7. HEALTH CARE

This chapter examines Muslim experiences of health care. Access to adequate health care is important to social inclusion. Long-term illness affects people's opportunities for economic and social participation and employment, thus reducing income levels, which in turn have the effect of hindering people's opportunities for social and leisure activities. The chapter begins with an overview of the data on Muslims' health status. In the UK, these data are available on the basis of religion; in other states, in the absence of data on religion, the data on predominantly Muslim ethnic-minority groups are explored. The ways in which religion can be relevant to health status are examined before looking at the experiences of Muslims in the health services that are available in the different cities. The OSI survey and focus group findings are used to understand levels of satisfaction with health-care services among respondents. The OSI research across the 11 cities also provides an insight into the ways in which doctors and hospitals in local areas with large Muslim populations respond to the needs of Muslim patients, focusing in particular on the provision of *halal* food and the inclusion of imams in hospital chaplaincy services. Finally, the chapter gives examples of good practice across the different cities in ensuring health services are effectively accessed by Muslims.

7.1 Health Status

For many Muslims, poverty remains the most significant influence on their health status. The *Joint Report on Social Protection* notes: "despite overall improvements in health there remain striking differences in health outcomes not only across Member States but also within each country between different sections of the population according to socio-economic status, place of residence and ethnic group, and gender."[305] However, for Muslims who are migrants, the emotional impact of uprooting and resettling in a new social context also affects mental health.[306] There may be very specific pressures on Muslim women who are migrants:

> Women migrants are a main source of physical and emotional support for older and younger family members. As such, women have additional responsibilities, whether they migrate with their families or leave them behind, and additional

305 Council of the European Union, *Joint report on Social Protection and Inclusion*, 7274/08 Brussels, 2008 p. 11, http://register.consilium.europa.eu/pdf/en/08/st07/st07274.en08.pdf (accessed November 2009).

306 R. Park, "Human Migration and the Marginal Man", *The American Journal of Sociology*, 33, 1928, pp. 881–893.

> stress that can strain the fabric of their lives. The cost to their families and communities may not be completely quantifiable, but it is none the less real.[307]

Furthermore, experiences of Islamophobia, racism and discrimination affect people's mental health, as "societal forces of marginalisation and 'faith-blind' health policies challenge the health of Muslim families and their access to culturally appropriate care".[308]

The UK is the only state in the OSI research where data on health care can be disaggregated by religion. Questions about health, asked in the 2001 Census, show that Muslims in the UK had the highest rates of reported ill-health. Age-standardised rates of "not good" health were 13 per cent for Muslim males and 16 per cent for Muslim females. These rates, which take account of the difference in age structures between the religious groups, were higher than those of Jews and Christians, who were the least likely to rate their health as "not good". Females were more likely than males to rate their health as "not good" among most groups. The gender difference was most notable for Muslims, Sikhs and Hindus. Among females, 16 per cent of Muslims, 14 per cent of Sikhs and 11 per cent of Hindus rated their health as "not good". These rates were 3–4 percentage points higher than their respective male counterparts.[309]

Ethnicity or nationality data on groups that are predominantly Muslim provide a limited but nevertheless important insight into the experiences of Muslims in other EU states. Research in Belgium found that 30 per cent of Turks and Moroccans perceive their health as average, bad or very bad, compared with 20 per cent of the general population.[310] The Rotterdam Health Survey also found that around a third of Moroccans and half of Turkish respondents reported their health status as moderate or bad.[311]

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[307] UN Population Fund and International Organization on Migration, *Female Migrants: Bridging the Gaps throughout the Life Cycle*, Selected Papers from the UNFPA-IOM Expert Group Meeting, May 2006, p. 3, available at http://www.unfpa.org/upload/lib_pub_file/658_filename_migration.pdf (accessed November 2009).

[308] L. Laird, M. Amer, E. Barnett, and L. Barnes, "Muslim Patients and Health Disparities in the UK and US" *Archives of Disease in Childhood* vol. 92, 2007, at 924; see also K. Bhui, S. Standfeld, K. McKenzie, S. Karlsen, J. Nazroo and S. Welch, "Racial/Ethnic Discrimination and Common Mental Disorders Among Workers: Findings from the EMPIRIC Study of Ethnic Minority Groups in the United Kingdom", *American Journal of Public Health* Vol. 95, 2005, No. 3, p. 496.

[309] Office of National Statistics, *Focus on Religion*, 2004, p. 8.

