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Focus groups have gained increasing acceptability as a data collection technique in qualitative research in recent years. Although used extensively with Western populations, they have been used only in a limited way in cross-cultural research. The authors describe a series of focus groups with women of childbearing age in the United Arab Emirates. The purpose was to identify Emirati women's health needs as a prelude to planning additional services and programs. Recommendations are outlined, with the appropriate cultural modifications for using this data collection tool. Major considerations that might be relevant to other parts of the Arab world include timing, location, topic, group composition, culture, religion, and selection of a facilitator and translator.

Focus groups as a data collection technique have gained increasing acceptability in qualitative research in recent years. They were widely used in the Western world, originally for market research and later to shape political campaigns. In the last decade, they have been used to gather in-depth views and opinions of homogeneous groups of people for social science research. Focus groups can be used to generate constructs, develop models, generate data for product development, and evaluate new programs and products (McDaniel & Bach, 1994). The group interaction provides data and insights that would not be accessible without the dynamics that occur within the group. For the purposes of this article, a focus group is defined as "either a naturally occurring or researcher selected group convened for the purpose of discussing a specific research topic" (Barbour, 1999, p. S19).

This approach to collecting qualitative data is based on the assumption that people are an important source of information about themselves and the issues that affect their lives and that they can articulate their thoughts and feelings. Additional information and rich data can be generated through group dynamics and focused interview techniques with a skilled facilitator.

Focus groups are seen to have a variety of advantages. They are an effective approach to collecting data from members of groups who are generally hard to reach, such as the disadvantaged or disfranchised (Barbour, 1999). It is also argued that focus groups can evoke a level of candor and spontaneity from members that

AUTHORS' NOTE: We would like to express our appreciation to the 60 Emirati women who participated in this study and who so willingly shared their experiences and described their health needs.

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provide data not accessed by more conventional interview techniques. With a supportive group, people might be encouraged to discuss sensitive issues. In all cases, a skilled facilitator is the key to success (Sim, 1998).

Some authors see focus groups as a more cost-effective and efficient way to collect data than individual interviews. Others argue that, as with any other research method, a great deal of time and effort needs to go into focus group planning, implementation, and data analysis if it is to be done successfully (Reed & Payton, 1997).

Although there is considerable discussion in the literature on the use of focus groups with English-speaking populations in developed countries, there is little on their use in non-English-speaking communities or in developing countries. Our purpose is to present the lessons we have learned in conducting focus groups in one region of the Arab world.

LITERATURE REVIEW

A literature review revealed extensive use of focus groups in the past decade in North America, where they have been used to look at diverse issues such as the experience of older people moving into nursing homes (Reed & Payton, 1997), sexual health (Robinson, 1999), women's satisfaction with prenatal care settings (Handler, Raube, Kelley, & Giachello, 1996), and management of family and workplace stress as experienced by women of color (Majumdar & Ladak, 1998).

Focus groups have been used increasingly in cross-cultural research. Relevant research includes studies with Chinese women (Twinn, 1998; Wong, Li, Burris, & Xiang, 1995), American aboriginal people, women of color in the United States (Napholz, 1998), immigrant women in Australia (Yelland & Gifford, 1995), and Hispanic Americans. In addition to these studies, two articles concerned the use of focus groups to study health services for Arabs. Kulwicki (1996) explored the concept of culturally competent care for Arab Americans in Michigan. Borkan, Morad, and Shvarts (2000) examined health and health care attitudes, practices, and usage patterns among the Negev Bedouin Arabs in Israel. Both studies concluded that focus groups are a useful data collection approach for studying health services for an Arab community. Kulwicki described many of the barriers to health services experienced by Arab Americans, including modesty, a lack of English language skills, religious practices, gender preferences in seeking and accepting health care from male or female providers, values related to not exposing family problems to outsiders, folk practices, values regarding honor and shame, and the stresses of living as an immigrant in an entirely different culture. Kulwicki, a bilingual Lebanese nurse-researcher with expertise in the area of Arab American health, conducted the Arab client focus groups primarily in Arabic, and the transcripts were translated into English by a professional translator.

