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Masculinity and Immigrant Health Practices: How Male Kurdish Immigrants to the United States Think about and Practice Health

DOI: <http://dx.doi.org/10.18778/1733-8077.14.1.02>

Abstract Researchers have identified a host of factors that influence immigrant men's understanding of and commitment to health, but overall the scholarship is still unsettled, in large part because the experiences of immigrant groups are so varied. In this paper, based on interviews with Kurdish immigrants in the United States, we demonstrate that the field of health provides both opportunities and pitfalls for men whose social, familial, and masculine aspirations simultaneously pull them into American life and push them towards a segregated existence. We conclude that men use a discourse of health to simultaneously assert themselves as men and maintain their connections to their original culture, just as they use a discourse of masculine responsibility to account for the health-related choices they make.

Keywords Masculinity; Immigration; Health; Family; Exercise; Food

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Men from developing nations who immigrate to the United States find themselves in a contradictory space when it comes to health. When they first arrive, immigrants are generally healthier than the native-born population (Goldman et al. 2014; Hamilton 2014). This is so even though they have fewer resources, which otherwise is associated with worse health (Leopold 2016), and even though health is vigorously emphasized and advocated in the United States. Over time, immigrant men typically see their health deteriorate, and researchers have identified a host of factors that influence this development, but overall the scholarship is still unsettled (Steffen et al. 2006; El-Sayed and Galea 2009; Arévalo, Tucker, and Falcón 2015). This is so in large part because the experiences of immigrant groups are so varied as to make generalist explanations unsuitable to account for the many different life course trajectories observed both across and within immigrant groups (Barry 2005; Aqtash and Van Servellen 2013). We simply do not know enough at this point about either how immigrant men think about and engage in health or how their masculinity is implicated in their health-related behavior.

In this paper, we engage the literatures on immigrant health and masculinity and health to address the question of how immigrant men approach—think about and practice—health as both immigrants and men. More specifically, the study examines the health practices of Kurdish men who have settled in the United States and aims to understand how they make sense of and adjust to a very different health environment than the one they knew before coming to the United States. The findings demonstrate that the field of health provides both opportunities and pitfalls for immigrant men whose social, familial,

and masculine aspirations simultaneously pull them into American life and push them towards a segregated existence in an immigrant enclave. That is, they use a discourse of health to simultaneously assert themselves as men and maintain their connections to their original culture, just as they use a discourse of masculine responsibility to account for the health-related choices they make. Overall, though, the men typically 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. In this sense, food emerges as a cultural practice that simultaneously signals alignment with American health imperatives and resistance to the many elements of American culture that the men struggle with and/or disapprove of.

Masculinity and Health

In much of the developed world, men are less healthy than women. They engage in more risky behavior, die sooner, and, in general, have significantly less healthy lifestyles than women (Courtenay 2000a; Johnson 2005). They also are less likely to go to the doctor (O'Brien, Hunt, and Hart 2005; Springer and Mouzon 2011), and less likely to prioritize and seek information about health (Mahalik, Burns, and Syzdek 2007; Garfield, Isacco, and Rogers 2008; Manierre 2015). Most scholars who address the issue conclude that the health differences between men and women are related to masculinity, even though the specifics of that association are subject to much debate and ongoing research (Courtenay 2000b; Noone and Stephens 2008).

It was especially Connell's (1987; 1995) work on hegemonic masculinity that provided the inspiration for what has become a burgeoning field of health research. In essence, scholars have shown how men "use health beliefs and behaviours to demonstrate dominant—and hegemonic—masculine ideals that clearly establish them as men" (Courtenay 2000b:1388; also see: Cameron and Bernardes 1998; Creighton and Oliffe 2010). In other words, if it is the norms of masculinity that inspire men to define risky behavior as masculine (Dolan 2011:587), then men's poorer health is the price of masculinity (Fleming, Lee, and Dworkin 2014:1029). It is for this reason that men in much of the health literature are simultaneously viewed as "risk-takers" and "at risk" (Robertson 2006:179).

