Collaborative Partnership for Culture Care: Enhancing Health Services for the Arab Community

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The purpose of this study was to discover perceptions, experiences, and patterns of health care behavior among Arab Americans in an urban Midwestern area of the United States and then to discover perceptions and experiences of health care providers related to culturally competent care. The goal of the study was to generate findings that would provide the basis for implementing system-wide changes to include culturally competent care. A qualitative focus group methodology was used to discover the care patterns and perceptions of Arab Americans and the local health care providers. The nurse researchers conducted 10 focus groups. Six themes were identified, including the unique caring behaviors of Arab families, the complexity of the health care system to Arab Americans, communication gaps, the diversity of perceptions of cultural competency, obstacles to accessibility of care, and workforce diversity issues.

The purposes of this study were to (a) discover perceptions, experiences, and expectations of a select group of Arab Americans in a large Midwestern urban area and (b) discover perceptions and experiences of select groups of Arab Americans and non-Arab Americans about how local health care organizations provided care and if it was perceived as culturally competent by Arab Americans. A partnership between the Arab community, the local health care system, and a school of nursing was formed to investigate current health care patterns and to make recommendations in providing culturally competent care using feedback from Arab American community leaders, clients of the health care systems, and local health care providers.

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Based on the current literature on culturally competent models of health care delivery systems, we sought to discover health care perceptions and behaviors of the local Arab community while investigating the perceptions and behaviors of the health care providers with regard to this population. The domain of inquiry for the study was the perception of culturally competent care for Arab Americans from both professional and community perspectives. A focus group methodology was used to discover the care patterns and perceptions of Arab clients and the local professional health system providers (Morgan & Krueger, l998). Based on the research findings, the results of this study were presented with recommendations for providing culturally competent care to key leaders in the health care system and the Arab community.

REVIEW OF THE LITERATURE

Although there is limited literature on the health status of Arab Americans in the United States, several research studies that address the special needs of this large Arab immigrant population in the metropolitan area of Detroit have been conducted. The first qualitative nursing study designed to discover perceptions and experiences related to health and illness in the Arab American community of this Midwestern urban area was conducted by Kulwicki (1987). Kulwicki, of Lebanese origin and fluent in the Arabic language, interviewed 30 monolingual Yemeni American immigrant women to explore their health perceptions and practices employed in recovery from illness. Based on the data collected, the following themes were identified: religious beliefs that God is the cause of all that is, gender differences in susceptibility to illnesses and treatment modalities, belief in the rational mind of man, reliance and trust in the superiority of U.S. health care providers, and desirability of adapting to change. Kulwicki also identified several barriers Yemeni Americans described

in accessing the U.S. health care system. Included were language barriers, misconceptions about genetically transmitted diseases, lack or limited knowledge about reproductive health, and lack of understanding of preventive services. As research director of the local Arab Community Center, Kulwicki (1991) developed and implemented several community-wide, culturally specific, language-appropriate health promotion programs that incorporated the findings of the research.

Kulwicki and Cass's (1994) study of knowledge, beliefs, and behaviors of 411 Arab Americans in the Dearborn area of Detroit about HIV/AIDS indicated that a sizable number of Arabs participating in the study had no knowledge about HIV transmission. Among the subjects who had heard about HIV/AIDS, the level of knowledge about HIV transmission was lower than the general U.S. population's, and their fear of HIV/AIDS was greater than that of their counterparts in the United States. The study also indicated that more Arab women than Arab men lacked awareness of available HIV/AIDS services (Kulwicki & Cass, 1994).

The Michigan Behavioral Risk Factor Survey indicated that the rate of reproductive health screening was lower among Arab women in metropolitan Detroit than among other women. In this survey, the percentage of Arab women who performed self breast exams was 39.6 compared to 56.8 for the White population, and the rate of cervical pap tests was 59.9% as compared to 78.5% of other women (Michigan Department of Public Health, 1995).

Rice and Kulwicki (1992) reported on the high prevalence of smoking among Arab Americans in Dearborn and its vicinity. Approximately 40% of Arab American immigrants in Wayne County smoked; most started smoking earlier and smoked more cigarettes than the general U.S. smoking population. Research on domestic violence by Kulwicki and Miller (1999) indicated that Arab American women experienced domestic violence similar to the general U.S. population and that barriers for use of local domestic violence services for Arab women were greater than barriers for Anglo-Saxon American women.

