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The experiences of refugee Muslim women in the Aotearoa New Zealand healthcare system

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ABSTRACT

This study explores the experiences of refugee Muslim women as they accessed and navigated the healthcare system in Aotearoa New Zealand (NZ). A case-oriented approach was used, where semi-structured interviews were carried out with nine Muslim women who arrived in NZ as refugees. Interviews were carried out in 2020, in Hamilton, NZ. Analysis involved a 'text in context' approach which employed an iterative and interpretive process, by engaging with participant accounts and field notes to unpack the various meanings behind the experiences of the participants in relation to the literature as well as the broader socio-cultural contexts in which these experiences occurred. The findings of this research identified various structural barriers to accessing healthcare such as cost and issues with interpreters, as well as instances of othering in the healthcare settings experienced by refugee Muslim women. In order to tackle inequity in the health system, structural and institutional barriers need to be addressed first, to prompt other levels of othering and discrimination to reduce over time.

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Introduction

Promoting equity and improving the health and wellbeing of refugee communities is an increasing global priority, spurred on by the inequities evident in global responses to the recent Covid-19 pandemic (Abubakar et al. 2018; Lancet Migration 2020; UNHCR 2020b). At the end of 2019, there were 26 million refugees worldwide (UNHCR 2020a). Aotearoa New Zealand (NZ) is one of 37 countries who accept refugees within Refugee Resettlement Quota Programmes (UNHCR 2019). As such, NZ accepted 750 refugees per annum since 1987, until the quota was raised to 1000 per annum in July 2018. A further increase to 1500 per annum due in July 2020 was hindered by the

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Covid-19 pandemic (Immigration New Zealand 2020). Six of the top 10 nationalities of refugees arriving into NZ in the last 5 years were from majority Muslim countries including Syria, Afghanistan, Pakistan, Eritrea, Palestine and Iraq (Ministry of Business Innovation & Employment 2019). The Muslim refugee population in NZ is a highly diverse community, in terms of ethnicity, length of time in NZ, age, profession, education and income. While this population in NZ is small, it is a diverse and fast-growing, yet underexplored group in health research.

Refugee communities arriving in many countries including NZ have significant health and social needs, which impact on their quality of life alongside health and social service utilisation (Gavagan and Brodyaga 1998; Burnett and Peel 2001; McLeod and Reeve 2005; Ramsey and Celedón 2005). Briefly, when refugees arrive in NZ, they enter a residential orientation programme at the Mangere Refugee Resettlement Centre (MRRC) in Auckland. During their stay at MRRC, refugees receive medical screening and treatment. On leaving MRRC, all refugees are given a copy of their medical records, and a support worker helps them to register with a GP. Quota refugees are considered NZ residents on arrival and have the same entitlements as all New Zealanders to publicly provided health and disability services, and to subsidised primary health care (Minister of Health 2003). However, there is a discrepancy between entitlement and *access*, with research suggesting that in practice, access for refugee communities was limited and inequitable (Mortensen 2011).

In particular, refugee *women's* experiences are vital to understanding issues of inequity in the health system. Within this group, refugee Muslim women are often the most 'visible' groups (among both men and women), for instance through their attire, and can represent one of the more vulnerable groups in our society. Moreover, considering a woman's key role in a traditional nuclear and extended family, health equity for Muslim women can also have a much wider bearing beyond the direct impact for women, extending to children's and men's health. However, services (including health) for female refugees are described as being 'gender-blind' (Refugee Women's Resource Project 2003).

