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Male Arab-Muslims Health and Health Promotion Perceptions and Practices

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Male Arab-Muslims Health and Health Promotion Perceptions and Practices

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Dedication

This dissertation is dedicated to my family; my father who died when I was a nursing student, he shared a deep commitment for education, my lovely mother who has always believed in me and prayed for me, and to my great wife RANA who has been very supportive, I would never have accomplished this without their love and support.

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Abstract

The Arab Muslim population is one of the dramatically increasing minorities in the United States. In addition to other factors, gender, religion and cultural background influence individuals' beliefs, behaviors, and attitudes to health and illness. Little is known about Arab American male immigrants, how they perceive illness, how they promote their health, and the stressors they experience and barriers they face in accessing the American health care system.

The purpose of this study was to develop knowledge about the male Arab-Muslims' health perceptions and health promotion perceptions and practices. This qualitative exploratory study used a grounded theory approach to gain an understanding of Arab Muslim men's health perceptions and practices within their cultural context.

The research participants were 20 Arab-Muslim men living in Orange County, California. Participants took part in one of four focus groups, conducted in the personal residences of some participants. Each group lasted from one and a half to two hours. Data analysis occurred concurrently with data collection. Tape recordings of each focus group were transcribed immediately, and additional notes were made regarding the date, the time, and the place of the discussion, the age of the participants, other personal and situational characteristics, and events associated with the discussion.

The model presented in this study provides a comprehensive and unique view of health that is particularly pertinent to a subculture living in the United States. The dimensions of health presented in this view include the ability to function, engagement in healthy behaviors, the absence of disease, the sense of control, feelings of spiritual well-being, and body/mind integration.

Participants in this study identified several factors that influence their health and their ability to engage in healthful behaviors. These factors can be categorized as behavioral forces, mental/psychological forces, social forces, and health system forces.

This model presents the experiences of American Arab Muslims males and reflects the stressors they experience, including immigration stressors, family responsibilities, and cultural strain. It also demonstrates how these stressors may affect the health and health-related behaviors of this target population

In order to close the gap between the health of minority and majority populations, an in-depth understanding of health perceptions and health promotion beliefs and practices among immigrant populations in the United States should be used to provide culturally-sensitive health care and health promotion services.

Chapter One

Introduction

Health care is a basic human right and an important aspect of community development. Health promotion is a practical approach to achieving greater equality in health. Health care providers in the United States are facing many challenges; one of which is dealing with multicultural communities. In January 2000, the U.S. Department of Health and Human Services (USDHHS) and the Surgeon General released the nation's health goals for this decade, *Healthy People 2010.* One of the major themes of *Healthy People 2010* is the elimination of racial and ethnic disparities in health status. In response, health care providers need to work on closing the gap between the health of the minority and majority populations (USDHHS, 2000).

The Arab Muslim population is one of the dramatically increasing minorities in the United States. According to a report from the Council on American-Islamic Relations, the estimated total number of Muslims in the United States is 6 to 7 million (Bagby, Perl, & Froehle, 2001). Muslims in the United States come from different ethnic groups or countries of origin: 42% African-American, 24.4% South Asian, 12.4% Arab, 5.2% African, and 3.6% Iranian. There are also small numbers of Muslims from other countries. In the near future, Islam is expected to be the second largest religion in the

United States. In 1930, there were 19 mosques throughout the United States; now there are more than 1200 mosques, 400 Islamic schools, 400 associations, and over 200 publications, journals, and weekly newspapers (Council on Islamic Education [CIE], 2000).

In 1980, U.S. census figures indicated that there were 53,920 Arab immigrants in California; 60% of them were male, and 64% of the Arab American population in California were between 15 and 44 years of age. The educational level of Arab Americans in California was slightly lower than the general population. Fifty four percent of this population reported family incomes less than $20,000, which limited their access to health care and put them at high risk for stress (Laffrey, Meleis, Lipson, Solomon, & Omidian, 1989).

By 2000, U.S. census figures showed 190,890 Arab immigrants in California, a more than threefold increase from 1980. In 2000, 30,000 people of Arab ancestry lived in Los Angeles, and it was ranked the U.S. city with the third largest Arab population, after New York City and Dearborn, Michigan (Cruz & Brittingham, 2003).

Individual perceptions of health and illness are influenced by many factors, such as age, personal experience, education, and socio-economic and other factors. Gender also plays a big role in an individual's health perceptions and beliefs. Socialization into the masculine role affects men's health, beliefs, attitudes, and perceptions. Men believe they are strong, and they are viewed as providers and protectors, which might make it hard for them to seek medical help or show feelings (Barton, 2000). Cultural background is another important influence on individuals' beliefs, behaviors, and attitudes to health

and illness (Spector, 2004). These factors work together to determine individuals' belief systems. For example, men from different cultures perceive health differently.

Men in general use health services less frequently than women and often wait too long to seek medical help. Studies have found that men die younger than women. About 60%-70% of deaths in men are the result of cardiovascular disease. Suicide is approximately four times more common in men than in women, and men experience more mental health problems, such as paranoia and antisocial behaviors, than women. Most problems that affect men's health are related to their behaviors and lifestyle. Studying men's health perceptions and practices is essential in preventing these problems (ICN on Men's Health, 1999).

Background and Significance to Nursing

Few studies of Arab Muslims focus on the health promotion practices of this population or address how to provide appropriate health promotion services. Most of the scholarly writing about Arab Muslim health in the United States has been focused on how to provide culturally sensitive hospital nursing care. Studies that focus on health promotion and disease prevention among Muslim populations are crucial. This is a rapidly growing population. Several studies showed that this population is at high risk for several diseases and lacks the knowledge needed to prevent these diseases (Laffrey, et al., 1989; Rice & Kulwicki, 1992; Hatahet, Khosla, & Fungwe, 2002; Jaber, Brown, Hammad, Zhu, & Herman, 2003; Jaber, Brown, Hammad, Nowak, Zhu, Ghafoor, & Herman, 2003; Kulwicki & Rice, 2003). In addition, this population is facing several obstacles in obtaining care in the American health care system. Some barriers, such as modesty, provider gender preference, and illness causation misconceptions are derived

from cultural beliefs and practices. Other barriers are related to the complexity of the health care system and the lack of culturally competent services. (Hattar-Pollara & Meleis, 1995; Kulwicki, Miller, & Schim, 2000).

Most published studies in this area focused on concepts such as causation of illness or caring; none of them studied the concepts of health and health promotion. In some of these studies, all participants were female. None of them focused on male perceptions of health. Little is known about Arab American male immigrants, how they perceive illness, how they promote their health, or the stressors they experience and barriers they face in accessing the American health care system. To be able to plan, conduct, and evaluate health promotion programs that target this population, we need first to learn more about this population and their health perceptions and health-related practices. The need for a study that explores Arab Muslim men's health and health promotion perceptions and practices is obvious. Insight into and knowledge of the health perceptions and health promotion beliefs and practices of the male Arab Muslim population in the United States is needed to provide culturally sensitive health care and health promotion services.

According to Leininger, "Nursing needed to shift from a largely ethnocentric and unicultural position to a multicultural knowledge base in order to be relevant and effective in working with people worldwide" (Leininger, 1997, p. 34). This continues to be true relative to the male Arab Muslim population.

The findings of this study will contribute to a growing body of nursing knowledge related to providing culturally competent health promotion services and to closing the gap between the health of the minority and majority populations. Findings of

this and similar studies will serve as baseline knowledge for nursing researchers to guide them in planning future studies.

Purpose of the Study

The purpose of this study was to develop knowledge (grounded theory) about male Arab-Muslims' health perceptions and health promotion perceptions and practices. The specific aims are: (a) to describe how this population defines health; (b) to describe what they do to stay healthy; (c) to identify practices that impede their health; and (d) to describe perceived barriers to obtaining health care. The related research questions were as follows:

1. How do male Arab-Muslims define health?
2. What positive and negative health behaviors do Arab Muslim men engage in?
3. What barriers do they face in obtaining health care?

This was a qualitative study using a focus group approach to gain insight into and knowledge of the health perceptions and health promotion beliefs and practices of the male Arab Muslim population in the United States. The reasons for health disparities are complex; in-depth data collected using a qualitative research approach is needed when studying health perceptions and beliefs. This study was based on the assumption that qualitative research can add new insight into the real life issues that contribute to health disparities among minorities. Health perceptions and beliefs are more likely to be revealed via the social interaction that participating in a focus group entails. Further details of the research approach are described in Chapter Three.

Chapter Two

Literature Review

This chapter will be divided in three parts; the first part will discuss literature on gender socialization and health and Arab Muslim male gender socialization. The second section will address the cultural influences of the Islamic religion on health and health-related behaviors. The final part will examine prior research related to the health of Muslims in the United States.

Gender Socialization and Health

Gender socialization theories suggest that social environments teach men and women to display distinct sex-typed behaviors and attitudes. This teaching is accomplished through the adoption of norms and stereotypes. Norms are prescriptions for how men and women should behave, while stereotypes are generalizations about what men and women are like (Pleck, 1995).

Critical feminist thinkers emphasize that power differences shape relationships between men and women, women and women, and men and men. They also argue that gender identity and behavior are not simply imposed on individuals by socialization, but that individuals actively construct their gender identity and behavior. Gender identity is

actively worked out, revamped, and maintained by individuals who are immersed in socially and historically constructed webs of power relations (Messner, 1998).

Gender-based inequalities in health have been frequently documented. Gender influences the power men and women have to control their lives, cope with health risks, and influence the process of health development. When men actively participate in the construction of their gender identity and behavior they are at greater risk for morbidity and mortality as explained in the following.

Male Gender Socialization

Masculinity ideologies are ideas and concepts that individual men hold about what it means to be a man. The study of masculinity ideologies is concerned with the extent to which men endorse ideologies that emphasize self-reliance, competitiveness, emotional control, power over others, and aggression (Pleck, 1995).

Eisler and Hersen (2000) noted that there are cultural messages imposed on men that put them at greater risk for morbidity and mortality. One of the messages is "be tough and restrict emotions"; this will restrict men from openly expressing their feelings and lead them to unhealthy coping such as drug abuse, or suicide. Another message is "be competitive and successful"; competition could be stressful and cause anger, high blood pressure and cardiovascular disease one of the leading causes of premature death in men.

Another cultural message is "be aggressive, fearless, and invulnerable"; this message make men engage in extreme behaviors such as driving motor vehicles very fast, drinking large amounts of alcohol, and other high risk behaviors. Also men perceive themselves as invulnerable which makes them not use preventive health measures. "Be

independent" is another cultural message that puts men at high risk for delaying seeking medical help. Seeking medical help means being dependent and vulnerable and that may conflict with perceptions of masculinity (Eisler & Hersen, 2000).

Men make fewer contacts with health care providers across the lifespan than do women and are twice as likely as women to have gone two years or more since their last contact with a physician. Men suffer higher mortality rates than women but seek help less often than women for a variety of problems in living including depression, cocaine use, alcohol use, and medical problems (ICN on Men's Health, 1999).

Arab Male Gender Socialization

Gender differences in Arab culture tend to remain strong, and the social structure is male dominant. Women are perceived as physically and mentally weak in comparison to men. The male is the leader and highest authority in the household (Haddad & Esposito, 1998).

Islam and the Arabic culture influence gender socialization. Islamic teaching provides guidance in what is expected of a man. Men are expected to exhibit toughness, bravery, and responsibility for family and friends. These expectations put men at a higher risk for certain unhealthy behaviors such as smoking. These expectations may also delay seeking medical help (Al Ansari, 1996).

According to Islam, man and woman are created from one spirit; they are to be each other's supporters. The Quran gives the man the right of guardianship or superiority over the family structure. Some Muslim scholars emphasize that man's superiority did not occur because some favoritism has been shown for males over females, but rather out of necessity predicted on the nature of the two sexes. There are disparities between

genders because God has gifted men and women with different qualities to perform their different tasks; women to bear and raise children and men to provide and protect the family (Haddad & Esposito, 1998).

The superiority God gave to the man is not an honor but a burden involving responsibilities and duties. The man is in a constant struggle to gain his income and to feed his family. Therefore he faces danger and life threatening situations. Men are not only responsible for their families but also for the religious and political leadership of their communities (Haddad & Esposito, 1998).

Islam & Johnson (2003) found that being a male was significantly associated with an increased risk of smoking susceptibility and experimentation among a sample of Muslim Arab American high school students. The researchers related their findings to traditional gender specific norms under which it is socially acceptable for men but women to smoke.

In the Arabic culture the definition of manhood includes provider and protector to his family, it is important to recognize immigrant men face challenges in meeting these roles due to such barriers as poverty, lack of education, underemployment, and reduced access to services. These barriers may lead men to adopt several coping strategies that threaten their health such as alcohol and drug abuse (Eisler & Hersen, 2000).

The Faith of Islam and Health

Cultural factors arising from religious beliefs and practices can have a profound impact on health. For that reason, we will explore the faith of Islam and the value of health in Islam. Two other related concepts are also discussed, health promotion practices

according to Islam's teaching and Islamic mandates that might hinder health promotion within the American health care system.

The Faith of Islam

The history of Islam goes back approximately fourteen hundred years. Mohammed, the founder of Islam, was born in 571 C. E. in the city of Makkah (Mecca) in Arabia. After more than a decade of preaching in Makkah, Mohammed immigrated to the town of Madina, where he established the Islamic State. Mohammed died in June 632 C. E. Within a half century of the Prophet Mohammed's death, the message of Islam had spread to Spain in the west and China in the east. (CIE, 2000; Islamic Affairs Department [IAD], 1997).

