DEVELOPMENT OF AN INSTRUMENT TO MEASURE THE ATTITUDES OF NON MUSLIM HEALTH CARE PROVIDERS TOWARD THE MUSLIMS

A THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
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IN THE GRADUATE SCHOOL OF THE
TEXAS WOMAN'S UNIVERSITY

COLLEGE OF HEALTH SCIENCES

BY
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11 - 04 - 1997

To the Associate Vice President for Research and Dean of the Graduate School:

I am submitting herewith a thesis written by Fatemeh Youssefi by " Development Of An Instrument To Measure The Attitudes Of Non Muslim Health Care Providers Toward The Muslims ". I have examined this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree Master of Science with a major in Health Studies.

William B Cissell

We have read this thesis and recommend its acceptance:

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Accepted

Leslie M Thompson

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DEDICATION

I would like to dedicate this work to Asghar, Maryam, and Reihaneh. They supported me with their love and patience every step of the way.

ACKNOWLEDGMENTS

First, I would like to thank Allah for giving me the strength to complete this study.

I wish to thank my chairperson Dr. William Cissell for his guidance, time and support throughout this work and to my committee members, Dr. Susan Ward and Dr. Eva Doyle, who both provided extensive help and support in my work. I have been honored to have a team of three experts as my committee members.

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ABSTRACT

COMPLETED RESEARCH IN HEALTH SCIENCES
Texas Woman's University

Youssefi, F. Development of an Instrument to Measure the Attitudes of Non Muslim Health Care Providers Toward the Muslims. M. S. in Health Studies, 1997, (W. Cissell)

Due to an increased population of Muslims in the United States, health care providers are challenged to consider the aspect of culture when providing care to a Muslim. The conflict of values between the health care provider and the patient may cause tension. A review of literature revealed a lack of instruments to measure the attitudes of non Muslim health care providers toward Muslims. This study was conducted to establish reliability of an attitude instrument designed to measure attitude of non Muslim health care providers toward Muslims. The instrument consisted of 24 statements on the attitude scale and eight statements on the contact inventory. An expert panel of six Muslims and non Muslim health care providers reviewed the statements and the investigator changed the statements on the questionnaire as recommended. Copies of the

instrument were distributed to a convenience sample of 46 health care providers in a north Texas teaching hospital. Twenty- four participants responded to the questionnaires on two different occasions for a test - retest reliability measurement. A Cronbach's alpha coefficient was computed for the attitude scale using the first set of responses. The alpha value was .26. After reviewing the statements, 9 of the 24 statements with negative alpha were deleted which then changed the alpha value to .83. The test - retest result on the attitude scale with 24 statements was .79 and on the remaining 15 statements was .84. Further studies are needed to further explore the reliability of this attitude instrument.

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CHAPTER I

INTRODUCTION

Historically, policy makers in the United States have viewed itself as a melting pot of many peoples. They denied the uniqueness of the various cultures. This ideology extended to health care providers. In a sense, health care providers care for individuals but responded to treatment policies all in similar ways. They tended not to consider the individual's particular cultural background (Spector, 1996). However, throughout the years, there have been authoritative reports in the professional literature which states that under - standing one's culture, when promoting positive health seeking behavior (Mo, 1992), increases individual use of available services (Bowes & Domokes, 1993).

Provider confrontation of the individual's values may cause unnecessary tension (Klessig, 1992). When a provider views a treatment as necessary one and the patient resists the treatment, a health care provider experiences frustration (Molloy, 1980). Health care providers should make an effort to understand the cultural background of those for whom they provide care. Exerting the necessary effort is particularly challenging if one has a bias

against a particular culture. Therefore, one may have to assess his/her own feelings and attitudes toward a specific population and their beliefs (Foster, 1996).