As productive as this line of research has been, it is readily evident that there are significant health variations across different groups of men. Important variations here are linked to social class (Dolan 2011), race and ethnicity (Griffith, Gunter, and Watkins 2012; Towns 2013), age (Noone and Stephens 2008; Springer and Mouzon 2011), profession (O'Brien, Hunt, and Hart 2005), rurality (Stough-Hunter and Donnermeyer 2010), and, as will be discussed further below, immigration status. Scholarship addressing such variations has demonstrated that not only are men differently (un)healthy, and not only do men enact masculinity in many different ways, but men also think about and define health differently (Williams 2003; Oliffe 2009; Evans et al. 2011; Robinson and Robertson 2014). Moreover, as of yet we know very little about masculinities outside of the western world (Van Hoven and Meijering 2005) and have only begun to understand how cultural factors

impact men's health (Gilgen et al. 2005; Aqtash and Van Servellen 2013; Shishehgar et al. 2015). In what follows, we first discuss the scholarship on immigration and health, with a focus on immigrant men, and then key in on the sparse research that addresses the experiences of Kurdish immigrants.

Immigrant Men and Health

The paradoxical aspects of men's health get even more complex when we consider the experiences of immigrant men. Scholarship has consistently shown that recent immigrants to the United States are healthier than their native-born counterparts, but also that this "healthy immigrant effect" largely evaporates as immigrants assimilate into American society (McDonald and Kennedy 2005; Lu and Wong 2013; Goldman et al. 2014; Hamilton 2014; 2015; Hamilton, Palermo, and Green 2015; Li and Hummer 2015; Martin, Van Hook, and Quiros 2015). The reasons for the initial immigrant health advantage and subsequent health decline are varied and multifaceted and involve practices, expectations, opportunities, and experiences associated with both the nations of origin and the new country, including food, exercise, availability of doctors, health insurance, language abilities, stress, discrimination, poverty, drugs and alcohol, exercise, and car dependency (Young et al. 1987; Schachter, Kimbro, and Gorman 2012; Aqtash and Van Servellen 2013).

The deterioration of immigrant health over time is additionally puzzling given the all-pervasive discourse on health that immigrants encounter when they arrive in the United States. Health-related initiatives are permeating social life at every con-

ceivable space, place, and occasion—bike paths and walking trails to facilitate exercise; healthy foods in schools, workplaces, and restaurants; campaigns against smoking, obesity, saturated fat, and sugary drinks; promotion of preventive medical care; and any number of other initiatives directed at populations considered at risk, such as the elderly, children, the poor, and racial and ethnic minorities (Phillips 2005; Fusco 2006; Pike 2011). Such developments suggest that health has become “moralized” to the degree that it is now a “duty to achieve and maintain good health” (Robertson 2006:179).

To the vast majority of immigrants arriving from more traditional and less developed societies, the ways in which the western world emphasizes health are unfamiliar. As of yet, however, we know little about how this new environment of health impacts how immigrants think about and practice health. Moreover, while the literature on the health status of immigrants is fairly sizeable, it has only recently begun to pay attention to gender. When it comes to immigrant men, then, we have much to learn about how their gender identities facilitate and/or impede their health practices (Van Hoven and Meijering 2005; Mahalik, Lagan, and Morrison 2006). In other words, we do not know enough about how immigrant men’s definitions of themselves as men impact how they respond to the particular health climate they encounter in the United States.

Kurdish Immigrants and Health

When immigrants come to a new place, they often choose to settle in communities where others from similar national and/or cultural backgrounds al-

ready live (Andersen 2010). Doing so gives them access to resources and helps them maintain some of their traditional cultural practices while adjusting to life in a new country (Bhugra 2004; Alba 2005). Over time, however, most immigrants become at least partially assimilated and/or acculturated into the dominant culture (Barry 2005; Amin 2014). This settlement pattern also describes Kurdish immigrants to the United States.

Of the few studies that address Kurdish migrants, only a handful address health-related issues. A series of studies done on Kurdish men in Sweden show that their lives are stressful because they have difficulties managing the contradictory cultural demands they experience. They also suffer from elevated stress due to the political persecution they have long been subject to in their homelands (Taloyan 2008; Taloyan et al. 2006; 2008; 2011). A study of older Kurdish immigrants in the United States confirms the negative health consequences of migration and also points to the many health problems associated with war that the immigrants brought with them (Cummings et al. 2011). Moreover, they were reluctant to seek medical services due to language barriers and social isolation (Cummings et al. 2011).

In this study, we expand on the literature on immigrant men’s health with a qualitative study of Kurdish¹ men in the United States. These men

¹ Kurdistan encompasses Northern Kurdistan (eastern Turkey), Southern Kurdistan (northern Iraq), Eastern Kurdistan (northwestern Iran), and Western Kurdistan (northern and north-eastern Syria). Given persistent violence and volatile political situations, Kurds from the Middle East have long migrated to other parts of the world, including the United States (Lyon and Uçarer 2001; Ufkes, Dovidio, and Tel 2015). Today, approximately 8% of all Kurds live outside their region of origin.

come from a collectivist culture that de-emphasizes men's health (Taloyan et al. 2011), and also provides limited resources (e.g., lack of doctors) to promote health (Husni, Taylor, and Koye 2006). When they come to the United States, they are confronted with a health-obsessed culture that encourages people to live right, eat right, exercise, go to the doctor, and so on, but also with a culture that encourages ill health in many other ways (e.g., fast food, cars). Moreover, considering that their gender identities are fostered in a patriarchal social milieu, the men are also confronted with a very different gender environment that brings challenges to their masculine selves.

