ARAB AMERICANS AND THE INVISIBLE HEALTH CRISIS

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ABSTRACT

The Social Determinants of Health (SDH) Framework posits that structural factors including (1) economic stability, (2) neighborhood and physical environment, (3) education, (4) food, (5) community, safety, and social context, and (6) the health care system affect the health outcomes of populations. Informed by the SDH framework, this essay assesses the health of Arab Americans who are an invisible minority due to their required White designation on the U.S. Census. Arab Americans comprise approximately 3.7 million of the U.S. population and the population continues to grow. While limited research has examined their health and wellbeing; fewer studies have focused on interventions aimed to promote their health. This paper relies on the sparse existing literature on Arab Americans to evaluate how socioeconomic, physical, and mental health factors contribute to poor health outcomes among this population. Moreover, this paper builds on existing research with other ethnic populations to assess potential policy and practice recommendations that can be implemented to promote Arab Americans' health.

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INTRODUCTION

Arab Americans are one of the multiple ethnic groups who contribute to America's melting pot. Upon migrating to the United States Arabs are forced to identify as White by the American government. This White designation on the U.S. Census makes it impossible to identify individuals of the Arab American population, thus making them an invisible minority. When Arab Americans are forced to mark 'White', this decreases the resources for Arab Americans and makes them unidentifiable when examining health outcomes. In other words, since Arab Americans are difficult to identify, their health is adversely affected. Most recently, the COVID-19 pandemic has made it clear how there are no opportunities for patient-centered care since there is no medical research funding to understand the health of these Arab Americans and the communities in which they live. Arab communities in the U.S. have significant COVID high-risk factors (i.e diabetes). However, according to Arab American physicians, nurses, and scientists, it is difficult to understand exactly how many Arab Americans and other people with roots in the Middle East or North Africa (MENA) have been impacted by the COVID-19 pandemic (*Arab American News).* There is no way to measure the population, especially with their 'White' designation on the U.S. Census. For the scope of this project, the overall health of Arab Americans will be examined using the Social Determinants of Health (SDH) Model. Unfortunately, since Arab Americans have little research conducted on specific health outcomes due to lack of data, examining their health from a broad and overall health lens is the objective of this paper.

WHO ARE ARABS?

Arabs are one of four main cultural groups which comprise the Middle East and North Africa (MENA) region, with the other groups being Persians, Turks, and Jews (Kayyali, 2006). The Arab World comprises 22 different countries that are located in the southwestern part of Asia and North African region (Saeb, 2021). The 22 countries are Lebanon, Syria, Jordan, Iraq, Palestine, Algeria, Morocco, Tunisia, Egypt, Sudan, Libya, Mauritania, Djibouti, Comoros, Somalia, Saudi Arabia, Kuwait, Bahrain, Qatar, United Arab Emirates, Oman, and Yemen (Kayyali, 2006). These countries have declared Arabic as their national language (Saeb, 2021) and there are approximately 270 million people who speak Arabic in the world.

While Arabs in the Arab World speak Arabic as the primary language, Arab Americans of various generations do not state Arabic as their native language. This, along with the White designation for race have made it difficult to identify how many Arabs reside in the United States to guide data analysis and needs assessment (Eraqi, 2014). According to Awad (2010), the lack of understanding and recognition of this minority by the US government continues to yield unauthentic data statistics. It was not until recently that 'MENA', or sometimes 'SWANA' (Southwest Asian/ North African) has been an available category for ethnicity on college applications, censuses, and health forms for certain states, yet this data is inconclusive as this designation or category is not consistent across the United States (Saeb, 2021). Until the required White designation is revised for Arab Americans, they will continue to be the invisible minority losing access to basic services reserved for certain minorities, including patient-centered care specific to the health issues surrounding this population (Awad, 2010).

There are approximately 3.7 million Arab Americans who reside in the United States. According to the Arab American Institute, "Arab Americans are found in every state, but more

than two thirds of them live in just ten states: California, Michigan, New York, Florida, Texas, New Jersey, Illinois, Ohio, Pennsylvania, and Virginia. Metropolitan Los Angeles, Detroit, and New York are home to one-third of the population." Out of the main three metropolitan cities, Detroit is home to the largest number of Arab Americans in the nation. Since the US census identifies anyone who comes from a country that has Arabic as the national language as White, there is not enough data to analyze for this minority group who remains invisible (Saeb, 2021). Yet for Arab Americans who value education and are active members in all facets of American life, this visibility is overshadowed by the lack of recognition for their racial and ethnic identity in the American narrative. As Saeb shares, "Imagine being one of the most nationally visible, yet highly invisible [...] populations in America and that is the reality for Arab Americans" (p. 30).