Islam is the fastest growing religion in United States. Experts predict that Islam will become the second largest religion, with the first being Christianity (Sapp & Gables, 1996). For a Muslim, Islam is not only a religion but also a way with which one deals with every day life. To adequately address the health and medical needs of Muslims, health care providers including physicians, nurses, dietitians, and other members of health teams plan or modify traditional health practices. Successful delivery of health care for Muslims requires new knowledge and skills. However, the attitude of health care providers may play an even greater role in satisfying the health and medical services needs of this sub population. An accurate assessment of health care providers' attitudes prior to planning any effective health education program is apt to contribute to its success.

This study was designed to develop an instrument to measure the attitudes of health care providers; including physicians, nurses, and dietitians; toward the Muslim population.

Purpose of the Study

The purpose of this research was to develop an instrument for measuring the attitudes of non Muslim health care providers in North Texas toward

immigrated Muslims and their descendants.

Research Question

The research question for this study was: Does the attitude instrument reliably measure the attitudes of the health care providers toward the Muslims?

Definition of Terms

For the purpose of this study, the terms listed below were defined as follows:

1. Attitude. A recognized or unrecognized feeling toward something which determines how one would act when encountering this entity (King & McGinnies, 1972).
2. Culture. The existing norm within a population (Matiella, 1994).
3. Fasting. Avoidance of food or drink during Ramadan.
4. Hajab. An Arabic term describing a cover (i.e., Muslim woman's head cover).
5. Health care provider. A health or medical professional (i.e. physician nurse, or dietitian).
6. Immigrated Muslim. Anyone who immigrated to the United States and practices Islamic religion.
7. Muslim. A person who practices Islamic religion.
8. Muslim's descendent. Child of immigrated Muslim to USA.

9. Non Muslim Health care provider. A health or medical professional who is not Muslim.
10. Ramadan. Holy month in Islam.
11. Reliability. Consistent and repeatable result after administrating a test two or more times and internal consistency within the test.
12. Validity. Term that means a scale measures what it is intended to measure.

Limitations

Due to sample selection and instrument design, the results would only reveal the perceptions of health care providers toward Muslims.

Delimitation

The study would be delimited to health care providers in the North Texas area.

Assumptions

For this study the following assumptions were made:

1. The participants will answer the questions to the best of their ability.
2. Each health care provider will have the proper credentials required by the State of Texas to function as a health care provider.
3. Attitudes can be accurately measured.

CHAPTER II

LITERATURE REVIEW

The importance of culture as a causative factor of health status and health behavior has been discussed in the literature. Therefore, researchers need to focus on the concept of culture when describing providers' attitudes toward their patients. The providers' perceptions tend to be communicated to the patients and influence the use of health care services by them. Perceptions of the individual toward a health care provider play an important role in health care seeking behavior. For example, the perception of being ignored or being considered inferior when being cared for by a member of the dominant culture is discouraging. These behaviors may be caused by racism or merely be a commonly accepted behavior pattern within the dominant culture. However, this is likely to result in a negative effect in the health care seeking behavior of the minority person (Bowes & Domokes, 1993).

There are several findings reported in the literature which indicate that cultural differences must be considered when treating a patient (Spector, 1996; Caudle, 1993; EL-Islam & Abu-Dagga, 1992). Sometimes western - trained

doctors fail to deliver or delay treatment because of cultural misconceptions (EL-Islam & Abu-Dagga, 1992). When a provider looks at a religious practice or cultural behavior as a barrier (Nanji, 1992), ultimately a conflict will be created between the provider and the individual (Foster, 1992).

Misunderstanding the health orientation and health practices within a certain sector of the community is likely to create conflict between a patient and health care providers. Health care providers are challenged by the need to develop or increase their skill in intercultural communication and assessment of a diverse population. This requires a determined effort to comprehend the dynamic of a culture distinctly different from one's own culture when providing care. Exerting the necessary effort is particularly challenging if one has a bias against a particular culture. Therefore, one may have to assess his/her own feelings and attitudes toward a specific population and their beliefs (Foster, 1996).

Each health care provider brings their own culturally based values into their practice (Spector, 1996). The conflict of these values and those of the patients may cause unnecessary tension (Klessig, 1992). However, those health care providers who acknowledge the cultural differences and view these differences as a positive challenge will have a more successful result (Marin et al, 1995).

