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Masculinity and Health Practices Among Male Kurdish Immigrants to the United States

ABSTRACT

The purpose of this research study is to learn how Kurdish men immigrants in the United States navigate an environment that is both considerably more health conscious than the one they came from and guided by a different set of masculine values and expectations. It investigates Kurdish immigrant men’s health behaviors along with their masculine values as a minority group in the United States. It addresses how immigrant men make sense of and adjust to, on the one hand, a widespread emphasis on health that compels them to exercise and watch what they eat and, on the other hand, a culture defined by cars and fast food. The study is qualitative and based on interviews with 17 Kurdish men immigrants. The findings show that Kurdish men immigrants express their new-found ambition for health and general wellbeing through exercise and prevention. But they do so in ways that seek to smooth over the evident gap in the role of health practices in the expression of masculinity in Kurdistan compared with the United States.
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INTRODUCTION

In the US, men are less healthy than women; they suffer from chronic conditions more than women and their life expectancy is six years shorter than women. Overall, men have a significantly less healthy lifestyle than women (Johnson 2005, Courtenay 2000a). Most of the studies in the United States conclude that the health disparities between men and women have something to do with masculinity. More specifically, scholars emphasize the importance of masculine values for understanding men’s health practices and behaviors. Moreover, there is also evidence that institutional structures, such as corporations, the military, academia, and the judicial system help reinforce men’s health risks (Courtenay 2000b).

This study focuses on immigrant men and asks how they respond to and manage a new environment that comes with different health expectations and different norms of masculinity. Generally speaking, immigrants are significantly healthier when they arrive than are their native-born counterparts; this is so because their diets are healthier and their life styles are less sedentary (McDonald & Kennedy 2005). When new immigrants settle in a new place, they often choose communities where other immigrants—who come from similar national and/or cultural backgrounds—live (Andersen 2010). Doing so gives them access to resources and helps them to maintain their traditional cultural practices (Alba 2005). However, as time goes by, most immigrants become somewhat assimilated into the dominant culture (Albright et al. 2011). There are several reasons for this, but one of the most important one is their children, who are likely to become fluent in both language and cultural practices.

More specifically, this study investigates Kurdish immigrant men’s health behaviors along with their masculine values as a minority group in the United States.
The study is important because it addresses how immigrant men make sense of and adjust to a very different health environment than the one they knew before coming to the United States. Kurdish immigrants come from a society where health as an individual attribute is not valued in the same way as it is in the United States. And yet, they bring with them a lifestyle, especially in terms of food, that in many ways is considerably healthier than the one they encounter in the new country. The findings of other studies show that most of the men have absorbed the message that health is an important thing to worry about. For example, they know that smoking and drinking are “bad” habits, that exercise is “good,” and that going to the doctor for regular checkups is an important thing to do. Overall, though, the men do not refer to their own health as an end in itself; rather they place it in a context of family responsibilities. Food plays a particularly important role in the men’s efforts to live healthy lives, but it does so as much for cultural reasons as for nutritional ones. That is, food itself emerges as a cultural practice that simultaneously signals alignment with the American health imperative (the men aspire to good and healthy food) and resistance to the many elements of American culture that the men struggle with and/or disapprove of.

BACKGROUND

MASCULINITY AND HEALTH

As a part of the new scholarly emphasis on masculinity, there is a growing literature addressing men’s health behaviors. Yet, in comparison to the scholarship focusing on the health of women, children, and minorities, we know considerably less about men’s health and health behaviors. This is particularly interesting in light of scholarship demonstrating not only that men take greater health risks than women (Lyons 2009) but also that the dictates of masculinity discourage men from
prioritizing health (Garfield et al. 2008; Good et al. 2006; Mahalik et al. 2007; Sloan et al. 2010). Studies have shown that, generally, masculine values and men’s health are negatively correlated, but there is extensive variation linked to social networks, social change, and the structure of social life (Creighton & Oliffe 2010).

Contemporary theories of masculinity have identified several different types of masculinities, primary among them hegemonic masculinity, which theorists conceptualize as a dominant force in social life, especially in relation to femininity (Williams 2003). If men in the US want to demonstrate common ideals of manhood, they need to adhere to culturally defined masculine values and habits and reject that which is feminine (Courtenay, 2000c).

Although the literature on masculinity does address differences in terms of race and class, as of yet we know very little about masculinities outside of the United States and the rest of the western world (Baker 2001). Van and Meijering point out that international migrants’ masculinities highlight their gender identities, especially when they want to be regarded as real men and/or practice their values in a specific community and culture (2005). We know even less about cultural differences in men’s approach to health even though there are good reasons for assuming important variations. For example, the extent to which a society is individualistic or collectivist in orientation influences social behavior in a number of ways (Taloyan et al. 2008). This study provides important information regarding the health behaviors of Kurdish men who are currently living in the United States.

IMMIGRANT MEN AND HEALTH

Migration is an often quite dramatic process of social and cultural change as people move from one place to one another because of economic, educational, political, or safety reasons. When people migrate, they do not abandon their beliefs or
values; rather, their beliefs and values continue to guide their behavior and help them in the new country even as they increasingly adjust to the new environment. Cultural identity can be used as a way to measure a group’s assimilation level by looking at the group members’ interactions with others in society (Bhugra 2004). Migration involves the loss of attitudes, values, support network and cultural identity. By looking at those losses, we gain insights into the immigrants’ healthy and natural reactions, and vise versa (Bhugra 2005). In this study, I examine Kurdish men immigrants’ cultural identity as it relates to health and discuss how they deal with the new expectations on health that they encounter in the United States.

Immigration typically changes immigrants’ health for the worse, especially for those who migrate more or less involuntarily or have insecure legal status in the host country; studies consistently find that they rate their health poorer and live with more distress and health problems compared to the natives of the host country (Affronti et al. 2013, Gilgen et al. 2005). Studies also show that men’s health behaviors are affected by nationality and cultural background (Mahalik et al. 2006). The living and working conditions of men in general, and of minority men in the United States specifically, have harmful impacts on their health (David 2003). David also points out that, when it comes to health, minority men are doing worse than women. This is so especially for poor men, who live at the economic margins, are subject to unhealthy working conditions, and are coping with lots of stress (David 2003).