[310] Levecque *et al., Gezondheid en gezondheidszorg bij allochtonen in Vlaanderen cited in OSI, At Home in Europe: Muslims in Antwerp.*

[311] L.P. van Buren, E. Joosten-van Zwanenburg, *Gezondheidsenquete Turken en Marokkanen*, GGD Rotterdam en omstreken, December 2006 available at: http://www.ggdkennisnet.nl/kennisnet/paginaSjablonen/raadplegen.asp?display=2&atoom=41944&atoomsrt=17&actie=2, (accessed November 2009, hereafter, van Buren & Joosten-van Zwanenburg, *Gezondheidsenquete Turken en Marokkanen*).

In addition to differences in self-reported levels of poor health, rates of illness for particular conditions also vary between different ethnic or national groups. Diabetes appears to be one illness that affects Turks, Moroccans, Pakistanis and Bangladeshis to a greater extent than the general population in Europe. In Belgium, one in five Turks and Moroccans have diabetes.[312] In the UK, Pakistanis and Bangladeshis are five times more likely to have diabetes than whites.[313] In the Netherlands, higher levels of obesity are found among Turks and Moroccans than the general population; in Rotterdam, 55 per cent of Moroccans and 60 per cent of Turks are obese.[314] In Amsterdam, Turks (66 per cent) and Moroccans (57 per cent) are also more likely than the city's general population (45 per cent) to be overweight.[315] In the UK, among those over the age of 40, one in four Pakistanis and Bangladeshis have been diagnosed with heart disease or severe chest pain, the highest for any ethnic group.[316]

7.2 Impact of Long-term Illness

Long-term illhealth not only affects individuals but also families that bear the primary caring responsibility for the sufferers. Research in the UK, for example, found that individuals with long-term health conditions were more likely to be found in Bangladeshi (44 per cent) and Pakistani (39 per cent) households than in white British (29 per cent) and black African (15 per cent) households. Pakistanis and Bangladeshis, as a consequence of limited language skills and the confidence required to negotiate the health service among first-generation migrants, relied more on their children taking time off from work or school to accompany them to medical appointments. The research found that these individuals had to alter work patterns, work part-time or take work closer to home to accommodate this situation. They also found that in Pakistani and Bangladeshi households, even when long-term illhealth was affecting the primary income earner, there was no impetus for women to enter the labour market; instead there was pressure on them to provide the necessary care. The effect was therefore to make take-up of paid work more difficult and a lower priority. Long-term health conditions lead not only to reduced earning and income but also to increased costs and expenditures. The reduction of spending on other items can further reduce the quality of life, for example, when housing falls into disrepair.[317]

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312 Levecque et al., *Gezondheid en gezondheidszorg bij allochtonen in Vlaanderen,* cited in OSI, *At Home in Europe: Muslims in Antwerp.*

313 J. Nazroo, *Ethnicity, Class and Health*, Policy Studies Institute, London, 2001, pp. 74–76 (hereafter, J. Nazroo, *Ethnicity, Class and Health*).

314 van Buren and Joosten-van Zwanenburg, *Gezondheidsenquete Turken en Marokkanen.*

315 Amsterdam Health Monitor, 2004, cited in OSI, *At Home in Europe: Muslims in Amsterdam.*

316 J. Nazroo, *Ethnicity, Class and Health,* pp. 74–76.

317 S. Salway, L. Platt, P. Chowbey, K. Harriss and E. Bayliss, *Long-term Ill Health, Poverty and Ethnicity*, The Policy Press/Joseph Rowntree Foundation, Bristol/York, 2007.

7.3 Religion and Health

Aspects of life influenced by religion can affect health. For example, it has been suggested that lower than average levels of alcohol consumption contribute to lower than average risks of some heart and vascular diseases.[318] There have been studies into the links between theological and spiritual influences and group experiences. Some religious practices can also affect the health of individuals adversely. For Muslims this includes the impact of fasting during the month of Ramadan on the management of chronic diseases such as diabetes.[319]

Another example of a religious activity that has implications for health care is participation in the Muslim pilgrimage, the *Hajj*. Every year large numbers of Muslims from across Europe go to Saudi Arabia to perform the *Hajj*. Participation in the *Hajj* entails risks exposure to infectious diseases and heat: "The severe congestion of people means that emerging infectious diseases have the potential to quickly turn into epidemics." [320] Furthermore, "Extended stays at *Hajj* sites, extreme heat, and crowded accommodation encourage disease transmission, especially of airborne agents. Traffic jams, and inadequately prepared or stored food are added health risks. The advanced age of many pilgrims adds to the morbidity and mortality risks."[321] The potential for the *Hajj* to be an epidemiological "amplifying chamber" was seen during an outbreak of *Neisseria meningitides* W135 in 2000 and 2001. The outbreaks in those two years affected 1,300 and 1,109 pilgrims respectively, in total. During this period, there were 79 cases of UK pilgrims returning with W135 meningococcal disease, of whom 18 died.[322] In response to these health risks, the British government in partnership with the Muslim communities established the British Hajj Delegation (BHD) in 2000; the UK became the first predominantly Christian country to have such a delegation. The core of BHD's work is in the provision of medical and consular support. In 2006, the delegation provided both medical and consular services in Mekkah and Mina.