The concepts of health and health practice are not always defined the same way in all the cultures. For example, the issue of patient autonomy is not important within some nonwestern cultures (Klessig, 1992). Also western treatment is not always suitable for an individual who adheres to a nonwestern life style (Ibraihm & Ibraihm, 1993). When a provider views a treatment as the necessary one and the patient resists the treatment; a health care provider experiences frustration (Molloy, 1980).

Every individual needs to be treated according to his/her unique belief system (Klessig, 1992). The issue of individuality within the context of culture does not mean that every health care provider needs to provide their exclusively according to specific cultures. It simply suggests attention be given to an individual with courtesy, understanding, and attention to specific needs of that individual (Matiella, 1994). There are areas such as death and dying, abortion, organ transplant, and many more in which a health care provider may need to extend beyond his/her own belief in order to provide individualized care (Molloy, 1980).

One minority in the United States is the Muslim population. Islam is the fastest growing religion in United States. According to experts, Islam is

projected to eventually become the second largest religion in this country (Sapp & Gables, 1996). For a Muslim, Islam is considered more than just a religion. It is a framework and foundation for life-style, social interaction, and health practices (Sutherland & Morris, 1995). There are rituals within the Islamic religion which are unique to this population. These rituals include: Ramadan (holy month of fasting from sunrise to sunset), five prayers during twenty four hours, Hajabs (although there are different types of Hajab in Islam, this study will focus only on the Hajab of women wearing a head cover), death and dying, organ/tissue donation, relationship with the extended family, dietary consumption and many other issues (Quomi, 1978).

Traditional Muslims have a sense of respect for health care providers. In Islam, public welfare and charitable works for the poor are highly valued. The health care providers have assumed these roles by becoming care givers. Therefore, for Muslims, patient autonomy in medical decisions is not important. To Muslims, physicians have the obligation to treat patients to the best of their ability (Nanji, 1988). However, many physicians of western cultures view Muslims as not interested in making health decision (Molly, 1996).

Muslim immigrants to the United States have different needs as other existing cultures within this country. Muslims practice their religion according to their holy book, Quran (Quomi, 1978). However, the degree that one practices

one's religion differs among individuals within their own culture. It is extremely important for health care providers to become acquainted with individual preferences within a particular cultural context (Klessig, 1992).

CHAPTER III

METHODOLOGY

In describing methodology of this study, the setting, protection of human subjects, selection of the sample, procedures for collecting the data, development of the instrument, and methods for establishing validity and reliability are presented.

Setting

The study was conducted at a north Texas teaching hospital. This teaching hospital was chosen due to the high volume of diverse cultures represented among its clients. The teaching hospital provided not only inpatient care but also outpatient care and extended care to community based clinics.

The investigator chose two inpatient areas, five outpatient areas, one dietary area, and two community based clinics for distribution of the questionnaires. Also, the investigator was responsible for distributing the questionnaires and collecting some of the questionnaires and receiving others mailed to the investigator through the hospital interoffice mail service.

Protection of Human Subjects

Permission to conduct this study was obtained from the institution through the Corporate Communications department of the hospital. The approval of the data collection procedure was also obtained from the Human Subjects Review Committee at Texas Woman's University (Appendix A).

The participants were asked not to disclose their identity or place of employment. All participants were informed in writing that their identity would be kept confidential. The investigator designated a number on the left side of the questionnaire and documented the number with the participant's name on a separate form. Also, the investigator kept the number form and participant's name in her possession.

Population and Sample

The study was conducted with a convenience sample of health care providers. These included nurses, physicians, and dietitians who provide health care for individuals. The participants were health care providers who practiced in the selected north Texas teaching hospital. Each participant was asked not to complete the questionnaire if she/he was a Muslim or practiced Islamic rituals.

The size of the sample was targeted for 20 participants. Due to an anticipated failure to respond on the parts of some questionnaire recipients, the

investigator distributed forty- five questionnaires to a convenience sample in the selected areas. The completed questionnaires were returned to the investigator within the range of two hours to three days. Only 24 completed questionnaires were returned to the investigator.