A study of Arab immigrants to the United States shows that availability of resources, access to health care and social support, plus their level of integration all matter for their health behavior (Aqtash & Servellen 2013). Young et al. compared refugee groups to each other and found that Iraqis are the most likely to seek medical and health services because they had more untreated health issues than any other
group due to the lack of an effective health care system (1987). Several scholars have examined immigrant men’s health practices. For example, the eating practices of Latino immigrants in the United States change from their original healthy diet to negative dietary practices fostered by fast food accessibility (Chang & Wallace 2014).

Yet we know little about the health practices of Kurdish male immigrants in the United States. Kurds are an ethnic group in the Middle East that has recently increased its pace of migration to other parts of the world, including the United States (Lyon & Emek 2001). The small literature on male Kurdish immigrants points to the many difficulties they face in their new countries. Even though the Kurds are a disadvantaged ethnic group, they have a strong collective identity that they foster through various collective activities and actions that help them stay in touch with each other and their shared culture (Ufkes et al. 2014).

Only a few studies have addressed Kurdish immigrants in terms of their health. For example, a study done in Sweden on Kurdish immigrant men showed that their lives in Sweden are stressful because they have difficulties managing the contradictory cultural demands they experience as strangers in a new land (Taloyan et al. 2011). Specifically, Taloyan’s study shows that Kurdish men immigrants suffer from elevated stress due to the negative experience of political persecution in their homelands, which sometimes included violence and family breakdown. (2008). Another study of older Kurdish immigrants in the United States confirms the negative health consequences of migration and also points to the many health problems that the immigrants brought with them. Specifically, the Kurdish men in the study rated their health as poor and had high rates of both depression and high cholesterol due to a number of factors, including exposure to chemicals during the war and a general
neglect of their health. The study also found that new immigrants do not seek medical services due to the language barrier and social isolation (Cummings et al. 2011).

In this study, I expand on the literature on the potential negative health consequences of immigration by focusing on Kurdish men who have lived in the United States for either a shorter or longer period of time. These men come from a collectivist culture that not only de-emphasizes men’s health (Taloyan et al. 2011), but also has few resources (e.g., lack of doctors and modern medical institutions to promote health) to promote health (Husni et al. 2006). When they come to the United States, the men are confronted with a health-obsessed culture that encourages people to live right, eat right, exercise, go to the doctor, and so on. My question is: how do male Kurdish immigrants respond to all the signals that encourage people to think of and take care of their health?

METHOD

The Kurds in the United States are the target population of the study. It is important to describe them in some detail in order to avoid making obvious methodological mistakes. Kurdistan, the land of the Kurds, has no legal or international recognition (Hasanpoor 1999); rather, it encompasses Northern Kurdistan (eastern Turkey), Southern Kurdistan (northern Iraq), Eastern Kurdistan (northwestern Iran), and Western Kurdistan (northern and north-eastern Syria). The many military conflicts and wars in their region have caused them to migrate from their homeland to a number of other countries, including the United States (Cummings et al 2011, Lyon & Uçarer 2001). Today, approximately 7 to 8% of all Kurds live outside their region of origin, including an estimated 746,000 in Europe and about 40,000 in the United States.
There have been four waves of Kurdish immigration to the United States since 1976 (Nashville Public Television 2008). The first wave happened in 1976, when Kurds were fleeing a failed revolution in Iraqi Kurdistan. The second wave was in 1979, when Kurds from the Kurdistan region of Iran left after the Iranian revolution. The third wave took place between 1991 and 1992, when Iraqi Kurds fled the genocidal campaign, known as Anfal, imposed by the dictator Saddam Hussein in the late 1980s. The last wave happened between 1996 and 1997; this wave included Kurds from Iraqi Kurdistan, people who wanted to escape conflict and look for better opportunities, plus those who worked with the western military organizations that put their lives in danger from local attackers in Iraq specifically. Even though most Kurdish people follow Sunni Islam, there are also minorities of Shi’a Muslims, Jews, Christians, Alevi, Yezidis, Yarsans, Zoroastrians, Babis, and followers of different Sufi and Mystic orders.

There are no precise data on the Kurds in the United States because Kurdish immigrants in foreign countries are registered as citizens of the states from which they come, such as Iraq, Iran, Syria, and Turkey. Still, the number of the Kurds in the United States is estimated to be about 40,000 (most coming from Iraq) (Karimi 2010). Most of them have settled in Nashville, Tennessee, but many live in other states, such as New Jersey, New York, Texas, and Massachusetts. An estimated 11,000 Kurds currently live in Nashville, where they have tried to keep their cultural heritage and values. One of the central communal places in Nashville is the Salahaddin Center of Nashville, founded in 1998, in which the Kurds practice their religion and hold national celebrations. Kurds are far from the only immigrant group in Nashville; the city has welcomed and embraced countless refugees and immigrants, and now is home to ethnic groups from all over the world (Karimi 2010).
Most Kurdish immigrants in the United States entered the country as a part of the refugee programs established by the federal government between 1975 and 1992 to protect and reward Kurds who took part in the fight against Saddam’s regime (Dahlman 2001). The fact that they came via an organized refugee program had some impact on their encounters with the American health care system. Most importantly, they were required, or encouraged, to go to the doctor regularly for the first few years in the country as part of the services the US government provides for most refugees.

Knowing how Kurdish male immigrants to the United States think of their health practices requires a qualitative study that can identify common themes but also points of divergence. Okazaki and Sue (1995) argue that by researching ethnic minorities and groups from other cultures, we can gain a better understanding of the social processes about which we often theorize based on very limited samples and social contexts.

Interview-based studies, which have a small number of participants, are getting more popular in social sciences; this is the way in which analytic, exploratory, and comprehensive studies are best done. However, such a sample requires the researcher to establish fruitful relationships with his or her respondents in order to address the research question deeply. A small sample size (less than 20) makes it possible for the researcher to establish a strong connection to all participants in their naturalistic setting and thus enhance the validity of the study (Crouch and McKenzie, 2006). According to Baker et al the number of participants in my study is sufficient to draw meaningful conclusions (2012). The analysis presented in this study is based on 17 semi-structured interviews (see appendix 1).

Researchers who conduct qualitative studies with immigrants or minority ethnic groups should know that the immigrants come from various cultural
backgrounds and have achieved different levels of acculturation (Suh, Kagan, and Strumpf, 2009). These differences in background and acculturation make it important to include immigrant and other minority populations in research studies; their lives are not only different from the majority groups’ but often also more complicated and tenuous due to the difficulties they face in their everyday lives. Yet, scholars often exclude refugees and minority groups from studies conducted on “the general population;” such exclusion happens for any number of reasons, some having to do exactly with the features of their lives that make them atypical, and some having to do various technical reasons, such as language difficulties and religious concerns (Ellis et al. 2007).