Many barriers exist for Arab Americans in using health care services in the United States. These include language barriers related to lack of English language skills, cultural barriers related to modesty and embarrassment in exposing one's body to strangers, religious practices, gender preferences in seeking and accepting health care from male or female providers, strong family values related to not exposing family problems to outsiders, folk practices, values with regard to honor and shame, and barriers related to stresses of immigration and acculturation (Kulwicki, 1996; Kulwicki & Miller, 1999).

There are also barriers related to health care providers and the health care system that contribute to the low use of health care services by Arab American immigrants. These barriers relate to the inability of health care systems to provide culturally competent services; the lack of bilingual health care providers, especially nurses; stereotyping; and discrimination (Kulwicki, 1987, 1996; Kulwicki & Miller, 1999).

Aswad (1974) studied the Arab community in the same geographic area of the Midwest. She identified norms that were commonly shared as an ethos of organization by all Middle Easterners. These were the patrilineal nature of the family, strong values related to family and kinship ties, segregation of sexes, and concepts of honor and shame. Later, Aswad published a history of Arab immigration and settlement that serves as a valuable ethnohistorical interdisciplinary reference for the study of Arab American cultural patterns and acculturation needs (Aswad & Bilge, l996).

Luna (1994) conducted a study, in the same geographic area, of Lebanese Muslim immigrants. Themes discovered in this research were similar to the themes identified in other studies on Arab Americans, that is, gender roles, religious-based care, and care based on collective meanings of honor.

Several authors have defined cultural competence and have developed models for providing culturally competent care for health care providers. Koerner (1992) defined cultural competence as the provision of health care that incorporates understanding of and respecting for another culture. Cross, Bazron, Dennis, and Isaac (1989) defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or those professionals to work effectively in cross-cultural situations" (p. iv). They view cultural competence as a process, on a continuum ranging from culturally destructive to culturally competent. On this continuum, they identified several phases through which agencies move to become culturally competent. The phases they identified are cultural destructiveness, cultural incapacity, cultural blindness, cultural precompetence, cultural competence, and cultural proficiency. Borkan and Neher (1991) focused on ethnosensitivity that is in concert with the concept of cultural competence, a process of becoming more sensitive and respecting differences. Their approach to ethnosensitive care is developmental, with seven distinct stages consisting of fear and mistrust of different cultural groups, denial of cultural differences, feelings of cultural superiority over other cultural groups, minimizing cultural differences, cultural relativism, empathy, and cultural integration. Lavizzo-Mourey and Mackensie (1995) defined cultural competence for physicians as population-specific, health-related beliefs and treatment outcomes and suggested specific treatment modalities for several ethnic cultures. Camphina-Bacote (1998) developed a model called the process of cultural competence in the delivery of health care services, in which she defined cultural competence as "a process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family or community)" (p. 4). The author

considers her model dynamic, cyclic, and multivariate, encompassing five interdependent constructs. The constructs identified by Camphina-Bacote are cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Other authors have focused on communication styles in developing skills for cultural competence: For example, Bell and Evans (1981) identified five interpersonal and communication styles that can hinder or improve culturally competent care. These are overt hostility, covert prejudice, cultural ignorance, color blindness, and cultural liberation. Meleis (1996) views nursing research on cultural competence from a scholarly perspective. She identified eight criteria for culturally competent research to help avoid stereotyping or marginalization in the research process. Meleis defined culturally competent care as care that is "sensitive to the differences individuals may have in their experiences and responses due to their heritage, sexual orientation, socioeconomic situation, ethnicity, and cultural background" (Meleis, l999, p. 12). The American Academy of Nursing (1995, 1997) published a comprehensive critical review and plan for action for cultural competence. Included were guidelines for evaluating cultural competence in and through nursing education.

Leininger's theory of culture care diversity and universality (1995) and sunrise model also provide a guide for the provision of culturally based care. She views culturally based care in three decision-making modes: culture care preservation, culture care accommodation and negotiation, and culture care repatterning and restructuring (Leininger, l995). A more recent model of cultural competence was developed by Purnell and Paulanka (1998). This model is considered comprehensive and practical, encompassing 12 domains for assessing ethnocultural attributes of clients, families, and communities. These domains include overview of the cultural group, communication, family roles and organization, workforce issues, biocultural ecology, high-risk health behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, health care practices, and health care practitioners. Purnell and Paulanka's model shares many of the concepts previously described in the nursing literature on cultural competency and attempts to operationalize these concepts for clinical application.

