*Health Care for Women International*, 28:285–308, 2007

ISSN: 0739-9332 print / 1096-4665 online
DOI: 10.1080/07399330601180206

Routledge
Taylor & Francis Group

# Bridges and Barriers to Health: Her Story—Emirati Women's Health Needs

WENDY WILKINS WINSLOW
*College of Registered Nurses of British Columbia, Vancouver, BC, Canada; School of Nursing, University of British Columbia, Vancouver, BC, Canada*

GLADYS HONEIN
*Health Policy, Management and Evalvation, University of Toronto, Toronto, Ontario, Canada*

*Health care services in the United Arab Emirates have developed rapidly in the last 30 years fueled by oil revenues. These services have been planned and provided predominantly by non-nationals, with mixed success. The authors identify aspects of the health care system and the sociocultural environment that create both barriers and bridges to holistic health for Emirati women. Barriers include early/consanguineous marriage, frequent childbearing, polygamy, and care that is lacking in competence and cultural sensitivity. Bridges include Islam, folk medicine, cultural traditions, and the opportunity to travel abroad for health care. Maids are seen as both a barrier and bridge at different times. Recommendations for future improvements include listening to Emirati women and providing more gender-appropriate, holistic, and culturally congruent programs.*

If human beings are to survive and live in a healthy, peaceful and meaningful world, then nurses and other health care providers need to understand the cultural care beliefs, values and life ways of people in order to provide culturally congruent and beneficial health care.

Madeleine Leininger, 1978 (Leininger & McFarland, 2002, p. 3)

Received 20 June 2005; accepted 13 April 2006.
This study was partially funded by the Faculty of Medicine and Health Sciences, UAE University, and was approved by its Research Ethics Committee.
Address correspondence to Wendy Wilkins Winslow, RN, MSN, 5321 Aspen Drive, West Vancouver, BC, Canada V7W 3C8. E-mail: winpat@telus.net

Little is known about the health care concerns and needs of women in the Arab world. In this study, the authors explore the impact of the health care system and the sociocultural environment on the health of Emirati women. By listening to the voices of Emirati women the authors identify a range of barriers and bridges to this group of childbearing women attaining holistic health.

The United Arab Emirates (UAE) is a country on the southeastern edge of the Arabian Peninsula. It is slightly smaller than the American state of Maine. In 2002, the predominantly Muslim population was estimated at 3.44 million, with less than 20% being Emirati (World Fact Book, 2004). The UAE has developed rapidly and dramatically since the country was established as a federation of seven sovereign sheikhdoms in 1971. Fueled by oil revenues, the UAE experienced rapid social and economic development. There is now an impressive infrastructure of private and public hospitals, primary health centers, school health, and public health programs as well as medical and nursing schools.

UAE society is primarily traditional and tribal. Although lifestyles are changing as they are exposed to Western influences, Emirati women live very conservative and sheltered lives by Western standards. They marry young, usually through an arranged marriage, and often to a first cousin. Most women do not drive; they live largely within the confines of their extended families, only going out with the approval of their fathers, brothers, or husbands, although, contrary to some Western views, Muslim women play an influential role in family decision making (Kulwicki, 2003). Women usually share the same household as their in-laws. Most homes have private rooms (majlis), which are segregated to entertain men and women separately. The birth rate is high, with 18.78 births/1,000 population (World Fact Book, 2004). Many children, especially sons, are a source of pride and security. There is a strong emphasis on the central role of an Emirati woman as mother and caretaker of her large family, and there is great respect for the extended family and elders.

Islam is an integral part of daily life. Islam requires women to dress modestly. Emirati women wear the traditional hijab (black head scarf) and abaya (full length black cloak) whenever they are in public. More conservative women also wear a burqa (mask or opaque veil) covering their faces. Under Islamic law, men are entitled to have up to four wives, but each should be treated equally. Religious leaders (mutawa) play an important role in the UAE; they are versed in the Koran, and Emiratis refer to them for their daily concerns, including health problems.

Al Ain Medical District (AAMD) covers 22,000 square kilometers within the Abu Dhabi Emirate. As in the rest of the UAE, health services in AAMD have developed rapidly since 1960 when patients and their families traveled to a small American-run hospital by foot or camel. As the UAE has established extensive health services, there has been a dramatic rise in life expectancy

and a reduction in infant and maternal mortality (Winslow, 1997). In the absence of appropriately qualified Emiratis, the vast majority of health services have been planned and provided by non-nationals. Historically planners and providers have been in a position of power, influence, and authority, while the Emirati population, lacking medical knowledge, has been in a dependent position, accepting the services provided.

