graham, et al., 2010). Many of the women in this study felt this would be best achieved by a woman from their own community as she would understand them better.

In contrast to the philosophy of neoliberalism in individualist societies, where individuals are assumed to make decisions on their own health behaviours, providing Muslim women with information on cervical screening may not be sufficient to ensure participation in screening. It is thought that in collectivist societies decisions
are not made by individuals but by families and groups (McLaughlin & Braun, 1998). Individuals may also be less likely to question the decisions made for them, believing that the decisions are made for the overall good of the family. Weber and Hsee (2000) contend that there are cultural influences on many aspects of decision making such as risk perception, probability judgements, risk preference and modes of decision making. As a result, a decision made by a person in an individualist society may not appear rational to a person in a collectivist society and vice versa. For Muslim women it is important for the entire community to be accepting of cervical screening, as the social control exerted by strong community networks (Farahani, 2010) could negatively impact on the uptake of a screening programme, especially for unmarried women. Engaging in sexual relationships prior to marriage is prohibited in Islam (Padela & Pozo, 2010) and would impact on family reputation (Becher, 2008). Young Muslim women have been found to avoid cervical screening due to the perception in the community that this may mean that they are having sexual relationships (Box, 1998). It is important that young women who are involved in sexual relationships feel comfortable in participating in cervical screening without fear of the effects this may have on their reputation.

**Women’s priorities**

The women in this study had a vast array of responsibilities. Some were full-time mothers with up to five children and others were balancing part-time work with concurrent household duties. Muslim women are mainly involved in the maintenance of the household, management of the children and maintaining social relations. Similar to Becher’s (2008) findings, many women in this study felt that their lives had been easier in Pakistan where they had access to extended family and servants. The
large demands placed on the women in this study had resulted in them prioritising their tasks. They described many situations where they put their family's needs before their own. It was felt that for some women this may be the reason for them not attending for cervical screening. This is in agreement with Bottorff et al (1998) who found that breast screening was often neglected due to putting others first. It is, therefore, important to make it easier for Muslim women to access cervical screening. This may require wider support than the health system is able to provide, such as childcare support and income support. Awareness of the importance of cervical screening was felt to be essential by the women in this study for increased prioritisation of cervical screening. If women do not feel that cervical screening is important then they may feel that it is a waste of their limited time to attend.

The Role of Religion and Culture

Acculturation involves people's experiences of contact with cultures other than their own. Berry and Sam (1997) have identified four strategies that can be used when adapting to a new culture. However, the extent to which women are conscious of the strategies they are using can be questioned. The way Muslim women choose to integrate with society may also be dependent on particular situations and vary over time. The multiple domains of women's lives may also be affected by acculturation differently. Women in this study felt that they were dissimilar to other New Zealand women in terms of sexual values and had no intention of changing this, but they were willing to integrate more by learning English and not wearing traditional dress. Therefore, it is important that further research is carried out to see how different aspects of Muslim women's lives are influenced by acculturation.
Although religious views may appear to act as a barrier to cervical screening the women in this study did not feel that this was necessarily true. They believed that Islam encouraged women to look after their bodies and seek medical help when required. Muslim women in other studies have also identified that Islam encourages people to participate in health promotion activities (Underwood, et al., 1999).

However, some aspects of Islam and Pakistani culture may lead to misperceptions surrounding cervical screening. This was highlighted by participants' belief that New Zealand women were promiscuous, whilst they were not and, therefore, did not need cervical screening. This finding is not uncommon and other studies have found the same perception among Muslim women (Box, 1998). This important misperception needs to be realigned as Muslim women may be under the assumption that they are not at risk. Awareness of risk may be influential in their attendance for cervical screening.

Inability to speak English is an important contributor to communication difficulties. This can have an enormous impact on women's knowledge and perception of cervical screening. As Szczepura (2005) identified, although all the participants in this study were able to speak English, they highlighted that this would be an issue for other women. Translators are not a satisfactory answer for many women (Abdullahi, et al., 2009). Women in this study voiced their desire to express themselves in order to be understood and felt that translators were unable to do this. The ideal solution would be to employ a health professional capable of speaking the same language. However, this may be an unrealistic solution given the different health services Pakistani women access.
Cultural Awareness of Health Professional

In their definition of acculturation Redfield, Linton and Herskovits (1936) claimed that acculturation would affect the culture patterns of either or both the host and migrant groups. Since then it has been acknowledged that those immigrating into a new culture will acculturate more than those already in it (Berry & Sam, 1997). As a result it may be difficult for New Zealanders to understand the culture of Muslim women. It is important that health professionals are sensitive to the different values and beliefs that Muslim women have in order for an understanding relationship to be developed. Many studies have found that a lack of cultural understanding in a health professional can act as a barrier to health services (Elkan, et al., 2007; Szczepura, 2005; Underwood, et al., 1999). Women in this study felt that they were different to New Zealand women in a number of ways that was important for health professionals to recognise.