A handful of international studies (mostly with a broad focus on Muslim *migrant* women) indicate that a patient's religious and cultural values and norms, perceived religious discrimination, stigma, issues relating to interpreters, cultural issues of modesty and female patients' preference for female clinicians can serve as barriers to accessing healthcare by Muslim migrant women (Bhatia and Wallace 2007; Simpson and Carter 2008; Mehta 2012; Padela et al. 2014; Wray et al. 2014; Padela et al. 2015; Padela et al. 2016; Zorogastua et al. 2017). Furthermore, for Muslim migrant women, the healthcare system presents a much broader array of barriers. Studies from the USA indicate that, as an often negatively stereotyped minority group, Muslim women face discrimination in the health system, including exclusion, negative remarks and physical assault (Martin 2015; Samari et al. 2018). Such barriers, alongside an unfamiliarity of the new healthcare system can lead to reduced access to, and use of preventive services, where women may delay help-seeking and seek healthcare only in acute situations (Straiton and Myhre 2017). For refugees in particular, various societal determinants of health can also affect access to and use of health care. For instance, social discrimination, stigma, socio-economic status, employment status and accommodation situation are factors that emerge repeatedly as negative health influences that require broad, holistic responses (Bhatia

and Wallace 2007; Miedema et al. 2008; DeSouza 2011; Campbell et al. 2018; Plaza Del Pino et al. 2020).

In NZ, further substantive academic research exploring both barriers and inequity experienced by refugee Muslim women within healthcare settings is needed. The recurrent themes of discrimination and stigma emerging from international research into Muslim migrant women's experiences within the healthcare system paired with the current gap in similar research in NZ, indicates that this is a vital area that requires further investigation. Accordingly, this study aimed to carry out a qualitative exploration of experiences of nine refugee Muslim women accessing healthcare in NZ.

Methods

Our diverse research team comprised five Muslim migrant women with academic, clinical and community service backgrounds (SC, MA, FB, DJ and NAH), a female Māori academic with a clinical background (JK), a Māori male with both an academic and clinical background (RK), and a male of European descent who also had an academic and clinical background (RL).

Semi-structured interviews were carried out from June to August 2020, with nine purposively recruited Muslim women who arrived in NZ as refugees, and resided in Hamilton. Their ages ranged from 20to 50 years old, and they had lived in NZ for 1–19 years. The participants' countries of origin included: Eritrea, Afghanistan, Syria, Somalia and Thailand. Recruitment was carried out through snowball sampling, via the researchers' networks with refugee resettlement services and a local community Trust for Ethnic women. The researchers approached key individuals in these groups to explain the research. These individuals then contacted potential participants to explain the aims of the project and inquire if they would be interested in participating. If interested, then with their consent, contact details were forwarded onto MA (also a Muslim female who arrived in NZ as a refugee), who contacted the participant, further explained details of the project and scheduled the interview. Each interview was 1–2 hours in duration and occurred at the participants' homes or a local cafe. Most interviews occurred in English, one occurred in Farsi (Persian) and another in Arabic. MA was fluent in Farsi, and so she translated the interview. The participant who spoke in Arabic requested a professional interpreter, who translated the conversation. In the interviews, participants discussed their experiences relating to both primary and secondary health care in NZ.

We perceive this small participant group as both a strength and a weakness of the present study. We acknowledge that we cannot generalise our findings beyond this group to the population in the traditional sense. However, this study does not intend to provide numerical or deductive generalisations of the experiences of refugee Muslim women in healthcare. Rather, we carry out a case-oriented exploration of the experiences of this particular group of refugee Muslim women in the healthcare system in Hamilton, NZ. Our approach prioritises hearing from these women as unique cases, rather than as a subgroup in a larger population. Therefore, using a case-oriented approach, our methods allowed us to make general observations from these particular experiences (Hodgetts and Stolte 2012) and engage in referential generalisations to the broader socio-culturally patterned experience of Muslim women within

the healthcare system, by drawing on theoretical or conceptual generalisations from previous research (Hodgetts et al. 2019).