Arabs in the United States are defined as one category based on a misconception that they are monolithic; however, this adds to the challenges surrounding identification and health outcomes. According to Abboud et. al (2019), "Arabs are diverse in terms of nationalities, religions, and ethnicities. The conflation of 'Arab' with 'Middle Eastern' and with 'Muslim' undermines the unique characteristics of these three categories, in particular regarding to their health and health disparities.

IMMIGRATION TO THE UNITED STATES

Arabs are a religiously diverse population group united by a common language with different dialects of the vernacular but share an identity that is unique to the heterogeneous region from which they emigrated (Kayyali, 2006). There were four waves of immigration based on the sociopolitical, economical, and governmental climate of the Arab countries for these immigrants entering the United States (Eraqi, 2014). The first Arabs that immigrated to America were from Syria and Lebanon in the 1860's (*California Department of Education*, 2021). The

first group was primarily made up of Christians who were fleeing war in their homelands and who wanted to pursue economic opportunities. These immigrants were Christian laborers, farmers, and merchants that emigrated from Syria and Lebanon for more economic stability (Awad, 2010). They quickly assimilated into American society but did not add to the education sector. For example, the famous Muscle Beach south of the Santa Monica pier is home to Khoury's Café, a café owned by Arabs from Lebanon. Roughly 95,000 Arabs were a part of this group and most of them became business or merchant owners.

The second wave of immigration was after World War Two in 1940s-1960's which included more Christians and some Muslims, who were highly educated and had positive influences on the education sector (Kayyali, 2006). This group was made up of lawyers, scientists, engineers, doctors, etc. This was also called the brain depletion of the Arab World. Since highly educated Arab Americans were leaving their homelands to go to the United States, there was a permanent depletion of professional resources and highly skilled laborers from their homelands (Eraqi, 2014). This group of immigrants emigrated from Jordan, Egypt, Palestine, and Iraq and provided the foundation for the next group of immigrants that would follow from other countries.

The third wave of immigration began in the 70's and was comprised of Arabs fleeing their homes from persecution and wars such as in Iraq, Syria, Egypt, Lebanon, and Palestine. Most of their home countries were politically unstable, so they were coming to the United States seeking economic and educational opportunities (Eraqi, 2014). The fourth wave of immigration occurred in the 2000s, however what distinguished this group of immigrants was the negative stereotyping and anti-Arab sentiments as a consequence of the September 11, 2001 attacks. The

discrimination Arab Americans face after September 11, 2001 will set the stage for further discrimination that affects their health and their quality of care.

HEALTH STATUS AMONG ARAB AMERICANS

According to Laffrey et. al (1989), the predominant illnesses that Arab Americans continue to experience were "upper respiratory infections, cardiovascular and hypertension, diabetes, and family and social stress." A high prevalence of diabetes and tobacco use among Arab Americans comprise the major cardiovascular disease risk factors. Furthermore, as cited in Timraz et. al (2016), "A recent study sponsored by the American Diabetes Association documented a 15.5% prevalence rate of diabetes among the Arab American population, compared to 5%– 8% found in the general population." Thus, it becomes clear how diabetes is a prevalent health concern among this ethnic population. As the Social Determinants of Health model is explored, it becomes clear how the poor health of Arab Americans is partially due to the limited access to knowledge of symptoms, treatment, and prevention.

