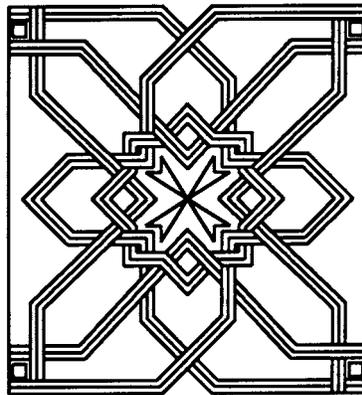


**ACCESS**  
**Arab Community Center for Economic and Social Services**

**Community Health Center**  
**Public Health Education and Research Department**

**Guide to Arab Culture:  
Health Care Delivery to the  
Arab American Community**



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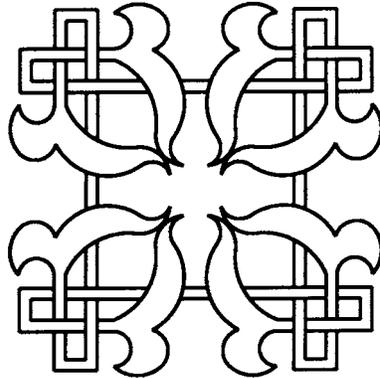
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**April, 1999**

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### **Acknowledgements**

The ACCESS Community Health Center is deeply indebted to each participant of this project, as well as, public and community health organizations and agencies. This Guide to Arab Culture will, hopefully, lead to more understanding to the Arab and Arab American cultural needs and how they impact health care delivery to the Arab American Community.

Our sincere gratitude goes to the Michigan Department of Community Health which, generously funded this project. We extend special thanks to our community agencies who gave their insight to this project .

ACCESS Community Health Center thanks the project team and colleagues who helped me to complete this project: Raja Rabah, M.D., Rashid Kysia, M.P.H., Michael Connelly, B.A., B.S., and Rosina Hassoun Ph.D..

We believe the present study will be of use for all decision-making, planners, community members, and all those interested in applied community health in general and the betterment of medically underserved Arab American health in particular.

Finally, this guide is an evolving project that will likely go through several iterations and editions in the future. We hope that it will prove useful and that feedback from its users will enable us to provide improvements.

Adnan Hammad, Ph.D.  
Director, ACCESS Community Health Center  
April , 22, 1999

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## Foreword

The need for a guide to Arabic culture designed specifically for health care providers grew from my own work and personal experience. As director of the ACCESS (Arab Community Center for Economic and Social Services) Community Health Center in Dearborn, Michigan, I have heard the Concerns of numerous Arab clients about their experiences with the Western health system. Funding agencies and other organizations have often requested information. Finally, it was also a recent personal experience that strengthened my determination to write this guide. The myths, stereotyping, and ignorance about Arab and Islamic culture stand in the way of providing sensitive and quality health care to Arab patients. The following cultural guide is designed to address these problems and to provide a detailed introduction to Arabic culture. The sections on health and healing in the Arab Middle East and on Islamic socio-religious behavior are designed to provide a practical and realistic view of Arab culture and Islam. The section on the health care sector in the Middle East is based on many years of experience in the management of health services in the Arab World and provides a unique perspective not found in other sources.

The following guide has been produced with the intention of addressing the lack of cross-cultural comprehension between the health providers and the Arab American health care consumer. It has been designed to help doctors, nurses, midwives, health administrators and planners to better comprehend the needs and preferences of the Arab American patient/client.

Though it is impossible to complete a cross-cultural bridge with one work such as this, we have put forth a beginning. We hope that you, as one involved in health care, will read and act on the content of this guide. The five sections will give you an overview of Arab culture and society and will provide you with an Arabic patient perspective you might not otherwise know. Included are specific anecdotes and descriptions that may parallel certain medical situations where an enhanced cultural understanding would be beneficial. The material contained in the appendix includes more in depth views of history, customs, and language, that you may read now or use to further your Arabic education in the future. We hope that you will read the main content of the guide as soon as you are able, for the sooner we share an increased understanding the sooner both you and those you serve in the health care field will benefit from it. Then keep this on a shelf or in your personal library, and use it for reference if you ever need it in the future. Regardless of your position in the health care field, we feel that this guide will be a foundation for you to establish a fruitful connection with your Arabic patients and partners in health. This is the beginning, your subsequent experiences will solidify and make the bridge whole.

It is our desire that health care providers apply this information with discretion, mindful of individual, regional, religious, and ethnic diversity within Arab culture. We hope that the end result will be more satisfactory medical experiences for both providers and patients.

Sincerely,

Adnan Hammad, Ph.D.  
Director, ACCESS Community Health Center

## Preface on Medical Anthropology

### Anthropological Medicine:

"Sickness is, in essence, a condition of persons unwanted by themselves, and conceptions, theories, and experiences of sickness are elements of socially transmitted cultural systems...the anthropological perspective conceives of sickness in terms of the perceptions and experiences of patients. And the perception and experience of sickness by individuals is fundamentally shaped by their cultural setting. As individuals grow up in society, they are taught how to label their sickness experiences; they learn the cultural explanations of these conditions, the standard treatments, and the appropriate responses to others with the same conditions. It is the patient's experiences and life goals that define the distinction of normal and abnormal function ...."

(Robert Hahn 1995: 267)

We are living in one of the most volatile periods of human history- in an age when masses of humans and information race around the planet at incredible speeds. All things, including distant cultures and new diseases, are just a plane ride away. At this time in history there are more people living on this small planet than have ever lived before- all with a need for proper health care, sanitation, food, and a decent quality of life. The United States enjoys one of the highest standards of living but is also facing a challenge in providing quality health care for all. The 1980-1990's has been a period of very high immigration rates- cities like Miami, Chicago, and Los Angeles are now dominated by populations of immigrants that arrived since 1965. At the same time the numbers of foreign born physicians, social workers, and health care workers are also increasing. In addition to being a nation of immigrants, America has also become a worldwide backup health care provider for people who can afford to pay for American medical technology from countries around the globe. "Medical tourism", people visiting the US only for medical care, is an increasing phenomenon.

In the midst of these changes, the skyrocketing cost of health care has given birth to the concept of managed care. The rationing of health care and the numbers of patients per day has placed great pressures on physicians and health care providers. In the midst of this crisis in care, there is an apparent lessening of faith in biomedicine (the standard model taught in US medical schools). Concurrently, there has been a tremendous rise in interest in "alternative" health care. The number one complaint by patients is not about the type of medications or medical technology, it is that their doctors do not take the time to listen to them (Good and Good 1982).

Physicians and social workers are crying out for help in coping with patient expectations and with methods to deal with the rapid changes. Two decades ago, a health care worker would not have considered asking an anthropologist or a native healer to accompany them on rounds. Today, clinical anthropology, cultural and linguistic specialists, and integrated medicine (the integration of ethnomedicine, and/or "alternative" medicine with biomedicine) are not uncommon aspects of medicine in the United States. The need for specific cultural information on different ethnic groups and people of differing linguistic and religious backgrounds is increasingly important for health care providers and other care givers in American society. For this reason, this guide to Arab culture was written as another tool for care providers. With approximately 3 million Arabs in the United States and with American hospitals soliciting paying customers from the Middle East, the need for such information is greatest in states like Michigan, California, New York, and Illinois which have large populations of Arab Americans.

One of the dangers in writing a guide to a culture is that the guide reports on normative behaviors. In the case of this guide, the normative behaviors refer to recent unacculturated Arabs and cultural norms for the Arab World. Even in the Arab World there are 21 different countries, numerous sub-cultures, and religious and ethnic minorities. A great danger lies in the misuse of a little knowledge without critical thought. Diversity exists in every group of humans. In addition, the one greatest aspect of immigrant life is cultural change through acculturation and for some by assimilation. Therefore, any such guide must be applied with caution and common sense.

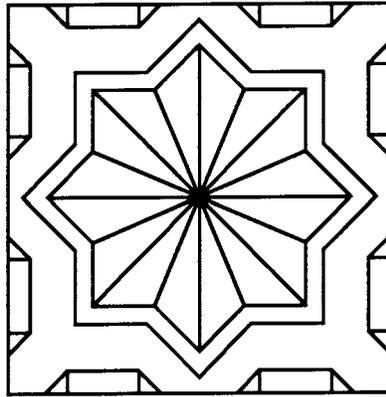
Each individual needs to be assessed along a scale of acculturation and change. We also must avoid jumping to assumptions. Just because a person wears traditional ethnic dress may not mean that they lack English language skills or if a woman wears traditional clothing that she does not work outside the home. And the converse may be true of someone wearing typical western clothing. We have to evaluate each person using a number of cultural clues and when in doubt learn to ask questions in a culturally sensitive fashion. We also have to be ready to reevaluate them as they undergo change.

On a recent trip to a physician's office, upon realizing I was an ethnic American the physician asked me if I did "anything weird" in referring to my cultural practices. Suffice it to say that I am looking for a new doctor. Learning to evaluate our own level of cultural competency is also part of the ongoing effort to provide better care. It is really difficult to be honest in performing a self evaluation of our cultural competence (see appendix) no one wants to admit that we may suffer from cultural insensitivity, cultural blindness, or in the worse case, harbor negative stereotypes and prejudice. It is also important to remember that no one, not even the most accomplished anthropologist, can be totally competent in and knowledgeable of all cultures. There is a learning curve with each culture and rather than emphasize our weaknesses, we can relish the feeling of accomplishment as we become more aware and comfortable with each new situation.

While working in the Arab community in Dearborn, Michigan, I remember seeing a particular young Arab girl. She was dressed in an extra large football T-shirt that almost covered her from head to foot, over a pair of blue jeans. She had on tennis shoes. She also wore a brightly colored scarf covering her hair and on top of it all a baseball cap worn backwards. On a number of occasions, I saw her on her in-line roller skates cruising the sidewalk. She had accommodated both her religious requirement for modest dress and the need for typical American teenage self-expression. I think of her often when I think of the Arab American experience.

Nothing in the typical American stereotyping of Arabs prepares Americans for dealing with the complexity of Arab culture. The gulf of misunderstanding between the West and East is large and runs in both directions. If ever there was a need for understanding between people, it is here. Hopefully, this small guide to Arabic culture will provide a first step on an adventure of discovery. Every culture has something of value to teach us, if we listen.

Rosina Hassoun, Ph.D.,  
Medical Anthropologist



## I. INTRODUCTION

Arabs in the state of Michigan are the third largest minority group and the fastest growing population in the state (Michigan Department of Health 1988). Despite this fact, knowledge of Arab culture has not increased accordingly among the general population. With respect to health care, many providers continue to find themselves in a position in which they are unable to understand the cultural patterns of their diverse patient populations nor comprehend the health-related behavioral motivations of these patients. Moreover, health providers tend to perceive client satisfaction from their own perspective, without the ability to view their clients' culturally specific perceptions of these services.