Interviews were recorded via an audio recorder and as field notes. Audio recordings were transcribed. Pseudonyms were used to maintain the anonymity of participants. Analysis involved a 'text in context' approach. Here, four members of the research team (SC, MA, JK, FB) employed an iterative and interpretive process, by engaging with participant accounts and field notes to unpack the various meanings behind the experiences of the participants in relation to literature as well as the broader socio-cultural contexts in which these experiences occurred. Analysis was carried out individually by all four researchers, and then together as two groups (one with SC, MA and JK, and the other with SC, MA and FB) to ensure a rigorous process. Participant accounts were categorically and interpretively analysed with respect to the key issues that formed the initial basis of the study. Here, the interpretive aspect involved the researchers engaging with participant accounts repeatedly, discussing these as a team, and also reflecting on MA's own experiences of the research encounters to draw meanings from the accounts. Relevant literature was drawn on throughout the analytical process as an interpretive tool to provide context for, unpack and develop emergent issues that became apparent. Overall, our analysis perceived each of our participants as situated cases, embedded within their socio-cultural contexts, rather than being part of a decontextualised and culturally removed 'sample' (Hodgetts and Stolte 2012).

Ethical approval for this project was granted by University of Waikato Human Research Ethics Committee- HREC(Health). Written consent was obtained from all study participants prior to the interviews.

Findings

Findings were grouped into three broad themes, each having sub-themes. The themes were: 'barriers to accessing healthcare', 'othering in the healthcare space' and 'perceptions of care'.

Barriers to accessing healthcare

Participants indicated that they experienced various barriers to accessing healthcare in NZ. These included cost, long waiting times, and communication and language barriers.

Cost

The cost of appointments was a significant barrier to refugee Muslim women accessing primary healthcare services in NZ. According to Shehnaz, while Red Cross covered their General Practitioner (GP) fees for the first year, they had to bear the cost following this period. Here, Red Cross recommended a GP practice to these participants when they were newly settled into their homes in NZ – this is often the closest practice to the house in which they lived. However, often the practice recommended by Red Cross is impractical for these women and their families, as despite being close-by, the cost of an appointment, when they are required to bear it, is unaffordable. As mentioned by Shehnaz:

*… I think they choose for us – Red Cross. Like when you came here [to NZ], [they] choose which GP to be with. So we live in [settlement suburb] with my mum and my sister and the closest one to us was the [name of local GP clinic] … It was free for us that time for a year but then after that we used to pay and so the fees were so expensive like $40! (**Shehnaz**, 20s, Afghanistan, 5 years in NZ)*

This results in some women avoiding going to the GP, whereas others must actively shop for, and change to an alternative, more affordable primary care provider.

Long waiting times

Long waiting times to be seen by a Health Care Practitioner (HCP) in both primary and secondary care was also a barrier to accessing health care for these participants:

*Here [in NZ], if something happens to you … .even if you die, you have to make an appointment! Or for example, if you go to Emergency, we have to wait for ages that you say okay I prefer to die at home but not here. (**Shehnaz**, 20s, Afghanistan, 10 years in NZ)*

While Shehnaz's statement that they would 'prefer to die at home' was expressed in humour, many other participants indicated that such long waiting times was an issue that deterred them from going to see their doctor.

Communication and language barrier

Many participants also talked about language being a barrier to accessing healthcare. While some GP practices offer interpreters for appointments, others require patients to bring their own interpreters if required, which then incurs an additional cost to patients:

*… I always ask the reception, "do you guys provide an interpreter?" They say "no, [patients] need to bring one themselves". But it's a very high cost, especially for refugee women. It's like $90 or $100 per hour, for interpreter fees. (**Asma,** 20s, Afghanistan, 5 years in NZ)*

Shehnaz: Some of the GPs, they don't provide interpreters … If a GP receives people [who speak] different languages, they have to provide that service, you know? There are some GPs who are cheaper but because they don't have interpreters [we can't go] … Red Cross encourages our families to go to the ones who provide interpreters. But what I'm thinking is, why don't all GPs do this.

Interviewers: So, you mean that the families have to make the compromise and go to the doctors that provide the service?