Following Okazaki and Sue (1995), we suggest that our understanding of complex social processes like men's health can be greatly enhanced by the inclusion of understudied and invisible groups (also Shah et al. 2008; Aqtash and Van Servellen 2013). As refugees from a volatile region of the world and as members of a persecuted minority in their nations of origin, Kurdish immigrants probably have less of a health advantage when they arrive in the United States (Cummings et al. 2011), but otherwise share many experiences with other immigrant groups. Moreover, like many other immigrants from the developing world, they arrive with an understanding of gender relations that differs in significant ways from prevailing discourse in the United States (Scheibelhofer 2012; Röder 2014). Thus, in asking how Kurdish male immigrants respond to the new health signals they encounter, we are also seeking answers to larger questions of how health practices, masculinity, and immigrant identities interact to produce distinct sets of health-related responses to the challenges immigrant men face.

Method

There are no precise data on the number of Kurds in the United States because Kurdish immigrants² are registered as citizens of the states from which they come, such as Iraq, Iran, Syria, and Turkey. But, estimates suggest that the number of Kurds in the United States is about 40,000, most coming from Iraq (Karimi 2010). Many have settled in Nashville, Tennessee, where an estimated 11,000 Kurds currently live (Karimi 2010). Most Kurdish immigrants arrived between 1975 and 1996 as part of the federal government's refugee program (Dahlman 2001). The fact that many came via an organized refugee program has had some impact on their encounters with the American healthcare system, including especially required medical health screenings upon arrival.

In order to understand how Kurdish male immigrants interpret, think about, and respond to the conflicting health messages they receive in their daily lives, we designed a qualitative interview study (Dolan 2011). Because snowball sampling is the most effective method to identify members of marginalized populations (Cummings et al. 2011; Ritchie et al. 2013), we used this method to recruit

² There have been four waves of Kurdish immigration to the United States since 1976 (Nashville Public Television 2008). The first wave was in 1976, when Kurds were fleeing a failed revolution in Iraqi Kurdistan. The second wave was in 1979, when Kurds from Iran left after the Iranian revolution. The third wave took place in 1991-1992, when Iraqi Kurds fled the genocidal campaign, known as Anfal, imposed by the dictator Saddam Hussein in the late 1980s. The last wave happened in 1996 and 1997; this wave included Kurds from Iraqi Kurdistan who wanted to escape conflict and look for better opportunities, plus those who had worked with the western military organizations and hence were in danger from local attackers in Iraq specifically.

participants. The first participant, an acquaintance of the first author, was a doctor living in Nashville; he introduced us to other participants, who, in turn, connected us to yet other participants. The interviews were done in Nashville and were all conducted by the first author who himself comes from Kurdistan. To be eligible, the men had to have lived in the United States for at least 5 years, be older than 18, and come from the Kurdish region of the Middle East. In total, 17 men were interviewed, which is a sufficient number to identify patterns and achieve thematic saturation (Crouch and McKenzie 2006; Guest, Bunce, and Johnson 2006).

The interviews were conducted in January of 2015 at locations chosen by the participants, such as workplaces, homes, and community centers. We let the participants choose the language of the interview; 13 chose Kurdish and 4 English. The interviews lasted on average 40 minutes and were all recorded, transcribed, and translated by the first author. All participants were given pseudonyms. All but one of the men were married and all but 4 had children, the average number of children being almost 4 (ranging in age from infants to adults). The men ranged in age from 28 to 53, with an average age of 41. They had lived in the United States from 5 to 24 years, with 14 years being the average.

The semi-structured interview guide was designed to get at how the men think about health and what, if anything, they do to protect their health. We asked the men general questions about what health meant to them, what they did to stay healthy, how they approached health in the family, what they did when they got sick, and what they thought about

the American health system. The purpose of these questions was to identify themes that can help us understand how they think about and make decisions about health. To get at those themes, we relied on grounded theory as our analytical approach (Charmaz 2006). The three broad thematic categories we present below resulted from several rounds of coding aimed at capturing the breadth and diversity of the data, as well as identifying themes and analytical categories that both align with and extend existing knowledge.