Cultural competence is an important component of effective health care. Health care professionals need to understand the role of culture in health and sickness. They need to develop the competencies to care appropriately for people from different cultures and to understand the beliefs and the values of cultural groups that may be very different from their own (Jones, Cason, & Bond, 2004; Leininger & McFarland, 2002; Rothschild, 1998). Leininger has written prolifically about transcultural nursing care. Culturally congruent care is at the heart of Leininger's cultural care diversity and universality theory (Leininger, 2002). This theory focuses on the close interrelationships of culture and care on health, illness, and death. Various factors influence cultural values such as language, religion, kinship, politics, education, economy, technology, ethnohistory, and the environment. The theory describes cultural differences and commonalities from a multidimensional and holistic perspective. This theory has been used extensively to develop knowledge about culture and care, and we used it to generate knowledge about Emirati women and their health needs.

In many health care settings, including in the UAE, culturally congruent care is not a reality. It was our experience that many well-intended health professionals worked in the UAE without understanding culturally based care. Taylor (2005) identifies that this problem, compounded by language differences, often results in misdiagnosis, a poor understanding of the care plan, poor health outcomes, and client dissatisfaction.

Various international studies have shown that there are major gender inequalities in access to health services and in the way men and women are treated by the system, generally resulting in inadequate and inappropriate care for women (Gijsbers van Wijk, van Vliet, & Kolk, 1996). Women internationally have diverse health care needs that historically have been neglected by health care systems worldwide (Barry, 1993; Brems & Griffiths, 1993). It is increasingly recognized that, despite lower mortality among women now seen virtually throughout the world, women experience more morbidity than men (Pettigrew, McKee, & Jones, 2000). Women present myriad health concerns that are unique to women (such as pregnancy), predominate in women (such as osteoporosis or depression), or manifest themselves differently in women (such as heart disease). Meleis and Im (2002) point out that there is a paucity of models that reflect the complexity and the social, cultural, and historical context of women's health experiences; they advocate a more integrated and coherent model:

> It is not the culture that shapes the healthcare experiences of clients. It is the extent to which they are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized and ordered around. The inequities that people experience in the societies where they are living tend to marginalize them and to deprive them of quality care. (Meleis & Im, 1999, p. 96).

There has been some preliminary work done to look at women's health problems and reproductive health policy in the Arab world. Zurayk, Sholkamy, Younis, and Khattab (1997) describe the patriarchal Arab family where finances are strictly the man's perogative. Within the extended family, young women are assigned the most strenuous household chores. Marriage and motherhood are highly valued, and the pressure to produce sons is strong. Others identified an inverse relationship beween the number of children an Arab woman has and her education, income, and age at marriage (Abu, Tabenkin, & Steinmetz, 2003). These social factors that prescribe the role of women have a negative impact on the health and well-being of Arab women. Not much is known about the health needs of the UAE population, however, particularly the women. In the midst of the rapid expansion of health services, there is little evidence that anyone has consulted Emiratis about their health care needs. The development of future health services needs to be targeted toward the national population who will remain in the country as expatriate workers are phased out and replaced by appropriately qualified Emirati health professionals. As part of the process of designing new, culturally appropriate health services and in recognition of the impact women have on the health of their families, we believed it was timely to consult Emirati women about their health needs. We wanted to explore their health from a holistic perspective, not just from the perspective of their reproductive health. This study was designed to identify the health concerns and needs of Emirati women, ages 16–45, and living in AAMD.

## THE INVESTIGATORS

The investigators, two nurses and a medical educator, were expatriate women from diverse backgrounds working in the UAE. Through our work we came to believe the existing health care system did not address Emirati women's needs well. As health care professionals we were deeply committed to learning more and helping to improve the system for women in particular. All the investigators spoke Arabic to some extent but one investigator (GH) spoke Arabic and English fluently. She became the focus group moderator and provided translation. A fourth team member was a young Emirati woman who played a supportive role as cultural interpreter and transcriptionist. Her presence at each focus group, her language skills, and her cultural awareness enhanced our understanding of what the women were saying. In addition to

the bilingual investigator/moderator, at least one other investigator attended each focus group to provide a welcoming environment, help with logistics, and take field notes.

## METHODOLOGY

The issues associated with women's health are wide ranging, multifaceted, and not readily quantified. We considered a qualitative research methodology the most appropriate to explore this uncharted area of health needs. We used grounded theory (Strauss, 1998) to explore the complex arena of health needs from the women's perspectives and to develop a theoretical construct that described these needs. We wanted to understand the extent to which the existing health care system met women's needs and to learn what they believed would improve the system.

## DATA COLLECTION AND ANALYSIS: FOCUS GROUPS

To collect data, we invited Emirati women to talk about their health needs in focus groups. McLafferty (2004) describes focus groups as a data collection strategy that provides rich sources of information. Focus groups can be used to generate constructs, develop models, guide product development, and evaluate new programs and products (McDaniel & Bach, 1994). They have been used in social and health science and in evaluation research, predominantly with Western-speaking populations, to gather in-depth views and thoughtful opinions of peers who share a common frame of reference (Kidd & Parshall, 2000). Krueger (1994) describes six advantages of focus groups. He says they provide a natural social environment that prompts interaction and candor; there is a flexibility that enables the moderator to explore unanticipated issues; there is high face validity and the results are readily understood through the use of quotations; the cost can be relatively low; they can provide speedy results; and the size of the study can be increased through group rather than through individual interviewing. Krueger also suggests focus groups are an effective approach to collect data from less literate people. We were also cognizant of the disadvantages Krueger attributes to focus groups, particularly those related to logistical issues such as assembling the women and managing their enthusiasm, but we believed with thoughtful planning and a skilled moderator, we could avoid most pitfalls and make it an interesting and enjoyable experience for the participants. Because of the varying levels of women's literacy, we kept our approach to the focus groups simple. We did not use expressive drawing, laddering, or other techniques suggested by Krueger to involve participants, although these techniques would be interesting to explore in the future.