Shehnaz: Yes, yes because if you go to the other one, they don't have interpreters and then if you get [an interpreter yourself], it's gonna be much more expensive. Yes some of the GPs are like that. They say: 'we don't provide it, so bring one yourself'.

Interviewer: And that has an extra cost to that person?

Shehnaz: Of course, it is because [name of the interpreting service] is gonna charge!

*(**Shehnaz**, 20s, Afghanistan, 10 years in NZ)*

Consequently, participants find themselves having to take family members or friends to their appointments to translate for them:

> … My dad's friend can speak English very well, she translates for us and after maybe one year or two years my brother or me go to translate for my parents. (**Thabasum**, 20s, Thailand, 7 years in NZ)

However, using friends of family becomes a problem for participants who prefer to keep their health issues confidential. Women sometimes also have to use male family members as the interpreter, which then prevents them from discussing any issues potentially relating to family violence as well as sexual and reproductive health with their healthcare providers.

Overall, many of these barriers are closely intertwined, and this serves to deter refugee Muslim women from engaging in help-seeking behaviour. For instance, cost becomes an issue to accessing HCPs with higher fees. However, even if an HCP charges lower fees, if their practice does not cover the cost of an interpreter, then the cost of the interpreter becomes a barrier to accessing that practice.

Othering in the healthcare space

Many women discussed experiences of othering in both primary and secondary health care spaces. These experiences ranged from dismissal and disregard from HCPs, being made to feel different, and passive discrimination.

Dismissal and disregard

Participant accounts demonstrate that HCPs were dismissive of things that they considered different or that they are unfamiliar with. For instance, in secondary care, Rashda describes an instance where her uncle was repeatedly given ham for lunch during his hospital stay:

> My uncle was in hospital and I told them, he doesn't eat any pork. His meal should be vegetarian … Three times I went to the room in the morning, he had a ham sandwich. And I tried to tell the nurses … you know I said 'look, he doesn't eat pork and pork should not even come near him'. I've had to say that more than 10 times. (**Rashda,** 30s, Somalia, 15 years in NZ)

Pork, in any form (including ham), is considered a haram, or forbidden food item in Islam. Therefore, Muslims do not consume pork, nor is it appropriate for their food to come into contact with pork products. Therefore, despite being informed multiple times of this cultural convention, the healthcare staff that Rashda and her uncle encountered repeatedly disregarded their request. Similarly, a participant describes another occasion where a male staff member was ignorant of the fact that Muslim women should not be touched on their body by men without their consent, even if they're unconscious:

> I remember another time there was this lady. She had an operation and then after the operation, so she was not conscious. And there was this male nurse … was coming and checking her. So the operation was in her stomach. [He was] checking the stomach and stuff. I was there, he came, so I didn't say anything because I'm not the patient. So I didn't say anything. But when she got conscious, when she opened her eyes and stuff, she was very worried. She's like, "oh my god! A male nurse checked me it's a sin!" She kept talking about that. (**Asma**, 20s, Afghanistan, 5 years in NZ)

Asma also describes an incident in primary care where a male nurse dismissed her request for a female nurse when she went in for a flu vaccine:

*I wanted [a flu vaccine], so I was going to the clinic and made an appointment with the nurse. The nurse was a guy. I was like "can I have a female nurse?" But … he was arguing with me. He is like "what's the matter? It's only an arm" and stuff you know? Yeah he was arguing back … I did not listen to him, I just said "no, still I want a female nurse". So yeah I was like "so what if it's my arm, still I want a female nurse". (**Asma**, 20s, Afghanistan, 5 years in NZ)*

Many participants perceive modesty as a core principle of being a Muslim woman, and some consider it a sin to be touched by men who are not their immediate family members (e.g. husband, father, brother etc.). This applies to any part of the body, especially the midriff region, and also including the arms. In the context of healthcare, this means that female Muslim patients often request female doctors to care for them. Therefore, HCPs need to ensure that they act in a culturally safe manner, even if it is a seemingly trivial instance within Western cultures, such as an arm for a vaccine, or the stomach for a post-operation check-up.

