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Perceptions of Contraceptive Practice Among Arab American Victims of Intimate Partner Violence

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Abstract

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MPH, Benedictine University, 2017

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

There has been limited research on Arab Americans as they are an unidentified minority population. The specific research problem addressed through this study is that there is little research pertaining to the role of intimate partner violence (IPV) in poor contraceptive practice among Arab Americans, contributing to the larger problem of unwanted pregnancies, reproductive coercion, and other aspects of reproductive health. The problem with a high prevalence rate of IPV among Arab American women is that they are more susceptible to becoming pregnant and not accessing the reproductive health services that they may need. Thus, the purpose of this qualitative study was to understand perceptions in contraceptive practice for Arab American victims of IPV and how those perceptions influenced their reproductive health decisions, based on the conceptual framework of the health belief model. Interviews were conducted as the primary source of data. Data were coded, and NVivo software was employed organize data and assist with identification of concepts and themes. Findings suggest that Arab American women of IPV had negative experiences with contraceptive use and with Arabic cultural beliefs, and societal expectations were the biggest indicator in influencing negative perceptions and poor contraceptive use. This is important to address for Arab Americans as they remain an unidentified minority group who lack intervention and prevention services due to a gap in research pertaining to Arab Americans. Implications for positive social change include raising awareness and changing the perceptions of medical, public health, and research professionals in better understanding Arab Americans and providing tailored interventions that meet their reproductive health needs.

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Dedication

I dedicate this research study to all the unheard and silent voices of Arab American victims of intimate partner violence. I hope that one day these women can find their voice and have the power to take control of their own decisions.

Acknowledgments

First and foremost, I want to thank the strongest woman in my life who believed in me and made me the woman I am today, my beautiful mother. I also want to thank my loving partner who supported me throughout the way. I want to thank my family for being there for me when I needed them most. Also, a special thanks to my chair and committee for guiding me along the way and having helped me reach this point in my academic career.

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Chapter 1: Introduction to the Study

Introduction

Intimate partner violence (IPV) is a serious public health problem that affects millions in the United States, no matter race, class, or socioeconomic status (CDC [Centers for Disease Control and Prevention], 2020). IPV can lead to severe health issues, such as issues in reproductive health. IPV can lead to homicide, suicide, PTSD, and other physical and mental ailments that can result in costly healthcare (CDC, 2020). Although IPV can affect both women and men, it is even harder to detect and confront for many ethnic groups, such as Arab Americans, due to stigma and shame. Furthermore, Arab women who experience IPV have adverse reproductive health effects such as higher rates of spontaneous abortion, low-birth rate babies, delayed pre- and post-natal care, postpartum complications, and improper or poor use of contraceptives, such as birth control pills (Hawcroft et al., 2019).

Thus, in this study, I examined the perceptions of Arab American victims of IPV and how those perceptions influence their contraceptive practice. Examining Arab perceptions and how they influence contraceptive practice may give a clearer idea on what health professionals and medical facilities may need to educate and aid in the poor reproductive health of Arab American women of IPV. Giving a chance for Arab women to speak about their perceptions and influences regarding contraceptive practice and how they base their decisions will not only shed light on this unfamiliar area but help to empower these women and give them a voice.

This study helps build the foundation of this under researched topic and puts meaning behind the contraceptive decisions being made and situations that these women are placed in. This will hopefully pave the way for future research, helping to meet the reproductive needs of Arab American women. Furthermore, being able to raise awareness about the perceptions of Arab American women of IPV may help in reducing (reproductive) health disparities between Arabs and other subgroups. Thus, it is important to explore this phenomenon as a qualitative study because it gives a voice to this invisible population who have not yet been recognized as a separate minority group.

Background

The prevalence of IPV and the various contexts and issues surrounding it affect Arab American women in terms of informed decision making regarding any aspect of their life and their role in the household, particularly affecting their reproductive decisions (Abuelezam et al., 2018). Understanding and assessing this issue is crucial to implement tailored programming pertaining to this population, especially because IPV is a major problem within the Arab countries, with a lack of population-based data informing prevention and response efforts towards IPV (Elghossian et al., 2019). Furthermore, previous studies have shown that IPV is a prevalent problem in the Arab American community as well (Abuelezam et al., 2018). In the United States, women of color experience higher rates of IPV, in which these acts are deemed as appropriate or acceptable, when compared to their White counterparts (Stockman et al., 2015). Surveys conducted in many Arab countries, such as Egypt, Palestine, and Tunisia, have revealed that 1 out of 3 Arab women experience physical abuse from their spouses due to IPV

being seen as a private and permissive matter, a pattern that is seen within Arabs in the United States as well (Abuelezam et al., 2018).

In addition, the southwest side of Chicago has witnessed IPV with rates ranging between thirty-eight and forty-eight percent (Chicago Health Atlas, 2019). According to a community health survey conducted at a social services agency in the southwest suburbs of Chicago that serves Arab Americans, IPV and child abuse was seen as one of the major issues presented (Zayed et al., 2020). Currently, there are approximately 3.7 million Arab residents in the United States, with Chicago being among the top five metropolitan areas in which Arabs reside (Arab American Institute, 2018).

IPV affects the reproductive health decisions of Arab women and may alter their contraceptive practice (Abuelezam et al., 2018). This is increasingly concerning due to the health consequences that go with the lack of or poor use of contraceptives. According to the Illinois Department of Public Health (2018), the number of sexually transmitted disease (STD) cases, especially chlamydia and syphilis, has increased, which is a concern for women, as missed infections could lead to potentially serious consequences such as infertility and pelvic inflammatory disease. Illinois has the highest sexually transmitted infections (STI) rates in the nation according to the Cook County Department of Public Health Advisory Board Committee (2018).

As for unwanted pregnancies, Cook County, which is the county that represents the largest portion of Arab residents in the Chicago suburbs, has the highest birth rate of all the counties in Illinois (66,759 births), in which more than half of those births are in Chicago (Illinois Department of Public Health, 2018). Paradoxically, Illinois also has the

most comprehensive contraceptive law in all the country, as was required under the Federal Affordable Care Act that expanded birth control access beyond the requirements and took effect January 2016 (House Bill 5576; Olsen, 2016). Because laws are already in place pertaining to contraception, my goal was to understand what is affecting Arab American women from seeking or using contraceptives when it comes to their reproductive health. With attached stigma pertaining to reproductive behavior for Arabs, cultural perceptions are a large part of Arabs making informed decisions about their reproductive health (Munro-Kramer et al., 2016). According to one study, Arab Americans were less likely to report reproductive behavioral risks or activity due to the influence of Arab culture and tradition, even though 12.5% of the sample were recommended by their physicians to test for STI's and pregnancy (Munro-Kramer et al., 2016).

Although researchers have investigated this issue, IPV has not been explored regarding poor contraceptive practice and how the perceptions of Arab American women who are in this situational context greatly influence these practices. This study helps fill the gap in understanding the perceptions of Arab American women who have experienced IPV and how those perceptions contribute to their contraceptive practice. This study was needed to highlight the importance of how perception and unique situational contexts, such as being a victim of IPV, may greatly influence health decisions, such as contraceptive practice. Thus, this can give medical and public health professionals greater knowledge on this population's unique needs, in which they can better tailor interventions to meet this minority group's needs.

Problem Statement

The specific research problem addressed through this study is that there is little research pertaining to the role of IPV in poor contraceptive practice among Arab Americans, which ultimately contributes to the larger problem of unwanted pregnancies, reproductive coercion, and other aspects of reproductive health that affects their reproductive health decisions. The problem with a high prevalence rate of IPV among Arab American women is that they are more susceptible to becoming pregnant and not accessing the reproductive health services that they may need, including guidance on contraception (Abuelezam et al., 2018). According to Hawcroft et al. (2019), an estimated thirty percent of women worldwide experience IPV during their lifetime, with one in two women experiencing some type of violence from their partner resulting in an increase in adverse health, such as having higher rates in pregnancies and STD transmission. In another study, reproductive coercion was linked to IPV and thus results in unwanted pregnancies with an increase in STIs (Elghossian et al., 2019). These studies further highlight the influence of IPV among Arab American women and their perceptions on contraceptive use.

Many studies have been conducted overseas regarding Arab health, IPV, and contraceptive practice, but there is a lack in research pertaining to Arabs in the United States (with many studies conducted in the Michigan and New York areas; Elghossian, 2019; Zayed, 2020). According to the U.S. Census Bureau, Arabs and Middle Easterners are considered “White,” forcing them to become an invisible community whose health needs, concerns, and voices remain unheard (as cited in Zayed et al., 2020). This has

resulted in a lack of research, data, and statistics towards evidence-based programming and lack of competency for tailoring the needs of Arab Americans from medical providers, institutions, and public health workers (Zayed et al., 2020). The recent and few studies pertaining to Arab American populations have revealed that IPV and reproductive consequences are a prevalent issue due to several factors, such as females tending to stay in their relationship due to sociocultural perspectives, among many others (Abuelezam et al., 2018).

Purpose of the Study

The purpose of this qualitative study was to understand the perceptions of contraceptive practice of Arab American women who have experienced IPV and how those perceptions contribute to their poor contraceptive practice.

Research Questions

1. What are the perceptions of contraceptive practice among Arab American victims of IPV?
2. How do the perceptions of contraception among Arab American victims of IPV influence their contraceptive practice?

Conceptual Framework for the Study

The theory that grounded this study was the health belief model (HBM). The HBM focuses on belief and perception of humans and how these rationales aid in their decision making (which leads to their performed behavior; Hall, 2012). Developed in the 1950s, the HBM was originally created to assess the components of health behavior through a person's desire or belief to avoid illness or get well if they are ill, and the belief

of a health-related action or practice that will prevent the illness or threat (LaMorte, 2019). In fact, the HBM has been used to study and understand contraceptive practice in populations since the late 1970s and 80s and in many foundational and original studies (Hall, 2012). Thus, the constructs of the HBM include perceived susceptibility or threat, perceived severity, perceived barriers, and perceived benefits; The last two constructs (cues of action and self-efficacy) were added onto this model as research and literature evolved throughout the years (LaMorte, 2019).

In this case, the construct of perceptions of this group of women aids in their decisions they make about their contraceptive practice and whether they use contraception. Regarding building a conceptual framework for contraceptive use according to the HBM, the motivation of using contraception would be to (a) prevent or avoid a pregnancy (desire to not be pregnant as a perceived threat), (b) perceived barriers (disadvantages of using contraception), (c) perceived benefits (advantages of using contraception), (d) cues to action (a trigger or the perceived threat that enables the person to decide regarding the use of contraception), and finally (e) any modifying/enabling factors that interfere with the perceptions of a person in making decisions regarding contraceptive use (more detail provided in Chapter 2; Hall, 2012). Thus, interview questions are based on such constructs to reflect the perception of contraceptive practice.

The logical connections between the framework presented and the nature of my qualitative study revealed the perceptions of a behavior or practice to better understand people and why they make the decisions they do, such as understanding contraceptive practice in Arab American victims of IPV. The HBM has been used to study and

understand contraceptive practice in populations since the late 1970s and 80s and in many foundational and original studies (Hall, 2012). Since then, research has been lacking in conceptualizing a framework that aims to understand contraceptive use among populations; thus, many studies have recognized this gap and have started utilizing the HBM again in exploring contraceptive practice all over the world (Gemmill, 2018; Hall, 2012; Kahsay et al., 2018). Therefore, with many past and present research studies using the HBM to understand contraceptive practice, it was a suitable model for me to use in this qualitative study to explore perceptions of Arab American women.

Nature of the Study

To address the research questions in this qualitative study, the specific research design included phenomenology. Phenomenology is a qualitative research design that focuses on understanding the chosen phenomenon through the participants' point of view (such as understanding contraceptive practice through the perceptions of victims of IPV). These perceptions and reactions are all part of the lived experiences of these participants, in which phenomenology aids in structuring these events and experiences as part of understanding people's story beyond quantitative measures. Furthermore, studies pertaining to understanding the lived experiences of women and how or why they practice contraception are not only limited but are better conducted through a phenomenological approach (Alano & Hanson, 2018). The reason this approach worked is because of my exploratory investigation of perceptions of contraceptive practice through the lens of IPV that were not bounded by certain criteria but allowed for the complete and holistic nature of participants' responses on how they perceived

contraceptive practice, which allowed for a variety of emerging themes and patterns of thoughts regarding this phenomenon.

Definitions

Arab Americans: Refers to the people of Arab descent who live and/or were born in the United States but who are originally from the Middle Eastern and North African region (Zayed et al., 2020). Because Arabs are grouped as one ethnic group despite the country or religion they are associated with or are from, Arab Americans, in this case, include anyone living in the United States, whether they were or were not born in the United States (Zayed et al., 2020).

Contraceptive practice: Involves the practice of preventing intentional conception through various barrier methods, such as condoms, pills, intrauterine device (IUD), and other devices, drugs, and surgical procedures (Jain & Muralidhar, 2011). Contraceptives are the barrier methods themselves.

Intimate partner violence: Pertains to any physical and/or sexual violence, stalking, or mental harm by a current or former partner (CDC, 2020). IPV also refers to any emotional or financial abuse, as well as lacking the power of control for oneself and their right to autonomy (CDC, 2020).

Assumptions

An assumption that is critical to the meaning of the study but cannot be demonstrated to be true is that women would talk freely about IPV and their responses would be truthful. However, that may not have been the case as many women recalled events that were uncomfortable for them to discuss.

Scope and Limitations

Barriers included difficulty in recruiting participants due to COVID. Some interviews were not face-to-face as planned, which may have led to bias or obscured the data collection. If interviews were not conducted in-person, implementing interviews through Zoom was also an option. Another limitation was the inability to reach out to subgroups within the broad category of Arab Americans due to various Arab ethnicities living altogether in the same area but accounted for as one culture. Thus, the scope of my study was limited to established Arab Americans who were born and were citizens of the United States.

Significance

This study is significant in that it helped fill a gap by focusing on the perceptions of contraceptive practice of Arab American victims of IPV. There is a lack in research, data, and statistics towards evidence-based programming and lack of competency for tailoring the needs of Arab Americans from medical providers, institutions, and public health workers, mainly due to not recognizing Arabs as a separate minority group (Zayed et al., 2020). Examining variables such as perceptions in contraceptive practice and how those perceptions influence contraceptive practice can help gain a better understanding of Arab American victims of IPV and the challenges they face. Understanding and assessing IPV in contraceptive practice is crucial to implement tailored programming pertaining to this population, especially because Arabs are not an official minority in the United States. Agencies such as medical institutions and centers, police and emergency room departments, and social service and medical providers do not keep track on updated data

when occurrences happen for this population. Thus, this study may help pave the way for understanding Arab perceptions while being vulnerable to a prevalent situation to tailor interventions and account for competency regarding Arab American women.

Summary

With IPV being a prevalent issue for the Arab American community, IPV has resulted in many emotional and physical ailments that have hindered contraceptive practices, among others. With many Arabs residing in the southwest suburbs of Chicago, there is a high prevalence rate in pregnancies and STI transmission due to weak contraceptive practice. This study aimed to address contraceptive practice through Arab American perception of IPV while applying the HBM. Gaining insight on these perspectives can help medical professionals and others to tailor program interventions that best meet the needs of the population group. Implications of this research may lead to other issues that may arise and add further knowledge to the literature.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative study was to understand the perceptions of contraceptive practice among Arab American women who have experienced IPV and how those perceptions have contributed to their poor contraceptive practice. The problem is that Arab women who experience IPV often have adverse reproductive health effects such as higher rates of spontaneous abortion, low-birth rate babies, delayed pre- and post-natal care, postpartum complications, and improper or poor use of contraceptives, such as birth control pills (Hawcroft et al., 2019). With one in two Arab women experiencing some type of violence from their partner, experiences in adverse health outcomes increase, such as having higher rates in pregnancies and STD transmission (Hawcroft, et al., 2019). The problem with a high prevalence rate of IPV is that Arab American women are more susceptible to becoming pregnant and not accessing the reproductive health services that they may need (Abuelezam et al., 2018).