Procedure to Collect Data

The investigator compiled a booklet which contained the introduction letter, items for collection of demographic data, an attitude scale, and contact inventory. This booklet and a self addressed envelope or interoffice mail envelope were placed in a larger envelope for distribution. These questionnaires were delivered by the researcher to the subjects in their places of employment; inpatient, outpatient, dietary, and community based clinics.

Subjects who chose to participate in the study wrote their name on a separate form along with the designated number on the questionnaire next to their name. Permission to use the interoffice mail was obtained from the Corporate Communications department.

After completion of the first questionnaire, a second identical copy of the questionnaire was administered to each subject one week later by using the corresponding number on the questionnaire. By this means, the response to the first questionnaire could be compared with that of the second questionnaire.

Development of the Instrument

The instrument used during the study consisted of an introduction letter (Appendix B), an attitude and a contact inventory and several items for collection of demographic data (Appendix C). The scale was the Attitude Toward Muslims by Health Care Provider. The Attitude Scale and the Contact Inventory were a modified version of the Attitude Toward Disabled Persons and the Contact with Disabled Person Scale which were designed by Yuker, Block, and Younng (1970) and Yuker and Hurley (1987) respectively.

The Attitude Toward Muslims by Health Care Provider Scale was composed of 24 statements which were 6 - point Likert - type statements. The participants were to respond to each statement with a different level of "Agreement or Disagreement." There was no neutral response (Appendix D).

The Contact with Muslims Inventory consisted of 8 statements which were 5 - point Likert - type statements. These statements assessed the frequency of contact which the participant had previously with Muslim persons (Appendix E). The investigator excluded any double-barreled statements which refers to those statements that have negative and positive comments within a statement (Oppenheim, 1960).

The Method Used for Establishing Validity and Reliability

The demographic page, the attitude scale, and the contact inventory were given to an expert panel for review in order to establish the content validity of the questionnaire prior to administration. The expert panel consisted of a Muslim doctor, Muslim dietitian, non Muslim doctor, non Muslim dietitian, and two non Muslim nurses. The expert panel received the booklet by facsimile.

The expert panel supported the content the original version of the demographic data page and the Contact Inventory. However, a few changes were suggested for the Attitude Scale. These suggestions are as follows:

1. On the statement which indicated that "Muslims should participate in social activities more frequently", the expert panel suggested that the statement needs to be omitted or clarified. The investigator chose to eliminate this statement.

2. On the statement which indicated that "Muslims do not worry any more than anyone else", two of the experts suggested to rephrase the statement as "Muslims have difficulty expressing their feelings." This was done.

3. The experts recommended changing the statement, "Health care providers should not be allowed to prevent care due to Muslims health practice," to "Health care professionals should not limit their care due to Muslims health practice." This was done.

4. The experts recommended that the statement, " Muslims are generally not as happy as others" be changed to "Muslims comply with health professionals advice". This was done.

5. The experts recommended that the statement, "The worse thing is to practice Islamic rituals", be changed to "Islamic rituals are healthy to practice." 2This was done.

6. The experts recommended that the statement, "Most Muslims do not feel sorry for themselves", be changed to "Most Muslims feel they are treated poorly." This was done.

7. The experts recommended that the statement, "Most Muslims have different personality than other people", be omitted or clarified. The investigator chose to omit the statement.

8. The Muslim experts suggested to add the statement "Muslims health standard practices are consistent with my beliefs."

The questionnaire was revised according to the changes suggested by the expert panel (Appendix F).

The questionnaire was administered on two separate occasions using number coding to assure that the subjects' responses on both occasions could be matched. After completion, the investigator performed the Cronbach's alpha test to determine the internal consistency of the instrument (Drummond, 1996).

CHAPTER IV

FINDINGS

The descriptive data, including demographics, the Attitude Scale, and the Contact Inventory, are presented. The investigator used Statistical Package for the Social Sciences (SPSS) and Biomedical Data Package (BMDP) in conducting the data analysis.