Although there was little evidence that focus groups could be used successfully in the Arab world, we believed that, like women in Western

countries, Emirati women would be willing and able to participate in focus groups and that they were the best source of information about themselves and their health needs. We believed that Emirati women would see the interaction and discussion of a focus group similar to that of a typical gathering in a majlis. Our awareness of the oral heritage of the country further reinforced our belief that, with a culturally sensitive approach and a skilled Arabic-speaking moderator, focus groups would be a relatively quick, inexpensive, flexible, and effective way to collect relevant data from women with varying levels of literacy (Winslow, Honein, & Elzubeir, 2002).

Most of the women in our study had little knowledge of research and were unfamiliar with tape recording. At the beginning of each focus group the moderator described the purpose and process of the focus group and she explained that each participant's contribution was important and valued and her role was to keep the group on task. She assured the women about the confidentiality of individual contributions. All participants signed the Arabic consent form that emphasized their right to withdraw at any time. The moderator began by asking, "What does health mean to you?" As the discussion proceeded she asked, "How do you as women in the UAE see your health?" In some groups a few further prompts were needed such as, "You have no problems? What happens when you are sick?" The moderator's listening ability and skillful probing supported the women to describe their individual and collective views of health, their health needs, and system problems.

Immediately following each focus group the investigators met to debrief, discuss major issues, and identify any refinements for future focus groups. After each tape recording was transcribed in Arabic and translated into English, each investigator read the transcripts independently to identify themes that could be coded, categorized, labeled, and compared. The investigators met regularly to share and compare their independent data analyses; to consider the intensity, frequency, and specificity of the discussions; and to explore emerging concepts and ideas through a process of constant comparative analysis. As the investigators identified issues arising from one focus group, they developed follow-up questions to probe, amplify, or clarify in subsequent focus groups. When there was a concern about the English transcript, the bilingual investigator reviewed key parts of the Arabic tapes to clarify the original meaning. By the fifth focus group no new data were emerging and a conceptual framework was created and refined by immersing ourselves again in the data and exploring relevant literature. The framework then was offered for discussion to a sixth and final focus group and strongly endorsed by the women as an accurate representation of their experiences.

## THE SAMPLE

Arab and Muslim women are often victims of stereotyping; myths persist that they are imprisoned behind a veil of powerlessness (Al Hegelan, 2000).

In reality, young women in the UAE are enrolling in higher education and entering the work force in increasing numbers. Despite the challenges of a patriarchal society, women are playing an increasingly significant role in society and becoming active partners with their men in the rapid economic and social development of the UAE, building one of the most rapidly developing countries in the Middle East. We selected a convenience sample of Emirati women who were predominantly recruited through the Abu Dhabi Women's Association (ADWA), an organization to encourage education and abolish illiteracy among women. We held the first session in the evening at a health clinic but quickly discovered transportation was a problem for these women who relied entirely on men to chauffeur them. To avoid this problem with the subsequent four focus groups, we decide to meet the women where they normally congregated—in their classrooms at the ADWA. The ADWA director extended our invitation to the women, and those who were available, and either interested or curious, participated. The sixth and final focus group was held on campus with women we knew from the UAE University. There were 4 to 12 women in each group.

The 60 participants in this study ranged in age from 16 to 45; two thirds of the women were 30 years old or younger. Thirty-seven were married; 11 were single; 10 were divorced; and 1 woman was widowed. Fourteen women had primary education and 34 had completed some secondary education. Seven were university graduates. The majority were housewives (28) and students (19). Thirteen women had 1 to 3 children; 17 had 4 to 6 children; and 8 had more than 7 children.

## FINDINGS

At the beginning of each focus group the women tended to assert that they were healthy and had no problems. They said they were well provided for by the Ruler of the UAE on earth and by Allah in heaven. They were unwilling to be critical of the health care system for fear of denying the good work done by the government. With a little prompting, however, they were more forthright about the health care system and their own health status. The discussion became free flowing and far ranging, often with several women speaking loudly and enthusiastically at the same time, putting the moderator's skills to the test.

When the Emirati women talked about their health, they talked about their lives. They described good health from a broad perspective. Excerpts from the transcripts illustrate their views:

> It is not only physical health but also social health—it impacts on human health. Health is a crown for healthy people and no one can appreciate how important it is except those who have passed through sickness.

