2024-12-04

Exploring the Experiences of Black Muslim Women in Alberta Emergency Departments: An Interpretive Description Study

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Exploring the Experiences of Black Muslim Women in Alberta Emergency Departments:

An Interpretive Description Study

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF NURSING

GRADUATE PROGRAM IN NURSING

CALGARY, ALBERTA

DECEMBER, 2024

Abstract

Background: Black Muslim women have a unique set of religious and cultural beliefs that impact how they receive healthcare. A growing body of literature on health equity suggests that gaps in healthcare providers' systemic, social, and cultural awareness of the unique needs of diverse patient populations can add to poor patient health outcomes.

Aim: This research project aims to explore how race, faith, and gender impact Black Muslim women's experiences receiving care in emergency departments (EDs) in Alberta.

Methods: Six Albertan Black Muslim women who self-reported a personal ED visit within the last five years were interviewed, and data were analyzed using qualitative interpretive description methodology.

Findings: Participants described patient-provider relations as strained due to communication challenges rooted in past experiences of racism and distrust in the healthcare system. Further, participants' race, faith, and cultural needs in a healthcare setting fundamentally impacted their ED care experience. Lastly, participants highlighted that healthcare system challenges such as lack of access to family physicians across the province, long wait times, and rural barriers to care were exceedingly difficult to navigate when compounded with past experiences of discrimination.

Discussion: This study provides insight for healthcare professionals on the experiences of Black Muslim women who present to the ED. Using the Population Health Promotion Model (Hamilton & Bhatti, 1996) as a framework, I located and analyzed the findings of this study in the context of the social systems and determinants of health that impact Black Muslim women. Discussing the findings from a health promotion perspective highlights the barriers and challenges Black Muslim women face. Further, it supports

knowledge translation to practically inform clinical best practices and health promotion initiatives for this population.

Acknowledgments

First and foremost, to Allah belongs my highest gratitude and praise. The personal challenges I overcame while writing this work were the most difficult circumstances I've ever had to navigate, and holding on to His word brought me through.

I am deeply, incredibly proud of every past version of myself who kept hopeful, who saw the light, who continued dreaming, who continued being purposeful, and who continued being curious. It leaves me in awe that I demonstrated enough grit and patience to keep the difficult promises I made to myself no matter what, I can only attribute that strength to Allah.

Hoyoo, thank you for your unconditional love. I am honored to be the daughter of a woman who is open-minded and taught me to walk to the beat of my own drum. Thank you for trusting me, supporting me, and pushing me to bloom into the fullest version of myself without the constraints of convention. You taught me that the safest thing to do is take risks, that the world is kind to those who are brave, and that this life isn't a zero-sum game. Hoyoo, you have given me the foundation and secrets to a beautifully secure future where I'll be winning no matter what. You've engrained in me that abundance is in my mind, in my heart, and in full faith that Allah has the absolute best in store for me. Aabo, may Allah have mercy on you and grant you Jannah. To my siblings, thank you for being by my side.

To my friends, thank you for supporting me along this journey and making me feel seen in ways I did not know I needed until you showed up. We will go far together, and I can't wait to see it all unfold.

I am incredibly grateful for the women who participated in this study and shared their sensitive, challenging, and eye-opening experiences with me. Thank you. My gratitude to you is boundless, without your courage, this work would not have come to fruition. The point of conducting this study is for it to be used to make our communities healthier and stronger, you have my word that I will use this work to do that and more in the future. May Allah accept this work as a *sadaqah jaariyah* (ceaseless charity) that continuously benefits you, me, our communities, and our ummah. Ameen.

To my supervisor, Dr. Aniela dela Cruz who consistently offered support and feedback that improved my critical thinking and expanded my view, thank you for guiding me. Thank you for your insights and methodological expertise; I cannot put into words how much I appreciate your kindness in championing me to the very end.

Finally, to my committee members, Dr. Jennifer Jackson and Dr. Lorraine Venturato, I greatly appreciate your time, effort, and consistent feedback that helped me reframe my understanding of this work and iterate.

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Chapter 1: Introduction

Canada's Muslim population is growing; according to Statistics Canada (2022), Muslims currently make up 5% of Canada's total population. Islam has become the second most common religion practiced in the country. Within the vast and diverse community of 1.8 million Canadian Muslims, Black Muslim women exist at a unique set of intersections of gender, race, and faith. However, their healthcare experiences have been seldom explored and documented in available research. In this study, I utilized a qualitative approach to explore how Black Muslim women's intersecting identities impact their experiences in the healthcare system. The guiding research question for this study is as follows: "What are the experiences of Black Muslim women who have received emergency department care in Alberta?"

Researchers have indicated that racialized individuals are among the least likely to have regular access to primary and preventative care (Duong & Vogel, 2023). Without access to primary care, the only available option for receiving healthcare is through an ED. The recent assessment conducted by the Alberta Medical Association (2022) also points out that EDs in Alberta are now more overwhelmed than ever before, largely because of province-wide challenges in accessing primary and preventive care. This situation is making many across the province, including Black Muslim women, increasingly rely on ED care as an immediate solution.

The unique set of religious and cultural beliefs of Black Muslim women necessitates that healthcare providers understand how these beliefs shape their interactions with the healthcare system. This understanding helps healthcare staff to provide culturally safe care in order to reduce exposure to anti-Black racism,

Islamophobia, and unchecked biases that can be detrimental to the care and experience of Black Muslim women in general.

Using the interpretive description (ID) approach (Thorne, 2016), this study explores the ED experiences of Black Muslim women in Alberta to uncover the facilitators and challenges they face. In addition, this study offers recommendations to nurses and other healthcare professionals. These recommendations are intended to inform clinical practice, potentially improve Black Muslim women's healthcare experiences in Alberta's EDs, and contribute to the literature on equity in healthcare.

Chapter Overview

This chapter aims to provide background information to this study. It includes a basic description of the core tenets of Islam and an exploration of how certain aspects of women's practice of Islam can affect their care in EDs. The chapter uniquely defines and describes Black Muslim women in the context of their ethnic and racial roots as well as how histories of anti-Black racism impact the health outcomes of Black people. This distinction is critical as not all Muslim women face the same barriers and health determinants as Black Muslim women. Lastly, the concept of culturally safe care (Williams, 1999) is defined to acknowledge the power dynamics between healthcare providers and patients. Highlighting and defining this concept is particularly important because these power dynamics underlie the pervasive themes of sexism, Islamophobia, and anti-Black racism faced by Black Muslim women.

Islam

Islam is the world's second-largest and fastest-growing religion. The name "Islam" is an Arabic word that connotes submission and peace. It is a monotheistic

religion, fundamentally based on the declaration that there is only one God (Allah) and that Muhammad (peace and blessings be upon him) is Allah's last and final messenger. This declaration, known as the Shahada, is the central tenet of the faith. Muslims adhere to six articles of faith: belief in one God, belief in angels, belief in divinely revealed books (including the Bible, Torah, and Quran) as the word of God, belief in the Messengers of God, belief in the Day of Judgment, and belief in divine predestination in life (Muslim Ibn al-Ḥajjāj, 2007, p. 44). The practice of Islam revolves around its five pillars: believing in the Shahada, praying five daily prayers, paying obligatory charity (zakat), fasting in Ramadan, and making a pilgrimage to the *Ka'bah*, Islam's holiest site (Muslim Ibn al-Ḥajjāj, 2007, p. 51).

Faith is a profoundly defining factor in the lives of Muslim women; Islam shapes their worldviews and perceptions of health in numerous ways. When facing difficulties such as ill health, a Muslim woman often turns to prayer as a means of emotional support (Simonovich et al., 2022). *Sabr*, a concept in Islam, embodies patience, forbearance, and perseverance during difficult times, with the hope of earning a good reward from God. This concept helps Muslim women maintain strong resolve when faced with challenges such as ill health. In a hospital setting, such as an ED, there are a multitude of ways in which women's practice of Islam can affect their care. In Islam, obligations such as daily physical prayers—which require standing, kneeling, and bowing—and fasting from food and drink, as well as modesty guidelines, are all lifted or modified to accommodate times of sickness, for the sake of putting health first (Blankinship, 2018).

Basic privacy and clean surroundings for daily obligatory prayers are essential needs for many Muslim women. Even in ill health, maintaining the routine of prayer can

be grounding. Practicing modesty, such as wearing a headscarf and loose clothing that covers the body except for the hands and face—a practice known as hijab—is another important aspect of Islam for many Muslim women. Modesty is central to many Muslim women's identities, and being uncovered or in less modest clothing during a hospital stay can feel distressing and uncomfortable (Blankinship, 2018). Dietary restrictions, such as abstaining from pork and pork byproducts, are strictly adhered to by many Muslim women. Lastly, family and community play a significant role in the lives of Muslims. Maintaining close kinship ties and involving multiple family members in decision-making is common in many Muslim cultures. Additionally, one of the most highly revered deeds in Islam is visiting a sick person, meaning that members of their wider community may offer support in times of need (Blankinship, 2018).

Islamophobia

Islamophobia is defined as fear, hatred, or prejudice against Islam or Muslims who practice the faith. According to a report by the Senate of Canada (2023), the Standing Senate Committee on Human Rights clearly defines Islamophobia as an acute threat to Canadian Muslims and emphasizes that direct action must be taken to address it. Furthermore, the report highlights that Canada leads all G7 nations in targeted killings of Muslims with specific Islamophobic hate crime motivations. Black Muslim women, especially those who wear hijab, are at a significant risk of facing Islamophobia. The report describes women as the primary target of violence and intimidation (Senate of Canada, 2023). While the faith practices of Islam impact Black Muslim women daily, it is important to acknowledge that these practices can make them targets of

marginalization, intimidation, and assumptions, both in public and in healthcare settings (Senate of Canada, 2023).

These examples demonstrate how Islam can impact the healthcare experience of a Muslim woman. Therefore, understanding how Islam influences the care of a Muslim woman is a crucial concept for healthcare providers. Without this knowledge, delivering safe, effective, and culturally sensitive care becomes challenging (Simonovich et al., 2022). In rapid care environments, maintaining cultural safety remains essential to providing safe and effective care.

Black Muslim Women

According to a report by Toronto Metropolitan University (2023), most Black Muslim individuals in Canada are immigrants or first-generation citizens. The report states that 84% of Canada's Black Muslim population has African ethnic origins, with 38% originating from East Africa. This population primarily resides in the major urban centers of Alberta, Quebec, and Ontario.

Black Muslim women occupy a unique intersection of identity. They face compounded risks of Islamophobia, anti-Black racism, and sexism when navigating social systems (Rajaram & Rashidi, 2003). A concept termed *triple consciousness* (Mohamed, 2017) aptly describes the experiences of Black Muslim women. This phenomenon is characterized by their constant awareness of how their race, religion, and gender identities impact their lived experiences and access to social systems (Mohamed, 2017). Kimberle Crenshaw (1989), in coining the term *intersectionality* outlined a similar concept. She highlighted how feminist and anti-racist discourses often fail to fully address the experiences of Black women.

Black communities across Canada face inequity and health disparities (Abdillahi & Shaw, 2020). They are affected by anti-Blackness, Islamophobia, gender discrimination, limited access to health services, lower health literacy, language barriers, immigration status barriers, reduced social support, and low income. These societal and systemic challenges negatively impact the health outcomes of Black people in Canada (Abdillahi & Shaw, 2020). Notably, the Black population in Canada reports higher rates of diabetes and hypertension compared with White Canadians (Abdillahi & Shaw, 2020).

Understanding the background of Black Muslim women, particularly in the context of their race and its implications on health, is key to upholding the foundational pillars of dignity, safety, and trust in the patient-provider relationship (Vu et al., 2018). Without this understanding, healthcare providers may have blind spots and unconscious biases that can result in a negative patient experience, which ultimately impacts the patient's adherence to treatment and willingness to seek care (Hasnain et al., 2011). Providing culturally safe care to Black Muslim women requires healthcare providers to incorporate three concepts into their immediate care plan: race and its associated factors as determinants of health, religious accommodation, and cultural accommodations. Furthermore, being open to understanding each patient's unique barriers can help healthcare providers build an effective plan of care that addresses social gaps and health disparities post-discharge.

Culturally Safe Care

The concept of culturally safe care was developed by Maori nursing scholars in New Zealand in the 1980s. The goal of providing culturally safe care is "no assault on a person's identity" (Williams, 1999, p. 213). Cultural safety accounts for the impacts of

colonialism and systemic discrimination on the health of Indigenous and systemically marginalized populations (Williams, 1999), while culturally safe care refers to the implementation of cultural safety practices (Papps & Ramsden, 1996). Canada's healthcare institutions carry a colonial past, where certain groups were treated poorly in the context of their social position. Understanding and unlearning behaviors rooted in the colonial legacies of mistreating marginalized groups is a core tenet of cultural safety (Williams, 1999).

I applied the concept of cultural safety, particularly in interacting with study participants during the data collection phase. This was achieved by guiding the interviews with reassurance, compassion, and respect, and by validating their experiences in the context of healthcare providers holding power in a patient-provider dynamic. Additionally, cultural safety was implemented in the analysis phase by critically considering the impact of patient-provider power dynamics on the interpretation of the study participants' experiences.

Black populations in Canada have specifically faced centuries of discrimination. Enslaved Black persons have lived in Canada as early as 1604, facing discrimination, maltreatment, and a lack of basic freedom due to being owned by White settlers (Government of Canada Department of Justice, 2023). While in 1833, slavery was formally abolished through the Act on the Abolition of Slavery in the British Empire, anti-Black racism was still extremely prevalent (Government of Canada Department of Justice, 2023). Racism in the Canadian legal system through the Immigration Act of 1910 is one example; it prevented immigrants deemed "unsuited to the climate or requirements of Canada," leading to the rejection of most non-White immigrants to Canada

(Government of Canada Department of Justice, 2023). Anti-Black racism was also ingrained in Canadian society over a century after the legal abolition of slavery, as Viola Desmond—a prominent Canadian figure and businesswoman—was arrested for refusing to comply with a rule to not sit in a "whites-only" section of a movie theater in 1946 (Government of Canada Department of Justice, 2023). Discrimination exists against Black peoples in Canada who were enslaved by white settlers to further the goals of European colonization of North America (Government of Canada Department of Justice, 2023). The failure to adequately recognize and address this history, and how it has gone unaddressed in healthcare systems has resulted in poor health outcomes for Black Canadian communities (Jefferies et al., 2022). Culturally safe care is a valuable approach when working with Black Canadian populations, especially given the deep roots of anti-Black racism in Canada's nursing profession and healthcare system overall. The concept of culturally safe care has been incorporated into nursing education to promote nurses' ability to critically reflect on their own biases and social positioning when interacting with Indigenous patients and those experiencing marginalization (Curtis et al., 2019). Similarly, understanding cultural safety is also an effective way to foster health equity when caring for Muslim patients. Islamophobia, another form of discrimination, can be addressed by understanding the social, cultural, and religious needs of Muslim patients, particularly when they are ill.

Study Significance

Camargo et al. (2023) conducted a scoping review that covers available literature on Islamophobia and highlights a significant gap in research concerning the experiences of Muslims in Canadian healthcare systems. The present study addresses this critical

research gap and is a step towards creating solutions to address Islamophobia in Canada. Documenting and examining the experiences of Black Muslim women would provide much-needed insight into inclusive, intersectional, and culturally safe approaches for improving Muslim care.

Conclusion

The concepts outlined above are foundational to understanding Black Muslim women's experiences, and the central motivation for conducting this study – fostering cultural safety in clinical settings. In addition, cultural safety was explained as a foundational motivation to further explore the experiences of Black Muslim women. Cultural safety is unique because it acknowledges power dynamics; from its inception, the concept is rooted in justice for Indigenous peoples through nursing practice. The emphasis on the roots of cultural safety being reflective of the guiding intent behind this research is intentional. Setting a clear foreground that systemic discrimination and global coloniality impact the health of historically oppressed peoples leads the reader to understand the importance of knowledge translation in justice. My hope is that the information gathered in this research is used to fuel creative, imaginative, and iterative solutions to support the health and well-being of Black Muslim women.

Chapter 2: Literature Review

I conducted a review of the available literature to gather what is known about the experiences of Black Muslim women seeking ED care, guided by the following research question: "What are the experiences of Black Muslim women in emergency department care in Alberta?" Notably, there were no studies specifically addressing ED care for Black Muslim women. I expanded my search to include literature on Muslims and ED care, Black populations and ED care, and the broader healthcare experiences of Muslim women. This search revealed a significant gap in research that explores the intersectional identities of Muslim women and their experiences in ED care.

In this chapter, I describe the search methodology and article selection criteria. Next, I completed a critical analysis and synthesis of relevant literature. In addition, I explored and appraised articles within each search category that cover themes relevant to this study. The identified knowledge gaps in this literature review highlight a critical need for research on the experiences of Muslim and Black populations in the ED. A comprehensive investigation into the journey of Black Muslim women through the ED—including their interactions with healthcare providers, post-discharge system navigation, and their behaviors, perceptions, attitudes, and beliefs about the ED—can uncover important areas for further exploration.

This section describes the inclusion and exclusion criteria, along with the analysis of the available literature. A detailed description of the search strategy can be found in Appendix A. The literature review was conducted using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database. Notably, no specific literature was found on the experiences of Black Muslim women in ED care. To capture a broader

scope, searches were expanded to include Black women, including various ethnic groups, to ensure the inclusion of research on the most populous Black and Muslim diaspora groups.

The keywords used for these searches included the following terms: “emergency department,” “emergency room,” “accident and emergency,” “A&E,” “health,” “health disparities,” “Muslim women,” “Islam,” “Muslim,” “Islamic,” “Black Canadian,” “Somali Canadian,” “African Canadian,” “East African Canadian,” “Sudanese Canadian,” “Eritrean Canadian,” “African American women,” “Black females,” and “Black women.” These terms were selected to comprehensively cover the relevant topics and demographics for this study.

Inclusion criteria included empirical research that explored relationships and resultant experiences across each keyword. Included research was required to have also occurred in a Western country to ensure similarity to Black Canadian Muslim women’s experiences. Search results from the United States (US), United Kingdom, Europe, Australia, and New Zealand were included due to a lack of Canadian literature. The exclusion criteria were as follows: no grey literature, and no literature from non-Western or Muslim-majority countries. Following a comprehensive article review, the elimination of duplicates, and selection based on the aforementioned criteria, a total of 70 articles for all categories combined were deemed relevant. The following sections discuss each search category, its prevalent themes, and an analysis of gaps in the literature.

Muslims in the Emergency Department

There was a lack of literature exploring how ED care differs for individuals whose faith practices influence their interactions with the healthcare system. This gap is

particularly noticeable in the literature about Muslims and ED care, which is almost non-existent. While some studies, such as Awang et al. (2022), recognize the diversity within the Muslim community, no studies included in this search specifically examined the experiences of any racial or ethnic Muslim group. Pasic et al. (2010) explored the challenges many Muslims face when accessing ED care and addressed barriers such as linguistic problems, refugee status, and other socio-economic issues. Their study specifically pointed out the importance of patient-provider trust, especially in psychiatrically focused diagnosis and treatment (Pasic et al., 2010). In relation to this, Padela et al. (2010) noted that ethnic medical minority staff are particularly attuned to the care needs pertaining to their minority groups. This can help in establishing trust between the patients and the providers, especially when the two belong to the same ethnic minority; sometimes it minimizes language barriers.

Other studies also highlighted the limitations in providing culturally safe care among health professionals. Attum et al. (2018) discussed that healthcare providers must understand their customs and health beliefs, which are essential in providing care to Muslim patients. Similarly, Ding et al. (2018) conducted a scoping review on the delivery of culturally safe care for Muslim patients presenting in the ED. Their study identified that nurses play a paramount role in the provision of such care. They emphasized that a lack of nurses' knowledge and understanding of culturally safe practices for Muslim populations can compromise care and safety for patients (Ding et al., 2018).