Health and Masculinity among Kurdish Immigrants in the United States

The most basic finding of this study is that the men all accept health as an important imperative. Moreover, the evidence points to the importance of health practices for the men's sense of themselves as fathers and husbands. Considering that the men come from a culture that does not prioritize health, especially not men's health, the fact that they all value individual health is significant in itself. This suggests that the men have somehow absorbed the language of health that penetrates American culture. In the words of Sherzad, "If you are not healthy, you cannot do anything, you become disabled in society. So you have to be healthy, at least try to be healthy" [53, 7 children, 22 years in the United States]. Rahem, similarly, says that "being healthy is key to survival in America because if you are not healthy...you are not going to be able to work... [or] support your family" [37, 1 child, 9 years in the United States]. In this sense, we can say that the men have acquired a certain amount of health capital since coming to the United States (Madden 2015).

Three broad themes related to masculinity and health emerged from the data analysis: 1) Health and Control, 2) Health and Family, and 3) Health and Culture. Each of these themes points to the complex ways that immigrant men simultaneously try to 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. The health arena provides opportunities for the men to demonstrate they are modern, health-conscious American men, by going to the doctor, exercising, and eating right (Health and Control). But, health-related practices also provide ways for the men to retain a sense of themselves as family men, by taking charge of the health needs of their wives and children (Health and Family). Finally, the men used food and nutrition concerns as a link to a cultural past that posed fewer challenges to both their health and their manhood (Health and Culture).

Health and Control

Most participants emphasized that they feel confident about their health and have control over it through a combination of exercise and prevention. The significance of control for men's health practices has been noted in other studies as well (Arévalo, Tucker and Falcón 2015). The two primary strategies the men use to take care of their health are prevention and exercise, as the discussion below demonstrates. They also prioritize healthy eating, but because food is also so central to their cultural identities, we discuss it under the Health and Culture theme. These strategies give the men a sense of control over their own health. At the same time, they reinforce the idea that health is both an indi-

vidual responsibility and an imperative. And yet, the data do not allow us to conclude that the men's health practices are best understood as a quest for individual well-being and a fit appearance (Frew and McGillivray 2005; Coffey 2016). Rather, as we describe more fully in the section that addresses man's family obligations, the men place their own health practices in a larger context of familial and cultural responsibilities.

Prevention

The Kurdish immigrant men we interviewed all want to stay healthy, and most of them took preventative measures to do so. While their efforts at prevention varied a great deal, regular medical checkups emerged as a particularly important means of prevention. Regardless of how often or regularly they did medical checkups, they talked about them in similar ways, emphasizing how such checkups enabled them to stay in control over their own health. Rahem [37, 1 child, 9 years in the United States] says:

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

Rahem makes a connection between checkups and staying healthy. The checkup in his view is a precaution against serious illness. In this, he echoes

contemporary discourses of preventative medicine that has extended the reach of illness into healthy bodies (Armstrong 1995; Fusco 2006). Even though he is talking about sickness as something that can consume you without your knowledge and that requires medical expertise to identify, he and several of the other participants are trying to stay in control of their health by going to the doctor. In Dara's words, by doing regular checkups "you feel you are caring for your own body" [35, 5 children, 6 years in the United States].

What is particularly noteworthy here is that this is a new practice they have adopted since coming to the United States. It is not only that it is a new practice, linked in part to the much greater availability of doctors in the United States and in part to the requirement of refugee immigration, but also that the very 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. As both Salman and Soran point out, medical checkups are an American thing,

In our culture, it is not a normal thing to do checkups. My father and mother were sick and they had symptoms, but they did not go to the doctor until they got heart attacks. For me, right now, it is important to prevent [such] major hits. [Salman, 31, no children, 24 years in the United States]

I had never heard of health checkups in my country. But, when we arrived in the United States, they did a checkup and taught us how to take better care of ourselves. [Soran, 44, 5 children, 17 years in the United States]

Hence, by reporting that they care about their health and go to the doctor for regular checkups, the men show that they are influenced by the American emphasis on health. And, by linking such checkups to a sense of responsibility for their own health, as well as that of their families, the men also signal that they are in control of this realm of family life.