They described their own health as falling far short of the holistic model in which they believed. They described the inter-relationship between their lives and their health:

> I am nervous and keep it inside—I feel heartburn and headache. It can cause heart problems.
>
> Many of us eat fattening meals, which leads to obesity. There is a lot of short sightedness and anemia. We have postnatal problems.
>
> The more we are tense and anxious, the more it affects our health negatively. On the other hand, if our minds are relaxed, we are less negatively affected and our health is better.

They identified both bridges and barriers to meeting their health needs and they identified what they needed to improve their health (Figure 1). Their perceptions were rooted in their own experience and that of their families and friends.

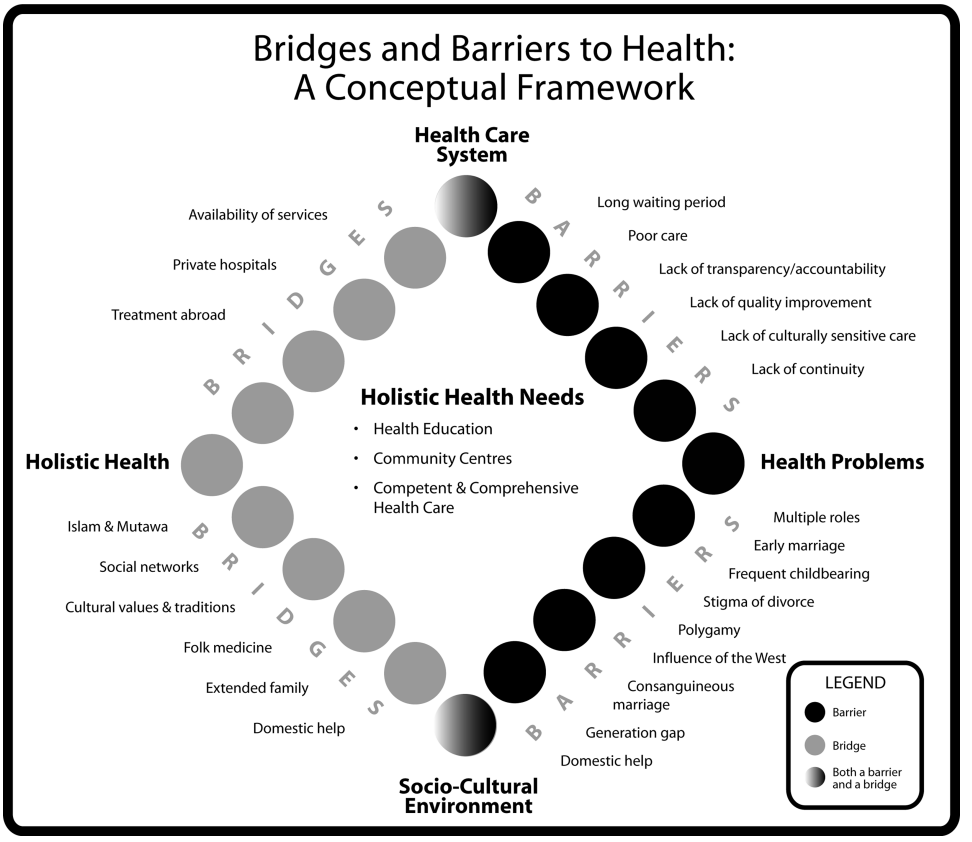


**FIGURE 1**

## Barriers to Health—SocioCultural Environment

These young women enumerated many physical and psychosocial problems that they and their peers experienced. The women described many components of the sociocultural environment that led to stress, fatigue, and health problems related to nutrition, hypertension, obesity, diabetes, and women's health issues:

> Fatigue is not only due to the house and our responsibilities, but there are other problems too, like contraception pills that can cause depression and fatigue—also the menstrual period.
>
> If a lady keeps her problems to herself and she is unhappy, it will cause her heart problems.

### Multiple roles

The women described the multiple roles women have that create stress. Increasingly they were working outside the home or participating in higher education, yet they still had major domestic responsibilities as mothers and wives, with little support from their husbands. They faced challenges managing these roles:

> The father is away most of the time so she *(the mother)* is the primary person raising her children and she is responsible for educating them and she herself goes out to study too, and she has to run the house and the whole family too.
>
> I don't have time to look after myself with the pressure of my duties. All the time—do, do, do. . ..
>
> Long hours. Lunch is not enough. I reach home tired, I grab anything I find, eat, and then sleep. I am so tired that I don't sit with my family—not even for an hour—so I became introvert while I am usually sociable, but my circumstance and my employment dictate this lifestyle.

### Early marriage and frequent childbearing

The women often repeated that early marriage and frequent childbirth had a negative impact on their health. They agreed that a young girl is not physically or mentally ready to have a husband or a family:

> The problem of having many kids is big. The husband wants more kids even if this is going to compromise his wife's health. The husband asks for kids in spite of the woman's health, and when the number of kids increases, he tells her, "You are old. I should be marrying another one."
>
> Many deliveries affect a woman and lead to her physical and psychological exhaustion.