Patient-Provider Relationships

Providing culturally safe care to Muslims in EDs includes fostering psychological safety. Padela et al. (2010) surveyed participants at the 2007 American College of

Emergency Physicians Scientific Assembly. Their results revealed that nearly one-third of the physicians believed patients receive better care from providers of the same race (Padela et al., 2010). In addition, a higher proportion of female physicians were in favor of same-sex care providers compared to their male counterparts.

Sociopolitical Context and Access to Care

Immigration status is a social determinant of health (Samuels et al., 2021). It is often associated with language barriers, difficulties in navigating the healthcare system, a history of trauma as a refugee, and extremely limited access to care for undocumented immigrants. Immigrants frequently encounter racism in public and within various systems. Unfortunately, a law further marginalizing Muslim immigrants was codified into law in 2017, profoundly impacting the lives and livelihoods of Muslim immigrants in the US. President Trump's Executive Order 13769, commonly known as the "Muslim Ban," was implemented under the title of "Protecting the Nation from Foreign Terrorist Entry into the United States." This executive order prohibited travel and refugee resettlement from Iran, Iraq, Libya, Somalia, Sudan, Syria, and Yemen. The order directly impacted access to healthcare for individuals from these countries (Samuels et al., 2021).

A comprehensive cohort study in Minnesota, involving health records of over 250,000 patients from Muslim-majority countries, revealed a significant increase in missed primary care appointments and ED visits among individuals from the countries listed in the order (Samuels et al., 2021). This study indicated that the fear of arrest and deportation, exacerbated by intersecting Muslim faith and racial prejudice, became a substantial barrier to accessing primary care for both documented and undocumented individuals.

Hassouneh's (2017) study cut through the obscurity surrounding systemic racism in the daily lives of Muslims. The researcher discussed that prejudice against Muslims extends beyond the xenophobia defined by Islamophobia; it manifests as an active policy choice (Hassouneh, 2017). Hassouneh (2017) frequently used the term "anti-Muslim racism" in the article, defining it with examples of structural inequity faced by Muslims. Notably, the researcher referred to the previously mentioned "Muslim Ban" as well as provided insightful analysis of important previous studies in this area.

In Canada, openness and encouragement of immigration as a nation-building activity backed by clear pathways to citizenship creates the idea that immigrants can integrate nearly seamlessly into Canadian life, though this isn't the case for Black or Muslim immigrants. Canada is no different than other global northern countries with increasing rates of islamophobia since 9/11. Canadian census data points to Muslims being the least liked of all religious identities in Canada, and this translates into discrimination in the workplace, in public, and in education (Wilkins-Laflamme, 2018). Although this discrimination in various social systems has been documented, and data on its prevalence in healthcare is scarce, the documented healthcare experiences of Muslims in Canada through qualitative studies mirror similar instances and attitudes of discrimination (Yeasmeen et al., 2022).

In one study, Oyewuwo-Gassikia (2016) revealed that one-third of its Muslim participants experienced discrimination in healthcare settings. Further highlighted in this article was the study of Budhwani and Hearld (2017), who reported that religious discrimination against Muslim women is correlated with a higher risk of depression, which highlights the direct impact of structural racism on health outcomes. Hassouneh's

(2017) study highlighted key issues faced by Muslim women and also called for action and greater awareness as well as for research to address the gaps identified.

Policy to Improve Care

Queensland Health and the Islamic Council of Queensland (2010) created a resource available in Australia for ED staff called *Health Care Providers Handbook on Muslim Patients*. Ding et al. (2018) described this handbook as a holistic reference tool. It covers Islamic guidelines on various aspects including modesty, familial involvement, fasting, maternity care, and the care of deceased Muslim patients, which impact health (Queensland Health & Islamic Council of Queensland, 2010). Similarly, the Fraser Health Authority (2014) in British Columbia, Canada developed a guide titled *Providing Diversity Competent Care to Muslims*. This guide, addressing similar topics, is another accessible tool for healthcare providers when caring for Muslim patients (Fraser Health Authority, 2014).

Black Populations in the Emergency Department

There is a significant amount of literature available focusing on the improvement of healthcare and defining health disparities for Black populations in Western countries. Thousands of articles were found under search terms relating to the health of Black populations and Black women overall. In an effort to maintain clarity, the focus of this search was narrowed from the experiences of Black populations in healthcare down to better understanding simply the ED experiences of Black populations.

One recurring theme in the studies reviewed was the consistent and glaring health disparities faced by Black women receiving care in EDs. Quantitative studies have consistently found an association between being Black and a range of poor health

outcomes. For example, Lipsky and Caetano (2007) investigated the correlation between intimate partner violence and ED visits and found that reproductive health-related visits to the ED were almost three times higher for Black women compared with White women. This higher prevalence among Black women points to the need for culturally safe care informed by an intersectional understanding of violence against women of color in the ED setting.

Another recurring theme is the poor quality of care Black patients receive. Allamby et al. (2022) reported that Black patients typically experience much longer wait times for evaluation, care, and intervention upon presenting to an ED for symptoms such as chest pain. This issue of poor health outcomes related to race is also reflected in Canada. Abdillahi and Shaw (2020), in a national report by the Public Health Agency of Canada, identified several determinants that lead to poor health outcomes among Black populations. The self-rated mental health of young Black women was considerably lower compared with White women, 64% compared to 77.2%. Besides that, the prevalence of diabetes was 2.1 times higher in the case of Black Canadians compared with White ones (Abdillahi & Shaw, 2020).

In another Canadian longitudinal study following the life experiences and health outcomes of Black women as they age, Foster et al. (2023) found that experiences of racism creating chronic stress greatly impacted the mental health of participants across the lifespan. Etowa and Hyman (2021) analyzed the intersections of race, gender, and immigration when studying the impacts of the COVID-19 pandemic in Black communities in Canada. Precarious employment conditions, food insecurity, and an increase in gendered violence were glaring social and health challenges faced by Black

communities during the pandemic (Etowa & Hyman, 2021). Notably, this study highlights how government policy choices that do not center access to appropriate social services and culturally sensitive care produced health disparities and social inequalities in Black Canadian communities post pandemic (Etowa & Hyman, 2021).

In summary, Black populations face a well-documented stack of health inequities, both in Canada and globally. Yet, qualitative literature exploring the experiences of Black women in ED care is limited.

Intimate Partner Violence

Various studies have been conducted in the US focusing on Black women who present to EDs and are screened for intimate partner violence (IPV) in waiting rooms. Two of these studies (Hankin et al., 2010; Mathew et al., 2012) specifically recruited Black women in ED waiting rooms. They found significant correlations between poor health behaviors—such as not using seatbelts, drug use, and excessive alcohol consumption—and a higher incidence of IPV reports (Hankin et al., 2010; Mathew et al., 2012). One study established a link between depression, substance use, and IPV (Hankin et al., 2010). Understanding the medical and social context of Black women's presentations to the ED and associated risk factors in the literature can support an understanding of their experiences. Defining what commonly brings Black women to the ED can provide context on what gaps in care they face prior to presenting at the ED, and what resources, assessments, and approaches would be necessary for nurses and allied health professionals to be aware of when caring for a Black woman during her ED experience.

Reproductive Health

Reproductive and breast health among Black women emerged as a recurring theme in the available literature on Black populations in EDs. A qualitative study by Hatcher-Keller et al. (2014) examined the beliefs of Black women regarding mammography screening in ED waiting rooms in the US. The researchers found that these women are less inclined to undergo screenings and less compliant with the recommended frequency of mammography throughout their lifespan (Hatcher-Keller et al., 2014). These findings raise questions about the accessibility of primary care for Black women, and whether a lack of access to health-promoting information that stresses the importance of mammography screenings (Hatcher-Keller et al., 2014). This study also raises questions about Black women's trust in healthcare systems, which is known to impact health behaviors and compliance with treatment (Hatcher-Keller et al., 2014). Cox et al. (2011) undertook a retrospective cohort study by examining more than 300,000 ED visits in Maryland, the US. They cited racial disparities in women presenting to EDs with reproductive health concerns treatable in a primary care setting. Cox et al. (2011) further established that Black women experience a three times higher likelihood of creating genital tract infections and similar issues of reproductive health that can be treated on an outpatient basis compared with their White counterparts. These results raised questions about the accessibility of health-promoting information and primary care for Black women. Recognizing that trust is a core component of safe patient care, nurses and allied health professionals may thus reflect upon and make amends to better approaches in the care provided to Black women presenting to the ED within the context of past experiences.

Disparities in Pain Treatment

Another recurring theme in the literature with regard to Black populations in EDs is racial disparities in pain treatment. Mills et al. (2011) conducted a double-blind retrospective cohort study that analyzed over 20,000 patient records from two urban EDs in the US. They concluded that white patients are 10% more likely to receive opiates for their pain symptoms as opposed to their non-white patients (Mills et al., 2011). Moreover, patients of color are subject to longer waiting periods before an analgesic is administered compared with White patients. Mills et al. (2011) pointed out that more studies are needed concerning the understanding of mechanisms of racial bias and how they influence the prescription behavior of healthcare providers. Existing literature outlines the dismissal behavior Black patients face regarding their pain and its poor health outcomes based on qualitative and quantitative data. Examining the training gaps and behaviors of providers underlying this phenomenon can provide insights and perspectives that support the provision of better treatment for Black women in EDs.

Lillis et al. (2018) conducted a qualitative study surveying low-income, inner-city women, including Black women, to examine the relationship between post-traumatic stress disorder (PTSD) symptoms and acute pain presentations in EDs. They found that sensitivity and intensity of pain were increased among ED patients who presented for acute pain with comorbid symptoms or diagnosis of PTSD (Lillis et al., 2018). This finding adds to the rich literature on pain as a biopsychosocial experience, influenced by more than just the physical injury or pathophysiology causing the pain (Lillis et al., 2018). An understanding of this multifaceted issue is crucial in ED encounters, particularly with women affected by the multiple social determinants of health.

Integration of a holistic, patient-centered understanding of pain into ED care has the potential to better inform both patients and providers (Lillis et al., 2018).

Muslim Women's Healthcare Experiences

Although the healthcare experiences of Muslim women are largely underrepresented in Canadian literature, existing research explores the influence of systemic racism and the lack of cultural safety on Muslim women. For example, Yeasmeen et al. (2022) explored the effect of racism on the mental health of Muslim women in Victoria, Australia. They found that compared with non-Muslim women, Muslim women were more likely to experience racism (Yeasmeen et al., 2022). Furthermore, these women self-reported severe psychological distress as a consequence of experiencing racism (Yeasmeen et al., 2022). The study concluded that the intersectional identities of race and religion increase the risk for Black Muslim women to encounter racism and related psychological distress (Yeasmeen et al., 2022).

In another study, Reitmanova and Gustafson (2008) explored the maternity care experiences of Muslim women in St. John's, Newfoundland, to identify barriers to accessing health services. Muslim women in their study reported challenges such as language barriers and a lack of culturally relevant health information, which affected both them and the healthcare providers serving them.

Faith Practices and Health

Literature that outlines the needs of Muslim women outside of an investigative purpose plays a vital role in educating healthcare providers to improve their practice. Here I present two articles that explored the topics of modesty and fasting among Muslim women.

Modesty, intertwined with culture and faith, is not exclusive to Muslim women (Andrews, 2006), as modesty is significant in the cultures of Asian, Latinx, Muslim, and Jewish women. Andrews (2006) concluded that modesty impacts self-esteem, public behavior, and comfort, although the reasons and methods for practicing modesty vary widely across different cultures and religions. For Muslim women, the impact of modesty on healthcare becomes evident when they face decisions about undressing for medical procedures, balancing the necessity of the procedure with adherence to modest dressing practices of only uncovering the face and hands (Andrews, 2006). Andrews (2006) also points out that modesty leads to reduced adherence to preventive breast cancer screenings. To better understand the specific impact of modesty on health outcomes, qualitative studies that explore the experiences of Muslim women adhering to Islamic modesty practices would be valuable in filling this research gap.

Kridli (2011) focused on outlining the health beliefs and practices of Muslim women during Ramadan. The article accurately summarized the key points of fasting for practicing Muslims, its relevance to the faith, and how the practice of absolute fasting from dawn to dusk impacts the health practices of Muslim women. Kridli (2011) highlighted the necessity for healthcare providers to understand the significance of fasting for practicing Muslim women, its medical implications, and strategies to accommodate those in need of care during Ramadan (Kridli, 2011). The medical implications discussed include the need to adjust the timing of essential medications, a case-by-case assessment of the safety of fasting during pregnancy, and the impact of fasting on milk supply while breastfeeding. Further, addressing nutritional deficiencies such as anemia is crucial to support healthy functioning (Kridli, 2011). One proposed

accommodation for culturally sensitive care is offering after-hours services for women who may require IV infusions, as saline is considered a form of hydration that breaks the fast (Kridli, 2011).

Behaviors, Perceptions, and Beliefs

Researchers documented the reactions of Muslim women after they were introduced to the idea of using mosques, the Muslim holy places of prayer, and the khutbahs, sermons that take place within them, as sites for health promotion (Vu et al., 2018). These researchers shared that Muslim women consider Imams, or leaders of the mosque, as promoters of healthy behavior. Even Muslim women also expressed their acceptance of peer mentors, females who have health expertise and at the same time are armed with Islamic knowledge (Vu et al., 2018). This study lays the groundwork for the practical application of culturally safe workshops regarding common women's health concerns across a range of age groups, to take place at mosques, run by peer mentors. It also suggests an avenue for a possible intervention in training Imams to incorporate health-promoting information into their sermons.

Salma et al. (2018) conducted a quantitative survey and semi-structured interviews with a sample of Arab Muslim immigrant women to explore the social dimensions of health that affect this population. They reported experiences of loneliness resulting from the loss of social connections from their home countries and difficulties managing chronic illnesses without a tight support network (Salma et al., 2018). Another key theme that emerged from this study was caregiver burnout; indeed, most participants in their study, being mothers and grandmothers, struggled with self-care while attending

to family both in their home countries and with their children in their new environment (Salma et al., 2018).

Another qualitative study using similar data collection methods focused on the health behaviors of immigrant Muslim women (Sabir et al., 2017). These women expressed reluctance to seek healthcare due to fears of encountering racism, particularly in vulnerable situations (Sabir et al., 2017). Sabir et al. (2017) also found that changes in gender roles affected their time for self-care that was different from the traditional norms in Islamic cultures where men are typically the sole financial providers (Sabir et al., 2017). Additionally, the women expressed concerns about unfamiliar and processed foods in grocery stores, contrasting sharply with the farm-to-table diets prevalent in their country of origin (Sabir et al., 2017). Moreover, the respondents also avoided trying new forms of exercise, which included kickboxing classes. Sabir et al. (2017) highlighted the need for further research on specific health behaviors including diet, exercise, and self-care capacity, to develop culturally aware and language-specific health promotion materials for immigrant Muslim women.

Overall, the literature suggests that the health and well-being of Muslim women are intricately linked to their care needs and cultural concerns. Empowering Muslim women to speak up and clearly communicate their needs while also encouraging providers to embody an equity-centered, culturally safe approach can enhance trust and lay the foundation for positive interactions with the healthcare system.

Conclusion

In conclusion, the literature examining the healthcare experiences of Muslim women reveals a recurring theme: Black Muslim women are at increased risk of

receiving lower-quality healthcare and need healthcare workers who are aware of their unique cultural and religious needs. The literature presented in this review provides necessary context on Black women's healthcare experiences, Muslim women's healthcare experiences, and relevant factors that would affect their ED experiences. The literature presented in this review highlights the social, political, and religious contexts that impact Black Muslim women's ED experiences and points out what nurses and allied health professionals can reflect on to improve ED care and professional practice in an evidence-based way when caring for Black Muslim women. This study, therefore, aims to explore the experiences of Black Muslim women who seek ED care. The findings of this study may support equipping healthcare providers with relevant information to promote cultural safety and better meet the needs of Black Muslim women. A critical reflection on the existing literature about this specific topic underscores a clear need for further exploration into how religion, race, gender, and social determinants of health impact the experiences of Black Muslim women seeking ED care.

Chapter 3: Methods

Chapter Overview

The primary objective of this study is to explore the experiences of Black Muslim women in Alberta's EDs. For this reason, I chose to conduct a qualitative study designed to explore and understand such experiences. I designed an ID study to explore the experiences of Black Muslim women in Alberta's EDs. This chapter describes the rationale for designing a qualitative study and details the ID methodology (Thorne, 2016), and the methods used to implement this study.

Qualitative Research

As a registered nurse and grassroots community organizer, I am bound by principles that emphasize holistic thinking and the valuation of human perspectives as an integral part of data in decision making. These principles blend well with the constitutive ethos of qualitative inquiry. My approach to this study was significantly shaped by my community engagement work and clinical experience with marginalized populations, in addition to the literature review conducted prior to the study design.

I have benefited significantly from my active involvement in initiatives for the empowerment of Black Muslim women. My experiences ranged from volunteering with nonprofit organizations that support this demographic to serving as a board director at one of Alberta's largest nonprofit organizations which support immigrant women. These roles provided me with a strong understanding of the strengths and needs of this demographic community. Furthermore, my clinical practice experience of working with this demographic shaped my understanding of the specific factors that Black Muslim women need to thrive in both health and social domains. The insights I gained through

this work, which deeply resonated with the lived experiences of these women, have informed my Master of Nursing thesis work and designing my qualitative study.

Qualitative research serves to capture a subject matter in its natural setting and make sense of the subject in terms of the meanings people attribute to it (Denzin & Lincoln, 2005). This form of research generally describes and explains human experiences, identifies patterns and themes, and makes appropriate interpretations by analyzing methods that contain subjective judgment (Denzin & Lincoln, 2005). The necessity for qualitative research methods arises from the need to capture behaviors, stories, experiences, and emotions that reflect the human experience (Denzin & Lincoln, 2005). Specifically, qualitative descriptive methods are frequently used in nursing research studies focused on clinically relevant questions, with the aim of quality improvement and change (Doyle et al., 2019).

A key driving force behind the use of these methods is knowledge translation that serves to positively impact the health experiences and outcomes of the populations being studied (Doyle et al., 2019). Considering this, designing a qualitative research study dedicated to exploring and providing a comprehensive, coherent description of the experiences of Black Muslim women accessing ED care was appropriate.

Research Methodology: Interpretive Description (ID)

Nurses must have a combination of theory, clinical knowledge, and practice in order to fulfill their essential role (Thorne et al., 1997). The use of a qualitative approach to addressing clinical questions has been a long-standing component of nursing research (Thorne et al., 2004). Thorne (2016) created ID to give nurses a new qualitative methodology enhanced by grounding it within the nursing discipline, with the intent of it

being a method to produce multifaceted yet practical answers to nursing questions. As an alternative to traditional and prescriptive qualitative approaches, Thorne (2016) developed a versatile qualitative methodology to support the generation of clinical knowledge. Thus, Thorne et al. (1997) created ID as a tool for constructing relevant clinical knowledge. They introduced ID to bridge a gap between qualitative and quantitative work, translating the health experiences of different clinical scenarios into knowledge applicable to nursing practice.