Not all men do regular medical checkups, of course, but this means neither that they do not value health nor that they do not take preventive measures to secure it. Instead, they reveal some of the complexities involved in the efforts of immigrant men to secure health. Although most of the men say they value checkups as a way to stay on top of their health, they express more ambivalence around actually going to the doctor with their ailments. One reason for this, as is amply documented, is that not all of them have health insurance, which means they have to weigh the potential advantage of a doctor's visit with the cost. Another important reason is that they think they can control their own health, either by not becoming sick or by curing themselves without the help of doctors. In Sarko's words, "we should be doctors for ourselves" [43, 2 children, 16 years in the United States]. Pashew [52, 4 children, 14 years in the United States] thinks that "everything is about control" and Shakar says that "we have to take care of ourselves" [45, 3 children, 18 years in the United States]. Exactly how the men take care of themselves varies—they discuss things like home remedies, cold water swims, rest—but what is significant here is not primarily that they favor home remedies over professional care, but instead that they distinguish themselves from the rest of their family. Sherzad [53, 7 children, 15 years in the United States],

for example, says that “when I get sick, I try to stay home and I do not like medicine.” But, “the kids are different, I take them to the doctor right away...[because] they are not like me...I am stronger and can control myself.” Kamaran, similarly, says that when his wife gets sick, “I take her to the ER [but]...when I get sick, I can handle it better” and deal with it by “taking it easy” rather than going to the hospital [29, no children, 18 years in the United States].

In general, then, whether or not the men go to the doctor and regardless of the methods they use for staying healthy, they all talk about health as something they value and feel they have control over. In so doing, they simultaneously demonstrate that they have acquired a certain amount of health capital and have found ways to use it that do not undermine their sense of themselves as men.

Exercise

Exercise is a modern practice. People in traditional societies obviously exercise too, but they do not do it as an end in itself. Life in traditional societies is typically less sedentary than contemporary automobile-driven life in the United States, hence reducing the need for focused exercise. Moreover, traditional masculinity is considerably less body-oriented than contemporary American masculinity has become (Rosenmann and Kaplan 2014). This 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. As Shakar [45, 2 children, 18 years in the United States] observes, “I come from a culture where exercise is not valued.”

Over time, however, some men come to adopt physical exercise as a way to deal with American life. Dara, for example, who has lived in the United States for 6 years, links his weight concerns to the sedentary nature of his new life. He says he has to “use the car to go anywhere,” whereas back in Kurdistan he might “walk 5 to 6 miles a day.” Sherzad [53, 7 children, 22 years in the United States], similarly, remembers that back in his village in Kurdistan “we used to walk around and go to the mountains,” whereas here in the United States, “we do not move around too much.” Finally, Hawar [39, 4 children, 20 years in the United States] says that:

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... to the mountains, so we used to be healthier. But, when you come to this environment, where you do not move [as much]...you store all of your sugar and oil on your body, [which] eventually [will] kill you!

Hawar’s reference to cholesterol and blood pressure shows that he is using health knowledge he has gained in the United States to make sense of his own health practices. But, he is also using his new health knowledge to complain about how life in the United States impacts his health negatively because life is considerably more sedentary here than in Kurdistan.

The time commitment was a concern for several of the men who said that family obligations took so much time that they had difficulties fitting exercise into their daily lives. Sherzad [53, 7 children, 15 years in the United States] laments that he does “not

have much time," but tries to "do exercise machines at the gym and home" whenever he can. Exercising, he says, "helps you to control your weight and blood pressure. You stay healthy when you exercise." Although he has fitness equipment at home, Soran [44, 17 years in the United States] says he is "too tired to use them"; he explains that he has 5 children "that I have to take care of and that doesn't leave me any time to work out." As we show in the next section, however, family obligations do not so much divert the men's health commitments as they change how the men express their commitment to health.

Taken together, the findings in this section show that male Kurdish immigrants express their ambition for health and general well-being through exercise and prevention. But, they do so in ways that smooth over the evident gap in the role of health practices in the expression of masculinity in Kurdistan compared with the United States. The emphasis on control, as other studies have demonstrated, is one significant way that men try to reconcile their health concerns with their masculinity. But, for these Kurdish immigrants, the reconciliation between masculinity and health is made complicated by the additional challenges to their masculinity that they experience in the United States. The cost of medical care and health insurance, for example, is a potential challenge to the men's provider roles, but one they resolve by emphasizing other ways to stay in control of family health and, not the least, to present themselves as less in need of care than their more vulnerable wives and children. More generally, the findings suggest that the men have resolved the potential dilemmas they face around health by articulating health as one of their primary family

obligations and by infusing their cultural practices, especially those linked to food, with health considerations. In the next two sections, we elaborate on these points further.