The preceding research and theoretical models were useful in conceptualizing this research study. Previous studies with Arab Americans served to provide background information with regard to the community in which the study took place. Cultural competency and culturally competent care were important concepts defined for the project. For the purpose of this study, Cross et al.'s (1989) definition of cultural competence will be used. The collaborative approach among three diverse communities, a health care institution, a lead Arab American community organization, and a school of nursing offered an innovative dimension providing opportunities to translate the findings of this research into system-wide changes that could improve the quality of culturally competent care. In addition, having a bilingual Lebanese nurse researcher with expertise in the area of Arab American health as principal investigator increased the credibility of findings and enhanced the direct linkages between the Arab community and the health care system.

SETTING OF THE STUDY

The Arab community in the Midwestern city in which this study took place is one of the largest in North America. It is estimated that there are approximately 300,000 Arab Americans in the state of Michigan. This group is also known to be one of the most cohesive Arab communities in the United States, despite the fact that its members represent diverse national (22 countries) and religious backgrounds. The community is largely composed of first-generation immigrants and second-generation Arab Americans whose parents or grandparents immigrated to the United States for economic and political reasons. Many of the Arab American immigrants in Michigan are affluent; however, many of the new immigrants are of middle or lower socioeconomic status and are monolingual in Arabic. Family and kinship ties are the predominant cultural feature, along with strong religious (Muslim and Christian) values and practices (Kulwicki, l996).

Dearborn, a suburb of approximately 100,000 residents, which is adjacent to Detroit, is considered the center of the Arab American community in Michigan and in North America. Dearborn is best known as the world headquarters of the Ford Motor Company and site of the Ford Rouge Plant. Within Dearborn, there is a central commercial district consisting largely of Arabic stores, restaurants, and coffeehouses. Five mosques are located within the city vicinity, the most impressive of which is the Islamic mosque with its unique turquoise dome, located close to the Ford Rouge Plant.

Dearborn is also known to be the point of entry for the more recent Arab American immigrants. The majority of the immigrants in Dearborn are Lebanese, Syrians, Palestinians, Yemenis, and, most recently, refugees from Iraq. The city is proud to be the center for Arab social and political organizations, Islamic schools, and community organizations—most notably, the Arab Community Center for Economic and Social Services.

The health care agency collaborating in this study was the study site, which is located in Dearborn near the Arab community. It is a satellite primary health care center of one of the largest nonprofit hospitals located in Detroit. This satellite ambulatory primary health care center has a diverse and multidisciplinary system of health services and an ethnically diverse workforce. Although there are a limited number of Arab nurses in the metropolitan area of Detroit (approximately 20 RNs), 5 of these are employed in this primary

health center. Also, there are five Arabic-speaking physicians and one Arabic-speaking patient advocate who are full-time employees of this center. The center provides primary health care services to the Arab population at an estimated 40,000 to 50,000 client visits each year.

The local health care system and satellite ambulatory care center that serve this population have initiated several creative projects to enhance services to Arab Americans. The research reported here was initiated in response to the institution's ongoing interest in providing culturally competent care to the Arab American population.

RESEARCH METHODOLOGY

A qualitative research design was used to explore perceptions, experiences, and expectations of a select group of Arab Americans and perceptions and experiences of select groups of Arab American and non-Arab American health care providers about how local health care organizations provided care and if they perceived this care as culturally competent for Arab Americans. Focus group methodology was selected as the method that best fit the domain of inquiry and the purposes of the study. The steps of focus group research were followed carefully to insure the research process was rigorous and accurate (Morgan & Krueger, l998). An inquiry guide was developed to elicit information about the cultural experiences and behaviors of the health care system staff in providing care to this group. A similar guide was used with modifications to elicit information from Arab participants about their experiences and expectations with regard to health care for Arab Americans.