> There are girls who marry while very young, and they have no idea what marriage is, so their marriage fails. I was married when I was still 14 and had 4 children. At 19, he divorced me.

### Stigma of divorce

Divorce was seen as a social disgrace and was painful for these women:

> It (divorce) affects her psychology and her health and her children—even her school performance is affected.

One resolute woman described how she coped:

> It is hard to face people as a divorced woman, but I tried to strengthen myself and depend on myself and I said to myself, "Divorced women are not a cancerous disease and this happens and I have chosen my way and I put my studies as a priority."

### Polygamy

Some women described how the prospect of a second wife affected their well-being and the negative impact on them and their children when another wife came into the house:

> Multiple marriages are not healthy because the man needs one woman, not several women! This affects how the woman raises her children because she always worries. She is always under pressure and it affects her health.
>
> The presence of (two) families under one roof leads to problems in raising children. Each mother wants to raise her children her own way... and it affects everyone's behavior.
>
> (When there are) multiple wives in one house, and children from each wife, with different thinking and ways of living, even diseases spread among them.

### Influence of the west

The women spoke of undesirable Western social influences such as clothing, television, cars, and drugs as threats to the Emirati family's integrity and well-being:

> Young men are imitating the West in their clothes, the hairstyles, and their behavior in the streets, and, sorry to say, they don't take the positive aspects like education, culture, and thinking about the future. They are

heading to lots of things which are not good for them—these are not our traditions and not part of our culture.

### Consanguineous marriage

While many women were aware of the hereditary diseases associated with consanguineous marriage, they found it difficult to disregard social norms and parental expectations. They spoke of the tensions between traditional cultural norms and new knowledge:

> Hereditary diseases are very common, but people keep on marrying close family. I prefer to marry my first cousin because I know his style and his personality, while I am afraid of a stranger's style and personality.
>
> Even if premarital tests reveal potential health problems, some will reject the idea and believe in fate and still marry their cousin.

### Generation gap

The women said their parents and parents-in-law held different views from them on a range of issues. Since respect for elders was paramount, when the parents forced their views on their children, it had a negative effect on the women and their families:

> Sometimes the old mother forbids her daughter from taking vitamins or iron because the mother does not know their importance.
>
> The mother tells her daughter not to go to the hospital in the first months of pregnancy, and this of course is wrong. Here we see that the mother doesn't know the importance of antenatal care and so (the daughter) goes in the eighth or nineth month and these are bad practices—like we are in old times.
>
> Even if my husband is understanding, his family may not be—they may insist on children, so this is causing me always to be anxious, and it's affecting my psychological health.

### Domestic help

One aspect of the sociocultural environment was identified as both a bridge and a barrier. Foreign domestic helpers are present in all but the poorest rural families and were seen as instrumental in relieving women of onerous domestic responsibilities, but these maids also posed a threat to family confidentiality, integrity of language, and cultural norms:

> A maid becomes an important aspect of the house, and the working woman or student must have a maid.

> It depends on the family. If the mother is fully depending on the maid for home management, this is very negative, but if the maid's power is limited and the mother's role is primary in raising the children and managing the home, so this is good.
>
> When the mother works, children are influenced by the maid and they are learning her habits, traditions, and religious beliefs. Some maids disclose family secrets.

## Barriers to Health—Health Care System

As each focus group proceeded and the women became more comfortable, it became clear that, on the whole, the women modified their perspective and began to describe their dissatisfaction with the health care system. Many aspect of the system were seen as barriers to attaining good health. Their harshest criticism focused on the acute care hospitals and their specialty clinics.

### Long waiting periods

The women identified many problems with existing services such as long waiting periods for primary and specialty services. This problem was compounded because most clinics had no appointment system. Even when appointments were given, most Emiratis paid them little notice. It was a source of considerable frustration and led to poor care:

> When we arrive at the hospital for treatment, we sit from 8 in the morning until 4 in the afternoon. And we notice the doctor takes a break after examining patients. So they don't even try to see as many patients as possible and they are always late.
>
> My husband had a hole in his eardrum, but they gave him an appointment in 3 months for tests and treatment—in the meantime, he is suffering.

### Poor care

The women also complained about poor diagnosis and treatment and gave many examples of what they considered substandard care, including overuse of medications. They lacked confidence in the staff:

> Even if they give us a diagnosis, we don't believe them. Many don't even speak Arabic. So we go to more than one hospital in Abu Dhabi and Al Ain until a diagnosis is confirmed.
>
> Panadol or antibiotics become a must for every prescription.
>
> It is not the hospital itself, but those working there. . . .

### Lack of accountability, transparency, and quality improvement

The women lacked confidence in the system itself. They were frustrated by the lack of accountability, transparency, and quality improvement mechanisms:

> There are some departments that cover the mistakes of their employees, especially (named) hospital. There are lots of complaints against the doctors there—wrong diagnosis, wrong drugs—and those responsible cover the mistakes. They forget about our complaints, so we don't know whether it is an agreement between them or what. . . .
>
> If someone has a disease, we take it as fate and God's will for him. But when we know that our mother's long suffering was caused by a misdiagnosis, that really upset us—it was wrong! It was a big lie! The doctors should have told us! We don't trust them anymore—never, never!