The most effective method to identify members of marginal populations is snowball sampling (Cummings et al 2011, Ritchie et al 2013). Therefore, I used snowball sampling in this project to recruit the participants. The project was accepted by the Institutional Review Board (IRB) of the University of Cincinnati. The interviews were all done in Nashville, Tennessee, where a fairly large Kurdish community is located. I began the snowball with a doctor that I knew; he introduced me to other participants, who in turn gave me other participants. In total, I interviewed 17 men. I interviewed them all during 5 days in January of 2015 at different places, such as work places, homes, and community centers.

The requirements of being a participant in the study were: having lived in the United States for at least 5 years, being older than 18, and being a Kurdish man. I let the participants choose the language of the interview. About 75 percent of them (13) chose Kurdish and 25 percent (4) chose English. The interviews lasted on average around 40 minutes.
FINDINGS

Based on the data analysis, four themes related to masculinity and protective health behaviors emerged 1) Control over Health, 2) Health and Family, 3) Health and Technology, and 4) Health and Cultural Values. Taken together, these themes point to the complex ways that immigrant men try to simultaneously adjust to the ways of their adopted country and stay connected to their culture of origin. As the findings show, health practices play a central role in these negotiations. On the one hand, they provide opportunities for men to demonstrate they are modern health conscious American men, by adopting exercise routines (Control over Health), for example, or by taking advantage of advanced medicine (Health and Technology). On the other hand, health related practices also provide ways for the men to retain a sense of themselves, by taking care of the health needs of their spouses and children (Health and Family), for example, or by using food as a link to a cultural past that posed fewer challenges to their manhood (Health and Culture).

Theme 1: Control over Health

Most of the Kurdish men I talked to emphasized that they were confident about their health and had control over it by a combination of exercise and prevention. Considering that the men all come from a culture that does not prioritize health, especially not men’s health, the basic finding that they all seem to accept individual health as a value is significant in itself. That is, the men have somehow absorbed the language of health that has come to penetrate American culture, and they all report that taking care of the body is important in order to stay healthy. In this sense, we can say that the men have acquired a certain amount of health capital since coming to the United States (Hacker et al. 2011). The two primary ways to take care of the body,
according to the men, are prevention and exercise, as the discussion below demonstrates.

**Prevention**

It is clear that the Kurdish immigrant men I interviewed want to stay healthy and most of them took preventative measure to do so. While their efforts at prevention varied a great deal, ranging from going for regular checkups to watching their diet and paying attention to food and nutrition, the men nevertheless talked about the efforts in similar ways, emphasizing how they were in control over their own health. Rahem, who is 37 years old, married, and has been living in the United States for 9 years, says:

*We do checkups to make sure that you know it is always good to prevent something it is happening. Do not let it get too serious because you know if, for instance, put it this way if you have a low vitamin D or low potassium or anything like that, it is good to find out if you have high blood pressure or anything like that. Maybe you would never know if you have diabetes or anything like that. If you know it at the first stage, you can be prevented. That is the only reason we do checkups.*

We can clearly see that Rahem makes a connection between checkups and staying healthy. The checkup in his view is a precaution against serious disease and illness. Even though he is talking about illnesses as things that can consume you without your knowledge and that requires medical expertise to identify, he is nonetheless staying in control of his health by going to the doctor. In this way, he and several other of the men I interviewed, do regular checkups to make sure they are healthy. What is noteworthy here is that this is a new practice they have adopted since coming to the United States. Not only is it a new practice, linked in part to the much greater
availability of doctors in the United States, but it is also that the idea of a man going 
to the doctor when he is not sick would have been incomprehensible to the men 
before coming to the United States. By that I mean, they do not do that in their home 
country because health as an end in itself is not valued nearly as much in their home 
culture as it is in the United States. Hence, by reporting that they are going for regular 
checkups, the men are showing that they are under the influence of the American 
health mainstream.

Dara, who has been living in the country for 6 years and is married, says he 
does checkups to feel safe and confident on his health:

_I do the checkups on a regular basis so I can be away from illness or diseases.
When you do such thing you feel you are caring for your own body and your own stomach. So you would be on the lookout of any occurrences. But if you just ignore it, you may lose your body. That is why we want to be assured._

Like Rahem, Dara relies on checkups to prevent potential health problems from 
getting serious. He too relies on the ability of doctors to detect physical problems, but 
it is in ensuring that he goes to the doctor regularly that he exercises his control over 
his health. Other men, as I discuss in the next section, emphasize physical exercise as 
a way to stay in control their health and prevent health problems from emerging.

_Exercise_

_Exercise is a modern practice (Franklin et al. 2014, Noakes 2008). It is not so that people in traditional societies do not exercise at all, but instead that they do not do it as an end in itself. Not only is life in traditional societies typically less sedentary than automobile-driven life in the United States, hence reducing the need for exercise, but it is also that traditional masculinity is considerably less body oriented than American masculinity has become (Rosenmann and Kaplan 2014). That is why Kurdish men,_
when they first arrive in the United States, generally do not pay attention to exercise as a practice that has any appeal or even meaning to them. Over time, however, some men come to adopt physical exercise as a valued part of their health regimen. For instance, Salman who has lived in the US for 24 years and spent most of his life in Nashville, turns to exercise when I ask him about his health practices:

I do exercise, I work out, sometimes 5 times a week. Sometimes 6 days a week but I try to stay with 4 days and doing weight lifting for an hour and a half a day. That is when I am actually done with my job normally around the evening at 6 o’clock.

We clearly see how important exercise is for him and how completely he has accepted the idea that exercise is a way to take care of his health. Moreover, his emphasis on weightlifting signals that he connects health with being in a good shape; that is, a healthy body is one that is worked on. When he says that he works out “sometimes 5 times a week” he shows that he has almost completely adopted a form of masculinity that would be foreign in his home country of Kurdistan.

Although Salman was a clear outlier in my sample when it comes to his devotion to exercise, many other men mentioned the importance of exercise for a healthy life. Rzgar, who has lived in the US for 14 years and who recently got married, talks about exercise as an important way to stay healthy:

For sure, yes. I do walk, I try to walk regularly, not as much as I used to. I do play sports; I play basketball, tennis and soccer. Whatever the season that is what I play. And it is really important for me because it helps me to stay healthy. It helps me get a lot of energy and to function better.