There has been a prevailing assumption in the health care field that the Arab immigrant patient should assimilate to the Western views of health and disease. From a health economy point of view, this assumption is flawed, since the burden of understanding must be carried by the provider more so than the consumer. Consumer satisfaction is measured by what the consumer him or herself feels about the service received, rather than what the provider perceives as appropriate service. Therefore, in our transforming American society, competence in understanding cultural diversity is an essential component in effective health care delivery. Understanding the Middle Eastern health environment, the cultural perceptions of health and illness, and the social factors that interplay in the patient's personal decisions are essential for the betterment of health service provision to this population.

### **Who is an Arab?**

The term Arab is associated with a particular region of the world. Almost all of the people in the region extending from the Atlantic coast of Northern Africa to the Arabian Gulf (See map from Teebi, 1997) call themselves Arabs. The classification is based largely on common language (Arabic) and a shared sense of geographic, historical, and cultural identity. The term Arab is not a racial classification, but includes peoples with widely varied physical features. The total population of the Arab world is approximately 230 million in 22 nations (UNDP, 1993). As the map illustrates there are 10 Arab countries in Africa (Morocco, Mauritania, Algeria, Tunisia, Libya, Sudan, Somalia, Eritrea, Djibouti and Egypt) and 12 countries in Asia (Iraq, Jordan, Lebanon, Syria, Kuwait, Bahrain, Qatar, Oman, United Arab Emirates, Saudi Arabia, Yemen, and the people of Palestine). Palestinians are presently either living under Israeli rule, autonomy of partial Palestinian Authority, or dispersed throughout the

world). Despite the national boundaries drawn between the Arabs in the post-colonial period, the Arabs on the popular level view themselves as a unified entity.

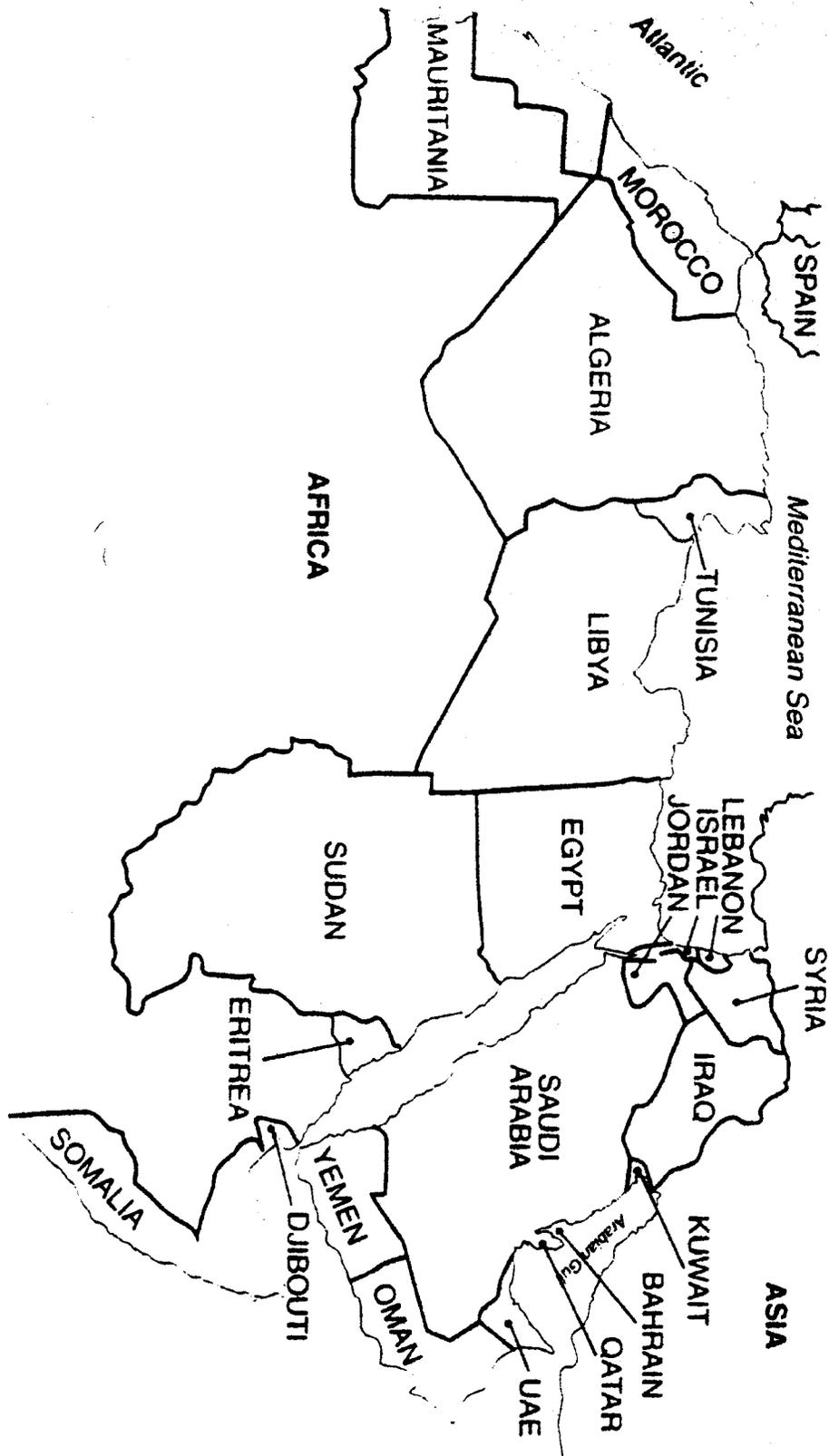
Arabs are not homogeneous with respect to religious belief, but include Christians, Jews, and Muslims. The large majority of Arabs are Muslim (92%), however, in total the Arabs comprise only about 17% of the Islamic population worldwide (with other substantial populations in Indonesia/Malaysia, South Asia, Iran, Central Asia, Turkey, and Sub-Saharan Africa). The religion of Islam is closely associated with Arab identity because of the origin of Islam in the Arabian peninsula and the fact that the language of Arabic is the sacred language of the Holy Qur'an.

Within Arabic countries live other minority groups as well. Thus there may be found social and familial mixing with other groups such as Persians, Turks, Kurds, Berbers, and other minorities. Differences within Arabic culture also exist between those from urban versus rural areas. The makeup of specific Arab countries is quite variable, for example, while only 29% of the population of Yemen hails from city life, 84% of those in Lebanon call an urban region home. Fertility is high in the Arab world while so are many negative health indicators such as IMR (infant mortality rate), but no statistic is consistent throughout the Arab countries (see Appendix C) (Deeb, 1997). These varied backgrounds must be kept in mind when one tries to apply the cultural norms described in the following pages. No practice is universal, and behaviors and attitudes, while they may follow certain guidelines or common influences, are incredibly variable despite being born from the same culture.

### **Immigration to the United States**

Arab immigration to the United States began as early as the 1890s and has been marked by distinct periods of population movement. The first wave of immigrants from the Arab Middle East was largely (90%) Christian immigrating from the then Ottoman Turkish administered district of Syria (which included Syria, Lebanon, Jordan and part of Palestine). These immigrants came to the United States seeking better economic opportunities. Among the minority of Muslim immigrants there were individuals escaping Turkish military recruitment after 1908 (Abraham, S.Y. 1981). Among all immigrants from the Arab Middle East, this first influx assimilated American norms and integrated into the society with the greatest ease and economic success. Of today's Arab Americans, 50% descend from immigrants that arrived in the United States between 1890 and 1940 (Abraham and Abraham 1983).

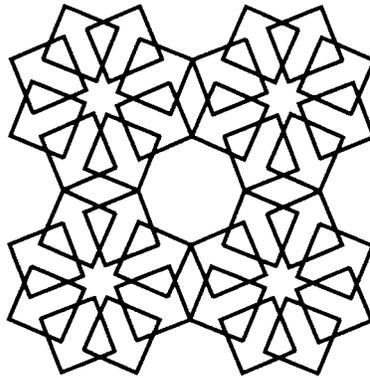
In the late 1960s, American immigration laws were relaxed and more significant numbers of immigrants from the Arab world began to arrive to the United States. Compared to the earlier immigrants, this population is proportionately more Muslim and the people more likely to have fled their homelands due to political and social upheaval. They were forced immigrants, many of whom were rural agriculturists who were entirely unprepared for life outside their previous environment. The waves of Arab immigration have corresponded closely to the tremendous political events of the Middle East in the post-colonial period. These immigrants include civilians displaced from Palestine in the formation of Israel (1948), and the 1967 Israeli occupation of the Palestinian West Bank and Gaza Strip, as well as civilians displaced by the Lebanese war of 1977-1992 (most significantly the full-scale Israeli invasion of 1982 and subsequent occupation of southern Lebanon), the Yemeni civil war (1990s), the Iraqi government persecution of the Shi'ite minority in the early 1980s, and the Gulf War coalition assault on Iraq in 1991. Each of these upheavals displaced civilians from ancestral lands. These displaced individuals are largely from



**Figure 1-1. Map of the Arab world.**

(The above map is from Teebi, A.S., 1997. "Introduction", in Teebi, A.S., Farag, T.I., eds. Genetic Disorders Among Arab Populations, 1997. New York: Oxford University Press).

agricultural backgrounds, representing some of the least technologically skilled and least educated segments of their respective nations of origin. Consequently, linguistic and social factors are significant barriers for health care access among many of the recent immigrants.



## **II. ARAB AMERICANS IN THE STATE OF MICHIGAN**

### **Socio-Economic Background of the Local Community**

The Arab population in the Metropolitan Detroit area is approximated at 250,000, 32% of whom reside in Southwest Wayne County (Abraham, S.Y. 1981). This community comprises one of the largest concentrations of Middle Eastern people living outside the Middle East, second only to Paris, France. The population varies according to political and religious affiliation and country of origin, but it is cohesively structured according to linguistic and cultural ties. The recent trend in immigration has weighted the Arab American population toward a greater proportion of immigrants born overseas (about 40%). In 1995, the Arab-origin population in Michigan had a median age of 27 years. This relatively young age is to be expected as immigrant populations tend to be younger than average. Sex distribution of the Arab population indicates that, in 1990, about 52% were males, while 48% were females.

Although the community is comprised of immigrants from varied geographic countries of origin, the cultural values are characterized by a great degree of uniformity. These cultural values play a prominent role in the health care seeking behavior among members of the community.