Data Collection and Analysis

We conducted 10 focus groups. The nurse researcher who is bilingual in Arabic and English conducted the Arab client focus groups (four) to ensure accuracy of translation and findings. Each focus group was audiotaped with full text transcripts prepared from the tapes. The transcripts were then entered into the NUD*IST qualitative software program for sorting, coding, and data retrieval (NUD*IST, l997). Analysis entailed both manual and computerized data coding. In-depth discussion between the three nurse researchers helped to insure confirmability and credibility of the discovery of patterns and themes. In addition, selected focus group participants were asked to read and comment on the content and meaning of the themes to enhance credibility, meaning in context, and confirmability of findings (Lincoln & Guba, l985).

Participant Selection

Data collection was conducted over a 3-month period beginning in June l998. The focus groups were selected based on content areas of particular interest expressed by the community leaders and health care system administrators. The specific focus groups selected were Arab teens, Arab pregnant women, Arab women, Arab adults, Arab community leaders, Arab American health care professionals working in the Arab community, Arab and non-Arab health care system staff, and Arab and non-Arab health care system physicians. Focus group participants were selected through a purposeful sampling technique. Arab participants were invited to participate through recommendations and contacts within the local Arab community center. Non-Arab and Arab health system staff were recruited by a nurse manager within the health care setting. Criteria for selection of focus group participants included experience with the health care system, ability and willingness to participate in the focus group discussions, and representation of the specific groups targeted. Four groups were conducted primarily in Arabic and later translated into English by the principal investigator (see Table 1). Seven groups were conducted in the Arab community and three at the health care agency.

A total of 67 individuals participated in 10 focus groups. Informants agreed to participate through verbal consent at the beginning of each group. The Arab and non-Arab health care professionals made up the largest of the groups, with 10 participants each. The non-Arab health professional session was attended by only 1 participant and is included in the findings as a personal interview rather than a focus group. The principal investigator facilitated 10 of the 11 focus group discussions. Of the 10 focus group discussions, 3 were attended by one of the two coinvestigators, and the 1 interview with a non-Arab physician was conducted by one of the coinvestigators.

DATA COLLECTION PROCEDURE

In addition to the three investigators, the research team consisted of one consultant who had expertise in focus group data analysis and two assistants who participated in the focus group recruitment efforts. Each potential participant was contacted by telephone to invite him or her to participate in the study. At the time of initial contact, verbal consent was obtained for participation in the study and for audio taping. A follow-up formal invitation letter was sent to each individual who agreed to attend. Sessions ranged from 60 to 90 minutes in duration. Light refreshments were served. Anonymity was maintained by omission of all personal identifying information at the time of transcription. A professional (Arabic-English) translator transcribed the taped discussions. Tapes, transcripts, and all other study materials were held securely to prevent breach of confidentiality.

MAJOR FINDINGS

Systematic analysis of the information collected from the 10 focus groups included identification of descriptors, patterns, and, finally, major themes across all groups. Whereas each individual was a unique, information-rich individual with particular experiences, expectations, and perceptions

TABLE 1
Focus Group Composition

Focus Group	*Number of Participants*	*Language Used*
Arab teens	10	English
Arab American community health care professionals	10	English
Arab pregnant women (Group 1)	3	Arabic
Arab pregnant women (Group 2)	6	Arabic
Arab adults	8	Arabic
Community leaders	6	English
Arab adult women	6	Arabic
Non-Arab health care professionals	10	English
Arab health care professionals (PHC)	4	English
Arab physicians (PHC)	3	English
Non-Arab physicians (PHC)[a]	1	English

NOTE: PHC = Primary Health Care Center. Each focus group met one time.
a. Personal interview.

about health care, themes emerged from the transcripts that explained some issues surrounding efforts at provision of culturally competent care within the local system. Themes are described below with a sampling of some of the verbatim quotes that illustrate these findings. It is from these themes and patterns and from appreciation of both the similarities and differences in the findings between and within the focus groups that specific recommendations are derived.

Theme 1: Arab Expectations of Care Are Influenced by the Complexity of the Overall American Health Care System

There was consensus among Arab American community leaders, Arab American service providers, and Arab American consumers about the superiority of medical care in the United States. However, most Arab participants agreed that the U.S. health care system is complex for Arab American consumers and different from the health care services they were accustomed to in their countries of origin.