The Arabic word Islam means "to turn oneself over to, to submit." In religion it means submission to the will of God. Muslims submit to God's will and obey God's precepts as set forth in the Quran and transmitted to mankind by Mohammed. To practice their faith, Muslims must accept five primary obligations, which are called the Five Pillars of Islam (Bakhtiar, 1995; CIE, 2000; IAD, 1997; Murad, 1998).

The first pillar, the profession of faith, is the repetition of the statement, "There is no god but God; Mohammed is the Messenger of God". It is a simple statement, yet also profound, for in it a Muslim expresses his complete acceptance of, and total commitment to, the message of Islam. The second pillar, devotional worship or prayer, requires Muslims to pray five times a day - the dawn prayer, the noon prayer, the afternoon prayer, the sunset prayer, and the evening prayer - while facing toward the *Ka'bah*, the House of God in Makkah. The third pillar is *zakah*, which is defined as a percentage of

one's acquired property or profit for the year that is paid to the needy (Bakhtiar, 1995; CIE, 2000; IAD, 1997; Murad, 1998).

The fourth pillar is fasting during Ramadan, the ninth month of the Muslim year. Fasting consists of refraining from eating, drinking, smoking, and sexual activity from sunrise to sunset everyday for the whole month (with exceptions for sick people, pregnant women, and travelers). The fifth pillar of Islam is the pilgrimage to Makkah - the "*hajj*". *Hajj* is a set of rituals that take place in and around Makkah every year during the last lunar month. Muslims are required to perform hajj once in their lifetime if they have the means to do so (Bakhtiar, 1995; CIE, 2000; IAD, 1997; Murad, 1998).

The Value of Health in Islam

Muslims believe that God created human beings and gave them their bodies as gifts that they have to take care of. In the Day of Judgment, God will ask what they did with their bodies and their health. Human beings express gratitude to God for their good health through worship and not harming their bodies. The Prophet Mohammed's Hadith (teachings of the prophet) says "A person's body has a due right over him" (Rahman, 1998, p. 34). This Hadith obligates all Muslims to give the body its "right," to be fed when hungry, rested when tired, cleaned when it gets dirty, protected against harm and diseases, treated when suffering illness, and not overburdened (Kasule, n.d.; Rahman, 1998).

The prophet Mohammed said "Ask of God his forgiveness and health, for after faith, no one can get a greater good than health" (Rahman, 1998, p. 48). In another Hadith, the Prophet Mohammed said "There are two blessings for which so many people are enviable, health and lack of worry" (Rahman, 1998, p. 47). The Prophet Mohammed

also said "Wealth is appropriate to a God-fearing person, but good health is better for God-fearing than wealth" (Khan, n.d., V8, B6, p. 421). All these Hadith show how Islam values human health. Islam looks at health in a holistic manner and emphasizes the importance of spiritual, physical, psychological, and social aspects of health.

The prophet Mohammed supported health promotion and disease prevention as well as seeking health care in sickness. Prophet Mohammed encouraged Muslims to store up their health to draw on during illness, so the prophet promoted maintaining physical fitness to enable the body to fight disease. A companion of the prophet said to the prophet, "I much prefer to be in good health and be grateful for it than be afflicted with ill health and bear it with patience" upon which the Prophet replied "God prefers you to be in good health" (Rahman, 1998, p. 47).

In the Hadith stated above, the Prophet Mohammed stated clearly that God wants human beings to be in good health, which means it is an obligation for all Muslims to work hard to maintain good health. Many Hadith gave instructions for Muslims on how to practice a healthy life style, including general hygiene, diet, prohibiting alcohol, and exercising. These instructions will be discussed later.

In order to protect Muslims from the spread of contagious diseases, the prophet Mohammed instructed his followers in health quarantine. He said " If you hear of a break out of plaque in a land, do not enter it; but if the plaque breaks out in a place while you are in it, do not leave that place" (Khan, n.d., V7, B71, p. 624).

In many Hadith, the Prophet Mohammed often encouraged seeking health care. The Prophet said "Allah (God) never inflicts a disease unless He makes a cure for it" (Khan, n.d., V7, B71, p. 582). Someone asked the Prophet whether he or she should get

treatment, and the Prophet replied in the affirmative. On another occasion, the Prophet was asked if medical treatment was against the decree of God and he replied that medicines are part of the decree of God (Ali, Hussain, & Sakr, 1987).

Health Promotion Practices in Islam

Islam is a way of life; it gives Muslims guidance for their daily life activity through the Quran and the Hadith. Islam encourages Muslims to maintain their health by following God's guidance in all aspects of life. The following discussion illustrates how the Islamic faith teaches Muslims a healthy life-style.

General hygiene. Muslims believe that God is pure and likes purity, and that God is clean and likes cleanliness; therefore, general hygiene is emphasized in the Quran and the Hadith. Islam made body hygiene part of the Muslim's daily activity by asking Muslims to pray five times a day. Before praying, Muslims have to wash their hands, face, head, and feet. Hand washing, the single most effective infection control method, is part of every Muslim's daily activity. The Prophet said to Muslims "Cleanse your bodies, Allah (God) will cleanse you (your hearts)" (Ali et al., 1987, p. 22).

The prophet Mohammed used to brush his teeth using the "Siwak" (like a tooth brush made from wood), and he said " Were it not difficult for my people, I would have ordered them to clean their teeth with the Siwak before every prayer" (Khan, n.d., V2, B13, p. 12). Siwak is a stick obtained from a plant called Salvadore Perscia. This plant contains high levels of fluoride, silica, chlorides, and vitamin C (El-Mostehy, Jassem, Yassin, El-Gindy, & Shoukry, n.d.). The Prophet also advised Muslims on flossing. As part of bodily hygiene, Muslims are also instructed in removing axillary hair, clipping finger nails, removing the hair of the pubic area, male circumcision, and using water to

clean after urinating or defecating. General hygiene is of great importance in Islam because it is the simplest and most effective way of preventing disease (Ali et al., 1987; Athar, n.d.).

Diet. Islam focuses on diet as one of the most important methods in maintaining health. Islam gives detailed instructions for Muslims in controlling their diet. God said in the Quran chapter 26 Taha sorah, "Eat of the good things we have provided for your sustenance, but commit no excess therein" (Ali, 1938, Vol. II, p. 806). God also said in chapter 8 Al-a'raf sorah, "Eat and drink, but waste not by excess, for God loves not the prodigals" (Ali, 1938, Vol. I, p. 347). The Prophet encouraged Muslims to leave one third of the stomach empty after finishing a meal. Once he said, "No son of Adam would fill a container worse than his stomach" (Rajah, 1993, p. 15). He also said "the stomach is the home of illness and diet the head of all treatment" (Rajah, 1993, p. 15).

Islam forbids some foods such as "dead meat" (all meat not slaughtered according to Islamic beliefs), blood, and the flesh of swine. Blood and "dead meat" could have germs that might cause diseases, and pork is high in cholesterol and salt and may have worms. The Quran and the Hadith emphasize the purity of food and moderation in eating, quality and quantity, by asking people to eat good food but not to exceed the limit (Athar, n.d.; Kasule, n.d.).

Another aspect of the Islamic diet is fasting. Muslims are instructed to fast during the month of Ramadan from sunrise to sunset. This includes complete abstinence from food, drink, smoking, and sexual activity. Fasting is a method of self-purification; a fasting person gains true sympathy with those who go hungry as well as growth in one's spiritual life. Fasting also has scientifically approved benefits for the human body such

as increasing serum magnesium levels, decreasing bile secretion and pressure in the bile duct, and other benefits beyond the scope of this discussion (Bakhtiar, 1995). The prophet said, "Fast (the month of Ramadan) so as to heal your bodies from diseases" (Ali et al., 1987, p. 11).

Prohibiting intoxicants. The prophet called intoxicants the mother of evils. Islam protects human beings from harm by prohibiting intoxicants; persons under drug and alcohol influence may commit acts dangerous to themselves or others. In addition, the physical harm that alcohol and drugs might cause, such as liver diseases and neurological disorders, is prevented (Ali et al., 1987; Athar, n.d.).

Exercise. Exercise is part of the Muslim's daily activity through the five prayer times. Additionally, the Prophet Mohammed used to walk fast all the time and worked in the field with his hands. The Prophet Mohammed also encouraged Muslims to train their children in swimming, archery, and horse riding. Islam encourages Muslims to be active and physically fit (Athar, n.d.; Kasule, n.d.).

These health promotion practices are part of the Islamic faith. Muslims believe that God created the human body and gave instructions on how to care for this body. These instructions are found in the Quran and the Prophet Mohammed's Hadith, which prohibit some unhealthy behaviors and practices and encourage other healthy ones. There are basic rules in Islam that focus on preventing harm to the person him or herself, to the community, and to the environment. These rules can be used to judge new habits, such as smoking. Smoking was not a common habit at the time of the prophet Mohammed, but according to the rule in Islam that states "no harm," most Muslim scholars have prohibited smoking. Islam also prohibits any sexual relationship except

between wife and husband. Islam assigned the death penalty for married people who have any sexual activity outside the marriage relationship. In addition, Islam encourages safety behaviors, such as wearing helmets and seat belts and safety measures at work (Rajah, 1993).

Islamic Mandates That Hinder Health Promotion

Although most tents of Islam promote health, there are some that might hinder health promotion including modesty, provider gender preference, and the misinterpretation of predestination. Modesty is an extremely important Islamic mandate; women and men should behave in a modest manner. Women should cover their hair and their bodies; nothing should be exposed except their faces and their hands. Men and women should turn their eyes away from temptations to preserve their chastity. Another consideration, which is part of modesty, is "gender preference." The Islamic religion does not allow the use of a health care professional of the opposite gender, unless it is impossible to locate one of the same gender. Muslims, men and women, prefer to deal with providers of the same gender especially in providing physical care or while exposing the body for examination. It is very stressful for Muslim women to expose their bodies in front of male health care providers, or even to discuss sensitive topics related to women's health with them (Rajaram & Rashidi, 1999).

One of the misinterpretations of Islam is the way some Muslims define "predestination." Some Muslims might not participate in health promotion activities because they do not believe that they can prevent something from happening if God has pre-ordained that for them. However, the Prophet Mohammed clarified this issue and encouraged Muslims to maintain their health and seek medical help. Also, the human

being does not know what is written for him. Therefore, participating in health promotion activities and preventing diseases could be part of what God wrote for human beings.

As we have seen, there are many aspects of Islamic religion and culture that promote health. There are also aspects that may impede healthful practices. Nurses need information on the effects of these religious and cultural factors in order to be able to provide culturally competent health promotion services for this population.

Prior Research

Few studies have been done regarding the health of Muslims in the United States. These studies can be placed in three categorizes: (a) studies that assess the health needs of this population and show them at high risk for several diseases, (b) studies that explore this population's health beliefs and perceptions, and (c) studies that explore the nature of interactions with the health care system in the United States.

Studies of Health Needs

In 1989, a team of researchers reported a health needs assessment of Arab-American immigrants in California. The researchers found that this population was at risk for illness and other health problems because of the trauma associated with immigration, cultural conflict in the United States, loss of social support systems, and their limited knowledge of the complex American health care system. The data for this study were obtained from community forums; key informants; social indicators, such as age, sex, income, and education level; and from a survey of 47 Arab immigrants. Several community forums were held; most of those attending were women, most of them Palestinian, Jordanian, Lebanese, and Yemenis, and included both Muslims and

Christians. From the community forums, the researchers identified issues of parenting difficulties and marital conflicts. The participants in the community forums expressed their concern about several health problems such as AIDS, heart disease, and cancer (Laffrey et al., 1989).

Key informants such as clergy, community leaders, and health care providers identified the following issues: mental health problems related to child rearing, referral for appropriate services, and translation and cultural interpretation for Arab patients. The Arab patients requested guidance in accessing the health care system. Three general areas of health need were identified, education about preventive care, greater understanding of self-care, and cooperation with health care provider requests for personal health information (Laffrey et al., 1989).

The researchers discussed direct and indirect social indicators of this population's health needs. The direct indicators included a lack of morbidity and mortality data because the U.S. census does not identify Arabs as a separate ethnic group. So the researchers had to use indirect indicators such as age, sex, income, and education level. The educational level of Arab Americans in California was slightly lower than the general population. Fifty four percent of this population reported family incomes less than $20,000, which limited their access to health care and put them at high risk for stress (Laffrey et al., 1989).

The survey was conducted in two major cities in California, a sample of 15 men and 32 women aged 22 to 63 years participated. Twenty were Muslim, seven were Christian, and ten did not specify their religion. Participants were born in several countries including Jordan, Palestine, Lebanon, Iraq, and Syria. The length of stay in the

United States ranged from 1 to 40 years with a mean of 18 years. The researchers developed a self-administered questionnaire, the content validity of which was established by a panel of experts. In addition to demographic information, the questionnaire consisted of questions to identify the most common health problems that this population had faced in the previous year and to rank the importance of a list of services which could best address their needs.