Employment activity, being the most important source of household income, directly affects living conditions. In 1990, the employment rate among the adult Arab population in Michigan was 69.6 %, while the remaining 30.4% were either unemployed or underemployed. Family structure among Arab Americans is predominately extended rather than nuclear. Kulwicki (1990) determined 49% of the population had five to eight persons living in the household. Statistics from the Office of the State Registrar indicate that about 20% of families in the Arab population are below the federal poverty line. This low income level for the Arab population has important implications in the unaffordability of health services for a large percentage of people. Many community members that are working, own or are employed in small shops or work several part time positions, and thus do not receive health insurance coverage through their employment. In 1994 the Wayne County Health Risk Behavior Report stated that 37% of the Arab population lacked health or medical insurance. This high rate of no medical insurance may adversely impact mortality measures and a broad range of health problems associated with obstetric care, mother and child health care, and other medical and surgical care. This high number of uninsured is expected to rise due to new federal legislation. Federal law will soon implement a policy in which any person who arrived to the United States

after August 1996 in a permanent residency status is not entitled to state Medicaid health coverage.

Literacy in English is low in the Southwest Wayne County community. Some of the residents are illiterate in both Arabic and English, while others are only literate in Arabic. Among these immigrants, educational attainment is low and employment skills are directed toward agriculture. Therefore, most of the work force in this community relies on unskilled jobs, largely in the automobile industry. As a result in the downsizing within this industry, the community has lost and continues to lose jobs. The unemployment caused by this economic contraction hits the Arab population particularly hard, since low educational levels and language skills make obtaining new jobs difficult.

Transportation is a significant barrier among low income Arab American families. A lack of transportation inhibits one's ability to access the health care system. Public transportation within the city of Dearborn is limited. Among the low income Arab American families that do have automobiles, the single family car is needed to transport the wage earner to work. Women and children are particularly affected by this barrier.

Lack of insurance coverage, and financial and linguistic barriers to regular health check-ups is predictive of a lack of preventive care and screening. Among the Arab population in Wayne County, members of low socioeconomic status are at particular risk for health problems since they tend to use medical care less regularly and neglect preventive health care, seeking attention for serious health problems only when they reach crisis proportions.

The most common leading causes of death among Arab females between the years 1989-1991 were: heart disease, cancer, cerebrovascular diseases, diabetes, accidents, and perinatal complications (Johnson, 1995). Among Arab males in the same period, the five leading causes of death were: heart disease; cancer; accidents; diabetes; and cerebrovascular diseases.

Health behavior among Arab community members in Wayne County additionally harbors a number of negative health risks. Smoking and sedentary lifestyle both are common in the Arab community in comparison to the general population of Michigan. Moreover, stress resulting from the transition to a different society and the social and economic difficulties associated with this transition might be an important contributor to poor health outcomes among the Arab population of Wayne County.

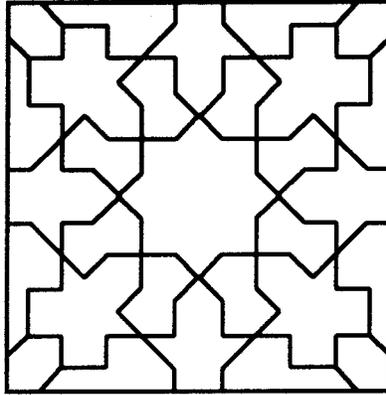
### **Environmental Health in Southwest Wayne County**

The Healthy People 2000 report states "Environmental factors play a central role in the processes of human development, health and disease....efficient programs to improve environmental health must be based on primary prevention --reductions in the amounts of toxic agents used and released into the environment each year. Additional progress in improving environmental health will come from emphasizing the prevention of human exposure to agents already released".

The physical environment of Southwest Wayne County, particularly the South End community, is a clear ecological health risk. The South End of Dearborn is among the most highly industrialized areas in Wayne County, the worst county in the nation for industrially hazardous air emission (Savoie, 1995). The community is bounded on three sides by sprawling industrial complexes. It is crisscrossed with railroad and truck routes to neighboring industrial areas. The South End region has been the central location of Ford Motor Company car production since Henry Ford established the Rouge Plant. The Ford Rouge complex is a mile long industrial expanse that emits large amounts of particulate matter into the air. Surrounding industrial operations include Great Lakes Steel, Kasle Steel, Double Eagle Steel Coating, Detroit

Coke Corporation, Allied Tar Plant, Marathon Oil Refinery, and an array of other meat packing, waste disposal, and trucking industries running along the Rouge River. Particulate emissions are exacerbated by the high flow of slag trucks that transfer slag from steel plants to the Levy Slag Company, located behind the residential portion of the South End. Each day, these trucks drive through the neighborhood regularly, emitting hot slag vapors. Consequently, the air has a distinct unpleasant odor.

Research by Savoie (1995) using 1992 data from the Toxic Release Inventory found an exceedingly high level of toxic air emission exposure. The 13 auto-related sites within the South End are required to report emissions which indicate the generation of more than 138 million pounds of toxic waste in 1992. The total release of toxic material was 50 million pounds composed of a mixture of more than 30 chemicals released into the air, soil, and water. Among the chemicals released were carcinogens including benzene, chromium, and cadmium; chromosomal mutagens known to cause both birth defects and cancers; developmental toxins including cadmium, lead, and zinc; nervous system toxins including lead, mercury, dichloro methane, and xylene. Among the health effects of chronic exposure to these pollutants are kidney, liver, and cardiovascular complications, and respiratory illnesses like emphysema, chronic bronchitis, and asthma (Savoie 1995).



### III. Health and Healing in the Arab Middle East

#### **The History of Arabic Medicine By: Raja Rabah, M.D.**

The sciences of health and healing among the Arabs is a tradition with roots in the earliest of recorded history. The distinct system of Islamic or Arab medicine (*unani tibb*) was formulated in its current form over one millennium ago (Hamarneh 1983:173-202). The impetus for the development of this healing system arose with the burst of Islamic civilization. In the 7th century AD, Islamic civilization emerged from the Arabian peninsula, expanding east and west and ultimately extending from Morocco and Spain (Andalusia) across the spice route to China. The Prophetic dictate to “seek knowledge as far as China” and the Islamic culture’s perception of itself as an expression of the primordial wisdom tradition stimulated widespread establishment of schools and centers of learning (Ibid 1983). The Islamic Caliphates of the 7th and 8th centuries encouraged the translation and study of scholastic works from a wide range of cultures. Islamic scholastic centers began to disseminate Islamic studies as well as absorb and integrate the scholastic inheritance of the ancient cultures, East and West. This emerging civilization synthesized wide ranging ancient Greek, Turkish, Indian, Persian, and indigenous Arab traditions within an Islamic framework, producing a comprehensive, analytic and scientific system of healing.

The Muslim scholars of medicine including Ibn Sina (Avicenna), Hunayn ibn Ishaq al-Ibadi, and al-Razi (Rhazes) revived and expounded upon the medical thought of Hippocrates, Dioscodres, Galen, and Plato, pioneering many of the elements of scientific medicine as it is known today (Hamarneh 1983:174-180). These scholars forwarded medical practice in both theory and application. For example, the physician Ibn an-Nafis predated Harvey in the discovery of pulmonary circulation (Ibid:180-82). Arab medical texts were among the foundations of the Western modern medical tradition; the canon of Ibn Sina formed half of the medical curriculum of European medical schools until the mid 17th century (Ibid:196-197).

In the 13th century, the Islamic sage Ibn Sina described medicine as “a branch of knowledge which deals with the states of health and disease in the human body, with the purpose of employing suitable means for preserving or restoring health” (Ibid). Microbial diseases were identified in a basic fashion (named *madah*) within Arabic medicine, and were described in terms of mode of infection and particular pathological effects on organs and tissue. Numerous internal and external etiologies were identified. In addition, Arab theorists noted that the mere presence of the germ did not constitute disease, but that the disease process was dependent on the state of balance of the exposed individual.

Islamic medicine followed the system of humoral pathology developed by Hippocrates. This healing system envisions the body in terms of humors-blood, phlegm, yellow bile, and black bile, corresponding to the elements of the natural world--fire, air, water, and earth. Each bodily humor possesses two natures. For example, blood is considered hot and moist, phlegm cold and moist, yellow bile hot and dry, and black bile cold and dry. The body brings together these four elements, and when this mixture is in equilibrium the human body is in a state of health. Within the humoral system, the humors were not defined as mechanical, but rather functional entities. For example, phlegm within the modern perspective has a specialized mechanical role in the body, whereas in the Arab humoral system, it is understood in a broader sense beyond the physical substance. It is a systematic functional entity, understood only in terms of its functional role in the balance within the whole organism in relation to the other three humors and three qualities.

Traditional cures were generally aimed at countering an excess or deficiency in one of the humors. For example, a particular problem might be described as an excess of cold and moisture that has invaded a particular humor or organ system. Pharmaceutical extractions might be prescribed and particular foods, spices, and teas might be taken to heat this system and to rebalance the humoral disunity. Beliefs about hot and cold effects on the bodily humors are maintained to varying degrees among Arabs as part of the transmitted cultural folk wisdom.

One of the most significant achievements of the golden age of Islamic medicine was the development of hospitals. The first hospital in the Islamic world was established as early as the 7th century in Damascus to help lepers, the blind, and disabled (Hamarneh 1983:178). This hospital utilized sophisticated methods of admission, discharge, record keeping, and administration. The early Muslim concept of the hospital became the prototype for the development of the modern hospital--an institution operated by private owners or by government and devoted to the promotion of health, the cure of diseases, and the teaching and expanding of medical knowledge. The hospitals attracted gifted students and were generously endowed by rich patrons (Ibid:179). Hospitals also served as schools of medicine to teach interns and residents. Through this system, an impressive method of testing and licensing doctors with rules and regulations for standards of practice was developed.

Islamic medical doctors utilized a variety of therapeutic approaches for the treatment of patients. Medical treatment relied primarily on exercise, baths, and diet and its modification. By the 13<sup>th</sup> century Ibnal-Bitar had recorded over 1300 drugs that were derived from plants, animals, or minerals (ACCESS Museum). Surgical techniques were known and utilized. Techniques were employed for fractures, treatment of trauma, and obstetrics. A number of Arab physicians compiled textbooks and case histories compendiums in the process of their professional duties.

The golden age of Islamic medicine extended from the 9-12th centuries. Islamic medicine did not disappear at the end of the Middle Ages with the unseating of the Arabic empire. It continued in the form of traditional healers following the Unani or Greco-Islamic system. In the colonial period, this Greco-Islamic system was undermined by emerging Western allopathic medicine and its administrative discouragement of the practice of the traditional system. The traditional health system of Arabs is still present to varying degrees throughout the Arab Middle East, though today, the number of adept practitioners (*hakim*) of the traditional Islamic medical system are few.

The traditional medical system is more pervasive in rural regions, while in the cities, Western technological medicine is now almost exclusively utilized. In other nations with significantly strong Islamic medical traditions, India and Pakistan state regulations have allowed

practitioners to be licensed after completion of special four year courses, where the curriculum includes the Canon of Avinciena.