### Lack of culturally sensitive care

The hospitals and specialty clinics were staffed largely by expatriate health professionals; many did not speak Arabic or understand the culture. Women with diabetes described being offered Western snacks such as bread and cheese in hospital, when they normally ate dates and camel milk. It was also culturally inappropriate for a women to be examined, or even be seen unveiled, by a male doctor:

> As women we would rather go to private female doctors. In (name) hospital they are not sensitive to our concerns and do not care who is looking after us.

### Lack of continuity

Continuity of care was challenging for both staff and women. It was hindered by the staff's rotating schedules, incomplete or missing health records, and sporadic follow-up:

> When they examined her, they said she had kidney problems and until now they are not able to reach a decision about her disease. We asked for another doctor who used to treat her, but they said that he was not around. Until now they don't know what is wrong with her and they can't find her file!

## Bridges to Health—Health Care System

Despite the many problems described and barriers identified, the women expressed appreciation to the Ruler of the UAE for the health care system

and the availability of health professionals, hospitals, clinics, technology, and equipment. We had a sense they felt a need to be appreciative of the strides the country had taken in recent years to provide health care to the population, even if it did not meet their needs very well.

### Availability of services/private hospitals

Although the public hospitals offered comprehensive, if basic, services, many women preferred the private hospitals that had fewer restrictions and more single rooms to accommodate the entire family:

> The government provides everything from cleanliness, housing, health centers, monitoring, and good follow-up for the human being from beginning until the end. Allah be praised!
>
> Everything is available in the government hospital, but we feel better in the private hospital for visiting. In the private hospital we can take our children and they stay with us in the room. This is not permitted in the government hospital.

### Treatment abroad

Many women and their families, who lacked confidence in local doctors and treatments, sought alternate opinions for their care. They often welcomed the opportunity for a government-sponsored trip to Europe or the United States for treatment that was not available, or at least not to their satisfaction, in the UAE:

> We are traveling for treatment (abroad) because we are afraid about the treatment and carelessness here. They do not make sure of the diagnosis and disease. We need more care in the hospitals.

## Bridges to Health—SocioCultural Environment

Despite a well-developed health care system, the women found major health benefits outside the hospitals and clinics. They attributed much of their well-being to their sociocultural environment. They affirmed the role of religion, their social networks, and cultural traditions in helping them stay or become healthy.

### Islam/mutawa

Islam is an integral part of daily life in the UAE and was seen as a strong, positive influence on their health, with both psychological and physical benefits. Women also described the therapeutic benefits of visiting the Mutawa, a religious authority believed to have healing abilities:

> Islam forbids certain bad habits like drinking alcohol, and the individual who is tired or weary can read the Koran and pray and he will feel psychologically better. Religion calls upon us to be clean and pure. Calling on the name of Allah calms down the irritated spirit.
>
> If my child gets sick I read the Koran so he will feel better. There is nothing better than religion; religion has a positive impact on health. Allah be praised!
>
> . . . So we took her to a Mutawa and he read the Koran over her and after a while her health became better.

### Social networks/cultural values and traditions

There were also positive social influences on women's health. Friends, family, and cultural values and traditions provided support and anchors for women and their families:

> Every country has its own habits and traditions that they like, and supposedly every family should live by them and reflect the values of the country they live in and live as a strong family respecting Islam and decency and lots of other things.
>
> I feel shy about going to the doctor, so I go and talk to my friend.
>
> If I feel stressed and depressed, I go to my friend. She understands better than anyone.

### Folk medicine

The women often used traditional approaches such as herbal medicines, particularly as remedies for adult problems. They used them to deal with pregnancy and less serious health problems, particularly when they were in remote parts of the country:

> When I am pregnant, I take thyme infusion. It is very beneficial for me and the baby.
>
> We use folk medicine at home—we use it more than hospital drugs. We adults use folk medicine, but for children, we take them to private centers—sometimes to government centers—but if the situation gets worse, I take them to private (clinics). As for me as an adult, as I said, I take local medicine.
>
> If I am in the desert with no nearby health centers, we use local treatment and herbal medicine. In simple cases we use herbal medicine, but for difficult cases, we cannot treat them with herbs.

### Extended family

Although Emirati women struggled with the generation gap, most saw their extended families as reliable sources of tangible, emotional, and moral support:

> The presence of grandparents and in-laws teaches children traditions and good Islamic values. Our (extended) family keeps us strong and close.
>
> Mothers are able to work (outside the home) while their children are looked after by in-laws or mothers.

## Health Needs of UAE Women

The women emphasized that good health is not just a matter of physical well-being. They described health in holistic terms:

> For a person to be healthy and free of diseases is very essential and important. Health is physical, psychological, and social.