7.4 Satisfaction with Health Services

In general both Muslims and non-Muslim respondents share similar levels of satisfaction with health services in their local area.

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318 *Jaarrapport integratie 2008,* p. 42.

319 A.G. Naeem, "The role of culture and religion in the management of diabetes: a study of Kashmiri men in Leeds", *The Journal of the Royal Society for the Promotion of Health* Vol. 123, No. 2, 2003, pp.110–116.

320 Q. A. Ahmed, Y. M. Arabi and Z. A. Memish, "Health risks at the Hajj", *The Lancet*, 2006: 367, pp. 1,008–1,015, p. 1,008 (hereafter, Ahmed, *et al.*, "Health risks at the Hajj").

321 Ahmed, *et al.*, "Health risks at the Hajj", p. 1008.

322 *British Medical Journal*, 2 February 2002, 324: 301. See also: "Returning Pilgrims Fight Meningitis", BBC News 12 April 2000 http://news.bbc.co.uk/1/hi/health/710437.stm

Table 87. Satisfaction with health services (G1.6)

	Frequency	Percent
Muslim	95	80.5
Non-Muslim	23	19.5
Total	**118**	**100**

Source: Open Society Institute data

The majority is either "fairly" (18 per cent) or "very" (48 per cent) satisfied, and a far smaller proportion are "fairly" (9 per cent) or "very" (6 per cent) dissatisfied. A further 14 per cent are neither satisfied nor dissatisfied. When religion, gender and country of birth are taken into account, Muslim women born abroad (10 per cent), are slightly more likely than others to be "very dissatisfied" with health services in their area.[323]

The OSI survey data are consistent with the focus group discussions from across the 11 cities, which indicate that, in general, there are high levels of satisfaction with the quality of the health care that people receive. Among Muslim who are migrants, this high level of satisfaction is often amplified when they compare the health care they have access to in Europe with what is available in their countries of origin. As a focus group participant in Berlin noted, "Health services are excellent in Germany [...] we couldn't find these kinds of services in Turkey." Discussion of health-care services generally elicited very positive comments. In the Hamburg focus group, for example, Muslims frequently answered that they had "never experienced something bad", people were "happy when they have been in hospital", "all patients are treated equal, irrespective of their religion or ethnicity" and "treated equally friendly". "The doctors do their work, without looking at the religion or the appearance", "medical treatment is in the foreground". Some referred to additional training that is given to doctors concerning the needs of Muslims. A focus group participant in Berlin noted the experience of one of her relatives, who had been in hospital: "She was on the fourth, or fifth floor. The doctors and nurses there were very nice and said that we could always visit, even at midnight. And when we had to pray they even cleared the room for us."

Satisfaction with health care was low in London, where 50 per cent of Muslim OSI respondents were "fairly", or "very" satisfied with local health services and 30 per cent were "fairly" or "very" dissatisfied. However, discussions with Muslim participants in a focus group in London suggested that though perceptions of health care were lukewarm, weaknesses in service provision were on the whole seen as generalised shortfalls, not specific to Muslims.

[323] See Table 88. in Annex 2 for breakdown of data.

> Health, I think I get a good service, better than before. At least I get my GP in an emergency basis on the same day and I can make an appointment beforehand after a week if I have to make an appointment, but a lot of our friends don't share my view, they think it's gone worse.
>
> It's gone worse I think, especially the doctor. If we want to see a doctor we have to wait. Either today you want to see a doctor, you can't see a doctor on this time, cancellation etc. or they give you 2 days, 3 days later [...] if you have more than one problem it's difficult to explain it in 10 minutes and get a solution and what the doctors are doing they just say please try to shorten it down but people is waiting so can you come again. So you are losing more time seeing a time than before if you are […] you know, if you have more than one problem its difficult to see a doctor on the same day…

7.5 Respect for Religious Needs in Health Care

A majority of Muslim (60 per cent) and non-Muslim (50 per cent) respondents feel that hospitals and health clinics sufficiently respect the customs of people belonging to different religious traditions.