Participants felt that their modesty of dress easily differentiated them from New Zealand women. Having to remove clothing for cervical screening was particularly embarrassing for them. In other studies, health professionals are said to be insensitive regarding these issues (Rajaram & Rashidi, 1999). The marked segregation between genders in Muslim society can lead to some women feeling uncomfortable in the presence of men, let alone having a cervical smear performed by a man. Many Muslim women prefer female health professionals to carry out examinations (Simpson & Carter, 2008; Underwood, et al., 1999). This view was repeated in this study but women also agreed that in the case of emergency a male doctor was acceptable (Padela & Pozo, 2010). If a good doctor-patient relationship can be reached women would feel more comfortable in discussing cervical screening and
other sensitive topics. It is important that health professionals recognise the unease that Muslim women face in attending cervical screening and attempt to accommodate their needs with compassion.

Whilst Ferguson and Candib (2002) support cultural competency training for health professionals, evidence is not available as to whether these have beneficial results. They suggest that diversification of the workforce is required so that ethnic minorities can be treated by somebody from their own culture.

**Limitations of the study**

All the women in the study were keen to be involved in the study and had experienced health services differently, with some women having frequent contact and others rarely visiting their GP. As a result of using the snowballing technique to recruit participants, all the women were close friends and may, therefore, have had similar views on many aspects of life. Muslim women not part of this group of friends or not part of the Pakistani community in Christchurch may have had different experiences of cervical screening, which would not have been captured in this study. A common problem of the snowballing technique is that the characteristics of the initial participant may be similar to those in the entire sample (Rice & Ezzy, 2001). All women lived in similar geographical areas of Christchurch, but as socio-economic data were not collected, there is uncertainty as to whether they all belonged to the same socio-economic group. However, qualitative research does not aim to generate a statistically representative group but to provide cases that are information rich. The Pakistani community in Christchurch is also relatively small and there is the possibility that in larger communities, perceptions may have differed.
In order to participate in the study women had to be able to speak English. Not only would these women have had different experiences with health services to non-English speakers, but they would also have experienced different levels of acculturation. Those who are less acculturated may have different views on cervical screening, which would not have been found in this study.

Due to time pressures it was decided that only Muslims of South Asian ethnicity would be interviewed. However, Muslims in Christchurch are of varying ethnicity and may have different perceptions of cervical screening. As the cultural values of the women in this study had a strong influence on their perceptions of cervical screening, this may be true in other ethnicities as well. It is important that the perceptions of other ethnicities are explored in further qualitative research.

As a result of resource pressures and the nature of a dissertation, I was the only researcher involved in the thematic analysis. My preconceptions may have biased the themes that were found. Braun and Clarke (2006) consider the judgement of the researcher to be heavily involved in determining what a theme will be. However, as Rice and Ezzy (2001) argue, this should be embraced rather than avoided. My position as a Muslim Pakistani woman was made explicit in the methodology chapter and the findings should be interpreted in this light.

**Recommendations**

Many of the participants felt that they were not fully informed on cervical screening and would like to have more knowledge about it. Due to the influence of the
community on the woman’s decision it is important that all members of the community are informed about cervical screening. A community development project initiated by health promoters from local public health units could be used to do this. It is important that community input is strong in the project and that community members are trained in continuing the promotion of cervical screening. The project can then become sustainable and the community empowered. A project such as this will allow women to relate more to cervical screening and the community to support them more in its participation.

The interviews also revealed that the doctor-patient relationship was important in the women’s experiences of cervical screening. The sensitivity and awareness of the health professional in the differences in culture and religious beliefs, such as modesty, is important in building the relationship. Increasing the cultural awareness of health professionals through training would be one way of improving this understanding. Others feel that an increased number of minority ethnic health professionals is required for this to occur (Ferguson & Candib, 2002). Muslim women feel more comfortable in developing relationships with female GPs. Health practices should be encouraged to have at least one female GP. Muslim women could be directed to the female GP so that they may be more likely to build a strong relationship and feel at ease when discussing sensitive issues.

It will also be important to collect data on the uptake of cervical screening by Muslim women. This data is currently unavailable in New Zealand and is needed to inform the screening service of gaps in uptake. Routinely collected data on the ethnicity of the women screened could be used as an indicator for Muslim women as religious
affiliation questions can be contentious. It could also be obtained through quantitative studies on the uptake of cervical screening in Muslim women.