While the Islamic system developed and expanded from the ancient Greek system, an additional system of folk belief exists in the Middle East. This system is also still prominent in the consciousness of many Arabs. Among the components of this belief are the acceptance of unseen forces that affect the individual. Within the traditional Arab world view, seen and unseen forces coexist within the material world. Unseen forces are thought to be in operation throughout the material realm, but veiled from the comprehension of most humans, excluding the spiritually adept who can perceive them. Some health disorders are attributed to unseen forces, most commonly jinn, or evil spirits. Mental disorders in particular are often attributed to the disruptive influence of these spirits.

The traditional view understands the human consciousness within this realm as a non-local entity, subject to influencing and being influenced by the thoughts and intentions of other individuals (human and jinn). There is a widespread belief that bad intentions toward a person can cause illness. The evil eye is said to affect a person when another individual is envious toward them, either knowingly or unknowingly. People are particularly aware of the evil eye around children. Turquoise pendants or verses from holy books are commonly worn. When a person complements a child, care is taken to mention God in the compliment so as to exclude jealousy that might make the child ill. These beliefs are ubiquitous in the Middle East and should be understood as an important part of the traditional world view to which disease causality is often attributed. It must be understood that the assumptions about health and illness held by Arabs is embedded in this time-held traditional system.

### **Health Context of the Modern Middle East**

It is important for health practitioners to understand the Middle Eastern medical context in their Arab patients' countries of origin. It is this environment in which many immigrant Arabs' attitudes, beliefs, and practices toward health care were formed.

Throughout the Arab World today, the Western allopathic system of cosmopolitan/technological medicine is widely available, often through a socialized government system. Availability, however, tends to be much greater in the urban centers than in the rural countryside. In addition, in many regions there tends to be a private fee-for-service sector that provides care to more wealthy patients with greater perceived quality and decreased waiting times. Public health and health education tend to be limited in the Arab nations. The idea of preventive care is an unknown luxury. Moreover, health education is highly limited. The general level of public awareness about health issues tends to be low.

#### *Traditional Sector*

Alongside the Western medical services are a number of traditional practitioners for particular health needs. These practitioners are not officially established and certified by state mechanisms, but tend to exist in many areas as individual practitioners who have apprenticed and learned their skill from other expert lay practitioners. For example, in the Levant (Lebanon, Palestine, Syria) traditional bone-setters are still considered effective healers for broken bones and some people even view their services as superior to the Western method of bone-setting. Similarly, midwives in the Levant continue to be skilled attendants for birth. Birth in the hospital, however, is considered more prestigious.

#### *Development of the Modern Sector*

The health and medical services in the Arab world were entirely based on the above described traditional *Unani Tibb* system (see appendix) established prior to the colonial period. Superimposition of Western cultural norms and rise of technological medicine in the Middle East almost entirely replaced the role of locally-based traditional healers, except in more isolated regions. A biotechnological approach to health is predominant in health care thinking: searching for technological solutions. Health ministries, are purchasing MRIs while basic prevention measures (immunizations, primary care, public health, smoking cessation) are underdeveloped.

### *Service Sector Structure*

In general, there are two distinct types of health providers in the Arab world: the government and the private providers. The government system is the largest of the sectors. These services are funded by general taxes and are established on the basis of a social insurance system. Government services are usually open for everybody, but the quality, efficiency, and effectiveness of this system is markedly inferior to private services.

Private services are for profit. They are owned by health alliances that are analogous to HMOs. These services are limited in number and access is limited to those who have the ability to pay up front for services or through private insurance. Private services are perceived to be of better quality and impart higher social status. The private services for profit provide private doctors, tertiary care, and private labs. There are also numerous private obstetrics and gynecological hospitals.

Health ministries in the Middle East, in general, have a strong urban bias in their priority distribution of medical and health services geographically. Practically all comprehensive secondary and tertiary care is provided in the city. In contrast to the United States, the majority (over 60%) of the Middle Eastern population is based in rural agricultural regions. In these rural areas, the private for-profit health sector is virtually non-existent. The government health system normally provides limited secondary health services in these regions, though long distances must often be traveled from outlying areas to obtain these health services.

The urban bias for medical services is compounded by the desirability of urban practice in the perception of many doctors. Doctors tend to think that city practice is more prestigious and a greater experience than is rural practice. Many doctors trained in biotechnological techniques find the rural centers under-equipped without 'high tech' implements and even deficient of more basic equipment. Residents from rural areas generally visit the rural primary care centers for most conditions, and only travel to the city for care when they are very sick.

### *Service Availability and Accessibility*

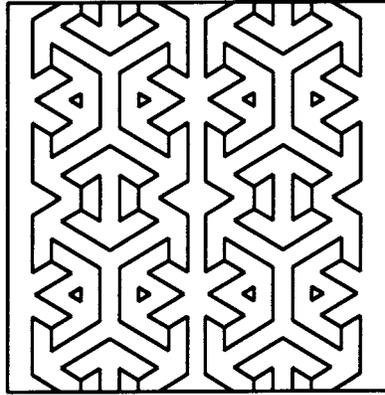
Due to the government sector provision of health care services, many poorer individuals in the Arab world do not obtain medical insurance coverage for private services. In general, these government services are accessible and are available to all citizens.

### *Public Health in the Arab World*

Due to the bureaucratic nature of many Arab health ministries and the lack of a uniform system of record keeping in many areas, public health is notably under-developed in many Arab countries. Epidemiological data is difficult to obtain due to the lack of consistent medical charting and absence of health information collection at the state level. Consequently, epidemiology and disease morbidity/mortality tracking is conducted in a decentralized manner by associations of physicians, NGOs (non-governmental organizations), limited regional health

studies, international health bodies like the World Health Organizations, and to a limited extent, government health ministries.

Without high priority for public health, health educational materials are limited and health promotion is only in nascent form in many Arab nations. There is little widespread public discourse about health (e.g. cancer prevention or early detection screening, cholesterol, high-fat diet) putting the entire health sector at a disadvantage.



#### **IV. Understanding Islamic Socio-Religious Behavior**

##### **Basic Beliefs**

Islam is the second largest religion worldwide and is the fastest growing of the world's religions. The word Islam means submission to *Allah* (God) and is a derivation of the Arabic root *salaam*, meaning peace. A Muslim is literally "one who submits to the will of God". The system of Islam was established in the 7th century A.D., though Muslims consider Islam to be the primordial religion of devotion to God that began with the first human, Adam.

The religion of Islam is considered by Muslims as the continuation of a line of monotheist prophets, said traditionally to be 124,000 that came to different people in different times. Among these prophets are the prophets of the Abrahamic line shared in common with the Jews and Christians -- Adam, Noah (Nooh), Abraham (Ibrahim), Enoch (Idries), Moses (Musa), Soloman (Suleyman), David (Daud), and Jesus (Isa). The Prophet Muhammad, who lived in the 7th century AD, is considered the final prophet and the messenger of the final universal law for all humanity in all subsequent times. Muslims view Islam as the final synthesis of the previous revelations, including Judaism and Christianity, and accept belief in the afterlife and Final Judgment. Islam emphasizes respect for the adherents of these preceding religious forms, that of Judaism and Christianity, referring to them as *Ahl al-Kitab* (People of the Book), and considers them in a privileged status within the Islamic system. This status protected their rights as a religious minority and encouraged the People of the Book to rule themselves by their own scriptural laws.

The sacred scripture revealed to the Prophet Muhammad, the Qur'an, is considered by Muslims as pure Divine revelation and as such is the ultimate source for the judgment of human behavior. Because of the perception of the Qur'an as divinely revealed, the norms set down within the codified Islamic law are considered absolute and are not believed to be subject to temporal change. Thus, the injunctions of the Qur'an are the ultimate source of behavioral norms and social allegiance, above all man-made laws and norms.

The division of Muslims into Sunni and Shi'ite occurred on the basis of the differences between the early Muslim community after the death of the Prophet, Mohammad. The schism resulted over conflict of who was to be the Prophet's rightful successor and what was the proper method of adherence to the Qur'an and the Prophet's sayings. Despite these differences, all Muslims adhere to an essentially uniform practice with respect to the fundamentals of Divine Law and religious obligation.

Islam is a complete way of life--a social, economic, spiritual and political system. As such, it is different from religion as understood in the West. In the current Western world view,

religion and daily life tend to be viewed dichotomously, whereas the Semitic traditions of Judaism and Islam both viewed all aspects of life within the context of religion. Islamic Divine Law (*shari'a*) is believed immutable and Islamic norms are considered the ideal towards which Muslims strive to conform in all societies at all times. Islamic injunctions based on the Qur'an and way of the Prophet Muhammad (the *Sunna*) are outlined for an array of practices of daily life. These practices range from spiritual actions like prayer and meditation, to washing, eating, dress, economic activity, rules for war and peace, relationships and roles in society, family interactions, marriage, birth, and death.

The five fundamental pillars of Islam are: 1) *shahadatan*, testimony of the unity of God and the prophethood of Muhammad, 2) prayer five times daily (*salah*), 3) almsgiving and social responsibility to the poor (*zakah*), 4) fasting during the month of *Ramadan* (*sawm*), and 5) performance of the pilgrimage to Mecca, the *Hajj*.

Among the basic pillars of the religion that a health professional would be most likely to encounter is the Islamic prayer and fasting. Prayer is required in Islam five times a day (before sunrise, noon, midday, sundown, and nighttime), and must be preceded by a ritual ablution. This ablution is called wudu' and Islam stipulates that the performance of this washing include intention to purify one's bad acts and the washing of the mouth, nose, face, ears, back of the neck, hands, arms up to the elbows, and feet to the ankles. Prayer includes the recitation of certain Qur'anic verses and series of prostrations to God in the direction of Mecca (East). Sick patients who are unable to pray with full prostrations are allowed to pray sitting up in a chair or bed, and if that is not possible, then allowed to pray in the position from which they cannot move. Obligations are removed when health is threatened. Keeping this in mind health care professionals should be aware and respectful of these needs for prayer should a Muslim patient want to exercise his or her religious obligations. Clinical staff should not be taken aback if a patient asks them, "which way is east?", and staff may even volunteer this information if they know the patient is religious.

An additional pillar encountered by health professionals is the fast. Muslims observe a month long period of fasting from any sexual activity, food, or drink from dawn until dusk daily, as stipulated by the Qu'ran during the lunar month of Ramadan. Fasting is considered a method of both physical and spiritual purification and as a means to annually re-acquaint the observer with the physical sensation of hunger to foster empathy toward the poor. Because Muslims follow a lunar calendar year, the time of year that this month occurs by the solar calendar each year varies. Muslims are exempt from the fast if they are traveling or if their health is jeopardized. Women are not required to fast during menstruation or forty days postpartum. Fasting is dictated by medical considerations while women are pregnant or nursing.