Description of Subject

The questionnaires were distributed to a convenience sample among physicians, nurses, and dietitians. Out of the 24 returned questionnaires, 2 physicians, 2 dietitians, and 20 nurses completed the questionnaires. The length of their work experience varied from 2 months to greater than 20 years. The age variation was between 24 years and greater than 60 years of age.

Description Analysis of the Attitude Scale

Each questionnaire was randomly assigned an identification number before the data from it was entered into the computer. Each Likert - scale item response was recorded as a number from one to six in order to rank the

response: Agree Very Much = 1, Agree Pretty Much = 2, Agree A little = 3, Disagree A Little = 4, Disagree Pretty Much = 5, Disagree Very Much = 6. After all the data were entered into the computer, the Cronbach's Alpha (alpha coefficient) was computed for the Attitude Scale to establish the internal reliability of the scale. The alpha value on the 24 statements, which are referred to as Items, was .26. Table 1 presents the items, corrected item - total correlation, and alphas if items deleted are presented. The items which resulted in negative alpha values included: "Muslims have a hard time being told of poor prognosis.", "Very few Muslims are ashamed of their health practices.", "Health care professionals should not limit their care due to Muslims health practice.", "Muslims comply with health professionals advice.", "Islamic rituals are healthy to practice.", "Muslim children should not practice their Islamic rituals in school.", "Most Muslims don't want more affection and praise than other people.", "Muslims health standard practices are consistent with my beliefs.", "I approve the health habits of the Muslims."

Table 1

Item - total Statistics / 24 statements

Items	Corrected Item - Total Correlation	Alpha if Item Deleted
Item 1	.4242	.2028
Item 2	.3366	.1820
Item 3	-.3390	.3729
Item 4	.4231	.2077
Item 5	-.1580	.3257
Item 6	.3018	.1755
Item 7	.4427	.1389
Item 8	.4947	.1287
Item 9	.1615	.2197
Item 10	-.4109	.3891
Item 11	-.4863	.3848
Item 12	.1625	.2218

Table 1 (continued)

Item - total Statistics / 24 statements

Items	Corrected Item - Total Correlation	Alpha if Item Deleted
Item 13	.3797	.1698
Item 14	.3421	.1790
Item 15	.1198	.2411
Item 16	-.6067	.1090
Item 17	-.3006	.3485
Item 18	-.1183	.3122
Item 19	.3343	.1816
Item 20	.1883	.2215
Item 21	.4755	.1271
Item 22	-.0942	.3016
Item 23	-.1842	.3362
Item 24	-.5239	.4083

Based on Table 1, the investigator decided to delete the negative statements. The resulting, corrected item - total correlation, and alphas if item deleted are presented in Table 2.

Table 2

Item - total Statistics / 15 statements

Items	Corrected Item - Total Correlation	Alpha if Item Deleted
Item 1	.5380	.8216
Item 2	.4678	.8206
Item 4	.3614	.8280
Item 6	.2661	.8355
Item 7	.4847	.8194
item 8	.6680	.8074
Item 9	.5670	.8136
Item 12	.5646	.8136
Item 13	.5989	.8126
Item 14	.2210	.8353

Table 2 (continued)

Item - total Statistics / 15 statements

Items	Corrected Item - Total Correlation	Alpha if Item Deleted
Item 15	.2669	.8323
Item 16	.8002	.8006
Item 19	.3976	.8248
Item 20	.3505	.8277
Item 21	.4065	.8246

The calculated alpha in Table 1 was .26 and in Table 2 was .83. Statistically, the scale with the deleted statements has more internal consistency than the scale with all the statements included. However, further discussion will follow in Chapter V on the reliability of the scale.

The second reliability test performed on the attitude scale was test - retest. The test - retest demonstrated the reliability of the scale as a whole rather than inter-item measurement (Cronbach's alpha). The test - retest was calculated by using BMDP. The correlation between the first and second tests with the 24

statements was .79. However, the correlation between the first and second tests after deleting statements three, five, ten, eleven, seventeen, eighteen, twenty-two, twenty-three, and twenty-four was .83. Therefore, the original scale was statistically less reliable than scale with 15 statements (Portney & Watkins, 1993).