Health and Family

The evidence we present in this section demonstrates how the men have incorporated the health-consciousness they have acquired since coming to the United States into their larger obligations as husbands and fathers. Although the men talked about family as an obligation that competes with health, it is nonetheless an obligation that propels them towards health in other ways. That is, the men see it as their responsibility to make sure that their wives and children are healthy and well provided for, a finding that has also been documented on studies of working-class men in the west (Robertson 2006; Dolan 2011).

In what follows, we first describe how the men talked about health as a family obligation and then discuss the role that masculinity plays in the men's narratives.

Health as a Family Obligation

As with their own health practices, the men pointed to food and exercise as the most significant health-related areas of family life, although a few also mentioned hygiene and cleanliness as part of their health regimen. They described how they tried to steer their families in the direction of health and emphasized the importance of their own interventions in these areas. Even though a few of the men

credited their wives with making good health decisions, they all referenced their own involvement in their families' health practices as active and deliberate. Sherzad, for instance, who has lived in the United States for 15 years and has 7 children, clearly saw it as part of his responsibility to make sure that all members of his family are healthy. He observed that "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." Asked if he was involved in his family's health practices, Rahem [37, 1 child, 9 years in the United States] answered "Yeah. Yeah, I am actually; I want to see my wife and kids be healthy." Nawzad [48, 4 children, 15 years in the United States], too, 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. He says that he and his wife "always advise our children, even the grown ones, to eat healthy. Sometimes they do not like our involvement, but we have to keep our eyes on them to stay healthy." Karmand, similarly, mentions that "I watch my children a lot in order to prevent them from eating bad food"; in this context, he also points to the importance of health instructions in the schools which, he says, "I advise them to follow" [45, 3 children, 14 years in the United States]. Observing that he himself had "no chance to take care of my health...because of the society I grew up in" and that he "learned those things here," Soran, as a final example, tries to teach his 5 children "to take care of their body and health right from the beginning, so that they can do many things" when they grow up.

These findings suggest that the emphasis the men place on their children's health has emerged as part

of their parental obligations once they settled in the United States. The point is not that living in the United States has made them better parents, on the contrary, but instead that health has come to occupy an increasingly central position in their paternal practices. That is, the men are more alert to the children's health practices in the United States than they were, or would have been, in Kurdistan. The men's concerns about health are evident also for the few men who acknowledge that their wives do most of the work around health in the family. Pashew, for example, indicates that his main responsibility in the children's health practices is to make sure that they do what their mother tells them to do; he says that he steps in "When they do not obey their mom, but they are very close, so they don't disobey" [52, 4 children, 14 years in the United States]. Nawzad, similarly, says that "Their mom is very helpful to me, and she is very attentive to these things [health practices]. Because moms are closer to children, she does most of the work at home" [48, 4 children, 15 years in the United States].

Health, Family, and Masculinity

The men's health narratives invoke masculinity in the control they see themselves as exercising over their health and in the obligations they feel to their families. Masculinity is also evident in how they formulate health as an important aspect of their manhood. According to the men, their manhood is implicated in health practices in two distinct, but interrelated ways. The first of these, regarding the importance men place on their provider role, has been documented in other research on masculinity and health as well (Robertson 2006), whereas the other, concerning

the role of health behavior in the gendered relationships the men have with their wives, is more novel, at least in this context, even though the emergent literature on health behaviors in intimate relationships has begun to untangle the role of gender in partner negotiations around health (Reczek and Umberson 2012).

Speaking of the importance of his own health, Rahem [37, 1 child, 9 years in the United States] explains that

as a man, if you are not healthy, you cannot take care of your family as a man. You cannot do what you are supposed to do to support your family. So, it is very important to be healthy. Nobody wants to live with a sick man, and nobody wants to see a man at the house who cannot do anything.

Sarko, similarly, says that health “is really important to me because I want to have a healthy life and I want to have my own energy...to serve my family and children, so I can take care of them well” [43, 2 children, 5 years in the United States]. As a final example, Pashew emphasizes that “If you take precautions and prevent diseases, you will be in control of your life and stay a father to your children” [52, 4 children, 14 years in the United States].

Beyond the provider role, it is evident that the men have incorporated health-related concerns into their sense of themselves as men. As an example, Sarko [43, 2 children, 5 years in the United States] observes that many women

do not know about their health status, which is why we [men] have to teach them or let them know that

some things are not good for their health. It also makes the relationship better because...we show that we care more about them. Yes, we should watch them and tell them all the time.