ID researchers support inductive analysis within a subject matter's natural setting, in line with constructivist inquiry methods (Thorne et al., 2004). Thorne (2016) refers to the idea of understanding phenomena in context, rather than attempting to change or control the context of the subject's natural setting as constructivism, a theoretical paradigm that prioritizes observation first and deduction of meaning second when studying a particular subject (Thorne et al., 2004). *Constructivism*, ontologically rooted in the view that reality is socially and experientially created, is central to ID (Hunt, 2009). ID requires the researcher and participant to use social and experiential knowledge to interpret reality in its natural context (Hunt, 2009). ID's epistemological foundation asserts that the knower and the known are inseparable (Thorne et al., 2004). Thus, the interaction and mutual influence between researcher and participant in co-creating meaning and interpreting lived reality are central to understanding (Schwandt, 1994). This process is the essence of interpretation. A key facet of the constructivist approach is its avoidance of imposing preconceived theories onto collected data or analyzing data to support existing notions (Schwandt, 1994). Instead, researchers are encouraged to let reality emerge organically from the data (Schwandt, 1994). Methodologies grounded in

constructivism aim to understand the human experience and the lived reality of those being studied (Schwandt, 1994).

ID is based on a set of philosophical underpinnings that govern research conducted under its framework (Thorne, 2016):

- It posits that multiple constructed realities can only be studied holistically. Therefore, reality is perceived as complex, contextual, constructed, and ultimately subjective.
- The inquirer and the "object" (p. 82) of inquiry interact to influence one another; indeed, the knower and known are inseparable.
- No "a priori" (p. 82) theory can fully encompass the multiple realities that are likely to be encountered; rather, theories must emerge from or be grounded in the data.

In some research traditions, researchers are required to define their position clearly within a study to minimize their influence on data collection and analysis (Thorne et al., 2004). However, this is not the case with ID. In ID, the researcher's role is premised on the understanding that the knower and known cannot be fully separated. Here, the researcher is regarded as a tool for co-creating interpretations or conceptual descriptions alongside the subjects of the research. The initial role of the researcher involves gaining a thorough understanding of the existing literature to develop a preliminary grasp of existing knowledge (Thorne et al., 2004). The researcher is encouraged to challenge themselves within the data by engaging in collection, rigor, and analysis methods that expand or introduce new elements to the foundational knowledge (Thorne et al., 2004). They are urged to move beyond the known and find new ways to

engage with and present the new linkages they have found from their data collection and research. Like other qualitative methodological approaches rooted in the constructivist theoretical paradigm, ID encourages understandings that emerge from and are shaped by the data. This aspect is crucial because a key research activity in an ID study is the researcher's documentation of reflexivity and awareness of their own lived realities within the context of the inquiry (Thorne et al., 2004). This process enables critical reflection that upholds the epistemological, ontological, and methodological integrity of ID.

ID draws its descriptive and exploratory methods from grounded theory, naturalistic inquiry, and ethnography (Thorne et al., 1997). However, its outcomes are not directly comparable to those of these qualitative methods (Thorne et al., 2004). The ideal outcome of an ID study is a thorough and precise description of the concept being studied in a format that accounts for the unique patterns within that concept. The result of an ID study, called a "conceptual description" (Thorne, 2016, p. 187), can be a useful informational resource for nurses caring for the population a conceptual description is about. A conceptual description gives the reader succinct and practical information that can be easily contextualized and applied in nursing practice (Thorne, 2016, p. 187).

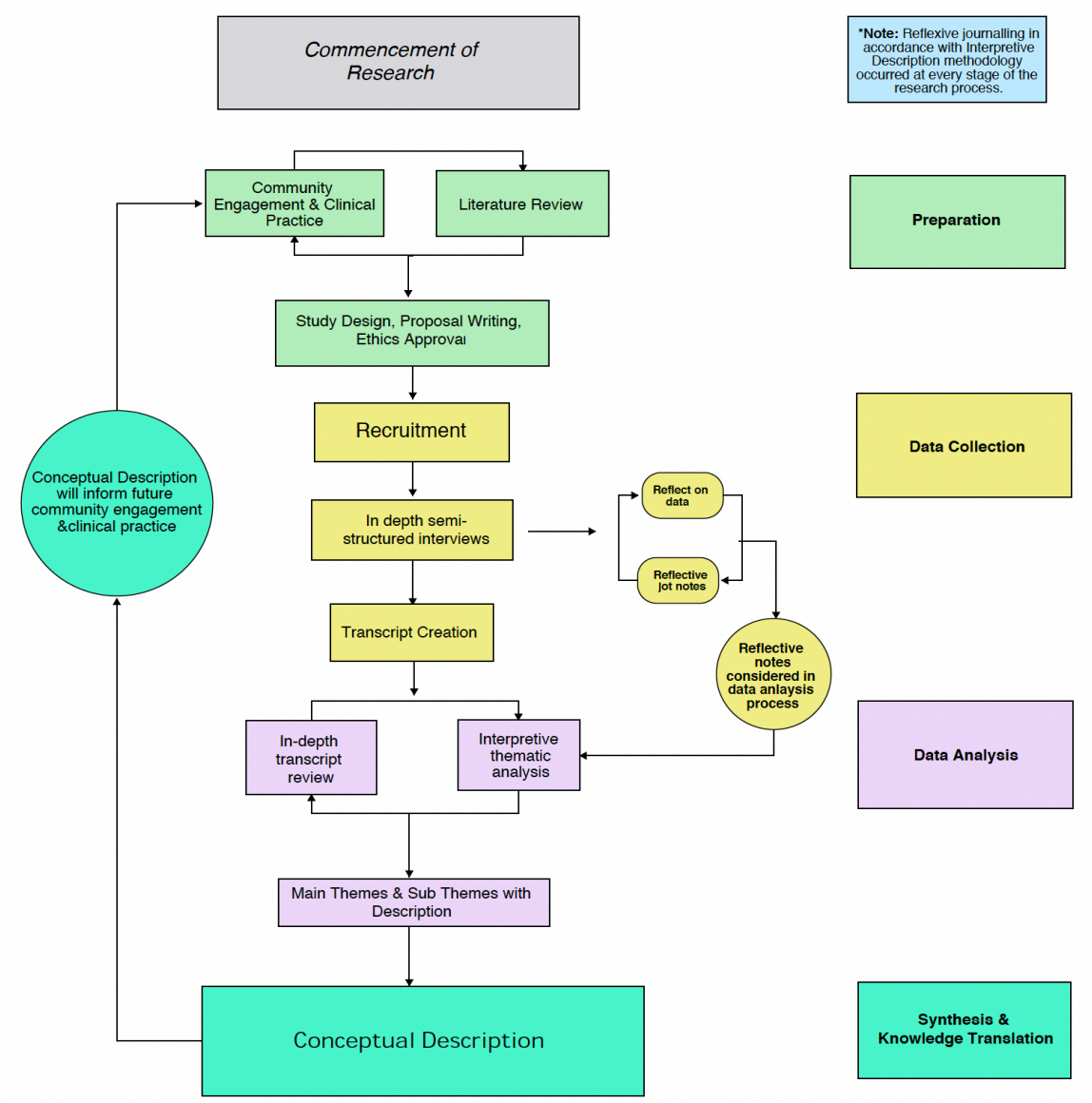
Thorne et al. (1997) intentionally focused on nursing epistemology and the human experience as the framework for designing qualitative research. One of the many factors that significantly shape nursing knowledge is nurse-patient interactions. ID is a flexible framework to study the unique facets of health or illness in each interaction with a patient or client (Thorne et al., 2004). ID emphasizes patient-centered care that considers the whole person and their unique needs during each interaction (Thorne et al., 1997).

Recognizing this, ID offers a structured methodology for documenting and exploring the subjective realities of the human experience within the context of health and illness (Thorne et al., 1997). In essence, both ID and patient-centered care in nursing practice are grounded in the recognition and acknowledgment of multiple realities (Thorne et al., 1997). The acknowledgment of social and experiential context forms the core of ID's process and philosophical underpinnings (Thorne et al., 2004).

Figure 1 illustrates how ID methodology was considered and implemented throughout the research process. This approach includes the following: (a) preparation; (b) data collection; (c) data analysis; and (d) synthesis and knowledge translation (Thorne et al., 2004).

Figure 1

How ID methodology was considered and implemented throughout the research process.



Positionality

Positionality is part of the key components of ethical engagement with marginalized groups, especially in data collection and analysis. As a Black Muslim woman conducting research centering on the experiences of other Black Muslim women, I am identified as an "insider researcher" (Griffith, 1998). Thorne (2016) indicated that insider researchers hold several advantages, including easier access to information, spaces, and communities that may be otherwise difficult to reach. Nevertheless, this role also faces some challenges; for example, an insider researcher may be confronted by the inability to step out of their roles or identities to engage with participants and the data without confirmation of their pre-existing knowledge (Thorne, 2016). Insider researchers must avoid personal relationships or favors that are associated with participation in research as they may create a serious ethical problem (Griffith, 1998).

To mitigate these ethical concerns, recruitment was purposefully limited to extended professional networks and social media. To ensure robust data analysis and knowledge construction, I have regularly involved perspectives outside my own through consistent consultation with my supervisor and supervisory committee. This ongoing engagement with scholarly researchers has provided a variety of perspectives on the available data and enriched the inductive data creation process. In addition, the ID methodology advocates for continuous self-reflection through journaling and note-taking to document reflections and ideas stemming from the researcher, this was an integral part of my research process throughout the interview phase, transcript review stage, and data analysis (Thorne, 2016). ID encourages researchers to use this self-reflection as a tool to better understand the impact of these data on them and to remain aware of their influence

during the inductive process of thematic analysis (Thorne, 2016). The reflexive notetaking throughout my research process as highlighted in Figure 1 was done to uphold methodological integrity and document a clear analytical path towards the final conceptual description.

Methods

Recruitment and sampling

Through my extensive professional networks, I identified key stakeholders who have a formal understanding of the social location and health disparities Black Muslim women face. These stakeholders were Black Muslim women I selected on the basis of their personal and professional backgrounds in providing services to or being in a community with Black Muslim women. They served as a connection point to grassroots organizations, nonprofits, and community groups who could circulate recruitment materials.

The research poster was disseminated through emails and weekly newsletter postings to these groups. Additionally, a social media platform called Instagram was utilized to reach potential participants using purposive sampling to select individuals based on their relevant experiences or connections to the research topic (Thorne, 2016).

The inclusion criteria for this study were as follows:

- Must be a Black Muslim Woman
- Over the age of 18
- Resides in Alberta
- Self-reports an ED visit? In Alberta within the last five years

Inclusion criteria were developed to ensure the sample represents a wide scope of the population. This involved broadening the age requirement to include all individuals over 18 and mandating a self-reported ED admission to prevent bringing secondary experiences of family and friends as the main experience shared in the interview. The specified timeframe was within the last five years to ensure the ED experiences were recent enough in memory.

The sample size for this research study comprised six participants in total. In consultation with the supervisory committee, this size was determined to be appropriate within the scope of a Master of Nursing thesis. Although ID does not impose a sample size restriction or quota for methodological integrity, the methodology encourages small sample sizes to effectively handle the extensive information generated by in-depth interviews (Thorne et al., 2004). A sample size of between six to eight participants is generally considered adequate for an ID study. Notably, the specific recruitment and sample selection methods that ID requires do not exist (Thorne, 2016). Overall, the focus of qualitative research is on depth rather than scale. Having six to eight participants allows for an in-depth analysis of a single demographic or subject matter (Thorne, 2016).

Data Collection

I developed a semi-structured interview guide (Appendix B) with open-ended questions with prompts that allowed participants to thoroughly discuss their experiences in ED. In ID, researchers are encouraged to ask further probing questions to ensure that lived experiences are fully explored, I applied this by going into my interviews with an understanding that my participants' answers and experiences would shape my interview questions (Thorne, 2016, p. 135).

As a nurse and a Black Muslim woman, I acknowledged the significance of my own experiences and perceptions throughout the data collection process, adhering to the recommendations of Thorne (2016) in line with the ID methodology. Thorne (2016) emphasized that the researcher co-creates the resulting themes and brings a valuable contribution to the interpretation of findings. During the interviews, I maintained a field note journal and took notes to reflect on my understanding of the participants' experiences and formulate real-time probing questions based on what was being shared. These notes also served as a basis for reflection on the overall experience and my thoughts after the interviews.

The interviews were conducted using a university-licensed Zoom account. With the participants' consent, each interview was audio recorded and transcribed using Zoom's built-in software for recording and transcription**.**

Data Analysis

ID emphasizes continuous reflection throughout the analysis process (Thorne et al., 2004). Thorne (2016, p. 155–156) poses a variety of critical questions to guide researchers through the interpretive process of data analysis; two questions I found helpful throughout my data analysis process were "What are the data telling me? What is it that I want to know, and what is the relationship between both?" and "how are these groupings different, and how are these groupings the same?". These questions guided my reflexive comparison throughout the data analysis process because they were useful in helping me think in line with the observer approach required in constructive data analysis (Thorne et al., 2004).

To initiate this analysis, I maintained a field note journal that captured my organic reflections before, during, and after data analysis in notes, sporadic thoughts, or longer journal entries. This exercise served a dual purpose: maintaining methodological integrity in ID and distancing myself from my preconceptions about the research process to objectively analyze the relationship between myself and the data (Thorne et al., 2004). This constant reflection also served as a personal emotional release for me hearing the details of some of the participant's complex and sensitive encounters in ED care.

Thorne (2016) discussed embodying the role of the researcher as a tool during analysis; I reviewed each transcript three times to clean the transcripts, ensure the accuracy of transcripts to audio recordings, and remove identifying information. During this process, I also reflected and recorded my own emotions and reactions to the data. This step provided an initial impression of the depth and overarching messages emanating from the data.

I reviewed each transcript through audio and text twice and once through audio alone. Choosing to reflect on these data using two different methods allowed me to immerse myself in the data in a way that moved my constructive analysis beyond the obvious – as is the goal of data analysis in ID (Thorne, 2016, p. 166). These two different methods of consuming the data broadened my initial understanding and summary of the data. After this process, the reflective notes I created served as an initial summary for each interview and my first codes. Next, the note summaries were gathered and analyzed against each other to highlight differences, similarities, and patterns. Thorne (2016, p. 156) encourages the researcher to use a critical lens by revisiting their reflexive notes and noting assumptions alongside the data, which was my next step. I analyzed the data and

my reflexive notes side by side, creating further notes that would serve as additional codes. I did this further analysis using my reflexive notes and journaling as a tool (Thorne et al., 2004), understanding that extensive, repeated, iterative organic reflection bolsters the quality of findings when using an interpretive constructive approach (Thorne et al., 2004). From these summaries and further analysis, I selected data-rich quotes related to my initial quotes that stood out across more than ten ideas in the data.

Following this step, I used NVIVO12, a qualitative coding software, to organize my data as I analyzed my transcripts again. A fourth review of my transcripts broadened my understanding of the data and better supported the quality of my constructed findings (Thorne et al., 2004). I re-read each transcript using my interview guide as a reference point for each part of the ED journey discussed with each participant. I highlighted relevant or recurring codes about the most data-rich stage or stages of the ED journey for each participant. These codes were organized into coding summary tables. Using reflexive notetaking and summarizing, I gathered the codes into groups and used mind maps to connect ideas from the data during this review. Many new codes emerged from the data. This step allowed me to go beyond my initial perspective of the data and reinforced methodological integrity and rigor (Thorne et al., 2004).

Finally, the conceptual description was created by connecting the ideas present in the initial codes gathered from the first three transcript reviews and the code groups created from the fourth review of the transcripts. I created final themes and sub-themes by reviewing, side-by-side comparison, and reflection on the data gathered through two different interpretive approaches, in line with interpretive thematic analysis (Thorne et al., 2004).

The final themes and sub-themes highlight the most common barriers to and facilitators of positive clinical encounters for Black Muslim women in the ED. The final themes and sub-themes from this inductive approach—representing the research findings—were consolidated into a table (Table 1). This table categorized main themes and corresponding subthemes, culminating in what is referred to in ID research as a conceptual description (Thorne et al., 2004).

Rigor

Thorne (2016) set out four criteria that are designed so that the credibility and rigor of a study be maintained by researchers throughout the research: epistemological integrity, representative credibility, analytic logic, and interpretive authority. In designing the present research, full consideration was given to each of the four tenets of credibility.

In this study, *epistemological integrity* was maintained through the acknowledgment of the multiple realities of Black Muslim women and taking personal reflection about my impact on the research process. *Representative credibility* involved including Black Muslim women from multiple age groups, immigration statuses, and ethnic backgrounds. *Analytic logic* played an integral part in the process of data collection and analysis throughout this research study. This was achieved through an audit trail of reflexive notes, audio-recorded interviews, systematic reviews of transcripts, and the use of electronic qualitative coding software to further review the transcripts. Reviewing the data multiple times ensures that the researcher has an audit trail, strongly recommended by Thorne (2016), to strengthen the validity of the qualitative findings that ID produces. The approach is in line with ID principles and helped make sense of the data in this study. I consulted an academic supervisory committee and a direct supervisor

to ensure that the *interpretive authority* was accurate. Such consultation ensured that reflections from various perspectives were considered in processing the data. The adherence to these four tenets and the outlined procedures of data analysis ensured that the rigor requirements of ID's methodological integrity principles were satisfactorily met.

Ethical Considerations

Before conducting this research, I completed the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course* and received a certificate in Research Ethics. The research project was conducted with approval from the University of Calgary Conjoint Health Research Ethics Board. To preserve the privacy of the participants, all identifying information was removed. Informed consent forms, digital recordings, and notes were securely stored on a secure server and password-protected in appropriate accordance with the University of Calgary's data management policies.

Trauma-Informed Approach to Research

In addition to complying with research ethics processes, I also applied a trauma-informed approach to this study, particularly because of the vulnerability of the population and the topics being explored in this study (e.g., religion, systemic racism, and gender) (Voith et al., 2020). Although research ethics boards now mitigate the risk of catastrophic harm to human lives, preventing trauma and re-traumatization remains a critical concern in socially just research involving marginalized populations. Adherence throughout the interviews to the core principles of Trauma-Informed Care (Substance Abuse and Mental Health Services Administration, 2014) is vital in preventing re-traumatization. I was able to do this by ensuring my approach to each question throughout the interviews was compassionate and allowing participants to share as they

felt comfortable and supporting them to self-regulate emotionally while recounting difficult experiences. The Trauma-Informed Socially Just Research framework (Voith et al., 2020), presents critical questions that I reflected upon throughout my fieldwork, particularly during data collection. This reflection was crucial to ensure that I, as the researcher, was adapting my practice to prevent the re-traumatization of participants.

My nursing background, which forms the basis of my epistemological approach to conducting research, underscores the importance of this consideration. Safety, a fundamental aspect of nursing practice, was thus paramount in ensuring the well-being of participants in this study.

Conclusion

In conclusion, the data analysis was achieved through a thorough review of the data collected from interviews carried out using open-ended questions. The subsequent chapter describes the themes resulting from the data analysis and the conceptual description. Following these findings, the interpretation of these findings and their practical implications by means of the Population Health Promotion Model (PHPM; Hamilton & Bhatti, 1996) are shared. PHPM allows for Black Muslim women to be understood in relation to their religious values and social location, along with determinants of health, as they present to the ED. The findings of the study are then critically discussed, and possible knowledge translation strategies in society, literature, policy, and nursing practice that can potentially improve the experiences of Black Muslim women presenting to the ED are shared.

Chapter 4: Findings

This study examined the experiences of six Black Muslim women in the EDs of Alberta. Six in-depth, individual interviews were conducted using open-ended questions to thoroughly understand each participant's experience. The use of open-ended questions facilitated the gathering of rich, detailed data. The interviews allowed participants to share their ED visit experiences, from decision-making prior to admission to post-discharge access to necessary care.