It should be noted that when Rzgar says “I try to walk regularly, not as much as I used to,” he not only refers to an actual life change – in this case his marriage –
that takes time away from exercise, but also signals his understanding that exercise is a serious undertaking that requires a lot of time and commitment. Many of the men I talked to said that family and children take so much time that they had to stop or reduce their exercise hours in order to meet their family obligations. When I asked Rzgar, who just got married, about his health practices, he told me about the sports he used to play when he was single. As I show in a later section, however, family obligations did not eliminate the men’s health commitments; rather, family obligations changed how the men expressed their commitment to health.

Although it is evident that exposure to American health discourse is at the root of the men’s ideas and practices regarding health, several of the men nonetheless linked their health consciousness to traditional religion. In this sense, religion emerged as an additional motivator for the men’s positive health attitudes, thus smoothing the transition to a new life in the United States. The fact that most of them started by saying “Yes, thank god I am healthy” when I asked them about their health is perhaps not in itself noteworthy – Americans too use “thank god” as a common expression – but some of them continued to refer to God as they developed their answers thus indicating that they saw a real connection between their health practices and their Islamic religion background. When I asked Pashew, who has been living in the US for 14 years, how healthy he was, he responded:

Yes, thanks god I am healthy because I am 43 years of and have no health issues. And this is something that the god gives me and I do care about my health in general, such as I do know what I eat. All of those things are helpful to make me healthy.

Although Pashew ultimately credits god, not his own preventive health practices, with his good health, it is nonetheless clear that he considers it his own
responsibility to stay healthy and be careful about what he eats. And by linking the value of health to god rather than America, he finds a way to reconcile the potential contradiction between individual health concerns and religious commitments.

In conclusion, all the men I interviewed thought that health was an important goal to pursue. That does not mean they all did the same thing to stay healthy, far from it, but they all did what they thought they could to control their health. Although many of the men thought they could do better – exercise more, eat healthier – they all nonetheless approached health as something they had control over, even if all they did was go to the doctor regularly. Taken together, the findings show that Kurdish men immigrants express their ambition for health and general wellbeing through exercise and prevention. But they do so in ways that seek to smooth over the evident gap in the role of health practices in the expression of masculinity in Kurdistan compared with the United States. In the next three sections I will elaborate on this point further.

**Theme 2: Health and Family**

Most of the Kurdish men I interviewed clearly indicated that they were interested in healthy life practices, such as eating healthy, exercising, and going to the doctor regularly. But some of them mentioned obstacles they faced in pursuing their health goals, primary among them work commitments and family obligations. Generally speaking, these two kinds of obstacles point to the sometimes competing dictates of masculinity, especially as they get expressed in the United States, where obligations to personal health plays a much greater role than in Kurdistan, As I showed in the previous section, the men value their health, appreciate the services they get from American health facilities, such as emergency rooms and hospitals, and frequently make use of the opportunities to exercise and eat a healthy diet. In this section I show how the men’s health ambitions easily get thwarted by competing
obligations, especially those linked to work and family. The most important findings here do not concern the objective obstacles they face (e.g., the number of hours spent at work), but instead how the men weave together a narrative of manhood when they explain why their competing obligations make it difficult for them to spend as much time as they might have wanted on their health. But they also show how these competing obligations themselves have health implications.

To the participants of my study, work is an important factor that prevents them from doing exercise or taking care of their bodies. It is not only a matter of time - both work and exercise take time – but also because exercise itself requires work. That is, the men I interviewed for the most part viewed exercise as a serious commitment, not a mere leisure activity, which clearly shows that they have at least partially absorbed an American exercise mentality that always beckons us to do more. But some of them nonetheless managed to achieve some sort of balance between work and exercise.

Hawar, a father of 4 children who has lived in the US for 29 years, talked passionately about his lack of time to do exercise:

Yes, I am one of the persons that likes exercise, such as gym or running, but unfortunately I do not have the chance to do that due to my work. I work full time and it does not allow me to do those things, but I really like them. If I get another part time job with the same money that I get now, I would do exercise.

As I mentioned, most of the Kurdish men like exercise but not all of them do as much of it as they would like, in many cases for reasons having to do with work. That is, to these men, work and exercise are two entirely different things. But some of the men, including Kaka, who has been living in the US for 15 years and has 2 kids. Kaka has a job that is physically demanding and this, he says, is enough exercise for his body. As he said:
...Actually, I can say that I am lazy for exercising, because I have a lot of work to do, and my job is like exercising, I lift heavy stuff, put them down, walk, getting up and down ... I do not stop in my job, that is the nature of my job, there is movement in what I do. But still, exercise is necessary.

Kaka’s comment is illuminating in several different ways. First, he calls himself lazy even though he has a physically demanding job, thus pointing to the distinction between work-related body work and self-conscious exercise. Moreover, even though his job is, as he says, “like exercising” he nonetheless thinks that exercise for the sake of exercising is necessary and this he cannot do because of his job.

Although several of the men talked about their inability to do exercise due to work obligations in terms of failure, it is important to point out that in doing so, the men also made it clear that they met the far more important duty of taking care of their families. All the men I talked to were the main, and in many cases the only, provider of their families. And this was a role they would never voluntarily have given up. Even for the men who have lived in the United States for several decades and seen the emergence of more egalitarian families, it would have been unthinkable to cede the provider role to their wives.

*Family Obligations*

Another subtheme emerged around the men’s references to their wives, children, and other family members. Just like with work, men talked about family as an obligation that competed with health. And yet, in this case it is also an obligation that propels others towards health. That is, the men see it as their responsibility to make sure their wives and children are healthy. One of the men I interviewed, Sherzad, who has lived in the US for 15 years and has 7 kids, insisted that health is
important for the whole family and clearly saw it as part of his responsibility to them to make sure they stay healthy. He stated:

_We do actually; every family wants to have a healthy life. We all want to be healthy, if I want to be healthy, I want to see my wife and kids healthy. Yes, we do talk about that all the time and say let’s go to the gym and work out. I ask my wife to come with me and . . . do at least about 45 minutes exercise at the gym or running because she does not have to do weight lifting. And I have a son, he is about a year and half, we try to teach him to eat healthy from now on because in America the way that food [is processed] you are going to get a lot of weight_”.