The women had many ideas to help overcome the barriers they encountered in their quest for good health. They identified a need for health education, community centers and competent and comprehensive care.

### Health education

In particular, they identified the need for general health education and education related to marriage, childbearing, and child rearing:

> As for sex, we did not have a clue—not even the slightest idea! So it was a shock after marriage. No one taught us those things, not even our mothers, because they think it is shameful to talk about those things. But after marriage, the shock . . . ! Can you help us?
>
> [We also need] education during pregnancy on how to breast feed, bath the baby, how to hold the newborn.
>
> We want you to provide these teachings in Al Ain for the next generation who are educated and want to understand these things like hereditary disease, nutrition, medication, hypertension. . ..

They also wanted their men educated about women and their psychosocial and sexual needs:

> There are a certain number of men who are educated in the new generation and they do understand more about women. But in most cases, even though they are highly educated, their way of thinking

> stays behind. So some of them don't accept the psychological or sexual problems of women and this can affect their married life and affect (the woman's) psychological status.
>
> You are holding focus group discussions for women; you should be doing them for men! Especially to increase their awareness about these issues.

### Community centers

The women identified the need for recreational and social centers for women and they wanted professional help for social problems:

> We would very much like to do sports, but we don't find enough encouragement. The government in Abu Dhabi and Sharjah has sports clubs especially for women. If we had similar ones in Al Ain, we would be encouraged to join them.
>
> We need ladies specialized in psychology to give us solutions, and we can turn to her to be a friend who we can go to when we are in need.

### Competent and comprehensive health care

To achieve the level of health they aspired to, the women articulated the need for comprehensive and integrated women-centered services. They envisaged a primary health care system that was supportive and responsive to their needs, with a focus on health promotion. They wanted well-women clinics to provide inclusive care under one roof:

> It is important that health centers like (names of three primary health care clinics) hold well-woman clinics for periodic check-ups and also for women's health classes.

They wanted competent health care providers and they wanted accountability within their own health care system:

> We want the top quality medical services here and . . . specialized doctors who provide the best care in the country . . . and we don't want to travel abroad for diagnosis.
>
> There should be secret supervision—following up the activities in the hospitals to discover all their secrets.

## LIMITATIONS

There are several limitations of this study related to translation, validity, and generalizability. There are issues arising from collecting data in Arabic, transcribing it into Arabic, and translating it into English for analysis. Twinn (1998) described the importance of undertaking data analysis in the language of the interview. The complexities of Arabic grammar and dialect and the challenge of translating words for which there is no English equivalent made it difficult at times to capture the true meaning of what the participants were feeling and experiencing. We attempted to overcome this problem whenever possible by clarifying language directly with participants during the focus groups. If questions arose during translation, the translator (who was also the moderator) discussed the concern with our Emirati assistant. When further questions arose during the analysis of the data, the translator reviewed the original Arabic transcript to determine what was actually said. A lack of resources only allowed back-translation of any problematic or confusing segments of the transcripts to clarify their meaning. A complete back-translation of all transcripts would have enhanced the validity of this study.

As well, Strauss and Corbin (1994) contend that theories cannot be frozen in time. Changing conditions can alter any area of inquiry, particularly in a rapidly developing country like the UAE. This study was conducted in 1999; it represents one group of Emirati women at one point in time.

Finally, as qualitative research using small numbers, this study may be limited in its generalizability, although Sharp (1998) says that theoretical generalization, arising from a nonrepresentative sample, is valid. He says that "case studies" of social groups are one way of generating theoretical explanations of phenomena. Our findings are a description of the experience of 60 women from AAMD who participated in the study. While we believe the issues raised are relevant for many young women in the UAE, further research is necessary to learn if these findings resonate with other women of a similar age and education in other parts of the UAE and the Arab world. In the end, we leave the reader to make judgments about the soundness or usefulness of the findings.

## DISCUSSION/CONCLUSIONS

Meleis makes the point strongly when she says, "The women's perspective must drive health care" (Smith, 1999, p. 1470). Meeting the health needs of women requires a comprehensive understanding of many inter-related issues in their social, cultural, economic, and physical environments (Dunlop, Kyte, & MacDonald, 1996). We believed that Emirati women themselves were in the best position to define and describe their own health needs, and we were not disappointed.

These women had health care needs that transcended their reproductive role; they wanted a holistic approach to meet these needs. Freedman (1995) believes holism underpins psychosocial interactions and health education and leads to more humanitarian health care. Women in this study identified various ailments, such as back ache and menstrual problems, that they appeared to accept as normal and part of their lives. Papenek (1990) suggests that in many cultures women learn to believe that suffering is their lot and problems such as these are normal. Lack of education and the limitations this places on women's awareness and knowledge also was identified by our participants as a barrier to their health.