The feeling of being different

Participants also discussed occasions when their experiences in the healthcare space made them feel different and underserving of proper care. Ayan attributes the fact that her doctor regularly turns her away with only painkillers, rather than taking the time to do a thorough investigation of her symptoms, to the fact that they (as refugees) don't conform to the conventional perception of a 'contributing citizen' of NZ – in terms of work or taxes:

*We don't work, we don't pay tax, that's why they are treating us like that. That's the answer we [come up with] when we are in the community. [We] don't pay tax. The government cares only [for those] who pay tax. So that's why they [doctors] only give us a painkiller. Why [waste] my money and my time, and at the end you give me a painkiller. And you say to me, drink water. They don't [even] check. (**Ayan**, 50s, Somalia, 5 years in NZ)*

Here, Ayan is referring to income tax, rather than other forms of tax such as GST, which they would actually be paying. These repeated feelings of being different, and treated as an 'outsider' leads to refugee Muslim women accepting the status quo, and putting up with suboptimal care from their HCPs:

Zaiba: it's a cultural thing as well for us because you're always taught from a young age like oh, don't speak out or like, you know, don't go against what they say whatever they say just take it and accept it.

Interviewer: You are in their country..

Zaiba: Yeah, you're already shy as well if you're talking and your English isn't good. You just take whatever they say. And I think they [the community] can get used a lot in that way.

*(**Zaiba**, 20s, Afghanistan, 19 years in NZ)*

As Zaiba indicates, a lack of fluency in the English language can exacerbate the feeling of being 'the other' experienced by refugee Muslim women in healthcare spaces.

Passive discrimination

In addition to dismissal and being made to feel different, participants also described incidents that could be perceived as passive discrimination. Asma, for instance, encountered an HCP who assumed that she had a nutrient deficiency due to a lack of exposure to the

sun, solely because she wore a hijab and abaya (traditionally Muslim head covering and robe-like dress):

Asma: like most of them, like, say that oh yeah, like your vitamin D is low.

Interviewer: Because you're covered [by a hijab and abaya]?

Asma: Yeah. Because of the sun and stuff. And they literally ask you … If you wear [your sleeves] this short or that short you know. Like your sleeve is where you're going to get some vitamin D and stuff. So you'll find some of them when they approach this matter, because I believe it's not in the words, which they say … it's like about the facial expression. And it's about the tone of their voice. It's about how they approach it. Yeah. And I face that a lot. Yeah.

(**Asma**, 20s, Afghanistan, 5 years in NZ)

Similarly, Thabasum describes an incident with a GP who treated her differently, compared to the patients who preceded her. The experience caused her to change GPs:

Thabasum: I don't know how to explain … Like, maybe not the same. Like we went with hijab, we're like different looking. They didn't say anything but their face is … we can see on their face. It's different … changed..

Interviewer: So, you mean that they treated you differently?

Thabasum: Yeah. … When we went home, and we talked with our parents [about it] and my dad is like very, I don't know. My dad thinks it's like … [he said] don't tell them [don't complain].. it's like a small thing. My dad thinks it's like [a] very small thing. He said that every country has it.

Interviewer: Okay, and then he asked you to let it go.

Thabasum: Yeah

Interviewer: So you just changed your GP?

Thabasum: Yeah

*(**Thabasum**, 20s, Thailand, 7 years in NZ)*

Similarly, Rashda attempts to articulate examples of passive discrimination that she has experienced in secondary care:

*Well sometimes it's hard, sometimes it's not like fully straight in your face. You get discriminated, but it's just like the backhanded services you get, it's just like how they handle things. (**Rashda**, 30s, Somalia, 15 years in NZ)*

Importantly, many participants discuss how they struggle to describe the discrimination that they have experienced, given its passive, intangible delivery. However, what all participants were sure of, was that such experiences left them feeling uncomfortable. When some participants attempt to raise such issues as a problem, others shut them down by stating that it's a 'small thing' that they should not raise a fuss about – as done by Thabasum's father.