The survey indicated that the most common health problems during the past year had been respiratory infection, cardiovascular disease, diabetes, and hypertension. Other health related problems were identified, including family stress, the difficulty of adjusting to the American culture, handling adolescents, and marital stress. The most important health services needed by this group included health education, availability of Arabic speaking health care providers, and technical assistance in referrals for appropriate treatment. (Laffrey et al., 1989).

Rice and Kulwicki (1992) conducted a study to examine the prevalence and characteristics of cigarette smoking in a randomly selected sample of Arab Americans living in Detroit. There were 237 subjects in this study; 75% were Lebanese, 11% were Yemeni, 11% were Palestinian, and 3% were Syrian and Iraqi. Seventy members of the sample were female; the mean age of the sample was 40.4 years. Data collection for this study was part of another study that examined cardiovascular risk factors in Arab Americans. The sample was selected randomly from a list of Arab American residents in Detroit. Bilingual registered nurses contacted the families by phone and conducted in-home interviews with one of the adults. The interviews were guided by the Cardiovascular Risk Factor Survey, which was developed by the researchers. The

instrument was reviewed by a panel of experts for content validity and pre-tested with 15 Arab American subjects for clarity.

Study results showed that 38.9% of the participants were current cigarette smokers, 11.1% were former smokers, 50% had never been smokers, and the overall quit ratio (percentage of ever smokers who are former smokers) was 22.2%. The majority of smokers (68.2%) consumed one-half to two packs of cigarettes a day. The majority of the subjects who smoked for 16 years or more had no formal schooling. No significant difference was found in smoking rates between men and women. The overall results of this study showed that Arab-Americans have a higher smoking rate and a much lower quitting ratio compared to national and state data.

Kulwicki and Rice (2003) also conducted a qualitative study to gather information about Arab American adolescent smoking behaviors and to obtain their opinions about a smoking cessation program called Toward No Tobacco Use (Project TNT). The researchers recruited 28 participants (93% men); the age range of the sample was 15 to 18 years. Seventy percent of subjects were Lebanese, 63% were born in America, 55% had a household income of less than $40,000. A focus group approach was used to explore the shared meaning of tobacco use and opinions regarding the TNT project. Commonly reported reasons for smoking were being "cool", being able to hang out with friends, and that smoking feels good, tastes good, and keeps one's mind off trouble. Other issues emerging from the data included availability and accessibility of tobacco and barriers to smoking cessation programs. Other significant findings included an average age of smoking initiation at 13 years and smoking associated with low school

performance and low socioeconomic status. All participants reported at least one family member who smoked at home and that about five of their closest friends smoked.

Jaber, Brown, Hammad, Zhu, & Herman (2003) recruited 520 Arab Americans to participate in a cross sectional population-based study to examine the associations between dysglycemia and acculturation, physical activity, and perceived stress. The random sample consisted of 206 men and 314 women who were born in the Middle East and immigrated to the United States. Their mean age was 38 years (s.d. 13), the length of stay in the United States was 11 years (s.d. 10). The researchers modified a four-item scale that assessed integration into American society. They did not report validity or reliability of this scale, but noted that it is a general acculturation index validated in Mexican Americans. Acculturation was assessed using factors that have been shown to influence the adaptation of immigrant populations to western lifestyles. These factors included food preferences, the ratio of Arabic meals to total meals, language use, and ethnicity of friends. The results showed that there is an association between dysglycemia in men and older age at immigration, unemployment, speaking Arabic with friends, more frequent consumption of Arabic food, and less integration into American society. In essence, less acculturation was associated with a greater risk of diabetes.

Jaber, Brown, Hammad, Nowak, et al. (2003) conducted a quantitative study to examine the prevalence of diabetes and glucose intolerance by age and gender in the Arab American population living in Dearborn, Michigan. A random sample of 542 Arab Americans participated, 214 men and 328 women; the mean age of subjects was 38 years. The majority of participants (65%) were Lebanese, but there were Iraqi and Yemeni participants as well. The researchers used a standardized questionnaire to assess

demographic and socioeconomic status. They did not provide details about this questionnaire. Medical history was obtained from each participant and height, weight, and hip and waist circumferences were measured. Fasting blood sugar and glucose tolerance tests were performed for each participant. The age-adjusted rate of diabetes was 15.5% in women and 20.1% in men. In this study, abnormal glucose tolerance affected more than 70% of those over 60 years of age. Diabetes affected 36% of men and 54% of women over the age of 60 years. These rates are considerably higher than those reported for the white, African American and Hispanic American populations in the United States. The prevalence of undiagnosed diabetes among Arab American was 10%, which could be a result of lack of access to and use of health care or cultural barriers including fear of uncovering medical problems. The researchers recommended fostering public awareness and regular surveillance for diabetes and its complications in the Arab American community.

In another recent study, a group of researchers used a cross sectional population-based sample of 542 Arab Americans aged 20-75 years to examine the prevalence of Insulin Resistance Syndrome among Arab Americans. This syndrome is characterized by obesity, glucose intolerance, hypertension, and dyslipidemia, putting Arab Americans at high risk for cardiovascular diseases and increased mortality. In this study, 20% of the 214 men and 16% of the 328 women who participated were diabetic. Using the Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III or ATP III) established by the National Cholesterol Education Program (NCEP), the prevalence of the metabolic syndrome was 23%; using the WHO diagnostic criteria resulted in a prevalence of 28%. By the ATP III criteria, the aged-

adjusted prevalence of the metabolic syndrome was 20% in men and 25% in women. The prevalence of Insulin Resistance Syndrome among Arab Americans is considered high; as a result the researchers recommended community-based programs for dieting and weight loss for Arab Americans to minimize the chance of developing coronary heart disease (Jaber, Brown, Hammad, Zhu, & Herman, 2004).

Studies of Health Knowledge, Beliefs, and Perceptions

Other studies have explored health beliefs and practices among the Arab Muslim population in the United States. Kulwicki (1991) studied the illness causation perceptions of Yemeni-Americans using an ethnographic approach. Data collection for this study included direct observation of the community and face-to-face interviews of 30 female Yemeni-Americans in their homes. The researcher made observation visits to community health centers, met with community leaders, and had casual conversations with visitors to these centers. During the interviews, the researcher asked participants to name some terms used in their culture to refer to illness and to talk about the causes of illness. The researcher found that religion was the most significant factor influencing this ethnic group's perceptions of illness and disease causation.

The researcher classified perceived causes of illness into four categories: supernatural causes, social causes, natural causes, and hereditary causes. Supernatural causes referred to illnesses caused by God or by devils. Social causes reflected illnesses caused by others or by the person himself such as the evil eye, stresses, or family conflicts. Natural causes of disease included environmental causes, such as air pollution, cold weather, and sudden changes in weather. Some families have hereditary causes of illness such as diabetes (Kulwicki, 1991).

Kulwicki and Cass (1994) assessed Arab-Americans' knowledge, attitudes, and beliefs about AIDS. A random sample of 411 Arab American households was selected from a telephone list of residents in Dearborn, Michigan. The sample consisted of 59% women and 41% men; 65% were Lebanese, 23% were Yemenis, 9% were Palestinians, and 3% were from other countries. The researcher developed an Arabic/English AIDS questionnaire by using the Center for Disease Control model for knowledge-attitude-belief surveys. A panel of experts reviewed the questionnaire; then it was pre tested with 53 participants. Bilingual interviewers were recruited and trained to administer the survey questionnaire. The results indicated that Arab-Americans have a low level of self-assessed knowledge about AIDS, a high number of misconceptions about the transmission of HIV, and a high level of anxiety about HIV infection. These findings show the need for health education programs that target this population.

Kulwicki (1996) studied the illness perceptions and practices of Yemeni-Americans in Michigan. This was an ethnographic study in which the researcher conducted structured and unstructured interviews with 30 Yemeni-American women. One of the cultural themes derived from this study was confidence in empirical knowledge and the rational mind of man, often motivating this ethnic group to take action based upon the best knowledge available. Western medicine was found to be highly valued by the Yemeni-Americans. These themes showed the willingness of this population to participate in health promotion activities if they receive scientific data supporting them.

Studies of Interactions with the Health Care System

Hattar-Pollara and Meleis (1995) examined the lived experiences and perceived stress associated with being Jordanian immigrant women in the United States. The researchers used a semistructured, open-ended interview guide that was developed by them. A panel of experts reviewed the guide, and it was pilot tested with 9 Arab American women. The guide consisted of 34 questions, 19 addressed demographic information and the rest were open-ended questions to assess the participants' own experiences of immigration and related stressors. Thirty Jordanian immigrant women participated in this study. The average age of participants was 45 years and 92% were homemakers. All the participants were Christians born in Jordan. Interviews were conducted at the participants' homes in English or Arabic according to the participant's preference. Results showed that Jordanian American women experienced stressors as a result of their immigration to the United States. These stressors included feelings of loneliness and social isolation, being apart from the host society, disruption of their families' stability, and a sense of inadequacy due to language barriers. These stressors could be barriers to obtaining health care in the United States.

Other previously mentioned studies identified several obstacles that the Muslim population faces in obtaining health care in the United States. Laffrey et al. (1989) discussed several barriers such as the Arab American tendency to rely on others for advice and guidance. Their close unity and high need for affiliation results in Arab Americans anticipating each others' needs without verbalizing them. As a result, they frequently expect health care providers to automatically know what they need and provide the best for them.

In 1991, Kulwicki studied illness causation perceptions of Arab Americans, and in 1996, she studied illness perceptions and practices of this population. In both studies, the researcher pointed to the perceived supernatural causes of illnesses, that is illness caused by God or by devils. Among more traditional Arab Americans, it is thought that speaking about something evil can bring it about or that thinking about certain diseases, such as cancer, may cause the disease.

Kulwicki, Miller, & Schim (2000) conducted a qualitative study to explore professional and community perceptions of culturally competent care for Arab Americans. Ten focus groups were conducted with Arab American community leaders, Arab clients of the health care system, and Arab and non-Arab health care providers. The Arab clients who participated in this study were teenagers, pregnant women, and other adults. A total of 67 subjects participated in 10 focus groups over a period of three months. Themes identified in this study included the unique caring behaviors of Arab families, the complexity of the health care system for Arab Americans, communication gaps, the diversity of perceptions of cultural competence, obstacles to accessibility of care, and health workforce diversity issues. Arab family patterns of caring included family involvement in care, the unique needs of Arab teenagers, confidentiality issues, and the diversity of men's and women's health needs.

The health care system in the United States is more complicated than the health care systems in Arab countries, making it confusing for the Arab immigrant to obtain American health care services. Language barriers, cultural misconceptions, and perceptions of disrespect toward Arabs were examples of the obstacles to obtaining care.

Developing effective cultural competency training programs is a key to improving the quality of culturally competent care.

A significant finding in Kulwicki, Miller, and Schim's (2000) study was the difference between Arab participants' and non-Arab health care providers' perceptions of what culturally competent care meant. The non-Arab health care providers stated that all clients should be treated the same regardless of race or cultural orientation. This is what Lindsey, Robins, and Terrell (1999) called cultural blindness, which means that the service providers act as if the cultural differences do not matter or do not even exist. On the other hand, the Arab participants indicated that treating Arab clients without addressing Arab culture is an indication of culturally insensitive care.

Obstacles to obtaining care can be summarized as language barriers, cultural barriers related to modesty, and gender preferences in seeking and accepting health care from male or female providers. Other obstacles included strong values relating to family privacy, values of honor and shame, and barriers related to the stresses of immigration and acculturation (Kulwicki et. al., 2000).

From all of these studies, we can conclude that the Arab Muslim population in the United States is at high risk for several diseases. At the same time, they lack the knowledge that is needed to prevent, detect, and treat these diseases. This population faces many barriers in accessing the American health care system. Some barriers, such as modesty, gender preference, and illness causation misconceptions, come from their cultural beliefs and practices. Other barriers are related to the complexity of the health care system and the lack of culturally competent services within this system.

Most studies of Arab Muslims living in the United States have been focused on how to provide culturally competent hospital care, but very few focus on health promotion practices. The majority of the studies focused on female perceptions of health and illness; in some of these studies, all the participants were female. None of these studies focused on male perceptions or practices. To be able to provide health promotion services to the male Arab Muslim population, we need to know more about how they view their health, how they stay healthy, what concerns them about their health, and what barriers they might face in obtaining health care. The need for this information provides the rationale for the study of male Arab Muslim's health perceptions, and health practices described in Chapter Three.

Chapter Three

Study Methodology

Introduction

This qualitative exploratory study used a grounded theory approach in gaining understanding of Arab Muslim men's health perceptions and practices within their cultural context. Data collection for this study employed focus groups. The appropriateness of a grounded theory approach and focus groups is discussed below.

Grounded Theory

Grounded theory was developed in the 1960s. It was a reaction to the dominance of quantitative research methods in which a theory is formed then tested. Grounded theory is an inductive research technique designed to develop or discover theory directly from data, rather than previous assumptions or existing frameworks (Strauss, 1987). Data collection and analysis for this study were based on the grounded theory approach where real life phenomena or issues may be examined inductively building theory as data is collected. Instead of testing an existing theory about male Arab-Muslims' health perceptions and practices, the researcher attempted to develop a theory that is unique to this population. This was an appropriate approach to this study since little is known about

Arab American males' health perceptions and practices; grounded theory has been used most frequently to study areas in which little research has been done.