Descriptive Analysis of the Contact Inventory

The contact scale contained eight statements. The health care providers contact with a Muslim ranged from " Never " to " Very Often". Out of 24 providers, 15 responded to " Never " contact with a Muslim.

Summary

After applying the statistical analysis on the attitude scale, the results showed a Cronbach's alpha of .26 on original scale and an alpha of .83 on the 15 items scale. The result for the test - retest on the original scale revealed .79 and on the 15 items scale showed .83.

CHAPTER V

SUMMARY, DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

In describing this chapter, the information will be presented as the follows: (a) summary of the study, (b) discussion of the findings, (c) conclusions and (d) recommendations.

Summary of the Study

The study was designed to develop an instrument to measure the attitudes of health care providers toward Muslims. The purpose of this study was to determine if the instrument is reliable for measuring the attitudes of non Muslims health care providers toward Muslims.

This study was conducted in September and October of 1997. The developed instrument consists of demographic data, the attitude scale, and the contact inventory. The initial forms of the Attitude Scale and the Contact Inventory were the result of modifying existing previously developed instruments by Yuker, Block, and Younng (1970) and Yuker and Hurley (1987). The sample selection was based on a convenience sample of health care providers in the north Texas area. The content validity of the instruments was established

through use of an expert panel of Muslims and non Muslim physicians, dietitians, and nurses. Twenty - four questionnaires were returned to the investigator out of 46 distributed.

Discussion of the Findings

Two tests were selected for assessing the reliability of the instrument, Cronbach's alpha and test - retest correlation. Cronbach's alpha, which determined the inter-item reliability of the Attitude Scale was calculated by using SPSS. The obtained Attitude Scale alpha value first was .26. This was based on the original scale which consisted of 24 statements. The alpha value found on the revised 15 items scale, after deleting nine from the original 24 was .83.

The test - retest result was performed on the questionnaires by using BMDP for the Attitude Scale. The test - retest was performed to establish the consistency of the scale as a whole. The test - retest result on the Attitude Scale with the initial 24 statements was .79, and on the revised 15 items scale it was .83.

Conclusions

A review of the literature shows that the attitudes of the health care providers toward a specific population may promote or hinder that population's health seeking behaviors. Health care providers must consider one's culture when providing care for these patients. However, when the patient's belief is

contrary to the health care provider's belief, there maybe tension. Based on Islamic beliefs, providing care to one is a holy act, many Muslims accept the opinion of the health care provider out of deference to a religious authority. This contributes to considerable risk that Muslims patients will decline to provide all information necessary for accurate diagnosis and treatment to a health care professional.

In order to assess the attitudes of the health care providers toward Muslims, the investigator designed an instrument. The research question for this study was: Does the attitude instrument reliably measure the attitudes of the health care providers toward Muslims? Reliability of the instrument was estimated by Cronbach's alpha and test - retest correlations on the Attitude Scale.

The inter-item reliability on the initial version of the instrument indicated a low alpha value of .26, which is considered an unreliable instrument. After deleting the statements which had negative correlations , the reliability increased to .83. The test - retest on the initial version of the instrument resulted in a statistically moderate correlation. Therefore, the initial version of this instrument did meet the statistically accepted test - retest correlation; however, the alpha value was low (Portney & Watkins, 1993). The second version had an acceptable alpha value reflecting internal validity.

Recommendations

The following recommendations will assist in the further exploration of the Attitude Scale:

1. The validity of the instrument with only 15 statements on the Attitude Scale needs to be established.

2. The Attitude Scale must be subjected to a pilot study in order to establish reliability.

3. Use of an interview technique along with a questionnaire may be a more reasonable option.

Summary

The designed instrument needs to be redesigned and further evaluated. Statistically, the instrument with 15 items has a good correlation with a good alpha value (Portney & Watkins, 1993). For a instrument to be fully validated and proven reliable, many years of testing are required (Burns & Grove, 1987).