Table 89. Do hospitals and medical clinics respect different religious customs? (G8)

		Muslim	Non-Muslim	Total
Too much		4.6%	3.3%	4.0%
About right		60.3%	49.5%	55.0%
Too little		14.1%	7.1%	10.6%
Don't know		21.0%	40.1%	30.4%
Total	**Per cent**	**100.0%**	**100.0%**	**100.0%**
	Count	**1110**	**1088**	**2198**

Source: Open Society Institute data

Only 11 per cent of respondents (234 in number) felt that hospitals and health clinics did too little to respect different religious customs. Further analysis found that Muslims are twice as likely as non-Muslims to feel hospitals do too little (14 per cent Muslims, 7 per cent non-Muslims), and those who display visible signs of their religious identity are 1.7 times more likely to be dissatisfied with the treatment compared with those who are not.

Table 90. Do hospitals and medical clinics respect different religious customs (by display of visible religious identity)? (G8)

		Visible signs of religious identity		
		Yes	**No**	**Total**
Too much		4.0%	4.0%	4.0%
About right		65.5%	52.2%	55.0%
Too little		15.8%	9.3%	10.7%
Don't know		14.7%	34.5%	30.4%
Total	**Per cent**	**100.0%**	**100.0%**	**100.0%**
	Count	**455**	**1737**	**2192**

Source: Open Society Institute data

Women are marginally more likely than men to feel hospitals do not sufficiently respect religious customs (12 per cent women, 9 per cent men), as do those born outside the EU in comparison with those born inside the EU (12 per cent non EU-born, 10 per cent EU-born).[324]

It was found that university graduates (14 per cent) were more likely than respondents with primary, secondary or no formal education (9 per cent) to feel this way.[325]

If gender, religion and country of birth are taken into account, then Muslim women born in Europe (17 per cent) are the group most likely to feel that hospitals and health clinics do too little to respect different religious customs. Muslim women born abroad are the most likely (64 per cent) to say that they do the right amount.

A significant proportion of Muslim (20 per cent) and non-Muslim respondents (40 per cent), however, were unable to answer this question.

7.6 *Halal* Food

Respect for Muslim dietary requirements emerges as an important part of respecting patients' cultural needs. Even though a large proportion of patients at the Catholic Saint Lucas hospital in Slotervaart, Amsterdam, are Muslim, it was only in 2005 that it became the first in the Netherlands to serve *halal* meals.[326] The OSI research in Marseille found that the accommodation of religious needs in terms of food in many hospitals extended only to recognising that Muslims cannot eat pork rather than

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[324] See Table 91. and Table 92. in Annex 2 for breakdown of data.

[325] See Table 93. in Annex 2 for breakdown of data.

[326] The hospital's website is http://www.lucasandreasziekenhuis.nl/ (accessed November 2009).

providing *halal* food. The research suggests that hospital staff's ignorance of dietary restrictions that may be relevant to Muslim patients is only part of the explanation. Stakeholder interviews implied that some hospital officials see the provision of *halal* food as compromising on state secularism and so resist it on that basis. While the hospitals provide kosher meals for Jewish patients, providing *halal* food is perceived by these officials as giving into the demands of "Muslim fundamentalists". As one stakeholder said in an interview in Marseille in 2009:

> The people in charge were very embarrassed, when I approached this "*halal* question". I wanted even to launch the idea of a call for tender so that companies can supply meals halal to Muslim patients. But they did not really want to hear about it, while the Jewish patients could benefit from kosher meals. The Jewish Consistory of Marseille had even made placard posters on which we could read that it was capable of delivering 13,000 kosher meals every year.

7.7 Chaplaincy Services

Where hospitals provide chaplaincy services, the inclusion of an imam is also an important component of the respect for religion in health care. In the OSI Berlin focus group, there were positive reports about efforts being made by the Christian hospital in Kreuzberg to be sensitive to religious needs. An example given was where a young girl died and the family was asked if it needed an imam.