Grounded theory is based on symbolic interactionist theory. One of the principles of symbolic interactionism is that researchers can understand what is going on only if they understand what the participants themselves believe about their world. Symbolic interactionist theory explores how participants describe their reality and how their beliefs shape their actions. Participants in this study were all male, and as noted earlier, socialization into the masculine role affects men's health, beliefs, attitudes, and perceptions. Symbolic interactionist theory addresses gender differences and how men and women avoid behaving in ways that contradict, in the eyes of others, their socially given sex identity (Charon & Cahill, 2003).

Focus Groups

Use of focus groups was more appropriate to the nature of the study, the grounded theory approach, and the study population than other data collection methods, such as individual interview. One of the purposes of a focus group approach is to contribute to fundamental theory and knowledge which is congruent with the grounded theory approach. A focus group approach is usually used to probe the underlying assumptions that gave rise to particular views and opinions. Not only are participants' knowledge and experience explored but also what they think, how they think, and why they think that way (Kreuger, & Casey, 2000; Morgan, 1996; Robinson, 1999).

This data collection approach allowed interaction between participants and used various methods of communication employed by people in everyday interaction, such as jokes, and teasing. Usually Arab decisions are made in a social context and often result

from discussion with other family members. Interaction between participants helped to identify cultural values as a result of shared and common knowledge and promoted some level of consensus on health perceptions. The assumption of a focus group is that opinions are not always readily available and are open to influence by others in an interactive setting rather than during individual interviews. Perceptions and beliefs may be partially independent of a group or its social context, but are more likely to be revealed via social gathering and the interaction than via individual interviews (Kreuger, & Casey, 2000; Morgan, 1996; Robinson, 1999).

Several researchers have recommended a focus group approach in cross-cultural work with ethnic minority groups. Focus groups are particularly useful when there are power differences between the participants and health care professionals (Kulwicki et. al., 2000; Robinson, 1999). Focus group methodology is very congruent with the Arab culture; it is similar to Arab patterns of socialization, and Arab culture is a collective culture. Arab families are usually extended families; they meet frequently and discuss family issues especially during times of hardship. All of these facts make focus groups more appropriate to this population than individual interviews as a mode of data collection.

Winslow, Honein, and Elzubier (2002) conducted a study in United Arab Emirates using focus groups to identify Emirati women's health needs as a basis for planning additional services and programs. The researchers stated that the focus group methodology was very appropriate for the Arab culture because Arabs like to discuss shared concerns in groups and the discussion usually encourages participants to reflect on each other's opinions.

Kulwicki et al. (2000) conducted ten focus groups to explore the perception of culturally competent care for Arab Americans from both professional and community perspectives. Kulwicki and Rice (2003) used focus groups to explore Arab American adolescents' smoking perceptions and behaviors. Dr. Kulwicki strongly recommended focus groups for Arab American studies (A. Kulwicki, personal communication, March 2, 2004).

The Study Population

Arab Muslims come from a number of nation states throughout the Middle East and North Africa. They have different life styles and cultural patterns but all of them share the same religion and language. Previous studies have shown that religion is the most influential factor in Muslims' health beliefs (Kulwicki, 1996). Islam is a way of life; the Quran (God's words) and the Prophet Mohammed's Hadith (sayings) provide guidelines for Muslims in their beliefs and daily practices.

The population for this study was Arab Muslim men living in the United States. A convenience sample of 20 Arab Muslim men living in Orange County was selected to participate in this study. Subjects were eligible for the study if they were men who identified themselves as Arab and Muslim, were 21 years of age or older, and had been living in the United States for more than one year.

Focus Group Facilitator

The investigator, an Arab American male, facilitated all focus group discussions. The researcher was fluent in Arabic and English and shared the same cultural background as the participants. Morgan (1996) discussed the level of moderator involvement in focus group discussion and suggested that if the purpose of the study is to explore a

phenomenon without imposing the researcher's agenda, then a low level of involvement is recommended. In spite of the researcher's background and knowledge of the topic, the researcher only facilitated the discussion without providing his opinion and let the participants reflect on each other's opinions. The researcher conducted all the focus group sessions to promote comparability and consistency of approach across groups.

Research Procedure

Participant recruitment

The recruitment process began with flyers that provided potential participants with the information need to determine if they were eligible and interested in participating (see Appendix A for a copy of the flyer). The information provided in flyer included the investigator's name, contact information for interested participants, the institution that approved or sponsored the research, the research purpose and procedure, eligibility criteria, time and other commitments required of the participants, and the potential risks and benefits of the study. The flyers were distributed via Islamic and Arabic associations and organizations, such as mosques, social clubs, and social service centers.

After distributing the flyers, the researcher received very minimal responses. Therefore, he and friends decided to start contacting men they knew who had experience with the health care system in the U.S. and who were willing to talk about these experiences. After conducting the first focus group, the researcher recruited participants by asking participants to identify other individuals with special understanding of the phenomena, a practice called snowball sampling (Ulin, Robinson, & Tolley; 2005).

As data collection proceeded, additional subjects were recruited in similar ways to maximize their ability to shed additional light on emerging themes and concepts. This approach to recruitment is referred to as theoretical or purposive sampling (Strauss, 1987). In this study, subjects were purposefully recruited; key informants were chosen for their role, knowledge, and willingness to talk about their beliefs and practices.

Protection of Human Subjects

Several strategies were used to protect study participants, including minimization of risk, informed consent, and assurance of confidentiality. The study and risk minimization procedures were approved by the Institutional Review Board of the University of San Diego prior to the initiation of recruitment (Appendix B).

Risk minimization. Minimal psychological risks were anticipated and might have included feelings of guilt about unhealthy behaviors, such as smoking or recall of painful experiences that might generate distress. Participants were informed of the right to withdraw from the discussion at any time. The researcher set aside time for any participants to discuss related issues after the focus group sessions. The researcher had arranged to refer participants to social resources available in the community as needed. No referrals were needed, participants enjoyed the discussion, and no psychological risks were noted during the discussion. Focus group participants did not incur any expense related to participation in the study.

Informed consent. Informed consent was obtained from each participant at the beginning of the focus groups sessions. Prior to obtaining signed consent to participation (Appendix C), participants were informed of the purpose of the study, the extent of their participation, absence of anticipated risks, and the lack of any immediate benefits to self

from participation in the study, although some subjects might gain insights into healthier lifestyles through participation. Subjects were also informed of the need for audio taping of focus group sessions, the voluntary nature of participation, and their right to withdraw from the study at any time. Participants were given the opportunity to ask questions about the study.

Assuring confidentiality. Due to the nature of the method, focus group participants may fear losing privacy or confidentiality. This risk was managed by assuring the participants that everything said would be confidential, no names or other personal information would be mentioned, and the results of the study would be disseminated in aggregate form only. The investigator also stressed group members' role in maintaining confidentiality about what they heard in the group. Audio tapes and transcripts of focus group sessions were kept in safe place accessible only to the researcher.

Data Collection

Data collection for this study used focus groups. Four focus groups of four to six participants each were conducted. The focus groups were conducted either in Arabic or in English according to the participants' preference. Each focus group met for one and a half to two hours, and meetings took place in the personal residences of some participants. At the beginning of each focus group, the researcher again explained the study, its voluntary nature, time requirement, and potential risks and benefits. At that time, the researcher asked participants to sign the informed consent form (Appendix C).

The researcher emphasized the value of each participant's responses. The focus groups were audio taped, and participants were informed of the need for audio taping prior to consenting to participation. Participants were encouraged to discuss any issues or

ideas privately with the facilitator after the group ended if they felt uncomfortable sharing concerns during the group session.

Focus group discussion centered on the following initial questions:

1. What does it mean to be healthy?
2. What do you do to be healthy?
3. What things do you do that might be bad for your health?
4. Are there things that make it hard for you to get health care? If so, what are they?

These questions were followed, as needed, with other questions designed to amplify and clarify participants' responses. Data from early focus groups also led to modification and addition of other questions based on emerging themes.

Data Analysis

Strauss (1987) proposed two major strategies for data analysis in the development of grounded theory. The first strategy involves using the indicator-concept model or constant comparison of indicator to indicator, which means the researcher simultaneously codes and analyzes data in order to develop concepts. The second strategy is theoretical sampling, in which the researcher selects new participants to expand or support the emerging concepts. Both of these strategies were used in this study.

Data analysis occurred concurrently with data collection. Tape recordings of each focus group were transcribed immediately, and additional notes were made regarding the date, the time, and the place of the discussion, the age of the participants, other personal and situational characteristics, and events associated with the discussion. Transcripts were read several times and notes regarding emerging issues and concerns written in the

margins. Emerging themes, concepts, ideas and concerns lead to additional questions in subsequent focus group sessions. Selective sampling was used to support emerging concepts; the researcher selected participants who had experienced the phenomenon and who were willing to provide in-depth description of their experience.

The study design and procedures described here were employed to provide information on the health perceptions and health-related behaviors of Arab Muslim men. The intent of the study was to provide information to permit the design of health care delivery programs that can enhance the health status of this population.

Chapter Four

Findings

Introduction

This chapter addresses the findings of this study. The investigator will describe the research participants and the data collection and data analysis processes. The data analysis includes thematic analysis and the resulting theoretical construct.

Research Participants and Data Collection

The research participants were 20 Arab-Muslim men living in Orange county, California. Participants were recruited via Islamic and Arabic associations and through personal communications. All the participants had been born in Arab countries, including Jordan, Palestine, Syria, Iraq, Egypt, and Lebanon, and had immigrated to the United States sometime during their early adult years. All spoke both English and Arabic. The age of the men ranged from 28 to 65, with a mean age of 40. They had been living in United States from 4 to 22 years, with a mean of 13 years.

All but three of the men were employed; two were retired and one was receiving disability benefits. Participants work in a variety of jobs including construction, car dealerships, civil engineering, and their own businesses. None of them were in the health

care field. The investigator intentionally excluded health care providers because they are more knowledgeable than the average Muslim Arab American man and would not represent the typical study population. Half of the men had graduated from bachelor's programs, some had graduated from high school only, and one participant had a master's degree. Demographic information regarding participants is provided in Appendix D.

Participants took part in one of four focus groups, conducted in the personal residences of some participants. Each group lasted from one and a half to two hours. The groups ranged in size from four to six participants. A research assistant who is a male nurse, bilingual and has a master degree in nursing helped in coordinating some of the focus groups. The purpose of the study and the participants' roles were restated and informed consent was obtained. The focus group questions presented in Chapter 3 were modified and new questions were added throughout the data collection process. Appendix E lists the questions that were used by the investigator to lead the discussion.

The group discussion was audio taped, transcribed, and utilized in the data analysis. The discussions were held in Arabic, so the investigator translated the text into English during transcription of the audio tapes. To validate the translation, the research assistant translated one of the focus groups discussions; the assistant's translation was very similar to the investigator's translation.

The Data Analysis Process

Data analysis occurred concurrently with data collection. Strauss (1987) discussed procedures to capture the complexity of reality and emphasized the importance of the evolving interpretations during data collection. After each focus group, the transcript was

analyzed by the investigator, and the analysis was validated by a dissertation committee member.

The investigator used the data analysis method described by Auerbach & Silverstein (2003), which involves three levels of analysis. The lowest level is text-based analysis, which involved identification of repeating ideas in each transcript. Repeating ideas were those concepts identified by several participants in the same group. Repeating ideas were also identified across groups, and the investigator combined the repeating ideas from all the transcripts into a complete list.

The middle level of analysis involves synthesizing concepts, in which the investigator organized the repeating ideas into larger groups that expressed a common theme. Ulin, Robinson, & Tolley (2005) called this level "coding sorts"; they recommended using highlighting and cut-and-paste technique with simple word processing to build theme-related files.

Higher level analysis involves developing a theoretical construct. The researcher organized the themes into abstract concepts to develop a theoretical construct. The process of data analysis suggested by Auerbach & Silverstein (2003) is not a linear process that proceeds from lower to higher levels of analysis. The investigator went through the three levels low to high and high to low several times to revise the evolving interpretation of the group discussions. Strauss (1987) also described reading and rereading data and intense analysis to bring forth the complexity of what lies in, behind, and beyond the data.

Thematic Analysis of the Group Discussion Data

The purpose of this study was to develop knowledge (grounded theory) about male Arab-Muslims' health perceptions and health promotion perceptions and practices. The specific aims were: (a) to describe how this population defines health; (b) to describe how they stay healthy; (c) to identify practices that impede health; and (d) to describe perceived barriers to obtaining health care.

During the data analysis process, the investigator attempted to meet these specific aims, leading him to consider the data in two parts. The first part describes how these participants perceived health and the second part addresses the perceived forces that influence health. The first data element reflects the first study aim, and the rest of the aims are reflected in the second part of the data.

Perceptions of Health and Ill Health

Themes related to participant's definitions of health and ill health arose in response to the first two focus group questions "What does it mean when someone is healthy?" and "What does it mean when someone is unhealthy?" In some of the groups the investigator asked an additional probe question, "Do we, as Arabs and Muslims, define health in a different way than others in the United States?"

At the first level of data analysis, the investigator identified a number of repeating ideas in the focus group transcripts that reflected participants' definitions of health and ill health. During the second level of analysis, the investigator organized the repeating ideas into common themes. These themes included the ability to function, engaging in healthy behavior, absence of disease, control, feelings of spiritual well-being, and body/mind integration.