Three patterns were abstracted to higher levels of analysis to generate this first theme. They included the superiority of the U.S. health care system, different perceptions between staff and clients with regard to what is appropriate, and the system's being confusing to Arab American immigrants. Specific verbatim excerpts from the data included the following: "The care here is good. It is better than in Yemen. They do a lot of tests here. . . . I think the American doctors give you better care." Another informant described problems that women have with regard to health care: "99% of the women are not educated about the health care system. So we don't know what is going on." Comments related to the complexity of the health care system were repeated in each of the Arab focus groups. Participants related that it was difficult to learn how to access and move through the health system although the care was viewed as much more comprehensive than was experienced in the informants' homelands.

Theme 2: Caring Behaviors of the Arab Family That Have an Impact on Culturally Competent Care Are Support, Nurturance, Physical Presence, and Behaviors That Bring Honor and Shame

Family caring values and behaviors are among the defining characteristics of the Arab culture. Arab Americans highly value behaviors such as presence of family members at times of family crisis, supportive and nurturing behaviors toward family members who are experiencing illness, and protective behaviors related to honor and shame by male family members toward female family members. Modesty of dress is valued for both males and females. Conversely, disrobing in public, even in the hospital environment, is considered immodest. Because female purity, chastity, and modesty are held in such high regard by the Arab culture, a woman who is physically exposed to a male or has sexual relations outside culturally prescribed norms will bring shame to the family.

We identified five patterns that led to the abstract theme related to Arab family caring patterns. The theme related to Arab family caring patterns included family involvement in care, the unique needs of Arab teens, confidentiality issues, the diversity of men's and women's health needs, and the existence of hidden health problems within families. This theme related to Arab family caring patterns was an important finding of the research, described by caregivers as well as Arab client groups. An example of a descriptor from a non-Arab nurse in the non-Arab health care providers group included, "Why do they bring their kids, why do they bring all their people?" Concerning adolescent female group issues, one Arab service provider stated, "I think the Arab teen has the worst health care until she gets married. . . . We are not allowed to say when we have certain issues." An Arab client discussing women's health issues stated, "It's like *ayb* [shame] to talk about this [women's health issues]."

With regard to gender issues, problems of clinic staffing were dominant in group discussions. It is common for traditional Arab women to expect to see female providers, yet this caused staffing difficulty for the ambulatory health care center. One Arab woman described it this way: "Because I am a woman, I don't feel comfortable with a male doctor. . . . As long as they [female doctors] are available, I will not see a male doctor."

Some health problems—for example, the existence of disabilities or mental retardation—were not shared outside the family. There are health problems in the community that are unknown because the family has not sought health care or

TABLE 2
Recommended Topics to Be Included in Health Care Provider Cultural Competency Training Programs

Arab family values
Ethics of reporting/confidentiality/family conflicts
Gender issues
Hidden health issues
Spiritual care
Women's health issues
Impact of acculturation/generational change on health behaviors
Teaching/counseling with regard to diet modifications within individual, cultural, and religious dietary practices
Unique concerns of Arab teens

professional help for the problems. Much of this is due to embarrassment and shame. One Arab service provider informant described the following: "I went on a home visit . . . there is a 4-year-old boy . . . hydrocephaly . . . doesn't walk, doesn't talk, and nobody knows about him."

Theme 3: Communication Barriers Create Obstacles to Culturally Congruent Care

The existence of significant communication barriers was a dominant theme found across all focus groups. Attention to language barriers, cultural misconceptions, and perceptions of disrespect or rudeness toward Arabs were repeatedly cited. Specific patterns associated with this theme included language barriers and respect for Arab clients as adults.

A language barrier was one of the most prominent communication gaps supporting this theme. One of the Arab informants stated, "It would be helpful if some of the staff could speak Arabic . . . if someone could explain what's going on, it might be easier." Another informant, a non-Arab clinic employee, asked, "Why do they come here if they don't speak English?" One Arab service provider stated, "I think the ability to be able to communicate with them in their own language puts them at relief."

Descriptions from participants related to their concerns about health care providers' showing respect or disrespect to Arab clients were important data. One Arab informant stated, "If they see an Arabic woman who cannot speak English, they laugh at us. They make fun of us." Another stated, "I am the patient, I have the right to ask [questions]. I want to know that you are going to spend time with me to explain things."