Despite their illness, the Muslim patient may attempt to fast during this month. This fasting would involve the refusal of any food, drink or other substance (including pharmaceuticals) from before sunrise to after sunset. This would involve the refusal of I.V.s, tablets and enemas. If this appears to be a life threatening situation, health care practitioners may talk with an elder in the patient's family or an Imam from the community Mosque who may persuade the patient that in his or her current state fasting is not appropriate. For the Muslim patient observing the fast, a light meal (*suhour*) before dawn should be provided. At the time of sunset, a larger meal is taken (*iftar*) and this meal is often eaten with a group of other Muslims. Considerations should be taken for the family of the patient who might require different visiting hours, and the probability of mental fatigue toward the end of the fast. These circumstances should also be understood for Muslim health care personnel.

At the end of the fasting month of Ramadan, Muslims celebrate one of two major religious holidays (*Eid al-fitr*) during which people of the community gather and have feasts. At the end of the hajj season, a second holiday, *eid al-adha* is celebrated.

The concept of human freedom is understood differently in Islam from that of Western culture. Whereas in the West freedom is viewed in terms of freedom of action and personal independence, the Muslim understands freedom only in the context of social and spiritual considerations. The individual as such does not have absolute freedom or rights except through fulfillment of social and religious obligation. Such considerations apply to all spheres of life, including health behavior. This translates into the Muslim's conception of "self" being less individually defined, but instead defined by the family and participation in the Islamic community.

Misunderstanding of the totality of religious practice in Islam leads non-Muslims to form misguided topics for dialogue with Muslims and blocks their understanding of the Islamic perspective. This may translate into a number of cultural clashes related to medical care. The Islamic world view tends to emphasize the will of God as the mover of all actions and the originator of all fate and events. The humility and the dependency of humans on God are often stressed, so that it is common for Muslims to attribute some personal achievement to Allah, but fault the errors to the human being. Moreover, the Islamic norm for politeness includes not making definite assertions about the future. Instead of saying this disease is curable or we will come here next week- the Muslim will almost invariably add *In sha Allah*--God-willing. A conscientious health provider might also incorporate such a statement as "God-willing" when making assertions about the future, as the Muslim tends to perceive bold assertions about the future as arrogant disrespect for God's will and an open invitation for disaster.

The rewards and punishments from God are not limited to the afterlife, but instead can occur in the present life as well. Muslims tend to view calamity as a test that tempers the individuals spiritual development. Stories of the affliction of Job, the trials of Joseph, and Jonah in the whale are all examples of this perspective for Muslims. Although the Bible and Torah also contain similar accounts, Muslims tend to place more emphasis on these lessons than might Jews or Christians. Therefore, Muslims are sometimes perceived by health providers as fatalistic in their acceptance of bad health outcomes. This is largely the result of miscommunication between differing world views. Additionally, Muslims may sometimes be resistant to the idea that their disease is the product of a carcinogen or risk behavior rather than the result of Divine Will.

One religious tradition extols the benefit of visiting the sick. Therefore, it is common to see community members that are not related to the patient come to visit a sick Muslim. Health care professionals should understand that the extensive social support received by the Arab patient is an important part of recovery, and *not* an impediment to medical therapy.

### **Dietary Restrictions**

Islamic law, similar to Judaic religious law, stipulates a well-defined dietary code. Consumption of pork is entirely forbidden by Islam. This has presented ethical issues in modern times, as some medical products are produced through pigs and other animals. For example, genetic research has developed the ability to produce medically usable forms of insulin in pigs. Lard, gelatin (unless specified as beef gelatin), and some forms of non-soy lecithin, are pork products that are generally widespread in processed foods. Because of the prominence of these products in prepared foods, the Arab Muslim patient is often wary of hospital meals.

Based on the Qur'anic injunction against consumption of meat killed other than in the name of God, most Muslims only consume meat that is specially slaughtered according to particular standards (*halal* meat). These standards include humane treatment of the animal while slaughtering, making of a prayer and invocation of the name of God before slaughter, and draining of the animal's blood. Kosher meat is roughly equivalent to *halal* meat for Muslims. If the hospital has taken steps to prepare *halal* or Kosher meals, the Muslim patient should be reassured of this so they may eat comfortably.

For Muslims, alcohol may not be consumed in any form--as beverage, in cooking, or in non-emergency medication. Consumption of alcohol among Muslims is considered shameful and therefore abuse of alcohol and intoxicants is less common among Muslims than the general population.

### **Modesty and Sex Separation**

Although there is considerable variation in degrees of separation in the sexes in the different Arab countries, generally male/female interaction in Islamic societies is limited to the family unit and is explicitly defined by Islamic law. Sex separation is generally observed in public interactions, including separation within adolescent and adult hospital wards. It is generally inappropriate for non-family members of the opposite sex to approach for conversation or other casual encounters. Hand shakes between non-related men and women are considered improper according to Islamic norms. However, there are really four different philosophies of Islam proclaiming varying degrees of contact to be inappropriate. There are some Muslims who would expect a handshake regardless of the gender of the health practitioner. Because of this the practitioner may always extend his or her hand with the awareness that a refusal from the other party to do the same should not be considered insulting.

Eye contact is frequently avoided, regardless of Islamic philosophy. This is most often true for cross-gender interactions, the female patient might not look directly at the male practitioner when speaking or the male patient might not look directly at the female practitioner when speaking. This will naturally vary with the duration the patient has lived in a society with Western norms.

A married person that looks upon a member of the opposite sex with improper intention is considered to have committed the spiritual equivalent of adultery. Therefore, much of the Western fashion esthetic and emphasis on physical appearance in order to be attractive to the opposite sex is considered spiritually and socially damaging by Muslims. Health education messages that emphasize looking trim or utilize models that are scantily clad are ineffective for reaching a Muslim population.

Outside of the extended family unit, men and women do not tend to interact socially. Related to this is a conservative norm for modesty in Islam. Stipulations exist within Islamic law that dictate a specific amount of covering that is permissible in front of non-family members. Short or exposing clothing for both men and women, but particularly for women, is considered contrary to proper modesty behavior. It is important for health professionals to realize this requirement when examining Muslims of the opposite sex. In general, same-sex providers should be made available if possible and examinations in front of other individuals (for example, opposite sex medical interns or assistants) should be avoided. In Islamic law, these norms are suspended for life-threatening emergencies only. Strong modesty norms make issues that are related to reproductive health embarrassing. Keeping this in mind when interpretive services are needed, same sex interpreters are desirable, particularly for female patients. If this is not possible an interpreter who is of opposite gender of the patient will suffice.

## **Dependency on God**

Islam could affect the outlook on life and the everyday behavior of the Arab Muslim. Although the official teaching of Islam is largely ignored, the people in Arab society have developed a philosophy of life that includes the following religious traditional values:

- 1) a feeling of dependency on God
- 2) the fear of God's punishment on earth as well as in the hereafter
- 3) a deep-seated-respect for tradition and for the past
- 4) politeness to all and generosity

'Insha'a Allah', or the phrase 'if God wills it', looms large in the thinking of the average Arab Muslim. Implicit in this saying is the fatalism which is characteristic of most of those who use it. One hears this phrase repeated constantly, frequently in reply to a question and after looking to the future.

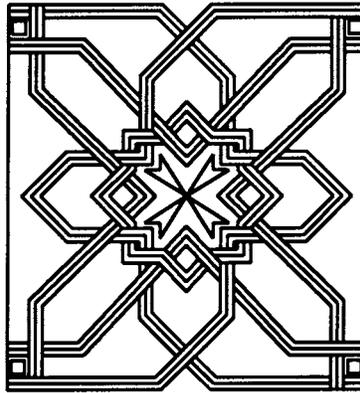
If something is lost or goes wrong, for example death etc., the Arab Moslem would not stop to examine the causes for the loss, but will merely sigh philosophically 'this is the will of God'. This phrase will similarly be reiterated by friends and relatives of the bereaved. Lutfiyya (1970) states that the same philosophy was evident in a discussion on Poverty and Birth Control that took place in one of the coffee shops in a village. The consensus of those present was that all children were born simply because God willed it. No child is born without his 'ruzq' (livelihood) being sent down from heaven with him. Hence the child is never a burden to his family'. It is God who decides how much property and wealth anyone should have. How unwise and foolish then of anyone to try and limit his offspring, hoping that this might increase his wealth. Indeed, to practice birth control is to oppose the will of God.

The dependency on God is so strong that it tends to manifest itself in almost every phase of the Arab Moslem's behavior. It is perhaps this 'dependency on God' which evokes the greatest desire to challenge when, for example, an Arab comes to the U.S., the student has been exposed to a society which seeks reason or motive for an accident or other events, rather than acknowledging interference from a divine power (Hammad, 1989).

## **The fear of God's punishment**

Arab Muslims, as noted above, feel that God keeps a very close 'watch over them. God is interested In his everyday behavior, he will be punished for his 'bad acts', and rewarded for his 'good'. Consequently, if he commits a sin or undertakes a move which might be construed as sinful, he will ask himself "Would God be pleased or displeased with my behavior?" If he subsequently proceeds to commit the sin, he lives in fear of God's punishment and hopes that he might appease God by repentance and doing good deeds in the future. Laboring under this sense of guilt, the Arab Muslim is apt to interpret any ill-fortune that befalls him as God's retribution for the wrong he has committed. For example, a traditional Arab Muslim may report that two days after he had committed adultery, one of his sons drowned.

In summary, the fear of God's punishment tends to direct the Arab Muslim to take a course of action in his daily behavior that is in keeping with Islamic ethics. Alternatively, the idea that God can be appeased and that his forgiveness can be obtained by repentance and the offer of sacrifices, leads many Arab Moslems to deviate from Islamic teaching and to commit criminal acts (Ibid).



## V. Arab Cultural Issues in Health Care

### The Arab Family Structure

Sociologists for many years have stressed the family unit as the basic social institution of society. In the Arab world, the family structure is much more rigid and highly emphasized in comparison to the West.

Four types of family units are found in the Arab Middle East. The first and most simple structure is the nuclear unit, which consists of the father, mother, and offspring. This type of family unit is the least significant in the culture of the Arab world. Such limited units are most prominent among urban, upper class, Westernized individuals. In the rural regions where the traditional Arab norms are most intact, this form of limited unit is virtually non-existent.

The second familial unit is the *'aila* (the extended family) or the joint family. It consists of father, mother, unwed children, as well as wedded sons and their wives and children, unwed paternal aunts, and, sometimes, unwed paternal uncles. In short, this unit is composed of blood relatives plus women who were brought into the kinship through marriage. Large as it may be, this unit is an economic as well as a social unit and is governed by the grandfather or eldest male.