It is not altogether surprising that a man who comes from a society where most food is organic and significantly less processed than much of the food in American, pays attention to what he and his family eat. But it is nonetheless significant that he places this discussion in a context that also involves workouts at the gym and a concern for weight gain. Thus, even if his food preferences have been formed in a traditional society, his overall concern with his family’s health shows that he has also acquired some American health capital.

Nawzad, similarly, emphasized that his children’s health is important to him and that he considers it part of his duty to ensure that they stay healthy. As he stated:

_In regards to our kids, they first are born at the Hospital, they come to this world in a very clean place. And daily bathing, kids normally come home and bathe every night, and some things they learn from school, we make sure to do, like brushing teeth that we think is important. I always tell them to brush their teeth every night. And wash their hands, we always teach them when they_
*do something outside, like play games, when they come back inside they will need to wash their hands before eating.*

Beyond showing the importance Nawzad places on everyday preventive health practices, his comment is also significant in that it points to the larger context in which he determines what is best for his family. In this case, the reference to what the children learn in school signals that Nawzad is not simply preparing his children for a healthy future, but a healthy future in America, which requires a degree of cultural assimilation (Gibson 1988). And part of that cultural assimilation is precisely about health. Thus, it is reasonable to suggest that the emphasis the men place on their children’s health emerged as part of their parental obligations once they settled in the United States. The point is not that living in United States has made them better parents, but instead that health has come to occupy an increasingly central position in parental practices. Hence, we can say that they are more alert to the children’s health practices in the United States than they would be in their original home.

And yet, even though the men talk a lot about the work they do to make sure their children are healthy, it soon becomes evident that it is their wives who do most of the work. Traditionally speaking, Kurdish men think that women are closer to the children than they themselves are. Even though they appreciate the major role their wives play in taking care of the children and implementing health practices they still consider it part of their obligation to direct and lead their families. As Nawzad says:

*Their mom is very helpful to me, and she is very attentive to these things.*

*Because moms are closer to children and she does most of the works at home.*

*These issues are talked about among our family members because we want our children to be clean so they stay healthy.*
In addition to seeing their family’s health as their responsibility, a few of the men also linked their own health to their family responsibility. That is, they emphasized the importance of staying healthy for their families. This is most clearly expressed by Pashew, who said:

*It is really important to me because I want to have a healthy life and I want to have my own energy in my life to serve my family and children, so I can take care of them well. I also do watch my diet and not eat junk food or fast food.

*And I know that I am healthy because I do checkups every 6 months*

Although Pashew considered his own health important, his motivation is more traditional than modern. He wants to have a healthy life in order to better serve and take care of the family, not to feel better for himself. In this way, he simultaneously expresses a commitment to health and a commitment to his family, and he does it in a way that reduces the potential tension between the two commitments.

In conclusion, I have shown in this section how the men try to negotiate the value they place on health with their many other life commitments. Although the men resolved the tensions somewhat differently, it is clear that many of the men would have liked to spend more time on their own health, especially when it comes to exercise and sports. But no one would have been prepared to renege on their other responsibilities, especially work and family, in order to get exercise. In fact, by emphasizing what they have to give up in order to meet their work obligations and their duties to their families, the men simultaneously emphasize their masculinity – their obligations are linked to their manhood and they meet them as men.

**Theme 3: Health and Technology**

When I introduced the subject of health to the participants of the study, many started talking about food. They described the differences between American foods
and the Kurdish foods they used to eat and many insisted that American food is not as
good as Kurdish food because it generally is not organic. I will address how the men
think about the differences between the United States and Kurdistan more fully in the
next section which deals with culture. Here I use this example to introduce the theme
of health and technology. Although the men now observe that the food they used to
eat is healthier than much regular American fare, it is not so that they deliberately ate
healthy before coming to the United States. On the contrary, it was not until they
arrived in the US that they developed some form of health consciousness. They
became increasingly concerning about their health and diet and they started thinking
about giving up smoking and drinking. Many have also become aware of the impacts
of nutrients, and the potential health risks associated with oil, sugar, and salt. Thus,
we can say that their perspective on health is increasingly linked to technology, both
in terms of using technology to improve health and understanding health through
technology. The two major subthemes related to this that emerged from the data are:
A) Nutrition and the technology of food; and B) The use of technology to describe
and understand health patterns and develop strategies to prevent diseases and
illnesses. Both themes implicate masculinity, albeit in somewhat different ways. The
first, on the technology of food, addresses how, once they came to the United States,
food has emerged as an aspect of life that men ar much more involved in than they
used to be in Kurdistan. The second subtheme, on technology and health
understanding, picks up on the theme of control that I discussed above. It is the
element of technology in the men’s understanding of health that encourages them to
take control over both their own health and that of the families.

*Nutrition and the Technology of Food*
Most of the men are aware of the kind of food that they eat in the US. This is so in part at least because they have felt less healthy since they have been here and this, they claimed, is linked to the low quality of American food in comparison with Kurdish food. They talked about how their health is now and how it used to be. They also expressed concerns about developing health issues by eating processed and inorganic American food. And yet, despite criticizing American food, the men also generally credit Americans with better health overall. This means that some of their opinions about Kurdish food culture has changed – they now criticize heavy meals, and the use of lots of salt and oil – because they have observed that eating appropriately makes people healthier in the US. For example, Karmand who is 45 years old, married, with 3 children, and has been in the US for 18 years, told me how he had cut down on his heavy meals and that he cares about the quality of the nutrition that he eats:

*Before I was the healthier one, I was a smoker for a long time, but I quit it. I used to eat a lot of sugar. But, now I have cut down on the sugar and I try to get sugar from the fruits and natural things. I try to cut down on the carbon, I do not want to eat rice with heavy oil in it. This comes from our dietary needs that is a part of what we eat in Kurdistan, but here, I realized it’s a bad idea to have heavy meals.*

Although several men, like Karmand, had adjusted their eating habits quite a bit since coming to the United States, many nonetheless made a strong effort to retain key elements of a Kurdish diet. This was so especially in relation to their children. The men talked about passing on a Kurdish diet to the next generation; most families regularly prepare home cooked foods for their children, even when they go to school. This tells us how protective they are when it comes to their nutrients and diet, but also
how the determination of what is healthy gets filtered through cultural traditions.