Theme 4: Cultural Competency Is Perceived Differently by the Health Care Community and the Arab American Community

Both staff and Arab client groups described recent improvements in the cultural sensitivity of staff toward Arab clients. They indicated that some institutions provided translators for non-English-speaking Arab patients, some included Arabic food in the hospital menus, and some provided a place for Muslim patients to pray. However, participants from all groups also stated that there was a long way to go. There were differences as to how Arab consumers and non-Arab health care providers perceived cultural sensitivity and competence. Non-Arab health care providers valued consistent quality care for all clients and stated, "we treat everybody the same," regardless of race, cultural orientation, and so on. Other non-Arab health professionals repeatedly stated that all patients were treated the same, and none was afforded special treatment because of cultural needs. An example from a non-Arab nurse provider was, "The specialness is that everybody is treated the same. They [Arabs] want special care, and we're going to show them that we treat everybody the same regardless of race or whatever." Another focus group participant agreed by stating, "don't think we should make anyone feel special and we should not treat anybody better or more special than somebody else."

Arab American participants indicated that treating Arab clients without addressing Arab cultural practices or values was an indication of lack of culturally competent care and insensitivity to the needs of Arab clients. Specific patterns that led to this theme were stereotyping and lack of individualized care, discrimination and insensitivity, and lack of knowledge of cultural dietary practices.

Arab clients stated that stereotyping led to deficiencies in cultural competence among non-Arab staff. For example, a staff member who is unable to identify the acculturation status of clients often assumes that an Arab client has traditional beliefs and does not speak English. These assumptions lead to insulting communication patterns. One Arab service provider stated, "You cannot look at somebody and accept that they are [traditional] Arab. They may be second, third, fourth, or fifth generation Arab and very much Americanized." Another service provider stated, "As a female provider, you cannot walk up to a male Arab or Islam person and shake their hand. A more Americanized Arab would find it acceptable, whereas a more traditional Arab would find it insulting."

One pattern that led to this theme is the clinic staff's lack of awareness of the cultural diversity among Arab clients. One Arab service provider pointed this out by describing, "Lebanon is half Christian, half Muslim, and you can't tell the difference. Automatically, they stereotype Muslim as Arabic." This is a serious cultural sensitivity issue. It is common for non-Arab staff to label all Arabs as Muslims, which creates a barrier to cultural competence.

Differences between Arab participants' and non-Arab health care providers' perceptions of what culturally competent care meant was an important finding related to the ability of staff in providing culturally competent care.

Theme 5: Obstacles to Accessibility and Cultural Acceptability of Health Services Cause Frustration in Service Utilization

Arab American participants cited difficulties in accessing primary care providers, especially female medical care pro-

TABLE 3
Recommendations to Improve Accessibility and Acceptability of Health Care Services to Arab American Clients

Develop a program to inform recent Arab immigrants about American health care.
Create patient literature and signs in areas where large numbers of Arabic clients are served.
Develop a program for assessment of and intervention in hidden health issues within the Arab community.
Develop/market a health promotion campaign targeted at Arab health issues.
Improve access to primary care providers.
Provide continuity of care.
Identify resources to support staff decision making with regard to ethics and culture issues as they occur in practice.
Provide access to an Imam as part of chaplain services within the system.
Provide space for traditional Muslim religious practices/prayer.
Explore transportation needs to assist clients.

TABLE 4
Recommendations for Staff Diversity

Recruit/employ bilingual Arab Americans at all levels of service and service administration.
See Table 3 for specific recommendations with regard to accessibility and acceptability of health care to Arab Americans.
Recruit/employ/train Arabic English translators.
Recruit/employ/train female providers.
Consider identifying bilingual Arab advocates in medical centers to assist staff and clients.
Recruit/employ more female providers (especially in women's health).
Recruit/employ more "front line" Arab staff who are bilingual (English and Arabic).
Recruit/employ Arab staff in administrative positions.
Identify core cultural competency indicators/behaviors/expectations.
Include measures of cultural competency in performance evaluations of all levels of staff.
Monitor for and respond to concerns with regard to overt/covert discrimination in the work environment.

viders. They often cited long waiting periods in making office visit appointments, lack of continuity of medical care services, long waiting hours for emergency care, and physical/geographic and financial barriers for low-income Arabs. Specific barriers to care were a cause of much frustration for Arab clients in accessing health care services. Patterns identified included waiting for care, knowing the doctor, care by nonphysician providers, transportation difficulties in accessing care, and the unique needs of low-income Arab clients.