In France, hospital regulations allow for the creation of chaplaincy services for different religions.[327] Furthermore, the French Patients Charter, in relation to freedom of religion provides that: "Each patient must be able to, as far as possible, follow the obligations of his religion (meditation, the presence of person able to minister to their religious needs, food, freedom of action and expression…). These rights are exercised while respecting the freedom of others. All proselytism is forbidden, whether it comes from a person welcomed into the establishment, a volunteer, a visitor or a member of staff". Compared with other issues like mosque construction or burial, Muslims have mobilised less on access to hospital chaplaincy, and the position differs throughout France. Some departments have developed chaplaincy services more fully than others. There is in fact now a Charter for Muslim Patients, modelled on the French Patients

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[327] "...services of chaplaincy, in the sense of the article 2 of the law of 1905, can be set up for every cult which asks for it, according to needs expressed or listed by the concerned hospital, social or medical and social establishment. Whatever is the worship to which they belong, the chaplains are recruited or authorized by the head teachers on proposition of the religious authorities from which they recover according to their internal organization: bishop's palaces, Jewish consistories exchange, regional or local, hospitable national chaplain of the French council of the Muslim cult or the regional councils of the Muslim worship and the national or regional commissions of the chaplaincies of the sanitary establishments." Translation in OSI, *At Home in Europe: Muslims in Marseille,* from the website http://www.droitdesreligions.net/rddr/aumonerie_hopitaux.htm (accessed November 2009).

Charter, which tries to define more carefully the rights and duties of the Muslim chaplain:

> The Muslim chaplain works in collaboration with the staff in the visited department. His task is meant to be coherent with the treatment process. Treatment needs come before religious obligation. The Muslim chaplain must give religious responses which allow the sick Muslim a better hospitalisation such as having recourse to dispensation and relief. This will allow the Muslim patient to be at one with his religious convictions as well as with the prescriptions of the medical team [….]. the very first role of the Chaplaincy is attention to the wellbeing of the person, as an indivisible element, to give heed to everything that can help healing and relieve suffering. It is attentive, listens, and offers friendship to all sick people. The Muslim Chaplain must respond, with discretion, to the spiritual needs of those patients who wish it by supporting them and comforting them, whether through a word or a religious liturgy, or simply by listening to them. They are also available for families of the sick or the hospital staff to offer explanation, accompaniment and help.[328]

In 1999, the Mosque in Nasr de La Capelette (10th district of Marseille) set up the first Muslim chaplaincy service in the city's hospitals. They created a small prayer room in the basements of the Timone Hospital next to the Catholic chapel and the synagogue. Initial support for the chaplaincy from the hospital management, however, gave way to greater hostility. According to a former hospital chaplain, the increasing Muslim visibility in the hospital generated resistance from some hospital staff who viewed their presence as religious activism and proselytism. However, a few saw it as a positive development. Interviews with stakeholders suggest that there was also concern from the hospital managers when other Muslim staff began to make use of the services provided by the chaplaincy, as this was viewed as contrary to the religious neutrality of the hospital.

7.8 Communication with Older Migrants

Although there are high levels of satisfaction with health-care services, for older Muslims who are migrants the research suggests that difficulties of communication with medical staff are a significant problem. In many cases, patients rely on family and friends to provide interpretations in their doctor appointments; however, this is more difficult to arrange for hospital appointments, as there is generally less flexibility in scheduling.

When hospitals do try to provide translation services, however, there may be insufficient understanding of the diversity of language and dialects that are spoken across different Muslim communities. In the Antwerp OSI focus group, a Moroccan

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[328] The Charter is available online (in French) at http://aumonerie-musulmane.over-blog.com/article-18547203.html (accessed November 2009).

woman who works in a health centre recalled her experience of being asked to translate between doctors and patients for Egyptian, Iraqi and other Middle Eastern patients,

> For example, in the hospital now, I interpret, and I have made it clear to them that Moroccan-Arabic is not the same as Egyptian or Iraqi Arabic, since they send me off to every foreigner who comes in…. Really everyone, and then I end up asking: "what language do they speak?" What am I supposed to do here" But then you teach them about the difference between cultures and you just get…Because they don't know anything, they really don't know anything.

Problems with language can lead to patients feeling disempowered, misunderstood or not taken seriously:

> When my mother goes to the doctor's, she doesn't speak very good Dutch and it seems like they don't want to listen. But if I go with her and explain, they suddenly understand. But because she doesn't really master the language, they want to take the trouble to understand, that's how it seems to me.[329]

Problems with communication mean that consultations often take longer. However, doctors are also restricted in the time they have to see each patient:

> There is an additional problem for foreigners. I realise that because of my husband. They have language difficulties and the doctors don't have the time or the patience to explain. They explain for two or five minutes, the patient doesn't understand anything [...] they sometimes write something on a paper and say if you don't understand bring in a translator.[330]

7.9 Advice about Health Care

The OSI survey asked a question about whether respondents had sought advice and information on a number of issues – education, employment, housing and health – in the preceding 12 months. The survey found that 860 respondents had sought information on health in the preceding 12 months, 39 per cent of the sample. Of these, 48 per cent were Muslims, 52 per cent were non-Muslims.[331]

Women were more likely to seek information on health than men (44 per cent of the women compared with 34 per cent of the men).[332]

When gender, religion and country of birth are taken into consideration, non-Muslim women born abroad (48 per cent) are the most likely to have sought medical

[329] OSI focus group, Rotterdam.