When I asked Abo, who has been living in the US for almost two decades and has three kids, about his family’s health plans and practices, he said:

_We even prepare food for them when they go to school because they do not eat at school’s cafeteria. We prefer our food because it is healthier and better_. . . .

_I do want my kids to be healthy and be away from junk food, even though they sometimes eat out but we do our best to keep them away and eat at home or I take them to a Kurdish style restaurant, which is better for us._

In a larger sense, Abo’s criticism of “junk food” is also a criticism of America. Thus, he is using the health consciousness he has developed since coming to the United States to criticize cultural food habits that he does not want his own children to adopt. Again, the tensions associated with their immigrant status that runs through several of the men’s comments will be further developed in the next section.

However, in other cases, especially when the men were less educated than their children, it was the children who brought health information to the family. In such cases, the men pointed to the role of educational institutions in their health knowledge development. For instance, Nihad, who has been in the US for 5 years and is married and has children, talked about his kids who are attending American schools:

_We do not talk that much about health practices, but we do once in a while, but I watch my kids a lot in order to prevent them from bad foods. And to be honest, they are well aware of these things through school and educational places that they go to. I advise them to follow the instructions._

Most of the men I interviewed shared Nihad’s and Abo’s way of managing their children’s diet. They were all strongly devoted to Kurdish food but had their
own complaints when I asked them about heavy meals, and too much oil and salt in Kurdish foods. Although few if any of the men did the cooking in their households, they spoke as if they nonetheless had a strong influence on their family’s eating practices, including what to eat and what not to eat. I have no way of knowing if this accurately captures what goes on in their families, but it is nonetheless important to observe how they consider it part of their responsibility as husbands and fathers to take command over their family’s nutrition.

*Technology and the Understanding of Health*

Technology and electronic devices have brought dramatic changes to people’s lives, including in terms of the economy, education, and health (McClellan et al 2008). In this section, I discuss technology and health from the perspective of Kurdish men immigrants whose exposure to the technologies of health were minimal before coming to the United States. As studies have shown, Kurdish immigrants face cultural and health management pressures when they migrate to a new country (Taloyan et al 2008, Taloyan et al 2006). The Kurds of the US face the same health disparities, but some of them seemed to be doing better than others. According to the men who feel healthy, it is because they have gained some health knowledge while they have lived in the U.S. For example, Hawar, who has been living in the US for 20 years and has 4 children, stated:

*We do exercise because it helps cholesterol and blood pressure. You know what, we used to live in our village and nobody had diabetes. And we used to go around and go to the mountains, so we used to be healthier. But, when you come to this environment, where you do not move around too much, and you store all of your sugar and oil on your body, eventually they kill you!*
This statement from someone who is in his 40s shows that his health knowledge has changed a lot from when he lived in a village in Kurdistan where technology and health resources are not nearly as available as in the U.S. He is aware of cholesterol and blood pressure, and this can be seen as a sign of increased health knowledge. However, when he says “when you come to this environment, where you do not move around too much, and you store all of your sugar and oil on your body, eventually they kill you!” we also see how he uses his new health knowledge to complain about how life in the U.S. impacts his health negatively because there is not much walking or body activities compared to life in Kurdistan. This is why, as I already discussed, some of the men talk about the importance of going to the gym.

It is evident that the men use technology in various ways to understand their health and whatever changes they adopt to their health practices. Speaking generally, they become informed of health technology simply by living in the US – from talking to people, watching television, receiving information from the children’s school – and they come to think of it as part of the American way of life. As already introduced, Rahim, who has been in the U.S. since 2006 and has a wife and a child, said:

_We do checkups to make sure that you know it is always good to prevent something it is happening. Do not let it get to serious because you know if, for instance, put it this way if you have a low vitamin D or low potassium or anything that, it is good to find out if you have high blood pressure or anything like that. Maybe you never if you have diabetes or anything like that. If you know it at the first stage, you can be prevented. That is the only reason we do checkups._

We clearly see how he uses terms and concepts of health technology that can be used as tools for developing health practices for himself and his family. More
importantly, his comment captures the extent to which technology has penetrated his health consciousness – poor health is something for doctors to find with the help of expertise and technology. Serwan, 35 years old, who has been living in the US for 5 years and is recently married, provides another example of this. When I asked him whether he was healthy or not and based on what, he said:

*Yes, as far as I can consider I am pretty healthy. My body mass index, my body is healthy. I had a checkup too, so I can say that I am healthy. Diabetes runs in my family, so I always watch what I eat, exercise I am trying to get a little bit better, but as far as I know I am healthy, yes.*

Like Rahim, Serwan turns to technology to answer the question; he *thinks* he is healthy because his body mass index is fine and he watches what he eats and exercises a bit, not because he *feels* healthy. This shows, albeit in a small way, how technology has come to penetrate the men’s understanding of their own health as well as that of their children and wives. As such, it also implicates their sense of themselves as men. It is because health is so infused with technology that the men approach it as something they can control (as discussed in a previous section).

**Theme 4: Health and Cultural Values**

Culturally based knowledge, beliefs and values cause people to make behavioral choices that affect their health pattern (Hunt et al. 2004). Ultimately, these health patterns create paradigms that are strongly affected by those cultural beliefs. Kurdish cultural values and norms seemed deeply rooted in the participants’ health behaviors. In the following, I present the health behaviors of the Kurdish participants of the study that were affected by their cultural-based beliefs. Those cultural-based beliefs are sub-themed into A) cultural values and medicine; and B) cultural values and food.
In this study, some of the participants said they have had some negative experiences in their encounters with the medical system in the United States. Such experiences, according to the men, are rooted in the cultural difference between the United States and Kurdistan, and include discomfort around how they are treated as patients, embarrassment over not having a health record, a lack of trust between doctors and patients, and not valuing each other’s lives completely.

Many others, however, had a favorable impression about the American system when it comes to health culture, values, and medical encounters. For example, Shakar, who has been living in the US for 18 years, is married, and has 3 children, expressed his positive experiences with the American health culture and system. When I asked him how the two health systems differ, he said:

*When I go to the doctor here, I feel safe because they have morals to keep my privacy information. Back home, we do not have records and protection for patients.*

In this brief comment, Shakar captures some of the differences the men identified between the American health system and the one they came from. The American system is guided by a rationalized “moral” that makes it more predictable in terms of built-in safe guards. Although Shakar clearly favors the American health values over the Kurdish ones, not all men share his enthusiasm.