Many studies have been conducted overseas regarding Arab health and contraceptive practice, but there is a lack in research pertaining to Arabs in the United States (with many studies conducted in the Dearborn, Michigan, and New York areas; Zayed et al., 2020). Thus, I examined the perceptions of Arab American women of IPV who resided in the suburbs of Chicago and how they practiced contraception (especially because the region these women were in had the highest rates in pregnancies and STD transmission compared to the other counties in Illinois). Studying the factors that affect these perceptions may give a clearer idea on what health professionals and medical

facilities may need to educate and/or aid in the reproductive health of Arab American women of IPV.

The recent and few studies pertaining to Arab American populations revealed that IPV and reproductive consequences were a prevalent issue due to the many contributing factors that provoke the problem, such as females tending to stay in their relationship due to sociocultural perspectives (Abuelezam et al., 2018). Arousell and Carlbom (2016) stated that the effects of culture and religious beliefs in contraceptive and/or reproductive practice in Arab Muslim women, specifically in terms of using healthcare services, indicated that cultural perspectives play a major role in accessing and practicing contraception. In the United States, women of color have higher rates of experiencing IPV, where these acts are deemed as appropriate or acceptable, when compared to their White counterparts (Stockman et al., 2015).

In this chapter, I present information on the following major sections: a literature search strategy, the conceptual framework of the study, a literature review of the topic, and a summary.

Literature Search Strategy

The databases and search engines used for this study included Google Scholar, Ebscohost, Medline, ProQuest, PubMed, and Thoreau. Keywords in the search included the following: *Arab Americans, Arabs, intimate partner violence or IPV, contraceptive practice or contraception or family planning, perceptions or perspectives or experiences or attitudes or beliefs, qualitative studies, health belief model in contraceptive practice,*

Arab Americans and contraceptive practice, and *Arab Americans and intimate partner violence.*

For my topic of choice, I searched the Medline full text database through the Walden Library portal and entered the terms “intimate partner violence” and “women.” I also limited the search to peer-reviewed articles, which led me to my chosen topic from the Journal of Urban Health: Bulletin of the New York Academy of Medicine. I made sure that the article was peer-reviewed by searching about the journal in Ulrich’s Web Directory to validate that it was a peer-reviewed journal. After obtaining all this information and examining all the citations, credentials, and author information of the journal article, I decided to use it for my topic of choice: IPV on Arab American women.

The search process consisted of looking up keywords in the mentioned databases to see if there was a similarity in the articles obtained and to gather various articles from each database for a more comprehensive literature review of the topic. I also consulted with a Walden librarian, and after several literature review searches, I broke down the topic constructs into categories instead of searching for all three study constructs, such as searching for *Arabs or Arab Americans and contraception or contraceptive practic*e and *Arabs or Arab Americans and intimate partner violence*. This not only yielded a more thorough and relevant search but also yielded more literature to back up the research topic, as there was little current research to begin with pertaining to Arab Americans, contraceptive practice, and IPV.

Conceptual Framework

The framework for this study was based on the HBM. The HBM focuses on belief and perception of humans and how these rationales aid in their decision making (which leads to their performed behavior; Hall, 2012). The HBM focuses on health behavior components that depict a person's belief to want to avoid illness through a health-related practice that will prevent that illness (LaMorte, 2019). The HBM was especially famous during the late 1970s and 80s in understanding contraceptive practice and behavior (Hall, 2012). Many studies have recognized this and aimed to bring the HBM back in studying contraceptive behavior and reproductive practice (Hall, 2012). The constructs of the HBM focus on perception of susceptibility, severity, barriers, and benefits that are used to explain and understand why people make the decisions they do and how their behavioral perceptions affect their practices (LaMorte, 2019). This aligned well in understanding perceptions of contraceptive practice in my population of study.

In this case, the construct of perceptions of Arab American women aided in their decisions about their contraceptive practice and whether they used contraception. In regards to building a conceptual framework for contraceptive use according to the HBM, the motivation of using contraception was to (a) prevent or avoid a pregnancy (desire to not be pregnant as a perceived threat), (b) perceived barriers (disadvantages of using contraception), (c) perceived benefits (advantages of using contraception), (d) cues to action (a trigger or the perceived threat that enables the person to make a decision regarding the use of contraception), and finally (e) any modifying/enabling factors that interfere with the perceptions of a person in making decisions regarding contraceptive use

(see Hall, 2012). Perceived susceptibility and perceived barriers were most relevant to this health behavior as it determined the relationship between the women's knowledge and their contraceptive use, which most affected their behaviors towards contraception (Silverstein, 2017).

Using the HBM to better understand contraceptive use for this population sample was an appropriate framework as it helped guide the interview questions to seek perceptional themes for these Arab American women. Despite the HBM being used to study and understand contraceptive practice in populations since the late 1970s and 80s, current research has been lacking in conceptualizing a framework that aims to understand contraceptive use among populations; thus, many researchers have recognized this gap and have started using the HBM again in exploring contraceptive practice all over the world (Gemmill, 2018; Hall, 2012; Kahsay et al., 2018). Therefore, because many past and present research studies have used the HBM to understand contraceptive practice, I rendered it to be a suitable model for this qualitative study to explore perceptions of Arab American women.

The constructs, or variables, I focused on were perceptions of contraceptive practice for Arab American victims of IPV, which included the threat of getting pregnant (unwanted pregnancy), disadvantages of using contraception, advantages of using contraception, perceptions and/or triggers that account for using contraception, factors that may lead to using (or not using) contraception (such as domestic violence) and other attitudes, social/subjective norms, and perceived efficacy. I aimed to better understand the perceptions and views that Arab American women who have experienced IPV have

on contraceptive practice. This can better guide practitioners and medical professionals on the views and culture of these women to give them the tailored reproductive care that they need.

The HBM has been applied to practice regarding one study involving HPV vaccine adoption (Glanz et al., 2015). HPV has been increasing for both males and females (Glanz et al., 2015). Fifteen studies were assessed using the HBM constructs in vaccine acceptability, in which 7 of the 15 strictly used the HBM (Glanz et al., 2015). The main route for applying HBM through the research practice was mainly descriptive, while a couple used longitudinal designs (Glanz et al., 2015). The descriptive studies examined how the constructs of the HBM were associated with vaccine initiation (Glanz et al.,2015). The most measured construct of the HBM was perceived susceptibility (70%), with five studies finding a positive association between perceived susceptibility and vaccination (Glanz et al., 2015).

Another study related to the research topic was by Booth et al. (2018), They analyzed the decision-making process through the HBM and engaged and identified communication channels of postpartum women when it came to contraceptive use. Booth et al. found that family planning and contraceptive decisions for postpartum women were made based upon social norms and networks and in-person healthcare visits. Although the population may not be Arab, this study was relevant to my research as it highlighted the importance of perceiving contraception after having children, and how these women based their decisions on these networks.

The strengths of the HBM model have been shown through the results of critical reviews implying the magnitude of the HBM constructs through empirical support (Glanz et al., 2015). Although small, the magnitude of the HBM constructs makes a difference in behavior, particularly perceived barriers being the strongest predictor of HBM model (Glanz et al., 2015). With the constructs of the HBM defined as the most intuitive, the HBM relates the most to experiences of life and is the easiest model to define, another strength of this model (Glanz et al., 2015).

One limitation of the HBM model is that specific relationships, combinations, and weights between variables are not delineated, thus leading to variations in the application of the HBM in research (Glanz et al., 2015). Another limitation is the model's less sophisticated concepts. With theory developments and methods becoming more revolutionized throughout the years, researchers now use the HBM with constructs of other theories for a more comprehensive approach to behavior changing interventions (Glanz et al., 2015). Overall, the HBM is more descriptive than explanatory and does not suggest a strategy for changing health-related actions. In preventive health behaviors, early studies showed that perceived susceptibility, benefits, and barriers were consistently associated with the desired health behavior; perceived severity was less often associated with the desired health behavior. The individual constructs are useful, depending on the health outcome of interest, but for the most effective use of the model, it should be integrated with other models that account for the environmental context and suggest strategies for change (Lane County.org, n.d). Table 1 highlights how the model was used according to this study's constructs.

Table 1

Contraceptive Practice Health Belief Model

Conceptual framework title: health belief model	Health behavior: contraceptive practice
List of constructs of HBM	List of behavior constructs
1- Perceived threat/susceptibility	1- Perceptions in preventing or avoiding a pregnancy or (desire to not be pregnant)
2- Perceived barriers	2-Disadvantages of using contraception
3- Perceived benefits	3-Advantages of using contraception
4- Cues to action	4- A trigger or the perceived threat that enables the person to decide regarding the use of contraception
5- Enabling factors	5- factors that interfere with the perceptions of a person in making decisions regarding contraceptive use

Literature Review

IPV and Contraceptive Practice in Arab Countries

According to the most current research, qualitative studies based on perception of contraceptive practice for Arab American victims of IPV is lacking, especially when combining all three of these constructs. Because of this, the following studies have mainly been conducted overseas, with a large focus being on the consequences of IPV, with one of those consequences affecting poor contraceptive or reproductive practice. Damra and Abjilban (2018) provided information on the association between IPV and the

reproductive health of Arab women in the country of Jordan, also examining its consequences. They found that most women who were experiencing some type of violent abuse (which were many of the participants) were also using some type of contraception or family planning. This indicates a relationship between contraception and IPV and how these women perceive contraception and respond to violence by aiming to use contraception to prevent unwanted pregnancies.

In addition, Pierce (2019) provided information on Arab refugees in Jordan and their utilization of reproductive healthcare services in an IPV context. Pierce (2019) found that although these women had greater access to family planning and contraception, their position in an IPV relationship gave them a weaker status for contraceptive decisions, validating the concept that contraceptive practice depends on the severity of the situation a victim is in, such as being a refugee in an IPV context. Another factor to consider is the population itself, such as Arabs overseas versus Arabs in the United States, which further validates that there is a gap in literature for perceived contraceptive practice for Arabs in the United States.

Hawcroft et al. (2019) provided information on how IPV affects the health outcomes of Arab women and how it affects their utilization of healthcare. They found that IPV was associated with very poor health outcomes, including reproductive health, which affects their utilization or lack of healthcare and poor contraceptive practice. This further indicates that Arab women in general are reproductively affected by IPV and that IPV can ultimately affect their decision to use contraception. Furthermore, there has been more research done on Arabs overseas versus in the United States, which validates a gap

in literature for population (again, most articles found did not target all aspects of the research constructs and referred to Arabs outside the United States). Although contraceptive practice may be perceived differently, resulting in different ways of using or not using contraceptives, relational contexts (such as IPV) play an important role for these women in how they practice contraceptives and how they view contraceptive practice as well. Thus, IPV not only affects the decisions made upon practicing contraception but also the poor use of it.

IPV and Contraceptive Use Among Arab Americans

Although there are plenty of studies related to the associations between IPV and contraceptive use, there are limited studies about the prevalence of IPV for Arab Americans and its effects on contraceptive practice (Khan et al., 2017). What is known is that IPV seems to be a prevalent concern in Arab countries and that IPV negatively affects poor contraceptive use, which ultimately leads to reproductive coercion (Elghossian et al., 2019). Reproductive coercion is defined as “a male partner's attempt to pressure a female partner to become pregnant or to interfere with contraception,” (Khan et al., 2017). It has also been found that, depending on the severity of the relationship between partners and the vulnerability of the situation victims are placed in, contraceptive use is desired among victims but is less likely to be accessed or practiced, especially long-term contraceptives (Khan et al., 2017; Pierce, 2019). It has also been revealed in many studies that culture, which comes across as a major theme, has a significant influence on practicing contraception among Arabs (Khan et al., 2017; Zayed et al., 2020). What is not yet known or apparent are the perceptions of contraceptive

practice among Arab Americans and the prevalence of the issue of IPV (and how that contributes to Arab American reproductive health).

A recent qualitative study done in Dearborn, Michigan on the perspectives of Arab Americans regarding IPV revealed that it was a major concern among Arab Americans and that many factors influenced the lack of access to IPV support services (Khan et al., 2021). In another qualitative study where Arab immigrants and Arab Americans were both interviewed about their perspectives on IPV, the themes that emerged were both similar in terms of culture and societal norms, indicating similar perceptions in both Arab immigrants and Arab Americans (Crabtree-Nelson et al., 2018). When combining the factor of contraceptive use with IPV among Arab Americans, the same themes emerge in that culture, community, and family get in the way of practicing contraception, accessing needed IPV and reproductive services, and often lead to reproductive coercion (Khan et al., 2018).

In many findings IPV and contraceptive use are issues that are kept in private and are accepted due to family and societal norms within Arab culture, making women more susceptible in getting pregnant and not being able to leave the relationship (Khan et al., 2018). In addition, women in the Arab community are often pressured to become pregnant right after marriage and are encouraged to have multiple children, with a lack in family planning (Khan et al., 2018). Thus, IPV among Arab Americans is a hidden, but prevalent issue that consequently affects their contraceptive practice and leads to reproductive coercion and poor reproductive health. Furthermore, cultural norms and

societal and familial expectations contribute to the onset of poor contraceptive practice and lack of family planning.

Cultural Norms on IPV and Contraceptive Practice

In terms of culture, it has been found that cultural norms are deeply engraved into the lives of many Arabs and Arab Americans and is also a major contributing factor to how Arab Americans view family dynamics and what is considered appropriate or accepted within the community (Zayed et al., 2020). Additionally, it is important to note religious and cultural factors in examining Arab American victims as literature on IPV within Arab Muslim communities is limited and scarce (Nedegaard, 2014). According to Nedegaard, Arab Muslim women were at a higher risk for IPV than their Arab Christian counterparts, and were more likely to have reproductive health issues, were more likely to experience unintended pregnancies and have more children and were more prone to using contraceptives (2014). Yet according to another study, women in the country of Jordan were more likely to experience interference with trying to avoid pregnancy, thus not being able to access contraceptives (Damra & Abujilban, 2018). Thus, depending upon location and setting, contraceptive use among Arab women who experience IPV may differ, despite the cultural and religious perceptions being the same, indicating yet another gap within the literature between Arabs of various locational settings.

In addition to cultural norms, according to one study, Arab Americans were less likely to report sexual behavioral risks or activity due to the influence of Arab culture and tradition, even though 12.5% of the sample were recommended by their physicians to test for STI's and pregnancy (Munro-Kramer et al., 2016). Although more than 70% declared

no sexual activity, the gap between self-declared sexual activity and reality was apparent, with men more likely to admit to sexual activity more than the women (Munro-Kramer et al., 2016). This further highlights the effects of social norms and gender roles in Arab culture that ultimately affect reproductive health behaviors and thus contraceptive practice. Khan et al. (2017) argued that the Arab American community in the midwestern U.S. region are at an increased risk for reproductive coercion and have little control of their reproductive autonomy in making decisions regarding contraceptives when they experienced IPV. The study further indicated the significance of societal and family norms within Arab culture and how those cultural perceptions ultimately affected family planning and contraceptive practice, with an increase in reproductive coercion and keeping private or accepting the issue of IPV. The pressure to become pregnant soon after marriage is just one perception or reason for lack of contraceptive practice (Khan et al., 2017).