Engaging in healthy behavior. At least some participants in every focus group equated being healthy with performing healthful behaviors. Most participants started defining health by saying "not smoking, eating healthy food, exercising, not drinking alcohol, not being lazy." For example a 40-year-old participant defined being health as "I agree with Mo; I do not smoke; I do not drink; I eat moderate; exercise is important; if you exercise then you are healthy."

A 55-year-old participant defined being unhealthy by "the person who works long hours and does not take care of his body. This person is not in good health even if he does not complain of anything." Another participant started his answer to the first question by saying, "for me healthy means he does not smoke does not drink alcohol. If he is overweight, he does not eat bad food such as fat."

Absence of disease. A second theme in defining health was absence of disease. This theme created argument among participants. Some participants defined being healthy as having no disease and being unhealthy by having a disease. One participant defined a healthy person by saying "if he does not have any chronic disease." Another participant defined unhealthy by saying "the person with the chronic disease."

One of the participants elaborated, saying "I think there are some hereditary diseases. If the person has it, then he is not in a good health." Some other participants disagreed with that, and said, "That is not right, because I have diabetes and hypertension but I am very active. I run on the machine 2 hours a day." Another participant agreed that having a chronic disease was not equivalent to being unhealthy, saying, "I do not think so, sometimes you may have several chronic diseases and still be working." So the absence of disease was not a consistent theme across the groups.

Ability to function. Participants frequently referred to health as a continued ability to function or to perform expected roles and responsibilities even in the face of chronic disease as noted above. For example, one participant defined health as being "able to perform the job, able to work, strong and functioning well." Similarly, in describing the differences in health between Arab and non-Arab Americans, one participant stated "I think the Americans have a better health than us, and you can see that in the elderly. The elderly people here are strong and functioning very well." Another participant agreed with this perspective, "That is right, the elderly here they are volunteers at a hospital or school because they still feel healthy and they can give." Others defined health in terms of the ability to remain physically, mentally, and socially active. As one participant said, "Healthy means he is able to work; as long as you are able to work then you are healthy."

Control. Another related theme defined health as being in control. Several participants defined being healthy as gaining control over your body or maintaining control and being unhealthy as losing that control. The following statements by the participants supported this theme. "I am controlling it by the food and the activity" and "I had to control my diabetes and my weight." Another participant mentioned the role of control in decisions to seek medical help, saying, "We do not go to the doctor unless things go out of control." Still another expressed the same thought somewhat differently, "I will wait few days, then if I am unable to wait any more I will go to the doctor."

In the last two statements participants expressed their feeling of being unhealthy as losing control or feeling "unable to wait any more." Several forces and factors affecting that control will be discussed in part two of the data analysis.

Feelings of spiritual well-being. The fifth theme in perceptions of health as defined by participants involved feelings of well-being. Some participants spoke of health as enjoying their lives, going for vacation, feeling fresh and active, or feeling relaxed and not stressed.

Spiritual factors played a large part in these feelings of well-being. The theme of spiritual health, was obvious in all focus groups. Islamic teaching was used to define and determine health by most of the participants. The following quote shows the strong influence of Islam in defining health, "But our spiritual life, our prayer makes us relax more than if we go on vacation, it is how close you are to God." Another participant agreed, saying, "That is right, when I wake up in the morning and do my prayer, I start the day with clear mind and I feel mentally relaxed." Similar thoughts were voiced by other participants, "We try to pray to God and use our faith to help us deal with the stressors" and "If you are stressed out or nervous just read some verses of the Quran. You will feel relaxed and healthy."

Body/mind integration. The last theme in participants' perceptions of health reflected the importance of the integration of body and mind. Participants described health as a holistic phenomenon, referring to physical, mental, and social health. They also referred to the effect of each aspect on the others. The following statement described the theme of body/mind integration. "The healthy brain (mental ability) in the healthy body." Similarly, other participants stated, "If you are physically active, you will be mentally active too" and "If you are stressed, your BP and blood sugar will go out of control." Another man said, "I feel mentally relaxed, and as you know your brain affects the other parts of the body, so if you are mentally healthy, then you will be physically

healthy." One participant voiced the importance of both physical and mental health in his comment, "You may be healthy physically and mentally not. Then you can not work." This last comment also attests to the importance of the ability to function as an aspect of health.

The third level of analysis for the first part of the data will be discussed later in this chapter.

Forces that Influence Health

The data analysis process in grounded theory is not a linear process, so level one and level two data analysis for the second data element will be presented together in this section. Participants identified several factors that influenced their health and their ability to engage in healthful behaviors. These factors can be categorized as behavioral forces, mental/psychological forces, social forces, and health system forces.

Behavioral forces. Behavioral forces are one category of determinants of participants' perceived health. These behaviors included engaging in healthy life style activities such as dieting, the quality and the quantity of food, exercise, and some habits before and after eating. Exercise and weight control were behaviors that were described by several participants. Some participants went to the gym; some others considered prayer as an exercise. Personal hygiene, such as hand washing, and using water to clean up after using the restroom, was also repeatedly mentioned by participants.

One participant stated that "Dieting, eating at certain times, variety in the food, after you eat lunch try to rest, after dinner take a walk or exercise." Another participant mentioned unhealthy habits regarding diet "fast food, eating outside." Another man mentioned that "We try not to eat out and we try to eat fresh fruits." In addition to diet,

exercise was also mentioned by several participants. One of them stated "for me I join 24 hours fitness and I go there 6 times a week." Similarly, another man stated "I run on the machine 2 hours a day." On the other hand, some participants mentioned that being lazy and not exercising affect your health.

Other participants mentioned smoking and drinking alcohol as examples of behaviors that affect their health such as "smoking, cigar, drinking alcohol." Others focused on hand washing and personal hygiene. One participant was referring to behaviors that could affect our health when he stated, "Not washing your hands before eating; the prophet encourages us to wash our hands before and after eating." Another participant said "when we use the restroom we always use water to clean our bodies we do not use toilet paper only."

In addition, participants mentioned other behaviors that affect their health, such as "I usually check my BP and blood sugar before and after doing exercise." Another participant mentioned a different behavior that may affect health. He was describing other members of the same culture, saying "they do not follow the work place safety."

Mental/psychological forces. Mental and psychological forces were identified as influences on the participants' health. Participants experienced stressors related to several factors; some of the stressors were related to immigration and family responsibilities. Several participants mentioned the stress of maintaining their culture, particularly among their children. One of the participants stated that "We try our best to raise them the same like us." Another participant said "the other issue is our worries about our kids. We keep taking care of them even after they are grown up." One participant mentioned the difficulty of maintaining the culture saying, "but I think it is

very hard to do, so our kids like the fast food and like to sit for hours playing with the play station."

Another issue was the stress of immigration and cultural strain. One of the participants commented, "We are living two lives, the life here and the life back home. We have responsibilities in both lives." Another participant mentioned both cultural and political stressors when he stated, "For us as Arabs and Muslims, we experience different stresses than others, such as our worries about raising our kids in a non-Muslim environment, also the pressure we experience as Muslims living in USA after September 11, so I think we experience more stress than others."

Another participant supported the idea and stated "the pressure we experience as Arabs and Muslims comes from the government in our countries and the pressure from here in USA." Participants mentioned the importance of managing their stress and having fun, they also compared what they do to what other Americans do to manage their stress. One participant described how he deals with stress saying "I also try to have a fun environment at home, try to avoid any stress at home. We go out as family. For example, today I took my daughter to the Park. We walked around the lakes; we played. For me it was exercise; my daughter went home happy; and my wife took a little break." Another participant said "they come every Friday to the game to scream and ventilate." Another participant explained how other Americans deal with stress, saying, "Americans plan to take a vacation, they try to relax in the weekend, for us even our day off we have things to do,"

The men in this study expressed their family responsibilities and how that can create stress for them. One of the participants commented, "Sometimes the person is sick

but still he has to work." Participants gave priority to their families. One man stated, "I think it is a matter of priority, instead of going to play (which is selfish), we go to work or we do more things for the family." Another participant supported this idea, saying, "I agree with you. We devote our time to our families." Another parent gave priority to his children's health, saying, "For our kids, we are always taking them to the doctors for any reasons. We do not take chances, and even if we do not have insurance, we still take them to the doctor, but when it comes to us, we sacrifice."

Social forces. Social forces played a big role in determining the participants' perceived health. These forces included religion, culture, social activity, and economic status. Islam was a strong influence on how participants defined and determined their health. Islam had an influence on other forces as well. Most participants viewed Islam as a way of life that can determine Muslims' perceptions, beliefs, and practices. Participants' statements showed the great influence of Islam on health perceptions and practices.

Islam affected how the participants defined their life and health. One participant stated that, "but there is a big difference in how we define the life. Others believe that this is their only life. They want to make use of every minute. But for us, this life is temporary; it is a bridge to the other life (life after death). For others, this is all that they have. There is no life after that. That is why they take care of themselves and their health." But a participant in another focus group mentioned that "the prophet (Mohammed) instructed us to work in this life as if we are going to live for ever and work for the other life as if we are going to die tomorrow."

Participants mentioned several times how praying or following Islamic teaching made them feel healthy. During prayer Muslims feel very close to God; one participant stated, "Our prayer makes us relaxed more than if we go vacation." Doing the morning prayer gives Muslims a fresh start. One participant said that, "When I wake up in the morning and do my prayer, I start the day with clear mind and I feel mentally relaxed."

Reading verses of the Quran is a stress management method used by the participants. For example, one participant recommended the following; "If you are stressed out or nervous, just read some verses of the Quran. You will feel relaxed and healthy."

Other participants mentioned that believing in God "Allah" made them feel healthy. For example, one man stated, "It is how close you are to God that will make you more relaxed and enjoying your life." Another participant commented, "We as Muslims count on God "Allah" to help us; we drink hot tea or some herbs and we believe that it will help with God's will." Another man agreed, stating, "We believe that herbs will help you, but "Allah" is always and is the first that we count on helping us stay healthy." Other participants emphasized the importance of doing what we are supposed to do and counting on God, such as "the Prophet said; do your part then count on God for the rest."

Several participants across the four focus groups made statements that show how their religion will make them engage in a healthy life style or avoid unhealthy behaviors. For example, one participant said, "Following the prophet's teaching will make you always healthy. Do what the prophet encouraged you to do, and avoid all that the prophet asked you to avoid." Similarly, "The prophet said 'when we eat, we don't eat a lot, and we do not eat unless we are hungry.'" Other participants noted, "According to our

religion, we are not suppose to smoke, drink alcohol, or be lazy. Even if you have money you still need to work." Still other comments highlighted the centrality of religious beliefs. One participant said that, "The prophet said teach your kids swimming and horse riding which are all exercises." Sport and exercise are parts of the prophet's teaching. Also the prophet encouraged Muslims to avoid behaviors that may put them at health risks. One participant mentioned that, "The Islam prohibits us from being homosexual, or having sex outside the marriage relationship."

In other cases, some participants expressed the belief that their religion, when combined with other contextual factors, might not allow them to engage in certain healthy activities. Some of them also came up with solutions for this conflict. For example, in discussing the difficulty in getting enough exercise, one participant said, "Besides the price, there are other reasons, such as what the Emam said in the Friday prayer about the fitness centers. He said do not go there and do not let your family go there because of how the ladies dress in these centers." Another participant suggested a possible solution, saying, "Some guys in San Diego, they were thinking about a gym for Muslims that has three or four days for men and four days for women, because some Muslims may not go because of the mixing."

In addition to religion, culture was another of the social forces influencing health. Culture influenced participants' decisions about going for a physical check. Some participants stated, "You go to the doctor only when you are sick" or "I do not go to the doctor unless there is a reason." Others commented on the influence of fear on the decision to seek care, "I am afraid to find out what I have; I do not want to know what I

have." Another spoke of economic fears, "Fears, that when you go to the doctor you open an account there."

Seeking medical help was sometimes delayed because Arabs usually try to treat themselves at home. "Self-care" comes first; one participant stated that, "We, as Arabs, try to treat ourselves at home before we go to the doctor. If you go to the doctor, he will prescribe so many medications that you will feel overwhelmed." They usually try to use their culture and religion to treat themselves instead of going to the doctor. As one participant said, "We drink hot tea or some herbs, and we believe that it will help with God's will." Another participant emphasize that saying, "Even sometimes when you get sick, you try not to go to the doctor. You try to take some herbs and that is it."

Participants' expectations of health care providers were also influenced by their culture, as clearly stated by one participant, "We used to back home go to the doctors. They just give you medicine and you go home; they do not run all these tests." Another man said, "Some doctors will tell you, you need to rest or reduce your weight, but I think that is not medicine. I need you to give me some medicine."

Participants' views of mental illness were affected by their cultural background. One participant highlighted this in his comments, "In our countries, they think if you have any mental or psychological problem then you are crazy." Others agreed, saying, "The word 'mentally sick' is bad and we do not accept it." Another participant disagreed, however, saying, "but I think people are changing and started seeking medical help when the person has mental problems, but we are not up to the other people's level in accepting the mental problem."

Some participants also mentioned the influence of their culture on their ability to follow a healthy life style. For example, "When you visit somebody and they offer you something to eat or drink then you have to eat it. It is not acceptable to say no, even if you are on a diet." In Arabic, this is called "Mojamalat." Participants described trying to seek social acceptance from their family and friends by not refusing their offer because it is not acceptable to do so.