The third type of blood kinship unit is the *hammula*, or clan. It consists of all individuals who claim descent from the same paternal ancestor. The Arab village community is normally composed of three or four such *hammula* units, which may be called the *qabila*, and each of these units of *hammulas* are composed of several joint families.

The Arab family is the center of all loyalty, obligation, and status of its members. The social, psychological, and economic security of the Arab individual stems from membership in the extended family and this membership is the primary motivating factor for the decision making of the individual. The individual identity in Arab society tends to be much less important than the identity defined by the extended family affiliation. Family relationships are the ultimate standard to which the individual seeks social approval. The individual's loyalty and duty to his or her family are greater than any other social obligation.

From birth until death, the Arab individual is always identified with other members of the Joint family in name and social status. Once a child is born to a young couple, the people stop referring to the parents by their first names and begin calling them after the name of their child--for example, *Abu* Anwar (father of Anwar) and *Umm* Anwar (mother of Anwar). A child also adds the name of his father to his own name and often precedes it with the word *ibn*, which

means “son of”. Women are related in the same fashion through the patrilineal line, and they maintain such identification even after marriage; though women do not add their husband’s name to their own after marriage.

All members of a *hammula* identify and relate themselves to one another in a very systematic way. For example, a young man refers to every one of his fellow young men of the *hammula* as *ibn 'anim*, or “paternal first cousin”. The same for every one of the young women referring to each other as *bint 'amm*, or “paternal female cousin”. Such a system of identification shows that the Arab is necessarily a family-oriented individual, and that he is always considered an integral part of a much larger family unit than the biological one. His loyalty is always greatest to those closest in kin, but it transcends even these individuals to include the *hammula* and village to which he belongs, rather than the place in which he may be living.

### **Shame and Honor**

The feeling of kinship is so strong that the easiest way to insult an Arab is to curse one of his relatives. In an Arab's eyes, the *hammula* rather than the individual is held liable in the event of dispute or conflict. Conflicts or feuds are not normally settled by individuals, but rather settlements are mediated through an agreement of the *hammula*. In an event of a monetary settlement, the entire *hammula* is expected to contribute to such a fund.

Shame and honor are highly emphasized within this context, and personal bad action not only dishonors the individual, but also the entire family unit. This norm has a great deal of bearing on health behavior. Social norms are conservative--disapproving of out-of-wedlock relations, homosexual relations, and drug or alcohol use.

Mental illness is a condition that is highly shunned in the Middle East. While Islamic norms dictate kindness and care be given to the mentally ill, Arab social norms tend to approach mental illness with fear and social avoidance. It might be said of the ill person that he is touched by demons (*jinn*) or that God is punishing him. While it is acceptable to disclose mental stress, a breakdown is considered totally shameful and blameworthy for the individual, for his or her family, and in some instances, for his or her village.

Both chronic diseases, and mental illness are viewed as a matter of shame with this context. Illnesses are generally hidden from disclosure for fear that people will view the condition as a sign of hereditary defect or as an indication that the family has earned the wrath of Divine Will, which might affect the social standing and marriageability of all associated family members. An example was an Arabic woman who refused further diagnostic work-up after having mammogram suggestive of malignancy. Her refusal was based in her belief that if it is known that she is going to the clinic for evaluation of breast cancer her daughter would be undesirable to other families in the community as a marital partner. Only after strong reassurance that all proceedings and testing would be confidential did she comply to seek further follow-up. This has important bearing on the level of disclosure an outside surveyor, including a physician, will be able to uncover in a health interview. As described, the sick individual would often prefer to hide than to seek care and face open disclosure of the ‘defect’.

### **Marriage and Divorce**

Marriage is viewed as the basic constructing unit of a strong society and is highly valued. The emphasis of marriage and natality is an ever-present social pressure among Arabs. From the youngest age, people often wish the child '*farahtik*', happiness on your wedding day. The age of marriage for women is low in comparison to United States averages and many Arab women have married during their teenage years.

Marriage is often arranged to secure wealth within a family. Thus, while marriage between two first cousins may be considered incestuous in the American context, it will be socially acceptable in Arabic contexts. The most common form of familial marriage is between paternal first cousins. In the Arabic world the rates of intermarriage range from 25% in Beirut to 90% in the Bedouins of Kuwait and Saudi Arabia. The average rate for most Arabic countries is about 40%. This practice may predispose some groups to genetic disorders including certain hemoglobinopathies (Teebi, 1997).

While Polygyny is allowed in the words of Qu'ran, it is not frequently practiced. From estimates of polygynous rates in the 1970's and earlier, in most Arab countries, less than 5% of Muslim men had more than one wife (Deeb and Sayegh, 1997).

Two fundamental generalizations may be made about divorce. First, obtaining a divorce is often more of a man's privilege. Secondly, the problem of divorce has never been as great in the Arab community as it is in many other parts of the world. Divorce is very rare among Arabs, especially in rural areas since marriage is viewed as a relationship between two *hammulas* rather than two individuals.

Women face some difficulties in their attempts to obtain a divorce, since the husband's agreement to the divorce is necessary. However, a woman can bring a suit against her husband in front of a *mahkamma shar'iyya* (religious court) and pronounce acceptable reasons for divorce. A number of conditions under Islamic law validate the woman's divorce. The man is required to pay for food, clothing, and shelter for his wife and children, and failure to do so is grounds for dissolution of the marriage contract. *Shi'i*, legal scholars, even recognize sexual dissatisfaction as fair grounds for acceptance of a woman's divorce petition, thus alleviating the possibility that the woman will seek satisfaction outside of the marriage and create a serious social ill.

In spite of the ease with which the man may obtain a divorce, very few husbands resort to divorce. This is so for a number of reasons. The religion of Islam, although permitting divorce, discourages it and teaches that reconciliation is better. Islam recommends to its followers that if they fear a breach between a couple, they "appoint a judge from his people and a judge from her people; and if the two desire an agreement, Allah will effect harmony between them" (Qur'an 4:35). The Prophet was reported to have said "with Allah, the most detestable of all things permitted is divorce".

Non-religious factors also discourage divorce. Important among these is the economic loss involved in a divorce case, i.e. *al-muajjal*. In addition, familial intervention usually prevents most divorce cases from happening. For emotional reasons, most men prefer to remain married to the same woman rather than divorce her and allow another man to marry her. Divorce is also considered a shameful act among the Arabs, and individuals worry that once they divorce, it will be difficult to remarry. This is reflected in an attitude that "if she was worthwhile, her husband would not have divorced her". A reciprocal, though not as prominent, attitude looks down on the divorced man.

## **Children**

Natality is highly respected as an Arab cultural norm. The pregnant mother is given a lot of attention from members of the family and community. A woman is often seen to be truly mature by other women only after bearing a child. Infertility within the context of marriage is viewed as a mark of shame rather than a medical condition. It can ultimately be the cause of marital separation due to the level of pressure applied by the couple's extended families. Family pressure, similarly, tends to create strong incentive for large numbers of children.

Having children as heirs is a strong motivation for marriage. The birth and care of children, especially males (who act as future means of security for the parents) play a very important role in Arab culture. As a general principle, all children born in wedlock are regarded as legitimate and viewed as gifts from God. A marriage that produces many children is considered a blessed match.

The Arab family invests a great deal of love and expectation in their children. A well-developed system of etiquette is present within the Arab family for relationships between parent and child. In general, children are highly obedient to their parents and view this obedience as a lifelong commitment that supersedes all other social commitments, including marital allegiance. Children are encouraged to live in the parents' home until marriage, and little pressure exists for the child to seek his/her own social independence. Similarly, it is shameful by Arab cultural standards to place a parent in a nursing home instead of providing the care for the parent within one's own home. The responsibility of raising children in the Arab family is extended to all adult family members, and creates a network of support that eases the burden of high natality.

Discipline of the child tends to be punishment-oriented rather than reward-oriented. In Arab norms, light physical discipline and strong verbal reprimands of the child or even screaming at the child is considered proper parenting and is viewed as correcting the child's etiquette (*adib al-walad*) rather than being seen as violence. This physical discipline most often is spanking, but may include slapping the face or hitting the body of the child. It must be emphasized that hurting the child by inflicting serious bruising or wounds is not acceptable in Arabic discipline.

In general, the well-being of the child is of concern and the fulfillment of educational and economic needs of the child is considered of great importance. In early childhood, the child is predominately trained and disciplined by the mother, who sometimes spansks the child for misbehavior. The authority of the father begins to manifest itself more strongly as the child grows older. Once the child is about age seven, it is the father who becomes the most important disciplinarian in the child's life. The child learns from an early age to obey and respect the parents and other elderly people in the family.

The children are taught a system of etiquette called *adab*, which is a set of expected behaviors that, when fulfilled, earns the child the approval of being *adib* (well mannered). Under this system, children are taught to obey their parents and respect their elders. The child is expected to rise and offer his/her seat to an older person, to talk in a respectful manner, and to kiss the hand of the elder when introduced to him. Generosity is an important behavioral norm transmitted to children. Emphasis is also placed on bravery for male children. Children are expected to courteously greet everyone that they meet regardless of whether the person is known. The phrase used in this respect is "*as-salaamu alaykum*" (peace be upon you) which is answered with "*wa alaykum as-salaam wa rahmatu Allah wa barakatuh*" (and upon you peace and God's mercy and blessings). Males greet males, older women, and their acquaintances among younger females. Females greet females, older men, and their acquaintances among younger males.

In traditional Arab society the basic socialization aim pursued by the family, whether consciously or not, is to mold the child into an obedient member of the family group, able to integrate into the working of his immediate social environment. The growing child has to learn to subordinate his wishes to his family. He has to learn that the interest of the family comes first, and has to govern his actions with the family point of view in mind (Hammad, 1989).

The sex impulse in both men and women is strictly suppressed before marriage. Sexual relations outside of marriage are considered a great social ill and a behavior that is divisive and

undermines societal stability. As such, premarital and extra-marital sexual relations are considered highly shameful and blameworthy. Girls are expected to be virgins (physically intact) at their marriage. If either a man or woman is found to be unchaste, harm and shame comes to that individual and his/her family. Emphasis on sexual abstinence among girls is greater than among boys, as the girl's dignity normally represents the honor of her family.

While rates of pre-marital sex are very high in the general U.S. population, rates of pre-marital sex are quite low for Arabic youth. Because this is such a forbidden issue the health practitioner should take great care to ensure that a question regarding sexual behavior is absolutely necessary before it is asked. On one occasion a pediatrician asked his adolescent patient, a 14 year-old, Arab girl, if she had sex. The mother, upon hearing this question became irate at her daughter thinking that because the doctor asked this question he must believe that she had intercourse. It took several days to calm the family and the girl was still obviously upset. Even if the adolescent patients are alone, questioning about sex may be psychologically disturbing to the individual if they are unmarried.