Sherzad [53, 7 children, 15 years in the United States], similarly, explains that “I advise my kids to stay away from bad food” and also that he still tells his wife, even after 20 years of marriage, to “not put too much oil on the rice.” But, overall, he is satisfied that, when it comes to health, his wife “listens to me as, you know, in our culture, wives should listen to their husbands.” Observing that it is “a very important part of my religion to educate the family on good practices [such as] exercise, food, or health,” Salman [31, no children, 24 years in the United States], too, talks about how he encourages his wife to be healthier. He says he makes sure “that she comes along” when he goes for a run or a hike and also that he does “not allow her [to] put a lot of sugar on her food.” As yet another example, Dara [35, 5 children, 6 years in the United States] relates how he had to convince his wife to be more health-conscious:

At first she wasn't into it because organic food is more expensive and she didn't care; she was trying for us to be like other people. But, [I said] no, instead of having meat every day, have it once, but it should be organic. So I think she is convinced and she agrees with what I say.

Finally, Pashew, who acknowledges that his “wife takes care of herself,” nonetheless emphasizes that, although he does “not intervene much,” he often tells “her to be careful, [and] try not to get cold.”

Given that the men come from a culture that is considerably more gender-traditional than the one they encountered when they came to the United States, it is not altogether surprising that they emphasize and invoke their status as men in conversations about health and family life.³ While only a few of the men directly related their understanding of gender, their thoughts are quite revealing. Karmand [45, 3 children, 18 years in the United States], for example, said about men and women that “we are different, biologically, physically, and our reactions are different; I am talking scientifically.” Pashew [52, 4 children, 14 years in the United States], similarly, stated that

We can say that men and women are equal in some things, but I personally don't believe in male-female equality because neither can men play the role of women, nor women the role of men. These can't be equal. This doesn't mean that women should be subordinated to men, but that is how God created [men and women]...In America...the woman is free, but the burden on her shoulders is heavier here; in our country, women have half of that burden.

In conclusion, in this section, we have shown 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, no one would have been prepared to re-

nege on his other responsibilities, especially those linked to family, in order to tend to his own health. In fact, by emphasizing what they have to give up in order to meet their duties to their families, the men simultaneously emphasize their masculinity—their obligations are linked to their manhood and they meet them as men.

Health and Culture

When introduced to the subject of health, many of the participants immediately started talking about food. They described the differences between American and Kurdish food, and many insisted that American food is not as good, and not as good for you, as Kurdish food because it generally is processed and not organic. Studies of other immigrant groups have found similar patterns regarding perceptions of American food (Guarnaccia et al. 2011). As a cultural marker of sorts, then, food is an important symbol of identity and distinction, quite apart from its nutritional value (D'Sylvia and Beagan 2011). When it comes to gender, identity, and food practices, however, we know more about immigrant women in various contexts (Srinivas 2006; Ristovski-Slijepcevic, Chapman, and Beagan 2007) than we do about men, especially when it comes to food negotiations and practices that extend beyond household labor.

Most men in this study observed that the food they used to eat in Kurdistan is healthier than much regular American fare, but this is not to say that they deliberately ate healthy before coming to the United States. On the contrary, it was not until they arrived in the United States that they developed

³ It is also important to point out that a few of the men spoke of more gender egalitarian partnerships with their wives. Salman, who came to the United States as a child and who is newly married, says that he and his wife started talking about health “since we were married because we want to be here for each other and support each other...we talk about not eating too much and doing some regular exercise.” We do not have enough data in this project, however, to examine what factors might contribute to greater gender egalitarianism.

health-consciousness and became concerned with their diets. That is, food has emerged as a part of life that the men are much more involved in than they used to be in Kurdistan. Although few, if any, of the men did any cooking in their households, they nonetheless spoke as if they not only cared about food, but also had a strong influence on their families' eating practices, including what to eat and what not to eat. We have no way of knowing if this accurately captures what goes on in their families, but it is nonetheless important to observe that the men have come to consider it part of their responsibilities, as husbands and fathers, to take command over their families' nutritional needs. In so doing, the men also establish a link that runs through health between their new life in the United States and their old life in Kurdistan.

Kurdish cultural values and norms deeply pervade the participants' health practices, and when it comes to food especially, the participants clearly favor traditional Kurdish food. And many, like Dara, who has 5 children and has lived in the United States for 6 years, conclude that "we are healthy because we eat our Kurdish and healthy food," and this is so because American food is filled with "chemical substances." The emphasis on healthy food was especially pronounced when the men talked about their children. They were clearly determined to pass on a Kurdish diet to the next generation. This points not simply to a concern for a healthy diet, but also to how the determination of what is healthy gets filtered through cultural traditions. Soran [44, 5 children, 18 years in the United States], for example, talked about why he thought it was important to keep 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 your health, but our food is better and healthier. That is why we want to stay with our food.