In terms of perceptions, it is important to point out that gender norms, social support and networks, and religious and cultural beliefs have been brought up in many of the studies as well, regarding Arabs overseas and in America. For example, Fitzgerald and Chi (2021) provided information on the perspectives of Arab Palestinian women who are affected by IPV and the factors that enable IPV, along with IPV effects such as the use of contraception and unplanned pregnancies. The study found that gender norms and a lack of social support networks were barriers to seeking help for these women and that employed and educated women were more likely to seek help. This validates the concept that cultural norms stood in the way of practicing contraception while women with more

knowledge and education about contraceptives tended to seek contraceptives. This also aims to prove that Arabs as a whole, despite them being from various countries, have similar perspectives in IPV and contraceptive practice but may practice contraception differently based upon the severity of their relationship or how much knowledge they obtain.

Arousell and Carlbom (2016) provided information on the effects of culture and religious beliefs in contraceptive and/or reproductive practice in Arab Muslim women, specifically in terms of utilizing healthcare services. The study found that the sexual and reproductive health care knowledge of these women was limited and could not guide successful outcomes in reproductive healthcare for these women from existing providers. Thus, Arabic culture played a role in lack of access to contraception, which meant that the women were more likely to become pregnant due to their beliefs and lack of knowledge, resulting in poor contraceptive practice. These two studies depict a conflicting result where women who are in a violent situation are more likely to practice contraception whereas women who are more engraved to Arabic culture and beliefs are less likely to practice contraception. Thus, the question remains as to what perceptions are given when combining both an IPV context with Arab American women regarding contraceptive practice, the main research question of this study.

In addition, Budhwani, and Hearld (2017) stated that the relationships between stigma and physical and sexual abuse or violence were based upon depression among Muslim women in the United States, a sub-portion of Arab women. Sexual abuse and stigma were associated with higher rates of depression, despite higher socio-economic

status among the women. Perceptions and contraceptive practice among Arab American women of IPV, as many of the cultural perceptions of Arab women is also dependent upon their culture and religion (in which many of them identify as Muslim), which is another factor to point out.

Relationship Between IPV and Contraceptive Practice

In contrast, Cannon et al. (2017) provided insight on the relationships between IPV, reproductive decisions, and contraceptive practice to better understand the preferences of intervention, barriers, and use of implementation services for women of IPV. This study found that those women who experienced reproductive coercion and IPV were less likely to utilize various types of contraceptive methods and more likely to use withdrawal or condoms. This study proclaimed the opposite result and deemed women who were victims of IPV less likely to use contraception, mainly due to reproductive coercion, but was not done on Arab American women. The study is relevant to this research as it provides information on how contraception is perceived through general IPV experiences, further indicating a gap in research for Arab American women, in which their culture inhibits their use of contraceptive practice and leads to reproductive coercion. This could also indicate that women in this situational context perceive contraceptive practice differently, depending on the severity of the situation they are in or what cultural group they are from, in this case being Arab American. Furthermore, while IPV may lead to using contraceptives for some women, it inhibits the use of long-term contraceptives, such as the pill or IUD versus withdrawal or condoms, which increases the risk of unwanted pregnancies.

Harvey et al. (2018) further argued on how relational contexts of individuals affect their contraceptive practice, especially among young adults. The study found that (among a variety of women with various races) contraceptive decisions were based upon the context of their relationships (the stronger the relationship dynamic, the more likely longer-acting contraceptives were used). This further validates the point that, depending on the context of the relationship or situation, contraceptives may or may not be practiced, with more detail to long-term family planning if the relationship is a healthier one, versus using condoms or pills as a contraceptive method. These situations also highlight the kinds of contraceptives used and how families are viewed, depending on the relationship.

Despite this, the few studies that were found for Arab Americans also showed that IPV significantly affected their contraceptive practice. Khan et al. (2021) conducted a qualitative study that provided information on Arab American perspectives on IPV and how IPV affects Arab American women, including contraceptive practice. The study found that IPV was not only a major concern but factors such as generational status, education, and social support influenced access to needed services for these women. This further indicates that contraceptive practice is dependent upon the situation and relationship, in this case IPV, along with the Arabic culture and society these victims face that potentially encourage getting pregnant despite the women's status within the relationship.

Factors That Influence Contraceptive Practice

In addition to culture, IPV relationships, and consequences of IPV, Silverstein (2017) argued that there are underlying factors that may affect the relationship between the knowledge of family planning and contraceptive use. According to the constructs of the HBM, the study found that the more knowledge a person had, the more likely they were to use contraception, thus highlighting the importance of perceived knowledge towards contraceptive practice, another area that can be further explored. Therefore, the less perceived knowledge a person has, the less likely they are to use contraception and vice versa. In addition, depending on the severity of the relationship and its contexts, women may be more likely or less likely to engage in contraceptive practice, further relying on their perceptions or beliefs about how they view contraception and how it can affect their decision to practice in their relationship. Carvajal et al. (2017) argued that the main use for contraception was to avoid unintended pregnancies with a major focus on physician involvement and support in making contraceptive decisions. Thus, the more positive social support and involvement one has, the more likely they are to practice contraception, which further validates the point that societal norms and knowledge play a major role in making contraceptive decisions for these women.

In the case of IPV, socio-demographic characteristics such as gender roles, unplanned pregnancies/reproduction, divorces/marital statuses, and lack of education are all contributing factors to increasing the risk of IPV (CDC, 2019). In one foundational study, which included 727 young women between the ages of 14-26, it was found that the use of contraceptives was a protective factor against physical abuse along with an

increased level of education (Rickert et al., 2002). This validates the earlier point that was made in more recent studies regarding practicing contraception to prevent pregnancies, if the women had the knowledge to do so. Other surveys have indicated that women involved in an IPV relationship tend to seek either formal (police, health professional, counselor, and agency) or informal support (friends, family, neighbors, and community). But because many women tend to seek informal support first, they feel shut down or hopeless due to community perceived social norms regarding assisting women in IPV relationships, especially for the Arab community (McDonnell et al., 2011).

Khan et al. (2021) further argued that IPV was not only deemed a major concern for Arab Americans in the Dearborn, Michigan region but also that education, knowledge, and support from family, friends, and society influenced the perceptions of these women about IPV and whether to access the services they needed. In addition, Stubbs & Szoeke (2021) argued that IPV not only affects a person's physical health in a variety of areas, especially reproductive health, and contraceptive practice, but also their health behaviors regarding the decisions they make and how they perceive IPV. This further validates the argument that the lived experiences of victims of IPV and societal/cultural perception significantly influences everyday autonomy regarding reproductive health and thus practicing contraception.

Thus, perceived social norms within a community can drastically affect the steps needed to be taken in assisting women who are in an IPV relationship (McDonnell et al., 2011). It can hinder the decision of these women to flee the relationship, because they will feel like no one is going to help them. The larger the support system for these

women, the more likely they will make informed decisions about their relationship regarding contraceptive practice and be assisted.

Summary and Conclusions

The cycle of abuse and effects of IPV is merely the same, but what differs is everyone's perception and lived experience of the phenomenon, which leads to varying influences and results for each person regarding their personal autonomy and contraceptive practice. What we can conclude from the literature is that a) the more perceived knowledge one has, the more likely they are to practice contraception, b) practicing contraception depends on the severity of the relationship and situation, c) Arab culture, society, and gender norms significantly influence the perception and poor use of contraception, and d) IPV significantly affects the poor use of contraceptives, inhibiting the use of longer-acting contraceptives.

Although for some Arab women contraceptives were more likely to be practiced preventing unwanted pregnancies, this was combined with women who were victims of IPV but had more perceived knowledge about contraceptives and were in a less severe situation whereas women who were controlled by Arabic culture, had less knowledge, and were in a severe relationship or situational context were less likely to practice contraception, or had poor contraceptive use. In addition, the types of contraceptives used also depended on the severity of the situation, cultural perceptions, and how healthy the relationship was. Thus, the Arabic perceptions of victims of IPV greatly influences their contraceptive practice, leaving the question: What are those perceptions or factors of influence and how do they affect the contraceptive practice of Arab women who are

victims of IPV and who live in the United States, specifically the southwest suburbs of Chicago?

Chapter 3: Research Method

Introduction

The purpose of this study was to examine the perceptions of Arab American victims of IPV regarding their contraceptive practice. Examining these perceptions through the lens of IPV can offer a way to aid healthcare workers and public health professionals to tailor needed programs and interventions that meet the needs of this understudied population and topic. Combining the three constructs of IPV, contraceptive practice, and being of Arab American descent aimed to fill the gap in literature regarding this invisible population and stigmatized topic. Thus, the following sections are addressed in this chapter: research design and rationale, role of the researcher, methodology, and issues of trustworthiness.

Research Design and Rationale

In this study, I used a qualitative approach to better understand how Arabic perception played a role in contraceptive practice for victims of IPV. My research was based on primary data due to its qualitative, phenomenological nature that encompassed the lived experiences of these women. A phenomenological approach was appropriate for this study because it allowed me to better understand the lived experiences of the participants and how their intimate partner experiences affected their perception in contraceptive practice (see Alano & Hanson, 2018). The phenomenological approach in understanding contraceptive practice has been used in previous studies as well (Alano & Hanson, 2018).

Research Questions

1. What are the perceptions of Arab American victims of IPV regarding contraceptive practice?
2. How do the perceptions of Arab American victims of IPV regarding contraception influence their contraceptive practice?

Role of the Researcher

My experience as a former domestic violence advocate and in working with the Arab American population rendered my intentional responsibility to create a voice for the so-called "invisible" population, especially because I am a part of this population. Culture and social norms play a major role in the decisions and behaviors that people engage in, as these kinds of perceptions dictate decisions and behaviors. Being aware of my own biases and assumptions, in being Arab American, was crucial for my research credibility and validity. My role as the researcher was to recognize and understand Arab American victims of IPV on how they perceived contraception and practiced it by not only being an advocate for awareness and change, but also aiming to fill an apparent gap within the literature.

Methodology

Participant Selection Logic

My research was based on primary data due to its qualitative, phenomenological nature. Data and theoretical saturation are a major component of determining the sample size within the study (Baker et al., 2012). For qualitative studies, data saturation is usually achieved around 12 interviews, varying for each study (Guest et al., 2006).

Interviews were conducted with 10 women, with each interview lasting at least 30 minutes. Interviews continued to be conducted until data and theoretical saturation was reached.

The women were between the ages of 18 and 39 and were recruited voluntarily through flyers placed at a local social services agency that helps women of IPV and serves the Arab American population in the southwest suburbs of Chicago. The inclusion criteria included a select group of Arab American women born and/or citizens of the United States and were victims of IPV. The women were 18 years of age or older, of Arab American descent, and were past victims of IPV to ensure the confidentiality and safety of these victims. The exclusion criteria included women younger than 18 years of age, women who had never been in a relationship, women who were not Arab American, women who were still victims of IPV, women who were never victims of IPV, pregnant women, and women who were not U.S. citizens.

To ensure the privacy and identity protection of the volunteered group of women, the data was collected through semi structured, face to face interviews in a private setting to allow for confidentiality and comfort in speaking about the topic. I informed my participants about the purpose and reason for the interviews, the topics that would be discussed, and how the information from the interviews would be used. I also informed the women how long the interviews would be, that the study was approved by an institutional review board (IRB), and that recordings would be secured. Along with the procedure, I explained to the participants their rights, such as confidentiality and how all

identifying information would be removed, including how the data would be stored and analyzed, along with the consenting forms/process.

Instrumentation

Because contraceptive practice is a sensitive topic, semi structured, face-to-face interviewing worked best as it provided more confidentiality, anonymity, and privacy for the women to discuss freely what was on their mind, versus in a focus group where they may fear judgment or be shy (see Patton, 2015). Semi structured questions allowed for more creativity in responses and a broader range of themes that came up, which was used for probing (see Patton, 2015). Spending time with the women established rapport (which helped me gain participant trust and transparency in responses) but also gave the chance to attentively listen to each woman's story individually and how it compared to others. A pilot study was conducted with the first two interviewees to test the reliability and validity of the survey instrument. The first two participants agreed that the questions were clear, easy, and understandable, so their responses were used for the data. If the participants had suggested any changes, their responses would have not been used and would not have become part of the data collection.

Data was collected through participant responses from conducted interviews and analyzed through coding that was stored in a secure password driven excel. Participants remained anonymous, and all identifying information was removed. Data points from the interviews were focused on contraceptive practice and IPV for Arab Americans, the interconnection between contraceptive practices and IPV, and how those perceptions

influenced contraceptive practice within the Arab American community in the southwest suburbs of Chicago.

The kinds of questions asked were personal, as participants discussed their thoughts on contraceptive practice and how it interconnected with IPV. Thus, it was uncomfortable at times, which is why the face-to-face interviews were so important. Participants were at risk for additional trauma as certain events were recalled. A list of mental health resources was given to the participants before the start of the interview. There was a brief discussion that the interview questions could be painful and that participants had the right to refuse any question. I formulated my research questions by combining my research concepts, methodology, and framework. I made sure to include semi structured questions that were broad enough to illicit creativity and depth but also specific enough for breadth and richness (see Patton, 2015). I made sure to word the questions simplistically, started with the basics, and then moved on to more difficult questions and concepts and made sure the questions made sense and were not too long (see Jacob & Furgerson, 2012). Field notes were taken during the interview to capture any tone of voice or real-time body language and thoughts after the interview were written as a memo/journal (interview guide, questions, and ethical consent are included in the appendix). Some examples of these questions included the following:

- What kinds of contraception do you use, if any?
- What factors drive you to use or not use contraception?
- What are your thoughts on contraceptive practice in general?
- Do you have the control in whether to use contraception?

- How does cultural norms affect your decisions regarding contraception?
- How does intimate partner violence affect your decisions regarding contraception?

Procedures for Recruitment, Participation, and Data Collection

Before recruiting participants, an approved consent form for participants from the IRB was obtained that highlighted the important details of the study. The interview guide and questions were also approved by IRB to ensure that all questions were ethical. Approval was obtained from the social service agency to place flyers for the study by asking for permission. Voluntary and anonymous recruitment occurred at the agency from the flyers placed, which had my contact information. When participants contacted me and were interested in participating, a brief discussion about the main topic of the study was discussed, and a consent form was emailed or sent to the participant. After signing the consent form, participants chose a day and time that worked best for them to conduct the interview face to face in a private room at the agency. If participants did not wish to do the interview face to face, an option of a Zoom, phone, or email interview was conducted. After the interview, compensation, such as a gift card, was given to the participants for their time. Participant inclusion criteria included being of Arab descent, being a past victim of IPV, being a citizen of the United States, and speaking English.

I conducted the interviews in person (face to face) and over the phone. Face to face interviewing allowed for probing rich and holistic data, considered nonverbal cues in which facial expressions and body language were further analyzed, and allowed for more rapport building and trust between the interviewee and interviewer in creating a more

comfortable environment (especially with a sensitive topic such as contraceptive practice) (see Opdenakker, 2006; Patton, 2015; Rubin & Rubin, 2012). I coordinated a pilot study to ensure the reliability and validity of my data collection instrument before data collection.

As for interviewing, I conducted face to face interviews in a safe and confidential space. I gave the women the option of choosing Zoom or meeting in person. This kept the confidentiality and anonymity of the participants. Data were collected and stored only on my laptop through a secured passcode. No one had access to the data except for me. Data collected during the interview process were also reviewed by repeating back what the participants stated during the process to ensure validity, privacy, and accuracy of the data. My research study was reviewed and approved through IRB. Collection of data was through the participant interviews, which avoided collecting data through my workplace. The research was based on primary data due to its qualitative, phenomenological nature, which included data collection through face-to-face interviews.

My sampling plan was purposive sampling for my phenomenological qualitative analysis, in which IPV victims were recruited voluntarily through flyers placed at the local social service agency that served the nearby Arab American population and housed a domestic violence department. The analysis strategy included analyzing what the cases illuminated about the chosen concept being studied; this included inductively examining whether and how patterns identified shed on the concept that framed the inquiry (in my case, the HBM framing the phenomenological qualitative approach or inquiry; see Patton, 2015).