[330] OSI focus group, Berlin.

[331] See Table 94. in Annex 2 for breakdown of data.

[332] See Table 95. in Annex 2 for breakdown of data.

information in the preceding 12 months, while Muslim men born in Europe were the least likely to be seeking medical advice (27 per cent).[333]

University graduates show the highest propensity for seeking out information on health (44 per cent), while those with no formal education show the lowest (32 per cent).

Table 97. In the last 12 months have you sought information on health? (by highest level of education completed) (G20.4)

		Highest level of education completed				Total
		No formal education	Primary	Secondary	University	
Yes		32.3%	39.2%	37.0%	44.0%	39.2%
No		67.7%	60.8%	63.0%	56.0%	60.8%
Total	**Per cent**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
	Count	**127**	**250**	**1108**	**704**	**2189**

Source: Open Society Institute data

However, there is no strict correlation between the level of education and the search for health information: the proportion of respondents with primary-school education is greater than that of those with secondary-school qualifications (39 per cent and 37 per cent respectively). The majority of permanently disabled respondents (53 per cent) and those in government training programmes (58 per cent) had sought information on health on the preceding 12 months.[334]

Large proportions of part-time employees and retirees also said they looked for information (47 per cent and 45 per cent respectively). Less than a third of stay-at-homes, students, unemployed and full-time employed respondents sought information (33 per cent, 33 per cent, 32 per cent and 30 per cent, respectively).

7.10 Discrimination and Unfair Treatment

Levels of reported unfair treatment on the grounds of religion are low. Only 1 per cent of non-Muslims reported experiences of religious discrimination from hospitals or local doctors. For Muslims the figure was higher, with four per cent reporting discrimination from local doctors and five per cent reporting discrimination from hospitals.[335]

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333 See Table 96. in Annex 2 for breakdown of data.

334 See Table 98. in Annex 2 for breakdown of data.

335 See Table 99. in Annex 2 for breakdown of data.

Although numbers are small, in the Muslim sample it is noticeable that 1 per cent of Muslim men reported discrimination in health care compared with 6 per cent of Muslim women.

Research in Denmark showed that 12–16 per cent of respondents from Bosnia-Herzegovina, Turkey, Lebanon and the Occupied Palestinian Territories had experienced discrimination and adverse and hostile treatment in health care.[336] In contrast, discrimination over social services was among the highest in the different areas covered by the survey. The survey also suggests that a significant minority of Bosnians (16 per cent), Turks (19 per cent), Palestinians (24 per cent) and Somalis (38 per cent) faced racial discrimination during encounters with social services in the municipality.

A closer examination of the 118 respondents who said they had faced unfair treatment over health care found that two-thirds were women (67 per cent) and over half (57 per cent) were born outside the EU. Most of those who had experienced discrimination over health care had secondary education (47 per cent) and nearly a third (31 per cent) had a degree; 14 per cent had no formal education and 9 per cent had primary schooling.

In general, OSI focus group participants were hesitant to define a specific action as racist or discriminatory. Discrimination can take the form of negative attitudes, inattentive body language, neglect or rudeness, and in some cases, verbal abuse. In a few cases, respondents identified situations where they were treated on the basis of stereotypes. Some Muslim focus group participants working in the health-care system criticised the way colleagues approached and treated patients. For example, the following quotation from the focus group in Antwerp concerns the differential treatment of Muslim patients wearing "traditional" clothing.

> [Woman:] People are treated very bad, really. Parents come with their children who need to be operated for tubes or something like that and I don't know to what extent doctors always give the same explanation. That really depends on how you are dressed. When they come in djellaba they automatically assume they won't understand much, so they give a simple explanation. They do not explain what happens when you're under the anaesthetic and why it is necessary. So then, I find a worried mother on the hallway of the hospital asking why her child has been sent to sleep. I then ask the doctor and they respond: "You know these kind of people. Low IQ and so on," when, in fact, the mother is capable of understanding the proper explanation.
>
> I have been at the doctor today. I am new to him. He is my family doctor. He is older. I talk with him and he always has a big surprise in his face. I have been

[336] B. Møller, and L. Togeby *Oplevet Diskrimination* (The Experienced Discrimination), Board for Ethnic Equality, Copenhagen, 1999, cited in Hussain, *Muslims in the EU Literature Review: Denmark*, p. 28.