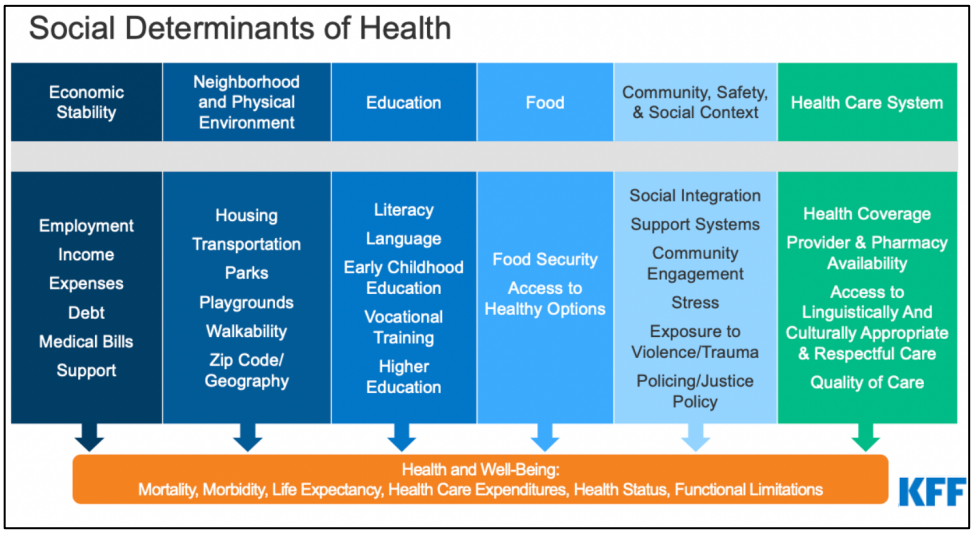
ARAB AMERICAN HEALTH CRISIS: SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

As defined by the World Health Organization (WHO), the Social Determinants of Health refers to the "conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels." Ultimately, the Social Determinants of Health (*Figure 1*) is a framework which is used to understand the health and well-being of populations, with focus on six categories: (1) economic stability, (2) neighborhood and physical environment, (3) education, (4) food, (5) community, safety, and social context, and (6) the healthcare system. By using this framework,

one can identify which sectors contribute to the Arab American health crisis and evaluate what policies can be implemented to better address the needs of the Arab American population.

Figure 1

The Social Determinants of Health Framework



Food

From a SDH framework perspective the focus is on food security; however, much of the research on food consumption among the Arab American community has been framed from a cultural framework. That is, how do cultural practices inform food preferences and practices around food. One area where this research has been developed is in response to diabetes. Arab Americans suffer from multiple health concerns, however a popular one among this population is diabetes. According to Bertran et. al (2015), "Detroit [is where] 80% of Michigan Arab Americans live [and] 18% of metropolitan Detroit Arab American adults are affected by diabetes". The authors also explain how despite Arab Americans suffering from this disease, they receive "suboptimal care and achieve fewer treatment goals compared to the national

average", which they suspect is due to the frequent health disparities within this immigrant health group. Since Arab Americans are often overlooked on Censuses and other population indicators, they are an underrepresented and invisible minority. With that being said, the true statistics of Arab Americans who are prone to and suffer from diabetes could be much higher. One female in the study conducted by Betran et. al (2015) shared how prominent carbohydrates are within their diet. She shares how they, meaning Arabs, eat in the United States like how they would in their home country. The female expresses how "In [their] home, legumes, lentils, and chickpeas and bulgur" are eaten, but they do not participate in the consumption of canned foods or restaurant dining. Unfortunately, since carbohydrates are so prominent in the diets of Arab Americans, it puts them at a higher risk for obesity and even diabetes.

Within Arab American culture, food is considered a main focal point of their hospitable nature and even a part of their identity. Food is an essential part of Arab American culture, especially for women. In a journal piece written by Dr. Shireen Shihab Hamad (2018), she explores the way food is a defining point in one's culture and identity, with a focus on Arab Americans. Hamad shared how in one literature piece, the character "keeps serving such dishes to her friends in college to prove and show her Arabic culture" and how the "bread sat skyscraper high on plates at either end." With how important it is to know how to cook within the Arab culture and the prominent presence of carbohydrates, it is hard for Arab Americans to combat the likelihood of obesity, diabetes, and even other metabolic diseases. According to Feinman et. al (2015), "During the epidemics of obesity and type to diabetes, caloric increases have been due almost entirely to increased carbohydrates". Aside from simply the presence of carbohydrates within the Arab American diet, portion control is another factor in play with increased health risks. Another female within the study by Betran et. al (2015) explained how

Arabs typically do not follow the 'American way' of going out to eat at restaurants, claiming "it is not healthy". So, Arab Americans typically opt to cook at home instead to avoid this 'unhealthy American food'. However, as another female in the study shares, "the problem [is] that we cook in big quantities…because we love our kids and the family…we are like 'come on, eat' […] used to make my kids big plates until they became fat…" (Betran et. al, 2015). As aforementioned, the current research surrounding Arab American health in regard to food is from a cultural framework perspective. However, the lack of assessment on the effect of food as a structural component hinders the potential implications of food insecurity or even access to healthy food options on Arab Americans. For example, one can explore if the heavy carbohydrate diet is solely a cultural component which is affecting their health, or if it is also since carbohydrates are the most convenient or readily available food source. This can also be in conjunction with neighborhood and location of residency. In areas which are heavily populated by Arab Americans, one can explore the food options within that area. For Arab Americans, this cultural lens on food is directly related to the health disparities they face, such as diabetes and obesity. However, much research is still to be done on the structural component of food on Arab American health.

