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## Original research

# The Arab American experience with diabetes: Perceptions, myths and implications for culturally-specific interventions

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## ABSTRACT

**Aims:** Culturally-specific lifestyle diabetes prevention programs require an assessment of population disease perceptions and cultural influences on health beliefs and behaviors. The primary objectives were to assess Arab Americans' knowledge and perceptions of diabetes and their preferences for a lifestyle intervention.

**Methods:** Sixty-nine self-identified Arab or Arab Americans  $\geq 30$  years of age and without diabetes participated in 8 focus groups.

**Results:** Emerging themes from the data included myths about diabetes etiology, folk remedies, and social stigma. The main barrier to healthcare was lack of health insurance and/or cost of care. Intervention preferences included gender-specific exercise, group-delivered education featuring religious ideology, inclusion of the family, and utilization of community facilities.

**Conclusion:** Lifestyle interventions for Arab Americans need to address cultural preferences, diabetes myths, and folk remedies. Interventions should incorporate Arabic cultural content and gender-specific group education and exercise. Utilization of family support and religious centers will enable culturally-acceptable and cost-effective interventions.

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## 1. Introduction

Lifestyle interventions are effective in preventing or delaying diabetes in various populations [1–7]. The landmark Diabetes Prevention Program (DPP) demonstrated that modest lifestyle modifications effectively reduced the incidence of diabetes in high-risk racially diverse individuals [1]. However, translation of these effective interventions into real-world settings for vulnerable communities with limited resources remains a challenge [8–11].

Diabetes is an emerging problem in the rapidly growing and underserved Arab American (AA) community [12–14]. In a cross-sectional, population-based study of AAs aged 20–75 years, the age- and sex-standardized prevalence rates of diabetes and prediabetes were 18% and 23%, respectively and were associated with obesity, physical inactivity, and lack of acculturation [14,15]. Given these rates, it is expected that the burden of diabetes and its cardiovascular sequelae will substantially increase as the population ages, imposing an enormous public health burden.

The relationship of culture to health beliefs and behaviors is important in any diabetes prevention or treatment strategy that involves changing patterns of eating, physical activity, and other culturally-embedded behaviours [16]. Such knowledge informs the tailoring of interventions to the individual's culture and environment. The AA population is politically and religiously diverse, however, individuals share a common language, history, and culture [17]. Little is known about the impact of culture on health of AAs. Accurate assessment of AA health beliefs, knowledge, perception, and practices relevant to diabetes will enable successful translation of culturally-specific and sustainable interventions targeting diabetes prevention and management in this community [18]. The primary objectives of the current study were to assess AA knowledge, perceptions, and practices relevant to diabetes and their preferences for a lifestyle intervention.

## 2. Methods

### 2.1. Participants

Individuals were randomly selected from different stages of a larger study that was assessing the effectiveness of a culturally-specific lifestyle intervention in AAs. Participants in this larger study were randomly selected from a constructed list of 542 individuals and from the general public in Dearborn, MI. We conducted focus groups with 69 self-identified Arabs or AAs  $\geq 30$  years of age and without diabetes. A total of eight focus group sessions were completed, including three pilot focus groups (male-only, female-only, or mixed-gender). The Wayne State University Institutional Review Board approved study procedures.

### 2.2. Data collection

We followed the principles specified by Morgan [19] for the format and conduct of focus groups. A sociologist (SJS) and an AA who is fluent in Arabic (LAJ) developed the focus group

protocols. The same, trained, Arabic-speaking moderator conducted all sessions in Dearborn, MI between November 2007 and April 2009. A range of 6–14 individuals participated in focus group sessions lasting from 90 to 115 min. The moderator ensured that the topic outline was covered systematically and completely.

### 2.3. Measures

The moderator presented each group with the same guiding questions regarding the definition, symptomatology, etiology, prevalence and perception of personal risk of diabetes. The moderator also posed questions regarding diabetes prevention and barriers to healthcare. A brief survey was completed at the conclusion of each session to collect demographic information.

### 2.4. Analysis

Investigators digitally recorded all sessions. A bilingual transcriptionist transcribed the sessions verbatim and a professional translator translated transcripts into English. The Principal Investigator (LAJ) reviewed transcripts for accuracy prior to analysis. A co-investigator (SJS) performed content analysis with MAXQDA2, version 2 (VERBI Software, Consult, Sozialforschung, Germany) using a grounded theory approach [20].

A co-investigator (SJS) abstracted categories and subcategories and generated narrative reports summarizing the comments of participants in each category. The authors analyzed survey responses with SPSS version 17.0 (SPSS Inc., Chicago, IL).

## 3. Results

Demographic characteristics are presented in Table 1. The mean age was approximately 44 years and most participants

**Table 1 – Demographic characteristics of Arab Americans participating in focus groups on diabetes perceptions and intervention preferences, November 2007–April 2009.**

N	69
Age, mean $\pm$ SD	44.2 $\pm$ 9.9
Sex, n (%)	
Male	26 (38)
Female	43 (62)
Country of birth, n (%)	
Lebanon	39 (57)
Iraq	7 (10)
Yemen	7 (10)
Palestine	4 (6)
Syria	4 (6)
Other countries	8 (11)
Length of stay in the US, n (%)	
Short Duration ( $\leq 5$ years)	8 (12)
Mid Duration (6–9 years)	19 (27)
Long Duration ( $\geq 10$ years)	34 (49)
Born in US/No response	8 (12)

SD, standard deviation.

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