Although Islam, the established religion of the community, allows a man to marry more than one wife at a time, few people practice plurality in marriage. Polygamy is the exception, not the rule in the Arab community. One of the most important factors that motivates a man to take a second wife during his lifetime is the first wife's inability to produce children. In exceptional social circumstances, the man may take a widowed woman as a second wife to provide for her security.

### **Time and Social Interchange**

It is important for the health professional to understand the Arab context of time and space, in order to respect the patient's perspective. The general pace of Arab social interaction tends to be slower and unhurried. Arab norms stress the importance of politeness and generosity in social interaction. Within this politeness is a well-developed system of etiquette for greetings and establishing new acquaintances. It is important for a health professional not to rush his or her contact with the Arab client. In fact, if a person wishes to rush a social transaction, the person will often be told "do not worry" or "do not be nervous". When a person visits an Arab home, the host is expected to greet the visitor in a most friendly and hospitable way. Commonly, the person is told *wahlan wa sahlán* meaning you are among your own people and (treading upon) common ground (Hammad, 1989). Gifts, food, and coffee are commonly exchanged and viewed as socially obligatory. If offered food or drink, a visitor should accept the offer with gratitude and consume it in its entirety.

On invitation to the home of an Arabic family the visitor is not expected to bring a gift though it is appreciated. The visitor should expect to drink coffee during his or her stay and may receive a gift before his or her departure. The visitor may feel uncomfortable receiving a gift as they are often things that were admired by the visitor while in the home. A person may say "that's a nice statue" and then be offered that statue later at which point it would be offensive to the family if the visitor refused to accept the gesture. Thus, one should be careful on how to express admiration.

This culture difference in expressing admiration need also be considered in admiring children or the spouse of an Arab individual. Whereas a pediatrician often says, "what a beautiful child" to complement the parents, that may potentially be taken as to exhibit improper, sexual connotation. A more appropriate comment would be, "what a nice child" or "you have a very nice wife" with regards to a spouse, which would be taken in a positive manner by the individual.

An outside health professional should seek to establish a relationship of trust with the entire family, not just the patient. A common attitude within hospitals is that the family is an obstructive burden to the patients' care. For Arab patients, it should be understood that the family's presence is highly emotionally supportive and important. Therefore, the health professional should make efforts to address both the patient and the family in interactions and should seek to develop their trust. Such a trust is not readily developed, but generally withheld from Arabs until they view the outsider's character. Once this trust is developed, however, the family can play an important supportive role in health therapy and place much weight on the physician's opinion.

Some consideration of the Middle Eastern context should be taken in order to understand current norms of Arab Americans. While many Arabs have immigrated to the United States as professionals seeking economic opportunity, a number of communities are essentially refugees. In the Dearborn Southend community, for example, the bulk of residents are forced emigrants from war and social upheaval in the Middle East. Many were previously agricultural workers living in simple rural situations. High rates of illiteracy and low educational achievement are observed within that population. Moreover, many have been forcibly separated from their family, and they still must support the from abroad family left behind in war situations. Economic pressure bears heavily on these individuals.

The rural existence in the Middle East is much less technological than encountered in the United States. Unintentional injuries might be expected in the United States to some extent from the lack of familiarity with new technology. Also, due to linguistic barriers, many are unable to read instructions for machines or to read pharmaceutical instructions.

Daily life tends to be very physically active in the Middle East. People commonly conduct their daily activities by foot and walk to visit neighbors and family. Agriculture is a predominant form of livelihood that requires physical labor from dawn to dusk. In transition to American life, many Arabs find themselves much less active than previously. Physical activity tends to be low among these immigrants and the idea of exercising for its own sake seems strange and foreign. Because of cultural modesty values, men and women tend to feel shy to exercise outside or in a mixed sex atmosphere, and few sex-segregated facilities exist for them.

Diet similarly changes in transition to American society. Many Arabs live on a diet that is largely seasonal in the Middle East. They consume a high fiber intake of fruit and vegetables locally grown in the summer and dried beans and pulses in the winter. Meat is considered a luxury and is consumed infrequently. After immigration, many Arabs find much greater access to meat and tend to consume it more often. They also encounter foods that are more often processed and high in fat. This is predictive of rising rates of diabetes, cardiovascular diseases, and certain cancers that did not previously affect these individuals.

### **Birth and Death**

Among Arabs, both birth and death are usually met with great community and family participation. Within both Islamic and Arab cultural norms, these two occasions are events in which support from the extended family unit and broader community are expected.

Arabs in the state of Michigan have the highest recorded natality rates of any sub-population in the state. A state statistic established Michigan's Arab American women's average total fertility rate (TFR) is over 2.5 and though this is high within the American context, it is significantly lower than the TFRs seen in many Arab nations where the number of offspring per family ranges from 4-7 children on average. Within Arab culture, there are a number of supporting factors associated with this observed high natality. As explained previously, children

are considered the foremost source of social security and stability for the parents in old age. Within Islam, there is a tradition that “every baby comes with his own provision”. This is supported by the Qur'anic verse (17:242) that states: “Do not abandon your children out of fear of poverty, We will provide for them and for you”. This is consistent with the view that every event for the individual from birth to death relies on God’s will. Such a conception tends to deter the use of birth control and subsequently increases the natality rate, though within Islamic legal interpretation the use of some forms of birth control is allowed. In general, both birth and death are not planned for because this is viewed as taking the will of God for granted.

Within Arabic culture, there is strong pro-natality. Respect is conferred on the individual by having a large number of successful children. For the women, the first birth is viewed as an important initiation into womanhood. The position of mother holds a great amount of respect among the Arabs. A tradition of the Prophet Muhammad states that “heaven is underneath the feet of mothers”.

The women during the prenatal period are strongly supported by the surrounding family unit. Numerous family members will participate in ensuring the women’s proper nutrition and offering advice. Smoking and alcohol consumption are strongly looked down upon during the pregnancy. The more traditional Arab women are not likely to participate in a hospital/health care provider mixed male/female prenatal education class. Health care providers must know that these traditional women do not mix with men in non-emergency circumstances.

Birth is normally considered a strictly feminine experience and lack of male participation in this experience (i.e. in the labor room) is normal and does not imply negligence. The typical supporting participant for the woman in delivery is the mother, sister, sister-in-law, or mother-in-law. For these expecting mothers appropriate partners for birthing classes would be these female relatives. Because of sex separation issues, a birthing class where any men were present would be uncomfortable for many Arab women. In pregnancies where the father would like to help his wife during the delivery classes may have to be done in a one-on-one fashion or the couple could be left alone to learn with the aid of a birthing video in the Arabic language.

Modesty is an important consideration in the birth space. Many Arab women are extremely uncomfortable delivering without clothes. Families might request the hospital to provide a female ob/gyn to supervise the delivery; this implies that those families do not wish to have any male staff in the birth room. Health care providers should ask Arab American clients of this preference and make prior arrangement to provide a female-only team (for both Arab Muslims and Arab Christians).

The mother and child in the post-natal period are additionally supported by a number of family and community members. Breastfeeding is traditionally encouraged within Arab societies. Islam exhorts women to breast feed her child for two years. In the post-colonial period, Western advertising promoted the idea that infant formula was more beneficial to the child, and perceptions of formula feeding became associated with cosmopolitan living among urban residents.

Death is considered the point at which the individual’s actions in this life are sealed and sent forward to the afterlife for judgment. For Muslims, prolonging a person’s life in this world with no possibility of further action is seen as futile and an interference with the person’s passing to judgment. Islam’s legal position on life support is neutral, but it is probably discouraged after the possibility of recovery is diminished. Death is not prepared for with prior funeral arrangements and for a physician to suggest that preparations should be made before a patient dies is viewed as incompetence on the part of the doctor and interference in God’s will. At the

death of a patient, it is considered disrespectful for the health care professional to bypass the elder figure of the family and inform a spouse or other younger members of the family unit.

Arabs view the dead as having returned to God. The tradition exhorts Muslims to bury the dead quickly and with utmost respect and dignity (Note: Many Christian Arabs also bury their dead quickly- often on the third day in commemoration of the concept of the resurrection). At the time of death in a Muslim family, witnesses may encourage the dying patient to recite the *shahadatan* (testimony of faith) and may read Qu'ran over the individual. At death, the body is cleaned and perfumed by the family and wrapped in a simple white garb. This simple preparation is symbolic of the fact that Muslims believe that at birth and death, every human is equal, coming to the world with no possessions and leaving with nothing but the record of their deeds.

Autopsies are often refused and Arabs consider them disrespectful to the dead. An Arab family will tend to react with hostility toward pressure from physicians to consent to an autopsy and will become more suspicious with additional pressure. Embalming is only consented to if the body is to be flown overseas for burial. Cosmetic preparation of the body is not considered acceptable. Muslims often prefer not to die in the hospital due to fear that they will not receive proper funeral (*janaza*) treatment. This *janaza* includes the requirements of burying the dead with utmost respect as close as possible to the same day of death with washing, perfuming (*attar*), visitation of the dead by family and community, and group participation in their burial.

Death is an occurrence that is viewed as a community obligation in which all community members that are aware of the death must participate. Health care providers should expect a number of people to be present after the death of the patient and these individuals will want to remain with the body and assure a prompt release from the hospital for preparation and burial. Feelings are very vocally and openly expressed after death, but not before. People stay with the body until it is ready for transportation from the hospital. They begin the grief process by counseling the deceased's closest relatives. Wailing and gasping is a common reaction in grieving. If the patient who dies is young, the grieving process requires more time and significance. The death of young parents who leave small children behind is particularly traumatic with the loss of the children's primary support system. Similarly, the death of a child is a tremendous loss that is surrounded by extensive grieving.

The concept that Arabs value life less than Americans is an incorrect stereotype. However, there is a different world view and a greater acceptance of the will of God. All events *kharyun ow sharr*, happen according to the will of God. Part of being Muslim is submission to the will of God and acceptance of fate. Sickness is also the will of God. The day of your death is written for you at birth and all of life happenings are written on the Preserved Tablet. However, Arab people are also pragmatic. There is an old Arabic saying: "trust in God but tie your camel first".