Chapter Overview

This chapter presents the findings that emerged through qualitative analysis of the interview data. As described in Chapter 3, the findings are organized into themes and sub-themes that construct a conceptual description of Black Muslim women's experiences in Alberta's EDs. The analysis identified three main themes. The first theme centers on the relations between healthcare providers and patients which has emerged as an important factor that shapes the experiences of Black Muslim women. This theme also demonstrates how trust and communication style influence patient care. The second theme highlights how race, faith, and culture influence these women's experiences. The final theme is related to how system challenges at the provincial level in Alberta impact women's care experiences. These findings emerged from a rigorous, multifaceted interpretive thematic analysis. Throughout this chapter, these three themes and supporting quotes will be shared to illustrate the data. An analysis of the data that brings the conceptual description into a discussion of promoting the health of Black Muslim women receiving ED care in Alberta using the PHPM (Hamilton & Bhatti, 1996) will follow.

Sample

The study included a total of six participants who met the inclusion criteria. Participants were Black Muslim women from various ethnic backgrounds and ages, originating from a variety of urban and rural locations across the province. The sample size was appropriate for an ID study, allowing for the manageability of rich data derived from semi-structured interviews (Thorne et al., 2004). In addition, the sample size was within the scope of a Master of Nursing thesis project. To protect the confidentiality of each participant, I provide a general description of the study participants, as context to the findings. Participant A, a recent immigrant from West Africa sought emergency care in a rural Alberta ED. Participant B presented at an urban Alberta ED. Participant C presented to an urban Alberta ED due to a lack of access to a family doctor. Participant D sought care at an urban Alberta ED, reporting a positive experience. Participant E sought care in an urban Alberta ED. Participant F sought care at a rural Alberta ED due to a lack of access to her primary care physician or other primary care alternatives.

Conceptual Description

In an ID study, the conceptual description represents the final framing and understanding of the core elements of the studied phenomenon (Thorne et al., 1997). It focuses on capturing and describing the underlying concepts arising from participant experiences. In this study, the three main themes shown in the conceptual description are the central ideas that emerged from the data through interpretive analysis guided by the research question (Thorne et al., 1997). Further analysis of major themes facilitated the creation of sub-themes (Thompson Burdine, Thorne, & Sandhu, 2021). The analysis process produced a wide range of information, and the sub-themes selected from this

information serve to answer the research question and support a clear and multifaceted view of Black Muslim women's ED experiences (Thompson Burdine, Thorne, & Sandhu, 2021). The conceptual description in Table 1 synthesizes the diverse experiences of the six interviewed Black Muslim women into three key themes. The first theme that emerged is *healthcare provider and patient relations*. The second theme is *race, faith, and culture shaping healthcare experiences*, while the third is *health system challenges*. These themes reflect participant experiences of healthcare-provider interactions, how cultural and religious identities shape their ED experience, and the systemic issues that affect accessibility and quality of care. For each of these primary themes, additional sub-themes detail specific aspects of the participants' experiences.

The theme *Healthcare Provider and Patient Relations* focuses on the interpersonal relations between Black Muslim women and healthcare professionals. Participants often felt mistrusted and their opinions disregarded, which further made them feel vulnerable and frustrated during their ED visits. Participants often cited a need for advocacy, where they discussed the need to assert their needs through family members or repeatedly advocate for themselves to receive appropriate care. The most frequent strategy that can nurture relationships both between patients and providers is building trust through effective communication. Healthcare providers, therefore, need to communicate with patients respectfully, empathetically, and with a culturally sensitive attitude. The theme *Race, Faith, and Culture Shaping Healthcare Experiences* emphasizes the role that racial, religious, and cultural identities play in shaping participants' healthcare experiences. Participant experiences illustrate how different identities shape patient care as participants also recounted negative and positive

experiences. Participants' experiences also demonstrate the need for culturally safe care as participants noted that their experiences tended to improve when healthcare providers were responsive to their cultural and religious needs, including modesty, dietary restrictions, prior experiences of discrimination, and gender-specific concerns related to reproductive health. The final theme, *Health System Challenges*, emphasizes the presence of structural barriers such as lack of access to family physicians, long waiting times, and obstacles to care due to living in rural areas. These systemic challenges exacerbate healthcare inequities for Black Muslim women in Alberta EDs, underscoring the need for systemic improvements to address these inequities.

Table 1

Conceptual Themes and sub-themes

Themes	Sub-themes
Healthcare Provider and Patient Relations	Mistrust and feeling dismissed
	Need for advocacy
	Building trust with effective communication
Race, Faith, and Culture Shaping Healthcare Experiences	Race, faith, and culture in patient care
	Culturally safe care
Health System Challenges	Lack of access to family physicians
	Long wait times
	Rural barriers to care

Themes

Three themes emerged from the interpretive thematic analysis of the participants' experiences, perceptions, decision-making processes, and conclusions related to their experience of accessing an Alberta ED as a Black Muslim woman. Table 1, the conceptual description, outlines these themes and their associated sub-themes. Below, each theme and the participant's experiences are explored.

Theme 1: Healthcare Provider and Patient Relations

Positive healthcare provider-patient relations are fundamental for delivering high-quality, patient-centered care. Within this theme, three sub-themes emerged: a) mistrust and feeling dismissed, b) need for advocacy, and c) building trust with effective communication.

The interviews highlighted that women's experiences in the ED were significantly shaped by their ability to establish trust with providers. In the following sub-theme descriptions, quotes will be shared to describe how participants recounted instances where their voiced concerns were overlooked or minimized by healthcare providers, leading to feelings of mistrust. This mistrust often resulted in negative healthcare experiences and failed to establish a foundation for supportive and culturally safe care. Further, in the quotes below, women who experienced more strained patient-provider relations explained a continuous need to advocate for themselves due to a lack of empathetic communication, disregard for their concerns, and ignorance of their cultural contexts.

Trust emerged as a cornerstone of positive healthcare experiences. Below in the quotes, participants described that interactions characterized by effective, compassionate,

and culturally sensitive communication noted a significant improvement in their trust toward healthcare providers. The participant's experiences shed light on a need to improve the healthcare experiences and, ultimately, the health outcomes of Black Muslim women, through close attention to how communication might create mistrust and whether patients feel compelled to advocate for themselves due to feeling unheard. Participants who reported such experiences indicated a more positive healthcare experience:

> In this instance, I was met with like, kindness and empathy, and like understanding. It made me feel like the nurse did have professional conduct. I felt, like…I was seen when I needed help. (Participant D)

Mistrust and Feeling Dismissed. A common concern among most participants was the feeling of being dismissed by healthcare providers within the ED setting. Participants experienced a lack of clear communication from healthcare providers, leading to feelings of invalidation and dismissal. Many participants described instances where their pain was disregarded, and their concerns were overlooked. For example, Participant F shared an incident where her expression of pain was met with a dismissive attitude from a healthcare provider:

> Honestly, telling the story to any person that has never experienced micro-aggression or racism or discrimination, it might seem wild to them ... is the way she looked at me, and the assessment that took barely few seconds. All she did was take my vitals and ask me about my pain and because I was clutching my abdomen because I was in pain, she was very dismissive in her attitude and told me to go have a seat. (Participant F)

The provider's brief assessment, as well as nonverbal cues such as a dismissive look and body language, made her feel invalidated. Participant F described how her past experiences of micro-aggressions and discrimination influenced her experiences with healthcare providers during her ED visit. Participant F noted a difference in the way a nurse communicated with her compared to other patients, suggesting that bias and discrimination may have influenced the quality of care she received. Her past experiences of discrimination that mirrored her current ED experience further exacerbated her sense of being marginalized in a healthcare setting:

> So, I remember, like the way the nurse was talking to me, just was not the same how she was interacting with other people. And again, you might ask me exactly, what did she say to you? And how does that compare to what she said to somebody else? I don't remember exactly what she said, but I could tell from her tone, from the rest of the patients how she was interacting with them because the triage is not soundproof, and I was not sitting far away from there and I'm used to, I'm used to people treating me differently. Not as a Black Muslim woman. I do feel like there was one part that bias could have played in the terms of assessment. (Participant F)

Participants also shared that their multifaceted concerns were not fully acknowledged by the healthcare providers. For example, Participant E shared her experience with an ED physician during a visit, where she expressed severe abdominal pain: "[...] very dismissive of what I was saying, as if I'm like lying [...] or seemed to [be] lying about this." She noted similar dismissive attitudes during multiple ED visits, particularly regarding her expressions of pain. She explained, "I've always felt very

minimized, especially when it came to my pain. I've always felt very minimized, like, 'Oh, no one's taking me serious.'"

All participants acknowledged that they resorted to the ED only when their condition became extremely difficult to cope with and when they had no other options for treatment. For example, Participant F shared that her medical history included cysts and endometriosis. She sought ED care due to abnormally heavy menstrual bleeding and severe pain that was unresponsive to her typical self-care and prescribed pain medication at home. Despite believing her concern was serious, Participant F felt that it was not adequately acknowledged during her ED visit, as she described her experience with an ED physician: "[...] He didn't touch me at all. He didn't assess me at all. He didn't listen too. He didn't do any assessment, no abdominal assessment, nothing. I think I lost him when I said, I'm having my period [...]"

In another example, Participant B recounted her ED visit after an unexpected syncopal episode[1]. During this visit, she received a cancer diagnosis. She tearfully shared how she felt dismissed after her request for privacy to process her new, life-altering diagnosis was denied by the ED physician:

> [...]when my dad comes, they're repeating everything, and I tell them, hey, you already sat down with me for 40 min? I had nothing. I was forced to listen to this. Can you leave and have this conversation with my parents in another room? He said "You're grown. You're 25 years old. You can listen to this." And I'm, like, Okay, I understand that. But, like, my whole life changed within a couple, like, a

[1] A syncopal episode is also known as fainting and is a temporary loss of consciousness with quick recovery.

> few hours, like, just you, I already had this conversation. Why do I have to have this conversation again? They are watching my parents cry, watching me cry and, like […] Why are you putting me in this position? Just go have this conversation with my parents outside of the room. (Participant B)

This feeling of dismissal led her to question the ED physician, highlighting a sense of mistrust. Her tone conveyed immense sadness, particularly when her request for a moment of privacy—as her parents were being informed of her diagnosis for the first time—was denied by the physician.

Participants also reported feeling dismissed through nonverbal communication, including behaviors that convey a lack of interest, respect, or attention toward the patient. For instance, Participant B explained, "I just…I felt like I was saying words, but for her, it was going through one ear through the other, and then, she kind of said like, 'Oh, go sit down, sit there, and then you'll get called.'"

Overall, the sense of being dismissed emerged as a common concern among participants, with only one exception. Those who felt dismissed reported an overall lack of care or concern for their needs. Participants who experienced dismissal, misunderstanding, and invalidation developed mistrust towards the ED, leading to a negative perception of ED healthcare. These experiences created an impression that ED care was inadequate, even in emergencies. Although no participant in this study reported receiving suboptimal care during an emergency, the fear of potentially inadequate care discouraged them from seeking ED assistance when necessary. For example, Participant F recounted several past ED visits, detailing how these experiences shaped her overall perception of ED healthcare:

> […] but I didn't want to go to hospital, I told myself. I'm not going. I told myself. I'm not going to get help there. If I'm gonna suffer and die I prefer to die in my house. I was resolved to not go to the hospital which makes me very sad because great many things could have been wrong, but because of my treatment there, I chose not to seek care. (Participant F)

Although she did not provide detailed accounts, Participant E mentioned that her past experiences of poor treatment made her hesitant to seek ED healthcare, even when suffering from severe COVID-19 symptoms. Participant E expressed a strong aversion to the emergency room, stating, "I hate going to the emergency room just because of previous experiences; I absolutely despise it."

Participants, many of whom lacked access to a regular family physician, shared similar feelings. They often endured severe pain and other symptoms for weeks or opted out of ED care altogether. They consistently reported that negative experiences had permanently impacted their trust in ED care. For many participants, past instances where their concerns were minimized, and their pain dismissed negatively influenced their perception of the ED and the healthcare system as a whole. This made them hesitant to seek ED care in the future.

Need for Advocacy. Advocacy in healthcare involves defending or upholding patients' interests, needs, and rights within the healthcare system (Nsiah et al., 2019). It includes the provision of information, making requests, asking questions, and communicating the needs of a patient to a healthcare provider most suited to addressing their concern. In many cases, patients may not be able to advocate for themselves due to their health condition, stress, or a lack of knowledge about effective advocacy strategies

(Negarandeh et al., 2006). In the context of this study, advocacy emerged as a significant factor influencing the ED experiences of participants. The findings indicate that all but one participant arrived at the ED with a support person as an advocate or was joined by one shortly after admission. The presence of this support person was consistently described as both a source of comfort and an essential component of a positive ED experience. Participants highlighted the importance of having someone with general medical knowledge or familiarity with their medical history as integral to a positive ED experience. Participant E, for example, shared her experience of having a friend accompany her in the ED:

> […] we've been friends for a long time. Also, her knowing how, you know, pain medications don't really…don't tend to work on me. You know, just having that person there that understands my history with medication and them not listening, and her advocating for me was helpful because I just couldn't. I've been in so much pain, can't even think straight or make out one coherent sentence. So, it was great having her there. (Participant E)

Participants explained that self-advocacy was challenging during their ED experiences, emphasizing the benefit of having a support person advocate on their behalf. For example, Participant E, who has a history of fibromyalgia, highlighted the necessity of having an advocate to communicate with healthcare professionals on her behalf to secure adequate pain medication during her ED visit. She recounted, "[...] literally, my friend had to again like almost fight the doctors to try and give me something stronger."

One of the obstacles to self-advocacy in the ED stemmed from the stress that participants felt while in the ED. They described how their health condition during their

ED visit, along with related stressors, made it challenging to communicate clearly and express their needs to physicians and nurses. For example, Participant A recounted her experience of seeking ED care alone due to unexpected bleeding during her first pregnancy. While in the waiting room, she described bleeding through her clothes and feeling the onset of a migraine. She later discovered she was experiencing a miscarriage as she waited in the ED waiting room. Participant A explained, "I wasn't able to communicate my needs or advocate for myself effectively. […] There was no space to effectively communicate my needs in my own head."

In summary, participants emphasized the necessity of having an advocate to receive adequate care in the ED. From their experiences, an advocate was someone capable of effectively communicating their needs to healthcare professionals. Without one, they felt unable to clearly express their needs and symptoms to their healthcare providers, resulting in their healthcare needs not being adequately addressed. The participants noted a significant improvement in care when accompanied by an advocate. Participant B shared an evident difference in the treatment received from nurses in the absence and presence of their mother, who served as their advocate during a hospital stay for hyperparathyroidism:

> Yes, when I was like first diagnosed with, like my hyperparathyroidism, like, I was in the hospital for like 2 weeks, and sometimes like, of course, like my family can't be there the entire time, so, like my mom would go run errands, and then come back, and, like, I noticed, like a difference with the nurses the way they treated me like before, like when my mom's gone and when my mom was there,

> like, yeah. So, I think that's right, like, with the clear, like examples on the way they treated me. (Participant B)

Building Trust with Effective Communication. Findings revealed that compassionate communication by healthcare providers can lead to a positive ED experience and support trust in the healthcare system. For example, Participant D, who presented to the ED with abdominal pain, reported a positive experience due to effective communication with a physician. She appreciated the ED physician's detailed explanation of his assessment process:

> […] I kind of realized like, what if it's my appendix? And he was like, you know, because of where the pain kind of is going, where the pain is, where it's located, that's where it could be. And then he was kind of explaining, and He even like drew it. And he was like, well, this is what could be happening like this […]. (Participant D)

She also highlighted the physician's overall demeanor and bedside manner as reasons for her positive experience: "…in this instance, I was met with like kindness and empathy, and like understanding…" (Participant D).

Two participants also shared positive experiences in the ED, such as follow-up by the ED physician with interdisciplinary care team members and referrals for further investigation of their symptoms. Follow-up care after the initial ED visit often left a positive impression on the participants. For example, Participant D recounted her favorable interaction with the ED physician who initiated follow-up care and consulted with a surgeon regarding her abdominal pain. She said,

> […] I don't recall if, he said, like a surgeon or a specialist regarding my gallbladder to look at potentially getting it taken out, or, you know, how else it could be helped. So that was really good because I feel like…I guess that was like a really positive experience. (Participant D)

Throughout her experience, this participant noted that consistent communication, acknowledgment, and follow-up support fostered a sense of trust in the healthcare system. Another participant, Participant F, noted that professional conduct and being treated equally—without the racism she had experienced in the past—were primary factors in her ability to trust healthcare providers in the ED:

> I just wish people will take their professional responsibility to heart. You know you became a nurse. You became a doctor physician not to help just a certain group of people, right? You are here to take care of all Albertans. So, if you don't like me out on the street, I'm comfortable with that. I'm okay with that, I wish you well. It's just that when I'm in the hospital I would love to be treated equal. (Participant D)

Overall, participants shared a variety of experiences within the healthcare system, including both positive and negative aspects. Notably, positive experiences were rare. For example, Participant A described: "Again, this experience has really shaped my view of emergency rooms, and I like to add now that I avoid going into the emergency room…" However, positive encounters had a significant impact on their perception of the healthcare system, fostering hope for equitable treatment in moments of vulnerability.

Theme 2: Race, Faith, and Culture Shaping Healthcare Experiences

Findings revealed the influence that racial, religious, and cultural contexts have on the healthcare experiences of Black Muslim women. This theme includes various factors that shape the participants' backgrounds, such as social settings, cultural activities, religious beliefs, and prior experiences, all of which impact their healthcare experiences. Participants disclosed that their unique social, religious, and cultural backgrounds played a significant role in shaping their experiences within the ED.

Race, Faith, and Culture in Patient Care. Participants noted a lack of awareness among healthcare providers about the health determinants and experiences that impact Black Muslim women in healthcare settings such as immigration-related knowledge gaps, modesty practices, past experiences of racism, and cultural influences on women's health. For example, Participant A, a recent immigrant to Canada, had never visited an ED before. She described experiences of confusion and expressed feeling unable to effectively advocate for her needs:

> I did not understand the system […] I was relatively new in Canada […]. So, I hadn't […] I don't fall sick, so I rarely go into the hospital…So, this was my first ER visit in Canada. I had no idea of how things were done. I had experience from being sick and needing to visit kind of a [*sic*] urgent care on emergency room from back home […] where I come from. You get seen by a doctor when you present there, and it's not your regular family doctor that you go to. You get seen by a doctor within an hour. So here, one, I did not understand the system. So, I couldn't communicate my needs effectively. Two, I felt like, I also wasn't properly acknowledged. So, it would have helped if someone said, okay, this is

> what you're going through; one, probably if I had like I said, if I had a private space, it would have helped me think better or be able to communicate better. But while outside, in the waiting room, with other groups of people, one side […] on one part […] on one end, I am wondering what's happening. On another end, I am wondering about how I'm presenting to other people. There was no space to effectively communicate my needs in my own head. (Participant A)

For this participant, the contrast between ED care in Canada and her country of origin was stark, leading to confusion and distress. Communication barriers and her inability to advocate for herself during the ED visit further heightened her stress. Moreover, cultural factors exacerbated her discomfort when she experienced bleeding during a miscarriage, sitting in a waiting room while her clothing became marked with blood:

> […] there's cultural and religious stigma for me […] being raised, having personal beliefs and life views that helps [*sic*] you see periods of bleeding from the female body as something that should be done in private, something people shouldn't see or be able to tell you're going through, something they shouldn't know that you're experiencing. I wasn't a visibly pregnant woman, so at no point, would anybody there think that I was pregnant and bleeding. What I had at the back of my mind was, they would think that I am on my period, and I am, you know, very soiled and didn't even plan for it. This is an adult that can't even take care of themselves. (Participant A)

The cultural stigma surrounding menstruation or other vaginal bleeding, and women's bodies presented an emotional challenge for her. She further expressed that the lack of privacy in the waiting room, uncertainty about requesting a change of clothes, and

self-consciousness about how she was perceived as a Muslim woman by others in the waiting room intensified her distress: "[…] this was me, a visible Muslim woman, 'epitome of modesty.' But then, the moment I stood up, everyone could see that, 'Oh, she doesn't even know [how] to take care of herself.'" She continued to explain that if the nurses had considered the social and cultural context of her ED visit, a brief conversation and acknowledgment of her situation could have met her needs and provided her with more information: "[…] when you're going through something you haven't experienced before for a patient, for the patient that I was, it would have helped to feel validated."