Borkan et al.'s (2000) study took place in the Middle East. They described selecting a focus group approach because not only would they be able to collect rich and diverse data but also this approach is similar to Bedouin patterns of socialization: "Tribal members, generally divided by gender, will frequently meet for leisure and discussion in homes, tents, or designated structures" (p. 209). The focus group modifications they described included selecting and training Bedouins from various communities to conduct the groups, inviting participants who were from the same community but were not community leaders, holding separate groups for men and

women with same-sex facilitators, using handwritten note-taking rather than audio or video recording, and reviewing and refining the question guide with the Bedouin facilitators to check for cultural appropriateness. Although the research design called for equal numbers of male and female groups, cultural barriers prevented Bedouin women from participating to the extent desired.

In contrast, medical researchers at the United Arab Emirates (UAE) University provided anecdotal reports about their attempts to use focus groups to collect data on urinary incontinence in women. They speculated that they were unsuccessful because of the sensitivity of the subject and because the potential participants held the misapprehension that a male doctor would be involved in the focus group interviews.

With little evidence that focus groups could be conducted successfully with Arab women, the researchers, three women who represented three different cultures themselves, decided to proceed. We were encouraged by young Emirati colleagues, and we believed that Emirati women, like women in the West, would indeed be willing focus group participants given the right approach and environment. An awareness of the oral tradition of the country and the concept of the *majlis* (a formal reception or sitting room) further reinforced this belief. Furthermore, we believed focus groups were the most appropriate technique for collecting the variety and depth of data required for the study of the health needs of UAE women. Ethical approval for this grounded theory research was obtained from the Research Ethics Committee of the Faculty of Medicine and Health Sciences at the UAE University.

Koerner and Bunkers (1992) defined cultural competence as the provision of health care that demonstrates understanding of and respect for another culture. Meleis (1999) defined culturally competent care as care that is "sensitive to the differences individuals may have in their experiences and responses dues to their heritage, sexual orientation, socioeconomic situation, ethnicity, and cultural background" (p. 12).

BACKGROUND

The UAE is a rapidly developing country with a population estimated at 3 million. Ninety-six percent are Muslim. Fifty-five percent are less than 30 years old (UAE Ministry of Health, 1998). Approximately 20% of the population is Emirati. Since oil was first exported in 1962, the UAE has grown from a poor country of pearl divers, camel herders, and subsistent date farmers to a wealthy and diversified one. A burgeoning health care system forms part of the rapidly growing infrastructure. It is a country of contrasts, where women wear beautiful bejeweled long silk gowns to work but never take off the covering black *abeya*. Camels wander alongside superhighways. Men armed with mini mobile phones head into the desert in luxurious four-wheel drives to practice the ancient art of falconry.

The UAE is a very conservative Islamic culture in which most women remain within the confines of their home, venturing out only with a male family member as escort. Education is a priority for the country, and now 70% of women attend university. More and more are entering the workforce, often behind their veils. As women become better educated, they are beginning to defer marriage and childbearing beyond their teens.

Al Ain District, where the research was conducted, covers about a third of the country (21,000 square kilometers). The city of Al Ain has a population of 341,300 and is surrounded by many small rural communities, each with its own primary health clinic. Because of the large number of expatriate male workers, less than a third of the population is female (UAE Ministry of Health, 1998).

In this article, we describe a series of focus groups that involved 60 Emirati women of childbearing age living in Al Ain District. The purpose of the study was to identify the health needs of these women as a prelude to planning further services and programs. Six focus groups were held, and a number of recommendations for using such a data collection tool with similar populations are outlined.

The Process

A pilot focus group was planned to test the researchers' assumption that it could work. We approached three Emirati coworkers, who agreed to participate and bring other eligible family members (i.e., women between the ages of 16 and 45). The women identified a convenient date and time and agreed to meet the researchers at a local primary health clinic (PHC). The PHC was a familiar and socially acceptable place for women to gather, and where their fathers/husbands would probably allow them to attend.