Perceptions of care

The Muslim women perceive listening (on the part of the GP) as caring, or proper patient care. Shehnaz describes the doctor that she had recently switched to:

> *The doctor that I am with now, he really cares, he really listens to you and I think that's the more important thing. Because I know some people in my family, they prefer to just deal with the pain or the problems they have but they don't want to go [to see a doctor] because they kind of think the doctor doesn't listen to them. (**Shehnaz,** 20s, Afghanistan, 10 years in NZ)*

Many other participants also highlight instances where their GPs did not listen to them properly, and thus did not engage in proper patient care:

> *I just think they need to listen to the information that the people give them, and listen to it carefully instead of just giving them Paracetemol, Ibubrofen. (**Nazima**, 20s, Eritrea, 15 years in NZ)*

> *He examined us and he said, do this do that … and he records it, typing and, most of the time we saw the doctor, he got onto Google and he told us what Google said. Speaking, typing, that's it. (**Iman**, 40s, Syria, 14 years in NZ)*

> *I am not saying the doctor was not good, they were good … but I was thinking they were not really listening … they didn't care … You know … here for example if you say I think that I have this issues, they are kind of like no it is just your thinking and maybe they just give you Paracetemol you know like things like that. Just the painkillers but not like investigating like really what is going on with you … I told my mom I don't want to go to the doctor anymore because they just give you painkillers and I can just get that from [the supermarket] anywhere. (**Shehnaz**, 20s, Afghanistan, 10 years in NZ)*

Interestingly, many participants repeatedly discussed the fact that the GPs who did not listen or care, tended to give them Paracetamol or painkillers rather than engage with them to find out why exactly they sought health care.

Discussion

This study takes a case-oriented approach to explore the experiences of nine refugee Muslim women as they accessed and navigated the healthcare system in Hamilton, NZ. The findings of this research identified various barriers to accessing healthcare, as well as instances of othering in the healthcare space experienced by these women. Many of the barriers identified pertain to broader structural factors within the NZ healthcare space, whereas many experiences of othering and discrimination seem to be rooted in interpersonal factors.

First, focusing on the structural factors, cost and issues with interpreters were key barriers particularly to accessing primary care. In saying this, however, while the language barrier was a significant hindrance to accessing services, this also often related to cost and unaffordability (i.e. the cost of interpreters when patients had to fund their own). As such, accumulating cost is a recurrent theme relating to primary healthcare access in NZ, affecting many minority communities (e.g. Cassim et al. 2020). Similarly, previous research demonstrates that many patients in the Waikato region of NZ are not enrolled with the GP clinic closest to their residential address, primarily due to a lack of affordability (Whitehead et al. 2019). In NZ, all primary care providers receive partial funding from the Government. However, some are funded more than others and are considered 'very low cost access'/VLCA providers. VLCA providers charge lower fees, while others, due to this variable funding, often charge considerably higher fees. Additionally, a recent initiative in NZ enabled refugees to be eligible for a Community Services Card, which would enable them to access any GP clinic (irrespective of whether it was a

VLCA provider or not) for the same fee as that charged by a VLCA provider. Therefore, in the current context, given that support workers or volunteers often assist newly resettling refugees to enrol in a local GP practice, there needs to be an awareness of the differences in cost in the first instance, alongside the socio-economic status of the refugees being supported, and their eligibility for a Community Services Card. Moreover, many primary health organisations (PHOs) in NZ have access to funding for interpreter services particularly targeted at refugee communities, which all staff working in PHOs should be aware of and utilise. Given the availability of targeted funding (albeit limited), refugee patients should not have to bear the cost of interpreters themselves, nor should it serve as a barrier to accessing primary care.