Participants emphasized modesty as an important aspect of their religious context, which is relevant to interacting with healthcare providers. They pointed out that staff frequently misunderstood the concept of the *hijab*,[2] which involves covering the entire body except for the hands and face. While most participants expressed no concerns regarding undressing for a medical examination, Participant C recounted an instance

[2] In Islam, hijab is an overarching spiritual concept that connotes modesty in presentation and action, the act of covering the head and body, an act of religious devotion, and a moral ideal. When it comes to clothing, it usually means covering the full body, leaving only the face and hands visible. The hijab (head covering) covers the hair, neck, and sometimes the shoulders depending on the type and length of the hijab. Loose-fitting clothes cover the rest of the body. The hijab is more than a piece of clothing for women, it stands for modesty, respect, and honour. Different Muslim women may wear and understand hijab in very different ways, depending on their culture, region, and personal views and values. Many Muslim women's identities are closely tied to the concept of hijab, wearing the head covering, and modest dressing. For this reason, many Muslim women find comfort and a sense of dignity in remaining fully covered unless it is absolutely necessary to remove the clothing or head covering.

where a hospital gown failed to provide sufficient coverage. She addressed this concern with a nurse during her assessment in the ED:

> She didn't understand like why I couldn't wear [a gown], and I had to tell her like, Oh, that's going to like, expose my back and unless I can have, like my, and I, actually, I was wearing like, I even have a T-shirt on under. So I was wearing like a tank top. So, I try to explain her like that's going to expose my arms and like I can't wear it. And she was kind of like a, kind of confused like, she didn't understand. My mom tried to explain to her like in a religion, we have to like to cover up and stuff. Then she said, like she said, Okay, like, she went back to the doctor, came back, said, oh, he said, you need ECG. Mom said that she, like I have no heart, like, problems, like, I did complain of chest pain, and none of that. And then yeah. And then, she came back, and literally like she came back, kept going back and forth. And then eventually, she told the doctor came after, and he said, like, if you have, you know, I don't need to wear it, because I'd have no concern from ECG, or my heart. I just felt like she didn't understand. (Participant C)

Wearing a hospital gown that exposes the body outside of absolute necessity was extremely concerning for Participant C. When she tried to convey her concerns to her nurse, the nurse seemed not to understand the importance of this issue. Although hospital gowns are a standard practice in the ED to ensure medical staff have the necessary access to the body for assessments, procedures, intravenous access, and various procedures, Participant C pointed out that the nurse's lack of awareness regarding the significance of her hijab led to miscommunication. She felt misunderstood and had to repeat herself to

her nurse about her hijab. With appropriate knowledge of religious context, clear communication about modesty in a healthcare setting could have been easily facilitated by the nurse.

When participants were asked if they thought their identity impacted their view of and interactions with the healthcare system, one participant shared insights into their awareness of living with an intersectional identity. Participant E thought about her experiences of fractured communication and being dismissed through the lens of her race and gender, she shared the following, "I know that in generally women are not believed, in general, and then add it, as you know, being a Black woman, it adds another layer, right? So, I'm very well aware of these things." When further probed to discuss the connection between her challenging healthcare experiences and her identity, she shared:

> I think it's both connected to being a woman, and also more so being a Black woman than maybe the religion part because, you know, I wear hijab. I present as Muslim, maybe adds another layer. But like, yeah. So it's a layer, within layer, within a layer. Yeah. (Participant E)

In discussing how her experience and the experiences of other Black Muslim women could be improved in the ED, she described:

> […] I think just being more sensitive to the fact of that, you know, especially Black women. Black Muslim women just have different experiences in these, with any systems, and that they just could go about things with more care. You know, just being more cognizant of their own biases in these realms. (Participant E)

Participant D shared another suggestion on what could improve Black Muslim women's healthcare experiences, citing prejudice and assumptions from healthcare providers as barriers to optimal care:

> I suppose just being treated like everybody else, not using any like past prejudice that you may have and then not always assuming anything about the person like, you know. Like me, you know, maybe I can't read and write, but I can speak English very well, you know, but somebody else who like my mom, for instance. Maybe her, you know, she has an accent and speaking in English, and she may be nervous […] (Participant D)

It is evident that Black Muslim women are aware of how their intersectional identity impacts their experiences in the healthcare system, and wider systems overall. Participants' experiences and insights highlighted how their identities, cultures, and religious preferences impact their care experiences. The immigrant experience, modesty practices, past experiences of racism, and cultural influences on women's health stood out as important factors expressed by participants reflecting on their ED care.

Culturally Safe Care. The findings highlighted how past experiences of racism, islamophobia, and sexism influence participants' perceptions and experiences of healthcare. The participants recounted feeling unsafe in the healthcare environment when healthcare staff demonstrated dismissive tones and body language and did not listen to their health concerns. This included experiences where participants felt that assumptions about them based on their ethnicity, religion, or gender, without a healthcare provider making an effort to understand their unique needs and perspectives could affect the care they receive. The participants expressed experiences of racism and microaggressions

encountered in the past in healthcare settings. Participants recounted how they were treated according to an assumption related to their appearance in past ED experiences rather than being asked clarifying questions. For example, Participant F stated:

> I do exist as a Black Muslim woman. I'm not oblivious to how people perceive me. I've seen people talk to me loudly, as if that will overcome any language barrier that they perceive I might have, like…if I don't speak English, you, speaking louder, is not going to help me. (Participant F)

Participant D shared a contrasting experience, highlighting a sense of safety in the ED. She described how a physician acknowledged the influence of race and gender on her symptom presentation. She explained that this acknowledgment made her feel validated and that she perceived the physician's assessment as thorough and well-informed:

> […] I asked him like, oh, why do you? Why do you have to like test my heart like, you know, cause like he did like listen to like my heart, and like told me to breathe, and all that kind of stuff. So, I was like, is there like an irregularity like, or is something going on, or whatever? And the one thing he said was that he was like, you know, with, and he was like, if I had to guess, like, from, what I think, I think he was like East Indian in background. But one thing he said to me was like, you know, women of color, and that like they present differently, if they're having, like, you know, like anything going on with the heart. Like, if it's a heart, condition, heart attack, heart disease whatever. So, he was like, you know, I just like to make sure and I guess I really appreciated that I was like, well, that's good. That he's going to like they're going to check that, too. (Participant D)

Participant D expressed comfort when the staff showed an understanding of the specific health nuances associated with being a Black Muslim woman, a perspective rooted in historical treatment disparities. This understanding, when integrated into her care, made her ED healthcare experience positive. Participant D remarked, “I felt comfortable in that […] during that visit and that it and I suppose my comfort comes from that I was treated well, you know.”

In summary, the participants emphasized that thoughtful consideration, compassion, and respect for their intersecting identities as Black Muslim women supported positive healthcare experiences. This recognition of their multifaceted lived experiences proved fundamental to establishing trust and facilitating positive healthcare encounters. The importance of compassionate care that acknowledged the compound effects of racial and religious discrimination in healthcare settings was emphasized by the two participants quoted in this section.

Theme 3: Health System Challenges

The experiences of Black Muslim women seeking emergency care in Alberta reveal systemic barriers that negatively influenced their access to and quality of care. The sub-themes identified in this analysis included a) lack of access to culturally competent family physicians, b) excessively long wait times for emergency treatment, and c) geographical barriers posed by rural locations. First, participants faced challenges in finding family physicians who could understand and accommodate their unique intersectional identities and specialized medical needs. The challenge of establishing long-term care with empathetic physicians, who share similar backgrounds, led many to rely on EDs for conditions typically managed by a primary care provider. Second, the

prolonged wait times in EDs, often extending for many hours, exacerbated distress and physical discomfort in addition to their existing medical issues. Unaware of the typical delays, the women questioned their decision to seek emergency care at all. Finally, those residing in rural areas, where comprehensive services and equipment are limited, had to travel long distances to get proper diagnostic testing and appropriate therapy in urban hospitals. This continuity of care disruption added stress to already challenging health situations. Collectively, these systemic barriers—lack of culturally safe care, excessive wait times, and limitations in rural access—significantly reduced the quality of emergency care participants received.

Lack of Access to Family Physicians. Participants disclosed that this lack of access to family physicians led them to seek the ED for care. The participants repeatedly mentioned that either they did not have a family doctor or that it was difficult to find one whose expertise met their specific medical needs. The difficulty of locating an appropriate family physician was especially pronounced for those with cultural, religious, or health needs that necessitated a physician with specialized credentials or background.

Participant B described the challenge she faced in finding a family physician she could trust, particularly when her cancer was no longer spreading:

> That's not the same thing: I don't have a family doctor. How am I? Yes, I'm in remission. But how am I in remission? And I can't even access a family doctor. I've been calling people for so long, like, it wasn't up until recently, like, that I was able to get a family doctor, either they're like, hey, I'm not specialized in this or, like, I can't, like, we're not taking. We don't have the availability for new patients. (Participant B)

Although the Canadian Partnership Against Cancer states that the best practice upon discharging someone in the cancer system into the community is to ensure they have a primary care provider, and delaying discharge for this reason is reasonable, it is not always possible (Canadian Partnership Against Cancer, 2023). Some participants noted that appointments with their family doctor were often booked several weeks in advance, making it challenging to access timely care for their health concerns. Participant D highlighted her difficulty in obtaining a prompt appointment with her family doctor: "So, like, my family doctor's quite busy […]."

The availability of, and access to, a family doctor emerged as a common concern among most participants, affected by both medical and identity-related factors. For example, Participant C emphasized the importance of cultural understanding in her search for a family doctor. Consequently, she carefully considers the provider's race, religion, or background before deciding to consult with them. She explained,

> I try my absolute best to have all the medical professionals that I see, and even if somebody is not Muslim or African, I will basically see how they are, and I'll be sort of on guard with them. And it's like I'm going to see, like I really had to find like a special […] like a specialized, like a developmental pediatrician for my autistic son, and like I was looking through all the pediatricians. I'm like this person is White. No. This person's White, no, like I just have to go through the list, and all the ones that I wanted were full. So, we ended up with a White pediatrician, but he seemed good so far. Therefore, I'm going to stay with him. But it's like I said, I'm on guard, and I find also sometimes it's like some of the […] I guess some of the expectations. Sometimes it's like it doesn't match up

> with our culture. Like, if some of the things it is like, oh, why are you doing these things for your child? Well, because this is how we grew up. This is what we eat, you know, if they're getting certain assessments or certain things done, yeah. So, it is like, I don't want any […] like to have to like […] always have to explain these things, so. (Participant C)

Long Wait Times. Throughout the interviews, participants identified lengthy ED wait times as a significant challenge in their ED care experiences. For example, Participant E recounted a particularly lengthy wait of over 12 hours in the ED while waiting for pain management: "I was at that point already, like what 12 hours at the hospital. I was like, I'm just over and done with. I just want to go home. I'm done with this."

Participant A, a newcomer to Canada who was seeking ED care for the first time, described how a lack of communication regarding Canadian ED norms, coupled with prolonged wait times, resulted in confusion, emotional distress, and physical discomfort:

> My ER visits ended up being about 6 hours. I also had a migraine while in the ER that developed while in the ER, because I hadn't eaten for the whole day, and I was obviously stressed. No one was communicating with me. I didn't know what was happening. I was just told to sit down and wait. (Participant A)

Spending several hours in an ED waiting room before receiving care is an aspect of ED care in Canada that led participants to question their decision to seek ED assistance, despite having no other alternatives. Contrary to their expectations of receiving immediate care, the inability to access timely treatment significantly influenced their overall perception of accessing ED care.

Rural Barriers to Care. Participants in this study came from various parts of Alberta, including rural areas. Those from rural areas highlighted how residing in such areas limited their access to healthcare. For example, Participant A revealed her inability to obtain comprehensive testing and treatment for her miscarriage at a local rural hospital:

> The hospital was about 1 hour and 30 min drive, because like I said, I used to live in a rural town, so he said they did not have the facilities to kind of do an internal ultrasound for me or know what exactly is going on. So, I had to drive one-and-a-half hours to a bigger hospital the next day for, especially to see me and be able to determine if I was really having a miscarriage, or if this was just some random bleeding that was happening. (Participant A)

While dealing with a challenging medical condition such as a miscarriage, a lack of ultrasound equipment at the hospital in which she first presented did not allow for adequate diagnosis. The geographical barriers she faced required her to travel to a second facility, significantly disrupting the continuity of her care.

Participant F further emphasized the scarcity of healthcare resources in rural areas: “We only have one health center. Yeah. [removed for confidentiality] Regional Health Center.” Participant F pointed out the limited healthcare infrastructure available to residents. This limitation becomes even more pronounced when seeking specialized care. Participant F described her struggle with accessing an OB/GYN for her endometriosis, a condition that necessitates specialized care:

> My family doctor after telling me that it’s okay. It’s okay. And me insisting on getting like an OB/GYN referral because we are a small town with very limited

> doctors, especially specialties. I had an appointment, I think, 4 months out or 3 months out. Hadn't seen a proper OB/GYN to help me with my endometriosis. (Participant F)

Her account highlights the lengthy wait times for specialized services, which is a common issue in rural healthcare settings. This delay in receiving appropriate care can exacerbate health conditions, leading to worsened outcomes for patients.

Conclusion

In conclusion, this ID study revealed important insights into the unique ED experiences of Black Muslim women in Alberta. The findings highlighted the profound impact of systemic barriers, cultural insensitivity, and interpersonal dynamics on their healthcare encounters. Black Muslim women in Alberta reported profound distrust related to the healthcare system, rooted in cumulative negative past experiences in which their concerns were dismissed, their symptoms were minimized, and their identities were disregarded by healthcare providers lacking basic cultural and religious competencies. These experiences of unaddressed pain and concerns affected their ability to find and trust a consistent family doctor, leading to a greater reliance on emergency services. However, a few compassionate providers managed to foster engagement, trust, and satisfaction through caring communication that acknowledged the patients' cultural contexts.

Key systemic challenges were identified within emergency services, including the scarcity of culturally aware family physicians, prolonged ED wait times, and insufficient accommodations for patients' modesty and religious practices. These barriers limit access to timely and respectful care and exacerbate feelings of isolation and reluctance to seek

necessary medical attention among Black Muslim women. While some ED providers facilitate positive experiences through compassionate communication, persistent issues of dismissal, systemic delays, and cultural disconnects continue to compromise care quality for this group and discourage future care-seeking. The following chapter will discuss concepts surrounding the experiences shared by the participants with supporting literature. The themes will also be analyzed and discussed using the PHPM (Hamilton & Bhatti, 1996) as a framework to contextualize the findings into possibly clinically relevant and applicable health promotion strategies. In the following chapter, I also explore knowledge translation strategies that may support clinical practice when caring for this population, alongside the strengths and limitations of this research will be discussed.

Chapter 5: Discussion

This study aimed to explore the experiences of Black Muslim women accessing ED care in Alberta. Through the collection and analysis of individual interviews, participants' experiences highlight the barriers and facilitators that affected the quality of care they received. Such experiences provide insights that may inform and enhance clinical nursing practice or policy to foster health equity for this population. Furthermore, the conceptualization of such experiences provides an opportunity for nurses to critically reflect on strategies to promote health equity and improve the healthcare experiences of Black Muslim women.

Overview

In this chapter, I discuss the findings presented in Chapter 4, drawing on available literature related to the healthcare experiences of Black Muslim women and the relevant health promotion strategies aimed at improving the care and health of this population. This discussion is outlined by the conceptual description and themes identified in Chapter 4. The findings are contextualized through the lens of the PHPM (Hamilton & Bhatti, 1996). The PHPM acknowledges the different determinants of health that Black Muslim women face, alongside strategies to promote health for this population. This approach provides a holistic lens to understand the healthcare experiences of Black Muslim women in Alberta. Next, I discuss the implications for nursing practice, nursing research, and considerations for health policy. Lastly, I outline knowledge translation strategies as well as the strengths and limitations of the study and conclude with my final reflections on this work.

Conceptual Description: Black Muslim Women's Emergency Department Experiences

Healthcare Provider and Patient Relations

Barriers to communication repeatedly reported by participants resulted from both linguistic differences and cultural misunderstandings. Such issues often resulted in frustration and feelings of alienation during their visits to EDs. The literature corroborates these findings, emphasizing the importance of effective communication in building trust and rapport between patients and healthcare providers (Abdillahi & Shaw, 2020). The lack of culturally competent communication can exacerbate the existing mistrust, especially for marginalized populations; thus, healthcare professionals need to be trained in cultural sensitivity and cultural awareness.

Despite the challenges, participants also shared experiences of supportive encounters in the ED, often facilitated by healthcare providers who demonstrated empathy and understanding. These interactions were crucial in fostering a sense of safety and trust. Pannucci and Wilkins (2010) suggested that patient-centered care, which prioritizes the needs and preferences of patients, can significantly improve healthcare experiences and outcomes. Encouraging healthcare professionals to adopt a patient-centered approach can help bridge the gaps in care that Black Muslim women are facing.

The participants shared experiences of their concerns being overlooked, particularly regarding pain, complex medical conditions, and, in one participant’s experience, receiving a cancer diagnosis without adequate acknowledgment or validation. This sense of dismissal was communicated not only through verbal interactions but also through nonverbal cues such as dismissive body language, facial expressions, and tone of

verbal communication. The lack of clear, compassionate, and professional communication left participants feeling invalidated, overlooked, and distressed.

Researchers have found that the quality of patient-provider communication with Black patients remains poor. In one study, physicians were 23% more verbally dominant and engaged in 33% less patient-centered communication when interacting with Black patients compared with White patients (Johnson et al., 2004). In addition, Black patients consistently received poorer communication, less information, and fewer opportunities for participatory education than their White counterparts (Johnson et al., 2004). Additionally, existing literature on health disparities that affect Black populations in Canada supports that communication challenges contribute to significant gaps in care (Abdillahi & Shaw, 2020). The expressed concerns of participants in this study regarding communication with healthcare providers that left them feeling invalidated or dismissed mirror the experiences of Black populations in the literature facing communication challenges at higher rates than their White counterparts. This supports the findings of this study which highlight the crucial impact that effective communication has on the healthcare experiences of minority groups.

In this study, care delivered with compassion and respect for diverse backgrounds facilitated meaningful connections between the participants and healthcare providers. Participants who experienced meaningful connections developed trust in their practitioners and increased confidence in treatment plans. Clear, professional communication is foundational to creating supportive environments; however, a provider's personal unconscious biases can still negatively impact the therapeutic relationship between healthcare providers and patients (Johnson et al., 2004). Addressing

these concerns requires advocacy and targeted interventions at the individual, cultural, and systemic levels to achieve high-quality, equitable, patient-centered care built on strong patient-provider engagement (Abdillahi & Shaw, 2020). The findings of this study further revealed that most participants experienced communication challenges with healthcare providers within the ED setting, which contributed to feelings of mistrust. These findings corroborate other studies that report high levels of distrust among Black populations in healthcare settings.