> there the second time. This time I especially noticed this. In the first meeting, I give people a chance and think, that I might have said something wrong. I mentioned for example that I take antibiotics. I think, that I should take additional vitamin B and told him what I eat. He looked strange […] My interpretation is that he didn't expect it. He expected a stereotyped Turkish society […] They have this image in front of their eye, Turks don't know anything. They come from Anatolia. How can that be that a person comes and knows such things. I read this question in his eyes.

The context and vulnerability of people in need of medical support can of course intensify experiences of discrimination and heighten perceptions of discrimination. The examples given in focus groups suggest that even though there are few reported experiences of discrimination in the health sector, the vulnerability that arises from illness makes people more sensitive and react more angrily in many circumstances.

Discrimination is not only experienced by Muslims as patients, but also by Muslims working in health care. In Antwerp, a Muslim nurse wearing a headscarf reported how she received negative treatment from patients. However, the incident also showed that hospital staff supported the nurse:

> [Woman:] There is a lot of negativity but there are also many positive experiences. A patient was … I wasn't allowed to go in [her room]. She would rather die than be treated by me. But the whole crew with the director – I work in Hospital X – so the whole crew, director, head of doctors, everybody stood behind me. The family of the patient came to the hospital and said: yes, you have to respect the wishes of our mother and then the head of doctors said: "My staff will not be treated like this. If you don't like it, there is the door. There are other hospitals." I mean, I don't wear a headscarf but X does wear one. I have a bit, we have a quite pale skin, you know, and even with me you saw this happening.[337]

7.11 Access to Health Care

One key debate in health services is the low take-up of services by minorities. A review of the evidence for the take-up of early intervention and preventative services in the UK suggests that the two crucial problems are a lack of information in minority communities about the services that are available as well as the failure to deliver culturally appropriate or sensitive services.[338] A case study of a Luton (UK) social services department for example, found that most South Asian families only came into contact with the support services that were available after referral by another agency

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[337] OSI focus group, Antwerp.

[338] S. Ahmad, "What is the Evidence of Early Intervention, Preventative Services for Black and Minority Ethnic Group Children and their Families?", *Practice*, 17:2, 2005, pp. 89–102.

and once the problems the individuals and families faced had become critical.[339] Even when people are aware of services that are available there may be a reluctance to use mainstream services, where patients feel that their needs may not be recognised or understood. The absence of culturally appropriate and sensitive services is identified as an issue in a review of the practices of eight social services departments in England.[340]

The importance of culturally-sensitive service delivery to ensure access appears to be behind the success of the Muslim Youth Helpline in the UK, a telephone helpline set up in 2001 by a group of young Muslims, which now receives public support and funding for its work on mental health. Analysis of the client database and discussion with users of the helpline suggest that young Muslims were "reluctant to access mainstream support services for fear of being discriminated and misunderstood".[341] The research focused on the importance of a Muslim-led, faith-sensitive service for clients, who experienced a lack of acceptance by both mainstream service providers and the Muslim community. The report suggests that "receiving recognition through the eyes of another Muslim, around issues that are often contentious, was significant" to the helpline's clients, as it "allowed the holding together of, at times, contradictory conflicting issues in a way that enabled growth and integrative solutions to emerge without fragmenting identities". Furthermore, "a sense of belonging and connection enabled empowerment and self-authorship. For clients, this was facilitated by seeking support from within the Muslim community; something they had not previously felt able to do".[342]

The OSI research found examples of initiatives taken by health-care professionals to increase take-up of services by Muslims. In most cases, initiatives are not directed at Muslims as a group but at different ethnic groups. Religion is nevertheless relevant to these initiatives. The General Hospital in Slotervaart, Amsterdam, provides special consulting hours for Moroccan diabetes patients. These are led by a Moroccan nurse. In giving advice on fasting it is recognised that fasting with the family is very important to Muslims. Patients tend to ignore advice not to fast. In these sessions, Muslims with diabetes are therefore given advice on how to participate in fasting in a responsible way.

In Amsterdam, the Dutch Intercultural Care Counsellors Foundation, founded in 2003 by a doctor of Turkish origin, provides outreach in health-care information through informal settings, providing information that is culturally sensitive and accessible in terms of language. In Leicester, the health promotion programme "Dil"

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[339] T. Qureshi, D. Berridge, and H. Wenman. *Where to turn? Family support for south Asian communities – A case study*, National Children's Bureau and Joseph Rowntree Foundation, London, 2000.