Second, we focus on the issue of othering in primary and secondary healthcare. Here, othering is perceived as a set of dynamic processes and structures that prompt marginality and persistent inequality based on group identities. Othering can encompass expressions of prejudice and discrimination on the basis of group identity and can also provide a clarifying frame that reveals the processes that propagate inequity and marginality (Powell and Menendian 2016). Our participant accounts demonstrate the religious discrimination experienced by these Muslim women. For instance, the hospital staff blatantly and repeatedly disregarding Rashda's requests to stop serving her uncle ham sandwiches due to it being haram (forbidden) in Islam, and the sense of discomfort that Thabasum felt at the GP's clinic because she was wearing a hijab (clothing worn as part of her Muslim faith).Sadly, however, many refugee Muslim women such as those in the present study tend to minimise and justify the unprofessional and discriminatory behaviour of HCPs (Plaza Del Pino et al. 2020). Othering then, can serve as a form of racism that is difficult to explain and see; a form of passive racism. As highlighted by our findings, this can take the form of seemingly mundane expressions of a lack of care, dismissal and disregard of cultural beliefs/practices and making patients feel different. A particularly significant example discussed by a participant was the assumption and unconscious bias by the HCP relating to vitamin D deficiency, because she wore covered clothing pertaining to her Muslim faith (a hijab and abaya). A number of significant studies, in NZ and globally, recently suggested that migrant women with increased skin pigmentation and those who wear veiled clothing are at a particularly higher risk of vitamin D deficiency (Judkins and Eagleton 2006; Narang et al. 2020), which may have led to HCPs' generalised perceptions of Muslim women being at higher risk. However, the latter claim regarding people who wear *veiled* clothing is unfounded. Rather, what the research does indicate is that women of non-European ethnicity (particularly those from Asian descent), alongside those who were more likely to wear 'more extensive clothing' during non-summer months could be at higher risk for vitamin D deficiency (Nessvi et al. 2011). Vitamin D can also be gained from dietary sources, and not simply from sun exposure (Hollis 2005; Nessvi et al. 2011). Therefore, HCPs should more consciously avoid such broad generalisations when engaging with refugee Muslim women, and to respectfully explain the factors involved in potentially being at high risk for vitamin D deficiency.

Communication is an important factor here. HCPs can still be cautious and vigilant about risk of vitamin D deficiency for instance, but by expressing it in a manner that demonstrates concern and care, rather than bias. This also applies to other examples of dismissal and disregard experienced by participants, such as having to tell hospital

staff repeatedly that a patient did not eat ham. Good communication skills entail attentive listening. A busy or stressed system must still listen to and accommodate patients' needs, or respectfully communicate why they cannot be accommodated if necessary. Such instances link back to structural factors that serve to perpetuate racism within a healthcare system that is plagued by the tyranny of dominant Eurocentric norms, where the system cannot cope with any alternative value or belief systems. Such inequities in the NZ health system have been reported consistently by research with other non-European groups such as Māori (the Indigenous peoples of NZ) communities (Harris et al. 2018; Waitangi Tribunal 2019; Cassim et al. 2020). Here, given the NZ context of these experiences, it also then becomes imperative to give effect to Te Tiriti o Waitangi (or the Treaty of Waitangi) within NZ healthcare spaces. Te Tiriti is the founding document of NZ and describes the principles of kāwanatanga (decision making), rangatiratanga (self-determination), ōritetanga (equity) and wairuatanga (spirituality) that underpin the relationship between the NZ Government and Māori (Kukutai and Rata 2017). Te Tiriti also encompasses a human rights dimension that applies to all peoples of NZ. In particular, religious discrimination is a potential breach of Te Tiriti which guarantees the right to freedom of religion and belief for all peoples of NZ (Human Rights Commission 2010). Moreover, despite cultural safety training being compulsory for HCPs in the NZ health system, and HCPs having a duty and obligation to comply with the Code of Health and Disability Services Consumers' Rights (Health and Disability Commissioner 2020), the enduring legacy of racism in the system serves as the underlying cause of ethnic minority and Māori health inequities. This then emphasises the importance of regular and updated cultural sensitivity and cultural safety training for HCPs across the NZ health system.