Data Analysis Plan

Qualitative inductive analysis focuses on generating new ideas, results, and explanations from a data set in a qualitative study, thus letting the data explain how the natural phenomena works (Patton, 2015). This includes patterns, themes, and categories within the data set, often called open coding (Patton, 2015). One important inductive approach that related to my study was the indigenous analytic concept that involved emic analysis or in vivo coding (see Patton, 2015). Thus, the analysis plan included an inductive indigenous concept analysis that identified meanings and interpretations from the perspectives of the interviewed (Patton, 2015). A qualitative management software, such as NVivo, helped in the process of data analysis but did not analyze the data (see Patton, 2015). Analysis and coding were conducted by hand to get to know the data, and through software such as MS Word, which was password-driven (see Patton, 2015; Rubin & Rubin, 2012).

The statistical plan included analyses of interviews that were coded through categorical variables and involved inductive conceptual analysis based upon the HBM. Manual coding was conducted to become intimate with the data, and NVivo qualitative software was used to address any missing information that was overlooked and compared categories and themes. This provided a more holistic approach to analyzing the data while checking for data saturation, which probed for more interviews and data collection (see Creswell & Creswell, 2018). Transcribing interviews was conducted via an audio recorder that only I had access to. This allowed the recorded interviews to come to life so that I could see if there was anything important that was missed during the interview, in

addition to the field notes I took. This also allowed for any missed codes or themes that were not noticed during the interview, and I compared my field notes to the transcribed interview. Furthermore, transcribing data and taking notes, by using more than one technique, allowed for full data saturation, increased data credibility and validity, and holistically aimed to identify all patterns or themes that emerged from the data for better analyses and management (see Sutton & Austin, 2015).

Issues of Trustworthiness

Ensuring the quality, rigor, and trustworthiness of qualitative research studies has been the argument of many researchers who view numerical values as efficient quality for studies (Ravitch & Carl, 2016). Thus, throughout the years, there have been frameworks and strategies for trustworthiness regarding qualitative research studies (Shenton, 2004). Despite the framework or strategy, four important concepts make for ensuring rigor within qualitative research studies: credibility, transferability, dependability, and confirmability (all which address trustworthiness in qualitative research; Shenton, 2004). Therefore, by ensuring that these components are addressed, the quality and trustworthiness of the qualitative research may be effective in terms of its data (Ravitch & Carl, 2016).

Establishing trustworthiness in one's findings and results is crucial to prove the validity of the study (Trochim, 2020). Credibility ensures that the phenomena being studied or presented is in its truest form, which focuses on the quality or trustworthiness of the research (Shenton, 2004). Achieving credibility depends on the richness of the data presented and not how much data are gathered (Trochim, 2020). By understanding the

phenomena of interest through the participants' eyes, the results should not only be believable but also are to be judged legitimately by the participants (Trochim, 2020). In this case, a variety of data sources were used to enrich the data. In addition, the whole study focused on understanding contraceptive practice through Arab American women victims of IPV and their perspectives, further increasing credibility of the study. Transcriptions included word-for-word data context while the interviews were also transcribed and recorded, which presented the data at its truest form.

Transferability refers to how well the research was implemented in other research settings or studies, or how generalizable are the results (Trochim, 2020). The qualitative researcher can promote transferability by thoroughly describing the research context and the assumptions made through the research (Trochim, 2020). Thus, not only has similar research been previously implemented, but the research context has been backed up by the literature and qualitative research components.

Dependability or reliability refers to how well the study can be repeated or replicated to achieve the same results (Trochim, 2020). Although this study was not a replication of another study, it can be easily replicated with another Arab American group in a differing location, such as New York. And finally, confirmability refers to how well the results can be confirmed by others, which can be done by checking and rechecking the data throughout the study by documenting the procedures (Trochim, 2020). A data audit can be conducted to examine the data and analysis procedures for any bias or distortion (Trochim, 2020). In addition to this case, confirmability was also implemented

by studying my own biases, self-reflecting on notes, re-reading and adding on to reflexive notes and memos, and discussing topics with my peers and scholars.

By following strategies to increase these components, validity and trustworthiness of the qualitative research study can be achieved (Shenton, 2004). Strategies that measure credibility are the most important component in achieving trustworthiness within a study (Trochim, 2020). Further specific techniques and strategies that ensure credibility include adoption of research methods that have been used previously in other well-established studies, developing familiarity, or building relational rapport, with the chosen participating group and their culture (such as visiting and prolonged engagement), incorporating random sampling to hinder bias in research, and incorporating triangulation (such as using a wide range of data sources, data collection methods, and more than one participating site) (Shenton, 2004). Other strategies to ensure quality, trustworthiness, and credibility in qualitative research include being transparent and honest so that participants can be honest as well, incorporating iterative questioning that encompasses probing to collect other data, repeating what the participants say to ensure validity of their responses, establishing a reflexive researcher journal or commentary (as the researcher is the instrument within the qualitative study), providing detailed descriptions of phenomena under study (including its research design and implementation, data gathering, and research analysis), and considering data auditing (Shenton, 2004; Ravitch & Carl, 2016).

Due to the many strategies that are available in ensuring study trustworthiness, it is impossible to implement them all. Thus, understanding what is feasible to implement

in one's own study and what strategies can be incorporated is a major part on the researcher (Ravitch & Carl, 2016). One way to ensure this, is to implement strategies from all four components of ensuring study trustworthiness to increase study rigor. Utilizing a range of strategies addresses trustworthiness issues and increased validity of the study (Shenton, 2004).

Ethical Procedures

Ethical considerations are an important part of the research process, especially when talking about sensitive issues. Thus, learning how to handle these situations is crucial for a smooth research process. Some important ethical considerations to consider was to make sure that all identifying information was removed during the study, that privacy and confidentiality was achieved for the participants, that I respected the autonomy of individuals, and that I disclosed all information pertaining to the research study prior to consenting individuals. These steps, and more, prevented issues that may have occurred beforehand.

The type of letters of approval I needed to obtain before I conducted my study included getting approval from Walden University IRB and approval from the social services agency in which I placed the flyers for voluntary recruiting of my sample (and of course participant consent as well after I obtained IRB approval first for my project). IRB approval was needed to go over all different types of ethical concerns and considerations that were tied to the study to ensure confidentiality and safety of the selected participants (Rudestam & Newton, 2015). This included ensuring how participants would be recruited, what kinds of questions would be asked, the feasibility of the study, how

consent would be obtained, gift card incentives that would be given, how the data would remain confidential as I was conducting interviews, coding the data, if there were any risks or benefits to the study for the participants, and how the results would be communicated by giving participants a copy of the final study if asked upon (Rudestam & Newton, 2015).

Summary

In this chapter, data collection methods and analyses plan were reviewed. The constructs that were asked depended upon the Health Belief that constructed and probed the appropriate questions. Constructs were categorical and descriptive in nature to identify the main concepts and themes that emerged from the interviews (related perceptions). The secondary sources used were to back up the study's relevance in the literature review and to see how other qualitative studies related to my study and how my study would fill in the gap.

The statistical plan included analyses of interviews that were coded through the categorical variables and involved inductive conceptual analysis based upon the HBM. I started out with 10 women and started coding the data from those interviews to see if a) more data needed to be collected and if the data had reached saturation and b) if there were any emerging themes that needed further probing (Creswell & Creswell, 2018; Laureate Education, 2010). I continued interviewing women and coding throughout the process until saturation was reached. Manual coding was conducted to become intimate with the data and NVivo qualitative software was used to address any missing information that was overlooked and to compare categories and themes from both

techniques. This provided a more holistic approach to analyzing the data while checking for data saturation, which probed for more interviews and data collection (Creswell & Creswell, 2018). Once categories of data were placed into main concepts and themes, I provided the results for my data. Qualitative validity and reliability included triangulation, member checking, and conducting a pilot study (Creswell & Creswell, 2018).

Chapter 4: Results

Introduction

The purpose of this research study was to understand the perceptions in contraceptive practice of Arab American women who have experienced IPV and how those perceptions and lived experiences influence their contraceptive practice and in making reproductive health decisions. Thus, the research questions were as follows:

Research Question (RQ)1: What are the perceptions of Arab American victims of IPV regarding contraceptive practice?

Research Question (RQ)2: How do the perceptions of Arab American victims of IPV regarding contraception influence their contraceptive practice?

In attempt to answer these RQs and better understand these experiences, a qualitative study was conducted that provided insight on these constructs. The following chapter addresses the results to these RQs and discusses the pilot study, settings, demographics, data collection, data analysis, evidence of trustworthiness, and the results.

Pilot Study

To ensure the reliability of my data collection instrument, a pilot study was conducted to test my interview questions. The pilot study was conducted with the first two participants interested in participating and were recruited to the study through the flyer that was posted at an anonymous agency that serves domestic violence victims. Both participants verbally consented, and the interviews were audio recorded and lasted for approximately 30 minutes each. Resources and gift cards were given at the end of the pilot interviews. The two participants were then asked to give feedback on the interview

questions and process. Based on both participants' responses, the interview questions were easy to follow and were understood, indicating that no changes needed to be made to the data collection instrument. Therefore, the data collected was used as part of the analyses for the main study. Implementing the pilot study aided in the reliability of my instrument by making sure the language and interview questions were fully understood by the participants.

Setting

To ensure confidentiality and privacy for the interviewees, the agency that worked with my target population provided me with a private room setting to conduct the face-to-face interviews. Due to fewer COVID restrictions, in-person interviews were able to be conducted. In addition, some interviews were conducted on the phone based on the participants' preferences. This provided flexibility on how to conduct the interviews for the participants, whether it was in-person at the agency or over the phone. Six people conducted their interviews in person while four people conducted their interviews over the phone. I made sure to follow IRB protocol whether the interviews were conducted in person or over the phone. Implementing this protocol ensured the privacy of the participants in this organizational setting, which may not have influenced the participants' experience at the time of the study. On the contrary, personal conditions (such as the remembrance of traumatic events from IPV) may have influenced the participants' experiences at the time of the study, which may have influenced the interpretation of the study results. Remembering these events and discussing them may

have caused discomfort or emotional triggers during the interviews, causing some women to hold back in answering the interview questions in detail.

Demographics

In conducting this qualitative study, 10 women of Arab American descent were audio-recorded and interviewed for 30 minutes or more. The demographics of these women varied in many aspects. The age range criteria were women ages 18 to 39, with some women being in their 20s and some in their late 30s. The women descended from various Arab countries in the Middle East and different regions, including Palestine, Egypt, Syria, and Jordan. Half the sample was originally from Palestine. In addition, 7 out of 10 women participants were born in the United States while 3 out of 10 women were born overseas. All the women were American citizens and English-speaking. Another similarity between all the participants was that all the women were Muslims of Arab descent. All the women were given a pseudonym to maintain their confidentiality and anonymity. The names were assigned randomly by searching a list of the most common Arabic names used. The following participants were assigned these pseudonyms: Participant 1 (Fatima), Participant 2 (Jamilah), Participant 3 (Khadija), Participant 4 (Leyla), Participant 5 (Taliya), Participant 6 (Dalilah), Participant 7 (Esraa), Participant 8 (Rania), Participant 9 (Amira), Participant 10 (Sara). Table 2highlights the participants' sociodemographic characteristics.

Table 2

Participants' Sociodemographic Data

Participant	Age	Relationship status	Highest level of education	Number of children	Region of birth/roots
Fatima	33	Divorced	Bachelor's	0	USA-Egyptian roots
Jamilah	39	Divorced	Bachelor's	4	Middle East-Palestine
Khadija	36	Separated	Associate's	2	Middle East- Egypt
Leyla	31	Separated	High school	0	USA-Palestinian roots
Taliya	39	Divorced	9th grade	5	USA-Jordanian roots
Dalilah	30	Divorced	High school	4	USA-Palestinian roots
Esraa	29	Married	Associate's	1	USA-Syrian roots
Amira	32	Married	High school	4	USA-Palestinian roots
Sara	38	Divorced	Associate's	4	Middle East- Jordan

Data Collection

There were 10 participants who were audio recorded through my iPhone voice memos. Six participants were interviewed face to face in a private setting at the agency where the flyers were placed for study recruitment, and four participants were interviewed over the phone. The room at the agency was private for the women, and the agency itself was in the southwest suburbs of Chicago, where over 30,000 Arab American families reside. Thus, the location was convenient and nearby to many of the women. Those who chose to not meet at the agency were given the option to conduct the interview via phone call. The interviews lasted 30 minutes or more, some lasting 35 to 60 minutes, with each of the 10 participants. Data collection occurred over the span of 3 months (June, July, and August 2022). The data were audio recorded using voice memos on the phone during the interviews, saved as files, and password locked. All written notes and reflections during and after the interviews were in a journal that was locked in a safe cabinet. The shortest interview time was up to 30 minutes, and the longest interview time was 75 minutes long. Many of the interviews lasted over 30 minutes because the participants were fully engaged during the interviews. There were no other unusual circumstances encountered during the data collection process. All participants were given 20-dollar gift cards and resources as needed, such as a referral to a mental health therapist if needed.

Data Analysis

After the collection and transcription of the data, hand coding was used to intimately analyze the data from the transcribed interviews, notes and observations during

the interviews, and the reflections taken in a journal after the interview. Preliminary data analysis was done by re-reading the transcripts and reflecting on the data collected, highlighting key words and major quotes throughout the process. Hand coding was then used to inductively move and create codes into categories seen within the data from each interview. From those categories for each interview, major themes and concepts were derived that emerged from the data. Concepts were further combined from all the data to highlight significant themes and key findings. Each interview question was assigned to the RQ where preliminary themes emerged. The following interview questions were assigned to the RQs:

RQ1: What are the perceptions of Arab American victims of IPV regarding contraceptive practice?

- Related interview questions:
    - What kinds of contraception do you use, if any?
    - What are your thoughts and beliefs on contraceptive practice in general?
    - What does intimate partner violence mean to you?
    - How is intimate partner violence defined within your community?
    - What are your experiences with intimate partner violence?
    - What do you think is the connection between intimate partner violence and contraceptive practice?
    - How does your culture play a role in intimate partner violence and contraception?

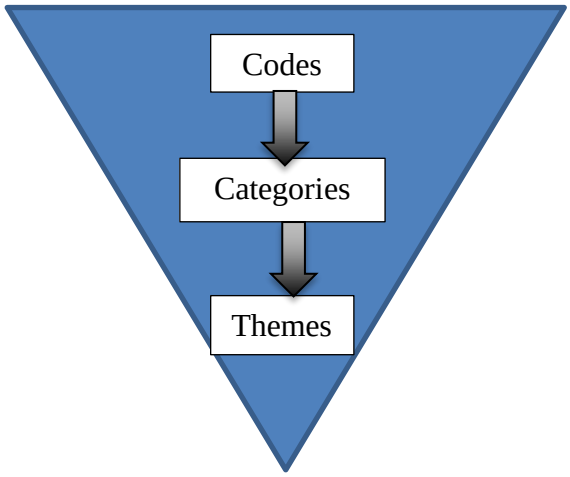
RQ2: How do the perceptions of Arab American victims of IPV regarding contraception influence their contraceptive practice?

- Related interview questions:
    - What factors drive you to use or not use contraception?
    - Tell me more about how you make decisions when choosing your contraceptives. (Is there full autonomy or control over these decisions?)
    - How does the Arabic culture and society around you affect your decisions regarding contraception?
    - How does intimate partner violence affect your decisions regarding contraception?
    - How does your culture play a role in intimate partner violence and contraception?
    - What do you think needs to be done or changed for Arab women to manage their decisions regarding contraceptive practice?

Important subthemes were then identified, along with highlighting key quotes from each transcript and color coding them to differentiate each quote with its participant. NVivo qualitative software was used to quantify the data and provide a more accurate platform to create and compare major themes and concepts that emerged from the collected transcript data to my preliminary analysis. Figure 1 highlights the order in which the data were coded and analyzed.