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APPENDIXES

APPENDIX A

Human Subjects Review Committee Approval

TEXAS WOMAN'S
UNIVERSITY

DENTON/DALLAS/HOUSTON

HUMAN SUBJECTS
REVIEW COMMITTEE
P.O. Box 425619
Denton, TX 76204-5619
Phone: 817/898-3377
Fax: 817/898-3416

August 1, 1997

Ms. Fatemeh Youssefi
P.O. Box 2622
Coppell, TX 75019

Dear Ms. Youssefi:

Your study entitled "Development of Attitude of Health Care Provider Toward Muslims Scale" has been reviewed by a committee of the Human Subjects Review Committee and appears to meet our requirements in regard to protection of individuals' rights.

Be reminded that both the University and the Department of Health and Human Services (HHS) regulations typically require that agency approval letters and signatures indicating informed consent be obtained from all human subjects in your study. **These consent forms and agency approval letters are to be filed with the Human Subjects Review Committee at the completion of the study. However, because you do not utilize a signed consent form for your study, the filing of signatures of subjects with the Human Subjects Review Committee is not required.**

Your study was determined to be exempt from further TWU HSRC review. However, another review by the Committee is required if your project changes. If you have any questions, please feel free to call the Human Subjects Review Committee at the phone number listed above.

Sincerely,

Glenn Engelbrecht

Chair
Human Subjects Review Committee

cc. Graduate School
Dr. William Cissell, Department of Health Studies

APPENDIX B

Introduction Letter

Introduction

The purpose of this study **to develop an instrument to measure health care providers attitudes toward Muslims. Participation in this study is voluntary. The confidentiality of the institution and participant will be maintained.** Participants will be asked not to disclose their identity or place of employment. The investigator will keep all the collected data in her possession.

The questionnaire will be administered in two different periods of times by using number coding on the questionnaire.

The first page in the booklet is demographic data. The next page provides statements regarding attitudes.

Please do not complete the questionnaire if you are a Muslim or practice Islamic rituals.

Please refer to the following statement:

" I understand that the return of my completed questionnaire constitutes my informed consent to act as a subject in this research."

Thank you for your cooperation,

Fatemeh Youssefi

APPENDIX C

Demographic Data

Demographic Data

Age ----------

Gender : Female ---- Male -----

Occupation ----------

How long have you worked in this position ? ----------

APPENDIX D

The Attitude Scale

Attitude Scale

Instructions: Please place an "X" in the Blanca space below the word that best describes your response to each statement.

	Agree			Disagree		
	Very Much	Pretty Little	A Much	Very Much	Pretty Much	A Little
1. Muslims are usually friendly.	------	------	------	------	------	------
2. Muslims are no more emotional than other people.	------	------	------	------	-----	------
3. Muslims should participate in social activities more frequently.	------	------	------	------	------	------
4. Muslims can be as successful as other people.	-----	------	------	------	------	------
5. Very few Muslims are ashamed of their health practices.	------	------	------	------	------	-----
6. Most health care providers feel uncomfortable when providing care for Muslims.	------	------	------	------	------	------
7. Muslims show less enthusiasm about their health.	------	------	------	------	------	------
8. Muslims are often less aggressive regarding their health than others.	------	------	------	------	------	-----
9. Muslims do not worry any more than anyone else.	------	-------	------	------	-------	------
10. Health care providers should not be allowed to prevent care due to Muslims health practice.	------	-------	-------	-----	------	------
11. Muslims are generally not as happy as others.	------	------	-------	------	-------	------
12. Muslim Women with Hajab (head cover) are difficult people to give care to.	------	------	------	------	------	------