We arrived early, as did our Emirati assistant, to ensure that the meeting room was comfortable. Tape-recording equipment was selected and set up to be as unobtrusive as possible, with only a central microphone visible. Snacks were provided in the tradition of Arab hospitality. The Arabic-speaking researcher (GH) wore an elegant Arab dress, and her English-speaking colleagues dressed conservatively. We welcomed the participants, who arrived late because they were dependent on a male driver, who had other priorities, to pick each one up at her home. Some did not arrive at all.

The women, all members of an extended family, sat around a table. After introductions and an explanation of the purpose of the meeting, the facilitator obtained written consent and demographic data from each woman. To our surprise, no concerns about tape-recording were expressed.

Initially, the participants tended to answer the open-ended questions briefly, and only two or three members contributed. The facilitator seemed to be doing most of the talking, and the women looked very serious. After about 15 minutes of rather stilted discussion, the group gradually became more animated. They began talking over each other and to each other while others were talking. An impassioned opinion by a younger, previously silent woman generated more interaction and simultaneous discussion. The group elder engaged the facilitator in a one-to-one discussion for a short time before getting up and announcing that it was time to pray.

After a short prayer break and refreshments, the group reconvened. The last 30 minutes were planned to discuss a list of health education topics developed from a previous survey. There was not much interest in prioritizing these topics; the women were more interested in discussing hereditary diseases. By allowing the participants to pursue and focus on issues of interest to them, the focus group process enabled access to data that might otherwise not be revealed. An hour and a half after it began, the focus group finished.

A review of the pilot focus group led to several modifications for subsequent groups. To reduce the problems with transportation and the need to rely on male approval, we decided to seek women in places they normally congregated. The Abu Dhabi Women's Association is an organization that provides Emirati women who have left school early with the education and domestic skills needed to care for their families. The director of the Association agreed to find women willing to participate in the focus groups and provided classroom space. The three subsequent focus groups held at the Women's Association ran smoothly. The women were interested in attending, and the groups ranged in size from 6 to 16.

Logistically for both the participants and the researchers, the focus groups at the Women's Association were much easier. The researchers wore conservative dress but refreshments were not necessary. Everyone sat comfortably on the floor, as is the custom, lending a whole new dimension to grounded theory, our research method. The women shared their thoughts and ideas freely, and the facilitator had to work hard to keep them focused on the subject at hand.

In the interest of learning more about the health needs of women living in rural communities, we also planned a focus group outside Al Ain. It was held in Al Hayer, a small agricultural community 40 kilometers north of Al Ain. Again, the Women's Association provided access through their local school. This session was entirely different from the earlier one. About 25 women of all ages and some curious onlookers poured into the room, and we were invited to share their "breakfast break." It was a time when the women shared food brought from home and socialized intensely as they sat majlis-style on mats.

Children ran in and out of the room. The women all ate and talked simultaneously. Two had a heated and loud debate. Nothing could begin until the researchers were persuaded to take some food. After eating, the women left to wash, and 14 women returned along with 3 non-Emirati staff members. It seemed rude to ask them to leave. They sat on chairs outside the focus group and chatted among themselves.

The facilitator began by explaining the process and distributing consent forms and demographic questionnaires. It quickly became apparent that the women were illiterate, so they gave verbal consent, and the school secretary took the demographic forms to complete from the school records.

Initially, the group listened quietly as the facilitator began, but very soon cross-legged women in small groups were talking and laughing. Some were wrapping food, some were counting their prayer beads, and children continued to go in and out of the room. The door was shut on two occasions in an attempt to reduce noise and traffic, but it was quickly opened again. When the facilitator tried to attract their attention by sitting up on her knees and speaking more loudly, the women would pay attention briefly and then burst into simultaneous discussion about some aspect of the question or something altogether different.