The need for social acceptance was related to another social force, that of social activity. Social activity was used by some participants to define being healthy or unhealthy. For example, "If you have a healthy life, this means you have social relations. You visit others and you are socially active." Conversely, "Being not socially active or not interacting with others means you are not in good health." Another participant expressed this concept of social interaction in a similar fashion, "The person who is not in a good health, you see him not involved with others."

Other participants gave priority to social activity and described how being socially active helped them deal with stress. One man said, "I think it is a matter of priority. Exercise is not our priority; visiting each other and socializing is more priority for us than exercise." Another agreed, as noted earlier, "I think it is a matter of priority, instead of going to play (which is selfish) we go to work or we do more things for the family." In addition to detracting from health behaviors such as exercise, some participants saw social activity as a health promoting behavior. As expressed by one participant, "Sometimes the social activities and the exercise help me deal with stress, and not focus on my problems."

Participants also expressed their lack of social support systems and suggested a support group as a solution. For example, they said, "We, as Arabs, do not have the clubs or community centers where we can talk to each other and express our feelings." Another man noted, "For me I do not do anything. By 8 pm I will be in bed so tired. Even if I am not tired it is boring here so I just go to bed." Still another noted the lack of family support, saying, "Here most of the guys have no family." Others agreed with him and commented, "That is right I miss everybody back home. We used to get together and drink tea and talk, it was fun."

The participants' economic status and other contextual factors are also considered part of the social forces that affected participants' health perceptions and practices. Cost could be a barrier for them to engage in healthy activities. One man said, "For me, sometimes I have ideas like buying bikes for me and my wife and go biking in the park, but when I go and check the prices for the bikes, I found out it is very expensive. " Another participant commented, "if the membership for these places was cheaper and the employers gave staff one hour to go to the gym, that will make more people go." Money also affected other behaviors that influence health; for example, "if you have money, you can go vacation; you can enjoy your weekends."

Participants also discussed how financial status might make them delay seeking medical help. They commented on the need for health insurance, but also noted, "Even if we have insurance, sometimes the co-payment is high. That is why I may not go to the doctor, because I do not want to pay the $20." Another agreed, "Sometimes even if you have the money you can not afford it. I had to file for bankruptcy one time because I received $45,000 bill from the hospital when I had a kidney stone." Others also noted the

economic influences on access to health care, "In addition to that, the money you have to pay with each visit, if I have to go the emergency room I have to pay $100 for each visit."

Health system forces. The fourth category of forces that was identified related to the health care system in the United States. These perceptions can be categorized as the complexity of the system, participants' lack of knowledge, language barriers, and the lack of culturally appropriate care.

Participants perceived the health care system as a complex system in which it was difficult for them to obtain care. They also lacked the knowledge needed to access this system. Participants commented on the many different types of health insurance as well as the difficulty in getting appointments. For example, one participant said, "I believe that the system or the insurance could be complicated for somebody new here." Another man commented on the difficulty of having to go many different places to get care, "For me, sometimes the system is hard, like the doctor clinic is at one location, the lab in another location, and the pharmacy in a different location." They also noted the difficulty of getting appointments, "Sometimes you have to wait several weeks for the insurance approval. Sometimes the problem goes away before you get the approval or they give you approval with a doctor who is so far so you decide not to go."

One managed care system was described by the participants as simple and easy to use due to in the ease of getting appointments and referrals and also the convenience of having all the services at one location.

Lack of health-related knowledge and knowledge about the health care system was reported by several participants, as barriers to obtaining care. Several participants commented on this lack of knowledge. For instance, "I think that there are so many

services may be exciting but we as Arabs do not know about it because we do not interact with others or we do not read about it." Participants also discussed their own failure to seek information, "Also we lack the health awareness, we do not search for the information. We count on others bring the information to us." Similar comments were voiced by other participants, "I think we need to get more educated about our health that will help us in taking care of our bodies" and "I think we need to be educated about our rights, so we can ask for it."

Language barriers were one of the difficulties reported by the participants in accessing health care services. Barriers were created by participants' limited English as well as the lack of English fluency among providers. One man commented, "Even when the doctor asks you what is wrong, I cannot describe for him what I feel" and another stated, "I am afraid to say something wrong which could make them misunderstand me then mistreat me." Others agreed, saying, "It is really hard. I am an engineer and I have worked in California for several years, and sometimes when I go to the doctor I cannot express myself" or "Even if you understand some English still it is hard because the nurses are from different countries, and it is hard to understand their English."

Some participants provided suggestions to overcome language barriers. For example, one participant requested "having an Arabic speaking doctor you can understand him and he can understand you and your concerns" and another suggested "maybe if we have a booklet that has some medical terms in Arabic and English, even if you can not read English you can point to the word in Arabic." Available interpreters and health literature in Arabic were also suggested.

The lack of culturally appropriate care and the lack of knowledge among health care providers about the participants' religion and culture was another issue reported by the participants. "If the staff knows more about our culture that will make it easy for us." One participant suggested, "I think the schools should teach nurses and doctors about cultures, it should be a standard practice for each religion or culture." Another noted that cultural differences arise particularly for women, "It is hard for them to go to the doctor because doctors are not familiar with our religion and culture." One man described an incident that suggested willingness on the part of providers to respect their culture, "We told them to always knock at the door and wait, they did that, they actually put a sign at the door, so I think if they knew they would take care of these issues."

Before presenting the third level of the data analysis the investigator would like to share some of the field notes he gathered during the data collection process. One of the surprising notes is that it was hard to stop the participants from talking. The participants actually enjoyed the group discussion and sometimes they stayed more than an hour afterwards chatting and expressing their feeling. The investigator as a member of the same culture can relate that to the issue of missing their extended family. Most of them are here with their wives and children, but they miss their brothers, sisters, cousins and friends. Men talking and elaborating extensively is something not expected in Arabic culture, but due to immigration and being away from their extended family members, that is understandable.

The second note is that most of the time when the investigator asked participants about their health or their experiences accessing the health care system, they talked about their children or their wives, shifting the focus to their families. That can be related to

their feelings of responsibility or, as mentioned before, they gave priority to others in their family rather than to themselves.

Theoretical Construct

Developing theoretical constructs is the third level in analyzing qualitative data. As noted by Auerbach & Silverstein (2003), the theoretical constructs have to be supported by the identified themes and have to be grounded in the data collected. Strauss (1987) discussed how to capture the complexity of reality by developing a conceptually dense theory that has many concepts and many linkages between them.

The investigator identified two major themes, the dimensions of health and health determinants. One of the methods mentioned by Ulin, Robinson, & Tolley (2005) to help in showing the bigger picture and the wider perspective of the constructs is using visual approaches such as a diagram or taxonomies. So to help the reader visualize this theoretical construct and understand the linkage between the major themes the investigator developed the conceptual model depicted in Figure 1.

The central concept of the model is health, which has six perceived dimensions; engaging in healthy behavior, absence of disease, ability to function, control, feelings of spiritual well-being, and body/mind integration. These dimensions are overlapping and interrelated. They all affect each other and were used by the participants to define health. Several participants referred to being healthy as engaging in a positive behavior such as exercising, and to being unhealthy as engaging in a negative behavior such as smoking.

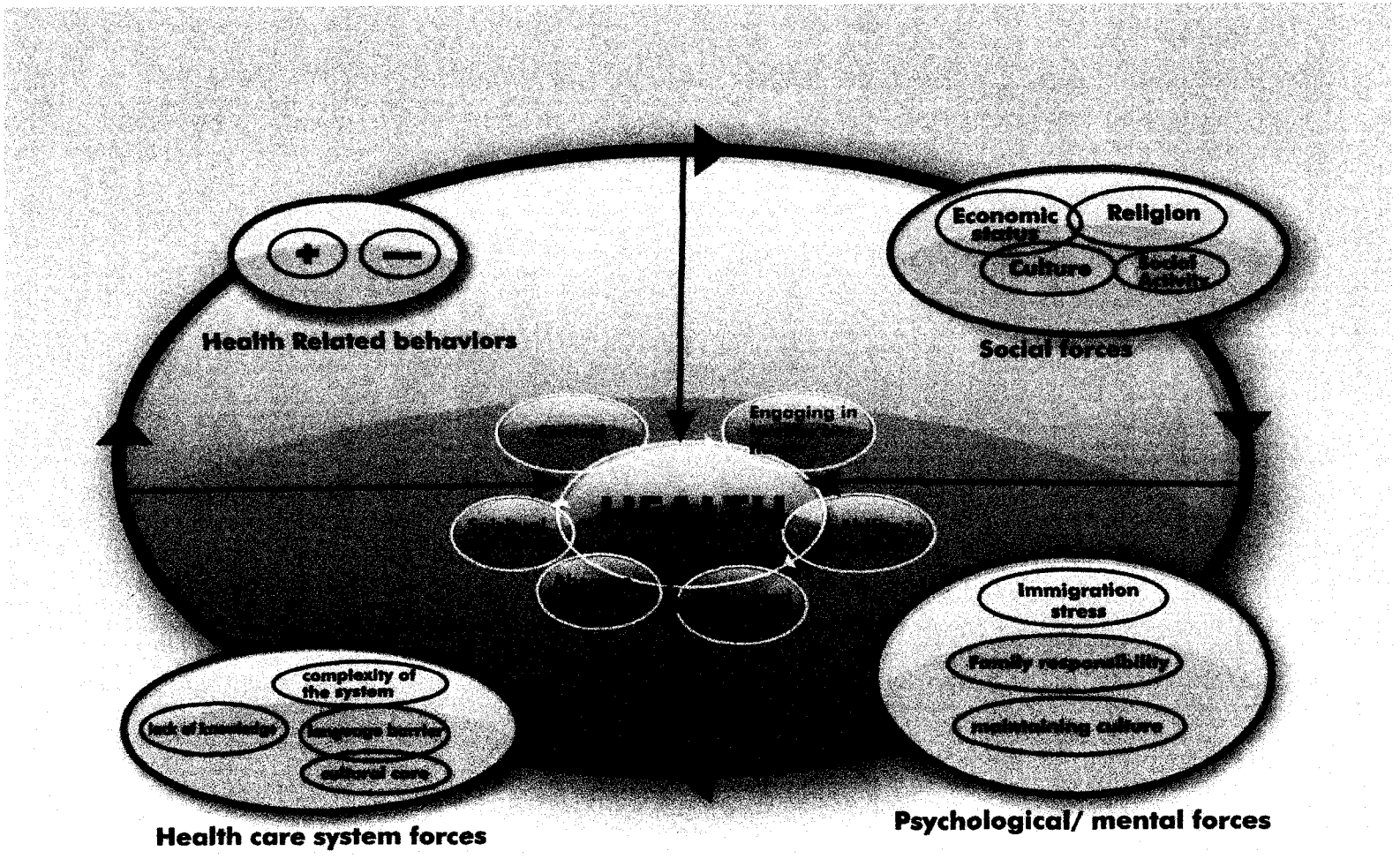

Figure 1: Health Dimensions & Determinants

Spiritual sources of feelings of well-being were highly valued by most participants. They referred to being healthy as being close to "Allah" God or doing the prayer. Having control over their body or mind was used by some participants to define health, participants referred to being unhealthy when they lose control. Being able to function effectively in carrying out roles and responsibilities was another important aspect of health.

Participants reported and valued the integration between their bodies and minds. They referred to being health as "having the healthy mind in the healthy body", so they view their health as the product of the integration of both body and mind. These dimensions of health are reflected by circles in the conceptual model, these circles are overlapping and connected with a bigger circle which is health.

There were perceived forces identified that affected the participants' health. These forces were health-related behavioral forces, psychological/mental forces, social forces, and health care system forces. As illustrated in the conceptual model these forces are interrelated and overlapping so the interaction between these forces affected the participants' health perceptions. Behavioral forces were both positive and negative, and these behaviors affected the participants' health dimensions.

Challenges in the health care system in the United States, such as the complexity of the system, the language barriers, and the lack of culturally sensitive care, affected the participants' perceived health dimensions. Psychological/mental forces, such as immigration stressors and family responsibilities, affected the participants' health perceptions. Participants felt they were living two lives, and were trying to maintain their

culture especially among their children. In addition, the participants gave their family health higher priority than their own health.

Social forces, which included religion, culture, social activities and economic status, also played a big role in defining health among the participants. Religion was a very influential force that affected all other forces and affected how participants defined their health and determined if participants would engage in a healthy life style or not. The participants' culture also affected their health dimensions; self care and using herbs delayed seeking medical help. Culturally, having a physical check up was not a valid reason to visit the doctor. The participants' social activity affected their perceived health; involvement with others and visiting each other was a higher priority for the participants than exercising. The economic status of the participants determined, in some cases, whether or not the participants would seek medical help and also affected the participants' ability to engage in healthy life style behaviors such as exercise.

All these forces interacted and affected each other, and the interaction among these forces affected the participants' health beliefs and perceptions as presented in the conceptual model. In the following chapter, the investigator will discuss the credibility of findings, the limitations of the study and its findings, compare the resulting conceptual model with other health theories, and implications for practice and for future research.

Chapter Five

Discussion

Study Findings and Other Health Theories

In this section, the investigator first will present the current health definition models and health behaviors models, and then compare his model to these older models.

Health Definition Models

The definition of health has changed over the years. The concept of health has evolved from emphasizing the physical or biological aspects to a more holistic view. Larson (1999) described this process of evolution by means of four major models: the medical model, the World Health Organization (WHO) model, the wellness model, and the environmental model.