[340] V. O'Neale, *Excellence Not Excuses: Inspection of Services for Ethnic Minority Children and Families,* Department of Health, London, 2000.

[341] R. Malik, A. Shaikh and M. Suleyman, *Providing Faith and Culturally Sensitive Support Service to Young British Muslims,* National Youth Agency, Leicester, 2008, p. 9 (hereafter, Malik *et al., Providing Faith and Culturally Sensitive Support Service*).

[342] *Malik et al., Providing Faith and Culturally Sensitive Support Service,* p. 9.

("Heart"), whose mission is to improve the understanding of coronary heart disease in the South Asian community, recruits "peer" educators who have access to communities and understand the perspectives and needs of patients. These peer educators were also important in overcoming language and other cultural barriers. Mosques were used to provide information about a campaign for immunisation for the human papilloma virus. The local health body also realised that many Muslim women who were in kitchens preparing food for the end of fasting during the month of Ramadan were listening to Radio Ramadan. The authorities therefore decided to use Radio Ramadan to broadcast information about cervical smears. Stakeholder interviews suggest that in the year the campaign ran, using the radio combined with more targeted information and employment of a Somali receptionist led to an increased take-up of services from 60 per cent to 90 per cent in one doctor's surgery in the target population.

The I-Psy centre for intercultural psychiatry has a branch in Slotervaart, Amsterdam. These centres offer specialist and easily accessible help to people with mental health problems relating to migration, change of culture and living conditions. The specialists are often from the minority groups and services are delivered in their mother tongues. The service aims to be culturally and faith-sensitive, respecting for example, requests for treatment by same-sex professionals and having single-sex group sessions. There is particular attention paid to the problems encountered by those who have migrated to join spouses.

In the London Borough of Waltham Forest, the prevalence of smokers has been estimated at 30 per cent of the total population, higher than the national average of 27 per cent. In 2004, the council undertook a major media campaign to challenge smoking, advertising in local papers and working with community groups and businesses. It also incorporated an important black, minority and ethnic (BME) component in its outreach, broadcasting infomercials on local radio in a variety of African languages. In the UK, the Department for Communities and Local Government, highlighting the need to actively engage vulnerable groups, has also emphasised the value of working through local community structures, such as mosques and imams, in stop smoking campaigns. Other London boroughs, such as Newham, have channelled some of their campaigns through local imams, for example. The Waltham Forest Faith Communities Forum partnered with the Local Strategic Partnership to implement a system of "health preachers".[343] The central concept of this programme was to identify and train local religious representatives from the borough's Muslim, Christian and Sikh communities, to draw on their positions as faith leaders to communicate important messages on health to their congregations.

[343] See the Waltham Forest Faith Communities Forum website at http://www.faithcommunities.org.uk/7.html (accessed November 2009).

7.12 Care for the Elderly

One issue of health care that is likely to increase in importance over the next decade is the care provision of older Muslims who are migrants. In many Muslim communities there remains a taboo around the idea an elderly person is being cared for by an "outsider" rather than a family member. In Copenhagen, concern about care was evident in the older focus group discussions on health care. There was a desire for culturally specific care homes, and a fear that Danes would not have the understanding needed to deliver these services. The first German residential home for the elderly, specialising in the needs of Turkish (largely Muslim) elders, has been built in Kreuzberg, Berlin. It includes religious facilities like prayer rooms and meets cultural needs in the provision of food and the languages spoken by the staff. In Hamburg, the HHAP estimates that by 2015, 16 per cent of older people will be migrants. The city identifies access to health care for older migrants as a key challenge: because of language barriers and lack of information, it is necessary to develop a diverse range of services that take into account the various needs of different groups.

7.13 Key Findings

Poverty remains the most significant factor in health inequalities, but both religion and being a migrant have their impact on health. The OSI research found high levels of satisfaction in the health care that individuals receive. Reports of discrimination and unfair treatment are low and most respondents felt that doctors and health clinics respect the needs of people of different faiths. Nevertheless, accommodating the needs of Muslim patients remains an issue that needs to be addressed, in particular the provision of *halal* food and access to imams in those hospitals that provide chaplaincy services. For older Muslims who are migrants, communication with doctors and nurses is a problem. The need for appropriate care services for older migrants is an emerging concern for many Muslims and one that is likely to grow in importance as the Muslims who are first-generation migrants grow older. Across the cities there are examples of service delivery and provision that have been effective because they take the cultural and religious needs of Muslims into account.