The women described health care that often was culturally insensitive and disrespectful. They had concerns that doctors did not listen, their health problems were dismissed with a pill, and mistakes were covered up. Women's health advocates have shown the sexism of some doctors, combined with the biases inherent in the institution of medicine, at times, make an encounter with the system a demeaning, distressing experience (Browne, 2000; Doyal, 1984; Fischer, 1986). Others indicate that a failure to communicate information, gender bias, lack of cultural sensitivity, and dehumanizing treatment often affects women's willingness to use services (Franks & Clancy, 1993; Heston & Lewis, 1992; Jacobson, 1993; Leppert, Washington, & Partner, 1996; Turpin, Darcy, Weaver, & Kruse, 1992; Vlassoff, 1994). There is substantial evidence that culturally competent approaches to care, including language services, staff training, culturally appropriate health promotion, and organizational support, are effective (Taylor, 2005). Kulwicki, Miller, and Schim (2000) advocate for cultural diversity training for health care professionals caring for Arabs to address issues of discrimination, stereotyping, and prejudice. Culturally sensitive care would enhance the health of Emirati women.

Few mental health services are available to women in developing countries, yet there is growing evidence that their needs are great (Desjarlais, Eisenberg, Good, & Kleinman, 1995; Paltiel, 1987; Patel, Araya, & Bolton, 2004; Paykel, 1991). While social networks are positively associated with mental functioning and general well-being (Achat et al., 1998; Michael, Colditz, Coakley, & Kawachi, 1999; Michael, Berkman, Colditz, Holmes, & Kawachi, 2002; Wellman, 1990a, 1990b), our study suggests that there is also a need to train health professionals to recognize and treat mental health problems rather than to rely on family and friends.

Women's domestic lives often are the cause of considerable anxiety and depression (Desjarlais et al., 1995; Malik et al., 1992). Research has shown that a closer examination of women's lives, their psychosocial issues, and their working conditions would be preferable to dismissing women's problems with medication (Altshuler et al., 2001; Ashton, 1991; Ross, Sellers, Gilbert Evans, & Romach, 2004). Women in our study talked of domestic tensions, fatigue, and anxieties related to polygamy, multiple roles, and

frequent childbearing, which impinged on their physical and psychological health. Worldwide, women's entry into paid work rarely seems to free them from domestic responsibilities, and the pressure of their multiple roles often creates a drain on their mental and physical health (Khlat, Sermet, & Le Pape, 2000). Our findings support theorists who have argued that women's well-being is not determined solely by biological factors and reproduction, but also by the effects of workload, working conditions, nutrition, and other social factors (Ahmad-Nia, 2002; Matthews & Power, 2002; Vlassoff, 1994).

Alternatives to conventional, biomedical therapies are growing in popularity in the Western world. Typical users are educated, middle-class women from 20 to 49 years of age (Bennett & Brown, 2000). Alternative approaches such as self-care, folk medicine, and religious healers have been used widely in developing countries (Eisenberg et al., 1998). Studies show that people are quite astute at knowing what sorts of conditions to take to what sorts of practitioners (Coss, McGrath, & Caggiano, 1998; Eisenberg et al., 1993). Likewise, the Emirati women used alternative therapies, particularly for adults, for less severe problems and when conventional medicine was not at hand. McCaffrey and colleagues (2004) report that women in many cultures prefer traditional healers because they provide meaningful explanations of their illnesses, whereas modern health care providers tend to give limited information. In our study this tendency often was compounded by a language and cultural chasm between health care providers and recipients. While our study participants believed modern medicines had a role in their well-being, they deeply believed in the spiritually healing and uplifting power of Islam for themselves and their families.

A need for accessible, timely, and safe health care was clearly articulated in this study. This need is not unique to women or to the UAE; these issues are receiving international attention (Leape, 2004). A framework for achieving quality care includes good practitioner–client communication and information exchange, provider competence, a professional relationship, mechanisms to encourage continuity and follow-up, and an appropriate constellation of services (Barnett, 1997; Bruce, 1996). Emirati women were looking for such quality improvement initiatives.

Perhaps the most important point the women made is that health care can be improved substantially by listening to and respecting the voices of women. Transporting Western, male-dominated, and biased health programs and services onto the Emirati population is not the solution. Health services in the UAE need to be culturally appropriate, gender sensitive, and consumer driven. Although there are significant cultural, religious, social, and environmental differences between Emirati women and Western women, there are also many similarities. When it comes to health needs, Emirati women are like women anywhere. They want the best possible care for themselves and for their families, and they have many ideas about achieving it (Craft, 1997; Kabira, Gachukia, & Matiangi, 1997; Wuest, Merritt-Gray,

Berman, & Ford-Gilboe, 2002). The findings of this study have been presented to officials within the UAE Ministry of Health to assist with public policy development, resource allocation, and interventions better suited to the needs of Emirati women. This study is a preliminary step toward building bridges and eliminating barriers to the health care of Emirati women, their families, and their communities. Opportunites abound for further research related to the health of Emirati men and women of all ages. There is also a need to evalute the effectiveness of new and evolving health programs managed and delivered increasingly by Emiratis themselves in this rapidly developing country.

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