The medical model. The medical model defines health as the absence of disease or disability. Saylor (2004) called this model the early western view of health that focused on physical health. This model has several limitations, which include its failure to describe psychiatric disorders, its ignorance of social factors, and its general disregard for health promotion and disease prevention. Another major limitation of this definition is that a person may perceive symptoms of illness without having a disease, or a person may

have a disease without experiencing any symptoms. In spite of all these limitations, this model has guided medical research for most of the last century (Larson, 1999).

In this study, absence of disease was identified as one dimension of health. The absence of disease was not a consistent theme across the groups, however, because some participants argued that a person may have a disease, like hypertension, but still have no complaints and be able to function; in fact, in the case of hypertension, sometimes the only symptoms a patient experiences are those arising as side effects of treatment. Additionally, some participants considered themselves to be healthy as long as they remain able to control their disease.

The WHO model. The second model defines health according to the WHO (1948, No. 2, p. 100) definition, which is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This definition expanded the concept of health to include not only the physical, but also the mental, emotional, and social dimensions. The WHO defines health as a status of well-being; but well-being, itself, was not clearly defined by the WHO, a failing that made this model very broad and abstract. It also rendered the model culturally insensitive, because health is defined differently in different cultures. Despite all these limitations, the WHO model was the first to introduce the social dimension of health, and is the most widely used definition worldwide (Larson, 1999).

Body/mind integration was one of the health dimensions identified in this study. Participants described health as a holistic phenomenon, referring to physical, mental and social health. They also referred to the various effects each of these aspects could have on the others.

The status of well-being was described as the ability to enjoy life, live a full creative life, and have social relationships (Saylor, 2004). In this study, some participants spoke of health as enjoying their lives, going for vacations, feeling fresh and active, or feeling relaxed and not stressed. Spiritual factors played a large part in these feelings of well-being. The participants in this study defined well being in a different way, due to the effects of Islamic teaching on their view of health. They described well-being as being close to God.

Consequently, the findings of this study agree with the WHO definition of health in terms of three aspects: 1) health is not only the absence of disease; 2) health must be viewed multi-dimensionally; and 3) one's sense of well-being is an integral component of one's sense of health. However, the participants in this study also emphasized the spiritual aspect of well-being, something the WHO definition ignores.

The wellness model. The third model Larson discussed is the wellness model, which defines health as the strength and ability to overcome illness. This model emphasizes health promotion and progress toward higher function. This model views health as an integration between body, mind, and spirit. Religious and spiritual beliefs have an influence on the physical, mental, and social well-being. This model, like the WHO model, interprets health as being more than the absence of disease. It also includes positive dimensions of health, such as well-being, energy, ability to work, and efficacy (Larson, 1999).

The wellness model values one's social network, including one's spouse, friends and relatives, church organizations, and other organizations. This model values the broad influence these social networks can have upon health. This model

also identifies some common habits and their effect upon health and mortality. These habits are smoking, drinking excessive alcohol, being physically inactive, being obese or underweight, and sleeping fewer than 7 hours or more than 8 hours per night (Larson, 1999).

This model emphasizes the concept of well-being, which includes happiness, quality of life, and other subjective perceptions that are difficult to measure. Also, individuals may define well-being differently, in accordance with their own cultural context. Despite the potential for ambiguity from this, this model provided a broad definition of health which includes personal sense of well-being and is a basis for health promotion (Larson, 1999; & Saylor, 2004).

In this study, the investigator identified control as one dimension of health. Several participants defined being healthy as gaining control over your body or maintaining control, and being unhealthy as losing that control. This is similar to the concept of overcoming illness in the wellness model.

Body/mind integration was another health dimension identified in this study that agrees with the wellness model. Three more areas of agreement between the wellness model and the study findings are: 1) the ability to function dimension of health; 2) the influence of the spiritual dimension on other health dimensions; and 3) the health-related behaviors dimension of health. It seems that several aspects of the wellness model are congruent with the findings of this study.

The environmental model. The fourth model is the environmental model, which defines health as the ability to adapt to one's physical and social surroundings without experiencing pain, limitations, or disability. Health is the capacity to live

physically, mentally, and socially. Hence, this model views health as a dynamic equilibrium between a person and their environment, including their ability to function in that environment. Ill health, conversely, is defined as the inability to function in one's environment. Positive health means that a person has both the ability and the willingness to perform necessary tasks. This model also emphasizes the effects of the social and political environment on the effectiveness of health improvement interventions. Similar to the wellness model, this model's definition of health is broad and, therefore, difficult to measure (Larson, 1999).

The ability to adapt to one's surrounding physical and social environment was identified as important by the focus group participants in this study. Participants experienced several forces that determine their health, such as the health care system, which is a new environment, and also the new living environment in which participants found themselves as a result of immigration. Consequently, adaptation to these new environments shaped the participants' health perceptions. In addition, the political environment affected the participants' view of their health.

One of the dimensions of health identified in this study was one's ability to function, which is similar to the definition of health presented by the environmental model. The ability to function appears to be affected by one's ability to adapt to a new environment. Also, the integration of physical, mental, and social aspects of health was similar to what was reported in the focus groups.

The ICF model. In addition to the four models discussed above, Shaw and Mackinnon (2004) presented a multidimensional view of health which was introduced by the International Classification of Health Function and Disability (ICF) (WHO,

2001). The ICF view of health is inclusive of biological, psychological, social, and contextual determinants in defining and measuring health. According to the ICF definition, heath dimensions are body structure, activity (performing tasks), and participation (social activity), while health determinants are biological, social, contextual, and psychological.

The ICF framework provides a broad view of health. The findings of this study identified somewhat similar dimensions of health. Ability to function was a dimension of health the study participants identified which is similar to activity. Well-being was identified and includes participation and being socially active. The dimension of body structure can be considered to be similar to the absence of disease, and it is part of the body/mind integration dimension. Overall, the dimensions of health presented by this study covered more aspects of health than the ICF framework.

Some determinants of health presented by the ICF model were identified in this study, such as social forces, psychological forces, and health care system forces (contextual). The biological determinant was not identified; instead, health-related behavioral forces were identified.

The proposed health model. The model presented in this study provides a comprehensive and unique view of health that is particularly pertinent to a subculture living in the United States. The dimensions of health presented in this view include the ability to function, engagement in healthy behaviors, the absence of disease, the sense of control, feelings of spiritual well-being, and body/mind integration.

In certain aspects, this model agrees with the previously-discussed models. For example, the body/mind integration dimension is congruent with the WHO model, the wellness model, and the ICF model. The concept of well-being is similar to that proposed in the WHO model and the ICF model. Sense of control is congruent with the wellness model view. Ability to function is similar to what was proposed in several models, including the wellness model, the environmental model, and the ICF model.

Nonetheless, the definition of health provided in this study is unique, because it is more relevant to the current study population than the other models. None of the previously-discussed models provides as comprehensive a view of health as the current model, when considering the current study population. This is because the relevant features of each of the other models have been integrated into one model.

The influence of religion and the spiritual dimension of well-being on other aspects of health was identified to be an important determinant of how study participants defined their health. Another unique dimension of health was engaging in healthy behavior, thereby defining health as a behavior. The participants of this study defined being healthy as engaging in a healthy life style.

Health Behavior Models

Several health models have tried to describe how individuals behave and how they change their health-related behaviors. The current study presented the participants' perceived health dimensions and determinants, which can be used to guide health care providers' understanding of health behaviors and direct future

research and program development for this study population. Before discussing these implications, a review of existing health behavior models is necessary.

Health Belief Model. The health belief model (HBM) states that the likelihood of a person engaging in a healthy life style depends upon four factors: perceived susceptibility, perceived severity, perceived effectiveness, and perceived cost. Perceived susceptibility refers to how vulnerable an individual feels with respect to developing a given health condition or getting sick. If an individual views him or herself as being at high risk for cancer, that perception will make it more likely for him or her to quit smoking or obtain an annual physical examination. Perceived severity refers to the individual's perception about how serious the consequences of developing a given disease will be. For example, if a person views the consequence of developing cancer as being serious, the client most probably will quit smoking. Perceived effectiveness refers to how effective the individual perceives engaging in a given health-promotion behavior will be in preventing illness from happening. For example, if a person does not believe that quitting smoking will prevent cancer, then most probably that person will not quit smoking. For perceived cost, individuals assess the costs and benefits of engaging in a healthy behavior. For a behavior to be adopted, its perceived benefits should outweigh its perceived costs (Glanz, Lewis, & Rimer, 2002).

In addition to these four factors, there are other issues that may affect health behaviors. Cues to action are stimuli that can trigger an action, and include internal and external stimuli. For example, severe headaches may make a given person decide to quit smoking. The value of health is another factor. Individuals who value health

more have a higher likelihood of engaging in a healthy life style. Self-efficacy is another factor that may affect an individual's health behaviors. If the individual is confidant in his or her ability to undertake an action, most likely that individual will do so. Mediating factors, like social, structural, and situational factors, affect all other factors and, consequently, affect one's likelihood of engaging in a healthy life style (Glanz et al., 2002) .

Social cognitive theory. According to this theory, an individual's behavior is determined by personal factors, behavior, and the environment. The personal factors include demographic, personality, and cognitive factors. The behavioral capacity includes the knowledge and skills needed to perform a given behavior. The environment can be physical, social, cultural, political, and situational.

This theory states that individuals do not change behavior in a linear fashion. Rather, changes take place bi-directionally. In other words, as an individual learns more, behaviors and environment may change, which may result in them gaining more knowledge which will reinforce the healthy behavior. The individual's expectations, goals, self-perceptions, and beliefs give shape and direction to his or her behavior. However, the behavior that is carried out then will affect that individual's thoughts and emotions (Bandura, 1986).

Individuals with high self-efficacy believe that their actions will affect outcomes. Self efficacy entails perceiving control over actions that will affect outcomes. A person's self-efficacy develops from their history of accomplishment, from observations of the successes and failures of others, from the influence of

others, and from one's own psychological state (such as emotional arousal, nervousness, or anxiety) while performing a behavior (Bandura, 1986; 1997).

Transtheoretical theory. This theory describes the stages of change, the process of change, decisional balance, and situational confidence and temptation. It describes the stages of change that an individual will go through to adopt a new health behavior. Each stage has distinctive characteristics, and is dependent upon the previous stage. Finding out which stage an individual is in may help the health care provider to tailor interventions appropriate to that stage. The theory describes six stages; pre-contemplation, contemplation, preparation, action, maintenance, and termination (Glanz et al., 2002).

In the pre-contemplative stage, individuals have no desire to change their behaviors in the immediate future. The immediate future usually refers to a six-month time frame. During the contemplative stage, the individual has the intent to change his or her behavior within the next six months. The individual already is conscious of the benefits and barriers of the desired behavior, and plans to change their behavior based on their interpretation of these benefits and barriers. In the preparation stage, the individual is ready to make a change, and may plan to start the change. In the action stage, the change has been adopted and, then, the individual progresses to the maintenance stage. This last stage is one that starts six months after initiation of the action stage and can last for several years. The termination stage is when the individual permanently adopts the change, and feels as if the prior behavior never existed (Glanz et al., 2002).

The processes of change mediate the transition from one stage to the next. The processes of change include the personal, behavioral, emotional, and cognitive strategies that a person will use while changing his behavior. These processes can be clustered into experiential and behavioral processes. These processes are congruent with Social Cognitive Theory (SCT) constructs.

Decisional balance is another construct presented in this theory. It is the pros and cons that guide a person's decision to move from one stage to another. The pros are the positive aspects of changing the behavior, and the cons are the barriers to changing the behavior.

The situational confidence and temptation construct is similar to the self efficacy construct in the SCT. Situational confidence and temptation work against each other during the stages of changes. High confidence will make the individual move from one stage to the next; high levels of temptation result in relapse.

The theory of reasoned action. According to the theory of reasoned action, individuals behave in a certain way because they choose to behave that way, and they use a rational decision-making process while planning these behaviors. The individuals' beliefs, attitudes, intentions, and perceived control over the behavior are strongly associated with the actual performance of behavior. The intension to perform behavior is affected by subjective norms, attitudes, and a sense of self-efficacy. The subjective norms include the individual's perception about what others believe about his or her ability to perform the behavior. The attitudes are influenced by the person's beliefs about the outcome of his or her behavior. This theory focuses on

predicting the intention to perform a behavior, rather than the actual performance of the behavior (DiClemente, Crosby, & Kegler, 2002).

The proposed health behavior model. Participants in this study identified several factors that influenced their health and their ability to engage in healthful behaviors. These factors can be categorized as behavioral forces, mental/psychological forces, social forces, and health system forces.

Previous literature regarding health in Arab Muslims living in the United States has identified several factors that may affect their health. These factors are congruent with the current study's findings which validate these findings. In 1989, Laffrey and other investigators identified the following factors: the trauma associated with immigration; cultural conflict in the United States; loss of social support systems; and the immigrants' limited knowledge of the complex American health care system.

Hattar-Pollara and Meleis (1995) identified several stressors that Arab Americans experience. These stressors include feelings of loneliness and social isolation, being apart from the host society, disruption of their families' stability, and a sense of inadequacy due to language barriers.

Kulwicki and associates (2000) identified obstacles experienced by Arab Americans trying to access health care services. These obstacles can be summarized as language barriers, cultural barriers related to modesty, and gender preferences when seeking and accepting health care from male or female providers. Other obstacles include strong values related to family privacy, the values of honor and shame, and barriers related to the stresses of immigration and acculturation.