Overall, existing research emphasizes feelings of dismissal and mistrust among both Black (Molina et al., 2015; Treder et al., 2022) and Muslim women (Camargo et al., 2023). However, research exploring Muslim women's experiences was predominantly conducted outside of the Canadian context and did not specifically address the perceptions of Black Muslim women as distinct from Muslim women in general (Alaloul et al., 2021; Camargo et al., 2023). Moreover, previous studies on Muslim women in Canada were limited and focused on mental health services (Hunt et al., 2020; Moscovitz et al., 2023; Zia et al., 2022) and perinatal care (Alzghoul et al., 2021). Previous findings regarding Muslim women not being taken seriously pertained to those located outside Canada and were focused on perceptions of mental health services (Michlig et al., 2022), experiences in oncology services (Alaloul et al., 2021), and biopsychosocial wellbeing in healthcare settings (Tanhan & Strack, 2020). Therefore, while the findings of this study align with existing literature, they also provide new insights into the experiences of Black Muslim women specifically within the Canadian context.

Previous research supports the association between effective communication and trust-building in minority populations (Asan et al., 2021), underscoring the importance of

encouraging healthcare practitioners to implement practices aimed at improving communication with diverse patient populations (Johnson et al., 2004; Martin et al., 2013; Pérez-Stable & El-Toukhy, 2018; Shen et al., 2018). The present study corroborates existing literature regarding the challenges Black populations face in terms of poor communication in healthcare settings and a lack of trust in medical practitioners.

Participants shared experiences of feeling dismissed and unsupported when communicating their concerns in the ED. Therefore, healthcare professionals, including nurses, must engage in reflective practices to regularly identify and examine their implicit and unconscious biases (Localio et al., 2018). This approach helps address potentially culturally or religiously insensitive attitudes and behaviors to maintain safe and supportive environments. Reflexivity—the process of recognizing and confronting personal biases—enables healthcare practitioners to be aware of any biases or prejudices that may compromise culturally safe care (FitzGerald & Hurst, 2017). As a result, self-reflection can help in promoting a culturally sensitive environment and mitigating the potential risk of unintentional discriminatory behaviors and practices based on healthcare practitioners' biases or stereotypes (College of Registered Nurses of Alberta, 2021).

The findings of this study put emphasis on having a support person or advocate in EDs for patients, especially when it is challenging to effectively advocate for oneself. To participants, not having a support person mostly meant greater difficulty in communicating their needs to healthcare providers, while the presence of a support person helped foster a feeling of safety and trust. Existing literature also illustrates the important role that patient advocates can play in healthcare settings, especially for minority populations (Washington & Randall, 2023). By understanding the issues

experienced by Black women, patient advocates can mitigate the negative impacts of discrimination in healthcare settings where mistrust is a factor, as Black women often feel they are not taken seriously when concerns are expressed (Washington & Randall, 2023). Advocates can promote competent communication, adequately emphasize the needs of the person they are advocating for to healthcare providers, and ensure that the medical concerns of these women are expressed clearly and taken seriously by all medical professionals (Washington & Randall, 2023).

Race, Faith, and Culture Shaping Healthcare Experiences

Participants highlighted the impact of cultural misunderstandings and biases within the healthcare system, which hindered their access to emergency services. This assertion is echoed in research indicating that these socio-cultural factors significantly affect healthcare experiences among marginalized groups (Abdillahi & Shaw, 2020). In this research, participants shared experiences that are connected to social determinants such as social environments, culture, and gender. Participants' experiences in the ED demonstrated that care did not adequately address cultural contexts regarding gender, faith, and previous healthcare experiences. They shared experiences about a lack of proper assessment and provision of information tailored to the unique needs and identities of Black Muslim women, which caused confusion and gaps in their care. Furthermore, participants described modesty as an important part of their religious beliefs, which influenced their interactions with healthcare professionals. They noted that staff often failed to understand that wearing a *hijab* typically involves covering the entire body, leaving only the hands and face exposed. While most participants expressed no concerns about undressing for an assessment, some Muslim women prefer to remain fully covered

in hijab unless it is absolutely necessary to undress, as the hijab is fundamental to many Muslim women's identity (Sheen et al., 2018).

Various researchers have investigated disparities in healthcare among underrepresented minority patient populations. They found that a lack of cultural and religious sensitivity among healthcare practitioners negatively influences patient health outcomes (Fante-Coleman et al., 2022; Nair & Adetayo, 2019). Specifically, minority patient populations may distrust medical practitioners and feel unheard when their cultural or religious needs are not addressed (Fante-Coleman et al., 2022; Nair & Adetayo, 2019). As a result of the many grievances associated with culturally and religiously insensitive healthcare practices, the healthcare-seeking behaviors of many minority populations are negatively influenced, further contributing to their being underserved (Fante-Coleman et al., 2022; Nair & Adetayo, 2019).

In addition to a lack of cultural and religious sensitivity, the Public Health Agency of Canada and the Pan-Canadian Public Health Network (2018) highlighted the relationship between health and a person's social condition. For example, factors such as immigration status and language barriers make accessing healthcare more difficult due to knowledge gaps and reduced capacity for effective communication (Public Health Agency of Canada & Pan-Canadian Public Health Network, 2018). Similarly, low socioeconomic status and housing insecurity contribute to poor health outcomes through challenges such as food insecurity, inability to afford prescription medication, and exposure to environmental hazards (Public Health Agency of Canada & Pan-Canadian Public Health Network, 2018). Furthermore, according to Public Health Ontario (2020), health equity is achieved "when individuals have the fair opportunity to reach their fullest

health potential" (p. 7). This concept goes beyond direct patient care to advocate for a society free from social barriers that negatively impact health. Determinants of health such as housing, food security, and race, while not directly related to patient care, are acknowledged as stressors that impact an individual's overall health outcomes. Ensuring that the needs of patients of diverse ages, geographic locations, races, religions, genders, and sexual orientations are incorporated into care is central to the objective of health equity (Public Health Agency of Canada & Pan-Canadian Public Health Network, 2018).

The women in this study described experiences indicating that nurses and other healthcare providers often lacked knowledge and openness around the social, cultural, and religious nuances of caring for Muslim women. Specifically, the women struggled with nurses and other healthcare providers lacking knowledge and responsiveness regarding modesty concerns, cultural stigmas surrounding women's health, and how previous experiences of overt racism inside and outside of healthcare settings in the past impact Black Muslim women's current experiences in EDs. During healthcare encounters, providers should demonstrate sensitivity and basic awareness regarding *modesty*, a cultural and religious concern for many women from diverse backgrounds (Sheen et al., 2018). Such awareness can alleviate distress for women already dealing with medical challenges. For Muslim women, *hijab* represents a concept of modesty that typically involves covering the entire body, except for the hands and face (Sheen et al., 2018). Most participants in this study reported no issues with undressing for necessary assessments in the ED; however, one participant felt the gowns provided did not offer sufficient coverage, and her concerns were dismissed by the ED physician. The nurse tasked with assisting her also failed to understand her need for modesty, even after she

explained the concept of the hijab, highlighting a significant area of discomfort and misunderstanding. This case also shows the negative impacts of lack of culturally sensitive care on patient experience (Fante-Coleman et al., 2022; Nair & Adetayo, 2019). The *hijab*, for many Muslim women, is an integral part of their identity because it protects their dignity and privacy. It is rarely taken off, except when medically indicated during observation or treatment. These findings stress the building of medical professionals' awareness and respect regarding patients' modesty and culture as ways to promote a supportive and inclusive care environment for underrepresented populations.

In the current study, prior experiences of racism across different healthcare settings, including non-ED environments, also shaped three participants' experiences in EDs. Participants described how healthcare staff who displayed dismissive tones, negative body language, and an inability to listen to their concerns contributed to their feelings of unsafety, causing them to reflect on past experiences of racism in and outside of healthcare settings. To enhance healthcare experiences and outcomes for Black Muslim women in EDs, it is essential to recognize and address the lack of cultural safety, biases, and structural racism they face in Canada.

Black Muslim women are at risk of experiencing compounded anti-Black racism, sexism, and Islamophobia (Mohamed, 2017; Senate of Canada, 2023). Many are also immigrants and face additional social and racial barriers that further reduce the quality of care they receive. Crenshaw's (1989) theory of intersectionality provides a critical framework for understanding how intersecting social identities impact the experiences of Black women, who face unique forms of discrimination that cannot be adequately addressed through traditional analyses of their individual identities. Crenshaw (1989)

critiqued both feminist and anti-racist movements because they often failed to recognize the compounded effects of race and gender discrimination on Black women's lives (Crenshaw, 1989). Crenshaw (1989) demonstrated that Black women experience discrimination in ways that are distinct from those faced by White women or Black men, due to the intersection of race and gender. Crenshaw's (1989) intersectionality theory sheds light on how the experiences of Black women are often rendered invisible in broader feminist and anti-racist discourses. By focusing on the specific ways in which Black women's experiences diverge from those of other groups, Crenshaw (1989) called for a more inclusive and nuanced approach to social justice, recognizing and addressing the compounded nature of discrimination (Crenshaw, 1989). An important part of her analysis is that she argues for policies and advocacy efforts to be designed with an understanding of how intersecting identities create unique forms of oppression that require tailored solutions (Crenshaw, 1989). Acknowledging that the experiences of Black women require a unique understanding and tailored solutions in her work opens a discussion for the healthcare experiences of Black women to also be considered in their own unique context. Simply discussing disparities faced by women or general Black health disparities risks overlooking the compounded impact of intersecting identities within this population. One participant in this study described that challenges with communicating her concerns might have stemmed from her being a woman, Muslim, or Black as her identity was a layered one. This acknowledgment of her intersectional identity supports that the experiences of this population need to be analyzed and contextualized using their whole identity to foster health equity for them.

Culturally safe care is achieved when healthcare practitioners are able to provide care with “no assault on a person’s identity” (Williams, 1999, p. 213). Recognizing that colonialism against Indigenous Peoples in Canada clearly demonstrates the presence of systemic racism within our healthcare systems, cultural safety in healthcare is essential for establishing open communication and trust with Indigenous populations and all other systemically marginalized populations through the implementation of cultural safety practices (Papps & Ramsden, 1996; Williams, 1999). Culturally safe care is described as “healthcare that is free of stigma, racism, and discrimination” (College of Registered Nurses of Alberta, 2021, p. 1). However, implementing culturally safe care requires nurses to continuously and consciously assess the environment and patient needs with cultural and religious sensitivity, remaining prepared to act when necessary (College of Registered Nurses of Alberta, 2021, p. 1).

The distinction between cultural awareness and cultural safety represents a crucial change in healthcare delivery frameworks, and both terms are used purposefully throughout this study. While cultural awareness focuses on recognizing and acknowledging cultural differences in patient assessment and care delivery (Curtis et al., 2019), cultural safety requires engagement at a more profound level with power relationships and patient-centered practices in care delivery (Curtis et al., 2019). This research adopts a cultural safety framework instead of limiting its scope to cultural awareness, emphasizing that effective healthcare interactions require more than the recognition of cultural differences.

In nursing practice, cultural awareness is typically understood as the recognition of cultural differences during patient assessments, which includes sensitivity to diverse

cultural norms, beliefs, and practices that may impact healthcare delivery (Kaihlanen et al., 2019). However, this awareness alone is not enough for ensuring improved patient outcomes or experiences. Curtis et al. (2019), on the other hand, argued that the limitation of cultural awareness lies in its potential to inadvertently reinforce stereotypes and oversimplify complex cultural identities.

Cultural safety extends beyond awareness to encompass active engagement with patients' cultural needs through three key dimensions: demeanor, communication, and responsiveness to patient requests. This approach aligns with the seminal definition of cultural safety (Ramsden, 2002) as a framework that addresses power relationships and prioritizes the patient's experience. In practice, this means healthcare providers must progress from simply recognizing cultural differences to actively creating environments where patients feel safe expressing their cultural needs and preferences.

Throughout this study, cultural safety is recognized as a framework for professional development and as a strategy for improving the delivery of patient-centered care. In professional development, it manifests through healthcare providers' intentional adoption of an informed approach that acknowledges power imbalances and prioritizes patient-centered care (Curtis et al., 2019). Cultural safety is considered a component of professional practice that involves self-reflection for the purpose of changing and improving communications and interactions with diverse populations of patients (Kaihlanen et al., 2019), thus aiding in building better therapeutic relationships.

Cultural safety cannot be ensured through a competency checklist, but rather it has to be nurtured through ongoing reflection and responsive care practices. According to Kaihlanen et al. (2019), this process requires healthcare providers to develop skills in

critical self-reflection and awareness of their own cultural positioning. The shift from cultural awareness to cultural safety signifies a progression from passive knowledge acquisition to active engagement in constructing healthcare settings that are respectful and responsive to the cultural identities and needs of patients.

By emphasizing cultural safety rather than cultural awareness in nursing practice, this study highlights that effective healthcare delivery requires theoretical understanding, personal reflection, the acknowledgment of power dynamics, and practical implications in professional practice. These elements enable providers not only to recognize cultural differences but also to actively foster environments where patients feel safe, valued, and understood within their cultural context. This approach aligns with health equity as a best practice and patient-centered care since cultural safety plays a core role in achieving positive health status across different populations (Curtis et al., 2019). It is important to note that the term ‘culturally safe care’ is the practical application of cultural safety in patient care (Ramsden, 2002).

Incorporating culturally safe care that respects identity requires nurses to be appropriately mindful, sensitive, open, and respectful of the recipient of the care, in alignment with the principles of cultural safety in nursing practice (Papps & Ramsden, 1996). This approach is especially important when addressing the preferences of Muslim women who choose to be modestly covered, ensuring that proper assessment and treatment are conducted regardless of their attire. Culturally aware and considerate healthcare providers can create a sense of trust, respect, and inclusivity among Muslim women by respecting and openly communicating with Muslim women about modesty concerns and cultural nuances, checking their own biases, and taking into consideration

how past experiences of racism for a Black Muslim woman may affect her current care (Ding et al., 2018).

One of the themes that came out across participants was the gap in culturally safe care practices in healthcare service provision. Participants reported how certain parts of their cultural practices and religious beliefs were misunderstood or not appropriately recognized. Further, participants believed that communication gaps and mistrust associated with healthcare providers were related to a lack of culturally safe care. Healthcare professionals can enhance the quality of care for Black Muslim women by creating an environment that appropriately assesses, acknowledges, respects, and addresses the impacts of race, faith, and cultural differences on their care needs (Taherdoost, 2022).

While negative perceptions of menstruation and sexism are prevalent across various cultures and religions (Mohamed, 2017), Islam does not consider menstruation shameful. Instead, it regards menstruating women as ritually impure, exempting them from certain religious obligations, such as prayers and fasting, that require ritual purity. The stigma faced by Muslim women often stems from cultural misinterpretations of Islam, rather than from the religion itself (Mohamed, 2017). In this study, one participant's unfamiliarity with the Canadian healthcare system, as a recent immigrant, compounded by the distress of bleeding, left her unable to fully communicate the extent of her discomfort. This experience is rooted in a broader context of migrant health challenges, such as the "healthy migrant effect" (De Maio & Kemp, 2010, p.10), a phenomenon where immigrants initially exhibit better overall health upon arrival in Canada, although this advantage tends to decline over time. This decline is related to

immigrants experiencing the impacts of social determinants of health such as low socioeconomic status, language barriers, knowledge gaps, and adopting unhealthy behaviors (De Maio & Kemp, 2010). Language barriers and knowledge gaps increase the likelihood of poor continuity of care, gaps in care, and poor communication which can lead to reduced quality of care and overall health (De Maio & Kemp, 2010), structural inequalities and systemic racism in host countries can exacerbate health disparities. Addressing these barriers through tailored assessment questions that consider the patient's social, religious, and cultural context can improve communication, build trust, and enhance healthcare experiences (De Maio & Kemp, 2010).

In this study, participants suggested that a brief conversation with healthcare providers acknowledging their social and cultural context during ED visits could have addressed their needs and provided valuable information. Nurses, who work closely with patients, are strategically positioned to advocate for rapid, system-wide improvements to reduce wait times and enhance the efficiency of care delivery (College of Registered Nurses of Alberta, 2021). Effective communication about care processes can alleviate patient anxiety and uncertainty (De Maio & Kemp, 2010). Furthermore, recognizing the diverse needs of patient communities, including cultural sensitivities, can significantly enhance patient care, making it more equitable and tailored to specific population requirements (De Maio & Kemp, 2010).

To adequately support Black Muslim women, staff should recognize the different experiences Black Muslim women face in relation to their backgrounds and identities—such as anti-Black racism, immigration, language barriers, and faith practices—as these factors influence their perceptions and experiences of health and healthcare. This

acknowledgment should guide their care and interventions. Cultural safety is a useful theory to consider because it acknowledges the existence of systemic racism and power imbalances between nurses and marginalized populations seeking care (Papps & Ramsden, 1996). Open and respectful communication about the individual preferences of each Muslim woman regarding modesty during care, language barriers, and how past experiences of racism have impacted their trust in nurses should be facilitated by nurses. Acknowledging the cultural, social, and religious barriers Black Muslim women face and respecting their preferences to shape their care experience in line with cultural safety's "no assault to a person's identity" will create a supportive environment (Papps & Ramsden, 1996). Participants articulated how their identities influenced their interactions with healthcare providers and the healthcare system at large. The intersectional lens reveals that Black Muslim women face unique challenges that are not solely attributable to race or gender but also are compounded by their religious identity. This aligns with the growing body of literature that emphasizes the importance of considering intersectionality in systems (Crenshaw, 1989). By recognizing the multifaceted nature of identity, healthcare providers can better understand the specific needs and experiences of Black Muslim women, leading to more tailored and effective care.

One challenge, highlighted by participants in this study as well as other research, is the emotional burden of navigating healthcare systems where racial biases and cultural insensitivity are prevalent. A growing body of literature links multiple marginalized identities with an increased prevalence of traumatic stress symptoms (Berg, 2006; Richman & Jonassaint, 2008; Watson et al., 2016). In Black women, traumatic stress—particularly when compounded by gendered racism—profoundly influences mental

health, leading to an increase in these symptoms (Watson et al., 2016). Manifestations include hypervigilance, emotional distress, and physiological responses to stress, such as hypertension and elevated cortisol levels, which are disproportionately high in Black women due to unique stressors (Richman & Jonassaint, 2008). Minorities face challenges when healthcare practitioners fail to treat them as whole individuals, considering their cultural and religious contexts. This oversight presented a clear challenge to the participants of this study. Addressing this issue through the application of the PHPM (Hamilton & Bhatti, 1996) may be particularly helpful as it provides a systematic framework for delivering health services equitably, with a focus on Black Muslim women. Equity is an important perspective that should be emphasized within this framework; the context of multiple barriers and poor health outcomes should be considered for patients who carry intersectional identities (Allamby et al., 2022).

Health System Challenges

In some cases, participants visited the ED due to a lack of access to primary care. They described various reasons for difficulties in visiting a family physician, including a shortage of physicians and a lack of specialized medical or healthcare services. This resulted in a lack of access to care, which in turn made the participants experience prolonged delays in finding suitable medical care; some of them even endured long waiting hours in clinics to visit their family physicians. Although such strains in the Canadian healthcare system are found across Canada (Curtis et al., 2019), the findings of this study in relation to healthcare system challenges are important to discuss due to their compounded effect of increasing the difficulty for Black Muslim women to receive care on top of existing barriers such as racism and language barriers. Although challenges in

accessing healthcare are not specific to this population, the current barriers to accessing adequate healthcare, coupled with policies that fail to support care access, significantly amplify the difficulties in seeking and receiving healthcare. In addition, the findings of this study highlight the concerns of mistrust rooted in past experiences of racism. Participants expressed a preference for physicians who share their identity group, believing that this would ensure better understanding and engagement in their healthcare (Yeasmeen et al., 2022).