It became apparent to the researchers that these rural women had a very different view of the health care system. Unlike their city sisters, they expressed a complete trust in it. They had complete confidence in the decisions of their ruler, Sheikh Zayad, and they believed Allah would look after them. The general activity and cacophony in the room precluded any group discussion or tape-recording. The facilitator, believing the group to be a complete failure, halted it after half an hour. As we were packing up, a worried participant returned three times to ensure that no

photographs had been taken, having mistaken the tape-recorder for a camera, neither of which was familiar to her.

The sixth and final focus group was held at the UAE University with a group of educated women, who were invited to review and critique the preliminary analysis of data from the previous five groups.

RECOMMENDATIONS

Based on our experiences, we believe that focus groups are a feasible method of collecting data with UAE women. However, there are a number of factors to consider, and these are outlined below.

Location

Researchers should seek out women in settings where they normally congregate to reduce the problems associated with transportation and male sanction of the event. The setting should be private, comfortable, nonthreatening, and readily accessible. Participants should clearly understand the purpose of the meeting, and the socializing should be used to create a comfortable atmosphere but should not overtake the focus group.

Facilitator

A facilitator who is the same gender as the participants is essential and appropriate to the culture. In addition to being a skilled facilitator, he or she must be fluently bilingual with Arabic as a first language. A non-Emirati or an Emirati from another region is preferable, as these women had great concerns about confidentiality and did not want family secrets to be shared with other Emiratis in their small community.

Facilitator's Assistant

The Emirati assistant was selected because of her familiarity with the culture and language. She kept a low profile and intervened only to clarify local dialect. The researchers were concerned that discussion might be guarded in her presence, but she did not seem to inhibit discussion. Her presence enhanced the quality of the transcripts, which she later typed.

Subject

The city women were quite open in their criticism of the health care system and saw the focus groups as a way to channel their concerns to the higher authorities. They described their use of folk and religious remedies, but when it came to psychological, social, or sexual issues, they spoke in generalities of other women. More in-depth discussion of sensitive matters would require individual interviews or possibly more time with the facilitator to develop trust and confidence.

Language

The focus groups were conducted in Arabic and translated into English for analysis, although Twinn (1998) described the importance of undertaking data analysis in the language of the interview. The complexities of Arabic grammar and dialect and the challenges 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 in three ways. First, the facilitator's assistant helped clarify meaning directly with the participants during the focus group. Second, as the facilitator was translating the transcripts into English, she sought further clarification from the assistant about the meaning or intent of certain phrases. Third, as we were analyzing the transcripts, the English-speaking researchers queried awkward wording or unclear meaning with the bilingual researcher, and an interpretation of the meaning was arrived at through discussion and a review of the original Arabic transcripts.

Gender

The women said that although focus groups with men were needed, "there will be a big difference because women are talkative and men are not." In this culture, it would be unacceptable to have a mixed focus group unless they were all close family members. The culture and the religion of the UAE require strict segregation of the sexes.

Age/Marital Status

With postsecondary education for Emirati women becoming the norm, the average age of marriage is rising. In addition, the UAE is a country that has seen such rapid growth in the last 30 years that each decade has provided a vastly different environment for the population. Adults who were Bedouins, tending goats and farming dates, have children driving Land Cruisers and studying in America. Younger women are educated whereas women over 30 years of age might be illiterate. Thus, Emirati women in their 20s have a very different experience of the world from those in their 30s or 40s. Depending on the topic of discussion, it might be better to have women who are close in age in each focus group.

Culture and Religion

Religion permeates all aspects of life in the UAE. Focus group members should be of the same cultural and religious background for meaningful discussion of most topics. Extended family groupings are naturally occurring focus groups. Arabs are generally considered to be hospitable and talkative, qualities that were helpful in conducting the focus groups. The Emiratis cherish their ruler, Sheikh Zayad. Everything related to him and his work is regarded highly. Because the women were reluctant to be critical of the health care system, some important information might not have been shared. Further research on religion and its impact on health is needed.