Community and Social Context

In the United States, it is commonly incorrectly assumed that all Arabs are Muslims and are represented with negative stereotypes and stigma (Awad, 2010). Contrary to this popular belief, 70% of Arab Americans are actually Christians, while the remaining 30% practice Islam. In fact, in the Arab World itself, only 20% of the 1.5 billion Muslims worldwide reside in the Arab World. This lack of understanding of the religious dichotomy causes Americans to classify

all Arab Americans as being Muslim. After September 11, 2001, Arab Americans became the target for discrimination and increased surveillance by the government. According to Padela and Heisler (2009), the researchers contend that the events of September 11, 2001 negatively impacted Arab Americans constantly facing discrimination and abuse. Moreover, the researchers classified abuse and discrimination within three areas: (1) psychological stress, (2) level of happiness, and (3) health status with their population being Arab Americans in the Detroit area. According to their findings, "25% of respondents reported post- September 11 personal familial abuse, and 15% reported that they personally had a bad experience related to their ethnicity". These statistics correlate with the depression, anxiety, psychological distress, and other mental health factors caused by the lack of respect that Arab Americans feel from U.S. society.

Mental health is directly linked to one's psychological well-being and distress. Fischer and Shaw (as cited in Moradi & Hasan, 2004) found that the link between "perceived racist events and mental health (operationalized as a single measure that collapsed psychological well-being and distress) was stronger for those with high self-esteem than for those with low self-esteem." Self-esteem has also been correlated with a person's self-identification and worth. Because Arab Americans must identify as White on the U.S. Census, they are placed in between two cultures and perceptions. Moreover, when Arab Americans visit their ancestral homeland, they are viewed by their society as being 'too White/American' yet in America, they are viewed as foreigners. According to Abdulrahim and James (2012), while "not all Arabs report discrimination at the same level, those who [do] experience discrimination are equally affected" no matter the level or degree of discrimination experienced; there remains a positive association between psychological distress and racial/ethnic discrimination. The researchers further support the claim that the overall health of Arab Americans, especially mental health, is affected through

discrimination and stress. As Arab Americans continue to face discrimination and the generation gap between their children, stress continues to be an important factor which is detrimental to their health. Moreover, the lack of Arab speaking health providers and health education for these groups contribute to their health outcomes. This limited health education coupled with their need to provide for their families lead to a lack of understanding on proper self-care, nutrition, and overall lifestyle.

Healthcare System

Arab Americans suffer from language barriers within the healthcare system and cultural differences. These cultural differences include patriarchal beliefs in which the healthcare provider can only communicate with the head of the household male. This communication is still lacking as some of these males have limited English proficiency. According to Shamsi and Almutairi (2020) share "Language barriers are responsible for reducing the satisfaction of medical providers and patients, as well as the quality of healthcare delivery and patient safety". If Arab Americans, especially those lacking proficiency in the English language are unable to understand healthcare professionals, then they are automatically disadvantaged, and their overall health is affected through this lack of access. According to Betran et. al (2015). "This [health] disparity is attributed […to] cultural norms and health behaviors". Thus, the language barrier and lack of access to interpreters for Arab Americans affect their overall health and access to healthcare.

Arab Americans are unable to express to their healthcare professionals what their needs are from a health perspective and what struggles they are facing. Similarly, Arab Americans are unable to understand the advice given to them, even if they can translate their needs. This is

supported by Jumaili et. al (2020) who shared that Arabic-speaking immigrants self-rated their health lower than Arab immigrants who were either born in the U.S. or were English-speaking immigrants. Their study thus suggested language barrier as a contributing factor to healthcare access (or lack thereof), healthcare quality, or their overall health status. Regarding language as a factor to healthcare, the authors looked at (1) language barrier, (2) interpreter need, and (3) health literacy level. Jumaili et. al (2020) concluded that there was a positive correlation between health literacy and education level. They state: "[…] the perception of language as a barrier to healthcare was found to associate positively with the level of education of the participant such that those with college education and higher have no issues with comfortably communicating in English." (Jumaili et.al, 2020). Despite only 16% of participants perceived having a language barrier this was typically a result of education and not too reliant on the presence or availability of an interpreter or translation services. Consequently, Arab Americans whether born or naturalized in the U.S. continue to be at a disadvantage in a healthcare system which systematically discriminates against them, thus affecting their overall health.