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## Appendix A: Other Salient Background Features Related to the Middle East

### A Primer of Concepts

a. **'ayb** : The role of shame in motivation of Arab behavior. Individuals are inseparable from their family unit in the Arab world and the family is the ultimate source of allegiance and the ultimate measure of success. Disease is considered a mark of imperfection or weakness that reflects on the entire family even to the extent that family members might be unmarriageable. Disabilities and mental disturbance are the most prominent elicitors of *'ayb*-oriented behavior. Arab culture holds an expectation of perfection, particularly physically.

b. **perception of mental illness**--punishment from God for the sins of the individual or his family, touched by *jinn* (usually perceived as malevolent spirits), or ridden by the devil. Mental illness is shunned. It is not uncommon to see a reluctance to send a disturbed family member to an asylum or for treatment out of desire not to recognize and disclose the problem.

c. **non-recognition of chronic disease**--stigma, *'ayb*-oriented. Chronic diseases like cancer, diabetes are considered hereditary and reflect on the whole family. There is also a fear of reducing the marriageability of children by disclosure of these kinds of illnesses.

d. **belief in unseen forces**: Arabs from the Middle Ages theorized about the germ theory and it is well established within our consciousness. However, there is also an acceptance that unseen forces may cause disease such as *jinn*, by the evil eye. While *jinn* are feared as malevolent and capricious spirits that may cause illness and other evil, the evil eye can best be understood in the context of fearing the envy of others which may also be the cause of sickness or even death.

e. **deep seated respect for age and expertise**-- respect increases with age and authority. Doctors do receive a great respect and trust. Arab patients submit to that authority without questioning. This contributes to the low rate of medical-legal cases among Arabs. Perception that the doctor is incompetent or not trustworthy will not result in an open confrontation/discussion with the doctor, but instead will result in noncompliance with his directions.

f. **alternative healing**: a long tradition of treatment exists in the Arab world. The Arabs have a system of healing tradition that is over 3,000 years old, including herbalism and conception of the body as a unified system composed of interacting humors. While the Western approach is to look for the smallest particular cause, the Arab system looked for the imbalance in the body as a whole. Problems like gastrointestinal disorders, fevers, headaches, orthopedic difficulties, and fractures all have a well-established traditional approach for their alleviation. Bonesetters are considered better than orthopedic doctors in the Middle East. Traditional midwives are well skilled in the Arab World.

g. **concept of time**: In Arab culture, time is not linear and is not constricted in the way that it is in the West. Not tomorrow at 9:30AM but *insha 'Allah*" (God-willing) I'll see you before lunch. Lateness is accepted and anger about it is not understood.

h. **Arab family structures:** Extended family structure is the most common form for Arab families. There are four types of family organization: nuclear (mother, father and children found in the minority of Arab households), extended (which may also include grandparents, aunts, uncles, and cousins), *hammula* (3-4 extended families) and *qabila* (4-5 *hammulas* ).

i. **role of the family in decision making:** The consideration of the welfare of the family takes precedence over individual considerations. Indeed, the American focus on individuality is seen as verging on pathological behavior in the Arab world. Because of the supremacy of the family, decisions are more likely to be made collectively in Arab families. Both the considerations of the family and the individual are carefully weighed. Older males, the patriarchs, of families may be asked to make health decisions for an individual family member. This role of the family complicates informed consent and confidentiality issues.

j. **position of men, women, children, elderly in the family--**men's power and influence is in the external realm, while women control the internal matters of the household. Elderly enjoy final power and respect for consultation and guidance. Children are not participants in family decisions and are expected to be obedient to the family elders.

k. **marriage:** Premarital sexual relations are considered shameful, dirty, and sinful. Marriage is a prerequisite for respect and consideration as a mature member of the society.

l. **health risk behavior:** smoking, diet, exercise--Arab culture is supportive of many risk behaviors that are not considered within the context of good health. Smoking is considered both part of manhood and of generosity. Cigarettes are offered like tea and coffee as a matter of hospitality. The Arab diet in the Arab World is considered to be healthy with a tendency toward high fiber, lots of fruit and vegetables, and fresh daily preparation of food. Meat is emphasized as good, but is generally restricted by cost. It is not a part of Arab consciousness to consider diet as a contributor to bad health. Similarly, Arab lifestyle is active due to the nature of life activities (70% rural, family visits, and walking).

Consequently, aerobics and exercise machines are considered foreign and silly. However, after immigrating to the United States, The Arab diet and lifestyle changes. The consumption of meat, snacks, fat, and sweets increases while the amount of exercise declines leading many Arab Americans, especially the elderly, to suffer from obesity, high cholesterol, and other related illnesses (Hassoun 1995).

m. **primary health care access in the Middle East and preventive service utilization:** health services and education are free and accessible in the Arab countries, but quality varies. This is why the rate of medical insurance is very low, since it is not thought of as a requirement for health care. Medical services are generally only sought when the individual is acutely sick. A doctor who does not perform some invasive procedure (injections, clinical tests) or does not prescribe medications is considered incompetent.

n. **political and social background:** organizational structures and affiliation--Arabs in the United States have a variety of national differences compounded with a wide variety of political, social and religious underpinnings. Also, social stratification exists along class and urban/rural/refugee camps.

## **Appendix B: Arabic Phrases**

|                 |                     |
|-----------------|---------------------|
| Ahlan wa sahlān | Welcome (greeting)  |
| Marhabah        | Hello               |
| Keef Halak      | Hello, How are you? |
| Mabsut          | Good (Happy)        |
| Mneeh, wa ente  | Fine, and you?      |
| Esmee...        | My name is ...      |
| Naam            | Yes                 |
| Lah             | No                  |
| Shukran         | Thank you           |
| Afwān           | You're welcome      |
| Maa al salama   | God-Bye             |
| In'sha Allah    | God-willing         |

## Appendix C: Tables

**Table 1. Health Statistics from the Arab World**

| Country                    | Life Expectancy at Birth (1990-94) <sup>a</sup> | IMR (1990-1994) <sup>a</sup> | TFR (1990-1994) <sup>a</sup> | GNP per Capita (1990) (US\$) <sup>b</sup> | Total Illiteracy (%) <sup>b</sup> | Female Illiteracy (%) <sup>b</sup> | Population (millions) (1991) <sup>b</sup> | Urban (%) (1991) <sup>b</sup> |
|----------------------------|---|------------------------------|------------------------------|---|-----------------------------------|------------------------------------|---|-------------------------------|
| Algeria                    | 67.5  | 54                           | 4.19                         | 1,980                                     | 55                                | 43                                 | 25.6                                      | 52                            |
| Bahrain                    | 74.4  | 23                           | 5.38                         | 7,130                                     | 31                                | 23                                 | 0.5                                       | 83                            |
| Djibouti                   | 49.0  | 112                          | 6.50                         | 1,210 <sup>c</sup>                        | --                                | --                                 | 0.5                                       | 81                            |
| Egypt                      | 66.0  | 68                           | 4.87                         | 610                                       | 66                                | 52                                 | 53.6                                      | 47                            |
| Iraq                       | 65.2  | 63                           | 5.83                         | 2,140                                     | 51                                | 40                                 | 18.7                                      | 71                            |
| Jordan                     | 67.9  | 34                           | 5.87                         | 1,050                                     | 30                                | 20                                 | 4.1                                       | 68                            |
| Kuwait                     | 78.3  | 9                            | 5.96                         | 16,160                                    | 33                                | 27                                 | 2.1                                       | 96                            |
| Lebanon                    | 75.9  | 28                           | 2.99                         | 2,150                                     | 27                                | 20                                 | 2.8                                       | 84                            |
| Libya                      | 63.1  | 68                           | 6.66                         | 5,310                                     | 50                                | 36                                 | 4.7                                       | 70                            |
| Mauritania                 | 48.0  | 117                          | 6.50                         | 510                                       | 79                                | 66                                 | 2.1                                       | 47                            |
| Morocco                    | 67.2  | 66                           | 3.59                         | 1,030                                     | 62                                | 51                                 | 25.7                                      | 48                            |
| Oman                       | 65.0  | 54                           | 6.42                         | 6,120                                     | --                                | --                                 | 1.6                                       | 11                            |
| Qatar                      | 72.0  | 21                           | 5.54                         | 14,770                                    | --                                | --                                 | 0.4                                       | 89                            |
| Saudi Arabia               | 69.0  | 56                           | 6.85                         | 7,820                                     | 52                                | 38                                 | 15.4                                      | 77                            |
| Somalia                    | 47.1  | 122                          | 6.60                         | 120                                       | 86                                | 76                                 | 8.9                                       | 36                            |
| Sudan                      | 51.8  | 99                           | 6.26                         | 420 <sup>c</sup>                          | 88                                | 73                                 | 25.9                                      | 22                            |
| Syria                      | 63.6  | 44                           | 5.56                         | 1,160                                     | 49                                | 36                                 | 12.8                                      | 50                            |
| Tunisia                    | 67.8  | 36                           | 3.18                         | 1,500                                     | 44                                | 35                                 | 8.2                                       | 54                            |
| United Arab Emirates (UAE) | 75.0  | 22                           | 5.99                         | 20,140                                    | --                                | --                                 | 1.6                                       | 78                            |
| West Bank and Gaza         | 68.7  | 33                           | 7.82                         | --  | --                                | --                                 | 1.6                                       | 51                            |
| Yemen                      | 49.0  | 117                          | 8.62                         | 520                                       | 74                                | 62                                 | 12.1                                      | 29                            |
| Total                      | 63.4  | 68                           | 5.37                         | --  | --                                | --                                 | 228.9                                     | 59                            |

IMR – Infant Mortality Rate; TFR – Total Fertility Rate; GNP – Gross National Product

a- Courbage and Khlal [1993] in Deeb and Sayegh, 1997.

b- UNDP, World Development Report [1993] in Deeb and Sayegh, 1997.

c- UNICEF, State of the World's Children [1994] in Deeb and Sayegh, 1997.

**Table 2. Median Age at Marriage by Age Categories in Arab Countries**

| Country                    | Year    | Age Bracket |       |       |       |       |       |
|----------------------------|---------|-------------|-------|-------|-------|-------|-------|
|                            |         | 20-24       | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 |
| Bahrain                    | 1989    | --          | 22.5  | 19.9  | 17.9  | 15.6  | 14.8  |
| Egypt                      | 1991    | 20.3        | 19.0  | 18.4  | 18.0  | 17.6  | 17.1  |
| Jordan                     | 1990    | --          | 21.2  | 19.7  | 18.8  | 18.9  | 18.9  |
| Kuwait                     | 1987    | --          | 19.1  | 18.7  | 18.0  | 17.3  | 17.1  |
| Morocco                    | 1987    | --          | 19.9  | 18.9  | 18.1  | 16.8  | 16.3  |
| Oman                       | 1988    | 16.2        | 15.7  | 15.6  | 15.2  | 15.0  | 14.7  |
| Qatar                      | 1987    | --          | 21.4  | 18.0  | 16.6  | 16.5  | 15.9  |
| Saudi Arabia               | 1987    | 20.3        | 18.1  | 17.2  | 16.5  | 16.5  | 16.6  |
| Sudan                      | 1989-90 | --          | 20.5  | 18.1  | 16.4  | 15.8  | 16.3  |
| Tunisia                    | 1988    | --          | 22.8  | 21.3  | 20.6  | 19.4  | 19.9  |
| United Arab Emirates (UAE) | 1987    | 21.0        | 17.7  | 16.8  | 16.3  | 16.0  | 16.2  |

Source: Al-Qudsi, S. (1997)