The forces identified in the study are consistent with this previously-discussed theory. The behavioral forces identified here are similar to the behavioral capacity presented in the SCT and the behavioral processes presented by the transtheoretical theory. They are similar because they all propose that the person's positive and negative behaviors affect his or her health status. In this study, the individual's positive and negative health-related behaviors affected that individual's health.

Mental/psychological forces also appear to affect the participants' health and health-related behaviors. Participants experience stressors related to several factors, some of which are related to immigration and family responsibilities. This is similar to the mediating factors mentioned in the health belief model, and also similar to the environmental factors discussed in the SCT. These situational factors affect the participants' likelihood of engaging in healthy behavior.

Social forces, such as religion, culture, social activities, and economic status, were identified. These forces are consistent with the personal and environmental factors identified in the SCT and similar to the attitudes and beliefs presented in the theory of reasoned action. They also are congruent with the situational factors presented by the health belief model. Religion was mentioned as a factor in some theories, but Islam has a strong influence on the participants' behaviors, which is a unique finding. Several participants across the four focus groups made statements that show how their religion causes them to engage in a healthy life style and/or avoid unhealthy behaviors. In addition to religion, culture is another social force that appears to influence health and health-related behaviors.

Health system forces that were felt to be important included participants' perceptions that can be categorized as the complexity of the system, the participants' lack of knowledge, language barriers, and the lack of culturally-appropriate care. Previously discussed theories mention situational factors and the level of knowledge and skills needed for a person to perform a given behavior. However, our study groups described even more relevant forces that apply to them.

The conceptual model shown in Figure 1 presented a unique view of the health dimension and health behavioral determinants. This view provided insights into the male Arab-Muslims' health perceptions and health promotion perceptions and practices. Understanding this is important in appreciating the nature of the target population's health behaviors; it can explain the dynamics of their behaviors, the processes for changing behaviors, and the effects of external influences on behavior. However, before discussing the implications of these findings, it is important to discuss their credibility and limitations.

Credibility of the Findings

Ulin, Robinson, & Tolley (2005) published guidelines by which to establish the trustworthiness of investigative findings. These guidelines required an inspection of the following criteria: credibility, dependability, confirmability, and transferability. The current investigator used these same four criteria to assess the truth value of the study findings.

Credibility means that the findings are consistent with the data collected, and that they are understandable to the study population and to other researchers. Auerbach & Silverstein (2003) argued that data analysis must be transparent and

communicable. Transparent means that other researchers can determine the steps by which the investigator arrived at his or her interpretations. In Chapter 4, the findings were presented very clearly, revealing the participants' actual statements to show the reader how and why certain inferences were drawn.

Communicability means that the themes and constructs can be understood by other researchers and research participants. For this study, the themes and constructs were reviewed and approved by one dissertation committee member who is an expert in qualitative research. This does not mean that other researchers necessarily would derive the same constructs or agree with them; it only means that they should be able to understand the findings. At the end of the last focus group, the current investigator presented his findings to some focus group participants and was able to explain the findings successfully, so that the participants understood and concurred with the findings.

Dependability means that findings can be replicated by repeating the process used to obtain the results (Ulin et al., 2005). This investigator presented the data collection and analysis process very thoroughly, so that other researchers can replicate this study, should they so choose. The findings chapter included the revised questions and other procedural notes, so as to make it even more possible for other researchers to replicate the study.

Confirmability of findings can be achieved by opening the study process to outside inspection and verification (Ulin et al., 2005). This study was supervised and verified by the dissertation committee members, and findings were reviewed and approved by these members. The investigator does not claim to be a detached and

neutral observer, but he realize his subjectivity and has painstakingly utilized the guidance and monitoring of others to help him limit the effect of this subjectivity on his research, thereby allowing participants to express their experiences, values and beliefs without constraint. During the interviews themselves, the investigator used open-ended questions without providing suggestions to participants, thereby trying to avoid guiding their answers.

Transferability means that the study findings (constructs) can be extended beyond the study sample to other similar contexts and populations (Auerbach & Silverstein, 2003). The author believes that the theoretical constructs identified in this study can be extended to other immigrant subcultures living in the United States. Despite differences in subcultures, immigrants all experience many of the same stressors, like health care forces, barriers to accessing health care, and immigration stressors, so that these general principles usually apply to other subcultures.

Limitations of the Study

Before discussing the implications of this study, it is crucial to acknowledge some limitations inherent in its design. First, the data were collected via focus groups, which allowed for the expression of collective themes, but may have prohibited personal exploration of these themes. The participants in the focus groups were known to each other, and most of them were known to the investigator, which resulted in a lack of anonymity and perhaps precluded more in-depth personal expression. In some cases, the focus group members may have felt pressured to conform to the attitudes expressed by other members of the group.

Second, the participants were volunteers and may not have been representative of the Muslim Arab American males they represent, having been a self-selected sample of men who were willing to talk about their health beliefs and practices. Therefore, the study findings may not be generalizable to all Muslim Arab American men.

Third, the data collected in this study were self-report data. The participants in this study described their attitudes and behaviors; however, reported behaviors may differ from actual behaviors.

Fourth, the focus groups were semi-structured, using pre-determined questions, so that responses also were structured, to some degree, by the investigator. Most of the questions were open-ended. Nonetheless, some aspects of the health perceptions and practices of these men may not have been uncovered.

Fifth, the presence of a Muslim Arab male moderator who is imbedded within the culture also may have influenced the content of the participants' responses. On the other hand, having this moderator conducting all the focus groups made the data more culturally relevant. Additionally, the moderator was able to understand the participants' expressions, jokes, and discussion. To minimize his influence on the study results, the investigator tried to obtain an appropriate balance of cultural relevance and objectivity.

To control personal bias during the focus group discussions, the investigator used open-ended questions without providing suggestions to participants, thereby trying to avoid guiding their answers. During data analysis, the investigator used several additional strategies to control personal bias. First, the judgments he made in

identifying the themes were made explicit and clear, so readers can see what led to the investigator's conclusions. The second strategy was to use two independent coders in analyzing the data. In this study, the dissertation committee members participated in coding and analyzing the data. A strong intercoder agreement suggests that the themes are not just an invention of the investigator's imagination but adds to the validity of these themes.

The third strategy was to give the participants the opportunity to examine and comment on themes and categories. At the end of the last focus group, the investigator presented his findings to some focus group participants and gave them the chance to reflect on these themes; they agreed with the findings. The investigator does not claim to be a detached and neutral observer, but the theoretical constructs identified were empirically grounded in the data and each theme or concept was supported with several quotes from participants.

Finally, the investigator would like to insist that the findings of this study could not have emerged using a quantitative research design. Focus group discussions and having a moderator of the same culture and gender allowed for a more in-depth examination of perceptions and beliefs than pre-determined, statistically-testable hypotheses would have permitted.

Implications for Practice and for Future Research

The Arab Muslim population is one of the dramatically increasing minorities in the United States. In addition to other factors, gender, religion and cultural background influence individuals' beliefs, behaviors, and attitudes to health and illness. Little is known about Arab American male immigrants, how they perceive

illness, how they promote their health, and the stressors they experience and barriers they face in accessing the American health care system.

This model provides guidance during the various stages of planning, implementing, and evaluating health care and health promotion programs. The dimensions of health identified in this study provide guidance for health care planners and providers. The spiritual aspect of well-being was identified as a dimension of health which should be considered in planning health care services for this population.

This model presents the experiences that American Arab males face, and reflects the stressors they experience, including immigration stressors, family responsibilities, and cultural strain. It also demonstrates how these stressors may affect the health and health-related behaviors of this target population. Also, American Arab males appear to experience financial difficulties that affect their health and likelihood of engaging in healthful behaviors.

The study findings also identified perceived obstacles to accessing the health care system, like language barriers, the complexity of the system, and the lack of culturally-appropriate care. In addition to all these environmental and situational factors, American Arab males experience stresses related to their culture, religion, and gender.

Recognizing these factors and integrating this knowledge into future health and health promotion services is crucial to obtaining successful health outcomes. We, as nurses, need to be aware of these religious and cultural factors, in order to provide culturally-competent health promotion services for this population. We also need to

integrate Islamic teachings in our interventions to provide appropriate care. Providing instructions in the Arabic language also will be important if we wish to optimize the nursing care we deliver. In order to close the gap between the health of minority and majority populations, an in-depth understanding of health perceptions and health promotion beliefs and practices among immigrant populations in the United States should be used to provide culturally-sensitive health care and health promotion services.

In order to test the validatity and transferability of the study findings, future research should be conducted in two steps. The first step is to validate the findings among members of the same culture. Further research with other members of the same culture should be based on the current study findings rather than simple replication. To refine the theoretical constructs, further researchers should conduct studies based on the unique findings as explained in the following paragraphs.

The influence of Islam in defining health and engaging in healthy behaviors was a significant finding in this study. The current study did not examine directly the participants' level of commitment to Islamic teaching and how that influences their health dimensions and health determinants. Future research should test this relationship through participant observation to evaluate the level of commitment to Islamic teaching and how that influences participants' health dimensions and health determinants. In addition, conducting another study with participants who are less committed to Islamic teaching to compare results is essential.

The influence of the Arabic culture in defining health and determining health behaviors was also a significant finding. This study did not examine acculturation

and the effect of the length of stay in the U. S. and how that affects the participants' health dimensions and health determinants.

Another finding that needs to be examined further is the influence of the social intention or social support on the participants' health beliefs and practices. Usually Arab Muslim men immigrate to the U.S. alone; so they have no family and may have few friends. Studying the effects of social support on participants' health perceptions, beliefs and practices will provide a more comprehensive understanding of the phenomena.

One of the forces identified in this study that determined the participants' health was the health care system. Integrating studies that focus on the perceptions of those who provide health care services to immigrant populations would allow for a more balanced view of the phenomena described in this dissertation.

The second step in future research is to establish the transferability of the study findings. To validate the theoretical constructs developed in this study and examine the transferability of these constructs, researchers should conduct similar studies with men who have immigrated to the U.S. from different cultural and religious backgrounds.

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Appendix A

Recruitment Flyer

Dear Sir,

My name is Abdel Raheem Yosef, I am a PhD student at University of San Diego, Hahn School of Nursing and Health Science. As a PhD dissertation, I am conducting a research study. The purpose of this research is to explore health and health promotion perceptions and practices among Arab Muslim men living in the United States.

This research will involve participating in a group discussion for a period of one to two hours. There are no potential risks in this study, and there are no immediate benefits to the participants. Your participation is voluntary, and you have the right to withdraw from the study at any time.

If you are Arab and Muslim, 21 years of age or older, and have been living in the United States for more than one year, then you are eligible to participate in this study. All the sessions will be confidential, no names or other personal information will be mentioned, and the results of the study will be used for research purposes only. At the end of the study all tapes and transcripts will be destroyed.

Health care providers need to understand how you view your health to be able to provide you with culturally appropriate health and health promotion services.

If you are interested in participating, please contact me at (714) 878-6713, or inform the person who gave you this flyer.

Regards

A. Yosef

Appendix C

Informed Consent Form

Dear Participant,

The purpose of this study is to explore health and health promotion perceptions, beliefs, and practices among Arab Muslim men living in the United States. Your participation in the study will involve participating in a group discussion for a period of one to two hours. After the first group meeting, another meeting may be conducted to review the first meeting findings. The group discussions will be conducted either in Arabic or in English according to the participants' preference. These group sessions will take place at the community service center conference room. The researcher will provide free food and beverages. The group session will be audio taped for the research purposes. There are no potential risks in this study, and there are no immediate benefits to the participants. Your participation is voluntary, and you have the right to withdraw from the study at any time. All the sessions will be confidential, no names or other personal information will be mentioned, and the result of the study will be used for research purposes only. At the end of the study all tapes and transcripts will be destroyed.

Prior to signing this consent form, you will have the opportunity to ask about the research and the researcher will answer your questions. There is no agreement, written or verbal, beyond that expressed in this consent form.

I, the undersigned, understand the above explanations and on that basis, I give consent to my voluntary participation in this research.

Signature of subject: _____.

Date_____.

Signature of principle researcher: _____.

Date_____.

Signature of witness: _____.

Date_____.

Appendix D

Participant Demographics

Category	N	(%)
Age		
28-38	7	35
39-49	8	40
50-65	5	25
Education		
High School	6	30
Associate degree	3	15
Bachelor's degree	10	50
Master's degree	1	5
Annual Income (in $1000)		
0-30	3	15
31-40	4	20
41-50	6	30
51-60	3	15
61-70	3	15
71-80	1	5
No. Years in USA		
2-5	1	5
6-10	4	20
11-15	6	30
16-20	8	40
21-25	1	5
Country of Origin		
Jordan	5	25
Palestine	6	30
Syria	5	25
Iraq	1	5
Egypt	2	10
Lebanon	1	5

Appendix E

Focus Group Questions

1. What does it mean when someone is healthy?
2. What does it mean when someone is unhealthy?
3. Do we, as Arabs and Muslims, define health in a different way than others in the United States?
4. What do you do to stay healthy?
5. What do you do that may harm your health?
6. Why we do not go for physical checks up even if we have insurance?
7. Do you face any difficulty going to the doctor?
8. What things could facilitate for you going to the clinic or the hospital?