Education

The education level is another factor which contributes to the overall health of Arab Americans. To demonstrate the degree of which Arab American health is affected by their education level and health literacy, Saad et. al (2020) found a direct link from the level of education on understanding colorectal cancer (CRC). The researchers found that the U.S. national average of people who know the different types of screenings for colorectal cancer is 57.3%, compared to the small percentage of 22% of Arab American study participants. The researchers further share "32% of Arab Americans knew what the FOBT was, 49% knew what

the colonoscopy was and 7% knew what the sigmoidoscopy was [compared to] a national sample [where] 73.7% of [U.S.] participants had heard of FOBT and 84.3% had heard of sigmoidoscopy or colonoscopy." It is alarming how low these statistics are for Arab Americans compared to the U.S. national averages, especially with a health concern as serious as cancer. The high statistics of cancer in Arab Americans does not stop at just colorectal cancer. A study conducted by El-Sayed and Galea (2009) demonstrates that Arab Americans "had 36% greater proportions of liver cancer, 44% greater thyroid cancer, 29% greater leukemia, 28% greater brain, 25% greater kidney, and 24% greater bladder cancers compared to non-Arab whites. They had 25% less skin melanoma, 27% less esophagus and 20% less oral cavity cancers than non-Arab whites." Their cancer statistics of Arab Americans are much higher than non-Arab whites which is strongly speculated to be due to lack of education in health literacy, especially on the specific cancers. This includes preventative measures of cancer, treatment of cancer, and the overall warning signs of cancer. Since some of the Arab American population is less educated on the overall processes of cancer screening, prevention, and care, they are more prone to poorer health.

Economic Stability

Another factor of the Social Determinants of Health model which applies to Arab Americans is economic stability. As Arab Americans strive to provide a comfortable lifestyle for their families and often times meeting their basic needs, they may not have access to insurance nor take the time to lead a healthy lifestyle. Sarsour et. al (2010) assessed the health status, needs, behaviors, and access to services of Arab Americans. The researchers found that "one quarter were unemployed. Over 50% reported household incomes below poverty level. Nearly 30% had no health insurance". In addition, they also found how "43% reported problems in

getting health care, including ability to pay, language barriers and immigration" which further addresses economic (in)stability within the Arab American immigrant population. Typically, one would assume the higher the education level, the higher the socioeconomic status. For Arab Americans, generation is another factor in play. According to Abuelezam et. al (2019), health outcomes typically improved with "subsequent immigrant generations, suggesting that socioeconomic factors and other social determinants may have a significant impact on health [for Arab Americans]." In addition, they discuss how first-generation Arab American immigrants were older and more educated but were more likely to be "unemployed and live below the federal poverty level" in comparison to second-generation Arab Americans. Moreover, these first-generation Arab Americans or those still awaiting citizenship have limited access to hospitals, physicians, and other specialists, thus leading to difficulties in providing necessary patient-centered care (Walid, 2007).

Neighborhood and Physical Environment

The final factor of the Social Determinants of Health (SDH) Model which contributes to the health of Arab American immigrants is the neighborhood and physical environment. Arab Americans live in predominantly metropolitan areas, such as Los Angeles, New York, and Detroit. These environments are typically heavily racially and ethnically diversified, so it is helpful for Arab Americans to be around other non-White individuals due to cultural similarities. However, there are cultural and environmental risk factors which come from living in these metropolitan areas. For Arab Americans, asthma is a common health issue with living in these metropolitan areas. Johnson et. al (2005) examined asthma prevalence and severity among Arab Americans living in the Detroit area. The researchers demonstrate how socioeconomic status is a

factor with environment and asthma prevalence or severity. However, they also showcase how factors such as English fluency and birth in the United States also can affect healthcare access and behaviors consistent with asthma management and prevention. Moreover, they found "a significant relationship between asthma prevalence and degree of acculturation", meaning that "asthma prevalence was highest among moderately acculturated immigrants compared with new immigrants" who just migrated to the United States. Based on their findings, it is clear how living in these metropolitan areas, such as Detroit, affects the health of Arab Americans and in this case affects their asthma prevalence and severity. However, there is this added factor of their degree of acculturation, especially if one were to examine ethnic enclaves. If Arab Americans live in ethnic enclaves, they have a lower degree of acculturation with the dominant populations.