Theme 6: Workforce Diversity and Cultural Competence Are Key to Providing Quality Care

Similar patterns were identified for Arabs, and Arab health professional focus groups related to the need for increased cultural sensitivity and competence training among health care providers. These comments were made in response to a question on an inquiry guide with regard to what the focus group members would recommend to improve care for the Arab American community. Specific patterns identified for this theme included the need for female providers, the need for more Arab staff, the perception of hiring practices for Arab employees, and the cultural sensitivity of the work environment at the local institution.

Specific informant quotes support this theme. An Arab service provider stated, "They need to hire at a higher level. . . . If 30% of the hospital business is Arab clients, then their administration should be 30% Arabic." An Arabic client stated, "We need an Arab American on every floor in the department." In support of the pattern of work environment, an Arab service provider stated, "I was very disappointed to hear their comments (ancillary staff, registered nurses) to ethnic groups as 'why should we cater to them?' Very disappointing!" An Arab service provider stated, "Important recommendation is zero tolerance for discrimination."

DISCUSSION

This study was conducted through a partnership of three key groups: nurse researchers, health care system administrators, and Arab Americans. A qualitative focus group methodology was used to discover care patterns, expressions and meanings of the Arab community, and the perception of the health system's cultural competence. Major themes identified in the study included the influence of the complexity of the health care system on Arab clients, the unique caring behaviors of Arab families, communication gaps as obstacles to the provision of culturally competent care, the diversity of the perception of cultural competency, obstacles to the accessibility of health services, and workforce diversity issues.

Study findings indicated that most Arab American focus group participants viewed health care for Arab Americans as favorable (Theme 1) but with significant room for improvement. Within the focus group discussions, a number of barriers to providing culturally competent care to Arab Americans were indicated. Arab and non-Arab health professionals and Arab American community focus group participants stated that a lack of awareness by health care providers about Arab cultural and religious values and behaviors and gender and family issues (Theme 2) was a major concern. Focus group participants also indicated that a lack of knowledge with regard to the American health care system among Arab Americans contributed to communication barriers (Theme 3). Accessibility and cultural acceptability (Theme 5) of American health service delivery were also concerns for the Arab focus group participants.

The findings of this study identified differences in perceptions between Arab American participants and the health care providers with regard to cultural competence (Theme 4). Dif-

ferences in perceptions with regard to cultural competence can create conflicts in expectations between health care providers and clients. Health care professionals and administrators need to take these differences into consideration and provide cultural competence training programs for their staff serving diverse populations. Camphina-Bacote (1998) described cultural competence as the ability to effectively work within the cultural context of the client. Cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire were important concepts that were included in her model. In this study, Arab American participants were cognizant of the needs of their cultural groups. Nurses need to take into consideration their clients' needs and incorporate them in the care they provide to Arab Americans. Another significant finding of this study was the workforce issues (Theme 6) reported by the Arab American health care providers. Most Arab health care providers reported experiencing some form of discrimination in the workplace. Some reported discomfort with being stereotyped and continuously exposed to negative comments about the Arab in general or Arab clients. The findings of this study support the need for health care systems to develop cultural diversity training in the workforce and address issues of discrimination, stereotyping, and prejudice among employees.

Findings of this study supported the results of previous research conducted in the same community by Kulwicki (1987, 1991, 1996), Kulwicki and Cass (1994), Kulwicki and Bloink (1996), and Kulwicki and Miller (1999) by identifying family values, health issues, and barriers to providing care to Arab Americans.

Recommendations

Findings were used to develop specific recommendations for system-wide changes that would improve cultural competence.

Develop an effective cultural competency training program aimed at increasing cultural awareness, cultural sensitivity, and cultural competence for Arab Americans. Table 2 includes content areas that should be included in developing the cultural competency training program for health care providers.

Improve the quality of care to Arab American clients by providing culturally specific and linguistically relevant materials, and enhance the accessibility and availability of services, especially to low-income, non-English-speaking Arab immigrants (see Table 3).

Increase the amount of Arab American health care personnel, especially in areas where large numbers of Arab American clients are being served, and develop administrative guidelines for addressing workforce issues. Recommendations for improving staff diversity and addressing workforce issues are included in Table 4.

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