The study further identified systemic issues such as long wait times and inadequate communication between healthcare providers and patients as significant barriers to effective care. These findings align with existing research that emphasizes the need for more equitable healthcare delivery systems (McGibbon et al., 2008). Curtis et al. (2019) stressed the widespread shortage of healthcare providers and specialized services in Canada, a reality reflected in participants' accounts of prolonged wait times and difficulties in accessing appropriate medical care. This scarcity, compounded by existing barriers such as racism and language differences, exacerbates the hurdles faced by this demographic group in securing healthcare (Yeasmeen et al., 2022). Moreover, participant experiences reveal the complex intersectionality of their identities and its impact on healthcare interactions. Instances of poor communication and a lack of knowledge or responsiveness to their specific needs not only affected their encounters with family physicians but also contributed to feelings of psychological insecurity within healthcare settings.

The preference expressed by participants for physicians who share their identity group reflects a desire for greater understanding and cultural competence in their care.

This finding aligns with literature that emphasizes the importance of culturally appropriate healthcare (Yeasmeen et al., 2022). This preference requires careful consideration within the context of power dynamics and healthcare inequities. While such preferences might superficially appear discriminatory, this interpretation overlooks the role of systemic racism and power imbalances in healthcare settings. As Ramsoondar et al. (2023) emphasized, racism operates through systems of power, where discrimination is rooted in the ability of dominant groups to create and maintain barriers for marginalized populations. When Black Muslim women express a preference for physicians who share their identity, this reflects a protective response to historically negative healthcare experiences and systemic barriers, rather than discrimination. This perspective on power dynamics helps clarify why marginalized patients' preferences for providers from their own communities should not be equated with discrimination. Emami and de Castro (2021) emphasized that addressing healthcare inequities requires "redistributing power and privilege to those historically excluded and currently underrepresented." Patient preferences, therefore, represent strategies for navigating an unequal system rather than exercises of discriminatory power, as marginalized groups lack the institutional power to create or maintain systemic barriers.

One of the major problems participants reported was their long waiting periods in EDs. This is an urgent issue within the Canadian healthcare system (Yeasmeen et al., 2022). According to the participants, most viewed the long waits as traumatic experiences involving difficult decision-making, confusion, and distress. Some viewed the extended wait times as marginally acceptable, which highlights the particular challenges faced by newcomers unfamiliar with Canadian ED procedures. For example, one of the

participants, a recent immigrant visiting the ED for the first time, struggled due to a lack of communication about ED norms in Canada. This situation resulted in long queues, confusion, emotional distress, and physical discomfort. The absence of patient-focused communication regarding ED operational norms, coupled with extended waiting periods, exacerbated her confusion and psychological distress. The situation not only made the participant feel vulnerable but also physically uncomfortable. Communication barriers are often experienced because the native languages of the patients are different from English. It is, therefore, vital to make sure that appropriate communication strategies are put in place in healthcare facilities to meet the demands of individuals with different backgrounds. Implementing guidelines to support and guide all patients, particularly recent immigrants, would help alleviate discomfort and improve the overall quality of care in the ED.

More importantly, the experiences and perceptions of the patients in receiving timely treatment in the ED highlight a wide gap in knowledge between optimum and real healthcare delivery. The expectation of prompt medical response upon arrival at the ED often clashes with the reality of both brief and lengthy delays, which is a major source of dissatisfaction. This discrepancy between expectations and real conditions creates a wide range of adverse outcomes, from heightened feelings of insecurity and discomfort to doubts about the effectiveness and efficiency of the healthcare system (Ding et al., 2018). Delays in getting timely treatment not only aggravated the physical condition of the participants, but they also negatively shaped their overall perception about the healthcare system. Many were frustrated and disillusioned; some even questioned whether it was worth waiting to seek ED care. This feedback underscores a critical issue in healthcare

delivery regarding aligning health activities to match the demands and needs of the patients, especially in emergencies where time is of the essence.

Addressing this issue requires the implementation of policy strategies by healthcare systems to minimize waiting times and improve the flow of patients through the ED (Yeasmeen et al., 2022). Possible strategies include optimizing triage processes, increasing staffing during peak hours, and employing technological efficiencies to support day-to-day activities (Yeasmeen et al., 2022). Furthermore, communication about wait times and the reasons for delays can reassure patients and reduce dissatisfaction. These efforts are crucial for ensuring patient satisfaction and trust in emergency healthcare services, emphasizing that individuals are supported and valued during critical times (Yeasmeen et al., 2022). This becomes particularly important for Black Muslim women since such complications in accessing timely care add to other obstacles these women face and further impede their access to equitable healthcare.

In this study, several participants shared experiences of healthcare barriers specific to rural areas. Living in rural areas presents additional challenges in accessing healthcare on top of the barriers already faced by Black Muslim women. Participants from non-urban areas reported limited access to necessary healthcare services. One participant's experience with inadequate facilities at a rural hospital during a miscarriage episode emphasized the lack of comprehensive care; the absence of essential medical equipment ultimately forced her to seek treatment elsewhere. This example illustrates how geographic location can further widen the gap in care quality for rural residents (Yeasmeen et al., 2022). Faced with structural obstacles, participants adopted individual management strategies to bridge the access gap to timely healthcare. For many, a

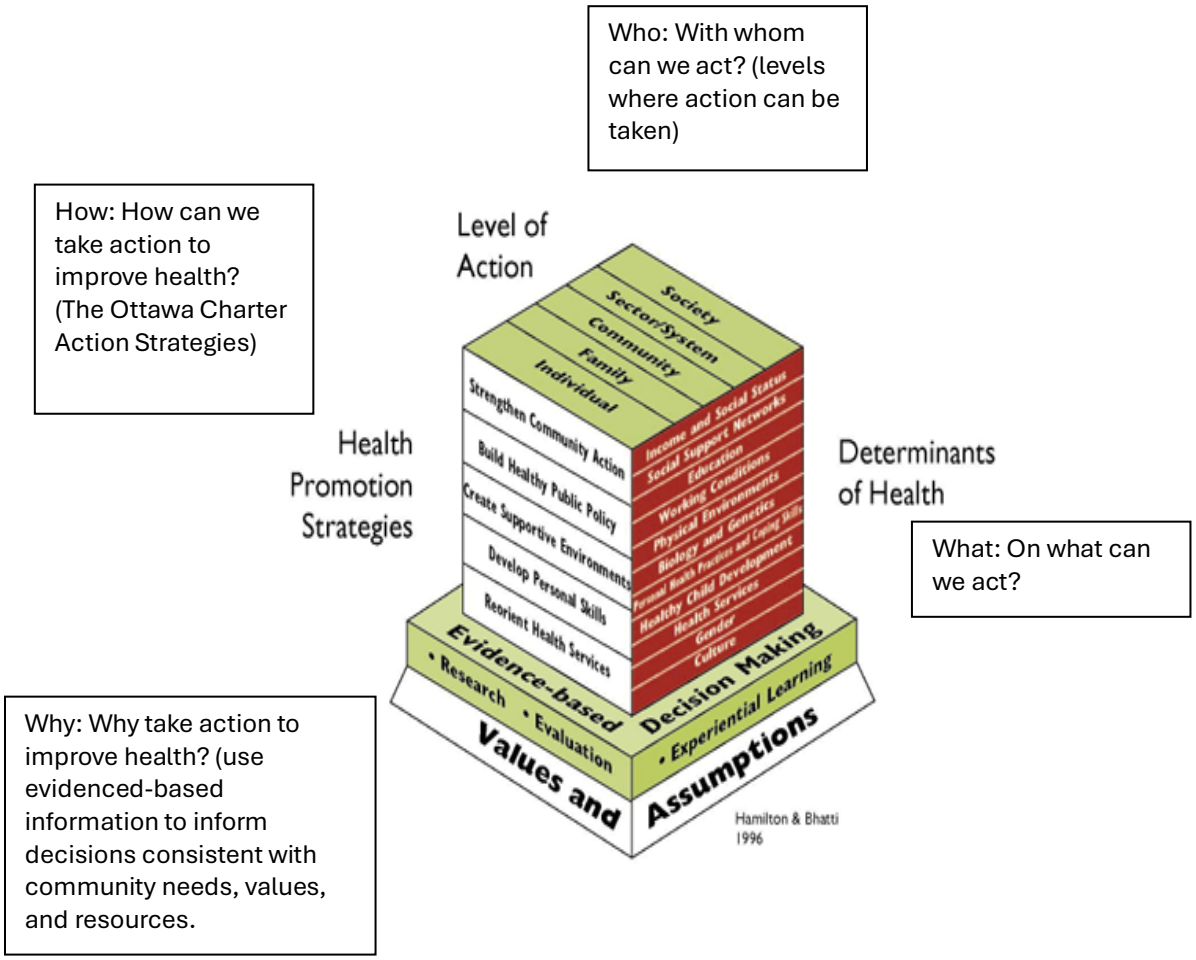
common alternative was to use urgent care centers to avoid the long waits and overcrowding often found in traditional ED settings. However, this option was not available to participants in rural areas. Expanding access to urgent care and other care alternatives in rural areas can provide critical support for patients who need to address non-emergent yet significant health concerns in a timely manner, particularly in the absence of a family physician, thereby improving their overall care experiences (Allamby et al., 2022).

Positioning Findings Alongside the PHPM

The PHPM is used as a framework to identify the *why*, *what*, *who*, and *how* of promoting health. Figure 2 depicts the model which provides a structured way to understand the findings of the study. The PHPM serves as a foundation to identify why action is needed to improve health and to apply evidence-based information to support decisions that are most effective for a specific population's needs, values, and resources. The PHPM comprises three facets: *determinants of health* ("What can action be taken on?"), *levels of action* ("Who can we act upon?"), and *action strategies* ("How can we take action to improve population health?"). The three facets offer a framework for improving population health by addressing the social determinants of health, identifying appropriate levels of action, and implementing effective health promotion strategies.

Figure 2

The Population Health Promotion Model



Note. Adapted from *Healthy School Environments: A Public Health Partnership* [Conference presentation], by C. MacLeod, 2011, The 5th National Community Health Nurses Conference, Halifax, Canada.

First, the *determinants of health* facet allows practitioners to identify factors that influence people's experience of health. These factors include (a) *income and social services*, (b) *social support networks*, (c) *education*, (d) *working conditions*, (e) *physical environments*, (f) *biology and genetics*, (g) *personal health practices and coping skills*, (h) *healthy child development*, (i) *health services as areas where action could improve*

health, (j) *gender*, and (k) *cultural factors* (Hamilton & Bhatti, 1996). In this study, analyzing the determinants of health helped identify the specific factors that influence the health of Black Muslim women. Framing the findings of this study within these determinants of health helped to contextualize and understand the key barriers to health equity highlighted by participants. This facet identifies the various factors that influence health, including income, education, social support, working conditions, physical environments, and cultural aspects. By analyzing these determinants, healthcare practitioners can pinpoint specific areas for targeted interventions to enhance health equity, particularly for marginalized groups.

Second, the *levels of action* facet identifies potential targets for health promotion actions. It categorizes them into individual, family, community, sector/system or organizational, and societal levels. This classification helps practitioners determine the most effective level at which to implement health initiatives, ensuring that interventions are relevant and impactful for the intended population. By focusing on the appropriate level, practitioners can tailor their approach to improve health outcomes for marginalized populations.

Finally, the *action strategies* facet includes implementing different health promotion strategies to effect positive change. This facet of the PHPM is based on the five key action areas of the Ottawa Charter for Health Promotion (World Health Organization, 1986). The *health promotion strategies* outlined in the PHPM include (a) *strengthening community action*, (b) *building healthy public policy*, (c) *creating supportive environments*, (d) *developing personal skills*, and (e) *reorienting health services*. Using levels of action in this analysis allows for the barriers faced by Black

Muslim women in the results to be placed in a broader context of where the barrier is presented from, and the levels where solutions or initiatives to enact change could be directed. These strategies provide a roadmap for implementing effective health promotion initiatives that address the identified determinants of health and target the appropriate levels of action.

Overall, by emphasizing a critical analysis of determinants of health and health promotion strategies with a focus on knowledge translation, the PHPM serves as a holistic framework that supports a multifaceted discussion of the findings of this study.

Creating Supportive Environments

Creating supportive environments is a key health promotion strategy that facilitates positive interactions within the healthcare system. It is recognized by the Ottawa Charter for Health Promotion as a strategy that addresses the social and cultural contexts that influence health (World Health Organization, 1986). A crucial aspect of creating supportive environments involves fostering safety within social interactions. In this way, supportive environments function as a pillar of social justice: interactions can either be validating and inclusive or, conversely, perpetuate harm (McGibbon et al., 2008). Supportive environments can be established through effective, open communication that is culturally and religiously sensitive, and by considering the whole person, not just their medical condition (McGibbon et al., 2008). Creating supportive environments in healthcare settings, in line with principles of social justice and health equity, requires practitioners to engage in compassionate communication, examine personal biases that may affect patient-provider relationships, provide culturally appropriate care, and recognize the advocacy role of family members.

Implementing culturally safe care (Papps & Ramsden, 1996) to establish supportive environments for patients with intersecting identities, such as Black Muslim women, requires that nurses practice with integrity and respect, ensuring they protect patients' rights to dignity and actively avoid prejudgment (Papps & Ramsden, 1996). This approach involves viewing each patient as an individual, acknowledging histories of systemic oppression, and recognizing the impact of prior negative healthcare experiences rooted in discrimination. Nurses can shape the supportive environment between patients and providers by challenging their own biases, remaining open-minded, communicating effectively, and supporting a collaborative decision-making process between the patient and provider (College of Registered Nurses of Alberta, 2021).

Reorienting Health Services

As a determinant of health, *health services* encompass the healthcare system itself in terms of access and reliability, service delivery, and the ability of providers and allied health staff to provide safe and equitable care (McGibbon et al., 2008). This study supports that the re-orientation of health services to become more supportive of Black Muslim women can lead to improved health outcomes for this group (Abdillahi & Shaw, 2020). A social justice framework applied to health services will enable the fostering of health equity and better care for Black populations, including Black Muslim women (Abdillahi & Shaw, 2020). Achieving health equity in healthcare services depends on understanding the difference between equity and equality and how that impacts access to care for diverse populations (McGibbon et al., 2008).

Alberta Health Services (AHS) has established cultural safety frameworks that guide and support improvements to care delivery; however, significant systemic issues

persist that require critical reflection (Fitzpatrick et al., 2024). While AHS has initiated programs such as the Indigenous Wellness Program, which integrates traditional healing practices along with Western medicine, and established the Provincial Advisory Council on Diversity, Inclusion, and Health Equity, the effectiveness of these programs varies significantly across Alberta's diverse geographic and demographic landscape (Fitzpatrick et al., 2024). In urban centers, healthcare providers often have access to translation services, cultural competency training, and specialized community health centers designed to serve specific cultural populations (Opoku, 2009). These resources are significantly less available in rural and remote areas, leading to disparities in the access and quality of culturally appropriate care (Opoku, 2009).

The current landscape particularly highlights challenges in workforce development and resource allocation (Drost, 2019). While commitments to cultural safety exist at an institutional level, healthcare centers currently lack representation in terms of providers from diverse cultural backgrounds and are not consistently offering training in cultural competency (Fitzpatrick et al., 2024). This shortage is especially acute in mental health services, where gaps in cultural safety measures significantly impact care delivery for diverse populations (Fitzpatrick et al., 2024). Resource constraints further exacerbate these challenges, resulting in extended wait times for culturally specific services and limited availability of interpreters, particularly in non-urban areas (Drost, 2019). The disparity between institutional frameworks and practical implementation suggests a critical need for systematic evaluation and enhancement of cultural safety initiatives, particularly in resource-constrained environments (Drost, 2019).

Achieving equitable health outcomes requires nurses to better understand and implement equitable healthcare service delivery and health promotion using the PHPM as a central framework. *Reorienting health services* (Hamilton & Bhatti, 1996) to improve access, care outcomes, and service delivery should begin at the management level by creating or improving policies that explicitly address health equity concerns and social determinants of health (Kalich et al., 2015). Creating and regularly revising policies related to fostering health equity provides those who work within the system with a framework to follow when implementing these principles (Kalich et al., 2015). Recent literature highlights the importance of culturally safe healthcare, training nurses to uphold health equity, accessible services in communities, the impact of language barriers, and the strengths of a diverse healthcare workforce. These efforts endorse the PHPM's approach to centering social justice in the reorientation of health services.

Reorienting health services to increase accessibility and promote culturally safe care can include educating nurses, physicians, and all other allied health professionals through courses that interactively teach healthcare providers to challenge their own biases, recognize the gaps a patient may face in navigating the healthcare system, and plan care and interventions in a way that considers the experiences of patients with diverse cultures, religions, and ethnicities. While AHS demonstrates significant institutional commitment to culturally appropriate care through various policies and programs, the practical realization of these objectives remains an ongoing challenge as the need grows for culturally responsive care in an increasingly diverse province (Fitzpatrick et al., 2024).

This strategy of *reorienting health services* by better-educating healthcare providers through an equity-centered approach fosters organizational change that supports the needs of patients with intersectional identities (Opoku, 2009). For example, the Sigma Theta Tau International Nursing Honor Society offers a virtual mini-academy on health equity that focuses on challenging biases, discovering personal values, and distinguishing between equity, equality, and justice through a lens of empathy and belonging (Sigma Nursing, 2024). Designed to support nurses in recognizing barriers within their practice related to health equity, this course aims to effect change in the outlooks and behaviors of nurses, enhancing their understanding of and commitment to health equity through accessible virtual education.

At the sector/system level, providing comprehensive cultural sensitivity training and funding community-based health initiatives for diverse communities can better support the specific challenges Black Muslim women face (Olukotun et al., 2024). Although AHS has implemented cultural sensitivity training through its Diversity and Inclusion learning modules (Drost, 2019), a more comprehensive approach is necessary. This includes policy-level interventions and dedicated funding for community-based health initiatives to address healthcare inequities effectively (Fitzpatrick et al., 2024).

Additionally, healthcare organizations should aim to employ Black Muslim women physicians to better meet the needs of this population, as workforce diversity has been shown to improve healthcare experiences and outcomes in diverse populations (Naseem et al., 2023). Workforce diversity in Alberta's healthcare system, particularly regarding Black physicians and nurses, remains limited. While AHS has established the Provincial Advisory Council on Diversity, Inclusion, and Health Equity, concrete

pathways for increasing the representation of Black Muslim healthcare providers are limited. Recent research has highlighted a significant underrepresentation of Black physicians in Alberta, especially in leadership and academic positions (Ruzycki et al., 2022). Healthcare organizations must move beyond diversity statements to implement actionable strategies for increasing workforce representation, following successful models from other Canadian provinces.

Medical education institutions in Alberta have begun incorporating health equity content into their curricula. However, the inclusion of cultural safety principles and bias recognition training varies widely across programs. Olukotun et al. (2024) noted that institutional and systemic barriers continue to affect healthcare access for Black women in Alberta, highlighting the urgent need for stronger educational standards in cultural safety training. Current continuing professional education requirements for Alberta healthcare providers include limited mandatory cultural safety training, despite evidence that comprehensive cultural safety education, when properly integrated into professional standards, can significantly improve healthcare experiences for marginalized populations (Olukotun et al., 2024; Ruzycki et al., 2022).

Building Healthy Public Policy

In the context of this study, Black Muslim women faced numerous healthcare system challenges, including barriers to accessing primary care, long wait times in EDs, and limited healthcare access in rural areas. *Building healthy public policy* (Hamilton & Bhatti, 1996) is a core part of health promotion and healthcare accessibility, as healthcare systems form the root that enables population health. Although Canadians are often considered among the healthiest populations globally, the *Canadian Health Inequalities*

Report reveals that specific populations do not receive the necessary care to achieve optimal health outcomes (Government of Canada, 2019). Based on 22 indicators of health status and determinants of health, the report identifies disparities affecting individuals "with lower socioeconomic status, Indigenous peoples, sexual and racial/ethnic minorities, immigrants, and people living with functional limitations (such as physical or mental impairments)" (Government of Canada, 2019, p. 1).