Consistent with these findings, Johnson et. al (2010) also examined the environmental and socioeconomic factors which Arab Americans face when it comes to asthma and hypertension. The researchers used the environmental risk index (ERI) to establish any connections between asthma and the environment. They also used the ERI to establish if hypertension and environment had any correlation. The ERI includes factors such as pollution in the area, humidity, cold temperatures, etc. The results showcased "the relationship between ERI score and asthma was consistent with the goal of developing the environmental risk index to assess household environmental risk factors for asthma". Therefore, the higher the ERI score, the less likely it is to have environmental risks which could contribute to asthma. The researchers broadly stated that "poor housing quality, high levels of pollution, barriers to quality health care and other risk factors found in urban immigrant reception areas such as Detroit, Michigan [could cause] significant health impacts, particularly among vulnerable populations" which include Arab Americans. The aspect of the neighborhood and physical environment from the SDH model

is intertwined with their economic stability/ socioeconomic status and even their communities, as Arab Americans. As research continues to be conducted on Arab American health, it should be interesting to see if the findings of Johnson et. al (2005) and Johnson et. al (2010) are consistent in other metropolitan areas, such as Los Angeles and New York.

IMMIGRATION AS A SOCIAL DETERMINANT OF HEALTH

The health outcomes of Arab Americans, in most respects, are consistent with the *immigrant health paradox*, from a cultural framework this concept is used to demonstrate that individuals' health declines with their duration in the United States and increase acculturation. As cited in Abdulrahim and Baker (2009), "a large number of studies reveal that immigrants are healthier than their U.S.- born ethnic counterparts and that their health deteriorates with longer residence in the U.S." which perfectly explains the immigrant health paradox. As an immigrant, these Arab Americans have another factor which contributed to their health, in addition to the six from the Social Determinants of Health model. Immigrants face another barrier to health which is their immigration status. However, since such little research exists on the specifics of Arab American health due to the lack of proper representation, it is difficult to establish the degree to which immigration status affects Arab American health. One can assume that Arab Americans follow similar trends as other ethnic populations, however due to the lack of more research and research from a structural framework, it is not certain if Arab Americans follow the immigrant health paradox. Many studies instead focus on acculturation (cultural framework) and the knowledge of the language, which in the case of the United States would be English. So, to better understand Arab American health through the lens of immigration as a social determinant of health, research conducted from a structural framework would prove to be beneficial.

POLICY RECOMMENDATIONS

In order for Arab Americans to be accurately represented and served by the healthcare system, the first policy that must be instilled is in regard to the U.S. Census. When indicating race, individuals are asked to choose which race with which they identify. The U.S. Census only has the following options: (1) American Indian and Alaska Native, (2) Asian, (3) Black or African, (4) Hispanic or Latino, (5) Native Hawaiian and Pacific Islander, (6) Not Hispanic or Latino, (7) Some Other Race, (8) Two or More Races, and (9) White. These categories exclude Arab Americans who do not identify with any of these races and consequently do not have an accurate box to check on the U.S. Census. Most of this immigrant population are forced to select White, if they do not opt to be count as "some other race" or "two or more races," in some cases. This lack of clarity on the U.S. Census is a vital catalyst contributing to the invisible health crisis of Arab Americans. Since Arab Americans are not properly accounted for, there cannot be research conducted with this population to evaluate specific health concerns and potential solutions. This national policy recommendation calls for the U.S. Census to include 'Southwest Asia and North Africa (SWANA)' as a tenth available category to select. Since the term will be new on the Census, they should also include all the countries of origin which fall under this category. This will assist Arab Americans in identifying the proper box to mark so that their voices may be accounted for. It is important to note that SWANA includes countries that are not identified as those of the Arab World, yet are identified as SWANA due to their geographic location. Thus, it is essential to keep Arabs visible by having an 'Arab' subcategory under SWANA, since this population is characterized by the national language of Arabic.