Some of them mentioned that the access is easier in Kurdistan because you go directly to the local doctor instead of having to go through a maze of hospitals and referrals and specialists. But they also recognize that the quality of care may be impaired, in part because the Kurdish health system is less technologically advanced and less specialized. Moreover, some, like Dara, who has been living in the US for 6
years and is 35 years old, suspected that the doctors back home are less diligent when it comes to identifying what might be wrong with you; he said:

*When you get sick, you go to the doctor and you do not have your doctor, you just go to a doctor. And anybody there can look at you; they can pretty much prescribe anything. And that is the down point of that because back home they are not that serious about illness and all the staff. They cannot identify the problems and you do not know what is going to happen with your body or illness.*

What Dara is describing here is a system that is less efficient, more geared towards basic medical care and considerably less driven by medical specialization. It is also quite clear from his continued discussion that, in retrospect, he thinks that the lack of having a good health system somehow devalues the people; he said:

*One of the cultural differences between here and Kurdistan is that the Americans value human’s lives more than us because when you go to the emergency room here in the US you do not get rejected and you get treated well by a specialist. But, I have seen people got rejected in Kurdistan because they did not have enough money or had bad doctors who were not the experts of the illness that the patient had. This is a kind of culture that Americans have which is more humanistic.*

The key point he mentions here is that doctors in the United States are generally more aware of their professional responsibilities. What he refers to as a “humanistic” medical culture is really a culture that values professionalism, rationality and equal treatment, and abhors (too much) individual discretion that leads to divergent treatments and outcomes.

*Cultural Values and Food*
As already discussed briefly in a previous section, when it comes to food, Kurdish men are in favor of their traditional food. However, with increased health knowledge, they have come to realize how harmful traditional foods can be because portions are too big, and they contain too much salt and fat. That is why most of them talked about cutting back on heavy Kurdish meals since they came to the United States. Nawzad, who has been to the US for 15 years, has 4 children, and is 48 years old, talked about the importance of eating healthy foods:

*Still, in our family, advice and suggestions are given regarding the kinds of foods we should eat and health issues. My wife and I always advise our kids, even the grown ones, to eat healthy. Even sometimes they do not like our involvements, but we have to keep our eyes on them to stay healthy.*

Kamaran, 29 years old and recently married, who has lived in the United States for 18 years, shared his experiences with food since coming to the U.S.

*We used to eat everything or whatever was available in Kurdistan, but since we have been here, we watch our diet and foods because we do not want to get health issues. Moreover, the costs are higher here, so we want to keep ourselves safe. I see fat people here more than in Kurdistan, this is due to the oily and junk food that they eat. This is why we care about good quality food, I also tell my wife that.*

These comments make it clear that living in the US has affected how they think about food, exercise, and health more generally. With their new health knowledge, however, they also recognize the pitfalls of the American food culture, which they describe in terms of junk food. For instance, Hawar who has been living in the U.S. for 20 years, is married and has 4 kids, said:
So my wife cooks, we have to have a big salad because I tell her all the time to have a salad. Sometimes we get around with some junk food, but for the most part we do take care of our food (Kurdish food).

Hawar’s insistence that the family meal of traditional Kurdish foods also includes “a big salad” is a clear example of how the men creatively meld two different food and health cultures. While it is currently popular to have salad for health purposes in the more modern places of Kurdistan, when Hawar left 20 years ago, it was not common in Kurdish culture to either eat salad or to think about food in terms of its health value. When he says “Sometimes we get around with some junk food,” he acknowledges that it is practically impossible to live in the United States without becoming Americanized to some extent.

Nihad, who has lived in the U.S. for 5 years and has 4 children, also talked about trying to find a balance between readily available fast food and traditional Kurdish food:

Yes, I have been keeping my Kurdish diet, but sometimes we eat out such as Pizza, hamburger or fries, but it is not on a daily basis or routinely.

Soran (married with 5 children; 18 years in the U.S.), similarly, talked about the importance of keeping a diet of Kurdish foods:

Yes, we do always talk about what we eat, and I advise my kids to stay away from bad food, especially the American fast foods because most of them are bad for health, but our food is better and healthier. That is why we want to stay with our food.

Taken together, the evidence suggests that food is an important element when it comes to the efforts of Kurdish men who settle in the United States with their families to reconcile the tensions between the culture they left and the culture they
now live in. In other words, it is in large part through food and all the rituals surrounding food that the men manage their identities and try to retain a sense of themselves as Kurdish men. It is through food, then, that the men demonstrate to both themselves and others that they still are good Kurdish men. However, their newfound health knowledge also requires that they make adjustments to their food practices and it is here that the men combine in various what they see as distinct Kurdish and American cultures and create a new kind of Kurdish-American identity.

Most of the men whom I talked to stated that they were very proud of their nationality and the reason behind their gathering in Nashville was their national and cultural identity. The have created an ethnic enclave that facilitates their access to most of the Kurdish goods they need. Moreover, the community they have created also ensures that they stay connected to Kurdish culture and values. Abo, for example, was in favor of living a life that is close to the one that he used to have in Kurdistan when it comes to food, clothes, and participating in cultural activities within the community. He has been in the US for two decades and has 3 children; he said:

*I sometimes order food from Kurdistan to here, especially some of the kinds of food that cannot be found here, even if they exist here, they are not as good as Kurdish food, such as honey, some spicy flavors and Sumac. We, in our community share those things together sometimes, or we bring that for each other when we go back to see our families there.*

Family life is the central node that connects them to both the larger Kurdish community – especially through family activities at the community center – and to the American community – especially through their children’s participation in the school system. It is in the family, moreover, that Kurdish immigrant men continue to play a comfortable masculine role that is clearly distinguished from the role their wives play.
Here it is important to note that all the men I talked to had married within their ethnic group. Taken together, the findings show how Kurdish men try to protect their identity through doing or exercising the cultural values that, in the men’s memories, characterized life in Kurdistan. But, through the vantage point of health practices, it is also evident that the men have adjusted quite a bit to life in America and, in a sense, have come to use the health knowledge they have acquired to stake out a new sort of masculine identity.