In this study, poor communication was noted, which the Black Muslim women participants attributed to unconscious biases among healthcare providers, a lack of responsiveness to religious concerns, and a lack of acknowledgment of the impact of past traumas associated with racism. Such findings align with broader Canadian studies that have identified racism as a fundamental factor in how healthcare is delivered (Ramsoondar et al., 2023). When examining Black Muslim women's experiences in EDs, it is crucial to contextualize these within the broader landscape of systemic racism in Canadian healthcare settings. Phillips-Beck et al. (2020) documented how systemic exclusion from quality care continues to be perpetuated via the institutional structures and practices that result in poor communication, cultural insensitivity, and a lack of recognition of how historical trauma shapes current healthcare interactions.

Health promotion strategies such as *creating supportive environments*, *reorienting health services* to address health inequities, and *creating healthy public policy* have the potential to support and enhance the healthcare experiences of Black Muslim women in Alberta's EDs. Understanding these strategies through the PHPM provides an action-oriented perspective on the findings of this study and the current status of health promotion for marginalized populations (Hamilton & Bhatti, 1996).

The aim of this study was to examine the experiences of Black Muslim women in Alberta's EDs. The key findings of this study include the critical role of communication and mistrust in patient-provider relationships, the influence of Black Muslim women's intersecting identities on their healthcare experiences, and the compounded impact of health system challenges faced by all Albertans on this specific population's ability to seek care. Analyzing the context of Black Muslim women's healthcare needs through the lens of the PHPM helps better understand how social and systemic barriers affect the health of Black populations in Canada. Using a health promotion framework, individuals, healthcare providers, and systems can collaborate to dismantle these barriers, thereby improving healthcare access and outcomes for Black Muslim women.

Implications for Nursing Practice

While this study specifically focused on the experiences of Black Muslim women in Alberta's EDs, Olukotun et al. (2024) reported that, despite institutional commitments to diversity and inclusion in Alberta, significant gaps persist in nursing education regarding the specific needs of Black women. Canadian nurses have a duty to address these inequities by taking action on both individual and systemic levels (Canadian Nurses Association, 2017). Such action requires learning, yet many nurses report feeling inadequately equipped with the education and tools needed to address health disparities within diverse populations (Ofosu et al., 2023). Understanding how determinants of health impact the health of individuals and communities is key to understanding the whole picture of a patient's health (Hamilton & Bhatti, 1996).

Addressing health inequities requires moving beyond the simple identification of social determinants of health to fully integrating such concepts into nursing education.

However, the current landscape of cultural safety education in Canada reflects several critical challenges. Healthcare institutions face issues including “lack of conceptual clarity, fragmented and variable programs, inadequate faculty and staff support and development, and staff and students' ambivalence toward this aspect of education” (Guerra & Kurtz, 2017, p. 138). These challenges are particularly evident in nursing and medical education, where, despite institutional commitments to cultural safety, program implementation often lacks standardization and comprehensive evaluation methods. Several noteworthy cultural safety programs have emerged across Canadian healthcare institutions, although their approaches and depth vary significantly. Guerra and Kurtz (2017) highlighted initiatives such as the Aboriginal Nurses Association of Canada’s curriculum, which has been implemented across six nursing schools nationwide, emphasizing cultural safety competencies through a structured framework.

Culturally safe care practices that center health equity and deepen understanding of Black People’s health are essential for nursing students to uphold the human rights of the Black patient populations they serve (Chauhan et al., 2020). Integrating standardization, conceptual clarity, and evaluation methods to ensure the positive impact of applying cultural safety methods into nursing curricula will strengthen both the curricula and nursing students’ ability to integrate health equity practices into their bedside care (Chauhan et al., 2020). Providing ongoing opportunities for registered nurses to continue learning about health equity in practice as it relates to Black populations is also key to maintaining these skills and a relevant knowledge base, as research and social understanding of health equity continue to evolve from previous years.

It is crucial to cultivate environments where nurses and nursing students can challenge their own biases and structural racism to advocate for the religious and cultural accommodations their patients require (Chauhan et al., 2020). This approach ensures that nurses actively implement health equity at the individual level in the ED. The goal of this research on the ED experiences of Black Muslim women has been to further understand the healthcare experiences of this group and the intersecting identities that shape their interactions with the healthcare system (Chauhan et al., 2020).

Considerations for Knowledge Dissemination and Translation

Current literature shows a critical need to develop and improve culturally safe healthcare for minority populations (Yeasmeen et al., 2022). In an increasingly diverse Canadian society, healthcare professionals have a social responsibility to be aware of the unique needs of different patient populations and the systemic issues that impact their health outcomes. Without this awareness, nurses cannot provide "safe, compassionate, competent, ethical care" (Canadian Nurses Association, 2017, p. 11) to which they are professionally bound when serving diverse patients.

The findings of this study reveal the critical need for policy reforms to address the unique challenges faced by Black Muslim women in healthcare systems (Jefferies et al., 2022). Based on the findings, nurses and other allied health professionals can improve practice in a variety of ways. Promoting cultural safety by engaging in critical self-reflection, recognizing and addressing unconscious biases, advocating for effective communication practices, implementing available health equity-promoting policies, increasing minority representation among staff, and strengthening patient advocacy can

all contribute to better healthcare experiences for marginalized populations (Curtis et al., 2019).

Furthermore, policies aimed at enhancing workforce diversity by recruiting and retaining Black, Muslim, and Black Muslim healthcare professionals can create a more compassionate and inclusive patient environment (Ding et al., 2018). Policies should also support the presence of patient advocates, particularly for immigrants and those facing language barriers, to help all patients navigate the healthcare system effectively and advocate for their needs (Abdillahi & Shaw, 2020).

Provincial efforts should focus on cultural safety and update continuous education programs for staff members to understand the cultural, religious, and gender identities of patients, based on evolving literature on health equity (Abdillahi & Shaw, 2020). Healthcare providers should be encouraged and trained to engage in effective, friendly, and receptive communication, tailoring care to the specific needs of Black Muslim women (Abdillahi & Shaw, 2020). This includes addressing considerations related to modesty, dietary restrictions, and religious practices.

Developing clinical practice standards that address the unique healthcare needs and concerns of Black Muslim women in emergency settings is key to improving care (Mohamed, 2017). Furthermore, it is critical to engage with Black Muslim communities and other populations to learn from their healthcare experiences. It also serves as a tool for continuous improvement in care delivery and helps develop a tangible relationship between healthcare professionals and their patients (Simonovich et al., 2022). The availability of readily accessible patient advocates or cultural liaisons at healthcare facilities is crucial, particularly for new immigrants or in instances when a language

barrier exists (Simonovich et al., 2022). This study supports prioritizing such resources province-wide as urban centers are more well-resourced in this respect, yet rural and remote areas face the challenge of reduced funding and access in Alberta (Opoku, 2009). Patient advocates play an essential role in facilitating communication between patients and healthcare providers, ensuring that patients' needs and concerns are understood and addressed accordingly (Curtis et al., 2019).

Applying these knowledge translation strategies for policy and practice can help healthcare systems move closer to providing equitable, respectful, and culturally competent care for Black Muslims, potentially leading to improved outcomes and experiences. Recognizing the barriers Muslim women face, as revealed through qualitative research on their lived experiences, is essential for promoting health equity among this population. Understanding the specific needs of Muslim women can facilitate the translation of knowledge into clinical practice guidelines and initiatives. These efforts aim to educate healthcare providers, helping them better understand and serve Black Muslim women more effectively, with consideration for their complex social and cultural backgrounds. According to Allamby et al. (2022), enhancing cultural safety through training, education, and policy initiatives is crucial to addressing the unique challenges faced by Black Muslim women. Reflecting on the suggestions and recommendations from this study will help EDs across Alberta become more welcoming and inclusive for marginalized populations seeking emergency care (Abdillahi & Shaw, 2020).

Strengths and Limitations

The current study has various strengths, especially in regard to its methodology. The qualitative approach allowed for an in-depth and complex comprehension of the

investigated phenomena, providing insights into participants' experiences across different historical and social contexts (Taherdoost, 2022). The flexibility of this approach allowed for the exploration of complex issues, which made it a significant asset to the study. Semi-structured interviews, therefore, enriched the study through allowing in-depth discussions. The focused objective of the study, the target sample being discussed, my positionality as a researcher, and the analytical rigor implemented in qualitative analysis all provide further strength to the study.

A qualitative approach was particularly well-suited for examining the experiences, beliefs, and perceptions of participants. It proved especially suitable for exploring the experiences of Black Muslim women and analyzing their experiences, daily realities, and the socio-cultural dynamics influencing their healthcare experiences. This approach allowed for the identification of subtle barriers and enablers not easily captured by quantitative methods. Furthermore, it facilitated a comprehensive exploration of the lived experiences of Black Muslim women in the Canadian context, providing a rich and detailed description of their experiences (Taherdoost, 2022).

The use of semi-structured interviews as a data collection method aligned with the ID approach, enabling the gathering of rich descriptions of participants' experiences and narratives. This approach allowed me to capture the depth of the participants' experiences in a comprehensive manner (Thorne et al., 2004). The qualitative methodology also facilitated the exploration of thematic areas of interest in this study, thus keeping the research aligned with its intended purpose. Semi-structured interviews were instrumental in uncovering the "real meanings of the actions" described by participants (Thorne et al., 2004).

Another strength of this study is its focus on the intersections between Black Muslim women's identities and their access to EDs in Alberta, alongside considerations of gender, race, religion, and the surrounding social constructs impacting their experiences. Emphasizing intersectionality allowed for a deeper understanding of the target population's experiences, showcasing the power of qualitative research in analyzing complex situations. The insights gained from the participants' experiences provide evidence for the importance of leveraging human experiences as one of many tools to enhance clinical practice. The study also benefited from strong analytical rigor through the application of interpretive thematic analysis. The iterative process of refining conclusions, codes, and ultimately themes, utilizing a constructive and interpretive approach, laid a solid analytical basis for the concepts presented. Employing these methods for data analysis demonstrated systematic parallel processing in the analysis phase, enhancing the study's analytical rigor and supporting the reliability of its findings.

However, this research has key limitations, including its geographical scope and the inherent constraints of a master's thesis, which may not be able to cover the full depth and breadth of the women's experiences or offer an extensive analysis (Joanna & Helen, 2014; Pannucci & Wilkins, 2010). Different research methodologies inherently carry their own limitations (Taherdoost, 2022). The study was geographically limited to Alberta, Canada. Therefore, the findings of this research and this analysis on Black Muslim women are limited to the social, political, and geographic nuances of this specific region. The experiences of Black Muslim women may be similar, but the action strategies and determinants of health mentioned in this analysis to promote their health may not be

applicable widely. Thus, the findings may not fully apply to broader contexts or to other settings and populations.

Conclusion and Final Reflections

The purpose of the current study was to explore the experiences of Black Muslim emergent patients in Alberta to document the challenges they face and identify potential improvements to their care by medical practitioners. According to the PHPM, it is evident that the primary determinants of health are multifaceted, including race, religion, and gender, all of which significantly influence accessibility to and quality of healthcare. The findings highlight critical challenge areas such as communication barriers, mistrust towards healthcare practitioners, insufficient cultural and religious competence in healthcare service provision, and systemic obstacles hindering effective access to or utilization of care. These insights point to actionable measures for healthcare professionals to enhance trust in healthcare relationships, normalize and increase discussions about healthcare concerns, and adopt patient-centered approaches that consider the social conditions impacting patients' health.

To address the wider social determinants of health, strategies must extend beyond the clinical setting to consider factors such as institutional racism and other systemic influences on health. This approach provides a comprehensive framework for improving health outcomes for Black Muslim women. The study's findings contribute to existing literature that provides insight into inclusive care that respects each unique need concerning Black Muslim women in practice. These findings, reflections, and analysis also commence an important conversation for nurses and allied health professionals on what providing culturally safe care means for Black Muslim women. The data can be

used to support conversations in nursing education, policy, and practice. By shedding light on the specific challenges and risks faced by Black Muslim women in emergency healthcare settings, this study contributes valuable insights towards fostering a more inclusive and dynamic healthcare system. Implementing the recommended strategies could guide healthcare toward achieving equity, with care that is patient-centered, compassionate, and indifferent to race, religion, or gender. Finally, I found that my position as an "insider," a Black Muslim woman and nurse researcher investigating healthcare experiences within my own community, significantly enhanced the depth and richness of the study. My shared identity with participants created what Asselin (2003) described as a unique opportunity for authentic data collection and nuanced cultural interpretation. This positioning proved particularly valuable when exploring sensitive aspects of healthcare interactions, as participants shared their experiences with me as someone who inherently understood the complexities of navigating healthcare systems with intersecting marginalized identities.

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Appendix A: Trauma-Informed, Socially Just Research (TISJR) Framework Application Inventory

Table 1:
Trauma-Informed, Socially Just Research (TISJR) Framework Application Inventory

Stage of Research	Priority Tenets of TISJR Framework	Guiding Questions for TISJR Framework Application
Pre-study	Sociopolitical, cultural, and historical context; peer support; transparency	What systems of privilege and oppression at the micro, meso, exo, and macro levels could affect your study (for example, study staff, population, sociocultural/historical context)? How could these dynamics promote or violate the assumptions of healing-centered engagement? Are there any ways to mitigate violations of key assumptions?
Study design	Safety; transparency; empowerment, voice, and choice; centralization of participants' identities	Does the study design consider the goals of the study while still promoting safety, transparency, and choice among participants? Does the study design consider the goals of the research study while centralizing the lived experiences and identities of participants?
Recruitment	Safety, transparency, shared power, collaboration	Is the recruitment process transparent? Do protocols and procedures reduce power differentials and promote collaboration between participants and those involved directly or indirectly with the study? Is the study team prepared to discuss their social location in the context of the sociopolitical, historical context relative to the social location of participants?
Informed consent	Empowerment, voice, and choice; transparency	How can we promote agency, choice, and control during the informed consent process? Do documents and procedures protect against potential challenges for trauma-exposed populations (for example, cognition overload)? What elements of this process might threaten the safety (psychological, physical) of participants? What changes can be made to make the process more transparent?
Data collection	Safety, building and maintaining trust	What threats to safety can we anticipate for participants and study staff? How can safety and security be addressed while collecting quality data? Is the study team equipped to maintain and promote emotional and behavioral regulation with participants?
Post–data collection	Safety; empowerment, voice, and choice	How will participants who have given their time to share deeply personal information be acknowledged? Which tools to assess participants' stress levels are most appropriate for the study context? What resources are available to empower participants post-study?

Note. Adapted from "Using a Trauma-Informed, Socially Just Research Framework with Marginalized Populations: Practices and Barriers to Implementation," by L. A. Voith, T. Hamler, M. W. Francis, H. Lee, and A. Korsch-Williams, 2020, *Social Work Research, 44*(3), p. 5, https://doi.org/10.1093/swr/svaa013. Copyright 2020 by Oxford Academic

Appendix B: Interview Guide

Interview Guide:

Introduction:

Welcome to this interview! This research aims to understand Black Muslim women's experiences in Alberta emergency departments and explore how healthcare providers can better support their patients. Thank you so much for agreeing to be part of this study. Your contribution is greatly appreciated.

The research question for this study is, "What are the experiences of Black Muslim women who have received emergency department care in Alberta?" We seek to learn about your experiences with emergency department care, including any challenges or positive aspects you have encountered.

We want to acknowledge that sharing your experiences may be sensitive and challenging, and we want to assure you that we are trained in trauma-informed care practices. We want to create a safe and supportive space for you to share your experiences, and we encourage you to take breaks at any point during the interview if you need to.

The interview will last between 45 minutes to 1 hour and will be audio-only through this Zoom call, so please ensure your camera is off. The interview will be recorded to ensure accuracy in our research, but your confidentiality and anonymity will be protected.

If you have any questions before we begin, please feel free to ask.

The interview will be open-ended in alignment with Interpretive Description's prescribed interview style, it will generally follow the below guide. Unique probing questions based on each participant's experience may be asked. Under each question, potential probing questions have been added to ensure depth.

The structure of each question is shown below:

1. *Question Probing questions*

Acronym: ED for Emergency Department

***Questions*:**

1. I'd like to learn more about your most recent ER visit or an ER visit that stood out to you most in the last five years. Why did you initially decide to go to the emergency department? What factors influenced that decision?
    a. Did you consider or attempt to go to your family physician, a Medicentre, a nearby walk-in clinic, urgent care, etc., before coming to the ED?
    b. How did you get to the emergency department? Was transportation/arranging to come/arranging to stay a difficult issue? What were your supports? Have you been to the emergency department for a non-emergent reason before? Can you tell me more about what factors influenced that decision?

c. Why did you decide to go to the ED instead of (your family physician, a Medicentre, or a nearby walk-in clinic, urgent care, etc.)?
d. Before coming to the ED, did you attempt to access any of the services mentioned earlier?

2. Can you tell me about your experiences arriving at the ED? What were your supports at that moment?
    b. What were you hoping for when a nurse first saw you?
    c. What were your needs at the moment at triage? Did you feel that they were met/addressed?
    d. Were you able to effectively communicate your needs?
    e. Did you feel heard, acknowledged, and believed at that moment?
    f. What would have made your triage experience better?
    g. Can you tell me about your experience in the waiting room?
    h. What were your thoughts in the waiting room?
    i. Were there any symptoms that needed to be managed while you were waiting in the waiting room, and were those addressed?
    j. Were you able to communicate your needs effectively? Did you feel comfortable doing so?
    k. What would have made your waiting room experience better as a Black Muslim woman?

3. Can you tell me about your experience in your assigned room inside the ED? From being called to come inside to your room to before discharge.
    a. What was your experience like with the nurses? What were you hoping for?
    b. Were you able to communicate your needs? Were they effectively communicating a plan with you? Did you feel heard?
    c. Were they effectively communicating why they were doing any care they were doing for you? Were your needs met?
    d. What went well? What did not go well?
    e. What was your experience like with the physician? What were you hoping for? Were you able to effectively communicate your needs? Did you feel heard? Was the reason you came to the ED addressed by the physician? Were your needs met in the moment? What went well? What did not go well?
    f. Was there any other staff involved in your care? (Ambulance, X-ray, Radiology, Porters, Healthcare aides, Student nurses or UNEs, Social workers, and other allied health professionals) What were your experiences like with them? Did you feel heard? Were your needs met?

4. Can you tell me about your experience being discharged from the ED?
    a. What or who were your supports at the point of discharge?
    b. Were you discharged home or sent to another unit within the hospital?
    c. Were you able to effectively communicate your needs to the nurse, physician, or other staff as you were getting ready for discharge?
    d. Was your care while in the ED explained to you effectively and in full?

e. Were you provided with a full explanation and understanding of what care you needed after discharge or what the plan was? Were you provided with sick notes/prescriptions/forms as required?
f. Did you feel safe going home? What were your supports as you left the hospital?
g. What were your needs as you were being discharged? Were your needs met?
h. Were you told to follow up or book further testing somewhere? Were there any gaps that you were facing that would make it difficult for you to do follow-ups addressed by anyone caring for you?
i. Were you connected to any resources outside of the hospital for your needs?

5. During your ED visit, did you feel at any point that your cultural or religious beliefs were respected during your visit?
    a. Were your cultural or religious beliefs considered or accommodated in the ED setting?
    b. Were your cultural or religious practices respected in the ED setting?
    c. Do you feel that Emergency Department staff were knowledgeable and sensitive to the unique needs of Black Muslim women? Describe how they were or were not.
    d. What specific challenges or obstacles have you faced as a Black Muslim woman in Emergency Departments?
    e. How do you think the experiences of Black Muslim women in Emergency Departments could be improved?
    f. Do you have any recommendations for how Emergency Departments can better serve the needs of Black Muslim women?