Figure 1

Inductive Analysis

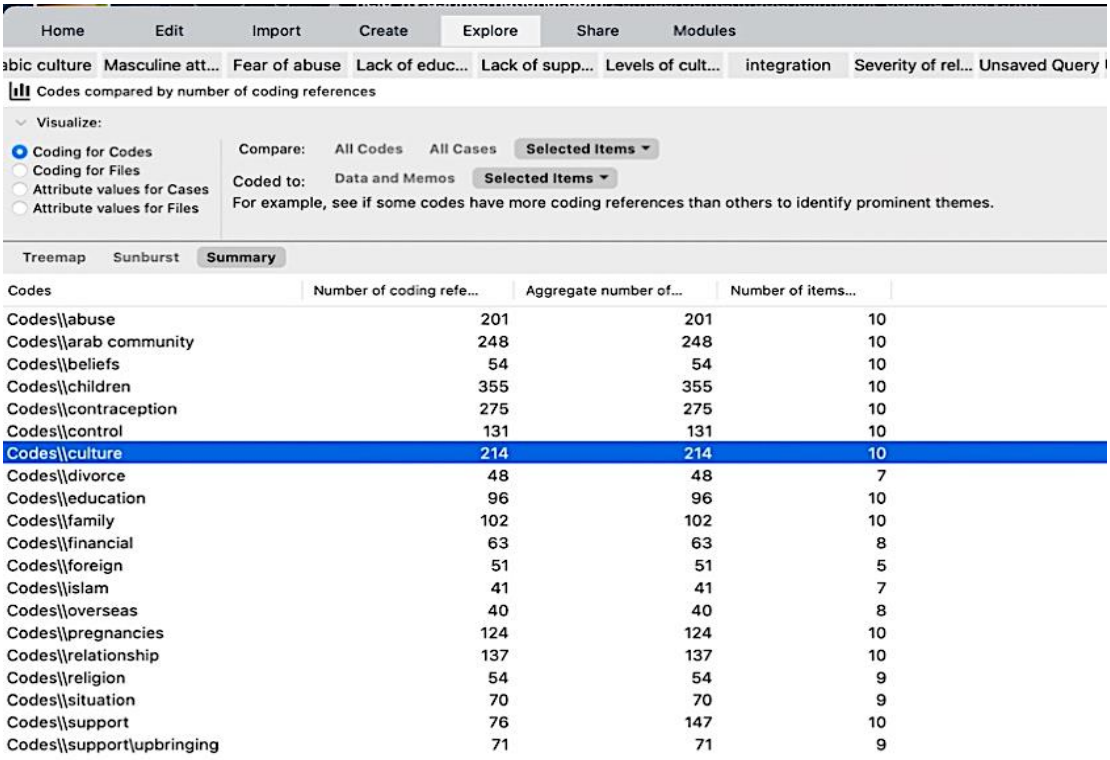


Major codes were created by conducting word frequency criteria search that highlighted the most frequent referenced words that emerged from the 10 transcripts. The top 100 and top 1,000 code words were reviewed to determine the most important and relevant data codes that came from the transcripts. After running the word frequency criteria query, a text search was used to establish an aggregate number of frequently derived codes and categories that were the most referenced from the data. By doing this, I compared the most frequent codes with each other to see which codes were the most referenced to identify prominent themes. After running this query analysis in NVivo, a hierarchy chart was created to highlight important codes and themes to compare to my preliminary analysis that was conducted prior to using NVivo. Figure 2 highlights the most prominent data codes and categories that emerged. Data were then compared to

further analyze the codes into prominent themes that were frequently seen from both the preliminary data analysis by hand and using NVivo qualitative software.

Figure 2

Hierarchy Chart for Emerging Data Codes



Codes	Number of coding refe...	Aggregate number of...	Number of items...
Codes\\abuse	201	201	10
Codes\\arab community	248	248	10
Codes\\beliefs	54	54	10
Codes\\children	355	355	10
Codes\\contraception	275	275	10
Codes\\control	131	131	10
Codes\\culture	214	214	10
Codes\\divorce	48	48	7
Codes\\education	96	96	10
Codes\\family	102	102	10
Codes\\financial	63	63	8
Codes\\foreign	51	51	5
Codes\\islam	41	41	7
Codes\\overseas	40	40	8
Codes\\pregnancies	124	124	10
Codes\\relationship	137	137	10
Codes\\religion	54	54	9
Codes\\situation	70	70	9
Codes\\support	76	147	10
Codes\\support\upbringing	71	71	9

Evidence of Trustworthiness

Credibility

In achieving credibility, the richness of the data is emphasized versus how much data is gathered (Trochim, 2020). This was achieved by using several data sources to enrich the data. Because this was a qualitative study that focused on participants' perspectives and understanding the phenomena through their eyes, this also increased credibility of the study, as qualitative studies focus on quality over quantity. In addition,

the data context from the interviews were transcribed word-for-word, presenting the data at their truest form. The audio recordings allowed for capturing the feelings, tones, and words being said from the participants in their truest form. I also made sure to build relational rapport with the chosen participating group by introducing myself in a nonformal way and having a warm conversation with the participants before attempting to interview them. I let them know a little about myself and was able to speak the same language (Arabic) when greeting them. This allowed the participants to feel comfortable in opening to me and assured them that I was culturally responsive. This also involved being transparent and honest about myself and my research so that participants could be honest as well. I also made sure to incorporate iterative questions that encompassed probing to collect other data themes and repeated what the participants said to ensure validity of their responses.

Transferability

Transferability refers to how well the research may be implemented in other research settings or studies (Trochim, 2020). Transferability was achieved by describing the study, the context, and its components thoroughly and in detail so if another researcher were to implement the same study, they would know how to do so clearly. This involved making sure all study and research components aligned, along with presenting a good research background about the topic of study.

Dependability

Dependability refers to how well the study can be repeated or replicated to achieve the same results (Trochim, 2020). Although this study was an original study, it

could be easily replicated in other settings where Arabs are populous, such as Dearborn, Michigan, to see if the same results can be achieved in other geographic locations. This goes back to how well the study is transferred in its original form and the study being explained in full detail for other researchers to replicate.

Confirmability

Confirmability refers to how well the results can be confirmed by others (Trochim, 2020). This was achieved by checking and rechecking the data throughout the study by documenting the procedures, taking notes, and reflecting for any bias. Data context and procedures were also discussed with senior colleagues who were more experienced in the qualitative field. Re-reading and self-reflecting on the data was constantly being implemented to ensure the best presentation of the data possible with avoiding bias.

Results

Based on the data analyses conducted by hand coding and NVivo for each research question, the following major themes emerged (See Figures 3 and 4). The study results will be presented through each research question, following major themes and subthemes under each research question section.

Figure 3

Research Question 1: Major Themes

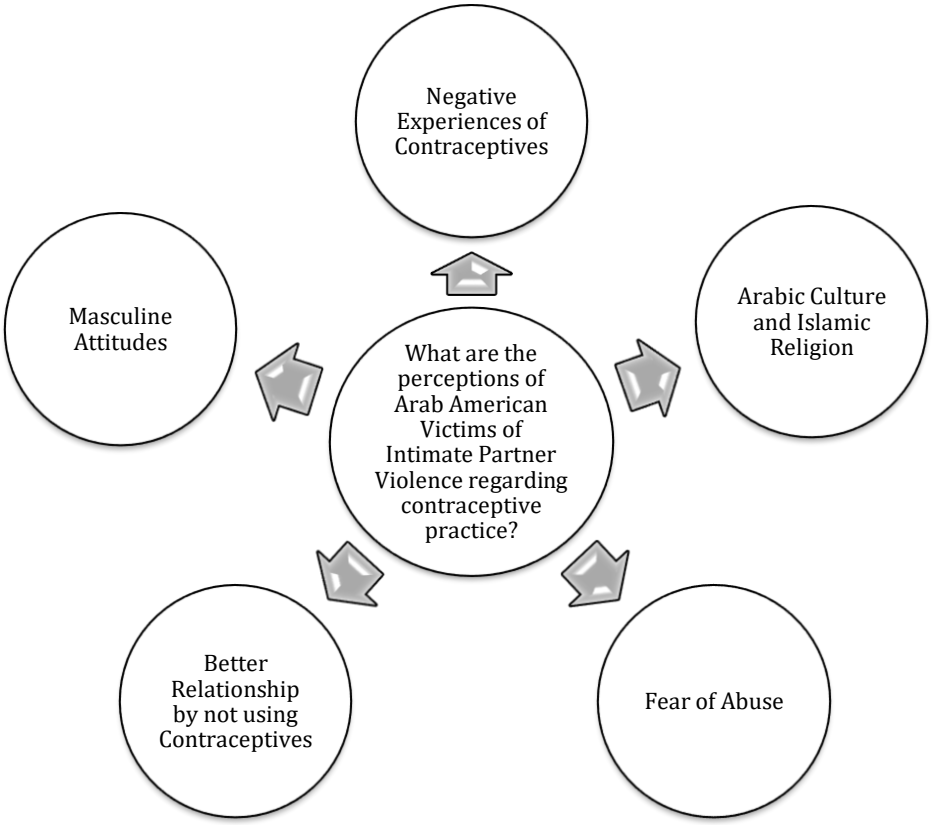
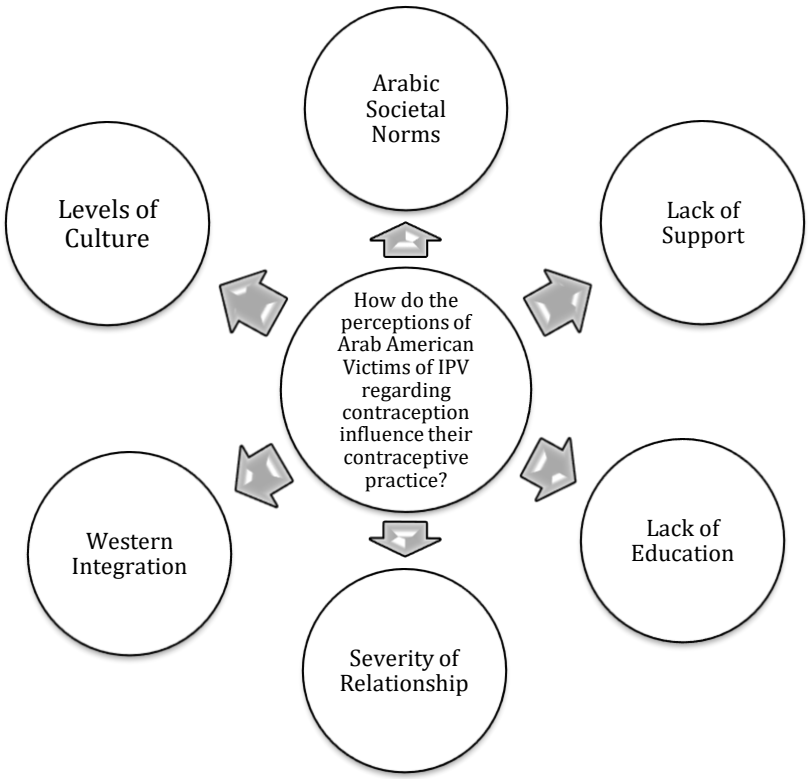


Figure 4

Research Question 2: Major Themes



Research Question 1: Major Themes

RQ1: What are the perceptions of Arab American victims of IPV regarding contraceptive practice?

Theme 1: Negative Experiences of Contraceptives

Arab American Victims of IPV perceived that contraceptives were harmful and toxic to the body. Negative experiences were associated with using contraceptives overall, whether it was mood swings, gaining weight, hormonal issues, or contraceptives not working properly. Eight out of ten women did not believe that using contraceptives was a good practice and believed that it would harm their reproductive system. Many

preferred the calendar counting method, withdrawal method, or using condoms as a "safer" alternative for avoiding hormonal imbalances from other contraceptive methods. The following examples support this theme:

Leyla shared, "To me, it's dangerous. I prefer to use natural remedies. It can damage your body and reproductive system." Taliya also explained, "I'd rather not put anything in my body that will affect my hormones or the way I feel in general." Moreover, Sara stated, "I read about it a lot. It's not healthy to anyone. I count my period days and I know when the time that I'm going to be pregnant. For almost 15 years, I do this."

Along with negative experiences, 7 out of the 10 women were strongly recommended a contraceptive method by their healthcare providers who pushed specific contraceptives towards the women, specifically the IUD, Depo shot, or Nexplanon. Others steered away from contraceptives due to their family's and friend's negative experiences.

Fatima commented,

"It's a lot more suggested and pushed for women to be on it from the medical field. It's constantly suggested by your doctor or they tell you should be on it… they are approaching it as if you are a part of the mainstream. They don't really understand the culture, that it's not something that's a norm."

Leyla also stated,

> I had a friend of my sister. She was taking them and she got a blood clot in her leg and almost died because of that if her dad did not catch it on time because he's also a doctor. Ever since then, I was against it.

Along those same lines, Dalilah said, "The doctors did actually push me towards the Nexplanon. I don't know if it's because it's their newest method, but I was advised that the Nexplanon would be my best option."

Theme 2: Arabic Culture and Islamic Religion

Arab American victims of IPV perceived that it was against their Arabic culture and Islamic religion to use contraceptives. Most of the women were raised to believe that using contraceptives was "haram" or forbidden in Islam, and that marriage was to be complete by having children. Eight out of the 10 women believed it went against their religion to use structured family planning and 10 out of 10 women believed that the Arabic culture did not believe or support the use of consistent contraceptives or played a role in influencing their contraceptive practice and getting pregnant. The following examples support this theme:

Fatima stated, "As far as my religious beliefs, and even in the culture, it's also looked down upon." Esraa mentioned, "Most people don't believe in it. To them, it's as if you don't have a choice to do with your own body. They see it wrong, and most people are against it." Meanwhile, Jamilah said, "We shouldn't be using them because they think it's haram (forbidden) to use birth control. That's how my ex always use to say to me, and he wouldn't allow me to take birth control."

Many women (9 out of 10) believed that using contraceptives went against the familial concept of having many children in the Arabic culture, and that the number of children depended not only on the woman, but her husband and his family. Using contraceptives were not only a woman's decision to make. As Rania stated, "You have to have kids in the Arab culture…you should have kids within two years of marriage. Anything more than that is definitely unaccepted."

Amira shared, "Sometimes they tell women it's allowed if your husband hits you or if your husband asks to sleep with you and you don't want to…that makes God mad if you don't give him whatever he wants, which, that's wrong."

Finally, Sara stated, "The whole family takes a decision, 'You are not allowed to take birth control because you married my son' or 'We will let someone else marry my brother because we need a lot of kids.'"

Theme 3: Fear of Abuse

Arab American victims of IPV perceived that using contraceptives would damage their relationship and increase the abuse. In addition to being surrounded in a culture where contraceptives is not widely used and being raised to believe that using contraceptives is against the Islamic religion, being in an abusive context further complicated the issue of using contraceptives, as 10 out of the 10 women believe that using some form of contraceptives, whether it was them or someone else they witnessed, increased the abuse from their partner and further contributed to damaging the relationship between the woman and her partner. Seven out of the ten women

experienced increased violence from their partners when they suggested family planning or some type of contraceptive method. The following examples support this theme:

Jamilah shared, “Some women, they’re scared to take birth control because the spouse, he didn’t want that….he used to hit me if he knows I’m taking birth control.” Similarly, Sara said, “Sometimes, he abused me because I don’t want to sleep with him.”

Khadija also said, “That’s why a lot of women that take these birth control behind their husband’s back and this is a problem because if he catch the woman taking birth control, it’ll lead to divorce and serious problems between both of them.”