In addition, it would be beneficial to know which languages are most commonly spoken among our SWANA population. Since SWANA includes countries that do not have Arabic as

the national language. Unlike Arabs who have the Arabic language as their national language, other countries located within the SWANA region speak other languages including Turkish, Farsi, and Kurdish. By listing Arabic as a language on the US Census, data can be collected on Arab Americans. Overall, there is a dire need for more specific data across the board so that researchers can identify the needs of the Arab American population.

In addition to this policy change on the U.S. Census, another policy change which could start at a county level is culturally responsive/culturally sensitive training. In a policy brief from the regional office of Europe of the *World Health Organization,* proponents stated that health literacy responsiveness of health services and resources can be improved "through creation of a culturally competent workforce and provision of readily accessible information, for example in multiple languages and through outreach initiatives." For Arab Americans, it is important to have health care professionals who can accommodate their lack of English proficiency and cultural components. As mentioned in Almutairi (2020), language barriers affected the satisfaction of providers and patients. Thus, eliminating this barrier will allow Arabs to have better access to quality healthcare which will increase their overall health. To assist with the language barrier, hospitals and healthcare facilities can provide helpful tools, such as having translators available to communicate information from healthcare professionals to patients or even having important documents translated into their native language. By being culturally competent, health care providers will be better equipped to communicate with Arab Americans and will be more understanding of any cultural differences which may cause miscommunication of information.

In their study on the importance of cultural competency, White et. al (2019) demonstrated the positive effects of "developing cultural awareness, involving patients in communication and information sharing, and effectively working alongside professional

interpreters" was on overall patient care and patient satisfaction. The participants of their study "reported the reliance on family members and untrained staff, who were not skilled in interpreting medical terminology, was a barrier to accessing professional interpreters." Their findings further demonstrate the importance of having culturally competent healthcare workers on overall health outcomes for patients. In order to incentivize healthcare professionals to learn a second language or attend through culturally competent workshops/trainings, financial compensation should be provided for the individuals. Having culturally competent workers is important for overall positive health outcomes. For Arab Americans, having culturally competent healthcare workers who not only could communicate and explain health outcomes (i.e. diabetes), but also respect and understand their culture could assist with closing the gaps in the 'healthcare system', as showcased by the SDH framework.

PRACTICE RECOMMENDATIONS

To increase the overall health of Arab Americans, community-based efforts can take place. Through the findings of Saad et. al (2020), it became clear the lack of health literacy among Arab Americans. For example, the researchers found that only 7% of Arab Americans knew what the sigmoidoscopy was compared to the U.S. national average of 84.3%. This practice recommendation involves the collaboration of schools and communities. Within communities, schools can host informative workshops that can focus on a variety of common illnesses and diseases. These workshops can also be in partnership with local hospitals where medical professionals can come to the host school and educate the participants. Every month or every two weeks, depending on financial capacity, there can be a different illness or disease highlighted based on the commonality found among immigrant groups. For Arab Americans,

attending the workshop on diabetes could be extremely helpful so they are aware of what food choices could be contributing to their increased likelihood of having diabetes.

Hosting these events within the community increases the likelihood that these immigrants can walk to the school, especially if the school is within their zip code. Taking it one step further, these sessions can be available online via platforms like Zoom. If also hosted remotely using a platform such as Zoom, then Arab American immigrants would have more accessibility to these educational opportunities to learn what lifestyle changes can happen to lead a healthy life. With this Zoom function, participants have the option to activate closed captioning which would assist with following along with the presentation. When hosting these events, it will also be important to have interpreters present who can speak the native language of the immigrant, which in this case would be Arabic. If attending in person, participants would be able to receive headphones that would allow for them to hear the presentation in Arabic via an onsite translator. If they are participating virtually, Zoom has the capability to join a breakout room where they could also listen to the presentation in Arabic. If participants are unable to make the time of the presentation, the Zoom meeting can be recorded and uploaded to YouTube for viewing at a later time. By providing multiple access points to this valuable information, Arab Americans will be to be better equipped to make lifestyle changes which can prevent diseases, such as diabetes. They will also be able to develop health literacy and understand medical terminology they might hear in an office visit. Through this community-based approach, Arab Americans will have the social support and community engagement which falls under the SDH model. They will also have increased accessibility to the healthcare system by default through the gaining of medical terminology.