SUMMARY AND CONCLUSION

The purpose of this study is to increase our understanding of how Kurdish men immigrants to the United States think about and manage their health. Such an understanding, I argue here, must be grounded in an analysis of the ways in which Kurdish men immigrants simultaneously manifest their traditional masculine values in their health practices and adapt to the very different context of both health and masculinity that characterize the United States. From this perspective, the stories the participant told me about their health values and health practices were also stories about themselves as Kurdish men.

More specifically, the thesis addresses how Kurdish immigrant men make sense of and adjust their health practices in a health environment that is different from the one that they had in their homeland. As I have demonstrated throughout this study, Kurdish men immigrants expressed a desire to be in good shape by doing regular exercise and to stay healthy by eating good food and avoiding bad food. And most of them talked about both their own health and the health of their families as something they had power over. And yet, it was also evident that many of them struggled to find the time to take care of their own health, especially in terms of exercise. The participants made it clear that their social and familial duties always had
priority; hence, a lack of time to exercise was for many of the men a concern. Although it is not something I have data on, other research (Johnson 2005, Courtenay 2000a) suggests that immigrant men are less healthy than women and live shorter lives. Most men told me they worked hard so it is not unreasonable to assume that they take less care of their health than perhaps they should, but a more important finding for the purposes of this study is the value they placed on health and how important they thought it was to make sure their wives and children led healthy lives.

Considering that few of the men had ever thought about health before they came to the United States, this is an important finding that tells us something about how life in the United States has impacted them, both as immigrants and as men. The four interrelated themes that emerged from the interviews all speak to the complex ways in which Kurdish immigrant men navigate an environment that emphasizes health even as they try to hold on to a traditional sense of masculinity that would have disregarded health talk and health work as irrelevant to their lives.

The first theme, Control over Health, shows how the men have adopted general American health values and approach health as a task that it is possible to be in control of. The men emphasize prevention above all; by exercising, eating right, and doing medical checkups, the men think they can keep ill health at bay. In short, health is something they care about and think is important. But, as the second theme, Health and Family, makes clear, the men prefer to talk about health as a family obligation rather than an individual project. That is, their newfound health consciousness does not translate into a personal health agenda as much as it becomes part of their family responsibility. From this perspective they need to stay healthy in order to take good care of their families, but they also have come to think of health as something they need to ensure for their wives and children as well. The third theme,
Health and Technology, picks up on the importance the men place on health knowledge and the science of health. Here the men talk about how they use such knowledge to guide what the family eats and what they try to stay away from. Of particular importance here is how the men use their knowledge about what is healthy and unhealthy to navigate a food territory that involves a mix of traditional Kurdish food, American junk food, and food their children are exposed to in school or when they are with their friends. It is evident from the men’s discussions that food decisions are about a lot more than food. The final theme, Health and Culture, develops this insight further, and shows how health practices – especially food – are central to the process whereby the men continuously seek to reconcile their traditional Kurdish masculine identity with the new American demands on health.

Ethnic groups experience the immigration process somewhat differently, but all experience some pressure to assimilate. Taken together, the findings of this study show that Kurds too have been impacted by mainstream United States, which in turn provides insights into the patterns of change and resistance when it comes to their cultural identity. The study shows that Kurdish men immigrants are proud of their national and cultural identity along with their American experiences. It is also evident that having access to a Kurdish enclave is very important to the men. There is much research (e.g., Andersen 2010) that shows that new immigrants tend to settle in places where people from similar national or cultural backgrounds already live. Such immigrant enclaves have long facilitated the entry into a new country – the enclave helps with general support, jobs, and a whole host of other challenges that immigrants often face. What my study adds to this literature is to show how Kurds in the United States, a group notoriously understudied, have adjusted to their new lives in large part with the help of the resources available through the Kurdish community – such as
food, gatherings, religious worship, and communal relationships. But the study also points to the importance of health practices to the process of assimilation. The men were clearly influenced by the American emphasis on health that penetrates schools, workplaces, and media, but they used their newfound health knowledge in creative ways. Rather than completely surrendering to American health dictates – which, several of the men pointed out, are also characterized by poor health practices – the men used his new knowledge to also stay connected to Kurdish traditions, especially through food.

The findings show that the Kurdish men who participated in the study for the most part hold on to traditional masculine values that make clear distinctions between the roles husbands and wives are expected to play in the family. More specifically, the men put themselves in a position of complete authority over the family even though the women have specific familial responsibilities, including especially cooking. Van and Meijering point out that international male migrants highlight their gender identities when they arrive in a new country (2005); because life is often difficult and immigrants typically experience a status slide, traditional masculinity becomes a way for men to hold on to their values, their community, their culture and, most of all, their sense of themselves as respectable men. That is, Kurdish immigrant men in the United States try to protect their masculine identity through exercising the cultural values and norms that recognize men as the head of the household. In order to do so, however, they also need to change in some ways. Health practices emerge as a particularly stark example of how the men have adjusted their masculine selves. From having not thought about health at all before coming to the United States – back home, they might have gone to the doctor if they were ill, but that was the extent to
their engagement with health practices – they now have incorporated health into their responsibilities as husbands and fathers.

This study, as all studies, has limitations. Although qualitative studies do not aim for generalizability, and hence worry less about sample size, it is nonetheless the case that more participants would have made it possible for me to explore more systematic differences among the men. Both length of stay in the United States and age of immigration would have been interesting to explore further. However, the study provides an examination of Kurdish men’s health behaviors and masculinity in the United States that has not previously been done. Therefore, future studies should pay attention to their assimilation level more deeply because it matters for how they act in their new country. Lastly, it would also be interesting to include women in a study about how they have adjusted to life in a new country, how they negotiate the health dictates that their husbands and children bring to the household, and how they deploy their femininity in the process.
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Interview Guide:

First set of questions about their own health practices

1. Are you healthy? Based on what? Does it matter to you?

2. Do you exercise, such as running, gym or playing any kinds of sports? Why?

3. When you get sick what do you do usually?

4. Have you had checkups when you came here? Do you do checkups? Why or why not?

5. What do you do to stay healthy?

Second set of questions about the involvement in other family members’ health practices

1. Do you and your wife (or family members) talk about health practices?

2. Are you involved in your children’s health practices?

3. Are you involved in your wife’s health practices?

4. What do you when your kids get sick?

5. How the US’s healthcare differs to Kurdistan’s healthcare to you?

Demographic questions:

How old are you? ___________

How long have you been in the United States? __________

Are you married? _______________ For how long? __________________

Do you have children? _______________ How many? /Ages/Gender

_________________________