Fear of abuse increasing was not the only perception that affected how these women viewed contraceptive use, but also the belief that using contraceptives would damage the relationship between the woman and her partner by preventing the relationship from getting better. Seven out of ten women believed that using contraceptives would potentially damage the relationship between her and her partner by making it less “fixable”.

For example, Dalilah stated, “My ex used to pressure me a lot because he wanted more kids and he would always say things like ‘I’m going to remarry because you can’t have any more kids and I need to have a lot of kids’ because that’s just how the Arabic culture teaches.”

Esraa also stated, “The whole point of getting married is for you to have kids. When they say kids, they’re saying a group, like 10 kids. They’re not talking about 1 or 2. To them, you are not respecting the spouse.” Amira added, “No, don’t take birth control because he’s going to leave you if you don’t have too much kids.”

Theme 4: Better Relationship by not Using Contraceptives

Arab American victims of IPV perceived that not using contraceptives and having children will make the relationship better, or improve it, between the woman and her partner. Eight out of the ten women believed that having children with their partners, having a boy, and having many children would improve their recent relationship with their partners or create a better relationship with them in the future. As Rania shared, "They think that when you get married, you have to have kids and the more you have kids, the more your relationship will be better with your partner which is not true." This would involve not using invasive contraceptive methods to disrupt the "natural" will of the number of children a woman is supposed to have. The best contraceptive practice for many (7 out of 10 women) would be to use the natural counting method to avoid pregnancy or the withdrawal method, which solely depends on the husband and whether he is cooperative, which is difficult when placed in an IPV situation. The following examples support this theme:

Khadija shared, "By the influence they get from the husband and his family, women remove the birth control….to keep the man, you have to have children, which is what my thinking was in the beginning, to let him stop playing around a lot, let him have children that's going to make him happy. That's the way they raised us in our culture." Khadija went on to further explain, "Maybe once he got the second baby, he will stop…and going to be more mature. And after the second baby, they were seeking and asking me on the phone about the third baby, right away, maybe like the same day that I delivered the baby."

Leyla also shared, “I know a lot of people who decide to get pregnant to say, maybe if I get pregnant, he will love me more. He’ll keep me or he’ll treat me better.” Similarly, Dalilah mentioned, “Some people, they think if they have a lot of kids, the man will change and the abusing will be less.”

Based on these data quotes, many of the women also perceived that by having children, the abuse would go away, or the man would stop doing the things that were the main cause of the relationship issues, such as cheating, hitting, or not being financially supportive. It is encouraged to not use contraceptives and have children to “keep the man and make him happy” and to make the family happy as well. If abuse does occur despite having children, the women is still blamed for it because she was not cooperative or submissive. As Khadija’s in-laws once told her, “Your parents didn’t raise you well. You are not behaving. Go back to your family. My son never does anything wrong.”

Theme 5: Masculine Attitudes

Arab American victims of IPV perceived that Arab men have the final say on whether a woman uses contraceptives. All the women participants agreed that the culture they have been raised in, brought up in, and were surrounded by was a masculine culture with masculine attitudes. Despite being married or not, all the Arab women participants always had to consider the masculine attitudes surrounding them before they decided, or even ask a male figure in making any decision, whether it was their father, brother, uncle, or husband, especially if the environment was abusive. All the women agreed that there was a lack in decision making, somehow, when it comes to their reproductive health, or making decisions in general. The following data quotes support this theme:

Leyla said, “I tried using condoms, but my husband kept on not using it properly and trying to get me pregnant.” Meanwhile, Esraa also said, “There is no give and take. It’s ‘You have to do what you have to do or else I am going to force it upon you.’” Amira also stated, “As soon as I would get pregnant and he knows it would be a girl, he would give me dirty looks the whole time…He’s really trying for a boy.”

Furthermore, Taliya shared, “I got married at 15. He was 11 years older than me. He controlled every aspect in my life. I had no say so, whether it was him buying a house, buying a car, giving me money. He controlled it all. I was pretty much barefoot and pregnant, just like he wanted.” Dalilah also shared, “He would be mad that it’s not a boy and then he would try to get me pregnant right away after I had my child.”

These masculine attitudes led to more abuse and control from partners who took advantage of the masculine culture. Furthermore, it is encouraged to keep having children until a woman gets the boy, which is considered the next “man of the house” to keep the lineage going.

Research Question 2: Major Themes

RQ2: How do the perceptions of Arab American victims of IPV regarding contraception influence their contraceptive practice?

Theme 1: Arabic Societal Norms

Arab American victims of IPV were not as likely to use contraceptives and were more likely to get pregnant due to surrounding Arabic societal norms and emphasized masculine culture. All the women agreed that the surrounding society and what was accepted or not accepted within the community played a major role on how many

children a woman had, whether she uses contraceptives, and even the relationship between the woman and her partner. Nine out of ten women agreed that major influences came from the women's families, and their husband's families, to abide by societal norms by having a large family and listening to the head of the household, which was the husband or partner. All the women agreed that making decisions regarding how many children a woman should have, was not in the woman's control most of the time, and that divorce was not accepted within the Arabic community. If a woman does speak up and get divorced, she was shamed for it.

As Khadija stated, "After the first month of marriage, his parents keep asking, 'Why she's not pregnant?' and told me that 'My son is a man. He can do whatever he wants. The people or the community you live in, they're not going to support you. They will say, 'Oh my gosh, she got divorced after all these years? But why she was patient with him before, why she didn't talk before? Why she didn't leave him long time ago?'"

Fatima also stated, "There has been times where the abuser is actually trying to get a woman pregnant and tied down with a child or have her nine months pregnant, so she is not able to do anything. And that's part of that abuse… A lot of women are told to be quiet." Additionally, Jamilah said, "It's 100% a man's society," and Leyla said, "I felt like I didn't have a full choice and I wasn't fully respected in that area."

All the women also agreed that abuse in a relationship, or IPV, was accepted within society and seen as something "normal" between a man and woman, and it was not something that a woman should get a divorce for, especially if she has children. Eight out of the ten women believed that an Arab woman is raised to be submissive and

obedient to her husband, even if he is abusive, and that the abuse is caused due to the woman's behavior; The woman, in this case, is always blamed for the man's abusive behavior. As Sara stated, "What did you do to him so he can hurt you and cause you bruises? That's always on you, the woman, always." All the women agreed that there was a generational cycle of abuse that started with their families and then transferred onto their relationships with their partners later. This further normalized abusive behavior as it started from the women's homes. The following examples support this theme:

Fatima explained, "That's the problem with our society, is that they don't really understand that it affects someone, so you have to smile and act like you're ok and continue to walk on in your life like nothing happened. You have to always act like you're ok."

Esraa went on to explain, "My dad actually used to pressure me to be obedient. Most Arab families don't allow divorce. He just felt like I have to be obedient to my husband because that's the man of the house. He has the last say so in the family. So that helped my abuser take more control of me."

Rania also shared, "I grew up in a toxic Arab community….you got verbal abuse from your family, and you just never realized it. Then you end up in a relationship where they're doing the exact same thing. But this time, it's not your family doing it to you, it's somebody else. And you don't realize it because this was always a norm for you."

Finally, Dalilah stated, "Basically, stay with your husband no matter what. My

mom tells me that if I would've told her in the beginning of my marriage when I only had one child, she would've let me get a divorce, but I don't believe that because of the way she treated me from before."

All the women agreed that major emphasis is placed on the man to make the decisions within the household while the woman's job is to have many children whom she is responsible for raising and taking care of the household. Seven out of the ten women agreed that staying in an abusive relationship is a mother's duty towards her children, as leaving the relationship was looked down upon. As Sara stated, "It's so sad that in our community they raised us, 'Oh it's okay. He's a man. It's ok if he hit you. You have to forgive him. You have to keep living with him because of your kids. You cannot get divorced.'" These Arabic societal norms place women and men in very specific gender roles that sometimes results in abusive behavior from the man and lack of decision making (or a submissive) woman. Having a large family, many children who are boys, and both parents living together is equivalent to the "American dream" for Arab households.

Theme 2: Lack of Support

Arab American victims of IPV were not as likely to use contraceptives and were more likely to get pregnant due to lack of community, family, and financial support. In addition to confined societal norms and cultural expectations, 9 out of 10 women agreed that the lack of support for women kept them from leaving the abusive relationship earlier and resulted in more children than they wanted or expected. Seven out of ten women also agreed that they had little control over their reproductive decisions which led to more

pregnancies. This lack of control in decision making and not using contraceptives was a way of abuse and control over the women to stay in the abusive relationship and not be able to support herself financially, which made it very hard to leave the relationship with children. Furthermore, the lack of support from families, both from the women's and partner's side, placed the women in assigned roles within their relationship. As Amira shared, "Because when it comes to these realms of these issues, you can't go to your parents to talk about it." Eight out of ten women believed that they did not receive support from their families to leave the abusive relationship and were expected to have children with their partner in attempt to "make things better." The following data quotes support this theme:

Sara said, "I'm the one that used to give lessons to women on how not to let anybody abuse you…but I'm the one somebody abuse me at home. I could not leave because my family does not accept divorce and I had to stay for my children."

Dalilah went on to say, "If I go to my mom and I told her, 'He is abusing me,' she will say, 'That's ok, that's your husband, you have kids now, you're married, don't embarrass us. People, they're going to start talking.''

Moreover, Khadija said, "His father told him once, 'Don't support her financially, Ibtirja3 zay il kalba (she will come back like a dog).' So, if you leave, you have to come back crying, asking for support to bring him back so he can pay the rent and you're not kicked out with two kids."

Jamilah added, "I don't know anybody at that time, I didn't have a car, I don't have money, I didn't pay the rent, school is coming, he left us, he stole the car, took

the WIC and link card, everything. What should I do with two little kids?"

Finally, Rania said, "I feel like it has to do a lot with the support you have. I've met women who didn't have a good support system, or didn't have anyone or anything to turn to. They are basically forced to live their lives with the guy that they are with and handle the abuse."

Because the man is the head of the household, men are usually the ones that control the finances and provide for their families. Women lack support from their families emotionally to keep women in their relationships from fear of reputation and backlash from the community, as divorce is not accepted as a norm culturally. At the same time, women lack support from their husbands financially to control the women to stay in the relationship, despite the abuse, and not be able to support herself and her children. As Sara stated, "They let the abuse be more because they don't support the woman when she gets abused. Always they say, 'That's ok he is your husband. Tomorrow, it will be fine. Maybe he is mad, maybe he's come from work tired. You're his wife, you have to support him.'"

Theme 3: Lack of Education

Arab American victims of IPV were less than likely to use contraceptives and more than likely to get pregnant due to lack of education and awareness. All the women agreed that having some type of awareness and/or general education can give them strength and an upper hand to be able to leave an abusive relationship to support themselves and their children financially with their degree. As Amira stated, "My husband's family didn't let me go to school. They're very toxic…and don't like

divorces…so you basically got to make it work." Eight out of ten women agreed that if they did have an education prior to getting married and were more aware, they probably would have not had children or gotten pregnant to begin with, if they found out their partners were abusive. They also would have left earlier instead of being patient and increasing their chances of getting pregnant. All the women agreed that education was not encouraged for women sometimes to control women and place them in a certain gender role so that they would not be as independent and make their own decisions. The following examples support this theme:

Taliya stated, "I never finished my school and right at that moment, I knew that everything was going down the line...I didn't have enough money to rely on myself and I had to wait for him."

Esraa also stated, "My husband's family took advantage of me…because I didn't know the language properly, I couldn't travel, I couldn't work…I asked him to go back to school to finish my diploma and go to college…he agreed with that but his family got involved and they told him, 'No, she's going to be going out a lot. She's going to learn from other women and she's going to be free.'"

Moreover, Dalilah added, "I feel like the more educated the woman is, the more that she feels like, 'I can do better.' And the more that she respects herself and I feel like she wouldn't allow what a high school dropout like me would allow."

Similarly, Rania shared, "I feel like education gives us an upper hand...to provide for ourselves. I've met a few girls from overseas and they don't have any type of

education. They know they are not in a good marriage...they want to leave but find themselves that they have nothing to fall back on."

Additionally, all the women agreed that being educated in the religion and more Islamically-aware made women stronger in their decisions and gave them autonomy, as Islam gives women many rights, but most were raised culturally. All the women agreed that if men were educated Islamically and were not brought up culturally, there would be no abuse and family planning would be encouraged, along with the education of women. All the women agreed that Arabic culture is often intertwined with religion to justify the actions, behaviors, and beliefs of the community in normalizing many unaccepted behaviors in Islam. All the women agreed this was a form of manipulation and abuse, and that many were made to believe that this is how Islam works, when in fact it was the culture. Nine out of the ten women who did leave the abusive relationship after many years, and those who had children, obtained their education, and became more aware of their Islamic rights, were able to support themselves mentally and financially. All the women agreed that the more educated a woman was, the more she could support herself and leave the relationship and less likely to get pregnant multiple times.

Fatima explained, "They actually bring religion into this, but they interpret it on their own way to manipulate you into thinking that they're actually right." Jamilah also agreed, "They try to tie that into the religion, which if you know the religion so well, is completely different than the culture." Khadija went on to explain, "You have the right to choose sometimes, if you help him with the expenses, even if the decision goes to the man, but at least you can talk."

Additionally, Leyla stated, “I think just knowing my own religion and how we take Islam and our relationship on how we are supposed to treat each other...just being educated in that alone should just be able to tell people right from wrong.”

Esraa also stated, “I don’t need him. I can do everything by myself. I can make my own money. He is literally losing his mind how he can’t control me now…because I’m making decisions, I left his family, I came to America, because I actually did it.”

Finally, Sara shared, “The regular Arab men who don’t abuse, their family raised them right, sent them to good school, raise them in religion more than culture. The regular man treats his wife good, with respect and love.”

Theme 4: Severity of Relationship

Arab American victims of IPV were not as likely to use contraceptives and were likely to get pregnant when they are in an extremely abusive and controlling relationship. All the women participants ranged in terms of how severe their relationship was with their partner. Some experienced mental or financial abuse while others were more physical and sexual. Despite this, all the women agreed that it depended on the situation and circumstances the woman was in when it came to getting pregnant or using contraceptives. Ten out of ten women experienced a form of control over their decisions and lives, whether it was using or not using contraceptives, getting pregnant or avoiding pregnancy, or not being supported. All the women agreed that having children would hold back a woman from leaving an abusive relationship because they were all taught to prioritize their family, or children, over themselves and to be secretive about their lives to

avoid a bad reputation and being shamed for divorce. As Khadija stated, “It’s going to be in your kids’ reputation too if you talk, so you have to shut up for the rest of your life.”

Dalilah went on to say, “My husband used to tell me ‘If you are using this kind of stuff (contraceptives), you have to stop because I want to have kids, I want to show them that I am still able to have kids.’”

Amira shared, “I feel like when your intimate partner is violent, it’s very hard for you to control your health decisions.” While Sara stated, “I wish I used any birth control and just didn’t have kids after I divorced.”

Theme 5: Western Integration

Arab American victims of IPV were more likely to consider using contraceptives for family planning and more likely to leave an abusive relationship if they are integrated in western culture. Eight out of ten women agreed that being in a western society made them feel like they could speak up about the abuse they were enduring and made it somewhat easier to leave their abusive relationship. Nine out of the ten women believed that being integrated in a western society, being born in America, and going to American schools raised women to be more outspoken and honest about how they feel, which challenged their cultural upbringing of being taught to be quiet and submissive about their lives. As Fatima stated, “Here, I do feel that we do have more of a voice than we do overseas.” Being integrated in more than one culture seems to change the perspectives of Arab women in how they respond to their abusive relationship with their partners. All the women agreed that being in America gave them opportunities to access contraceptives

and that there were no barriers to accessing contraceptives if they wanted to. The following examples support this theme:

Rania shared, “Women who are actually brought up and raised here and went to school, they have an open mind and view relationships differently. We are taught that we should always speak up...always be honest about how we feel and the women from overseas are taught, ‘No, it’s not good for a female to speak up. You’re going to be judged for speaking up.’”