When we asked Abo [46, 3 children, 19 years in the United States] about his family's health practices, he said:

We even prepare food for them when they go to school because they do not eat at the school's cafeteria. We prefer our food because it is healthier and better...I do want my kids to be healthy and stay 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.

Salman, similarly, talks about how he and his wife, who have no children, "try to make sure that [our nephews and nieces] are not eating too many sweets or ice cream...We try to educate them about health practices and exercise. Especially in a country like this where most of the food is processed, chemically enhanced." In this way, the men use the health-consciousness they have developed since coming to the United States to criticize cultural food habits that they do not want their own children to adopt. In this sense, the men's concerns about "junk food" also express a more general concern about life in America.

However, with increased health knowledge, many have also come to view traditional foods, which contain lots of salt and fat, as potentially harmful.

Most of the men talked about having cut back on heavy Kurdish meals since they came to the United States. Sherzad, for instance, reports that he has “cut down on the meat I eat. I eat a lot of vegetables, and I like raw things. I mean organic things because I come from a village originally. Those things keep me healthy. Plus, I like nuts a lot because they have good oils in them, and I drink water as much as I can” [53, 7 children, 22 years in the United States]. Hawar [39, 4 children, 20 years in the United States], who acknowledges that the family sometimes eats “some junk food,” tells us how he encourages his wife to serve healthy foods; he says that “we have to have a big salad, I tell her all the time to have a salad.” Nihad, who has lived in the United States 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.

Kamaram, 29-year-old and recently married, who has lived in the United States for 18 years, said that “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.”

Such evidence points to food as an important element in the efforts of Kurdish men who have settled in the United States 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 ways what they see as distinct Kurdish and American cultures and create a new kind of Kurdish-American identity.

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 we talked to had married within their ethnic group (one man was unmarried). The findings show how the men try to protect their identity by adhering to the cultural values and practices that, in their memories, characterize life in Kurdistan. But, through the vantage point of health practices, it is also evident that the men have adjusted 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.

Conclusion

The purpose of this study has been to increase our understanding of how immigrant men in the United States think about and manage their health. Such an

understanding, we argue here, must be grounded in an analysis of the ways in which immigrant men simultaneously manifest their masculine values in their health practices and adapt to the very different contexts of both health and masculinity that characterize life in the United States. From this perspective, the stories the participants told us about their health values and health practices were also stories about themselves as Kurdish men.

The three 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, Health and Control, 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. 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 responsibilities. 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. 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. Here the men talk about how they use such knowledge to guide what the family eats and what they should 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 friends. It is readily evident from the men's discussions, then, that food decisions are about a lot more than food. It is, in essence, about who they are as men.

Taken together, these findings make a few important contributions to our understanding of the puzzles associated with men's health. As other qualitative studies have demonstrated, this one, too, provides evidence of the complex nature of the entanglement of health and masculinity. With the focus on an understudied group of men the study contributes new empirical knowledge to the field, even though some of the themes that emerge from the study align fairly well with existing knowledge. This is so especially regarding the importance to the men of staying in control of their health and, albeit less commonly noted, the significance of family life for the men's health practices. Our findings also confirm that an understanding of men's health practices must rest on a foundation that view men as gendered beings. More surprising is the evident importance the men place on health, but in light of some other research that has shown variations in the extent to which men care about their health this is not an altogether novel contribution (O'Brien, Hunt, and Hart 2005). Rather, it

is in the findings regarding the importance of health practices to the experiences of immigrant men that the study makes its most important contribution. 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 surrender to American health dictates—which, several of the men pointed out, are also characterized by poor health practices—the men use their new knowledge to also stay connected to Kurdish traditions, especially those related to food.

The 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. Other studies have shown that international male migrants highlight their gender identities when they arrive in a new country (Van Hoven and Meijering 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. This was true of the Kurdish immigrant men in our study as well; they tried to protect their masculine identities by adhering to a set of cultural values that recognize men as heads of the household. In order to do so, however, they also had to change in some ways. In this study, health practices emerge as a particularly important and illustrative example of how the men have adjusted their masculine selves. From having not thought about health at all before coming to the United States, they now have incorporated health into their responsibilities as husbands and fathers. Hence, and in conclusion, they use a discourse of health to simultaneously assert themselves as men and maintain their connections to their original culture, just as they use a discourse of masculine responsibility to account for the health-related choices they make.

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