	Agree			Disagree		
	Very Much	Pretty Much	A Little	Very Much	Pretty Much	A Little
13. Muslims expect special treatment.	-----	------	------	------	------	------
14. Muslims should not expect same care as others.	------	------	-------	------	-------	------
15. Muslims should not expect to practice their rituals in health care setting.	------	------	------	------	------	-----
16. Muslims tend to get discouraged easily.	------	------	-------	------	-------	------
17. The worse thing is to practice Islamic rituals.	------	------	-------	------	-------	----
18. Muslim children should not practice their Islamic rituals in school.	------	------	-------	------	-------	------
19. Most Muslims do not feel sorry for themselves.	------	------	-------	------	------	-------
20. Most Muslims prefer to work with other Muslims.	------	------	-------	------	------	------
21. Muslims are not as self-confident as other people.	------	------	-------	------	------	------
22. Most Muslims don't want more affection and praise than other people.	------	------	-------	------	------	------
23. Most Muslims have different personality than other people.	------	------	-------	------	------	------
24. I approve the health habits of the Muslims.	------	------	-------	------	------	------

APPENDIX F

The Revised Copy of the Attitude Scale

APPENDIX E

The Contact Inventory

Contact Scale

Instructions: Please place an "X" in the blank space below the word that best describes your response to each statement.

	Never	Once or twice	A Few times	Often	Very Often
1. How often have you had a long talk with a person who is Muslim?	-----	-----	------	------	-------
2. How often have you had a brief conversation with persons who are Muslim?	-----	-----	------	------	-------
3. How often have you eaten a meal with a person who is Muslim ?	-----	-----	------	------	-------
4. How often have you contributed money to organizations that help Muslims ?	-----	-----	------	------	-------
5. How often have Muslims discussed their social problems with you ?	-----	-----	------	------	-------
6. How often have Muslims discussed their health problems with you ?	-----	-----	------	------	-------
7. How often have you tried to help Muslims with their problems ?	-----	-----	------	------	-------
8. How often have you provided care to a Muslim patient ?	-----	-----	------	------	-------

Attitude Scale

Instructions: Please place an "X" in the Blank space below the word that best describes your response to each statement.

	Agree			Disagree		
	Very Much	Pretty Much	A Little	A Little	Pretty Much	Very Much
1. Muslims are usually friendly.	---	---	---	---	---	---
2. Muslims are no more emotional than other people.	---	---	---	---	---	---
3. Muslims have a hard time being told of poor prognosis.	---	---	---	---	---	---
4. Muslims can be as successful as other people.	---	---	---	---	---	---
5. Very few Muslims are ashamed of their health practices.	---	---	---	---	---	---
6. Most health care providers feel uncomfortable when providing care for Muslims.	---	---	---	---	---	---
7. Muslims show less enthusiasm about their health.	---	---	---	---	---	---
8. Muslims are often less aggressive regarding their health than others.	---	---	---	---	---	---
9. Muslims have difficulty expressing their feeling.	---	---	---	---	---	---
10. Health care professionals should not limit their care due to Muslims health practice.	---	---	---	---	---	---
11. Muslims comply with health professionals advice.	---	---	---	---	---	---

	Agree			Disagree		
	Very Much	Pretty Much	A Little	A Little	Pretty Much	Very Much
12. Muslim Women with Hajab (head cover) are difficult with which to give care.	---	---	---	---	---	---
13. Muslims expect special treatment.	---	---	---	---	---	---
14. Muslims should not expect the same care as others.	---	---	---	---	---	---
15. Muslims should not expect to practice their rituals in health care setting.	---	---	---	---	---	---
16. Muslims tend to get discouraged easily.	---	---	---	---	---	---
17. Islamic rituals are healthy to practice.	---	---	---	---	---	---
18. Muslim children should not practice their Islamic rituals in school.	---	---	---	---	---	---
19. Most Muslims feel they are treated poorly.	---	---	---	---	---	---
20. Most Muslims prefer to be treated by other Muslims.	---	---	---	---	---	---
21. Muslims are not as self-confident as other people.	---	---	---	---	---	---
22. Most Muslims don't want more affection and praise than other people.	---	---	---	---	---	---
23. Muslims health standard practices are consistent with my beliefs.	---	---	---	---	---	---

	Agree			Disagree		
	Very Much	Pretty Much	A Little	A Little	Pretty Much	Very Much
24. I approve the health habits of the Muslims.	---	---	---	---	---	---