Jamilah went on to share, “I feel like living here in the states, we have the opportunity and we have the ease. It’s at the palm of our hands, we are able to get contraceptives whenever we want, whether we are in abuse or not.”

Amira added, “I feel like now we’re reaching more of an educated, more enlightenment phase with our generation. I feel like the people who were closed off about contraceptives were our grandparents from back home… That old mindset.”

Along the same lines, Sara said, “If she has an education… she has a lot of information about how to protect herself from abuse...it’s going to make a difference. But if she never went to school and not allowed to go out, have friends, or not allowed to go to social media technology, how will she protect herself?”

Theme 6: Levels of Culture

Arab American victims of IPV who were born overseas were not as likely to use contraceptives and more likely to get pregnant and stay in an abusive relationship long-term compared to Arab American victims of IPV that were U.S. born. All the women agreed that there were differences in perception and response between Arab women born

here and Arab women born in the Middle East based on various cultural settings, despite the cultural upbringing being the same. As Leyla stated, “It’s not like here the American way, the Arab countries is completely different, and you have to keep quiet about your life.” Ten out of ten women believed that abuse is tolerated more so overseas than it is in America and that a woman will be shamed if she leaves the relationship or gets divorced. All the women agreed that there were different levels of culture: one being an older generational way of thinking (the overseas mindset) and one being an educational and enlightened way of thinking (more Islamically-aware and being integrated in western society). Seven out of ten women were first generation Middle Eastern Arab women while 3 out of 10 women were born overseas.

Over half of the women lived overseas and all the women lived in America, experiencing “levels of culture.” The first level of culture, the older generational mindset, discourages contraceptives and encourages women to get pregnant despite the abuse. Leaving the abusive relationship is not an option as the woman must be patient and stay for her children. All the women agreed that the older generation did not believe in IPV and that having many children would make the relationship better with the husband. The second level of culture, the educated and enlightened mindset, focuses on Islam more than culture, encourages education and support for women, and is more integrated in western society. All the women potentially left their abusive relationships with 7 out of 10 women divorced or separated after becoming more educated, aware, and integrated. All the women agreed that the way a person is raised depends on how they behave in a relationship, respond, and treat their spouse. The following examples support this theme:

Khadija stated, “You are ashamed of how the people will talk about you, especially overseas…or your family and reputation will be bad and hurt the kids in the future. So, there is like something grabbing you to come back. The culture, the way we raised up on our countries ruined everything, ruined our life.”

Fatima went on to say, “When there are issues, there’s violence, there’s abuse, the first thing they would push as a culture, especially the older generation, is ‘Well have a baby or have another baby. It’ll make things better.’”

Additionally, Taliya said, “It happens with the people that come from overseas and are used to that way of life over there. They bring that mentality back with them from overseas because of what they’ve seen. They’ve seen their parents go through it, so, they think that’s the only way to do it. It all falls back on the way you grew up.”

Taliya further explained, “Him being Middle Eastern and being from overseas does not understand the concept of mental abuse. Only physical abuse. They don’t know what depression means. When you’re sad and depressed, they ask you, ‘Why? You have everything?’ I don’t care if I have a million-dollar home. You’re doing something that’s making me feel this little, in a big house, but I’m not happy.’”

Dalilah shared, “If you have the view from overseas, for them, you should be having a kid every year. That’s normal. Of course, in America it’s a lot different here. Everyone’s like, ‘oh you’re so blessed you have four kids’ but the way he nags at me, he just wants more and more kids.”

Finally, Sara exclaimed, “The culture, they hold me, and I can’t say anything because when I talk to my family overseas, they said, ‘You have two kids now. If you divorce, who will raise your kids? If you want a divorce, you’re not allowed to stay in the United States by yourself. You have to come back home.’ And I have to leave my kids with their father because the rules with the American citizen. You can’t take them anywhere unless the father signs the release...so I try to fix my relationship with my spouse for almost 17 years, I keep trying. He used to hit me and call me names.”

Summary

Most of the women (9 out of 10) participants perceive the same beliefs when it comes to practicing contraceptives, with many believing it is either toxic, harmful, against their religious beliefs, can cause more abuse, and not in their control due to masculine attitudes and culture. With many women (9 out of 10) agreeing that the masculine culture and Arabic societal norms has a major influence on their lives, relationships, family planning, and contraceptive decisions, being in an abusive context can further exacerbate the issue and hinder a woman’s reproductive health decisions. Furthermore, the lack of family and financial support, lack of general and Islamic education, and the severity of the relationship influences perception and how the women practice family planning and contraception. All the women agreed that a well-educated, financially stable, and well-integrated Arab woman has the strength and potential to not only avoid reproductive coercion but also leave an abusive relationship. Being accustomed to the older generational mindset can place women in a specific gender role that encourages women to keep getting pregnant and endure the abuse from her partner

no matter the circumstances. Whether it is IPV or societal and cultural norms, the combination of these two constructs leaves Arab American women of IPV with little to no choice over their everyday decisions, even their own bodies. In the next chapter, I will interpret the findings found from this study by examining other peer-reviewed literature regarding these constructs.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study was to understand the perceptions of contraceptive practice among Arab American women who have experienced IPV and how those perceptions have contributed to their poor contraceptive practice. The reason for conducting this study was the gap in literature pertaining to the Arab American population and the gap found in the constructs of IPV and contraceptive practice. My aim was to pave the way for future research to be conducted pertaining to this population and to aid in culturally understanding a population that is vulnerable and underrecognized as its own minority group.

Major themes emerged from the data, confirming results in previous studies, and finding new study results. According to my study results, Arab American victims of IPV had an overall negative perception and experience with using contraceptives and believed them to be harmful and toxic to the body. Many perceived that using contraceptives went against their religious beliefs and that it was not accepted as a norm culturally. Being in an abusive context further exacerbated the belief that using contraceptives was not perceived as a good practice due to fear of the abuse increasing from the victims' partners, as contraceptives are not accepted culturally. Masculine attitudes contributed to this as victims perceived to have little control over their decisions when it came to family planning, and that reproduction is usually coerced. Many of the women had also been raised to believe that avoiding contraceptives and having many children would make the relationship better between the victims and their partners.

Additionally, these perceptions about contraceptives have influenced the way Arab American women of IPV practice contraception in general. The Arabic culture and societal norms were the biggest indicators found that influenced the way Arab American victims of IPV viewed and practiced contraceptive and family planning. Having a lack of family support and being financially dependent upon their partner for basic needs has placed these women in a gender-specific role. Furthermore, the lack of education exacerbates the issue, keeping the woman in an abusive cycle that makes it hard for her to leave and depend on herself financially and emotionally. New information has been found that differs from previous studies regarding the constructs of IPV and contraceptive practice. The severity of the relationship between the victims and their partners determined their use of contraceptives, while considering other factors that played into the role of contraceptive use, such as how integrated the women were in Western society and what level of culture, they have adapted from their grandparents' generation overseas. Western integration and adaptation of generational culture are new constructs that need to be further explored.

Interpretation of the Findings

RQ1 was as follows: What are the perceptions of Arab American victims of IPV regarding contraceptive practice?

Some results of this study confirmed similar findings from other peer-reviewed literature pertaining to Arabs, IPV, and contraceptive practice. With few studies conducted in the United States pertaining to Arabs, IPV, and contraceptive practice, it is apparent that IPV is not only an issue within the Arab American community but also

results in negative contraceptive practice and reproductive coercion (Abuelezam et al., 2018). Arabic culture and societal norms were founded as the biggest indicator in influencing women's perception and health behaviors regarding contraceptive use (Arousell & Carlbom, 2016; Khan et al., 2021). These cultural and societal norms that have been embedded in masculine attitudes have contributed to poor contraceptive practice, have promoted multiple pregnancies and reproductive coercion, and have exacerbated the issue of IPV (Arousell & Carlbom, 2016; Khan et al., 2021). Additionally, similar findings found in other studies confirmed fear of abuse increasing if contraceptives were to be used and the belief in having many children to improve the existing relationship between the victim and her partner, further promoting masculine attitudes pertaining to cultural beliefs and a woman's role in the household (Crabtree-Nelson et al., 2018; Damra & Abjilban, 2018). Being in an IPV relationship within an Arab American community not only influences how a woman practices contraceptives but also changes her perception (Crabtree-Nelson et al., 2018; Khan et al., 2021).

Other studies have confirmed the concept of cultural influence on IPV and contraceptive practice, indicating a major concern for IPV not being recognized within the Arab community and the lack of family support on hindering the use of contraceptives and promoting reproductive coercion (Budhwani et al., 2018; Stockman et al., 2015). Additional studies conducted in the United States and overseas confirmed similar cultural perceptions of Arab women, such as believing contraceptive use is harmful and goes against religious beliefs, despite that these studies have been conducted in different geographic locations (Elghossian et al., 2019; Fitzgerald & Chi, 2021).

Cultural beliefs and societal norms have led to the under recognition of IPV within Arab communities, which influences the poor use of contraceptives and promotes reproductive coercion, similar themes seen in other studies presented (see Crabtree-Nelson et al., 2018; Hawcroft et al., 2019).

Additional factors found revealed that the poor use of contraceptives, lack of awareness towards contraceptives, and reproductive coercion led to negative health consequences, such as heart failure, stress and anxiety, increased risk in STIs, unwanted pregnancies, among others, due to IPV hindering the woman's decision in practicing contraceptives. This is similar to another study's findings that found IPV was associated with overall poor health outcomes due to poor contraceptive practice, despite there being access to contraceptives (Cannon et al., 2017). Despite the consequences of reproductive coercion and poor contraceptive practice (Cannon et al., 2017), I found that many of the victims perceived contraceptive use as harmful and toxic to their bodies and reproductive health, leading to temporary solutions, such as using the calendar or the withdrawal method. Additionally, using these short-term methods, such as the withdrawal method, often depends on the man to abide by this commitment, further perpetuating masculine attitudes that give the man the power to make all the decisions within the household (Khan et al., 2021).

The concept of privacy within a household and not discussing confidential issues such as IPV and contraceptive use are a major part of Arabic cultural beliefs, making it harder for victims to speak up about the abuse and more susceptible to reproductive coercion (Khan et al., 2018; Khan et al., 2021). Additionally, Arab American women of

IPV may perceive contraceptive use as going against their Islamic religion, with being raised to believe that it is “haram” or forbidden to use contraceptives and that the number of children should be left to the will of God, pressuring many women to get pregnant multiple times and immediately after marriage (Khan et al., 2021). Family dynamics is extremely important within the Arab culture, indicating a need for many children to pass on the lineage and keep trying to have the boy in the family, or multiple boys (Budhwani et al., 2018). These societal and cultural expectations, along with integrating the concept of religion to justify the cultural beliefs, have contributed to poor contraceptive practice, and manipulating the women in believing contraceptive use is harmful and goes against all their beliefs (Arousell & Carlbom, 2016; Budhwani et al., 2018).

Adding a religious component has been found to increase the vulnerability of the situation, as often religion is intertwined with culture to manipulate Arab women into a more submissive role and perpetuates masculine attitudes that give men a more dominant role (Nedegaard, 2014). My study sample consisted of all Arab Muslim women who were victims of IPV and had been controlled in some way or another towards their reproductive health decisions, using contraceptives or not. Masculine attitudes, such as men being the sole decision makers, contributed to the victim’s lack of control in family planning, resulting in poor contraceptive use and multiple pregnancies, especially for Arab Muslim women who were at a higher risk for IPV and were more likely to experience unwanted pregnancies, resulting in having multiple children (Budhwani et al., 2018; Nedegaard, 2014).

Masculine cultural attitudes place women in gender-specific roles as they are expected to get pregnant and raise children while men are the financial supporters of the household (Fitzgerald & Chi, 2021). According to the HBM (LaMorte, 2019), the more knowledge a person has, the more likely they are to practice the desired behavior, in this case, practicing contraceptives and contributing to family planning (Silverstein, 2017). Similarly, and according to other studies, the more educated and aware the woman victim was, the more likely she was to depend on herself and able to make decisions regarding her reproductive health, such as using contraceptives and the desire to avoid unwanted pregnancies in an abusive relationship (Brown et al., 2011; Hall, 2012). Knowledge and education contributed to better practices in family planning and contraceptive use, with the lack of knowledge in an IPV context leading to negative health behaviors and decisions regarding contraceptive practice (Stubbs & Szoeke, 2021).

Although cultural beliefs and expectations surrounding Arab American women of IPV do not encourage the use of contraceptives (Khan et al., 2021), many providers encourage women to practice contraception for best practices in family planning and to avoid health issues that can result from having multiple pregnancies (Carvajal et al., 2017). Despite this, I discovered that most of the women had a negative experience when using contraceptives that resulted in a physical state, such as increased body weight, anxiety/stress, increased mood swings, and hormonal changes, aside from being in an abusive context and adhering to cultural beliefs. The association of contraceptive use to these health concerns, despite the recommendations from providers to Arab American women, contributed to their poor practice of contraceptives. The belief that

contraceptives are truly harmful seem to result from personal experiences or hearing about the experiences of others, without being fully knowledgeable about contraceptives.

There is also the belief that contraceptives may delay pregnancy and may harm the reproductive system altogether, indicating a lack of awareness about contraceptive use. While I aimed to understand perceptions of contraceptive practice among Arab American women, the results of the study revealed that Arab American women lacked knowledge on the logistics of contraceptives and how they worked, associating many myths to using contraceptives. This led to poor contraceptive practice and using the recommended cultural method of withdrawal or the calendar method. The prevalence of long-acting contraceptive use among Arab Americans and their current knowledge about contraceptives and tackling myths may need to be further explored. Providers may need to educate Arab Americans regarding contraceptives while considering their cultural adherence, a factor that also needs further exploration.

RQ2 was as follows: How do the perceptions of Arab American victims of IPV regarding contraception influence their contraceptive practice?

Domestic violence, specifically IPV, is a taboo subject that is prevalent but not recognized enough within the Arab community because it is believed that private matters are to be kept within the household (Zayed et al., 2020). Studies found that the severity of the relationship between a victim and her partner defines how she perceives contraceptive use, and, in turn, influences her overall contraceptive use and reproductive practice (Elghossian et al., 2019; Pierce, 2019). The severity of the relationship can significantly hinder a victim’s contraceptive use and promote unwanted pregnancies, specifically if the

abuse is extremely severe, despite there being access to contraceptives and family planning (Pierce, 2019). Other factors, such as lack of family support, financial dependence, and lack of education, have been shown to further perpetuate the issue of IPV and poor contraceptive practice (Pierce, 2019).

On the contrary, other studies have indicated that when a woman has more financial stability, is well educated and aware, and has a strong support system despite being in an extremely abusive relationship, she is more likely to use contraceptives and practice family planning to avoid unwanted pregnancies (Cannon et al., 2017; Fitzgerald & Chi, 2021). Certain factors such as education, family support, and financial stability can contribute to how contraceptives are practiced in the context of IPV despite the severity of the relationship (Fitzgerald & Chi, 2021) and the cultural beliefs that inhibit contraceptive use (Khan et al., 2021).

Newly founded knowledge emerged within my study results, with more research needed to explore these concepts: the concept of Western integration on Arabic cultural beliefs and influences in practice and the concept of there being “levels of culture” or cultural thinking. I found that there were certain levels of culture that influenced perceptions of Arab American women and how they practiced contraception. These levels of culture depend on how integrated the women are in Western society, how much they have adapted from their cultural upbringing, how educated they are, and how supportive their social system is that surround them. Cultural levels revealed that many of the cultural beliefs and societal norms towards poor contraceptive use and perpetuating IPV were established overseas and adapted from the older generation, who emphasized

gender-specific roles. The old generational way of thinking does not believe in IPV, believes that having children improves the relationship between partners, believes the woman should be submissive to the man, and believes that the woman should never the leave the man no matter what, contributing to a masculine culture.