Another practice recommendation for Arab Americans is to have mobile clinics travel in metropolitan areas where they are heavily populated, such as Detroit, Los Angeles, and New York. Mobile clinics are other access points to receive healthcare in conjunction with gained health literacy from the community-based school events. Due to the simple fact that mobile clinics are satellite facilities to access healthcare, a larger demographic is able to be served. Mobile clinics are yet another way for patients to access services such as "primary care and screening, preventative specialty care, and social interventions" (Singh et. al, 2022). Through the option of mobile clinics, the barrier of transportation presented by the SDH model is removed. Since the mobile clinics would be coming to the communities, the patients would not have to travel far to receive care. As supported by Singh et. al (2022), mobile clinics "remove the potential healthcare barrier of transportation for those who do not have a reliable source, and increase the convenience of healthcare access for the population who may have a reliable source of transportation." Not only do mobile clinics provide the possible removal of the transportation barrier, but it also can assist with decreasing the fear of deportation, which may be present amongst immigrant populations.

In conjunction with mobile clinics, interpreters are going to be a crucial part in making sure Arab Americans are able to communicate their questions or health to their health care providers and ensuring they are accurately receiving information from their health care providers. As mentioned in policy recommendations, cultural competency is another added layer which will allow these mobile clinics to be optimally successful. As previously mentioned, there are some cultural factors such as the patriarchal idea where only males can receive the information for the household. Understanding these cultural differences and accommodating them in their capacity will allow for Arab Americans to receive optimal health care. The idea of

mobile clinics is primarily based on accessibility. If one were to look at the American Red Cross, they have mobile clinics where one can donate blood. By doing so, it removes the transportation barrier for people wanting to donate blood. Using this model can be applied successfully to the accessibility for Arab Americans as well. Research could be conducted to see the effectiveness of these proposed mobile clinics and use the data conducted in these metropolitan areas as their study groups.

RESEARCH RECOMMENDATIONS

Overall, more data is needed on specific illnesses or diseases among Arab Americans. There are few studies which can be connected to one another regarding a specific health issue for Arab Americans. Since there is little to no research on Arab Americans as a whole, it becomes difficult to address and examine them on a microscopic level. Not only is there a lack of research, but the framework which is currently utilized does not meet the needs of Arab Americans as a minority group. As demonstrated, most available research is conducted through the lens of a cultural framework which tends to problematize cultural practices and ignores structural equities faced by communities. There must be research conducted on Arab American health from a structural framework perspective. Only researching Arab American health from a cultural framework diminishes the assessment of structural influences which contribute to poor Arab American health. As Arab Americans are classified as 'White', they are placed in a structurally violent category which "encompasses social forces that perpetuate harm, producing and reproducing inequities in health" (Abboud et. al, 2019). This inequity leads to trauma as their health disparities remain undocumented.

If the U.S. Census includes SWANA as a category as well as language, this can assist researchers in identifying the Arab American population, allowing more specific studies to be conducted. For example, one could examine the effectiveness of mobile clinics on overall health of Arab Americans as a broad question. More specifically, it would be interesting to see multiple data findings which correspond to one another on issues like cancer or diabetes. This is not to say that there is *no* research at all because there have been studies which are examined in the scope of this paper. However, cross-referencing data is important to understanding the true underlying issues of Arab American health and what can be done at a microscopic level to increase Arab American health. More research could also be conducted to evaluate the effect of immigration on Arab American health. In other research targeting Latino immigrants, a fear of deportation affected their health. Is the same true for Arab Americans? These type of research questions could help better understand Arab Americans as a whole and better assess the optimal ways to improve their health.

CONCLUSION

Arab Americans make up roughly 3.7 million of the population but have a scant amount of research focusing on their health. Consequently, it is important to use the research which exists regarding specific health outcomes for Arab Americans and apply them to the Social Determinants of Health Framework. By doing so, one can put together the pieces to create a larger picture which can evaluate the health outcomes of Arab American immigrants. Exploring how these different aspects can be applied to overall health of Arab American immigrants can help research expand through more specific health risks and diseases. For example, one can study how diabetes, a health outcome explored in this paper, stems from all six aspects of the Social Determinants of Health Model. The same can be done for asthma, hypertension, and/or even cancer. As Arab Americans are finally given a box to check on the Census which reflects their race and language, as opposed to 'White' previously, the United States will be able to provide more accurate numbers of our Arab American population. Having these more accurate numbers will allow for more data collection and studies to be conducted which would accurately reflect the population. Moreover, specific policy and practice recommendations include mobile clinics, partnering with local school districts, among other recommendations.

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