Education Level

The uneducated women in this study were very reluctant to make any criticism or negative comments. They reiterated their appreciation for the ruler and all he had done for them. Focus group techniques with illiterate and unsophisticated rural people require further exploration and adaptation of approaches, including the use of a smaller group in a more controlled environment.

Length/Timing of Focus Group

The focus groups lasted 1 1/2 hours on average and ended by mutual agreement of the women and the facilitator that the topic had been adequately explored. Selecting a morning or evening time is most suitable as many Emiratis sleep during the intense heat of the afternoon. It is also important to choose a time that does not interfere with the five daily prayers, although prayer time can be used as a natural break during a focus group. The members were able to resume discussion easily again as prayers are just part of the natural rhythm of a day.

Size

The focus groups ranged in size from 6 to 16 women. As the purpose was to explore ideas in depth rather than to generate many ideas, the smaller groups were more effective. Given the voluble nature of the women and the oral/majlis tradition of the society, women in larger groups often talked at the same time or held side conversations during which they were not responsive to the facilitator's attempts to engage them. Consequently, it was impossible to hear parts of the tapes clearly, and data were lost. To overcome these problems, Twinn (1998), who studied Hong Kong Chinese women, suggested that 4 to 5 participants are optimal.

Seating

Sitting cross-legged in a circle on a rug with shoes off is a familiar and comfortable arrangement for Emiratis. It encouraged a natural involvement and interaction that might not have occurred except with those younger women who were used to more formal classrooms with tables and chairs. An unobtrusive microphone was placed in the middle of the circle, and after its purpose was explained, all participants ignored it.

Refreshments

Providing guests with food or offering drinks is an important part of Arab hospitality. Our experiences varied widely. At the first meeting, the research team provided light snacks during the prayer break; however, the participants took only soft drinks. We did not offer refreshments when we went to the Women's Association but were ourselves offered drinks by our host. In the rural group, an extensive breakfast was part of their normal morning routine and a great opportunity for

sharing and socializing. Nothing was possible until the women had eaten and washed and ensured that we were looked after as well. It would appear that light refreshments are appropriate when the group comes to your territory but not necessary if you go to them, although never inappropriate.

SUMMARY

Because focus groups are used commonly in the West for market research and increasingly for health care research, the population is familiar with the format and expectations. As focus groups are a new phenomenon in the Arab world, the population is not familiar with this approach. As researchers and the Arab world become more familiar with this data collection technique, it is expected that some rich qualitative studies will occur. It is an approach that fits well with the oral traditions of the society.

The focus group experience provided us, expatriate health care providers, with a unique opportunity to learn about the lives and health needs of Emirati women. Based on our experience of 6 focus groups with a total of 60 women, we believe it is a viable data collection technique in the UAE and worthy of more exploration with women in particular. In many ways, our experience shows, Emirati women are like women anywhere. They are interested in participating in a process that might improve the quality of their health care. They are willing to answer questions, discuss topics at hand, and express their personal opinions after an initial period of shyness. They were stimulated by the discussions and were willing to explore all ideas. Interaction among group members stimulated thoughts and relevant recall of ideas, feelings, and experiences.

Researchers can use focus groups with culturally appropriate adaptations to listen to the voice of the people and obtain information. Focus groups in the UAE can provide a rich source of data for qualitative research. They can facilitate inclusion of segments of society that have not had the opportunity to contribute previously. Focus groups provide rich insight into the needs and problems of women. We learned what was meaningful and important to women. Women talked spontaneously about themselves, their families, and their health care needs. Focus groups can provide aggregate community information. The stimulus of group discussion provides insights, ideas, and data. Attempts to overcome the problems associated with collecting data in one language and translating it for analysis into another language included a process of presenting the findings in Arabic to a final focus group. This group provided some validation of our findings by confirming that our framework described their experience of the health care system concisely and clearly.

More attention needs to be paid to the development of culturally appropriate research methods. Researchers cannot automatically assume that data collection techniques used successfully with Western populations are transferable across cultures. In this article, we have described one experience with adapting focus groups for an Emirati population.

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