The second level of culture revealed in my study results promoted a more enlightened way of thinking that emphasized the right of women to speak up, be honest, and get educated to raise a healthier generation of children in the future. The factors often associated with this level of culture identified within my study include being educated, being Islamically-aware, being brought up in a supportive household that differentiates Islamic religion from culture, and being financially independent, which often leads to a more open-minded and enlightened way of thinking. Additional factors revealed with this level of culture was adapting a Western viewpoint, where Arabs are more integrated into Western society and have been brought up according to Islamic perception, away from cultural beliefs that are frequently intertwined with the Islamic religion.

With Arabic cultural norms and beliefs being integrated similarly no matter the geographic location, education and upbringing in Western society has been found to play a major role in how women respond to IPV and contraceptive practice. Being raised in American schools at a young age and adapting a more independent attitude has been seen in Arab women of descent who were born in the United States and were able to leave the relationship sooner and avoid unwanted pregnancies versus Arab women who were born overseas who tended to have more submissive perceptions, multiple pregnancies, and severe abusive relationships. The effects of Western integration on cultural perceptions

and how U.S.-born Arab women respond to abuse versus foreign-born Arab women need further exploration. Arab women's knowledge in the differences between culture and religion need further exploration as well, as I found that many Arab women perceived cultural beliefs to be the same as Islamic beliefs due to their cultural upbringing, indicating a lack of knowledge and education in the Islamic religion in Arab women of descent.

Differences have been shown in my study findings on how Arab women born overseas and Arab women born in the United States respond to IPV, how long they stay in the relationship, how many children they have, and how they practice contraception. While cultural upbringing within the household may be the same, additional factors revealed that women who were born in the United States tended to be more outspoken and aware, making them more likely to leave an abusive relationship sooner and control their reproductive health decisions while women overseas tended to be quiet and submissive, making it harder to leave the relationship and more likely to get pregnant.

While increased education, increased social support, and employed Arab women were more likely to respond to IPV by seeking help when needed in leaving an abusive relationship and seeking contraceptives in family planning (Fitzgerald & Chi, 2021), the effects of Western integration and adaptation of different levels of culture were founded factors in women seeking help in leaving an abusive relationship. Conclusively, the effects of cultural beliefs and societal expectations have a major influence on the perception and poor use of contraceptives for Arab American women in general (Arousell & Carlbom, 2016). Adding an IPV context to this equation has been found to further limit

the use of contraceptives for Arab women with increasing severity of abuse in the relationship (Damra & Abujilban, 2018). Lack of education, lack of financial and family support, masculine attitudes, and strict cultural and societal beliefs have been shown to perpetuate the abuse and hinder the use of contraceptives, giving women little control on decisions pertaining to their reproductive health (Khan et al., 2021). Additionally, poor contraceptive use due to IPV decreases the chance of using long-term reliable contraceptives and increases the chance of using temporary, unreliable methods, such as condoms and the withdrawal method, exacerbating the risk of reproductive coercion and resulting in multiple unwanted pregnancies (Cannon et al., 2017).

Disconfirmed findings included the perception and belief of the women that contraceptives are truly harmful (away from the context of IPV and accessing contraceptives) and the push from medical providers for these women to practice contraception (see Carvajal et al., 2017), indicating a lack of cultural competency and sensitivity from medical providers. The main use for contraceptives is to avoid unintended pregnancies, with a major emphasis from healthcare providers to practice contraceptives (Carvajal et al., 2017). Similarly, and despite the negative cultural perceptions related to contraceptives, almost all the women in this study were pushed to use long-lasting contraceptives from their healthcare providers, with most ending up using some type of contraceptive, such as the IUD, Depo shot, or Nexplanon. Physician involvement has a major influence on women making contraceptive decisions, despite the cultural perceptions imposed on the women, which confirms that providers can play a significant role in helping women become more aware of contraceptives and impose

better practices when using contraceptives (see Carvajal et al., 2017). With many of the women feeling like providers pushed certain types of contraceptives, this indicates a lack of cultural competency and sensitivity from medical providers related to this population and topic, another area that needs further exploration.

Limitations of the Study

This qualitative study focused solely on Arab American women who were in an abusive relationship and generated cultural perceptions within the context of IPV. This is not to generalize that all Arab American women and men fit into this cultural mindset and that all are abusive or are in abusive relationships. It is simply to understand Arab American women who are in an abusive context and their surrounding perceptions, in addition to the abusers using cultural and religious beliefs as a form of abuse towards their victims pertaining to contraceptive practice. Due to this study's qualitative nature and small sample size, the study results cannot be generalized to adhere to the population but can provide insight to issues that are often hidden within cultural and societal norms and that can potentially hinder overall physical and mental health (Hawcroft et al., 2019). In addition, the study sample was limited because participants were recruited from only one facility which was in a dominantly Arab community.

Another limitation to the study was that some of the women were not able to have an in-person interview, which limited the researcher viewing some data in its truest, credible form such as observing body language, facial expressions, and hand gestures. The nature of the topic, due to its sensitivity, may have also triggered memories of unpleasant events for the women, who may have held back in fully disclosing all details

pertaining to the study constructs. In addition, the cultural beliefs in maintaining privacy and not talking about things that relate within the household may have held some women back in fully disclosing details as well (Khan et al., 2021). With this study being conducted on Arab Americans who fully spoke English, many Arab descendants who do live here but could not speak English very well, despite them being here for years and were American citizens, were not able to participate due to the language barrier present. Other researchers who would want to replicate this study may have difficulty accounting for and may require a translator and/or interpreter to include these groups of women.

Recommendations

Recommendations for further research can be explored with the new findings from this study. The concept of western integration on cultural perceptions for Arab American women in IPV, the adaptation of generational culture and different levels of culture, and Arab women's lack of knowledge about contraceptives needs further exploration. Arab Americans can be defined as citizens of a country who were born and raised in America versus women of Arab descent who are foreign citizens, to capture a more accurate perception of Arab Americans and how western integration intertwined with Arabic cultural and societal norms influence the use of contraceptives and in the women responding to IPV. This can aid in creating data explicitly for Arab Americans in recognizing them as an identified minority group.

This study can further be explored with Arab immigrants who have resided here for years as well to see the effects of integration and culture developing overtime and how perceptions and health behavior practices can change regarding IPV and

contraceptive practice. With culture being the biggest indicator in this study in influencing perception, determining health behaviors, and making reproductive health decisions, this concept can further be explored regarding Arab Americans and cultural standards. Additionally, research on Arab women's knowledge about Islamic beliefs and the interchange between culture and religion needs further exploration, specifically towards the role of Arab women and how that pertains to abuse and reproductive health. Understanding provider perspectives on Arab culture, how they provide reproductive care, and their knowledge on the symptoms of abuse in Arab patients could further be explored, especially since many of the women stated that long-lasting contraceptives were pushed upon them by their healthcare providers.

Implications

This study not only contributes to a scarce literature, but also focuses on a group that is unidentified (Zayed et al., 2020) and addresses topics that are stigmatized, taboo, and forbidden to discuss within the Arabic culture. Additionally, this study can pave the way for conducting other public health research studies exploring new constructs such as western integration and adaptations from different levels of culture pertaining to IPV and contraceptive practice. With this study being of qualitative nature, other implications can lead to research studies that may quantify these constructs and aid in developing study results that can be generalized towards the Arab American population pertaining to the constructs of IPV and contraceptive practice.

Furthermore, the impact this study can potentially hold for public health practice can raise awareness and change the perceptions of medical, public health, and research

professionals in better understanding Arab Americans and providing tailored interventions that meet their reproductive health needs. Being culturally competent and responsive is crucial for delivering equitable practices that meet the specific needs of this population, in this case, reproductive health (Carvajal et al., 2017). In addition to this research study, conducting future research studies pertaining to Arab Americans will aid in recognizing them as a separate minority group and gather data to implement tailored programs in the future that meets the unique needs of this population, creating a community wide impact and positive social change (Zayed et al., 2020).

Creating community wide impact and social change requires recognizing culture and surrounding society as a social determinant of health and how cultural beliefs can ultimately determine a person's health behaviors, a core element of the HBM (Hall, 2012; Silverstein, 2017). Recognizing cultural differences that are not part of mainstream society will aid in tailored practices that are culturally responsive and effective in creating social change (Arousell & Carlbom, 2016; Halabu, 2006). It is important to implement studies pertaining to Arab Americans, as studies regarding this population are not only limited (Zayed et al., 2020), but the concepts of IPV and contraceptive practice is even more limited, which can further contribute to health disparities between various ethnic and racial groups (Stubbs & Soezcke, 2021).

Conclusion

This study focused on the perceptions of Arab American victims of IPV regarding contraceptive practice and how those perceptions influenced their contraceptive practice. Additionally, this study shed light on the lack of reproductive rights for Arab women,

common cultural norms, and recognizing IPV as a serious issue that needs to be addressed, creating a voice for those that were silenced and unheard. Conclusively, the severity of a relationship, lack of family and financial support, and lack of education were all key findings confirming the influence on how Arab American women of IPV practice poor contraception and make reproductive health decisions.

Despite the violent situation these women were placed in, contributing factors found that altered the perceptions of Arab American women practicing contraceptives included being educated, being born, and raised in America, being financially independent, and having a good support system. Additionally, the new concepts of western integration, adaptation of different levels of culture, and lack of knowledge towards contraceptives and the true role of women in Islam probed for more research exploration. Arab American women that have these altering factors are more likely to respond by leaving the abusive relationship sooner and are more likely to family plan and avoid multiple pregnancies. Masculine attitudes that contribute to the Arabic culture hinder the use of contraceptives, encourage multiple pregnancies, and shame women for thinking of leaving the relationship, with religious manipulation being used to justify the abusive actions and cultural beliefs that surround these women. This contributes to a lack of knowledge for Arab women towards Islamic religion, another new concept that needs to be explored.

Being bound by masculine cultural standards favors the man to be the decision-maker and head of the household while the woman raises the children and plays the caretaker role, increasing violence and abuse, an unrecognized and unaddressed topic

within the Arabic community. With the belief that having many children, specifically boys, will improve relationships and encourage a household to come together, in addition to unrecognized abuse, this promotes little to no choice in reproductive health decisions for women. This leaves cultural standards and norms as the biggest indicator to not only establishing beliefs and perceptions, but significantly influencing health behaviors and how people make their health decisions. Arab women victims of IPV are often muted, silenced, shamed, and are raised to obey their partners under all circumstances. For all the women who were silenced, your voice is finally heard.

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Appendix: Interview Guide

Introductory Statement and Interview Questions

"Hello. I am Linda Humaidan, the Walden University Research student that will be conducting your interview. As mentioned previously in the consent, the interview may last up to 30 minutes and you will be recorded for analyses purposes. All identifiers of your information will be removed, meaning your personal information will stay confidential. If you have any questions during the interview or feel uncomfortable, please let me know. You do not have to answer any questions that make you feel uncomfortable. I appreciate you talking to me about these very sensitive issues."

Demographic information

Age:

Relationship status:

Highest level of education:

Number of children:

Town or suburb:

Interview

"I would like to start out by asking you about using contraceptives.

1. What kinds of contraception do you use, if any?
    - Why did you choose these contraceptives?
    - Why do you not use contraceptives?
2. What factors drive you to use or not use contraception?
    - What are your experiences in using or not using contraception?
    - What motivates you to use or not use contraception?
    - What are your Barriers/Challenges?

3. What are your thoughts and beliefs on contraceptive practice in general?
    - What do most people in your community think about contraceptives?
    - What is accepted or not accepted in the community regarding contraceptives? Norms?
    - What are your likes and dislikes about contraceptives?
4. Tell me more about how you make decisions when choosing your contraceptives. (Is there full autonomy or control over these decisions?)

5. How does the Arabic culture and society around you affect your decisions regarding contraception?
    - Is culture a barrier or a drive?
    - Do your beliefs, or other people in your community, inhibit or encourage contraception?
6. What does intimate partner violence mean to you?

7. How is intimate partner violence defined within your community?
    - What are your cultural beliefs?
    - What are your religious beliefs?
    - What other community or societal norms affect how intimate partner violence is viewed?
8. What are your experiences with intimate partner violence?
    - What circumstances were you put in?
    - What were the most difficult parts?
    - How was your relationship with your partner?
    - What does your support system look like?
9. What do you think is the connection between intimate partner violence and contraceptive practice?

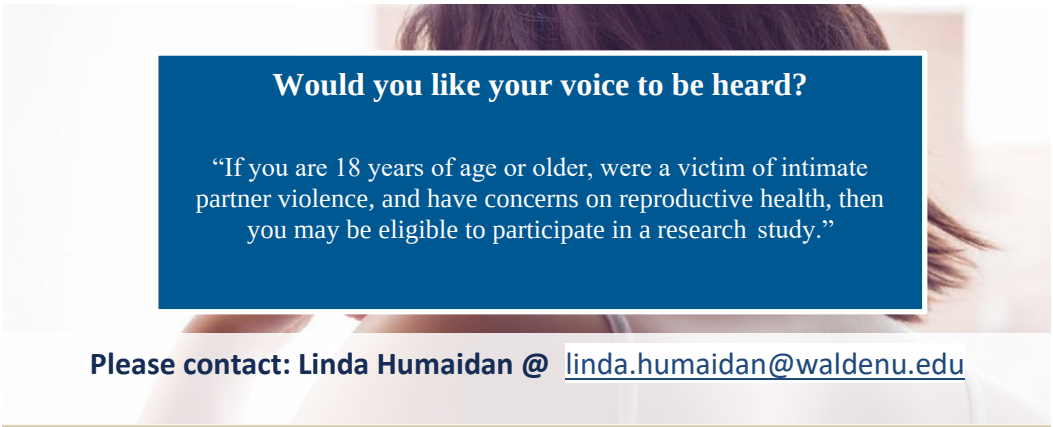
10. How does intimate partner violence affect your decisions regarding contraception?
    - Do you think it increases or decreases pregnancies?
    - Did you have a lack in decision making?

11. How does your culture play a role in intimate partner violence and contraception?
    - Which one affects the other more regarding contraceptive practice?

12. What do you think needs to be done or changed for Arab women to manage their decisions regarding contraceptive practice?
    - Do cultural beliefs need to be changed?
    - Does intimate partner violence need to be challenged within the community?
    - Is there a lack of access to contraceptives?
    - What resources are currently available?

13. Please feel free to share anything else with me regarding this topic at the moment…

- **Closing Statement**
  “Thank you so much for your time in answering my questions. Please feel free to utilize the resources provided to you along with the gift card. Please feel free to reach out to me if you have any questions regarding the interview or study.”



Would you like your voice to be heard?

"If you are 18 years of age or older, were a victim of intimate partner violence, and have concerns on reproductive health, then you may be eligible to participate in a research study."

Please contact: Linda Humaidan @ linda.humaidan@waldenu.edu

Create Your Own Voice and Help Other Women to Create Theirs!

You are invited to take part in an interview for a research study that I am completing as part of my doctoral program. The purpose of the interview is to learn more about the perception on contraceptive practice among Arab American women who have experienced intimate partner violence. All information will remain anonymous and confidential.

Participants will receive:

- A gift card
- Resources

Location

- In-person or zoom interview for 30 minutes in a private setting.
-

Are you eligible?

- 18 years of age or older
- U.S. Citizen
- English-speaking
- WAS a victim of intimate partner violence
- WANTS their voice to be heard anonymously!

If you're unsure if you meet the requirements, call or email me:

- Linda Humaidan (MPH, PhD candidate)
- Doctoral research study coordinator