The findings of this study hold broader implications relating to caring for female refugee Muslim patients in a way that is culturally safe and respectful, not only for doctors and nurses but also for other staff working in healthcare. This is particularly imperative given that sadly, similar findings were reported by DeSouza's research with Refugee women in NZ 10 years ago (DeSouza 2011), underscoring the need for more active intervention to ensure that the next study in 10 years' time does not echo the same findings.

Primarily, HCPs need to have the ability and training to handle complex and gender-sensitive cases, and have relevant cultural diversity training and cultural sensitivity training (Mortensen 2011). HCPs should also tap into the existing national health promotion strategies that have a focus on refugee communities. Examples include the NZ HIV/AIDS Refugee health education programme (Worth et al. 2003), the healthy eating-healthy action programme (Ministry of Health 2003) and various other community-based health services (Wishart et al. 2007; Mortensen 2011). The use of refugee community health workers and/or intercultural mediators can also serve as a cultural bridge between HCPs and patients (Plaza Del Pino et al. 2020). While we acknowledge that these initiatives are not specific to Muslim communities, they can provide a good starting point. Second, HCPs need to be aware of and access available funding for interpreters. The findings of this study further reveal an opportunity for DHBs to allocate and provide access to funding for interpreters equitably across primary and secondary healthcare services in a manner that suits the demographics of the populations they serve.

Alternatively, refugee patients could be provided access to funding for interpreters, so that they have the autonomy to use interpreters based on their needs.

Globally, healthcare institutions are designed to serve all citizens equally. However, equal access can hinder equal outcomes for minority groups such as refugee Muslim women, by putting barriers in place, such as those discussed by the participants of this and other related studies (Mortensen 2011). To ensure equal and positive outcomes for refugee Muslim women, there needs to be a turn towards equity, rather than equality. Yet, in NZ at a structural level there is ambiguity and ambivalence surrounding the inclusion of refugees as 'health populations' or a priority group into the healthcare system, and as such the system has been largely unresponsive to the disparities experienced by these communities (ADHB 2002; Mortensen 2011). Nonetheless, there are some signs of support for refugee communities at a local level, with HCPs identifying health needs and initiating specific projects to address these concerns locally (McLeod and Reeve 2005; Mortensen 2011). Many such projects had been funded through voluntary fundraising, charitable grants, or out of baseline health agency budgets.

Conclusion

Overall, refugee Muslim women arrive in a nation like NZ in search of safety, security and protection, fleeing a past weighed down by many inequities and atrocities. Therefore, host nations should ensure that the rights of refugee women are upheld, and that they do not get re-victimised in their new homes. The experiences of the women in healthcare spaces point towards a deeper set of dynamics that speak to how refugee Muslim women are inequitably positioned within NZ society, and how they are perceived and regarded (*cf.* Powell and Menendian 2016; Kale et al. 2020). Therefore, in order to tackle inequity, particularly in the health system, structural and institutional barriers need to be addressed first, to prompt other levels of othering and discrimination to reduce over time (Jones 2000). Our findings stand alongside the call by Indigenous scholars to rethink how NZ receives immigrant communities; a call to adopt a 'Treaty-based model of manaakitanga'[1] (Berghan et al. 2017; Kukutai and Rata 2017) when hosting and caring for refugee Muslim women.

Ethical approval

Ethical approval for this project was obtained by the University of Waikato Human Research Ethics Committee - HREC(Health).

Note

1. 'Manaakitanga' is a core Māori value comprising the process of showing and receiving kindness, respect, generosity and hospitality.

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