Studies are also required to further elicit the attitudes towards and experiences of cervical screening for Muslim women in New Zealand. Studies involving larger numbers of women in different communities throughout New Zealand may reveal further views on cervical screening. It will also be important to involve different Muslim ethnicities. This may reveal that different ethnicities hold the same or markedly different views. It will also be important to repeat the study with different generations of immigrant women. Due to acculturation the views of women may change in future generations. Screening services need to be aware of this so they can provide services appropriately.

Muslim women are a group in New Zealand that have been largely overlooked. This study aimed to explore the views Muslim women have regarding cervical screening in order to increase their participation in the screening process. The study found that reasons for avoidance of cervical screening lay deep in their cultural and religious upbringing and the way they were integrating into a society whose beliefs and values were very different to their own.

The ideals of a collectivist society were still of great importance to the women and resulted in them making decisions regarding cervical screening which were not in line with the philosophy of an individualist society. For any health promotion strategy to be successful for this group of women, acknowledgement and incorporation of their cultural values and religious beliefs will be required for cervical screening to have
relevance for them. Islam places the requirement on Muslims to take care of their health, yet current screening services do not facilitate the participation of Muslim women. Changes are needed to encourage these women to attend a test that can improve the outcome of cervical cancer.
References


Appendix 1: Information sheet and consent form

An exploratory study of Muslim women’s attitudes towards and experiences of cervical screening

Principal Investigator: Nadia Bartholomew
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Introduction

This research will collect information for a study to complete a Masters of Public Health, University of Otago. I am interested in finding out Muslim women’s attitudes towards cervical screening and the experiences they have had. I invite you to take part in this study. You do not have to take part in the study and you can take the next week to decide whether or not you want to take part.

What are the aims of the study?

The study aims to explore Muslim women’s attitudes towards and experiences of cervical screening. I would like to interview 6-8 Muslim women in the study as I am interested in your views.

What is involved in the study?
You will take part in an interview lasting between 1 to 1.5 hours. Interviews will be held between October and February. The interview will be held in a location where you feel comfortable eg your home or another place of your choice. The interview will not have set questions and will cover topics around cervical screening. The interview will be recorded. All information will be kept confidential and your identity will not be revealed in any reports based on this study. The information from the study will be stored for 10 years.

**Will I receive any reimbursement of expenses?**

You will receive a $30 voucher to cover your costs and time.

**What are the benefits of the study?**

The study will provide valuable information on the attitudes and experiences of Muslim women in Christchurch in relation to cervical screening. This information can then be used to improve cervical screening services for Muslim women with the aim of increasing the uptake of this service.

**Participation**

It is entirely your choice to take part in this study. You do not have to take part.

I will need written consent for the study.

You do not have to answer all questions and you can stop the interview at any point.

If you have any concerns about your rights as a participant in this study, you may wish to contact a Health and Disability Advocate on 03 377 7501.

The results of the study will be available in the form of an academic paper in July 2011. A summary report will be available should you wish to receive a copy.

This study has received ethical approval from Upper South B Regional Ethics Committee, ethics reference number URB/10/10/040.

Please feel free to contact me if you have any questions about this study.
Consent Form
An exploratory study of Muslim women's attitudes towards and experiences of cervical screening

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This study will collect information for a dissertation for a Masters of Public Health, University of Otago.

I have read and understand the information sheet dated 18 October 2010 for volunteers taking part in the study designed to explore Muslim women’s attitudes towards and experiences of cervical screening in Christchurch.

I have had the opportunity to discuss this study and am satisfied with the answers I have been given.

I have had the opportunity to use the support of family and friends to help me ask questions and I understand the study.

I understand that taking part in the study is voluntary (my choice) and that I may withdraw from the study at any time.

I understand that my participation in the study is confidential and that no material, which would identify me will be used in any reports in this study.

I understand that the interview will be recorded.

I have had time to consider whether to take part.

I know who to contact if I have any questions about the study.

I wish to receive copy of the results of the study: Yes/No

I consent to take part in the study
Appendix 2: Interview guideline

Introduce the study and gain consent

Obtain demographic data

The following topic areas will be explored in in-depth, semi-structured interviews:

Experiences of being a Muslim woman in New Zealand.

Attitudes towards accessing primary care.

Attitudes towards cervical smears and cervical screening.

Perceptions of the National Cervical Screening Programme.

Individual Experiences with cervical screening.

Issues affecting the uptake of cervical screening in Muslim women.

What participants feel can be done to encourage Muslim women to participate in cervical screening?

Anything else that participants feel is important.